

STATE BEHAVIORAL HEALTH PLANNING COUNCILS

An Introductory Manual

April 2023

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State Behavioral Health Planning Councils: An Introductory Manual

April 2023

Introduction

This manual is intended primarily for two audiences:

- The behavioral health agencies in the 50 states, Washington, DC, Puerto Rico, the U.S. Virgin Islands, and 6 Pacific jurisdictions (American Samoa, the Northern Mariana Islands, the Federated States of Micronesia, Guam, Marshall Islands, and Palau), which will collectively be referred to as “state behavioral health agencies.”
- The planning councils that are required under federal law as a requirement of receiving Community Mental Health Services Block Grant (MHBG) funding from the Substance Abuse and Mental Health Services Administration (SAMHSA), which in many states take the form of a combined planning council also advising the agency receiving SAMHSA’s Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS BG) funding.

Under federal law, the planning councils have three primary duties, which will be discussed in detail in this manual in the *Primary Duties of a Planning Council* section. They are as follows:

- To review the state’s MHBG application and report and make recommendations to the agency receiving the grant, which may be a mental health agency or a behavioral health agency that also has responsibility for substance use disorder (SUD) prevention and treatment.
- To serve as advocates for people with mental illness, including adults with serious mental illness (SMI) and children and adolescents with serious emotional disturbance (SED).
- To monitor, review, and evaluate the adequacy of mental health services in the state.

To give councils the independence to evaluate and advocate for services for those with mental illness with the state behavioral health agencies, the block grant statute specifies that state employees and mental health service providers, collectively, may not make up more than 50 percent of the planning council’s membership. Within that category of membership (i.e., state employees and mental health service providers), the statute mandates participation from specific agencies. Additionally, the statute specifies that adults who receive services and parents of children who receive services must have adequate representation on the planning council, as described in detail in the *Composition* section.

Beyond the minimum statutory requirements, planning councils have quite a bit of flexibility in how they assemble their membership and carry out their duties. Over the years, however,

SAMHSA has helped planning councils identify best practices that ensure their membership is broadly representative of the people served by the behavioral health agency. This assists the council in having the greatest positive impact on behavioral health services availability and quality. This manual presents a number of best practices, some of which are adapted from the 2014 SAMHSA publication [*Best Practices for State Behavioral Health Planning Councils*](#). However, this manual primarily contains new material that reflects the growing trend toward integration of mental health and SUD agencies and planning councils, along with changes in the way people conduct meetings, which were greatly accelerated by the COVID-19 pandemic. Unless identified as a statutory requirement, the material in this manual should be considered advisory, and individual planning councils should continue to make innovations that best serve the needs of the individuals and families whose interests they represent.

Composition, 42 U.S. Code § 300x–3(c)

The MHBG authorizing statute, 42 U.S. Code § 300x–3(c), contains specific requirements for the composition of a mental health planning council, which are described in this section. In addition to the minimum requirements, states are urged to diversify their planning council membership and include voices of lived experience. The legal requirements and best practices for council membership are included in this section, and additional advice on recruiting and retaining council members is offered in the *Effective Operation* section. A planning council must reflect a balance of representatives of state agencies and service providers, on the one hand, and other participants such as people with lived experience, on the other.

State Agencies and Providers

Participation Requirements

State employees and mental health service providers must, by statute, collectively make up no more than 50 percent of the council. The statute specifies that the membership must include people who meet the following criteria:

- Employees of mental health, education, vocational rehabilitation, criminal justice, housing, social services, and Medicaid agencies
- Employees of public and/or private entities concerned with the need, planning, operation, funding, and use of mental health services as well as related support services

A state employee may not represent more than one required position. For example, if vocational rehabilitation falls under the state’s education department, a single person could not fulfill the participation requirement for both vocational rehabilitation and education. Instead, the department should assign two staff: one with vocational rehabilitation expertise and another with expertise in another aspect of education, such as K-12 schools.

People who are not state agency employees or mental health service providers should be more actively recruited, as individuals who are state agency employees or mental health service

providers cannot occupy more than 50 percent of the council, even if there are open positions. Individuals who are not state agency employees or mental health service providers must occupy at least 50 percent of the council but can occupy more, if available.

Recommendations

More extensive and varied professional experience among agency employees and mental health professionals means more insight offered to the planning council. Therefore, SAMHSA recommends that, in addition to meeting the requirement described above, states should consider recruiting agency employees and mental health providers from the following categories:

- Representatives of substance use, aging, and child welfare agencies
- Healthcare providers serving diverse populations, based on characteristics such as:
 - Race and ethnicity
 - Age (children and youth, older adults)
 - LBGTQ+ identity
 - Co-occurring disorders
- Healthcare providers operating in diverse settings, such as:
 - Inpatient care
 - Residential care
 - Outpatient care
 - Intensive outpatient care

Other Participants (Not a State Employee or Provider)

Participation Requirements

People who are neither state employees nor providers of mental health services must, by statute, make up at least 50 percent of the council. The statute specifies that the membership must include people who meet the following criteria:

- Adults with SMI who are receiving (or who have received) services
- Families of such adults or children with SED

Further, the statute specifies that the planning council must include adequate representation of parents of children with SED in relation to other members of the council. SAMHSA recommends that councils include more than one parent representative.

Recommendations

When a diverse group of individuals with lived experience participates in the planning council, the state benefits. SAMHSA has long supported the idea that people with lived experience should have a “seat at the table” when important decisions are being made. Therefore, it is a longstanding recommendation that states fulfill the participation requirement described above by ensuring that at least 50 percent of the council is made up of people with lived experience (either as service recipients or as parents of children receiving services).

Furthermore, while not required by statute, including individuals who have received services when they were children—for example, a transition-aged youth representative—can give the council valuable insight into children’s services that might differ from a parent’s perspective.

A diverse membership will improve the planning council’s ability to evaluate the adequacy of mental health services across the state, particularly for underserved populations. Therefore, consideration should be given to the following membership goals:

- Representation from all geographic regions of the state
- Representation from urban, suburban, and rural communities
- Diversity of race, ethnicity, and primary language spoken
- Inclusion of Tribal communities
- Inclusion of at least one youth representative
- Inclusion of at least one older adult representative
- Representation of the LGBTQI+ community, including youth
- Ensuring all meetings and materials are accessible to persons with disabilities

Many states have combined planning councils with the council responsible for reviewing the SUPTRS BG. In states that have not integrated their planning councils, it is particularly helpful for the mental health planning council to include perspectives of people from the SUD treatment and recovery community, including the following:

- People in recovery from SUDs
- Families of children or adults with SUDs
- Treatment and recovery support providers, including peer providers

Relationship to State Government

The authorizing statute requires states to “establish and maintain” a planning council, suggesting that the planning council is not entirely independent of state government. States take a variety of approaches to appointing members to the council, including the following:

- All members are appointed by the governor.
- All members are appointed by the director of the behavioral health agency.
- All members are appointed by the secretary of the agency within which the behavioral health agency is situated.
- Representatives of state agencies are appointed by a director or secretary of the department in which they work, and the remainder are appointed by the governor.
- Agency heads are identified in state law as planning council members, but they may designate an alternate, and the remainder of the council members are appointed by the governor.
- Voting members are appointed by the governor, but the planning council chair may appoint others to serve on subcommittees.

In some states, the council members elect all officers, including the chair. In other states, the governor, health secretary, or behavioral health agency director appoints the chair, while other officers such as the vice-chair and secretary are elected by council members.

States also differ on the level of independence the planning council has in adopting bylaws and setting meeting schedules. In some states, the bylaws and meeting schedules are established by law, while in other states, the planning council is empowered to adopt its own bylaws and set its own meeting schedule.

Most, if not all, states have open meeting laws that require that meeting notices be posted, sessions be open to the public, and minutes and correspondence be made available to the public. In some states, the law establishing the planning council explicitly makes the planning council subject to the open meeting law. In other states, the council meets the requirements of the open meeting law even though it may not be specifically named as a body that is subject to that law.

Primary Duties of a Planning Council, 42 U.S. Code § 300x–3(b)

By statute, planning councils have three primary duties:

- To review the state’s annual block grant application and the state’s implementation report of the previous year and make formal recommendations
- To advocate for persons with mental illness
- To monitor and review the adequacy of mental health services statewide

Although the statute does not impose specific requirements on how planning councils fulfill these duties, this section offers suggestions for how planning councils may choose to proceed.

Review Block Grant Plans and Make Recommendations

The primary duty of planning councils listed in the authorizing statute is to review the state’s plan using SAMHSA’s MHBG funds for any modifications.

Overview of the Block Grant

The MHBG provides funding to 59 state behavioral health agencies, as described in the introduction to this manual. As a formula grant (as opposed to a competitive grant), the amount of the grant is calculated based on factors such as population, rather than the content of the state’s application. States must only comply with the minimum statutory requirements to receive their annual allocation.

The MHBG is intended to support comprehensive community mental health services for adults with SMI and children with SED, but grantees (states and jurisdictions) have flexibility in how they use the funds for new and existing services, as well as administrative costs. The law establishing the block grant can be found beginning at [42 U.S. Code §300x](#).

States are required by 42 U.S. Code §300x(b) to expend grant funds only for the following purposes:

- Providing community mental health services for adults with SMI and children with SED
- Carrying out the plan submitted by the state for the fiscal year involved
- Evaluating programs and services carried out under the plan
- Planning, administration, and educational activities related to providing services under the plan

Within these requirements, SAMHSA encourages states to use MHBG funds for the following purposes:

- To fund services for individuals with SMI/SED who are uninsured or underinsured
- To fund services that have a demonstrated effectiveness for individuals with SMI/SED but are not covered by insurance
- To support statewide planning and evaluation of mental health services
- To support recovery of individuals with SMI/SED through case management, evidence-based practices, alternatives to hospitalization, suicide prevention, recovery support services, and integration of behavioral and primary health care.

The block grant is to be used to create a “comprehensive system of care” for individuals with mental illness, including those who have co-occurring SUDs. Required components of the plan include descriptions of case management, evidence-based practices, alternatives to hospitalization, suicide prevention, integration of behavioral and primary health care, and recovery support services (42 U.S. Code §300x–1). For children with SED, the statute separately requires “a system of integrated social services, educational services, child welfare services, juvenile justice services, law enforcement services, and substance use disorder services that, together with health and mental health services” (42 U.S. Code §300x–1). States are also generally required to spend at least 10 percent of MHBG funds on services for persons with early SMI, including psychotic disorders (42 U.S. Code §300x–9).

The authorizing statute also contains several key prohibitions on the use of block grant funds, including their use to provide inpatient services, to make cash payments to service recipients, to acquire real estate, or to assist for-profit entities (42 U.S. Code §300x–5).

Application and Reporting Process

Each grantee has a designated unit of the executive branch that is responsible for administering the MHBG (for example, the Division of Behavioral Health), which must submit a plan to SAMHSA explaining how they will use MHBG funds to provide comprehensive, community mental health services for adults with SMI and children with SED. SAMHSA also requires recipients to provide annual reports on their plans.

States must submit their applications through SAMHSA’s Web Block Grant Application System (WebBGAS). States have the option of submitting a combined application for the MHBG and SUPTRS BG. Well over half of states/jurisdictions submit combined applications.

Review by the Planning Council

By statute (42 U.S. Code § 300x–4), the state must submit both the block grant plan and the previous year’s block grant report to the mental health planning council for review before submitting them to SAMHSA. The state is not obligated to incorporate the suggestions of the planning council into either the plan or the report, but the state must forward these suggestions to SAMHSA by uploading the planning council’s comments about the application and previous year’s report as part of the block grant application. SAMHSA also requests that states submit a letter from the planning council chair detailing the planning council’s activities, including their review of the plan and report.

In conducting its review, the planning council should focus on whether the state plan fulfills the five statutory criteria listed in 42 U.S. Code § 300x–1(b)(1) by describing the following:

- *Comprehensive community-based health systems* (42 U.S. Code § 300x–1(b)(1)(A))
 - Identification of the agency administering the grant
 - An organized community-based system of care that provides services for individuals with mental illness, including co-occurring disorders
 - Coordination of health, mental health, rehabilitation, employment, housing, educational, SUD, legal, law enforcement, social, child welfare, medical, and dental services
 - Coordination with services provided by local school systems under the Individuals with Disabilities Education Act (IDEA, 20 U.S. Code § 1400 et seq.)
 - Promotion of evidence-based practices
 - Services for people in early stages of SMI
 - Efforts to engage individuals (and caregivers) in treatment decisions
 - Case management services
 - Activities to reduce hospitalization
 - Suicide prevention activities
 - Integration of primary and behavioral health
 - Recovery support services
- *Mental health system data and epidemiology* (42 U.S. Code § 300x–1(b)(1)(B))
 - Estimates of the incidence and prevalence of SMI among adults
 - Estimates of the incidence and prevalence of SED among children
 - Quantitative goals to be achieved through the implementation of the comprehensive community-based health system
- *Children’s services* (42 U.S. Code § 300x–1(b)(1)(C))
 - Health and mental health services
 - SUD services
 - Health services
 - Family supports
 - Social services and child welfare services
 - Educational services, including services provided under IDEA
 - Juvenile justice and law enforcement interventions

- Crisis interventions
- *Targeted services to rural and homeless populations* (42 U.S. Code § 300x–1(b)(1)(D))
 - Intended outreach and services for individuals with SMI/SED experiencing homelessness
 - Community-based services for individuals with SMI/SED in rural communities
- *Management services* (42 U.S. Code § 300x–1(b)(1)(E))
 - Financial resources
 - Existing mental health workforce
 - Existing workforce with co-occurring disorder training
 - Training of providers of emergency health services regarding mental health
 - Plans for expending block grant funds
 - Plans for complying with funding agreements

In reviewing the plan and the report, the planning council may also wish to examine whether the state fully and accurately describes quality improvement measures, as well as the availability and coordination of the following services:

- Services for individuals with co-occurring mental and substance use disorders
- Peer support services
- Services to transition people to less-restrictive settings
- Crisis interventions, including mobile crisis services

Advocate for Persons with Mental Illness

The authorizing statute requires a planning council “to serve as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems.” However, the statute does not specify how this is to be accomplished, allowing for a great deal of interpretation. Planning councils vary from state to state in their approaches, including the types of advocacy efforts taken on, how they accomplish their efforts, and their partners. The recommendations below may prove useful, but it is ultimately the responsibility of the council to determine how it will fulfill its statutory obligation.

Areas for Advocacy

One of the key challenges for planning councils is to ensure that advocacy efforts are not focused too narrowly on specific issues that affect only a small percentage of people receiving block-grant-funded services. It is not unusual for planning councils to have members with a particular passion for an issue that affects them personally. However, planning councils should be advocating broadly on behalf of children and adults who need mental health services.

Some of the ways planning councils can achieve a broader impact include the following:

- Promote workforce development, including educational programs, mentored internships, and expansion of the peer workforce, to improve both access to and quality of services benefitting the entire service population.
- Take an interest in effective business processes, information technology, and other system-level process improvements that can reduce costs, making more funding available

for direct services. For example, a planning council may draw from models such as the [Triple Aim](#): patient experience, population health, and reduced per capita costs.

Council Processes Supporting Advocacy

Councils have numerous options for fulfilling the requirement that they advocate for adults and children with mental illnesses or emotional problems. The suggestions below are illustrative, rather than mandatory or exclusive:

- *Forming an advocacy committee or one or more committees focusing on issues of concern identified by the council.* These committees might be standing committees focused on a particular population (e.g., children) or setting (e.g., adult care homes), or they could be ad hoc committees formed to respond to current events (e.g., the settlement of a lawsuit against the state).
- *Issuing white papers or other products.* The planning council has unique access to information about mental health services in the state.
- *Making formal recommendations on issues outside the scope of the block grant.* Although the planning council is a requirement of the block grant, the planning council may choose to expand its advocacy beyond services covered by the block grant. This might include making the following types of recommendations:
 - To the behavioral health agency about inpatient services
 - To another state agency that provides behavioral health services in settings such as schools or jails
 - To another state agency that provides supports (e.g., housing or employment) to large numbers of persons with mental illness
- *Participating in regular advocacy training.* Regular training opportunities could cover topics such as data analysis, legislative and administrative processes, media relations, and effective communication.
- *Using social media.* Although state agencies might have social media policies that limit the “official” social media presence of the council, individual members—particularly those who are not state employees—can establish social media accounts that advocate for specific positions. This might be particularly important in energizing youth and young adults as allies.
- *Forming contact lists.* In addition to building “followers” on social media, councils can accumulate contact lists that allow them to alert the public to emerging issues or send out calls for action.
- *Inviting presentations by advocacy groups.* At least one state has allowed advocacy organizations to sponsor planning council meetings.
- *Collaborating with SUD prevention, treatment, and recovery stakeholders.* Collaboration can help to promote integration of mental health and SUD services for those who have co-occurring disorders.

Partnerships with Advocacy Organizations

The following national advocacy organizations (including their local and state affiliates) also might be able to recommend planning council members or provide other resources and support:

- [National Association of Peer Supporters](#): N.A.P.S is a nonprofit organization composed of peer support specialists who exchange resources and insights concerning a variety of health services and community systems.
- [Mental Health America](#): MHA is a national network of advocates who provide behavioral health education, outreach, public policy reform, and peer advocacy across more than 200 affiliates in 41 states.
- [National Alliance on Mental Illness](#): A collaboration between over 600 local affiliates and 49 state organizations, NAMI is the largest grassroots behavioral health organization in the United States, working to raise awareness, provide support, and educate communities about mental health issues.
- [National Federation of Families](#): The Federation is an advocacy organization that specifically supports families affected by behavioral health issues, collaborating with child-serving organizations, and promoting policy change to provide resources for families and professionals.
- [Youth Move National](#): Youth Move works to elevate the voices of children and provide resources to incorporate the lived experience of children in community-building and public policy by empowering them to be leaders in their communities and the systems that impact them.
- [National Coalition for Mental Health Recovery](#): NCMHR advocates for psychiatric consumers and their recovery process by ensuring that the experiences of these individuals play a significant role in the development and practice of behavioral health care and the policies that inform treatment.
- [National Coalition on Mental Health and Aging](#): NCMHA provides opportunities for professional, consumer, and government organizations to work together toward improving the availability and quality of mental health preventive and treatment strategies to older Americans and their families through education, research, and increased public awareness.
- [Judge David L. Bazelon Center for Mental Health Law](#): The Bazelon Center is active in litigation related to the rights of children with SED and adults with SMI and provides technical assistance and advocacy support.

In addition to the local and state affiliates of national organizations, many states are home to independent organizations that operate locally or statewide. Many of these organizations have been formed by people with lived experience of mental illness. The following sources might be helpful in locating such organizations:

- National Empowerment Center, [Consumer-Run Statewide Organizations](#) list
- Charity Navigator, [Search by Charity or Cause](#), which may be limited to a single state

Monitor, Review, and Evaluate Adequacy of Mental Health Services in State

The third primary duty of a planning council is “to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State” (42 U.S. Code §300x-3). Although this function could be performed in conjunction with providing input on the block grant plan, the statute lists this duty separately. The percentage of a state’s mental health services that are funded by the block grant varies considerably from state to state, and the third duty could be interpreted to include services funded by the state or even services paid for privately.

One possible method to fulfill this statutory duty would be to conduct a gap analysis, comparing the current condition of services with an ideal condition. The ideal condition might be described, for example, as follows: *High-quality mental health services and related supports are available from a choice of providers, without long waits, to people throughout the state, regardless of their ability to pay.*

Using the above example, a gap analysis would begin by gathering information about the following:

- The quality of services (e.g., consumer satisfaction, outcome measures, or penetration of evidence-based practices)
- The availability of supports such as housing, employment, and peer supports
- The state of the workforce, including job vacancies by region
- Wait times for services by region
- How these indicators differ according to income, race, ethnicity, or other factors

While a gap analysis would be a comprehensive approach, planning councils have latitude in determining how they wish to fulfill their duty to monitor, review, and evaluate. For example, they might wish to rely on one or more of the following:

- Requesting reports from the leadership of the behavioral health agency, to be presented at council meetings
- Requesting data reports from agency staff
- Conducting an environmental scan to identify best practices
- Performing a Strengths–Weaknesses–Opportunities–Threats (SWOT) analysis
- Reviewing state performance on National Outcome Measures (NOMs), focusing on unusually high or low outcomes
- Distributing a needs assessment to service providers, adult service recipients, and parents of child service recipients and compiling the results

Effective Operation Planning councils have a great deal of flexibility in how they operate, outside of the statutory requirements described above. Some states may have longstanding practices in place that guide the operation of the planning council and other bodies with a similar role in state government. In other states, the planning council chair might have greater influence in the way the planning council operates. In either case, the best practices described in this section can help the planning council fulfill its mission.

Forming the Council

Recruiting/Diversity

As noted in the *Composition* section, planning councils have statutory membership requirements that ensure multiple viewpoints are represented. However, the statutory requirements do not necessarily ensure representation of underserved groups, including but not limited to people living in rural areas; people belonging to underserved racial, ethnic, and language groups; older adults; the LGBTQ+ community; and people experiencing homelessness. Below are some best practices that can be used to ensure the planning council has broad representation.

One strategy is to reach out to community organizations outside of the mental health community, for example:

- Groups advocating for rural communities, including affiliates of the [National Grange](#) and the [Rural Coalition](#)
- Local affiliates of groups advocating for the needs of specific racial and ethnic groups, including but not limited to the [National Council on Asian Pacific Americans](#), the [NAACP](#), and [UnidosUS](#)
- Federally mandated [Area Agencies on Aging](#) (AAAs)
- LGBTQ+ groups with local chapters, such as [PFLAG](#) and the [Human Rights Campaign](#)
- Local [Continuums of Care](#) serving people experiencing homelessness

Inviting people who are not members of the planning council to participate in committees (assuming this is not prohibited by the planning council's bylaws) and keeping these individuals engaged and abreast of planning council activities can also be an effective way to recruit and onboard new council members when seats are vacant. The voices and opinions of subcommittee members are valuable, too. Other recruiting strategies that planning councils have found useful include the following:

- Make planning council meetings as accessible as possible to the public
- Publicize meetings through state websites, social media, email, and outside organizations
- Maintain an email list of all interested stakeholders
- Develop a regular newsletter that can be sent to all members and interested stakeholders

Having diverse representation on planning councils means accommodating the needs of potential members, which includes:

- Holding all meetings in accessible spaces or using accessible meeting software
- Providing sign language interpretation as needed
- Providing meeting material in alternative formats as needed
- Considering school/employment obligations of members who are not state employees
- Pairing new council members (particularly youth and people receiving services) with an experienced member as a mentor

Involving State Agencies

As noted above, the statute specifies the types of state agencies (such as education and housing) that must be represented on the planning council. The purpose of these positions is to ensure coordination among agencies in mental/behavioral health planning. However, it can be challenging to engage state-level members whose agencies' primary responsibilities are not directly associated with behavioral health. To encourage further engagement and buy-in from state agency staff, planning councils may consider the following strategies:

- Describing in council bylaws the roles and responsibilities of each member of the planning council, including state agency staff, so they will better understand the expectations associated with their involvement.
- Understanding and respecting the priorities, goals, and time constraints placed on representatives from other state agencies. By respecting each other's priorities, planning councils and other state agencies can promote more effective collaboration.
- Inviting the state agency to regularly present at meetings on activities of relevance to the planning council.
- Recruiting leadership from other state agencies, who are likely to contribute a broader perspective to council discussions and potentially connect the council to more state agency members.
- Relating issues (e.g., workforce development, recovery, prevention, effective treatment, and stigma) to all populations (e.g., older adults and students) and different environments (e.g., nursing homes, schools, or jails) when addressing issues during planning council meetings or through written correspondence.
- Establishing protocols for communicating with state agency staff outside of scheduled meetings. For instance, an emailing list could facilitate conversation between non-state and state agency membership. Interagency communication outside of meetings will promote relationship development and encourage buy-in from the state agency staff. The addition of networking events to scheduled meetings may further improve interagency communication.

State Logistical Support

Assigning sufficient state staff resources to assist the planning council in its work is instrumental. Most council members, including leaders, either have full-time employment or are private citizens without administrative staff to assist with their council duties. Councils therefore need to be able to depend on at least one state employee to maintain council records, manage meeting logistics, navigate the state system, and serve as a general sounding board for the council's work. Additional logistical support necessary for effective operation includes a webpage and email address for the council, meeting space, virtual meeting hosting, and travel reimbursement for council members not employed by the state.

Integration with SUD Council

Mental health planning councils focus primarily on issues facing the delivery of public mental health services in their respective states. However, an increasing number of states are choosing to merge the responsibilities of their state mental health authorities and their single state agencies

for substance misuse into one authority or submit combined block grant applications. In turn, they are also electing to transition their mental health planning councils into behavioral health planning councils that address issues concerning both mental health and substance use services. SAMHSA strongly encourages state mental health planning councils to integrate issues related to SUDs into their scope to better meet the needs of their consumers and communities.

Although not part of its statutory duties, the mental health planning council may review the state's application for the SUPTRS BG (which provides funding to all MHBG jurisdictions and one tribal entity), even if the state does not choose to submit a combined MHBG/SUPTRS BG application.

Overall Direction

Mission Statement/Bylaws

In many states, the planning council's bylaws are found in state law and may be difficult to change. However, planning councils may be permitted to adopt mission statements that guide their work. The mission statement should reflect the council's three primary duties and should demonstrate a function distinct from the state agency it supports.

Some councils have adopted guiding principles that fall somewhere between mission statements and bylaws. These principles may be practical (such as focusing on building up the behavioral health workforce) or aspirational (such as valuing the voice of every individual served by the state system).

Planning councils may adopt specific pledges, for example to follow the [*National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care*](#) in communications and in all actions taken by the council.

Collaboration with the State Agency

As noted above in the discussion of the council's composition, planning councils are not entirely independent of the state agency that submits the block grant application, even though it is the planning council's job to review, critique, and ultimately improve the work that the state agency does. A planning council can succeed in its mission only with the support and backing of the state agency, and therefore it is important for planning councils to nurture the relationship.

Some state agencies view the planning council's role as more limited than its potential allows. For example, the agency may show little interest in comments on activities outside the scope of the block grant, even though block grant review is only one part of the planning council's statutory role. To ensure that their voices are valued, planning councils have implemented the following recommended strategies:

- Ensure that meetings appear on the agency's annual calendar and that agency leadership are encouraged to attend
- Request specific information from the state agency, as described further below under *Using Data*

- Demonstrate value by providing constructive input on projects such as demonstration projects or applications for other types of federal funding
- Request staff presentations about upcoming initiatives to “stay ahead of the curve”

Meeting Frequency/Format

As with most aspects of council operations, the block grant statute is silent on the frequency with which a planning council must meet. Some states specify a meeting cadence or fix the dates on which the council is to meet (e.g., every other month on the second Tuesday). Other states have more flexibility and can establish a schedule that accommodates the needs of planning council members. For example, the planning council could have a full-day meeting once a year in conjunction with the block grant review and shorter meetings on other months.

Some states’ statutes or regulations, written before the COVID-19 pandemic, specify that council members must attend a minimum number of meetings in person each year. However, using technologies such as Zoom, Webex, or Teams, virtual meetings may offer advantages:

- Travel time and travel expenses are eliminated.
- Meetings can be recorded for those who are unable to attend.
- It may be particularly useful for parents or other caregivers, who may find it difficult to arrange care.

Planning councils may benefit from examining how virtual meeting technology could benefit council operations. For example, a council that has traditionally held 4 half-day, in-person meetings per year might instead hold 1 daylong in-person meeting and 10 virtual meetings, skipping a busy month such as December or the last month of the fiscal year. For councils that must, by law, meet in person, committee meetings could be held virtually. Some strategies for taking advantage of virtual meeting technology are provided in *Regaining Momentum in the Post-COVID Workplace*, below.

To the extent that in-person meetings remain, it is particularly important that planning councils provide travel and logistical support to those council members who are not participating as part of their job duties. Adult service recipients and parents of child service recipients could face financial strains if they are forced to cover their own travel expenses. Numerous states specify in statute and regulation that planning council members are not paid but receive travel reimbursement.

Committee Structure

Most planning councils find it helpful to have at least one standing committee, whether it is an executive committee to handle council business such as setting meetings and reviewing membership applications, or a committee to focus more in depth on the children’s system of care. Appendix A lists the committee structure for many states’ planning councils, but a planning council’s committee structure should be based on its own needs, rather than following the leads of other states.

Getting members to fully invest in committee work can be difficult, due to the extra time and level of effort required for meaningful participation. To ease the added burden, planning councils may consider having breakout sessions during regularly scheduled council meetings to allow

members time to meet and discuss issues of importance. Another option would be to have committees meet virtually even when the larger council meets in person.

Establishing committees that are relevant and interesting to the membership, rather than just assigning committee participation randomly, can help promote participation. Some councils have no standing committees and form ad hoc committees only in response to member suggestions. At the other extreme, some councils have multiple standing committees and require each council member to participate in at least one committee. Such a requirement could make full council meetings more focused and productive.

For states that have standing committees, keeping them on task can be difficult, particularly if the committee members do not fully understand the committee's role within the larger council. To stay focused, some planning councils require each committee to have a charter that spells out its function, membership, roles, and responsibilities. Another way to keep committees' work focused is to have the executive committee closely work with committee chairs to help them run smoothly and make optimal use of committee members' time. Finally, planning council leadership must ensure that committee reports and proposals are valued and given adequate time during full council meetings, so that committee members see their work as valuable.

Making the Most of the Council

Staying Focused

It is not uncommon for some members of state planning councils to want to focus primarily on specific, narrow areas of interest during meetings. To ensure that these members' concerns are addressed and valued without distracting from broader priorities, planning councils may consider employing the following strategies:

- *Developing a process for including concerns and issues on the meeting agenda and limiting discussions to the planned agenda.* If a member raises an issue not on the agenda, it can be deferred to a "new business" segment at the end of the meeting or placed on the agenda for the next meeting. However, when finalizing the agenda, leadership should decline any agenda requests that do not seem relevant or beneficial to the overall goals of the planning council.
- *Providing an informal venue for conversations about issues and concerns that may be relevant to only a few members of the planning council.* Such venues include meals and dedicated networking time during a scheduled meeting.
- *Forming ad hoc committees if an issue regularly detracts from broader discussions.* This allows for voices to be heard, while minimizing the impact on the full council meetings.

Regaining Momentum in the Post-COVID Workplace

Since the onset of the COVID-19 pandemic, telecommuting and virtual forms of business communication have become increasingly commonplace in professional environments. While videoconferencing services such as Zoom, Microsoft Teams, and Webex can facilitate effective face-to-face communication between team members and partners across the world, overuse or misuse of these services can lead to an undesirable phenomenon called "Zoom fatigue," which

diminishes the benefits of virtual communication. To avoid Zoom fatigue, consider the following best practices for videoconferencing:

- *Create an agenda before and share minutes after.* When hosting a videoconference, it is critical to respect the time of your participants and ensure that time is being used efficiently. Creating and following a set agenda can help to appropriately structure a videoconference session, while immediately sharing the minutes of a session after its conclusion can ensure that all participants are clear on a meeting’s main takeaways and action items, improving overall information retention and team cohesion.
- *Encourage participants to avoid multitasking.* When using videoconferencing software, participants often attempt to take on other tasks simultaneously. However, current research suggests that multitasking during virtual meetings (e.g., checking phones or other devices, working on other projects, and preparing for other meetings) significantly reduces overall productivity and memory. The more engaging your virtual meeting, however, the less likely participants are to multitask.
- *Support videoconferences with visual elements.* To attract and maintain the attention of your participants, regularly integrate engaging visual materials, such as slideshows, images, a running transcript of notes, etc. These visual elements create a focal point to which participants can direct their attention, in turn increasing participation.
- *Schedule breaks.* While extremely useful, virtual conferences can cause a great deal of visual strain for participants. To increase engagement and participation, schedule short, 5-minute breaks for every 30 minutes of telecommunication. If multiple virtual conferences are scheduled back-to-back, schedule short breaks in between these sessions to allow participants to stretch their legs and rest their eyes.
- *Shorten meetings or use alternative communication methods.* To maximize the benefits of virtual conferencing, only use this method of communication when the opportunity for face-to-face interaction creates clear value for the involved parties. Avoid scheduling unnecessary meetings, and schedule shorter phone calls whenever possible to reduce strain on participants.

To accommodate the varied scheduling needs of remote and hybrid participants (especially when spread across multiple time zones), offer multiple possible meeting times to identify when most participants will be able to attend. Moreover, most videoconferencing software includes the option of recording sessions; these recordings, along with meeting agendas and minutes, can be shared with participants who are unable to attend.

Member Engagement/Preventing Turnover

If planning council members do not understand the responsibilities of their respective roles, their degree of engagement is likely to suffer. One cause of role confusion is frequent turnover, resulting in a lack of “institutional knowledge” to be passed to new members. Lack of prior exposure to the jargon or processes of state government may alienate council members who are not state employees, unless they receive adequate mentoring.

Council members are more likely to feel energized if they feel they can make a real difference for persons served by the public behavioral system, offer meaningful input for the development

of the state’s block grant application, and have a positive working relationship with the state behavioral health agency and other state agencies. However, these opportunities require thoughtful organization and clear communication of roles and expectations by council leadership and the state behavioral health agency.

One way to ensure meaningful participation by all council members is to conduct annual training sessions with new council members and agency staff to discuss the following topics:

- Organization and responsibilities of the state’s behavioral health care system, including the operation and funding of behavioral health service providers
- The history, purpose, and scope of the block grants
- The planning council’s responsibility in writing, reviewing, and commenting on applications and reports
- Guidance concerning the use of mental health and substance use disorder funding
- The mission, vision, and goals of the planning council, including the three federally mandated responsibilities
- The operations and processes of the planning council, including a review of the bylaws, membership composition requirements, and meeting procedures

Supporting/Mentoring Non-Professional Members

Another challenge with engagement is the time and logistical commitment required to participate in planning council meetings and events. By offering to reimburse travel costs (including transportation, meals, and lodging), this burden may be offset by the planning council, encouraging greater participation from members who live further away. If a planning council meeting is held during a mealtime, the planning council may wish to identify volunteers and donors to provide food for the meal if state law restricts the purchase of food for meetings. Shared meals will not only incentivize participation but also create networking opportunities for members.

Obtaining Training and Technical Assistance

Numerous training and technical assistance (TTA) opportunities are available to planning councils in helping them fulfill their mission of improving behavioral health services in their state. Before requesting TTA, the planning councils should discuss their needs with the state behavioral health agency. After clarifying their needs, planning councils can readily obtain TTA by one of the following methods:

- *Contacting the SAMHSA State Technical Assistance project by [email](#).* SAMHSA and the state behavioral health agency will review the request.
- *Contacting the [state project officer](#) assigned to their MHBG.* This might be an efficient way to get answers to technical questions about the MHBG.
- *Requesting TTA directly from a SAMHSA-funded TTA center.* Examples include:
 - [Mental Health Technology Transfer Center \(MHTTC\) Network](#)
 - [National TTA Center for Child, Youth, and Family Mental Health](#)
 - Other, more specialized [SAMHSA TTA centers](#)

Establishing a Web Presence

A lack of awareness surrounding planning council meetings and activities can be a major barrier to community engagement. One of the most effective means of sharing information about the planning council is by providing regular updates on the associated state website. Of particular importance is making the transcribed minutes of each meeting available to the public. The more consistently information is shared with community members, the more likely they are to engage meaningfully with the planning council and support its activities.

However, many other means of releasing current information could support or replace the use of state websites. Posting about the planning council on social media sites such as Twitter, Instagram, or Facebook, partnering with a local organization that has an established social media presence or public reach, and creating an e-newsletter or mailing list could effectively increase awareness and, in turn, overall engagement. The critical component of any of these methods, however, is the consistent and timely dissemination of information to community members that establishes the relevance of the planning council to their community.

Using Data

The block grant plan must include an estimate of the incidence and prevalence of SMI (adults) and SED (children). It also must contain service targets and outcome measures for any block-grant-funded services. Many reports, including charts and graphs, can be obtained in WebBGAS. All council members can obtain citizen access to WebBGAS by doing the following –

1. Login to WebBGAS using these credentials:
 - Username: citizen + 2-letter postal abbreviation with no spaces (e.g., **citizenAL** for Alabama or **citizenPR** for Puerto Rico)
 - Password: **citizen**
2. Go to the Reports tab at the top of the page.

For the council to be able to fulfill its duty to monitor, review, and evaluate the allocation and adequacy of mental health services within the state, access to comprehensive data is essential. Among the types of data the council should obtain from the state, to the extent these data are available, are:

- Numbers of people served by the publicly funded behavioral health system
- Demographic data (age, race, gender, ethnicity, etc.)
- National Outcome Measures (NOMs) related to increased access to service, increased/retained employment, increased stability in living situation, decreased criminal/juvenile justice involvement, increased school attendance, reduced utilization of psychiatric inpatient beds, use of evidence-based practices, increased social supports/social connectedness, and improved functioning
- Incidence and prevalence figures for SMI, SED, and co-occurring disorders
- Medicaid enrollment figures
- Detailed budgets, including block grant funds, state general funds, and other revenue streams

Obtaining Useful Data

Although the state mental health or behavioral health agency should provide planning councils with comprehensive data, planning councils may find that other sources of data can help them form a more comprehensive understanding of the state of mental health and SUD needs and services within the state.

SAMHSA Data Sets

- [Substance Abuse and Mental Health Data Archive \(SAMHDA\)](#) is the largest collection of public use data collected by SAMHSA. Integrated online analysis tools allow for streamlined study of SAMHDA's expansive data collections.
- [Mental Health Client-Level Data \(MH-CLD\)](#) compiles demographic, clinical, and outcome characteristics of individuals receiving mental health treatment services funded or operated by the state mental health authorities.
- [Mental Health Treatment Episodes Data Set \(MH-TEDS\)](#) compiles treatment events, such as admissions and discharges from service centers, and enhances states' ability to report data on individuals with co-occurring mental and substance use disorders. SAMHSA produces an annual report synthesizing MH-CLD and MH-TEDS data.
- [National Mental Health Services Survey \(N-MHSS\)](#) provides national- and state-level data on the mental health services delivery system reported by both publicly and privately operated specialty mental health treatment facilities.
- [Treatment Episodes Data Set \(TEDS\)](#) is divided between TEDS-A, which records SUD treatment admissions, and TEDS-D, which records discharges, TEDS curates the demographic and drug history of individuals over the age of 12 who have engaged with SUD treatment multiple times.
- [Uniform Reporting System \(URS\)](#) allows for uniform reporting of both state- and national-level data describing public mental health system development and program outcomes. In support of the MHBG program, the URS also includes state-by-state estimates of SMI and SED prevalence.
- [Drug Abuse Warning Network \(DAWN\)](#) is derived directly from electronic records of participating hospitals. DAWN consists of data collected from nationwide public health surveillance of emergency department (ED) visits related to substance use or misuse. DAWN allows for monitoring of emergent trends in substance-related ED visits and both demographic and geographic distribution of hospitalizations.
- [National Survey on Drug Use and Health \(NSDUH\)](#) offers annual national- and state-level data concerning mental health and the use of tobacco, alcohol, and illicit drugs (including nonmedical use of prescription drugs). Moreover, the NSDUH tracks trends in substance use and misuse, assesses the potential consequences of such behaviors, and identifies those populations who are most at risk for SUD.
- [National Survey of Substance Abuse Treatment Services \(N-SSATS\)](#) supports program administration and policy analysis. The N-SSATS provides an annual census of the location, organization, structure, services, and utilization of SUD treatment facilities in the United States.

- [National Substance Use and Mental Health Services Survey \(N-SUMHSS\)](#) merges N-SSATS and N-MHSS data. N-SUMHSS offers a cumulative accounting of SUD and mental health treatment facilities in the United States and its territories.

Other Federal Data Sets

- [Youth Risk Behavior Surveillance System \(YRBSS\)](#) is a system of surveys conducted by the Centers for Disease Control and Prevention (CDC) as well as state and local health agencies and tribal governments. Together, YRBSS surveys monitor the major health-related behaviors that contribute to the leading causes of death and disability among both youth and adults.
- [Behavioral Risk Factor Surveillance System \(BRFSS\)](#) is based on 400,000 interviews every year and is the largest continuously conducted health study in the world. BRFSS collects data at both state and local levels concerning behavioral health risk, chronic health conditions, and use of preventive services.
- [Behavioral Health Services Provided to the Medicaid and CHIP Population](#) is a data set comprising the monthly count and rates of behavioral health services provided to Medicaid and Children’s Health Insurance Program (CHIP) beneficiaries by state. ED services, inpatient services, intensive outpatient/partial hospitalizations, and telehealth services are detailed.
- [Healthcare Cost & Utilization Project Statistical Briefs](#) represent the most extensive source of hospital care data in the United States, detailing information regarding inpatient stays, ambulatory surgery, service visits, and ED encounters.
- [Continuum of Care Homeless Populations and Subpopulations Reports](#) use point-in-time information provided to the U.S. Department of Housing and Urban Development to tabulate the number of persons experiencing homelessness by household type and subpopulation, including persons with SMI and SUD.

Private Data Sets

- [Kaiser Family Foundation Medicaid Fact Sheets](#) provide a significant amount of insight into both state and national data concerning the utilization and coverage of Medicaid and CHIP.
- [Healthy Minds Study among Colleges and Universities](#) reflects the responses of over half a million undergraduate and graduate students at more than 450 colleges and universities. The study surveys students’ perspectives and behaviors concerning mental health and service use.

Data Visualization Tools

Decision-making conducted by planning councils should always be informed by current data and the lived experience of the population being served. However, the amount of data required to effectively generate such insight can be overwhelming at first glance. To organize and present this information in a digestible and engaging manner, planning councils can use current innovations in visualization technology to increase information retention and community buy-in. Moreover, using such technology makes all findings more easily shared and understood, allowing for rapid data dissemination.

While data visualization might sound intimidating, there are a variety of free or low-cost, readily available software options that can be used without extensive prior experience:

- [Canva](#) is a graphic design platform that replicates many of the features of the Adobe Creative Cloud in one free, user-friendly package. Easily create engaging tables, graphs, charts, white papers, and more. For guidance on specific projects, many users have posted helpful step-by-step guides on platforms such as YouTube.
- [Jamovi](#), a favorite of quantitative scholars and researchers, is a free and open-source data analysis program that can also be used to create polished and professional data visualizations. Data files can be uploaded directly to the program and easily converted into tables, charts, and graphs, representing everything from mean, median, and mode to R-values and frequency.
- [Microsoft PowerPoint](#) is already installed on most computers running Windows (and can be installed on Macs). PowerPoint can be used to create data visualizations that are easily transferred to other documents and modified for different uses. Within the “Insert” tab, there is a display titled “Illustrations” that provides a variety of visualizations, including 3D models, charts, graphs, and a “SmartArt” function that can automatically create images to accompany provided data. For more capability, Microsoft Office users can purchase [Power BI](#), a specialized data visualization tool that integrates with other Microsoft applications.

Appendix A: Index of Planning Councils by State/Jurisdiction

State	Website (if any)	Email (if any)	Meetings/yr. (if known)	Format	Committees (if known)
AL	https://www.alabamacouncil.org/about-the-alabama-council/	holly.mccorkle@alabamacouncil.org	12	Integrated BH	Executive, children's, client rights
AK	N/A	mhpc@ak.state.us	4 min.	MH only	N/A
AS	https://www.pbhcc.com/	N/A	N/A	Integrated BH	N/A
AZ	https://www.azahcccs.gov/Resources/Grants/CMHS/	N/A	12	Integrated BH	N/A
AR	https://humanservices.arkansas.gov/about-dhs/boards-commissions/	N/A	N/A	Integrated BH	N/A
CA	https://www.dhcs.ca.gov/services/MH/Pages/CBHPC-PlanningCouncilWelcome.aspx	N/A	4	Integrated BH	Performance outcomes, executive, patients' rights, systems, Medicaid, housing and homelessness, workforce and employment, legislation
CO	https://bha.colorado.gov/behavioral-health-planning-and-advisory-council	CDHS_BHA@state.co.us	5	Integrated BH	Data and evaluation, legislative, membership, prevention, recovery, steering, treatment
CT	https://www.cga.ct.gov/ph/bhpc/	david.kaplan@cga.ct.gov	12	Integrated BH	Adult; child/adolescent; coordination of care; diversity, equity, and inclusion; operations
DE	N/A	N/A	N/A	Integrated BH	N/A
DC	https://dbh.dc.gov/service/behavioral-health-planning-council-bhpc	dbh@dc.gov	6	Integrated BH	Connection to care, system and benefit design, planning and accountability, advocacy, and outreach
FL	https://myflfamilies.com/sites/default/files/2022-11/Florida%20SAMH%20Planning%20Council%20Guidance%20DF_05_13_15.pdf	N/A	2 min.	Integrated BH	N/A
GA	https://www.gmhcn.org/behavioral-health-planning-advisory	info@gmhcn.org	1 min.	Integrated BH	N/A

State	Website (if any)	Email (if any)	Meetings/yr. (if known)	Format	Committees (if known)
GU	https://gbhwc.guam.gov/	care@gbhwc.guam.gov	12	Integrated BH	Crisis response, planning, children's
HI	https://scmh.hawaii.gov/	DOH.SCMHChairperson@doh.hawaii.gov	12	Integrated BH	N/A
ID	https://healthandwelfare.idaho.gov/about-dhw/boards-councils-committees/idaho-behavioral-health-planning-council-bhpc	MyBenefits@dhw.idaho.gov	3	Integrated BH	N/A
IL	https://www.dhs.state.il.us/page.aspx?item=135664	N/A	6	MH only	Development, adult inpatient, criminal justice, child, and adolescent
IN	https://www.in.gov/fssa/dmha/indiana-behavioral-health-commission/	N/A	N/A	Integrated BH	N/A
IA	https://hhs.iowa.gov/about/mhds-advisory-groups/MH_Planning_Council	wdephil@dhs.state.ia.us	6	Integrated BH	Executive, monitoring, nominations
KS	https://kdads.ks.gov/kdads-commissions/behavioral-health/gbhspc	N/A	6	Integrated BH	Children's; employment; evidence-based practices; housing and homelessness; justice-involved youth and adults; Kansas Citizens on Alcohol and Drug Abuse; problem gambling; prevention; rural and frontier; service members, veterans, and families
KY	https://dbhdid.ky.gov/dbh/kbhpac.aspx#	N/A	4	Integrated BH	Executive, by-laws, membership, finance, data
LA	https://ldh.la.gov/index.cfm/directory/detail/327	melanie.roberts@la.gov	4	Integrated BH	N/A
ME	https://maineqic.org/	maineqicchair@gmail.com	12	MH only	Executive
MH	N/A	N/A	N/A	MH only	N/A
MD	https://health.maryland.gov/bha/Pages/-Planning.aspx	N/A	N/A	Integrated BH	N/A

State	Website (if any)	Email (if any)	Meetings/yr. (if known)	Format	Committees (if known)
MA	https://www.mass-smhpc.org/	SMHPC@MASSMAIL.STATE.MA.US	4	Integrated BH	Housing; child, adolescent, and family; transformation; employment; older adult; youth development
MI	https://www.michigan.gov/mdhs/keep-mi-healthy/mentalhealth/mentalhealth/advisorycouncil	hardend1@michigan.gov	4	Integrated BH	N/A
FM	https://www.pbhcc.com/	N/A	N/A	Integrated BH	N/A
MN	https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/behavioral-health/bh-planning-council/	N/A	8	Integrated BH	N/A
MS	N/A	N/A	N/A	MH only	N/A
MO	N/A	N/A	N/A	Integrated BH	N/A
MT	https://dphhs.mt.gov/BHDD/Prevention/BehavioralHealthAdvisoryCouncilBHAC	N/A	N/A	Integrated BH	Children's system of care; planning
NE	https://dhhs.ne.gov/Pages/Advisory-Committees-on-Mental-Health-and-Substance-Abuse.aspx	DHHS.BehavioralHealthDivision@Nebraska.gov	3	Integrated BH	Mental health; substance use
NV	https://dpbh.nv.gov/Programs/ClinicalBHSP/Meetings/Behavioral Health Planning and Advisory Council/	N/A	10	Integrated BH	N/A
NH	https://www.dhhs.nh.gov/programs-services/health-care/mental-health/community-mental-health-block-grant	Janelle.C.Lavin@dhhs.nh.gov	N/A	Integrated BH	N/A
NJ	https://nj.gov/humanservices/dmhas/home/councils/bhpc.html	N/A	12	Integrated BH	Community mental health, nominations, block grant, membership, executive
NM	https://newmexico.networkofcare.org/content/client/1446/BHPCPlatform.final.10.22.18.pdf	Natalie.Rivera2@state.nm.us	N/A	Integrated BH	Adult substance use and Medicaid; child and adolescent; Native American

State	Website (if any)	Email (if any)	Meetings/yr. (if known)	Format	Committees (if known)
NY	https://omh.ny.gov/omhweb/bh_services_council/	N/A	5	Integrated BH	Project review, regulations
NC	https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-abuse/grants/mental-health-block-grant	N/A	8	MH only	N/A
ND	https://www.hhs.nd.gov/ndmhp/c	N/A	16	Integrated BH	Executive
MP	N/A	N/A	N/A	Integrated BH	N/A
OH	https://mha.ohio.gov/community-partners/advisory-groups/planning-council	scott.wingenfeld@mha.ohio.gov	11	Integrated BH	N/A
OK	https://oklahoma.gov/odmhsas/policy/pac.html	Sgay@odmhsas.org	N/A	Integrated BH	N/A
OR	https://www.oregon.gov/oha/HSD/AMHPAC/Pages/index.aspx	russha.grinstead@state.or.us	12	Integrated BH	Executive, nomination
PW	N/A	N/A	N/A	Integrated BH	N/A
PA	https://www.dhs.pa.gov/about/DHS-Information/Pages/Mental-Health-Planning-Council.aspx	N/A	4	MH only	Children's, adult, older adult, transition age youth, persons in recovery
PR	N/A	N/A	N/A	Integrated BH	N/A
RI	https://bhddh.ri.gov/mental-health/governors-council-behavioral-health	N/A	12	Integrated BH	N/A
SC	https://scdmh.net/about/commission/	N/A	12	Integrated BH	Audit, inpatient facilities
SD	https://boardsandcommissions.sd.gov/Meetings.aspx?BoardID=55	N/A	7	Integrated BH	N/A

State	Website (if any)	Email (if any)	Meetings/yr. (if known)	Format	Committees (if known)
TN	https://www.tn.gov/behavioral-health/planning1/council-overview.html	Avis.Easley@tn.gov	45	Integrated BH	Six regional committees, statewide planning and policy
TX	https://www.hhs.texas.gov/about/leadership/advisory-committees/behavioral-health-advisory-committee	bhac@hhs.texas.gov	4	Integrated BH	N/A
UT	https://sumh.utah.gov/provider-services/behavioral-health-planning-council	pbennett1@utah.gov	12	Integrated BH	Nominating-membership-bylaw, mental health resources, planning, legislative-regulatory, children's
VT	https://mentalhealth.vermont.gov/about-us/boards-and-committees/state-mental-health-block-grant	N/A	5	MH only	N/A
VI	N/A	N/A	N/A	Integrated BH	N/A
VA	https://dbhds.virginia.gov/about-dbhds/Boards-Councils/BH-Advisory-Council/	Nathanael.Rudney@dbhds.virginia.gov	6	Integrated BH	N/A
WA	https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/behavioral-health-advisory-council	nathan.lusk@hca.wa.gov	6	Integrated BH	Executive, community members, representative members, DBHR Staff
WV	https://wvbhpc.org/	floydjoyce908@yahoo.com	N/A	Integrated BH	Executive, membership, children and families, adult, housing
WI	https://dhs.wisconsin.gov/wcmh/index.htm	WCMH@dhs.wisconsin.gov	6	MH only	Adult, children and youth, criminal justice, executive, legislative and policy
WY	https://health.wyo.gov/behavioralhealth/mhsa/about-us/bhac/	https://health.wyo.gov/header-contact-form/?page-id=152	4	Integrated BH	N/A

Appendix B: Authorizing Statute for Planning Councils

42 U.S.C. § 300x-3. State Mental Health Planning Council

(a) *In general.* A funding agreement for a grant under section 300x of this title is that the State involved will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) *Duties.* A condition under subsection (a) of this section for a Council is that the duties of the Council are--

(1) to review plans provided to the Council pursuant to section 300x-4(a) of this title by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;

(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems; and

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

(c) *Membership.*

(1) *In general.* A condition under subsection (a) of this section for a Council is that the Council be composed of residents of the State, including representatives of--

(A) the principal State agencies with respect to--

(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and

(ii) the development of the plan submitted pursuant to title XIX of the Social Security Act [42 U.S.C.A. § 1396 et seq.];

(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;

(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and

(D) the families of such adults or families of children with emotional disturbance.

(2) *Certain requirements.* A condition under subsection (a) of this section for a Council is that--

(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is

sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

(d) *“Council” defined.* For purposes of this section, the term “Council” means a State mental health planning council.

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SAMHSA STATE PROGRAM IMPROVEMENT TECHNICAL ASSISTANCE PROJECT

Photos are for illustrative purposes only.
Any person depicted in a photo is a model.

SAMHSA's mission is to lead public health and service delivery efforts that promote mental health, prevent substance misuse, and provide treatments and supports to foster recovery while ensuring equitable access and better outcomes.

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