

**Department of Health and Human Services**

**Substance Abuse and Mental Health Services Administration**

**PPHF- 2015 Cooperative Agreements for State-Sponsored Youth  
Suicide Prevention and Early Intervention (PPHF-2015)**

**(Short Title: State/Tribal Youth Suicide Prevention Cooperative  
Agreements)**

**(Initial Announcement)**

**Request for Applications (RFA) No. SM-15-004**

**Catalogue of Federal Domestic Assistance (CFDA) No.: 93.243**

**PART 1: Programmatic Guidance**

[Note to Applicants: This document must be used in conjunction with SAMHSA’s “Request for Applications (RFA): PART II – General Policies and Procedures Applicable to all SAMHSA Applications for Discretionary Grants and Cooperative Agreements”. PART I is individually tailored for each RFA. PART II includes requirements that are common to all SAMHSA RFAs. You must use both documents in preparing your application.]

**Key Dates:**

<b>Application Deadline</b>	<b>Applications are due by June 2, 2015.</b>
<b>Anticipated Award Date:</b>	<b>September 30, 2015</b>
<b>Budget Period:</b>	<b>Start Date: September 30, 2015 End Date: September 29, 2020</b>
<b>Intergovernmental Review (E.O. 12372)</b>	<b>Applicants must comply with E.O. 12372 if their state(s) participates. Review process recommendations from the State Single Point of Contact (SPOC) are due no later than 60 days after application deadline.</b>
<b>Public Health System Impact Statement (PHSIS)/Single State Agency Coordination</b>	<b>Applicants must send the PHSIS to appropriate state and local health agencies by application deadline. Comments from Single State Agency are due no later than 60 days after application deadline.</b>

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## EXECUTIVE SUMMARY

The Substance Abuse and Mental Health Services Administration, Center for Mental Health Services is accepting applications for fiscal year (FY) 2015 PPHF-2015 Cooperative Agreements for State-Sponsored Youth Suicide Prevention and Early Intervention (Short Title: State/Tribal Youth Suicide Prevention Cooperative Agreements) (PPHF-2015). The purpose of this program is to support states and tribes (including Alaska Villages and urban Indian organizations) in developing and implementing statewide or tribal youth suicide prevention and early intervention strategies. The program includes public/private collaboration among youth-serving institutions and agencies and should include schools, educational institutions, juvenile justice systems, foster care systems, substance abuse and mental health programs, and other child and youth supporting organizations.

<b>Funding Opportunity Title:</b>	State/Tribal Youth Suicide Prevention Grants
<b>Funding Opportunity Number:</b>	SM-15-004
<b>Due Date for Applications:</b>	June 2, 2015
<b>Anticipated Total Available Funding:</b>	\$8,644,636
<b>Estimated Number of Awards:</b>	Up to 12
<b>Estimated Award Amount:</b>	Up to \$736,000 per year
<b>Cost Sharing/Match Required</b>	No
<b>Length of Project Period:</b>	Up to 5 years
<b>Eligible Applicants:</b>	Eligible applicants are states, federally recognized tribes/tribal organizations and private/non-profit organizations designated by the state and/or tribe/tribal organization.  [See <u>Section III-1</u> of this RFA for complete eligibility information.]

**Be sure to check the SAMHSA website periodically for any updates on this program.**

# I. FUNDING OPPORTUNITY DESCRIPTION

## 1. PURPOSE

The Substance Abuse and Mental Health Services Administration, Center for Mental Health Services is accepting applications for fiscal year (FY) 2015 PPHF-2015 Cooperative Agreements for State-Sponsored Youth Suicide Prevention and Early Intervention (Short Title: State/Tribal Youth Suicide Prevention Cooperative Agreements) (PPHF-2015). The purpose of this program is to support states and tribes (including Alaska Villages and urban Indian organizations) in developing and implementing statewide or tribal youth suicide prevention and early intervention strategies. The programs include collaboration among youth-serving institutions and agencies and should include schools, educational institutions, juvenile justice systems, foster care systems, substance abuse and mental health programs, and other child and youth supporting organizations; these efforts should include both a strong community component and a strong health system component. The ultimate goal of this program is to reduce suicide deaths and non-fatal suicide attempts.

SAMHSA has demonstrated that behavioral health is essential to health, prevention works, treatment is effective, and people recover from mental and substance use disorders. Behavioral health services improve health status and reduce health care and other costs to society. Continued improvement in the delivery and financing of prevention, treatment and recovery support services provides a cost effective opportunity to advance and protect the nation's health. To continue to improve the delivery and financing of prevention, treatment and recovery support services, SAMHSA has identified six Strategic Initiatives to focus the Agency's work on improving lives and capitalizing on emerging opportunities. The State and Tribal Youth Suicide Prevention grants closely align with SAMHSA's Strategic Initiative on Prevention of Substance Abuse and Mental Illness. More information is available at the SAMHSA website: <http://www.samhsa.gov/prevention>.

The State/Tribal Youth Suicide Prevention Cooperative Agreements program seeks to address behavioral health disparities among racial and ethnic minorities by encouraging the implementation of strategies to decrease the differences in access, service use and outcomes among the racial and ethnic minority populations served. (See PART II: Appendix G – Addressing Behavioral Health Disparities.)

State/Tribal Youth Suicide Prevention Cooperative Agreements is one of SAMHSA's services grant programs. SAMHSA intends that its services grants result in the delivery of services as soon as possible after award. Service delivery should begin by the 4<sup>th</sup> month of the project at the latest.

State/Tribal Youth Suicide Prevention Cooperative Agreements grants are authorized under Section 520E of the Public Health Service Act, as amended, and are financed

solely by 2015 Prevention and Public Health Funds. This announcement addresses Healthy People 2020 Mental Health and Mental Disorders Topic Area HP 2020-MHMD.

## 2. EXPECTATIONS

SAMHSA expects states and tribes are committed to making suicide prevention a core priority in statewide or tribal youth and young adult serving systems, and are paired with at least one intensive community-based effort. Efforts must include linkage with behavioral health care programs/systems committed to making suicide prevention a core priority through implementation of Goals 8 and 9 of the 2012 National Strategy for Suicide Prevention (<http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/>).

In addition, SAMHSA also expects applicants to address the needs of youth at high-risk identified by the [National Action Alliance for Suicide Prevention](#) (NAASP) and utilize materials from applicable NAASP Task Forces; populations include, but are not limited to lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth, American Indians and Alaska Natives (AI/AN), youth in contact with juvenile justice, military family members, and veterans. Other high-risk groups might include Latina youth, individuals with disabilities, survivors of suicide attempts and of suicide loss, youth involved in the juvenile justice system, and youth with serious mental illness. Applicants are also expected to consider to what degree their proposed activities can coordinate with other streams of prevention funding/programs (such as substance abuse prevention, violence prevention, “Now is the Time” Healthy Transitions grant program) in the community as well as with current SAMHSA suicide prevention-funded university campuses in the state/tribe. Grantees are encouraged to visit <http://www.findyouthinfo.gov> to locate potential program partners.

Applicants must show that their suicide prevention plans are consistent with priorities of the tribe, tribal organization, state, or county that has primary responsibility for the service delivery system.

Grantees will work collaboratively with, and utilize resources from, the Suicide Prevention Resource Center (<http://www.sprc.org/>) and partner with other prevention and/or health/wellness related programs including other State/Tribal Youth Suicide Prevention grantees or other SAMHSA grantees in your area.

Grantees must use SAMHSA’s services grant funds primarily to support allowable direct services. This includes the following types of activities:

- Providing outreach and other engagement strategies to increase participation in, and access to, treatment or prevention services for diverse populations. If you are proposing to provide only outreach and other strategies to increase access, you must show that there are treatment services available and your organization has the ability to connect individuals with those services.

- Providing direct treatment (including screening, assessment, and care management) or prevention services for diverse populations at risk. Treatment must be provided in outpatient, day treatment (including outreach and engagement services) or intensive outpatient, or residential programs.
- Providing “wrap-around”/recovery support services (e.g., child care, vocational, educational and transportation services) designed to improve access and retention. [Note: Grant funds may be used to purchase such services from another provider.]
- Provide and implement system-wide suicide prevention training in schools, educational institutions, juvenile justice systems, substance abuse programs, primary care, mental health programs, foster care systems, family organizations and other child and youth support organizations. All training must be evidence-based or a promising practice.
- Develop, implement, and embed state-sponsored statewide or tribal youth suicide early intervention and prevention strategies in schools, educational institutions, juvenile justice systems, substance abuse programs, primary care, mental health programs, foster care systems, family organizations and other child and youth support organizations and systems.
- Support public and private nonprofit organizations actively involved in the development and continuation of state-sponsored statewide or tribal youth suicide early intervention and prevention strategies.
- Provide support to institutions of higher education to coordinate or implement state-sponsored youth suicide early intervention and prevention strategies.
- Collect and analyze data on state-sponsored statewide or tribal youth suicide early intervention and prevention services that can be used to monitor the effectiveness of such services and to advance research, technical assistance, and policy development. Assist eligible entities, through state-sponsored statewide or tribal youth suicide early intervention and prevention strategies, to achieve targets for youth suicide reductions under Title V of the Social Security Act.
- Conduct and/or monitor local surveillance on non-lethal suicide attempts and deaths by suicide. These local surveillance systems should include but are not limited to juvenile justice care, foster care, and behavioral health, including both mental health and substance abuse services.
- Applicants must provide a plan for assuring that suicide prevention activities within youth-serving systems are sustained post-grant cycle.

- Applicants must incorporate suicide prevention activities across the entire 10-24 age range set by statute, including efforts to reduce risk factors and prevent youth from becoming suicidal; activities that identify, refer, and monitor youth with suicide ideation; and the provision of intervention and follow-up with youth who have made suicide attempts.
- Applicants must form or participate in an existing public/private coalition of youth-serving institutions and agencies, which advises, participates in, and supports grant activities. Membership should include schools and other educational institutions, foster care systems, juvenile justice systems, family and peer organizations, childcare systems, health, mental health and substance abuse agencies, and other child- and youth-supporting organizations, youth, family members and suicide loss and suicide attempt survivors.
- Applicants and sub-recipients of grant funds shall obtain prior written, informed voluntary consent from each child's parent or legal guardian for assessment services, school sponsored programs and treatment involving medication related to youth suicide conducted in elementary and secondary schools except:
  - In an emergency, where it is necessary to protect the immediate health and safety of the student or other students, or
  - In other instances, as defined by the state or tribe, where parental consent cannot be reasonably obtained.

Note: These requirements do not supersede section 444 of the General Education Provisions Act, including the requirement of prior voluntary parental consent for the disclosure of any educational records. These requirements also do not modify or affect parental notification requirements for programs authorized under the Elementary or Secondary Education Act of 1965 (as amended by the No Child Left Behind Act of 2001).

- When screening for suicide risk, grantees will also screen and assess clients for the presence of substance abuse and serious mental illness, and use the information obtained from the screening and assessment to develop appropriate treatment approaches.
- Suicide assessment, early intervention, and treatment services may not be provided for youth whose parents or legal guardians object based on their religious beliefs or moral objections.
- School personnel may not require that a student obtain any medication as a condition of attending school or receiving services.

Applicants must meet the following requirements:

- At least 85 percent of grant funds must be used for direct services, of which at least 5 percent must be given to institutions of higher learning to coordinate suicide prevention efforts among campuses across the state, or to implement, or evaluate youth suicide early intervention or prevention strategies.
- Submit and follow a statewide or tribal suicide prevention plan submitted in Attachment 4 of your application. This suicide prevention plan should incorporate the 2012 *National Strategy for Suicide Prevention* (available online at [http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/.](http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/))
- Grant-funded initiatives do not have to be proposed for every locality in a state or tribe. Some applicants may develop programs that do address every locality, but others may choose to focus on specific geographical areas or populations. Those who do the latter must target areas, regions, or populations with rates of youth suicide attempts or suicide that exceed the national average as determined by the Centers for Disease Control and Prevention surveillance systems. In providing assistance to entities within the state, grantees must give preference to public organizations, private nonprofit organizations, political subdivisions, institutions of higher education, and tribal organizations actively involved with the state-sponsored statewide or tribal youth suicide early intervention and prevention strategy that:
  - Provides early intervention and assessment services to youth who are at risk for mental or emotional disorders, substance abuse disorders, and co-occurring mental and substance abuse disorders that may lead to suicide or a suicide attempt, and that are integrated with school systems, educational institutions, juvenile justice systems, substance abuse programs, mental health programs, foster care systems and other child and youth support organizations.
  - Demonstrates collaboration among early intervention and prevention services or certify that the grantee will engage in future collaboration.
  - Employ or include a commitment to evaluate youth suicide early intervention and prevention practices and strategies adapted to the local community to show impact of practices implemented.
  - Provides timely referrals and decrease wait time over the course of the grant for appropriate community mental health care and treatment to youth who are at risk for suicide or suicide attempts.



- Provides immediate support and information resources to families of youth who are at risk for suicide, such as families of youth who have attempted suicide.
- Offers access to services and care to youth with diverse linguistic and cultural backgrounds.
- Offers appropriate intervention services, care, and information to families, friends, schools, educational institutions, juvenile justice systems, substance abuse programs, mental health programs, foster care systems, and other child and youth support organizations of youth who recently died by suicide.
- Ensures that educators, foster care, juvenile justice, childcare professionals and community care providers are properly trained to effectively identify youth who are at risk for suicide.
- Ensures the input of consumers, survivors of loss, and survivors of suicide attempts, youth, and families in assessing, planning, and implementing your project.
- Provides ongoing training for those individuals on effective youth suicide early intervention and prevention services, practices, and strategies. Ensures that health, mental health, and substance abuse professionals are properly trained on an ongoing basis to effectively identify, assess, and manage youth who are at risk for suicide.
- Ensures that training and public awareness campaigns are up to date, connected to action items (e.g., what to do if you are worried about a friend) and part of a more comprehensive suicide prevention plan.
- States and/or tribes who have been previous recipients of the State/Tribal Youth Suicide Prevention Program award who do not currently have a grant are eligible but are required to address how this grant award will build on and/or expand the work of the earlier grant awards and not simply continue what was done previously.

If your application is funded, you will be expected to develop a behavioral health disparities impact statement no later than 60 days after your award. In this statement you must propose: (1) the number of individuals to be served during the grant period and identify subpopulations (i.e., racial, ethnic, sexual and gender minority groups) vulnerable to behavioral health disparities; (2) a quality improvement plan for the use of program data on access, use and outcomes to support efforts to decrease the differences in access to, use and outcomes of service activities; and (3) methods for the development of policies and procedures to ensure adherence to the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. (See PART II: Appendix G – Addressing Behavioral Health Disparities.)

It is well known that the effects of substance abuse are cumulative, and contribute significantly to costly social, physical, mental, and public health problems and issues. These include: teenage pregnancy; HIV/AIDS; other sexually transmitted diseases (STDs); domestic violence; child abuse; motor vehicle crashes; physical fights; homicide; and suicide. National Survey on Drug Use and Health data also indicate that individuals who experience mental illness or use illegal drugs have higher suicide attempts and suicide death rates.

Grantees are encouraged to consider these substance abuse-related effects carefully as they: 1) assess the demographics and problems in their particular high need communities; and 2) plan together with these communities to implement effective strategies to address their problems. Grantees will be required to work with youth substance abuse prevention and substance abuse treatment programs.

SAMHSA strongly encourages all grantees to provide a tobacco-free workplace and to promote abstinence from all tobacco products (except in regard to accepted tribal traditions and practices).

Serious mental illness is a significant risk factor for suicide. More than 60 percent of suicide deaths occur among individuals with mood disorders, particularly among those suffering with bipolar disorders or acute episodes of major depression. (NSSP, 2012). Almost 5 percent of those diagnosed with schizophrenia will die by suicide during their lifetimes, usually near the onset of their illness (2005).<sup>1</sup>

Inadequate assessment of suicide risk and insufficient access to effective treatments are major contributing factors to suicide. State/Tribal Suicide Prevention applicants are encouraged to target improved access to suicide prevention services for young persons who are either at risk for serious mental illness, are experiencing their first episode of psychosis, or have received a diagnosis of schizophrenia or a psychotic mood disorder.

Applicants must comprehensively implement strategies from applicable sections of the 2012 *National Strategy for Suicide Prevention*. Applicants are required to implement the following activities:

- Utilize timely surveillance data of youth suicide deaths and non-fatal suicide attempts at both the start of their grant to target efforts, during the grant to

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<sup>1</sup> The lifetime risk of suicide in schizophrenia: a reexamination. Palmer BA, Pankratz VS, Bostwick JM. Arch Gen Psychiatry, 2005 Mar; 62(3):247-53.

modify their efforts as needed, and at the end of their grant to demonstrate the impact of their grant activities.

- Require crisis response plans to be developed/adjusted, implemented, and monitored within systems receiving grant funding.
- Link specifically with emergency departments and inpatient psychiatric units to ensure care coordination and follow-up of youth identified at risk for suicide.
- Incorporate efforts to reduce access to lethal means among youth with identified suicide risk.
- Provide a protocol for response to suicide clusters.
- Ensure that all public awareness initiatives, including social media outreach and awareness efforts, are tied to the grantee's larger strategic plan, with a specific target audience and a specific goal. Communication campaigns should contain messages that are action-oriented and must be grounded in the concepts of safe messaging. (See "Safe and Effective Messaging for Suicide Prevention" at <http://www.sprc.org/sites/sprc.org/files/library/SafeMessagingrevised.pdf>).
- Involve youth through mechanisms such as Youth Councils to encourage their input and feedback.
- Encourage the involvement, input of, and feedback from suicide loss and suicide attempt survivors and family members.
- Utilize feedback and involvement from suicide loss and suicide attempt survivors and their family members.
- Utilize appropriate materials targeting specific populations produced by National Action Alliance for Suicide Prevention Task Forces (e.g., Clinical Workforce Preparedness, and Youth in Contact with the Juvenile Justice System).
- With adequate justification, applicants may elect to implement strategies from additional sections of the 2012 *National Strategy for Suicide Prevention* as relevant to youth suicide prevention in your area.

Grantees must utilize third party and other revenue realized from provision of services to the extent possible and use SAMHSA grant funds only for services to individuals who are ineligible for public or commercial health insurance programs, individuals for whom coverage has been formally determined to be unaffordable, or for services that are not sufficiently covered by an individual's health insurance plan. Grantees are also expected to facilitate the health insurance application and enrollment process for eligible uninsured clients. Grantees should also consider other systems from which a potential service recipient may be eligible for services (for example, the Veterans Administration) if appropriate for and desired by that individual to meet his/her needs. In addition, grantees are required to implement policies and procedures that ensure other sources of funding are secured first when available for that individual.

Recovery from mental and/or substance use disorders has been identified as a primary goal for behavioral health care. SAMHSA's Strategic Initiative on Recovery Support is leading efforts to advance the understanding of recovery and ensure that vital recovery supports and services are available and accessible to all who need and want them. Building on research, practice, and the lived experiences of individuals in recovery from mental and/or substance use disorders, SAMHSA has developed the following working definition of recovery: *A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.* See <http://store.samhsa.gov/product/SAMHSA-s-Working-Definition-of-Recovery/PEP12-RECDEF> for further information, including the four dimensions of recovery, and 10 guiding principles. Programs and services that incorporate a recovery approach fully involve people with lived experience (including consumers/peers/people in recovery, youth, and family members) in program/service design, development, implementation, and evaluation.

SAMHSA's standard, unified working definition is intended to advance recovery opportunities for all Americans, particularly in the context of health reform, and to help clarify these concepts for peers/persons in recovery, families, funders, providers and others. The definition is to be used to assist in the planning, delivery, financing, and evaluation of behavioral health services. SAMHSA grantees are expected to integrate the definition and principles of recovery into their programs to the greatest extent possible.

The Affordable Care Act (ACA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act place strong emphasis on the widespread adoption and implementation of electronic health record (EHR) technology. Accordingly, all SAMHSA grantees that provide services to individuals are encouraged to demonstrate ongoing clinical use of a certified electronic health record (EHR) system in each year of their SAMHSA grant. A certified EHR is an electronic health record system that has been tested and certified by an approved Office of National Coordinator's (ONC) certifying body.

This activity is considered infrastructure development; not more than 15 percent of the total grant award may be used for infrastructure development activities.

Over 2 million men and women have been deployed to serve in support of overseas contingency operations, including Operation Enduring Freedom, Operation Iraqi Freedom and Operation New Dawn. Individuals returning from Iraq and Afghanistan are at increased risk for suffering post-traumatic stress and other related disorders. Experts estimate that up to one-third of returning veterans will need mental health

and/or substance abuse prevention and/or treatment and related services<sup>2</sup>. In addition, the family members of returning veterans have an increased need for related support services<sup>3</sup>. To address these concerns, SAMHSA strongly encourages all applicants to consider the unique needs of returning veterans and their families in developing their proposed project and consider prioritizing this population for services where appropriate.

## 2.1 Using Evidence-Based Practices

SAMHSA's services grants are intended to fund services or practices that have a demonstrated evidence base and that are appropriate for the population(s) of focus. An evidence-based practice (EBP) refers to approaches to prevention or treatment that are validated by some form of documented research evidence. In [Section B](#) of your project narrative, you will need to:

- Identify the evidence-based practice(s) you propose to implement for the specific population(s) of focus.
- Identify and discuss the evidence that shows that the practice(s) is (are) effective for the specific population(s) of focus.
- If you are proposing to use more than one evidence-based practice, provide a justification for doing so and clearly identify which service modality and population of focus each practice will support.
- Discuss the population(s) for which the practice(s) has (have) been shown to be effective and show that it (they) is (are) appropriate for your population(s) of focus.

[Note: See PART II: Appendix D – Funding Restrictions, regarding allowable costs for EBPs.]

SAMHSA recognizes that EBPs have not been developed for all populations and/or service settings. See [Appendix I](#) of this document for additional information about using EBPs.

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<sup>2</sup> Tanielian, T. L., Jaycox, L., & Rand Corporation. (2008). Invisible wounds of war: Psychological and cognitive injuries, their consequences, and services to assist recovery. Santa Monica, CA: RAND.

<sup>3</sup> Chandra, A., Lara-Cinisomo, S., Jaycox L., Tanielian T., Burns R., Ruder, T., & Han, B., "Children on the homefront: The experience of children from military families," *Pediatrics*, Vol. 125 No. 1 January 1, 2010. pp. 16 -25.

## 2.2 Data Collection and Performance Measurement

All SAMHSA grantees are required to collect and report certain data so that SAMHSA can meet its obligations under the Government Performance and Results (GPRA) Modernization Act of 2010. You must document your ability to collect and report the required data in [Section E: Data Collection and Performance Measurement](#) of your application. Grantees will be required to report performance on the following performance measures:

- The number of people in the mental health and related workforce training in specific mental health-related practices/activities as a result of the grant.
- The number of organizations that entered in formal written inter/intra-organizational agreements (such as MOUs, MOAs) to improve mental health-related practices/activities as a result of the grant.
- The number of organizations collaborating/coordinating/sharing resources with other organizations as a result of the grant.
- The number of individuals exposed to mental health awareness messages.
- The number of individuals who have received training in prevention or mental health promotion.
- The number of individuals screened for mental health or related interventions.
- The number of individuals referred to mental health or related services. The number and percentage of individuals receiving mental health or related services after referral.
- The number of policy changes completed as a result of the grant.<sup>4</sup>
- The number of organizations or communities that demonstrate improved readiness to change their systems in order to implement mental health-related practices that are consistent with the goals of the grant.
- The numbers of organizations that regularly obtain, analyze, and use mental-health related data as a result of the grant.
- The number of communities that establish management information/information technology system links across multiple agencies in order to share service population and service delivery as a result of the grant.

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<sup>4</sup> For purposes of this FOA, “policy” refers to programs and guidelines adopted and implemented by institutions, organizations and others to inform and establish practices and decisions and to achieve organizational goals. Policy efforts do not include activities designed to influence the enactment of legislation, appropriations, regulations, administrative actions, or Executive Orders (“legislation and other orders”) proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, and awardees may not use federal funds for such activities. This restriction extends to both grass-roots lobbying efforts and direct lobbying. However, for state, local, and other governmental grantees, certain activities falling within the normal and recognized executive-legislative relationships or participation by an agency or officer of a state, local, or tribal government in policymaking and administrative processes within the executive branch of that government are not considered impermissible lobbying activities and may be supported by federal funds.

- The number and percentage of work group/advisory group/council members who are consumers/family members.
- The number of individuals contacted through program outreach efforts.
- The total number of contacts made through program outreach efforts.
- The number of programs/organizations/communities that implemented specific-mental health related practices/activities that are consistent with the goals of the grant.
- The number of programs/organizations/communities that implement specific mental health related practices as a result of the grant.

This information will be gathered using a uniform data collection tool provided by SAMHSA. The current tool is being updated and will be provided upon award. An example of the type of data collection tool required can be found at <http://www.samhsa.gov/grants/gpra-measurement-tools>. Data will be collected quarterly. Technical assistance for the Web-based data entry, fiscal and annual report generation is available. SAMHSA grantees will be given training and ongoing technical assistance to perform data collection requirements through a separate information technology contract.

The collection of these data will enable SAMHSA to report on key outcome measures relating to mental health. In addition to these outcomes, data collected by grantees will be used to demonstrate how SAMHSA's grant programs are reducing disparities in access, service use and outcomes nationwide. If you have an electronic health records (EHR) system to collect and manage most or all client-level clinical information, you should use the EHR to automate GPRA reporting.

In addition to these measures, grantees will be expected to collect and report the following data:

Within the grant catchment area, how did the activities of the grant affect suicide deaths and non-fatal suicide attempts, including suicide deaths and attempts within key sectors such as health and behavioral health?

How has the competence/confidence of health and behavioral health, including mental health and substance abuse services, juvenile justice, and foster care staff changed over the course of the grant?

Performance data will be made public.

### **2.3 Program Evaluation**

Grantees must periodically review the performance data they report to SAMHSA (as required above) and assess their progress and use this information to improve management of their grant projects. The assessment should be designed to help you

determine whether you are achieving the goals, objectives and outcomes you intend to achieve and whether adjustments need to be made to your project. Performance assessments also should be used to determine whether your project is having/will have the intended impact on behavioral health disparities. You will be required to report on your progress achieved, barriers encountered, and efforts to overcome these barriers in a performance assessment report to be submitted at least annually.

At a minimum, your performance assessment should include the required performance measures identified above. You may also consider outcome and process questions, such as the following:

*Outcome Questions:*

- What was the effect of the intervention on key outcome goals?
- What program/contextual/cultural/linguistic factors were associated with outcomes?
- What individual factors were associated with outcomes, including race/ethnicity/sexual identity (sexual orientation/gender identity)?
- How durable were the effects?
- Was the intervention effective in maintaining the project outcomes at 6-month follow-up?

As appropriate, describe how the data, including outcome data, will be analyzed by racial/ethnic group or other demographic factors to assure that appropriate populations are being served and that disparities in services and outcomes are minimized.

*Process Questions:*

- How closely did implementation match the plan?
- What types of changes were made to the originally proposed plan?
- What types of changes were made to address disparities in access, service use, and outcomes across subpopulations, including the use of the National CLAS Standards?
- What led to the changes in the original plan?
- What effect did the changes have on the planned intervention and performance assessment?



- Who provided (program staff) what services (modality, type, intensity, duration), to whom (individual characteristics), in what context (system, community), and at what cost (facilities, personnel, dollars)?
- What strategies were used to maintain fidelity to the evidence-based practice or intervention across providers over time?
- How many individuals were reached through the program?

Performance assessments will be included in required monthly calls with federal staff and may be requested as part of annual reporting requirements.

## **National Evaluation**

In addition to SAMHSA program measures, grantees must collect and report findings for the Congressionally-mandated national evaluation which will be conducted under a separate SAMHSA evaluation contract. The national evaluation will focus on demonstrating the impact of the State/Tribal Suicide Prevention program on suicidal behavior among youth and young adults. Participation in the national evaluation is required, and will involve participation in either the initial national evaluation approach or a revised alternative approach. To support implementation of the national evaluation, grantees will receive training and technical assistance from the Suicide Prevention Evaluation Contractor. Applicants must state their commitment to cooperate with the Suicide Prevention Evaluation Contractor in their applications. Participation in the national evaluation will likely entail participation in training visits, completing data reports/inventories, data entry, applying for and receiving Institutional Review Board Clearance when appropriate, respondent identification and utilizing a Web-based database developed in consultation with the contractor. Data will be collected quarterly and are to be entered into a Web system created by the national evaluation contractor or included in written progress reports. SAMHSA is interested in assessing the extent to which strategies employed by the grantees are consistent with the *National Strategy for Suicide Prevention* (NSSP), assessing the feasibility of implementing the NSSP in real-world settings, and determining the outcomes associated with implementation. Enhanced evaluation questions may also be required of some grantees to address these key evaluation goals.

**At least 10 percent but no more than 15 percent of the total grant award may be used for data collection, performance measurement, and performance assessment, e.g., activities required in Sections I-2.2 and 2.3 above.**

### **2.4 Infrastructure Development (maximum 15 percent of total grant award)**

Although services grant funds must be used primarily for direct services, SAMHSA recognizes that infrastructure changes may be needed to implement the services or improve their effectiveness. You may use no more than 15 percent of the total services

grant award for the following types of infrastructure development, if necessary to support the direct service expansion of the grant project, and describe your use of grant funds for these activities in [Section A](#) of the Project Narrative.

- Developing partnerships with other service providers for service delivery.
- Adopting and/or enhancing your computer system, management information system (MIS), and electronic health records (EHRs) to document and manage client needs, care process, integration with related support services, and outcomes.
- Training/workforce development to help your staff or other providers in the community identify mental health or substance abuse issues or provide effective services consistent with the purpose of the grant program.

## 2.5 Grantee Meetings

Grantees must plan to send a minimum of two people (including the Project Director) to at least one joint grantee meeting every other year of the program. You must include a detailed budget and narrative for this travel in your budget. At these meetings, grantees will present the results of their projects and federal staff will provide technical assistance. Each meeting may be up to 3 days. These meetings are usually held in the Washington, D.C., area and attendance is mandatory.

## II. AWARD INFORMATION

<b>Funding Mechanism:</b>	Cooperative Agreement
<b>Anticipated Total Available Funding:</b>	\$8,644,636
<b>Estimated Number of Awards:</b>	Up to 12
<b>Estimated Award Amount:</b>	Up to \$736,000
<b>Length of Project Period:</b>	Up to 5 years

Proposed budgets cannot exceed \$736,000 in total costs (direct and indirect) in any year of the proposed project. Annual continuation awards will depend on the availability of funds, grantee progress in meeting project goals and objectives, timely submission of required data and reports, and compliance with all terms and conditions of award. This program is financed solely by 2015 Prevention and Public Health Funds.

**Funding estimates for this announcement are based on potential funding from the Department of Health and Human Services' Prevention and Public Health Fund (PPHF). Applicants should be aware that SAMHSA cannot guarantee that sufficient funds will be available to fully fund this program.**

### **Cooperative Agreement**

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

#### Role of Grantee:

The role of the grantee is to comply with the terms of the award and all cooperative agreement rules and regulations, and satisfactorily perform activities to achieve the goals described below:

- Seek SAMHSA approval for key positions to be filled. Key positions include, but are not limited to, project director and evaluation director;
- Consult with and accept guidance from SAMHSA staff on performance of programmatic and data collection activities to achieve goals of the cooperative agreement;
- Maintain ongoing communication with SAMHSA, including a minimum of one call per month, keeping federal program staff informed of emerging issues, developments, and problems, as appropriate;
- Include the GPO on policy, steering, advisory or other task forces;
- Maintain ongoing collaboration with SAMHSA's Evaluation Contractor, the Suicide Prevention Resource Center, and the National Suicide Prevention Lifeline;
- Participate in data/program performance assessment efforts explained in Section I-2.2 and I-2.3 of this RFA.

#### Role of SAMHSA Staff:

- Approve proposed key positions/personnel;
- Facilitate linkages to other SAMHSA/federal government resources and help grantees access appropriate technical assistance;
- Coordinate cross-site evaluation participation of grantee and staff required conference calls;

- Assure that state/tribe's youth suicide prevention and early intervention projects are responsive to SAMHSA's mission, including implementation of the 2012 *National Strategy for Suicide Prevention*;
- Promote collaboration with other SAMHSA and federal health and behavioral health initiatives, including the Community Mental Health Services and the Substance Abuse Prevention and Treatment Block Grant programs; and the National Action Alliance for Suicide Prevention; and
- Provide technical assistance on sustainability issues.

### **III. ELIGIBILITY INFORMATION**

#### **1. ELIGIBLE APPLICANTS**

Eligible applicants are:

- States (Including D.C. and the territories)
- Federally recognized Indian tribes, tribal organizations (as defined in the Indian Self-Determination and Educational Assistance Act), or urban Indian organizations (as defined in the Indian Health Care Improvement Act) that are actively involved in the development and continuation of a tribal youth suicide early intervention and prevention strategy
- Public or private non-profit organizations designated by a state, federally recognized Indian tribe, tribal organization, or urban Indian organization, to develop or direct the state/tribal-sponsored youth suicide prevention and early intervention strategy

No single state agency is mandated to be the lead for State/Tribal Youth Suicide Prevention Program grants, as states differ in which state agency has taken the lead for suicide prevention (e.g., Department of Health, Department of Mental Health). Where states have a plan that designates a lead agency, that agency should act as the lead or should designate an alternative lead for State/Tribal Youth Suicide Prevention Grant Program. If the state plan does not designate a lead agency, justify the selection of the lead agency for this application. The lead agency or designated partner (if applicable) who will be lead on the State/Tribal Youth Suicide Prevention Grant Program must be reported in Section G of the Supporting Documentation. Although only one agency should be the lead, inclusion of all youth-serving agencies is expected.

#### **2. COST SHARING and MATCH REQUIREMENTS**

Cost sharing/match is not required in this program.

### 3. EVIDENCE OF EXPERIENCE AND CREDENTIALS

SAMHSA believes that only existing, experienced, and appropriately credentialed organizations with demonstrated infrastructure and expertise will be able to provide required services quickly and effectively. You must meet three additional requirements related to the provision of services.

The three requirements are:

- A provider organization for direct client (e.g., substance abuse treatment, substance abuse prevention, mental health) services appropriate to the grant must be involved in the proposed project. The provider may be the applicant or another organization committed to the project. More than one provider organization may be involved;
- Each mental health/substance abuse treatment provider organization must have at least 2 years' experience (as of the due date of the application) providing relevant services in the geographic area(s) in which services are to be provided (official documents must establish that the organization has provided relevant services for the last 2 years); and
- Each mental health/substance abuse treatment provider organization must comply with all applicable local (city, county) and state licensing, accreditation and certification requirements, as of the due date of the application.

**[Note: The above requirements apply to all service provider organizations. A license from an individual clinician will not be accepted in lieu of a provider organization's license. Eligible tribes and tribal organization mental health/substance abuse treatment providers must comply with all applicable tribal licensing, accreditation, and certification requirements, as of the due date of the application. See Appendix II, Statement of Assurance, in this document.]**

Following application review, if your application's score is within the funding range, the government project officer (GPO) may contact you to request that the following documentation be sent by overnight mail, or to verify that the documentation you submitted is complete:

- a letter of commitment from every mental health/substance abuse treatment provider organization that has agreed to participate in the project that specifies the nature of the participation and the service(s) that will be provided;
- official documentation that all mental health/substance abuse treatment provider organizations participating in the project have been providing relevant services for a minimum of 2 years prior to the date of the application in the area(s) in which the services are to be provided;

- official documentation that all participating mental health/substance abuse treatment provider organizations: 1) comply with all applicable local (city, county) and state requirements for licensing, accreditation and certification; OR 2) official documentation from the appropriate agency of the applicable state, county or other governmental unit that licensing, accreditation and certification requirements do not exist; and
- for tribes and tribal organizations only, official documentation that all participating mental health/substance abuse treatment provider organizations: 1) comply with all applicable tribal requirements for licensing, accreditation and certification; OR 2) documentation from the tribe or other tribal governmental unit that licensing, accreditation and certification requirements do not exist.

**If the GPO does not receive this documentation within the time specified, your application will not be considered for an award.**

## **IV. APPLICATION AND SUBMISSION INFORMATION**

**In addition to the application and submission language discussed in PART II: Section I, you must include the following in your application:**

### **1. ADDITIONAL REQUIRED APPLICATION COMPONENTS**

- **Project Narrative and Supporting Documentation** – The Project Narrative describes your project. It consists of Sections A through E. Sections A-E together may not be longer than 30 pages. (Remember that if your Project Narrative starts on page 5 and ends on page 35, it is 31 pages long, not 30 pages.) More detailed instructions for completing each section of the Project Narrative are provided in [Section V](#) – Application Review Information of this document.

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

- **Attachments 1 through 5** – Use only the attachments listed below. If your application includes any attachments not required in this document, they will be disregarded. Do not use more than a total of 30 pages for Attachments 1, 3 and 4 combined. There are no page limitations for Attachments 2 and 5. Do not use attachments to extend or replace any of the sections of the Project

Narrative. Reviewers will not consider them if you do. Please label the attachments as: Attachment 1, Attachment 2, etc.

- **Attachment 1:** (1) Identification of at least one experienced, licensed mental health/substance abuse treatment provider organization; (2) a list of all direct service provider organizations that have agreed to participate in the proposed project, including the applicant agency, if it is a treatment or prevention service provider organization; (3) letters of commitment from these direct service provider organizations; **(Do not include any letters of support – it will jeopardize the review of your application if you do.)** (4) the Statement of Assurance (provided in [Appendix II](#) of this announcement) signed by the authorized representative of the applicant organization identified on the first page (SF-424) of the application, that assures SAMHSA that all listed providers meet the 2-year experience requirement, are appropriately licensed, accredited and certified, and that if the application is within the funding range for an award, the applicant will send the GPO the required documentation within the specified time.
- **Attachment 2:** Data Collection Instruments/Interview Protocols – if you are using standardized data collection instruments/interview protocols, you do not need to include these in your application. Instead, provide a web link to the appropriate instrument/protocol. If the data collection instrument(s) or interview protocol(s) is/are not standardized, you must include a copy in Attachment 2.
- **Attachment 3:** Sample Consent Forms
- **Attachment 4:** A copy of the state or tribe suicide prevention plan or Community Readiness plan that incorporates the 2012 National Strategy for Suicide Prevention
- **Attachment 5:** A letter from the state or county indicating that the proposed project addresses a state- or county-identified priority. Tribal applicants must provide similar documentation relating to tribal priorities.

## 2. APPLICATION SUBMISSION REQUIREMENTS

Applications are due by **11:59 PM** (Eastern Time) on **June 2, 2015**.

## 3. FUNDING LIMITATIONS/RESTRICTIONS

- No more than 15 percent of the total grant award may be used for developing the infrastructure necessary for expansion of services

- At least 10 percent but no more than 15 percent of the total grant award may be used for data collection, performance measurement and performance assessment, including incentives for participating in the required data collection follow-up.
- Be sure to identify these expenses in your proposed budget.

**SAMHSA grantees also must comply with SAMHSA’s standard funding restrictions, which are included in PART II: Appendix D – Funding Restrictions.**

## **V. APPLICATION REVIEW INFORMATION**

### **1. EVALUATION CRITERIA**

The Project Narrative describes what you intend to do with your project and includes the Evaluation Criteria in Sections A-E below. Your application will be reviewed and scored according to the quality of your response to the requirements in Sections A-E.

- In developing the Project Narrative section of your application, use these instructions, which have been tailored to this program.
- The Project Narrative (Sections A-E) together may be no longer than 30 pages.
- You must use the five sections/headings listed below in developing your Project Narrative. **You must indicate the Section letter and number in your response or it will not be considered, i.e., type “A-1”, “A-2”, etc., before your response to each question.** Your application will be scored according to how well you address the requirements for each section of the Project Narrative.
- Although the budget and supporting documentation for the proposed project are not scored review criteria, the Review Group will consider their appropriateness after the merits of the application have been considered. (See PART II: Section V and Appendix F).
- The number of points after each heading is the maximum number of points a review committee may assign to that section of your Project Narrative. Although scoring weights are not assigned to individual bullets, each bullet is assessed in deriving the overall Section score.



## **Section A: Population of Focus and Statement of Need (15 points)**

1. Provide a comprehensive demographic profile of your population of focus in terms of race, ethnicity, federally recognized tribe, language, gender, age, socioeconomic characteristics, sexual identity (sexual orientation, gender identity), and other relevant factors, such as literacy, substance abuse, or serious mental illness.
2. Discuss the relationship of your population of focus, including sub-populations, to the overall population in your geographic catchment area and identify sub-population disparities, if any, relating to access/use/outcomes of your provided services, citing relevant data. Demonstrate an understanding of these populations consistent with the purpose of your program and intent of the RFA.
3. Describe the nature of the problem, including service gaps, and document the extent of the need (i.e., current prevalence rates or incidence data) for the population(s) of focus based on data. Identify the source of the data. This statement of need should include a clearly established baseline for the project including suicide deaths and non-fatal suicide attempts among youth and young adults between 10-24 years old. Provide sufficient information on the source of the data and how the data were collected so reviewers can assess the reliability and validity of the data. Documentation of need may come from a variety of qualitative and quantitative sources. Examples of data sources for the quantitative data that could be used are local epidemiologic data, state data (e.g., from state needs assessments, SAMHSA's National Survey on Drug Use and Health), and/or national data [e.g., from SAMHSA's National Survey on Drug Use and Health or from National Center for Health Statistics/Centers for Disease Control and Prevention (CDC) reports, and Census data]. Examples of data sources for the qualitative data that could be used include Community Readiness Assessments performed within the previous 18 months. This list is not exhaustive; applicants may submit other valid data, as appropriate for your program.
4. If you plan to use grant funds for infrastructure development, describe the infrastructure changes you plan to implement and how they will enhance/improve service effectiveness. If you do not plan to use grant funds for infrastructure changes, indicate so in your response.
5. Describe the state or tribal systems-level system and the proposed impact of your project.

## **Section B: Proposed Evidence-Based Service/Practice (25 points)**

1. Describe the purpose of the proposed project, including its goals and objectives. These must relate to the intent of the RFA and performance measures you identify in Section E: Data Collection and Performance Measurement.
2. Describe the Evidence-Based Practice (EBP) that will be used and justify its use for your population of focus, your proposed program, and the intent of this RFA. Describe how the proposed practice will address the following issues in the population(s) of focus: demographics (race, ethnicity, religion, gender, age, geography, and socioeconomic status); language and literacy; sexual identity (sexual orientation, gender identity); and disability. [See [Appendix I: Using Evidence-Based Practices \(EBPs\)](#).]
3. If an EBP does not exist/apply for your program, fully describe the practice you plan to implement, explain why it is appropriate for the population of focus, and justify its use compared to an appropriate existing EBP. Describe how the proposed practice will address the following issues in the population(s) of focus: demographics (race, ethnicity, religion, gender, age, geography, and socioeconomic status); language and literacy; sexual identity (sexual orientation, gender identity); and disability.
4. Include a statement indicating your intention to, and how you will, follow-up after discharge from an emergency department or inpatient unit after a non-fatal suicide attempt.

## **Section C: Proposed Implementation Approach (30 points)**

1. Describe how the proposed activities will be implemented. Provide a chart or graph depicting a realistic time line for the entire project period showing key activities, milestones, and responsible staff. These key activities should include the requirements outlined in [Section I-2: Expectations](#). Be sure to show that the project can be implemented and service delivery can begin as soon as possible and no later than 4 months after grant award. [Note: The time line should be part of the Project Narrative. It should not be placed in an attachment.]
2. Identify any other organization(s) that will participate in the proposed project. Describe their roles and responsibilities and demonstrate their commitment to the project. Include letters of commitment from these organizations in **Attachment 1** of your application.

3. State the unduplicated number of individuals you propose to serve (annually and over the entire project period) with grant funds, including the types and numbers of services to be provided and anticipated outcomes. Explain how you arrived at this number. You are required to include the numbers to be served by race, ethnicity, gender, and sexual orientation.
4. Describe your plan for maintaining and/or improving the provision of high quality services that are cost effective throughout the life of the grant. Provide a per-unit cost for this program. Justify that this per-unit cost is providing high quality services that are cost effective.

[NOTE: One approach might be to provide a per-person or unit cost of the project to be implemented. You can calculate this figure by: 1) taking the total cost of the project over the lifetime of the grant and subtracting 20 percent for data and performance assessment; 2) dividing this number by the total unduplicated number of persons to be served. Another approach might be to calculate a per-person or unit cost based upon your organization's history of providing a particular service(s). This might entail dividing the organization's annual expenditures on a particular service(s) by the total number of persons/families who received that service during the year. Another approach might be to deliver a cost per outcome achieved.]

5. Describe your plan to continue the project after the funding period ends. Include a description of how program continuity will be maintained when there is a change in the operational environment (e.g., staff turnover, change in project leadership) to ensure stability over time.
6. Describe plans for ensuring how access to emergency care will be assured for youth identified as being at immediate risk for suicide or suicide attempts and how follow up after emergency care will be promoted.
7. Describe your plan to demonstrate linkages between program activities and improved outcomes, including how surveillance data will be used to inform SAMHSA on the impact of your program.
8. Describe how the core priorities from the zero suicide models will be implemented in your work to embed suicide prevention as a core priority in your state or tribe. Efforts must include linkage with behavioral health care programs/systems committed to making suicide prevention a core priority through implementation of Goals 8 and 9 of the 2012 National Strategy for Suicide Prevention.

## **Section D: Staff and Organizational Experience (10 points)**

1. Discuss the capability and experience of the applicant organization and other participating organizations with public/private suicide prevention coalitions and/or similar projects that include youth and young adult serving organizations as described in [Section I.1](#). Demonstrate that the applicant organization and other participating organizations have linkages to the population(s) of focus and ties to grassroots/community-based organizations that are rooted in the culture(s) and language(s) of the population(s) of focus.
2. Provide a complete list of staff positions for the project, including the Project Director and other key personnel, showing the role of each and their level of effort and qualifications.
3. Discuss how key staff has demonstrated experience and are qualified to serve the population(s) of focus and are familiar with their culture(s) and language(s).
4. Describe how your staff will ensure the input of individuals with lived experience, suicide attempt and loss survivors in assessing, planning and implementing your project.
5. Discuss experience or capability of the applicant organization and staff to effectively a) promote system-level change, b) perform intensive community work, c) incorporate substance abuse prevention and treatment providers, and d) follow-up with in-patient and emergency department discharges for suicide attempts.

## **Section E: Data Collection and Performance Measurement (20 points)**

1. Describe how achievement of the goals will produce meaningful and relevant results for your community (e.g., increase access, availability, prevention, outreach, pre-services, treatment, and/or intervention) and support SAMHSA's goals for the program. Describe and provide a rationale for the anticipated impact the proposed project will have on your community and your ability to do the intensive community work required to make the anticipated impact.
2. Document your ability to collect and report on the required performance measures as specified in [Section I-2.2](#) of this RFA. Describe your plan for data collection, management, analysis and reporting. If applicable, specify and justify any additional measures or instruments you plan to use for your grant project.
3. Describe the data-driven quality improvement process by which sub-population disparities in access/use/outcomes will be tracked, assessed and reduced.

4. Describe your plan for conducting the local performance assessment as specified in Section I-2.3 of this RFA and document your ability to conduct the assessment, including the identification of data sources which can be used to assess impact on youth suicide deaths and non-fatal suicide attempts. Describe your plan for demonstrating linkages between program outcomes and improved outcomes.

## **SUPPORTING DOCUMENTATION**

### **Section F: Literature Citations**

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

### **Section G: Lead Agency Description**

You must list the lead state/tribal agency for the grant or, if applicable, designated partner who will lead the GLS State/Tribal Youth Suicide Prevention Grant Program and justify the selection of the lead.

### **Section H: Biographical Sketches and Job Descriptions**

See PART II: Appendix E – Biographical Sketches and Job Descriptions, for instructions on completing this section.

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

You must describe procedures relating to Confidentiality, Participant Protection and the Protection of Human Subjects Regulations in Section I of your application. See [Appendix III](#) of this document for guidelines on these requirements.

## **VI. ADMINISTRATION INFORMATION**

### **1. REPORTING REQUIREMENTS**

In addition to the data reporting requirements listed in Section I-2.2, grantees must comply with the reporting requirements listed on the SAMHSA website at <http://www.samhsa.gov/grants/grants-management/reporting-requirements>.

This award requires the recipient to complete projects or activities which are funded under the 2015 Prevention and Public Health Fund (PPHF). PPHF funded activities are subject to reporting requirements outlined in Section 218 of the Consolidated and Further Continuing Appropriations Act of 2015 (P.L. 113-235), which states that recipients must report on the use of PPHF funds provided through this award twice each

year (in January and July). Information from these reports will be made available to the public.

Responsibilities for Informing Sub-recipients:

- Recipients agree to separately identify to each sub-recipient and document at the time of sub-award and at the time of disbursement of funds, the Federal award number, any special CFDA number assigned for 2015 PPHF fund purposes, and amount of PPHF funds.

## **VII. AGENCY CONTACTS**

For questions about program issues contact:

LCDR Christina James, MS  
Center for Mental Health Services, Division of Prevention, Traumatic Stress and Special Programs  
1 Choke Cherry Road  
Room 6-1094  
Rockville, Maryland 20857  
(240) 276-1874  
[christina.james@samhsa.hhs.gov](mailto:christina.james@samhsa.hhs.gov)

For questions on grants management and budget issues contact:

Gwendolyn Simpson  
Office of Financial Resources, Division of Grants Management  
Substance Abuse and Mental Health Services Administration  
1 Choke Cherry Road  
Room 7-1091  
Rockville, Maryland 20857  
(240) 276-1408  
[gwendolyn.simpson@samhsa.hhs.gov](mailto:gwendolyn.simpson@samhsa.hhs.gov)

## **Appendix I – Using Evidence-Based Practices (EBPs)**

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

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

Describe how the effectiveness of each evidence-based practice will be quantified in the performance assessment of the project.

- Discuss training needs or plans for training to successfully implement the proposed evidence-based practice(s).

### **Resources for Evidence-Based Practices:**

You will find information on evidence-based practices at <http://store.samhsa.gov/resources/term/Evidence-Based-Practice-Resource-Library>. SAMHSA has developed this website to provide a simple and direct connection to websites with information about evidence-based interventions to prevent and/or treat mental and substance use disorders. The *Resource Library* provides a short description and a link to dozens of websites with relevant evidence-based practices information – either specific interventions or comprehensive reviews of research findings.

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

[Note: Please see PART II: Appendix D – Funding Restrictions, regarding allowable costs for EBPs.]



## Appendix II – Statement of Assurance

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

- a letter of commitment from every mental health/substance abuse treatment service provider organization listed in **Attachment 1** of the application that specifies the nature of the participation and the service(s) that will be provided;
- official documentation that all mental health/substance abuse treatment provider organizations participating in the project have been providing relevant services for a minimum of 2 years prior to the date of the application in the area(s) in which services are to be provided. Official documents must definitively establish that the organization has provided relevant services for the last 2 years; and
- official documentation that all mental health/substance abuse treatment provider organizations: 1) comply with all local (city, county) and state requirements for licensing, accreditation and certification; OR 2) official documentation from the appropriate agency of the applicable state, county or other governmental unit that licensing, accreditation and certification requirements do not exist.<sup>5</sup> (Official documentation is a copy of each service provider organization's license, accreditation and certification. Documentation of accreditation will not be accepted in lieu of an organization's license. A statement by, or letter from, the applicant organization or from a provider organization attesting to compliance with licensing, accreditation and certification or that no licensing, accreditation, certification requirements exist does not constitute adequate documentation.)
- for tribes and tribal organizations only, official documentation that all participating mental health/substance abuse treatment provider organizations: 1) comply with all applicable tribal requirements for licensing, accreditation and certification; OR

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<sup>5</sup> Tribes and tribal organizations are exempt from these requirements.

2) documentation from the tribe or other tribal governmental unit that licensing, accreditation and certification requirements do not exist.

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Signature of Authorized Representative

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Date

## **Appendix III – Confidentiality and SAMHSA Participant Protection/Human Subjects Guidelines**

### **Confidentiality and Participant Protection:**

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

#### 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 population(s) of focus for the proposed project. Include age, gender, and racial/ethnic background and note if the population includes homeless youth, foster children, and children of substance abusers, pregnant women or other targeted groups.

- Explain the reasons for including groups of pregnant women, children, people with mental disabilities, and people in institutions, prisoners and individuals who are likely to be particularly vulnerable to HIV/AIDS.
- Explain the reasons for including or excluding participants.
- Explain how you will recruit and select participants. Identify who will select participants.

### 3. Absence of Coercion

- Explain if participation in the project is voluntary or required. Identify possible reasons why participation is required, for example, court orders requiring people to participate in a program.
- If you plan to compensate participants, state how participants will be awarded incentives (e.g., money, gifts, etc.). Provide justification that the use of incentives is appropriate, judicious and conservative and that incentives do not provide an “undue inducement” which removes the voluntary nature of participation. Incentives should be the minimum amount necessary to meet the programmatic and performance assessment goals of the grant. Applicants should determine the minimum amount that is proven effective by consulting with existing local programs and reviewing the relevant literature. In no case may the value of an incentive paid for with SAMHSA discretionary grant funds exceed \$30.
- 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 **Attachment 2**, “Data Collection Instruments/Interview Protocols,” copies of all available data collection instruments and interview protocols that you plan to use (unless you are providing the web link to the instrument(s)/protocol(s)).

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, and 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 **Attachment 3, “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**

SAMHSA expects that most grantees funded under this announcement will not have to comply with the Protection of Human Subjects Regulations (45 CFR 46), which requires Institutional Review Board (IRB) approval. However, in some instances, the applicant’s proposed performance assessment design may meet the regulation’s criteria for research involving human subjects.

In addition to the elements above, applicants whose projects must comply with the Human Subjects Regulations must fully describe the process for obtaining IRB approval. While IRB approval is not required at the time of grant award, these grantees will be required, as a condition of award, to provide documentation that an Assurance of Compliance is on file with the Office for Human Research Protections (OHRP). IRB approval must be received in these cases prior to enrolling participants in the project.

General information about Human Subjects Regulations can be obtained through OHRP at <http://www.hhs.gov/ohrp> or (240) 453-6900. SAMHSA-specific questions should be directed to the program contact listed in Section VII of this announcement.