

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

**Guidance for Applicants (GFA) No. TI 02-002
Part I - Programmatic Guidance**

**Recovery Community Organization Development
and Community Mobilization Program**

Short Title: Recovery Community Support Program (RCSP)

Application Due Date: January 10, 2002

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Date of Issuance: November 2001

Catalog of Federal Domestic Assistance (CFDA): 93.230

Authority: Section 509 of the Public Health Service Act, as amended, and subject to the availability of funds*

*This program is being announced prior to the full annual appropriation for fiscal year (FY) 2002 for the Substance Abuse and Mental Health Services Administration's (SAMHSA) programs. Applications are invited based on the assumption that sufficient funds will be appropriated for FY 2002 to permit funding of a reasonable number of applications being hereby solicited. All applicants are reminded, however, that we cannot guarantee sufficient funds will be appropriated to permit SAMHSA to fund any applications. Questions regarding the status of the appropriation of funds should be directed to the Program Officer listed under "How to Get Help" in this announcement.

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

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Agency

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

Action

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) announces the availability of Fiscal Year 2002 funds for grants to foster the participation of people in recovery, their family members, and other allies (*the recovery community*) in the public dialogue about addiction, treatment, and recovery, and to build their capacity to identify, develop, and support treatment and recovery policies, systems, and services that meet their needs as they define them.

Applications for two separate Tracks will be funded under this Guidance for Applicants (GFA).

Track I solicits applications for new recovery community organizing initiatives from: (a) **recovery community organizations (RCOs)**, which are organizations comprised of and led by recovery community members; or (b) **facilitating organizations**, which though themselves not necessarily comprised of recovery community members, will either enable the formation of an independent RCO or will develop some other organizational structure within which to carry out recovery community organizing.

Track II is designed to enable existing organizations that have demonstrated their capacity in recovery community organizing to: (a) **expand or intensify** their current program (e.g., an existing project might add new program components, or significantly increase its membership by focusing on a new segment of the recovery community; a county-wide project might expand to several counties or to the State level; a State-wide project might expand regionally; or a State-wide or regional project might retain its original organizing locus but expand into new areas, such as resident or neighboring counties or local communities that were not included in the original effort); or (b) **replicate** their promising program model in another setting (e.g., an approach or model implemented with one cultural group might be replicated with a different population; or a model implemented in a particular type of setting, such as public housing or a community multi-service center, might be implemented in one or more similar settings, either in the same geographical area or in a different one).

Approximately \$900,000 will be available to fund approximately 4-5 grants in Track I. The award for a Track I grant is expected to range from \$175,000 to \$200,000 per year in total costs (direct and indirect). **Track I grants will be awarded for a period of up to 5 years.**

Approximately \$1,100,000 will be available to fund approximately 4 grants in Track II. The award for a Track II grant is expected to range from \$225,000 to \$275,000 per year in total costs (direct and indirect), depending on the complexity and scope of the expansion/intensification or replication. **Track II grants will be awarded for a period**

of up to 3 years .

(Note: A longer grant period is provided for Track I than for Track II because past experience indicates that the many tasks involved in getting an initiative up and running, recruiting and engaging members, developing an organizational structure, providing capacity-building and leadership training, developing and implementing activities, and preparing a case study [Track I] necessitate a longer period than required for an established program to expand, intensify, or replicate their efforts [Track II].)

Annual awards will be subject to continued availability of funds to SAMHSA/CSAT and progress achieved by the grantee.

PURPOSE

As has been specified in SAMHSA's appropriations acts for several years, **Federal funds may not be used for lobbying.**

Federal law prohibits grantees from using Federal funds under this program for lobbying activities to influence legislation or appropriations pending before Congress or any State legislature. This prohibition includes directly lobbying Congress or State legislators on such matters or "grassroots" lobbying, which consists of appeals to members of the public suggesting that they contact their elected representatives to indicate support for or opposition to pending legislation, or to urge those representatives to vote in a particular way.

Federal cost principles prohibit lobbying. For example, OMB Circular A-122 sets out activities that are unallowable under grants with respect to lobbying, including (but not limited to) any attempts to influence any Federal or State legislation or any "grassroots" lobbying to do so by urging members of the general public or any segment thereof to contribute to or participate in any mass demonstration, march, rally, fund-raising drive, lobbying campaign, or letter-writing or telephone campaign.

In keeping with the law and policies, this program will not permit *lobbying* activities of any kind to be charged to grant funds.

Based on past experience, CSAT believes that successful projects usually include a combination of the following organizing activities:

- # encouraging and facilitating participation by people in recovery and their family members in the planning, design, delivery, and evaluation of addiction treatment and recovery policies, systems, and services at the local, State, regional, and national levels;
- # promoting linkages among recovery community members, and between the recovery community and service delivery systems;
- # developing and conducting public education to help reduce the stigma associated with addiction, treatment, and recovery.

Funded projects must

- # document promising approaches in recovery community organizing that can be shared with others attempting similar

efforts throughout the Nation.

This is a reissuance, with modifications, of SAMHSA/CSAT's Fiscal Year 2001 Guidance for Applicants, No. TI 01-003 (*Recovery Community Organization Development and Community Mobilization Program*; Short Title: *Recovery Community Support Program*).

SAMHSA/CSAT released *Changing the Conversation: Improving Substance Abuse Treatment: The National Treatment Plan Initiative (NTP)* on November 28, 2000. This grant program addresses several of the NTP strategies, specifically: Number 3, *Commit to Quality*, by helping to promote communication and collaboration between and among the recovery community and providers, academic institutions, researchers, and other relevant stakeholders in treatment systems; Number 4, *Change Attitudes*, by engaging the recovery community in the public debate and the decision-making process concerning alcohol and drug dependence and addiction, as well as by supporting recovery community members in developing and implementing specific anti-stigma activities and products; and Number 5, *Build Partnerships*, by encouraging the formation of groups that will unite members of the recovery community with each other and with other relevant stakeholders who are responsible for various dimensions of alcohol and drug dependence problems and solutions.

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

Target/Involved

Population

The primary target population for this recovery community organizing initiative consists of people with a history of alcohol and/or drug problems who are in or seeking recovery, along with their family members, significant others, and other supporters and allies (*the recovery community*¹).

Within the context of the RCSP, the individual in or seeking recovery and his/her family are the primary focus of community organizing efforts, rather than others who may be allies for recovery community issues, but who do not have direct experience with alcohol and drug problems. At the same time, allies and supporters may be part of the RCSP organizing

¹The term, *recovery community*, is used here as a broad and encompassing term that includes persons having a history of alcohol and drug problems who are in recovery or recovered, those currently in treatment, those seeking treatment and/or recovery, as well as their family members, significant others, and other supporters and allies. The program seeks to enable the authentic voice of people in recovery and their families, rather than enabling others to speak for them. It should be noted that in many contexts, the term, *consumer*, is often used to designate an individual who is a former or current recipient of services who possesses the necessary knowledge and skills to make informed choices about his/her own care and who may also advocate for others needing or desiring services. Within the context of the alcohol and drug field, however, a significant number of individuals find the designator, *consumer*, to be inappropriate and stigmatizing. Therefore, CSAT generally avoids the term, even though it has a specific recognizable—and relevant—meaning within the context of the *consumer advocacy movement*, especially as related to the health care consumer advocacy movement. Moreover, CSAT recognizes that there are several terminologies—such as recovery community member, recovering person, consumer, client, service recipient, and others—that might be applied, and we respect that some individuals may choose to identify themselves differently.

effort, so long as people in or seeking recovery and their family members are the primary target audience for the organizing effort and they are enabled to function as leaders for the project.

Persons having co-occurring disorders (e.g., psychiatric disorders, physical disabilities, HIV/AIDS) may be the target population, so long as the organizing efforts emphasize addiction treatment and recovery issues identified by the target population.

Background

In Federal fiscal year 1998, CSAT awarded 19 grants to organize the recovery community and to build members' capabilities to identify and support policies, programs, and services that would meet their self-identified needs. (See Appendices B-1 & B-2² for further background information on recovery community organizing and about the 1998 cohort of RCSP projects.)

Much has been learned from the pioneering efforts of these 19 projects, and the grantees made significant in-roads in mobilizing diverse populations, fighting stigma, forging alliances, educating policy-makers and opinion leaders, providing input to treatment systems, and celebrating and supporting recovery.

CSAT sustains its commitment to foster meaningful recovery community involvement in

²Additional information about the RCSP may also be found at the following Internet address:
<http://www.treatment.org/Topics/rcsp.htm>.

the development of public policy related to alcohol and drug treatment, and in the design, delivery, and evaluation of treatment and recovery systems and services that are responsive to consumer/family needs. CSAT believes this can best be accomplished using a community organizing/empowerment approach where those directly affected lead the effort. To this end, CSAT made awards to 21 organizations under a second RCSP GFA released in Federal Fiscal Year 2001

With this announcement, CSAT seeks to continue its support for the recovery movement by facilitating the formation of new recovery organizations and by enabling established organizations with demonstrated accomplishments to expand/intensify or replicate their efforts.

Who Can Apply

Applicants may be domestic private nonprofit organizations, such as community-based organizations, universities, faith-based organizations, or units of State or local governments or Indian Tribes and tribal organizations.

Consortia comprised of various types of eligible organizations are permitted; however, a single organization representing the consortium must be the applicant, the recipient of any award, and the entity responsible for administering the grant.

Organizations that were funded, either directly or indirectly (i.e., through a facilitating organization or as part of a consortium) under the 1998 RCSP GFA are not eligible to apply for **Track I** grants, but are encouraged to apply

for Track II grants. So that CSAT can begin new initiatives in as many different communities as possible, organizations that were funded, directly or indirectly, under the 2001 RCSP GFA are not eligible for awards in either Track.

Applicant Characteristics

Applications for both Track I and Track II may be submitted by either independent *recovery community organizations (RCOs)* or *facilitating organizations*.

RCOs are organizations comprised of and led by people in recovery and their family members and other allies.

Facilitating organizations may not necessarily be comprised of people in recovery; however, people in recovery and their family members must be involved in all aspects of application development, program design and implementation, and evaluation. The facilitating organization's ultimate aim will be either to:

- # enable the formation of an independent RCO to carry out recovery community organizing activities; or
- # develop some other viable organizational structure that enables recovery community members to carry out recovery community organizing activities.

Whether through formation of a RCO or another organizational structure, the

facilitating organization will build the capacity of the recovery community to participate in decision-making as treatment and recovery policies and services are planned, implemented, and evaluated.

Members of the recovery community must have a meaningful leadership role in any **Track I** or **Track II** project, whether carried out by a *RCO* or *facilitating organization*.

Consortia may apply, so long as a recovery community organization or member of the recovery community have a lead role in the consortium.

Applicants for **Track I** will propose a new recovery community organizing initiative, whereas applicants for **Track II** will propose to expand, intensify, or replicate an existing recovery community organizing initiative that has already produced concrete accomplishments (as delineated in the Level One Review, Organizational Capability Narrative, in the Project Narrative/Review Criteria section).

Note: The reference to a “new” recovery community organizing initiative for **Track I** applicants does not relate to the applicant organization, but, rather, to the programmatic activities (recovery community organizing activities) that are proposed, which should represent a new initiative for the applicant.

Applicants for **Track II** must, at the time of application, have in place a well-defined organizational infrastructure and have demonstrated experience implementing a promising organizing approach. **Track II** grantees will expand, intensify, or replicate a set of recovery community organizing activities that

are already in place.

RCSP grantees funded under the 1998 GFA who did not receive funding under the 2001 GFA are encouraged to apply for **Track II** awards. However, this Track is not limited to 1998 RCSP awardees, but, rather, is open to any applicant that meets the criteria in Level One Review in the Program Narrative/Review Criteria section.

The same organization may not apply for both a Track I and Track II award.

Application Kit

The grant announcement has two parts. Part I is individually tailored for each grant announcement or "GFA." This document is Part I. Part II contains important policies and procedures that apply to all SAMHSA applications for discretionary grants. Responding to both Parts I and II is necessary for a complete application.

In addition to the grant announcement, the application kit also includes the blank form (PHS-5161) you will need to complete your application. To get a complete application kit, including Parts I and II of the grant announcement, 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.
2. Be sure to type **one** of the following in Item No. 10 on the face page of the application form:

TI 02-002 RCSP/Track I

- or -

TI 02-002 RCSP/Track II

Application Dates

Applications must be received by **January 10, 2002.**

Applications received after January 10, 2002, must have a proof-of-mailing date from the

carrier before January 3, 2002.

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

Grant awards for **Track II** are expected to be made in March 2002.

Grant awards for **Track I** are expected to be made in June 2002.

How to Get Help

For questions on *program issues*, contact:

Catherine Nugent
Recovery Community Support Program
Division of State and Community Assistance
CSAT/SAMHSA
Rockwall II, Suite 880
5600 Fishers Lane
Rockville, MD 20857
(301) 443-2662
E-Mail: cnugent@samhsa.gov

For questions on *grants management issues*, contact:

Steve Hudak
Division of Grants Management
OPS/SAMHSA
Rockwall II, 6th floor
5600 Fishers Lane
Rockville, MD 20857
(301) 443-9666
E-Mail: shudak@samhsa.gov

Developing Your Grant Application

Applicants for both **Track I** and **Track II** are required to demonstrate familiarity with key concepts, strategies, and practices in community organizing as these relate to building the capacity of people in recovery from alcohol and drug dependence/addiction problems, along with their family members, significant others, and other allies and supporters. (A list of selected references and resources on community organizing and other closely related topics can be found in Appendix C.)

You must articulate the **core values** that will guide your approach and discuss how each of these will be operationalized in the proposed program. At a minimum, you must explain the steps you will take to: (a) involve the recovery community in all aspects of application development, and program design, implementation, and evaluation (*participatory process*); (b) ensure that the program enables the recovery community to identify and mobilize around its own self-identified needs and action agenda, and safeguard against exploiting or co-opting the recovery community (*authenticity of voice*); (c) safeguard individual members' recovery (*primacy of recovery*); (d) build leadership among members of the recovery community (*leadership development*); and (e) build a recovery community organization that is inclusive (*cultural diversity/inclusion*).

Applications must demonstrate an understanding of various issues at the systems and public policy levels that could possibly become the focus of organizing efforts. You must explain the

processes by which you will engage and enable the recovery community in defining an action agenda.

You must include a detailed description of the methods and approaches you will use to reach and engage the recovery community, including a discussion of how the project will reach out to diverse members in the community, including those with culture- and gender-specific needs, especially racial/ethnic minority groups, girls and women, and other groups that, traditionally, have been underserved or who have lacked access to mainstream venues for voicing their opinions, concerns, and needs.

If the program plans to focus on one segment of the recovery community (e.g., recovering people with disabilities; recovery community members who are gay, lesbian, bisexual, or transgendered; recovery communities comprised of a particular racial/ethnic group; members of the medication-assisted recovery community; persons with co-occurring addiction and mental health disorders), the application must include the rationale for limiting the target population/community.

Facilitating organizations must ensure that they will enable the formation of a viable organizational structure comprised of people in recovery and their family members who will advance their aims, as they define them, even though these aims may not necessarily be the same as those of the facilitating organization.

You must describe the approaches and/or processes you will use to bring together the targeted segments of the recovery community and the steps and activities you will take to carry out the organizing effort.

If you are applying for a **Track II** award, you must fully describe the existing project that you propose to expand/intensify or replicate. You must also demonstrate the viability and accomplishments of the existing program by meeting the criteria for Track II, Level One Review in the Program Narrative/Review Criteria section. **Track II** applicants must also discuss how the expanded/intensified or replicated component(s) can be expected to be effective in building the capacity of the recovery community.

Track II applicants that are seeking to expand/intensify their projects will, by definition, increase the scope, magnitude, and membership of their existing project, thereby enlarging the existing organization.

Track II applicants that are seeking to replicate their projects will not necessarily subsume the replication site(s) into their existing organizational structure or membership rolls, but, rather, may sustain the original project while, simultaneously, providing training, technical assistance, mentoring, and other supports to enable the new site to reproduce the recovery community organizing approach that was successfully pioneered in the original project site.

Applications for both **Track I** and **Track II** grants must discuss plans for sustaining the project or components of the project beyond the period of Federal funding (sustainability plans).

The primary purpose of this program is to build the capacity of the recovery community to participate in the public dialogue on addiction, treatment, and recovery. This may involve activities such as identifying and developing public policy that is responsive to consumer and family needs, identifying and supporting service

systems change efforts, and carrying out public education initiatives to address stigma.

However, in some cases, it may be necessary to offer limited recovery support services as a way to reach out to and engage the recovery community in project activities. If you plan to employ recovery support activities as part of your project's outreach or member retention strategy, you must describe these in detail, and you must explain how these support services will aid in member outreach, engagement, and retention and will generally support the purpose and goals of the Recovery Community Support Program (see Purpose Section).

Whether applying for **Track I** or **Track II**, you are encouraged to demonstrate planning and coordination of services at the local level with the Single State Authority for Alcohol and Drug Services (SSA).

Funding Restrictions

Grant funds may **not** be used for:

- G** Direct or grassroots lobbying (SAMHSA's Policy on Lobbying may be found in Part II of the grant announcement.)
- G** Provision of treatment services

Funding Criteria

Decisions to fund a grant are based on:

1. The strengths and weaknesses of the application as shown by the peer review committee
2. Concurrence of the National Advisory

Council

3. Availability of funds
4. Distribution of awards in terms of:
 - C geography, including rural/urban areas
 - C target population/cultural diversity
5. Evidence of non-supplantation of funds
6. Balance between Track I and Track II awards.

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 by collecting information on the following qualitative questions that will provide results-based data on RCSP efforts.

For **Track I**:

1. Number of community-building events (e.g., membership meetings, meetings with stakeholders, training events, conferences, etc.)
2. Percentage of participants satisfied with each of these community-building

events.

For **Track II**:

1. Number of community-building events (e.g., membership meetings, meetings with stakeholders, training events, conferences, etc.)
2. Percentage of participants satisfied with each of these community-building events.
3. Percentage of participants who report using information, knowledge, or skills acquired from these community-building events.

The protocol and all necessary forms for collecting the required GPRA measures will be provided by CSAT. For a detailed description of CSAT's GPRA strategy, see **Appendix D**.

Track I grantees will be required, at the end of the grant period, to submit a *case study* that documents the project's organizational structure, community organizing model or approach, and strategy for sustaining the project or components of the project beyond the period of Federal funding. The case study will also discuss major obstacles encountered and how these were addressed. The overall purpose of the case study is to distill insights, ideas, and concrete suggestions ("lessons learned") that CSAT can synthesize and disseminate to others attempting recovery community organizing initiatives.

Your **Track I** application must present the types of issues and questions you would

anticipate discussing in a detailed, lessons-learned case study that would have value to the field. You must also discuss how recovery community members will be involved in helping to identify the lessons learned from the project for incorporation into the case study.

You are required to write one case study that reports on project accomplishments and lessons learned over the life of the grant.

Track II grantees are required to conduct a *process evaluation* that documents, in detail, how the expansion/intensification or replication effort was carried out, as well as the success of the program as measured, at a minimum, by the percentage of members who report using the information, knowledge, and skills acquired through community capacity-building events conducted by the Track II grantee.

For **Track II** applications, you are also encouraged to include other impact measures (e.g., documentation of consumer-identified needs for services, increases in quality of services as assessed by recovery community members, changes in public attitudes toward persons with addictions and/or persons in recovery), that you anticipate using for your project evaluation.

Track II applications should also discuss how you will involve the recovery community in the evaluation process.

For both **Track I** and **Track II**, if you propose to use the services of a case study/evaluation consultant, you must explain his/her role, as well as how you envision this individual interacting with project staff and members.

Selected references and resources related to participatory evaluation can be found in Appendix C.

Track I and Track II grantees will be required to prepare *quarterly progress reports* in a format specified by CSAT.

Post Award Requirements

Grantees will be required to attend (and thus must budget for) one small and one large technical assistance (TA) meeting convened by CSAT in each year of the grant. (Grantees may also plan to convene their own meetings and conferences, and these must also be included in the project budget.)

Track I applicants should allocate funds to support travel-related costs for two or three key individuals from their project to attend the yearly small TA meeting. For the larger annual TA meeting, **Track I** applicants should budget for approximately 5-10 individuals (including their community-based members), depending on the scope of the project.

Track II grantees may plan to bring more individuals to the CSAT TA meetings, depending on the nature and scope of their expansion/intensification or replication effort, and you should budget accordingly. In your **Track II** application, provide a brief rationale for the numbers of individuals you propose to bring to the CSAT-convened meetings.

All CSAT-sponsored TA meetings will be three days in duration, and will be held in the Washington, DC, area.

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** of the grant announcement 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** of the grant announcement for instructions. (Note: How to estimate an indirect cost rate is discussed in Appendix B of Part II.)

' **5. PROJECT NARRATIVE/REVIEW CRITERIA AND SUPPORT**

DOCUMENTATION

The project narrative/review criteria is made up of Sections B through E. (If you are applying for **Track II**, you must also complete Section A, which describes your organizational capability to carry out the proposed expansion/intensification or replication.) More detailed information regarding A-E follows #10 of this checklist. Sections B-E may not be longer than 25 pages. Section A (for **Track II** only) may not be longer than 10 pages.

- **Section A - For Track II applicants only - Organizational Capability Narrative - Description of organizational structure and capability, organizing approach, and discussion of accomplishments that demonstrate ability to carry out expansion/intensification or replication**

For Track I & Track II:

- **Section B - Project Narrative/Review Criteria:**
Project Description/Justification of Need
- **Section C - Project Narrative/Review Criteria:**
Project Plan
- **Section D - Project Narrative/Review Criteria:**
Project Evaluation
- **Section E - Project Narrative/Review Criteria:**
Project Management:

Implementation Plan, Organization, Administrative and Fiscal Capability, Staff, Equipment/Facilities, and Other Support

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

- **Section F- Supporting Documentation:**
Literature citations
This section must contain complete citations, including titles and all authors, for any literature you cite in your application.
- **Section G - Supporting Documentation:**
Itemized description of expenditures, existing resources, other support

Follow instructions in Appendix B, **Part II** of the grant announcement. Fill out sections B, C, and E of the Standard Form 424A. (Note: A Replacement Example A, illustration of a detailed worksheet for completing SF 424A, is included as Appendix E of this document.)

- **Section H - 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, include a letter of

commitment from him/her with his/her sketch.

- 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 I - 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 5**

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

Appendix 1:
Letters of Coordination/Support

Appendix 2:
Non-Supplantation of Funds Letter

Appendix 3:
Letter to Single State Agency (SSA)

Appendix 4:
Data Collection Instruments/Interview Protocols

Appendix 5:
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** of the grant announcement for lobbying prohibitions.

' **10. CHECKLIST**
 See Appendix C in **Part II** of the grant announcement for instructions.

Project Narrative/Review Criteria – Sections A Through E Highlighted

Your application consists of sections A through I if you are applying for **Track II**, and sections B through I if you are applying for **Track I**. Section A describes your organization's capability if you are applying for **Track II**. Sections B through E, the project narrative/review criteria 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 E.

/ For **Track I**, the peer review will be conducted with one level of review.

/ For **Track II**, the peer review will be

conducted with two levels of review. At Level One, the peer review committee will limit its review to an evaluation of the extent to which the applicant meets the specified criteria in Section A (Organizational Capability Narrative.) Only those applications that pass the Level One review will receive further review.

/ Section A (for **Track II only**) may not be longer than 10 pages.

/ Sections B through E (for **both Track I and Track II**) may not be longer than 25 pages.

Section A: Organizational Capability Narrative (Level One Review) - for Track II Only (Track I applicants should not respond to these items.)

The following criteria will be used for Level One review of **Track II** applications. Seven screening items will be used to determine whether you have the necessary organizational capability to carry out an expansion/intensification or replication project. The majority of the reviewers must give you a “yes” on each of the following items for you to be eligible for further review at Level Two. If you receive a “no” on any of these criteria, your application will not be eligible for funding.

' The applicant has discussed the history and background of the existing project and has explained why it is necessary or important to expand/intensity or replicate it.

' The applicant has a well defined organizational structure with clearly

defined relationships and roles for project staff and grassroots members. The organizational structure promotes meaningful recovery community involvement and leadership.

' The applicant has successfully recruited, engaged, and retained the target/involved recovery community members in project activities. There is demonstration that the recovery community “owns” and supports the project.

' The applicant has taken steps to ensure the authenticity of the recovery community voice and to avoid exploiting or coopting the recovery community.

' The applicant, in partnership with the target/involved population, has developed a well-defined action agenda for the organization. The applicant has clearly described the action agenda and the steps that have been taken to accomplish it.

' The applicant has clearly described project accomplishments, including specific details, as appropriate (e.g., numbers of individuals involved; number and types of events implemented; number of individuals reporting satisfaction with events; number and types of products developed and distributed; examples of organizing outcomes; and any other successes or accomplishments).

' The applicant has described accomplishments in acquiring or leveraging fiscal and/or in-kind support

other than from CSAT/RCSP (e.g., other Federal, State, local, or foundation grants and contracts; membership dues; sales of products and services; support or in-kind contributions from local agencies or partners); and/or any other successful steps toward meeting the project's sustainability plan.

Applications that proceed to Level Two will be reviewed and evaluated according to the review criteria in Sections B through E.

In the following Sections B-E (Level Two Review), a peer review committee will assign a point value to your application based on how well you address Sections B through E. The number of points after each section heading shows the maximum points a review committee may assign. For example, a perfect score for Section B will result in a rating of 15 points.

Reviewers will also be looking for cultural competence. Points will be deducted from applications that do not adequately address the cultural aspects of the criterion. See Appendix D in **Part II** of the grant announcement for guidance.

Section B:
Project Description and Justification of Need (15 points)

For Tracks I & II:

- ' Describe why it is necessary or important to organize the recovery community.
- ' Identify and briefly describe the

target/involved population and provide justification for any exclusions under SAMHSA's Population Inclusion Requirement (see **Part II** of the grant announcement). (Note: Extensive demographic information is not required.)

- ' Clearly state the purpose of the proposed project, with goals and objectives. Describe how achievement of goals will support meaningful and relevant results and expand the capacity of the recovery community.

Section C:
Project Plan (50 points)

For Tracks I & II:

- ' Describe the program you plan to implement, including the approaches and/or processes you will use to organize the recovery community.
- ' Discuss and explain the core values that will guide the project design, development, implementation, and evaluation, and explain how each of these values will be operationalized. At a minimum, discuss each of the following as it relates to the proposed project: (a) participatory process; (b) authenticity of voice; (c) primacy of individual recovery; (d) leadership development; and (e) cultural diversity/inclusion.
- ' Give examples of the types of issues, needs, concerns, and problems that may be relevant to the target/involved

population.

- ' Discuss how you will engage and involve the target/involved population in identifying their needs and developing an action agenda.
- ' Discuss your plans for building recovery community members' leadership skills and their capacity to serve as informed, empowered spokespersons for recovery policies, systems, and services that are responsive to community needs.
- ' Describe and give examples of products and materials you expect to produce.
- ' Discuss the steps you will take to ensure that your program is appropriate and sensitive to the cultural needs of the target/involved population.

Section D:

Project Evaluation (15 points)

For Track I:

- ' Give examples of the types of questions and issues that you anticipate discussing in your case study. At a minimum, include questions related to organization development, community organizing approach, member recruitment and retention, and project sustainability issues.
- ' Describe how you will involve the recovery community in identifying

lessons learned and developing the case study as described in the Reporting/Evaluation Requirements section.

For Track II:

- ' Describe the process evaluation you propose.
- ' Discuss how you will document lessons learned from your expansion/intensification or replication effort so that others attempting a similar initiative may benefit from your experience.
- ' Discuss how you will involve the recovery community in the design of the evaluation.

For Tracks I & II:

- ' If you propose to use an evaluation consultant, explain his/her role and how the consultant will interact with project staff and members.

Section E:

Project Management: Implementation Plan, Organization, Administrative and Fiscal Capability, Staff, Equipment/Facilities, and Other Support (20 points)

For Tracks I & II:

- ' Present a realistic management plan for the project that describes the individuals and organizations that will be involved in the project; presents their roles in the project; and addresses their relevant experience. Provide letters of support reflecting these issues from these

organizations in **Appendix 1**.

- ' Describe time-lines for implementing the project. Provide a detailed time-line for the first year, followed by a time-line showing major milestones for the remaining years.
- ' Discuss the applicant organization's capability and experience with similar projects and populations.
- ' Explain whether the applicant organization is a RCO, facilitating organization, or consortium. Facilitating organizations must also explain how they will enable the formation of a viable organizational structure or component comprised of people in recovery and their family members who will advance recovery community aims.
- ' Describe the organizational structure that will be in place at the time of project start-up and, if relevant, plans for any new organizational structure (e.g., the formation of an independent recovery organization) that is envisioned over the life of the project.
- ' If a consortium is proposed, describe all partners and their organizations in detail.
- ' If a consortium is proposed, discuss the involvement of the RCO or recovery community members.
- ' Provide a staffing plan, including the level of effort and qualifications of the

Project Director, other key personnel, and support staff.

- ' Describe the resources available (e.g., facilities, equipment), and provide evidence that activities will be conducted in a location/facility that is adequate and accessible and that the environment is conducive to the target/involved 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 the proposed staff have requisite experience and sensitivity to conduct community organizing activities with the recovery community.
- ' Provide evidence that required resources not included in this Federal budget request are adequate and accessible.
- ' Discuss how you plan to secure resources or obtain support to continue the project or components of the project after the grant project period has ended.

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 of the grant announcement provides additional information regarding 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. (**Attention: Some of the items below are clearly intended to protect participants in projects that will be implemented in clinical settings, which is not the case for RCSP projects. However, there are risks involved in recovery community organizing and in project evaluation, and these should be discussed in relation to each of the seven items. Please discuss any potential risks and**

safeguards related to (a) participation in recovery community organizing activities, and (b) participation in the project evaluation (case study for Track I, process evaluation for Track II).

The following 7 issues must be discussed:

Ø Protect Participants 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 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 procedures for carrying out recovery community organizing activities that might be beneficial to the participants.
 - c Offer reasons if you do not decide to use other beneficial procedures.
- ### 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, pregnant women, or other special population groups.

C Explain the reasons for including special types of participants, such as pregnant women, children, institutionalized or mentally disabled persons, prisoners, persons with or at risk of HIV, etc.

C Explain the reasons for including or excluding participants.

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

Ú 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 people 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 participate and receive incentives even if they do not complete the data collection.

Ù 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.

C Provide in **Appendix No. 4**, "Data Collection Instruments/Interview Protocols," copies of all available data collection instruments and interview protocols that you plan to use.

Û 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: RCSP grantees are not to provide treatment services. However, because participants may include patients in active treatment status, grantees must agree to comply with applicable requirements regarding the confidentiality of alcohol and drug abuse client records according to the provisions of Title 42 of the Code of Federal Regulations, Part II.

Ý 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, 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 should get written informed consent.

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

C Include sample consent forms in your **Appendix 5**, 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 participation in recovery community organizing activities 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?

Risk/Benefit Discussion:

C 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** of the grant announcement 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 2)

- C Letter of Intent
- C Single State Agency (SSA)
Coordination (include documentation
in **Appendix 3)**
- C Intergovernmental Review
- C Confidentiality/SAMHSA Participant
Protection
- C Lobbying Prohibitions

Appendix A: Changing the Conversation: Improving Substance Abuse Treatment: The National Treatment Plan Initiative

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-1: Additional Background on Recovery Community Organizing

The contemporary field of community organizing is frequently associated with the labor organizing work of leaders like Saul Alinsky and Cesar Chavez. It also has strong roots in the civil rights movement, the women's movement, the social justice movements associated with Catholic liberation theology, and other community-based movements that have mobilized groups—particularly groups that have been marginalized or oppressed—around common concerns. Stoecker and Stall (1996) have defined community organizing as the process of organizing relationships, identifying issues, mobilizing around those issues, and building an enduring organization.

Wallerstein & Bernstein (1994) have defined community empowerment as “a social-action process in which individuals and groups act to gain mastery over their lives in the context of changing their social and political environment. This process can occur in communities interpreted...as geographic, institutional, and relational interest-based associations” (p. 142).

In recent decades, community organizing and empowerment concepts have taken root in the American health care system. With the advent of managed care and other changes in the health care delivery system, increased emphasis has been placed on involving consumers in the design, delivery, and evaluation of services that affect them. Involving consumers in their own care is seen as a means to enhance satisfaction, adherence, and outcome, as well as to increase accountability and overall quality of care (Olson & Perkins, 1999).

One commentator (Wallack, 1993) has noted that “contemporary public health is as much about facilitating a process whereby communities use their voice to define and make their health concerns known as it is about providing prevention and treatment” (p. 5).

Within the behavioral health arena, there has been a long and successful history of people with mental disorders (often referred to as *consumers* or *survivors*) and their families in organizing around action agendas on their own behalf. Until very recently, however, community organizing efforts with those directly affected by alcohol and drug dependence problems have not been so successful as similar efforts in mental health and other disability areas.

A number of challenges that are specific to the recovery community must be successfully addressed in organizing this population. Primary among these challenges is the pervasive stigma associated with alcohol and drug problems, which is often compounded by multiple, overlapping stigmas (e.g., related to gender, race, ethnicity, class, and other demographic or cultural variables, such as criminal justice history, sexual orientation or physical disability).

Other organizing obstacles include a philosophical disapproval, on the part of some recovery community members, for political organizing (e.g., some individuals interpret the 12-step traditions of

anonymity to preclude any forms of speaking out publicly). In addition, some organizers have suggested that there may be a lack of political consciousness and knowledge of political processes on the part of some segments of the recovery community, particularly among those whose access to mainstream routes to power and political process has been limited (Bernstein, et al, 1994).

Moreover, many persons needing treatment for alcoholism or drug dependence enter the formal treatment system in crisis, use one type of service, and leave the system. Although this may happen more than once, they and their family members may not gain a perspective on the full continuum of services that, optimally, would be available. Lacking a well-conceived vision of a comprehensive system, they are not prepared to identify and support comprehensive treatment and recovery systems that might better meet the needs of persons with alcoholism and/or drug dependence and their families.

Furthermore, the recovery community is exceedingly diverse. People in recovery differ not only in terms of gender, race, ethnicity, class, sexual orientation, physical ability/disability, and other cultural variables, but also in their history of alcohol and other drug use, the nature of their treatment experiences, and their chosen mode of recovery. There is significant variation—in philosophy, language, approach, and practice—among the different “cultures of recovery”. Though a source of potential richness, this diversity can also be an obstacle to mobilizing the community around a common action agenda.

With this announcement, CSAT seeks to enable the continuing organization and empowerment of the recovery community by supporting the formation of new recovery organizations and by enabling established organizations with demonstrated accomplishments to expand/intensify or replicate their efforts.

References (for Appendix B-1 and GFA, Part I)

Bernstein, E.; Wallerstein, N.; Braithwaite, R.; Gutierrez, L.; Labonte, R.; & Zimmerman, M. (1994). A dialogue between guest editorial board members, *Health Education Quarterly*, Vol. 21, No. 3, Part II: 281-294.

Olson, K.; & Perkins, J. (1999). Recommendations for making the consumers' voice heard in medicaid managed care: A guide to effective consumer involvement. National Health Law Program, Inc., 211 N. Columbia Street, Chapel Hill, NC 27514. <<http://www.healthlaw.org>>.

Stoecker, R. & Stall, S. (1996). *Community organizing or organizing community? Gender and the crafts of empowerment*. COMM-ORG: The On-Line Conference on Community Organizing and Development. <<http://uac.rdp.uToledo.edu/docs/comm-org/papers.htm>>

Wallack, L.; Dorfman, L.; Jernigan, D.; & Themba, M. (1993). *Media advocacy and public health: Power for prevention*. Newbury Park, CA: Sage.

Wallerstein, N. & Bernstein, E. (1994). Introduction to community empowerment, participatory

education, and health. Health Education Quarterly, Vol. 21. No. 3, Part I: 141-148.

Appendix B-2: What Is The RCSP? (Program Fact Sheet)

• WHAT IS THE RECOVERY COMMUNITY SUPPORT PROGRAM?

In Federal Fiscal Year 1998, the Center for Substance Abuse Treatment (CSAT) initiated the Recovery Community Support Program (RCSP) as its first focused and systematic effort to engage the addiction recovery community in the public dialogue about addiction, treatment, and recovery. Nineteen projects were funded to stimulate the participation of the recovery community in decision-making about the planning and implementation of addiction treatment policies and services. More specifically, the grantees are charged to:

- P Encourage and facilitate informed and empowered participation by consumers and families in the planning, delivery, and evaluation of addiction treatment/recovery policies and services.
- P Promote linkages among persons in recovery and their family members and their allies, and between the recovery community and formal delivery systems.
- P Reduce the stigma associated with addiction, treatment, and recovery.
- P Foster independence and financial self-sufficiency of the projects.
- P Document organizational structures and processes used in RCSP organizing efforts.

• WHO ARE THE RCSP GRANTEEES ?

The 19 RCSP grantees, working in 24 States and across Indian Country, include community-based organizations comprised of people in recovery and family members, as well as other organizations—such as coalitions of treatment providers, community service centers, treatment centers, and governmental agencies—that are facilitating the formation of grassroots recovery community organizations. Some grantees are organizing from the bottom up, working at the town, city, or county level. Others are organizing on the State level, and still others have a regional or interstate organizing strategy. Some seek to include the full spectrum of the recovery community, including those whose recovery is abstinence-based and those whose recovery is maintained by methadone, as well as recovery community members of diverse racial, ethnic, and cultural groups. Other projects focus on particular segments of the recovery community, such as the gay, lesbian, bisexual, and transgendered population; people with co-occurring disorders and physical disabilities; or members of specific racial and ethnic groups.

• **WHAT ARE THE RCSP GRANTEEES DOING ?**

RCSP grantees are implementing organizing activities to meet the self-identified needs of the particular segment(s) of the recovery community they are organizing. Therefore, the challenges they face—and the strategies they are developing—are unique, and, collectively, the projects are conducting a diverse array of activities. Following are some examples of RCSP grantees' accomplishments:

MOBILIZING DIVERSE POPULATIONS

Within the recovery community, the term “diversity” refers not only to the usual demographic variables (e.g., age, race, ethnicity, gender, economic, and educational status) but also to the many different experiences and cultures of addiction, treatment, and recovery, including differences in treatment modalities and recovery supports. Recovery community organizing requires a careful balance between focusing on commonalities and recognizing the importance of different perspectives and voices.

It also requires outreach to people who are underserved by the treatment system as it is currently configured. Following are some of the segments of the recovery community that are receiving specific outreach by RCSP grantees:

- P People who cannot access treatment services or recovery supports because they have coexisting physical, sensory, mental, or cognitive disabilities that treatment programs are not prepared to accommodate (Arizona).
- P Gays, lesbians, bisexuals, and people of transgender experience, who often encounter heterosexism and discrimination in treatment and recovery environments (New York).
- P Women, whose fear of losing their children is a barrier to treatment and recovery (Wisconsin).
- P Children and adolescents, whose treatment options, when they exist, are typically based on adult models with inadequate consideration of their special developmental needs (Connecticut, Massachusetts, Pennsylvania, Virginia).
- P Native Americans, who continue to struggle for culturally relevant modes of treatment and recovery (Colorado, Iowa).

FIGHTING STIGMA

Stigma—the blame and shame associated with addiction, treatment, and recovery—is an impediment to policies and practices that would maximize opportunities for recovery. Putting a human face and voice on recovery could reduce that stigma. In an environment rife with stigma and discrimination, however, it can be daunting to acknowledge one's recovery publicly. In some cases, reluctance to self-disclose also may be influenced by some people's interpretation of the tradition of anonymity in the 12-Step community.

RCSP grantees are developing strategies that respect 12-Step traditions of anonymity, while simultaneously enabling community members to contribute to the dialogue on treatment policies

and services. For recovery community members who wish not to self-disclose, grantees are developing ways to participate anonymously. They also are developing ways to help manage the risks of disclosure for those who are ready to tell their personal stories as part of their organizing and anti-stigma efforts. These strategies include:

- P Creation of confidential vehicles, such as consumer surveys, on treatment systems needs (California).
- P Peer workshops on how to tell one's story with safety (Connecticut, New York).

Grantees use multiple modalities for telling one's story and describing the hope that is represented by recovery. These include:

- P Speakers' bureaus (California, Connecticut, Massachusetts, New York)
- P Videos and CD-ROM presentations (Connecticut, Oregon)
- P Public access cable TV programming (California)
- P Talk radio (Missouri, Texas)
- P Print media interviews and op-ed pieces (New York, Oregon, Virginia).

Grantees also are developing innovative and values-based strategies for publicizing the value of recovery that go beyond telling one's personal story, such as:

- P Amends in Action, where people in recovery, wearing tee-shirts with "Ambassadors for Recovery" logos, partner with Habitat for Humanity to rehabilitate low-income housing, including a former crack house (Pennsylvania).
- P Trees of Hope, decorated in community settings during the December holidays with ornaments bearing messages of gratitude and hope crafted by people in recovery and their families (Illinois, Pennsylvania).
- P Wiping the Tears, a nationwide march through Indian Country to Washington, D.C., promoting the value of recovery, community healing, and "wellbriety" (Colorado).

FORGING ALLIANCES

The voice of recovery is amplified, and reaches expanded audiences, when recovery community organizations develop alliances and partnerships. RCSP grantees are creating valuable alliances with:

- P Mental health consumer and family groups (Connecticut, California, Massachusetts, Texas, Virginia, Vermont)
- P Families of the mentally retarded (Virginia)
- P Homeless coalitions (California)
- P Gay pride organizations (California, New York, Pennsylvania)
- P Faith communities, public schools, and other voluntary associations involved in community organizing (Oregon)
- P The business community (California)
- P Labor unions and employee assistance plans (Illinois, Michigan, Pennsylvania)

- P Providers of recovery housing (Illinois, Virginia)
- P Tribal colleges (Colorado).

EDUCATING POLICY-MAKERS AND OPINION LEADERS

People in recovery and their families have many valuable insights into the journeys that can lead from addiction to recovery. Grantees are sharing these insights through policy forums; legislative days; self-advocacy conferences; Day of Sobriety proclamations; Recovery Month events; grantee-sponsored public meetings, negotiating sessions, and training programs; and issue briefs on policy matters of concern to the community (California, Connecticut, Massachusetts, Michigan, Missouri, New Hampshire, Oregon, Texas, Vermont, Virginia, Wisconsin). Some grantees are initiating voter registration drives within the recovery community to increase political awareness of the importance of the recovery constituency (California, Pennsylvania, New York). Other grantees are becoming regular sources for media stories on addiction and recovery (Oregon, Virginia).

These efforts with policy-makers and opinion-shapers are beginning to bear fruit. For example, one grantee, working in concert with other local organizations, helped secure a major expansion of Medicaid funding for addiction treatment and the largest increase in addiction treatment funding in the history of the State. Another grantee negotiated with local officials to fund a recovery mentor program for newly recovering heroin addicts and to implement specific actions to address both the epidemic of Hepatitis C and the staggering number of heroin overdose deaths in the local area. This grantee also increased safe and sober housing opportunities for people new to recovery by working with a city official responsible for the city's affordable housing programs (Oregon).

PROVIDING INPUT TO TREATMENT SYSTEMS

Grantees are providing direct recovery community input into systems at local, State, and Federal levels through such means as:

- P Service on advisory boards and stakeholders' councils relating to addiction treatment (Arizona, Connecticut, Texas)
- P Service on advisory boards for cross-system collaboration (Connecticut, Massachusetts)
- P Consumer satisfaction surveys (California, Michigan, Pennsylvania)
- P Consumer and family surveys on specific treatment issues (California)
- P Survey capturing the recovery community perspective on elements of treatment program design (California)
- P Consumer focus groups on systems issues (California, Connecticut)
- P Managed care surveys (Texas)
- P Managed care hotlines (Pennsylvania)
- P Consumer bill of rights design (Connecticut)
- P Focus groups with the recovery community to provide input on the CSAT National Treatment Plan (California)
- P Providing comment on a draft policy statement of the White House Office of

National Drug Control Policy on drug-dependent individuals involved in the criminal justice system (all grantees)



- P Serving on the Consumer Bill of Rights Stakeholders' Panel of the Substance Abuse and Mental Health Services Administration (California, Oregon, Pennsylvania, Texas, Connecticut).

CELEBRATING AND SUPPORTING RECOVERY

RCSP grantees celebrate and support recovery in many ways, including:

- P Participating in community events such as health fairs and Runs for Recovery that celebrate healing and wellness (Illinois, Pennsylvania, Texas, Virginia, Wisconsin)
- P Providing volunteer peer mentors to patients in treatment programs (Virginia) and following treatment (Oregon), and assisting in developing community service opportunities for people in recovery (Pennsylvania)
- P Sponsoring Recovery Month celebrations (most grantees)
- P Creating clean and sober places for the recovery community, such as a volunteer-rehabilitated storefront used as a recovery drop-in center (Iowa)
- P Working to develop culturally-relevant recovery support activities and materials, such as recovery-oriented talking circles and an Indian Big Book (Iowa, Colorado).

• WHAT SITES WERE FUNDED?

Arizona

People With Recovery & Disabilities (PWRD)

A Project of the Pima Prevention Partnership

345 E. Toole Avenue, Suite 104, Tucson, AZ 85701

(520) 884-1300

California

Always Working Toward Advancing Recovery Environments (AWARE)

A Project of the California Association of Alcohol and Drug Program Executives

1127 11th Street, Suite 208, Sacramento, CA 95814

(916) 329-7409

Partners in Recovery Alliance (PIRA)

A Project of the Contra Costa County Health Services Department
597 Center Avenue, Suite 320, Martinez, CA 94553
(925) 313-6389

Santa Barbara Community Recovery Network

A Project of the Santa Barbara Council on Alcoholism and Drug Abuse
226 East Canon Perdido Street, Suite H, P.O. Box 28,
Santa Barbara, CA 93101-1422
(805) 899-2933

Colorado

Circles of Recovery

A Project of White Bison, Inc.
6145 Lehman Drive, Suite 200, Colorado Springs, CO 80918
(719) 548-1000

Connecticut

Connecticut Community for Addiction Recovery (CCAR)

465 Silas Deane Highway, Wethersfield, CT 06109
(860) 571-2985

Illinois

Recovery Communities United, Inc.

An Affiliate of the National Council on Alcoholism and Drug Dependence
1010 Lake Street, Suite 210, Oak Park, IL 60301
(708) 383-2885

Iowa

Sacred Circle Project

A Project of the Winnebago Service Area Healthy Start, Inc.
809 West 7th Street, P.O. Box 3704, Sioux City, IA 51102
(712) 252-5902

Michigan

Project Vox

A Project of the National Council on Alcoholism and Drug Dependence of Michigan
913 West Holmes Road, Suite 111, Lansing, MI 48910
(517) 394-1252

Missouri

Missouri Recovery Network

A Project of the Missouri Department of Mental Health
1648 East Elm Street, Jefferson City, MO 65101
(573) 635-6669

New England (Maine, Massachusetts, New Hampshire, Rhode Island, Vermont)

New England Alliance for Addiction Recovery (NEAAR)

A Project of the New England Institute of Addiction Studies

99 Western Avenue, Suite 12, Augusta, ME 04330

(207) 621-2549

New York

SPEAK OUT!: LGBT Voices for Recovery

A Project of the Lesbian and Gay Community Services Center

One Little West 12th Street, New York, NY 10014

(212) 620-7310

Oregon

Recovery Association Project (RAP)

A Project of Central City Concern

2 NW Second Avenue, Portland, OR 97209

(503) 294-1681

Pennsylvania

Pennsylvania Recovery Organizations Alliance (PRO-A)

A Project of the Gaudenzia Foundation, Inc.

500 North Progress Avenue, Harrisburg, PA 17109

(717) 541-9313

Promoting Recovery Organizations-Achieving Community Togetherness (PRO-ACT)

A Project of the Bucks County Council on Alcoholism and Drug Dependence

Bailiwick Office Campus, 252 West Swamp Road, Suite 12,

Doylestown, PA 1 8901

(215) 345-6644

Texas

El Paso Alliance/Recovery Community Organization

A Project of Aliviane NO-AD, Inc.

7722 North Loop, El Paso, TX 79915

(915) 782-4000

Association of Persons Affected by Addictions (APAA)

A Project of Dallas Helps, Inc.

2200 Main Street, Dallas, TX 75201

(214) 954-0090

Virginia

Substance Abuse and Addiction Recovery Alliance (SAARA)

100 North Washington Street, Suite 239, Falls Church, VA 22046

(703) 237-6141

Wisconsin

STAR Project

A Project of the University of Wisconsin - Madison
523 Lowell Hall, 610 Langdon Street, Madison, WI 53703
(608) 265-2679

Appendix C: Selected References and Resources on Community Organizing, Stigma & Participatory Evaluation

Recovery Community

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Internet Web Sites on Related Topics

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- Citizen's Handbook, (<http://www.vcn.bc.ca/citizens-handbook/Welcome.html>)
- Community Tool Box, University of Kansas, (<http://ctb.lsi.ukans.edu/>)
- COMM-ORG: The On-Line Conference on Community Organizing and Development, (<http://uac.rdp.utoledo.edu/comm-org>)
- Consumer Organization and Networking Technical Assistance Center (CONTAC), (<http://www.contac.org>)

Center for Substance Abuse Prevention's Training Curriculum,
(<http://www.preventiondss.org>) (Click on "Step 7 - Get Training and Support")

Center for Substance Abuse Treatment's Recovery Community Support Program (Special Topic Area of the Treatment Improvement Exchange Forum, Center for Substance Abuse Treatment), (<http://www.treatment.org/Topics/rcsp.htm>)

Collaborative, Participatory and Empowerment Evaluation, by Dr. David Fetterman
(<http://www.stanford.edu/~davidf/empowermentevaluation.html>)

Developing a Civic Culture, by Ralph Nader,
(<http://www.vcn.bc.ca/citizens-handbook/Nader.html>)

Empowerment Evaluation Virtual Conference, (<http://www.webx.stanford.edu/webx>)

Grassroots Rot, by Charles Dobson, (<http://www.vcn.bc.ca/citizens-handbook/wilt.html>)

National Alliance for the Mentally Ill (NAMI), (<http://www.nami.org>)

National Council on Alcoholism and Drug Dependence, (<http://www.ncadd.org>)

National Empowerment Center, (<http://www.power2u.org>)

National Mental Health Association (NMHA) Consumer Supporter Technical Assistance Center,
(<http://www.nmha.org>)

National Mental Health Consumer's Self-Help Clearinghouse, (www.mhselfhelp.org)

National Technical Assistance Center (NTAC) for State Mental Health Planning,
(<http://www.nasmhpd.org/ntac/>)

National Training and Information Center, (<http://www.tenant.net/Organize/orgbas.html>)

The 10 Principles of Community Organizing,
(<http://uac.rdp.utoledo.edu/comm-org/papers97/beckwith.htm>)

APPENDIX D: 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. ³ |
| 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. |

³GPRA 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 years. As the efforts to incorporate outcome indicators into the SAPT Block Grant are

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.⁵ 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
-

2. MEET UNMET OR EMERGING NEEDS

⁵Only 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.

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).⁶ 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.⁷ Within CSAT, these activities currently include the Product Development and Targeted Dissemination contract (to include TIPS, TAPS, CSAT by Fax, and

⁶The 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.

⁷Most, 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 System Performance,” below).

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.”⁸ 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 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

⁸Ultimately, 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.

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 E: Example for Completing SF 424A, Customized for RCSP Track I

NOTE: This example is illustrative only. Actual figures proposed should be based on specific requirements related to the nature, scope, and location of the proposed project. Applicants should also carefully review the example in Part II of the GFA, which provides additional information.

| | | |
|---------------------------------------|-------|------------------|
| A. Personnel | | |
| Project Director | 1 FTE | \$ 45,000 |
| Community Organizer | 1 FTE | \$ 38,000 |
| Administrative Assistant | 1 FTE | <u>\$ 28,000</u> |
| Total Personnel | | \$111,000 |
| B. Fringe Benefits⁹ | @24% | \$ 26,640 |

(Total Salaries & Fringe Benefits = \$137,640)

| | | |
|--|---|-----------------|
| C. Travel ¹⁰ | | |
| 1. Travel to CSAT TA Meetings: | | |
| (a) Small TA meeting for 3 attendees | | |
| airfare @ \$700 x 3 | = | \$2,100 |
| lodging @\$120/day x 4 nights x 3 attendees | = | \$1,440 |
| per diem @ \$46/day x 3.5 days x 3 attendees | = | \$ 483 |
| ground transportation x 3 attendees (\$15/ea) | = | <u>\$ 45</u> |
| Subtotal | = | \$4,068 |
| (b) Large TA meeting for 7 attendees | | |
| airfare @ \$700 x 7 | = | \$4,900 |
| lodging @ 120/day x 4 nights x 7 attendees | = | \$3,360 |
| per diem @ \$46/day x 3.5 days x 7 attendees | = | \$1,127 |
| ground transportation x 7 attendees (\$15/ea) | = | <u>\$ 105</u> |
| Subtotal | = | \$ 9,492 |
| 2. Local Travel (Project Staff & Members) | | |
| 500 miles @ \$0.31 | = | \$ 155 |

Total Travel Costs **\$ 13,715**

⁹Includes items such as FICA/Medicare, Workers Compensation, Unemployment Insurance, Health Insurance, Liability Insurance (including Directors and Officers Insurance), and Retirement. The fringe benefit rate should be based on the organization's written internal operating policy. The rate shown is for illustrative purposes.

¹⁰Example assumes grantee must travel significant distance to DC area. Actual airfare from your area may be greater or less, depending on your location.

| | | |
|-----------|--|------------------|
| D. | Equipment ¹¹ (list individually) | \$ 10,000 |
| E. | Supplies | \$ 1,000 |
| F. | Contractual | |
| | 1. Case Study/Evaluation Consultant - \$300/day x 8 days | \$ 2,400 |
| | 2. Bookkeeper/Accountant - \$160/day x 24 days | <u>\$ 3,840</u> |
| | Total Contractual | \$ 6,240 |
| G. | Construction | - 0 - |
| H. | Other | |
| | 1. Program promotion (mugs, t-shirts, bookmarks, greeting cards, etc.) | \$ 1,000 |
| | 2. Volunteer/member incentives (baby-sitting costs, scholarships to training events and conferences, etc.) | \$ 5,000 |
| | 3. Meeting/conference costs | \$ 1,500 |
| | 4. Graphics and reproduction | \$ 700 |
| | 5. Fiscal Audit | <u>\$ 750</u> |
| | Total Other | \$ 8,950 |
| I. | Total Direct Changes | \$177,545 |
| J. | Indirect Charges ¹² | \$ 13,764 |
| K. | TOTAL REQUEST (sum of direct and indirect costs) | \$191,309 |

¹¹ "Equipment" means an article of nonexpendable, tangible property having a useful life of more than one year and an acquisition cost that equals the lesser of (a) the capitalization level established by the governmental unit or nongovernmental applicant for financial statement purposes, or (b) \$5,000. Includes office equipment and furnishings, such as computers, work stations, fax machines, telephones, and other items necessary to appoint an individual or organizational office.

¹²If you do not have a negotiated indirect cost rate, you may calculate up to 10% of salary and fringe benefits for an indirect cost rate, and you will have 90 days after award of the grant to negotiate and establish an indirect cost with DHHS. If you are unable to establish an indirect cost rate, you may lose these funds. Alternately, you may waive your indirect cost rate, and, in that case, you should itemize all costs as direct in the "Other" category. (Note: Examples of costs that you should list if you do not plan to negotiate an indirect cost rate include: monthly telephone charges, mail costs, office rental, janitorial services, utilities, and any other costs for maintaining an office and program.)

