**Translation Fellowships 2021: Mental Health**

# **Application Form**

**Application Period closes: 1:00pm (AWST), Tuesday 8 February 2022**

***When completing this Application Form refer to the*** [***Translation Fellowships 2021: Mental Health Guidelines and Conditions***](https://fhrifund.health.wa.gov.au/Funding/Current-opportunities/Translation-Fellowships-2021---Mental-Health)***, which include application instructions.***

## Project title

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## Project summary

Provide a summary of the proposal, including the aims, objectives, significance and expected benefits to the WA health system in the area of mental health. This summary may be used for publicity purposes.

*[Maximum 200 words]*

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## Fellowship funding request summary

The information provided below must align with the ‘Budget details’ table. All amounts must be excluding GST.

|  |  |
| --- | --- |
| Fellowship FTE requested*Must be at least 0.5 FTE* |  |
| Fellowship funding request *A minimum of $180,000 ($60,000 per annum) must be allocated to research project costs.**Indirect/infrastructure costs must be maximum 10% of the total Fellowship funding request.* | Fellowship salary $ Research project costs $Indirect/infrastructure costs $ |
| Total Fellowship funding request*Maximum $600,000 for the three year period* | $ |

## Support package summary

The information provided below must align with the ‘Fellowship support package’ section of this form and the ‘Budget details’ table. All amounts must be excluding GST.

|  |  |
| --- | --- |
| Cash contributions *A minimum of $90,000 ($30,000 per annum) must be contributed for research project costs.*  | Fellowship salary $ Research project costs $ |
| In-kind contributions  | Fellowship salary $ Research project costs $Indirect/infrastructure costs $ |
| Total Support Package*Must be at least equal to the total Fellowship funding request* | $  |
| Support package includes at least one linked PhD Scholarship | Yes [ ]   |

## Administering institution

|  |  |
| --- | --- |
| Name of administering institution*Entity which would administer grant funds**Must be a WA university or WA research institute* |  |
| Administering institution ABN |  |
| Contact officer name |  |
| Contact officer email address |  |

## Coordinating Principal Investigator (CPI)

Provide the details of the CPI. Insert an abridged (two-page maximum) Curriculum Vitae (CV) of the CPI, which includes key publications from the last 5 years. CVs can be inserted at the back of this application form.

|  |  |
| --- | --- |
| Title, First name, SURNAME |  |
| Citizenship status*Australian Citizen or Permanent Resident* |  |
| Affiliated institutions*Institutions with which the CPI may be affiliated, other than the administering institution* |  |
| Discipline/Profession |  |
| Position title |  |
| Telephone number |  |
| Email address |  |
| CV attached *Maximum two pages* | Yes [ ]  |

## Research career stage

|  |  |
| --- | --- |
| Research career stage*An early-career researcher is equivalent to the NHMRC Emerging Leadership Level 1 and a mid-career researcher is equivalent to the NHMRC Emerging Leadership Level 2 as defined in Appendix A of the Guidelines and Conditions.*  | Early-Career [ ]  Mid-Career [ ]  |
| Postgraduate research degree*PhD or Masters by research**The nominated years since award of degree/years of research experience must align with the justification below* | Yes [ ]  No [ ] If Yes, years since award of degree: \_\_\_\_\_\_\_\_If No, years of research experience: \_\_\_\_\_\_\_\_ |

**Research career stage justification**

Provide a justification for the nominated research career stage taking into consideration any career disruptions (as defined by the [NHMRC](https://www.nhmrc.gov.au/about-us/policy-and-priorities) Relative to Opportunity Policy). Refer to Section 4 and Appendix A of the Guidelines and Conditions.

*[Maximum 250 words]*

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**Administering institution research career stage endorsement**

[ ]  I, \_\_\_\_\_\_\_\_\_\_, declare that the applicant has selected the appropriate research career stage. Refer to Section 4 and Appendix A of the Guidelines and Conditions.

Administering institution endorsement comments.

*[Maximum 250 words]*

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## Supporting team

Provide details for each of the supporting team members involved in the research project. This will include team members associated with the administering institution, the provider/s of mental health services (there must be at least one WA provider involved) and any other participating organisations.

To demonstrate the capacity of the team and its suitability to conduct the research, insert an abridged (two-page maximum) CV of each team member, which includes key publications from the last 5 years (where applicable). CV’s can be inserted at the back of this application form.

Insert additional tables as required.

|  |
| --- |
| **Team member 1** |
| Title, First name, SURNAME |  |
| Institution/Organisation |  |
| Institution/Organisation is a WA provider of mental health services | Yes [ ]  No [ ]  |
| Institution/Organisation address |  |
| Position title |  |
| Role in this activity |  |
| Time commitment to this project (hours/week) |  |
| Telephone number |  |
| Email address |  |
| CV attached *Maximum two pages* | **Yes** [ ]  |

## Significance of the research project (15%)

Applications must address contemporary challenges or needs faced by the WA health system in the area of mental health.

Describe the following:

1. the issue and its significance to the WA health system (e.g. incidence, prevalence, burden of disease, impact on delivery or cost of health service)
2. how the proposed research will address the issue described above
3. the expected benefits to the WA health system (e.g. reduce inequities, improved efficiencies and cost savings)
4. the project’s impact on existing programs that are currently operating in this area.

*[Maximum 500 words]*

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## Research plan (15%)

Describe the research plan including:

1. the hypothesis, research questions and objectives. Ensure objectives are specific, measurable, attainable relevant and time-bound
2. the methodology, including techniques, target group(s), a realistic sample size and measures to be used
3. a list of all approvals and agreements that will be required before the research project can proceed.
4. an achievable timeline.

*[Maximum 2000 words]*

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List the major activity milestones for the research project and their duration.

Note that the timeline should include milestones and the timeframe as separate items for ethics and governance approvals, employment of staff, data collection, patient recruitment (as applicable) and analysis and report writing.

The project must be completed within 36 months.

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| **Activity Milestones*****(insert additional rows as required)*** | **Timeframe** |
|  |  |
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| Progress Report 1 submitted to RIO | At 12 months |
|  |  |
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| Progress Report 2 submitted to RIO | At 24 months |
|  |  |
|  |  |
| Final Report, Financial Acquittal, Community Stakeholder Brief and Future Health Research and Innovation (FHRI) Fund Advisory Council report submitted to RIO  | At 36 months |

## Consumer involvement (10%)

Describe how consumers have been involved in the development of the research proposal and the plan for ongoing engagement during the study. Include what formal processes will be put in place to link consumer engagement with the research and implementation. Refer to Section 9 of the Guidelines and Conditions.

*[Maximum 500 words]*

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Please provide details of each consumer representative involved in the development of this proposal and/or proposed to be involved in the research. Note that named consumers must be aware of and agree to contribute to the work proposed in this application.

*Additional tables can be inserted as required.*

|  |  |
| --- | --- |
| Title, First Name, SURNAME |  |
| Email address |  |
| Role in this activity |  |

## Partnership with provider(s) of mental health services (10%)

Describe the partnership with each provider(s) of mental health services including:

* the name and a brief description of each provider of mental health services
* the capacity for the provider(s) of mental health service to achieve translational outcomes
* the plan for integrating the work and outputs of the Fellow into their policy and/or practice
* how this partnership/s will result in benefits to WA health system.

Address each provider of mental health services separately. There must be at least one WA provider of mental health services partnering on this application. Refer to Section 10 of the Guidelines and Conditions.

*[Maximum 1000 words]*

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## Fellowship support package (20%)

Describe the proposed Fellowship support package including:

* cash and in-kind contributions (separately address the Fellowship CPI salary and research project support costs)
* relevance and strength of qualifications and availability of the team to conduct project
* collective gain of the team to the project
* access to required resources, including expertise.

The information provided below must align with the ‘Budget details’ table. Refer to Section 6 of the Guidelines and Conditions.

*[Maximum 500 words]*

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## Track record and potential of the CPI (10%)

Describe the following:

1. the CPI’s contribution to translational research
2. the CPI’s track record of influencing policy and/or practice
3. the CPI’s career plan, including key milestones for achieving an independent and self-sustaining career and broader translational research interests
4. the CPI’s capacity and plan for meeting the Fellowship deliverables (as outlined in Section 3 of the Guidelines and Conditions).

*[Maximum 500 words]*

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## Translation and implementation (20%)

Describe the following:

1. planned steps for the translation and or implementation of research findings and the project timeframes for translational impacts
2. how the knowledge, expertise and experience of the team members and collaborating partners will assist with the process of translating findings into policy and/or practice
3. future plans for the research activity. For example, a possible extension of the research activity to a broader geographical area, population or to other disciplines.

*[Maximum 1000 words]*

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## Budget details

Provide budget details for the Fellowship in the table below. There must be maximum $200,000 for Fellowship Funding per year; and the total value of the Support Package must be at least equal to the total Fellowship Funding Request. The Additional Cash Contribution must be ‘new’ cash for the purposes of conducting the Fellowship (refer to Section 5 in the Guidelines and Conditions).

| **BUDGET ITEM** | **FELLOWSHIP FUNDING REQUEST** **($ EX GST)** | **SUPPORT PACKAGE****($ EX GST)** |
| --- | --- | --- |
| **Fellowship salary costs** (for nominated FTE) | **Year 1** | **Year 2**  | **Year 3**  | **TOTAL**  | **ADDITIONAL IN-KIND SUPPORT** | **ADDITIONAL CASH CONTRIBUTION** | **TOTAL**  |
| **Salary costs**Include Award/ Agreement increases and salary increments  |  |  |  |  |  |  |  |
| **Salary on-costs**24% applied to salary |  |  |  |  |  |  |  |
| **Research project costs** (minimum total cash value of $90,000 per annum) | **Year 1** | **Year 2**  | **Year 3**  | **TOTAL**  | **ADDITIONAL IN-KIND SUPPORT** | **ADDITIONAL CASH CONTRIBUTION** | **TOTAL**  |
| **Personnel***specify for each position***Position 1*** *title*
* *new/ existing*
* *%FTE*
* *salary and on-costs*

Position 2* *title*
* *new/ existing*
* *%FTE*
* *salary and on-costs*
 |  |  |  |  |  |  |  |
| **Minor essential equipment***maximum $10,000**quotations must be attached* |  |  |  |  |  |  |  |
| **Consumables** |  |  |  |  |  |  |  |
| **Consumer Involvement***e.g. honoraria payments etc.* |  |  |  |  |  |  |  |
| **Other***specify each item*  |  |  |  |  |  |  |  |
| **Other items** | **Year 1** | **Year 2**  | **Year 3**  | **TOTAL**  | **ADDITIONAL IN-KIND SUPPORT** | **ADDITIONAL CASH CONTRIBUTION** | **TOTAL**  |
| **Indirect/infrastructure costs***maximum of 10%*  |  |  |  |  |  |  |  |
| **TOTAL** |  |  |  |  |  |  |  |

## Fellowships funding request justification

Provide a justification for the Fellowship funding request budget items provided in the ‘Budget details’ table. It is intended that funds will be spent in WA only. An exception to this may be considered in the case where specific expertise or equipment is required and is not available in WA. When this situation occurs, adequate justification must be provided.

*[Maximum 250 words]*

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## Submission to other funding sources for this activity

List any funding source(s) and the amount(s) requested. Include applications already submitted and planned submissions. These must complement, but not duplicate, the work for which the Fellowship funding is requested. The Fellowship research project activity must not be dependent on the receipt of these other funding sources.

*[Maximum 250 words]*

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## Bibliographic references

If applicable, provide bibliographic references to any publications or reports cited in the application. Please only include publications strictly pertinent to the application.

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## Translational research team certification

We certify that:

1. we commit to taking part in the activities proposed in this application for the duration of the Fellowship if successful
2. the information supplied by us on this form is complete, true and correct in every particular
3. we agree to abide by the *Translation Fellowships 2021: Mental Health Guidelines and Conditions*
4. we have discussed the likely impact of the activity on participating organisations, and this activity is acceptable to them
5. we will submit this application to the administering institution’s grant administration office
6. we agree to obtain any research ethics and governance approvals that might be required for undertaking funded activities
7. we understand and agree that if the application is successful, that no further claim will be made on the Department of Health to cover any expenditure beyond the approved budget
8. no member of the Translational research team has outstanding reporting obligations for any other funding programs administered by RIO (including FHRI Fund Programs).

**Coordinating Principal Investigator**

|  |
| --- |
| **Full Name**  |
| **Signature**  | **Date**  |

Other Team Members associated with the administering institution and any other participating organisations.

Insert additional tables as required.

**Team Member 1**

|  |
| --- |
| **Full Name**  |
| **Signature**  | **Date**  |

## Consumer representative certification

I certify that:

1. I commit to taking part in the activities proposed in this application for the duration of the Fellowship if successful
2. I agree to abide by the *Translation Fellowships 2021: Mental Health Guidelines and Conditions.*

Insert additional tables as required.

**Consumer Representative 1**

|  |
| --- |
| **Full Name**  |
| **Signature**  | **Date**  |

## Administering institution representative certification

I certify that:

1. I am an authorised representative of the administering institution
2. the CPI would be employed by the administering institution and reside in WA for the period of the Fellowship
3. the administering institution endorses this application, confirms that the information supplied on this form, including the justification of the CPI’s career stage, is complete, true and correct in every particular and is willing to administer the Fellowship grant under the conditions specified in the *Translation Fellowships 2021: Mental Health Guidelines and Conditions*
4. the support package offered is sufficient to support additional research project costs, not included in the Fellowship funding request
5. I confirm that the support package cash contribution is ‘new’ cash for the purposes of conducting the Fellowship
6. the grant does not constitute the entire financial base of the administering institution
7. the Department of Health will be notified immediately of any changes to the applicant’s eligibility or changes to the information originally provided in this application.

|  |  |
| --- | --- |
| **Title, First Name, SURNAME** |  |
| **Position** |  |
| **Signature** |  |
| **Date** |  |
| **Telephone number** |  |
| **Email address** |  |

## Administering institution finance officer (or equivalent) certification

I certify that:

1. I am an authorised representative of the administering institution
2. the budgeted costs in this application are true and correct and reflect the latest costing information available to me
3. amounts claimed are exclusive of Australian GST
4. I understand that funding will only be made available for the scope of work described in the application, or with any modifications approved by the Department of Health. The Department of Health is not obliged to underwrite any recurrent or capital costs beyond funding awarded through this Program.

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| --- | --- |
| **Title, First Name, SURNAME** |  |
| **Position** |  |
| **Signature** |  |
| **Date** |  |
| **Telephone number** |  |
| **Email address** |  |

Where different to the officer named above, please provide contact details for the person responsible for the payment of funds and financial acquittal reporting for this Fellowship.

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| --- | --- |
| **Title, First Name, SURNAME** |  |
| **Position** |  |
| **Telephone number** |  |
| **Email address** |  |

## Provider of mental health services representative certification

I certify that:

1. I am an authorised representative of the provider of mental health services
2. the provider of mental health services endorses this application and will contribute to the activities of the Fellowship in accordance with the *Translation Fellowships 2021: Mental Health Guidelines and Conditions*
3. the information presented in the ‘Partnerships with provider/s of mental health services’ section of this application form is true and correct, with regards to the service I represent
4. the provider of mental health services is committed to working with the Fellow in supporting the translation of the research project outputs (subject to these outputs being found to be useful).

|  |  |
| --- | --- |
| **Title, First Name, SURNAME** |  |
| **Name of the provider of mental health services**  |  |
| **Department** |  |
| **Position title** |  |
| **Telephone number** |  |
| **Email address** |  |
| **Signature** |  | **Date** |  |

Insert additional table/s if more than one provider of mental health services is involved in this application.

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