Department of Health and Human Services

Substance Abuse and Mental Health Services

Administration

Cooperative Agreements for Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances

Short Title: System of Care Expansion and Sustainability Cooperative Agreements

(Modified Announcement)

Request for Applications (RFA) No. SM-15-009

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

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:

Application Deadline	**Applications are due by April 10, 2015**
Intergovernmental Review **(E.O. 12372)**	**Applicants must comply with E.O. 12372 if their state(s) participates. Review process recommendations from the State Single Point of Contact (SPOC) are due no later than 60 days after application deadline.**
Public Health System Impact Statement (PHSIS)/Single State Agency Coordination	**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.**

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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 Cooperative Agreements for the Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances (Short title: System of Care Expansion and Sustainability Cooperative Agreements). The purpose of this program is to improve mental health outcomes for children and youth (birth to 21 years of age) with serious emotional disturbances (SED) and their families. This program will support the wide scale operation, expansion and integration of the system of care (SOC) approach by creating sustainable infrastructure and services that are required as part of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances (also known as the Children's Mental Health Initiative or CMHI).

Funding Opportunity Title:	Cooperative Agreements for Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances
Funding Opportunity Number:	SM-15-009
Due Date for Applications:	April 10, 2015
Anticipated Total Available Funding:	$45,000,000
Estimated Number of Awards:	15 – 45
Estimated Award Amount:	Up to $3 million per year for state applicants only and up to $1 million per year for political subdivisions of states, tribes, tribal organizations and territories.
Cost Sharing/Match Required	Yes. [See Section III-2 of this RFA for cost sharing/match requirements.]
Length of Project Period:	Four years

Eligible Applicants:	Eligibility for this program is statutorily limited to public entities. [See Section III-1 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 Cooperative Agreements for the Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances (Short title: System of Care Expansion and Sustainability Cooperative Agreements). The purpose of this program is to improve mental health outcomes for children and youth (birth to 21 years of age) with serious emotional disturbances (SED) and their families. This program will support the wide scale operation, expansion and integration of the system of care (SOC) approach by creating sustainable infrastructure and services that are required as part of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances (also known as the Children's Mental Health Initiative or CMHI).

This cooperative agreement will support the provision of mental health and related recovery support services to children and youth with serious emotional disturbances. and those with early signs and symptoms of serious mental illness including first episode psychosis, and their families.

The SOC Expansion and Sustainability Cooperative Agreements will build upon progress made in developing comprehensive systems of care across the country by focusing on sustainable financing, cross-agency collaboration, the creation of policy and infrastructure, and the development and implementation of evidence-based and evidence-informed services and supports. Other activities supported will include the implementation of systemic changes, training, and workforce development.

The Children's Mental Health Initiative (CMHI) provides an excellent example of SAMHSA's Theory of Change (http://store.samhsa.gov/product/PEP14-LEADCHANGE2). Based on data demonstrating improved outcomes for children, youth and families, service system improvements, and a positive return on investment, CMHI has been successful in moving the system of care approach from a demonstration program towards a more widescale adoption of the system of care values and principles. The goal is to continue these efforts to ensure that this approach becomes the primary way in which mental health services for children and youth with SED are delivered throughout the nation.

The System of Care Expansion and Sustainability Cooperative Agreements closely aligns with SAMHSA's Recovery Support Strategic Initiative (http://www.samhsa.gov/about-us/strategic-initiatives). In addition, this 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.)

System of Care (SOC) Expansion and Sustainability Cooperative Agreements are authorized under Sections 561-565 of the Public Health Service Act, as amended. This announcement addresses Healthy People 2020 Mental Health and Mental Disorders Topic Area HP 2020-MHMD.

2. EXPECTATIONS

The SOC Expansion and Sustainability Cooperative Agreements are one of SAMHSA's hybrid grant programs. SAMHSA intends that its hybrid grants result in the development of infrastructure and the delivery of services as soon as possible after award. Service delivery should begin by 6 months after the project award.

Applicants are expected to articulate their knowledge and vision for creating, expanding and sustaining the family-driven and youth-guided system of care approach for addressing the needs of children and youth with serious emotional disturbances and their families. There are two levels of grant applications:

1. System of care expansion and sustainability for **states** focused on statewide implementation. Applicants must identify in their application at least two localities who have not received an implementation expansion grant (RFA SM-12-003 and RFA SM-14-002), to implement service innovations, and demonstrate how they will systematically expand the approach in additional localities over time. Provide Letters of Commitment from localities in **Attachment 1.** Please note, if a state applicant submits an application with a local jurisdiction that is already a grantee, the application will be screened out.

   OR

2. System of care expansion and sustainability for **political subdivisions of states, tribes, tribal organizations, or territories** focused on implementation within their jurisdiction. Applicants must demonstrate that they are working with their respective states (including State Medicaid Agencies) to achieve the broader systemic changes needed to expand and sustain systems of care. In addition, applicants are required to demonstrate and/or create a linkage with the lead state agency for mental health services for youth, and specify how high-level systemic changes will be achieved that builds on the work in their jurisdiction. Provide Letters of Commitment from the State in **Attachment 1.**

In addition all grantees must:

a. Create reporting and monitoring processes to ensure that resources are invested both at the state/tribal/territorial system level and at the local community level.

b. Demonstrate support for a sequential and continuous approach for the wide scale adoption of the system of care approach consistent with SAMHSA's Theory of Change, see **Appendix III**.

c. Demonstrate implementation progress during bi-annual reviews and that plans are dynamic documents that are refined based on assessments of progress, environmental changes, and emerging opportunities.

d. Fully involve families and youth in the development, implementation, and evaluation at both state and local levels.

e. Develop or enhance an existing Governance Structure/Board that is responsible for decision making at the policy level. This governing entity should have the ability to provide legitimacy, authority and accountability for the system of care. Governance bodies for systems of care can exist at the state level, at tribal levels, at the local or neighborhood levels, and in some places at all levels for the same system of care. Government structures are interagency bodies that include family members, youth and young adults. In addition, these bodies represent the cultural and ethnic diversity of the entity involved. Governance structures can be created by legislation or by community will, and may be governmental or quasi-governmental bodies, and some are 501(c) (3) (private, not-for-profit) entities.

f. Develop a statewide/tribal/territorial/community interagency coordination and collaboration processes that clearly support an infrastructure to increase the focus on expanding, implementing and sustaining SOC, including an organizational structure that identifies a locus of authority and responsibility, and ability to provide oversight of the SOC (e.g., letters of agreements, MOU's, statewide/tribal/territorial Interagency SOC Expansion and Sustainability Board). Consider including the lead substance abuse treatment agency and collaborating with other SAMHSA substance use grants.

g. Develop a culturally and linguistically competent social marketing/communication strategic plan by the end of year one of the grant award. The purpose of the plan is to aid in the promotion, development, and sustainability of service and systems change necessary to positively impact the lives of children and youth with serious emotional conditions and their families. The plan should:

    i. Provide an outline of the communication goals, strategies and tactics which will support the goals of the program.
    ii. Be both youth-guided and family-driven while promoting social inclusion of children, youth and young adults with serious mental health challenges, develop partnerships and community outreach efforts that support capacity-building and sustainability efforts, and promote system of care values and principles.
    iii. Be developed by a social marketing committee comprised of families, youth, young adults, evaluators, system of care staff and partners and be approved by the governance board.
    iv. Grantees are also required to have at least one half time equivalent staff position (.5 FTE) or a contract consultant for social marketing-communications manager.

h. Develop a strategic financing plan to be completed by the end of year two of the grant program award. The plan must be implemented no later than the beginning of year three of the grant program. In addition, the plan should demonstrate how the SOC will financially link and/or coordinate with other child serving systems, how Medicaid dollars will be used, how SOC will be connected and integrated with MH/SA Block Grant activities, and how SOC will be included and integrated in the implementation of the Affordable Care Act.

Applicants must focus on both infrastructure and service capacity, and demonstrate how the system of care approach will be expanded and sustained consistent with SAMHSA's Theory of Change. Applicants must clearly demonstrate the linkages between local governments and higher-level system change efforts at the state/tribal/territorial level. System change at only one of these levels is insufficient to expand and implement sustainable systems of care. Therefore, States must include service delivery in at least two localities, and political subdivisions of states, tribes, tribal organizations or territories must identify how the locality will provide services and connect with broader governmental agencies (i.e., state/tribal/territorial) to expand and sustain the system of care approach.

Lessons learned thus far from state-level grants and local-level grants support the conclusion that neither strategy alone is sufficient to implement, sustain, and expand SOCs. SOC implementation is a multi-level process that involves: 1) making changes at the state/tribal/territorial system level in policies, financing mechanisms, workforce

development, and other structures and processes to support SOCs, 2) making changes at the local system level needed to plan, implement, manage, and evaluate the system, and 3) making changes at the service delivery or practice level to provide a broad array of evidence-informed treatment and supports to achieve the ultimate goal of improving outcomes for children and families. All of these changes are critical components of implementing, sustaining, and expanding SOCs.

The approach should include a focus on identifying youth who are early in the course of developing serious mental illness, and provide necessary services and supports. Early intervention for individuals experiencing a first episode of mental illness is important to reduce the burden of future disability. This includes developing and implementing effective outreach and engagement approaches.
If your application is funded, you will be expected to develop a behavioral health disparities impact statement no later than 60 days after receiving your award. In this statement, you must propose: (1) the number of individuals to be served during the grant period and identify specialty populations (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.)

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).

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 or senior services) 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 disorders and/or substance use disorders has been identified as a primary goal for behavioral health care. SAMHSA's Recovery Support Strategic Initiative 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.

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 treatment and related services. In addition, the family members of returning veterans have an increased need for related support services. 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 Population of Focus

The authority for the SOC Expansion and Sustainability Cooperative Agreements (Sections 561- 565 of the Public Health Service Act, as amended) requires that the population of focus for these implementation efforts be children and/or adolescents with a serious emotional disturbance as defined by the criteria listed below:

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

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

Disability: The child or youth is unable to function in the family, school or community, or in a combination of these settings; or the level of functioning is such that the child or adolescent requires multi-agency intervention involving two or more community service agencies providing services in the areas of mental health, education, child welfare, juvenile justice, substance abuse, or primary health care. For children under 6 years of age, community service agencies include those providing services in the areas of childcare, early childhood education (e.g., Head Start), pediatric care, and family mental health. For youth ages 18 to 21 years, 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 multi-agency intervention, is expected to last more than 1-year.

2.2 Required Activities

During the 4-year implementation period, grantees will be expected to realize goals and actions identified in their comprehensive strategic plans to expand and sustain systems of care. Activities must demonstrate the ability to improve, expand, and sustain required comprehensive services and supports throughout the geographic area that are consistent with SOC principles and philosophy. These funds must be used to create infrastructure, facilitate access to required services and supports (including mental health, related recovery supports, case management, and outreach services) and to provide required mental health and related recovery support services that are identified under Sections 561- 565 of the Public Health Service Act, as amended. See Appendix IV for Required Mental Health and Support Services.

SOC Expansion and Sustainability Cooperative Agreements funds must be used to support infrastructure development and services not covered by Medicaid, private or other types of insurance. **Up to thirty percent of funds may be used for infrastructure development**.

The following are required activities designed to implement, expand, operate, and sustain systems of care to include:

- Provision of the following mental health services: (1) diagnostic and evaluation services; (2) outpatient services, including individual, group and family counseling services, professional consultation, and review and management of medications; (3) 24-hour emergency services, 7 days a week; (4) intensive home-based services for the children and their families when the child is at imminent risk of out-of-home placement; (5) intensive day treatment services; (6) respite care; (7) therapeutic foster care services, and services in therapeutic foster family homes or individual therapeutic residential homes, and group homes caring for not more than 10 children; (8) assisting the child in making the transition from services received as a child to the services to be received as an

adult; and (9) other recovery support services (e.g. supported employment) and focus efforts to provide early treatment for those youth with early onset of serious emotional disturbances/serious mental illness (SED/SMI).

- Services that are delivered with cultural and linguistic competence and address issues of diversity and disparity.

- Services that are delivered within a family-driven, youth-guided/directed framework and that engagement of family and youth is demonstrated through integral partners in their own treatment services and supports.

- Integral involvement of families and youth in the planning, governance, implementation, evaluation and oversight of grant activities and in the system planning efforts to expand and sustain systems of care.

- Incorporation of trauma-related activities into the service system, including trauma screening, trauma treatment, and a trauma-informed approach to care. Implementing evidence-based, and promising approaches to treatment while integrating mental health and substance abuse services, supports, and systems.

- Mechanisms to promote and sustain youth and family participation, e.g., peer support, development of youth leadership, mentoring programs, and the partnership between family, adult consumer and youth organizations, youth-guided activities, youth peer specialists, parent support providers establishing permanent youth and family advisory and evaluation bodies, and self-help organizations/programs.

- Collaborations across child-serving agencies (e.g., substance use, child welfare, juvenile justice, primary care, education, early childhood) and among critical providers and programs to build bridges among partners, including relationships between community and residential treatment settings. Collaboration between child and adult serving agencies are critical when serving older youth who are transitioning to adulthood.

- Training/workforce development to help staff and providers in the community identify mental health or substance abuse issues and/or provide effective services.

- Development of outreach and engagement strategies that identify and engage youth and families in SOC efforts including those focusing on youth experiencing early on-set of SED/SMI and other hard to reach populations.

2.3 Other Allowable Activities

SAMHSA's SOC Expansion and Sustainability Cooperative Agreements will also support the following types of activities:

- Collaborating with existing federal grant programs and/or interagency teams serving the same population of focus such as state children's cabinet youth council, shared youth vision team, state and local youth and family organizations.

- Ensuring the development, implementation and evaluation of cultural and linguistic competence at the system, organizational and direct service levels of care.

- Reviewing policies and regulations to improve service delivery.

- Building capacity of state/tribal and local levels to provide sustained service delivery to children, youth and families.

- Conducting needs assessments.

- Adopting and/or enhancing your computer system, management information system (MIS), electronic health records (EHRs), etc., to document and manage client needs, care process, integration with related support services, and outcomes.

2.4 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 policy changes completed as a result of the grant.

- The number of organizations or communities implementing mental health-related training programs as a result of the grant.

- The number of youth/family members/peers who provide mental health-related services as a result of the grant.

- The number of agencies/organizations that entered into formal written inter/intra-organizational agreements (e.g., MOUs/ MOAs) to improve mental health-related practices/activities as a result of the grant

- The number of individuals contacted through program outreach efforts.

- The number of individuals referred to mental health or related services.
- The number of individuals receiving mental health or related services after referral.

For services, grantees will be expected to report on the following performance measures:

- Mental illness symptomatology;
- Employment/education;
- Crime and criminal justice;
- Stability in housing; access, i.e., number of persons served by age, gender, race and ethnicity;
- Rate of readmission to psychiatric hospitals;
- Social support/social connectedness; and
- Client perception of care.

This information will be gathered using the CMHS Child Outcome Measures for Discretionary Programs (Child or Adolescent Respondent Version and Caregiver Respondent Version), which can be found at (http://www.samhsa.gov/grants/gpra-measurement-tools) along with instructions for completing it. Data will be collected at baseline, 6-month follow-up, and at discharge. Data are to be entered into the Common Data Platform (CDP) web system within seven days of data collection. Technical Assistance related to data collection and reporting, data entry, fiscal and annual report generation is available.

The collection of these data will enable CMHS to report on the National Outcome Measures (NOMs), which have been defined by SAMHSA as key priority areas relating to mental health. In addition to the NOMs, data collected by grantees will be used to demonstrate how SAMHSA's grant programs are reducing disparities in access, service use, and outcomes nationwide.

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

2.5 Local Performance Assessment

Grantees must periodically review the performance data they report to SAMHSA (as required above) and assess progress and use this information to improve management of grant projects. The assessment should be designed to help you determine whether you are achieving the goals, objectives, and outcomes you intended to achieve and whether adjustments need to be made. Performance assessments should be used to determine if the intended impact on behavioral health disparities is being met. Reporting on progress achieved, barriers encountered, and efforts to overcome these

barriers in a performance assessment report to be submitted annually with progress report.

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 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?

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 behavioral health disparities, including the use of 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)?

No more than 20 percent of the total grant award may be used for data collection, performance measurement, and performance assessment, e.g., activities required in Sections I-2.4 and 2.5 above.

2.6 Grantee Meetings

Grantees must plan to send a minimum of ten people (including the Project Director and key stakeholders that are mutually identified between the grantee and Government Project Officer) to at least one SOC training activity during the grant period (these can be divided into multiple training events). The applicant must include a detailed budget

and narrative for this travel in your budget. At these meetings, grantees will receive training on the development and implementation of various aspects of a SOC, present results of their projects and participate in technical assistance that may be provided by federal staff or partners.

In addition, grantees must have key staff and partners participate in virtual training events that will be held to provide information, direction and technical assistance to grantees.

II. AWARD INFORMATION

Funding Mechanism: **Cooperative Agreements**

Anticipated Total Available Funding: **$45,000,000**

Estimated Number of Awards: **15 – 45**

Estimated Award Amount: **$1,000,000 - $3,000,000**

Length of Project Period: **4 years**

Proposed budgets cannot exceed $3,000,000 for state applicants and $1,000,000 for political subdivisions of states, tribes, tribal organizations, and territories 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.

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

Role of Grantee:

- Comply with the terms and conditions of the agreement, which will be specified in the Notice of Award (NoA).
- Agree to provide SAMHSA with all required data.
- Regularly assess technical assistance needs and agree to work closely with federal staff and technical assistance providers to address identified needs.

- Comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care which can be found at http://www.ThinkCulturalHealth.hhs.gov.

Role of SAMHSA Staff:

- The assigned Government Project Officer (GPO) will monitor each grantee's progress in the implementation of program requirements, and provide direct assistance to advance the goals of the program, and to improve the effectiveness of the SOC.
- Review and approve each stage of project implementation (e.g. continuation applications, and proposed programmatic and budgetary modifications).
- Review and approve all key staff, social marketing, strategic, and financing plans.
- Participate in making decisions with the grantee to help achieve project goals and objectives.
- Approve decisions for each grantee regarding:
    - Use of technical assistance resources for developing and operating the SOC according to requirements of the cooperative agreement, and for increasing the likelihood that the SOC will be expanded and sustained beyond the federal funding period; and
    - 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 discrimination associated with mental health challenges.

- Conduct a formal federal site visit in Year 2 or 3 of the cooperative agreement. Additional formal or informal site visits may be conducted, as needed.
- Coordinate with CMHS, SAMHSA, and other federal initiatives, as appropriate.

III. ELIGIBILITY INFORMATION

1. ELIGIBLE APPLICANTS

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

State governments; Indian or tribal organizations (as defined in Section 4[b] and Section 4[c] of the Indian Self-Determination and Education Assistance Act); Governmental units within political subdivisions of a state, such as a county, city or town; District of Columbia government; and the Commonwealth of Puerto Rico, Northern Mariana Islands, Virgin Islands, Guam, American Samoa, and Trust Territory of the Pacific Islands (now Palau, Micronesia, and the Marshall Islands).

Tribal organization means the recognized body of any AI/AN tribe; any legally established organization of American Indians/Alaska Natives which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of American Indians/Alaska Natives in all phases of its activities.

Note: Public entities that are currently receiving funds under the Implementation Cooperative Agreements for the Expansion of the Comprehensive Community Mental Health Services for Children and Their Families Program (System of Care Expansion Implementation Cooperative Agreements), RFA SM-12-003 and RFA SM-14-002, are not eligible to apply under this funding announcement. State governments, Indian or tribal organizations; and Governmental units within political subdivisions of a state which have already received one of the grants are not eligible to apply.

Eligible state applicants for this grant may not choose local jurisdictions that have received an implementation expansion grant previously. If a state applicant submits an application with a local jurisdiction that is already a grantee, this application will be screened out.

Indian or tribal organizations, and governmental units within political subdivisions of a state, may apply as long as they have not received this grant previously.

If a state applicant identifies a local jurisdiction that has also submitted a separate application, SAMHSA will score both. The highest priority scored application will be awarded should both applications be in the fundable range.

SAMHSA is limiting eligibility in order to expand the number of states, jurisdictions and localities within a state, political subdivision, tribe, tribal organization or territory that wish to adopt and expand the SOC approach.

See Appendix II of the RFA for a list of ineligible entities.

2. COST SHARING and MATCH REQUIREMENTS

Cost sharing/match is required by statutory mandate to provide matching funds from other non-federal sources, either directly or through donations from public or private entities:

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

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

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

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

A letter from the director of the agency applying for the grant should certify that matching funds for the proposed initiative are available and are non-federal funds. It is expected that non-federal match dollars will include contributions from various child-serving systems (e.g., education, child welfare, and juvenile justice). You must specify the names of the expected sources, the types of sources (e.g., education, child welfare, and juvenile justice) and the amount of matching funds, to show evidence of your potential to sustain the system of care as you bring it to scale in your state/territory/tribe. The letter must be included in **Attachment 5** of the application, Non-Federal Match Certification letter. This letter should also indicate that proposed changes in funding streams required for the match or other funding innovations necessary for implementation of the proposed initiative will be allowed.

Tribes receiving funds under the Indian 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

Applicants must show that identified needs are consistent with priorities of the tribe, tribal organization, state or county that has primary responsibility for the service delivery system. The applicant must include, in **Attachment 6**, a copy of the state or county strategic plan, a state or county needs assessment, or 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.

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

Narrative and Supporting Documentation – The Narrative describes the applicant's approach. It consists of Sections A through E. Sections A-E together may not be longer than 35 pages. (Remember that if the applicant's Project Narrative starts on page 5 and ends on page 40, it is 36 pages long, not 35 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 the application. This supporting documentation should be provided immediately following the Narrative in Sections F and G. There are no page limits for these sections, except for Section F, 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 6 – Use only the attachments listed below. If the 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 Attachment 2. Do not use attachments to extend or replace any of the sections of the Project Narrative. Reviewers will not consider them. Please label the attachments as: Attachment 1, Attachment 2, etc.

- **Attachment 1:** Letters of Commitment from any organization(s) participating in the proposed project. **(Do not include any letters of support – it will jeopardize the review of your application if you do.)**
- **Attachment 2:** Data Collection Instruments/Interview Protocols – if the applicant uses standardized data collection instruments/interview protocols, they do not need to include these in the 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, include a copy in Attachment 2.
- **Attachment 3:** Sample Consent Forms
- **Attachment 4:** Letter to the SSA (if applicable; see PART II: Appendix C – Intergovernmental Review (E.O. 12372) Requirements).
- **Attachment 5:** Non-Federal Funds Match Certification Letter
- **Attachment 6:** Strategic Plan, Needs Assessment, or Prioriy Letter

2. APPLICATION SUBMISSION REQUIREMENTS

Applications are due by **11:59 PM** (Eastern Time) on **April 10, 2015**.

3. FUNDING LIMITATIONS/RESTRICTIONS

No more than 20 percent of the grant award may be used for data collection, performance measurement, and performance assessment expenses.

No more than 30 percent of funds may be used for infrastructure.

Remaining funds must be used for services and supports.

Be sure to identify these expenses in the proposed budget, See Part II: Appendix F.

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 how the applicant will implement, expand and sustain the system of care and includes the Evaluation Criteria in Sections A-E below. The application will be reviewed and scored according to the quality of the response to the requirements in Sections A-E.

In developing the Narrative section of the application, use these instructions, which have been tailored to this program.

The Narrative (Sections A-E) together may be no longer than 35 pages.

The applicant must use the four sections/headings listed below in developing your Narrative. **You must indicate the Section letter and number in the response or it will not be considered, i.e., type "A-1", "A-2", etc., before the response to each question.** Ther application will be scored according to how well you address the requirements for each section of the 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 the Narrative. Although scoring weights are not assigned to individual bullets, each bullet is assessed in deriving the overall Section score.

Section A: Statement of Need/Readiness/Evidence of Strategic Planning (25 points)

1. Applicants are required to articulate their vision for how program activities in the grant connect to SAMHSA's Theory of Change. Specifically, the applicant must identify how their proposed activities will lead to expansion and widespread adoption of the system of care approach, and should include strategies to implement and sustain best and promising practices in areas including financing, governance, family and youth engagement, family and youth driven care, formal and informal collaborations among system partners and other child serving agencies, cultural and linguistic competence, evidenced based and evidenced informed services and supports. **Appendix III** shows a diagram of the SAMHSA Theory of Change. These grants are focused on dissemination, implementation and widespread adoption of the system of care approach, and applicants must show how their activities will move the system of care approach towards widescale adoption. Activities can include capacity building, effective and appropriate services and supports, program evaluation, continuous quality improvement, policy changes, system improvements and infrastructure development. Widespread adoption means that these system changes are institutionalized and become the "way we do business".

    a. State applicants will identify how the theory of change will be used to expand and sustain the system of care approach within and beyond local levels across the state. The state will articulate a plan to develop, enhance, expand and sustain services and infrastructure to ensure widespread adoption of system of care.

    b. At the local level, applicants should articulate how they will work with the state, tribes, tribal organizations, territories and/or other jurisdictions to develop, enhance, expand and sustain services and infrastructure to ensure widespread adoption of system of care within and beyond their local areas.

2. State applicants addressing statewide systems change must identify at least two local jurisdictions where the system of care approach will be implemented. Include supporting documents from those local jurisdictions (e.g., letter from a local official) demonstrating that they have agreed to participate. Describe how the two local jurisdications will systematically expand the approach in additional communities over time. Include in **Attachment 1** letters from localities their commitment to expand and sustain system of care in their jurisdictions.

3. Applicants focusing on the local, tribal or territory level must demonstrate that they are working with their respective states (including state Medicaid agencies), tribes, or territories to achieve the broader systemic changes needed to expand and sustain systems of care. Local applicants must demonstrate a linkage with the lead state agency for mental health services to youth and specify how high-level systemic changes will be achieved to build on the work in localities to take SOCs to scale. Include in **Attachment 1** letters from the state, tribal or territory

leadership demonstrating their commitment to broader system level changes to support the local level adoption of system of care.

4. Identify the proposed catchment area(s)(e.g. catchment area may refer to the entire state) and provide demographic information on the population(s) to engage in activities and receive services through the grant in terms of race, ethnicity, federally recognized tribe, language, gender, age, socioeconomic status and sexual identity (sexual orientation, gender identity). This should include youth who experience early on-set of SED/SMI. Explain how this meets the priority to expand and sustain systems of care at the state, local, tribal, and/or territorial level.

5. Document clear evidence of the priority in your jurisdiction of expanding and sustaining systems of care through a strategic plan, needs assessment and/or priority letter. Demonstrate progress to date to create a comprehensive strategic plan that will expand and sustain required services and supports that are consistent with Sections 561- 565 of the Public Health Service Act, as amended and the systems of care values and principles. Include in **Attachment 6** your strategic plan, needs assessment and/or Priority Letter.

Section B: Proposed Services and Infrastructure Approach (20 points)

1. Describe the purpose of the proposed project, including a clear statement of its goals and objectives. These must relate to the performance measures identified in Section E: Data Collection and Performance Measurement.

2. Describe how the proposed services and infrastructure approach will result in the achievement of goals and increase system capacity to support effective mental health services and systems of care for children, youth and families. Articulate how this approach supports SAMHSA theory of change.

3. Describe how family, youth and consumer organizations will be fully involved and supported in all planning, implementation, and evaluation efforts of the SOC. Demonstrate how these organizations, as well as other key stakeholders and resources in the catchment area, have made a commitment to implement the needed infrastructure and services. Identify any other organization(s) that will participate in the proposed activities. Describe roles and responsibilities and demonstrate commitment to the project. Include letters of commitment from these organizations in **Attachment 1** of your application.

4. Describe how the proposed activities will be implemented and how they will adhere to the National Standards for Culturally and Linguistic Appropriate Services (CLAS) in Health and Health Care. For additional information go to: http://ThinkCulturalHealth.hhs.gov.

Section C: Expectations and Required Activities (30 points)

1. 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. [Note: The time line should be part of the Project Narrative. It should not be placed in an attachment.] Describe how the project will address the Expectations outlined in Section 1-2.

2. Describe how the proposed approach will address the following required activities as described in Section 1-2.2 :

    a. Provision of the following mental health services: (1) diagnostic and evaluation services; (2) outpatient services, including individual, group and family counseling services, professional consultation, and review and management of medications; (3) 24-hour emergency services, 7 days a week; (4) intensive home-based services for the children and their families when the child is at imminent risk of out-of-home placement; (5) intensive day treatment services; (6) respite care; (7) therapeutic foster care services, and services in therapeutic foster family homes or individual therapeutic residential homes, and group homes caring for not more than 10 children; (8) assisting the child in making the transition from services received as a child to the services to be received as an adult; and (9) other recovery support services (e.g. supported employment) and focus efforts to provide early treatment for those youth with early onset of serious emotional disturbances/serious mental illness (SED/SMI).

    b. Services that are delivered with cultural and linguistic competence and address issues of diversity and disparity.

    c. Services that are delivered within a family-driven, youth-guided/directed framework and that engagement of family and youth are demonstrated through integral partners in their own treatment services and supports.

    d. Integral involvement of families and youth in the planning, governance, implementation, evaluation and oversight of grant activities and in the system planning efforts to expand and sustain systems of care.

    e. Incorporation of trauma-related activities into the service system, including trauma screening, trauma treatment, and a trauma-informed approach to care. Implementing evidence-based, and promising approaches to treatment while integrating mental health and substance abuse services, supports and systems.

    f. Mechanisms to promote and sustain youth and family participation, e.g., peer support, development of youth leadership, mentoring programs, and the partnership between family, adult consumer and youth organizations, youth-guided activities, youth peer specialists, parent support providers

establishing permanent youth and family advisory and evaluation bodies, and self-help organizations/programs.

g. Collaborations across child serving agencies (e.g., substance use, child welfare, juvenile justice, primary care, education, early childhood) and among critical providers and programs to build bridges among partners, including relationships between community and residential treatment settings. Collaboration between child and adult serving agencies are critical when serving older youth who are transitioning to adulthood.

h. Training/workforce development to help staff and providers in the community identify mental health or substance abuse issues and/or provide effective services.

i. Development of outreach and engagement strategies to identify and engage youth and families in SOC efforts include those focusing on youth experiencing early on-set of SED/SMI and other hard-to-reach populations.

Section D: Staff, Management, and Relevant Experience (15 points)

1. Discuss the capability and experience of the applicant organization with similar projects and populations, including experience in providing culturally appropriate/competent services.

2. Provide a complete list of staff positions to support planning and implementation of the system of care approach, including the Project Director and other key personnel, showing the role of each and their level of effort and qualifications. Discuss how key staff has demonstrated experience and are qualified to take a leadership role in developing the infrastructure and services for the population(s) of focus, including culture and language.

3. Describe how youth and family members will be hired/engaged as staff with the project.

Section E: Data Collection and Performance Measurement (10 points)

1. Document the ability to collect and report on the required performance measures as specified in Section I-2.4 of this RFA. Describe the plan for data collection, management, analysis and reporting of data for the population served by the infrastructure program. If applicable, specify and justify any additional measures.

2. Describe how data will be used to manage the grant activities and assure that the goals and objectives at a systems level will be tracked and achieved. Goals and objectives of the infrastructure program should map onto any continuous quality improvement plan, including consideration of behavioral health disparities. Describe how information related to process and outcomes will be routinely

communicated to program staff, governing and advisory bodies, and stakeholders.

3. Describe the data-driven quality improvement process by which specialty population disparities in access/use/outcomes will be tracked, assessed and reduced.

4. Describe the plan for conducting the local performance assessment as specified in Section I-2.5 of this RFA and document the ability to conduct the assessment.

SUPPORTING DOCUMENTATION

Section F: Biographical Sketches and Job Descriptions

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

Section G: Confidentiality and SAMHSA Participant Protection/Human Subjects

The applicant must describe procedures relating to Confidentiality, Participant Protection and the Protection of Human Subjects Regulations in Section F of your application. See Appendix I 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-2.4, grantees must comply with the reporting requirements listed on the SAMHSA website at http://www.samhsa.gov/grants/applying/reporting-requirements. Grantees are required to submit semi-annual reports.

VII. AGENCY CONTACTS

For questions about program issues contact:

Debra Cady
Public Health Advisor/Government Project Officer
Child, Adolescent and Family Branch
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 6-1048
Rockville, MD 20857
(240) 276-1929
debra.cady@samhsa.hhs.gov

Diane Sondheimer
Deputy Chief
Child, Adolescent, and Family Branch
Federal Center for Mental Health Services
1 Choke Cherry Road, Room 6-1043
Rockville, Maryland 20857
(240) 276-1922
diane.sondheimer@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

Appendix I – 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. 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, children of substance abusers, pregnant women, or other targeted groups.

Explain the reasons for including groups of pregnant women, children, people with mental disabilities, people in institutions, prisoners, and individuals who are likely to be particularly vulnerable to HIV/AIDS.

Explain the reasons for including or excluding participants.

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

3. Absence of Coercion

Explain if participation in the project is voluntary or required. Identify possible reasons why participation is required, for example, court orders requiring people to participate in a program.

If you plan to compensate participants, state how participants will be awarded incentives (e.g., money, gifts, etc.). Provide justification that the use of incentives is appropriate, judicious, and conservative and that incentives do not provide an "undue inducement" which removes the voluntary nature of participation. Incentives should be the minimum amount necessary to meet the programmatic and performance assessment goals of the grant. Applicants should determine the minimum amount that is proven effective by consulting with existing local programs and reviewing the relevant literature. In no case may the value if an incentive paid for with SAMHSA discretionary grant funds exceed $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 data will be collected (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 (unless you are providing the web link to the instrument(s)/protocol(s)).

5. Privacy and Confidentiality

Explain how the applicant will ensure privacy and confidentiality. Include who will collect data and how it will be collected.

Describe:

- How data collection instruments will be used.
- 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 it will be kept 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 consent for youth, the elderly, people with limited reading skills, and people who do not use English as their first language will be obtained.

NOTE: If the project poses potential physical, medical, psychological, legal, social or other risks, written informed consent must be obtained.

Indicate how the applicant 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 applicant read the consent forms? Will applicant ask prospective participants questions to be sure they understand the forms? Will applicant 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 the 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 the 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, 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?

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.

Appendix II – List of Current Grantees Ineligible to Apply

SOC Implementation Grantees

Expansion Implementation Grantees (2012-2016)

SM061220	District of Columbia Dept. Of Mental Health	DC
SM061221	Virginia State Dept. of Mental Health/Mental Retardation/Substance Abuse Services	VA
SM061224	Oklahoma Dept. of Mental Health /Substance Abuse	OK
SM061226	Hawaii State Department of Health	HI
SM061228	Pueblo Of San Felipe	NM
SM061231	Maine State Dept. of Corrections	ME
SM061233	Monroe County Public Health Department	NY
SM061234	Rhode Island State Dept. for Child/Family	RI
SM061235	Florida State Dept. of Children & Families	FL
SM061237	Washington State Dept. Social/Health Services	WA
SM061241	Colorado Division of Behavioral Health	CO
SM061243	Pascua Yaqui Tribe	AZ
SM061245	Humboldt County Department of Health and Human Services	CA
SM061247	Tennessee State Dept. of Health	TN
SM061249	NH State Dept./Health Statistics/Data Mgmt.	NH
SM061253	Maryland State Department. Of Health/Mental Hygiene	MD

Expansion Implementation Grants FY 2013-2017

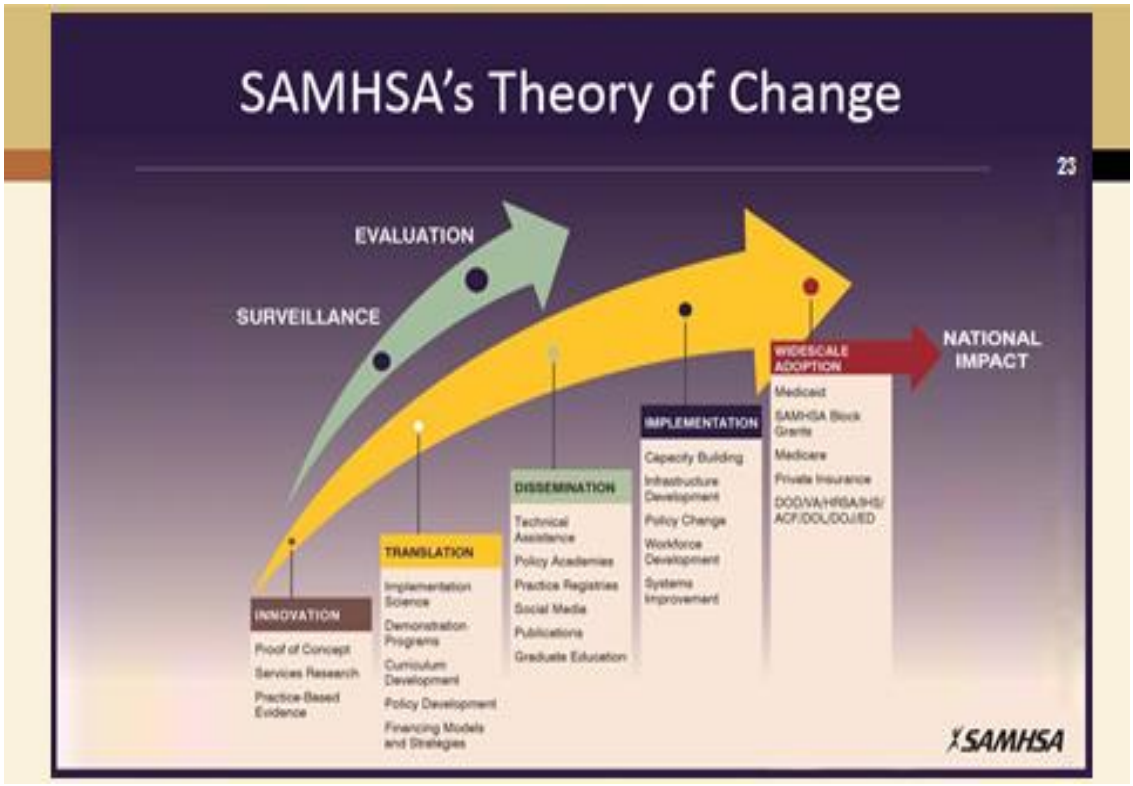
SM061219	Texas Health & Human Services Commission	TX
SM061222	Cabinet for Health & Family Services	KY
SM061225	Ohio Dept. of Mental Health	OH
SM061227	Dept. of Mental Health & Substance Abuse	GU
SM061229	Charter County of Wayne	MI
SM061230	Mississippi Dept. of Mental Health Center	MS
SM061232	Montana Office Public Instruction	MT
SM061236	Oglala Lakota Nation	SD
SM061238	Commonwealth of MA Dept. of Health	MA
SM061239	Yellowhawk Tribal Health Center	OR
SM061244	Florida Dept. Of Children & Families	FL
SM061248	Cherokee Nation	OK
SM061250	Commonwealth of PA Dept. of Public Welfare	PA
SM061251	State of Georgia Dept. of Behavioral Health	GA
SM061252	Delaware State Dept. of Services/Children Youth and Their Families	DE

Expansion Implementation Grantees (2014-2018)

SM060628	Yukon-Kuskokwim Health Corporation	AK
SM061629	Tohono O' Odham Community College	AZ
SM061630	City of Jackson	MS
SM061632	Arkansas State Dept. of Human Services	AR
SM061631	Utah State Department of Human Services	UT
SM061633	South Carolina State Division of Health and Human Services	SC
SM061634	Lummi Nation	WA
SM061635	Adamhs Board for Montgomery County	OH
SM061636	Yurok Tribe	CA
SM061637	Mental Health/Mental Retardation Tarrant County	TX
SM061638	County of Beaver	PA

SM061639	City of San Antonio	TX
SM061640	City of Pasadena	CA
SM061641	San Francisco Dept. of Public Health	CA
SM061642	NC State Dept. /Health & Human Services	NC
SM061645	Tule River Tribal Council	CA
SM061646	Connecticut Department Children and Families	CT
SM061651	Illinois State Department of Human Services	IL
SM061647	Indiana State Division of Mental Health/AD	IN
SM061643	Saginaw County Community Mental Health Authority	MI
SM061648	New Mexico State Dept./Children/Youth/Family	NM
SM061650	Santee Sioux Nation	NE

Appendix III – SAMHSA Theory of Change Diagram



Appendix IV – REQUIRED MENTAL HEALTH AND SUPPORT SERVICES

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

- Diagnostic and evaluation services;
- Cross-system care management processes;
- Individualized service plan development inclusive of caregivers;
- Community-based services provided in a clinic, office, family's home, school, primary health or behavioral health clinic, or other appropriate location, including individual, group and family counseling services, professional consultation, and review and medication management;
- Emergency services, available 24 hours a day, 7 days a week, including mobile crisis outreach and crisis intervention;
- Intensive home-based services available 24 hours a day, 7 days a week, for children and their families when the child is at imminent risk of out-of-home placement, or upon return from out-of-home placement;
- Intensive day treatment services;
- Respite care;
- Therapeutic foster care;
- Therapeutic group home services caring for not more than 10 children (i.e., services in therapeutic foster family homes or individual therapeutic residential homes);
- Assistance in making the transition from the services received as a child and youth to the services received as a young adult;
- Family advocacy and peer support services delivered by trained parent/family advocates.

[Note: The required services listed above should be integrated, when appropriate, with established alternative or traditional healing practices (practice-based evidence) of racial, ethnic or cultural groups represented in the community, especially if there are indications that such integration will reduce racial or ethnic disparities in mental health care.]

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

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

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

[Note: Cooperative agreement funds and matching funds may be used to purchase individualized optional services from appropriate agencies and providers that directly address the mental health needs of children and adolescents in the population of focus. However, the funding of these services may not take precedence over the funding of the array of required services in this RFA.]

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

- Educational services, especially for children and youth who need to be placed in special education programs;
- Health services, especially for children and youth with co-occurring chronic illnesses;
- Substance abuse prevention and treatment services, especially for youth with co-occurring substance abuse problems;
- Out-of-home services such as acute inpatient and residential;
- Vocational counseling and rehabilitation and transition services offered under IDEA, for those children 14 years or older who require them;

- Protection and advocacy, including informational materials for children with a serious emotional disturbance and their families.

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

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