

2000 ANNUAL REPORT



NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

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The National Council for Community Behavioral Healthcare is the country's oldest and largest membership organization dedicated to ensuring appropriate and affordable community-based mental health and substance abuse services are available for all individuals. Our mission is to champion opportunities that advance our members' ability to deliver proactive and holistic healthcare services and is dependent on individual members actualizing this mission through learning and the sharing of knowledge.

For nearly three decades, we have worked at the national level to give our members — Direct Care Providers, State Associations, Authorities, Integrated Delivery Systems and Advocates — a voice before Congress and to provide them with the educational and training opportunities that are essential in rapidly changing times. We are committed to creating and sustaining healthy and secure communities, a commitment built upon a network of organizations and advocates promoting and delivering behavioral health services of unparalleled value.



We are committed to creating and sustaining healthy and secure communities, achieved through a system that holds the needs of the consumer paramount, regardless of their ability to pay. Vital to this commitment is a network of organizations and advocates promoting services of unparalleled value.

Beliefs

- Our historic values and practices provide a strong foundation for the design and provision of an accessible, community-based service continuum.
- All individuals should have the right to accessible behavioral healthcare services, and National Council members advocate for this principle at the local, state, and national levels.
- Services must be based on the strengths and needs of the consumer, who is treated with dignity and respect.
- Responsive, accessible, and culturally competent services require the involvement of consumers and their families.
- Services must reflect a holistic approach that responds to the needs of individuals throughout their lives.
- Prevention and early intervention are essential elements in a community-based system of care.
- Effective, resource-sensitive, and outcome-based healthcare must include behavioral services.
- In today's healthcare environment, competence-based management, clinical practice, and advocacy depend on our commitment to learning and sharing.

Mission

The mission of the National Council for Community Behavioral Healthcare is to champion opportunities that advance our members' ability to deliver proactive and holistic healthcare services.

Goals

- ADVOCATE** Public policy that promotes our vision and secures adequate resources;
- PROMOTE** Development of innovative, locally-responsive services in community-based settings;
- PROMOTE** Development of fair exchange partnerships and alliances among and between consumers, public and private payors, organizations, and advocates;
- PROVIDE** Business development and training that empowers our members to support our vision in a rapidly changing healthcare environment.



Peter W. Zevenbergen Jr.

Board Chair
1999-2000

Do people with serious mental or addiction illnesses deserve access to comprehensive treatment and care, even if they can't afford to pay for such care? Can we afford to treat them? Can we afford not to treat them? Are these people faceless, forced by social stigma and the nature of their illnesses to hide from view and shun assistance?

The questions sometime seem to loop back upon themselves, seldom revealing pat answers, and too often simply spawning new questions. How do you gather public support for people too few know (or want to know) and — most troubling — fewer still may believe are worthy of our help?

In communities across America, behavioral healthcare professionals are doing what they can for those most in need. In the process, they are raising the standards by which communities recognize and reach out to their own. They measure progress in small steps for consumers toward dignity, self-respect and empowerment. For many people with serious mental illness, substance abuse and addictions illnesses, the behavioral healthcare provider is their only chance to reach for a cure when one is available, find stability for their chronic condition, or access the range of community services that represent their best chance of becoming independent, contributing members of the community.

The National Council seeks to shape and strengthen the national voice of our community-based member organizations. In the process, we work to build bridges between them and the officials who regulate and fund behavioral healthcare programs. We work to educate providers, link them with one another, and provide them with tools they need to do the best job possible for the constituents they serve.

Our work is shaped by and measured against our “Principles for Behavioral Healthcare Delivery.” Throughout this annual report, you will see excerpts of those principles that have helped us build organizational responses to member needs, and our members’ programs for the people they serve.

We don't have answers to all of this nation's behavioral healthcare questions. But we do have a clearly marked path for progress; a path by which our principles serve as guide. We are happy to provide anyone with a complete copy of our principles upon request and would welcome the opportunity to discuss their applicability in building effective community behavioral healthcare programs.

Clearly, we believe those with serious mental and addictions illnesses deserve our help, regardless of their ability to pay. We believe most Americans share that value. But we are a long way from turning that value into a reality. This annual report describes our progress in pursuit of that goal. Implicit in each National Council program is the realization we have far to go and need all the help we can get. We think our members — community-based behavioral healthcare providers — represent this nation's best chance to some day reach all of those most in need with the help they require.



Charles G. Ray

President and Chief Executive Officer

The National Council for Community Behavioral Healthcare enjoyed a year in which its role as a trade association was focused on change. Everywhere one looked, there was change — from hardware to software, from clinical delivery to management systems, from best practices to better ideas, and from one administration to the next. Nowhere was this change felt more acutely than among our members, many of whom continued to reinvent themselves in the face of this full scale change; change that is reshaping how we pay for and deliver behavioral healthcare services in community settings.

Our strategy in the face of all this change has been one of due diligence. That is, we have sought to focus on what works for our members and discard what doesn't. We have served as member allies in bringing thoughtful consideration and careful analysis to those areas in which we can best be of service. We have attracted into our consulting services some of the leading experts on a vast array of behavioral health issues, expanded our annual training conference to include a curriculum that is unmatched in the breadth and depth of new knowledge it offers, and ventured into new online training worlds that offer much promise for the future.

Perhaps our best service to members in 2000 was our renewed commitment to simply listening to what they need and expect from the National Council. Members told us they are eager and willing to be more engaged in the collective advocacy efforts spearheaded by the National Council. They are interested in finding web-based ways to make staff better and more productive.

The annual report you hold in your hands reflects the results of that careful listening and due diligence. Our successes derive from member collaboration, partner support and determined advocates. Yet in serving members we never forget we are serving this nation's most vulnerable populations — those with mental health and addictions illness needs who are least able to access or pay for them.

As you read this annual report, we hope you'll celebrate our successes with us, even as you seek ways to make your own contribution to addressing the critically important behavioral healthcare needs of this nation's poorest, often-sickest and certainly much-deserving population.

A handwritten signature in black ink that reads "Charles G. Ray". The signature is fluid and cursive, with a large loop at the end of the last name.



The National Council's Public Policy staff pursues a legislative agenda that is shaped by member insights and an environmental scan by staff of issues at the federal level. Our agenda is also informed by the needs of the consumers those members serve, as well as by the stakeholders who support meaningful behavioral healthcare policy.

“Behavioral healthcare organizations should work to identify unmet behavioral health needs in the community, especially those of vulnerable populations, and should advocate for the resources required to meet those needs.”

— Principles for Behavioral Healthcare Delivery

To this end, the National Council works with:

- Congressional leaders to shape effective legislation that provides important federal support for the financing and delivery of community programs;
- Federal agency leaders to shape effective regulations pursuant to legislation, as well as updating regulations to meet the changing needs of vulnerable populations; and
- Key coalition partners to shape effective advocacy initiatives that ensure the voice of behavioral healthcare providers is heard.

The National Council’s work in these three arenas during the year 2000 provided a solid foundation for the range of significant federal legislative and regulatory advances that were made. It was work enhanced with the addition of two new public policy staff members, one of whom is tasked with expanding the National Council’s work in the public policy arena around addictions illness and substance abuse issues. This expanded emphasis on addictions issues reflects the fact that more community-based organizations than ever before are being called upon to provide treatment for dually diagnosed populations with mental and addictions illnesses.



From left, National Council Board member Elizabeth Earls discusses public policy initiatives with Government Relations Vice President Tom Leibfried and Senior Vice President Pope Simmons.

Many Americans labeled the 106th Congress a “do-nothing” Congress because it was unable to pass legislation that almost all Americans agreed upon, mainly a Patients Bill of Rights, prescription coverage within Medicare, legislation protecting the confidentiality of medical records, as well as tax credits and minimum wage increases.

But what few may realize is that much of the legislation that eventually made it into law was of significant value to behavioral healthcare providers and consumers.

Key to this success was the National Council’s grassroots organization and the persistence in which members pursued our goal of building healthy communities. For when membership is unfailingly dedicated to and aligned with the public policy of an organization, results do happen.

Legislative Initiatives

Legislative activity of particular importance to community providers and to the consumers who receive National Council member services during the 106th Congress included:

- The Ticket to Work and Work Improvement Act** — Removes disincentives for consumers to return to work by allowing them to maintain their medical benefits through Medicaid and Medicare. Also of tremendous importance are the employer networks that allow community providers to set up employment networks and potentially receive up to \$20,000 for each consumer gainfully employed over a five-year period.
- Mental Health and Substance Abuse Block Grants** — The first increases to the mental health and substance abuse block grants in more than eight years were accomplished during the 106th Congress. Last year's budget increased the mental health block grant \$68 million and the substance abuse block grant received a \$15 million increase.
- Future Block Grant Increases** — While the 2001 budget has not been finalized, the mental health block grant is slated to receive an additional \$64 million increase and the substance abuse block grant an additional \$30 million. (Some negotiations could further increase these numbers).
- The PATH Program (Program in Assistance in Transition from Homelessness)** — Provides funding to community providers to provide outreach, screening and services to the homeless, one in three of whom has a serious mental illness also received \$5 million, and \$6 million increases, respectively, in 2000 and 2001.
- Substance Abuse and Mental Health Services Administration (SAMHSA) Reauthorization** — While some governmental entities like the Department of Justice have not been reauthorized in more than 20 years, we were able to achieve reauthorization of SAMHSA. As part of this legislation, we were also able to establish new formulas for a more equitable distribution of the block grants.
- Co-Occurring Disorders Support** — The National Council was able to help pass legislation authorizing \$40 million for grants to provide integrated treatment for persons with co-occurring disorders. This authorizing legislation also requires a study on the most effective treatment models, in which the National Council is also participating.
- Funding for Children's Programs** — The National Council was also able to help pass legislation authorizing \$10 million for programs to integrate services provided by child welfare agencies and mental healthcare providers, including intervention to at-risk youth.
- Seclusions and Restraints** — As one of the two providers groups on a national coalition on the appropriate use of seclusion and restraint, the National Council was able to help pass legislation that protects the rights of consumers while setting conditions that could be managed within community settings.



Charles G. Ray, foreground, the National Council's president and CEO, is shown at the U.S. Capitol with National Council Government Relations staff members, from left, Jason Hill, associate director; Tom Leibfried, vice president; and Pope Simmons, senior vice president.

Regulatory Activities and Other Initiatives

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

While HIPAA essentially created federal standards on insurance practices used by indemnity plans, it also required the U.S. Department of Health and Human Services (HHS) to establish regulations dealing with administrative simplification. Strategies for this simplification include use of standardized claims forms and standards to protect consumer privacy. While behavioral healthcare providers have always had an eye on privacy issues, the issues involved in "simplifying" transactions now represent new challenges.

In addition, universal reimbursement codes must be developed for all services regardless of whether they are provided in the private or public sector. As the Health Care Financing Administration (HCFA) acknowledges, no such codes exist for many behavioral health services. Further, many service providers under contract through county carve-outs are not duplicated in other areas of the country.

Thus a unique challenge for the National Council is to press for policies that guarantee that all providers who are being reimbursed today will receive reimbursement for these same services when HIPAA regulations go into effect in two years. The National Council will continue working to provide input to the regulatory process that reflects the unique needs of behavioral healthcare providers and the consumers they serve.

- **Mental Health Drug Courts** — Legislation expanding demonstration Mental Health Drug Courts was also passed that has the potential to divert persons with behavioral health disorders who come into contact with the criminal justice system into appropriate community-based treatment.
- **Housing Support for Persons with Disabilities** — Major increases in rental assistance to persons with disabilities, including behavioral health disorders, as well as major increases to help provide housing to the homeless with mental illnesses were achieved. Also, Congress created a new discharge policy to promote local coordination among homeless programs and public institutions like state psychiatric hospitals and jails.

Balanced Budget Act of 1997

This legislation established, in part, consumer protections and enrollment standards for persons of behavioral health disorders mandatorily enrolled in managed Medicaid plans. The National Council was successful in securing guarantees that single plans, with an appropriate choice of providers and levels of care, could be offered at the regional level, as opposed to the choice of two plans HCFA required to ensure quality.

Parity

The National Council was instrumental in securing a Senate hearing on legislation dealing with parity for behavioral health needs. Presently, behavioral healthcare provided through federal programs such as Medicare and Medicaid do not provide the same levels of care as for covered physical health conditions. The National Council successfully argued that providing behavioral health parity would meet an exceptional unmet need, even as it has been demonstrated to be cost effective in terms of reducing productivity that has been diminished by untreated behavioral healthcare illnesses.

Partial Hospitalization

The National Council continued to press Congress for comprehensive reform that would establish conditions of provider participation and national standards. Through the regulatory process, we were able to deal with the “screening” function of a CMHC to a state hospital, particularly where some areas had moved to a single point of entry, by allowing that screening function to be provided under contract. We were also able to receive approval for CMHCs to use 1996 data as a baseline for reimbursement as part of a formula that allows a gradual reduction from fee-for-services to a prospective payment system under Medicare.

Housing

The National Council continues to push for greater access to both housing and accompanying supports and services necessary for individuals with behavioral health disorders to live in the community. This includes both production of new rental housing and preservation of existing affordable rental housing, as well as opportunities to purchase their own homes. To this end, the National Council continues to support increased federal funding for programs that include:

- Program in Assistance in Transition from Homelessness (PATH);
- The Section 811 program, which was designed to provide housing and supports to people with severe disabilities who might otherwise be forced to live at home with aging parents, on the streets, or in jail or prison;
- A separate allocation of Section 8 vouchers for non-elderly people with disabilities;
- Shelter Plus Care program rental vouchers, so formerly homeless adults with severe mental illnesses are not forced back onto the streets; and
- Creation of a permanent supply of non-profit owned rental housing to limit reliance on private landlords who frequently discriminate against people with disabilities.



Nelba Chavez, PhD., administrator of the Substance Abuse and Mental Health Services Administration during the Clinton Administration, discusses community behavioral health issues with Charles G. Ray, National Council president and CEO.

Addictions Disorders

During 2000, the National Council expanded its initiatives around services for addictions disorders. These activities were expanded in response to feedback that a large percentage of member organizations provide these services, and the public policy work of the National Council should encompass the interests of these providers. Given the significant and growing number of consumers that are presenting for both mental health and addictions disorder needs, the National Council has given priority to advocacy for a “no wrong door” policy for people with co-occurring disorders.

While the National Council has long worked in coalition with a number of addictions groups to press a national agenda on these issues, it expanded its in-house capabilities with the addition of a full-time government relations staff member whose primary duties focus on addictions disorder issues. In 2000, the Council was active in advocacy for addictions treatment issues.

- Integrated Treatment for Consumers with Co-Occurring Disorders** — In negotiations over the crafting of the SAMHSA reauthorization legislation enacted this fall, the National Council lobbied for provisions that would allow for the blending of the mental health and substance abuse block grants. The blended funding was sought as a means of forcing “siloes” state mental health and addictions treatment agencies to remove bureaucratic barriers which stand in the way of the establishment of integrated treatment programs for people with co-occurring addictions and mental health disorders. Unfortunately, the issue bred divisiveness among national mental health and addictions treatment advocacy organizations — divisiveness based in many cases on the fear that funding would be shifted from existing services. The National Council looks to move forward in a bridge-building role in the behavioral healthcare community. By emphasizing the need for new funding and focusing on the bureaucratic barriers that inhibit the development of new programs, progress can be made in setting up new programs for consumers.



included in the goals of

the National Council are our efforts to:

- **PROMOTE** development of innovative, locally responsive services in nontraditional settings;
- **PROMOTE** development of fair exchange partnerships and alliances among and between consumers, public and private payors, providers and others who share our vision; and
- **PROVIDE** business development and managerial training that empower our members to support our vision in a rapidly changing healthcare environment.

We believe each of our new member benefits and organizational initiatives meet identifiable member needs and are delivered in a manner that brings real value to recipients.

Responsibility for pursuing three of the National Council's four goals rests in the Membership and Educational Services Division. (The fourth goal — to advocate for public policy that promotes our vision and secures adequate resources — is pursued by the staff of the government relations division in cooperation with its grassroots network of members and supporters.)

During 2000, the Membership and Educational Services Division marked a number of operational milestones that reflected our commitment to member education, partnerships and growth. To this end, the year was marked by continued emphasis on building member value, the rollout of new strategies made possible by the changeover to a rolling three-year workplan, and significant new forays into the Internet world.

Membership Recruiting and Retention

Membership recruiting and retention enjoyed a banner year with significant increases in both areas. Our member renewal rate was the highest it has been in six years. We recruited 77 new members, which was the highest number of new members since 1995, and welcomed Colorado and Alabama as new 100% States.*

We have also conducted — and continue to conduct in an ongoing process — a comprehensive review and revalidation of all member benefits with an eye toward improving their quality and increasing their value. Members of the Ad Hoc Committee on Membership provided important insights to this ongoing process as both organizational leaders and members. In addition, we routinely solicit member input and ideas. As a result, we believe each of our new member benefits and organizational initiatives meet identifiable member needs and are delivered in a manner that brings real value to recipients.

* 100% States are those with State Associations, the members of which have all joined the National Council. Member organizations in 100% States pay discounted dues and receive additional other member benefits.

National Council Learning Center

The year 2000 marked the launch of the most ambitious educational and training initiative ever undertaken by the National Council. When the final elements are in place and functioning by mid-2001, the National Council Learning Center will provide a series of integrated, multi-disciplinary, continuing education and training opportunities for behavioral healthcare professionals that we believe are unmatched by any other association or organization.

This ambitious project is being designed to build upon a number of highly successful National Council educational efforts — including its annual training conference, consulting services, and professional publications — to provide the behavioral healthcare industry with critically important targeted training. New training elements that have been added or that are in final development include the Professional Development Institute and a growing curriculum of distance learning courses (called **NC Online**). Both are discussed in detail below.

The Learning Center represents the National Council's response to a number of growing challenges to the industry that have made it increasingly difficult to obtain the training necessary for successful management of behavioral healthcare organizations. Always important, this issue has reached near crisis proportions for our members as a tight labor market, growing need, and limited resources makes it increasingly difficult for them to attract and retain skilled supervisors, middle management, and executive leadership.

We have also known for a number of years that professional development within the behavioral healthcare world offers particular and significant challenges. Specifically:

- Extraordinary advances in rapidly changing care delivery, and psychosocial and pharmacological therapies, require a high level of sustained continuing education in these areas if staff are to provide the best services possible.
- Fragmented, often unreliable and traditionally insufficient funding sources require effective behavioral healthcare managers to be entrepreneurial in seeking creative solutions to acquiring adequate resources to deliver minimum levels of care, and particularly astute in developing and implementing effective management strategies that get the most from those resources.
- *Community-based* behavioral healthcare services — designed specifically to meet the mental health and addictions illness needs of a community's most vulnerable populations — is a highly specialized subset of the behavioral healthcare world for which few targeted educational resources exist.

NATIONAL COUNCIL LEARNING CENTER

ANNUAL TRAINING CONFERENCE

Institutes, workshops and speakers representing the best strategies and finest minds in the behavioral healthcare industry.

PROFESSIONAL DEVELOPMENT INSTITUTE

Structured, intensive management training provided through the Middle Manager Academy, Senior Manager Academy and Executive Level Academy.

NC ONLINE

Online training designed specifically for behavioral healthcare managers.

NC CONSULTING SERVICES

More than 20 of the behavioral healthcare industry's finest experts in more than a dozen community-based behavioral healthcare specialty areas.

NC PUBLICATIONS

Materials designed to keep behavioral healthcare managers knowledgeable and up-to-date on the cutting-edge strategies that define delivery of effective community-based services.



Professional Development Institute

The Professional Development Institute was conceptualized as an intensive, on-going, and outcomes-based career development path for staff in the behavioral health field. The Institute will be comprised of three sections, each of which is targeted toward a different phase in the career evolution of behavioral healthcare management.

Each section or "academy" will provide a comprehensive curriculum tailored specifically to the behavioral health market, emphasizing practical skills and building upon the real-life situations in which participants find themselves. Based on a sound foundation of adult learning theory, the curriculum and instructional approach will be highly experiential and emphasize peer learning, development and support.

Continuing Education Units (CEUs) will be offered to further enhance the value of the educational experience to the participants. Our vision includes exploring linkages to higher education

institutions with an ultimate goal of offering a recognized "Certification" process and credit towards a degree program. Our goal is to not only impart knowledge, but to facilitate the development of a career track for the behavioral health leadership of tomorrow.

Middle Management Academy

The first section of the Professional Development Institute, the Middle Management Academy, launches the participant on a career path in behavioral health leadership. It is targeted specifically for supervisors and mid-level managers, many of whom are likely transitioning from direct service clinical roles to management.

Consistent with our adult learning focus, the Academy uses a unique approach to content delivery and learning. At registration, participants in the academy are assigned to a virtual provider organization that provides the context for their

learning experience. The organizations typically will be comprised of no more than 15 participant “managers” and will be facilitated by an instructor “CEO” for the duration of the Academy.

As originally conceived, the complete curriculum for the face-to-face version of the Middle Management Academy spans more than 30 hours of class and project time over four consecutive days, in addition to reading, exercises, and self-assessment outside of class.

Senior Management Academy

The second phase of the Professional Development Institute, the Senior Management Academy, is targeted for middle managers moving to senior management positions such as division directors and vice presidents, or for senior managers wishing to sharpen their skills for career enhancement. As with the Middle Management Academy, the curriculum is comprehensive and focused on skill building.

Executive Leadership Academy

Targeted for executive leadership and Boards or for those positioning themselves for advancement into executive management, the Executive Leadership Academy is the third phase of our Professional Development Institute.

NC Online

While the Professional Development Institute is a significant initiative to enhance training efforts, members have also provided consistent feedback that there are logistical barriers to getting onsite training for their staff members. Those barriers include: not being able to free up work time; travel constraints (the appropriate training requires prohibitive travel); the appropriate training is not available when it is needed; the available training is not industry specific; and the available training is too expensive.

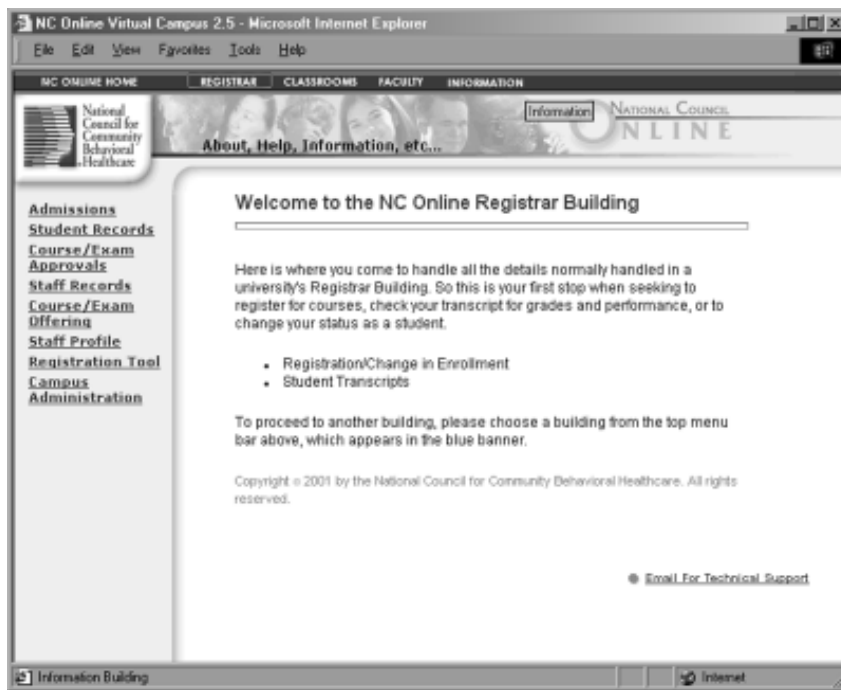
NC Online is a perfect solution. It will reach our members and their staff, as well as nonmembers, in disparate geographic locations. It will be tailored to our-specific member needs, experiences, and situations. It will be affordable. It can be done at a time that works for employees.

But online learning also includes a significant investment in research and development, due diligence, initial startup and project management, as well as selection of online learning application vendors. During 2000, the National Council’s Board of Directors took a significant step in approving a \$50,000 investment from reserves to launch the effort.

The National Council has launched course development activities and now partnered with vendors to create:

- An intuitive, user-friendly system for administrative and content delivery functions using the familiar metaphors of a college campus;
- Courseware developing tools which facilitate a uniform 'look and feel' for all courses, and which supports state-of-the-art computer graphics and plug-ins;
- Staff development and training for course developers and system administrators;
- Easy management of the online courses, enrollments, and student progress for administrators and faculty; and
- Off-site server hosting and in-house technical support services.

The online courses, which will initially focus on behavioral healthcare management issues, are being built to eventually support a curriculum that augments training received from the annual training conference and/or the Professional Development Institute. In addition, a comprehensive course list of appropriate skills-building courses will be offered through partnerships with other vendors at little or no cost to our members.



NC Online provides behavioral healthcare management students with an opportunity to acquire critically important instruction any time, day or night, at home or at work.



The National Council's annual training conference traditionally features leaders in the behavioral healthcare field, such as Surgeon General David Satcher, M.D., Ph.D., shown at the 2000 annual conference in Washington, D.C.

Annual Training Conference

As we work to incorporate the comprehensive workshop and daylong training institutes of the National Council's annual training conference into the National Council Learning Center, it is with the realization that the training conference is a particularly valuable element of the educational mix.

The 2000 annual training conference was, by almost any measure, the most successful in the National Council's history: higher registration, largest exhibit hall with the greatest number of exhibitors, and highest evaluations by attendees. In this regard, the National Council's annual training conference has bucked the trend of dwindling attendance at such gatherings. But, as previously mentioned, attendance at such conferences is growing increasingly difficult to sustain, and more members say they are finding it increasingly difficult to spare staff and staff time to attend.

While we believe the annual training conference will continue to provide the best way to meet members' training and networking needs, and will continue to enjoy considerable popularity among members as a result, we also recognize the growing influence of Internet-based distance learning and the real value such training may hold for members.

National Council Web Site — www.nccbh.org

As the variety of web-based applications grows and use of the Internet becomes more widespread, the National Council has moved out on a number of fronts besides NCOline that directly inform our efforts to support member needs.

Use of the National Council's web site during fiscal year 2000 increased 55 percent over the previous fiscal year. The web site continues to serve as an important information and reference source for both members and nonmembers alike.

This year, we have begun the process of using our web site as an alternative to costly printings and mailings whenever possible, and are urging members and nonmembers alike to go to the web for expanded information and registration for things such as the training conference, exhibitor registration, publication sales, etc.

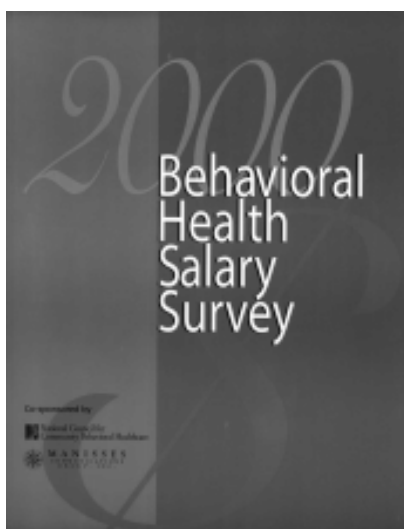
For the 2000 Annual Training Conference, we created a special section for marketing and provided information on speakers, workshops, and institutes. We also introduced the "virtual exhibit hall" which gave exhibitor information and useful links as an interactive exhibit hall map. We found these sites to be particularly valuable to attendees and exhibitors. For 2001, we have created a new Portland conference section making it much more user-friendly and informative.

During 2000, we unveiled a redesigned web site that is designed to make navigation easier and quicker, improve the appearance, and incorporate new applications more effectively. The result is a product that we believe will provide us with an attractive and user-friendly platform that more and more members and nonmembers will access.

Publications

We introduced a redesigned *NCNews* for the April/May Conference issue that was created to enhance the readability and attractiveness of the publication. We have also begun posting the complete issue on our web site, including all articles and advertisements. In addition, we have brought added emphasis to the editorial content of *NCNews*, including more and varied articles, professional development articles, and editorials from organizational leaders. The National Council Bookstore had an increase of 15 percent over the previous fiscal year, making it the most successful year for the bookstore. Our most successful publications this year were *Ahead of the Game*, *Preferred Clinical Practice Guidelines*, *2000 Behavioral Health Salary Survey*, and *How to Maximize Service Capacity*.

The *2000 Behavioral Health Salary Survey* is a joint venture with Manisses Communications. We have received very positive feedback and are hoping this will be the first of many collaborative publications. In the coming year, we will publish a second version of *How to Maximize Service Capacity*, a clinical supervision book, and capitalize on our new relationship with Aspen Publishing to expand market reach of all National Council publications.



Consulting Services

The National Council's Consulting Services reflects its commitment to helping behavioral healthcare organizations serve vulnerable populations in a cost-effective manner; a manner that reflects the best thinking and strategies currently being employed.

National Council consultants are carefully screened professionals with demonstrated records of success, men and women who possess the mix of practical knowledge and collaborative strategies necessary to get the job done.

The organization's consulting services continue to be a mainstay of its non-dues revenue initiatives. During the year, the National Council invested additional resources in marketing our consulting competencies and product lines. That resulted in one of the best years in consulting services for the National Council and continued high demand for National Council consulting services. In addition, the National Council expanded its pool of expert consultants with the addition of industry leaders in corporate compliance and regulatory implementation.

ABHM and the National Council

ABHM is the nation's oldest individual membership trade association for mental health and addictions treatment professionals. The organization merged with the National Council in 1999. ABHM offers its members resources and information designed to help managers carry out more precise behavioral healthcare management methods, which is in keeping with a longtime National Council goal — to “provide business development and managerial training that empowers members...in a rapidly changing healthcare environment.”



ABHM enjoyed its second year as a section of the National Council in the year 2000 with an extraordinary 15-percent growth in membership. ABHM Advisory Council members and National Council staff worked together throughout the year to expand ABHM's comprehensive benefits package, and to continue the successful partnership between both organizations.

Members continued to enjoy in-depth industry and organizational information through ABHM's monthly newsletter *Progress Notes*, and quarterly publication, the *ABHM Leader*. New chapters bylaws were passed to encourage chapter growth and create new chapters, in order to increase local networking opportunities. And a new publisher — Aspen Publishers of Gaithersburg, Maryland — was selected to publish *The Journal of Behavioral Health Services & Research*. The *Journal* will now be available to members online as a result of the new publishing contract.

**“Organizations should form alliances and exchanges
with other organizations in order to actualize its vision.”**
— Principles for Behavioral Healthcare Delivery

Development of the new Middle Management Training Academy highlighted the organization’s efforts to provide its members with a variety of continuing education opportunities. The Academy is a 3½-day intensive training program that focuses on important skills necessary for clinicians who are transitioning to management, new managers eager to continue their professional growth and development, and senior managers interested in brushing up their skills.

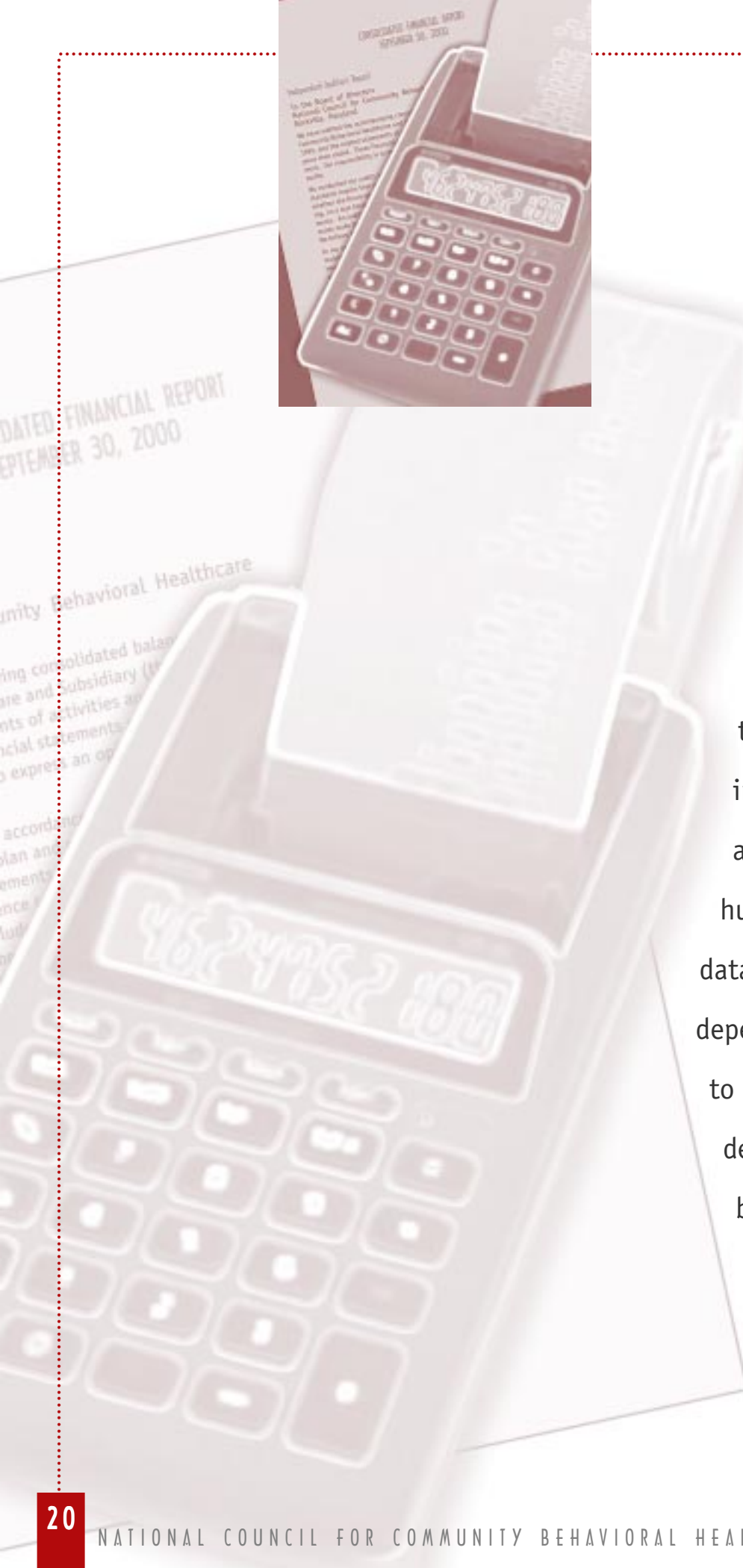
The Middle Management Training Academy was completed in time to debut at the 2001 annual training conference in Portland, Oregon. Plans are to offer the Academy at regional conferences each year.

Additionally, online continuing education courses will be available at a special discounted rate to members in the near future through the new National Council Learning Center. The organization’s CBHE 50-question, sub-specialty exam and the Middle Management Training Academy will soon be available via the ABHM web site, as well.

ABHM’s benefit package now includes:

- The award-winning, peer-reviewed *Journal of Behavioral Health Services and Research* (now available online to members);
- A Certified Behavioral Healthcare Executive (CBHE) program through the American College of Healthcare Executives;
- Local chapters for increased networking opportunities;
- The *ABHM Leader*, a quarterly publication;
- *ABHM Progress Notes*, a monthly newsletter;
- *Behavioral Healthcare Tomorrow*, an industry trade magazine published six times per year;
- The ABHM web site (www.nccbh.org/abhm);
- The ABHM membership directory;
- A \$200 discount on the yearly subscription rate to *Mental Health Weekly*;
- Discounts to the National Council’s annual training conference;
- A full-time staff member designated as the ABHM liaison.

The cost for ABHM membership is \$175 for Active Members and \$125 for Associate Members.



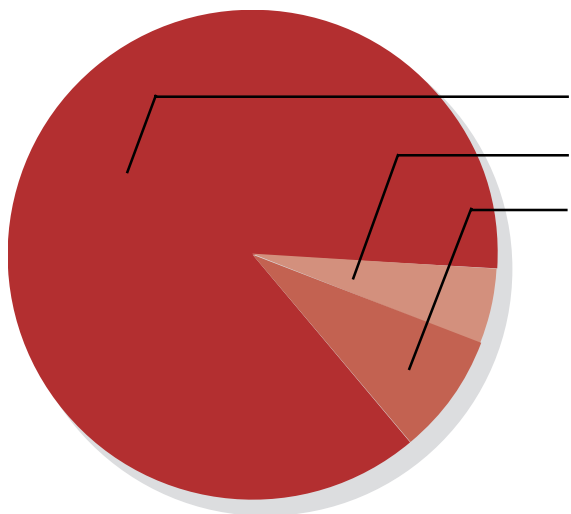
The Administrative Services Division of the National Council provides centralized support services to all divisions in areas including office management, accounting, financial reporting, human resources, technology and data management. The Council depends upon a team approach to office communications and decision-making in order to be an effective and efficient organization.

Policies, procedures and systems are designed to encourage competence, maximize efficiency and provide prudent documentation. The Board of Directors receives regular reports from the Administrative Services Division and, through the Finance and Administration Committee, provides due diligence oversight of all administrative areas.

During FY2000, human resource support, training and competitive benefit programs were administered to the staff of 17. Personnel policies were reviewed and updated to meet both governmental requirements and best human resource practices. Managing a national association office that responds promptly to membership and policy needs is a challenge that requires competent staff and shared ownership of the organization. A variety of supportive programs for staff were implemented during the year and staff retention was the highest in seven years.

The Council's technology provides the backbone for effective management and program services. Capabilities for integrated internal/external communications, data management, publishing and production were regularly upgraded and improved during the year. All technology was certified for Y2K compliance prior to December 31. Security practices for network efficiency, backup documentation and virus prevention provided a trouble-free and crash-free fiscal year.

Despite a 10 percent increase in annual expenditures and membership activity, administrative services decreased from 35 percent of overall expenditures in 1999 to 32 percent in 2000, meeting the goal to be both an effective and efficient organization.



MEMBERSHIP COMPOSITION IN FY2000

Direct Care Providers	87 percent
State Association Members	5 percent
Other	8 percent



KELLER BRUNER & COMPANY

Certified Public Accountants • Management Consultants

Independent Auditor's Report

**To the Board of Directors
National Council for Community Behavioral Healthcare
Rockville, Maryland**

We have audited the accompanying consolidated balance sheets of the National Council for Community Behavioral Healthcare and Subsidiary (the Council) as of September 30, 2000 and 1999, and the related statements of activities and changes in net assets, and cash flows for the years then ended. These financial statements are the responsibility of the Council's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the National Council for Community Behavioral Healthcare and Subsidiary as of September 30, 2000 and 1999, and the changes in their net assets and their cash flows for the years then ended in conformity with generally accepted accounting principles.

Keller Bruner & Company, LLP

November 30, 2000

CONSOLIDATED BALANCE SHEETS

September 30, 2000 and 1999

ASSETS	2000	1999
Current Assets		
Cash and cash equivalents	\$ 703,927	\$ 976,930
Receivables	360,359	234,820
Inventory	23,724	22,364
Prepaid expenses	24,278	61,362
TOTAL CURRENT ASSETS	1,112,288	1,295,476
Property and Equipment, net	158,065	116,964
Other Assets	16,220	16,220
	\$ 1,286,573	\$ 1,428,660
LIABILITIES AND NET ASSETS		
Current Liabilities		
Accounts payable and accrued expenses	\$ 206,572	\$ 179,591
Accrued leave	61,209	52,766
Deferred revenue	489,587	672,226
TOTAL LIABILITIES	757,368	904,583
Commitments		
Net Assets – unrestricted	529,205	524,077
	\$ 1,286,573	\$ 1,428,660

See Notes to Consolidated Financial Statements on pages 26-27.

CONSOLIDATED STATEMENTS OF ACTIVITIES AND CHANGES IN NET ASSETS

Years Ended September 30, 2000 and 1999

	2000	1999
Revenue		
Membership dues	\$ 1,106,081	\$ 1,080,884
Educational services	774,878	636,335
ABHM membership section	108,462	78,691
Royalties	83,893	79,243
NSS contract	66,646	68,273
Membership services	46,368	73,448
Interest	31,293	37,029
Public policy	2,983	100,466
Other	13,393	35,563
TOTAL REVENUE	2,233,997	2,189,932
Expenses		
Program services		
Educational services	872,012	643,644
Membership services	234,537	275,668
Public policy	197,824	241,540
ABHM membership section	99,591	73,307
Board and Regions	74,198	61,582
NSS contract	29,824	19,905
TOTAL PROGRAM SERVICES EXPENSES	1,507,986	1,315,646
Support services		
General and administrative	720,883	704,124
TOTAL EXPENSES	2,228,869	2,019,770
CHANGE IN NET ASSETS	5,128	170,162
Net Assets		
Beginning	524,077	353,915
Ending	\$ 529,205	\$ 524,077

See Notes to Consolidated Financial Statements on pages 26-27.

CONSOLIDATED STATEMENTS OF CASH FLOWS

Years Ended September 30, 2000 and 1999

	2000	1999
Cash Flows from Operating Activities		
Change in net assets	\$ 5,128	\$170,162
Adjustments to reconcile change in net assets to net cash (used in) provided by operating activities:		
Depreciation	54,939	48,421
Bad debts	3,953	4,195
Changes in assets and liabilities:		
Decrease (increase) in:		
Receivables	(129,492)	(2,844)
Inventory	(1,360)	(526)
Prepaid expenses	37,084	(42,985)
Increase (decrease) in:		
Accounts payable and accrued expenses	26,981	85,731
Accrued leave	8,443	6,901
Deferred revenue	(182,639)	49,833
NET CASH (USED IN) PROVIDED BY OPERATING ACTIVITIES	(176,963)	318,888
Cash Flows from Investing Activities		
Purchase of property and equipment	(96,040)	(70,442)
NET CASH (USED IN) INVESTING ACTIVITIES	(96,040)	(70,442)
NET (DECREASE) INCREASE IN CASH AND EQUIVALENTS	(273,003)	248,446
Cash and cash equivalents:		
Beginning	976,930	728,484
Ending	\$ 703,927	\$ 976,930
Supplemental Disclosure of Cash Flow Information:		
Cash paid during the year for income taxes	\$ —	\$ 400

See Notes to Consolidated Financial Statements on pages 26-27.

Notes to Consolidated Financial Statements

Note 1. Nature of Activities and Significant Accounting Policies

• **Nature of activities:** The National Council for Community Behavioral Healthcare and Subsidiary (the Council) consists of two entities, the National Council for Community Behavioral Healthcare (NCCBH) and NCCBH's wholly owned subsidiary, National Service Systems, Inc. (NSS).

NCCBH is a not-for-profit organization engaged in creating healthy and secure communities through a system that holds the needs of the consumer paramount, with a network of providers offering behavioral healthcare services of unparalleled value. NCCBH advocates public policy, which promotes this vision and secures adequate resources. Educational activities provide training in business development, managerial training and quality care in a rapidly changing healthcare environment. Membership programs further promote effective community services through partnerships and sharing of knowledge. NCCBH also provides national leadership for research and design of models for both the promotion of behavioral health and the prevention of illness.

National Service Systems, Inc. (NSS), was incorporated in the State of Maryland as a wholly owned subsidiary of NCCBH. NSS is a for-profit organization that provides services to the behavioral healthcare industry in order to strengthen the quality of care available.

A summary of the significant accounting policies of the Council is as follows:

- **Basis of accounting:** The accompanying consolidated financial statements are presented in accordance with the accrual basis of accounting, whereby, revenue is recognized when earned and expenses are recognized when incurred. Revenue received, which obligates the Council to perform future services, is recorded as deferred revenue.
- **Consolidation policy:** The accompanying consolidated financial statements include the accounts of NCCBH and its wholly owned subsidiary, NSS. All significant transactions between NCCBH and NSS have been eliminated in the consolidation.
- **Basis of presentation:** The consolidated financial statement presentation follows the recommendations of the Financial Accounting Standards Board in its Statement of Financial Accounting Standards (SFAS) No. 117, *Financial Statements of Not-for-Profit Organizations*. Under SFAS No. 117, the Council is required to report information regarding its financial position and activities according to three classes of net assets: unrestricted net assets, temporarily restricted net assets, and permanently restricted net assets. There are no temporarily restricted or permanently restricted net assets at September 30, 2000 and 1999.
- **Cash and cash equivalents:** For the purpose of reporting cash flows, the Council considers cash and cash equivalents to be cash and short-term, highly liquid investments, with maturities of three months or less.
- **Financial risk:** The Council maintains its cash in bank deposit accounts, which, at times, may exceed Federally insured limits. The Council has not experienced any losses in such accounts. The Council believes it is not exposed to any significant credit risk on cash.
- **Provision for doubtful accounts:** The provision for uncollectible accounts is based on management's evaluation of the collectibility of receivables.
- **Inventory:** Inventory is stated at the lower of cost or market, using the first-in, first-out method.
- **Property and equipment:** Property and equipment is recorded at cost and is being depreciated on a straight-line basis over their estimated useful lives. The Council capitalizes all property and equipment purchased with a cost of \$750 or more.
- **Revenue:** The Council's memberships run concurrent with the fiscal year. Membership dues received in advance are reported as deferred revenue and recognized during the period of membership.
Conference and seminar fees are recognized at the time of the conference or seminar. Amounts received in advance are recorded as deferred revenue.
Publication revenue is recognized upon delivery of the materials.
- **Expenses:** Direct costs associated with specific programs are recorded as program expenses. General and administrative expenses are unallocated and reported as a separate activity in the Statement of Activities.
- **Income tax:** NCCBH is generally exempt from Federal income taxes under the provisions of Section 501(c)(3) of the Internal Revenue Code. In addition, NCCBH qualifies for charitable contribution deductions under Section 170(b)(1)(A) and has been classified as an organization that is not a private foundation under Section 509(a)(2). Under current Internal Revenue Service regulations, advertising revenue earned in the publication of NCCBH's magazines are subject to unrelated business income tax. There was no net income tax liability for unrelated business income for the years ended September 30, 2000 and 1999.

NSS is not exempt from income taxes. NSS accounts for income taxes for financial reporting purposes under the provisions of Statement of Financial Accounting Standards (SFAS) No. 109 *"Accounting for Income Taxes,"* which requires an asset and liability approach for financial reporting of income taxes. Income tax expense for the years ended September 30, 2000 and 1999, is estimated to be \$0 and \$400, respectively.

- **Estimates:** The preparation of consolidated financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

Note 2. Merger

On May 28, 1999, the Association of Behavioral Healthcare Management (ABHM) merged with NCCBH. As a result of the merger, NCCBH acquired \$4,312 in net assets. The operations of ABHM were incorporated into the ABHM membership section of NCCBH.

This acquisition has been accounted for as a purchase, pursuant to Accounting Principle Board Opinion No. 16, Business Combinations.

Note 3. Receivables

Receivables at September 30, 2000 and 1999, consist of the following:

	2000	1999
Accounts receivable	\$ 370,359	\$ 244,820
Less provision for doubtful accounts	10,000	10,000
	\$ 360,359	\$ 234,820

Note 4. Property and Equipment

Property and equipment and accumulated depreciation at September 30, 2000 and 1999, and depreciation for the years ended September 30, 2000 and 1999, is as follows:

2000			Accumulated	
Asset category	Estimated Lives	Cost	Depreciation	Depreciation
Furniture and fixtures	5 - 7 years	\$ 265,710	\$ 203,023	\$ 42,481
Software	5 - 7 years	169,458	74,080	12,458
		\$ 435,168	\$ 277,103	\$ 54,939
1999			Accumulated	
Asset category	Estimated Lives	Cost	Depreciation	Depreciation
Furniture and fixtures	5 - 7 years	\$ 263,173	\$ 168,693	\$ 39,200
Software	5 - 7 years	84,106	61,622	9,221
		\$ 347,279	\$ 230,315	\$ 48,421

Note 5. Commitments

The Council entered into a new lease agreement for office space during the year ended September 30, 1999. The lease provides for escalation of rental payments based upon increases in operating costs of the lessors and increases in Consumer Price Index. Rent expense for the years ended September 30, 2000 and 1999, was \$121,868 and \$111,071, respectively. Future minimum lease commitments for this noncancelable operating lease are as follows:

Years ending September 30	
2001	\$ 108,988
2002	111,706
2003	114,495
2004	38,478
	\$ 373,667

The Council has entered into a contract for hotel rooms for the annual conference scheduled for March 2001 and April 2002. In the event of cancellation, NCCBH is required to pay an amount stipulated in the contract. The amount to be paid is dependent upon the date of cancellation.

Note 6. Related Party Transactions

NCCBH owns one share of Class B stock in the Mental Health Risk Retention Group, Inc. (MHRRG), and is entitled to elect two members of their Board of Directors. NCCBH is the only stockholder to own Class B stock. Pursuant to an agreement with MHRRG, NSS is engaged to assist the MHRRG in offering its Class D shares to qualified purchasers and marketing its insurance products to qualified owners. MHRRG pays NSS annual compensation of \$50,000 for its services. Accounts receivable under the agreement amounted to \$25,000 and \$37,500 at September 30, 2000 and 1999, respectively.

NCCBH's President is a member of the Board of Directors of the Community Healthcare Facilities Fund (CHFF). Pursuant to an agreement with CHFF, the Council receives royalties on certain bond offerings. Royalties received were \$83,893 and \$79,243 for the years ended September 30, 2000 and 1999, respectively.

Note 7. Retirement Plan

The Council maintains a defined contribution retirement plan, which covers substantially all of its employees. Employees are eligible to participate in the plan upon completion of six months of service. Individual annuity accounts are maintained for each participant. The Council makes contributions to each account equal to 6 percent of a participant's monthly wages. These contributions amounted to \$44,989 and \$35,978 for the years ended September 30, 2000 and 1999, respectively.

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