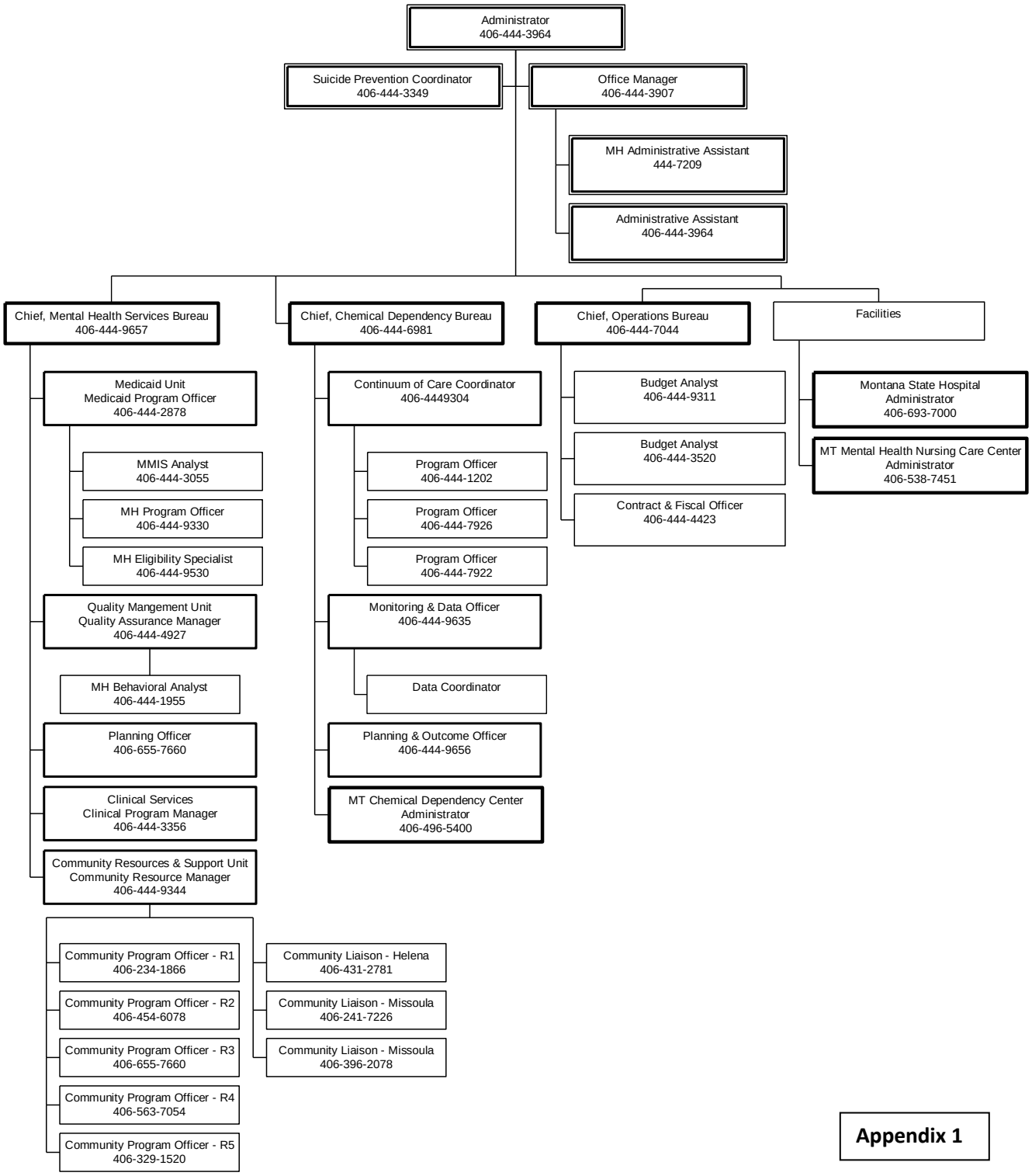
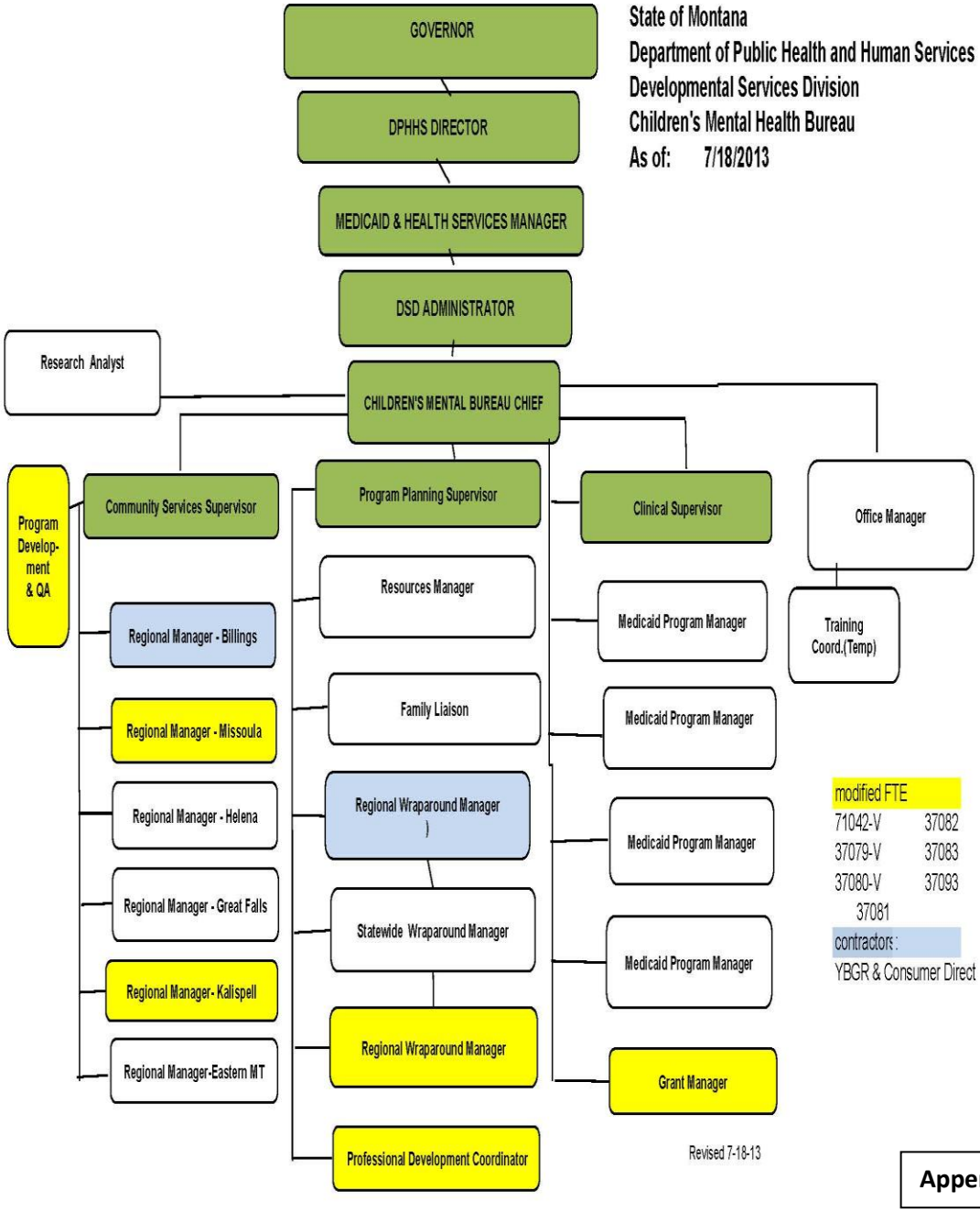
Addictive & Mental Disorders Division (AMDD)
Montana Department of Public Health and Human Services



Appendix 1


GOVERNOR
DPHHS DIRECTOR
MEDICAID & HEALTH SERVICES MANAGER
DSD ADMINISTRATOR
Research Analyst
CHILDREN'S MENTAL BUREAU CHIEF
Program Develop-ment & QA
Community Services Supervisor
Program Planning Supervisor
Clinical Supervisor
Office Manager
Regional Manager - Billings
Regional Manager - Missoula
Regional Manager - Helena
Regional Manager - Great Falls
Regional Manager- Kalispell
Regional Manager-Eastern MT
Resources Manager
Family Liaison
Regional Wraparound Manager)
Statewide Wraparound Manager
Regional Wraparound Manager
Professional Development Coordinator
Medicaid Program Manager
Medicaid Program Manager
Medicaid Program Manager
Medicaid Program Manager
Grant Manager
Training Coord.(Temp)
State of Montana
Department of Public Health and Human Services
Developmental Services Division
Children's Mental Health Bureau
As of: 7/18/2013
modified FTE
71042-V 37082
37079-V 37083
37080-V 37093
37081
contractors:
YBGR & Consumer Direct
Revised 7-18-13

Appendix 1

State Wide Mental Health Services Matrix for Adults

Jun-13

SERVICES AVAILABLE	Where service is available	Who is eligible	Contacts
Medicaid for Workers with disabilities	Anywhere in state with a participating provider.	SSI/SSDI recipient with SDMI for mental health center services.	Medicaid Program Manager 444-2878
Mental Health Services Plan - MHSP	Mental Health Center's; prescribers in communities who are enrolled.	An Adult with income below 150% of federal poverty level and SDMI.	Clinical Program Officer 444-3356 (clinical, training) MH Program Officer 444.9330 (claims, labs, pharmacy)
MHSP Waiver	Mental Health Centers	An Adult who is MHSP eligible and carries a primary diagnosis of schizophrenia or bipolar mood disorder.	Medicaid Program Manager 444-2878
72 Hour Program	Mental Health Centers. **Hospital contracts:** Kalispell, Missoula, Helena, Billings, Havre, Great Falls, Plains; **Crisis Stabilization Facilities** (see below).	Any Adult in a psychiatric crisis who is uninsured or under-insured.	Clinical Program Officer 444-3356 (clinical, training) MH Program Officer 444.9330 (claims)
Program for Assertive Community Treatment - PACT	Helena, Billings, Great Falls, Kalispell	An Adult with Medicaid or MHSP who meets admission criteria.	Clinical Program Officer 444-3356
Crisis Response Team - CRT	**WMMHC**-Kalispell, Missoula, Butte, Bozeman **CMH**- Helena	Any Adult in a psychiatric crisis.	Missoula 532-9700 Butte 723-5489 Bozeman 522-7357 Kalispell 728-6870 Helena 443-7151
Home & Community Based Services Waiver - HCBS Waiver	Counties: Yellowstone, Silver Bow, Cascade, Missoula, Lewis and Clark	An Adult who has a SDMI with funding through Medicaid and meets admission criteria.	Medicaid Program Manager 444-2878
Goal 189 funds	Contracts are with the licensed MHC's.	An Adult exiting MSH or with a history of MSH hospitalization.	Clinical Program Officer 444-3356
PATH - Outreach to Homeless	Billings, Missoula	Homeless-Mentally Ill	Planning Officer 655-7660
MH Group Homes, Adult Foster Care and Day Treatment	Billings, Great Falls, Helena, Kalispell, Hamilton, Bozeman, Missoula, Miles City, Havre	An Adult who has a SDMI with funding through Medicaid, MHSP or Goal 189.	**SCMRHC** - Billings 252-5658 **C4MH**: GF 761-2100 Helena 443-7151 **WMMHC** - Msla. 532-9700 Kal. 257-1336 Bozeman 522.7357 Hamilton 532-9101 **AWARE** 449-3120 **EMCMHC** - Miles City 234-1687 **Winds of Change** - 721-2038
Psychiatric Hospitalization Inpatient	Great Falls, Missoula, Kalispell, Billings, Helena	Any Adult meeting admission criteria.	**Benefis Hosp**. (GF) 455-2380 **St. Patrick's Hosp**. (Msla.) 543-7271 **Pathways Treatment Center** (Kalispell), 751-6414 **Billings Clinic** (800-255-8400) **St. Peter's Hosp.** (Helena) 495-6560
Crisis Stabilization Facilities	Billings, Kalispell, Bozeman, Butte, Missoula, Hamilton	Adults with MI or SDMI meeting admission criteria	Clinical Program Officer 444-3356
Drop In Centers	Billings, Hays, Bozeman, Livingston, Helena, Superior, Butte	Any Adult	Community Program Officer: 234-1866 (Miles City), 454-6078 (Hays), 655-7622 (Billings), 498-7358 (Bozeman, Livingston, Helena), 241-7369 (T. Falls, Superior, Hamilton)
Supported Employment Programs	Butte, Missoula (2), Helena, Bozeman	SDMI	Mental Health Center in that area.

Appendix 1

SERVICES AVAILABLE (cont.)	Where service is available	Who is eligible	Contacts
Intensive Community Based Rehabilitation	Billings, Great Falls, Butte, Glendive	Adults with MI or SDMI having discharged from MSH and MMHNCC; prior approval for admission	Administrator 444-9657
Network of Care	http://montana.networkofcare.org/mh/home/index.cfm	Information for consumers, families, providers, and other interested persons.	Medicaid Program Manager 444-2878
HB 130 - Crisis grants	Lewis & Clark, Missoula, Ravalli and Yellowstone Counties.		Bureau Chief 444-2013
Mental Health Warm Line	Telephonic	Anyone	State Wide 1-877-688-3377
Suicide Hot Line	Telephonic	Anyone	State Wide 1-800-273-8255
Training			
IMR - Illness, Management & Recovery	State-wide trainings available.	MH Providers, Peer specialists	Medicaid Program Manager 444-2878
WRAP - Wellness, Recovery, Action Plan	Billings, Great Falls, Butte	Consumers	Medicaid Program Manager 444-2878
DBT - Dialectical Behavior Therapy	State-wide trainings available.	MH & CD Clinicians, Case Managers, Peer Specialists	Clinical Program Officer 444-3356
Strength Based CM	State-wide trainings available.	Case Managers	Medicaid Program Manager 444-2878
SOAR - SSI / SSDI Outreach, Access and Recovery	State-wide trainings available.	Those individuals needing assistance in the SSI/SSDI application process.	Planning Officer 655-7660
Crisis Intervention Team - CIT	State-wide trainings available.	Law enforcement / 1st responders.	Bureau Chief 444-2013
Peer to Peer/Family to Family/ In Your Own Voice trainings	State-wide trainings available.	Anyone	NAMI Montana 443-7871
Recovery International	MSH, Butte, Missoula	Anyone	Charlotte Moran 825-3063
State Facilities			
Montana State Hospital	Warm Springs	Any Adult in Montana meeting admission criteria.	406-693-7000
Montana Chemical Dependency Center	Butte	Any Adult in Montana meeting admission criteria.	406-496-5400
Montana Mental Health Nursing Care Center	Lewistown	Any Adult in Montana meeting admission criteria.	406-538-7451

Appendix 1

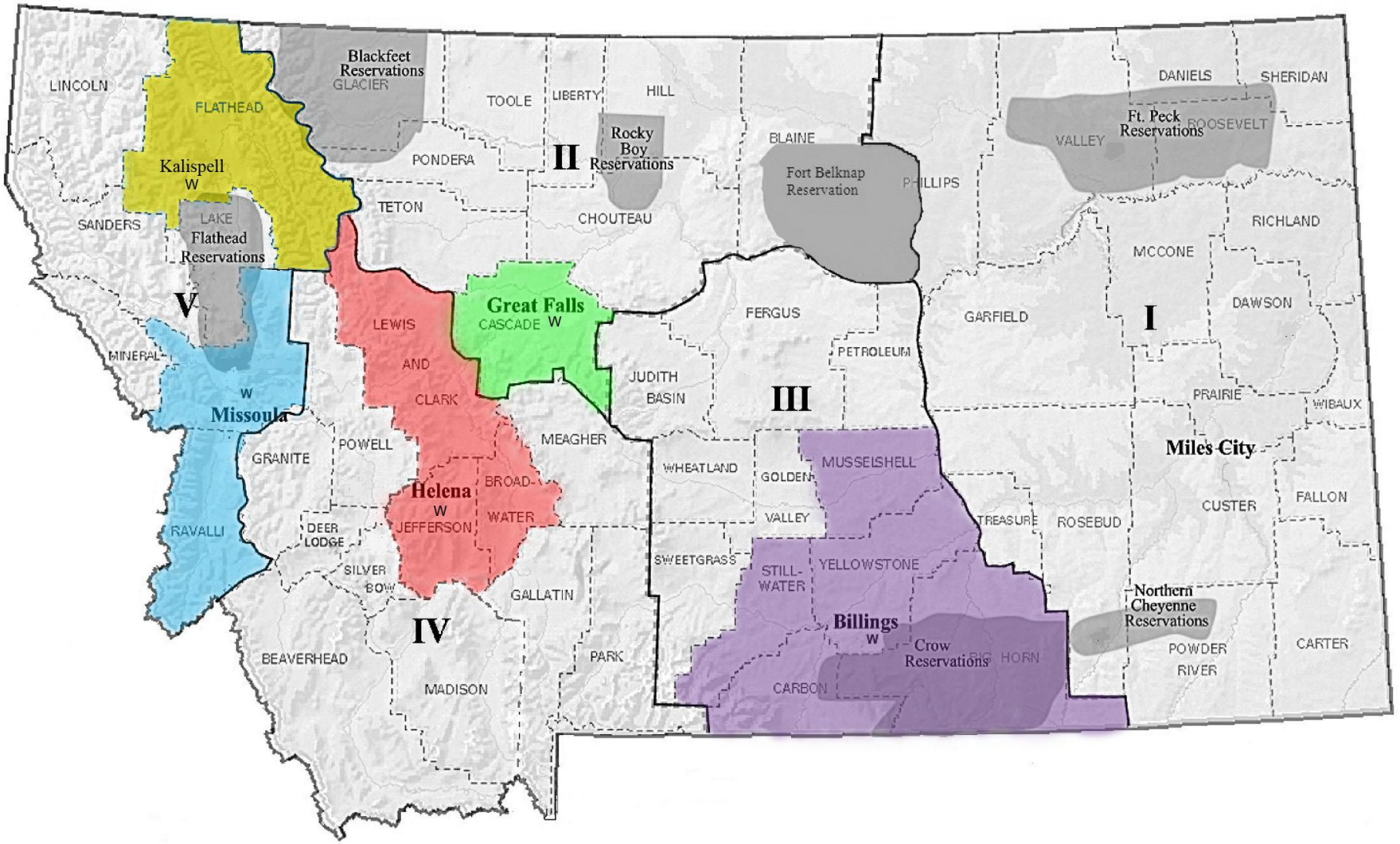
CMHB's Regional Program Officers	CMHB's i-home Regional Managers
REGION I &III Regional Program Officer 2121 Rosebud, D-17 Billings, MT 59102 (406) 655-7626	**REGION I** Regional Manager 1523 14th Street West, Suite 2, Billings, MT 59102 (406) 254-7028
REGION II & IV Regional Program Officer 201 1st Street South #3, Great Falls MT 59405 (406) 454-6088	**REGION II** Regional Manager 201 1st Street South #3, Great Falls MT 59405 (406) 454-6088
REGION V Regional Program Officer 2677 Palmer, Suite 300, Missoula MT 59808 (406)329-1594	**REGION III** Regional Manager 1523 14th Street West, Suite 2, Billings, MT 59102 (406) 254-7028
REGION IV Regional Manager 111 Last Chance Gulch Ste 3E, Helena, MT 59602 (406) 444-5938	**REGION V** Regional Manager 2685 Palmer Suite E, Missoula MT 59808 (406) 329-1330 Regional Manager 121 Financial Dr. Suite B, Kalispell, MT 59901 (406) 751-2486

Appendix 1

Children's Mental Health Bureau Regional Map and PRTF Waiver Sites

For information about local children's mental health services
contact the regional program officer nearest you.

Key: W=PRTF Waiver office



State Wide Children's Mental Health Services and Resources Paid through Montana Medicaid - October 2013

SERVICES AVAILABLE	Where service is available	Who is eligible	Contacts
Acute inpatient-psychiatric hospital	Missoula, Kalispell, Billings, Helena	A Medicaid eligible youth under the age of 18 (unless in secondary school), who meets diagnostic and functional guidelines.	**Clinical Program Officer - 406-444-1535** Missoula - St. Patrick's Hospital, 406-543-7271 Kalispell - Pathways Treatment Center, 406-751-6414 Billings - Billings Clinic, 800-255-8400 Helena - Shodair Children's Hospital, 406-444-7500
Partial Hospitalization Program (PHP) active treatment program that offers therapeutically intense coordinated structured clinical services to youth.	Billings, Kalispell, Missoula	A Medicaid eligible youth with SED who meets medical necessity criteria for this level of care.	**Clinical Program Officer - 406-444-1535** Billings - Billings Clinic, 800-255-8400 Kalispell - Turtle Bay, 406-844-2890 Missoula - St. Patrick's Hospital, 406-573-7271
Psychiatric Residential Treatment Facility (PRTF) - a secure 24 hour facility with psychiatric supervision. This also includes a 14 day assessment admission paid at a higher rate.	Helena, Billings, Butte	A Medicaid eligible youth with SED who meets medical necessity criteria for this level of care.	**Clinical Program Officer - 406-444-1535** Helena - Shodair Children's Hospital, 406-444-7500 Billings - Yellowstone Boys & Girls Ranch, 406-651-2852 Butte - Acadia, 406-477-1067

Appendix 1

PRTF Home and Community Based Services Waiver for youth with SED (alternative for residential treatment). Will be 1915i state plan amendment on October 1, 2012.	**Yellowstone County (core site)** plus surrounding counties of Carbon, Stillwater, Musselshell and Bighorn; **Missoula and Ravalli Counties (core sites)**; **Lewis & Clark County (core site)** plus surrounding counties of Jefferson and Broadwater; **Cascade County (core site)**; **Flathead County (core site)**.	A Medicaid eligible youth age 6 through 17 who meets SED criteria, resides in one of the waiver counties, has parents/guardian willing to participate in the waiver and meets PRTF level of care.	**Waiver Supervisor - 406-444-1460** Plan Managers: Billings, 406-254-7028 Missoula, 406-329-1330 Helena, 406-444-5938 Great Falls, 406-454-6088 Kalispell, 406-751-2486
MH Therapeutic Group Homes (TGH) --- **Extraordinary Needs Aid (ENA)**	Anaconda, Billings, Boulder, Bozeman, Butte, Great Falls, Helena, Kalispell, Lewistown, Missoula --- Available for a youth in a therapeutic group home who needs short term 1:1 aide to remain in placement.	A Medicaid eligible youth with SED who meets medical necessity criteria for TGH level of care.	**Clinical Program Officer - 406-444-3819**
Targeted Youth Case Management (TYCM)	Available through licensed mental health centers across the state.	A Medicaid eligible youth with SED who meets medical necessity criteria for this level of care.	**Clinical Program Officer - 406-444-3819**
Therapeutic Family or Foster Care (TFC, TFOC)	Various locations - available from some child placing agencies.	A Medicaid eligible youth who meets admission criteria.	**Clinical Program Officer - 406-444-7391**
Comprehensive School & Community Treatment (CSCT)	189 school districts across the state.	A Medicaid eligible youth with SED who meets medical necessity criteria for this level of care.	**School Based Services Program Officer 406-444-1290**

Appendix 1

Outpatient children's mental health services (therapy, day treatment, medication monitoring, community based psychiatric rehab and support aide (CBPRS)	Available through licensed mental health centers across the state. Outpatient therapy also available from licensed mental health professionals across the state. Medication management available from licensed prescribers.	A Medicaid eligible youth under the age of 18 (unless in secondary school), who meets diagnostic and functional guidelines.	**Clinical Program Officer - 406-444-7391**
TRAINING			
Wraparound 101 or Coach Training	Billings, Great Falls, Butte, Helena, Kalispell	All interested trainers at no cost to them.	**Community Services Supervisor - 406-444-7064**
SOAR - SSI/SSDI Outreach, Access and Recovery	State-wide trainings available.	Those individuals needing assistance in the SSI/SSDI application process.	**Program Officer - 406-655-7660**
CIT - Crisis Intervention Team	State-wide trainings available.	law enforcement / first responders	**Mental Health Services Bureau Chief - 406-444-2013**
Family to Family / In Your Own Voice / NAMI Basics Training	State-wide trainings available.	Anyone	**NAMI Montana, 406-443-7871**
Recovery International	MSH, Butte, Missoula	Anyone	**Lead Trainer - 406-825-3063**
MENTAL HEALTH ADVOCACY ORGANIZATIONS			
Child Abuse Neglect Hotline	1-866-820-5437		
Disability Rights Montana	1-800-245-4743		
Board of Visitors	1-800- 332-2272		
Mental Health Ombudsman	1-888-444-9669		
Mental Health America of MT	1-406-587-7774		
NAMI Montana	1-406-443-7871		
Montana Youth Move	1-406-444-3814		
Parents Let's Unite For Kids (PLUK)	1-800-222-7585		
Federation of Families	1-877-376-4850		

Appendix 1

NON-MEDICAID SERVICES			
Children's Mental Health Services Plan (CMHSP)	State Wide	160% of Federal Poverty Level not eligible for Medicaid or CHIP (HMK) who are SED.	**Clinical Program Officer - 406-444-3819**
Supplemental Services Plan (SSP)	State Wide	Eligible families with income under 185% of Federal Poverty Level. Duration is limited to no more than 4 calendar months per FFY.	**Community Services Supervisor - 406-444-7064**
Respite Services	State Wide - through licensed mental health centers and PRTF waiver only	A Medicaid eligible youth under the age of 18, who meets diagnostic and functional guidelines.	**Clinical Program Officer - 406-444-3819**
Vocational Rehabilitation	State Wide	Individuals with disabilities.	**Montana State Vocational Rehabilitation Contact - 1-877-296-1197**
Supported Employment Programs	Butte, 2 in Missoula	A Medicaid eligible youth transitioning to adult services.	**Butte - WMMHC, 406-723-4033** **Missoula - WMMHC, 406-532-9700** **Missoula - Winds of Change MHC, 406-721-2038**
Crisis Response Team - CRT	Kalispell, Missoula, Butte, Bozeman, Helena	Any youth in psychiatric crisis.	**Missoula - WMMHC, 406-531-9700** **Butte - WMMHC, 406-723-5489** **Bozeman - WMMHC, 406-522-7357** **Kalispell - WMMHC, 406-728-6870** **Helena - C4MH, 406-443-7151**

Appendix 1

Network of Care	Web: http://montana.networkofcare.org/mh/	Information for consumers, families, providers, and other interested persons.	**Program Officer - 406-444-2878**
Mental Health Warm Line (MMHA)	Telephonic	Anyone	**State Wide 1-877-688-3377**
Suicide Hot Line	Telephonic	Anyone	**State Wide 1-800-273-8255**
Montana 211 For Community Resources	Telephonic and Web: http://www.montana211.org/	Anyone	**211**
For more detailed information on services visit:			
Children's Mental Health Bureau Web Site: http://www.dphhs.mt.gov/mentalhealth/children			
Providers refer to the Clinical Management guidelines and/or the Medicaid Children's Mental Health Manual.			
For Medicaid Claims questions call Xerox Provider Relations at 406-449-7693.			

Appendix 1

53-21-702. Mental health care system -- eligibility -- services -- advisory council. (1) The department of public health and human services shall develop a delivery system of mental health care from providers or other entities that are able to provide administration or delivery of mental health services. The public mental health care system shall:

(a) include specific outcome and performance measures for the administration or delivery of a continuum of mental health services;

(b) provide for local advisory councils that shall report to and meet on a regular basis with the advisory council provided for in subsection (4);

(c) provide level-of-care appeals that are understandable and accessible; and

(d) provide a system for tracking children who need mental health services that are provided under substantive interagency agreements between state agencies responsible for addictive and mental disorders, foster care, children with developmental disabilities, special education, and juvenile corrections.

(2) The department may establish resource and income standards of eligibility for mental health services that are more liberal than the resource and income standards of eligibility for physical health services. The standards of eligibility for mental health services may provide for eligibility for households not eligible for medicaid with family income that does not exceed 160% of the federal poverty threshold or that does not exceed a lesser amount determined at the discretion of the department. The department may by rule specify under what circumstances deductions for medical expenses should be used to reduce countable family income in determining eligibility. The department may also adopt rules establishing fees, premiums, or copayments to be charged recipients for services. The fees, premiums, or copayments may vary according to family income.

(3) The department shall establish the amount, scope, and duration of services to be provided under the program. Services for nonmedicaid-eligible individuals may be more limited than those services provided to medicaid-eligible individuals. Services to nonmedicaid-eligible individuals may include a pharmacy benefit.

(4) (a) The department shall form an advisory council, to be known as the mental health oversight advisory council, to provide input to the department in the development and management of any public mental health system. The advisory council is not subject to 2-15-122. The advisory council membership must include:

(i) one-half of the members as consumers of mental health services, including persons with serious mental illnesses who are receiving public mental health services, other recipients of mental health services, former recipients of public mental health services, and immediate family members of recipients of mental health services; and

(ii) advocates for consumers or family members of consumers, members of the public at large, providers of mental health services, legislators, and department representatives.

(b) The advisory council under this section may be administered so as to fulfill any federal advisory council requirements to obtain federal funds for this program.

(c) Geographic representation must be considered when appointing members to the advisory council in order to provide the widest possible representation.

(d) The advisory council shall provide a summary of each meeting and a copy of any recommendations made to the department to the legislative finance committee and any other designated appropriate legislative interim committee. The department shall provide the same committees with the department's rationale for not accepting or implementing any recommendation of the advisory council.

History: En. Sec. 7, Ch. 577, L. 1999; amd. Sec. 8, Ch. 466, L. 2001.

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Appendix 2

Resource Mapping – Essential Tools: National Center on Secondary Education and Transition; http://www.ncset.org/publications/essentialtools/mapping

Introduction

Community resource mapping is not a new strategy or process. It has been in use for many years in varying forms. Community resource mapping is sometimes referred to as asset mapping or environmental scanning. Community resource mapping is best noted as a system-building process used by many different groups at many different stages in order to align resources and policies in relation to specific system goals, strategies, and expected outcomes.

Mapping of mental health services, supports, and programs within a community can have essentially three outcomes: 1) the identification of resources available to individuals (youth and adults) in a particular community, 2) the identification of new or additional resources to sustain existing specific activities or initiatives within a community, and/or 3) the identification of resources to assist in creating and building capacity to support a more comprehensive community system for serving persons with mental illness. The first outcome typically occurs at the local level while the second and third outcome can happen at any level—local, state, or federal.

The community resource mapping process acknowledges that individuals, organizations, and local institutions all have the capacity to create real change in their communities, **but that no agency can do it alone**. With increased accountability, tight budgets, resource shortages, and fragmented services, it is a sound decision for communities to encourage cross-agency and cross-systems coordination. Insight into a community's existing partnerships and programs, resource allocations and policies, and priorities and assets can contribute to its ability to evaluate its overall effectiveness in serving persons with disabilities. The need for the strategic alignment of resources within a community has been part of the federal agenda for many years. **Resource mapping can also support the creation of a strategic plan** to improve the alignment, coordination, and, ultimately, delivery of services. When combined with community information, resource maps can provide a comprehensive picture of a community's vision, goals, projects, and infrastructure.

Community resource mapping can help communities to accomplish a number of goals, including:

1. Identifying new resources;
2. Insuring that all youth have access to the resources they need;
3. Avoiding duplication of services and resources;
4. Cultivating new partnerships and relationships;
5. Providing information across agencies that work with youth; and
6. Encouraging collaboration.

The Mapping Process

There are four steps to the community resource mapping process: 1) pre-mapping; 2) mapping; 3) taking action; and 4) maintaining, sustaining, and evaluating mapping efforts.

The **pre-mapping** step allows stakeholders to lay the foundation for productive collaboration and to establish a clear vision and goals for building a system.

The second step, **mapping,** determines which resources to map and how to best map them. The collection and analysis of data at this time helps stakeholders to identify strengths and challenges.

The next step, **taking action**, allows stakeholders to determine the most useful plan of action for effectively addressing the data findings and established goals. Communicating and disseminating information are key throughout the implementation step.

The final step involves **maintaining, sustaining, and evaluating the efforts** outlined in the map by continuously evaluating progress, making necessary changes to the plan, and learning from experiences.

Step 1: Pre-Mapping

1. Establish a Task Force to Guide the Process – include relevant and committed stakeholders.
2. Set a Vision – what do you want to accomplish. Your shared image of the future. A guide for each step of the mapping process.
3. Set Goals – Specific, measurable, action-oriented, realistic and time-limited. Positive, Precise, and Practical.
4. Communicate Continuously – Report progress. Seek in-put through process. Consider all ideas – Do not rule out until carefully considered. Readjust Goals.
5. Ask Reflective Questions – Is our vision and goals supported? Do we have a clear direction? Are our Goals realistic and measureable?

Your Map Is Only as Good as the Information That Goes Into It

Step 2: Mapping

1. Identify Resources – what resources need to be collected in order to provide the information needed to make informed decisions about change (based on Goal). Do not limit resource identification to $$ only; include human resources, technical assistance, in-kind resources, etc.
2. Develop Mapping Tools and Strategies – develop data collection tools (surveys, questionnaires)
3. Gather Information – relevant to information you want and who sharing with. Methods can include questionnaires, surveys, interviews (telephone/persona), focus groups, roundtable discussions, and written or oral public testimony. Use more than one method. Use what already exists.

Criteria for Selecting Appropriate Data

- Credibility—information that is accurate and relevant to your audiences;
- Practicality—information collected without too much disruption;
- Timeliness—information produced in time to meet stakeholder needs;
- Accuracy—information that is relevant and trustworthy;
- Ease—information that is easily analyzed;
- Objectivity—information collected by objective personnel;
- Clarity—information that is clear and understandable to numerous audiences;
- Scope—information that provides answers without unnecessary detail;
- Availability—information that is easily accessible (i.e., existing data);
- Usefulness—information that addresses current stakeholder concerns;
- Balance—information that represents a multitude of perspectives and values; and
- Cost effectiveness—information worth the expense to collect

4. Determine the Meaning of the Information – can be difficult and time-consuming. Organize info based on your vision and goals.

Four-step process in examining your information:

1. Review the original purposes for information collection;
2. Describe the information in a narrative or using tables;
3. Examine your information for trends or patterns (e.g., gaps and overlaps in resources) that may point to untapped resources or new ways to align current resources for improved outcomes; and
4. Assess the comprehensiveness of the information in light of your goals. You may recognize a gap in your collection process and need to repeat the process for more targeted information.
5. Communicate and Use the Mapping Results – engage stakeholders in the results of mapping. Information can be used to make recommendations to improve, develop, and/or continue new and existing practices or programs. Use to develop informational bulletins, fact sheets, recommendation letters, etc.
6. Ask Reflective Questions – Have goals been identified to be mapped? Have we determined how to collect information? Are existing resources being considered?

Step 3: Taking Action

1. Develop an Action Plan – the Plan aligns your resources with your goals. The Plan will outline a course for possibly redirecting resources, fill gaps or eliminate duplication. Include all stakeholders in developing action plan. Document who is accountable, target dates for completion, and how action will be measured for success.
2. Achieve Consensus – process of responding to interests of everyone; does not mean that everyone will or should be completely happy with all decisions, but that all are willing to implement the action.

What Helps People Reach Consensus

Express your ideas as well as the logic behind them. Often agreement is more easily reached at the logic level—the group agrees with the logic, if not the proposed action, and an alternative option can be found.

- Listen to and be open to the logic of others.
- Explore ideas rather than debate them; actively seek agreement; and look for common ground. This is not a competitive process—an effort to see whose ideas can win; it is a search for what ideas the whole group can support.
- Ask yourself, "Can I support this?" If you find that you see a decision differently from others in the group, ask yourself, "Did the group listen to my points? Have I listened to them? Even if I wouldn't have put this idea on the list, I can understand why others want it there."
- Anticipate potential challenges to proceeding with the Plan and document methods for addressing.

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3. Implement the Action Plan – don't let the Plan sit on a shelf and collect dust. Establish an organizational structure to implement the Plan; who, how where, when.
4. Sharing the Action Plan – in a comprehensive and meaningful way. Consider audience and how Plan is compatible with their needs; how may motivate change.
5. Ask Reflective Questions – Do we have a Plan for "next steps?"; Do we understand the time and resources needed to move ahead? Can we measure improvement? Do we have a plan for communicating the Plan?

Step 4: Maintaining, Sustaining, and Evaluating Mapping Efforts

1. Evaluate Progress – Take a critical look at process, achievements, and impact of your efforts. Must be an on-going process. May need to change vision, goals, or action plan. Change can prevent costly missteps down the road. Continually measure progress with goals.
2. Maintain Momentum – Nurture and expand partnerships. Maintain awareness of stakeholders' needs and expectations. Be flexible enough to meet challenges and modify plans as result of input.
3. Sustain the Effort – Demonstrate a long-term commitment to change. Have a plan for're-mapping' to meet new or changing goals. Communicate on a regular and consistent basis. Engage others. Discuss coordination of community resources with creating turf battles. Articulate common concerns. Identify opportunities and mechanisms for aligning and coordinating resources. (Miller, 2001; Mooney & Crane, 2002)
4. Ask Reflective Questions – How do we monitor progress and gauge results? Have we shared the information? How do we promote our results? How do we improve our efforts? Are we satisfied with our progress? Do we have the funds to sustain our efforts? Are we building capacity with our community?

You will hit Small Bumps, Big Bumps, and Occasionally See a Few Mountains. Adjust to Changes. Embrace New Opportunities

Appendix 3

MY STRATEGIC PLAN

Strategic Planning Cheat Sheet

Your Planning Framework

By placing all the parts of a plan into the following three areas, you can clearly see how the pieces fit together.

- √ **Where are we now?** Review your current strategic position and clarify your mission, vision, and values.
- √ **Where are we going?** Establish your competitive advantage. See clearly the direction your organization is headed.
- √ **How will we get there?** Layout the road to connect where you are now to where you're going. Set your strategic objectives, goals, and action items, and then decide how you want to execute your plan.

Major Pieces of a Strategic Plan

An effective strategic plan includes all of the following pieces. It's easy to get confused with all the different parts of a strategic plan. If you're feeling lost, use this list as an outline for putting you strategic plan together.

- √ **Mission Statement:** To define the organization's core purpose. Why do we exist?
- √ **Vision Statement:** To explain where you are headed, your future state. To formulate a picture of what your organization's future makeup will be and where the organization is headed. What will your organization look like 5 to 10 years from now?
- √ **Values Statement or Guiding Principles:** To clarify what you stand for and believe in.
- √ **SWOT:** To assess the particular strengths, weaknesses, opportunities, and threats that are strategically important to your organization.
- √ **Competitive Advantage:** To define what you are best at. What can your organization potentially do better than any other organization?
- √ **Strategic Objectives:** To connect your mission to your vision. Strategic objectives are long-term, continuous strategic areas that get you moving from your mission to achieving your vision. What are the key activities that you need to perform in order to achieve your vision?
- √ **Strategies:** To establish a guide that matches our organization's strengths with market opportunities to position your organization in the mind of the customer. Does your strategy match your strengths with how you will provide value to and be perceived by your customers?
- √ **Short-Term Goals/Priorities/Initiatives:** To set goals that convert the strategic objectives into specific performance targets. Effective goals clearly state what, when, how, and who and are specifically measurable. What are the 1 to 3-year goals you are trying to achieve to get to your strategic objectives?
- √ **Action Items/Plans:** To set specific action plans that lead to implementing your goals. Are your action items comprehensive enough to achieve your goals?
- √ **Scorecard:** To measure and manage your strategic plan. What are key performance measures you can track in order to monitor whether you are achieving your goals?
- √ **Financial Assessment:** To determine whether your strategic plan makes financial sense. Do the estimated revenue projections exceed your estimated expenses

Planning Pitfalls

Strategic planning is as much about planning as it is about execution. Avoid these planning pitfalls and you'll have a strategic plan that is a living, breathing document.

- √ **Lack of Ownership:** The most common reason a plan fails is lack of ownership. If people don't have a stake and responsibility in the plan, it will be business as usual for all but a frustrated few.
- √ **Lack of Communication:** The plan doesn't get communicated to employees, and they don't understand how they contribute.
- √ **Getting mired in the day-to-day:** Owners and managers, consumed by daily operating problems, lose sight of long-term goals.
- √ **Out of the Ordinary:** The plan is treated as something separate and removed from the management process.
- √ **An Overwhelming Plan:** The goals and actions generated in the strategic planning session are too numerous because the team failed to make tough choices to eliminate non-critical actions.
- √ **A Meaningless Plan:** The vision, mission and value statements are viewed as fluff and not supported by actions or don't have employee buy-in.
- √ **Annual Strategy:** Strategy is only discussed at yearly weekend retreats.
- √ **Not Considering Implementation:** Implementation is not discussed in the strategic planning process. The planning document is seen as an end in itself.
- √ **No Progress Report:** There's no method to track progress. No one feels forward momentum.
- √ **No Accountability:** Accountability and high visibility are needed to help drive change. This means that each measure, objective, data source, and initiative must have an owner.
- √ **Lack of Empowerment:** While accountability may provide strong motivation for improving performance, employees must also have the authority, responsibility, and tools necessary to impact relevant measures. Otherwise, they may resist involvement and ownership.

The Guidelines for a Good Strategy

Need a quick gut check to see if your strategy is sound? Here are the guidelines for a good strategy. Make sure that your strategy…

- √ Establishes unique value proposition compared to your competitors
- √ Is executed through operations that provide different and tailored value to customers
- √ Identifies clear tradeoffs and clarifies what not to do
- √ Focuses on activities that fit together and reinforce each other
- √ Drives continual improvement within the organization and moves it toward its vision

Making Strategy a Habit

Your strategic planning process isn't linear; it's circular. Strategic planning isn't just a one-time event, so you need to make it a habit. Use the following suggestions to embed the concepts into you organization.

- √ Get ready for the strategic planning process
- √ Articulate your mission and vision
- √ Review your strategic position
- √ Agree on priorities
- √ Organize the plan
- √ Identify next actions
- √ Roll out the plan
- √ Hold everyone accountable

MHLAC STRATEGIC PLAN FOR 20--

Purpose **Develop the Mission, Goals & Objectives of the LAC.**

Agenda
A. Intro
B. Mission Definition
C. Define Goals
D. Develop Objectives
E. Review & Close

MISSION STATEMENT

The Mission of the MHLAC is to increase education and access to services and to reduce barriers and stigma associated with mental illness through collaboration with individuals living with mental illness, mental health providers, advocates, local government and law enforcement agencies, and other community stakeholders.

GOALS & OBJECTIVES

Goal I Collaborate with individuals affected by mental illness

Objectives:

Outreach to the community about the MHLAC through media, presentations, community forums, mailings and direct communication.

Contact the university about possibility of getting a student who can develop a video and radio PSA that can be used for marketing purposes.

Increase accessibility for LAC meetings – advertise time and date, open meeting to the public with posters, media appearances and community bulletin boards.

Establish the LAC as the centralized contact for mental health information and services.

Develop a website for the LAC that includes resources and links for mental health services and other information.

Goal II Reduce mental health stigma

Objectives:

Educate public about mental health, recovery and the experience of individuals living with mental illness.

Use Mental Health Awareness Month (May) to raise awareness about mental illness and recovery through letters to the editor and Brown Bag Lunches and the video PSA.

Goal III Improve access to mental health care

Objectives:

Develop a resource guide for mental health services.

Provide a link on the LAC website – living document that can be easily revised and updated.

Work with North Central Montana Transit (NCMT) to provide transit for mental health consumers.

Goal IV Advocate for individuals with mental illness and their families

Objectives:

Establish peer support network.

Partner with NAMI to provide support for family members.

Educate elected officials about the impact of mental illness on the community.

Goal V Identify gaps in mental health services

Objective:

Develop a questionnaire that is distributed to providers, people who use mental health services, community stakeholders, etc. and use the data to revise and refine the strategic plan.

SAMPLE 60 Second PSA

The Miles City Local Mental Health Advisory Council, your connection to development of mental health services in Miles City, wants you to know that persons with mental illness have the same needs and wants as persons without mental illness; a job, a place to live and a date on Saturday night. Staying healthy is one of those needs and desires. For all of us, this is more than eating broccoli every week. The federal Substance Abuse Mental Health Service Administration has outlined eight important dimensions of wellness to help our community understand and promote recovery for those with mental illness and substance use disorder. Three of the eight wellness dimensions are:

Physical.

Occupational.

Spiritual.

The Miles City Local Mental Health Advisory Council invites you to participate in a Wellness Initiative to learn more and promote wellness for people with mental health and substance use disorders. Together, let's work toward improved quality of life, cardiovascular health, and decreased early mortality rates for those we care about. Please join us Wednesday evening, January 9, 5:00 p.m. in the Board Room at Holy Rosary Healthcare Center to find out more about how you can get involved!

To learn more and sign the Pledge for Wellness, visit http://www.samhsa.gov/wellness.

Appendix 5

PUBLIC SERVICE ANNOUNCEMENT TEMPLATE

The following contains two PSA examples: one 10-second piece and one 30-second piece. After you personalize it for your Local Area, read it aloud with a stop watch to ensure it conforms strictly to the time limit.

Call your local radio station to ask about the process for having a PSA aired.

PUBLIC SERVICE ANNOUNCEMENT

LENGTH: 0:10

SUBJECT: Combating Stigma – Sponsored by (NAME):

FOR USE: [DATE]

VOICE: The (NAME) is hosting Local Mental Health Advisory Meeting to combat stigma associated with causes and origins of mental illness. Join us to educate yourself and your community on how to combat destructive untruths related to mental health on [DATE] at [TIME] at [PLACE]. To learn more Go to [URL] for details.

PUBLIC SERVICE ANNOUNCEMENT

LENGTH: 0:30

SUBJECT: Combating Stigma – Sponsored by (NAME):

FOR USE: [DATE]

VOICE: The (NAME) is hosting Local Mental Health Advisory Meeting to combat stigma associated with causes and origins of mental illness. (Include enough data or other information on MH in your community to add :20 seconds. Join us to educate yourself and your community on how to combat destructive untruths related to mental health on [DATE] at [TIME] at [PLACE]. To learn more Go to [URL] for details.

How to Write a Radio Public Service Announcement

Public Service Announcements can serve as free marketing opportunities to get the word out about what the Council is doing. PSAs can inform the public about important issues; provide opportunity for community members to support or participate in; and to share information.

Restrictions are placed on PSAs by the Federal Communications Commission and community radio stations. These restrictions guide the content, subject matter and length of PSAs. The requesting organization (Council) has little to no control over when PSAs are run; they are most often run at times when there are no paid advertisements available.

Helpful Instructions

1. Contact the local radio station(s) and request specific information about requirements, restrictions and limitations. Request a hard copy for future reference.
2. Most PSAs are limited to 30 – or 60 second spots; decide which limit may work best.
3. Write down key points that must be covered. Always answer the Who, What, When, Where, Why and How Questions. Leave no obvious question unanswered.
4. Capture the audience's attention at the beginning of the PSA. Ways to do this may be to: use humor, quotations, asking a question, a thought-provoking state, or sharing facts.
5. Develop a Draft PSA using words that will draw attention and encourage the public to listen.
6. Do not lie or bend the truth to emphasize.
7. Time the drafted PSA to make certain with timeframe.
8. Ask the radio state for guidance in the process.

Appendix 5

Sample Informational Bulletin

Facts About Mental Illness http://www.nami.org

- Mental Illness is a medical condition that disrupts a person's thinking, feeling, mood, ability to relate to others and daily functioning.
- Just as diabetes is a disorder of the pancreas, mental illnesses are medical conditions.
- Serious mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, posttraumatic stress disorder (PTSD) and borderline personality disorder.
- The good news about mental illness is that recovery is possible.
- Mental illnesses can affect persons of any age, race, religion or income.
- Mental illnesses are not the result of personal weakness, lack of character or poor upbringing.
- Mental illnesses are treatable.
- Most people diagnosed with a serious mental illness can experience relief from their symptoms by actively participating in an individual treatment plan.
- Mental health medications do not cure mental illness. However, they can often significantly improve symptoms and help promote recovery and are recognized as first-line treatment for most individuals.
- An array of mental health services and supports are important to ensure recovery for most people living with mental illness.

Local Mental Health Advisory Councils will include their contact information, meeting dates, a welcome brochure, and information from their Strategic Plan.

Appendix 6

SAMPLE LETTER TO COMMUNITY PARTNERS

Date
City/County Officials
Your city, MT

RE: Participation in the Local Advisory Council

Dear City/County Official:

The local mental health advisory council seeks city/county support to help those with mental health challenges receive outcome based and efficient services. Cross agency collaboration has proven to reduce cost of service, thus saving significant amounts of money over a life-time. We would like your help and collaboration to identify and reduce gaps in mental health services in our region of Montana. We extend an invitation for you to join us in those efforts. The local advisory council meets every third Tuesday at 5:00 p.m. at St. Joseph Hospital in the board room. A detailed brochure is included and will provide you information about the purpose and goals of local mental health advisory councils.

Service gaps the council has identified in our community, antidotal and through surveys, include crisis services for children and adults, community education and awareness on mental illness and the impact to families and the community, and, improved services for youth reaching age 18 to be able to transition into the adult mental health system. We know people can and do recover from mental health conditions through community treatment, support, and collaboration.

We would like you to participate, with us, in reaching the goals included in our Strategic Plan; including addressing the items, listed above, and improving the lives of those with mental illness. Please join us in our planning at the next council meeting scheduled for Tuesday, February 6. We look forward to the opportunity to receive input from the city and/or county planners.

Sincerely,

Adrian Haddock
Local Advisory Council Chair

Enclosure: Brochure

August 5, 20__

Joe Goodman, County Commissioner
Lewis & Clark County
P.O. Box 2222
Helena, MT 59601

RE: Recommendation: Prioritize Crisis Services

Dear Commissioner:

The Lewis & Clark County Local Mental Health Advisory Council (LMHAC) has been working together for a very short period of time; especially relative to how long the issue of crisis services for persons struggling with mental health issues has been discussed.

(Provide some History of Work Started/Completed) We know systemic issues/barriers still exist and we will continue to discuss and debate them. However, we believe it is important not to allow on-going challenges prevent us from making recommendations that are practical and doable.

(May put recommendation in narrative form or consider bullet points for a succinct but clear presentation).

Recommendation Points:

1. All individuals presenting with a mental health crisis will have the opportunity to receive a thorough assessment by a qualified mental health professional.
2. Opportunity to be treated with dignity and restrained without cause.
3. Opportunity to receive referrals for treatment and after care.

We believe we can provide a safe community environment for individuals with mental illness and other community members by: (Briefly list some potential opportunities/methods the Council would do to support/fulfill recommendation points).

It is our intent that every individual have the opportunity to experience safe and outcome based crisis services; and, be provided every opportunity to begin a life of independence with the support of the community. All the human commitment and financial resources the City/County uses to respond to Crisis Services deserve to be supported and dedicated to a positive outcome.

Respectfully submitted,
(Name), Chair

Appendix 7

(City/County) Local Mental Health Advisory Council
(Date)

TO: Chair, Mental Health Oversight Advisory Council (MHOAC)

The _____Advisory Council requests official recognition from Addictive and Mental Disorders Division and the Mental Health Oversight Advisory Council. The _____ Advisory Council consists of: (LIST groups represented and number, i.e., Family Members (2), Primary Consumers (3), Providers (1), City/County Officials (2), etc.) (NOTE: YOU MUST SHOW YOUR LOCAL GOVERNMENT'S SUPPORT FOR THE COUNCIL EITHER THROUGH MEMBERSHIP OR IN SOME OTHER WAY.)

The Council meets on the first Tuesday of the month at the Library (personalize). Fliers with more information about our Council are available at the Mental Health Center, the Drop-in Center and at other agencies such as Vocational Rehabilitation and Office of Public Assistance to encourage individuals with mental illness and family members to attend meetings. In addition we plan to publicize our meetings on community bulletin boards and through TV and radio PSAs.

The priorities of the Council are expanding mental health crisis services, improving access to mental health services and increasing peer services. We have identified the following goals for this year:

- Create the bylaws and policies for the council
- Develop a strategic plan
- Publicize the Council
- Provide information and education on mental illness to other community stakeholder groups.
- Recruit new members
- Map community resources
- Network with other organizations
- Participate in the Veteran's Stand Down

We appreciate the endorsement of the MHOAC and are excited to begin our work.

Sincerely,

Chair, _____Advisory Council

Appendix 8

CASCADE COUNTY MENTAL HEALTH LOCAL ADVISORY COUNCIL
BYLAWS
ADOPTED ON: June 1, 2009

Article 1: Name

The name of this council is the Cascade County Mental Health Local Advisory Council, and will be referred to as the LAC in the following Bylaws.

Article 2: Purpose

The purpose of the LAC is to assist in the improvement of public mental health services in the local community and to review and make recommendations about local public mental health services as well as provide input and recommendations to Mental Health Oversight and Advisory Council (MHOAC) and the Central Service Area Authority (SAA) that serve the state and regional communities.

Specific objectives include providing the following via a welcoming, approachable, respectful, supportive, accommodating, and safe place for all to have a voice:

- Examine gaps in child and adult services.
- Identify potential additions to services within the community.
- Analyze and discuss local problems with local service providers, advocacy groups, public officials and the general public.
- Facilitate accurate and timely communications between the local community and MHOAC and the regional SAA.
- Assess the effectiveness of local mental health services and suggest ways of making services more effective.
- Serve as a catalyst and facilitator in solving local mental health service problems.
- Organize and coordinate needed mental health-related services in the community.
- Educate the local community on mental health issues.

Article 3: Membership

Sec. A: Regular Members. LAC membership is open to interested parties, and the membership body may include:

- consumers, families or advocates to equal 50% of membership
- a County Commissioner or their designee
- a City Commissioner or their designee
- a provider of adult mental health services
- a provider of child mental health services
- a representative from a provider of co-occurring disorders (mental health & addictions) &/or Addiction services
- a representative from criminal justice
- a representative from Benefis Healthsystems Behavioral Health
- a representative from Public Health
- a representative from Law Enforcement
- a representative from Disability &/or Independent Living services
- a representative from Domestic and Sexual Violence services
- And other persons interested in participating in the planning and development of local mental health services.

Sec. B: Terms and Service. Executive Board Members are appointed for 2-year terms. Terms are staggered, with 50% of initial members serving 2 year terms, and 50% serving 2-year terms. Members will be encouraged to resign if they miss three consecutive meetings. Members may also vote to remove a member for cause. Cause may consist of, but is not limited to, failure of any member to attend three consecutive regular meetings without good cause. The Nominating Committee will appoint members to serve for the un-expired terms of Executive Committee members who resign or are recommended for removal.

Sec. D: Conflict of Interest. Members of the MHLAC shall recuse themselves of any vote when they have a conflict of interest, including, but not limited to a direct financial stake in the outcome of a decision.

Article 4: Meetings

Sec. A: Regular Meetings. The LAC shall meet no less than once a month, at a place and time specified by the Chair, and with adequate public notice.

Sec. B: Designees. Members may designate a person from their office or organization to represent them at meetings.

Sec. C: Action. Action may be taken by a majority of those members present.

Sec. D: Convening Special Meetings. The Chair of the LAC may convene a special meeting by written notice served at least 24 hours in advance, and otherwise in case of an emergency. It is the Chair's prerogative to determine an emergency.

Sec. E: Clerical Support. The Secretary will serve as the Assistant to the LAC; and will prepare, distribute, and retain minutes of the meetings.

Sec. F: Voting. Each LAC member present has one vote. Voting by proxy will not be permitted.

Sec. G: Parliamentary Authority. Robert's Rules of Order, revised, governs all LAC meetings. The LAC may, by a vote of two-thirds of the quorum, suspend the Rules at any time.

Article 5: Public Involvement

- All meetings are open to the public.
- An opportunity for public comment will be provided at each meeting.
- Participating LAC members will be notified of future meeting dates at each meeting.

Article 6: Amendments to the Bylaws

LAC members will review the Bylaws each July, and submit proposed amendments for action at the regular August meeting. The LAC may, by a vote of two-thirds of the quorum, recommend suspension of any provision of the Bylaws.

Article 7: Compensation

Service on the LAC is strictly voluntary. Members shall not be reimbursed for mileage or expenses and shall not be granted a per diem or salary for conducting the work of the LAC.

Article 8: Committee Structure

Sec. A: Officers. A Chair, Vice Chair, Secretary and Treasurer will be elected by a majority of the members to serve a two-year term, and may be re-elected to a second term. Election of these two positions will take place every even numbered year at the regular August Meeting.

Sec. B: Duties. The Chair is the parliamentary chair of the LAC; will preside over all meetings; and will set the agenda with the advice of the members. The Vice Chair shall perform the duties of the Chair in case of absence or disability. Secretary will send agenda to membership no later than one week prior to the meeting and will distribute minutes after each meeting. The Treasurer will be responsible for the general ledger and will provide a financial report at each meeting.

Sec. C: Subcommittees. To expedite business, the Chair may appoint subcommittees with the majority vote or consensus of the members.

Article 9: CSAA Representation. The LAC shall elect a representative to serve as liaison to the Central Service Area Authority. The LAC representative is eligible to serve a CSAA liaison for up to four years.

Adopted on this First day of June, 2009.

CCMHLAC Chair

Universal design standards and practices for accessibility are used in this document.

Appendix 9

Local Mental Health Advisory Council
Terms, Recruitment and Appointments, Elections
Procedure Adopted _____

Under Council By-Laws, Article III: Membership, Section 2. Terms, Appointments and reappointments, representatives shall be made for a term of four (4) years. Appointments for vacancies shall be for the remainder of that term. Members may apply for reappointment.

It is the Policy of the Local Mental Health Advisory Council that the following policy/procedure be reviewed and updated as required annually, respectfully considered and followed:

Member Terms and Appointments:

- Individuals may be reappointed to the Council for one four-year term. Term Limits?
- The Council will elect, by majority vote, through the prescribed election process, the chair and vice-chair for a two year term; and, re-elected for one additional term.
- The _____ Committee of the Council will initiate and manage appointments and reappointments in adherence to Council By-Laws and Policy/Procedure.
- Any member of the Development Committee whose term has expired and is being considered for reappointment will not participate in the appointment/reappointment process.
- When a Council member resigns or is no longer able to represent the interest of the Council, the Council will follow Council By-Laws and Member Recruitment and Appointment policy.
- Council members may not send a proxy to represent their interests but may send someone to listen on their behalf.

Recruitment and Appointment/Reappointments:

- At the time of a member vacancy, the Development Committee shall begin the recruitment process.
- Any individual interested in Council membership shall submit a completed application provided by the Council;
- Any applications not received by the required suspense date shall not be considered;
- All applications must be considered based on geographical and membership requirements established in Council By-Laws.
- Any member whose term has expired and is being considered for reappointment will not participate in the appointment/reappointment process.
- All appointment/reappointment recommendations will be forwarded to the Director of DPHHS for consideration and appointment.

Election Process:

- Elections for Chair and Vice-Chair shall adhere to Council By-Laws;
- Elections shall be through a confidential/secret Ballot process;
- Election of officers will be bi-annually at the spring meeting; or no later than June of a fiscal year that terms have expired;
- Nominations shall be called for a month prior to Elections;
- Paper Nomination and Election forms shall be provided to Council members;
- Election Ballots shall be mailed or delivered to Council members no later than mid-June of a fiscal year that terms have expired;
- Elections will be counted by a team of Council members not being considered for appointment.
- Officers shall take office effective _____ following Elections.

Appendix 9

ROBERTS RULES OF ORDER – SOME BASICS

The following was condensed from The Robert's Rules of Order and includes typical rules to manage a board meeting.

About Motions
All motions must be seconded and adopted by a majority vote unless otherwise noted. All motions may be debated unless otherwise noted.

Motions	Purpose of Motion	To Enact Motion
Main Motion	To take action on behalf of the body	Debatable; requires majority vote
Adjourn	End the meeting	Not debatable; immediately voted upon and requires majority vote
Call for Orders of the Day	Asks to stick to the agenda	Not debatable; requires one-third majority to sustain
Call to Question	Closes debate and forces vote	Not debatable; requires two-thirds majority vote
Motion to Limit or Extend Debate	Limits or extends debate	Not debatable; requires two-thirds majority vote
Point of Order	Is a question about the process or a particular motion	Automatic if granted by Chair
Motion to Rescind	To change the results of a vote	Requires two-thirds majority vote to reverse results of earlier vote
Motion to Suspend the Rules	Suspend formal process for a short period	Debatable and requires two-thirds majority vote

About Debate
Each motion that is debated receives 10 minutes of debate. The member initiating the motion speaks first. The Chair asks for a rebuttal. All members wishing to speak about the motion receive the opportunity to speak before any one member speaks for a second time.

About Voting
Majority vote is more than half of the members. Two-thirds vote is two-thirds or more of the members. Be sure to announce what is being voted on before the vote.

Taken from http://managementhelp.org/boards/roberts.htm

LAC/SAA Report to MHOAC
Report Template

_____LAC/SAA

Reporting Date: _____

Reporter: _____

PRIORITIES	LAC/SAA GOALS TO ACHIEVE PRIORITY	LAC/SAA SPECIFIC ACTIONS TAKEN AND OUTCOMES ACHIEVED	TIMELINE TO ACHIEVE
LAC/SAA Support of MHOAC's Top 3 Priorities **#1: Transitions: Improved Transitions/Discharge Planning for Youth to Adult Mental Health System**	1. 2. 3.	1. 2. 3.	
#2: Crisis Services: Advocate for Community Crisis Services for Children	1. 2. 3.	1. 2. 3.	
# 3: Education/Prevention: Provide advocacy in funding and promotion of Early Intervention Strategies to promote holistic wellness.	1. 2. 3.	1. 2. 3.	
LAC/SAA Top 3 Priorities **#1:**	1. 2. 3.	1. 2. 3.	

PRIORITIES	LAC/SAA GOALS TO ACHIEVE PRIORITY	LAC/SAA SPECIFIC ACTIONS TAKEN AND OUTCOMES ACHIEVED	TIMELINE TO ACHIEVE
#2:			
#3:			

Other Information Requested:

When Does the LAC/SAA Meet? (Monthly, Quarterly, Designated Week, etc.) _____

Please Note the Number (#) of Mental Health Local Advisory Councils Reporting to SAA For **This** Reporting Period? _____

Topics of Concern or Discussion Not Included in Priorities Above

Topic	Discussion	Action Items	Responsible Party & Due Date

Local Advisory Council and SAA Successes

Topic	Success	How Achieved	Other Partners Involved

Appendix 11

History and Purpose of Planning Councils – Mental Health Oversight Advisory Council (MHOAC)

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

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:

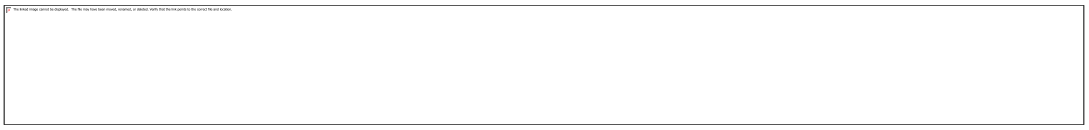
1. To review the Mental Health Block Grant Plan and to make recommendations.

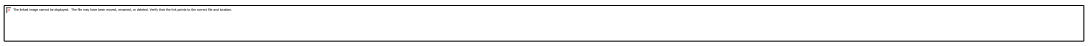
2. To serve as an advocate for adults with a serious mental illness, children with a serious emotional disturbance, and other individuals with mental illnesses.

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

Reference: National Association of Mental Health Planning and Advisory Councils; Orientation + Resource Toolkit: http://www.namhpac.org/PDFs/toolkit.pdf

Appendix 12





53-21-1013. Purpose. The purpose of this part is to:

(1) create service area authorities that collaborate with the department and local advisory councils to plan, implement, and evaluate regional public mental health care within the budget constraints for each service region;

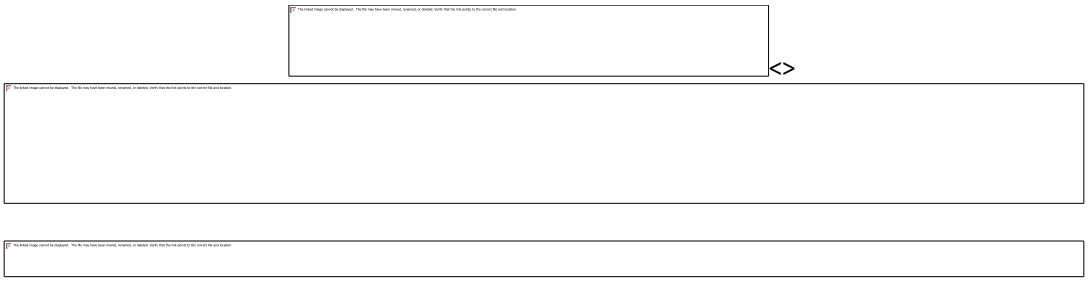
(2) promote consumer and family leadership within the public mental health system through service area authorities; and

(3) foster a consumer-driven and family-driven system of public mental health care that advances:

(a) access to a continuum of mental health services; and

(b) individual choice of services and providers.

History: En. Sec. 1, Ch. 553, L. 2005.



53-21-1006. Service area authorities -- leadership committees -- boards -- plans. (1) In the development of a service area authority, public meetings must be held in communities throughout a service area as defined by the department by rule. The purpose of the meetings is to assist the department to establish a stakeholder leadership committee. The meetings must be designed to solicit input from consumers of services for persons with mental illness, advocates, family members of persons with mental illness, mental health professionals, county commissioners, and other interested community members.

(2) The leadership committee within each service area must include but is not limited to a significant portion of consumers of services for persons with mental illness, family members of persons with mental illness, and a mental health services provider. The department shall provide assistance for the development of a leadership committee. The department shall approve a leadership committee within each service area.

(3) The leadership committee within each service area shall establish a service area authority board and create bylaws that describe the board's functions and method of appointment. The bylaws must be submitted to the department for review. The majority of the members of the board must be consumers of mental health services and family members of consumers.

(4) The service area authority board must be established under Title 35, chapter 2. Nonprofit corporations incorporated for the purposes of this part may not be considered agencies of the department or the state of Montana.

(5) A service area authority board:

(a) shall collaborate with the department for purposes of planning and oversight of mental health services of the service area, including:

(i) provider contracting;

(ii) quality and outcome management;

(iii) service planning;

(iv) utilization management and review;

(v) preadmission screening and discharge planning;

(vi) consumer advocacy and family education and rights protection;

(vii) infrastructure;

(viii) information requirements; and

(ix) procurement processes;

(b) shall review and monitor crisis intervention programs established pursuant to 53-21-1202;

(c) shall submit a biennial review and evaluation of mental health service needs and services within the service area;

(d) shall keep all records of the board and make reports required by the department;

(e) may enter into contracts with the department for purposes of planning and oversight of the service area if the department certifies that the service area authority is capable of assuming the duty;

(f) may receive and shall administer funding available for the provision of mental health services, including grants from the United States government and other agencies, receipts for established fees rendered, taxes, gifts, donations, and other types of support or income. All funds received by the board must be used to carry out the purposes of this part.

(g) may reimburse board members for actual and necessary expenses incurred in attending meetings and in the discharge of board duties as assigned by the board;

(h) shall either include a county commissioner or work closely with county commissioners in the service area; and

(i) shall take into consideration the policies, plans, and budget developed by the children's system of care planning committee provided for in 52-2-303.

(6) A service area authority may not directly provide mental health services.

History: En. Sec. 4, Ch. 602, L. 2003; amd. Sec. 2, Ch. 200, L. 2005; amd. Sec. 4, Ch. 553, L. 2005.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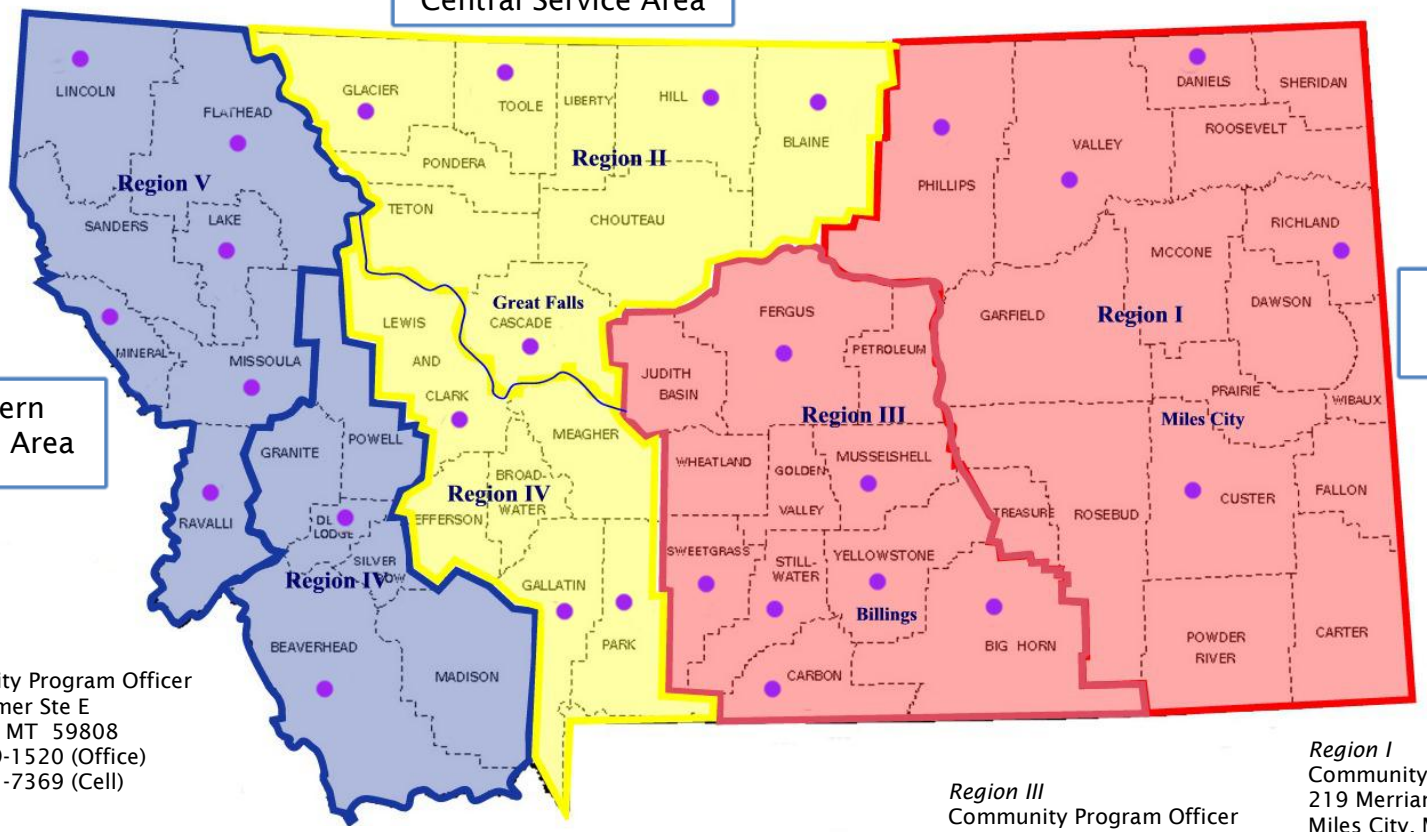
Appendix 13

Local Mental Health Advisory Councils (LMHACs); Service Area Authorities (SAAs), and Community Program Officers (CPOs)

Region II
Community Program Officer
201 1st St S. Ste 3 Rm 165
Great Falls, MT 59405
(406) 454-6078 (Office)
(406) 788-8167 (Cell)

Central Service Area



Western Service Area

Eastern Service Area

Region V
Community Program Officer
2685 Palmer Ste E
Missoula, MT 59808
(406) 329-1520 (Office)
(406) 241-7369 (Cell)

Region IV
Community Program Officer
307 E. Park Rm 415
Anaconda, MT 59711
(406) 563-7045 (Office)
(406) 498-7358 (Cell)

● *Counties where a LAC contact person is available.*

Region III
Community Program Officer
2121 Rosebud Drive Ste. F
Billings, MT 59102
(406) 655-7622 (Office)
(406) 670-6910 (Cell)

Region I
Community Program Officer
219 Merriam
Miles City, MT 59301
(406) 234-1866 (Office)
(406) 853-4421 (Cell)

AMDD Local Advisory Council Map
Updated September 2013

Appendix 14

ADDICTIVE AND MENTAL DISORDERS DIVISION Commonly Used Acronyms	
ACS	Affiliated Computer Services, Inc.
ACT	Assessment, Course and Treatment (Also referred to as DUI School or ACT Training)
ADA	Americans with Disabilities Act
ADRT	Admission and Discharge Review Team
ADC	Average Daily Census
ADIS	Alcohol and Drug Abuse Information System (SAMS replacing)
ADP	Average Daily Population
AMDD	Addictive and Mental Disorders Division
AOD	Alcohol and Other Drugs
APRN	Advanced Practice Registered Nurse
APS	Adult Protective Services
ARM	Administrative Rules of Montana
ASAM	American Society of Addiction Medicine
ATTC	Addiction Technology and Transfer Center
AWACS	Agency-Wide Accounting and Client System
BHIF	Behavioral Health Inpatient Facilities (short-term, acute psychiatric Treatment facilities intended as alternative to the MSH) similar to crisis stabilization beds
BOV	Mental Disabilities Board of Visitors
CASSP	Child and Adolescent Service System Project
CD	Chemical Dependency
CCISC	Comprehensive Continuous Integrated Systems of Care
CFR	Code of Federal Regulation
CHIP	Children's Health Insurance Program
CIP	Community Incentive Program

ADDICTIVE AND MENTAL DISORDERS DIVISION Commonly Used Acronyms	
CLO	Community Liaison Officer
C4MH	Center for Mental Health, Great Falls
CMHC	Community Mental Health Center
CMHS	Center for Mental Health Services (federal)
CMS	Centers for Medicare and Medicaid Services (formerly HCFA)
CON	Certificate of Need
COO or COD	Co-Occurring Disorders
CPO	Community Program Officer
CSAP	Center for Substance Abuse Prevention (federal)
CSAA	Central Service Area Authority
CSAT	Center for Substance Abuse Treatment (federal)
DASIS	Drug and Alcohol Services Information System
DBT	Dialectical Behavioral Theory
DIG	Data Infrastructure Grant
DME	Durable Medical Equipment
DPHHS	Department of Public Health and Human Services
DUI	Driving Under the Influence
DUR	Drug Utilization Review
DUNS	Data Universal Number System number (DPHHS has one; used in grant apps)
ESAA	Eastern Service Area Authority
EMCMHC	Eastern Montana Community Mental Health Center (Miles City)
FAIM	Families Achieving Independence in MT
FFS	Fee For Service
FMAP	Federal Medical Assistance Percentage

ADDICTIVE AND MENTAL DISORDERS DIVISION Commonly Used Acronyms	
FY	Fiscal Year
FFY	Federal Fiscal Year
FQHC	Federally Qualified Health Clinic
GBMI	Guilty by Mental Illness
HCBS	Home and Community Based Services
HIFA	Health Insurance Flexibility and Accountability (Waiver)
HIPPA	Health Insurance Portability and Accountability Act
HPSA	Health Professional Shortage Area
HIDTA	High impact drug traffic area
HRD	Human Resources Division (DPHHS)
ICBR	Intensive Community-Based Rehabilitation
IEP	Individual Education Plan
IMD	Institute for Mental Disease - - Medicaid prohibits funding anyone over 21 & under 65 who is in an IMD. MSH is an IMD & have currently requested feds to make a ruling on MCDC.
ICM	Intensive Case Management
ICMs	Intensive Case Managers
IHS	Indian Health Service
IMR	Illness Management and Recovery
IOP	Intensive Outpatient
JCAHO	Joint Commission of Accreditation of Health Care Organizations
KMA	Kids Management Authority
LAC	Licensed Addiction Counselor (used to be CCDC)
LAC	Local Advisory Council
MAADAC	Montana Association of Alcohol and Drug Abuse Counselors
MACo	Montana Association of Counties

ADDICTIVE AND MENTAL DISORDERS DIVISION Commonly Used Acronyms	
MAP	Montana Advocacy Program
MASP	Montana Addiction Service Providers
MCA	Montana Codes Annotated
MCDC	Montana Chemical Dependency Center
MCO	Managed Care Organization
MCMHCA	Montana Clinical Mental Health Counselors Association
MDS	Minimum Data Set
MHA	Montana Hospital Association
MHA	Mental Health Association (of Montana)
MHOAC	Mental Health Advisory Council
MIAMI	MT Initiative for the Abatement of Mortality in Infants
MHC	Mental Health Center
MHSIP	Mental Health Statistics Improvement Program
MHSP	Mental Health Services Plan (Non-Medicaid services)
MIP	Minor in Possession
MMHNCC	Montana Mental Health Nursing Care Center (long-term care Lewistown)
MMA	Medicare Modernization Act
MMIS	(Montana) Medicaid Management Information System
MonAMI	Montana Alliance for the Mentally Ill
MOE	Maintenance Of Effort
MOMs	Montana Operating Manuals
MSH	Montana State Hospital (typically short duration stays—Warm Springs)
MTCCP	Montana Community Change Project (CD Bureau)
NAMI	National Alliance for the Mentally Ill

ADDICTIVE AND MENTAL DISORDERS DIVISION Commonly Used Acronyms	
NASADAD	National Association of State Alcohol and Drug Abuse Directors
NASMHPD	National Association of State Mental Health Program Directors
NCADD	National Council on Alcoholism and Drug Dependence
NCADI	National Clearinghouse for Alcohol and Drug Information
NFC	New Freedom Commission
NFR	National Family Register
NGBMI	Not Guilty But Mentally Ill
NIATx	Network for the Improvement of Addiction Treatment
NPI	National Provider Identifier
NPN	National Prevention Network
OCD	Obsessive/Compulsive Disorder
PACT	Program of Assertive Community Treatment
PASRR	Preadmission Screening and Resident Review (program)
PATH	Projects for Assistance in Transition from Homelessness (Homeless Grant)
PERQS	Purchasing, Entry, Receiving, Query System
PIO	Public Information Officer
PMPM	Per Person Per Month
PLOD	Place of last drink
PPCIIR	Patient Placement Criteria II Revised Manual (chemical dependency)
PRU	Psych-Rehab Unit
PSA	Prevention & Stabilization Account
PSO	Provider Service Organization
RADAR	RADAR Network - Regional Alcohol & Drug Information Resource Network
RFI	Request for Information

ADDICTIVE AND MENTAL DISORDERS DIVISION Commonly Used Acronyms	
RFP	Request for Proposal
RTC	Residential Treatment Center
RTEC	Residential Treatment Expansion Consortium
SAA	Service Area Authority (IRS code designation as 501 C(3))
SABHRS	Statewide Accounting, Budgeting & Human Resources System
SADAP	State Alcohol and Drug Abuse Profile
SAMS	Substance Abuse Management System
SAMSHA	Substance Abuse and Mental Health Services Administration (federal)
SAPT	Substance Abuse Prevention and Treatment (Block Grant)
SCRMHC	Southcentral Regional Mental Health Center (Billings)
SDMI	Severe and Disabling Mental Illness
SED	Severe Emotional Disturbance (children and adolescents)
SIG	State Incentive Grant (MT used term CIP Community Incentive Program)
SOAR	SSI/SSDI Outreach Access Recovery (training)
SOC	System of Care (Children's Mental Health)
SPFSIG	Strategic Prevention Framework State Incentive Grant
SURS	Surveillance Utilization Review Section
SMHA	State Mental Health Authority
STEP	Secure Treatment and Evaluation Program (MSH)
TAC	Technical Assistance Center
TAC	Transportation Advisory Council
TANF	Temporary Assistance to Needy Families
TCM	Targeted Case Management
TEAMS	The Economic Assistance Management System

ADDICTIVE AND MENTAL DISORDERS DIVISION Commonly Used Acronyms	
TESS	The Eligibility Screening System
TEDS	The Treatment Episode Data Set
UFDS	The Uniform Facility Data Set
UR	Utilization Review
WSAA	Western Service Area Authority
WICHE	Western Interstate Commission for Higher Education
WMCMHC	Western Montana Community Mental Health Center (Missoula)
WRAP	Wellness Recovery Action Plan

Appendix 15