

DEPARTMENT OF HEALTH AND HUMAN SERVICES

**Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment**

**Guidance for Applicants (GFA) No. TI 01-004
Part I - Programmatic Guidance**

**Cooperative Agreements for Strengthening Communities in the
Development of Comprehensive Drug and Alcohol
Treatment Systems for Youth**

Short Title: Strengthening Communities- Youth

Application Due Date:
May 21, 2001

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Table of Contents

[Note to Applicants: To prepare a complete application, PART II - “General Policies and Procedures Applicable to all SAMHSA Applications for Discretionary Grants and Cooperative Agreements” (February 1999), must be used in conjunction with this document, PART I - “Programmatic Guidance.”]

Action and Purpose	1
Target Population	1
Background	1
Who Can Apply	2
Applicant Characteristics	3
Application Kit	3
Where to Send the Application	3
Application Dates	4
How to Get Help	4
Developing Your Grant Application	4
Cooperative Agreement	8
Funding Criteria	9
Reporting/Evaluation Requirements	9
Post Award Requirements	11
Detailed Information on What to Include in your Application	11
Project Narrative –Sections A through D Highlighted	13
Confidentiality and SAMHSA Participant Protection (SPP)	16
Special Considerations and Requirements	19
Appendices:	
Appendix A - National Treatment Plan	20
Appendix B - CSAT’s GPRA Strategy	21
Appendix C - CSAT’s Core Client Outcomes	28

Agency

Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment

Action and Purpose

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) announces the availability of Fiscal Year 2001 funds for cooperative agreements to encourage communities to strengthen their drug and alcohol identification, referral and treatment systems for youth.

Approximately \$2.5 million will be available to fund 3 to 5 cooperative agreements. The average award is expected to range from \$500,000 to \$750,000 per year in total costs (direct and indirect). **Cooperative Agreements will be awarded for a period of up to 5 years.** Annual awards will be made subject to continued availability of funds to SAMHSA/CSAT and progress achieved by the grantee.

Target Population

Services must be directed to youth (i.e., individuals who are 21 years of age or younger) who are identified as experiencing substance abuse problems or who are determined to be at imminent risk of problem behavior related to substance abuse. Services may also be provided to the youth's

parents, legal guardians or significant adults in their lives.

Background

The treatment gap for youth is extremely high. Even with an increase from 1992 - 1997 of 33% in the number of youth admitted for treatment (Treatment Episode Data Set, Office of Applied Studies, Substance Abuse and Mental Health Services Administration) the most conservative estimates of the untreated population in need are four of every five youth (ages 12-18) in the Nation with a drug or alcohol problem. At these most conservative of estimates, there are over ½ million youth in the ages of 12-18 who are in need of substance abuse treatment, but do not receive any help for their problem. Moreover, the Treatment Episode Data Set indicates that most youth who receive treatment are referred from the juvenile justice system. Clearly, early and comprehensive intervention for youth is a major need throughout the Nation. It is important that expansion of services as well as increased knowledge throughout communities on where and how to successfully identify, refer and intervene with youth, are supported.

SAMHSA/CSAT released *Changing the Conversation: Improving Substance Abuse Treatment: The National Treatment Plan Initiative* (NTP) on November 28, 2000. This cooperative agreement addresses four of the NTP strategies.

C *Invest for Results.* Assists in closing serious gaps in treatment capacity for youth.

C *No Wrong Door To Treatment.* Promotes appropriate assessment, referral and treatment in all systems serving youth; provides access to the most appropriate type and level of substance abuse treatment in all systems individuals enter and become engaged; and applies a commonly accepted, evidence-based model for the continuum of services and care for substance abuse and dependence across health, human services, and justice systems as well as in the substance abuse speciality sector.

C *Commit to Quality.* Promotes wise use of resources that depends on ongoing improvement in the quality of care. This is accomplished through developing a system that promotes consistent communication and collaboration among service providers, academic institutions, researchers and other relevant stakeholders, while establishing incentives and assistance for programs and staff in applying new standards and treatment methods as they are identified and validated.

C *Build Partnerships.* Promotes linkages among agencies/organizations to bridge systems of care and services for youth and their families experiencing problems related to substance abuse.

For additional information about the NTP and how to obtain a copy, see Appendix A.

Who Can Apply

Public and domestic private non-profit entities such as units of State and local governments; Native Alaskan entities, Indian tribes and tribal organizations; and community-based organizations, including faith based organizations.

The applicant agency and all direct providers of substance abuse treatment services involved in the proposed system of care must be in compliance with all local, city, county and/or State licensing and/or accreditation/certification requirements.

Licensure/Accreditation/Certification documentation (or documentation supporting why the local/State government does not require Licensure/Accreditation/Certification) must be provided in **Appendix 1** of your application

The applicant agency, if providing substance abuse treatment services directly, and any direct providers of substance abuse treatment services involved in the proposed system of care, must have been providing substance abuse treatment services for a minimum of two years prior to the date of this application. A list of the substance abuse treatment providers and two-year experience documentation must be provided in **Appendix 1** of your application.

SAMHSA believes that only existing experienced providers have the infrastructure and expertise to provide services and to address emerging and unmet needs of youth and their families in a timely fashion, with state-of-the-art treatment interventions for this population.

Applications will be screened by SAMHSA prior

to review. Applications that do not meet eligibility requirements will not be reviewed.

Applicant Characteristics

SAMHSA/CSAT encourages applications submitted by organizations that demonstrate the following characteristics. We believe these characteristics increase the ability to perform the tasks in this program.

1. Are aware of the need for youth services and have made previous efforts to improve or expand services.
2. Have the commitment (as demonstrated by memoranda of agreement, letters of support, etc.) from key agencies (justice, substance abuse and mental health treatment systems, prevention programs, schools, health care entities, the faith community, etc.) to participate in this grant program.
3. Understand the prevalence of drug and alcohol problems among their youth population.
4. Possess adequate infrastructure of treatment options on which to build a coordinated and systematic approach to youth treatment within the constraints of the funding provided.
5. Have preliminary plans as to how they can continue expanded systems development and collaboration for treatment services at the end of the period of Federal funding.

6. Have demonstrated leadership in developing a community-based system of care for youth substance abuse treatment.

Application Kit

Application kits have several parts. The grant announcement (GFA) has 2 parts. Part I is individually tailored for each GFA. **This document is Part I.** Part II has general policies and procedures that apply to **all** SAMHSA grants and cooperative agreements. You will need to use both Parts I and II for your application.

The kit also includes the blank forms (SF-424 and PHS-5161) you will need to submit your application.

To get a complete application kit, including Parts I and II, you can:

- C Call the National Clearinghouse for Alcohol and Drug Information (NCADI) at 1-800-729-6686, or
- C Download from the SAMHSA site at www.SAMHSA.gov

Where to Send the Application

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

SAMHSA Programs
Center for Scientific Review
National Institutes of Health
Suite 1040

6701 Rockledge Drive MSC-7710
Bethesda, MD 20892-7710

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

Please note: 1) Use application form PHS
5161-1, and 2) type the following in Item
No. 10 on the face page of the application: TI
01-004, Strengthening Communities - Youth.

Application Dates

Your application must be received by May
21, 2001.

Applications received after May 21, 2001
will only be accepted if they have a proof-of-
mailing date from the carrier not later than
May 14.

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

Grant awards are expected to be made by
September 30, 2001.

How to Get Help

For questions on program issues, contact:

Randolph Muck, M.Ed.

CSAT/SAMHSA

Rockwall II, 7th Floor

5600 Fishers Lane

Rockville, MD 20857

(301) 443-6574

E-Mail: rmuck@samhsa.gov

**For questions on grants management
issues, contact:**

Kathleen Sample
Division of Grants Management
OPS/SAMHSA
Rockwall II, 6th floor
5600 Fishers Lane
Rockville, MD 20857
(301) 443-9667
E-Mail: ksample@samhsa.gov

Developing Your Grant Application

The goal of this cooperative agreement is to assist
communities (“community” is defined by the
applicant and may refer to an entire city, a section
of a large urban area, an entire Tribal Authority
or section of their jurisdiction, a rural area such as
a county, or a consortium of agencies in a
contiguous geographic area, etc.) in their efforts
to address drug and alcohol problems among
youth where there is a lack of a treatment system,
infrastructure, and continuum of care to
effectively intervene with the drug using youth
population. There are six mandatory objectives
that must be met as part of this cooperative
agreement:

1. To develop linkages and networking
mechanisms throughout the community (including
educational, juvenile justice, social services, and
other appropriate entities) to facilitate
identification, assessment, referral and treatment
of youth with substance abuse problems and their
families.

2. To increase substance abuse treatment
capacity, applying evidence-based and cost
effective methods, where gaps exist.
Treatment interventions shall be gender-specific
and culturally appropriate, involve work with the
families of youth receiving treatment, and have an

aftercare component.

3. To provide a continuum of treatment services for youth, to include early intervention and detection, referral, assessment, counseling, case management, and aftercare services for youth experiencing drug and alcohol problems, and their families.

4. To develop a Management Information System to facilitate the identification, referral, assessment, treatment, and tracking of youth through the continuum of care.

5. To address the relationship between substance abuse and violence throughout the continuum of care.

6. To develop and implement outreach activities that will educate the community (e.g., youth, parents, teachers, justice personnel, pediatricians and primary care physicians, the faith community, etc.) leading to earlier identification, referral, and treatment. Applicants are required to demonstrate familiarity with state-of-the-art science and practices in the areas of identification, referral and treatment for youth with substance abuse problems.

Applicants must include a detailed description of the methods and approaches that will be used to coordinate the identification, referral and treatment of youth with substance abuse problems consistent with the “Action and Purpose” section of this document.

SUGGESTED ACTIVITIES

Applicants may propose activities from the following list. These activities are related to the six objectives listed above.

C Substance abuse identification, referral and treatment services for youth with substance abuse problems or at imminent risk of development of substance abuse problems, including interventions for their families and other significant adults in their lives.

C Development of one or more comprehensive centralized units (which may include mobile units) for uniform identification, assessment, referral, and treatment for youth with substance abuse problems, and referral to other needed services (e.g., primary care, dental care, mental health treatment). These centralized units/operations should be under the purview of entities already engaged in services for youth (e.g., substance abuse treatment providers already serving youth and their families, a juvenile justice agency that is currently providing assessment and appropriate referral for youth identified with substance abuse problems, school based health centers, etc.).

C Training for treatment providers in state-of-the-art science and practice for provision of substance abuse and concomitant mental health services for youth and their families.

C Outreach to identify youth who might not normally be identified with substance abuse problems, (e.g., training for school personnel, the faith community, primary care physicians, mental health treatment professionals, youth recreational services, etc., in how to identify and where to refer youth for substance abuse treatment).

C Strengthening the collaboration among providers of services for youth with substance abuse and related mental health problems throughout the community (e.g., ongoing meetings with collaborating agencies, cross-training between agencies such as treatment and justice, etc.).

C Development of a network of providers of care for adolescents who are experiencing substance abuse problems (e.g., development of necessary infrastructure such as standardized assessment instruments, electronic communication, referral protocols, etc.).

C Development/adoption and maintenance of a Management Information System (MIS) that will facilitate collaboration and formation of a network of providers who can share appropriate information about youth for whom substance abuse services are being provided, and provide a mechanism for youth and their families to access information and services.

C Expansion of services to provide a fuller array of treatment and ancillary services for youth with substance abuse problems. Awardees are encouraged to explore co-location, where practical, of currently dispersed services.

Applicants should describe how the proposed project will be a comprehensive, coordinated, collaborative, creative and community-based response. Examples of

the agencies and activities that may be a part of the developed network include, but are not limited to:

C community focused educational and preventive efforts;

C school-based activities such as School Based Health Care programs or Student Assistance Programs;

C faith based organizations;

C Child Protective Services;

C support for homeless youth;

C health education and risk reduction information;

C access and referrals to STD and TB testing;

C substance abuse treatment;

C primary care;

C mental health services, either integrated, or linked with substance abuse treatment services; and

C the juvenile justice system.

While not all communities will be able to engage all of the aforementioned services and agencies (and some may have other agencies or activities important for accomplishing the goals of the cooperative agreement), the applicant should address in the narrative section of the application where gaps exist and how, through the course of the cooperative agreement, they will work toward a comprehensive network of agencies

and menu of services.

The applicant must also address the following in the Narrative Section:

- C the demographic characteristics of the youth in the self-defined “community;”
- C the need and current gaps in services in the local community;
- C the boundaries of the defined community and a rationale for this choice;
- C the prevalence of drug using youth and the major drugs of choice in the local community;
- C the age range proposed to be served and the rationale for the selected age range;
- C the gender, race and ethnic composition of the proposed youth population to be served and how this matches current demographic data of youth in the community; and
- C any inclusion or exclusion criteria that will be used for youth/family participation.

The applicant, as the lead agency for the cooperative agreement, must identify the role of the community participants in responding to the targeted intervention. Letters of coordination/support (outlining services to be provided, and level and intensity of resources committed) from participating and coordinating organizations should be included

in **Appendix 2.**

CSAT expects that applicants will be able to demonstrate that they have already initiated planning efforts in their communities to establish comprehensive, coordinated, systems of care for youth with substance abuse problems. The first year of the cooperative agreement is expected to be a continuation of the work begun prior to the application. It is expected that awardees may take up to one year to fully plan/develop this community-wide intervention to ensure successful implementation. The first year will also be a crucial period for the development/adoption of the MIS. CSAT staff will be involved throughout the first year to assist in the development of the proposed project.

CSAT has supported previous cooperative agreements that served similar goals for adult and juvenile justice populations. For more information on these previous grant programs, and to further understanding of this announcement see the following:

Scott K., R. Muck, and M. Foss. 2000. “The Impact of Centralized Intake on Access to Treatment and Satisfaction with Intake Procedures.” Pp. 131-150. in *Emergent Issues in the Field of Drug Abuse*, edited by J. Levy, R. Stephens, D. McBride, Stamford, Connecticut, JAI Press.

“Special Focus Section: The Target Cities Initiative, The Challenge of Managed Care in Drug Abuse Treatment.” Pp. 193-278. *Journal of Psychoactive Drugs*, edited by J. Guydish and R. Muck. 1999. Volume 31, Number 3, San Francisco, California.

“Executive Summary, Strategies for Integrating Substance Abuse Treatment and the Juvenile

Justice System: A Practice Guide.” 1999. Center for Substance Abuse Treatment. U.S. Department of Health and Human Services. Rockville, Maryland.

The latter publication, and limited copies of the first two, are available from the National Clearinghouse on Alcohol and Drug Abuse Information (NCADI) at 1-800-729-6686.

Cooperative Agreement

Because of the complexity of this program, and the anticipation of ongoing involvement of the Federal Government in the development of these community systems, this program will be administered as a cooperative agreement.

Role of Grantees:

Grantees are expected to participate in and cooperate fully with CSAT staff, its representative contractor(s) and other program grantees in the implementation and evaluation of the program. Activities include:

- C compliance with all aspects of the terms and conditions of the cooperative agreement (to be issued with the award);
- C adherence to SAMHSA’s need for information related to the Government Performance and Results Act (GPRA);
- C cooperation with CSAT staff and representative contractor(s) in accepting guidance and responding to requests for information and data

relevant to the program;

- C authorship or co-authorship of publications to make results of the projects available to the field; and
- C preparation of SAMHSA/CSAT required reports.

Role of Federal Staff:

It is the responsibility of the CSAT project officer to monitor the overall progress of the program.

The CSAT project officer will:

- C provide technical assistance to grantees in implementing project activities throughout the course of the project;
- C review and approve each stage of project activities;
- C provide guidance on project design and study components;
- C conduct site visits to monitor the development and implementation of programmatic activities and/or engage consultants to advise on programmatic issues and conduct site visits;
- C provide support services or outside consultants for training, evaluation and data collection activities;
- C author or co-author publications to disseminate program findings; and
- C provide technical assistance on strategies to enhance the dissemination and application of project findings.

Funding Criteria

Decisions to fund a cooperative agreement are based on:

1. The strengths and weaknesses of the application as judged by the peer review committee.
2. Concurrence of the National Advisory Council
3. Availability of funds.
4. Distribution of awards in terms of geographic distribution, including rural/urban areas.
5. Evidence of non-supplantation of funds. (Include in **Appendix 3**)

Reporting/Evaluation Requirements

The Government Performance and Results Act (GPRA) mandates increased accountability and performance-based management by Federal agencies. This has resulted in greater focus on results or outcomes in evaluating effectiveness of Federal activities, and in measuring progress toward achieving national goals and objectives.

Grantees are expected to comply with GPRA, including but not limited to, the collection of SAMHSA Core Client Outcomes. Applicants should state the procedures that they will put in place to ensure compliance with GPRA and the collection of CSAT GPRA Core Client Outcomes (see **Appendix C**). For a detailed description of CSAT's GPRA strategy, see **Appendix B**.

CSAT's standard outcome requirements are:

Older Youth (ages 18-21): Percent of service recipients who: have no past month substance abuse; have no or reduced alcohol or illegal drug consequences; are permanently housed in the community; are employed; have no or reduced involvement with the criminal justice system; and have good or improved health and mental health status.

Younger Youth (up to the age of 17): Percent of service recipients who: have no past month use of alcohol or illegal drugs; have no or reduced alcohol or illegal drug consequences; are in stable living environments; are attending school; have no or reduced involvement in the juvenile justice system; and have good or improved health and mental health status.

Local Evaluation

Strengthening Communities is a program designed to enhance the capabilities of communities to provide effective substance abuse treatment and related services; therefore, grantees must evaluate the extent to which they have provided effective services to the proposed population. The purpose of the local evaluation is to determine the effectiveness of the program in meeting its specific goals and objectives. The local evaluation must include but should not be

limited to GPRA requirements. Because different programs will differ in their target populations, services, systems linkages, and desired service outcomes, no single evaluation plan or design will apply to all applicants. Experimental or rigorous quasi-experimental evaluation designs are NOT required. In general, the applicant's local evaluation plan should include four major components:

- C Implementation fidelity, addressing 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 planned intervention and evaluation?
- C Process, addressing issues such as: *Who provided* (program, staff) *what services* (modality, type, intensity, duration) *to whom* (client characteristics) *in what context* (system, community, political climate) *at what cost* (facilities, personnel, dollars)?
- C Outcome, addressing issues such as: What was the effect of treatment on service participants? What program/contextual factors were associated with outcomes? What client factors were associated with outcomes? How durable were the effects?
- C GPRA requirements.

Further, the evaluation plan should attend to the appropriateness of the evaluation

approaches and instruments for the cultures, genders, and ages of your target population, and should include the integrated use of quantitative and qualitative data.

In tracking outcomes, the evaluation plan must address the following:

1. **Treatment Effectiveness, including indicators for:**

- C health status (physical and mental health);
- C self-sufficiency including employment, legal income, and public assistance status;
- C social support and functioning, including family and social relationships, living arrangements, and legal status; and
- C alcohol and drug use.

2. **Treatment Efficiency, including:**

- C identification;
- C engagement;
- C utilization;
- C retention; and
- C completion rates.

Applicants may obtain free downloads of variety of evaluation tools, developed by CSAT, that may be useful in developing an evaluation plan from:

<<http://neds.calib.com>>

The evaluation plan must describe the

approaches that will be used to collect and report these data to SAMHSA as part of the annual progress report. Data collection points will be at baseline/intake, 6-months, and 1-year follow-up (See Appendixes B and C). Applicants must agree to participate in all technical assistance and training activities designed to support this initiative and must budget for collection and provision of required data (see Appendixes B and C). CSAT will provide grantees with reporting formats that specify the minimum information required.

Post award support will be provided to grantees through the provision of clinical and programmatic technical assistance, assistance with data collection, reporting, analysis and publication, and assistance with evaluating the impact of expanded new services as well as the community-based strategic initiative.

CSAT will provide examples of one or more Management Information Systems (MIS) that can be modified and ported into the community for data collection, tracking and management of the project. Applicants should set aside a minimum of \$200,000 in the first year for MIS development/adoption. One or more web-enabled systems will be demonstrated that can be modified for local use, in line with the dollars available in this cooperative agreement. Should a community decide to augment an existing MIS or build a new MIS then they must show how this can be done within the existing budget and still meet the required objectives.

Post Award Requirements

Grantees will be required to attend (and, thus must budget for) two technical assistance meetings in the first year of the cooperative agreement, and two meetings in each of the remaining years. A minimum of three persons (Program Director, Program Evaluator, and MIS Manager) are expected to attend. These meetings are expected to be held in the Washington, DC, area. These meetings will be 2 ½ days in duration.

Grantees will be responsible for ensuring that all direct providers of services involved in the proposed system are in compliance with all local, city, county, and/or State licensing, certification, or accreditation requirements.

DETAILED INFORMATION ON WHAT TO INCLUDE IN YOUR APPLICATION

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

1. FACE PAGE

Use Standard Form 424. See Appendix A in **Part II** for instructions. In signing the face page of the application, you are agreeing that the information is accurate and complete.

2. ABSTRACT

Your total abstract may not be longer 35 lines.

In the first 5 lines or less of your abstract, write a summary of your project that can be used in publications, reporting to Congress, or press releases, if funded.

' **3. TABLE OF CONTENTS**

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

' **4. BUDGET FORM**

Standard Form 424A. See Appendix B in **Part II** for instructions. (Note: How to estimate an indirect cost rate is discussed in Appendix B.)

' **5. PROJECT NARRATIVE AND SUPPORT DOCUMENTATION**

The project narrative is made up of Sections A through D. More detailed information regarding A-D follows #10 of this checklist. Sections A-D may not be longer than 25 pages.

— **Section A - Project Narrative:**
Project Description/Justification of Need

— **Section B - Project Narrative:**
Project Plan

— **Section C - Project Narrative:**
Evaluation/Methodology

— **Section D - Project Narrative:**
Project Management: Implementation Plan, Organization, Staff, Equipment/Facilities, and Other Support

The supporting documentation for your application is made up of the following sections E through H. There are no page limits for the Supporting Documentation sections, except for Section G, the Biographical Sketches/Job Descriptions.

— **Section E- Supporting Documentation:**
Literature citations

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

— **Section F - Supporting Documentation:**
Itemized description of expenditures, existing resources, other support

Follow instructions in Appendix B, **Part II**. Fill out sections B, C, and E of the Standard Form 424A.

— **Section G - Supporting Documentation:**
Biographical sketches and job descriptions

C Include a biographical sketch for the project director and for other key positions. Each sketch should not be longer than **2 pages**. If the person has not been hired, but has been identified, include a letter of commitment and sketch of the individual.

C Include job descriptions for key personnel. They should not be longer than **1 page**.

[Note: Sample sketches and job descriptions are listed in Item 6 in the Program Narrative section of the PHS 5161-1.]

— **Section H - Supporting Documentation:**
Confidentiality and SAMHSA

*Participant Protection
(SPP)*

The seven areas you need to address in this section are outlined after the Project Narrative description in this document.

' **6. APPENDICES 1 THROUGH 6**

- C Use only the appendices listed below.
- C Don't** use appendices to extend or replace any of the sections of the Program Narrative.
- C **Don't** use more than **30 pages** (plus all instruments) for the appendices.

Appendix 1:

Certification of two years of experience and Licensure/Accreditation documentation.

Appendix 2:

Letters of Coordination/Support

Appendix 3:

Non-supplantation of Funds Letter

Appendix 4:

Letters to Single State Agencies

Appendix 5: Data Collection

Instruments/Interview Protocols

Appendix 6:

Sample Consent Forms

' **7. ASSURANCES**

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

' **8. CERTIFICATIONS**

' **9. DISCLOSURE OF LOBBYING ACTIVITIES**

Please see **Part II** for lobbying prohibitions.

' **10. CHECKLIST**

See Appendix C in **Part II** for instructions.

Project Narrative – Sections A Through D Highlighted

Your application consists of sections A through H. Sections A through D, the project narrative parts of your application, describe what you intend to do with your project. Below you will find detailed information on how to respond to sections A through D.

/ **Sections A though D may not be longer than 25 pages.**

/ **A peer review committee will assign a point value to your application based on how well you address these sections.**

/ In the description below, the number of points after each section heading shows the maximum points a review committee may assign. For example, a perfect score for Section A will result in a rating of 20 points.

/ Reviewers will be instructed to review

and evaluate each relevant criterion in relation to cultural competence. Points will be deducted from applications that do not adequately address the cultural aspects of the criteria. See Appendix D in Part II for guidelines for applicants and peer reviewers that will be used to assess cultural competence.

C Describe the demographic characteristics of the youth in the community.

C Describe the geographic boundaries of the community and a rationale for this choice.

C Describe the age range proposed to be served and the rationale for the selected age range.

C Describe the gender, race and ethnic composition of the proposed youth population to be served and how this matches current demographic data of youth in the community.

C Describe the prevalence of drug using youth and the major drugs of choice in the local community

***Section A:
Project Description and Justification of
Need (20 points)***

' Describe the nature of the local problem, current gaps in services and extent of the need including the inability to respond to the needs within the existing treatment resources. [Documentation may come from a variety of qualitative and quantitative sources. The quantitative data could come from locally generated data or trend analyses, from State data such as that available through State Needs Assessments, and/or through national data such as that available from the National Household Survey on Drug Abuse (NHSDA), the Drug Abuse Warning Network (DAWN), the Drug and Alcohol Services Information System (DASIS), or the Treatment Episode Data Set (TEDS)].

' Define the target population and provide justification for any exclusions under SAMHSA's Population Inclusion Requirement (**see Part II**).

' Describe the current infrastructure of treatment options on which will be built a coordinated and systematic approach to youth treatment.

' Describe previous leadership roles in the community and previous efforts to plan and implement improved and expanded services for youth.

***Section B:
Project Plan (40 points)***

' Clearly state the purpose of the proposed project, and how it will meet the six

mandatory objectives outlined in the “Developing Your Grant Application” section of this document. Describe how achievement of goals will support meaningful and relevant results that coordinate and improve services and expand capacity.

- ‘ Describe and justify the system and continuum of care design chosen for the proposed project.
- ‘ Describe the development of the coordination of needed services, to include all providers to be involved and how outreach, identification, assessment, referral, and treatment will be integrated and/or linked. Attach letters of support/memoranda of agreement from participating agencies in **Appendix 2**.
- ‘ For all services to be provided in the community continuum of care, document that they demonstrate best practices based on research and clinical literature or successful outcomes based on local outcome data. This explanation should include data on current capacity, average length of treatment, retention rates, and outcomes. It should also address age, race/ethnic, cultural, language, sexual orientation, disability, literacy and gender issues and how the treatment component will handle these issues relative to the target population.

- ‘ Describe how information will be coordinated and youth tracked through the treatment process.
- ‘ Provide a description of current outreach and referral methods, and proposed changes to current procedures.
- ‘ If, and ONLY if, the applicant proposes a MIS other than adoption of a system already within the public domain (see Reporting/Evaluation Requirements section) provide specific details on current and proposed Management Information Systems and their compatibility for communication across sites and agencies, along with a timetable and budget for implementation.
- ‘ Describe how the treatment component will be embedded within the existing community-based response to substance abuse problems. This should include what roles other community organizations will have in the overall, coordinated effort.

***Section C:
Evaluation/Methodology (15 points)***

- ‘ Provide quantitative goals and objectives for the treatment services in terms of the numbers of individuals to be served, types and numbers of services to be provided, and outcomes to be achieved.
- ‘ Describe how the targeted population will be identified, referred, engaged, and retained in treatment.
- ‘ Present a plan for collecting, analyzing,

and reporting the information required to document that the grantee's goals and objectives have been reached. This should include a description of the community's existing approach to the collection of client, service use, and outcome data and how that will be modified to meet the requirements described in this GFA.

- ' Describe the local evaluation plan per the 4 major components in the "Reporting/Evaluation Requirements" section of this document.
- ' Discuss the extent to which the program can supply necessary GPRA data for information on implementation and validity of results.

**Section D:
Project Management: Implementation Plan, Organization, Staff, Equipment/Facilities, and Other Support (25 points)**

- ' Present a realistic management plan for the project that describes the organizations that will be involved in the project; present their roles in the project; and address their relevant experience.
- ' Describe time lines for implementing the project.
- ' Discuss the capability and experience

of the applicant organization with similar projects and populations.

- ' Discuss linkages/collaborations with other organizations and their roles in the project. Clearly identify those organizations that have agreed to a particular level of collaboration/support, and provide a plan for bringing other key services/organizations into the project.
- ' Provide a staffing plan, including the level of effort and qualifications of the Project Director and other key personnel.
- ' Provide an organizational chart exhibiting the staff positions related to the project and their relationships to each other.
- ' Describe the resources available (e.g., facilities, equipment), and provide evidence that services will be provided in a location/facility that is adequate and accessible and that the environment is conducive to the target population.
- ' Show evidence of the appropriateness of the proposed staff to the language, age, gender, sexual orientation, disability, and ethnic/racial/cultural factors of the target population.
- ' Provide evidence that required resources not included in this Federal budget request are adequate and accessible.
- ' Provide a preliminary plan to secure resources or obtain support to continue expanded systems development and collaboration at the end of the period of Federal funding.

NOTE: Although the budget for the proposed project is not a review criterion, the Review Group will be asked to comment on the budget after the merits of the application have been considered.

Confidentiality and SAMHSA Participant Protection (SPP)

You must address 7 areas regarding confidentiality and participant protection in your supporting documentation. (**Note: Part II provides additional information re confidentiality.**) There are no page limitations, and no points will be assigned to this section.

This information will:

- / Reveal if the protection of participants is adequate or if more protection is needed.
- / Be considered when making funding decisions.

Some projects may expose people to risks in many different ways. In this section of your support documentation you will need to:

- C Report any possible risks for people in your project.
- C State how you plan to protect them from those risks.
- C Discuss how each type of risk will be dealt with, or why it does not apply to the project.

The following 7 issues must be discussed:

- Ø Protect Clients and Staff from Potential Risks:
- C Identify and describe any foreseeable physical, medical, psychological, social, legal, or other risks or adverse effects.
- C Discuss risks which are due either to participation in the project itself, or to the evaluation activities.
- C Describe the procedures that will be followed to minimize or protect participants against potential health or confidentiality risks. Make sure to list potential risks in addition to any confidentiality issues.
- C Give plans to provide help if there are adverse effects to participants, if needed in the project.
- C Where appropriate, describe alternative treatments and procedures that might be beneficial to the subjects.
- C Offer reasons if you do not decide to use other beneficial treatments.
- Ù Fair Selection of Participants:
- C Describe the target population(s) for the proposed project. Include age, gender, racial/ethnic background. Address other important factors such as homeless youth, foster children, children of substance abusers, or other special population groups.
- C Explain the reasons for including/excluding special types of

participants, such as pregnant teens, institutionalized youth, mentally or physically disabled youth, incarcerated youth, or others who are likely to be vulnerable.

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

U Absence of Coercion:

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

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

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

U Data Collection:

C Identify from whom you will collect data. For example, participants themselves, family members, teachers, others. Explain how you will collect data and list the site. For example, will you use school records, interviews, psychological assessments, observation, questionnaires, or other sources?

C Identify what type of specimens (e.g., urine, blood) will be used, if any.

State if the material will be used just for evaluation and research or if other use will be made. Also, if needed, describe how the material will be monitored to ensure the safety of participants.

C Provide in **Appendix No. 5**, "Data Collection Instruments/Interview Protocols," copies of all available data collection instruments and interview protocols that you plan to use.

U Privacy and Confidentiality:

C List how you will ensure privacy and confidentiality. Include who will collect data and how it will be collected.

C 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.

Y Adequate Consent Procedures:

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

- C State:
- If their participation is voluntary
 - Their right to leave the project at any time without problems
 - Risks from the project
 - Plans to protect clients from these risks.

- C Explain how you will get consent for youth in general, and youth and/or guardians with limited reading skills, and youth and/or guardians who do not use English as their first language.

Note: If the project poses potential physical, medical, psychological, legal, social, or other risks, you should get written informed consent.

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

- C Include sample consent forms in your **Appendix 6**, titled "Sample Consent Forms." If needed, give English translations.

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

- C Describe if separate consents will be obtained for different stages or parts of the project. For example, will they be needed for both the treatment intervention and for the collection of data. Will individuals who do not consent to having individually identifiable data collected for evaluation purposes be allowed to participate in the project?

P Risk/Benefit Discussion:

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

Special Considerations and Requirements

SAMHSA's policies and special considerations and requirements can be found in **Part II** in the sections by the same names. The policies, special considerations, and requirements related to this program are:

- C Population Inclusion Requirement;
- C Government Performance Monitoring;
- C Healthy People 2010 (the Healthy People 2010 focus areas related to this program are in Chapter 26: Substance Abuse);

- C Consumer Bill of Rights;
- C Promoting Nonuse of Tobacco;
- C Supplantation of Existing Funds
(include documentation in **Appendix 3**);
- C Letter of Intent;
- C Single State Agency Coordination
(include documentation in **Appendix 4**);
- C Intergovernmental Review;
- C Public Health System Reporting
Requirements; and
- C Confidentiality/SAMHSA Participant
Protection.

APPENDIX A

NATIONAL TREATMENT PLAN

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) initiated *Changing the Conversation: Improving Substance Abuse Treatment: The National Treatment Plan Initiative* (NTP) to build on recent advances in the field, to bring together the best ideas about improving treatment, and to identify action recommendations that could translate ideas into practice.

The NTP combines the recommendations of five Expert Panels, with input from six public hearings and solicitation of experience and ideas through written and online comments, into a five-point strategy: (1) Invest for Results; (2) No Wrong Door to Treatment; (3) Commit to Quality; (4) Change Attitudes; and

(5) Build Partnerships. The recommendations represent the collective vision of the participants in the NTP “conversation” over the past year. The goal of these recommendations is to ensure that an individual needing treatment—regardless of the door or system through which he or she enters—will be identified and assessed and will receive treatment either directly or through appropriate referral. Systems must make every door the right door.

The NTP is a document for the entire substance abuse treatment field, not just CSAT. Implementing the NTP’s recommendations go beyond CSAT or the Federal Government and will require commitments of energy and resources by a broad range of partners including State and local governments, providers, persons in recovery, foundations, researchers, the academic community, etc.

Copies of the NTP may be downloaded from the SAMHSA web site—www.samhsa.gov (click on CSAT and then on NTP) or from the National Clearinghouse for Alcohol and Drug Information (NCADI) at 1-800-729-6686.

APPENDIX B

CSAT's GPRA STRATEGY

OVERVIEW

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

DEFINITIONS

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

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

CENTER (OR MISSION) GPRA OUTCOMES

The mission of the Center for Substance Abuse Treatment is to support and improve the effectiveness and efficiency of substance abuse treatment services throughout the United States. However, it is not the only agency in the Federal government that has substance abuse treatment as part of its mission. The Health Care Financing Administration, Department of Veterans Affairs, and the Department of Justice all provide considerable support to substance abuse treatment. It shares with these agencies responsibility for achieving the objectives and targets for Goal 3 of the Office of National Drug Control Policy's Performance Measures of Effectiveness:

Reduce the Health and Social Costs Associated with Drug Use.

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

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

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

activities is to be developed that will provide the basis for establishing targets and reporting performance. While some preliminary discussions have been held, at this time there are no agreed upon performance measures or methods for collecting and analyzing the data.³ In the following sections, CSAT's performance monitoring plans for each of the programmatic areas are presented. It should be understood that they are subject to change as the OA and other Centers enter into discussion and negotiate final measures. In addition, at the end of the document, a preliminary plan for the use of evaluation in conjunction with performance monitoring is presented for discussion purposes.

1. ASSURE SERVICES AVAILABILITY

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

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

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

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

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

2. MEET UNMET OR EMERGING NEEDS

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

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

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

- ! Percent of adults receiving services increased who:
 - a) were currently employed or engaged in productive activities
 - b) had a permanent place to live in the community
 - c) had reduced involvement with the criminal justice system
 - d) had no past month use of illegal drugs or misuse of prescription drugs
 - e) experienced reduced alcohol or illegal drug related health, behavior, or social consequences, including the misuse of prescription drugs

- ! Percent of children/adolescents under age 18 receiving services who:
 - a) were attending school
 - b) were residing in a stable living environment
 - c) had no involvement in the juvenile justice system
 - d) had no past month use of alcohol or illegal drugs
 - e) experienced reduced substance abuse related health, behavior, or social consequences.

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

3. BRIDGE THE GAP BETWEEN RESEARCH AND PRACTICE

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

the impact of managed care on substance abuse treatment, and the persistence of treatment effects. In FY1999, a general program announcement to support knowledge development activity will be added to the CSAT portfolio.

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

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

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

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

3.1 PROMOTE THE ADOPTION OF BEST PRACTICES

This “program” involves promoting the adoption of best practices and is synonymous currently with Knowledge Application.⁵ Within CSAT, these activities currently include the Product

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

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

Development and Targeted Dissemination contract (to include TIPS, TAPS, CSAT by Fax, and Substance Abuse in Brief), the Addiction Technology Transfer Centers, and the National Leadership Institute. In FY1999, the Community Action Grant program will be added and in FY2000, the Implementing Best Practices Grant program will be added.

Activities in this program have the purpose of moving “best practices”, as determined by research and other knowledge development activities, into routine use in the treatment system. Again simplistically, the immediate success of these activities can be measured by the extent to which they result in the adoption of a “best practice.”⁶ In order to provide appropriate GPRA measures in this area, CSAT plans to require that all activities that contribute to this goal to collect information on the numbers and types of services rendered, the receipt of the service by the clients and their satisfaction with the services, and whether the services resulted in the adoption of a best practice related to the service rendered.

4. ENHANCE SERVICE SYSTEM PERFORMANCE

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

EVALUATIONS

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

To date, CSAT has not developed any evaluations explicitly within the GPRA framework. The

System Performance,” below).

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

initial requirements will, of necessity, involve examinations of the reliability and validity of the performance measures developed in each of the four program areas. At the same time, it is expected that CSAT managers will begin to ask questions about the meaning of the performance monitoring data as they begin to come in and be analyzed and reported. This will provide the opportunity to design and conduct evaluations that are tied to “real” management questions and, therefore, of greater potential usefulness to CSAT. CSAT will be developing a GPRA support contract that permits CSAT to respond flexibly to these situations as they arise.

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

APPENDIX C

CSAT's Core Client Outcome Measures for Discretionary Programs

Public reporting burden for this collection of information is estimated to average 20 minutes per response if all items are asked of a client; to the extent that providers already obtain much of this information as part of their ongoing client intake or followup, less time will be required. Send comments regarding this burden estimate or any other aspect of this collection of information to SAMHSA Reports Clearance Officer, Room 16-105, 5600 Fishers Lane, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The control number for this project is 0930-0208.

- h. Inhalants, poppers, rush, whippets |____|____|
- i. Other Illegal Drugs--Specify_____ |____|____|

3. In the past 30 days have you injected drugs? Yes No

C. FAMILY AND LIVING CONDITIONS

- 1. In the past 30 days, where have you been living most of the time?**
- Shelter (Safe havens, TLC, low demand facilities, reception centers, Other temporary day or evening facility)
 - Street/outdoors (sidewalk, doorway, park, public or abandoned building)
 - Institution (hospital., nursing home, jail/prison)
 - Housed (Own, or someone else's apartment, room, house halfway house, residential treatment)
- 2. During the past 30 days how stressful have things been for you because of your use of alcohol or other drugs?**
- Not at all
 - Somewhat
 - Considerably
 - Extremely
- 3. During the past 30 days has your use of alcohol or other drugs caused you to reduce or give up important activities?**
- Not at all
 - Somewhat
 - Considerably
 - Extremely
- 4. During the past 30 days has your use of alcohol and other drugs caused you to have emotional problems?**
- Not at all
 - Somewhat
 - Considerably
 - Extremely

D. EDUCATION, EMPLOYMENT, AND INCOME

- 1. Are you currently enrolled in school or a job training program? [IF ENROLLED: Is that full time or part time?]**
- Not enrolled
 - Enrolled, full time
 - Enrolled, part time

Other (specify) _____

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

|__|__| level in years

2a. **If less than 12 years of education, do you have a GED (Graduate Equivalent Diploma)?**

- Yes No

3. **Are you currently employed?** [Clarify by focusing on status during most of the previous week, determining whether client worked at all or had a regular job but was off work]

- Employed full time (35+ hours per week, or would have been)
- Employed part time
- Unemployed, looking for work
- Unemployed, disabled
- Unemployed, Volunteer work
- Unemployed, Retired
- Other Specify _____

4. **Approximately, how much money did YOU receive (pre-tax individual income) in the past 30 days from...**

		INCOME							
a. Wages	\$,				.00
b. Public assistance	\$,				.00
c. Retirement	\$,				.00
d. Disability	\$,				.00
e. Non-legal income	\$,				.00
f. Other _____ (Specify)	\$,				.00



E. CRIME AND CRIMINAL JUSTICE STATUS

- 1. **In the past 30 days, how many times have you been arrested?** |__|__| times
- 2. **In the past 30 days, how many times have you been arrested for drug-related offenses?** |__|__| times
- 3. **In the past 30 days, how many nights have you spent in jail/prison?** |__|__| nights

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT

1. How would you rate your overall health right now?

- Excellent
- Very good
- Good
- Fair
- Poor

2. During the past 30 days, did you receive

a. Inpatient Treatment for:

	No	Yes ±	If yes, altogether for how many nights (DK=98)
i. Physical complaint	<input type="radio"/>	<input type="radio"/>	_____
ii. Mental or emotional difficulties	<input type="radio"/>	<input type="radio"/>	_____
iii. Alcohol or substance abuse	<input type="radio"/>	<input type="radio"/>	_____

b. Outpatient Treatment for:

	No	Yes ±	If yes, altogether how many times (DK=98)
i. Physical complaint	<input type="radio"/>	<input type="radio"/>	_____
ii. Mental or emotional difficulties	<input type="radio"/>	<input type="radio"/>	_____
iii. Alcohol or substance abuse	<input type="radio"/>	<input type="radio"/>	_____

c. Emergency Room Treatment for:

	No	Yes ±	If yes, altogether for how many times (DK=98)
i. Physical complaint	<input type="radio"/>	<input type="radio"/>	_____
ii. Mental or emotional difficulties	<input type="radio"/>	<input type="radio"/>	_____
iii. Alcohol or substance abuse	<input type="radio"/>	<input type="radio"/>	_____

H. DEMOGRAPHICS (ASKED ONLY AT BASELINE)

1. Gender

- Male
- Female
- Other (please specify) _____

2. Are you Hispanic or Latino?

- Yes
- No

3. What is your race?

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

4. What is your date of birth?

|_|_|_|_| / |_|_|_|_|_| / |_|_|_|_|_|
Month / Day / Year