

Department of Health and Human Services

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

Cooperative Agreements for the Comprehensive Community Mental Health Services for Children and Their Families Program (SM-05-010)

Short Title: Child Mental Health Initiative (CMHI)

Announcement Type: Initial

Catalog of Federal Domestic Assistance (CFDA) No. 93.104

Authority: Part E of Title V, Section 561 et. seq., of the Public Health Service Act, as amended and subject to the availability of funds.

Key Dates:

Application Deadline	Applications are due by May 17, 2005
Intergovernmental Review (E.O. 12372)	Letters from State Single Point of Contact (SPOC) are due no later than 60 days after application deadline.

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I. FUNDING OPPORTUNITY DESCRIPTION

1. INTRODUCTION

As authorized under Part E of Title V Section 561 et.seq. of the Public Health Service Act, as amended, the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), announces the availability of funds for fiscal year 2005 cooperative agreements. These cooperative agreements will 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.

[Note: Applicants may access a Technical Assistance Resource Guide which provides additional detail about the history and philosophy of systems of care, definitions and explanations for key terms and activities, and identifies additional reference materials that may be useful in developing a response to this application. This document may be found at http://www.samhsa.gov/Matrix/edocs_ta_cmhi.aspx].

Target Population

It is required that the target population be children and/or adolescents with a serious emotional disturbance as defined by the age, diagnosis, disability and duration criteria listed below:

Age. The child or youth must be from birth to 21 years of age.

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

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, and 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 target population.

- *Youth with a co-occurring serious emotional disturbance and substance use disorder*
- *Infants and young children from birth to 5 years with a serious emotional disturbance*
- *Emerging adults ages 18-21 with a serious emotional disturbance*
- *Children and youth involved with the child welfare system*
- *Youth involved with the juvenile justice system*

2. EXPECTATIONS

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 with serious emotional disturbances and their families.

2.1 Background

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. To address concerns about mental health service delivery, President Bush created the National Commission on Mental Health to "study and make recommendations for improving America's mental health service delivery system." The *President's New Freedom Commission on Mental Health* as described in *Achieving the Promise: Transforming Mental Health Care in America* (available at <http://www.mentalhealthcommission.gov/reports/reports.htm>) calls for a fundamental transformation in the way mental health services are delivered in America.

The Substance Abuse and Mental Health Services Administration (SAMHSA), and its Center for Mental Health Services, has been charged with the responsibility to implement the goals and recommendations of the New Freedom Commission. The Child Mental Health Initiative (CMHI), described herein, represents the largest and most targeted federal effort to transform children's mental health services.

2.2 PROGRAM GOALS

The overarching 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 effective services, treatments and supports;
- Create a case management team with an individualized service plan for each child;
- Incorporate culturally and linguistically competent practices for serving all children, youth and their families. Further, to eliminate disparities related to race, ethnicity, or geographic location; and,
- Promote full participation of families and youth in service planning and in the development of local services and supports.

The above goals and system of care approach are compatible with the 6 goals in the mental health transformation process described in *Achieving the Promise: Transforming Mental Health Care in America*, in the following ways:

- Systems of care promote recovery and resilience, and work toward reducing stigma.
- Mental health care for children is youth-guided and family-driven, and based on the development of individualized plans of care.
- Systems of care work to reduce service disparities by promoting cultural and linguistic competence and responsiveness.
- The needs of youth with co-occurring disorders are met.
- Excellent mental health care is identified by research and is supported by implementation of evidence-based practices.
- Systems of care promote federal/state/local partnerships across child and youth-serving systems.

Major projected clinical and system outcomes of the CMHI include:

- System level infrastructure will be created and sustained.
- Over 75% of the referrals will come from non-mental health sources.
- Cross-agency individualized care planning for children will increase over time.
- Behavioral and emotional problems will improve.
- Law enforcement contacts will be reduced.
- School attendance and performance will improve.
- Stable living arrangements will increase.
- Clinical and functional improvements will be achieved for children and youth.
- Children with co-occurring mental and substance use disorders will experience significant improvements in mental health functioning.
- Children will experience reductions in the use of inpatient care while being served in the community through systems of care.

2.3 PROGRAM REQUIREMENTS AND ALLOWABLE ACTIVITIES

The Comprehensive Community Mental Health Services Program for Children and their Families provides funds for infrastructure development and service provision for children and youth with a serious emotional disturbance 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.

The system-of-care development approach described below is guided by the values and principles of the system of care, as articulated in Stroul and Friedman (1994).

2.3.1 Infrastructure Development

Infrastructure development refers to the administrative structures and procedures that awardees must implement on a phased schedule throughout the 6-year Federal funding period to increase the capacity of a community-based system of care 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 must develop include the following:

- *Establishment of Governance body*
- *Systems integration*
- *Financing Approach*
- *Flexible Funds*
- *Interagency collaboration*
- *Service integration*
- *Wraparound process*
- *Care review*
- *Access*
- *Clinical network*
- *Workforce development*
- *Training Capacity*
- *Support from community leaders*
- *Administrative team*
- *Performance standards*
- *Management information system*

2.3.2 Required and Allowable Services and Supports

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

- Diagnostic and evaluation services;
- Care management;
- Development of an individualized service plan;
- Outpatient services provided in a clinic, office, school, or other appropriate location, including individual, group and family counseling services, professional consultation, and review and management of medication;
- Emergency services, available 24 hours a day, 7 days a week, including crisis outreach and crisis intervention;
- Intensive home-based services for children and their families when the child is at imminent risk of out-of-home placement, or upon return from out-of-home placement;
- Intensive day treatment services;
- Respite care;
- Therapeutic foster care;
- Therapeutic group home services caring for not more than 10 children (i.e., services in therapeutic foster family homes or individual therapeutic residential homes); and
- Assistance in making the transition from the services received as a child and youth to the services received as an adult.

(Note: The required services listed above should be integrated, when appropriate, with established alternative or traditional healing practices of racial or ethnic minority 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.

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

- Screening assessments to determine whether a child is eligible for systems-of-care services;
- Training in all aspects of system of care development and implementation, including evidence-based interventions.
- Therapeutic recreational activities; and
- 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 serious emotional disturbance.

(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 target population. 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 who need to be placed in special education programs;
- Health services, especially for children with co-occurring chronic illnesses;
- Substance abuse treatment and prevention services, especially for children with co-occurring substance abuse problems;
- Vocational counseling and rehabilitation, and transition services offered under IDEA, for those children 14 years or older who require them; and
- Protection and advocacy, including informational materials for children with a serious emotional disturbance and their families in the foster care system, who need to know about their rights as consumers of services, and assistance for any child with a serious emotional disturbance and the child's family about appropriate services available to them.

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 with a serious emotional disturbance often have co-occurring chronic illnesses and/or developmental disabilities. Therefore, collaboration with the 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 wraparound process.

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
- Title IV-B - Child Welfare/Family Preservation and Support Services and Title
- Title IV-E- Foster Care, Adoption and Independent Living.
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program, and
- 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.
- Strategic Prevention Framework State Infrastructure Grants (CSAP)
- Co-Occurring State Incentive Grants (CSAT/CMHS)
- 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

[Note: These memoranda of understanding are to be included in Appendix 1 entitled, Memoranda of Understanding for Services Coordination and Evaluation.]

2.3.3 Key Activities and Concepts of Service Provision

The provision of systems-of-care services for children with a serious emotional disturbance and their families emphasizes:

- delivery of effective clinical interventions, which as research has demonstrated, produce positive child and family outcomes;
- provision of care management services for each child and the child’s family; and
- development of an individualized care plan for each child and the child’s family.
- presence of a strong family and youth voice in all aspects of governance of the system of care, service delivery and evaluation.
- promotion of cultural and linguistic competence and responsiveness by individual service providers and agencies to ensure and support the well-being of children and their families.

Applicants must articulate a plan that addresses the philosophy of care delivery strategies for the following areas:

Delivery of Clinical Interventions. Clinical interventions include diagnostic assessments, treatment planning and service delivery provided to individuals and families. Clinical

interventions should be adapted for racial and ethnic minority populations, and strategies related to clinical training and the use of evidence based treatments must be incorporated.

[Note: Communities interested in seeking information on evidence-based interventions and best practices are encouraged to review sources of information such as the National Registry of Effective Programs and Practices (NREPP) (See the www.samhsa.gov web site.), the *Blueprint for Change: Research on Child and Adolescent Mental Health* (National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment, 2001; see <http://www.nimh.nih.gov/child/blueprint.cfm>), and the *Mental Health: A Report of the Surgeon General* (U.S. Department of Health and Human Services, 1999).]

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

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, which includes the child's parents or legally responsible adult and, unless clinically inappropriate, 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***. This team is comprised of representatives from child-serving agencies that provide services to the child and the family, as well as other significant individuals in the community who relate closely to the child and family, such as a minister, friend, or community leader.

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. Family-driven means that families have a decision making role in the care of their own children as well as the policies and procedures governing care for all children in the community, state, and nation. This includes choosing supports, services, and providers; setting goals; designing and implementing programs; monitoring outcomes; and determining effectiveness of all efforts to promote the mental health of children and youth. (See Appendix H for definition of Family-Driven Care).

Youth-Guided. Youth are playing an increasingly important role in planning their own treatment, and for seeking ways to improve the service delivery system. Youth involvement in these activities must be encouraged and supported.

Cultural and Linguistic Competence is defined as an integrated pattern of human behavior that includes thoughts, communications, languages, practices, beliefs, values, customs, courtesies, rituals, manners of interacting, roles, relationships and expected behaviors of a racial, ethnic,

religious or social group; the ability to transmit the above to succeeding generations; is dynamic in nature. (See Appendix D for Cultural and Linguistic Competence Elements).

2.3.4 Sustainability

Sustainability results from developing a strategic plan for maintaining the key elements that make an initiative successful and generate positive outcomes. Sustainability inevitably requires identifying and accessing adequate funding streams, and also requires an array of other resources: political, technical, and administrative. Sustainability planning should be done throughout the life of an initiative and will work best when it is used and reviewed on a periodic and continuing basis. As part of strategic planning activities, there is a requirement that selected applicants develop and update sustainability plans throughout the duration of the project as such a plan is essential to ensuring its future.

Applicants are required to detail plans for infrastructure and service sustainability beyond the six years of the federal grant. This initial plan should describe how the project will link with other state efforts to promote systems of care and other efforts to transform children's mental health services, and how this program can collaborate with other federal programs to promote sustainability efforts.

2.3.5 System Development Schedule

Below is a description of the activities that should be scheduled during each phase in the development of the system of care

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

- Develop a logic model of the system of care, which will serve as the basis for developing the strategic plan for the project. The logic model should, at a minimum, describe the context in which the system of care will be developed, the resources available for the system of care, the activities that will drive systems-of-care development, and the individual, service, and system outcomes expected from the system of care.
- Develop a strategic plan for implementation of the system of care throughout the 6-year Federal funding period. The strategic plan should specify how each of the activities described in Program Requirements for the Development of Systems of Care will be developed. In addition, the strategic plan should include a technical assistance plan that shows how training and technical assistance activities will be targeted to areas that require further development within the system of care. The plan must also address social marketing needs, local level evaluation, compatibility with state-level transformation and sustainability strategies.
- Hire key personnel.
- Establish the administrative team.
- Organize the governing body.

- Enhance and develop required services through: (1) the direct creation of new programs, (2) contracts with existing private, nonprofit service organizations, (3) coordination and expansion of services delivered by collaborating child-serving agencies, (4) and other such mechanisms.
- Develop an approach for service integration and coordination that is appropriate for the target population;
- Create a format for the individualized service plan that incorporates a full array of mental health and support services.
- Identify resources and activities to address family involvement, youth involvement, and cultural competence in the system of care.
- Create the capacity to implement the National Evaluation and develop a local evaluation plan.

Full Implementation – Two through Six. It is anticipated that the system of care will begin to operate during Year Two of the cooperative agreement. In other words, the system of care should begin to enroll and serve children and their families through its array of services and supports and begin to enroll children and their families in the National Evaluation and transmit data to the national evaluator.

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

2.4 Data and Performance Measurement

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 evaluate, especially after Federal funding ceases. Awardees are required to participate in the implementation of the National Evaluation.

During the first year of the cooperative agreement, each awardee will receive detailed instructions about the design of the evaluation and the procedures for implementing each component of the evaluation. For example, one component requires implementation of a longitudinal outcome study that includes the enrollment and follow-up of approximately 100 children per service year, with a total representative sample of about 300 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.

In addition, each awardee is encouraged to enhance the National Evaluation with its own **local evaluation activities**. 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 quarterly reports. Finally, local level evaluations are an important strategy for long-term sustainability of the system of care.

The National Institute of Mental Health (NIMH) has established a program announcement (i.e., PA-04-019: see <http://grants.nih.gov/grants/guide/pa-files/PA-04-019.html>) to promote effectiveness, implementation or practice research within communities awarded a cooperative agreement from the Comprehensive Community Mental Health Services Program for Children and Their Families. The systems-of-care communities funded by SAMHSA/CMHS are encouraged to partner with an experienced researcher and to jointly submit, with the researcher, applications for grants funded through the NIMH program announcement. These research grants can be used to implement scientific studies to test the effectiveness of an entire system of care, or to test the effectiveness of specific interventions and practices offered within a system of care. It is hoped that systems-of-care communities will apply for the research funds from this program announcement to further illustrate how science can be used to increase the effectiveness of service systems and specific services.

The Government Performance and Results Act of 1993 (P.L.103-62, or "GPRA").

GPRA requires all Federal agencies to set program performance targets and report annually on the degree to which the previous year's targets were met.

Agencies are expected to evaluate their programs regularly and to use results of these evaluations to explain their successes and failures and justify requests for funding. The National Evaluation described above satisfies the GPRA requirements and as such Grantees are required to report these data to SAMHSA on a timely basis. In your application, you must demonstrate your ability to collect and report on these measures, and you are required to provide baseline data on number of youth served in the system and the average number of residential and inpatient days.

The terms and conditions of the grant award will specify the data to be submitted (see chart below) and the schedule for submission. Grantees will be required to adhere to these terms and conditions of award.

GPRA Measures for the CMHI

Performance Measures (Capacity)
1. Increase number of children receiving services
2. Improve children’s outcomes and systems outcomes: (a) Increase percentage attending school 75% or more of time after 12 months (b) Increase percentage with no law enforcement contacts at 6 months (c) Decrease utilization of inpatient facilities at 6 months (d) Decrease inpatient costs
Long-Term Measures (Outcomes)
Improve Children’s Outcomes (60% of grantees will exceed a 30% improvement in outcomes)
Increase percent of systems of care that are sustained post federal funding (80%)
Percent of grantees that decrease inpatient costs (25% of systems of care will exceed a 10% Decrease in inpatient care)

2.5 Grantee Meetings

Applicants are required to budget for attendance of a core team of approximately 10 individuals at one national meeting and one regional meeting per year to create and sustain a learning community among all awardees. The core team must include the project director, evaluator, key family contact, clinical director, youth coordinator, technical assistance coordinator, communications manager, representatives from at least two other child-serving systems in the community, and the State contact for the project.

II. AWARD INFORMATION

1. Estimated Funding Available/Number of Awards: It is expected that approximately \$24 million will be available to fund up to 24 awards in FY 2005. The maximum allowable award for Year 1 is \$1 million in total costs (direct and indirect); Year 2: \$1.5million; Year 3: \$2 million; Year 4: \$2 million; Year 5: \$1.5 million; Year 6: \$1 million.

Proposed budgets cannot exceed the allowable amount in any year of the proposed project. The actual amount available for awards may vary, depending on unanticipated program requirements and quality of the applications received.

[Note: There are cost sharing/matching requirements for this program. Please refer to Section III.2. Cost Sharing]

2. FUNDING MECHANISM

Cooperative Agreements:

These awards are cooperative agreements because they require substantial Federal staff involvement in monitoring and assisting grantees in meeting extensive program requirements.

Awardees must:

- 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.

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.

Awardees 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 half-time equivalent staff person to serve as technical assistance coordinator.

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

Awardees will be required to:

- Develop a culturally and linguistically competent social marketing plan that includes: (1) providing information to the public regarding the system of care and its services; (2) educating the public about the needs of children with serious emotional disturbances and their families; and (3) recommending good mental health practices for meeting those needs.
- Designate at least a half-time equivalent position for a social marketing-communications manager.
- Provide support to a family organization associated with the system of care to implement outreach strategies with families of children with a serious emotional disturbance who are from racial and ethnic minority groups represented in the community.

- Implement a social marketing strategy that determines the informational needs of target audiences and 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>.)

SAMHSA Staff will:

- Monitor each awardee'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, and proposed programmatic and budgetary modifications).
- Participate in making decisions with the awardee to help achieve project objectives.
- Approve decisions of each awardee about:
 - Use of technical assistance resources for developing the system of care, according to requirements of the cooperative agreement, and for increasing the likelihood that the system of care will be sustained beyond the Federal funding period;
 - Use of communications, public awareness, and social marketing techniques in the community to promote good mental health practices among children and youth with serious emotional disturbances and their families; advertise systems-of-care services and reduce community-wide stigma associated with serious emotional disturbances;
 - Ways to insure implementation of the National Evaluation to: (1) demonstrate the effectiveness of each system of care through evidence that the well-being of children with serious emotional disturbances and their families increases as a result of receiving systems-of-care services; (2) ensure timely submission of data to the National Evaluation contractor; (3) use data to improve and 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 are 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 tribes 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
- Government of the Territories of Guam, Commonwealth of Puerto Rico, Northern Mariana Islands, Virgin Islands, American Samoa, and Trust Territory of the Pacific Islands (now Palau, Micronesia, and the Marshall Islands).

For applicants that have previously received a CMHI cooperative agreement, an application for a new cooperative agreement must specify a geographic service area within the State, county, tribe, or territory that is different from the geographic area of the current or past award (see Table 1).

An exception to this requirement will be made specifically for States whose previous award(s) was to develop systems of care across the entire State. Such States with a previous statewide implementation approach may apply for this cooperative agreement, as long as any previous awards under this program have expired in their entirety, including their no-cost extension years. States with prior CMHI grants must also demonstrate that the programs implemented under these previous awards have been sustained and that the target population they are now proposing is different from that in the previous award(s).

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

The legislation specifies 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, as long as the geographic area specified in a cooperative agreement application does not overlap with the geographic area specified in another cooperative agreement 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.

- ▶ As an indicator of potential sustainability, the applicant public entity must include a letter of assurance from the governor of the State or Territory, or the governor's designee, stating that the public entity will provide directly any service required in this cooperative agreement, which is also covered in the State Medicaid Plan, and that it has entered into a participation agreement under the State plan and is qualified to receive payments under such plan. If the public entity will not provide direct services, then the letter of assurance must indicate that the public entity 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 under this Request for Applications (RFA) 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 these State or Territory 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 tribes or tribal organization applicants.

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

[Note: No awards will be made to applicants who do not submit a letter of assurance from the Governor. Applicants should see 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 government	Eligible if targeted to a new 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, such 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.	Governor or chief executive officer of State agency, designated in writing by the governor.	Yes
Counties, cities, Territories	Eligible if targeted to a new geographic area; proposed geographic area may not overlap with geographic area from any other concurrent application within the State or Territory.	Chief executive officer, designated in writing by the governor or by the chief executive of a Territory or the District of Columbia.	Yes
Tribe	Eligible only if targeted to a Tribe or tribal organization not previously funded under this Program.	Tribal leader or Tribal council	No

2. COST SHARING

By statutory mandate, this program requires the applicant entity to provide, directly or through donations from public or private entities, nonfederal contributions:

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

Matching resources may be in cash or in-kind, including facilities, equipment, or services, and must be derived from 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). The applicant should specify the names of the expected sources, the types of sources (e.g., education, child welfare, juvenile justice), and the amounts of matching funds, as evidence of the project'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.

A letter from the director of the State, county, or city mental health agency applying for the cooperative agreement should certify that nonfederal matching funds for the proposed project are available. The letter must be included in Appendix 5 of the application entitled, Nonfederal Match Certification. Such letter also should indicate that proposed changes in funding streams required for the match or other funding innovations necessary for implementation of the proposed project will be allowed. Additional letters from other non-mental health agency directors (e.g., education, child welfare, juvenile justice) at the State, county, or city levels, also may be included in Appendix 5 of the application.

Indian tribes 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

Applications must comply with the following requirements, or they will be screened out and will not be reviewed: use of the PHS 5161-1 application; application submission requirements in Section IV-3 of this document; and formatting requirements provided in Section IV-2.3 of this document.

IV. APPLICATION AND SUBMISSION INFORMATION

(To ensure that you have met all submission requirements, a checklist is provided for your use in Appendix A of this document.)

1. ADDRESS TO REQUEST APPLICATION PACKAGE

- You may request a complete application kit from the National Mental Health Information Center at 1-800-789-CMHS (2647).
- You also may download the required documents from the SAMHSA web site at www.samhsa.gov . Click on “Grants”.

Additional materials available on this web site include:

- a technical assistance manual for potential 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
- enhanced instructions for completing the PHS 5161-1 application.

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, budget forms, assurances, certification, and checklist. You must use the PHS 5161-1. **Applications that are not submitted on the PHS 5161-1 will be screened out and will not be reviewed.**
- Request for Applications (RFA) – Provides specific information about the availability of funds along with instructions for completing the grant application. This document is the RFA. The RFA will be available on the SAMHSA web site (www.samhsa.gov) and on the Federal grants web site (www.grants.gov). A Notice of Funding Availability summarizing the RFA will be published in the Federal Register.

[Note: The applicant must use all of the above documents in completing the application.]

2.2 Required Application Components

To ensure equitable treatment of all applications, applications must be complete. In order for your application to be complete, it 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** – Use Standard Form (SF) 424, which is part of the PHS 5161-1. [Note: Beginning October 1, 2003, applicants will need to provide a Dun and Bradstreet (DUNS) number to apply for a grant or cooperative agreement from the Federal Government. SAMHSA applicants will be 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. 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 5161-1. Fill out Sections B, C, and E of the SF 424A.
- ❑ **Project Narrative and Supporting Documentation** – The Project Narrative describes your project. It consists of Sections A through D. These sections in total may not be longer than 35 pages: if your Project Narrative begins on page 1, it must end on or before page 35; if your Project Narrative begins on page 2, it must end on or before page 36; if your Project Narrative begins on page 3, it must end on or before page 37; etc. 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.

- *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 20% of the total grant award will be used for data collection and evaluation.
 - *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 letter of commitment from the individual with a current biographical sketch.
 - Include job descriptions for key personnel. Job descriptions should be no longer than 1 page each.
 - Sample sketches and job descriptions are listed on page 22, Item 6 in the Program Narrative section of the PHS 5161-1.
 - *Section H* - Confidentiality and SAMHSA Participant Protection/Human Subjects. Section IV-2.4 of this document describes requirements for the protection of the confidentiality, rights and safety of participants in SAMHSA-funded activities. This section also includes guidelines for completing this part of your application.
- **Appendices 1 through 6** – Use only the appendices listed below. If your application includes any appendices not required in the grant announcement, they will be disregarded.
- *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. Use Standard Form 424B found in PHS 5161-1.
- **Certifications** – Use the “Certifications” forms found in PHS 5161-1.
- **Disclosure of Lobbying Activities** – Use 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.

- ❑ **Checklist** – Use the Checklist found in PHS 5161-1. The Checklist ensures that you have obtained the proper signatures, assurances and certifications and is the last page of your application.

2.3 Application Formatting Requirements

Applicants also must comply with the following basic application requirements. Applications that do not comply with these requirements will be screened out and will not be reviewed.

- ❑ Information provided must be sufficient for review.
- ❑ Text must be legible. (For Project Narratives submitted electronically in Microsoft Word, see separate requirements below under “Guidance for Electronic Submission of Applications.”)
 - Type size in the Project Narrative cannot exceed an average of 15 characters per inch, as measured on the physical page. (Type size in charts, tables, graphs, and footnotes will not be considered in determining compliance.)
 - Text in the Project Narrative cannot exceed 6 lines per vertical inch.
- ❑ Paper must be white paper and 8.5 inches by 11.0 inches in size.
- ❑ To ensure equity among applications, the amount of space allowed for the Project Narrative cannot be exceeded. (For Project Narratives submitted electronically in Microsoft Word, see separate requirements below under “Guidance for Electronic Submission of Applications.”)
 - Applications would meet this requirement by using all margins (left, right, top, bottom) of at least one inch each, and adhering to the 35-page limit for the Project Narrative.
 - Should an application not conform to these margin or page limits, SAMHSA will use the following method to determine compliance: The total area of the Project Narrative (excluding margins, but including charts, tables, graphs and footnotes) cannot exceed 58.5 square inches multiplied by 35. This number represents the full page less margins, multiplied by the total number of allowed pages.
 - Space will be measured on the physical page. Space left blank within the Project Narrative (excluding margins) is considered part of the Project Narrative, in determining compliance.

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, following these guidelines will help reviewers to consider your application.

- ❑ Pages should be typed single-spaced in black ink, with one column per page. Pages should not have printing on both sides.
- ❑ Please number pages consecutively from beginning to end so that information can be located easily during review of the application. The cover page should be page 1, the abstract page should be page 2, and the table of contents page should be page 3. 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 limit of a total of 30 pages for Appendices 2, 4 and 5 combined should not be exceeded.
- ❑ Send the original application and two copies to the mailing address in Section IV-6.1 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.

Guidance for Electronic Application Submission

SAMHSA is now offering the opportunity for you to submit your application to us either in electronic or paper format. 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.

You must search the Grants.gov site for the downloadable application package, 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: www.Grants.gov apply site, on the Customer Support tab. 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.

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: DUNS Number registration, Central Contractor Registry (CCR) registration, Credential Provider registration, and Grants.gov registration.

It is strongly recommended that you submit your grant application using Microsoft Office products (e.g., Microsoft Word, Microsoft Excel, etc.). If you do not have access to Microsoft Office products, you may submit a PDF file. 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 above, and 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 to 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 one inch each. Adhering to these standards will help to ensure the accurate transmission of your document. If the type size in the Project Narrative of an electronic submission exceeds 15 characters per inch, or the text exceeds 6 lines per vertical inch, SAMHSA will reformat the document to Times New Roman 12, with line spacing of single space. Please note that this may alter the formatting of your document, especially for charts, tables, graphs, and footnotes.
- *Amount of space allowed for Project Narrative:* The Project Narrative for an electronic submission may not exceed 18,025 words. **Any part of the Project Narrative in excess of the word limit will not be submitted to review.** To determine the number of words in your Project Narrative document in Microsoft Word, select file/properties/statistics.

Applicants are strongly encouraged to submit their applications to Grants.gov early enough to resolve any unanticipated difficulties prior to the deadline. You may also submit a back-up paper submission of your application. Any such paper submission must be received in accordance with the requirements for timely submission detailed in Section IV-3 of this announcement. The paper submission must be clearly marked: “Back-up for electronic submission.” The paper submission must conform with all requirements for non-electronic submissions. If both electronic and back-up paper submissions are received by the deadline, the electronic version will be considered the official submission.

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.

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), the assurances (SF 424B), and the certifications, and hard copy of any other required documentation that cannot be submitted electronically. **You must reference the Grants.gov tracking number for your application, on these documents with original signatures, and send the documents to the following address. The documents must be received at the following address within 5 business days of 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 service (DHL, Falcon Carrier, Federal Express, United Parcel 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 **20850**
ATTN: Electronic Applications

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

2.4 SAMHSA Confidentiality and Participant Protection Requirements and Protection of Human Subjects Regulations

Applicants must describe procedures relating to Confidentiality, Participant Protection and the Protection of Human Subjects Regulations in Section H of the application, using the guidelines provided below. Problems with confidentiality, participant protection, and protection of human subjects identified during peer review of the application may result in the delay of funding.

Confidentiality and Participant Protection:

All applicants must describe how they will address the requirements for each of the following elements relating to 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.).
- 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 **other than** those required by the National Evaluation 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:
 - How you will use data collection instruments.
 - Where data will be stored.
 - Who will or will not have access to information.
 - How the identity of participants will be kept private, 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. Adequate Consent Procedures

- 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:
 - Whether or not their participation is voluntary.
 - Their right to leave the project at any time without problems.
 - Possible risks from participation in the project.
 - Plans to protect clients from these risks.

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

NOTE: If the project poses potential physical, medical, psychological, legal, social or other risks, you **must** obtain written 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

Grantees funded under this RFA will be required to comply with the Protection of Human Subjects Regulations (45 CFR 46).

Applicants 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://hhs.gov/ohrp>. You may also contact OHRP by e-mail (ohrp@osophs.dhhs.gov) or by phone (301-496-7005). SAMHSA-specific questions related to Protection of Human Subjects Regulations should be directed to the program contact listed in Section VII of this RFA.

3. SUBMISSION DATES AND TIMES

Applications are due by close of business on May 17, 2005. Hand carried applications will not be accepted. Applications may be shipped using only DHL, Falcon Carrier, Federal Express (FedEx), United Parcel Service (UPS), or the United States Postal Service (USPS).

Your application must be received by the application deadline, or you must have proof of its timely submission as specified below.

- For packages submitted via DHL, Falcon Carrier, Federal Express (FedEx), or United Parcel Service (UPS), timely submission shall be evidenced by a delivery service receipt indicating the application was delivered to a carrier at least 24 hours prior to the application deadline.
- For packages submitted via the United States Postal Service (USPS), proof of timely submission shall be a postmark not later than 1 week prior to the application deadline, and the following upon request by SAMHSA:
 - Proof of mailing using USPS Form 3817 (Certificate of Mailing), or
 - A receipt from the Post Office containing the post office name, location, and date and time of mailing.

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

Applications not meeting the timely submission requirements above will not be considered for review. Please remember that mail sent to Federal facilities undergoes a security screening prior to delivery. Allow sufficient time for your package to be delivered.

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

Executive Order 12372, as implemented through Department of Health and Human Services (DHHS) regulation at 45 CFR Part 100, sets up a system for State and local review of applications for Federal financial assistance. A current listing of State Single Points of Contact (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 a federally recognized Indian tribal government.
- 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-05-010

For other delivery 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 **20850**
 ATTN: SPOC – Funding Announcement No. SM-05-010

5. FUNDING LIMITATIONS/RESTRICTIONS

Cost principles describing allowable and unallowable expenditures for Federal grantees, including SAMHSA grantees, are provided in the following documents:

- Institutions of Higher Education: OMB Circular A-21
- State and Local Governments: OMB Circular A-87
- Nonprofit Organizations: OMB Circular A-122
- Appendix E Hospitals: 45 CFR Part 74

In addition, SAMHSA’s *Child Mental Health Initiative Cooperative Agreement* recipients must comply with the following funding restrictions:

- These cooperative agreement funds must be used for purposes supported by the program.
- No more than 20% of the grant award may be used for evaluation and data collection expenses.
- Funds may not be used to pay for the purchase or construction of any building or structure to house any part of the grant project. Applications may request up to \$75,000 for renovations and alterations of existing facilities.

6. OTHER SUBMISSION REQUIREMENTS

6.1 Where to Send Applications

(Guidance for Electronic Submission of Applications is contained in Section IV-2.3 of this announcement. Following are instructions for submission of paper applications.)

Send applications to the following address:

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**

For other delivery 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 **20850**

Do not send applications to other agency contacts, as this could delay receipt. Be sure to include ***Child Mental Health Initiative/ SM-05-010*** in item number 10 on the face page of the application. If you require a phone number for delivery, you may use (240) 276-1199.

6.2 How to Send Applications

(Guidance for Electronic Submission of Applications is contained in Section IV-2.3 of this announcement. Following are instructions for submission of paper applications.)

Mail or deliver an original application and 2 copies (including appendices) to the mailing address provided above, according to the instructions in Section IV-3. The original and copies must not be bound. Do not use staples, paper clips, or fasteners. Nothing should be attached, stapled, folded, or pasted.

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

V. APPLICATION REVIEW INFORMATION

1. EVALUATION CRITERIA

Your application will be reviewed and scored according to the quality of your response to the requirements listed below for developing the Project Narrative (Sections A-D). These sections describe what you intend to do with your project.

Project Narrative Sections A through D

Use the instructions below that are specific to the CMHI. These are to be used instead of the Program Narrative instructions found on page 21 of the PHS 5161-1 document. Responses to Sections A through D represent the Project Narrative of your application. Below are instructions on how to respond to Sections A through D. Responses to these sections may not be longer than 35 single-spaced typewritten pages.

- A committee will review and score your application, based on the requirements described below for Sections A through D. These requirements also will serve as review criteria for the review committee.
- A peer review committee will assign a total point value to your application, based on how well you respond to each of the sections.
- The number of points indicated after each section heading shows the maximum number of points the review committee will assign to your responses for that section.
- Statements indicated by a bullet provide instructions for developing a response to each section, but no points are assigned specifically to each of these bullet statements.
- Reviewers also will be looking for evidence of cultural and linguistic competence in each section of the Project Narrative. Points will be assigned based on how well you address the cultural and linguistic competency aspects of the review criteria. SAMHSA's guidelines for cultural competence are included in Appendix D.

Section A: Understanding of the Project (15 Points)

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

- Provide a brief literature review, which demonstrates:
 - Knowledge of the principles of systems of care for children with a serious emotional disturbance;
 - Knowledge of the history of systems of care in the United States; and
 - Need for systems-of-care reform in this country, and specifically, in the targeted community.

(Note: List in Section E the literature citations you reference in your application.)

- Describe the population of children with a serious emotional disturbance in the geographic service area that will be targeted by the project. Include in this description:
 - Projected age range (e.g., birth to 21, 5 to 17);
 - Prevalence estimate (in numbers) of children with a serious emotional disturbance within the geographic service boundaries of the project;
 - 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, and literacy levels;
 - Family or institutional settings in which these children live or are currently served (e.g., special education programs, foster care, probation), and which will be potential sources of referrals. Include expected number of referrals from each source; and
 - Primary language, level of acculturation, migration and immigration characteristics, and service disparities for children from racial or ethnic minority groups. 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 racial or ethnic access to quality care.
- Describe the current capacity to serve children with a serious emotional disturbance and their families. Specifically, describe the existing resources and services available within the jurisdiction of the proposed project. If possible, try to estimate the number of children currently served.
- Establish the significance of the proposed project by identifying the gaps in, inadequacies of, and barriers to current service structures that justify the need for the proposed project.

- Describe how the proposed project also will collaborate with other Federal, State, and local programs and reform initiatives.

Section B: Implementation Plan (55 Points)

In this section the applicant must provide explanation for how they 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 approach sustainability.

Infrastructure Development (15 Points)

- Describe how the infrastructure for the system of care will be developed.
- Describe 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, wraparound processes, 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 mental health.
- Describe a plan for replication of the local systems-of-care model in other communities of the State, tribe, or territory. Indicate how the local system of care is 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, 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 project will increase the capacity and quality of services delivered to children with a serious emotional disturbance. State the number of children expected to be served annually in the system of care and the number of children 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.
- Describe how the following individuals have participated in the development of the implementation plan contained in this application:
 - State and local child-serving agencies and community leaders;
 - Family members and family-run organizations;
 - Youth
 - Racial or ethnic minority groups in the community. [Note: These may include youth from the target population, family members, service providers, or community leaders.]
- Discuss the extent to which nonfederal match dollars demonstrate interagency collaboration through contributions from different child-serving agencies.
- Include a letter of assurance from the Governor or the Governor's designee, as described on pages 18-20 (Indian tribes 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 systems-of-care services. Identify whether a priority population will be served.
- Explain how the service provision components of the system of care will be developed in your project. Include how the following services will be implemented throughout the 6-year period:
 - Required mental health services and supports;
 - Optional services; and
 - Non-mental health services.

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 serious emotional disturbance and substance use disorder; (2) substance abuse prevention interventions for pre-adolescents with a serious emotional disturbance; (3) medical services for children with a co-occurring serious emotional disturbance and chronic illness; and (4) literacy interventions specific for children with a serious emotional disturbance.

- 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;
- 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 project 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 project 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. In addition, describe any adaptations that will be made to the evidenced based interventions to address service delivery for racial and ethnic minority populations. There also should be a description of how these evidence-based interventions will become integrated into the individualized service plan and wraparound process for children with a serious emotional disturbance for whom the evidence-based interventions apply.

Care management services

- 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 wraparound and care management service approaches.

Individualized service plans

- Articulate how individualized service plans will be developed and how they will build upon the existing strengths 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:
 - a. Description of the need for services;
 - b. Recognition of existing strengths of the child and the child's family;
 - c. Development of objectives that meet the needs and builds upon the existing strengths of the child and the child's family;

- d. Development of a methodology for meeting these objectives;
 - e. Provision of non-mental health services, as appropriate; and,
 - f. Designation of the lead agency responsible for care management services.
- Describe the process for quality assurance 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 project.
 - Describe how a local parent support organization will be created or how an existing parent support organization will be included to complement the initiative (such as a CMHS-funded Statewide Family Network grantee).
 - Identify a full-time equivalent position for a family member to serve as the key family contact for the system of care. At a minimum, the responsibilities of the *key family contact* should include advocacy for other family members of children receiving services; outreach to family members of children not receiving services; and serving as one of the family member representatives on the governance body.
 - Describe how the project will provide financial support to sustain family involvement in the system of care throughout the duration of the project and beyond the Federal funding period.
 - Describe how the project will create a strong partnership between professionals and family members that enables family members to participate in the planning, management, and evaluation of the system of care.
 - Describe how compensation and fiscal support will be provided for families whose children are eligible for services, as well as the existing family organizations whose focus is on these children and families. The aim of such support is to enable family members and family organizations to participate in activities related to the development, implementation, and evaluation of the system of care. The support also should be provided for families and family organizations from racial or ethnic minority backgrounds in the community.
 - **Describe Youth Guided Care**
 - Describe how youth will be included in the planning and implementation of individualized and system level interventions.
 - Identify an individual to serve as 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; advocating for youth who are receiving services; reaching out to eligible youth who are not receiving services; and representing youth on the governance body.

- **Explain how cultural and linguistic competence will be addressed within the system of care, including how the project will:**
 - Comply with Title VI of the Civil Rights Act.
 - Fulfill the guidelines as delineated in the (1) Culturally and Linguistically Appropriate Standards in Health Care (CLAS), and (2) CMHS' Cultural Competence Standards published by the Department of Health and Human Services.
 - Use the Planning for Cultural and Linguistic Competence in Systems of Care for Children and Youth with Social-Emotional and Behavioral Disorders and their Families, developed by the National Center for Cultural Competence (available at <http://gucchd.georgetown.edu/nccc/products.html>).
 - Address disparities in access and utilization, quality of mental health services, availability of effective clinical interventions, clinical and functional outcomes, satisfaction with services and supports, and other systems-of-care outcomes for children, youth and their families from culturally and linguistically diverse groups.
 - Enhance the organization's policies, structures, practices, and procedures and dedicate resources to assure that the delivery of services and supports are effective for diverse populations.
 - Assure that the individualized service plan is consistent with the cultural context of the family. This may include the preferred language of the child, youth and family; recognize and build upon the cultural beliefs, practices, traditions, customs or norms of children, youth and their families, affirm the inherent strengths and resiliency of families and communities; use natural networks of support with diverse communities.
 - Assure meaningful participation and advocacy from culturally and linguistically diverse groups in system-or-care entities such as the governing body, administrative teams, care review groups, and individualized care teams.
 - Provide evidence that the management plan, staffing pattern, project organization, and resources are adequate to support the practice models that incorporate culture and language in the delivery of services to diverse groups.
 - Expand the service array to include providers representing the cultural and linguistic diversity of the community.
 - Assure evidence-based practices and interventions have proven efficacy for specific cultural, racial, ethnic and linguistic groups.
 - Designate an individual to serve as *cultural and linguistic coordinator* in the system of care. This person will provide direction and guidance to the system of care and its constituent organizations in the efforts to establish and implement the policies, practices, procedures, structures required to support culturally and linguistically competent practice.

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

- Indicate how the primary goals and objectives of the project 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.

- Discuss strategies for ensuring project sustainability after the sixth year of the cooperative agreement through amounts and sources of nonfederal match contributions. Please 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 project will coordinate with other relevant federally funded initiatives, including the Mental Health Block Grant Program, Safe Schools, Health Students Program, Child and Adolescent Mental Health and Substance Abuse State Infrastructure Grants, etc.
- Describe specific strategies for sustainability. 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.

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

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

- Provide a brief description of the applicant organization and its relationship to other child- and family-serving organizations. Please include an organizational chart in Appendix 6 of the application. Memoranda of understanding with any collaborating agencies and organizations must be provided in Appendix 1 of the application.
- The qualifications and experience of required personnel, including:
 - Principal investigator;
 - Project director;
 - Clinical director;
 - Key evaluation staff;
 - Lead family contact;
 - Youth coordinator;
 - Technical assistance coordinator;
 - Communications/Social marketing manager;
 - State and local agency liaison; and
 - Key consultants.

- The percentage of time that each person will dedicate to the project. Provide a rationale for the dedicated time of each person. Include a staffing pattern chart in Appendix 6 of the application.
- Provide a description of the tasks to be performed and their relationship to the project goals and objectives. The staff position responsible for implementing each task should be identified. Include a management chart in Appendix 6.
- Provide a timeline of activities and tasks that will be implemented each year of the 6-year Federal funding period. Discuss the feasibility of accomplishing the proposed sequence of activities and tasks specified in the timeline. Please include the timeline in Appendix 6.

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

- Provide a description of the facilities, equipment, and resources (e.g., management information system, office space, computer networks) available for the project.
- Provide evidence that the services are provided in a location that is accessible, compliant with the Americans with Disabilities Act (ADA), and culturally appropriate for the children and families who will be served.
- Provide evidence that the practices for protecting the privacy of children and families served through the system of care, as well as the practices for reimbursement of services through electronic transmission of invoices and payments, are compliant with standards of the Health Insurance and Portability Accountability Act (HIPAA).

Section D: Evaluation Plan (15 Points)

The evaluation plan must:

- 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 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.
- Describe the knowledge and experience of individuals with evaluation expertise who are available from local universities or the community, and especially address how you intend to obtain and use the expertise of these individuals for implementation of evaluation activities. Specify the degree to which these individuals have specialized knowledge and experience about:

- Applied research and evaluation methods, especially longitudinal study techniques, as well as family and community study approaches;
 - Children’s mental health services;
 - Direction and supervision of research and evaluation projects; and
 - Writing and reporting of research and evaluation findings in peer-reviewed journals, and also among multiple public audiences, including family members, policy makers, administrators, and clinicians.
- Describe the facilities, equipment, materials, and resources that will be dedicated to evaluation activities. Include a description of the data management, spreadsheet, and statistical software available to the project.
 - Describe how the project staff will perform the functions of data entry, storage, management, analysis, and reporting. Indicate how completed surveys and records will be kept secure and confidential.
 - Provide a detailed description of the type of administrative and service utilization data currently available in management information systems (MIS), and indicate the child-serving agencies that have already developed these MIS. Also, discuss the feasibility of creating one integrated MIS among the collaborating child-serving agencies.
 - Explain how family members and youth will be incorporated into evaluation activities. These activities may include providing feedback on the design and objectives of the evaluation, conducting interviews, analyzing data, and interpreting and reporting results.
 - Describe the nature of any local evaluation activities that will be implemented, in addition to the required activities for implementing the National Evaluation.

[Note: Although the budget for the proposed project is not a review criterion, the review committee will be asked to comment on the appropriateness of the budget after the merits of the application have been considered.]

2. REVIEW AND SELECTION PROCESS

SAMHSA applications are peer-reviewed according to the review criteria listed above. For those programs where the individual award is over \$100,000, the National Advisory Council must also review applications.

Decisions to fund a grant are based on:

- the strengths and weaknesses of the application as identified by peer reviewers and, when appropriate, approved by the appropriate National Advisory Council;
- availability of funds;
- equitable distribution of awards in terms of geography (including urban, rural and remote settings) and balance among target populations and program size; and

- after applying the aforementioned criteria, the following method for breaking ties: When funds are not available to fund all applications with identical scores, SAMHSA will make award decisions based on the application(s) that received the greatest number of points by peer reviewers on the evaluation criterion in Section V-1 with the highest number of possible points (Implementation Plan-55 points). Should a tie still exist, the evaluation criterion with the next highest possible point value will be used, continuing sequentially to the evaluation criterion with the lowest possible point value, should that be necessary to break all ties. If an evaluation criterion to be used for this purpose has the same number of possible points as another evaluation criterion, the criterion listed first in Section V-1 will be used first.

VI. AWARD 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, the Notice of Grant Award, signed by SAMHSA's Grants Management Officer. The Notice of Grant Award is the sole obligating document that allows the grantee to receive Federal funding for work on the grant project. It is sent by postal mail and is addressed to the contact person listed on the face page of the application.

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

2. ADMINISTRATIVE AND NATIONAL POLICY REQUIREMENTS

- 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 www.samhsa.gov/grants/2004/useful_info.asp.
- Depending on the nature of the specific funding opportunity and/or the proposed project as identified during review, additional terms and conditions may be negotiated with the grantee prior to grant award. These may include, for example:
 - actions required to be in compliance with 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.
- 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.

- 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. Applicants are encouraged to complete the survey and return it, using the instructions provided on the survey form.

3. REPORTING REQUIREMENTS

3.1 Progress and Financial Reports

- CMHI grantees must provide quarterly, 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 project, 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

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 *Child Mental Health Initiative* Grants are described in Section I-2.4 of this document under “Data 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 (301-443-8596) of any materials based on the SAMHSA-funded 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 on 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:

Kimberly Pendleton
Office of Program Services, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Room 7-1097
Rockville, MD 20857
(240) 276-1421
Kimberly.Pendleton@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. Due to limited space, prospective applicants are invited to register early at the following address: <http://tapartnership.raindance.com/iccdocs/seminarList.shtml>.

For more information about these webinars, please contact:

Emmett Dennis
Communications Director
Technical Assistance Partnership for Child and Family Mental Health
202-403-6860 (office) edennis@air.org

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.** In addition to these formatting requirements, programmatic requirements (e.g., relating to eligibility) may be stated in the specific funding announcement. Please check the entire funding announcement before preparing your application.*

- Use the PHS 5161-1 application.
- Applications must be received by the application deadline or have proof of timely submission, as detailed in Section IV-3 of the grant announcement.
- Information provided must be sufficient for review.
- Text must be legible. (For Project Narratives submitted electronically in Microsoft Word, see separate requirements in Section IV-2.3 of this announcement under “Guidance for Electronic Submission of Applications.”)
 - Type size in the Project Narrative cannot exceed an average of 15 characters per inch, as measured on the physical page. (Type size in charts, tables, graphs, and footnotes will not be considered in determining compliance.)
 - Text in the Project Narrative cannot exceed 6 lines per vertical inch.
- Paper must be white paper and 8.5 inches by 11.0 inches in size.
- To ensure equity among applications, the amount of space allowed for the Project Narrative cannot be exceeded. (For Project Narratives submitted electronically in Microsoft Word, see separate requirements in Section IV-2.3 of this announcement under “Guidance for Electronic Submission of Applications.”)
 - Applications would meet this requirement by using all margins (left, right, top, bottom) of at least one inch each, and adhering to the page limit for the Project Narrative stated in the specific funding announcement.
 - Should an application not conform to these margin or page limits, SAMHSA will use the following method to determine compliance: The total area of the Project Narrative (excluding margins, but including charts, tables, graphs and footnotes) cannot exceed 58.5 square inches multiplied by the total number of allowed pages. This number represents the full page less margins, multiplied by the total number of allowed pages.

- Space will be measured on the physical page. Space left blank within the Project Narrative (excluding margins) is considered part of the Project Narrative, in determining compliance.

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 our 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. These are:
 - Face Page (Standard Form 424, 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 (a form in PHS 5161-1)
 - 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, participant protection and the protection of human subjects specified in Section IV-2.4 of the specific funding announcement.
 - Budgetary limitations as specified in Sections I, II, and IV-5 of the specific funding 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.
- Please number pages consecutively from beginning to end so that information can be located easily during review of the application. The cover page should be page 1, the abstract page should be page 2, and the table of contents page should be page 3. 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 limit for Appendices stated in the specific funding announcement cannot be exceeded.
- Send the original application and two copies to the mailing address in the funding announcement. 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.

ILLUSTRATION OF DETAILED BUDGET AND NARRATIVE JUSTIFICATION (cont'd.)

Supplies

Office Supplies	\$500
Computer Software - 1 WordPerfect	500

Enter Supplies subtotal on 424A, Section B, 6.e. \$1,000

Contractual Costs

Evaluation

Job Title	Name	Annual Salary	Salary being Requested	Level of Effort
Evaluator	J. Wilson	\$48,000	\$24,000	0.5
Other Staff		\$18,000	\$18,000	1.0

Fringe Benefits (25%) \$10,500

Travel

2 trips x 1 Evaluator (\$600 x 2)	\$ 1,200
per diem @ \$120 x 6	720
Supplies (General Office)	500

Evaluation Direct \$54,920

Evaluation Indirect Costs (19%) \$10,435

Evaluation Subtotal \$65,355

Training

Job Title	Name	Level of Effort	Salary being Requested
Coordinator	M. Smith	0.5	\$ 12,000
Admin. Asst.	N. Jones	0.5	\$ 9,000
Fringe Benefits (25%)			\$ 5,250

Travel

2 Trips for Training	
Airfare @ \$600 x 2	\$ 1,200
Per Diem \$120 x 2 x 2 days	480
Local (500 miles x .24/mile)	120

Supplies

Office Supplies	\$ 500
Software (WordPerfect)	500

ILLUSTRATION OF DETAILED BUDGET AND NARRATIVE JUSTIFICATION (cont'd.)

Other

Rent (500 Sq. Ft. x \$9.95)	\$ 4,975
Telephone	500
Maintenance (e.g., van)	\$ 2,500
Audit	\$ 3,000

Training Direct \$ 40,025

Training Indirect \$ -0-

Enter Contractual subtotal on 424A, Section B, 6.f. \$105,380

Other

Consultants = Expert @ \$250/day X 6 day \$ 1,500
(If expert is known, should list by name)

Enter Other subtotal on 424A, Section B, 6.h. \$ 1,500

Total Direct Charges (sum of 6.a-6.h)

Enter Total Direct on 424A, Section B, 6.i. \$192,640

Indirect Costs

15% of Salary and Wages (copy of negotiated
indirect cost rate agreement attached)

Enter Indirect subtotal of 424A, Section B, 6.j. \$ 9,600

TOTALS

Enter TOTAL on 424A, Section B, 6.k. \$202,240

JUSTIFICATION

PERSONNEL - Describe the role and responsibilities of each position.

FRINGE BENEFITS - List all components of the fringe benefit rate.

EQUIPMENT - List equipment and describe the need and the purpose of the equipment in relation to the proposed project.

SUPPLIES - Generally self-explanatory; however, if not, describe need. Include explanation of how the cost has been estimated.

TRAVEL - Explain need for all travel other than that required by SAMHSA.

ILLUSTRATION OF DETAILED BUDGET AND NARRATIVE JUSTIFICATION (cont'd.)

CONTRACTUAL COSTS - Explain the need for each contractual arrangement and how these components relate to the overall project.

OTHER - Generally self-explanatory. If consultants are included in this category, explain the need and how the consultant's rate has been determined.

INDIRECT COST RATE - If your organization has no indirect cost rate, please indicate whether your organization plans to a) waive indirect costs if an award is issued, or b) negotiate and establish an indirect cost rate with DHHS within 90 days of award issuance.

**CALCULATION OF FUTURE BUDGET PERIODS
(based on first 12-month budget period)**

Review and verify the accuracy of future year budget estimates. Increases or decreases in the future years must be explained and justified and no cost of living increases will be honored. (NOTE: new salary cap of \$180,100 is effective for all FY 2005 awards.)*

	First 12-month Period	Second 12-month Period	Third 12-month Period
Personnel			
Project Director	30,000	30,000	30,000
Secretary**	9,000	18,000	18,000
Counselor	25,000	25,000	25,000
TOTAL PERSONNEL	64,000	73,000	73,000

*Consistent with the requirement in the Consolidated Appropriations Act, Public Law 108-199.

**Increased from 50% to 100% effort in 02 through 03 budget periods.

Fringe Benefits (24%)	15,360	17,520	17,520
Travel	5,400	5,400	5,400
Equipment	-0-	-0-	-0-
Supplies***	1,000	520	520

***Increased amount in 01 year represents costs for software.

Contractual Evaluation****	65,355	67,969	70,688
Training	40,025	40,025	40,025

****Increased amounts in 02 and 03 years are reflected of the increase in client data collection.

Other	1,500	1,500	1,500
Total Direct Costs	192,640	205,934	208,653
Indirect Costs (15% S&W)	9,600	9,600	9,600
TOTAL COSTS	202,240	216,884	219,603

The Federal dollars requested for all object class categories for the first 12-month budget period are entered on Form 424A, Section B, Column (1), lines 6a-6i. The total Federal dollars requested for the second up to the fifth 12-month budget periods are entered on Form 424A, Section E, Columns (b) – (e), line 20. The RFA will specify the maximum number of years of support that may be requested.

Appendix C

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
Piscataquis, Hancock, Penobscot, and Washington Counties, Maine	4	Piscataquis, 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
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
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	
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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
Rhode Island	3	Providence, Kent, Washington
Travis County, Texas	1	Travis
Rural Utah	6	Beaver, Carbon, Emery, Garfield, Grande, Kane (<i>Also proposed: San Juan, Piute, Wayne, Rich, Daggett</i>)
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
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, Hillsborough
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 (<i>Newton County not listed in application, but part of agency's service area</i>)
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
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
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
Totals	66	

Appendix D

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/target population is critical to the success of the proposed project. Factors impacting community diversity involve more than race and ethnicity. Other factors include, but are not limited to, geographic location, population density, population stability, (e.g. rates of in-migration, out-migration, interstate migration, and immigration), the age distribution of the population, social history, intergroup relationships, and the social, political and economic climates.

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

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

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

Staff Qualifications and Training - The staff of the organization should reflect the racial and ethnic characteristics of the population to be served and have training in how to respond effectively and sensitively to multiple characteristics of the target population (such as race/ethnicity, primary language, gender, age, disability, and literacy). For purposes of this item, “staff” would include, at a minimum, administrators, advisors, board members, supervisors, and service providers.

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) targeted. The evaluators should be sensitized to the culture and familiar with the gender/age/culture, whenever possible and practical. Program evaluation methods and instruments should be culturally appropriate to the population/community served.

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

Appendix E

Limited English Proficiency Assistance

Effective August 30, 2000, the 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 from 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 F

Key Personnel

Principal Investigator

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 PHS 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.

Project Director

Responsible for overseeing the development of a comprehensive strategic plan for creating and implementing the proposed system of care; establishing the organizational structure; hiring staff; and providing leadership in all facets of the development of the system of care. This key position should be staffed by one individual in a full-time equivalent position.

Lead Family Contact

Typically, this position is filled by a parent or other family member of a child or adolescent with a serious emotional disturbance, who has received 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 target population. 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 key position should be staffed by one individual in a full-time equivalent position.

Youth Coordinator

This position, typically filled by a young adult, is responsible for developing activities to represent the voice of youth who have a serious emotional disturbance 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 research 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 youth and family members in multiple activities of the evaluation. At least two full-time equivalent positions should be designated for these key personnel.

Social Marketing-Communications Manager

Responsible for developing a comprehensive social marketing/communications strategy for the awardee community, including a social marketing strategic plan, public education activities, and overall outreach efforts. 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 competent practices and services, leadership, partnership/collaboration, strategic planning, wraparound planning, 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 project's structure and process by developing and/or changing interagency agreements and other public policies relevant to the creation of the system of care.

Appendix G

Requirements of the National Evaluation

Phase IV of the National Evaluation

COMPONENT	TASKS	FREQUENCY OF DATA COLLECTION
System-of-Care Assessment	<p>All communities will submit the following information prior to their assessment visit:</p> <ul style="list-style-type: none"> 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 <p>Site representatives to be interviewed:</p> <ul style="list-style-type: none"> 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	<p>All eligible families in the Cross-sectional Descriptive Study will complete the following measures, depending on respondent and data collection point:</p> <ul style="list-style-type: none"> 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	<p>All families in the Longitudinal Child and Family Outcome Study will complete the following measures:</p> <ul style="list-style-type: none"> 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	<p>Four respondents will complete the survey:</p> <ul style="list-style-type: none"> Project director Key mental health agency representative Family representative Representative from another child-serving agency <p>One person in each community will serve as point of contact, provide contact information, and assist with updating contact information.</p>	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 H

Family-Driven Care

Definition of Family-Driven Care

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.

Guiding Principles of Family-Driven Care

1. Families and youth are given accurate, understandable, and complete information necessary to make choices for improved planning for individual children and their families.
2. Families and youth are organized to collectively use their knowledge and skills as a force for systems transformation.
3. Families and youth embrace the concept of sharing decision-making and responsibility for outcomes with providers.
4. Providers embrace the concept of sharing decision-making authority and responsibility for outcomes with families and youth.
5. Providers take the initiative to change practice from provider-driven to family-driven.
6. 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.
7. Families and family-run organizations engage in peer support activities to reduce isolation and strengthen the family voice.
8. Community attitude change efforts focus on removing barriers created by stigma.
9. Communities embrace and value the diverse cultures of their children, youth, and families.
10. Everyone who connects with children, youth, and families continually advance their cultural and linguistic responsiveness as the population served changes.

Characteristics of Family-Driven Care

1. 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.

2. 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.
3. 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.
4. Administrators and staff actively demonstrate their partnerships with all families and youth by sharing power, resources, authority, and control with them.
5. 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.
6. All children, youth, and families have a biological, adoptive, foster, or surrogate family voice advocating on their behalf.