

carrier or the U.S. Postal Service will be accepted in lieu of a postmark. Private metered postmarks will not be accepted as proof of timely mailing. Late applications not accepted for processing will be returned to the applicant and will not be considered for funding.

**Hand Delivered Proposals**—Hand delivered proposals will be accepted daily between the hours of 8 a.m. to 5 p.m. Eastern Standard Time, Monday through Friday. Proposals will not be accepted after 5 p.m. on July 11, 2003.

#### *Additional Dates*

(a) Application Review Date: July 28, 2003.

(b) Applicants Notified of Result: On or about August 15, 2003 (approved, recommended for approval but not funded, ineligible, or disapproved).

(c) Anticipated Start Date: On or about September 1, 2003.

#### **Contacts for Assistance**

If you have questions after reviewing the contents of all the documents, you may contact Crystal Ferguson, Grants Management Officer, Grants Management Branch, Division of Acquisitions and Grants Management, Indian Health Service, Twinbrook Parkway, Suite 100, Rockville, Maryland 20852, at (301) 443-5204, regarding business management technical questions or to obtain additional application kits. For programmatic technical assistance for the MHCSI program, contact Jamie Davis Hueston, Ph.D., Office of Public Health, Office of Clinical and Preventive Services, Division of Behavioral Health, 12300 Twinbrook Parkway, Suite 605; Rockville, MD 20852, at (301) 443-2038, Internet address: [JDAVIS@HQE.GOV](mailto:JDAVIS@HQE.GOV). The telephone numbers are not toll-free.

#### **General Program Information**

##### *(a) Background*

According to statistics provided by the IHS, of the 1.43 million Indians living on or near reservations, nearly 500,000 or 29% are under the age of 15. Homicide is the second leading cause of death among Indians from 1-14 years of age, and third for 1-24 year-olds. The suicide death rate for 15 to 24 year-old Indians is 2.4 times the corresponding rate for U.S., all races. A study by the National Household Survey on Drug Abuse indicated that the AI/AN population demonstrated the greatest illicit drug use of all racial/ethnic populations. According to the Federal Bureau of Prisons, although AI/ANs only represent 8% of the general population, 61% of the juveniles were in confinement. More than 180 gangs

have been identified in AI/AN communities. Jurisdictional differences for troubled youth within the Tribal communities. Forty-five percent of Indian mothers have their first child before age 20, compared to 24% for U.S., all races. Increasingly the number of AI/AN youth involved with the juvenile justice system are found to have serious mental illness. Similarly, Department of Justice statistics indicate that more than 50% of the AI/AN children and youth involved in the juvenile justice system have been abused and/or neglected.

##### *(b) Target Population*

For purposes of the MHCSI cooperative agreement program, the target population is federally recognized and eligible AI/AN communities with substantial Tribal youth mental health and community safety issues, including such indicators of youth issues such as:

- (1) Elevated rates of depression, behavioral problems, and suicide among the youth population;
- (2) Substance abuse problems among the Tribal youth population;
- (3) Low educational attainment and high drop-out rates;
- (4) High levels of child abuse and family violence in the community; and
- (5) High levels of juvenile crime, violence, and gang activity.

**Age:** Children and adolescents under the age of 18 years and their families.

**Diagnosis:** The child or adolescent at risk of or experiencing a serious emotional, behavioral, or mental disorder diagnosable under the Diagnostic and Statistical Manual IV (DSM IV).

**Disabilities:** The child or adolescent is in some way limited to the degree or level of functioning. Inability to perform in the family, school, and/or community is the basic factor which determines the need for services.

##### *(c) Program Purpose*

The MHCSI Program requires applicants to address and include specific information from one or both of the areas of focus: Child Abuse and Neglect (CAN) and/or Seriously Mentally Ill (SMI) as a part of their program description.

**Area of Focus 1:** Child Abuse and Neglect (CAN): Identifies and develops systems of care for victims of child abuse and neglect who are involved and/or at risk of being involved with the juvenile justice system.

**Area of Focus 2:** Seriously Mentally Ill (SMI): identifies and develops systems of care for children and youth with serious mental illness and are involved and/or at risk for being

involved with the juvenile justice system.

The purpose of the MHCSI cooperative agreement is to target AI/AN children and youth involved with or at risk for involvement with the juvenile justice system and their families. Applicants should also identify children and youth with serious mental illness. This type of cooperative agreement should plan for establishing innovative demonstration programs for child protective services, child abuse prevention (including family violence prevention) programs, and education programs that are community based and culturally relevant as well as provide a "system of care" for the identified children, youth and their families. Tribes are required to identify, evaluate, and refer children and youth who are suspected or know to be SMI and to develop a "system of care."

#### **Cooperative Agreement Activities**

In conducting activities to achieve the purpose of this program the cooperative agreement recipient (Tribes or Tribal/urban Indian organization) will be responsible for the activities listed under A, and IHS will be responsible for activities listed under B.

##### *(a) Cooperative Agreement Recipient Activities*

Additional efforts would include, but not be limited to the following activities:

Planning, designing, and assessing

(1) Child abuse prevention (including family violence prevention programs);

(2) Multi-disciplinary child abuse investigation and prevention programs;

(3) Child protection codes and regulations;

(4) Training programs that highlight and/or provide community education on child abuse for juvenile justice staff (e.g., detention staff, officers, and court staff, including judges, prosecutors, parole officers, etc.);

(5) Innovative and culturally relevant programs, projects, and services for AI/AN children and youth who are either involved with or at risk for becoming involved with the juvenile justice system; and

(6) Day services for AI/AN children and youth that improve case management as evidenced by a decrease in the number of psychiatric hospitalizations and an increase in the attainment of family and individual goals through participation in the treatment plan.