

MEMORANDUM
DEPARTMENT OF COMMUNITY HEALTH
LANSING, MICHIGAN 48913

February 11, 2005

TO: Community Mental Health Services Program (CMHSP) Executive Directors
FROM: Irene Kazieczko, Director, Bureau of Community Mental Health Services 
SUBJECT: Fiscal Year (FY) 2005/2006 Adult Mental Health Block Grant - Request for Proposals
Proposal Application Deadline: April 20, 2005

Attached for your careful review and response is the Mental Health Block Grant Request for Proposals (RFP). Community Mental Health Services' Block Grant funds are targeted for development of new community-based service initiatives for adults with serious mental illness, as specified in the Michigan of Department of Community Health plan approved by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (CMHS).

MDCH is engaged, with its stakeholders, in a systems transformation process. A transformed public mental health system will be based on a vision of recovery. A recovery vision is grounded in the idea that people can recover from mental illness, and that the service delivery system must be constructed based on this knowledge. Projects in the following program areas are invited: Anti-Stigma; Advance Directives (Crisis Planning); Peer Support Specialists; Person-Centered Planning; Self-Determination; Jail Diversion; Recovery; Consumer-Run, Delivered, or Directed Services; Supports and Services for Older Adults; Clubhouse Programs; Supported Employment; Homeless Populations; and Other Special Populations. New projects funded under this initiative will be effective October 1, 2005 through September 30, 2006. Total funding for new projects to begin during this period is approximately \$2.5 million.

Program areas within a CMHSP that have not received block grant funding in the last three years and projects in rural areas are a priority for funding. Planning for sustaining new programs funded continues to be an important consideration in funding new initiatives. Projects aimed at one-time purchases and training may be funded for one year only. Projects aimed at service innovation or service development may be funded for a two-year period with the second year contingent on first year progress. Maximum funding per service innovation or service development project is up to \$75,000 for the first year, and up to \$56,250 for a second year, with a 25% CMHSP match requirement for the second year. Review criteria are included in the RFP.

It is important that CMHSPs review and edit proposals for submission, including proposals drafted by CMHSP subcontractors intending to perform services. Department staff will contact CMHSP staff to resolve any questions they may have regarding proposals. Please make sure the face sheet contains the appropriate contact information.

An **informational meeting** for CMHSPs interested in responding to this RFP is scheduled for **Thursday, February 24, 2005, from 1:00 to 4:00 p.m.**, in the Manty Conference Room at Baker Olin West, 3423 North Martin Luther King Jr. Boulevard, Lansing, MI. The entrance to Baker Olin West is on the backside of the building. Due to space limitations, each CMHSP may have one or two representatives at this meeting. A summary of questions and answers from the meeting will be compiled and sent to all CMHSPs following the meeting.

Please direct questions regarding this RFP to the specialist identified for each program area. Please share this RFP with program and financial staff.

Attachments

cc: Patrick Barrie, Mark Kielhorn, Judy Webb, Patricia Degnan, Specialists, Contract Managers

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
BUREAU OF COMMUNITY MENTAL HEALTH SERVICES
DIVISION OF PROGRAM DEVELOPMENT, CONSULTATION, & CONTRACTS**

**MENTAL HEALTH BLOCK GRANT
REQUEST FOR PROPOSALS-ADULT SERVICES**

**FY2005/2006
ONE-TIME ONLY FUNDING
SUBMISSION DUE DATE: APRIL 20, 2005**

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I. Purpose and Available Funds

Federal Community Mental Health Services Block Grant funds are used to provide community-based services for adults with serious mental illness and children with serious emotional disturbance. Service initiatives are designed to carry out the goals and objectives of the Michigan Department of Community Health (MDCH) in accordance with the “State Comprehensive Mental Health Services Plan,” approved by the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA). The Comprehensive Plan describes the state’s public mental health system, established in Michigan’s Mental Health Code, and operated through 46 Community Mental Health Service Programs (CMHSPs) and 18 Prepaid Inpatient Health Plans (PIHPs) for specialty services. The plan also describes MDCH intent to use Mental Health Block Grant funds to expand service capacity and foster service innovation and development in this system of care. Federal block grant funds may not be used to supplant existing funding or existing mental health services in the State of Michigan. This RFP implements objectives in the adult portion of the plan.

Currently, MDCH is engaged, with its stakeholders, in a systems transformation process. The Mental Health and Substance Abuse Administration has adopted the following vision:

Michigan’s children, families, and adults will have access to a public mental health and substance abuse service system that supports individuals with mental illness, emotional disturbance, developmental disabilities and substance disorders by promoting good mental health, resiliency, recovery and the right to control one’s life within the context of the ordinary responsibilities of community membership.

The systems transformation is reflected in several initiatives. MDCH has initiated a project to work with consumer-run programs to develop consensus on a set of core elements for these programs. The Evidence-Based Practice Steering Committee is examining mental health practices that are best practices, promising practices and emerging practices. It has selected three evidence-based practices for concentrated implementation over the next two to three years: Integrated Treatment for Individuals with Co-occurring Disorders, Family Psychoeducation, and Parent Management Training. MDCH has also committed to work on improving model fidelity with the state’s existing Assertive Community Treatment services and Supported Employment. Information regarding the use of block grant funds for implementation of evidence-based practices will be sent in late spring.

The Quality Improvement Council is evaluating existing performance indicators and will be making recommendations for indicators that will more effectively measure the results of the services and supports provided in the public mental health system. The council will also advise and make recommendations in the following areas: quality and utility of administrative data; utility and response rate of the annual consumer satisfaction surveys; site review process; contents and methods of displaying the annual quality management report; implementation of Data Infrastructure Grant outcomes; quality strategy for Medicaid waiver renewals; sentinel events; and recipient rights.

MDCH's federal Data Infrastructure Grant will support a process to select and implement an outcomes measurement tool for adults with mental illness. In the current year, a project advisory committee will be formed and instruments will be selected for field testing in Michigan. MDCH and the advisory committee will coordinate evaluative activities and select a measurement tool for statewide implementation based on the results of this evaluation. Longitudinal, individual-level outcome data will assist MDCH, PIHPs, and CMHSPs to use outcome management in service delivery.

The Governor's appointed Mental Health Commission completed its work in October 2004 and has submitted its report to Governor Granholm. The commission emphasized the promotion of recovery and resiliency for individuals with serious mental illness or serious emotional disturbance. It recognized the values of consumer inclusion, quality services, access to care, and efficiency. It called for accountability, integration, coordination and collaboration. MDCH supports local agency collaboration that finds better ways for meeting the range of needs of the people we serve and the communities in which they live.

CMHSPs are strongly encouraged to prioritize funding requests based upon the following:

- Projects that can be replicated based on shared information and/or products
- Projects that build on local partnerships to implement innovative systems that lead to improved outcomes
- Projects that promote recovery, empowerment, and inclusion
- Projects that address priority areas identified by the CMHSP in its own needs assessment process
- Priority areas identified in this Request for Proposals (RFP).

Funding decisions will be made based on proposals submitted in response to the criteria included in this RFP. It is expected that funding of approximately \$2.5 million will be available for new projects that address mental health services for the adult population.

Program areas within a CMHSP that have not received block grant funding in the last three years and projects in rural areas are a priority for funding. Planning for sustaining new programs funded continues to be an important consideration in funding new initiatives. Projects aimed at one-time purchases and training may be funded for one year only. Projects aimed at service innovation or service development may be funded for a two-year period with the second year contingent on first year progress. Maximum funding per service innovation or service development project is up to \$75,000 for the first year, and up to \$56,250 for a second year, with a 25% CMHSP match requirement for the second year.

Michigan's mental health block grant funds for children have already been allocated for FY 05 and are not included in this RFP.

Federal authorizing legislation specifies that these funds **MAY NOT** be used to:

- (1) *provide inpatient services;*
- (2) *make cash payments to intended recipients of health services;*

- (3) *purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;*
- (4) *satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds; or*
- (5) *provide financial assistance to any entity other than a public or nonprofit private entity.*

In addition, this RFP emphasizes the mental health block grant's emphasis upon service provision, and the following restrictions are also included:

- (6) *no vehicle purchases; and*
- (7) *no administrative or indirect expenses.*

Proposals, unless specified otherwise, must be written for the period of October 1, 2005 through September 30, 2006. For some program areas, proposals may be submitted which include a request for "second year" funding for the October 1, 2006 to September 30, 2007 fiscal year. Please note the additional requirements for two-year proposals under II. Proposal Requirements. Second year funding for two-year projects will be contingent upon satisfactory progress achieved during the first year, the availability of funds, and funded separately from the competitive first year process described here. For the second year of any projects approved to begin October 1, 2006, CMHSPs must commit public funding it manages to the project; this amount must equal 25% or more of the total project budget.

II. Proposal Requirements

The CMHSP must submit:

- A proposal face sheet for each program request. The face sheet is included in this packet as Attachment A.
- A narrative, which addresses all the criteria by which the proposal will be reviewed (refer to Review Criteria for Proposals Submitted in Response to this Request in section III), including a planned time line for implementation of block grant activity. Additional review criteria may be specified in this document under the specific program areas for which funding is requested. Please refer to those sections as well.
- A Program Budget Summary and Program Budget Cost Detail (current DCH forms 385 and 386 are contained in Attachment B).

The following additional information must be included in proposals for two-year projects:

- A work plan which addresses the full project period and specifies goals, measurable objectives and concrete activities that will be achieved during each quarter (October 1, 2005 through September 30, 2007).

- A budget and a detailed budget description for the total project period and individual budgets for each year.
- If the proposal is from a CMHSP that serves multiple counties and plans to pilot an intervention in one area during the first year and then expand the initiative in other areas during the second year, the proposal must describe the involvement of key project personnel from all these areas in first year planning and implementation.

These are one-time only funds unless otherwise identified. It is expected that, after this start-up period, CMHSPs will secure other sources of funding to support ongoing services. Also note that the acceptance of these funds requires that the CMHSP satisfy federal single audit and reporting requirements.

The original and five (5) copies of each proposal request must be received at the Department of Community Health by **5:00 p.m. on April 20, 2005**. The proposals must be unbound and on eight and a half by eleven paper (i.e., no staples, no off-size paper, no inserts). Every page, including the face sheet and any attachments, must be numbered consecutively.

The mailing address is:

Department of Community Health
Bureau of Community Mental Health Services
Division of Program Development, Consultation & Contracts
Attention: Patricia Degnan
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III. Adults with Serious Mental Illness

A transformed public mental health system will be based on a vision of recovery. A recovery vision is grounded in the idea that people can recover from mental illness, and that the service delivery system must be constructed based on this knowledge.

The MDCH contract between MDCH and CMHSPs requires that services be based on a plan developed through a person-centered planning process and provided through the public system which promotes individuals to be empowered to exercise choice and control over all aspects of their lives; involved in meaningful relationships with family and friends; supported to live with family while children and independently as adults; engaged in daily activities that are meaningful, such as school, work, social, recreational and volunteering; and fully included in community life and activities. Supports offered through the public mental system promote the recovery of individuals with mental illness. Consumer choice and control are integrated into all policy, financing and evaluation activities in its managed system of care and consumer control is the foundation for best practice. Initiatives funded through this RFP will be those that reduce stigma and support recovery.

Priorities

Proposals targeted at the following service populations or interventions are invited:

- Rural Initiatives
- Anti-Stigma
- Advance Directives (Crisis Planning)
- Recovery
- Peer Support Specialists
- Person-Centered Planning
- Self-Determination
- Jail Diversion
- Consumer Run, Delivered, or Directed Initiatives
- Supports and Services for Older Adults
- Clubhouse Programs
- Supported Employment
- Homeless Populations
- Other Special Populations
- Other Types of Projects

More detailed information about each priority area and the name of the program specialist to contact for technical assistance is included in this RFP.

Review Criteria for Proposals Submitted in Response to this Request

1. The proposal is for development of services or interagency system change that goes beyond basic contract requirements. The applicant provides a description of how the results of the project will be shared with the department for possible dissemination throughout the state. The proposal addresses a priority sub-population group or type of intervention that is consistent with the RFP. It includes a description of need, provides data to support evidence of the need and rationale for why current efforts have been insufficient to address the concern. It demonstrates the applicant is knowledgeable about other efforts to address the identified need. The proposal clearly demonstrates that the intervention is an enhancement, replication, new approach or innovation, not continuation or substitution of a current intervention or source of funding (e.g., cost-shifting). It describes how the proposed intervention is different from current resource or program capacity (**20%**).
2. The proposal addresses the values of Michigan's public health system to: reduce stigma; facilitate access; promote recovery and wellness; seek support arrangements that facilitate independence, personal responsibility and full participation in community life; promote consumer choice; maximize least restrictive opportunities for community alternatives; and increase opportunities for employment. The proposal describes and includes evidence of consumer involvement, collaboration or support in developing, implementing and monitoring the project. Proposals that involve collaboration with consumers, other professionals or community organizations include letters of support that specify the nature of partners' contributions (**10%**).

3. The proposal demonstrates organizational capacity to carry out the proposal. It includes evidence of consumer participation. It includes evidence of project personnel who are knowledgeable about recovery, the target population, proposed intervention and who have prior experience in working with the target population. Position descriptions and/or resumes of key project personnel are included. Examples are provided of other successful projects the applicant has carried out to expand or enhance services for the identified population. The proposal and budget demonstrate that sufficient staff resources will be allocated to the project (10%).
4. The proposal includes a Project Work Plan that provides clear goal statements, measurable objectives and activities. It includes time lines by which specific objectives and activities will be achieved, for each quarter of the contract period (10%).
5. The proposal includes an evaluation plan that involves consumers and provides a clear description of proposed outcomes that address one or more of the MDCH priorities, the number of people who will be impacted and specific changes that are expected to occur in the target population, program or system as the result of the intervention. The evaluation plan includes:
 - Clearly defined goals and objectives that specify *who* is the target for change (i.e., consumers, family caregivers or staff), *what* to change, and described expected *differences* in terms of choices, quality of services or quality of life that consumers and their caregivers may experience as the result of receiving services delivered by this initiative.
 - A description of proposed outcomes that are clearly defined, relate to the goals and objectives stated in the work plan, and measure things the organization can change.
 - A description of the methods that will be used to evaluate the impact of the intervention, the types of data that will be collected to demonstrate the outcomes and the process by which the data will be analyzed, reported and disseminated (20%).
6. The proposal demonstrates commitment by the CMHSP to the initiative. For all applications other than time limited projects such as a one-time only training event, evidence of commitment is reflected by the level of CMHSP funds directed to the project and inclusion of a specific written plan for continuation which identifies specific funding sources to be used once mental health block grant funding ends. For CMHSPs that previously received block grant funding, evidence of demonstrated commitment will also consider the extent to which previously funded mental health block grant initiatives have remained in place (15%).
7. The proposal addresses the departmental priority for designated rural county system and service development for adults with serious mental illness. It demonstrates integration of the remaining review criteria and clearly demonstrates how the proposal will enhance the current system (5%).

8. The proposed budget and budget narrative demonstrate the level of funding requested is reasonable to achieve the proposed outcomes. Proposed costs are aligned with project objectives, personnel needs and other resources required to complete project activities. Line item costs are specified and reasonable (10%).

IV. RFP by Program Areas

RECOVERY IS KEYSTONE FOR SYSTEM TRANSFORMATION

A transformed public mental health system will be based on a vision of recovery. A recovery vision is grounded in the idea that people can recover from mental illness, and that the service delivery system must be constructed based on this knowledge. “Characteristics of a recovery-oriented service system are reflected in system design, evaluation, leadership, management, system integration, comprehensiveness, consumer involvement, cultural relevance, advocacy, training, funding and access.” (Anthony, “A Recovery –Oriented Service System: Setting Some System Level Standards,” *Psychiatric Rehabilitation Journal*, Fall 2000).

Applicants for this RFP are encouraged to review their organization’s current capacities to support recovery. Helpful resources may be obtained at the following websites:

Boston University Center for Psychiatric Rehabilitation at Sargent College of Health and Rehabilitation Sciences

The mission of the Center is to “increase knowledge in the field of psychiatric rehabilitation and to apply this body of knowledge to train treatment personnel, to develop effective rehabilitation programs, and to assist in organizing both personnel and programs into efficient and coordinated service delivery systems.” The site includes information on recovery services, professional training, and a repository of online resources.

www.bu.edu/cpr/

Consumer/Survivor Mental Health Information from SAMHSA/CMHS

Site visitors can find a collection of guidance from the federal government’s Center for Mental Health Services on the topic of Recovery. The site includes information on federal programs on employment, housing, transportation, patient assistance plans, and self-help.

www.mentalhealth.samhsa.gov/consumersurvivor/recovery.asp

Consumer Organization and Networking Technical Assistance Center (CONTAC)

A self-help advocacy organization, CONTAC is a national technical assistance center that “serves as a resource center for consumers/survivors/ex-patients and consumer-run organizations across the United States, promoting self-help, recovery and empowerment.” The site offers access to training opportunities, program overviews, and great links to other peer support organizations.

www.contac.org/

Mary Ellen Copeland’s Mental Health Recovery Self-Help Strategies

A nationally known recovery educator and author of the Wellness Recovery Action Plan (WRAP), Copeland has produced a comprehensive Web site on her mental health recovery self-help strategies. Site visitors can read her Mental Health Recovery quarterly newsletter, register

for training seminars, or order from her archive of publications, organizations, and Web sites that focus on Recovery.

www.mentalhealthrecovery.com

See also the: www.copelandcenter.com/

NAMI

NAMI (National Alliance for the Mentally Ill) has produced a site full of information on Recovery issues. The site includes access to public awareness projects, models for self-help groups, contact with the National Consumer Council and courses on illness management and wellness taught by people with mental illness, for people with mental illness.

www.nami.org

National Empowerment Center Inc.

In the site's own words: "The mission of the National Empowerment Center Inc. is to carry a message of recovery, empowerment, hope and healing to people who have been diagnosed with mental illness. We carry that message with authority because we are a consumer/survivor/expatient-run organization and each of us is living a personal journey of recovery and empowerment."

www.power2u.org/

National Mental Health Association

This site offers consumers help in creating a Dialogue for Recovery. The NMHA program is "aimed at enhancing communication between doctors and patients about treatment goals, medication side-effects and other quality of life issues affecting the recovery of individuals diagnosed with serious mental illness." The site also offers helpful information on psychiatric advance directives, support services, and treatment options for recovery.

www.nmha.org/

New Freedom Initiative: State Coalitions to Promote Community-Based Care

The federally funded program offers support and services to states to promote community-based care for adults with serious mental illness and children with severe emotional disturbances. Site visitors can order audio, MS PowerPoint, and text transcripts of "Retraining the Workforce to Support Recovery."

www.olmsteadcommunity.org

The President's New Freedom Commission on Mental Health

Among other guiding principles, the commission was tasked to "promote successful community integration for adults with a serious mental illness and children with a serious emotional disturbance." The site includes access to a variety of reports and information including a report on consumer issues that calls for a "Recovery-Oriented Mental Health System."

www.mentalhealthcommission.gov

RURAL INITIATIVES

Alyson Rush

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The department recognizes that both the prevalence and incidence of serious mental illness (the three major categories: Schizophrenia, Affective disorders, Anxiety disorders) occur at similar rates in both rural and urban populations, but that the suicide rate is higher in rural areas (Kessler et al., 1994, “One Healthy People 2010,” National Center for Health Statistics 2001). Mental health and mental disorders are the fourth highest ranked rural health concern (Journal of Rural Health 18(1)9-14, 2002). Rural populations tend to either not recognize mental illness or not perceive the need for care until later than urban populations and tend to be more concerned about costs. In addition, the rural population experiences other barriers (e.g., transportation, age, isolation, substance misuse and unemployment) and a lack of availability of mental health providers, which make accessing care more difficult than in urban areas. This may lead to under utilization of the available service array. Support for consumer involvement and staff training in continuing education as well as the development and delivery of evidence-based, promising or emerging practices is challenging but critical for rural areas.

The seventy-two eligible counties for rural initiatives can be located on the county list (Attachment D) and are identified as a rural county. Proposals must address the needs of adults who experience serious and persistent mental illness, increase awareness of mental health and mental disorders, support recovery, and the availability and successful outcomes of treatment and supports among the rural populations in Michigan. Proposals also may improve the availability and accessibility of mental health services in rural areas. Each proposal must budget travel expenses for one possible regional meeting, either in the Upper or Lower Peninsula that includes travel, meals, and lodging if needed.

RECOVERY

Colleen Jasper

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Recovery encompasses all aspects of an individual’s life, not only mental health. All these areas are important to be addressed, in order to provide support to the individual through self-advocacy, hope, responsibility, and education (see components of recovery, Attachment E).

Training on all these aspects of recovery in the mental health system is needed. Recovery education is critical to an individual’s personal interaction within the mental health system. A system based on recovery is progressive in that it allows the individual freedom to make decisions (i.e., advance directives) and choose other areas that improve their own personal quality of life (housing, person-centered planning, friends, work, travel, support system, etc.).

It is important to realize that support, personal responsibility, hope, education, and self-advocacy are all intertwined. In order to grow in recovery, one needs to be able to educate oneself and thereby create a positive self-image. Educating oneself in other definitions of recovery is necessary to utilize the full range of recovery concepts, models, and theories to the utmost benefit. The individual will then be able to choose needed recovery ingredients for his/her

unique situation. There are as many definitions of recovery as there are individual consumers and rightly so, as each person is unique in their personality and life's journey.

Recovery also includes the educational model of training staff, administrators and consumers. Education allows recovery ideas to be incorporated in all areas of the system. It pulls together the strengths of the system as well as the strengths of the staff and consumers to generate recovery from all angles.

Hope, another component of recovery, needs to be generated in individuals in order to empower them to make decisions, receive support, and create the strength to be a self-advocate. The hope connected to recovery entails individuals to move forward with their desires and dreams.

A recovery environment entails a partnership between providers and consumers, flexible programs and services, informed choice, a holistic approach rather than just the medical model, consumers' voices employed at all levels of the system, and teaching of wellness, etc.

Projects

Block grant initiatives in the areas of Recovery Training, Recovery Supportive Environment, Advance Directives, and Anti-Stigma allow administrators, staff, and consumers to work together to promote, implement, and embrace recovery in all areas of the county and state systems. The Office of Consumer Relations is focused on primary consumers; therefore, all block grant proposals approved by MDCH in the area of recovery need to utilize primary consumers for 80% of their plan with 20% staff that will participate in supportive roles. Projects connected with the areas of recovery need to involve primary consumers in leadership roles. With the emphasis on one area of recovery such as personal responsibility, the remaining components of recovery (hope, education, self-advocacy, and support) need to be shown to be involved also (but to a lesser degree). Following is a description of the four areas of recovery in which block grant proposals will be accepted.

Recovery Training

Recovery training needs to be taught to consumers so they then can train other consumers and staff (train the trainer model). Various definitions of recovery, including Mary Ellen Copeland's, can be utilized. Other personal consumer recovery definitions are also usable. Audiences of 15 to 100 are the focus. What is also emphasized is the use of Speakers' Bureaus (that the individuals give personal recovery speeches) or other types of speaking formats that utilize many consumers. The training that consumers will do will involve research on recovery, development of training materials, arrangements for speaking engagements, etc.

Recovery Supportive Environment

Support, partnership, and advocacy (elements of recovery) need to be shown that they are being implemented in the services/programs/CMHSPs environment. Support is helping consumers move ahead on their recovery journey. Partnership between consumers and providers needs to be implemented, based on helping and equality. This can be one specific area that excels in

incorporating the components of recovery fully supported by staff and consumers. This may be expressed in improvements of consumer and staff knowledge of recovery, areas of programs devoted to recovery, speakers on recovery, before/after introduction of recovery and comparative to consumers' quality of life. Other creative ways to integrate recovery into the lives of consumers and the system are welcome.

Advance Directives (Crisis Planning), Patient Advocate (Agent)

MDCH is developing information and training materials on the identification of a patient advocate and advance directives consistent with the new legislation in this area. Projects that will use these materials to provide training, information and assistance with Advance Directives and Patient Advocate Designation are invited. Applicants must describe how the training audience will be targeted, how the training will be implemented, and how the information is to be communicated to consumers by consumer trainers. The role of the staff in this initiative will be to assist consumers in preparation, audience location, training implementation, and follow-up.

Anti-Stigma

The expected goal of an anti-stigma project is to create and promote equality, acceptance of differences, and education about the lives of people with serious mental illness. Anti-stigma projects aimed at educating the public, service system, staff, and consumers are critical in embracing positive self-images for consumers. Development of creative ways to achieve this objective is important in order to be effective and powerful. Proposals that embrace recovery, and involve anti-stigma techniques are encouraged. Anti-stigma projects include both visual and language mediums. Creative anti-stigma projects should also include consumers as leaders in designing, planning, and implementing the project.

PEER SUPPORT SPECIALISTS

Pam Werner

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Proposals are requested for hiring and supporting Peer Support Specialists for people with a serious mental illness. Peer Support Specialists promote hope, personal responsibility, empowerment, education, assist individuals with person-centered processes and self-determination in the communities in which they serve. They share their experiences in their journey of recovery and work directly with individuals to support the recovery process. Peer Support Specialists are part of the supports and services in the B3 category available to Medicaid beneficiaries who meet the criteria for specialty services and supports. The services and supports may be provided in addition to Medicaid State Plan Services through the authority of 1915 (b)(3) of the Social Security Act.

The hiring of Peer Support Specialists enhances supports for persons with mental illness while providing cost effective services that promote community inclusion, participation, independence and productivity. The Peer Support Specialist works closely in partnership with a Case Manager/Support Coordinator in serving individuals with serious mental illness. The Peer Support Specialist is supervised and supported by a primary case manager/supports coordinator.

Some of the activities that Peer Support Specialists can assist with may include: co-facilitate the person-centered planning process; assist with individual budgeting and implementation of the plan; develop a Wellness Recovery Action Plan/Crisis Plan; access entitlements and assist with vocational interests to generate additional personal income; provide ongoing support in connecting people to services and supports in the broader community; and provide support in the area of health and safety as part of the Individual Plan of Service.

Proposals must include how the grantee will recruit, train and provide ongoing support for Peer Support Specialists and the Case Manager/Supports Coordinator, including how each team will be matched to establish partnerships. Work hours and schedule are determined by the needs and wants of the individual and the beneficiaries they support. Funding for up to two years will be considered, depending on the work plan, and performance/outcomes resulting in year one funding. Peer Support Specialists and the partnering Case Manager/Supports Coordinators will be invited to attend statewide meetings. Peer Support Specialists will be encouraged and supported to attend trainings with national experts to receive information that will support and strengthen knowledge and skills while enhancing the services and supports provided with beneficiaries. The training will be provided separately by MDCH, however, travel, meals and lodging need to be included in the budget. To be considered for funding, the PIHP/CMHSP must demonstrate in the grant that the positions will continue after completion of block grant funding. The agency must address whether it has union representation and what support the bargaining units will have in supporting the continuation of Peer Support Specialist positions.

ACT teams that desire project funding for peer advocates may apply under this category.

PERSON-CENTERED PLANNING

Pam Werner

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A. Independent Facilitation of the Person-Centered Planning Process

Beneficiaries and their family and friends can provide a valued role in facilitating person-centered processes. Proposals to strengthen independent facilitation for developing the Individual Plan of Service through the person-centered process for individuals with serious mental illness are requested. Funding will be provided for one year. Proposals must include:

- documentation that a variety of stakeholders assisted in writing the proposal with the majority (over 50%) being individuals who have a serious mental illness;
- how opportunities for individuals to facilitate their own plan are provided and supported;
- how individuals are informed of independent facilitation;
- how independent facilitators are trained with opportunities for networking and continued skill development;
- how the performance of each independent facilitator will be evaluated and how the results of the evaluation will be available for individuals selecting the option of independent facilitation;
- how independent facilitators are supported;
- how individuals trained in facilitating their plans are provided with paid opportunities to facilitate plans for others; and

- how independent facilitators will be compensated by the agency, not through the use of the block grant funding.

B. Building Natural Supports for People With Mental Illness

Proposals for innovative ideas for working with the larger community to develop connections for individuals to enhance their current support networks and develop meaningful friendships through active participation in their community are invited. The proposals must describe the role individuals with mental illness had in developing the proposal and how these individuals will carry out activities of the work plan as equal partners with paid staff. The plan must include how the agency will continue the initiative after funding has ended. Proposals for one or two years of funding may be submitted.

SELF-DETERMINATION

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wernerp@michigan.gov

Innovative proposals are requested for applying the principles of self-determination and working toward implementation of the Michigan Department of Community Health Self-Determination Policy & Practice Guideline. Proposals for one or two years of funding may be submitted. The proposal must contain:

- documentation that a variety of stakeholders assisted in writing the proposal with the majority (over 50%) being beneficiaries who have a serious mental illness and are currently receiving services through the PIHP/CMHSP;
- how the self-determination principles of Freedom, Authority, Support Responsibility and Confirmation will be actualized and implemented in the initiative;
- how beneficiaries will be offered an array of arrangements that provide a high level of choice and control over defining, selecting, directing and purchasing needed services and supports;
- how knowledge, networking and advocacy will occur for beneficiaries, and their allies in the principles and practices of self-determination;
- how the grant will address and implement independence plus design features (information available upon request) of person-centered planning, individual budgeting, self-directed supports and quality assurance and improvement;
- changes the current system may need to make to support and facilitate the recovery process;
- the specific mental health service areas in the PIHP/CMHSP will be included in the initiative with a statement from directors/program directors in these areas providing written support for efforts, including the role management and leadership will play throughout the grant period; and
- the valued role beneficiaries will have in the development, implementation and evaluation processes of the grant.

If the proposal contains a request to fund consumer/beneficiaries in the grant, the PIHP/CMHSP must demonstrate that the positions will continue after completion of block grant funding.

Candidates may be requested to participate in a site visit and/or a telephone interview as part of the selection process. Successful grantees will be involved in the statewide meetings on this topic. Travel, lodging and meals need to be included for these activities in the budget.

JAIL DIVERSION

Michael Jennings

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Section 207 of the Michigan Mental Health Code requires all CMHSPs to provide services designed to divert persons with serious mental illness, serious emotional disturbance, or developmental disability from possible jail incarceration when appropriate. Jail diversion policies and programs are an important public interest consideration. The department's administrative directive defines the conditions for establishing and implementing an integrated and coordinated jail diversion program. The department has recently revised its Jail Diversion Guidelines for adults.

The Council of State Governments coordinated a Criminal Justice/Mental Health Consensus Project, which published its report in June 2002. CMHSPs are invited to review the report which is located at www.consensusproject.org and, building on information in the report, submit proposals for innovative jail diversion programs which go beyond the minimum standards contained in the department guidelines. The department is interested in identifying at least one program site, which may be used as a statewide model for implementing the Criminal Justice/Mental Health Consensus Project.

CONSUMER RUN, DELIVERED, OR DIRECTED INITIATIVES

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A. Drop-In Program Development or Enhancement

Proposals targeted at enhancement of existing drop-in centers, or the development of new drop-in initiatives where interest and the ability to promote consumer independence and growth are indicated will be considered. Development of transportation supports and maintenance, and the provision of support of current consumer programs in the area of equipment, computer training, furniture, and supplies that will enhance the facility, is encouraged.

Proposals under this program are intended to be a partnership between the CMHSP and the consumer run drop-ins. Proposals should reflect that partnership by showing a collaborative development of proposals, sharing of budget information, narrative program implementation, and by supplying of a sub-agreement or sharing of the grant award contract when awards are made. Proposals should show that both the CMHSP and the consumer groups are equally involved in the total preparation and implementation of any grant initiatives (see Review Criteria #3).

Proposals under this program area should be able to demonstrate through the proposal submissions, quarterly narrative progress reports, and the evaluation plan that the intended intervention helps address the values of the public mental health system to reduce stigma, promote recovery, facilitates independence, personal responsibility, and allows for full

participation in community life, promotes consumer choice, and maximized the opportunity for consumer autonomy and peer directed and run service alternatives. It is the intent that block grant support in this area can demonstrate outcomes which support systems transformation that is the goal of the block grant effort. Evaluation of proposals should reflect the goals and objectives of the project and how they fit into a system transformation.

B. Consumer Run, Delivered or Directed Innovations and Replications

Proposals targeted at the development of innovative, new consumer-run, delivered or directed initiatives are encouraged, such as Project Stay, person-centered planning within a drop-in center setting, peer case management support, and statewide resource development. Current DCH policy regarding consumer run, delivered or directed services is included in this RFP packet as Attachment C.

Additional information regarding consumer-run programs can be obtained at the websites on recovery noted at the beginning of this RFP and at:

Consumer Operated Services Program: Multi-site Research Initiative
www.cstprogram.org

Please note that it is expected that all proposals directed toward consumer-run initiatives provide responses to the seven review criteria questions within this RFP. Purchase of equipment, furniture, supplies, computer training, etc., require addressing each of the seven criteria for funding.

SUPPORTS AND SERVICES FOR OLDER ADULTS

Alyson Rush

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The department recognizes that individuals age 65 and above who have a serious mental illness include the following subsets of hard-to-reach and underserved populations: individuals with severe and persistent mental illness, individuals who may be at risk of committing suicide, individuals who develop depression or another type of mental disorder as the direct result of having one or more co-occurring medical conditions or chronic diseases that require active monitoring and different types of medications, adults of any age who have dementia with delusions, dementia with depressed mood, dementia with behavioral disturbances or a co-occurring disorder of dementia with a diagnosable mental illness, individuals with a co-occurring mental illness and substance use disorder, and family caregivers of isolated older adults with mental illness or progressive, disabling medical conditions.

Block grant proposals should describe proposed projects that address at least one of the following areas:

- promote prompt and easy access to mental health services;
- service penetration rates for people ages 65 and above that are equal to or greater than the representation of those groups in the service area population;
- improved availability of quality mental health supports;
- improved availability of quality mental health supports and services for family caregivers;

- improved knowledge and skills of PIHP, CMHSP and providers; or
- replication of a service model that reflects MDCH values, policies, practice-guidelines or other evidenced-based practices, promising practices and emerging practices.

Proposals must clearly describe the target audience, goals, and anticipated outcomes as a result of the project, the methodology or protocol, how the information will be disseminated and incorporated into future practice. Proposals should also include in the budget plan, a possible regional block grant meeting.

Applicants can learn more about the mental health needs of older adults at the Older Adult Consumer Alliance website: <http://www.oacmha.com/>

CLUBHOUSE PROGRAMS

Su Min Oh

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ohs@michigan.gov

Improving Employment Outcomes

One way of measuring effective clubhouse programs is to examine the number of individuals who are receiving employment services and supports. Employment is a guaranteed right of membership. Assistance in moving members toward full-time employment is needed. Proposals that look at creative initiatives for transitional, supported and competitive employment opportunities are encouraged. The proposal must provide 1) background information on how many people the clubhouse serves and the percentage of individuals who were in an employment situation in the past year; 2) organizational climate and culture that supports work; 3) facilitation of employment; 4) emphasis on member preferences and strengths; 5) ongoing flexible, individualized support; 6) covering employee absences; and 7) what the desired outcomes are and a plan to achieve them.

Clubhouse Long-Term Housing Supports

Clubhouse members living in adult foster care may be living in residential environments that provide limited opportunities to lead a self-determined life. This initiative will target persons currently living in adult foster care and wishing to live independently or with roommates of their own choosing. Through the development of a clubhouse housing unit, members and staff will provide assistance with transition issues, locating housing, furnishings, etc., and provide long-term support for members living independently in the community. Block grant funds cannot be used to subsidize rent or security deposits, but may be used for limited start-up supplies.

Anticipated outcomes may include increased activity of the clubhouse program through the development of a housing unit, increase in the number of members living independently, decrease the number of persons living in dependent (foster) care, and/or increased consumer satisfaction and quality of life.

Clubhouse Start-Up, Site Development and Operational Supports

Limited one-time only funding support for furnishings, equipment, and minor renovations for new or existing clubhouse programs. Priority will be given to newly developing clubs and those moving to an off-site location. Itemized budget detail must be included in the proposal.

ICCD Clubhouse Training (Four Participants)

This training is targeted for **new** clubhouse programs or new managers of existing clubhouse programs. This training group must include (1) the clubhouse manager, (2) one clubhouse staff, (3) one clubhouse member, and (4) agency administrator/supervisor attending the third week. The block grant award covers the fixed tuition and lodging cost of \$4,800 and \$1,500 toward transportation and meals related to the training. Funding support over and above the block grant award are the responsibility of the CMHSP. Block grant funds cannot be used for clubhouse members or staff that have already participated in block grant funded training. Available training dates can be found at www.iccd.org. The proposal should indicate the target date and location for their training.

ICCD Three-Week Training (Three Participants)

This training is for established clubhouse programs with new staff or new clubhouse managers with no prior training. The training group includes (1) the new club manager or one clubhouse staff, (2) one clubhouse member, and (3) the agency administrator/supervisor who attends the third week. The block grant award covers the fixed tuition and lodging cost of \$4,000 and \$1,000 toward transportation and meals related to the training. Funding support over and above the block grant award is the responsibility of the CMHSP. Block grant funds cannot be used for clubhouse members or staff who have already participated in ICCD training. Available training dates can be found at www.iccd.org. The proposal should indicate the target date and location for their training.

SUPPORTED EMPLOYMENT

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Supported employment is one of the evidence-based practices for people with severe mental illness that have demonstrated positive outcomes in multiple research studies. The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) define supported employment as:

1. Supported employment programs assist people in finding competitive employment – community jobs paying at least minimum wage, which any person can apply for according to their choices and capabilities.
2. Supported employment is a successful approach that has been used in various settings by culturally diverse consumers, employment specialists, and practitioners.
3. Supported employment programs do not screen people for work readiness, unlike other vocational approaches, but help all who say they want to work.
4. Supported employment programs are staffed by employment specialists who help consumers look for jobs soon after entering the program. Extensive pre-employment assessment and training, or intermediate work experiences, such as prevocational work units, transitional employment, or sheltered workshops are not required.
5. Employment specialists facilitate job acquisition. For example, they may assist with application forms or accompany consumers on interviews.

6. Employment specialists support consumers as long as they want the assistance, usually outside of the work place. Support can include help from other practitioners, family members, coworkers, and supervisors.

The proposals must address how to implement core principles of the supported employment programs:

- *Eligibility is based on consumer choice.* No one is excluded who wants to participate.
- *Supported employment is integrated with treatment.* Employment specialists coordinate plans with the treatment team, e.g., case manager, therapist, psychiatrist, etc.
- *Competitive employment is the goal.* The focus is community jobs anyone can apply for that pay at least minimum wage, including part-time and full-time jobs.
- *Job search starts soon after a consumer express interest in working.* There are no requirements for completing extensive pre-employment assessment and training, or intermediate work experiences.
- *Follow-along supports are continuous.* Individualized supports to maintain employment continue as long as consumers want the assistance.
- *Consumer preferences are important.* Choices and decisions about work and support are individualized based on the person's preferences, strengths, and experiences.

Initiatives **must** include a benefits planning component so that consumers have information about how work activity will impact their ability to maintain benefits. In addition, each proposal should complete the 15-item Supported Employment Fidelity Scale for a consideration for funding. The 15-item Supported Employment Fidelity Scale can be obtained from MDCH or on the website at www.mentalhealthpractices.org (refer to the Supported Employment Implementation Resource Kit). The Supported Employment Implementation Resource Kit contains copies of research articles and an annotated bibliography, implementation tips for practitioner and mental health authorities, fidelity scale, tools for measuring consumer outcomes, and workbook.

HOMELESS POPULATION

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Proposals under this category should be able and ready to address a homeless population that has demonstrated additional issues of concern, which directly impact their homelessness, such as substance abuse/co-disorder diagnosis. Interventions in this area are intended to address a homeless population who abuses substances and are homeless, those who are homeless and mentally ill, and those who are homeless and have mental illness issues and require assistance in the areas of mental health assessment, detoxification, life skills training, employment opportunities, and coordination of services for the homeless. Proposals are encouraged that promote outreach, integration of mental health and substance abuse services, prevention services, and support services to individuals in stable housing. Under this category, please note that proposals which propose to provide direct payment of rent, security deposits, utilities, etc., for consumers are not acceptable.

Applicants may wish to consult: Substance Abuse and Mental Health Services Administration. Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and Co-Occurring Substance Use Disorders. DHHS Pub. No. SMA-04-3870, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2003. A copy of this publication is available at: <http://www.mentalhealth.samhsa.gov/publications/allpubs/SMA04-3870/default.asp>

OTHER SPECIAL POPULATIONS

Michael Jennings (517) 335-0126 jennings@michigan.gov

Innovative ideas are encouraged for any special populations of persons with serious mental illness, such as women, ethnic minorities who may require unique services and supports based on cultural diversity, ethnic diversity, unique barriers or differences. Special population proposals can address any of the aforementioned categories with the emphasis placed on a special population. When submitting a proposal in this category, please note your submission as a special population proposal with another specialty area focus.

OTHER TYPES OF PROJECTS

Alyson Rush (517) 335-0250 rusha@michigan.gov

The department recognizes that, through the Federal Community Mental Health block Grant, Michigan has developed and improved, in innovative ways, a community-based system of support. Funding for areas not previously described will be considered for service innovations, service replications, service capacity development, and projects designed for system change.

V. Assertive Community Treatment (ACT) Statewide Training Information

Approximately 25 years ago across Michigan, the first evidence-based practice, Assertive Community Treatment (ACT), was implemented. ACT addressed the needs of adults who experienced serious mental illness with essential treatment, rehabilitation and support services. ACT helped individuals live as independently as possible in natural community settings. ACT was and remains an effective practice. When the essential elements are followed, fidelity to the model is achieved and ACT services result in predictable outcomes. As one component of the current evidence-based practice initiative within Michigan, ACT is a part of the continuous quality improvement process. Over many years, adaptations and revisions not in the model have become an institutionalized component of some ACT teams and, as a result, significant program drift away from the model has occurred. To varying degrees, understanding of the principals and practices of ACT eroded.

Michigan is currently involved in a significant effort to identify and implement new evidence-based practices, such as Integrated Treatment of Co-Occurring Disorders and Family Psycho-Education as demonstrated in the SAMSHA toolkits recently available. At the same time, Michigan has recommitted to enhancing fidelity in the existing and previously implemented

evidence-based practices (Supported Employment and ACT) by incorporating them into the continuous quality improvement processes at the agency and state level.

This process has been enhanced for ACT teams and sponsoring agencies through a private grant that 1) evaluated the current ACT fidelity to the model in Michigan, 2) made recommendations toward improvement, and 3) created a Field Guide for use by ACT teams and administrators that will: a) survey current fidelity, b) assist staff to make a plan to correct deviations from model fidelity, and c) determine how to implement the plan. The Field Guide is divided into individual components that allow teams to identify and work on each identified component as needed. Training on use of the Field Guide will be offered multiple times at multiple locations (times, dates and locations will be available soon) and technical assistance will also be available.

Completed in 2004, Michigan ACT was evaluated through a grant from the Flinn Family Foundation. Key findings to success noted that knowledge of the ACT model and its application is necessary, as are team building, administrative support and adequate staffing. Access to community resources and linkages with community providers are required. The high need levels of ACT consumers contribute to staff burnout and turnover and the case management function is not always balanced with in vivo community contact time. CMHSPs must provide resources to the teams to work with ACT consumers with the most serious challenges, such as Dialectical Behavioral Therapy groups, Substance Abuse treatment resources, and other community resources to stabilize and support ACT consumers. Consumers also desire employment or other meaningful daily activities. Greater efforts are needed to provide employment, educational supports, and leisure activities to consumers receiving ACT services. Administrative support on the ACT model, philosophy and efforts to develop cooperative and collaborative agreements for service coordination by ACT teams, support for greater model fidelity with particular attention to in vivo contacts, staffing and responsibility for treatment services are issues confronting agencies and enhancement through the RFP process will be considered.

ACT-specific training is offered at no cost to all ACT teams in Michigan through the Federal Mental Health Block Grant; ACT specific training is a requirement of the current Medicaid Chapter III Bulletin. Agencies and teams receive training information and registration materials provided through the Assertive Community Treatment Association (ACTA) and can find it on the website www.actassociation.org. Participation for a specified number of registrants for each training will be funded for members of Michigan ACT teams by the MDCH through block grant funds. Additional spaces, as well as spaces for those who are not members of Michigan ACT teams, may be available on a fee-for-training basis. Many of the trainings offer continuing educational credits. Training materials and refreshments are provided, as is lunch for all-day sessions; transportation is not included in the training and must be provided through the individual agency.

**Michigan Department of Community Health
Mental Health and Substance Abuse Services Administration**

**FY 2005/2006 COMMUNITY MENTAL HEALTH BLOCK GRANT
PROPOSAL FACE SHEET**

1. CMHSP: _____

2. Priority Service Intervention or Population (*Check only one category*)

- | | |
|-----------------------------------------------------------------------------|-----------------------------------------------------------------|
| <input type="checkbox"/> Anti-Stigma | <input type="checkbox"/> Peer Support Specialists |
| <input type="checkbox"/> Recovery | <input type="checkbox"/> Clubhouse Programs |
| <input type="checkbox"/> Person-Centered Planning | <input type="checkbox"/> Supported Employment |
| <input type="checkbox"/> Self-Determination | <input type="checkbox"/> Supports and Services for Older Adults |
| <input type="checkbox"/> Advance Directives | <input type="checkbox"/> Homeless Populations |
| <input type="checkbox"/> Jail Diversion | <input type="checkbox"/> Special Populations |
| <input type="checkbox"/> Consumer Run, Delivered
or Directed Initiatives | <input type="checkbox"/> Other Types of Projects |

3. Type of Project Request: 1-Year Proposal 2-Year Proposal
 Rural County Urban County

4. Proposal Information:

A. Project Title: _____

B. Specific counties to be served: _____

C. Summary of service(s) that will be developed: _____

D. Total amount of Block Grant funds requested: _____

Year 1 Subtotal: _____ Year 2 Subtotal: _____

E. Rank this proposal in relation to the total number of requests submitted by your CMHSP:

Rank Order of This Request: _____ Total Number of Requests Submitted: _____

F. Has this project been funded previously with Block Grant funds? _____

If yes, what years? _____

5. Name and telephone number of the individual(s) **at the CMHSP** to be contacted regarding this application in the event the review panel requests changes that will make the proposal appropriate to recommend for funding. **The budget person must have the authority to modify the budget forms. The work plan person must have the authority to modify the work plan.**

	Name	Position Title	Telephone No.	E-Mail Address
Budget				
Work Plan				

Signature: _____

CMHSP Director

Date: _____

PROGRAM BUDGET - COST DETAIL

ATTACHMENT B.2

- View at 100% or Larger
- Use WHOLE DOLLARS Only

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

Page Of

Program		BUDGET PERIOD		Date Prepared
		From:	To:	
Contractor Name:		Budget: <input type="checkbox"/> ORIGINAL <input type="checkbox"/> AMENDMENT		Amendment #
1. SALARIES & WAGES: POSITION DESCRIPTION	COMMENTS	POSITIONS REQUIRED	TOTAL SALARY	
1. TOTAL SALARIES and WAGES:			\$ -	
2. FRINGE BENEFITS: (Specify)		Composite Rate %		
<input type="checkbox"/> FICA	<input type="checkbox"/> HOSPITAL INS	<input type="checkbox"/> VISION	<input type="checkbox"/> WORK COMP	
<input type="checkbox"/> UNEMPLOY INS	<input type="checkbox"/> LIFE INS	<input type="checkbox"/> HEARING INS	<input type="checkbox"/> OTHER:specify-	
<input type="checkbox"/> RETIREMENT	<input type="checkbox"/> DENTAL INS			
2. TOTAL FRINGE BENEFITS:			\$ -	
3. TRAVEL: (Specify if any item exceeds 10% of Total Expenditures)				
3. TOTAL TRAVEL:			\$ -	
4. SUPPLIES & MATERIALS: (Specify if any item exceeds 10% of Total Expenditures)				
4. TOTAL SUPPLIES & MATERIALS:			\$ -	
5. CONTRACTUAL: (Subcontracts)				
Name	Address	Amount		
5. TOTAL CONTRACTUAL:			\$ -	
6. EQUIPMENT: (Specify)				
6. TOTAL EQUIPMENT:			\$ -	
7. OTHER EXPENSES: (Specify if any item exceeds 10% of Total Expenditures)				
Communication:		Amount		
Space Cost:				
Others (explain):				
(List all items and provide each cost, then enter total below)			7. TOTAL OTHER EXPENSES:	
			\$ -	
8. TOTAL DIRECT EXPENDITURES: (Sum of Totals 1-7)				\$ -
9. INDIRECT COST CALCULATIONS:				
Rate #1	Base \$	x Rate	=	\$ -
Rate #2	Base \$	- x Rate	=	\$ -
9. TOTAL INDIRECT EXPENDITURES:			\$ -	
10. TOTAL ALL EXPENDITURES: (Sum of lines 8-9)				\$ -
AUTHORITY: P.A. 368 of 1978		The Department of Community Health is an equal opportunity employer, services and programs provider.		
COMPLETION: Is Voluntary, but is required as a condition of funding.				
DCH-0386(E) (Rev. 9-04) (EXCEL) Previous Edition Obsolete		<i>Use Additional Sheets as Needed</i>		

Peer Delivered and Operated Services

The MDCH contract requires CMHSPs to have, as part of its service array, at least one consumer-delivered or operated service.

Peer-operated Support Services are defined as:

Service activities intended to provide recipients with opportunities to learn and share coping skills and strategies, move into active assistance roles, and to build and/or enhance self esteem and self confidence.

Such services may include:

- < consumer run drop-in centers; and
- < other peer-operated services (e.g., peer-run hospital diversion services).

Additional examples include:

- < consumer owned and run businesses;
- < “Project Stay” peer support services; and
- < housing programs run by consumer organizations.

The criteria to evaluate CMHSP contract compliance includes:

- < Evidence that services or supports are delivered by primary consumers to existing or prospective primary consumers. (Therefore, professionally led self help groups would not constitute compliance.)
- < Evidence that services or supports are alternatives or in addition to existing Medicaid covered CMHSP services such as PSR Clubhouse, ACT teams, etc.
- < Evidence that, if the service or support is to be delivered in the same site or facility as a PSR Clubhouse, day program, etc. that the services or supports are:
 - occurring at times outside of the “ordered day” or socialization component of the clubhouse;
 - occurring at times outside of the day program schedule;
 - publicized and made available to persons other than clubhouse members or day program participants; and
 - those in which consumers have exclusive decision making authority over the planning and implementation of the service and support (i.e., professional staff are involved only as consultants at the request of consumers and not part of the actual service delivery).
- < In the case of self-help organizations or activities, the group must consist of non-professionals who have control of the purpose and content of the discussion and evidence of CMHSP direct financial or in-kind support (e.g., donation of building space, phones, travel expenses, etc.) in addition to formal referral agreements.

Evidence of best practice includes:

- < The person providing the service or support is a member/employee of a group or organization external to the CMHSP which decides its own mission, goals, methods, and use of resources (both human and financial).
- < In the case of organizations:
 - the organization’s governing body is comprised exclusively of persons who are primary consumers;
 - all of the organization’s employees are comprised exclusively of persons who are primary consumers; and
 - the organization has a formal contractual relationship with the CMHSP with an identified liaison responsible for advocacy, consultation and support to the consumer organization.
- < With respect to self help groups, the group has multiple members which meet regularly and are offered in addition to other consumer operated and delivered services.
- < The organization or group is well integrated into the community.

ATTACHMENT D

Rural Counties:

Alcona	Keweenaw
Alger	Lake
Allegan	Lapeer
Alpena	Leelanau
Antrim	Lenawee
Arenac	Livingston
Baraga	Luce
Barry	Mackinac
Bay	Manistee
Benzie	Marquette
Berrien	Mason
Branch	Mecosta
Cass	Menominee
Charlevoix	Midland
Cheboygan	Missaukee
Chippewa	Monroe
Clare	Montcalm
Clinton	Montmorency
Crawford	Newaygo
Delta	Oceana
Dickinson	Ogemaw
Eaton	Ontonagon
Emmet	Osceola
Gladwin	Oscoda
Gogebic	Otsego
Grand Traverse	Ottawa
Gratiot	Presque Isle
Hillsdale	Roscommon
Houghton	St. Clair
Huron	St. Joseph
Ionia	Sanilac
Iosco	Schoolcraft
Iron	Shiawassee
Isabella	Tuscola
Jackson	Van Buren
Kalkaska	Wexford

Urban Counties:

Calhoun
Genesee
Ingham
Kalamazoo
Kent
Macomb
Muskegon
Oakland
Saginaw
Washtenaw
Wayne

National Mental Health Information Center

Article location:

<http://www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooccurring/usersguide/project.asp>

Evidence-Based Practices: Shaping Mental Health Services Toward Recovery

Implementation Resource Kit User's Guide

Project Philosophy and Values

The project rests on two philosophical tenets:

First, mental health services for people with severe mental illnesses should have the goal of helping people to develop high-quality, satisfying functional lives. That is, services should aim not just at helping consumers stay out of the hospital and reducing or stabilizing symptoms, but also at helping them to pursue their own personal recovery process. People want services that help them to manage their illnesses and to move ahead with their lives.

Second, consumers and their families have a right to information about effective treatments, and in areas where evidence-based practices exist, consumers and family members have a right to access effective services.

Evidence-based practices are not intended to be exclusive, mandatory, or rigid. Rather, they imply self-knowledge, self-determination, choice, individualization, and recovery.

Defining recovery

There have been many efforts to define the recovery philosophy. The Consumer Advisory Panel for the Implementing Evidence-Based Practices Project drafted the following brief statement.

The principles of recovery that informed the development of the implementation resource kit materials are:

- hope
- personal responsibility
- education
- self-advocacy
- support

The cessation of symptoms is not necessarily equal to recovery. Each person develops their own definition of recovery, which many view as a process rather than a destination.

It is important to know what is meant by "support." While the support of others is a valuable element in recovery, it does not include solving problems for another person or giving advice.

Empowerment is another critical component to recovery. A person becomes dis-empowered when choices are made for them, even when well-meaning supporters do it. Disempowerment also occurs when assumptions or judgments are made concerning an individual and their choices.

Recovery is most easily achievable when a person and those around them recognize the individual as a whole and complete person regardless of symptoms. One of the most valuable things a person can do for someone with psychiatric symptoms is to listen.

For more information

Copeland, Mary Ellen. *Wellness Recovery Action Plan*. 1997. Peach Press.

Ralph, Ruth O. *Review of Recovery Literature: A Synthesis of a Sample of Recovery Literature 2000*. Report produced for NASMHPD/National Technical Assistance Center for State Mental Health Planning.

- You will discover resources that you never knew were available to you that will help you reach your goals.
- You will find ways to celebrate every step that moves you closer to the life you want.

What is Recovery?

Recovery is an important idea that is sweeping the mental health field. Recovery is a word that is used to describe the many positive changes that can happen in people’s lives after the experience of prolonged psychiatric disability.

There are many definitions of recovery from consumers, researchers and leaders in the rehabilitation and mental health field. Here are two that are often used:

Recovery is a process, a way of life, an attitude, and a way of approaching the day’s challenges...The need is to meet the challenge of the disability and to reestablish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work and love in a community in which one makes a significant contribution.

~Patricia E. Deegan,
National Consumer Leader

Recovery is a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It’s a way of living a satisfying, hopeful, and contributing life even within the limitations caused by the illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness.

~William Anthony,
Director, Center for Psychiatric Rehabilitation,
Boston University

“There are as many ways to live and grow as there are people.”
~Evelyn Mandel

a high percentage of those of us with serious psychiatric problems can perform well in typical social roles, the idea that people with psychiatric disabilities cannot recover has completely lost credibility.

Recovery and a Strengths Orientation

We know that we increase our chances of recovery when we focus on our strengths, hopes and aspirations and the positive resources around us, rather than focusing primarily on our problems, psychiatric symptoms or deficits. Consumers have written about the importance of strengths to the whole process of recovery. Here's what Jay Mahler, a California consumer leader has to say:

When we begin to feel more confidence in ourselves, we begin to acknowledge positive aspects of ourselves that are also a part of our reality. People are not a collection of psychiatric symptoms. We also have many talents, strengths and inner wisdom. We have important relationships with family, friends and helpers...As we gradually begin to identify with positive aspects within ourselves and our surroundings we come to realize we can call upon our inner and outer resources and strengths to move us forward in our recovery. The mental illness gradually becomes a less dominating and all-encompassing part of our lives.

*~Jay Mahler,
California Consumer Leader*

As we enter the pathway to recovery, we find we can interact with our environment and other people in ways that help us move forward. There are many powerful sources of help and healing all around us.

Perhaps most importantly, we have many sources of hope and healing *within ourselves*. We can have more control over our lives and have a more positive future by building upon our own resources.

“When people tell you that you can’t do something, you kind of want to try it.”
~Senator Margaret Chase Smith

“You gain strength, courage and confidence by every experience in which you really stop to look fear in the face. You must do the thing which you think you cannot do.”
~Eleanor Roosevelt