

*The following is a summary of the information published in the Federal Register on April 27, 2001, regarding PA 00-002, Community Action Grants for Service Systems Change (Short Title: CSAT Action Grant Program).*

**AGENCY:** Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA), DHHS

**ACTION:** Change in eligibility *and* a special funding opportunity under SAMHSA/CSAT Action Grant Program (PA 00-002)

**CHANGE IN ELIGIBILITY:** This notice is to inform the public that the eligibility requirements in the SAMHSA/CSAT program announcement, PA 00-002, Community Action Grants for Service Systems Change (Short Title: CSAT Action Grant Program) are being changed. Effective May 11, 2001, for-profit entities will not be eligible applicants under this program. On October 17, 2000, Public Law 106-310 reauthorized SAMHSA Section 509 of the law authorized CSAT, through the Secretary, DHHS, to carry out activities described in the section directly or through grants or cooperative agreements with States, political subdivisions of States, Indian tribes and tribal organizations, and other public or nonprofit private entities. For-profit entities are **excluded** under section 509; therefore, for-profit entities are no longer eligible to apply for grants under PA 00-002. Applications received prior to May 11, 2001, are not affected by this change.

PA 00-002, CSAT Action Grant Program, was published in the Federal Register on February 17, 2000 (Vol. 65, Number 33, pages 8184-8186).

**SPECIAL FUNDING OPPORTUNITY:** Subject to the availability of funds, an additional \$500,000 will be allocated to PA 00-002, CSAT Action Grant Program, to support exemplary practice models for rural communities experiencing problems with addiction to heroin or prescription opiates such as OxyContin or hydrocodone. Proposed projects are intended to help treatment providers, including physicians, hospitals, community health centers and community mental health centers adopt exemplary practice models for opioid agonist treatment (OAT) into their communities. These exemplary practices will be targeted at delivering medication assisted therapy (with opioid agonists) to rural populations where previous access to OAT services has been limited or nonexistent. Projects should be prepared to provide leadership in developing consensus among key stakeholders in the State and local community(ies) toward the goal of developing OAT services to meet the unique needs of the community, and to address new and emerging treatment needs related to the increased availability of heroin or prescribed opioid medications, such as OxyContin or hydrocodone, which are being diverted for illicit use.

Applications for this special funding related to exemplary practice models for OAT will be accepted under the **special one-time receipt date of September 10, 2001, only**. It is anticipated that 5 grants will be awarded. Applications under the standing CSAT Community Action Grant program must be submitted for the standing January 10 receipt date.

Applicants must follow the eligibility criteria (except, as noted above, for profit entities are not eligible) and guidelines for preparing and submitting an application presented in the complete program announcement (PA 00-002). The complete announcement and application materials are available through the SAMHSA web site—[www.samhsa.gov](http://www.samhsa.gov) or from the National Clearinghouse for Alcohol and Drug Information (telephone 800-729-6686).

Additional information about exemplary practice models for OAT may be obtained from:

Mike Bacon  
Office of Pharmacologic and Alternative Therapies  
Center for Substance Abuse Treatment, SAMHSA  
Tele: 301-443-7749

General questions related to program announcement PA 00-002 should be directed to:

Jim Herrell, Ph.D.  
Division of Practice and Systems Development  
Center for Substance Abuse Treatment, SAMHSA  
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Potential applicants under this SAMHSA/CSAT initiative should be aware that this program could be updated and reannounced in the *Federal Register* within the next year.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PUBLIC HEALTH SERVICE

**SUBSTANCE ABUSE AND MENTAL HEALTH  
SERVICES ADMINISTRATION**

CENTER FOR SUBSTANCE ABUSE TREATMENT

***COMMUNITY ACTION GRANTS FOR SERVICE SYSTEMS CHANGE***

SHORT TITLE: **CSAT Action Grant Program**

**Program Announcement (PA) No. PA 00-002  
Part I - Programmatic Guidance**

Catalog of Federal Domestic Assistance (CFDA) No. 93.230

Under the authority of Section 501(d)(5) of the Public Health Service Act, as amended (42 U.S.C. 290aa), and subject to the availability of funds, the SAMHSA Center for Substance Abuse Treatment will accept applications in response to this Program Announcement for the initial receipt date of May 17,2000.

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Date of Issuance: February 2000

**Part I - PROGRAMMATIC GUIDANCE**  
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[Note to Applicants: In order to prepare an application, PART II, "General Policies and Procedures Applicable to all SAMHSA Applications for Discretionary Grants and Cooperative Agreements" (February 1999 edition), must be used in conjunction with this document, PART I, "Programmatic Guidance."]

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## Section I - OVERVIEW

### Purpose

The Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT) announces the availability of grant funds to support the adoption of specific exemplary practices related to the delivery or organization of services or supports into their systems of care for adolescents and adults seeking treatment for alcohol and/or other drug use problems, including women and their children.

This program, hereinafter referred to as "CSAT Action Grant Program," solicits applications to stimulate activities by communities that will result in adoption of specific exemplary service delivery practices that yield the best results for these target populations. This Program Announcement (PA) is a reissuance (with minor revisions) of prior Guidance for Applicants (GFA) by the same title, "CSAT Action Grant Program" GFA No. TI 99-003.

### Eligibility

Applications for grants will be accepted from public and domestic private entities. Public entities include State and local government agencies, and federally designated Indian tribes and tribal organizations. Private entities include those organized as not-for-profits and those organized as for-profits. Such organizations include, but are not necessarily limited to, those responsible for service delivery policy, those representing consumers and families, those providing services to the target population, and those responsible for training and accrediting service providers.

### Availability of Funds

It is estimated that \$1,350,000 will be available to support approximately 10 awards under this PA in FY 2000. The average award is expected to range from \$50,000 to \$150,000 in total costs (direct+indirect). Actual funding levels will depend upon the availability of appropriated funds.

Grant funds may be used for any activity that is a part of the consensus building and decision-support process. **Note: Grant funds may not be used to support direct services.**

## Period of Support

CSAT Action Grant projects will be funded for 1 year.

## **Section II - PROGRAM DESCRIPTION**

### Supporting Documentation

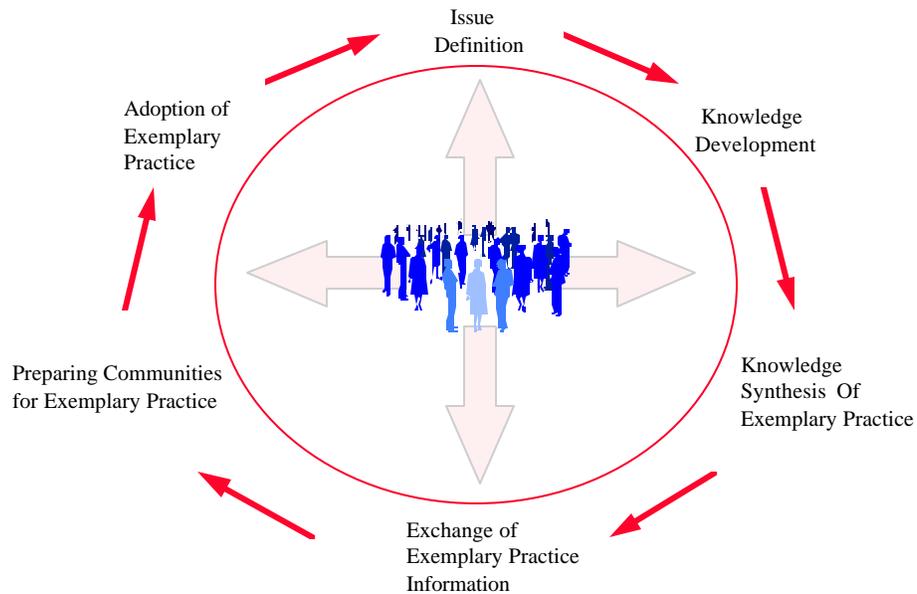
SAMHSA seeks to promote the adoption of exemplary practices in communities nationwide. This CSAT Action Grant Program builds on and supplements past and present agency efforts to promote the exchange of information about exemplary practices, and to help communities make and implement their own decisions designed to improve service delivery in systems of care. The CSAT Action Grant Program is intended to stimulate the adoption of exemplary practices through convening partners, building consensus, and aiding in eliminating barriers, that will result in the adaptation of service models to meet local needs. The term exemplary practice connotes that the proposed practice has a reliable record of improving outcomes for those receiving the service. A proven outcome-based record of success will be a prerequisite to Federal support for adoption of a proposed exemplary practice. Grants will not support direct funding of service delivery.

The Program is designed to encourage communities to identify and build consensus around exemplary service delivery practices that meet their own needs, and that meet criteria identified herein for defining what constitutes an exemplary practice. For purposes of this program, exemplary practices are limited to those that involve service delivery or the organization of services or supports. Proposed exemplary practices should be limited to practices which are consistent with the concept of "systems of care" as defined herein.

The Program is one of several that is designed within the conceptual framework of SAMHSA's Knowledge Development and Application (KD&A) mission. One aspect of the KD&A mission is to influence service systems change beneficial to persons with substance abuse problems. The mission is premised on the fundamental proposition that well-integrated, barrier-free, individual-oriented, family-centered services systems are more effective and less costly for persons with serious substance abuse problems than are fragmented service programs that are often only available where those in most need cannot access them. The KD&A process seeks to stimulate positive service system change that increases positive outcomes for consumers, and their families, as effectively and efficiently as

possible. This process involves several phases in a continuum that begins with field identification of knowledge development priorities, moves through research and evaluation, into dissemination and adoption of best practices in the field. Research and evaluation questions are driven by community needs, rather than by investigator interests. Knowledge gained becomes the subject of active discussion and analysis by decision makers and other key stakeholders. The process is successfully concluded when the knowledge developed about an exemplary practice is actually adopted by a community. Aggressive and sustained effort throughout the life of KD&A activity is the essence of SAMHSA's KD&A program. The KD&A Life Cycle looks like this:

## The KDA Life Cycle



In this context, the CSAT Action Grant Program sits at the left - the application (i.e., Adoption of Exemplary Practice) end - of the KD&A Life Cycle.

## Consensus Building for Systems Change

The behavioral sciences fields have generated a great deal of information that suggests the appropriateness of this step-by-step consensus building approach to improving services delivery. A body of literature has evolved that addresses techniques and processes that can be employed to achieve agreement, make decisions, and adapt social policy to community practice. Lessons include:

- ! providing education and technical assistance, direct engagement of community leaders, families and consumers and other stakeholders, and creation of shared expectations and commitments all serve to stimulate positive systems change;
- ! decisions built on consensus will be more widely supported and more likely to be sustained;
- ! strategies at the community level that take advantage of the strengths and opportunities that exist in those communities are more likely to produce positive system change; and
- ! evaluation of change processes in order to identify methods that work best in particular environments will aid in their replication in other communities.

Strategies for creating and sustaining community coalitions and other partnerships have been devised and studied in fields including education (Kochhar & Erickson, 1993; Tushnet, 1993), mental health (Center for Improving Mental Health Systems, 1995) and others (AHEC/Community Partners, 1995; Mattessich & Monsey, 1992; Schneider, 1994). Frequently, the success of such collaborative efforts hinges on their ability to empower disenfranchised groups in the community, and to deal positively with cultural diversity (Kavanaugh, 1995). Such efforts are especially effective in assessing and enhancing readiness for change in a community (Backer, 1995a), an essential ingredient for systems change.

Government agencies, foundations, and corporations are finding value in focusing on exemplary practices that are state of the art in service delivery, or in administration. Approaches to identifying exemplary practices have been developed in fields such as education, health care, and business (Backer, 1995b; Klein, 1993a,b; Powers, 1995). Exemplary practice information systems to identify, code, store, retrieve, and share this kind of information have been studied by management researchers; some of the best systems are computer aided (Goodman & Darr, 1996). Lessons learned in this diverse environment can be translated into the substance abuse

field.

It has been demonstrated that once an exemplary practice is identified, its acceptance, adoption and sustained success in a community require careful attention to: (1) how is the decision to adopt communicated to all stakeholders; (2) what is the evaluative evidence to support the practice's value, as well as to address any possible downside; (3) what financial, human and other resources are needed in order to achieve effective adoption; and (4) how will the complex human dynamics of change be adequately dealt with. Many years of behavioral and management science research address these four factors for success (Agency for Health Care Policy and Research, 1992; Backer, 1993; Backer, David & Soucy, 1995; Rogers, 1995; Backer, Kuchnel & Liberman, 1986; Sechrest, et al, 1992).

Success or failure in implementing any exemplary practice depends in part, on the larger context of systems change in which the process occurs (Backer, 1995c;). Such processes can be assessed using standard methods of technology transfer evaluation (Backer, Brown & Howard, 1994; Kiresuk, 1993).

This knowledge base forms the foundation applicants should consider in developing their proposals to execute action grants in their communities.

### Target Population

There are two subgroups in the target population. A project may focus on both of them, but CSAT anticipates that it generally will make sense to limit a project to only one. The subgroups are: a) adolescents with alcohol and/or illicit drug abuse problems; and b) adults with alcohol and/or illicit drug abuse problems, including women and their children affected by substance abuse. It is recognized that many individuals who are in these categories suffer from, or are at risk of, HIV infection, co-occurring disorders, homelessness, and/or physical or cognitive disabilities. Adolescents transitioning into adulthood often "fall through the cracks" in service systems, and it is the intent here to include them, where appropriate, in the adolescent subgroup population.

Note: If the program intentionally excludes any one of the populations mentioned in the SAMHSA Population Inclusion Requirement Policy, other than those programs which are specifically targeted to a particular group by design, then a justification for the exclusion must be included.

### Program Plan

## **Goal**

The goal of the CSAT Action Grant Program is to promote adoption by communities of exemplary practices in the delivery of substance abuse treatment services. Successful implementation of exemplary practices results in improved outcomes for the target population.

It is understood that adoption of exemplary practices involves more than consensus building and decisions to act. Projects under this Program will obtain a decision by developing consensus among key stakeholders to adopt an exemplary practice in substance abuse treatment services that is best for and needed in the target community. A plan for implementing the adapted practice must also be developed. Grantees and other applicants who can show that they have already developed the necessary consensus and implementation plans will be eligible to apply for additional support to aid in the actual implementation of an exemplary practice. This second phase of the grant program will be implemented if practices are, in fact, put into place in the target community and funds are available.

## **Design**

The CSAT Action Grant Program is comprised of two types of grants:

Phase I: Preparation for adoption of an exemplary practice

Phase II: Implementation of the exemplary practice

This PA describes only Phase I grant application requirements. Based on experience with projects funded under this PA, and depending upon the availability of funds, the CSAT may issue one or more revised and expanded PAs/GFAs to cover either Phase II grants only, or both Phase I and Phase II grants.

## **PROJECT SUPPORT ACTIVITIES**

The following are examples of potential activities that may be supported project funds:

- ! education/training and technical assistance regarding: understanding and awareness of the proposed exemplary practice(s), the pros and cons for adopting the practice(s), the mechanics of the consensus building processes, and models for technology transfer and application;
- ! education and training regarding organizational and change dynamics; dissemination of information to the community-at-large; expert consultation on substance abuse issues and treatment;

- ! consultation on the accommodation of any processes that may result in the passing of local and/or state legislation essential for the adoption and support of an exemplary practice;
- ! convening and direct facilitation of the consensus building and decision support process;
- ! expert consultation on community needs assessment, service modeling and adapting exemplary practices to unique community requirements;
- ! travel and other logistical costs necessary to ensure attendance and participation by consumers, family members and others needing financial assistance;
- ! consultation and training for consumers, family members and others concerning project goals, objectives and processes within the project;
- ! evaluation of the consensus building process and outcomes.

**Note: Grant funds may not be used to support direct services.**

### **Section III - PROJECT REQUIREMENTS**

**Project Summary:** In 5 lines or fewer, 72 characters per line, applicants must provide a summary for later use in publications, reporting to Congress, press releases, etc., should the application be funded. This must be the first 5 lines of the Project Abstract.

All applicants must provide the information specified below under the proper section heading. The information requested relates to the individual review criteria in Section IV of the PA.

#### **A. Review of Exemplary Practices (Level I)**

##### Description of Proposed Exemplary Practice(s)

The application must contain a concise description of the specific exemplary practice proposed for implementation and the target population for the practice. Applicants must ensure that the exemplary practice proposed meets the following criteria that define what constitute an exemplary practice:

- (1) it has been validated as an exemplary practice by one or more of the following means:

- ! formal evaluation or research as evidenced by the availability of

peer-reviewed empirical findings;

- ! meta-analytic results on a body of investigation demonstrating effectiveness;
  - ! evidence of significant consensus among experts, including evaluator policy-makers, providers, consumers, and families;
- (2) it has been used and replicated in a different geographic area by a different service provider organization; and
- (3) it has been fully documented.

In addressing the definition of exemplary practices, the application should address each of the following criteria for qualifying a practice as exemplary:

- ! A detailed discussion of the basis for claiming that the proposed practice is exemplary, specifying the means of validation. It should address both the empirical evidence supporting the proposed practice and the extent of consensus among experts on the subject. Particular attention should be given to describing why the practice is exemplary for the target population and the circumstances that exist in that community.
- ! A description of the previous replication (s) including descriptions of the communities where the practice has been replicated.
- ! A detailed discussion that describes and defends the basis for claiming that the exemplary practice has been fully documented.

**B. Technical Merit (Level II)**

1. Project Impact/Feasibility

Applicants should describe in detail the significance of implementing the proposed exemplary practice to the community and the evidence that the expected results are likely to occur if the grant is awarded. Specifically, the applicant should include the following information:

- ! Describe the extent to which key stakeholders indicate support for the project. All key stakeholders, including consumers and families, should be identified and their place in the decision-making explained. A key element of a successful application will be that it assures that key decision-makers are willing to engage in discussion and make commitments including the

possibility of resources. (Letters and documents should be included in Appendix 1, Letters of Coordination and Support.)

- ! Describe the potential barriers to project implementation and methods to overcome them. Issues (delivery system's policy and human resource needs, alternate funding sources, State legislation, systems, provider and consumer "readiness" status) currently blocking implementation of the "exemplary-practice" should be identified, described, and accompanied by a discussion of how the proposed project will overcome the barriers and result in the adoption of the exemplary practice.
- ! Describe how the proposed adaptations meet community needs. The anticipated changes or adaptations to the exemplary practice should convey how the balance between preserving the exemplary characteristics of the practice and accommodating local needs will be achieved.
- ! Describe the anticipated impact of the proposed exemplary practice on the target population.

## 2. Project Approach/Plans

Applicants must submit a work plan that describes the processes and milestones for developing agreement to implement an exemplary practice. The following information should be included:

- ! A description of the objectives of the project and how they will be achieved.
- ! Identification of the elements for systems change in the proposed exemplary practice and the methodology for adaption to local needs.
- ! A description of the applicant's understanding of alcohol and substance abuse issues related to the target population.
- ! A description of the process for identifying and convening key stakeholders and expert resources; for providing necessary orientation, training and consultation for the participants.
- ! A description of the proposed consensus building and decision support methodology and an explanation how implementation of this methodology will result in decisions to adopt the practice.
- ! A detailed description of the steps to ensure consumer and family involvement in the decision-making process.

- ! A description of the age, cultural, language, gender issues as they relate to the proposed exemplary practice.
- ! A description of the extent to which individuals representative of the target population are involved in the conception and planned implementation of the project.

### 3. Evaluation, Design, and Analysis Plan

Applicants should clearly define the consensus building and decision-support process that will be utilized to measure the results of the program. (An individual project will be successful if a decision to adopt the proposed practice is made).

Each project will need to include an evaluation of the project by an experienced, objective evaluator. The evaluation will need to document the implementation of the project and identify factors that contributed to the success or failure of the project's implementation, especially in regard to the appropriateness for the specific target population. There should also be frequent discussions with stakeholders on the evaluation design and findings and on the progress that is being made in their decisions to act towards adopting the exemplary practice.

Evaluation designs should ensure the best possible assessment of the intervention and include:

- ! A detailed description of the plan to conduct an evaluation that will document implementation of the project.
- ! A description of the design to evaluate the consensus building among key stakeholders as part of the decision support process.
- ! A description of the qualitative and quantitative data which will be collected, the instruments to be used, any adaptations/modification to instruments for special populations, the schedule for data collection, who will collect the data, and how it will be analyzed.
- ! A description of the plan to collect information and data on project implementation.
- ! A description of plans to provide feedback from the evaluation to the participants.
- ! A detailed description to ensure how projects plan to comply

with the Government Performance and Results Act (GPRA) requirement (see Appendix C for a more detailed description of CSAT's GPRA strategy).

For Quarterly Reporting purposes the following activities should be reported:

- 1) Number of consensus building events (e.g., committee meetings, meetings with stakeholder, etc);
- 2) Percentage of stakeholders satisfied with these consensus building events;
- 3) Percentage of stakeholders that report using information from these consensus building events.

4. Project Management: Implementation Plan, Organization, Staff, Equipment/Facilities, and Other Support.

Project management should include the following:

- ! A description of the qualifications and experience of the project director, evaluator staff and other key personnel with respect to building consensus for change.
- ! A description of the qualifications and appropriateness of key personnel with respect to the diversity of the project's population/community and attention to cultural, language, and gender issues.
- ! A description of the capability and experience of the applicant organization with similar projects and populations.
- ! A description of the relevant experiences, capability and commitment of proposed collaborators, consultants, and subcontractors with evidence of commitment documented to the extent required and described in Part II of the PA. Letters should be attached in Appendix No. 1 - "Letters of Coordination and Support."
- ! A description of the project management plan including timelines and staffing patterns (e.g., rationale for percent of time for key personnel and consultants).
- ! A description of the relevant resources available (e.g., computer facilities).

## Post Award Requirements

Grantees will be required to attend (and, thus, must budget for) a 3- day National Grantee meeting to be held within the first few months of the award. A minimum of two persons (Program Director and the Program Evaluator) are expected to attend. For budget purposes, applicants should plan that this meeting will be held in the Washington, D.C., area.

Evaluation results must be included in each required interim and final report. CSAT program staff will use this information in determining whether or not a particular grantee has reached a decision to implement the proposed exemplary practice (i.e., was successful).

## **Section IV - REVIEW of APPLICATIONS**

### **Guidelines**

Applications submitted in response to this PA will be reviewed for scientific/technical merit in accordance with established PHS/SAMHSA review procedures outlined in the Review Process section of Part II. Applicants must review the Special Considerations/Requirements and Application Procedures sections that follow, as well as the guidance provided in Part II, before completing the application.

The IRG review will be conducted with two levels of review. At Level One, the IRG will limit its review to an evaluation of the extent to which the exemplary practice meets the specified criteria noted in the PA for exemplary practices. Only those applications that pass the Level One review will receive further review.

For the IRG Level Two review, the reviewers will be asked to assign scores only to those applications that passed Level One review, and which they consider to have sufficient technical merit for program staff to consider for funding.

Applications that proceed to Level Two will be reviewed and evaluated according to the review criteria that follow. The points noted for each criterion indicate the maximum number of points the reviewers may assign that criterion if the application is considered to have sufficient merit for scoring. **The bulleted statements that follow each review criterion do not have weights.** The assigned points will be used to calculate a raw score that will be converted to the official priority score.

**The review criteria below correspond to Section III above to assist in the**

application process. Reviewers will assess responses to each review criterion on the basis of the information provided in Section III by the applicants. Therefore it is important for applicants to follow carefully the outline, headings, and subheadings when providing the requested information.

Peer reviewers will be instructed to review and evaluate each relevant criterion in relation to cultural competence. Points will be deducted for applications that do not adequately address the cultural aspects of the criteria. (See Appendix D in Part II, for guidelines that will be used to assess cultural competence.)

## **Review Criteria**

### **A. Level One: Review Of The Exemplary Practice**

The following three criteria will be used for the Level One review. The maximum possible points are noted for each. All applications must score a minimum of 5 points per criterion and at least 70 points total within Level One to be eligible for further review at Level Two.

1. The extent to which the practice has been validated as exemplary in community settings (45 points).
2. The extent of evidence that the practice has been successfully replicated (25 points).
3. The extent to which the practice is fully documented (30 points).

### **B. Level Two: Technical Merit Review**

The following criteria will be included in the Level Two scientific/technical merit review of applications.

#### **1. Project Impact and Feasibility (35 points):**

- ! The evidence of the extent to which key stakeholders indicate support for the project.
- ! The extent to which potential barriers and methods for overcoming them for successful adoption of the exemplary practice are described.
- ! The degree to which the proposed project and possible adaptations meet community needs.

! The extent of the anticipated impact of the proposed exemplary practice on the target population.

2. Project Approach and Plans (40 points):

! The extent to which the objectives of the project are achievable and realistic.

! The extent to which the project plan identifies the elements of systems change in the proposed practice, and includes the methodology for adaptation to local needs.

! The extent to which the project plan demonstrates an understanding of the alcohol and substance abuse issues related to the target population.

! The appropriateness of the plan for identifying and convening key stakeholders and expert resources; for providing necessary orientation, training, and consultation for the participants.

! The feasibility of the proposed consensus building plan and the appropriateness of the decision support methodology.

! The extent of consumer and family involvement in the decision-making process.

! The extent to which the project plan addresses age, cultural, language, and gender issues in the proposed exemplary practice(s).

! The extent to which the application demonstrates the involvement of representatives of the target population in the conception and planned implementation of the project.

3. Evaluation, Design, and Analysis Plan (10 points):

! The appropriateness of the plan to conduct an evaluation to document the implementation of the project.

! The appropriateness of the design to assess consensus building among key stakeholders.

! The appropriateness of evaluation measures selection; that is, validity and reliability of existing measures selected or strategies for obtaining validity and reliability of measures to be developed, and their appropriateness for the target population.

- ! The appropriateness of the plan to collect information and data on project implementation.
  - ! The appropriateness of the plan to provide feedback from the evaluation to the participants.
  - ! The extent to which the proposed project can supply the necessary agency GPRA outcomes measures.
4. Project Management: Implementation Plan, Organization, Staff, Equipment/Facilities, and Other Support (15 points):
- ! The qualifications and experience of the project director, evaluator and other key personnel.
  - ! The extent to which the staffing plan reflects appropriate attention to the diversity of the population/community to be served, including culture, language, and gender issues.
  - ! The capability and experience of the applicant organization with similar projects and populations.
  - ! The capability, experience, and evidence of commitment of proposed collaborators, consultants and subcontractors.
  - ! The adequacy of the description of the project management plan including timelines and staffing patterns.
  - ! The extent to which the applicant and collaborators commit available and relevant resources to the project (e.g., computer facilities).

NOTE: Although the reasonableness and appropriateness of the proposed budget for the proposed project are not review criteria for this PA, the Initial Review Group will be asked to consider these after the merits of the application have been considered.

## **Section V. SPECIAL CONSIDERATIONS/REQUIREMENTS**

SAMHSA's policies and special considerations/requirements related to this program include:

- o Population Inclusion Requirement
- o Government Performance Monitoring
- o Healthy People 2000 (The Healthy People 2000 priority areas related this program are Alcohol and Other Drugs)

- o Consumer Bill of Rights and Responsibilities
- o Promoting Nonuse of Tobacco
- o Letter of Intent
- o Coordination with Other Federal/Non-Federal Programs (include documentation in Appendix 1)
- o Single State Agency Coordination (include documentation in Appendix 2)
- o Intergovernmental Review (E.O. 12372)
- o Confidentiality/SAMHSA Participant Protection. The SAMHSA CSAT Director has determined that projects funded under this program must meet SAMHSA Participant Protection requirements.

Specific guidance and requirements for the application related to these policies and special considerations/requirements can be found in Part II the section by the same name.

## **Section VI - APPLICATION PROCEDURES**

All applicants must use application form PHS 5161-1 (Rev. 6/99), which contains Standard Form 424 (face page). The following must be typed in Item Number 10 on the face page of the application form:

### ***PA 00-002 CSAT Action Grant Program***

For more specific information on where to obtain application materials and guidelines, see the Application Procedures section in Part II. Completed applications must be sent to the following address.

SAMHSA Programs  
 Center for Scientific Review  
 National Institutes of Health  
 Suite 1040  
 6701 Rockledge Drive MSC-7710  
 Bethesda, MD 20892-7710\*

\*Applicants who wish to use express mail or courier service should change the zip code to 20817.

Complete application kits for this program may be obtained from the National Clearinghouse for Alcohol and Drug Information (NCADI), phone number: 800-729-6686. The address for NCADI is provided in Part II.

## **APPLICATION RECEIPT AND REVIEW SCHEDULE**

The initial schedule for receipt and review of applications under this PA is as follows:

<u>Receipt Date</u>	<u>IRG Review</u>	<u>Council Review</u>	<u>Earliest Start Date</u>
May 17, 2000	July 2000	Sept. 2000	Sept. 2000

Thereafter, applications will be received and reviewed annually according to the following schedule:

<u>Receipt Date</u>	<u>IRG Review</u>	<u>Council Review</u>	<u>Earliest Start Date</u>
Jan 10	May/June	September	Dec. 1

Applications must be received by the above receipt dates to be accepted for review. An application received after the deadline may be acceptable if it carries a legible proof-of-mailing date assigned by the carrier and the proof-of-mailing date is not later than 1 week prior to the deadline date. Private metered postmarks are not acceptable as proof of timely mailing. (NOTE: These instructions replace the "Late Applications" instructions found in the PHS 5161-1.) If the receipt date falls on a weekend, it will be extended to Monday; if the date falls on a holiday, it will be extended to the following work day.

Applicants are advised that one or more of the above receipt dates may be withdrawn, depending on the availability of funds. The SAMHSA Center for Substance Abuse Treatment will annually publish in the Federal Register a Notice of Funding Availability (NOFA) and a statement of the applicable receipt dates for this program. Applicants are strongly encouraged to verify receipt dates and terms of funding before preparing a submitting applications.

### **CONSEQUENCES OF LATE SUBMISSION**

Applications received after the specified receipt dates will be returned to the applicant without review.

### **APPLICATION REQUIREMENTS/COMPONENT CHECK LIST**

All applicants must use the Public Health Service (PHS) Grant Application form 5161-1 (Rev. 6/99) and follow the requirements and guidelines for developing an application presented in Part I Programmatic Guidance and Part II General Policies and Procedures Applicable to all SAMHSA Applications for Discretionary Grants and Cooperative Agreements.

The application should provide a comprehensive framework and description of all aspects of the proposed project. It should be written in a manner that

is self-explanatory to reviewers unfamiliar with the prior related activities of the applicant. It should be succinct and well organized, should use section labels that match those provided in the table of contents for the Program Narrative that follows, and must contain all the information necessary for reviewers to understand the proposed project.

To ensure that sufficient information is included for the technical merit review of the application, the Programmatic Narrative section of application must address, but is not limited to, issues raised in the sections of this document entitled:

1. Program Description
2. Project Requirements
3. Review of Applications

Note: It is requested that on a separate sheet of paper the name, title, and organization affiliation of the individual who is primarily responsible for writing the application be provided. Providing this information is voluntary and will in no way be used to influence the acceptance or review of the application. When submitting the information, please insert the completed sheet behind the application face page.

A **COMPLETE** application consists of the following components **IN THE ORDER SPECIFIED BELOW**. A description of each of these components can be found in Part II.

\_\_\_\_\_FACE PAGE FOR THE PHS 5161-1 (Standard Form 424 - See Appendix A in Part II for instructions.)

\_\_\_\_\_OPTIONAL INFORMATION ON APPLICATION WRITER (See note above)

\_\_\_\_\_ABSTRACT (not to exceed 35 lines)

\_\_\_\_\_TABLE OF CONTENTS (include page numbers for each of the major sections of the Program Narrative, as well as for each appendix)

\_\_\_\_\_BUDGET FORM (Standard Form 424A - See Appendix B in Part II for instructions.)

\_\_\_\_\_PROGRAM NARRATIVE (The information requested for sections A and B of the Program Narrative is discussed in the subsections with the same title in Section III - Project Requirements, and Section IV - Review of Applications. **Sections A and B may not exceed 25 single-spaced pages. Applications exceeding these page limits will not be accepted for review and will be returned to the applicant.**)

- A. Description of Exemplary Practice (Level I)
- B. Technical Merit (Level II)
  - \_\_\_\_\_1. Project Impact/Feasibility
  - \_\_\_\_\_2. Project Approach/Plans
  - \_\_\_\_\_3. Evaluation Design and Analysis Plan
  - \_\_\_\_\_4. Project Management: Implementation Plan, Organization

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**There are no page limits for the following sections except as noted in Biographical Sketches/Job Descriptions.**

\_\_\_\_\_C. Literature Citations (This section must contain complete citations, including titles and all authors, for literature cited in the application.)

\_\_\_\_\_D. Budget Justification/Existing Resources/Other Support

\_\_\_\_\_Sections B, C, and E of the Standard Form 424A must be filled out according the instructions in Part II, Appendix B.

\_\_\_\_\_A line item budget and specific justification in narrative form for the first project year's direct costs AND for each future year must be provided. For contractual costs, provide a similar yearly breakdown and justification for ALL costs (including overhead or indirect costs.

\_\_\_\_\_All other resources needed to accomplish the project for the life of the grant (e.g., staff, funds, equipment, office space) and evidence that the project will have access to these, either through the grant or, as appropriate, through other resources, must be specified.

Other Support ("Other Support" refers to all current or pending support related to this application. Applicant organizations are reminded of the necessity to provide full and reliable information regarding "other support," i.e., all Federal and non-Federal active or pending support. Applicants should be cognizant that serious consequences could result if failure to provide complete and accurate information is construed as misleading to the PHS and could, therefore, lead to delay in the processing of the application. In signing the face page of the application, the authorized representative of the applicant organization certifies that the application information is accurate and complete.

For your organization and key organizations that are collaborating with you in this proposed project, list all currently active support and any applications/proposals pending review or funding that relate to the project. If there are none, state "none." For all active and pending support listed, also provide the following information:

1. Source of support (including identifying number and title)
2. Dates of entire project period.
3. Annual direct costs supported/requested.
4. Brief description of the project.
5. Whether project overlaps, duplicates, or is being supplemented by the present application; delineate and justify the nature and extent of any programmatic and/or budgetary overlaps.

\_\_\_\_\_E. Biographical Sketches/Job Descriptions

A biographical sketch must be included for the project director and for other key positions. Each of the biographical sketches must not exceed **2 pages** in length. In the event that a biographical sketch is included for an individual not yet hired, a letter of commitment from that person must be included with his/her biographical sketch. Job descriptions for key personnel must not exceed **1 page** in length. The suggested contents for biographical sketches and job descriptions are listed in Item 6 in the Program Narrative section of the PHS 5161-1.

\_\_\_\_\_F. Confidentiality/SAMHSA Participant Protection

The information provided in this section will be used to determine whether the level of protection of participants appears adequate or whether further provisions are needed, according to SAMHSA Participant Protection (SPP) standards. Adequate protection of participants is an essential part of an application and will be considered in funding decisions.

Projects proposed under this announcement may expose participants to risks in as many ways as projects can differ from each other. Following are some examples, but they do not exhaust the possibilities. Applicants should report in this section any foreseeable risks for project participants, and the procedures developed to protect participants from those risks, as set forth below. Applicants should discuss how each element will be addressed or why it does not apply to the project.

Note: So that the adequacy of plans to address protection of participants, confidentiality, and other ethical concerns can be evaluated, the information requested below, which may appear in other sections of the narrative, should be included in this section of the application as well.

1. Protection from Potential Risks:

- (a) Identify and describe any foreseeable physical, medical, psychological, social, legal, or other risks or adverse effects besides the confidentiality issues addressed below, which are

due either to participation in the project itself, or to the evaluation activities.

(b) Where appropriate, describe alternative treatments and procedures that might be advantageous to the subjects and the rationale for their nonuse.

(c) Describe the procedures that will be followed to minimize or protect participants against potential risks, including risks to confidentiality.

(d) Where appropriate, specify plans to provide needed professional intervention in the event of adverse effects to participants.

2. Equitable selection of participants:

Target population(s):

Describe the sociodemographic characteristics of the target population(s) for the proposed project, including age, gender, racial/ethnic composition, and other distinguishing characteristics (e.g., homeless youth, foster children, children of substance abusers, pregnant women, institutionalized individuals, or other special population groups).

Recruitment and Selection:

(a) Specify the criteria for inclusion or exclusion of participants and explain the rationale for these criteria.

(b) Explain the rationale for the use of special classes of subjects, such as pregnant women, children, institutionalized mentally disabled, prisoners, or others who are likely to be vulnerable.

(c) Summarize the recruitment and selection procedures, including the circumstances under which participation will be sought and who will seek it.

3. Absence of Coercion:

(a) Explain whether participation in the project is voluntary or mandatory. Identify any potentially coercive elements that may be present (e.g., court orders mandating individuals to participate in a particular intervention or treatment program).

(b) If participants are paid or awarded gifts for involvement, explain the remuneration process.

(c) Clarify how it will be explained to volunteer participants that their involvement in the study is not related to services and the remuneration will be given even if they do not complete the study.

4. Appropriate Data Collection:

(a) Identify from whom data will be collected (e.g., participants themselves, family members, teachers, others) and by what means or sources (e.g., school records, personal interviews, written questionnaires, psychological assessment instruments, observation).

(b) Identify the form of specimens (e.g., urine, blood), records, or data. Indicate whether the material or data will be obtained specifically for evaluative/research purposes or whether use will be made of existing specimens, records, or data. Also, where appropriate, describe the provisions for monitoring the data to ensure the safety of subjects.

(c) Provide in Appendix No. 3, entitled "Data Collection Instruments/Interview Protocols," copies of all available data collection instruments and interview protocols that will be used or proposed to be used in the case of cooperative agreements.

5. Privacy and Confidentiality:

Specify the procedures that will be implemented to ensure privacy and confidentiality, including by whom and how data will be collected, procedures for administration of data collection instruments, where data will be stored, who will/will not have access to information, and how the identity of participants will be safeguarded (e.g., through the use of a coding system on data records; limiting access to records; storing identifiers separately from data).

Note: If applicable, grantees must agree to maintain the confidentiality of alcohol and drug abuse client records in accordance with the provisions of Title 42 of the Code of Federal Regulations, Part 2 (42 CFR, Part 2).

6. Adequate Consent Procedures:

(a) Specify what information will be provided to participants

regarding the nature and purpose of their participation; the voluntary nature of their participation; their right to withdraw from the project at any time, without prejudice; anticipated use of data; procedures for maintaining confidentiality of the data; potential risks; and procedures that will be implemented to protect participants against these risks.

(b) Explain how consent will be appropriately secured for youth, elderly, low literacy and/or for those whose English is not their first language.

Note: If the project poses potential physical, medical, psychological, legal, social, or other risks, awardees may be required to obtain written informed consent.

(c) Indicate whether it is planned to obtain informed consent from participants and/or their parents or legal guardians, and describe the method of documenting consent. For example: Are consent forms read to individuals? Are prospective participants questioned to ensure they understand the forms? Are they given copies of what they sign?

Copies of sample (blank) consent forms should be included in Appendix No. 4, entitled "Sample Consent Forms." If appropriate, provide English translations.

Note: In obtaining consent, no wording should be used that implies that the participant waives or appears to waive any legal rights, is not free to terminate involvement with the project, or releases the institution or its agents from liability for negligence.

(d) Indicate whether separate consents will be obtained for different stages or aspects of the project, and whether consent for the collection of evaluative data will be required for participation in the project itself. For example, will separate consent be obtained for the collection of evaluation data in addition to the consent obtained for participation in the intervention, treatment, or services project itself? Will individuals not consenting to the collection of individually identifiable data for evaluative purposes be permitted to participate in the project?

7. Risk/Benefit Discussion:

Discuss why the risks to subjects are reasonable in relation to the anticipated benefits to subjects and in relation to the

importance of the knowledge that may reasonably be expected to result.

\_\_\_\_ APPENDICES (Only the appendices specified below may be included in t application. **These appendices must not be used to extend or replace any the required sections of the Program Narrative.** The total number of page in the appendices **CANNOT EXCEED 30 PAGES**, excluding all instruments.)

- \_\_\_\_ Appendix 1: Letters of Coordination/Support. . . . .
- \_\_\_\_ Appendix 2: Copy of Letter(s) to SSA(s) . . . . .
- \_\_\_\_ Appendix 3: Data Collection Instruments/Interview Protocols..... . . . .
- \_\_\_\_ Appendix 4: Sample Consent Forms . . . . .

\_\_\_\_ ASSURANCES NON-CONSTRUCTION PROGRAMS (STANDARD FORM 424B)

\_\_\_\_ CERTIFICATIONS

\_\_\_\_ DISCLOSURE OF LOBBYING ACTIVITIES

\_\_\_\_ CHECKLIST PAGE (See Appendix C in Part II for instructions)

**TERMS AND CONDITIONS OF SUPPORT**

For specific guidelines on terms and conditions of support, allowable ite of expenditure and alterations and renovations, applicants must refer to the sections in Part II by the same names. In addition, in accepting the award the Grantee agrees to provide SAMHSA with GPRA Client Outcome and Evaluation Data.

Reporting Requirements

For the SAMHSA policy and requirements related to reporting, applicants must refer to the Reporting Requirements section in Part II.

Lobbying Prohibitions

SAMHSA's policy on lobbying prohibitions is applicable to this program; therefore, applicants must refer to the section in Part II by the same name.

**AWARD DECISION CRITERIA**

Applications will be considered for funding on the basis of their overall technical merit as determined through the IRG and the CSAT National Advisory Council review process.

Other award criteria may include:

- C Availability of funds;
- C Overall program balance in terms of geography (including rural/urban areas), race/ethnicity of proposed project population, and project size;
- C Balance among projects in terms of types of exemplary practices;
- C Overall program balance in terms of target sub-groups, (i.e., adolescents and adults, including women and their children).

### **CONTACTS FOR ADDITIONAL INFORMATION**

Questions concerning program issues may be directed to:

Jane Ruiz  
Treatment and Systems Improvement Branch  
Division of Practice and Systems Development  
Center for Substance Abuse Treatment  
Substance Abuse and Mental Health Services Administration  
Rockwall II, Suite 740  
5600 Fishers Lane  
Rockville, MD 20857  
(301) 443-8802

Questions regarding grants management issues may be directed to:

Peggy Jones  
Grants Management Officer  
Division of Grants Management, OPS  
Substance Abuse and Mental Health Services Administration  
Rockwall II, 6th Floor  
5600 Fishers Lane  
Rockville, Maryland 20857  
(301) 443-9666

## **APPENDIX A. DEFINITIONS**

Consensus is agreement among all key stakeholders that the exemplary practice can and should be implemented. Consensus must be in sufficient detail that it resolves all critical issues and represents a commitment to adopt the practice within a certain timetable. Consensus must also address the issue of the sustainability of the practice into the future once it is adopted.

Exemplary Practice Implementation is the incorporation of an exemplary practice into a system of care, including funding and maintenance of the practice supported by permanent funding sources.

Co-occurring Disorders means the simultaneous existence of a substance abuse disorder and a non-substance abuse DSM IV Axis I or II mental disorder; and the mental disorder is of a type and severity that exacerbates the substance abuse disorder and/or complicates treatment of the substance abuse disorder.

Permanent Funding Sources are State and local (City and County) governmental appropriations and private funding sources such as foundations, charitable organizations, private non-profits, lending institutions, and private individuals.

Key Stakeholders are all those entities and individuals whose approval and support are needed in order for an exemplary practice to be implemented and sustained. They include, but are not necessarily limited to, consumers of substance abuse treatment services, families of consumers, advocates for consumers and families, elected and appointed policy makers, service system managers, service providers, and other systems such as legal, educational, welfare, and social services.

State is any of the 50 states of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the Northern Mariana Islands, American Samoa and the Trust Territory of the Pacific Islands.

A System of Care meets these six criteria: (1) it is comprehensive - it provides directly or through referral for all needed services; (2) it is community based - it reflects the values of the community and includes a reasonable measure of local control; (3) it is coordinated/integrated - it ensures effective collaboration/integration among the providers of all needed services; (4) it is flexible - it provides for individualized care that meets the particular circumstances of each individual and family, and includes services that may not be part of mainstream practice; (5) it is family centered - it involves family advocacy organizations and individual family members in every aspect of

service delivery including planning, budgeting, implementation and evaluation; and (6) it is culturally appropriate (see Part II, Appendix D "Guidelines for Assessing Cultural Competence").

Community is the geo-political entity or geographic area in which the proposed exemplary practice is to be implemented. It can be a county, a city or other municipality, or a state. It can be an Indian tribe or tribal organization. It can be a geographical area that is not coterminous with a geo-political entity where the individuals residing in that area share common cultural or other characteristics (for example, a particular region or neighborhood of a large city).

Practice is any consistently applied service delivery mechanism intended to improve outcomes for individuals with a substance abuse disorder(s). It might be specific, such as a precise clinical or related service protocol designed to ameliorate one aspect of an individual's disorder or it might be general such as a set of principles and criteria for treating individuals within the target population. In both cases, the practice must be fully documented with a detailed description of all the key operational components.

## APPENDIX B. REFERENCES

- Agency for Health Care Policy and Research. (1992). An annotated bibliography: Effective dissemination to health care practitioners and policy makers. Rockville, MD: Author.
- AHEC/Community Partners. (1995). From the ground up: A workbook on coalition building and community development. Amherst, MA: Author.
- Backer, T.E. (1995a). Assessing and enhancing readiness for change: Implications for technology transfer. In Backer, T.E., David, S.L. & Soucy, G. (Eds). Reviewing the behavioral science knowledge base on technology transfer. Rockville, MD: National Institute on Drug Abuse.
- Backer, T.E., Brown, B.S. & Howard, E.A. (1994). Evaluating drug abuse technology transfer: An analytic review. Los Angeles: Human Interaction Research Institute.
- Backer, T.E. (1995b). Dissemination and utilization strategies for foundations; Adding value to grantmaking. Kansas City, MO: Ewing M. Kauffman Foundation.
- Backer, T.E., Liberman, R.P. & Kuchnel, T. (1986). Dissemination and adoption of innovative psychosocial interventions. Journal of Clinical & Consulting Psychology, 54(1), 111-118.
- Goodman, P.S. & Darr, E.D. (1996). Exchanging best practices through computer-aided systems. Academy of Management Executive, 1996, 10(2), 7-19.
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- Kiresuk, T.J. (1993). The evaluation of knowledge utilization: Placebo and nonspecific effects, dynamical systems, and chaos theory. Journal of the American Society for Information Science, 44(4), 235-241.
- Klein, S.S. (1993a). Are there better ways to identify and share the best within and among federal education programs? Evaluation and Program Planning, 16(3), 227-239.
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federal government to use evaluation to guide the dissemination of promising and exemplary education solutions. Evaluation and Program Planning, 16(3), 213-217.

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McLellan, Thomas A., Hagan, Teresa A., Levine, Marvin, Gould, Frank, Meyers, Kathleen, Bencivengo, Mark, & Durell, Jack (1998). Supplemental social services improve outcomes in public addiction treatment. Addiction, 1998, 93(10), 1489-1499.

Powers, V. (1995). Corporate networks. Continuous Journey, April 1995, 34-36.

Schneider, A. (1994). Building strategic alliances. New Designs for Youth Development, 11(3), 23-26.

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Sechrest, L., Backer, T.E., Rogers, E.M., Campbell, T.F., & Grady, M.L. (Eds). (1994). Effective dissemination of clinical and health information. AHCPR Pub. No. 95-0015. Rockville, MD: Agency for Health Care Policy and Research.

Tushnet, N. (1993). A guide to developing educational partnerships. Washington, DC: U.S. Department of Education, Office of Educational Research and Improvement.

## APPENDIX C. CSAT'S GPRA STRATEGY

### OVERVIEW

The Government Performance and Results Act of 1993 (Public Law-103-62) requires all federal departments and agencies to develop strategic plans that specify what they will accomplish over a three to five year period, to annually set performance targets related to their strategic plan, and to annually report the degree to which the targets set in the previous year were met. In addition, agencies are expected to regularly conduct evaluations of their programs and to use the results of those evaluations to “explain” their success and failures based on the performance monitoring data. While the language of the statute talks about separate Annual Performance Plans and Annual Performance Reports, ASMB/HHS has chosen to incorporate the elements of the annual reports into the annual President’s Budget and supporting documents. The following provides an overview of how the Center for Substance Abuse Treatment, in conjunction with the Office of the Administrator/SAMHSA, CMHS, and CSAP, are addressing these statutory requirements.

### DEFINITIONS

Performance Monitoring	The ongoing measurement and reporting of program accomplishments, particularly progress towards preestablished goals. The monitoring can involve process, output, and outcome measures.
Evaluation	Individual systematic studies conducted periodically or “as needed” to assess how well a program is working and why particular outcomes have (or have not) been achieved.
Program	For GPRA reporting purposes, a set of activities that have a common purpose and for which targets can (will) be established. <sup>1</sup>
Activity	A group of grants, cooperative agreements, and contracts that together are directed toward a common objective.
Project	An individual grant, cooperative agreement, or contract.

### CENTER (OR MISSION) GPRA OUTCOMES

The mission of the Center for Substance Abuse Treatment is to support and improve the effectiveness and efficiency of substance abuse treatment services throughout the United States. However, it is not the only agency in the Federal government that has substance abuse treatment as part of its mission. The Health Care

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<sup>1</sup>GPRA gives agencies broad discretion with respect to how its statutory programs are aggregated or disaggregated for GPRA reporting purposes.

Financing Administration, Department of Veterans Affairs, and the Department of Justice all provide considerable support to substance abuse treatment. It shares with these agencies responsibility for achieving the objectives and targets for Goal 3 of the Office of National Drug Control Policy's Performance Measures of Effectiveness:

Reduce the Health and Social Costs Associated with Drug Use.

Objective 1 is to support and promote effective, efficient, and accessible drug treatment, ensuring the development of a system that is responsive to emerging trends in drug abuse. The individual target areas under this objective include reducing the treatment gap (Goal 3.1.1), demonstrating improved effectiveness for those completing treatment (Goal 3.1.2), reducing waiting time for treatment (Goal 3.1.3), implementing a national treatment outcome monitoring system (Goal 3.1.4), and disseminating treatment information (Goal 3.1.5). Objective 4 is to support and promote the education, training, and credentialing of professionals who work with substance abusers.

CSAT will be working closely with the OAS/SAMHSA, ONDCP, and other Federal demand reduction agencies to develop annual targets and to implement a data collection/information management strategy that will provide the necessary measures to report on an annual basis on progress toward the targets presented in the ONDCP plan. These performance measures will, at an aggregate level, provide a measure of the overall success of CSAT's activities. While it will be extremely difficult to attribute success or failure in meeting ONDCP's goals to individual programs or agencies, CSAT is committed to working with ONDCP on evaluations designed to attempt to disaggregate the effects. With regard to the data necessary to measure progress, the National Household Survey on Drug Abuse (conducted by SAMHSA) is the principal source of data on prevalence of drug abuse and on the treatment gap. Assessing progress on improving effectiveness for those completing treatment requires the implementation of a national treatment outcome monitoring system (Target 3.1.4). ONDCP is funding an effort to develop such a system and it is projected in Performance Measures of Effectiveness to be completed by FY 2002.

Until then, CSAT will rely on more limited data, generated within its own funded grant programs, to provide an indication of the impact that our efforts are having in these particular target areas. It will not be representative of the overall national treatment system, nor of all Federal activities that could affect these outcomes. For example, from its targeted capacity expansion program (funded at the end of FY 1998), CSAT will present baseline data on the numbers of individuals treated, percent completing treatment, percent not using illegal drugs, percent employed, and percent engaged in illegal activity (i.e., measures indicated in the ONDCP targets) in its FY 2001 report with targets for future years. As the efforts to incorporate outcome indicators into the SAPT Block Grant are completed over the next several years, these will be added to the outcomes reported from the targeted capacity expansion program.

In addition to these "end" outcomes, it is suggested that CSAT consider a routine customer service survey to provide the broadest possible range of customers (and potential customers) with a means of providing feedback on our services and input into future efforts. We would propose an annual survey with a short, structured questionnaire that would also include an unstructured opportunity for respondents to provide additional input if they so choose.

## CSATs “PROGRAMS” FOR GPRA REPORTING PURPOSES

All activities in SAMHSA (and, therefore, CSAT) have been divided into four broad areas or “programmatic goals” for GPRA reporting purposes:

- ! Goal 1: Assure services availability;
- ! Goal 2: Meet unmet and emerging needs;
- ! Goal 3: Bridge the gap between research and practice;
- ! Goal 4: and Enhance service system performance<sup>2</sup>

The following table provides the crosswalk between the budget/statutory authorities and the “programs”:

	KD&A	TCE	SAPTBG	NDC
Goal 1			X	
Goal 2		X		
Goal 3	X			
Goal 4			X	X

KD - Knowledge Development

SAPTBG - Substance Abuse Prevention and Treatment Block Grant

KA - Knowledge Application

TCE - Targeted Capacity Expansion

NDC - National Data Collection/Data Infrastructure

For each GPRA [program] goal, a standard set of output and outcome measures across all SAMHSA activities is to be developed that will provide the basis for establishing targets and reporting performance. While some preliminary discussions have been held, at this time there are no agreed upon performance measures or methods for collecting and analyzing the data.<sup>3</sup> In the following sections, CSAT’s performance monitoring plans for each of the programmatic areas are presented. It should be understood that they are subject to change as the OA and other Centers enter into discussion and negotiate final measures. In addition, at the end of the document, a preliminary plan for the use of evaluation in conjunction with performance monitoring is presented for discussion

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<sup>2</sup>Goal 4 activities are, essentially, those activities that are funded with Block Grant set-aside dollars for which SAMHSA seeks a distinction in the budget process (i.e., National Data Collection/Data Infrastructure).

<sup>3</sup>Only measures of client outcomes have been developed and agreed to by each of the Centers. However, these measures are really only appropriate for “services” programs where the provision of treatment is the principal purpose of the activity (i.e., Goals 2 and 3). The client outcome measures will be presented under Goals 2 and 3.

purposes.

## **1. ASSURE SERVICES AVAILABILITY**

Into this program goal area fall the major services activities of CSAT: the Substance Abuse Prevention and Treatment Block Grant. In FY 2000 the Block grant application was revised and approved by the Office of Management and Budget to permit the voluntary collection of data from the States. More specifically:

- Number of clients served (unduplicated)
- Increase % of adults receiving services who:
  - (a) were currently employed or engaged in productive activities;
  - (b) had a permanent place to live in the community;
  - (c) had no/reduced involvement with the criminal justice system.
- Percent decrease in
  - (a) Alcohol use;
  - (b) Marijuana use;
  - (c) Cocaine use;
  - (d) Amphetamine use
  - (e) Opiate use

In addition, in the Fall of 1999 a customer satisfaction survey was designed and approved for collection from each state on the level of satisfaction with Technical Assistance and Needs Assessment Services provided to the States. More specifically:

- Increase % of States that express satisfaction with TA provided
- Increase % of TA events that result in systems, program or practice improvements

## **2. MEET UNMET OR EMERGING NEEDS**

Into this program goal area fall the major services activities of CSAT: Targeted Capacity Expansion Grants. Simplistically, the following questions need to be answered about these activities within a performance monitoring context:

- ! Were identified needs met?
- ! Was service availability improved?
- ! Are client outcomes good (e.g., better than benchmarks)?

The client outcome assessment strategy mentioned earlier will provide the data necessary for CSAT to address these questions. The strategy, developed and shared by the three Centers, involves requiring each SAMHSA project that involves services to individuals to collect a uniform set of data elements from each individual at admission to services and 6 and 12 months after admission. The outcomes (as appropriate) that will be tracked using this data are:

- ! Percent of adults receiving services increased who:
  - a) were currently employed or engaged in productive activities
  - b) had a permanent place to live in the community
  - c) had reduced involvement with the criminal justice system
  - d) had no past month use of illegal drugs or misuse of prescription drugs
  - e) experienced reduced alcohol or illegal drug related health, behavior, or social consequences, including the misuse of prescription drugs
  
- ! Percent of children/adolescents under age 18 receiving services who:
  - a) were attending school
  - b) were residing in a stable living environment
  - c) had no involvement in the juvenile justice system
  - d) had no past month use of alcohol or illegal drugs
  - e) experienced reduced substance abuse related health, behavior, or social consequences.

These data, combined with data taken from the initial grant applications, will enable CSAT to address each of the critical success questions.

### **3. BRIDGE THE GAP BETWEEN RESEARCH AND PRACTICE**

This “program” or goal covers that set of activities that are knowledge development/research activities. Initially funded in FY1996, CSAT’s portfolio in this area currently includes multi-site grant and cooperative agreement programs, several of which are being conducted in collaboration with one or more of the other two Centers. These activities cover a broad range of substance abuse treatment issues including adult and adolescent treatment, treatments for marijuana and methamphetamine abuse, the impact of managed care on substance abuse treatment, and the persistence of treatment effects. In FY1999, a general program announcement to support knowledge development activity will be added to the CSAT portfolio.

The purpose of conducting knowledge development activities within CSAT is to provide answers to policy-relevant questions or develop cost-effective approaches to organizing or providing substance abuse treatment that can be used by the field. Simplistically then, there are two criteria of success for knowledge development activities:

- ! Knowledge was developed; and
- ! The knowledge is potentially useful to the field.

While progress toward these goals can be monitored during the conduct of the activity, only after the research data are collected, analyzed, and reported can judgments about success be made.

CSAT proposes to use a peer review process, conducted after a knowledge development activity has been completed, to generate data for GPRA reporting purposes. While the details remain to be worked out, the proposal would involve having someone (e.g., the Steering Committee in a multi-site study) prepare a document that describes the study, presents the results, and discusses their implications for substance abuse treatment. This document would be subjected to peer review (either a committee, as is done for grant application review or “field reviewers”, as is done for journal articles). The reviewers would be asked to provide ratings of the activity on several scales designed to represent the quality and outcomes of the work conducted (to be developed).<sup>4</sup> In addition, input on other topics (such as what additional work in the area may be needed, substantive and “KD process” lessons learned, suggestions for further dissemination) would be sought. The data would be aggregated across all activities completed (i.e., reviewed) during any given fiscal year and reported in the annual GPRA report.

### **3.1 PROMOTE THE ADOPTION OF BEST PRACTICES**

This “program” involves promoting the adoption of best practices and is synonymous currently with Knowledge Application.<sup>5</sup> Within CSAT, these activities currently include the Product Development and Targeted Dissemination contract (to include TIPS, TAPS, CSAT by Fax, and Substance Abuse in Brief), the Addiction Technology Transfer Centers, and the National Leadership Institute. In FY1999, the Community Action Grant program will be added and in FY2000, the Implementing Best Practices Grant program will be added.

Activities in this program have the purpose of moving “best practices”, as determined by research and other knowledge development activities, into routine use in the treatment system. Again simplistically, the immediate success of these activities can be measured by the extent to which they result in the adoption of a “best

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<sup>4</sup>The ratings would include constructs such as adherence to GFA requirements, use of reliable and valid methods, extent of dissemination activities, extent of generalizability, as well as the principal GPRA outcome constructs.

<sup>5</sup>Most, if not all, of the activities conducted under the rubric of technical assistance and infrastructure development are appropriately classified as activities supporting this program goal. Technical assistance activities within GPRA have not been discussed within CSAT. Further, at this time, SAMHSA has a separate program goal for infrastructure development (see “Enhance Service System Performance,” below).

practice.”<sup>6</sup> In order to provide appropriate GPRA measures in this area, CSAT plans to require that all activities that contribute to this goal to collect information on the numbers and types of services rendered, the receipt of the service by the clients and their satisfaction with the services, and whether the services resulted in the adoption of a best practice related to the service rendered.

#### **4. ENHANCE SERVICE SYSTEM PERFORMANCE**

As described earlier, this programmatic goal is distinguished from “Promote the adoption of best practices” primarily by its reliance on the Block Grant set-aside for funding and the explicit emphasis on “systems” rather than more broadly on “services.” The CSAT activities that fall into this goal are the STNAP and TOPPS. While CSAT has established performance measures for these activities individually, it is waiting for SAMHSA to take the lead in developing SAMHSA-wide measures. In addition, CSAT continues to believe that this goal should be collapsed into the broader goal of “Promoting the adoption of best practices.”

#### **EVALUATIONS**

As defined earlier, evaluation refers to periodic efforts to validate performance monitoring data; to examine, in greater depth, the reasons why particular performance measures are changing (positively or negatively); and to address specific questions posed by program managers about their programs. These types of evaluation are explicitly described, and expected, within the GPRA framework. In fact, on an annual basis, the results of evaluations are to be presented and future evaluations described.

To date, CSAT has not developed any evaluations explicitly within the GPRA framework. The initial requirements will, of necessity, involve examinations of the reliability and validity of the performance measures developed in each of the four program areas. At the same time, it is expected that CSAT managers will begin to ask questions about the meaning of the performance monitoring data as they begin to come in and be analyzed and reported. This will provide the opportunity to design and conduct evaluations that are tied to “real” management questions and, therefore, of greater potential usefulness to CSAT. CSAT will be developing a GPRA support contract that permits CSAT to respond flexibly to these situations as they arise.

On a rotating basis, program evaluations will be conducted to validate the performance monitoring data and to extend our understanding of the impacts of the activities on the adoption of best practices.

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<sup>6</sup>Ultimately, the increased use of efficient and effective practices should increase the availability of services and effectiveness of the system in general. However, measures of treatment availability and effectiveness are not currently available. Within existing resources, it would not be feasible to consider developing a system of performance measurement for this purpose.