

orientation + resource toolkit

for mental health planning and advisory councils



produced by



the national association of mental health planning and advisory councils



the national technical assistance center for state mental health planning of the national association of state mental health program directors

funded by



the center for mental health services

introduction

The National Association of Mental Health Planning and Advisory Councils (NAMHPAC) and the National Technical Assistance Center for State Mental Health Planning (NTAC) of the National Association of State Mental Health Program Directors (NASMHPD) have jointly produced this Orientation Toolkit to provide mental health planning and advisory council (PAC) members with a thorough understanding of the roles, responsibilities, and possibilities of planning and advisory councils. We extend our thanks to the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA) for funding this project.

The overall goal of this toolkit, and all of our projects, is to improve the services delivered to persons living with mental disorders by improving the planning, evaluation, and monitoring of these services by stakeholders. We affirm the common sense notion that persons affected by the mental health system, including consumers, parents, and family members, must be true partners in the planning and oversight of mental health services.

This toolkit is intended to be used both as a foundation for new member orientation to the workings of PACs, and as an ongoing information resource and reference for current planning council members. The first part of the toolkit includes a review of the federal law, an explanation of PAC mandates, and examples of how some councils have organized themselves to meet these responsibilities. The second part of this toolkit contains background information related to planning councils, along with suggestions about the kinds of resources that your state mental health authority will make available to you. As a companion to the toolkit, a brief video is available that provides a glimpse into the important work accomplished by mental health planning and advisory councils.

It is our hope that this toolkit will become a valuable resource for your planning council not only for new member orientation, but also for ongoing reference as you perform your important work. We welcome your comments, suggestions, and feedback and wish you well in your endeavors to improve the lives of those affected by the mental health system. The respective organizations outlined above are available to offer technical assistance to your planning council, and information about our programs is included in the resource section of this binder.

Please note that all of the materials in the toolkit, except where noted, are in the public domain and may be reproduced and distributed by your PAC.

some tips for planning an orientation session

This Toolkit has been designed to accomplish four goals:

- Impart information.
- Increase participation.
- Engender hope and possibility about the work of planning councils.
- Build cohesion among planning council members.

We think that these are the general goals that should guide all orientation efforts. We offer the following tips to help guide your planning and implementation of an orientation session.

Orientation Planning

First impressions tend to last a long time. If you are taking the time to host an orientation session, you probably realize this. In order to ensure that new members feel comfortable and benefit from orientation, you may want to consider the following:

- Make the date, time and location convenient for the target audience, your new members.
- Do not limit attendance only to new members. All members of the council benefit from a review of the planning council mandate, bring a variety of experiences and have the opportunity to build mentoring relationships.
- Keep it real and practical. Don't forget that you are doing this for the planning council, focus on what they need to know and why it is important.
- Use a variety of formats during the day, including formal presentations, print, group discussion, and brainstorming, as well as video and other multimedia platforms.
- You should explain how planning council meetings are run (*Robert's Rules of Order*, etc.) as well as any other policies and guidelines that are important for new members to know for effective participation.
- New members should be encouraged to bring questions or concerns about the current mental health delivery system for discussion or action by the larger council. This helps build a sense of action and recognizes that new people have something to contribute to the planning council.

acknowledgements

The *Orientation and Resource Toolkit for Mental Health Planning and Advisory Councils* was written by Charles Ingoglia, the National Association of Mental Health Planning and Advisory Councils' executive director. Direction and oversight of the project was provided by an advisory committee comprised of planning council and state representatives. We are indebted to the advisory committee members for their invaluable contributions to this project: Monica Anthony, Missouri; Samuel Awosika, Washington, DC; Rebecca Miles, South Carolina; Leila Salmon, New York; Lois Smith, Mississippi; Teri Toothman, West Virginia; and Andrew Zeiser, Nevada. Susan Flanigan, Gail Hutchings, and Paul Musclow of the National Association of State Mental Health Program Directors managed the production of the Toolkit. Project support provided by Melanie Lewis of the National Association of Mental Health Planning and Advisory Councils. Design and layout provided by the Center for Educational Design and Communication, Washington, DC.

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orientation materials

History and Purpose of Planning Councils

Mental health planning and advisory councils (PACs) exist in every State and U.S. Territory because of the passage of federal law 99-660 in 1986, continuing through Public Law 101-639 and Public Law 102-321 in 1992. These federal laws require States and Territories to perform mental health planning in order to receive federal Mental Health Block Grant funds. These laws further require that stakeholders, including mental health consumers, their family members, and parents of children with serious emotional or behavioral disturbances, must be involved in these planning efforts through membership in the PAC.

States are required to submit yearly applications to receive federal block grant funds. This application is known as the Block Grant Plan. The Mental Health Block Grant program is administered by the Center for Mental Health Services (CMHS), which is an agency of the Substance Abuse and Mental Health Services Administration (SAMHSA). The objective of Public Law 102-321 and block grant planning, in general, is to support the State creation and expansion of comprehensive, community-based systems of care for adults with serious mental illness and children with serious emotional disturbance.

The block grant is a formula grant awarded to States based upon an allotment calculated for each fiscal year by a legislated formula. Awards are made in response to the States' applications and to the implementation reports submitted by the States for the previous fiscal year.

State applications are developed with input from the State mental health planning and advisory councils and must address the need for services among special populations, such as individuals who are homeless and those living in rural areas. The goal of the Mental Health Block Grant program is to help individuals with serious mental illnesses lead independent and productive lives. The block grant program has served as an impetus in promoting and encouraging States to reduce the number of people receiving care in State psychiatric hospitals, and to develop community-based systems of care.

Federal Legislation

In this section, we will attempt to summarize the sections of the federal legislation that deal with the duties of the planning council, and later we describe the information that must be included in the State plan.

Membership Composition

As stated previously, Public Law 102-321 is very clear about the composition of mental health planning councils. The federal law (42 USC [United States Code] § 300x-3 [c]) states that planning councils must contain the following people:

- Representatives from the following State agencies: Mental Health, Education, Vocational Rehabilitation, Criminal Justice, Housing, Social Services, and the State Medicaid Agency.
- Public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services.
- Adults with serious mental illness who are receiving (or have received) mental health services.
- Families of such adults and families of children with serious emotional disturbance.

Note: The ratio of parents of children with serious emotional disturbance to other members of the council must be sufficient to provide adequate representation of such children.

Most importantly, the law states that at least 51% of the members should be affiliated with constituency groups other than providers of services or State employees.

Duties of the Membership

The federal law states that the planning council is expected to do the following (see § 300-x [b]):

- 1 To review the Mental Health Block Grant Plan and to make recommendations.
- 2 To serve as an advocate for adults with a serious mental illness, children with a serious emotional disturbance, and other individuals with mental illnesses.
- 3 To monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

Duty 1

To review the Mental Health Block Grant Plan and to make recommendations.

States are required to submit yearly applications to receive block grant funds. This application is known as the Block Grant Plan. The plans are evaluated according to the criteria established in federal law and explained in the application form. The criteria for the block grant are described on pages 5 and 6 of this toolkit. The Block Grant Plan must be accompanied by a cover letter from the Chair of the planning council indicating that members of the planning council have reviewed and commented on the plan. Additionally, States are required to submit to CMHS all comments from the planning council regarding the Block Grant Plan.

Ideally, planning is a continuous process and not something that begins upon the release of the application form. Furthermore, we recommend that planning councils be involved in all aspects of the planning process. The planning council and the State should develop a planning timeline that clearly identifies all required tasks and corresponding responsibilities, with planning council roles clearly articulated. This type of timeline should be developed by the State mental health planner and the planning council at the beginning of the year and include target dates and opportunities for participation.

Current federal law stipulates a yearly planning process with rather strict implementation guidelines. The Center for Mental Health Services allows States to submit two and three year plans, but these plans must meet the implementation guidelines established in the federal law. According to this law, States are evaluated on the complete implementation of the Block Grant Plan. If States are found to be out of compliance with this requirement, the federal government has the authority to withhold a portion of the mental health block grant money from the State.

With this said, true system change necessitates a longer planning and implementation time frame. The relationship between planning, budgeting, implementation, and evaluation requires a long-range, strategic form of planning. Many States engage in a strategic planning process in addition to the planning associated with the block grant. You will find a brief overview of strategic planning with suggestions for obtaining additional information later in this toolkit. Additionally, copies of State strategic plans can be obtained from the NAMHPAC or NTAC offices.

Duty 2

To serve as an advocate for adults with a serious mental illness, children with a serious emotional disturbance, and other individuals with mental illnesses.

The membership requirements of PACs are designed to ensure broad stakeholder representation and input into the planning, evaluation, and monitoring of mental health services. Many stakeholders are motivated by their own, or a family member's, involvement with the mental health system. The planning council provides a forum for a variety of advocacy interests to work together to effect change.

Advocacy, which is defined as to "speak on behalf of" or to "argue for" a person, a group, an action, or a cause, comprises a wide range of activities. Advocacy is often associated with visible activities on behalf of a cause, such as letter writing, working with the media, educating decision makers, and in extreme circumstances, public demonstration. Advocacy also embraces the act of learning more about a topic or issue and sharing that information with family, friends, and colleagues, or supporting a cause through community service. The very act of serving on a planning council is a form of advocacy.

There is great variability among planning councils in the way advocacy is accomplished. The federal mandate provides no guidance on this matter, nor does it impose limits on the ways that the planning council can choose to act on its advocacy mandate. In the end, each planning council needs to decide how it wants to organize itself in order to accomplish this important function. In the examples that follow, we highlight the advocacy activities of a sampling of planning councils.

Example 1

Some planning councils have interpreted the mandate for advocacy to involve legislative monitoring and action. Many planning councils are called upon to testify at legislative hearings, or before other State, regional, and local bodies concerned with mental health service delivery or appropriations. Some planning councils produce white papers on issues of importance within their mental health system, such as the lack of communication between the criminal justice system and mental health system, the needs of children with serious emotional disturbance, or other important issues. This type of advocacy can also be expressed in position papers, press releases, and other forms of formal communication from the planning council.

Example 2

One mental health planning council has developed a comprehensive legislative monitoring system. Planning council members volunteer to research and track bills related to mental health and to report to the planning council should bills need amendments or to recommend that the planning council take a position on a particular bill. The council maintains an automated, online bill tracking service to facilitate this process. This is a highly developed and intense form of legislative advocacy that may be beyond your council's current capacities. However, it serves to show what is possible for PACs in the area of advocacy.

Example 3

Another mental health planning council has engaged in advocacy in several different ways. One of the most successful activities of the council has involved developing a positive relationship with the State Mental Health Administration. The planning council demonstrated an ability to influence the legislative process in a way that was advantageous to the Mental Health Administration. This helped create a foundation of trust and mutual respect. The planning council then convinced the State that all advisory groups concerned with mental health issues should be subsumed under the planning council, thus ensuring that the planning council is the foremost body asked to represent mental health issues within the State. Formerly separate advisory organizations are now accounted for in the committee structure, and the planning council has positioned itself as a leader within the mental health community. The Medicaid Capitation Committee of the planning council wrote a concept paper/proposal for the creation of an independent, mental health specific ombudsman program in the State. During the two years that it took for the Office of the Ombudsman to be established, the planning council kept the pressure on and ultimately met with success.

Planning councils may also wish to consider working in coalition with other advocacy organizations and reform movements within their State. Ideally, the planning council meeting should be the forum where a diversity of reform activities in the State are discussed. Some planning councils have found it helpful to establish a standing advocacy committee that discusses public policy issues and current events. This committee also develops action items related to these issues and presents recommendations to the entire council.

Duty 3

To monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state.

This is, perhaps, the most difficult task facing planning councils because of the broadness of the mandate and the resources, time, and energy that it requires. We do not know of any State that has been found out of compliance for not fulfilling this part of the PAC mandate. However, many PACs are not even aware that evaluation and monitoring are part of its responsibility.

Based on this, there are several efforts underway in this area and new models and information are becoming available everyday. There are a variety of ways that planning councils can approach this task, ranging from designing new initiatives to taking advantage of existing programs.

There are a few planning councils that have approached this task in creative ways.

Example 1

In one southern State, the mental health planning council participated in the Peer Review Team visitation of their State's 15 community mental health centers and two state hospitals. The Adult Community Services Peer Review team has established a process for assessing the strengths and weaknesses of community programs from the perspective of primary consumers, family members, and community mental health service providers, thus establishing a monitoring process that also provides technical assistance at the community level.

Example 2

Another mental health planning council has partnered with the Office of Behavioral Health Services in creating a process and instruments for the evaluation and allocation of federal block grant monies. This process includes the review of program requests for funding and recommendations for fund allocation from the planning council. Once funding decisions are made, the planning council also partners with the State to conduct on-site utilization review of public mental health service providers.

Although there are some examples of planning councils that have created new initiatives, evaluation is not a process that the planning council must approach on its own. There are several national initiatives funded by the Center for Mental Health Services that can be of use to planning councils for their evaluation activities. These initiatives include the following:

The Mental Health Statistics Improvement Program (MHSIP)

This program seeks to build the capacity for uniform, comparable statistical information about mental health services to enable broad-based research on systems of care and models for service delivery. Most notable in this project was the development and implementation of a consumer-focused mental health report card for managed care that is in use in many States. You may want to find out if your State is using the MHSIP report card and how the data is being utilized to monitor and evaluate services.

The 16- State Pilot Indicator Project

This is a grant program from the Center for Mental Health Services operating in 16 States. The purpose of these grants is to pilot 32 selected performance indicators in participating States. This grant effort stems from the growing need to have information on the performance of existing mental health systems and services for improved planning. Part of this program focuses on the development of common performance indicators across participating States that will allow for the comparison of similar data. This program requires stakeholder input and the planning council should be aware of developments in the project. The States participating in this project include: Arizona, Colorado, Connecticut, Illinois, Indiana, Missouri, New York, Oklahoma, Rhode Island, South Carolina, Texas, Utah, Vermont, Virginia, Washington, and Washington DC.

NAMHPAC hopes to survey planning councils regarding the level of activity in the evaluation and monitoring of mental health services. Once complete, this survey will enable the identification of promising practices in evaluation that will be replicable by other planning councils.

Criteria for Mental Health Block Grant Plan

States are required to submit yearly applications to receive block grant funds. This application is known as the Block Grant Plan. The Block Grant Plan is evaluated according to the 12 criteria established in Federal Law 102-321, section 1912(b).

States may choose to consolidate the 12 criteria into five. Both options are presented here for your information.

<i>Five Consolidated Criteria (Optional)</i>	<i>Twelve Original Criteria (Required)</i>
<p><i>Criterion 1:</i> Establish a comprehensive community-based mental health service system</p> <ul style="list-style-type: none"> • Establishment and implementation of comprehensive community-based mental health service system • Reduction of hospitalization • Description of available services and resources in a comprehensive system of care, including case management 	<p><i>Criterion 1:</i> The plan provides for the establishment and implementation of an organized community-based system of care for adults with an SMI and children with an SED</p> <p><i>Criterion 3:</i> The plan describes available services, available treatment options, and resources (including federal, State, and local public services and resources and, to the extent practicable, private services and resources) to be provided for adults with an SMI and children with an SED</p> <p><i>Criterion 4:</i> The plan describes health and mental health services, rehabilitation services, employment services, housing services, educational services (including services to be provided by local school systems under the Individuals with Disabilities Education Act), medical and dental care, and other support services to be provided to enable adults with an SMI and children with an SED to function outside inpatient and residential institutions to the maximum extent of their capacities with federal, State, and local public and private resources</p> <p><i>Criterion 6:</i> The plan provides for activities to reduce the rate of hospitalization of adults with an SMI and children with an SED</p> <p><i>Criterion 7:</i> The plan requires the provision of case management services for each adult with an SMI and child with an SED who receives substantial amounts of public funds or services</p>
<p><i>Criterion 2:</i> Estimate the prevalence and treated prevalence of mental illness</p> <ul style="list-style-type: none"> • Establish quantitative targets for services • Estimate prevalence rates of serious mental illness (SMI) and serious emotional disturbance (SED) 	<p><i>Criterion 2:</i> The plan contains quantitative targets to be achieved in the implementation of the mental health system, including the number of adults with a SMI and children with an SED residing in the areas to be served under each system</p> <p><i>Criterion 11:</i> The plan contains the estimate of the incidence and prevalence in the State of SMI among adults and SED among children</p>

<i>Five Consolidated Criteria (Optional)</i>	<i>Twelve Original Criteria (Required)</i>
<p><i>Criterion 3:</i> Establish management information systems</p> <ul style="list-style-type: none"> • Identify financial resources, staffing, and training • Estimate the manner in which the State intends to expend the Block Grant funds 	<p><i>Criterion 5:</i> The plan describes financial resources and staffing necessary to implement the plan, including programs to train individuals as providers of mental health services, with emphasis on training of providers of emergency health services regarding mental health</p> <p><i>Criterion 12:</i> The plan contains a description of the manner in which the State intends to expend the grants for the fiscal year involved to carry out the provisions of the plan</p>
<p><i>Criterion 4:</i> Identify targeted service to homeless and rural populations</p> <ul style="list-style-type: none"> • Describe outreach efforts and services to homeless • Describe service provision to rural areas 	<p><i>Criterion 8:</i> The plan provides for the establishment and implementation of a program of outreach to and services for adults with an SMI and children with an SED who are homeless</p> <p><i>Criterion 10:</i> The plan specifies the manner in which mental health services will be provided to adults with an SMI and children with an SED residing in rural areas</p>
<p><i>Criterion 5:</i> Specify provisions of children's service</p> <ul style="list-style-type: none"> • Describe comprehensive community-based service for children with SED 	<p><i>Criterion 9:</i> The plan provides for the establishment and implementation of an integrated system of social, educational, juvenile, and substance abuse services that together with health and mental health services for children with an SED will be provided in order for such children to receive care appropriate for their multiple needs. The plan provides for the establishment of a defined geographic area for the provision of the services of such system, which will include services provided under the Individuals with Disabilities Education Act. (The Block Grant funds for the fiscal year involved will not be expended to provide any service of such services.)</p>

How to be an Effective PAC Member

This Toolkit focuses on the duties, responsibilities and possibilities of planning and advisory councils in improving the planning, evaluation and delivery of mental health services. The potential of planning councils is only realized through the active involvement of individual members. For those new to planning councils, we highlight some strategies for making sure your voice is heard and for advancing the effectiveness of your planning council.

Even though mental health systems are recognizing more and more the importance of stakeholder oversight, many barriers prevent mental health consumers, family members and parents from participating in policy and decision making. There are now resources designed for and by these groups to help insure an active voice for stakeholders.

The National Mental Health Consumers' Self-Help Clearinghouse has prepared a *Self-Advocacy Technical Assistance Guide* that helps mental health consumers identify and develop strategies for overcoming obstacles they face. Many of the principles discussed in this curriculum are relevant to mental health planning councils in their work. Information on contacting the Clearinghouse is located in the resources section of this toolkit. Below we highlight some self-advocacy strategies.

The most important principle in self-advocacy is the belief that you are someone worth advocating for. Once you believe in yourself it is often possible to be more assertive. Sometimes our moods may prevent us from being as assertive as we need to be, or sometimes there is a fear of reprisal or punitive measures.

A very simple first step to becoming assertive is to ask the question, "why?" when confronted with conditions or situations that do not seem to make sense. This lesson is as important in mental health planning as it is in service delivery.

Very often our reasons for becoming involved in mental health advocacy stem from our own or a family members involvement with the mental health system. At its worst, the mental health system can be fragmented and unresponsive to the needs of vulnerable persons. Sometimes these kinds of experiences lead to anger, which if not directed appropriately may actually make self-advocacy and appropriate assertiveness difficult. Use your anger appropriately to motivate actions, but control it so that it does not become a liability to your efforts.

The National Consumer-Supporter Technical Assistance Center located at the National Mental Health Association has published a booklet titled, *How to Develop and Maintain a Consumer Advisory Board* that contains these tips:

General Expectations

- **Know your PAC's mission, purposes, goals, policies, strengths and needs.** Review the material in the orientation manual, and ask questions about things that do not make sense to you. Find another member of the council that you feel comfortable asking questions of and find out about the work and functioning of the planning council.
- **Bring good will and a sense of humor to the PAC's deliberations.** Things will not always go as hoped. It is important to be persistent and to demand what is right, but do not let little things keep you from addressing the important issues.

Meetings

- **Prepare for and participate in all PAC and committee meetings.** Read materials that are sent out ahead of time. Ask questions of the chair or other committee members if things do not make sense to you. Learn where you can get answers to your questions. Take advantage of the resources listed in this toolkit.
- **Complete assignments on time and present results as requested.** You want people to take you seriously and to know that you are a valuable member of the planning council, this is better accomplished through actions and example.
- **Feel comfortable asking questions; other people are probably wondering the same thing.** By asking questions you are indicating your interest in the work of the planning council and also that you do not just accept what people are telling you.

- **Make an effort to know the larger mental health community.** Attend community meetings and events as time allows. The planning council is but one avenue for change in the mental health system and it needs the information from the larger mental health community to make the best decisions possible.
- **Know your organization or constituency.** Make a point to share information with the PAC about your constituents' work and vice versa. If you represent a particular interest group make that perspective known, but try not to become myopic. The goal of planning councils is to make recommendations that are good for all of the persons and populations served by the mental health system.
- **If you have a topic that you wish to bring to the agenda,** follow through to make sure that it is addressed. Talk with other PAC members and the chair to have it placed on the agenda.

Having expectations for your own involvement on the planning councils does not absolve others of theirs. In general, the planning council and the state mental health administration must make a commitment to making the planning council effective. There are some generally agreed upon components that make stakeholder participation meaningful, they include:

- cultural competency;
- on-going training;
- on-going logistical support and child-care support;
- adequate and timely information and staff support to allow for in-depth consideration of complex issues;
- open meetings, on a regular schedule, and in a location and setting convenient and welcoming to PAC members;
- open meetings fostering meaningful and respectful dialogue among PAC members and decision makers;
- broad dissemination of minutes and reports to PAC members; and
- staff follow-up to assure that PAC members are informed of the results of meetings and that the results are effectively disseminated for maximum impact.
- As more outcome data and consumer report card results becomes available, this information needs to be disseminated in a timely manner to PAC members, and used as a tool in the planning, evaluation and monitoring processes.
- Organizational development activities need to be given a priority to increase board effectiveness.

Strategic Planning: An Overview

The information on strategic planning is taken in large part from the FAQs (Frequently Asked Questions) section of the Alliance for Nonprofit Management's web page. For more detail on strategic planning, or other nonprofit development issues, please visit their site at <http://www.allianceonline.org>. You can reach the Alliance by dialing 202.955.8406.

The FAQs were inherited from Support Centers of America (SCA), following a merger between SCA and Nonprofit Management Association (NMA), and are now a product of the Alliance for Nonprofit Management.

What is strategic planning?

Strategic planning is a management tool, period. As with any management tool, it is used for one purpose only: to help an organization do a better job – to focus its energy, to ensure that members of the organization are working toward the same goals, to assess and adjust the organization's direction in response to a changing environment. In short, strategic planning is a disciplined effort to produce fundamental decisions and actions that shape and guide what an organization is, what it does, and why it does it, with a focus on the future. (Adapted from Bryson's *Strategic Planning in Public and Nonprofit Organizations*.)

A word-by-word dissection of this definition provides the key elements that underlie the meaning and success of a strategic planning process:

The process is strategic because it involves preparing the best way to respond to the circumstances of the organization's environment. Whether or not its circumstances are known in advance, nonprofits often must respond to dynamic and even hostile environments. Being strategic, then, means being clear about the organization's objectives, being aware of the organization's resources, and incorporating both into being consciously responsive to a dynamic environment.

The process is about planning because it involves intentionally setting goals (i.e., choosing a desired future) and developing an approach to achieving those goals.

The process is disciplined in that it calls for a certain order and pattern to keep it focused and productive. The process raises a sequence of questions that helps planners examine experience, test assumptions, gather and incorporate information about the present, and anticipate the environment in which the organization will be working in the future.

Finally, the process is about fundamental decisions and actions because choices must be made in order to address the issues mentioned above. The plan is ultimately no more, and no less, than a set of decisions about what to do, why to do it, and how to do it. Because it is impossible to do everything that needs to be done in this world, strategic planning implies that some organizational decisions and actions are more important than others – and that much of the strategy lies in making the tough decisions about what is most important to achieving organizational success.

The strategic planning can be complex, challenging, and even messy, but it is always defined by the basic ideas outlined above – and you can always return to these basics for insight into your own strategic planning process.

Strategic Planning and Long-Range Planning

Although many use these terms interchangeably, strategic planning and long-range planning differ in their emphasis on the "assumed" environment. Long-range planning is generally considered to mean the development of a plan for accomplishing a goal or set of goals over a period of several years, with the assumption that current knowledge about future conditions is sufficiently reliable to ensure the plan's reliability over the duration of its implementation.

On the other hand, strategic planning assumes that an organization must be responsive to a dynamic, changing environment (not the more stable environment assumed for long-range planning). Certainly a common assumption has emerged in the nonprofit sector that the environment is indeed changeable, often in unpredictable ways. Strategic planning, then, stresses the importance of making decisions that will ensure the organization's ability to successfully respond to changes in the environment.

Strategic Thinking and Strategic Management

Strategic planning is only useful if it supports strategic thinking and leads to strategic management – the basis for an effective organization. Strategic thinking means asking, "Are we doing the right thing?" Perhaps, more precisely, it means making that assessment using three key requirements about strategic thinking: a definite purpose be in mind; an understanding of the environment, particularly of the forces that affect or impede the fulfillment of that purpose; and creativity in developing effective responses to those forces.

It follows, then, that strategic management is the application of strategic thinking to the job of leading an organization. Dr. Jagdish Sheth, a respected authority on marketing and strategic planning, provides the following framework for understanding strategic management: continually asking the question, "Are we doing the right thing?" It entails attention to the "big picture" and the willingness to adapt to changing circumstances, and consists of the following three elements:

- 1 Formulation of the organization's future mission in light of changing external factors such as regulation, competition, technology, and customers.
- 2 Development of a competitive strategy to achieve the mission.

3 Creation of an organizational structure that will deploy resources to successfully carry out its competitive strategy.

Strategic management is adaptive and keeps an organization relevant. In these dynamic times it is more likely to succeed than the traditional approach of "if it ain't broke, don't fix it."

What are the basic steps in a strategic planning process?

Strategic Planning Model

Many books and articles describe how best to do strategic planning, and many go to much greater lengths than this planning response sheet, but our purpose here is to present the fundamental steps that must be taken in the strategic planning process. Below is a brief description of the five steps in the process. These steps are a recommendation, but not the only recipe for creating a strategic plan; other sources may recommend entirely different steps or variations of these steps. However, the steps outlined below describe the basic work that needs to be done and the typical products of the process. Thoughtful and creative planners will add spice to the mix or elegance to the presentation in order to develop a strategic plan that best suits their organization!

Step One: Getting Ready

To get ready for strategic planning, an organization must first assess if it is ready. While a number of issues must be addressed in assessing readiness, the determination essentially comes down to whether an organization's leaders are truly committed to the effort, and whether they are able to devote the necessary attention to the "big picture." For example, if a funding crisis looms, the founder is about to depart, or the environment is turbulent, then it does not make sense to take time out for strategic planning effort at that time.

An organization that determines it is indeed ready to begin strategic planning must perform five tasks to pave the way for an organized process:

- Identify specific issues or choices that the planning process should address.
- Clarify roles (who does what in the process).
- Create a Planning Committee.
- Develop an organizational profile.
- Identify the information that must be collected to help make sound decisions.
- The product developed at the end of the step one is a workplan.

Step Two: Articulating Mission and Vision

A mission statement is like an introductory paragraph: it lets the reader know where the writer is going, and it also shows that the writer knows where he or she is going. Likewise, a mission statement must communicate the essence of an organization to the reader. An organization's ability to articulate its mission indicates its focus and purposefulness. A mission statement typically describes an organization in terms of its:

- **Purpose:** why the organization exists, and what it seeks to accomplish.
- **Business:** the main method or activity through which the organization tries to fulfill this purpose.
- **Values:** the principles or beliefs that guide an organization's members as they pursue the organization's purpose.

Whereas the mission statement summarizes the what, how, and why of an organization's work, a vision statement presents an image of what success will look like. For example, the mission statement of the Support Centers of America is as follows:

The mission of the Support Centers of America is to increase the effectiveness of the nonprofit sector by providing management consulting, training, and research. Our guiding principles are: promote client

independence, expand cultural proficiency, collaborate with others, ensure our own competence, and act as one organization.

We envision an ever-increasing global movement to restore and revitalize the quality of life in local communities. The Support Centers of America will be a recognized contributor and leader in that movement.

With mission and vision statements in hand, an organization has taken an important step towards creating a shared, coherent idea of what it is strategically planning for.

At the end of step two, a draft mission statement and a draft vision statement is developed.

Step Three: Assessing the Situation

Once an organization has committed to why it exists and what it does, it must take a clear-eyed look at its current situation. Remember that part of strategic planning, thinking, and management is an awareness of resources and an eye to the future environment, so that an organization can successfully respond to changes in the environment. Situation assessment, therefore, means obtaining current information about the organization's strengths, weaknesses, and performance – information that will highlight the critical issues that the organization faces and that its strategic plan must address. For planning councils this means compiling information in the mental health system. These could include a variety of primary concerns, such as funding issues, new program opportunities, changing regulations or changing needs in the client population, and so on. The point is to choose the most important issues to address. The Planning Committee should agree on no more than five to ten critical issues around which to organize the strategic plan.

The products of step three include: a database of quality information that can be used to make decisions and a list of critical issues that demand a response from the organization – the most important issues the organization needs to deal with.

Step Four: Developing Strategies, Goals, and Objectives

Once an organization's mission has been affirmed and its critical issues identified, it is time to figure out what to do about them: the broad approaches to be taken (strategies) and the general and specific results to be sought (the goals and objectives). Strategies, goals, and objectives may come from individual inspiration, group discussion, formal decision-making techniques, and so on – but the bottom line is that, in the end, the leadership agrees on how to address the critical issues.

This can take considerable time and flexibility: discussions at this stage frequently will require additional information or a reevaluation of conclusions reached during the situation assessment. It is even possible that new insights will emerge that change the thrust of the mission statement. It is important that planners are not afraid to go back to an earlier step in the process and take advantage of available information to create the best possible plan.

The product of step four is an outline of the organization's strategic directions – the general strategies, long-range goals, and specific objectives of its response to critical issues.

Step Five: Completing the Written Plan

The mission has been articulated, the critical issues identified, and the goals and strategies agreed upon. This step essentially involves putting all that down on paper. Usually one member of the Planning Committee, the Executive Director, or even a planning consultant will draft a final planning document and submit it for review to all key decision makers (usually the board and senior staff). This is also the time to consult with senior staff to determine whether the document can be translated into operating plans (the subsequent detailed action plans for accomplishing the goals proposed by the strategic plan) and to ensure that the plan answers key questions about priorities and directions in sufficient detail to serve as a guide. Revisions should not be dragged out for months, but action should be taken to answer any important questions that are raised at this step. It would certainly be a mistake to bury conflict at this step just to wrap up the process more quickly, because the conflict, if serious, will inevitably undermine the potency of the strategic directions chosen by the Planning Committee.

The product of step five is a strategic plan!

What should a strategic plan include?

The Draft and Review Process

First of all, who actually writes the plan? Remember that one or two individuals do writing most efficiently, not by a whole group – the writer simply crafts the presentation of the group's ideas. Often an Executive Director will draft the plan, or the task may be delegated to a staff person, board member, or a consultant who has been working with the planning committee. In the end, it really does not matter who writes the strategic plan; what matters is that it accurately documents the decisions made, that it represents a shared vision, and that it has the support of those responsible for carrying it out.

That is why the process of review and approval is the most important consideration in this step – much more so than who does the writing. The planners should decide in advance who may review and respond to the draft plan; obviously committee members will participate in the review process, but should the full board and the full staff? The guiding principle of participation in the strategic planning process is that everyone who will help execute the plan should have some input into shaping it; whether or not this includes review of the final drafts of the plan is a judgment call that really depends upon the particular circumstances of an organization.

Ideally, the big ideas have been debated and resolved so that revisions only amount to small matters of adding detail, revising format, or changing some wording in a particular section. Still, if reviewers get bogged down in crossing too many t's and dotting too many i's, the plan could linger in draft form forever. The Planning Committee must exercise leadership in setting a realistic time frame for the review process and in bringing the process to a timely close: the committee needs to choose the level of review appropriate for the organization, provide copies for review to the selected individuals, and set a deadline for submitting feedback (usually allowing one to two weeks is sufficient). Upon receiving all the feedback, the committee must agree on which suggested revisions to accept, incorporate these into the document, and submit the strategic plan to the full board of directors for approval.

Standard Format for a Strategic Plan

A strategic plan is simply a document that summarizes, in about ten pages of written text, why an organization exists, what it is trying to accomplish, and how it will go about doing so. Its "audience" is anyone who wants to know the organization's most important ideas, issues, and priorities: board members, staff, volunteers, clients, funders, peers at other organizations, the press, and the public. It is a document that should offer edification and guidance – so, the more concise and ordered the document, the greater the likelihood that it will be useful, that it will be used, and that it will be helpful in guiding the operations of the organization. Below is an example of a common format for strategic plans, as well as brief descriptions of each component listed, which might help writers as they begin trying to organize their thoughts and their material. This is just an example, however, not the one and only way to go about this task. The point of the document is to allow the best possible explanation of the organization's plan for the future, and the format should serve the message.

Table Of Contents

The final document should include a table of contents. These are the sections commonly included in a strategic plan:

I. Introduction by the President of the Board

A cover letter from the president of the organization's board of directors introduces the plan to readers. The letter gives a "stamp of approval" to the plan and demonstrates that the organization has achieved a critical level of internal agreement. (This introduction is often combined with the Executive Summary below.)

II. Executive Summary

In one to two pages, this section should summarize the strategic plan: it should reference the mission and vision; highlight the long-range goals (what the organization is seeking to accomplish); and perhaps note the process for developing the plan, as well as thank participants involved in the process. From this summary, readers should understand what is most important about the organization.

III. Mission and Vision Statements

These statements can stand alone without any introductory text, because essentially they introduce and define themselves.

IV. Organization Profile and History

In one or two pages, the reader should learn the story of the organization (key events, triumphs, and changes over time) so that he or she can understand its historical context (just as the Planning Committee needed to at the beginning of the planning process).

V. Critical Issues and Strategies

Sometimes organizations omit this section, choosing instead to "cut to the chase" and simply present goals and objectives. However, the advantage of including this section is that it makes explicit the strategic thinking behind the plan. Board and staff leaders may refer to this document to check their assumptions, and external readers will better understand the organization's point of view. The section may be presented as a brief outline of ideas or as a narrative that covers several pages.

VI. Program Goals and Objectives

In many ways the program goals and objectives are the heart of the strategic plan. Mission and vision answer the big questions about why the organization exists and how it seeks to benefit society, but the goals and objectives are the plan of action – what the organization intends to "do" over the next few years. As such, this section should serve as a useful guide for operational planning and a reference for evaluation. For clarity of presentation, it makes sense to group the goals and objectives by program unit if the organization has only a few programs; if some programs are organized into larger program groups (e.g., Case Management Program in the Direct Services Program Group), the goals and objectives will be delineated at both the group level and the individual program level.

VII. Management Goals and Objectives

In this section, the management functions are separated from the program functions to emphasize the distinction between service goals and organization development goals. This gives the reader a clearer understanding both of the difference and the relationship between the two sets of objectives, and enhances the "guiding" function of the plan.

VIII. Appendices

The reason to include any appendices is to provide needed documentation for interested readers. Perhaps no appendices are truly necessary (many organizations opt for brevity). They should be included only if they will truly enhance readers' understanding of the plan; not just burden them with more data or complicating factors.

planning council members

This is the location for the most current copy of the planning council's membership roster. Whenever a new roster is circulated we suggest that you place a copy here for quick reference.

officers + committee rosters

This is the location for officers' job descriptions, committee rosters and committee charges. It is helpful to keep this information current.

officers + committees

Many planning councils share work by establishing officers and committees. These structures are not mutually exclusive, nor are they the only way to organize to accomplish work. They are, however, the most commonly used methods and therefore we provide some information on their structure and use.

The NAMHPAC office has officer job description and committee charges from a variety of planning councils. Please contact us to obtain these samples.

Officer Job Descriptions

In PACs, as in life, the best way to avoid problems is to have very clear expectations about roles, accountabilities, and resources. Additionally, members should understand and agree upon the ways in which roles and accountabilities are evaluated. We recommend that PACs develop very specific job descriptions for chairs, at a minimum, and ideally for all officers.

Following are some suggestions for job descriptions drawn from the National Center for Nonprofit Boards:

Chair

- Oversee board and executive committee meetings.
- Serve as ex-officio member of all committees.
- Work in partnership with the planner to make sure council resolutions are carried out.
- Call special meetings if necessary.
- Appoint all committee chairs and with the planner, recommend who will serve on committees.
- Assist in preparing agenda for council meetings.
- Assist in conducting new member orientation.
- Work with the nominating committee to recruit new council members.
- Act as a spokesperson for the council.
- Periodically consult with members on their roles and help them assess their performance. From, *The Role of the Board Chairperson*. Washington, DC: National Center for Nonprofit Boards, 1993.

Vice-Chair

- Attend all council meetings.
- Serve on the Executive Committee.
- Understand the responsibilities of the Chair and be able to perform these duties in the Chair's absence.
- Participate as a vital part of the planning council leadership.

Secretary

- Attend all council meetings.
- Serve on the Executive Committee.
- Maintain all planning council records and ensure their accuracy and safety.
- Review meeting minutes.
- Assume responsibilities of the Chair in the absence of the Board Chair, Chair-Elect, or Vice-Chair.
- Provide notice of meetings of the council and/or of a committee when such notice is required.

Committees

Effective committees can be one of the most important working forces at the heart of an organization. The purpose and objectives of a committee may be clear and concise, but as with any group of people trying to achieve a common goal, many other factors will determine whether or not the committee will in fact succeed in accomplishing its task.

Do We Need a Committee?

There are several basic reasons for setting up committees that are common to all regardless of the tasks they are to complete:

- Responsibilities are shared.
- More members become involved.
- Specialized skills and areas of interest, including children's mental health, advocacy, evaluation, managed care, etc., can be used to the group's best advantage.
- Inexperienced members gain confidence while serving on a committee.
- Matters may be examined in more detail by a committee.
- The planning council is able to complete its business more efficiently by delegating some work to committees.

When to Establish Committees

Unless the purpose of a committee can be stated in writing, the committee is probably unnecessary. If a committee is proposed, the following questions should be answered in developing its terms of reference:

- What is the purpose of the committee?
- What are the responsibilities and limitations?
- What are the specific tasks?
- When should the job be completed and what type of report is expected?
- What is the role of officers and how is the membership decided?
- What is the term of office for members, methods of filling vacancies, and appointment of the Chair?
- What is the authority of the committee?
- What resources are needed? What resources are already available?

It is the responsibility of the planning council, usually through the Chair or Executive Committee, to define committee purpose, limitations, and responsibilities. These written terms of reference should be included in the by-laws or recorded via the motion that created the committee. Names of members of standing committees should also be documented. All written reference to committees is then made available to members and readily accessed by the organization.

Types of Committees

There are two basic kinds of committees:

Standing

These committees are created by the by-laws of the planning council. They exist and function more or less on a permanent basis, e.g., children's mental health, managed care, evaluation, membership, diversity, etc.

Ad Hoc

These committees are appointed for a particular purpose on a short-term basis, in response to an immediate need, crisis, or opportunity within the State.

Both types of committees may form subcommittees if the workloads are very heavy or complex in nature.

Tips for Effective Committees

Selection

Selecting committee members is most effective if consideration can be given to skills, interest, and size of the group. Five to nine people on a committee are best for most situations.

Orientation

The committee Chair orients the members as to the purpose of the committee and expectations of the organization. Structure of the committee, reporting procedures, roles, and responsibilities are clearly defined. Individual member's expectations should also be brought out at this time.

The committee Chair is the "key leader" of all committee work. This person should be selected after careful consideration by the planning council. Choose someone who is interested and can work easily with others. The Chair's role is not necessarily one of bringing technical expertise to the group. (The fact that a person is a good membership salesman does not mean that he or she will be good at chairing the membership committee.) The Chair must be organized and know how to organize both programs and people. He or she must know how to involve others – the experts and the workers – and to motivate them to do the work of the committee.

Other responsibilities of the committee Chair include:

- Preparing and presenting committee reports to the council.
- Ensuring that a successor is "groomed" to assume the Chair's role sometime in the future.
- Setting agendas, calling meetings, and soliciting input from all members.

The planning council Chair must orient the committee Chair. Do it honestly! "Take the job, there's nothing to it" is unwise, unproductive, and untrue!

Reporting

Committee reports should be included as agenda items for general meetings. Usually the committee Chair presents the report. Specific recommendations should be listed at the end of the report. Conciseness is essential; otherwise, the time saved by referring the business to a committee may be negligible. The report should clearly indicate, however, that full discussion was held and all options considered. If it does not, the organization may suspect that the committee "missed something." A sample committee report from the Tennessee Planning Council is attached as a reference.

Motions dealing with the report, usually made by the committee chair, are:

- To receive a report: This is a common motion if no specific recommendations are made or no action is required or desired.
- To adopt a report: If the report is adopted then any recommendations contained become decisions of the planning council and imply that action is to be taken. The responsibility, both legal and otherwise, becomes that of the planning council.

Signs of a Committee Functioning Well

- Purpose of the committee is clear to all.
- Careful time control: length of meetings as well as development of overall committee time path.
- Sensitivity within to each other's needs; good communication among all members.
- An informal, relaxed atmosphere.
- Good preparation on part of the Chair and members.
- Interested, committed members.

- Minutes are complete and concise.
- Periodic self-assessment of committee's performance.
- Recognition and appreciation are given to members so that they feel they are really making a contribution.
- The work of the committee is accepted and makes a valuable contribution to the organization.
- Committees, if structured properly, can be an important tool in expanding the scope and effectiveness of the planning council. Careful attention must be given to composition, purpose, and expected outcomes of the committee. Planning councils are advised that thoughtful preparation will result in better outcomes.

bylaws + operating procedures

This is the location for the planning council's bylaws and any operating or policies and procedures.

bylaws + operating procedures

Many planning councils have developed bylaws that describe the work, structure and accountabilities of the planning council. Some planning councils also have operating policies that further spell out functions described in the bylaws.

NAMHPAC staff has collected bylaws from a number of states that are useful for comparison purposes. Please contact the NAMHPAC office at 703.838.7522 to obtain copies of bylaws from other planning councils.

We have also included bylaws from a State planning council to illustrate the structure and purpose of bylaws. These bylaws are presented for informational purposes only and are not meant to be proscriptive for other planning councils.

Bylaws Of The [Insert State Name] Mental Health Planning And Advisory Council

Article I - Name

The name of this unincorporated association shall be the [Insert State Name] Mental Health Planning and Advisory Council (the "Council").

Article II - Purpose

The purposes of the Council shall be: (1) to exchange information and develop, evaluate and communicate ideas about mental health planning, (2) to write and/or amend the Federal Mental Health Services Block Grant plan for mental health services in the State of [Insert State Name] and recommend the plan to the [Insert State Name] state government, (3) to advise the [Insert State Name] state government concerning proposed and adopted plans affecting mental health services provided or coordinated by the state and the implementation thereof, (4) to monitor, review and evaluate the allocation and adequacy of mental health services in [Insert State Name] and to advise the [Insert State Name] state government concerning the need for and quality of services and programs for persons with mental illness in the state, and (5) to develop and take advocacy positions concerning legislation and regulations affecting mental health.

Article III - Membership

Section 1. Qualification

Council membership composition shall follow the guidelines set forth in P.L. 102-321 and any subsequent federal regulations pertaining to council membership. Status as a "provider" of mental health services shall be determined by the Council, upon recommendation of the Nominating/Membership Committee. Such determination shall be made upon recommendation of appointment by the Council and may be changed upon receipt of new or changed information. In order to facilitate such determination, applicants for and members of the Council shall be required to disclose to the Nominating/Membership Committee any work regularly performed for pay as or for a provider of mental health services.

- (a) Organizations or individuals that spend ___% or more of their budget or paid time providing mental health services shall be considered as providers.
- (b) Volunteers and advisory and governing board members shall not be considered as providers solely because of such status.
- (c) Under general ethical principles, members of the Council shall recuse themselves when they have a direct financial stake in the outcome of a Council decision, independent of their status as a provider.

Section 2. Appointment

Membership shall be by appointment of the Governor/Executive Director of the [Insert State Name] Department of Human Services or (_____) or their designee. From time to time, the Council may rec-

ommend appointment of new members or removal of existing members. Failure of the Executive Director or designee to veto such recommendation within thirty days of mailing shall constitute approval of the recommendation.

Section 3. Meetings

Regular meetings of the Council shall be held on [insert day, time and location, e.g.: the second Friday of each month from 9:00 a.m. through 12:00 noon at the Fort Logan Mental Health Institute], unless changed by the Council or the Chair. Special meetings of the Council may be called at any time by the Chair or by any (____) members.

Section 4. Notice

The call for regular or special meetings of the Council shall be published by mailing an agenda to all of the members at least 7 days prior to any such meeting, and not more than 60 days prior to any such meeting.

Section 5. Quorum

A quorum of the Council shall exist if (____)% or more of the total members as of the day prior to the meeting are present. A majority (____)% of the members present is required for any action of the Council.

Section 6. Powers

The Council shall have all of the powers vested in it by virtue of these Bylaws, together with any other reasonable and necessary powers to carry out the purposes of the Council. The Council may commit the Council, but not the state of _____ or any member, concerning any matter within the purpose of the Council.

Section 7. Open Meetings

All meetings of the Council shall be open to the public. A reasonable period shall be set aside at all meetings of the Council for members of the public to address the Council. Members of the public shall be permitted to propose "new business" for the next meeting of the Council. Subject to veto by the Council, such new business shall be placed on the next Council meeting agenda.

Section 8. Alternates; Abstention

There shall be no proxies for meetings of the Council. However, state employees and members of advocacy organizations who are designated as members by virtue of their office or advocacy organization representation may appoint a designated alternate to attend meetings in their stead, and such alternate may cast a vote upon presentation of a written appointment signed by the member. No Council member may abstain in any matter not involving a conflict of interest for that member, and all non-voting members who do not declare a conflict shall be counted as affirmative votes.

Section 9. Rules of Order

In all procedural matters not governed by these Bylaws, the Council shall be bound by the provisions of *Robert's Rules of Order*, Newly Revised (1990). But the Council may, by the vote of two-thirds of a quorum of the Council present at a meeting of the Council, suspend any provision of these Bylaws or of *Robert's Rules*, at any time, whether or not such suspension is on the call.

Section 10. Amendment of Bylaws

These bylaws may be amended by the Council at any time, provided that any such potential amendment is noticed as provided in Section III. 4, above, ordered published by a majority of a quorum of the Council, published in final form by a notice as provided in Section III. 4 above, and approved by a majority of a quorum of the Council present at a meeting held after publication in final form, without any substantive amendment.

Section 11. Compensation

The members of the Council shall serve without pay, but the Council may authorize or recommend the payment of reasonable and necessary expenses incurred by members in the performance of their duties.

Article IV - Officers

Section 1. Fiscal Year; Terms

The Council shall use the same fiscal year as the State. The officers of the Council shall consist of a Chair, who shall be, elected by the council, appointed by the Executive Director of the [Insert State Name] Department of Human Services, the Governor or designee from a list of three nominees presented by the Council, and a Vice Chair, who shall be elected by the members at the first meeting of the Council following the appointment of a Chair. Each officer shall serve for two years or until such person ceases to be qualified to serve as an officer. Each officer shall hold office until his or her successor shall have been duly appointed or elected, as set forth above.

Section 2. Nominations

Nominations for positions as officers may be made by: (a) submitting an application to the Nominating Committee appointed by the Council which reviews applications and makes recommendations to the Council for three nominees for the position of Chair and for at least one nominee for the position of Vice Chair; or (b) nominations from the floor. Nominees receiving a majority vote for the available vacancies shall be declared nominated or elected, as set forth in Section 1, above. Cumulative voting shall not be permitted for either nomination or election of officers. The low vote getter, plus ties, shall be eliminated at each round of voting until two nominees remain for each position for which a nomination or election is required. Each position, including each of the three nominees for the post of Chair, shall be voted on separately.

Section 3. Duties of Chair

The Chair shall be the parliamentary chair of the Council. It shall be the duty of the Chair to preside over all meetings of the Council, and, subject to the control of the Council, to supervise and control all of the business affairs of the Council. The Chair shall be an ex-officio member of all committees. The Chair shall see that all motions and resolutions of the Council are carried into effect.

Section 4. Removal

An officer may be removed by the Council whenever in its judgment the best interests of the Council would be served thereby, but such removal shall be without prejudice to such officer's position as a member. Any officer may resign at any time by giving written notice to the Council. Removal may occur only at a properly called meeting of the Council, after at least thirty days notice to the person proposed to be removed.

Section 5. Vacancy

A vacancy shall exist whenever an officer is removed, resigns, dies, or ceases to be a member of the Council. A vacancy in the office of Chair shall be filled by the Executive Director of the [Insert State Name] Department of Human Services or designee for the remainder of the term, using the same procedure set forth in Sections 1 and 2 above. A vacancy in the office of Vice Chair shall be filled by the Council for the remainder of the term.

Section 6. Agenda; Executive Committee

After consultation with the Vice Chair, the immediate past Chair, and the Director of Mental Health Services of the State of [Insert State Name], to the extent feasible, the Chair shall set the agenda for meetings of the Council and recommend action to the Council. Upon delegation by a majority of a quorum of the Council at a properly called meeting of the Council, including authorization of action on any matter otherwise properly before the Council, to the extent limited by such authorization, the Chair, the Vice Chair and the immediate past Chair of the Council may be constituted as an Executive Committee to make any other decision concerning the affairs of the Council in the interim between properly called meetings of the Council.

Section 7. Duties of Vice Chair

The Vice Chair shall, in the absence or disability of the Chair, perform the duties and exercise the powers of the Chair, and shall perform such other duties as the Council shall prescribe.

Article V - Committees

Section 1. Appointments

Except for the Nominating Committee, the Chair, in consultation with the Council, shall appoint all chairs and members of all sub-committees of the Council. The Nominating Committee shall be appointed by the Council.

Section 2. Standing Committees

The standing committees shall be as follows:

- (a) Nominating/Membership/Bylaws Committee: This committee shall be responsible for receiving and reviewing applications and nominating members to be members and officers of the Council. This committee shall include at least 5 members.
- (b) Mental Health Resources Group: This committee shall be responsible for budgetary advocacy on behalf of the Council.
- (c) Planning Committee: This committee shall be responsible for working with the Department of Mental Health in the development of the Federal Mental Health Services Block Grant Plan/or review and amend the state application.
- (d) Legislative/Regulatory Committee: This committee shall be responsible for reviewing and recommending to the Council positions on legislative and regulatory changes affecting mental health.
- (e) Children's Committee: This committee shall be responsible for coordinating information about children's mental health issues.
- (f) Capitation Committee: This committee shall be responsible for coordinating information about capitation and managed care for mental health services.
- (g) Others as determined by the Council: e.g., older adults, hospital based services, etc.

Section 3. Powers

The committees shall have the power and authority to make decisions only as may be specifically assigned by a majority of a quorum of the Council at a properly called meeting of the Council. Chairs shall be responsible for keeping minutes of committee meetings and for reporting activities to the Council.

Section 4. Other Committees

Other committees may be appointed by the Chair as the Council shall from time to time deem necessary or expedient to carry on the business of the Council. The members are encouraged to suggest and to serve on committees in order to further the activities of the Council.

Section 5. Removal

The chair or any member of any committee may be removed for willful misconduct by a majority of a quorum of the Council at any time at a properly called meeting of the Council.

Article VI - Anti-Discrimination

The Council shall not discriminate in any regard with respect to race, creed, color, sex, sexual orientation, marital status, religion, national origin, ancestry, pregnancy, parenthood, custody of a minor child or physical or mental disability.

Approved by the [Insert State Name]

Mental Health Planning and Advisory Council:

Date:

Signed by the Members:

Approved:

Executive Director

[Insert State Name] Dept. of Human Services or other state authority

state information

Information on the Mental Health System

In this section of the toolkit you may wish to include resources that describe your state's mental health system. This is the place to include such information as:

- Names and contact information of staff that work with the planning council;
- Mental Health Department's organizational charts;
- Mental Health Department's telephone directory;
- Strategic plan for the Mental Health Department;
- Names and contact information of mental health advocacy organizations in the state; and
- Other documents relevant to mental health service delivery/policy in your state.

acronyms + glossary

acronyms + glossary

Mental health advocacy as well as participation in mental health planning councils can sometimes be made more difficult by the use of unfamiliar terms and acronyms. In this section we attempt to provide an overview of some of the common (and not so common) words and phrases associated with mental health service delivery and policy. Your state may have its own list of words and phrases used in the mental health arena. If they do, please include it in this section of the toolkit.

Glossary of Healthcare Reform Terms

From the National Mental Health Association

Access

The ability to obtain desired healthcare. Access is more than having insurance coverage or the ability to pay for services. It is also determined by the availability, acceptability, cultural appropriateness, location, hours of operation, transportation and cost of services.

Accreditation

The process by which an organization recognizes an institution as meeting predetermined standards.

Actuary

A person trained in the insurance field who determines policy rates, reserves and dividends, as well as conducts other statistical and financial studies.

Administrative Services Organization (ASO)

An arrangement under which an insurance carrier or an independent organization will, for a fee, manage claims, benefits and other administrative functions for a public or private sector client.

Alternative Delivery Systems

A phrase used to describe all forms of health care delivery except traditional fee-for-service, private practice and inpatient hospitalization. The term may also include HMOs, PPOs, IPAs and other systems of providing healthcare.

Allowable Costs

Charges for services rendered or supplies furnished by a mental health professional that qualify as covered expenses.

Ambulatory Care

All types of health services that are provided on an outpatient basis, in contrast to services provided in the home or in hospitals.

Benefits

The health care services provided under terms of a contract by an MCO or other benefits administrator.

Capitation

A dollar amount established to cover the cost of all health care services delivered per person during a specified period of time. This term may refer to either the amount paid to an MCO by its private and public sector clients or a negotiated per capita rate to be paid periodically to a health care provider by an MCO. The MCO or provider is then responsible for delivering or arranging the delivery of all health services required by the covered person under the conditions of the contract.

Carve-In

A model of delivering and financing healthcare services in which mental health and/or substance abuse services are provided under the same delivery system as physical healthcare; the integration of behavioral healthcare and physical healthcare.

Carve-Out

The practice of having a specific benefit, such as mental health or substance abuse, operated as a distinct program, separate from the general health program.

Case Management

The process of having a person's healthcare needs coordinated by using an ongoing plan.

Case Manager

A clinician who works with consumers, providers and insurers to coordinate services. This term also is applied to MCO employees who conduct utilization review.

Categorically Needy

A term that describes the group of individuals that states are generally required to cover under Medicaid in order to receive Federal funds. This group includes people who receive assistance through Temporary Aid for Needy Families (TANF) and Supplemental Security Income (SSI), as well as other Federally assisted income maintenance payments.

Clinical Criteria

Criteria by which managed care organizations decide whether a specific treatment setting is the appropriate level of care for a given consumer.

Closed Panel

A managed healthcare arrangement in which covered persons are required to select providers only from the plan's participating providers. Also called an Exclusive Provider Organization (EPO).

Community Mental Health Center (CMHC)

Community-based, mental healthcare centers that provide a variable range of services, including inpatient, outpatient, emergency, partial hospitalization, consultation, education, case management, drop-in centers and vocational rehabilitation programs.

Continuum of Care

The availability of a broad range of treatment services so that care can be flexible and customized to meet a consumer's needs.

Contract Discounts

An economic incentive offered to consumers to encourage them to use providers belonging to a group or organization preferred by a health plan. Usually, the out-of-pocket expenses incurred by the patient are reduced.

Copayment

A cost-sharing arrangement in which a consumer pays a specified charge for a specified service (e.g., \$10 for an office visit). The consumer is usually responsible for payment at the time the service is rendered.

Covered Expenses

Hospital, medical and other healthcare expenses paid for under a health insurance policy.

Deductible

A specified amount of money a consumer must pay before insurance benefits begin. Usually expressed in terms of an annual amount.

Discounted Fee for Service

A contracted payment rate that is discounted from the provider's customary fee. This agreement may be between the MCO and the provider or between the consumer and the provider.

Drug Formulary

A listing of medications that consumers may readily access through their health plans. Non-formulary medications may not be accessible or may be accessible only if prior authorization is obtained. Often, the medications on the formulary tend to be the cheapest, rather than the most effective.

Drug Utilization Review (DUR)

Efforts to control drug utilization and costs by a facility or a health plan. Common methods include the use of a formulary (see above), substitution of generic products for more expensive name brands and encouraging use of drugs that will trigger rebates or discounts.

Dual Eligible

An individual who qualifies for health benefits under two plans, such as Medicare and Medicaid, simultaneously.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

A program that covers physical and mental health screening and diagnostic services to Medicaid recipients under the age of 21. Federal law requires that the treatment of a mental or physical illness discovered during an EPSDT screen must be covered, even if that state's Medicaid plan does not normally cover those services.

Employee Assistance Program (EAP)

Preventive employer-sponsored services designed to assist employees and their families in addressing both workplace and personal problems before they affect workforce productivity.

Employee Retirement Income Security Act (ERISA)

Enacted in 1974, this is a group of Federal statutes that, among other things, prohibits states from regulating the employee welfare benefit plans, including health plans, of self-insured businesses. ERISA does, however, establish certain regulations related to reporting and disclosure, fiduciary standards, claims review and enforcement. It also provides limited protection against discrimination to ERISA health plan participants.

Enrollment

The total number of covered persons in a health plan. The term also refers to the process by which a health plan signs up groups and individuals for membership or the number of enrollees who sign up in any one group.

Exclusive Provider Organization (EPO) See Closed Panel.**External Quality Review Organization (EQRO)**

States are required to contract with an entity that is external to and independent of the State and its managed care contractors to perform a review of the quality of services at least annually.

Fee-For-Service (FFS)

A system through which doctors, hospitals and other providers are paid a specific amount for each service performed as identified by a claim for payment.

Fee Schedule

A listing of fees or allowances for specific procedures which usually represents the maximum amount the program will pay for specific procedures.

Gag Clause

A clause within a contract that restricts the ability of a provider to discuss treatment options with a consumer that may be beneficial but are not covered by the health plan.

Gatekeeper

An arrangement in which a primary care provider determines when a consumer may have access to specialty care, such as to a mental health clinician or service.

Group or Network HMO

An HMO that contracts with one or more independent group practices to provide services to its members.

Health Care Financing Administration (HCFA)

The agency within the U.S. Department of Health and Human Services that oversees the Medicaid and Medicare programs. There are also regional HCFA offices throughout the country, with each responsible for working with a group of states.

Health Maintenance Organization (HMO)

An entity that provides, offers or arranges for coverage of designated health services needed by members for a fixed, prepaid premium. There are three basic models of HMOs: group model, individual practice association (IPA) and staff model.

HEDIS

The Health Plan Employer Data and Information Set is a set of performance measures developed to assess the quality of managed care across public and private sectors. It is a product of the National Committee on Quality Assurance.

Health Insuring Organization (HIO)

An entity that contracts on a prepaid, capitated risk basis to provide comprehensive health services to recipients.

Hospital Affiliation

A contract between an MCO and a hospital in which the hospital agrees to provide inpatient benefits to the MCO's beneficiaries according to terms negotiated and a (usually discounted) payment schedule.

Individual Practice Association (IPA) Model HMO

A network of providers that contracts as an entity to provide health care services in return for a negotiated fee. The individual practice association, in turn, compensates its participating clinicians on a per capita, fee schedule or other agreed basis.

Institution for Mental Diseases (IMD)

A facility of more than 16 beds in which at least 50 percent of the residents have a primary diagnosis of a mental illness. IMDs cannot receive Medicaid funds for services to persons ages 22-64.

Insolvency

A legal determination occurring when a contracted entity no longer has the financial capacity to meet its contractual obligations.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

A private, not-for-profit organization that evaluates and accredits hospitals and other healthcare organizations that provide mental healthcare, home care, ambulatory care and long-term care services.

Legal Reserves

The minimum reserve that an entity must keep to meet future claims and obligations, as calculated under the state insurance code. The reserve amount is usually determined by an actuary.

Long-term Care

A range of healthcare services that are regularly used over a long period of time; sometimes over the course of a lifetime. Residence-based services, such as nursing home care, are one of the most common forms of long-term care and are what most individuals and policy makers have in mind when they speak of this type of care.

Managed Behavioral Healthcare Organization (MBHO)

An MCO that specializes in the management, administration and/or provision of behavioral healthcare benefits.

Managed Care

A term used to describe a set of tools to control costs primarily through resource allocation, volume discounts and service utilization limitations.

Managed Care Organization (MCO)

An entity that is contracted to administer the cost controlling tools listed under the definition of managed care.

Medicaid

A nationwide health insurance program, adopted in 1965, for eligible disabled and low-income persons. It is administered by the Federal government and participating states. The program's costs, paid for by general tax revenue, are shared by the Federal and state governments.

Medical Necessity

The determination that a specific health care service is: medically appropriate; necessary to meet a consumer's health needs; consistent with the diagnosis; the most cost-effective option; and consistent with clinical standards of care.

Medically Needy

A term used to describe the population covered under a state's Medicaid program, but not through the Federally mandated categorically needy group. This group of Medicaid eligible individuals varies from state to state, but it is generally comprised of people for whom the cost of medical care is greater than the ability to pay for those services.

Medicare

A nationwide, federally administered program that covers the costs of hospitalization, medical care and some related services for elderly and select other individuals. Medicare has two parts: Part A generally covers inpatient costs; and part B primarily covers outpatient costs.

Medicare+Choice

An expansion of the traditional Medicare program that will augment the fee-for-service and HMO health plans currently available to participants to include a variety of new managed care and fee-for-service options. It will also strengthen a limited number of consumer protections. The plan is scheduled to begin in January 1999.

Medicare Supplement Policy (Medigap)

A policy that pays coinsurance, deductibles and copayments for Medicare recipients. It also guarantees additional coverage for services up to a predefined benefit limit (the portion of the cost of services not covered by Medicare).

Mental Health Statistics Improvement Program (MHSIP)

A project, funded and coordinated through the U.S. Center for Mental Health Services, in which individuals, organizations, state government agencies and associations are working to improve the information management capacity to support decision making in meeting the needs of persons with mental health disorders. The goal of MHSIP is to implement uniform, integrated mental health data collection systems. One of the program's premier accomplishments has been the production of The MHSIP Consumer-Oriented Mental Health Report Card, which is a prototype consumer-oriented report card developed to assess the quality and cost of mental health and substance abuse services.

National Committee on Quality Assurance (NCQA)

A private, not-for-profit organization that assesses and accredits managed care organizations, including managed behavioral health organizations.

Network Model HMO

A healthcare model in which the HMO contracts with more than one physician group or IPA, and may contract with single and multi-specialty groups that work out of their own office facilities. The network may or may not provide care exclusively for the HMO's members.

Network Provider

A healthcare professional or facility that is part of the managed care organization's (MCO's) network and has a contractual arrangement to provide services to the MCO's covered members.

Ombudsman

A person or program responsible for investigating and seeking to resolve consumer complaints. An ombudsman should also collect and analyze information that will enable health plans to correct systemic problems in collaboration with consumers, clinicians, purchasers and regulators.

Open Access

A term describing a consumer's ability to self-refer for specialty care. Open access arrangements allow a consumer to see a participating provider without a referral from a gatekeeper. This is also called open panel.

Open Enrollment Period

A period during which consumers have an opportunity to select among health plans, usually without evidence of insurability or waiting periods.

Outcomes Measure

A tool that systematically evaluates the impact that services have on the health and mental health of consumers and their families. The measure typically focuses on functioning issues.

Out-of-Pocket Expenses

Costs borne by the consumer that are not covered by a healthcare plan.

Outpatient Prescription Drug Program

A program that provides prescription drug services on an outpatient basis.

Peer Review

The evaluation of the quality of the services provided by a plan's clinical staff by equivalently trained clinical personnel.

Peer Review Organization (PRO)

An organization established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) to review quality of care and appropriateness of admissions, readmissions and discharges for Medicare and Medicaid.

Performance Measure

An indicator to help determine the quality of services provided by the health plan, facility or clinician. Many are process measures, such as how many times a phone rings before it is picked up, rather than outcomes measures that deal with a consumer's functioning.

Pharmaceutical Benefits Manager (PBM)

An entity that is responsible for managing prescription benefits.

Point-Of-Service (POS)

A health plan arrangement in which consumers may choose to receive a service from a participating or a non-participating provider or facility. Generally, the level of coverage is reduced, or the consumer pays more out-of-pocket, for services associated with the use of non-participating providers.

Practice Guidelines

Statements on medical practice that assist physicians and other professionals in developing treatment plans for specific conditions.

Preferred Provider Organization (PPO)

An organized network of healthcare providers, typically reimbursed on a discounted fee-for-service basis. Coverage may or may not be available outside of the network for a higher copayment.

Premium

Money paid in advance for insurance coverage.

Prepaid Health Plan (PHP)

An entity that either contracts on a prepaid, capitated risk basis to provide services that are not risk-comprehensive services, or contracts on a non-risk basis. Additionally, some entities that meet the above definition of HMOs are treated as PHPs through special statutory exemptions.

Prepayment

A method of paying for the cost of health care services in advance of their use.

Primary Care Provider (PCP)

The provider that serves as the initial interface between the consumer and the healthcare system. The PCP is usually a physician, selected by the consumer upon enrollment, who is trained in one of the primary care specialties and who coordinates the treatment of consumers under his/her care.

Primary Care Case Management (PCCM)

A Primary Care Case Management program is a Freedom of Choice Waiver program under the authority of section 1915(b) of the Social Security Act. States contract directly with primary care providers to be responsible for the provision and/or coordination of medical services to Medicaid recipients under their care. Currently, most PCCM programs pay the primary care physician a monthly case management fee, in addition to fee-for-service payment.

Prior Authorization/Approval

A cost-control procedure in which a payor requires a service to be approved for coverage in advance of delivery.

Program for All-Inclusive Care for the Elderly (PACE)

A federally initiated program for elderly persons that is funded with both Medicaid and Medicare dollars. The program attempts to integrate the services that are traditionally divided between these two programs and is designed to assist elderly individuals who may qualify for nursing home placement, but who live in the community.

Qualified Medicare Beneficiary (QMB) Program

A public program that pays the premiums, deductibles and coinsurance for individuals who are on Medicare and at or below the Federal poverty level.

Quality Assurance

A formal methodology designed to assess the quality of services provided. Quality assurance includes formal review of care, problem identification, corrective actions to remedy any deficiencies and evaluation of actions taken.

Quality Improvement

Includes the functions listed under Quality Assurance, plus directs system enhancements on an ongoing basis.

Request For Proposals (RFP)

A request for bids to provide specific services, such as mental health benefits, to a specific population. They are issued by both public and private payors.

Senior Care Organization (SCO)

A Federal program designed to assist the dually eligible population by providing a wide range of medical and social services.

Specified Low-Income Medicare Beneficiary (SLMB) Program

A public program that pays a portion of Medicare premiums for those whose incomes are slightly above the Federal poverty level.

Staff Model HMO

This model employs physicians and other professionals to provide health care to its consumers. All premiums and other revenues accrue to the HMO, which compensates providers by salary.

Substance Abuse and Mental Health Services Administration (SAMHSA)

Under the U.S. Department of Health and Human Services, SAMHSA is responsible for improving the quality and availability of prevention, treatment and rehabilitation services for substance abuse and mental illnesses.

Supplemental Security Income (SSI)

A national income maintenance program for older and certain other Americans that guarantees a minimum income to those with insufficient financial resources.

Selective Serotonin Re-uptake Inhibitors

A widely used group of antidepressants, which includes such drugs as fluoxetine and paroxetine. Most used for treatment of depression, but individual members of the group have other, specialized uses eg. anxiety, panic disorder, obsessive compulsive disorder, eating disorders, and social phobia.

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)

The Federal law that created the current risk and cost contract provisions under which health plans contract with HCFA.

Temporary Assistance For Needy Families (TANF)

The Federal program that replaced Aid to Families with Dependent Children (AFDC) as the monthly cash assistance program for families with low incomes.

Utilization

The extent to which beneficiaries within a covered group use a program or obtain a particular service, or category of procedures, during a given period of time. Usually expressed as the number of services used per year or per 1,000 persons covered.

Utilization Management

The process of evaluating the medical necessity, appropriateness and efficiency of healthcare services against established guidelines and criteria.

Utilization Review (UR)

A formal review of healthcare services for appropriateness and medical necessity. UR may be conducted on a prospective, concurrent or retrospective basis.

Waiver

An agreement between the U.S. Health Care Financing Administration and a state that permits the state to deviate from Federal guidelines that dictate the administration of its Medicaid program. It is through a waiver, either an 1115 or 1915(b) waiver, that states have traditionally obtained approval to implement mandatory managed care programs for their Medicaid populations. However, state plan amendments, as spelled out in the Balanced Budget Act of 1997, have now essentially replaced the need for Federal waivers.

State Healthcare Reform Acronyms

From the National Mental Health Association

AAHC	Accreditation Association for Ambulatory Health Care
AABD	Aid to Aged, Blind, and Disabled
AAHA	American Association of Homes for the Aging
AAC	Actual Acquisition Cost
AAPCC	Adjusted Average Per Capita Cost
AAPI	American Accreditation Program Inc.
AARP	American Association of Retired People
AB	Aid to the Blind
ABC	Adjusted Billed Charge
ABMT	Autologous Bone Marrow Transplant
ABO	Accumulated Benefit Obligation
ACGME	Accreditation Council for Graduate Medical Education
ACHE	American College of Healthcare Executives
ACP	American College of Physicians
ACR	Adjusted Community Rate
ADA	Americans with Disabilities Act
ADL	Activities of Daily Living
ADME	Absorption, Distribution, Metabolism and Excretion Studies
ADR	Adverse Drug Reactions
ADRP	AIDS Drug Reimbursement Program
ADS	Alternative Delivery System
AFDC	Aid to Families with Dependent Children
A&G	Administration & General
AGPA	American Group Practice Association
AHA	American Hospital Association
AHCCS	Arizona Health Care Cost Containment System
AHCPR	Agency for Health Care Policy and Research
AHP	Accountable Health Plan
AHPB	Adjusted Historical Payment Basis
AHSA	American Health Security Act
AHSAB	American Health Security Advisory Board
AHQC	American Health Standards Board
AHQC	American Health Quality Council
AIM	Acuity Index Method

ALEC	American Legislative Exchange Council
AMA	American Medical Association
AMC	American Managed Center
AMCRA	American Managed Care and Review Association
AMCS	Automated Medical Coding System
AMGM	Aggregate Monthly Growth Model
AMP	Average Manufacture Price
AMPCA	American Managed Care Pharmacy Association
AMRRC	American Medical Review Research Center
AMSUS	Association of Military Surgeons of the United States
ANDA	Abbreviated New Drug Application
ANOVA	Analysis of Variance
ANSI	American National Standard Institute
AONFS	Access Oriented Negotiated Fee Service
APACHE	Acute Physiology and Chronic Health Evaluation
APC	Average Projected Cost
APG	Ambulatory Patient Group
AphA	American Pharmaceutical Association
APS	Ambulatory Patient Severity
APT	Admissions Per Thousand
APTD	Aid to the Permanently and Totally Disabled
ARCO'S	Automation of Reports and Consolidated Orders
ARF	Area Resource File
ARS	Advanced Record System
ART	Assistive Reproductive Technology
ASC	Ambulatory Surgical Center
ASCP	American Society of Consulting Pharmacists
ASHHRA	American Society of Healthcare Human Resource Administrators
ASHP	American Society of Hospital Pharmacists
ASHRM	American Society for Hospital Risk Management
ASO	Administrative Services Only
ASPA	American Society for Personnel Administration
AUC	Acceptance Utilization Control
AUR	Ambulatory Utilization Review
AVG	Ambulatory Visit Group
AWP	Average Wholesale Price

BCCH	Bipartisan Commission on Comprehensive Healthcare
BDPC	Breakthrough Drug Pricing Committee
BLS	Bureau of Labor Statistics
BNA	Biotech National Association
BPB	Based Plus Benefit
BTO	Biotechnology Industry Organization
CABG	Coronary Artery Bypass Graft
CBA	Cost Benefit Analysis
CBO	Congressional Budget Office
CBP	Country Based Plan
CCO	Coordinated Care Organization
CDF	Conservative Democratic Forum
CEA	Cost Effectiveness Analysis
CEAP	Clinical Efficacy Assessment Program
CFIS	Clinical Financial Information Systems
CFR	Code of Federal Regulations
CGMP	Current Good Manufacturing Practice
CH	Current Health
CHA	County Health Authorities
CHAMPUS	Civilian Health and Medical Program for the Uniformed Services
CHAP	Child Health Assurance Program
CHBI	Commission on Health Benefits and Integration
CHC	Comprehensive Health Centers
CHCS	Composite Healthcare Computer System
CHCT	Council on Healthcare Technology
CHO	Comprehensive Health Organization
CHP	Certified Health Plan
CHPA	Community Health Purchasing Alliance
CHSO	Comprehensive Health Services Organization
CIP	Competitive Incentive Program
CLIA	Certified Laboratory Institution Administration or Clinical Laboratory Improvement Amendments
CMC	Center for Medical Consumers
CMO	Case Management Organization
CMOPS	Consolidated Mail Out Pharmacy Service
CMP	Competitive Medical Plan

COB	Certificate of Benefit
COBRA	Consolidated Omnibus Reconciliation Act of 1986
COC	Certificate of Coverage
COGME	Council on Graduate Medical Education
CON	Certificate of Need
COPC	Community Oriented Primary Care
CORF	Comprehensive Outpatient Rehabilitation Facility
COTH	Council of Teaching Hospitals
CPI	Consumer Price Index
CPR	Comparative Performance Reports
CPRC	Customary Prevailing and Reasonable Charge
CPT	Current Procedural Terminology
CPU	Combined Provider Units
CQI	Continuous Quality Improvement
CRF	Certification Report Form
CRI	CHAMPUS Reform Initiatives
CSG	Council of State Governments
CWF	Common Working File (HCFA database)
CWW	Clinics Without Walls
DAW	Dispense As Written
DAWN	Drug Abuse Warning Network
DBPR	Decentralized Blanket Purchase Agreement
DCG	Diagnostic Cost Group
DEA	Drug Enforcement Agency
DEFRA	Deficit Reduction Act of 1984
DEMPACQ	Develop and Evaluate Methods for Promoting Ambulatory Care Quality
DES	Department of Economic Security
DHHS	Department of Health and Human Services
DHRS	Department of Health and Rehabilitation Services
DME	Durable Medical Equipment
DMSB	Defense Medical Standardization Board
DOS	Date of Service
DPR	Drug Price Review
DRGs	Diagnostic Related Groupings
DRR	Drug Regimen Review
DSS	Department of Social Services

DUE	Drug Use Evaluation
DUR	Drug Utilization Review
EAC	Estimated Acquisition Cost
EBRI	Employee Benefits Research Institute
ECI	Extended Care Facility
ECG	Echocardiography
ECG	Electronic Claims Management
ECRC	Enhanced Community Rating by Class
ED	Emergency Department
EEG	Electroencephalogram
EKG	Electrocardiogram
ELIC	Eligible Low-Income Children
EPO	Exclusive Provider Organizations
EPSDT	Early and Periodic Screening Diagnosis and Treatment
ER	Experience Rating
ERIS	Employee Resources Information Systems
ERISA	Employee Retirement Income Security Act/Federal Act of 1974
ESRD	End-Stage Renal Disease
ET	Expenditure Target
FAC	Freestanding Ambulatory Center
FAR	Federal Acquisition Regulation
FDA	Food and Drug Administration
FED	Front End Deductible
FEHBP	Federal Employee Health Benefits Program
FEP	Federal Employee Plan
FFD	Federal Financial Participation
FFS	Fee for Service
FI	Fiscal Intermediary
FICA	Federal Insurance Contributions Act
FMAP	Federal Medical Assistance Percentage
FMC	Foundations for Managed Care Pharmacy
FP	For Profit
FQHC	Federally Qualified Health Centers
FSS	Federal Supply Schedule
FTE	Full-Time Equivalents
FY	Fiscal Year

GAD	Government Affairs Division
GAO	Government Accounting Office
GATT	General Agreement on Tariffs and Trade
GDEA	Generic Drug Enforcement Act
GDR	Government Distribution Report
GEP	General Enrollment Period
GHAA	Group Health Associations of America
GHI	Group Health Institute
GHRI	General Health Rating Index
GMP	Good Manufacturing Practice
GNP	Gross National Product
GPC	General Price Ceiling
GPCI	Geographic Practice Cost Index
GPO	Group Purchasing Organization
GPWW	Group Practice without Walls
HA	Health Alliance
HBP	Hospital Based Plan
HCA	Health Care Authority
HCBS	Home and Community-Based Services
HCFA	Health Care Financing Administration
HCIN	Health Care Information Network
HCPP	Healthcare Prepayment Plan
HCTA	Health Care Technology Assessment
HEART	Health Equity and Access Reform Today Act
HEASB	Health Standard Board
HEDIS	Health Plan Employer Data and Information Set or HMO Employer Data and Information Set
HFMA	Healthcare Financial Management Association
HHA	Home Health Agency
HHS	Health and Human Services
HIAA	Health Insurance Association of America
HIB	Health Insurance Benefits or Hospital Insurance Benefit
HICN	Health Insurance Claim Number
HIM	Health Insurance Manual
HIMA	Health Industry Manufacturers Association
HIN	Health Insurance Network

HIO	Health Insuring Organizations
HIPC'S	Health Insurance Purchasing Cooperative
HIR	Health Insurance Regulation
HIRO	Health Insurance Regional Office
HISB	Health Insurance Standard Board
HIT	Home Infusion Therapy
HJR	House Joint Resolution
HMBI	Hospital Market Basket Index
HME	Health Marketing Executive
HMO	Health Maintenance Organization
HPA	Health Policy Agenda
HPB	Health Projection Branch
HPO	Hospital Physician Organization
HPPC	Health Plan Purchasing Cooperative
HPQ	Health Perspective Questionnaire
HQIA	Healthcare Quality Improvement Act
HRET	Hospitals Research and Education Trust
HRQOL	Health Related Quality of Life Scale
HRSA	Health Resources and Service Administration
HAS	Health Systems Agency or Health Supports and Appliances
HSQ	Health Status Questionnaire
HSQB	Health Standards and Quality Bureau
IBNE	Incurred but not Enough
IBNR	Incurred but not Reported
ICCS	International Classification of Clinical Services
ICF	Intermediate Care Facility
ICF-MR	Intermediate Care Facility for the Mentally Retarded
ICL	Independent Clinical Laboratory
ICU	Intensive Care Unit
IDS	Integrated Delivery System
IEP	Initial Enrollment Period
IG	Inspector General
HIS	Indian Health Service
IME	Indirect Medical Education
IND	Investigation New Drug
IOG	Illness Outcomes Group

IOM	Institute of Medicine
IP	Inpatient
IPA	Individual Practice Association
IPL	Independent Psychological laboratory
IPR	Independent Professional Review
IPS	Integrated Practice System
IQP	Institutes of Quality Program
IRB	Institution Review Board
ISC	Integrated Systems of Care
ISN	Integrated Service Network
IVF	In Vitro Fertilization
IVF-ET	In Vitro Fertilization-Embryo Transfer
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCPP	Joint Commission of Pharmacy Practitioners
JHG	Jackson Hole Group
LCME	Liaison Committee on Medical Education
LIMRA	Life Insurance Marketing Research Associates
LOS	Length of Stay
LSC	Life Safety Code
LTC	Long-Term Care
LTCF	Care Facility
LTCIAC	Long-Term Care Insurance Advisory Council
MA	Medical Assistance
MAA	Medical Assistance for the Aged
MAAC	Maximum allowable Actual Cost
MAC	Maximum Allowable Cost
MADPA	Medicaid Anti-Discriminatory Price and Patient Benefits Restoration Act
MAMSI	Mid-Atlantic Medical Services Inc.
MAO	Medical Assistance Only
MAPC	Maximum Allowable Prevailing Charge
MASLPI	Mexican American State Legislators Policy
MCH	Maternal and Child Health Services
MCO	Managed Care Organization
MCP	Managed Care Plan
MCPI	Medical Care Price Index
MCR	Modified Community Rating

MDC	Major Diagnostic Category
M&E	Monitoring and Education
MECA	Medicare Expanded Choice Act
MEDISGRPS	Medical Illness Severity Group System
MEDTEP	Medical Treatment Effectiveness Program
MEI	Medicare Economic Index
MET	Multiple Employer Trust
MEWA'S	Multiple Employer Welfare Arrangements
MFS	Medical Fee Schedule
MGMA	Medical Group Management Association
MHSA	Mental Health and Substance Abuse
MI	Medically Indigent
MIG	Medicare Insured Groups
MMIS	Medicaid Management Information System
MMP	Mixed Model Plan
MMSA	Managed Medical Service Account
MOPDP	Mail Order Prescription Drug Program
MOS	Medical Outcomes Study
MOU	Memorandum of Understanding
MPPPA	Medicaid Prudent Pharmaceutical Purchasing Act
MQC	Medical Quality Control
MQSA	Mammography Quality Standards Act
MRMID	Major Risk Medical Insurance Board
MRR	Medical Records Research
MSO	Managed Second Opinion or Management Service Organization
MSP	Medicare Secondary Payer or Mail Service Pharmacy
MSW	Medical Social Worker
MVPS	Medicare Volume Performance Standard
NABP	National Association of Boards of Pharmacy
NACDS	National Association of Chain Drug Stores
NACHCT	The National Advisory Committee on Health Care Technology
NAEHCA	National Association of Employers on Health Care Action
NAHDO	National Association of Health Data Organizations
NAHMOR	Nation Association of HMO Regulators
NAIC	National Association of Insurance Commissioners
NAMCR	National Association for Managed Care Regulators

NAMI	formerly the National Alliance for the Mentally Ill
NAPH	National Association of Public Hospitals
NAPHS	National Association of Psychiatric Health Systems
NARD	National Association of Retail Druggists
NAS	National Academy of Science
NASC	National Alliance of Senior Citizens
NBCSL	National Black Caucus of State Legislators
NBME	National Board of Medical Examiners
NCACM	National Coalition or the Advancement of Case Management
NCEDP	National Cholesterol Education Project
NCHSR	Nation Center for Health Services Research
NCI	National Cancer Institute
NCQA	National Committee for Quality Assurance
NCSL	National Conference of State Legislatures
NCVIA	National Childhood Vaccine Injury Act
NDA	New Drug Application
NDC	National Drug Code
NDMA	Nonprescription Drug Manufacturers Association
NEAMPA	Northeast Association of Medicaid Pharmacy Administration
NFP	Not-For-Profit
NHAC	National Health Advisory Committees
NHB	National Health Board
NHDAC	National Health Data Advisory Council
NIA	National Institute on Aging
NIH	National Institute of Health
NIMH	National Institute for Mental Health
NLSSA	National Legislative Service and Security Association
NMCUES	National Medicare Care Utilization and Expenditure Survey
NMHA	National Mental Health Association
NMHCC	National Managed Health Care Congress
NORD	National Organization of Rare Disorders
NP	Nurse Practitioner
NPAP0	National Program for the Assessment of Patient Outcomes
NPC	National Pharmaceutical Council
NPIC	National Pharmacy Identification Code
NWDA	National Wholesale Drug Association

OAA	Old Age Assistance
OACT	Office of the Actuary
OASDI	Old Age, Survivors, and Disability Insurance
OASI	Old Age and Survivors Insurance
OBRA '90	Omnibus Budget Reconciliation Act of 1990
OCR	Optical Character Recognition
OEP	Open Enrollment Period
OGD	Office of Generic Drugs
OHCPSI	Office of Health Coalitions and Private Sector Initiatives
OHMO	Office of Health Maintenance Organizations
OHTA	Office of Health Technology Assessment
OIC	Office of Insurance Commissioner
OIG	Office of Inspector General
OMS	Outcomes Management System
OMSB	Outcomes Management Standard Board
OPHC	Office of Prepaid Health Care
OPHCOO	Office of Prepaid Health Care Operations and Oversight
OPM	Office of Personnel Management
OPRB	Other Post-Retirement Benefits
OPT	Outpatient Physical Therapy
ORD	Office of Research and Demonstration
ORR	Office of Research Resources
OSC	Organized Systems of Care
OT	Occupational Therapy
OTA	Office of Technology Assessment
OCT	Over-the-Counter (drugs)
PA	Physician's Assistant
PAC	Political Action Committee
PADS	Prescription Abuse Data Synthesis
PAPPA	Pharmaceuticals Access and Prudent Purchasing Act of 1990
PBM	Pharmacy Benefit Manager
PBP	Provider Based Physician or Prudent Buyer Plan
PCCM	Primary Care Case Management
PCF	Program Characteristics File
PCM	Primary Care Manager
PCN	Primary Care Network

PCP	Personal Care Physician or Primary Care Physician
PDMA	Prescription Drug Marketing Act
PEC	Pharmacy Economic Center
PERS	Public Employment Retirement System
PGA	Pure Geographic Adjustment
PGP	Prepaid Group Practice
PHCA	Prepaid Health Care Act
PHO	Physician Hospital Organization
PHP	Prepaid Health Plan
PHPO	Private Health Plan
PHS	United States Public Health Services (USPHS)
PI	Performance Indicator, Package Insert or Prescribing Information
PIAA	Physicians Insurers Association of America
PIP	Personal Injury Protection or Pharmacists Incentive Plan
PMCS	Patient Management Categories
PM-DRG	Pediatric Modified- Diagnosis Related Group
PHMO	Physician Multi-Hospital Organizations
PMPM	Per Member Per Month
PMPY	Per Member Per Year
POARP	Patient Outcomes Assessment Research Program
PODS	Pools of Doctors
POE	Point of Enrollment
POL	Physician Office Laboratory
PON	Physician Office Network
PORTs	Patient Outcome Research Teams
POS	Point of Sale or Point Service
PPA	Preferred Purchaser Agreement
PPI	Producer Price Index
PPO	Preferred Provider Organization
PPRC	Physician Payment Review Commission
PPSC	Pharmacy Providers Service Corp.
PRO	Peer Review Organization
PRO-PAC	Prospective Payment Assessment Commission
PSAO	Pharmacy Service Administration Organization
PT	Physical Therapy or Physical Therapist
P&T	Pharmacy and Therapeutics

PWBA	Pension Welfare and Benefits Administration
QA	Quality Assurance
QAAC	Quality Assurance and Assessment Committee
QUALYs	Quality Adjusted Life Years
QAP	Quality Assurance Program
QARI	Quality Assurance Reform Initiative
QMB	Qualified Medicare Beneficiary
QOL	Quality of Life
QRO	Quality Review Organization
QRRB	Qualified Railroad Retirement Beneficiary
RAAC	Risk Adjustment Advisory Committee
RAMI	Risk Adjustment Mortality Index
RBRVS	Resource-Based Relative Value Scale
R&C	Reasonable and Customary
RFP	Request for Proposal
RHC	Rural Health Clinic
ROA	Return on Assets
ROE	Return on Equity
RVS	Relative Value Scale
RWJF	Robert Wood Johnson Foundation
SAMPA	Southern Association of Medicaid Pharmacy Administration
SBIPC	Small Business and Individual Purchasing Group
SCOPE	Shared Cost Option for Private Employers
SECA	Self-Employment Contribution Act
SEHPA	Small Employers Health Purchase Allowance
SGF	State Guaranty Funds
SGO	Surgeon General's Office
SCHIP	State Child Health Insurance Program
SHIP	State Health Insurance Program
SHMO	Social HMO
SMI	Supplementary Medical Insurance
SMM	State Medicaid Manual
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSACT	Social Security Act
SSI	Supplemental Security Income

SSN	Social Security Number
SSP	State Supplemental Payments
SSRIs	Selective Serotonin Re-uptake Inhibitors
TA	Technology Assessment
TAB	Therapeutic Agents Board
TDM	Target Drug Monitoring
TDOC	Total Days of Care
TEFRA '82	Tax Equity & Fiscal Responsibility Act of 1982
TEMINEX	Technology Management Information Exchange
TPA	Third-Party Administrator
TPCM	Third-Party Claims Management
UB	Uniform Bill or Uniform Billing
UBP	Uniform Benefit Package
UCDS	Uniform Clinical Data Set
UCR	Usual, Customary and Reasonable (charges)
UM	Utilization Management
UMGA	United Medical Group Association
UMQC	Unified Medical Quality Commission
UR	Utilization Review
URAC	Utilization Review Accreditation Commission
URC	Utilization Review Committee
URO	Utilization Review Organization
USBPI	Uniformed Services Benefit Plans Inc.
USC	United States Code
USP	United States Pharmacopoeia
USPCC	United States Per Capita Cost
USPHS	United States Public Health Service
VEBA	Voluntary Employees Beneficiary Association
WAMPA	Western Association of Medicaid Pharmacy Administration
WAP	Wholesale Acquisition Price
WC	Worker's Compensation
YOLS	Years of Life Saved

additional resources

additional resources

Planning Council Technical Assistance

National Association of Mental Health Planning and Advisory Councils

1021 Prince Street
Alexandria, VA 22314-2971
Phone: 703.838.7522
Fax: 703.684.5968 – fax
E-mail: melanie@namhpac.org
URL: www.namhpac.org

National Technical Assistance Center for State Mental Health Planning

National Association of Mental Health Program Directors
66 Canal Center Plaza, Suite 302
Alexandria, VA 22314
Phone: 703.739-9333
Fax: 703.548.9517
URL: www.nasmhpd.org

CMHS Sponsored Technical Assistance Centers

National Technical Assistance Center for Children's Mental Health

Georgetown University Child Development Center
3307 M Street, NW
Suite 401

Washington, DC 20007-3935

Phone: (202) 687- 5000

Fax: (202) 687- 8899

E-mail: gucdc@gunet.georgetown.edu

URL: <http://www.dml.georgetown.edu/depts/pediatrics/gucdc>

- Information packets, issue briefs, and monographs on children and adolescents with serious emotional disturbances
- Conferences and training institutes on planning, delivery, and financing of services
- Consultation on systems change and services development and delivery

Research and Training Center for Children's Mental Health

Department of Child and Family Studies

Florida Mental Health Institute

13301 Bruce B. Downs Boulevard

University of South Florida

Tampa, Florida 33612-3899

Phone: (813) 974-4661

Fax: (813)974-4406

URL: <http://rtckids.fmhi.usf.edu/>

E-mail: frediman@hal.fmhi.usf.edu

- Studies of children with serious emotional disturbances and services systems research
- Annual research conference

Research and Training Center on Family Support and Children's Mental Health

Regional Research Institute of Portland State University

P.O. Box 751

Portland, Oregon 97207-0741

Phone: (503) 725-4040

Fax: (503) 725-4180

E-mail: Friesb@rri.pdx.edu

URL: <http://www.rtc.pdx.edu>

- Research and training on family support issues, family/professional collaboration, and diverse cultural groups
- Annual research conference on family support issues
- Information on publications and events through an electronic bulletin board

National Research and Training Center on Psychiatric Disability and Peer Support

104 South Michigan Avenue, Suite 900

Chicago, Illinois 60603

Phone: (312) 422-8180

Fax: (312) 422-0740

URL: <http://www.psych.uic.edu/~rtc>

- Psychiatric rehabilitation research and training in 9 major areas: peer support and consumer service delivery, treatment models, vocation rehabilitation, managed care, women's issues, HIV/AIDS, familial experience, diversity issues, and transition-age youth
- Extensive dissemination and technical assistance at replacement cost or no cost
- Workshops, seminars, academic courses, and training to providers
- Technical assistance to federal, state, and local agencies for public policy initiatives

The Evaluation Center

The Human Services Research Institute

2336 Massachusetts Avenue

Cambridge, Massachusetts 02140

Phone: (617) 876-0426

Fax: (617) 492-7401

URL: <http://www.hsri.org/eval/eval.html>

- Consultation program through site visits or telephone/e-mail
- Topical evaluation network program
- Tool kits to provide evaluators with tested methodologies and instruments
- Evaluation materials program
- Mini-grant program for system-of-change evaluation projects
- Training program on evaluation-relation skills
- Multicultural issues in evaluation

Center for Psychiatric Rehabilitation

Sargent College of Health and Rehabilitation Services

Boston University Psychiatric Rehabilitation Center

940 Commonwealth Avenue West

Boston, Massachusetts 02215

Phone: (617) 353-3550

Fax: (617) 353-7700

E-mail: w.anthony@bu.edu

URL: <http://wwwbu.edu/saepsych>

- Consultation and training using psychiatric rehabilitation technologies and topics related to rehabilitation and recovery
- Workshops, conferences, professional development programs, and academic degree programs
- Service demonstration programs for consumer/survivor rehabilitation and recovery
- Information dissemination via a newsletter, journal, web site, and catalog
- Research on psychiatric rehabilitation and related topics

National Empowerment Center

599 Canal Street

Lawrence, Massachusetts 01840

Phone: (800) 769-3728

Fax: (978) 681-6426

URL: <http://www.Power2u.org>

- Consumer technical assistance center
- National directory of mutual support groups, drop-in centers, and Statewide organizations
- Networking and coalition-building
- Workshops, public speaking, and training to providers

National Mental Health Consumers' Self-Help Clearinghouse

1211 Chestnut Street, 10th Floor

Philadelphia, Pennsylvania 19107

Phone: (800) 553-4539

Fax: (215) 636-6310

E-mail: info@mhsselfhelph.org

URL: <http://www.mhsselfhelp.org>

- Consumer information and referrals
- On-site consultation
- Training events
- Teleconferences and national conferences
- Consumer library
- Newsletter
- Consumer and consumer-supported nationwide database

Center for Support of Mental Health Services in Isolated Rural Areas

Frontier Mental Health Services Resource Network

University of Denver

Denver, Colorado 80208

Phone: (303) 871-3099

Fax: (303) 871-4747

E-mail: jciarlo@du.edu

URL: <http://www.du.edu/frontier-mh>

- Knowledge synthesis
- Technical assistance to organizations
- Human resource development
- Conferences and workshops
- Demonstrations and evaluations

National Resource Center on Homelessness and Mental Illness

Policy Research Associations, Inc.

262 Delaware Avenue

Delmar, New York 12054

Phone: (800) 444-7415

Fax: (518) 439-7612

E-mail: nrc@prainc.com

URL: <http://www.prainc.com/nrc>

- State, regional, and national consultation
- Special topic technical assistance and training
- Consensus development conferences and teleconferences
- Consultant database
- Publications and reports
- Model service system standards review and analysis
- Project for Assistance in Transition from Homelessness (PATH), Technical Assistance Center

Advocates for Human Potential, Inc.

323 Boston Post Road
Sudbury, Massachusetts 01776
Phone: (978) 443-0055
Fax: (978) 443-4722

- Training curricula in topic areas identified through a comprehensive needs assessment of State PATH contacts
- Ad hoc technical assistance to State and local PATH programs in response to special requests

The National GAINS Center Policy Research, Inc.

262 Delaware Avenue
Delmar, New York 12054
Phone: (800) 311- GAINS (4246)
Fax: (518) 439-7612
e-mail: gainsctr@aol.com

URL: <http://www.prainc.com/gains/index.html>

- Integrated technical assistance network for knowledge development
- Analysis of state-of-the-art practices and synthesis documents
- Targeted fact sheet, briefs, and brochures
- Specially designed training sessions and workshops delivered on-site and via e-mail

Consumer Organization and Networking Technical Assistance Center (CONTAC)

West Virginia Mental Health Consumers Association
1036 Quarrier Street
Suite 208A
Charleston, West Virginia 25301
Phone: (888) 825-TECH (8324) or (304) 346-9992
Fax: (304) 345-7303
E-mail: contac@contac.org
URL: <http://www.contac.org>

- Resource center for consumers/survivors/ex-patients and consumer-run organizations across the United States
- Services include materials development and dissemination, training, skill development, interactive communication opportunities, networking, and other activities to promote self-help, recovery, and empowerment
- Technical assistance to organizations in identifying and exemplifying points of entry into consumer programs
- Outcome orientation for non-traditional services

National Consumer Supporter Technical Assistance Center

National Mental Health Association
1021 Prince Street
Alexandria, Virginia 22314
Phone: (703) 684-7722
Fax: (703) 684-5968
URL: www.ncstac.org

- Information and referrals
- Technical assistance on site and by phone
- Resource library
- Coordination of local coalitions
- Training conference

National PACT Center

National Alliance for the Mentally Ill (NAMI)

200 North Glebe Road

Suite 1015

Arlington, Virginia 22203-3754

Phone: (703) 524-7600

Fax: (703) 524-9094

E-mail: Elizabeth@nami.org

URL: <http://www.nami.org>

- Technical assistance in developing programs of assertive community treatment
- Teleconferences on various aspects of PACT program planning and implementation
- Information dissemination via mail and a web site

National Center for American Indian and Alaska Native Mental Health Research

University of Colorado Health Sciences Center

Campus Box AO11-13

4455 East Twelfth Avenue

Denver, Colorado 80220

Phone: (303) 315-9326

Fax: (303) 315- 9579

URL: <http://www.uchsc.edu/sm/ncaianmhr>

- Research, research training
- Information dissemination
- Technical assistance provided on American Indian and Alaska Native populations.
- Cross site evaluation of 9 sites in the Circles of Care grant program.

National Indian Child Welfare Association

3611 SW Hood Street

Suite 201

Portland, Oregon 97201

Phone:(503) 222-4044

Fax: (503) 222-4007

URL: <http://www.nicwa.org>

- Technical Assistance for Community Development
- Public Policy Development
- Information Exchange

Technical Assistance and Training for Tribal grantees of the Child, Adolescent and Family Branch of the Center for Mental Health Services.

For mental health information, contact:

Knowledge Exchange Network

U.S. Mail: P.O. Box 42490, Washington, DC 20015

Toll-Free: (800) 789-2647

E-mail: ken@mentalhealth.org

Web site: <http://www.mentalhealth.org>

National Mental Health Organizations**Bazelon Center for Mental Health Law**

1101 Fifteenth Street, N.W., Suite 1212

Washington, DC 20005

Phone: (202) 467-5730

TDD: (202) 467-4232

Fax: (202) 223-0409

E-mail: HN1660@handsnet.org

URL: <http://www.bazelon.org>

Federation of Families for Children’s Mental Health

1101 King Street, Suite 420
Alexandria, VA 22314
(P) 703.684.7710
(F) 703.836.1040
URL: www.ffcmh.org

NAMI

Colonial Plaza Three
2107 Wilson Blvd., Suite 300
Arlington, VA 22201-3042
(P) 703.524.7600
(F) 703.524.9094
URL: www.nami.org

National Mental Health Association

1021 Prince Street
Alexandria, VA 22314-2971
Phone: 703.684.7722
Fax: 703.684.5968
URL: www.nmha.org