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BILL ANALYSIS

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Senate Bill 525 (Substitute S-2 as passed by the Senate)
Sponsor: Senator Joel D. Gougeon
Committee: Families, Mental Health and Human Services

Date Completed: 10-17-95

SUMMARY OF SENATE BILL 525 (Substitute S-2):

The bill would amend the Mental Health Code to:

-- Require the Department of Mental Health (DMH) to shift primary responsibility for the direct delivery of public mental health services from the State to a community mental health services program (CMHSP), rather than to the county as currently provided. A CMHSP would be an official county agency, a community mental health (CMH) organization, or a CMH entity (a new entity created by the bill).

-- Allow two or more counties to organize and operate a CMHSP by creating a community mental health organization under the Urban Cooperation Act.

-- Replace references to mentally ill and developmentally disabled adults with references to adults or individuals with serious mental illness or developmental disability; replace references to county community mental health boards with community mental health services programs; and include the Federal definitions of a number of terms.

-- Require consumer representation on the Citizens Mental Health Advisory Council and on the board of a CMHSP.

-- Specify the priority for the delivery of mental health services.

-- Replace provisions for the establishment of a DMH Office of Recipient Rights and recipient rights advisory committee, and similar offices and committees by licensed hospitals and CMHSPs.

-- Provide for the establishment of special fund accounts by CMHSPs, rather than by CMH boards as currently provided; delete the requirement that the funds be used in conformance with DMH guidelines for CMH programs; and require quarterly rather than monthly reports on the funds.

-- Apply the family support subsidy program provisions to “eligible minors” rather than “family members” as currently specified.

-- Require all CMHSPs to obtain and maintain certification from the DMH.

-- Allow the DMH to accept local matching funds over an extended period of time or waive a portion of the required local match for financial hardship.

-- Require the State to pay 90% of the annual net cost of a CMHSP. Beginning in the fiscal year after a CMHSP became an entity, if the DMH increased the amount of state funds provided to CMHSP for the fiscal year, the amount of local match required of an entity for community mental health services for that fiscal year would not exceed the amount of funds provided by the CMHSP as local match in the year in which the program became an entity.

-- Require each CMHSP to establish at least one preadmission screening unit

-- Require approval from CMH service screening units for hospitalization and from CMHSPs for admission to centers.

-- Require that hospitalization and treatment be provided by hospitals or programs recommended by a CMHSP.

-- Require timely physical and mental examination of recipients and applicants for mental health services.

-- Require, rather than permit as currently provided, the court to order hospitalization or alternative treatment if it found that an individual needed treatment.

-- Add a new chapter to the Code to provide for dispute resolution.

-- Specify time periods for the use of physical restraints and seclusion.

-- Revise the financial liability provisions for recipients, their spouses, and their parents.

-- Require the DMH to support research, evaluation and quality improvement activities, and training, consultation and technical assistance regarding mental health programs and services.
-- Change the licensure of psychiatric hospitals, psychiatric units, and psychiatric partial hospitalization programs from annual to biennial and increase the license fees.
-- Require the resolution establishing a CMH entity to specify that the entity's employees were public employees and that they and the entity would be subject to the Public Employees Relations Act, and that an employee who was transferred to an entity would not, by reason of the transfer, be in a worse position with respect to the benefits he or she enjoyed as an employee of the former CMHSP.
-- Change the licensure of psychiatric hospitals, psychiatric units, and psychiatric partial hospitalization programs from annual to biennial and revise the license fees.
-- Specify that if the Michigan Supreme Court ruled that the sections of the Administrative Procedures Act that pertains to the promulgation of rules (MCL 24.245 and 24.246) were unconstitutional, and a statute requiring legislative review of administrative rules were not enacted within 90 days after the ruling, the provisions in the Code and the bill pertaining to the promulgation of rules would not apply.
-- Require that all modifications to rules needed to comply with the bill be submitted to public hearing within two years after the bill's effective date.
-- Repeal a number of provisions concerning Lafayette Clinic, CMH centers, cost of services, preliminary hearings, medical reports, and other mental health issues.

Following is a more detailed description of the bill.

Chapter 1 - Department of Mental Health

Definitions

"Abilities" would mean the qualities, skills, and competencies of an individual that reflected the individual's talents and acquired proficiencies.

"Abuse" would mean nonaccidental physical or emotional harm to a recipient, or sexual contact with or sexual penetration of a recipient as those terms are defined in the Michigan Penal Code, that was committed by an employee or volunteer of the DMH, a CMHSP, or a licensed hospital, or an employee or volunteer of a service provider under contract with the DMH, CMHSP, or licensed hospital.

"Adaptive skills" would mean skills in communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and/or work.

"Adult foster care facility" would mean an adult foster care facility licensed under the Adult Foster Care Facility Licensing Act. "Applicant" would mean an individual or his or her legal representative who requested mental health services. "Board" would mean the governing body of a CMHSP. "Board of commissioners" would mean a county board of commissioners. "Center" would mean a facility operated by the DMH to admit individuals with developmental disabilities and provide habilitation and treatment services. "Certification" would mean formal approval of a program by the DMH.

"Child psychiatrist" would mean all of the following:

-- A physician who had completed a residency program in child or adolescent psychiatry approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association, or who had completed 12 months of child or adolescent psychiatric rotation and was enrolled in an approved residency program.
-- A psychiatrist with educational and clinical experience in the evaluation and treatment of children or adolescents with serious emotional disturbance who was employed by or under contract with the DMH or CMHSP on the effective date of the bill.
-- A psychiatrist approved by the DMH Director.

"Children's diagnostic and treatment service" would mean a program operated by or under contract with a CMHSP, that provided examination, evaluation, and referrals for minors, including emergency referrals; provided or facilitated treatment for minors; and had been certified by the DMH.
"Community mental health entity" would mean a separate public legal entity created under the bill to operate as a CMHSP. "Community mental health organization" would mean a CMHSP that was organized under the Urban Cooperation Act. "Community mental health services program"

would mean a program operated as a county community mental health agency, a community mental health entity, or a community mental health organization.

"Consent" would mean a written agreement executed by a recipient, a minor recipient's parent, or a recipient's legal representative with authority to execute a consent, or a verbal agreement of a recipient that was witnessed and documented. "County community mental health agency" would mean an official county or multicounty agency that operated as a CMHSP and that had not elected to become a community mental health entity or a community mental health organization.

"Developmental disability" in an individual older than five years would mean a severe, chronic condition that:

-- Was attributable to a mental impairment other than a serious mental illness, serious emotional disturbance, or substance abuse disorder or to a physical impairment or a combination of mental and physical impairments.
-- Was manifested before the individual was 22 years old.
-- Was likely to continue indefinitely.
-- Resulted in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency.
-- Reflected the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that were of lifelong or extended duration and were individually planned and coordinated.

"Developmental disability" for a minor from birth to age five, would mean a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability as defined above if services were not provided.

"Discharge" would mean an absolute, unconditional release of an individual from a facility by action of the facility or a court. "Eligible minor" would mean an individual less than 18 years of age who was recommended in the written report of a multidisciplinary team under rules promulgated by the Department of Education to be classified as severely mentally impaired, severely multiply impaired, or autistic impaired and receiving special education services in a program designed for the autistic impaired or for the severely mentally impaired or severely multiply impaired.

"Emergency situation" would mean a situation that required the immediate placement of an individual in a State facility or a licensed hospital if alternative services were not provided. "Executive director" would mean an individual appointed to direct a CMHSP or his or her designee. "Facility" would mean a residential facility for the care or treatment of individuals with serious mental illness, serious emotional disturbance, or developmental disability that was either a State facility or a licensed facility. "Family" would mean an eligible minor and his or her parent or legal guardian. "Family member" would mean a parent, spouse, sibling, child, or grandparent of a primary consumer, or an individual upon whom a primary consumer was dependent for at least 50% of his or her financial support.

"Federal funds" would mean funds received from the Federal government under a categorical grant or similar program and would not include Federal funds received under a revenue sharing arrangement. "Functional impairment" would mean both of the following:

-- With regard to serious emotional disturbance, substantial interference with or limitation of a minor's achievement or maintenance of one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills.
-- With regard to serious mental illness, substantial interference or limitation of role functioning in one or more major life activities including basic living skills such as eating, bathing, and dressing; instrumental living skills such as maintaining a household, managing money, getting around the community, and taking prescribed medication; and functioning in social, vocational, and educational contexts.

"Guardian" would mean a person appointed by the Court to exercise specific powers over an individual who is a minor, legally incapacitated, or developmentally disabled. "Hospital" or "psychiatric hospital" would mean an inpatient program operated by the DMH for the treatment of individuals with serious mental illness or serious emotional disturbance or a licensed psychiatric hospital or psychiatric unit.

"Individual plan of services" or "plan of services" would mean a written individualized plan of services developed with a recipient as required by the bill. "Licensed facility" would mean a psychiatric unit, psychiatric hospital, or psychiatric partial hospitalization program licensed by the DMH or an adult foster care facility "Mental health professional" would mean an individual who was trained and experienced in the areas of mental illness or developmental disabilities and who was a licensed physician or psychologist, a registered professional nurse, a certified social worker, a social worker, a registered social worker technician, a licensed professional counselor, or a licensed marriage and family therapist.

"Mental retardation" would mean a condition manifesting before the age of 18 years that was characterized by significantly subaverage intellectual functioning and related limitations in two or more adaptive skills and that was diagnosed based on the following assumptions:

-- "Valid assessment considers cultural and linguistic diversity, as well as differences in communication and behavioral factors."
-- "The existence of limitation in adaptive skills occurs within the context of community environments typical of the individual's age peers and is indexed to the individual's particular needs for support."
-- "Specific adaptive skill limitations often coexist with strengths in other adaptive skills or other personal capabilities."
-- "With appropriate supports over a sustained period, the life functioning of the individual with mental retardation will generally improve."

"Neglect" would mean an act or failure to act committed by an employee or volunteer of the DMH, a CMHSP, or a licensed hospital or a service provider, or a volunteer or employee of a service provider, under contract with the DMH, CMHSP, or a licensed hospital, that denied a recipient the standard of care or treatment to which he or she was entitled.

"Peace officer" would mean an officer of the Department of State Police or of a law enforcement agency of a county, township, city, or village who was responsible for the prevention and detection of crime and enforcement of the criminal laws of this State. For the purpose of taking a person into protective custody, "peace officer" also would include an officer of the United States Secret Service with the officer's consent and a police officer of the Veterans' Administration Medical Center Reservation.

"Peer review" would mean a process, including the review of professional practices in a psychiatric hospital, psychiatric unit, or psychiatric partial hospitalization program, in which mental health professionals of a State facility, licensed hospital, or a CMHSP evaluated the overall performance of staff and the quality of care provided to recipients. Peer evaluations would be based on criteria established by the facility or CMHSP itself, the accepted standards of the mental health professions, and the Departments of Mental Health and Public Health.

"Primary consumer" would mean an individual who received or was receiving services from the DMH or a CMHSP or services from the private sector equivalent to those offered by the DMH or a CMHSP. "Priority" would mean preference for and dedication of a major proportion of resources to specified populations or services. Priority would not mean serving or funding the specified populations or services to the exclusion of other populations or services. "Protective custody" would mean the temporary custody of an individual by a peace officer with or without the individual's consent for the purpose of protecting that individual's health and safety, or the health and safety of the public, and for the purpose of transporting the individual if he or she appeared, in the judgment of the peace officer, to require treatment or required treatment. Protective custody would be civil in nature and could not be construed as an arrest.

"Psychiatric partial hospitalization program" would mean a nonresidential treatment program that provided psychiatric, psychological, social, occupational, nursing, and therapeutic recreational services under the supervision of a physician to adults diagnosed as having serious mental illness or minors diagnosed as having serious emotional disturbance who did not require 24-hour continuous mental health care, and that was affiliated with a psychiatric hospital or psychiatric unit to which clients could be transferred if they needed inpatient psychiatric care. "Psychiatrist" would mean a physician who had completed a residency program in psychiatry approved by the accreditation council for graduate medical education or the American Osteopathic Association, or who had completed 12 months of psychiatric rotation and was enrolled in an approved residency program; who was a psychiatrist employed by or under contact with the DMH or a CMHSP program with the effective date of the bill; or who was a physician

who devoted a substantial portion of his or her time to the practice of psychiatry and was approved by the director.

"Recipient" would mean an individual who received mental health services from the DMH, a CMHSP, or a facility or from a provider that was under contract with the DMH or a CMHSP. "Recipient rights advisory committee" would mean a committee of a CMHSP board or a recipient rights advisory committee appointed by a licensed hospital. "Resident" would mean an individual who received services in a facility. "Responsible mental health agency" would mean the hospital, center, or CMHSP that had primary responsibility for the recipient's care or for the delivery of services or supports to that recipient.

"Serious emotional disturbance" would mean a diagnosable mental, behavioral, or emotional disorder affecting a minor that existed or had existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association (APA) and approved by the DMH and that had resulted in functional impairment that substantially interfered with or limited the minor's role or functioning in family, school, or community activities. A substance abuse disorder, a developmental disorder, and disorders constituting "V" codes in the diagnostic and statistical manual of mental disorders would be included only if they occurred in conjunction with another diagnosable serious emotional disturbance. "Serious mental illness" would mean a diagnosable mental, behavioral, or emotional disorder affecting an adult that existed or had existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the APA and approved by the DMH and that had resulted in functional impairment that substantially interfered with or limited one or more major life activities. Serious mental illness would include dementia with delusions, dementia with depressed mood, and dementia with behavioral disturbance but would not include any other dementia unless it occurred in conjunction with another diagnosable serious mental illness. A substance abuse disorder, a developmental disorder, and a disorder constituting a "V" code in the diagnostic and statistical manual of mental disorders also would be included only if they occurred in conjunction with another diagnosable serious mental illness.

"Specialized program" would mean a program of services, supports, or treatment provided in an adult foster care facility to meet the unique programmatic needs of individuals with serious mental illness or developmental disability as set forth in the resident's individual plan of service and for which the adult foster care facility received special compensation. "Specialized residential service" would mean a combination of residential care and mental health services that were expressly designed to provide rehabilitation and therapy to a recipient, were provided in the recipient's residence, and were part of a comprehensive individual plan of services.

"State facility" would mean a center or a hospital operated by the DMH. "State recipient rights advisory committee" would mean a committee appointed by the DMH Director to advise the Director and the director of the Office of Recipient Rights. "Transition services" would mean a coordinated set of activities for a special education student designed within an outcome-oriented process that promoted movement from school to postschool activities, including postsecondary education, vocational training, integrated employment including supported employment, continuing and adult education, adult services, independent living, or community participation.

"Treatment" would mean care, diagnostic, and therapeutic services, including the administration of drugs, and any other service for the treatment of an individual's serious mental illness or serious emotional disturbance. "Urgent situation" would mean a situation that would require the placement of an individual in a State facility or licensed hospital within 30 days or less if alternative services were not provided.

Citizens Mental Health Advisory Council

The bill would require the composition of the council, which was established under the Code, to be representative of primary consumers, family members, agencies, and professionals having a working involvement with mental health services, and the general public. At least four members of the council would have to be primary consumers or family members, and at least two of those four would have to be primary consumers.

Duties of the DMH

Currently, the Code requires the DMH to function in the areas of mental illness, developmental disabilities, organic brain and other neurological impairment or disease, alcoholism, substance abuse, the prevention of mental disability, and the promotion of good mental health. Within the

area of mental illness, priority must be given to the more severe forms of disability.

The bill would delete these provisions and, instead, would require the DMH to direct services to individuals who had a serious mental illness, developmental disability, or serious emotional disturbance. The DMH would have to give priority to the services for individuals with the most severe forms of serious mental illness, serious emotional disturbance, or developmental disability and to services for individuals with serious mental illness, serious emotional disturbance, or developmental disability who were in urgent or emergency situations.

The Code allows the DMH to provide on a residential or nonresidential basis, any type of patient or client service including, but not limited to, prevention, diagnosis, treatment, care, education, training, and rehabilitation; to engage in research programs, and staff and professional training programs; and to operate directly or through contractual arrangements the facilities that are necessary or appropriate. The bill would delete these provisions and would permit the DMH to provide, on a residential or nonresidential basis, any type of the patient or client service; to operate mental health programs directly or through contractual arrangement; and to direct services to individuals with mental disorders that met diagnostic criteria specified in the most recent diagnostic and statistical manual of mental health disorders published by the APA and approved by the DMH and to the prevention of mental disability and the promotion of mental health. Resources that had been appropriated specifically for services to individuals with dementia, alcoholism, or substance abuse, or for the prevention of mental disability and the promotion of mental health would have to be used for those specific purposes.

The DMH would be required to support research activities, evaluation and quality improvement activities, and training consultation, and technical assistance regarding mental health programs and services and appropriate prevention and mental health promotion activities, including those that are culturally sensitive, to employees of the department, community mental health programs, and other nonprofit agencies providing mental health services under contract with CMHSPs, and establish standards of training and experience for executive directors of CMHSPs. The bill also would require the DMH to shift primary responsibility for the direct delivery of public mental health services from the State to a CMHSP, rather than to the county as currently specified. Further, the DMH would be required to submit to the Legislature an annual report summarizing its assessment of the mental health needs of the State and incorporating information received from CMHSPs. The report would have to include an estimate of the cost of meeting all identified needs.

The DMH also would be allowed to do the following:

-- If considered appropriate by the Director, issue a voucher to a recipient of State services according to the recipient's individual plan of services developed by the DMH.
-- Provide funding for the purpose of establishing revolving loans to assist recipients of public mental health services to acquire or maintain affordable housing. Funding could be provided only through an agreement with a nonprofit fiduciary.
-- Enter into an agreement, contract, or arrangement with any individual or public or nonpublic entity that was necessary or appropriate to fulfill those duties or exercise those powers given by statute to the DMH.

Waiting Lists

Currently, the DMH may establish waiting lists for admissions to, or the provision of services by, its facilities. The lists may be by patient, client, or program categories and must be based on space and other resource availability.

The bill, instead, would require the DMH to establish waiting lists for admissions to State-operated programs. Waiting lists would have to be by diagnostic groups or program categories, age, and gender and would have to specify the length of time each individual had been on the waiting list from the date of the initial request for services. Further, the DMH would have to require that CMHSPs maintain waiting lists if not all service needs were met, and that the waiting lists include data by type of services, diagnostic group or program category, age, gender and length of time individual was on the list. The order of priority on the waiting lists would have to be based on severity and urgency of need.

Licensure

The Code prohibits a person from constructing, establishing, or maintaining a psychiatric hospital, psychiatric unit, or psychiatric partial hospitalization program or using the terms psychiatric hospital, psychiatric unit, or psychiatric partial hospitalization program,

without first obtaining a license. Generally, a license is for one year and costs $400, plus $5 for each patient bed or treatment position. The total license fee, however, may not exceed $2,500.

The bill would change the annual license to a biennial license and revise the fee to $600, plus $7.50 for each patient bed or treatment position, up to a maximum license fee of $5,000.

Nondiscrimination

The bill would require a licensed facility to certify to the DMH that its policies, procedures, and practices were consistent with the Americans with Disabilities Act, the Rehabilitation Act, the Elliott-Larsen Civil Rights Act, and the Michigan Handicappers' Civil Rights Act. This would replace the Code's current requirement that a licensed facility certify that it does not discriminate against persons on the basis of race, creed, color, sex, or national origin.

Family Support Subsidy Program

The Code requires the DMH Director to establish a family support subsidy program to help keep families together and to reduce capacity in State facilities by defraying some of the special costs of caring for a family member. If an application for a subsidy is approved, the subsidy is paid to the parent or legal guardian on behalf of a family member. The bill would delete references to "family member" and, instead, would apply the provisions to an "eligible minor" (defined above).

Chapter 2 - County Community Mental Health Programs

Community Mental Health Service Programs

The Code specifies that a county community mental health program established under the Code is an official county agency. The bill specifies that a CMHSP established under the Code would be a county community mental health agency, a community mental health organization, or a community mental health entity. Further, a county community mental health agency would be an official county agency. A community mental health organization or a community mental health entity would be a governmental unit separate from the county or counties that established it. The procedures and regulations for a community mental health organization or a community mental health entity would have to be set by the board of the CMHSP. The procedures and regulations for a county community mental health agency would have to be set by the board or boards of commissioners as prescribed in the bill.

Community Mental Health Entity

The bill would allow two or more counties to organize and operate a community mental health services program by creating a community mental health organization under the Urban Cooperation Act.

Further, a county agency or organization that was certified by DMH as a CMHSP could become a CMH entity through an enabling resolution adopted by the board of commissioners of each creating county after at least three public hearings held in accordance with the Open Meetings Act. The resolution would be considered adopted if it were approved by a majority of the commissioners elected and serving in each county creating the entity. The enabling resolution would not be effective until it had been filed with the Secretary of State and with the county clerk of each county creating the entity. If any provision of the enabling resolution conflicted with the Code, the Code would supersede the conflicting provision.

The resolution would have to state all of the following:

-- The purpose and the authority to be exercised by the CMH entity, which would have to comply with and carry out the provisions of the Code.
-- The duration of the existence of the entity and the method by which it could be dissolved or terminated by itself or by the county board or boards of commissioners.
-- The manner in which any assets or liabilities would be returned to the participating county or counties or distributed after the dissolution or termination of the entity.
-- The liability of the entity for costs associated with real or personal property purchased or leased by the county for use by the CMHSP to the extent necessary to discharge the financial liability if desired by the county or counties.
-- The manner of employing, compensating, transferring, or discharging necessary personnel, subject to the provisions of applicable civil service and merit systems and the following restrictions: 1) employees of an entity would be public employees and the entity and its employees would be subject to the Public

Employees Relations Act, and 2) an employee who was transferred to a position with a newly formed entity could not, by reason of the transfer, be placed in any worse position with respect to workers' compensation, pension, seniority, wages, sick leave, vacation, health and welfare insurance, or any other benefits that the employee enjoyed as an employee of the former CMHSP.

-- Any other matter consistent with the Code that was necessary to assure operation of the entity as agreed upon by the creating county or counties.

If a county CMH agency became a CMH entity, both of the following would apply:

-- All assets, debts, and obligations of the agency, including, but not limited to, equipment, furnishings, supplies, cash, and other personal property, would be transferred to the entity.

-- All the privileges and immunities from liability and exemptions from laws, ordinances, and rules that were applicable to county CMH boards, board members, officers, administrators, elected officials, and employees of county government would be retained by the board members, officers, agents, and employees of the entity.

In addition to its other powers, a CMH entity would have the power to:

-- Fix and collect rents, fees, and other charges.

-- Make purchases and contracts.

-- Transfer, divide, or distribute assets, liabilities, or contingent liabilities, unless the community mental health entity was a single-county CMHSP and the county has notified DMH of its intention to terminate participation in the CMHSP during the interim period between notification by a county of its intent to terminate participation in a multi-county CMHSP and the official termination of that participation, an entity's power under this provision would be subject to any agreement between the entity and the county that was terminating participation, if that agreement were consistent with the enabling resolution that created the entity.

-- Accept gifts, grants, or bequests and determine their use.

-- Acquire or sell real or personal property, unless the community mental health entity was a single-county CMHSP and the county had notified DMH of its intention to terminate participation in the CMHSP. During the interim period between notification by a county of its intent to terminate participation in a multi-county CMHSP and the official termination of that participation, an entity's power under the provision would be subject to any agreement between the entity and the county that was terminating participation, If that agreement were consistent with the enabling resolution that created the entity.

-- In its own name, enter into contracts and agreements; employ staff; acquire, build, or manage buildings or improvements; acquire, operate, or dispose of real or personal property; incur debts, liabilities, or obligations; and commence litigation and defend itself in litigation.

-- Invest funds in accordance with statutes regarding investments.

-- Set up reserve accounts, using State funds in the same proportion that they related to all revenue sources, to cover vested employee benefits. In addition, an entity could set up reserve accounts for depreciation of capital assets and for expected future expenditures for an organizational retirement plan.

-- Develop a charge schedule for services provided to the public and use the schedule for first- and third-party payers. All revenue over cost generated in this manner would have to be used to provide services to priority populations.

In addition to other duties and responsibilities of a CMHSP as specified in the Code, a community mental health entity would have to provide a copy of an annual independent audit to each county creating the entity and to the DMH, and be responsible for all executive administration, personnel administration, finance, accounting, and management information system functions. The entity could discharge this responsibility through direct staff or by contracting for services.

A county creating a CMH entity would not be liable for any intentional or negligent or grossly negligent act or omission or for any obligation of the entity or its board, employees' representatives, or agents. Further, a CMH entity could not levy any type of tax or issue any type of bond in its own name or financially obligate any unit of government other than itself.

A community mental health entity would be the sole employer of all of its employees with regard to all laws pertaining to employee and employer rights, benefits, and responsibilities.

The bill specifies that as a public body, a community mental health entity would be subject to the Open Meetings Act and the Freedom of Information Act except for those documents produced as a part of the peer review process and made confidential. If a CMHSP elected to merge with an established community mental health entity, the resulting entity would have to be created according to these provisions.

CMH Services Program Purpose

The Code specifies that the purpose of a county CMH program is to provide a range of mental health services for persons who are located within that county. The DMH is required to designate, by rule, the minimum types and scopes of mental health services that must be provided within a county program.

The bill specifies, instead, that the purpose of a CMHSP would be to provide a comprehensive array of mental health services appropriate to conditions of individuals who were located within its geographic service area. Services for children and families would have to be designed to strengthen and preserve the family unit. The CMHSP would have to deliver services in a manner that demonstrated that they were based upon recipient choice and involvement. The DMH would have to designate, by rule, the minimum array of services that all CMHSPs would have to provide. The DMH would have to submit the proposed rules for the array of services to pubic hearing within six months after the effective date of the bill.

Service Priorities

The Code specifies that a service operated within a county program must be directed to at least one of the five following mental health areas: mental illness, developmental disabilities, organic brain and other neurological impairment or disease, alcoholism, or substance abuse. The bill would require, instead, that services provided by a CMHSP be directed to individuals who had a serious mental illness, serious emotional disturbance, or developmental disability. Further, services could be directed to individuals who had other mental disorders that met criteria specified in the most recent diagnostic and statistical manual of mental health disorders published by the APA, and also could be directed to the prevention of mental disability and the promotion of mental health. Resources that were designated specifically to CMHSPs and for services to individuals with dementia, alcoholism, or substance abuse or for the prevention of mental disability and the promotion of mental health would have to be used for those specific purposes.

The bill would require priority to be given to the provision of services to individuals with the most severe forms of serious mental illness, serious emotional disturbance, and developmental disability, and to individuals with a serious mental illness, serious emotional disturbance, or developmental disability in urgent or emergency situations. The Code requires priority to be given to the areas of mental illness and developmental disabilities.

Prerelease Planning

Under the Code, upon notification that an individual has been admitted to a State facility, the appropriate county program with the assistance of the State facility must develop an individualized prerelease plan for appropriate community placement and for aftercare services appropriate for each individual about whom the program was notified. The bill specifies instead that the appropriate CMHSP, with the assistance of the State facility or licensed hospital under contract with a CMHSP, or the State facility would have to develop the prerelease plan.

The Code specifies that if a minor needs an aftercare service with a residential component or an alternative to hospitalization and such a service is not available in the service area of the minor's county program, the program may contract with another county program that offers the service, or with the agency operating the service or the service alternative. The bill would delete this provision and specify instead that if the responsible community mental health services program could not locate suitable aftercare service with a residential component or an alternative to hospitalization in its service area, but the service were available from another service provider, the responsible community mental health service program could contract for the provision of services. The service would have to be located as close to the individual's residence as possible.

The Code requires a State facility to advise an individual about whom the county program has not been notified, of the availability of prerelease planning services offered by the county program. If the individual requests the services, the county program must be notified and must develop a plan for that individual. The bill would require, instead, that a licensed hospital under contract with a CMHSP or a State facility provide the responsible CMHSP with advance notice of an individual's anticipated discharge from patient

care. The CMHSP would have to offer prerelease planning services and develop a release plan in cooperation with the individual unless the individual refused this service.

The bill would delete a provision that allows the county program and the State facility, with the DMH's approval, to agree that the staff of the State facility, on a temporary basis, will conduct prerelease planning services, pending development by the county program of the capability to provide those services.

The Code requires each county program to review regularly the appropriateness of programs, treatment, and community services rendered to individuals. The bill would require the CMHSP to review regularly the outcomes for recipients as a result of the programs, treatment, and community services rendered.

CMHSP Board Composition

The bill would require that at least one-third of the membership of a CMHSP board be primary consumers or family members and at least two of those members be primary consumers. All board members would have to be 18 years of age or older. Currently, representation on a county CMH board need not be in any fixed proportion.

The bill further provides that to meet the requirement concerning the appointment of primary consumers and family members without terminating the appointment of a board member serving on the effective date of the bill, the size of a board could exceed the prescribed 12 members. If a board differed from the prescribed size, it would have to be brought into compliance within three years after the appointment of the additional board members.

The bill also would delete the prohibition against appointing to the board a DMH employee, an employee of the county program, or an employee or representative of an agency under contract to the county program. Instead, the bill specifies that an individual could not be appointed to, and could not serve on, a board if he or she were employed by the DMH or the CMHSP or were an employee or representative of an agency having a contractual relationship with the CMHSP.

The bill would delete a requirement that the DMH reimburse the county for county allotments and matchable expenses for per diem payments as well as the number of meetings per year.

CMH Powers and Duties

The Code requires a county CMH board annually to examine and evaluate the mental health needs of the county or counties it represents and the public and nonpublic services necessary to meet those needs. Information about the mental health needs of the developmentally disabled, mentally ill adults, and emotionally disturbed children, and plans to meet the needs, must be reported to the DMH, which then has to submit a needs assessment report to the Legislature, incorporating the information from the county boards.

The bill would require the board of a CMHSP annually to conduct a needs assessment to determine the mental health needs of the residents of the county or counties it represented and identify the public and nonpublic services necessary to meet those needs. It would be the responsibility of the CMHSP to resolve the public and private providers of mental health services located in the county or counties served by the CMHSP in the assessment and service identification process. In addition, the bill would require a CMH agency to obtain approval of its needs assessment, annual plan, annual operative budget, and request for new funds from the board of commissioners of each participating county prior to submission of the plan to the DMH. A CMH entity or CMH organization would have to provide a copy of its needs assessment, annual plan, and request for new funds to the board of commissioners of each county creating the entity. Also, the bill would require a CMHSP to submit its annual request for county funds to each board of commissioners for approval. Currently, the Code does not require the board's approval for an annual request for county funds. Further, the CMHSP would have to approve annually its operating budget for the year, require the executive direction to select a physician or a psychologist other than a psychologist with a limited license to advise the executive director on treatment issues; and pursue, develop, and establish partnerships with private individuals or organizations, whenever possible, to provide mental health services.

The bill also would delete a requirement that the DMH establish standards for physicians and nonphysicians, and a provision allowing a CMH board to determine whether to appoint a physician as county director. The bill would require the executive director of a CMHSP to select a physician or a psychologist other than a psychologist with a limited license to advise the executive director on treatment issues.

A CMHSP could, if considered appropriate by its executive director, issue a voucher to a recipient according to the recipient's plan of services developed by the CMHSP, and provide funding for the purpose of establishing revolving loans to help recipients of public mental health services to acquire or maintain affordable housing. Funding could be provided only through an agreement with a nonprofit fiduciary. Further, a CMHSP could carry forward the operating margin up to 5% of the CMHSP's State share of the operating budget. "Operating margin" would mean the excess of State revenue over State expenditures for a single fiscal year exclusive of capitated payments under a managed care system. In the case of a community mental health entity, this carryforward would be in addition to the reserve accounts.

In the case of a county community mental health agency, the appointment of the executive director would be effective unless rejected by a 2/3 vote of the county board of commissioners within 15 calendar days after appointment by the board of the CMHSP.

CMH Special Fund Account

The Code allows each county CMH board to create a special fund account with the approval of the county board of commissioners to receive recipient fees and third-party reimbursements for services rendered. The bill specifies that a CMHSP board could create the special fund account, and would delete the requirement that the county board approve the account. A county CMH agency, however, would have to obtain the approval of the board of commissioners of each participating county before creating the account. A report of the receipts into the fund would have to be submitted to the DMH on a quarterly basis, rather than monthly as is currently required.

Currently, money in the account may be used only for matching State funds or for the provision of community mental health services, excluding capital expenditures; the bill would delete the exclusion. The bill also would delete requirements that all expenditures of special fund account funds be made in conformance with the priorities established in the DMH's approved program policy guidelines for community mental health programs, and that the DMH annually evaluate the impact of these provisions on CMH boards and certain recipients and the equity of the distribution of State CMH funds and the availability of mental health services.

Transition Services

The bill would require CMHSPs to participate in the development of school-to-community transition services for individuals with serious mental illness, serious emotional disturbance, or developmental disability. This planning and development would have to be done in conjunction with the individual's local school district or intermediate school district as appropriate and would have to begin not later than the school year in which the individual student reached 16 years of age. The services would have to be individualized. The bill specifies that these provisions are not intended to increase or decrease the responsibility of school districts, CMHSPs, or any other agency or organization with respect to individuals receiving the transition services.

Medical Director

The executive director of a CMHSP would have to appoint a medical director who was a physician who had completed a psychiatric residency program accredited by the accreditation council for graduate medical education or the American Osteopathic and had at least 5 years of clinical experience. The medical director would have to advise in all of the following:

-- Policies relating to medical diagnosis, treatment, rehabilitation, and quality assurance.

-- The clinical aspects of policies relating to research, training certification, development of the CMHSP's annual plan, and the delivery of mental health services.

-- Providing liaison with the medical director of the DMH, community physicians, hospital staff, and other professionals and agencies with regard to psychiatric services.

Contracts and Leases

The bill specifically would allow a board to enter into contracts for mental health services and property lease arrangements with private or public agencies or individuals, and contracts with facilities and entities.

Certification Procedures

The bill would require the DMH to promulgate rules to establish standards for certification and the certification review process for CMHSPs. The standards would have to include, but would

not be limited to matters of governance, resource management, quality improvement, service delivery, and safety management, and the promotion and protection of recipient rights.

After reviewing a CMHSP, the DMH would have to notify a program that substantially complied with the established standards that it was certified by the DMH.

The DMH could waive the certification review process in whole or in part and consider a CMHSP to be in substantial compliance with the established standards if the CMHSP received accreditation from a National accrediting organization recognized by the DMH that included review of matters of governance, resource management, etc.

If the DMH certified a CMHSP despite some items of noncompliance with the established standards, the notice of certification would have to identify the items of noncompliance and the CMHSP would have to correct them. The DMH would have to require the community mental health board to submit a plan to correct items of noncompliance before recertification or sooner at the DMH's discretion.

Certification would be effective for three years and would not be transferable. Requests for recertification would have to be submitted to the DMH at least six months before certification expired. Certification would remain in effect after the submission of a renewal request until the DMH conducted a review and made a redetermination.

The DMH would have to conduct an annual review of each CMHSP's recipient rights system to ensure compliance with established standards. An on-site review would have to be conducted once every three years.

A CMHSP would have to notify the DMH promptly of any changes that could affect continued certification.

The DMH could deny certification if a CMHSP could not demonstrate substantial compliance with the established standards. In lieu of denying certification, the DMH could issue a provisional certification for a period of up to six months upon receiving a plan of correction submitted by the CMHSP. The DMH would have to provide a copy of the review and the approved plan of correction to the board of commissioners of each county that established the county CMH agency or created the CMH organization or CMH services entity. A provisional certification could be extended, but the entire provisional period could not exceed one year. The DMH would have to conduct a review to determine the CMHSP's compliance with the plan of correction at least 30 days before the provisional certification expired. A provisional certification automatically would expire either on its original expiration date or on the expiration date of the extension granted.

If a CMHSP were denied certification, failed to comply with an approved plan of correction before a provisional certification expired, or failed to comply substantially with the established standards, the DMH would have to notify the community mental health services board and the board of commissioners of each county that established the agency or created the organization or entity of the DMH's intention to suspend, deny, or revoke certification. The notice would have to be sent by certified mail and would have to set forth the particular reasons for the proposed action and offer an opportunity for a hearing with the director of the DMH's division that managed contracts with CMHSPs. If it desired a hearing, the community mental health services board would have to request one in writing within 60 days after receiving the notice. The DMH would have to hold the hearing not less than 30 days from the date it received the request.

The director of the DMH's division that managed contracts with CMHSPs would have to make a decision regarding suspension, denial, or revocation of certification based on evidence presented at the hearing or on the default of the community mental health services board. A copy of the decision would have to be sent by certified mail within 45 days after the close of the hearing to the CMH services board and to the board of commissioners of each county that established the agency or created the organization or entity. The CMH services board could appeal the decision under the Administrative Procedures Act.

During the period of certification, the DMH could conduct an unannounced review of a certified CMHSP. The DMH would be required to conduct an unannounced review of a program in response to information that raised questions regarding recipient health or safety. If, based on its review, the DMH found that the CMHSP did not substantially comply with the standards established in the bill, it would have to provide notice and a hearing.

If a CMHSP failed to obtain certification as a result of the DMH's review, had exhausted the

time period for provisional certification, and were not engaged in the process of appeal, or appeal had been unsuccessful, the DMH could cancel the State funding commitment to the community mental health services board, and use the funds previously provided to the board to secure services from other providers of mental health services that the DMH had determined could operate in substantial compliance with the established standards and continue the delivery of services within the county or counties.

If State funding were canceled and the CMHSP were an entity, the county or counties that created the entity would be financially liable only for the local match formula established for the entity under Chapter 3. If State funding were canceled and the CMHSP were a county CMH agency or a CMH organization, the county or counties that established it would be financially liable for the local match for all services contractually or directly provided by the DMH to residents of the county or counties in accordance with Chapter 3.

The DMH could not use the certification process under these provisions to require a CMHSP to become a community mental health entity. Community mental health entity status would be voluntary.

The DMH would have to submit proposed rules for certification to public hearing within six months after the effective date of the bill.

Maintenance and Repair Expenses

Expenditures for the maintenance and repair of adult foster care facilities owned or leased by a CMHSP would be eligible for State financial support. Expenses incurred in renovating an adult foster care facility that was leased or owned by a CMH services program also would be eligible for State financial support if the expenses were incurred for one or more of the following purposes:

-- To correct physical plant deficiencies cited by the Department of Social Services under State licensing rules.
-- To purchase and install fire safety equipment or make physical plant changes that measurably assured a reasonable level of fire protection for all of the residents of the facility.
-- To correct physical plant deficiencies in accordance with State and Federal certification standards.
-- To restore the facility to its prelease condition, if its lease contained a clause stipulating that renovation was the lessee's responsibility at the time the lease expired or was terminated.

Chapter 3 - State and County Financial Responsibility

Local Match

Currently, a county is financially liable for 10% of the net cost of any service that is provided by the DMH to a resident of that county. The bill specifies that if a county demonstrated an inability to meet its local match obligation due to financial hardship, the DMH could either accept a joint plan of correction from the county and its CMH services program that ensured full payment over an extended period of time, or waive a portion of the county's obligation based on hardship criteria established by the DMH.

Currently, a person's county of residence is the county in which he or she maintained his or her primary place of residence at the time he or she entered the DMH facility for services including nighttime sleeping accommodations; or the county in which he or she maintains his or her primary place of residence if he or she is receiving a service that does not include nighttime sleeping accommodations. Under the bill, an individual's county of residence would be the county in which the individual maintained his or her primary place of residence at the time he or she entered a dependent living setting, a boarding school, or a facility.

State Matching Funds

Subject to the appropriations process, the State currently is required to pay 90% of the annual net cost of a county community mental health program. The bill would require the State to pay 90% of the annual net cost of a CMHSP. Beginning in the fiscal year after a CMHSP becomes a community mental health entity, if the DMH increases the amount of state funds provided to CMHSPs for the fiscal year, the amount of local match required of an entity for community mental health services for that fiscal year shall not exceed the amount of funds provided by the CMHSP as local match in the year in which the program became an entity.

The bill would delete a requirement that the DMH make grants from the Community Mental Health Grant Fund to those CMH services boards that have established the special fund account (as described in Chapter 2).

Chapter 4 - Civil Admission and Discharge Procedures: Mental Illness

Definitions

"Clinical certificate" would mean the written conclusion and statements of a physician or a fully licensed psychologist that an individual was a person requiring treatment, together with the information and opinions, in reasonable detail, that underlay the conclusion, on the form prescribed by the DMH or on a substantially similar form. "Competent clinical opinion" would mean the clinical judgment of a physician, psychiatrist, or fully licensed psychologist. "Court" would mean the probate court for the county of residence of the subject of a petition, or for the county in which the subject of a petition was found.

"Formal voluntary hospitalization" would mean hospitalization of an individual based on his or her execution of an application for voluntary hospitalization and the hospital director's determination that the individual was clinically suitable for voluntary hospitalization. "Informal voluntary hospitalization" would mean hospitalization of an individual based on his or her request for hospitalization and agreement to accept treatment, and the hospital director's determination that the individual was clinically suitable for voluntary hospitalization.

"Involuntary mental health treatment" would mean court-ordered hospitalization, alternative treatment, or combined hospitalization and alternative treatment. "Licensed psychologist" would mean a doctoral level psychologist licensed under the Public Health Code. "Mental illness" would mean a substantial disorder of thought or mood that significantly impaired judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life. "Preadmission screening unit" would mean a CMHSP's service component established under the bill. "Private-pay patient" would mean a patient whose services and care were paid for from funding sources other than the CMHSP, the DMH, or other State or county funding. "Release" would mean the transfer of an individual who was subject to an order of combined hospitalization and alternative treatment from one treatment program to another in accordance with his or her individual plan of services. "Subject of a petition" would mean an individual regarding whom a petition had been filed with the court asserting that the individual was or was not a person requiring treatment or for whom an objection to involuntary mental health treatment had been made.

Need for Treatment

The bill specifies that an individual whose mental processes had been weakened or impaired by a dementia, an individual with a primary diagnosis of epilepsy, or an individual with alcoholism or other drug dependence would not require treatment under this chapter unless he or she also met the other criteria for requiring treatment. The individual could be hospitalized under the informal or formal voluntary hospitalization provisions of this chapter if he or she were considered clinically suitable for hospitalization by the hospital director.

Private Pay Admissions

A licensed hospital could admit and treat private pay voluntary or involuntary patients without complying with the preadmission screening requirements or consulting with the CMHSP before release or discharge of the patient, if no CMHSP funds were obligated for the services provided by the licensed hospital, including aftercare services. All other provisions of the Code regarding involuntary admission and recipient rights would apply to the provision of service by licensed hospitals.

Transfers

Currently, a patient in a DMH hospital may be transferred to any other hospital, or to any DMH facility that is not a hospital, if the transfer would not be detrimental to the patient and the DMH approves the transfer. The bill would require the transfer to be approved by both the DMH and the CMH services program.

Preadmission Screening Units

The bill would require each CMHSP to establish one or more preadmission screening units with 24-hour availability to provide assessment and screening services for individuals being considered for admission into hospitals or alternative treatment programs. The CMHSP would have to employ mental health professionals to provide the preadmission screening services or contract with another agency, which would have to meet the requirements of the bill.

Each CMHSP would have to provide the address and telephone number of its preadmission screening unit or units to law enforcement agencies, the DMH, the court, and hospital emergency rooms.

A preadmission screening unit would have to assess individuals who sought authorization for admission into hospitals operated by the DMH or under contract with the CMHSP. If the individual were suitable for hospitalization, the preadmission screening unit would have to authorize voluntary admission to the hospital. If the individual were assessed and found not to be clinically suitable for hospitalization, the preadmission screening unit would have to provide appropriate referral services.

A preadmission screening unit would have to assess and examine, or refer to a hospital for examination, an individual who was taken to the unit by a peace officer or ordered by a court to be examined. If the individual met the requirements for hospitalization, the preadmission screening unit would have to designate the hospital to which the individual would have to be admitted. The preadmission screening unit would have to consult with the individual and, if he or she agreed, it would have to consult with the individual's family member of choice, if available, as to the preferred hospital for admission of the individual.

If the individual chose a hospital not under contract with a CMHSP, and the hospital agreed to the admission, the preadmission screening unit would have to refer the individual to the hospital that was requested by the individual. Any financial obligation for the services provided by the hospital would have to be satisfied from funding sources other than the CMHSP, the DMH, or other State or county funding.

Hospital Admission

The bill specifies that an individual seeking either informal or formal voluntary admission to a hospital either operated by the DMH or under contract with a CMHSP could be considered for admission by the hospital only after authorization by a community mental health services preadmission screening unit.

Guardian Involvement

The Code allows an individual 18 years of age or over to be hospitalized as a formal voluntary patient if he or she applies for hospitalization as a formal voluntary patient and if the hospital director considers the individual to be clinically suitable for that form of hospitalization. The bill, in addition, would allow an individual to be hospitalized if he or she assented and his or her full guardian or limited guardian with authority to admit applied for the hospitalization.

Preadmission Screening Test

The bill would require each CMHSP to designate the hospitals with which it had contracted to receive and detain individuals who were taken into protective custody. Each CMHSP would have to notify the DMH and the State Court Administrative Office of the hospital. The DMH would have to designate the hospitals that would be required to receive and detain individuals presented for examination.

Transport to Preadmission Screening

The Code requires a peace officer, upon receiving an application and a physician's or psychologist's certificate, to take the individual named in an application for hospitalization into protective custody and transport the individual immediately to a hospital. The bill, instead, would require a peace officer upon receipt of a clinical certificate to take the individual into protective custody and transport him or her immediately to the preadmission screening unit or hospital designated by the CMHSP. If an individual taken to the screening unit met the requirements for hospitalization, the peace officer would have to take the individual to a hospital designated by the CMHSP, unless the program made other arrangements. Transportation to another hospital due to a transfer would be the responsibility of the CMH program.

Protective Custody and Transportation

The Code specifies that if a peace officer observes an individual conducting himself or herself in a manner that causes the peace officer reasonably to believe that the individual requires treatment, the peace officer may take the individual into protective custody and transport him or her to a hospital for examination or may notify the CMH emergency service unit for the purpose of requesting mental health intervention services. The CMH emergency service must provide the intervention services it considers appropriate unless the individual declines them. If the individual declines, the officer must immediately transport the person to a hospital. The services may be provided at a site mutually agreed upon by the officer and the CMH emergency service unit or at the site of the CMH emergency unit.

The bill specifies, instead, that the officer could transport the individual to a preadmission screening unit designated by a CMHSP for examination or for mental health intervention

services. The screening unit would have to provide either those services it considered appropriate or an examination. The services could be provided either at the site of the screening unit or at a site designated by the screening unit. Upon arrival at the screening unit or the designated site, the peace officer would have to execute an application for hospitalization of the individual. As soon as practical, the preadmission screening unit would have to offer to contact an immediate family member of the recipient to let the family know that the recipient had been taken into protective custody and where he or she was located. The preadmission screening unit would have to honor the recipient's decision as to whether an immediate family member was to be contacted and would have to document that decision in the recipient's record.

The bill also would delete provisions that allow a peace officer to exercise his or her reasonable judgment and specify that if a peace officer determines that an individual will be released from protective custody as a result of consultation with a CMH emergency service unit, the unit must ensure provisions of follow-up counseling and diagnostic and referral services as needed unless the individual refuses. The bill provides, instead, that the preadmission screening unit would have to ensure that an examination was conducted by a physician or licensed psychologist prior to a recommendation to release the individual. The unit would have to ensure provision of follow-up services if needed, if the person did not meet the requirements for hospitalization.

The bill would require a preadmission screening unit that provided an examination to persons taken into protective custody to conduct the examination as soon as possible after the individual arrived at the site and complete the examination within two hours.

Hearing Process

The Code specifies that the subject of a petition (e.g., an individual asserted to require treatment or to be legally incapacitated) has the right to be present at all hearings but he or she may waive the right by signing a waiver that is witnessed by the subject's legal counsel and filed with the court. The bill would add that the right could be waived in open court at a scheduled hearing. The subject's right to be present at a hearing would be considered waived by his or her failure to attend the hearing after receiving notice of it. The court could exclude the subject from a hearing if his or her behavior at the hearing made it impossible to conduct the hearing. The court would have to enter on the record its reasons for excluding the subject of a petition from the hearing. The subject's presence could be waived by the court if there were testimony by a physician or licensed psychologist who recently had observed the subject that the subject's attendance would expose him or her to serious risk of physical harm.

Requiring Treatment

The Code specifies that an individual may not be found to require treatment unless at least one physician or licensed psychologist who has personally examined the individual testifies in person or by written deposition at the hearing. The bill would add that an individual could be found to require treatment even if the petitioner did not testify, as long as there was competent evidence from which relevant criteria for determining if the person needed treatment could be established.

Independent Evaluation

The Code grants the subject of a petition the right to obtain an independent evaluation by a physician or a psychologist as to whether he or she needs treatment, should be hospitalized, and is of legal capacity. The bill would grant the subject the right to an independent clinical evaluation by a physician, psychiatrist, or psychologist if it were requested before the first scheduled hearing or at the first scheduled hearing before the first witness had been sworn on an application or petition.

The independent clinical evaluation would be for the sole use of the subject of the petition. The evaluation or the testimony of the individual performing the evaluation could not be introduced into evidence without the consent of the subject.

Court-Ordered Treatment

Currently, if the court finds that an individual needs treatment, and the individual is a resident of a county in which the county CMH board has been designated by the DMH as having full management responsibility for all public mental health service delivery to persons located within that county, the court may order the individual to:

-- Be hospitalized in a hospital recommended by and under contract with the CMH board, or in any other public, private, or Federal hospital.

-- Undergo a program of treatment as an alternative to hospitalization that is recommended by the CMH board.
-- Undergo a program of combined hospitalization and alternative treatment.

The bill would make it mandatory that the court order the individual to be hospitalized or undergo treatment, would replace references to county community mental health board with references to CMHSP, and specifies that the individual would be hospitalized Veterans' Administration hospital or a private hospital at the request of the individual or his or her family, if private or Federal funds were to be used. If the individual were hospitalized in a Veterans' Administration hospital or a private hospital, any financial obligation for the hospitalization would have to be satisfied from funding sources other than the CMHSP, the DMH, or other county or State funding.

If private arrangements were made for the reimbursement of mental health treatment services in an alternative setting, the court would have to state on the order for alternative treatment the name of the mental health agency or professional responsible for supervising the individual's alternative treatment program.

The bill would delete provisions allowing the court to order treatment or hospitalization if the person is found by the court to be requiring treatment and is not a resident of a county with a CMH board that has management responsibility for mental health service delivery.

Alternatives to Hospitalization/Continuing Order

The bill specifies that before the expiration of a one-year order of alternative treatment or of combined hospitalization and alternative treatment, if the hospital director or the agency or mental health professional directed to supervise the individual's alternative treatment program believed that the individual continued to require treatment, and he or she were expected to refuse to continue treatment voluntarily when the order expired, the hospital director, agency, or mental health professional would have to petition the court for a determination that the individual continued to require treatment and for an order authorizing one of the following:

-- Continuing hospitalization. An order of continuing hospitalization could be for an unspecified period of time.
-- Combined hospitalization and alternative treatment for a period of not more than one year from the date of issuance of the second order. The hospitalization portion of the order could not exceed 90 days.
-- Alternative treatment for a period of not more than one year from the date of issuance of the second order.

Initial Hospitalization/Continuing Treatment

Currently, an initial order of hospitalization may not exceed 60 days although that can be extended for an additional 90 days, or alternative treatment or a combination of hospitalization and alternative treatment may be ordered for up to one year. Before the 90-day order of hospitalization expires, the court, upon petition, may determine that the person continues to require treatment, and may order continuing hospitalization for an unspecified period, or alternative treatment or a combination of alternative treatment and hospitalization for up to one year. The bill would allow continuing hospitalization for up to one year, continuing alternative treatment for up to one year, or a continuing program of combined hospitalization and alternative treatment to continue for up to one year. The hospitalization portion of a combined order could not exceed 90 days.

Further, the bill specifies that during the period of continuing alternative treatment or continuing hospitalization and alternative treatment, if the court became aware that the individual was not complying with the order or that the alternative treatment had not been or would not be sufficient to prevent harm or injuries that the individual could be inflicting upon himself or herself or upon others, the court, without a hearing and based upon the record and other available information, could order the individual hospitalized for 10 days. Before the expiration of the 10 days, the court would have to hold a hearing. If the court found at the hearing that the individual no longer required treatment, the court would have to enter a finding to that effect and would have to order that the individual was no longer subject to involuntary mental health treatment. If the court found that the individual continued to require treatment, the court could either continue the order of alternative treatment or combined hospitalization and alternative treatment for up to one year or issue a new order for continuing alternative treatment or combined hospitalization and alternative treatment for up to one year. The hospitalization portion of the order could not exceed 90 days.

Regular Review of Status

The bill would delete current requirements that the director of the community mental health

services board for the county of residence of the individual, if the individual is the subject of an order of continuing hospitalization, and the director of an alternative treatment program and the director of a hospital if the person is subject to an order of alternative treatment or a combination of alternative treatment and hospitalization, be informed of a pending review of the person's status and be offered a chance to participate in the review. Instead, the bill specifies that a person subject to an order of involuntary mental health treatment or a one-year order of hospitalization and/or alternative treatment would be entitled to a review of his or her clinical status, which would have to be conducted by the executive director or designee of the CMHSP responsible for treatment.

Referral of a Minor

The bill specifies that if a minor were assessed by the preadmission screening unit or a CMHSP and found not to be clinically suitable for hospitalization, the unit or the executive director of the CMHSP would have to inform the individual or individuals requesting hospitalization of the minor of appropriate available alternative services to which a referral should be made.

Chapter 5 - Civil Admission and Discharge Procedures: Developmental Disabilities

Temporary Admission

Currently, the Code allows an individual to be admitted temporarily to a facility for appropriate purposes and requires the services to be determined by mutual agreement between the facility and the person applying for admission. The bill, instead, provides that an individual with a developmental disability who was referred by a CMHSP could be admitted temporarily to a center for appropriate clinical services. The services would have to be determined by mutual agreement between the center, the person applying for the temporary admission, and the CMHSP.

Administrative Admission

The bill would require an individual with a developmental disability to be referred by a CMHSP before being considered for administrative admission to a center. Currently, an individual may be admitted upon application for admission; no referral is required.

Currently, prior to administrative admission, an individual may be received by a facility for up to 10 days for a preadmission examination. The bill, instead, specifies that prior to administrative admission, an individual could be received by the center designated and approved by the CMHSP for a preadmission examination.

Notice to Leave

The bill would require a center to notify the appropriate CMHSP of a resident's intention to leave the center.

Petition for Judicial Admission

The Code allows a court to order a peace officer to take an individual into protective custody and transport him or her immediately to a facility recommended by the CMHSP or other suitable place for an examination if it appears that the individual will not comply with an order of examination. The bill would require that the other suitable place be designated by the CMHSP. The bill also would require the report of the individual's condition that currently must be completed after the examination to include a judgment of the most appropriate living arrangement for the individual in terms of type and location of living arrangement and the availability of requisite support services. Further, a copy of the report would have to be sent to the court immediately upon completion.

The bill also would delete requirements for a preliminary hearing after an individual is admitted to a facility under these provisions.

Findings on Judicial Admission

The Code specifies that if an individual is found to meet the criteria for judicial admission, the court may order the individual to be admitted to a facility designated by the DMH or to any other public or private facility if it agrees, or to receive care and treatment other than admission to a facility for a period of one year. The bill would make it mandatory that the court do one of the following:

-- Order the individual to be admitted to a center designated by the DMH and recommended by the CMHSP.
-- Order the individual to be admitted to a private facility at the request of the individual or his or her family member, if private funds were to be used and the private facility complied with all of the admission, continuing care, and discharge duties and requirements for centers.
-- Order the individual to undergo a program for one year of care and treatment

recommended by the CMHSP as an alternative to being admitted to a center.

Preferred Facilities

Under the Code, preference between the DMH designated facility and other available facilities must be given to the facility that is nearest to the individual's residence unless the individual requests otherwise or there are compelling reasons for an order reversing the preference. The bill specifies, instead, that preference between the center recommended by the CMHSP and other available facilities under contract with the CMHSP would have to be given to the facility that could appropriately meet the individual's needs in the least restrictive environment and that was located nearest to the individual's residence. If the individual requested it, or there were other compelling reasons for an order reversing the preference, the CMHSP could place the individual in a facility that was not the nearest to his or her residence.

Chapter 6 - Guardianship

The Code defines "facility" in this chapter as a child caring institution, a boarding school, a convalescent home, an adult foster care facility for more than six residents, a nursing home or home for the aged, a mental hospital, psychiatric hospital or psychiatric unit and an institution or a community residential program that is licensed by the State, and that regularly admits developmentally disabled persons and provides residential and other services. The bill would delete this definition (and would redefine the term in Chapter 1).

The bill also would define "respondent" as the individual who was the subject of a petition for guardianship filed under Chapter 6.

The Code currently requires guardianship for developmentally disabled persons to be used only as necessary to promote and protect the well-being of the person; be designed to encourage the development of maximum self-reliance and independence in the person; and be ordered only to the extent necessitated by the person's actual mental and adaptive limitations. The bill would require that guardianship also take into account the individual's abilities.

The Code specifies that the court may not ordinarily or customarily appoint as guardian the DMH or any other agency, public or private, that is directly providing services to the developmentally disabled person. The bill, too, would prohibit the appointment unless extraordinary circumstances existed.

Chapter 7 - Rights of Recipients

Definitions

"Criminal abuse" would mean one or more of the following:

-- An assault that was a violation, or an attempt or conspiracy to commit a violation, of the assault provisions of the Michigan Penal Code. Criminal abuse would not include an assault, or an assault and battery, that was committed by a recipient against another recipient.
-- A criminal homicide that was a violation or an attempt or conspiracy to commit a violation of first- and second-degree murder and manslaughter provisions of the Michigan Penal Code.
-- Criminal sexual conduct that was a violation, or an attempt or conspiracy to commit a violation, of the first-, second-, third-, and fourth-degree criminal sexual conduct provisions and the assault with the intent to commit criminal sexual conduct provision in the Michigan Penal Code.
-- Vulnerable adult abuse that was a violation or an attempt or conspiracy to commit a violation of the Penal Code's provisions that prescribe fines and prison terms for various degrees of vulnerable adult abuse, ranging from a reckless act or failure to act to serious physical or mental harm.

"Experimental psychotropic drug would mean a drug for the treatment of a mental disorder that had been approved and classified as an experimental drug by the Federal Food and Drug Administration.

"Person-centered planning" would mean a process for planning and supporting the individual receiving services that built on the individual's capacity to engage in activities that promoted community life and that honored the individual's preferences, choices, and abilities. The person-centered planning process would involve families, friends, and professionals as the individual desired or required. "Psychosurgery" would mean a surgical procedure to alter or intervene in a serious mental illness or serious emotional disturbance. "Restraint" would mean the use of a physical device to restrict an individual's movement. Restraint would not include the use of a device primarily intended to

provide anatomical support. “Seclusion” would mean the temporary placement of a recipient in a room, alone, where egress was prevented by any means. “Support plan” would mean a written plan that specified the personal support services or any other support that was to be developed with and provided for a recipient. “Treatment plan” would mean a written plan that specified the goal-oriented treatment or training services, including rehabilitation or habilitation services, that were to be developed with and provided to a recipient.

“Wraparound services” would mean an individually designed set of services provided to minors with serious emotional disturbance or serious mental illness and their families that includes treatment services and personal support services or any other supports necessary to maintain the child in the family home. Wraparound services would be developed through an interagency collaborative approach, and a minor’s parent or guardian and a minor age 14 or older would have to participate in planning the services.

Notice of Rights

The bill would require that both applicants and recipients of mental health services, and the parents or guardians of minors, be notified by the service providers of the rights guaranteed by Chapter 7 and 7A. Providers would have to give notice by providing an accurate summary of the chapters at the time services were first requested and by having a complete copy of the chapters readily available for review by applicants and recipients. The Code currently requires that recipients and their parents or guardians be informed of the rights and that they be provided an accurate summary of the chapter.

Rights Pamphlets

The DMH would have to prepare and distribute to each CMHSP copies of a pamphlet containing information regarding resources available to individuals with serious mental illness and their families. The information would have to include a description of advocacy and support groups and other information of interest to recipients and their families. The pamphlet would have to include the name, address, and telephone number of the organization designated by the Governor to provide protection and advocacy for individuals with developmental disability or mental illness.

A CMHSP would have to distribute the pamphlet to each recipient receiving services through the CMHSP and, if applicable, to the recipient’s guardian or the parent of a minor recipient.

Suitable Services

The Code specifies that a resident is entitled to mental health services suited to his or her condition and to a safe, sanitary, and humane living environment. The bill would require that mental health services suited to a recipient’s condition be provided in a safe, sanitary, and humane treatment environment. For a minor recipient, the services could include wraparound services. Mental health services would have to be offered in the least restrictive setting that was appropriate and available within the local CMHSP. A recipient would have the right to be treated with dignity and respect.

Physical and Mental Examination

The Code requires each resident to receive a comprehensive physical and mental examination prior to or soon after admission. The bill would require that the examination be given to each resident of a hospital or center within 24 hours after admission.

Individualized Plan of Services

The Code requires that an individualized written plan of services be developed for each resident; that it be kept current and be modified when indicated; and that the person in charge of implementing it be designated in the plan. The bill would require, instead, that the responsible mental health agency for each recipient ensure that a person-centered planning process be used to develop a written individual plan of services in partnership with the recipient. The individual plan of services would have to consist of a treatment plan, a support plan, or both. The individual plan of services would have to be developed within seven days of the commencement of services or, if an individual were hospitalized, before discharge or release.

If a recipient were not satisfied with his or her individual plan of services, he or she or his or her guardian or the parent of a minor recipient could request a review from the individual in charge of implementing the plan. The review would have to be completed within 30 days and would have to be carried out in a manner approved by the appropriate governing body.

An individual chosen or required by the recipient could be excluded from participation in the planning process only if inclusion of that individual would constitute a substantial risk of physical or emotional harm to the recipient or disruption of the planning process. Justification for an individual's exclusion would have to be documented in the case record.

Surgery and Other Procedures

Currently, a recipient of mental health services cannot undergo surgery or electroconvulsive therapy or any other procedure intended to produce convulsions or coma unless consent is obtained from the recipient, his or her guardian, or his or her parent. The bill specifies that a recipient of mental health services could not undergo surgery unless consent were obtained from the recipient, his or her guardian, the parent who had legal and physical custody of the recipient, or the representative authorized to consent under a durable power of attorney or other advance directive.

Psychosurgery/Electroconvulsive Therapy

The bill would prohibit a recipient from being the subject of psychosurgery, electroconvulsive therapy, or a procedure intended to produce convulsions or coma unless consent were obtained from the following:

-- The recipient, if he or she were 18 years of age or older and did not have a guardian for medical purposes.
-- The recipient's parent who had legal and physical custody of the recipient, if the recipient were less than 18 years of age.
-- The recipient's guardian, if the guardian had the power to execute a consent to these procedures.
-- The recipient's designated representative, if a durable power of attorney or other advance directive granted the representative authority to consent to these procedures.

If a guardian consented to a procedure, it could not be initiated until two psychiatrists had examined the recipient and documented in the recipient's medical record their concurrence with the decision to administer the procedure. If a parent or guardian of a minor consented to a procedure, it could not be initiated until two child psychiatrists, one of whom could be the treating psychiatrist, had examined the minor and documented in the minor's medical record their concurrence with the decision to administer the procedure.

A minor or his or her advocate could object to the administration of a procedure. The objection would have to be made in writing to the probate court, and the procedure could not be initiated before a court hearing on the objection. At least 72 hours, excluding Sundays or holidays, before the initiation of a procedure, a minor would have to be informed that he or she had a right to object to the procedure.

If a procedure were considered advisable for a recipient and an individual eligible to give consent for the procedure were not located after diligent effort, a probate court could, upon petition and after a hearing, consent to administration of the procedure in lieu of the individual eligible to give consent.

Experimental psychotropic drugs would have to be administered to a recipient unless two psychiatrists, one of whom could be the treating psychiatrist, have examined the recipient and documented in the recipient's medical record their concurrence with the decision to administer the treatment.

The prescribing physician would have to explain to a recipient the specific risk, if any, to the recipient of the most common adverse effects that had been associated with psychotropic medication prescribed for the recipient. A written summary of the possible adverse effects would be provided to the recipient by the person dispensing the drug.

Abuse and Neglect

The Code prohibits a recipient of mental health services from being physically, sexually, or otherwise abused and requires the governing body of each facility to adopt written policies and procedures designed to protect recipients from abuse and to prevent the repetition of acts of abuse. A facility is required to cooperate in the prosecution of appropriate criminal charges against those who have engaged in unlawful abuse.

The bill specifies, instead, that a recipient could not be subjected to abuse or neglect. Further, the DMH, each CMHSP, and each licensed hospital would have to ensure that appropriate disciplinary action was taken against those who had engaged in abuse or neglect.

Right to Communication

The Code specifies that the right of a resident to communicate by mail or telephone may be limited if the limitation is essential to prevent the resident from violating a law or to prevent substantial and serious physical or mental harm to the resident, and if each limitation is approved by the head of the facility or his or her designee. The resident also may be prevented by a facility from telephoning an individual who has complained to the facility of previous telephone harassment by the resident and has requested that the resident be prevented from calling him or her in the future. The resident's right to visit with persons of his or her choice may be limited if each limitations essential to prevent substantial and serious physical or mental harm to the resident, and if each limitation is approved by the head of the facility or his or her designee. Any limitation adopted, the date it will expire, and justification for its adoption must be noted promptly in the resident's record.

The bill would delete these provisions and specify instead that the right of a resident to communicate by mail or telephone or receive visitors could not be further limited except as authorized in the resident's individual plan of services.

Fingerprints and Photographs

The Code prohibits the fingerprinting and photographing of recipients of mental health services except under the conditions outlined in the Code. The bill would extend the prohibition to include audiotaping, videotaping, and viewing the recipient through a one-way glass. Photographs would include still pictures, motion pictures, and videotapes.

Money

The bill would delete the current provisions that allow a DMH facility to deny a resident access to and ability to spend or otherwise use the money in his or her account if it has been determined that the denial is essential to prevent the resident from unreasonably and significantly dissipating his or her assets.

Physical Restraints

The Code prohibits a resident from being placed in physical restraint except under the circumstances and conditions specified in the Code. Among other criteria, a resident may be restrained only if it is essential to prevent the resident from physically harming himself, herself, or others or from causing substantial property damage, and only if the resident is restrained by order of a physician who has personally examined him or her, under authorization by a physician until he or she can examine the resident, or temporarily, without an order or authorization, in an emergency. Restraints must be removed when they are no longer essential to achieve the objective that justified their application.

The bill would amend these provisions by:

-- Allowing a person to be restrained only after less restrictive interventions had been considered, and requiring that the consideration of less restrictive measures be documented in the medical record. If restraint were essential in order to prevent the resident from physically harming himself, herself, or others, the resident could be physically held with no more force than was necessary to limit the resident's movement until a restraint could be applied.

-- Allowing a person to be restrained on a physician's order or authorization to a maximum of eight hours.

-- Allowing a recipient to be temporarily restrained for a maximum of 30 minutes without an order or authorization in an emergency. Immediately after imposition of the temporary restraint, a physician would have to be contacted. If the physician did not order or authorize the restraint, it would have to be removed.

-- Allowing a resident to be restrained under a physician's order after personal examination of the resident. An ordered restraint could be used only for the time specified in the order or for eight hours, whichever was less.

-- Requiring the restraints to be removed every two hours for at least 15 minutes unless medically contraindicated, or when they were no longer essential to achieve the objective that justified their initial application.

-- Specifying that if a recipient were restrained repeatedly, the recipient's individual plan of services would have to be reviewed and modified to facilitate the reduction of the use of restraints.

Seclusion

The Code prohibits a resident from being kept in seclusion except in the circumstances and under the conditions specified in the Code. Among other criteria, a resident temporarily may be placed in seclusion only if it is essential to prevent the resident from physically harming himself or herself or others, or if it would be of clinical or therapeutic benefit for the resident.

The bill would:

-- Allow seclusion to be used only in a hospital or center.
-- Delete the provision that seclusion may be used for the clinical or therapeutic benefit of the resident.
-- Limit temporary emergency seclusion to a maximum of 30 minutes.
-- Allow seclusion to occur only on a physician's orders, rather than on the orders of a qualified professional person, and only until a physician could personally examine the resident, or for one hour, whichever was less.
-- Limit seclusion to a maximum of eight hours after the resident had been examined, or four hours for a minor. The Code currently limits seclusion to the time specified in the seclusion order.

The bill specifies further that if a resident were secluded repeatedly, his or her individual plan of services would have to be reviewed and modified to facilitate the reduced use of seclusion.

Freedom of Movement

The Code prohibits a resident's freedom of movement from being restricted more than is necessary to provide mental health services to him or her, to prevent injury to him or her or to others, or to prevent substantial property damage, except that security precautions appropriate to the condition and circumstances of a resident admitted by order of a criminal court or transferred as a sentence-serving convict from a penal institution may be taken.

The bill would add that a restriction adopted under this authority, the date it expired, and justification for its adoption would have to be noted promptly in the recipient's record. Further, the restriction would have to be removed when the circumstances that justified its adoption ceased to exist.

Access to Records

The Code requires the DMH, county CMH programs, and licensed private facilities to grant a representative of the protection and advocacy system access to the records of a person with developmental disabilities or of a mentally ill person who resides in a facility for mentally ill persons if a complaint has been received by the protection and advocacy system from or on behalf of the resident and if the resident does not have a legal guardian, or the State or its designee is the legal guardian.

The bill specifies, instead, that if required by Federal law, the DMH, CMHSPs, and licensed facilities would have to grant a representative of the protection and advocacy system access to records of all of the following:

-- A recipient, if the recipient, his or her guardian with authority to consent, or a minor recipient's parent with legal and physical custody of the recipient consented to the access.
-- A recipient, including a recipient who had died or whose whereabouts were unknown, if the recipient were unable to consent to access because of his or her mental or physical condition; the recipient did not have a guardian or other legal representative or the recipient's guardian were the State; and the protection and advocacy system had received a complaint on behalf of the recipient or had probable cause to believe, based on monitoring or other evidence, that the recipient had been subject to abuse or neglect.
-- A recipient who had a guardian or other legal representative, if a complaint had been received by the protection and advocacy system or there were probable cause to believe the health or safety of the recipient was in serious and immediate jeopardy; upon receiving the name and address of the recipient's legal representative, the protection and advocacy system had contacted the representative and offered assistance in resolving the situation; and the representative had failed or refused to act on behalf of the recipient.

The bill specifies that the case records would not be part of the peer review process. Reports of investigations concerning an individual employed by or under contract to a state facility, licensed hospital, or CMHSP would not be part of the

peer review process. The Holder of an individual's record, if authorized to release information for clinical purposes by the individual or the individuals guardian or a parent of a minor, could release a copy of the entire medical and clinical record to the provider of mental health services.

A recipient, guardian, or parent of a minor recipient, after having gained access to treatment records, could challenge the accuracy, completeness, timeliness, or relevance of factual information in the recipient's record. The recipient, guardian, or parent of a minor recipient would have to be allowed to insert into the record a statement correcting or amending the information at issue. The statement would become part of the record.

Policies and Procedures

The Code requires providers of mental health services to recipients to adopt official policies and procedures in writing as necessary to implement this chapter. The policies and procedures may amplify, particularize, or expand the rights guaranteed to recipients by the Code. Further, the policies and procedures must provide a simple mechanism for recipients and others to report apparent violations of this chapter, and a system for determining whether in fact violations have occurred, and must ensure that firm and fair disciplinary and appropriate remedial action is taken in the event of a violation. The bill would delete these provisions and instead would require all providers of mental health services to establish written policies and procedures concerning recipient rights and the operation of an office of recipient rights. The policies and procedures would have to be consistent with this chapter and Chapter 7A and would have to be designed to protect recipients from, and prevent repetition of, violations of rights guaranteed by this chapter and Chapter 7A. The policies and procedures would have to include, at a minimum, all of the following:

-- Complaint and appeal processes; treatment and services; sterilization, contraception, and abortion; fingerprinting, photographing, audiotaping, and use of one-way glass; abuse and neglect, including detailed categories of type and severity; confidentiality and disclosure; treatment by spiritual means; qualifications and training for recipient rights staff; change in type of treatment; medication procedures; use of psychotropic drugs; use of restraint; right to be treated with dignity and respect; least restrictive setting; and services suited to condition.

-- Policies and procedures that addressed all of the following matters with respect to residents: right to entertainment material, information, and news; comprehensive examinations; property and funds; freedom of movement; resident labor; communication and visits; and use of seclusion.

All policies and procedures required by the bill would have to be established within 12 months after the effective date of the bill.

The DMH would be required to review the recipient rights system of each CMHSP in accordance with established standards to ensure a uniformly high standard of recipient rights protection throughout the State.

DMH Office of Recipient Rights

Currently, the Code requires the DMH, each county CMH program, and any facility operated by a political subdivision of the State separate from a county CMH program to establish an office subordinate only to the chief official of the agency establishing it. The office must receive reports of, and may investigate, apparent violations of the rights guaranteed by the Code. Further, the office may act to resolve disputes relating to apparent violations, may act on behalf of recipients of mental health services to obtain remedy for any apparent violations, and must otherwise endeavor to safeguard the rights guaranteed by the Code. The bill would delete these provisions and instead would require the DMH to establish a State Office of Recipient Rights subordinate only to the DMH Director. The DMH would be required to ensure that:

-- The process for funding the Office included a review of the funding by the State recipient rights advisory committee.

-- The Office would be protected from pressures that could interfere with the impartial, evenhanded, and thorough performance of its duties.

-- The Office would have unimpeded access to all programs and services operated by or under contract with the DMH unless other recipient rights systems authorized by the Code existed; all staff employed by or under contract with the DMH; and all evidence necessary to conduct a thorough investigation or to fulfill its monitoring function.

-- Staff of the Office received training each year in recipient rights protection.
-- Each contract between the DMH and a provider required that the provider and his or her employees received recipient rights training and that the recipients would be protected from rights violations while they were receiving services under the contract.
-- Technical assistance and training in recipient rights protection were available to all CMHSPs and other mental health service providers subject to the Code.

The DMH would have to try to ensure that the Office had sufficient staff and other resources necessary to perform its duties; complainants, staff of the State Office, and any staff acting on behalf of a recipient would be protected from harassment or retaliation resulting from recipient rights activities; and appropriate remedial action was taken to resolve violations of rights and notify the complainants of substantiated violations in a manner that did not violate employee rights.

After consulting with the State recipient rights advisory committee, the DMH Director would have to select a director of the State Office of Recipient Rights who had the education, training, and experience to fulfill the responsibilities of the Office. The DMH Director could not replace or dismiss the director of the State Office of Recipient Rights without first consulting the State recipient rights advisory committee. The director of the Office would have no direct service responsibility.

The State Office of Recipient Rights could do all of the following:

-- Investigate apparent or suspected violations of the rights guaranteed by this chapter.
-- Resolve disputes relating to violations.
-- Act on behalf of recipients to obtain appropriate remedies for any apparent violations.
-- Apply for and receive grants, gifts, and bequests in order to effectuate any purpose of this chapter.

The State Office of Recipient Rights would be required to ensure that recipients, parents of minor recipients, and guardians or other legal

representatives had access to summaries of the rights guaranteed by this chapter and Chapter 7A and were notified of those rights in an understandable manner, both at the time services were requested and periodically during the time services were provided to the recipient. The Office would have to ensure that its number and address and the names of rights officers were conspicuously posted in all service sites. The Office also would have to maintain a record system for all reports of apparent or suspected rights violations received, including a mechanism for logging in all complaints and a mechanism for secure storage of all investigative documents and evidence for a reasonable period of time.

In addition, the Office would be required to initiate actions that were appropriate and necessary to safeguard and protect rights guaranteed by this chapter to recipients of services provided directly by the DMH or by its contract providers other than CMHSPs. The Office would have to receive reports of apparent or suspected violations of rights guaranteed by this chapter, and refer reports of apparent or suspected rights violations to the recipient rights office of the appropriate provider to be addressed by its internal rights protection mechanisms. The State Office would have to intervene as necessary to act on behalf of recipients in extraordinary situations in which the DMH Director considered the rights protection system of the provider to be out of compliance with the Code and rules promulgated under it.

Upon request, the Office would have to advise recipients of the process by which a rights complaint could be made and help recipients prepare written rights complaints. The Office also would have to advise recipients that there were advocacy organizations available to help them prepare written rights complaints and offer to refer them to those organizations; upon receipt of a complaint, advise the complainant of the complaint process, appeal process, and mediation option; ensure that each service site operated by the DMH or by a provider under contract with the DMH, other than a CMHSP, was visited by recipient rights staff at least annually, and as frequently as necessary to protect rights; ensure that all individuals employed by the DMH received training related to recipient rights protection before or within 30 days after being employed; and ensure that all reports of apparent or suspected violations of rights within State facilities were investigated and that those reports that did not warrant investigation were duly recorded.

Further, the Office would be required to review semiannual statistical rights data submitted by CMHSPs and licensed hospitals to determine trends and patterns in the protection of recipient

rights in the public mental health system and provide a summary of the data to CMHSPs; serve as consultant to the Director in matters related to recipient rights; and, at least quarterly, provide aggregate data consistent with the annual report on complaints, together with a summary of remedial action taken on substantiated complaints, to the DMH and the State recipient rights advisory committee.

The Office also would have to submit to the DMH Director, for availability to the public, an annual report on the current status of recipient rights in this State. The report would have to be submitted by December 30 of each year for the preceding fiscal year. The annual report would have to include, at a minimum, all of the following: aggregate data regarding the rights of recipients receiving services from the DMH including complaints received, the number of reports filed, and the number of reports investigated; the number of substantiated rights violations by category; the remedial actions taken on substantiated rights violations; training received by staff of the State Office of Recipient Rights; training provided by the Office to contract providers; outcomes of assessments of the recipient rights system of each CMHSP; identification of patterns and trends in rights protection in the public mental health system in this State; review of budgetary issues including staffing and financial resources; a summary of the results of any consumer satisfaction surveys conducted; and recommendations to the DMH.

The bill also would require each CMHSP and each licensed hospital to establish an office of recipient rights subordinate only to the executive director or hospital director. Each CMHSP and each hospital would have the same rights and responsibilities in relation to its office of recipient rights as the DMH would have in relation to the State Office, and the local offices would have duties and responsibilities similar to those of the State Office.

State Recipient Rights Advisory Committee

The bill would require the DMH Director to appoint a 12-member State recipient rights advisory committee. The membership of the committee would have to be broadly based so as to best represent the varied perspectives of Department staff, government officials,

attorneys, community mental health services program staff, private providers, recipients, and recipient interest groups. At least four of the members would have to be primary consumers or family members, and of those four, at least two would have to be primary consumers. In appointing members to the advisory committee, the Director would have to consider the recommendations of the director of the State Office of Recipient Rights and individuals who were members of the recipient rights advisory committee on the effective date of the bill.

The State recipient rights advisory committee would have to do all of the following:

-- Meet at least quarterly, or more frequently as necessary, to carry out its responsibilities.
-- Maintain a current list of members' names and a separate list of categories represented, to be made available to individuals upon request.
-- Protect the State Office of Recipient Rights from pressures that could interfere with the impartial, evenhanded, and thorough performance of its functions.
-- Recommend to the DMH Director candidates for the position of director of the State Office of Recipient Rights and consult with the Director regarding any proposed dismissal of the director of that Office.
-- Serve in an advisory capacity to the DMH Director and the director of the State Office of Recipient Rights.
-- Review and provide comments on the report submitted by the State Office of Recipient Rights to the DMH.
-- If designated by the board of the CMHSP, serve as the appeals committee for a recipient's appeal.

Meetings of the State recipient rights advisory committee would be subject to the Open Meetings Act, and minutes would have to be maintained and made available to individuals upon request.

The board of each CMHSP would have to appoint a recipient rights advisory committee. Further, unless otherwise provided by contract, each licensed hospital would have to appoint a recipient rights advisory committee. At least one-third of the membership of the committees would have to be primary consumers or family members, and of that one-third, at least one-half would have to be primary consumers.

The recipient rights committees would have to meet at least semiannually or as necessary to

carry out their responsibilities, which would be similar to those of the State recipient rights advisory committee.

Chapter 7A - Dispute Resolution

Definitions

"Allegation" would mean an assertion of fact made by an individual that had not yet been proved or supported with evidence. "Appeals committee" would mean a committee appointed by the Director or by the board of a CMHSP or a licensed hospital. "Applicant" would mean the recipient, parent, or guardian who appealed a recipient rights finding or a respondent's action to an appeals committee. "Complainant" would mean an individual who filed a rights complaint. "Investigation" would mean a detailed inquiry into and systematic examination of an allegation raised in a rights complaint. "Mediation" would mean a private, informal dispute resolution process in which an impartial, neutral individual assisted parties in reaching their own settlement of issues in a dispute and had no authoritative decision-making power. "Office" would mean the State Office of Recipient Rights, if the rights complaint involved services provided or contracted by the DMH, or the office of recipient rights established by a CMHSP or a licensed hospital if the complaint involved services provided by a CMHSP or a licensed hospital. "Respondent" would mean the service provider that had responsibility at the time of an alleged rights violation for the services with respect to which a rights complaint had been filed.

Appeals Committee

The bill would require the DMH Director to appoint a seven-member appeals committee to hear appeals of recipient rights matters. The committee would have to include at least three members of the State recipient rights advisory committee and two primary consumers. The board of a CMHSP would have to do one of the following:

-- Appoint a seven-member appeals committee to hear appeals of recipients' rights matters. The appeals committee would have to include at least three members of the recipient rights advisory committee, two board members, and two primary consumers. A member of the appeals committee could represent more than one of these categories.

-- Designate the recipient rights advisory committee as the appeals committee.

The governing body of a licensed hospital would have to designate the appeals committee of the local CMHSP for the appeal of a rights complaint brought by a consumer of that CMHSP. Further, the governing body would have to do one of the following with respect to an appeal of a rights complaint brought by an individual who was not a consumer of a CMHSP:

-- Appoint a seven-member appeals committee; two of the members would have to be primary consumers and two would have to be community members.
-- By agreement with the DMH, designate the appeals committee appointed by the DMH to hear appeals of rights complaints brought against the licensed hospital.

An appeals committee could request consultation and technical assistance from the DMH.

Rights Complaints

A recipient, or another individual on behalf of a recipient, could file a rights complaint with the office alleging a violation of the Code or rules promulgated under it. A rights complaint would have to contain a statement of the allegations that gave rise to the dispute, a statement of the right that the complainant believed had been violated, and the specific outcome that the complainant was seeking as a resolution to the complaint.

Each rights complaint would have to be recorded by the office, and acknowledgment of the recording would have to be sent to the complainant orally or in writing by the next working day. The office would have to notify a complainant if it determined that no investigation of the rights complaint was warranted.

If someone filed a rights complaint regarding the conduct of the executive director of a CMHSP, the rights investigation would have to be conducted by the office of another CMHSP by agreement of both boards.

Investigation

The office would have to initiate investigation of apparent or suspected rights violations in a timely and efficient manner. Investigation would

have to be initiated immediately in cases involving alleged abuse, neglect, serious injury, or death of a recipient involving an apparent or suspected rights violation. Investigation activities for each rights complaint would have to be recorded accurately by the office.

The office would have to determine whether a right was violated by using the preponderance of the evidence as its standard of proof. The office would have to issue a written status report every 30 calendar days during the course of the investigation. The report would have to be submitted to the complainant, the respondent, and the responsible mental health agency. A status report would have to include a statement of the allegations and the issues involved; citations to relevant provisions of the Code, rules, and policies; investigative progress to date; and the expected date for completion of the investigation.

Upon completion of the investigation, the office would have to submit a written investigative report to the respondent and to the responsible mental health agency. Issuance of a final investigative report could be delayed pending completion of investigations that involved external agencies, including law enforcement agencies and the Department of Social Services. The report would have to include a statement of the allegations and the issues involved; citations to relevant provisions of the Code, rules, and policies; investigative findings; conclusions; and recommendations, if appropriate. The office could reopen or reinvestigate a rights investigation if there were new evidence that was not presented at the time of the investigation.

If it were determined through investigation that a right had been violated, the respondent would have to take appropriate remedial action that corrected or remedied rights violations, was implemented in a timely manner, and attempted to prevent a recurrence of the rights violation. The action would have to be documented and made part of the record maintained by the office.

The executive director or hospital director would have to submit a written summary report to the complainant and to the recipient, if he or she were not the complainant, within 90 days after it received the rights complaint. The summary report would have to include a statement of the allegations; a summary of investigative findings; recommendations made by the office; action taken, or plan of action proposed, by the respondent; and, in the case of a rights complaint that was not substantiated, a statement describing the complainant's right to

appeal and the conditions for appeal. Information in the summary report would have to be provided within the constraints prescribed in the bill and could not violate the rights of any employee.

Within 45 days after receiving the summary report, the complainant could file a written appeal with the appeals committee with jurisdiction over the office of recipient rights that issued the summary report. The appeal would have to be based on the grounds that the investigative findings of the office were not consistent with the facts or with law, rules, or guidelines, or the action taken or plan of action proposed by the respondent did not provide an adequate remedy.

The office would have to advise the complainant that there were advocacy organizations available to help the complainant prepare the written appeal, and would have to offer to refer the complainant to those organizations. In the absence of assistance from an advocacy organization, the office would have to help the complainant meet the procedural requirements of a written appeal.

Within five business days after receiving the written appeal, the members of the appeals committee would have to review the appeal to determine whether it met the specified criteria. If the appeal were denied, the complainant would have to be notified in writing. If the appeal were accepted, notice would have to be provided to the complainant, and a copy of the appeal would have to be provided to the respondent and the responsible mental health agency.

Within 30 days after receiving a written appeal, the appeals committee would have to meet and review the facts as stated in all complaint investigation documents. Within 30 days after it first met to review an appeal, the appeals committee would have to 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, or, if the responsible mental health agency were a CMHSP or a licensed hospital, recommend that the board of the CMHSP or the

governing board of the licensed hospital request an external investigation by the State Office of Recipient Rights.

The appeals committee would have to document its decision in writing. Within 10 working days after reaching its decision, it would have to provide copies of the decision to the respondent, appellant, recipient, if different than the appellant, the recipient's guardian if a guardian had been appointed, and the responsible mental health agency.

Mediation

At any time after the Office completed the investigative report, the parties could agree to mediate the dispute. A mediator would have to be selected jointly to facilitate a mutually acceptable settlement between the appellant and respondent. The mediator would have to be an individual who had received training in mediation and who was not involved in any manner with the dispute or with the provision of services to the appellant. The appellant would not be responsible for any costs of mediation.

The office would have to inform the appellant that an appeal hearing before the appeals committee would proceed if the appellant did not agree to mediation. If the parties agreed to mediation and reached agreement through the mediation process, the mediator would have to prepare a report summarizing the agreement, which would have to be signed by the complainant and respondent. The signed agreement would be binding on both parties.

If the parties failed to reach agreement through the mediation process, the mediator would have to document that fact in writing and provide a copy of the documentation to both parties within 10 days after the end of the mediation process. If the parties engaged in mediation, all appeal and response times required under this chapter would be suspended during the period of time the mediation process took place. The suspension of time periods would begin on the day the parties agreed to mediate and would expire five days after the day the mediator provided the written documentation to the parties that mediation was not successful.

Chapter 8 - Financial Liability

Definitions

"Ability to pay" would mean the ability of a responsible party to pay for the cost of services.

"Cost of services" would mean the total operating and capital costs incurred by the DMH or a CMHSP with respect to, or on behalf of, an individual. Cost of services would not include the cost of research programs or expenses of State or county government unrelated to the provision of mental health services.

"Inpatient services" would mean 24-hour care and treatment services provided by a State facility or a licensed hospital. "Insurance benefits" would mean payments made in accordance with insurance coverage for the cost of health care services provided to an individual.

"Insurance coverage" would mean any policy, plan, program, or fund established or maintained for the purpose of providing for its participants or their dependents medical, surgical, or hospital benefits. Insurance coverage would include, but would not be limited to, Medicaid or Medicare; policies, plans, programs, or funds maintained by nonprofit hospital service and medical care corporations, health maintenance organizations, and prudent purchaser organizations; and commercial, union, association, self-funded, and administrative service policies, plans, programs, and funds.

"Nonresidential services" would mean care or treatment services that were not inpatient or residential services. "Residential services" would mean 24-hour dependent care and treatment services provided by adult foster care facilities under contract to the DMH or a CMHSP or provided directly by a CMHSP. "Responsible party" would mean a person who was financially liable for services furnished to the individual. Responsible party would include the individual and, as applicable, the individual's spouse and parent or parents.

Financial Liability

Financial liability for services provided to an individual by the DMH or by a CMHSP would be established as provided in this chapter.

The bill would require the DMH or a CMHSP to charge responsible parties for that portion of the financial liability that was not met by insurance coverage. The amount of the charge would be whichever of the following was the least amount: ability to pay determined under the bill, cost of services, or the amount of coinsurance and deductible in accordance with the terms of participation with a payer or payer group. The DMH or CMHSP would have to waive payment of that part of a charge that exceeded financial

liability. The DMH or CMHSP could not impose charges in excess of ability to pay.

Insurance

The bill specifies that insurance coverage would be considered available to pay for an individual's financial liability for services provided by the DMH or a CMHSP or its contractee in the amount and to the same extent that coverage would be available to cover the cost of services if the individual had received the services from a health care provider other than the DMH or a CMHSP or its contractee.

The bill would require the DMH or a CMHSP to be subrogated to a responsible party's right of recovery for insurance benefits for the cost of services to the individual.

The Code currently specifies that if parents willfully refuse to apply for insurance proceeds that cover, in part or in whole, the cost of services provided to an individual, or other benefits to which an individual may be entitled, the financial liability of the parents must be determined in the same manner as for the individual. The bill, instead, provides that if a responsible party failed to provide relevant insurance coverage information to the DMH or the CMHSP, or if a responsible party failed to apply to have insurance benefits that covered the cost of services provided to the individual paid to the DMH or the CMHSP, the responsible party's ability to pay would have to be determined to include the amount of insurance benefits that would be available. If the amount of insurance benefits were not known, the responsible party's ability to pay would have to be determined to be the full cost of services.

For an individual who received inpatient or residential services on a voluntary or involuntary basis, the DMH or the CMHSP would have to determine the responsible parties' insurance coverage and ability to pay as soon as practical after the individual was admitted. For an individual who received nonresidential services, the DMH or CMHSP would have to determine the responsible parties' insurance coverage and ability to pay before, or as soon as practical after, the start of services.

Ability to Pay Determination

The bill would delete current provisions concerning financial liability for services provided to residents of facilities. Instead, the bill would require the DMH and CMHSPs to determine an adult responsible party's ability to pay for adult inpatient psychiatric services of less than 61 days, all nonresidential services, and all services to minors, on the basis of the adult responsible party's income according to the following:

-- The DMH or CMHSP would have to consider the adult responsible party's income to be taxable income as specified in his or her most recently filed State income tax return. If the parents of an individual, or the individual and spouse, were members of the same household but filed separate income tax returns, the DMH or CMHSP would have to add together the separate taxable incomes to determine the ability to pay. If the parents or the individual and spouse were not members of the same household and they filed separate tax returns, the ability to pay of each parent or of the individual and his or her spouse would have to be determined separately.

-- If an adult responsible party had not filed a State income tax return, the DMH or CMHSP would have to determine his or her income from those financial documents that were legally available, based on the same factors that determine taxable income under the previous provision.

-- Relying on an adult responsible party's income as determined under the two previous provisions, the DMH and CMHSP would have to determine ability to pay based on an ability to pay schedule developed under the bill.

-- An adult responsible party's ability to pay for a calendar month or any part of a calendar month would be the amount specified as the monthly amount in the applicable ability to pay schedule.

-- A parent would not be determined to have an ability to pay for more than one individual at any one time. A parent's total liability for two or more individuals could not exceed 18 years.

-- If either parent or either spouse had been made solely responsible for an individual's medical and hospital expenses by a court order, the other parent or spouse would have to be determined to have no ability to pay. The ability to pay of the parent or the spouse made solely responsible by court order would have to be determined in accordance with these provisions, and

would have to be reduced by the amount of child support the parent paid for the individual.

-- If an individual received services for more than one year, the DMH or CMHSP annually would have to redetermine the adult responsible parties' ability to pay on the basis of the most recently filed State income tax return or from financial documents that were legally available.

The DMH would have to promulgate rules to establish an ability to pay schedule that was fair and equitable. The schedule could take into consideration geographic cost-of-living differences and could establish nominal charges for certain services. The DMH would have to review the schedule at least every three years and would have to update the respective schedule as necessary. The DMH would have to submit proposed rules under these provisions within six months after the effective date of the bill.

The DMH or CMHSP would have to determine an adult responsible party's ability to pay for residential services and inpatient services other than psychiatric inpatient services of less than 61 days by taking into consideration the adult responsible party's total financial circumstances, including, but not limited to, income, expenses, number and condition of dependents, assets, and liabilities. Further, the DMH and CMHSPs would have to determine a minor's ability to pay for the cost of services by considering the minor's total financial circumstances, including, but not limited to, income, expenses, number and condition of dependents, assets, and liabilities.

Except with respect to inpatient psychiatric services of less than 61 days, the DMH or a CMHSP would have to determine a spouse's ability to pay for the first 730 days of inpatient or residential services during the individual's lifetime. After the first 730 days, the DMH or CMHSP would have to determine ability to pay solely for the individual.

The code currently specifies that a determination of ability to pay made by the DMH cannot impose an undue financial burden on the individual or his or her family. The bill would add that if through no fault of the individual or the individual's family members the DMH fails to bill for services in a timely manner, an undue financial burden has been created. The DMH could only obligate an individual or the individual's family to pay for services based on their ability to pay when the initial bill for services was presented within three years from the date the services were provided.

Revised Ability to Pay

The Code requires the DMH to review at appropriate intervals each determination of ability to pay and, if there has been a significant change in a person's ability to pay, a new determination must be made. The bill would require, instead, that the DMH or a CMHSP determine annually the insurance coverage and ability to pay of each individual who continued to receive services and of each additional responsible party, if applicable. The DMH or CMHSP also would have to complete a new determination of insurance coverage and ability to pay, if informed of a significant change in a responsible party's ability to pay.

The Code provides that the individual, spouse, or parents are legally liable "only for the amounts that it had been previously established they had the ability to pay". The bill specifies, instead, that if the DMH or a CMHSP redetermined a responsible party's ability to pay and the amount the responsible party was determined to be able to pay was higher than the amount under previous determinations, the DMH or CMHSP could charge the higher amount only for financial liability that was incurred after the date of the redetermination.

Chapter 9 - Other Provisions

The bill would require the DMH to support training, studies, and research in its effort to prevent mental disease and promote mental health.

Repealer

The bill would repeal the following sections of the Code:

-- Section 130: Community mental health center.
-- Section 132: Mental retardation service facility.
-- Section 200: Definitions.
-- Section 209: Notifying county program of admittance of individual to state facility.
-- Section 246: Michigan conference of county CMH programs.
-- Section 450: Preliminary hearing to determine probable cause for treatment.

-- Section 492: Specific evidence and findings as to legal capacity required; appointment of guardian or conservator.
-- Section 493: Petition for restoration to legal competence and termination of guardianship.
-- Section 494: Physician's or psychologist's report.
-- Section 495: Appointment of physician or psychologist; examination; report.
-- Section 495a: Code applicable to involuntary commitment procedure; construction.
-- Section 496: Restoration to legal competence.
-- Section 738: Right to education.
-- Section 816: Cost of services.
-- Section 826: Limitation on exhaustion of net worth.
-- Section 840: No liability for services provided under criminal statute.
-- Section 844: Rules; uniformity between liability for services provided by Department and community programs.
-- Sections 900, 902, 904, 906, 908, 910, and 912: Lafayette Clinic.
-- Sections 914, 916, and 918: Neuropsychiatric institute.
-- Section 950: Definitions.

MCL 330.1100 et al.

Legislative Analyst: L. Burghardt

FISCAL IMPACT

The bill could have a potentially significant fiscal impact on State government funding. A review of the amendments indicate that there are two provisions--the 100% State General Fund responsibility for the cost of programs that were in excess of program provision in the year prior to the CMH program's conversion to county entity status (Section 308(1)), and the financial hardship waiver for county programs (Section 302(4))--that are of particular concern.

According to the Department, the language in Section 308(1) is intended, once a county program became a county entity, to freeze the county's financial share of the annual net cost of county programs at the 10% level. If, however, new programs were mandated by the State, the State could assume "all the annual net cost of services". The development of new programs and their cost cannot be predetermined, nor can the need be assumed. But the assumption that any new programs' costs will be shared by the county could no longer be made in the State budget.

As program costs grow, the freezing of the county portion of the costs would have a considerable fiscal impact. Assuming a 4% growth rate in State-mandated programs, by the fifth year the net fiscal impact would be up to $10 million GF/GP, and by the 20th year it would be up to $60 million GF/GP.

The financial hardship waiver located in Section 302(4) provides that if a county demonstrated financial difficulties, the Department could accept a plan for extended payment or excuse a portion of the amount of the obligation. It is assumed that these actions could cause a reduction in the payment of local funds within a particular fiscal year. The bill does not clearly outline when or if there is a provision for boards to request State General Fund dollars to make up the difference.

Other provisions that have fiscal considerations include but are not limited to: 1) a carry-forward of up to 5% of the State share of the operating budgets in excess of State revenues over State expenditures; 2) reserve funds accounts using State funds; 3) the elimination of a specific consumer payment fee schedule outlined in the Code; 4) the appearance of the elimination of the mental health grant fund; and 5) changes in the licensing requirements for psychiatric hospitals. These and other issues need to be reviewed in more depth (at greater length) to reach some sense of the magnitude of the impact.

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