

Department of Health and Human Services

Substance Abuse and Mental Health Services Administration

Community Resilience and Recovery Initiative

Short Title: CRRI

Request for Applications (RFA) No. SM-10-015

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

Key Dates:

Application Deadline	Applications are due by May 28, 2010
Intergovernmental Review (E.O. 12372)	Applicants must comply with E.O. 12372 if their State(s) participates. Review process recommendations from the State Single Point of Contact (SPOC) are due no later than 60 days after application deadline.
Public Health System Impact Statement (PHSIS)/Single State Agency Coordination	Applicants must send the PHSIS to appropriate State and local health agencies by application deadline. Comments from Single State Agency are due no later than 60 days after application deadline.

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Executive Summary:

The Substance Abuse and Mental Health Services Administration is accepting applications for fiscal year (FY) 2010 Community Resilience and Recovery Initiative (CRRRI) grants. The purpose of this place-based initiative is to improve behavioral health outcomes through enhanced coordination and evidence-based health promotion, illness prevention, treatment, and recovery support services in communities affected by the recent economic downturn.

Funding Opportunity Title:	Community Resilience and Recovery Initiative (CRRRI)
Funding Opportunity Number:	SM-10-015
Due Date for Applications:	May 28, 2010
Anticipated Total Available Funding:	\$4.2 million
Estimated Number of Awards:	Up to 5
Estimated Award Amount:	Up to \$1,400,000 per year
Length of Project Period:	Up to 4 years
Eligible Applicants:	Eligible applicants are mayors' offices, the offices of county executives, or the offices of chief executive of tribal or territorial governments in communities with high levels of unemployment. [See Section III-1 of this RFA for complete eligibility information.]

I. FUNDING OPPORTUNITY DESCRIPTION

1. INTRODUCTION

The Substance Abuse and Mental Health Services Administration is accepting applications for fiscal year (FY) 2010 Community Resilience and Recovery Initiative (CRRI) grants. The purpose of this place-based initiative is to improve behavioral health outcomes through enhanced coordination and evidence-based health promotion, illness prevention, treatment, and recovery support services in communities affected by the recent economic downturn.

Through coordinated services the CRRI will work in funded communities to:

- Reduce depression and anxiety;
- Reduce excessive drinking (and other substance use if the community chooses);
- Reduce child maltreatment and family violence;
- Enable communities to better identify and respond to suicide risk;
- Build a sense of cohesiveness and connectedness;
- Enable coordination across service systems and community organizations; and
- Improve community resilience and reduce the impact of the economic downturn on behavioral health problems.

The intent of the program is to help communities mobilize to better manage behavioral health issues despite budgetary cuts in existing services and to promote a sense of renewal and resilience. The CRRI will use a place-based strategy to implement multiple evidence-based interventions targeted to four levels in the community. It will direct resources towards preventing or intervening early in behavioral health problems. It aims to prevent a downward cycle that leads to chronic declines in community resilience and long term behavioral health issues and unemployment among its residents. The CRRI is intended to develop and evaluate a new approach to targeting communities that are in need of intensive behavioral health interventions due to the recent economic decline. The initiative is not designed to address communities that had extremely high unemployment before the most recent economic downturn. Instead, it is designed to intervene in previously stable communities where the economic downturn poses major barriers or challenges to preserving community-wide behavioral health.

A large body of literature shows that economic downturns have negative effects on behavioral health. Americans reported heightened levels of stress and anxiety during the recent financial downturns¹. During times of recession and high unemployment mental health problems become more prevalent² and are related to increases in binge drinking³ and adolescent substance abuse⁴.

¹ Witters, D (2009). *Americans Less Happy, More Stressed in 2009*. (Gallup Wellbeing Index Summary of Findings) Washington, DC: Gallup. Retrieved January 18th, 2009, from <http://www.gallup.com/poll/124904/Americans-Less-Happy-Stressed-2009.aspx?CSTS=tagrss>

² Paul, K, & Moser, K. (2009) Unemployment Impairs Mental Health: Meta-Analyses. *Journal of Vocational Behavior*, 74, 264-282

This increased need places additional demands on providers^{5,6} as they experience budget cuts that result in forced reductions in services. Recessions also place great strain on families, as evidenced by increases in family violence during times of economic turmoil⁷.

SAMHSA has demonstrated that prevention works, treatment is effective, and people recover from mental and substance use disorders. Behavioral health services improve health status and reduce health care and other costs to society. Continued improvement in the delivery and financing of prevention, treatment and recovery support services provides a cost effective opportunity to advance and protect the Nation's health. To continue to improve the delivery and financing of prevention, treatment and recovery support services, SAMHSA has identified ten Strategic Initiatives to focus the Agency's work on people and emerging opportunities. More information on these Initiatives is available at the SAMHSA website:

<http://www.samhsa.gov/About/strategy.aspx>.

Grantees will be expected to implement a range of evidence based services in community settings including prevention interventions, short-term therapies for depression and anxiety, brief interventions and treatments for problematic alcohol use, psycho-education, motivational interviewing, as well as medication-assisted treatments. Applications responsive to this Request for Application must implement evidence-based or best practices that will create or expand capacity to address the following SAMHSA Strategic Initiatives:

- Jobs and Economy - Promote the behavioral health of individuals, families, and communities affected by the economic downturn, the employment of people with mental and substance use disorders, and policies for employers that support behavioral health in the workplace.
- Prevention of Substance Abuse and Mental Illness - Create prevention prepared communities where individuals, families, schools, workplaces, and communities take action to prevent and reduce mental illness and substance abuse across the lifespan.
- Military Families - Support of our service men and women and their families and communities by leading efforts to ensure needed behavioral health services are accessible and outcomes are successful. Like many people affected by the economic downturn, most returning veterans need to seek employment as they reintegrate into the community. They will likely be affected by the reduced availability of jobs and will face similar stresses of other unemployed people. Through this initiative, grantees should work to address the specific behavioral health needs of veterans, and be aware that returning veterans and their families may experience additional stressors because of the experience of multiple deployments coupled with the impact of the recent economic downturn.

³ Dee, T (2001) Alcohol Abuse and Economic Conditions: Evidence from Repeated Cross-Sections of Individual-Level Data. *Health Economics*, 10, 157-270

⁴ Arkes, J. (2007). Does the Economy Affect Teenage Substance Use?. *Health Economics*, 16, 19-36.

⁵ Kaiser Family Foundation. (2009) *Rising Health Pressures in an Economic Crisis: a 360 Degree Look at Four Communities*. Menlo Park, CA: Perry, M. et al.

⁶ Collier, R (2009). Recession Stresses Mental Health System. *Canadian Medical Association Journal*, 181, 3-4

⁷ Zagorsky, Schlesinger, Sege, R., Economic Conditions and Child Maltreatment: Intimate Partners or Disparate Enemies, July 24, 2009 in press.

- Trauma and Justice – Reduce the pervasive, harmful, and costly health impact of violence and trauma by integrating trauma-informed approaches throughout health and behavioral healthcare systems and to divert people with substance use and mental disorders from criminal justice and juvenile justice systems into trauma-informed treatment and recovery.

The CRRI will address the behavioral health needs of the communities affected by the economic downturn. SAMHSA will provide funding and technical assistance to communities to implement a continuum of behavioral health services including substance abuse prevention and mental health promotion activities; screening for alcohol use, brief interventions and treatments for depression, anxiety, and problematic alcohol use; and referral and crisis response for individuals at risk for suicide or severe psychological problems. The initiative will coordinate existing treatment services for mental health and substance abuse problems with a new framework for early identification and provide connections to community groups, vocational education, employment support services and other local services.

These programs will be delivered through a network of service providers including local prevention coalitions, community-based behavioral health care providers and primary care providers. Staff in these settings will be trained to identify individuals with or at risk for mental illness and substance abuse. Identified individuals will then be provided with brief interventions and/or brief treatments or referred to more intensive services. Where feasible, grant funded behavioral health care services will be co-located to expedite access to and delivery of services.

The CRRI is one of SAMHSA's services grant programs. SAMHSA's services grants are designed to address gaps in mental health and substance abuse prevention and treatment services and/or to increase the ability of States, units of local government, American Indian/Alaska Native Tribes and tribal organizations, and community- and faith-based organizations to help specific populations or geographic areas with serious, emerging behavioral health problems. **The delivery of services should begin no later than 4th months after grant award.**

SAMHSA anticipates that from time to time additional funds may be available to be used as supplements to support and enhance the primary grant activities. An integrated approach that includes criminal justice is a key priority of SAMHSA. To address this issue SAMHSA may provide supplemental awards in FY 2011 to CRRI grantees that apply for an optional supplement not to exceed \$300,000 per grantee for up to 4 years, for a total of up to \$1,200,000 to expand and/or enhance substance abuse treatment services in "problem solving" courts (including Driving While Intoxicated (DWI)/Driving Under the Influence (DUI) Courts, Co-Occurring Drug and Mental Health Courts, and Veterans Courts) which use the treatment drug court model in order to provide alcohol and drug treatment, recovery support services supporting substance abuse treatment, screening, assessment, case management, and program coordination to adult defendants/offenders.

CRRI grants are authorized under 520A of the Public Health Service Act, as amended. The Drug Court Treatment Supplements are authorized under Section 501 (d)(18) and 509 of the Public Health Service Act, as amended. This announcement addresses Healthy People 2010 focus areas 18 (Mental Health and Mental Disorders) and 26 (Substance Abuse).

2. EXPECTATIONS

Through the CRRRI grantees will be expected to develop a multi-level initiative to address increased behavioral health needs resulting from the economic downturn in the community of focus. This approach will connect local leadership, community leaders, organizations, and coalitions, behavioral health care providers, the courts and law enforcement, Department of Labor One Stops or employment centers, primary care providers, Community Health Centers (CHC), SBHCs and employers with clearly defined roles for each partner/setting.

Grantees will be expected to build capacity at 4 levels. See Section I-2.2 for additional information on implementing activities under the 4 levels.

Level 1: Implement a broad-based community engagement effort that includes social marketing, a media and information campaign to inform community members about behavioral health needs that may result from economic distress and the resources that are available to meet these needs, and broader messaging designed to promote a sense of resilience and prevent community hopelessness.

Level 2: Provide evidence-based practices to prevent the emergence of behavioral health problems. These programs will address risk and protective factors to prevent depression, anxiety, and negative behaviors such as problematic alcohol use.

Level 3: Provide screening, brief interventions, brief treatment and referral to treatment for depression, anxiety and problematic alcohol use (grantees may also choose to address broader substance use issues under this level). These services will be provided in community settings that are readily accessed by residents. Possible settings and venues for care delivery include Federally Qualified Health Centers (FQHC), One Stop Career Centers or other employment centers, primary care clinics and emergency rooms, community health centers, school-based health centers (SBHC), faith-based organizations, community colleges, work sites and Employee Assistance Programs (EAPs). Activities under Level Three of the initiative which address problematic alcohol use or broader substance use are designed to mitigate the negative mental health effects of the economic downturn.

Level 4: Provide crisis intervention for residents that are suicidal or in significant psychological distress, and connect these individuals to existing services and community supports.

Each of these four levels should be integrated into your existing community behavioral health system. You will be responsible for the coordination and integration of the existing service network in your community with grant funded activities. This will include creating referral mechanisms, data collection systems, cross-system training, and new communication pathways and management structures. Please note that activities under the Treatment and Recovery Services for Drug Court Clients supplement should be integrated with the other aspects of your planned initiative.

As of February 2009, approximately 1.89 million men and women have been deployed to serve in support of overseas contingency operations, including Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). Individuals returning from Iraq and Afghanistan are at increased risk for suffering post-traumatic stress and other related disorders. Experts estimate that up to one-third of returning veterans will need mental health and/or substance abuse treatment and related services. In addition, the family members of returning veterans have an increased need for related support services. To address these concerns, SAMHSA strongly encourages all applicants to consider the unique needs of returning veterans and their families in developing their proposed project.

Like many people affected by the economic downturn, most returning veterans need to seek employment as they reintegrate into the community. They will likely be affected by the reduced availability of jobs and will face similar stresses of other unemployed people. Through this initiative, you should work to address the behavioral health needs of veterans, and be aware that returning veterans and their families will experience additional stressors because of the experience of multiple deployments coupled with the impact of the recent economic downturn.

2.1 Using Evidence-Based Practices

SAMHSA's services grants are intended to fund services or practices that have a demonstrated evidence base and that are appropriate for the population of focus. An evidence-based practice, also called EBP, refers to approaches to prevention or treatment that are validated by some form of documented research evidence.

Grantees will be expected to incorporate evidence-based practices at multiple levels. You must provide information about the evidence base for all interventions used as a part of this initiative including the prevention interventions chosen in Level 2, screening and assessment activities under Level 3, the brief interventions and treatments selected in Level 3, and crisis counseling models employed in Level 4. Additional information on EBPs for CRRI is included in Section I-2.2.

In Section B of your project narrative, you will need to:

- Identify the evidence-based practice(s) you propose to implement for the specific population of focus. Clearly identify which level of the initiative each practice will support.
- Identify and discuss the evidence that shows that the practice(s) is (are) effective. [See note below.]
- Discuss the population(s) for which the practice(s) has (have) been shown to be effective and show that it (they) is (are) appropriate for your population(s) of focus. [See note below.]

Note: SAMHSA recognizes that EBPs have not been developed for all populations and/or service settings. For example, certain interventions 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 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.

- Document the evidence that the practice(s) you have chosen is appropriate for the outcomes you want to achieve.
- Explain how the practice you have chosen meets SAMHSA’s goals for this grant program.
- Describe any modifications/adaptations you will need to make to your proposed practice(s) to meet the goals of your project and why you believe the changes will improve the outcomes. We expect that you will implement your evidence-based service(s)/practice(s) in a way that is as close as possible to the original service(s)/practice(s). However, SAMHSA understands that you may need to make minor changes to the service(s)/practice(s) to meet the needs of your population 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 of focus or in managing similar programs. However, you will need to convince the people reviewing your application that the changes you propose are justified.
- Explain why you chose this evidence-based practice over other evidence-based practices.
- If applicable, justify the use of multiple evidence-based practices. Discuss in the logic model and related narrative how use of multiple evidence-based practices will be integrated into the program, while maintaining an appropriate level of fidelity for each practice. Describe how the effectiveness of each evidence-based practice will be quantified in the performance assessment of the project.
- Discuss training needs or plans for training to successfully implement the proposed evidence-based practice(s).

Resources for Evidence-Based Practices:

You will find information on evidence-based practices in SAMHSA’s *Guide to Evidence-Based Practices on the Web* at <http://www.samhsa.gov/ebpwebguide>. SAMHSA has developed this Web site to provide a simple and direct connection to Web sites with information about evidence-based interventions to prevent and/or treat mental and substance use disorders. The *Guide* provides a short description and a link to dozens of Web sites with relevant evidence-

based practices information – either specific interventions or comprehensive reviews of research findings.

Please note that SAMHSA’s Guide to Evidence-Based Practices also references another SAMHSA Web site, the National Registry of Evidence-Based Programs and Practices (NREPP). NREPP is a searchable database of interventions for the prevention and treatment of mental and substance use disorders. NREPP is intended to serve as a decision support tool, not as an authoritative list of effective interventions. *Being included in NREPP, or in any other resource listed in the Guide, does not mean an intervention is “recommended” or that it has been demonstrated to achieve positive results in all circumstances.* You must document that the selected practice is appropriate for the specific population of focus and purposes of your project.

In addition to the Web site 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.

2.2 Services Delivery

You must use SAMHSA’s services grant funds primarily to support required and allowable direct services. Service provision should include paraprofessional staff as appropriate to promote workforce development within the identified community.

Required Activities

Level 1: Broad-based community engagement and social marketing

Level 1 of the CRRI initiative is designed to engage the community through a broad public awareness and outreach to community organizations and leaders. This may include a variety of activities such as the creation and distribution of flyers, brochures, tip sheets, educational materials, Web-based resources and public service announcements. It may also include efforts to involve community groups and promote events or information resources in public spaces (like supermarkets, libraries, community centers, etc.).

The activities you undertake as a part of Level 1 should:

- Increase awareness of behavioral health issues and the connection between the economic downturn and stress on individuals and families. These activities should help residents understand and anticipate the grief, anger, anxiety, stress and the sense of loss that occurs during financial crises.
- Increase awareness about methods for coping with and reducing stress and promoting wellness, including public health messaging (e.g. excessive alcohol or caffeine use can increase stress, exercise and physical activity can increase wellness and reduce stress, lack of sleep contributes to stress). For examples of this type of messaging see:

- SAMHSA’s Webpage “Getting Through Tough Economic Times”
<http://www.samhsa.gov/ECONOMY/>
- *Say it Loud* – Illinois’ state sponsored mental health promotion campaign
<http://www.mentalhealthillinois.org/>
- Mental Health America’s Live Your Life Well Campaign
<http://www.liveyourlifewell.org/>
- Increase awareness of services and supports available in the community. You must include efforts to increase awareness of national crisis hotlines like 1-800-273-TALK, local crisis hotlines if applicable, local service providers (including places where services can be accessed such as local behavioral health care providers, medical facilities, or family doctors), and grant funded activities like screening, prevention and health promotion activities. An important aspect of this portion of your program is ensuring that members of the public know where to go if they are in a state of crisis, and that people who would not naturally come into contact with the network of services provided under this grant know how to access these services.
- Facilitate community networking and support. You should work to build public awareness of natural supports in the community (e.g. faith based organizations, community coalitions, cultural and ethnic organizations, and other community groups). You should also engage these groups to assist in the dissemination of information related to your initiative. Partnership with outside organizations may provide the opportunity to reach people who are not reached through your other activities, and may help to improve the credibility of your efforts within the community. Active engagement of these groups will be central to obtain community buy in and will be a central part of building support to sustain reforms and services created through this effort beyond the life of the grant.

Level 2: Evidence-based prevention practices

You will be responsible for implementing evidence-based prevention interventions in your community to address the underlying risk and protective factors that affect the behavioral health outcomes in your community.

You must identify one to three prevention interventions to implement as a part of your project. In addition to the guidance provided in this RFA, resources are also available at: <http://prevention.samhsa.gov/evidencebased/evidencebased.pdf> (Identifying and Selecting Evidence-Based Interventions: Revised Guidance Document for the Strategic Prevention Framework State Incentive Grant Program).

SAMHSA has identified 7 prevention interventions that are appropriate for implementation as a part of this initiative. We strongly recommend that you choose your prevention interventions from this menu. More information about each of these interventions is available on SAMHSA’s National Registry of Evidence-based Programs and Practices (NREPP) Web site,

<http://www.nrepp.samhsa.gov>, with the exception of the JOBS program. More information about the JOBS program can be found at <http://www.isr.umich.edu/src/seh/mprc/>.

Menu of recommended prevention interventions:

- Triple P - Positive Parenting Program
- Strengthening Families Program
- Strengthening Families Program: For Parents and Youth 10-14
- Families and Schools Together
- The JOBS Program
- Coping with Work and Family Stress
- Coping and Support Training (CAST)

In order to select the appropriate intervention for your community, it is important to conduct an initial needs assessment to identify which evidence-based program is most appropriate to meet the unique needs of your community. You must identify the settings in which you will be implementing your selected evidence-based practice, the demographic profile of those who will be served by the preventative interventions (including factors such as ethnicity and age), and the behavioral health issues that you intend to address with your interventions. As part of this needs assessment you should look to accessing available community data from social services, community behavioral health providers, other health care providers, law enforcement, educational entities, local and/or state health departments and any other available sources.

You must develop a set of eligibility criteria for individuals to participate in your prevention programs related to the individual risk of developing behavioral health problems. Prevention programs are more effective and cost beneficial when they focus on individuals at elevated risk. As a result you should ensure that you have procedures and standards in place to identify these individuals, recruit them into your preventative interventions, and provide outreach to other individuals who may benefit from participation. In some cases this identification takes place as part of the chosen preventative intervention (for example, the JOBS Program is designed to work with the recently unemployed). In other cases, you will need to develop your own criteria for program participation. It is important that these criteria be established as a part of a formal system to ensure that limited resources are used as efficiently as possible. These criteria and your rationale for choosing them should be described in section B of your project narrative. In addition to establishing criteria, you may consider developing pathways for the identification of eligible individuals (for example, doing outreach in systems that typically work with individuals at higher levels of risk such as child welfare; public assistance; family, specialty, and criminal courts; and the broader criminal justice system).

In choosing an intervention appropriate for your community, it is suggested that you consider the following:

- Is the intervention appropriate for the population identified in the community needs assessment and community logic model? Has the intervention been implemented successfully with the same or a similar population? Are the population differences likely to compromise the results?

- Is the intervention delivered in a setting similar to the one planned by the community? In what ways is the context different? Are the differences likely to compromise the intervention's effectiveness?
- Is the intervention culturally appropriate? Did members of the culturally identified group participate in developing it? Were intervention materials adapted to the culturally identified group?
- Are implementation materials (e.g., manuals, procedures) available to guide intervention implementation? Are training and technical assistance available to support implementation?
- Are monitoring or evaluation tools available to help track implementation quality?

The following questions should also be addressed regarding the feasibility of the selected interventions:

- Is the intervention culturally feasible, given the values of the community?
- Is the intervention politically feasible, given the local power structure and priorities of the implementing organization? Does the intervention match the mission, vision, and culture of the implementing organization?
- Is the intervention administratively feasible, given the policies and procedures of the implementing organization?
- Is the intervention technically feasible, given staff capabilities, time commitments, and program resources?
- Is the intervention financially feasible, given the estimated costs of implementation (including costs for purchase of implementation materials and specialized training or technical assistance)?

Each of these questions warrants thoughtful consideration by those involved in planning, implementing, and evaluating the chosen prevention strategies.

It is important that you undertake the process of selecting an appropriate intervention or interventions early in the application period. After you identify an appropriate prevention intervention or interventions for implementation, you must still work with the organization that offers the intervention to address issues of cost, the feasibility of training, coordination of the evaluation of the preventative intervention that will be required as a part of your participation in this project, identification of the settings and timeline for the implementation of the intervention, and the development of any MOAs with your partners that reflect all activities pertaining to the collaborations.

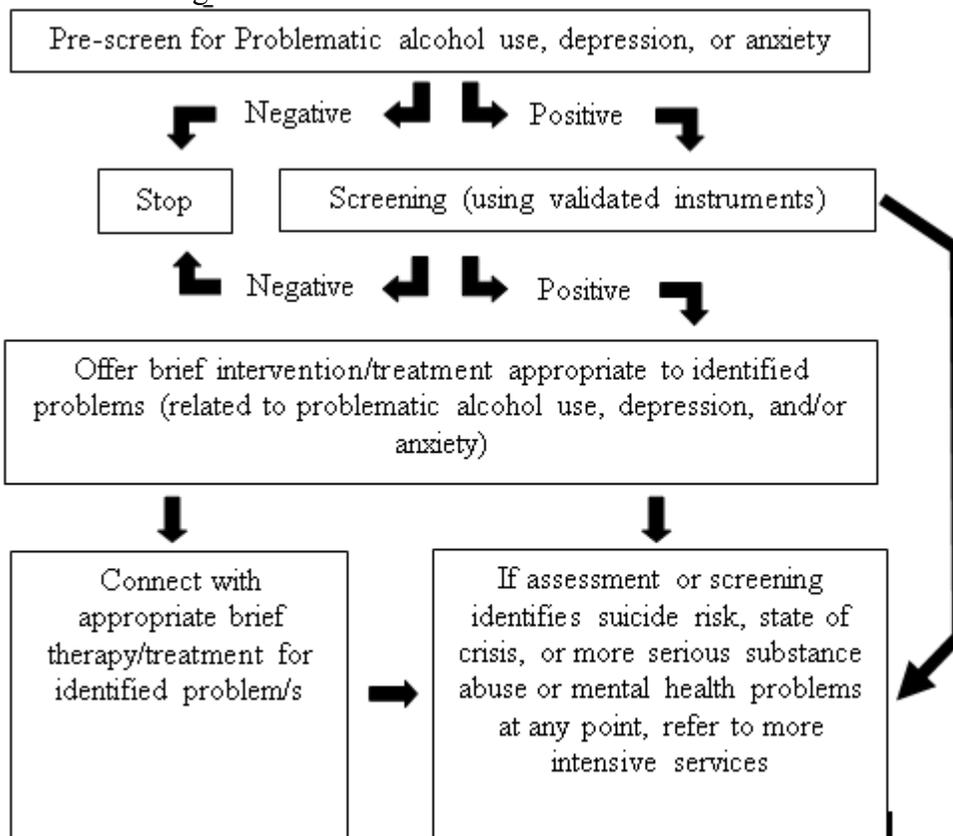
Careful attention should be paid to the settings in which the prevention programs will be conducted. The settings should be accessible to the populations of focus. Accessibility for some populations includes locating services within faith-based or community settings to increase the likelihood of participation. For others, locating programs in primary care settings, schools, courts, or employment centers may result in better access and outcomes.

Level 3: Screening, brief interventions, brief treatments and referral to treatment for depression, anxiety, and problematic alcohol use

You will be expected to implement a system for screening, brief interventions, brief treatments

and referral to treatment for depression, anxiety, and problematic alcohol use (While research has not demonstrated a clear link between economic trends and broader substance use, SAMHSA remains committed to addressing behavioral health problems comprehensively (including substance use and mental health problems) and in an integrated manner, as a result you may also choose to address broader substance use issues under this level using the Screening, Brief Intervention, and Referral to Treatment model). This system must be described in Section B of your project narrative. This component of your program should be composed of: 1) Screening services that are designed to rapidly identify problematic alcohol use, anxiety, and depression using validated screening instruments; 2) Evidence-based brief interventions and brief treatments addressing problematic alcohol use, anxiety, and depression; and a 3) Referral system to treatment providers, when necessary, including a plan to track and follow up on individuals being referred. These services can occur within a variety of settings including community health clinics, schools, human service programs, community health clinics, community mental health centers, employment centers, workplaces, etc.

For more information about screening, brief intervention, and brief treatment please visit: <http://sbirt.samhsa.gov/index.htm>. The following diagram maps out the pathways for individuals being screened.



The diagram above describes a pre-screening tool for problematic alcohol use depression or anxiety that maps out the pathways for individuals being screened. Prescreen the individual for problematic alcohol use, depression or anxiety, if negative then stop. If positive, do screening

using validated instruments. If this is negative, then stop. If it is positive, then offer brief intervention/treatment appropriate to the identified problems related to problematic alcohol use, depression or anxiety. The next step is to connect with appropriate brief therapy/treatment for identified problems. At any time if the assessment or screening identifies suicide risk, state of crisis or more serious substance abuse or mental health problems at any point, then refer to more intensive services.

Screening and Assessment

Screening and assessment are critical initial steps for this system. Screening is a process in which clients are identified based on their reported hazardous or risky alcohol or substance use, and/or experiences of depression or anxiety. Screening identifies the need for more in-depth assessment but is not an adequate substitute for complete assessment. Grantees will be expected to offer screening in multiple settings including emergency rooms, primary care settings, community and school based health centers, and employment centers (including One Stop Career Centers), job training agencies, private practice and homeless and domestic violence centers, courts and criminal justice settings, as well as other nontraditional settings.

Assessment is a more extensive process that involves a broad analysis of the factors contributing to and maintaining a person's substance abuse or mental health disorder, the severity of the problem, and the variety of consequences associated with the issues. Assessments will be done by the specialty treatment system to which more serious mental health and substance abuse issues may be referred.

Screening for depression and anxiety should be provided concurrently with the screening provided for problematic alcohol use. In large patient flow areas, a pre-screen may be done to eliminate the majority of individuals who may not evidence mental distress or substance abuse. A positive pre-screen will direct a client to a full screen. Based on a positive screen, evidence-based short term interventions or treatments for problematic alcohol use, anxiety and depression should be offered. In cases where the problems identified by the screening indicate the need for more intensive services, such as medication, longer term inpatients/outpatients treatment, and/or other therapies and supports, appropriate referrals should be made to existing specialty treatment systems that provide these services. Brief interventions and brief treatment should be administered immediately in cases where there is a positive screen. The screening and assessment process should determine whether the client's substance abuse and/or mental health problem is suitable for a brief therapy approach.

In some cases individuals may not meet the clinical threshold for anxiety, depression, or problematic alcohol or substance use based on screening or assessments. However, some of these individuals may benefit from brief interventions or treatments. You may choose to provide services to people at risk of depression, anxiety, or risky alcohol or substance use who come close to, but do not meet the criteria for the specific mental health or substance/alcohol abuse problem.

Behavioral health providers can use a variety of instruments for screening and assessment, many of which are part of public domain. These instruments should be supplemented in the first

session (following a positive screen, brief intervention and referral) by a clinical assessment interview that covers current use patterns, history of substance use, consequences of substance abuse, coexisting psychiatric disorders, major medical problems and health status, education and employment status, support mechanisms, client strengths and situational advantages, and family history.

Behavioral health providers who primarily provide brief interventions and brief treatments should be adept at determining the need for referral for assessment and/or treatment. To facilitate this process, grantees are expected to establish a network of relationships so that referrals can be made in a timely manner when the client's needs or goals cannot be met through brief therapy.

Risk of suicide should also be addressed during screening and assessment. Providers should ensure that any system of activities funded through this grant takes appropriate measures to respond to individuals who reveal an elevated suicide risk through their screening, assessment, brief intervention, or therapy.

Brief Intervention or Therapy

Brief Interventions:

Brief interventions are those practices that aim to investigate a potential problem and motivate an individual to begin to do something about his/her substance abuse, anxiety, or depression, either by natural, client-directed means or by seeking additional treatment. A brief intervention may consist of motivational interviewing techniques designed to engage clients in a discussion about their use and their desire to reduce or eliminate substance use.

A brief intervention consists of five basic steps:

1. Introducing the issues in the context of the client's health.
2. Screening, evaluating, and assessing.
3. Providing feedback.
4. Talking about change and setting goals.
5. Summarizing and reaching closure.

Brief interventions will differ based on the problems being addressed. For a person experiencing alcohol use disorder, goals may include identifying patterns of use and intermediate goals for reduction in use and harm. For anxiety and depression, brief interventions may be more focused on psychoeducation, with the goal of educating an individual about anxiety and/or depression and explaining options for addressing the problems faced by the individual.

Brief Treatment

Brief Therapy is a systematic, focused process that relies on assessment, client engagement, and rapid implementation of change strategies. For substance abuse, brief therapies entail structured, motivational interviewing and cognitive-behavioral approaches to behavior change.

Brief therapies usually feature more (as well as longer) sessions than brief interventions. The duration of brief treatment differs by presenting condition. For risky or hazardous substance abuse, brief treatment may range from 5 to 12 sessions of manualized encounters designed to enhance appropriate decision making regarding alcohol and substance use. For mental health problems, the duration of brief treatments is reported to be anywhere from 1 to 40 sessions, with the typical therapy lasting between 6 and 20 sessions. In some cases brief treatments for mental health may be accompanied by pharmacological therapy.

Brief treatments also differ from brief interventions in that their goal is to provide clients with the tools to change basic attitudes and address various underlying problems for mental health patients, and appropriate decision making and behavioral change for those with risky or hazardous alcohol use. For mental health issues, brief treatment differs from longer term treatment in that it focuses more on the present, downplays psychic causality, emphasizes the effective use of therapeutic tools in a shorter time, and focuses on a specific behavioral change rather than large-scale or pervasive change. Assessment is critical not only before beginning brief therapy but also as an ongoing part of the process. Brief treatment may be a spring board for referral and entry into traditional specialty and extensive treatment, if necessary.

Components of effective brief therapy

While there are a variety of different schools of brief therapy available to the clinician, all forms of brief therapy share some common characteristics:

- They are either problem focused or solution focused--they target the symptom, not its causes.
- They clearly define goals related to a specific change or behavior.
- They should be understandable to both client and clinician.
- They should produce immediate results.
- They can be easily influenced by the personality and counseling style of the provider (for mental health and problematic alcohol use).
- They rely on rapid establishment of a strong working relationship between client and therapist
- The therapeutic style is highly active, empathic, and sometimes directive.
- Responsibility for change is placed clearly on the client.
- Early in the process, the focus is to help enhance the client's self-efficacy and understand that change is possible.
- Termination is discussed from the beginning.
- Outcomes are measurable.

For individuals who screen positive, a number of effective, low cost early interventions for depression, anxiety and alcohol disorders are widely available. Individual and group cognitive behavioral interventions have been shown to be effective in ameliorating the early onset of depression and anxiety^{8 9}. Interpersonal Psychotherapy (IPT) has also been shown to effectively

⁸ Munoz, R. F., Ying, Y. W., Bernal, G., Perez-Stable, E.), Sorensen, J. L., Hargreaves, W. A., Miranda, J., & Miller, L. S. (1995). Prevention of

treat depression and anxiety disorders. Antidepressant medications like SSRIs and SNRIs have been shown to be effective in addressing symptoms and early onset of both depression and many of the anxiety disorders¹⁰. In each of these cases cost-effectiveness studies show the interventions to be cost effective under most common clinical scenarios. Care coordination may also be a central part of an effective brief treatment for depression or anxiety.

There is also strong evidence for behavioral and pharmacotherapeutic interventions for substance use disorders. Cognitive Behavioral Therapy (CBT) Motivation Enhancement Therapy and Brief Couples Interventions all have been shown to be effective in treating alcohol and substance abuse problems in multiple randomized controlled evaluations. Medication assisted therapies (e.g., Naltrexone, etc.) also meet the standard for evidence¹¹.

Level 4: Crisis intervention referral and follow up for residents that are suicidal or in extreme psychological distress

In community outreach offered under Level 1, prevention programs offered under Level 2, and screening, assessment, brief intervention, brief treatment and referral to treatment offered under Level 3, it is likely that individuals with behavioral health needs will be identified. For some of these individuals, grant funded services will be sufficient to meet their needs. Others may require more intensive supports or treatment. In these cases, you must develop appropriate procedures to ensure these individuals are connected with the necessary services.

The effectiveness of the referral process to additional specialty treatment will be central to the success of your program. Proactive collaboration between participating agencies and specialty treatment providers is necessary to ensure access to the appropriate level of care. This is especially important for individuals in a state of crisis and those who are at an increased risk for suicide. Grantees must develop established procedures to respond to these individuals. Grant funds may be used to facilitate referral and follow up to specialty services, as well as for immediate crisis response. These referral processes should be coordinated closely and incorporated into your activities under Levels 2 and 3 of this grant.

As you develop your network of participating providers, be sure to include local crisis centers and crisis hotlines. These services should have working relationships with your other agencies so that they are able to appropriately respond when an individual in a state of crisis is identified. First responders should also be provided with training and service coordination to ensure that they can connect to the local behavioral health crisis response infrastructure (this includes law enforcement, emergency medical care, and fire/rescue services).

Note: Longer term treatment for serious substance use or mental health disorders, or disorders outside of the scope presented in Levels 1-3 cannot be paid for through this grant.

depression with primary care patients: A randomized controlled trial. American Journal of Community Psychology, 23, 199-213.

⁹ World Health Organization. (2004). Prevention of Mental Disorders. Geneva, Switzerland

¹⁰ Office of the Surgeon General. (1999). *Mental Health: A Report of the Surgeon General* (ISBN 0-16-050300-0) Washington, DC: U.S. Government Printing Office,

¹¹ Kranzler HR, Gage A. Acamprosate efficacy in alcohol-dependent patients: summary of results from three pivotal trials. Am J Addict. 2008;17:70-76.

Systems and Infrastructure Building

Grantees will be expected to coordinate services through a planned system of referral and intervention. This system will clearly lay out the locations in which services are provided including the co-location of supported services in nontraditional settings. This system should also describe access points at which assessments will be offered including primary care settings, One Stop Career Centers, CHCs, SBHCs, emergency rooms, and community behavioral health providers.

Developing Memoranda of Agreement

You will be required to develop Memoranda of Agreement (MOA) between your local government and behavioral health care providers, One Stop Career Centers, school based health centers (SBHCs), and community health centers (CHCs), primary care providers, emergency rooms, and any other partnering organizations. You must include these MOA in Attachment 1 of your application. These MOA must address the specific roles and responsibilities of each of the participating agencies. They will provide the framework for an integrated service system designed to address increased levels of depression, anxiety and problematic alcohol use that accompany the economic downturn.

In each MOA, One Stop Career Centers, SBHCs, CHCs, primary care providers, and emergency rooms and any other partnering organizations must commit to work with their local government to:

- Provide depression, anxiety, and problematic alcohol use screening through their respective agencies;
- Offer brief interventions for problematic alcohol use, depression, or anxiety at the point of screening whenever possible;
- Cooperate with training related to assessment and referral;
- Participate in referral networks;
- Participate in necessary governance and administrative activities; and
- Provide the necessary data for program assessment.

In addition, a subset of these agencies that are providing evidence-based prevention programs (Level 2), providing brief treatments (Level 3), or crisis counseling (Level 4) must commit in their MOA, as appropriate, to:

- Provide space and support for coordinating services, including support of services located in community settings;
- Provide staff to conduct trainings in other settings (i.e. the local mental health provider may send staff to train job center staff to conduct screening);
- Support the use of evidence-based short term interventions and treatments for anxiety and depression, and problematic alcohol use;
- Support the implementation of evidence-based prevention programs; and

- Support crisis response for individuals in a state of crisis or demonstrating an elevated suicide risk.

The MOA should reflect your proposed project as described in your project narrative and should include the:

- Specific role of each partnering organization in the proposed project, including the intervention model(s) each will be use;
- Specific validated screening tools that each will use;
- Training necessary to implement these screening tools and programs;
- Settings in which screening and interventions will be provided; and
- Plans and procedures for referral in those cases when more serious or different substance abuse or mental health problems are identified, when an individual is in a state of crisis, or when there is an identified suicide risk. These plans should include a system for tracking individuals who have been referred and following up on these referrals.

These activities should be reflected in the MOA you establish with your partners.

Project Phases and Operations

Developing a Coordinated System for Screening, Intervention, and Referral across Grant funded Systems and Services

In your application, include a plan of activities as a part of your response to Section C of the project narrative. This plan will serve as your staff roadmap for implementation. Because **service implementation must begin by the 4th month of the project, at the latest**, it is very important that this plan lay out clear steps for implementation.

Implementation of CRRRI projects will have three phases:

Phase I: Project Planning and Start-Up. This phase is expected to last approximately 4 months. During this time, SAMHSA will work collaboratively with the grantee, project, and Policy Steering Committee members (see Section II-2 below). The start-up tasks to be completed in this phase are, at a minimum:

- Selecting the members of the Policy Steering Committee with representation from the office of the mayor, county executive, or chief executive and primary care settings, CHCs, SBHCs, emergency rooms, the courts, law enforcement, and One Stop employment centers among other collaborative agencies (and subcommittees, if appropriate).
- Developing an organizational structure that involves or enlists the participation of an appropriate array of service providers and funders that represent the full spectrum of community and specialist services required to serve the needs of persons at risk for, or diagnosed with, a Substance Use Disorder (Substance Abuse or Dependence including problematic alcohol use), anxiety, depression or other mental illnesses in the sub-recipient communities.

- Refining the project management, reporting, quality improvement, and cost control mechanisms.
- Refining the needs assessment and survey of existing system gaps and precisely identifying the populations of focus and communities to be served.
- Refining the plan for public outreach, community coordination, and public awareness and education activities under Level 1.
- Refining the plan to provide training and technical assistance, including evidence-based prevention programs under Level 2, information about screening and assessment for problematic alcohol use, depression and anxiety, brief interventions, and appropriate models of evidence-based brief treatments for problematic alcohol use, anxiety and depression under Level 3, and crisis response and referral protocols under Level 4.
- Beginning training necessary to enable staff to implement the components of the plan for your initiative.
- Finalizing all necessary interagency agreements, contracts, subcontracts, billing procedures and fiscal controls, and reporting and monitoring procedures with the agency or agencies in the communities that will deliver services.
- Introducing reporting instruments and obtaining baseline data covering existing levels of service, patient/client needs, program performance characteristics, and training and technical assistance.
- Developing a plan for garnering and sustaining necessary policy changes and resources required to continue the project when Federal support has ended.
- Demonstrating that required resources not included in the Federal budget request are adequate and readily accessible.
- Initiating service delivery in the expanded continuum of care in each sub-recipient community of focus, if required.
- Establishing the mechanism for monitoring performance against targets for: (1) reducing alcohol use and improving mental health outcomes for persons receiving services through the initiative; (2) increasing the number of persons at risk for, or diagnosed with problematic alcohol use, anxiety, or depression who receive treatment in each sub-recipient community; (3) increasing the number of community settings where screening, brief intervention and brief treatment services are provided; and (4) providing treatment services within approved cost parameters for each treatment modality (see Section E and F of the Evaluation Criteria).
- Submitting an acceptable final Project Implementation Plan that includes specific objectives and milestones, implementation timeframes and designation of staff responsible for accomplishing individual program objectives.

Release of funds for project implementation will be contingent on SAMHSA's approval of the Project Implementation Plan finalized during the initial phase and submitted for approval by the end of the third month following award. At the conclusion of Phase I, every component of the project should be fully operational.

Phase II: Operations. This phase is expected to last approximately 3 years and 8 months. During this time, SAMHSA will work collaboratively with the grantee, project staff, other relevant agencies, Policy Steering Committee members, and sub-recipients to implement project management, monitoring and reporting, training, technical assistance to sub-recipients, and service delivery. In Phase II, the grantee will be responsible for these activities:

- Operation of the Policy Steering Committee (and its subcommittees, if appropriate), including regular meetings; monitoring project activities and achievements with regard to the specific objectives and milestones, implementation timeframes, and designation of staff according to the Project Implementation Plan; and communications with the sub-recipients.
- Determining the need for and providing the requisite training and technical assistance needed to achieve project goals.
- Project management, reporting, quality improvement, and cost control.
- Managing the continuation award process to the sub-recipients.
- Accomplishing and tracking systems change (i.e., overcoming funding and other resource barriers, policy changes, improving linkages among specialist and community agencies, providing training and technical assistance, carrying out service delivery in the expanded continuum of care in each sub-recipient target community) and achieving the targets for: (1) reducing alcohol use and improving mental health outcomes for persons receiving services through the initiative; (2) increasing the number of persons at risk for, or diagnosed with problematic alcohol use, anxiety, or depression who receive treatment in each sub-recipient community; (3) increasing the number of community settings where screening, brief intervention and brief treatment services are provided; and (4) providing treatment services within approved cost parameters for each treatment modalities (see Section E and F of the Evaluation Criteria).
- Refining operations as barriers are encountered and lessons are learned through feedback from the monitoring and reporting systems.

Phase III: Phase Out. During the final 4 months of the grant award and concurrently with the final 4 months of Phase II, SAMHSA will work cooperatively with the grantee, project staff, Policy Steering Committee members, and sub-recipients to make the transition from the cooperative agreement to local control and to sustain the system changes achieved by the project.

2.2.1 – Optional Supplement –Treatment and Recovery Services for Drug Court Clients

SAMHSA anticipates that from time to time additional funds may be available to be used as supplements to support and enhance the primary grant activities. An integrated approach that includes criminal justice is a key priority of SAMHSA. To address this issue SAMHSA may provide supplemental awards in FY 2011 to CRR I grantees that apply for an optional supplement not to exceed \$300,000 per grantee for up to 4 years, for a total of up to \$1,200,000 to expand and/or enhance substance abuse treatment services in “problem solving” courts (including Driving While Intoxicated (DWI)/Driving Under the Influence (DUI) Courts, Co-Occurring Drug and Mental Health Courts, and Veterans Courts) which use the treatment drug court model in order to provide alcohol and drug treatment, recovery support services supporting substance abuse treatment, screening, assessment, case management, and program coordination to adult defendants/offenders. Priority for the use of the supplemental funding should be given to addressing gaps in the existing continuum of treatment for this justice-involved, drug court population. Please note that the SAMHSA supplemental funds are not designed to support the planning, implementation or operation of the treatment drug court itself, but to expand or enhance treatment services for clients in drug court dockets. (See Appendix K: Supplement – Treatment and Recovery Services for Drug Court Clients for more information on the drug court model.) As a result, communities must be able to demonstrate that they have an existing drug court infrastructure to connect to these supplemental treatment services.

To receive consideration for the supplemental funding the Project Narrative of your application must include “Section F: Supplement - Treatment and Recovery Services for Drug Court Clients.” In this section you are required to demonstrate the level of substance use or co-occurring disorders services needs, explain your approach for either expanding or enhancing treatment and recovery services for this population, demonstrating the necessary collaborations among key stakeholders in order to provide these services, demonstrating the organizational capabilities to provide the continuum of services, and establishing project outcomes using the CSAT Discretionary Services Client Level GPRA Tool (See Section I-2.4).

The points awarded for “Section F: Supplement - Treatment and Recovery Services for Drug Court Clients” will not be factored into the priority score for the basic CRR I award. Only grantees funded under this CRR I announcement are eligible for supplements for treatment and recovery services for drug court clients. Applicants should be aware that all grantees may not receive supplemental awards.

In order to request supplemental funding for treatment and recovery services for drug court clients the applicant must have an existing misdemeanor or felony drug court in operation for at least one year that serves the population within the defined geographic area being served by CRR I. For the purposes of this solicitation, the term “drug court” includes: Driving While Intoxicated (DWI)/Driving Under the Influence (DUI) Courts, Co-Occurring Drug and Mental Health Courts, Veterans Courts, and Community Courts that serve substance-abusing adults in the respective problem-solving court, as long as the court meets all the elements required for drug courts. (See **Appendix K** for information on the Key Components of a Drug Court.)

Drug Courts which serve the geographical area of government (city, county, etc.) for CRR I that received SAMHA treatment drug court discretionary grant funds in FYs 2008, 2009, or 2010 are not eligible to receive supplemental funding as part of the CRR I grant program. As the purpose

of the supplement is to expand or enhance existing treatment and recovery services supplemental funds may not be used to supplant existing funds designated to paying for substance abuse treatment and recovery services.

EXPECTATIONS:

Grantees will be expected to provide a coordinated, multi-system approach designed to combine the sanctioning power of treatment drug courts with effective treatment services to break the cycle of criminal behavior, alcohol and/or drug use, and incarceration or other penalties.

Treatment Drug Courts use regular appearances of the client before a judge (who is part of, or guided by, a team of relevant professionals) in order to monitor compliance with court ordered conditions and treatment for substance use disorders.

Treatment Drug Courts are problem-solving courts, often used as an alternative to incarceration, that quickly identify offenders with substance use disorders and place them under strict court monitoring and community supervision as well as provide the participant with effective treatment services. They are being created at a high rate with over 2,400 in operation in 2009, but many lack sufficient funding for treatment of substance use disorders. Treatment Drug Courts represent the coordinated efforts of the judiciary, prosecution, defense bar, probation, law enforcement, mental health, social service, and treatment communities to actively intervene and break the cycle of substance use disorders and crime. Stakeholders work together to give individual clients the opportunity to improve their lives, including recovery from substance use disorders, and develop the capacity and skills to become fully-functioning parents, employees and citizens.

Required Activities

Applicants may propose to expand treatment for substance use disorders and recovery support services, to enhance the treatment of substance use disorders and outreach and recovery support services, or to do both.

1) Service Expansion: An applicant may propose to increase access and availability of services to a larger number of clients. Expansion applications should propose to increase the number of clients receiving services as a result of the award. For example, if a treatment facility currently serves 50 persons per year and has a waiting list of 50 persons (but no funding to serve these persons), the applicant may propose to expand service capacity to be able to admit some or all of those persons on the waiting list. Applicants must state clearly in their application the number of additional drug court clients to be served for each year of the proposed grant.

2) Service Enhancement: An applicant may propose to improve the quality and/or intensity of services, for instance, by adding state-of-the-art treatment approaches, or adding a new service to address emerging trends or unmet needs. For example, a project for the treatment of substance use disorders may propose to add a co-occurring treatment intervention to the current treatment protocol for a population being served by the program. Applicants proposing to enhance services must indicate the number of clients who will receive the new enhancement services for each year of the proposed grant.

Although applicants have some flexibility in expanding and/or enhancing treatment for their Treatment Drug Court, there are recognized designs and operational protocols. Applicants are expected to develop a project that is consistent with these designs and protocols. Effective Treatment Drug Courts have several well-defined elements known as the “The Ten Key Components of a Drug Court” that all applicants must address in their application to ensure that these elements are incorporated into their Treatment Drug Court model or approach (See Appendix K). In addition to addressing “The Ten Key Components of a Drug Court”, DWI Court applicants must also address “The Ten Guiding Principles of DWI Courts” (See Appendix K).

Recognizing that Medication-Assisted Treatment (MAT) may be an important part of a comprehensive treatment plan, supplemental awardees may use up to 20% of the annual supplemental grant award to pay for appropriate medication (e.g., Naltrexone, Disulfiram, Acamprosate Calcium, Buprenorphine) when the client has no other source of funds to do so.

Applicants must provide a detailed description of the methods and approaches that will be used to reach the specified population(s) of focus.

Applicants must also provide evidence that the proposed expansion and/or enhancement will address the overall goals and objectives of the project within the grant period.

Applicants must also screen and assess clients for the presence of co-occurring substance use (abuse and dependence) and mental disorders and use the information obtained from screening and assessment to develop appropriate treatment approaches for persons identified as having such co-occurring disorders. For more information on the process of selecting screening instruments to identify co-occurring substance use and mental disorders, go to http://www.coce.samhsa.gov/products/cod_presentations.aspx.

Applicants must demonstrate that they have developed linkages with community-based organizations with experience in providing services to these communities.

Examples of possible community linkages include, but are not limited to:

- primary health care;
- mental health and substance abuse treatment services;
- community-focused educational and preventive efforts;
- private industry-supported work placements for recovering persons;
- faith-based organizational support;
- support for the homeless;
- HIV/AIDS community-based outreach projects;
- opioid treatment programs;
- health education and risk reduction information; and
- access/referral to STD, hepatitis B (including immunization) and C, and TB testing in public health clinics.

Grantees are encouraged to provide HIV rapid preliminary antibody testing as part of their treatment regimen in accordance with state and local requirements. No more than 5% of supplemental grant funds may be used for HIV rapid testing.

2.3 Infrastructure Development (maximum 20% of total grant award)

Although services grant funds must be used primarily for direct services, SAMHSA recognizes that infrastructure changes may be needed to implement the services or improve their effectiveness. You may use no more than 20% of the total services grant award for the following types of infrastructure development, if necessary to support the direct service expansion of the grant project:

- Developing partnerships with other service providers for interagency coordination, network development and service delivery
- Training/workforce development to help credentialed, paraprofessional or other providers in the community identify mental health or substance abuse issues or provide effective services
- Needs assessment
- Strategic planning

2.4 Data Collection and Performance Measurement

All SAMHSA grantees are required to collect and report certain data so that SAMHSA can meet its obligations under the Government Performance and Results Act (GPRA). You must document your ability to collect and report the required data in “Section E: Performance Assessment and Data” of your application. At SAMHSA’s discretion, Grantees will be required to report performance data by using either the Adult Consumer NOMs Tool, which can be found at <https://www.cmhs-gpra.samhsa.gov/index.htm> along with instructions for completing it or through the CSAT Discretionary Services Client Level GPRA Tool, which can be found at <http://www.samhsa.gov/grants/tools.aspx>. Hard copies of the CMHS Adult Consumer NOMs Tool are available in the application kits available by calling the SAMHSA Information Line at 1-877-SAMHSA7 [TDD: 1-800-487-4889]. CMHS anticipates that a revised version of this tool will be available in April, 2010; when available, grantees will be expected to use the revised tool, which will be available through the same Web site. Data will be collected at baseline (i.e., the consumer’s entry into the project), discharge, and every six months for as long as the consumer receives services as part of the grant program. Data are to be entered regularly into either the Transformation Accountability (TRAC) Web system at <https://www.cmhs-gpra.samhsa.gov/index.htm> or the SAIS data system <https://www.samhsa-gpra.samhsa.gov/>. The collection of these data will enable CMHS and SAMHSA to report on the National Outcome Measures (NOMs), which have been defined by SAMHSA as key priority areas relating to mental health.

Grantees will also be required to report performance on infrastructure development and/or prevention and mental health promotion activities. The infrastructure measures are derived from the following domains: policy development; workforce development; financing; organizational restructuring; partnership/collaboration; accountability; types/targets of practices, and cost efficiency. The prevention and mental health promotion measures are derived from the following

domains: awareness; training; knowledge/attitudes/beliefs; screening; outreach; referral, and access. SAMHSA grantees are expected to collect and report data only on those domains that are germane to their program. Final determination of the domain/s will be made collaboratively with SAMHSA after award.

Data will be entered into either the CMHS transformation system or into CSAT's GPRA Data Entry and Reporting System. If the determination is made to use the CMHS Transformation Accountability (TRAC) system, data collected will be entered into the Web-based system TRAC on a quarterly basis at <https://www.cmhs-gpra.samhsa.gov/index.htm> on data collection forms similar to the one in Appendix H. Initial training and ongoing technical assistance on the use of the TRAC system will be provided. If the determination is made to use the CSAT's GPRA Data Entry and Reporting System, data are to be entered into CSAT's GPRA Data Entry and Reporting System via the Internet within 7 business days of the forms being completed. In addition, 80% of the participants must be followed-up. Training and technical assistance on data collection, tracking, and follow-up, as well as data entry, will be provided by CSAT. The collection of these data will enable CSAT to report on the National Outcome Measures (NOMs), which have been defined by SAMHSA as key priority areas relating to substance use.

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

The remainder of this Section (Section 2.4) applies to the supplemental drug court material in "Section F: Treatment and Recovery Services for Drug Court Clients" of your application:

Grantees will be required to report performance on the following performance measures: client's substance use, family and living condition, employment status, social connectedness, access to treatment, retention in treatment, and criminal justice status. This information will be gathered using the data collection tool referenced below. The collection of these data will enable CSAT to report on the National Outcome Measures (NOMs), which have been defined by SAMHSA as key priority areas relating to substance use.

Grantees must collect and report data using the CSAT Discretionary Services Client Level GPRA Tool, which can be found at <http://www.samhsa.gov/grants/tools.aspx>, along with instructions for completing it. Hard copies are available in the application kits available by calling the SAMHSA Health Information Network at 1-877-SAMHSA7 [TDD: 1-800-487-4889].

GPRA data must be collected at baseline (i.e., the client's entry into the project), discharge, and 6 months post baseline. Data are to be entered into CSAT's GPRA Data Entry and Reporting System via the Internet within 7 business days of the forms being completed. In addition, 80% of the participants must be followed-up. Training and technical assistance on data collection, tracking, and follow-up, as well as data entry, will be provided by CSAT. The collection of these data will enable CSAT to report on the National Outcome Measures (NOMs), which have been defined by SAMHSA as key priority areas relating to substance use.

2.5 Performance Assessment

This initiative involves a new approach to addressing the behavioral health effects of economic trends. This approach leverages several evidence based strategies in a novel framework with the intent of creating community level change. As a result it is important for you to work with federally funded evaluation efforts to document and evaluate the effectiveness of these new approaches. In addition to the material described below, participation in qualitative interviews and other efforts to evaluate the process and impact of the initiative will likely be required should you receive funding.

You must periodically review the performance data you report to SAMHSA (as required above). You should use this information to assess your progress and use this information to improve management of your grant project. The assessment should be designed to help you determine whether you are achieving the goals, objectives and outcomes you intend to achieve and whether adjustments need to be made to your project. You will be required to report on your progress achieved, barriers encountered, and efforts to overcome these barriers in a performance assessment report to be submitted at least annually. Additionally, you should include copies of any educational materials, training materials, and summary data reports that have been developed or collected.

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

Outcome Questions:

- What was the effect of the intervention on key outcome goals?
- What program/contextual factors were associated with outcomes?
- What individual factors were associated with outcomes, including race/ethnicity?
- How durable were the effects?

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

Process Questions:

- How closely did implementation match the plan?
- What types of changes were made to the originally proposed plan?
- What led to the changes in the original plan?
- What effect did the changes have on the planned intervention and performance assessment?
- Who provided (program staff) what services (modality, type, intensity, duration), to whom (individual characteristics), in what context (system, community), and at what cost (facilities, personnel, dollars)?
- What strategies were used to maintain fidelity to the evidence-based practice or intervention across providers over time?
- How many individuals were reached through the program?

At a minimum, grantees will be required to report on the following outcomes. (Data should be collected at baseline before the fourth month of your grant, and then annually after that during the grant period):

- Rates of domestic violence (rate of emergency calls for domestic violence/population served)
- Rates of alcohol-related hospitalizations (Rate of hospital admissions for injuries where alcohol is an identified factor)
- Rates of suicide risk (# of calls to regional suicide hotlines, # of ER admissions for attempted suicide/population served)
- Rates of depression (positive depression screenings across community settings)
- Rates of anxiety (positive anxiety screenings across community settings)
- Rates of binge drinking (from school-based or community-based survey)
- Rates of child maltreatment reports (local child welfare data)
- Perceived cohesiveness and sense of connectedness in the community (local survey)
- Knowledgeable about the behavioral health impact of unemployment and economic downturns and other public health messaging through the initiative (local survey)
- Awareness of local behavioral health supports and screening officered through the grant (local survey)

At a minimum, grantees will be required to report on the following program level variables:

- Number of screenings, brief interventions for alcohol, depression or anxiety (and broader substance use issues if you choose to address these) by community settings
- Number of individuals screened positive for alcohol, depression and anxiety (and broader substance use issues if you choose to address these)
- Outcomes for individuals screened at 6 month follow up based on repeat screening for depression, anxiety and problematic alcohol use (and broader substance use issues if you choose to address these).
- Number of families participating in prevention programs
- Number of individuals participating in Job-related support and prevention programs
- Number of collaborations established across various community settings that provide prevention programs, screening, brief interventions and referral to behavioral health services
- Number of collaborations established between behavioral health specialty settings and non-behavioral health settings
- Number of and penetration of media campaigns regarding behavioral health and unemployment, economic recession

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

2.6 Grantee Meetings

You must plan to send a minimum of five people (including the Project Director) to at least one joint grantee meeting in each year of the grant. You must include a detailed budget and narrative for this travel in your budget. At these meetings, grantees will present the progress/results of their projects and Federal staff will provide technical assistance. Each meeting will be 3 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: \$4.2 million

Estimated Number of Awards: Up to 5

Estimated Award Amount: Up to \$1,400,000 per year

Length of Project Period: Up to 4 years

Proposed budgets cannot exceed \$1,400,000 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.

SAMHSA anticipates that from time to time additional funds may be available to be used as supplements to support and enhance the primary grant activities. Supplemental awards will be made based on Section F of your Project Narrative, the score you receive for this section, and other factors relevant to the project. The points awarded for Section F will not be factored into the priority score for the CRRI award.

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 listed below.

Role of Grantee:

- Comply with the terms of the cooperative agreement award as specified in the requirements section of the Notice of Grant Award (NOGA);
- Participate in grantee meetings;
- Accept guidance and respond to requests for data from SAMHSA;
- Participate in post-award activities including TRAC, and provide GPRA data; and
- Implement specified activities, data collection,, reporting requirements and quality control measures;
- Complete required SAMHSA reports; and
- Participate in any SAMHSA approved evaluation activities.

Role of SAMHSA Staff:

- Approve and provide guidance for 4 levels of CRRI activity to ensure accomplishment of the implementation plan;
- Participate in policy and steering committee meetings;
- Review critical project activities for conformity to the goals of the CRRI;
- Review quarterly reports and conduct site visits, as warranted;
- Consult with federally funded technical assistance providers on all phases of the project to ensure accomplishment of the goals of the initiative; and
- Approve data collection plans and institute policies regarding data collection and reporting.

III. ELIGIBILITY INFORMATION

1. ELIGIBLE APPLICANTS

Eligible applicants are mayors' offices or the offices of county executives or Territorial governments, or the highest ranking official and/or the duly authorized official of a federally recognized American Indian/Alaska Native Tribe or tribal organization in communities of high levels of unemployment. Tribal organization means the recognized body of any AI/AN tribe; any legally established organization of American Indians/Alaska Natives which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of American Indians/Alaska Natives in all phases of its activities.

To be eligible, applicants must propose to provide services in a geographic area with at least 60,000 residents, but no more than 100,000 residents. You must identify the geographic area to be served and provide documentation that the population meets these criteria in Attachment 5 of your application.

Eligible applicants must provide evidence that the communities they propose to serve had an unemployment rate of at least 12 %, in February of 2009 and that they had an unemployment rate of less than 10% in December of 2007 based on Local Area Unemployment Statistics from the Bureau of Labor Statistics. You can access this data at <http://www.bls.gov/lau/data.htm>. Follow the links for the one screen data search or the multi screen data search to obtain your local information. You are expected to use the data from the smallest jurisdiction with data available that contains your chosen geographic area and provide these data in Attachment 5 of your application.

As a place-based initiative, the CRRI depends on coordinating services within a defined area and providing sufficient resources to enable community-level change. In order to achieve this level of change, the population of focus has been limited to no more than 100,000 people. The success of the initiative also requires coordination across several systems to implement a multi-level approach. In order for the initiative to be most effective, the community of focus must include a population of at least 60,000 people to ensure that a sufficient infrastructure is in place. States are

not eligible to apply because they do not have the direct connection to the community level that is necessary for this place-based initiative. Non-governmental organizations are not eligible to apply because they do not have the institutional/political authority to coordinate the array of systems and services involved in this initiative.

2. COST SHARING and MATCH REQUIREMENTS

Cost sharing/match is not required in this program.

3. OTHER

3.1 Additional Eligibility Requirements

You must comply with the following requirements, or your application will be screened out and will not be reviewed: use of the PHS 5161-1 application form; application submission requirements in Section IV-3 of this document; and formatting requirements provided in [Appendix A](#) of this document.

3.2 Evidence of Experience and Credentials

SAMHSA believes that only existing, experienced, and appropriately credentialed applicant organizations with demonstrated infrastructure and expertise will be able to provide required services quickly and effectively. You must demonstrate that your selected service providers for evidence-based short term treatments for anxiety and depression and brief interventions for substance abuse/alcohol treatment meet three additional requirements related to the provision of services.

The three requirements are:

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

[Note: The above requirements apply to all service provider organizations. A license from an individual clinician will not be accepted in lieu of a provider organization's license.]

In **Attachment 1** of your application, you must: (1) identify at least one experienced, licensed service provider organization; (2) include a list of all direct service provider organizations that have agreed to participate in the proposed project, including the applicant agency if the applicant is a treatment or prevention service provider organization; and (3) include the Statement of Assurance (provided in Appendix C of this announcement), signed by the authorized representative of the applicant organization identified on the face-page (SF 424 v2) of the application, attesting that the applicant organizations:

- meet the 2-year experience requirement;
- meet any applicable licensing, accreditation, and certification requirements; and
- if the application is within the funding range for grant award, the applicant will provide the Government Project Officer (GPO) with the required documentation within the time specified.

In addition, if, following application review, your application's score is within the funding range, the GPO will call you and request that the following documentation be sent by overnight mail:

- a letter of commitment from every service provider organization that has agreed to participate in the project that specifies the nature of the participation and the service(s) that will be provided;
- official documentation that the applicant organizations has been providing relevant services for a minimum of 2 years before the date of the application in the area(s) in which the services are to be provided; and
- official documentation that all applicant organizations comply with all applicable local (city, county) and State/tribal requirements for licensing, accreditation, and certification or official documentation from the appropriate agency of the applicable State/tribal, county, or other governmental unit that licensing, accreditation, and certification requirements do not exist.

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

IV. APPLICATION AND SUBMISSION INFORMATION

1. ADDRESS TO REQUEST APPLICATION PACKAGE

You may request a complete application kit from the SAMHSA Information Line at 1-877-SAMHSA7 [TDD: 1-800-487-4889].

You also may download the required documents from the SAMHSA Web site at <http://www.samhsa.gov/grants/apply.aspx>.

Additional materials available on this Web site include:

- a grant writing technical assistance manual for potential applicants;
- standard terms and conditions for SAMHSA grants;

- guidelines and policies that relate to SAMHSA grants (e.g., guidelines on cultural competence, consumer and family participation, and evaluation); and
- a list of certifications and assurances referenced in item 21 of the SF 424 v2.

2. CONTENT AND GRANT APPLICATION SUBMISSION

2.1 Application Kit

SAMHSA application kits include the following documents:

- PHS 5161-1 (revised July 2000) – Includes the face page (SF 424 v2), budget forms, assurances, certification, and checklist. You must use the PHS 5161-1. **Applications that are not submitted on the required application form will be screened out and will not be reviewed.**
- Request for Applications (RFA) – Provides a description of the program, specific information about the availability of funds, and instructions for completing the grant application. This document is the RFA. The RFA will be available on the SAMHSA Web site (<http://www.samhsa.gov/grants/index.aspx>) and a synopsis of the RFA is available on the Federal grants Web site (<http://www.Grants.gov>).

You must use all of the above documents in completing your application.

2.2 Required Application Components

Applications must include the required application components (Face Page, Abstract, Table of Contents, Budget Form, Project Narrative and Supporting Documentation, Attachments, Assurances, Certifications, Disclosure of Lobbying Activities, and Checklist).

- **Face Page** – SF 424 v2 is the face page. This form is part of the PHS 5161-1. [Note: Applicants must provide a Dun and Bradstreet (DUNS) number to apply for a grant or cooperative agreement from the Federal Government. SAMHSA applicants are required to provide their DUNS number on the face page of the application. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS number, access the Dun and Bradstreet Web site at <http://www.dunandbradstreet.com> or call 1-866-705-5711. To expedite the process, let Dun and Bradstreet know that you are a public/private nonprofit organization getting ready to submit a Federal grant application.]
- **Abstract** – Your total abstract should not be longer than 35 lines. It should include the project name, population to be served (demographics and clinical characteristics), strategies/interventions, project goals and measurable objectives, including the number of people to be served annually and throughout the lifetime of the project, etc. In the first five lines or less of your abstract, write a summary of your project that can be used, if your project is funded, in publications, reporting to Congress, or press releases.

- **Table of Contents** – Include page numbers for each of the major sections of your application and for each attachment.
- **Budget Form** – Use SF 424A, which is part of the PHS 5161-1. Fill out Sections B, C, and E of the SF 424A. A sample budget and justification is included in Appendix G of this document.
- **Project Narrative and Supporting Documentation** – The Project Narrative describes your project. It consists of Sections A through F. Sections A-F together may not be longer than 37 pages if you are applying for the optional drug court supplement and 30 pages if you are not applying for the optional supplement. If you are not applying for the optional supplement please indicate this under section F (Remember that if your Project Narrative starts on page 5 and ends on page 35, it is 31 pages long, not 30 pages.) More detailed instructions for completing each section of the Project Narrative are provided in “Section V – Application Review Information” of this document.

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

- **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, 4, 5 and 6 combined. There are no page limitations for Attachment 2. Do not use attachments to extend or replace any of the sections of the Project Narrative. Reviewers will not consider them if you do. Please label the attachments as: Attachment 1, Attachment 2, etc.
 - *Attachment 1:* (1) Identification of at least one experienced, licensed service provider organization; (2) a list of all direct service provider organizations that have agreed to participate in the proposed project, including the applicant agency, if it is a treatment or prevention service provider organization; (3) the Statement of Assurance (provided in Appendix C of this announcement) signed by the authorized representative of the applicant organization identified on the face page of the application, that assures SAMHSA that all listed providers meet the 2-year experience requirement, are appropriately licensed, accredited, and certified, and that if the application is within the funding range for an award, the applicant will send the GPO the required documentation within the specified time; (4) letters of intent/support, MOAs.
 - *Attachment 2:* Data Collection Instruments/Interview Protocols
 - *Attachment 3:* Sample Consent Forms
 - *Attachment 4:* Letter to the SSA (if applicable; see Section IV-4 of this document)

- *Attachment 5*: Identification of the community to be served; documentation of an unemployment rate of 12% or higher in February of 2009 and 10% or lower in December of 2007 in that community, and documentation of the population of the community being served
- *Attachment 6*: Quantified Objectives
- **Project/Performance Site Location(s) Form** – This form is part of the PHS 5161-1. The purpose of this form is to collect location information on the site(s) where work funded under this grant announcement will be performed.
- **Assurances** – Non-Construction Programs. You must read the list of assurances provided on the SAMHSA Web site or in the application kit before signing the face page (SF 424 v2) of the application.
- **Certifications** – You must read the list of certifications provided on the SAMHSA Web site or in the application kit before signing the face page (SF 424 v2) of the application.
- **Disclosure of Lobbying Activities** – You must submit Standard Form LLL found in the PHS 5161-1. Federal law prohibits the use of appropriated funds for publicity or propaganda purposes or for the preparation, distribution, or use of the information designed to support or defeat legislation pending before the Congress or State legislatures. This includes “grass roots” lobbying, which consists of appeals to members of the public suggesting that they contact their elected representatives to indicate their support for or opposition to pending legislation or to urge those representatives to vote in a particular way. If no lobbying is to be disclosed, mark N/A on the form.
- **Checklist** – Use the Checklist found in PHS 5161-1. The Checklist ensures that you have obtained the proper signatures, assurances and certifications. If you are submitting a paper application, the Checklist should be the last page.

2.3 Application Formatting Requirements

Please refer to Appendix A, *Checklist for Formatting Requirements and Screenout Criteria for SAMHSA Grant Applications*, for SAMHSA’s basic application formatting requirements. Applications that do not comply with these requirements will be screened out and will not be reviewed.

3. SUBMISSION DATES AND TIMES

Applications are due by close of business on **May 28, 2010**. Hard copy applications are due by 5:00 PM (Eastern Time). Electronic applications are due by 11:59 PM (Eastern Time).

Applications may be shipped using only, Federal Express (FedEx), United Parcel Service (UPS), or the United States Postal Service (USPS).

You will be notified by postal mail that your application has been received.

SAMHSA will not accept or consider any applications that are hand carried or sent by facsimile.

Your application must be received by the application deadline or it will not be considered for review. Please remember that mail sent to Federal facilities undergoes a security screening prior to delivery. You are responsible for ensuring that you submit your application so that it will arrive by the application due date and time.

If an application is mailed to a location or office (including room number) that is not designated for receipt of the application and, as a result, the designated office does not receive your application by the deadline, your application will be considered late and ineligible for review.

SAMHSA accepts electronic submission of applications through <http://www.Grants.gov>. Please refer to Appendix B for “Guidance for Electronic Submission of Applications.” **If you plan to submit electronically through Grants.gov it is very important that you read thoroughly the application information provided on Appendix B “Guidance for Electronic Submission of Applications.”**

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

This grant program is 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. Certain jurisdictions have elected to participate in the EO process and have established State Single Points of Contact (SPOCs). A current listing of SPOCs is included in the application kit and can be downloaded from the Office of Management and Budget (OMB) Web site at http://www.whitehouse.gov/omb/grants_spoc.

- Check the list to determine whether your State participates in this program. You **do not** need to do this if you are an American Indian/Alaska Native Tribe or tribal organization.
- If your State participates, contact your SPOC as early as possible to alert him/her to the prospective application(s) and to receive any necessary instructions on the State’s review process.
- For proposed projects serving more than one State, you are advised to contact the SPOC of each affiliated State.

The SPOC should send any State review process recommendations to the following address within 60 days of the application deadline. **For United States Postal Service:** Crystal Saunders, Director of Grant Review, Office of Program Services, Substance Abuse and Mental Health Services Administration, Room 3-1044, 1 Choke Cherry Road, Rockville, MD **20857**. ATTN: SPOC – Funding Announcement No. SM-10-015. Change the zip code to **20850** if you are using another delivery service.

In addition, if you are a community-based, non-governmental service provider and you are not transmitting your application through the State, you must submit a Public Health System Impact Statement (PHSIS)¹² to the head(s) of appropriate State and local health agencies in the area(s) to be affected no later than the application deadline. The PHSIS is intended to keep State and local health officials informed of proposed health services grant applications submitted by community-based, non-governmental organizations within their jurisdictions. If you are a State or local government or American Indian/Alaska Native Tribe or tribal organization, you are not subject to these requirements.

The PHSIS consists of the following information:

- a copy of the face page of the application (SF 424 v2); and
- a summary of the project, no longer than one page in length, that provides: 1) a description of the population to be served; 2) a summary of the services to be provided; and 3) a description of the coordination planned with appropriate State or local health agencies.

For SAMHSA grants, the appropriate State agencies are the Single State Agencies (SSAs) for substance abuse and mental health. A listing of the SSAs for substance abuse can be found on SAMHSA's Web site at <http://www.samhsa.gov>. A listing of the SSAs for mental health can be found on SAMHSA's Web site at <http://mentalhealth.samhsa.gov/publications/allpubs/SMA01-3509/page4.asp>. If the proposed project falls within the jurisdiction of more than one State, you should notify all representative SSAs.

If applicable, you must include a copy of a letter transmitting the PHSIS to the SSA in **Attachment 4, "Letter to the SSA."** The letter must notify the State that, if it wishes to comment on the proposal, its comments should be sent no later than 60 days after the application deadline to the following address. **For United States Postal Service:** Crystal Saunders, Director of Grant Review, Office of Program Services, Substance Abuse and Mental Health Services Administration, Room 3-1044, 1 Choke Cherry Road, Rockville, MD **20857**. ATTN: SSA – Funding Announcement No. SM-10-015. Change the zip code to **20850** if you are using another delivery service.

In addition:

- Applicants may request that the SSA send them a copy of any State comments.
- The applicant must notify the SSA within 30 days of receipt of an award.

¹² Approved by OMB under control no. 0920-0428; Public reporting burden for the Public Health System Reporting Requirement is estimated to average 10 minutes per response, including the time for copying the face page of SF 424 v2 and the abstract and preparing the letter for mailing. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0920-0428. Send comments regarding this burden to CDC Clearance Officer, 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0428).

5. FUNDING LIMITATIONS/RESTRICTIONS

Cost principles describing allowable and unallowable expenditures for Federal grantees, including SAMHSA grantees, are provided in the following documents, which are available at <http://www.samhsa.gov/grants/management.aspx>:

- Institutions of Higher Education: OMB Circular A-21
- State and Local Governments and federally Recognized Indian Tribal Governments: OMB Circular A-87
- Nonprofit Organizations: OMB Circular A-122
- Hospitals: 45 CFR Part 74, Appendix E

In addition, SAMHSA's CRRI grant recipients must comply with the following funding restrictions:

- No more than 20% of the total grant award may be used for developing the infrastructure necessary for expansion of services.
- No more than 20% of the total grant award may be used for data collection and performance assessment, including incentives for participating in the required data collection follow-up.

SAMHSA grantees must also comply with SAMHSA's standard funding restrictions, which are included in [Appendix F](#).

6. OTHER SUBMISSION REQUIREMENTS

You may submit your application in either electronic or paper format:

Submission of Electronic Applications

SAMHSA accepts electronic submission of applications through <http://www.Grants.gov>. Electronic submission is voluntary. No review points will be added or deducted, regardless of whether you use the electronic or paper format.

To submit an application electronically, you must use the <http://www.Grants.gov> apply site. You will be able to download a copy of the application package from <http://www.Grants.gov>, complete it off-line, and then upload and submit the application via the Grants.gov site. E-mail submissions will not be accepted.

Please refer to Appendix B for detailed instructions on submitting your application electronically.

Submission of Paper Applications

You must submit an original application and 2 copies (including attachments). The original and copies must not be bound. Do not use staples, paper clips, or fasteners. Nothing should be attached, stapled, folded, or pasted.

Send applications to the address below:

For United States Postal Service:

Crystal Saunders, Director of Grant Review
Office of Program Services
Substance Abuse and Mental Health Services Administration
Room 3-1044
1 Choke Cherry Road
Rockville, MD **20857**

Change the zip code to **20850** if you are using another delivery service.

Do not send applications to other agency contacts, as this could delay receipt. Be sure to include “**CRRI-SM-10-015**” in item number 12 on the face page (SF 424 v2) of any paper applications. If you require a phone number for delivery, you may use (240) 276-1199.

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-F 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. **These are to be used instead of the “Program Narrative” instructions found in the PHS 5161-1.**
- The Project Narrative (Sections A-F) together may not be longer than 37 pages if you are applying for the optional drug court supplement and 30 pages if you are not applying for the optional supplement. If you are not applying for the optional supplement please indicate this under section F.
- You must use the five sections/headings listed below in developing your Project Narrative. Be sure to place the required information in the correct section, **or it will not be considered.** Your application will be scored according to how well you address the requirements for each section of the Project Narrative.

- Reviewers will be looking for evidence of cultural competence in each section of the Project Narrative, and will consider how well you address the cultural competence aspects of the evaluation criteria when scoring your application. SAMHSA’s guidelines for cultural competence can be found on the SAMHSA Web site at <http://www.samhsa.gov/grants/apply.aspx> at the bottom of the page under “Resources for Grant Writing.”
- The Supporting Documentation you provide in Sections G-J and Attachments 1-6 will be considered by reviewers in assessing your response, along with the material in 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: Statement of Need (20 points)

- Describe the geographic area to be served and the needs of the population related to problematic alcohol use, depression, anxiety, and behavioral health crisis response. Include demographic information about the population, (e.g., race, ethnicity, age, socioeconomic status, geography) and specify any high-risk groups or populations of special concern (e.g. children, adolescents, older adults, ethnic and racial groups, lower income populations).
- Describe the effects of the economic downturn on the community, including details about the extent of physical, psychological and social problems observed and loss of community infrastructure. Include detail about changes in employment rates, Medicaid enrollment rates for children, levels of homelessness, crime, etc. Place special emphasis on changes that occurred concurrently with the economic downturn, and may be attributed to the economic downturn (Nationally, the recession began in December of 2007, but this may vary by geographic region).
- Provide estimates of how many people will be screened for depression, anxiety, and problematic alcohol use; how many people will be served by brief interventions and brief treatments for problematic alcohol use, anxiety and/or depression; how many people will be referred to additional services related to mental health or substance abuse issues, and how many people will be served by your chosen evidence-based prevention interventions. Also describe the rationale behind these estimates.
- Provide a clearly established baseline for the project that reflects rates of change in unemployment from December of 2007 to February of 2009, and changes in the number of “Discouraged Workers” as defined by the Bureau of Labor Statistics. Documentation of need may come from a variety of qualitative and quantitative sources. The quantitative data could come from local epidemiologic data or trend analyses, State data (e.g., from State Needs Assessments, SAMHSA’s National Survey on Drug Use and Health), and/or national data (e.g., from SAMHSA’s National Survey on Drug Use and Health or from National

Center for Health Statistics/Centers for Disease Control reports). For data sources that are not well known, provide sufficient information on how the data were collected so reviewers can assess the reliability and validity of the data.

- Non-tribal applicants must show that identified needs are consistent with priorities of the State or county that has primary responsibility for the service delivery system. Tribal applicants must provide similar documentation relating to tribal priorities.

Section B: Proposed Evidence-Based Service/Practice (15 points)

- Clearly state the purpose, goals and objectives of your proposed project. Describe how achievement of the goals will address the needs of the populations (e.g., increase access, availability, prevention, outreach, pre-services, and/or intervention) and meet SAMHSA's goal of mediating the negative behavioral health effects of the economic downturn on the population served.
- Identify the evidence-based services/practices that you propose to implement and the source of your information (see Section I-2.1, Using Evidence-Based Practices). Discuss the evidence that shows that this practice is effective with the population you are serving. If the evidence is limited or non-existent for this population, provide other information to support your selection of the interventions for the population you are serving. Provide **this information for your chosen prevention programs in Level 2, and all screening tools used, your models of brief intervention and brief treatment for problematic alcohol use, anxiety, and depression (and broader substance use issues if you decide to address these) in Level 3, and models of crisis response used in Level 4.**
- Identify and describe the SAMHSA Strategic Initiative(s) (See Section I-1) that you propose to address and how you will incorporate these guiding principles in your approach to address this initiative(s).
- Discuss the eligibility criteria you will use to determine who will receive prevention interventions under Level 2 of the initiative.
- Document the evidence that the practices you have chosen are appropriate for the outcomes you want to achieve.
- Identify and justify any modifications or adaptations you will need to make – or have already made – to the proposed practices to meet the goals of your project and why you believe the changes will improve the outcomes.
- Explain why you chose these evidence-based practices over other evidence-based practices. If this is not an evidence-based practice, explain why you chose this intervention over other interventions.
- Describe how the proposed project will address the following issues in the population of focus, while retaining fidelity to the chosen practice:

- Demographics – race, ethnicity, religion, gender, age, geography, and socioeconomic status;
 - Language and literacy;
 - Sexual identity – sexual orientation and gender identity; and
 - Disability.
- Demonstrate how the proposed service(s)/practice(s) will meet your goals and objectives. Provide a logic model that links need, the services or practice to be implemented, and outcomes (see Appendix D for a sample logic model).

Section C: Proposed Implementation Approach (30 points)

- Describe how the proposed activities or practice(s) will be implemented in each of the four (4) levels of the initiative identified in Section I-2.2.
- Provide a realistic timeline for the entire project period (chart or graph) showing key activities, milestones, and responsible staff. [Note: The time line should be part of the Project Narrative. It should not be placed in an attachment.]
- Describe how members of the Policy Steering Committee will be chosen, how many members will be included, and how the applicant will ensure participation across the spectrum of partnering organizations.
- Clearly state the unduplicated number of individuals you propose to serve (annually and over the entire project period) with grant funds, including the types and numbers of services to be provided and anticipated outcomes.
- Describe the infrastructure development and/or mental health prevention/promotion activities that you plan to conduct during the grant project period to support the implementation of the transformative services both during the grant period and after the grant ends. Select the CMHS-TRAC Infrastructure Prevention/Promotion Indicators from Appendix I of this announcement that represent changes you plan to make during the grant period; in **Attachment 6** of your application, provide a table quantifying your objectives (in terms of the numeric phrases that are underlined in Appendix I of this announcement) for each selected indicator during each year of the grant.
- Provide an estimate of the percentage and dollar amount of the grant award that you will spend on each of the following categories during each year of the grant:
 - service provision
 - infrastructure development [can be no more than 20%]
 - technical assistance
 - data collection and performance measurement and assessment
 - grant administration

- Describe how the population served will be identified, recruited, and retained. Using your knowledge of the language, beliefs, norms, values and socioeconomic factors of the population of focus, discuss how the proposed approach addresses these issues in outreaching, engaging and delivering programs to this population, e.g., collaborating with community gatekeepers. Describe specifically how you will include returning veterans.
- For the prevention programs included in Level 2 of this initiative, please describe how individuals will be identified as “at risk” for developing behavioral health problems, and how this information will be used to inform outreach efforts and eligibility criteria to participate in these prevention programs.
- Describe how project planning, implementation and assessment will include input from the population you anticipate serving.
- Describe the settings in which screening for anxiety, depression and problematic alcohol use (and broader substance use issues if you decide to address these) will occur. Discuss the brief interventions and brief treatments that will be offered and the settings in which these treatments will be provided. Provide a detail plan for referrals to treatment providers, when necessary, and how these clients will be tracked and followed up.
- Describe how the project components will be embedded within the existing service delivery system, including other SAMHSA-funded projects, if applicable. Identify any other organizations that will participate in the proposed project, including primary care settings, courts, and law enforcement, CHCs, SBHCs, emergency rooms, and One Stop Career Centers at a minimum. Describe their roles and responsibilities, including specifics around what training they will be receiving or offering, what services they will be providing (including screening), and how they will be participating in data collection and reporting, and project planning and management. Discuss how program services will be coordinated, monitored and assessed across multiple sites. Include letters of intent from community organizations supporting the project in **Attachment 1**.
- In Attachment 1, include MOAs with primary care settings, CHCs, SBHCs, emergency rooms, One Stop Career Centers, courts, law enforcement, and any other partnering organizations. These MOAs must include commitments to participate in screening, training, interventions, data collection and reporting, and project planning and management as described in your application.
- Describe previous work undertaken between primary care settings, CHCs, SBHCs, emergency rooms, One Stop Career Centers and any other partnering organizations and the local government to demonstrate that the relationships necessary to implement the planned project already exist.
- Show that the necessary groundwork (e.g., planning, consensus development, development of MOA, identification of potential facilities) has been completed or is near completion so that the project can be implemented and service delivery can begin as soon as possible and no later than four months after grant award.

- Describe the potential barriers to successful conduct of the proposed project and how you will overcome them.
- Describe your plan to continue the project after the funding period ends. Also describe how program continuity will be maintained when there is a change in the operational environment (e.g., staff turnover, change in project leadership) to ensure stability over time.
- Describe your plans for a community response for individuals in a state of crisis. These plans should include coordination with local or regional crisis centers or hotlines, as well as demonstrate that procedures have been established for responding to individuals identified as at risk for suicide.

Section D: Staff and Organizational Experience (15 points)

- Discuss the capability and experience of the applicant organization and other participating organizations with similar projects and populations, including experience in providing culturally appropriate/competent services. Demonstrate that the applicant organization and other participating organizations have linkages to the population of focus and ties to grassroots/community-based organizations that are rooted in the culture and language of the population of focus.
- Describe your plan for training professionals and paraprofessionals (including team leaders) to implement the program. Discuss who will provide the training, how those needing training will be identified, where the training will take place, and how the success of the training will be assessed.
- Provide a complete list of staff positions for the project, showing the role of each and their level of effort and qualifications. Include the Project Director and other key personnel, such as prevention personnel.
- Discuss how key staff have demonstrated experience in serving the population of focus and are familiar with the culture and language of the population of focus. If the population of focus is multicultural and multilingual, describe how the staff are qualified to serve this population.
- Describe the resources available for the proposed project (e.g., facilities, equipment), and provide evidence that services will be provided in a location that is adequate, accessible, compliant with the Americans with Disabilities Act (ADA), and amenable to the population of focus. If the ADA does not apply to your organization, please explain why.

Section E: Performance Assessment and Data (20 points)

- Document your ability to collect and report on the required performance domains as specified in Section I-2.4 of this RFA. Describe your plan for data collection, management,

analysis and reporting. Specify and justify any additional measures or instruments you plan to use for your grant project.

- Describe how data will be used to manage the project and assure continuous quality improvement, including consideration of disparate outcomes for different racial/ethnic groups. Describe how information related to process and outcomes will be routinely communicated to program staff.
- Describe your plan for conducting the performance assessment as specified in Section I-2.5 of this RFA and document your ability to conduct the assessment.
- Provide a per-person or unit cost of the project to be implemented. You can calculate this figure by: 1) taking the total cost of the project over the lifetime of the grant and subtracting 20% for data and performance assessment; 2) dividing this number by the total unduplicated number of persons to be served.

Section F: Supplement – Treatment and Recovery Services for Drug Court Clients
This section is optional. (100 Points - The score will be used only for supplemental awards for Special Projects.)

- Describe how you will plan, prepare for, and implement the proposed expansion or enhancement of treatment and recovery services for drug court clients.
- You must address how the 10 key components of the treatment drug court model (see Appendix K) are included in your program design. If a particular key element/characteristic of the Treatment Drug Court model is missing, you must provide a justification for not including it. If you are DWI Court applicant, you must address how “The Ten Guiding principles of DWI Courts” (See Appendix K) are included in your program design (see Appendix K).
- Applicants must demonstrate that they have developed linkages with community-based organizations with experience in providing services to these communities.
- Provide a per-person or unit cost of the project to be implemented. You can calculate this figure by: 1) taking the total cost of the project over the lifetime of the drug court supplement and subtracting 20% for data and performance assessment; 2) dividing this number by the total unduplicated number of persons to be served.

Program Costs – the following is considered a reasonable range for Drug Court programs regardless of client treatment modality including residential, outpatient, non-methadone, outpatient, methadone, intensive outpatient, screening/brief treatment, outreach, pretreatment services or peer recovery support services: \$3,000-\$5,000.

- Describe how you will screen and assess clients for the presence of co-occurring substance use (abuse and dependence) and mental disorders and use the information

obtained from the screening and assessment to develop appropriate treatment approaches for the persons identified as having such co-occurring disorders.

- Provide a realistic time line for the entire project period (chart or graph) showing key activities, milestones, and responsible staff. [Note: The time line should be part of the Project Narrative. It should not be placed in an attachment.]
- Clearly state the unduplicated number of individuals you propose to serve (annually and over the entire project period) with grant funds, including the types and numbers of services to be provided and anticipated outcomes.
- Describe how the population of focus will be identified, recruited, and retained. Using your knowledge of the language, beliefs, norms, values and socioeconomic factors of the population of focus, discuss how the proposed approach addresses these issues in outreaching, engaging and delivering programs to this population, e.g., collaborating with community gatekeepers.
- Describe how project planning, implementation and assessment will include client input.
- Describe how the project components will be embedded within the existing service delivery system, including other SAMHSA-funded projects, if applicable. Identify any other collaborating organizations that will participate in the proposed project. Describe their roles and responsibilities and demonstrate their commitment to the project. Specifically, detail how supplemental drug court treatment services will be integrated with the other services provided through the CRRI.
- Show that the necessary groundwork (e.g., planning, consensus development, development of memoranda of agreement, identification of potential facilities) has been completed or is near completion so that the project can be implemented and service delivery can begin as soon as possible and no later than 4 months after grant award. This includes having the necessary drug court infrastructure that will use the supplemental drug court treatment services.
- Describe the potential barriers to successful conduct of the proposed project and how you will overcome them.
- Describe your plan to continue the project after the funding period ends. Also describe how program continuity will be maintained when there is a change in the operational environment (e.g., staff turnover, change in project leadership) to ensure stability over time.
- Discuss the capability and experience of the applicant organization and other collaborating organizations with similar projects and populations. Demonstrate that the applicant organization and other collaborating organizations have linkages to the

population of focus and ties to grassroots/community-based organizations that are rooted in the culture and language of the population of focus.

- Provide a complete list of staff positions for the project, showing the role of each and their level of effort and qualifications. Include the manager of drug court supplement and other key personnel of the drug court supplement including the Evaluator and Clinical Director, and other treatment personnel.
- The identified manager of the drug court supplement must be an employee of the court that receives the grant award.
- Discuss how key staff for the drug court supplement has demonstrated experience in serving the population of focus and are familiar with the culture and language of the population of focus. If the population of focus is multicultural and multilingual, describe how the staff is qualified to serve this population.
- Describe the resources available for the proposed project (e.g., facilities, equipment), and provide evidence that services will be provided in a location that is adequate, accessible, compliant with the Americans with Disabilities Act (ADA), and amenable to the population of focus. If the ADA does not apply to your organization, please explain why.
- Document your ability to collect and report on the required performance domains as specified in Section I-2.4 of this RFA. Describe your plan for data collection, management, analysis and reporting. Specify and justify any additional measures or instruments you plan to use for your grant project.

NOTE: Although the budget for the proposed project is not a scored review criterion, the Review Group will be asked to comment on the appropriateness of the budget after the merits of the application have been considered.

SUPPORTING DOCUMENTATION

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

Section H: Budget Justification, Existing Resources, Other Support. 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. Be sure to show that no more than 20% of the total grant award will be used for infrastructure development, if necessary, and that no more than 20% of the total grant award will be used for data collection and performance assessment. An illustration of a budget and narrative justification is included in Appendix G of this document.

Section I: Biographical Sketches and Job Descriptions.

- Include a biographical sketch for the Project Director and other key positions. Each sketch should be 2 pages or less. If the person has not been hired, include a position description and/or a letter of commitment with a current biographical sketch from the individual.
- Include job descriptions for key personnel. Job descriptions should be no longer than 1 page each.
- Information on what should be included in biographical sketches and job descriptions can be found on page 22, Item 6, in the Program Narrative section of the PHS 5161-1 instruction page, available on the SAMHSA Web site.

Section J: 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 J of your application, using the guidelines provided below.

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 must address the seven elements below. If some are not applicable or relevant to the proposed project, simply state that they are not applicable and indicate why. In addition to addressing these seven elements, read the section that follows entitled Protection of Human Subjects Regulations to determine if the regulations may apply to your project. If so, you are required to describe the process you will follow for obtaining Institutional Review Board (IRB) approval. While we encourage you to keep your responses brief, there are no page limits for this section and no points will be assigned by the Review Committee. Problems with confidentiality, participant protection, and the protection of human subjects identified during peer review of the application must be resolved prior to funding.

1. Protect Clients and Staff from Potential Risks

- Identify and describe any foreseeable physical, medical, psychological, social, and legal risks or potential adverse effects as a result of the project itself or any data collection activity.
- Describe the procedures you will follow to minimize or protect participants against potential risks, **including risks to confidentiality**.
- Identify plans to provide guidance and assistance in the event there are adverse effects to participants.
- Where appropriate, describe alternative treatments and procedures that may be beneficial to the participants. If you choose not to use these other beneficial treatments, provide the reasons for not using them.

2. Fair Selection of Participants

- Describe the population(s) of focus for the proposed project. Include age, gender, and racial/ethnic background and note if the population includes homeless youth, foster children, children of substance abusers, pregnant women, or other targeted groups.
- Explain the reasons for including groups of pregnant women, children, people with mental disabilities, people in institutions, prisoners, and individuals who are likely to be particularly vulnerable to HIV/AIDS.
- Explain the reasons for including or excluding participants.
- Explain how you will recruit and select participants. Identify who will select participants.

3. Absence of Coercion

- Explain if participation in the project is voluntary or required. Identify possible reasons why participation is required, for example, court orders requiring people to participate in a program.
- If you plan to compensate participants, state how participants will be awarded incentives (e.g., money, gifts, etc.). Provide justification that the use of incentives is appropriate, judicious, and conservative and that incentives do not provide an “undue inducement” which removes the voluntary nature of participation. Incentives should be the minimum amount necessary to meet the programmatic and performance assessment goals of the grant. Applicants should determine the minimum amount that is proven effective by consulting with existing local programs and reviewing the relevant literature. In no case may the value of an incentive paid for with SAMHSA discretionary grant funds exceed \$20.
- 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.

5. Privacy and Confidentiality

- Explain how you will ensure privacy and confidentiality. Include who will collect data and how it will be collected.
- Describe:
 - How you will use data collection instruments.
 - Where data will be stored.
 - Who will or will not have access to information.
 - How the identity of participants will be kept private, for example, through the use of a coding system on data records, limiting access to records, or storing identifiers separately from data.

NOTE: If applicable, grantees must agree to maintain the confidentiality of alcohol and drug abuse client records according to the provisions of **Title 42 of the Code of Federal Regulations, Part II.**

6. Adequate Consent Procedures

- List what information will be given to people who participate in the project. Include the type and purpose of their participation. Identify the data that will be collected, how the data will be used and how you will keep the data private.
- State:
 - Whether or not their participation is voluntary.
 - Their right to leave the project at any time without problems.
 - Possible risks from participation in the project.
 - Plans to protect clients from these risks.
- Explain how you will get consent for youth, the elderly, 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. For assistance in determining if your proposed performance assessment meets the criteria in 45 CFR 46, Protection of Human Subjects Regulations, refer to the SAMHSA decision tree on the SAMHSA Web site, under “Applying for a New SAMHSA Grant,” <http://www.samhsa.gov/grants/apply.aspx>.

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 ohrp@osophs.dhhs.gov, or (240) 453-6900. SAMHSA–specific questions should be directed to the program contact listed in Section VII of this announcement.

2. REVIEW AND SELECTION PROCESS

SAMHSA applications are peer-reviewed according to the evaluation criteria listed above. For those programs where the individual award is over \$100,000, applications also must be reviewed by the appropriate National Advisory Council.

Decisions to fund a grant are based on:

- The strengths and weaknesses of the application as identified by peer reviewers and, when applicable, approved by the Center for Mental Health Services’ National Advisory Council;
- Availability of funds; and
- Documented commitment of community partners intent to collaborate in the implementation of the project through either a MOU or letter of intent.

VI. ADMINISTRATION INFORMATION

1. AWARD NOTICES

After your application has been reviewed, you will receive a letter from SAMHSA through postal mail that describes the general results of the review, including the score that your application received.

If you are approved for funding, you will receive an **additional** notice through postal mail, the Notice of Award (NoA), signed by SAMHSA’s Grants Management Officer. The Notice of Award is the sole obligating document that allows you to receive Federal funding for work on the grant project.

If you are not funded, you may re-apply if there is another receipt date for the program.

2. ADMINISTRATIVE AND NATIONAL POLICY REQUIREMENTS

- If your application is funded, you must comply with all terms and conditions of the grant award. SAMHSA’s standard terms and conditions are available on the SAMHSA Web site at <http://www.samhsa.gov/grants/management.aspx>.
- If your application is funded, you must also comply with the administrative requirements outlined in 45 CFR Part 74 or 45 CFR Part 92, as appropriate. For more information see the SAMHSA Web site (<http://www.samhsa.gov/grants/management.aspx>).

- Depending on the nature of the specific funding opportunity and/or your proposed project as identified during review, SAMHSA may negotiate additional terms and conditions with you prior to grant award. These may include, for example:
 - actions required to be in compliance with confidentiality and participant protection/human subjects requirements;
 - requirements relating to additional data collection and reporting;
 - requirements relating to participation in a cross-site evaluation;
 - requirements to address problems identified in review of the application; or
 - revised budget and narrative justification.
- If your application is funded, you will be held accountable for the information provided in the application relating to performance targets. SAMHSA program officials will consider your progress in meeting goals and objectives, as well as your failures and strategies for overcoming them, when making an annual recommendation to continue the grant and the amount of any continuation award. Failure to meet stated goals and objectives may result in suspension or termination of the grant award, or in reduction or withholding of continuation awards.
- Grant funds cannot be used to supplant current funding of existing activities. “Supplant” is defined as replacing funding of a recipient’s existing program with funds from a Federal grant.
- In an effort to improve access to funding opportunities for applicants, SAMHSA is participating in the U.S. Department of Health and Human Services “Survey on Ensuring Equal Opportunity for Applicants.” This survey is included in the application kit for SAMHSA grants and is posted on the SAMHSA Web site at <http://www.samhsa.gov/grants/downloads/SurveyEnsuringEqualOpp.pdf> . You are encouraged to complete the survey and return it, using the instructions provided on the survey form.

3. REPORTING REQUIREMENTS

In addition to the data reporting requirements listed in Section I-2.4, you must comply with the following reporting requirements:

3.1 Progress and Financial Reports

- You will be required to submit quarterly and final progress reports, as well as annual and final financial status reports.
- Because SAMHSA is extremely interested in ensuring that treatment and prevention services can be sustained, your progress reports should explain plans to ensure the sustainability of efforts initiated under this grant.
- If your application is funded, SAMHSA will provide you with guidelines and requirements for these reports at the time of award and at the initial grantee orientation

meeting after award. SAMHSA staff will use the information contained in the reports to determine your progress toward meeting its goals.

3.2 Government Performance and Results Act (GPRA)

The Government Performance and Results Act (GPRA) mandates accountability and performance-based management by Federal agencies. To meet the GPRA requirements, SAMHSA must collect performance data (i.e., “GPRA data”) from grantees. The performance requirements for SAMHSA’s CRRI grant program are described in Section I-2.4 of this document under “Data Collection and Performance Measurement.”

3.3 Publications

If you are funded under this grant program, you are required to notify the Government Project Officer (GPO) and SAMHSA’s Publications Clearance Officer (240-276-2130) of any materials based on the SAMHSA-funded grant project that are accepted for publication.

In addition, SAMHSA requests that grantees:

- Provide the GPO and SAMHSA Publications Clearance Officer with advance copies of publications.
- Include acknowledgment of the SAMHSA grant program as the source of funding for the project.
- Include a disclaimer stating that the views and opinions contained in the publication do not necessarily reflect those of SAMHSA or the U.S. Department of Health and Human Services, and should not be construed as such.

SAMHSA reserves the right to issue a press release about any publication deemed by SAMHSA to contain information of program or policy significance to the substance abuse treatment/substance abuse prevention/mental health services community.

VII. AGENCY CONTACTS

For questions about program issues contact:

Nainan Thomas, M.S.W. LL.B, Ph.D
Center for Mental Health Services
1 Choke Cherry Road
Room 6-1099
Rockville, Maryland 20857
(240) 276-1744
nainan.thomas@samhsa.hhs.gov

For questions on grants management and budget issues contact:

Gwendolyn Simpson
Office of Program Services, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Room 7-1085
Rockville, Maryland 20857
(240) 276-1408
gwendolyn.simpson@samhsa.hhs.gov

Appendix A – Checklist for Formatting Requirements and Screenout Criteria for SAMHSA Grant Applications

SAMHSA's goal is to review all applications submitted for grant funding. However, this goal must be balanced against SAMHSA's obligation to ensure equitable treatment of applications. For this reason, SAMHSA has established certain formatting requirements for its applications. If you do not adhere to these requirements, your application will be screened out and returned to you without review.

Use the PHS 5161-1 application form.

- Applications must be received by the application due date and time, as detailed in Section IV-3 of this grant announcement.
- Information provided must be sufficient for review.
- Text must be legible. Pages must be typed in black ink, single-spaced, using a font of Times New Roman 12, with all margins (left, right, top, bottom) at least one inch each. (For Project Narratives submitted electronically, see separate requirements in Section IV-6 of this announcement under “Submission of Electronic Applications.”)
- To ensure equity among applications, page limits for the Project Narrative cannot be exceeded.
- Paper must be white paper and 8.5 inches by 11.0 inches in size.

To facilitate review of your application, follow these additional guidelines. Failure to adhere to the following guidelines will not, in itself, result in your application being screened out and returned without review. However, the information provided in your application must be sufficient for review. Following these guidelines will help ensure your application is complete, and will help reviewers to consider your application.

- The application components required for SAMHSA applications should be included and submitted in the following order:
 - Face Page (Standard Form 424 v2, which is in PHS 5161-1)
 - Abstract
 - Table of Contents
 - Budget Form (Standard Form 424A, which is in PHS 5161-1)
 - Project Narrative and Supporting Documentation
 - Attachments
 - Project/Performance Site Location(s) Form
 - Disclosure of Lobbying Activities (Standard Form LLL, which is in PHS 5161-1)
 - Checklist (a form in PHS 5161-1)

- Applications should comply with the following requirements:
 - Provisions relating to confidentiality and participant protection specified in Section V-1 of this announcement.
 - Budgetary limitations as specified in Sections I, II, and IV-5 of this announcement.
 - Documentation of nonprofit status as required in the PHS 5161-1.
- Pages should be typed single-spaced in black ink with one column per page. Pages should not have printing on both sides.
- Pages should be numbered consecutively from beginning to end so that information can be located easily during review of the application. The abstract page should be page 1, the table of contents should be page 2, etc. The four pages of Standard form 424 v2 are not to be numbered. Attachments should be labeled and separated from the Project Narrative and budget section, and the pages should be numbered to continue the sequence.
- The page limits for Attachments stated in Section IV-2.2 of this announcement should not be exceeded.
- Send the original application and two copies to the mailing address in Section IV-6 of this document. Please do not use staples, paper clips, and fasteners. Nothing should be attached, stapled, folded, or pasted. Do not use heavy or lightweight paper or any material that cannot be copied using automatic copying machines. Odd-sized and oversized attachments such as posters will not be copied or sent to reviewers. Do not include videotapes, audiotapes, or CD-ROMs.

Appendix B – Guidance for Electronic Submission of Applications

If you would like to submit your application electronically, you may search <http://www.Grants.gov> for the downloadable application package by the funding announcement number (called the opportunity number) or by the Catalogue of Federal Domestic Assistance (CFDA) number. You can find the CFDA number on the first page of the funding announcement.

You must follow the instructions in the User Guide available at the <http://www.Grants.gov> apply site, on the Help page. In addition to the User Guide, you may wish to use the following sources for help:

- By e-mail: support@Grants.gov
- By phone: 1-800-518-4726 (1-800-518-GRANTS). The Grants.gov Contact Center is available 24 hours a day, 7 days a week, excluding Federal holidays.

If this is the first time you have submitted an application through Grants.gov, you must complete three separate registration processes before you can submit your application. Allow at least two weeks (10 business days) for these registration processes, prior to submitting your application. The processes are: 1) DUNS Number registration; 2) Central Contractor Registry (CCR) registration; and 3) Grants.gov registration (Get username and password.). **REMINDER: CCR registration expires each year and must be updated annually.**

Please also allow sufficient time for enter your application into Grants.gov. When you submit your application you will receive a notice that your application is being processed and that you will receive two e-mails from Grants.gov. within the next 24-48 hours. One will confirm receipt of the application in Grants.gov and the other will indicate that the application was either successfully validated by the system (with a tracking number) or rejected due to errors. It will also provide instructions that if you do not receive a receipt confirmation **and** a validation confirmation or a rejection e-mail within 48 hours, you must contact Grants.gov directly. Please note that it is incumbent on the applicant to monitor their application to ensure that it is successfully received and validated by Grants.gov. **If your application is not successfully validated by Grants.gov it will not be forwarded to SAMHSA as the receiving institution.**

It is strongly recommended that you submit your grant application using Microsoft Office 2003 products (e.g., Microsoft Word 2003, Microsoft Excel, etc.). The new Microsoft Vista operating system and Microsoft Word 2007 products are not currently accepted by Grants.gov. If you do not have access to Microsoft Office 2003 products, you may submit PDF files. Directions for creating PDF files can be found on the Grants.gov Web site. Use of file formats other than Microsoft Office or PDF may result in your file being unreadable by our staff.

The Project Narrative must be a separate document in the electronic submission. Formatting requirements for SAMHSA grant applications are described in Appendix A of this announcement. These requirements also apply to applications submitted electronically, with the

following exceptions only for Project Narratives submitted electronically in Microsoft Word. These requirements help ensure the accurate transmission and equitable treatment of applications.

- *Text legibility:* Use a font of Times New Roman 12, line spacing of single space, and all margins (left, right, top, bottom) of at least one inch each. Adhering to these standards will help to ensure the accurate transmission of your document.
- *Amount of space allowed for Project Narrative:* The Project Narrative for an electronic submission may not exceed **37 pages if you are applying for the optional drug court supplement or 30 pages if you are not applying for the optional drug court supplement. If the Project Narrative for an electronic submission exceeds the page limit, the application will be screened out and will not be reviewed.** To determine the number of words in your Project Narrative document in Microsoft Word, select file/properties/statistics.

Keep the Project Narrative as a separate document. Please consolidate all other materials in your application to ensure the fewest possible number of attachments. Be sure to label each file according to its contents, e.g., “Attachments 1-3”, “Attachments 4-5.”

Ensure all pages in your application are numbered consecutively, with the exception of the standard forms in the PHS-5161 application package. **Documents containing scanned images must also contain page numbers to continue the sequence.** Failure to comply with these requirements may affect the successful transmission and consideration of your application.

Applicants are strongly encouraged to submit their applications to Grants.gov early enough to resolve any unanticipated difficulties prior to the deadline. After you electronically submit your application, you will receive an automatic acknowledgement from Grants.gov that contains a Grants.gov tracking number. It is important that you retain this number. **Receipt of the tracking number is the only indication that Grants.gov has successfully received and validated your application. If you do not receive a Grants.gov tracking number, you may want to contact the Grants.gov help desk for assistance.**

If you are submitting any documentation that cannot be submitted electronically, please send a hard copy to the address below. [SAMHSA no longer requires submission of a signed paper original of the face page (SF 424 v2) or the assurances (SF 242B)]. **You must include the Grants.gov tracking number for your application on these documents. The documents must be received at the following address within 5 business days after your electronic submission.** Delays in receipt of these documents may impact the score your application receives or the ability of your application to be funded.

For United States Postal Service:

Crystal Saunders, Director of Grant Review
Office of Program Services
Substance Abuse and Mental Health Services Administration
Room 3-1044

1 Choke Cherry Road
Rockville, MD **20857**
ATTN: Electronic Applications

For other delivery services, change the zip code to 20850.

If you require a phone number for delivery, you may use (240) 276-1199.

Appendix C – Statement of Assurance

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

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

Signature of Authorized Representative

Date

Appendix D – Sample Logic Model

A logic model is a tool to show how your proposed project links the purpose, goals, objectives, and tasks stated with the activities and expected outcomes or “change” and can help to plan, implement, and assess your project. The model also links the purpose, goals, objectives, and activities back into planning and evaluation. A logic model is a *picture* of your project. It graphically shows the activities and progression of the project. It should also describe the relationships among the resources you put in (inputs), what you do (outputs), and what happens or results (outcomes). Your logic model should form a logical chain of “if-then” relationships that enables you to demonstrate how you will get to your desired outcomes with your available resources. Because your logic model requires you to be specific about your intended outputs and outcomes, it can be a valuable resource in assessing the performance of your project by providing you with specific outputs (objectives) and outcomes (goals) that can be measured.

The graphic on the following page provides an example of a logic model that links the inputs to program components, the program components to outputs, and the outputs to outcomes (goals).

Your logic model should be based on a review of your Statement of Need, in which you state the conditions that gave rise to the project with your target group. A properly targeted logic model will show a logical pathway from inputs to intended outcomes, in which the included outcomes address the needs identified in the Statement of Need.

Examples of **Inputs** (resources) depicted in the sample logic model include people (e.g., staff hours, volunteer hours), funds and other resources (e.g., facilities, equipment, community services).

Examples of **Program Components** (activities) depicted in the sample logic model include outreach; intake/assessment (e.g., client interview); treatment planning/treatment by type (e.g., methadone maintenance, weekly 12-step meetings, detoxification, counseling sessions, relapse prevention, crisis intervention); special training (e.g., vocational skills, social skills, nutrition, child care, literacy, tutoring, safer sex practices); other services (e.g., placement in employment, prenatal care, child care, aftercare); and program support (e.g., fundraising, long-range planning, administration, public relations).

Examples of **Outputs** (objectives) depicted in the logic model include waiting list length, waiting list change, client attendance, and client participation; number of clients, including those admitted, terminated, inprogram, graduated and placed; number of sessions per month and per client/month; funds raised; number of volunteer hours/month; and other resources required.

The **Inputs**, **Program Components** and **Outputs** all lead to the **Outcomes** (goals). Examples of Outputs depicted in the logic model include inprogram (e.g., client satisfaction, client retention); and in or postprogram (e.g., reduced drug use-self reports, urine, hair; employment/school progress; psychological status; vocational skills; safer sexual practices; nutritional practices; child care practices; and reduced delinquency/crime).

[Note: The logic model presented is not a required format and SAMHSA does not expect strict adherence to this format. It is presented only as a sample of how you can present a logic model in your application.]

Sample Logic Model

Resources (Inputs)	Program Components (Activities)	Outputs (Objectives)	Outcomes (Goals)
Examples	Examples	Examples	Examples
<p>People</p> <ul style="list-style-type: none"> Staff – hours Volunteer – hours <p>Funds</p> <p>Other resources</p> <ul style="list-style-type: none"> Facilities Equipment Community services 	<p>Outreach</p> <ul style="list-style-type: none"> Intake/Assessment Client Interview <p>Treatment Planning</p> <p style="padding-left: 40px;">Treatment by type:</p> <ul style="list-style-type: none"> Methadone maintenance Weekly 12-step meetings Detoxification Counseling sessions Relapse prevention Crisis intervention <p>Special Training</p> <ul style="list-style-type: none"> Vocational skills Social skills Nutrition Child care Literacy Tutoring Safer sex practices <p>Other Services</p> <ul style="list-style-type: none"> Placement in employment Prenatal care Child care Aftercare <p>Program Support</p> <ul style="list-style-type: none"> Fundraising Long-range planning Administration Public Relations 	<p>Waiting list length</p> <ul style="list-style-type: none"> Waiting list change Client attendance Client participation <p>Number of Clients:</p> <ul style="list-style-type: none"> Admitted Terminated Inprogram Graduated Placed <p>Number of Sessions:</p> <ul style="list-style-type: none"> Per month Per client/month <p>Funds raised</p> <p>Number of volunteer hours/month</p> <p>Other resources required</p>	<p><u>Inprogram:</u></p> <ul style="list-style-type: none"> Client satisfaction Client retention <p><u>In or postprogram:</u></p> <ul style="list-style-type: none"> Reduced drug use – self reports, urine, hair Employment/school progress Psychological status Vocational skills Social skills Safer sexual practices Nutritional practices Child care practices Reduced delinquency/crime

Appendix E – Logic Model Resources

Chen, W.W., Cato, B.M., & Rainford, N. (1998-9). Using a logic model to plan and evaluate a community intervention program: A case study. *International Quarterly of Community Health Education*, 18(4), 449-458.

Edwards, E.D., Seaman, J.R., Drews, J., & Edwards, M.E. (1995). A community approach for Native American drug and alcohol prevention programs: A logic model framework. *Alcoholism Treatment Quarterly*, 13(2), 43-62.

Hernandez, M. & Hodges, S. (2003). *Crafting Logic Models for Systems of Care: Ideas into Action*. [Making children's mental health services successful series, volume 1]. Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute, Department of Child & Family Studies. <http://cfs.fmhi.usf.edu> or phone (813) 974-4651

Hernandez, M. & Hodges, S. (2001). Theory-based accountability. In M. Hernandez & S. Hodges (Eds.), *Developing Outcome Strategies in Children's Mental Health*, pp. 21-40. Baltimore: Brookes.

Julian, D.A. (1997). Utilization of the logic model as a system level planning and evaluation device. *Evaluation and Planning*, 20(3), 251-257.

Julian, D.A., Jones, A., & Deyo, D. (1995). Open systems evaluation and the logic model: Program planning and evaluation tools. *Evaluation and Program Planning*, 18(4), 333-341.

Patton, M.Q. (1997). *Utilization-Focused Evaluation* (3rd Ed.), pp. 19, 22, 241. Thousand Oaks, CA: Sage.

Wholey, J.S., Hatry, H.P., Newcome, K.E. (Eds.) (1994). *Handbook of Practical Program Evaluation*. San Francisco, CA: Jossey-Bass Inc.

W.K. Kellogg Foundation, (2004). *Logic Model Development Guide*. Battle Creek, MI. To receive additional copies of the Logic Model Development Guide, call (800) 819-9997 and request item #1209.

Appendix F – Funding Restrictions

SAMHSA grant funds must be used for purposes supported by the program and may not be used to:

- Pay for any lease beyond the project period.
- Provide services to incarcerated populations (defined as those persons in jail, prison, detention facilities, or in custody where they are not free to move about in the community).
- Pay for the purchase or construction of any building or structure to house any part of the program. (Applicants may request up to \$75,000 for renovations and alterations of existing facilities, if necessary and appropriate to the project.)
- Provide residential or outpatient treatment services when the facility has not yet been acquired, sited, approved, and met all requirements for human habitation and services provision. (Expansion or enhancement of existing residential services is permissible.)
- Pay for housing other than residential mental health and/or substance abuse treatment.
- Provide inpatient treatment or hospital-based detoxification services. Residential services are not considered to be inpatient or hospital-based services.
- Make direct payments to individuals to induce them to enter prevention or treatment services. However, SAMHSA discretionary grant funds may be used for non-clinical support services (e.g., bus tokens, child care) designed to improve access to and retention in prevention and treatment programs.
- Make direct payments to individuals to encourage attendance and/or attainment of prevention or treatment goals. However, SAMHSA discretionary grant funds may be used for non-cash incentives of up to \$20 to encourage attendance and/or attainment of prevention or treatment goals when the incentives are built into the program design and when the incentives are the minimum amount that is deemed necessary to meet program goals. SAMHSA policy allows an individual participant to receive more than one incentive over the course of the program. However, non-cash incentives should be limited to the minimum number of times deemed necessary to achieve program outcomes. A grantee or treatment or prevention provider may also provide up to \$20 cash or equivalent (coupons, bus tokens, gifts, child care, and vouchers) to individuals as incentives to participate in required data collection follow up. This amount may be paid for participation in each required interview.
- Food is generally unallowable unless it's an integral part of a conference grant or program specific, e.g., children's program, residential.

- Pay for pharmacologies for HIV antiretroviral therapy, sexually transmitted diseases (STD)/sexually transmitted illnesses (STI), TB, and hepatitis B and C, or for psychotropic drugs.

SAMHSA will not accept a “research” indirect cost rate. The grantee must use the “other sponsored program rate” or the lowest rate available.

Appendix G – 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: an employee of the applying agency whose work is tied to the application

FEDERAL REQUEST

Position	Name	Annual Salary/Rate	Level of Effort	Cost
Project Director	John Doe	\$64,890	10%	\$ 6,489
Coordinator	To be selected	\$46,276	100%	\$46,276
			TOTAL	\$52,765

JUSTIFICATION: Describe the role and responsibilities of each position.

The Project Director will provide daily oversight of the grant and will be considered a key staff. The coordinator will coordinate project services and project activities, including training, communication and information dissemination. Key staff positions requires prior approval of resume and job description.

FEDERAL REQUEST (enter in Section B column 1 line 6a of form SF424A) **\$52,765**

B. Fringe Benefits: List all components of 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 SF424A) **\$10,896**

C.Travel: Explain need for all travel other than that required by this application. Local travel policies prevail.

FEDERAL REQUEST

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

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

Cost for two staff to attend a grantee meeting in Washington, DC. Local travel is needed to attend local meetings, project activities, and training events. Local travel rate is based on agency's policies and procedures privately owned vehicle (POV) reimbursement rate.

FEDERAL REQUEST (enter in Section B column 1 line 6c of form SF424A) **\$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.

FEDERAL REQUEST – (enter in Section B column 1 line 6d of form SF424A) **\$ 0**

E. Supplies: materials costing less than \$5,000 per unit 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 need and include explanation of how costs were estimated.

Office supplies, copies and postage are needed for general operation of the project. The laptop computer is needed for both project work and presentations. The projector is needed for presentations and workshops. All costs were based on retail values at the time the application was written.

*Provide adequate justification for purchases.

FEDERAL REQUEST – (enter in Section B column 1 line 6e of form SF424A) **\$ 3,796**

F. Contract: A consultant is an individual retained to provide professional advice or services for a fee but usually not as an employee of the organization. The grantee must have policies and procedures governing their use of consultants that are consistently applied among all organization’s agreements.

FEDERAL REQUEST

Name	Service	Rate	Other	Cost
Joan Doe	Training staff	\$150/day	15 days	\$2,250
	Travel	.38/mile	360 miles	\$137
			TOTAL	\$2,387

JUSTIFICATION: Explain the need for each agreement and how they relate to the overall project.

This person will advise staff on ways to increase the number clients and client services. Consultant is expected to make up to 6 trips (each trip a total of 60 miles) to meet with staff and other local and government experts. Mileage rate is based on grantee’s POV reimbursement rate.

FEDERAL REQUEST

Entity	Product/Service	Cost
To Be Announced	Marketing Coordinator \$25/hour x 115 hours	\$2,300
ABC, Inc.	Evaluation \$65/hr x 70 days	\$4,500
	TOTAL	\$6,800

JUSTIFICATION: Explain the need for each agreement and how they relate to the overall project.

The Marketing Coordinator will develop a marketing plan to include public education and outreach efforts to engage clients of the community about grantee activities, provision of presentations at public meetings and community events to stakeholders, community civic organizations, churches, agencies, family groups and schools. Information disseminated by written or oral communication, electronic resources, etc. A local evaluator will be contracted to produce the outcomes and report input of GPRA data.

FEDERAL REQUEST – (enter in Section B column 1 line 6f of form SF424A) **\$ 9,187**
(combine the total of consultant and contact)

G. Construction: NOT ALLOWED – Leave Section B columns 1&2 line 6g on SF424A blank.

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

FEDERAL REQUEST

Item	Rate	Cost
Rent*	\$15/sq.ft x 700 sq. feet	\$10,500
Telephone	\$100/mo. x 12 mo.	\$1,200
Client Incentives	\$10/client follow up x 278 clients	\$2,784
Brochures	.89/brochure X 1500 brochures	\$1,335
	TOTAL	\$15,819

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

Office space is included in the indirect cost rate agreement; however other rental costs are necessary for the project as well as telephone service to operate the project. The rent is calculated by square footage and reflects SAMHSA’s share of the space. The monthly telephone costs reflect the % of effort for the personnel listed in this application for the SAMHSA project only. Survey copyright requires the purchase of the ATOD surveys. Brochures will be used at various community functions (health fairs and exhibits).

*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 since mortgage costs are unallowable.

FEDERAL REQUEST – (enter in Section B column 1 line 6h of form SF424A) **\$ 15,819**

Indirect cost rate: Indirect costs can only 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: samhsa.gov then click on Grants – Grants Management – HHS Division of Cost Allocation – Regional Offices.

FEDERAL REQUEST (enter in Section B column 1 line 6j of form SF424A)
 8% of personnel and fringe (.08 x \$63,661) **\$5,093**

BUDGET SUMMARY: (identical to SF-424A)

Category	Federal Request
Personnel	\$52,765
Fringe	\$10,896
Travel	\$2,444
Equipment	0
Supplies	\$3,796
Contractual	\$9,187
Other	\$15,819
Total Direct Costs*	\$94,907
Indirect Costs	\$5,093
Total Project Costs	\$100,000

*** TOTAL DIRECT COSTS:**

FEDERAL REQUEST – (enter in Section B column 1 line 6i of form SF424A) \$94,907

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

FEDERAL REQUEST (enter in Section B column 1 line 6k of form SF424A) \$100,000

¹ FFY QUARTER 1 (10/1– 12/31); FFY QUARTER 2 (1/1– 3/31); FFY QUARTER 3 (4/1– 6/30); FFY QUARTER 4 (7/1– 9/30)

Appendix I - CMHS-TRAC Infrastructure and Mental Health Prevention/Promotion Categories and Indicators

TRAC Infrastructure CATEGORIES AND INDICATORS

POLICY DEVELOPMENT (PD)

PD1. A policy change completed as a result of the grant

PD2. The number of organizations or communities that demonstrate improved readiness to change their systems in order to implement specific mental health-related practices

WORKFORCE DEVELOPMENT (WD)

WD1. The number of organizations or communities implementing mental health-related training programs as a result of the grant

WD2. The number of people in the mental health and related workforce trained in specific mental health-related practices/activities as a result of the grant

WD3. The number of people credentialed/certified to provide specific mental health-related practices/activities as a result of the grant

WD4. A change made to a credentialing and licensing policy in order to incorporate expertise needed to improve mental health-related practices/activities as a result of the grant

WD5. The number of consumers/family members who provide mental health-related services as a result of the grant

FINANCING (F)

F1. The amount of funding for mental health-related practices/activities as a result of the grant

F2. A change to a financing policy to fund and/or improve mental health-related practices/activities as a result of the grant

F3. The amount of pooled/blended or braided funding with other organizations used for mental health-related practices/activities as a result of the grant

ORGANIZATIONAL CHANGE (OC)

OC1. An organizational change made to support improvement of mental health-related practices/activities as a result of the grant

TRAC Prevention and Promotion CATEGORIES AND INDICATORS

AWARENESS (AW)

AW1. The number of individuals exposed to mental health awareness messages

TRAINING (TR)

TR1. The number of individuals who have received training in prevention or mental health promotion

KNOWLEDGE/ATTITUDES/BELIEFS (NAB)

NAB1. The number and percentage of individuals who have demonstrated improvement in knowledge/attitudes/beliefs related to prevention and/or mental health promotion

SCREENING (S)

S1. The number of individuals screened for mental health or related interventions

OUTREACH (O)

O1. The number of individuals contacted through program outreach efforts

O2. The total number of contacts made through program outreach efforts

REFERRAL (R)

R1. The number of individuals referred to mental health or related services

ACCESS (AC)

AC1. The number and percentage of individuals receiving mental health or related services after referral

Appendix K – Supplement – Treatment and Recovery Services for Drug Court Clients

Drug courts integrate alcohol and other drug treatment services with justice system case processing. The mission of drug courts is to stop the abuse of alcohol and other drugs and related criminal activity. Drug courts promote recovery through a coordinated response to offenders dependent on alcohol and other drugs. Realization of these goals requires a team approach, including cooperation and collaboration of the judges, prosecutors, defense counsel, probation authorities, other corrections personnel, law enforcement, pretrial services agencies, TASC programs, evaluators, an array of local service providers, and the greater community. State-level organizations representing AOD issues, law enforcement and criminal justice, vocational rehabilitation, education, and housing also have important roles to play. The combined energies of these individuals and organizations can assist and encourage defendants to accept help that could change their lives.

Applicants must explain how the program will adhere to “The 10 Key cComponents of a Drug Court”. For specific information about the Ten Key Components of Drug Courts, please visit the following site at the National Association of Drug Court Professionals/National Drug Court Institute: <http://www.ndci.org/publications/ten-key-componets>. In addition to addressing “The Ten Key Components of a Drug Court”, DWI Court applicants must also address “The Ten Guiding Principles of DWI Courts”. For more information on DWI Courts, go to <http://www.dwicourts.org/learn/about-dwi-courts/-guiding-principles>.