DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention

Request for Applications (RFA) No. SP - 03 - 005

Grants to fund

Targeted Capacity Expansion Initiatives for Substance Abuse Prevention (SAP) and HIV Prevention in Minority Communities: Services Grants

Short Title: Minority SAP and HIV Prevention Services Program

Part I - Programmatic Guidance

Application Due Date: May 23, 2003

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Catalog of Federal Domestic Assistance (CFDA) No. 93.243
Authority: Section: 516 of the Public Health Service Act, as amended and subject to the availability of funds

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[Note to Applicants: To prepare a complete application, "Part II – General Policies and Procedures Applicable to all SAMHSA Applications for Discretionary Grants and Cooperative Agreements," must be used in conjunction with this document, "Part I - Programmatic Guidance."]

Agency

Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration (SAMHSA)

Purpose of this Announcement

The Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention (CSAP) is accepting applications for Fiscal Year 2003 grants to help community-based organizations expand their capacity to provide and sustain effective, integrated substance abuse prevention and HIV prevention services in high risk minority communities disproportionately impacted by the HIV/AIDS epidemic.

It is expected that approximately $3.8 million will be available for 10 - 14 awards in FY 2003. The average annual award will range from $250,000 to $350,000 in total costs (direct and indirect). Cost-sharing is not required in this program. However, all successful applicants will develop and implement a sustainability plan to ensure continued provision of services subsequent to cessation of Federal funding.

The actual amount available for Fiscal year 2003 awards may vary depending on unanticipated program requirements, and the quality and number of applications received. .

Applications with proposed budgets that exceed $350,000 will be returned without review.

Awards may be requested for up to 5 years. Annual continuation awards will depend on the availability of funds and progress achieved.

Who Can Apply?

Eligible applicants are domestic public and private non-profit entities such as:

- Not for profit community based organizations
- National organizations
- Colleges and universities
- Clinics and hospitals
- Faith-based organizations
- Health care delivery organizations
- Tribal government and tribal/urban Indian entities and organizations
- Historically Black colleges and universities (HBCUs)
- Tribal colleges and universities (TCUs)
- Hispanic serving institutions (HSIs)
- Members of the Hispanic Association of Colleges and Universities.

Since the purpose of this RFA is to expand the capacity of community-based organizations, State and local government agencies are not eligible to apply.

Application Kit

SAMHSA application kits include the following:

1. PHS 5161-1 - *(revised July 2000)* **-** Includes the Face Page, Budget forms, Assurances, Certifications and Checklist.

2. PART I - of the Request for Applications (RFA) includes instructions for the specific grant or cooperative agreement application. This document is Part I.

3. PART II - of the Request for Applications (RFA)- provides general guidance and policies for SAMHSA grant applications. The policies in Part II that apply to this program are listed

in this document under "Special Considerations and Requirements."

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

How to Get an Application Kit:

- Call: the National Clearinghouse for Alcohol and Drug Information (NCADI) at 1-800-729-6686 or

- Download **Part I, Part II and the PHS 5161-1** of the application kit from the SAMHSA web site at www.samhsa.gov. Click on "Grant Opportunities" and then "Current Grant Funding Opportunities."

Where to Send the Application

Send the original and 2 copies of your grant application to:

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

**Change the zip code to 20817 if you use express mail or courier service.

All applications MUST be sent via a recognized commercial or governmental carrier. Hand carried applications will not be accepted. Faxed or e-mailed applications will not be accepted. You will not be notified that your application has been received.

Be sure to type "RFA # SP-03-005, Minority SAP and HIV Prevention Services Program" in Item Number 10 on the face page of the application form.

If you require a phone number for delivery, you may use (301) 435-0715.

Application Due Date

Your application must be received by May 23, 2003

Applications received after this date must have a proof-of-mailing date from the carrier before May 6, 2003.

Private metered postmarks are not acceptable as proof of timely mailing. Late applications will be returned without review.

How to Get Help

For questions on program issues, contact:

Francis C. Johnson, M.S.W.
Center for Substance Abuse Prevention
Rockwall II, Suite 950
5600 Fishers Lane
Rockville, MD 20857
(301) 443-2332
E-Mail: fjohnson@SAMHSA.gov

For questions on grants management issues, contact:

Stephan Hudak
Division of Grants Management
Substance Abuse and Mental Health Services Administration/OPS
5600 Fishers Lane/ Rockwall II, 6th floor
Rockville, MD 20857
(301) 443-9666
shudak@samhsa.gov

Award Criteria

Decisions to fund a grant are based on:

1. The strengths and weaknesses of the application as identified by the Peer Review Committee and approved by the Center for Substance Abuse Prevention National Advisory Council.

2. Availability of funds

3. Overall program balance in terms of geography and race/ethnicity of target populations. An attempt will be made to distribute awards across all regions of the country and across all targeted minority groups; however, this funding criterion will be balanced against the priority score.

Funding Restrictions

You may **not** use grant funding for the following activities:

✗ - - Substance abuse treatment services (substance abuse treatment and other terms are defined in Appendix A, using the definitions adopted by the Institute of Medicine (1994)).

✗ - - Mental health treatment services

✗ - - HIV/AIDS treatment services

✗ - - Primary health care services

✗ - - Any services or treatments that would be covered under public or private programs such as Medicaid or Medicare

Grant funds cannot be used to supplant current funding of existing activities.

Post Award Requirements

1. Phase 1 Report: Strategic Plan to provide and sustain effective, integrated substance abuse prevention and HIV prevention services. Note that a viable plan to ensure sustainability is a key part of the Phase 1 Report.

   The Phase 1 Report is due with the first year 3rd quarterly report.

   Approval of Phase 1 is required prior to starting Phase 2.

2. Progress Reports

   Year 01: 1st, 2nd, 3rd Quarterly Reports and Annual Report

   Year 02: Biannual and Annual Reports

   Year 03: Biannual and Annual Reports

   Year 04: Biannual and Annual Reports

   Year 05: Biannual and Final Reports

3. Financial Status Reports (FSRs), Standard Form 269 (long form) are due within 90 days after expiration of the budget period, and 90 days after the expiration of the project period on a cumulative basis.

4. Grantees must inform the Project officer of any publications based on the grant project. An acknowledgement shall be included to the effect that "This publication was made possible by grant number _____ from SAMHSA/CSAP" or "The project described was supported by grant number _____ from SAMHSA/CSAP" and "Its contents are solely the responsibility of the authors and do not

necessarily represent the official view of SAMHSA/CSAP."

5. Attendance by key staff, identified in the Terms and Conditions of the grant award, at required grantee meetings, which may include a New Grantee Workshop, Learning Community Conferences, and other SAMHSA/CSAP conferences.

6. Grantees must provide information needed by SAMHSA to comply with the Government Performance and Results Act (GPRA) reporting requirements.

   GPRA mandates accountability and performance-based management by Federal agencies, focusing on results or outcomes in evaluating the effectiveness of Federal activities and on measuring progress toward achieving national goals and objectives.

   Grantees must comply with GPRA data collection and reporting requirements.

   To comply with GPRA reporting requirements, grantees are expected to administer the GPRA Client Outcome Measures instrument included in Appendix C to adult participants and child participants over 12 years of age.

   Grantees are expected to collect baseline GPRA data at intake on all project participants. Grantees are expected to collect and submit intake data on as many project participants as possible. Grantees are expected to collect and submit exit and six month follow-up GPRA data on a minimum of 80% of all participants with intake data.

   Grantees are required to submit GPRA (and other data as appropriate) to CSAP's **Program Evaluation Center (PEC) quarterly.**

   Program Evaluation Center

   In addition to collecting the required GPRA data for cross site and cross program evaluation, the Program Evaluation Center will also be conducting an expanded cross-site evaluation of projects funded under this program.

   This cross-site evaluation will expand from the GPRA Client Outcome Measures to include additional HIV-related measures and measures selected from CSAP's compendium of Core Measures. SAMHSA/CSAP Core Measures can be obtained from www.preventiondss.org or upon request.

   Grantee participation in the expanded cross-site evaluation is expected.

7. 45 C.F.R. 74.36(a) provides that grantees may copyright any work that is subject to copyright and was developed under a grant. SAMHSA reserves a royalty-free, nonexclusive and irrevocable right to publish or otherwise use the work under a grant. In this regard, SAMHSA plans to use the data under the grant and to publish the results of the data. Project sites are required to share their data and associated data documentation as soon as the data are cleaned, coded and ready for analyses by SAMHSA/CSAP, including the relevant Program Coordinating Centers (PCCs)/ Program Evaluation Center (PEC) and CSAP's Data Coordinating Center (DCC). These data will be used to perform cross-site (PCC/PEC) and cross-program (DCC) analyses.

The specific, common data to be submitted to the PCCs/PEC and DCC will be communicated shortly after award and, where applicable, be determined by consensus of the program's steering committee. The data will be submitted according to an agree-upon schedule and will include, at a minimum, data to meet programmatic and CSAP GPRA requirements (including demographics and relevant intervention characteristics) and any other core measures deemed appropriate by the steering committee and/or necessary to address ONDCP's Performance Measures of Effectiveness and Healthy People 2010. If no steering committee exists, common data requirements will be determined as defined by the individual program. Data typically are submitted by grantees to the PCC/PEC who will then forward copies to the DCC. Where no PCC/PEC exists, data will be forwarded to the DCC by CSAP program staff.

Those entities (e.g., the PCC/PEC, the DCC) that will have responsibilities for and access to the data will strictly follow all regulations and protocols concerning protection of human subjects, confidentiality, and privacy. All steering committee agreements, e.g., publication policies, guidelines about sensitivity to cultural issues, will be honored.

Program Overview

BACKGROUND

Both substance abuse and HIV/AIDS continue to be serious health threats in the United States. Minority communities are at particularly high risk for HIV.

In 2001, almost 17 million Americans aged 12 or older were abused or were dependent on either alcohol or illicit drugs. (SAMHSA's National Household Survey on Drug Abuse [NHSDA] Report: Substance Abuse or Dependence).

According to the Department of Health and Human Services Office of HIV/AIDS Policy, by June 2000, more African Americans/Blacks were reported with HIV than any other racial/ethnic group. HIV infection is one of the leading causes of death for Hispanics/Latinos ages 25 to 44. Asian American/Pacific Islander and American Indian/Alaska Native men who have unprotected sex with men are increasingly impacted by HIV. More than 800,000 persons are living with HIV/AIDS, and the majority are people of color. An estimated half of all new HIV infections are among people under 25 years of age.

According to the latest report by the CDC on HIV/AIDS among minority populations (CDC, 2001), 13,895 or 44 percent of the total U.S. HIV/AIDS cases were among African Americans/Blacks. For Hispanic/Latinos the number of cases was 6,289, or 20 percent of the total, also disproportionately high given this group's actual representation in the total U.S. population.

According to the Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report*, 2000; Vol. 12 (No. 2), through December 2000, women accounted for 32% of HIV (not AIDS) cases reported in 2000 from areas with confidential HIV reporting. Among these, African American/Black and Hispanic women accounted for 77% of HIV cases. Among men with HIV (not AIDS) in the same time period, African American/Black and Hispanic men accounted for 58% of HIV cases. In areas with confidential HIV reporting, persons ages 13-24 accounted for 16% of new HIV (not AIDS) cases reported in

2000. Of these persons, females accounted for 47% of the cases in this age group.

According to *The National Institute on Drug Abuse (NIDA) Community-Based Outreach Model*, NIH Publication No. 00-4812, September 2000, for all sexually active individuals, drug and alcohol use may reduce inhibitions and increase the likelihood of unsafe sexual behaviors. Many non-injecting drug users and their partners are at risk for HIV infection and its transmission because of unsafe behaviors associated with their drug use, such as engaging in unprotected sex. Drug users are at high risk for HIV infection because substance abuse impairs judgment and communication and makes individuals more likely to engage in risky sexual behaviors that may transmit HIV. Injection drug users are also at high risk for HIV infection because of the risks associated with sharing injection equipment and drug solutions.

In addition, a large body of published research reveals that racial and ethnic minorities experience a lower quality of health services, and are less likely to receive even routine medical procedures than are white Americans. Evidence of racial and ethnic disparities in healthcare is, with few exceptions, remarkably consistent across a range of illnesses and healthcare services. The majority of studies find that racial and ethnic disparities remain even after adjustment for socioeconomic differences and other healthcare access-related factors. Racial and ethnic disparities in healthcare occur in the context of broader historic and contemporary social and economic inequality, and evidence of persistent racial and ethnic discrimination in many sectors of American life. (Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, National Academy Press, March, 2002).

GOAL

The goal of this program is to increase access to substance abuse prevention and HIV prevention programs in areas with hard to reach populations and high incidence rates of substance abuse and HIV infection, such as rural communities, by increasing both the number and quality of prevention programs in traditionally under-served areas.

By expanding the capacity of community-based organizations to provide effective, **integrated** substance abuse prevention and HIV prevention services in minority communities and to sustain these services, real progress can be made in addressing health care disparities (such as access to culturally- and linguistically appropriate services) that perpetuate the disproportionate burden of HIV disease in communities of color.

The purpose of this announcement is to:

- ► Increase provision of effective, integrated substance abuse prevention and HIV prevention services to more minority youth and adults at-risk for substance abuse and HIV infection.
- ► Increase the number of community based organizations that provide effective, integrated substance abuse prevention and HIV prevention to minority youth and adults at-risk.
- ► Increase the capacity of community-based organizations to successfully sustain their integrated prevention services.

This targeted capacity expansion initiative responds to the health emergency in ethnic minority populations described by the Congressional Black and Hispanic Caucuses.

TARGET POPULATION

This program seeks to increase and sustain the availability of effective, integrated substance abuse prevention and HIV prevention services for women, youth and other at-risk populations in African-American, Hispanic/Latino, American Indian/Alaska Native, and Asian-American/Pacific Islander communities which have traditionally been underserved or not served at all.

Other at-risk populations may include:

- adolescents
- female adolescents and women
- runaway youth
- homeless individuals
- commercial sex workers
- individuals re-entering the community from prison, jail or juvenile justice facilities
- partners of individuals in or re-entering the community from correctional facilities
- gay, lesbian, bi-sexual, transgender and questioning individuals
- individuals, both male and female, with a history of sexual abuse or intimate partner violence
- migrant workers, or other immigrant populations living away from home for extended periods
- immigrants from countries with high HIV seroprevalence rates

High risk behaviors may include:

- using injection drugs (ID)
- binge drinking, or use of alcohol or drugs and engaging in unprotected sex
- use of alcohol or drugs that may lead to rape/non-consensual sex
- having sex without a condom, or other unsafe sexual practices
- men having unprotected sex with other men (MSM)s
- women having unprotected sex with MSMs
- having unprotected sex with an ID user
- trading sex for drugs

PROGRAM PLAN

This program is designed to be implemented in 3 Phases:

Phase 1: Strategic Planning / Start Up
Not to exceed 9 months

Completion of Phase 1 Report: Strategic Plan to deliver effective, integrated substance abuse prevention and HIV prevention services.

Phase 1 activities can include:

- Needs assessment activities, including identifying and using data sources

- Community consensus-building and planning activities, such as:

  Identification and engagement of key individual and organization stakeholders,

  Establishment of agreements and commitments

  Recruitment and engagement of target population representatives in designing services for themselves and their peers, and

  Formation and meetings of advisory and/or focus planning groups.

- Organizational activities, such as:

  Governing board development for assuring organizational and responsibility

  Organizational policies on personnel, travel, equipment, financial management, etc.

  Staff development including recruitment and hiring,

  Management information and quality assurance systems development.

- Prevention intervention model development activities, such as:

  Identification of effective, science-based models for substance abuse prevention and HIV prevention interventions.

  Assessment of identified models for cultural appropriateness, gender relevance, staffing and training requirements, etc.

  Process for selection of science-based models, and

  Plans to integrate science-based substance abuse prevention and HIV prevention interventions.

- Obtaining IRB approval for human subjects protection

CSAP approval of Phase 1 is required prior to starting Phase 2.

Phase 1 Reports will be approved based on the following criteria:

1. Evidence of participatory involvement of representatives of the target population and the community.

2. Selection of evidence-based interventions to prevent substance abuse and HIV, with plans to integrate the interventions.

3. An Institutional Review Board (IRB) approval for your project and/or SAMHSA/CSAP approval of your Participant Protection Plan.

4. A draft strategic work plan, and accompanying logic model, to deliver the interventions that includes:

- ✓ A problem statement;
- ✓ Goals;
- ✓ Measurable objectives for each goal;
- ✓ Key activities to reach the objectives;
- ✓ Targeted completion dates for each activity;
- ✓ Qualified persons responsible for each activity; and
- ✓ Methods for evaluating completed objectives.

5. Program and key staff positions (project director and evaluator) filled

6. Plans to conduct process and outcome evaluations of your project.

7. Plans to sustain the project.

Phase 2: Implementation

Phase 2 activities include:

- Involvement of target population and community representatives

- Recruitment and retention of target population participants

- Delivery of effective, integrated substance abuse prevention and HIV prevention services.

- Administration of GPRA Client Outcome Measures Instrument, at baseline, exit and 6-month follow-up, and quarterly submission of these data. Administration of selected CSAP Core Measures and HIV-related measures as appropriate.

- Activities to sustain project after Federal funding ends, such as gaining further support for the project, mobilizing additional community resources, identifying alternate funding sources, completing proposals or other activities for securing funding, etc.

Phase 3: Evaluation and Sustainability

Phase 3 activities include:

- Compiling, analyzing and reporting on the outcomes of the services delivered

- Completing the approved sustainability plan designed to ensure continuation of services.

What to Include in Your Application

In order for your application to be complete, it must include the following in the order listed. Check off areas as you complete them for your application.

❑ **1. FACE PAGE**

Use Standard Form 424, which is part of the PHS 5161-1. See Appendix A in Part II of the RFA for instructions. In signing the face page of the application, you are agreeing that the information is accurate and complete.

❑ **2. ABSTRACT**

Your total abstract should not be longer than 35 lines. Two additional versions of your abstract are required and do not count against page limitations. Include a 5-line abstract and a 10-line abstract which briefly summarize your project, for use, if your project is funded, in publications, reporting to Congress, or press releases.

❑ **3. TABLE OF CONTENTS**

Include page numbers for each of the major sections of your application and for each appendix.

❑ **4. BUDGET FORM**

Standard Form (SF) 424A, which is part of the PHS 5161-1 is to be used for the budget. Fill out sections B, C, and E of the SF 424A. Follow instructions in Appendix B of Part II of the RFA.

❑ **5. PROJECT NARRATIVE AND SUPPORTING DOCUMENTATION**

The Project Narrative describes your project. It consists of Sections A through E. These sections may not be longer than 25 pages. More detailed information about Sections A through E follows #10 of this checklist.

❑ **Section A –** Documentation of Need

❑ **Section B** – Literature Review and Justification of Prevention Strategies

❑ **Section C** – Project Plan

❑ **Section D** – Project Evaluation and Reporting/Dissemination

❑ **Section E** – Organizational Capacity

The Supporting Documentation section of your application provides additional information necessary for the review of your application. This Supporting Documentation should be provided immediately following your Project

Narrative in Sections F through I. There are no page limits for these sections, except for Section H, the Biographical Sketches/Job Descriptions.

☐ **Section** F **-** Literature Citations. This section must contain complete citations, including titles, dates, and all authors, for any literature you cite in your application.

☐ **Section G -** 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. **(See Part II of the RFA/PA, grant announcement, Example A, Justification).**

☐ **Section H** - Biographical Sketches and Job Descriptions

- Include a biographical sketch for the project director and for other key positions. Each sketch should not be longer than **2 pages**. 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. They should not be longer than **1 page**.

- **Sample sketches and job descriptions are listed <u>on page 22</u>, Item 6 in the Program Narrative section of the PHS 5161-1.**

☐ **Section I –** Protection of Human Subjects, 45 CFR Part 46. The elements you need to address in this section are outlined after the Project Narrative description in this document.

❑ **<u>6. APPENDICES 1 THROUGH 7</u>**

- Use only the appendices listed below.

- **Do not** use appendices to extend or replace any of the sections of the Project Narrative unless specifically required in this RFA (reviewers will not consider them if you do).

- **Do not** use more than ***30*** pages (plus all instruments) for the appendices.

Appendix 1

Organizational chart – clearly show the professional roles of all key staff and reporting relationships. Also include a project-specific management chart.

Appendix 2

Letters of Commitment and Support, including any Memoranda of Understanding (MOUs) or Letters of Agreement with service providers or other local organizations.

Appendix 3

Copies of your letters to the Single State Agency (SSA) and Single Point of Contact (SPOC) in your State. Please refer to Part II for instructions and further information about State coordination and Intergovernmental Review by the SPOCs.

Appendix 4

In this appendix, you should provide the following information on the proposed participants for your project:

- Total unduplicated number of participants from your target population who will receive grant-supported services and participate in the evaluation, for the total grant period.

- Enrollment pattern; for example: 3 cohorts of 75 each with 1 cohort per year, or open, ongoing enrollment during the entire grant period, etc.

- Demographic information (for mixed groups indicate the percentage of your unduplicated number of participants):
    - Gender
    - Race
    - Ethnicity or country of origin
    - Primary language
    - Age in years (not school grade)
    - Other special characteristics, such as recent immigrants

- Identified risk factors

- Identified protective factors

Provide the same information on any additional populations you intend to serve. For example, if you intend to target primarily 9-12 year olds, but will also be providing services to their parents, provide the same information on the parents.

A chart or table format is suggested and recommended for providing this information, but not required.

Appendix 5

Area Map – indicate the proposed service area and the location(s) of your organization and service sites.

Appendix 6

Data collection instruments and interview protocols. Please be sure to specify the GPRA client outcome measures, CSAP Core Measures and HIV-related measures as appropriate.

Appendix 7

Sample consent forms to participate in both the proposed services and the evaluation.

❑ 7. ASSURANCES

Non- Construction Programs. Use Standard form 424B found in PHS 5161-1.

❑ 8. CERTIFICATIONS

Use the "Certifications" forms, which can be found in PHS 5161-1. See Part II of the RFA for instructions.

❑ 9. DISCLOSURE OF LOBBYING ACTIVITIES (See form in PHS 5161-1)

Appropriated funds, other than for normal and recognized executive-legislative relationships, may not be used for lobbying the Congress or State legislatures. 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. (Please read **Part II** of the RFA**,** General Policies and Procedures for all SAMHSA applications for additional details.)

- ❑ **10. CHECKLIST** (Found in the PHS 5161)

You must complete the Checklist. See Part II Appendix C of the RFA for detailed instructions.

Project Narrative

Sections A through E

In developing your application, use the instructions below that have been tailored to this program. These are to be used in lieu of the "Program Narrative" instructions found in the PHS 5161 on page 21.

Sections A through E are the Project Narrative of your application. These sections describe what you intend to do with your project**.** Below you will find detailed information on how to respond to Sections **A** through **E.** Sections **A** through **E** may not be longer than 25 pages.

- **Your application will be reviewed and scored against the requirements described below for sections A through E. These sections also function as review criteria.**
- A peer review committee will assign a point value to your application based on how well you address **each** of these sections.
- The number of points after each main heading shows the maximum number of points a review committee may assign to that category.
- Bullet statements do not have points assigned to them; they are provided to invite attention to important areas within the criterion.
  - Reviewers will also be looking for evidence of cultural competence **in each section** of the Project Narrative. Points will be assigned based on how well you address cultural competency aspects of the review criteria. SAMHSA's guidelines for cultural competence are included in Part II of the RFA, Appendix D.

Section A*:* **Documentation of Need**
15 points

The purpose of this section of your application is to provide detailed information on your target community and the unmet needs for effective, integrated substance abuse prevention and HIV prevention services.

You should address all of the following topics as thoroughly as possible, as your application will be judged on the extent to which you demonstrate strong knowledge of, experience with, and access to your community.

You should include the following information in this section of your application:

- A description of how you have involved members of the target population/community in the collection of information about prevention needs.
- An overview of your community that includes detailed information on why your proposed project is needed.
- A "risk profile" of the community that includes information on risk factors for substance abuse **and** HIV infection and/or related problems. Include as much data as

possible on the current trends of substance abuse and the HIV/AIDS epidemic in your community, especially HIV transmission/new HIV infections rates. Provide local data, appropriate for your population and target area, on relevant risk behaviors such as: use of alcohol and other drugs, use of injecting drugs, prevalence of sexually-transmitted diseases, teen pregnancy rates, use of condoms and other data related to safer sex practices, and other local epidemiological data related to HIV transmission – for the population(s) of interest in your target area. Also, describe how the data you present was collected, keeping a focus on the adequacy, appropriateness and replicability of the methods used in both collection and analysis.

- A profile of the population you intend to provide services to (your target population), which includes information on race, ethnicity, age, gender and sexual orientation. Detailed information, including specific numbers of target population members who will participate in your project should be included in Appendix 4 of your application.

- Information on resiliency and protective factors in the target population and community and how your proposed project will enhance and build on these positive aspects. Include any available information on:

    - ***Individual protective factors***, such as: a positive sense of self, a sense of purpose and of the future, social skills and coping/ problem-solving skills, social competence, cooperativeness, and emotional stability;

    - ***Family protective factors***, such as: parental attention to children's interests, attachment to parents, parental involvement in school-related activities, and high parental expectations; and

    - ***Community protective factors***, such as: caring and supportive social networks, high expectations of youth, and opportunities for participation.

- Descriptions of the capacity of local service providers. Provide a clear picture of the SAP and HIV prevention, and other related services that are already in place in your community.

- Descriptions of the unmet needs among your target population and gaps in SAP and HIVP services in your community that you intend to fill. Include information on the availability of appropriate, culturally-competent services.

- Information on other relevant services needed by your target population, such as the availability of transportation, educational/ vocational/employment services, child care, and other services.

- An area map, which indicates your proposed service area and the location(s) of your service sites. This should be included in Appendix 5 of your application.

Section B: Literature Review and Justification of Prevention Strategies
10 points

In this section you should include:

- Provide background information from current literature (such as peer-reviewed

journals, monographs, and other published documentation) on relevant substance abuse prevention and HIV prevention interventions, which addresses all important aspects of your target population, including race, ethnicity, language, gender, sexual orientation, age, developmental status, and disabilities. Please also include any relevant information on prevention interventions and strategies from your experience or the experience of other relevant service providers.

- Make sure to include information that shows the *effectiveness* of the prevention strategies that you propose to implement. Include information on what is known about their effectiveness for population(s) like those you wish to address. Examples of effective prevention interventions include but are not limited to those identified by SAMHSA's National Registry of Effective Programs (NREP), available online at www.modelprograms.SAMHSA.gov.

- A justification for the interventions you are proposing for your population. Address why you think these interventions will be appropriate for your community and your target population.

- A description of how you have and will continue to involve target population members in determining appropriate prevention interventions.

Section C: Project Plan
45 points

In this section of your application, you should:

- Describe how your project addresses the goals of this RFA.

- Clearly state the goals and objectives of your project: what specifically your project is trying to change (i.e., measurable, positive changes in substance abuse and HIV-related knowledge, attitudes and behaviors among the target population.

- Describe how members of the target population will be included in **ALL PHASES** of your project and have membership on advisory boards or other groups.

- Describe how you will involve community members and leaders in your project in **ALL PHASES** and clearly describe any commitments from them to provide ongoing support for your project.

- Describe a 5 year (60 months) work plan and accompanying logic model in the following 3 phases:

  - Phase 1: Strategic Planning / Start Up (not to exceed 9 months)

  - Phase 2: Implementation

  - Phase 3: Evaluation and Sustainability

- At a minimum, the work plan should include:

  - ✓ A problem statement;
  - ✓ Goals;
  - ✓ Measurable objectives for each goal;
  - ✓ Key activities for to reach the objectives;
  - ✓ Targeted completion dates for each activity;
  - ✓ Responsible persons for each activity; and
  - ✓ Methods for evaluating the objectives.

Include the following in your Work Plan for Phase 1, "Strategic Planning / Start Up"

- A description of your proposed activities, including a time line, to complete the required Phase 1 Report, such as:
  - Needs assessments
  - Community support development

    Include Memoranda of Understanding, Letters of Commitment or Agreement, etc. in Appendix 2 of your application.

    Ongoing support commitments should address the following basics: who, what, when, where, why and how, and should be signed and dated by authorized officials of collaborating entities.
  - Organizational development
  - Identification and selection of interventions to prevent substance abuse and HIV, including an outline of the nature and type interventions
  - Plans for integrating substance abuse and HIV prevention interventions
  - Plans to collect the required data at three points: intake, baseline and 6-month follow-up, and plans to submit these data quarterly to the PEC.
  - Plans for securing IRB approval
  - Plans to sustain your project after Federal funding ends

Include the following in your Work Plan for Phase 2, "Implementation":

- A description of how you propose to implement the substance abuse prevention and HIV prevention interventions you have identified or will be selecting in Phase 1. Include all relevant activities for implementing your services. Specify which staff positions are responsible for all implementation activities. Include a time line. Also describe how you plan to integrate the substance abuse and HIV prevention interventions.
- A description of how and from where the participants will be recruited and enrolled in your project.
- An explanation of how you will keep participants engaged in your project. Will you provide incentives? What kind? Why? How many? When? How?
- An explanation of how you plan to resolve potential recruiting problems, including how you intend to handle lack of participation and project dropouts.
- If you will exclude any individuals from participating in your project, clearly describe any "exclusionary criteria" and why you are using them.
- A description of your activities to sustain your project.

Include the following in your Work Plan for Phase 3, "Evaluation and Sustainability":

- Plans, including a time line, to compile and analyze both process and outcome data you have collected in order to determine the effectiveness of your project. Include the methods you propose to use to conduct the analysis,

and other evaluation activities for your project.

- Plans for reporting and disseminating information on your project

- Plans for completing the approved sustainability activities designed to ensure continuation of services.

Section D: Evaluation
15 points

In this section, you should:

- Describe how you will involve members of your community and target population in the evaluation process to ensure that your evaluation is culturally appropriate.

- Present a proposed evaluation plan that will assess whether your project is implemented in the time and manner proposed (process evaluation) and whether it meets the goals and objectives you specified above (outcome evaluation). The evaluation plan should clearly state how you will know if your project is successful in effecting the measurable, positive changes in substance abuse and HIV-related knowledge, attitudes and behaviors among the target population. You may propose an evaluation plan that includes comparison groups.

- Describe plans to comply with GPRA requirements. Provide assurances that you will collect the required GPRA client outcome measures and provide those data to the PEC in a timely manner. You may either state your commitment in the text of your application or include a signed letter of commitment in your appendices.

- Note that the 3 data collection points or the GPRA client outcome measure are intake, exit, and 6-month (from exit) follow-up. Instructions for administering the GPRA Client Outcome Measure and the Adult and Youth Measures are in Appendix C of this RFA.

- Describe plans to supply other data such as Healthy People 2010 and the Office of National Drug Control Policy's (ONDCP's) Performance Measures of Effectiveness and other data for cross-site purposes , including selected CSAP Core Measures and HIV-related measures which are determined post-award by CSAP, grantees and other specified representatives.

- Describe plans to collect data related to HIV –related knowledge, attitudes and behavior. If you propose to use any additional evaluation instruments or protocols, describe them and include copies in Appendix 6 of your application.

- *Please note that the use of instruments in addition to CSAP's GPRA tool is not required, and that the evaluation budget may not exceed 15% of the total project budget. However, specific CSAP Core Measures and HIV-related measures are required as appropriate to your project objectives and target population. CSAP strongly encourages all applicants to propose evaluation designs and strategies that ensure that they will be able to assess the effectiveness of their interventions in achieving the intended goals and producing the desired results among participants – i.e. measurable, positive changes in substance abuse and HIV-*

related knowledge, attitudes and behaviors.

- In addition to the CSAP Core Measures and HIV-related measures you select, all evaluation instruments you propose to use should be reliable and valid, as well as appropriate for the age, developmental status, culture, language, and gender of your target population.

- Describe how your data collection plan will comply with the 3 required data collection points: intake, exit and 6-month follow-up. Provide a time line that clearly identifies all data collection points and quarterly submission of required data to the PEC.

- Describe how you will input, submit and store data. Provide details on how you will ensure that your data are kept confidential and secure.

- Specify the number of participants projected to receive your integrated substance abuse prevention and HIV prevention interventions. This is the number of participants to be included in the evaluation. This number should also be reflected in your Appendix 4 – Target Population Profile.

- Discuss how many participants you expect to lose – through drop out or minimal attendance.

- Discuss other relevant topics in your evaluation plan, including additional data on services received by individual participants, such as dosage data and cost effectiveness based on project costs.

- Describe your plans for developing all required grant reports and products, as listed under "Post Award Requirements."

- Describe your plans for disseminating products and accomplishments as appropriate to the RFA goals.

Section E: Organizational Capacity: Project Management, Organization, Staff, Equipment, Facilities and other support
15 points

In this section, you should:

- Describe the mission of your organization and how the proposed activities related to substance abuse prevention and HIV prevention fit within that mission.

- Describe the capability and experience of your organization and collaborating agencies with similar projects and populations. Provide information on experience that is relevant to substance abuse prevention, HIV prevention, and other related services.

- Clearly describe the activities and services you currently offer to members of your target population and provide clear evidence that you have been providing relevant services to significant numbers of your target population *for a minimum of 2 years.*

- Describe your experience collaborating with other relevant agencies and organizations in the community.

- Discuss your organizational structure. Provide an organizational chart in

Appendix 1 of your application that outlines the professional roles of all staff and reporting relationships. Also include, in Appendix 1, a project-specific management chart with time lines.

- Describe your proposed staffing plan. Discuss staffing patterns and provide rationale for percent of time for key personnel and consultants

- Describe the qualifications and relevant experience of the Project Director, other key staff, the proposed consultants and/or subcontractors.

- Describe the cultural capabilities of the staff and explain how your staff will ensure that services are culturally competent. Document the staff's experience, familiarity, and links with, as well as acceptance by the communities and the target population to be served.

- Describe relevant existing resources, such as computer facilities and equipment, and facility location, space, environment, and accessibility (in compliance with the Americans with Disabilities Act).

- Describe any other resources not accounted for in the proposed budget but necessary for the project.

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.

SAMHSA Participant Protection and Protection of Human Subjects

Part II of the RFA provides a description of SAMHSA's Participant Protection Requirements and the Protection of Human Subjects Regulations (45 CFR 46). The Federal policy for the protection of human subjects is stipulated in the Code of Federal Regulations (CFR), Title 45, Part 46.

SAMHSA will place restrictions on the use of funds until all participant protection issues are resolved. Problems with participant protection identified during peer review of your application may result in the delay of funding. See Part II of the RFA for more information on participant protection

For this announcement, all grant applications must adhere to the following requirements:

You must address each element regarding participant protection in your supporting documentation. If any one or all of the elements is not relevant to your project, you must document the reasons that the element(s) does not apply.
This information will:

1. Reveal if the protection of participants is adequate or if more protection is needed.

2. Be considered when making funding decisions

Projects may expose people to risks in many different ways. In this section of your application, you will need to:

- Identify and report any possible risks for participants in your project.

- State how you plan to protect participants from those risks.

- Discuss how each type of risk will be dealt with, or why it does not apply to the project.

Each of the following elements must be discussed:

❶ Protect Clients and Staff from Potential Risks

- Identify and describe any foreseeable physical, medical, psychological, social, legal, or other risks or adverse affects.

- Discuss risks that are due either to participation in the project itself, or to the evaluation activities.
- Describe the procedures that will be followed to minimize or protect participants against potential risks, including risks to confidentiality.

- Give plans to provide help if there are adverse effects to participants.

- Where appropriate, describe alternative treatments and procedures that may be beneficial to the participants. If you do not decide to use these other beneficial treatments, provide the reasons for not using them.

❷ Fair Selection of Participants

- Describe the target population(s) for the proposed project. Include age, gender, racial/ethnic background and note if the population includes homeless youth, foster children, children of substance abusers, pregnant women, or other groups.

- Explain the reasons for including groups of pregnant women, children, people with mental disabilities, people in institutions, prisoners, or others who are likely to be 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.

❸ Absence of Coercion

- Explain if participation in the project is voluntary or required. Identify possible reasons why it is required. For example, court orders requiring people to participate in a program.

- If you plan to pay participants, state how participants will be awarded money or gifts.

- State how volunteer participants will be told that they may receive services even if they do not complete the study.

❹ Data Collection

- Identify from whom you will collect data; for example, participants themselves, family members, teachers, others. Describe the data collection procedure and specify the sources for obtaining data; for example, 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 6, "Data Collection Instruments/Interview Protocols," copies of all available data collection instruments and interview protocols that you plan to use.

❺ 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.**

❻ Adequate Consent Procedures:

- List what information will be given to people who participate in the project. Include the type and purpose of their

  participation. Include 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** get written informed consent.

- Indicate if you will get informed consent from participants or 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 sample consent forms in your Appendices 7, titled "Sample Consent Forms." 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?

❼ Risk/Benefit Discussion:

Discuss why the risks are reasonable compared to expected benefits and importance of the knowledge from the project.

❽ Institutional Review Board (IRB)

All grant programs collecting individual level data and administering GPRA measures at pre-intervention, post-intervention and 6-month follow-up MUST adhere to Protection of Human Subjects Regulations (45 CFR 46) and MUST propose plans for implementing these regulations including obtaining Institutional Review Board (IRB) approval. IRB approval is not required at the time of grant award, however the process for IRB approval should be discussed fully in the grant application and obtained before the recruitment of participants. As a condition of grant award, funds will be restricted for recruitment of participants until a grantee submits documentation of IRB approval to the CSAP Project Officer.

You must refer to Part II of the RFA, SAMHSA Participant Protection and Protection of Human Subjects for additional information regarding confidentiality and the requirements of 45 CFR Part 46, Protection of Human Subjects, including Assurance of Compliance and documentation of Institutional Review Board (IRB) approvals.

Special Considerations and Requirements

SAMHSA's policies, special considerations and requirements related to grants and cooperative agreements are found in **Part II** of the RFA. The policies and special considerations that apply to this program are:

- Population Inclusion Requirement
- Government Performance Monitoring
- Healthy People 2010
- Consumer Bill of Rights
- Promoting Nonuse of Tobacco
- Supplantation of Existing Funds
- Letter of Intent
- Single State Agency Coordination
- Intergovernmental Review
- Public Health System Reporting Requirements
- Confidentiality/SAMHSA Participant Protection

Appendix A: Acronyms and Definitions

ACRONYMS:

AIDS - Acquired Immunodeficiency Syndrome
CBO - Community-Based Organization
CDC - Centers for Disease Control and Prevention
CFR - Code of Federal Regulations
CSAP - Center for Substance Abuse Prevention
CSAT - Center for Substance Abuse Treatment
CMHS - Center for Mental Health Services
DHHS - Department of Health and Human Services
FY - Fiscal Year
GPRA - Government Performance and Results Act
HACU's - Hispanic Association of Colleges and Universities members
HBCU's - Historically-Black Colleges and Universities
HIV - Human Immuno-deficiency Virus
HIVP - HIV Prevention
HRSA - Health Resources and Services Administration
HSI's - Hispanic-Serving Institutions
IDU - Injection Drug User
IRB - Institutional Review Board
MSM's - Men who have Sex with other Men
NIH - National Institutes of Health
SAMHSA - Substance Abuse and Mental Health Services Administration
SAP - Substance Abuse Prevention
SPP - SAMHSA Participant Protection
STD - Sexually Transmitted Disease
TCU's - Tribal Colleges and Universities

DEFINITIONS:

Evaluation - the process of determining whether a project achieves its intended goals and produces the desired results.

Integration of Services - developing a services system which provides clients with a full range of comprehensive services which are accessible from any one point in the services system

and are coordinated with other services. Effective integration should provide clients with "seamless" delivery of the full range of culturally-competent SAP, HIVP, and other related services required.

Minority Communities - African-Americans, Hispanics/Latinos, American Indians/Alaska Natives, and Asian-Americans/Pacific Islanders

Non-profit organizations - organizations which either have obtained or are in the process of obtaining 501(c) (3) status from the Internal Revenue Service.

Prevention - According to the IOM (1994) classification system, the term "prevention" is reserved for only those interventions that occur before the initial onset of a disorder. Preventive interventions may be universal, selective, or indicated, depending on their targeted audience.

Seroconversion - The process by which a person's antibody status changes from negative to positive.

Seroprevalence - As related to HIV infection, the proportion of persons who have serologic (i.e., pertaining to serum) evidence of HIV infection at any given time. (Source: Glossary of HIV/AIDS-Related Terms, HIV/AIDS Treatment Information Service)

Treatment:

Substance Abuse and Mental Health Treatment - According to the IOM (1994) classification system, treatment interventions are therapeutic in nature (such as psychotherapy, support groups, medication, and hospitalization), and are provided to individuals who meet or are close to meeting DSM[-V] diagnostic levels.

HIV/AIDS Treatment - activities and interventions undertaken with individuals already infected with HIV for the purpose of slowing the progression of the disease.

Appendix B: Background Information and References

Epidemiological data show that HIV disease continues to disproportionately affect minority communities throughout the United States and has indeed proven to be an 'epidemic of color'. According to the Centers For Disease Control and Prevention (CDC), rates of new HIV infections continue to increase disproportionately among American Indians/Alaska Natives, Asian-Americans/Pacific Islanders, however, among African-Americans and Hispanics/Latinos, rates have been overwhelming. Additionally, incidence rates of new HIV infections in women and adolescents of color have dramatically increased since the epidemic began in the 1980's. HRSA reported, "Studies of women living with HIV disease indicated that a large proportion are living in poverty and that many were poor prior to seroconversion" (4). Despite significant declines in HIV infection rates among men of color who have sex with men since the early years of the epidemic, they continue to be the group at highest risk for HIV, accounting for the majority of all AIDS cases, but an even greater proportion of all HIV diagnoses (3).

Selected seroprevalence studies among populations at risk provide an even clearer picture of why the epidemic continues to spread in communities of color. Aside from opportunistic illnesses associated with HIV transmission, data suggest that the following three interrelated issues play a key role in the excessive rates of HIV and STDs in communities of color (1):

- Continued health disparities among economic classes,
- Challenges related to controlling substance abuse, and
- Intersection of substance abuse with the epidemic of HIV and other sexually transmitted diseases.

Furthermore, studies have shown a direct link between substance abuse and HIV infection since risky behaviors associated with substance abuse continues to fuel the spread of HIV in the United States, especially in minority communities with high rates of STDs. Studies have also revealed that substance abuse reduces inhibitions associated with transmitting HIV to others (5). In order to overcome many of the current barriers associated with the spread of this epidemic, immediate action must be taken to make effective integrated prevention services available and accessible to populations at risk. Many studies, in fact, have verified that changes in knowledge about HIV are not, by themselves, sufficient to bring about changes in HIV risk behavior. Reduction of HIV risk behavior requires integrated, multi-faceted, and long-term interventions.

HIV is directly transmitted though injection drug use when users share and re-use syringes and other blood-contaminated equipment. However, users of non-injection drugs such as marijuana, crack cocaine, alcohol and some prescription drugs are also at greater risk of HIV infection compared to those who do not use drugs (6). A CDC study of inner-city young adults found that crack smokers were three times more likely than non-smokers to be infected with HIV (10). Because drug use can affect judgment and interfere with communication, users are more likely to engage in riskier sexual behavior (7). In a study on gay and bisexual men seeking

methamphetamine abuse treatment, those who reported being HIV-positive were significantly more likely to report that their use of crystal was always associated with sexual behavior (4).

HIV/AIDS has especially affected African-American communities. Researchers estimate approximately 1 in 50 African American men and 1 in 160 African American women are infected with HIV (3). While African-Americans are just 13 percent of the U.S. population, they account for more than half of all new HIV infections (1). Among women, African-American women account for 64 percent of all new infections in the U.S. (3).

African-Americans are 10 times more likely than whites to be diagnosed with AIDS, and 10 times more likely to die from it (1). As of June 2000, African-Americans accounted for 38 percent of all reported AIDS cases (3). Forty eight percent of these reported AIDS cases indicated African-American adults and adolescents; 57 percent indicated African-American women and African-American children accounted for 59 percent of total AIDS cases among children (3).

HIV rates among Hispanics/Latinos are also disturbing. In 1998, HIV was the third leading cause of death for Hispanic/Latino men and the fourth leading cause of death for Hispanic/Latina women aged 24-44 years (3). From July 1999 to June 2000, 19 percent of reported AIDS cases were among Hispanic/Latino adults and adolescents (3). Among women, Hispanic/Latina women accounted for 20 percent of AIDS cases, and Hispanic/Latino children accounted for 23 percent of AIDS cases among children (3).

Although HIV prevention efforts have proven to be more effective in gay communities, racial disparities persist. Men of color who have sex with men (MSM) account for an estimated 42 percent of all new infections in the United States (3). Young MSM, especially African American and Latino MSM are particularly at higher risks for HIV infection. In a recent study of young MSM in seven U.S. cities, more than one in ten young MSM were HIV infected, with 15 percent of infection rates among young Latino MSM and 30 percent among young African American MSM (3).

AIDS cases are also increasing at an alarming rate among other minority communities. For example, Asian-Americans/Pacific Islanders accounted for 0.7 percent of all AIDS cases reported through June 2000 (3) and more recently accounted for 0.9 percent (3). Through June 2000, American Indians/Alaska Natives accounted for 0.6 percent of new HIV cases from 36 areas with confidential HIV reporting (3). For all AIDS cases through June 2000, American Indians/Alaska Natives accounted for 0.3 percent, which in recent times has increased to 0.4 percent (3).

Finally, the HIV epidemic continues to be an unprecedented threat to youth, especially minority youth. According to CDC, half of all new HIV infections in this country occur in young people under the age of 25. While the actual number of American youth who have been infected with HIV is unknown, it is estimated that 20,000 young people are infected with HIV every year, resulting in two young Americans between the ages of 13 and 24 contracting HIV every hour. CDC reported that African Americans and Hispanics constitute about 15 percent of U.S.

teenagers and that African Americans represent 49 percent of the 3,725 AIDS cases (among those aged 13 to 19), and 67 percent of the 4,796 HIV infections reported to date in this age group (7). Hispanic teens account for 20 percent of AIDS cases among teens and young adults (ages 20-24) and account for about 65 percent of AIDS cases from racial or ethnic minority groups. Among young women, women of color account for 78 percent of AIDS cases (9). Researchers believe that cases of HIV infection diagnosed among 13 to 24 year olds are indicative of overall trends in incidence rates, because this age group has recently initiated high-risk behaviors.

CDC studies conducted every 2 years in high schools (grades 9-12) consistently indicated that by the twelfth grade, 1) approximately two-thirds of high school students had sexual intercourse, 2) about half of sexually active 12th graders reported using latex condoms all of the time and 3) nearly one-quarter of 12th graders had four or more lifetime sex partners (9). In addition, many students report using alcohol or drugs when they have sex, and 1 in 50 high school students reported having injected an illegal drug (9). Recent findings from the University of Michigan's Monitoring the Future Survey demonstrated that, “Drug use among young people has stabilized but still remains close to all-time highs” (9). The survey also reported that twenty-six percent of eighth graders tried illegal drugs and one out of every two teenagers tried an illegal drug by twelfth grade (8). To date, many are still engaging in behaviors that may put them at risk of acquiring HIV infection and other sexually transmitted diseases. Even through health messages on risky behaviors around HIV transmission, very few youth have shown behavioral changes especially among those from minority populations (9).

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3. Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report, 12 (1), 2001.
4. Health Resources and Services Administration. HRSA Care Action, Providing HIV/AIDS Care In A Changing Environment. "Substance Abuse in the United States: An Update". May 2001, p. 4.
5. National Alliance of State and Territorial AIDS Directories (NASTAD) HIV Prevention Bulletin. Focus on the Integration of HIV, Substance Abuse and Mental Health Services, March 2002.
6. National Institute on Drug Abuse. Director's Report to the National Advisory Council on Drug Abuse, September 2001.
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8. The White House Office of the Press Secretary. The President's National Drug Control Strategy, February 2002.
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10. Office of Minority Health (OMH). (2000) "HIV/AIDS and Drug Use Among Minorities," HIV Impact: A Closing the Gap newsletter of the Office of Minority Health, U.S. Department of Health and Human Services, Fall 2000, p. 2.

Appendix C

INSTRUCTIONS TO PROVIDERS/GRANTEES ON COMPLYING WITH THE SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA) GOVERNMENT PERFORMANCE AND RESULTS ACT (GPRA) INFORMATION NEEDS

SAMHSA has a corporate strategy to standardize its client/participant outcome measures wherever programs and grants would usually be collecting the same information items. This strategy addresses a requirement under GPRA to report program outcomes as a part of the Federal budgeting cycle. Recipients of grants for Targeted Capacity Expansion (TCE) and some Knowledge Application (KA) programs will be required to collect these measures.

The attached document lists the standard measures for which you are expected to provide client/participant outcome information. SAMHSA's goal is to measure program performance using these measures, not to require the use of a specific instrument or question. As a general guide, the approach to creating GPRA measures has been designed to minimize any increase in the time and financial costs associated with complying. The list of standard measures was developed with input from programs across all parts of SAMHSA, and is intended to produce comparable outcome estimates for all SAMHSA efforts.

CSAP SPECIFIC INSTRUCTIONS

Recipients of grants for TCE and some KA programs will be required to collect these measures pre and post intervention and at 6-month follow-up. Most grants already include items from this list appropriate to the grant goals and population. You may already be using the same question with more detail. If your measure is equivalent and the response categories can be rolled up into the same reporting categories required, please contact the GPRA point of contact for CSAP to confirm that this is acceptable.

It is assumed that you will already be collecting some of these measures on all client/participants in your program as a standard part of identifying client/participants and baselining their needs or prevention status. Relevant sites would use a census approach at baseline and post-test. Response rates for follow-up are expected to be 80% of the baseline.

Reporting processes will not change. If your grant reports to a coordinating center, forward your client/participant information in the same method and at the same frequency. If you report directly to your GPO, these data should be included in your standard annual report. The only change required may be the addition of items to your instruments if you are not now covering the set identified in the attachment.

General Instrument Instructions — Adult Instrument

You are being asked to complete this survey because you have agreed to participate in a local and a national evaluation, ANAME OF PROGRAM@. Through your participation, you will helping us to learn more about the effectiveness of prevention programs to prevent substance abuse and related risk factors as well as strengthen protective factors among children, youth, adults, families, and communities.
Answering these questions is voluntary; you do not have to answer any question that makes you feel uncomfortable.

Your responses will be kept private. Your name will NOT be on any of the pages with your answers. Your survey will be given a code number so that your answers will NOT and CANNOT be linked to your name. You will be completing this survey several times, once before the start of the study and at two follow-up times.

Instructions for Completing Responses

- Read all the possible choices before marking your answers.
- Mark the oval for the answer that best fits your response.
- Make heavy marks that fill the oval for your answer.

Specific Instructions developed for CSAP GPRA Questions

B. DRUG AND ALCOHOL USE

The questions in this section ask about cigarettes, alcohol and other drugs. Sometimes people feel uncomfortable when answering these questions. Remember that these questions are voluntary. Also remember that your answers are private --the page with your name was taken off the survey.

There are different groups of people in the United States that may use alcohol for religious reasons. However, this may not be true for your religious, cultural or ethnic group. For example, some churches serve wine during a church service. If you drink wine at church or for some other religious reason, do not count these times in your answers to the questions below.

Please mark one response for each question. The next questions ask about alcohol, tobacco, and other drug use within the past month (30 days).

(Age of First Use Items)
The next few questions ask about age of first use for alcohol, tobacco, and other drugs. These questions do NOT assume that YOU have used alcohol, tobacco or other drugs.

(Problems Related to Drug Use)
The next few questions ask about problems related to alcohol or other drug use. This does not mean that we think YOU have these problems. Please mark the answer that shows how much you think the statement describes you.

(Attitudes Toward Drug Use)
The next few questions ask about attitudes toward alcohol, tobacco, and other drugs.

Please read each question and mark the answer that best describes what YOU think. Remember that there are no right or wrong answers. Fill in only one bubble per question.

(Risk for Drug Use Behavior)
The following statements ask about how risky you think some things are.
For these next few questions, the answers include:
No Risk: You think nothing bad will happen if people do this.

Slight Risk: You think something bad might happen if people do this. Moderate Risk: You are pretty sure something bad will happen if people do this.

Great Risk: You really think something bad will happen if people do this.

Please read each question and mark the answer that best describes what YOU think. Remember that there are no right or wrong answers.

General Instrument Instructions — Youth Instrument

You are being asked to complete this survey as part of an evaluation study so that we may understand how young people feel about themselves, friends, school, and family. You will be asked questions about your feelings toward alcohol, tobacco, and other drugs, and whether or not you use them. Please answer all of the questions honestly and thoughtfully. Your answers will be kept private. Your completion of this survey will help us to learn more about the effectiveness of programs to prevent substance abuse and related risk factors as well as enhance protective factors among youth.

No one in your school or community will ever know how you answered the questions. The survey is completely voluntary. If you do not want to fill out the survey or any of the questions, you do not have to. No one else will know your decisions.

This is not a test, so there are no right or wrong answers. Please work quietly and by yourself. We think you will find the survey interesting and that you will like filling it out. Thank you very much for taking the time to complete this survey.

Specific Instructions developed for CSAP GPRA Questions.

B. DRUG AND ALCOHOL USE

The questions in this section ask about cigarettes, alcohol and other drugs. Sometimes people feel uncomfortable when answering these questions. Remember that these questions are voluntary. Also remember that your answers are private --the page with your name was taken off the survey.

There are different groups of people in the United States that may use alcohol for religious reasons. However, this may not be true for your religious, cultural or ethnic group. For example, some churches serve wine during a church service. If you drink wine at church or for some other religious reason, do not count these times in your answers to the questions below.

Mark one answer for each question.

NOTE: The rest of the instructions are the same as adults, since the questions are the same.

Form Approved
OMB No. 0930-0208
Expiration Date 10/31/2005

CSAP GPRA Participant Outcome Measures for Discretionary Programs

ADULTS

RECORD MANAGEMENT

Participant ID |____|____|____|____|____|____|____|____|____|____|____|____|

Contract/Grant ID |____|____|____|____|____|____|____|____|____|____|____|____|

Grant Year |____|____|____|____|
Year

Interview Date |____|____| / |____|____| / |____|____|____|____|

Interview Type
1. Pre-Test 2. Post-Test 3. 6-Month Follow-up

A. DEMOGRAPHICS (QUESTIONS 1-4 ASKED ONLY AT BASELINE)

1. Gender

- ○ Male
- ○ Female

2. Are you Hispanic or Latino?

○ Yes ○ No

3. What is your race? (Select one or more)

- ○ Black or African American
- ○ Asian
- ○ American Indian
- ○ Native Hawaiian or Other Pacific Islander
- ○ Alaska Native
- ○ White
- ○ Other (specify)_____

4. What is your date of birth? |____|____| / |____|____| / |____|____|____|____|
Month / Day / Year

B. DRUG AND ALCOHOL USE

1. What is your best estimate of the number of days you used chewing tobacco during the past 30 days?

0 0 days
1 1 or 2 days
2 3 to 5 days
3 6 to 9 days
4 10 to 19 days
5 20 to 29 days
6 all 30 days

2. What is your best estimate of the number of days you smoked all or part of a cigarette during the past 30 days?

0 0 days
1 1 or 2 days
2 3 to 5 days
3 6 to 9 days
4 10 to 19 days
5 20 to 29 days
6 all 30 days

3. What is your best estimate of the number of days you drank alcohol during the past 30 days?

0 0 days
1 1 or 2 days
2 3 to 5 days
3 6 to 9 days
4 10 to 19 days
5 20 to 29 days
6 all 30 days

4. What is your best estimate of the number of days you used marijuana or hashish during the past 30 days?

0 0 days
1 1 or 2 days
2 3 to 5 days
3 6 to 9 days
4 10 to 19 days
5 20 to 29 days
6 all 30 days

5. What is your best estimate of the number of days you used cocaine during the past 30 days?

0 0 days
1 1 or 2 days
2 3 to 5 days
3 6 to 9 days
4 10 to 19 days
5 20 to 29 days
6 all 30 days

6. What is your best estimate of the number of days you used "crack" during the past 30 days?

0 0 days
1 1 or 2 days
2 3 to 5 days
3 6 to 9 days
4 10 to 19 days
5 20 to 29 days
6 all 30 days

7. What is your best estimate of the number of days you used any inhalant for kicks or to get high during the past 30 days?

0 0 days
1 1 or 2 days
2 3 to 5 days
3 6 to 9 days
4 10 to 19 days
5 20 to 29 days
6 all 30 days

8. What is your best estimate of the number of days you used heroin during the past 30 days?

0 0 days
1 1 or 2 days
2 3 to 5 days
3 6 to 9 days
4 10 to 19 days
5 20 to 29 days
6 all 30 days

9. What is your best estimate of the number of days you used hallucinogens during the past 30 days?

0 0 days
1 1 or 2 days
2 3 to 5 days
3 6 to 9 days
4 10 to 19 days
5 20 to 29 days
6 all 30 days

10. How old were you the <u>first time</u> you smoked part or all of a cigarette?

____ years old If never smoked part or all of a cigarette please mark the box. □

11. Think about the <u>first time</u> you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink.

____ years old If never had a drink of an alcoholic beverage please mark the box. □

12. How old were you the <u>first time</u> you used marijuana or hashish?

____ years old If never used marijuana or hashish please mark the box. □

13. How old were you the <u>first time</u> you used any other illegal drugs?

____ years old If never used any illegal drugs please mark the box. □

D. EDUCATION, EMPLOYMENT, AND INCOME

1. What is the highest level of education you have finished, whether or not you received a degree? [01=1st grade, 12=12th grade, 13=college freshman, 16=college completion]

|____|____| level in years

1a. If less than 12 years of education, do you have a GED (General Equivalency Diploma)?

○ Yes ○ No

G. ATTITUDES AND BELIEFS

1. How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day?

- ○ No risk
- ○ Slight risk
- ○ Moderate risk
- ○ Great risk

2. How much do people risk harming themselves physically and in other ways when they smoke marijuana once a month?

- ○ No risk
- ○ Slight risk
- ○ Moderate risk
- ○ Great risk

3. How much do people risk harming themselves physically and in other ways when they:

a. Have four or five drinks of an alcoholic beverage nearly every day?

- ○ No risk
- ○ Slight risk
- ○ Moderate risk
- ○ Great risk

b. Have five or more drinks of an alcoholic beverage once or twice a week?

- ○ No risk
- ○ Slight risk
- ○ Moderate risk
- ○ Great risk

4. How do you feel about adults smoking one or more packs of cigarettes per day?

- ○ Neither approve nor disapprove
- ○ Somewhat disapprove
- ○ Strongly disapprove

5. How do you feel about adults trying marijuana or hashish once or twice?

- ○ Neither approve nor disapprove
- ○ Somewhat disapprove
- ○ Strongly disapprove

6. How do you feel about adults having one or two drinks of an alcoholic beverage nearly every day?

- ○ Neither approve nor disapprove
- ○ Somewhat disapprove
- ○ Strongly disapprove

7. How do you feel about adults driving a car after having one or two drinks of an alcoholic beverage?

- ○ Neither approve nor disapprove
- ○ Somewhat disapprove
- ○ Strongly disapprove

Form Approved
OMB No. 0930-0208
Expiration Date 10/31/2005

CSAP GPRA Participant Outcome Measures for Discretionary Programs

YOUTH - Age 12 to 17 Years

RECORD MANAGEMENT

Participant ID |____|____|____|____|____|____|____|____|____|____|____|____|

Contract/Grant ID |____|____|____|____|____|____|____|____|____|____|____|____|

Grant Year |____|____|____|____|
Year

Interview Date |____|____| / |____|____| / |____|____|____|____|

Interview Type
1. Pre-Test 2. Post-Test 3. 6-Month Follow-up

A. DEMOGRAPHICS (QUESTIONS 1-4 ASKED ONLY AT BASELINE)

1. Gender

- ○ Male
- ○ Female

2. Are you Hispanic or Latino?

○ Yes ○ No

3. What is your race? (Select one or more)

- ○ Black or African American
- ○ Asian
- ○ American Indian
- ○ Native Hawaiian or Other Pacific Islander
- ○ Alaska Native
- ○ White
- ○ Other (specify)_____

4. What is your date of birth? |____|____| / |____|____| / |____|____|____|____|
Month / Day / Year

B. DRUG AND ALCOHOL USE

1. How frequently have you smoked cigarettes during the past 30 days?

1 Not at all
2 Less than one cigarette per day
3 One to five cigarettes per day
4 About one-half pack per day
5 About one pack per day
6 About one and one-half packs per day
7 Two packs or more per day

2. How often have you taken smokeless tobacco during the past 30 days?

1 Not at all
2 Once or twice
3 Once to twice per week
4 Three to five times per week
5 About once a day
6 More than once a day

3. To be more precise, during the past 30 days about how many cigarettes have you smoked per day?

1 None
2 Less than 1 per day
3 1 to 2
4 3 to 7
5 8 to 12
6 13 to 17
7 18 to 22
8 23 to 27
9 28 to 32
10 33 to 37
11 38 or more

Alcoholic beverages include beer, wine, wine coolers, and liquor.

4. On how many occasions during the last 30 days have you had alcoholic beverages to drink (more than just a few sips)?

1 0 occasions
2 1 to 2 occasions
3 3 to 5 occasions
4 6 to 9 occasions
5 10 to 19 occasions
6 20 to 39 occasions
7 40 or more occasions

5. On how many occasions during the last 30 days (if any) have you been drunk or very high from drinking alcoholic beverages?

1 0 occasions
2 1 to 2 occasions
3 3 to 5 occasions
4 6 to 9 occasions
5 10 to 19 occasions
6 20 to 39 occasions
7 40 or more occasions

6. On how many occasions during the last 30 days (if any) have you used marijuana (grass, pot) or hashish (hash, hash oil)?

1 0 occasions
2 1 to 2 occasions
3 3 to 5 occasions
4 6 to 9 occasions
5 10 to 19 occasions
6 20 to 39 occasions
7 40 or more occasions

7. During the LAST MONTH, about how many marijuana cigarettes (joints, reefers), or the equivalent, did you smoke a day, on the average? (If you shared them with other people, count only the amount YOU smoked).

1 None
2 Less than 1 a day
3 1 a day
4 2 to 3 a day
5 4 to 6 a day
6 7 to 10 a day
7 11 or more a day

8. On how many occasions during the last 30 days (if any) have you sniffed glue, or breathed the contents of aerosol spray cans, or inhaled any other gases or sprays in order to get high?

1 0 occasions
2 1 to 2 occasions
3 3 to 5 occasions
4 6 to 9 occasions
5 10 to 19 occasions
6 20 to 39 occasions
7 40 or more occasions

9. On how many occasions (if any) during the last 30 days have you taken LSD (>acid=)?

1 0 occasions
2 1 to 2 occasions
3 3 to 5 occasions
4 6 to 9 occasions
5 10 to 19 occasions
6 20 to 39 occasions
7 40 or more occasions

Amphetamines are sometimes called: uppers, ups, speed, bennies, dexies, pep pills, diet pills, meth or crystal meth. They include the following drugs: Benzedrine, Dexedrine, Methedrine, Ritalin, Preludin, Dexamyl, and Methamphetamine.

10. On how many occasions (if any) during the last 30 days have you taken amphetamines on your own that is, without a doctor telling you to take them?

1 0 occasions
2 1 to 2 occasions
3 3 to 5 occasions
4 6 to 9 occasions
5 10 to 19 occasions
6 20 to 39 occasions
7 40 or more occasions

11. On how many occasions (if any) during the last 30 days have you taken "crack" (cocaine in chunk or rock form)?

1 0 occasions
2 1 to 2 occasions
3 3 to 5 occasions
4 6 to 9 occasions
5 10 to 19 occasions
6 20 to 39 occasions
7 40 or more occasions

12. On how many occasions (if any) during the last 30 days have you taken cocaine in any other form (like cocaine powder)?

1 0 occasions
2 1 to 2 occasions
3 3 to 5 occasions
4 6 to 9 occasions
5 10 to 19 occasions
6 20 to 39 occasions
7 40 or more occasions

13. Tranquilizers are sometimes prescribed by doctors to calm people down, quiet their nerves, or relax their muscles. Librium, Valium, and Miltown are all tranquilizers. On how many occasions (if any) have you taken tranquilizers on your own that is, without a doctor telling you to take them...during the last 30 days?

1 0 occasions
2 1 to 2 occasions
3 3 to 5 occasions
4 6 to 9 occasions
5 10 to 19 occasions
6 20 to 39 occasions
7 40 or more occasions

14. Barbiturates are sometimes prescribed by doctors to help people relax or get to sleep. They are sometimes called downs, downers, goofballs, yellows, reds, blues, rainbows. On how many occasions (if any) have you taken barbiturates on your own that is, without a doctor telling you to take them...during the last 30 days?

1 0 occasions
2 1 to 2 occasions
3 3 to 5 occasions
4 6 to 9 occasions
5 10 to 19 occasions
6 20 to 39 occasions
7 40 or more occasions

15. On how many occasions (if any) have you smoked (or inhaled the fumes of) crystal meth ('ice')...during the last 30 days?

1 0 occasions
2 1 to 2 occasions
3 3 to 5 occasions
4 6 to 9 occasions
5 10 to 19 occasions
6 20 to 39 occasions
7 40 or more occasions

16. Amphetamines have been prescribed by doctors to help people lose weight or to give people more energy. They are sometimes called uppers, ups, speed, bennies, dexies, pep pills, and diet pills. Drugstores are not supposed to sell them without a prescription from a doctor. Amphetamines do NOT include any non-prescription drugs, such as over-the-counter diet pills (like Dexatrim) or stay-awake pills (like No-Doz), or any mail-order drugs. On how many occasions (if any) have you taken amphetamines on your own that is, without a doctor telling you to take them...during the last 30 days?

1 0 occasions
2 1 to 2 occasions
3 3 to 5 occasions
4 6 to 9 occasions
5 10 to 19 occasions
6 20 to 39 occasions
7 40 or more occasions

17. On how many occasions (if any) have you used heroin...during the last 30 days?

1 0 occasions
2 1 to 2 occasions
3 3 to 5 occasions
4 6 to 9 occasions
5 10 to 19 occasions
6 20 to 39 occasions
7 40 or more occasions

18. There are a number of narcotics other than heroin, such as methadone, opium, morphine, codeine, demerol, paregoric, talwin, and laudanum. They are sometimes prescribed by doctors. On how many occasions (if any) have you taken narcotics other than heroin on your own that is, without a doctor telling you to take them...during the last 30 days?

1 0 occasions
2 1 to 2 occasions
3 3 to 5 occasions
4 6 to 9 occasions
5 10 to 19 occasions
6 20 to 39 occasions
7 40 or more occasions

19. On how many occasions (if any) have you used MDMA ('ecstasy') during the last 30 days?

1 0 occasions
2 1 to 2 occasions
3 3 to 5 occasions
4 6 to 9 occasions
5 10 to 19 occasions
6 20 to 39 occasions
7 40 or more occasions

20. On how many occasions (if any) have you used Rohypnol (>rophies,= >roofies=) during the last 30 days?

1 0 occasions
2 1 to 2 occasions
3 3 to 5 occasions
4 6 to 9 occasions
5 10 to 19 occasions
6 20 to 39 occasions
7 40 or more occasions

21. During the last 30 days, on how many occasions (if any) have you used GHB (>liquid G,= >grievous bodily harm=)?

1 0 occasions
2 1 to 2 occasions
3 3 to 5 occasions
4 6 to 9 occasions
5 10 to 19 occasions
6 20 to 39 occasions
7 40 or more occasions

22. During the last 30 days, on how many occasions (if any) have you used Ketamine (>special K,= >super K=)?

1 0 occasions
2 1 to 2 occasions
3 3 to 5 occasions
4 6 to 9 occasions
5 10 to 19 occasions
6 20 to 39 occasions
7 40 or more occasions

23. On how many occasions (if any) in your lifetime have you had an alcoholic beverage more than just a few sips?

- ○ Never
- ○ 1 to 2
- ○ 3 to 5
- ○ 6 to 9
- ○ 10 to 19
- ○ 20 to 39
- ○ 40 or more

24. How old were you the <u>first time</u> you smoked part or all of a cigarette?

____ years old If you never smoked part or all of a cigarette please mark the box. □

25. Think about the <u>first time</u> you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink.

____ years old If never had a drink of an alcoholic beverage please mark the box. □

26. How old were you the <u>first time</u> you used marijuana or hashish?

____ years old If never used marijuana or hashish please mark the box. □

27. How old were you the <u>first time</u> you used any other illegal drugs?

____ years old If never used any illegal drugs please mark the box. □

D. EDUCATION, EMPLOYMENT, AND INCOME

1. What is the highest level of education you have finished, whether or not you received a degree? [01=1st grade, 12=12th grade, 13=college freshman, 16=college completion]

|____|____| level in years

G. ATTITUDES AND BELIEFS

1. It is clear to my friends that I am committed to living a drug-free life.

- ○ False
- ○ Maybe
- ○ True

2. I have made a final decision to stay away from marijuana.

- ○ False
- ○ Maybe
- ○ True

3. I have decided that I will smoke cigarettes.

- ○ False
- ○ Maybe
- ○ True

4. I plan to get drunk sometime in the next year.

- ○ False
- ○ Maybe
- ○ True

5. How much do you think people risk harming themselves (physically or in other ways) if they smoke one or more packs of cigarettes per day?

- ○ No risk
- ○ Slight risk
- ○ Moderate risk
- ○ Great risk
- ○ Can=t say/Drug unfamiliar

6. How much do you think people risk harming themselves (physically or in other ways) if they try marijuana once or twice?

- ○ No risk
- ○ Slight risk
- ○ Moderate risk
- ○ Great risk
- ○ Can't say/Drug unfamiliar

7. How much do you think people risk harming themselves (physically or in other ways) if they smoke marijuana regularly?

- ○ No risk
- ○ Slight risk
- ○ Moderate risk
- ○ Great risk
- ○ Can=t say/Drug unfamiliar

8. How much do you think people risk harming themselves (physically or in other ways) if they take one or two drinks nearly every day?

- ○ No risk
- ○ Slight risk
- ○ Moderate risk
- ○ Great risk
- ○ Can't say/Drug unfamiliar

9. How much do you think people risk harming themselves (physically or in other ways) if they have five or more drinks once or twice each weekend?

- ○ No risk
- ○ Slight risk
- ○ Moderate risk
- ○ Great risk
- ○ Can't say/Drug unfamiliar

10. How wrong do you think it is for someone your age to drink beer, wine or hard liquor (for example, vodka, whiskey or gin) regularly?

- ○ Very wrong
- ○ Wrong
- ○ A little bit wrong
- ○ Not wrong at all

11. How wrong do you think it is for someone your age to smoke cigarettes?

- ○ Very wrong
- ○ Wrong
- ○ A little bit wrong
- ○ Not wrong at all

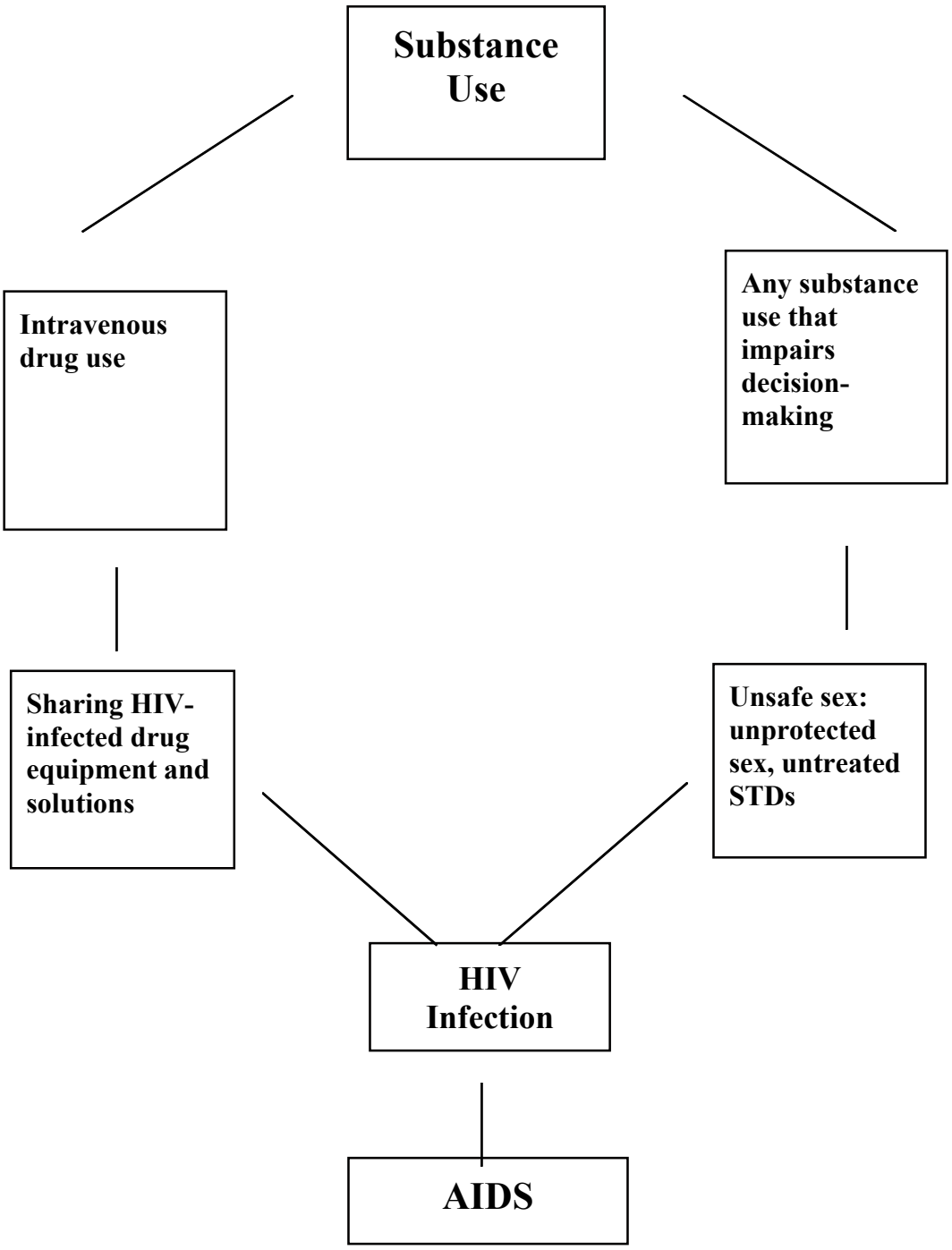
12. How wrong do you think it is for someone your age to smoke marijuana?

- ○ Very wrong
- ○ Wrong
- ○ A little bit wrong
- ○ Not wrong at all

13. How wrong do you think it is for someone your age to use LSD, cocaine, amphetamines or another illegal drug?

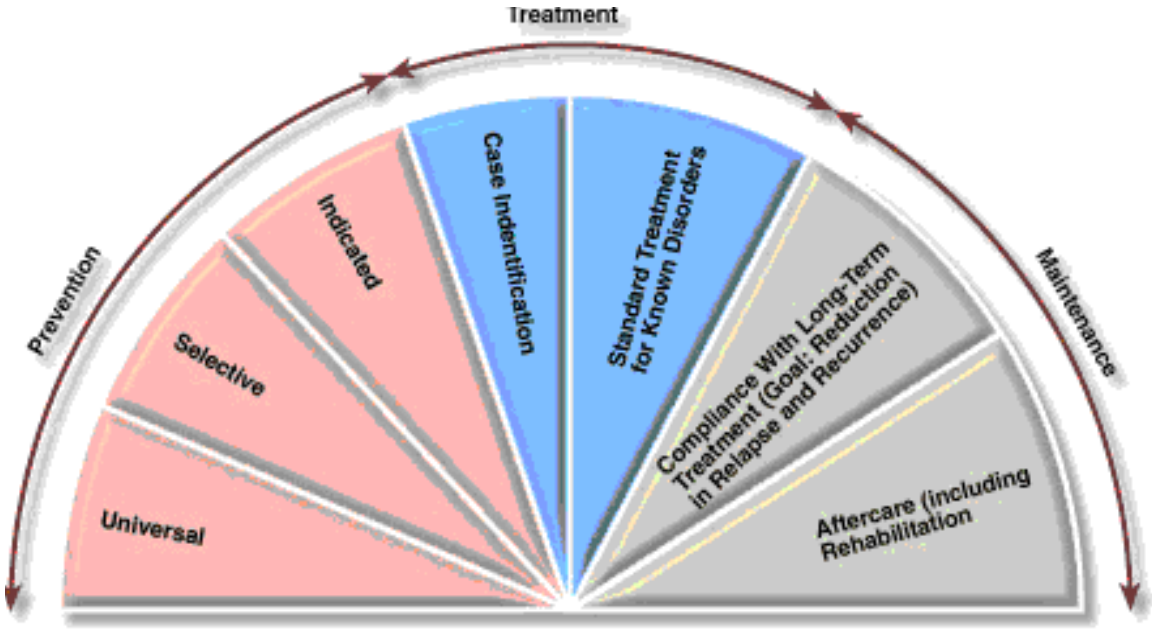
- ○ Very wrong
- ○ Wrong
- ○ A little bit wrong
- ○ Not wrong at all

Appendix D. Relationship Between Substance Use and HIV



Appendix E:

IOM Classification System: Prevention, Treatment, Maintenance



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