



**STATE OF VERMONT**  
JOINT FISCAL OFFICE

**MEMORANDUM**

To: James Reardon, Commissioner of Finance & Management  
From: Nathan Lavery, Fiscal Analyst  
Date: November 30, 2010  
Subject: JFO #2467, #2470

No Joint Fiscal Committee member has requested that the following items be held for review:

**JFO #2467** — \$3,670,995 grant from the U.S. Department of Health and Human Services to the Department of Mental Health. This grant will support the implementation of new techniques to make Vermont's mental health services more consumer-driven and recovery-oriented, including the development of a workforce of credential Peer Specialists trained to offer early intervention outreach services to 850 adults who are at risk for mental illness. **One (1) limited service position is associated with this request.**

*[JFO received 10/25/10]*

**JFO #2470** — \$345,000 land donation from the Estate of Alice Hadley to the Department of Fish & Wildlife. This request is for the approval of a donation of 91% of the appraised value of the property. The property will be managed as part of the Missing Link Wildlife Management Area.

*[JFO received 11/16/10]*

The Governor's approval may now be considered final. We ask that you inform the Secretary of Administration and your staff of this action.

cc: Michael Hartman, Commissioner  
Wayne Laroche, Commissioner

**Nathan Lavery - FW: \*\*Media Advisory\*\* Governor Douglas Heads to Asia with EB-5 Delegation**

---

**From:** "Johnson, Harriet" <Harriet.Johnson@state.vt.us>  
**To:** "Lavery, Nathan" <nlavery@leg.state.vt.us>  
**Date:** 11/3/2010 4:15 PM  
**Subject:** FW: \*\*Media Advisory\*\* Governor Douglas Heads to Asia with EB-5 Delegation

---

Nathan – let me know if this helps.  
Thanks, Harriet

Harriet Johnson | Agency of Administration  
109 State Street | Montpelier, VT 05609-0201  
ph: 802.828.3322 | fax: 802.828.3320

---

**From:** Coriell, David  
**Sent:** Wednesday, October 13, 2010 4:13 PM  
**To:** Coriell, David  
**Subject:** \*\*Media Advisory\*\* Governor Douglas Heads to Asia with EB-5 Delegation

JAMES H. DOUGLAS  
GOVERNOR



State of Vermont  
OFFICE OF THE GOVERNOR

**For Immediate Release:**  
October 14, 2010

**Contact:** David M. Coriell  
(802) 828-3333

**\*\*MEDIA ADVISORY\*\***

**Governor Douglas Heads to Asia with EB-5 Delegation**

Montpelier, Vt. – Governor Jim Douglas today departed for Japan on the first leg of a 12 day EB-5 trade mission to Asia to help Vermont employers attract foreign investment and create jobs. The EB-5 program is a federal investment program run by the United States Citizenship and Immigration Services (USCIS). The goal of the program is to incent investment and create American jobs by setting aside a pool of green cards for qualified foreign investors that invest capital into approved EB-5 projects. The Vermont EB-5 Regional Center is run through the Agency of Commerce and Community Development and has raised over \$100 million in new capital for companies and projects.

Governor Douglas and the delegation will be travelling to Tokyo, Hong Kong, Beijing, Shanghai and Vietnam between October 14 and October 26. If members of the media are interested in speaking to the Governor while he is travelling, contact David Coriell at 802-828-3333.

###

David M. Coriell  
Communications Director  
109 State Street ♦ The Pavilion ♦ Montpelier, VT 05609-0101  
Telephone: 802.828.3333 ♦ Fax: 802.828.3339 ♦ TDD: 802.828.3345



**STATE OF VERMONT**  
JOINT FISCAL OFFICE

**MEMORANDUM**

To: Joint Fiscal Committee Members  
From: Nathan Lavery, Fiscal Analyst  
Date: October 27, 2010  
Subject: Grant Request

Enclosed please find one (1) request that the Joint Fiscal Office has received from the administration. This request includes the establishment of one (1) limited service position.

**JFO #2467** — \$3,670,995 grant from the U.S. Department of Health and Human Services to the Department of Mental Health. This grant will support the implementation of new techniques to make Vermont's mental health services more consumer-driven and recovery-oriented, including the development of a workforce of credential Peer Specialists trained to offer early intervention outreach services to 850 adults who are at risk for mental illness. **One (1) limited service position is associated with this request.**  
[JFO received 10/25/10]

In accordance with the procedures for processing such requests, we ask you to review the enclosed and notify the Joint Fiscal Office (Nathan Lavery at 802-828-1488; [nlavery@leg.state.vt.us](mailto:nlavery@leg.state.vt.us)) if you have questions or would like an item held for Joint Fiscal Committee review.

cc: James Reardon, Commissioner  
Michael Hartman, Commissioner



**STATE OF VERMONT**  
JOINT FISCAL OFFICE

**MEMORANDUM**

To: Joint Fiscal Committee Members  
From: Nathan Lavery, Fiscal Analyst  
Date: October 27, 2010  
Subject: Grant Request

Enclosed please find one (1) request that the Joint Fiscal Office has received from the administration. This request includes the establishment of one (1) limited service position.

**JFO #2467** — \$3,670,995 grant from the U.S. Department of Health and Human Services to the Department of Mental Health. This grant will support the implementation of new techniques to make Vermont's mental health services more consumer-driven and recovery-oriented, including the development of a workforce of credential Peer Specialists trained to offer early intervention outreach services to 850 adults who are at risk for mental illness. **One (1) limited service position is associated with this request.**

*[JFO received 10/25/10]*

In accordance with the procedures for processing such requests, we ask you to review the enclosed and notify the Joint Fiscal Office (Nathan Lavery at 802-828-1488; [nlavery@leg.state.vt.us](mailto:nlavery@leg.state.vt.us)) if you have questions or would like an item held for Joint Fiscal Committee review.

cc: James Reardon, Commissioner  
Michael Hartman, Commissioner



**STATE OF VERMONT**  
JOINT FISCAL OFFICE

**MEMORANDUM**

To: Joint Fiscal Committee Members  
From: Nathan Lavery, Fiscal Analyst  
Date: October 27, 2010  
Subject: Grant Request

Enclosed please find one (1) request that the Joint Fiscal Office has received from the administration. This request includes the establishment of one (1) limited service position.

**JFO #2467** — \$3,670,995 grant from the U.S. Department of Health and Human Services to the Department of Mental Health. This grant will support the implementation of new techniques to make Vermont's mental health services more consumer-driven and recovery-oriented, including the development of a workforce of credential Peer Specialists trained to offer early intervention outreach services to 850 adults who are at risk for mental illness. **One (1) limited service position is associated with this request.**  
[JFO received 10/25/10]

In accordance with the procedures for processing such requests, we ask you to review the enclosed and notify the Joint Fiscal Office (Nathan Lavery at 802-828-1488; [nlavery@leg.state.vt.us](mailto:nlavery@leg.state.vt.us)) if you have questions or would like an item held for Joint Fiscal Committee review.

cc: James Reardon, Commissioner  
Michael Hartman, Commissioner



**STATE OF VERMONT**  
JOINT FISCAL OFFICE

**MEMORANDUM**

To: Joint Fiscal Committee Members  
From: Nathan Lavery, Fiscal Analyst  
Date: October 27, 2010  
Subject: Grant Request

Enclosed please find one (1) request that the Joint Fiscal Office has received from the administration. This request includes the establishment of one (1) limited service position.

**JFO #2467** — \$3,670,995 grant from the U.S. Department of Health and Human Services to the Department of Mental Health. This grant will support the implementation of new techniques to make Vermont's mental health services more consumer-driven and recovery-oriented, including the development of a workforce of credential Peer Specialists trained to offer early intervention outreach services to 850 adults who are at risk for mental illness. **One (1) limited service position is associated with this request.**  
[JFO received 10/25/10]

In accordance with the procedures for processing such requests, we ask you to review the enclosed and notify the Joint Fiscal Office (Nathan Lavery at 802-828-1488; [nlavery@leg.state.vt.us](mailto:nlavery@leg.state.vt.us)) if you have questions or would like an item held for Joint Fiscal Committee review.

cc: James Reardon, Commissioner  
Michael Hartman, Commissioner



**STATE OF VERMONT**  
JOINT FISCAL OFFICE

**MEMORANDUM**

To: Representative Ann Pugh  
From: Nathan Lavery, Fiscal Analyst  
Date: October 27, 2010  
Subject: JFO #2467

Representative Michael Obuchowski asked that I forward to you a copy of the enclosed grant materials and cover memo. He requests your observations regarding the enclosed item.

cc: Rep. Michael Obuchowski



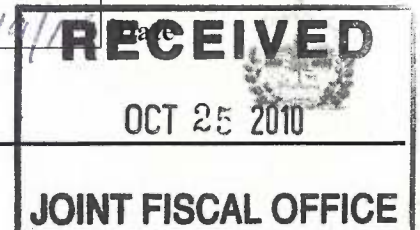
**State of Vermont**  
 Department of Finance & Management  
 109 State Street, Pavilion Building  
 Montpelier, VT 05620-0401

Agency of Administration

[phone] 802-828-2376  
 [fax] 802-828-2428

**STATE OF VERMONT**  
**FINANCE & MANAGEMENT GRANT REVIEW FORM**

<b>Grant Summary:</b>		This is a five year grant to foster adoption and implementation of permanent transformative changes in the management, organization, and delivery of Vermont's public mental health services to make these services consumer-driven, recovery-oriented and supported through evidence-based best practices.			
<b>Date:</b>		10/5/2010			
<b>Department:</b>		Department Mental Health			
<b>Legal Title of Grant:</b>		Mental Health Transformation Grants			
<b>Federal Catalog #:</b>		93.243			
<b>Grant/Donor Name and Address:</b>		Department of Health and Human Services, Office of Program Services, Substance Abuse and Mental Health Services Administration, One Choke Cherry Road, Rockville Maryland, 20857			
<b>Grant Period:</b>		<b>From:</b>	<b>To:</b>		
		9/30/2010	9/29/2015		
<b>Grant/Donation</b>		\$3,670,995			
	<b>SFY 1</b>	<b>SFY 2</b>	<b>SFY 3</b>	<b>Total</b>	<b>Comments</b>
<b>Grant Amount:</b>	\$229,637	\$734,199	\$2,707,159	\$3,670,995	SFY3 amount shown is the total for last three years of the grant.
<b>Position Information:</b>		<b># Positions</b>	<b>Explanation/Comments</b>		
		1	This is for a Project Director for this five year grant.		
<b>Additional Comments:</b>		This grant does not require any state match.			
<b>Department of Finance &amp; Management</b>		10/12/10		(Initial)	
<b>Secretary of Administration</b>		10/13/10		(Initial)	
<b>Sent To Joint Fiscal Office</b>		10/19/10			



<b>STATE OF VERMONT</b> <b>FINANCE &amp; MANAGEMENT GRANT REVIEW FORM</b>		

--	--	--



STATE OF VERMONT REQUEST FOR GRANT ACCEPTANCE (Form AA-1)

**BASIC GRANT INFORMATION**

<b>1. Agency:</b>	Human Services
<b>2. Department:</b>	Mental Health
<b>3. Program:</b>	Adult Mental Health
<b>4. Legal Title of Grant:</b>	Mental Health Transformation Grants
<b>5. Federal Catalog #:</b>	93.243

<b>6. Grant/Donor Name and Address:</b> Substance Abuse and Mental Health Services Administration, Rockville, MD	
<b>7. Grant Period:</b>	<b>From:</b> 9/30/2010 <b>To:</b> 9/29/2015

**8. Purpose of Grant:**  
To foster adoption and implementation of permanent transformative changes in how public mental health services are organized, managed and delivered so that they are consumer-driven, recovery-oriented and supported through evidence-based and best practices.

**9. Impact on existing program if grant is not Accepted:**  
none

**10. BUDGET INFORMATION**

	SFY 1 FY 11	SFY 2 FY 12	SFY 3 FY 13 and beyond	Comments
<b>Expenditures:</b>				
Personal Services	\$91,072	\$192,718	\$679,802	
Operating Expenses	\$28,816	\$40,916	\$134,846	
Grants	\$109,749	\$500,565	\$1,892,511	
<b>Total</b>	<b>\$229,637</b>	<b>\$734,199</b>	<b>\$2,707,159</b>	
<b>Revenues:</b>				
State Funds:	\$	\$	\$	
Cash	\$	\$	\$	
In-Kind	\$	\$	\$	
Federal Funds:	\$229,637	\$734,199	\$2,707,159	
(Direct Costs)	\$220,805	\$705,961	\$2,603,037	
(Statewide Indirect)	\$87	\$280	\$1,031	
(Departmental Indirect)	\$8,745	\$27,958	\$103,091	
Other Funds:	\$	\$	\$	
Grant (source )	\$	\$	\$	
<b>Total</b>	<b>\$229,637</b>	<b>\$734,199</b>	<b>\$2,707,159</b>	

<b>Appropriation No:</b>	3150070000	<b>Amount:</b>	\$229,637
			\$
			\$
			\$
			\$
			\$
			\$

REC'D OCT 9 8 2010

**STATE OF VERMONT REQUEST FOR GRANT ACCEPTANCE (Form AA-1)**

					<b>Total</b>	\$
<b>PERSONAL SERVICE INFORMATION</b>						
<b>11. Will monies from this grant be used to fund one or more Personal Service Contracts?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", appointing authority must initial here to indicate intent to follow current competitive bidding process/policy.  Appointing Authority Name: Michael Hartman Agreed by: <u>MMH</u> (initial)						
<b>12. Limited Service Position Information:</b>						
	<b># Positions</b>		<b>Title</b>			
	1		Project Director			
<b>Total Positions</b>		1				
<b>12a. Equipment and space for these positions:</b>			<input checked="" type="checkbox"/> Is presently available.		<input type="checkbox"/> Can be obtained with available funds.	
<b>13. AUTHORIZATION AGENCY/DEPARTMENT</b>						
I/we certify that no funds beyond basic application preparation and filing costs have been expended or committed in anticipation of Joint Fiscal Committee approval of this grant, unless previous notification was made on Form AA-1PN (if applicable):			Signature: <u>Michael A. Hunt</u>		Date: <u>9/29/10</u>	
			Title: <u>Commissioner, Dept of Mental Health</u>			
			Signature: <u>Patrick Flood</u>		Date: <u>9/30/10</u>	
			Title: <u>Deputy Secretary</u>			
<b>14. ACTION BY GOVERNOR</b>						
<input checked="" type="checkbox"/>	Check One Box: Accepted	<u>Brian E. Tucke</u>			Date: <u>10/18/10</u>	
<input type="checkbox"/>	Rejected	(Governor's signature)			Date:	
<b>15. SECRETARY OF ADMINISTRATION</b>						
<input checked="" type="checkbox"/>	Check One Box: Request to JFO	<u>Tom M...</u>			Date: <u>10/13/10</u>	
<input type="checkbox"/>	Information to JFO	(Secretary's signature or designee) <u>TH</u>			Date:	
<b>16. DOCUMENTATION REQUIRED</b>						
<b>Required GRANT Documentation</b>						
<input type="checkbox"/> Request Memo <input type="checkbox"/> Dept. project approval (if applicable) <input type="checkbox"/> Notice of Award <input type="checkbox"/> Grant Agreement <input type="checkbox"/> Grant Budget			<input type="checkbox"/> Notice of Donation (if any) <input type="checkbox"/> Grant (Project) Timeline (if applicable) <input type="checkbox"/> Request for Extension (if applicable) <input type="checkbox"/> Form AA-1PN attached (if applicable)			
<b>End Form AA-1</b>						

REC'D OCT 04 2010



**Vermont Department of Mental Health**

**Supporting Schedule for SAMHSA Mental Health Transformation Grant AA-1 dated 09/30/10**

<u>Item</u>	<u>Amount in application budget for year one</u>	<u>Amount in AA-1 budget for SFY 2011</u>	<u>Amount in AA-1 budget for SFY 2012</u>
Project Director (PD)	61,100	\$30,550 - Assumes PD will begin work on January 2nd, 2011	61,100
Travel expenses for 2 Trips to SAMHSA grantee meeting	11,550	\$11,550	11,550
Supplies (training materials)	3,666	\$3,665	3,666
Grant Award to Another Way	107,160	\$53,580 for six months	107,160
Grant Award to Burlington Provider	186,675	\$46,669 for one-quarter of a year (25% of annualized amount)	186,675
Grant Award to Rural Provider 1	82,365	\$ 0 - This will not occur until after June '11	82,365
Grant Award to Rural Provider 2	82,365	\$ 0 - This will not occur until after June '11	82,365
IMR and SE Training	13,500	\$6,750 for six months (50% of annualized amount)	13,500
Peer Specialist Training	12,000	\$6,000 for six months (50% of annualized amount)	12,000
Evaluation	75,500	\$37,750 for six months (50% of annualized amount)	75,500
Cultural Coordinator	2,380	\$1,190 for six months (50% of annualized amount)	2,380
Subgrant to Data Remedies	2,000	\$2,000	2,000
Incentive Planning Grants	40,000	\$7,500	40,000
Instate Training Meetings	22,500	\$12,000 for 8 meetings	22,500
Stipends/Mileage	3,200	\$1,600 for 4 meeting	3,200
<b>Total Direct Costs</b>	<b>705,961</b>	<b>220,804</b>	<b>705,961</b>
<b>Indirect</b>	<b>28,238</b>	<b>8,833</b>	<b>28,238</b>
<b>Total Costs</b>	<b>734,199</b>	<b>229,637</b>	<b>734,199</b>

Personal Services	91,072	192,718
Operating Expenses	28,816	40,916
Grants	109,749	500,565
<b>Total</b>	<b>229,637</b>	<b>734,199</b>



State of Vermont

Department of Mental Health  
108 Cherry Street, PO Box 70  
Burlington, VT 05402-0070  
[healthvermont.gov/mh](http://healthvermont.gov/mh)

[phone] 802-652-2000  
[Legal] 802-657-4310  
[fax] 802-652-2005  
[tty] 800-253-0191

Agency of Human Services

To: Shirley Dow, AHS

From: Bill Snyder, DMH Financial Manager *Bill*

Re: AA-1 for Mental Health Transformation Grant

Date: September 29, 2010

I am enclosing the documents requesting approval for a new **Mental Health Transformation Grant** for the Department of Mental Health, including a copy of the original application for funding, the grant award letter from the Substance Abuse and Mental Health Services Administration, the AA-1 form with an attached Supporting Schedule for the first year's funding, the Joint Fiscal Committee Review Limited Service - Grant Funded Position Request Form, and the RFR for the proposed limited service position. Please let me know when the AA-1 has been signed by the Secretary and the packet is on its way to Budget and Management in Montpelier.

Per the attached SAMHSA Notice of Award, we have already submitted a revised detailed budget and budget justification (see attached), reflecting the total award amount of **\$734,199 for Year One**. SAMHSA has approved the revised budget (see attached email from Gwendolyn Simpson).

Please note that DMH plans to create a Limited Service Position (Project Director) that will be fully funded by this grant. This position was approved by Secretary Hofmann (see attached memo). This position will oversee and coordinate the grant.

If you have any questions, please contact me at 241- 4033 or Nick Nichols at 241- 4007.

Request for Grant Acceptance  
Summary - Mental Health Transformation Grant 09/30/10

The Department of Mental Health (DMH) has been awarded \$ 3,670,995 over a period of 5 years by the Substance Abuse and Mental Health Services Administration through its Mental Health Transformation (MHT) grant program. DMH will use these grant funds to foster adoption and implementation of permanent transformative changes in how Vermont's public mental health services are organized, managed and delivered so that they are consumer-driven, recovery-oriented and supported through evidence-based and best practices.

Under this grant, DMH will expand services for young adults (ages 18-34) with or at risk of serious mental illness who are not currently accessing Community Rehabilitation and Treatment services at their local designated community mental health agency. This population often "falls through the cracks" of our services systems because they are not eligible for CRT services and/or they choose not to access community mental health services. In some cases, these individuals have multiple interactions with law enforcement, homeless shelters, corrections, and hospital emergency rooms.

DMH will use grant funds to create an effective early intervention system which delivers peer-based, evidence based interventions for this population. In partnership with consumer, family and professional stakeholders, the state will develop a workforce of credentialed Peer Specialists to engage with this population and provide peer services focused on wellness-promotion, self-management and supported employment. These peer specialists will also assist this population with accessing other services and supports in their community (e.g. psychiatric treatment, supported housing, economic services).

The grant will augment existing Adult Local Interagency Teams (Adult LIT's) to create community steering committees for grant activities. These committees will include relevant community partners who may be interacting with this population and support collaboration between local peer specialists and other community partners to improve access to services. As peer specialists engage with this population and achieve positive outcomes, the "lessons learned" from that process will be used by the local steering committees to improve how local programs provide welcoming and accessible services to this population.

The grant will also augment the Agency of Human Services Adult State Interagency Team (Adult SIT) to focus on the identification of state-level barriers to treatment and support of this population and strategies to address those barriers.

The project will be managed by the Department of Mental Health, and Dr. Trish Singer will act as the principle investigator.

During the first 12 months of the initiative funds will be spent on the following:

- \$61,100 to fund a 1.0 FTE project director (limited service)



- \$75,500 to contract for evaluation of grant activities
- \$25,500 to purchase expert training and consultation.
- \$40,000 sub granted to designated agencies to support local planning and implementation activities and participate in state-level planning
- \$458,565 sub-granted to local provider programs (e.g. Another Way) to support peer support for the target population
- \$3,666 for development/production/purchase of training materials

The remaining funds will be used each year to support travel costs for grant staff to attend required SAMHSA Grantee meetings, expenses for stakeholder meetings (e.g. steering committee) to assist in the oversight of the initiative, and cultural and linguistic consultation.

A supporting schedule of projected expenditures for State Fiscal '11 is attached. This schedule is based on the assumption that project activities would begin on January 1<sup>st</sup>, 2011. Expenditure of federal funding in subsequent years will be included in DMH's annual budget request.

## Abstract

Vermont's Department of Mental Health will offer effective outreach and early intervention services to 850 adults (18 - 34) who show early signs of mental illness or who are at risk for mental illness (SAMHSA Strategic Initiative # 1). In partnership with consumers, consumer run organizations, and the communities, the state will develop a workforce of credentialed Peer Specialists trained in two SAMHSA National Registry of Evidence-Based Programs and Practices (NREPP) evidence based interventions: Illness Management and Recovery (IMR) and Supported Employment (SE). Peer Specialists will engage consumers in community settings; help them connect with community services, particularly employment; and assist them in building skills to support a successful life in the community. This transformation will utilize existing interagency planning structures at the state and local levels with experience in implementing system change: the State Interagency Team (SIT) and the Local Interagency Teams (LITs). These interagency planning structures will be expanded to include representation of consumers from the population of focus as well as advocacy groups such as Vermont Psychiatric Survivors, NAMI-VT, and Friends of Recovery-Vermont (FOR-VT). Implementation will be a rolling process starting with Montpelier (within six months), Burlington (within year 1), and two rural communities selected by RFP (within year 2). Four communities, which represent a diverse urban center, a small town, and two rural areas, will demonstrate how IMR and SE can be implemented by Certified Peer Specialists in partnership with community mental health, substance abuse, employment and other community resources. fifty consumers will be served in the first year and two hundred new consumers will be served each year in years two through five. By the end of year four, the Project Director will present a statewide Training Plan to generalize lessons learned. Throughout the grant period, consumer and peer organizations as well as Community Mental Health Center representatives from across Vermont will be invited to participate in training. A continuous quality improvement process will evaluate our model of care to improve outcomes for consumers; ensure consumer engagement in decision making at every level; and ensure that evidence based practices are implemented with fidelity. The project will utilize existing models of Peer Specialists developed by other states (e.g. North Carolina, Georgia) which balance consumer preferences with federal Medicaid requirements for re-imbusement. Together with evaluation findings demonstrating fiscal and programmatic effectiveness, utilizing this tested model will assist in sustaining transformation. The credentialed peer workforce developed through the grant will be sustained through changes in Vermont's Medicaid waiver to sustain transformation.

## Table of Contents

<b>Abstract</b> .....	<b>1</b>
<b>Program Narrative</b> .....	<b>5</b>
<b>Section A: Statement of Need</b> .....	<b>5</b>
<b>Section B: Strategic Initiative and Proposed Practice</b> .....	<b>10</b>
<b>Section C: Proposed Implementation Approach</b> .....	<b>18</b>
<b>Section D: Staff and Organizational Experience</b> .....	<b>27</b>
<b>Section E: Performance Assessment and Data</b> .....	<b>30</b>
<b>Section F: Literature Citations</b> .....	<b>35</b>
<b>Section G: Budget Justification, Existing Resources, Other Support</b> .....	<b>37</b>
<b>Section H: Biographical Sketches and Job Descriptions</b> .....	<b>44</b>
<b>Section I: Confidentiality and Participant Protection Requirements</b> .....	<b>58</b>
 <b>Appendices:</b>	
<i>Attachment 1: (1) Identification of at least one experienced service provider organization; (2) a list of all direct service provider organizations that have agreed to participate in the proposed project; (3) the Statement of Assurance, (4) Service Provider Letters of Commitment</i> .....	<b>62</b>
<i>Attachment 2: Letter to the SSA</i> .....	<b>81</b>
<i>Attachment 3: Draft Service Implementation Plan</i> .....	<b>82</b>
<i>Attachment 4: Signed Documentation of Stakeholder Commitment</i> .....	<b>85</b>
<i>Attachment 5: CMHS-TRAC Infrastructure Categories and Indicators</i> .....	<b>106</b>
<i>Attachment 6: Data Collection Instruments</i> .....	<b>108</b>
<i>Attachment 7: Sample Consent Forms</i> .....	<b>131</b>

**STATE OF VERMONT**  
**Joint Fiscal Committee Review**  
**Limited Service - Grant Funded**  
**Position Request Form**

This form is to be used by agencies and departments when additional grant funded positions are being requested. Review and approval by the Department of Human Resources must be obtained prior to review by the Department of Finance and Management. The Department of Finance will forward requests to the Joint Fiscal Office for JFC review. A Request for Classification Review Form (RFR) and an updated organizational chart showing to whom the new position(s) would report must be attached to this form. Please attach additional pages as necessary to provide enough detail.

Agency/Department: AHS/Mental Health      Date: September 23, 2010

Name and Phone (of the person completing this request): Nick Nichols, 241-2601

Request is for:

- Positions funded and attached to a new grant.
- Positions funded and attached to an existing grant approved by JFO # \_\_\_\_\_

1. Name of Granting Agency, Title of Grant, Grant Funding Detail (attach grant documents):

*Department of Health and Human Services-Substance Abuse and Mental Health Services Administration*  
Mental Health Transformation Grant

2. List below titles, number of positions in each title, program area, and limited service end date (information should be based on grant award and should match information provided on the RFR) position(s) will be established only after JFC final approval:

<u>Title* of Position(s) Requested</u>	<u># of Positions</u>	<u>Division/Program</u>	<u>Grant Funding Period/Anticipated End Date</u>
Project Director	1	Adult Mental Health	9/30/10 – 9/29/2015

\*Final determination of title and pay grade to be made by the Department of Human Resources Classification Division upon submission and review of Request for Classification Review.

3. Justification for this request as an essential grant program need:

This position will oversee all grant activities and ensure coordination between 4 different demonstration sites. The management of this grant requires a full-time position, and existing staff at DMH would be unable to manage these responsibilities.

I certify that this information is correct and that necessary funding, space and equipment for the above position(s) are available (required by 32 VSA Sec. 5(b)).

*[Signature]* \_\_\_\_\_ Date *9/29/10*

*Molly Paulsen* \_\_\_\_\_ Date *10/6/10*

*[Signature]* \_\_\_\_\_ Date *10/18/10*

*[Signature]* \_\_\_\_\_ Date *10/13/10*

REC'D OCT 04 2010

10/10/10

10/10/10

10/10/10

10/10/10

STATE OF VERMONT  
Joint Fiscal Committee Review  
Limited Service - Grant Funded  
Position Request Form

Approved/Denied by Secretary of Administration

Date

Comments:

DHR approval is contingent upon  
approval of funding by F&M.

Handwritten text, possibly a signature or date, located in the lower-left quadrant of the page.

Small handwritten mark or signature at the bottom left corner.

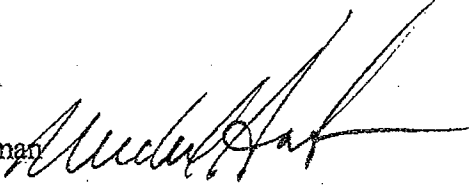


State of Vermont  
Department of Mental Health  
Office of the Commissioner  
103 South Main Street  
Wasson Hall  
Waterbury, VT 05671-2510  
[www.mentalhealth.vermont.gov](http://www.mentalhealth.vermont.gov)

Agency of Human Services

[phone] 802-241-4008  
[fax] 802-241-4009  
[tty] 800-253-0191

**MEMORANDUM**

**TO:** Rob Hofmann  
**FROM:** Michael Hartman   
**DATE:** April 27, 2010  
**RE:** Request for Limited Service Position


The Vermont Department of Mental Health's (DMH) will be applying for a federal *Mental Health Transformation Grant*. This grant program is being offered by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, and will provide up to \$750,000 per year for five years to foster adoption and implementation of permanent transformative changes in how public mental health services are organized, managed and delivered so that they are consumer-driven, recovery-oriented and supported through evidence-based and best practices. Specifically, grantees under this program will be expected to create or expand capacity to serve adults with or at risk of serious mental illness who are currently underserved.

Due to the size of the grant and the need for state-level coordination, we would like to propose creating a 5-year limited service position to act as the project director. The position would be entirely funded by federal funds and would no longer be needed at the conclusion of the grant.

There is no requirement for matching funds under this grant.

Please let me know if AHS can support this proposal at this time.

MH/psp

Concur.  
  
4/27/10



**Nichols, Nick**

---

**From:** Simpson, Gwendolyn G. (SAMHSA/OPS) [Gwendolyn.Simpson@samhsa.hhs.gov]

**Sent:** Friday, September 24, 2010 11:19 AM

**To:** Nichols, Nick

**Subject:** RE: Grant #: 1 H79 SM 0601 46-01

Mr. Nichols, you will be receiving a revised Notice of Grant approving this after October. Currently, our #1 priority is to finish making the new awards and obligating the funds.

But, if you must have something right now, until you receive the official notice in the form of a revised Notice of Grant Award from SAMHSA Division of Grants Management, let this email serve as acceptance of the revised budget submitted and received on September 22, 2010.

Thank you,

*Gwendolyn Simpson*

Gwendolyn Simpson  
Team Leader/Lead Grants Management Specialist  
Division of Grants Management, SAMHSA  
1 Choke Cherry Road, 7-1085  
Rockville, MD 20857  
240-276-1408  
240-276-1430 (Fax No.)  
[gwendolyn.simpson@samhsa.hhs.gov](mailto:gwendolyn.simpson@samhsa.hhs.gov)

---

**From:** Nichols, Nick [mailto:Nick.Nichols@ahs.state.vt.us]

**Sent:** Friday, September 24, 2010 10:51 AM

**To:** Simpson, Gwendolyn G. (SAMHSA/OPS); Morrissette, David (SAMHSA/CMHS)

**Subject:** RE: Grant #: 1 H79 SM 0601 46-01

Ms. Simpson - Assuming this is approved, can we get something in writing (e.g. an email) to verify that the modified budget has been approved? Our legislative approval process for federal funds requires that we show that SAMHSA has approved our modified budget, and, given how long it can take for that state approval process, we hope to submit the application early next week.

thanks,

**Nick Nichols**

Mental Health Policy Director  
Department of Mental Health  
103 South Main Street  
Wasson Hall  
Waterbury, VT 05671  
802-241-2601  
802-241-4004 (fax)

---

**From:** Simpson, Gwendolyn G. (SAMHSA/OPS) [mailto:Gwendolyn.Simpson@samhsa.hhs.gov]

**Sent:** Thursday, September 23, 2010 5:32 PM

**To:** Nichols, Nick

**Subject:** RE: Grant #: 1 H79 SM 0601 46-01

9/24/2010



**Grant Number:** 1H79SM060146-01

**Program Director:**  
Patricia Singer

**Project Title:** Implementation of Vermont Mental Health Transformation

Grantee Address	Business Address
VERMONT DEPARTMENT OF HEALTH Heidi Hall Finance Director 103 South Main Street, Wasson Hall Waterbury, VT 056712510	Heidi Hall Finance Director Vermont Department of Mental Health 103 South Main Street, Wasson Hall Waterbury, VT 05671

**Budget Period:** 09/30/2010 – 09/29/2011

**Project Period:** 09/30/2010 – 09/29/2015

Dear Grantee:

The Substance Abuse and Mental Health Services Administration hereby awards a grant in the amount of \$734,199 (see "Award Calculation" in Section I and "Terms and Conditions" in Section III) to VERMONT DEPARTMENT OF HEALTH in support of the above referenced project. This award is pursuant to the authority of Section 520A, PHS Act as Amended and is subject to the requirements of this statute and regulation and of other referenced, incorporated or attached terms and conditions.

Award recipients may access the SAMHSA website at [www.samhsa.gov](http://www.samhsa.gov) (click on "Grants" then SAMHSA Grants Management), which provides information relating to the Division of Payment Management System, HHS Division of Cost Allocation and Postaward Administration Requirements. Please use your grant number for reference.

Acceptance of this award including the "Terms and Conditions" is acknowledged by the grantee when funds are drawn down or otherwise obtained from the grant payment system.

If you have any questions about this award, please contact your Grants Management Specialist and your Government Project Officer listed in your terms and conditions.

Sincerely yours,

Kathleen Sample  
Grants Management Officer  
Division of Grants Management

See additional information below



State of Vermont

Department of Mental Health

103 South Main Street

Wasson Hall

Waterbury, VT 05671-2510

[www.mentalhealth.vermont.gov](http://www.mentalhealth.vermont.gov)

*Agency of Human Services*

[phone] 802-241-2601

[fax] 802-241-2004

[tty] 800-253-0191

**MEMORANDUM**

September 22, 2010

Gwendolyn Simpson

Office of Program Services, Division of Grants Management

Substance Abuse and Mental Health Services Administration

One Choke Cherry Road, Room 7-1091

Rockville, MD 20857

RE: Special Conditions of Award

Grant #: 1 H79 SM 0601 46-01

Dear Ms. Simpson,

Per the SAMHSA Notice of Award for Grant #: 1 H79 SM 0601 46-01, we are submitting the attached revised detailed budget and budget justification reflecting the total award amount of \$734,199 for Year 1.

If you have any questions, please contact me at 802-241-2601.

Thank you.

Sincerely,

Nick Nichols

MH Policy Director

Cc: Trish Singer, MD

Kathleen Sample, SAMHSA

David Morrissette, SAMHSA

**Section G: Budget/Budget Justification/Calculation of Future Budgets**

**Grant # 1 H79 SM 0601 46-01**

**Year One Budget**

<b>Personnel</b>				
<u>Job Title</u>	<u>Name</u>	<u>Annual Salary</u>	<u>Level of Effort (FTE)</u>	<u>Salary Requested</u>
Project Director	TBA	\$ 47,000.00	1.0	\$ 47,000.00
<b>Total Personnel</b>				<b>\$ 47,000.00</b>
Fringe Benefits (30%)				\$ 14,100.00
<b>Total Fringe</b>				<b>\$ 14,100.00</b>
<b>Travel</b>				
2 Trips for SAMHSA for 3 attendees (grantee meeting and consumer leadership forum):				
Airfare (\$600/person x 3 people x 2 trips/year)				\$ 3,600.00
Lodging (\$200/person x 3 people x 3 nights X 2 trips/year)				\$ 3,600.00
Per Diem - Meals (\$75/day X 3 attendees X 3 days X 2 trips/year)				\$ 1,350.00
Expenses + Travel @ \$.50/mile for Project Director				\$ 3,000.00
<b>Total Travel</b>				<b>\$ 11,550.00</b>
<b>Equipment</b>				
<b>Total Equipment</b>				<b>\$ -</b>
<b>Supplies</b>				
Production of Training/Educational Materials				\$ 3,665.58
<b>Total Supplies</b>				<b>\$ 3,665.58</b>
<b>Contractual</b>				
<b>Grant award to Another Way for local implementation of Peer Specialists</b>				
2.5 Staff @ \$35,000 X (50 % of one position will be funded in kind by DVR)				\$ 70,000.00
Fringe				\$ 21,000.00
Travel, expenses (mileage @ \$.50/mile)				\$ 1,000.00
Meeting Expenses for LIT (consumer stipends, mileage @ \$.5/mile)				\$ 2,000.00
Administration (14%)				\$ 13,160.00
Subtotal - Another Way				\$ 107,160.00
<b>Grant award to Burlington Provider (TBA) for local implementation of peer specialists</b>				
4.5 FTE Staff @ \$35,000 (50 % of two positions will be funded in kind by DVR)				\$ 122,500.00
Fringe				\$ 36,750.00
Travel, expenses (mileage @ \$.50/mile)				\$ 2,500.00
Meeting Expenses for LIT (consumer stipends, mileage @ \$.5/mile)				\$ 2,000.00
Administration (14%)				\$ 22,925.00
Subtotal - Burlington Provider				\$ 186,675.00

<b>Grant award to Rural Provider 1 (TBA) for local implementation of peer specialists</b>			
2.0 FTE Staff @ \$35,000 (50 % of one position will be funded in kind by DVR)			\$ 52,500.00
Fringe			\$ 15,750.00
Travel, expenses (mileage @ \$.50/mile)			\$ 2,000.00
Meeting Expenses for LIT (consumer stipends, mileage @ \$.5/mile)			\$ 2,000.00
Administration (14%)			\$ 10,115.00
Subtotal - Rural Provider 1			\$ 82,365.00
<b>Grant award to Rural Provider 2 (TBA) for local implementation of peer specialists</b>			
2.0 FTE Staff @ \$35,000 (50 % of one position will be funded in kind by DVR)			\$ 52,500.00
Fringe			\$ 15,750.00
Travel, expenses (mileage @ \$.50/mile)			\$ 2,000.00
Meeting Expenses for LIT (consumer stipends, mileage @ \$.5/mile)			\$ 2,000.00
Administration (14%)			\$ 10,115.00
Subtotal - Rural Provider 2			\$ 82,365.00
<b>IMR and SE Training - Dartmouth Psychiatric Research Center</b>			
6 days @ \$2000/day			\$ 12,000.00
Expenses + Travel @ \$.50/mile			\$ 1,500.00
Subtotal - Dartmouth PRC			\$ 13,500.00
<b>Peer Specialist Training - Margaret Swarbick</b>			
10 days @ \$900/day			\$ 9,000.00
Expenses + Travel @ \$.50/mile			\$ 3,000.00
Subtotal - Margaret Swarbick			\$ 12,000.00
<b>Evaluation - Flint Springs Consulting</b>			
.45 FTE X \$75,000 X 2 staff (Joy Livingston and Donna Reback)			\$ 67,500.00
Expenses + Travel @ \$.50/mile			\$ 6,000.00
Interview Incentives for Consumer Participation in Evaluation: (\$20/interview X 50 consumers X 2 interviews)			\$ 2,000.00
Subtotal - Evaluation			\$ 75,500.00
<b>Cultural and Linguistic Competence Coordinator - Maria Avila</b>			
.05 FTE X \$41,600			\$ 2,080.00
Expenses + Travel @ \$.50/mile			\$ 300.00
Subtotal - Maria Avila			\$ 2,380.00
Subgrant to Data Remedies for ServicePoint Licensing and adaptation			\$ 2,000.00
Incentive Planning Grants to CMHC's: \$10,000 X 4 CMHC's			\$ 40,000.00
<b>Contractual Subtotal</b>			<b>\$ 603,945.00</b>
<b>Other</b>			
Instate Meeting/Training Expenses for training and SIT meetings/events (room rental, AV (15 meetings X \$1500/meeting)			\$ 22,500.00

Stipends/Mileage for Consumer/Family Participation at SIT (\$100/meeting X 8 meetings X 4 consumer/family members)	\$ 3,200.00	
<i>Other Subtotal</i>		\$ 25,700.00
<b>TOTALS - Direct</b>		<b>\$ 705,960.58</b>
Indirect		\$ 28,238.42
<b>TOTAL</b>		<b>\$ 734,199.00</b>

Percentage/Amount spent on Services, Infrastructure, Evaluation and Administration		
Category	Amount	Percentage of Total Funds
Direct Service	\$ 505,565.00	68.86%
Infrastructure	\$ 80,484.00	10.96%
Evaluation	\$ 75,500.00	10.28%
Grants Management	\$ 72,650.00	9.90%
Total	\$ 734,199.00	100.00%

## BUDGET JUSTIFICATION

Grant # 1 H79 SM 0601 46-01

### PERSONNEL

**Trish Singer, MD, Principal Investigator (.1 FTE - inkind):** Dr. Singer will oversee the grant. Dr. Singer is the DMH Director of Adult Mental Health Services and has extensive experience working with SAMHSA on the implementation of evidence-based practices and integrated dual disorder treatment. While working at the Dartmouth Psychiatric Research Center, she oversaw the development of the SAMHSA Evidence-based Practices Toolkit's, and she has been the project director for both the New Mexico and Vermont Co-Occurring State Incentive Grant funded by SAMHSA.

**Project Director (1 FTE - to be hired):** The Project Director will oversee all grant activities and ensure coordination between the 4 demonstration sites. Qualifications will include: 1) minimum of 5 years experience in SAMHSA grant management, system development, and implementing evidence based practices statewide, 2) masters degree in behavioral health services, 3) experience in public mental health administration. The Project Director will report to Dr. Singer. DMH will actively seek to recruit a consumer for this position.

### FRINGE BENEFITS

The actual cost of fringe benefits (not a fringe benefit rate) will be reported as a direct cost of the program. The actual cost of fringe benefits varies from employee to employee based on salary, employee choice of health care plan, and employee election of certain other benefits. The usual, major components of this cost are FICA at 7.65% of salary, retirement at 9% of salary, and a portion – 80% for medical, 75% for life and 100% for dental - of the actual costs of the medical, dental and life insurance coverage selected by the employee. The cost of each employee's fringe benefits will be allocated to the program based on hours worked in the program relative to all hours worked by the employee. Based on the current cost of fringe benefits for employees in similar programs, we are estimating the cost of these fringe benefits at 30% of salary.

### TRAVEL

**SAMHSA Grantee Meetings:** SAMHSA Funds will be used to cover the costs of three grant participants to attend yearly SAMHSA grantee meetings and three consumer representatives to attend a yearly SAMHSA leadership forum.

**Expenses and Travel for Project Director:** Fund will be used to cover the cost of instate travel (e.g. mileage @ \$.50/mile) and related expenses.

### EQUIPMENT

## SUPPLIES

Funds will be used to create, purchase and duplicate training and educational materials (e.g. treatment manuals, DVD's) re: evidence-based practices

## CONTRACTUAL COSTS

**Grant award to Another Way for local implementation of Peer Specialists:** Funds will be sub-granted to Another Way for the hiring of 2.5 FTE Peer Specialists. Peer Specialists will provide individualized, recovery focused service based on a relationship of mutuality that allows consumers to learn to manage their own recovery and advocacy process. Peer Specialists provide outreach in community settings, engage consumers, and offer supportive services including self help, advocacy, skill building and sharing information, and assisting each consumer identify personal goals and interventions utilizing the IMR framework. Peer Specialists will also provide Supported Employment and will receive general and clinical supervision from a qualified professional identified by the Local Interagency Team (LIT). 50% of one position will be funded in-kind by the Vermont Division of Vocational Rehabilitation. Funds will also cover the cost of fringe benefits for the peer specialists, travel expenses (@ \$.50/mile), meeting expenses for the LIT, and administration of the sub-grant.

**Grant award to Burlington Provider (TBA) for local implementation of Peer Specialists:** Funds will be sub-granted to a local Burlington Provider for the hiring of 4.5 FTE Peer Specialists. The provider will be chosen by the Burlington LIT during the first six months of the grant. Peer Specialists will provide individualized, recovery focused service based on a relationship of mutuality that allows consumers to learn to manage their own recovery and advocacy process. Peer Specialists provide outreach in community settings, engage consumers, and offer supportive services including self help, advocacy, skill building and sharing information, and assisting each consumer identify personal goals and interventions utilizing the IMR framework. Peer Specialists will also provide Supported Employment and will receive general and clinical supervision from a qualified professional identified by the Local Interagency Team (LIT). 50% of two positions will be funded in-kind by the Vermont Division of Vocational Rehabilitation. Funds will also cover the cost of fringe benefits for the peer specialists, travel expenses (@ \$.50/mile), meeting expenses for the LIT, and administration of the sub-grant.

**Grant award to 2 Rural Providers for implementation of Peer Specialists:** Funds will be sub-granted to 2 rural providers for the hiring of 2.0 FTE Peer Specialists in each rural setting. The rural providers will be chosen by DMH using an RFP during the second year. Peer Specialists will provide individualized, recovery focused service based on a relationship of mutuality that allows consumers to learn to manage their own recovery and advocacy process. Peer Specialists provide outreach in community settings, engage consumers, and offer supportive services including self help, advocacy, skill building and sharing information, and assisting each consumer identify personal goals and interventions utilizing the IMR framework. Peer Specialists will also provide Supported



Employment and will receive general and clinical supervision from a qualified professional identified by the Local Interagency Team (LIT). 50% of one position will be funded in-kind by the Vermont Division of Vocational Rehabilitation. Funds will also cover the cost of fringe benefits for the peer specialists, travel expenses (@ \$.50/mile), meeting expenses for the LIT, and administration of the sub-grant.

**New Hampshire Dartmouth Psychiatric Research Center (PRC):** The PRC will provide training (via contract) to Peer Specialists, clinicians, and service providers in each of the four communities on evidence based practices. The PRC has trainers certified in IMR and Supported Employment and provides training and coaching to peers and professionals in 17 states. PRC will provide 3 days of training and ongoing coaching in IMR and 3 days of training and coaching on Supported employment to each of the four demonstration communities.

**Margaret Swarbrick, PhD.:** Dr. Swarbrick will provide training and coaching (via contract) to each of the four demonstration communities on the development of Peer Specialists and peer-based IMR and SE. Dr. Swarbrick is a part time assistant faculty in the department of Psychiatric Rehabilitation a Counseling Professions at UMDNJ - School of Health Related Professions and the Institute for Wellness and Recovery Initiatives Training Director for Collaborative Support Programs of New Jersey, a large peer-operated self-help organization. Dr. Swarbrick has presented and published on the topics of peer delivered services, wellness, recovery and employment.

**Evaluator – Flint Springs Associates (FSA):** FSA will oversee and implement the evaluation for the grant. Funds will be used for staff time, mileage/expenses (@ \$.50/mile), and interview incentives for consumer participation in evaluation activities (\$20/interview X 50 consumers X 2 interviews). Flint Springs Associates has extensive experience in evaluating SAMHSA grants within the state of Vermont. Its principal partners, Joy Livingston, Ph.D. and Donna Reback, MSW, LICSW, are trained social science researchers with considerable experience designing, conducting and managing evaluation research. FSA has held numerous contracts over the past 15 years with Vermont Agency of Human Services Departments, including Mental Health, Health, Disabilities, Aging and Independent Living, and Corrections. FSA is currently the evaluator for Vermont's *Alternatives to Seclusion and Restraint* SAMHSA grant.

**The Cultural and Linguistic Competence Coordinator (.05 FTE - Maria Mercedes Avila)** will provide leadership in the implementation, and monitoring of the cultural and linguistic competence in all transformation activities. Ms. Avila provides training, coaching and support to DMH and participating communities in the implementation of a SAMHSA System of Care grant for Youth in Transition. Ms Avila is bi-lingual.

**Incentive Planning Grants:** Incentive Service Grants will be offered to the community mental health center (CMHC) operating in each of the four demonstration sites. Funds will be provided to CMHC for participation on the LIT and planning to incorporate lessons learned from local implementation into CMHC practice. CMHC's receiving planning grants will be expected to modify their policies and practices to better serve the

target population. Grant awards will be made to Washington County Mental Health, the HowardCenter, and the CMHC's operating in the two rural demonstration sites (TBA). An estimate of how the \$10,000 award to each agency will be spent by that agency is as follows:

Staff Participation in LIT and development of grant implementation activities (\$65/hour X 150 hours):	\$ 9750
Mileage for travel to grant planning events (@ \$.50/mile):	\$ 250

**Sub grant to Data Remedies:** Funds will be used to pay for licenses for usage of ServicePoint and for the modification of ServicePoint by Data Remedies for grant data collection.

## **OTHER**

**Instate Meeting/Training Expense:** Funds will be used to cover the cost of planning meetings to support oversight and management of the grant initiative and training events focused on trauma-informed care. Funds will cover the cost of the meeting space and audio/visual equipment.

**Stipends/Mileage:** Stipends (\$50 per meeting) and reimbursement for mileage (up \$50 per meeting - @ \$.50/mile) will be provided to consumer and family members who participate in the grant planning and oversight meetings.

## **INDIRECT COST RATE**

The Vermont Department of Mental Health uses a Cost Allocation Plan, not an Indirect Rate. This Cost Allocation Plan was approved by the U.S. Department of Health and Human Services effective October 1, 1987 and is available at <http://humanservices.vermont.gov/departments/office-of-the-secretary/cost-allocation-plan>. The Cost Allocation Plan summarizes and allocates actual, allowable costs incurred in the operation of the program. These costs include items often shown as direct costs, such as telephone and general office supply expenses, as well as items usually included in an indirect rate, such as the cost of office space and administrative salaries. These costs are allocated to the program based on the subgrants paid in the program relative to the total subgrants paid in the department overall. Because these are actual costs, unlike an Indirect Cost Rate, these costs will vary from quarter to quarter and cannot be fixed as a percentage of program costs.

## **EXISTING SUPPORT**

Every CMHC has an existing infrastructure of clinical, supervisory and support staff, building facilities, administration, Medicaid billing, IT hardware and support, etc. Other existing resources that will be mobilized for this project include the availability of the State web- and phone- conferencing systems. These technologies will be used for the distance learning activities to provide trainings, consultations and meetings with all regions of the state without unduly impacting the limited resources at the local level.

(reducing staff travel time and costs). The DMH website will host a page on the grant initiative. Additionally, Listservs supported by DMH will be established to connect all participating individuals and agencies for discussions on implementation efforts, upcoming events and trainings, and other important information.

**SECTION I – AWARD DATA – 1H79SM060146-01**

**Award Calculation (U.S. Dollars)**

Salaries and Wages	\$47,000
Fringe Benefits	\$14,100
Personnel Costs (Subtotal)	\$61,100
Supplies	\$4,000
Consortium/Contractual Cost	\$603,015
Travel Costs	\$11,550
Other	\$25,700
<b>Direct Cost</b>	<b>\$705,365</b>
<b>Indirect Cost</b>	<b>\$28,834</b>
<b>Approved Budget</b>	<b>\$734,199</b>
<b>Federal Share</b>	<b>\$734,199</b>
<b>Cumulative Prior Awards for this Budget Period</b>	<b>\$0</b>
<b>AMOUNT OF THIS ACTION (FEDERAL SHARE)</b>	<b>\$734,199</b>

SUMMARY TOTALS FOR ALL YEARS	
YR	AMOUNT
1	\$734,199
2	\$734,199
3	\$734,199
4	\$734,199
5	\$734,199

\* Recommended future year total cost support, subject to the availability of funds and satisfactory progress of the project.

**Fiscal Information:**

CFDA Number: 93.243  
 EIN: 1036000274E7  
 Document Number: 10SM60146A  
 Fiscal Year: 2010

<b>IC</b>	<b>CAN</b>	<b>Amount</b>
SM	C96C514	\$734,199

**SM Administrative Data:**

PCC: MHT-SIG / OC: 4145

**SECTION II – PAYMENT/HOTLINE INFORMATION – 1H79SM060146-01**

Payments under this award will be made available through the HHS Payment Management System (PMS). PMS is a centralized grants payment and cash management system, operated by the HHS Program Support Center (PSC), Division of Payment Management (DPM). Inquiries regarding payment should be directed to: The Division of Payment Management System, PO Box 6021, Rockville, MD 20852, Help Desk Support – Telephone Number: 1-877-614-5533.

The HHS Inspector General maintains a toll-free hotline for receiving information concerning fraud, waste, or abuse under grants and cooperative agreements. The telephone number is: 1-800-HHS-TIPS (1-800-447-8477). The mailing address is: Office of Inspector General, Department of Health and Human Services, Attn: HOTLINE, 330 Independence Ave., SW, Washington, DC 20201.

**SECTION III – TERMS AND CONDITIONS – 1H79SM060146-01**

This award is based on the application submitted to, and as approved by, SAMHSA on the above-title project and is subject to the terms and conditions incorporated either directly or by reference in the following:

- a. The grant program legislation and program regulation cited in this Notice of Award.
- b. The restrictions on the expenditure of federal funds in appropriations acts to the extent those restrictions are pertinent to the award.
- c. 45 CFR Part 74 or 45 CFR Part 92 as applicable.
- d. The HHS Grants Policy Statement.
- e. This award notice, INCLUDING THE TERMS AND CONDITIONS CITED BELOW.

**Treatment of Program Income:**  
Additional Costs

---

**SECTION IV – SM Special Terms and Condition – 1H79SM060146-01**

**SPECIAL CONDITION(S) OF AWARD:**

The "Contract" Cost Category was reduced by \$15,500 to meet the recommended total funding level of \$734,199.

Within 15 days of receiving the award, the grantee must submit to the SAMHSA Division of Grants Management (and a copy to the Government Project Officer) a revised detailed budget and budget justification reflecting the total award amount of \$734,199 for Year 1.

Failure to comply with the above stated condition may result in suspension, classification as High Risk status, termination of this award or denial of funding in the future.

**STANDARD TERMS OF AWARD:**

- 1) This grant is subject to the terms and conditions, included directly, or incorporated by reference on the Notice of Award (NoA). Refer to the order of precedence in Section III (Terms and Conditions) on the NoA.
- 2) The grantee organization is legally and financially responsible for all aspects of this grant, including funds provided to sub-recipients.
- 3) Grant funds cannot be used to supplant current funding of existing activities. Under the HHS Grants Policy Directives, 1.02 General – Definition: Supplant is to replace funding of a recipient's existing program with funds from a Federal grant.
- 4) The recommended future support as indicated on the NoA reflects TOTAL costs (direct plus indirect). Funding is subject to the availability of Federal funds, and that matching funds, (if applicable), is verifiable, progress of the grant is documented and acceptable.
- 5) By law, none of the funds awarded can be used to pay the salary of an individual at a rate in excess of the Executive Level I, which is \$199,700 annually.
- 6) "Confidentiality of Alcohol and Drug Abuse Patient Records" regulations (42 CFR 2) are applicable to any information about alcohol and other drug abuse patients obtained by a "program" (42 CFR 2.11), if the program is federally assisted in any manner (42 CFR 2.12b).

Accordingly, all project patient records are confidential and may be disclosed and used only in accordance with (42 CFR 2). The grantee is responsible for assuring compliance with these regulations and principles, including responsibility for assuring the security and confidentiality of all electronically transmitted patient material.

7) Accounting Records and Disclosure - Awardees and sub-recipients must maintain records which adequately identify the source and application of funds provided for financially assisted activities. These records must contain information pertaining to grant or subgrant awards and authorizations, obligations, unobligated balances, assets, liabilities, outlays or expenditures, and income. The awardee, and all its sub-recipients, should expect that SAMHSA, or its designee, may conduct a financial compliance audit and on-site program review of grants with significant amounts of Federal funding.

8) Per (45 CFR 74.36 and 45 CFR 92.34) and the HHS Grants Policy Statement, any copyrighted or copyrightable works developed under this cooperative agreement/grant shall be subject to a royalty-free, nonexclusive and irrevocable license to the government to reproduce, publish, or otherwise use them and to authorize others to do so for Federal Government purposes. Income earned from any copyrightable work developed under this grant must be used a program income.

9) A notice in response to the President's Welfare-to-Work Initiative was published in the Federal Register on May 16, 1997. This initiative is designed to facilitate and encourage grantees and their sub-recipients to hire welfare recipients and to provide additional needed training and/or mentoring as needed. The text of the notice is available electronically on the OMB home page at <http://www.whitehouse.gov/omb/fedreg/omb-not.html>.

10) Program Income accrued under the award must be accounted for in accordance with (45 CFR 74.24) or (45 CFR 92.25) as applicable. Program income must be reported on the Financial Status Report, Standard Form 269 (long form).

Program income accrued under this award may be used in accordance with the additional costs alternative described in (45 CFR 74.24(b)(1)) or (45 CFR 92.25(g)(2)) as applicable. Program income must be used to further the grant objectives and shall only be used for allowable costs as set forth in the applicable OMB Circulars A-102 ("Grants and Cooperative Agreements with State and Local Governments") and A-110 ("Uniform Administrative Requirements for Grants and Agreements With Institutions of Higher Education, Hospitals, and Other Non-Profit Organizations").

11) Actions that require prior approval must be submitted in writing to the Grants Management Officer (GMO), SAMHSA. The request must bear the signature of an authorized business official of the grantee organization as well as the project director. Approval of the request may only be granted by the GMO and will be in writing. No other written or oral approval should be accepted and will not be binding on SAMHSA.

12) Any replacement of, or substantial reduction in effort of the Program Director (PD) or other key staff of the grantee or any of the sub-recipients requires the written prior approval of the GMO. The GMO must approve the selection of the PD or other key personnel, if the individual being nominated for the position had not been named in the approved application, or if a replacement is needed should the incumbent step down or be unable to execute the position's responsibilities. A resume for the individual(s) being nominated must be included with the request. Key staff (or key staff positions, if staff has not been selected) are listed below:

Project Director

13) Refer to the NoA under Section II (Payment/Hotline Information) regarding the Payment Management System and the HHS Inspector General's Hotline concerning fraud, waste or abuse.

14) As the grantee organization, you acknowledge acceptance of the grant terms and conditions by drawing or otherwise obtaining funds from the Payment Management System. In doing so, your organization must ensure that you exercise prudent stewardship over Federal funds and that all costs are allowable, allocable and reasonable.

15) No HHS funds may be paid as profit (fees) per (45 CFR Parts 74.81 and 92.22(2)).

16) RESTRICTIONS ON GRANTEE LOBBYING (Appropriations Act Section 503).

(a) No part of any appropriation contained in this Act shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, radio, television, or video presentation designed to support or

defeat legislation pending before the Congress, except in presentation to the Congress itself or any State legislature.

(b) No part of any appropriation contained in this Act shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence legislation or appropriations pending before the Congress or any State legislature.

17) Where a conference is funded by a grant or cooperative agreement the recipient must include the following statement on all conference materials (including promotional materials, agenda, and Internet sites):

Funding for this conference was made possible (in part) by (insert grant or cooperative agreement award number) from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

18) This award is subject to the requirements of Section 106 (g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. 7104). For the full text of the award term, go to <http://samhsa.gov/grants/trafficking.aspx>.

19) Grantees must comply with the requirements of the National Historical Preservation Act and EO 13287, Preserve America. The HHS Grants Policy Statement provides clarification and uniform guidance regarding preservation issues and requirements (pages I-20, "Preservation of Cultural and Historical Resources"). Questions concerning historical preservation, please contact, Mike Daniels, SAMHSA Federal Preservation Coordinator, SAMHSA at [mike.daniels@samhsa.hhs.gov](mailto:mike.daniels@samhsa.hhs.gov) or 240-276-0759.

20) Executive Order 13410: Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs promotes efficient delivery of quality health care through the use of health information technology, transparency regarding health care quality and price, and incentives to promote the widespread adoption of health information technology and quality of care. Accordingly, all grantees that electronically exchange patient level health information to external entities where national standards exist must:

A) Use recognized health information interoperability standards at the time of any HIT system update, acquisition, or implementation, in all relevant information technology systems supported, in whole or in part, through this agreement/contract. Please consult <http://www.hhs.gov/healthit> for more information, and

B) Use HIT products (such as electronic health records, personalized health records, and the network components through which they operate and share information) that are certified by the Certification Commission for Healthcare Information Technology (CCHIT) or other recognized certification board, to ensure a minimum level of interoperability or compatibility of health IT products (<http://www.cchit.org/>). For additional information contact: Jim Kretz (CMHS) at 240-276-1755 or [jim.kretz@samhsa.hhs.gov](mailto:jim.kretz@samhsa.hhs.gov); Richard Thoreson (CSAT) at 240-276-2827 or [richard.thoreson@samhsa.hhs.gov](mailto:richard.thoreson@samhsa.hhs.gov); or Sarah Wattenberg (OPP) at 240-276-2975 or [sarah.wattenberg@samhsa.hhs.gov](mailto:sarah.wattenberg@samhsa.hhs.gov).

21) If federal funds are used by the grantee to attend a meeting, conference, etc. and meal(s) are provided as part of the program, then the per diem applied to the Federal travel costs (M&IE allowance) must be reduced by the allotted meal cost(s).

22) By signing the application (PHS-5161-1) face page in item #21, the Authorized Representative (AR) certifies (1) to the statements contained in the list of certifications\* and (2) provides the required assurances\* and checking the "I AGREE" box provides SAMHSA with the AR's agreement of compliance. It is not necessary to submit signed copies of these documents, but should be retained for your records.

\*The documents are available on the SAMHSA website at <http://www.samhsa.gov/Grants/new.aspx> or contained within the Request for Applications (RFA).

**REPORTING REQUIREMENTS:**

1) Financial Status Report (FSR), Standard Form 269 (long form) is required on an annual basis and must be submitted for each budget period no later than 90 days after the close of the budget period. The FSR 269 is required for each 12 month period, regardless of the overall length of the approved extension period authorized by SAMHSA. In addition, a final FSR 269 is due within 90 days after the end of the extension. If applicable, include the required match on this form under Transactions (#10 a-d), Recipient's share of net outlays (#10 e-i) and Program Income (q-t) in order for SAMHSA to determine whether matching is being provided and the rate of expenditure is appropriate. Adjustments to the award amount, if necessary, will be made if the grantee fails to meet the match. The FSR must be prepared on a cumulative basis and all program income must be reported. Disbursements reported on the FSR must equal/or agree with the Final Payment Management System Report (PSC-272). The FSR may be accessed from the following website at <http://www.whitehouse.gov/omb/grants/sf269.pdf> and the data can be entered directly on the form and the system will calculate the figures and then print and mail to this office.

2) Submission of a Programmatic Annual Report is due within 90 days after the end of each budget period.

3) The grantee must comply with the GPRA requirements that include the collection and periodic reporting of performance data as specified in the RFA or by the Project Officer. This information is needed in order to comply with PL 102-62 which requires that SAMHSA report evaluation data to ensure the effectiveness and efficiency of its programs.

4) Submission of audit reports in accordance with the procedures established in OMB Circular A-133 is required by the Single Audit Act Amendments of 1966 (P.L. 104-156). An audit is required for all entities which expend \$500,000 or more of Federal funds in each fiscal year and is due to the Clearinghouse within 30 days of receipt from the auditor or within nine (9) months of the fiscal year, whichever occurs first, to the following address:

Federal Audit Clearinghouse  
Bureau of the Census  
1201 E. 10th Street  
Jeffersonville, IN 47132

Failure to comply with the above stated terms and conditions may result in suspension, classification as High Risk status, termination of this award or denial of funding in the future.

**INDIRECT COSTS:**

If the grantee chooses to establish an indirect cost rate agreement, it is required to submit an indirect cost rate proposal to the appropriate office within 90 days from the start date of the project period. For additional information, please refer to HHS Grants Policy Statement Section I, pages 23-24.

SAMHSA will not accept a research indirect cost rate. The grantee must use other-sponsored program rate or lowest rate available.

Please contact the appropriate office of the Division of Cost Allocation to begin the process for establishing an indirect cost rate. To find a list of HHS Division of Cost Allocation Regional Offices, go to the SAMHSA website [www.samhsa.gov](http://www.samhsa.gov), then click on "grants"; then click on "Important offices".

All responses to special terms and conditions of award and postaward requests must be mailed to the Division of Grants Management, OPS, SAMHSA below.

For Regular Delivery:  
Division of Grants Management,  
OFR, SAMHSA  
1 Choke Cherry Road, Room 7-1091  
Rockville, MD 20857

For Overnight or Direct Delivery:  
Division of Grants Management,  
OFR, SAMHSA  
1 Choke Cherry Road, Room 7-1091  
Rockville, MD 20850

**CONTACTS:**



David J Morrisette, Program Official  
Phone: 240-276-1912 Email: david.morrisette@samhsa.hhs.gov Fax: (240) 276-1970

*W*/Gwendolyn Simpson, Grants Specialist  
Phone: 240-276-1408 Email: gwendolyn.simpson@samhsa.hhs.gov Fax: 240-276-1430

VERMONT DEPARTMENT OF PERSONNEL  
Request for Classification Review  
Position Description Form A

- **This form is to be used by managers and supervisors to request classification of a position (filled or vacant) when the duties have changed, and by managers and supervisors to request the creation of a new job class/title (for a filled, vacant, or new position), and by employees to request classification of their position.**
- This form was designed in Microsoft Word to download and complete on your computer. This is a form-protected document, so information can only be entered in the shaded  areas of the form.
- If you prefer to fill out a hard copy of the form, contact your Personnel Officer.
- To move from field to field use your mouse, the arrow keys or press Tab. Each form field has a limited number of characters. Use your mouse or the spacebar to mark and unmark a checkbox.
- Where additional space is needed to respond to a question, you might need to attach a separate page, and number the responses to correspond with the numbers of the questions on the form. Please contact your Personnel Officer if you have difficulty completing the form.
- The form must be complete, including required attachments and signatures or it will be returned to the department's personnel office. All sections of this form are required to be completed unless otherwise stated.

**INSTRUCTIONS:** Tell us about the job. The information you provide will be used to evaluate the position. It will not be used in any way to evaluate an employee's performance or qualifications.

Answer the questions carefully. The information you give will help ensure that the position is fairly evaluated. Here are some suggestions to consider in completing this questionnaire:

- Tell the **facts** about what an employee in this position is actually expected to do.
- Give **specific examples** to make it clear.
- Write in a way so a person unfamiliar with the job will be able to understand it.
- Describe the job **as it is now**; not the way it was or will become.
- Before answering each question, read it carefully.

**To Submit this Request for Classification Review:** If this is a filled position, the employee must sign the original\* and forward to the supervisor for the supervisor's review and signature. The Personnel Officer and the Appointing Authority must also review and sign this request before it is considered complete. The effective date of review is the beginning of the first pay period following the date the complete Request for Classification Review is date stamped by the Classification Division of the Department of Personnel.

\*An employee may choose to sign the form, make a copy, submit original to supervisor as noted above, while concurrently sending the copy to the Classification Division, 144 State Street, Montpelier, with a cover note indicating that the employee has submitted the original to the supervisor and is submitting the copy as a **Concurrent** filing.

**If this is a request (initiated by employees, VSEA, or management) for review of all positions in a class/title please contact the appropriate Classification Analyst or the Classification Manager to discuss the request prior to submitting.**

## Request for Classification Review Position Description Form A

For Department of Personnel Use Only

Notice of Action # _____	Date Received (Stamp) _____
Action Taken: _____	
New Job Title _____	
Current Class Code _____	New Class Code _____
Current Pay Grade _____	New Pay Grade _____
Current Mgt Level ____ B/U ____ OT Cat. ____ EEO Cat. ____ FLSA ____	
New Mgt Level ____ B/U ____ OT Cat. ____ EEO Cat. ____ FLSA ____	
Classification Analyst _____	Date _____
Comments: _____	Effective Date: _____
	Date Processed: _____
Willis Rating/Components: Knowledge & Skills: _____	Mental Demands: _____
Working Conditions: _____	Accountability: _____
	Total: _____

### Incumbent Information:

Employee Name:  Employee Number:   
Position Number:  Current Job/Class Title:   
Agency/Department/Unit:  Work Station:  Zip Code:   
Supervisor's Name, Title, and Phone Number:   
How should the notification to the employee be sent:  employee's work location  or  other address, please provide mailing address:

### New Position/Vacant Position Information:

New Position Authorization:  Request Job/Class Title:   
Position Type:  Permanent or  Limited / Funding Source:  Core,  Partnership, or  Sponsored  
Vacant Position Number:  Current Job/Class Title:   
Agency/Department/Unit:  Work Station:   
Zip Code:   
Supervisor's Name, Title and Phone Number:

### Type of Request:

**Management:** A management request to review the classification of an existing position, class, or create a new job class.

**Employee:** An employee's request to review the classification of his/her current position.

## 1. Job Duties

This is the **most critical** part of the form. Describe the activities and duties required in your job, **noting changes (new duties, duties no longer required, etc.) since the last review**. Place them in order of importance, beginning with the single most important activity or responsibility required in your job. The importance of the duties and expected end results should be clear, including the tolerance that may be permitted for error. Describe each job duty or activity as follows:

- **What** it is: The nature of the activity.
- **How** you do it: The steps you go through to perform the activity. Be specific so the reader can understand the steps.
- **Why** it is done: What you are attempting to accomplish and the end result of the activity.

For example a Tax Examiner might respond as follows: **(What)** *Audits tax returns and/or taxpayer records.* **(How)** *By developing investigation strategy; reviewing materials submitted; when appropriate interviewing people, other than the taxpayer, who have information about the taxpayer's business or residency.* **(Why)** *To determine actual tax liabilities.*

Developmental, administrative, coordinating and monitoring work for the Department of Mental Health involving the development of state and local capacity to provide evidence-based treatment and support through the administration of a federal grant program. Oversees and administratively coordinates the approximately \$730,000 annually of a 5 year 3.6 million dollar federal grant project to foster the adoption and implementation of permanent transformative changes in how Vermont's public mental health services are organized, managed and delivered so that they are consumer-driven, recovery-oriented and supported through evidence-based and best practices. Oversees all grant activities and ensures coordination between multiple demonstration sites. Develops and collaborates with an adult state interagency team to develop and implement state-level grant activities. Oversees and supports local grant planning in partnership with local Adult Local Interagency Teams (LITs) and peer service providers. Supports implementation and service delivery, evaluation and adaptation of peer service model in demonstration sites. Coordinates technical assistance support for state and local work teams to enhance their capability to address grant activities. Coordinates and develops structured peer services with relevant stakeholders, including recruitment, training, certification, job placement and support. Organizes training of non-peer service providers, coordinating/combining with peer services training whenever possible. Identifies and coordinates use of data for program evaluation and management purposes. Negotiates and administers contracts and grant agreements as needed. Oversees allocation of grant budget. Completes timely grant reporting in consultation with the grant evaluator. Submits quarterly and annual progress reports to SAMHSA. Develops plan to sustain services with state funding after cessation of the grant.

Other duties as required.

## 2. Key Contacts

This question deals with the personal contacts and interactions that occur in this job. Provide brief typical examples indicating your primary contacts (**not** an exhaustive or all-inclusive list of contacts) other than those persons to whom you report or who report to you. If you work as part of a team, or if your primary contacts are with other agencies or groups outside State government describe those interactions, and what your role is. For example: you may *collaborate, monitor, guide, or facilitate change*.

Works closely with broad range of local, regional, state and federal stakeholders. Works with federal grant administrators to ensure grant activities meet federal guidelines. Works with other AHS departments to coordinate work of an AHS adult state interagency team to implement state-level grant activities. Collaborates with local service providers (including local designated agency and hospital emergency department), community members, municipal representatives, families and consumers of mental health services to develop and implement local demonstration pilots. Works with national consultants and trainers to support implementation of evidence-based practices in Vermont. Regular contact with state-level representatives of multiple stakeholder groups (e.g. Friends of Recovery-Vermont, Vermont Council of Substance Abuse and Mental Health Providers, Vermont Psychiatric Survivors) and Executive Directors and Program Directors of Designated Agencies to facilitate consensus-building, treatment capacity development, and systems improvement among treatment providers.

**3. Are there licensing, registration, or certification requirements; or special or unusual skills necessary to perform this job?**

Include any special licenses, registrations, certifications, skills; (such as counseling, engineering, computer programming, graphic design, strategic planning, keyboarding) including skills with specific equipment, tools, technology, etc. (such as mainframe computers, power tools, trucks, road equipment, specific software packages). Be specific, if you must be able to drive a commercial vehicle, or must know Visual Basic, indicate so.

Education: Master's Degree in behavioral health services or equivalent. Master's Degree may be substituted for at least 5 years of relevant experience.

Experience: Four years working mental health field, with at least 2 years in a management, supervisory or administrative level position

Experience in grants and project management, systems development, and implementation of best practices

Skills and Knowledge:

Knowledge of mental health recovery principles and the use of consumers to provide peer support and services

Knowledge of federal, state, and local mental health services and programs.

Knowledge of best and evidence-based practices regarding the treatment and support of individuals with mental health disorders.

Knowledge of the principles and practices of public administration.

Knowledge and skills in coalition-building and planning.

Knowledge and skills in strategic planning and systems change.

Knowledge and skills in project management

Skills in leadership and multi-stakeholder consensus-building

Ability to develop and negotiate contracts.

Ability to evaluate program effectiveness

Ability to communicate effectively orally and in writing.

Ability to establish and maintain effective working relationships.

#### 4. Do you supervise?

In this question "supervise" means if you direct the work of others where you are held **directly** responsible for assigning work; performance ratings; training; reward and discipline or effectively recommend such action; and other personnel matters. List the names, titles, and position numbers of the classified employees reporting to you:

The position oversees and coordinates state-level and regional work projects and promotes team collaboration.

#### 5. In what way does your supervisor provide you with work assignments and review your work?

This question deals with how you are supervised. Explain how you receive work assignments, how priorities are determined, and how your work is reviewed. There are a wide variety of ways a job can be supervised, so there may not be just one answer to this question. For example, some aspects of your work may be reviewed on a regular basis and in others you may operate within general guidelines with much independence in determining how you accomplish tasks.

Works with supervisor to effectively set goals and establish priorities; understand, prepare and adhere to project goals, objectives, tasks, deadlines and time lines

Effectively solicits, integrates and responds to regular input, consultation and directives from multiple sources, including state work team, state leadership, project staff, national expert consultants, federal administrators, treatment providers, consumers, families, and community representatives

Works with supervisor to monitor and adhere to expectations and requirements of federal administration funding the project

Clearly communicates grant project and departmental expectations, desired outcomes, and effectively delegates responsibilities to project staff, providing necessary oversight and management of resources to accomplish expectations

Performs work activities with modest supervision; expected to complete many work projects independently without direct supervision

#### 6. Mental Effort

This section addresses the mental demands associated with this job. Describe the most mentally challenging part of your job or the most difficult typical problems you are expected to solve. Be sure to give a specific response and describe the situation(s) by example.

- For example, a purchasing clerk might respond: *In pricing purchase orders, I frequently must find the cost of materials not listed in the pricing guides. This involves locating vendors or other sources of pricing information for a great variety of materials.*
- Or, a systems developer might say: *Understanding the ways in which a database or program will be used, and what the users must accomplish and then developing a system to meet their needs, often with limited time and resources.*

Expected to effectively understand, evaluate, and develop strategies to overcome multiple, complex barriers at local, state and federal level to implementing evidence-based treatment and support. Examples include:

-evaluating how federal, state and private funds are and can be used to pay for evidence-

based practices and how those funds can be used to efficiently support improved outcomes

- evaluating how multiple DMH initiatives overlap and contribute to the overall improvement of the mental health system
- evaluating how existing DMH policy and operation practices need to be modified/improved to improve system capacity

Expected to oversee implementation of multiple multi-year, state-wide systems change initiative involving multiple service systems.

**7. Accountability**

This section evaluates the job's expected results. In weighing the importance of results, consideration should be given to responsibility for the safety and well-being of people, protection of confidential information and protection of resources.

What is needed here is information not already presented about the job's scope of responsibility. What is the job's most significant influence upon the organization, or in what way does the job contribute to the organization's mission?

Provide annualized dollar figures if it makes sense to do so, explaining what the amount(s) represent.

For example:

- A social worker might respond: *To promote permanence for children through coordination and delivery of services;*
- A financial officer might state: *Overseeing preparation and ongoing management of division budget: \$2M Operating/Personal Services, \$1.5M Federal Grants.*

Overseeing implementation and management of multiple, multi-year, federal grant totaling over \$3.6 million.

Changing the Vermont mental health system to make peer support and other evidence-based practices more accessible and effective for people.

Improving clinical and quality of life outcomes for young adults with or at risk of serious mental illness.

**8. Working Conditions**

The intent of this question is to describe any adverse conditions that are routine and expected in your job. It is not to identify special situations such as overcrowded conditions or understaffing.

- a) What significant mental stress are you exposed to? All jobs contain some amount of stress. If your job stands out as having a significant degree of mental or emotional pressure or tension associated with it, this should be described.

Type	How Much of the Time?

- b) What hazards, special conditions or discomfort are you exposed to? (Clarification of terms: **hazards** include such things as potential accidents, illness, chronic health conditions or other

harm. Typical examples might involve exposure to dangerous persons, including potentially violent customers and clients, fumes, toxic waste, contaminated materials, vehicle accident, disease, cuts, falls, etc.; and **discomfort** includes exposure to such things as cold, dirt, dust, rain or snow, heat, etc.)

Type	How Much of the Time?

- c) What weights do you lift; how much do they weigh and how much time per day/week do you spend lifting?

Type	How Heavy?	How Much of the Time?

- d) What working positions (sitting, standing, bending, reaching) or types of effort (hiking, walking, driving) are required?

Type	How Much of the Time?

**Additional Information:**

Carefully review your job description responses so far. If there is anything that you feel is important in understanding your job that you haven't clearly described, use this space for that purpose. Perhaps your job has some unique aspects or characteristics that weren't brought out by your answers to the previous questions. In this space, add any additional comments that you feel will add to a clear understanding of the requirements of your job.

This position will oversee a multi-year federal grant project focused on the improvement of services and expansion of treatment and support capacity to address gaps in the mental health system. Given the amount of funding available through the federal grant (over \$3.6 million), the federal expectations regarding deliverables and reporting requirements, and the need to coordinate local and state-level implementation activities simultaneously, DMH requires a state position to ensure proper oversight and coordination of the grant.

Employee's Signature (required): \_\_\_\_\_ Date: \_\_\_\_\_



**Supervisor's Section:**

Carefully review this completed job description, but **do not** alter or eliminate any portion of the original response. Please answer the questions listed below.

1. What do you consider the most important duties of this job and why?

Strategically develop and coordinate a systems improvement project occurring at the state and local level involving a complex mix of stakeholders, outside consultants, and state representatives

2. What do you consider the most important knowledge, skills, and abilities of an employee in this job (not necessarily the qualifications of the present employee) and why?

A keen understanding of the federal, state and local mental health treatment and support systems, including the historical, political, economic and cultural factors which must be taken into consideration when attempting to make changes to the system

Ability to provide leadership among high-level staff at DMH and in the community regarding changing the status quo of how Vermont provides treatment and support services to young adults who are not currently engaged in services.

Ability to strategically plan for and manage a multi-year, multi-stakeholder and multi-pronged initiative focused on achieving substantial change at the state and local level in multiple counties within Vermont

Ability to work collaboratively with complex mix of federal, state, regional and local stakeholders to initiate change

3. Comment on the accuracy and completeness of the responses by the employee. List below any missing items and/or differences where appropriate.

N/A

4. Suggested Title and/or Pay Grade:

Mental Health Transformation Project Director PG 26

Supervisor's Signature (required):

*PWSmyr*

Date:

*9/29/10*

**Personnel Administrator's Section:**

Please complete any missing information on the front page of this form before submitting it for review.

Are there other changes to this position, for example: Change of supervisor, GUC, work station?

Yes  No If yes, please provide detailed information.

Attachments:

- Organizational charts are **required** and must indicate where the position reports.
- Draft job specification is **required** for proposed new job classes.

Will this change affect other positions within the organization? If so, describe how, (for example, have duties been shifted within the unit requiring review of other positions; or are there other issues relevant to the classification review process).

Suggested Title and/or Pay Grade:


Personnel Administrator's Signature (**required**): \_\_\_\_\_ Date: \_\_\_\_\_

**Appointing Authority's Section:**

Please review this completed job description but **do not alter** or eliminate any of the entries. Add any clarifying information and/or additional comments (if necessary) in the space below.

Suggested Title and/or Pay Grade:

*Mental Health Transformation Project Director Guchzio*

  
\_\_\_\_\_  
Appointing Authority or Authorized Representative Signature (**required**)

*9/29/10*  
\_\_\_\_\_  
Date

**Application for Federal Assistance SF-424**

Version 02

<b>*1. Type of Submission:</b> <input type="checkbox"/> Preapplication <input checked="" type="checkbox"/> Application <input type="checkbox"/> Changed/Corrected Application	<b>*2. Type of Application:</b> <input checked="" type="checkbox"/> New <input type="checkbox"/> Continuation <input type="checkbox"/> Revision	<b>*If Revision, select appropriate letter(s):</b> _____ <b>*Other (Specify)</b> _____
--	--	---

<b>*3. Date Received:</b> _____	<b>4. Applicant Identifier:</b> _____
------------------------------------	--

<b>5a. Federal Entity Identifier</b> _____	<b>*5b. Federal Award Identifier:</b> _____
---	--

**State Use Only:**

<b>6. Date Received by State:</b> _____	<b>7. State Application Identifier:</b> _____
---	---

**8. APPLICANT INFORMATION**

**\*a. Legal Name:** Vermont Department of Mental Health

<b>*b. Employer/Taxpayer Identification Number (EIN/TIN):</b> 03-6000274	<b>*c. Organization DUNS:</b> 809376155
---	--

**d. Address**

\*Street1: 103 South Main Street, Wasson Hall  
Street2:  
\*City: Waterbury  
County:  
\*State: Vermont  
Province:  
\*Country: USA  
\*Zip/Postal Code: 05671-2510

**e. Organizational Unit**

<b>Department Name:</b> Mental Health	<b>Division Name:</b> _____
--	--------------------------------

**f. Name and contact information of person to be contacted on matters involving this application:**

Prefix: \_\_\_\_\_ \*First Name: Nick  
Middle Name:  
\*Last Name: Nichols  
Suffix: \_\_\_\_\_

**Title:** Policy Director

**Organizational Affiliation:**  
Vermont Department of Mental Health

**\*Telephone Number:** (802) 241-2601 **Fax Number:** (802) 241-4004

**\*Email:** nick.nichols@ahs.state.vt.us

**Application for Federal Assistance SF-424**

Version 02

**9. Type of Applicant 1: Select Applicant Type:**

A: State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

\* Other (specify)

**10. Name of Federal Agency:**

Substance Abuse & Mental Health Services Adminis.

11. Catalog of Federal Domestic Assistance Number: 93.243

CFDA Title:

\*12. Funding Opportunity Number:

MHTG SM-10-010

\*Title:

Mental Health Transformation Grants

13. Competition Identification Number:

Title:

**14. Areas Affected by Project (Cities, Counties, States, etc.):**

Vermont

**15. Descriptive Title of Applicant's Project:**

Implementation of Vermont Mental Health Transformation

Attach supporting documents as specified in agency instructions.

**Application for Federal Assistance SF-424**

Version 02

**16. Congressional Districts Of:**

\*a. Applicant VT-All

b. Program/Project VT-All

Attach an additional list of Program/Project Congressional Districts if needed:

**17. Proposed Project:**

\*a. Start Date: October 1, 2010

b. End Date: September 30, 2015

**18. Estimated Funding(\$):**

*a. Federal	\$749,699.60
*b. Applicant	<input type="text"/>
*c. State	<input type="text"/>
*d. Local	<input type="text"/>
*e. Other	<input type="text"/>
*f. Program Income	<input type="text"/>
*g. TOTAL	\$749,699.60

**\* 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

- a. This application was made available to the State under the Executive Order 12372 Process for review on
- b. Program is subject to E.O. 12372 but has not been selected by the State for review.
- c. Program is not covered by E.O. 12372.

**\*20. Is the Applicant Delinquent on Any Federal Debt? (If "Yes", provide explanation.)**

Yes  No

21. \*By signing this application, I certify (1) to the statements contained in the list of certifications\*\* and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances\*\* and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties (U.S. Code, Title 218, Section 1001)

\*\* I AGREE

\*\* The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

**a. Authorized Representative**

Prefix:  \*First Name: Michael

Middle Name:

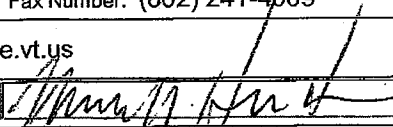
Last Name: Hartman

Suffix:

\*Title: Commissioner, Department of Mental Health

\*Telephone Number: (802) 241-4008 Fax Number: (802) 241-4009

\*Email: michael.hartman@ahs.state.vt.us

\*Signature of Authorized Representative: 

Date Signed: 4/29/10

**Application for Federal Assistance SF-424**

Version 02

**\* Applicant Federal Debt Delinquency Explanation**

The following field should contain an explanation if the Applicant organization is delinquent on any Federal Debt. Maximum number of characters that can be entered is 4,000. Try and avoid extra spaces and carriage returns to maximize the availability of space.

[Empty text box for Applicant Federal Debt Delinquency Explanation]

## BUDGET INFORMATION - Non- Construction Programs

SECTION A - BUDGET SUMMARY						
Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non- Federal (f)	Total (g)
1. MHTG	93.243	\$	\$	\$ 749,699.60	\$	\$ 749,699.60
2.		\$	\$	\$	\$	\$ 0.00
3.		\$	\$	\$	\$	\$ 0.00
4.		\$	\$	\$	\$	\$ 0.00
5. TOTALS		\$ 0.00	\$ 0.00	\$ 749,699.60	\$ 0.00	\$ 749,699.60
SECTION B - BUDGET CATEGORIES						
6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total (5)	
	(1)	(2)	(3)	(4)		
a. Personnel	\$ 47,000.00	\$	\$	\$	\$ 47,000.00	
b. Fringe Benefits	\$ 14,100.00	\$	\$	\$	\$ 14,100.00	
c. Travel	\$ 11,550.00	\$	\$	\$	\$ 11,550.00	
d. Equipment	\$ 0	\$	\$	\$	\$ 0	
e. Supplies	\$ 4,000.00	\$	\$	\$	\$ 4,000.00	
f. Contractual	\$ 618,515.00	\$	\$	\$	\$ 618,515.00	
g. Construction	\$ 0	\$	\$	\$	\$ 0	
h. Other	\$ 25,700.00	\$	\$	\$	\$ 25,700.00	
i. Total Direct Charges (sum of 6a -6h)	\$ 720,865.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 720,865.00	
j. Indirect Charges	\$ 28,834.60	\$	\$	\$	\$ 28,834.60	
k. TOTALS (sum of 6i and 6j)	\$ 749,699.60	\$ 0.00	\$ 0.00	\$ 0.00	\$ 749,699.60	
7. Program Income		\$	\$	\$	\$ 0.00	

**SECTION C - NON- FEDERAL RESOURCES**

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8.	\$	\$	\$	\$ 0.00
9.	\$	\$	\$	\$ 0.00
10.	\$	\$	\$	\$ 0.00
11.	\$	\$	\$	\$ 0.00
12. TOTALS (sum of lines 8 and 11)	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00

**SECTION D - FORECASTED CASH NEEDS**

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	\$ 749,699.60	\$ 187,424.90	\$ 187,424.90	\$ 187,424.90	\$ 187,424.90
14. Non- Federal	\$ 0.00	\$	\$	\$	\$
15. TOTAL (sum of lines 13 and 14)	\$ 187,424.90	\$ 187,424.90	\$ 187,424.90	\$ 187,424.90	\$ 187,424.90

**SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT**

(a) Grant Program	FUTURE FUNDING PERIODS (Years)			
	(b) First	(c) Second	(d) Third	(e) Fourth
16. MHTG	\$ 749,699.60	\$ 749,699.60	\$ 749,699.60	\$ 749,699.60
17.	\$	\$	\$	\$
18.	\$	\$	\$	\$
19.	\$	\$	\$	\$
20. TOTALS (sum of lines 16 -19)	\$ 749,699.60	\$ 749,699.60	\$ 749,699.60	\$ 749,699.60

**SECTION F - OTHER BUDGET INFORMATION**

21. Direct Charges:	22. Indirect Charges:
---------------------	-----------------------

23. Remarks



## SECTION A: STATEMENT OF NEED

Vermont's Department of Mental Health (DMH) provides comprehensive mental health services to adults through private, nonprofit Community Mental Health Centers (CMHCs). The CMHCs offer outreach, rehabilitation, wraparound and emergency services to adults and children with psychiatric disabilities. The CMHC Community Rehabilitation and Treatment (CRT) Programs serve adults with serious mental illnesses including schizophrenia, bi-polar disorder and major depression. Vermont has demonstrated a commitment to consumer directed service easily accessible in the community. As a result, a number of peer support groups, recovery education classes, and drop-in centers are available at the local level. Our state was among the first to adopt a parity law requiring that behavioral health services be covered by insurers in the same way as primary health care. Our commitment to bringing science to service is reflected in our implementation of SAMHSA-identified evidenced-based practices, including Integrated Dual Diagnosis Treatment (IDDT) and Supported Employment (SE) in every CMHC CRT Program, and a Housing First initiative in Burlington and Montpelier.<sup>1</sup> Nevertheless, our system remains heavily weighted towards consumers over the age of 35 who are diagnosed with major mental illness. A sizable underserved population of adults, aged 18 to 34, who, are at substantial risk for or who have serious mental health problems are not connected to our CMHCs. Only 10 percent of adults who received services from Vermont's CMHCs at the age of 17 are still connected by the age of 24.<sup>2</sup> Indeed, across demographics, there are no discernable differences in levels of disconnection.<sup>3</sup> *Vermont seeks a Mental Health Transformation Grant to address SAMHSA Strategic Priority 1 to prevent mental illness through outreach, screening and to provide early intervention services for adults aged 18-34 who are at risk for or showing early signs of serious mental illness. Vermont will use grant funds to develop enhanced services for this population in Montpelier, Burlington, and two rural sites selected through a competitive request for proposals*

**Project jurisdiction/demographics information:** With a population of 621,254, Vermont is one of the most rural states in the country. Burlington, our largest city, has a population of 38,889, and Montpelier, Vermont's state capitol, has a population of 7,760. Most Vermonters live in or near communities with populations of 2,000 to 20,000.<sup>4</sup> The state has a mountainous topography, with roads covered by snow and ice many months of the year, and limited public transportation. While Vermont's size and rural nature help to maintain its beauty, independence, and strong family ties, these factors contribute to isolation and fewer jobs, limit access to affordable and quality child care, social services and medical care, and mask mental health and social service need.<sup>5</sup> Vermont rates of serious psychological distress and depression in adults under 35 and rates of illicit drug use and alcohol bingeing are among the highest in the U.S.<sup>6</sup>

Historically, Vermont was settled by French Canadians, Italian, Irish Catholics, Scots and English people; 95.3% of the population are Caucasians who are non-Hispanic, 0.8% are Black, and 0.4% are Native Americans.<sup>7</sup> In addition, 1.3% of the population identify themselves Hispanic or Latino, 1.2% as Asian, 1.1% as bi-racial.<sup>8</sup> Through the Vermont Refugee Resettlement Program, however, Burlington and Montpelier have become home to a highly diverse population including Vietnamese, Bosnians, Somalis, Meskhetian Turks, Sudanese, Congolese, and people from 20 additional countries.<sup>9</sup> About 3.8% of Vermont's population is foreign-born and 5.9% speak a language other than English at home. Most Native Americans live in rural Northwestern Vermont, including the Abenaki Nation, with about 1500 members.<sup>10</sup>

A narrow employer base of mostly small businesses and limited job development and placement services are common statewide. Most available jobs are in the service industry.<sup>11</sup> Federal census data suggest that only 39 % of Vermont's jobs pay enough to meet basic needs.<sup>12</sup> In 2006, almost half of renters couldn't afford the fair market rent for a two bedroom apartment.<sup>13</sup> While the average hourly wage was \$9.87, the wage level required to maintain housing and pay living expenses was estimated at \$18.90 per hour.<sup>14</sup> High rents in Vermont are driven by the high percentage of vacation homes. Almost a third of Vermont's 33,000 low income households live in sub-standard units.<sup>15</sup>

**Population of focus/demographic information:** The project will serve adults aged 18-34 who have or are at risk for serious mental illness and who are not accessing publicly funded mental health services. While it is difficult to describe statistically a population that is not participating in services, the state has evidence of substantial unmet need. Within Vermont, consumers aged 20 to 34 account for 30 % of all inpatient days, 36 % of individuals served, and half of all admissions in Vermont's State Hospital (our most intensive and restrictive setting<sup>16</sup> -- admissions are involuntary 99 % of the time).<sup>17</sup> Yet, consumers aged 18-34 account for *only* 18 % of CMHC intensive programming (CRT) services for those diagnosed with major mental illness. Indeed, 81% of CRT clients are 35 or older, and almost half (46%) are 50 years or older<sup>18</sup>. The Vermont chapter of the National Alliance on Mental Illness (NAMI-VT) reports that a significant number of calls on their warmline are from parents of young adults who are experiencing serious mental health issues but accessing comprehensive mental health treatment<sup>19</sup>. Much of this population seeks care at local emergency rooms. As the Medical Director of the Brattleboro Memorial Hospital noted, "At [our] Emergency Department, we see a heavy dose of this age group for mental health needs on a regular basis. The most common diagnoses are depression, suicidality, drug abuse, alcohol abuse, PTSD." This is true even for those who are receiving mental health services: 63% of CRT consumers age 18-34 visited the Emergency Room in 2008, which is twice the rate for the general population.<sup>20</sup> Consumers aged 18 - 34 account for almost half of substance abuse treatment services in Vermont;<sup>21</sup> rates of co-occurring disorders documented in numerous publications by SAMHSA suggest that as many as three quarters of these consumers have co-occurring mental health needs,<sup>22</sup> yet they are not accessing evidence-based Integrated Dual Disorder Treatment provided by their local CMHC. Consumers (18-34) with serious mental illness are more likely to have involvement with law enforcement, either as an offender or as a victim, than older adults. Police identified almost 7 % of adult CMHC consumers with serious mental illness in rural Vermont as criminal offenders during 2006. Men were more likely than women to be identified as offenders (9.3% compared with 4.5%).<sup>23</sup> Identification of offending behavior decreased with increasing age—from 15.7% among those aged 18 to 34 to 2.3% among those aged 50 and older. Victimization decreased with increasing age (from 13.2% among those aged 18 to 34 to 4.5% among those aged 50 and older). Overall, service recipients were 2.4 times as likely as persons in the general population to be identified as victims. The elevated risk of being identified as a victim was greater for women than for men and was greatest among 18- to 34-year olds.<sup>23</sup> Consumers, 18-34, served by CMHCs in CRT, Outpatient and Substance Abuse services also have significantly higher rates of incarceration than older adults.<sup>24</sup> For incarcerated young adults, mental health needs have often disrupted education and acquisition of employment skills: 90 % had no high school diploma.<sup>25</sup> In Vermont, as in the rest of the nation, African Americans were more likely to be incarcerated than Caucasians - data that hold true for consumers with mental health needs.<sup>26</sup>

***Justify with respect to CMHS population of focus:*** Consumers at risk (aged 18-34) present in community settings with conditions consistent with diagnosable a mental health disorder and with related functional impairment, which interferes with or limits major life activities. Some consumers will have diagnosed mental health disorders but will not be connected to therapeutic resources. Consistent with CMHS priorities, this age group is underserved in Vermont's publicly funded, adult mental health system. By year 2, the project will reach consumers (18-34) in rural areas, which the President's New Freedom Commission has identified as woefully underserved.<sup>27</sup>

***Nature of the problem/extent of the need:*** Demographics described above for Vermont have been documented for consumers (18-34) in other states and nationally. The National Institute of Mental Health (NIMH) has indicated that the 2009 median age for first onset of Schizophrenia is 24; for Mood Disorders is before age 30; for Major Depression is age 32; for Generalized Anxiety Disorder is 31, and for Dysthymia is 31.<sup>28</sup> The New Freedom Commission noted that suicide is the second cause of death among 25 to 34 years olds and that the majority of these individuals were not connected to mental health services.<sup>29</sup> Both NIMH and the New Freedom Commission recognized that consumers must reach a high level of disability before receiving mental health services. While the 18 to 34 years are a critical period for onset for many mental illnesses, the nation's publicly funded mental health system cannot accommodate clinical or supportive needs as soon as they emerge. Epidemiological research indicates that since 2000 treatment rates for consumers with mental health needs are declining, there are longer delays between symptom onset and therapeutic support, and further fragmentation in financing and services make a coherent and comprehensive approach to early intervention less likely.<sup>30</sup> A recent US GAO study reported that these consumers face challenges which include: finding mental health, employment and housing services tailored to their needs, qualifying for adult programs, and navigating multiple delivery systems. Existing public mental health, employment, and housing programs are not tailored to this age range, which may discourage these young adults from participating. States' clinical criteria for receiving public mental health services are generally narrower for adults than for children and Medicaid income requirements are more stringent which can result in a loss of benefits at age 18.<sup>31</sup> For adults age 18-34, the completion of education and establishment of careers are important developmental milestones, yet difficulties associated with mental illness and a lack of access to support prevents this population from achieving these milestones. As noted below, vocational training and employment are the number 1 service identified by Vermont consumers (18-34). The New Freedom Commission notes, "even though supported employment is effective, few people with mental illnesses receive these services . . . [many] vocational services lack the key ingredients that make supported employment effective."<sup>32</sup> The Commission also noted needs very relevant to Vermont: "Virtually all of the rural counties in this country have a shortage of practicing psychiatrists, psychologists, and social workers. In addition, many primary care providers who work in rural areas are unprepared to diagnose or treat mental illnesses. Where general health providers in rural areas often use physician extenders, mental health extenders are not yet widely used."<sup>33</sup>

These national trends are evident in Vermont. Homelessness among this age group is higher than other age groups, even for those who are receiving comprehensive mental health services through the CMHCs. Homelessness was almost twice as high for consumers under 35 as compared to those over 50.<sup>34</sup> Consumers (18-34) experiencing the onset of mental illness may not meet eligibility criteria for intensive CRT services at the CMHCs that are tailored to those with serious and persistent mental illness. Some consumers are eligible for CMHC outpatient

services, but may require a level of case management currently unavailable in that modality. Age differences in utilization may in themselves discourage young adults. Since more than three quarters of individuals served in the CMHCs are over 35, younger consumers are less likely to meet peers whose values and life experience they share. At a recent focus group at the peer-run *Another Way* drop-in center in Montpelier, consumers in this age range reported that they avoid going to the CMHCs because: 1) they don't feel they need mental health treatment, 2) CMHC's are not supportive of their needs, and 3) they can get better support from the community and peers. The CMHCs do not have a well developed capacity for outreach in the community settings. Unengaged with the CMHCs, these consumers - male and female, of diverse racial and ethnic groups, rural and urban - present at hospital emergency rooms, doctor's offices, homeless shelters, and jail/correctional facilities with symptoms and issues directly related to mental health conditions. In addition, consumers in this focus group stated that additional assistance in becoming employed was their highest priority. While Vermont has implemented the evidence-based Supported Employment model, it is only available to CRT consumers and has not had the capacity to reach this target population where they are and build on their goals to engage them.

SAMHSA has identified the key elements for system transformation:

- creating or strengthening coalitions that place consumers and advocacy agencies at the center of decision making;
- ensuring that state and local transformation activities are consistent and mutually reinforcing;
- identifying evidence based practices that can catalyze transformation;
- monitoring to disseminate lessons learned and implement them system wide; and
- robust commitment by state mental health leadership to support new models with demonstrated success.

Vermont will utilize this SAMHSA blueprint in transforming our system. Consumers and advocacy organizations will join an existing state workgroup, the Adult State Interagency Team (SIT), and local workgroups, the Adult Local Interagency Teams (LITs), in each of the four local jurisdictions. Evidence based practices will catalyze transformation: developing a workforce of credentialed Peer Specialists, expanding access to peer-based Supported Employment (SE), and implementing Illness Management and Recovery (IMR) with Peer Specialists and community partners. Continuous quality improvement activities will provide regular updates to further guide system development and to assist in sustainability. Lessons learned will also guide statewide changes in our CMHC CRT and Adult Outpatient Programming to ensure that all critical clinical supports are relevant, helpful, and amenable to adults aged 18-34.

**Baseline for the project:** Based on the US GAO prevalence rate for serious mental illness among non-institutionalized young adults (6.5%)<sup>35</sup>, approximately 8,613 Vermont consumers (age 18-34) have SMI, yet only 2,712 are receiving services at CMHC's. In year one DMH will provide outreach and early intervention to a minimum of 50 new young adults (unduplicated). In years two through five this number will increase to 200 (unduplicated) each year.

**Consistent with State priorities:** In 2008, Vermont received Technical Assistance from the National Association of State Mental Health Project Directors (NASMHPD) in strategic planning to identify responses to gaps in adult mental health services. The 2-day planning event brought DMH, Vermont Psychiatric Survivors (our statewide consumer run advocacy

organization), and the Council of Developmental and Mental Health Services (which represents all of the CMHCs) together with 70 consumers, professionals, and advocates. Led by two nationally recognized consumer leaders, Gayle Bluebird and Holly Dixon, the attendees identified developing a credentialed peer work force that could partner with all service providers at the local level, as the highest priority. This representative group of state officials, consumers, consumer organizations, and clinicians emphasized the role that Peer Specialists would play in reaching out to consumers in the community, approaching them as equals, and engaging them in supportive services as early as possible. A focus on early intervention is also consistent with the state's emerging priorities. In March of 2010, DMH completed the first phase of a state strategic plan for the next five years. One of the priority strategic goals is: "DMH will implement strategies within a public health framework that: 1) promote health for all, 2) prevent problems, and, 3) intervene with early treatment."<sup>36</sup>

**Show that identified needs are consistent with the priorities of the community of focus:** Steven Morgan, Director of the peer-run drop-in center *Another Way* in Montpelier has stated: "Lately, I've been working a lot with young males who are not getting what they want or need. While they are clearly struggling to get hold of their lives, they don't meet the criteria for more intense mental health services, so they can't access the supported housing and employment or case management that comes with that package. My experience is that these folks need housing and jobs. And to access these, they need someone to connect and work with them on a continual basis - not in a caretaking role, but as a mutual support with common interests and experiences."<sup>37</sup> These sentiments were also expressed Another Way focus group (see above) and discussions with the Burlington LIT<sup>38</sup>. Consumers identified peer delivered supports in non-stigmatizing community settings as fundamental to engagement. Moreover, consumers identified assistance in building their independence through education and employment with a living wage as their highest priorities.

**Role of target population/consumers in identifying needs/priorities/completing application:** As noted above, Vermont's strategic emphasis on early intervention with a credentialed Peer Workforce/service provider partnership was set in a strategic planning session in 2008 co-sponsored by DMH, Vermont's Psychiatric Survivors, and representatives of the Community Mental Health Centers. In addition, in March 2010 DMH held a statewide public forum to solicit stakeholder feedback on the way in which this specific grant opportunity could help us implement this priority. Over 20 consumer representatives attended either in person or by telephone and reiterated the need for early intervention to adults (18-34), who fall through the cracks, landing in hospitals, corrections, homeless shelters, or hospital emergency rooms. DMH's Adult State Standing Committee, a consumer, family and provider stakeholder advisory committee for adult mental health services in Vermont, and the Mental Health Transformation Council, a consumer and stakeholder advisory committee focused on transformation of the adult mental health system, were also consulted. Both emphasized the urgent need to provide early intervention and peer support to this population. DMH also partnered with Another Way to hold a focus group of young adults with mental health needs; members of both the Montpelier and Burlington Local Interagency Teams (LIT) were consulted as well. LIT members reiterated a commitment to transformation through Peer Specialists partnering with local service providers and urged a focus on underserved adults aged 18-34 who are showing significant signs of mental

health needs in a range of community settings, but do not feel comfortable going to the CMHCs for assistance.

---

**SECTION B: STRATEGIC INITIATIVE AND PROPOSED PRACTICE**

**Clearly state the purpose, goals and objectives of your proposed project.**

**Purpose:** Vermont will offer effective outreach and early intervention services to adults (18 - 34) who show early signs of mental illness or who are at risk for mental illness (SAMHSA Strategic Initiative # 1). In partnership with consumers, consumer run organizations, and the communities, the state will develop a workforce of credentialed Peer Specialists trained in two SAMHSA NREPP evidence based interventions: Illness Management and Recovery (IMR) and Supported Employment (SE). Peer Specialists will engage consumers in community settings; help them connect with community services, particularly employment; and assist them in building skills to support a successful life in the community. This transformation will utilize existing interagency planning structures at the state and local levels with experience in implementing system change: the State Interagency Team (SIT) and the Local Interagency Teams (LITs) expanded to include representation of consumers from the population of focus as well as advocacy groups such as Vermont Psychiatric Survivors and NAMI-VT. Implementation will be a rolling process starting with Montpelier (within six months), Burlington (within year 1), and two rural communities selected by RFP (within year 2). A continuous quality improvement process will evaluate our model of care to improve outcomes for consumers; ensure consumer engagement in decision making at every level; and implement evidence based practices with fidelity.

**Goal 1: The State Interagency Team (SIT) will become an inclusive forum to provide project management and support the statewide infrastructure for transformation.**

**Objective 1:** Within 30 days of grant award, the SIT is expanded to include consumers and representatives of peer service and advocacy organizations.

**Objective 2:** The SIT oversees a statewide training plan which includes training in consumer engagement; in assessing community needs and strengths; in implementing the Evidence Based Practices with fidelity; in shaping and using evaluation data to inform system development; and in identifying additional resources in the community.

**Objective 3:** The SIT acts as a clearing house for information sharing so that lessons learned are disseminated statewide and can be utilized for on-going refinement of the emerging system.

**Objective 4:** The SIT develops an approval process and guidelines for local planning to ensure consistency and fidelity with SAMHSA's goals and objectives in each of the four communities.

**Objective 5:** The SIT amends Medicaid reimbursements to include credentialed Peers Specialists to ensure program sustainability.

**Objective 6:** The SIT utilizes evaluation data from local demonstration sites to identify and implement changes needed to make mental health programming amenable to adults aged 18-34.

**Goal 2: The Local Interagency Teams (LITs) will become inclusive forums to oversee local implementation and ensure that transformation incorporates the unique characteristics of consumers and each community.**

**Objective 1:** Within 30 days of grant award, the Montpelier and Burlington LITs are expanded to include consumers and representatives of Peer Service and Advocacy organizations.

Objective 2: Within 60 days, the Montpelier and Burlington LITs participate in orientation on IMR, Peer Specialists, and SE to frame local planning.

Objective 3: Within 60 days, the Montpelier and Burlington LITs complete a community assessment to identify community settings in which consumers are encountered, community needs, gaps, and strengths for implementation of the Evidence Based Practices.

Objective 4: Each LIT develops a training and implementation plan, which identifies the host agency for the Peer Specialists, for discussion and coordination with the SIT.

Objective 5: Each LIT identifies 10 local clinical, case management, and recovery oriented staff, including the Peer Specialists, to be certified in the identified evidence based practices.

Objective 6: After rural communities are selected by RFP in year 2, each completes objectives 1-5 for their community.

Objective 7: Each LIT participates in continuous quality improvement activities and receives regular feedback from the project evaluator to guide local transformation.

**Goal 3: Vermont will develop a credentialed workforce of Peer Specialists to engage and provide evidence based services to the population of focus.**

Objective 1: In coordination with the SIT and the LITs, the Project Director utilizes the SAMHSA Pillars of Peer Support to structure initial Peer Specialist training, establishes a hiring timeline, and implements a certification process in year 2.

Objective 2: In coordination with the LITs and with peer organizations, the Project Director establishes protocols for recruiting peers, develops a detailed job description, completes the hiring process, and implements the curriculum developed by the National Association of Peer Specialists for Peer Specialist Training.

Objective 3: The Project Director coordinates training and certification for Peer Specialists in IMR and SE.

Objective 4: Within each of the four model communities, 10 clinical and service professionals are trained on working effectively with Peer Specialists utilizing IMR and SE.

Objective 5: In coordination with the SIT and the LITs, the Project Director develops a “train the trainer” plan to guarantee that evidence-based practice training is institutionalized and accessible statewide by the end of year 5.

Objective 6: Seven (7 FTE) Certified Peer Specialists will be working in multiple settings during the first year of the grant and eleven (11 FTE) will be working in multiple settings by year 2.

**Goal 4: Consumers will achieve demonstrated improvements in self determination, self efficacy and recovery due to the implementation of evidence based practices.**

Objective 1: Peers Specialists teams in each demonstration site will conduct outreach to a minimum of 25 consumers in community settings in the first year and 50 consumers in each of the following years of implementation.

Objective 2: Peer Specialists teams in each demonstration site will engage at least 10 consumers in Illness Management and Recovery activities in the first year and 25 consumers in each of the following years.

Objective 3: 75 % of consumers engaged in IMR will experience significantly improved outcomes as defined by the IMR Consumer Outcome Survey (See Section E – P. 34)

Objective 4: Of consumers engaged in IMR, 75 % will participate in SE and/or community educational opportunities in each year of implementation.

Objective 5: 50 % of consumers engaged in SE and educational activities will achieve stable, competitive employment in each year of implementation.

Objective 6: 20 % of consumers engaged with Peer Specialists will elect to participate in re-designed Adult Outpatient Services in each year of implementation.

Objective 7: 20 % of consumers engaged with Peer Specialists will elect to participate in re-designed Community Rehabilitation Services (CRT) for individuals with severe and persistent mental illness in each year of implementation.

**Goal 5: A continuous quality improvement process will provide formative and summative information to guide transformation and demonstrate its successes**

Objective 1: The IMR and SE fidelity measures will be implemented annually with each of the four communities. The results of the fidelity measures will result in each site achieving moderate to high fidelity in IMR and SE by year five..

Objective 2: The evaluator will work with the SIT and the Burlington and Montpelier LITs to develop a draft fidelity scale for Peer Specialists in year 1, which will be tested and refined in the all four communities over the course of the grant.

Objective 3: In Year 1, the evaluator will work with the LITs and SIT to design a comprehensive annual Performance Assessment that includes input from all key stakeholders including consumers and providers. This design will be reviewed and refined in coordination with the LITs and SIT over the course of the grant.

Objective 4: The evaluator will provide each LIT with a written Performance Assessment report, meet with each LIT annually to review results, and facilitate discussion of how to interpret and use results to improve services and the local system of care.

Objective 5: The evaluator will provide the SIT with a written Performance Assessment report summarizing the results for each community and for the statewide system of care, meet with the SIT annually to review results, and facilitate discussion to interpret and use results to improve the statewide system of care.

Objective 6: The evaluator will provide annual assessment of infrastructure changes such as policy and financing that are designed to contribute to sustainability of the system transformation.

**Achievement of goals will produce meaningful and relevant results/support SAMHSA's goals:**

Four communities, which represent a diverse urban center, a small town, and two rural areas, will demonstrate how IMR and SE can be implemented by Certified Peer Specialists in partnership with community mental health, substance abuse, employment and other community resources. These four communities will implement core elements of each evidence based practice with fidelity within 4 very different environments. By the end of the grant period, Certified Peer Specialists will be key providers of service throughout the mental health system; every mental health center will have a core of Peer Specialists, clinicians and case managers certified in IMR and SE; and the public mental health system, including CRT and Adult Outpatient services, will be fully oriented to the choices of confident adult consumers (18-34). At the state and local level, changes in funding mechanisms, policy, and contracts will be implemented to sustain the transformed system of mental health recovery, treatment and support.

**Strategic Initiative #1 addressed/incorporating guiding principles of RFA:** Vermont will address Strategic Initiative #1, preventing mental illness through outreach, screening, and early interventions for Adults (18-34) with early signs of mental illness or who are at risk for it.  
**Consumer engagement at every step of the change process:** Consumers will be active members of decision-making bodies at the state (SIT) and local (LIT) levels. Evaluators will chart the



extent to which consumers feel that they are real partners in this transformation. The evidence based practices selected have been demonstrated in randomized control studies identified by SAMHSA NREPP to assist consumers in articulating and prioritizing the goals, content, sequence and intensity of service.

*Top down/bottom up approach:* Vermont will utilize existing local (LIT) and state (SIT) interagency teams which are expanded to include consumer voice and empowered to act as agents of transformation. The SIT will monitor the quality and consistency of local planning and implementation efforts; ensure that consumers are represented and heard on the LITs; and provide for training and technical assistance, fidelity monitoring, policy change (including credentialing Peer Specialists), and changes in the Medicaid reimbursement process to allow for reimbursement of Certified Peer Specialists. The LIT will assess strengths and gaps in service; the points in service, justice and forensic systems in which consumers can be identified; develop outreach and engagement plans utilizing Certified Peer Specialists, and ensure that a permanent core of providers is trained and certified in IMR and working with Peer Specialists.

*Incorporating the unique characteristics of community/consumers:* The Project Evaluator will assist the four model communities in tracking the level of consumer influence in decision making; the fidelity in implementation of core elements, customized to very different settings. Urban Burlington, for example, has a multitude of treatment, service and wrap around options and easily identifiable settings in which consumers can be found. Vermont's very rural areas must wrestle with distances between providers and limited service options, as well as the potentially more hidden nature of mental health need in widely dispersed, rural populations. The individual community plans, developed with training and technical assistance from the SIT will address these issues, document success, and utilize evaluation findings to refine efforts.

*Services are strength based and promote wellness:* The evidence based practices chosen help consumers with mental illness discover or re-discover their strengths, pursue personal goals and to develop a positive sense of identity beyond their mental illness. Peer Specialists, themselves consumers of mental health services, are living examples of recovery and offer empathetic and practical assistance. Peer Specialists will connect consumers, according to consumer choice, to a rich array of recovery oriented services including SE, housing, and a range of clinical and therapeutic options that can assist in sustaining recovery.

*Screening for behavioral health disorders in primary care settings:* All of the LITs have identified hospital emergency rooms as places where consumers present. The four participating LITs will specifically address outreach in community health settings in their plans. Each LIT will specifically address consumers presenting in health settings including emergency rooms and federally qualified health centers and will include health stakeholders in decision making.

***How selected practices will promote Strategic Initiative #1/ meet needs of community of focus:***

***Illness Management and Recovery (IMR):*** is a SAMHSA/CMHS/NREPP recognized evidence based practice that helps consumers with mental illness collaborate effectively with Peer Specialists and clinicians to identify highly personalized strategies to understand their mental health challenges, manage their symptoms, pursue recovery oriented services, and prevent disruptive experiences including hospitalization.<sup>39</sup> IMR provides a manualized set of interventions as well as fidelity measures that ensure core elements are implemented appropriately by either Peer Specialists or clinicians. Psycho-education, motivational interviewing, cognitive behavioral approaches, training in relapse prevention, coping skills and

stress management are key components which are tailored to each consumer's strengths, needs, interests and goals. IMR conceptualizes recovery as both a process and an outcome and seeks to discover the personal meaning that each consumer attaches to it. Highly concrete goals are defined which allow consumers to gain a sense of mastery over their symptoms and to establish more collegial and less hierarchical relationships with clinicians and treatment professionals. Because the SAMHSA Toolkit teaches Peer Specialists and clinicians to follow consumers' leads in every interaction, IMR is relevant at any stage in the recovery and therapeutic process. IMR core components address: recovery strategies; practical facts about mental illness; the stress-vulnerability model and treatment strategies; building social support; reducing relapses; using medication effectively; coping with problems and symptoms and getting needs met in the mental health system. SAMHSA/NREPP documents multiple randomized studies in which components of IMR improved outcomes, community engagement, reduction of disruption symptoms, and community re-engagement for men and women, diverse racial and ethnic groups, and consumers with varying levels of disability, literacy and acuity of psychiatric symptoms. A recent meta-analysis of 40 randomized controlled studies found that the benefits of this modality were substantially enhanced for all populations when IMR was fully integrated with motivational interviewing and when the treatment and recovery Team included Peer Specialists.<sup>40</sup>

**Peer Specialists:** the meta-analysis of IMR found that Peers providing IMR were less likely to be perceived by consumers in hierarchical terms and that implementation of IMR by Peer Specialists with *access to clinical support consistently produced the best results in randomized trials.*<sup>41</sup> This finding has been ratified by SAMHSA and a growing literature which demonstrates that consumers show improved outcomes when Peer Specialists and their partners in the service and mental health systems are co-trained in evidence based practice and careful planning clarifies roles and responsibilities.<sup>42</sup> Peer Specialists will reach consumers wherever they are in the community and help them identify concrete steps toward their recovery goals. Peers will bridge consumers' goals and values and community therapeutic and recovery assets. Peers will broker community services and assist in communication, engagement, and advocacy. Peers are also a living model of the potential for success for consumers and offer an open, non-judgmental connection. The President's New Freedom Commission on Mental Health has endorsed Peer Support as a key recovery strategy.<sup>43</sup> SAMHSA/NREPP cites research demonstrating that Peer Specialists are effective in improving outcomes for men and women, consumers of diverse ethnic and racial groups, as well as consumers with a wide range of disabling conditions and levels of acuity. These studies demonstrate that peer-to-peer models increase the amount and types of recovery services available. The social support that develops in the peer-to-peer model of mental health care for co-occurring disorders has been shown to increase feelings of well-being and engagement in treatment, as compared to single-focus self-help groups. Providing IMR through Peer Specialists will improve outcomes for Vermont's consumers.

**Supported Employment (SE):** is an evidence-based model, endorsed by SAMHSA and distributed as one of their six toolkits for consumers with severe mental illness. SE builds on the assumption that work is an essential part of mental health treatment for individuals with severe mental illnesses, and everyone who wants employment should receive support to find and keep a job. Recent research has found that between 60 and 70 percent of people with mental illness want to work, a finding re-iterated by Vermont consumers in focus groups for this application.<sup>44</sup> The CMHS Toolkit for SE emphasizes core elements: referral, engagement and benefits

counseling offered in community setting and following consumer choice; assessment, vocational training and job finding; and on the job support delivered through collaboration of employers and service providers. Throughout the process each consumer has a team of supports of their own choosing who develop an individualized employment plan fully integrated into other supports.

**Adaptations/Modifications to the proposed practice:** There will be no adaptations to any of the proposed evidence based practices; fidelity will be demonstrated by measures through the project evaluation. In addition to clinicians, Peer Specialists will also be trained in IMR and will offer services to consumers in community settings. Delivery of IMR by Peer Specialists was demonstrated as extremely effective in a meta-analysis of randomized studies of this practice.<sup>45</sup>

**Training on evidence based practices:** The New Hampshire Dartmouth Psychiatric Research Center (PRC) will provide training to Peer Specialists, clinicians, and service providers in each of the four communities on IMR. The PRC has trainers certified in IMR and SE and provides training and coaching to peers and professionals in 17 states. PRC will provide 3 days of training and ongoing coaching in IMR and 3 days of training and coaching on SE to each of the four demonstration communities. In addition, all of Vermont's Community Mental Health Centers (CMHCs) currently offer SE to consumers. DMH funds a full-time state SE coordinator who provides TA, training, and fidelity assessments to the CMHCs to ensure high quality. Margaret Swarbrick, a national leader in Peer Specialist training and peer-provided IMR and SE, will utilize the National Association of Peer Specialists Curriculum to provide 8 days of training with follow up coaching to each of the four demonstration communities. Each community will develop a training plan reflective of their strengths and gaps to schedule these trainings over the first year of implementation in each site and to develop a community based ongoing coaching strategy.

**Rationale for selection of evidence based practice over others:** These practices reflect the preferences identified by consumers who assisted in preparing this application. Each practice has an evidence base demonstrating efficacy for adults (18-34) with or at risk for mental illness. Each practice begins with the belief that recovery is possible for every consumer and takes a person-directed approach to outreach, assessment, planning and service. Each practice utilizes a team approach and brings community resource into an integrated effort supporting recovery. Each practice has been tested with males and females, with victims of trauma, and with diverse racial and ethnic populations. These practices emphasize continuous quality improvement and the use of data to improve practice. This combination of evidence based practices will transform our system placing consumer choice and recovery at the center of all decision making.

**Evidence based practice will meet goals and objectives:** The Project identifies a state and local infrastructure that will ensure fidelity in the implementation in urban, rural and small town settings. The Project has also identified training resources with proven credentials in providing training to professionals and Peer Specialists. Evaluation will test fidelity in implementation and disseminate results to the remainder of Vermont's communities. IMR, Peer Specialists, and SE have evidence bases recognized and documented by SAMHSA and have produced improved outcomes for consumers to be served.

### Program Logic Model

Inputs	Activities	Outputs	Outcomes
<p>Broad support among stakeholders to focus on consumers age 18 to 34</p> <p>Over past 2 years Vermont Psychiatric Survivors built consensus and developed plan for establishing Peer Specialists</p> <p>Statewide Interagency Team (SIT) and Local Interagency Teams (LITs) well established to coordinate system transformation</p> <p>First demonstration site already engaged with and providing peer-run services to target population</p> <p>Stakeholders have been developing capacity to engage with target population</p> <p>DMH and local providers have data collection and management systems in place to facilitate collection and reporting individual client data</p>	<p>SIT and 4 LITs expanded to include consumers and peer representatives</p> <p>SIT oversees LIT planning, coordinates information sharing, and works toward Medicaid reimbursement for Peer Specialists</p> <p>SIT facilitates CMHC changes</p> <p>Four LITs conduct community assessment, develop local training and implementation plans, select core team of 10 professionals for EBP training</p> <p>Project Director establishes recruiting and hiring protocols, develops training curriculum, and coordinates Peer Specialist training and certification</p> <p>LITs recruit, hire train Peer Specialists</p> <p>Community core team trained to work effectively with Peer Specialists</p> <p>Project Director develops, tests and refines train the trainer program</p> <p>Peer Specialists engage consumers in community settings with Illness Management and Recovery (IMR), Supported Employment (SE) and connections to community resources</p> <p>Evaluator conducts annual Performance Assessment, including fidelity of EBP, and facilitates SIT and LIT review of assessment report to ensure continuous quality improvement</p>	<p>3 consumers and peer organization representatives added to SIT and each LIT</p> <p>LIT report SIT provides accessible, useful and timely information</p> <p>SIT secures Medicaid reimbursement by Year 5</p> <p>CMHCs institute new policies, hire Peer Specialists, and increase number of target population served</p> <p>LITs complete community assessments, develop plans consistent with guidelines and assessment data</p> <p>IMR and PE Training provided to 40 core staff, including Peer Specialists, across four communities</p> <p>10 FTE Peer Specialists hired, trained and certified;</p> <p>40 core staff across four communities trained to work with Peer Specialists</p> <p>Train the Trainer Program in place by Year 5 with four persons trained</p> <p>Peer Specialists connect with 850 consumers through outreach and engage 420 consumers in at least one IMR activity</p> <p>75% of consumers engaged in IMR participate in supported employment or education each year of implementation</p> <p>CMHCs modify polices and hire peer specialist to better engage/serve target population</p> <p>Evaluator completes annual Performance Assessment including fidelity scales, process measures and outcome data</p>	<p>LITs and SIT include consumers and peer representatives, and serve to sustain systems of care that address the needs of consumers age 18 to 34</p> <p>Vermont has a credentialed Peer Specialist workforce to engage consumers age 18 to 34 in evidence-based practices</p> <p>Medicaid reimbursement for Peer Specialists is secured to provide sustained funding</p> <p>Consumers perceive CMHCs as welcoming source for supports and services</p> <p>Consumers age 18 to 34 report increased self-efficacy and recovery (each year of the grant 75% of consumers engaged in IMR show improvement in individual consumer recovery scores; 50% of consumers engaged in SE achieve stable employment; 20% of consumers engaged with Peer Specialists participate in CMHC services)</p>

**How project will address the following issues while retaining fidelity to the chosen practice:**

SAMHSA notes that personal values and culture are dynamic forces that shape every “aspect of care, starting with whether the person thinks care is needed or not. Culture influences what concerns that person brings to the clinical setting, what language is used to express those concerns, and coping styles”<sup>46</sup> Culture and beliefs influence patterns of help seeking - whether a consumer starts with a Peer Specialist, primary care doctor, a minister, spiritual advisor, or community elder. By emphasizing consumer choice at every stage from project development to identification of personal need and the best way of meeting it, we will structure interventions in a culturally competent and welcoming manner. The National Standards for Culturally and Linguistically Appropriate Services (US DHHS) note: “Cultural and linguistic competence is a set of congruent behaviors, attitudes and policies that come together in a system to enable effective work in cross cultural situations.”<sup>47</sup> Training, hiring practices, and protocols will be guided by these standards to address each consumer’s personal and cultural identity:

**Race and ethnicity:** While 95 % of Vermonters are Caucasians of European descent, an increasingly diverse group of citizens live in the state including African and Native Americans, Hispanic/ Latino, Vietnamese, Bosnians, Somalis, Turks, Sudanese, and Congolese consumers. IMR, MI, and Peer Specialists were chosen as interventions because they begin with the goals, norms, beliefs and values of each consumer and allow all decision making to flow from them. The Peer Specialists hired will include consumers who reflect the ethnic and racial diversity of the community. The Vermont Refugee Re-settlement Program has developed expertise and resources to assist these diverse communities and will be invited to work with the Burlington and Montpelier LIT in this effort.

**Religion:** Vermonters hold a diverse range of religious and spiritual beliefs and many describe themselves as secular. Within the planning process, attention will be paid to the religious and spiritual supports as well as civic organizations for recovery within each community so that consumers can choose from a full range of recovery supports that reflect their values.

**Gender:** Peers Specialists will include both males and females and the LITs will seek to expand primary health, behavioral health, and substance abuse treatment and recovery supports that take a gender informed approach. A component of Peer Specialist training will be recognizing signs of trauma and the different ways trauma is often reflected in the behaviors of men and women. Within each LIT, trauma informed care providers will be identified for individuals whose needs require clinical interventions. Many of our community providers, including Another Way in Montpelier, offer gender specific support groups.

**Age:** Consumers served will be between 18 and 34 and have expressed an urgent concern for employment opportunities. The project will expand access to an evidence-based SE model that has a long history of meeting the needs of consumers with a range of disabilities. This age range is also associated with the onset of many major mental illness and mental health challenges and is a period in which adults are building life skills. IMR is specifically relevant to this developmental task and will assist consumers in understanding and developing strategies to manage illness and build on strengths.

**Geography:** The project will be located in four communities representative of the state: and urban center, a small town, and two rural areas. These communities have common needs in serving the population of focus - helping the uninsured, providing SE with a living wage, addressing engagement through Peer Specialists and the identified evidence based practices. There are also significant differences that will be addressed in each local plan so that implementation is customized to consumers in the community served.

**Socioeconomic status:** Consumers aged 18-34 are even less likely than older peers to have a work history or a set of job skills that will bring a living wage. The project's emphasis on SE is due in equal part to a commitment to ensuring a life in the community for all and to assisting consumers in meeting basic needs. DMH will also sponsor *Bridges Out of Poverty*, a state-supported training for human service staff on cultural differences specific to socio-economic status, for members of the SIT and LITs.

**Language and literacy:** Project materials will be written at a 4th grade level and all interventions can be delivered verbally. Literacy will not be a barrier; interpreters are available through the Refugee Re-settlement Program for those who are not fluent in English.

**Sexual identity/orientation/gender identity:** All staff and agencies participating in this project provide service in a culture of respect for all consumers and look to help them build on the strengths of their gender identity in recovery. LITs will also work with local and regional support programs for lesbian, gay, bisexual and transgendered individuals (e.g. RU12? In Burlington) to ensure local peer are responsive to these populations

**Disability:** Vermont's Center on Independent Living, Protection and Advocacy Organization, Legal Aide, as well as Vermont Psychiatric Survivors, are resources to consumers who present with any disabling conditions. Stakeholders from these advocacy groups will be involved in planning at the state and local level. Consumers with disabilities will also participate in policy development at the state level as participants on the SIT and locally as participants on the LIT.

---

## **SECTION C: PROPOSED IMPLEMENTATION APPROACH**

*See Appendix 3 for Draft Service Implementation Plan*

Vermont's Agency for Human Services (AHS) is the umbrella organization the coordinates all state services for adults and children. Within AHS, the Department of Mental Health (DMH) provides leadership in ensuring consumer centered, culturally competent and state of the art services for adults and children with mental health challenges. DMH will be the lead agency for this Mental Health Transformation Grant and will ensure compliance with SAMHSA programmatic and evaluation requirements. Patricia Singer, MD, the Director of Adult Mental Health Services, will be the Principal Investigator. Throughout the grant period and beyond, the Dr. Singer will ensure availability of necessary resources for implementation. Dr. Singer will supervise the Project Director (1 FTE) who will be hired within 90 days of grant award by a committee including representatives of DMH, the State Interagency Team (SIT), the Montpelier and Burlington Interagency Teams and a consumer aged 18 to 34. The Project Director will:

- Ensure that consumers are represented in all settings in which decisions are made;
- Work closely with the Project's Cultural and Linguistic Competence Coordinator (.5 FTE), who will provide leadership in the development, implementation, and monitoring of the cultural and linguistic competence in all transformation activities;
- Provide support to the State Interagency Team (SIT);
- Coordinate training, planning, implementation with Local Interagency Teams (LITs);
- Orient the LITs to SAMHSA requirements and the selected evidence based practices, so that initial strategic planning, hiring Peer Specialists, and service to consumers can begin in Montpelier by month 6 and Burlington within the first year;
- Coordinate the development and promulgation of the Request For Proposals to identify and implement transformation in two rural sites in year 2;

- Assist stakeholders in using evaluation data to develop a Medicaid re-imbursable job description, training and credentialing program, and supervision structure for Peer Specialists;
- Identify lessons learned to reshape Community Rehabilitation Services (CRT) and Adult Outpatient Services to become more welcoming to consumers 18-34.

At the State level, Planning, evaluation, contracting, policy and funding reform will be led by the State Interagency Team, which is chaired by the AHS Deputy Secretary. SIT was established to identify and address the most challenging and difficult situations faced by consumers with multiple needs and to provide integrated responses to their needs. The SIT includes key staff from the AHS Secretary's Office, the Departments of Mental Health, Disabilities, Aging and Independent Living, Corrections, and the Office of Alcohol and Drug Abuse. A Medicaid representative participates as necessary. The SIT also includes representatives from the CMHC system for mental health and developmental disability issues. The SIT has the breadth of representation and the authority within their respective organizations to commit resources and staff as are necessary to support this complex process. In addition, SIT members are decision makers within their organizations and have the ability to recommend and follow through on policy changes. Because AHS is the umbrella organization for all human services, the SIT will also have the capacity to recommend and implement changes to the Medicaid Waiver necessary to sustain transformation. The SIT will be expanded within 30 days of grant award to include consumers aged 18-34 to represent the population of focus as well as advocacy organizations including Vermont Psychiatric Survivors and NAMI-VT. The SIT meets monthly (and more often as necessary) to review and problem solve difficult issues referred by the Local Interagency Teams. A collaborative relationship as well as a history of working together to address and resolve barriers to integrated, consumer focused service already exists between the SIT and the Local Interagency Teams.

The Local Interagency Teams (LIT) are multidisciplinary teams convened weekly by the AHS Field Director to provide consultation, expertise, and resources to consumers and families. The LITs facilitate the coordination of services, including Supported Employment in their region. The LIT includes service providers in the following areas: mental health, substance abuse, shelter, benefit programs, housing, food, fuel, and utility assistance, family support, child protection, corrections, domestic violence, veteran's issues and supports for people with disabilities. When a consumer facing service barriers is referred to the LIT, the team provides creative solutions and identifies additional resources. LIT members can commit their agency to plans developed and have a deep knowledge of service resources and gaps impacting consumers. The LITs also have ties to informal supports, including civic organizations, faith communities, grassroots and advocacy organizations. Within 30 Days of grant award, the LITs will be expanded to include consumers aged 18-34 who are members of the target population, as well as advocacy organizations including Psychiatric Survivors and NAMI-VT. With training and technical assistance coordinated by the Project Director, the expanded LITs will develop and submit strategic plans to the SIT, identify a local agency to host and provide supervision to the Peer Specialists, identify the core of service providers to be trained (together with Peer Specialists) in IMR and SE, and participate in continuous quality improvement activities.

Hiring, supporting, and training Peers Specialists: will be accomplished by each community LIT as specified by their approved plan. Each LIT will identify a lead agency to host and

supervise local Peer Specialists, who will work with LIT partners to meet consumers needs. Seven (7 FTE) Certified Peer Specialists will be funded during the first year of the grant and eleven (11 FTE) will be working in multiple settings by year 2. Peer Specialists will be half time staff in most cases. This will allow consumers to accept these positions without compromising their vital public benefits. Teaming will ensure that in all of the communities, Peer Specialists can provide mutual support as well as coverage for each other if necessary due to illness job changes. In the first year, recommendations of the North Carolina Peer Support and Recovery Task Force will guide implementation.<sup>48</sup> This model is Medicaid reimbursable.

Position responsibilities: Peer Specialists provide individualized, recovery-focused service based on a relationship of mutuality that allows consumers to learn to manage their own recovery and advocacy process. Peer Specialists provide outreach in community settings, engage consumers, and offer supportive services including self-help, advocacy, skill building and sharing information, and assisting each consumer to identify personal goals and interventions utilizing the IMR framework. Peer Specialists offer "bridging" services to help consumers connect with the full range of community services. The LIT is a continuous resource to the Peer Specialists, identifying services and adapting existing services to consumers' identified needs.

Credentials: Peer Specialists self identify as consumers with life experience of serious mental illness, are well grounded in their own recovery, and receive general and clinical supervision from a qualified professional identified by the LIT.

Hiring: Each LIT will empanel a committee including professionals and consumers who will develop plans for wide dissemination of information about the position, as well as advertising, interviewing and making a final hiring decision.

Training: Peer Specialists will be oriented to their role by their supervisor who will also assist them in assessing their personal strengths and resources. A personalized training plan will be developed for each Peer Specialist that includes participation in IMR, Peer Specialist and SE Training (described below). It will also include coaching, weekly supervision, shadowing, and practice/feedback on newly acquired skills.

**Training in Evidence Based Practice:** Each LIT will identify a team of 10 including the Peer Specialists, CMHC clinicians and case managers, and community service providers and recovery supports. The Project Director will work with the New Hampshire Dartmouth Psychiatric Research Center (PRC) and Dr. Margaret Swarbrick, a national leader in Peer Specialist training to develop schedules and sequences for manualized training in IMR, SE, and the National Association of Peer Specialists Curriculum that addresses each LITs resources and challenges. Training offered in each site in the first year of implementation will include: 3 days on Illness Management and Recovery, 3 days on Supported Employment and 8 days on Peer Specialists as providers of services. Core team members will participate in trainings consistent with their roles, but all will receive at least a one day overview of each evidence based approach. In addition, ongoing coaching, through webinars and on site consultation, will be offered through the course of the grant period. The Project Director, PRC, and Margaret Swarbrick will also work with the LITs to develop a Peer/Professional Team approach to training that models partnership. Within 60 days of hiring Peer Specialists, the teams will receive a day long training on working with peer supports. This training event will provide time for Team members to discuss opportunities for partnering and identify barriers and solutions.

**Expanding access to evidence based therapeutic and recovery services:**



Peers Specialists: Peer Specialists will engage consumers in community settings including emergency rooms, police stations, homeless shelters and libraries. Utilizing IMR, they will assist consumers to identify understand mental health and recovery challenges, to identify interventions that would be helpful, to learn about the range of services available in the community and to access these services. Peer Specialists will provide IMR independently and/or in conjunction with other recovery, clinical and therapeutic supports. With access to clinical and general supervision, the Peer Specialist will have a constant resource to discuss questions and concerns that arise in providing services and information to consumers.

Supported Employment: DMH collaborates with Vermont's Division of Vocational Rehabilitation (DVR) to provide employment programs for individuals with mental illness. DVR funds benefits counselors to assist consumers who wish to go back to work but are concerned about losing other social benefits that are income based. Vermont's success in employment of CRT clients is relatively high, yet consumers in outpatient services or consumers not engaged with the CMHCs do not receive SE services. The project will expand these services to the target population. At least one Peer Specialist will be trained on SE and work closely with DVR to provide evidence-based employment supports.

Housing: In each site, a Peer Specialist will be trained in supported and transition housing services including HUD subsidized Housing, Housing Assistance Subsidies, Housing First, Recovery Housing and transitional housing. In addition, the LITs will work with Peer Specialists to strategize when barriers to housing services are compromising consumers' recovery.

Clinical supports: All consumers will benefit from IMR as well as bridging services through community contacts with the Peer Specialists. Consumers are not obligated to participate in formal clinical services to receive these services. It is expected that many consumers could benefit from clinical support and these services will be expanded during the grant period in several ways. Peer Specialists will be able to act as bridgers with the CMHCs, assisting clinicians to build relationships with consumers and to better understand consumers' goals for treatment and recovery. CMHC clinicians and case managers in the CRT and Outpatient Programs will also be trained as a part of the core team in IMR, which has been associated with strengthening attachment to clinical services in randomized trials. Finally, over the course of the grant, lessons learned will be used to re-shape these services to make them relevant to consumers aged 18-34. For example, DMH is considering enhancing adult outpatient services by providing case management for adults at risk for or who are showing early signs of mental illness. This project will test extent to which case management assists consumers in *maintaining* a life in the community by connecting them to employment, educational, and housing resources. Evaluation outcomes will support sustainability.

**Implementation within 6 months of grant award:** The Montpelier LIT has agreed to implement services within the first 6 months of grant award and has identified Another Way, a consumer run agency which provides supportive services to individuals with mental health needs, as the lead agency. Another Way has an established supervision and hiring structure, complies with ADA and has experience in managing state and federal funds. The Montpelier LIT will receive support needed in the first six months from the Principal Investigator, Dr. Singer, who will take an active role in rapid implementation and ensure that funds are released expeditiously to for local hiring, planning, training and consumer service within six months time.

***A Realistic Timeline for Transformation (Years 1-5) follows immediately.***

Activity/Milestone	Responsible Party	Y E A R				Y E A R				Y E A R				Y E A R				Y E A R			
		1				2				3				4				5			
		Q U A R T E R																			
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Expanded SIT Meets monthly for planning, oversight and implementing system changes	SIT*, PM*	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Medicaid Reimbursement for Certified Peer Specialists secured	SIT																X	X	X	X	X
Expanded LIT in Montpelier/Burlington meet monthly to assess community, develop training & implementation plan, EBP certify core staff	LIT, SIT, PM	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Montpelier/Burlington LITs & SIT recruit, hire, train and certify Peer Specialists	SIT, LIT, PM		X	X	X	X			X			X			X			X			X
Core team trained to work with Peer Specialists	LIT, PM		X				X				X				X					X	
Request for Proposed disseminated and awarded for 2 Rural communities	SIT, LITs, PM				X	X															
Expanded LIT in rural sites meet to assess community, develop plan, EBP certify core staff, hire/train/certify Peer specialists	SIT, LIT, PM						X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Train the Trainer Plan to sustain EBPs tested and implemented	SIT, LITs, PM PE				X				X				X			X	X	X	X	X	X
Peer Specialists engage consumers	LIT, PM			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Training certification model for Peer Specialists identified, tested and refined	SIT, LITs, PM PE*		X	X	X	X	X	X	X	X			X				X			X	
Service Implementation Plan revised/submitted annually to CMHS	SIT, LITs, PM PE				X				X				X				X				X
Evaluator assess fidelity of IMR, SE	Evaluator			X				X				X				X				X	
Evaluator develop & test fidelity scale for Peer Specialists with LITs and SIT	Evaluator,		X	X				X				X				X				X	
Evaluator design & conduct Performance Assessment with LITs and SIT	Evaluator,		X	X				X				X				X				X	
Evaluator collect& report sustainability data	Evaluator			X	X			X	X			X	X			X	X			X	X
Evaluator facilitate CQI activities w/ LIT, SIT	Evaluator				X				X				X				X				X
Required data provided through TRAC	Evaluator, DMH				X				X				X				X				X
Project Director and two staff attend SAMHSA conferences annually	SIT, PD				X				X				X				X				X
Two Consumer attend SAMHSA leadership Conference Annually	SIT, PD				X				X				X				X				X

**How the practice will be revised and full implemented across the entire community and population of focus by the end of the fourth year of the grant:** By the end of the first year the SIT and Montpelier LIT will develop and implement the local train the trainer (TOT) plan. The TOT will be implemented in Burlington in year two and in the two rural communities in year three. The Project Director will coordinate TOT training. By the end of year four, the Project Director will present a statewide Training Plan to generalize lessons learned to the SIT, which will identify resources to support its rollout. Throughout the grant period, consumer and peer organizations as well as CMHC LIT representatives from across Vermont will be invited to participate in training on an as available basis. Quarterly conferences and webinars will also be held to allow the four demonstration sites to share experiences and brain storm challenges. These events will also be opened to consumer and peer organizations as well as CMHC LIT representatives statewide.

<b><u>Unduplicated number of consumers served and anticipated outcomes</u></b>						
Service	Year 1*	Year 2*	Year 3*	Year 4*	Year 5*	Anticipated Outcomes
Outreach	50	200	200	200	200	Increase in referrals to community resources, increase in consumers receiving IMR and SE
IMR	20	100	100	100	100	Increase in mental health wellbeing for consumer receiving IMR (measured by IMR Consumer Outcomes Survey)
Supported Employment	14	76	76	76	76	Increases in number of consumers with stable, competitive employment
Housing Assistance	10	40	40	40	40	Increase in number of consumers will stable long-term housing
Enhanced Adult Outpatient	10	40	40	40		Increase in # of young adults receiving evidence-based practices through CMHCs
Enhanced CRT services	10	40	40	40		Increase in # of young adults receiving evidence-based practices through CMHCs

\* numbers of consumers served

**How consumers will be identified, recruited, and retained:** Each LIT will formalize a protocol based on SAMHSA criteria for identifying consumers showing early signs of serious mental illness. This protocol will be refined over the project period and utilized by Peer Specialists and community partners to **identify** consumers in community settings. Each LIT will map the settings, times and circumstances in which consumers are found. Peer Specialists will have flexible schedules which allow them to meet consumers in these settings. Peer Specialists will utilize skills learned in MI/IMR to **recruit** consumers initially identifying concrete goals and needs that can be met, including access to such services as Supported Employment, housing resources, assistance with establishing benefits eligibility for SSI. As consumers see their identified goals met, trust with the Peer Specialist will develop. Peer Specialists will also share the experience and understand the challenges faced by consumers and will offer true partnership in skill building and in accessing services. **Retention** will be achieved by continuing attention to consumer identified recovery goals, clear progress in meeting them, as well as the support of the Peer Specialist utilizing the IMR framework and strategies.

**Approach addresses language, beliefs, norms, values and socioeconomic factors of the population of focus and collaborates with community gatekeepers:** The Project's Cultural and Linguistic Competence Coordinator is bi-lingual/bi-cultural individual and has 5 years of experience in assisting Vermont to implement programming to diverse young adults cultural and linguistic needs and strengths. Also, while English is the first language of more than 95 % of Vermonters but when consumers require interpreters, they can be provided by the Refugee Resettlement Program. Use of language may also relate to levels of familiarity with the service system and/or with disability. The project will be attentive to utilizing clear and straight forward language, devoid of acronyms and clinical jargon. Where consumers have disabilities that impact language, Peer Specialists will work with supervisors to generate strategies to communicate effectively. Beliefs, norms and values expressed by consumers who helped develop this project have emphasized a desire for independence, self sufficiency, and a life in the community that includes companionship and housing stability. Consumers expressed a desire to receive service in non-stigmatizing community setting. Project services will be provided in these settings and will focus on building life skills and resources associated with resiliency and strong interpersonal relationships. The Burlington and Montpelier LITs will also work closely with the Refugee Resettlement Program to identify community representatives and consumers who can help us shape transformation to address the languages, beliefs, norms, and values of these diverse communities. The need for employment that can support a life in the community is the principal socioeconomic factor that must be addressed. SE is a core project service and will be offered to all consumers. The LITs are composed of community gatekeepers for mental health, substance abuse, housing, employment, and other ancillary services. The LITs are fully vested in the development of this program and will be working with consumers as partners to effectuate system re-design.

**Consumer Input in project implementation and selection of the practice to be implemented:** Consumers and consumer organizations will be engaged in planning, implementation and assessment as members of the State Interagency Team (SIT) and the Local Interagency Teams (LITs). Peer Specialists will also be critical service delivery personnel and all will be individuals who self identify as consumers of mental health services. By the beginning of the third year, all training activities will be conducted by a consumer/peer and professional team. These are the governing and design teams for system transformation. As described in detail in Section A, DMH held a statewide public forum to solicit ideas for this grant application in which over 20 consumer representatives participated. Focus groups were held in Montpelier and Burlington. Our initial implementation plan Peer Specialists is based on other peer-driven state models (Georgia) and was brought to our attention in the context of these planning activities.

**Stakeholders who will develop/update the Service Implementation Plan:** The Service Implementation Plan will be developed at the local levels by the Local Interagency Teams. These Local Plans will be integrated into one Statewide Service Implementation Plan by the Project Director and approved by the State Interagency Team. As described in detail above, the SIT and the LITs include all of the state and local human service agencies needed to implement this project including representatives of: health, mental health, substance abuse, Medicaid, TANF, S E and other community resources. In addition, both the SIT and the LIT will be expanded within 30 days of grant award to include representative of Psychiatric Survivors and NAMI, grass roots, consumer run advocacy organizations. In addition, Vermont's local and regional consumer run organizations will join the SIT and the LITs and will assist in identifying consumers aged 18-34

to join both the SIT and the LIT (see Attachment 4). These fully representative state and local interagency teams will be the governing authorities for the project.

**Necessary groundwork completed for implementation within 6 months of award:** The readiness of Montpelier is discussed in this section above: Another Way is already working with the target population and ready to add peer specialists to their program. Key stakeholders in Montpelier support this initiative and are ready to augment the Montpelier LIT with consumer and advocacy members (see Appendix 4). This initiative will also build on a statewide strategic plan developed by representatives of DMH, Psychiatric Survivors, Peer Organizations, consumers, and the CMHCs, who identified developing a credentialed Peer Specialist work force as a critical strategy for transforming our mental health system.

**Specific services funded through the grant/plans for developing alternate funding sources to continue providing these services after the grant project period ends:** The principal service to be funded through the grant is the development of credentialed peer specialists. As noted above, the development and credentialing of this position will be accomplished in partnership with our state Medicaid agency to assure that by the end of the grant period, funding is provided state wide through our Medicaid waiver. Training will also be grant funded and to ensure continuation after the grant period, a Train the Trainer Program (TOT) will be developed and implemented within each LIT. The DMH will provide resources to support this TOT program, an approach that has been successfully utilized in Vermont to sustain other evidence based practices, including Integrated Dual Disorder Treatment at each CMHC. Finally, as discussed immediately below, Vermont's Vocational Rehabilitation (DVR) will be a partner in this grant and will assist in sustaining SE services.

**Funding sources to help implement practice/funders to join planning:** DVR will join the SIT in grant planning and implementation and will match grant funds used to pay Peer Specialists focusing on SE. DVR will maintain this commitment after the grant period (see Attachment 4). DMH also employs a state SE specialist who can augment SE training and fidelity assessments. Vermont's current Medicaid waiver also allows the re-investment of savings from system change back into services. By diverting consumers from emergency rooms and jails, we will generate funds that can sustain practices demonstrated effective by our evaluation.

**Potential barriers and strategies to overcome them:** While Vermont has valued and worked with Peer Advocacy organizations successfully for many years, this transformation will take that partnership to a new level in local systems of care by the end of the grant. In implementing its Peer Specialist programming in North Carolina, NAMI identified several potential challenges including confusion about roles among front line staff, supervision models that do not fully support Peer Specialists, and lack of consensus on credentials and ethical boundaries in early system implementation. The Project will address these issues by utilizing a curriculum for training developed by the National Association of Peer Specialists and by ensuring that all core staff (including identified supervisors) at the local level receive training on the role of Peer Specialists. As the project rolls out, initial descriptions of roles, responsibilities, supervision, credentials, and boundaries will be refined. The experience of the four LITs, which will all include consumers and consumer organizations, will shape the job description presented to Medicaid as well as ongoing training for Peer Specialists and local service providers.

**Infrastructure development during the grant project period and after the grant ends:**

**Policy Development:** The SIT will develop state policy necessary to sustain transformation. Planning grants to the CMHC's will allow them to incorporate "lessons learned" and develop more welcoming practices these consumers. The number and breadth of state and local policies developed will be the measure of this infrastructure change.

**Workforce Development:** Through the development of a credentialed peer specialists workforce, we will increase the number of consumers credentialed as peer specialists and increase the number of consumers who provide mental health-related services.

**Financing:** Working with the Office of Vermont Health Access, we will to establish peer specialists services that can be billed to Medicaid.

**Accountability:** The Project will increase consumer voice in planning by adding consumer members and representatives of Vermont Psychiatric Survivors to the SIT and LITs. Consumers receiving grant-related services will inform the project's performance assessment.

**Types/Targets of Practices:** The project will increase the number of programs/communities utilizing evidence-based practices (Peer Specialists, IMR, and SE).

**Percentage/Amount spent on Services, Infrastructure, Evaluation and Administration:**

<b>Category</b>	<b>\$ Amount</b>	<b>Percentage of Total Funds</b>
Direct Service	\$ 506,135.00	67.51%
Infrastructure	\$ 87,914.00	11.73%
Evaluation	\$ 83,000.00	11.07%
Grants Management	\$ 72,650.00	9.69%

The Vermont Division of Vocational Rehabilitation has committed to providing in-kind funds to fund 50% of the salaries of the 5.0 FTE Peer Specialists that will focus on Supported Employment. (\$113,750).

**Plan to continue the project after the funding period ends:** Sustainability will have several facets: fiscal, training, and practice re-design. The largest portion of grant funds to be sustained will be support for the Peer Specialists. The Project has identified as a starting point models developed by North Carolina and Georgia which are also congruent with Medicaid requirements. This is the balance that we will continue to seek throughout transformation: refining our model of Peer Specialists to meet consumer needs while maintaining Medicaid participation.. Vermont has an extremely flexible Medicaid Waiver and the state is committed to utilizing it to sustain the Peer Specialists. As noted above, each LIT will develop a train the trainer model which identifies core local staff across the service system at the front line and supervisory levels as ongoing resources. Finally, we will re-design core mental health services, including Community Rehabilitation Services and Outpatient Services, to increase utilization by consumers age 18-34.

**Maintaining program continuity when there is a change in the operational environment:**

DMH provides an excellent salary and benefit package as well as a welcoming work environment. We have very high retention rates for staff and expect that these will be maintained in this initiative. At the state level, the Project Director will have administrative support from the Principal Investigator, Dr. Singer, who will be well versed in transformation goals, plans and operations. At the local level, Peer Specialists will operate as a part of a team with support from the LIT and at least 10 local service providers, including consumer run

organizations, trained in evidence based practices. If there is a change in personnel, this local infrastructure will continue service to consumers without interruption.

---

**SECTION D: STAFF AND ORGANIZATIONAL EXPERIENCE**

**Capability/experience of the applicant organization/links to population of focus:** DMH is one of six departments within the **Agency of Human Services (AHS)** which is the umbrella organization for all human service activities. The Agency is led by the Secretary, appointed by the Governor. AHS integrates programmatic and funding responsibility for mental health services to children and adults; child and youth protection and development services, TANF; aging and disability services; corrections; and Medicaid. AHS departments and offices administer a broad range of federal and state programs, block grants, and entitlements. **The Department of Mental Health (DMH)** administers federal and state programs, block grants, and entitlements for all Vermonters with mental health needs through network of independent, private, non-profit Community Mental Health Centers (CMHCs) that comply with stringent state and federal laws, regulations and quality standards for delivering mental health services. Strong ties with the Dartmouth Psychiatric Research Center has allowed us to implement Supported Employment and Integrated Dual Disorder Treatment with high fidelity in our CMHC CRT programs. Strong connections with our sister departments (e.g. Division of Vocational Rehabilitation, Division of Alcohol and Drug Abuse) have ensured broad support for sustaining those practices. DMH has a long history of collaboration with Vermont Psychiatric Survivors (VPS), Another Way and NAMI-VT to develop peer-based and family-led supports, and each of these peer groups will be involved at the state (SIT) and local (LITs) to support transformation. The **State Interagency Team (SIT)** was created to ensure coordination of care for adults with complex needs across the six AHS departments. Chaired by the Deputy Secretary, the SIT includes decision makers who can commit resources to remove barriers to service. The SIT represents an overarching structure that already exists to support mental health transformation. The SIT works closely with **Local Interagency Teams (LITs)**. LITs are convened by an AHS staff member, and which include membership of all of the local agencies providing service to adults with complex needs. The SIT and the LITs have a history of collaborating to address needs which arise at the local level but have statewide significance. Both the SIT and the LITs have extensive experience in meeting the needs of adult consumers with mental health and other complex needs at the local level. Several of the LITs have developed partnerships with key community stakeholders (e.g. Federally Qualified Health Centers, Local Police Departments, Emergency Departments), and this experience will be shared with the SIT and other LITs to increase participation of healthcare, law enforcement, and other community stakeholders across all the teams. Since the 1960s, the **Community Mental Health Centers (CMHCs)** have offered intensive, community-based treatment for adults with serious and persistent mental illness (SPMI), outpatient programming for adults, psychiatric crisis services, and screening for hospitalization. CMHCs have worked with DMH to develop evidence-based practices for adults with SPMI (Integrated Dual Diagnosis Treatment, Supported Employment, and Dialectical Behavior Therapy), and many have partnered with Vermont Psychiatric Survivors (VPS) to enhance peer support in their region. CMHCs in the 4 demonstration sites will participate on the LIT and are committed to redesigning services (changing policy, hiring peer specialists) based on lessons learned (see Attachment 1). The **Vermont Council of Developmental and Mental Health Services**, which represents the 10 CMHCs, will play a critical role in disseminating

“lessons learned” on how to better meet the clinical needs of the target population across all the CMHCs. The peer-run organizations **Vermont Psychiatric Survivors, Another Way, NAMI-VT and Friends of Recovery-VT** (peer support for co-occurring disorders) are already engaged with the target population. Both VPS and Another Way will be incorporating Peer Specialists, IMR and SE into their supports, and all three organizations will participate on the SIT and LITs to support redesign of services. NAMI-VT already offers education and supports to families of the target population and is committed to improving their services to better meet the target population’s needs.

**Organizational links to grassroots/community-based agencies:** Vermont Psychiatric Survivors and NAMI-VT are peer-based organizations that have been providing peer support, education and advocacy for over twenty years. DMH and these organizations regularly collaborate on projects and both of these organizations will be represented on the State Interagency Team (SIT) and the Local Interagency Teams (LITs). Another Way in Montpelier is a grass roots peer resource center which has serviced people with mental illness who choose services outside the CMHC network for more than 20 years.

**Staff positions, role, level of effort and qualifications:**

***The Principal Investigator (.1 FTE - Patricia Singer, MD)***, will oversee the grant. Dr. Singer is the DMH Director of Adult Mental Health Services and has extensive experience working with SAMHSA on the implementation of evidence-based practices and integrated dual disorder treatment. While working at the Dartmouth Psychiatric Research Center, she oversaw the development of the SAMHSA Evidence-based Practices Toolkit’s, and she has been the project director for both the New Mexico and Vermont Co-Occurring State Incentive Grant funded by SAMHSA.

***The Project Director (1 FTE - to be hired)*** will oversee all grant activities and ensure coordination between the 4 demonstration sites. Qualifications will include: 1) minimum of 5 years experience in SAMHSA grant management, system development, and implementing evidence based practices statewide, 2) masters degree in behavioral health services, 3) experience in public mental health administration. The Project Director will report to Dr. Singer. DMH will actively seek to recruit a consumer for this position.

***The Cultural and Linguistic Competence Coordinator (.05 FTE - Maria Mercedes Avila)*** will provide leadership in the implementation, and monitoring of the cultural and linguistic competence in all transformation activities. Ms. Avila provides training, coaching and support to DMH and participating communities in the implementation of a SAMHSA System of Care grant for Youth in Transition. Ms Avila is bi-lingual.

***Peer Specialists (11 FTE)*** will provide individualized, recovery focused service based on a relationship of mutuality that allows consumers to learn to manage their own recovery and advocacy process. Peer Specialists provide outreach in community settings, engage consumers, and offer supportive services including self help, advocacy, skill building and sharing information, and assisting each consumer identify personal goals and interventions utilizing the IMR framework. Peer Specialists self identify as consumers with life experience of serious mental illness; are well grounded in their own recovery, and receive general and clinical supervision from a qualified professional identified by the LIT.

***New Hampshire Dartmouth Psychiatric Research Center (PRC)*** will provide training (via contract) to Peer Specialists, clinicians, and service providers in each of the four communities on



evidence based practices. The PRC has trainers certified in IMR and SE and provides training and coaching to peers and professionals in 17 states. PRC will provide 3 days of training and ongoing coaching in IMR and 3 days of training and coaching on SE to each of the four demonstration communities.

**Margaret Swarbrick, PhD.**, will provide training and coaching (via contract) to each of the four demonstration communities on the development of Peer Specialists and peer-based IMR and SE. Dr. Swarbrick is a part time assistant faculty in the department of Psychiatric Rehabilitation a Counseling Professions at UMDNJ - School of Health Related Professions and the Institute for Wellness and Recovery Initiatives Training Director for Collaborative Support Programs of New Jersey, a large peer-operated self-help organization. Dr. Swarbrick has presented and published on the topics of peer delivered services, wellness, recovery and employment.

**Evaluator:** Flint Springs Associates has extensive experience in evaluating SAMHSA grants within the state of Vermont. Its principal partners, Joy Livingston, Ph.D. and Donna Reback, MSW, LICSW, are trained social science researchers with considerable experience designing, conducting and managing evaluation research. FSA has held numerous contracts over the past 15 years with Vermont Agency of Human Services Departments, including Mental Health, Health, Disabilities, Aging and Independent Living, and Corrections. FSA is currently the evaluator for Vermont's *Alternatives to Seclusion and Restraint* SAMHSA grant.

**Abilities/experience of proposed personnel to implement services with fidelity:** Dr. Singer, the project's Principal Investigator, was the national project manager for the development of SAMHSA's Evidence-Based Practices Project and has extensive experience in leading implementation of evidence based practice in both Vermont and New Mexico. The Project Director hired will have both demonstrated knowledge of these evidence based practices and experience in Public Mental Health Administration and systems planning necessary to achieve project goals. The Peer Specialists will be chosen because of their shared experience with and commitment to consumers of the population of focus. Extensive training and ongoing support will allow them to fulfill responsibilities effectively.

**Experience of key personnel in serving the population of focus:** The Principal Investigator, identified trainers, and the evaluator each have more than 10 years of service in working within their roles with the identified population of focus. In hiring the Project Director and Peer Specialists, attention will be paid to representation of the whole community of focus as well as demonstrated successful engagement with these consumers. In addition, the project's Cultural and Linguistic Competence Coordinator will assist in planning and implementation activities.

**Project personnel are qualified to serve a multi-linguistic/multi-cultural population of focus:** Within Vermont, consumers from diverse cultural and linguistic groups are overwhelmingly refugees. Project staff will have access to resources of the *Refugee Resettlement Program*, which works with DMH and local community mental health agencies to ensure appropriate, culturally sensitive mental health services. Project staff will also receive guidance and support from the *Abenaki-University of Vermont Partnership*, which has focused on providing culturally sensitive mental health and social services to Native Americans for a number of years.

**Resources available to the Project:** DMH performs utilization review, quality management, system development, system operational oversight, financial monitoring and data-collection and

analyses for contractors. DMH has an outstanding record of providing community-based services to Vermonters with mental illness. Fiscal administrative oversight to more than 800 grants totaling \$38 million is provided by the Business Office in conjunction with individual Project Directors. DMH utilizes a cost allocation plan approved by the federal Department of Health and Human Services to allocate its overhead and leave time costs. The DMH Information and Computer Services Divisions and the Business offices have extensive analytic capabilities. The DMH Research and Statistics Unit has extensive experience working with other data bases maintained by Vermont state government including the Medicaid Claims Processing, Medicaid Pharmacy, Hospital Discharge Data Set, the wage and salary data base maintained by the Department of Employment and Training, and the Department of Corrections data. DMH regularly reports on cross-data systems analysis through the federally supported Performance Indicator Project and our information system has the capacity to collect SAMHSA GPRA data required.

**Locations are adequate, accessible, ADA compliant, amenable to the population of focus:** All agencies receiving DMH funding comply with uniform reporting requirements both programmatically and fiscally which are compatible with SAMHSA fiscal and GPRA requirements. In addition, all Vermont AHS agencies, including DMH, require community agencies to provide services in locations compliant with the Americans with Disabilities Act (ADA). To ensure that services that are adequate, accessible and amenable to consumers, DMH requires that all service providers:

- Believe and act on the principle that recovery is possible for every consumer;
- Are appropriately licensed and accredited (by JACHO, COA, or CARF);
- Embrace industry, state, and city standards for high quality care;
- Meet US DHHS standards for cultural competence in hiring and retention of staff;
- Have regular and consistent ways of securing consumer feedback on programming and shaping programming accordingly;
- Adopt a culturally sensitive approach to issues of race, ethnicity, age, gender, sexual identity, literacy, language, disability/differing ability, values, norms and beliefs; and
- Have at least 3 years experience in direct care with adult consumers with mental illness.

---

## **SECTION E: PERFORMANCE ASSESSMENT AND DATA**

**Ability to collect and report required performance measures:** The following measures will be included as part of data collection and management: 1) Adult NOMS, 2) Individual Consumer Recovery using the IMR Consumer Outcome Survey, 3) Infrastructure changes, 4) Fidelity of evidence based practices (IMR, Supported Employment and Peer Specialists), 5) Process data to assess achievement of project objectives. In addition, the evaluation team and our existing information systems will enable us to easily accommodate the needs of cross-site evaluators. We can assist with identifying and providing access to data sources and analysis results; helping to organize visits of evaluators; participating in interviews or focus groups; reviewing and providing input on cross site evaluation plans and report; collecting client level data; helping cross site evaluators arrange for direct data collection

**Data collection: NOMS and Individual Consumer Recovery:** Vermont will use ServicePoint, a web-based data-collection program, to collect and report information specific to the Adult

NOMS and individual consumer recovery (i.e., IMR Consumer Outcome Survey). As a Housing and Urban Development (HUD) Homeless Management Information (HMIS) Grantee for 8 years, Vermont has already been using ServicePoint at its homeless shelters, CMHC's and Community Action Programs to report Projects for Assistance in Transition from Homelessness (PATH) data to SAMHSA and project performance to HUD. ServicePoint is already configured to report on the HUD program and PATH reporting requirements. We will include the Adult NOMS for the purposes of monitoring, tracking and evaluating performance of this grant. Another Way, the host organization for our first demonstration site in Montpelier, is a PATH provider and already uses ServicePoint to collect required data. The infrastructure and capacity for data collection already exists. As the host organizations are chosen for the Burlington and the two other rural demonstration components, it is very likely they will already be using ServicePoint for data collection. In the unlikely event that the program is not using ServicePoint, grant funds will be used to purchase a license, training and support for the use of ServicePoint. ServicePoint, which is utilized by the Balance of State Continuum of Care, is easily modified for use at specific programs. During the first six months of the grant, DMH will work with Data Remedies, the IT administrator, to add the IMR Consumer Outcome Survey for the collection of individual consumer recovery. NOMS and the IMR Consumer Outcome Survey data will be collected by Peer Specialists within three days of consumer enrollment in the program and entered into the TRAC database within the following seven business days. Follow-up data will be gathered for at least 80% of consumers at six month intervals while the consumer continues to receive services.

Infrastructure Changes: To assess progress on creating and sustaining infrastructure changes, we will collect the following data in these categories (as outlined by Appendix J in the RFA) using annual structured interviews with SIT and LIT members, as well as document reviews:

***Policy Development*** – Data on the number of new CMHC policies adopted to create a more welcoming service system at the local level for the target population. Data on the number of state level polices adopted to continue support on the target population as a priority and for the Peer Specialist workforce and credentialing process

***Workforce Development*** – Data on the number of people trained as Peer Specialists and in IMR and Supported Employment and credentialed as Peer Specialists; and, the number of consumers who provide mental health related services as Certified Peer Specialists.

***Financing*** -- Data on the amount of funding for mental health related practices. For example, community-based crisis services, hospitals, and municipalities may contribute to the Peer Specialists as a means of reducing the demand on emergency and law enforcement services. Data on the number of changes to financing policies to fund grant services; specifically the use of Medicaid funds to support Peer Specialists. Data on the amount of pooled or braided funding with other agencies used for services supported through the grant; specifically the amount of funding Vocational Rehabilitation provided for Peer Specialists.

***Organizational Change*** -- Data on the number of organizational changes made to support improvement in mental health practices as a result of the grant. Specifically, these data will focus on the inclusion of consumers and other appropriate community members in both the LITs and SIT to better address the target population's needs.

***Accountability*** – Data on the number of organizations that regularly obtain, analyze and share data – that is, the degree to which the LITs and SIT share and discuss information provided in

the annual Performance Assessment (see below); the number of consumers representing consumer organizations involved in planning activities as members of the LITs and SIT; and, the number of consumers involved in evaluation through participation in annual review of the Performance Assessment/evaluation of the practices implemented through the grant.

***Types/Targets of Practices*** – Through annual structured interviews with LIT members and fidelity assessment (see below) we will gather data on the number of communities utilizing evidence based mental health related practices including Peer Specialists, IMR, and Supported Employment. In addition, the providers of these services will gather and report the number of people served by these evidence based practices.

***Fidelity:*** We will use the SAMSHA *Evidence Based Practice Kit on Evaluating Your Program* to gather fidelity data on IMR and SE. The evaluation team will conduct day-long site visits with each provider, view video-taped sessions, review samples of charts, examine handouts and other educational materials, and interview staff, consumers and family members. Using these sources of data, the evaluation team will complete the fidelity scales. Site visits and fidelity data collection will be conducted annually throughout the grant period. As noted in the project objectives, the evaluation team will work with the LITs and SIT to develop a fidelity scale for Peer Specialists, modeled on the SAMSHA kit during Year 1 of the project. Data to assess fidelity will be gathered annually through site visits to Peer Specialists, and the fidelity scale tested and revised over the course of the project.

***Data management:*** Data Remedies will manage NOMS and individual consumer recovery data entered into ServicePoint. The evaluators will manage all data gathered to assess infrastructure changes and fidelity assessments using electronic data bases and following strict procedures for confidentiality. Data Remedies and the evaluators will provide reports of data that DMH administrative staff will use to enter required NOMS and infrastructure data into TRAC..

***Data analysis:*** The evaluators will analyze quantitative and qualitative data to address each of the process and outcome questions. Content analysis will be used on qualitative data such as structured interviews. Descriptive and where appropriate, inferential statistics will be used to analyze quantitative data. Data Remedies will provide evaluators with needed quantitative data from NOMS and the individual consumer recovery instrument. In addition, once consumers have been entered into ServicePoint, DMH will also be able to run ad hoc reports on how the target population is interacting with the rest of the CMHC system for use by the evaluators in addressing process and outcome questions. As of 1992, all state-funded CMHC's submit electronic Service Reports to DMH on a person and encounter specific basis, using a state designed common format. The Research and Statistics Unit is able to gather, analyze and report on these data from community-based providers, the Vermont State Hospital, designated inpatient units, other Agency of Human Services programs, and other state, federal and private entities. We designed effective and efficient systems to integrate data across local and state levels and a variety of agencies. Cross-agency data analysis is facilitated by the use of Probabilistic Population Estimation, a statistical methodology providing unduplicated counts of the number of individuals served by multiple agencies, without reference to personally identifying information.

***Reporting:*** In addition to ongoing reports available through Data Remedies and DMH, the evaluators will produce annual Performance Assessment reports to summarize data relevant to

process and outcomes questions such as NOMS indicators, individual consumer recovery, fidelity scores, and infrastructure changes. These written reports will be shared with all LIT and SIT members; the evaluators will meet with each LIT and with the SIT to facilitate a discussion of findings, the meaning of the results, and implications for program changes and improvements. In addition, these discussions will be used to improve the methods for gathering process data.

**Individual Consumer Recovery Instrument:** The IMR Consumer Outcome Survey (see Attachment 6) was developed in collaboration with IMR practitioners and consumers. Consumers were involved in developing the IMR program itself, as well as developing and reviewing items in this tool designed to tap areas targeted by IMR using as few items as possible. The IMR Consumer Outcome Survey has been used in peer-run programs and settings. Studies thus far support the reliability and validity of the tool, both face validity and significant correlations with established measures (see *Measuring the Promise: A Compendium of Recovery Measures, Volume II*). Inclusion of this measure in the Compendium indicates it is consistent with the *2005 SAMHSA National Consensus Statement on Mental Health Recovery*. In addition, IMR and the Consumer Outcome Survey were piloted at two Vermont CMHC's in 2003. Representatives from Vermont Psychiatric Survivors, were involved in this review of IMR and provided valuable feedback on how best to implement the model and the evaluation tool. DMH has also consulted with two consumer organizations, Vermont Psychiatric Survivors and Another Way, on the selection of an individual recovery tool for this grant. In particular, Steven Morgan, director of Another Way, provided a great deal of feedback on how individual recovery tools can be used with members of the target population who attend his program. The evaluator will work with Mr. Morgan and other consumers to further refine the process for using the IMR Consumer Outcome Survey to collect the required information without overburdening or alienating consumers.

**Process to collect and enter consumer-level data using NOMS:** As discussed above, Peer Specialists will gather NOMS data when consumers enter services and every six months thereafter using ServicePoint.

**Use of Data for Project Management and Continuous Quality Improvement:** The evaluation team will provide the LITs and the SIT with annual Performance Assessment reports (see below). These reports will be used by the LITs and SIT to assess progress on the grant objectives, determine the degree to which evidence based practices are being implemented with fidelity and evaluate the achievement of intended outcomes. With facilitation from the evaluators, the LITs and SIT will then be able to use these data to examine possible mid-course changes to improve the delivery or services and success of systems transformation to best serve the young adult population. It is important to note that DMH has a strong track record in using data for continuous quality improvement. For example, since 1997 the DMH Performance Indicator Project (PIP) has identified and reported on key indicators of mental health program performance, including treatment outcomes, access to care, and services provided. The ongoing process includes weekly distribution of reports and periodic face-to-face meetings with stakeholders. PIP is designed to promote a culture that supports rational data-based thinking and decision-making among providers, consumers, and advocates in Vermont. Program staff, through their LIT representatives, will receive copies of all Performance Assessment reports, and will be invited to participate in discussions about how these results can be used for continuous quality

improvement. As members of both the LITs and SIT, consumers will be represented in these CQI discussions as well.

**Plan for Conducting Performance Assessment:** The evaluators have a long and successful track record conducting implementation and performance assessments, including recent work with on the DMH SAMHSA funded project to reduce the use of seclusion and restraint in in-patient psychiatric care. DMH has well-developed systems for collecting and managing data which will contribute significantly to a smooth process for conducting the assessment. The performance assessment is designed to rely on existing data bases where possible (including data managed by the Agency of Human Services that will be accessible for individual clients through DMH). In addition, the evaluation team will gather data through review of documents and structured interviews with consumers, family members, LIT and SIT members, and other key stakeholders. Once the SIT and first two community LITs have consumer and peer representatives on board, the evaluators will meet with these bodies to review the performance assessment method. This review will include refining assessment methods and sources of information, and explore how best to include LIT and SIT participation in gathering, reviewing and overseeing the assessment. As described above, the LITs and SIT will be review findings of the performance assessment as well as work with the evaluators to interpret and use results for project improvement.

**Outcome and Process Questions:** There are two outcome questions the evaluation will address, one at the individual consumer level: *Does access to peer-based evidence based practices (Peer Specialists, IMR and SE) lead to improved individual self-determination, efficacy and recovery?* and one at the statewide system level: *Will the proposed infrastructure changes (see above) result in a system of care that is welcoming and supportive of young adults with SMI age 18-34?* Data to assess individual outcome includes NOMS, the IMR Consumer Outcome Survey, and Department of Labor employment and wage data. Plans for these data collection, management and analyses have been described above. Data to assess the systems level question will include the number of Peer Specialists recruited, trained, credentialed and retained, as well as the number of consumers who engage with mental health outpatient and Community Rehabilitation Services. In addition, annual CMHC consumer satisfaction surveys will be revised to include an item assessing the degree to which those agencies and other mental health providers welcome young adults. The process questions include: 1) *To what degree were grant objectives achieved (based on specific measures of each objective as outlined in table)?* 2) *To what extent were evidence-based practices implemented with fidelity?* 3) *What were the challenges to implementing the grant objectives? How were the challenges addressed?* Data will be gathered through annual process evaluation structured interviews and document review, as well as surveys of LIT and SIT members. Service Point and CMHC data will also be used to track use of services. Training and orientation will be evaluated through surveys of participants. Finally, as described above, fidelity data will be gathered and analyzed using fidelity scales. These data will all be analyzed and reported in the annual Performance Assessment.

**Per-person unit cost:** It will cost approximately \$3,539 per person to provide outreach and early intervention to the 850 individuals who will receive services through this grant.

## SECTION F: LITERATURE CITATIONS

- <sup>1</sup> Substance Abuse and Mental Health Administration, *National Registry of Evidence Based Programs and Practices*, SAMHSA.GOV.
- <sup>2</sup> Vermont DMH (2006). Statistical Report; Pandini, J & Kobel, O. (2007) *Movement from Children's Services into Adult Services*.
- <sup>3</sup> Ibid.
- <sup>4</sup> US Census Bureau, 2007 Population Estimation. [quickfacts.census.gov](http://quickfacts.census.gov)
- <sup>5</sup> The Vermont Children's Forum. (2003). Children and Poverty in Vermont. You must have report somewhere for adults - strategic plan - that I can cite for this?
- <sup>6</sup> National Survey on Drug Abuse (2006). [OAS.SAMHSA.GOV/2k6State/Vermont.htm](http://OAS.SAMHSA.GOV/2k6State/Vermont.htm)
- <sup>7</sup> US Census Bureau, 2007 Population Estimation. [quickfacts.census.gov](http://quickfacts.census.gov)
- <sup>8</sup> IBID.
- <sup>9</sup> Vermont refugee Resettlement Program, [vermont.gov](http://vermont.gov)
- <sup>10</sup> US Census Bureau, 2007 Population Estimation. [quickfacts.census.gov](http://quickfacts.census.gov)
- <sup>11</sup> Kievit-Kylar, R. & Porter, A. (2007) Career Start Connections, p. 5.
- <sup>12</sup> US Census Bureau, 2000. [.census.gov](http://.census.gov)
- <sup>13</sup> Vermont Children's Forum. (2003). *Children and Poverty in Vermont*, p 3,6, 11,
- <sup>14</sup> Voices for Vermont's Children (2007). *Homeless in Vermont: Children, Youth and Families*.
- <sup>15</sup> IBID.
- <sup>16</sup> DMH FY 2009 Statistical Report, [mentalhealth.vermont.gov](http://mentalhealth.vermont.gov)
- <sup>17</sup> IBID.
- <sup>18</sup> [http://mentalhealth.vermont.gov/sites/dmh/files/data/annualstat/2009/DMH-2009\\_Statistical\\_Report.pdf](http://mentalhealth.vermont.gov/sites/dmh/files/data/annualstat/2009/DMH-2009_Statistical_Report.pdf)
- <sup>19</sup> Kummings, K. (2010). NAMI-VT Letter of Support (see Attachment 4 )
- <sup>20</sup> <http://mentalhealth.vermont.gov/report#adult>
- <sup>21</sup> IBID.
- <sup>22</sup> New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*. DHHS Pub. No. SMA-03-3831. Rockville, MD.
- <sup>23</sup> John A. Pandiani, Ph.D., Steven M. Banks, Ph.D., Barbara B. Carroll, Ed.D. and Max R. Schlueter, Ph.D., *Crime Victims and Criminal Offenders Among Adults With Serious Mental Illness*. Psychiatryonline. 58:1483-1485, November 2007
- <sup>24</sup> [mentalhealth.vermont.gov](http://mentalhealth.vermont.gov)
- <sup>25</sup> Davis, M & Stoep, A.V (1996) *Transition to Adulthood for Adolescents who Have Serious Emotional Disturbance*, p ii..
- <sup>26</sup> Bellas, M.L. (2004) Disproportionate Minority Confinement at Woodside Detention Program. [human.services.vermont.gov/disproportionate minority confinement](http://human.services.vermont.gov/disproportionate%20minority%20confinement)
- <sup>27</sup> IBID, p51.
- <sup>28</sup> NIMH, *Numbers Count: Mental Disorders in America*, [nimh.nih.gov](http://nimh.nih.gov)
- <sup>29</sup> New Freedom Commission, 21.
- <sup>30</sup> Srihari, V, et al (2009) *Early Intervention for Psychotic Disorders in a Community Mental Health Center*. [psychiatryonline.org](http://psychiatryonline.org).
- <sup>31</sup> [gao.gov/new.items/d08678](http://gao.gov/new.items/d08678)
- <sup>32</sup> New Freedom Commission, 41.

---

<sup>33</sup> IBID, p 51.

<sup>34</sup> [mentalhealth.vermont.gov](http://mentalhealth.vermont.gov)

<sup>35</sup> United States Government Accountability Office. (2008). *Young Adults with Serious Mental Illness*. <http://www.gao.gov/new.items/d08678.pdf>

<sup>36</sup> <http://mentalhealth.vermont.gov/>

<sup>37</sup> Personal Communication, Steven Morgan, March 19<sup>th</sup>, 2010.

<sup>38</sup> Personal Communication, Burlington LIT, April 15<sup>th</sup>, 2010

<sup>39</sup> [nrepp.samhsa.gov](http://nrepp.samhsa.gov)

<sup>40</sup> Mueser, Kim T, et al, *Illness Management and Recovery: Review of the Research*. psychiatryonline. Vol. 53 No 10

<sup>41</sup> IBID.

<sup>42</sup> Mueser, Kim T., 2002.

<sup>43</sup> New Freedom Commission, p 51.

<sup>44</sup> D.R. Becker & R.E. Drake, "Individual Placement and Support: A Community Mental Health Center Approach to Vocational Rehabilitation," *Community Mental Health Journal* 30: 1994 (193-205); K.T. Mueser, M.P. Salyers, and P.R. Mueser, "A Prospective Analysis of Work in Schizophrenia," *Schizophrenia Bulletin* 27(2): 2001 (281-96); M. McQuilken et alia, "The Work Project Survey: Consumer Perspectives on Work," *Journal of Vocational Rehabilitation* 18: 1994 (59-68); John Pandiani and Barbara Carroll (2008), "Employment of CRT Clients Through June 2007," Vermont Performance Indicator Project. <http://healthvermont.gov/mh/docs/pips/2006/Pip101306.pdf>.

<sup>45</sup> Mueser, Kim T., 2002.

<sup>46</sup> IBID.

<sup>47</sup> Deby Dihoff, Chair, NAMI, NC. (August, 2009) *Peer Support /Recovery Task Force Report*.

<sup>48</sup> IBID.



**Section G: Budget/Budget Justification/Calculation of Future Budgets**

**Year One Budget**

<b><u>Personnel</u></b>				
<u>Job Title</u>	<u>Name</u>	<u>Annual Salary</u>	<u>Level of Effort (FTE)</u>	<u>Salary Requested</u>
Project Director	TBA	\$ 47,000.00	1.0	\$ 47,000.00
<b>Total Personnel</b>				<b>\$ 47,000.00</b>
Fringe Benefits (30%)				\$ 14,100.00
<b>Total Fringe</b>				<b>\$ 14,100.00</b>
<b><u>Travel</u></b>				
2 Trips for SAMHSA for 3 attendees (grantee meeting and consumer				
Airfare (\$600/person x 3 people x 2 trips/year)				\$ 3,600.00
Lodging (\$200/person x 3 people x 3 nights X 2 trips/year)				\$ 3,600.00
Per Diem - Meals (\$75/day X 3 attendees X 3 days X 2 trips/year)				\$ 1,350.00
Expenses + Travel @ \$.50/mile for Project Director				\$ 3,000.00
<b>Total Travel</b>				<b>\$ 11,550.00</b>
<b><u>Equipment</u></b>				
<b>Total Equipment</b>				<b>\$ -</b>
<b><u>Supplies</u></b>				
Production of Training/Educational Materials				\$ 4,000.00
<b>Total Supplies</b>				<b>\$ 4,000.00</b>
<b><u>Contractual</u></b>				
<b>Grant award to Another Way for local implementation of Peer S</b>				
2.5 Staff @ \$35,000 X (50 % of one position will be funded in kind				\$ 70,000.00
Fringe				\$ 21,000.00
Travel, expenses (mileage @ \$.50/mile)				\$ 2,000.00
Meeting Expenses for LIT (consumer stipends, mileage @ \$.5/mile)				\$ 2,000.00
Administration (14%)				\$ 13,300.00
Subtotal - Another Way				\$ 108,300.00

<b>Grant award to Burlington Provider (TBA) for local implementation of peer specialists</b>				
4.5 FTE Staff @ \$35,000 (50 % of two positions will be funded in kir			\$	122,500.00
Fringe			\$	36,750.00
Travel, expenses (mileage @ \$.50/mile)			\$	2,000.00
Meeting Expenses for LIT (consumer stipends, mileage @ \$.5/mile)			\$	2,000.00
Administration (14%)			\$	22,855.00
Subtotal - Burlington Provider			\$	186,105.00
<b>Grant award to Rural Provider 1 (TBA) for local implementation of peer specialists</b>				
2.0 FTE Staff @ \$35,000 (50 % of one position will be funded in kir			\$	52,500.00
Fringe			\$	15,750.00
Travel, expenses (mileage @ \$.50/mile)			\$	2,000.00
Meeting Expenses for LIT (consumer stipends, mileage @ \$.5/mile)			\$	2,000.00
Administration (14%)			\$	10,115.00
Subtotal - Rural Provider 1			\$	82,365.00
<b>Grant award to Rural Provider 2 (TBA) for local implementation of peer specialists</b>				
2.0 FTE Staff @ \$35,000 (50 % of one position will be funded in kir			\$	52,500.00
Fringe			\$	15,750.00
Travel, expenses (mileage @ \$.50/mile)			\$	2,000.00
Meeting Expenses for LIT (consumer stipends, mileage @ \$.5/mile)			\$	2,000.00
Administration (14%)			\$	10,115.00
Subtotal - Rural Provider 2			\$	82,365.00
<b>IMR and SE Training - Dartmouth Psychiatric Research Center</b>				
9 days @ \$2000/day			\$	18,000.00
Expenses + Travel @ \$.50/mile			\$	2,000.00
Subtotal - Dartmouth PRC			\$	20,000.00
<b>Peer Specialist Training - Margaret Swarbick</b>				
10 days @ \$900/day			\$	9,000.00
Expenses + Travel @ \$.50/mile			\$	3,000.00
Subtotal - Margaret Swarbick			\$	12,000.00
<b>Evaluation - Flint Springs Consulting</b>				
.5 FTE X \$75,000 X 2 staff (Joy Livingston and Donna Reback)			\$	75,000.00
Expenses + Travel @ \$.50/mile			\$	6,000.00
Interview Incentives for Consumer Participation in Evaluation:			\$	2,000.00
(\$20/interview X 50 consumers X 2 interviews)				
Subtotal - Evaluation			\$	83,000.00

<b>Cultural and Linguistic Competence Coordinator - Maria Avila</b>					
.05 FTE X \$41,600				\$	2,080.00
Expenses + Travel @ \$.50/mile				\$	300.00
Subtotal - Maria Avila				\$	2,380.00
Subgrant to Data Remedies for ServicePoint Licensing and adaptatio				\$	2,000.00
Incentive Planning Grants to CMHC's: \$10,000 X 4 CMHC's				\$	40,000.00
<b>Contractual Subtotal</b>					<b>\$ 618,515.00</b>
<b>Other</b>					
Instate Meeting/Training Expenses for training and SIT meetings/ev				\$	22,500.00
( 15 meetings X \$1500/meeting)					
Stipends/Mileage for Consumer/Family Participation at SIT				\$	3,200.00
(\$100/meeting X 8 meetings X 4 consumer/family members)					
<b>Other Subtotal</b>					<b>\$ 25,700.00</b>
<b>TOTALS - Direct</b>					<b>\$ 720,865.00</b>
<b>Indirect</b>					<b>\$ 28,834.60</b>
<b>TOTAL</b>					<b>\$ 749,699.60</b>

**Percentage/Amount spent on Services, Infrastructure, Evaluation and Administration**

Category	Amount	Percentage of Total Funds
Direct Service	\$ 506,135.00	67.51%
Infrastructure	\$ 87,914.60	11.73%
Evaluation	\$ 83,000.00	11.07%
Grants Management	\$ 72,650.00	9.69%
Total	\$ 749,699.60	100.00%

## BUDGET JUSTIFICATION

### PERSONNEL

**Trish Singer, MD, Principal Investigator (.1 FTE - inkind):** Dr. Singer will oversee the grant. Dr. Singer is the DMH Director of Adult Mental Health Services and has extensive experience working with SAMHSA on the implementation of evidence-based practices and integrated dual disorder treatment. While working at the Dartmouth Psychiatric Research Center, she oversaw the development of the SAMHSA Evidence-based Practices Toolkit's, and she has been the project director for both the New Mexico and Vermont Co-Occurring State Incentive Grant funded by SAMHSA.

**Project Director (1 FTE - to be hired):** The Project Director will oversee all grant activities and ensure coordination between the 4 demonstration sites. Qualifications will include: 1) minimum of 5 years experience in SAMHSA grant management, system development, and implementing evidence based practices statewide, 2) masters degree in behavioral health services, 3) experience in public mental health administration. The Project Director will report to Dr. Singer. DMH will actively seek to recruit a consumer for this position.

### FRINGE BENEFITS

The actual cost of fringe benefits (not a fringe benefit rate) will be reported as a direct cost of the program. The actual cost of fringe benefits varies from employee to employee based on salary, employee choice of health care plan, and employee election of certain other benefits. The usual, major components of this cost are FICA at 7.65% of salary, retirement at 9% of salary, and a portion – 80% for medical, 75% for life and 100% for dental - of the actual costs of the medical, dental and life insurance coverage selected by the employee. The cost of each employee's fringe benefits will be allocated to the program based on hours worked in the program relative to all hours worked by the employee. Based on the current cost of fringe benefits for employees in similar programs, we are estimating the cost of these fringe benefits at 30% of salary.

### TRAVEL

**SAMHSA Grantee Meetings:** SAMHSA Funds will be used to cover the costs of three grant participants to attend yearly SAMHSA grantee meetings and three consumer representatives to attend a yearly SAMHSA leadership forum.

**Expenses and Travel for Project Director:** Fund will be used to cover the cost of instate travel (e.g. mileage @ \$.50/mile) and related expenses.

### EQUIPMENT

### SUPPLIES

Funds will be used to create, purchase and duplicate training and educational materials (e.g. treatment manuals, DVD's) re: evidence-based practices

## **CONTRACTUAL COSTS**

**Grant award to Another Way for local implementation of Peer Specialists:** Funds will be sub-granted to Another Way for the hiring of 2.5 FTE Peer Specialists. Peer Specialists will provide individualized, recovery focused service based on a relationship of mutuality that allows consumers to learn to manage their own recovery and advocacy process. Peer Specialists provide outreach in community settings, engage consumers, and offer supportive services including self help, advocacy, skill building and sharing information, and assisting each consumer identify personal goals and interventions utilizing the IMR framework. Peer Specialists will also provide Supported Employment and will receive general and clinical supervision from a qualified professional identified by the Local Interagency Team (LIT). 50% of one position will be funded in-kind by the Vermont Division of Vocational Rehabilitation. Funds will also cover the cost of fringe benefits for the peer specialists, travel expenses (@ \$.50/mile), meeting expenses for the LIT, and administration of the sub-grant.

**Grant award to Burlington Provider (TBA) for local implementation of Peer Specialists:** Funds will be sub-granted to a local Burlington Provider for the hiring of 4.5 FTE Peer Specialists. The provider will be chosen by the Burlington LIT during the first six months of the grant. Peer Specialists will provide individualized, recovery focused service based on a relationship of mutuality that allows consumers to learn to manage their own recovery and advocacy process. Peer Specialists provide outreach in community settings, engage consumers, and offer supportive services including self help, advocacy, skill building and sharing information, and assisting each consumer identify personal goals and interventions utilizing the IMR framework. Peer Specialists will also provide Supported Employment and will receive general and clinical supervision from a qualified professional identified by the Local Interagency Team (LIT). 50% of two positions will be funded in-kind by the Vermont Division of Vocational Rehabilitation. Funds will also cover the cost of fringe benefits for the peer specialists, travel expenses (@ \$.50/mile), meeting expenses for the LIT, and administration of the sub-grant.

**Grant award to 2 Rural Providers for implementation of Peer Specialists:** Funds will be sub-granted to 2 rural providers for the hiring of 2.0 FTE Peer Specialists in each rural setting. The rural providers will be chosen by DMH using an RFP during the second year. Peer Specialists will provide individualized, recovery focused service based on a relationship of mutuality that allows consumers to learn to manage their own recovery and advocacy process. Peer Specialists provide outreach in community settings, engage consumers, and offer supportive services including self help, advocacy, skill building and sharing information, and assisting each consumer identify personal goals and interventions utilizing the IMR framework. Peer Specialists will also provide Supported Employment and will receive general and clinical supervision from a qualified professional identified by the Local Interagency Team (LIT). 50% of one position will be funded in-kind by the Vermont Division of Vocational Rehabilitation. Funds will also cover the cost of fringe benefits for the peer specialists, travel expenses (@ \$.50/mile), meeting expenses for the LIT, and administration of the sub-grant.

**New Hampshire Dartmouth Psychiatric Research Center (PRC):** The PRC will provide training (via contract) to Peer Specialists, clinicians, and service providers in each of the four communities on evidence based practices. The PRC has trainers certified in IMR and Supported Employment and provides training and coaching to peers and professionals in 17 states. PRC will provide 3 days of training and ongoing coaching in IMR and 3 days of training and coaching on Supported employment to each of the four demonstration communities.

**Margaret Swarbrick, PhD.:** Dr. Swarbrick will provide training and coaching (via contract) to each of the four demonstration communities on the development of Peer Specialists and peer-based IMR and SE. Dr. Swarbrick is a part time assistant faculty in the department of Psychiatric Rehabilitation a Counseling Professions at UMDNJ - School of Health Related Professions and the Institute for Wellness and Recovery Initiatives Training Director for Collaborative Support Programs of New Jersey, a large peer-operated self-help organization. Dr. Swarbrick has presented and published on the topics of peer delivered services, wellness, recovery and employment.

**Evaluator – Flint Springs Associates (FSA):** FSA will oversee and implement the evaluation for the grant. Funds will be used for staff time, mileage/expenses (@ \$.50/mile), and interview incentives for consumer participation in evaluation activities (\$20/interview X 50 consumers X 2 interviews). Flint Springs Associates has extensive experience in evaluating SAMHSA grants within the state of Vermont. Its principal partners, Joy Livingston, Ph.D. and Donna Reback, MSW, LICSW, are trained social science researchers with considerable experience designing, conducting and managing evaluation research. FSA has held numerous contracts over the past 15 years with Vermont Agency of Human Services Departments, including Mental Health, Health, Disabilities, Aging and Independent Living, and Corrections. FSA is currently the evaluator for Vermont’s *Alternatives to Seclusion and Restraint* SAMHSA grant.

**The Cultural and Linguistic Competence Coordinator (.05 FTE - Maria Mercedes Avila)** will provide leadership in the implementation, and monitoring of the cultural and linguistic competence in all transformation activities. Ms. Avila provides training, coaching and support to DMH and participating communities in the implementation of a SAMHSA System of Care grant for Youth in Transition. Ms. Avila is bi-lingual.

**Incentive Planning Grants:** Incentive Service Grants will be offered to the community mental health center (CMHC) operating in each of the four demonstration sites. Funds will be provided to CMHC for participation on the LIT and planning to incorporate lessons learned from local implementation into CMHC practice. CMHC’s receiving planning grants will be expected to modify their policies and practices to better serve the target population. Grant awards will be made to Washington County Mental Health, the HowardCenter, and the CMHC’s operating in the two rural demonstration sites (TBA). An estimate of how the \$10,000 award to each agency will be spent by that agency is as follows:

Staff Participation in LIT and development of grant implementation activities (\$65/hour X 150 hours):	\$ 9750
Mileage for travel to grant planning events (@ \$.50/mile):	\$ 250

**Sub grant to Data Remedies:** Funds will be used to pay for licenses for usage of ServicePoint and for the modification of ServicePoint by Data Remedies for grant data collection.

## **OTHER**

**Instate Meeting/Training Expense:** Funds will be used to cover the cost of planning meetings to support oversight and management of the grant initiative and training events focused on trauma-informed care. Funds will cover the cost of the meeting space and audio/visual equipment.

**Stipends/Mileage:** Stipends (\$50 per meeting) and reimbursement for mileage (up \$50 per meeting - @ \$.50/mile) will be provided to consumer and family members who participate in the grant planning and oversight meetings.

## **INDIRECT COST RATE**

The Vermont Department of Mental Health uses a Cost Allocation Plan, not an Indirect Rate. This Cost Allocation Plan was approved by the U.S. Department of Health and Human Services effective October 1, 1987 and is available at <http://humanservices.vermont.gov/departments/office-of-the-secretary/cost-allocation-plan>. The Cost Allocation Plan summarizes and allocates actual, allowable costs incurred in the operation of the program. These costs include items often shown as direct costs, such as telephone and general office supply expenses, as well as items usually included in an indirect rate, such as the cost of office space and administrative salaries. These costs are allocated to the program based on the subgrants paid in the program relative to the total subgrants paid in the department overall. Because these are actual costs, unlike an Indirect Cost Rate, these costs will vary from quarter to quarter and cannot be fixed as a percentage of program costs.

## **EXISTING SUPPORT**

Every CMHC has an existing infrastructure of clinical, supervisory and support staff, building facilities, administration, Medicaid billing, IT hardware and support, etc. Other existing resources that will be mobilized for this project include the availability of the State web- and phone- conferencing systems. These technologies will be used for the distance learning activities to provide trainings, consultations and meetings with all regions of the state without unduly impacting the limited resources at the local level. (reducing staff travel time and costs). The DMH website will host a page on the grant initiative. Additionally, Listservs supported by DMH will be established to connect all participating individuals and agencies for discussions on implementation efforts, upcoming events and trainings, and other important information.

## Section H: Biographic Sketches and Job Descriptions

### *Job Description - Project Director* (to be hired)

#### Duties and Responsibilities include:

- will oversee all grant activities and ensure coordination between the 4 demonstration sites.
- Collaborate with the Adult State Interagency Team (SIT) to develop and implement state-level grant activities
- In partnership with the local Adult Local Interagency Teams (LITs) and the Certified Peer Specialist program, oversee and support development of local planning, implementation and service delivery, evaluation and adaptation of service model in the demonstration sites
- Coordinate technical assistance support for the SIT and LITs to enhance their capability to address grant activities
- Coordinate and develop the Certified Peer Specialist Program with relevant stakeholders, including recruitment, training, certification, job placement and support
- Ongoing interaction and coordination with other state agencies, federal officials, peer and family advocacy organizations, and other community service providers in support of grant activities
- Organize training of non-peer service providers, coordinating/combining with peer specialist training whenever possible
- Coordinate use of data for program evaluation and management purposes.
- Negotiate and administer contracts and grant agreements as needed
- Oversee allocation of grant budget
- Complete timely grant reporting in consultation with the grant evaluator
- Submit quarterly and annual progress reports to SAMHSA
- Develop plan to sustain services with state funding after cessation of the grant

#### Qualifications

Education: Master's degree in behavioral health services or equivalent

Experience: Experience in SAMHSA grant management, system development, and implementing evidence based practices statewide

At least 5 years experience in public mental health administration.

The Project Director will report to Dr. Singer.

DMH will actively seek to recruit a consumer for this position

#### Amount of Travel

Travel required for all trainings, meetings, and consultation and training for future sites.



### ***Job Description - Certified Peer Specialists***

Under supervision, the Certified Peer Specialist serves as an advocate for effective recovery-oriented services; assists consumers to access services that support the individual's recovery, and provide peer support services. The Certified Peer Specialist performs a wide range of tasks to assist consumers in regaining control over their own lives and over their own recovery process, i.e. in diminishing disability and enhancing mental wellbeing.

#### **Duties and responsibilities include:**

- role model competency in recovery, e.g. coping and other self-help strategies
- outreach in community settings to engage consumers and facilitate access to needed services, e.g. housing, employment, medical services
- build a relationship of empathic mutuality
- assist individuals in articulating personal goals, and identifying steps to achieve those goals
- provide individualized, recovery focused service that facilitates the individual's achievement of personal goals and management of their own lives
- support the vocational and educational choices consumers make and assist them in building skills to enhance job acquisition and tenure, using skills from Supported Employment model
- understanding of skills and knowledge from Certified Peer Specialist training, including IMR, to best serve the individual consumer
- continue to develop and maintain skills and knowledge through regular clinical supervision and educational activities
- participate in multi-disciplinary teams meetings to address needs and coordinate services for individual consumers

#### **Minimum Qualifications:**

Certified Peer Specialists self identify as consumers with life experience of serious mental illness, and are well grounded in their own recovery.

Certified Peer Specialists will receive clinical supervision from a qualified professional identified by the LIT.

***Education:*** Certification as Peer Specialist.

**Patricia W. Singer**  
Department of Mental Health  
103 South Main Street, Wasson Hall  
Waterbury, Vermont  
[patricia.singer@ahs.state.vt.us](mailto:patricia.singer@ahs.state.vt.us)

## Education

Dartmouth College: AB 1979, high distinction in psychology major.  
Dartmouth Medical School: MD 1992.  
Pediatric internship: 1992-1993, Dartmouth-Hitchcock Medical Center (DHMC).  
Diagnostic Radiology residency: 1994-1997, DHMC.  
Psychiatry residency: 1997-2000, DHMC. Focus: public community psychiatry.  
Chief resident in psychiatry: 1999-2000.

## Work Experience

*September 2008 to present*

### **Director of adult mental health**

#### **Vermont Department of Mental Health, Waterbury, Vermont**

Management, coordination, planning, policy development and quality oversight involving administration and programmatic direction of community mental health services.

Management and oversight of Vermont's Co-Occurring Disorders State Incentive Grant (COSIG).

*November 2002 to September 2008*

### **Expert psychiatric consultant, acting medical director**

#### **New Mexico Department of Health, Division of Behavioral Health Services**

Provision of clinical expertise including

- Assertive Community Treatment
- leadership of Best Practices workgroup
- development of a treatment model for integrated services for youth with co-occurring substance use, mental health/ behavioral health problems (SED)
- development of state implementation model for transfer of knowledge to programs regarding evidence-based practices
- recommendations to improve re-entry services for individuals with COD leaving prison
- review of medication formulary and guidelines
- participation in State Behavioral Health Mortality Reviews
- liaison to University of New Mexico's Public Psychiatry Program
- consultation for 3 SAMHSA grants: ATR, SBIRT, COSIG.

Principle writer of New Mexico's successful proposal for Co-Occurring Disorders State Incentive Grant (COSIG).

Co-leader of New Mexico's Co-Occurring Disorders (COD) Policy Academy.

Trainer, topics included

- Integrated service model for adults with co-occurring mental health and substance use conditions and youth with severe emotional disturbance (SED)
- Stage wise treatment interventions
- Motivational interviewing
- Collaborative treatment team formation
- Community re-entry for prisoners/inmates with co-occurring disorders
- Trauma informed systems of care
- State level strategies for implementation of evidence-based practices
- Peer and family partnerships at all levels of systems of care

*2006 - 2008*

**Member**

**Pharmacy and Therapeutics Committee, ValueOptions New Mexico**

(ValueOptions was the administrative service organization for all out-patient public behavioral health services in New Mexico)

Committee work focused on using the formulary to improve quality of care, as well as maximizing consumer coverage in a system of limited resources.

*July 2005 - June 2006*

**Consultant to Assertive Community Treatment team**

**City of Albuquerque's Department of Family & Community Services**

Training support, including implementation of the evidence-based practice of Medication Management (SAMHSA's MedMAP toolkit).

*June 2000 - August 2002*

**Project manager, SAMHSA's Implementing Evidence-Based Practices Project**

**New Hampshire-Dartmouth Psychiatric Research Center**

**Lebanon, New Hampshire**

Oversaw development of six evidence-based practices Implementation Resource Kits (toolkits) for SAMHSA:

- assertive community treatment
- family psychoeducation
- supported employment
- illness management and recovery
- medication management (anti-psychotics for people with schizophrenia)
- integrated dual disorders (mental health and substance use) treatment.

Appointment: Research Associate in Psychiatry and Community and Family Medicine at Dartmouth Medical School.

**Publications**

Mueser KT, Torrey WC, Lynde D, Singer P & Drake RE: Implementing evidence-based practices for people with severe mental illness. *Behavior Modification*, 2002.

Contributor and editor of Implementation Resource Kit materials for the Implementing Evidence-Based Practices Project (SAMHSA), 2000-2002

Editor and writer: Evidence-Based Practices Project newsletter 2001-2002

**JOY ANNE LIVINGSTON**  
402 Fletcher Farm Rd.  
Hinesburg, VT 05461  
(802) 482-5100  
[joy@madriver.com](mailto:joy@madriver.com)  
[www.flintspringsassociates.com](http://www.flintspringsassociates.com)

### **Education**

B.A., Magna Cum Laude, Psychology, University of California, Los Angeles, 1975  
M.A. Psychology, Department of Psychology, University of Vermont, 1979  
Ph.D., Psychology, Department of Psychology, University of Vermont, 1982

### **Professional Experience**

1992 to present: Senior Partner, Flint Springs Associates, Vermont

Conduct research, facilitate strategic planning and manage projects. Specialize in program evaluation and system assessment to provide information for human services and education planning and policy decision making.

1988 to 1992: Director of Evaluation Studies, Center for Community Change through Housing and Support. University of Vermont, Burlington, VT

1988 to 1992: Assistant Research Professor, Department of Psychology, University of Vermont, Burlington, VT

1983 – 1987: Assistant Academic Director, Burlington College, Burlington, VT

### **Experience in program evaluation**

Role: design research plan, create data collection tools (e.g., survey instruments, structured interviews), collect and/or supervise collection of data, analyze data, and write summary reports for wide range of evaluation projects. Recent examples include:

- Central Vermont Community Action Council: *Program Evaluation and Impact Analysis* (February 2010 to present) Work with five Vermont community action agencies which manage three economic development programs (i.e., Micro Business Development Program (MBDP), Vermont Individual Development Account (IDA) Program, and the Vermont Women's Business Center (VWBC) Program) to improve internal capacity for outcome evaluation and performance measurement.
- Vermont Department of Mental Health: *Evaluation of Substance Abuse and Mental Health Services Administration (SAMHSA) Alternatives to Seclusion/Restraint Initiative* (December 2008 to present). Design and conduct qualitative evaluation of this SAMHSA funded project to reduce the use of seclusion and restraint at two psychiatric in-patient hospitals.
- Vermont Behavioral Health Network: *Health Resources and Services Administration (HRSA) Rural Health Network Development Grant Evaluation* (October 2008 to present) Design and implement process and performance evaluation for this HRSA funded planning project for BHN, a statewide network of Community Mental Health Centers.
- National Science Foundation (NSF) Experimental Program to Stimulate Competitive Research (EPSCoR), University of Vermont: *EPSCoR Evaluation* (January 2008 to present). Provide evaluation services to this NSF funded interdisciplinary program designed to improve Vermont's research competitiveness and resources for academic and private sector science and technology.

- Howard Center for Community Services: *Community Outreach Team Evaluation*, (2003 to present). Conduct annual evaluation of the community mental health outreach program to address the needs of individuals with mental illness not engaged in services.
- Vermont Department of Mental Health: *Annual Act 114 Assessment* (October 2002 to present). Conduct annual legislatively required assessment of Act 114 (involuntary psychiatric medication legislation) implementation through structured interviews of administrators, psychiatric hospital staff, and psychiatric patients and documentation review.
- Vermont Department of Disabilities, Aging and Independent Living: *Aging and Disabilities Resource Center (ADRC) Evaluation* (March 2007 to May 2009) Develop evaluation design, refine or develop data collection tools, supervise data collection, analyze data and complete written reports for three year grant designed to streamline access to services for older adults and persons with physical and developmental disabilities.
- Vermont Department of Disabilities, Aging and Independent Living: *Summative Evaluation of the MyCare Vermont Project to Integrate Medicaid and Medicare Funding Long-Term Care Services* (August 2008 to October 2008). Evaluated this three year CMS funded project to integrate Medicaid and Medicare funding along with medical, social and long term care services for frail elders and adults with disabilities. Evaluation methods included structured individual and group interviews with key stakeholders along with content analysis of extensive project documentation.
- Vermont Department of Disabilities, Aging and Independent Living: *Evaluation of the Senior Center Earmark Project* (October 2005 to April 2007). Developed outcome indicators and measures for the Senior Center Earmark Grant which provided funds to senior centers and meal sites to improve programming; training materials and a training curriculum to help grantees collect and compile data; and, analyzed data across 15 grantee sites.
- United Way of Vermont: *Statewide Information, Referral and Assistance (I,R&A) Coordinating Council* (February 2006 to June 2008): Convened and facilitated the work of a Statewide Coordinating Council made up of more than 25 human service agencies that provide I,R&A; educated agencies on I,R&A best practices through use of a self-assessment instrument; developed foundations for creating an I,R&A system statewide.
- Real Change Systems Change Project, Department of Disabilities, Aging and Independent Living: *Assessment of Information and Assistance Systems for Elders, Persons with Physical, Developmental and Psychiatric Disabilities*. (April 2003 to October 2005). Worked with a Task Force of consumers, advocates and providers to identify criteria for assessment, conduct systems assessment, and develop recommendations for systems change in delivery of information and assistance to elders, persons with physical, developmental, and psychiatric disabilities.
- HIV/AIDS Services Advisory Council (HASAC), Vermont Department of Health: *Assessing Barriers to HIV/AIDS Prevention and Care for Vermonters of Color* (September 2003 to January 2005). Developed assessment methods, supervise data collection, and analyze data in this study. Methods include survey of persons incarcerated in Vermont correctional facilities, focus groups with communities of color, and structured interviews with care providers.
- Division of Vocational Rehabilitation, Department of Aging and Disabilities: *Traumatic Brain Injury (TBI) Needs Assessment and Service Planning* (June 2002 to November 2003). Working with statewide TBI Advisory Board, including TBI survivors, family members, advocates, service providers and policy makers. designed and conducted a statewide assessment of TBI needs and resources.

## **DONNA J. REBACK**

741 Old County Rd.

Stowe, VT 05672

(802) 253-9618

[dreback@stowevt.net](mailto:dreback@stowevt.net)

[www.flintspringsassociates.com](http://www.flintspringsassociates.com)

### **Education and Credentials**

Licensed Independent Clinical Social Worker (LICSW), State of Vermont, 1996 - present

Licensed Independent Clinical Social Worker (LICSW), State of Massachusetts, 1986 - 1996

Doctoral Program, Florence Heller Graduate School of Social Welfare Policy, ABD

Brandeis University, 1984 - 1992

Masters of Social Work (MSW), Adelphi University, 1981

Vermont Teaching Certificate, University of Vermont, 1972

B.A., American Civilization, Lake Forest College, 1970

### **Professional Experience**

2001 – present: Senior Partner, Flint Springs Associates - Conduct research (research design, data collection and analysis), facilitate strategic planning and manage projects. Specialize in program evaluation and system assessment to provide information for human services, criminal justice and public health planning and policy decision making.

1990 – present: Social Policy and Research Consultant – Technical assistance provider under contracts to Edna McConnell Clark and JEHT Foundations, U.S. Department of Justice agencies, state and county governments, and not-for profit organizations. Manage multi-year criminal and juvenile justice policy development initiatives, lead strategic planning, design and oversee evaluation research, design and conduct qualitative system assessment research.

1986 – 1989: Associate Director, National Institute for Sentencing Alternatives, Brandeis University, Waltham, MA. - Conduct research (research design, data collection and analysis), facilitate strategic planning and manage criminal justice policy reform projects funded by U.S. Department of Justice agencies and Edna McConnell Clark Foundation.

1984-1986: Research Associate, National Institute for Sentencing Alternatives, Brandeis University, Waltham, MA. - Conduct research (research design, data collection and analysis).

### **Experience in program evaluation**

Role: design research plan, create data collection tools (e.g., survey instruments, structured interviews), collect and/or supervise collection of data, analyze data, and write summary reports for wide range of evaluation projects. Recent examples include:

- Central Vermont Community Action Council: *Program Evaluation and Impact Analysis* (February 2010 to present) Work with five Vermont community action agencies which manage three economic development programs (i.e., Micro Business Development Program (MBDP), Vermont Individual Development Account (IDA) Program, and the Vermont Women's Business Center (VWBC) Program) to improve internal capacity for outcome evaluation and performance measurement.
- Vermont Department of Mental Health: *Evaluation of Substance Abuse and Mental Health Services Administration (SAMHSA) Alternatives to Seclusion/Restraint Initiative* (December 2008 to present). Design and conduct qualitative evaluation of this SAMHSA funded project to reduce the use of seclusion and restraint at two psychiatric in-patient hospitals.
- Vermont Department of Mental Health: *Annual Act 114 Assessment* (October 2002 to present). Conduct annual legislatively required assessment of Act 114 (involuntary

- psychiatric medication legislation) implementation through structured interviews of administrators, psychiatric hospital staff, and psychiatric patients and documentation review.
- Vermont Department of Disabilities, Aging and Independent Living: *Aging and Disabilities Resource Center (ADRC) Evaluation* (March 2007 to May 2009) Develop evaluation design, refine or develop data collection tools, supervise data collection, analyze data and complete written reports for three year grant designed to streamline access to services for older adults and persons with physical and developmental disabilities.
  - Vermont Department of Disabilities, Aging and Independent Living: *Summative Evaluation of the MyCare Vermont Project to Integrate Medicaid and Medicare Funding Long-Term Care Services* (August 2008 to October 2008). Evaluated this three year CMS funded project to integrate Medicaid and Medicare funding along with medical, social and long term care services for frail elders and adults with disabilities. Evaluation methods included structured individual and group interviews with key stakeholders along with content analysis of extensive project documentation.
  - Community of Vermont Elders (COVE): *Evaluation of Gold Star Nursing Home Employer Program* (September 2006 to January 2007) Conduct qualitative evaluation of the Gold Star program to improve recruitment and retention of direct care workers. Project included site visits to 15 nursing homes throughout Vermont, collection of retention data, and summary report of findings.
  - Vermont Department of Disabilities, Aging and Independent Living: *Evaluation of the Senior Center Earmark Project* (October 2005 to April 2007). Developed outcome indicators and measures for the Senior Center Earmark Grant which provided funds to senior centers and meal sites to improve programming; training materials and a training curriculum to help grantees collect and compile data; and, analyzed data across 15 grantee sites.
  - United Way of Vermont: *Statewide Information, Referral and Assistance (I,R&A) Coordinating Council* (February 2006 to June 2008): Convened and facilitated the work of a Statewide Coordinating Council made up of more than 25 human service agencies that provide I,R&A; educated agencies on I,R&A best practices through use of a self-assessment instrument; developed foundations for creating an I,R&A system statewide.
  - Real Change Systems Change Project, Department of Disabilities, Aging and Independent Living: *Assessment of Information and Assistance Systems for Elders, Persons with Physical, Developmental and Psychiatric Disabilities*. (April 2003 to October 2005). Worked with a Task Force of consumers, advocates and providers to identify criteria for assessment, conduct systems assessment, and develop recommendations for systems change in delivery of information and assistance to elders, persons with physical, developmental, and psychiatric disabilities.
  - HIV/AIDS Services Advisory Council (HASAC), Vermont Department of Health: *Assessing Barriers to HIV/AIDS Prevention and Care for Vermonters of Color* (September 2003 to January 2005). Developed assessment methods, supervise data collection, and analyze data in this study. Methods include survey of persons incarcerated in Vermont correctional facilities, focus groups with communities of color, and structured interviews with care providers.
  - Division of Vocational Rehabilitation, Department of Aging and Disabilities: *Traumatic Brain Injury (TBI) Needs Assessment and Service Planning* (June 2002 to November 2003). Working with statewide TBI Advisory Board, including TBI survivors, family members, advocates, service providers and policy makers. designed and conducted a statewide assessment of TBI needs and resources.

**STEVEN MORGAN**  
PO Box 1219 Barre, VT 05641  
stevenmorganjr@gmail.com  
404-376-4523

### **PROFESSIONAL EXPERIENCE**

**Executive Director**, March 2009 – Present, Another Way Inc, Montpelier VT

- Managed a non-profit organization that operates a daytime peer support center.
- Supervised staff members and oversaw the administration of state funds.
- Applied for and received several grants from various sources.
- Acted as landlord for two tenants.

**Housing Specialist (part-time)**, February 2010 – Present, Pathways to Housing, Montpelier VT

- Worked as part of a support team with homeless individuals to obtain and sustain housing.
- Helped establish program operations in Washington County.

**Recovery Educator (part-time)**, Fall 2009, Washington County Mental Health & VT State Hospital, Montpelier VT

- Facilitated weekly Recovery classes and peer support groups to clients and in-patients.

**Recovery Specialist**, 2006–2008, Peer Recovery Center at Health Care & Rehabilitation Services, Springfield VT

- Oversaw daily operations of a community center for adults diagnosed with major psychiatric disorders.
- Supported, advocated for, and assisted clients in their recovery process.
- Trained staff in mental health recovery principles at multiple agencies and hospitals across Vermont.
- Created and taught 8-month comprehensive wellness program; created and taught 9-month Peer Support and Recovery Training; facilitated two weekly recovery support groups.
- Coordinated with senior staff to integrate principles of mental health recovery model into services.
- Managed client computer program and supervised computer teachers.

**Support Group Facilitator**, 2007–2008, Brattleboro Retreat Healthcare, Brattleboro VT

- Facilitated weekly Wellness Recovery Action Plan classes and peer support groups to in-patients.

**Certified Peer Specialist**, 2005–2006, The Peer Center, Atlanta GA

- Created and facilitated daily psycho-educational, recovery-themed, & peer support groups.
- Assisted clients in setting goals, obtaining resources, and reintegrating into their communities.
- Designed computer training program to teach clients basic & advanced computer skills.

### **VOLUNTEER EXPERIENCE**

**Board Member**, 2006–Present, Vermont Psychiatric Survivors

**Creator and Webmaster, Vermont Recovery**, [www.vermontrecovery.com](http://www.vermontrecovery.com), 2007–

- Vermont Recovery offers resources and information to psychiatric survivors and mental health workers.

**Plainfield Cooperative**, 2009–2010, Plainfield VT

- Volunteered two hours a week stocking items at the local food co-op.

**Board Member**, 2007–2008, Vermont Counterpoint Newspaper Advisors



### **Depression and Bipolar Support Alliance, 2005–2006, Atlanta GA**

- Facilitated weekly support group for children diagnosed with bipolar disorder.
- Mentored teenager diagnosed with bipolar disorder via one-on-one weekly meetings.

### **ADVOCACY EXPERIENCE**

**Member, Vermont State Hospital Futures Peer Support Program Development Workgroup, 2006–2009**

- Researched, developed, and presented on a project to develop a peer-run crisis alternative for adults in Vermont, which is currently in the early stages of development.

#### **Presentations**

- *The Myths of Mental Illness*, 2010, Washington County Mental Health Services, Johnson State University
- *The New Vision: Making Recovery a Reality*, 2008 - 2010, Health Care & Rehabilitation Services, Brattleboro Retreat Healthcare, Vermont State Hospital, Howard Center, 2008 Vermont Annual CRT Conference, Meadowview Recovery Residence
- *Peer Support: Recovery in Action*, 2008, Vermont State Hospital, Waterbury VT
- *Recovery in Practice*, 2007, Valley Vista Treatment Center, Bradford VT
- *Strategies to Promote and Protect Self-Determination*, 2007, United States Psychiatric Rehabilitation Association's 32<sup>nd</sup> Annual Conference, Orlando FL

#### **Articles Published** (see [www.vermontrecovery.com/writings.html](http://www.vermontrecovery.com/writings.html))

- *The Wind Never Lies*, Summer 2009, Counterpoint Newspaper
- *The Other Side of Mental Health Science*, Winter 2008, Counterpoint Newspaper
- *Rethinking the Potential of the Brain in Major Psychiatric Disorders*, Spring 2008, Counterpoint Newspaper
- *Integrated Services and Trauma-Informed Care Are Priorities...*, Winter 2007, Counterpoint Newspaper
- *Letter to NAMI: A Plea for Reconciliation*, Winter 2007, Counterpoint Newspaper
- *Springfield Finds It's 'Come a Long Way'*, Winter 2007, Counterpoint Newspaper

### **EDUCATION**

Georgia State University, 2005, 9 credits towards MA Professional Counseling, GPA: 4.0

University of Colorado at Boulder, 2002, BFA Film Studies, GPA: 3.75

### **CERTIFICATIONS**

- Intentional Peer Support – Shery Mead & Associates, 2009, Burlington VT
- Common Ground: Recovery Oriented Practice Training – Pat Deegan PhD, 2007, Tyngsboro MA
- Certified Mental Health Recovery Educator – Wellness Recovery Action Plan, 2006, Copeland Center
- National Alliance of the Mentally Ill Provider Education Program, 2006, White River Junction VT
- Certified Peer Specialist, 2005, Georgia Certified Peer Specialist Project

### **AWARDS**

- Advocacy Award, Vermont Association of Mental Health, Fall 2009, Montpelier VT

Maria Mercedes Avila

1044 North Avenue Unit #2, Burlington, VT, 05408 | 802-660-2909 | 802-999-4985 |  
[maria.avila@med.uvm.edu](mailto:maria.avila@med.uvm.edu) | [mavila@howardcenter.org](mailto:mavila@howardcenter.org)

Education

University of Vermont, Burlington, VT -- Ed.D. candidate - Educational Leadership and Policy Studies - cohort 2010

University of Vermont, Burlington, VT -- M.Ed. Educational Leadership 2007

Universidad del Salvador, Buenos Aires, Argentina--B.A. English Language 2000

Teaching Experience

*Universidad Nacional de La Plata*, Santa Teresita, Argentina: Lecturer – English as a Second Language (ESL) 2002. Developed syllabus and overall course structure, and administered all grades.

*Universidad Atlántica Argentina*, Mar de Ajó, Argentina: Director of English as a Second Language (ESL) Department 2002. Coordinated staff teaching observations and evaluations. Developed syllabus and overall course structure, and administered all grades.

*Fundación de Altos Estudios en Ciencias Comerciales*, Buenos Aires, Argentina: Instructor – English for Academic Purposes (EAP) 1997-2002. Developed syllabus and overall course structure, and administered all grades. Taught EAP courses in marketing, accounting, tourism, international trade, media production and direction, journalism and hospitality management.

*Universidad de Ciencias Empresariales y Sociales*, Buenos Aires, Argentina: Adjunct Instructor – English for Academic Purposes (EAP) 1999-2002. Developed syllabus and overall course structure, and administered all grades. Collaborated on curriculum and exam development, and graded final exam papers. Taught EAP courses in marketing and international trade.

*Instituto Superior de Enseñanza Radiofónica*, Buenos Aires, Argentina: Instructor – English as a Second Language 1999-2002. Developed syllabus and overall course structure, and administered all grades.

*Britannia Schools of English*, Buenos Aires, Argentina: Instructor – English as a Second Language and English for Academic Purposes 1996-2001. Developed syllabus and overall course structure, and administered all grades. Taught in-company ESL; teacher for: KPMG Argentina, Hospital “Garrahan”, Lloyd’s Bank, ABN-AMRO Bank, Laboratorios Roemmers, Telefónica de Argentina.

Related Experience

*Vermont Child Health Improvement Program*, UVM’s College of Medicine, Burlington, VT.

Program Evaluator: Vermont Youth Suicide Prevention Project and Interdisciplinary Leadership June 2009 – present

*Education for Health Professionals (VT-ILEHP)*—Design the measurement schema and qualitative and quantitative tools for monitoring goals and objectives of both projects. Create and maintain databases to support programmatic data collection efforts.

*Howard Center*, Burlington, Vermont. Cultural and Linguistic Competence Coordinator May 2009 – to date. Provide leadership in the development, implementation, and monitoring of the cultural and linguistic portion of the State of Vermont’s Youth in Transition grant.

*ICF Macro*, Burlington, Vermont. Bilingual Research Interviewer, Quality Assurance Assistant, Data Collection Best Practices Coordinator 2005 – 2009. Conducted validity and reliability testing of data collection instruments in English, Spanish and Portuguese. Wrote technical reports documenting the statistical analysis of data collection productivity.

*Even Start Family Literacy Programs*, Chittenden County, Vermont. Family Literacy Program Manager 2003 – 2007. Coordinated the first Event Start ESL family literacy program for refugees and immigrants in Vermont. Promoted the program within the organization and community to expand interagency resources and service providers.

#### Certifications and Licenses

- Vermont Department of Education, Vermont
- Level I Educator’s License – 3-91 principal preK-12 endorsement 2007
- University of Cambridge, England
- Certificate in English Language Teaching to Adults (CELTA) 1999
- International Teaching and Training Centre, Bournemouth, England
- Teacher of English as a Foreign Language (TEFL) 1994

#### Professional Presentations

- “Webinar: Towards Cultural and Linguistic Competency in Mental Health”
- Vermont Department of Mental Health, Waterbury, Vermont 2009
- “Are We Using Culturally Appropriate Assessments for ELL Children?”
- New England Head Start Association (NEHSA) Annual Conference, Stowe, Vermont 2007
- “A Successful Example of Collaboration and Integration of Services for Refugees and Immigrants”
- National Conference on Family Literacy, Louisville, Kentucky 2005
- “Exploring Diversity in Health Care”
- Visiting Nurse Association (VNA), Colchester, Vermont 2005

**Margaret Swarbrick, PhD, CPRP**, is the Institute for Wellness and Recovery Initiatives Training Director for Collaborative Support Programs of New Jersey, a large consumer-operated self-help organization in New Jersey. CSP employees many persons living with a mental illness in many capacities within the agency structure (full time there are over 45 consumers working and part-time over 120 consumers working).

Peggy has been involved in the mental health field since 1977 personally and professionally since 1986. Peggy was able to access work and education as key tools for personal recovery and has been able to articulate the value of work and meaningful occupation as key elements for recovery and well-being. Dr. Swarbrick is currently a post doctoral fellow in the Psychiatric Rehabilitation Program at university of Medicine and Dentistry of NJ (Psychiatric rehabilitation Program) and also worked as an adjunct faculty for two occupational therapy programs in New Jersey. Peggy worked in as an occupational therapist in a variety of settings (state hospital, crisis intervention unit, partial hospital program, cognitive rehabilitation and home health care) designing and delivering services focused on wellness and recovery. Peggy successful passed her doctoral oral examination on July 5, 2005. The dissertation study focused on examination of the relationship between the social environments of consumer operated self-help centers and its effects on member empowerment and satisfaction.

## Dartmouth Psychiatric Research Center

The Dartmouth PRC was established in 1987 as a public-academic liaison involving the New Hampshire Division of Behavioral Health and the Dartmouth Medical School. Initial research in New Hampshire focused on integrating case management and substance abuse services, and on integrating vocational and mental health services. In the early 1990's, the PRC expanded beyond New Hampshire and replicated its earlier findings through research in urban settings in Connecticut and Washington, DC. In the late 1990's, the PRC developed new research areas; further developed existing programs; enhanced economics, statistics, and data management capacity; developed a greater number of research collaborations around the country; and enhanced junior faculty support and training. Today the PRC staff are involved in various capacities (e.g., investigators, consultants, trainers) in many states.

Our current areas of research are:

- Implementation of Evidence Based Practices
- Vocational rehabilitation/supported employment
- Services for homeless persons
- Integrated treatment of co-occurring substance abuse
- Services for the elderly
- Trauma and post-traumatic stress disorder
- Infectious diseases (including HIV and hepatitis)
- Methodology of services research.

The PRC conducts interdisciplinary research on services for individuals who have serious mental illness, primarily schizophrenia spectrum and bipolar disorders. The PRC specializes in developing effective interventions under research conditions, then translating these interventions into actual mental health service practices and evaluating their effectiveness in routine practice settings. PRC research incorporates multiple scientific perspectives, such as clinical, economic, and ethnographic. The PRC works with efficacy and services researchers to address the needs of multiple stakeholders through effectiveness research in routine practice settings.

The Dartmouth Evidence-Based Practices Center (DEBPC), formerly the West Institute, was founded in 2000 thanks to a generous gift from the West Family Foundation. The Center facilitates the implementation of Evidence-Based Practices (EBPs) in sustainable ways in public mental health systems and agencies across the country.

## Section I: Confidentiality and SAMHSA Participant Protection/Human Subjects

1. Protection from Potential Risks: Because this grant is focused on improving treatment and implementing an empirically-based practice that has shown effectiveness in other treatment settings, there are little foreseeable physical, medical, psychological, social, or legal risks or potential adverse effects as a result of the project itself or any data collection activity. Individuals may participate in the grant initiative in several different ways. Professionals, consumers, family members and advocates will participate in planning, implementation and training activities. These individuals will participate on a voluntary basis. In situations where participants may be asked to identify areas for improvement or faults in the current system, individuals receiving services may fear that access to services might be limited if they criticize the treatment providers they currently work with. Professional staff involved in the project may be concerned that criticisms of the system might jeopardize their employment. To mitigate this real or perceived barrier, facilitators of the planning process will work to create a safe environment for both positive and negative critiques of the system. The purpose of stakeholder involvement and inclusion of professional staff, consumers and families is to honestly assess and improve the current treatment and support system for the target population. Because consumers will receive enhanced services using nationally recognized empirically-based models/practices, and there are no known risks associated with receiving these types of services. As such, individuals receiving enhanced services funded through this grant will likely benefit from improved support.

Implementation of enhanced services will be overseen by clinical experts, which will help to ensure services are developed and provided correctly without posing any risk to participants resulting from incorrect application of an intervention.

2. Fair Selection of Participants: Grant activities are designed to include participation from a wide range of stakeholder groups, including representatives across ages, genders, and racial/ethnic backgrounds. Participants will include consumer leaders, family members, advocates, and administrative and treatment professionals, as evidenced by the *Letters of Support* included in Attach 1 and 4. Consumers and their family members will be included in the stakeholder groups because of their ability to speak about the mental health system based on personal experience. No one will be excluded from participation in grant activities.

Peer Specialists will provide IMR and SE services to young adults (age 18-34) with or at risk of serious mental illness. Consumers will be identified through outreach of the Peer Specialists. No one who meets these criteria will be excluded from having access to these treatments. If the existing service providers are unable to serve all individuals who request supports, every effort will be made to expand the number of service providers. In fact, the grant will specifically focus on expanding the number of services that are available.

3. Absence of Coercion: Participation in the planning and implementation activities will be entirely voluntary for members of each stakeholder group. In addition, participation in any surveys or interviews used to gather information for the project will be voluntary, without any direct or implied coercion.

Individuals who are eligible for services will not be required to participate; the consumer may choose to access other treatment services instead of participating in this program to meet their needs.

4. Data Collection: Performance measurement and assessment efforts will rely on data from existing sources as well as information gathered through grant evaluation activities described in Section E. Data collection instruments and interview protocols will be conducted by the service provider at community-based settings (e.g. drop in centers, homeless shelters). No specimens such as urine or blood will be collected for this project. Data collected on individuals involved in this grant project will be a “limited data set” as defined at 45 CFR 164.514(e). This data may be extracted from protected health information, but will exclude the following direct identifiers of individuals:

- *Names;*
- *Postal address information, other than town or city, State, and zip code;*
- *Telephone numbers;*
- *Fax numbers;*
- *Electronic mail addresses;*
- *Social security numbers;*
- *Medical record numbers;*
- *Health plan beneficiary numbers;*
- *Account numbers;*
- *Certificate/license numbers;*
- *Vehicle identifiers and serial numbers, including license plate numbers;*
- *Device identifiers and serial numbers;*
- *Web Universal Resource Locators (URLs);*
- *Internet Protocol (IP) address numbers;*
- *Biometric identifiers, including finger and voice prints; and*
- *Full face photographic images and any comparable images.*

The evaluation component of this project will only use any protected health information provided by consumers for the purpose of evaluating service performance. Data analyses or reports produced by this project will not include individually identifiable information. This project will not disclose any information in a manner that would violate the requirements of the HIPAA Privacy Rule. This project will not identify the individuals who are the subject of this evaluation. All identifying personal information will be removed prior to compiling data for review by grant planning participants.

Consumers who participate in the evaluation will receive \$20.00 in compensation for each round (i.e., at intake, 3, 6, 9 and 12 months) of data collection session they participate in.

5. Privacy and Confidentiality: Acknowledgement of involvement in grant activities in any public or written documentation will be voluntary. Data analyses and reports produced by this grant will not include individually identifiable information. The project will not disclose any information in a manner that would violate the requirements of the HIPPA Privacy Rule.

The data collected on individuals involved in the grant will be a “limited data set” as defined at 45 CFR 164.514(e). This data may be extracted from protected health information, but will exclude direct identifiers of individuals (see #4). The evaluation component of this project will only use any protected health information provided by participants for the purpose of evaluating service performance. Data analyses or reports produced by this project will not include individually identifiable information. This project will not disclose any information in a manner that would violate the requirements of the HIPAA Privacy Rule. This project will not identify the individuals who are the subject of this evaluation. All data will be entered into, and maintained within, password protected MS Access database on Data Remedies and DMH secure servers, and only the evaluation staff directly involved with the grant will have access to the data.

6. Adequate Consent Procedures: Stakeholders participating in the grant planning activities and participants receiving services will be free to participate or not, as they desire. Requests for individuals to complete any evaluation documents will include written explanations, including: (1) completing surveys is voluntary, (2) purpose of surveys, (3) benefits for completing surveys, (4) description of the grant initiative and role of the surveys, (5) no anticipated risks for completing surveys, (6) protections for confidentiality (data collection will use a non-PHI unique identifier), (7) whom to call with questions about the surveys and grant activities, and (8) costs for completing the survey and an explanation of how participants will be paid.

7. Risk-Benefit Discussion: Because this grant is focused on improving and expanding peer services using evidence-based practices that have shown effectiveness in other treatment settings, we feel there is great benefit to be had from participating in and/or evaluating the activities of this grant and no increased risk. Professionals, consumers, family members and advocates participating in the planning and implementation activities will do so on a voluntary basis. Individuals receiving services may fear that access to services might be limited if they criticize the treatment providers they currently work with. Professional staff involved in the project may be concerned that criticisms of the system might jeopardize their employment. As such, facilitators of the planning process must work to create a safe environment for both positive and negative critiques of the system. However, because the purpose of stakeholder involvement is to improve the current system, we feel the benefits greatly outweigh the potential risks. The benefits of participation provide a great deal of promise. We expect broad based stakeholder and professional staff participation to result in successful efforts to expand trauma treatment for children and their caregivers.

There are no known risks associated with receiving the specified services. As such, individuals receiving enhanced services funded through this grant will likely benefit from improved treatment.

#### Protection of Human Subjects Regulations

We do not anticipate that any of our evaluation efforts will require compliance with the Protection of Human Subjects Regulations (45 CFR 46). It is important to note that we consider this project the implementation and evaluation of effective peer services and not a research study in which an unproven treatment intervention is being tested/piloted with a vulnerable population. However, we will submit an application to the Agency of Human Services Review Board to



ensure that our activities comply with the requirements. AHS' IRB has a well developed process, including the requirement that all applicants review Protection of Human Subjects Regulations.

<b>Attachment 1: Service Providers and Commitments</b>
(1) licensed service provider organization;
(2) a list of all direct service provider organizations
(3) the Statement of Assurance
(4) letters of commitment from direct service providers that have agreed to participate in proposed project

(1) Identification of at least one experienced, licensed service provider organization:  
 Another Way, Montpelier, Vermont

(2) Direct service provider organizations:  
 Another Way  
 Community Health Center of Burlington  
 Clara Martin Center  
 Counseling Service of Addison County  
 Health Care and Rehabilitation Services of Southeastern Vermont  
 HowardCenter  
 Lamoille Community Connections  
 Northwestern Counseling and Support Services  
 Northeast Kingdom Human Services  
 Rutland Mental Health Services  
 Spectrum Youth and Family Services  
 United Counseling Service of Bennington County  
 Washington County Mental Health Services

(3) Statement of Assurance:



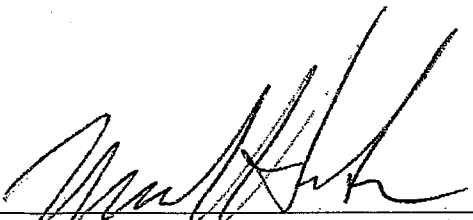
State of Vermont  
 Department of Mental Health  
 103 South Main Street  
 Wasson Hall  
 Waterbury, VT 05671-2510  
<http://mentalhealth.vermont.gov/>

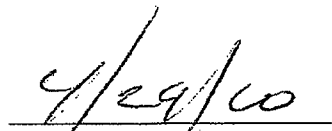
Agency of Human Services

[phone] 802-241-2601  
 [fax] 802-241-4004  
 [tty] 800-253-0191

As the authorized representative of the Department of Mental Health, I assure SAMHSA that all participating service provider organizations listed in this application meet the two-year experience requirement and applicable licensing, accreditation, and certification requirements. If this application is within the funding range for a grant award, we will provide the SAMHSA Government Project Officer (GPO) with the following documents. I understand that if this documentation is not received by the GPO within the specified timeframe, the application will be removed from consideration for an award and the funds will be provided to another applicant meeting these requirements.

- a letter of commitment from every service provider organization listed in Attachment 1 of the application that specifies the nature of the participation and the service(s) that will be provided;
- official documentation that all service provider organizations participating in the project have been providing relevant services for a minimum of 2 years prior to the date of the application in the area(s) in which services are to be provided. Official documents must definitively establish that the organization has provided relevant services for the last 2 years; and
- official documentation that all participating service provider organizations are in compliance with all local (city, county) and State/tribal requirements for licensing, accreditation, and certification or official documentation from the appropriate agency of the applicable State/tribal, county, or other governmental unit that licensing, accreditation, and certification requirements do not exist. (Official documentation is a copy of each service provider organization's license, accreditation, and certification. Documentation of accreditation will not be accepted in lieu of an organization's license. A statement by, or letter from, the applicant organization or from a provider organization attesting to compliance with licensing, accreditation and certification or that no licensing, accreditation, certification requirements exist does not constitute adequate documentation.)

  
 \_\_\_\_\_  
 Signature of Authorized Representative

  
 \_\_\_\_\_  
 Date

(4) Letters of Commitment/Support:

Another Way  
Community Health Center of Burlington  
Clara Martin Center  
Health Care and Rehabilitation Services of Southeastern Vermont  
HowardCenter  
Lamoille Community Connections  
Northwestern Counseling and Support Services  
Northeast Kingdom Human Services  
Rutland Mental Health Services  
Spectrum Youth and Family Services  
United Counseling Service of Bennington County  
Washington County Mental Health Services

Another Way, Inc.  
PO Box 264  
Montpelier, VT 05601  
(802) 224-0420  
anotherwayvt@gmail.com



April 27<sup>th</sup>, 2010

To Michael Hartman, Commissioner:

On behalf of Another Way, I am pleased to write a letter of support for the Vermont Department of Mental Health's application for a federal Mental Health Transformation Grant.

For over twenty years, Another Way has operated a peer-run center in Montpelier, Vermont that offers peer support, advocacy, resources, and crisis response to psychiatric survivors and people at risk of psychiatric intervention. Our homelike atmosphere is a place for people to relax and connect with others, learn how to live in community, share meals, attend support gatherings and educational workshops, create art and music, and access phones and computers. Many of the folks who come here have either avoided traditional mental health services or are not satisfied with their offerings. Another Way tries to literally provide them "another way" of finding their truth and living well.

Recently, we have seen an in-flux of young adults. These individuals are particularly skeptical of traditional, medical-model mental health services because of the stigma associated with using them, because they feel traumatized by their previous encounters with them, or because they are not willing to resign to a diagnosis of lifelong mental illness. Even for folks who do want traditional services, many are denied because they do not meet stringent criteria. Thus, young adults who are at-risk – having lost a job, housing, or dealing with intense life challenges – often slip through the cracks of social services and feel isolated within their community.

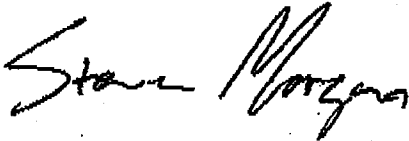
Since Another Way is first and foremost about providing peer support and connection, we intend to utilize peer support specialists proposed in the Mental Health Transformation Grant to connect with these young adults, to inspire them, to help them access resources, to collaborate in creativity, and to partner with them in having meaningful lives. We are pleased to potentially act as a designated service provider for the grant and hire and manage these positions in our area.

Another Way is also committed to communicating and connecting with other service providers at the local and state level. Our Executive Director currently participates on the regional Adult Local Interagency Team, and peer support specialists will be a great addition to help improve the

implementation of services discussed there. Additionally, we plan to assist the Adult State Interagency Team in identifying state-level barriers and creating strategies to overcome them.

Overall, a key component of participating in this grant will be to learn what works and what doesn't in Vermont concerning recruiting, training, and using peer support specialists, and to understand how best to serve young adults that are at-risk. We intend for those lessons learned to become part of the broader transformation of mental health services to a more recovery-oriented and person-centered approach. Another Way is excited to participate in this process, and supports the Department of Mental Health's efforts to obtain a Mental Health Transformation Grant.

Sincerely,

A handwritten signature in black ink that reads "Steven Morgan". The signature is written in a cursive style with a large, stylized "S" and "M".

Steven Morgan  
Executive Director, Another Way Inc.  
(404) 376-4523  
stevenmorganjr@gmail.com



**Community Health Center of Burlington, Inc.**  
617 Riverside Avenue • Burlington, VT 05401-1601 • (802) 864-6309 (TDD) • Fax (802) 860-4325

April 22, 2010

Mr. Michael Hartman, Commissioner  
State of Vermont  
Department of Mental Health  
Office of the Commissioner  
103 South Main Street, Wasson Hall  
Waterbury, Vermont 05671-2510

Dear Commissioner Hartman,

The Community Health Center of Burlington is in support of the Vermont Department of Mental Health's application for a federal Mental Health Transformation Grant.

The Community Health Center (CHCB) does serve the targeted population at both our main site clinic and at our Pearl Street Clinic for adolescents and we agree that this population would benefit from an early intervention system which delivers peer-based interventions and credentialed Peer Specialists to engage and serve this population.

CHCB is eager to participate in planning and implementation activities to support the use of peer specialists to serve this population.

We believe that participating in the implementation of this proposed new service can improve how CHCB engages with and serves this population in the future.

CHCB staff currently attend the Adult Local Interagency Team meetings in our community and we would be willing to assist the Adult State Interagency Team in identifying state-level barriers and strategies to address those barriers.

Sincerely,

Naya Pyskacek, LICSW, LADC  
Behavioral Health Services Coordinator

cc: Jack Donnelly, Executive Director



**CLARA  
MARTIN  
CENTER**

COMMUNITY MENTAL  
HEALTH SERVICES

April 26, 2010

Michael Hartman, Commissioner  
Department of Mental Health  
103 South Main Street  
Waterbury, VT 05671

Dear Commissioner Hartman:

The Clara Martin Center is writing to express our strong support for the Department of Mental Health's grant application for a SAMSA funded Mental Health Transformation Grant. The young adult population the grant targets is underfunded and underserved in the State and would benefit from the services outlined in the grant. The planning and implementation of peer and evidenced based services is one that fits with what the Clara Martin Center is considering right now; and we would gladly participate in supporting the use of peer specialists for our region. We are actively involved at the local Adult LIT team, as well as being the lead agency for the larger AHS Hartford District's efforts at engaging and providing support to Transition Age Youth through the federally funded Youth in Transition grant. We would hope through implementation of this grant that we would learn ways of improving our local system of care to this important and underserved population, and be able through the local Adult LIT team, to give feedback to the Adult State Interagency team to improve services for the whole State.



Green Mountain  
**United Way**

P.O. Box G  
Randolph  
Vermont  
05060-0167  
802/728-4466  
802/728-4197 fax

P.O. Box 278  
Bradford  
Vermont  
05033-0278  
802/222-4477  
802/222-3242 fax

P.O. Box 816  
Wilder  
Vermont  
05088-0816  
802/295-1311  
802/295-1312 fax

Sincerely,

Jeff Rothenberg, MS, LCMHC  
Senior Director of Program Services





# HCRS

HEALTH CARE & REHABILITATION SERVICES  
OF SOUTHEASTERN VERMONT

**Springfield**  
390 River Street  
Springfield, VT 05156  
886-4500

**Hartford**  
49 School Street  
Hartford, VT 05047  
295-3031

**Windsor**  
14 River Street  
Windsor, VT 05089  
674-2539

**Bellows Falls**  
One Hospital Court  
Bellows Falls, VT 05101  
463-3947

**Brattleboro**  
51 Fairview Street  
Brattleboro, VT 05301  
254-6028

**Brattleboro CRT**  
29 Elm Street  
Brattleboro, VT 05301  
254-7511

**HCRS Connection**  
1-888-888-5144

**Emergency**  
1-800-622-4235

[www.hcrs.org](http://www.hcrs.org)



*A member of the  
Vermont Council of  
Developmental and  
Mental Health Services*

April 26, 2010

Michael Hartman, Commissioner  
Vermont Department of Health  
P.O. Box 70  
Burlington, VT 05402

Re: Vermont Department of Mental Health Application  
Federal Mental Health Transformation Grant

Dear Michael,

I am writing to whole-heartedly support the grant proposal for the Mental Health Transformation Grant Program being submitted by the Vermont Department of Mental Health.

I represent a local community mental health provider, Health Care and Rehabilitation Services (HCRS), in southeastern Vermont. HCRS is a non-profit state designated agency serving almost 5,000 individuals in Windsor and Windham counties each year. HCRS offers five major programs for mental health and substance abuse needs as well as developmental disabilities.

Funding for this proposal from SAMHSA's Center for Mental Health Services will allow Vermont to improve treatment and services for young adults (ages 18-34) with, or at-risk of, serious mental illness who are not currently receiving services. These transition age young adults in Vermont are currently being underserved, often "falling through the cracks" of our mental health services system because they are not eligible for CRT services or they choose not to access community mental health services. In many cases, these individuals have multiple interactions with law enforcement, homeless shelters, corrections, and hospital emergency rooms.

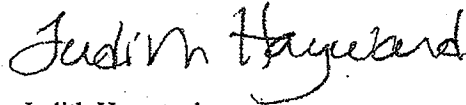
It is our understanding that this grant proposal will create an effective early intervention system for young adults through the development of a workforce of credentialed Peer Specialists who will engage this population and provide peer services focused on wellness promotion, self-management, and supported

employment. The Peer Specialists will also assist this population with accessing other services and supports in their community.

As the community mental health agency serving southeastern Vermont, HCRS will participate in the planning and implementation activities of this grant project to include supporting the use of peer specialists to serve this population, participation on the Regional Adult Local Interagency Team, using information learned from this project to improve our mental health services for these transition age adults, and assisting the Adult State Interagency Team with identifying state-level barriers and strategies to address those barriers.

Please consider funding this critical and necessary effort.

Sincerely,



Judith Hayward  
Chief Executive Officer

April 24, 2010

Michael Hartman, Commission  
Department of Mental Health  
103 South Main Street  
Waterbury, VT 05671

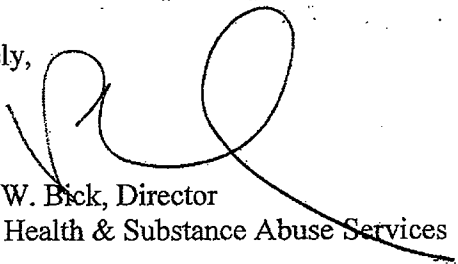
Dear Michael:

On behalf of the HowardCenter, I am writing to express our support for the Vermont Department of Mental Health's (DMH) application for the SAMHSA *Mental Health Transformation Grant*.

Based on our very significant experience with adults 18-24 years old, we strongly agree that those who have or are at risk of serious mental illness could greatly benefit from increased outreach using peer specialists in the Chittenden County area and specifically, Burlington, which serves as the communal hub. Many of the individuals we serve are not eligible for CRT services and/or have a tendency to avoid mental health services that are available. Additionally, we have found that this population tends to have frequent and multiple interactions with law enforcement, corrections, crisis services, emergency rooms, and homeless shelters in our county.

We will do what we can to support regional planning and implementation activities to support the use of peer specialists to serve this population in Chittenden County, actively continue our participation on the Local Interagency Team, and we anticipate that the "lessons learned" from the initiative will help to improve how our program engages with and serves this population.

Sincerely,

  
Robert W. Bick, Director  
Mental Health & Substance Abuse Services

Lamoille  Community Connections

• WHERE PEOPLE & POSSIBILITIES COME TOGETHER •

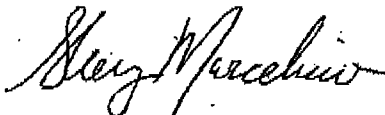
Dear Michael Hartman,

Lamoille Community Connections is in agreement that currently in the State of Vermont, has a population of young adults (ages 18-34) who have or are at risk of serious mental illness who do not meet CRT criteria. These individuals are vastly underserved. Often the people in this population end up in the legal system, homeless or in emergency rooms before they receive adequate treatment for their mental health symptoms.

Currently LCC is broadening its utilization of peer services and peer supports within the agency and has seen first hand its benefits and the hope that it has created by for our consumers. Given that the population, as mentioned above, may not meet CRT Criteria, developing other treatment options such as use of peer specialist may be essential in giving these young adults not only support, but to also identify solid pathways to treatment. This may include supported employment, self management skills and guidance on how to access other community supports. Lamoille Community Connections would like to expand on this concept in order to help serve our most vulnerable populations in our local community. This would also give us an opportunity as an agency and a community to establish the best and most effective way to treat this population so that they may lead productive and successful lives. Lamoille Community Connections would be interested in nominating a staff person from our CRT program to become a member of the Adult State Interagency Team in order to identify barriers and strategies that work on the state level.

We hope that you may consider this proposal for the benefit of those who need it, as well as for all Vermonters who are eager to have more efficient, cost effective and successful treatment options.

Sincerely,



Sherry Marcelino, BA  
Lamoille Community Connections

72 Harrel St. • Morrisville, VT 05661 • P: (802) 888-5026 • F: (802) 888-6393

107 Fisher Pond Road  
St. Albans, VT  
05478

Telephone:  
(802) 524-6554  
Toll Free in VT:  
(800) 834-7793  
Fax:  
(802) 527-7801



April 27, 2010  
Michael Hartman  
Commissioner  
Vermont Department of Mental Health  
103 South Main Street, Wasson Hall  
Waterbury, VT 05671-2510

Re: Letter of Support / Mental Health Transformation Grant

Dear Commissioner Hartman,

I am writing to support Vermont Department of Mental Health's application to address the unmet needs of adults who are at risk of developing a serious mental illness. As director of behavioral health services in one of the ten designated community mental health regions in our state, I get to see the gaps in our system of care on a daily basis when it comes to adults who are not eligible for services and also experience significant risks for developing a serious mental illness. Many of these individuals are involved with the Department of Corrections. Our region of the state has a growing suicide rate and many of these individuals are adults we are not serving.

Your proposed project design will enhance the limited peer services efforts in our region and throughout the state. We are seeing the value of peer services and the unique connection peers have in supporting each other and in identifying our "blind spots" in how our services are organized. Our Local Interagency Team has been active in offender re-entry planning and a pattern of need among adults with mental illness who are not eligible for our services is becoming clearer and clearer. Often times our crisis services end up responding to these individuals and no substantive treatment is delivered.

I am willing and eager to participate in the proposed planning and implementation activities to support the use of peer specialists and will make our Local Interagency Team aware of this potential and much needed resource in our region and state. Related to this commitment is my willingness to participate in the lessons learned from this proposed grant implementation to improve our policies and practices to better meet the unmet needs of adults at risks of developing a serious mental illness. I am an active member on our Local Interagency Team and this grant will revitalize the important collective work ahead of us.

Sincerely,

Steve Broer, Psy.D.  
Director, Behavioral Health Division



**Northeast Kingdom Human Services, Inc.**

Eric T. Grims  
Executive Director

Providing April 22 2010  
Community-Based

Behavioral Health, Michael Hartman  
Substance Abuse Commissioner  
and Department of Mental Health  
Developmental Services Wasson Hall

154 Duchess Ave.  
P.O. Box 724  
Newport, VT  
05855-0724  
Phone  
802-334-6744  
Fax  
802-334-7455

103 South Main Street  
WATERBURY VT 05671-2510

Dear Commissioner Hartman

**RE: Mental Health Transformation Grant as applied for by  
Vermont's Department of Mental Health**

2225 Portland St.  
P.O. Box 368  
St. Johnsbury, VT  
05819-0368  
Phone  
802-748-3181  
Fax  
802-748-0704

We here at Northeast Kingdom Human Services (NKHS) are pleased to hear of your application for the Mental Health Transformation Grant via the Center of Mental Health Services at SAMHSA. This letter is to acknowledge our support for your application.

55 Seymour Lane  
Newport, VT 05855  
Phone 802-334-5246  
Fax 802-334-1093

Our NKHS agency has been the predominant provider of community mental health services, for 50 years now, in the large and rugged Orleans and Caledonia counties of northeastern Vermont. We have not only provided direct services, but have also been governed by direct participation of community members and consumer peers at board, advisory committee and service levels. We have also collaborated with notable organizations, such as NAMI, Vermont Psychiatric Survivors, and the Dartmouth Psychiatric Research Center, in the development of our programs. We participate in each of two (Newport & St. Johnsbury) Adult Local Interagency Teams for managing cases of serious functional impairment.

[www.nkhs.net](http://www.nkhs.net)

We have operated our Community Rehabilitation and Treatment (CRT) services since their inception in Vermont in 1999. We can also boast that we operate a wide range of evidenced based practices and were the first to implement the Program of Assertive Community Treatment (PACT). Building upon PACT we have in the last decade gone on to implement the practices & principles of Recovery & Wellness, Supported Employment, and Integration for Co-Occurring Disorders.

Our Children's Programs serve young persons until their 22<sup>nd</sup> birthday through the JOBS Program, School Based Services, Post Adoption and Therapeutic Case Management. We are also active partners in the Youth in Transition statewide and regional grants for serving youth and young adults of ages 16 through 22 years old. The Transition years



between 17 and 26 seem to pose significant challenges for most young adults, and most definitely for those with trauma histories, mental illness or at risk for serious emotional issues.

From our experience over the past 50 years we can confirm that there are many cases of young persons with signs of serious mental illness, or risk for same, of whom do not qualify for CRT services. Nor are these CRT services currently resourced sufficiently to accommodate such clients. Hence, the purpose of the Transformation Grant in providing for earlier identification and intervention for serious mental illness in young persons would indeed assist many in our community with a more favorable prognosis vs. becoming long term consumers of the mental health or correctional systems.

Because the Transformation Grant is very consistent with our own mission and experience we envision it being very appropriate for us to participate in the inter-agency, community, and peer processes for planning, development and implementation of the grant. We are very open to learning new strategies to help in out-reaching to younger clients and thereby implement intervention as early as possible.

If you have any questions pertaining to our interest and capability in participating in this grant please do contact either of us, as per the below contact details.

Sincerely



Bernard F Norman, PhD  
Chief of Clinical Operations  
& Director of CRT  
Email: [bnorman@nkhs.net](mailto:bnorman@nkhs.net)  
Ph: 802 334 5247



Carol Boucher, BA  
Chief of Behavioral Health Operations  
& Director of Children's Programs  
Email: [cboucher@nkhs.net](mailto:cboucher@nkhs.net)  
Ph: 802 334 6744

April 22, 2010

Michael Hartman, Commissioner  
Department of Mental Health  
103 South Main Street  
Waterbury, VT 05671

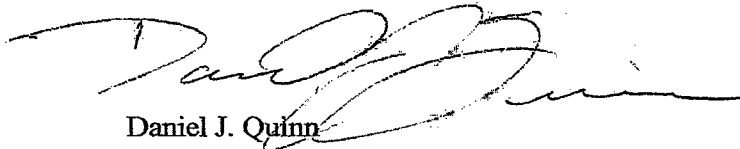
Dear Commissioner Hartman:

On behalf of RMHS, I am writing to express our support for the Vermont Department of Mental Health's (DMH) application for the SAMHSA *Mental Health Transformation Grant*.

We strongly agree that the proposed target population (adults 18-34 who have or are at risk of serious mental illness) is currently being underserved in our region. Because much of this population is not eligible for CRT services and has a tendency to avoid mental health services that are available, we have found that this population tends to have multiple interactions with law enforcement, corrections, crisis services, emergency rooms, and homeless shelters in our county.

We are happy to do what we can to support regional planning and implementation activities to support the use of peer specialists to serve this population in Rutland County, and we anticipate that the "lessons learned" from the initiative will help to improve how our program engages with and serves this population.

Sincerely,



Daniel J. Quinn  
President and Chief Executive Officer





April 26, 2010

Commissioner Michael Hartman  
Vermont Agency of Human Services: Department of Mental Health  
108 Cherry Street, P.O. Box 70  
Burlington, VT 05402-0070

Dear Commissioner Hartmann,

---

31 Elmwood Avenue  
Burlington, Vermont 05401  
802-864-7423  
Fax: 802-660-0576  
Spectrum One Stop  
177 Pearl Street  
Burlington, Vermont 05401  
802-862-5396  
TTY: 802-660-0542  
A United Way Agency

I am writing a letter of support for the Vermont Department of Mental Health's (DMH) application for a federal *Mental Health Transformation Grant*. I understand that this grant is being offered by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, and that it could provide up to \$750,000 per year for five years to foster adoption and implementation of permanent transformative changes in how public mental health services are organized, managed and delivered so that they are consumer-driven, recovery-oriented and supported through evidence-based and best practices. And that specifically, grantees under this program will be expected to create and expand capacity to serve adults with or at risk of serious mental illness who are currently under-served.

For the past 7 years I have been the Clinical Director of Spectrum Youth & Family Services, a private non profit agency in Burlington Vermont which provides an array of evidence based co-occurring, recovery oriented clinical, case management and life skills programs and services for youth and transition aged adults.

I have experienced first hand the difficulties in serving the needs of this population. For example, we operate a Shelter and a Single room Occupancy program and the majority of the youth and young adults who come to us have severe mental health problems but do not meet the criteria for CRT services.

We try to "patch" together the best plans of care for them with all of our community partners but the gaps between services and the level of effort need to surmount these gaps and barriers are often too large. For most of our youth the effort and the plan are not sustainable and they cycle in and out of our facilities and programs and the larger community system of care.

All too frequently they become discouraged and eventually stop trying and typically become involved with the police and/or in the supervision of the correctional system. Clearly, we need the technical assistance being offered in the RFP to change the way we help these clients and we are very interested in receiving this help as part of this grant effort.

On another note, a strength that Spectrum will bring to this effort is that we have a long track record of being innovators and change leaders and have been involved in evidence based practice implementation for the past 7 years.

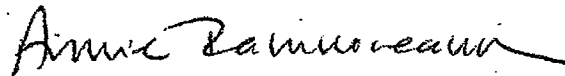
We have been awarded a three year Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment, (CSAT) Recovery Oriented System of care grant and are currently delivering recovery oriented consumer driven services.

And most recently, our Counseling Program received a 2010 iAward from NIATx which is a national process improvement collaborative that works with substance abuse and behavioral health organizations across the country and recognized by SAMHSA. We are committed to providing evidence based programs and to ongoing quality assurance and program improvement.

Lastly, we have hosted and participated in the regional Youth Local Interagency Team meeting for many years and have also been a participant in the Adult Local Interagency Team meeting as well.

In closing, we would be very committed to being part of the planning and implementation of any innovative services to improve our existing system of care for this population.

Sincerely,



Annie Ramniceanu, MS, LCMHC, LADC  
Clinical Director  
Spectrum Youth & Family Services

# UCS

100 Ledge Hill Drive, P.O. Box 533  
Bennington, Vermont 05202-0533  
802.442.5491 802.442.9389 Fax  
www.ucsvt.org

Ralph J. Provenza  
Executive Director

April 23, 2010

Michael Hartman, Commissioner  
State of Vermont  
Department of Mental Health  
103 South Main Street, Wasson Hall  
Waterbury, VT 05671-2510

Dear Commissioner Hartman:

We are writing in support of your application for a federal *Mental Health Transformation Grant*. As the director of Community Rehabilitation and Emergency Services and the director of Mental Health and Substance Abuse Services at United Counseling Service we are intensely aware of the many people who are in need of services yet do not meet the criteria for Community Rehabilitation Treatment (CRT) services provided by the CRT division. It is often the young adult that has experienced emotional and behavioral set-backs that falls through the cracks and fails to have his or her needs met in the current array of services that are available.

With this letter, we would like to express our willingness and desire to participate in planning and implementation activities that might assist in establishing much-needed peer specialists who would benefit this population. We believe that participation in a regional Adult Local Interagency Team would help assure the success of the grant funded activities.

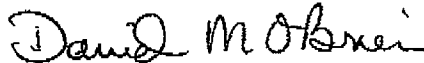
UCS has a very active system of quality improvement governed by our Quality Council and worked on continuously by our Quality Management Committee. We commit to incorporating into our practices any learnings and improvements that will come from this program as they become clear and interrelate with evidence-based work that we are already doing. Additionally, we will assist the Adult State Interagency Team in identifying and hopefully removing barriers of care on a state-wide level.

We are pleased that the department is actively seeking this grant, and remain available to help implement this grant project in any way that might be useful.

Sincerely,



Victor Martini, Division Director  
Community Rehabilitation and Emergency Services



David M. O'Brien, Division Director  
Mental Health and Substance Abuse Services

united counseling service of bennington county, inc.

Developmental Services • Outpatient Mental Health and Substance Abuse • Head Start • Big Brothers Big Sisters  
Community Rehabilitation and Emergency Services • Specialized Children's Services

Mailing Address:  
P.O. Box 647  
Montpelier, VT 05601-0647



Telephone (802) 229-1399  
FAX (802) 223-8623



what matters.™  
Green Mountain United Way

Main Office Location:  
174 Hospital Loop  
Berlin, Vermont

April 26, 2010

Michael Hartman  
Commissioner  
Vermont Department of Mental Health  
103 South Main Street  
Wasson Hall  
Waterbury, Vermont 05671-2510

Re: Mental Health Transformation Grant

Dear Michael:

I am pleased to write this letter of support for the Vermont Department of Mental Health's application for the federal *Mental Health Transformation Grant*. I, and my team, encourage the State's intent to expand their services for young adults (ages 18-34) with or at risk of serious mental illness who are not currently accessing Community Rehabilitation and Treatment services at their local designated community mental health agency. This is an underserved and often overlooked population that would greatly benefit from an expansion of services through the use of credentialed Peer Specialists.

Washington County Mental Health Services, Inc. is willing to participate in planning and implementation activities to support the use of peer specialists to serve this population within our catchment area. Washington County Mental Health Services (WCMHS) looks forward to working with the regional Adult Local Interagency Team. WCMHS is willing to assist the Adult State Interagency Team with identifying state-level barriers and strategies to address those barriers.

It is WCMHS' hope that the lessons learned from the implementation of this grant will broaden our understanding of this population and make changes to our services based upon this knowledge -- specifically how we engage with and serve them.

Implementation of this grant will improve services for this population as well as strengthen WCMHS' existing relationships with participating community partners.

Please do not hesitate to contact me if you have any questions or need more information.

Sincerely,

Paul Dupre  
Executive Director, Washington County Mental Health Services, Inc.

Attachment 2: Letter to SSA: N/A

## Attachment 3: Draft Service Implementation Plan

1. The practice(s) that will be newly available in the community of focus:

Certified Peer Specialists will provide evidence-based Illness Management and Recovery Supported Employment.

2. Population of focus for the identified services

Adults age 18-34 with or at risk for serious mental illness who are not currently accessing comprehensive CMHC services (CRT)

3. Community(s) in which the services will be available

Montpelier  
Burlington  
Two rural communities (TBD)

4. Number of individuals who will be served by the newly available services

850

5. How service delivery will be funded in terms of specific dollar amounts, funding streams

\$ 504,135 in SAMHSA grants funds will be sub-granted to designated service providers on a monthly basis once the service providers (the Peer Specialist) are hired

The Division of Vocational Rehabilitation will provide matching funds for 50% of any peer specialists position that s focused on supported employment. Those funds will be transferred form DVR to DMH, and DMH will include those funds in sub grants to the service providers.

6. The role consumers will play in designing, providing, monitoring, and evaluating the services

Consumers will serve on the Adult State Interagency Team (SIT) and the Adult Local Interagency Teams (LITs), both of which will oversee the design of service provision at the local level.

Consumers will be hired and credentialed as Certified Peer Specialists to provide the services described in the grant application.

The SIT and LITs, which will include consumer members, will receive regular evaluation reports specific to monitoring and evaluating the services that are being provided (see Section E).

The evaluator and peer specialists will meet with consumers receiving grant funded-services on regular intervals to seek evaluation feedback on those services (See Section E).

7. How the workforce (including all relevant agencies) will be trained, supported, and developed on an ongoing basis to deliver the services:

Hiring, supporting, and training Peers Specialists will be accomplished by each community LIT as specified by their approved plan. Each LIT will identify a lead agency to host and supervise local Peer Specialists, who will work with LIT partners to meet consumers' needs. Seven (7 FTE) Certified Peer Specialist Positions will be funded during the first year of the grant and eleven (11 FTE) will be working in multiple settings by year 2. Peer Specialists will be half time staff in most cases. This will allow consumers to accept these positions without compromising their public benefits. Teaming will ensure that in all of the communities Peer Specialists can provide mutual support as well as cover for each other if necessary. In the first year, recommendations of the North Carolina Peer Support and Recovery Task Force will guide implementation. This model is Medicaid reimbursable.

Peer Specialists will provide individualized, recovery focused service based on a relationship of mutuality that allows consumers to learn to manage their own recovery and advocacy process. Peer Specialists provide outreach in community settings, engage consumers, and offer supportive services including self help, advocacy, skill building and sharing information, and assisting each consumer identify personal goals and interventions utilizing the IMR framework. Peer Specialists offer "bridging" services to help consumers connect with the full range of services available in the community. The LIT is a continuous resource to the Peer Specialists, identifying services and adapting existing services to consumers' identified needs.

Credentials: Peer Specialists self identify as consumers with life experience of serious mental illness and are well grounded in their own recovery. They will receive general and clinical supervision from a qualified professional identified by the LIT.

Hiring: each LIT will empanel a committee including professionals and consumers who will develop plans for wide dissemination of information about the position, as well as advertising, interviewing and making a final hiring decision.

Training: Peer Specialists will be oriented to their role by their supervisor who will also assist them in assessing their personal strengths and resources. A personalized training plan will be developed for each Peer Specialist, which will include participation in IMR, Peer Specialist and SE Training (described below). It will also include coaching, weekly supervision, shadowing, and practice/feedback on newly acquired skills. Each LIT will identify a team of 10 including the Peer Specialists, CMHC clinicians and case managers, and community service providers and recovery supports. The Project Director will work with the New Hampshire Dartmouth Psychiatric Research Center (PRC) and Dr. Margaret Swarbrick, a national leader in Peer Specialist training to develop schedules and sequences for manualized training in IMR, SE, and the National Association of Peer Specialists Curriculum. Training offered in each site in the first year of implementation will include: 3 days on Illness Management and Recovery, 3 days on Supported Employment and 8 days on Peer Specialists as providers of services. Core team members will participate in trainings consistent with their roles, including at least a one day overview of each evidence based approach. In addition, ongoing coaching, through webinars and on site consultation, will be offered through the course of the grant period. The Project Director,

PRC, and Margaret Swarbrick will also work with the LITs to develop a Peer/Professional Team approach to training and service provision. Within 60 days of hiring Peer Specialists, the teams will receive day long training on working with peer supports. This training event will provide time for Team members to discuss opportunities for partnering and identify barriers and solutions. Workforce development will be funded by SAMHSA grant funds.

For additional information on timelines, see section C – Timeline.

8. How communications/coordination among relevant agencies, providers, and organizations will occur on an ongoing basis to support service delivery

Existing Local Interagency Teams (LITs) in each demonstration site will be augmented to include all relevant agencies, provider and organizations. LITs will meet on a monthly basis with the host agency that is providing peer specialist services to support service delivery.

9. Policies, statutes, and regulations that will need to be put into place to support and sustain service delivery, and mechanisms that will be put into place to ensure the accountability of the service delivery

DMH will establish a formal Peer Specialists Credential that will be eligible for Medicaid reimbursement. The credential will continue beyond the grant and allow for existing funding through Medicaid to sustain the service.

The SIT will develop state policy necessary to sustain transformation. Planning grants to the CMHCs will allow them to incorporate “lessons learned” and develop more welcoming practices for these consumers. The number and breadth of state and local policies developed will be based on specific areas of need identified during the implementation of grant activities. These CMHC policies may focus on the hiring of peer specialists and the adoption of practices that are more welcoming to the target population.

The Project will permanently increase consumer voice in planning by adding consumer members and representatives of Vermont Psychiatric Survivors to the SIT and LITs.

Participating service providers will continue to report consumer-level data using ServicePoint (see Section E) following the end of the grant, and this data will be analyzed for ongoing evaluation by DMH. Funding required to continue data collection and analysis will be minimal and will be supported by state funds.

Fidelity Assessment used to maintain the quality of service provision will be incorporated into the DMH quality management function and will continue following the end of the grant. DMH already has capacity to complete SE and IMR fidelity assessments (see section D). Once service provision achieves high fidelity, the frequency of assessments by DMH can be reduced.



#### Attachment 4: Signed Documentation of Stakeholder Commitment

Patrick Flood, State of Vermont, Agency of Human Services  
Diane Dalmasse, VocRehab Vermont, Agency of Human Services, Department  
of Disabilities, Aging and Independent Living  
Jane Helmstetter, Agency of Human Services  
Don Mandelkorn, Agency of Human Services  
National Alliance on Mental Illness of Vermont  
Vermont Psychiatric Survivors, Inc.  
Vermont Recovery Network  
Friends of Recovery--Vermont  
Burlington Police Department  
City of Burlington  
City of Montpelier  
City of Barre  
Dartmouth Evidence-Based Practices Center  
Margaret Swarbrick, PhD, OTR, CPRP  
Vermont Council of Developmental and Mental Health Services



State of Vermont State  
Agency of Human Services  
Office of the Secretary  
103 South Main Street  
Waterbury, VT 05671-0204  
[www.humanservices.vermont.gov](http://www.humanservices.vermont.gov)

Robert D. Hofmann, Secretary

[phone] 802-241-2244  
[fax] 802-241-2979

April 26, 2010

Michael Hartman, Commissioner  
Department of Mental Health  
103 South Main Street  
Wasson Hall  
Waterbury, VT 05671

Dear Commissioner Hartman:

I am writing to support the Vermont Department of Mental Health's (DMH) application for a federal *Mental Health Transformation Grant* to foster adoption and implement permanent transformative changes in how public mental health services are organized, managed and delivered so that they are consumer-driven, recovery-oriented and supported through evidence-based and best practices. I understand that DMH plans to expand services for young adults (ages 18-34) with or at risk of serious mental illness who are not currently accessing Community Rehabilitation and Treatment services at their local designated community mental health agency.

The target population often "falls through the cracks" of our services systems because they are not eligible for CRT services and/or they choose not to access community mental health services. In some cases, these individuals have multiple interactions with law enforcement, homeless shelters, corrections and hospital emergency rooms.

Over the past year, Vermont has developed Adult State and Local Interagency Teams to address the needs of individuals involved in the criminal justice system with a serious functional impairment. As chair of the State Interagency Team, it is abundantly clear to me that we need to continue to strengthen our community capacities to adequately support individuals and their families from going deeper into the criminal justice system and to successfully reenter the community from prison. The Local Interagency Teams and community systems will benefit immensely from the support and collaboration between local peer specialists and other community partners to improve access to services.

We will be pleased to support the state and local planning and implementation efforts to support the use of peer specialists to serve this population in specific Vermont communities. Once implemented, we may utilize the State and Local Interagency Teams to develop strategies to address system and program barriers.

Please let me know if I can be of any additional assistance.

Sincerely,

Patrick Flood  
Deputy Secretary

State of Vermont  
VocRehab Vermont  
Department of Disabilities, Aging and Independent Living  
103 South Main Street, Weeks IA  
Waterbury VT 05671-2303  
[www.vocrehab.vermont.gov](http://www.vocrehab.vermont.gov)

Agency of Human Services

Phone or TTY: 802-241-2186  
Toll Free: 866-879-6757  
Fax: 802-241-3359

Michael Hartman  
Commissioner  
Department of Mental Health  
103 South Main Street  
Wasson Hall  
Waterbury, VT 05671

Dear Commissioner Hartman,

I am very happy to commit the Vermont Division of Vocational Rehabilitation (DVR) to be a partner in the Department of Mental Health (DMH) application for the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services, Mental Health Transformation Grant.

The DMH application plans to expand services for young adults (ages 18-34) with or at risk of serious mental illness who are not currently accessing local community mental health services. This population often "falls through the cracks" of the Vermont service system because they are either not eligible for services and/or they choose not to access community mental health services. In some cases, these individuals have multiple interactions with law enforcement, homeless shelters, corrections, and hospital emergency rooms.

We believe the focus of the DMH application on peer outreach and evidence based employment services is exactly the right approach to engaging this population. When surveyed, a very high proportion of these young people identified getting a job as their primary goal. We see employment as being an essential component of recovery and ongoing wellness for young people with psychiatric disabilities. What could be more debilitating for a twenty five year old than the being unemployed, poor and having few prospects?

DVR believes so strongly in this application, that we are willing to commit the following resources to the project if funded by SAMHSA.

- DVR will provide 50% of the funding for up to five Peer Vocational Specialists to be located in five sites across the state. This commitment will equal approximately \$125,000 per year, when all five sites are implemented.



- DVR will assign a designated VR counselor in each of the five sites to facilitate access to DVR services. The VR counselor will work as part of the peer outreach team in community settings.
- DVR will ensure the Peer Vocational Specialists become part of the Creative Workforce Solutions local employer outreach teams. Being part of these teams will greatly facilitate their access to local employer contacts and link them in with local employment and supported employment providers.
- DVR will ensure program participants can access “progressive employment” opportunities through Creative Workforce Solutions. Progressive employment offers low risk opportunities for participants to try out competitive employment opportunities through a variety of options (company tours, short term job tryouts, temp to hire options and on the job training options). Combined with evidence based supported employment, progressive employment can really facilitate rapid entry into the workplace.
- DVR will ensure project participants have access to VR case service funds. VR case service funds can be used to support any activities directly related to the young person’s employment plan including vocational training, transportation, work clothing, tools and equipment and short term maintenance (food, rent etc).

We strongly support the Vermont application for the SAMHSA Mental Health Transformation Grant and are willing to bring significant resources to the table to make the project a success. If funded I believe this proposal has the potential to not only transform mental health services in Vermont but could transform vocational rehabilitation services for this population.

Sincerely,



Diane Dalmasse  
Director





**State of Vermont**

**AGENCY OF HUMAN SERVICES**

AHS Field Services  
Burlington District Office  
59-63 Pearl St.  
Burlington, Vermont 05401

802-651-1684  
fax: (802) 863-7655

April 26, 2010

Michael Hartman, Commissioner  
VT Dept. of Mental Health  
103 South Main St., Wasson Hall  
Waterbury, VT 05671-2510

Dear Commissioner Hartman:

I am writing this letter of support for the Vermont Department of Mental Health's (DMH) application for a federal Mental Health Transformation Grant. It is my understanding this grant program, offered by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, could provide up to \$750,000 per year for five years to create and/or expand capacity to serve adults with or at risk of serious mental illness who are currently under-served. From my vantage point in the community, this is a much needed resource.

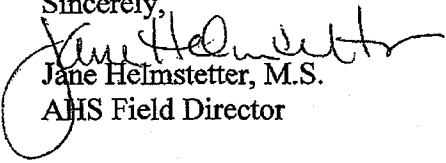
As you are aware, I facilitate the district Adult Local Interagency Team (LIT) weekly meeting which brings together multiple mental health programs from our designated agency as well as service providers from the Police Dept., Homeless Shelters, State and Non-profit Services and Faith-based Organizations. Together - we work to support those individuals you have targeted in your grant proposal who "fall through the cracks of our services systems because they are not eligible for CRT services and/or they choose not to access community mental health services." They do, in many cases, have multiple interactions with law enforcement, homeless shelters, corrections, and hospital emergency rooms and yet, are not able to get the significant support they need. Although we have seen some success with our model - it has been "one case at a time". Your proposal could assist our work toward changing the way the system functions to better meet this challenge regardless of the players involved and increase the numbers of those served.

In discussing your proposal with our Adult LIT, there was an interest on the part of our team to participate in the planning process for peer specialists and to include these positions in the work of the LIT. We have consistently identified the need not only for increased flexible funding to bring to the table, but also an increase in "non-categorical" case management with the flexibility to provide more of a "peer support" model. Our

team would be interested in working together with DMH to share resources and the knowledge we have accrued through this work. As you may know, the group came together in August of 2006 in regard to one specific case and has been meeting weekly since. Not only has this model produced many successful results for the clients served, it has functioned as a peer support forum. We believe our success is directly related to the shared responsibility and teaming approach used. It is exciting to think about the expansion the resource of this grant could provide for both assessment and increased service to clients. It could also further enhance the connection from our local Adult LIT to the Adult State Interagency Team.

I look forward to exploring the concepts of this grant proposal should the State of Vermont be fortunate to receive it.

Sincerely,



Jane Helmstetter, M.S.  
AHS Field Director



State of Vermont  
AHS Field Services  
McFarland State Office Bldg  
5 Perry Street, Suite 10  
Barre, Vermont 05641  
[www.ahs.state.vt.us](http://www.ahs.state.vt.us)

[phone] 802-479-7594  
[fax] 802-479-4230

Agency of Human Services

April 28, 2010

Michael Hartman, Commissioner  
Vermont Department of Mental Health

Dear Michael,

It's a pleasure to support the Department of Mental Health's application for a *Mental Health Transformation Grant*, and if funded, we look forward to working with your staff to build on the strengths of our local system of care to improve services and supports to young adults, ages 18 to 34.

As you know, our area has a strong history of working together to address the needs of children with serious emotional disturbance, and their families. The longstanding and successful collaborative efforts between DCF and Washington County Mental Health, in particular, help create the needed foundation to bring that same collaborative spirit to the needs of the population this grant hopes to address. Despite our best efforts, this target group for the grant remains one of our most challenging areas in which to bring services to meet the need.

Recent efforts, however, such as our Women and Corrections initiative, begun in 2005, helps meet the needs of women returning to our communities. This past year, we actively participated in the development of a regional plan to meet the requirements of the Youth in Transition grant. Our adult local interagency committee meets whenever there's a call to action. While we're preparing to "close the book" on our AHS peer navigation program, we've had a very successful run. Finally, our System of Care Team, which oversees the above mentioned task forces and interagency teams, is well-positioned to help provide the management oversight and leadership needed to get started if DMH receives this needed funding.

We look forward to working with your staff, the state Adult Local Interagency Team, and anyone else to help learn from the implementation of this pilot in Washington County.

Thanks for thinking of us. If I can be of further assistance, let me know.

Sincerely,

A handwritten signature in black ink, appearing to read "Don Mandelkorn".

Don Mandelkorn  
Director of Field Services





## NAMI – VERMONT

National Alliance on Mental Illness of Vermont

162 S. Main St. - Waterbury VT 05676

Toll-free in VT: (800) 639-6480

(802) 244-1396 ♦ (802) 244-1405 (fax)

---

on the web at: [www.namivt.org](http://www.namivt.org) ♦ email: [info@namivt.org](mailto:info@namivt.org)

April 26, 2010

Michael Hartman, Commissioner  
Vermont Department of Mental Health  
Wasson Hall  
Waterbury, VT 05676

Dear Commissioner Hartman:

On behalf of the Board of Directors of NAMI-Vermont and over five-hundred of our members and other Vermonters with mental illness and their families, we are pleased to offer our support of the Vermont Department of Mental Health's (DMH) application for a *Mental Health Transformation Grant* offered by the SAMHSA.

NAMI is the National Alliance on Mental Illness, the nation's largest grassroots mental health organization dedicated to improving the lives of individuals and families affected by mental illness. The National Alliance on Mental Illness-Vermont (NAMI-VT) is a statewide chapter of NAMI which engages in advocacy, research, support and education for the more than 1 in 5 Vermonters who are impacted by serious mental illness. Members of NAMI-Vermont are individuals, families, and friends living with mental illness such as major depression, schizophrenia, bipolar disorder and posttraumatic stress disorder. For more than twenty-five years, NAMI-VT has promoted and provided education programs for families and providers, organized support groups for both consumers and family members, advocated funding of mental health services, helped advance mental health parity and reduce stigma, and worked for legislative, regulatory, and system changes from the family perspective.

As you well know, The National Alliance on Mental Illness-Vermont (NAMI-Vermont) endorses the investment in and development of an integrated, cost-effective mental health care system in Vermont that is accessible to all persons disabled by mental illness. Currently, in addition to our offerings of educational workshops, classes and other programs for families and providers, we offer *Connections*, a recovery support group for adults with mental illness regardless of their diagnosis. Moreover, we offer volunteer-led family support groups in twelve towns throughout Vermont. As part of our contract with the Department of Mental Health, we provide information and referral services to family members whose siblings, children and friends are impacted by serious mental illness.

Registration and evaluation data collected by program teachers reveal that a significant proportion of our *Connections* participants are young adults between the ages of 18 and



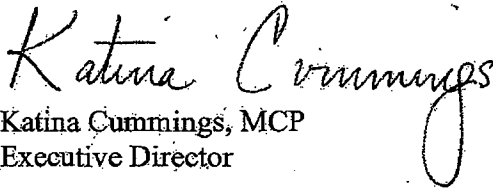
35. Periodic reports from our facilitators and teachers of our family support groups and educational offerings also confirm that a high proportion of those who seek these programs either are young adult consumers or family members who are involved because of their relationship with young adults with mental illness—many of whom with no access to community mental health services. Moreover, membership information gathered by NAMI-Vermont as well as summary reports from our Warm Line telephone calls point to a similar conclusion that this target population is currently underserved and would benefit from the services proposed in this grant application.

NAMI-Vermont is pleased to participate in planning and implementation activities to support the work of peer specialists to serve this population in targeted Vermont. We also look forward to working with the Adult State Interagency Team to assist with identifying systemic state-level barriers to serving this population and developing strategies to eliminate those barriers. Finally, it is in all of our best interest to understand and use the lessons learned during the planning and implementation of this grant to improve the effectiveness of our programs in reaching and serving this population.

As an organization of family members and consumers, we feel that the stigma attached to mental illness has been a strong impediment to identifying and serving young adults with mental illness. As you know, it is often a family member who is the first voice seeking support for their loved ones living with mental illness. Thus, it is our sincere hope that the implementation of this grant will combine peer-based, evidenced based interventions with family-based NAMI programs addressing the needs of this population.

Thank you for the opportunity to support this long-overdue initiative and we look forward to becoming an active and positive partner to meet the unique behavioral health needs of this special population.

Sincerely yours,



Katina Cummings, MCP  
Executive Director

VPS  
Vermont  
Psychiatric  
Survivors

1 Scale Ave., Suite 52  
(Building 6A)  
Rutland, Vermont 05701  
802-775-6834  
Consumers 1-800-564-2106  
Fax 802-775-6823  
e-mail: vpsinc@together.net

April 23, 2010

To Whom it May Concern:

Vermont Psychiatric Survivors (VPS) is recognized as a statewide 501c3 peer-run program. VPS contracts with the state of Vermont to do peer programs in the state .

The population of 18-34 are often lost in the shuffle from child to adult services. They are often picked up by corrections before getting services or become a suicide statistic. Any programming to assist in preventing the loss of this population in the system would be extremely valuable.

Peer programs can be an asset but there needs to be an avenue to reach out to them and get them involved in finding a solution. Professional services need to reach out and listen to what the population is saying they need.

This grant could assist Vermont in doing this.

VPS is willing to assist in developing training to peers to effectively interact with this population. Presently VPS is exploring needs of training to adults to do peer activities in the community. The peer population in Vermont hasn't develop terminology for what the positions will be called. However we have been exploring peer specialist training throughout the United States. This grant could help on building this avenue to a statewide peer workforce. VPS is also one of the few organizations that is presently actively reaching out to this population by using art and dialoguing with them to support them in exploring their choices. As an organization we would be willing in serving on committees to develop the overall plan of the grant and following up on it's progress. VPS is always open to new ways to expand or better their services. It is felt that for the program to have a future, it must be open to ideas. Also VPS is willing to share their experiences with this population to address what they have learned. Barriers will need to be identified and VPS is willing to assist in identifying and helping to find solutions. VPS has a good working relationship with the Vermont Department of Mental Health. Through this relationship peer programs are wide spread within the community.

Sincerely,  
Linda J Corey MS  
*Linda J Corey MS*  
Executive Director



P.O. Box 37  
White River Junction, VT 05001  
vtrecoverynetwork@gmail.com  
www.vtrecoverynetwork.org  
802-738-8998

April 28, 2010

Michael Hartman  
Commissioner  
Department of Mental Health  
103 S Main Street  
Waterbury, Vermont

Dear Michael,

I'm heartened to learn that you are applying for the Substance Abuse and Mental Health Services Administration's, Mental Health Transformation Grant. Your current efforts toward adopting and implementing changes in mental health services delivery are clearly making a difference and this will help to further your efforts. This grant will help further your efforts to include consumer voices, increase recovery-orientation, and adopt evidence-based practices. We really need to expand on our ability to reach and serve adults with serious mental illness. Those of us who provide recovery supports for people with substance abuse problems have found that about half of the people we serve have co-occurring disorders. Our growing Network of Recovery Centers (soon to be 11) has experienced difficulty in finding ways to refer and to serve those people with co-occurring disorders who have significant levels of mental illness. They try to utilize our recovery centers, but their needs are really to great for our volunteer based services. Your proposed grant will provide the basis for conversations and services which should help us solve this problem.

Thank you for your invitation to participate in the planning and the implementation activities that will lead to the use of peer specialists to serve this population. Let me express my willingness to assist the Adult State Interagency Team with identifying state-level barriers and strategies to address these barriers. The service delivery this grant will make possible is going to directly respond to a significant gap in services. Filling this gap will make a difference.

Sincerely yours,

Mark A. Ames  
Network Coordinator

# Friends of Recovery – Vermont

www.friendsofrecoveryvt.org

Michael Hartman  
Office of the Commissioner  
Department of Mental Health  
State of Vermont  
103 South Main St.  
Wasson Hall  
Waterbury VT 05671

April 27, 2010

Dear Commissioner Hartman:

This letter is in reference to the Vermont Department of Mental Health's (DMH) application for a federal *Mental Health Transformation Grant*. In the grant proposal, DMH plans to expand services for young adults (ages 18-34) with or at risk of serious mental illness who are not currently accessing Community Rehabilitation and Treatment services at their local designated community mental health agency. This population often "falls through the cracks" of our services systems because they are not eligible for CRT services and/or they choose not to access community mental health services. In some cases, these individuals have multiple interactions with law enforcement, homeless shelters, corrections, and hospital emergency rooms.

Friends of Recovery- Vermont, a statewide, grassroots advocacy and education organization, is thoroughly committed to supporting the DMH in applying for this grant. As a Recovery Community Organization (RCO), FOR-VT has clearly identified the proposed target population as one with the greatest need of a range of proactive, engaging, practical, community-based peer-support and treatment practices. FOR-VT's focus is on peer-led recovery support services as an integral part of the system of care. With that in mind, FOR-VT will support the implementation of the project by engaging peers in recovery from mental health and substance abuse conditions to join the workforce as peer recovery support specialists.

If this grant is received, FOR-VT will

- Participate in planning and implementation activities to support the use of peer specialists to serve this population statewide and in specific Vermont communities
- Use the lessons learned from implementation of this grant to improve how Friends of Recovery- Vermont engages with and serves this population
- Assist the Adult State Interagency Team with identifying state-level barriers and strategies to address those barriers.

Feel free to contact me for further assistance and support of your application.

Sincerely,

  
Patty McCarthy  
Executive Director  
Friends of Recovery - Vermont

PO BOX 1202 Montpelier, VT 05601 1 (802) 229-6103 Toll free 1 (800) 769-2798 Fax: 1 (802) 828-5252



**BURLINGTON POLICE DEPARTMENT**

1 North Avenue  
Burlington, Vermont 05401

Michael E. Schirling  
Chief of Police

Phone (802) 658-2704  
Fax (802) 865-7579  
TTY/TDD (802) 658-2700

April 27<sup>th</sup>, 2010

Michael Hartman, Commissioner  
Department of Mental Health  
103 South Main Street  
Waterbury, VT 05671

Dear Commissioner Hartman,

On behalf of the Burlington Police Department, I am writing to express our support for the Vermont Department of Mental Health's (DMH) application for the SAMHSA *Mental Health Transformation Grant*.

We strongly agree that the proposed target population (adults 18-34 who have or are at risk of serious mental illness) is currently being underserved in our region. As Chief Schirling has testified at the Vermont legislature, much of this population is not eligible for more intensive community mental health services, and, as a result, a portion of this population has frequent interactions with our officers. Many of these interactions are the result of or related to their mental health issues and/or substance use, and the lack of available services creates an additional burden on our police department and many other community agencies.

*Respect ~ Honor ~ Remember*

*Officer James W. McGrath, end of watch May 12, 1904; Officer J. Albert Fisher, end of watch December 15, 1947*  
Vermont Department of Mental Health -97- SAMHSA SM-10-010 MHTG

We fully support the implementation of this grant in our city and the addition of mental health staff to engage with and support this population. Please let us know what we can do to support this initiative.

Sincerely,



Walter C. Decker  
Deputy Chief  
Burlington Police Department

*Respect ~ Honor ~ Remember*

**Office of  
the Mayor  
Burlington,  
Vermont**



**Bob Kiss**  
Mayor  
Room 34, City Hall  
Burlington, VT 05401  
Tel: (802) 865-7272  
Fax: (802) 865-7270  
TDD: (802) 865-7142

April 23, 2010

Michael Hartman, Commission  
Department of Mental Health  
103 South Main Street  
Waterbury, VT 05671

Dear Michael,

On behalf of the City of Burlington, I am writing to express our support for the Vermont Department of Mental Health's (DMH) application for the SAMHSA *Mental Health Transformation Grant*.

We strongly agree that the proposed target population (adults 18-34 who have or are at risk of serious mental illness) is currently being underserved in our region. Because much of this population is not eligible for more intensive community mental health services and has a tendency to avoid those mental health services that are available, we have found that this population tends to have multiple interactions with law enforcement, corrections, crisis services, emergency rooms, and homeless shelters in our city.

We support the implementation of this grant in our city and the addition of mental health staff to engage with and support this population. Please let us know what we can do to support this initiative.

With best regards,

  
Bob Kiss  
Mayor



## CITY OF MONTPELIER, VERMONT

- THE SMALLEST CAPITAL CITY IN THE UNITED STATES -

Mayor Mary S. Hooper

City Council:

Tom Colonka  
Andy Hooper  
Sarah Jarvis  
Jim Sheridan  
Nancy Sherman  
Alan Welas

William Fraser,  
City Manager  
wfraser@montpelier-vt.org

Beverlee Pembroke Hill  
Assistant City Manager  
bhill@montpelier-vt.org

April 28, 2010

Michael Hartman, Commissioner  
Department of Mental Health  
103 South Main Street  
Waterbury, VT 05671

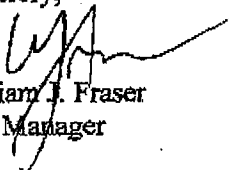
Dear Commissioner Hartman,

On behalf of the City of Montpelier, I am writing to express our support for the Vermont Department of Mental Health's (DMH) application for the SAMHSA *Mental Health Transformation Grant*.

We strongly agree that the proposed target population (adults 18-34 who have or are at risk of serious mental illness) is currently being underserved in our region. Because much of this population is not eligible for more intensive community mental health services and has a tendency to avoid those mental health services that are available, we have found that this population tends to have multiple interactions with law enforcement, corrections, crisis services, emergency rooms, and homeless shelters in our city.

We support the implementation of this grant in our city and the addition of mental health staff to engage with and support this population. Please let us know what we can do to support this initiative.

Sincerely,

  
William J. Fraser  
City Manager

cc: Mayor Hooper & City Council Members  
Police Chief Anthony Facos

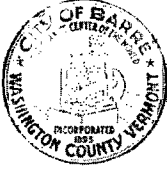
(802) 223-9502, TELEPHONE

39 MAIN STREET, MONTPELIER, VT 05602

(802) 223-9519, FAX

WWW.MONTPELIER-VT.ORG





# *City of Barre, Vermont*

*"Granite Center of the World"*

John C. Craig  
City Manager

6 N. Main St., Suite 2  
Barre, VT 05641  
Telephone (802) 476-0240  
FAX (802) 476-0264  
[manager@barrecity.org](mailto:manager@barrecity.org)

Michael Hartman, Commissioner  
Department of Mental Health  
103 South Main Street  
Waterbury, VT 05671

Commissioner Hartman,

On behalf of the City of Barre, I am writing to express our support for the Vermont Department of Mental Health's (DMH) application for the SAMHSA Mental Health Transformation Grant.

We strongly agree that the proposed target population (adults 18-34 who have or are at risk of serious mental illness) is currently being underserved in our region. Because much of this population is not eligible for more intensive community mental health services and has a tendency to avoid those mental health services that are available, we have found that this population tends to have multiple interactions with law enforcement, corrections, crisis services, emergency rooms, and homeless shelters in our city. We welcome the opportunity to assist the Department to address this population of residents in our city.

We support the implementation of this grant in our city and the addition of mental health staff to engage with and support this population. Please let us know if there is anything additional we can do to support this initiative.

Best Regards,

John Craig  
Barre City Manager

**Dartmouth Evidence Based Practices Center**



***Dartmouth Psychiatric Research Center***

Hugh Gallen State Office Park  
105 Pleasant Street  
Concord, New Hampshire 03301  
Phone (603) 271-5747  
Fax (603) 271-5265

April 22, 2010

Michael Hartman, Commissioner  
Department of Mental Health  
103 South Main Street  
Waterbury, VT 05671

Dear Michael,

On behalf of the Dartmouth Evidence-Based Practices Center, I am writing to express our interest in working with the Vermont Department of Mental Health to expand the availability of Illness Management and Recovery and Supported Employment to young adults (ages 18-34) who are not currently engaged with your community mental health centers. We are excited about the use of peer specialists to deliver elements of these evidence-based practices and look forward to working with you.

Sincerely,

A handwritten signature in black ink, appearing to read 'D Lynde'.

David

David Lynde, MSW  
Co-Director Dartmouth Evidence Based Practices Center

Dr. Trish Singer  
Adult Mental Health Director  
103 South Main Street  
Wasson Hall  
Waterbury, VT 05671-2510

Dear Dr. Singer,

I am very excited to support your Mental Health Transformation Grant. I am very willing to provide peer support training for this project.

I have multiple levels of experience in the area of peer support including personal experiences as a service recipient who benefited at a very young age from support to pursue employment as a means for recovery. As a professional I have designed and implemented a variety of peer support trainings focused on employment, recovery and wellness. I am willing and able to assist in providing the peer support training for your project.

Margaret (Peggy) Swarbrick, PhD, OTR, CPRP

**Staff**

Julie Tessler  
Executive Director

Erin Campos  
Administrative  
Coordinator

Mariys Waller  
Developmental Services  
Coordinator

Nick Emlen  
Mental Health  
Services Coordinator



April 27, 2010

**Council Members**

Champlain Community  
Services

Clara Martin Center

Counseling Service  
of Addison County

Families First in  
Southern Vermont

Health Care and  
Rehabilitation Services  
of Southeastern Vermont

Howard Center

Lamoille County  
Mental Health Services

Lincoln Street, Inc.

Northeast Kingdom  
Human Services

Northwestern Counseling  
and Support Services

Northeastern Family  
Institute

Rutland Mental Health  
Services

Sterling Area Services

United Counseling Services  
of Bennington County

Upper Valley Services

Washington County  
Mental Health Services

**National Memberships**

National Council for  
Community Behavioral  
Healthcare

American Network of  
Community Options  
and Resources

Michael Hartman, Commissioner  
Attn. Patty Breneman  
Department of Mental Health  
103 S. Main St, Wasson Hall  
Waterbury VT 05671-2510

Dear Commissioner Hartman,

As you know the Vermont Council of Developmental and Mental Health Services promotes a statewide, non-profit system of developmental and behavioral health care services for individuals with developmental disabilities, serious persistent mental illness, substance abuse and severe emotional disturbance. The Council represents sixteen agencies designated by the state to provide a continuum of quality care and services in every community in Vermont.

On behalf of the Council I am writing to support the Department's application for a Mental Health Transformation Grant from SAMHSA. The stated purpose of the grant directly addresses several identified goals of Vermont's system of care for adult mental health.

In November 2007 and May 2008 the Council co-hosted statewide forums on expanding the availability of evidence-based peer services in Vermont's mental health system of care. Participants included members of Local & State Program Standing Committees, legislators, community members, service providers and representatives from your Department. These forums demonstrated the depth and breadth of support within Vermont for developing statewide resources for peer-based mental health services. Several of the major recommendations that emerged from the forums align with the intent of the current grant application, including the creation of an ongoing statewide team to foster peer services. Our existing state and local interagency teams would be an excellent vehicle for advancing this work with grant support.

It is well known in Vermont that our system of care does not reach a significant portion of the young adult population in need of mental health services. We believe that the use of credentialed peer specialists to perform this function would greatly assist in reaching this underserved group and reducing the demand on other more intensive 'downstream' community resources. Our organization would be available

137 Elm Street, Montpelier, Vermont 05602 Telephone: 802-223-1773

Fax: 802-223-5523 Website: www.vtcouncil.org

-104-

SAMHSA SM-10-010 MHTG

The National Association  
for Rural Mental Health  
Vermont Department of Mental Health

T n n B A

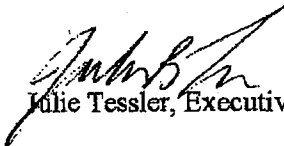
VT COUNCIL

04/28/2010 10:40 FAX 8022235523

to take part in the planning and implementation activities associated with this initiative, and to assist the State Interagency Team as needed in the effort. I am confident that our member agencies will welcome the momentum generated by the grant activities and support the resulting innovations in the use of peer specialists.

Thank you for taking this important step toward our shared goal of improving the quality of services to this underserved population.

Sincerely,

  
Julie Tessler, Executive Director

Attachment 5: CMHS-TRAC Infrastructure Categories and Indicators

<b>Infrastructure Category</b>	<b>Indicator</b>
<i>Policy Development</i>	<p><u>Number of new CMHC policies</u> adopted to create a more welcoming service system at the local level for the target population.</p> <p><u>Number of state level polices</u> adopted to continue support on the target population as a priority and for the Peer Specialist workforce and credentialing process</p>
<i>Workforce Development</i>	<p><u>Number of people</u> trained as Peer Specialists and in IMR and Supported Employment and credentialed as Peer Specialists</p> <p><u>Number of consumers</u> who provide mental health related services as Certified Peer Specialists.</p>
<i>Financing</i>	<p><u>Amount of funding</u> for mental health related practices (e.g. community-based crisis services, hospitals, and municipalities may contribute to the Peer Specialists as a means of reducing the demand on emergency and law enforcement services)</p> <p><u>Number of changes to financing policies</u> to fund grant services (use of Medicaid funds to support Peer Specialists).</p> <p><u>Amount of pooled or braided funding</u> with other agencies used for services supported through the grant; specifically the amount of funding Vocational Rehabilitation provided for Peer Specialists.</p>
<i>Accountability</i>	<p><u>Number of organizations</u> that regularly obtain, analyze and share data – that is, the degree to which the LITs and SIT share and discuss information provided in the annual Performance Assessment</p> <p><u>Number of consumers</u> representing consumer organizations involved in planning activities as members of the LITs and SIT;</p> <p><u>Number of consumers</u> involved in evaluation through participation in annual review of the Performance Assessment and evaluation of the evidence based practices implemented through the grant.</p>

<p><i>Types/Targets of Practices</i></p>	<p>Through annual structured interviews with LIT members and fidelity assessment, evaluator will gather data on the <u>number of communities</u> utilizing evidence based mental health related practices including Peer Specialists, IMR, and Supported Employment.</p> <p>Providers of these services will gather and report the <u>number of people</u> served by these evidence based practices.</p>
<p><i>Organizational Change</i></p>	<p><u>Number of organizational changes</u> made to support improvement in mental health practices as a result of the grant - data on the inclusion of consumers and other appropriate community members in both the LITs and SIT to better address the target population's needs.</p>

Attachment 6: Data Collection Instruments (Other than TRAC; including individual consumer recovery measure, measure of recovery promoting environment, applicable fidelity scale)

### **Consumer Outcome Survey: Illness Management and Recovery**

Please take a few minutes to fill out this survey. We are interested in the way things are for you, so there are no right or wrong answers. If you are unsure about a question, just answer it as well as you can. Check the box for the answer that best fits you.

Name or I.D. number: \_\_\_\_\_ Date: \_\_\_\_\_

**1. Progress toward goals:** In the past 3 months, the consumer has come up with ...

- . No personal goals
- . A personal goal, but has not done anything to achieve the goal
- . A personal goal and made it a little way toward achieving it
- . A personal goal and has gotten pretty far in achieving the goal
- . A personal goal and has achieved it

**2. Knowledge:** How much do you feel the consumer knows about symptoms, treatment, coping strategies (coping methods), and medication?

- . Not very much
- . A little
- . Some
- . Quite a bit
- . A great deal

**3. Involvement of family and friends in the consumer's mental health treatment:** How much are family members, friends, boyfriends or girlfriends, and other people who are important to the consumer (outside the mental health agency) involved in his or her treatment?

- . Not at all
- . Only when there is a serious problem
- . Sometimes, such as when things are starting to go badly
- . Much of the time
- . A lot of the time and they really help with the consumer's mental health

**4. Contact with people outside of the family:** In a normal week, how many times does the consumer talk to someone outside of his or her family (a friend, co-worker, classmate, roommate, etc.)?

- . 0 times a week
- . 1 to 2 times a week
- . 3 to 4 times a week
- . 5 to 7 times a week
- . 8 or more times a week



**5. Time in structured roles:** How much time does the consumer spend working, volunteering, being a student, being a parent, taking care of someone else or someone else's house or apartment? That is, how much time does the consumer spend doing activities that are expected of him or her for or with another person? (This would not include self-care or personal home maintenance.)

- 2 hours or less a week
- 3 to 5 hours a week
- 6 to 15 hours a week
- 16 to 30 hours a week
- More than 30 hours a week

**6. Symptom distress:** How much do symptoms bother the consumer?

- Symptoms *really* bother the consumer *a lot*
- Symptoms bother the consumer *quite a bit*
- Symptoms bother the consumer *somewhat*
- Symptoms bother the consumer *very little*
- Symptoms don't bother the consumer *at all*

**7. Impairment of functioning:** How much do symptoms get in the way of the consumer's doing things that he or she would like to do or needs to do?

- Symptoms *really* get in the consumer's way *a lot*
- Symptoms get in the consumer's way *quite a bit*
- Symptoms get in the consumer's way *somewhat*
- Symptoms get in the consumer's way *very little*
- Symptoms don't get in the consumer's way *at all*

**8. Relapse Prevention Planning:** Which of the following would best describe what the consumer knows and has done in order to not have a relapse?

- Doesn't know how to prevent relapses
- Knows a little, but hasn't made a relapse prevention plan
- Knows one or two things to do, but doesn't have a written plan
- Knows several things to do, but doesn't have a written plan
- Has a written plan and has shared it with others

**9. Relapse of symptoms:** When is the last time the consumer had a relapse of symptoms (that is, when symptoms have gotten much worse)?

- Within the last month
- In the past 2 to 3 months
- In the past 4 to 6 months
- In the past 7 to 12 months
- Hasn't had a relapse in the past year

**10. Psychiatric hospitalizations:** When is the last time the consumer has been hospitalized for mental health or substance abuse reasons?

- Within the last month
- In the past 2 to 3 months

- . In the past 4 to 6 months
- . In the past 7 to 12 months
- . No hospitalization in the past year

**11. Coping:** How well do you feel that the consumer is coping with his or her mental or emotional illness from day to day?

- . Not well at all
- . Not very well
- . All right
- . Well
- . Very well

**12. Involvement with self-help activities:** How involved are you in consumer run services, peer support groups, Alcoholics Anonymous, drop-in centers, WRAP (Wellness Recovery Action Plan), or other similar self-help programs?

- . I don't know about any self-help activities.
- . I know about some self-help activities, but I'm not interested.
- . I'm interested in self-help activities, but I have not participated in the past year.
- . I participate in self-help activities occasionally.
- . I participate in self-help activities regularly.

**13. Using medication effectively:** How often do you take your medication as prescribed?

- . Never
- . Occasionally
- . About half the time
- . Most of the time
- . Every day
- . Check here if no psychiatric medications have been prescribed for you.

**Illness Management and Recovery (IMR) Fidelity Scale**

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>1. # People in a Session or Group:</b> IMR is taught individually or in groups of 8 or less consumers.	Some sessions taught with over 15 consumers	Some sessions taught with 13-15 consumers	Some sessions taught with 11 or 12 consumers	Some sessions taught with 9 or 10 consumers	All IMR sessions taught individually or in groups of 8 or less
<b>2. Program Length:</b> Consumers receive at least 3 months of weekly IMR sessions or equivalent (e.g., biweekly for at least 6 months).	<20% of IMR clients receive at least 3 months of weekly sessions	20%-39% of IMR clients receive at least 3 months of weekly sessions	40%-69% of IMR clients receive at least 3 months of weekly sessions	70%-89% of IMR clients receive at least 3 months of weekly sessions	≥90% of IMR clients receive at least 3 months of weekly sessions
<b>3. Comprehensiveness of the Curriculum:</b> <ul style="list-style-type: none"> <li>• Recovery strategies</li> <li>• Mental illness facts</li> <li>• Stress-vulnerability model</li> <li>• Social support</li> <li>• Using medication</li> <li>• Preventing relapse</li> <li>• Stress management</li> <li>• Coping symptoms</li> <li>• Mental health system</li> </ul>	Curriculum materials include only 1 topic, or educational handouts are not available	Curriculum materials include 2 or 3 topic areas	Curriculum materials include 4 or 5 topic areas	Curriculum materials include 6 or 7 topic areas	Curriculum materials include 8 or 9 topic areas
<b>4. Provision of Educational Handouts:</b> All consumers participating in IMR receive IMR handouts.	<20% of IMR clients receive educational handouts	20%-39% of IMR clients receive educational handouts	40%-69% of IMR clients receive educational handouts	70%-89% of IMR clients receive educational handouts	≥90% of IMR clients receive educational handouts

<b>5. Involvement of Significant Others:</b> At least one IMR-related contact in the last month OR involvement with the consumer in pursuit of goals (e.g., assisting with homework assignments).	<20% of IMR clients have significant other(s) involved	20%-29% of IMR clients have significant other(s) involved	30%-39% of IMR clients have significant other(s) involved	40-49% of IMR clients have significant other(s) involved	≥50% of IMR clients have significant other(s) involved
<b>6. IMR Goal Setting</b> <ul style="list-style-type: none"> <li>• Realistic and measurable</li> <li>• Individualized</li> <li>• Pertinent to recovery process</li> <li>• Linked to IMR plan</li> </ul>	<20% of IMR clients have at least 1 personal goal in chart	20%-39% of IMR clients have at least 1 personal goal in chart	40%-69% of IMR clients have at least 1 personal goal in chart	70%-89% of IMR clients have at least 1 personal goal in chart	≥90% of IMR clients have at least 1 personal goal in their chart
<b>7. IMR Goal Follow-up:</b> Practitioners and consumers collaboratively follow up on goal(s) (See examples in the IMR Practitioner Workbook)	<20% of IMR clients have follow-up on goal(s) documented in chart	20%-39% of IMR clients have follow-up on goal(s) documented in chart	40%-69% of IMR clients have follow-up on goal(s) documented in chart	70%-89% of IMR clients have follow-up on goal(s) documented in chart	≥90% of IMR clients have follow-up on the goal(s) documented in their chart
<b>8. Motivation-Based Strategies:</b> <ul style="list-style-type: none"> <li>• New info &amp; skills</li> <li>• Positive perspectives</li> <li>• Pros &amp; cons of change</li> <li>• Hope &amp; self-efficacy</li> </ul>	<20% of IMR sessions use at least 1 motivation-based strategy	20-39% of IMR sessions use at least 1 motivation-based strategy	30-39% of IMR sessions use at least 1 motivation-based strategy	40-49% of IMR sessions use at least 1 motivation-based strategy	≥50% of IMR sessions use at least 1 motivation-based strategy
<b>9. Educational Techniques:</b> <ul style="list-style-type: none"> <li>• Interactive teaching</li> <li>• Checking for understanding</li> <li>• Breaking down info</li> <li>• Reviewing info</li> </ul>	<20% of IMR sessions use at least 1 educational technique	20%-39% of IMR sessions use at least 1 educational technique	30%-39% of IMR sessions use at least 1 educational technique	40%-49% of IMR sessions use at least 1 educational technique	≥50% of IMR sessions use at least 1 educational technique
<b>10. Cognitive-Behavioral Techniques:</b> <ul style="list-style-type: none"> <li>• Reinforcement</li> <li>• Shaping</li> <li>• Modeling</li> <li>• Role playing</li> <li>• Cognitive restructuring</li> <li>• Relaxation training</li> </ul>	<20% of IMR sessions use at least 1 cognitive behavioral technique	20%-39% of IMR sessions use at least 1 cognitive-behavioral technique	30%-39% of IMR sessions use at least 1 cognitive behavioral technique	40%-49% of IMR sessions use at least 1 cognitive-behavioral technique	≥50% of IMR sessions use at least 1 cognitive behavioral technique

<p><b>11. Coping Skills Training:</b></p> <ul style="list-style-type: none"> <li>• Review current coping</li> <li>• Amplify current coping or develop new coping skills</li> <li>• Behavioral rehearsal</li> <li>• Review effectiveness</li> <li>• Modify as necessary</li> </ul>	<p>Few or none of the practitioners are familiar with the principles of coping skills training</p>	<p>Some of the practitioners are familiar with the principles of coping skills training, with a low level of use</p>	<p>Some of the practitioners are familiar with the principles of coping skills training, with a moderate level of use</p>	<p>The majority of the practitioners are familiar with the principles of coping skills training and use it regularly</p>	<p>All practitioners are familiar with the principles of coping skills training and use it regularly</p>
<p><b>12. Relapse Prevention Training:</b> • Identify triggers • Identify early warning signs • Stress management • Ongoing monitoring • Rapid intervention as needed</p>	<p>Few or none of the practitioners are familiar with the principles of relapse prevention training</p>	<p>Some of the practitioners are familiar with the principles of relapse prevention training, with a low level of use</p>	<p>Some of the practitioners are familiar with the principles of relapse prevention training, with a moderate level of use</p>	<p>The majority of the practitioners are familiar with the principles of relapse prevention training and use it regularly</p>	<p>All practitioners are familiar with the principles of relapse prevention training and use it regularly</p>
<p><b>13. Behavioral Tailoring for Medication:</b> Behavioral tailoring includes developing strategies tailored to each individual's needs, motives and resources (e.g., choosing medication that requires less frequent dosing, placing medication next to one's toothbrush).</p>	<p>Few or none of the practitioners are familiar with the principles of behavioral tailoring for medication</p>	<p>Some of the practitioners are familiar with the principles of behavioral tailoring for medication, with a low level of use</p>	<p>Some of the practitioners are familiar with the principles of behavioral tailoring for medication, with a moderate level of use</p>	<p>The majority of the practitioners are familiar with the principles of behavioral tailoring for medication and use it regularly</p>	<p>All practitioners are familiar with the principles of behavioral tailoring for medication and use it regularly</p>

**SUPPORTED EMPLOYMENT FIDELITY SCALE\***

**1/7/08**

**Rater:**

**Site:**

**Date:**

**Total Score:**

**Directions:** Circle one anchor number for each criterion.

Criterion

Data  
Source\*\*

Anchor

**Staffing**

1. Caseload size: Employment specialists have individual employment caseloads. The maximum caseload for any full-time employment specialist is 20 or fewer clients.

MIS,  
DOC, INT

- 1= Ratio of 41 or more clients per employment specialist.
- 2= Ratio of 31-40 clients per employment specialist.
- 3= Ratio of 26-30 clients per employment specialist.
- 4= Ratio of 21-25 clients per employment specialist.
- 5= Ratio of 20 or fewer clients per employment specialist.

2. Employment services staff: Employment specialists provide only employment services.

MIS, DOC  
INT

- 1= Employment specialists provide employment services less than 60% of the time.
- 2= Employment specialists provide employment services 60 - 74% of the time.
- 3= Employment specialists provide employment services 75 - 89% of the time.
- 4= Employment specialists provide employment services 90 - 95% of the time.
- 5= Employment specialists provide employment services 96% or more of the time.

\*Formerly called IPS Model Fidelity Scale

\*\*See end of document for key  
Vermont Department of Mental Health

3. Vocational generalists: Each employment specialist carries out all phases of employment service, including intake, engagement, assessment, job placement, job coaching, and follow-along supports before step down to less intensive employment support from another MH practitioner. (Note: It is not expected that each employment specialist will provide benefits counseling to their clients. Referrals to a highly trained benefits counselor are in keeping with high fidelity, see Item # 1 in “Services”.)

MIS, DOC,  
INT, OBS

- 1= Employment specialist only provides vocational referral service to vendors and other programs.
- 2= Employment specialist maintains caseload but refers clients to other programs for vocational services.
- 3= Employment specialist provides one to four phases of the employment service (e.g. intake, engagement, assessment, job development, job placement, job coaching, and follow along supports).
- 4= Employment specialist provides five phases of employment service but not the entire service.
- 5= Employment specialist carries out all six phases of employment service (e.g. program intake, engagement, assessment, job development/job placement, job coaching, and follow-along supports).

**ORGANIZATION**

1. Integration of rehabilitation with mental health treatment thru team assignment: Employment specialists are part of up to 2 mental health treatment teams from which at least 90% of the employment specialist’s caseload is comprised.

MIS, DOC,  
INT, OBS

- 1= Employment specialists are part of a vocational program that functions separately from the mental health treatment.
- 2= Employment specialists are attached to three or more mental health treatment teams. OR Clients are served by individual mental health practitioners who are not organized into teams. OR Employment specialists are attached to one or two teams from which less than 50% of the employment specialist’s caseload is comprised.
- 3= Employment specialists are attached to one or two mental health treatment teams, from which at least 50 - 74% of the employment specialist’s caseload is comprised.
- 4= Employment specialists are attached to one or two mental health treatment teams, from which at least 75 - 89% of the employment specialist’s caseload is comprised.
- 5= Employment specialists are attached to one or two mental health treatment teams, from which 90 - 100% of the employment specialist’s caseload is comprised.

\*Formerly called IPS Model Fidelity Scale  
 \*\*See end of document for key  
 Vermont Department of Mental Health

2. Integration of rehabilitation with mental health treatment thru frequent team member contact:

Employment specialists actively participate in weekly mental health treatment team meetings (not replaced by administrative meetings) that discuss individual clients and their employment goals with shared decision-making. Employment specialist's office is in close proximity to (or shared with) their mental health treatment team members. Documentation of mental health treatment and employment services is integrated in a single client chart. Employment specialists help the team think about employment for people who haven't yet been referred to supported employment services.

MIS, DOC  
INT, OBS

1= One or none is present.

2= Two are present

3= Three are present.

4= Four are present.

5= Five are present.

All five key components are present.

- Employment specialist attends weekly mental health treatment team meetings.
- Employment specialist participates actively in treatment team meetings with shared decision-making.
- Employment services documentation (i.e., vocational assessment/profile, employment plan, progress notes) is integrated into client's mental health treatment record.
- Employment specialist's office is in close proximity to (or shared with) their mental health treatment team members.
- Employment specialist helps the team think about employment for people who haven't yet been referred to supported employment services.

3. Collaboration between employment specialists and Vocational Rehabilitation counselors: The employment specialists and VR counselors have frequent contact for the purpose of discussing shared clients and identifying potential referrals.

DOC, INT  
OBS, ISP

1= Employment specialists and VR counselors have client-related contacts (phone, e-mail, in person) less than quarterly to discuss shared clients and referrals. OR Employment specialists and VR counselors do not communicate.

2= Employment specialists and VR counselors have client-related contacts (phone, e-mail, in person) at least quarterly to discuss shared clients and referrals.

3= Employment specialists and VR counselors have client-related contacts (phone, e-mail, in-person) monthly to discuss shared clients and referrals.

4= Employment specialists and VR counselors have scheduled, face-to-face

\*Formerly called IPS Model Fidelity Scale

\*\*See end of document for key



meetings at least quarterly, OR have client-related contacts (phone, e-mail, in person) weekly to discuss shared clients and referrals.

5= Employment specialists and VR counselors have scheduled, face-to-face meetings at least monthly and have client-related contacts (phone, e-mail, in person) weekly to discuss shared clients and referrals.

4. Vocational unit: At least 2 full-time employment specialists and a team leader comprise the employment unit. They have weekly client-based group supervision following the supported employment model in which strategies are identified and job leads are shared. They provide coverage for each other's caseload when needed. MIS, INT, OBS

1= Employment specialists are not part of a vocational unit.

2= Employment specialists have the same supervisor but do not meet as a group. They do not provide back-up services for each other's caseload.

3= Employment specialists have the same supervisor and discuss clients between each other on a weekly basis. They provide back-up services for each other's caseloads as needed. OR, If a program is in a rural area where employment specialists are geographically separate with one employment specialist at each site, the employment specialists meet 2-3 times monthly with their supervisor by teleconference.

4= At least 2 employment specialists and a team leader form an employment unit with 2-3 regularly scheduled meetings per month for client-based group supervision in which strategies are identified and job leads are shared and discuss clients between each other. They provide coverage for each other's caseloads when needed. OR, If a program is in a rural area where employment specialists are geographically separate with one employment specialist at each site, the employment specialists meet 2-3 times per month with their supervisor in person or by teleconference and mental health practitioners are available to help the employment specialist with activities such as taking someone to work or picking up job applications.

5= At least 2 full-time employment specialists and a team leader form an employment unit with weekly client-based group supervision based on the supported employment model in which strategies are identified and job leads are shared. They provide coverage for each other's caseloads when needed.

\*Formerly called IPS Model Fidelity Scale

\*\*See end of document for key

5. Role of employment supervisor: Supported employment unit is led by a supported employment team leader. Employment specialists' skills are developed and improved through outcome-based supervision. All five key roles of the employment supervisor are present.

MIS, INT,  
DOC, OBS

- 1= One or none is present.
- 2= Two are present.
- 3= Three are present.
- 4= Four are present.
- 5= Five are present.

Five key roles of the employment supervisor:

- One full-time equivalent (FTE) supervisor is responsible for no more than 10 employment specialists. The supervisor does not have other supervisory responsibilities. (Program leaders supervising fewer than ten employment specialists may spend a percentage of time on other supervisory activities on a prorated basis. For example, an employment supervisor responsible for 4 employment specialists may be devoted to SE supervision half time.)
- Supervisor conducts weekly supported employment supervision designed to review client situations and identify new strategies and ideas to help clients in their work lives.
- Supervisor communicates with mental health treatment team leaders to ensure that services are integrated, to problem solve programmatic issues (such as referral process, or transfer of follow-along to mental health workers) and to be a champion for the value of work. Attends a meeting for each mental health treatment team on a quarterly basis.
- Supervisor accompanies employment specialists, who are new or having difficulty with job development, in the field monthly to improve skills by observing, modeling, and giving feedback on skills, e.g., meeting employers for job development.
- Supervisor reviews current client outcomes with employment specialists and sets goals to improve program performance at least quarterly.

\*Formerly called IPS Model Fidelity Scale

\*\*See end of document for key

6. Zero exclusion criteria: All clients interested in working have access to supported employment services regardless of job readiness factors, substance abuse, symptoms, history of violent behavior, cognition impairments, treatment non-adherence, and personal presentation. These apply during supported employment services too. Employment specialists offer to help with another job when one has ended, regardless of the reason that the job ended or number of jobs held. If VR has screening criteria, the mental health agency does not use them to exclude anybody. Clients are not screened out formally or informally.

DOC, INT  
OBS

- 1= There is a formal policy to exclude clients due to lack of job readiness (e.g., substance abuse, history of violence, low level of functioning, etc.) by employment staff, case managers, or other practitioners.
- 2= Most clients are unable to access supported employment services due to perceived lack of job readiness (e.g., substance abuse, history of violence, low level of functioning, etc.).
- 3= Some clients are unable to access supported employment services due to perceived lack of job readiness (e.g., substance abuse, history of violence, low level of functioning, etc.).
- 4= No evidence of exclusion, formal or informal. Referrals are not solicited by a wide variety of sources. Employment specialists offer to help with another job when one has ended, regardless of the reason that the job ended or number of jobs held.
- 5= All clients interested in working have access to supported employment services. Mental health practitioners encourage clients to consider employment, and referrals for supported employment are solicited by many sources. Employment specialists offer to help with another job when one has ended, regardless of the reason that the job ended or number of jobs held.

7. Agency focus on competitive employment: Agency promotes competitive work through multiple strategies. Agency intake includes questions about interest in employment. Agency displays written postings (e.g., brochures, bulletin boards, posters) about employment and supported employment services. The focus should be with the agency programs that provide services to adults with severe mental illness. Agency supports ways for clients to share work stories with other clients and staff. Agency measures rate of competitive employment and shares this information with agency leadership and staff.

DOC, INT,  
OBS

- 1= One or none is present.
- 2= Two are present.
- 3= Three are present.
- 4= Four are present.
- 5= Five are present.

Agency promotes competitive work through multiple strategies:

- Agency intake includes questions about interest in employment.
- Agency includes questions about interest in employment on all annual.(or semi-annual) assessment or treatment plan reviews.

\*Formerly called IPS Model Fidelity Scale

\*\*See end of document for key

8. Executive team support for SE: Agency executive team members (e.g., CEO/Executive Director, Chief Operating Officer, QA Director, Chief Financial Officer, Clinical Director, Medical Director, Human Resource Director) assist with supported employment implementation and sustainability. All five key components of executive team support are present.

- Agency displays written postings (e.g., brochures, bulletin boards, posters) about working and supported employment services, in lobby and other waiting areas.
- Agency supports ways for clients to share work stories with other clients and staff (e.g., agency-wide employment recognition events, in-service training, peer support groups, agency newsletter articles, invited speakers at client treatment groups, etc.) at least twice a year.
- Agency measures rate of competitive employment on at least a quarterly basis and shares outcomes with agency leadership and staff.

1= One is present.

2= Two are present.

3= Three are present.

4= Four are present.

5= Five are present.

- Executive Director and Clinical Director demonstrate knowledge regarding the principles of evidence-based supported employment.
- Agency QA process includes an explicit review of the SE program, or components of the program, at least every 6 months through the use of the Supported Employment Fidelity Scale or until achieving high fidelity, and at least yearly thereafter. Agency QA process uses the results of the fidelity assessment to improve SE implementation and sustainability.
- At least one member of the executive team actively participates at SE leadership team meetings (steering committee meetings) that occur at least every six months for high fidelity programs and at least quarterly for programs that have not yet achieved high fidelity. Steering committee is defined as a diverse group of stakeholders charged with reviewing fidelity, program implementation, and the service delivery system. Committee develops written action plans aimed at developing or sustaining high fidelity services.

\*Formerly called IPS Model Fidelity Scale

\*\*See end of document for key

- The agency CEO/Executive Director communicates how SE services support the mission of the agency and articulates clear and specific goals for SE and/or competitive employment to all agency staff during the first six months and at least annually (i.e., SE kickoff, all-agency meetings, agency newsletters, etc.). This item is not delegated to another administrator.

- SE program leader shares information about EBP barriers and facilitators with the executive team (including the CEO) at least twice each year. The executive team helps the program leader identify and implement solutions to barriers.

**SERVICES**

1. Work incentives planning: All clients are offered assistance DOC, INT in obtaining comprehensive, individualized work OBS, ISP incentives planning before starting a new job and assistance accessing work incentives planning thereafter when making decisions about changes in work hours and pay. Work incentives planning includes SSA benefits, medical benefits, medication subsidies, housing subsidies, food stamps, spouse and dependent children benefits, past job retirement benefits and any other source of income. Clients are provided information and assistance about reporting earnings to SSA, housing programs, VA programs, etc., depending on the person's benefits.

1= Work incentives planning is not readily available or easily accessible to most clients served by the agency.

2= Employment specialist gives client contact information about where to access information about work incentives planning.

3= Employment specialist discusses with each client changes in benefits based on work status.

4= Employment specialist or other MH practitioner offer clients assistance in obtaining comprehensive, individualized work incentives planning by a person trained in work incentives planning prior to client starting a job.

5= Employment specialist or other MH practitioner offer clients assistance in obtaining comprehensive, individualized work incentives planning by a specially trained work incentives planner prior to starting a job. They also facilitate access to work incentives planning when clients need to make decisions about changes in work hours and pay. Clients are provided information and assistance about reporting earnings to SSA, housing programs, etc., depending on the person's benefits.

\*Formerly called IPS Model Fidelity Scale

\*\*See end of document for key

2. Disclosure: Employment specialists provide clients with accurate information and assist with evaluating their choices to make an informed decision regarding what is revealed to the employer about having a disability.

DOC, INT  
OBS

- 1= None is present.
- 2= One is present.
- 3= Two are present.
- 4= Three are present.
- 5= Four are present.

- Employment specialists do not require all clients to disclose their psychiatric disability at the work site in order to receive services.
- Employment specialists offer to discuss with clients the possible costs and benefits (pros and cons) of disclosure at the work site in advance of clients disclosing at the work site. Employment specialists describe how disclosure relates to requesting accommodations and the employment specialist's role communicating with the employer.
- Employment specialists discuss specific information to be disclosed (e.g., disclose receiving mental health treatment, or presence of a psychiatric disability, or difficulty with anxiety, or unemployed for a period of time, etc.) and offers examples of what could be said to employers.
- Employment specialists discuss disclosure on more than one occasion (e.g., if clients have not found employment after two months or if clients report difficulties on the job.)

3. Ongoing, work-based vocational assessment: Initial vocational assessment occurs over 2-3 sessions and is updated with information from work experiences in competitive jobs. A vocational profile form that includes information about preferences, experiences, skills, current adjustment, strengths, personal contacts, etc, is updated with each new job experience. Aims at problem solving using environmental assessments and consideration of reasonable accommodations. Sources of information include the client, treatment team, clinical records, and with

DOC, INT,  
OBS, ISP

- 1= Vocational evaluation is conducted prior to job placement with emphasis on office-based assessments, standardized tests, intelligence tests, work samples.
- 2= Vocational assessment may occur through a stepwise approach that includes: prevocational work experiences (e.g., work units in a day program), volunteer jobs, or set aside jobs (e.g., NISH jobs agency-run businesses, sheltered workshop jobs, affirmative businesses, enclaves).
- 3= Employment specialists assist clients in finding competitive jobs directly without systematically reviewing interests, experiences, strengths,

\*Formerly called IPS Model Fidelity Scale

\*\*See end of document for key

the client's permission, from family members and previous employers.

etc. and do not routinely analyze job loss (or job problems) for lessons learned.

- 4= Initial vocational assessment occurs over 2-3 sessions in which interests and strengths are explored. Employment specialists help clients learn from each job experience and also work with the treatment team to analyze job loss, job problems and job successes. They do not document these lessons learned in the vocational profile, OR The vocational profile is not updated on a regular basis.
- 5= Initial vocational assessment occurs over 2-3 sessions and information is documented on a vocational profile form that includes preferences, experiences, skills, current adjustment, strengths, personal contacts, etc. The vocational profile form is used to identify job types and work environments. It is updated with each new job experience. Aims at problem solving using environmental assessments and consideration of reasonable accommodations. Sources of information include the client, treatment team, clinical records, and with the client's permission, from family members and previous employers. Employment specialists help clients learn from each job experience and also work with the treatment team to analyze job loss, job problems and job successes.

4. Rapid job search for competitive job: Initial employment assessment and first face-to-face employer contact by the client or the employment specialist about a competitive job occurs within 30 days (one month) after program entry.

DOC, INT,  
OBS, ISP

- 1= First face-to-face contact with an employer by the client or the employment specialist about a competitive job is on average 271 days or more (> 9 mos.) after program entry.
- 2= First face-to-face contact with an employer by the client or the employment specialist about a competitive job is on average between 151 and 270 days (5-9 mos.) after program entry.
- 3= First face-to-face contact with an employer by the client or the employment specialist about a competitive job is on average between 61 and 150 days (2-5 mos.) after program entry.
- 4= First face-to-face contact with an employer by the client or the employment specialist about a competitive job is on average between 31 and 60 days (1-2 mos.) after program entry.
- 5= The program tracks employer contacts and the first face-to-face contact with an employer by the client or the employment specialist about a competitive job is on average within 30 days (one month) after program entry.

\*Formerly called IPS Model Fidelity Scale

\*\*See end of document for key

5. Individualized job search: Employment specialists make employer contacts aimed at making a good job match based on clients' preferences (relating to what each person enjoys and their personal goals) and needs (including experience, ability, symptomatology, health, etc.) rather than the job market (i.e., those jobs that are readily available). An individualized job search plan is developed and updated with information from the vocational assessment/profile form and new job/educational experiences.

DOC, INT  
OBS, ISP

- 1= Less than 25% of employer contacts by the employment specialist are based on job choices which reflect client's preferences, strengths, symptoms, etc. rather than the job market.
- 2= 25-49% of employer contacts by the employment specialist are based on job choices which reflect client's preferences, strengths, symptoms, etc., rather than the job market.
- 3= 50-74% of employer contacts by the employment specialist are based on job choices which reflect client's preferences, strengths, symptoms, etc., rather than the job market.
- 4= 75-89% of employer contacts by the employment specialist are based on job choices which reflect client's preferences, strengths, symptoms, etc., rather than the job market and are consistent with the current employment plan.
- 5= Employment specialist makes employer contacts based on job choices which reflect client's preferences, strengths, symptoms, lessons learned from previous jobs etc., 90-100% of the time rather than the job market and are consistent with the current employment/job search plan. When clients have limited work experience, employment specialists provide information about a range of job options in the community.

6. Job development - Frequent employer contact: Each employment specialist makes at least 6 face-to-face employer contacts per week on behalf of clients looking for work. (Rate for each then calculate average and use the closest scale point.) An employer contact is counted even when an employment specialist meets the same employer more than one time in a week, and when the client is present or not present. Client-specific and generic contacts are included. Employment specialists use a weekly tracking form to document employer contacts.

DOC, INT

- 1= Employment specialist makes less than 2 face-to-face employer contacts that are client-specific per week.
- 2= Employment specialist makes 2 face-to-face employer contacts per week that are client-specific, OR Does not have a process for tracking.
- 3= Employment specialist makes 4 face-to-face employer contacts per week that are client-specific, and uses a tracking form that is reviewed by the SE supervisor on a monthly basis.
- 4= Employment specialist makes 5 face-to-face employer contacts per week that are client-specific, and uses a tracking form that is reviewed by the SE supervisor on a weekly basis.

\*Formerly called IPS Model Fidelity Scale

\*\*See end of document for key



7. Job development - Quality of employer contact:  
 Employment specialists build relationships with employers through multiple visits in person that are planned to learn the needs of the employer, convey what the SE program offers to the employer, describe client strengths that are a good match for the employer. (Rate for each employment specialist, then calculate average and use the closest scale point.)

DOC, INT,  
 OBS

5= Employment specialist makes 6 or more face-to-face employer contacts per week that are client specific, or 2 employer contacts times the number of people looking for work when there are less than 3 people looking for work on their caseload (e.g., new program). In addition, employment specialist uses a tracking form that is reviewed by the SE supervisor on a weekly basis.

1= Employment specialist meets employer when helping client to turn in job applications, OR Employment specialist rarely makes employer contacts.

2= Employment specialist contacts employers to ask about job openings and then shares these "leads" with clients.

3= Employment specialist follows up on advertised job openings by introducing self, describing program, and asking employer to interview client.

4= Employment specialist meets with employers in person whether or not there is a job opening, advocates for clients by describing strengths and asks employers to interview clients.

5= Employment specialist builds relationships with employers through multiple visits in person that are planned to learn the needs of the employer, convey what the SE program offers to the employer, describe client strengths that are a good match for the employer.

8. Diversity of job types: Employment specialists assist clients in obtaining different types of jobs.

DOC, INT,  
 OBS, ISP

1= Employment specialists assist clients obtain different types of jobs less than 50% of the time.

2= Employment specialists assist clients obtain different types of jobs 50-59% of the time.

3= Employment specialists assist clients obtain different types of jobs 60-69% of the time.

4= Employment specialists assist clients obtain different types of jobs 70-84% of the time.

\*Formerly called IPS Model Fidelity Scale

\*\*See end of document for key

9. Diversity of employers: Employment specialists assist clients in obtaining jobs with different employers.

DOC, INT,  
OBS, ISP

5= Employment specialists assist clients obtain different types of jobs 85-100% of the time.

1= Employment specialists assist clients obtain jobs with the different employers less than 50% of the time.

2= Employment specialists assist clients obtain jobs with the same employers 50-59% of the time.

3= Employment specialists assist clients obtain jobs with different employers 60-69% of the time.

4= Employment specialists assist clients obtain jobs with different employers 70-84% of the time.

5= Employment specialists assist clients obtain jobs with different employers 85-100% of the time.

10. Competitive jobs: Employment specialists provide competitive job options that have permanent status rather than temporary or time-limited status, e.g., TE (transitional employment positions). Competitive jobs pay at least minimum wage, are jobs that anyone can apply for and are not set aside for people with disabilities. (Seasonal jobs and jobs from temporary agencies that other community members use are counted as competitive jobs.)

DOC, INT,  
OBS, ISP

1= Employment specialists provide options for permanent, competitive jobs less than 64% of the time, OR There are fewer than 10 current jobs.

2= Employment specialists provide options for permanent, competitive jobs about 65- 74% of the time.

3= Employment specialists provide options for permanent competitive jobs about 75-84%% of the time.

4= Employment specialists provide options for permanent competitive jobs about 85-94% of the time.

5= 95% or more competitive jobs held by clients are permanent.

\*Formerly called IPS Model Fidelity Scale

\*\*See end of document for key

11. Individualized follow-along supports:

Clients receive different types of support for working a job that are based on the job, client preferences, work history, needs, etc. Supports are provided by a variety of people, including treatment team members (e.g., medication changes, social skills training, encouragement), family, friends, co-workers (i.e., natural supports), and employment specialist. Employment specialist also provides employer support (e.g., educational information, job accommodations) at client's request. Employment specialist offers help with career development, i.e., assistance with education, a more desirable job, or more preferred job duties.

DOC, INT,  
OBS, ISP

- 1= Most clients do not receive supports after starting a job.
- 2= About half of the working clients receive a narrow range of supports provided primarily by the employment specialist.
- 3= Most working clients receive a narrow range of supports that are provided primarily by the employment specialist.
- 4= Clients receive different types of support for working a job that are based on the job, client preferences, work history, needs, etc. Employment specialists provide employer supports at the client's request.
- 5= Clients receive different types of support for working a job that are based on the job, client preferences, work history, needs, etc. Employment specialist also provides employer support (e.g., educational information, job accommodations) at client's request. The employment specialist helps people move onto more preferable jobs and also helps people with school or certified training programs. The site provides examples of different types of support including enhanced supports by treatment team members.

12. Time-unlimited follow-along supports:

Employment specialists have face-to-face contact within 1 week before starting a job, within 3 days after starting a job, weekly for the first month, and at least monthly for a year or more, on average, after working steadily, and desired by clients. Clients are transitioned to step down job supports from a mental health worker following steady employment. Employment specialists contact clients within 3 days of learning about the job loss.

DOC, INT,  
OBS, ISP

- 1= Employment specialist does not meet face-to-face with the client after the first month of starting a job.
- 2= Employment specialist has face-to-face contact with less than half of the working clients for at least 4 months after starting a job.
- 3= Employment specialist has face-to-face contact with at least half of the working clients for at least 4 months after starting a job.
- 4= Employment specialist has face-to-face contact with working clients weekly for the first month after starting a job, and at least monthly for a year or more, on average, after working steadily, and desired by clients.
- 5= Employment specialist has face-to-face contact within 1 week before starting a job, within 3 days after starting a job, weekly for the first month, and at least monthly for a year or more, on average, after working steadily and desired by clients. Clients are transitioned to step down job supports, from a mental health worker following steady employment clients. Clients are transitioned to step down job supports from a mental health worker following steady employment.

\*Formerly called IPS Model Fidelity Scale

\*\*See end of document for key

Employment specialist contacts clients within 3 days of hearing about the job loss.

13. Community-based services: Employment services such as engagement, job finding and follow-along supports are provided in natural community settings by all employment specialists. (Rate each employment specialist based upon their total weekly scheduled work hours, then calculate the average and use the closest scale point.)

DOC, INT  
OBS

- 1= Employment specialist spends 30% time or less in the scheduled work hours in the community.
- 2= Employment specialist spends 30 - 39% time of total scheduled work hours in the community.
- 3= Employment specialist spends 40 -49% of total scheduled work hours in the then community.
- 4= Employment specialist spends 50 - 64% of total scheduled work hours in the community.
- 5= Employment specialist spends 65% or more of total scheduled work hours in the community.

14. Assertive engagement and outreach by integrated treatment team: Service termination is not based on missed appointments or fixed time limits. Systematic documentation of outreach attempts. Engagement and outreach attempts made by integrated team members. Multiple home/community visits. Coordinated visits by employment specialist with integrated team member. Connect with family, when applicable. Once it is clear that the client no longer wants to work or continue SE services, the team stops outreach.

MIS, DOC,  
INT, OBS

- 1= Evidence that 2 or less strategies for engagement and outreach are used.
- 2= Evidence that 3 strategies for engagement and outreach are used.
- 3= Evidence that 4 strategies for engagement and outreach are used.
- 4= Evidence that 5 strategies for engagement and outreach are used.
- 5= Evidence that all 6 strategies for engagement and outreach are used: i) Service termination is not based on missed appointments or fixed time limits. ii) Systematic documentation of outreach attempts. iii) Engagement and outreach attempts made by integrated team members. iv) Multiple home/community visits. v) Coordinated visits by employment specialist with integrated team member. vi) Connect with family, when applicable.

\*Formerly called IPS Model Fidelity Scale

\*\*See end of document for key

\*Data sources:

- MIS Management Information System
- DOC Document review: clinical records, agency policy and procedures
- INT Interviews with clients, employment specialists, mental health staff, VR counselors, families, employers
- OBS Observation (e.g., team meeting, shadowing employment specialists)
- ISP Individualized Service Plan

2/14/96  
6/20/01, Updated  
1/7/08, Revised

---

\*Formerly called IPS Model Fidelity Scale

\*\*See end of document for key

Supported Employment Fidelity Scale Score Sheet

<b>Staffing</b>		
1.	Caseload size	Score:
2.	Employment services staff	Score:
3.	Vocational generalists	Score:
<b>Organization</b>		
1.	Integration of rehabilitation with mental health thru team assignment	Score:
2.	Integration of rehabilitation with mental health thru frequent team member contact	Score:
3.	Collaboration between employment specialists and Vocational Rehabilitation counselors	Score:
4.	Vocational unit	Score:
5.	Role of employment supervisor	Score:
6.	Zero exclusion criteria	Score:
7.	Agency focus on competitive employment	Score:
8.	Executive team support for SE	Score:
<b>Services</b>		
1.	Work incentives planning	Score:
2.	Disclosure	Score:
3.	Ongoing, work-based vocational assessment	Score:
4.	Rapid search for competitive job	Score:
5.	Individualized job search	Score:
6.	Job development—Frequent employer contact	Score:
7.	Job development—Quality of employer contact	Score:
8.	Diversity of job types	Score:
9.	Diversity of employers	Score:
10.	Competitive jobs	Score:
11.	Individualized follow-along supports	Score:
12.	Time-unlimited follow-along supports	Score:
13.	Community-based services	Score:
14.	Assertive engagement and outreach by integrated treatment team	Score:
Total:		

115 – 125	= Exemplary Fidelity
100 - 114	= Good Fidelity
74 – 99	= Fair Fidelity
73 and below	= Not Supported Employment

\*Formerly called IPS Model Fidelity Scale

\*\*See end of document for key  
Vermont Department of Mental Health

## Attachment 7: Sample Consent Forms

### Statement of Informed Consent

**Title of Project:** Vermont Mental Health Transformation (VMHT)

**Principal Investigator:** Dr. Trish Singer

**Sponsor:** Department of Mental Health

**You are being invited to take part in an evaluation of the Vermont Mental Health Transformation (VMHT) project because you may benefit from services being offered through the grant. This evaluation is being conducted by Flint Springs Associates. We encourage you to ask questions and take the opportunity to discuss the study with anybody you think can help you make this decision.**

#### Why is this Evaluation Being Conducted?

- It is very important that we assess how well the VMHT project is working, in order to understand the impact the project is having on people's lives.
- The results of this evaluation should go far in understanding which aspects of the VMHT project are associated with improved outcomes for people receiving VMHT services, and to help us improve the VMHT project.

#### How Many People Will Take Part in this Evaluation?

- All people who receive services through the VMHT project are being asked to participate in the evaluation.

#### What is Involved in this Study?

- The main part of the evaluation will involve paper-and-pencil surveys that individuals will fill out during a meeting with the project evaluator. Only individuals who assent (agree) to be in the evaluation will fill out the surveys. It is expected to take approximately one and one half hours to complete the surveys, and we will try to schedule a time to do them soon after the child starts receiving services through the VMHT project.
- Approximately three months, six months, nine months and one year later, we will contact you to schedule a time to do another round of the same or similar surveys.

#### What are the Risks and Discomforts of the Study?

- The only possible risk is a breach of confidentiality. VCHIP will use only trained interviewers to minimize this risk. In addition, VCHIP will store all data in a locked cabinet and on a secure, password-protected network. Furthermore, all identifying information about you (name, age, etc.) will be kept separate from the actual data we collect.

#### What are the Benefits of Participating in this Evaluation?

- This evaluation will help us understand which aspects of the VMHT project are working well, and which aspects may need to be improved, and we will then work to improve how the project is working with the aim of all people who receive services benefitting.

What is the Compensation?

- You will a \$20 payment for each interview; each child over the age of 12 will also receive \$20 for participating in each interview.

Can You Withdraw from the Evaluation?

- Yes, you can stop participating or skip any questions that you do not want to answer, without penalty.
- Participating in the first interview does not obligate you to participate in any future interviews.

What about Confidentiality?

- All surveys and questionnaires will be coded with a number that protects your identity and keeps your their responses confidential.
- The master list of individuals will be kept separately from the data, in a locked laboratory at UVM.
- The surveys will be kept in a locked filing cabinet in a locked suite (PI's laboratory).
- The electronic data will be kept on a secure network, with password access. Only members of the VCHIP evaluation team will have access to these data.
- The results of this study may eventually be published and information may be exchanged between researchers; however, your confidentiality will be maintained.

Contact Information

You may contact Dr. Trish Singer, the Principal Investigator in charge of this study, at 802-241-2601 for more information about this study. If you have any questions about your rights as a participant in a research project or for more information on how to proceed should you believe that you may have been injured as a result of your participation in this study you should contact \_\_\_\_\_, the Institutional Review Board Administrator at (802) 656-5040.

Statement of Consent

**You have been given and have read or have had read to you a summary of this evaluation. Should you have any further questions about the evaluation, you may contact the person conducting the study at the address and telephone number given below. Your participation is voluntary and you may refuse to participate or withdraw at any time without penalty or prejudice to your present and/or future care.**

**You agree to participate in this study and you understand that you will receive a signed copy of this form.**

\_\_\_\_ Yes, I agree to participate.



No, I do not agree to participate.

---

**Signature**

**Date**

---

**Printed Name of Principal Investigator or Designee**

### Project/Performance Site Location(s)

I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

#### Project/Performance Site Primary Location

Organization Name: Vermont Department of Mental Health

DUNS Number: 809376155

\* Street1: 103 South Main Street, Wasson Hall

Street2:

\* City: Waterbury County:

\* State: Vermont

Province:

\* Country: United States

\* ZIP / Postal Code: 05671-2510 \* Project/Performance Site Congressional District: VT-All

I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

#### Project/Performance Site Location 1

Organization Name:

DUNS Number:

\* Street1:

Street2:

\* City:  County:

\* State:

Province:

\* Country:

\* ZIP / Postal Code:  \* Project/Performance Site Congressional District:

See next page for instructions.

## ASSURANCES - NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

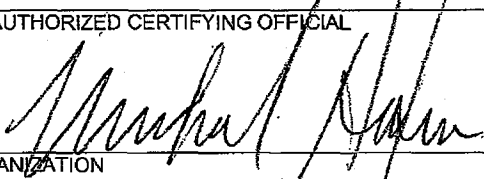
**PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET.  
SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.**

**Note:** Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age;
- (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL		TITLE
		Commissioner
APPLICANT ORGANIZATION		DATE SUBMITTED
St of VT		4/29/00

## CERTIFICATIONS

### 1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion—Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

### 2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about—
  - (1) The dangers of drug abuse in the workplace;
  - (2) The grantee's policy of maintaining a drug-free workplace;
  - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
  - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will—
  - (1) Abide by the terms of the statement; and
  - (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--
  - (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
  - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management  
 Office of Grants Management  
 Office of the Assistant Secretary for Management and Budget  
 Department of Health and Human Services  
 200 Independence Avenue, S.W., Room 517-D  
 Washington, D.C. 20201

### 3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the under-

signed, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

### 4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

**5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE**

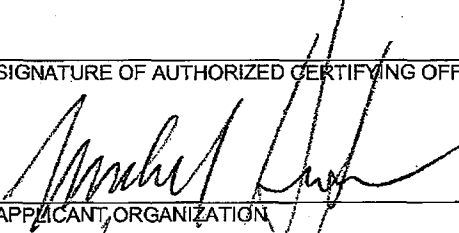
Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL 	TITLE <i>Commissioner</i>
APPLICANT ORGANIZATION <i>St of Vermont</i>	DATE SUBMITTED <i>4/29/10</i>

## DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB  
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352  
(See reverse for public burden disclosure.)

<b>1. Type of Federal Action:</b> <input type="checkbox"/> a. contract <input type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance	<b>2. Status of Federal Action</b> <input type="checkbox"/> a. bid/offer/application <input type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award	<b>3. Report Type:</b> <input type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change <b>For Material Change Only:</b> Year <u>N/A</u> Quarter <u>N/A</u> date of last report <u>N/A</u>
<b>4. Name and Address of Reporting Entity:</b> <input type="checkbox"/> Prime <input type="checkbox"/> Subawardee Tier <u>N/A</u> , if known: <u>N/A</u> N/A  Congressional District, if known: <u>N/A</u>		<b>5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:</b> N/A  Congressional District, if known: <u>N/A</u>
<b>6. Federal Department/Agency:</b> N/A	<b>7. Federal Program Name/Description:</b> N/A  CFDA Number, if applicable: <u>N/A</u>	
<b>8. Federal Action Number, if known:</b> N/A	<b>9. Award Amount, if known:</b> \$ N/A	
<b>10. a. Name and Address of Lobbying Entity</b> <i>(if individual, last name, first name, MI):</i> N/A	<b>b. Individuals Performing Services</b> <i>(including address if different from No. 10a.) (last name, first name, MI):</i> N/A	
<b>11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.</b>		
<b>Federal Use Only:</b>		Signature: _____ Print Name: <u>N/A</u> Title: <u>N/A</u> Telephone No.: <u>N/A</u> Date: <u>N/A</u>
		Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)



## INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in item 4 checks "subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., "RFP-DE-90-001."
9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.
10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.  
  
(b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).
11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No.0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

DISCLOSURE OF LOBBYING ACTIVITIES  
CONTINUATION SHEET

Approved by OMB  
0348-0046

Reporting Entity:   N/A   Page \_\_\_\_\_ of \_\_\_\_\_

[Empty table area for reporting details]