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 (CMHA) 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.

CMHA 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 CMHA, 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 CMHA, 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

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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 Health and Human Services, it is important that they be kept apprised of the local mental health needs and problems as assessed by your Board. Through the Community Mental Health Association of MI, 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.
- Facilitate 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 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 Acknowledgement and Disclosure Statement form (attached).
- 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 of 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.
MACMHB	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

- **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%.
- **Medicaid Savings** – PIHP's can save or "carry forward" the first 5% of unspent Medicaid to use in the following year. Medicaid Savings the Internal Service Fund help PIHP"s manage their financial risk.
- **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 Health and Human Services establishes categories and process for application each year. Funds are time limited for 1, 2, or 3 years.
- **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 10 PIHPs; 3 are individual CMHSPs, 7 are affiliations. The affiliations have governance representation from all of the affiliate members.
- **Revenues** – Income into an organization. Money received.

2. State 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 PIHP funds is the Michigan Department of Health and Human Services.

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.

3. CMHSP Financing Basics

- A CMH is government – different accounting system than non-profit or business
- Not required to file 990
- Do not have profit or loss statements in the traditional sense
- Contracts for funding are often cost settled.
- Not subject to ERISA (pension plan laws)

- Operate under GAAP (generally accepted accounting principles) and 2CFR200 (formally A-87)
- Governs how purchases and expenses are accounted for, and spread across cost centers to determine unit costs

There are several federal, state and local sources of funds.

- Federal is OBRA, Medicaid, grants, Medicare. Will often have a federal grant number. Federal funds over $750,000 require a single audit separate from financial audit.
- State funds are general funds and anything categorical.
- Local funds are county match, interest, donations, and for CMHSP's that are "423" boards, client fees and insurance payments (3rd party)
- Not all CMHSPs are 423 boards. They are not able to count client fees and insurance payments as local. You must use GF to cover costs for 423 revenues.
- Under the Mental Health code, CMH's are responsible for 10% match on state expenditures. This includes GF and state inpatient. For state inpatient, we pay 10% of the State's net cost for providing care for a client, after insurance reimbursement.
- We receive these bills periodically, and they may not be entirely accurate or easy to understand.
- Local funds will also cover a general fund overrun and is essentially a CMHSP's risk reserve.
- Unrestricted Fund balance is made up entirely of excess local that was not needed to match either general fund, pay for state hospital local, or used for the local match drawdown.
- If a CMHSP has a negative fund balance, they are required to file a plan with the Michigan Department of Treasury to correct the deficiency within 5 years. These plans must be approved by treasury.

4. Medicaid Funding Rules

- Procurement laws
- No payments directly to beneficiaries
- Medicaid does not pay for room and board (substance used disorder residential excluded).

- Medicaid does not pay for food for consumers in residential
- Medicaid does not pay for Alcohol (under any circumstances)
- Medicaid does not pay for services to incarcerated individuals
- Medicaid does not pay for services without a valid contract
- Medicaid does not pay for extravagant or unnecessary services
- Medicaid does not pay for services that are not medically necessary
- Medicaid does not pay retirement contributions in excess of the actuarially required distribution – can not “throw extra money” at unfunded retirement
- Medicaid does not pay for services not properly documented
- Medicaid does not pay for rent in excess of fair market value or cost (depending on circumstances)
- Medicaid does not pay for car repairs for consumers
- Medicaid does not pay for transportation that is the requirement of another agency, or not related to programs
- Medicaid does not pay for long term housing costs for consumers
- Medicaid does not buy people cars, housing, or businesses
- Medicaid does not pay for services that are the responsibility of another party

Medicaid DOES cover

- IS – the payor of last resort
- Will – cover medically necessary services that are the responsibility of the CMHSP/PIHP under the Medicaid manual/contract
- IS a prudent purchaser of services
- Does support services provided in accordance with the Plan of Services, and authorized by the CMHSP/PIHP.
- Is an entitlement
- Does not allow for a wait list/non-provision of medically necessary services

1. CMHA Organization and Governance Structure

What is CMHA?

The Community Mental Health Association of Michigan (formerly known as the Michigan Association of Community Mental Health Boards) was created in 1967 to support county mental health services programs (CMHSPs) in promoting, maintaining and improving a comprehensive range of community-based mental health services, which enhance the quality of life, promote the emotional well-being, and contribute to healthy and secure communities which benefit all of Michigan's citizens. Over the years CMHA has become one of the most influential behavioral health trade associations in the nation representing Michigan's 46 community mental health boards, 10 Prepaid Inpatient Health Plans, and over 100 provider organizations that deliver mental health, substance use disorder, and developmental disabilities services in every community across the state.

CMHA's membership represents a $3 billion industry and employees over 50,000 people in the state of Michigan, while serving over 300,000 of Michigan's most vulnerable citizens. The Community Mental Health Association of Michigan is one of the most respected trade associations in Michigan for its training and educational services as well as its legislative and advocacy efforts.

CMHA Mission Statement

The Community Mental Health Association of Michigan supports its membership by informing, educating, and advocating for mental health, emotional disturbance, intellectual and developmental disability, and substance use disorder services by strengthening collaboration with persons served, community, partners, and government.

What does CMHA do?

CMHA provides their members:

- Legislative and public policy advocacy
    - CMHA staff work closely with state and federal elected officials as well as state regulators regarding issues impacting our membership.
- Ongoing conferences and trainings to provide education and training services
    - CMHA provides ongoing professional development and networking opportunities to enhance its members' ability to respond to the ever-changing health care environment including 3 annual CMHA conferences, as well as several other CMHA affiliated conferences and over 200 trainings per year.
- Access to products and services as 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 & MDHHS.
    - CMHA members are often asked to help state leaders work through complicated issues impacting Michigan's behavioral health system.

How is CMHA Governed?

CMHA is governed by its Board of Directors, formerly known as the Executive Board (total of 41 members), which is made up of the following:

- Two board members and one director appointee from each of CMHA'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 CMHA's five (5) standing committees (total of 10). These co chairs are appointed annually by the CMHA president.
- The officers of CMHA, 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, Board of Directors, and Standing Committee meetings. These designated provider representatives are nominated by CMHA's Provider Alliance and approved by the Board of Directors.
- The Association changed its By-Laws in 2014 to provide four (4) PIHP representatives with full voting rights at Board of Directors meetings.

What is CMHA's Regional Structure?

CMHA 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 CMHA's Standing Committees and How do They Operate?

CMHA has organized four 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 four standing committees and their current meeting schedules include:

- *Children's Issues,* which focuses on mental health issues related to children's services – Jan., March, April, June, Sept. and Nov., 3rd Tuesday at 1:00 p.m.
- *Contract and Financial Issues,* which focuses on CMHSP and PIHP contracts with DCH – Jan., March, April, June, Sept. and Nov., 3rd Thursday at 1:00 p.m.
- *Legislation & Policy Committee*, which reviews bills and legislation effecting mental health and substance abuse issues and policy initiatives by MDHHS – Jan., March, April, June, Sept. and Nov., 3rd Wednesday at 9:30 a.m.
- *Member Services,* which develops and arranges for delivery of services to members – Jan., March, April, June, Sept. and Nov., 3rd Thursday at 9:30 a.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. History of Michigan's public mental health system

While the history of community mental health in Michigan and the Community Mental Health Association of Michigan (CMH Association) 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."

Groundbreaking actions by state and federal governments: 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."

On October 31, 1963, President John F. Kennedy signed into law the Community Mental Health Act (also known as the Mental Retardation and Community Mental Health Centers Construction Act of 1963), which drastically altered the delivery of mental health services and inspired a new era of optimism in mental healthcare. This law led to the establishment of comprehensive community mental health centers throughout the country. It helped people with mental illnesses who were "warehoused" in hospitals and institutions move back into their communities.

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.

Michigan Mental Health Code adopted; 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).

Mental Health Code Mandates Transfer of Responsibility to CMH system: 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.

Medicaid becomes chief funding source for system: Medicaid became the major source of funding for mental health services during the 1980s and 1990s 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 funds, both state General Fund, Medicaid, Healthy Michigan Plan (Medicaid expansion), PA2, and Federal Block Grant dollars, appropriated annually for CMH services.

1970	$13.1 million
1980	$104.2 million
1990	$626.7 million
2000	$1.1 billion
2010	$2.5 billion
2020	$3.5 billion

An economic analysis of the conversion of Michigan's mental health system from one in which the bulk of the public dollars were spent on state psychiatric hospitals and state developmental disability centers to one in which the bulk of the dollars were spent to support community-based services is striking.

If the dollars currently spent by Michigan's community-based public mental system $3.469 billion, were spent solely on the provision of traditionally long-term inpatient care at the state's psychiatric hospital and developmental disability centers, those dollars would serve 9,500 persons per year. In contrast, those dollars, used to fund community-based services and supports, as they are now used, allows the public system to serve over 350,000 persons per year.

The impact of this transition is staggering**. Michigan's community based mental health system meeting the mental health needs of <u>37 times more persons</u>, in the community, than would be served if those same dollars were used to provide long term inpatient care in the state's psychiatric hospitals and developmental disability centers.**

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 concurred in 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.

Move to 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, CMHs 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 move to managed care and to "carve out" Medicaid specialty services and supports for persons with mental illnesses, substance use disorders and developmental disabilities (behavioral health and intellectual/developmental disability services; BHIDD) from Medicaid physical health care. DCH submitted a set of Medicaid waiver applications [1915 (b) and (c)] to the Health Care Financing Administration (HCFA), now known as the Centers for Medicare and Medicaid Services (CMS), requesting the ability to move to a Medicaid managed care system and to have the Medicaid Specialty (BHIDD) benefit carved out ,with the CMHSPs responsible for service coordination and system management. The waivers, if granted, would allow Michigan to replace the state's Medicaid fee for service payment system with a capitated risk-based funding mechanism.

A set of federal Medicaid waivers [1915 (b) and (c) waivers] were approved by CMS and **all of Michigan's CMHSPs became managers of the specialty services benefit, as Prepaid Inpatient Health Plans (PIHPs) 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, as PIHPs, 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, in 2004, **46 CMH programs organized themselves into either stand-alone or regional affiliations**, each with a "hub" CMHSP board, which would serve as the regional PIHP, and would hold the contract with the state for Medicaid financed services. The PIHP then, in turn, contracted with the "spoke" CMHSPs within their region. Not all of the state's CMHs were in hub-and-spoke arrangements, with 8 PIHPs made up of 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.

In 2014, the PIHP system was redesigned to **reduce the number of PIHPs from 18 to 10 and to create, across the state with the exception of Macomb, Oakland, and Wayne counties, regional PIHPs**. These regional PIHPs are quasi-public and were formed and governed by the CMHSPs in the region, with each CMHSP in the region appointing members to the regional PIHP board of directors. As in the past, these PIHPs hold the shared risk Medicaid managed care contract with the state and make Medicaid payments, to the CMHSPs within their region. The CMHSPs then provide or purchase Medicaid services to the Medicaid enrollees in their communities.

As part of the federal Affordable Care Act (ACA), Michigan expanded, in 2014, its Medicaid program through the Healthy Michigan Plan (HMP), providing healthcare coverage to over 600,000 Michigan residents. As a result, a wide range of BHIDD services became available to persons to whom such care had been, up until that point, hard to access.

Substance Use Disorder Funding and Services Integration: While a number of CMHSPs, in the role of PIHPs, began to merge with and/or take on the role formerly played by the Substance Abuse Coordinating Agencies (CAs), prior to its passage, with the passage of PA 500 of 2012, this pace of this process accelerated. PA 500 mandated that CMH entities take on the coordination and regional funding and oversight role for the publicly funded regional substance use disorder system – the role formerly held by the CAs. The CMH entities that assumed this role were the PIHPs in each region, managing Medicaid, PA2, and Federal Block Grant dollars, through the network of SUD prevention and treatment providers in each community. With the formation of the newly structured PIHPs, in 2014, these CA responsibilities moved to these PIHPs.

With this integration of local/regional SUD management into the PIHP/CMH system, the efforts to clinically integrate SUD services with the mental health, intellectual/developmental services system, while taking place, for decades, in communities across the state, received greater attention and support. While much is still needed to integrate these services, without losing the system's ability to meet the unique needs of persons without co-occurring conditions nor losing the integrity of the SUD system, long underfunded and under-represented in policy discussion.

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. In the spring of 2016, the Association's Center for Healthcare Research and Innovation (a policy analysis center formed by the Association) conducted a study of the healthcare integration initiatives led by Michigan's Community Mental Health Services Programs, the state's public Prepaid Inpatient Health Plans (PIHPs), and providers within the CMH system. The study examined varying efforts aimed at integrating behavioral health and intellectual/developmental disability services with physical health care services. Results showed that more than 750 healthcare integration efforts, led by these public sector parties, were in operation in Michigan. Of this number, work in bi-directional co-location, integration of electronic health records, and high/super-utilizer initiatives underscored the variety and maturity of these efforts.

Mental Health Commissions and Task Forces: Over the years, a number of mental health commissions or similar efforts have been formed, by the Michigan Governor, the State Legislature, or MDMH/ MDCH/MDHHS. These commissions are listed below with links to the reports and recommendations developed by these groups:

- Governor Granholm's Mental Health Commission; 2004; Commission report can be found at: https://www.michigan.gov/documents/mdch/Final_MHC_Report_Part_1_375106_7.pdf
  Appendix to this report can be found at: https://publicsectorconsultants.com/wp-content/uploads/2017/01/FINAL-MHC-REPORT-PART-2.pdf
  Plan for implementing recommendations of the Granholm. Mental Health Commission; 2005; Plan can be found at: https://www.michigan.gov/documents/mdch/Transforming_Mental_Health_Care_in_Michigan_375062_7.pdf
- Behavioral Health Section 298 Workgroup; 2016; Workgroup report can be found at: https://www.michigan.gov/documents/mdhhs/Behavioral_Health_Section_298_Final_Report_7-15-16_531073_7.pdf
- Governor Snyder's State of Michigan Mental Health and Wellness Commission; 2013; Commission report available at: https://www.michigan.gov/documents/mentalhealth/CommissionReportFinal1212014_445161_7.pdf
- Community, Access, Resources, Education, and Safety (CARES) Task Force formed by the Michigan House of Representatives; 2018; Task Force report can be found at: http://gophouse.org/wp-content/uploads/2018/01/HouseCARES_Report.pdf).

Changes in state department: The state department responsible for the design, funding, and oversight of the state's public mental health system has undergone a number of changes in make-up, name, and leadership since the 1940s. The Michigan Department of Mental Health, formed in 1945, was merged, in the 1990s, with the Michigan Department of Public Health to form the Michigan Department of Community Health. In the 2010s, this department was merged with the Michigan Department of Human Services to form the Michigan Department of Health and Human Services.

The Directors of the state department responsible for the design, funding, and oversight of the state's public mental health system, since its early days are provided below:

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 December 2009
Olga Dazzo .....February 2010 to September 2012
James K. Haveman, Jr. .....September 2012 to April 2015
Nick Lyon. .....April 2015 to December 2018
Robert Gordon.....January 2019 to January 2021
Elizabeth Hertel…… ..... ……. January 2021 to present

3. History of the Community Mental Health Association of Michigan

As noted in the history of the system, above, 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.

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

Michigan State Association of Community Mental Health Services Boards 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."

Association of Community Mental Health Directors formed: 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.

Boards and Directors Associations merge: 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. MACMHB 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, having served as its Executive Director since 1985. In 2009, Michael Vizena was hired as the executive director. In 2015, Robert Sheehan followed Mike Vizena as the Association's executive director.

Affiliate Members and PIHPs added to Association membership: In 1997, the MACMHB executive board approved affiliate membership for organizations whose purpose is consistent with that of MACMHB. As of 2017, affiliate membership was at nearly one hundred (100) members, adding an important voice and ability and strength to MACMHB in achieving its goals. In 2011, MACMHB amended its bylaws to provide four (4) designated provider representatives

with full voting privileges at MACMHB's Member Assembly, Executive Board, and Standing Committee meetings.

In 2015, soon after the creation of regional PIHPs as distinct organizations from the state's CMHs, four seats at the CMH Association Executive Board and Steering Committee were added for PIHP representatives. Additionally, the Association's by-laws were revised to allow PIHP representatives to serve as officers and committee members.

ALSAO joins Association: Early in the 21st century, the members of ALSAO (Alliance of Licensed Substance Abuse Organizations) joined the CMH Association, with the ALSAO members becoming affiliate members, as part of the Association's Provider Alliance. With the addition of ALSAO members to the Association, the Association brought on the multi-client lobbying firm formerly used by ALSAO, with an eye toward substance use disorder issues, especially those issues impacting SUD providers.

Name changes for Association: During 1972, the name of the association was changed to the Michigan Association of Community Mental Health Boards.

In 2017, the name of the Association was changed to the Community Mental Health Association of Michigan. The new name retained the words "community mental health" to represent the association's link to the community mental health movement that, fifty years since its genesis, is in robust and continual development. However, the name no longer contains the word "Boards". While the Association is still led by the members of the Boards of Directors of the state's public Community Mental Health centers (CMHs) and public Prepaid Inpatient Health Plans (PIHPs) – with Board members making up 2/3 of the Association's Member Assembly – the Michigan Mental Health Code has not, for years, used the term "Board" to describe the local and regional organizations that make up the public BHIDD system. Additionally, none of the Association's members use the word "Board" in their names.

The Association's new name underscored that, in the midst of the innovation required for the public system to respond to an ever changing environment (both opportunities and challenges), the system and the Association have never forgotten their roots in the community mental health movement – a civil rights movement in every sense of the word. A movement that is grounded in the commitment to the dignity of the person and to each person's right, regardless of ability or disability, to self-determination, full citizenship, community inclusion, and equality of opportunity.

Partnerships: The Association has longstanding and deep partnerships with state-wide advocacy groups and associations. While too numerous to name, some of the advocacy groups with which the Association regularly works include: Arc Michigan, NAMI-Michigan, Mental Health Association in Michigan, Association for Children's Mental Health, Michigan Disability Rights Organization, Michigan Protection and Advocacy, Autism Alliance of Michigan, Epilepsy Foundation of Michigan, incompass Michigan, Michigan Assisted Living Association, Area Agencies on Aging Association of Michigan, Michigan League for Public Policy, and Michigan Health Policy Forum.

The Association and its 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).
Core to the work of the Association is its partnerships with the Michigan Department of Mental Health (MDMH) and its successor organizations, the Michigan Department of Community Health (MDCH) and the Michigan Department of Health and Human Services (MDHHS).

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

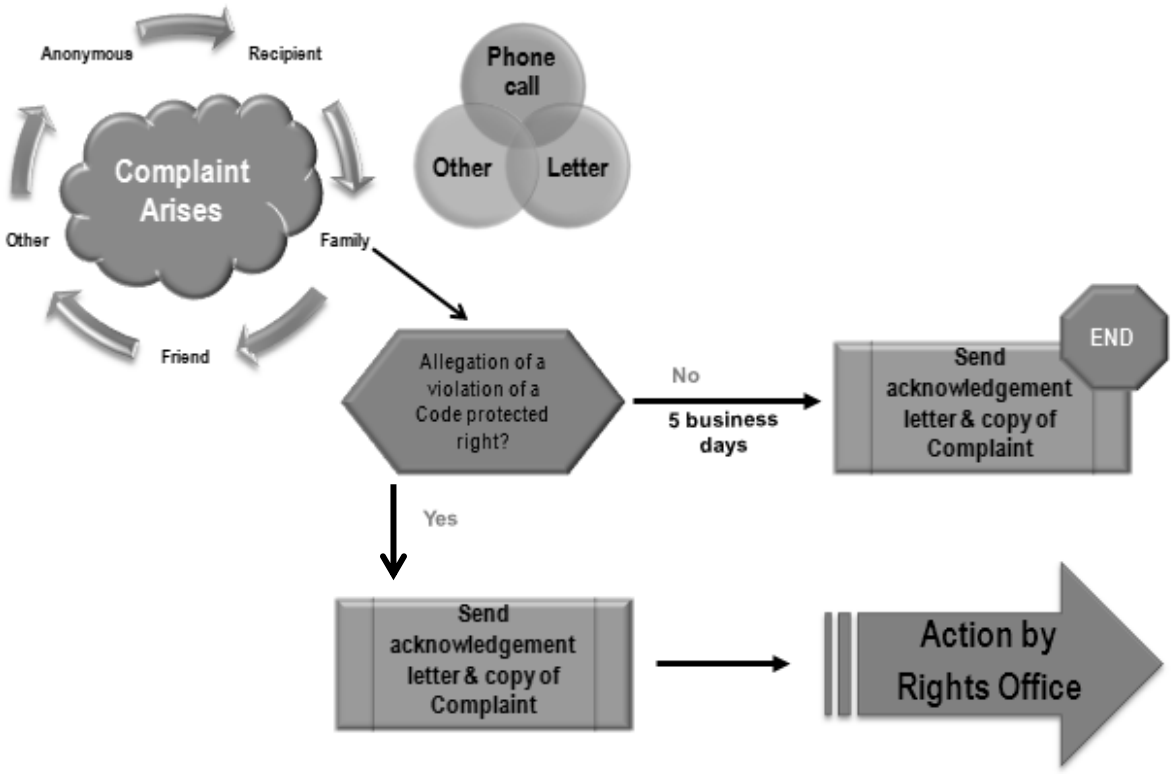
Education

- 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.

Intervention	Investigation
• Action • Response • Letter to complainant	• Investigation • Report • Response • Summary Report

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)