DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

Guidance for Applicants (GFA) No. SM- 02-002
Part I - Programmatic Guidance

Cooperative Agreements for the Comprehensive Community Mental Health Services For Children and Their Families Program

Short Title: Child Mental Health Initiative

Application Due Date: April 26, 2002

Bernard S. Arons, M.D.
Director
Center for Mental Health
Services

Charles G. Curie, M.A., A.C.S.W.
Administrator
Substance Abuse and Mental Health
Services Administration

Date of Issuance: January 26, 2002

Catalog of Federal Domestic Assistance (CFDA) No. 93.104
Authority: Part E of Title V Section 561 et. seq. of the Public Health Service Act, as amended and subject to the availability of funds.

Table of Contents

Agency

US Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration (SAMHSA).

Action and Purpose

The Center for Mental Health Services (CMHS), SAMHSA, announces the availability of funds for cooperative agreements to develop systems of care that deliver effective comprehensive community mental health services for children and adolescents with serious emotional disturbance and their families.

The cooperative agreements will award funds to develop community service systems for the target population, and also to fund a broad array of services within these community service systems.

In addition, awardees will participate in a national multi-site evaluation, conducted under a separate contract, and will be encouraged to develop the capacity for continuous evaluation of their systems of care.

Approximately $13 million will be available for 13-16 awards. About $6 million of these funds will be set aside to fund up to four cooperative agreements in cities with a population larger than 500,000, and up to two cooperative agreements in territories. About $7 million will be for 7-10 cooperative agreements awarded to states, counties, cities, tribes and tribal organizations. Funds from any of these cooperative agreements must be used to develop systems of care in geographic areas that have not been targeted for a Children's Mental Health Initiative (CMHI) award in the past. Actual funding levels will depend on the availability of funds.

The project period is 6 years. It is anticipated that the maximum amount available for each year of the award will be as follows:

- Year 1: $1 million
- Year 2: $1.5 million
- Year 3: $2.5 million
- Year 4: $2 million
- Year 5: $1.5 million
- Year 6: $1 million

Continuation of the cooperative agreement beyond the first year of funding will require annual review of progress achieved, and demonstration that the system of care under development is included in specific goals of the State Mental Health Plan.

Non-Federal Match

By statutory mandate, this program requires that the applicant entity will provide, directly or through donations from public or private entities, non-federal contributions:

- For the first, second and third fiscal years of the cooperative agreement, the awardee must provide at least $1 for each $3 of federal funds;
- for the fourth fiscal year, the awardee must provide at least $1 for each $1 of federal funds; and
- for the fifth and sixth fiscal year, the awardee must provide at least $2 for each $1 of federal funds.

Matching resources may be in cash or in-kind, including facilities, equipment, or services, and must be derived from non-federal sources (e.g., State or sub-State non-federal revenues, foundation grants).

It is expected that non-federal match dollars will include contributions from various child-serving systems (e.g., education, child welfare, juvenile justice). The applicant should specify the names of the expected sources, the types of sources (e.g., education, child welfare, juvenile justice), and amounts of matching funds as evidence of the project's potential to sustain itself beyond the six-year award period.

CMHS is concerned that the federal funds for this program might be used to replace existing non-federal funds. Therefore, in the first year of the cooperative agreement, applicants may include non-federal match contributions in excess of the average amount of non-federal funds spent on community-based mental health services for children with serious emotional disturbance within the jurisdiction of the cooperative agreement over the 2 fiscal years before the proposed cooperative agreement starts. Non-federal public contributions, whether they are from State, county or city governments, must be dedicated to the community(ies) served by the cooperative agreement.

A letter from the Director of the State, county or city mental health agency which is applying for the cooperative agreement should certify that non-federal matching funds for the proposed project are available. The letter must be included in Appendix No. 5 entitled, Non-Federal Match Certification. Such letter should also indicate that proposed changes in funding streams required for the match or other funding innovations necessary for the implementation of the proposed project will be allowed.

Additional letters from other non-mental health agency directors (e.g., education, child welfare, juvenile justice) at the State, county or city levels, may be included in Appendix No. 5.

Indian tribes receiving funds from the Indian Self Determination and Education Assistance Act (as amended) PL93-638, are exempt from the restriction which prohibits the use of those Federal funds as a match.

Who Can Apply?

Eligibility for any applicant is limited to public entities defined as:

- State
- Indian tribe or tribal organization (as defined in Section 4[b] and Section 4[c] of the Indian Self-determination and Education Assistance Act)
- Political subdivision of a State (e.g., County, City)

the District of Columbia, and the territories of

- Guam,
- Commonwealth of Puerto Rico,
- Northern Mariana Islands,
- Virgin Islands,
- American Samoa, and
- Trust Territory of the Pacific Islands (now Palau, Micronesia, and the Marshall Islands).

Only cities or territories that have not previously received grant funds through this program may apply for the $6 million that have been set aside for cities and territories. Current or former awardees of the program may apply for the approximately $7 million that have not been set-aside for cities or territories. However, a new cooperative agreement application must be targeted to a geographic location within the State,

County, or Tribe that is different from the geographic location of existing awards.

An exception to the requirement that funds be targeted to new geographic areas will be made for States whose previous award(s) were to develop systems of care across the entire State. Such States may apply for this cooperative agreement, as long as any previous awards under this program have expired in their entirety, including their no-cost extension years. (Please note that current and previous awardees received funds through grants, not cooperative agreements. See Appendix G for a list of current and past grant recipients, including the geographic areas in which each of these grants has been implemented.

The legislation intends only one application per public entity. However, a State government and a State subdivision, such as a county or city in the same State, may apply for separate cooperative agreements, as long as the geographic regions where each cooperative agreement will be implemented do not overlap.

A public entity within a State or territory that has not been funded previously is encouraged to apply. States not previously funded include Connecticut, Idaho, Iowa, Louisiana, Oklahoma, Missouri, and Montana. None of the territories nor the District of Columbia have been funded yet.

Eligible applicants must meet the following requirements:

< The application may only be submitted by the Office of the Governor, or chief executive officer in a State subdivision (e.g., county, city), or an Indian tribe or tribal organization, or any subordinate executive agency specifically designated in writing by the Governor (or chief executive officer for an entity other than one of the several States).

< As an indicator of potential sustainability, eligible public entities in States and political subdivisions of States must include a letter of assurance from the Governor of the State, or his or her designee, that the system of care proposed under this Guidance for Applicants (GFA) is specifically included in the goals of the State's Community Mental Health Services Block Grant Plan, as authorized in Section 564 (b) of the PHS Act, and in the State Mental Health Plan for Children and Adolescents with Serious Emotional Disturbance, submitted under Public Law 102-321. If the proposed system of care is not included in these State plans, the letter of assurance should indicate that it will be included in a revision of the Plan at its next renewal date. This letter is not required of Indian Tribe or tribal organization applicants.

  The letter of assurance must appear in Appendix No. 2 entitled, "Health Coverage Modification Plans/Governor's Assurance." **If this letter does not appear in the appendix, the application will not be reviewed.**

See Table 1 on page 6 for a summary of eligibility requirements.

Summary of Eligibility Requirements					
Cities and Territories					
Eligible Applicant	Previous Award	Application signed by	Letter of Assurance Required	# of awards	$
Cities larger than 500,000	Ineligible if awarded in the past	Chief executive officer or other designated in writing by governor	Yes	4	$6 million
Territories	Ineligible if awarded in the past	Chief executive officer or other designated in writing by governor	Yes	2	
All Other Public Entities					
Eligible Applicant	Previous Award	Application signed by	Letter of Assurance Required	# of awards	$
State government	Eligible if targeted to new geographic area; may not overlap target area from sub-State application. Exception: If applicant was previously awarded a grant for the entire State, such applicant may be eligible, as long as previous award has expired, including any no-cost extension year.	Office of the Governor	Yes	7-10	$7 million
counties, cities, territories	Eligible if targeted to new geographic area; may not overlap target area from any other concurrent application within the State	Chief executive officer or other designated in writing by governor	Yes		
Tribe	Eligible only if targeted to new Tribe or tribal organization.	Tribal leader or Council	No		

Application Kit

Application kits have several parts. One of them is the cooperative agreement announcement itself called Guidance for Applicants (GFA). **The GFA has two parts.** Part I describes application requirements specific to the cooperative agreement program that SAMHSA is announcing. Part II informs about general policies and procedures that apply to **all** SAMHSA grant and cooperative agreements. You will need to use both Parts I and II for your application. **This document is Part I.**

A complete application kit includes Parts I and II of the GFA, as well as forms SF 424 and PHS 5161, which you will need to submit with your application.

Written requests for an application kit may be sent to:

Knowledge Exchange Network
P.O. Box 42490
Washington, DC 20015

Please indicate in the request that you are ordering the application kit for the **Child Mental Health Initiative, GFA No. SM-02-002.** Only one application kit will be sent per request.

An additional copy of the kit may also be ordered by phone at 800-789-2647. Be prepared to provide the name of the GFA ("Child Mental Health Initiative") and the GFA number ("SM-02-002") that you are ordering.

You may also download the application kit from the SAMHSA website at www.SAMHSA.gov. Go to the "Grant Opportunities" link.

Where to Send the Application

Send the original and 2 copies of your cooperative agreement application to:

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

Note: Please change the zip code to 20817, if you use express mail or courier service to send your application.

Please note:

1. Use application form PHS 5161-1.

2. Be sure to type:
"***SM -02-002*** Cooperative Agreement for the Comprehensive Community Mental Health Services for Children and Their Families Program " in Item Number 10 on the face page of the application form. If you are applying through the city or territory set-asides then also add in Item Number 10 "city set-aside" or "territory set-aside."

3. **Effective immediately, all applications MUST be sent via a recognized commercial or governmental carrier. Hand-carried applications will not be accepted.**

Application Date

Your application must be received by April 26, 2002.

Applications received after this date will only be accepted if they have a legible proof-of-mailing date from the carrier no later than April 19, 2002.

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

Contacts for Further Information

For questions on *program issues*, contact:

Diane L. Sondheimer, M.S., M.P.H. or
Rolando L. Santiago, Ph.D.
Child, Adolescent, and Family Branch
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, Room 11C-16
Rockville, MD 20857
(301) 443-1333
E-Mail: *dsondhei@samhsa.gov*, *rsantiag@samhsa.gov*

For questions on *grants management issues*, contact:

Steve Hudak
Grants Management Officer
Division of Grants Management, OPS
Substance Abuse and Mental Health Services Administration
5515 Security Lane, Rockwall II, Room 630
Rockville, MD 20852
Phone: (301) 443-9666
E-Mail: shudak@samhsa.gov.

Technical Assistance Workshops

CMHS intends to sponsor two technical assistance workshops in mid-March for potential applicants. The first workshop is scheduled for March 13-14, 2002, in Denver, Colorado, and the second workshop is scheduled for March 18-19, 2002, in Washington, D.C.

To receive logistical information, contact Knowledge Exchange Network (KEN) by calling 800-789-2647. A registration form for the TA workshop may be downloaded form the SAMHSA website at www.SAMHSA.gov. Go to "Grant Opportunities" in the SAMHSA home page and click on it. Then click on "Current Grant Funding Opportunities" and then look for Child Mental Health Initiative GFA No. SM-02-002, and click on the link for the CMHS Child TA Workshops. Or, you may contact:

Pam Cook
Technical Assistance Partnership for Child and Family Mental Health
1000 Thomas Jefferson Street, N.W.
Washington, D.C. 20007
Phone No.: 202 298-2645
E-mail: pcook@air.org

Cooperative Agreements

This award is being made as a cooperative agreement because it will require substantial Federal staff involvement that will include:

- Monitoring of each awardee's progress in the implementation of program requirements;
- Review and approval of each stage of project implementation;
- Participation in making decisions with the awardee that will help achieve project objectives;
- Approval of decisions of each awardee about:
  - use of technical assistance resources for developing the system of care according to requirements of the cooperative agreement, and for increasing the likelihood that the system of care will be sustained beyond the federal funding period;
  - use of communications, public awareness, and social marketing techniques in the community to promote good mental health practice among children and youth with serious emotional disturbance and their families; advertise system-of-care services; and reduce community-wide stigma associated with serious emotional disturbance;
  - ways to insure implementation of the national evaluation to demonstrate the effectiveness of each system of care through evidence that the well-being of children with serious emotional disturbance and their families increases as a result of receiving system-of-care services; how to ensure timely submission of data to the national evaluation contractor; use of data to improve and to sustain the system of care; and, insuring that capacity for evaluation continues beyond the federal funding period;
- Conducting a site visit in Years 2 and 4 of the cooperative agreement, or more frequently, as needed; and,
- Ensuring that system-of-care activities under this program are coordinated with CMHS, SAMHSA, and other Federal initiatives, as appropriate.

Role of Awardee:

- Comply with the terms and conditions of the agreement, as specified in the Notice of Grant Award (NOGA) and other such documents.
- Collaborate with CMHS staff in project implementation and monitoring.
- Participate in national program evaluation which includes required SAMHSA measures for complying with the Government Performance and Results Act (GPRA)

Role of the Project Officer

- The Project Officer (PO) manages negotiation, award, financial and other administrative aspects of assigned cooperative agreements. The PO utilizes information from federal visits, quarterly progress reports, re-application forms,

technical assistance and national evaluation reports, phone calls, e-mail messages, and other appropriate means to help make decisions with the awardees.

The PO has direct responsibility for assuring that the project is operated in compliance with applicable Federal laws, regulations, guidelines and the terms and conditions of award. The PO works with the Grants Management Officer to respond to questions about regulations and policies that apply to this cooperative agreement, and to answer requests for required prior approval.

Funding Criteria

Decisions to fund a cooperative agreement under this announcement are based on:

1. The strengths and weaknesses of the application as determined by the Peer Review Committee and approved by the CMHS National Advisory Council.

2. Availability of funds.

3. Availability of matching non-Federal resources.

4. Equitable allocation of assistance among the principal geographic regions of the United States, as indicated in the PHS Act, Section 561(b)(3)(A).

5. Distribution of awards to public entities in cities with a population larger than 500,000; in territories; and in geographic areas that have not been funded previously.

Post Award Requirements

After an applicant has been awarded a cooperative agreement, the applicant is required to:

1. Comply with the terms and conditions negotiated for the award.

2. Provide at least the following reports:

   < Quarterly reports

   < Annual report (in place of fourth quarterly report) summarizing project progress, problems, and alterations in approaches. This report will be used to determine whether the awardee has achieved its goals and will be eligible for a noncompetitive renewal.

   < Final report at the end of the 6 year project period summarizing progress, problems, and alterations in approaches.

3. Provide information needed by SAMHSA to comply with GPRA reporting requirements. Awardees will be able to provide information on GPRA measures through participation in the national evaluation.

Target Population

Children and adolescents with a serious emotional disturbance are eligible for services provided under this program if they:

Age. Are under 22 years of age.

Diagnosis. Have an emotional, behavioral, or mental disorder diagnosable under DSM-IV or its ICD-9-CM equivalents, or subsequent revisions (with the exception of DSM -IV "V" codes, substance use disorders and developmental disorders, unless they co-occur with another diagnosable serious emotional, behavioral, or mental disorder).

Disability. Are unable to function in the family, school, or community, or in a combination of these settings. (Awardees must define level of functioning required for eligibility.)

Or, level of functioning is such that the child or adolescent requires multiagency intervention involving two or more community service agencies, such as mental health, education, child welfare, juvenile justice, substance abuse, and health.

Duration. Have a disability that must have been present for at least one year or, on the basis of diagnosis, severity, or multiagency intervention, be expected to last more than one year.

Program Goals

The statutory goal of the program is to award federal funds to public entities to provide comprehensive community mental health services to children with a serious emotional disturbance. The goal can only be carried out by operating one or more systems of care as defined in the Definitions Section of this GFA (see Appendix A).

The statute further requires that evaluations of systems of care carried out under the program include longitudinal studies of the outcomes of services provided by such systems. These evaluations are conducted by awardees in collaboration with a CMHS contractor to assess the effectiveness of systems of care.

In brief, the primary goals of the program are to:

1. Develop systems of care for children with serious emotional disturbance and their families.
2. Provide a broad array of mental health and other related services treatments and supports to the target population.
3. Evaluate the effectiveness of the system of care and its component services.
4. Involve families in the development of the system and the services, and in the care of their own children.
5. Use cultural competence approaches for serving children and their families from minority racial and ethnic populations in the community.

For a background and history of systems of care which was influential in the creation of the Comprehensive Community Mental Health Services for Children and Their Families Program, please see Appendix C.

Program Requirements

Appendix B: Program Requirements for System of Care Development contains the requirements of the Center for Mental Health Services for developing a system of care through this cooperative agreement. These requirements include those mandated in Section 561-565 of the Public Health Service Act, as amended.

The applicant must have a thorough

understanding of these requirements before writing the Project Narrative of this application. The Project Narrative instructions refer directly to the requirements and guidance in Appendix B. Successful applications will be those which best address the requirements and guidance in Appendix B.

Use of Funds

Allowable Items of Expenditure

Cooperative agreement funds may be used for the costs of planning, implementing, and evaluating the project. These costs include:

1) Salaries, wages, and fringe benefits of the project director and other support staff who are engaged in project activities. (Support from the cooperative agreement for salaries and wages of staff who are engaged less than full-time in activities supported by the cooperative agreement, must be commensurate with the effort provided under the cooperative agreement);

2) Travel directly related to carrying out activities under the approved project;

3) Office supplies and equipment, and rental of space directly related to approved project activities;

4) Contracts for performance of project activities such as implementation of required mental health services, interagency coordination, evaluation, and communications.

5) Training activities as specified in the Program Requirements section of this GFA.

6) Other approved activities necessary to support the development of the project, so long as they are allowable under applicable cost principles.

Funds cannot be used for:
Non-mental health services including medical services, education services, vocational counseling and rehabilitation, and protection and advocacy.

The purchase, renovation or construction of facilities to house any portion of the proposed project. Any lease arrangements associated with the proposed project that utilizes PHS funds may not be funded by PHS beyond the project period nor may the portion of the space leased with PHS funds be used for purposes not supported by the cooperative agreement.

Room and board in any residential setting (including therapeutic foster homes or group homes) serving 10 or more children.

Room and board or other services or expenditures associated with care of children in residential breakout centers serving more than 10 children or in inpatient hospital settings, except intensive home-based services and other services provided on an ambulatory or outpatient basis.

Any training activity with the exception of those mentioned above.

Limitation on Imposition of Fees for Services

If a charge is imposed for the provision of services funded under the cooperative agreement, such charge:

- Will be made according to a schedule of charges that is made available to the public;

- Will be adjusted to account for the income level of the family of the child involved; and

- Will not be imposed on any child whose family has income and resources equal to or less than 100 percent of the official poverty line as established by the Director of the Office of Management and Budget and revised by the Secretary in accordance with Section 673 (2) of the Omnibus Budget Reconciliation Act of 1981.

Administrative Costs

Section 564 (e) of the Public Health Service Act, states that not more than 2 percent of each cooperative agreement is to be used for administrative expenses incurred by the awardee.

Other Costs

Applicants are required to budget for attendance of a core team of approximately ten (10) individuals at three 3-day meetings per year, one in the Washington, D.C. area and two elsewhere in the Nation, to create a learning community among all awardees. The learning community will be used to: (1) provide the most recent information about best practices, policy trends, and research findings on systems of care; (2) provide innovative training, technical assistance, and educational experiences that will directly contribute to developing and sustaining systems of care; (3) discuss improvements in system-of-care practice based on the most recent national evaluation findings; and (4) assist with the development of strategic plans for the national program and for each funded community.

The core team must include the project director, evaluator, key family contact, clinical director, youth coordinator, technical assistance coordinator, communications manager, representatives from at least two other child-serving systems in the community, and the State contact for the project.

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.

G ***1. FACE PAGE***

Use Standard Form 424. See Appendix A in Part II for instructions. In signing the face page of the application, you are agreeing that the information is accurate and complete. Be sure to sign the application.

G ***2. ABSTRACT***

Your total abstract may not be longer than 35 lines. In the first 5 lines or less of your abstract, state the main goal of your project. This statement will be used in publications, reports to Congress, press releases, and other such dissemination products, if the 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***

Standard Form 424A. Fill out sections B, C, and E of the Standard Form 424A. Follow instructions in Appendix B of Part II.

‘ ***5. PROJECT NARRATIVE AND SUPPORT DOCUMENTATION***

These sections describe your project. The Project Narrative is made up of Sections A through D. More detailed information of A-D follows #10 of this checklist. The total number of pages for Sections A-D may not exceed 35.

G **Section A -** Understanding of the Project

G **Section B -** Implementation Plan

G **Section C -** Project Management and Staffing Plan

G **Section D -** Evaluation Plan

The support documentation for your application is made up of sections E through H.

There are no page limits for the following sections, except for Section G, the Biographical Sketches and Job Descriptions.

G **Section E-** References to Literature Citations
This section must contain a complete list of references for literature citations. Each reference should include at least the title, author(s), and date of publication.

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

NOTE: Although the budget for the proposed project is not included in a review criterion, the Review Group will be asked to comment on the adequacy, appropriateness, and reasonableness of the budget for implementing the project. These comments will be requested after the merits of the application have been considered.

G **Section G-** Biographical Sketches and Job Descriptions

-- Include a biographical sketch for the project director and for other key positions. Each sketch should not be 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 should not be longer than **1 page**.

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

G **Section H-** Confidentiality and SAMHSA Participant Protection (SPP)

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

‘ ***6. APPENDICES 1 THROUGH 6***

--Use only the appendices listed below.
--**Don’t** use appendices to extend or replace any of the sections of the Project Narrative (reviewers will not consider them if you do).
--**Don’t** use more than **30 pages** for the appendices. Any data collection instruments should be included within these pages.

Appendix 1: Memoranda of Understanding for Services Coordination and Evaluation

Appendix 2: Health Coverage Modifications Plans/Governor’s

Assurance

Appendix 3: Data Collection Procedures

Appendix 4: Sample Consent Forms

Appendix 5: Non-Federal Match Certification

Appendix 6: Organizational Chart, Staffing Pattern, Timeline, and Management Chart

‘ ***7. ASSURANCES***

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

‘ ***8. CERTIFICATIONS***

‘ ***9. DISCLOSURE OF LOBBYING ACTIVITIES***

Please see Part II for lobbying prohibitions.

‘ ***10. CHECKLIST***

See Appendix C in Part II for instructions.

Project Narrative/ Review Criteria – Sections A Through D Highlighted

The application consists of responses to sections A through H. **Sections A through D, the Project Narrative part of your application, describe what you intend to do with your project.** Below you will find detailed information on how to respond to sections A through D.

- T A peer review committee will assign a total score to your application based on how well you address these sections.

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

- T Reviewers will also be looking for plans to address cultural competence. Points will be awarded to applications that adequately address the cultural aspects of the review criterion.

To assure that sufficient information is included for technical merit review, the application should develop complete and concise responses to each of the following sections. The total number of pages for Sections A to D should not exceed 35.

Section A: Understanding of the Project

(15 Points)

This section should demonstrate an understanding of systems of care, and especially the need and significance of developing systems of care in the proposed geographic area.

< Provide a brief literature review which demonstrates:

  - C knowledge of the history of systems of care for children with serious emotional disturbance in the United States; and,
  - C need for system-of-care reform in this

country, and specifically, in the targeted community.

(List in Section E references for literature citations.)

- Describe the population of children with serious emotional disturbance in the geographic area which will be targeted by the project. Include in this description:
  - projected age range (e.g., birth to 21 years of age, 5 to 17 years of age);
  - prevalence estimate (in numbers) of children with serious emotional disturbance within the geographic boundaries of the project;
  - racial and ethnic composition of the children and their families;
  - other demographic characteristics such as gender, family income levels, level of disability, literacy levels;
  - institutional and family settings in which these children are currently located (e.g., special education programs, foster care, probation), and which will be potential sources of referrals. Include expected number of referrals from each source;
  - primary language, level of acculturation, migration and immigration characteristics, and mental health and service disparities (e.g. out-of-home or out-of-state placement rates, representation in juvenile justice facilities, restrictive mental health treatment settings, barriers in access to services, and quality of care) of children from racial or ethnic minority groups.

- Describe the current capacity to serve children with serious emotional disturbance and their families. Specifically, describe the existing resources and services available within the jurisdiction of the proposed project. If possible, try to estimate the number of children currently served.

- Establish the significance of the proposed project by identifying the gaps, inadequacies, and barriers in current service structures that justify the need for the proposed project.

- Describe how the proposed project will also benefit from other State and local reform initiatives.

- Discuss how the proposed project will help to achieve the goals of the cooperative agreement program.

Section B: Implementation Plan
(45 Points)

Use Appendix A: Program Requirements for System of Care Development as a guide for developing the implementation plan required in this section. Specifically,

- Describe how you will develop the system of care.
  - Include the approach for developing the procedures of systems integration, interagency collaboration, services integration, wraparound process, case review, access, fiscal sustainability, and community leader support.
  - Also include the approach and strategies for developing the structures of infrastructure, governance body, administrative team, office in the community, and management information system.

- Explain how the services provision components of the system of care will be developed in your project. Include how the

following services will be implemented throughout the six-year period:

- required mental health services and supports;
- optional services; and
- non-mental health services.

< Describe the strategies to implement key activities for providing services including:

- clinical interventions;
- case management services; and,
- individualized service plans.

< Explain how family involvement, youth involvement, and cultural competence will be applied throughout the six-year period.

< Describe the strategies to support the development of the system of care including training and technical assistance, and social marketing. *(Do not describe evaluation activities in this section, but please do so in Section D.)*

< Explain how the project will increase the capacity and quality of services delivered to children with serious emotional disturbance. State the number of children expected to be served annually by the system of care, and the number of children to be served through some key services such as case management, intensive home-based services, day treatment, therapeutic foster care, respite care, among others.

< Specify eligibility criteria, referral sources and enrollment procedures to be developed for creating efficient access into sytem-of-care services.

< Describe how the following individuals have participated in the development of the implementation plan contained in this application:

- representatives of State and local child-serving agencies and community leaders;
- family members and representatives of family-run organizations;
- representatives of racial or ethnic minority groups in the community. Such racial or ethnic representatives may be youth from the target population, family members, service providers, or community leaders.

< Discuss the extent to which non-federal match dollars demonstrate interagency collaboration through contributions from child-serving agencies.

< Discuss strategies for ensuring project sustainability after the sixth year of the cooperative agreement through amounts and sources of match requirements.

Section C: Project Management and Staffing Plan
(25 Points)

The management and staffing plan should be clearly explained in this section. Please include the following in the plan:

< A brief description of the applicant organization and its relationship and experience with other relevant child and family serving organizations. Please include an organizational chart in Appendix 6. Memoranda of understanding with any collaborating institutions or subcontractors must be provided in Appendix 1.

< The qualifications and experience of key personnel including:

- principal investigator
- project director

- clinical director
- key evaluation staff
- key family contact
- youth coordinator
- technical assistance coordinator
- communications manager
- State and local agency liaison
- key consultants.

See Appendix F for a description of several of these key staff persons.

- The percentage of time that each person will dedicate to the project. Provide a rationale for the time dedicated by each person. Include a chart for the staffing pattern in Appendix 6.

- A description of the tasks to be performed and the relationship of the tasks to each other and to the project objectives. The staff position responsible for each task should be identified. Include a management chart in Appendix 6.

- A timeline of activities and tasks which will be implemented throughout the six-year federal funding period. Discuss the feasibility of accomplishing the proposed order of activities and tasks in the timeline. Please include the timeline in Appendix 6.

(The charts for the above management plan and activities timeline can be incorporated into one chart, and included in Appendix 6.)

- A description of the facilities, equipment and resources (e.g., office space, computer and computer networks) available to the project.

- Evidence that the services are provided in a location that is accessible, compliant with ADA, and culturally appropriate for the children and their families which will be served.

Section D: Evaluation Plan
(15 Points)

Use the description of evaluation activities in the Program Requirements section to prepare the evaluation plan. The evaluation plan should:

- describe the evaluation activities and procedures that will assure successful implementation of the national evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program.

- describe how data derived from the national evaluation will be used for
  - improving the service system,
  - increasing the quality of service delivery,
  - developing system of care policies in the local community, and
  - sustaining the system of care beyond the six-year period of federal funding.

- describe the knowledge and experience of individuals with evaluation expertise who are available in universities or in the community, and especially how you intend to obtain and use the expertise of these individuals for implementation of evaluation activities. Specify the degree to which these individuals have specialized knowledge and experience about:
  - applied research and evaluation methods, especially longitudinal study techniques, as well as family and community study approaches;
  - children's mental health services;
  - directing and supervising research and

evaluation projects;

- writing and reporting of research and evaluation findings for peer-reviewed journals but also for multiple public audiences including family members, policymakers, administrators and clinicians.

- describe the facilities, equipment, materials, and resources that will be dedicated to evaluation activities. Include a description of the data management, spreadsheet, and statistical software available to the project.

- describe how the project will perform the functions of data entry, data storage, data management, data analysis, and data reporting. Especially indicate how completed surveys and records will be kept in a secure and confidential location.

- provide a detailed description of the type of data currently available in management information systems (MIS), as well as the child-serving agencies which have these MIS. Also, assess the feasibility of creating one integrated MIS among the collaborating child-serving agencies;

- explain how family members and youth will be incorporated into evaluation activities including, but not limited to, providing feedback on the design and objectives of the evaluation, conducting interviews, analyzing data, interpreting results, among other evaluation tasks.

- describe the purpose, nature and feasibility of any local evaluation efforts which will be added to the required efforts for implementing the national evaluation.

- indicate the institution which will be approving an Institutional Review Board (IRB) application for protection of human subjects after the award is made, and relating to data collected through the evaluation.

Confidentiality and SAMHSA Participant Protection (SPP)

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

(Please refer to the required procedures for the national evaluation described in the Program Requirements section of this GFA for responding to this section. Also, refer to additional procedures included in any local evaluation efforts of your project.)

This information will:

- reveal if the protection of participants is adequate or if more protection is needed.
- be considered when making funding decisions.

Some projects may expose people to risks in many different ways. In Section H 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 issues must be discussed:

1. 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 which 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, if needed in the project.

2. Data Collection:

- Identify from whom you will collect data.

- Provide in Appendix No. 3, "Data Collection Procedures," a description of strategies for obtaining data.

3. Privacy and Confidentiality:

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

- Describe:
  -How data will be obtained.
  - Where data will be stored.
  - Who will or will not have access to information.
  - How the identity of participants will be kept private. For example on data records, limiting access to records, or storing identifiers separately from data.

4. 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, 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, you should get 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.

5. Risk/Benefit Discussion:

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

Appendix A

Definitions Section

Community-

For the purpose of this program, community is any discrete geographic entity that is defined by the applicant. The scope and size of the community is left to State or local discretion. States, and non-State applicants, may choose to create systems in communities as small as a single school district or an area comprising a county or a group of contiguous counties. A State with a sparse population may wish to develop a system to cover the entire State but it is expected that this will be the exception. The amount of funds requested through the cooperative agreement should be proportional to the number of children in the community, and applicants should ensure that sufficient funds are requested and available to develop a comprehensive system of care with sufficient service capacity in the designated target community.

System of Care-

For the purpose of this program, system of care is defined as a comprehensive spectrum of mental health and other support services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with serious emotional disturbances and their families. The creation of such systems of care involves a multi-agency, public/private approach to delivering services, an array of service options, and flexibility to meet the full range of needs of children, adolescents and their families. Mechanisms for managing, coordinating, and funding services are necessary.

The system of care concept developed through the federal Child and Adolescent Service System Program (CASSP) in the 1980's is based upon the core values that the system of care should be child-centered and family-focused and that it should be community-based. In addition, the following set of guiding principles, articulated in the CASSP monograph, ***A System of Care for Children and Youth with Severe Emotional Disturbance***, by Stroul and Friedman (1986, 1994), represent a clear philosophy about the way in which services should be delivered to youngsters and their families. Children and adolescents with serious emotional disturbances and their families should:

- Have access to a comprehensive array of services that address the child's physical, emotional, social, and educational needs.

- Receive individualized services in accordance with the unique needs and potential of each child and guided by an individualized service plan.

- Receive services within the least restrictive, most normative environment that is clinically

appropriate.

- Receive services that are integrated, with linkages between child-caring agencies and programs and mechanisms for planning, developing and coordinating services.

- Be provided case management or similar mechanism to ensure that multiple services are delivered in a coordinated and therapeutic manner ands that they can move through the system of services in accordance with their changing needs.

- Be able to participate in family/professional partnerships in all aspects of the planning, implementing, managing delivery, and evaluation of the service delivery system responsible for serving their children.

- Have early identification and intervention by the system of care in order to enhance the likelihood of positive outcomes.

- Be assured a smooth transition to the adult service system as they reach maturity.

- Have their rights protected and effective advocacy efforts promoted.

- Receive culturally competent/appropriate services which are sensitive and responsive to cultural and gender differences and special needs and are provided without regard to race, religion, national origin, sex, physical disability, sexual orientation, or other characteristics.

The system of care concept is also built on the recognition that children and adolescents and their families have multiple needs that cross traditional agency boundaries and that coordination among child- and family-serving agencies is essential both at the system and client levels. The services that comprise the system of care include an array of non-residential and residential services which go well beyond the outpatient, inpatient, and residential treatment center services traditionally provided by many communities. Since residential services have proven to be costly and of questionable effectiveness in integrating youth back into their families and communities, the system of care required by this program includes a range of community-based service options including home-based services, therapeutic foster care, and individualized services. Thus, the system of care concept upon which this program is based calls for an organized service support system that emphasizes comprehensive and individualized, culturally competent/appropriate services provided in the least restrictive environment, full involvement of families, interagency collaboration at the system level, and care coordination at the client level. This organized system of care should be the template for any managed care initiative(s) that may be occurring in a State or political subdivision.

Family Involvement -

Family involvement refers to the identification, outreach to, and engagement of diverse families (an

inclusive term to describe families of various races, ethnicities, gender orientations, socio-economic backgrounds, and family structures) receiving services from the proposed system-of-care community and of the target population (as defined in the GFA) so that their experiences and perspectives collectively drive the planning, implementation and evaluation of the system of care.

Family-Run Organization -

A family run organization is a private, nonprofit entity that meets these criteria:
(1) its explicit purpose is to serve families who have a child, youth or adolescent with a serious emotional disorder (children, youth and adolescents who have an emotional behavioral or mental disorder, age 0-18, or age 21, if served by an Individual Education Plan (IEP).
(2) it is governed by a board of directors comprised of a majority (at least 51%) of individuals who are family members
(3) it gives preference to family members in hiring practices
(4) it is incorporated as a private nonprofit entity

Family Member -

A family member is an individual who is a **primary** care giver for a child, youth or adolescent with a serious emotional disturbance (an emotional, behavioral or mental disorder). The primary care giver may be provided a significant level
of support by extended family members. Families who have children, youth, and adolescents with serious emotional disturbance are organized in a wide variety of configurations regardless of social or economic status. Families can include biological parents and their partners, adoptive parents and their partners, foster parents and their partners, grandparents and their partners, siblings and their partners, kinship caregiver, friends, and others as defined by the family.

Appendix B

Program Requirements for System of Care Development

The Comprehensive Community Mental Health Services for Children and Their Families Program provides funds for system development and services provision for children with serious emotional disturbance and their families. This section describes the requirements and the approach for (1) system development and (2) services provision.

In addition, it outlines requirements for implementing (3) key activities of services provision including the delivery of clinical interventions, delivery of case management services, and development of an individualized service plan. Furthermore, this section provides details about the critical (4) system-of-care activities of family involvement, youth involvement, and cultural competence.

System-of-care development efforts are difficult to implement without the (5) support activities of evaluation, technical assistance, and social marketing. This section also describes the requirements for participation in these support activities. At the end of this section, awardees will find a (6) schedule which explains the requirements for developing the system of care in phases throughout the six-year period.

1. System Development

System development refers to the administrative procedures and structures that awardees must implement on a phased schedule throughout the six-year federal funding period to increase the capacity of a community-based system of care to provide a broad array of services for children with serious emotional disturbance and their families.

Some key administrative procedures that awardees must develop include:

- ***Systems integration*** which is viewed as the organization and coordination of institutional resources available through federal, State and local human service systems responsible for serving children with serious emotional disturbance and their families. Strategic planning, consolidation of funding streams, and policy formation are used as tools for these integration efforts. These efforts should result in the creation of a well-organized system of care entity, which is the main goal of the CMHS program, but additionally, they may lead to the creation of an integrated public health and welfare service authority, a managed care organization, a commission of children and their families as consumers, a youth and family support organization, among other such system-wide entities.

- ***Interagency collaboration*** defined as formal arrangements that child-serving agencies make

among themselves to enable provision of the broad array of services. ***Child-serving agencies*** include those that deliver services in the areas of mental health, education, child welfare, child protection, juvenile courts, juvenile corrections, primary health care, and specialty services such as substance abuse treatment and prevention, vocational counseling and rehabilitation. They must be located in the community, or have the capacity and authority to provide services in the community. Formal arrangements must be clearly stated in memoranda of agreement, policy manuals, board minutes, or other documents shared among the agencies. They should specify the role that each agency plays in the system of care. At a minimum, they specify each agency's financial or in-kind contribution, official representation in the governance structure, participation in strategic planning, and participation in service delivery tasks. They should also specify whether the agency is a local or a State entity, and any special requirements that must be met for participation of the local or State agency. A staff person should be designated to implement the above arrangements.

< ***Services integration*** which refers to the efforts of a case manager, together with an individualized care team, to organize and coordinate multiple services, and to arrange for their efficient and effective delivery to a child with serious emotional disturbance and the child's family. An individualized service plan is a tool that the case manager and individualized care team that includes the primary family caregiver, use for services integration. One goal of services integration is to eliminate and avoid duplication of efforts, especially when services are delivered through collaborating child-serving agencies. But more importantly, the goal is for the child and the child's family to have a unified, efficient, and supportive service experience.

< ***Wraparound process*** defined as activities that help organize the delivery of a set of multiple services, treatments and supports to a child and the child's family. This set of multiple services, treatments and supports is aimed at meeting the unique needs of the child and the child's family. Some of the services may be delivered through formal agency procedures, but others may be delivered through informal arrangements in the community. One of the formal activities which is often associated with the wraparound process is use of flexible funds. ***Flexible funds*** refers to service monies that can be used for many non-reimbursable service items to meet non-traditional needs. For example, flexible funds may be used to pay for horseback riding lessons for a child with serious emotional disturbance who expresses a strong interest in this recreational activity. In this situation, horseback riding has the potential of having a positive therapeutic effect on the child. Like the individualized service plan, wraparound process is another tool of services integration.

< ***Case review*** which is used by a designated interagency group to examine how well services are being delivered to individual children and to their families. The purpose of such examination is to develop recommendations for improvement of the adequacy, appropriateness, and quality of the services and the procedures for delivery of those services. Special attention should be given to how well each child-serving agency is contributing to meet the individual needs of children. The intent is not to review each case, but rather to select cases that exemplify the variety of needs found among the children and their families, as well as the most frequent service delivery barriers and difficulties encountered. The review group should at least examine the individualized service plan

and other case records, but it may also want to arrange for interviews with the child, key family members, case managers, and other caregivers involved in service delivery. Although the term ***"case"*** is useful for representing an individual child and the package of services for the child and the child's family, it is recommended that the term be used sparingly. Individual children and their families often view the term as impersonal and insensitive, and prefer terms that recognize their individuality and affirm their human dignity.

< ***Access*** which refers to the ease with which eligible children and their families are able to receive services. Children and their families should be provided with clear and comprehensible eligibility criteria. Procedures for determining eligibility and entry into services should be efficient and timely. The location of services should be at distances that make it relatively easy for children and families to reach.

< ***Fiscal sustainability*** which refers to the capacity to obtain the necessary funding to maintain and enhance the system of care beyond the six-year federal funding period. Specifically, it refers to (1) funding for services from collaborating State and community child-serving agencies, (2) access to existing categorical service funds from public and private sources for which children with serious emotional disturbance and their families are eligible, such as Medicaid, Child Health Insurance Program, and private insurance, and (3) other public and private funds to support system-of-care activities and structures, other than services, such as training, research, and equipment. The system of care must be fiscally accountable to each funding source.

< ***Support from community leaders***, defined as the endorsement given by community leaders (e.g., judges, mayors, clergy, business executives, presidents of educational institutions) including leaders from racial and ethnic minority populations, to the goals and activities of the system of care. Such endorsement may be given through public statements, financial contributions, or direct representation in the governing body of the system of care.

The awardee must also implement several administrative structures that are necessary for the development of the system of care. They include:

< ***Infrastructure*** defined as the set of services, treatments and supports that exist and are available within the system of care to serve children with serious emotional disturbance and their families. Each awardee is urged to enhance and develop its infrastructure to the highest level of quality possible. It should aim to to serve as a model of system reform in the State. To achieve this goal, awardee's should avail themselves of training and technical assistance opportunities offered by the Comprehensive Community Mental Health Services for Children and Their Families Program which have the potential to increase the quality of the infrastructure. Awardees should also use findings from the Program's national evaluation to identify gaps and make adjustments in the infrastructure and how it functions. In addition, awardees should implement to the greatest extent possible federal or professional practice standards and guidelines for the delivery of children's mental health services. These standards and guidelines may focus on the delivery of specific clinical interventions,

but they may also address the delivery of system-of-care services such as intensive case management, therapeutic foster care, and home-based crisis intervention. Awardees are strongly encouraged to include in their infrastructure one or more evidence-based services or treatments which have been shown to be effective in research studies.

- ***Governance body*** which refers to a group of individuals with the authority to make policy decisions for the system of care. The group should include representatives of the public entity which was awarded the federal funds, but also representatives of collaborating State or community child-serving agencies, family members, and other community representatives, including representatives from racial or ethnic minority populations. This governing body may be organized as a board of directors of a newly incorporated system of care, or as a committee, task force, workgroup or other such decisionmaking body of an existing human service agency. This body will also develop and uphold formal agreements and memoranda of understanding between the collaborating child-serving agencies, including those from the State and from other relevant political subdivisions of the State. It will also hold the system of care accountable for meeting high standards of care including standards for cultural competence and family involvement, as well as standards of practice that have been shown to be effective through research and evaluation studies. The governance body must see that cooperative agreement funds are expended appropriately within the community. It should be aware of relevant reform efforts in the State, and incorporate each into the system of care as required, or as appropriate. It must monitor regularly the clinical and functional outcomes of children to insure that services are making a positive contribution to the well-being of the children and their families.

- ***Administrative team*** which represents the group of individuals responsible to manage, implement, and develop the system of care. This team is specifically responsible to:
  - coordinate services delivered through the collaborating child-serving agencies;
  - develop a strategic plan;
  - budget, manage, and expend service funds on required services;
  - integrate funding streams, as appropriate;
  - award and manage contracts for service delivery, training, technical assistance, evaluation, and communications, as appropriate;
  - use findings from the national evaluation and from any local evaluation to shape future program direction, decisions about practices and policies that work, and the development of a managed care approach, as appropriate.
  - implement case review procedures;
  - monitor the extent and quality of implementation of individualized service plans,
  - examine the extent to which living and service placements for children are made in the least restrictive, most normative, and most safe environments that are clinically appropriate;
  - monitor the degree to which case management and other services enhance the strengths, resilience, and well-being of the child and the child's family;
  - comply with rules and regulations for electronic exchange of information and for confidentiality of case records as required by the Health Insurance Portability and Accountability Act (HIPAA);

- ***Office in the community*** defined as a facility located within the geographic bounds of the system of care, and from which service delivery is managed and coordinated.

- ***Management information system*** (MIS) that refers to a computerized system for the electronic storage, management, and exchange of information within the system of care. At a minimum, this system should be used to record the type, amount and costs of services delivered to each child in the system of care. These services should include those reimbursed by Medicaid, but also those covered by cooperative agreement funds and by any other State or private funding streams. There should be a close correspondence between the services delivered as part of the individualized care plan and the services recorded on the MIS. As much as possible, the MIS should be integrated across the collaborating child-serving agencies and be used as a tool for the coordination of service delivery. In addition, the MIS should have the capacity to integrate child and family outcome data from the national evaluation.

2. Services Provision

Certain mental health and support services are required and must be provided by awardees. Other services, including training and continuing education, are optional. Some non-mental health services need to be included in the individualized service plan, even though funds from the cooperative agreement cannot be used to purchase them.

Required Mental Health and Support Services. The system of care developed by the local public entity must establish a full array of mental health and support services in order to meet the clinical and functional needs of the target population. This array must consist of, but is not limited to, the following:

- Diagnostic and evaluation services;

- Case management;

- Individualized service plan;

- Outpatient services provided in a clinic, office, school or other appropriate location, including individual, group and family counseling services, professional consultation, and review and management of medication,

- Emergency services, available 24 hours a day, 7 days a week, including crisis outreach and crisis intervention,

- Intensive home-based services for children and their families when the child is at imminent risk of out-of-home placement or upon return from out-of-home placement,

- Intensive day treatment services,

- Respite care,

- Therapeutic foster care;

- Therapeutic group home services caring for not more than 10 children (i.e. services in therapeutic foster family homes or individual therapeutic residential homes) and,

- Assistance in making the transition from the services received as a child to the services received as an adult.

The required services listed above should be integrated, when appropriate, with established alternative healing practices of racial or ethnic minority groups represented in the community, especially if there are indications that such integration will held reduce racial or ethnic disparities in mental health care.

Section 562(g) of the Public Health Service Act allows for a waiver of one or more of the above services requirements for applicants who are an Indian Tribe or tribal organization, or American Samoa, Guam, the Marshall Islands, the Federated States of Micronesia, the Commonwealth of the Northern Mariana Islands, the Republic of Palau, or the United States Virgin Islands if CMHS staff determine, after peer review, that the system of care indis family-focused, culturally competent, and uses the least restrictive environment that is clinically appropriate.

Optional Services. In addition to the mental health services described above, the system of care may provide the following optional services:

- Screening assessments to determine whether or not a child is eligible for system-of-care services;

- Training in the following areas:

    - Implementation of individualized service plans, and management of individualized care teams;

    - Provision of intensive case management, intensive home-based services, intensive day treatment, therapeutic foster care or therapeutic group homes caring for not more than 10 children, clinical practices, emergency services, crisis outreach, crisis intervention, respite care;

    - Administration of the system in areas such as managed care, strategic planning, interagency coordination, fiscal management, management information systems, personnel management, and project management, as long as such training is directed toward reinforcing system-of-care practices and not the practices of a conventional service system;

- Implementation of evidence-based clinical interventions which are defined as interventions that have been scientifically shown to be effective;

- Development and implementation of practices and interventions that are appropriate for specific racial or ethnic groups, and have the potential to eliminate disparities in mental health care.

- Recreational activities, and;

- Other mental health services determined by the individualized care team to be necessary, appropriate, and meet a critical need of the child or the child's family related to the child's serious emotional disturbance.

NOTE: Cooperative agreement funds and matching funds can be used to purchase individualized optional services from appropriate agencies and providers that directly address the mental health needs of children and adolescents in the target population. However, the funding of these services should not take precedence over the funding of the array of required services in this GFA.

Non-Mental Health Services. Funds from this program cannot be used to finance non-mental health services. Nonetheless, non-mental health services play an integral part in the individualized service plan of each child. The system of care must facilitate the provision of such services through coordination, memoranda of understanding and agreement, with relevant agencies and providers. These services should be supplied by the participating agencies in the system of care and include, but not be limited to:

- Educational services;
- Health services;
- Substance abuse treatment and prevention services;
- Vocational counseling and rehabilitation; and,
- Protection and advocacy.

A relatively high percentage of children with serious emotional disturbance are expected to have a co-occurring substance use disorder. In such cases, treatment for the substance use disorder should be included in the individualized service plan. For those children with a serious emotional disturbance who are at risk, but have not yet developed, a co-occurring substance use disorder, prevention activities for substance abuse may be included in the individualized service plan.
In addition, the local entity must develop memoranda of understanding with appropriate agencies and providers for delivery of services available under Federal entitlements including:

- Title XIX,
- Title IV-A,
- Title IV-B and Title IV-E of the Social Security Act,
- Early Periodic Screening, Diagnostic and Treatment Program (EPSDT),

< Individuals with Disabilities Education Act, both Parts B and H, specifically linking an ISP developed under this program with an Individualized Education Plan or efforts developed in compliance with the Family Preservation and Support Act.

These memoranda of understanding are to be included in Appendix No. 1 entitled, Memoranda of Understanding for Services Coordination and Evaluation.

3. Key Activities of Services Provision

The provision of system-of-care services for children with serious emotional disturbance and their families emphasizes (1) delivery of effective clinical interventions, which research has demonstrated to produce positive child outcomes, (2) provision of case management services for each child and the child's family, and (3) development of an individualized service plan for each child and the child's family.

Delivery of Clinical Interventions*.** The system of care must assure that children with serious emotional disturbance have access to the most effective clinical interventions. A ***clinical intervention refers to a service, treatment, or therapy that is used to treat a specific diagnosable emotional, behavioral, or mental disorder, or a combination of co-occurring disorders, and is delivered by trained personnel. The system of care should at least:

< implement one or more evidence-based interventions which have been scientifically studied and have been found to produce positive outcomes in children;

< insure that procedures for diagnostic and treatment planning will match the most appropriate treatment or combination of treatments with the specific mental health needs of the child;

< encourage implementation of state-of-the-art, community-based treatments;

< make necessary adaptations of innovative evidenced-based interventions for the target populations, particularly for racial and ethnic minority populations in the specific communities involved;

< conduct clinical assessments in a manner that recognizes gender and cultural differences in the diagnosis of overt behaviors and the evaluation of presenting problems; and

< address the training needs of clinicians in several areas including delivery of evidenced-based treatments and appropriate application of DSM-IV diagnostic categories.

Delivery of Case Management Services. Case management, or care coordination services, tailored to the needs of individual children are required for all children and adolescents offered access to the system of care under this program. ***Case management*** represents the procedures that a trained

service provider uses to access and coordinate services for a child with a serious emotional disturbance, and the child's family.

The system of care will provide each child in the target population an appropriate level of case management. Case management services should at least:

< Unify services provided to the child and the child's family including those specified in the individualized service plan, and any other service.

< Establish eligibility of the child and the child's family for any financial assistance and services under Federal, State and local programs, and document that such services and supports are received;

< Reassess the needs of the child and the child's family at regularly established intervals and modify the individualized service plan accordingly; and,

< Provide to the family information on the extent of progress made toward the objectives in the individualized service plan.

Development of an Individualized Service Plan

Each child or adolescent served within the system of care funded under this program must have an individualized service plan developed by an interagency team which includes the child's parents and, unless clinically inappropriate, the child. The ***individualized service plan*** refers to the procedures and activities that are appropriately scheduled and used to deliver services, treatments, and supports to a child and the child's family. These procedures and activities must fit the unique needs of the child and the child's family. The group which assists the case manager, family member, and child to implement the individualized service plan is the ***individualized care team***. This team consists of representatives from child-serving agencies that provide services to the child and the family, as well as other significant individuals in the community who relate closely to the child and family, such as a minister, friend, or community leader.

Development of the individualized service plan must include:

< An emphasis on building upon the existing strengths of the child and the child's family;

< Coordination with services available under parts B and H of the Individuals with Disabilities Education Act (IDEA), including consistency and coordination with the Individualized Education Plan (IEP).

< Coordination with services available through the U.S. Department of Health and Human Services, Administration for Children and Families' Family Preservation and Support Program (Title IV-B,

Subpart 2, Social Security Act.)

< Inclusion and implementation of the following components of the plan:

a. Description of the need for services;

b. Recognition of existing strengths of the child and the child's family;

c. Development of objectives that meet the needs of the child and the child's family and which build upon the existing strengths of the child and the child's family;

d. Development of a methodology for meeting these objectives;

e. Provision of the services as appropriate, including vocational counseling and rehabilitation services and transition services offered under IDEA, for those children 14 years or older who require them; and

f. Designation of lead agency responsible for case management services.

< Review of the appropriateness of services in the individualized service plan, and revise when necessary, or at least quarterly.

4. Activities of Family Involvement, Youth Involvement and Cultural Competence

Family involvement, youth involvement and cultural competence represent other key activities that must be implemented in a system of care. ***Family involvement*** refers to the active participation of family members in decisions about the care of their child with a serious emotional disturbance, but also in decisions about system-of-care development and services provision for other children and their families. ***Youth involvement*** is viewed as the active participation of youth in decisions about the care they receive, as well as decisions about system-of-care development and services provision to other youth. ***Cultural competence*** is defined as the attitudes of individual service providers toward children with a serious emotional disturbance and their families who are from racial or ethnic minority groups in the community. These attitudes must contribute to the well-being of the target children and their families. It also refers to the policies and practices of the system of care that have a positive effect on the well-being of these children and their families.

Racial or ethnic minority groups refers in this GFA to the four racial or ethnic groups which have been found to be nationally underserved in the area of healthcare, including the African American, Hispanic, American Indian and Alaskan Native, and Asian American and Pacific Islander groups. It also includes underserved immigrant and refugee groups who have recently arrived in the United States from other countries of the world.

Family Involvement. The system of care must develop and incorporate practices of family involvement that include:

< Family member participation in planning, implementing and evaluating the project;

< Creation of a local parent support organization, or complement an established initiative (such as a CMHS-funded Statewide Family Network grantee), where there is no existing family-run organization in the target community;

< Designation of a full-time equivalent position for a family member to serve as key family contact for the system of care. At a minimum, the responsibilities of the ***key family contact*** should include advocacy for other family members of children receiving services; outreach to family members of children not receiving services; and, serving as one of the family member representatives on the governance body.

< Financial support to sustain family involvement in the system of care beyond the federal funding period.

< Creation of a strong partnership between professionals and family members which enables family members to participate in the planning, management, and evaluation of the system of care.

< Compensating and fiscally supporting families whose children are eligible for services, as well as the existing family organizations whose focus is on these children and families. The aim of such support is to enable family members and family organizations to participate in activities related to the development, implementation and evaluation of the system of care. The support should also be for families and family organizations from racial or ethnic minority backgrounds in the community.

Youth Involvement. Activities to support youth involvement should include:

< Designation of an individual who will serve as youth coordinator in the system of care. Duties of the ***youth coordinator*** should at least include helping to form an organized group among youth receiving services; advocating for youth who are receiving services; reaching out to eligible youth who are not receiving services; and, representing youth on the governance body.

Cultural Competence. The following activities are designed to enhance the cultural competence of the system of care:

< Compliance with Title VI of the Civil Rights Act.

< Reaching cultural competence standards as suggested in documents such as the Culturally and

Linguistically Appropriate Standards (CLAS) in Health Care, and those included in CMHS' **Cultural Competence Standards** publication.

< Recommending the incorporation of culturally appropriate practices in the individualized service plan such as using the preferred language of the child and the child's family during service delivery; nurturing the strengths and customs of the child and the child's family that are part of their cultural or religious heritage; and, recognizing behaviors and beliefs of the child and the child's family that are normal in their culture, but perceived as different in the community at-large.

< Inviting individuals from racial or ethnic minority groups in the community to participate in activities of such system-of-care entities as the governing body, administrative team, case review group, and individualized care team. These individuals should be able to serve as advocates for children and families from these cultural groups.

< Providing evidence that the management plan, staffing pattern, project organization, and resources are appropriate and adequate for carrying out all aspects of the proposed project, and are sensitive to issues of language, age, gender, sexual orientation and race, ethnicity, and culture.

< Expanding the services available through the system of care to include service providers representing the racial and ethnic composition of the community.

< Addressing disparities in access to care, quality of mental health services, availability of effective clinical interventions, satisfaction with services, and other system-of-care outcomes, for children and their families from racial or ethnic minority groups.

< Planning for service provision (1) in the cultural context preferred by the child and the child's family, (2) without discrimination against the child or the child's family on the basis of race, religion, national origin, sex, disability or age (i.e., for the child, within the age range of 21 years or younger).

Please also refer to the SAMHSA documents, Elements of Cultural Competence in Appendix D and Limited English Proficiency Assistance in Appendix E.

5. Activities that Support System-of-Care Development

The Comprehensive Community Mental Health Services for Children and Their Families Program provides evaluation, technical assistance and communications support to awardees to assist them with their efforts to develop systems of care.

Evaluation. Section 565(c) of the Public Health Service Act requires that evaluations be conducted to assess the effectiveness of systems of care. Specifically, these evaluations must include:

- longitudinal studies of outcomes of services provided through systems of care;
- other studies regarding service outcomes;
- studies on the effect of systems of care on the utilization of hospital and other institutional settings;
- studies on the barriers and achievements that result from interagency collaboration; and,
- studies on parental perceptions of the effectiveness of systems of care.

The Comprehensive Community Mental Health Services for Children and Their Families Program will award a contract to a private entity to develop a cross-site program evaluation which will be used to comply with the requirements described above. This cross-site evaluation is referred to in this GFA as ***the national evaluation***. It applies multiple methods for conducting the evaluation, and it is designed to maximize the usefulness of the results for developing systems of care among awardees. It is also designed to create long-term capacity among the awardee communities to evaluate themselves, especially after federal funding ceases. Awardees are required to participate in the implementation of the national evaluation.

During the first year of the cooperative agreement, each awardee will receive detailed instructions about the design of the evaluation, and the procedures for implementing each component of the evaluation. For example, one component requires implementation of a longitudinal outcome study that includes the enrollment and follow-up of approximately 100 children per service year, with a total representative sample of about 300-400 children over the 6-year federal funding period. At the time of enrollment, a baseline assessment of the child and the child's family will be administered. Follow-up assessments will occur at periodic intervals (e.g., every 6 months for up to 3 years) while children are receiving services and after these services have terminated

The national evaluation includes measures on the characteristics and outcomes of children, their families, the system of care, and the services delivered through the system of care. Measures on the characteristics of children and families include, but are not limited to:

- Number of children enrolled and served by the system of care;
- Demographic information on each child and the child's family served by the initiative (e.g., age, sex, race and ethnicity, family composition, family income, family member employment status, family member educational status);
- Diagnostic information --- primary, secondary, tertiary diagnosis, as well as primary presenting problem(s);
- Child and family risk and protective factors;

- Mental health service history;
- Standardized clinical and functional assessments;
- Satisfaction with services;
- Family-professional relationships or alliance;
- Restrictiveness of the service placement and living situation.
- Immigration and migration status and characteristics.
- Level of acculturation of the child and the child's family.

On the other side, measures of the characteristics and outcomes of the system of care and the services delivered through the system include, but are not limited to:

- Estimate of unmet need;
- Access to services;
- Types of services provided to each child and the child's family through the individualized service plan;
- Fiscal information including budget figures, as well as charges and actual expenditure data on services from each collaborating child-serving agency obtained from management information systems;
- Use of third party reimbursements (e.g., private insurance, Medicaid);
- Collaboration and coordination among system components (e.g., child-serving agencies, family organizations, services);
- Adequacy and effectiveness of interagency governance structures;
- Adequacy of participation of youth and family members in service development and planning;
- Capacity of the system of care and its collaborating child-serving agencies to serve children with serious emotional disturbance and their families;
- Availability of mental health providers who are from the racial and ethnic communities represented

in the system of care;

- Availability of culturally competent specialty providers in areas such as clinical interventions and substance abuse services;

- Compliance with limited English proficiency standards and requirements (LEP);

- Integration of individuals from diverse communities into the governance structure of the system of care.

- Capacity of the project to (1) establish a jurisdiction-wide system of care, (2) develop the system of care into a managed care initiative, and (3) provide children and their families with access to case records.

Regular training and technical assistance sessions will be conducted on site, during awardee meetings, and at other scheduled times throughout the six-year federal funding period. Evaluation staff and other system-of-care staff will be asked to participate in these training and technical assistance sessions.

To meet requirements of the national evaluation, awardees will be responsible to:

- adhere closely to the design of the national evaluation.

- implement procedures for collection, entry, management, and storage of data.

- transmit data to the national evaluation contractor on a regular basis.

- report evaluation findings on the local system-of-care to the stakeholders of the system of care including family members, personnel of collaborating child-serving agencies, clinical staff, members of the governing body, among others.

- use evaluation findings to inform system-of-care development efforts including improvement of management procedures, adoption of new system and service policies, attaining new sources of public and private financing, among other efforts.

- involve youth who are receiving services and their family members in the implementation of the national evaluation.

- obtain written assurances from each participating agency indicating a willingness to cooperate with the required activities of the national evaluation. Assurances are to be included in Appendix No.1.

- hire at least <u>two full time equivalent (FTE) evaluation staff</u>. One FTE must have an earned Ph.D. in public health, psychology, social work, or other relevant area of the human services. At least one

of the full-time evaluation staff should have an office located in the awardee community. Evaluation staff must be knowledgeable of and experienced in coordinating and implementing longitudinal data collection activities including tracking of cases, data management, data analysis, basic quantitative and qualitative evaluation methods, and report writing.

< participate in an annual 2 to 3 day site visit conducted by the national evaluation contractor to assess development of the awardee's system(s) of care. Applicants must secure agreement from each collaborating child-serving agency that staff will be available for the visit. (Relevant agreements should be provided in Appendix No. 1).

< obtain approval from an Institutional Review Board (IRB) associated with the system of care to perform the data collection requirements of the national evaluation.

CMHS will obtain OMB clearance to conduct data collection for the national evaluation in compliance with the Paperwork Reduction Act of 1995. Such clearance will be obtained during the first year of the federal funding period. Awardees will not implement the national evaluation until OMB has approved the national evaluation plans.

Each awardee will receive regular evaluation reports from the national evaluator that describe how well the system of care is developing in its own community. Staff in the awardee communities should use this information to improve their systems of care, improve the clinical and functional outcomes of children with serious emotional disturbance, and increase the participation of family caregivers in meeting the needs of their own children and in the system-of-care development activities.

Each awardee is encouraged to also enhance the national evaluation with its own local evaluation activities. These local evaluation activities will help insure that the unique needs for system-of-care development in the awardee's site is being met. Data and findings from local evaluation efforts do not need to be transmitted to the national evaluation contractor, unless arrangements are made for a special study that can be valuable for the development of systems of care across the nation. However, critical findings from local evaluation efforts may be reported in cooperative agreement re-applications and quarterly reports.

Technical Assistance. The program provides awardees training and technical assistance to assist them with the planning, development, and operations of the system of care.

Awardees will be responsible to:

< Develop a technical assistance plan for the system of care.

< Assess continuously the technical assistance needs of the system of care.

- Organize and implement training activities to address developmental needs of the system of care.

- Establish an interagency team to assist with the assessment, planning, and implementation of training and technical assistance activities. The interagency team will also assist with the identification of resources to address training and technical assistance needs of each stakeholder group associated with the system of care.

- Designate at least a half-time equivalent staff person to serve as technical assistance coordinator.

Social Marketing. Awardees will also receive support from a communications contractor of the program to implement social marketing and communications activities.

Awardees will be responsible to:

- Develop a culturally and linguistically competent social marketing plan that includes (1) providing information to the public regarding the system of care and its services; and, (2) educating the public about the needs of children with serious emotional disturbances and their families, and (3) good mental health practices for meeting those needs.

- Designate at least a half-time equivalent position for social marketing- communications manager.

- Provide support to a family organization associated with the system of care to implement outreach strategies with families of children with serious emotional disturbance who are from racial and ethnic minority groups represented in the community.

- Implement a social marketing strategy that determines the informational needs of target audiences, and that develops messages, materials and activities that are in compliance with Title VI of the Civil Rights Act, CLAS standards, and the standards identified in SAMHSA's Cultural Competence Standards.

6. System Development Schedule

Below is a description of the activities that should be scheduled during each phase in the development of the system of care. Please see Table 1 for a summary of these activities.

First Year Activities. The first year of the cooperative agreement will be used to:

- develop a logic model of the system of care which will serve as the basis for developing the strategic plan for the project. The logic model should at least describe the context in which the system of care will be developed, the resources available for the system of care, the activities that will drive system-of-care development, and the individual, services, and system outcomes expected

from the system of care.

- develop a strategic plan for implementation of the system of care throughout the six-year federal funding period. The strategic plan should specify how each of the activities in the Program Requirements section of this GFA will be developed. In addition, the strategic plan should include a technical assistance plan that shows how training and technical assistance activities will be targeted to areas that require further development within the system of care.

- hire key personnel.

- establish the administrative team

- organize the governing body.

- enhance and develop required services through (1) the direct creation of new programs, (2) contracts with existing private non-profit service organizations, (3) coordination and expansion of services delivered by collaborating child-serving agencies, (4) and other such mechanisms.

- develop an approach for service integration and coordination that is appropriate for the target population;

- create the format for the individualized service plan that incorporates a full array of mental health and support services.

- identify resources and activities to address family involvement, youth involvement, and cultural competence in the system of care.

- create the capacity to implement the national evaluation.

Full Implementation - Second through Sixth Year. It is anticipated that the system of care will begin to operate during Year Two of the cooperative agreement. In other words, the system of care should begin to enroll and serve children and their families through its array of services, and should begin to enroll children and their families into the national evaluation.

In Years Three to Six, the system of care will continue to enhance and maintain its capacity to meet the needs of target children and their families. It will also develop plans for sustaining the system of care beyond the six-year federal funding period.

Please see Table A-1 below for a summary of tasks that should be completed during each year of the cooperative agreement.

Table A-1. Summary of Main Tasks for the Six-Year Cooperative Agreement	
Funding Year	**Main Tasks**
First	c develop a logic model for the system of care which will serve as guide for the strategic plan c develop a six-year strategic plan, which expands on the implementation plan described in the application c develop a six-year plan for technical assistance and training activities c hire key personnel c establish the administrative team c organize the governance body c enhance or develop required services c develop the approach for services integration and coordination c create the format for the individualized service plan c implement activities for family involvement, youth involvement and cultural competence c build the capacity to implement the national evaluation
Second	c begin to operate the system of care c begin to enroll and serve children and their families c enroll children and their families into the evaluation

Three to Six	C enhance, and ultimately maintain, the capacity to serve children and their families C develop a strategic plan to sustain the system of care beyond the six-year period of federal assistance, and which expands on the plan included in the application

Appendix C

Background for Systems of Care

Public Law 94-142, The Individuals with Disabilities Education Act, was passed to assure that all children with disabilities have available to them...a free and appropriate public education. Passed at a time when one million children with disabilities were excluded from the public school system, the Act mandated procedures to assure that to the maximum extent appropriate, children with disabilities, including children in public or private institutions or other care facilities, are educated with children who are disabled. The Act has helped many children with disabilities to succeed in local schools and communities. However, children with serious emotional disturbance, identified as the most difficult population of children to serve within the school setting, had no appropriate service system within the school setting, had no appropriate service system within their home and community environment to offer support. As one Director of Special Education lamented, children with a serious emotional disturbance are the least understood, most difficult to serve and so little money exists to serve them well. ***Unclaimed Children***, commissioned by the Children's Defense Fund and authored by Jane Knitzer, Ph.D., in 1982, further documented the plight of children with serious emotional disturbance and their families.

Since 1984, the Federal government has supported the development of more accessible and appropriate service delivery systems for children and adolescents with serious emotional disturbance and their families. One such effort was the Child, Adolescent Service System Program (CASSP). This demonstration program offered grants to States to design a system of care for children and adolescents who are experiencing a serious emotional disturbance and their families. The key principles behind designing these systems were: 1) involvement of the mental health authority for the State, county and/or city; 2) child serving agencies collaborate on behalf of children and adolescents with a serious emotional disturbance and their families; 3) these systems involve families as partners in their planning, implementation and maintenance; 4) systems of care need to be culturally relevant and competent; 5) services need to be individualized for each child and family; 6) child and family assessments need to be strength-based; and 7) systems of care need to have a broad array of services delivered in the home and community.

Appendix D

Cultural Competence Elements

This appendix describes many of the important elements of cultural and linguistic competency. Applicants may refer to it -in addition to the standards and guidelines referred to in this GFA.

Project Description and Need Justification: Knowing the unique characteristics of the community/target population is critical to the success of the proposed project.

Experience, or Track Record of Involvement, with the Target Population – The applicant organization should have a documented history of programmatic involvement with the target population/community to be served by the proposed project. If your organization does not yet have a track record with this target population, your organization should plan to acquire the tools and information needed to become culturally competent (for instance, by establishing collaborations, designing and implementing a cohesive plan, seeking technical assistance, contracting services, staff sharing/co-location, or seeking special training and staff development).

Community Representation – The population/community targeted to receive services should participate actively in all phases of program design. There should be an established mechanism to provide opportunities for community members (including consumers, providers of services and representatives of informal systems of care) to influence and help shape the project's proposed activities and interventions. Such mechanisms may include, but are not limited to, establishment of an advisory council, cultural competence committee and/or board of directors, with written working agreements that ensure their active participation and advisory assistance concerning the course and direction of the proposed project.

Language and Communication – Project-related communications must be appropriate to the target population/community. Consider information that is available about the target group's primary language(s) and literacy levels (for instance, whether a significant percentage of the target population/community is known to be more comfortable with a language other than English). Multi-linguistic resources, which might include the use of skilled bilingual and bicultural individuals when appropriate, can be beneficial. Materials produced in English need to be adapted – not just translated – to meet the needs of non-English speakers. Audio-visual materials, public service announcements (PSAs), training guides and print materials can be used, as well as materials produced as a result of the project, are appropriate for the target population/community in terms of gender, age, culture, language and literacy level.

Staff Qualifications and Training – The staff of the organization should have training activities addressing characteristics of the target population (including race/ethnicity, gender, age, sexual

orientation, disability, and literacy). For purposes of this item, "staff" would include at least administrators, advisors, board members and service providers. Evaluation - There should be a rationale for the use of the evaluation instrument(s) that are chosen, and the rationale should include a discussion of the validity of the instrument (s) in terms of the gender/age/culture of the group(s) targeted. The evaluators should be sensitized to the cultural and familiar with the gender/age/culture whenever possible and practical. Program evaluation methods and instruments should be culturally appropriate to the population/community served.

Efforts should be made to ensure findings are interpreted in a culturally competent and sensitive manner. Describe cultural issues you anticipate may influence outcomes for your target population (including, potentially, the impact of using available instruments that may not be completely appropriate for the specific population).

Appendix E

Limited English Proficiency Assistance

Effective August 30, 2000, the Department of Health and Human Services issued policy guidance to assist health and social services providers in ensuring that persons with limited English skills (LEP) can effectively access critical health and social services. All organizations or individuals that are recipients of Federal financial assistance form DHHS including hospitals, nursing homes, home health agencies, managed care organizations, health and mental health service providers, and human services organizations have an obligation under Title VI of the 1964 Civil Rights Act to:

1. have policies and procedures in place for identifying the language needs of their providers and client population;

2. provide a range of oral language assistance options, appropriate to each facility's circumstances;

3. provide notice to persons with limited English skills of the right to free language assistance;

4. provide staff training and program monitoring; and

5. a plan for providing written materials in languages other than English where a significant number or percentage of the affected population needs services or information in a language other than English to communicate effectively.

Providers receiving DDHS funding including SAMHSA's mental health block grants and discretionary grants must take steps to assure that limited English skills do not restrict access to full use of services.

Appendix F

Key Personnel

Principal Investigator

Serves as the responsible official for the fiscal and administrative oversight of the cooperative agreement and is also responsible and accountable to the funded community for the proper conduct of the cooperative agreement. The awardee is, in turn, legally responsible and accountable to PHS for the performance and financial aspects of activities supported through the cooperative agreement. The Principal Investigator may also be responsible, or designate someone to be responsible, for liaison with state officials and agencies.

Project Director

Responsible for overseeing the development of a comprehensive strategic plan for creating and implementing the proposed system of care; establishing the organizational structure, hiring staff and providing leadership in all facets of the development of the system of care.

Key Family Contact

Typically this position is filled by a parent or other family member of a child or adolescent with a serious emotional disturbance who has received services from the public service system. This position is responsible for either setting up, or working with an existing family-run organization, representative of the cultural and linguistic background of the target population. Responsibilities include, but are not limited to, working in partnership with the awardee staff in all aspects of implementing the system of care and providing support services for families receiving services through the cooperative agreement.

Youth Coordinator

This position, typically filled by a young adult, is responsible for developing activities for bringing the voice of youth who have serious emotional disturbance to staff who are charged with the programming and implementation of the system of care. Responsibilities also include developing programs for young people to assist their involvement in the development of the system of care.

Key Evaluation Staff

These staff will fill at least two full-time positions to direct and coordinate the implementation of the national evaluation sponsored by the Comprehensive Community Mental Health Services for Children and Their Families Program. These individuals will be responsible for developing the procedures for conducting a longitudinal study of children served through the program and their families. They must also purchase and set-up the computer hardware and software required to enter, store, manage, analyze, and transmit data. They must also have the expertise to analyze, interpret, and report results. They are also expected to have the oral skills for presenting papers at key research conferences, and to have the writing skills to publish results in peer-reviewed journals as well as in publications for consumption of multiple public audiences including policymakers, family members, and agency professionals. Furthermore, they should be able to incorporate youth and family members in multiple activities of the evaluation.

Social Marketing-Communications Manager

Responsible for developing a comprehensive social marketing/communications strategy for the awardee community including: a social marketing strategic plan, public education activities and overall outreach efforts. Coordinates activities with the national communications campaign contractor.

Technical Assistance Coordinator

Serves as the central point within the system of care for strategizing and assessing the technical assistance needs of the community, and the primary link with the Technical Assistance Partnership for accessing the appropriate technical assistance. Technical assistance areas may include culturally competent practices and services, leadership, partnership/collaboration, strategic planning, wraparound planning, sustainability, family involvement, youth involvement.

State-Local Liaison

This position will serve as the bridge between the State and the awardee community in the work of creating a single system of care that will be sustained through collaborative and integrated funding investments from State and/or community-based child- and family-serving public agencies. This includes working to establish interagency involvement in the project's structure and process by developing and/or changing interagency agreements and other public policies relevant to the creation of the system of care.

Appendix G

Past and Current Grant Communities of the Comprehensive Community Mental Health Services for Children and Their Families Program

Grantees Funded in 1993-1994			
Project Name	**State**	**Number of Counties Included**	**Names of Counties**
East Baltimore Mental Health Partnership	MD	1	Baltimore City (Baltimore County)
Stark County Community Mental Health Board	OH	1	Stark
The Village Project	SC	2	Charleston, Dorchester
Department of Mental Health and Mental Retardation	VT	13	Franklin, Orleans, Essex, Lamoille, Caledonia, Chittenden, Washington, Addison, Orange, Rutland, Windsor, Bennington, Windham
Five Counties	CA	5	Riverside, San Mateo, Santa Cruz, Solano, Ventura
Family and Children Community Services	KS	1	Sedgewick
Wings Project	ME	4	Piscatquis, Hancock, Penobscot, Washington
Olympia	NM	1	Doña Ana
Pitt-Edgecombe-Nash Public Academic Liaison (PEN-PAL)	NC	3	Pitt, Edgecombe, Nash
Project Reach	RI	3	Providence, Kent, Washington
Wraparound Milwaukee	WI	1	Milwaukee
Multiagency Integrated System of Care	CA	1	Santa Barbara
Youth and Family System of Care	CA	2	Sonoma, Napa

Hawaii Ohana Project	HI	1	Honolulu
Community Wraparound Initiative	IL	1	Cook
Grantees Funded in 1993-1994 (continued)			
Project KanFoucs	KS	13	Labette, Cherokee, Crawford, Wilson, Elk, Chautauqua, Montgomery, Anderson, Woodson, Allen, Bourbon, Neosha, Linn
* Navajo Nation K'e Project	NM	5	San Juan, McKinley, Coconino, Apache, Navajo
FRIENDS Initiative - Mott Haven (South Bronx)	NY	1	Bronx Borough (County) – but encompassing only a few Census tracts around the Mott Haven community of the South Bronx
SED Partnership Grant	ND	17	Minot - Bottineau, Burke, McHenry, Mountrail, Pierce, Renville, and Ward Bismarck - Aurleigh, Oliver, Morton, Kidder, Grant, McLean, Mercer, Sheridan, Sioux, Emmons
The New Opportunities Program	OR	1	Lane
Philadelphia Kinship Care Program	PA	1	Philadelphia
Alexandria Children's Comprehensive and Enhanced Service System (ACCESS)	VA	1	Fairfax
Totals		**79**	

Grantees Funded in 1997

Project Name	State	Number of Counties Included	Names of Counties
The Jefferson County Community Partnership	AL	1	Jefferson
Intensive Services Evaluation Project	SD	1	San Diego
* Kmihqitahasultipon Project (Passamaquoddy Tribe Indian Township)	ME	1	Washington
Southwest Community Partnership	MI	1	Wayne

Central Nebraska Initiative for Families and Youth - Central Nebraska	NE	22	Blaine, Loup, Garfield, Wheeler, Custer, Valley, Greeley, Sherman, Howard, Merrick, Buffalo, Hall, Hamilton, Phelps, Kearney, Adams, Clay, Furnas, Harlan, Franklin, Webster, Nuckolls
Grantees Funded in 1997 (continued)			
North Carolina Families and Communities Equal Success (FACES)	NC	11	Ayson, Buncombe, Cleveland, Guilford, Hoke, Madison, Mitchell, Montgomery, Moore, Richmond, Yancey
* The Sacred Child Project (Fort Berthold, Standing Rock, Spirit Lake, and Turtle Mountain Indian Reservations)	ND	18	Benson, Divide, Dunn, Eddy, McLean, McKenzie, Mercer, Montrail, Nelson, Ramsey, Rolette, Sioux, Ward, Williams, North Dakota; Sheridan, Richland, Roosevelt, Montana; Corson, South Dakota
Children's Upstream Services	VT	13	Franklin, Orleans, Essex, Lamoille, Caledonia, Chittenden, Washington, Addison, Orange, Rutland, Windsor, Bennington, Windham
Northwoods Alliance for Children and Families	WI	6	Forest, Langdale, Lincoln, Marathon, Oneida, Vilas
Totals		**74**	

Grantees Funded in 1998

Project Name	State	Number of Counties Included	Names of Counties
Tampa-Hillsborough Integrated Network for Kids (THINK)	FL	1	Hillsborough
Kentucky Bridges Project (3 rural Appalachian regions)	KY	22	Breathitt, Knott, Lee, Leslie, Letcher, Owsley, Perry, Wolfe, Floyd, Johnson, Magoffin, Martin, Morgan, Pike, Bell, Clay, Harlan, Jackson, Knox, Laurel, Rockcastle, Whitley
* Mno Bmaadzid Endaad ("Be in good health at his house" - Sault Ste. Marie Tribe of Chippewa Indians and Bay Mills Ojibwa Indian Community)	MI	7	Alger, Chippewa, Delta, Luce, Marquette, Mackinac, Schoolcraft
Partnership with Families	MO	1	St. Charles

Families First and Foremowst Community Collaborative	NE	1	Lancaster
Neighborhood Care Center Project	NV	1	Clark
Grantees Funded in 1998 (continued)			
Clackamas Partnership	OR	1	Clackamas
Community Connections for Families	PA	1	Allegheny
Project Hope	RI	3	Providence, Kent, Washington
Travis County Children's Mental Health Partnership	TX	1	Travis
Utah Frontiers Project	UT	6	Beaver, Carbon, Emery, Garfield, Grande, Kane *(Also proposed: San Juan, Piute, Wayne, Rich, Daggett)*
Clark County Children's Mental Health Initiative	WA	1	Clark
Children and Families in Common	WA	1	King
* With Eagles Wings (Wind River Indian Reservation)	WY	2	Freemont, Hot Springs
Totals		**49**	

Grantees Funded in 1999-2000

Project Name	State	Number of Counties Included	Names of Counties
* Yuut Calilriit Ikaiyuquulluteng ("Peoplep Working Together") Project of the Yukon-Kuskokwim Delta Region of Southwest Alaska (58 Tribes)	AK	1	No County designations
Project MATCH	AZ	1	Pima
Spirit of Caring Project	CA	1	Contra Costa
* AKO-NES Wraparound System of Care	CA	2	Del Norte, Humbolt
Colorado Cornerstone System of Care Initiative	CO	4	Denver, Jefferson, Clear Creek, Gilpin
Families and Communities Work Better Together: FACT Project	DE	3	New Castle, Kent, Sussex
Family Helping Organize Partnerships for Empowerment (HOPE) Project	FL	1	West Palm Beach
Circle Around Families	IL	1	Lake
Dawn Project	IN	1	Marion
The Community Kids Project	MD	1	Montgomery
Worcester Communities of Care for Youth with Serious Emotional Disturbances	MA	1	Worcester
Putting All Communities Together (PACT) 4 Families Wraparound Initiative	MN	4	Kandiyohi, Meeker, Renville, Yellow Medicine
COMPASS	MS	1	Hinds
Care New Hampshire: Community Alliance Reform Effort	NH	3	Coos, Grafton, Hillsbourough
Burlington Partnership Project	NJ	1	Burlington
Westchester Community Network	NY	1	Westchester

Grantees Funded in 1999-2000 (continued)			
North Carolina System of Care Project	NC	11	Halifax, Orange, Person, Chatham, Swain, Haywood, Macon, Jackson, Cherokee, Clay, Graham
* Nagi Kicopi – Calling the Spirit Back Project (Oglala Sioux Tribe, Pine Ridge Indian Reservation)	SD	2	Jackson, Shannon
Young Adult Grant Project	SC	1	Greenwood
Nashville Connection Project	TN	1	Davidson
Region II Child Mental Health Initiative: Mountain State Family Alliance	WV	12	Boone, Cabell, Clay, Jackson, Kanawha, Lincoln, Logan, Mason, Putnam, Roane, Mingo, Wayne
The Peach State Wraparound Initiative	GA	2	Gwinnett, Rockdale *(Newton County not listed in application, but part of agency's service area)*
Totals		**56**	

* These grants were awarded to American Indian or Alaskan Native Tribes or tribal organizations. They were intended to serve only children in their tribal communities.

Report prepared by ORC Macro staff, Wayne Holden, Vice-President, Brigitte Manteuffel, Principal Investigator, to Rolando L. Santiago, CMHS Project Officer (June 7, 2001)