Department of Health and Human Services

Substance Abuse and Mental Health Services Administration

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

Short Title: Child Mental Health Initiative (CMHI)
(Initial Announcement)

Request for Applications (RFA) No. SM-09-002

Catalogue of Federal Domestic Assistance (CFDA) No.: 93.104

Key Dates:

Application Deadline	Applications are due by January 15, 2009
Intergovernmental Review (E.O. 12372)	Applicants must comply with E.O. 12372 if their State(s) participates. Review process recommendations from the State Single Point of Contact (SPOC) are due no later than 60 days after application deadline.

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Executive Summary:

The Substance Abuse and Mental Health Services Administration, Center for Mental Health Services is accepting applications for fiscal year (FY) 2009 for Cooperative Agreements for Comprehensive Community Mental Health Services for Children and Their Families (CMHI). The purpose of this program is to support States, political subdivisions within States, the District of Columbia, Territories, Native American and tribal organizations, in developing integrated home and community-based services and supports for children and youth with serious emotional disturbances and their families by encouraging the development and expansion of effective and enduring systems of care.

Funding Opportunity Title: Cooperative Agreements for Comprehensive Community Mental Health Services for Children and Their Families Program

Funding Opportunity Number: SM-09-002

Due Date for Applications: January 15, 2009

Anticipated Total Available Funding: $17 million

Estimated Number of Awards: 17

Estimated Award Amount: Up to $1 million

Length of Project Period: Up to 6 years

Eligible Applicants: State governments; Indian Tribes or tribal organizations; governmental units within political subdivisions of a State; District of Columbia; Puerto Rico, Northern Mariana Islands, Virgin Islands, American Samoa, and Trust Territory of the Pacific Islands (Palau, Micronesia, Marshall Islands)

[See Section III-1 of this RFA for complete eligibility information.]

I.   FUNDING OPPORTUNITY DESCRIPTION

1.   INTRODUCTION

The Substance Abuse and Mental Health Services Administration, Center for Mental Health Services is accepting applications for fiscal year (FY) 2009 for Cooperative Agreements for Comprehensive Community Mental Health Services for Children and Their Families (CMHI). The purpose of this program is to support States, political subdivisions within States, the District of Columbia, Territories, Native American Tribes and tribal organizations, in developing integrated home and community-based services and supports for children and youth with serious emotional disturbances and their families by encouraging the development and expansion of effective and enduring systems of care.

A "system of care" is an organizational philosophy and framework that involves collaboration across agencies, families, and youth for the purpose of improving access and expanding the array of coordinated community-based, culturally and linguistically competent services and supports for children and youth with a serious emotional disturbance and their families. Research has demonstrated that systems of care have a positive effect on the structure, organization, and availability of services for children and youth with serious mental health needs.

An estimated 4.5 to 6.3 million children and youth in the United States suffer from a serious emotional disturbance and approximately 65% to 80% of these children and youth do not receive the specialty mental health services and supports they need. Grantees will be expected to develop, implement, expand and disseminate broad, innovative system changes which improve outcomes for children, youth and families and create long-term positive transformation of services and supports.

Child Mental Health Initiative cooperative agreements are authorized under Section 561 of the Public Health Service Act, as amended. This announcement addresses Healthy People 2010 focus area 18 (Mental Health and Mental Disorders).

2.   EXPECTATIONS

2.1.   Population of Focus

The CMHI grant program requires that the population of focus be children and/or adolescents with a serious emotional disturbance (also referred to in this RFA as children and youth with "serious mental health needs") as defined by the criteria listed below:

Age: Children and youth from birth to 21 years of age.

Diagnosis: The child or youth must have an emotional, socio-emotional, behavioral or mental disorder diagnosable under the *DSM-IV* or its *ICD-9-CM* equivalents, or subsequent revisions (with the exception of *DSM -IV* A V codes, substance use disorders and developmental disorders, unless they co-occur with another diagnosable serious emotional, behavioral, or mental disorder). For children 3 years of age or younger, the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood-Revised (DC: 0-3R)* should be used as the diagnostic tool. (See www.zerotothree.org for more information.) For children 4 years of

age and older, the *Diagnostic Interview Schedule for Children* (*DISC)* may be used as an alternative to the *DSM-IV*.

Disability: The child or youth is unable to function in the family, school or community, or in a combination of these settings. Or, the level of functioning is such that the child or adolescent requires multiagency intervention involving two or more community service agencies providing services in the areas of mental health, education, child welfare, juvenile justice, substance abuse, or primary health care. For children under 6 years of age, community service agencies include those providing services in the areas of childcare, early childhood education (e.g., Head Start), pediatric care, and family mental health. For youth ages 18 to 21, community service agencies include those providing services in the areas of adult mental health, social services, vocational counseling and rehabilitation, higher education, criminal justice, housing and health.

Duration: The identified disability must have been present for at least 1 year or, on the basis of diagnosis, severity or multiagency intervention, is expected to last more than 1 year. Evidence from the National Evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program, as well as the extant research, suggest that the following populations of children and youth have unmet mental health needs. Although not required, applicants are encouraged to address one or more of these populations in their applications, provided they also meet the criteria in the above-referenced definition of the population of focus.

- Youth with a co-occurring serious emotional disturbance and substance use disorder or chronic illness;
- Infants and young children from birth to 5 years;
- Transition-age youth, (e.g.,16-21);
- Children and youth involved with the child welfare system;
- Youth involved with the juvenile justice system;
- Children and youth receiving special education services.

2.2. Services Delivery

SAMHSA's CMHI cooperative agreements support an array of activities to assist the grantee in building a solid foundation for delivering and sustaining effective systems of care for children and youth with serious emotional disturbances and their families.

- Applicants must explain how they intend to assure that participants from ethnically, racially and culturally diverse populations are involved with and served by the initiative in a culturally and linguistically competent manner.
- Applicants must explain how they intend to assure that services are delivered within a family-driven, youth-guided framework and how families and youth will be integrally involved in the governance and oversight of grant activities.
- Applicants must specify the geographic area to be covered by the initiative and must demonstrate how the system of care developed through the initiative will lead to broad based State-level reform where needed and support existing child-serving system reform efforts among health and human service agencies, the juvenile justice system and the child welfare and educational agencies. This includes the realignment of policies across State or tribal agencies as a means to

facilitate a coordinated approach to managing, financing and providing services to children, youth and families involved in the initiative.

- Applicants must develop coordinated processes between primary and behavioral health and other social services for children, youth and families involved in the initiative.
- Applicants must demonstrate how community services and residential services will be coordinated to ensure that a full array of services is available to meet the needs of children, youth and families.
- Applicants must demonstrate how policies will be or have been adopted to prevent families from having to relinquish custody of their child(ren) solely to access mental health services, and specify how the applicant intends to redesign policies in child welfare, Medicaid and juvenile justice to address this problem. Applicants must also track the effectiveness of their policies, i.e., how many children have been diverted from custody and served in the community.

2.3. Program Goals

The goals of the Child Mental Health Initiative are to:

- Expand community capacity to serve children and adolescents with serious emotional disturbances and their families;
- Provide a broad array of accessible, clinically effective and fiscally-accountable services, treatments and supports;
- Serve as a catalyst for broad-based, sustainable systemic change inclusive of policy reform and infrastructure development;
- Create a care management team with an individualized service plan for each child;
- Deliver culturally and linguistically competent services with special emphasis on racial, ethnic, linguistically diverse and other underrepresented, underserved or emergent cultural groups; and
- Implement full participation of families and youth in service planning, in the development, evaluation and sustainability of local services and supports and in overall system transformation activities.

2.4. Program Requirements and Allowable Activities

The CMHI program provides funds for infrastructure development and service provision for children and youth with serious mental health needs and their families. Applicants must clearly articulate their plan to address infrastructure, required services and supports, key activities and concepts of service provision, including a plan for sustainability.

2.4.1 Required Activities

Infrastructure development refers to the cross-agency administrative structures and procedures that awardees must implement on a phased schedule throughout the 6-year Federal funding period. This cross-agency system change must be designed to increase the capacity of States, s or communities to provide a broad array of services and supports for children and youth with a serious emotional disturbance and their families.

Some key administrative structures and procedures that awardees <u>must</u> develop include the following:

- Establishment of a governance body (either through a newly created structure or by building on the strengths of existing interagency structures);
- Establishment of processes for communication between the local project and the State or tribal organization;
- Multi-agency integration of functions, processes and policies;
- Development of financing approaches that promote the provision of a seamless cross-agency service delivery system;
- Creation of flexible funds with agency policy support;
- Interagency collaboration;
- Engagement of workforce development activities to improve access to qualified providers of services and supports;
- Integration of services provided by agencies that address the health and well-being of children, youth and families;
- Development of a care coordination process for linking strengths and needs with services and supports;
- Development of care review approaches that promote service quality and fiscal accountability;
- Development or expansion of clinical provider networks, inclusive of a broad array of evidence-based, culturally and linguistically competent services and supports;
- Increased capacity for cross-training among agencies;
- Establishment of an administrative team responsible for managing grant activities;
- Development of performance standards and quality assurance processes for monitoring, reporting and addressing strengths and challenges to infrastructure development and service delivery;
- Adoption of a management information system that supports system of care principles;
- Creation, adoption or changing of public policy or of agency specific internal policies as a means to support and sustain the work accomplished through the grant award;
- Development and implementation of intergovernmental consultation policies between tribal governments when Indian are located within the geographic area to be served by a grantee or when are direct grantees;
- Methods for ensuring on-going support from State, tribal or community leaders and child, youth and family advocates;
- Mechanisms for ensuring the full participation of families, youth and family run organizations in decision-making, governance and evaluation;
- Mechanisms for ensuring the development, implementation and evaluation of cultural and linguistic competence at the system, organizational and direct service levels of care.

Certain mental health and support services are required and must be provided by awardees. Other services are optional. Some non-mental health services need to be included in the

individualized plan of care, even though funds from the cooperative agreement cannot be used to purchase them. **(Note: see non-mental health services section below)**

Required Mental Health and Support Services. A full array of mental health and support services must be established in order to address the clinical and functional needs of the children, youth and families receiving services through this initiative. This array <u>must</u> consist of, but is not limited to, the following:

- Diagnostic and evaluation services;
- Cross-system care management processes;
- Individualized service plan development inclusive of caregivers;
- Community-based services provided in a clinic, office, family's home, school, primary health or behavioral health clinic, or other appropriate location, including individual, group and family counseling services, professional consultation, and review and medication management;
- Emergency services, available 24 hours a day, 7 days a week, including mobile crisis outreach and crisis intervention;
- Intensive home-based services available 24 hours a day, 7 days a week, 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);
- Assistance in making the transition from the services received as a child and youth to the services received as a young adult;
- Family advocacy and peer support services delivered by trained parent/family advocates.

[Note: The required services listed above should be integrated, when appropriate, with established alternative or traditional healing practices (practice-based evidence) of racial, ethnic or cultural groups represented in the community, especially if there are indications that such integration will 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 service 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 is family-focused, culturally competent, and uses the least restrictive environment that is clinically appropriate.

[Note: Eligible applicants intending to request a waiver of one or more service requirements must document in "Section B: Implementation Plan" of their Project Narrative their intended service array with an explanation of services they will not be providing.]

Key Concepts of Service Provision

Applicants must present a plan that addresses the philosophy of care delivery strategies, as articulated in Stroul and Friedman (1994), for the following areas:

Delivery of Clinical Interventions. Clinical interventions must be family-driven and youth guided and include diagnostic assessments, treatment planning and service delivery provided to individuals and families. Clinical interventions should be used that are effective within the cultural and linguistic contexts of children, youth and families. Some interventions will require cultural and/or linguistic adaptations. In other instances, culture-specific interventions will be most appropriate. Some interventions may be those that are indigenous to the cultural group. Strategies related to clinical training and the use of evidence-based treatments and practice-based evidence must be incorporated. The selection of clinical interventions should be a joint and inclusive activity with the community early in the funding cycle and based upon the specific needs of the population(s) of focus, ensuring that the interventions chosen have been normed and standardized on the population(s) of focus or that the practice-based evidence has been effective with the population(s) of focus. (See Appendix I, Using Evidence-Based Practices.)

Delivery of Cross-agency Care Management Services. Care management, or care coordination services, tailored to the needs of individual children and youth are required for all children and adolescents who are offered access to the services provided under this cooperative agreement. Care management represents the procedures that a trained service provider uses to access and coordinate multi-agency services for a child with a serious emotional disturbance and the child's family.

Development of an Individualized Care Plan. Each child or adolescent served within the system of care funded under this program must have an individualized care plan developed by an interagency team, with leadership from the child's parents or legally responsible adult and the child or youth. The individualized care 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 and build on child and family strengths. The group that assists the care manager, family member, and child to implement the individualized care plan is the individualized care team. Team members are identified in partnership with the individual child and family and comprised of representatives from 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. The team is guided by the principles of family-driven and youth guided care.

Family-Driven. The system of care must respect the goals and objectives of its ultimate consumers: the child or youth with a serious emotional disturbance and his/her family. (See Appendix O, Definition of Family-Driven Care.)

Youth-Guided. Youth-Guided means that youth are engaged as equal partners in creating systems change in policies and procedures at the individual, community, State and national levels. Applicants are required to develop plans for infusing a youth-guided approach throughout the system of care, including plans for training and supporting youth in positions of leadership and system transformation. (See Appendix P, Definition of Youth-Guided Care.)

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Cultural Competence. Cultural competence is the integration and transformation of knowledge, behaviors, attitudes and policies that enable policy makers, professionals, caregivers, communities, consumers and families to work effectively in cross-cultural situations. Cultural competence is a developmental process that evolves over an extended period of time. Individuals, organizations and systems are at various levels of awareness, knowledge and skills along the cultural competence continuum. (Cross, et. al, 1989). (See Appendix K, Cultural and Linguistic Competence Elements.)

2.4.2 Allowable Activities

Allowable 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 a child is eligible for services;
- Training in all aspects of system of care development and implementation, including evidence-based, practice-based or community-defined interventions;
- Therapeutic recreational activities;
- Mental health services (other than residential or inpatient facilities with ten or more beds) that are determined by the individualized care team to be necessary and appropriate and to meet a critical need of the child or the child's family related to the child's mental health needs;
- Customized suicide prevention and intervention approaches to promote protective factors and intervene as needed to address the needs of children who have been identified as at risk for suicide (e.g., previous suicide attempts, suicidal ideation, etc.);
- Customized suicide prevention interventions which identify children and youth at risk for suicide, including those who need immediate crisis services because of an imminent threat or active suicidal behavior. Include in the general portfolio of interventions the promotion of protective factors.

[Note: Cooperative agreement funds and matching funds may 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 population of focus. However, the funding of these services may not take precedence over the funding of the array of required services in this RFA.]

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/commitment with relevant agencies and providers. These services should be supplied by the participating agencies in the system of care and include, but are not limited to:

- Educational services, especially for children and youth who need to be placed in special education programs;
- Health services, especially for children and youth with co-occurring chronic illnesses;

- Substance abuse prevention and treatment services, especially for youth with co-occurring substance abuse problems;
- Out-of-home services such as acute inpatient and residential;
- Vocational counseling and rehabilitation and transition services offered under IDEA, for those children 14 years or older who require them;
- Protection and advocacy, including informational materials for children with a serious emotional disturbance and their families.

A relatively high percentage of adolescents with a 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 care plan. For those children with a serious emotional disturbance who are at risk for, but have not yet developed, a co-occurring substance use disorder, prevention activities for substance abuse may be included in the individualized care plan.

Children and youth with serious mental health needs often have co-occurring chronic illnesses and/or developmental disabilities. Therefore, collaboration with primary care and MR/DD service systems, including collaboration with family physicians, pediatricians and public health nurses, among others, must be developed within the system of care. Such collaboration must include, at a minimum, systematic procedures that primary care providers can follow to refer children and their families to the system of care. It also must include procedures for including primary care providers in individualized service planning teams and in the process utilized for development of an individualized plan of care that links strengths and needs with services and supports.

Memoranda of Understanding. In order to support the required array of services, the applicant organization must develop memoranda of understanding with appropriate agencies and providers for delivery of services available under Federal entitlements, including:

- Title XIX of the Social Security Act- Medicaid;
- Title XXI - State Children's Health Improvement Program (S-CHIP);
- Head Start Program;
- Title IV-A - Temporary Assistance for Needy Families (TANF) Program;
- Child Welfare Services: Title IV-B, Subpart 1 of the Social Security Act- Preventive intervention, alternative placements and reunification efforts to keep families together;
- Promoting Safe and Stable Families: Title IV-B, Subpart 2 of the Social Security Act- Family support, family preservation and support, time-limited family reunification services, and services to support adoptions;
- Title II of Keeping Families and Children Safe Act;
- Title IV-E-Foster Care, Adoption and Independent Living;
- John H. Chafee Foster Care Independence Program (Part of Title IV-E);
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program;
- Individuals with Disabilities Education Act (IDEA), both Parts B and H, specifically linking an individualized service plan developed under this program with an Individualized Education Plan or efforts developed in compliance with the Family Preservation and Support Act.

Applicants must also develop memoranda of understanding that specify any collaboration with other Federal discretionary grant programs available in the community, including:

- Safe Schools/Healthy Students Grants, funded by CMHS, SAMHSA, in partnership with the Departments of Education and Justice;
- Building Healthy Communities Grants, funded by CSAP, SAMHSA;
- Strengthening Communities –Youth Grants, funded by CSAT, SAMHSA;
- Child and Adolescent Mental Health and Substance Abuse State Infrastructure Grants, funded by CMHS/CSAT, SAMHSA;
- State Adolescent Substance Abuse Treatment Coordination Grants, funded by CSAT, SAMHSA;
- National Child Traumatic Stress Initiative Grants, funded by CMHS, SAMHSA;
- Statewide Family Network Grants, funded by CMHS, SAMHSA;
- Transformation State Incentive Grants funded by CMHS, SAMHSA;
- Campus Suicide Prevention Grants funded by CMHS, SAMHSA ;
- Cooperative Agreements for State-Sponsored Youth Suicide Prevention and Early Intervention (short title: State/Tribal Youth Suicide Prevention Grants) funded by CMHS, SAMHSA;
- Child Welfare Discretionary Grants funded by the Children's Bureau, Administration for Children and Families;
- Community-Based Grants for the Prevention of Child Abuse and Neglect (CBCAP), Support for Community-Based, Prevention-Focused Programs and Activities, funded by the Children's Bureau, Administration for Children and Families.

[Note: These memoranda of understanding are to be included in Appendix 1 of your application, Letters of Commitment and Support and Memoranda of Understanding.

2.4.3 Sustainability

The ultimate goal of the Child Mental Health Initiative is to put an infrastructure, services and philosophy in place that can be maintained as Federal funds decrease and after Federal funding is terminated. Applicants must comprehensively describe their plan for sustainability, which is defined as the **maintenance of systems of care over time, including the infrastructure, services and philosophy.** (See Appendix Q, Strategic Framework for Sustainability Planning.)

2.4.4 System Development and Implementation Plan

Experience with previous grantees has demonstrated the importance of sequential development of program activity as well as an on-going strategic planning process. Below is a description of the activities that should be scheduled during each phase of implementation of the cooperative agreement.

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

- Develop a logic model (see Appendix D) of the system of care, which will serve as the basis for strategic plan development. The logic model should, at a minimum, describe the context in which the system of care will be developed,

implemented and sustained, the resources available, the activities that will be conducted and the individual, service, and system outcomes expected from the initiative. The logic model should be developed with input from families, youth and other community partners.

- Develop a comprehensive strategic plan focused on the development of integrated, cross agency, culturally and linguistically competent, youth- and family-driven processes for financing, managing, coordinating, delivering and sustaining services aimed at improving the health and well-being of children, youth and families in need of services.

- Examples to include:
  - Mechanisms for interagency coordination of funding, including the involvement of the State Medicaid Office, State agencies and primary health entities;
  - Maximization of Medicaid revenue;
  - Development of the infrastructure, policies, procedures and processes that enable the use of integrated plans of care across agencies;
  - Evidence of full participation of culturally and linguistically diverse youth and families in all activities, including but not limited to strategic planning, infrastructure development, implementation and sustainability of tasks and functions associated with the initiative;
  - Development of a cultural and linguistic competence plan that will infuse all aspects of the system of care with cultural values, beliefs, processes and practices that reflect the diversity of the population(s) of focus;
  - Development of partnerships with medical schools and/or other institutions of higher education such as universities, graduate or doctoral programs, public or private foundations;
  - Processes for working with the education system (this may include incorporating Positive Behavioral Intervention and Supports (PBIS) as one of the adopted practices within the initiative or the enhancement of integrated school-based mental health services);
  - The development of networks of services that incorporate evidence-based, practice-based and promising home-, school- and community-based practices (inclusive of culturally and linguistically adapted and culture specific practices);
  - Processes for cross-training of primary and behavioral health care, child welfare, juvenile justice, education, substance abuse, other human service professionals and families and youth;
  - Methods for ensuring that there is ongoing communication between the initiative and the State agencies' responsible for the health, safety, welfare and well-being of children, youth and families so that this effort can be utilized as a means to inform the broader field and serve as a catalyst for system transformation (including methods for collecting and sharing data among multiple systems to inform policy and program development, quality improvement and accountability);
  - Methods for ensuring promotion and advancement of cultural and linguistic competence of system of care and component agencies and providers;

- Methods for addressing disparities in care; for example, individuals from rural areas, individuals in areas with high poverty rates or for those individuals from specific ethnic/cultural or sexual minority groups; and

- Development of policies and procedures that are designed to prevent the over-reliance of out-of-home placement.

  - Hire key personnel.
  - Establish the administrative team.
  - Organize the governing body.

- Enhance or develop required services through: (1) an analysis of the existing services available within the geographic area of service; (2) a needs assessment conducted with culturally and linguistically diverse families and youth in order to identify service gaps, strengths and needs; (3) selection of evidence-based practices or practice-based evidence based upon the cultural and linguistic needs of the population(s) of focus and matched to meet their needs; (4) demographic analysis to identify service gaps, strengths and needs relevant to the cultural and linguistic diversity of the community; (5) in-depth analysis of the methods available to fiscally sustain newly-developed services over time and post Federal funding; (6) a review of the revenue sources and funding agencies that are currently purchasing services, including the identification of areas where duplication of effort is occurring and can be eliminated through grant activities; (7) the direct creation of new services that match the cultural and linguistic needs of the population(s) of focus; (8) the development of community-based provider networks through contract and development with existing service providers; and (9) the coordination of services delivered by collaborating with child-serving agencies.
- Develop an approach for service integration and coordination that is appropriate for the population of focus.
- Create a format for the individualized service plan that incorporates a full array of mental health and support services.
- Identify resources and activities to address and sustain family involvement, youth involvement and cultural and linguistic competence, including the development of a Cultural and Linguistic Competence Plan, in all activities associated with the cooperative agreement.
- Create the capacity to implement the National Evaluation and develop a local evaluation plan.
- Develop a strategic plan for sustaining the system of care beyond the six-year period of Federal funding. The strategic sustainability plan should specify how the elements of the system of care infrastructure and each of the services and supports will be maintained. The sustainability plan should detail the general and financing strategies that will be used for long-term maintenance, how the system of care will be infused into the larger system (as opposed to being a separate, time-limited "project"), how the system of care will work with State partners to ensure the policy and financing mechanisms at the State level ensure long-term maintenance of the system of care and how the system of care will link with

partners in other child-serving systems for sustainability. (See Appendix Q, Strategic Framework for Sustainability Planning.)

- Develop a social marketing plan based upon the overall strategic plan. The social marketing plan should identify the appropriate audiences, strategies, tactics, including National Children's Mental Health Awareness Day activities, to address the effective development and sustainability of the system of care.

Full Implementation – Years Two through Six. It is expected that the system of care will be operational during Year Two of the cooperative agreement. That is, the community must begin to provide services to children, youth and families in year two. In addition, these children and their families must be enrolled in the National Evaluation, with data transmitted to the national evaluator from the local project.

In Years Three to Six, the system of care community must continue to enhance and maintain its capacity to meet the needs of children and their families. It also **must** implement a strategic plan for sustaining the system of care beyond the 6-year Federal funding period.

2.5.   Data Collection and Performance Measurement

All SAMHSA grantees are required to collect and report certain data so that SAMHSA can meet its obligations under the Government Performance and Results Act (GPRA). You must document your ability to collect and report the required data in "Section D: Evaluation Plan" of your application. Grantees will be required to report performance on the following performance measures: mental illness symptomatology; employment/education; crime and criminal justice; stability in housing; access, i.e., number of persons served by age, gender, race and ethnicity; rate of readmission to psychiatric hospitals; social support/social connectedness; and client perception of care. This information will be gathered using the CMHS NOMs Adult Consumer Outcome Measures for Discretionary Programs or the Child Consumer Outcome Measures for Discretionary Programs (Child or Adolescent Respondent Version or Caregiver Respondent Version), which can be found at https://www.samhsa-gpra.samhsa.gov, along with instructions for completing it. Hard copies are available in the application kits available by calling the SAMHSA Information Line at 1-877-SAMHSA7 [TDD: 1-800-487-4889]. Data will be collected at baseline, at 3- or 6- month follow-up depending on specific program requirements, and at discharge. Data are to be entered into TRAC (Transformation Accountability) Web system within seven days of data collection. TA related to data collection and reporting will be offered. The collection of these data will enable CMHS to report on the National Outcome Measures (NOMs), which have been defined by SAMHSA as key priority areas relating to mental health.

Performance data will be reported to the public, the Office of Management and Budget (OMB) and Congress as part of SAMHSA's budget request.

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 that will be used to comply with the requirements described above. This cross-site evaluation is referred to in this RFA 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 also is designed to create long-term capacity among the awardee communities to continue their evaluation, especially after Federal funding ends. 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 to 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.

2.6. Performance Assessment

Each awardee is encouraged to enhance the National Evaluation with its own **local evaluation activities**. Grantees must assess their projects, addressing the performance measures described in Section I-2.5. The assessment should be designed to help you determine whether you are achieving the goals, objectives and outcomes you intend to achieve and whether adjustments need to be made to your project. Grantee will be required to report on progress achieved, barriers encountered and efforts to overcome these barriers in a performance assessment report to be submitted at least annually. These local evaluation activities will help ensure that the unique needs for systems-of-care development of the awardee's site are 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 semi-annual reports. Finally, local level evaluations are an important strategy for long-term sustainability of the system of care.

In addition to assessing progress against the performance measures required for this program, your performance assessment must also consider outcome and process questions, such as the following:

Outcome Questions:

- What was the effect of the intervention on participants?
- What program/contextual factors were associated with outcomes?

- What individual factors were associated with outcomes?
- How durable were the effects?

Process Questions:

- How closely did implementation match the plan?
- What types of deviation from the plan occurred?
- What led to the deviations?
- What effect did the deviations have on the planned intervention and performance assessment?
- Who provided (program staff) what services (modality, type, intensity, duration), to whom (individual characteristics), in what context (system, community), and at what cost (facilities, personnel, dollars)?

No more than 20% of the total grant award may be used for data collection, performance measurement and performance assessment, e.g., activities required in Sections I-2.5 and 2.6 above.

2.7. Grantee Meetings

Applicants are required to budget for travel and attendance of a core team of approximately 10 individuals for at least two meetings per year to create and sustain a learning community among all grantees. The core team must include the project director, evaluator, key family contact, clinical director, youth coordinator, technical assistance coordinator, cultural and linguistic competence coordinator, communications manager, representatives from at least two other child-serving systems in the community and the State or tribal/territory government contact for the initiative. Grantees are also encouraged to bring other individuals who may be strategically important to make progress on grantee specific goals (e.g., additional family members and youth, local elected officials, community advocates and state Medicaid director).

II.   AWARD INFORMATION

Funding Mechanism: Cooperative Agreement
Anticipated Total Available Funding: $17million
Estimated Number of Awards: 17
Estimated Award Amount: Up to $1 million in Year 1
                                                                  Up to $1.5 million in Year 2
                                                                  Up to $2 million in Year 3
                                                                  Up to $2 million in Year 4
                                                                  Up to $1.5 million in Year 5
                                                                  Up to $1 million in Year 6
Length of Project Period: Up to 6 years

Proposed budgets cannot exceed the allowable amount in total costs (direct and indirect) in any year of the proposed project. Annual continuation awards will depend on the availability of funds, grantee progress in meeting project goals and objectives, timely submission of required data and reports and compliance with all terms and conditions of award.

This program is being announced prior to the appropriation for FY 2009 for SAMHSA's programs, with funding estimates based on the President's budget request for FY 2009. Applications are invited based on the assumption that sufficient funds will be appropriated for FY 2009 to permit funding of a reasonable number of applications solicited. All applicants are reminded, however, that we cannot guarantee that sufficient funds will be appropriated to permit SAMHSA to fund any applications.

Cooperative Agreement

These awards are being made as cooperative agreements because they require substantial post-award Federal programmatic participation in the conduct of the project. Under this cooperative agreement, the roles and responsibilities of grantees and SAMHSA staff are:

Role of Grantee:

- Comply with the terms and conditions of the agreement, which will be specified in the Notice of Grant Award (NOGA);
- Agree to provide SAMHSA with data required for the Government Performance and Results Act (GPRA), which can be done through participation in the National Evaluation of the Comprehensive Community Mental Health Services Program for Children and Their Families.
- Create an overall Logic Model for system of care services (see Appendix D).
- Develop a strategic plan that is reviewed and revised based on program needs. The overall strategic plan must have implementation benchmarks and at least four components, including plans for technical assistance, social marketing, family organization development and the development of cultural and linguistic competence.

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

Grantees will be required 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 also will assist with the identification of resources to address the training and technical assistance needs of each stakeholder group associated with the system of care;
- Designate at least a <u>half-time equivalent</u> person or contract consultant to serve as technical assistance coordinator.

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

Grantees will be required to:

- Develop a culturally and linguistically competent social marketing strategic plan that addresses the national Caring for Every Child's Mental Health Campaign goals:

  - Reduce stigma associated with mental illness and promote mental health;
  - Use social marketing strategies to help increase the likelihood that children and youth with serious mental health needs and their families are appropriately served and treated;
  - Increase awareness of mental health needs and services for children and youth among primary care providers, system of care communities, intermediary groups/organizations and the public;
  - Demonstrate to communities that the mental health needs of children and youth with serious mental health needs and their families are best met through utilization of a system of care framework;
  - Use social marketing strategies to help build capacity within communities to sustain services and supports to children and youth with serious mental health needs and their families.

The plan should be developed by a social marketing committee comprised of families, youth, evaluators, system of care staff and partners and approved by the governance board and should:

- Designate at least a half-time equivalent staff position or contract consultant for a social marketing-communications manager;
- Provide support to a family organization associated with the system of care to implement outreach strategies for families of children and youth with serious mental health needs who are from racial and ethnic groups represented in the community to be served;
- Implement a social marketing strategy that determines the informational needs of priority audiences and develops messages, materials, and activities that are in compliance with Title VI of the Civil Rights Act, *National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care* (U.S. Department of Health and Human Services, 2000; see http://www.omhrc.gov/clas/frclas2h.tm), and the standards identified in SAMHSA's *Cultural Competence Standards in Managed Mental Health Care Services* (U.S. Department of Health and Human Services, 2000; see http://www.wiche.edu/mentalhealth/ CCStandards/ccstoc.htm.).

Cultural and Linguistic Competence. The program provides awardees with technical assistance to assist them with the planning, development and implementation of a culturally and linguistically competent system of care. Awardees are expected to:

- Designate at least a half-time equivalent staff position or contract consultant for a cultural and linguistic competence coordinator;
- Develop a cultural and linguistic competence plan (CLCP). A template can be found at www.tapartnership.org/cc/CLC_Plan_Template_FINAL.pdf . The

(CLCP) is intended to ensure that all services and strategies are designed and implemented within the cultural and linguistic context of the children, youth and families to be served. The goal of the CLCP is to ensure that the system of care adopts a systemic, systematic and strategic approach to increasing the cultural responsiveness of services and supports delivered to children, youth and families and creates a sensitivity and appreciation for diversity and cultural issues throughout the system of care;

- Establish a cultural and linguistic competence activities budget that the CLC Coordinator is responsible for administering under the supervision of the project director.

Role of SAMHSA Staff:

- Monitor each grantee's progress in the implementation of program requirements and provide direct assistance to advance the goals of the program and to improve the effectiveness of service delivery;
- Review and approve each stage of project implementation (e.g., continuation applications, proposed programmatic and budgetary modifications and key personnel staffing changes).
- Participate in making decisions with the grantee to help achieve project objectives;
- Approve decisions of each grantee 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 funds and designated match resources to ensure compliance with Federal regulations and requirements of the cooperative agreement;
  - Use of communications, public awareness and social marketing techniques in the community to promote good mental health practices among children and youth with serious mental health needs and their families; advertise systems-of-care services and reduce community-wide stigma associated with childhood mental disorders; and, develop partnerships and secure support from the community and State/tribe to sustain efforts after federal funding expires;
  - Ways to ensure implementation of the National Evaluation to: (1) demonstrate the effectiveness of each system of care through evidence that the well-being of children and youth with serious mental health needs and their families increases as a result of receiving systems-of-care services; (2) insure timely submission of data to the National Evaluation contractor; (3) use data for continuous quality improvement and to sustain the system of care; and (4) ensure that the capacity for evaluation continues beyond the Federal funding period.

- Conduct formal Federal site visits in Years 2 and 4 of the cooperative agreement. Additional formal or informal site visits may conducted, as needed;

- Ensure that systems-of-care activities under this program are coordinated with CMHS, SAMHSA and other Federal initiatives, as appropriate.

III. ELIGIBILITY INFORMATION

1. ELIGIBLE APPLICANTS

Eligibility for this program is statutorily limited to public entities such as:

- State governments;
- Indian or tribal organizations (as defined in Section 4[b] and Section 4[c] of the Indian Self-Determination and Education Assistance Act);
- Governmental units within political subdivisions of a State, such as a county, city or town;
- District of Columbia government; and
- 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).

If you have previously received a CMHI award, you must specify a geographic service area within the State, county, tribe or territory that is different from the geographic area of your current or past award (See Table 1, pages 20-21).

An exception to this requirement will be made for States whose previous award(s) was to develop systems of care across the entire State. If your State had a previous CMHI award for a Statewide implementation approach, you may apply for funding under this announcement if your previous award(s) has expired, including all no-cost extension years. You must also demonstrate that the programs implemented under these previous awards have been sustained and that the population of focus you are now proposing is different from that in the previous award(s).

In keeping with SAMHSA's commitment to providing opportunities to serve American Indian/Alaska Native communities, an exception will also be made for cities, counties, States or other public entities that received a previous CMHI award but whose new CMHI application focuses on American Indians and Alaska Native children and families living off reservations in urban centers who were not served by a previous award. Such a new cooperative agreement must be developed in partnership with an American Indian non-profit organization that is recognized by the Indian Health Service Urban Indian Health Program under Title V of the Indian Health Care Improvement Act, PL 94-437, as amended.

[Note: Please refer to Appendix J for a list of current and past CMHI grantees, including the counties in which each of the funded systems of care has been implemented.]

The authorizing legislation for this program limits only one award per public entity. However, a State, county, city, tribal or territorial government may apply simultaneously for separate cooperative agreements within a State, if the geographic area specified in a CMHI application does not overlap with the geographic area specified in another CMHI application within the same State.

Eligible applicants must meet the following requirements:

- The application should be submitted by the Office of the Governor or by the chief executive officer of a tribe, Territory or the District of Columbia. However, it may also be submitted by the chief executive officer of a State agency, State political subdivision (e.g., county, city), Indian tribe, tribal organization or Territory, as long as this person is specifically designated in writing by the governor or by the chief executive officer of a tribe, territory or the District of Columbia to submit this application.
- To ensure sustainability of the proposed project, all government entities applying for this grant must include a letter of assurance from the Governor of the State or Territory, or the Governor's designee, stating that the applicant will directly provide any service under this grant that is also covered in the State Medicaid Plan. The letter must also state that the applicant has entered into a participation agreement under the State plan and is qualified to receive payments under this plan. If the applicant will not provide direct services, the letter of assurance must indicate that the applicant will enter into an agreement with an organization that will provide the service and the organization has entered into a participation agreement under the State Medicaid Plan and is qualified to receive Medicaid payments.
- In addition, the letter of assurance from the Governor or the Governor's designee must indicate that the system of care proposed in the application is specifically included in the goals of the State's or Territory's Community Mental Health Services Block Grant Plan (as authorized in Section 564 [b] of the PHS Act) and in the State or Territory's Mental Health Plan for Children and Adolescents with Serious Emotional Disturbances (submitted under Public Law [PL] 102-321). The proposed system of care must also be consistent with plans proposed under any SAMHSA-funded State Incentive Grant or State Infrastructure Grant (SIG) awarded to the State/tribe. If the proposed system of care is not included in the State's or Territory's plans, the letter of assurance should indicate that it will be included in a revision of the plan at its next renewal date. The letter signed by the Governor or designee should also provide evidence that the Governor supports the proposed system of care and is committed to assist in cultivating the community and interagency partnerships necessary to build and sustain the system of care.

This letter of assurance from the Governor or the Governor's designee is not required of Indian or tribal organizations.

The letter of assurance must appear in **Appendix 2** of the application, "Governor's Assurance." The Governor may use this same letter to designate the chief executive officer of the government entity who will sign and submit the application.

[Note: No awards will be made to government applicants who do not submit a letter of assurance from the Governor. Please consult Table 1 below for a summary of eligibility requirements.]

Table 1: Summary of Eligibility Requirements

Eligible Applicant	Requirement	Signature on Application	Letter of Assurance from Governor
State governments	Eligible if focused on a new population or geographic area; proposed geographic area may not overlap with geographic area in application from a political subdivision of the State. Exception: If applicant was previously awarded a grant for the entire State, the applicant may be eligible, as long as previous award has expired, including any no-cost extension year. Applicant must also provide evidence that activities awarded under previous CMHI grants have been sustained. Previous grantees are also eligible if application specifies a focus on American Indians/Alaska Native children and families living off reservations that were not served by a previous award. The new cooperative agreement must be developed in partnership with an American Indian non-profit organization recognized by the Indian Health Service Urban Indian Health program under Title V of the Indian Health Care Improvement Act, PL 94-437, as amended.	Governor or chief executive officer of State agency, designated in writing by the governor.	Yes
Counties, cities, Territories	Eligible if focused on a new population or geographic area; proposed geographic area may not overlap with geographic area from any other concurrent application within the State or Territory. Previous grantees are also eligible if application specifies a focus on American Indians/Alaska Native children and families living off reservations that were not served by a previous award. The new cooperative agreement must be developed in partnership with an American Indian non-profit organization recognized by the Indian Health Service Urban Indian Health program under Title V of the Indian Health Care Improvement Act, PL 94-437, as amended.	Chief executive officer, designated in writing by the governor or by the chief executive of a Territory or the District of Columbia.	Yes

Eligible Applicant	Requirement	Signature on Application	Letter of Assurance from Governor
Tribes	Eligible if tribe or tribal organization has not had a previous CMHI award. If applicant is a previous CMHI grantee, the new application must be focused on a new population or geographic area not served by the tribe's previous grant. Applicants may choose to focus on American Indian and/or Alaska Native children and families living off reservations in urban centers that were not served by a previous CMHI award if the new cooperative agreement is developed in partnership with an American Indian non-profit organization that is recognized by the Indian Health Service Urban Indian Health Program under Title V of the Indian Health Care Improvement Act, PL 94-437, as amended.	Tribal leader or Tribal council	No

2.   COST SHARING and MATCH REQUIREMENTS

Cost Sharing/Matching Funds are required. You are required by statutory mandate to provide matching funds from other nonfederal sources, either directly or through donations from public or private entities:

- For the first, second and third fiscal years of the cooperative agreement, you must provide at least $1 for each $3 of Federal funds;
- For the fourth fiscal year, you must provide at least $1 for each $1 of Federal funds; and
- For the fifth and sixth fiscal years, you 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 nonfederal sources (e.g., State or sub-State nonfederal revenues, foundation grants).

It is expected that nonfederal match dollars will include contributions from various child-serving systems (e.g., education, child welfare, juvenile justice). You must specify the names of the expected sources, the types of sources (e.g., education, child welfare, juvenile justice) and the amount of matching funds, as evidence of the initiative's potential to sustain itself beyond the 6-year award period.

There is concern that the Federal funds for this program might be used to replace existing nonfederal funds. Therefore, applicants may only include as nonfederal match, contributions in excess of the average amount of nonfederal funds available to the applicant public entity over the 2 fiscal years preceding the fiscal year when the Federal award is made. Non federal public contributions, whether from State, county or city governments, must be dedicated to the community(ies) served by the cooperative agreement.

Federal grant funds must be used for the new expenses of the program carried out by the grantee. That is, Federal grant funds must be used to supplement and not supplant, any funds available for carrying out existing services and activities, e.g., college suicide prevention activities.

A letter from the director of the State, county or city mental health agency applying for the cooperative agreement should certify that matching funds for the proposed initiative are available and are non-Federal funds. The letter must be included in **Appendix 5** of the application, Nonfederal Match Certification. This letter also should indicate that proposed changes in funding streams required for the match or other funding innovations necessary for implementation of the proposed initiative 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, also may be included in **Appendix 5** of the application.

Indian receiving funds under the Self-Determination and Education Assistance Act, PL 93-638, as amended, are exempt from the restriction that prohibits the use of those Federal funds as a match.

3. OTHER

3.1. Additional Eligibility Requirements

You must comply with the following requirements, or your application will be screened out and will not be reviewed: use of the PHS 5161-1 application form; application submission requirements in Section IV-3 of this document; and formatting requirements provided in Appendix A of this document.

IV. APPLICATION AND SUBMISSION INFORMATION

1. ADDRESS TO REQUEST APPLICATION PACKAGE

You may request a complete application kit from the SAMHSA Information Line at 1-877-SAMHSA7 [TDD: 1-800-487-4889].

You also may download the required documents from the SAMHSA Web site at www.samhsa.gov/grants/apply.aspx .

Additional materials available on this Web site include:

- A grant writing technical assistance manual for potential applicants;
- Information on Technical Assistance Webinars for perspective applicants.
- Standard terms and conditions for SAMHSA grants;
- Guidelines and policies that relate to SAMHSA grants (e.g., guidelines on cultural competence, consumer and family participation and evaluation); and
- A list of certifications and assurances referenced in item 21 of the SF 424 v2.

2. CONTENT AND FORM OF APPLICATION SUBMISSION

2.1. Application Kit

SAMHSA application kits include the following documents:

- PHS 5161-1 (revised July 2000) – Includes the face page (SF 424 v2), budget forms, assurances, certification, and checklist. You must use the PHS 5161-1. **Applications that are not submitted on the required application form will be screened out and will not be reviewed.**
- Request for Applications (RFA) – Provides a description of the program, specific information about the availability of funds and instructions for completing the grant application. This document is the RFA. The RFA will be available on the SAMHSA Web site (www.samhsa.gov/grants/index.aspx) and a synopsis of the RFA is available on the Federal grants Web site (www.Grants.gov).

You must use all of the above documents in completing your application.

2.2. Required Application Components

Applications must include the required ten application components (Face Page, Abstract, Table of Contents, Budget Form, Project Narrative and Supporting Documentation, Appendices, Assurances, Certifications, Disclosure of Lobbying Activities and Checklist).

‒ **Face Page –** SF 424 v2 is the face page. This form is part of the PHS 5161-1. [Note: Applicants must provide a Dun and Bradstreet (DUNS) number to apply for a grant or cooperative agreement from the Federal Government. SAMHSA applicants are required to provide their DUNS number on the face page of the application. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS number, access the Dun and Bradstreet Web site at www.dunandbradstreet.com or call 1-866-705-5711. To expedite the process, let Dun and Bradstreet know that you are a public/private nonprofit organization getting ready to submit a Federal grant application.]

‒ **Abstract** – Your total abstract should not be longer than 35 lines. It should include the project name, population to be served (demographics and clinical characteristics), strategies/interventions, project goals and measurable objectives, including the number of people to be served annually and throughout the lifetime of the project, etc. In the first five lines or less of your abstract, write a summary of your project that can be used, if your project is funded, in publications, reporting to Congress or press releases.

‒ **Table of Contents** – Include page numbers for each of the major sections of your application and for each appendix.

‒ **Budget Form** – Use SF 424A, which is part of the PHS 5161-1. Fill out Sections B, C, and E of the SF 424A. A sample budget and justification is included in Appendix H of this document.

‒ **Project Narrative and Supporting Documentation** – The Project Narrative describes your project. It consists of Sections A through D. Sections A-D together may not be longer than 40 pages. (Remember that if your Project Narrative starts on page 5 and ends on page 45, it is 41 pages long, not 40 pages.) More detailed instructions for completing each section of the Project Narrative are provided in "Section V – Application Review Information" of this document.

The Supporting Documentation provides additional information necessary for the review of your application. This supporting documentation should be provided immediately following your Project Narrative in Sections E through H. There are no page limits for these sections, except for Section G, Biographical Sketches/Job Descriptions. Additional instructions for completing these sections are included in Section V under "Supporting Documentation." Supporting documentation should be submitted in black and white (no color).

‒ **Appendices 1 through 6 –** Use only the appendices listed below. If your application includes any appendices not required in this document, they will be disregarded. Do not use more than a total of 40 pages for Appendices 1, 2, 4, 5 and 6 combined. There are no

page limitations for Appendix 3. Do not use appendices to extend or replace any of the sections of the Project Narrative. Reviewers will not consider them if you do.

- *Appendix 1*: Letters of Commitment and Support and Memoranda of Understanding
- *Appendix 2*: Governor's Assurance
- *Appendix 3*: Data Collection Procedures and Instruments
- *Appendix 4*: Sample Consent Forms
- *Appendix 5*: Non-Federal Match Certification
- *Appendix 6*: Organizational Chart, Staffing Pattern, Timeline and Management Chart.

‒ **Assurances** – Non-Construction Programs. You must read the list of assurances provided on the SAMHSA Web site or in the application kit before signing the face page (SF 424 v2) of the application.

‒ **Certifications** – You must read the list of certifications provided on the SAMHSA Web site or in the application kit before signing the face page (SF 424 v2) of the application.

‒ **Disclosure of Lobbying Activities** – You must submit Standard Form LLL found in the PHS 5161-1. Federal law prohibits the use of appropriated funds for publicity or propaganda purposes or for the preparation, distribution or use of the information designed to support or defeat legislation pending before the Congress or State legislatures. This includes "grass roots" lobbying, which consists of appeals to members of the public suggesting that they contact their elected representatives to indicate their support for or opposition to pending legislation or to urge those representatives to vote in a particular way. If no lobbying is to be disclosed, mark N/A on the form.

‒ **Checklist** – Use the Checklist found in PHS 5161-1. The Checklist ensures that you have obtained the proper signatures, assurances and certifications. If you are submitting a paper application the Checklist should be the last page.

2.3. Application Formatting Requirements

Please refer to Appendix A, *Checklist for Formatting Requirements and Screenout Criteria for SAMHSA Grant Applications***, for SAMHSA's basic application formatting requirements. Applications that do not comply with these requirements will be screened out and will not be reviewed.**

3. SUBMISSION DATES AND TIMES

Applications are due by close of business on **January 15, 2009**. Hard copy applications are due by 5:00 PM (EST). Electronic applications are due by 11:59 PM (EST). **Hand carried applications will not be accepted. Applications may be shipped using only DHL, Federal Express (FedEx), United Parcel Service (UPS) or the United States Postal Service (USPS).**

You will be notified by postal mail that your application has been received.

Your application must be received by the application deadline or it will not be considered for review. Please remember that mail sent to Federal facilities undergoes a security screening

prior to delivery. You are responsible for ensuring that you submit your application so that it will arrive by the application due date and time.

If an application is mailed to a location or office (including room number) that is not designated for receipt of the application and, as a result, the designated office does not receive your application by the deadline, your application will be considered late and ineligible for review.

SAMHSA will not accept or consider any applications sent by facsimile.

SAMHSA accepts electronic submission of applications through www.Grants.gov. Please refer to Appendix B for "Guidance for Electronic Submission of Applications."

4.   INTERGOVERNMENTAL REVIEW (E.O. 12372) REQUIREMENTS

This grant program is covered under Executive Order (EO) 12372, as implemented through Department of Health and Human Services (DHHS) regulation at 45 CFR Part 100. Under this Order, States may design their own processes for reviewing and commenting on proposed Federal assistance under covered programs. Certain jurisdictions have elected to participate in the EO process and have established State Single Points of Contact (SPOCs). A current listing of SPOCs is included in the application kit and can be downloaded from the Office of Management and Budget (OMB) Web site at www.whitehouse.gov/omb/grants/spoc.html.

- Check the list to determine whether your State participates in this program. You **do not** need to do this if you are an American Indian/Alaska Native tribe or tribal organization.
- If your State participates, contact your SPOC as early as possible to alert him/her to the prospective application(s) and to receive any necessary instructions on the State's review process.
- For proposed projects serving more than one State, you are advised to contact the SPOC of each affiliated State.
- The SPOC should send any State review process recommendations to the following address within 60 days of the application deadline. **For United States Postal Service:** Crystal Saunders, Director of Grant Review, Office of Program Services, Substance Abuse and Mental Health Services Administration, Room 3-1044, 1 Choke Cherry Road, Rockville MD **20857**. ATTN: SPOC – Funding Announcement No. **SM-09-002**. Change the zip code to **20850** if you are using another delivery service.

5.   FUNDING LIMITATIONS/RESTRICTIONS

Cost principles describing allowable and unallowable expenditures for Federal grantees, including SAMHSA grantees, are provided in the following documents, which are available at www.samhsa.gov/grants/management.aspx:

- Institutions of Higher Education: OMB Circular A-21
- State and Local Governments and Federally Recognized Indian Tribal Governments: OMB Circular A-87

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- Nonprofit Organizations: OMB Circular A-122
- Hospitals: 45 CFR Part 74, Appendix E

In addition, SAMHSA's CMHI grant recipients must comply with the following funding restrictions:

- No more than 15% of the total grant award may be used for developing the infrastructure necessary for expansion of services.
- No more than 20% of the total grant award may be used for data collection and performance assessment, including incentives for participating in the required data collection follow-up.

SAMHSA grantees must also comply with SAMHSA's standard funding restrictions, which are included in Appendix G.

6.   OTHER SUBMISSION REQUIREMENTS

You may submit your application in either electronic or paper format:

Submission of Electronic Applications

SAMHSA accepts electronic submission of applications through www.Grants.gov. Electronic submission is voluntary. No review points will be added or deducted, regardless of whether you use the electronic or paper format.

To submit an application electronically, you must use the www.Grants.gov apply site. You will be able to download a copy of the application package from www.Grants.gov, complete it off-line and then upload and submit the application via the Grants.gov site. E-mail submissions will not be accepted.

Please refer to Appendix B for detailed instructions on submitting your application electronically.

Submission of Paper Applications

You must submit an original application and 2 copies (including appendices). The original and copies must not be bound. Do not use staples, paper clips, or fasteners. Nothing should be attached, stapled, folded or pasted.

Send applications to the address below:

 For United States Postal Service:

Crystal Saunders, Director of Grant Review
Office of Program Services
Substance Abuse and Mental Health Services Administration
Room 3-1044
1 Choke Cherry Road

Rockville, MD **20857**

Change the zip code to **20850** if you are using another delivery service.

Do not send applications to other agency contacts, as this could delay receipt. Be sure to include "**CMHI – SM-09-002**" in item number 12 on the face page (SF 424 v2) of any paper applications. If you require a phone number for delivery, you may use (240) 276-1199.

Hand carried applications will not be accepted. Applications may be shipped using only DHL, Federal Express (FedEx), United Parcel Service (UPS), or the United States Postal Service (USPS).

SAMHSA will not accept or consider any applications sent by facsimile.

V. APPLICATION REVIEW INFORMATION

1. EVALUATION CRITERIA

The Project Narrative describes how you intend to implement your cooperative agreement and includes the Evaluation Criteria in Sections A-D below. Your application will be reviewed and scored according to the quality of your response to the requirements in Sections A-D.

- In developing the Project Narrative section of your application, use these instructions, which have been tailored to this program. **These are to be used instead of the "Program Narrative" instructions found in the PHS 5161-1**.
- The Project Narrative (Sections A-D) together may be no longer than 40 pages.
- You must use the four sections/headings listed below in developing your Project Narrative. Be sure to place the required information in the correct section, **or it will not be considered**. Your application will be scored according to how well you address the requirements for each section of the Project Narrative.
- Reviewers will be looking for evidence of cultural competence in each section of the Project Narrative and will consider how well you address the cultural competence aspects of the evaluation criteria when scoring your application. SAMHSA's guidelines for cultural competence can be found on the SAMHSA Web site at www.samhsa.gov. Click on "Grants/Applying for a New SAMHSA Grant/Guidelines for Assessing Cultural Competence."
- The Supporting Documentation you provide in Sections E-H and Appendices 1-6 will be considered by reviewers in assessing your response, along with the material in the Project Narrative.
- The number of points after each heading is the maximum number of points a review committee may assign to that section of your Project Narrative. Bullet statements in each section do not have points assigned to them. They are provided to invite the attention of applicants and reviewers to important areas within each section.

Section A: Understanding of the Project (15 Points)

Demonstrate your understanding of systems of care and especially address the significance of developing systems of care for children and youth with serious mental health needs and their families in the proposed geographic service area. Include any literature citations in Section E.

- Describe the population of children with serious mental health needs in the geographic service area that will be targeted by the initiative and cite your data source(s). Include:

    - Projected age range (e.g., birth to 21, 5 to 17);
    - Prevalence estimate (in numbers) of children with serious mental health needs within the geographic service boundaries of the initiative;
    - Estimated percentages of children and their families from racial and ethnic groups represented in the geographic service area;
    - Other demographic characteristics of children and their families such as gender, family income levels, level of disability, literacy levels and language;
    - Family or institutional settings in which these children and youth live or are currently served (e.g., special education programs, child welfare, probation) and which will be potential sources of referrals. Include expected number of referrals from each source; and
    - Service disparities for children from racial or ethnic minorities or other underserved or underrepresented groups based on sexual orientation, faith communities or national origin, etc. Service disparities may be indicated through differential racial or ethnic rates of out-of-home or out-of-State placements, representation in juvenile justice facilities or representation in restrictive mental health treatment settings. Disparities also may be indicated in differential rates of access to quality care.

- Describe the current capacity to serve children and youth with serious mental health needs and their families. Specifically, describe the existing resources and services available within the jurisdiction of the proposed initiative. If possible, estimate the number of children currently served.
- Establish the significance of the proposed initiative by identifying the gaps in, inadequacies of, and barriers to current service structures that justify the need for the proposed project.
- Describe how the proposed initiative also will collaborate with other Federal, State and local programs and reform initiatives.

Section B: Implementation Plan (55 Points)

In this section, you must provide an explanation for how you will develop a children's mental health infrastructure, address service delivery activities (including mechanisms for family-driven, youth-guided and culturally and linguistically competent care) and ensure sustainability.

Infrastructure Development (15 Points)

- Describe how the cross-agency infrastructure for the system of care will be developed.
- Describe the composition and responsibilities of the proposed governance body, including how families and youth will be incorporated and how cultural and linguistic competence will be demonstrated.
- Describe procedures for systems integration, interagency collaboration, services integration, care plan development, flexible funding, care review, access, financing, workforce development and community leader support. As part of financing, describe the range of funding streams to be accessed in establishing the system of care. Be sure to include all relevant funding streams beyond those utilized by the mental health system.
- Describe how you will replicate the local system of care in other communities of the State, tribe or territory. Indicate how the local system of care will be fiscally integrated into Statewide, tribal or territorial policy initiatives such as the Mental Health Plan for the State, tribe or territory, as well as the State or territorial Mental Health Block Grant Plan and how it will relate to other Federal and State initiatives in the proposed system of care site (e.g., Safe Schools Healthy Students, Child and Adolescent State Infrastructure Grants, Improving Child Welfare Outcomes through Systems of Care, etc).
- Describe strategies for developing the structures of a system-of-care such as the clinical network, administrative team, training capacity, performance standards, management information system and office in the community.
- Describe plans to collaborate with other child serving systems, including but not limited to the primary care system, education, juvenile justice, child welfare and education. Also identify the memoranda of understanding that were obtained and how the memoranda will be used to further system development efforts.
- Describe the training, technical assistance and social marketing strategies that will be used to support the development of the system of care.
- Explain how the initiative will increase the capacity and quality of services delivered to children and youth with serious mental health needs. State the number of children and youth expected to be served annually in the system of care and the number of children and youth to be served through specific key services such as care management, intensive home-based services, crisis intervention, day treatment, therapeutic foster care and respite care. Indicate how these services will address racial, ethnic, geographic or other cultural disparities.
- Describe your relationship with and involvement of individuals from the following constituent groups and their role if any in the development of the project;

  - State and local child-serving agencies and community leaders;
  - Family members and family-run organizations and advocates;
  - Youth;
  - Racial, ethnic and other cultural groups in the community. [Note: These may include youth from the population of focus, family members, service providers or community leaders.]

- Discuss the extent to which the nonfederal match dollars demonstrates interagency collaboration through contributions from different child-serving agencies or other organizations.
- Include in Appendix 2 a letter of assurance from the Governor or the Governor's designee (Indian and tribal organizations are exempt from this requirement).

Service Delivery (25 points)

- Specify eligibility criteria, referral sources and enrollment procedures that will be used for creating efficient access into the service delivery system. Identify whether a priority population will be served.
- Explain how the service components will be developed, implemented, funded and sustained throughout the 6-year grant period and beyond the expiration of the cooperative agreement:

  - Required mental health services and supports; [See Note below]
  - Optional services; and

- Non-mental health services.

[Note: Eligible applicants intending to request a waiver of one or more service requirements must document in their application their intended service array with an explanation of services they will not be providing (see Section I-2.4.1)]. Among the non-mental health services, the applicant must specify programmatic and fiscal strategies for incorporating into the individualized service plan: (1) substance abuse treatment services for adolescents with a co-occurring disorder; (2) substance abuse prevention interventions for pre-adolescents with serious mental health needs; (3) primary health services for children and youth with a co-occurring childhood mental disorder and chronic health condition; and (4) literacy interventions specific for children and youth with serious mental health needs.

- Describe the strategies to implement key service activities including:

Delivery of Clinical Interventions

- Describe procedures for diagnostic and treatment planning and how these procedures will match the specific mental health needs of the child with the most appropriate treatment or combination of treatments within the cultural context of the child or youth;
- Demonstrate how the proposed services will be community-based;
- Describe how clinical assessments will be conducted in a manner that recognizes gender and cultural differences in the diagnosis of overt behaviors and the evaluation of presenting problems;
- Describe how the initiative will address the training needs of clinicians, including the delivery of evidenced-based treatments and appropriate application of DSM-IV diagnostic categories;

- Describe how the initiative will incorporate one or more evidence-based interventions, which are defined as treatments that have been scientifically studied and found to produce positive outcomes in children and youth. In addition, describe any adaptations that will be made to the evidence-based interventions to address service delivery for racial, ethnic and other cultural populations. There also should be a description of how these evidence-based interventions will become integrated into the individualized service plan and the process utilized to develop the plan for children and youth with serious mental health needs for whom the evidence-based interventions apply. Practice-based interventions, which are often developed within diverse communities as interventions with culturally and linguistically diverse children, youth and their families, should also be described. (See Appendix I, Using Evidenced-Based Practices.)

Care Coordination/ Individual Service Plans

- Describe how the care coordination efforts will reflect the individualized needs of each child, adolescent and family.
- Describe how service providers will receive specific training and supervision related to the process used to develop the plan and care management service approaches.
- Articulate how individualized service plans will be developed and how they will build upon the existing strengths and needs of the child and the child's family.
- Describe how individualized service plans will act in 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).
- Describe how individualized service plans will act in 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).
- Describe how the individualized service plan will address the following components:

  - Description of the need for services;
  - Recognition of existing strengths of the child and the child's family;
  - Development of objectives that meet the needs and build upon the existing strengths of the child and the child's family;
  - Development of customized interventions for the child and the child's family if the child's history indicates that the child is at risk for suicide (e.g., previous suicide attempt(s), reported suicidal ideation);
  - Development of a methodology for meeting these objectives;
  - Provision of non-mental health services, as appropriate; and
  - Designation of the lead agency responsible for care management/coordination of services.

- Describe the quality assurance process for review of the appropriateness of services in the individualized service plan and how revisions and updates will be made. This should include ability to review plans at least quarterly.
- Describe any grievance processes that will be used and how youth and families can appeal decisions made about service delivery.

- **Describe Family-Driven Care**

  - Describe how family partnerships will occur and be demonstrated in planning, implementing and evaluating the initiative.
  - Indicate if there is a CMHS-funded Statewide Family Network grantee in your State and if so, how you will involve them in the initiative. Tribes are excluded from this requirement.
  - Describe how the initiative will provide financial support to sustain the family/consumer organization as a means to ensure family involvement in the system of care throughout the duration of the initiative and beyond the Federal funding period.
  - Describe plans for incentives for families whose children are eligible for services, as well as the existing family organizations whose focus is on these children and families. The purpose of such support is to enable family members and family organizations to participate in activities related to the development, implementation, evaluation and sustainability of the system of care. See Appendix G, Funding Restrictions for allowable incentives.

- **Describe Youth Guided Care**

  - Describe how youth partnership and participation will be demonstrated in planning, implementing and evaluating the initiative. Be attentive to developmental stages and cultural and linguistic norms regarding the role of youth in communities and families.
  - Identify an individual to serve as the full-time youth coordinator in the system of care. Duties of the *youth coordinator* should, at a minimum, include helping to form an organized group among youth receiving services as well as reaching out to eligible youth who are not receiving services; support youth and advocate for their participation on governance boards and other decision-making bodies; coordinate the development of a youth-run group in the community, specifically for those youth with serious mental health needs and advocate for increased authentic youth involvement within the system of care and the broader community.
  - Describe how the initiative will create a strong partnership between professionals and youth to participate in the planning, management and evaluation of the system of care.

- **Explain how cultural and linguistic competence and responsiveness will be addressed within the system of care, including how the initiative will:**

- Comply with Title VI of the Civil Rights Act.
- Comply with cultural and linguistic competence standards, included in Appendix K.
- Incorporate culturally and linguistically appropriate practices in the individualized service plan. Examples include using the preferred language of the child or youth and their family during service delivery; nurturing the strengths and customs of the child or youth and their family that are part of their cultural or religious heritage; and recognizing behaviors and beliefs of the child or youth and their family that are normal in their culture.
- Describe how individuals from racial, ethnic or other cultural and linguistic groups in the community will be invited to participate in activities of such systems-of-care entities as the governing body, administrative team, care review group and individualized care team. Also describe a plan to sustain the involvement of these individuals and how these individuals will serve as advocates for children, youth and families representative of diverse cultural and ethnic groups.
- Provide 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, race, ethnicity and culture.
- Explain how services available through the system of care will include service providers representing the racial and ethnic composition of the community and other cultural groups within the community.
- Explain how disparities in access to care will be addressed, as well as disparities related to quality of mental health services, availability of effective clinical interventions, satisfaction with services and other systems-of-care outcomes for children and their families from racial or ethnic minority groups.
- Develop plans for service provision that: (1) reflect the cultural and linguistic context preferred by the child or youth and their family; and (2) ensure that there is no discrimination against the child or youth and their family on the basis of race, religion, national origin, gender, sexual orientation, disability or age (i.e., for the child, age 21 years or younger).
- Identify an individual to serve as the cultural competence coordinator, recommended as at least a halftime (.5 FTE) position.
- Develop strategies and create the infrastructure to promote and advance cultural and linguistic competence at the organizational and system levels.

Sustainability/Linkages with Statewide Transformation Efforts and Other Relevant Federally-Funded Programs (15 Points)

- Indicate how the primary goals and objectives of the initiative link with transformation and Statewide reform efforts and how they address the priorities identified in this announcement. Provide specific examples of how linkages and partnerships will be established and maintained with key State personnel.

- Discuss strategies for ensuring project sustainability after the sixth year of the cooperative agreement through amounts and sources of nonfederal match contributions. These should include an approach to sustaining the vision and philosophy, the service array, management and coordination, human resources and training, as well as financing approaches. Indicate the extent to which services provided through the system of care will be paid through Medicaid and other public or private insurance.
- Explain how the initiative will coordinate with other relevant federally funded initiatives, such as the Mental Health Block Grant Program, Safe Schools/Healthy Students Program, Child and Adolescent Mental Health and Substance Abuse State Infrastructure Grants, etc.

Section C: Project Management and Staffing Plan (15 Points)

- Discuss the capability and experience of the applicant organization and other participating organizations with similar projects and populations. Demonstrate that the applicant organization and other participating organizations have linkages to the population of focus and ties to grassroots/community-based organizations that are rooted in the culture and language of the population of focus.
- Provide a complete list of staff positions for the project, showing the role of each and their level of effort and qualifications. Include the Project Director and other key personnel, such as treatment/prevention personnel.
- Discuss how key staff have demonstrated experience in serving the population of focus and are familiar with the culture and language of the target population. If the population of focus is multicultural and multilinguistic, describe how the staff are qualified to serve this population.
- Describe the resources available for the proposed project (e.g., facilities, equipment) and provide evidence that services will be provided in a location that is adequate, accessible, compliant with the Americans with Disabilities Act (ADA) and amenable to the target population. If the ADA does not apply to your organization, please explain why.

Section D: Evaluation Plan (15 Points)

- Describe the evaluation activities and procedures that will ensure successful implementation of the National Evaluation of the Comprehensive Community Mental Health Services Program for Children and Their Families and indicate your agreement to comply with the terms and conditions.
- Describe how data derived from the National Evaluation will be used for:

  - Improving the service system,
  - Increasing the quality of service delivery,
  - Developing systems of care policies in the local community, and
  - Sustaining the system of care beyond the 6-year period of Federal funding.

- Document your ability to collect and report on the required performance measures as specified in Section I-2.5 of this RFA. Describe your plan for data collection, management, analysis and reporting. Specify and justify any additional measures or instruments you plan to use for your grant project.
- Describe how data will be used to manage the project and assure continuous quality improvement.
- Describe your plan for conducting the performance assessment as specified in Section I-2.6 of this RFA and document your ability to conduct the assessment.

NOTE: Although the budget for the proposed project is not a scored review criterion, the Review Group will be asked to comment on the appropriateness of the budget after the merits of the application have been considered.

SUPPORTING DOCUMENTATION

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

Section F: Budget Justification, Existing Resources, Other Support. You must provide a narrative justification of the items included in your proposed budget, as well as a description of existing resources and other support you expect to receive for the proposed project. Be sure to show that no more than 15% of the total grant award will be used for infrastructure development, if necessary and that no more than 20% of the total grant award will be used for data collection and performance assessment. An illustration of a budget and narrative justification is included in Appendix H of this document.

Section G: **Biographical Sketches and Job Descriptions**.

- Include a biographical sketch for the Project Director and other key positions. Each sketch should be 2 pages or less. If the person has not been hired, include a position description and/or a letter of commitment with a current biographical sketch from the individual.
- Include job descriptions for key personnel. Job descriptions should be no longer than 1 page each.
- Information on what should be included in biographical sketches and job descriptions can be found on page 22, Item 6, in the Program Narrative section of the PHS 5161-1 instruction page, available on the SAMHSA Web site.

Section H: Confidentiality and SAMHSA Participant Protection/Human Subjects: You must describe procedures relating to Confidentiality, Participant Protection and the Protection of Human Subjects Regulations in Section I of your application, using the guidelines provided below. More detailed guidance for completing this section can be found in Appendix F of this RFA.

Confidentiality and Participant Protection:

Because of the confidential nature of the work in which many SAMHSA grantees are involved, it is important to have safeguards protecting individuals from risks associated with their participation in SAMHSA projects. All applicants must address the eight bullets below. If some are not applicable or relevant to the proposed project, simply state that they are not applicable and indicate why. In addition to addressing these eight bullets, read the section that follows entitled Protection of Human Subjects Regulations to determine if the regulations may apply to your project. If so, you are required to describe the process you will follow for obtaining Institutional Review Board (IRB) approval. While we encourage you to keep your responses brief, there are no page limits for this section and no points will be assigned by the Review Committee. Problems with confidentiality, participant protection and the protection of human subjects identified during peer review of the application must be resolved prior to funding.

- Identify foreseeable risks or adverse effects due to participation in the project and/or in the data collection (performance assessment) activities (including physical, medical, psychological, social, legal, and confidentiality) and provide your procedures for minimizing or protecting participants from these risks.

- Identify plans to provide guidance and assistance in the event there are adverse effects to participants.

- Describe the target population and explain why you are including or excluding certain subgroups. Explain how and who will recruit and select participants.

- State whether participation in the project is voluntary or required. If you plan to provide incentives/compensate participants, specify the type (e.g., money, gifts, coupons) and the value of any such incentives. Provide justification that the use of incentives is appropriate, judicious and conservative and that incentives do not provide an "undue inducement" which removes the voluntary nature of participation. Incentives should be the minimum amount necessary to meet the programmatic and performance assessment goals of the grant. Applicants should determine the minimum amount that is proven to be effective by consulting with existing local programs and reviewing the relevant literature. In no case may the value of an incentive paid for with SAMHSA discretionary grant funds exceed $20. (See Appendix G, Funding Restrictions.)

- Describe data collection procedures, including sources (e.g., participants, school records) and the data collecting setting (e.g., clinic, school). Provide copies of proposed data collection instruments and interview protocols in **Appendix 3** of your application, "Data Collection Instruments/Interview Protocols." State whether specimens such as urine and/or blood will be obtained and the purpose for collecting the specimens. If applicable, describe how the specimens and process will be monitored to ensure both the safety of participants and the integrity of the specimens.

- Explain how you will ensure privacy and confidentiality of participants' records, data collected, interviews and group discussions. Describe where the data will be stored, safeguards (e.g., locked, coding systems, storing identifiers separate from data) and who will have access to the information.

–   Describe the process for obtaining and documenting consent from adult participants and assent from minors along with consent from their parents or legal guardians. Provide copies of all consent forms in **Appendix 4** of your application, "Sample Consent Forms." If needed, give English translations.

–   Discuss why the risks are reasonable compared to expected benefits from the project.

Protection of Human Subjects Regulations

SAMHSA expects that most grantees funded under this announcement will not have to comply with the Protection of Human Subjects Regulations (45 CFR 46), which requires Institutional Review Board (IRB) approval. However, in some instances, the applicant's proposed performance assessment design may meet the regulation's criteria of research involving human subjects. Applicants whose projects must comply with the Human Subjects Regulations must, in addition to the bullets above, fully describe the process for obtaining IRB approval. While IRB approval is not required at the time of grant award, these grantees will be required, as a condition of award, to provide documentation that an Assurance of Compliance is on file with the Office for Human Research Protections (OHRP). IRB approval must be received in these cases prior to enrolling clients in the project. General information about Human Subjects Regulations can be obtained through OHRP at http://www.hhs.gov/ohrp or ohrp@osophs.dhhs.gov or (240) 453-6900. SAMHSA–specific questions should be directed to the program contact listed in Section VII of this announcement.

2.   REVIEW AND SELECTION PROCESS

SAMHSA applications are peer-reviewed according to the evaluation criteria listed above. For those programs where the individual award is over $100,000, applications also must be reviewed by the Center for Mental Heath Services National Advisory Council.

Decisions to fund a grant are based on:

- the strengths and weaknesses of the application as identified by peer reviewers and when applicable, approved by the Center for Mental Health Services' National Advisory Council;
- availability of funds; and
- equitable distribution of awards in terms of geography (including urban, rural and remote settings) and balance among populations of focus and program size.

VI.   ADMINISTRATION INFORMATION

1.   AWARD NOTICES

After your application has been reviewed, you will receive a letter from SAMHSA through postal mail that describes the general results of the review, including the score that your application received.

If you are approved for funding, you will receive an **additional** notice through postal mail, the Notice of Award, signed by SAMHSA's Grants Management Officer. The Notice of Award is the sole obligating document that allows you to receive Federal funding for work on the grant project.

If you are not funded, you may re-apply if there is another receipt date for the program.

2.   ADMINISTRATIVE AND NATIONAL POLICY REQUIREMENTS

- If your application is funded, you must comply with all terms and conditions of the grant award. SAMHSA's standard terms and conditions are available on the SAMHSA Web site at http://www.samhsa.gov/grants/management.aspx.
- If your application is funded, you must also comply with the administrative requirements outlined in 45 CFR Part 74 or 45 CFR Part 92, as appropriate. For more information see the SAMHSA Web site (http://www.samhsa.gov/grants/management.aspx).
- Depending on the nature of the specific funding opportunity and/or your proposed project as identified during review, SAMHSA may negotiate additional terms and conditions with you prior to grant award. These may include, for example:

  - actions required to be in compliance with confidentiality and participant protection/human subjects requirements;
  - requirements relating to additional data collection and reporting;
  - requirements relating to participation in a cross-site evaluation; or
  - requirements to address problems identified in review of the application.

- If your application is funded, you will be held accountable for the information provided in the application relating to performance targets. SAMHSA program officials will consider your progress in meeting goals and objectives, as well as your failures and strategies for overcoming them, when making an annual recommendation to continue the grant and the amount of any continuation award. Failure to meet stated goals and objectives may result in suspension or termination of the grant award or in reduction or withholding of continuation awards.
- Grant funds cannot be used to supplant current funding of existing activities. "Supplant" is defined as replacing funding of a recipient's existing program with funds from a Federal grant.
- In an effort to improve access to funding opportunities for applicants, SAMHSA is participating in the U.S. Department of Health and Human Services "Survey on Ensuring Equal Opportunity for Applicants." This survey is included in the application kit for SAMHSA grants and is posted on the SAMHSA Web site. You are encouraged to complete the survey and return it, using the instructions provided on the survey form.

3.   REPORTING REQUIREMENTS

In addition to the data reporting requirements listed in Section I-2.6, you must comply with the following reporting requirements:

3.1.   Progress and Financial Reports

- CMHI grantees must provide bi-annual and final progress reports. The final progress report must summarize information from the annual reports, describe the accomplishments of the project and describe next steps for implementing plans developed during the grant period.
- Grantees must provide annual and final financial status reports. These reports may be included as separate sections of annual and final progress reports or can be separate documents. Because SAMHSA is extremely interested in ensuring that infrastructure development and enhancement efforts can be sustained, your financial reports must explain plans to ensure the sustainability of efforts initiated under this grant. Initial plans for sustainability should be described in year 1 of the grant. In each subsequent year, you should describe the status of the initiative, successes achieved and obstacles encountered in that year.
- SAMHSA will provide guidelines and requirements for these reports to grantees at the time of award and at the initial grantee orientation meeting after award. SAMHSA staff will use the information contained in the reports to determine the grantee's progress toward meeting its goals.

3.2.   Government Performance and Results Act (GPRA)

The Government Performance and Results Act (GPRA) mandates accountability and performance-based management by Federal agencies. To meet the GPRA requirements, SAMHSA must collect performance data (i.e., "GPRA data") from grantees. The performance requirements for SAMHSA's CMHI grant program are described in Section I-2.6 of this document under "Data Collection and Performance Measurement."

3.3.   Publications

If you are funded under this grant program, you are required to notify the Government Project Officer (GPO) and SAMHSA's Publications Clearance Officer (240-276-2130) of any materials based on the SAMHSA-funded grant project that are accepted for publication.

In addition, SAMHSA requests that grantees:

- Provide the GPO and SAMHSA Publications Clearance Officer with advance copies of publications.
- Include acknowledgment of the SAMHSA grant program as the source of funding for the project.
- Include a disclaimer stating that the views and opinions contained in the publication do not necessarily reflect those of SAMHSA or the U.S. Department of Health and Human Services and should not be construed as such.

SAMHSA reserves the right to issue a press release about any publication deemed by SAMHSA to contain information of program or policy significance to the substance abuse treatment/substance abuse prevention/mental health services community.

VII. AGENCY CONTACTS

- For questions about program issues contact:
  Diane L. Sondheimer
  Deputy Chief
  Child, Adolescent and Family Branch
  Division of Service and System Improvement
  1 Choke Cherry Road
  Room 6-1043
  Rockville, Maryland 20857
  Phone: (240) 276-1980
  Fax: (240) 276-1930
  diane.sondheimer@samhsa.hhs.gov
  or
  Gary M. Blau, Ph.D.
  Chief
  Child, Adolescent and Family Branch
  Division of Service and System Improvement
  1 Choke Cherry Road
  Room 6-1041
  Rockville, Maryland 20857
  Phone: (240) 276-1980
  Fax: (240) 276-1930
  gary.blau@samhsa.hhs.gov

For questions on grants management issues contact:

Gwendolyn Simpson
Office of Program Services, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Room 7-1085
Rockville, Maryland 20857
(240) 276-1408
gwendolyn.simpson@samhsa.hhs.gov

Technical Assistance Webinars

SAMHSA/CMHS intends to sponsor a series of Webinars (linking telephone and Web-based presentations) to provide technical assistance on the preparation of applications for the CMHI. Prospective applicants are invited to register at the following address:

http://www.tapartnership.org/learning_opp/RFAworkshops.asp.

For more information about these Webinars, please contact:

Sharron Hunt
Deputy Director
Technical Assistance Partnership for Child and Family Mental Health
202-403-6914 (office) shunt@air.org

APPENDICES

Appendix A – Checklist for Formatting Requirements and Screenout Criteria for SAMHSA Grant Applications

*SAMHSA's goal is to review all applications submitted for grant funding. However, this goal must be balanced against SAMHSA's obligation to ensure equitable treatment of applications. For this reason, SAMHSA has established certain formatting requirements for its applications. **If you do not adhere to these requirements, your application will be screened out and returned to you without review.***

- Use the PHS 5161-1 application form.

- Applications must be received by the application due date and time, as detailed in Section IV-3 of this grant announcement.

- Information provided must be sufficient for review.

- Text must be legible. Pages must be typed in black ink, single-spaced, using a font of Times New Roman 12, with all margins (left, right, top, bottom) at least one inch each. (For Project Narratives submitted electronically, see separate requirements in Section IV-6 of this announcement under "Submission of Electronic Applications.")

- To ensure equity among applications, page limits for the Project Narrative cannot be exceeded.

- Paper must be white paper and 8.5 inches by 11.0 inches in size.

To facilitate review of your application, follow these additional guidelines. Failure to adhere to the following guidelines will not, in itself, result in your application being screened out and returned without review. However, the information provided in your application must be sufficient for review. Following these guidelines will help ensure your application is complete, and will help reviewers to consider your application.

- The 10 application components required for SAMHSA applications should be included and submitted in the following order:

  - Face Page (Standard Form 424 v2, which is in PHS 5161-1)
  - Abstract
  - Table of Contents
  - Budget Form (Standard Form 424A, which is in PHS 5161-1)
  - Project Narrative and Supporting Documentation
  - Appendices
  - Assurances (Standard Form 424B, which is in PHS 5161-1)
  - Certifications

- Disclosure of Lobbying Activities (Standard Form LLL, which is in PHS 5161-1)
- Checklist (a form in PHS 5161-1)

_ Applications should comply with the following requirements:

- Provisions relating to confidentiality and participant protection specified in Section V-1 of this announcement.
- Budgetary limitations as specified in Sections I, II, and IV-5 of this announcement.
- Documentation of nonprofit status as required in the PHS 5161-1.

_ Pages should be typed single-spaced in black ink with one column per page. Pages should not have printing on both sides.

_ Pages should be numbered consecutively from beginning to end so that information can be located easily during review of the application. The abstract page should be page 1, the table of contents should be page 2, etc. The four pages of Standard form 424 v2 are not to be numbered. Appendices should be labeled and separated from the Project Narrative and budget section, and the pages should be numbered to continue the sequence.

_ The page limits for Appendices stated in Section IV-2.2 of this announcement should not be exceeded.

_ Send the original application and two copies to the mailing address in Section IV-6 of this document. Please do not use staples, paper clips, and fasteners. Nothing should be attached, stapled, folded or pasted. Do not use heavy or lightweight paper or any material that cannot be copied using automatic copying machines. Odd-sized and oversized attachments such as posters will not be copied or sent to reviewers. Do not include videotapes, audiotapes, or CD-ROMs.

Appendix B – Guidance for Electronic Submission of Applications

If you would like to submit your application electronically, you may search www.Grants.gov for the downloadable application package by the funding announcement number (called the opportunity number) or by the Catalogue of Federal Domestic Assistance (CFDA) number. You can find the CFDA number on the first page of the funding announcement.

You must follow the instructions in the User Guide available at the www.Grants.gov apply site, on the Help page. In addition to the User Guide, you may wish to use the following sources for help:

- By e-mail: support@Grants.gov
- By phone: 1-800-518-4726 (1-800-518-GRANTS). The Customer Support Center is open from 7:00 a.m. to 9:00 p.m. Eastern Time, Monday through Friday, excluding Federal holidays.

If this is the first time you have submitted an application through Grants.gov, you must complete four separate registration processes before you can submit your application. Allow at least two weeks (10 business days) for these registration processes, prior to submitting your application. The processes are: 1) DUNS Number registration; 2) Central Contractor Registry (CCR) registration; 3) Credential Provider registration; and 4) Grants.gov registration.

It is strongly recommended that you submit your grant application using Microsoft Office 2003 products (e.g., Microsoft Word 2003, Microsoft Excel, etc.). The new Microsoft Vista operating system and Microsoft Word 2007 products are not currently accepted by Grants.gov. If you do not have access to Microsoft Office 2003 products, you may submit PDF files. Directions for creating PDF files can be found on the Grants.gov Web site. Use of file formats other than Microsoft Office or PDF may result in your file being unreadable by our staff.

The Project Narrative must be a separate document in the electronic submission. Formatting requirements for SAMHSA grant applications are described in Appendix A of this announcement. These requirements also apply to applications submitted electronically, with the following exceptions only for Project Narratives submitted electronically in Microsoft Word. These requirements help ensure the accurate transmission and equitable treatment of applications.

- *Text legibility*: Use a font of Times New Roman 12, line spacing of single space, and all margins (left, right, top, bottom) of at least one inch each. Adhering to these standards will help to ensure the accurate transmission of your document.

- *Amount of space allowed for Project Narrative*: The Project Narrative for an electronic submission may not exceed 20,600 words. **If the Project Narrative for an electronic submission exceeds the word limit, the application will be screened out and will not be reviewed.** To determine the number of words in your Project Narrative document in Microsoft Word, select file/properties/statistics.

Keep the Project Narrative as a separate document. Please consolidate all other materials in your application to ensure the fewest possible number of attachments. Be sure to label each file according to its contents, e.g., "Appendices 1-3", "Appendices 4-5."

Ensure all pages in your application are numbered consecutively, with the exception of the standard forms in the PHS-5161 application package. **Documents containing scanned images must also contain page numbers to continue the sequence.** Failure to comply with these requirements may affect the successful transmission and consideration of your application.

Applicants are strongly encouraged to submit their applications to Grants.gov early enough to resolve any unanticipated difficulties prior to the deadline. After you electronically submit your application, you will receive an automatic acknowledgement from Grants.gov that contains a Grants.gov tracking number. It is important that you retain this number. **Receipt of the tracking number is the only indication that Grants.gov has successfully received and validated your application. If you do not receive a Grants.gov tracking number, you may want to contact the Grants.gov help desk for assistance.**

The Grants.gov Web site does not accept electronic signatures at this time. Therefore, you must submit a signed paper original of the face page (SF 424 v2), the assurances (SF 424B), and hard copy of any other required documentation that cannot be submitted electronically. **You must include the Grants.gov tracking number for your application on these documents with original signatures, on the top right corner of the face page, and send the documents to the following address. The documents must be received at the following address within 5 business days after your electronic submission.** Delays in receipt of these documents may impact the score your application receives or the ability of your application to be funded.

For United States Postal Service:

Crystal Saunders, Director of Grant Review
Office of Program Services
Substance Abuse and Mental Health Services Administration
Room 3-1044
1 Choke Cherry Road
Rockville, MD **20857**
ATTN: Electronic Applications

For other delivery services, change the zip code to 20850.

If you require a phone number for delivery, you may use (240) 276-1199.

Appendix C - Statement of Assurance

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

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

_____   _____
Signature of Authorized Representative   Date

Appendix D – Sample Logic Model

A Logic Model is a tool to show how your proposed project links the purpose, goals, objectives, and tasks stated with the activities and expected outcomes or "change" and can help to plan, implement, and assess your project. The model also links the purpose, goals, objectives, and activities back into planning and evaluation. A Logic Model is a *picture* of your project. It graphically shows the activities and progression of the project. It should also describe the relationships among what resources you put in (inputs), what you do (outputs), and what happens or results (outcomes). Based on both your planning and evaluating activities, you can then make a "logical" chain of "if-then" relationships.

Look at the graphic on the following page to see the chain of events that links the inputs to program components, the program components to outputs, and the outputs to outcomes (goals).

The framework you set up to build your model is based on a review of your Statement of Need, in which you state the conditions that gave rise to the project with your target group. Then you look at the Inputs, which are the resources, contributions, time, staff, materials, and equipment you will invest to change these conditions. These inputs then are organized into the Program Components, which are the activities, services, interventions and tasks that will reach the population of focus. These outputs then are intended to create Outputs such as changes or benefits for the consumer, families, groups, communities, organizations and SAMHSA. The understanding and further evidence of what works and what does not work will be shown in the Outcomes, which include achievements that occur along the path of project operation.

Examples of **Inputs** (resources) depicted in the sample logic model include people (e.g., staff hours, volunteer hours), funds and other resources (e.g., facilities, equipment, community services).

Examples of **Program Components** (activities) depicted in the sample logic model include outreach; intake/assessment (e.g., client interview); treatment planning/treatment by type (e.g., methadone maintenance, weekly 12-step meetings, detoxification, counseling sessions, relapse prevention, crisis intervention); special training (e.g., vocational skills, social skills, nutrition, child care, literacy, tutoring, safer sex practices); other services (e.g., placement in employment, prenatal care, child care, aftercare); and program support (e.g., fundraising, long-range planning, administration, public relations).

Examples of **Outputs** (objectives) depicted in the logic model include waiting list length, waiting list change, client attendance, and client participation; number of clients, including those admitted, terminated, inprogram, graduated and placed; number of sessions per month and per client/month; funds raised; number of volunteer hours/month; and other resources required.

The **Inputs, Program Components** and **Outputs** all lead to the **Outcomes** (goals). Examples of Outputs depicted in the logic model include inprogram (e.g., client satisfaction, client retention); and in or postprogram (e.g., reduced drug use-self reports, urine, hair; employment/school progress; psychological status; vocational skills; safer sexual practices; nutritional practices; child care practices; and reduced delinquency/crime.

[Note: The logic model presented is not a required format and SAMHSA does not expect strict adherence to this format. It is presented only as a sample of how you can present a logic model in your application.]

Sample Logic Model

Resources (Inputs)		Program Components (Activities)		Outputs (Objectives)		Outcomes (Goals)
Examples	→	**Examples**	→	**Examples**	→	**Examples**

Resources (Inputs) Examples	Program Components (Activities) Examples	Outputs (Objectives) Examples	Outcomes (Goals) Examples

People
    Staff – hours
    Volunteer – hours
 	
Funds
 	
Other resources
    Facilities
    Equipment
    Community services
	Outreach
	Intake/Assessment
	    Client Interview
	
	Treatment Planning
	    Treatment by type:
	        Methadone maintenance
	        Weekly 12-step meetings
	        Detoxification
	        Counseling sessions
	        Relapse prevention
	        Crisis intervention
	
	Special Training
	    Vocational skills
	    Social skills
	    Nutrition
	    Child care
	    Literacy
	    Tutoring
	    Safer sex practices
	
	Other Services
	    Placement in employment
	    Prenatal care
	    Child care
	    Aftercare
	
	Program Support
	    Fundraising
	    Long-range planning
	    Administration
	    Public Relations
		Waiting list length
		Waiting list change
		Client attendance
		Client participation
		
		Number of Clients:
		    Admitted
		    Terminated
		    Inprogram
		    Graduated
		    Placed
		
		Number of Sessions:
		    Per month
		    Per client/month
		
		Funds raised
		Number of volunteer hours/month
		
		Other resources required
			Inprogram:
			    Client satisfaction
			    Client retention
			
			In or postprogram:
			    Reduced drug use – self
			        reports, urine, hair
			    Employment/school
			        progress
			    Psychological status
			    Vocational skills
			    Social skills
			    Safer sexual practices
			    Nutritional practices
			    Child care practices
			    Reduced delinquency/crime

Appendix E – Logic Model Resources

Chen, W.W., Cato, B.M., & Rainford, N. (1998-9). Using a logic model to

plan and evaluate a community intervention program: A case study. *International Quarterly of Community Health Education*, *18*(4), 449-458.

Edwards, E.D., Seaman, J.R., Drews, J., & Edwards, M.E. (1995). A community approach for Native American drug and alcohol prevention programs: A logic model framework. *Alcoholism Treatment Quarterly*, *13*(2), 43-62.

Hernandez, M. & Hodges, S. (2003). *Crafting Logic Models for Systems of Care: Ideas into Action*. [Making children's mental health services successful series, volume 1]. Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute, Department of Child & Family Studies. http://cfs.fmhi.usf.edu or phone (813) 974-4651

Hernandez, M. & Hodges, S. (2001).   Theory-based accountability. In M. Hernandez & S. Hodges (Eds.), *Developing Outcome Strategies in Children's Mental Health*, pp. 21-40. Baltimore: Brookes.

Julian, D.A. (l997). Utilization of the logic model as a system level planning and evaluation device. *Evaluation and Planning, 20*(3), 251-257.

Julian, D.A., Jones, A., & Deyo, D. (1995). Open systems evaluation and the

logic model: Program planning and evaluation tools. *Evaluation and Program*

Planning, 18(4), 333-341.

Patton, M.Q. (1997). *Utilization-Focused Evaluation* (3rd Ed.), pp. 19, 22,

241. Thousand Oaks, CA: Sage.

Wholey, J.S., Hatry, H.P., Newcome, K.E. (Eds.) (1994). *Handbook of Practical Program Evaluation.* San Francisco, CA: Jossey-Bass Inc.

Appendix F – Confidentiality and Participant Protection

1. Protect Clients and Staff from Potential Risks
   - Identify and describe any foreseeable physical, medical, psychological, social, and legal risks or potential adverse effects as a result of the project itself or any data collection activity.
   - Describe the procedures you will follow to minimize or protect participants against potential risks, **including risks to confidentiality**.
   - Identify plans to provide guidance and assistance in the event there are adverse effects to participants.
   - Where appropriate, describe alternative treatments and procedures that may be beneficial to the participants. If you choose not to use these other beneficial treatments, provide the reasons for not using them.
2. Fair Selection of Participants
   - Describe the target population(s) for the proposed project. Include age, gender, and racial/ethnic background and note if the population includes homeless youth, foster children, children of substance abusers, pregnant women or other targeted groups.
   - Explain the reasons for including groups of pregnant women, children, people with mental disabilities, people in institutions, prisoners and individuals who are likely to be particularly vulnerable to HIV/AIDS.
   - Explain the reasons for including or excluding participants.
   - Explain how you will recruit and select participants. Identify who will select participants.
3. Absence of Coercion
   - Explain if participation in the project is voluntary or required. Identify possible reasons why participation is required, for example, court orders requiring people to participate in a program.
   - If you plan to compensate participants, state how participants will be awarded incentives (e.g., money, gifts, etc.). Provide justification that the use of incentives is appropriate, judicious, and conservative and that incentives do not provide an "undue inducement" which removes the voluntary nature of participation. Incentives should be the minimum amount necessary to meet the programmatic and performance assessment goals of the grant. Applicants should determine the minimum amount that is proven effective by consulting with existing local programs and reviewing the relevant literature. In no case may the value if an incentive paid for with SAMHSA discretionary grant funds exceed $20.
   - State how volunteer participants will be told that they may receive services intervention even if they do not participate in or complete the data collection component of the project.
4. Data Collection

   - Identify from whom you will collect data (e.g., from participants themselves, family members, teachers, others). Describe the data collection procedures and specify the sources for obtaining data (e.g., school records, interviews, psychological assessments, questionnaires, observation, or other sources). Where data are to be collected through

observational techniques, questionnaires, interviews or other direct means, describe the data collection setting.

- Identify what type of specimens (e.g., urine, blood) will be used, if any. State if the material will be used just for evaluation or if other use(s) will be made. Also, if needed, describe how the material will be monitored to ensure the safety of participants.
- Provide in **Appendix 3, "Data Collection Instruments/Interview Protocols,"** copies of all available data collection instruments and interview protocols that you plan to use.

5. Privacy and Confidentiality
- Explain how you will ensure privacy and confidentiality. Include who will collect data and how it will be collected.
- Describe:
  o How you will use data collection instruments.
  o Where data will be stored.
  o Who will or will not have access to information.
  o How the identity of participants will be kept private, for example, through the use of a coding system on data records, limiting access to records, or storing identifiers separately from data.

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

6. <u>Adequate Consent Procedures</u>
   - List what information will be given to people who participate in the project. Include the type and purpose of their participation. Identify the data that will be collected, how the data will be used and how you will keep the data private.
   - State:
     o Whether or not their participation is voluntary.
     o Their right to leave the project at any time without problems.
     o Possible risks from participation in the project.
     o Plans to protect clients from these risks.
   - Explain how you will get consent for youth, the elderly, people with limited reading skills and people who do not use English as their first language.

NOTE: If the project poses potential physical, medical, psychological, legal, social or other risks, you **must** obtain <u>written</u> informed consent.
   - Indicate if you will obtain informed consent from participants or assent from minors along with consent 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, as appropriate, sample consent forms that provide for: (1) informed consent for participation in service intervention; (2) informed consent for participation in the data collection component of the project; and (3) informed consent for the exchange (releasing or requesting) of confidential information. The sample forms must be included in **Appendix 4, "Sample Consent Forms"**, of your application. If needed, give English translations.

NOTE: Never imply that the participant waives or appears to waive any legal rights, may not end involvement with the project, or releases your project or its agents from liability for negligence.
   - Describe if separate consents will be obtained for different stages or parts of the project. For example, will they be needed for both participant protection in treatment intervention and for the collection and use of data?
   - Additionally, if other consents (e.g., consents to release information to others or gather information from others) will be used in your project, provide a description of the consents. Will individuals who do not consent to having individually identifiable data collected for evaluation purposes be allowed to participate in the project?

7. Risk/Benefit Discussion
    Discuss why the risks are reasonable compared to expected benefits and importance of the
    knowledge from the project.

Protection of Human Subjects Regulations

Applicants may also have to comply with the Protection of Human Subjects Regulations (45
CFR 46), depending on the evaluation and data collection procedures proposed and the
population to be served.

Applicants must be aware that even if the Protection of Human Subjects Regulations do not
apply to all projects funded, the specific performance assessment design proposed by the
applicant may require compliance with these regulations.

Applicants whose projects must comply with the Protection of Human Subjects Regulations must
describe the process for obtaining Institutional Review Board (IRB) approval fully in their
applications. While IRB approval is not required at the time of grant award, these applicants will
be required, as a condition of award, to provide the documentation that an Assurance of
Compliance is on file with the Office for Human Research Protections (OHRP) and that IRB
approval has been received prior to enrolling any clients in the proposed project.

General information about Protection of Human Subjects Regulations can be obtained on the
Web at http://www.hhs.gov/ohrp. You may also contact OHRP by e-mail
(ohrp@osophs.dhhs.gov) or by phone (240/453-6900). SAMHSA-specific questions related to
Protection of Human Subjects Regulations should be directed to the program contact listed in
Section VII of this RFA.

Appendix G – Funding Restrictions

SAMHSA grant funds must be used for purposes supported by the program and may not be used to:

- Pay for any lease beyond the project period.
- Pay for the purchase or construction of any building or structure to house any part of the program. (Applicants may request up to $75,000 for renovations and alterations of existing facilities, if necessary and appropriate to the project.)
- Provide residential or outpatient treatment services when the facility has not yet been acquired, sited, approved, and met all requirements for human habitation and services provision. (Expansion or enhancement of existing residential services is permissible.)
- Pay for housing other than residential mental health and/or substance abuse treatment.
- Provide inpatient treatment or hospital-based detoxification services. Residential services are not considered to be inpatient or hospital-based services.
- Make direct payments to individuals to induce them to enter prevention or treatment services. However, SAMHSA discretionary grant funds may be used for non-clinical support services (e.g., bus tokens, child care) designed to improve access to and retention in prevention and treatment programs.
- Make direct payments to individuals to encourage attendance and/or attainment of prevention or treatment goals. However, SAMHSA discretionary grant funds may be used for non-cash incentives of up to $20 to encourage attendance and/or attainment of prevention or treatment goals when the incentives are built into the program design and when the incentives are the minimum amount that is deemed necessary to meet program goals. SAMHSA policy allows an individual participant to receive more than one incentive over the course of the program. However, non-cash incentives should be limited to the minimum number of times deemed necessary to achieve program outcomes. A grantee or treatment or prevention provider may also provide up to $20 cash or equivalent (coupons, bus tokens, gifts, child care, and vouchers) to individuals as incentives to participate in required data collection follow up. This amount may be paid for participation in each required interview.
- Food is generally unallowable unless it's an integral part of a conference grant or program specific, e.g., children's program, residential.
- Implement syringe exchange programs, such as the purchase and distribution of syringes and/or needles.
- Pay for pharmacologies for HIV antiretroviral therapy, sexually transmitted diseases (STD)/sexually transmitted illnesses (STI), TB, and hepatitis B and C, or for psychotropic drugs.

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

Appendix H – Sample Budget and Justification (match required)

THIS IS AN ILLUSTRATION OF A SAMPLE DETAILED BUDGET AND NARRATIVE. WITH GUIDANCE FOR COMPLETING SF 424A: SECTION B FOR THE BUDGET PERIOD.

A. Personnel: an employee of the applying agency whose work is tied to the application

FEDERAL REQUEST

Position	Name	Annual Salary/Rate	Level of Effort	Cost
Executive Director	John Doe	$64,890	10%	$6,489
Coordinator	To be selected	$46,276	100%	$46,276
			TOTAL	$52,765

JUSTIFICATION: Describe the role and responsibilities of each position.
The executive director will provide oversight of grant, including fiscal and personnel management, community relations and project implementation and evaluation. The coordinator will coordinate project services and activities, including training, communication, data collection and dissemination.

NON-FEDERAL MATCH

Position	Name	Annual Salary/Rate	Level of Effort	Cost
Executive Director	John Doe	$64,890	7%	$4,542
Prevention Specialist	Sarah Smith	$26,000	25%	$6,500
Peer Helper	Ron Jones	$23,000	40%	$9,200
Clerical Support	Susan Johnson	$13.38/hr x 100 hr.		$1,338
			TOTAL	$21,580

JUSTIFICATION: Describe the role and responsibilities of each position.
The executive director will provide oversight of grant, including fiscal and personnel management, community relations and project implementation and evaluation. The development specialist will provide staffing support to the working council. The peer helper will be responsible for peer recruitment, coordination and support. The clerical support will process paperwork, payroll, and expense reports.

FEDERAL REQUEST   (enter in Section B column 1 line 6a of form SF424A)   **$52,765**

NON-FEDERAL MATCH (enter in Section B column 2 line 6a of form SF424A)   **$21,580**

B. Fringe Benefits: List all components of fringe benefits rate

FEDERAL REQUEST

Component	Rate	Wage	Cost
FICA	7.65%	$52,765	$4,037
Workers Compensation	2.5%	$52,765	$1,319
Insurance	10.5%	$52,765	$5,540
		TOTAL	$10,896

NON-FEDERAL MATCH

Component	Rate	Wage	Cost
FICA	7.65%	$21,580	$1,651
Workers Compensation	2.5%	$21,580	$ 540
Insurance	10.5%	$21,580	$2,266
		TOTAL	$4,457

JUSTIFICATION: Fringe reflects current rate for agency**.**

FEDERAL REQUEST   (enter in Section B column 1 line 6b of form SF424A)   **$10,896**

NON-FEDERAL MATCH (enter in Section B column 2 line 6b of form SF424A)   **$4,457**

C. Travel: Explain need for all travel other than that required by this application. Local travel policies prevail.

FEDERAL REQUEST

Purpose of Travel	Location	Item	Rate	Cost
Conference (be as specific as possible)	Washington, DC	Airfare	$200/flight x 2 persons	$400
		Hotel	$180/night x 2 persons x 2 nights	$720
		Per Diem (meals)	$46/day x 2 persons x 2 days	$184
Local travel		Mileage	3,000 miles@.38/mile	$1,140
			TOTAL	$2,444

JUSTIFICATION: Describe the purpose of travel and how costs were determined.
Cost for two members to attend a grantee meeting in Washington.   Local travel is needed to attend local meetings, project activities, and training events. Local travel rate is based on agency's privately owned vehicle (POV) reimbursement rate.

NON-FEDERAL MATCH

Purpose of Travel	Location	Item	Rate	Cost
Regional Training Conference	Chicago, IL	Airfare	$150/flight x 2 persons	$300
		Hotel	$155/night x 2 persons x 2 nights	$620
		Per Diem (meals)	$46/day x 2 persons x 2 days	$184
Local Travel	Outreach workshops	Mileage	350 miles x .38/mile	$133
			TOTAL	$1,237

JUSTIFICATION: Describe the purpose of travel and how costs were determined.
Coalition agencies will provide funding for two members to attend the regional technical assistance workshop (our closest location is Chicago, IL).   Local travel rate is based on agency's POV reimbursement rate.

FEDERAL REQUEST   (enter in Section B column 1 line 6c of form SF424A)   **$2,444**

NON-FEDERAL MATCH (enter in Section B column 2 line 6c of form SF424A)   **$1,237**

D. Equipment: an article of tangible, nonexpendable, personal property having a useful life of more than one year and an acquisition cost of $5,000 or more per unit – federal definition.

FEDERAL REQUEST –   (enter in Section B column 1 line 6d of form SF424A)   **$ 0**

NON-FEDERAL MATCH – (enter in Section B column 2 line 6d of form SF424A)   **$ 0**

E. Supplies: materials costing less that $5,000 per unit and often having one-time use

FEDERAL REQUEST

Item(s)	Rate	Cost
General office supplies	$50/mo. x 12 mo.	$600
Postage	$37/mo. x 8 mo.	$296
Laptop Computer*	$900	$900
Printer*	$300	$300
Projector*	$900	$900
Copies	8000 copies x .10/copy	$800
	TOTAL	$3,796

JUSTIFICATION: Describe need and include explanation of how costs were estimated.
Office supplies, copies and postage are needed for general operation of the project. The laptop computer is needed for both project work and presentations. The projector is needed for presentations and outreach workshops. All costs were based on retail values at the time the application was written. *Provide justification for purchases, especially if they were requested and purchased under a previous budget.

NON-FEDERAL MATCH

Item(s)	Rate	Cost
General office supplies	$50/mo. x 12 mo.	$600
Bookcase*	$75	$75
Digital camera*	$300	$300
Fax machine*	$150	$150
Computer*	$500	$500
Postage	$37/mo. x 4 mo	$148
	TOTAL	$1,773

JUSTIFICATION: Describe need and include explanation of how costs were estimated.
The local television station is donating the bookcase, camera, fax machine, and computer (items such as these can only be claimed as match once during the grant cycle and used for the project). The "applying agency" is donating the additional costs for office supplies and postage.

FEDERAL REQUEST –   (enter in Section B column 1 line 6e of form SF424A)   **$ 3,796**

NON-FEDERAL MATCH - (enter in Section B column 2 line 6e of form SF424A)   **$ 1,773**

F. Contract: generally amount paid to non-employees for services or products. A consultant is a non-employee who provides advice and expertise in a specific program area.

FEDERAL REQUEST (Consultant)

Name	Service	Rate	Other	Cost
To be selected	Coalition Building	$150/day	15 days	$2,250
	Travel	.38/mile	360 miles	$137
			TOTAL	$2,387

JUSTIFICATION: Explain the need for each agreement and how they relate to the overall project.
This person will advise staff and coalition members of ways to maintain, increase membership, and develop a
Strategic Prevention Framework for the local coalition.   The rate is based on the average consulting rate in this
area. Consultant is expected to make up to 6 trips (each trip a total of 60 miles) to meet with staff and the coalition.
Mileage rate is based on POV reimbursement rate. A request for proposal will be issued to secure a competitive bid
before final selection is made.

FEDERAL REQUEST (Contract)

Entity	Product/Service	Cost
To be selected	1.5 minute Public Service Announcement (PSA)	$2,300
To be selected	Evaluation Report	$4,500
	TOTAL	$6,800

JUSTIFICATION: Explain the need for each agreement and how they relate to the overall project.
A local media outlet will produce a 1.5-minute PSA from the youth drug awareness video for the local television
market. Tasks will include cutting and editing the tape, preparing introductory statement, inserting music and/or
narrative, and synchronizing the sound track. A local evaluation specialist will be contracted to produce the year-
end results of the coalition efforts.   A request for proposal will be issued to secure a competitive bid before final
selection is made.

NON-FEDRAL MATCH (Consultant)

Name	Service	Rate	Other	Cost
Coalition members	Outreach meeting facilitation	$17.5/hour	6 members x $17.50 x20 hr./mo. x 12 mo.	$25,200
	Travel Expenses	.38/mile	12 members x 148 miles x .38/mile	$675
			TOTAL	$25,875

JUSTIFICATION: Explain the need for each agreement and how they relate to the overall project.
Twelve (12) coalition members are volunteering their time to facilitate the youth prevention and outreach sessions
outlined in the strategic plan. Hourly rate is based on average salaries of the volunteers. Travel is based on average
distance between volunteer's location and the meeting sites. Mileage rate is based on POV reimbursement rate.

NON-FEDERAL MATCH (Contract)

Entity	Product/Service	Cost
West Bank School District	Student Assistance Program	$15,000
	TOTAL	$15,000

JUSTIFICATION: Explain the need for each agreement and how they relate to the overall project.
West Bank School District is donating their contracted services to provide drug testing, referral and case management for 50 non-school attending youth. Average cost is $300/person. (MOU attached to application)

FEDERAL REQUEST –   (enter in Section B column 1 line 6f of form SF424A)   **$ 9,187**
(combine the total of consultant and contact)

NON-FEDERAL MATCH – (enter in Section B column 2 line 6f of form SF424A)   **$ 40,875**
(combine the total of consultant and contact)

G. Construction: NOT ALLOWED – Leave Section B columns 1&2 line 6g on SF424A blank.

H. Other: expenses not covered in any of the previous budget categories

FEDERAL REQUEST

Item	Rate	Cost
Rent	$15/sq.ft x 700 sq. feet	$10,500
Telephone	$100/mo. x 12 mo.	$1,200
Student Surveys	$1/survey x 2784	$2,784
Brochures	.89/brochure X 1500 brochures	$1,335
	TOTAL	$15,819

JUSTIFICATION: Breakdown costs into cost/unit: i.e. cost/square foot. Explain the use of each item requested.
Rent and telephone is necessary to operate the project. Monthly telephone costs reflect the % of effort for the personnel listed in this application. Survey copyright requires the purchase of the ATOD surveys. Brochures will be used at various community functions (health fairs and exhibits).

NON-FEDERAL MATCH

Item	Rate	Cost
Space rental	Varies between $75/event to over $300/event	$11,500
Television time	$250/spot x 50 spots	$12,500
Food and beverages	$2.50/meeting x 40 attendees x 3 meetings	$300
Internet services	$26/mo. x 12 mo.	$312
Student surveys	$1/survey x 1583 surveys	$1,583
Printing	$300/run x 6 runs	$1,800
	TOTAL	$27,995

JUSTIFICATION: Breakdown costs into cost/unit: i.e. cost/square foot. Explain the use of each item requested.
Various coalition and community organizations donate space for the various activities outlined in the scope of work, such as teen night out, after-school programs, and parent education classes. The prices range from$75/event for the West Bank School District to over $300/event for the Holiday Inn. The local ACME market is donating the food for three meetings. The local television station is donating airtime for the PSA (MOU attached to application). The applying agency is donating the internet services for the full-time coordinator. The West Bank School District is

donating the cost of 1,583 student surveys. All costs are the value placed on the service at the time of this grant application.   A coalition member is donating the printing for the bi-monthly newsletter.

FEDERAL REQUEST –   (enter in Section B column 1 line 6h of form SF424A)   **$ 15,819**

NON-FEDERAL MATCH – (enter in Section B column 2 line 6h of form SF424A)   **$ 27,995**

Indirect cost rate: Indirect costs can only be claimed if your organization has a negotiated indirect cost rate agreement. It is applied only to direct costs to the agency as allowed in the agreement.
 For information on applying for the indirect rate go to: samhsa.gov then click on grants – grants management – HHS Division of Cost Allocation – Regional Offices.

FEDERAL REQUEST (enter in Section B column 1 line 6j of form SF424A)
8% of personnel and fringe   (.08 x $63,661)   **$5,093**

NON-FEDERAL MATCH (enter in Section B column 2 line 6j of form SF424A)
8% of personnel and fringe   (.08 x $26,037)   **$2,083**

JUSTIFICATION: The indirect costs rate was approved by the Dept. of Health and Human Services in 200X and is applied to the personnel and fringe, per the negotiated agreement. A copy of the fully executed, negotiated, indirect cost agreement is attached.

BUDGET SUMMARY:

Category	Federal Request	Non-Federal Match	Total
Personnel	$52,765	$21,580	$74,345
Fringe	$10,896	$4,457	$15,353
Travel	$2,444	$1,237	$3,681
Equipment	0	0	0
Supplies	$3,796	$1,773	$5,569
Contractual	$9,187	$40,875	$50,062
Other	$15,819	$27,995	$43,814
Total Direct Costs*	$94,907	$97,917	$192,824
Indirect Costs	$5,093	$2,083	$7,176
Total Project Costs	$100,000	$100,000	$200,000

* TOTAL DIRECT COSTS:

FEDERAL REQUEST –   (enter in Section B column 1 line 6i of form SF424A)   **$94,907**

NON-FEDERAL MATCH – (enter in Section B column 2 line 6i of form SF424A)   **$97,917**

TOTAL PROJECT COSTS: Sum of Total Direct Costs and Indirect Costs

FEDERAL REQUEST (enter in Section B column 1 line 6k of form SF424A)   **$100,000**

NON-FEDERAL MATCH (enter in Section B column 2 line 6k of form SF424A)   **$100,000**

Appendix I – Using Evidence-Based Practices

SAMHSA's services grants are intended to fund services or practices that have a demonstrated evidence base and that are appropriate for the population of focus. An evidence-based practice, also called EBP, refers to approaches to prevention or treatment that are validated by some form of documented scientific evidence. In your application, you will need to:

- Identify the evidence-based practice you propose to implement.
- Identify and discuss the evidence that shows that the practice is effective. [See note below.]
- Discuss the population(s) for which this practice has been shown to be effective and show that it is appropriate for your population(s) of focus. [See note below.]

Note: SAMHSA recognizes that EBPs have not been developed for all populations and/or service settings. For example, certain interventions for American Indians/Alaska Natives, rural or isolated communities, or recent immigrant communities may not have been formally evaluated and, therefore, have a limited or nonexistent evidence base. In addition, other interventions that have an established evidence base for certain populations or in certain settings may not have been formally evaluated with other subpopulations or within other settings. Applicants proposing to serve a population with an intervention that has not been formally evaluated with that population are encouraged to provide other forms of evidence that the practice(s) they propose is appropriate for the target population. Evidence may include unpublished studies, preliminary evaluation results, clinical (or other professional association) guidelines, findings from focus groups with community members, etc. You may describe your experience either with the population of focus or in managing similar programs. Information in support of your proposed practice needs to be sufficient to demonstrate the appropriateness of your practice to the people reviewing your application.

- Document the evidence that the practice you have chosen is appropriate for the outcomes you want to achieve.
- Explain how the practice you have chosen meets SAMHSA's goals for this grant program.
- Describe any modifications/adaptations you will need to make to this practice to meet the goals of your project and why you believe the changes will improve the outcomes. We expect that you will implement your evidence-based service/practice in a way that is as close as possible to the original service/practice. However, SAMHSA understands that you may need to make minor changes to the service/practice to meet the needs of your target population or your program or to allow you to use resources more efficiently. You must describe any changes to your proposed service/practice that you believe are necessary for these purposes. You may describe your own experience either with the target population or in managing similar programs. However, you will need to convince the people reviewing your application that the changes you propose are justified.

- Explain why you chose this evidence-based practice over other evidence-based practices.

Resources for Evidence-Based Practices:

You will find information on evidence-based practices in SAMHSA's *Guide to Evidence-Based Practices on the Web* at www.samhsa.gov/ebpwebguide. SAMHSA has developed this Web site to provide a simple and direct connection to Web sites with information about evidence-based interventions to prevent and/or treat mental and substance use disorders. The *Guide* provides a short description and a link to dozens of Web sites with relevant evidence-based practices information – either specific interventions or comprehensive reviews of research findings.

Please note that SAMHSA's Guide to Evidence-Based Practices also references another SAMHSA Web site, the National Registry of Evidence-Based Programs and Practices (NREPP). NREPP is a searchable database of interventions for the prevention and treatment of mental and substance use disorders. NREPP is intended to serve as a decision support tool, not as an authoritative list of effective interventions. *Being included in NREPP, or in any other resource listed in the Guide, does not mean an intervention is "recommended" or that it has been demonstrated to achieve positive results in all circumstances.* You must document that the selected practice is appropriate for the specific target population and purposes of your project.

In addition to the Web site noted above, you may provide information on research studies to show that the services/practices you plan to implement are evidence-based. This information is usually published in research journals, including those that focus on minority populations. If this type of information is not available, you may provide information from other sources, such as unpublished studies or documents describing formal consensus among recognized experts.

Appendix J - Counties Served by Previous CMHI Grantees

Counties Served by Grantees Funded in 1993-1994

Site	Number of counties served by the system of care	Names of Counties
East Baltimore, Maryland	1	Baltimore City (Baltimore County)
Stark County, Ohio	1	Stark
Charleston/Dorchester Counties, South Carolina	2	Charleston, Dorchester
Vermont	13	Franklin, Orleans, Essex, Lamoille, Caledonia, Chittenden, Washington, Addison, Orange, Rutland, Windsor, Bennington, Windham
Riverside, San Mateo, Santa Cruz, Solano, and Ventura Counties, California	5	Riverside, San Mateo, Santa Cruz, Solano, Ventura
Sedgewick County, Kansas	1	Sedgewick
Piscatquis, Hancock, Penobscot, and Washington Counties, Maine	4	Piscatquis, Hancock, Penobscot, Washington
Doña Ana County, New Mexico	1	Doña Ana
Pitt, Edgecombe, and Nash Counties, North Carolina	3	Pitt, Edgecombe, Nash
Rhode Island	3	Providence, Kent, Washington
Milwaukee County, Wisconsin	1	Milwaukee
Santa Barbara County, California	1	Santa Barbara
Sonoma and Napa Counties, California	2	Sonoma, Napa
Waianae Coast and Leeward Oahu, Hawaii	1	Honolulu
Lyons, Riverside, and Proviso Townships, Illinois	1	Cook
Southeast Kansas (13 counties)	13	Labette, Cherokee, Crawford, Wilson, Elk, Chautauqua, Montgomery, Anderson, Woodson, Allen, Bourbon, Neosha, Linn

Site	Number of counties served by the system of care	Names of Counties
Navajo Nation	5	San Juan, McKinley, Coconino, Apache, Navajo
Mott Haven, New York	1	Bronx (Borough) (Bronx County)
Minot, Bismarck, and Fargo regions, North Dakota	17	Minot – Bottineau, Burke, McHenry, Mountrail, Pierce, Renville, and Ward Bismarck - Aurleigh, Oliver, Morton, Kidder, Grant, McLean, Mercer, Sheridan, Sioux, Emmons
Lane County, Oregon	1	Lane
South Philadelphia, Pennsylvania	1	Philadelphia
City of Alexandria, Virginia	1	Fairfax
Totals	**79**	

Counties Served by Grantees Funded in 1997

Site	Number of counties served by the system of care	Names of Counties
Jefferson County, Alabama	1	Jefferson
San Diego County, CA	1	San Diego
Passamaquoddy Tribe Indian Township, Maine (Washington County)	1	Washington
Detroit, Michigan	1	Wayne
Central Nebraska	22	Blaine, Loup, Garfield, Wheeler, Custer, Valley, Greeley, Sherman, Howard, Merrick, Buffalo, Hall, Hamilton, Phelps, Kearney, Adams, Clay, Furnas, Harlan, Franklin, Webster, Nuckolls
Blue Ridge, Cleveland, Guilford, and Sandhills Counties, North Carolina	11	Ayson, Buncombe, Cleveland, Guilford, Hoke, Madison, Mitchell, Montgomery, Moore, Richmond, Yancey

Site	Number of counties served by the system of care	Names of Counties
Fort Berthold, Standing Rock, Spirit Lake, and Turtle Mountain Indian Reservations, North Dakota	18	Benson, Divide, Dunn, Eddy, McLean, McKenzie, Mercer, Montrail, Nelson, Ramsey, Rolette, Sioux, Ward, Williams, North Dakota; Sheridan, Richland, Roosevelt, Montana; Corson, South Dakota
Vermont	13	Franklin, Orleans, Essex, Lamoille, Caledonia, Chittenden, Washington, Addison, Orange, Rutland, Windsor, Bennington, Windham
Forest, Langdale, Lincoln, Marathon, Oneida, and Vilas Counties, Wisconsin	6	Forest, Langdale, Lincoln, Marathon, Oneida, Vilas
Totals	**74**	

Counties Served by Grantees Funded in 1998

Site	Number of counties served by the system of care	Names of Counties
Hillsborough County, Florida	1	Hillsborough
Eastern Kentucky (3 rural Appalachian regions)	22	Breathitt, Knott, Lee, Leslie, Letcher, Owsley, Perry, Wolfe, Floyd, Johnson, Magoffin, Martin, Morgan, Pike, Bell, Clay, Harlan, Jackson, Knox, Laurel, Rockcastle, Whitley
Sault Ste. Marie Tribe, Michigan	7	Alger, Chippewa, Delta, Luce, Marquette, Mackinac, Schoolcraft
St. Charles County, Missouri	1	St. Charles
Lancaster County, Nebraska	1	Lancaster
Clark County, Nevada	1	Clark
Clackamas County, Oregon	1	Clackamas
Allegheny County, Pennsylvania	1	Allegheny

Site	Number of counties served by the system of care	Names of Counties
Rhode Island	3	Providence, Kent, Washington
Travis County, Texas	1	Travis
Rural Utah	6	Beaver, Carbon, Emery, Garfield, Grande, Kane *(Also proposed: San Juan, Piute, Wayne, Rich, Daggett)*
Clark County, Washington	1	Clark
King County, Washington	1	King
Wind River Indian Reservation, Wyoming	2	Freemont, Hot Springs
Totals	**49**	

Counties Served by Grantees Funded in 1999-2000

Site	Number of counties served by the system of care	Names of Counties
Yukon-Kuskokwim Delta Region of Southwest Alaska (58 Tribes)	1	No County designations
Pima County, Arizona	1	Pima
Contra Costa County, California	1	Contra Costa
Humbolt & Del Norte Counties, California	2	Del Norte, Humbolt
Denver, Jefferson, Clear Creek, and Gilpin Counties, Colorado	4	Denver, Jefferson, Clear Creek, Gilpin
Delaware	3	New Castle, Kent, Sussex
West Palm Beach County, Florida	1	West Palm Beach
East Chicago, Gary, and Hammond, Indiana	1	Lake
Marion County (Indianapolis), Indiana	1	Marion
Montgomery County, Maryland	1	Montgomery
Worcester, Massachusetts	1	Worcester

Site	Number of counties served by the system of care	Names of Counties
Kandiyohi, Meeker, Renville, and Yellow Medicine Counties, Minnesota	4	Kandiyohi, Meeker, Renville, Yellow Medicine
Hinds County, Mississippi	1	Hinds
Manchester, Littleton, and Berlin, New Hampshire	3	Coos, Grafton, Hillsbourough
Burlington County, New Jersey	1	Burlington
Westchester County, New York	1	Westchester
11 Counties, North Carolina	11	Halifax, Orange, Person, Chatham, Swain, Haywood, Macon, Jackson, Cherokee, Clay, Graham
Pine Ridge Indian Reservation, South Dakota	2	Jackson, Shannon
Greenwood, South Carolina	1	Greenwood
Nashville, Tennessee	1	Davidson
12 Counties, West Virginia (Region II)	12	Boone, Cabell, Clay, Jackson, Kanawha, Lincoln, Logan, Mason, Putnam, Roane, Mingo, Wayne
Gwinnett, Rockdale Counties, Georgia	2	Gwinnett, Rockdale *(Newton County not listed in application, but part of agency's service area)*
Totals	**56**	

Counties Served by Grantees Funded in 2002-2003

Site	Number of counties served by the system of care	Names of Counties
Fairbanks Native Association, Alaska	4	Denali, Fairbanks North Star, Southeast Fairbanks, Yukon-Koyukuk
Glenn County, California	1	Glenn
Sacramento County, California	1	Sacramento
San Francisco, California	1	San Francisco

Site	Number of counties served by the system of care	Names of Counties
Arapahoe, El Paso, Mesa, and Fremont Counties, Colorado	4	Arapahoe, El Paso, Fremont, Mesa
Connecticut	1	Fairfield
Washington, D.C	1	District of Columbia
Broward County, Florida	1	Broward
Guam	1	Guam
Idaho	44	Ada, Adams, Bannock, Bear Lake, Benewah, BIngham, Blaine, Boise, Bonner, Bonneville, Boundary, Butte, Camas, Canyon, Caribou, Cassia, Clark, Clearwater, Custer, Elmore, Franklin, Fremont, Gem, Gooding, Idaho, Jefferson, Jerome, Kootenai, Latah, Lemhi, Lewis, Lincoln, Madison, Minidoka, Nez Perce, Oneida, Owyhee, Payette, Power, Shoshone, Teton, Twin Falls, Valley, Washington
Chicago, Illinois	1	Cook
Green, Christian, Teany, Stone, Barry, and Lawrence Counties, Missouri	6	Barry, Christian, Green, Lawrence, Stone, Teany
New York City, New York	5	Bronx, Kings, New York, Queens, Richmond
Choctaw Nation, Oklahoma	10	Atoka, Bryant, Choctaw, Coal, Haskell, Latimer, LeFlore, McCurtain, Pittsburgh, Pushmataha
Kay, Tulsa, Oklahoma, Canadian, and Beckham Counties, Oklahoma	5	Beckham, Canadian, Kay, Oklahoma, Tulsa
Llorens Torres Housing Project in San Juan and the Municipality of Gurabo, Puerto Rico	2	Gurabo, San Juan municipalities
El Paso County, Texas	1	El Paso
Fort Worth, Texas	1	Tarrant
Monterey County, California	1	Monterey
City of Oakland, California	1	Alameda

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Site	Number of counties served by the system of care	Names of Counties
5 Parishes, Louisiana	5	Jefferson, Orleans, Plaquemines, St. Bernard, Tammany
St. Louis, Missouri	1	St. Louis
Cuyahoga County, Ohio	1	Cuyahoga
4 Counties, Oregon	4	Gilliam, Hood River, Sherman, Wasco
3 Counties and the Catawba Indian Nation, South Carolina	3	Catawba, Chester, Lancaster
Totals	**106**	

Counties Served by Grantees Funded in 2004

Site	Number of counties served by the system of care	Names of Counties
Albany County, New York	1	Albany
Erie County, New York	1	Erie
Boone, Kenton, Campbell, Grant, Carroll, Pendleton, Owen, and Gallatin Counties, Kentucky	8	Boone, Kenton, Campbell, Grant, Carroll, Pendleton, Owen, Gallatin
Montana and the Crow Nation	56	Beaverhead, Big Horn, Blaine, Broadwater, Carbon, Carter, Cascade, Chouteau, Custer, Daniels, Dawson, Deer Lodge, Fallon, Fergus, Flathead, Gallatin, Garfield, Glacier, Golden Valley, Granite, Hill, Jefferson, Judith Basin, Lake, Lewis & Clark, Liberty, Lincoln, Madison, McCone, Meagher, Mineral, Missoula, Musselshell, Park, Petroleum, Phillips, Pondera, Powder River, Powell, Prairie, Ravalli, Richland, Roosevelt, Rosebud, Sanders, Sheridan, Silver Bow, Stillwater, Sweet Grass, Teton, Toole, Treasure, Valley, Wheatland, Wibaux, Yellowstone

Site	Number of counties served by the system of care	Names of Counties
Totals	66	

Counties Served by Grantees Funded in 2005

Site	Number of counties served by the system of care	Names of Counties
Pittsburgh, Pennsylvania	1	Allegheny & City of Pittsburgh
Boston, Massachusetts	1	Worcester (except the city of Worcester)
Nashville, Tennessee	1	Maury
Sacramento, California	1	Los Angeles
Browning, Montana	5	Browning, Heart Butte, Glacier, Pondera, and Blackfeet Indian reservation
Little Rock, Arkansas	3	Craighead, Mississippi, Lee 7 Phillips
Chicago, Illinois	1	McHenry
Houston, Texas	1	Harris
Sarasota, FL	1	Sarasota
Cheyenne, Wyoming	1	Statewide
St. Cloud, Minnesota	4	Benton, Sherburne, Stearns and Wright
Rochester, New York	1	Monroe
Lansing, Michigan	1	Ingham
Augusta, Maine	3	Androscoggin, Oxford, and Franklin
Nazareth, Michigan	1	Kalamazoo
Chico, California	1	Butte
Los Angeles	1	Los Angeles
Beaver Falls, Pennsylvania	1	Beaver
Providence, Rhode Island	1	Statewide

Site	Number of counties served by the system of care	Names of Counties
Portland, Oregon	1	Multnomah
Honolulu, Hawaii	1	Honolulu & city of Honolulu
Wagner, South Dakota	1	Yankton Sioux Reservation
Charlotte, North Carolina	2	Charlotte and Mecklenburg
Hartford, Connecticut	1	Southeastern Connecticut
Placer, California	6	Placer, Kings Beach, North Auburn, Lincoln, Foresthill and Roseville
Totals	42	

Counties Served by Grantees Funded in 2006

Site	Number of counties served by the system of care	Names of Counties
Jackson, Mississippi	3	Forrest, Lamar, and Marion
Jefferson, Missouri	2	Buchanan and Andrew
Des Moines, Iowa	10	Allamakee, Howard, Winneshiek, Delaware, Dubuque, Fayette, Clayton, Buchannan, Jackson and Clinton
Pascua Yaqui, Arizona	3	Yaqui communities in the state of Arizona (Pima, Pinal and Maricopi)
Crookston, Minnesota	5	Kittson, Mahnomen, Norman, Polk, and Red Lake
Totals	14	

Appendix K - Cultural and Linguistic Competence Elements

This appendix describes many of the important elements of cultural and linguistic competence. **Project Description and Need Justification** - Knowing the unique characteristics of the community/population to be served is critical to the success of the proposed initiative. **Experience or Track Record of Involvement with the Population to Be Served** - A successful applicant will have a documented history of programmatic involvement with the population and/or community to be served by the proposed initiative. If the organization does not yet have a track record with the population to be served, planning should include strategies to increase awareness and acquire the knowledge and skills necessary to work effectively with these communities in a culturally and linguistically competent manner (for example, by establishing relationships with key informants, cultural brokers, key leaders within the cultural communities; planning staff development to gain knowledge on cultural practices and beliefs related to mental health; and/or seeking technical assistance from the community, national, State or local organizations, or consultants with expertise on cultural and linguistic competence and/or the specific cultural groups to be served.

Community Representation - The population/community targeted to receive services should participate actively in all phases of program design. A mechanism should be established to provide opportunities for community members (including families and youth, providers of services, and representatives of informal systems of care) to influence and help shape the initiative's proposed activities and interventions. Such mechanisms may include, but are not limited to, establishment of an advisory council, cultural and linguistic competence committee, mental health disparities committee, and via membership and participation on boards of directors.

Language and Communication - Project-related communications must be appropriate to the population to be served. Consider information that is available about the primary language(s) of the population to be served (for instance, whether a significant percentage of the population to be served/community is known to be more comfortable with a language other than English). Also consider literacy and health literacy in English and primary language spoken.

The following definition of linguistic competence provides numerous examples of approaches to address the language needs and preferences that span cultural groups: The capacity of an organization and its personnel to communicate effectively and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate and individuals with disabilities. Linguistic competency requires organizational and provider capacity to respond effectively to the health literacy needs of the populations served. The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity. This may include, but is not limited to, the use of:

- bilingual/bicultural or multilingual/multicultural staff;
- cross cultural communication approaches
- cultural brokers;
- sign language interpretation services;
- multilingual telecommunication services;

- videoconferencing and telehealth technologies;
- TTY and other assistive technology devices;
- computer assisted real time translation (CART) or viable real time transcriptions (VRT);
- print materials in easy to read, low literacy, picture and symbol format;
- materials in alternate formats (e.g., audiotape, Braille, enlarged print);
- varied approaches to share information with individuals who experience cognitive disabilities;
- materials developed and tested for specific cultural, ethnic and linguistic groups;
- translation services including those of:

  - legally binding documents (e.g., consent forms, confidentiality and patient rights statements, release of information, applications)
  - signage
  - health education materials
  - public awareness materials and campaigns and,

- ethnic media in languages other than English (e.g., television, radio, Internet, newspapers, periodicals). (NCCC, 2000).

Staff Composition and Training - The staff of the organization should have demonstrated experience in serving the population of focus and should be familiar with the culture and language of this population. If the population of focus is multicultural and multilinguistic, staff should be qualified to serve this population.] All staff should receive training and other supports to enhance and ensure their capacity to serve diverse populations effectively, respectively and takes culture and language into consideration. Content should include attention to the multiple characteristics of the population to be served (such as race/ethnicity, primary language, gender, age, sexual orientation, disability, socioeconomic class, and literacy). For purposes of this item, "staff" would include, at a minimum, administrators, advisors, board members, supervisors and service providers, and all family members who are employed or volunteer.

Evaluation - There should be a rationale for the use of any evaluation instruments that are chosen and the rationale should include a discussion of the validity of the instruments in terms of the gender/age/culture/language of the group(s) being served. The evaluators should be knowledgeable of the cultural contexts of the population being served (e.g., social history, language, mental health beliefs and practices, inter-group and intra-group dynamics). Program evaluation methods and instruments should be culturally appropriate to the population/community served. Family, youth and community should have meaningful participation in the evaluation including design, implementation, interpretation and dissemination of findings.

Appendix L - Limited English Proficiency Assistance

Effective August 30, 2000, the U.S. Department of Health and Human Services (DHHS) issued policy guidance to assist health and social service 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.   Develop 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 (such as this CMHI), must take steps to ensure that limited English skills do not restrict access to full use of services.

Appendix M - Key Personnel

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

<u>Project Director</u>
Responsible for overseeing the development of an ongoing comprehensive strategic plan for creating, implementing and sustaining 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, including guiding the establishment of inter agency collaborations with other child serving agencies. This key position should be staffed by one individual with knowledge of children's mental health and related service systems; with demonstrated experience in planning and building service systems, management, policy analysis and strategic thinking; leadership experience; and, demonstrated ability to foster collaborative relationships. This is a full-time equivalent position.

<u>Lead Family Contact</u>
Typically, this position is filled by a parent or other family member of a child or adolescent with a serious mental health need, who has received or currently is receiving services from the mental health service system. This position is responsible for either setting up, or working with an existing family-run organization, that represents the cultural and linguistic background of the population to be served. Responsibilities include, but are not limited to, working in partnership with the awardee staff in all aspects of developing, implementing and evaluating the system of care and providing support services for families receiving services through the cooperative agreement. This position enjoys full inclusion on the governance body. This key position should be staffed by one individual in a full-time equivalent position.

<u>Youth Coordinator</u>
This position, typically filled by a young adult, is responsible for developing activities to represent the voice of youth who have serious mental health needs with staff who are charged with the programming and implementation of the system of care. Responsibilities also include developing programs for young people to facilitate their involvement in the development of the system of care.

Key Evaluation Staff

At least two full-time positions will be filled by staff that direct and coordinate the implementation of the National Evaluation sponsored by the Comprehensive Community Mental Health Services for Children and Their Families Program. These staff will be responsible for developing the procedures for conducting a longitudinal study of children and their families served through the program. Other responsibilities include: purchasing and setting up the computer hardware and software required to enter, store, manage, analyze, and transmit data; analyzing, interpreting and reporting results; presenting papers at key professional conferences; writing and publishing results in peer-reviewed journals, as well as in publications for consumption by multiple public audiences, including policy makers, family members and agency professionals; and incorporating culturally and linguistically diverse youth and family members in multiple activities of the evaluation. At least two full- time equivalent positions should be designated for these key personnel.

Although not required, it is strongly recommended that these key personnel have credentials and professional experiences equivalent to a doctoral-level degree. Appropriate experience includes professional work in the areas of longitudinal research, evaluation, measurement, and research methodology. In addition, experience and expertise in children's mental health and related fields including psychology, social work, juvenile justice, education, and primary care will be very beneficial to meeting the requirements of national evaluation project work.

Social Marketing-Communications Manager

This position is 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. This position coordinates activities with the national communications campaign contractor. At least a half-time equivalent position should be allocated for this function.

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 as the primary link with the Technical Assistance Partnership for accessing the appropriate technical assistance. Technical assistance areas may include culturally and linguistically competent practices and services, leadership, partnership/collaboration, strategic planning, care plan development processes, sustainability, family involvement and youth involvement. At least a half-time equivalent position should be allocated for this function.

State-Local Liaison

Serves as the bridge between the State and the awardee community in efforts to create 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. Efforts include working to establish interagency involvement in the initiative's structure and process by developing and/or changing interagency agreements and other public policies relevant to the creation of the system of care.

Cultural and Linguistic Competence Coordinator

The responsibility for the implementation of cultural and linguistic competence belongs to all parties within the system of care. The cultural and linguistic competence coordinator has the authority and responsibility for assisting leadership, management staff, families, youth, contractors and all other system partners in ensuring culturally and linguistically competent practices in all aspects of the system of care. The cultural and linguistic competence coordinator

serves as a team leader and facilitates the organizational development process to accomplish these goals. (Adapted from TAP, CCAT, 2007). At least a half-time equivalent position should be allocated for this function.

Appendix N - Requirements of the National Evaluation

Phase VI of the National Evaluation

COMPONENT	TASKS	FREQUENCY OF DATA COLLECTION
System-of-Care Assessment	All communities will submit the following information prior to their assessment visit: Participant list for the governance council An annual listing of training events offered by the service system with identified cross-agency attendance A list of grant-funded staff with their function or position identified A list of available services in the community's array across multiple service providers A breakdown of funding sources that support the system of care Participant list for the case review committee Site representatives to be interviewed: Core agency representatives on the governing council (3) Project director (1) Family representative on the governing council (1) Lead evaluator (1) Case review committee members (2) Intake worker (1) Case management staff (3) Therapist or clinician (2) Other service delivery staff (e.g., respite provider, mentor) (2) Staff from core agencies (e.g., case worker, teacher, probation officer) (2) Director of family organization (1) Family representative on evaluation or case review team (1) Caregivers (4) Youth (2 or 3, starting in 2006)	Four 3-day site visits between years 2 through 6 of the grant
Services and Costs Study	All communities will complete the MIS and Technology Survey and provide MIS data for youth involved in the national evaluation, depending on their existing MIS system.	Transfer of MIS data in Years 3 through 6 of the grant
Cross-sectional Descriptive Study	All families in the system of care in all communities will complete the Enrollment and Demographic Information Form	Obtain information at entry into services.

COMPONENT	TASKS	FREQUENCY OF DATA COLLECTION
Longitudinal Child and Family Outcome Study	All eligible families in the Cross-sectional Descriptive Study will complete the following measures, depending on respondent and data collection point: Child Information Update Form Achenbach Child Behavior Checklist 1½–5 Achenbach Child Behavior Checklist 6–18 Behavior and Emotional Rating Scale–Parent Behavior and Emotional Rating Scale–Youth Caregiver Information Questionnaire Caregiver Strain Questionnaire Columbia Impairment Scale Delinquency Survey–Revised Education Questionnaire–Revised Family Life Questionnaire Global Appraisal of Individual Needs Quick–Substance Related Issues Living Situations Questionnaire Revised Children's Manifest Anxiety Scale Reynolds Adolescent Depression Scale Substance Use Questionnaire–Revised Vineland Screener (ages 0–2.11, 3–5, 6–12) Youth Information Questionnaire	Interview at intake and every 6 months, up to 36 months
Service Experience Study	All families in the Longitudinal Child and Family Outcome Study will complete the following measures: Cultural Competence and Service Provision Multi-Sector Service Contacts–Revised Youth Satisfaction Survey for Families Youth Satisfaction Survey	At follow-up points only (every 6 months from 6 to 36 months)
Sustainability Study	Four respondents will complete the survey: Project director Key mental health agency representative Family representative Representative from another child-serving agency One person in each community will serve as point of contact, provide contact information, and assist with updating contact information.	In years 3, 4, and 6 of funding.
Monthly Evaluation Activity Report	All communities will submit program and evaluation enrollment numbers.	Monthly
Data transfer	All communities will enter and submit their data to the Web-based Interactive Collaborative Network.	Weekly

Appendix O - Definition of Family-Driven Care

<u>Definition of Family-Driven Care</u>
Family-driven means families have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, State, tribe, territory and nation. This includes:

choosing supports, services, and providers;

setting goals;

designing and implementing programs;

monitoring outcomes; and

determining the effectiveness of all efforts to promote the mental health of children and youth.

<u>Guiding Principles of Family-Driven Care</u>
Families and youth are given accurate, understandable, and complete information necessary to make choices for improved planning for individual children and their families.

Families and youth are organized to collectively use their knowledge and skills as a force for systems transformation.

Families and youth embrace the concept of sharing decision-making and responsibility for outcomes with providers.

Providers embrace the concept of sharing decision-making authority and responsibility for outcomes with families and youth.

Providers take the initiative to change practice from provider-driven to family-driven.

Administrators allocate staff, training and support resources to make family-driven practice work at the point where services and supports are delivered to children, youth and families.

Families and family-run organizations engage in peer support activities to reduce isolation and strengthen the family voice.

Community attitude change efforts focus on removing barriers created by stigma.

Communities embrace and value the diverse cultures of their children, youth and families.

Everyone who connects with children, youth and families continually advance their cultural and linguistic responsiveness as the population served changes.

<u>Characteristics of Family-Driven Care</u>
Family and youth experiences, their visions and goals, their perceptions of strengths and needs and their guidance about what will make them comfortable steer decision making about all aspects of service and system design, operation, and evaluation.

Family-run organizations receive resources and funds to support and sustain the infrastructure that is essential to insure an independent family voice in their communities, States, Tribes, territories and the nation.

Meetings and service provision happen in culturally and linguistically competent environments where family and youth voices are heard and valued, everyone is respected and trusted and it is safe for everyone to speak honestly.

Administrators and staff actively demonstrate their partnerships with all families and youth by sharing power, resources, authority and control with them.

Families and youth have access to useful, usable and understandable information and data, as well as sound professional expertise so they have good information to make decisions.

All children, youth and families have a biological, adoptive, foster or surrogate family voice advocating on their behalf.

Appendix P – Definition of Youth-Guided Care

Youth-Guided Individual	• Youth is engaged in the idea that change is possible in his or her life and the systems that serve them. • Youth need to feel safe, cared for, valued, useful and spiritually grounded. • The program needs to enable youth to learn and build skills that allow them to function and give back in their daily lives • There is a development and practice of leadership and advocacy skills, and a place where equal partnership is valued. • Youth are empowered in their planning process from the beginning and have a voice in what will work for them. • Youth receive training on how systems operate, their rights, purpose of the system and youth involvement and development opportunities.
Youth-Guided Community	Community partners and stakeholders have: • An open minded viewpoint and there are decreased stereotypes about youth. • Prioritized youth involvement and input during planning and/or meetings. • A desire to involve youth • Begun stages of partnership with youth. • Begun to use language supporting youth engagement. • Taken the youth view and opinion into account. • A minimum of one youth partner with experience and/or expertise in the systems represented. • Begun to encourage and listen to the views and opinions of the involved youth, rather than minimize their importance. • Created open and safe spaces for youth • Appropriate incentives are provided to youth. This includes youth participation in the program as well as those who serve on boards or provide training.
Youth-Guided Policy	• Youth are invited to meetings • Training and support is provided for youth on what the meeting is about • Youth and board are beginning to understand the role of youth at the policy-making level • Youth can speak on their experiences (even if it is not in perfect form) and talk about what's really going on with young people. • Adults value what youth have to say in an advisory capacity. • Youth have a role in decision making. • Youth have an appointed mentor who is a regular attendee of the meetings and makes sure that the youth feels comfortable to express his or herself and clearly understands the process.

Appendix Q - Strategic Framework for Sustainability Planning

Sustainability Strategies
1. Ongoing Locus of Accountability
   * Create a viable, ongoing focal point for system management
2. Family Organization and Advocacy Base
   * Establish a strong family organization
   * Create an effective advocacy base
3. Evaluation/Accountability Data
   * Use evaluation/accountability results to "make the case" for sustaining the system and care and services
4. Interagency Partnerships
   * Cultivate strong interagency relationships and partnerships for service delivery and coordination
   * Cultivate strong interagency partnerships for ongoing financing of services
5. Infusion of System of Care Approach into Larger System
   * Make state-level and local-level policy and regulatory changes that support the system of care approach
   * Make the system of care philosophy and approach the way the community's larger service system operates
6. Training
   * Provide ongoing training and coaching re system of care philosophy and approach
   * Provide ongoing training re effective services (evidence-based and promising interventions)
7. Commitment and Support for System of Care Approach
   * Generate political and policy level support for the system of care approach
   * Generate state involvement and commitment
   * Generate local involvement and commitment
   * Cultivate ongoing leaders and champions for system of care philosophy and approach
8. The ultimate goal of the Child Mental Health Initiative is to put an infrastructure, services and philosophy in place that can be maintained as Federal funds decrease and after Federal funding is terminated.
9. Planning for sustainability should begin at the earliest stages of system of care implementation. As the strategic implementation plan is developed, so should a plan for long-term sustainability.
10. Every element of a system of care (including each service and support) that is developed and provided as part of this initiative should be accompanied by a strategy for long-term maintenance beyond the period of Federal funding.
11. The system of care that is developed should not be seen as a "project", per se, that is separate or apart from the rest of the State and local service system or that is time-limited. Rather, the system of care should build on the infrastructure and services that already are in place, should be "infused" into the larger service system, and should be seen as a vehicle for system change. The system of care philosophy and approach should ultimately become the philosophy and approach that is used by and guides the larger service system environment.
12. Sustaining a system of care involves utilizing multiple approaches and strategies that are part

of a strategic plan for sustainability, as shown below.

13. In addition, strong local-State partnerships are essential for sustainability, to ensure that the various policies and financing mechanisms that support the long-term maintenance of systems of care can be put into place at the State level. Ideally, the local system of care must be part of a larger State strategy for Statewide system of care development.

14. Selected applicants must update sustainability plans throughout the duration of the period of Federal funding, as such a plan is essential to ensuring the future pf the project

Financing Strategies for Sustainability

1. Medicaid
    - Increase ability to obtain Medicaid reimbursement for services
2. State Mental Health Funds
    - Obtain new or increased state mental health funds
3. Other Child Service Systems Funds
    - Obtain new or increased funds from other child-serving agencies
    - Coordinate, blend, or braid funds with other child-serving agencies
4. Redeployed Funds
    - Redeploy/shift funds from higher to lower cost services
5. Local Funds
    - Obtain new or increased local funds (e.g., taxing authorities, business and foundation support)