Quest Diagnostics Incorporated, 7600 Tyrone Ave., Van Nuys, CA 91405, 818–989–2520/800–877–2520, (Formerly: SmithKline Beecham Clinical Laboratories).
Scientific Testing Laboratories, Inc., 450 Southlake Blvd., Richmond, VA 23236, 804–378–9130.
Sciteck Clinical Laboratories, Inc., 317 Rutledge Rd., Fletcher, NC 28732, 828–650–0409.
S.E.D. Medical Laboratories, 5601 Office Blvd., Albuquerque, NM 87109, 505–727–6300/800–999–5227.
South Bend Medical Foundation, Inc., 530 N. Lafayette Blvd., South Bend, IN 46601, 574–234–4176 x276.
Southwest Laboratories, 2727 W. Baseline Rd., Tempe, AZ 85283, 602–438–8507/800–279–0027.
Sparrow Health System, Toxicology Testing Center, St. Lawrence Campus, 1210 W. Saginaw, Lansing, MI 48915, 517–377–0520, (Formerly: St. Lawrence Hospital & Healthcare System).
St. Anthony Hospital Toxicology Laboratory, 1000 N. Lee St., Oklahoma City, OK 73101, 405–272–7052.
Toxicology & Drug Monitoring Laboratory, University of Missouri Hospital & Clinics, 301 Business Loop 70 West, Suite 208, Columbia, MO 65203, 573–882–1273.
Toxicology Testing Service, Inc., 5426 NW. 79th Ave., Miami, FL 33166, 305–593–2260.
US Army Forensic Toxicology Drug Testing Laboratory, 2490 Wilson St., Fort George G. Meade, MD 20755–5235, 301–677–7085.

*The Standards Council of Canada (SCC) voted to end its Laboratory Accreditation Program for Substance Abuse (LAPSA) effective May 12, 1998. Laboratories certified through that program were accredited to conduct forensic urine drug testing as required by U.S. Department of Transportation (DOT) regulations. As of that date, the certification of those accredited Canadian laboratories will continue under DOT authority. The responsibility for conducting quarterly performance testing plus periodic on-site inspections of those LAPSA-accredited laboratories was transferred to the U.S. HHS, with the HHS' NLCP contractor continuing to have an active role in the performance testing and laboratory inspection processes. Other Canadian laboratories wishing to be considered for the NLCP may apply directly to the NLCP contractor just as U.S. laboratories do.

Upon finding a Canadian laboratory to be qualified, HHS will recommend that DOT certify the laboratory (**Federal Register**, July 16, 1996) as meeting the minimum standards of the Mandatory Guidelines published in the **Federal Register** on June 9, 1994 (59 FR 29908) and on September 30, 1997 (62 FR 51118). After receiving DOT certification, the laboratory will be included in the monthly list of HHS certified laboratories and participate in the NLCP certification maintenance program.

Anna Marsh,

Executive Officer, SAMHSA.

[FR Doc. 04–7025 Filed 4–1–04; 8:45 am]

BILLING CODE 4160–20–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Notice of Request for Applications for State Incentive Grants for Treatment of Persons with Co-Occurring Substance Related and Mental Disorders (COSIG)

AGENCY: Substance Abuse and Mental Health Services Administration, HHS.

ACTION: Notice of request for applications for State Incentive Grants for Treatment of Persons with Co-Occurring Substance Related and Mental Disorders (COSIG).

Authority: Sections 509 and 520A of the Public Health Service Act.

SUMMARY: The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), and Center for Mental Health Services (CMHS), are accepting applications for Fiscal Year 2004 grants to develop and enhance the infrastructure of States and their treatment service systems to increase the capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based treatment services to persons with co-occurring substance abuse and mental health disorders, and their families. COSIG also provides an opportunity to participate in an evaluation of the feasibility, validity and reliability of the proposed co-occurring performance measures for the future Performance Partnership Grants (PPGs), and to participate in a national evaluation of the COSIG program.

DATES: Applications are due on June 8, 2004.

FOR FURTHER INFORMATION CONTACT: For questions on program issues contact: Richard E. Lopez, J.D., PhD., SAMHSA/CSAT/DSCA, 5600 Fishers Lane, Rockwall II, Suite 8–147, Rockville, MD 20857, Phone: (301) 443–7615; E-Mail: *rlopez@samhsa.gov*; or Lawrence Rickards, PhD., SAMHSA/CMHS/DSSI, 5600 Fishers Lane, Room 11C–05, Rockville, MD 20857; Phone: 301–443–3707; E-mail : *lrickard@samhsa.gov.*

For questions on grants management issues contact: Kathleen Sample, SAMHSA/Division of Grants Management, 5600 Fishers Lane, Suite 630, Rockville, MD 20857, Phone: (301) 443–9667; E-mail: *ksample@samhsa.gov.*

SUPPLEMENTARY INFORMATION:

State Incentive Grants for Treatment of Persons with Co-Occurring Substance Related and Mental Disorders (SM 04–012) (Initial Announcement)

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

Key Dates

Application Deadline.—Applications are due by June 8, 2004.
Intergovernmental Review (E.O. 12372).—Letters from State Single Point of Contact (SPOC) are due August 7, 2004.

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I. Funding Opportunity Description

1. Introduction

As authorized under Section 509 and 520A of the Public Health Services Act, the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), and Center for Mental Health Services (CMHS), announce the availability of funds for Fiscal Year 2004 grants. These grants will develop and

enhance the infrastructure of States and their treatment service systems to increase the capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based treatment services to persons with co-occurring substance abuse and mental health disorders, and their families.

2. Expectations

2.1 Background

There is a growing consensus among key stakeholders about the critical importance of improving services to people with co-occurring disorders and the action steps that are needed to do so. SAMHSA released a landmark Report to Congress on Co-occurring Disorders (RTC) on December 2, 2002, creating a critical opportunity for SAMHSA to provide leadership to support State efforts to improve services for people with co-occurring disorders.

COSIG provides funding to the States to develop or enhance their infrastructure to increase their capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based treatment services to persons with co-occurring substance abuse and mental disorders. COSIG also provides an opportunity to participate in an evaluation of the feasibility, validity and reliability of the proposed co-occurring performance measures for the future Performance Partnership Grants (PPGs), and to participate in a national evaluation of the COSIG program.

COSIG is built on the following concepts and principles:

• COSIG uses the definition of co-occurring disorders developed by the consensus panel convened to draft SAMHSA's Treatment Improvement Protocol (TIP), *Substance Abuse Treatment for Persons with Co-occurring Disorders:* People with co-occurring substance abuse and mental disorders are * * * individuals who have at least one psychiatric disorder as well as an alcohol or drug use disorder. While these disorders may interact differently in any one person (*e.g.*, an episode of depression may trigger a relapse into alcohol abuse, or cocaine use may exacerbate schizophrenic symptoms) at least one disorder of each type can be diagnosed independently of the other.''

• COSIG will support infrastructure development and services across the continuum of co-occurring disorders from least severe to most severe (*i.e.*, Quadrants I, II, III, and IV of the State Directors' Conceptual Framework '' See Appendix E). However, under COSIG, SAMHSA's emphasis is on Quadrants II & III.

• COSIG is appropriate for States at any level of infrastructure development. States will not be at a disadvantage either for being at an early stage of development or at a more advanced stage. Some States and communities throughout the country already have initiated system-level changes and developed innovative programs that overcome barriers to providing services for individuals of all ages who have co-occurring substance abuse and mental disorders. The COSIG grant program reflects the experience of States to date. [See Appendix D for summaries of case studies of these efforts.]

2.2 Program Requirements

In developing their COSIG applications, States will select one or more of the capacity building goals enunciated in SAMHSA's Report to Congress on Co-Occurring Disorders and will implement infrastructure development and enhancement activities (tailored to State needs) that will support the selected goal(s) (Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders, USDHHS, SAMHSA, November 2002; Chapter V, Five-Year Blueprint for Action, Capacity, SAMHSA State Services and Treatment Capacity Goals, page 113). Applicants will identify measurable outcomes for each goal, establish targets, and describe how progress will be tracked and measured over the course of the grant. In addition, all COSIG grantees will be required to report on the proposed co-occurring performance measures for the PPGs and may be required to participate in an evaluation study to determine the feasibility, validity, and reliability of the co-occurring performance measures. This evaluation will be funded through a separate contract, though data collection and reporting costs are to be borne by the COSIG grantees.

COSIG program will have two phases:

• Phase I—The first three years of the grant will focus on infrastructure development/enhancement (as described below). Awards will be for up to $1.1 million per year for the first three years.

• Phase II—An additional 2 years of funding will be provided at a lower level for evaluation and continued collection/reporting of performance data. Grantees without service pilots (see below) will receive up to $100,000 per year in years 4 and 5. Grantees with service pilots will receive up to half of their third year award in year 4 and up to $100,000 in year 5.

The capacity building goals in SAMHSA's Co-Occurring Report to Congress are as follows:

• Screen all individuals for the presence of co-occurring disorders;

• Assess the level of severity of co-occurring disorders;

• Treat both disorders in a comprehensive and coordinated manner that is seamless to the client and, where feasible, that involves the client's family. This may involve consultation/collaboration with other providers, if the provider does not have the ability to offer comprehensive treatment;

• Train providers to screen, assess, and develop preventive interventions and treatment plans for people who have co-occurring disorders;

• Evaluate the impact of prevention and treatment services on individuals who have co-occurring disorders and their families.

States will have flexibility to identify specific infrastructure development and enhancement activities that support the goals selected and respond to the needs and priorities identified by the State. However, the experience of other States suggests that certain areas of infrastructure development (*e.g.*, standardized screening and assessment, complementary licensure and credentialing requirements, service coordination and network building, financial planning, and information sharing) reflect critical pathways for establishing complementary service delivery capacity in substance abuse and mental health service systems. Although COSIG awardees are not required to use COSIG funds in each of these areas, applicants must discuss in their applications the status of the State with regard to each area of infrastructure development, identify the area(s) that will be targeted with COSIG funds and describe how the State proposes to use COSIG funds in each area selected.

• *Standardized Screening and Assessment:* A number of screening and assessment instruments exist that can be used to identify and effectively assess the needs of persons with co-occurring disorders. At present, there is no standard for using these instruments or for ensuring that screening and assessment are even done in existing programs throughout the States. Adoption of acceptable protocols State-wide can help ensure that the initial objectives of the SAMHSA Report to Congress are achieved.

• *Complementary Licensure and Credentialing Requirements:* State licensure, credentialing policies, and legal requirements often act as barriers to providing effective integrated services

for persons with co-occurring disorders. Review and revision of these laws and policies are a critical initial step toward improving services and extending effective substance abuse treatment to existing mental health treatment programs and vice versa.

- *Service Coordination and Network Building:* Conventional boundaries between single-focus agencies impede the clinical progress of persons with co-occurring disorders. Network building will help States develop more effective linkages across systems of care. This activity area also includes the development of a permanent State-level coordinating body and assignment of specific ''boundary spanning'' responsibilities designed to ensure continuous coordination which yields the most efficient use of agency resources and the elimination of service redundancies.
- *Financial Planning:* Current reimbursement practices inhibit coordination/integration of services and effective treatment for persons with co-occurring disorders. Mental health and substance abuse services are funded through separate Federal, State, local, and private funding sources. The goal of comprehensive financial planning is the development of effective and innovative approaches for coordinating funds from these multiple programs to fund seamless services for individuals with co-occurring disorders—while maintaining accountability—and the removal of barriers that inhibit effective resource coordination.
- *Information Sharing:* Often there is little or no communication among various departments and levels of government that have separate administrative structures, constituencies, mandates, and target groups. The goal of information sharing, ideally through utilization of the State's integrated MIS, is to ensure communication between providers so that treatment is more suited to the person's personal needs and characteristics by linking services and information across different systems of care.

The program will allow (but not require) up to 50% of the grant to be used for services pilots to test the infrastructure enhancements that are being made through the grant. In other words, these service pilots will help States that choose to implement them to determine whether the enhancements are feasible and whether they are resulting in the intended outcomes. Patient services are required in a pilot.

Applicants must commit to cooperating with, coordinating with, and supporting the efforts of SAMHSA's Co-occurring Cross Training and Technical Assistance Center (separately funded). The purpose of the Center is to provide a broadly focused technical assistance and training to States and community agencies to enable them to provide effective prevention and treatment services to meet the needs of persons with, or at-risk of developing, co-occurring disorders (including the homeless), whether in the mental health, substance abuse, criminal justice, or other social/public health systems.

Pre-Application Assistance: In addition to other application materials, applicants may want to obtain a draft copy of SAMHSA's *Treatment Improvement Protocol (TIP), Substance Abuse Treatment for Persons with Co-occurring Disorders* and the *Co-Occurring Disorders: Integrated Dual Disorders Treatment Implementation Resource Kit,* referred to in this grant announcement. These SAMHSA-funded resources are not yet available for distribution to the general public. We fully expect that the TIP will be available for use when the grant awards are made. The Resource Kit is currently undergoing pilot testing. In the interim, to assist the States in preparing applications in response to this RFA, a limited number of copies of the TIP and Resource Kit are available exclusively for use by potential applicants.

Potential applicants must not reproduce these copies and should discard them after completing their grant application.

To receive draft copies of Treatment Improvement Protocol (TIP), Substance Abuse Treatment for Persons with Co-occurring Disorders and the Co-Occurring Disorders: Integrated Dual Disorders Treatment Implementation Resource Kit for use in preparing the application, provide your *name, position title, mailing address* for receipt of packages, *email address,* and *phone number* to:

Richard E. Lopez, J.D., Ph.D., SAMHSA/CSAT/DSCA, 5600 Fishers Lane/Rockwall II, 8–147, Rockville, MD 20857, (301) 443–7615, E-mail: *rlopez@samhsa.gov,*

or

Lawrence Rickards, Ph.D., SAMHSA/CMHS/DSSI, 5600 Fishers Lane, 11C–05, Rockville, MD 20857, (301) 443–3707, E-mail: *lrickard@samhsa.gov.*

2.3 Data and Performance Measurement

All awardees will use the co-occurring performance measures adopted by National Association of State Alcohol and Drug Abuse Directors (NASADAD), and the National Association of State Mental Health Program Directors (NASMHPD), in conjunction with SAMHSA, to monitor the growth of their service capacity for treating persons with co-occurring disorders. Costs for collecting and reporting data on these measures should be included in the proposed budget for the COSIG. The co-occurring performance measures are as follows:

- Percentage of clients (adults and children/adolescents) in mental health and substance abuse programs with symptoms of the corresponding co-occurring problem;
- Percent of treatment programs that:
  - —Screen for co-occurring disorders;
  - —Assess for co-occurring disorders;
  - —Provide treatment to clients through collaborative, consultative and integrated models of care;
- Percentage of clients who experience reduced impairment from their co-occurring disorders following treatment.

Applicants must describe their current capacity to collect data relating to each of these measures, must present baseline data if available, and must project targets for these measures for each year of the COSIG grant. Applicants must describe how they will collect and report data related to the PPG measures during the first 6–8 months of the grant, and must demonstrate a capacity to do so.

These measures will be used by all COSIG awardees. SAMHSA may award a separate contract to evaluate the interim measures for validity and reliability and to develop final standards.

The terms and conditions of the grant award also will specify the data to be submitted to SAMHSA and the schedule for submission. Grantees will be required to adhere to these terms and conditions of award.

Applicants should be aware that SAMHSA is working to develop a set of required core performance measures for four types of grants (*i.e.*, Services Grants, Infrastructure Grants, Best Practices Planning and Implementation Grants, and Service-to-Science Grants). As this effort proceeds, some of the data collection and reporting requirements included in SAMHSA's programs may change. All grantees will be expected to comply with any changes in data collection requirements that occur during the grantee's project period.

2.4 Grantee Meetings

Grantees must attend (and, thus must budget for) two technical assistance meetings during each year of the grant. Each meeting will be three days. At a

minimum, three persons (Project Director, Project Evaluator, and staff from the Governor's Office) are expected to attend each meeting. These meetings will usually be held in the Washington, DC area.

SAMHSA will provide post award support to grantees through technical assistance on clinical, programmatic, and evaluation issues. Applicants must agree to participate in these activities.

2.5 Evaluation

SAMHSA may require COSIG grantees to participate in an evaluation of the feasibility, validity, and reliability of the proposed co-occurring performance measures for the PPGs.

Grantees must evaluate their projects, and applicants are required to describe their evaluation plans in their applications. The evaluation should be designed to provide regular feedback to the project to improve services. The evaluation must include both process and outcome components. Process and outcome evaluations must measure change relating to project goals and objectives over time compared to baseline information. Control or comparison groups are not required. You must consider your evaluation plan when preparing the project budget.

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 impact did the deviations have on the intervention and evaluation?
- Who provided (program, staff) what services (modality, type, intensity, duration), to whom (individual characteristics), in what context (system, community), and at what cost (facilities, personnel, dollars)?

Outcome components should address issues such as:

- What was the effect of infrastructure development on service capacity and other system outcomes?
- What program/contextual factors were associated with outcomes?
- What individual factors were associated with outcomes?
- How durable were the effects?

If the project includes an implementation pilot involving services delivery, the evaluation should include client and system outcomes.

SAMHSA *may* choose to implement a cross-site evaluation of the COSIG grant program. If conducted, the cross-site evaluation will be managed through a public/private collaboration. States will be required to collaborate in the evaluation by attending up to two meetings annually, participating in the development of a cross-site evaluation plan, and by submitting information consistent with the plan. Applicants must specifically agree to participate in a cross-site evaluation and must budget for attendance by two persons at two meetings annually. These two annual meetings are in addition to the two annual technical assistance meetings discussed above. Once the final standards for the performance measures are developed, COSIG awardees will be required to collect and report outcomes using the final standards for the remainder of their grants.

No more than 20% of the total grant award may be used for evaluation and data collection. The evaluation and data collection may be considered "Infrastructure" and/or "Implementation Pilots" expenditures, depending on their purpose.

CMHS has developed a variety of evaluation tools and guidelines that may assist applicants in the design and implementation of the evaluation. These materials are available for free downloads from: *http://www.tecathsri.org.*

II. Award Information

1. Award Amount

It is expected $4.5 million will be available to fund up to 4 COSIG awards in FY 2004. The awards will range from $500,000 to $1.1 million in total costs (direct and indirect) per year. Grantees in years 1–3 will receive up to $1.1 million per year. Grantees with service pilots will receive up to half of the third year award in the 4th year to phase down the services pilot and up to $100,000 for evaluation in year 5. For example, if you ask for $1.1 million in year 3, you can request up to $550,000 in Year 4. If you request less than $1.1 million in year 3, then your year 4 request must be proportionately less. Grantees without service pilots will receive up to $100,000 for evaluation in both years 4 and 5. Proposed budgets cannot exceed the allowable amount in any year of the proposed project. The actual amount available for the awards may vary, depending on unanticipated program requirements and the number and quality of the applications received.

2. Funding Mechanism

Awards will be made as grants.

III. Eligibility Information

1. Eligible Applicants

Only the immediate Office of the Governor of States may apply. State-level agencies are not considered to be part of the immediate Office of the Governor. This means, for example, that the State Mental Health, or Substance Abuse Authorities, or other State-level agencies within the Office of the Governor, cannot apply independently. SAMHSA has limited the eligibility to Governors of States because the immediate Office of the Governor has the greatest potential to provide the multi-agency leadership needed to develop the State's infrastructure/treatment service systems to increase the State's capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based services to persons with co-occurring substance abuse and mental health disorders, and their families.

The Governor may designate a lead official to be Program Director for the grant. The application must reflect substantial involvement of the State Mental Health Authority (SMHA) and the State Substance Abuse Authority (SSA), and other relevant agencies, and must reflect substantial involvement and oversight by the immediate Office of the Governor.

The application face page (form 424) must be signed by the Governor.

As defined in the Public Health Service (PHS) Act, the term "State" includes all 50 States, the District of Columbia, Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, the Virgin Islands, American Samoa, and the Trust Territory of the Pacific Islands. Applications from State agencies other than the Office of the Governor, or from government entities that do not meet the definition of "State," are not eligible for funding.

This grant program is appropriate for all States regardless of their level of infrastructure development.

2. Cost-Sharing

Cost-sharing (see Appendix B. Glossary) is not required in this program, and applications will not be screened out on the basis of cost-sharing. However, you may include cash or in-kind contributions (see Glossary) in your proposal as evidence of commitment to the proposed project.

3. Other

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.

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 by calling one of SAMHSA's national clearinghouses:

- National Clearinghouse for Alcohol and Drug Information (NCADI) at 1–800–729–6686; or
- National Mental Health Information Center at 1–800–789–CMHS (2647).

You also may download the required documents from the SAMHSA Web site at *http://www.samhsa.gov.* Click on ''Grant Opportunities.''

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 Required Documents

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)—Includes instructions for the grant application. This document is the RFA.

You must use 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 ten 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:** Beginning October 1, 2003, applicants will need to provide a Dun and Bradstreet (DUNS) number to apply for a grant or cooperative agreement from the Federal Government. SAMHSA applicants will be required to provide their DUNS number on the face page of the application. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS number, access the Dun and Bradstreet Web site at *http://www.dunandbradstreet.com* or call 1–866–705–5711. To expedite the process, let Dun and Bradstreet know that you are a public/private nonprofit organization getting ready to submit a Federal grant application.]
- *Abstract*—Your total abstract should not be longer than 35 lines. In the first five lines or less of your abstract, write a summary of your project that can be used, if your project is funded, in publications, reporting to Congress, or press releases.
- *Table of Contents*—Include page numbers for each of the major sections of your application and for each appendix.
- *Budget Form*—Use SF 424A, which is part of the 5161–1. Fill out Sections B, C, and E of the SF 424A.
- *Project Narrative and Supporting Documentation*—The Project Narrative describes your project. It consists of Sections A through C. These sections in total may not be longer than 30 pages. More detailed instructions for completing each section of the Project Narrative are provided in ''Section V—Application Review Information'' of this document.

The Supporting Documentation provides additional information necessary for the review of your application. This supporting documentation should be provided immediately following your Project Narrative in Sections D through G. There are no page limits for these sections, except for Section F, Biographical Sketches/Job Descriptions.

- *Section D*—Literature Citations. This section must contain complete citations, including titles and all authors, for any literature you cite in your application.
- *Section E*—Budget Justification, Existing Resources, Other Support. You must provide a narrative justification of the items included in your proposed budget, as well as a description of existing resources and other support you expect to receive for the proposed project. Be sure to show that no more than 20% of the total grant award will be used for data collection and evaluation, and no more than 50% of the grant will be used for services pilots, if applicable.
- *Section F*—Biographical Sketches and Job Descriptions.

—Include a biographical sketch for the Project Director and other key positions. Each sketch should be 2 pages or less. If the person has not been hired, include a letter of commitment from the individual with a current biographical sketch.

—Include job descriptions for key personnel. Job descriptions should be no longer than 1 page each.

—Sample sketches and job descriptions are listed on page 22, Item 6 in the Program Narrative section of the PHS 5161–1.

- *Section G*—Confidentiality and SAMHSA Participant Protection/Human Subjects. Section IV–2.4 of this document describes requirements for the protection of the confidentiality, rights and safety of participants in SAMHSA-funded activities. This section also includes guidelines for completing this part of your application.
- *Appendices 1 through 3*—Use only the appendices listed below. Do not use more than 30 pages (excluding data collection instruments and interview protocols) for the appendices. 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:* Letters of Commitment/Support from stakeholders and project participants/involved agencies.

—*Appendix 2:* Sample Consent Forms

—*Appendix 3:* Data Collection Instruments/Interview Protocols. (Note: Appendix 3 has no page limit.)

—*Assurances*—Non-Construction Programs. Use Standard Form 424B found in PHS 5161–1. Because grantees in the COSIG program may use some of the grants funds to provide direct substance abuse services, applicants are 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 the National Clearinghouse for Alcohol and Drug Information and the National Mental Health Information Center.

—*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.

—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.

—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.

• The 30-page limit for Appendices 1 and 2 cannot be exceeded.

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 with one column per page.

• Pages should not have printing on both sides.

• Please use black ink, and 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.

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.

2.4 SAMHSA Confidentiality and Participant Protection Requirements and Protection of Human Subjects Regulations

You must describe your procedures relating to Confidentiality, Participant Protection and the Protection of Human Subjects Regulations in Section G of your application, using the guidelines provided below. Problems with confidentiality, participant protection, and protection of human subjects identified during peer review of your application may result in the delay of funding.

Confidentiality and Participant Protection:

All applicants *must* address each of the following elements relating to confidentiality and participant protection. You must describe how you will address these requirements.

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 3, ''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 2, ''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

Depending on the evaluation and data collection requirements of the particular funding opportunity for which you are applying or the evaluation design you propose in your application, you may have to comply with the Protection of Human Subjects Regulations (45 CFR part 46).

Applicants must be aware that even if the Protection of Human Subjects Regulations do not apply to all projects funded under a given funding opportunity, 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.

Additional information about Protection of Human Subjects Regulations can be obtained on the web at *http://ohrp.osophs.dhhs.gov*. You may also contact OHRP by e-mail (*ohrp@osophs.dhhs.gov*) or by phone (301–496–7005).

3. Submission Dates and Times

Applications are due by close of business on June 8, 2004. Your application must be received by the application deadline. Applications sent through postal mail and received after this date must have a proof-of-mailing date from the carrier dated at least 1 week prior to the due date. Private metered postmarks are not acceptable as proof of timely mailing.

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

Applications not received by the application deadline or not postmarked by a week prior to the application deadline will be screened out and will not be reviewed.

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 Indian tribal government.
- 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: Substance Abuse and Mental Health Services Administration, Office of Program Services, Review Branch, 5600 Fishers Lane, Room 17–89, Rockville, Maryland

20857, ATTN: SPOC—Funding Announcement No. [fill in pertinent funding opportunity number from the NOFA].

5. Funding Limitations/Restrictions

Cost principles describing allowable and unallowable expenditures for Federal grantees, including SAMHSA grantees, are provided in the following documents:

• Institutions of Higher Education: OMB Circular A–21
• State and Local Governments: OMB Circular A–87
• Nonprofit Organizations: OMB Circular A–122
• Appendix E Hospitals: 45 CFR Part 74

In addition, grant recipients must comply with the following funding restrictions:

• Grant funds must be used for purposes supported by the program.
• Grant funds may not be used to pay for the purchase or construction of any building or structure to house any part of the grant project. Applications may request up to $75,000 for renovations and alterations of existing facilities.

6. Other Submission Requirements

6.1 Where to Send Applications

Send applications to the following address: Substance Abuse and Mental Health Services Administration, Office of Program Services, Review Branch,5600 Fishers Lane, Room 17–89, Rockville, Maryland 20857.

Be sure to include the short title and funding announcement number (COSIG, SM 04–012) in item number 10 on the face page of the application. If you require a phone number for delivery, you may use (301) 443–4266.

6.2 How to Send Applications

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

You must use a recognized commercial or governmental carrier. Hand carried applications will not be accepted. Faxed or e-mailed applications will not be accepted.

V. Application Review Information

1. 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–C). 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.
• You must use the three 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.
• 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 *http://www.samhsa.gov.* Click on ''Grant Opportunities.''
• The Supporting Documentation you provide in Sections D–G and Appendices 1–3 will be considered by reviewers in assessing your response, along with the material in the Project Narrative.
• The number of points after each heading below 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 each section.

Section A: Documentation of Need/ Proposed Approach (55 points)

Note: If the applicant *does not* propose a Services Pilot, 55 points are allocated to Section A.1. If the applicant *does* propose a Services Pilot, 40 points are allocated to Section A.1. and 15 points are allocated to Section A.2.]

Section A.1. Current System and Proposed Activities

Specifically state in this section that the applicant is the Office of the Governor and that the Governor has signed the application. Describe the current system and the proposed activities for affecting positive system change. Address plans to implement the requirements in Section I–2.2, Program Requirements. Applicants are encouraged to use organizational charts and/or logic model depictions (see Appendix C) to illustrate the current elements, linkages, lines of communications, coordination mechanisms, responsibilities, and authorities, as well as areas where potential improvements or attention are needed.

• State that the applicant is the Office of the Governor and that the Governor has signed the application.
• Demonstrate a thorough understanding of co-occurring substance abuse and mental disorders, and the state-of-the art in providing a system of services for persons with co-occurring disorders.
• Demonstrate a thorough understanding of the State's current system of services for persons with co-occurring disorders. Describe the State's current infrastructure and capacity for providing coordinated/integrated services to persons with co-occurring disorders within both the State Mental Health Authority (SMHA) and Substance AbuseAuthority (SSA) and other relevant agencies/systems. Describe structural components, such as dedicated staff time, routine training activities, organizational roles and responsibilities, and relationships and priority areas for the provision of coordinated/integrated services to persons with co-occurring disorders across all four Quadrants. Describe any major limitations or challenges within both the SMHA and the SSA and other relevant agencies/systems including staffing limitations, limits to statutory authorities, organizational imperatives, or budget constraints.
• Present and justify the State's plan for using COSIG funds to improve infrastructure and capacity to serve persons with co-occurring disorders. State clearly which (one or more) of the five SAMHSA capacity building goals the State is selecting to implement. Describe how the State will implement these goals, through specific infrastructure development/ enhancement activities. Applicants must identify measurable outcomes for each goal, establish targets, and describe how progress will be tracked and measured over the course of the grant. Be sure to address all the critical areas of infrastructure development identified in Section I–2.2, Program Requirements. Specify how gaps in the system will be narrowed and other expected results, including any products to be developed through the project. State which Quadrants will be affected by proposed activities and demonstrate how the proposed plan is consistent with SAMHSA's emphasis on infrastructure improvements within Quadrants II and III.
• Describe the involvement of the SMHA and the SSA and of other relevant systems/agencies, such as primary care, criminal justice, labor, housing, and social service agencies in the proposed project. Demonstrate how involvement of these systems or

agencies will contribute to enduring infrastructure improvements. Note: Applicants are required to include letters of commitment and cooperation from these agencies. [Letters of Commitment/Support from each of the involved agencies and stakeholders must be provided in Appendix 1 of the application]. Identify any cash or in-kind contributions that will be made to the project.

• Describe the process for linking State-level planning and infrastructure development to regional, county, and community-based mental health and substance abuse organizations and their representatives. Describe the process for obtaining input and involving a diverse array of participants, including representation from cultural/ethnic communities, potential service recipients, mental health consumers and their families, the recovery communities, public and private service providers, businesses, faith communities, primary care professionals and other relevant community groups. Demonstrate that these processes will contribute to enduring infrastructure improvements.

• Demonstrate that the proposed project is feasible and practical. Demonstrate that the applicant's history of working toward systems coordination/integration will contribute to the success of the project. Demonstrate the scope and feasibility of successful collaboration among State entities involved in the proposed project—*e.g.*, inclusion of treatment and prevention; inclusion of public health entities other than those dealing with mental health and/or substance abuse (*e.g.*, primary care providers, communicable diseases, school health); inclusion of funding-related entities, especially Medicaid; inclusion of corrections and criminal justice; linkage with drug courts; collaborations with social/welfare/vocational services, etc.

Section A.2. Services Pilot

In this Section, the applicant should describe and justify the implementation of a Services Pilot Project, if applicable. Applicants that do not plan to conduct a services pilot must state this intent.

• Describe and justify the proposed services pilot. State the goals and objectives of the proposed pilot and document that the services pilot will support the overall goals of your grant project. Describe the geographic area to be served. What are the demographic and clinical characteristics of persons who will receive services? Who will provide the services, and what services? Demonstrate the need for implementing the services pilot in the proposed area(s) and with the proposed population(s). Provide an unduplicated estimate of the number of persons to be served through the pilot for each year of the grant.

• Provide relevant and recent literature supporting your services pilot plan. Demonstrate that the proposed service model is a science/evidence-based practice based on scientifically derived theory.

• Demonstrate that the services pilot will help test the feasibility of the infrastructure enhancement at various levels, with the goal of improving the effectiveness and efficiency of service delivery, and will contribute to statewide changes in the system.

• Describe how the project will address age, race/ethnic, cultural, language, sexual orientation, disability, literacy, and gender issues relative to the target population.

• Demonstrate the effective involvement of the target population in the planning and design of the proposed services pilot and in interpretation of results.

Section B: Organizational and Staffing Plans (30 points)

• Demonstrate the organizational capability to implement the proposed plan. Describe the organizational structure, lines of supervision, and management oversight for the proposed project. Specifically, describe the plans for partnership between the Governor's Office, the SMHA and the SSA, and proposed protocols for ongoing communications and joint planning activities. Identify a lead agency, if appropriate, for purposes of administering the grant, and describe the rationale for selecting this agency as the lead.

• Demonstrate the qualifications and roles of key personnel including evaluation staff and the Program Director.

• Provide an organizational chart showing the organizational placement of key personnel involved in the project. The applicant may also provide other visual diagrams showing key organizational components involved in the planning efforts and the structure for the involvement of organizational leadership.

• Demonstrate that the facilities and equipment that will be used to implement the proposed work plan are adequate. Indicate if the facilities will be compliant with the requirements of the American with Disabilities Act (ADA).

• Affirm a commitment to comply with reporting requirements, to attend two technical assistance meetings annually, to participate in technical assistance activities, and to cooperate and coordinate with SAMHSA's Co-occurring Cross Training and Technical Assistance Activity [see Section I–2.2, Program Requirements], and to participate in the cross-site evaluation, if SAMHSA elects to conduct it [see Section I–2.3 Data and Performance Measurement].

Section C: Evaluation/Methodology (15 points)

• Describe the State's current capacity to collect data related to the PPG measures. Present baseline data, if available, and project targets for these measures for each year of the grant. Describe plans to collect and report data related to the PPG measures during the first 6–8 months of the grant, and demonstrate a capacity to do so. Describe steps to be taken to enable the State to comply fully with PPG reporting requirements, and demonstrate the feasibility of implementing these steps.

• Describe a local evaluation plan that will provide useful information to the State about project progress. Describe plans for using evaluation findings to monitor and improve project implementation and to help implement durable improvements in the service delivery system. Describe and justify the targets and measures the applicant will use to track progress toward accomplishing implementation of the goals, plans to assess implementation fidelity, process and outcome, and plans to ensure the cultural appropriateness of the evaluation.

• Demonstrate appropriate plans for including members of the target population and/or their advocates in the design and implementation of the evaluation and in the interpretation of findings.

Note: Although the budget for the proposed project is not a review criterion, the Review Group will be asked to comment on the appropriateness of the budget after the merits of the application have been considered. Please remember that Grantees in years 1–3 will receive up to $1.1 million per year. Grantees with service pilots will receive up to half of the third year award in the 4th year to phase down the services pilot and up to $100,000 for evaluation in year 5. For example, if you ask for $1.1 million in year 3, you can request up to $550,000 in Year 4. If you request less than $1.1 million in year 3, then your year 4 request must be proportionately less. Grantees without service pilots will receive up to $100,000 for evaluation in both years 4 and 5. The actual amount available for the awards may vary, depending on unanticipated program requirements and the number and quality of the applications received.

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.

Only one award will be made per State.

Decisions to fund are based on:

- The strengths and weaknesses of the application as identified by peer reviewers and, when appropriate, approved by the appropriate National Advisory Council.
- Availability of funds.
- Considerations to help achieve the COSIG goal of being a national program based on population, geographic, and service characteristics. To achieve this goal, SAMHSA may distribute awards to achieve balance among areas of the country, or with differing population, or urban/rural characteristics.
- It is SAMHSA's intent to make awards to States at different levels of readiness or infrastructure development.
- SAMHSA will not award a COSIG grant to a State that already has one.
- After applying the aforementioned criteria, the following method for breaking ties: When funds are not available to fund all applications with identical scores, SAMHSA will make award decisions based on the application(s) that received the greatest number of points by peer reviewers on the evaluation criterion in Section V–1 with the highest number of possible points, Section A: Documentation of Need/Proposed Approach (55 points). Should a tie still exist, the evaluation criterion with the next highest possible point value will be used, continuing sequentially to the evaluation criterion with the lowest possible point value, should that be necessary to break all ties.

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 and it contains the terms and conditions of the grant. 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

- You must comply with all terms and conditions of the grant award. SAMHSA's standard terms and conditions are available on the SAMHSA Web site *http://www.samhsa.gov/grants/2004/useful_info.asp.*
- 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 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.

- You will be held accountable for the information provided in the application relating to performance targets. SAMHSA program officials will consider your progress in meeting goals and objectives, as well as your failures and strategies for overcoming them, when making an annual recommendation to continue the grant and the amount of any continuation award. Failure to meet stated goals and objectives may result in suspension or termination of the grant award, or in reduction or withholding of continuation awards.
- 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. 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

- Grantees must submit quarterly progress reports and a final report. Each report must include evaluation results and required co-occurring performance measures.
- The final report must summarize information from the quarterly reports and describe the accomplishments of the project and planned next steps for continuing to implement service delivery improvements after the grant period.
- Grantees must provide annual and final financial status reports. These reports may be included as separate sections of progress reports or can be separate documents. Because SAMHSA is extremely interested in ensuring that infrastructure development and enhancement efforts can be sustained, your financial reports must explain plans to ensure the sustainability (see Glossary) of efforts initiated under this grant. Initial plans for sustainability should be described in year 1 of the grant. In each subsequent year, you should describe the status of the project, successes achieved and obstacles encountered in that year.
- 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 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 (301–443–8596) of any materials based on the SAMHSA-funded 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 Additional Information

For questions about program issues, contact:

Richard E. Lopez, J.D., PhD, SAMHSA/CSAT/DSCA, 5600 Fishers Lane/Rockwall II, 8–147, Rockville, MD

20857, (301) 443–7615, E-mail: *rlopez@samhsa.gov;*
or
Lawrence Rickards, PhD, SAMHSA/CMHS/DSSI, 5600 Fishers Lane, 11C–05, Rockville, MD 20857, (301) 443–3707, E-mail: *lrickard@samhsa.gov*.

For questions on grants management issues, contact: Gwendolyn Simpson, SAMHSA/Division of Grants Management, 5600 Fishers Lane, Room 13–103, Rockville, MD 20857, (301) 443–4456, E-mail: *gsimpson@samhsa.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. In addition to these formatting requirements, programmatic requirements (*e.g.*, relating to eligibility) may be stated in the specific funding announcement. Please check the entire funding announcement before preparing your application.

- Use the PHS 5161–1 application.
- Applications must be received by the application deadline. Applications received after this date must have a proof of mailing date from the carrier dated at least 1 week prior to the due date. Private metered postmarks are not acceptable as proof of timely mailing. Applications not received by the application deadline or not postmarked at least 1 week prior to the application deadline will not be reviewed.
- Information provided must be sufficient for review.
- Text must be legible.

—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.

—Applications would meet this requirement by using all margins (left, right, top, 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 total number of allowed pages. 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.

- The page limit for Appendices stated in the specific funding announcement cannot be exceeded.

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:

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

- Applications should comply with the following requirements:

—Provisions relating to confidentiality, participant protection and the protection of human subjects specified in Section IV–2.4 of the specific funding announcement.
—Budgetary limitations as specified in Sections I, II, and IV–5 of the specific funding announcement.
—Documentation of nonprofit status as required in the PHS 5161–1.

- Pages should be typed single-spaced with one column per page.
- Pages should not have printing on both sides.
- Please use black ink, and 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.
- Send the original application and two copies to the mailing address in the funding announcement. 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

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.

Cost-Sharing or Matching: Cost-sharing refers to the value of allowable non-Federal contributions toward the allowable costs of a Federal grant project or program. Such contributions may be cash or in-kind contributions. For SAMHSA grants, cost-sharing or matching is not required, and applications will not be screened out on the basis of cost-sharing. However, applicants often include cash or in-kind contributions in their proposals as evidence of commitment to the proposed project. This is allowed, and this information may be considered by reviewers in evaluating the quality of the application.

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.

In-Kind Contribution: In-kind contributions toward a grant project are non-cash contributions (*e.g.*, facilities, space, services) that are derived from non-Federal sources, such as State or sub-State non-Federal revenues, foundation grants, or contributions from other non-Federal public or private entities.

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 C.

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—Logic Model Resources

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Appendix D: State Case Studies

Arizona

The SAPT and CMHS Block Grants have been used creatively to promote the development of services for people with co-occurring disorders. The original impetus for the Arizona Integrated Treatment Initiative was a SAMHSA Community Action Grant for Service System Change, coupled with other resources, including State appropriations and tobacco settlement funds.

Recognizing that individuals with co-occurring disorders were commonly found in both substance abuse and mental health service settings, the Arizona Department of Health Services' Division of Behavioral Health Services launched a major initiative in 1999 to develop a best practice treatment model for individuals with co-occurring disorders. The result was a statewide refocusing of service practices in the behavioral health care system.

In particular, the State chose to pursue a consensus-based practice development model to identify the principles and practices of integrated treatment within Arizona, with the knowledge that implementation of this model would vary within the State based on local resources and the characteristics of the individuals being served. Among the outcomes of this effort were:

1. *New Contract Language.* Contracts for regional behavioral health authorities were revised to include language regarding co-occurring disorders consistent with that contained in the CMHS Block Grant statute.

2. *New Policies and Guidelines.* A work group of local and national experts developed Service Planning Guidelines for Co-Occurring Disorders and revised the State's eligibility policy for people with serious mental illnesses. The new policy expedites entry into services, regardless of concurrent substance use, and allows for an expanded time frame to gather necessary records. This means that individuals are not denied eligibility based on the inability to clinically differentiate multiple disorders or for lack of information.

Consensus-Based System Change. One of the most significant findings of the Arizona initiative was that consensus-based system change encourages and sustains community action. System planners determined that had the initiative been developed in isolation at the State level and simply mandated by administrative requirement, the level of community "buy-in" needed to make change happen simply would not have taken place.

Connecticut

In 1995 the State of Connecticut created the Department of Mental Health and Addiction Services (DMHAS) as the Single State Agency for both mental health and substance abuse services for adults. The Connecticut Department of Children and Families (DCF) is charged with the care of youth for behavioral health services.

SAPT Block Grant funds are distributed across all DMHAS-funded substance abuse treatment programs, including programs that provide addiction services for people with both substance abuse disorders and co-occurring mental disorders. DMHAS, in coordination with DCF, uses CMHS Block Grant funds to fund and administer services for youth with serious emotional disturbances and adults with serious mental illness. Over the past several years, both an Alcohol and Drug Policy Council and a Mental Health Policy Council, with broad stakeholder representations jointly address policy and service issues related to the planning and coordination of adult and children's behavioral health services including those persons with co-occurring disorders.

DMHAS has directly focused SAPT Block Grant funds to provide services to adults with co-occurring substance abuse disorders and mental disorders in three methadone maintenance programs. These programs have implemented screening and assessment protocols to help identify clients with co-occurring mental disorders. Clients identified as possibly having a mental health disorder receive a full psychiatric assessment.

Clients determined to have a mild or moderate mental illness are seen by an on-site psychiatrist for medication review. They are assigned to a dual diagnosis counselor, and receive ongoing case management. The counselors also provide intensive, individual, or group counseling to these clients. Individuals diagnosed with a serious mental illness are referred to appropriate mental health services; care is coordinated across the two programs.

DMHAS continues to explore ways to enhance access to appropriate care for people with co-occurring substance abuse disorders and mental disorders. Various policy making and planning bodies within the State are involved in ongoing discussions regarding care coordination and implementation of best practices. The State has used State general fund dollars and other non-Block Grant resources to promote a coordinated system of care for individuals with co-occurring disorders.

New Mexico

In 1997, the State of New Mexico combined the Division of Mental Health and the Division of Substance Abuse into the Behavioral Health Services Division. The Division administers the SAPT and CMHS Block Grants and non-Medicaid mental health and substance abuse treatment funds. This integration has fostered significant collaboration between disciplines in policy and program implementation.

SAPT and CMHS Block Grant funds, as well as State appropriations in mental health and substance abuse, are used to develop system capacity for people with co-occurring disorders. As part of a statewide managed care initiative, the Behavioral Health Service Division implemented a regional model of service delivery that includes the following features:

I. Five regional contractors that are responsible for the delivery of continuum of care in mental health and substance abuse treatment;

II. Comprehensive Behavioral Health Standards established by the Division to guide service delivery, network management, and performance/outcome requirements; and

III. A Behavioral Health Information System to monitor contract compliance and service delivery protocols through standardized reporting and site visits.

Because New Mexico's system is based on the assumption that co-occurring disorders are an expectation and not an exception, both substance abuse and mental health treatment programs must screen all individuals for the presence of both disorders on a routine basis. All programs employ a ''no wrong door'' approach that welcomes and supports the individual. In addition to screening, standard practices include assessment by appropriately licensed practitioners, integrated treatment planning, and direct services for both substance abuse and mental disorders provided at the same time.

Some programs for individuals with co-occurring disorders have the in-house capacity to deliver services for both disorders; others coordinate services as part of a network of community partners. In addition, the system includes the capacity to address treatment and service needs throughout the entire continuum, including residential and hospital-based levels of care. The goal is to create a system that meets the standards of accessibility, integration, continuity, and comprehensiveness (Minkoff, 1998). A more comprehensive report on New Mexico's integrated services can be obtained by contacting SAMHSA's Office of Program, Planning, and Budget at (301) 443–4111.

Pennsylvania

In 1997, the Office of Mental Health and Substance Abuse Services in the Department of Public Welfare and the Bureau of Drug and Alcohol Programs in the Department of Health jointly sponsored a statewide Mental Illness and Substance Abuse (MISA) Consortium to examine integrated approaches in working with people who have co-occurring substance abuse disorders and mental disorders. Stakeholders from the mental health and drug and alcohol systems participated. The group's 1999 report recommended service and systems integration in four areas: assessment, professional credentialing and training, service standards, and adolescent services. Pennsylvania's MISA Pilot Project is the embodiment of those recommendations.

The MISA Pilot Project is a product of a collaboration between the State Departments of Health and the State Department of Public Welfare. Designed to promote systems and services integration for individuals with co-occurring substance abuse disorders and mental disorders, the project is composed of five county systems and a network of 11 providers offering integrated services. The network continues to expand as additional providers meet the required integrated service criteria. The projects total funding is $3.3 million annually and comes from the combined resources of three funding sources: State Intergovernmental Transfer Funds, CMHS Block Grant Funds, and the SAPT Block Grant Funds. Traditional reporting mechanisms are used for tracking and accountability.

Based on the consortium's recommendations, the State issued a solicitation for pilot projects to interested county mental health administrators and substance abuse directors. Available funds were to be used as seed money for development of program models that combine resources and expertise from both the community mental health and drug and alcohol systems. Four adult and one child/adolescent proposal were selected for funding.

Mental health and drug and alcohol funds have been allocated to the projects over a 2-year period, with an additional year for evaluation by the Center for Mental Health Policy and Services Research at the University of Pennsylvania. All pilot projects provide a varying number of services that meet criteria for enhanced/integrated services for co-occurring disorders.

The pilot projects are being evaluated to determine the impact of integrated treatment and systems of care on client outcomes; the impact on client satisfaction; the potential of specialized co-occurring disorders integrated treatment and support services; and best practice models of system integration, representing a variety of strategies that can be replicated for adult and adolescent services. Ultimately, the projects are expected to generate ideas for future policy and program development and identify potential funding sources for co-occurring disorders services.

Texas

The Texas Commission on Alcohol and Drug Abuse and the Texas Department of Mental Health and Mental Retardation created and funded a dual diagnosis coordinator position in 1995 to help ensure coordination between the two agencies. This position is funded with SAPT and CMHS Block Grant and general revenue funds. These monies also are funding 16 dual diagnosis projects throughout Texas.

The Commission on Alcohol and Drug Abuse purchases ''dual diagnosis specialized services'' to offer a coordinated approach to the delivery of integrated substance abuse and mental health services. The programs link patients to mainstream substance abuse and mental health services through research-based engagement strategies, and provide specialized dual diagnosis training and case consultation to service providers.

The target population includes people with substance abuse or dependence and a serious mental illness, including schizophrenia, major depression, and bipolar disorder. The State requires that ''dual diagnosis specialized services'' respond competently to age, gender, sexuality, geography, and culture for all people needing services in Texas. The Commission also provides statewide conferences on co-occurring disorders throughout the year to train staff and expand capacity to serve this population.

The Texas alcohol and drug and mental health agencies also have implemented significant system changes. To strengthen the ability of substance abuse providers to meet the multiple needs of people with co-occurring disorders and their families, the Commission on Alcohol and Drug Abuse has adopted statewide rules and regulations which require that mental health expertise be incorporated into existing programs and/or coordinated with other providers. These rules address requirements, including those for screening and admission, assessment, and treatment services for facilities licensed by the Commission. The two agencies operate under a Memorandum of Understanding (MOU) that addresses principles and practices for treating individuals with co-occurring disorders.

Wisconsin

In May 1996, then-Governor Tommy Thompson of Wisconsin, created the Blue Ribbon Commission on Mental Health to examine the mental health delivery system and propose changes that fostered system effectiveness in an environment emphasizing managed care, client outcomes, and performance contracting. The Bureau of Substance Abuse Services and the Bureau of Community Mental Health are currently working cooperatively to develop a coordinated and flexible managed care model of service delivery, that includes the design, implementation and evaluation of a single entry point for consumers of mental health, alcohol, and drug services. The initiative emphasizes recovery principles and a consumer-focused approach with long-term care enrollees. The target group for this model includes individuals with severe and persistent mental illness, including individuals in that group who have co-occurring disorders.

During fiscal year 2000, Wisconsin developed a coalition to address co-occurring substance abuse disorders and mental disorders among the aging population. Five regional training sessions with over 450 participants in attendance educated about, and enhanced coordination of, mental health and substance abuse interventions, including the provision of integrated treatment, for older adults. Both the coalition and training efforts have been in operation for approximately 2 years. Funding is aggregated from multiple sources, including the CMHS Block Grant.

In addition, the Bureau of Substance Abuse Services used SAPT Block Grant funding to develop eight women-specific treatment programs that either provide or refer their clients to qualified mental health services. Coordination of mental health services for substance abuse clients is required for State program certification.

Appendix E: Text from State Directors' Conceptual Framework

Just as individuals with co-occurring disorders are unique, so too are the service

systems through which they receive their care. The conceptual framework that meeting participants proposed, which is outlined in this section, provides a common set of reference points and allows policy makers, providers, and funders to plan services for individuals regardless of their specific diagnoses or the current structure of the health care delivery system in their State or community.

The New York Model

James Stone, M.S.W., Commissioner of the New York State Office of Mental Health, presented a model his State uses to locate individuals with co-occurring mental health and substance abuse disorders on a continuum of care. The underlying assumption of the New York model is the fact that people with co-occurring disorders vary in the severity of their mental health and substance abuse disorders, from less severe mental health and substance abuse disorders to more severe mental health and substance abuse disorders. Individuals for whom one or the other disorder is predominant fall between these two groups.

Further, the model is based on the fact that these differences in severity determine the service system location in which individuals receive their care, including the primary health care, mental health care, and alcohol and other drug treatment systems, as well as the criminal justice system, the homeless service system, and so on.

Participants chose to elaborate on the framework by expanding on these specific areas of concern. Most importantly, it was agreed that the framework could accommodate service coordination needs and (at some future point) funding sources quite well. Each of three areas—severity, primary locus of care, and service coordination—is discussed below.

The Revised Framework

The conceptual framework that meeting participants developed expands on the New York model and represents a new paradigm for considering both the needs of individuals with co-occurring substance abuse and mental health disorders and the system characteristics required to address these needs. Unique features of this approach include the following:

- The revised framework is based on symptom multiplicity and severity, not on specific diagnoses, and uses language familiar to both mental health and substance abuse providers. As such, it encompasses the full range of people who have co-occurring substance abuse and mental health disorders. In addition, it points to windows of opportunity within which providers can act to prevent exacerbation of symptom severity.
- The framework permits discussion of co-occurring disorders along several dimensions, including symptom multiplicity and severity, locus of care, and degree of service coordination. It permits a number of key decisions to flow from it, including the level of service coordination required and the best use of available resources.
- The framework accommodates different levels of service coordination rather than specifying discrete service interventions. It represents a flexible approach that can be adopted or adapted for use in any service setting.
- The framework identifies two levels of service coordination—consultation and collaboration—that do not require fully integrated services. It points to the fact that individuals can be appropriately served with interventions that do not require full service integration. This is important for those service settings in which integration is not feasible or desirable, and for those individuals whose needs can be addressed with a minimum amount of system change.

Regardless of specific diagnoses, meeting participants agreed that individuals with co-occurring disorders fall into one of four major quadrants based on the severity of their mental health and substance abuse disorders:

- Quadrant I: Less severe mental disorder/less severe substance disorder.
- Quadrant II: More severe mental disorder/less severe substance disorder.
- Quadrant III: Less severe mental disorder/more severe substance disorder.
- Quadrant IV: More severe mental disorder/more severe substance disorder.

This is a simplified categorization that permits further discussion. Individuals at various stages of recovery from mental health and substance abuse disorders may move back and forth among these quadrants during the course of their disease. States need to be most concerned with individuals in quadrants I and IV, meeting participants agreed. While individuals in quadrants II and III may be receiving some level of care in the substance abuse and mental health systems, respectively, quadrant I—those individuals whose disorders are not severe enough to bring them to the attention of the mental health or substance abuse treatment systems at this time—is largely ignored. This group is of particular concern because it includes many children and adolescents at risk for developing more serious disease. Meeting participants agreed that providers may have the greatest impact in minimizing future disease by providing appropriate prevention and early intervention strategies for people in quadrant I.

Members of quadrant IV—those with more severe mental health and substance abuse disorders—are more likely to be found in inappropriate settings (*e.g.*, jails, homeless), to use the most resources, and to have the worst outcomes. This group includes those with severe, chronic disease who may be the most difficult to serve. Because those in quadrant IV consume the bulk of a system's resources, attention to people in this group may help reduce treatment costs and produce better consumer outcomes.

Using the revised framework, States can decide how best to direct their mental health and substance abuse efforts. For example, the framework encourages States to respond to the needs of those individuals who fall into quadrant I by expanding their prevention and early intervention efforts. By the same token, States may choose to reduce expenses and improve outcomes associated with serving persons in quadrant IV by diverting them from inappropriate and more costly treatment settings. In general, the framework supports State-directed efforts to work toward meaningful integration of services for these persons with the most severe mental health and substance abuse disorders.

Based on the severity of their disorders, people with co-occurring mental health and substance abuse disorders currently tend to receive their care in the following settings:

- Setting I: Primary health care settings, school-based clinics, community programs; no care.
- Setting II: Mental health system.
- Setting III: Substance abuse system.
- Setting IV: State hospitals, jails, prisons, forensic units, emergency rooms, homeless service programs, mental health and/or substance abuse system; no care.

As with categories of illness, the use of such clearly delineated settings is for ease of discussion. In reality, there is a great deal of overlap between and among these settings; individuals with different combinations of severity are served in all of the systems highlighted above. In addition, individuals may move back and forth throughout the system of care based on their level of recovery at any given time.

Service Coordination by Severity

Based on the severity of their disorders and the location of their care, the following levels of coordination among the substance abuse, mental health and primary health care systems is recommended to address the needs of individuals with co-occurring mental health and substance abuse disorders:

- Level I: Consultation. Those informal relationships among providers that ensure both mental illness and substance abuse problems are addressed, especially with regard to identification, engagement, prevention, and early intervention. An example of such consultation might include a telephone request for information or advice regarding the etiology and clinical course of depression in a person abusing alcohol or drugs.
- Levels II & III: Collaboration. Those more formal relationships among providers that ensure both mental illness and substance abuse problems are included in the treatment regimen. An example of such collaboration might include interagency staffing conferences where representatives of both substance abuse and mental health agencies specifically contribute to the design of a treatment program for individuals with co-occurring disorders and contribute to service delivery.
- Level IV: Integrated Services. Those relationships among mental health and substance abuse providers in which the contributions of professionals in both fields are merged into a single treatment setting and treatment regimen.

Putting the Pieces Together

The revised framework has implications for funding strategies. For example, Dr. Bert Pepper strongly recommended making better use of existing resources through coordinated or shared funding at the local service delivery level. This may be of particularly value for those individuals who fall in quadrants II and III. Reducing the use of inappropriate service settings (*e.g.* jails and prisons) for people in quadrant IV would

help save costs. Recognizing that a topic of such significance could not adequately be addressed within the scope of the current meeting, participants stressed that future attention be paid to the topic of funding opportunities.

Finally, the framework is a necessary, but not sufficient, piece of the puzzle. To accomplish system change for people with co-occurring mental health and substance abuse disorders, policy makers, funders, and providers must define an effective system of care and delineate what successful consultation, collaboration, and integration look like.

The complete report is available for free download from: *http://www.nasadad.org/Departments/Research/ConsensusFramework/national_dialogue_on.htm.*

Dated: March 26, 2004.

Margaret Gilliam,

Acting Director, Office of Policy Planning and Budget, Substance Abuse and Mental Health Services Administration.

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BILLING CODE 4162–20–P

DEPARTMENT OF HOMELAND SECURITY

Bureau of Citizenship and Immigration Services

[CIS No. 2261–03]

Notice of Circuit Ride Location Changes for the Chicago and Houston Asylum Offices

AGENCY: Bureau of Citizenship and Immigration Services, Department of Homeland Security.

ACTION: Notice.

SUMMARY: This notice informs asylum applicants and applicants for relief under section 203 of the Nicaraguan Adjustment and Central American Relief Act (NACARA 203) of changes in certain asylum and NACARA 203 interview locations. Specifically, this notice advises certain asylum and NACARA 203 applicants within the jurisdiction of the Bureau of Citizenship and Immigration Services (CIS), Chicago, Illinois Asylum Office and the Houston, Texas Asylum Office of a change in the location where they will be scheduled for an asylum interview.

DATES: This notice is effective May 3, 2004.

FOR FURTHER INFORMATION CONTACT: Joanna Ruppel, Deputy Director, Asylum Division, Office of Asylum and Refugee Affairs, Bureau of Citizenship and Immigration Services, Department of Homeland Security, 425 I Street, NW., Attn: ULLICO, Third Floor, Washington, DC 20536; telephone (202) 305–2714.

SUPPLEMENTARY INFORMATION:

Background

The CIS has eight Asylum Offices at the following locations: Arlington, Virginia; Chicago, Illinois; Houston, Texas; Los Angeles, California; Miami, Florida; Lyndhurst, New Jersey; San Francisco, California; and Rosedale, New York. Asylum Office locations were chosen because they are close to where most asylum applicants reside.

While most asylum interviews within the jurisdiction of six of the eight Asylum Offices are conducted at the home Asylum Offices, Asylum Officers also routinely travel to CIS District and Sub Offices to interview asylum applicants and NACARA 203 applicants who reside farther from the local Asylum Offices. Interviews conducted at these District and Sub Office locations are known as circuit ride interviews. As populations of asylum seekers have changed over time, the number of individuals interviewed at circuit ride locations has significantly increased for the Houston and Chicago Asylum Offices. In fiscal year 1995, just over 30 percent of applications received by the Houston Asylum Office and just over 50 percent of the applications received by the Chicago Asylum Office were from individuals to be interviewed at circuit ride locations. Since fiscal year 2000, however, approximately 57 percent of the applications received by the Houston Asylum Office and 64 percent of the applications received by the Chicago Asylum Office have been from individuals to be interviewed at circuit ride locations. In contrast, between 4 percent and 20 percent of the applications filed at the other five Asylum Offices that circuit ride to CIS District Offices to conduct interviews were filed by individuals who reside within the circuit ride jurisdictions of those offices.

Section 208 of the Immigration and Nationality Act provides that, in the absence of exceptional circumstances, the first asylum interview or hearing on an asylum application shall commence before 45 days after the date an application is filed, and the final administrative adjudication of the asylum application, excluding administrative appeal, shall be completed within 180 days after the date an application is filed. If a final determination is not made on the asylum application within 150 days, the applicant becomes eligible to apply for employment authorization. If the asylum application is still pending after 180 days, CIS must grant the application for employment authorization. This statutory provision is based on a key component of the success of asylum reform, which was to minimize the number of individuals who could obtain employment authorization by submitting an application for asylum.

Applicants at circuit ride locations are more likely to become eligible for employment authorization based on the fact that their asylum applications often are not adjudicated within 180 days (because of the infrequency in which circuit ride interviews can be scheduled). Eliminating and consolidating circuit ride locations would enable the Chicago and Houston Asylum Offices to adjudicate more asylum applications within the 180 day timeframe, thus preventing ineligible applicants from obtaining employment authorization based solely on the filing of an asylum application and more quickly providing benefits to those who qualify for asylum.

Conducting asylum interviews at circuit ride locations is less efficient and more resource intensive than conducting asylum interviews at Asylum Offices. While on circuit rides Asylum Officers do not have access to many of the decision-making tools normally available when interviewing in their home office. Circuit ride interview space is limited, which restricts the number of interviews that can be scheduled at the circuit ride site. The time Asylum Officers spend traveling to circuit ride locations significantly detracts from the overall number of asylum interviews the Houston and Chicago Asylum Offices are able to complete each year, resulting in delays in asylum determinations for many asylum seekers interviewed at circuit ride locations.

To improve its asylum case processing, the CIS will eliminate two Houston Asylum Office circuit ride locations, Harlingen, Texas, and New Orleans, Louisiana, requiring certain applicants currently residing within those jurisdictions to travel to the Houston Asylum Office for their interview. Also, CIS will eliminate two Chicago Asylum Office circuit ride locations, Cincinnati, Ohio, and Louisville, Kentucky. Asylum applicants currently interviewed in Cincinnati will travel to the CIS District Office in Cleveland, Ohio for their interview. Applicants currently interviewed in Louisville, Kentucky, will travel to the Chicago Asylum Office for their interview.

Nationally, most existing circuit ride locations will be unchanged and Asylum Officers will continue to circuit ride to the majority of existing circuit