Dear Community Mental Health Board Member:

It is our pleasure to provide this letter of introduction to the newest edition of the Community Mental Health Association of Michigan's (CMHAM) board member orientation guide. Board members have always played a critical role in Michigan's public mental health, substance use disorder, and developmental disabilities services and support system. Today, in an environment of significant healthcare reform, increasing need, and limited resources, the need for effective boards to provide leadership and policy direction to their organizations has never been greater.

CMHAM exists to provide support and assistance to board members throughout the state to fulfill their responsibilities capably and successfully. By providing a general overview of the Michigan system, this guide is intended to provide a new board member with a better understanding of the history and evolution of the system and CMHAM, board member responsibilities, principles upon and within which the current system operates, and additional details on financing and funding aspects of the system.

This orientation guide has been developed and organized in a binder format so that updates to sections of the guide can be provided by CMHAM, and so that your own organization can insert additional documents pertaining to its specific operations in these same areas.

Thank you for your time, efforts, and wisdom in making an important and positive contribution to the publicly funded community-based system of care in your community.

Sincerely,

Member Services Committee
Community Mental Health Association of Michigan

BOARD MEMBER ORIENTATION GUIDE TABLE OF CONTENTS

BOARD MEMBER RESPONSIBILITIES - TABLE OF CONTENTS

1. Responsibilities of a Board Member

With your appointment as a CMHSP board member, you will become known as a representative of community mental health. You also become a key informant, an advocate, and an ambassador. However, you should not attempt to act as a formal representative of the Board unless specifically designated to do so by formal Board action. Boards are well advised to develop policies with regard to how members should relate to the community when wearing their board member "hat."

Serving as a community mental health board member is not only an honor, but a responsibility -- a tremendous responsibility to be the best board member you can be. This responsibility entails a commitment in time that offers no monetary reward. For those with the dedication to serve, a job well done is its own reward.

Much of the time and effort which you expend on behalf of your Board, your community, and the recipients of mental health services will be spent in understanding the public mental health system as it operates on the state level and in your area. Since this system is dynamic and ever-changing, you will also be asked to understand and analyze issues and information which seeks to change the system. You and your Board will be called upon to take a position on behalf of your community to decide if a proposed change is for the better and deserving of your support or one that should be rejected.

One of your most difficult challenges will be to make decisions on the best way to meet the identified needs for service with insufficient dollars. In order to do this, your Board will have to set priorities and, at times, you may have to say "no" to some very needy and worthy causes. Again, in order to make the right decisions, you will need to have access to the right information and to invest the time to analyze it to the best of your ability.

You and each of your fellow board members have your own unique personal backgrounds and experiences to offer to this process. Your diversity as a Board can be your greatest strength, as together you can share and consider a variety of viewpoints and perspectives. Thus, you are obliged to offer your opinion and speak on behalf of what you believe during Board deliberation on a given issue.

If you make the time to get a strong foundation of understanding of the mental health system, if you use all available information to make informed decisions on behalf of the most vulnerable within your community, if you speak out and make yourself heard when you have something to contribute, and if you have the ability to be part of a team effort, you will be the best board member you can be.

Legislative Advocacy/Political Action:

In your role as a key informant and advocate for community mental health, you will be called upon to share what you have learned about mental health needs and services. Whether your goal is to secure community support for a new group home or to secure funds for local programs, you may find it necessary to step into the political arena.

Your Agency can be extremely influential in affecting changes and improvements in the mental health system in your state and local community. As a group of citizens, your political efforts will have far more weight than those of mental health professionals who are seen by politicians as merely serving their own interest. Because your Board is already organized as a group and because you are already united in your desire for improved mental health care in your community, your Board is a natural vehicle for successful political action. Speaking with one voice, you will have an impact!

You should keep in mind that because CMHSP Boards are legally and financially accountable to the Michigan Department of Community Health, it is important that they be kept apprised of the local mental health needs and problems as assessed by your Board. Through the Michigan Association of CMH Boards, legislative advocacy efforts of the Boards are coordinated and, when appropriate, integrated with the efforts of other groups on a state level. On the national level, the Association is an active member of the National Council for Community Behavioral Healthcare, National Association of County Behavioral Health and Developmental Disabilities Directors, and the State Associations of Addiction Services.

General Guidelines for Boards:

As you take satisfaction in knowing that you are fulfilling your responsibilities as a board member, you must be mindful of the fact that you are part of a team. In order to have a successful Board you must work together, encourage one another and continue to strive for excellence. Effective CMHSP Boards are made up of successful board members, but they also have other important characteristics in common. Philip M. Nowlen identified some of these characteristics in his book, DEVELOPING AN EFFECTIVE BOARD ORGANIZATION (1981). According to Nowlen, the successful Board:

- Has a clear understanding of its own nature and purpose.
- Sets objectives against which it regularly measures its progress.
- Has identified to whom it is accountable and regularly communicates with such persons.
- Works primarily through small groups such as task forces, which are assigned concrete, specific projects for completion within a reasonably short time.
- Never meets for the sake of meeting.
- Regards recruiting and retaining effective board members as a year-round activity of prime importance.
- Uses the secretary's minutes, and the treasurer's report as an action aid, not as oral history.
- Has members who value time -- that is, they don't waste other people's time and don't want their own wasted.

This list provides a yardstick not only for the Board as a whole but for individual board members as well. You may find the list helpful as a guidepost to keep you on track in the future. The following list of do's and don'ts for board members may also assist you in retaining a focus on the tasks at hand.

What a Board Should Do:

- Inspire and lead.
- Recognize the importance of good rapport between the Board and the Director.
- Set priorities.
- Establish and maintain a working relationship with other agencies and organizations involved with funding or service.
- Encourage experimentation.
- Establish a means of recruiting and recommending new members.
- Research efforts to improve service.
- Organize for optimum production.
- Recognize the efforts and contributions of all board members and communicate with seemingly disinterested members.
- Maintain a level of objectivity regarding comments, complaints and suggestions by listening, administrative referral, and total Board consideration.
- Be aware of the voting position of a board member on items that might be for personal gain or narrow interests.

What A Board Should Not Do:

- Should not permit itself or staff to make exaggerated and misleading claims.
- Should not allow dollar signs to crowd out efforts of competence and usefulness.
- Should not allow rigid loyalties to the Board, irrespective of needs and welfare of community as a whole.
- Should not allow needed changes to be hampered due to apparently insurmountable difficulties.
- Should not regularly hold unpublished Board meetings.
- Should not get involved in clinical issues or management.

Formal Responsibilities:

- Hiring, evaluating, and (if necessary) firing the Director.
- Delegating the organization’s management functions including planning, organizing, staffing, directing, and controlling to the Director.
- Developing and approving strategic plans, including major commitments.
- Assuring the continuity of the Agency, making emergency decisions when management cannot, and stepping in when crisis endangers programs or existence of the agency.
- Maintaining a healthy, well-organized governing body that helps the Agency achieve its mission.

What is the Board Member's Role:

Board members set policies for the programs to follow and set goals for those programs to strive to complete. The authority to run the programs is delegated to the Director. The Director and his/her staff must be held accountable by the Board for the efficient and effective operation of programs that will move in the direction of the goals adopted.

The Board/Director/Staff Team:

The consumer is the focus of all efforts by the Board, Director and staff.

- The Board develops policy.
- The Director implements policies and reports to the Board.
- Staff deliver services to the consumers.

Corporate Compliance:

Your Agency will probably have a formal Corporate Compliance Program and a Corporate Compliance Officer that reports directly to the Board. There are specific requirements per the Balanced Budget Act that your Agency has to be compliant with to ensure integrity and compliance with prevailing regulations.

Key Corporate Compliance Requirements:

- Billing integrity
- Audit management
- Conflict of Interest
- Confidentiality
- Records retention and oversight
- Whistleblower Act
- Policy development/oversight
- Credentialing and sanctions

Key Provisions of Robert's Rules:

- All members have equal rights, privileges and obligations; rules must be administered impartially.
- All members, majority or minority, have the right to full and free discussion of all motions, reports and other items of business.
- In doing business the simplest and most direct procedure should be used.
- Logical precedence governs introduction and disposition of motions.
- Only one question can be considered at a time.
- Members must be recognized by the chair before they may make a motion or speak in debate.
- No one may speak more than twice on the same question on the same day without permission of the assembly. No member may speak a second time on the same question if anyone who has not spoken on that question wishes to do so.

- Members must not attack or question the motives of other members. Customarily, all remarks are - addressed to the presiding officer.
- In voting, members have the right to know at all times what motion is before the assembly and what affirmative and negative votes mean.

Not all Agencies use Robert's Rules. This is usually stated in the Agency By-Laws.

Robert's Rules can be exacted by a 2/3's vote to a new or existing Board.

All Boards that use Robert's Rules should have the current version of the manual on hand. All members of the Board should be familiar with basic protocols and key terms.

For more information:
Parliamentary Procedure Online: www.parlipro.org
National Association of Parliamentarians: www.parliamentarians.com
American Institute of Parliamentarians: www.aipparl.org
Robert's Family Trust official website: www.robertsrules.com

2. Board Chairperson Responsibilities

The board chairperson will assure an orderly, fair, and disciplined governance process that focuses on the mission of the Agency.

The board chairperson shall:

- Call and conduct meetings of the Board.
- Determine agenda content considering the Board's articulated governing priorities.
- Establish program and Board agenda for the coming year.
- Facilitate the Board's dialogue and decision-making.
- Make committee assignments, appoint chairpersons, and ensure committees meet.
- Serve as spokesperson for the Board.
- Serve as liaison between the Board and the Director.
- Ensure completion of the annual performance evaluation of the Director.
- Faciliate the annual governance self-assessment of the Board.
- Not make decisions on behalf of the Board or unduly influence of the Board's decision-making process.
- Excuse board members with conflict(s) of interest.

3. Board Member Governance

Board members carry out their governance role by complying with the following:

- Maintain strategic planning goals which support the vision and mission statement of the Agency. Review the strategic plan annually.
- Attend Board meetings and serve as a member on at least one committee.
- Be well informed and prepared for meetings by reviewing materials in advance.
- Encourage the development of an inclusive and diverse Board membership.
- Assume leadership roles in Board activities.
- Participate in board member educational opportunities and conferences.
- Develop a process for strategic planning, monitoring, and evaluating the Agency's programs and services.
- Evaluate Board performance annually.
- Employ, supervise, and annually evaluate the Director.
- Act and make policy decisions considering the long-term best interests of all Agency consumers.
- Meet the legal and fiduciary responsibilities while acting as good stewards of the financial resources that the Agency receives and distributes.
- Contribute skills, knowledge, and experience when appropriate.
- Serve as ambassadors on behalf of the Agency's mission to the community.
- Always act for the good of the Agency.
- Serve as positive linkages with the community, listening to community concerns and sharing the Agency's direction.
- Respect the confidentiality of the consumers. Annually sign a Confidentiality Statement, Code of Conduct/Ethics Statement, and Conflict of Interest Statement.
- Observe parliamentary procedures and the Open Meetings Act and display courteous conduct in all Board and Committee meetings.
- Refrain from intruding on administrative issues that are the responsibility of the staff except to monitor results and prohibit actions that conflict with the Board policies or the law.
- Avoid conflict of interest between Board issues and personal issues, declaring such conflicts when they arise.

4. Conflict of Interest

It is the policy of the Agency that the Board and its members will avoid any conflict of interest.

A conflict of interest for members of the Board may exist if the board member or committee member has a monetary or fiduciary interest in an organization with which the Board contracts or which is applying for funds from the Board or from one of its contract agencies.

No board member or committee member or any member of his/her immediate family should accept any gift, entertainment, service, loan, or promise of future benefits from any person who either personally or whose employees might benefit or appear to benefit from such board or committee members' connection with the Agency, unless the facts of such benefit, gift, service or loan are disclosed in good faith and are authorized by the Board.

No board or committee member or any member of his/her immediate family should have any beneficial interest in or substantial obligation to any Agency supplier of goods or services or any other organization that is engaged in doing business with or serving the Agency. It is the responsibility of the board member to promptly disclose any pecuniary interest in any matter before the Board. Such disclosure will be made a matter of record in the minutes. The Board would then determine appropriate action if necessary.

Policy Name: Conflict of Interest

Applicable to: Employees, Executive Board Members

Policy Statement

Employees and Executive Board members of the Community Mental Health Association of Michigan (CMHAM) must avoid any conflict or appearance of conflict between their interests and the interests of CMHAM so as to avoid compromising the honesty, integrity, and reputation of the organization.

Examples of conflict of interest situations include (but are not limited to):

- Serving as a board member or employee of a competing organization.
- Employment outside of CMHAM which would affect the person's ability to carry out their CMHAM-related responsibilities.
- Holding a financial interest in a competing organization.
- Using knowledge gained from CMHAM-related work for personal gain or gain of a competing organization.
- Accepting personal free or discounted goods or services or profiting personally from an organization doing or seeking to do business with CMHAM.
- Using CMHAM time, materials, or resources for outside or personal activities.

Employees and Executive Board members will exercise good judgment and business ethics in conducting CMHAM business. Questions, concerns, or actual incidents of conflict of interest behavior should be reported to the Executive Director or President of CMHAM. Reported questions, concerns, or actual incidents will be documented and investigated as necessary.

Conflict of interest situations not reported and/or resolved involving employees may result in disciplinary action. Conflict of interest situations not reported and/or resolved involving Executive Board members may result in actions determined by the Executive Board and consistent with CMHAM By-Laws.

Procedures

- Upon hire or appointment to the Executive Board, employees and members will review the Conflict of Interest policy and sign the Acceptance and Disclosure Statement form.
- Employees and members are responsible to report any change of status related to the conflict of interest policy and disclosure statement.

Dated 12/21/09
Approved by the Executive Board 5/17/10

5. Ethical Behavior

Members are expected to behave ethically in consideration of all matters which come before the Board. This includes expectations to:

- Perform their duties in such a way as to protect the rights, general well being, and best interests of recipients of the Agency's services.
- Actively promote public confidence and maintain a positive image in order to pass constant public scrutiny.
- Not accept anything of value from any source which is offered to influence his or her action as a public official.
- Expect board members to comply with the ethical standards developed by the Board.

All board members commit themselves to conduct their professional relationships in accordance with the Mental Health Code and agree that they:

- Shall regard as their primary obligations the welfare of the individual or group served.
- Shall not discriminate because of race, color, religion, age, sex, national ancestry, disability or social or economic status and will work to prevent and eliminate such discrimination in rendering services, in work assignments, and employment practices.
- Shall give precedence to their professional responsibility over their personal interests.
- Shall hold themselves responsible for the quality and extent of the services that they direct.
- Shall respect the confidentiality of the people they serve.
- Shall not engage in sexual or other inappropriate activities with persons served by the Board.
- Shall treat with respect the findings, views, and actions of colleagues and use appropriate channels to express judgments on these matters.
- Shall accept responsibility to report unethical behavior by any individuals or organizations.
- Shall regard the integrity of other agencies in order to further the interest of the public.

6. Board - Director Relationship

The Director is the Board's employee. It is critical that the Board and the Director function effectively as a team. An important element in being able to work effectively as a team is a clear understanding and delineation of the respective roles and responsibilities of board members and the Director. A mutual respect and active support for each other is also a critical component of an effective team relationship. A typical delineation of the roles of the Board and the Director is outlined on the chart at the end of this section.

Selecting an Executive Director:

As the legal employer of the Director, the CMHSP Board is responsible for selecting its Director. Should a vacancy occur, the Department of Community Health has promulgated Administrative Rules that specify minimum qualifications for CMHSP Directors. This section of the Rules includes the following language:

R. 330.2081 Education and experience of a county director
Rule 2081.
(1) The county director of a county community mental health program shall meet the education and experience requirements specified in either of the following provisions:

(a) Be a physician, psychologist, social worker, registered nurse, or other human services professional that has at least a master's degree, 3 years of professional experience in his or her field of training, and 1 year experience in the administrative supervision of mental health programs.

(b) Be a person who possesses at least a master's degree in a field of management relevant to the administration of a county community mental health program with 3 years of professional experience in management and 1 year of experience in the management of human services programs. The areas of community mental health administration, hospital administration, public administration, institution management, business administration, or public health are deemed to be relevant fields of management.

(2) Notwithstanding the requirements specified in subrule (1) of this rule, if a person is a county director on the effective date of this rule, that person shall be deemed to meet the minimum education and experience requirements to be the county director of that or any other county program.
(3) If a candidate does not meet the minimum education and experience qualifications and the board requests review of this matter, the candidate may be deemed qualified by the department director to be a county director if the candidate is found to have substantially met the education and experience requirements of this rule.

History: 1990 AACS

Executing a Contract:

General Roles and Responsibilities*
Board and Director

Another responsibility of the Board is to develop an employment agreement with the Director. The contract document should specify the relationship between both parties, the duties and responsibilities of each, compensation (salary and benefits) and a mechanism for performance evaluation.

Whatever structure or definition of responsibilities is decided upon, it is critical that personalities take a back seat, and that they are never allowed to interfere with the overall goal of providing quality services to those in need. It is critical that both parties respect one another and remain committed to the goals of the Agency despite any differences which might arise. Keep in mind that the Board, as a team, made a decision that this person was the best individual for the job. If you trust the Board's decision on this, you must trust and support the Director you have selected. Should the Board feel it necessary to review this decision, the results of the Director's performance evaluations should form the basis for such a review.

Performance Evaluation:

The final responsibility of the Board with regard to the Director is to evaluate his/her performance on a regular basis. There are many benefits to conducting regular performance evaluations, not the least of which is to help all parties remain clear on the relationship, the division of labor, and the overall direction of the Agency. This process clarifies expectations, highlights areas of success and areas for improvement, and allows both parties -- the Board and the Director -- an opportunity to share their points of view and their perspectives on the progress and direction of the Agency.

Performance evaluations should focus on activities that are within the purview and scope of authority of the Director, as specified in the employment agreement. The results of a performance evaluation should tell the Board if the Director has performed as expected, as long as the expectations are clearly defined in advance. Elements to be evaluated should be measurable in an objective manner. Evaluations based on subjective opinions and impressions are not valuable tools nor are they documents upon which decisions should be based. Performance evaluations should not be considered final until the Director has had an opportunity to respond to the preliminary conclusions.

	Board	Director
Budget	Adopts, monitors and seeks input from Director and fiscal officers.	Prepares, administers report details.
Capital Improvement	Approves construction, remodeling and develops use policies.	Project oversight, develops rules and regulations for building use.
Legal Matters	Approves legal strategies, studies information, acts on recommendations.	Works with legal counsel, alerts Board to legal problems, makes recommendations.
CMHAM	Serve as Association officers, Executive Board members and delegates; participates in committees, educational trainings, conferences and other activities.	Serve as Association officers, Executive Board members and delegates, participates on committees, educational trainings, conferences and other activities.
Meetings	Convene and preside.	Serves as a resource.
Negotiations	Provides guidelines, ratifies and signs contracts.	Negotiates specific language of contracts within guidelines of the Board.
Personnel	Approves or rejects personnel policies, hires and evaluates Director.	Hires/fires staff, evaluates, promotes, directs and oversees staff development programs.
Policy	Adopts and re-evaluation as necessary.	Implements and suggests.
Program Planning and Evaluation	Establish policy, reviews data, accepts input from advocacy and consumer groups, study outcomes and other data provided by Director and staff.	Establish a system for evaluation of programs and staff, monitors and draws conclusions from evidence; shares information.
Programs/Services	Approves, monitors and becomes educated on specific services.	Maintains compliance with state regulations, recommends, oversees staff's efforts through internal chain of command, ensure accountability, monitor outcomes.
Public Relations	Serve as liaison from the county to the community. Creates/maintains a positive image for the Board and its programs.	Serve as liaison from the Board to other community organizations and agencies and create a positive image for the board; directs communication.
Transportation	Adopts policy; re-evaluate its effectiveness as necessary.	Implement policy, write rules and regulations, makes recommendations, collects data/information.

*The above is an overview of the roles and responsibilities. Individual roles and responsibilities may be modified locally.

Principles

1. Person-First Language

Words are powerful. Old, inaccurate labels, used inappropriately, serve to perpetuate negative stereotypes. Person-first language is a way of referring to people with disabilities respectfully. When referring to someone with a disability, the person is put first, not their disability. For example, it's preferable to say, "Person with mental illness," rather than "the mentally ill." This emphasizes that they are people first and anything else is secondary. Further, the use of "having" rather than "being" is a very important concept. For example, it's best to refer to a person as having schizophrenia rather than being a schizophrenic. The order of words implies what is more important, the person rather than their disability. Person-first language is crucial when discussing persons with disabilities.

2. Person-Centered Planning

Person-Centered Planning (PCP) is a planning process required by the public mental health system that respects and promotes an individual's strengths and abilities to make choices that affect their life. Person-Centered Planning listens to people, and invited family members and friends, about important things in the person's life such as where they want to live, work, and spend leisure time, and their hopes and dreams for the future. This process respects a person's right to have a say about how the public mental health system will provide the services they need. Mental health consumers can decide if they want their Person-Centered Plan facilitated by a mental health employee, such as a supports coordinator or case manager, or by a qualified independent facilitator. An independent facilitator is someone who does not work in the mental health system but has been trained to facilitate Person-Centered Plans.

Person-Centered Planning has been required by law since 1996. It's as easy as listening to people, or their families, about things like where the individual would like to live and spend time during the day, who they would like to spend time with, and their hopes and dreams for the future.

3. Self-Determination

Self-determination is a process that supports people with mental illness (MI), substance use disorders (SUD), or developmental/intellectual disabilities (DD/ID) having control of their lives. It refers to a person having the basic human right to freedom, authority, support, responsibility, and confirmation over the public mental health services provided to them to achieve their goals.

The 5 Principles of Self-Determination Are:

Freedom: The ability for individuals, with family, friends, and legal representatives (as applicable), to assist to plan a life with necessary supports.

Authority: The ability for a person with a mental illness, substance use disorders, developmental/intellectual disabilities (MI/SUD/DD/ID) to control a certain sum of dollars in order to purchase these supports, with the backing of a social network of friends.

Support: The arranging of resources and personnel to assist a person with a disability MI/SUD/DD/ID to live a life in the community at the highest and safest level they are able to obtain, rich in community associations and contributions.

Responsibility: The acceptance of a valued role in a person's community through empowerment, affiliations, spiritual development, and general caring for others, as well as accountability for spending public dollars in ways that are life-enhancing.

Confirmation: Individuals with MI/SUD/DD/ID have the opportunity to be involved in the redesign of the public mental health system. The public mental health system will provide arrangements that ensure methods for persons with MI/SUD/DD/ID to control how, by whom, and to what end they are supported.

4. Recovery

While research shows that people can and do fully recover, even from the most severe forms of mental illness and substance abuse disorders, it is important to understand there is no single definition of recovery. Within the mental health community there is consensus that recovery is a process and not an event or destination; it does not mean being "cured". Individuals with developmental/intellectual disabilities do not recover.

The President's New Freedom Commission on Mental Health's Achieving the Promise report (2003) described recovery as: "The process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms." The New Freedom Commission Subcommittee on Consumer Issues Report expressed, "Most fundamentally, recovery means having hope for the future, living a self-determined life, maintaining self-esteem, and achieving meaningful roles in society. Most consumers report they want the same things other people want: a sense of belonging, an adequate income, a way to get around, and a decent place to live. They aspire to build an acceptable identity for themselves and in the community at large. These are the essential ingredients of recovery from mental illness".

The developmental disability system does not typically refer to recovery as a goal for individuals. In general, state-of-the-art mental health systems provide services and supports to individuals so that they can recover from their illnesses, while developmental disability systems focus on providing services and supports to live as independently as possible despite the continued existence of their disabilities (National Association of State Mental Health Program Directors, October 2004).

Transformed mental health systems acknowledge that (1) recovery in the community generally is possible only with a broad range of appropriate supports such as housing, employment, and income support; and (2) some kind of continuing care usually is necessary to ensure successful recovery. These are essentially the same principles that characterize the concepts of independent living and self-determination for developmental disabilities service systems.

Thus, although individuals do not “recover” from a developmental disability, the kinds of services and supports needed to facilitate meaningful community living are the same for both individuals with mental illnesses, substance use disorders and those with developmental/intellectual disabilities. Common principles include choice, hope, individual dignity and respect, accessibility, engagement, person centeredness, individual planning, meaningful roles, and elimination of stigma/discrimination.

The 10 Fundamental Components of Recovery:

Self-Direction: Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual who defines his or her own life goals and designs a unique path towards those goals.

Individualized and Person-Centered: There are multiple pathways to recovery based on an individual’s unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey as well as an overall paradigm for optimal wellness.

Empowerment: Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.

Holistic: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health, and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.

Non-Linear: Recovery is not a step-by step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.

Strengths-Based: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, and employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.

Peer Support: Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.

Respect: Community, systems, and societal acceptance and appreciation of consumers —including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

Responsibility: Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.

Hope: Recovery provides the essential and motivating message of a better future— that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process.

Stigma: Stigma refers to the negative attitudes and beliefs that individuals have that motivate them to fear, reject, avoid, and discriminate against individuals living with a MI/SUD/DD/ID. Stigma is not just a matter of using the wrong words or actions. Stigma is an attitude -- a strong barrier that discourages people and their families from seeking help. Stigma can lead to fear, mistrust, and violence against people living with MI/SUD/DD/ID and their families. To counter stigma, learn the facts and always treat people with disabilities with dignity and respect. Avoid negative labels and don't discriminate against people with disabilities when it comes to housing, employment or education. Finally, teach children about disabilities and help them to understand that having a MI/SUD/DD/ID is like having any other health condition.

Stigma can be overcome by practicing these easy steps:

- Use respectful language
- Speak in person-first language by saying "person with schizophrenia or autism"
- Emphasize abilities, not limitations
- Tell someone if they express a stigmatizing attitude
- Provide opportunities for participation and inclusion when you can.

5. Mental Health Parity

Significant insurance discrimination exists against people with MI/SUD/DD/ID. The U.S. Bureau of Labor Statistics has reported that 96% of insurance plans impose some kind of limits or managed care controls on mental health care that they do not place on physical health care. In 2010, a new federal law took effect to require parity in health insurance plans offered by employers with 51 or more employees. To combat the discrimination against mental health care that exists with regard to available benefits, co-pays and deductibles, and annual and lifetime dollar limits for all Michigan citizens, we must also pass a state parity law. Experience from 43 other states that have statutes to ban such discrimination tells us that it is not only the right thing to do for people's health, but cost effective for employers by reducing absenteeism, increasing productivity, and decreasing associated physical health care and disability costs.

6. Evidence Based Practice

An Evidence Based Practice refers to the use of the current best knowledge in providing services for MI/SUD/DD/ID. These services have been strongly researched and are shown to make a positive difference in the lives of individuals with MI/SUD/DD/ID and their families. The federal government Substance Abuse and Mental Health Services Administration has identified several Evidence Based Practices for mental health agencies to offer. Current Evidence Based Practices include Assertive Community Treatment, Family Psycho-Education, Dialectical Behavior Therapy, and Integrated Dual Disorders Treatment, just to name a few.

7. Gentle Teaching

The concept of Gentle Teaching is based on several basic foundations. First and foremost is the belief that all persons have a deep desire to be loved and cared for in a compassionate manner. If a person is engaged with in a loving manner, it is likely he or she will respond in kind. Aside from the desire to be loved, persons typically seek to feel safe and will gravitate toward individuals and environments which foster a sense of safety. Finally, the clear goal of Gentle Teaching is to promote the assumption that all persons are equal, and that we all thrive within an environment which supports unconditional positive regard, is devoid of verbal and physical disrespect, and is genuinely person-centered.

8. Recipient Rights

Every person who receives public mental health services has certain rights. The Michigan Mental Health Code protects those rights. Some of those rights include:

- Receive services that meet your needs and receive those services in a safe, sanitary and humane environment.
- Know the benefits and consequences of the services being offered.
- Be treated with dignity and respect when receiving services.
- Be free from abuse or neglect.
- Have your information kept confidential.

9. Cultural Competency

Cultural competence is the ability to relate effectively to individuals from various groups and backgrounds. Culturally competent services respond to the unique needs of members of minority populations and are also sensitive to the ways in which people with disabilities experience the world. Within the behavioral health system (which addresses both mental illnesses and substance abuse), cultural competence must be a guiding principle, so that services are culturally sensitive and provide culturally appropriate prevention, outreach, assessment, and intervention.

Cultural competence recognizes the broad scope of the dimensions that influence an individual's personal identity. Mental health professionals and service providers should be familiar with how these areas interact within, between and among individuals. These dimensions include:

- race
- ethnicity
- language
- sexual orientation
- education
- age
- disability
- class/socioeconomic status
- gender
- religious/spiritual orientation

1. Definitions/Terms

- **Adult Benefit Waiver (ABW)** – This is considered a Medicaid program, with state and federal funding, designed for childless adults with income between 100 - 200% of poverty. There are periodic open enrollment periods, managed by the state, to cap and control state matching obligations.
- **Audit** – A formal or official examination of an organization's records. Compliance audits are reviews of contractual obligations. Fiscal audits are a review of accounting/financial records.
- **Capitation** – A funding method that provides a set amount of funding per a prescribed time period (often monthly) for all persons eligible to utilize the services supported by the funding.
- **Expenditures** – Payments made by an organization. Money spent.
- **Fiscal Year** – The reporting period for an organization's budget planning and reporting purposes. The fiscal year of the state is October 1st to September 30th.
- **Internal Service Fund (ISF)** – The ISF is risk reserve account of unspent Medicaid funds that can be set aside for unanticipated future expenditures. It is limited to 7.5% of a PIHP's Medicaid funding.
- **Medicaid** – Medicaid was established in 1965 as a joint federal/state program. It provides medical care for individuals and families with low incomes and resources, or with a significant disability. The States share costs with the federal government; Federal Matching Rate (FMAP) ranges from 50% to 77%.
- **Mental Health Block Grant** – Federal funding for adults with psychiatric disorders and children with serious emotional disturbances (not for developmental disabilities services). Block grant funds are allocated through an annual application process – Department of Community Health establishes categories and process for application each year. Funds are time limited for 1, 2, or 3 years.
- **MI Child** - Insurance for children of low-income families between 150 - 200% of poverty. The state provides capitated payment per month for all MI Child beneficiaries
- **Preadmission Screening and Resident Review (PASARR)** – CMHSPs screen all persons entering a nursing home and assess those with previous mental health history and/or diagnosis. Costs for providing these screenings and reviews are billed to the state.
- **Prepaid Inpatient Health Plans (PIHPs)** – A term from federal regulations that describes entities able to receive and manage Medicaid funds. Currently, there are 18 PIHPs; 8 are individual CMHSPs, 10 are affiliations with from 2 - 5 CMHSPs. The largest CMHSP in an affiliation (in terms of Medicaid beneficiaries) is designated the hub; the other affiliation members are designated as spokes. This structure will change January 1, 2014.
- **Revenues** – Income into an organization. Money received.

2. Revenue Sources –
Types

Presently under state law there are two forms of CMHSPs: 1) county department and 2) separate authority. You should address the Mental Health Code for specific details pertaining to your agency.

Federal Funds: These are funds from the federal government. Some require state match (the state provides a portion of the funding based on a matching formula calculated on a state by state basis). Examples include:

- Medicaid – Capitated funding based on number of enrolled eligibles.
- Medicaid Fee for Service (Children's Waiver and Serious Emotional Disturbance (SED) Waiver) – Reimbursed for service encounters up to approved fee limits.
- Adult Benefit Waiver (ABW) – Capitated funding based on number of enrolled eligibles.
- MI Child – Capitated funding for low income children not qualifying for Medicaid, based on number of enrolled eligibles.
- Block grants - both Mental Health and Substance Abuse (SA).

State Funds include:

- General Fund/General Purpose (GF/GP) – State funding allocated for community-based services.
- PASARR /OBRA - (Pre Admission Screening and Annual Resident Review - Omnibus Reconciliation Act) – These are fee for service payments made for screening and assessment services for persons with mental illnesses and developmental disabilities in nursing homes.

Local Funds: Funding that is considered local and that can be included as sources of local match include:

- County appropriations – Funding appropriated annually from counties
- 1st party revenue – 1st party payments are from individuals receiving services (usually some portion of total cost of service). The amount individuals pay is based on a state-determined sliding fee scale.
- 3rd party revenue - private insurance payments.
- Interest income.

Other Sources:

- Earned contracts – These are funds received for providing specific services. These can include contracts with local partners, such as courts, school districts, substance use disorder funders, and service contracts with other CMHSPs.

The following is the total statewide amount of Medicaid, MI Child, Adult Benefit Waiver, and General Fund revenue, based on FY11 authorizations from the Michigan Department of Community Health to the CMHSP Boards:

Source	Amount	Percentage
Medicaid	$ 2,176,558,647	83 %
MI Child	$ 2,852,843	(.1%)
Adult Benefit Waiver	$ 66,917,885	3 %
General Fund	$ 366,165,015*	14 %
TOTAL	$ 2,612,494,390	100 %

* Includes $ 66,628,176 of general fund revenue for state facility residents.

How They Can be Spent

The following chart outlines the type of revenue that can be spent on individuals receiving services.

Funding Source	**Persons with Medicaid**	**Persons without Medicaid**	**Special Populations Enrollees (ABW,MI Child, SED Waiver)**
Medicaid	Yes	No	No
General Fund	Yes	Yes	Yes
Local Funds	Yes	Yes	Yes
Special Populations Funding – ABW, MI Child, Children and SED Waivers	No	No	Yes

3. Expenditure Types

The state reports expenditures by population groups, including children with serious emotional disturbances, adults with psychiatric disorders, and persons with developmental disabilities, as well as administrative costs. Costs are also reported by service encounters or types.

The following are statewide summaries (FY10) of those costs:
Expenditures by subpopulation groups:

Group	Amount	Percentage
Adults with psychiatric disorders	$ 820,354,622	40.0%
Children with SED	$ 168,821,571	8.3%
Persons with DD	$ 1,057,620,567	51.7%

Expenditures by service type:

Type	Amount	Percentage
State Inpatient	$ 71,705,499	3.3%
Community Inpatient/Crisis	$ 157,702,026	7.2%
Outpatient	$ 248,168,079	11.3%
Other Services	$ 1,569,222,416	71.6%
Administration	$ 143,585,412	6.6%

4. Contracting Process

The state contracts annually with PIHPs, CMHSPs, and Coordinating Agencies (CAs). There are three separate contracts for each of these entities. These contracts include the various obligations, requirements, and services the state expects in return for the funding that is provided.

If a CMHSP serves as each one of these entities, the Board will review and approve three separate contracts for providing these services.

Some PIHPs are formed as affiliations with a hub CMHSP (typically the largest CMHSP in terms of Medicaid beneficiaries) with one or more spoke CMHSPs. In these circumstances, the spoke CMHSPs contract with the hub CMHSP for the Medicaid services and funding.

Each CMHSP contracts with the state for receipt and utilization of its general fund allocation.

5. Financial Reporting Requirements

The financial reporting requirements are described in the annual contract(s) signed by the CMHSPs and PIHPs. These reporting requirements are modified periodically, usually based on changes negotiated through an annual contract negotiations process coordinated through CMHAM.

The financial reports submitted to the state are reviewed and approved by the CMHSP board.

6. Budgeting Process – Appropriations Process

The state typically begins its budgeting process in the first quarter of the preceding fiscal year (October 1st – December 31st). State department heads are given one or more budget targets by the executive branch (the Governor and her/his administrative staff). The state department which manages the CMHSP and CA funds is the Michigan Department of Community Health.

Based on the information from the departments and the Governor's budget priorities, a proposed budget for the next fiscal year is presented in the second quarter (January 1st to March 30th) to the Legislature (House and Senate). Legislative hearings are conducted through the committee and subcommittee process during the second and third (April 1st to June 30th) quarters.

Each of the legislative chambers (House and Senate) reviews, modifies, and passes a budget for each of the departments. These budgets are usually different. Conference committees are then formed so that they can reconcile these differences and both chambers can approve a single budget for each department.

These approved budgets are then forwarded to the Governor for her/his signature. The budget for the new fiscal year (beginning October 1st) must be approved by the end of the previous fiscal year (September 30th).

At the CMHSP level, the Mental Health Code, in Section 226, outlines the budget-related requirements for the Board. These include:

- Conducting an annual needs assessment process, and reporting that assessment and plan to the state based on a reporting format identified by the state.
- In the case of a CMHSP that is not an authority, obtaining approval of that assessment and report from the county(s) board of commissioners. CMHSP authorities submit a copy of the assessment and report to the county(s) board of commissioners.
- Provide and advertise a public hearing on the assessment and plan.
- Submit an annual request for county matching funds to the county(s) board of commissioners.
- Approve the annual CMHSP budget.
- Approve and authorize all contracts for provision of services.

7. Audit Requirements

The state requires that each CMHSP have an annual independent audit of its fiscal records. The annual audit must be reviewed by the Board. Following review, the CMHSP is required to submit the audit to the state.

1. CMHAM Organization and Governance Structure

What is CMHAM?

The Community Mental Health Association of Michigan (CMHAM) is a trade association of 46 CMHSP Boards and 74 affiliate members, who are mostly provider organizations under contract with one or more of the CMHSPs. It is organized under the Internal Revenue Code as a 501 (c)(4) - civic leagues or organizations not organized for profit but operated exclusively for the promotion of social welfare.

What does CMHAM do?

CMHAM provides:

- Legislative and public policy advocacy on behalf of its membership
- Ongoing conferences and trainings to provide education and training services to its members
- Access to products and services at discounted rates:
    - E learning
    - Publications (booklets, pamphlets)
    - Services (teleconference consultation; SUD-related testing and consultation)
- Organization and support of annual CMHSP and PIHP contract negotiations with Behavioral Health and Developmental Disabilities Administration (BHDDA).
- Regular access to members to leadership from BHDDA.
- Organization of standing and ad hoc workgroups membership to work with BHDDA

How is CMHAM Governed?

CMHAM is governed by its Executive Board (total of 37 members), which is made up of the following:

- Two board members and one director appointee from each of CMHAM's six regions (total of 18). These appointees are selected through the regional meetings held at the spring conference.
- The board member and director co chairs of each of CMHAM's five (5) standing committees (total of 10). These co chairs are appointed annually by the CMHAM president.
- The officers of CMHAM, include the President; 1st Vice President; 2nd Vice President, Treasurer, Secretary and Past President (total of 6). With the exception of the Past President, each of these officers are elected annually at the spring conference. No more than 2 officers may come from any one region. The President and 1st Vice President officers must be board members. The other elected officers may be either board members or directors.

- The Association changed its By-Laws in 2011 to provide four (4) members from its provider affiliate membership with full voting rights at Member Assembly, Executive Board, and Standing Committee meetings. These designated provider representatives are nominated by CMHAM's Provider Alliance and approved by the Executive Board.

What is CMHAM's Regional Structure?

CMHAM is made up of six regions that cover the entire state. The regions include the:

- Central (9 Boards)
- Metro (3 Boards)
- Northern (5 Boards)
- Southeast (8 Boards)
- Upper Peninsula (5 Boards)
- Western (16 Boards)

What are CMHAM's Standing Committees and How do They Operate?

CMHAM has organized five standing committees that meet every other month to discuss statewide issues. These committee discussions help inform board members and directors, and help the Association develop advocacy planning or positions to take on behalf of all members. The five standing committees and their current meeting schedules include:

- *Children's Issues,* which focuses on mental health issues related to children's services – Every other month, 3rd Tuesday at 1:00 p.m.
- *Contract and Financial Issues,* which focuses on CMHSP and PIHP contracts with DCH – Every other month, 3rd Thursday at 1:00 p.m.
- *Legislation*, which reviews bills and legislation effecting mental health and substance abuse issues – Every other month, 3rd Wednesday at 9:30 a.m.
- *Member Services,* which develops and arranges for delivery of services to members – Every other month, 3rd Thursday at 9:30 a.m.
- *Policy Committee*, which reviews policies issued by Department of Community Health effecting services – Every other month, 3rd Wednesday at 1:30p.m.

Each of these committees have co chairs (one board member, one director), which are appointed by the President each year. Committee co chairs are limited to six (6) consecutive terms as a co chair.

2. CMHAM & MDCH History

Introduction:

While the history of community mental health in Michigan and the Community Mental Health Association of Michigan (CMHAM) began during the 1960's, the early roots of community care in the United States date back to colonial New England.

In 1773 the first hospital for persons with mental illnesses was established in Williamsburg, Virginia. Advocates for appropriate care and treatment were pioneers such as Dr. Benjamin Rush, the father of American psychiatry in the late 1770s, Dorothea Dix, who crusaded for the establishment of more mental hospitals in the mid 1880s, and Clifford Beers, a consumer of mental health services, who brought the "mental hygiene" movement into being in 1900 when he shocked readers with a graphic account of hospital conditions in his famous book, "The Mind That Found Itself."

Throughout the history of the United States, we have grown in our understanding of the high incidence of mental illnesses, substance use disorders, and developmental disabilities among our population as well as the tremendous human and economic cost of these illnesses and disabilities.

In Michigan:

In September of 1959, the Michigan Society for Mental Health established a study committee to review the efforts of other states which had established community mental health programs. In May of 1961, the Michigan Senate established a special committee to study community mental health services. Based on the recommendation of the Senate special committee and with the support of the Mental Health Society, identical bills were introduced in both the House and Senate in February of 1963 to establish a community mental health services act in Michigan.

On April 29, 1963, Governor George Romney signed into law Act 54 of the Public Acts of 1963 - Michigan's Community Mental Health Services Act. Sections 190-192 of the Act describe its scope and purpose:

"Increasing numbers of persons afflicted with psychiatric disorders require care and treatment in mental institutions. The human suffering and social and economic losses caused by these costly infirmities are a matter of grave concern to the people of the state. This act is designed to encourage the development of preventative, rehabilitative and treatment services through new community mental health programs and the improvement and expansion of existing community services."

The Michigan Mental Health Society and the Department of Mental Health convened the first meeting of the county CMH boards in September of 1964. Issues to be reviewed were administrative rules to implement Act 54, relationships between Act 54 boards and the Department of Mental Health, relationships between CMH boards and their county boards of commissioners, and problems and questions relating to financing of CMH services.

By the end of 1964, the following counties had established community mental health programs under Act 54: Bay, Calhoun, Copper Country, Detroit-Wayne, Dickinson-Iron, Genesee, Ingham, Monroe, Muskegon, Oakland, Shiawassee, and Washtenaw. Counties having established formal committees to study their participation in PA 54 were Berrien, Ionia, Kalamazoo, Macomb, Midland, Montcalm, and Kent.

The Mental Health Society established an ongoing committee on community mental health services which convened periodic meetings of CMH board members.

The Association is Formed:

Throughout 1967, interest grew among the Act 54 boards to establish their own association. An organizational meeting took place on May 25, 1967, at the Capitol Park Hotel in Lansing. A call for membership was issued and on October 20, 1967, representatives of Act 54 boards agreed to the organization of the "Michigan State Association of Community Mental Health Services Boards" and adopted a constitution and By-Laws. Each member board was asked to appoint two delegates to the Association. Officers elected were:

Harold Brigham (Kent) President
Leon Schneider (Midland) Vice President
George Kallos (Shiawassee) Secretary
William Wagner (Oakland) Treasurer

The first Act 54 boards to join the Association were Bay, Berrien, Copper Country, Ingham, Kalamazoo, Kent, Livingston, Macomb, Midland, Monroe, Muskegon, Oakland, Saginaw and Shiawassee. By June of 1968, and with the addition of the Alger/Marquette, Calhoun/Branch, Detroit-Wayne, Genesee, Montcalm, St. Clair, and Washtenaw boards, twenty-one of thirty-two Act 54 boards were members in good standing of the new Association. Eventually, all 83 Michigan counties established CMH Services Programs. The number of boards has varied over the years with the largest number being 55. Currently there are 46. The Association achieved 100% membership for the first time during 1985. Membership has been at or near 100% for most subsequent fiscal years.

The first annual meeting of the Michigan State Association of Community Mental Health Services Boards was held on October 10, 1968, in Northland. The Association identified the areas of financial planning, budget building, contractual relationships, program development, program evaluation, community relations, personnel practices and recruiting and staff training as topics to discuss at the first annual meeting. In early 1969, Association President Harold Brigham wrote:

> "Greetings to our directors, board chairmen, and others interested in community mental health. Of overriding interest at this point, is the consideration by the legislature of the budget requests for mental health. The amount in the Governor's recommendation for PA 54 was $14.1 million, an increase of $3.1 million from 68-69. This amount would allow for only the most modest increase over the expenditure of this fiscal year because of increased personnel costs and because many of this year's

programs were funded for less than a full year. Because of the total budget picture, however, there is some indication that this amount of $14.1 million will be reduced in order to add to other items in the budget of the Department of Mental Health. The department has not indicated yet that they would oppose this. Support for the PA 54 funds will apparently have to come from other sources, such as your Association and the Michigan Society for Mental Health."

During 1972, the name of the association was changed to its present form, the Community Mental Health Association of Michigan.

A New Legal Mandate:

Public Act 54 was replaced with the enactment of the Mental Health Code, Act 258 of the Public Acts of 1974. This act was signed into law by Governor William Milliken and became effective on August 6, 1975. Its scope and purpose was described as:

> *"An act to codify, revise, consolidate, and classify the laws relating to mental health; to prescribe the powers and duties of certain state and local agencies and officials and certain private agencies and individuals; to regulate certain agencies and facilities providing mental health services; to provide for certain charges and fees; to establish civil admission procedures for individuals with mental illness or developmental disability; to establish procedures regarding individuals with mental illness or developmental disability who are in the criminal justice system; to provide for penalties and remedies; and to repeal acts and parts of acts."*

In 1979, Governor William Milliken appointed a committee to study and make recommendations on how to better coordinate and integrate state operated and CMH services. The Committee on Unification of the Public Mental Health System issued its report in January of 1980. The report, entitled "Into the 80's," described the principles and features of a model mental health system and included 80 recommendations for change. The report recommended a single point of responsibility for entry into and exit from the public mental health system. It further recommended that local mental health authorities made up of one or more counties be established to act as that single point of responsibility and to manage and deliver services. The report recommended that there be a sharing in system governance between the Department of Mental Health and the local community mental health authorities, that shared responsibility be extended, via a contract, to the operation of state psychiatric facilities and centers for developmental disabilities, and that increased control over direct services personnel and fiscal resources be recommended for CMH boards.

Representing the community mental health system on the Governor's unification committee were Ann White (Berrien), Chairperson of the Subcommittee on Administration and Finance, James Haveman (Kent), William McShane (St. Clair), Thomas Presnell (Detroit-Wayne), and Roger VanderSchie (North Central).

Directors and Board Associations Merge:

An association of community mental health directors was formed during the mid 1970's. Presidents of that association included Mel Ravitz (Detroit-Wayne; 1974-76), Thomas Ennis (Clinton-Eaton-Ingham; 1977-79), Saul Cooper (Washtenaw; 1980), William McShane (St. Clair; 1981), and James Haveman Jr. (Kent; 1982-85).

During 1979, both the associations of CMH Boards and Directors agreed to appoint a "Joint Action Committee" to explore matters of common interest. Co-chairpersons of the committee were Ralph Collins (Allegan) representing board members and Thomas Ennis (Clinton-Eaton-Ingham) representing directors.

In October of 1982, both associations agreed to undertake a study to consider the feasibility of consolidating the two groups. The committee was co-chaired by Harriet Kenworthy (Genesee) representing board members and Larry Grinwis (Ottawa) representing directors. The committee produced a report in April of 1983 which described the assets and liabilities of consolidation, proposed a process for further study and drafted a set of By-Laws for review and comment. In June of 1983 both associations debated the proposal to merge and in October both approved the consolidation plan.

This new organization was established for a two-year trial period. The first meeting took place on January 13, 1984. The membership of both organizations was again convened on October 4, 1985, and at that time approved the continuation of the consolidated organization on a permanent basis. The permanently consolidated organization held its first general membership meeting on January 27, 1986.

The Association hired its first full time executive director, David LaLumia, in July of 1985. In 1988 the Association purchased the former headquarters of the Michigan Association of Counties at 319 West Lenawee in downtown Lansing. This strategic location was ideal in supporting the mission of the Association and its interaction with the Executive and Legislative branches, the Department of Community Health, the infrastructure of state government and other stakeholder organizations interested in mental health and human services.

Unfortunately, this building was destroyed by fire on April 8, 1998. The Association purchased a building at 426 S. Walnut in downtown Lansing – an equally strategic location – in November of 1998. CMHAM staff moved into the new headquarters in April of 1999. This building contains meeting and conference space which supports the Association’s interest in training and technical assistance.

David LaLumia left as the Association’s executive director in 2008. In 2009, Michael Vizena was hired as the executive director.

Mental Health Code Mandates Transfer of Responsibility to CMH:

Encouraged by the Unification Report and recommendations, new ways were sought to accelerate the transfer of responsibility for direct delivery of mental health services from the state to county CMH boards as mandated by Section 116 of the Mental Health Code. In 1980, the Alger-Marquette, Kent, St. Clair and Washtenaw boards were selected to pilot a new method of contracting with the Department of Mental Health. This became known as “full management” contracting and provided flexibility within a CMH board’s budget to purchase inpatient care or develop community-based alternative services. After a successful pilot experience, the opportunity to enter into full management contracts was available to the entire system. Eventually all CMH boards sought and achieved full management status.

Through the flexibility of full management contracting, a major expansion of community-based alternative services began throughout Michigan. Full management became a model for changing the mix of institutional and community-based care which received national recognition and has since been replicated in other states. As a result, Michigan became a leader in assertive community treatment, psychosocial rehabilitation and other services and supports which provide clinically appropriate community-based services and supports which are alternatives to hospitalization. Throughout the 1990s, more assertive community treatment teams were initiated in Michigan than in any other state.

Medicaid became the major source of funding for mental health services during the 1980s as Michigan added clinic, home and community-based, children’s model II, habilitation, and rehabilitation coverages to its Medicaid state plan.

The growth of community-based alternative services made possible by full management contracting and new sources of Medicaid revenue have resulted in the major expansion of community based services and the significant decline in census at state operated psychiatric hospitals which have occurred throughout the 80's and 90's. Since 1965, thirty six (36) hospitals serving adults with mental illnesses, centers serving persons with developmental disabilities and programs serving emotionally disturbed children have been closed by the State of Michigan. CMH boards have become the primary providers of long term care for persons with severe and persistent mental illness and developmental disabilities.

The growth of the CMH system may best be illustrated by the increase in the amount of state funds appropriated annually for CMH services.

1970	--	$ 13.1 million
1980	--	$ 104.2 million
1990	--	$ 626.7 million
2000	--	$ 1,053 million ($1.053 billion)
2010	--	$ 2,190 million ($2.190 billion)

Managed Care:

Noting the move to managed care by private sector health care during most of the 1980s, the Association convened a committee to explore the impact of managed care on the delivery of public mental health services and began to negotiate with the Department of Mental Health and the Medical Services Administration regarding an expanded role for CMH boards in managing Medicaid mental health and substance abuse services.

In August of 1995, CMH boards began serving as gatekeeper for psychiatric admissions of persons enrolled in Medicaid and not members of qualified health plans. On June 18, 1996, the Michigan Department of Community Health (DCH) announced that it intended to "carve out" specialty services and supports for persons with mental illnesses, substance use disorders and developmental disabilities. DCH submitted a request to the Health Care Financing Administration (HCFA), now known as the Centers for Medicare and Medicaid Services (CMS), requesting the carve out with CMHSPs responsible for service coordination and system management. The plan would replace the fee for service payment system with a capitated risk-based funding mechanism.

The waiver was granted and CMHSPs became managers of the specialty services benefit with the plan taking effect on October 1, 1998. The waiver approval from HCFA stipulated that the state had to submit a plan for competitive procurement of management of those services. As a result, in September of 1999, DCH announced its plans to competitively bid out management of the Medicaid specialty services benefit. After a series of public hearings, input from stakeholders, and the impact of a procurement plan put forth by State Senators Bev Hammerstrom and Shirley Johnson, the DCH document submitted to CMS in October of 2000 requested a continuation of management by CMHSPs who met revised qualification and performance requirements. The waiver renewal request included a rigorous application process, and requirements that prospective CMH applicants have a geographic area with a minimum of 20,000 covered lives.

To accommodate these requirements, 38 CMH programs organized themselves into 10 regional affiliations, each with a "hub" CMHSP board that would do the contracting for Medicaid financed services with the state and in turn contract with the "spoke" CMHSPs within their region. In addition to these 10 affiliations, there are 8 single CMHSPs which met the minimum covered life requirement. Applications were reviewed by the Department of Community Health and submitted to a specialty services panel appointed by the Governor. All 18 applicant prepaid health plans were approved by the panel.

The revised waiver program began on October 1, 2002. In September of 2003, the Department of Community Health submitted a request for another renewal of the CMS waiver which authorizes Michigan's specialty services program. DCH continued to submit waiver renewal requests with CMS as required, and has maintained the essential "carve out" model for specialty services.

Mental Health Code Revised:

With a changing health care environment, a community mental health system taking more responsibility for management of public mental health services and Medicaid services, and new approaches to clinical and administrative practice, it became apparent that changes to the Mental Health Code were needed. While there had been amendments from time to time, no comprehensive rewrite of the Mental Health Code had taken place since it was enacted in 1974. In January of 1993, the Association and the Department of Community Health began meeting to discuss a Mental Health Code rewrite. After a lengthy period of comment and input from a broad spectrum of stakeholders including consumers and family members, identical bills were introduced in the House and Senate on May 10, 1995. The legislation was extensively discussed and debated. Work groups representing a wide range of mental health stakeholders met throughout the summer of 1995.

The bill passed the Senate on October 11, 1995. During House consideration of the bill, more than 400 amendments to the legislation were considered with 113 amendments offered on the floor of the House of Representatives. After a day long debate which ended shortly before midnight, the House of Representatives adopted the bill by a vote of 70-31 on December 5, 1995. The Senate concured with the House amendments by a vote of 30-4. The bill was signed into law by Governor Engler on January 9, 1996 and became Act 290 of the Public Acts of 1995.

This landmark legislation created an option for counties and community mental health boards to create a mental health authority, empowered consumers and family members by mandating their representation on CMH boards, strengthened recipient rights protections, allowed CMH boards to carry forward up to 5% of their state allocation, and improved accountability by requiring that CMH boards be certified. Perhaps most significantly, the act created the requirement that person-centered planning processes be utilized to ensure choice and consumer direction of his/her plan of service. The provisions of this historic legislation became effective on March 28, 1996.

Mental Health Commission:

On December 15, 2003 Governor Jennifer M. Granholm appointed the Mental Health Commission and charged it with the task of recommending sweeping changes in the delivery and effectiveness of Michigan’s public mental health system.

The Final Report of the Mental Health Commission summarized current problems with mental health care in Michigan: stigma and misunderstanding; barriers to access in both the public and private sectors; a paucity of prevention and early intervention programs; gaps in the service array and capacity constraints; insufficient consideration of children and families; slow adoption of best-practices; inadequate collaboration between mental health and law enforcement; system complexity, transaction costs and funding fragmentation; operational variance; inconsistent rights protection; limited cross-system integration and coordination; and lack of opportunities for consumers.

To address these concerns, the Commission Report offered an expansive vision for a transformed mental health system, a vision buttressed by a compelling set of values,

and amplified through seven core goals and seventy-one recommendations. The Commission's findings and proposals spoke to the present situation in the public mental health system, but also transcended the bounds of the public system to advocate change in federal policies, modifications within other state and local agencies, engagement by the private sector, and alterations in societal attitudes and perceptions.

While the Commission prioritized some of its proposals, there was insufficient consensus within the Commission to establish firm precedence among many compelling recommendations. Time constraints also hindered consideration of some prominent items (e.g., state hospitals, etc.), and other matters of operational importance (e.g., growth in the number of patients at state facilities with past forensic involvement, etc.) were similarly overlooked.

Integrated Care:

Following passage of the Affordable Care Act, Michigan began to examine opportunities to reform its healthcare delivery systems. One of the first opportunities pursued was a planning grant in 2011 to make changes in the organization, management, and financing of care for persons with both Medicare and Medicaid eligibility. The Association and its members were very active in providing input and, with other important consumer stakeholders, influencing the direction of the state's planning.

Partnerships:

Federal
The Association has enjoyed a number of beneficial partnerships over the years. Our Association and members have also been active participants and partners in advocacy on the national level through its membership in several national associations, including the National Council for Community Behavioral Healthcare (NCCBH), the National Association of County Behavioral Health and Developmental Disabilities Directors (NACBHDD), and the State Associations of Addiction Services (SAAS).

State
Perhaps the most significant partnership has been with the Michigan Department of Mental Health and its successor organization, the Michigan Department of Community Health. While differences of opinions and recommended approaches have occurred from time to time, the CMH system and DMH/DCH have worked well together over the years to improve administrative and clinical practice and on a variety of other issues and projects. A history of CMHAM would not be complete without recognizing the past directors of DMH/DCH for their service and support of community-based care:

DMH/DCH Directors:

Charles F. Wagg……September 1945 to March 1946
Charles F. Zeller, M.D……..April 1946 to July 1947
Charles F. Wagg……August 1947 to December 1947
R.L. Dixon, M.D…….January 1948 to May 1949
Charles F. Wagg…….June 1949 to June 1964
Robert A. Kimmick M.D…….July 1964 to November 1966
Vernon A. Stehman, M.D. (*Acting Director*)……...December 1966 to June 1967
William W. Anderson, M.D……..July 1967 to June 1970
E. Gordon Yudashkin, M.D……..July 1970 to May 1974
Donald C. Smith, M.D…….June 1974 to February 1978
Vernon A. Stehman, M.D. (*Acting Director*)……March 1978 to July 1979
Frank M. Ochberg, M.D……..August 1979 to August 1981
C. Patrick Babcock……..September 1980 to December 1986
Thomas Watkins……January 1987 to December 1990
James K. Haveman, Jr…….January 1991 to December 2002
Janet Olszewski……January 2003 to 2009
Olga Dazzo……February 2010 to September, 2012
James K. Haveman, Jr.……September, 2012 to present

There has also been an ongoing partnership between the CMH system and members of the Legislature and the state's governors. The history of mental health services in Michigan has been one of bipartisan support. Every legislature since Act 54 of 1963 has recognized and supported the growth, expansion and direction of the public mental health system. Governors George Romney, William Milliken, James Blanchard, John Engler, Jennifer Granholm, and Rick Snyder have also been partners in the development and delivery of mental health services.

It has participated actively with other organizations interested in enhancing mental health services on a state-wide basis, individually and through the statewide Mental Health Coalition. Partners for Parity has been a coalition of over 50 organizations working to provide parity for private insurance coverage of behavioral health services.

State based consumer advocacy organizations such as the Arc, National Association on Mental Illness (NAMI), Association for Children's' Mental Health (ACMH), and the Mental Health Association (MHA) have been active participants with the Association on many advocacy efforts.

Affiliate Members:

In 1997, the CMHAM executive board approved affiliate membership for organizations whose purpose is consistent with that of CMHAM. In 2012, affiliate membership was at seventy four (74) members, adding an important voice and ability and strength to CMHAM in achieving its goals. In 2011, CMHAM amended its By-Laws to provide four (4) designated provider representatives with full voting privileges at CMHAM's Member Assembly, Executive Board, and Standing Committee meetings.

Into the Future:

At the time of this updating of our history, our state and nation are celebrating the 50th Anniversary of the federal community mental health construction act of 1963. The Community Mental Health Association of Michigan – now in its 46th year – continues to strive to accomplish the goals and purposes for which it was established. Those goals are to improve the quality and accessibility of community-based public mental health services, to explore problems of common interest, to provide opportunities for the exchange of ideas, experiences and information, and to promote effective relationships between CMH boards and the Governor, Legislature and voluntary and professional organizations. Most importantly, the organization provides a means through which community mental health services programs may speak collectively on matters affecting Michigan's public mental health system. Our strength continues to be rooted in the commitment and unity of our members.

In his inaugural address in 1960, President John F. Kennedy said, “The torch has been passed to a new generation of Americans.” In this year of our 50th Anniversary, the torch representing the community mental health movement in our country has been passed to all of us. We are its new caretakers. It will be our vision, our commitment, our efforts that take this movement into the future.

It will take the collective will and commitment of consumers, family members, advocates, providers, clinicians, policy makers and citizens of our state and country to continue this progress. Thanks to all those who have contributed so much to Michigan’s public mental health system as well as to the Community Mental Health Association of Michigan.

MENTAL HEALTH CODE

Act 258 of 1974

AN ACT to codify, revise, consolidate, and classify the laws relating to mental health; to prescribe the powers and duties of certain state and local agencies and officials and certain private agencies and individuals; to regulate certain agencies and facilities providing mental health services; to provide for certain charges and fees; to establish civil admission procedures for individuals with mental illness or developmental disability; to establish guardianship procedures for individuals with developmental disability; to establish procedures regarding individuals with mental illness or developmental disability who are in the criminal justice system; to provide for penalties and remedies; and to repeal acts and parts of acts.

History: 1974, Act 258, Eff. Aug. 6, 1975 ;-- Am. 1980, Act 423, Eff. Mar. 31, 1981 ;-- Am. 1990, Act 263, Imd. Eff. Oct. 15, 1990 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996

The People of the State of Michigan enact:

330.1001 Short title.

Sec. 1.

This act shall be known and may be cited as the “mental health code”.

History: 1974, Act 258, Eff. Aug. 6, 1975
Compiler's Notes: For renaming of the department of mental health to the department of community health, see E.R.O. No. 1996-1, compiled at MCL 330.3101 of the Michigan Compiled Laws.

Chapter 2
COUNTY COMMUNITY MENTAL HEALTH PROGRAMS

330.1200 Repealed. 1995, Act 290, Eff. Mar. 28, 1996.

Compiler's Notes: The repealed section pertained to definitions.

330.1200a “Charter county” defined.

Sec. 200a.

As used in this chapter, “charter county” means a home rule county created under Act No. 293 of the Public Acts of 1966, being sections 45.501 to 45.525 of the Michigan Compiled Laws.

History: Add. 1995, Act 290, Eff. Mar. 28, 1996

330.1201 Rules.

Sec. 201.

The department shall promulgate rules which provide for the certification of children's diagnostic and treatment services. The rules shall require at least all of the following:

(a) Children's diagnostic and treatment services shall facilitate hospitalization, if hospitalization is necessary.

(b) Children's diagnostic and treatment services shall facilitate treatment.

(c) Children's diagnostic and treatment services shall be staffed by persons trained or experienced in providing mental health services to minors.

History: Add. 1984, Act 186, Imd. Eff. July 3, 1984
Admin Rule: R 330.1001 et seq. of the Michigan Administrative Code.

330.1202 Community mental health services programs; state support.

Sec. 202.

The state shall financially support, in accordance with chapter 3, community mental health services programs that have been established and that are administered pursuant to the provisions of this chapter.

History: 1974, Act 258, Eff. Aug. 6, 1975 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996

330.1204 Community mental health services program as county community mental health agency, community mental health organization, or community mental health authority; official county agency; procedures and policies.

Sec. 204.

(1) A community mental health services program established under this chapter shall be a county community mental health agency, a community mental health organization, or a community mental health authority. A county community mental health agency is an official county agency. A community mental health organization or a community mental health authority is a public governmental entity separate from the county or counties that establish it.

(2) Procedures and policies for a community mental health organization or a community mental health authority shall be set by the board of the community mental health services program. Procedures and policies for a county community mental health agency shall be set by the board of commissioners or boards of commissioners as prescribed in this subsection. If a county community mental health services agency represents a single county, the county's board of commissioners shall determine the procedures and policies that shall be applicable to the agency. If a county community mental health services agency represents 2 or more counties, the boards of

commissioners of the represented counties shall by agreement determine the procedures and policies that shall be applicable to the agency. In a charter county with an elected county executive, the county executive shall determine the procedures and policies that shall be applicable to the agency.

(3) The procedures and policies for multicounty community mental health services programs shall not take effect until at least 3 public hearings on the proposed procedures and policies have been held.

History: 1974, Act 258, Eff. Aug. 6, 1975 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996

330.1204. Amended community mental health services program as county community mental health agency, community mental health organization, or community mental health authority; official county agency; procedures and policies; establishment or administration of program by county with city having population of at least 500,000.

Sec. 204.

(1) Except as provided in subsection (4), a community mental health services program established under this chapter shall be a county community mental health agency, a community mental health organization, or a community mental health authority. A county community mental health agency is an official county agency. A community mental health organization or a community mental health authority is a public governmental entity separate from the county or counties that establish it.

(2) Procedures and policies for a community mental health organization or a community mental health authority shall be set by the board of the community mental health services program. Procedures and policies for a county community mental health agency shall be set by the board of commissioners or boards of commissioners as prescribed in this subsection. If a county community mental health services agency represents a single county, the county's board of commissioners shall determine the procedures and policies that shall be applicable to the agency. If a county community mental health services agency represents 2 or more counties, the boards of commissioners of the represented counties shall by agreement determine the procedures and policies that shall be applicable to the agency. In a charter county with an elected county executive, the county executive shall determine the procedures and policies that shall be applicable to the agency.

(3) The procedures and policies for multicounty community mental health services programs shall not take effect until at least 3 public hearings on the proposed procedures and policies have been held.

(4) Beginning October 1, 2013, in order to qualify for state support under section 202, if a single county that has situated totally within that county a city having a population of at least 500,000 establishes or administers a community mental health services program, that community mental health services program must be established and administered as a community mental health authority as specified under section 205. Any operational

changes made by the community mental health agency that will require a financial commitment from the community mental health authority established as a result of the provisions of this subsection shall be made in consultation with the department director.

History: 1974, Act 258, Eff. Aug. 6, 1975 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996 ;-- Am. 2012, Act 376, Eff. Mar. 28, 2013

330.1204a Creation of community mental health organization by two or more counties; creation of community mental health organization by one or more counties and institution of higher education; compliance of county.

Sec. 204a.

(1) Two or more counties may organize and operate a community mental health services program by creating a community mental health organization under the urban cooperation act of 1967, 1967 (Ex Sess) PA 7, MCL 124.501 to 124.512.

(2) One or more counties and an institution of higher education in this state that has the authority to grant a baccalaureate degree, has a medical school, has its main facility in a city having a population of at least 100,000 but no more than 500,000, and is located in a county initiating the formation of a community mental health organization under this subsection may organize and operate a community mental health services program by creating a community mental health organization under the urban cooperation act of 1967, 1967 (Ex Sess) PA 7, MCL 124.501 to 124.512.

(3) Subsequent to the formation of a community mental health organization under subsection (2), a county that joins or merges with that community mental health organization shall comply with all of the following:

(a) The manner of employing, compensating, transferring, or discharging necessary personnel is subject to the provisions of the applicable civil service and merit systems and the following restrictions:

(i) An employee of a community mental health organization is a public employee.

(ii) A community mental health organization and its employees are subject to the provisions of 1947 PA 336, MCL 423.201 to 423.217.

(b) At the time a community mental health organization is expanded under this subsection, the employees of the former community mental health services program shall be transferred to the community mental health organization and appointed as employees who shall retain all the rights and benefits for 1 year. An employee of the community mental health organization shall not, by reason of the transfer, be placed in a worse position for a period of 1 year with respect to worker's compensation, pension, seniority, wages, sick leave, vacation, health and welfare insurance, or another benefit that the employee had as an employee of the former community mental health services program. A transferred employee's accrued benefits or credits shall not be diminished by reason of the transfer.

(c) If a former county community mental health services program was the designated employer or participated in the development of a collective bargaining agreement, the community mental health organization assumes and is bound by the existing collective bargaining agreement. The expansion of a community mental health organization does not adversely affect existing rights or obligations contained in the existing collective bargaining agreement. For the purposes of this subsection, “participation in the development of a collective bargaining agreement” means that a representative of the community mental health services program actively participated in bargaining sessions with the employer representative and union or was consulted during the bargaining process.

History: Add. 1995, Act 290, Eff. Mar. 28, 1996 ;-- Am. 2000, Act 130, Imd. Eff. May 31, 2000

330.1204b Regional entity.

Sec. 204b.

(1) A combination of community mental health organizations or authorities may establish a regional entity by adopting bylaws that satisfy the requirements of this section. A community mental health agency may combine with a community mental health organization or authority to establish a regional entity if the board of commissioners of the county or counties represented by the community mental health agency adopts bylaws that satisfy the requirements of this section. All of the following shall be stated in the bylaws establishing the regional entity:

(a) The purpose and power to be exercised by the regional entity to carry out the provisions of this act, including the manner by which the purpose shall be accomplished or the power shall be exercised.

(b) The manner in which a community mental health services program will participate in governing the regional entity, including, but not limited to, all of the following:

(i) Whether a community mental health services program that subsequently participates in the regional entity may participate in governing activities.

(ii) The circumstances under which a participating community mental health services program may withdraw from the regional entity and the notice required for that withdrawal.

(iii) The process for designating the regional entity's officers and the method of selecting the officers. This process shall include appointing a fiscal officer who shall receive, deposit, invest, and disburse the regional entity's funds in the manner authorized by the bylaws or the regional entity's governing body. A fiscal officer may hold another office or other employment with the regional entity or a participating community mental health services program.

(c) The manner in which the regional entity's assets and liabilities shall be allocated to each participating community mental health services program, including, at a minimum, all of the following:

(i) The manner for equitably providing for, obtaining, and allocating revenues derived from a federal or state grant or loan, a gift, bequest, grant, or loan from a private source, or an insurance payment or service fee.

(ii) The method or formula for equitably allocating and financing the regional entity's capital and operating costs, payments to reserve funds authorized by law, and payments of principal and interest on obligations.

(iii) The method for allocating any of the regional entity's other assets.

(iv) The manner in which, after the completion of its purpose as specified in the regional entity's bylaws, any surplus funds shall be returned to the participating community mental health services programs.

(d) The manner in which a participating community mental health services program's special fund account created under section 226a shall be allocated.

(e) A process providing for strict accountability of all funds and the manner in which reports, including an annual independent audit of all the regional entity's receipts and disbursements, shall be prepared and presented.

(f) The manner in which the regional entity shall enter into contracts including a contract involving the acquisition, ownership, custody, operation, maintenance, lease, or sale of real or personal property and the disposition, division, or distribution of property acquired through the execution of the contract.

(g) The manner for adjudicating a dispute or disagreement among participating community mental health services programs.

(h) The effect of a participating community mental health service program's failure to pay its designated share of the regional entity's costs and expenses, and the rights of the other participating community mental health services programs as a result of that failure.

(i) The process and vote required to amend the bylaws.

(j) Any other necessary and proper matter agreed to by the participating community mental health services programs.

(2) Except as otherwise stated in the bylaws, a regional entity has all of the following powers:

(a) The power, privilege, or authority that the participating community mental health services programs share in common and may exercise separately under this act,

whether or not that power, privilege, or authority is specified in the bylaws establishing the regional entity.

(b) The power to contract with the state to serve as the medicaid specialty service prepaid health plan for the designated service areas of the participating community mental health services programs.

(c) The power to accept funds, grants, gifts, or services from the federal government or a federal agency, the state or a state department, agency, instrumentality, or political subdivision, or any other governmental unit whether or not that governmental unit participates in the regional entity, and from a private or civic source.

(d) The power to enter into a contract with a participating community mental health service program for any service to be performed for, by, or from the participating community mental health services program.

(e) The power to create a risk pool and take other action as necessary to reduce the risk that a participating community mental health services program otherwise bears individually.

(3) A regional entity established under this section is a public governmental entity separate from the county, authority, or organization that establishes it.

(4) All the privileges and immunity from liability and exemptions from laws, ordinances, and rules provided under section 205(3)(b) to county community mental health service programs and their board members, officers, and administrators, and county elected officials and employees of county government are retained by a regional entity created under this section and the regional entity's board members, officers, agents, and employees.

(5) A regional entity shall provide an annual report of its activities to each participating community mental health services program.

(6) The regional entity's bylaws shall be filed with the clerk of each county in which a participating community mental health services program is located and with the secretary of state, before the bylaws take effect.

(7) If a regional entity assumes the duties of a participating community mental health services program or contracts with a private individual or entity to assume the duties of a participating community mental health services program, the regional entity shall comply with all of the following:

(a) The manner of employing, compensating, transferring, or discharging necessary personnel is subject to the provisions of the applicable civil service and merit systems and the following restrictions:

(i) An employee of a regional entity is a public employee.

(ii) A regional entity and its employees are subject to 1947 PA 336, MCL 423.201 to 423.217.

(b) At the time a regional entity is established under this section, the employees of the participating community mental health services program who are transferred to the regional entity and appointed as employees shall retain all the rights and benefits for 1 year. If at the time a regional entity is established under this section a participating community mental health services program ceases to operate, the employees of the participating community mental health services program shall be transferred to the regional entity and appointed as employees who shall retain all the rights and benefits for 1 year. An employee of the regional entity shall not, by reason of the transfer, be placed in a worse position for a period of 1 year with respect to worker's compensation, pension, seniority, wages, sick leave, vacation, health and welfare insurance, or another benefit that the employee had as an employee of the participating community mental health services program. A transferred employee's accrued benefits or credits shall not be diminished by reason of the transfer.

(c) If a participating community mental health services program was the designated employer or participated in the development of a collective bargaining agreement, the regional entity assumes and is bound by the existing collective bargaining agreement. Establishing a regional entity does not adversely affect existing rights or obligations contained in the existing collective bargaining agreement. For the purposes of this subsection, “participation in the development of a collective bargaining agreement” means that a representative of the participating community mental health services program actively participated in bargaining sessions with the employer representative and union or was consulted during the bargaining process.

History: Add. 2002, Act 594, Imd. Eff. Oct. 17, 2002

330.1205 Community mental health authority.

Sec. 205.

(1) A county community mental health agency or a community mental health organization that is certified by the department under section 232a may become a community mental health authority as provided in this section through an enabling resolution adopted by the board of commissioners of each creating county after at least 3 public hearings held in accordance with the open meetings act, 1976 PA 267, MCL 15.261 to 15.275. The resolution is considered adopted if it is approved by a majority of the commissioners elected and serving in each county creating the authority. The enabling resolution is not effective until it has been filed with the secretary of state and with the county clerk of each county creating the authority. If any provision of the enabling resolution conflicts with this act, this act supersedes the conflicting provision.

(2) All of the following shall be stated in the enabling resolution:

(a) The purpose and the power to be exercised by the community mental health authority shall be to comply with and carry out the provisions of this act.

(b) The duration of the existence of the community mental health authority and the method by which the community mental health authority may be dissolved or terminated by itself or by the county board or boards of commissioners. These provisions shall comply with section 220.

(c) The manner in which any net financial assets originally made available to the authority by the participating county or counties will be returned or distributed if the authority is dissolved or terminated. All other remaining assets, net of liabilities, shall be transferred to the community mental health services program or programs that replace the authority.

(d) The liability of the community mental health authority for costs associated with real or personal property purchased or leased by the county for use by the community mental health services program to the extent necessary to discharge the financial liability if desired by the county or counties.

(e) The manner of employing, compensating, transferring, or discharging necessary personnel subject to the provisions of applicable civil service and merit systems, and the following restrictions:

(i) Employees of a community mental health authority are public employees. A community mental health authority and its employees are subject to 1947 PA 336, MCL 423.201 to 423.217.

(ii) Upon the creation of a community mental health authority, the employees of the former community mental health services program shall be transferred to the new authority and appointed as employees subject to all rights and benefits for 1 year. Such employees of the new community mental health authority shall not be placed in a worse position by reason of the transfer for a period of 1 year with respect to workers' compensation, pension, seniority, wages, sick leave, vacation, health and welfare insurance, or any other benefit that the employee enjoyed as an employee of the former community mental health services program. Employees who are transferred shall not by reason of the transfer have their accrued pension benefits or credits diminished.

(iii) If the former county community mental health agency or community mental health organization was the designated employer or participated in the development of a collective bargaining agreement, the newly established community mental health authority shall assume and be bound by the existing collective bargaining agreement. The formation of a community mental health authority shall not adversely affect any existing rights and obligations contained in the existing collective bargaining agreement. For purposes of this provision, participation in the development of a collective bargaining agreement means that a representative of the community mental health agency or organization actively participated in bargaining sessions with the employer representative and union or was consulted with during the bargaining process.

(f) Any other matter consistent with this act that is necessary to assure operation of the community mental health authority as agreed upon by the creating county or counties.

(3) If a county community mental health agency or a community mental health organization becomes a community mental health authority pursuant to this section, both of the following apply:

(a) All assets, debts, and obligations of the county community mental health agency or community mental health organization, including, but not limited to, equipment, furnishings, supplies, cash, and other personal property, shall be transferred to the community mental health authority.

(b) All the privileges and immunities from liability and exemptions from laws, ordinances, and rules that are applicable to county community mental health agencies or community mental health organizations and their board members, officers, and administrators, and county elected officials and employees of county government are retained by the authority and the board members, officers, agents, and employees of an authority created under this section.

(4) In addition to other powers of a community mental health services program as set forth in this act, a community mental health authority has all of the following powers, whether or not they are specified in the enabling resolution:

(a) To fix and collect charges, rates, rents, fees, or other charges and to collect interest.

(b) To make purchases and contracts.

(c) To transfer, divide, or distribute assets, liabilities, or contingent liabilities, unless the community mental health authority is a single-county community mental health services program and the county has notified the department of its intention to terminate participation in the community mental health services program. During the interim period between notification by a county under section 220 of its intent to terminate participation in a multi-county community mental health services program and the official termination of that participation, a community mental health authority's power under this subdivision is subject to any agreement between the community mental health authority and the county that is terminating participation, if that agreement is consistent with the enabling resolution that created the authority.

(d) To accept gifts, grants, or bequests and determine the manner in which those gifts, grants, or bequests may be used consistent with the donor's request.

(e) To acquire, own, operate, maintain, lease, or sell real or personal property. Before taking official action to sell residential property, however, the authority shall do all of the following:

(i) Implement a plan for alternative housing arrangements for recipients residing on the property.

(ii) Provide the recipients residing on the property or their legal guardians, if any, an opportunity to offer their comments and concerns regarding the sale and planned alternatives.

(iii) Respond to those comments and concerns in writing.

(f) To do the following in its own name:

(i) Enter into contracts and agreements.

(ii) Employ staff.

(iii) Acquire, construct, manage, maintain, or operate buildings or improvements.

(iv) Subject to subdivision (e), acquire, own, operate, maintain, lease, or dispose of real or personal property, unless the community mental health authority is a single-county mental health services program and the county has notified the department of its intention to terminate participation in the community mental health services program. During the interim period between notification by a county under section 220 of its intent to terminate participation in a multi-county community mental health services program and the official termination of that participation, a community mental health authority's power under this subdivision is subject to any agreement between the community mental health authority and the county that is terminating participation, if that agreement is consistent with the enabling resolution that created the authority.

(v) Incur debts, liabilities, or obligations that do not constitute the debts, liabilities, or obligations of the creating county or counties.

(vi) Commence litigation and defend itself in litigation.

(g) To invest funds in accordance with statutes regarding investments.

(h) To set up reserve accounts, utilizing state funds in the same proportion that state funds relate to all revenue sources, to cover vested employee benefits including, but not limited to, accrued vacation, health benefits, the employee payout portion of accrued sick leave, if any, and worker's compensation. In addition, an authority may set up reserve accounts for depreciation of capital assets and for expected future expenditures for an organizational retirement plan.

(i) To develop a charge schedule for services provided to the public and utilize the charge schedule for first and third-party payers. The charge schedule may include charges that are higher than costs for some service units by spreading nonrevenue service unit costs to revenue-producing service unit costs with total charges not exceeding total costs. All revenue over cost generated in this manner shall be utilized to provide services to priority populations.

(5) In addition to other duties and responsibilities of a community mental health services program as set forth in this act, a community mental health authority shall do all of the following:

(a) Provide to each county creating the authority and to the department a copy of an annual independent audit performed by a certified public accountant in accordance with governmental auditing standards issued by the comptroller of the United States.

(b) Be responsible for all executive administration, personnel administration, finance, accounting, and management information system functions. The authority may discharge this responsibility through direct staff or by contracting for services.

(6) A county that has created a community mental health authority is not liable for any intentional, negligent, or grossly negligent act or omission, for any financial affairs, or for any obligation of a community mental health authority, its board, employees, representatives, or agents. This subsection applies only to county government.

(7) A community mental health authority shall not levy any type of tax or, except as provided in subsection (13), issue any type of bond in its own name or financially obligate any unit of government other than itself.

(8) An employee of a community mental health authority is not a county employee. The community mental health authority is the employer with regard to all laws pertaining to employee and employer rights, benefits, and responsibilities.

(9) As a public governmental body, a community mental health authority is subject to the open meetings act, 1976 PA 267, MCL 15.261 to 15.275, and the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246, except for those documents produced as a part of the peer review process required in section 143a and made confidential by section 748(9).

(10) A community mental health authority may borrow money to finance or refinance the purchase of real property or tangible personal property of the authority. These contractual obligations shall be secured by a mortgage on the real property or a security interest or other lien on the tangible personal property. These contractual obligations shall be for not longer than the useful life of the collateral and shall be authorized by resolution approved by a majority of the community mental health board. A mortgage given by a community mental health authority to finance the purchase of real property under this subsection is not subject to the revised municipal finance act, 2001 PA 34, MCL 141.2101 to 141.2821.

(11) A community mental health authority may enter into an installment purchase agreement for the purchase or refinancing of tangible personal property for public purposes. The installment purchase agreement for the purchase of tangible personal property shall not be for a longer term than the useful life of the tangible personal property. The installment purchase agreements described in this subsection are not subject to the provisions of the revised municipal finance act, 2001 PA 34, MCL 141.2101 to 141.2821. The total of all outstanding installment purchase agreements under this subsection shall not exceed 1% of the taxable value of all property located within the area served by that community mental health authority.

(12) If a community mental health authority has financed the purchase of property in a substantially similar manner to that as described in subsection (10) or (11), prior to the effective date of the amendatory act that added this subsection, that purchase is ratified as if it was made under subsection (10) or (11).

(13) A community mental health authority may borrow money and issue notes by resolution of a majority vote of its governing board, which notes shall not exceed 20% of the previous year's annual income and shall mature not more than 18 months from the date of their issuance. Notes shall be issued for the purpose of meeting the expenses of the community mental health authority, including the expenses of operation and maintenance of its facilities, and payments due to its contracted service providers. The resolution authorizing the issuance of the notes shall provide for the pledge of income and revenues of the community mental health authority for the payment of the notes, and may also provide for a special sinking fund into which there may be paid, as collected, a sufficient fund from the revenues of the community mental health authority to retire both the principal of and interest on the notes at or before maturity. The resolution may also authorize 1 or more officers or board members of the authority to provide for the mortgage, pledge, or grant of security interests or other liens in other assets of the community mental health authority as additional security for the payment of notes. Notes issued by a community mental health authority under this subsection are not subject to the revised municipal finance act, 2001 PA 34, MCL 141.2101 to 141.2821.

History: Add. 1995, Act 290, Eff. Mar. 28, 1996 ;-- Am. 1996, Act 588, Imd. Eff. Jan. 21, 1997 ;-- Am. 2000, Act 228, Imd. Eff. June 27, 2000 ;-- Am. 2002, Act 343, Imd. Eff. May 23, 2002

330.1206 Community mental health services program; purpose; services.

Sec. 206.

(1) The purpose of a community mental health services program shall be to provide a comprehensive array of mental health services appropriate to conditions of individuals who are located within its geographic service area, regardless of an individual's ability to pay. The array of mental health services shall include, at a minimum, all of the following:

(a) Crisis stabilization and response including a 24-hour, 7-day per week, crisis emergency service that is prepared to respond to persons experiencing acute emotional, behavioral, or social dysfunctions, and the provision of inpatient or other protective environment for treatment.

(b) Identification, assessment, and diagnosis to determine the specific needs of the recipient and to develop an individual plan of services.

(c) Planning, linking, coordinating, follow-up, and monitoring to assist the recipient in gaining access to services.

(d) Specialized mental health recipient training, treatment, and support, including therapeutic clinical interactions, socialization and adaptive skill and coping skill training, health and rehabilitative services, and pre-vocational and vocational services.

(e) Recipient rights services.

(f) Mental health advocacy.

(g) Prevention activities that serve to inform and educate with the intent of reducing the risk of severe recipient dysfunction.

(h) Any other service approved by the department.

(2) Services shall promote the best interests of the individual and shall be designed to increase independence, improve quality of life, and support community integration and inclusion. Services for children and families shall promote the best interests of the individual receiving services and shall be designed to strengthen and preserve the family unit if appropriate. The community mental health services program shall deliver services in a manner that demonstrates they are based upon recipient choice and involvement, and shall include wraparound services when appropriate.

History: 1974, Act 258, Eff. Aug. 6, 1975 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996
Admin Rule: R 330.1001 et seq. of the Michigan Administrative Code.

330.1207 Diversion from jail incarceration.

Sec. 207.

Each community mental health services program shall provide services designed to divert persons with serious mental illness, serious emotional disturbance, or developmental disability from possible jail incarceration when appropriate. These services shall be consistent with policy established by the department.

History: Add. 1995, Act 290, Eff. Mar. 28, 1996

330.1208 Individuals to which service directed; priorities; denial of service prohibited.

Sec. 208.

(1) Services provided by a community mental health services program shall be directed to individuals who have a serious mental illness, serious emotional disturbance, or developmental disability.

(2) Services may be directed to individuals who have other mental disorders that meet criteria specified in the most recent diagnostic and statistical manual of mental health disorders published by the American psychiatric association and may also be directed to the prevention of mental disability and the promotion of mental health. Resources that have been specifically designated to community mental health services programs for

services to individuals with dementia, alcoholism, or substance use disorder or for the prevention of mental disability and the promotion of mental health shall be utilized for those specific purposes.

(3) Priority shall be given to the provision of services to individuals with the most severe forms of serious mental illness, serious emotional disturbance, and developmental disability. Priority shall also be given to the provision of services to individuals with a serious mental illness, serious emotional disturbance, or developmental disability in urgent or emergency situations.

(4) An individual shall not be denied a service because an individual who is financially liable is unable to pay for the service.

History: 1974, Act 258, Eff. Aug. 6, 1975 ;-- Am. 1978, Act 166, Imd. Eff. May 26, 1978 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996 ;-- Am. 2012, Act 500, Imd. Eff. Dec. 28, 2012

330.1209 Repealed. 1995, Act 290, Eff. Mar. 28, 1996.

Compiler's Notes: The repealed section pertained to notifying county program of admittance of individual to state facility.

330.1209a Prerelease plan for community placement and aftercare services; development; contracting for services; advance notice of patient release; release plan; postrelease plan; disclosure of information.

Sec. 209a.

(1) The appropriate community mental health services program, with the assistance of the state facility or licensed hospital under contract with a community mental health services program, or the state facility shall develop an individualized prerelease plan for appropriate community placement and a prerelease plan for aftercare services appropriate for each resident. If possible, the resident shall participate in the development of a prerelease plan. In developing a prerelease plan for a minor, the community mental health services program shall include all of the following in the planning process if possible:

(a) The minor, if the minor is 14 years of age or older.

(b) The parent or guardian of the minor.

(c) Personnel from the school and other agencies.

(2) If the responsible community mental health services program cannot locate suitable aftercare service with a residential component or an alternative to hospitalization in its service area, but the service is available from another service provider, the responsible community mental health service program may contract for the provision of services. The service shall be located as close to the individual's place of residence as possible.

(3) If a recipient of inpatient services provided through a community mental health services program is to be released, the licensed hospital under contract with a community mental health services program or a state facility shall provide the responsible community mental health services program with advance notice of an individual's anticipated release from patient care. The community mental health services program shall offer prerelease planning services and develop a release plan in cooperation with the individual unless the individual refuses this service.

(4) If a recipient of inpatient services provided through a community mental health services program is released before a prerelease plan can be completed, the community mental health services program shall offer to assist the recipient in the development of a postrelease plan within 10 days after release.

(5) Unless covered by contractual agreement, disclosure of information about the individual by the state facility or licensed hospital shall be made to those individuals involved in the development of the prerelease or postrelease plan or current individual plan of services, but shall be limited to the following:

(a) Home address, gender, date of discharge or planned date of discharge, any transfer, and medication record.

(b) Other information necessary to determine financial and social service needs, program needs, residential needs, and medication needs.

History: Add. 1980, Act 409, Imd. Eff. Jan. 8, 1981 ;-- Am. 1984, Act 186, Imd. Eff. July 3, 1984 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996

330.1209b Placement of individual in supervised community living arrangement; prerelease and postrelease planning; plan for community placement and aftercare services; sending department aggregate data upon request; list of services not provided.

Sec. 209b.

(1) Before an individual is placed in a supervised community living arrangement, such as a foster home, group care home, nursing home, or other community-based setting, the prerelease or postrelease planning for the individual shall involve the individual, the individual's legal guardian if a guardian has been appointed; any family member, friend, advocate, and professional the recipient chooses; the parents of a minor individual; the state facility or licensed hospital; the residential care provider, if such a provider has been selected; and, with the consent of the individual, the appropriate local and intermediate school systems and the department of social services, if appropriate. In each case, the community mental health services program shall produce in writing a plan for community placement and aftercare services that is sufficient to meet the needs of the individual and shall document any lack of available community services necessary to implement the plan.

(2) Each community mental health services program, as requested, shall send to the department aggregate data, which includes a list of services that were indicated on prerelease or postrelease plans, but which could not be provided.

History: Add. 1980, Act 409, Imd. Eff. Jan. 8, 1981 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996

330.1209d Review of outcomes, programs, treatment, and community services rendered in community settings; standards.

Sec. 209d.

Each community mental health services program regularly shall review the outcomes for recipients as a result of programs, treatment, and community services rendered to individuals in community settings and shall ensure that services are provided consistently with the standards of the department.

History: Add. 1980, Act 409, Imd. Eff. Jan. 8, 1981 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996

330.1210 Community mental health services program; election to establish; coordination of services.

Sec. 210.

(1) Any single county or any combination of adjoining counties may elect to establish a community mental health services program by a majority vote of each county board of commissioners.

(2) A department-designated community mental health entity shall coordinate the provision of substance use disorder services in its region and shall ensure services are available for individuals with substance use disorder.

History: 1974, Act 258, Eff. Aug. 6, 1975 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996 ;-- Am. 2012, Act 500, Imd. Eff. Dec. 28, 2012

330.1212 Board; establishment; appointment of members.

Sec. 212.

Upon electing to establish a community mental health services program, the county or combination of counties shall establish a 12-member community mental health services board, except as provided in section 214, 219, or 222(2) or (5). Each board of commissioners shall by a majority vote appoint the board members from its county. Recommended appointments to the board shall be made annually following the organizational meeting of the board of commissioners.

History: 1974, Act 258, Eff. Aug. 6, 1975 ;-- Am. 1986, Act 265, Imd. Eff. Dec. 9, 1986 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996

330.1212.amended Board; establishment; appointment of members; county with city having population of at least 500,000; vacancy; board member as governmental employee or contractor.

Sec. 212.

(1) Upon electing to establish a community mental health services program, the county or combination of counties shall establish a 12-member community mental health services board, except as provided in section 214, 219, or 222(2) or (5). Except as provided in subsection (2), each board of commissioners shall by a majority vote appoint the board members from its county. Recommended appointments to the board shall be made annually following the organizational meeting of the board of commissioners.

(2) When a single county establishes a community mental health services program and totally situated within that county is a city having a population of at least 500,000, the 12 board members shall be appointed to the board as follows:

(a) Six board members appointed by a majority vote of the county board of commissioners from a list of nominees submitted by the county executive of that county. Two board members appointed under this subdivision must be primary consumers or family members of primary consumers. Upon notification that the list provided under this subdivision does not meet with the county board of commissioners' approval, the county executive of that county shall submit another list to the county board of commissioners with 6 different nominees.

(b) Six board members appointed by the county board of commissioners from a list of nominees submitted by the mayor of the city having a population of at least 500,000 that is totally situated within that county. Two board members appointed under this subdivision must be primary consumers or family members of primary consumers. Upon notification that the list provided under this subdivision does not meet with the county board of commissioners' approval, the mayor of the city having a population of at least 500,000 that is totally situated within that county shall submit another list to the county board of commissioners with 6 different nominees.

(3) When a single county establishes a community mental health services program and totally situated within that county is a city having a population of at least 500,000, the 12 board members shall be appointed to the board as the appointments of current board members expire.

(4) When a vacancy occurs on a board that has members appointed under subsection (2), the vacancy shall be filled in the same manner as the board member being replaced was appointed.

(5) A board member appointed under subsection (2) shall not be an employee or contractor of any of the following:

(a) The city or county described in subsection (2).

(b) The state.

(c) The federal government.

(d) A community mental health authority.

History: 1974, Act 258, Eff. Aug. 6, 1975 ;-- Am. 1986, Act 265, Imd. Eff. Dec. 9, 1986 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996 ;-- Am. 2012, Act 376, Eff. Mar. 28, 2013

330.1214 Board; county representation.

Sec. 214.

When a single county establishes a board, all board members shall be representatives of that county. When a combination of counties establishes a board, unless otherwise agreed to by each of the participating counties, the board memberships shall be divided among the counties in proportion to each county's population, except that each county is entitled to at least 1 board membership.

History: 1974, Act 258, Eff. Aug. 6, 1975 ;-- Am. 2000, Act 21, Imd. Eff. Mar. 13, 2000

330.1216 Board; appointment of 6 members by city.

Sec. 216.

Notwithstanding the provisions of sections 212 and 214, when a single county establishes a community mental health services program and totally situated within that county is a city having a population of at least 500,000, 6 of the 12 board members shall be appointed to the board by the city's chief executive officer. In a charter county, the remaining 6 members shall be appointed to the board by the county's chief executive officer, with the advice and consent of the county board of commissioners. The 6 board members appointed by the city shall be residents of the city, and the 6 board members appointed by the county or by the county executive in a charter county shall be residents of the county but not of the city.

History: 1974, Act 258, Eff. Aug. 6, 1975 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996

330.1218 Joining established services program.

Sec. 218.

Any county that adjoins a county having an established community mental health services program may elect, by a majority vote of its board of commissioners, to join that established community mental health services program. The joining must be

approved by the board of commissioners of each county already participating in the established community mental health services program, and the joining shall become effective on January 1 following the date of final approval. Upon the joining, the board of the established community mental health services program shall be dissolved, and a new board shall be appointed in the manner provided in sections 212 and 214.

History: 1974, Act 258, Eff. Aug. 6, 1975 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996

330.1219 Merger of services programs; appointment of members to new board; compliance with MCL 330.1212, 330.1214, and 330.1222.

Sec. 219.

(1) A county having an established community mental health services program may elect to merge with an established community mental health services program in an adjoining county. A merger shall be approved by a majority vote of the board of commissioners of each participating county, and becomes effective on the first day of January, April, July, or October immediately following the date of final approval. The merger and creation of a community mental health authority shall be in accordance with this section and section 205.

(2) The board of commissioners of each participating county may elect by a majority vote to appoint 1 or more of the community mental health services board members to the new board, even if that action would result in a size or composition of the board that is different than that provided for in sections 212, 214, and 222.

(3) If the board of commissioners of 1 or more participating counties does not agree to permit appointment of members to the new board in the manner provided in subsection (2), the new board shall be appointed in the manner provided in sections 212, 214, and 222.

(4) A new board that is different in size or composition than that provided for in section 212, 214, or 222 shall be brought into compliance with those sections not later than 3 years after the date of merger.

History: Add. 1986, Act 265, Imd. Eff. Dec. 9, 1986 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996 ;-- Am. 1996, Act 588, Imd. Eff. Jan. 21, 1997

330.1220 Services program; termination of participation; notice.

Sec. 220.

Termination of a county's participation in a community mental health services program, whether that participation is singular or joint, may be accomplished by an official notification from the county's board of commissioners to the department and the other concerned county boards of commissioners or, in a charter county, by an official notification from the county's board of commissioners upon a request from the county executive. The date of termination shall be 1 year following the receipt of notification by the department, unless the director of the department consents to an earlier termination.

In the interim between notification and official termination, the county's participation in the community mental health services program shall be maintained in good faith.

History: 1974, Act 258, Eff. Aug. 6, 1975 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996

330.1221 Repealed. 1990, Act 263, Eff. Jan. 1, 1993.

Compiler's Notes: The repealed section pertained to powers and duties of governing board of county human services or human resources department and repeal of section.

330.1222 Board; composition; residence of members; exclusions; approval of contract; exception; size of board in excess of MCL 330.1212; compliance.

Sec. 222.

(1) The composition of a community mental health services board shall be representative of providers of mental health services, recipients or primary consumers of mental health services, agencies and occupations having a working involvement with mental health services, and the general public. At least 1/3 of the membership shall be primary consumers or family members, and of that 1/3 at least 1/2 of those members shall be primary consumers. All board members shall be 18 years of age or older.

(2) Not more than 4 members of a board may be county commissioners, except that if a board represents 5 or more counties, the number of county commissioners who may serve on the board may equal the number of counties represented on the board, and the total of 12 board memberships shall be increased by the number of county commissioners serving on the board that exceeds 4. In addition to an increase in board memberships related to the number of county commissioners serving on a board that represents 5 or more counties, board memberships may also be expanded to more than the total of 12 to ensure that each county is entitled to at least 2 board memberships, which may include county commissioners from that county who are members of the board if the board represents 5 or more counties. Not more than 1/2 of the total board members may be state, county, or local public officials. For purposes of this section, public officials are defined as individuals serving in an elected or appointed public office or employed more than 20 hours per week by an agency of federal, state, city, or local government.

(3) A board member shall have his or her primary place of residence in the county he or she represents.

(4) An individual shall not be appointed to and shall not serve on a board if he or she is 1 or more of the following:

(a) Employed by the department or the community mental health services program.

(b) A party to a contract with the community mental health services program or administering or benefiting financially from a contract with the community mental health services program, except for a party to a contract between a community mental health services program and a regional entity or a separate legal or an administrative entity

created by 2 or more community mental health services programs under the urban cooperation act of 1967, 1967 (Ex Sess) PA 7, MCL 124.501 to 124.512, or under 1967 (Ex Sess) PA 8, MCL 124.531 to 124.536.

(c) Serving in a policy-making position with an agency under contract with the community mental health services program, except for an individual serving in a policy-making position with a joint board or commission established under 1967 (Ex Sess) PA 8, MCL 124.531 to 124.536, or a regional entity to provide community mental health services.

(5) If a board member is an employee or independent contractor in other than a policy-making position with an agency with which the board is considering entering into a contract, the contract shall not be approved unless all of the following requirements are met:

(a) The board member shall promptly disclose his or her interest in the contract to the board.

(b) The contract shall be approved by a vote of not less than 2/3 of the membership of the board in an open meeting without the vote of the board member in question.

(c) The official minutes of the meeting at which the contract is approved contains the details of the contract including, but not limited to, names of all parties and the terms of the contract and the nature of the board member's interest in the contract.

(6) Subsection (5) does not apply to a board member who is an employee or independent contractor in other than a policy-making position with a joint board or commission established under 1967 (Ex Sess) PA 8, MCL 124.531 to 124.536, a separate legal or administrative entity established under the urban cooperation act of 1967, 1967 (Ex Sess) PA 7, MCL 124.501 to 124.512, a combination of municipal corporations joined under 1951 PA 35, MCL 124.1 to 124.13, or a regional entity to provide community mental health services.

(7) In order to meet the requirement under subsection (1) related to the appointment of primary consumers and family members without terminating the appointment of a board member serving on March 28, 1996, the size of a board may exceed the size prescribed in section 212. A board that is different in size than that prescribed in section 212 shall be brought into compliance within 3 years after the appointment of the additional board members.

History: 1974, Act 258, Eff. Aug. 6, 1975 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996 ;-- Am. 2002, Act 596, Imd. Eff. Dec. 3, 2002 ;-- Am. 2003, Act 278, Imd. Eff. Jan. 8, 2004

330.1224 Board; terms of members; vacancy; removal from office; compensation; expenses.

Sec. 224.

The term of office of a board member shall be 3 years from April 1 of the year of appointment, except that of the members first appointed, 4 shall be appointed for a term of 1 year, 4 for 2 years, and 4 for 3 years. A vacancy shall be filled for an unexpired term in the same manner as an original appointment. A board member may be removed from office by the appointing board of commissioners or, if the board member was appointed by the chief executive officer of a county or a city under section 216, by the chief executive officer who appointed the member for neglect of official duty or misconduct in office after being given a written statement of reasons and an opportunity to be heard on the removal. A board member shall be paid a per diem no larger than the highest per diem for members of other county advisory boards set by the county board of commissioners and be reimbursed for necessary travel expenses for each meeting attended. The mileage expense fixed by the county board of commissioners shall not exceed the mileage reimbursement as determined by the state officers compensation commission. A board member shall not receive more than 1 per diem payment per day regardless of the number of meetings scheduled by the board for that day.

History: 1974, Act 258, Eff. Aug. 6, 1975 ;-- Am. 1976, Act 348, Imd. Eff. Dec. 21, 1976 ;-- Am. 1977, Act 88, Imd. Eff. Aug. 2, 1977 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996

330.1224.amended Board; terms of members; vacancy; removal from office; compensation; expenses.

Sec. 224.

The term of office of a board member shall be 3 years from April 1 of the year of appointment, except that of the members first appointed, 4 shall be appointed for a term of 1 year, 4 for 2 years, and 4 for 3 years. A vacancy shall be filled for an unexpired term in the same manner as an original appointment. A board member may be removed from office by the appointing board of commissioners for neglect of official duty or misconduct in office after being given a written statement of reasons and an opportunity to be heard on the removal. A board member shall be paid a per diem no larger than the highest per diem for members of other county advisory boards set by the county board of commissioners and be reimbursed for necessary travel expenses for each meeting attended. The mileage expense fixed by the county board of commissioners shall not exceed the mileage reimbursement as determined by the state officers compensation commission. A board member shall not receive more than 1 per diem payment per day regardless of the number of meetings scheduled by the board for that day.

History: 1974, Act 258, Eff. Aug. 6, 1975 ;-- Am. 1976, Act 348, Imd. Eff. Dec. 21, 1976 ;-- Am. 1977, Act 88, Imd. Eff. Aug. 2, 1977 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996 ;-- Am. 2012, Act 376, Eff. Mar. 28, 2013

330.1226 Board; powers and duties; appointment of executive director; reimbursement to program providing assisted outpatient treatment services.

Sec. 226.

(1) The board of a community mental health services program shall do all of the following:

(a) Annually conduct a needs assessment to determine the mental health needs of the residents of the county or counties it represents and identify public and nonpublic services necessary to meet those needs. Information and data concerning the mental health needs of individuals with developmental disability, serious mental illness, and serious emotional disturbance shall be reported to the department in accordance with procedures and at a time established by the department, along with plans to meet identified needs. It is the responsibility of the community mental health services program to involve the public and private providers of mental health services located in the county or counties served by the community mental health program in this assessment and service identification process. The needs assessment shall include information gathered from all appropriate sources, including community mental health waiting list data and school districts providing special education services.

(b) Annually review and submit to the department a needs assessment report, annual plan, and request for new funds for the community mental health services program. The standard format and documentation of the needs assessment, annual plan, and request for new funds shall be specified by the department.

(c) In the case of a county community mental health agency, obtain approval of its needs assessment, annual plan and budget, and request for new funds from the board of commissioners of each participating county before submission of the plan to the department. In the case of a community mental health organization, provide a copy of its needs assessment, annual plan, request for new funds, and any other document specified in accordance with the terms and conditions of the organization's inter-local agreement to the board of commissioners of each county creating the organization. In the case of a community mental health authority, provide a copy of its needs assessment, annual plan, and request for new funds to the board of commissioners of each county creating the authority.

(d) Submit the needs assessment, annual plan, and request for new funds to the department by the date specified by the department. The submission constitutes the community mental health services program's official application for new state funds.

(e) Provide and advertise a public hearing on the needs assessment, annual plan, and request for new funds before providing them to the county board of commissioners.

(f) Submit to each board of commissioners for their approval an annual request for county funds to support the program. The request shall be in the form and at the time determined by the board or boards of commissioners.

(g) Annually approve the community mental health services program's operating budget for the year.

(h) Take those actions it considers necessary and appropriate to secure private, federal, and other public funds to help support the community mental health services program.

(i) Approve and authorize all contracts for the provision of services.

(j) Review and evaluate the quality, effectiveness, and efficiency of services being provided by the community mental health services program. The board shall identify specific performance criteria and standards to be used in the review and evaluation. These shall be in writing and available for public inspection upon request.

(k) Subject to subsection (3), appoint an executive director of the community mental health services program who meets the standards of training and experience established by the department.

(l) Establish general policy guidelines within which the executive director shall execute the community mental health services program.

(m) Require the executive director to select a physician, a registered professional nurse with a specialty certification issued under section 17210 of the public health code, 1978 PA 368, MCL 333.17210, or a licensed psychologist to advise the executive director on treatment issues.

(2) A community mental health services program may do all of the following:

(a) Establish demonstration projects allowing the executive director to do 1 or both of the following:

(i) Issue a voucher to a recipient in accordance with the recipient's plan of services developed by the community mental health services program.

(ii) Provide funding for the purpose of establishing revolving loans to assist recipients of public mental health services to acquire or maintain affordable housing. Funding under this subparagraph shall only be provided through an agreement with a nonprofit fiduciary.

(b) Carry forward any surplus of revenue over expenditures under a capitated managed care system. Capitated payments under a managed care system are not subject to cost settlement provisions of section 236.

(c) Carry forward the operating margin up to 5% of the community mental health services program's state share of the operating budget for the fiscal years ending September 30, 2009, 2010, and 2011. As used in this subdivision, "operating margin" means the excess of state revenue over state expenditures for a single fiscal year exclusive of capitated payments under a managed care system. In the case of a community mental health authority, this carryforward is in addition to the reserve accounts described in section 205(4)(h).

(d) Pursue, develop, and establish partnerships with private individuals or organizations to provide mental health services.

(e) Share the costs or risks, or both, of managing and providing publicly funded mental health services with other community mental health services programs through participation in risk pooling arrangements, reinsurance agreements, and other joint or cooperative arrangements as permitted by law.

(3) In the case of a county community mental health agency, the initial appointment by the board of an individual as executive director is effective unless rejected by a 2/3 vote of the county board of commissioners within 15 calendar days.

(4) A community mental health services program that has provided assisted outpatient treatment services during a fiscal year may be eligible for reimbursement if an appropriation is made for assisted outpatient treatment services for that fiscal year. The reimbursement described in this subsection is in addition to any funds that the community mental health services program is otherwise eligible to receive for providing assisted outpatient treatment services.

History: 1974, Act 258, Eff. Aug. 6, 1975 ;-- Am. 1986, Act 149, Imd. Eff. July 2, 1986 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996 ;-- Am. 1996, Act 588, Imd. Eff. Jan. 21, 1997 ;-- Am. 1998, Act 417, Imd. Eff. Dec. 22, 1998 ;-- Am. 2000, Act 273, Imd. Eff. July 7, 2000 ;-- Am. 2002, Act 595, Imd. Eff. Oct. 17, 2002 ;-- Am. 2004, Act 497, Eff. Mar. 30, 2005 ;-- Am. 2009, Act 103, Imd. Eff. Sept. 30, 2009

330.1226a Board; special fund account.

Sec. 226a.

A community mental health services program board may create a special fund account to receive recipient fees and third-party reimbursements for services rendered. In the case of a county community mental health agency, approval of the board of commissioners of each participating county is necessary before creation of the special fund account. Receipts into the fund shall be recorded by source of payment and by type of service rendered, and a report regarding this information shall be submitted on a quarterly basis to the department. Money in the special fund account shall be used only for matching state funds or for the provision of community mental health services.

History: Add. 1980, Act 423, Eff. Mar. 31, 1981 ;-- Am. 1984, Act 107, Imd. Eff. May 24, 1984 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996

330.1227 School-to-community transition services.

Sec. 227.

Each community mental health services program shall participate in the development of school-to-community transition services for individuals with serious mental illness, serious emotional disturbance, or developmental disability. This planning and development shall be done in conjunction with the individual's local school district or intermediate school district as appropriate and shall begin not later than the school year in which the individual student reaches 16 years of age. These services shall be individualized. This section is not intended to increase or decrease the fiscal

responsibility of school districts, community mental health services programs, or any other agency or organization with respect to individuals described in this section.

History: Add. 1995, Act 290, Eff. Mar. 28, 1996

330.1228 Board; contracts.

Sec. 228.

Subject to the provisions of this chapter, a board is authorized to enter into contracts for the purchase of mental health services and property lease arrangements with private or public agencies or individuals. A board may enter into a contract with any facility or entity of the department with the approval of the director of the department.

History: 1974, Act 258, Eff. Aug. 6, 1975 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996

330.1230 Services program; executive director as chief executive and administrative officer; terms and conditions of employment.

Sec. 230.

The executive director of a community mental health services program shall function as the chief executive and administrative officer of the program and shall execute and administer the program in accordance with the approved annual plan and operating budget, the general policy guidelines established by the board, the applicable governmental procedures and policies, and the provisions of this act. The executive director has the authority and responsibility for supervising all employees. The terms and conditions of an executive director's employment, including tenure of service, shall be as mutually agreed to by the board and the executive director and shall be specified in a written contract.

History: 1974, Act 258, Eff. Aug. 6, 1975 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996

330.1231 Medical director; appointment; duties.

Sec. 231.

The executive director shall appoint a medical director who is a psychiatrist. The medical director shall advise the executive director on medical policy and treatment issues.

History: Add. 1995, Act 290, Eff. Mar. 28, 1996

330.1232 Services program; review of annual plan, needs assessment, request for funds, annual contract, and budget; eligibility for state support; allocation of funds.

Sec. 232.

The department shall review each community mental health services program's annual plan, needs assessment, request for funds, annual contract, and operating budget and approve or disapprove state funding in whole or in part. Eligibility for state financial support shall be contingent upon an approved contract and operating budget and certification in accordance with section 232a. Prior to the beginning of each state fiscal year, the department shall allocate state appropriated funds to the community mental health service programs in accordance with the approved contracts and budgets.

History: 1974, Act 258, Eff. Aug. 6, 1975 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996

330.1232a Rules; certification and review process standards; compliance.

Sec. 232a.

(1) Subject to section 114a, the department shall promulgate rules to establish standards for certification and the certification review process for community mental health services programs. The standards shall include but not be limited to all of the following:

(a) Matters of governance, resource management, quality improvement, service delivery, and safety management.

(b) Promotion and protection of recipient rights.

(2) After reviewing a community mental health services program, the department shall notify a program that substantially complies with the standards established under this section that it is certified by the department.

(3) The department may waive the certification review process in whole or in part and consider the community mental health services program to be in substantial compliance with the standards established under this section if the program has received accreditation from a national accrediting organization recognized by the department that includes review of matters described in subsection (1)(a).

(4) If the department certifies a community mental health services program despite some items of noncompliance with the standards established under this section, the notice of certification shall identify the items of noncompliance and the program shall correct the items of noncompliance. The department shall require the community mental health board to submit a plan to correct items of noncompliance before recertification or sooner at the discretion of the department.

(5) Certification is effective for 3 years and is not transferable. Requests for recertification shall be submitted to the department at least 6 months before the expiration of certification. Certification remains in effect after the submission of a renewal request until the department conducts a review and makes a redetermination.

(6) The department shall conduct an annual review of each community mental health services program's recipient rights system to ensure compliance with standards established under subsection (1)(b). An on-site review shall be conducted once every 3 years.

(7) The community mental health services program shall promptly notify the department of any changes that may affect continued certification.

(8) The department may deny certification if the community mental health services program cannot demonstrate substantial compliance with the standards established under this section.

(9) In lieu of denying certification, the department may issue a provisional certification for a period of up to 6 months upon receiving a plan of correction submitted by the community mental health services board. The department shall provide a copy of the review and the approved plan of correction to the board of commissioners of each county that established the county community mental health agency or created the community mental health organization or community mental health authority. A provisional certification may be extended, but the entire provisional period shall not exceed 1 year. The department shall conduct an on-site review to determine the community mental health services program's compliance with the plan of correction at least 30 days before the expiration of the provisional certification. A provisional certification automatically expires either on its original expiration date or the expiration date of the extension granted.

(10) If a community mental health services program is denied certification, fails to comply with an approved plan of correction before the expiration of a provisional certification, or fails to comply substantially with the standards established under this section, the department shall notify the community mental health services board and the board of commissioners of each county that established the agency or created the organization or authority of the department's intention to suspend, deny, or revoke certification. The notice shall be sent by certified mail and shall set forth the particular reasons for the proposed action and offer an opportunity for a hearing with the director of the department's division that manages contracts with community mental health services programs. If it desires a hearing, the community mental health services board shall request it in writing within 60 days after receipt of the notice. The department shall hold the hearing not less than 30 days or more than 60 days from the date it receives the request for a hearing.

(11) The director of the department's division that manages contracts with community mental health services programs shall make a decision regarding suspension, denial, or revocation of certification based on evidence presented at the hearing or on the default of the community mental health services board. A copy of the decision shall be sent by certified mail within 45 days after the close of the hearing to the community mental health services board and to the board of commissioners of each county that established the agency or created the organization or authority.

(12) A community mental health services board may appeal a decision made under subsection (11) as provided in chapter 4 of the administrative procedures act of 1969,

Act No. 306 of the Public Acts of 1969, being sections 24.271 to 24.287 of the Michigan Compiled Laws.

(13) During the period of certification, the department may conduct an unannounced review of a certified community mental health services program. The department shall conduct an unannounced review of a certified community mental health services program in response to information that raises questions regarding recipient health or safety. If the department finds, based on its review, that the community mental health services program does not substantially comply with the standards established under this section, the department shall provide notice and a hearing under subsections (10) and (11).

(14) If a community mental health services program fails to obtain or retain certification as a result of the department's review, has exhausted the time period for provisional certification, is not engaged in the process of appeal or appeal has been unsuccessful, and if no agreement has been reached by the department with the community mental health services program to assure certification compliance within a specified time period, the department shall within 90 days do both of the following:

(a) Cancel the state funding commitment to the community mental health services board.

(b) Utilize the funds previously provided to the community mental health services board to do 1 or more of the following:

(i) Secure services from other providers of mental health services that the department has determined can operate in substantial compliance with the standards established under this section and continue the delivery of services within the county or counties.

(ii) Provide the service.

(15) If state funding is canceled under subsection (14) and the community mental health services program is an authority created under section 205, the county or counties that created the authority are financially liable only for the local match formula established for the authority under chapter 3. If state funding is canceled under subsection (14) and the community mental health services program is a county community mental health agency or a community mental health organization, the county or counties that established the agency are financially liable for local match for all services contractually or directly provided by the department to residents of the county or counties in accordance with chapter 3.

(16) The department shall not utilize the certification process under this section to require a community mental health services program to become a community mental health authority. Community mental health authority status is voluntary as provided in section 205.

(17) Subject to section 114a, the department shall submit proposed rules for certification to public hearing within 6 months after the effective date of the amendatory act that added this section.

History: Add. 1995, Act 290, Eff. Mar. 28, 1996
Admin Rule: R 330.1001 et seq. of the Michigan Administrative Code.

330.1232a.amended Certification and review process standards; rules; compliance; waiver; plan to correct items of noncompliance; duration of certification; review of recipient rights system; notification of changes affecting certification; denial of certification; provisional certification; suspension, denial, or revocation of certification; appeal; review; actions by department; financial liability; community mental health authority status as voluntary.

Sec. 232a.

(1) Subject to section 114a, the department shall promulgate rules to establish standards for certification and the certification review process for community mental health services programs. The standards shall include but not be limited to all of the following:

(a) Matters of governance, resource management, quality improvement, service delivery, and safety management.

(b) Promotion and protection of recipient rights.

(2) After reviewing a community mental health services program, the department shall notify a program that substantially complies with the standards established under this section that it is certified by the department.

(3) The department may waive the certification review process in whole or in part and consider the community mental health services program to be in substantial compliance with the standards established under this section if the program has received accreditation from a national accrediting organization recognized by the department that includes review of matters described in subsection (1)(a).

(4) If the department certifies a community mental health services program despite some items of noncompliance with the standards established under this section, the notice of certification shall identify the items of noncompliance and the program shall correct the items of noncompliance. The department shall require the community mental health board to submit a plan to correct items of noncompliance before recertification or sooner at the discretion of the department.

(5) Certification is effective for 3 years and is not transferable. Requests for recertification shall be submitted to the department at least 6 months before the expiration of certification. Certification remains in effect after the submission of a renewal request until the department conducts a review and makes a redetermination.

(6) The department shall conduct an annual review of each community mental health services program's recipient rights system to ensure compliance with standards established under subsection (1)(b). An on-site review shall be conducted once every 3 years.

(7) The community mental health services program shall promptly notify the department of any changes that may affect continued certification.

(8) The department may deny certification if the community mental health services program cannot demonstrate substantial compliance with the standards established under this section.

(9) In lieu of denying certification, the department may issue a provisional certification for a period of up to 6 months upon receiving a plan of correction submitted by the community mental health services board. The department shall provide a copy of the review and the approved plan of correction to the board of commissioners of each county that established the county community mental health agency or created the community mental health organization or community mental health authority. A provisional certification may be extended, but the entire provisional period shall not exceed 1 year. The department shall conduct an on-site review to determine the community mental health services program's compliance with the plan of correction at least 30 days before the expiration of the provisional certification. A provisional certification automatically expires either on its original expiration date or the expiration date of the extension granted.

(10) If a community mental health services program is denied certification, fails to comply with an approved plan of correction before the expiration of a provisional certification, or fails to comply substantially with the standards established under this section, the department shall notify the community mental health services board and the board of commissioners of each county that established the agency or created the organization or authority of the department's intention to suspend, deny, or revoke certification. The notice shall be sent by certified mail and shall set forth the particular reasons for the proposed action and offer an opportunity for a hearing with the director of the department's division that manages contracts with community mental health services programs. If it desires a hearing, the community mental health services board shall request it in writing within 60 days after receipt of the notice. The department shall hold the hearing not less than 30 days or more than 60 days from the date it receives the request for a hearing.

(11) The director of the department's division that manages contracts with community mental health services programs shall make a decision regarding suspension, denial, or revocation of certification based on evidence presented at the hearing or on the default of the community mental health services board. A copy of the decision shall be sent by certified mail within 45 days after the close of the hearing to the community mental health services board and to the board of commissioners of each county that established the agency or created the organization or authority.

(12) A community mental health services board may appeal a decision made under subsection (11) as provided in chapter 4 of the administrative procedures act of 1969, 1969 PA 306, MCL 24.271 to 24.287.

(13) During the period of certification, the department may conduct an unannounced review of a certified community mental health services program. The department shall conduct an unannounced review of a certified community mental health services

program in response to information that raises questions regarding recipient health or safety. If the department finds based on its review that the community mental health services program does not substantially comply with the standards established under this section, the department shall provide notice and a hearing under subsections (10) and (11).

(14) If a community mental health services program fails to obtain or retain certification as a result of the department's review, has exhausted the time period for provisional certification, is not engaged in the process of appeal or appeal has been unsuccessful, and if no agreement has been reached by the department with the community mental health services program to assure certification compliance within a specified time period, the department shall within 90 days do both of the following:

(a) Cancel the state funding commitment to the community mental health services board.

(b) Utilize the funds previously provided to the community mental health services board to do 1 or more of the following:

(i) Secure services from other providers of mental health services that the department has determined can operate in substantial compliance with the standards established under this section and continue the delivery of services within the county or counties.

(ii) Provide the service.

(15) If state funding is canceled under subsection (14) and the community mental health services program is an authority created under section 205, the county or counties that created the authority are financially liable only for the local match formula established for the authority under chapter 3. If state funding is canceled under subsection (14) and the community mental health services program is a county community mental health agency or a community mental health organization, the county or counties that established the agency are financially liable for local match for all services contractually or directly provided by the department to residents of the county or counties in accordance with chapter 3.

(16) The department shall not utilize the certification process under this section to require a community mental health services program to become a community mental health authority. Except as provided in section 204(4), community mental health authority status is voluntary as provided in section 205.

History: Add. 1995, Act 290, Eff. Mar. 28, 1996 ;-- Am. 2012, Act 376, Eff. Mar. 28, 2013
Admin Rule: R 330.1001 et seq. of the Michigan Administrative Code.

330.1232b Specialty prepaid health plans.

Sec. 232b.

(1) The department shall establish standards for community mental health services programs designated as specialty prepaid health plans under the medicaid managed care program described in section 109f of the social welfare act, 1939 PA 280, MCL 400.109f. The standards established under this section shall reference applicable federal regulations related to medicaid managed care programs and specify additional state requirements for specialty prepaid health plans. The standards established under this section shall be published in a departmental bulletin or by an updating insert to a departmental manual.

(2) As a condition for contracting and for receiving payment under the medicaid managed care program, a community mental health services program designated as a specialty prepaid health plan shall certify both of the following:

(a) That the program is in substantial compliance with the standards promulgated by the department and with applicable federal regulations.

(b) That the program has established policies and procedures to monitor compliance with the standards promulgated by the department and with applicable federal regulations and to ensure program integrity.

(3) The department shall conduct an annual review of all community mental health services programs designated as specialty prepaid health plans to verify the declarations made by the community mental health services program and to monitor compliance with the standards promulgated for specialty prepaid health plans and with applicable federal regulations. The annual review process established under this section shall be published in a departmental bulletin or by an updating insert to a departmental manual.

(4) The department may conduct separate reviews of a specialty prepaid health plan in response to beneficiary complaints, financial status considerations, or health and safety concerns.

(5) Contracts with specialty prepaid health plans shall indicate the sanctions that the department may invoke if it makes a determination that a specialty prepaid health plan is not in substantial compliance with promulgated standards and with established federal regulations, that the specialty prepaid health plan has misrepresented or falsified information reported to the state or to the federal government, or that the specialty prepaid health plan has failed substantially to provide necessary covered services to recipients under the terms of the contract. Sanctions may include intermediate actions including, but not limited to, a monetary penalty imposed on the administrative and management operation of the specialty prepaid health plan, imposition of temporary state management of a community mental health services program operating as a specialty prepaid health plan, or termination of the department's medicaid managed care contract with the community mental health services program.

(6) Before imposing a sanction on a community mental health services program that is operating as a specialty prepaid health plan, the department shall provide that specialty prepaid health plan with timely written notice that explains both of the following:

(a) The basis and nature of the sanction.

(b) The opportunity for a hearing to contest or dispute the department's findings and intended sanction, prior to the imposition of the sanction. A hearing under this section is subject to the provisions governing a contested case under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, unless otherwise agreed to in the specialty prepaid health plan contract.

History: Add. 2002, Act 597, Imd. Eff. Dec. 3, 2002

330.1234 Services program; review of proposed contract and operating budget; criteria.

Sec. 234.

In reviewing a community mental health services program's proposed contract and operating budget for the purpose of approval or disapproval, in whole or in part, or in making an allocation of state appropriated funds to a community mental health services program, the department shall consider:

(a) The state's mental health needs.

(b) The annual plan and needs assessment of the community mental health services program.

(c) The state's need for a reasonable degree of statewide standardization and control of services.

(d) The community mental health services program's need for a reasonable degree of flexibility and freedom to design, staff, and administer services in a manner that the program considers appropriate to its situation.

(e) The community mental health services program's need for a reasonable expectation that services meeting an essential mental health need and that are appropriately designed and executed will receive continuing state financial support within the constraint of state funds actually appropriated by the legislature.

(f) The demonstrated relevancy, quality, effectiveness, and efficiency of the community mental health services program's services.

(g) The adequacy of the community mental health services program's accounting for the expenditure of state funds.

History: 1974, Act 258, Eff. Aug. 6, 1975 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996

330.1236 Services program; review of expenditures; withdrawal of funds.

Sec. 236.

At intervals during the year, the department shall review the expenditures of each community mental health services program, and if the department determines that funds that have been allocated to a program are not needed by that program, the department may, with the concurrence of the board, withdraw the funds. Funds so withdrawn may be reallocated by the department to other community mental health services programs. The department may withdraw funds that have been allocated to a community mental health services program when the funds are being expended in a manner not provided for in the approved contract and operating budget. The department shall establish standards related to the frequency and timing of expenditure reviews described in this section.

History: 1974, Act 258, Eff. Aug. 6, 1975 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996

330.1238 Review of actions involving disapproval of proposed contract and operating budget, allocation of funds, or withdrawal of funds; consultation.

Sec. 238.

If an executive director or a board specifically so requests, any action by the department involving a disapproval of a community mental health services program's proposed contract and operating budget, in whole or in part, or involving an allocation of funds to a community mental health services program or a withdrawal of funds from a community mental health services program, shall be reviewed in consultation with the affected executive director or board before the action is considered a final action. In any consultation, the representative of the community mental health services program shall be afforded a full opportunity to present his or her position.

History: 1974, Act 258, Eff. Aug. 6, 1975 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996

330.1240 Expenditures eligible for state financial support.

Sec. 240.

All expenditures by a community mental health services program necessary to execute the program shall be eligible for state financial support, except those excluded under section 242. Expenditures necessary to carry out the responsibilities and duties of a community mental health services program include expenditures for staff training and staff education and for mental health research when those expenditures are necessary or appropriate to the execution of the program.

History: 1974, Act 258, Eff. Aug. 6, 1975 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996

330.1241 Adult foster care facilities; expenses eligible for state financial support.

Sec. 241.

Expenditures for the maintenance and repair of adult foster care facilities owned or leased by a community mental health services program are eligible for state financial support. Expenses incurred in renovating an adult foster care facility that is leased or owned by a community mental health services program are also eligible for state financial support if the expenses are incurred for 1 or more of the following purposes:

(a) To correct physical plant deficiencies cited by the department of social services under state licensing rules.

(b) To purchase and install fire safety equipment or make physical plant changes that measurably assure a reasonable level of fire protection for all of the residents who live in the facility.

(c) To correct physical plant deficiencies in accordance with state and federal certification standards.

(d) To restore the facility to its prelease condition, if the facility's lease contains a clause stipulating that renovation is the lessee's responsibility at the time the lease expires or is terminated.

History: Add. 1995, Act 290, Eff. Mar. 28, 1996

330.1242 Expenditures ineligible for state financial support.

Sec. 242.

The following expenditures by a community mental health services program are not eligible for state financial support except as permitted under section 241 or by the department:

(a) The construction, purchase, remodeling, or any similar capital cost of a building or facility, except that such cost is eligible for state financial support on an annual expense basis in an amount equal to a fair rental value of the space or building being utilized.

(b) The capital cost of equipment or similar items in an amount greater than that established by the department.

(c) Any cost item that does not represent or constitute a real or actual expenditure by the community mental health services program except to expend from a reserve account established by the board, as provided in section 205.

(d) That part of any expenditure that is obviously and manifestly extravagant in relation to its specific objective and context.

(e) Any category of expenditure or any portion of any category of expenditure, the ineligibility of which the department determines is necessary and appropriate to assure the reasonable use of state funds or to assure a legitimate interest of the state, and

which determination is in accord with the intent and provisions of this chapter. Subject to section 114a, this subdivision shall be effectuated by rules promulgated by the department.

History: 1974, Act 258, Eff. Aug. 6, 1975 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996
Admin Rule: R 330.1001 et seq. of the Michigan Administrative Code.

330.1244 Additional powers and duties of department.

Sec. 244.

In addition to the duties and powers elsewhere provided in this chapter, the department shall do all of the following:

(a) Seek to develop and establish arrangements and procedures for the effective coordination and integration of state services and community mental health services programs.

(b) Review and evaluate, at times and in a manner the department considers appropriate, the relevancy, quality, effectiveness, and efficiency of community mental health services programs. In developing or operating its community mental health services program information system, the department shall not collect any information that would make it possible to identify by name any individual who receives a service from a community mental health services program. Any such information in the possession of the department before August 6, 1974 shall not be disclosed by the department.

(c) Provide technical consultative services to counties seeking to establish or improve a community mental health services program, and provide other technical consultative services to community mental health services programs as the department considers feasible and appropriate.

(d) Audit, or cause to be audited, the expenditure of state funds by community mental health services programs. Copies of audit reports shall be forwarded to the auditor general.

(e) Subject to section 114a, promulgate rules it considers necessary or appropriate to implement the objectives and provisions of this chapter.

History: 1974, Act 258, Eff. Aug. 6, 1975 ;-- Am. 1980, Act 423, Eff. Mar. 31, 1981 ;-- Am. 1986, Act 289, Imd. Eff. Dec. 22, 1986 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996
Admin Rule: R 330.1001 et seq. of the Michigan Administrative Code.

330.1245 Granting staff privileges to psychiatrists.

Sec. 245.

The directors of psychiatric hospitals operated by the department may grant staff privileges to psychiatrists employed by or under contract with a community mental

health services program under guidelines established by the hospital's governing body if requested by the executive director of the program. Staff privileges authorized under this section include the admission, treatment, and discharge of patients admitted from that program's service area. The credentials committee of the medical staff of the hospital shall review the credentials of all applicants for staff privileges and recommend to the hospital director the approval or disapproval of the granting of staff privileges to the applicant. Denial of a request for staff privileges may be appealed by the executive director to the hospital's governing board.

History: Add. 1986, Act 289, Imd. Eff. Dec. 22, 1986 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996

330.1246 Repealed. 1995, Act 290, Eff. Mar. 28, 1996.

Compiler's Notes: The repealed section pertained to Michigan conference of county community mental health programs.

B Y - L A W S

Approved October 16, 2012

A R T I C L E I
NAME

The name of this corporation shall be the COMMUNITY MENTAL HEALTH ASSOCIATION OF MICHIGAN, a Michigan non-profit corporation hereinafter referred to in these By-Laws as CMHAM or "Association."

A R T I C L E II
PURPOSE

CMHAM shall be an independent organization that represents community mental health services programs (CMHSPs) and the Medicaid prepaid inpatient health plans (PIHPs). Its purpose is to promote collective action to improve funding, governmental relations, public awareness, education, training, cultural competency, development of community-based services and advocacy on behalf of consumers and providers of mental health, developmental disabilities and substance abuse services.

A R T I C L E III
MEMBERSHIP

(A) Eligibility:

Any CMHSP duly established under the provisions of P.A. 258 of 1974 as amended shall be eligible for membership in this Association. Any other agency, organization, or individual interested in mental health services, and whose objectives are not in conflict with the purposes of this Association, may be eligible for affiliate status membership in this Association based on guidelines adopted by the Member Assembly (Addendum B).

(B) Membership Classifications:

The following are the membership classifications of the Association:

1. Full Member Status
   Full member status with voting and other appropriate rights shall be extended only to CMHSPs as described in the Michigan Mental Health Code and confirmed by the payment of annual membership dues. It should be noted that while the CMHSP as a legal entity is the member, it is represented as specified in Subsection (D) below.

2. Affiliate Status
Affiliate status may be extended to any agency, organization, corporation, or individual whose purpose is the delivery and/or support of community mental health services and whose activities and goals are consistent with guidelines adopted by the Member Assembly under Article III (A).

(C) Membership Dues:

Dues for the membership shall be based on a formula approved by the Member Assembly.

(D) Voting Privileges of CMHSPs:

Voting privileges in the meetings of the Member Assembly shall be composed of three (3) delegates from each member CMHSP: two (2) board members and one (1) CMHSP executive director. The executive director vote may not be reassigned to any other individual. Voting by proxy is expressly prohibited.

(E) Rights and Duties of Membership:

1. Persons representing full member status CMHSPs described in Article III (B) 1 shall be:

   (a) Eligible to hold office, serve as a member of the Executive Board, and/or as chairperson or member of any committee;
   (b) Entitled to participate in the meetings of the Member Assembly, regional meetings, or other meetings of the Association;
   (c) Entitled to vote in the election of officers, regional representatives, members-at-large of the Executive Board, and on any matters of business coming before the membership at any meeting of the Member Assembly, according to the provisions of Article III (D) of these By-Laws;
   (d) Entitled to receive mailings and publications of the Association;
   (e) Entitled to attend and participate in programs sponsored by the Association;
   (f) Entitled to participate in and receive services provided by the Association; and
   (g) Entitled to receive and process data information requests provided by the Association.

2. All affiliate members described in Article III (B) 2 shall be entitled to:

   (a) Receive mailings and publications of the Association;
   (b) Attend and participate in designated programs sponsored by the Association;
   (c) Attend meetings of the Member Assembly;
   (d) Attend meetings of Standing Committees to provide input on the range of issues addressed by these committees. However, they are not voting members and, at the discretion of the co-

chairpersons, attendance at a meeting or portion thereof may be limited to CMHSP, PIHP, and designated “at large” provider representatives.

(e) Subject to guidelines adopted by the Member Assembly, receive services provided by the Association; but

(f) Excludes the privileges of voting, holding office, serving as standing committee co chairs, or Executive Board membership except as described in Article III (E) 3.

3. Certain affiliate members as described in Article III (B) 2 shall be designated as “at large” provider representatives. These “at large” representatives shall be identified through a process determined by meetings of the affiliate provider membership. Both the process for identifying designees and the recommended designees shall be subject to approval by the Executive Board.

   Individuals who serve as elected or appointed officers of advocacy organizations shall not be eligible to serve as such representatives.

   (a) Four (4) “at large” representatives as described in Article III (E)3 shall be designated as voting members to the Association’s Member Assembly meetings. These four designees shall represent:
   (1) Providers of services to children with serious emotional disturbances
   (2) Providers of services to adults with psychiatric disorders
   (3) Providers of services to persons with developmental disabilities.
   (4) Providers of services to persons with substance use disorders

   (b) Four (4) “at large” provider representatives as described in Article III (E)3 shall be designated as voting members of the Executive Board. These four designees shall represent:
   (1) Providers of services to children with serious emotional disturbances
   (2) Providers of services to adults with psychiatric disorders
   (3) Providers of services to persons with developmental disabilities.
   (4) Providers of services to persons with substance use disorders.

   (c) Four (4) “at large” representatives as described in Article III (E)3 shall be designated as voting members of each of the Association’s standing committees as described in Article X. Standing Committees. These four designees to each standing committee shall represent:
   (1) Providers of services to children with serious emotional disturbances
   (2) Providers of services to adults with psychiatric disorders
   (3) Providers of services to persons with developmental disabilities.
   (4) Providers of services to persons with substance use disorders

(F) Termination of Membership:

1. Membership in the Association shall be automatically terminated for failure to pay dues within 120 days of the beginning of the Association's fiscal year. Any exception to this policy requires approval of the Executive Board.
2. Any member may resign by submitting a letter of resignation to the CMHAM Secretary.
3. Affiliate members may be terminated for cause based on conduct that is injurious to the Association, or is contrary to or destructive of the purpose of the Association as described in Article II. Termination for cause as described above may only occur upon a motion for termination approved by two thirds vote of the Executive Board. Such a motion shall only be made following a fair and reasonable procedure by which the affiliate member has the opportunity to defend the action(s) which form the basis for termination.
4. No portion of dues paid by a member who resigns or whose membership is terminated is refundable.

A R T I C L E IV
MEETINGS OF THE MEMBER ASSEMBLY

(A) Function and Authority

The Member Assembly is the final authority for all matters before the Association related to policy making, goal setting and overall management of the organization and its resources, and shall approve the Association strategic plan.

(B) Voting

Each Member CMHSP shall designate its voting delegates to vote on matters coming before the Association, in accordance with Article III (D), each of whom shall have one vote.

(C) Meetings of the Member Assembly:

The Association shall hold at least two (2) meetings of the Member Assembly annually. The sites of the meetings shall be at such locations within the State of Michigan as the Executive Board shall determine.

(D) Special Meetings of the Member Assembly:

Special meetings of the Member Assembly may be called by the President or by a majority vote of the Executive Board or by a petition signed by at least fifty percent (50%) of member CMHSPs.

(E) Notice:

Written notice of the meetings of the Member Assembly shall be by mail, posted at least thirty (30) days prior to said meeting. The notice of a special meeting or adjourned meeting shall be by the most expedient method possible, and must be in a manner calculated to reach each member CMHSP at least seven (7) days prior to said meeting. The notice of any meeting shall state the time and place of the meeting, and the purpose or purposes of the meeting. No action taken at such a meeting shall be invalid for want of notice if duly waived by two-thirds (2/3) of the delegates present and eligible to vote.

(F) Quorum:

The presence of fifty percent (50%) of the member CMHSPs eligible to vote shall constitute a quorum for the transaction of business at any meeting of the Member Assembly and the members may continue to transact business until adjournment notwithstanding the withdrawal of enough members to leave less than a quorum.

(G) Meeting Agenda:

1. An agenda of the items to be considered at each meeting of the Member Assembly shall be established by the Executive Board and mailed to each member CMHSP not less than fifteen (15) days preceding a regular scheduled meeting. Items not on a regular agenda may be considered only with the approval of two-thirds (2/3) of the delegates present and eligible to vote.

2. Special Meeting Agenda:
   The agenda for any special meeting called by the President, Executive Board or Association petition, shall be mailed with the notice of such meeting. The agenda of a special meeting may not be amended nor added to by vote of the membership present.

(H) It shall be the intent of the Association to provide the membership with the opportunity for input on all issues affecting CMHSPs when the time frames for the resolution of issues and providing a system response allow for that input.

ARTICLE V
REGIONS

(A) It is the intention of the Association to support a strong regional structure to facilitate local input to Association decision making and to identify and bring to the Association problems, issues and concerns. Regions may also function as informational forums and decision making bodies for issues unique to their region. A CMHSP may make a request to the Executive Board that it be transferred to another region. Such a transfer will be effective when approved by a majority vote of the Executive Board. When the Executive Board approves a transfer, Addendum A will be adjusted to reflect the new regional alignment.

(B) The regions are defined as follows:

1. Northern
2. Central
3. Western
4. Southeast
5. Metro
6. Upper Peninsula

See Addendum A for regional membership by CMHSP.

(C) Each region shall be responsible for the following on an annual basis:

1. Electing a regional chairperson to preside over all regional meetings.
2. Electing a regional secretary to take minutes of all regional meetings and to be responsible for all regional correspondence on Association matters.
3. Electing regional representatives to the Executive Board and selecting alternates for those representatives as described in Article VII (C) to present positions; raise issues identified by regions as having Association-wide impact; and report to the region on the Board's activities.
4. Appointing two regional representatives as liaisons to each of the Standing Committees of the Association as specified in Article X (C), and representatives to any special task forces, workgroups or ad hoc committees as requested by the President of the Association to present regional positions; participate in an Association-wide process of resolution and decision making; and report to the region of the group's activities.
5. Electing regional representatives to the Nominating Committee, By-Laws Committee, the Budget & Finance Committee and certain Related Organizations (see Addendum C).

ARTICLE VI
OFFICERS

(A) Officers:

Officers of this Association shall be a President who shall be a CMHSP board member, a First Vice-President who shall also be a CMHSP board member, a Second Vice-President, a Treasurer, a Secretary and the immediate Past President, all of whom must be CMHSP board members or Executive Directors of CMHSPs. Not more than two (2) officers shall be from the same Association region as designated in Article V (B).

(B) President:

The President shall preside at all meetings but may, at the President's discretion, arrange for presiding officers at any meetings. The President shall appoint the co-chairpersons of all Standing Committees and be a member thereof. The

President may appoint ad hoc committees as needed. The President shall notify the membership of the committee appointments upon completion thereof. The President shall be Chairperson of the Personnel Committee. The President shall be chairperson of the Executive Board. The President shall perform such duties as are usually incumbent upon the office of President, or as may be authorized by resolution of the membership.

(C) Vice-Presidents:

1. In the absence of the President, the First Vice-President shall perform the duties of the President. Other duties of the Vice-Presidents will be at the discretion of the President.

2. In the absence of the President and the First Vice-President, the Second Vice-President shall perform the duties of the President.

(D) Treasurer:

The Treasurer shall assure that all funds are received and disbursed or otherwise accounted for, that an accurate accounting of all financial transactions is maintained, that an audit report of all receipts and disbursements is presented to the Executive Board on an annual basis, and that a financial report shall be submitted for review at each Member Assembly and Executive Board meeting. The Treasurer shall serve as chairperson of the Budget and Finance Committee.

(E) Secretary:

The Secretary shall assure that minutes of the official proceedings are kept and shall be responsible for records and files of the Association and the Executive Board. The Secretary shall assure that notices of all meetings will be sent to the membership of the Association and the Executive Board. The Secretary shall perform such duties as are usually incumbent upon the office of Secretary or as may be prescribed by the President, the Executive Board or the membership.

(F) Election and Term of Office:

Officers shall be elected by majority vote of the official delegates present and representing Member CMHSPs as defined by Article III (D) at the annual meeting of the Member Assembly designated for the election of officers and shall take office at the adjournment of the meeting. Officers shall serve one year or until their successors have been elected. A vacancy occurring in any office shall be filled by a majority vote of the Executive Board. The candidate so elected shall serve the unexpired balance of the term.

For all offices except President, a Board Member or Director can serve no more than four (4) consecutive years as an Association officer, as elected by the membership, (excluding any time served when appointed to fill a vacancy by the Executive Board). For the office of President, a Board Member must serve in at

least one other officer position but not more than 6 consecutive years as an officer, including the position of President.

In addition, officers of the Association are prohibited from simultaneously serving as a co-chairperson of any Standing Committee.

(G) Election of Officers:

1. Nominations:

The President shall appoint the chair of the Nominating Committee. Each region shall designate one member to serve on the Committee. The Committee shall solicit from each CMHSP suggestions for nominations for the officer positions beginning at least three months before the election. Nominations for office from individual CMHSPs shall be sent to the regional chairperson and to the Association office. All regions will consider nominations made by CMHSPs in their regions and recommend a roster of candidates to be nominated. Each region may nominate a candidate for each of the officer positions to be elected. The region shall send their roster of candidates to the Nominating Committee for submission to the membership. Persons may also be nominated for office by individual CMHSPs. If the individual has not been selected as part of the regional roster, they shall be reported to the membership.

2. Notice:

The Nominating Committee shall mail a slate listing all nominees together with biographical data to all members at least forty-five (45) days prior to the annual meeting of the Member Assembly designated for the election of Association officers and the slate shall be presented to the membership at that meeting. Nominations may be made from the floor during the annual election of officers provided that the nominee has given consent.

3. Election:

Officers shall be elected in the following order: President, First Vice-President, Second Vice-President, Treasurer, Secretary. There shall be no absentee or proxy voting.

(H) Removal from Office:

An elected officer may be removed from his or her position for misfeasance or nonfeasance when a two-thirds (2/3) vote of a meeting of the Member Assembly indicates that it would be in the best interests of the Association to do so. The Executive Board by majority vote may remove any elected officer who has accumulated three (3) unexcused absences at regular or special Executive Board meetings, or meetings incumbent upon his or her official duties within the elected officer's term of office.

A R T I C L E VII
EXECUTIVE BOARD

(A) The Executive Board has the charge and authority to manage the organization and act on behalf of the organization in a manner which is consistent with the policy, goals and purpose established by the full membership in meetings of the Member Assembly. The Executive Board shall implement and ensure the actions of the strategic plan. At the direction of the President and Executive Board, all policies will be reviewed on an annual basis.

(B) There will be an Executive Board consisting of: the officers of the Association; regional representatives composed of three (3) representatives from each of the regions, one of these representatives shall be an Executive Director and two (2) shall be board members; and Standing Committee co-chairpersons. Voting membership on the Executive Board is limited to the above.

(C) Regional Representatives:

1. Regional representatives to the Executive Board shall be elected by delegates in each region for three-year terms. One-third of the regional representatives shall be elected each year.

2. Vacancy:

   The unexpired term of a regional representative to the Executive Board shall be filled in the manner as provided in this Article. When a regional representative resigns or is removed from office before his or her term expires, the appropriate regional alternate shall serve the remainder of the unexpired term. Should the alternate be unwilling or unable to serve, the region may elect a new regional representative to serve for the remainder of the unexpired term at its next regularly scheduled meeting or at a special regional meeting which may be called at the discretion of the regional chairperson. The new regional representative shall assume the duties of the regional representative he or she replaces immediately upon election.

3. Removal:

   A regional representative may be removed from his or her position for misfeasance or nonfeasance when a two-thirds (2/3) vote of the Association decides that it would be in the best interests of the Association to do so. The Executive Board by majority vote may remove any regional representative who has accumulated three (3) unexcused absences at Executive Board meetings, regular or special, within the regional representative's term of office.

(D) Each region shall be represented by its designated representatives or their alternates. Each region shall select an alternate board member and an alternate Executive Director who may vote on matters before the Executive Board in the

absence of the regional representative for whom they are designated as an alternate.

(E) The co-chairpersons of all Standing Committees shall be members of the Executive Board and shall report on the recommendations of their respective Committees at each meeting of the Executive Board.

(F) Executive Board Meetings:

1. Meetings:

The Executive Board will meet at least six (6) times annually, at such time and in such place as it shall direct. Meetings of the Executive Board may be called by the President or by written notice signed by one-half (½) of the members of the Executive Board. Meetings may be conducted in person, by audio or video conference, or by a combination of the above.

2. Notice:

All meetings of the Executive Board shall be called by means of actual notice, written or oral, to each Executive Board member, at least seven (7) days prior to a meeting, stating the time, date, place and purpose of the meeting. No action taken at such a meeting shall be invalid for want of notice if duly waived by two-thirds (2/3) of the Executive Board.

3. Quorum:

The presence **(**including audio or video conference participation**)** of fifty percent (50%) of the members of the Executive Board eligible to vote shall constitute a quorum for the transaction of business at any meeting of the Executive Board and the members may continue to transact business until adjournment notwithstanding the withdrawal of enough members to leave less than a quorum.

A R T I C L E VIII
STEERING COMMITTEE

(A) The Steering Committee shall consist of the Association officers and Standing Committee co-chairpersons. The presence **(**including audio and video conference participation**)** of fifty percent (50%) of the members of the Steering Committee shall constitute a quorum for the transaction of business at any meeting of the Steering Committee and the members may continue to transact business until adjournment notwithstanding the withdrawal of enough members to leave less than a quorum.

(B) The Steering Committee shall serve as the Communication Committee. The Communication Committee shall endeavor to meet on a monthly basis with the mental health and substance abuse director within the Department of Community Health (DCH) and key administrative staff to discuss and resolve critical issues identified by Association members in a timely manner.

(C) The Steering Committee shall determine the agenda for Executive Board meetings and deal with emergencies when the Executive Board is not meeting. The Steering Committee may act upon recommendations made by Standing Committees and make decisions regarding Association positions when time does not allow for a greater level of membership input. The Steering Committee shall receive updates from the Executive Directors' Forum and may refer the recommendations to the appropriate committee.

(D) The Steering Committee shall be responsible for ensuring the development and monitoring of the strategic plan.

(E) The Steering Committee may communicate Association positions on issues affecting mental health and substance abuse services or consumers to departments and agencies of state government, the Governor, the Legislature or the general public when the timing of resolutions of such issues requires an immediate response. A summary of these communications shall be provided to the Executive Board and the Member Assembly.

A R T I C L E IX
ADMINISTRATIVE COMMITTEES

(A) The Administrative Committees shall exist in the areas of Budget & Finance, Personnel and By-Laws.

Budget & Finance Committee: On an annual basis, each region shall be responsible for electing a regional representative to the Budget & Finance Committee. CMHAM officers will also serve on the Committee. CMHAM's Treasurer shall serve as chairperson. The Budget & Finance Committee will develop and monitor the budget for each fiscal year, which shall be October 1 to September 30 and shall recommend this budget and the annual dues to be levied to the Executive Board for approval and referral to the Member Assembly. The Committee shall also oversee financial operations of the Association.

(C) Personnel Committee: CMHAM officers will serve as the Personnel Committee. The President shall serve as chairperson. The Personnel Committee will conduct an annual evaluation of the CEO, establish the CEO goals for the following year (based on the strategic plan), and the CEO compensation package based on input from the Executive Board, and present to the Executive Board for approval.

(D) By-Laws Committee: On an annual basis, each region shall be responsible for electing a regional representative to the By-Laws Committee. CMHAM officers will also serve on the Committee. The President shall appoint the chair of the Committee. The By-Laws Committee will meet once, at a minimum, each year to discuss any revisions to the By-Laws.

A R T I C L E X
STANDING COMMITTEES

(A) Standing Committees shall exist in the areas of Contract and Financial Issues, Member Services, Legislation, Policy, and Children's Issues to provide a focused and formal setting for resolution of issues that have been identified by the membership as having Association-wide impact. A Standing Committee must meet the stipulation that its topic/interest withstands the test of time. Each Standing Committee shall have a statement of purpose, scope and function which is approved by the Executive Board and shall develop an annual plan for its activities. This annual plan shall be consistent with the strategic plan and be approved by the Executive Board.

(B) Participation on all Association Standing Committees is encouraged. Every CMHSP is entitled to a maximum of three votes at any meeting. Executive Directors may assign CMHSP staff to attend Standing Committee meetings or subcommittees.

(C) Committee decisions at meetings will generally be made by consensus of the persons attending. In cases where a vote is deemed necessary, the decision will be made by a vote of the persons attending. If the meeting is conducted by audio or video conference, decisions will be made in the same manner.

(D) All regions shall appoint one board member and one Executive Director to each of the Standing Committees. The co-chairpersons of each committee shall be appointed by the President with the advice and input of the Executive Board. Each Standing Committee may have one co-chairperson who is a board member and one co-chairperson who is an Executive Director of a member CMHSP. Co-chairpersons of Standing Committees are limited to six (6) consecutive years as co-chairperson of any Standing Committee.

(E) The co-chairpersons of each Standing Committee shall have the authority to appoint subcommittees and assign chairpersons to those subcommittees as needed. Any subcommittees that are established shall make a report on a regular basis to the Standing Committee under whose authority they are formed. Standing Committee co-chairpersons may speak officially for the Association when specifically approved by the Executive Board, either in Board-approved committee annual plans or by specific Board action.

(F) Standing Committee co-chairpersons shall be members of the Steering Committee and the Executive Board to enable them to report recommendations regarding matters that require immediate attention and to determine issues which may properly be placed before the Member Assembly in a timely manner. Standing Committees may not make any representations on behalf of the Member Assembly, unless the positions taken on the issue at hand have been affirmed by the Steering Committee at a minimum.

(G) Standing Committees may direct the Association Executive Director to represent committee positions in preliminary work on issues affecting the community

mental health system and to engage in preliminary research or follow-up on issues properly before each committee.

(H) At the first Standing Committee meeting following the annual election of officers, each Standing Committee shall elect one vice co-chairperson from the committee who is a board member and one vice co-chairperson from the committee who is an Executive Director of a CMHSP.

(I) Committee and other workgroup members (including sub-committee members, delegates to joint committees with DCH, etc.) are named as advisors. As such they have the responsibility to offer their experience and knowledge to the group and to communicate discussions, recommendations and their own positions back to the Association. They may not speak officially for the Association unless such a delegated or redelegated responsibility is clearly spelled out by the Executive Board.

A R T I C L E XI
STAFF

The Executive Board will employ or otherwise provide for an Executive Director (CEO), who will employ other such staff as may be necessary to implement the purpose, policies, and goals of the Association within the approved budget. At no time may any Association staff serve as a delegate to the Association nor be entitled to vote as a representative of a member CMHSP.

A R T I C L E XII
RESOLUTIONS

Resolutions which are submitted to the Association Secretary a minimum of sixty (60) days prior to the meeting of the Member Assembly will be considered by the membership at that meeting. In such cases, the resolution must be mailed to member CMHSPs forty-five (45) days prior to the meeting.

A R T I C L E XIII
AMENDMENTS

Amendments to these By-Laws may be made at any meeting of the Member Assembly [Association] by vote of the member CMHSPs, provided the proposed amendments have been submitted to the member CMHSPs not less than forty-five (45) days prior to such meeting in order to allow adequate time for regional review. Such amendments shall be adopted by two-thirds (2/3) of the delegates present and eligible to vote.

A R T I C L E XIV
PARLIAMENTARY AUTHORITY

The rules contained in Robert's Rules of Order Revised shall govern this Association in all cases to which they are applicable and in which they are not inconsistent with these

By-Laws. The Association may suspend Robert's Rules of Order Revised by a two-thirds (2/3) vote of the delegates present and eligible to vote. The Association may also establish its own "rules of order" to facilitate the functioning and inter-facing of the various substructures of the Association. These rules of order may be established or revised at any meeting of the Member Assembly by two-thirds (2/3) vote of delegates present and eligible to vote but would not require prior review -- although such prior review would be desirable if possible.

A R T I C L E XV
RELATED ORGANIZATIONS

The Association may establish such subsidiaries and other related organizations as are necessary to effectively carry out its purpose. Changes to the Related Organizations, which are described in Addendum C, shall be approved by the Executive Board.

ADDENDUMS:

A. CMHAM Regions
B. CMHAM Affiliate Member Guidelines
C. Related Organizations

Revised December 3, 1993; January 25, 1994; May 26, 1996, February 3, 1999; October 14, 2003; March 1, 2006; October 23, 2007; May 20. 2009; May 18, 2011

CMHAM REGIONAL STRUCTURE

9/30/2003

CENTRAL REGION

BAY-ARENAC BEHAVIORAL HEALTH
CMH FOR CENTRAL MICHIGAN (Clare, Gladwin, Isabella, Mecosta, Midland and Osceola Counties)
GRATIOT COUNTY CMH SERVICES
HURON BEHAVIORAL HEALTH
LAPEER COUNTY CMH SERVICES
ST. CLAIR COUNTY CMH SERVICES
SAGINAW COUNTY CMH AUTHORITY
SANILAC COUNTY CMH
TUSCOLA BEHAVIORAL HEALTH SYSTEMS

METRO REGION

DETROIT-WAYNE COUNTY CMH AGENCY
MACOMB COUNTY CMH SERVICES
OAKLAND COUNTY CMH AUTHORITY

NORTHERN REGION

AU SABLE VALLEY CMH SERVICES (Iosco, Ogemaw & Oscoda Counties)
CENTRA WELLNESS (formerly MANISTEE-BENZIE CMH)
NORTH COUNTRY CMH (Antrim, Charlevoix, Cheboygan, Emmet, Kalkaska & Otsego Counties)
NORTHEAST MICHIGAN CMH SERVICES (Alcona, Alpena, Montmorency & Presque Isle Counties)
NORTHERN LAKES CMH AUTHORITY (Crawford, Grand Traverse, Leelanau, Missaukee, Roscommon & Wexford Counties)

SOUTHEAST REGION

CMH AUTHORITY OF CLINTON-EATON-INGHAM COUNTIES
GENESEE COUNTY CMH SERVICES
LENAWEE CMH AUTHORITY
LIFEWAYS (Hillsdale & Jackson Counties)
LIVINGSTON COUNTY CMH SERVICES
MONROE COUNTY CMH AUTHORITY
SHIAWASSEE COUNTY CMH SERVICES
WASHTENAW COMMUNITY HEALTH ORGANIZATION

U.P. REGION

COPPER COUNTRY CMH SERVICES (Baraga, Houghton, Keweenaw & Ontonagon Counties)
GOGEBIC CMH AUTHORITY
HIAWATHA BEHAVIORAL HEALTH (Chippewa, Mackinac, & Schoolcraft Counties)
NORTHPOINTE BEHAVIORAL HEALTHCARE SYSTEMS (Dickinson, Iron & Menominee Counties)
PATHWAYS (Alger, Delta, Luce, Marquette Counties)

WESTERN REGION

ALLEGAN COUNTY CMH SERVICES
BARRY COUNTY CMH SERVICES
BERRIEN MENTAL HEALTH AUTHORITY
CASS COUNTY CMH AUTHORITY (d/b/a Woodlands Behavioral Health)
IONIA COUNTY CMH
KALAMAZOO CMH SERVICES
THE MONTCALM CENTER FOR BEHAVIORAL HEALTH
CMH SERVICES OF MUSKEGON COUNTY
NETWORK180 (Kent)
NEWAYGO COUNTY MENTAL HEALTH CENTER
OTTAWA COUNTY CMH
PINES BEHAVIORAL HEALTH SERVICES (Branch County)
CMH SERVICES OF ST. JOSEPH COUNTY
SUMMIT POINTE (Calhoun County)
VAN BUREN COUNTY MENTAL HEALTH
WEST MICHIGAN CMH SYSTEM (Lake, Mason and Oceana Counties)

ADDENDUM C
RELATED ORGANIZATIONS

(A) Michigan Coordinated Behavioral Healthcare

1. Michigan Coordinated Behavioral Healthcare (MCBH) is a wholly-owned not-for-profit subsidiary of the Community Mental Health Association of Michigan (CMHAM). Its purpose is to support CMHSPs and PIHPs in promoting, maintaining and improving a comprehensive range of community-based mental health services. It is able to offer services to members such as pension, health care and other fringe benefit plans.

2. MCBH shall be governed by a board of directors consisting of one member elected from each Association region plus the co-chairpersons of the Member Services Committee. Staff members of the Association shall serve as the officers of this subsidiary as defined in its articles [acts] of incorporation.

3. MCBH shall report at least annually to the Association Executive Board.

(B) The Standards Group

1. The purpose of The Standards Group (TSG) is to develop recommendations for uniform and consistent administrative, programmatic and business practice standards for state-wide use. TSG also supports Medicaid prepaid inpatient health plans (PIHPs) in successfully accomplishing their management and service delivery responsibilities through policy analysis and interpretation and technical assistance aimed at successful compliance with relevant state and federal policies and requirements.

2. TSG shall be governed by a board of directors comprised of one representative from each PIHP as designated by the PIHP. The board of directors may add other members that are representative of the Department of Community Health, consumers, family members and other stakeholders. Leadership of TSG is elected by the TSG board of directors.

3. TSG shall report at least quarterly to the Association Steering Committee and Executive Board, but otherwise shall operate independently of the Association review and approval processes.

(C) Executive Directors' Forum

1. The Executive Directors' Forum is an informal grouping of the Association's executive directors. The purpose of the Executive Directors' Forum is to provide a venue for all CMHSP and PIHP executive directors to meet, discuss and agree on joint actions related to issues of current import.

2. The Executive Directors' Forum shall meet several times a year and elect its own officers.

3. The Forum may vote recommendations and other comments to be presented to the Association Steering Committee.

(D) CMH*PAC

1. CMH*PAC is a political action committee established by the Association under the Campaign Finance Act (P.A. 388 of 1974) and registered with the Michigan Secretary of State.

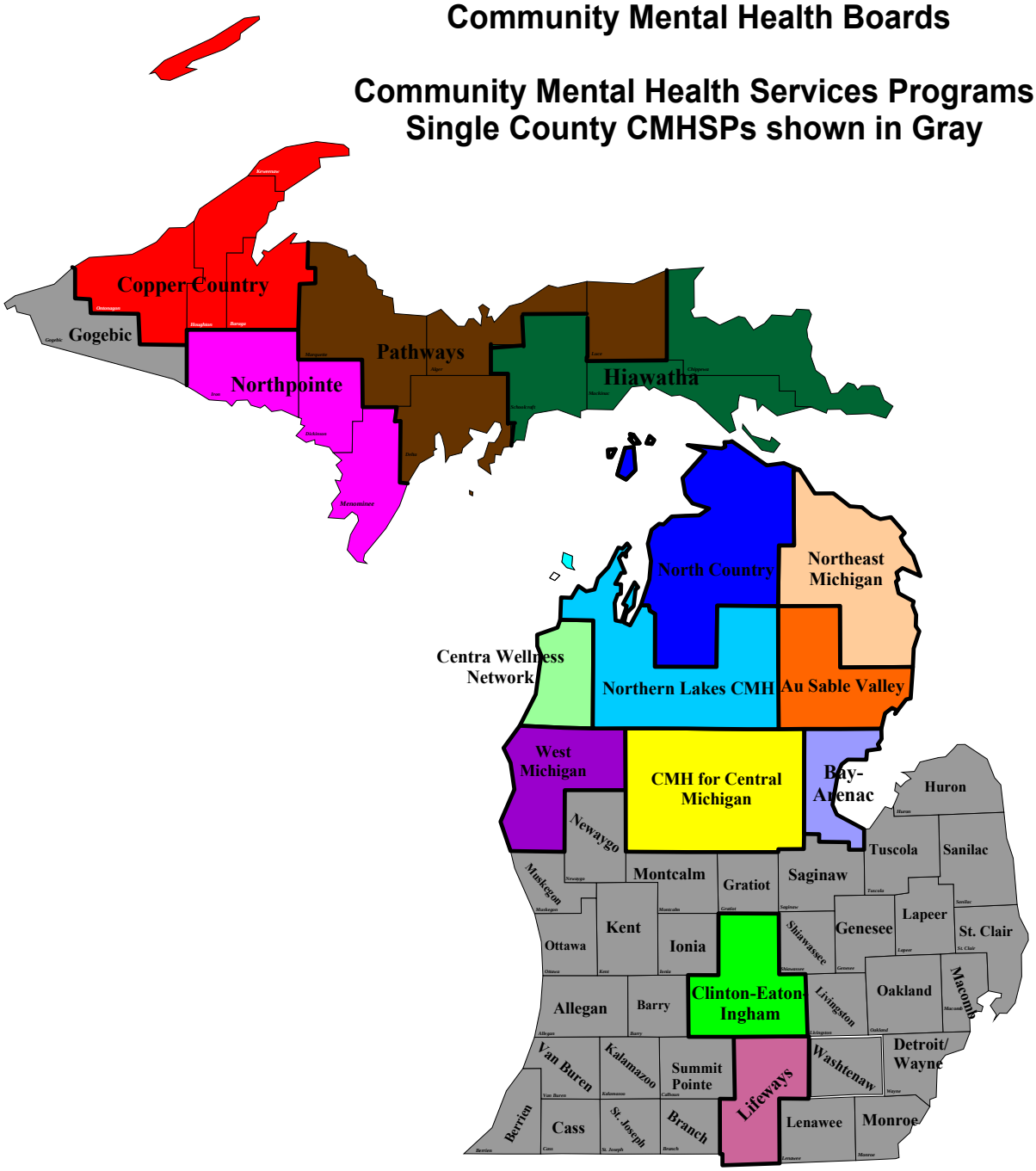
2. The purpose of the CMH*PAC is to solicit voluntary contributions from CMH board members, executive directors and eligible employees to support Association lobbying activities. Expenditures from these contributions provide campaign support to state and federal legislators who are familiar with and supportive of the public mental health and substance abuse system or who hold committee assignments having jurisdiction over health/mental health issues or positions of leadership.

3. The CMH*PAC shall be governed by a board consisting of the Executive Director of the Association, one member elected by each region, and up to three at-large members appointed by the President of the Association. The Executive Director shall chair this board. **This board shall meet at least two (2) times annually to review CMH PAC related issues.**

4. A full report of CMH*PAC contributions and expenditures shall be provided at every Association Member Assembly and Executive Board meeting.

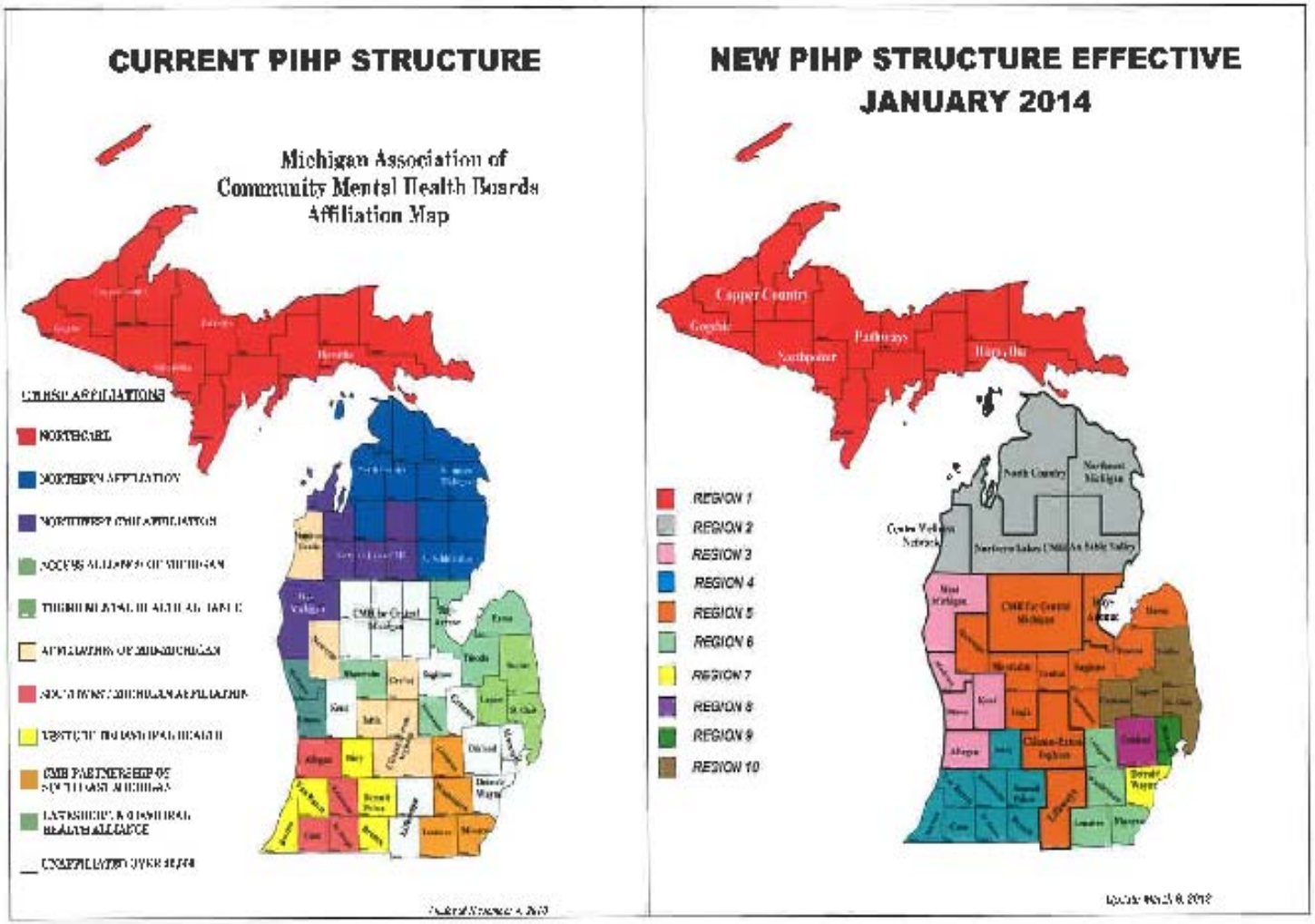
Michigan Association of Community Mental Health Boards

Community Mental Health Services Programs
Single County CMHSPs shown in Gray



Update March 8, 2013

Prepaid Inpatient Health Plan (PIHP) Consolidation



Glossary of Terms & Acronyms

ABW	Adult Benefit Waiver
ACA	Affordable Care Act
ACMH	Association for Children's Mental Health
ACO	Affordable Care Organization
BHDDA	Behavioral Health and Developmental Disabilities Administration
CA	Coordinating Agency
CMHSP	Community Mental Health Service Provider
DCH	Department of Community Health
DD/ID	Developmental/Intellectual Disabilities
DMH	Department of Mental Health
EBP	Evidence Based Practices
GF/GP	General Fund/General Purpose
FQHC	Federally Qualified Health Centers
ISF	Internal Service Fund
IT	Information Technology
CMHAM	Community Mental Health Association of Michigan
MCBH	Michigan Coordinated Behavioral Healthcare
MHA	Mental Health Association
MI	Mental Illness
NACBHDD	National Association of County Behavioral Health and Developmental Disabilities Directors
NACBHDD	National Council for Community Behavioral Healthcare
NAMI	National Association of Mental Illness
NASMHPD	National Association of State Mental Health Program Directors
OBRA	Omnibus Reconciliation Act
PASARR	Preadmission Screening and Resident Review
PAC	Political Action Committee
PCP	Person-Centered Planning
PIHP	Pre-Paid Inpatient Health Plan
SAAS	State Association of Addiction Services
SED	Serious Emotional Disturbance
SUD	Substance Use Disorders
TSG	The Standards Group

Boardworks 2.0
Governance and Leadership Development Education Program

Program Description

Boardworks 2.0, initiated in 2007, is organized on a public policy platform with four core components — the four pillars that provide direction, parameters and support. These four components are interrelated but also have a sequential nature about them. Although learning is not required to be completed in a sequential order, the interrelationship and the sense of order is necessary in pulling all of the learning together into a coherent package: the learning agenda.

Foundations: Boards need to first have an understanding of the foundations of their existence. This is accomplished through developing an understanding of the public policy origins and history of the community system as well as where the system is presently and what the future most likely holds. Central to the establishment of a foundation is development of an understanding of "who" is intended to benefit from the public policy the Board is charged to advance. Workshops include:

1. **PUBLIC POLICY** In this workshop you explore the historical origins (particularly related to Michigan), contemporary perspective, and the probable future of the public policy-driven community system through examination and exploration of the following:
    - Evolution of the Michigan Mental Health Code and federal statutes.
    - Eras of the consumer movement.
    - Eras of the community system.
    - Current and near future critical public policy expectations.

2. **INTENDED BENEFICIARY OWNERSHIP** In this workshop you will focus on the public policy expectations of intended beneficiaries from the community system through the examination and exploration of the following:
    - Relationship between the Board and intended beneficiaries (community and individual beneficiaries).
    - Opportunities and strategies for promoting and supporting intended beneficiaries (individual beneficiaries) in leadership, administrative, management and in the provision of supports, services, care and treatment.
    - Opportunities and strategies for promoting and supporting intended beneficiaries (community and individual beneficiaries) in community system assessment, evaluation, planning, implementation, management, monitoring and improvement efforts.

- Opportunities and strategies for promoting and supporting intended beneficiaries (individual beneficiaries) choice as an informed, responsible and prudent purchaser.

3. **INTENDED BENEFICIARY ORIENTATION** In this workshop you will address the public policy expectations of the community system, reflecting intended beneficiaries as the sole purpose of the existence of the community system itself, through the examination and exploration of the following:
    - Commitment to the Life Plan (person-centered planning and support).
    - Self-determination principles.
    - Recovery orientation.
    - Resiliency perspective.
    - Cultural representation and proficiency.
    - Community partnerships and collaboration.
    - Supporting community capacity building.

Leadership: Boards require an understanding of their responsibilities and corresponding authority as a collective body as well as individual members. This includes developing an understanding of governance structures, processes, practices and relationships with executive leadership as well as the nature of the character required of Board members. Workshops include:

1. **FUNDAMENTALS** In this workshop you will focus on the functional, operational, organizational and relational aspects of the Board through the examination and exploration of the following:
    - Role, responsibilities, and authority of the Board as individual members, as elected officers, and as a collective body.
    - The relationship between the CEO and the Board as individual members, as elected officers and as a collective body.
    - Implications of the accountability of a public Board as related to areas such as the Mental Health Code, parliamentary.
    - Board Bylaws and Governance Policies.

2. **CHARACTER** In this workshop you will focus on the public policy, ethical and moral requirements of the Board through the examination and exploration of the following:
    - Honor, loyalty and integrity.
    - Issues of special interest, influence and conflicts of interests.
    - Ethical problems inherent in operating outside defined role, responsibilities and corresponding authority.
    - Commitment to the promotion and protection of the full rights and responsibilities of citizenship of intended beneficiaries.

- Commitment to the values and intent of public policy and the public system.
- Remaining knowledgeable, informed and competent as a matter of ethical responsibilities.
- Distinguishing and confronting matters of Board and community ethical considerations from issues of personal morality.
- Commitment to the protection of consumers of services through the recognition of individual rights.

Management: Boards have the ultimate responsibility to ensure local management of public policy. Core competencies in this regard require advancing Board member knowledge in relevant areas of law, regulations, public policy direction, contractual obligations and finance as well as the organization, structure and functions of the community system where public policy is managed. Workshops include:

1. **LEGAL** Learning in this workshop will center on the public policy requirements– for which the Board serves as public stewards–through the examination and exploration of the following:
    - Michigan Mental Health Code, particularly Chapters two and seven.
    - MDCH, PIHP and CMHSP Contracts with particular attention to the relational nature of this public, state and local arrangement.
    - Other related critical statutes and regulations such as the Americans with Disabilities Act (ADA) and the Balanced Budget Act (BBA).

2. **CURRENT AND FUTURE FUNDING FOR CMHSPS AND PIHPS (Previously Budgets)** In this workshop you center on the public policy driven financing and accountability expectations – for which the Board serves as the fiduciary – through the examination and exploration of the following:
    - State, federal and local public revenues including definition as derived by statue, contract and/or public policy directive.
    - Conditions for use, determination of amounts to be distributed/available, method of distribution/receipt, application in practice.
    - Costing and cost accounting, risk implications, reporting and accounting and audit requirements.
    - Private sources of revenues and the conditions and manner in which they apply.
    - State and federal budgeting process and the relationship between these processes.

3. **SYSTEMS** In this workshop you will focus on the public policy oriented and defined management and organizational structures through the examination and exploration of the following:
    - Public policy systems management functions (utilization management, provider network support and management, customer services, recipient

rights, community collaboration and coordination and community relations).

- Structural foundations of organizations (total quality management and information infrastructure) as related to both managers and implementers of public policy.
- Organizational infrastructure (governance, executive leadership, budget and finance, personal, procurement and contracting, risk management, corporate compliance and needs assessment, planning, research, and evaluation) as related to both managers and implementers of public policy.
- Provider (public policy implementation) and manager (public policy management) types of public organizations, including "mixed" organizations and the cost and benefits of such an arrangement.
- Community systems (access and crisis, provider networks, health managers and providers, public partners, informed referral agents) as an ultimate unified community system.

Implementation: Boards have the ultimate responsibility to ensure local implementation of public policy. Core competencies in this regard require advancing Board member knowledge in practices associated with the direct delivery and provision of support, services, care and treatment. Workshop is:

1. **BEST PRACTICE** In this workshop you will address the public policy oriented and defined implementation of supports, services, care and treatment through the examination and exploration of the following:
    - "Best Practice" through the conceptual (distinguishing definitions) and operational (required conditions for consideration and classification) definitions of Evidence-Based Practice, Emerging and Promising Practice and Values-Based Practice.
    - Relevant community planning strategies, such as becoming informed, developing committed champions, capacity and competency building and planning for implementation, management and continuous improvement, as examples.
    - Specific applications of particular models of practice, including by populations, in micro (ACT, Wellness Management, as examples) as well as macro (Jail Diversion, Housing, as examples) practices. It is noted that the specific applications of this module will be modified annually in order to provide a wider range of examples and as a means to reflect state-of-the-art developments and policy priorities.

Two additional workshops – "Orientation" and "Critical Updates" – were originally planned. The "Orientation" workshop is the prerequisite for completing Learning Program Certification. This workshop provides a summary overview of the most critical, substantive, and technical information of the nine Learning Program Certification related

workshops. The “Critical Updates” workshop is designed to provide a learning opportunity for Board members relevant to the most critical issues emerging on the horizon. To best assure timely information, the topic areas, corresponding content and faculty arrangements for the “Critical Updates” are developed during the time period between conferences. These are now presented as part of the same workshop.

May 2013

FUNCTIONS OF THE RIGHTS OFFICE

The staff of the Recipient Rights Office are responsible for the following activities within the CMHSP and its contract agencies:

Monitoring

- Reviewing reports of unusual incidents or death of a recipient to ascertain if a right was violated
- Looking at Quality Assurance and Risk Management reports
- Reviewing reports from accrediting agencies as they pertain to rights
- Reviewing contracts with individuals or agencies to assure they contain mandated rights language
- Acting as a consultant to the Behavior Treatment Review Committee
- Visiting all service site at least annually
- Completing the Semi-Annual and Annual report required by the Mental Health Code

Prevention

- Consulting with the Agency Director and staff on rights related matters
- Assuring that required rights policies are reviewed regularly
- Assisting in the preparing for reviews by accrediting bodies
- Notifying the Agency Director of inappropriate practices

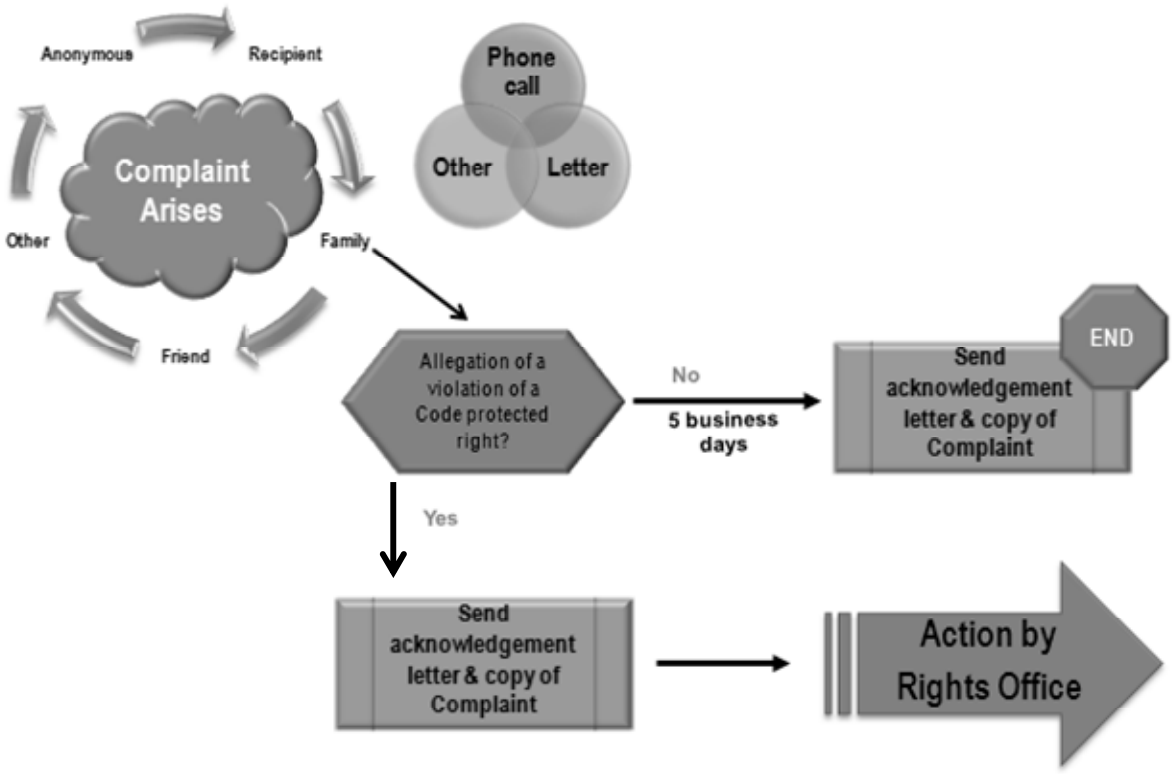
Education

- Training all agency and contract staff on the rights system and their responsibilities
- Training the Rights Committee and Appeals Committee on their roles and responsibilities.
- Successfully completing DCH Basic Skills Program within 90 days of hire
- Receiving annual training in rights protection

Complaint Resolution

- Receiving and reviewing complaints regarding alleged violations of rights
- Investigating to determine if violations have occurred
- Ensuring adequate remedial action is recommended and appropriate disciplinary action is taken
- Assisting recipients with filing appeal requests

THE RIGHTS COMPLAINT PROCESS



Rights complaints can be filed by recipients or by someone on behalf of a recipient. They are usually submitted on a Rights Complaint form but can be sent in letter form, via phone call, fax or secure email. The rights office must decide if the complaint concerns a Mental Health Code protected right and if it is within the jurisdiction of the office. In either case, the Rights Office must respond to the complainant within 5 business days and provide a copy of the complaint. Next the office must decide what action to take.

Action by the rights office can take one of two forms – investigation or intervention. When the complaint concerns an issue that is clear and has a clear simple remedy, the Rights Office can *intervene* on behalf of the complainant. When a response to their inquiry is received, the Office sends a letter to the complainant detailing the action that was taken, if necessary, to resolve the issue. If the complainant is not satisfied with this response he/she can ask the Rights Office to complete a full investigation.

In all other cases, the Office will conduct a full investigation into the allegation and must complete that process within 90 days. When the investigation is complete, the Rights staff will make a determination about whether a right has been violated This decision is based upon the preponderance of evidence standard; meaning that it is more likely – based upon the quality of evidence presented, not the quantity – that a right was violated. The Rights Office will prepare a **Report of Investigative Findings (RIF)** and send it to the CMH Director, who is responsible for taking action which will remedy the violation, prevent recurrence, and be accomplished in a timely manner.

The actions of the Director are communicated to the complainant, the recipient (if he or she was not the complainant) and the recipient's legal representative (parent of guardian) in a **Summary Report**. This report details the complaint, a summary of the investigative findings of the Rights Office, and the action taken by the Director (if required) and is sent out within 10 days of the date the Director receives the RIF from the Rights Office.

THE APPEAL PROCESS

The complainant, the recipient and his/her legal representative have the ability to file an appeal of the decision that is communicated in the Summary Report if they feel that:

- The findings of the Rights Office were inconsistent with facts, law, rules, etc.
- The action or plan of action to remedy the violation was inadequate.
- The investigation was not initiated or completed in a timely manner.

This appeal will be reviewed by the CMHSP Appeals Committee. This is a committee appoint by the CMHSP Board of Directors which must have at least 6 members. The appeals committee shall include at least 3 members of the recipient rights advisory committee, 2 board members, and 2 primary consumers. A member of the appeals committee may represent more than 1 of these categories. An appeals committee may request consultation and technical assistance from the Department of Community Health Office of Recipient Rights.

The appeal must be filed within 45 days of the receipt of the Summary Report and must be reviewed by the Appeals Committee with 5 days to see if it meets the criteria above. The Committee then has 25 more days to meet and consider the appeal. It will do this by reviewing the information provided by the Rights Office and the Director. The committee may take any of the following actions:

- Uphold the investigative findings of the office and the action taken or plan of action proposed by the respondent.
- Return the investigation to the office and request that it be reopened or reinvestigated.
- Uphold the investigative findings of the office but recommend that the respondent take additional or different action to remedy the violation.
- Recommend that the board of the community mental health services program request an external investigation by the State Office of Recipient Rights.

The appeals committee must document its decision in writing. Within 10 working days after reaching its decision, it shall provide copies of the decision to the appellant, the recipient, if different than the appellant, and the recipient's legal representative, if applicable. Copies shall also be provided to the Director and the Office of Recipient Rights.

Within 45 days after receiving written notice of the decision of an appeals committee, the appellant may file a written appeal with the Department of Community Health. The appeal shall be based on the record established in the previous appeal, and may be filed only if the original appeal alleged that the investigative findings of the local Office of Recipient Rights were not consistent with the facts or with law, rules, policies, or guidelines. Within 30 days after receiving the appeal, the department shall review the appeal and do one of the following:

- Affirm the decision of the appeals committee.
- Return the matter to the board with instruction for additional investigation and consideration.

THE RECIPIENT RIGHTS ADVISORY COMMITTTEE

The role of the Recipient Rights Advisory Committee is to **protect** the Rights Office and to **advise** the Office and the CMHSP Director on rights related matters. The members of this committee are appointed by the Board. The committee must have at least six members, 1/3 of whom must be primary consumers or family members. At least ½ of that group must be primary consumers.

The activities of the committee that fall under its “protection” responsibilities include:

- Commenting on the appointment or dismissal of the Director of the Rights Office
- Reviewing the budget of the Rights Office to assure that the is adequate funding to carry out its responsibilities
- Intervening when the Office is subject to retaliation or harassment
- Assuring that the Office has unimpeded access to all necessary documents, service sites and personnel in order to carry out a thorough investigation of alleged violations of rights.

The “advisory” activities of the committee include:

- Review of rights related policies
- Discussion of rights issues with the Director and other Agency policy makers
- Review of the data and information provided in the annual and semi-annual reports.

ROLE OF THE DIRECTOR IN THE RIGHTS SYSTEM

The Agency Director (CEO) plays an important role in assuring the impartiality of the Recipient Rights Office and the independence of the rights system. It is the responsibility of the Director to:

- Select a director of the office of recipient rights who has the education, training, and experience to fulfill the responsibilities of the office
- Supervise the Director of the Rights Office
- Submit a written summary report ten days after receiving an ORR Report of Investigative Findings.
- Take action to remedy violations of recipient rights including appropriate disciplinary or remedial action
- Take action if the appeals committee requests a different or additional action.
- Complete a new summary report if the Appeals Committee has returned a report for reinvestigation
- Assure those who utilize the rights protection system – recipients, agency and provider staff, and staff of the rights office – are free from retaliation and harassment for rights related activities.

ROLE OF THE BOARD IN THE RIGHTS SYSTEM

The CMHSP Board of Directors is responsible for oversight of the recipient rights system and for assuring that it operates in an impartial and even-handed manner. The Board plays a role in every aspect of the system.

In the Complaint and Appeal Process

- Assure summary reports are timely
- When the complaint is against Executive Director and the BOARD may ask DCH-ORR to investigate
- When an appeal is sent to Appeals Committee the Committee may ask the Board to request investigation by DCH-ORR
- Issue Summary Report when investigation completed by DCH-ORR (Issued by the Board Chairperson)