DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

Guidance for Applicants (GFA) No. SM 03-004
Part I - Programmatic Guidance

Targeted Capacity Expansion - Prevention and Early Intervention

Cooperative Agreements to Meet Emerging and Urgent Mental Health Services Needs of Communities to Build Mentally Healthy Communities

Short Title:
Prevention/Early Intervention Services

Application Due Date: October 22, 2002

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Date of Issuance: _____

Catalog of Federal Domestic Assistance (CFDA) No. 93.243
Authority: Section 520A of the Public Health Service Act, as amended and subject to the availability of funds.
This program is being announced prior to the full annual appropriation for fiscal year (FY) 2003 for the Substance Abuse and Mental Health Services Administration's (SAMHSA) programs. Applications are invited based on an assumption that sufficient funds will be appropriated for FY 2003 to permit funding of a reasonable number of applications being hereby solicited. This program is being announced in order to allow applicants sufficient time to plan and prepare applications. Solicitation of applications in advance of a final appropriation will also enable the award of appropriated grant funds in an expeditious manner and thus allow prompt implementation and evaluation of promising practices. All applicants are reminded, however, that we cannot guarantee that sufficient funds will be appropriated to permit SAMHSA to fund any applications. Questions regarding the status of the appropriation of funds should be directed to the Grants Management Officer listed under Contacts for Additional Information in this announcement.

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Agency

The Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS).

Action and Purpose

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), is accepting applications for fiscal year (FY) 2003 cooperative agreements for developing prevention and intervention mental health services and programs at the community level for children, adolescents and their families. These cooperative agreements will be made a part of CMHS' Targeted Capacity Expansion (TCE) program, *Prevention and Early Intervention*.

The purpose of the initiative is to increase the capacity of cities, counties, and tribal governments to provide prevention and early intervention treatment services to meet emerging and urgent mental health needs of communities. Projects funded through this program must target services to children and adolescents and their families. The program will help communities to build the service system infrastructure necessary to address serious local or regional mental health problems through prevention and early treatment interventions having a strong evidence base.

It is estimated that $1 million will be available to support 2-3 awards under this Guidance for Applicants in FY 2003.

Awards will range from $300,000 to $400,000 in total costs (direct plus indirect) per year. Ten percent of the total award is to be used to evaluate the program. Actual funding levels will depend upon the availability of funds.

Support may be requested for a period of up to 3 years (in three budget periods of 1 year each). Annual awards will be made subject to continued availability of funds and progress achieved by awardees.

Who Can Apply?

Eligibility to apply for *Prevention/Early Intervention* awards will be limited to cities, counties, and tribal governments and their agencies. Eligibility is restricted to local government because the purpose of the program is to add needed mental health services at the local level. The following are examples of units of local government who may apply:

- local Departments of Mental Health, Substance Abuse, Public Health
- local Departments of Education.

In developing their programs, these governmental units are strongly encouraged to partner with appropriate community-based organizations, including:

- community-based health, mental health, and social organizations
- public or private universities
- faith-based service organizations
- consumer and family groups
- parents' and teachers' organizations
- service organizations serving racial/ethnic minorities
- business community.

Application Kit

SAMHSA's grant application kits include the two-part Program Announcement (also called the Guidance for Applicants, or GFA) and the blank forms (SF 424 and PHS-5161, revised July 2000) needed to apply for a grant.

The GFA has two parts:

Part I - provides information specific to the grant or cooperative agreement and is different for each GFA. **NOTE: This document is Part I.**

Part II - provides general policies and procedures that apply to most SAMHSA grant and cooperative agreements. The policies in Part II that apply to this program are listed in this document under "Special Considerations and Requirements."

You will need to use both Part I and Part II to apply for a SAMHSA grant or cooperative agreement.

To obtain additional application kits, including Parts I and II, you may:

Call the National Mental Health Knowledge Exchange Network (KEN), phone number: 800-789-2647.

Application kits may also be downloaded from the SAMHSA site at www.SAMHSA.gov. Go to the "grants" link.

Where to Send the Application

Note: All applicants MUST be sent via a recognized commercial or governmental carrier. Hand-carried applications will not be accepted.

Send the **signed original and 2 copies** of your grant application to:

SAMHSA Programs
Center for Scientific Review
National Institutes of Health
Suite 1040
6701 Rockledge Drive MSC-7710
Bethesda, MD 20892-7710*

*Change the zip code to **20817** if you use express mail or courier service.

Please note:

- Use application form PHS 5161-1.
- Be sure to type:

  "***SP 03-004-Prevention/Early Intervention"*** in Item Number 10 on the face page of the application form.

Application Dates

Your application must be received by October 22, 2002. Applications received after this date will be accepted only if they have a proof-of-mailing date from the carrier no later than **October 15, 2002**, 1 week before the deadline date.

Private metered postmarks are **not** acceptable as proof of timely mailing. Late applications will be returned without review.

How to Get Help

For questions on program issues, contact:

Gail F. Ritchie, M.S.W.
Special Programs Development Branch
Division of Program Development, Special Populations, and Projects
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, Room 17C-05
Rockville, MD 20857
(301) 443-1752
E-Mail: gritchie@samhsa.gov

For questions on grants management issues, contact:

Steve Hudak
Division of Grants Management, OPS
Substance Abuse and Mental Health Services Administration
Rockwall II, 6th Floor
Rockville, MD 20857
(301) 443-9666
E-Mail: gsimpson@samhsa.gov

Cooperative Agreements

The *Prevention/Early Intervention* initiative will be implemented as cooperative agreements, and as such will require substantial participation on the part of the Federal staff. Government Project Officers and sites are expected to work closely together to ensure the success of this new program.

Role of Federal Staff

- Provide the Federal interpretation of the provisions of the GFA.
- Monitor the overall progress of the program sites.
- Provide training and technical assistance to program sites regarding the implementation of the project plans using the existing Technical Assistance Centers.
- Provide consultation in collaboration with the Prevention TA Coordinating Center as appropriate on the design and implementation of the evaluation plans.
- Provide guidelines for submission of annual and final financial and other required reports.
- Provide consultation on the development of tools and other products accruing from the projects.
- Conduct periodic site visits to each project to monitor the implementation of the program plans and evaluation activities.
- Convene annual national meetings of the Program Directors and Evaluators for sites.
- Collaborate with the sites in interpreting the results of the evaluations and the publications of program findings, other program products, and other dissemination activities.

Role of the Awardee

- Consult with the Government Project Officer and obtain Grants Management Officer approval on significant modifications or adaptations of the project plan.
- Accept guidance and respond to requests for information from the Government Project Officer (GPO) and Grants Management representatives.
- Attend an annual 3-day national meeting of sites to be held in Washington, D.C. (travel

expenses for the Program Director and Evaluator to attend the meeting must be included in the budget).

- Take advantage of the technical assistance that will be provided by CMHS staff and the Technical Assistance Centers in post-award activities.

- Facilitate the participation of consumers and/or representatives of the target population in the planning and implementation of the project.

- Disseminate the findings of the program through publications, presentations at conferences, collaboration with other sites, and other efforts to make the findings available to the field.

Funding Criteria

Decisions to fund a cooperative agreement under this announcement will be based upon:

- The strengths and weaknesses of the application as shown by the Peer Review Committee and approved by the CMHS Advisory Council.

- Availability of funds.

Post-Award Requirements

Prevention/Early Intervention awardees will be required to:

- Comply with the GFA requirements and the Terms and Conditions of Awards.

- Provide financial status reports as required in the PHS Grants Policy Statement.

- Submit an annual report summarizing:

  - project progress
  - changes in key personnel
  - problems incurred and how they were addressed
  - alterations in approaches utilized
  - actual expenditures for the year
  - proposed plans for the next budget period
  - a proposed budget and budget justification for the next budget year.

- Submit a final report at end of project summarizing:

  - project findings
  - lessons learned
  - manuals, protocols, or other tools developed as implementation guides
  - implications for services
  - results of the evaluation.

- Attend annual national meetings of sites with participation of at least the Program Director and Evaluator from each site.

- Grantees must inform the Project Officer of any publications based on the grant project.

- Awardees must provide SAMHSA/CMHS with the data required under the Government Performance and Results Act (GPRA). GPRA measures for this program have not been finalized but are expected to include the following:

  - services provided
  - types of clients served and dosage of

the intervention received
- who provided services
- where services were provided.

SAMHSA/CMHS staff will work with awardees to finalize measures and obtain appropriate clearances after awards have been made.

Program Overview

The structure of the *Prevention/Early Intervention* initiative is shown in the attached program logic model (Appendix 1). The overall goal of the program is to develop mental health prevention and early intervention services targeted to infants, toddlers, preschool and school-aged children, and adolescents in mental health settings and other settings that serve children and adolescents, such as school and day care.

Many experts recognize that children and families are suffering because of missed opportunities for prevention and early intervention. Prevention refers to those interventions that occur before the initial onset of a mental disorder, including prevention of a co-occurring disorder, and delaying onset for an approximate time period. Early intervention refers to interventions that are targeted for individuals who display for the first time the early signs and symptoms of a mental disorder. For the purposes of this initiative, the target population is defined as infants, toddlers, preschool and school-aged children, and adolescents from the prenatal stage to 18 years old (see Appendix 4 for these and other relevant definitions).

Fostering social and emotional health for infants, toddlers, preschool and school-age children, and youth requires investment in prevention of mental illnesses and early intervention strategies. The number of tested preventive mental health interventions is low, and many disorders have not been addressed by the mental health prevention research community. However, there is a growing consensus that prevention of **some** mental and behavioral disorders does work, as scientific methodologies in prevention have become increasingly sophisticated, with results from high-quality research trials being as credible as those in other areas of biomedical and psychosocial science.

For this target population, this initiative is designed to accomplish several goals. First is to **expand the capacity** to implement evidence-based prevention programs and services that promote mental health, prevent mental and behavioral disorders, and intervene early in a population with a diagnosable disorder. Included in this goal is the establishment of appropriate training for service providers so they develop an understanding of basic concepts related to preventive and early intervention strategies in a public health framework and issues related to the implementation of evidence-based practices (e.g., the need for ongoing consultation from prevention intervention experts).

The second goal is to build **linkages** between individuals and groups that serve the targeted population (e.g., mental health providers who specialize in early childhood mental heath connecting with preschool day care providers). These linkages will provide integrated developmentally appropriate services throughout childhood and adolescence in multiple domains. Building linkages among service providers and others who work with

this population, such as community mental health professionals and educators, will promote changing the environments of institutions and small social groups to foster mental health.

The third goal is to encourage the grantee to undertake **community outreach** to communicate to the larger community the importance of mental health and the capacity of well-executed preventive interventions to foster the healthy development of all children. Included in this community outreach is the goal of engaging the target population in the development and implementation of preventive and early intervention services.

Under this initiative, applicants must:

- Provide a copy of the letter sent to the State describing the plans outlined in the application, and offering an opportunity for comments (attach as Appendix 1).

- Propose prevention and early intervention strategies or mental health service models having a strong evidence base (see Appendix 2 for examples). Evidence-based refers to the extent to which an intervention is supported by scientific data to indicate its effectiveness. Evidence-based programs have met high standards of safety, efficacy, and effectiveness, based on the strength of the study design, magnitude of the beneficial effects of the intervention, sustainability of the effects over time, and replications of the benefits across different settings and populations.

- Propose viable plans to be executed during the award period for ensuring sustainability of the *Prevention/Early Intervention* program grants after cessation of funding.

- Include consumers and family members in planning and implementing programs (See Appendix 3 for guidelines).

- Evaluate the implementation of the program and assess the outcomes of the prevention and/or intervention strategies.

- Propose plans for disseminating the findings of the program through publications, presentations at conferences, collaboration with other sites, and other efforts to make the findings available to the field.

Detailed Information on What to Include in Your Application

In order for your application to be **complete and eligible**, it must include the following in the order listed. Check off areas as you complete them for your application.

❑ ***1. FACE PAGE***

Use Standard Form 424, which is part of the PHS 5161-1 (revised July 2000). See Appendix A in Part II of the GFA for instructions. In signing the face page of the application, you are agreeing that the information is accurate and complete.

❑ ***2. ABSTRACT***

Your total abstract must be no longer than 35 lines. In the first 5 lines or less of your abstract, write a summary of your project that can be

used in publications, reporting to Congress, or press releases, if your project is funded.

❑ *3. TABLE OF CONTENTS*

Include page numbers for each of the major sections of your application **and** for each appendix.

❑ *4. BUDGET FORM*

Use Standard Form 424A. See Appendix B in Part II for instructions.

❑ *5. PROJECT NARRATIVE AND SUPPORT DOCUMENTATION*

The **Project Narrative** describes your project. It consists of Sections A through E. These sections must be no longer than 30 pages. More detailed information about Sections A through E follows #10 of this checklist.

☐ **Section A -** Rationale for the Project

☐ **Section B -** Implementation Plan

☐ **Section C -** Evaluation Plan, Data Collection, and Analysis

☐ **Section D -** Dissemination Plan

☐ **Section E -** Project Management and Staffing Plan

Supporting documentation for your application should be provided in Sections F through I. There are no page limits for these sections, except for Section H (Biographical Sketches/Job Descriptions).

☐ **Section F -** Literature Citations. This section must contain complete citations, including titles and all authors, for any literature you cite in your application.

☐ **Section G -** Budget Justification, Existing Resources, Other Support

You must provide a narrative justification of the items included in your proposed budget as well as a description of existing resources and other support you expect to receive for the proposed project.

☐ **Section H** - Biographical Sketches and Job Descriptions

- Include a biographical sketch for the Project Director/Principal Investigator, Evaluator, Project Coordinator, Data Coordinator, Interviewers, and other key positions. Each sketch must be no longer than **2 pages**. If the person has not been hired, include a letter of commitment with the sketch.

  - Include job descriptions for key personnel. They must be no longer than **1 page**.

  - ***Sample sketches and job descriptions are listed in Item 6 in the Program Narrative section of PHS 5161-1.***

☐ **Section I** - Confidentiality and SAMHSA Participant Protection (SPP)

The seven areas you need to address in this section are outlined after the *Project Narrative Sections A - E Highlighted* section of this document.

❑ *6. APPENDICES 1 THROUGH 4*

- Use only the appendices listed below unless indicated elsewhere in application instructions.

- **Do not** use appendices to extend or replace any of the sections of the Project Narrative (reviewers will not consider them if you do).
- **Do not** use more than **35 pages** (plus all instruments) for the appendices.

Appendix 1: Copy of letter sent to the State describing the proposal and offering an opportunity for comment.

Appendix 2: References for the evidence-based programs to be utilized.

Appendix 3: Logic model for the proposed *Prevention/Early Intervention* program and data collection instruments.

Appendix 4: Letters documenting collaborative commitments (including Memoranda of Understanding, interagency agreements, in-kind contributions, commitments from consultants, etc.)

❑ ***7. ASSURANCES***

Non-Construction Programs. Use Standard Form 424B found in PHS 5161-1.

❑ ***8. CERTIFICATIONS***

Use the "Certifications" forms, which can be found in PHS 5161-1.

❑ ***9. DISCLOSURE OF LOBBYING ACTIVITIES***

Use Standard Form LLL (and SF LLL-A, if needed), which can be found in PHS 5161-1. Part II of the GFA also includes information on lobbying prohibitions.

❑ ***10. CHECKLIST***

See Appendix C in Part II for instructions.

Project Narrative/Review Criteria– Sections A Through E Highlighted

Sections A through E are the Review Criteria/ Project Narrative of your application. They describe what you intend to do with your project. Below you will find detailed information on how to respond to Sections A through E. The combined total of these pages cannot exceed 30 pages.

- Your application will be reviewed against the requirements described below for Sections A through E.

- A peer review committee will assign a point value to your application based on how well you address **each** of these sections.

- The number of points after each main heading shows the **maximum number of points** a review committee may assign to that category.

- Bullet statements do not have points assigned to them; they are provided to invite attention to important areas within the criterion.

- Reviewers will also be looking for evidence of cultural competence in **each section** of the Project Narrative. Points will be deducted from applications that do not adequately address the cultural competency aspects of the review criteria. SAMHSA's guidelines for cultural competence are included in Part II of the GFA.

Section A: Rationale for the Project (20 Points)

In this section, applicants should document the need for a *Prevention/Early Intervention* grant and justify their choice of priority populations by providing adequate information on the following:

- Indicate the specific age group to be targeted through the proposed project (e.g., infants, preschool children aged 3 to 4 years old).

- Demonstrate the need for the proposed program in the community, including:

  - documentation of emerging and urgent needs
  - service system gaps
  - barriers to serving the target population
  - needs for prevention and/or early intervention services.

- Describe the target population(s) in terms of:

  - sociodemographic characteristics, including racial/ethnic minority composition
  - population size and geographic distribution
  - number to be served by the program
  - estimated unmet need
  - risk factors for this age group that will be addressed by the preventive intervention or the mental or emotional disorder addressed by the early intervention strategy
  - the domain(s) where the risk factors will be addressed (e.g., aggressive behavior in the classroom or home).

- Indicate the likely impact of the proposed program on the existing services environment, including beneficial outcomes

at both the individual and the system level and potential adverse consequences of not implementing the proposed program.

- Provide the evidence base for the program proposed, including relevant literature citations and appropriateness for the target population (attach references as Appendix 2).

  Note: See Appendix 2 for examples of programs to prevent mental and behavioral disorders. Other programs, e.g., violence or substance abuse prevention programs, may also be de facto mental health promotion or prevention programs. However, if an applicant decides to use a program that is not specifically designed to prevent mental and behavioral disorders, he/she must justify its use by providing evidence that it will in fact prevent mental and behavioral disorders.

Section B: Implementation Plan (30 Points)

Applicants should demonstrate the viability of their proposed program and the adequacy of their implementation plans by providing the following:

- Describe the overall program and provide a logic model or flow chart for program activities (attach as Appendix 3).

- Discuss how the program will address the overall goals of the *Prevention and Early Intervention* program listed in this document.

- Describe the intervention(s) that will be implemented.

- Provide a time line for implementation.

- Describe how the potential clients will be identified, including:

  - eligibility criteria
  - screening and assessment
  - outreach
  - procedures for obtaining informed consent where applicable.

- Describe the strategic planning process necessary to develop the proposed program, including:

  - identification of key stakeholders
  - assessment of community resources and needs
  - development of fiscal responsibility and planning
  - plans for (1) building consensus among implementors and others whose agreement will foster the adoption of preventive interventions in the *specific setting* (e.g., school principals, directors of day care programs), and (2) for engaging quality staff training from persons experienced in implementing the intervention.

- Describe plans for ensuring cultural appropriateness of the program, including the participation of consumers in the planning and implementation activities of the program (see Appendix 3).

- Describe how stakeholders will be included in designing the implementation.

- Describe in detail the targeted local service expansion activities, such as:
  - outreach and engagement of target

population for prevention and early intervention
  - screening and assessment
  - integration/linkage with primary healthcare if applicable
  - training and ongoing technical assistance by prevention and early intervention experts.

- Describe service linking activities, such as:

  - identification of planning and service partnerships and development of coalitions
  - cross-training
  - if appropriate, co-location of services, including how a "no wrong door" policy will be effected
  - creating novel funding mechanisms, such as new payment streams, pooled or joint funding, flexible funding, and special waivers
  - development of interagency agreements and memoranda of understanding
  - development of interagency management systems and client tracking when appropriate
  - development of uniform applications, eligibility criteria, and intake assessments
  - development of interagency or inter-professional service delivery teams (e.g., mental health and school teachers collaboration).

- Describe community outreach activities, including:

  - plans to increase community awareness of the needs for the program and the availability of new services
  - plans to ensure that services are accessible to the target population
  - public education programs to gain community acceptance of the program
  - strategies for engaging stakeholders and developing coalitions
  - social marketing campaigns as appropriate
  - strategies for outreach and engagement of the target population.

- Proposed programs for **prevention and early intervention** targeting infants, toddlers, preschool and school-aged children, and adolescents **must** address:

  - strategies for promoting fidelity to the evidence-based intervention, such as (1) partnership with or formal training from the designer of the intervention or one trained by the designer, (2) use of an available manual, and (3) ongoing consultation during the implementation of the intervention

  - strategies for consultation to address ongoing implementation problems or concerns.

- Provide a plan for continuing the program activities after cessation of grant funding of the program.

Section C: Evaluation Plan, Data Collection, and Analysis (15 points)

In this section, applicants should provide a plan for conducting a process evaluation of the implementation of their proposed programs, and measuring client- and systems-level outcomes using data such as services use and GPRA core client outcome measures (if appropriate), including the following:

- Summarize the plan for evaluating the proposed program.

- Provide specific evaluation questions to be examined and hypotheses to be tested if appropriate.

- Document the strategic planning process.

- Discuss how service data and CMHS GPRA core client outcomes could be used to measure program outcomes. Examples of service data can include:

  - services provided
  - types of clients served and dosage of intervention received
  - who provided services
  - where services were provided.

- Describe the data collection plan, including:

  - sources of data
  - data management and quality control
  - training of records reviewers, as appropriate.

- Describe the analytic methods to be used.

- Indicate whether and/or how qualitative methods will be used.

- Describe plans for monitoring and ensuring the fidelity of the implementation of the intervention.

- Discuss how the target population and their families will participate and contribute to the data collection efforts and interpretation and dissemination of the findings.

- Provide evidence that the proposed evaluation plan is sensitive to age, gender, sexual orientation, race/ethnicity, and other cultural factors related to the target population and, as appropriate, to the community to be served.

- Describe plans to assess consumer satisfaction with services, e.g., anonymous survey and peer group discussions.

- Provide measures of quality of implementation including fidelity, e.g., outcome measures.

Section D: Dissemination Plan (15 Points)

Applicants should discuss their plans to disseminate the findings of their process and outcome evaluations of their proposed programs, including:

- Describe plans to provide feedback to community stakeholders and constituencies on the process and outcomes of the implementation of the program in a manner tailored to each constituency.

- Describe plans for preparing interim and final reports, conference presentations, publications, and other means of disseminating the program findings.

- Describe plans for collaborating with other sites with similar target populations or issues.

- Describe how representatives of the target population and their families will participate and contribute to the data collection efforts and interpretation and dissemination of the findings.

- Describe plans to disseminate findings to appropriate sources that could be financial partners in future years.

Section E: Project Management and Staffing Plan (20 Points)

Applicants must demonstrate their ability to carry out the proposed program activities in terms of staffing and management plans by providing the following:

- Describe the qualifications and experience of the key personnel, including:

  - project director
  - service providers
  - evaluator
  - analytic and data management staff
  - interviewers
  - other key personnel.

Include a description of the project director's and key service providers' experience with preventive interventions/early intervention strategies, interest in implementing preventive intervention/early intervention strategies if originating such programs, and willingness/experience in using expert consultation and training in implementing an evidence-based practice.

- Document the capability and experience of the applicant organization with similar projects and populations.

- Provide evidence of the capability, experience, and commitment of proposed consultants (e.g., prevention intervention research experts) and subcontractors, including letters of commitment (attach as Appendix 4).

- Discuss how professional staff and target population and/or family representatives will be recruited and trained, as well as what strategies have been developed for retaining staff in programs. Describe in-service training for staff and consumer development.

- Assign responsibility for specific tasks described in the evaluation plan to identified staff.

- Demonstrate the feasibility of accomplishing the project in terms of:

  - management plan
  - time frames
  - appropriate mix of skills in project staff
  - adequacy and availability of resources (e.g., staffing, and collaborating agencies, facilities, equipment).

- Describe the extent to which the staffing and management plans, project organization, and other resources are appropriate to carrying out all aspects of the proposed project.

- Demonstrate that the staff is reflective of or sensitive to the diversity of the target population; it must be sensitive to age, gender, sexual orientation, race/ethnicity, and other cultural factors related to the target population and, as appropriate, to the community to be served, including issues such as:

  - proficiency of staff at all levels of the organization in the languages and cultures of the target population
  - provision of cultural competence training specific to the target community

- availability of interpreters and translators trained in mental health prevention/treatment issues and terminology.

SAMHSA Participant Protection

Part II of the GFA (which is available on the SAMHSA Web page) provides a description of SAMHSA Participant Protection and the Human Subjects Regulations.

You must address seven areas regarding confidentiality and SAMHSA participant protection in your supporting documentation. However, no points will be assigned to this section.

This information will:

- Reveal if the protection of participants is adequate or if more protection is needed, and
- Be considered when making funding decisions.

Some projects may expose people to risks in many different ways. In Section I of your application, you will need to:

- Report any possible risks for people in your project,
- State how you plan to protect them from those risks, and
- Discuss how each type of risk will be dealt with, or why it does not apply to the project.

The following seven issues must be discussed:

❶ **Protect Clients and Staff from Potential Risks:**

- Identify and describe any foreseeable physical, medical, psychological, social, legal, or other risks or adverse effects.
- Discuss risks that are due either to participation in the project itself, or to the evaluation activities.
- Describe the procedures that will be followed to minimize or protect participants against potential health or confidentiality risks. Make sure to list potential risks in addition to any confidentiality issues.
- Give plans to provide help if there are adverse effects to participants.
- Where appropriate, describe alternative treatments and procedures that might be beneficial to the subjects.
- Offer reasons if you do not decide to use other beneficial treatments.

❷ **Fair Selection of Participants:**

- Describe the target population(s) for the proposed project. Include age, gender, and racial/ethnic background. Address other important factors such as homeless youth, foster children, children of substance abusers, pregnant women, or other special population groups.
- Explain the reasons for using special types of participants, such as pregnant women, children, institutionalized or mentally disabled persons, prisoners, or others who are likely to be vulnerable to HIV/AIDS.

- Explain the reasons for including or excluding participants.

- Explain how you will recruit and select participants. Identify who will select participants.

❸ Absence of Coercion:

- Explain if participation in the project is voluntary or required. Identify reasons participation may be required, such as court orders requiring people to participate in a program.

- If you plan to pay participants, state how they will be awarded money or gifts, and the anticipated amount or value of such payments.

- State how volunteer participants will be told that they may receive services and incentives even if they do not complete the study.

❹ Data Collection:

- Identify from whom you will collect data: participants themselves, family members, teachers, or others. Explain how you will collect data and list the site. For example, will you use school records, interviews, psychological assessments, observation, questionnaires, or other sources?

- Identify what type of specimens (e.g., urine, blood) will be used, if any. State if the material will be used just for evaluation and research or if other use will be made. Also, if needed, describe how the material will be monitored to ensure the safety of participants.

- Provide in Appendix No. 3, "Site-specific Data Collection Instruments/Interview Protocols," copies of all available data collection instruments and interview protocols that you plan to use.

❺ Privacy and Confidentiality:

- Describe how you will ensure privacy and confidentiality. Include who will collect data and how it will be collected.

- Describe:
  - How you will use data collection instruments.
  - Where data will be stored.
  - Who will or will not have access to information.
  - How the identity of participants will be kept private, such as through the use of a coding system on data records, limiting access to records, or storing identifiers separately from data.

  NOTE: If applicable, awardees must agree to maintain the confidentiality of alcohol and drug abuse client records according to the provisions of Title 42 of the Code of Federal Regulations, Part II.

❻ Adequate Consent Procedures:

- List what information will be given to people who participate in the project. Include the type and purpose of their participation. Include how the data will be used and how you will keep the data private.

- State:
  - If their participation is voluntary.
  - Their right to leave the project at any time without problems.

- Risks from the project.
- Plans to protect clients from these risks.

- Explain how you will get consent for youth, the elderly, people with limited reading skills, and people who do not use English as their first language.

  NOTE: If the project poses potential physical, medical, psychological, legal, social, or other risks, participants should give written informed consent.

- Indicate if you will get informed consent from participants or from their parents or legal guardians. Describe how the consent will be documented. For example: Will you read the consent forms? Will you ask prospective participants questions to be sure they understand the forms? Will you give them copies of what they sign?

- Include sample consent forms in your Appendix 4, titled "Sample Consent Forms." If needed, give English translations.

  NOTE: Never imply that the participant waives or appears to waive any legal rights, may not end involvement with the project, or releases your project or its agents from liability for negligence.

- Describe if separate consents will be obtained for different stages or parts of the project. For example, will they be needed for both the treatment intervention and for the collection of data? Will individuals who do not consent to having individually identifiable data collected for evaluation purposes be allowed to participate in the project?

❼ **Risk/Benefit Discussion:**

- Discuss why the risks are reasonable compared to expected benefits and importance of the knowledge from the project.

Special Considerations and Requirements

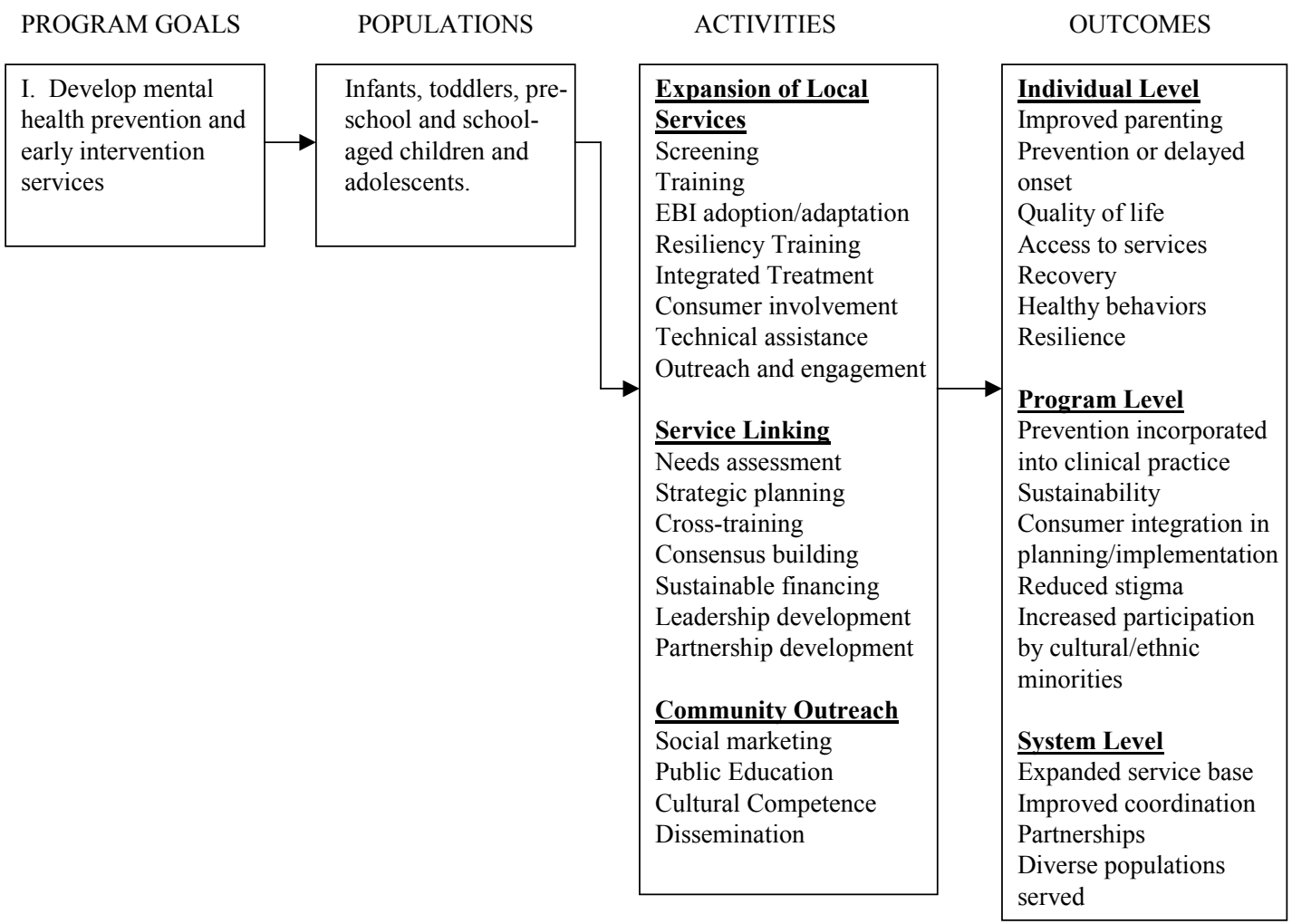
SAMHSA's policies, special considerations, and requirements can be found in Part II of the GFA.

The policies, special considerations, and requirements related to this program are:

- Population Inclusion Requirement
- Government Performance Monitoring
- Healthy People 2010
- Consumer Bill of Rights and Responsibilities
- Promoting Nonuse of Tobacco
- Coordination with Other Federal/Non-Federal Programs
- Single State Agency (SSA) Coordination
- Intergovernmental Review
- Public Health System Reporting Requirements
- Confidentiality/ SAMHSA Participant and Human Subject Protection

[redacted]

APPENDIX 1: LOGIC MODEL FOR TCE-- BUILD MENTALLY HEALTHY COMMUNITIES



Appendix II: References and Examples of Evidence-Based Programs

The organizations and resources listed below are not exhaustive, nor does the appearance of a program in the following list imply endorsement by the Federal Government. Rather, these listings are intended to assist grantees in formulating a response to the Guidance for Applicants (GFA) for *Build Mentally Healthy Communities*.

Infants, Toddlers, Preschool and School-Aged Children, and Adolescents

The Center for Mental Health Services commissioned two papers to review the literature related to the prevention of mental disorders for children and adolescents. The first paper, written by Dr. David Olds and his colleagues at the Prevention Research Center for Family and Child Health, University of Colorado Health Sciences Center, addressed preventive interventions for mental disorders during the first 5 years of life. The second paper, written by Dr. Mark Greenberg and his colleagues at the Prevention Research Center for the Promotion of Human Development, Pennsylvania State University, addressed prevention programs for school-aged children ages 5 to 18. Dr. Olds' report can be obtained from the Web site www.sshsac.org/PDFfiles/ReducingRisks.pdf or www.sshsac.org. Select Resources, Resources Links, Prevention; see #12. Dr. Greenberg's article can be downloaded from the Web site www.prevention.psu.edu**.** Each paper describes a number of prevention interventions using a set of standards for inclusion, as explained in the introduction. Risk factors and protective factors addressed by an intervention and the expected outcomes of the intervention are discussed.

Programs listed in the Olds et al. and Greenberg et al. Working Papers commissioned by CMHS have been identified by experts as programs to prevent mental and behavioral disorders. *Some* programs identified by other organizations (*Blueprints for Violence Prevention* identified by the Center for the Study and Prevention of Violence, or the National Registry of Effective Prevention Programs identified by the Center for Substance Abuse Prevention, SAMHSA) as violence or substance abuse prevention programs *may* also be *de facto* mental health promotion or prevention programs. However, any applicant who decides to use a program that is *not clearly identified* as a program to prevent mental and behavioral disorders must explain **clearly how the program will in fact** prevent mental and behavioral disorders.

Other resources listed below provide a discussion of evidence-based practices that the authors consider acceptable for use in community settings. Some programs listed in a domain other than mental health (e.g., violence prevention) can be used for mental health projects because the risk and protective factors addressed are shared. For example, a violence prevention protocol that addresses aggressive behavior in young children may also be viewed as a preventive intervention pertaining to the psychiatric diagnosis of conduct disorder.

It is essential that preventive interventions adopted for the first time by a grantee be done in collaboration with the researchers who designed the protocol, or their designee, to ensure

quality implementation. The environmental context in which preventive and early intervention strategies are implemented needs to be assessed for supportive elements. For example, when a county mental health center collaborates with a local school district to provide a social-emotional skills program (such as PATHS), or with several daycare centers to provide teacher and parent training such as *The Incredible Years*, key people such as a school principal or a day care director must be committed to the endeavor and must be willing to openly support the adoption of the prevention strategy.

Following are some examples of evidence-based interventions (EBIs) that can be used to design a mental health prevention or early intervention initiative.

- *The Incredible Years* is a research-based effective program that has been shown to reduce children's aggression and other behavior problems while increasing social skills. It was selected by the U.S. Office of Juvenile Justice and Delinquency Prevention as an "exemplary" best practice program and as a "Blueprints" program, selected by the Center for Substance Abuse Prevention as a "Model" program, and recommended by the American Psychological Assn. Division 12 Task force as a well-established treatment for children with conduct problems. This intervention can be used to prevent mental health problems, not just as an early intervention for a child with an externalizing disorder. Children ages 2 to 12 years, their parents, and their teachers are eligible for the training series. Training workshops offering certification for each of the Parent, Child, and Teacher programs are regularly offered in Seattle, Washington, and in other locations throughout the United States.

The Incredible Years was developed by Dr. Carolyn Webster-Stratton. For additional information, see the website www.incredibleyears.com/index.html.

References

Webster-Stratton, C. (1999). *How to Promote Social and Emotional Competence in the Classroom.* London: Sage Publishers.

Webster-Stratton, C. (1990a). Enhancing the effectiveness of self-administered videotape parent training for families with conduct-problem children. *Journal of Abnormal Child Psychology* 18(5):479-492.

Webster-Stratton, C. (1990b). Long-term follow-up of families with young conduct-problem children: From preschool to grade school. *Journal of Clinical Child Psychology* 19(2):144-149.

Webster-Stratton, C. (1984). A randomized trial of two parent training programs for families with conduct-disordered children. *Journal of Consulting and Clinical Psychology* 52(4):666-678.

- A psychoeducational preventive intervention to prevent depression in children of parents with severe affective disorders was developed by Dr. William Beardslee, Chairman, Department of Psychiatry, Children's Hospital, Boston, Massachusetts. Children aged 8-15 years and their parents were selected for a 6-10 session protocol tested in an experimental design. Follow-up studies indicate positive outcomes sustained for a 3-year period. The preventive protocol is carried out by a mental health professional**.**

  References

  Beardslee, WR. (1998). Prevention and the clinical encounter. *American Orthopsychiatric Association* 68(4):521-533.

  Beardslee, WR, Wheelock, I (1994). Children of parents with affective disorders: empirical findings and clinical implications. In: Reynolds WM, Johnson HF (eds.): *Handbook of Depression in Children and Adolescents*. New York: Plenum, pp 463-479.

- PATHS (Providing Alternative Thinking Strategies) is an empirically tested preventive intervention for elementary school-aged children designed to enhance self-control, emotional awareness, and problem-solving skills in an interpersonal setting. It is a program for educators and counselors to be used in schools. The Instructional Manual, including six volumes of lessons, is available from the program developer. Outcome studies showed that PATHS improves protective factors and reduces behavioral risk across a wide range of types of children. For more information, contact Mark Greenberg, Ph.D., Director, Prevention Research Center, Penn State University, HDFS/Henderson Building South [(814) 863-0112, fax (814) 865-2530].

  References

  Bierman, K, Greenberg, MT, and Conduct Problems Prevention Research Group (1966). Social skills in the FAST Track Program. In: DeV Peters R, McMahon RJ (eds.): *Prevention and Early Intervention: Childhood Disorders, Substance Abuse, and Delinquency*. Newbury Park, CA: Sage, pp. 65-89.

  Greenberg, MT, Snell, J. (1997). The neurological basis of emotional development. In: Salovey P. (ed.): *Emotional Development and Emotional Literacy*. New York: Basic Books, pp. 92-119.

  Greenberg, MT, Kusche, CA. (1993). *Promoting Social and Emotional Development in Deaf Children: The PATHS Project*. Seattle: University of Washington Press.

  Greenberg, MT, Kusche, CA, Cook, ET, Quamma, JP. (1995). Promoting emotional competence in school-aged children: The effects of the PATHS Curriculum. *Development and Psychopathology* 7:117-136.

  Kusche, CA, Greenberg, MT. (1994) *The PATHS Curriculum*. Seattle: Developmental

Research and Programs.

Web sites:

Center for School Mental Health Assistance
http://csmha.umaryland.edu

The Center for School Mental Health Assistance (CSMHA) provides leadership and technical assistance to advance effective interdisciplinary school-based mental health programs. They strive to support schools and communities in developing programs that are accessible, family-centered, culturally sensitive, and responsive to local needs. The Center offers forums for training, for exchange of ideas, and for promotion of coordinated systems of care that provide a full continuum of services to enhance mental health, development, and learning in youth.

Center for Substance Abuse Prevention
www.samhsa.gov/centers/csap

Safe Schools/Healthy Students Action Center
www.sshsac.org

The Safe Schools/Healthy Students Action Center works to assist Federal Safe Schools/Healthy Students grantees to attain their goals of interagency collaboration and adoption of evidence-based practices to reduce school violence and substance abuse, and to promote healthy development and resiliency. The Action Center also works to provide other local education agencies, communities, and families with access to resources and materials to enhance their ability to undertake collaborative efforts to prevent school violence and enhance resiliency. The clearinghouse provides links to prevention intervention resources and is publicly accessible.

Blueprints for Violence Prevention
www.colorado.edu/cspv/blueprints

The Center for the Study and Prevention of Violence (CSPV), with funding from the Colorado Division of Criminal Justice, the Centers for Disease Control and Prevention, and the Pennsylvania Commission on Crime and Delinquency, initiated a project to identify 10 violence prevention programs that met a very high scientific standard of effectiveness: programs had to provide an initial nucleus for a national violence prevention initiative. Blueprints were designed to be practical descriptions of effective programs that would allow States, communities, and individual agencies to

- determine the appropriateness of an intervention for their State or community;
- obtain a realistic cost estimate for the intervention;
- provide an assessment of the organizational capacity needed to ensure successful start-up and successful operation over time;

- give an indication of the potential barriers and obstacles that might be encountered while implementing this type of intervention.

The Collaborative to Advance Social and Emotional Learning (CASEL)
www.casel.org

CASEL was founded in 1994 by Daniel Goleman and Eileen Rockefeller Growald. CASEL's mission is to establish social and emotional learning (SEL) as an integral part of education from preschool through high school. The Collaborative's goals are to:

- advance the science of social emotional learning;
- translate scientific knowledge into effective school practice;
- disseminate information about scientifically sound educational strategies and practice;
- enhance training so that educators effectively implement high-quality SEL programs; and
- network and collaborate with scientists, educators, advocates, policy-makers, and interested citizens to better coordinate SEL efforts.

Within the CASEL Web site, prevention information is at
http://www.casel.org/links.htm#prevention.

The Prevention Research Center for the Promotion of Human Development
College of Health and Human Development
Pennsylvania State University
http://www.psu.edu/dept/prevention

Thirty-four effective prevention programs are identified and discussed in detail in *Preventing Mental Disorders in School-Age Children: A Review of the Effectiveness of Prevention Programs.* This review of the current state of preventing aggression, depression, and anxiety in children was produced for the Center for Mental Health Services (CMHS). It can be downloaded from the Web site.

School Mental Health Project/Center for Mental Health in Schools (UCLA)
www.smhp.psych.ucla.edu

The Center's mission is to improve outcomes for youth by enhancing policies, programs, and practices relevant to mental health in schools, with specific attention to strategies that can counter fragmentation and enhance collaboration between school programs and community programs.

Appendix III: Consumer and Family Participation Guidelines

Applicants should have experience or a track record of involving mental health consumers and their family members. The applicant organization should have a documented history of positive programmatic involvement of recipients of mental health services and their family members. This involvement should be meaningful and span all aspects of the organization's activities as described below:

Program Mission. An organization's mission should reflect the value of involving consumers and family members in order to improve outcomes.

Program Planning. Consumers and family members are involved in substantial numbers in the conceptualization of initiatives, including identifying community needs, goals, and objectives, and innovative approaches. This includes participation in grant application development including budget submissions. Approaches should also incorporate peer support methods.

Training and Staffing. The staff of the organization should have substantive training in and be familiar with consumer and family-related issues. Attention should be placed on staffing the initiative with people who are themselves consumers or family members. Such staff should be paid commensurate with their work and in parity with other staff.

Informed Consent. Recipients of project services should be fully informed of the benefits and risks of services and make a voluntary decision, without threats or coercion, to receive or reject services at any time.

Rights Protection. Consumers and family members must be fully informed of all of their rights, including those designated by the President's Advisory Commission's Healthcare Consumer Bill of Rights and Responsibilities: information disclosure, choice of providers and plans, access to emergency services, participation in treatment decisions, respect and non-discrimination, confidentiality of healthcare information, complaints and appeals, and consumer responsibilities.

Program Administration, Governance, and Policy Determination. Consumers and family members should be hired in key management roles to provide project oversight and guidance. Consumers and family members should sit on all boards of directors, steering committees, and advisory bodies in meaningful numbers. Such members should be fully trained and compensated for their activities.

Program Evaluation. Consumers and family members should be integrally involved in designing and carrying out all research and program evaluation activities. This includes determining research questions, designing instruments, conducting surveys and other research

methods, and analyzing data and determining conclusions. This includes consumers and family members being involved in all submissions of journal articles. Evaluation and research should also include consumer satisfaction and dissatisfaction measures.

Appendix IV: Definitions

Children and adolescents targeted for prevention and early intervention services for the purposes of this announcement include infants, toddlers, preschool and school-aged children, and adolescents, from the prenatal stage to 18 years old.

Cultural competence means attaining the knowledge, skills, and attitudes to enable administrators and practitioners within systems of care to provide effective care for diverse populations. This includes an understanding of a group's or member's language, beliefs, norms, and values, as well as socioeconomic and political factors which may have significant impact on their psychological well-being, and incorporating those variables into assessment and treatment.

An **evidence-based practice** is one with documented *effectiveness* (evidence that the practice will change or have an impact upon the target of intervention), *applicability* (evidence that the practice will be effective with clients from the specified target population), and *replicability* (evidence that the practice can be implemented with fidelity to the original model while achieving similar results). The higher the level of evidence, the more likely the program is to work in other settings. In 1998, the U.S. Preventive Services Task Force articulated the following ***levels of evidence***:

- Evidence obtained from at least one properly designed randomized controlled trial.
- Evidence obtained from well-designed controlled trials without randomization.
- Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group.
- Evidence obtained from multiple time series with or without the intervention, or dramatic results in uncontrolled experiments.
- Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

Non-mental health service sites include primary health care agencies, homeless shelters, faith-based organizations, private residences, schools, addiction service agencies, and other locations where the priority populations are located.

Mental health is defined by the Surgeon General as a state of successful performance of mental function, resulting in the capacity to be productive in various domains of living, including the establishment of satisfying relationships and the ability to approach difficult circumstances with resilience, and not simply the absence of mental illness.

Mental illness as defined by the Surgeon General refers collectively to all of the diagnosable mental disorders mediated by the brain and characterized by abnormalities in cognition, emotion, or mood; or the highest integrative aspects of behavior, such as social interactions or planning of future activities.

Psychiatric disorder refers to the condition of currently having, or at any time during the past year having had, a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV (Axis I). These disorders include any mental disorders listed in Axis I of the DSM-IV or their ICD-9-CM equivalent (and subsequent revisions), with the exception of DSM-IV "V" codes, substance use disorders, mental retardation, and developmental disorders, which are excluded unless they co-occur with another diagnosable psychiatric disorder meeting the above criteria. All of these disorders may have episodic, recurrent, or persistent features, and may vary in terms of severity and disabling effects.

Risk factors are defined by the Surgeon General as biological, psychological, or sociocultural variables that increase the probability for developing a disorder and antedate its onset.

Protective factors are defined by the Surgeon General as those variables that improve a person's response to some environmental hazard, resulting in an adaptive outcome.

Prevention refers to interventions that occur before the initial onset of a mental disorder to prevent the development of the disorder, including the prevention of comorbidity. Interventions can be classified into three categories: *universal* (everyone in a specific population, e.g., elementary school children who receive general life skills training), *selective* (a subgroup of a larger population with heightened risk, e.g., second graders who show signs of interpersonal difficulty who receive a specific targeted protocol), and *indicated* (individuals at the highest risk for the development of a mental or behavioral disorder and who may exhibit symptoms of a disorder insufficient for a clinical diagnosis, e.g., children with aggressive behavior who receive an individual intervention as well as an intervention designed to assist their parents and teachers who must respond to the child's problem behavior).

Early intervention refers to interventions that are targeted for individuals who for the first time display the early signs and symptoms of a mental disorder.

A program **logic model**, or flow chart, is a graphic representation of what the program is designed to accomplish, including services to be delivered, expected outcomes of these services, and ultimate program goals linked to the underlying assumptions of the program. In addition, a good logic model is a picture of plausible causal linkages between program components and outcomes and can serve as an evaluation map, identifying what services need to be documented in a process evaluation and what outcomes need to be measured in an outcomes evaluation (see Appendix I).

Appendix V

Form Approved
OMB No. 0930-0208
Expiration Date 10/31/2002

CMHS GPRA Client Outcome Measures for Discretionary Programs

Public reporting burden for this collection of information is estimated to average 20 minutes per response if all items are asked of a client; to the extent that providers already obtain much of this information as part of their ongoing client intake or followup, less time will be required. Send comments regarding this burden estimate or any other aspect of this collection of information to SAMHSA Reports Clearance Officer, Room 16-105, 5600 Fishers Lane, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The control number for this project is 0930-0208.

A. RECORD MANAGEMENT

Client ID |____|____|____|____|____|____|____|____|____|____|____|____|

Contract/Grant ID |____|____|____|____|____|____|____|____|____|____|

Grant Year |____|____|
Year

Interview Date |____|____| / |____|____| / |____|____|

Interview Type 1. INTAKE 2. 6 month follow-up 3. 12 month follow-up

B. DRUG AND ALCOHOL USE

1.	**During the past 30 days how many days have you used the following:**		**Number of Days**
	a.	Any Alcohol	|____|____|
	b.	Alcohol to intoxication (5+drinks in one sitting)	|____|____|
	c.	Illegal Drugs	|____|____|
2.	**During the past 30 days, how many days have you used any of the following:**		**Number of Days**
	a.	Cocaine/Crack	|____|____|
	b.	Marijuana/Hashish [Pot, Joints, Blunts, Chronic, Weed, Mary Jane]	|____|____|
	c.	Heroin [Smack, H, Junk, Skag] or other opiates	|____|____|
	d.	Nonprescription methadone	|____|____|
	e.	Hallucinogens/psychedelics, PCP [Angel Dust, Ozone, Wack, Rocket Fuel] MDMA [Ecstacy, XTC, X, Adam], LSD [Acid, Boomers, Yellow Sunshine], Mushrooms, Mescaline	|____|____|
	f.	Methamphetamine or other amphetamines [Meth, Uppers, Speed, Ice, Chalk, Crystal, Glass, Fire, Crank]	|____|____|
	g.	Benzodiazepines, barbiturates, other tranquilizers, downers, sedatives, or hypnotics [GHB, Grievous Bodily Harm, Georgia Home Boy, G, Liquid Ecstacy, Ketamine, Special K, K, Vitamin K, Cat, Valiums, Rohypnol, Roofies, Roche]	|____|____|
	h.	Inhalants [Poppers, Snappers, Rush, whippets]	|____|____|
	i.	Other Drugs - Specify_____	|____|____|

C. FAMILY AND LIVING CONDITIONS

1. In the past 30 days, where have you been living most of the time?

- ◯ Shelter (Safe havens, TLC, low demand facilities, reception centers, other temporary day or evening facility)
- ◯ Street/outdoors (sidewalk, doorway, park, public or abandoned building)
- ◯ Institution (hospital, nursing home, jail/prison)
- ◯ Housed (Own or someone else's apartment, room, house, halfway house, residential treatment)

2. During the past week, to what extent have you been experiencing difficulty in the area of: Managing day-to-day life (e.g., getting to places on time, handling money, making everyday decisions)

- ◯ No difficulty
- ◯ A little difficulty
- ◯ Moderate difficulty
- ◯ Quite a bit of difficulty
- ◯ Extreme difficulty
- ◯ Don't know
- ◯ Not Applicable
- ◯ Refused

3. During the past week, to what extent have you been experiencing difficulty in the area of: Household responsibilities (e.g., shopping, cooking, laundry, keeping your room clean, other chores)

- ◯ No difficulty
- ◯ A little difficulty
- ◯ Moderate difficulty
- ◯ Quite a bit of difficulty
- ◯ Extreme difficulty
- ◯ Don't know
- ◯ Not Applicable
- ◯ Refused

4. During the past week, to what extent have you been experiencing difficulty in the area of: Work (e.g., completing tasks, performance level, finding or keeping a job)

- ◯ No difficulty
- ◯ A little difficulty
- ◯ Moderate difficulty
- ◯ Quite a bit of difficulty
- ◯ Extreme difficulty
- ◯ Don't know
- ◯ Not Applicable
- ◯ Refused

5. During the past week, to what extent have you been experiencing difficulty in the area of: School (e.g., academic performance, completing assignments, attendance)

- ◯ No difficulty
- ◯ A little difficulty
- ◯ Moderate difficulty
- ◯ Quite a bit of difficulty
- ◯ Extreme difficulty
- ◯ Don't know
- ◯ Not Applicable
- ◯ Refused

6. During the past week, to what extent have you been experiencing difficulty in the area of: Leisure time or recreational activities

- ◯ No difficulty
- ◯ A little difficulty
- ◯ Moderate difficulty
- ◯ Quite a bit of difficulty
- ◯ Extreme difficulty
- ◯ Don't know
- ◯ Not Applicable
- ◯ Refused

7. During the past week, to what extent have you been experiencing difficulty in the area of: Developing independence or autonomy

- ◯ No difficulty
- ◯ A little difficulty
- ◯ Moderate difficulty
- ◯ Quite a bit of difficulty
- ◯ Extreme Difficulty
- ◯ Don't know
- ◯ Not Applicable
- ◯ Refused

8. During the past week, to what extent have you been experiencing difficulty in the area of: Apathy or lack of interest in things

- ◯ No difficulty
- ◯ A little difficulty
- ◯ Moderate difficulty
- ◯ Quite a bit of difficulty
- ◯ Extreme difficulty
- ◯ Don't know
- ◯ Not Applicable
- ◯ Refused

9. During the past week, to what extent have you been experiencing difficulty in the area of: Confusion, concentration, or memory

- ◯ No difficulty
- ◯ A little difficulty
- ◯ Moderate difficulty
- ◯ Quite a bit of difficulty
- ◯ Extreme difficulty
- ◯ Don't know
- ◯ Not Applicable
- ◯ Refused

10. During the past week, to what extent have you been experiencing difficulty in the area of: Feeling satisfaction with your life

- ◯ No difficulty
- ◯ A little difficulty
- ◯ Moderate difficulty
- ◯ Quite a bit of difficulty
- ◯ Extreme difficulty
- ◯ Don't know
- ◯ Not Applicable
- ◯ Refused

D. EDUCATION, EMPLOYMENT, AND INCOME

1. Are you currently enrolled in school or a job training program? [IF ENROLLED: Is that full time or part time?]

- ◯ Not enrolled
- ◯ Enrolled, full time
- ◯ Enrolled, part time
- ◯ Other (specify)_____

2. What is the highest level of education you have finished, whether or not you received a degree? [01=1st grade, 12=12th grade, 13=college freshman, 16=college completion]

|____|____| level in years

2a. If less than 12 years of education, do you have a GED (Graduate Equivalent Diploma)?

◯ Yes ◯ No

3. **Are you currently employed?** [Clarify by focusing on status during most of the previous week, determining whether client worked at all or had a regular job but was off work]

- ◯ Employed full time (35+ hours per week, or would have been)
- ◯ Employed part time
- ◯ Unemployed, looking for work
- ◯ Unemployed, disabled
- ◯ Unemployed, volunteer work
- ◯ Unemployed, retired
- ◯ Other, specify_____

4. **Approximately how much money did YOU receive (pretax individual income) in the past 30 days from…**

		INCOME							
a. Wages	$				,				.00
b. Public assistance	$				,				.00
c. Retirement	$				,				.00
d. Disability	$				,				.00
e. Nonlegal income	$				,				.00
f. Other_____ (Specify)	$				,				.00

E. CRIME AND CRIMINAL JUSTICE STATUS

1. **In the past 30 days, how many times have you been arrested?** |____|____| times

2. **In the past 30 days, how many times have you been arrested for drug-related offenses?** |____|____| times

3. **In the past 30 days, how many nights have you spent in jail/prison?** |____|____| nights

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT

1. **How would you rate your overall health right now?**

- ◯ Excellent
- ◯ Very good
- ◯ Good
- ◯ Fair
- ◯ Poor

2. **During the past 30 days, did you receive**

a. Inpatient Treatment for:	No	Yes ⇨	**If yes, altogether** for how many nights (DK=98)
i. Physical complaint	°	°	_____
ii. Mental or emotional difficulties	°	°	_____
iii. Alcohol or substance abuse	°	°	_____

b. Outpatient Treatment for:	No	Yes ⇨	**If yes, altogether** how many times (DK=98)
i. Physical complaint	°	°	_____
ii. Mental or emotional difficulties	°	°	_____
iii. Alcohol or substance abuse	°	°	_____

c. Emergency Room Treatment for:	No	Yes ⇨	**If yes, altogether** for how many times (DK=98)
i. Physical complaint	°	°	_____
ii. Mental or emotional difficulties	°	°	_____
iii. Alcohol or substance abuse	°	°	_____

H. DEMOGRAPHICS (ASKED ONLY AT BASELINE)

1. Gender

- ○ Male
- ○ Female
- ○ Other (please specify) _____

2. Are you Hispanic or Latino?

○ Yes ○ No

3. What is your race? (Select one or more)

- ○ Black or African American
- ○ Asian
- ○ American Indian
- ○ Native Hawaiian or other Pacific Islander
- ○ Alaska Native
- ○ White
- ○ Other (Specify)_____

4. What is your date of birth? |____|____| / |____|____| / |____|____|
Month / Day / Year