Department of Health and Human Services

Substance Abuse and Mental Health Services Administration

Cooperative Agreements for
Screening, Brief Intervention, Referral and Treatment (SBIRT)
(Initial Announcement)

Request for Applications (RFA) No. TI-06-002

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

Key Dates:

Application Deadline	**Applications are due by April 27, 2006.**
Intergovernmental Review (E.O. 12372)	**Letters from State Single Point of Contact (SPOC) are due no later than 60 days after application deadline.**

H. Westley Clark, M.D., J.D., M.P.H.
Director, Center for Substance Abuse Treatment
Substance Abuse and Mental Health
Services Administration

Charles G. Curie, M.A., A.C.S.W.
Administrator
Substance Abuse and Mental Health
Services Administration

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I. FUNDING OPPORTUNITY DESCRIPTION

1. INTRODUCTION

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) is accepting applications for fiscal year (FY) 2006 Cooperative Agreements for Screening, Brief Intervention, Referral and Treatment (SBIRT). SBIRT Cooperative Agreements will expand and enhance State substance abuse treatment service systems by:

- Expanding the State's continuum of care to include screening, brief intervention, referral, and brief treatment (SBIRT) in general medical and other community settings (e.g., community health centers, nursing homes, schools and student assistance programs, occupational health clinics, hospitals, emergency departments);

- Supporting clinically appropriate services for persons at risk for, or diagnosed with, a Substance Use Disorder (i.e., Substance Abuse or Dependence) (Note: for the purpose of the RFA 'at risk' is defined as persons who are using substances but who do not yet meet the criteria for a diagnosis of Substance Use Disorder[1]); and

- Identifying systems and policy changes to increase access to treatment in generalist and specialist settings.

The SBIRT program is authorized under Section 509 of the Public Health Service Act, as amended. This announcement addresses *Healthy People 2010*, Volume II (Part B: Focus Area 26--Substance Abuse).

SAMHSA's Services Grants are designed to address gaps in substance abuse services and/or to increase the ability of States, units of local government, federally recognized Tribes, Tribal organizations, and community- and faith-based organizations to help specific populations or geographic areas with serious, emerging substance abuse problems. SAMHSA intends that its Services Grants result in the delivery of services as soon as possible and no later than 6 months after award.

2. EXPECTATIONS

2.1 Background

For demand reduction, the 2005 National Drug Control Strategy (NDCS) emphasizes: (1) preventing initiation of drug use for those who have not initiated illegal drug use; (2) getting treatment resources where they are needed; and (3) attacking the economic basis of the drug

1 For purposes of this announcement, the need for treatment is discussed in terms of the categories of substance use disorders (substance dependence and substance abuse) used in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; 1994).

trade (ONDCP, 2005). SBIRT's focus on early intervention and treatment continues to be a vital component of the NDCS demand reduction initiatives.

Federal programs, including those operated by SAMHSA/CSAT, have tended to emphasize either universal prevention strategies aimed at those who have never initiated use (Mrazek and Haggerty, 1994) or specialist treatment for those who are dependent (Gerstein and Harwood, 1990). Little attention has been paid to the large group of individuals who use drugs but are not, or not yet, dependent and who could successfully reduce drug use through "early intervention". (Klitzner et al., 1992; Fleming, 2002). There is an emerging body of research and clinical experience that supports use of the SBIRT approach as providing effective early intervention for persons at risk for, or diagnosed with, a Substance Use Disorder (Substance Abuse or Dependence) (e.g., Barry, 1999; Babor and Higgins-Biddle, 2000; Bernstein et. al, 1997; Zweben and Fleming, 1999; Broskowski and Smith, 2001; Heather, 2001; Dennis, et al., 2002; Babor, 2002; Blow, 1998; Fleming 2002; Breslin, et at., 2002; Degutis, 2003; Fleming, 2003; Babor, 2004). (Note: A complete listing of the references and resources (including evidence-based practices/services) cited in this document can be found at http://www.mayatech.com/sbirt/tools_resources/references.htm. Copies of the listing are available in the application kits distributed by SAMHSA's National Clearinghouse for Alcohol and Drug Information.)

The specialist treatment system is often not appropriate for persons at risk for a Substance Use Disorder, nor can that system alone address the needs of all those persons diagnosed with either a Substance Abuse or a Substance Dependence Disorder. Consequently, new program efforts are needed to provide funding to introduce or expand screening and brief intervention and brief treatment for persons at risk for, or diagnosed with, a Substance Use Disorder (Substance Abuse or Dependence). These new program efforts should be initiated in general medical and other community settings (e.g., community health centers, nursing homes, schools and student assistance programs, occupational health clinics, hospitals, emergency departments).

2.2 SBIRT Allocation of Funds

SBIRT Services: Grantees must develop a systematic approach and must devote not less than **65 percent (65%)** of their award to expand and enhance their service system to carry out the following services in community agencies, including establishing referral linkages to specialist treatment agencies/providers.

- **Screening** for substance use problems and disorders
- **Brief Interventions** (1 to 5 sessions)
- **Brief Treatment** (up to 12 sessions) and monitoring of individuals who use drugs but are not yet dependent
- **Referral to Treatment** (when indicated) for those who have a Substance Use Disorder. Persons who qualify for a diagnosis of drug abuse or dependence and who are non-responsive to an initial brief intervention or brief treatment must be referred for specialty treatment.

Specialty Treatment Services: While the focus of this initiative is on screening, brief intervention, and brief treatment, it is critical to ensure that appropriate services are available to treat persons for whom such services in community settings are not appropriate. Therefore, a portion of the award may be used for referral to specialty treatment. Grantees may use up to **15 percent (15%)** of the award to expand specialty modalities (outreach/pretreatment services, methadone and non-methadone outpatient services, and residential services) for persons screened in this program who require more intensive and prolonged specialty treatments.

Guidance and requirements related to services design, project phases and operations are provided below.

Project Administration: Grantees may use up to **20 percent (20%)** of the award to carry out required project administration including: (1) policy and systems change; (2) staff training and technical assistance; (3) monitoring sub-recipients' service delivery and data collection; and (4) overall project reporting. This allowable percentage of the award may be passed along to sub-recipients to enable them to carry out project administration activities.

Guidance and requirements related to policy and systems change and project reporting are provided below.

2.3 Detailed Requirements

Policy and Systems Change

To implement policies that will successfully attract and effectively serve persons at risk for, or diagnosed with, a Substance Use Disorder (Substance Abuse or Dependence), the applicant will need to provide a systems change plan that reflects an understanding of the general reasons why people do not seek services, as well as how these barriers, which prevent individuals from successfully accessing the clinically appropriate level of care, may apply to their system of care.

A substantial body of research is related to barriers to access to health care, in general, as well as barriers to treatment for Substance Use Disorders, specifically. Various approaches exist to identify and classify barriers (Institute of Medicine, 1990; Fiorentine, 1993; Weisner and Schmidt, 1999; PLNP, 2000; Schermer et al., 2003; Barry et al., 2004). Less is known about those enabling factors that increase help-seeking and access (Grant, 1997; Weisner and Schmidt, 2001; Fortney and Booth, 2001).

Of major concern are the numerous studies documenting the failure of primary care physicians to identify persons at high risk of or already experiencing a Substance Use Disorder and initiating the appropriate referral for evaluation and treatment (Saitz et al., 1997; Hack and Adger, 2002; NCASA, 2002; Degutis, 2003). Such identification in mainstream medical care settings is necessary because perceived illness severity and stigma also may act as barriers to treatment.

Addiction policy and service provision in States occurs within the context of both general health systems and financing arrangements and carved-out specialty prevention and treatment systems

(Denmeade and Rouse, 1994; Jainchill, N., 2004). The implications of these arrangements for the diffusion of SBIRT must be considered in project formulation and implementation. Financial accessibility implies that the cost of the service is reasonable and there is no disincentive to use needed services because of their costs or the method of reimbursement. However, many studies identify barriers due to the manner in which substance abuse treatment is financed, such as a lack of parity with physical illness in commercial and public insurance leading to high co-pays and restrictions of payment for diagnostic assessments, and lack of coverage or payment for nontraditional specialist treatment modalities (e.g., residential therapeutic communities) or for screening services in emergency departments and primary care settings (Reader and Sullivan, 1992; Buck and Umland, 1997; Sing et al., 1998; Rivara et al., 2000; Rockett et al., 2005; Schmidt and Weisner, 2005). For example, several States still have Uniform Accident and Sickness Policy Provision Law (UPPL) provisions in their insurance policies that permit insurers to deny coverage for injuries sustained due to intoxication or because of the influence of other drugs. Although these policies are not always enforced, they may serve as disincentives to the provision of SBIRT-related services (Rivara, et al., 2000).

Another often cited barrier is the multiple, separate, and fragmented Federal, State, local, and private funding streams accessed by frequently uncoordinated agencies[2] that have different coverage policies, codes, and procedures for treatment modalities and ancillary services, different eligibility criteria for providers and patients, different reporting requirements, different placement criteria, and inconsistent benefit designs (Gerstein and Harwood, 1990; Schlessinger et al., 1991; Moss, 1998; Johnson, 1999; Horgan and Merrick, 2001; Garnick et al, 2002; Hodgkin et al., 2000; Hodgkin et al., 2004; Rockett et al., 2005; Schmidt and Weisner, 2005).

Eliminating these barriers through systems and policy change is a major emphasis of this program (e.g., Pauly, 1991; Libertoff, 1999; Zarkin et al., 1995). Integrating SBIRT in community settings will require the applicant to conduct an analysis of the inhibiting and facilitating policies and practices. Applicants must describe how these barriers will be removed and how applicants will facilitate access to clinically appropriate treatment, starting with screening for Substance Use Disorders in community settings.

Services Design

Grantees will be required to adopt and implement a treatment system that includes all of the following components:

- *Screening, Identification, Brief Intervention, Referral, and Brief Treatment*. This involves the implementation of a system within community and specialist settings that screens for and identifies persons at risk for, or diagnosed with, a Substance Use Disorder (Substance Abuse or Dependence). Depending on the level of problems identified, the system either provides for a brief intervention within the generalist setting, when appropriate, or motivates and refers persons with a probable diagnosis of substance abuse or substance dependence to the specialist setting for assessment, diagnosis, and either

2 The complexity of these multiple treatment subsystems at the State level has been described in a report submitted to SAMHSA/CSAT by the National Association of State and Drug Abuse Directors (NASADAD, 2002)

brief or long-term treatment. This includes training in self-management and involvement in mutual help groups, as appropriate (Workgroup on Substance Abuse Self-Help Organizations, 2003).[3] The evidence-based approaches and tools (discussed in the references and resources provided in this document -- see Appendix F) utilized for screening, brief intervention, referral, and brief treatment may vary; however, the core components of SBIRT remain and can be defined as follows:

- *Screening* – brief screening incorporated into the normal routine in medical and other community settings that provides identification of individuals at risk for Substance Use Disorders. SAMHSA is committed to: (1) standardizing the screening process so that screening produces consistent results across sites, in terms of individuals identified as requiring brief intervention or referral to treatment; and (2) detecting and intervening with individuals who have a Substance Use Disorder, but whose problems are not so severe that they require specialty treatment. Therefore, grantees will be required to screen adults using the Alcohol Use Disorders Identification Test (AUDIT), the Drug Abuse Screening Test (DAST), and the Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) for screening of adolescents.[4] Additional screening tools may be used with the agreement of the SAMHSA Project Officer.

- *Brief Intervention* – discussion that is focused on raising an individual's awareness of their substance use and motivating them toward behavioral change. Brief interventions are considered to be 1 to 5 sessions in length.

- *Brief Treatment* – a distinct level of care that consists of a limited course of highly focused cognitive behavioral clinical sessions. Brief treatment is considered to be 6 to 12 sessions in length. It may occur in the same session as the initial screening or in follow-up sessions.

- *Referral* – a proactive process that facilitates access to care for individuals who are assessed to have a Substance Use Disorder requiring a more intensive treatment specialty.

- *Sequential Assessment and Diagnosis.* This involves having a system in place to ensure that individuals who screen positive for Substance Use Disorders are appropriately assessed for the presence of co-morbid physical and mental disorders so that a diagnosis is made, an initial treatment plan is developed, and a referral is made to the clinically appropriate community or specialist treatment setting as dictated by the person's clinical status.

- *Treatment*. This involves having a system in place to ensure that individuals who are diagnosed with a Substance Use Disorder are provided an opportunity to undergo an

3 References and resources that support this approach are available at www.mayatech.com/sbirt/tools_resources/references.htm

4 OMB approval for these screening instruments will be sought.

integrated pharmacological and psychosocial treatment regimen in order to reduce or eliminate their harmful consumption and its adverse effects in the clinically appropriate community or specialist treatment setting. This includes training in self-management and involvement in mutual help groups, as appropriate.

- *Continued Management Support.* This involves having a system in place to ensure that individuals who complete their formal treatment episode will receive long term management support (care management and recovery support systems), as appropriate for their level of disability and relapse potential in the clinically appropriate community or specialist treatment setting. This includes training in self-management and involvement in mutual help groups.[5]

Patients manifesting signs of intoxication, withdrawal symptoms, and other physical problems that require emergency care or urgent action would be managed in other components of the generalist or specialist treatment systems. While stabilization and detoxification may be required for some persons presenting to community agencies, the availability of treatment resources, financing mechanisms, and other access barriers vary from those encountered in treating individuals who do not require withdrawal and stabilization.

This variation is recognized in the differentiation of the levels and settings of services for detoxification and rehabilitation in the latest version of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria (ASAM, 2001); Gastfriend et al., 2000) and the guidelines developed by the Evidence-Based Clinical Practice Guideline Working Group for the Veterans Health Administration and Department of Defense (2001).

2.4 Project Phases and Operations

The projects will have three phases.

Phase I: Project Planning and Start-Up. This phase is expected to last approximately 6 months. During this time, CSAT will work collaboratively with the grantee, project staff, and Policy Steering Committee members (see Section II-2 below). The start-up tasks to be completed in this phase are, at minimum:

- Selecting the members of the Policy Steering Committee (and subcommittees, if appropriate).

- Developing a solid organizational structure that involves or enlists the participation of an appropriate array of service providers and funders representing 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) in the sub-recipient communities.

[5] References and resources that support this model include CSAT's Treatment Improvement Protocols (TIPs) and Technical Assistance Publications (TAPs).

- 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 target populations and communities to be served.

- Refining the plan to provide training and technical assistance, including information about SBIRT methods, training for staff in the community and specialist settings in carrying out SBIRT, and technical assistance to the overall project and its sub-recipients.

- 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 following the period of Federal support.

- 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 target community, if required.

- Establishing the mechanism for monitoring performance against targets for: (1) reducing drug use by patients receiving services through the SBIRT project; (2) increasing the number of persons at risk for, or diagnosed with, a Substance Use Disorder (Substance Abuse or Dependence) who receive treatment in each sub-recipient community; (3) increasing the number of community settings where SBIRT services are provided; and (4) providing treatment services within approved cost parameters for each treatment modality.

- 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 CSAT 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 4 years and 3 months. During this time, CSAT will work collaboratively with the grantee, project staff, State Substance Abuse Authority (SSA), and 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 drug use by patients receiving treatment through the SBIRT project; (2) increasing the number of persons at risk for, or diagnosed with, a Substance Use Disorder (Substance Abuse or Dependence) who receive treatment in each sub-recipient community; (3) increasing the number of community settings where SBIRT services are provided; and (4) providing treatment services within approved cost parameters for a given treatment modality.

- 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 3 months of the cooperative agreement award, CSAT will work cooperatively with the grantee, project staff, Policy Steering Committee members, and sub-recipients to make the transition from the cooperative agreement to State/Tribe and local control and to sustain the system changes achieved by the project.

2.5 Data and Performance Measurement

During the course of the project, grantees must provide information needed by SAMHSA to comply with the Government Performance and Results Act (GPRA) reporting requirements. GPRA mandates accountability and performance-based management by Federal agencies,

focusing on results or outcomes in assessing the effectiveness of Federal activities and on measuring progress toward achieving national goals and objectives. The grantee must ensure that all sub-recipients submit the required data. A detailed description of CSAT's GPRA strategy and the Discretionary Services Client Level GPRA Tool can be found online at www.samhsa-gpra.samhsa.gov. This Website must be used to enter full GPRA baseline/intake, discharge and 6 months after intake data.

CSAT-GPRA requirements for this specific program include data collection and real time reporting about cooperative agreement-supported service recipients at baseline/intake, discharge and 6 months after intake, as noted above. Grantees are also expected to obtain a minimum of an 80 percent (80%) follow-up rate on those clients selected as part of the follow-up sample. Data must be entered into the CSAT GPRA web-based data entry and reporting system on a real-time basis. Grantees also are required to submit specified aggregate data in semi-annual reports. These requirements should be considered when preparing the data collection, monitoring, and reporting budget section of the application.

Applicants should carefully note that there are three categories of services or combinations of services to be supported by these cooperative agreement funds and each category has specific reporting requirements with regards to GPRA.

The three categories of services or combinations of services to be provided to individuals include:

- Screening Only;
- Screening and Brief Intervention (BI); and
- Screening and Brief Treatment (BT) or Screening and Referral to Other Types of Treatment for Substance Use Disorders (RT).

Varying levels of data are required on clients in each category of care. Intake and discharge data are required on all clients as specified below. The data will be used to allow CSAT to assess performance with respect to the National Outcome Measures (NOMs). Drug use, employment status, housing status, criminal justice status, social connectedness, access and retention will all be measured using the sections of the GPRA tool as detailed below. Also noted below are follow-up data specifications. Follow-up data will be required on 10 percent (10%) of the clients served in **each** category of care requiring intervention/treatment (BI, BT, RT).

All adult screenings must be conducted using the AUDIT, DAST for adults and CRAFFT for adolescents. Additional screening instruments/tools may be used with the agreement of the SAMHSA Project Officer. The following are the reporting requirements for each category:

Screening Only

Baseline Client Level Data

For clients who are screened and who, based on the results of the screen, should not require any level of substance abuse intervention or treatment services, the following will be required for each grantee and/or each community, if applicable:

Baseline (at screening) CSAT-GPRA data elements limited to the demographics must be collected on all clients in this category. (See Sections A and B of the GPRA tool.) This individual client level data will be used to count unduplicated clients served. No further data collection will be required on these clients.

Screening and Brief Intervention (BI)

For all clients who are screened and who, based on the results of the screen, should or do receive brief intervention, the following must be collected and reported:

Baseline Client Level Data

Baseline (at screening) CSAT-GPRA data elements limited to the demographic, and substance use domains must be collected on all clients in this category of service. (See Sections A and B of the GPRA tool.) This individual client level data will be used to count unduplicated clients served. It is important that all clients complete a tracking information sheet in the event they are selected for follow-up.

Discharge Client Level Data

For all clients in this category, discharge data must be submitted to CSAT. If a Brief Intervention is completed more than 7 days from the time of intake, Sections A, B, J and K of the GPRA tool must be completed on the client. If the intervention is 7 days or less from the time of intake, Sections A, J and K should be completed.

Follow-up Client Level Data

For a representative 10 percent (10%) sample of clients in this category who should have or did receive brief intervention, the follow-up GPRA items asked are limited to the substance use domain and follow-up sections of the tool. (See Sections A, B and I of the GPRA tool.) Data must be collected at 6 months after baseline and entered into the CSAT web-based GPRA data entry and reporting system. CSAT will provide grantees the sampling method to obtain the representative sample of 10 percent (10%). Grantees will be notified which clients have been selected as part of the representative sample and need to be located for follow-up via a web based notification report. Grantees are expected to achieve a follow-up rate of at least 80 percent (80%) of those selected for the follow-up sample.

For example, if 100 patients are screened and should receive Brief Intervention, 10 clients will be in the CSAT selected sample to be followed up. Grantees will be required

to attempt to locate all 10 clients. It is required that at a minimum eight of these clients complete a follow-up interview.

Aggregated Data

In the semi-annual report, the grantee must also provide data about the costs for the delivery of screening and brief intervention, including the mean, median, and range of costs overall, by facility type, and region and sub-recipient, if applicable. The grantee must also discuss how such costs compare to the CSAT approved cost parameters for screening and brief intervention and what efforts they are undertaking to bring costs into line with those expected.

Screening and Brief Treatment (BT) or Screening and Referral to Other Types of Treatment for Substance Use Disorders (RT)

For all clients that are screened and require either brief treatment or other treatment, the following must be collected and reported:

Baseline Client Level Data

Baseline (at screening) using all of the CSAT GPRA data elements must be collected on all clients in this category of service. (See Sections A through G of the GPRA tool.) It is important that all clients complete a tracking information sheet in the event they are selected for follow-up.

Discharge Client Level Data

For all clients in this category, discharge data must be submitted to CSAT. If a Brief Treatment is completed more than 7 days from the time of intake, Sections A through G, J and K of the GPRA tool must be completed on the client. If the treatment is 7 days or less from the time of intake, Sections A, J and K of the GPRA tool must be completed.

Follow-up Client Level Data

For a representative 10 percent (10%) sample of clients in this category who, based on the results of their screening, should have or did receive services beyond brief intervention, follow-up data (all domains, see Sections A through I of the GPRA tool) are to be collected at 6 months after the initiation of substance abuse treatment services and entered into the GPRA web-based data entry and reporting system. CSAT will provide grantees the sampling method to obtain the representative sample of 10 percent (10%). Grantees will be notified which clients have been selected as part of the representative sample and need to be located for follow-up via a web based notification report. Grantees are expected to achieve a follow-up rate of at least 80 percent (80%) of those selected.

Note that two levels of intervention are being described here. A 10 percent (10%) sample is required for each of the two levels (BT, RT).

For example, if 100 patients are screened and should receive Brief Treatment, 10 clients will be in the sample to be followed up. Grantees will be required to attempt to locate all 10 clients. It is required that at a minimum eight of these clients complete a follow-up interview.

In addition, if 100 patients were screened and should receive a Referral to Treatment, 10 clients will be in the sample to be followed up. Grantees will be required to attempt to locate all 10 clients. It is required that at a minimum 8 of these clients complete a follow-up interview.

Aggregated Data

In the semi-annual report, the grantee must also provide data about the costs for the delivery of screening and brief treatment as well as all other treatment modalities supported by this cooperative agreement including the mean, median, and range of costs overall, by modality, facility type and region, and sub-recipient, if applicable. The grantee must also discuss how such costs compare to the CSAT approved cost parameters for screening and brief intervention and what efforts they are undertaking to bring costs into line with those expected.

Grantees must comply with GPRA data collection and reporting requirements, including continuous reporting[6] of progress in meeting the targets proposed (in the application) for the number of persons to be served and the collection of the specified CSAT GPRA Core Client Outcomes at specified time points. Grantees are required to collect and report client level data for the overall project and for each sub-recipient using the CSAT GPRA data entry and reporting system.

Other Reporting Requirements

CSAT's GPRA Core Client Outcome domains are:

- Number of individuals served;
- Percent of service recipients who: have no past month substance use; have no or reduced alcohol or illegal drug consequences; are permanently housed in the community/living in a stable housing environment; are employed/in school; have no or reduced involvement with the criminal/juvenile justice system; have increased social connectedness; and, have good or improved health and mental health status.

Applicants must clearly state which GPRA service population(s) they propose to address as target populations. For more information, as well as the electronic versions of the CSAT GPRA materials, go to www.samhsa-gpra.samhsa.gov.

6 Continuous reporting is defined as entering client level data into the GPRA web based data system within 7 business days of collection.

2.6 Evaluation

While a formal local evaluation is not required, the grantee will be expected to monitor project implementation and document State-level and sub-recipient community level and provider agency level activities, accomplishments, and outcomes. The grantee will be expected to provide regular feedback to the project managers, staff, and Policy Steering Committee to ensure fidelity and improve operations and services.

Grantees are required to describe their evaluation plans in their application. The evaluation must include both process and outcome measures. Process and outcome evaluations measure change relating to project goals and objectives over time compared to baseline information. Control or comparison groups are not required.

Process components should address issues such as:

- How closely did implementation match the plan?
- What types of deviation from the plan occurred?
- What led to the deviations?
- What effect did the deviations have on the planned intervention and evaluation?
- Who (program, staff) provided what services (modality, type, intensity, duration), to whom (individual characteristics), in what context (system, community), and at what cost (facilities, personnel, dollars)?

Outcome components should address issues such as:

- What was the effect of the intervention on participants?
- What program/contextual factors were associated with outcomes?
- What individual factors were associated with outcomes?
- How durable were the effects?

SAMHSA will conduct a cross-site evaluation of all SBIRT projects funded under its SBIRT funding announcements. Projects funded under this announcement will be included in the cross-site evaluation and all grantees are required to participate in this evaluation. [7]

Data collection for the evaluation reports will be discussed and verified during an annual interview with a CSAT contractor, either conducted in-person or by telephone, with appropriate, knowledgeable project staff. [8]

2.7 Grantee Meetings

At least two people from each project (including the Project Director) must attend one grantee meeting in each year of the grant. The applicant must budget for these meetings. At these meetings, grantees will present the results of their projects and Federal staff will provide

7 OMB approval for this interview protocol will be sought by CSAT.

8 OMB approval for this interview protocol will be sought by CSAT.

technical assistance. Each meeting will be up to 3 days in length. These meetings will usually be held in the Washington, DC, metropolitan area and attendance is mandatory.

Additionally, grantees are required to attend two technical assistance meetings in the first year and one in each of the remaining years. The applicant must budget for these meetings. A minimum of four persons from each project is expected to attend the technical assistance meetings. Individuals who are required to attend technical assistance meetings are the Project Director, the individual responsible for overseeing clinical services by contracted providers participating in SBIRT, and the individual responsible for project GPRA reporting. The Government Project Officer (GPO) will identify the fourth person once the award is finalized. Meetings will be up to 5 days in length and will normally be held in the Washington, DC, metropolitan area.

Additional meetings may be convened over the course of the program to bring together project leadership from each grantee (e.g., the Policy Steering Committee Chairs, Project Directors) to share experiences, discuss implementation, policy change, financing, and reporting issues and to compare models in order to bring this program to full scale nationally, both in other States and other communities. The expenses for these meetings will be borne by SAMHSA/CSAT. Meetings will normally be held in the Washington, DC, metropolitan area.

II. AWARD INFORMATION

1. AWARD AMOUNT

It is expected that approximately $5.6 million will be available to fund up to two awards in FY 2006. Annual awards are expected to be approximately $2.8 million per year in total costs (direct and indirect) for up to 5 years. Should funding become available for SBIRT grants in FY 2007, SAMHSA may fund awards from among the highly scored but not funded applications received in FY 2006 (assuming a sufficient number of high quality applications) rather than issuing a new announcement in FY 2007.

Proposed budgets cannot exceed $2.8 million 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, and timely submission of required data and reports.

The applicant can propose to implement the project in as many sub-recipient communities[9] as it wishes. For each sub-recipient community chosen, the applicant must demonstrate need and potential for systems change to rapidly initiate the SBIRT approach. Each sub-recipient community must receive sufficient funds to enable the grantee to document an impact using the SBIRT performance targets.

9 For purposes of this announcement, a community may be a geopolitical unit (city, county), a health district or human services region, or a substate planning area as defined for purpose of allocating Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funds.

2. FUNDING MECHANISM

Awards for this funding opportunity will be made as cooperative agreements (see the Glossary in Appendix B for further explanation of this funding mechanism). The cooperative agreement mechanism is being used because substantial Federal staff involvement is required in the funded project. Grantees should anticipate significant interaction with Federal staff.

Grantees must:

- Comply with the terms and conditions of the cooperative agreement award.
- Agree to provide SAMHSA with data required for GPRA.
- Collaborate with CSAT staff in project implementation and monitoring.
- Select members and organize/conduct regular meetings of the project's Policy Steering Committee (PSC).
- Implement and monitor activities of the cooperative agreement project, including accountability for sub-recipients' service delivery.
- Collect, evaluate, and report Statewide treatment project and GPRA data.
- Respond to requests for program-related data.
- Document intended and actual systemic changes resulting from the project's activities.
- Submit the final Project Implementation Plan by the end of the third month following the award.
- Participate in the CSAT cross-site SBIRT evaluation.

SAMHSA staff will:

- Collaborate in selection of PSC members; review and approve final membership.
- Work collaboratively with the grantee, project staff, and PSC members to finalize the Project Implementation Plan; review and approve the plan to be submitted by the end of the third month for release of funds for implementation (i.e., Phases II and III).
- Provide best practice program information, resource materials, and technical assistance, e.g., examples of model programs, financing strategies and benefit designs, and screening and assessment tools/protocols to help grantees identify, select, and replicate evidence-based practices for implementing SBIRT.

- Provide guidance on how to assess resource allocation strategies in order to re-direct treatment resources toward an emphasis on persons at risk, or diagnosed with, a Substance Use Disorder (Substance Abuse or Dependence).

- Review and approve sub-recipient contracts and awards.

- Actively participate in PSC discussions.

- Work cooperatively with the grantee to make the transition from the cooperative agreement to State/Tribal and local control and to sustain the system changes achieved by the project.

The Policy Steering Committee will:

- Provide strategic policy and operational advice on the SBIRT project to the grantee as well as provide advice on integrating SBIRT into the existing system of care and on policies, as appropriate.

- Consist of 15 to 20 members and a chair, to be appointed by the grantee.

- Represent the Office of the Governor/highest ranking official and diverse stakeholders in the State/Tribe, including, for example, representatives from:
  -- Relevant State agencies (including the SSA)
  -- Community specialist treatment organizations
  -- General and specialist healthcare organizations (e.g., Federally Qualified Community Health Centers, hospitals, family practice clinics, emergency departments, ob-gyn clinics)
  -- Occupational health clinics and employee assistance programs or human resources departments
  -- Student health centers and student assistance programs
  -- Unions and member assistance programs
  -- Financial organizations (e.g., insurers, fiscal intermediaries, employers)
  -- Professional and trade associations
  -- Recovery community organizations
  -- Community coalitions
  -- Training agencies and universities
  -- Employers and business coalitions
  -- Insurers and managed care organizations

- Hold the initial meeting within 60 days of award and continue to meet once a month for the first year and quarterly in subsequent years.

- Coordinate with other State/Tribal agencies, commissions, and offices (including the SSA) as appropriate.

III. ELIGIBILITY INFORMATION

1. ELIGIBLE APPLICANTS

States, Territories, federally recognized tribes, and tribal organizations are eligible to apply. For States, the applicant must be the immediate Office of the Governor; for Territories, tribes, and tribal organizations, the applicant must be the highest ranking official. The Governor/highest ranking official must sign the application. Applications not signed by the Governor/highest ranking official are not eligible. State-level agencies are not considered to be part of the immediate Office of the Governor and are not eligible to apply. For example, the State Substance Abuse Authority (SSA) or other State-level agencies within the Executive Branch cannot apply independently. SAMHSA has limited eligibility because the immediate Office of the Governor/highest ranking official of a Territory, tribe and Tribal organization has the greatest potential to provide the multi-agency leadership needed to develop the applicant's treatment service systems to increase the applicant's capacity to provide accessible, effective, screening, brief intervention, referral and brief treatment services to persons at risk for, or diagnosed with, a Substance Use Disorder (Substance Abuse or Dependence). Eligible jurisdictions that have already begun to develop such integrated systems, stressing early intervention for persons at risk for, or diagnosed with, a Substance Use Disorder (Substance Abuse or Dependence), are especially encouraged to apply.

Current SBIRT grantees are not eligible applicants.

The Governor/highest ranking official will designate a lead official to be Project Director for the cooperative agreement. That individual may be, but is not required to be, part of the SSA. However, the services to be provided through this cooperative agreement program are to be integrated into the current system of care. Therefore, SAMHSA expects that the SSA will be involved in the project.

2. COST SHARING

Cost sharing (see Glossary in Appendix B) is not required in this program. Applications will not be screened out on the basis of cost sharing.

3. OTHER

3.1 Additional Eligibility Requirements

Applications must comply with the following requirements, or they will be screened out and will not be reviewed:

- Use of the PHS 5161-1 application;
- Application submission requirements in Section IV-3 of this document; and

- Formatting requirements provided in Section IV-2.3 of this document.

3.2 Evidence of Experience and Credentials

SAMHSA believes that only existing, experienced, and appropriately credentialed organizations with demonstrated infrastructure and expertise will be able to provide the required services quickly and effectively. Therefore, in addition to the basic eligibility requirements specified in this announcement, applicants must meet three additional requirements related to the provision of treatment services.

The three requirements are:

- A provider organization for direct client services (e.g., substance abuse treatment) appropriate to the cooperative agreement must be involved in each application. The provider may be the applicant or another organization committed to the project. More than one provider organization may be involved;

- Each direct service provider organization must have at least 2 years experience (as of the due date of the application) providing services in the geographic area(s) covered by the application; and

- Each direct service provider 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 **Appendix 1** of the 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 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 of the application, that all participating service provider organizations:

- Meet the 2-year experience requirement;

- Meet applicable licensing, accreditation, and certification requirements; and

- If the application is within the funding range, provide the Government Project Officer (GPO) with the required documentation within the time specified.

In addition, if, following application review, an application's score is within the fundable range for a grant award, the GPO will call the applicant and request that the following documentation be sent by overnight mail:

- A letter of commitment that specifies the nature of the participation and what service(s) will be provided from every service provider organization that has agreed to participate in the project;

- Official documentation that all participating organizations have 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 participating service provider 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, the application will be removed from consideration for an award.

IV. APPLICATION AND SUBMISSION INFORMATION

To ensure that you have met all submission requirements, a checklist is provided for your use in Appendix A of this document.

1. ADDRESS TO REQUEST APPLICATION PACKAGE

You may request a complete application kit from the National Clearinghouse for Alcohol and Drug Information (NCADI) at 1-800-729-6686.

You also may download the required documents from the SAMHSA web site at www.samhsa.gov/grants/index.aspx.

Additional materials available on this web site include:

- A 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

- Enhanced instructions for completing the PHS 5161-1 application.

2. CONTENT AND FORM OF APPLICATION SUBMISSION

2.1 Application Kit

SAMHSA application kits include the following documents:

- PHS 5161-1 (revised July 2000) – Includes the face page, 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 specific information about the availability of funds along with instructions for completing the grant application. This document is the RFA. The RFA will be available on the SAMHSA web site (www.samhsa.gov/grants/index.aspx) and a synopsis of the RFA is available on the Federal grants web site (www.Grants.gov).

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

2.2 Required Application Components

To ensure equitable treatment of all applications, applications must be complete. In order for your application to be complete, it must include the required 10 application components (Face Page, Abstract, Table of Contents, Budget Form, Project Narrative and Supporting Documentation, Appendices, Assurances, Certifications, Disclosure of Lobbying Activities, and Checklist).

- **Face Page –** Use Standard Form (SF) 424, which 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 www.dunandbradstreet.com or call 1-866-705-5711. To expedite the process, let Dun and Bradstreet know that your organization is a public/private nonprofit organization and that you are preparing to submit a Federal grant application.]

- **Abstract** – Your total abstract should be no longer than 35 lines. 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, in reports to Congress, and/or in press releases.

- **Table of Contents** – Include page numbers for each of the major sections of your application and for each appendix.

- **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 E of this document.

- **Project Narrative and Supporting Documentation** – The Project Narrative describes your project. It consists of Sections A through D. Sections A through D may not be longer than 30 pages. (Please Note: If the Project Narrative begins 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 the Project Narrative in Sections E through H. The only section with a page limitation is Section G, Biographical Sketches/Job Descriptions. Additional instructions for completing these sections are included in Section V under "Supporting Documentation".

- **Appendices 1 through 5 –** Use only the appendices listed below. If your application includes any appendices not required in this document, they will be disregarded. Do not use more than 30 pages for Appendices 1, 2, 3, and 5 combined. There is no page limitation for Appendix 4. Do not use appendices to extend or replace any of the sections of the Project Narrative. Reviewers will not consider them if you do.

  - *Appendix 1*: Provide: (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 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. The Statement of Assurance 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.

  - *Appendix 2*: Provide:

    - identification of the sub-recipient community within the State where the provider will deliver services;

    - a listing of modalities and services provided in the project; and

- a cross-walk that aligns the proposed modalities and costs with those that CSAT tracks if the modalities that the State funds within its continuum of care do not match those that CSAT tracks for GPRA and for which CSAT calculates program costs.

- *Appendix 3*: Provide: contracts; agreements; table of organization; performance schedule; task-sequencing chart; and letters of support/commitment.

  A plan, budget, budget justification and signed agreement for training and technical assistance.

- *Appendix 4:* Data Collection Instruments/Interview Protocols

- *Appendix 5:* Sample Consent Forms

- **Assurances** – Non-Construction Programs. Use Standard Form 424B found in PHS 5161-1. You are also required to complete the Assurance of Compliance with SAMHSA Charitable Choice Statutes and Regulations Form SMA 170. This form will be posted on SAMHSA's web site with the RFA and provided in the application kits available at SAMHSA's clearinghouse (NCADI).

- **Certifications** – Use the "Certifications" forms found in PHS 5161-1.

- **Disclosure of Lobbying Activities** – Use 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.

- **Checklist** – Use the checklist found in PHS 5161-1. The checklist ensures that you have obtained the proper signatures, assurances and certifications and is the last page of your application.

2.3 Application Formatting Requirements

Applicants also must comply with the following basic application requirements. Applications that do not comply with these requirements will be screened out and will not be reviewed.

- Information provided must be sufficient for review.

- ❑ Text must be legible. For Project Narratives submitted electronically in Microsoft Word, see separate requirements below under "Guidance for Electronic Submission of Applications."
  - Type size in the Project Narrative cannot exceed an average of 15 characters per inch, as measured on the physical page. (Type size in charts, tables, graphs, and footnotes will not be considered in determining compliance.)
  - Text in the Project Narrative cannot exceed 6 lines per vertical inch.

- ❑ Paper must be white paper and 8.5 inches by 11.0 inches in size.

- ❑ To ensure equity among applications, the amount of space allowed for the Project Narrative cannot be exceeded. For Project Narratives submitted electronically in Microsoft Word, see separate requirements below under "Guidance for Electronic Submission of Applications."
  - Applications would meet this requirement by using all margins (left, right, top, bottom) of at least one inch each, and adhering to the 30-page limit for the Project Narrative.
  - Should an application not conform to these margin or page limits, SAMHSA will use the following method to determine compliance: The total area of the Project Narrative (excluding margins, but including charts, tables, graphs and footnotes) cannot exceed 58.5 square inches multiplied by 30. This number represents the full page less margins, multiplied by the total number of allowed pages.
  - Space will be measured on the physical page. Space left blank within the Project Narrative (excluding margins) is considered part of the Project Narrative, in determining compliance.

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, following these guidelines will help reviewers to consider your application.

- ❑ Pages should be typed single-spaced in black ink, with one column per page. Pages should not have printing on both sides.

- ❑ Please number pages consecutively from beginning to end so that information can be located easily during review of the application. The cover page should be page 1, the abstract page should be page 2, and the table of contents page should be page 3. Appendices should be labeled and separated from the Project Narrative and budget section, and the pages should be numbered to continue the sequence.

- ❑ The page limit of a total of 30 pages for Appendices 1, 2, 3, and 5 combined should not be exceeded.

- ❑ Send the original application and two copies to the mailing address in Section IV-6.1 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.

Guidance for Electronic Submission of Applications

SAMHSA offers the opportunity for you to submit your application to us either in electronic or paper format. Register one time, and Grants.gov will generate your information for future applications so you don't have to re-enter it. Built-in error-checking increases the completeness and accuracy of your application. 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 www.Grants.gov apply site. You will be able to download a copy of the application package from 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.

You may search the Grants.gov site 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 www.Grants.gov apply site, on the Customer Support tab. 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 Customer Support Center is open from 7:00 a.m. to 9:00 p.m. Eastern Time, Monday through Friday.

If this is the first time you have submitted an application through Grants.gov, you must complete four 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: DUNS Number registration, Central Contractor Registry (CCR) registration, Credential Provider registration, and Grants.gov registration.

It is strongly recommended that you submit your grant application using Microsoft Office products (e.g., Microsoft Word, Microsoft Excel, etc.). If you do not have access to Microsoft Office products, you may submit a PDF file. 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 above, and 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 to ensure the accurate transmission and equitable treatment of applications.

- *Text legibility:* Use a font of Times New Roman 12 point, line spacing of single space, and all margins (left, right, top, bottom) of one inch each. Adhering to these standards will help to ensure the accurate transmission of your document. If the type size in the Project Narrative of an electronic submission exceeds 15 characters per inch, or the text exceeds 6 lines per vertical inch, SAMHSA will reformat the document to Times New Roman 12, with line spacing of single space. Please note that this may alter the formatting of your document, especially for charts, tables, graphs, and footnotes.

- *Amount of space allowed for Project Narrative:* The Project Narrative for an electronic submission may not exceed 15,450 words. If the Project Narrative for an electronic submission exceeds the word limit and exceeds the allowed space as defined in Appendix A, then **any part of the Project Narrative in excess of these limits will not be submitted to review**. To determine the number of words in your Project Narrative document in Microsoft Word, select file/properties/statistics.

While keeping the Project Narrative as a separate document, please consolidate all other materials in your application to ensure the fewest possible number of attachments. Ensure all pages in your application are numbered consecutively, with the exception of the standard forms in the PHS-5161 application package. Please name and number your attachments, indicating the order in which they should be assembled. 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. You may also submit a back-up paper submission of your application. Any such paper submission must be received in accordance with the requirements for timely submission detailed in Section IV-3 of this announcement. The paper submission must be clearly marked: **"Back-up for electronic submission."** The paper submission must conform with all requirements for non-electronic submissions. If both electronic and back-up paper submissions are received by the deadline, the electronic version will be considered the official submission.

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. **Include the Grants.gov tracking number in the top right corner of the face page for any paper submission.**

The Grants.gov Web site does not accept electronic signatures at this time. Therefore, you must submit a signed paper original of the face page (SF 424), the assurances (SF 424B), and the

certifications, and hard copy of any other required documentation that cannot be submitted electronically. **You must include the Grants.gov tracking number for your application on these documents with original signatures, on the top right corner of the face page, and send the documents to the following address. 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 service (DHL, Federal Express, United Parcel 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 **20850**
ATTN: Electronic Applications

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

3. SUBMISSION DATES AND TIMES

Applications are due by close of business on **April 27, 2006**. **Hand carried applications will not be accepted. Applications may be shipped using only DHL, Federal Express (FedEx), United Parcel Service (UPS), or the United States Postal Service (USPS).**

Your application must be received by the application deadline, or you must have proof of its timely submission as specified below.

- **For packages submitted via DHL, Federal Express (FedEx), or United Parcel Service (UPS), proof of timely submission shall be the date on the tracking label affixed to the package by the carrier upon receipt by the carrier. That date must be at least 24 hours prior to the application deadline. The date affixed to the package by the applicant will not be sufficient evidence of timely submission.**

- For packages submitted via the United States Postal Service (USPS), proof of timely submission shall be a postmark not later than 1 week prior to the application deadline, and the following upon request by SAMHSA:
  -- proof of mailing using USPS Form 3817 (Certificate of Mailing), or
  -- receipt from the Post Office containing the post office name, location, and date and time of mailing.

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

Applications not meeting the timely submission requirements above will not be considered for review. Please remember that mail sent to Federal facilities undergoes a security screening prior to delivery. Allow sufficient time for your package to be delivered.

If an application is mailed to a location or office (including room number) that is not designated for receipt of the application, and that results in the designated office not receiving your application in accordance with the requirements for timely submission, it will cause the application to be considered late and ineligible for review.

SAMHSA will not accept or consider any applications sent by facsimile.

SAMHSA is collaborating with www.Grants.gov to accept electronic submission of applications. Please refer to Section IV-2.3 above for "Guidance for Electronic Submission of Applications."

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

Executive Order 12372, as implemented through Department of Health and Human Services (DHHS) regulation at 45 CFR Part 100, sets up a system for State and local review of applications for Federal financial assistance. A current listing of State Single Points of Contact (SPOCs) is included in the application kit and can be downloaded from the Office of Management and Budget (OMB) web site at www.whitehouse.gov/omb/grants/spoc.html.

- Check the list to determine whether your State participates in this program. **You do not** need to do this if you are a federally recognized tribe.

- 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. TI-06-002

For other delivery 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 **20850**
ATTN: SPOC – Funding Announcement No. TI-06-002

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 www.hhs.gov/grantsnet/roadmap/index.html.

- 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 Cooperative Agreements for Screening, Brief Intervention, Referral and Treatment grant recipients must comply with the following funding restriction:

- Of the 20 percent (20%) of the award allowable for activities needed to carry out project administration (see Section I-2.2 SBIRT Allocation of Funds), no more than 10 percent (10%) of the award may be used for evaluation and data collection, including GPRA and incentives for completing the evaluation.

Cooperative Agreements for Screening, Brief Intervention, Referral and Treatment 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 substance abuse treatment.

- Provide inpatient treatment or hospital-based detoxification services. Residential services are not considered to be inpatient or hospital-based services.

- Pay for incentives to induce individuals to enter treatment. However, a grantee or treatment provider may provide up to $20 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.

- Implement syringe exchange programs, such as the purchase and distribution of syringes and/or needles.

- 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.

6. OTHER SUBMISSION REQUIREMENTS

6.1 Where to Send Applications

Guidance for Electronic Submission of Applications is contained in Section IV-2.3 of this announcement. Following are instructions for submission of paper applications.

Send applications 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**

For other delivery 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 **20850**

Do not send applications to other agency contacts, as this could delay receipt. Be sure to include **SBIRT** and the RFA number, **TI-06-002**, in item number 10 on the face page of any paper applications. If you require a telephone number for delivery, you may use (240) 276-1199.

6.2 How To Send Applications

SAMHSA is collaborating with www.Grants.gov to accept electronic submission of applications. Please refer to Section IV-2.3 of this announcement for Guidance for Electronic Submission of Applications.

Following are instructions for submission of paper applications.

Mail or deliver an original application and 2 copies (including appendices) to the mailing address provided above, according to the instructions in Section IV-3. The original and copies must not be bound. Do not use staples, paper clips, or fasteners. Nothing should be attached, stapled, folded, or pasted.

Hand carried applications will not be accepted. Applications may be shipped using only DHL, Federal Express (FedEx), United Parcel Service (UPS), or the United States Postal Service (USPS).

SAMHSA will not accept or consider any applications sent by facsimile.

V. APPLICATION REVIEW INFORMATION

1. EVALUATION CRITERIA

Your application will be reviewed and scored according to the quality of your response to the requirements listed below for developing the Project Narrative (Sections A–D). These sections describe what you intend to do with your project.

- 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-D) together may be no longer than 30 pages.

- You must use the four 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. Points will be assigned based on how well you address the cultural competence aspects of the evaluation criteria. SAMHSA's guidelines for cultural competence can be found on the SAMHSA web site at www.samhsa.gov. Click on "Grants/SAMHSA's Supporting Grant Information/Useful Information for Applicants/Guidelines and Resources for Grant Applicants."

- The Supporting Documentation you provide in Sections E-H and Appendices 1-5 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. Bullet statements in each section do not have points assigned to them. They are provided to invite the attention of applicants and reviewers to important areas within the criterion.

Section A: Statement of Need (10 points)

- Describe the need for treatment statewide and for each community in which SBIRT will be implemented. Include as much documentation as possible, with the focus on differentiating clinically appropriate treatment for persons at risk for, or diagnosed with, a Substance Use Disorder (Substance Abuse or Dependence).

  Note: Documentation of treatment need, demand, barriers to access, and resource availability may come from a variety of qualitative and quantitative sources (Dewit and Rush, 1996; NIDA, 1998; Weisner, 2001; McAuliffe, 2002.) The quantitative data could come from locally generated data or trend analyses, from State data such as that available through State Treatment Needs Assessments, social indicator analyses, waiting list analyses, and/or through national data sets, such as that available from SAMHSA's National Survey on Drug Use and Health (NSDUH), Drug Abuse Warning Network

(DAWN), and Drug and Alcohol Services Information System (DASIS), which includes the National Survey of Substance Abuse Treatment Services (N-SSATS) and the Treatment Episode Data Set (TEDS). The description and data will provide the baseline for monitoring performance against the SBIRT targets.

- Describe the State's/Tribe's current resources and continuum of care for persons at risk, or diagnosed with, a Substance Use Disorder (Substance Abuse or Dependence), including the provider and practitioner resources and the funding streams available for intervention and treatment services in the generalist and specialist systems.

- Describe how the applicant currently plans for, funds, and provides intervention and treatment services within its continuum of care (including SBIRT if it is part of the current continuum of care) and how SBIRT (or SBIRT expansion) can be integrated into the financing and provider systems. Include a discussion of the use of patient placement criteria and standardized screening and sequential assessment protocols, if these are used, and the modalities in which persons are placed. If the modalities that the applicant funds do not match those for which CSAT calculates program costs, provide a crosswalk that aligns your modalities and costs for each with those that CSAT tracks for GPRA (screening, brief intervention, brief treatment, outreach/pretreatment services, outpatient (non-methadone), outpatient (methadone), and residential). Where necessary, include the crosswalk between CSAT program cost modalities and the applicant's continuum of care in **Appendix 2**.

- Explain why the existing services are insufficient or inappropriate to respond to the demand for services and the treatment needs of the target population chosen for this application.

- Provide a description and analysis of the three most important barriers existing that prevent persons who need and seek treatment from accessing the clinically appropriate type and level of treatment. Barriers to be addressed might include laws, regulations, eligibility requirements for service receipt, facility and provider eligibility requirements, varied funding streams, coverage limitations, lack of patient placement criteria or standardized screening and sequential assessment protocols, etc.

- Describe the method used to select the communities for which funding is to be directed to increase services. Document for each how the need for treatment significantly exceeds the capacity to provide services, the potential for systems change, and that strategies exist to rapidly initiate SBIRT. Provide the same kinds of information about need, resources, and barriers for each community in which the project will be implemented that has been provided for the State/Tribe. Where policies are the same statewide so indicate, and describe only local variations (e.g., a local tax used to fund prevention or treatment).

Section B: Proposed Implementation and Systems Change Approach (55 points)

- Cleary state the purpose, goals, and objectives of your proposed project. Describe how achievement of the goals will produce meaningful and relevant results (e.g., increase access, availability, prevention, outreach, pre-services, treatment, and/or intervention).

- Provide a detailed Project Implementation Plan that explains how the grantee proposes to use project funds in conjunction with other available funding sources to provide SBIRT services. All funding sources that are or could be used to pay for screening and treatment of Substance Use Disorders (e.g., State General Fund, Medicaid, Preventive Health and Health Services Block Grant, Community Health Center grants, commercial insurance, Substance Abuse Prevention and Treatment Block Grant, Temporary Assistance for Needy Families (TANF) Block Grant, Child Care and Development (CCDF) Block Grant, Maternal and Child Health Block Grant) should be addressed, but the focus should be on the three major funding streams that you will use to increase support and decrease barriers.

- Demonstrate how the proposed services/practices will meet your goals and objectives. Provide a logic model (see Appendix B: Glossary and Appendix D: Logic Model Resources) that links need, the services or practice to be implemented, and outcomes.

- Describe how the applicant will increase the number of generalist settings that provide SBIRT in each sub-recipient community as a result of the award and redirection of other funding sources.

- Describe how the applicant will provide SBIRT within its continuum of care, within the geographic areas proposed, including a description of the modalities and services to be provided, the protocols that will be used for standardizing screening, assessment, determining the level of service required, referral, brief intervention, brief treatment, and follow up. Provide a justification for the procedures to be used, including a discussion of the evidence-based services/practices that you propose to implement. The modalities and services described should match those listed in **Appendix 2**.

- Describe how the proposed project will address issues of age, race, ethnicity, culture, language, sexual orientation, disability, literacy, and gender in the target population, while retaining fidelity to the chosen practice.

- If the applicant chooses to expend funds for other treatment modalities within the continuum of care, describe how these services will be implemented. Applicants that do not seek to fund specific components of their continuum of care through the SBIRT cooperative agreement must provide evidence that there is a sufficient amount of services in those elements of the continuum (modalities) for each community to be included.

- Describe how the applicant will overcome the barriers to accessing clinically appropriate care, using the SBIRT approach. Whenever possible, apply findings from recent

literature and other information that demonstrates a thorough understanding of the issues faced in introducing SBIRT into the applicant's continuum of care. Include literature citations in Supporting Documentation, Section E of your application.

- Describe the linkages to be developed between the participating specialist and community agencies for referrals, cooperation in case management, and information sharing.

- Provide a plan to make available training and technical assistance to sub-recipient communities, including information about SBIRT methods, training for staff in the community and specialist settings in carrying out SBIRT, and technical assistance to the overall project and its sub-recipients.[10] Include the plan, budget, budget justification and signed agreement in **Appendix 3** of the application.

- Describe how the applicant will increase access and availability of services to a larger number of persons at risk, or diagnosed with, a Substance Use Disorder (Substance Abuse or Dependence) as a result of the award. State clearly the number of additional persons to be served for each year of the proposed cooperative agreement in each element of SBIRT (i.e., number of persons projected to receive Screening Only, number of persons projected to receive Screening and Brief Intervention [BI], and the number of persons projected to receive Screening and Brief Treatment [BT] or Screening and Referral to Other Types of Treatment for Substance Use Disorders [RT]) and the number of persons to receive clinically appropriate treatment in all other modalities within the system. Show that the targets are feasible and reasonable.

- Describe the expected outcomes of treatment (e.g., decreased drug use in those patients receiving services through SBIRT) and the means by which you determined these targets. Show that the targets are feasible and reasonable.

- Describe your plan to ensure project sustainability when funding for this project 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.

Section C: Staff and Organizational Experience (20 points)

Project Management Plan. There will be three phases to the project: project planning and start up; operations; and phase out. For each phase of the project, provide a realistic management plan that describes the organizations and staff that will be involved in the project; present their roles in the project; and address their relevant experience.

10 The State may wish to consider subcontracting with the SAMHSA/CSAT funded Addiction Technology Training Centers (ATTCs) already working with its SSA or an in-state resource. A list of ATTCs, the States covered by each, and contact information is provided in Appendix I. If a subcontract with the ATTC, another academic institution, or a vender is used, the plan should include the cost for providing these activities as a separate budget component.

- Describe the structure, roles, and individual tasks to be performed to carry out the required service delivery activities and project administration including: (1) policy and systems change; (2) training and technical assistance:[11] (3) monitoring sub-recipients' implementation of service delivery and data collection; and (4) project reporting. The Governor's/highest ranking official's office must provide oversight to the grant and will be accountable for its related activities. This responsibility cannot be delegated. Be sure to include a description of the role and the processes to be used to ensure significant involvement and oversight of the project by the grantee, the Policy Steering Committee, the Project Director, the State Substance Abuse Authority (SSA), and other relevant agencies.

- Provide a staffing plan that includes the level of effort and qualifications of the Project Director and other key personnel, such as the administrative staff providing oversight in the Governor's/highest ranking official's office, the clinical personnel in the community and specialist treatment agencies, trainers, and support personnel, specifying the agency that will employ these persons.

- Provide a description of the project organization, Statewide and for each sub-recipient community system. Include Contracts, Agreements, Table of Organization, Performance Schedule, Task-Sequencing Chart, and Letters of Support/Commitment in **Appendix 3**.

- Provide evidence that the existing and proposed staff have or will receive training to develop the requisite experience and cultural sensitivity necessary to provide services to the target population. Show evidence of the appropriateness of the proposed staff in relation to the age, race, ethnicity, culture, language, sexual orientation, disability, literacy, and gender of the target population.

- Provide a performance schedule for task completion that includes a description of sequential relationships and approximate level of effort required per task (in person hours or full-time equivalents). Each task should be related to the project goals and objectives, as well as to management and staffing levels.

- **Phase I: Project Planning and Start up.** Describe how the applicant will complete each of the start up tasks specified above under I-2.4 Project Phases and Operations, Phase I: Project Phases and Operations, which are necessary to implement the project. Describe how the grantee and the Policy Steering Committee will ensure that every component of the project is fully operational at the conclusion of Phase I and will monitor task accomplishments.

- **Phase II: Operations**. Describe the actions and timelines necessary for carrying out the systems change and service delivery activities described as part of the initial planning phase. Describe how the applicant will carry out the activities necessary to implement the

11 Limited technical assistance on implementation, reporting, and monitoring progress toward meeting the SBIRT targets will be available if problems arise that cannot be resolved with the project's resources alone.

project as identified above under I-2.4 Project Phases and Operations, Phase II: Operations.

- **Phase III: Phase-Out**. Describe the activities planned to make the transition from the SBIRT cooperative agreement funding to State/Tribe and local control and funding in order to sustain the system changes achieved by the project.

Section D: Evaluation and Data (15 points)

- Provide a plan for collecting, analyzing, interpreting, and reporting data on activities, costs, and outcomes, including the means by which the overall project and each sub-recipient will comply with GPRA requirements--the collection of CSAT's GPRA Core Client Outcomes, and tracking and follow-up procedures.

- The applicant will be expected to monitor implementation of the project and the fidelity of implementation to the applicant's plan. Therefore, the plan should explain how the applicant intends to:

  -- Document the State/Tribal-level and the sub-recipient community level and provider agency level activities, accomplishments, and outcomes associated with the SBIRT project;

  -- Collect data in addition to the GPRA items, if any, using both quantitative and qualitative approaches as needed;

  -- Measure changes in these activities and accomplishments over the life of the project;

  -- Document what was actually done, what was learned, what barriers inhibited implementation, how such barriers were resolved, and what should be done differently in future projects;

  -- Provide for obtaining consistent and uniform information across programs and sub-recipient sites Statewide; and

  -- Provide regular feedback to the project managers, staff, and Policy Steering Committee to help the project improve operations and services. This feedback should include both process and outcome measures.

- Provide a per-person or unit cost of the project to be implemented, based on the applicant's actual costs and projected costs over the life of the project. Applicants must state whether or not the per person costs are within the following reasonable ranges by treatment modality. Applicants must also discuss the reasonableness of the per person costs. If proposed costs exceed reasonable ranges, a detailed justification must be provided.

  Program Costs. The following are considered reasonable ranges by treatment modality:

-- Residential: $3,000 to $10,000
-- Outpatient (Non-Methadone): $1,000 to $5,000
-- Outpatient (Methadone) : $1,500 to $8,000
-- Intensive Outpatient: $1,000 to $7,500
-- Screening/Brief Intervention/Brief Treatment/Outreach/Pretreatment Services: $200 to $1,200
--Drug Court Programs (regardless of client treatment modality): $3,000 to $5,000

The outreach and pretreatment services cost band only applies to outreach and pretreatment programs that do not offer treatment services but operate with a network of substance abuse treatment facilities. Treatment programs that add outreach and pretreatment services to a treatment modality or modalities are expected to fall within the cost band for that treatment modality.

NOTE: Applicants should be aware that the Review Group will also be asked to comment on the appropriateness of the budget after the merits of the application have been considered.

SUPPORTING DOCUMENTATION

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

Section F: 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.

Section G: Biographical Sketches and Job Descriptions.

- Include a biographical sketch for the Project Director and other key personnel. 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 at www.hhs.gov/forms/PHS-5161-1.doc.

Section H: Confidentiality and SAMHSA Participant Protection/Human Subjects: Applicants must describe procedures relating to Confidentiality, Participant Protection and the Protection of Human Subjects Regulations in Section H of the 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 bullets 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 bullets, 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 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 protection of human subjects identified during peer review of the application may result in the delay of 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 target population(s) 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.).

- 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 **Appendix 4, "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 **Appendix 5, "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

Applicants may also have to comply with the Protection of Human Subjects Regulations (45 CFR 46), depending on the evaluation and data collection procedures proposed and the population to be served.

Applicants must be aware that even if the Protection of Human Subjects Regulations do not apply to all projects funded, the specific evaluation design proposed by the applicant may require compliance with these regulations.

Applicants whose projects must comply with the Protection of Human Subjects Regulations must describe the process for obtaining Institutional Review Board (IRB) approval fully in their applications. While IRB approval is not required at the time of grant award, these applicants will be required, as a condition of award, to provide the documentation that an Assurance of Compliance is on file with the Office for Human Research Protections (OHRP) and that IRB approval has been received prior to enrolling any clients in the proposed project.

General information about Protection of Human Subjects Regulations can be obtained on the web at www.hhs.gov/ohrp. You may also contact OHRP by e-mail (ohrp@osophs.dhhs.gov) or by phone (240-453-6900). SAMHSA-specific questions related to Protection of Human Subjects Regulations should be directed to the program contact listed in Section VII of this RFA.

2. REVIEW AND SELECTION PROCESS

SAMHSA applications are peer-reviewed according to the review criteria listed above. For those programs where the individual award is over $100,000, applications must also 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 Substance Abuse Treatment's National Advisory Council;

- Availability of funds; and

- Equitable distribution of awards in terms of geography (including urban, rural and remote settings) and balance among target populations and program size.

SAMHSA/CSAT will make no more than one award per State or Tribe.

VI. AWARD 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, the Notice of Grant Award, signed by SAMHSA's Grants Management Officer. The Notice of Grant Award is the sole obligating document that allows the grantee to receive Federal funding for work on the grant project. It is sent by postal mail and is addressed to the contact person listed on the face page of the application.

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

2. ADMINISTRATIVE AND NATIONAL POLICY REQUIREMENTS

- Successful applicants 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 www.samhsa.gov/grants/generalinfo/grants_management.aspx.

- Successful applicants 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 (www.samhsa.gov/Grants/generalinfo/grant_reqs.aspx).

- Depending on the nature of the specific funding opportunity and/or the proposed project as identified during review, additional terms and conditions may be negotiated with the grantee 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; or
  -- Requirements to address problems identified in review of the application.

- Successful applicants 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. Applicants are encouraged to complete the survey and return it, using the instructions provided on the survey form.

3. REPORTING REQUIREMENTS

3.1 Progress and Financial Reports

- In addition to the data collection, monitoring, and reporting requirements listed in Section I of this document, grantees must submit semi-annual and annual progress reports and applications for continued funding near the end of each year. Specific submission dates, instructions, and format will be provided by CSAT. These reports will be one part of the SBIRT-specific evaluation. Because SAMHSA is extremely interested in ensuring that treatment services can be sustained, your progress reports should explain plans to ensure the sustainability (see Appendix B, Glossary) of efforts initiated under this grant. Initial plans for sustainability should be described in year 01. In each subsequent year, you should describe the status of your project, as well as the successes achieved and obstacles encountered in that year.

- Grantees must submit a final report. Specific submission dates, instructions, and format will be provided by CSAT. The final report must summarize information from the semi-annual reports and describe the accomplishments of the project and planned next steps for sustaining the systems and service changes developed during the cooperative agreement period.

- Grantees must commit to and report performance against targets for (1) reducing drug use by patients receiving treatment through the SBIRT project; (2) increasing the number of persons at risk for, or diagnosed with, a Substance Use Disorder (Substance Abuse or Dependence) who receive treatment in each sub-recipient community; (3) increasing the number of community settings where SBIRT services are provided, and (4) providing treatment services within approved cost parameters for each treatment modality.

- Grantees must provide annual and final financial status reports.

- SAMHSA will provide guidelines and requirements for these reports to grantees 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 the grantee's 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 Cooperative Agreements for Screening, Brief Intervention, Referral and Treatment are described in Section I-2.5 of this document under Data 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:

Tom Stegbauer
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Lane
Room 5-1099
Rockville, Maryland 20850
(240) 276-2965
tom.stegbauer@samhsa.hhs.gov

For questions on grants management issues contact:

Kimberly Pendleton
Office of Program Services, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Room 7-1097
Rockville, Maryland 20857
(240) 276-1421
kimberly.pendleton@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.

- ❑ Applications must be received by the application deadline or have proof of timely submission, as detailed in Section IV-3 of the grant announcement.

- ❑ Information provided must be sufficient for review.

- ❑ Text must be legible. (For Project Narratives submitted electronically in Microsoft Word, see separate requirements in Section IV-2.3 of this announcement under "Guidance for Electronic Submission of Applications.")
  - Type size in the Project Narrative cannot exceed an average of 15 characters per inch, as measured on the physical page. (Type size in charts, tables, graphs, and footnotes will not be considered in determining compliance.)
  - Text in the Project Narrative cannot exceed 6 lines per vertical inch.

- ❑ Paper must be white paper and 8.5 inches by 11.0 inches in size.

- ❑ To ensure equity among applications, the amount of space allowed for the Project Narrative cannot be exceeded. (For Project Narratives submitted electronically in Microsoft Word, see separate requirements in Section IV-2.3 of this announcement under "Guidance for Electronic Submission of Applications.")
  - Applications would meet this requirement by using all margins (left, right, top, and bottom) of at least one inch each, and adhering to the page limit for the Project Narrative stated in the specific funding announcement.
  - Should an application not conform to these margin or page limits, SAMHSA will use the following method to determine compliance: The total area of the Project Narrative (excluding margins, but including charts, tables, graphs and footnotes) cannot exceed 58.5 square inches multiplied by the page limit. This number represents the full page less margins, multiplied by the total number of allowed pages.
  - Space will be measured on the physical page. Space left blank within the Project Narrative (excluding margins) is considered part of the Project Narrative, in determining compliance.

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 10 application components required for SAMHSA applications should be included. These are:

    - o Face Page (Standard Form 424, which is in PHS 5161-1)
    - o Abstract
    - o Table of Contents
    - o Budget Form (Standard Form 424A, which is in PHS 5161-1)
    - o Project Narrative and Supporting Documentation
    - o Appendices
    - o Assurances (Standard Form 424B, which is in PHS 5161-1)
    - o Certifications (a form within PHS 5161-1)
    - o Disclosure of Lobbying Activities (Standard Form LLL, which is in PHS 5161-1)
    - o Checklist (a form in PHS 5161-1)

    - ❑ Applications should comply with the following requirements:

        - o Provisions relating to confidentiality and participant protection specified in Section V-1 of this announcement.
        - o Budgetary limitations as specified in Sections I, II, and IV-5 of this announcement.
        - o 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.

- ❑ Please number pages consecutively from beginning to end so that information can be located easily during review of the application. The cover page should be page 1, the abstract page should be page 2, and the table of contents page should be page 3. Appendices 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 Appendices stated in the specific funding announcement should not be exceeded.

- ❑ Send the original application and two copies to the mailing address in Section IV-6.1 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 – Glossary

At Risk: For the purpose of this Request of Applications, a person who is "at risk" is defined as one who is using substances but who does not yet meet the criteria for a diagnosis of Substance Use Disorder.

Best Practice: Best practices are practices that incorporate the best objective information currently available regarding effectiveness and acceptability.

Catchment Area: A catchment area is the geographic area from which the target population to be served by a program will be drawn.

Cooperative Agreement: A cooperative agreement is a form of Federal grant. Cooperative agreements are distinguished from other grants in that, under a cooperative agreement, substantial involvement is anticipated between the awarding office and the recipient during performance of the funded activity. This involvement may include collaboration, participation, or intervention in the activity. HHS awarding offices use grants or cooperative agreements (rather than contracts) when the principal purpose of the transaction is the transfer of money, property, services, or anything of value to accomplish a public purpose of support or stimulation authorized by Federal statute. The primary beneficiary under a grant or cooperative agreement is the public, as opposed to the Federal Government.

Fidelity: Fidelity is the degree to which a specific implementation of a program or practice resembles, adheres to, or is faithful to the evidence-based model on which it is based. Fidelity is formally assessed using rating scales of the major elements of the evidence-based model. A toolkit on how to develop and use fidelity instruments is available from the SAMHSA-funded Evaluation Technical Assistance Center at http://tecathsri.org or by calling (617) 876-0426.

Grant: A grant is the funding mechanism used by the Federal Government when the principal purpose of the transaction is the transfer of money, property, services, or anything of value to accomplish a public purpose of support or stimulation authorized by Federal statute. The primary beneficiary under a grant or cooperative agreement is the public, as opposed to the Federal Government.

Logic Model: A logic model is a diagrammatic representation of a theoretical framework. A logic model describes the logical linkages among program resources, conditions, strategies, short-term outcomes, and long-term impact. More information on how to develop logics models and examples can be found through the resources listed in Appendix D.

Practice: A practice is any activity, or collective set of activities, intended to improve outcomes for people with or at risk for substance abuse and/or mental illness. Such activities may include direct service provision, or they may be supportive activities, such as efforts to improve access to and retention in services, organizational efficiency or effectiveness, community readiness, collaboration among stakeholder groups, education, awareness, training, or any other activity

that is designed to improve outcomes for people with or at risk for substance abuse or mental illness.

Practice Support System: This term refers to contextual factors that affect practice delivery and effectiveness in the pre-adoption phase, delivery phase, and post-delivery phase, such as: a) community collaboration and consensus building; b) training and overall readiness of those implementing the practice; and c) sufficient ongoing supervision for those implementing the practice.

Stakeholder: A stakeholder is an individual, organization, constituent group, or other entity that has an interest in and will be affected by a proposed grant project.

Sustainability: Sustainability is the ability to continue a program or practice after SAMHSA grant funding has ended.

Target Population: The target population is the specific population of people whom a particular program or practice is designed to serve or reach.

Wraparound Service: Wraparound services are non-clinical supportive services—such as child care, vocational, educational, and transportation services—that are designed to improve the individual's access to and retention in the proposed project.

Appendix C - Statement of Assurance

As the authorized representative of the applicant organization, I assure SAMHSA that if [*insert name of organization*] application is within the funding range for a grant award, the organization 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 that specifies the nature of the participation and what service(s) will be provided from every service provider organization listed in Appendix 1 of the application, that has agreed to participate in the project;

- official documentation that all service provider organizations participating in the project have 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 all participating service provider organizations are 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 <u>does not</u> constitute adequate documentation.)

_____ _____

Signature of Authorized Representative Date

Appendix D – 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. (l997). 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.

Appendix E – Sample Budget and Justification

ILLUSTRATION OF A SAMPLE DETAILED BUDGET AND NARRATIVE JUSTIFICATION TO ACCOMPANY SF 424A: SECTION B FOR 01 BUDGET PERIOD

OBJECT CLASS CATEGORIES

Personnel

Job Title	Name	Annual Salary	Level of Effort	Salary being Requested
Project Director	J. Doe	$30,000	1.0	$30,000
Secretary	Unnamed	$18,000	0.5	$ 9,000
Counselor	R. Down	$25,000	1.0	$25,000

Enter Personnel subtotal on 424A, Section B, 6.a. $64,000

Fringe Benefits (24%) $15,360

Enter Fringe Benefits subtotal on 424A, Section B, 6.b. $15,360

Travel

2 trips for SAMHSA Meetings for 2 Attendees (Airfare @ $600 x 4 = $2,400) + (per diem @ $120 x 4 x 6 days = $2,880)	$5,280
Local Travel (500 miles x .24 per mile)	120

[Note: Current Federal Government per diem rates are available at www.gsa.gov.]

Enter Travel subtotal on 424A, Section B, 6.c. $ 5,400

Equipment (List Individually)

"Equipment" means an article of nonexpendable, tangible personal property having a useful life of more than one year and an acquisition cost which equals the lesser of (a) the capitalization level established by the governmental unit or nongovernmental applicant for financial statement purposes, or (b) $5000.

Enter Equipment subtotal on 424A, Section B, 6.d.

Supplies

Office Supplies	$500
Computer Software - 1 WordPerfect	500

Enter Supplies subtotal on 424A, Section B, 6.e. $1,000

Contractual Costs

Evaluation

Job Title	Name	Annual Salary	Salary being Requested	Level of Effort
Evaluator	J. Wilson	$48,000	$24,000	0.5
Other Staff		$18,000	$18,000	1.0

Fringe Benefits (25%)	$10,500		
Travel			
2 trips x 1 Evaluator ($600 x 2)		$ 1,200	
per diem @ $120 x 6		720	
Supplies (General Office)		500	
Evaluation Direct			$54,920
Evaluation Indirect Costs (19%)			$10,435
Evaluation Subtotal			$65,355

Training

Job Title	Name	Level of Effort	Salary being Requested
Coordinator	M. Smith	0.5	$ 12,000
Admin. Asst.	N. Jones	0.5	$ 9,000
Fringe Benefits (25%)			$ 5,250

Travel		
2 Trips for Training		
Airfare @ $600 x 2	$ 1,200	
Per Diem $120 x 2 x 2 days	480	
Local (500 miles x .24/mile)	120	
Supplies		
Office Supplies	$ 500	
Software (WordPerfect)	500	
Other		
Rent (500 Sq. Ft. x $9.95)	$ 4,975	
Telephone	500	
Maintenance (e.g., van)	$ 2,500	
Audit	$ 3,000	
Training Direct		$ 40,025
Training Indirect		$ -0-

Enter Contractual subtotal on 424A, Section B, 6.f. **$105,380**

ILLUSTRATION OF DETAILED BUDGET AND NARRATIVE JUSTIFICATION (cont'd.)

Other

Consultants = Expert @ $250/day X 6 day $ 1,500
(If expert is known, should list by name)

Enter Other subtotal on 424A, Section B, 6.h. **$ 1,500**

Total Direct Charges (sum of 6.a-6.h)
Enter Total Direct on 424A, Section B, 6.i. **$192,640**

Indirect Costs

15% of Salary and Wages (copy of negotiated indirect cost rate agreement attached)

Enter Indirect subtotal of 424A, Section B, 6.j. **$ 9,600**

TOTALS

Enter TOTAL on 424A, Section B, 6.k. **$202,240**

JUSTIFICATION

PERSONNEL - Describe the role and responsibilities of each position.

FRINGE BENEFITS - List all components of the fringe benefit rate.

EQUIPMENT - List equipment and describe the need and the purpose of the equipment in relation to the proposed project.

SUPPLIES - Generally self-explanatory; however, if not, describe need. Include explanation of how the cost has been estimated.

TRAVEL - Explain need for all travel other than that required by SAMHSA.

CONTRACTUAL COSTS - Explain the need for each contractual arrangement and how these components relate to the overall project.

OTHER - Generally self-explanatory. If consultants are included in this category, explain the need and how the consultant's rate has been determined.

INDIRECT COST RATE - If your organization has no indirect cost rate, please indicate whether your organization plans to a) waive indirect costs if an award is issued, or b) negotiate and establish an indirect cost rate with DHHS within 90 days of award issuance.

CALCULATION OF FUTURE BUDGET PERIODS
(based on first 12-month budget period)

Review and verify the accuracy of future year budget estimates. Increases or decreases in the future years must be explained and justified and no cost of living increases will be honored. (NOTE: new salary cap of $183,500 is effective for all FY 2006 awards.) *

	First 12-month Period	Second 12-month Period	Third 12-month Period
Personnel			
Project Director	30,000	30,000	30,000
Secretary**	9,000	18,000	18,000
Counselor	25,000	25,000	25,000
TOTAL PERSONNEL	64,000	73,000	73,000

*Consistent with the requirement in the Consolidated Appropriations Act, Public Law 108-447.
**Increased from 50% to 100% effort in 02 through 03 budget periods.

Fringe Benefits (24%)	15,360	17,520	17,520
Travel	5,400	5,400	5,400
Equipment	-0-	-0-	-0-
Supplies***	1,000	520	520

***Increased amount in 01 year represents costs for software.

Contractual			
Evaluation****	65,355	67,969	70,688
Training	40,025	40,025	40,025

****Increased amounts in 02 and 03 years are reflected of the increase in client data collection.

Other	1,500	1,500	1,500
Total Direct Costs	192,640	205,934	208,653
Indirect Costs (15% S&W)	9,600	9,600	9,600
TOTAL COSTS	202,240	216,884	219,603

The Federal dollars requested for all object class categories for the first 12-month budget period are entered on Form 424A, Section B, Column (1), lines 6a-6i. The <u>total</u> Federal dollars requested for the second through the fifth 12-month budget periods are entered on Form 424A, Section E, Columns (b) – (e), line 20. The RFA will specify the maximum number of years of support that may be requested.

Appendix F - Resources for Implementing Screening, Brief Intervention, Referral, and Treatment

Background

For purposes of this cooperative agreement, CSAT will not require grantees to use a specific methodology for determining need, implementing systems change, or introducing SBIRT within their continuum of care. CSAT is not recommending a specific approach for developing collaboration among participating generalist and specialist providers. CSAT is requiring specific protocols for carrying out the individual activities involved (the screening instruments will be the AUDIT, DAST and CRAFFT which provide a basis for brief intervention, referral, assessment, patient placement, and brief treatment). Additional screening tools may be used with the agreement of the CSAT Project Officer. The applicant is required to describe and justify the strategies that will be implemented under the proposed cooperative agreement project and to describe the methods that will be used to assess need, eliminate barriers to access, and to carry out each of these activities. Wherever possible, the applicant should provide a description of any prior services or research projects on which their proposed approach is based.

In order to introduce some commonality in responses, we will present a brief overview of terminology and anticipated issues and provide illustrative references that can serve as resources for proposal development and project implementation. The resources and references provided are not presented as an inclusive listing that must be used in proposal preparation.

Terminology

From the scientific and policy perspectives, there have been two distinct approaches for responding to the social and health problems posed by drug abuse and addiction—the **clinical**, or diagnostic, approach and the **environmental**, or problems, approach (Gerstein and Green, 1993; Institute of Medicine, 1990). Over the years, drug policy has been shaped by these perspectives, shifting between punitive and rehabilitative strategies for reducing consumption of illicit drugs and the criminal behaviors associated with illicit drug use (Gerstein and Harwood, 1990).

The two perspectives have led to differences in how persons receiving and seeking treatment are characterized in developing resource allocation and financing schemes and create potential problems in consolidating funding streams to carry out SBIRT. The financing of treatment for substance use problems has differed from the rest of health care financing in part because the public sector through block and categorical grants has been the major payer for services (e.g., Horgan and Merrick, 2001). The shifting perspectives and orientations of the policymakers and legislators have also influenced these systemic perspectives (Gerstein and Harwood, 1990). Criminal justice funding, originally through the Federal Law Enforcement Administration block and categorical grant programs (more recently, the Office of Justice Programs and the Office of Juvenile Justice programs) created a public safety orientation, while funds from the poverty programs (e.g., the Social Services Block grant) created a welfare orientation. On the other hand, health insurance, like Blue Cross and Medicaid created a medical orientation. All three orientations have co-existed in the categorical grant and block grants directly targeted at treatment of Substance Use Disorders, notably, the Substance Abuse Prevention and Treatment Block Grant, which attempts to integrate the perspectives, creating what has been labeled the

mixed medical and social model orientation (IOM, 1990; Reader and Sullivan, 1992). For example, Medicaid and other forms of health insurance require a clinical diagnosis and a determination of medical necessity for admission to treatment, while the Substance Abuse Prevention and Treatment Block Grant does not. The lack of common terminology has created problems in understanding who receives what services for treatment of Substance Use Disorders with what outcomes (Coffey et al., 2001)

Developing the policies and data for studying utilization and designing policies to increase access to clinically appropriate treatment requires use of common terms with clear definitions, starting with identifying the conditions for which treatment is needed. Diagnosis is the process of identifying and labeling specific diseases; diagnostic criteria for Substance Abuse and Dependence Disorders reflect the consensus of researchers and clinicians as to precisely which patterns of behavior or physiological characteristics constitute symptoms of these conditions. (Babor et al., 2005; Babor, 2001; NIAAA, 2002; NIDA, 1997) Agreement on diagnosis in this field is relatively new, and the definitions and techniques for establishing diagnoses are evolving. Having a consistent set of diagnostic criteria allows clinicians to plan treatment and monitor treatment progress; enables policymakers, and planners to ensure the availability of needed treatment resources in each community; helps health care insurers and other funders to decide whether treatment will be reimbursed; and allows patients access to medical insurance coverage.

As noted in the RFA, the need for treatment is discussed in terms of the categories used in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV; 1994).[12] DSM-IV includes a category called "Substance Related Disorders" that is divided into two major subcategories, Substance Induced Disorders and Substance Use Disorders. The focus of this program is on that part of the continuum of care that addresses treatment of Substance Use Disorders and not the treatment of Substance Induced Disorders, namely Substance Intoxication and Substance Withdrawal. Patients manifesting signs of intoxication, withdrawal symptoms, and other physical problems that require emergency care or urgent action would be managed in other components of the generalist or specialist treatment systems, stabilized and medically cleared before being screened for presence of a Substance Use Disorder (VHA/DoD, 2001; Room et. al., 2005; Babor et al. 2005;).

Substance Use Disorders are further differentiated by type of drug primarily involved (e.g., amphetamine, alcohol, cocaine, marijuana/cannabis). DSM-IV is the diagnostic approach primarily used in this country for determining treatment eligibility, developing substance-specific treatments, and conducting epidemiological and clinical research.

Based on the DSM-IV, *Substance Abuse Disorder* is characterized by the presence of social or health-related problems related to the person's consistent pattern of substance use. *Substance* D*ependence* Disorder is characterized by a cluster of recognizable symptoms, including physical withdrawal, loss of control over use episodes, and continued use of substance despite knowledge of having a physical or psychological problem that is likely caused by substance.

12 For a discussion of the methodology change, see Epstein, 2002. Substance Dependence, Abuse, and Treatment: Findings from the 2000 National Household Survey on Drug Abuse, Appendix C: Measurement of Dependence, Abuse, Treatment, and Treatment Need.

The World Health Organization has also developed diagnostic criteria for the purpose of compiling statistics on all causes of death and illness, including those related to substance abuse or dependence. These criteria are published as the *International Classification of Diseases* (ICD). In the current revision, ICD-10, substance dependence is defined in a way that is similar to the DSM-IV. The diagnosis focuses on an interrelated cluster of psychological symptoms, such as craving; physiological signs, such as tolerance and withdrawal; and behavioral indicators, such as the use of alcohol to relieve withdrawal discomfort. However, in a departure from the DSM-IV, rather than include the category "abuse," ICD-10 includes the concept of "harmful use." This category was created so that health problems related to alcohol and other drug use would not be underreported. Harmful use implies alcohol or drug use that causes either physical or mental damage in the absence of dependence (Babor et al, 2005; Babor, 2001). The ICD classification approach has served as the basis for much of the research underlying the use of brief interventions.

Review of the literature and discussions with practitioners and State Substance Abuse Authorities (SSAs) established that, while most of the research establishing the effectiveness of this approach has focused on alcohol use problems and disorders and has used the **problems** approach rather than the clinical approach, there is an emerging body of research and clinical experience that supports use of the SBIRT approach for persons at risk for, or diagnosed with, a Substance Use Disorder (Substance Abuse or Dependence) who are experiencing problems related to the use of illicit drugs, particularly for marijuana use disorders (e.g., Stephens, et al., 2004; Stephens et al., 1994; Samet et al., 1996; Sullivan et al., 1997: Babor et al. 2002; Barry, 1999; Bernstein et al., 1997; Zweben and Fleming, 1999; Dennis, et al. 2002a and b; Conrod et al., 2000; Baker et al. 2001; Babor, et al., 2002; Blow, 1999: Fleming, 2002; Kelso, 2002; WHO ASSIST Working Group, 2002).

While the effort to develop brief interventions for persons at risk for, or diagnosed with, a Substance Use Disorder (Substance Abuse or Dependence) has not been as extensive as that for persons with alcohol problems, there have been several precedents. Early in the effort to develop a national drug strategy, the Treatment Subcommittee of the Cabinet Committee on Drug Abuse Prevention, Treatment and Rehabilitation in responding to pressure on the limited availability of treatment slots, recommended the establishment of distinct, lower cost “Alternative Educational Programs” (Bloom, 1977). These “alternatives to treatment or incarceration were recommended as the vehicle for “treating the casual and recreational marijuana users” who were being “inappropriately” referred to drug abuse treatment centers, most often by the criminal justice system through diversion efforts (Domestic Council Drug Abuse Task Force, 1975). The stated goal was to allow the specialty drug abuse treatment system to focus on the “abusers of high risk drugs.” Marijuana, at that time, was considered a low risk drug.

The model programs presented by NIDA were short-term, inexpensive educational programs with both didactic presentations and group discussions. These alternative educational programs became the forerunners of many of the intervention programs that still exist in the gray area between prevention and treatment—often having statutory authorization as diversion programs.

There is evidence that a number of States have already begun to introduce protocols for screening and brief intervention for both alcohol and drug use problems and disorders into their

continuum of care (e.g., New York OASAS, 1996; Harrison et al., 1996; Hartwell et al., 1996: Kroutil et al., 1997).[13] Yet, in contrast to more traditional treatment services, early intervention services are often not specifically defined or regulated (IOM, 1990; Klitzner, et al., 1992). For purposes of this announcement, early intervention services (brief interventions) are those treatment procedures designed for persons who are exhibiting some problems associated with alcohol or other drug use but whose problems are not deemed serious enough to warrant treatment within a specialist setting. This would include those persons at risk for, or diagnosed with, a Substance Use Disorder (Substance Abuse or Dependence). Early intervention services are sometimes identified as pre-treatment interventions (Blow, 1998) or clinical preventive services (U.S. Preventive Task Force, 1998) or indicated preventive interventions (Haggerty and Mrazek, 1994). The goal of early intervention is to prevent the problems from becoming more serious, and to promote total abstinence from alcohol and other illegal drugs. Early intervention could include an assessment of substance use and related problems, individual counseling provided by a health care practitioner, or participation in school-based or community-based educational or counseling programs designed to deter further substance use and promote healthier alternatives.

Rather than negating the public health approach to defining primary, secondary, and tertiary prevention as some have held, the IOM model can be seen as complementary, expanding the public heath approach. The newer IOM model can be seen as actually further differentiating the public health construct of primary prevention into the categories of universal, selected, and indicative interventions, and the public health constructs of secondary and tertiary prevention into the categories of treatment and maintenance, respectively. The early intervention activities overlap the boundaries between primary prevention (indicated prevention) and secondary prevention (case finding).

In filling out the treatment portion of a State's continuum of care, the purpose of screening for substance use problems is to identify those persons who should receive either a brief intervention or referral for additional screening and assessment to establish whether more intensive treatment for a Substance Use Disorder (SUD) is needed. The persons screened *may* or *may not* meet the DSM-IV criteria for a Substance Abuse or Dependence Disorder (American Psychiatric Association, 1994). If they do not, but are deemed to be at risk users, then the same technology is employed as a clinical preventive service (or indicated preventive intervention). In practice, the activities are the same. However, the distinction is important for developing financing policies, for conducting epidemiological research and for tracking treatment access, appropriateness, utilization, and effectiveness.

---

13 A number of other States have included similar characterizations for differentiating intervention and treatment in their rules or planning efforts (e.g., Louisiana, Minnesota, Florida, North Carolina, Connecticut, Vermont, and Washington). For example, South Dakota has defined its approach as part of the regulations governing licensure of treatment facilities: "A facility that provides Early Intervention and Outpatient Services is a nonresidential facility that provides direct supportive client contact, indirect or collateral client contact, community information and liaison services. The program also provides formally planned counseling services to those persons harmfully affected by alcohol or drugs and who have been determined not to be in need of or accepting of structured outpatient or residential services." http://legis.state.sd.us/rules/rules/6716A.htm#67:16:11:03.04. Apparently some States (e.g., Florida) define intervention as both a treatment and non-treatment activity.

Since diagnosis has not always been used as a criterion for admission to treatment in publicly funded treatment programs, States and service providers will need to introduce and agree upon a uniform approach to diagnosis as part of their implementation of this program and efforts to provide sustained funding for SBIRT, particularly through public and private health insurance mechanisms.

Integrating the Diagnostic and Problems Approaches

As noted, the DSM-IV term S*ubstance Use Disorders* can be used to refer to a range of substance-related problems that require treatment. A spectrum of Substance Use Disorders, from least to most serious, which encompasses the problems approach used in developing screening protocols for the use of brief interventions might be represented as follows:

Problem Use or At Risk Use — Substance Abuse Disorder — Substance Dependence Disorder

In general, *problem or at-risk use* means use that exceeds an established threshold. The threshold may be defined in different ways depending on the source, the population, and other local conditions. The majority of work for developing such classifications in order to identify persons who could benefit from a brief intervention has been carried out for alcohol use problems and disorders. For example, the WHO manuals for introducing screening and brief intervention into primary care present general guidelines for assigning "risk levels" based upon AUDIT scores, that conform the spectrum above and lay out a spectrum of intervention and treatment responses.

Table 1: AUDIT Guidelines for Determining Intervention Strategy[14]

RISK LEVEL	Intervention	Audit Score
I	Education	0-7
II	Simple Advice	8-15
III	Simple Advice plus Brief Counseling and Continued Monitoring	16-19
IV	Referral to Specialist for Diagnostic Evaluation and Treatment	20-40

The risk levels are used as a basis for making clinical judgments to tailor interventions to the particular conditions of individual patients, assuming that higher AUDIT scores are generally indicative of more severe levels of risk and problems or dependence. The guidelines are to serve as a starting point for an appropriate intervention. If a patient is not successful at the initial level of intervention, than the protocol calls for follow-up to develop a plan to step the patient up to the next level of intervention. (Horng and Chueh, 2004; Babor and Higgins-Biddle, 2001; Babor et al., 2001)

This approach is similar to that used for other screening tests, such as the Drug Abuse Screening Test (DAST).

14 Based on Babor and Higgins-Biddle (2001) Brief Intervention For Hazardous And Harmful Drinking: A Manual for Use in Primary Care, Box 2, p.12

Table 2: DAST Guidelines for Determining Intervention Strategy[15]

Score	***Degree of Problems Related to Drug Abuse***	***Suggested Action***
0	No Problems Reported	None At This Time
1-2	Low Level	Monitor, Reassess At A Later Date
3-5	Moderate Level	Further Investigation
6-8	Substantial Level	Intensive Assessment

These classification systems reflect the different patterns of drug use consumption and problems that call for differential societal responses that reflect differences in the drug (substance) used, the history, frequency, and amount used, as well as the existence and severity of associated physical, emotional, and social consequences of use. The Institute of Medicine committee that carried out a Congressionally mandated study of the evolution, effectiveness and financing of public and private drug treatment systems (Gerstein and Harwood, 1990) described a four level classification system reflecting these patterns that was a starting point in developing their initial estimates of the need for treatment, a model that was adapted for creating national estimates of the treatment gap. Table 3 depicts individual drug use patterns and interventions associated with each pattern of use. Each stage of use elicits a different type of societal response. The definitions for the categories are:

> **Use**: Low or infrequent doses: experimental, occasional, "social." Damaging consequences are rare or minor.
>
> **Abuse**: Higher doses and/or frequencies: sporadically heavy, intensive. Effects are unpredictable, sometimes severe.
>
> **Dependence**: High, frequent doses: compulsion, craving, withdrawal. Severe consequences are very likely.

15 Based on Skinner HA (1982).

Table 3: Individual Drug Use Patterns and Intervention Strategies[16]

Stage	Category of Use	Use Pattern	Reason	Consequences	Societal Responses	
	Abstinence				Prevention Programs	
Early/light	Use	Low or infrequent doses	Experimental, occasional, "social"	Minor	Prevention Programs	Mild sanctions
Late/heavy	Abuse	Higher doses and/or frequencies	Sporadically heavy	Unpredictable, sometimes severe		
Late/heavy	Dependence	High, frequent doses	Compulsion, craving, withdrawal	Severe	Treatment programs	Severe sanctions

In the SBIRT approach, all persons are first screened and referred to the appropriate sector (community generalist, non-specialty or specialty) for intervention or treatment. Persons with a mild or moderate level of substance use problems would most often be offered a brief intervention in the non-specialty primary health care, criminal justice, educational, employment, or social service setting. Referral to intensive treatment in the specialty sector would be made only for those whose life situation is so unstable that prognosis is poor without specialty treatment or for those who fail to respond to an initial brief intervention--the stepped care approach (Sobell and Sobell, 1999, 2000).

Persons with substantial or severe problems would be referred from screening to specialty sequential assessment and treatment where problem and personal assessment would lead to assignment to more differentiated types of treatment modalities and levels of care, using a formal set of patient placement criteria.

Recent efforts have attempted to integrate the problem and diagnostic approaches, using both the research literature and clinical experience to refine the methods for screening, referring, and treating person's based on these concepts (e.g., ASAM, 2000; APA, 1994; VHA/DoD, 2001 Beich, et. al., 2003). A possible model for this integration is presented in Table 4. The model also attempts to integrate the public health and IOM models for defining the continuum of care.

16 Based on Figure 3-1. A model of individual drug history, Gerstein and Harwood (1990:61).

Table 4: Integrating the Problem and Diagnostic Perspectives--A Possible Model

Problems	**Risk Category or Diagnosis**	**Intervention Strategy**	**Exposures\ Sessions**	**Follow-up Suggested: Track: use, risk factors, and problems**
No problems	No risk Or low risk	Universal prevention	Variable	Periodic re-screen: every year
Mild problems	At low risk	Clinical preventive service Selective prevention-brief advice	1-2	Periodic re-screen: every year
Moderate problems	At high risk	Clinical preventive service Indicated prevention Brief advice Brief intervention	1-2	Periodic re-screen every 6 months for 3 years, every year if no relapse
Moderate problems	Substance Abuse Disorder (DSM-IV, Axis I)	Brief advice Brief intervention Brief treatment	1-2 1-5 6-20	Periodic re-screen and booster session: every 3 months for 2 years, every 6 months for 2 years, every year if no relapse
Substantial problems	Substance Dependence Disorder (DSM-IV, Axis I)	Sequential assessment; match to clinically appropriate consumption and quality of life treatment strategies	21-60+	Periodic re-screen: every 3 months for 2 years, every 6 months for 2 years, every year if no relapse
Severe problems	Substance Dependence Disorder (DSM-IV, Axis I)	Sequential assessment; match to clinically appropriate consumption and quality of life treatment strategies	Variable; Based on individual response to treatment	Periodic re-screen: every 3 months for 2 years, every 6 moths for 2 years, every year if no relapse

Using either the problems approach or the clinical approach, it is well recognized that within each community there is a spectrum of persons at risk for, or diagnosed with, a Substance Use Disorder (Substance Abuse or Dependence). In keeping with recent summaries of the international research literature, it is estimated that the majority of adults (approximately 75%) are either abstainers or light or moderate users including some persons with Substance Use Disorders (who qualify for a diagnosis of abuse or dependence on alcohol or illicit drugs). Persons in this group experience either no problems or mild or moderate substance use-related problems. There is a small but often highly visible minority of heavy, dependent users with

major substance-related problems (estimated at approximately 5%). In between these extremes, there is a sizeable group of persons (20%) who may be drinking or using illicit drugs substantially or heavily and who have encountered substantial or severe problems related to their substance use. The concepts have been more difficult to address for illicit drugs, since any use could be seen as "abuse" because of potential legal consequences. As will be noted below, treatment is not necessarily the best societal response for persons at risk for, or diagnosed with, a Substance Use Disorder, (Substance Abuse or Dependence), but a brief intervention, early in their use career may well be.

These findings suggest that the continuum of care in each community must include a spectrum of primary, secondary, and tertiary prevention responses that parallels the spectrum of problems associated with use and that the diagnostic and problem approaches must be reconciled to ensure introduction of evidence based clinical protocols (NIDA, 1999). Research on effectiveness of specific approaches continues, but there is sufficient evidence available to lead to the policy conclusion that more widespread SBIRT efforts will decrease the medical and social costs of illicit drug use.

Using a method similar to that employed by Skinner and his colleagues in the original development of screening for establishing brief interventions as a valid technology, persons can be classified into four graded categories of drug and alcohol use problems, each of which should lead to a different treatment or intervention strategy being employed and to a different set of resource requirements (See Table 4.):

> **Mild level of substance use problems**. Use is light or moderate; symptoms are rated as mild or moderate; dependence is probably not present or, if present, is psychological rather than physical; life problems related to use are rated as absent, mild, or moderate.
>
> **Moderate level of substance use problems**. Use is medium, substantial, or heavy; symptoms are rated as moderate; psychosocial problems related to use are likely and rated as moderate; psychological dependence may still be characteristic, but there are increasing signs of physical dependence, such as withdrawal symptoms; related life problems are rated as mild and/or moderate.
>
> **Substantial level of substance use problems**. Use is substantial or heavy; symptoms are rated as substantial; physical dependence is likely; physical disorders, mental disorders, and psychosocial problems related to substance use are rated as moderate and/or substantial.
>
> **Severe level of substance use problems**. Use is heavy; symptoms are rated as substantial and/or severe; physical dependence is highly pronounced; life problems are rated as substantial and/or severe; serious physical disorders and mental disorders related to use, such as liver disease, are likely.

As presented in Table 4, persons can also be classified as either persons with some level of risk for, or diagnosed with, a Substance Use Disorder, (Substance Abuse or Dependence), Substance Use Disorders, (those with no problems, mild or moderate problems) or persons with substance

use disorders (those who qualify for a diagnosis of drug abuse or dependence, either with moderate problems or with substantial and severe problems. The act of diagnosis shifts the nature of the services from prevention to treatment.

In developing strategies to increase access to clinically appropriate treatment, SAMHSA wants States to focus on the resources needed for improved screening, intervention, referral and treatment for Substance Use Disorders in order to increase the resources devoted to identifying and intervening with persons at risk for, or diagnosed with, a Substance Use Disorder (Substance Abuse or Dependence), as part of the generalist health care system. States should be able to provide for a similar linkage between whatever classification system the State is using and the DSM-IV categories in the protocol.

Resources for Implementing Screening

In health care, screening refers to a process designed to identify people who have, or who are at risk of having, an illness or disorder. The purpose of screening is to target persons for treatment, so as to reduce the long-term morbidity and mortality related to the condition. In addition, by intervening early and raising the individual's level of concern about the risk factors and substance-related problems, it is expected that screening for drug and alcohol problems in community settings can itself reduce subsequent use.

Two types of screening procedures are typically used. The first type includes self-report questionnaires and structured interviews; the second, clinical laboratory tests that can detect biochemical changes associated with excessive alcohol consumption or illicit drug use.

There are a variety of screening instruments available. As noted, the majority of studies and implementation efforts have focused on screening for alcohol problems, with the CAGE and the AUDIT being the most commonly used screening tools. The DAST has also been used in conjunction with the AUDIT in several projects, where there has been an effort to implement this approach for persons at risk, or diagnosed with, a Substance Use Disorder (Substance Abuse or Dependence). Several new instruments have been developed, but not yet rigorously tested to assess harmful use of either alcohol or drugs (e.g., the CAGE-D, the ASSIST, the TCUDS, the GAIN-QS, the PDES).

Brown, RL and Rounds LA. 1995. Conjoint screening questionnaires for alcohol and other drug abuse: criterion validity in a primary care practice. *Wisconsin Medical Journal*, 94, 135-140.

Brown R, Leonard T, Saunders LA, et al. (1997). A two-item screening test for alcohol and other drug problems. *Journal of Family Practice*, 44, 151-160.

A bibliography containing descriptions and evaluations of various interview, questionnaire, and laboratory test screening approaches is available from Project Cork.

Project Cork. 2002. *CORK Bibliography: Screening Tests.* 2001-2002, 58 Citations. www.projectcork.org/bibliographies/data/Bibliography_Screening_Tests.html.

Screening instruments have been developed or modified for use with different target populations, notably adolescents, offenders within the criminal justice system, and welfare recipients, women, and the elderly. Several have been translated into other languages and have been evaluated for cultural sensitivity.

It is well recognized that screening instruments used with adolescents must be developmentally appropriate, valid and reliable, and practical for use in busy medical settings. One example of a brief substance abuse screening instrument recently developed specifically for use with adolescents is the CRAFFT test.

Jull, A. 2003. "The CRAFFT Test Was Accurate for Screening for Substance Abuse Among Adolescent Clinic Patients." *Evid. Based. Nurs.* 6(1): 23.

Levy, S., Sherritt, L., Harris, S. K., Gates, E. C., Holder, D. W., Kulig, J. W., and Knight, J. R. 2004. "Test-Retest Reliability of Adolescents' Self-Report of Substance Use." *Alcoholism: Clinical & Experimental Research* 28(8): 1236-41.

Knight JR, Sherritt L, Shrier LA, Harris SK, Chang G. 2002. Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. *Arch Pediatr Adolesc Med*. 156(6): 607-14.

Additional screening tests and procedures targeted at adolescents, including the PDES and the GAIN-QS, are described in these publications:

Winters KC. 1992. Development of an adolescent alcohol and other drug abuse screening scale: Personal Experience Screening Questionnaire. *Addict Behav*. 17(5): 479-90.

Winters KC. 1999. **Screening and Assessing Adolescents For Substance Use Disorders**. Treatment Improvement Protocol (TIP) Series 31 DHHS Publication No. (SMA*)* 99-3282.

Winters KC. 1999. **Treatment of Adolescents With Substance Use Disorders.** Treatment Improvement Protocol (TIP) Series 32. DHHS Publication No. (SMA*)* 99-3283.

Winters KC. 2001. Assessing adolescent substance use problems and other areas of functioning: State of the art. In: PM Monti, SM. Colby, and TA. O'Leary (eds). **Adolescents, Alcohol, and Substance Abuse: Reaching Teens Through Brief Interventions**. New York, Guilford Publications, Inc., pp. 80-108.

Dennis ML 1998. **Global Appraisal of Individual Needs (GAIN) manual: Administration, Scoring and Interpretation**, (Prepared with funds from CSAT TI

11320). Bloomington IL: Lighthouse Publications.
www.chestnut.org/LI/GAIN/GAIN_QS/index.html

Martino S, Grilo CM, and Fehon DC 2000. Development of the drug abuse screening test for adolescents (DAST-A). *Addictive Behaviors* 25(1): 57-70.

Screening tests and procedures targeted at the elderly are described in these publications:

Beullens, J. and Aertgeerts, B. 2004. "Screening for Alcohol Abuse and Dependence in Older People Using DSM Criteria: a Review." *Aging Ment.Health* 8(1): 76-82.

Blow, F.C. Consensus Panel Chair. 1998. **Substance Abuse Among Older Adults**. Treatment Improvement Protocol (TIP) Series 26. DHHS Publication No. (SMA) 98-3179.

Blow FC and Barry KL. 1999-2000. Advances in alcohol screening and brief intervention with older adults. *Advances in Medical Psychotherapy*. 10:107-124

Screening tests and procedures targeted at persons in the criminal justice system are described in these publications:

Inciardi JA Consensus Panel Chair 1994. **Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System.** Treatment Improvement Protocol (TIP) Series 7. DHHS Publication No. (SMA) 94B2076

Peters, RH, Greenbaum, PE, Steinberg, ML, Carter, CR, Ortiz, MM, Fry, BC, Valle, SK. 2000. Effectiveness of screening instruments in detecting substance use disorders among prisoners. *Journal Substance Abuse Treatment*: 18(4): 349-58.

Simpson DD. 2001. Core set of TCU forms. Fort Worth: Texas Christian University, Institute of Behavioral Research. www.ibr.tcu.edu.

Efforts are also ongoing to develop methods for screening within the dual diagnosis population:

Maisto SA, Carey MP, Carey KB, Gordon CM, and Gleason JR. 2000. Use of the AUDIT and the DAST-10 to identify alcohol and drug use disorders among adults with a severe and persistent mental illness. *Psychological Assessment* 12(2): 186-192.

Resources for Implementing Brief Interventions and Brief Treatments

There are now a variety of approaches that have been labeled as Brief Interventions (BI) and Brief Treatments (BT). Examples of approaches that address specific drugs are the Cannabis Youth Treatment protocol and the Adult Marijuana Treatment protocol, developed through CSAT funded testing of models originally developed through NIDA and NIAAA research.

Brief intervention and brief treatment strategies range from relatively unstructured advice-giving, to counseling and formalized feedback, to formal structured manuals for the number, duration, frequency, and content of sessions. Many of the protocols are based on behavioral self-control training, motivational interviewing, and cognitive-behavioral psychotherapy.

One of the most extensive efforts to attempt to conceptualize and differentiate Brief Interventions and Brief Treatments (and Long Term Treatments) was CSAT's TIP 34: **Brief Interventions and Brief Therapies for Substance Abuse**, published in 1999. The Consensus Panel for CSAT TIP #34 describes the two activities as follows:

Brief Intervention

> 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, either by natural, client-directed means or by seeking additional substance abuse treatment.

Brief Treatment (Therapy)

> Brief treatment (therapy) is a systematic, focused process that relies on assessment, client engagement, and rapid implementation of change strategies. Brief therapies usually consist of more (as well as longer) sessions than brief interventions. The duration of brief therapies is reported to be anywhere from 1 session (Bloom, 1997) to 40 sessions (Sifneos, 1987), with the typical therapy lasting between 6 and 20 sessions. Twenty sessions usually is the maximum because of limitations placed by many managed care organizations. Any therapy may be brief by accident or circumstance, but the focus of this TIP 34 is on *planned* brief therapy. The therapies described here may involve a set number of sessions or a set range (e.g., from 6 to 10 sessions), but they always work within a time limitation that is clear to both therapist and client.

In distinguishing between Brief Intervention and Brief Treatments, Zweben and Fleming (1999) characterize Brief Interventions as a low-cost, effective treatment alternative for alcohol and drug problems that use time-limited, self-help and preventive strategies to promote reductions in the case of nondependent clients, and in the case of dependent clients to facilitate their referral to specialized treatment programs. The primary goal in all cases is to increase motivation for behavior change. Brief interventions do not teach specific cognitive or behavioral skills, nor do they attempt to change a client's social environment.

Some researchers, practitioners, and policy analysts have suggested that the differentiation should be made on the basis of the number of sessions, with Brief Intervention typically lasting 1-3 sessions, not more than 5 sessions, and Brief Treatment typically consisting of 6 or more sessions but not more than 20 sessions. Others have limited Brief Interventions to only 1 or 2 sessions and Brief Treatments to no more than 6 sessions.

Brief interventions and brief therapies may be thought of as elements on a continuum of care, but they can be distinguished from each other according to differences in outcome goals.

Interventions are generally aimed at motivating a client to perform a particular action (e.g., to enter treatment, change a behavior, think differently about a situation), whereas therapies are used to address larger concerns (such as altering personality, maintaining abstinence, or addressing long-standing problems that exacerbate substance abuse).

A bibliography containing descriptions and evaluations of various brief intervention and brief treatment approaches is available from Project Cork.

> Project Cork. 2002. *CORK Bibliography: Brief Treatment in Substance Abuse*: *2000-2002*, 78 Citations.
> www.projectcork.org/bibliographies/data/Bibliography_Brief_Treatment.html

Resources for Protocol Development

Treatment Improvement Protocols (TIPs) are best practice guidelines for the treatment of substance abuse. CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. Examples of protocols, screening instruments, and methods for carrying out activities required to implement the SBIRT program can also be found in several Treatment Improvement Protocols (TIPS) published by CSAT. TIPS can be accessed on the internet through the Treatment Improvement Exchange at:
www.treatment.org/Externals/tips.html

> Barry KL Consensus Panel Chair. 1999. **Brief Interventions And Brief Therapies for Substance Abuse.** Treatment Improvement Protocol (TIP) Series 34. DHHS Publication No. (SMA) 99-3353.
>
> Blow FC. Consensus Panel Chair. 1998. **Substance Abuse Among Older Adults**. Treatment Improvement Protocol (TIP) Series 26. DHHS Publication No. (SMA) 98-3179.
>
> Miller WR. Consensus Panel Chair. 1999. **Enhancing Motivation for Change in Substance Abuse Treatment.** Treatment Improvement Protocol (TIP) Series 35. DHHS Publication No. (SMA) 99-3354.
>
> Rostenberg PO. Consensus Panel Chair. 1995. **Alcohol and Other Drug Screening of Hospitalized Trauma Patients.** Treatment Improvement Protocol (TIP) Series 16. DHHS Publication No. (SMA) 95-3039.
>
> Siegal H.A Consensus Panel Chair. 1998. **Comprehensive Case Management for Substance Abuse** Treatment. Treatment Improvement Protocol (TIP) Series 27. DHHS Publication No. (SMA) 98-3222.
>
> Sullivan E., Fleming, M. Consensus Panel Co-Chairs. 1997. **A Guide to Substance Abuse Services for Primary Care Clinicians**. Treatment Improvement Protocol (TIP) Series 24. DHHS Publication No. (SMA) 97-3139.

Winters KC. Consensus Panel Chair. 1999. Treatment of Adolescents With Substance Use Disorders. Treatment Improvement Protocol**. (TIP) Series 32. DHHS Publication No. (SMA***)*** 99-3283.

An excellent example of a protocol that can guide implementation of a systematic approach to expanding the continuum of care is that developed by the VA/DoD Evidence-Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs, and Health Affairs, Department of Defense (2001). Electronic copies of the guideline are available from: Office of Quality and Performance web site: www.oqp.med.va.gov/cpg/SUD/SUD_Base.htm.

The VA/DoD guideline consists of five modules that address inter-related aspects of care for patients with Substance Use Disorders. Module A, Assessment and Management in Primary Care, provides a summary of the evidence base for the use of screening and brief interventions and outlines pathways for referral to specialty treatment.

Module A:	**Assessment and Management in Primary Care** includes screening, brief intervention, and specialty referral considerations.
Module C:	**Care Management** emphasizes chronic disease management for patients unwilling or unable to pursue rehabilitation goals.
Module P:	**Addiction-Focused Pharmacotherapy** addresses use of currently approved medications as part of treatment for alcohol and opioid dependence.
Module R:	**Assessment and Management in Specialty Care** focuses on patients in need of further assessment or motivational enhancement or who endorse rehabilitation goals.
Module S:	**Stabilization** addresses detoxification and pharmacological management of withdrawal symptoms.

The VA/DOD Guidelines and the TIPS are presented here as examples that may or may not fit a particular State's definition of its continuum of care. New York State has developed its own procedures, as may have other States:

New York State Office of Alcoholism and Substance Abuse Services (New York OASAS). 1996. **Changing Directions: Reference Manual for Early Intervention Services.** Albany NY: New York OASAS.

Brief Intervention Manuals

As noted in the RFA, CSAT has recently supported development and evaluation of manualized brief intervention and brief treatment strategies for adolescents and adults with marijuana use disorders that can be utilized.

Manuals in the Cannabis Youth Treatment (CYT) Series include:

Sample S., and Kadden R. 2002. **Motivational Enhancement Therapy and Cognitive Behavioral Therapy for Adolescent Cannabis Users: 5 Sessions**. Cannabis Youth Treatment (CYT) Series, Volume 1. http://ncadi.samhsa.gov/govpubs/bkd384/

Webb C, Scudder M, Kaminer Y, and Kadden R 2002. **The Motivational Enhancement Therapy and Cognitive Behavioral Therapy Supplement: 7 Sessions of Cognitive Behavioral Therapy for Adolescent Cannabis Users**. Cannabis Youth Treatment (CYT) Series, Volume 2. http://ncadi.samhsa.gov/govpubs/bkd385

Hamilton NL., Brantley LB, Tims FM, Angelovich N., and McDougall B. 2002. **Family Support Network for Adolescent Cannabis Users**. Cannabis Youth Treatment (CYT) Series, Volume 3. http://ncadi.samhsa.gov/govpubs/bkd386/cyt3.pdf

Godley SH., Meyers RJ, Smith JE, Karvinen T, Titus JC, Godley MD., Dent G, Passetti L, and Kelberg P. 2002. **The Adolescent Community Reinforcement Approach for Adolescent Cannabis Users.** Cannabis Youth Treatment (CYT) Series, Volume 4.

Liddle, HA. 2002. **Multidimensional Family Therapy for Adolescent Cannabis Users**, Cannabis Youth Treatment (CYT) Series, Volume 5.

These efforts build on prior research done under the auspices of the National Institute on Drug Abuse (NIDA), the National Institute on Alcoholism and Alcohol Abuse (NIAAA) and the World Health Organization (WHO), which have has also issued several manuals that can also serve as resources in project development:

Babor TF and Higgins-Biddle JF. 2001**. Brief Intervention For Hazardous And Harmful Drinking: A Manual for Use in Primary Car**e. Geneva: World Health Organization. WHO/MSD/MSB/01.6b.

Babor TF, Higgins-Biddle JC, Saunders JB, and Monteiro, MG. 2001. **AUDIT: The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care. Second Edition**. Geneva: World Health Organization. WHO/MSD/MSB/01.6a.

Carroll KM 1998. **A Cognitive-Behavioral Approach: Treating Cocaine Addiction**. National Institute on Drug Abuse Therapy Manuals for Drug Addiction, Manual 1, NIH Publication 98-4308.

Miller WR, Zweben A, DiClemente CC, et al. 1992. **Motivational Enhancement Therapy Manual: A Clinical Research Guide for Therapists Treating Individuals with Alcohol Abuse and Dependence.** NIAAA Project MATCH Monograph Series Vol. 2. DHHS Publication No. (ADM) 92-1894.

National Institute on Alcohol Abuse and Alcoholism (NIAAA) ***1995***. **The Physicians' Guide to Helping Patients With Alcohol Problems**. NIH Publication No. 95-3769.

National Institute on Alcohol Abuse and Alcoholism (NIAAA) 2003. **Helping Patients with Alcohol Problems: A Health Practitioner's Guide**. NIH Publication No. 03-3769.

Bethesda, MD: U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health.

Roberts LJ and McCrady BS 2002. **Alcohol Problems in Intimate Relationships: Identification and Intervention - A Guide for Marriage and Family Therapists**. Rockville MD: National Institute on Alcohol Abuse and Alcoholism.

Resources for Analyzing Barriers and Implementing Systems Change

Additional resources for analyzing barriers to access and linkage between the generalist and specialist agencies and devising policy changes are provided by CSAT Technical Assistance Publications (TAPs). TAPS are publications, manuals, and guides developed by CSAT to offer practical responses to emerging issues and concerns in the substance abuse treatment field. Each TAP is developed by an expert who has had firsthand experience with the topic. TAPS can be accessed on the internet through the Treatment Improvement Exchange at: www.treatment.org/Taps/

TAPS that may be useful resources include:

Crowe AH. and R Reeves. 1994. **Treatment for Alcohol and Other Drug Abuse: Opportunities for Coordination**. Technical Assistance Publication (TAP) Series 11.DHHS Publication No. (SMA) 94-2075.

Hansen C. 1995. **Forecasting the Cost of Chemical Dependency Treatment Under Managed Care: The Washington State Study**. Technical Assistance Publication (TAP) Series 15. DHHS Publication No. (SMA) 95–3045).

Moss S. 1998. **Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers.** CSAT Technical Assistance Publication Series, Number 22. www.treatment.org/taps/tap22/TAP22TOC.htm

Other publications that can be used to understand development of cost estimates, financing analyses, and systems change strategies are.

Broskowski A and Smith S. 2001. **Estimating the Cost of Preventive Services in Mental Health and Substance Abuse Under Managed Care**. Substance Abuse and Mental Health Services Administration. www.mentalhealth.org/publications/allpubs/SMA-02-3617R/appendix.asp

Denmead G and Rouse BA (eds) 1994. **Financing Drug Treatment Through State Programs.** (*Services Research Monograph No.1. NIH Publication No.94-3543.)* Rockville MD: National Institute on Drug Abuse.

Fleming MF, Mundt MP, French MT, Manwell LB, Stauffacher EA, Barry KL 2000. Benefit-cost analysis of brief physician advice with problem drinkers in primary care settings. *Med Care* 38(1): 7-18.

French MT, et al. 2001. Using the drug abuse screening test to analyze health services utilization and cost for substance users in a community-based setting (DAST-10). *Substance Use and Misuse* 36(6-7): 927-46.

Fortney J and BM Booth. 2001. Access to substance abuse services in rural areas. In Galanter M (ed). **Recent Developments in Alcoholism: Volume 15. Services Research in the Era of Managed Care**. New York: Plenum Press, pp. 177-197.

Horgan CM. and EL Merrick. 2001. Financing of substance abuse treatment services. In Galanter M (ed) Recent Developments in Alcoholism: Volume 15. **Services Research in the Era of Managed Care**. New York: Plenum Press, pp. 229-252.

Kunz, MF, French, MT, Bazargan-Hejazi, S. 2004. Cost-effectiveness analysis of a brief intervention delivered to problem drinkers presenting at an inner city hospital emergency department. *Journal of Studies on Alcohol* 65(3): 363-371.

Libertoff K 1999. **Fighting for Parity in an Age of Incremental Health Care Reform**. Montpelier VT: Vermont Association for Mental Health.

McCrady BS and Langenbucher JW. 1996. Alcohol treatment and health care system reform. *Archives of General Psychiatry*, 53(8): 737-746.

National Association of State Alcohol and Drug Abuse Directors (NASADAD). 2002. **Identification and Description of Multiple Alcohol and Other Drug Treatment Systems.**

Physician Leadership on National Drug Policy (PLNP). 2000. **Position Paper on Drug Policy.** Providence RI: Brown University Center for Alcohol and Addiction Studies www.caas.brown.edu/plndp/Resources/researchrpt.pdf

Weisner C. 1992. The Merging of Alcohol and Drug Treatment: A Policy Review. *Journal of Public Health Policy* 13(1): 66-80.

Weisner C, Mertens J, Parthasarathy S, Moore C, and Lu Y. 2001. Integrating Primary Medical Care with Addiction Treatment: A Randomized Controlled Trial. *Journal of the American Medical Association* 286(14): 1715-1723.

Weisner C, and Schmidt L. 1993. Alcohol and drug problems among diverse health and social service populations. *American Journal of Public Health* 83:824-829.

Weisner C and Schmidt L 2001. Rethinking access to alcohol treatment. In Galanter M. (ed). **Recent Developments in Alcoholism: Volume 15. Services Research in the Era of Managed Care**. New York: Plenum Press, pp. 107-135.

Weisner C, Matzger H, Tam T, and Schmidt L. 2002. Who goes to alcohol and drug treatment? Understanding utilization within the context of insurance. *J. Stud. Alcohol* 63**:** 673-682.

Zarkin GA, Galinis DN, French MT. Fountain DL, Ingram PW, and Guyett JA. 1995. Financing strategies for drug abuse treatment programs. 1995. *Journal of Substance Abuse Treatment*. 12(6): 385-399.

Additional articles that address strategies for overcoming resistance and implementing systems change include:

Babor TF and Higgins-Biddle JF. 2000. Alcohol screening and brief intervention: dissemination strategies for medical practice and public health. *Addiction.* 95(5): 677-686.

Lock CA and Kaner E 2000. Use of Marketing to Disseminate Brief Alcohol Intervention to General Practitioners: Promoting Health Care Interventions to Health Promoters. *Journal of Evaluation in Clinical Practice*. 6(4): 345-357.

Fleming MF. 2002. Screening, Assessment, and Intervention for Substance Use Disorders in Settings. In: ***Strategic Plan for Interdisciplinary Faculty Development: Arming the Nation's Health Professional Workforce for a New Approach to Substance Use Disorders*.** Providence RI: Association for Medical Education and Research in Substance Abuse (AMERSA).
www.projectmainstream.net/mainstream/supportdata/part1.pdf

Physician Leadership on National Drug Policy (PLNP). 2002**. Project Vital Sign.** Providence RI: Brown University Center for Alcohol and Addiction Studies.

The emphasis in this RFA is on expanding the State's continuum of care to include screening, brief intervention, referral, and brief treatment (SBIRT) in general medical and other community settings (e.g. community health centers, nursing homes, schools and student assistant programs, occupational health clinics, hospitals, and emergency departments). It is recognized that SBIRT activities are being, or could be, carried out in non-medical community settings (viz., student assistance programs, employee assistance programs, and welfare offices, drug courts, senior citizen centers).

While most of the research has been focused on screening in primary care medical settings, the approach can be effectively applied in many other contexts as well. In many cases, procedures have already been developed and used in these community settings for specific instruments, such as the AUDIT. To provide an example, Table 5 summarizes information about the settings, screening personnel, and target groups considered appropriate for a screening program using the screening instrument.

Table 5: Personnel, Settings and Groups Considered Appropriate for a Screening Program Using Screening Instruments[17]

Setting	Target Group	Screening Personnel
Primary care clinic	Medical patients	Nurse, social worker
Emergency room	Accident victims, Intoxicated patients, trauma victims	Physicians, nurses, or staff, health educators
Physician's office Surgery Prenatal and perinatal clinics	Medical patients	General practitioners, family physicians, physician extenders, nurses, or staff
General Hospital wards Outpatient clinic	Patients with hypertension, heart disease, gastrointestinal or neurological disorders	Internists, physician extenders, nurses, staff
Psychiatric hospital	Psychiatric patients, particularly those who are suicidal	Psychiatrists, psychologists, counselors, staff
Court, jail, prison	DWI offenders, violent criminals	Officers, counselors, probation officers
Other health-related facilities	Persons demonstrating impaired social or occupational functioning (e.g. marital discord, child neglect, etc.)	Health and human service workers
Military Services	Enlisted men and officers	Medics
Welfare Offices	Applicants and clients	Social Workers, case aides
Workplace Employee Assistance Program	Workers, especially those having problems with productivity, absenteeism or accidents	Employee assistance staff

A State that includes such efforts in their proposal must recognize that these efforts must comport to the diagnostic considerations outlined here. Examples of such activities can be found in these and other publications:

> Peters RH and Wexler HK, Consensus Panel Co-Chairs 2005. **"Substance Abuse Treatment for Adults in the Criminal Justice System." Treatment Improvement Protocol** (TIP) series number 44. DHHS Publication No. (SMA) 05-4056
>
> White WL and Dennis M. 2002. **The cannabis youth treatment experiment: Key lessons for student assistance programs.** *Student Assistance Journal*, 14: 16-19.

17 Modified from Box 1, Personnel, Settings and Groups Considered Appropriate for a Screening Programme Using the AUDIT (Babor et al., 2001).

Young, N. K. 1996. **Alcohol and Other Drug Treatment: Policy Choices in Welfare Reform**. Washington DC: National Association of State Alcohol and Drug Abuse Directors.

Young N. K., S. L. Gardner, and K. Dennis. 1998. **Responding to Alcohol and other Drug Problems in Child Welfare: Weaving Together practice and Policy**. Washington DC: Child Welfare League of America Press.

Young NK and Gardner SL. 2002. **Navigating the Pathways: Lessons and Promising Practices in Linking Alcohol and Drug Services with Child Welfare**. . Technical Assistance Publication (TAP) Series 27. SAMHSA Publication No. (SMA) 02–3639.

Resources for Developing Need Estimates

Resources that can be referred to for developing estimates of need for treatment and resource availability are:

DeWit DJ and Rush B 1996. Assessing the Need for Substance Abuse Services: A Critical Review of Needs Assessment Models. *Evaluation and Program Planning*. 19(1): 41-64.

Epstein JF 2002. **Substance Dependence, Abuse, and Treatment: Findings from the 2000 National Household Survey on Drug Abuse.** (*DHHS Publication No. SMA 02-3642, NHSDA Series A-16*). Rockville MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies

Gerstein D and Harwood H (eds). 1990. **Treating Drug Problems**, Vol. I. Washington DC: National Academy Press. (Chapter 3)

Institute of Medicine. 1990. **Broadening the Base of Treatment for Alcohol Problems**. Washington DC: National Academy Press. (Chapters 7 and 9)

Maxwell JC (ed). 2001. **Multiple Indicator Analysis: Using Secondary Data to Analyze Illicit Drug Use**. *(DHHS Publication No. SMA 01-3539. Rockville, MD: Center for Substance Abuse Treatment and Center for Mental Health Services).* Substance Abuse and Mental Health Services Administration.

McAuliffeWE, Woodworth R, Zhang CH, and Dunn, RP. 2002. Identifying substance abuse treatment gaps in substate areas. J. *Substance Abuse Treatment*. 23(3): 199-208.

Office of Applied Studies. 2002. **National and State Estimates of the Drug Abuse Treatment Gap: 2000 National Household Survey on Drug Abuse** *(NHSDA Series H-14, DHHS Publication No. SMA 02-3640).* Rockville, MD: Substance Abuse and Mental Health Services Administration. www.samhsa.gov/oas/TXgap/toc.htm

Rush B. 1996. Alcohol and other drug problems and treatment systems: A framework for research and development. *Addiction*. 91(5): 629-642.

Collaboration with Addiction Technology Training Centers as a Training Resource

SAMHSA/CSAT funds a network of 14 independent regional Addiction Technology Transfer Centers (ATTCs) and a National Office (www.nattc.org). The ATTCs constitute a nationwide, multi-disciplinary resource that draws upon the knowledge, experience and latest work of recognized experts in the field of addictions. A list of ATTCs, the States covered, and contact information is provided in Table 6. Each ATTC serves as a resource to 2 or more States, having memoranda of understanding with the State Substance Abuse Authorities (SSAs). For additional information related to ATTC's, please visit www.nattc.org.

Table 6: Addiction Technology Transfer Center Contacts

Maine, New Hampshire, Vermont, Massachusetts, Connecticut, Rhode Island ATTC of New England Center for Alcohol and Addiction Studies Brown University Providence, Rhode Island 02912 (401) 444-1808 www.attc-ne.org Director: Susan Storti, PhD, RN **New York, New Jersey, Pennsylvania** Northeast ATTC Institute for Research, Education and Training in Addictions Pittsburgh, Pennsylvania 15219 (866) 246-5344 www.ireta.org/attc Director: Michael Flaherty, PhD **District of Columbia, Delaware, Kentucky, Tennessee, Maryland** Central East ATTC DANYA Institute Silver Spring, Maryland 20910 (240) 645-1145 www.ceattc.org Director Cynthia Moreno Tuoley	**Georgia, South Carolina** Southeast ATTC Morehouse School of Medicine CORK Institute Atlanta, Georgia 30310 (404) 752-1016 www.sattc.org Director: Kay Gresham Morrison, LCSW, ACSW **Virginia, Maryland, North Carolina, West Virginia** Mid-Atlantic ATTC Virginia Commonwealth University Richmond, Virginia 23298-0469 (804) 828-9910 www.mid-attc.org Director: Paula Horvatich, PhD **Illinois, Ohio, Wisconsin, Indiana, Michigan** Great Lakes ATTC Jane Addams College of Social Work University of Illinois-Chicago Chicago, Illinois 60612 (312) 996-4450 www.glattc.org Director: Lonnetta Albright

Iowa, Nebraska, North Dakota, South Dakota, Minnesota
Prairielands ATTC
University of Iowa
Iowa City, Iowa 52242
(319) 335-5368
www.pattc.org
Director: Anne Helene Skinstad, PhD

Arkansas, Kansas, Missouri, Oklahoma
Mid-America ATTC
University of Missouri-Kansas City
5100 Rockhill Road
Kansas City, Missouri 64110
(816) 482-1100
www.mattc.org
Director: Pat Stilen, LCSW, CADAC

Nevada, Montana, Wyoming, Utah, Colorado
Mountain West ATTC
University of Nevada, Reno
Reno, Nevada 89557
(775) 784-6265
www.mwattc.org
Principal Investigator: Nancy Roget, MS
Co-PI: Gary L. Fisher, PhD

Alaska, Washington, Oregon, Idaho, Hawaii, Pacific Islands
Northwest Frontier ATTC
Salem, Oregon 97303
(503) 373-1322
www.nfattc.org
Director: Steve Gallon, PhD

Texas, Louisiana, Mississippi
Gulf Coast ATTC
University of Texas
Center for Social Work Research
Austin, Texas 78703
(512) 232-0608
www.utattc.net
Director: Richard Spence, PhD

California, Arizona, New Mexico
Pacific Southwest ATTC
UCLA Integrated Substance Abuse Programs
Los Angeles California 90025
(310) 445-0874
www.psattc.org/
Director: Thomas Freese, PhD
Co-Director: Michael Shafer, PhD

Puerto Rico, US Virgin Islands
Caribbean Basin and Hispanic ATTC
Centro de Estudios en Adiccion
Universidad Central del Caribe
Call Box 60-327
Bayamon, Puerto Rico 00960-6032
(787) 785-4211
web http://cbattc.uccaribe.edu/
Director: Rafaela Robles, EdD

Alabama, Florida
Southern Coast ATTC
Florida Certification Board
Tallahassee Florida 32301
(850) 222-6714
www.scattc.org
Director: Pam Waters

National Office
University of Missouri - Kansas City
Kansas City, MO 64110-2499
(816) 482-1200
www.nattc.org/
Director: Mary Beth Johnson, MSW