DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

State Incentive Grants for Treatment of Persons with Co-Occurring Substance Related and Mental Disorders

[Short Title: Co-Occurring State Incentive Grants – COSIG]

(Initial Announcement)
(TI-06-003)

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

Key Dates:

Application Deadline	**Applications are due by May 16, 2006.**
Intergovernmental Review (E.O. 12372)	**Letters from State Single Point of Contact (SPOC) are due no later than 60 days after application deadline.**

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I. FUNDING OPPORTUNITY DESCRIPTION

1. INTRODUCTION

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), and Center for Mental Health Services (CMHS), announce the availability of funds for fiscal year (FY) 2006 Co-Occurring State Incentive Grants (COSIG). These grants will develop and enhance the infrastructure of States, federally recognized Tribes, and tribal organizations (hereafter referred to as Tribes) and their treatment service systems to increase their capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based treatment services to persons with co-occurring substance abuse and mental health disorders, and to their families.

The COSIG program is authorized under Sections 509 and 520A of the Public Health Services Act, as amended. This announcement addresses Healthy People 2010 focus areas 18 (Mental Health) and 26 (Substance Abuse).

2. EXPECTATIONS

2.1 Background

There is a growing consensus among key stakeholders about the critical importance of improving services to people with co-occurring disorders and the action steps that are needed to do so. SAMHSA released a landmark *Report to Congress on Co-occurring Disorders* on December 2, 2002, creating a critical opportunity for SAMHSA to provide leadership to support State efforts to improve services for people with co-occurring disorders. The COSIG program is intended to support States/Tribes as they respond to this opportunity.

COSIG is built on the following concepts and principles:

- COSIG uses the definition of co-occurring disorders developed by the consensus panel convened to draft SAMHSA's TIP 42, *Substance Abuse Treatment for Persons with Co-occurring Disorders:* People with co-occurring substance abuse and mental disorders are "…individuals who have at least one psychiatric disorder as well as an alcohol or drug use disorder. While these disorders may interact differently in any one person (e.g., an episode of depression may trigger a relapse into alcohol abuse, or cocaine use may exacerbate schizophrenic symptoms) at least one disorder of each type can be diagnosed independently of the other."

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

- COSIG is appropriate for States and Tribes at any level of infrastructure development. Applicants will not be at a disadvantage either for being at an early stage of development or at a more advanced stage. Some States and communities throughout the country already have initiated system-level changes and developed innovative programs that overcome barriers to providing services for individuals of all ages who have co-occurring substance abuse and mental disorders. The COSIG grant program reflects the experience of States to date. [See Appendix D for Summary of Activities and Approaches of COSIG States Funded in 2003 & 2004.]

2.2 Program Requirements

In developing their COSIG applications, applicants will select one or more of the capacity-building goals enunciated in SAMHSA's Report to Congress on Co-Occurring Disorders and will implement infrastructure development and enhancement activities (tailored to the needs of States and Tribes) that will support the selected goal(s) (Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders, USDHHS, SAMHSA, November 2002; Chapter V, Five-Year Blueprint for Action, *Capacity,* SAMHSA State Services and Treatment Capacity Goals, page 113).

The COSIG program will have two phases:

- Phase I – The first three years of the grant will focus on infrastructure development/enhancement. This phase may also include service pilots. (See below for more information on infrastructure development/enhancement and service pilots.) Awards will be for up to $1.05 million per year for the first three years.

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

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

- **Screen** all individuals for the presence of co-occurring disorders;
- **Assess** the level of severity of co-occurring disorders;
- **Treat** both disorders in a comprehensive and coordinated manner that is seamless to the client and, where feasible, that involves the client's family. This may involve consultation/collaboration with other providers, if the provider does not have the ability to offer comprehensive treatment;
- **Train** providers to screen, assess, and develop preventive interventions and treatment plans for people who have co-occurring disorders;
- **Evaluate** the impact of prevention and treatment services on individuals who have co-occurring disorders and their families.

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

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

- **Complementary Licensure and Credentialing Requirements:** State licensure, credentialing policies, and legal requirements often act as barriers to providing effective integrated services for persons with co-occurring disorders. Review and revision of these laws and policies are a critical initial step toward improving services and extending effective substance abuse treatment to existing mental health treatment programs and vice versa.

- **Service Coordination and Network Building:** Conventional boundaries between single-focus agencies impede the clinical progress of persons with co-occurring disorders. Network building will help COSIG grantees develop more effective linkages across systems of care. This activity area also includes the development of a permanent coordinating body at the grantee level, as well as assignment of specific "boundary spanning" responsibilities designed to ensure continuous coordination which yields the most efficient use of agency resources and the elimination of service redundancies.

- **Financial Planning:** Current reimbursement practices inhibit coordination/integration of services and effective treatment for persons with co-occurring disorders. Mental health and substance abuse services are funded through separate Federal, State, tribal, tribal-organizational, and private funding sources. The goal of comprehensive financial planning is the development of effective and innovative approaches for coordinating funds from these multiple programs to fund seamless services for individuals with co-occurring disorders—while maintaining accountability—and the removal of barriers that inhibit effective resource coordination.

- **Information Sharing:** Often there is little or no communication among various departments and levels of government that have separate administrative structures, constituencies, mandates, and target groups. The goal of information sharing, ideally through utilization of the awardee's integrated MIS, is to ensure communication between providers so that

treatment is more suited to the person's personal needs and characteristics by linking services and information across different systems of care.

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

COCE: Applicants must commit to cooperating and coordinating with SAMHSA's Co-Occurring Center for Excellence (COCE – see www.coce.samhsa.gov). The purpose of COCE is to provide broadly focused technical assistance and training to grantees and to community agencies to enable them to provide effective prevention and treatment services to meet the needs of persons with, or at-risk of developing, co-occurring disorders (including the homeless), whether in the mental health, substance abuse, criminal justice, or other social/public health systems.

Pre-Application Assistance: In addition to other application materials, applicants may want to obtain a copy of SAMHSA's *Treatment Improvement Protocol (TIP Number 42), Substance Abuse Treatment for Persons with Co-Occurring Disorders* and the *Co-Occurring Disorders: Integrated Dual Disorders Treatment Implementation Resource Kit*, referred to in this grant announcement.

TIP 42 can be obtained by calling The National Clearinghouse for Alcohol and Drug Information (NCADI) at 1-800-729-6686 or by going to www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.74073

The Toolkit can be obtained by calling SAMHSA's National Mental Health Information Center at 1-800-789-2647 or by going to www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooccurring

2.3 Data and Performance Measurement

All SAMHSA grantees are required to collect and report certain data so that SAMHSA can meet its obligations under the Government Performance and Results Act (GPRA). Two types of performance measures will be used for COSIG grantees, infrastructure measures and SAMHSA's National Outcome Measures.

Infrastructure Measures: These measures monitor the growth of service capacity for treating persons with co-occurring disorders. The two infrastructure measures for this program are:

1) Increase the number of persons with co-occurring disorders served.

This measure will reflect increases in service capacity and access. Grantees will report the number of clients/patients diagnosed with both mental health and substance abuse disorders during the reporting period.

2) Increase the percentage of treatment programs that:

a) Screen for co-occurring disorders;
b) Assess for co-occurring disorders; and
c) Treat co-occurring disorders through collaborative, consultative, and integrated models of care.

SAMHSA expects grantees to make progress toward the screening, assessment, and treatment goals reflected in measure 2, in accord with these definitions:

- Programs that screen for co-occurring disorders are defined as programs that screen for co-occurring disorders 100% of those who present themselves at the service location.

- Programs that assess for co-occurring disorders are defined as programs that assess 100% of those who screen positive for co-occurring disorders.

- Programs that treat co-occurring disorders through collaborative, consultative, and integrated models of care are defined as programs that treat 100% of those who are assessed for co-occurring disorders.

This measure will reflect improvements in services. Grantees will report:

- The number of people who present themselves at the service location;
- The number of those people who are screened for co-occurring disorders;
- The number of those screened for co-occurring disorders who screen positive;
- The number of those who have screened positive for co-occurring disorders who are assessed;
- The number assessed who are determined to have co-occurring disorders; and
- The number of persons with co-occurring disorders who receive services.

SAMHSA is developing a set of questions and instructions for capturing these data, which will be distributed to grantees after it is approved by OMB. The instructions will also explain how often the data are to be collected and how they are to be submitted to SAMHSA.

Applicants must describe their current capacity to collect data relating to these measures, must present baseline data if available, and must project targets for these measures for each year of the COSIG grant.

SAMHSA's National Outcome Measures (NOMs): These are a set of common outcome measures to be implemented across SAMHSA programs. They address domains such as abstinence from substance use, decreased mental illness symptomology, employment/education, criminal justice involvement, housing stability, access/capacity, retention in services, reduced utilization of psychiatric inpatient beds, social connectedness, and perception of care. Additional systems measures to be reported include cost-effectiveness and use of evidence-based practices.

The NOMs are currently under development at SAMHSA, and are expected to be implemented fully by the end of FY 2007 (September 2007). *Grantees implementing service pilots must report on the NOMs,* and all grantees will be required to report on the cost-effectiveness and evidence-based practices measures. Additional information will be provided to grantees as the NOMs are developed.

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

2.4 Evaluation

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

Process components should address issues such as:

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

Outcome components should address issues such as:

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

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

Through a separate contract, SAMHSA will implement a cross-site evaluation of the COSIG grant program. Grantees are required to collaborate in the evaluation by attending one meeting annually, participating in the development of a cross-site evaluation plan, and by submitting information consistent with the plan. Applicants must specifically agree to participate in a cross-site evaluation and must budget for attendance by the project evaluator and one other relevant

person at one annual meeting. These annual 1-1/2 day meetings are in addition to the annual technical assistance meeting discussed below and will be held in the Washington, DC, area.

No more than 20% of the total grant award may be used for evaluation and data collection in the first four years of the grant for grantees with service pilots, and in the first three years of the grant for grantees without service pilots. The evaluation and data collection may be considered "Infrastructure" and/or "Implementation Pilots" expenditures, depending on their purpose.

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

2.5 Grantee Meetings

Grantees must attend (and, thus must budget for) one technical assistance meeting during each year of the grant. Each meeting will be three days. At a minimum, three persons (Project Director, Project Evaluator, and one staff member from the Office of the Governor of States or the Office of the Chief Executive Officer in Tribes) are expected to attend each meeting. These meetings will usually be held in the Washington, DC, area.

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

II. AWARD INFORMATION

1. AWARD AMOUNT

It is expected that $2.1 million will be available to fund up to 2 COSIG awards in FY 2006. The awards will be for no more than $1.05 million in total costs (direct and indirect).

- All grantees will receive up to $1.05 million per year in years 1-3.
- Grantees with service pilots may request half of their year 3 award for year 4 to phase down the service pilots. Grantees with service pilots may request up to $100,000 in year 5 for evaluation.
- Grantees without service pilots may request up to $100,000 in years 4 and 5 for evaluation.

For example, if you have a service pilot and your award in year 3 is $1.05 million, you can request up to $525,000 in year 4. If your award in year 3 is less than $1.05 million, then your year 4 request must be proportionately less. Grantees without service pilots will receive up to $100,000 for evaluation in both years 4 and 5.

Proposed budgets cannot exceed the allowable amount in any year of the proposed project. Annual continuation awards will depend on the availability of funds, grantee progress in meeting project goals and objectives, and timely submission of required data and reports.

Should funding become available for COSIG grants in FY 2007, SAMHSA may fund awards from among the highly scored but not funded FY 2006 applications (assuming a sufficient number of high quality applications) rather than issuing a new announcement in FY 2007.

2. FUNDING MECHANISM

Awards will be made as grants.

III. ELIGIBILITY INFORMATION

1. ELIGIBLE APPLICANTS

Only the immediate Office of the Governor of a State or the Chief Executive Officer (CEO) of federally recognized Tribes and tribal organizations may apply. Component agencies of the applicant's organizational structure are not considered to be part of the immediate Office of the Governor of States or CEO in Tribes and tribal organizations. This means, for example, that the Mental Health, or Substance Abuse Authorities, or other agencies within the Office of the Governor or Tribe, cannot apply independently. SAMHSA has limited the eligibility to the applicants' highest level of responsible leadership because that office has the greatest potential to provide the multi-agency leadership needed to develop the infrastructure/treatment service systems to increase the capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based services to persons with co-occurring substance abuse and mental health disorders, and their families.

A lead official of the applicant may be designated to be Program Director for the grant. State applications must reflect substantial involvement of the State's Mental Health Authority and the State's Substance Abuse Authority (or the equivalent entity in a Tribe or tribal organization), and other relevant agencies, and must reflect substantial involvement and oversight by the immediate Office of the Governor in a State or CEO in a Tribe or tribal organization.

The application face page (form 424) must be signed by the State Governor or tribal CEO, as appropriate.

As defined in the Public Health Service (PHS) Act, the term "State" includes all 50 States, the District of Columbia, Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, the Virgin Islands, American Samoa, and the Trust Territory of the Pacific Islands. Also eligible are federally recognized Tribes and tribal organizations. Applications from any other entities are not eligible for funding.

Tribal organization means the recognized governing body of any Indian Tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such

governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities (P.L. 93-638, as amended). Consortia of tribal organizations are eligible to apply, but each participating entity must indicate its approval.

This grant program is appropriate for all States and federally recognized Tribes and tribal organizations, regardless of their level of infrastructure development.

Current COSIG grantees are not eligible to apply.

2. COST-SHARING

Cost-sharing is not required in this program, and applications will not be screened out on the basis of cost sharing.

3. OTHER

Applications must comply with the following requirements or they will be screened out and will not be reviewed: use of the PHS 5161-1 application; application submission requirements in Section IV-3 of this document; and formatting requirements provided in Section IV-2.3 of this document.

IV. APPLICATION AND SUBMISSION INFORMATION

(To ensure that you have met all submission requirements, you should use the checklist provided in Appendix A of this document.)

1. ADDRESS TO REQUEST APPLICATION PACKAGE

You may request a complete application kit from:

- National Clearinghouse for Alcohol and Drug Information (NCADI) at 1-800-729-6686;

  or

- National Mental Health Information Center at 1-800-789-CMHS (2647).

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

Additional materials available on this web site include:

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

- guidelines and policies that relate to SAMHSA grants (e.g., guidelines on cultural competence, consumer and family participation, and evaluation); and
- Enhanced instructions for completing the PHS 5161-1 application.

2. CONTENT AND FORM OF APPLICATION SUBMISSION

2.1 Application Kit

SAMHSA application kits include the following documents:

- PHS 5161-1 (revised July 2000) – Includes the face page, budget forms, assurances, certification, and checklist. You must use the PHS 5161-1. **Applications that are not submitted on the required application form will be screened out and will not be reviewed**.

- Request for Applications (RFA) – Provides specific information about the availability of funds along with instructions for completing the grant application. This document is the RFA. The RFA will be available on the SAMHSA web site (www.samhsa.gov/grants/index.aspx) and a synopsis of the RFA is available on the Federal grants web site (www.Grants.gov).

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

2.2 Required Application Components

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

- **Face Page** – Use Standard Form (SF) 424, which is part of the PHS 5161-1. [Note: Applicants will need to provide a Dun and Bradstreet (DUNS) number to apply for a grant or cooperative agreement from the Federal Government. SAMHSA applicants will be required to provide their DUNS number on the face page of the application. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS number, access the Dun and Bradstreet web site at www.dunandbradstreet.com or call 1-866-705-5711. To expedite the process, let Dun and Bradstreet know that you are a public/private nonprofit organization getting ready to submit a Federal grant application.]

- **Abstract** – Your total abstract should not be longer than 35 lines. In the first five lines or less of your abstract, write a summary of your project that can be used, if your project is funded, in publications, reporting to Congress, or press releases.

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

- **Budget Form** – Use SF 424A, which is part of the 5161-1. Fill out Sections B, C, and E of the SF 424A. A sample budget and justification is included in Appendix F of this announcement.

- **Project Narrative and Supporting Documentation** – The Project Narrative describes your project. It consists of Sections A through C. Sections A-C together may not be longer than 30 pages. (For example, remember that if your Project Narrative starts on page 5 and ends on page 35, it is 31 pages long, not 30 pages.) More detailed instructions for completing each section of the Project Narrative are provided in "Section V—Application Review Information" of this document.

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

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

  - *Appendix 1*: Letters of Commitment/Support from stakeholders and project participants/involved agencies.
  - *Appendix 2*: Sample Consent Forms
  - *Appendix 3*: Data Collection Instruments/Interview Protocols. (Note: Appendix 3 has no page limit.)

- **Assurances** – Non-Construction Programs. Use Standard Form 424B found in PHS 5161-1. Because grantees in the COSIG program may use some of the grant funds to provide direct substance abuse services, applicants are also required to complete the Assurance of Compliance with SAMHSA Charitable Choice Statutes and Regulations, Form SMA 170. This form will be posted on SAMHSA's web site with the RFA and provided in the application kits available at the National Clearinghouse for Alcohol and Drug Information and the National Mental Health Information Center.

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

- **Disclosure of Lobbying Activities** – Use Standard Form LLL found in the PHS 5161-1. Federal law prohibits the use of appropriated funds for publicity or propaganda purposes, or for the preparation, distribution, or use of the information designed to support or defeat legislation pending before the Congress or State legislatures. This includes "grass roots" lobbying, which consists of appeals to members of the public suggesting that they contact

their elected representatives to indicate their support for or opposition to pending legislation or to urge those representatives to vote in a particular way.

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

2.3 Application Formatting Requirements

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

- ❑ Information provided must be sufficient for review.

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

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

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

To facilitate review of your application, follow these additional guidelines. Failure to adhere to the following guidelines will not, in itself, result in your application being screened out and returned without review. However, following these guidelines will help reviewers to consider your application.

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

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

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

- ❑ Send the original application and two copies to the mailing address in Section IV-6.1 of this document. Please do not use staples, paper clips, and fasteners. Nothing should be attached, stapled, folded, or pasted. Do not use heavy or lightweight paper or any material that cannot be copied using automatic copying machines. Odd-sized and oversized attachments such as posters will not be copied or sent to reviewers. Do not include videotapes, audiotapes, or CD-ROMs.

Guidance for Electronic Submission of Applications

SAMHSA offers the opportunity for you to submit your application to us either in electronic or paper format. Register one time, and Grants.gov will generate your information for future applications so you don't have to re-enter it. Built-in error-checking increases the completeness and accuracy of your application. Electronic submission is voluntary. No review points will be added or deducted, regardless of whether you use the electronic or paper format.

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

You may search the Grants.gov site for the downloadable application package, by the funding announcement number (called the opportunity number) or by the Catalogue of Federal Domestic Assistance (CFDA) number. You can find the CFDA number on the first page of the funding announcement.

You must follow the instructions in the User Guide available at the www.Grants.gov apply site, on the Customer Support tab. In addition to the User Guide, you may wish to use the following sources for help:

- By e-mail: support@Grants.gov
- By phone: 1-800-518-4726 (1-800-518-GRANTS). The Customer Support Center is open from 7:00 a.m. to 9:00 p.m. Eastern Time, Monday through Friday.

If this is the first time you have submitted an application through Grants.gov, you must complete four separate registration processes before you can submit your application. Allow at least two weeks (10 business days) for these registration processes, prior to submitting your application. The processes are: DUNS Number registration, Central

Contractor Registry (CCR) registration, Credential Provider registration, and Grants.gov registration.

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

The Project Narrative must be a separate document in the electronic submission. Formatting requirements for SAMHSA grant applications are described above, and in Appendix A of this announcement. These requirements also apply to applications submitted electronically, with the following exceptions only for Project Narratives submitted electronically in Microsoft Word. These requirements help to ensure the accurate transmission and equitable treatment of applications.

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

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

While keeping the Project Narrative as a separate document, please consolidate all other materials in your application to ensure the fewest possible number of attachments. Ensure all pages in your application are numbered consecutively, with the exception of the standard forms in the PHS-5161 application package. Please name and number your attachments, indicating the order in which they should be assembled. Failure to comply with these requirements may affect the successful transmission and consideration of your application.

Applicants are strongly encouraged to submit their applications to Grants.gov early enough to resolve any unanticipated difficulties prior to the deadline. You may also submit a back-up paper submission of your application. Any such paper submission must be received in accordance with the requirements for timely submission detailed in Section IV-3 of this announcement. The paper submission must be clearly marked: **"Back-up for electronic submission."** The paper submission must conform to all requirements for non-electronic submissions. If both electronic and back-up paper submissions are received by the deadline, the electronic version will be considered the official submission.

After you electronically submit your application, you will receive an automatic acknowledgement from Grants.gov that contains a Grants.gov tracking number. It is important that you retain this number. **Include the Grants.gov tracking number in the top right corner of the face page for any paper submission.**

The Grants.gov Web site does not accept electronic signatures at this time. Therefore, you must submit a signed paper original of the face page (SF 424), the assurances (SF 424B), and the certifications, and hard copy of any other required documentation that cannot be submitted electronically. **You must include the Grants.gov tracking number for your application on these documents with original signatures, on the top right corner of the face page, and send the documents to the following address. The documents must be received at the following address within 5 business days after your electronic submission.** Delays in receipt of these documents may impact the score your application receives or the ability of your application to be funded.

For United States Postal Service:

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

For other delivery service (DHL, Federal Express, United Parcel Service):

Crystal Saunders, Director of Grant Review
Office of Program Services
Substance Abuse and Mental Health Services Administration
Room 3-1044
1 Choke Cherry Road
Rockville, MD **20850**
ATTN: Electronic Applications

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

3. SUBMISSION DATES AND TIMES

Applications are due by close of business on **May 16, 2006. Hand carried applications will not be accepted. Applications may be shipped using only DHL, Federal Express (FedEx), United Parcel Service (UPS), or the United States Postal Service (USPS).**

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

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

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

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

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

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

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

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

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

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

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

- If your State participates, contact your SPOC as early as possible to alert him/her to the prospective application(s) and to receive any necessary instructions on the State's review process.

- For proposed projects serving more than one State, you are advised to contact the SPOC of each affiliated State.

- The SPOC should send any State review process recommendations to the following address within 60 days of the application deadline:

  For United States Postal Service:

  Crystal Saunders, Director of Grant Review
  Office of Program Services
  Substance Abuse and Mental Health Services Administration
  Room 3-1044
  1 Choke Cherry Road
  Rockville, MD **20857**
  ATTN: SPOC – Funding Announcement No. TI-06-003

  For other delivery service:

  Crystal Saunders, Director of Grant Review
  Office of Program Services
  Substance Abuse and Mental Health Services Administration
  Room 3-1044
  1 Choke Cherry Road
  Rockville, MD **20850**
  ATTN: SPOC – Funding Announcement No. TI-06-003

5. FUNDING LIMITATIONS/RESTRICTIONS

Cost principles describing allowable and unallowable expenditures for Federal grantees, including SAMHSA grantees, are provided in the following documents, which are available at http://www/hhs.gov/grantsnet/roadmap/index.html.

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

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

- Grant funds must be used for purposes supported by the program.

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

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

6. OTHER SUBMISSION REQUIREMENTS

6.1 Where to Send Applications

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

Send applications to the following address:

For United States Postal Service:

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

For other delivery service:

Crystal Saunders, Director of Grant Review
Office of Program Services
Substance Abuse and Mental Health Services Administration
Rockville, Maryland **20850**

Do not send applications to other agency contacts, as this could delay receipt. Be sure to include **COSIG** and **TI-06-003** in item number 10 on the face page of any paper applications. If you require a phone number for delivery, you may use (240) 276-1199.

6.2 How to Send Applications

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

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

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

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

V. APPLICATION REVIEW INFORMATION

1. EVALUATION CRITERIA

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

- In developing the Project Narrative section of your application, use these instructions, which have been tailored to this program. **These are to be used instead of the "Program Narrative" instructions found in the PHS 5161-1**.

- The Project Narrative (Sections A-C) together may be no longer than 30 pages.

- You must use the three sections/headings listed below in developing your Project Narrative. Be sure to place the required information in the correct section, **or it will not be considered**. Your application will be scored according to how well you address the requirements for each section.

- Reviewers will be looking for evidence of cultural competence in each section of the Project Narrative. Points will be assigned based on how well you address the cultural competence aspects of the evaluation criteria. SAMHSA's guidelines for cultural competence can be found on the SAMHSA web site at www.samhsa.gov. Click on "Grants/SAMHSA's Supporting Grant Information/Useful Information for Applicants/Guidelines and Resources for Grant Applicants."

- The Supporting Documentation you provide in Sections D-G and Appendices 1-3 will be considered by reviewers in assessing your response, along with the material in the Project Narrative.

- The number of points after each heading below is the maximum number of points a review committee may assign to that section of your Project Narrative. Bullet statements in each section do not have points assigned to them. They are provided to invite the attention of applicants and reviewers to important areas within each section.

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

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

Section A.1. Current System and Proposed Activities

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

- Demonstrate a thorough understanding of co-occurring substance abuse and mental disorders, and the state-of-the art in providing a system of services for persons with co-occurring disorders.

- Thoroughly describe the applicant's current system of services for persons with co-occurring disorders. Describe the current infrastructure and capacity for providing coordinated/integrated services to persons with co-occurring disorders within both the Mental Health Authority, Substance Abuse Authority, and other relevant/analogous agencies/systems. Describe structural components, such as dedicated staff time, routine training activities, organizational roles and responsibilities, and relationships and priority areas for the provision of coordinated/integrated services to persons with co-occurring disorders across all four Quadrants. Describe any major limitations or challenges within both the mental health and the substance abuse components and other relevant agencies/systems including staffing limitations, limits to statutory authorities, organizational imperatives, or budget constraints.

- Present and justify the applicant's plan for using COSIG funds to improve infrastructure and capacity to serve persons with co-occurring disorders. State clearly which (one or more) of the five SAMHSA capacity building goals have been selected to implement. Describe how you will implement these goals, through specific infrastructure development/enhancement activities. Identify measurable outcomes for each goal, establish targets, and describe how progress will be tracked and measured over the course of the grant. Be sure to address all the critical areas of infrastructure development identified in Section I-2.2, Program Requirements. Specify how gaps in the system will be narrowed and other expected results, including any products to be developed through the project. State which Quadrants will be affected by proposed activities and demonstrate how the proposed plan is consistent with SAMHSA's emphasis on infrastructure improvements within Quadrants II and III.

- Describe the involvement and contribution to the project of the mental health and substance abuse components, and of other relevant systems/agencies, such as primary care, criminal justice, labor, housing, and social service agencies. Note: Applicants are required to include letters of commitment and cooperation from these agencies. [Letters of Commitment/Support from each of the involved agencies and stakeholders must be provided in **Appendix 1** of the application]. Describe the process for linking overall planning and infrastructure development to regional, county, and community-based mental health and substance abuse organizations and their representatives. Describe the

process for obtaining input and involving a diverse array of participants, including representation from cultural/ethnic communities, potential service recipients, mental health consumers and their families, the recovery communities, public and private service providers, businesses, faith communities, primary care professionals and other relevant community groups. Demonstrate that these linkages and processes will contribute to enduring infrastructure improvements.

- Demonstrate that the proposed project is feasible and practical. Demonstrate that the applicant's history of working toward systems coordination/integration will contribute to the success of the project. Demonstrate the scope and feasibility of successful collaboration among the entities involved in the proposed project – e.g., inclusion of treatment **and** prevention; inclusion of public health entities other than those dealing with mental health and/or substance abuse (e.g., primary care providers, communicable diseases, school health); inclusion of funding-related entities, especially Medicaid; inclusion of corrections and criminal justice; linkage with drug courts; collaborations with social/welfare/vocational services, etc. State whether the State has participated in a SAMHSA Co-Occurring Policy Academy or a Homeless Policy Academy, and, if so, specify how activities associated with the Policy Academy will be coordinated with the proposed COSIG project. (There is no penalty for not having participated in a Policy Academy and no priority given to those States that have.)

Section A.2. Services Pilot

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

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

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

- Describe how the project will address issues of age, race, ethnicity, culture, language, sexual orientation, disability, literacy, and gender in the target population.

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

Section B: Organizational and Staffing Plans (30 points)

- Demonstrate the organizational capability to implement the proposed plan. Describe the organizational structure, lines of supervision, and management oversight for the proposed project. Specifically, describe the plans for partnership between the applicant office, the mental health and substance abuse components, and proposed protocols for ongoing communications and joint planning activities. Identify a lead agency, if appropriate, for purposes of administering the grant, and describe the rationale for selecting this agency as the lead.

- Demonstrate the qualifications and roles of key personnel including evaluation staff and the Project Director.

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

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

- Affirm a commitment to comply with reporting requirements, to attend one technical assistance meeting annually, to participate in technical assistance activities, and to cooperate and coordinate with SAMHSA's Co-Occurring Center for Excellence [see Section I-2.2, Program Requirements], and to participate in the cross-site evaluation, [see Section I-2.4 Evaluation].

- Describe your plan to ensure project sustainability when funding for this project ends. Also, describe how program continuity will be maintained when there is a change in the operational environment (e.g., staff turnover, change in project leadership) to ensure stability over time.

Section C: Data Collection/Evaluation (15 points)

- Describe your current capacity to collect data related to the infrastructure measures in Section I-2.3 above. Describe steps to be taken to enable the State/Tribe to comply fully with reporting requirements, and demonstrate the feasibility of implementing these steps.

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

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

NOTE: Although the budget for the proposed project is not a review criterion, the Review Group will be asked to comment on the appropriateness of the budget after the merits of the application have been considered. Please remember that Grantees in years 1-3 will receive up to $1.05 million per year. Grantees with service pilots will receive an amount up to half of the third year award in the 4th year to phase down the services pilot and up to $100,000 for evaluation in year 5. For example, if you receive $1.05 million in year 3, you can request up to $525,000 in Year 4. If you receive less than $1.05 million in year 3, then your year 4 request must be proportionately less. Grantees without service pilots will receive up to $100,000 per year for evaluation in years 4 and 5. The actual amount available for the awards may vary, depending on unanticipated program requirements and the number and quality of the applications received.

SUPPORTING DOCUMENTATION

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

Section E − Budget Justification, Existing Resources, Other Support. You must provide a narrative justification of the items included in your proposed budget, as well as a description of existing resources and other support you expect to receive for the proposed project. Be sure to show that no more than 20% of the total grant award will be used for data collection and evaluation, and no more than 50% of the grant will be used for services pilots, if applicable. An illustration of a budget and narrative justification is included in Appendix F of this document.

Section F − Biographical Sketches and Job Descriptions.

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

Section G − Confidentiality and Participant Protection Requirements: Applicants must describe procedures relating to Confidentiality, Participant Protection and the Protection of Human Subjects Regulations in Section G of the application, using the guidelines provided below.

Confidentiality and Participant Protection:

Because of the confidential nature of the work in which many SAMHSA grantees are involved, it is important to have safeguards protecting individuals from risks associated with their participation in SAMHSA projects. All applicants must address the seven bullets below. If some are not applicable or relevant to the proposed project, simply state that they are not applicable and indicate why. In addition to addressing these seven bullets, read the section that follows entitled Protection of Human Subjects Regulations to determine if the regulations may apply to your project. If so, you are required to describe the process you will follow for obtaining IRB approval. While we encourage you to keep your responses brief, there are no page limits for this section and no points will be assigned by the Review Committee. Problems with confidentiality, participant protection, and protection of human subjects identified during peer review of the application may result in the delay of funding.

1. Protect Clients and Staff from Potential Risks

   - Identify and describe any foreseeable physical, medical, psychological, social, and legal risks or potential adverse effects as a result of the project itself or any data collection activity.

   - Describe the procedures you will follow to minimize or protect participants against potential risks, **including risks to confidentiality**.

   - Identify plans to provide guidance and assistance in the event there are adverse effects to participants.

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

2. Fair Selection of Participants

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

   b. Explain the reasons for including groups of pregnant women, children, people with mental disabilities, people in institutions, prisoners, and individuals who are likely to be particularly vulnerable to HIV/AIDS.

   c. Explain the reasons for including or excluding participants.

   d. Explain how you will recruit and select participants. Identify who will select participants.

3. Absence of Coercion

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

- If you plan to compensate participants, state how participants will be awarded incentives (e.g., money, gifts, etc.).

- State how volunteer participants will be told that they may receive services intervention even if they do not participate in or complete the data collection component of the project.

4. Data Collection

- Identify from whom you will collect data (e.g., from participants themselves, family members, teachers, others). Describe the data collection procedures and specify the sources for obtaining data (e.g., school records, interviews, psychological assessments, questionnaires, observation, or other sources). Where data are to be collected through observational techniques, questionnaires, interviews, or other direct means, describe the data collection setting.

- Identify what type of specimens (e.g., urine, blood) will be used, if any. State if the material will be used just for evaluation or if other use(s) will be made. Also, if needed, describe how the material will be monitored to ensure the safety of participants.

- Provide in **Appendix 3, "Data Collection Instruments/Interview Protocols,"** copies of all available data collection instruments and interview protocols that you plan to use.

5. Privacy and Confidentiality

- Explain how you will ensure privacy and confidentiality. Include who will collect data and how it will be collected.

- Describe:

  - How you will use data collection instruments.
  - Where data will be stored.
  - Who will or will not have access to information.
  - How the identity of participants will be kept private, for example, through the use of a coding system on data records, limiting access to records, or storing identifiers separately from data.

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

6. Adequate Consent Procedures

- List what information will be given to people who participate in the project. Include the type and purpose of their participation. Identify the data that will be collected, how the data will be used and how you will keep the data private.

- State:

  - Whether or not their participation is voluntary.
  - Their right to leave the project at any time without problems.
  - Possible risks from participation in the project.
  - Plans to protect clients from these risks.

- Explain how you will get consent for youth, the elderly, people with limited reading skills, and people who do not use English as their first language.

NOTE: If the project poses potential physical, medical, psychological, legal, social or other risks, you **must** obtain written informed consent.

- Indicate if you will obtain informed consent from participants or assent from minors along with consent from their parents or legal guardians. Describe how the consent will be documented. For example: Will you read the consent forms? Will you ask prospective participants questions to be sure they understand the forms? Will you give them copies of what they sign?

- Include, as appropriate, sample consent forms that provide for: (1) informed consent for participation in service intervention; (2) informed consent for participation in the data collection component of the project; and (3) informed consent for the exchange (releasing or requesting) of confidential information. The sample forms must be included in **Appendix 2, "Sample Consent Forms,"** of your application. If needed, give English translations.

NOTE: Never imply that the participant waives or appears to waive any legal rights, may not end involvement with the project, or releases your project or its agents from liability for negligence.

- Describe if separate consents will be obtained for different stages or parts of the project. For example, will they be needed for both participant protection in treatment intervention and for the collection and use of data?

- Additionally, if other consents (e.g., consents to release information to others or gather information from others) will be used in your project, provide a description of the consents. Will individuals who do not consent to having individually identifiable data collected for evaluation purposes be allowed to participate in the project?

7. Risk/Benefit Discussion

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

Protection of Human Subjects Regulations

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

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

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

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

2. REVIEW AND SELECTION PROCESS

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

Only one award will be made per applicant entity (State, federally-recognized Tribe, tribal organization).

Decisions to fund are based on:

- The strengths and weaknesses of the application as identified by peer reviewers and, when appropriate, approved by the Center for Substance Abuse Treatment's National Advisory Council;

- Availability of funds; and

- Considerations to help achieve the COSIG goal of being a national program based on population, geographic, and service characteristics. To achieve this goal, SAMHSA may distribute awards to achieve balance among areas of the country, or with differing population, or urban/rural characteristics.

VI. AWARD ADMINISTRATION INFORMATION

1. AWARD NOTICES

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

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

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

2. ADMINISTRATIVE AND NATIONAL POLICY REQUIREMENTS

- Successful applicants must comply with all terms and conditions of the grant award. SAMHSA's standard terms and conditions are available on the SAMHSA web site at www.samhsa.gov/grants/generalinfo/grants_management.aspx.

- Successful applicants must also comply with the administrative requirements outlined in 45 CFR Part 74 or 45 CFR Part 92, as appropriate. For more information see the SAMHSA web site (http://www.samhsa.gov/Grants/generalinfo/grant_reqs.aspx).

- Depending on the nature of the specific funding opportunity and/or the proposed project as identified during review, additional terms and conditions may be negotiated with the grantee prior to grant award. These may include, for example:

  - actions required to be in compliance with confidentiality and participant protection/human subjects requirements;
  - requirements relating to additional data collection and reporting;
  - requirements relating to participation in a cross-site evaluation; or
  - requirements to address problems identified in review of the application.

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

in suspension or termination of the grant award, or in reduction or withholding of continuation awards.

- Grant funds cannot be used to supplant current funding of existing activities. "Supplant" is defined as replacing funding of a recipient's existing program with funds from a Federal grant.

- In an effort to improve access to funding opportunities for applicants, SAMHSA is participating in the U.S. Department of Health and Human Services "Survey on Ensuring Equal Opportunity for Applicants." This survey is included in the application kit for SAMHSA grants and is posted on the SAMHSA web site. Applicants are encouraged to complete the survey and return it, using the instructions provided on the survey form.

3. REPORTING REQUIREMENTS

3.1 Progress and Financial Reports

- Grantees must submit **quarterly** and **final progress reports**. Each report must include evaluation results and required co-occurring performance measures. The final report must summarize information from the quarterly reports and describe the accomplishments of the project and planned next steps for continuing to implement service delivery improvements after the grant period.

- Because SAMHSA is extremely interested in ensuring that infrastructure development and enhancement efforts can be sustained, your progress reports should explain plans to ensure the sustainability (see Glossary) of efforts initiated under this grant. Initial plans for sustainability should be described in year 1 of the grant.

- Grantees must provide **annual** and **final financial status reports**.

- SAMHSA will provide guidelines and requirements for these reports to grantees at the time of award and at the initial grantee orientation meeting after award. SAMHSA staff will use the information contained in the reports to determine the grantee's progress toward meeting its goals.

3.2 Publications

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

In addition, SAMHSA requests that grantees:

- Provide the GPO and SAMHSA Publications Clearance Officer with advance copies of publications.

- Include acknowledgment of the SAMHSA grant program as the source of funding for the project.

- Include a disclaimer stating that the views and opinions contained in the publication do not necessarily reflect those of SAMHSA or the U.S. Department of Health and Human Services, and should not be construed as such.

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

VII. AGENCY CONTACTS FOR ADDITIONAL INFORMATION

For questions about program issues, contact:

Edith Jungblut
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Room 5-1054
Rockville, Maryland 20857
(240) 276-2896
edith.jungblut@samhsa.hhs.gov

For questions on grants management issues, contact:

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

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

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

- ❑ Use the PHS 5161-1 application.

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

- ❑ Information provided must be sufficient for review.

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

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

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

To facilitate review of your application, follow these additional guidelines. Failure to adhere to the following guidelines will not, in itself, result in your application being screened out and returned without review. However, the information provided in your application must be

sufficient for review. Following these guidelines will help ensure your application is complete, and will help reviewers to consider your application.

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

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

- ❑ Applications should comply with the following requirements:

  - Provisions relating to confidentiality, participant protection and the protection of human subjects specified in Section V-1 of this announcement.
  - Budgetary limitations as specified in Section I, II, and IV-5 of this announcement.
  - Documentation of nonprofit status as required in the PHS 5161-1.

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

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

- ❑ The page limits for Appendices stated in the specific funding announcement should not be exceeded.

- ❑ Send the original application and two copies to the mailing address in Section IV-6.1 of this document. Please do not use staples, paper clips, and fasteners. Nothing should be attached, stapled, folded, or pasted. Do not use heavy or lightweight paper or any material that cannot be copied using automatic copying machines. Odd-sized and oversized attachments such as posters will not be copied or sent to reviewers. Do not include videotapes, audiotapes, or CD-ROMs.

Appendix B − Glossary

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

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

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

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

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

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

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

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

implementing the practice, and c) sufficient ongoing supervision for those implementing the practice.

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

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

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

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

Appendix C– Logic Model Resources

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

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

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

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

Julian, D.A. (l997). Utilization of the logic model as a system level planning and evaluation device. *Evaluation and Planning, 20*(3), 251-257.

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

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

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

Appendix D– Summary of Activities and Approaches of COSIG States Funded in 2003 and 2004

COSIG 2003 Grantees Comparison Matrix

COSIG	Alaska	Arkansas	Hawaii	Louisiana	Missouri	Pennsylvania	Texas
Screening and Assessment	▪ Goal – Universal Screening and Assessment ▪ Alaska Screening Tool developed	▪ Goal - to select valid and reliable screening and assessment instruments and implement statewide COD screening ▪ Structure - Screening and Assessment Protocol Committee ▪ Timeline-pilot implementation by Month 8 with full implementation at YR 2.	▪ Goal-identify screening and assessment measures to be used by contract providers ▪ Implementation guided by Project Task Force working with providers	▪ Goal-establish standard screening & assessment ▪ Implementation Structure-Coordinating Council using consultation	Goals I and II focus on developing, implementing standardized screening and assessments in pilot and then state-wide.	Project Plan: develop, pilot, and validate MISA Screening & Assessment Tool for children and adolescents (in one county)	▪ Web-based Behavioral Health Integrated Provider System (BHIPS) to assist with quadrant placement ▪ Existing screening measures selected State to require integrated screening and assessment (project plan: using CSAT tools)
Licensure and Credentialing	▪ Will develop credentialing standards ▪ Develop infrastructure changes to address barriers in clinical and program licensure using QI process.	▪ Plan: Licensing and credentialing requirements to be reviewed ▪ Currently, certification and licensing stds set by 2 agencies, with administration by state licensing boards	Plan: Cross system credentialing to be explored	Coordinating Council will develop a plan	Goal: Develop State-wide Coordinating Body with sub-committee on licensure and credentialing (currently, 2 State agencies share integrated program certification and fiscal sections).	▪ Goal: to develop additional credentialing process for Co-occurring services (current credentialing workgroup is in place and working on core competencies and exam). ▪ Goal: to have 50 facilities with dual licensure or credentialing	▪ Goal: to define 16 competencies for working with COPSD (COD) clients ▪ Goal: develop & implement a 45-hour web-based training curriculum with certification and competencies in screening, assessment and treatment for COD. ▪ Current licensure rules require integrated screening and assessment
PPG &	▪ AKAIMS	Goal: Implementation	PPG information to	PPG baseline data	▪ DMH Outcomes	▪ PPG data will be	• Integrate

COSIG	Alaska	Arkansas	Hawaii	Louisiana	Missouri	Pennsylvania	Texas
Evaluation	integrated MIS will facilitate PPG information gathering (Jan., 2004)	of statewide assessment (MO 6-9) will facilitate PPG data collection	be integrated into MIS system and/or submitted separately within 6-8 mo timeline	limited (with longer timeline for addressing PPG)	Web to be modified for full PPG collection; in interim, a Current Practices Survey will be used for first 6-8 months ▪ Evaluation: to test rural and urban implementation of protocol Evaluation: will compare agencies that contract with both ADA and CPS or only one	gathered from multiple systems.	performance measures and assessments into data collection systems • Evaluation: comparison of COPSD Specialist vs. COPSD system approaches to service integration
Systems Integration	▪ Create a Division of Behavioral Health by merging Divisions ▪ Create DBH Integration Steering Committee with Internal & External Integration Teams for implementation	▪ Recent merging of state agencies into Division of Behavioral Health (2 yr. Goal) ▪ Stakeholders Kick-off Conference planned ▪ Permanent Dual Diagnosis unit to be established at State level ▪ emphasis on CJ, homeless, primary care interface	▪ Goal: to establish a system-spanning Task Force ▪ Plans include meetings with multiple system stakeholders (emphasis on CJ collaboration)	▪ Goal: To establish a Coordinating Council with Regional Steering Committees	▪ Governor's Steering Committee to be established with targeted sub-committees ▪ MATTC to facilitate infrastructure development ▪ Goal: Revise administrative rules for standards of care in 4 quadrants	▪ Statewide COSSII Advisory Council to be developed ▪ One Pilot involves integration with CJ (Philadelphia service pilot focused on MISA population leaving local jails)	▪ COPSD (COD) Coordinator jointly funded and empowered by TCADA & TDMHMR ▪ State to propose minimum standards for assessing and serving COPSD
Services Integration	▪ Division of Behavioral Health (DBH) to oversee ▪ Goal: develop regional mechanisms for interagency care coordination	▪ Training includes awareness of treatment and service resources	▪ Services Pilot will have a ***Mobile Team*** for consultation, training, and services in rural and suburban communities.	Plan: To expand Louisiana Integrated Treatment Services (LITS) from one region to statewide	▪ Goal: use Services Pilot to implement integrated treatment for Quadrants II and III. ▪ State-wide Coordinating Body to address services coordination.	Project Pilot will expand MISA (COD) services in 6 counties including special populations (CJ/forensic, children & adolescents)	▪ Joint funding of specialized svs in 11 HHS regions and moving to COD system via RFA ▪ Jointly funded COPSD specialist position in place to provide COD services.

COSIG	Alaska	Arkansas	Hawaii	Louisiana	Missouri	Pennsylvania	Texas
	▪ Native Alaskan counselors included in plan ▪ Standards for care in each of 4 quadrants to be developed				▪ Goal: implement State Practice Guidelines (have been developed),		▪ Project Plan for COPSD System training ▪ State rules and contractual language prohibit exclusion from treatment
Financing	▪ Plan: to develop "consolidated grants" for program funding ▪ Plan: develop regulatory change using workgroups and consultants	Plan: explore changes to reimbursement policies	• Medicaid gap noted. • Poor reimbursement for Psychiatric services noted	▪ Plan: Coordinating Council committee to identify Medicaid funding opportunities ▪ LA Medicaid Authority has committed to providing funding for COD services	Plan: Promote the purchase of services between ADA and CPS providers, to include review and revision of billable service and administrative rules.	Plan: Reimbursement Project to review reimbursement mechanisms and provide recommendations of changes at State level.	▪ Plan: blending of MH and SA block grant ▪ Plan for voucher system to COPSD providers
Management and Information Systems	Plan: implement Alaska Automated Information and Management Systems (AKAIMS) (due FY 2004).	Data Coordinating Committee to be established	ECura system is being implemented for information management.	▪ Plan: Coordinating Council. committee to develop plan for MIS integration	Plan: to revise and expand existing DMH Outcomes Web	One combined database in development By OMHSAS and BDAP for Philadelphia. Plan to field test data integration model in Philadelphia County.	▪ Behavioral Health Integrated Provider System (BHIPS) is a web-based clinical client record-currently implemented TCADA and TDMHMR web-sites in place

COSIG 2004 Grantees Comparison Matrix

State	Screening and Assessment	Workforce Development/ Licensure and Credentialing	Evaluation	Systems Integration	Services Integration	Financing	Management and Information Systems	Pilot Project
Arizona	♦ Goal: Uniform Screening and Assessment process for COD in local and state Criminal Justice systems ♦ Pilot: implement assessment and services intervention for individuals with COD exiting correctional systems	♦ Implement multiple trng. Initiatives (e.g., Co-Occurring Cultural Competency Cross Training Institute) ♦ Workforce workgroup to oversee workforce outcomes ♦ Central coordination of training and TA requests ♦ Establish core competencies	♦ Process and outcome evaluation of Services Pilot and COSIG activities (ABHP)	♦Establish position of systems integration policy analysis in Governor's Office of CY&F ♦ AZ Policy Academy team (C-PAT) to provide policy coordination	♦ Implement service contract specifications across ADHS, ADC, ADJC, AOC to ensure "COD-informed" services ♦ Pilot project: use of inter-agency teams (ADC & RBHA)	♦ ADHS/DBHS contracts with 5 RBHAs, operating as managed behavioral health agencies to contract for all treatment services	♦ Plan: integrate information systems between CJ and behavioral health treatment systems and settings	♦ Design & Implement a pre- and post-release services intervention
New Mexico	♦ Goal – Universal screening and assessment in all major state behavioral health provider agencies ♦ Implementation Center to support activities	♦ Current legislation permits SA and MH counselors to receive licensure for COD screening, assessment and referral ♦ Plan: remove barriers to COD clinical competence	♦System, provider and client outcomes to be tied to CQI process	♦ Multi-Agency decision-making structure established: Interagency Collaborative led by DOH/BHSD to include CFYD, COD, Medicaid systems	♦ Collaborative to contract with statewide entity (SE) for delivery of COD services ♦ Implementation Center to provide supports, training and TA	♦ Plan: Develop contractual or reimbursement language in each funding stream requiring defined COD capability	♦ Plan: Develop data system for all agencies in Collaborative	♦ Focused clinical sites to receive more intensive support and evaluation of the implementation process

Oklahoma	♦ Goal-Develop, implement and evaluate a standard protocol for screening, assessment for clients in all State funded programs ♦ Pilot of protocol YR 1; train all providers subsequently	♦ Plan: All MH and SA providers to be trained in adopted S/A protocols and integrated system of care model ♦ Plan: Establish joint licensure, certification for MH and SA providers ♦ ODMHSAS (with licensure bodies) to review and modify requirements	♦ Current integrated MIS will facilitate all required data reporting ♦ Local eval.: Focus on implementation fidelity, process and outcome	♦ Focus on infra-structure development in Quadrants II and III	♦ Provide incentives for use of Integrated Tx. Model thru modifying contracting procedures (ODMHSAS)	♦ Plan: Modify contracting procedures to fund MH and SA providers. Funding rules to be reviewed and modified where legally permissible, to include SA tx, group counseling and case management for SA clients	♦ ODMHSAS operates an integrated MIS (ICIS) linking client and services info.	♦ Standardized S/A and integrated tx. Model to be implemented and evaluated in 2 urban and 1 rural setting-at specific MH and SA programs
Virginia	♦ Goal-establish statewide screening protocol for COD ♦ DMHMRSAS to modify performance contracts to mandate std. Screening ♦ Develop statewide protocol for assessment	♦ Conduct workforce survey to track clinician credentials ♦ Conduct 16 regional trainings on COD population and treatment techniques ♦ Create workgroup to address licensing and credentialing	♦ CCS (July, 2004) system to provide client level data ♦ Treatment outcomes, implementation and process measured in services pilot	♦ Plan: create interagency Advisory Council to develop strategic plan and provide oversight	♦ Services pilot to provide models for building capacity for adults and youth	♦ Plan: Create Finance workgroup to address all reimbursement mechanisms for COD services	♦ Plan: modify current MIS system: implement Community Consumer Submission (CCS) to capture data and track COD clients	♦ Services pilot at 11 CSB sites ♦ Pilot sites are serving adults and youth ♦ Includes expansion of crisis stabilization services

Appendix E - Text from State Directors' Conceptual Framework

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

The New York Model

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

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

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

The Revised Framework

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

- The revised framework is based on symptom multiplicity and severity, not on specific diagnoses, and uses language familiar to both mental health and substance abuse providers. As such, it encompasses the full range of people who have co- occurring substance abuse and mental health disorders. In addition, it points to windows of opportunity within which providers can act to prevent exacerbation of symptom severity.

- The framework permits discussion of co- occurring disorders along several dimensions, including symptom multiplicity and severity, locus of care, and degree of service coordination. It permits a number of key decisions to flow from it, including the level of service coordination required and the best use of available resources.

• The framework accommodates different levels of service coordination rather than specifying discrete service interventions. It represents a flexible approach that can be adopted or adapted for use in any service setting.

• The framework identifies two levels of service coordination–consultation and collaboration–that do not require fully integrated services. It points to the fact that individuals can be appropriately served with interventions that do not require full service integration. This is important for those service settings in which integration is not feasible or desirable, and for those individuals whose needs can be addressed with a minimum amount of system change.

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

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

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

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

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

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

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

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

Service Coordination by Severity

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

- Level I: **Consultation**. Those informal relationships among providers that ensure both mental illness and substance abuse problems are addressed, especially with regard to identification, engagement, prevention, and early intervention. An example of such consultation might include a telephone request for information or advice regarding the etiology and clinical course of depression in a person abusing alcohol or drugs.

- Levels II & III: **Collaboration**. Those more formal relationships among providers that ensure both mental illness and substance abuse problems are included in the treatment regimen. An example of such collaboration might include interagency staffing conferences where representatives of both substance abuse and mental health agencies specifically contribute to the design of a treatment program for individuals with co- occurring disorders and contribute to service delivery.

- Level IV: **Integrated Services**. Those relationships among mental health and substance abuse providers in which the contributions of professionals in both fields are merged into a single treatment setting and treatment regimen.

Putting the Pieces Together

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

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

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

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

Appendix F – Sample Budget and Justification

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

OBJECT CLASS CATEGORIES

Personnel

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

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

Fringe Benefits (24%) $15,360

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

Travel

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

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

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

Equipment (List Individually)

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

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

Supplies

Office Supplies	$500
Computer Software - 1 WordPerfect	500

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

Contractual Costs

Evaluation

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

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

Training

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

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

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

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

Other

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

Enter Other subtotal on 424A, Section B, 6.h.	**$ 1,500**
Total Direct Charges (sum of 6.a-6.h) **Enter Total Direct on 424A, Section B, 6.i.**	**$192,640**

Indirect Costs

15% of Salary and Wages (copy of negotiated indirect cost rate agreement attached)	
Enter Indirect subtotal of 424A, Section B, 6.j.	**$ 9,600**

TOTALS

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

JUSTIFICATION

PERSONNEL - Describe the role and responsibilities of each position.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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