Department of Health and Human Services

Substance Abuse and Mental Health Services Administration

Linking Actions for Unmet Needs in Children's Health in American Indian and Alaskan Native Communities, U.S. Territories, and Pacific Jurisdictions Cooperative Agreements

(Short Title: Indigenous - Project LAUNCH)

(Initial Announcement)

Funding Opportunity Announcement (FOA) No. SM-17-004

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 "Funding Opportunity Announcement (FOA) PART II: Administrative and Application Submission Requirements for Discretionary Grants and Cooperative Agreements". PART I is individually tailored for each FOA. PART II includes requirements that are common to all SAMHSA FOAs. You MUST use both documents in preparing your application.

Key Dates:

Application Deadline	**Applications are due by March 1, 2017.**
Intergovernmental Review (E.O. 12372)	**Applicants must comply with E.O. 12372 if their state(s) participate(s). 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 the application deadline. Comments from the Single State Agency are due no later than 60 days after the application deadline.**

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EXECUTIVE SUMMARY

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS)**,** is accepting applications for fiscal year (FY) 2017 Linking Actions for Unmet Needs in Children's Health in American Indian/Alaskan (AI/AN) Native Communities and U.S. Territories and Pacific Jurisdictions Cooperative Agreements (Short title: Indigenous Project LAUNCH). The purpose of this program is to promote the wellness of young children from birth to eight years within tribes, territories and Pacific Island jurisdictions by addressing the physical, social, emotional, cognitive and behavioral aspects of their development. The goal of Project LAUNCH is for children to be thriving in safe, supportive environments, and entering school ready to learn and able to succeed.

Funding Opportunity Title:	Linking Actions for Unmet Needs in Children's Health in American Indian and Alaskan Native Communities and U.S. Territories and Pacific Jurisdictions Cooperative Agreement
Funding Opportunity Number:	SM-17-004
Due Date for Applications:	March 1, 2017
Anticipated Total Available Funding:	$7,600,000
Estimated Number of Awards:	Up to 13
Estimated Award Amount:	Up to $550,000 per year
Cost Sharing/Match Required	No
Length of Project Period:	Up to five years
Eligible Applicants:	Federally recognized American Indian/Alaskan Native tribes, tribal organizations, consortia of tribes or tribal organizations and U.S. Territories and Pacific Jurisdictions. [See Section III-1 of this FOA for complete eligibility information.]

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

IMPORTANT: SAMHSA is transitioning to the National Institutes of Health (NIH)'s electronic Research Administration (eRA) grants system. Due to this transition, SAMHSA has made changes to the application registration, submission, and formatting requirements for all Funding Opportunity Announcements (FOAs). All applicants must register with NIH's **eRA Commons** in order to submit an application. Applicants also must register with the System for Award Management (SAM) and Grants.gov (see Appendix A for all registration

I. FUNDING OPPORTUNITY DESCRIPTION

1. PURPOSE

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS)**,** is accepting applications for fiscal year (FY) 2017 Linking Actions for Unmet Needs in Children's Health in American Indian/Alaskan (AI/AN) Native Communities and U.S. Territories and Pacific Jurisdictions Cooperative Agreements (Short title: Indigenous Project LAUNCH). The purpose of this program is to promote the wellness of young children from birth to eight years within tribes, territories and Pacific Island jurisdictions by addressing the physical, social, emotional, cognitive and behavioral aspects of their development. The goal of Project LAUNCH is for children to be thriving in safe, supportive environments, and entering school ready to learn and able to succeed.

This funding opportunity builds on the success of previous cohorts of Project LAUNCH grantees. Previously-funded tribal and territorial grantees have demonstrated the need for resources devoted to early childhood systems and prevention and promotion practices in tribal and territorial communities. Tribal and territorial grantees have also provided evidence of positive impacts on young children and families when resources are focused on early childhood wellness in a culturally-appropriate and strengths-based manner.

This program will foster culturally-responsive models to support and promote mental health and wellness and reduce the impacts of trauma, including historical trauma and adversity, on AI/AN and U.S. Territories and Pacific Island communities through a multi-generational and public health approach. The World Health Organization defines the public health approach as efforts that "aim to provide the maximum benefit for the largest number of people" and programs that "expose a broad segment of a population to prevention measures" (for more information, see

http://www.cdc.gov/violenceprevention/overview/publichealthapproach.html). The public health approach that is the foundation for Project LAUNCH focuses on the health needs of the community**,** rather than addressing the health problems of individuals. Indigenous Project LAUNCH seeks to improve outcomes at the individual, family and community levels by creating strategies to reduce risk factors that can lead to negative outcomes. Indigenous Project LAUNCH also promotes building on protective factors that support resilience, wellness, and healthy development of children and can prevent later social, emotional, cognitive, physical, and behavioral problems, including early substance use.

Another major objective of Indigenous Project LAUNCH is to serve as a catalyst for systemic change and to strengthen and enhance the partnership between health and mental health organizations and departments that are part of the Tribal and Territorial infrastructure. Grantees will bring together child-serving organizations, departments, and programs to increase collaboration and resource-sharing and develop policies and pathways to improve the integration of supports for young children and families.

For the purposes of Indigenous Project LAUNCH, the following terms will be defined as:

Historical trauma – "the cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma experiences" (Brave Heart, 2003, p. 7).

Wellness – Wellness is being in good physical and mental health. Because mental health and physical health are linked, problems in one area can impact the other. .

The Eight Dimensions of Wellness are:

1. **Emotional**—Coping effectively with life and creating satisfying relationships
2. **Environmental**—Good health by occupying pleasant, stimulating environments that support well-being
3. **Financial**—Satisfaction with current and future financial situations
4. **Intellectual**—Recognizing creative abilities and finding ways to expand knowledge and skills
5. **Occupational**—Personal satisfaction and enrichment from one's work
6. **Physical**—Recognizing the need for physical activity, healthy foods, and sleep
7. **Social**—Developing a sense of connection, belonging, and a well-developed support system
8. **Spiritual**—Expanding a sense of purpose and meaning in life

Mental Health Promotion - “Interventions that aim to enhance the ability to achieve developmentally appropriate tasks (developmental competencies) and a positive sense of self-esteem, mastery, well-being, and social inclusion and to strengthen the ability to cope with adversity.”

Prevention - “interventions that occur prior to the onset of a disorder that are intended to prevent or reduce risk for the disorder” (2009 IOM Report: Preventing Mental, Emotional, and Behavioral Disorders: Progress and Possibilities).

Project LAUNCH grants are authorized under Section 520A 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

SAMHSA’s Indigenous Project LAUNCH cooperative agreements have a dual focus on infrastructure development and the delivery of services and supports that promote young child wellness and healthy social and emotional development. Applicants will infuse culturally-driven and trauma-informed mental health and wellness promotion practices and mental illness prevention practices into the settings and service systems through which young children and families can be reached.

The Indigenous Project LAUNCH grant program requires that the population of focus be children from birth to eight years of age and their families. Efforts to improve and integrate systems and enhance services and supports should include those providers and settings serving children from birth to eight years, such as health/maternal and child health, community health, child care, Head Start, and elementary schools, as well as natural and non-formalized helpers and supports that exist within communities. There is a strong need to address early childhood social and emotional development, and to support caregivers and parents of young children, before the onset of behavioral health challenges, particularly in AI/AN communities and the U.S. Territories and Pacific Jurisdictions, where a strong infrastructure and capacity to support this population is not always present. Resources for promoting young children’s social and emotional wellbeing, addressing developmental and behavioral issues, and strengthening families are often scarce in those communities. Finally, many Native and Indigenous communities are impacted by widespread historical trauma. Indigenous Project LAUNCH aims to address these challenges by focusing specifically on AI/AN communities and the Indigenous populations of U.S. Territories and Pacific Jurisdictions.

Overall leadership and fiscal and operational oversight for Indigenous Project LAUNCH cooperative agreements must be within the lead health or public health organization or department for the tribe, Pacific Jurisdiction, or territory (e.g. Title V program or Tribal Health Department). All activities of the grant should be overseen and directed by the lead agency in collaboration and partnership with the lead children’s mental health department, office, or program. The purpose of this collaboration is to promote

integrated care for children, families, and communities that strengthen all aspects of development and wellbeing in a holistic manner.

Applicants must identify a geographic catchment area to serve as the pilot community for direct service implementation. Since the goal of Indigenous Project LAUNCH is to improve the health and wellbeing of a total population of young children and their families, it is important to clearly identify and limit the size and scope of the pilot community. The pilot community should: be definable by clear geographic boundaries; have available services with a set of entities that represent child and family serving systems; be suitable for the implementation of Indigenous Project LAUNCH activities; and not be so large in terms of population or geography that the project cannot make a significant impact within the pilot community. Barriers such as remoteness, or limited transportation should be considered when selecting the pilot community. Examples of pilot communities include, but are not limited to:

- For AI/AN applicants: a specific tribal area or jurisdiction, an entire tribal reservation, one or a cluster of Alaskan Village(s), one or several villages or towns contained within an area under tribal jurisdiction, a specific school district that serves a predominantly tribal population of children.

- For U.S. Territories and Pacific Jurisdictions: towns or villages, school districts, one or several municipalities, one or a cluster of islands, a service delivery hub such as a clinic or schools and surrounding areas defined by zip codes.

All activities should share a common goal of promoting the wellness of young children and their families and actively engage a wide range of community members in all aspects of the grant, including the evaluation. Community members must include, but are not limited to: caregivers and parents of children ages birth to eight, tribal/territorial and community leaders, elders, and cultural and/or spiritual advisors.

While Indigenous Project LAUNCH aims to serve families with young children from birth through age eight, services may also be provided to pregnant women and their families if these efforts are in the service of ensuring the health or wellbeing of the child and family.

Applicants should use strategies that have shown to be effective and promising in native and indigenous communities for both infrastructure development and direct service activities. Practice-based approaches and evidence-informed practices that align with the cultural practices and worldview of the community being served should be considered as well.

The key staff for this program will be the Young Child Wellness Expert/Project Director, Young Child Wellness Partner, Community Coordinator, and Evaluator.

2.1 Infrastructure Development and Direct Service Delivery Activities

This program combines infrastructure development and direct services (wellness promotion and prevention of mental, emotional, and behavioral disorders). Program activities are required to happen in two domains:

- Community-wide infrastructure development efforts aimed at creating an integrated system for promoting the wellness of young children. Such activities may include but are not limited to: capacity building, including workforce development; systems integration efforts, including development of shared data systems, protocols and policies that improve coordination of care; public education and awareness efforts; and community strengthening activities. These efforts should involve the lead agency/department who is the recipient of the grant and focus on systems improvements that would affect the entire tribe, territory, or jurisdiction (beyond the service-focused activities that happen within the pilot community).

- Direct service activities will entail wellness promotion and prevention activities that support children and families in the proposed pilot community, as well as other caregivers and providers working with young children and families.

For AI/AN applicant's, the required infrastructure development activities **must** be led through the collaboration between a Health department/organization/entity and a Children's Mental Health or Behavioral Health department/organization/entity that operates under the authority of a tribal government and do not represent city, county, or state run agencies.

For applicants in the U.S. Territories and Pacific Jurisdictions, the infrastructure development activities must be co-led by the Title V/Public Health entity and the lead Children's Mental Health entity at the government level.

Infrastructure development and service-focused activities share a common goal of promoting the wellness of young children and their families following a culturally-responsive, public health approach.

2.2 Infrastructure and System Development Required Activities

Year One

The first 12 months should be dedicated to start-up and planning activities that will prepare the applicant for implementation of systems and direct service activities. The required activities to take place within this time period include the following:

- Fill the following key positions that are required for the successful implementation and oversight of the grant:

- Young Child Wellness Expert/Project Director (YCWE/PD), 1.0 FTE- this position should be housed within the lead department/organization (e.g. the Title V program for territories and jurisdictions, and the Tribal Health Department for tribes) that will have fiscal and operational oversight of the grant. The YCWE/PD should possess knowledge and expertise in early childhood and mental health, and possess a solid understanding of the cultural and traditional values of the community where the activities will be implemented.

- Young Child Wellness Partner (YCWP), 0.5 FTE- this position should be housed in the lead children's mental health department or agency. The YCWP works in collaboration to co-lead the activities of the grant with the YCWE from the Title V or Tribal Health department/organization. The expertise of this position should complement the expertise of the YCWE/PD; one should have expertise in public health or maternal and child health, the other should have expertise in behavioral health. Ideally both will have expertise in early childhood and early childhood systems. The aim of the YCWP position is to increase collaboration between health and mental health programs/departments and reduce leadership and policymaking siloes.

- Community Coordinator, (recommended at 0.5 FTE) - this position will be responsible for providing direct outreach to the pilot community, families involved in the program, providers involved in direct services, as well as community leaders, and advocates. The Community Coordinator should have strong ties to the pilot community, be able to establish positive relationships, and engage community members. The candidate for this position should have experience, either voluntary or by employment, in community outreach, organizing, and preferably some experience working with early childhood-serving settings or systems. This position will work closely with the YCWE/PD and YCWP and will be part of the core team.

  Note: The Community Coordinator should, shortly after being hired, designate a Parent Partner who will serve as a consultant to the core team. The Parent Partner should be recruited early on and be involved in the planning activities of the grant. The level of effort and the amount of consultation provided by the Parent Partner should be established and included in the budget as a recurring expense to be sustained throughout the duration of the program. The recruitment of a Parent Partner aims to provide opportunity for community members to inform the work of the project, assist with conducting outreach and engagement efforts with families, and share their voice, as well as access to leadership and capacity building opportunities.

- Lead Evaluator - This position provides leadership for the required evaluation components of the program. The lead evaluator should

possess experience in participatory research methods and experience in working with AI/AN communities or with Indigenous populations of Territories and Pacific Jurisdictions. The lead evaluator should be well versed in implementation and outcome-focused evaluation.

Note: SAMHSA Project Officer approval is required for the key personnel positions (YCWE/PD, YCWP, Community Coordinator, and Lead Evaluator) prior to hiring. Grantees should not make offers to hire until written Project Officer approval for a candidate has been received.

- To ensure that cultural practices are incorporated into the infrastructure development and direct service activities, a formalized partnership with any existing cultural or language department or other comparable entity should be developed. This could include recruiting/hiring a cultural advisor(s), developing a cultural advisory committee, or establishing an agreement with an existing culture/language program.

- Within the first five months a planning and oversight Young Child Wellness (YCW) Advisory Group should be operationalized. The purpose of the YCW Advisory Group is to:

    - Bring together child and family-serving organizations to develop a shared vision and strategic plan for promoting the healthy development and wellness of young children.

    - Initiate or join efforts to increase public awareness and knowledge of young child wellness, particularly among parents and caregivers, and providers serving young children.

    - Integrate services and programs in order to ensure that resources are shared and used efficiently.

    - Increase communication and collaboration across programs and departments to break down silos and improve supports for young children and families.

    - Provide guidance and expertise to ensure successful planning, implementation and sustainability of the program.

    - Provide culturally-informed guidance ensuring program activities build upon the traditions, strengths, and cultural practices of the population as a means to promote child, family, and community wellness.

    - Propose and initiate changes in policies (such as data sharing strategies, leveraging funding opportunities, and improvements in service delivery);

    - Work toward the sustainability and scalability of program activities.

- The YCW Advisory Group must include the following representation:

    - Health and/or Maternal Child Health - this includes Tribal Health services as well as private and community nursing services or clinics; dispensaries; immunization clinics that serve a large number of families with young children; primary care; and prenatal care/midwifery services, if available;

    - Mental Health programs, organizations, or departments;

    - Substance misuse/behavioral health prevention and treatment services, especially if supports exist for addressing substance use in pregnant and postpartum women and substance exposed infants;

    - Child Welfare or Social Service Departments;

    - Early Care and Education (e.g., Head Start and Child Care) ;

    - Home Visiting (when applicable);

    - Elementary education- both representation from public county schools and Tribal schools (when relevant) is encouraged;

    - Cultural or Language Department /Office (when applicable);

    - Community leaders, cultural advisors, and elders should be active participants in the group;

    - Community members and parents/caregivers of children birth through age eight must constitute 25-50 percent of the YCW Advisory Group; and

    - Representation from the Tribal Council or Territorial Governing body is strongly encouraged. This will ensure program activities are aligned with overall tribal/territorial goals and values, are supported throughout the program and sustained once funding has ended.

- In addition to the above representation, applicants may include leadership from other organizations, such as representatives from the justice system, United Way (when applicable), law enforcement, and local non-profit or community organizations who primarily serve the population of focus.

  Note: The structure of the YCW Advisory Group may vary and have several tiers or workgroups that focus on specific goals and objectives of the program. Furthermore, the YCW Advisory Group can be integrated into an existing Body or Council that focuses on early childhood development and wellness. Community member/parent participation should be sought from the initial formation of the YCW Advisory Group.

- Within the first eight months of the program a community needs and readiness assessment should be conducted. The purpose of this planning activity is to map out the systems and programs (including federal and private grants) that serve children from birth to eight years of age and their families, identify unmet needs, and assess readiness for the implementation of the proposed program activities. Existing community readiness and capacity assessments should be utilized and information pertaining to young children and their families is being collected as part of this process. Culturally-informed and appropriate approaches to community needs and capacity assessments should be considered. Guidance and technical assistance will be provided. The community needs and readiness assessment must be submitted to the Government Project Officer (GPO) for review and approval.

- By the end of year one, a Strategic/Implementation Plan should be developed that incorporates what was learned from the community needs and readiness assessment, and maps out the goals, objectives, activities and implementation plans for the remainder of the project period. This should include infrastructure development and direct services (prevention and promotion) activities. The Strategic/Implementation Plan should be developed by the YCW Advisory Group and should be revised annually. Guidance and technical assistance will be provided. The Strategic/Implementation Plan must be submitted to the GPO for review and approval.

- A community-based process to engage community members, parents, stakeholders, partners, elders, cultural and spiritual advisors, and tribal leaders should be used throughout the entire program.

- Evaluation activities must be initiated within the first year of the grant. This includes the hiring of the Lead Evaluator; the development of an evaluation plan; and participation in cross-site evaluation-related activities (for example, participating in the creation of a cross-site evaluation and building tribal or territorial evaluation capacity and infrastructure, as needed). Guidance and technical assistance for the development of the Evaluation Plan will be provided.

Years two through five:

The infrastructure and direct service activities that were developed in year one are implemented. Grantees will be required to:

- Maintain the YCW Advisory Group;

- Continue to solicit input from the Parent Partner to inform the activities of the grant;

- Continue to develop cross-departmental, cross-organizational, and cross-program partnerships and create new pathways to more efficient and integrated child and family serving systems.

- Carry out required evaluation activities outlined in Sections 2.5 and 2.6.

The infrastructure development activities to be established and continued throughout the program are comprised of several cross cutting elements:

1. Public education and awareness campaign: A community based public education and awareness campaign to increase focus on early childhood wellness and early childhood social and emotional development. The campaign should be developed early in year two and maintained/expanded throughout the program.

2. Capacity building and workforce development: Provide capacity building and workforce development opportunities to strengthen the early childhood workforce (such as educators, head start staff and directors, WIC staff, community nurses, case managers/family navigators and home visitors, as well as informal caregivers and natural helpers who touch the lives of young children. Develop a plan for capacity building and leadership training opportunities for the Community Coordinator, YCWE/PD, YCWP, as well as the Parent Partner(s). These opportunities should be built into the program activities and happen in conjunction with broader workforce development activities. Grantees are encouraged to partner with tribal colleges (when available and possible), or other entities familiar with the culture and needs of the communities being served to provide professional development and capacity building. Leadership training should be included and opportunities for reflective supervision provided, when possible. For the Pacific Jurisdictions and Territorial grantees, culturally informed and geographically focused entities should be sought out to provide support with professional and workforce development. For example institutes or academic institutions that work primarily with Pacific Jurisdictions and located in close proximity to the pilot community should be engaged.

3. Systems Integration: Focus on increasing communication, collaboration, and resource sharing between child and family-serving systems and organizations/programs. This may include the development of comprehensive, up-to-date information and referral systems or the establishment of cross-program processes for sharing appropriate client data.

4. Community Strengthening: Provide culturally-focused community-wide supports that reach beyond the individual work with young children and their caregivers and beyond the formal capacity building for the workforce and providers of services. Activities that involve the sharing and teaching of traditions, culture, language, and history – particularly the sharing of elders and caregivers with young children to promote the development of positive identity may be a part of

this element. Examples of culturally-focused efforts that improve policies and procedures may include: cultural strengths assessments as part of intake or screening protocols, policies that encourage or require cultural consultation as part of referrals, programs that formalize or increase access to traditional healing across departments, policies that codify the role of a cultural advisory group, or cultural advisors in program and policy level decision making. Community strengthening activities may also address social determinants of health and include supports to families to address such risk factors as food insecurity, lack or resources, and poor access to health and mental health services due to geographic limitations.

2.3 Required Activities for Direct Services

Implementation of culturally-grounded, trauma informed, practice-informed, and, when appropriate, evidence informed programs and practices to support young child wellness should begin at the start of year two. The programs/practices to be implemented should enhance, improve and/or build upon existing services, or address gaps in services for young children and their families.

The public health approach embraced by Indigenous Project LAUNCH means that the population of focus includes all children from birth to age eight in the community. Please note that Indigenous Project LAUNCH funds should be spent primarily on promotion and prevention activities, *not* treatment for diagnosed behavioral health problems. Rather than providing mental health treatment, Indigenous Project LAUNCH activities should be focused on early identification of developmental or behavioral issues, capacity-building among caregivers to promote healthy social and emotional development and address challenging behaviors, and successful referrals for in-depth assessment and/or treatment to support young children and their families when needed.

Applicants should plan on a gradual, tiered roll-out of their implementation. At least two of the Core Strategies listed below should be selected based on community and system readiness and capacity to be implemented in year two. The remaining core strategies are to be implemented in years three through five of the program. This phased implementation strategy should be reflected in the Strategic Plan.

Applicants must implement practices in the following areas (also referred to as the Project LAUNCH Core Strategies):

Screening and assessment in a range of child-serving settings: The goal of this strategy is to increase the use of standardized screening instruments (with a particular emphasis on social and emotional functioning) to ensure that developmental issues or concerns are identified and addressed early. Screenings may be implemented in child and pediatric care settings and/or home visiting programs. Activities that support workforce development and training around screening or reduction of duplicative screens should also be included and considered. Trauma and adverse childhood experiences screening can also be included. Although there is an emphasis on

developmental screenings, screening for other behavioral health issues is also encouraged as relevant (e.g. maternal depression, anxiety, and substance use screening). When selecting screening instruments, the cultural applicability of these instruments, as well as any necessary adaptation or modifications that need to be done to better screen the population receiving services should be considered. Grantees are encouraged to select screening instruments that have sound validity and reliability; however, if none are available, grantees also have the ability to develop culturally relevant screening tools to better screen the population receiving services.

Integration of behavioral health into primary care settings: The goal of this strategy is to increase the likelihood that issues related to young child wellness (particularly social and emotional issues) can be identified and appropriately addressed within "primary care" settings. The primary care settings may include, but are not limited to, pediatric care, OBGYN/midwifery care, community nursing services, immunization community clinics, Tribal Health Services, and delivery hospitals. This goal can be achieved through increasing knowledge, changing practices, and integrating mental health and family support professionals into the primary care setting, as well as improving linkages and ongoing communication between primary care and other providers within the community. Communication and partnership between traditional medicine and healers, whenever culturally acceptable and appropriate, and formal primary care could be a part of this strategy.

Infant and Early Childhood Mental Health Consultation (IECMHC) in Early Care and Education Settings: The goal of this strategy is to ensure that child care and educational settings provide optimal learning environments for young children that lead to positive development, with a particular focus on social and emotional development. Mental health consultation can be at the program or classroom level to enhance teacher knowledge and strategies for promoting wellness and managing behavior, or at the individual child and family level in order to facilitate appropriate assessment, intervention, and/or referral for behavioral health concerns. Mental Health Consultation can also be embedded into Home Visiting services, when they are available in a community (see below). For additional guidance on IECMHC definition, models and approaches, please see http://www.samhsa.gov/iecmhc. Grantees have the option to implement consultation within their own cultural frameworks and use the language and terminology that best fits their community's needs.

Enhanced home visiting through increased focus on social and emotional well-being: The goal of this strategy is to expand and enhance existing home visiting programs, with particular attention on increasing the focus of promoting healthy social and emotional development and behavioral health among children and families participating in home visiting programs. Home visiting services that are funded through other federal initiatives should not be duplicated. However, home visiting services can be expanded or enhanced for the quality of care provided in existing programs through training, mental health consultation, and improved coordination. If home visiting services are not available, grantees may choose to establish a home visiting program with Indigenous Project LAUNCH funding.

Family strengthening and parent skills training: The goal of this strategy is to help improve outcomes for young children by helping their parents to provide healthy, safe and secure family environments in which to learn and grow. Family strengthening activities can range from broad-based parent education (e.g. workshops for parents) to more targeted and ongoing efforts such as parent support groups, preventive interventions, peer-to-peer support, and parent leadership training. Culturally focused and traditional parenting supports should be a central component of family strengthening activities.

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. (See PART II: Appendix E, Addressing Behavioral Health Disparities.**)**

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 not covered by 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 Health 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 utilized 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 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 of recovery 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.]

SAMHSA encourages all grantees to address the behavioral health needs of returning veterans and their families in designing and developing their programs and to consider prioritizing this population for services, where appropriate. SAMHSA will encourage its grantees to utilize and provide technical assistance regarding locally-customized web portals that assist veterans and their families with finding behavioral health treatment and support.

2.4 Using Evidence-Based Practices (EBPs)

SAMHSA recognizes that EBPs have not been developed for all populations and/or service settings. For example, certain interventions for AI/AN, rural or isolated communities, or recent immigrant communities may not have been formally evaluated and have a limited or nonexistent evidence base. In addition, other interventions that have an established evidence base for certain populations or in certain settings may not have been formally evaluated with other subpopulations or within other settings. Applicants proposing to serve a population with an intervention that has not been formally evaluated with that population are required to provide other forms of evidence that the practice(s) they propose is appropriate for the population 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 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.

In selecting an EBP, be mindful of how your choice of an EBP or practice may impact disparities in service access, use, and outcomes for your population(s) of focus. While this is important in providing services to all populations, it is especially critical for those working with underserved and minority populations.

[Note: See Appendix A - Using Evidence-Based Practices (EBPs) and PART II: Appendix C - Standard Funding Restrictions, regarding allowable costs for EBPs.]

2.5 Data Collection and Performance Measurement

All SAMHSA grantees are required to collect and report certain data so that SAMHSA can meet its obligations under the Government Performance and Results (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:

- Number of people in the mental health and related workforce trained in specific mental health-related practices/activities specified within the grant.
- Number of organizations collaborating/coordinating/sharing resources with other targeted organizations (e.g. child-serving agencies and organizations).
- Number and percentage of work group/advisory group/council members who are consumers/family members.
- Number of people receiving evidence-based mental health-related services as a result of the grant.
- Number of individuals screened for mental health or related intervention.
- Number of individuals referred to mental health or related services.

This information will be gathered using a uniform data collection tool provided by SAMHSA. Grantees will be required to submit data via SAMHSA's data-entry and reporting system; access will be provided upon award. An example of the type of data collection tool required can be found at https://cmhs-gpra.samhsa.gov. Data will be collected quarterly after entry of annual goals. Technical assistance for the web-based data entry, fiscal and annual report generation is available.

The collection of these data will enable SAMHSA to report on key outcome measures relating to the grant program. 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. Performance data will be reported to the public as part of SAMHSA's Congressional Justification.

2.6 Grantee-specific Evaluation

Grantees are also required to design a grantee-specific evaluation that will help determine whether you are achieving the goals, objectives, and outcomes you intend to achieve and whether adjustments need to be made to your project. The grantee-specific evaluation should also be used to determine whether the project is having/will have the intended impact on behavioral health disparities. Grantees will be required to report on progress achieved, barriers encountered, and efforts to overcome these barriers in an evaluation report to be submitted annually. The annual evaluation report is separate from the semi-annual progress reports and will be reviewed by the GPO with feedback to the grantee.

Indigenous peoples historically have used traditional knowledge gained through collecting many forms of data to create a perspective of the world (Barnhardt &

Kawagley, 2005). Traditional knowledge is shared through the passing on of oral histories, stories, observations, artwork, and languages (Lambert, 2014)[1]. A key element of the Project LAUNCH evaluation is to ensure that indigenous knowledge guides the collection of data from families and systems within the community, and that data is used to inform the community about the things it values and prioritizes.

Grantees are encouraged to use a participatory approach in their grantee-specific evaluation that incorporates indigenous knowledge and processes. As part of the grantee-specific evaluation, grantees should consider the following process and outcome questions:

Process

Who provided (program staff) what services (modality, type, intensity, duration), to whom (individual characteristics), and in what context (family, system, community)?

Outcome

To what extent did services and prevention practices improve child, family, provider, and community outcomes?

At a minimum, grantees must include the following in their grantee-specific evaluations:

- Parent and child data (e.g. demographic information; changes in parent/child attachment and interactions; caregiver knowledge of child development; family functioning; parenting practices; social connectedness; child functioning; and/or school readiness/academic performance);

- Provider data (e.g. changes in knowledge, attitude and/or behavior); and

- Community partners and Advisory Council members' data (e.g. perceptions of partner contributions, partnership functioning, partner roles, frequency of partner interactions, information sharing).

Grantees will be provided technical assistance to help with the design of their grantee-specific evaluations.

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[1] References: Barnhardt, R., & Kawagley, A. O. (2005). Indigenous knowledge systems and Alaska Native ways of knowing. *Anthropology and Education Quarterly*, *36*(1), 8–23; Lambert, L. (2014). *Research for indigenous survival: Indigenous research methodologies in the behavioral sciences.* Pablo, MT: Salish Kootenai College Press.

Cross-site Evaluation

Grantees will be required to participate in a cross-site evaluation that will be conducted under a SAMHSA contract. The cross-site evaluation will be designed collaboratively with grantee input. Grantees will also be required to conduct a grantee-specific evaluation as described in Section 2.6 above.

No less than 15 percent or no more than 20 percent of the total grant award may be used for data collection, performance measurement, and performance assessment (grantee-specific evaluation), e.g., activities required in Sections I-2.5 and 2.6 above.

2.7 Grantee Meetings

Grantees must plan to send a minimum of four people (including the YCWE/PD, YCWP, Community Coordinator, and Lead Evaluator) to at least one joint grantee meeting in every other year of the grant. For this grant cohort, grantee meetings will likely be held in years one, three and five of the grant. 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 will be up to three days. These meetings are usually held in the Washington, D.C., area and attendance is mandatory.

II. AWARD INFORMATION

Funding Mechanism: Cooperative Agreement

Anticipated Total Available Funding: $7,600,000

Estimated Number of Awards: Up to 13

Estimated Award Amount: Up to $550,000

Length of Project Period: Up to five years

Proposed budgets cannot exceed $550,000 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.

Funding estimates for this announcement are based on an annualized Continuing Resolution and do not reflect the final FY 2017 appropriation. Applicants should be aware that funding amounts are subject to the availability of funds.

Cooperative Agreement

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

Role of Grantee:

- Comply with the terms of the Cooperative Agreement, including implementation activities described in the approved grant proposal and fulfillment of requirements described in this FOA.
- Agree to provide SAMHSA with all required performance data.
- Collaborate with SAMHSA/CMHS staff in all aspects of the grant program.
- Submit all required forms, data, and reports in a timely fashion.
- Participate in grantee meetings.
- Participate in cross-site evaluation.
- Collaborate with the technical assistance providers (programmatic and evaluation) and other federally-funded resources.

Role of SAMHSA Staff:

- Assume overall responsibility for monitoring the conduct and progress of the Indigenous Project LAUNCH grantee.
- Facilitate linkages to other SAMHSA/federal government resources and help grantees access appropriate technical assistance.
- Monitor the completion of all required deliverables, planning, implementation and sustainability activities and provide technical assistance as needed.
- Ensure compliance with GPRA data requirements.
- Partner and collaborate with, at a minimum, the Health Resources and Services Administration (HRSA) the Administration for Children and Families (ACF), and the Centers for Disease Control and Prevention (CDC) on grant program activities.
- Approve key personnel responsible for the management, leadership, oversight, and evaluation.
- Review and approve the Needs and Capacity Assessment, Strategic/Implementation Plan, and Evaluation Plan.

III. ELIGIBILITY INFORMATION

1. ELIGIBLE APPLICANTS

Eligible applicants are:

- Federally recognized American Indian/Alaska Native (AI/AN) tribes, tribal organizations, and consortia of tribes or tribal organizations; and

- U.S. Territories and U.S. Pacific Jurisdictions

Tribal organization means the recognized body of any AI/AN tribe; any legally established organization of AI/ANs 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 AI/ANs in all phases of its activities. Consortia of tribes or tribal organizations are eligible to apply, but each participating entity must indicate its approval. A single tribe in the consortium must be the legal applicant, the recipient of the award, and the entity legally responsible for satisfying the grant requirements.

The purpose of this program is to promote the wellness of young children from birth to eight years within tribal, territorial and Pacific Islander jurisdictions by addressing the physical, social, emotional, cognitive, and behavioral aspects of their development. Therefore, SAMHSA is limiting eligibility to federally recognized American Indian/Alaskan Native tribes or tribal organizations, consortia of tribes or tribal organizations, and U.S. Territories and Pacific Jurisdictions.

NOTE: Previous and current grantees that received funding under the Cooperative Agreements for Linking Actions for Unmet Needs in Children's Health (Project LAUNCH) FOA# SM-14-004; SM-12-009; SM-10-012; SM-09-009; SM-08-011 and the Cooperative Agreements for Project LAUNCH State/Tribal Expansion (Project LAUNCH Expansion Grants) SM-15-006 are not eligible to apply.

2. COST SHARING and MATCH REQUIREMENTS

Cost sharing/match is not required in this program.

IV. APPLICATION AND SUBMISSION INFORMATION

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

1. ADDITIONAL REQUIRED APPLICATION COMPONENTS

- **Budget Information Form** – Use SF-424A. Fill out Sections B, C, and E of the SF-424A. A sample budget and justification is included in Appendix D of

this document**. It is highly recommended that you use the sample budget format in Appendix D. This will expedite review of your application.**

- **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 section provides additional information necessary for the review of your application. This supporting documentation must be attached to your application using the Other Attachments Form from the Grants.gov application package. Additional instructions for completing these sections and page limitations for Biographical Sketches/Position Descriptions are included in PART II: Section II-3.1, Required Application Components, and Appendix D, Biographical Sketches and Position Descriptions. Supporting documentation should be submitted in black and white (no color).

- **Budget Justification and Narrative** – The budget justification and narrative must be submitted as file BNF when you submit your application into Grants.gov. (See PART II: SectionII-3.1, Required Application Components.)

- **Attachments 1 through 6** – 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. Use the Other Attachments Form from Grants.gov to upload the attachments.

  - **Attachment 1**: (1) Letters of Commitment for 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 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**: Letter to the SSA (if applicable; see PART II: Appendix B, Intergovernmental Review (E.O. 12372) Requirements).

- **Attachment 5**: Memorandum of Agreement between the lead health or public health organization or department for the tribe, Pacific Jurisdiction, or territory (Title V Program or Tribal Health Department) and lead children's mental health department/office/program.

- **Attachment 6**: Letters of commitment from a representative of Tribal government or comparable leadership position in the U.S. Territories and Pacific Jurisdictions and required members of the Young Child Wellness Advisory Group; this includes representation from the following sectors: health; mental health; behavioral health; child welfare or social services; early care and education; home visiting (if applicable); elementary education; and cultural or language department (if applicable).

2. APPLICATION SUBMISSION REQUIREMENTS

Applications are due by **11:59 PM** (Eastern Time) on **March 1, 2017**.

IMPORTANT: Due to SAMHSA's transition to NIH's eRA grants system, SAMHSA has made changes to the application registration, submission, and formatting requirements.

Please be sure to read PART II of this FOA very carefully to understand the requirements for SAMHSA's new grant system. Applicants will need to register with NIH'S eRA Commons in order to submit an application. Applicants also must register with the System for Award Management (SAM) and Grants.gov (see PART II: Section I-1 and Section II-1 for all registration requirements).

Due to the new registration and application requirements, it is strongly recommended that applicants start the registration process **six (6) weeks in advance of the application due date.**

3. FUNDING LIMITATIONS/RESTRICTIONS

- No less than 15 percent or no more than 20 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 C, Standard Funding Restrictions.

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

All SAMHSA grant programs are covered under Executive Order (EO) 12372, as implemented through Department of Health and Human Services (DHHS) regulation at 45 CFR Part 100. Under this Order, states may design their own processes for reviewing and commenting on proposed federal assistance under covered programs. See PART II: Appendix B for additional information on these requirements as well as requirements for the Public Health System Impact Statement.

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, i.e., type "A-1", "A-2", etc., before your response to each question.** You may not combine two or more questions or refer to another section of the Project Narrative in your response, such as indicating that the response for B.2 is in C.7. **Only information included in the appropriate numbered question will be considered by reviewers.** Your application will be scored according to how well you address the requirements for each section of the Project Narrative.

- The number of points after each heading is the maximum number of points a review committee may assign to that section of your Project Narrative. 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. Identify the proposed pilot community to be served and justify the selection of the pilot community. Provide a comprehensive demographic profile of your population of focus. Describe challenges the population faces, including service

gaps and document the extent of the need (i.e., current prevalence rates or incident data.) If appropriate, include contextual historical and cultural information regarding the community or communities who will be receiving services and involved in the program. Identify the source of data provided.

2. Describe how you will address barriers to access such as geographic remoteness and transportation.

3. Discuss disparities that exist in access to, use of, and outcomes of services within the population of focus, especially those related to early childhood, maternal health, and caregiver mental health.

4. Discuss the prevalence of mental disorders of children from birth to age eight in the pilot community.

Section B: Proposed Implementation Approach (30 points)

1. Describe your approach for infrastructure development for the following elements: community strengthening, workforce development, systems integration (e.g. efforts to increase data and resource sharing), and public education/awareness activities.

2. Provide a chart or graph depicting a realistic timeline for the entire project period showing dates, key activities, and responsible staff. Note: The timeline should be part of the Project Narrative, and should not be placed in an attachment. The timeline should have the most detail in the first year.

3. Describe the evidence-based and culturally-informed practices that will be used for each of the five Project LAUNCH Core Strategy areas and justify their use for your population of focus. The practices you select should promote wellness and prevent behavioral health challenges. Note: It is understood that the strategies implemented may change or be refined based on the assessment and strategic planning conducted during the first year of the grant. Please include proposed practices based on current knowledge of needs and resources with this understanding in mind.

4. Describe how you will ensure the meaningful participation of families in your project. This includes both your strategies for engaging community members in planning, implementing, and evaluating your project, as well as your strategies for engaging families in services, particularly families that traditionally do not access services.

5. State the unduplicated number of individuals you propose to serve (annually and over the entire project period) with grant funds. Provide a logic model that

demonstrates the linkage between resources, proposed approach (including infrastructure activities and proposed services) and desired outcomes.

Section C: Proposed Collaboration/Partnership Approach (25 points)

1. Describe the goals of the project and discuss how these goals align with the priorities of the tribal government or Territorial governing body. Applicants should provide letters of commitment from a representative of the Tribal government or comparable leadership position in the U.S. Territories and Pacific Jurisdictions in **Attachment 6** demonstrating support for the activities proposed in the application.

2. Describe the partnership between the YCWE/PD and the YCW Partner. Include the frequency and strategies for communication, collaboration, and joint leadership. Include a Memorandum of Agreement between the two lead departments/organizations/programs (Tribal Health/Title V and the entity primarily responsible for children's mental health) in **Attachment 5** of your application, clearly delineating how these agencies will divide responsibilities and share leadership on the grant.

3. Demonstrate the commitment of the required members of the YCW Advisory Group; include letters of commitment with required partners in **Attachment 6** of your application.

4. Describe your approach to engaging cultural leaders/advisors and elders and the roles you envision for these individuals. Specific examples of cultural components and traditional practices that will be embedded into your services should be provided, when possible.

5. Describe your approach for coordination with substance use prevention and treatment efforts that are available in your community, with special emphasis on services targeting drug-exposed infants, families with children with fetal alcohol spectrum disorders, and/or pregnant or postpartum women with substance misuse issues.

Section D: Staff and Organizational Experience (10 points)

1. Provide a complete list of staff positions for the project, including key personnel, showing the role of each and their level of effort and qualifications. (Key personnel for this grant include: Young Child Wellness Expert/Project Director, YCW Partner, Community Coordinator, and Evaluator).

2. Describe the applicant organization’s expertise in the prevention of mental, emotional, and behavioral disorders among young children and the promotion of young child wellness and healthy development. Discuss the organization’s

experience, management capabilities, and capacity to provide culturally-appropriate/competent services to the community and specific populations of focus.

3. Describe the resources available for the proposed project (IT systems, financial management systems), as well as your approach towards capacity building and leadership/professional development of the key staff (excluding the evaluator). Provide information regarding easily accessible resources that are available to the organization that could be used to increase knowledge of early childhood development, mental health, data collection, and fiscal management (e.g. tribal college departments, other academic entities who partner with the community, centers of excellence or other organizations).

Section E: Data Collection, Performance Assessment and Evaluation (20 points)

1. Document your ability to collect and report on the required performance measures as specified in Section I-2.5 of this FOA.

2. Describe your plan for conducting the grantee-specific evaluation, including activities related to the process and outcome evaluation components of your grantee-specific evaluation. Describe your specific plan for:

   - data collection,
   - management,
   - analysis, and
   - reporting.

3. Demonstrate the capability of the evaluator and his/her organization to conduct a comprehensive and participatory evaluation of an initiative of this scope, including both process and outcomes components.

4. Describe how the grantee-specific evaluation will be used to assess the quality of interventions being implemented and how any necessary changes to these interventions will be made based on the findings.

Budget Justification, Existing Resources, Other Support (other federal and non-federal sources)

You must provide a narrative justification of the items included in your proposed budget, as well as a description of existing resources and other support you expect to receive for the proposed project. Other support is defined as funds or resources, whether federal, non-federal or institutional, in direct support of activities through fellowships, gifts, prizes, in-kind contributions, or non-federal means. (This should correspond to

Item #18 on your SF-424, Estimated Funding.) Other sources of funds may be used for unallowable costs, e.g., meals, sporting events, entertainment.

An illustration of a budget and narrative justification is included in Appendix C - Sample Budget and Justification, of this document. **It is highly recommended that you use the Sample Budget format in Appendix C. This will expedite review of your application.**

Be sure your proposed budget reflects the funding limitations/restrictions specified in Section IV-3. **Specifically identify the items associated with these costs in your budget**.

The budget justification and narrative must be submitted as file BNF when you submit your application into Grants.gov. (See PART II: Section II-3.1, Required Application Components.)

REQUIRED SUPPORTING DOCUMENTATION

Section F: Biographical Sketches and Position Descriptions.

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

Section G: 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 G of your application. **Failure to include these procedures will impact the review of your application.** See Appendix B of this document for guidelines on these requirements.

2. REVIEW AND SELECTION PROCESS

SAMHSA applications are peer-reviewed according to the evaluation criteria listed above.

Decisions to fund a grant are based on:

- the strengths and weaknesses of the application as identified by peer reviewers;
- when the individual award is over $150,000, approval by the Center for Mental Health Services National Advisory Council;
- availability of funds;
- equitable distribution of awards in terms of geography (including urban, rural and remote settings) and balance among populations of focus and program size; and

- In accordance with 45 CFR 75.212, SAMHSA reserves the right not to make an award to an entity if that entity does not meet the minimum qualification standards as described in section 75.205(a)(2). If SAMHSA chooses not to award a fundable application, SAMHSA must report that determination to the designated integrity and performance system accessible through the System for Award Management (SAM) [currently the Federal Awardee Performance and Integrity Information System (FAPIIS)].

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/grants-management/reporting-requirements. Grantees will be expected to submit progress reports semi-annually and an evaluation report annually.

VII. AGENCY CONTACTS

For questions about program issues contact:

Jennifer A. Oppenheim, PsyD
Senior Advisor on Early Childhood
Lead, Project LAUNCH
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, 14E77D
Rockville, MD 20857
240-276-1862
IndigenousLAUNCH@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
(240) 276-1408
FOACMHS@samhsa.hhs.gov

Appendix A – 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 EBP(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 EBP over other evidence-based practices.

- If applicable, justify the use of multiple EBPs. Discuss how the use of multiple EBPs 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 (EBPs):

You will find information on EBPs 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 EBPs 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 C – Standard Funding Restrictions, regarding allowable costs for EBPs.]

Appendix B – 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, 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 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 obtain consent for youth, the elderly, people with limited reading skills, and people who do not use English as their first language.

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

- Indicate if you will obtain informed consent from participants or assent from minors along with consent from their parents or legal guardians. Describe how the consent will be documented. For example: Will you read the consent forms? Will you ask prospective participants questions to be sure they understand the forms? Will you give them copies of what they sign?

- Include, as appropriate, sample consent forms that provide for: (1) informed consent for participation in service intervention; (2) informed consent for participation in the data collection component of the project; and (3) informed consent for the exchange (releasing or requesting) of confidential information. The sample forms must be included in **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.

Appendix C – Sample Budget and Justification (no match required)

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

A. Personnel: Provide employee(s) (including names for each identified position) of the applicant/recipient organization, including in-kind costs for those positions whose work is tied to the grant project.

FEDERAL REQUEST

Position	Name	Annual Salary/Rate	Level of Effort	Cost
(1) Project Director	John Doe	$64,890	10%	$6,489
(2) Grant Coordinator	To be selected	$46,276	100%	$46,276
(3) Clinical Director	Jane Doe	In-kind cost	20%	0
			TOTAL	**$52,765**

JUSTIFICATION: Describe the role and responsibilities of each position.

(1) The Project Director will provide daily oversight of the grant and will be considered key staff.

(2) The Coordinator will coordinate project services and project activities, including training, communication and information dissemination.

(3) The Clinical Director will provide necessary medical direction and guidance to staff for 540 clients served under this project.

Key staff positions require prior approval by SAMHSA after review of credentials of resume and job description.

FEDERAL REQUEST (enter in Section B column 1 line 6a of form S-424A) **$52,765**

B. Fringe Benefits: List all components that make up the fringe benefits rate

FEDERAL REQUEST

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

JUSTIFICATION: Fringe reflects current rate for agency.

FEDERAL REQUEST (enter in Section B column 1 line 6b of form SF-424A) $10,896

C. Travel: Explain need for all travel other than that required by this application. Applicants must use their own documented travel policies. If an organization does not have documented travel policies, the federal GSA rates must be used.

FEDERAL REQUEST

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

JUSTIFICATION: Describe the purpose of travel and how costs were determined.

(1) Two staff (Project Director and Evaluator) to attend mandatory grantee meeting in Washington, DC.

(2) Local travel is needed to attend local meetings, project activities, and training events. Local travel rate is based on organization's policies/procedures for privately owned vehicle reimbursement rate. If policy does not have a rate use GSA.

FEDERAL REQUEST (enter in Section B column 1 line 6c of form SF-424A) **$2,444**

D. Equipment: An article of tangible, nonexpendable, personal property having a useful life of more than one year and an acquisition cost of $5,000 or more per unit (federal definition). Organizations should follow their documented capitalization policy thresholds.

FEDERAL REQUEST – (enter in Section B column 1 line 6d of form SF-424A) **$ 0**

E. Supplies: Materials costing less than $5,000 per unit (federal definition) and often having one-time use

FEDERAL REQUEST

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

JUSTIFICATION: Describe the need and include an adequate justification of how each cost was estimated.

(1) Office supplies, copies and postage are needed for general operation of the project.

(2) The laptop computer and printer are needed for both project work and presentations for Project Director.

(3) The projector is needed for presentations and workshops. All costs were based on retail values at the time the application was written.

FEDERAL REQUEST – (enter in Section B column 1 line 6e of form SF-424A) **$ 3,796**

F. Contract: A contractual arrangement to carry out a portion of the programmatic effort or for the acquisition of routine goods or services under the grant. Such arrangements may be in the form of consortium agreements or contracts. A consultant is an individual retained to provide professional advice or services for a fee. The applicant/grantee must establish written procurement policies and procedures that are consistently applied. All procurement transactions shall be conducted in a manner to provide to the maximum extent practical, open and free competition.

COSTS FOR CONTRACTS MUST BE BROKEN DOWN IN DETAIL AND A NARRATIVE JUSTIFICATION PROVIDED. IF APPLICABLE, NUMBERS OF CLIENTS SHOULD BE INCLUDED IN THE COSTS.

FEDERAL REQUEST

Name	Service	Rate	Other	Cost
(1) State Department of Human Services	Training	$250/individual x 3 staff	5 days	$750
(2) Treatment Services	1040 Clients	$27/client per year		$28,080

Name	Service	Rate	Other	Cost
(3) John Smith (Case Manager)	Treatment Client Services	1FTE @ $27,000 + Fringe Benefits of $6,750 = $33,750	*****Travel at 3,124 @ .50 per mile = $1,562 *****Training course $175 *****Supplies @ $47.54 x 12 months or $570 *****Telephone @ $60 x 12 months = $720 *****Indirect costs = $9,390 (negotiated with contractor)	$46,167
(4) Jane Smith	Evaluator	$40 per hour x 225 hours	12 month period	$9,000
(5) To Be Announced	Marketing Coordinator	Annual salary of $30,000 x 10% level of effort		$3,000
			TOTAL	**$86,997**

JUSTIFICATION: Explain the need for each contractual agreement and how it relates to the overall project.

(1) Certified trainers are necessary to carry out the purpose of the statewide Consumer Network by providing recovery and wellness training, preparing consumer leaders statewide, and educating the public on mental health recovery.

(2) Treatment services for clients to be served based on organizational history of expenses.

(3) Case manager is vital to client services related to the program and outcomes.

(4) Evaluator is provided by an experienced individual (Ph.D. level) with expertise in substance abuse, research and evaluation, is knowledgeable about the population of focus, and will report GPRA data.

(5) Marketing Coordinator will develop a plan to include public education and outreach efforts to engage clients of the community about grantee activities, and provision of presentations at public meetings and community events to stakeholders, community civic organizations, churches, agencies, family groups and schools.

***Represents separate/distinct requested funds by cost category**

FEDERAL REQUEST – (enter in Section B column 1 line 6f of form SF-424A) **$86,997**

G. Construction: NOT ALLOWED – Leave Section B columns 1& 2 line 6g on SF-424A blank.

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

FEDERAL REQUEST

Item	Rate	Cost
(1) Rent*	$15/sq.ft x 700 sq. feet	$10,500
(2) Telephone	$100/mo. x 12 mo.	$1,200
(3) Client Incentives	$10/client follow up x 278 clients	$2,780
(4) Brochures	.89/brochure X 1500 brochures	$1,335
	TOTAL	**$15,815**

JUSTIFICATION: Break down costs into cost/unit (e.g. cost/square foot). Explain the use of each item requested.

(1) Office space is included in the indirect cost rate agreement; however, if other rental costs for service site(s) are necessary for the project, they may be requested as a direct charge. The rent is calculated by square footage or FTE and reflects SAMHSA's fair share of the space.

***If rent is requested (direct or indirect), provide the name of the owner(s) of the space/facility. If anyone related to the project owns the building which is less than an arms length arrangement, provide cost of ownership/use allowance calculations. Additionally, the lease and floor plan (including common areas) are required for all projects allocating rent costs.**

(2) The monthly telephone costs reflect the percent of effort for the personnel listed in this application for the SAMHSA project only.

(3) The $10 incentive is provided to encourage attendance to meet program goals for 278 client follow-ups.

(4) Brochures will be used at various community functions (health fairs and exhibits).

FEDERAL REQUEST – (enter in Section B column 1 line 6h of form SF-424A) **$15,815**

Indirect Cost Rate: Indirect costs can be claimed if your organization has a negotiated indirect cost rate agreement. It is applied only to direct costs to the agency as allowed in the agreement. For information on applying for the indirect rate go to: https://rates.psc.gov/fms/dca/map1.html. **Effective with 45 CFR 75.414(f), any non-federal entity that has never received a negotiated indirect cost rate, except for those non-federal entities described in Appendix VII part 75 (D)(1)(b), may elect to charge a de minimis rate of 10% of modified total direct costs (MTDC) which may be used indefinitely. If an organization has a federally approved rate of 10%, the approved rate would prevail.**

FEDERAL REQUEST (enter in Section B column 1 line 6j of form SF-424A)

8% of personnel and fringe **(.08 x $63,661)** **$5,093**

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TOTAL DIRECT CHARGES:

FEDERAL REQUEST – (enter in Section B column 1 line 6i of form SF-424A) $172,713

INDIRECT CHARGES:

FEDERAL REQUEST – (enter in Section B column 1 line 6j of form SF-424A) $5,093

TOTAL: (sum of 6i and 6j)

FEDERAL REQUEST – (enter in Section B column 1 line 6k of form SF-424A)
$177,806

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Provide the total proposed project period and federal funding as follows:

Proposed Project Period

a. Start Date: 09/30/2012 b. End Date: 09/29/2017

BUDGET SUMMARY (should include future years and projected total)

Category	**Year 1**	**Year 2***	**Year 3***	**Year 4***	**Year 5***	**Total Project Costs**
Personnel	$52,765	$54,348	$55,978	$57,658	$59,387	$280,136
Fringe	$10,896	$11,223	$11,559	$11,906	$12,263	$57,847
Travel	$2,444	$2,444	$2,444	$2,444	$2,444	$12,220
Equipment	0	0	0	0	0	0
Supplies	$3,796	$3,796	$3,796	$3,796	$3,796	$18,980
Contractual	$86,997	$86,997	$86,997	$86,997	$86,997	$434,985
Other	$15,815	$13,752	$11,629	$9,440	$7,187	$57,823
Total Direct Charges	$172,713	$172,560	$172,403	$172,241	$172,074	$861,991
Indirect Charges	$5,093	$5,246	$5,403	$5,565	$5,732	$27,039
Total Project Costs	**$177,806**	**$177,806**	**$177,806**	**$177,806**	**$177,806**	**$889,030**

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

FEDERAL REQUEST (enter in Section B column 1 line 6k of form SF-424A) **$889,030**

***FOR REQUESTED FUTURE YEARS:**

1. Please justify and explain any changes to the budget that differs from the reflected amounts reported in the 01 Year Budget Summary.

2. If a cost of living adjustment (COLA) is included in future years, provide your organization's personnel policy and procedures that state all employees within the organization will receive a COLA.

IN THIS SECTION, REFLECT OTHER FEDERAL AND NON-FEDERAL SOURCES OF FUNDING BY DOLLAR AMOUNT AND NAME OF FUNDER e.g., Applicant, State, Local, Other, Program Income, etc.
Other support is defined as funds or resources, whether federal, non-federal or institutional, in direct support of activities through fellowships, gifts, prizes, in-kind contributions or non-federal means. [Note: Please see PART II: Appendix C – Standard Funding Restrictions, regarding allowable costs.]

IN THIS SECTION, include a narrative and separate budget for each year of the grant that shows the percent of the total grant award that will be used for data collection, performance measurement and performance assessment. **Be sure the budget reflects the funding restrictions in Section IV-5.**

Infrastructure Development	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total Infra-structure Costs**
Personnel	$2,250	$2,250	$2,250	$2,250	$2,250	$11,250
Fringe	$558	$558	$558	$558	$558	$2,790
Travel	0	0	0	0	0	0
Equipment	$15,000	0	0	0	0	$15,000
Supplies	$1,575	$1,575	$1,575	$1,575	$1,575	$7,875
Contractual	$5,000	$5,000	$5,000	$5,000	$5,000	$25,000
Other	$1,617	$2,375	$2,375	$2,375	$2,375	$11,117
Total Direct Charges	$6,000	$11,758	$11,758	$11,758	$11,758	**$53,072**
Indirect	$750	$750	$750	$750	$750	**$3,750**

Infrastructure Development	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total Infra-structure Costs**
Charges						
Total Infrastructure Costs	**$6750**	**$12,508**	**$12,508**	**$12,508**	**$12,508**	**$56,782**

Data Collection & Performance Measurement	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total Data Collection & Performance Measurement Costs**
Personnel	$6,700	$6,700	$6,700	$6,700	$6,700	$33,500
Fringe	$2,400	$2,400	$2,400	$2,400	$2,400	$12,000
Travel	$100	$100	$100	$100	$100	$500
Equipment	0	0	0	0	0	0
Supplies	$750	$750	$750	$750	$750	$3,750
Contractual	$24,950	$24,950	$24,950	$24,950	$24,950	$124,750
Other	0	0	0	0	0	0
Total Direct Charges	$34,300	$34,300	$34,300	$34,300	$34,300	$171,500
Indirect Charges	$698	$698	$698	$698	$698	$3,490
Data Collection & Performance Measurement	**$34,900**	**$34,900**	**$34,900**	**$34,900**	**$34,900**	**$174,500**