Department of Health and Human Services

Substance Abuse and Mental Health Services Administration

Offender Reentry Program
(Short Title: ORP)

(Modified Announcement)

Request for Applications (RFA) No. TI-15-012

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

PART 1: Programmatic Guidance

[Note to Applicants: This document must be used in conjunction with SAMHSA's "Request for Applications (RFA): PART II – General Policies and Procedures Applicable to all SAMHSA Applications for Discretionary Grants and Cooperative Agreements". PART I is individually tailored for each RFA. PART II includes requirements that are common to all SAMHSA RFAs. You must use both documents in preparing your application.]

Key Dates:

Application Deadline	**Applications are due by May 26, 2015.**
Intergovernmental Review (E.O. 12372)	**Applicants must comply with E.O. 12372 if their state(s) participates. Review process recommendations from the State Single Point of Contact (SPOC) are due no later than 60 days after application deadline.**
Public Health System Impact Statement (PHSIS)/Single State Agency Coordination	**Applicants must send the PHSIS to appropriate state and local health agencies by application deadline. Comments from Single State Agency are due no later than 60 days after application deadline.**

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EXECUTIVE SUMMARY

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) is accepting applications for fiscal year (FY) 2015 Offender Reentry Program (ORP) grants. The purpose of this program is to expand and/or enhance substance use disorder treatment and related recovery and reentry services to sentenced substance-abusing adult offenders/ex-offenders who are returning to their families and community from incarceration in state and local facilities including prisons, jails, or detention centers (hereafter known as "the population of focus"). For the purpose of this RFA, sentenced substance-abusing adult offenders/ex-offenders are defined as persons 18 years of age or older (or adults as defined by your state or tribal law) under the jurisdiction of the criminal justice system who have been sentenced to incarceration as adults and who have a substance use and/or co-occurring mental disorders. If your state or tribe uses a different age range for adult offenders, you must document how the age of "adults" is defined in your state or tribal justice system. Applicants are expected to form stakeholder partnerships that will plan, develop and provide a transition from incarceration to community-based substance abuse treatment and related reentry services. Because reentry transition must begin in the correctional facility before release, limited funding may be used for certain activities in institutional correctional settings in addition to the expected community-based services.

Funding Opportunity Title:	Offender Reentry Program
Funding Opportunity Number:	TI-15-012
Due Date for Applications:	May 26, 2015
Anticipated Total Available Funding:	$13.6 million
Estimated Number of Awards:	Up to 18 awards
Estimated Award Amount:	Up to $400,000 per year
Cost Sharing/Match Required	No
Length of Project Period:	Up to 3 years
Eligible Applicants:	Eligible applicants are domestic public and private nonprofit entities. [See Section III-1 of this RFA for complete eligibility information.]

Be sure to check the SAMHSA website periodically for any updates on this program.

I. FUNDING OPPORTUNITY DESCRIPTION

1. PURPOSE

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) is accepting applications for fiscal year (FY) 2015 Offender Reentry Program (ORP) grants. The purpose of this program is to expand and/or enhance substance use disorder treatment and related recovery and reentry services to sentenced substance-abusing adult offenders/ex-offenders who are returning to their families and community from incarceration in state and local facilities including prisons, jails, or detention centers (hereafter known as "the population of focus"). For the purpose of this RFA, sentenced substance-abusing adult offenders/ex-offenders are defined as persons 18 years of age or older (or adults as defined by your state or tribal law) under the jurisdiction of the criminal justice system who have been sentenced to incarceration as adults and who have a substance use and/or co-occurring mental disorders. If your state or tribe uses a different age range for adult offenders, you must document how the age of "adults" is defined in your state or tribal justice system. Applicants are expected to form stakeholder partnerships that will plan, develop and provide a transition from incarceration to community-based substance abuse treatment and related reentry services. Because reentry transition must begin in the correctional facility before release, limited funding may be used for certain activities in institutional correctional settings in addition to the expected community-based services.

ORP provides an opportunity for stakeholders to work together to give the population of focus the opportunity to improve their lives, including recovery from substance use and mental disorders, and develop the capacity and skills to become parents, employees and citizens in recovery from behavioral health disorders. SAMHSA's interest is to actively support and shape offender reentry treatment partnerships so that clinical needs are met and clients are treated using evidence-based practices consistent with the disease model and the problem-solving model, rather than with the traditional criminal justice model. A long-term goal of this program is to build sustainable systems of care for the population of focus. ORP seeks to address behavioral health disparities among racial and ethnic minorities by encouraging the implementation of strategies to decrease the differences in access, service use and outcomes among the racial and ethnic minority populations served. (See PART II: Appendix G – Addressing Behavioral Health Disparities.)

In alignment with the goals of SAMHSA's Trauma and Justice Strategic Initiative, this program will help reduce the pervasive, harmful, and costly health impact of violence and trauma by integrating trauma-informed approaches throughout health, behavioral

health, and related systems and addressing the behavioral health needs of people involved in, or at risk of involvement in, the criminal justice system. By providing needed treatment and recovery services, this program is intended to reduce the health and social costs of substance abuse and dependence to the public, and increase the safety of America's citizens by reducing substance abuse related crime and violence. Additional anticipated outcomes include: increased number of individuals served, increased abstinence from substance use, increased employment rates, decreased recidivism rates, increased housing stability, decreased criminal justice involvement, improved individual and family functioning and well-being, increased social connectedness, and decreased risky behaviors.

ORP grants are authorized under Section 509 of the Public Health Service Act, as amended. This announcement addresses Healthy People 2020 Substance Abuse Topic Area HP 2020-SA.

2. EXPECTATIONS

SAMHSA is seeking applications that will include a stakeholder partnership of institutional corrections officials with community corrections and community-based treatment and recovery services in order to plan, develop, and implement a continuum of care services from the correctional institution (prison/jail/detention center) to the community setting. Grantees must provide a coordinated approach designed to combine transition planning in the correctional institution (screening and assessment of substance use and/or co-occurring mental disorders and coordination of continued care from institution to community) with effective community-based treatment, recovery and reentry-related services to break the cycle of criminal behavior, alcohol and/or drug use and incarceration or other penalties. Since the stakeholder partnership is expected to begin in the correctional institution, applicants should review **Section I-2.3 Allowable Activities in Institutional Correctional Settings**.

Grantees must serve individuals who are incarcerated (in custody) and scheduled to be released into the community within the next four months, and continue for at least two months post release into community-based services as part of a transition plan, in order to implement the desired continuum of care. **This grant program is not designed to address the needs of individuals in custody or detention settings awaiting adjudication, or sentenced to residential treatment facilities, or in school-based programs.**

In addition, the adult offender must meet the following criteria to receive services funded under this grant program:

- Be assessed as substance-using/abusing or diagnosed as having a substance use and/or co-occurring mental disorder;

- Must have been sentenced to and serving at least three months in a correctional institution (jail/prison/detention center);

- Be within four months of scheduled release to the community in order to receive services in the correctional/detention setting (See Section I-2.3 - Allowable Activities in Institutional Correctional Settings); and

- Upon immediate release from the correctional facility to the community, be referred to community-based treatment.

2.1 Required Activities and Services

Offender reentry is the process an offender in an adult correctional facility goes through as he/she transitions from the institution to the community. Applicants must identify and provide services only to offenders within four months of scheduled release to the community from state and local correctional facilities. SAMHSA has a substantial interest in funding projects that provide **both services/treatment and systems linkages** for the reentering offender. Applicants must propose to address both of these areas.

Grantees are required to begin providing activities/services in institutional correctional settings (see **Section I-2.3 Allowable Activities in Institutional Correctional Settings**), start transitional planning in the institution as soon as possible, and provide community-based treatment services within four months of grant award.

Services/Treatment

You must use SAMHSA's services grant funds primarily to support allowable direct services. Applicants must propose activities that will improve the behavioral health of the population of focus by providing comprehensive substance abuse treatment and recovery support services. This includes, but is not limited to, the following types of activities:

- Providing direct alcohol and drug substance use and/or co-occurring mental disorder treatment (including screening, assessment, and care management) for diverse populations at risk. Treatment must be provided in outpatient, day treatment (including outreach-based services) or intensive outpatient, or residential programs. [Note: An applicant proposing to use grant funds for any residential substance abuse treatment services must clearly identify these services or treatment modality as such in Section B of the Project Narrative.]

- Providing "wrap-around"/recovery support services (e.g., child care, vocational, educational and transportation services) designed to improve access and

retention. [Note: Grant funds may be used to purchase such services from another provider.]

- Drug testing as required for supervision, treatment compliance, and therapeutic intervention.

- Case management should encompass using a team approach that includes criminal justice supervising authorities, substance abuse treatment professionals, existing treatment alternatives organizations such as TASC or similar treatment referral and case management models, and law enforcement as appropriate to the community setting.

Please see Appendix V: Allowable Substance Abuse and/or Co-Occurring Treatment and Recovery Support Services for a comprehensive but not exhaustive range of treatment and recovery support services.

Opioid overdose continues to be a major public health problem in the United States and has contributed significantly to accidental deaths among those who use, misuse or abuse illicit and prescription opioids. Applicants must provide a plan and implement an overdose prevention program as part of their service delivery for soon-to-be released offenders and those recently released from a correctional setting. Applicants should also collaborate with community corrections, law enforcement, and judges to develop and implement an opioid overdose prevention program. Letters of commitment from these entities (community corrections, law enforcement, and judges) must be included in **Attachment 1**. The opioid overdose prevention program must include an educational component that includes SAMHSA's Opioid Overdose Prevention Toolkit (http://captus.samhsa.gov/access-resources/opioid-overdose-prevention-toolkit). See Section F: Opioid Overdose Prevention Program.

Applicants must screen and assess clients for the presence of co-occurring mental and substance use disorders and use the information obtained from the screening and assessment to develop appropriate treatment approaches for persons identified as having such co-occurring disorders. [For more information on the process of selecting screening instruments to identify co-occurring substance use and mental disorders, go to http://www.samhsa.gov/co-occurring/.]

Recognizing that Medication-Assisted Treatment (MAT) may be an important part of a comprehensive treatment plan, SAMHSA ORP grantees may use **up to 20 percent** of the annual grant award to pay for FDA-approved medications for the treatment of substance use disorders (e.g., methadone, buprenorphine products including buprenorphine/naloxone combination formulations and buprenorphine mono-product formulations, naltrexone products including extended-release and oral formulations, disulfiram, and acamprosate calcium) when the client has no other source of funds to do so.

There is increasing interest in demonstrating the value of science-based tools to measure the criminogenic risks and behavioral health needs of offender populations in order to develop more effective interventions and criminal justice controls to reduce reoffending and to improve the behavioral health of the individual. SAMHSA is interested in promoting the use of these "Risks, Needs, and Responsivity" (RNR) tools to help prioritize scarce treatment resources for those individuals with the most acute and serious behavioral health needs and criminal justice involvement. Upon award, grantees will be required to implement the specific RNR tools indicated in Appendix VI: The Risk, Needs and Responsivity Model within the first four months of the first year of the grant. Grantees will be provided guidance and technical assistance for the implementation of the Risk, Need, and Responsivity tools.

If your application is funded, you will be expected to develop a behavioral health disparities impact statement no later than 60 days after your award. In this statement you must propose: (1) the number of individuals to be served during the grant period and identify subpopulations (i.e., racial, ethnic, sexual and gender minority groups) vulnerable to behavioral health disparities; (2) a quality improvement plan for the use of program data on access, use and outcomes to support efforts to decrease the differences in access to, use and outcomes of service activities; and (3) methods for the development of policies and procedures to ensure adherence to the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. (See PART II: Appendix G – Addressing Behavioral Health Disparities.)

SAMHSA strongly encourages all grantees to provide a tobacco-free workplace and to promote abstinence from all tobacco products (except in regard to accepted tribal traditions and practices).

According to the National Survey on Drug Use and Health, individuals who experience mental illness or who use illegal drugs have higher rates of tobacco use than the total population. Data from the National Health Interview Survey, the National Death Index, and other sources indicate earlier mortality among individuals who have mental and substance use disorders than among other individuals. Due to the high prevalence rates of tobacco use and the early mortality of the target population for this grant program, grantees are encouraged to promote abstinence from tobacco products (except with regard to accepted tribal traditional practices) and to integrate tobacco cessation strategies and services in the grant program. Applicants are encouraged to set annual targets for the reduction of past 30-day tobacco use among individuals receiving direct client services under the grant.

Grantees must utilize third party and other revenue realized from provision of services to the extent possible and use SAMHSA grant funds only for services to individuals who are ineligible for public or commercial health insurance programs, individuals for whom coverage has been formally determined to be unaffordable, or for services that are not sufficiently covered by an individual's health insurance plan. Grantees are also

expected to facilitate the health insurance application and enrollment process for eligible uninsured clients. Grantees should also consider other systems from which a potential service recipient may be eligible for services (for example, the Veterans Administration or senior services) if appropriate for and desired by that individual to meet his/her needs. In addition, grantees are required to implement policies and procedures that ensure other sources of funding are secured first when available for that individual.]

Recovery from mental disorders and/or substance use disorders has been identified as a primary goal for behavioral health care. SAMHSA's Recovery Support Strategic Initiative is leading efforts to advance the understanding of recovery and ensure that vital recovery supports and services are available and accessible to all who need and want them. Building on research, practice, and the lived experiences of individuals in recovery from mental and/or substance use disorders, SAMHSA has developed the following working definition of recovery: *A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.* See http://store.samhsa.gov/product/SAMHSA-s-Working-Definition-of-Recovery/PEP12-RECDEF for further information, including the four dimensions of recovery, and 10 guiding principles. Programs and services that incorporate a recovery approach fully involve people with lived experience (including consumers/peers/people in recovery, youth, and family members) in program/service design, development, implementation, and evaluation.

SAMHSA's standard, unified working definition is intended to advance recovery opportunities for all Americans, particularly in the context of health reform, and to help clarify these concepts for peers/persons in recovery, families, funders, providers and others. The definition is to be used to assist in the planning, delivery, financing, and evaluation of behavioral health services. SAMHSA grantees are expected to integrate the definition and principles of recovery into their programs to the greatest extent possible.

SAMHSA encourages all our grantees to address the behavioral health needs of returning veterans and their families in designing and developing their programs and to consider prioritizing this population for services where appropriate. SAMHSA will encourage its grantees to utilize and provide technical assistance regarding locally-customized web portals that assist veterans and their families with finding behavioral health treatment and support.

All clients who are considered to be at risk for viral hepatitis (B and C) as specified by United States Preventive Services Task Force (USPSTF) recommendations for hepatitis B[1] and hepatitis C[2,3] screening, must be tested for viral hepatitis (B and C) in

[1] *Final Recommendation Statement: Hepatitis B Virus Infection: Screening, 2014a*. U.S. Preventive Services Task Force. October 2014.

accordance with state and local requirements, either onsite or through referral. **Up to $5,000** of grant funds per year (when no other funds are available) may be used for the following hepatitis testing and services (based on risk and United States Preventive Services Task Force guidelines):

- Viral hepatitis B and C (antibody and confirmatory) testing;
- Viral hepatitis A and B vaccination;
- Purchase of test kits and other required supplies (e.g., gloves, biohazardous waste containers, etc.); and
- Training for staff related to viral hepatitis (B and C) testing.

Applicants must provide a plan for providing referrals and linkages to follow-up care and treatment for all individuals infected with viral hepatitis (B or C) in Section C of the Project Narrative. Applicants must also provide memoranda of agreement demonstrating linkages with appropriate treatment providers in **Attachment 5** of the application.

Grantees must report all positive viral hepatitis test results to the local and state health department, as appropriate.

2.2 Systems Linkages

Upon release of the offender to the community, funds should be used to provide effective, comprehensive substance use disorder treatment and related reentry services to the population of focus being served. Additionally, applicants must propose activities that support communities in their development of a comprehensive, multi-agency approach to expanding and/or enhancing substance use disorder treatment in addition to criminal justice supervision to adults leaving incarceration and returning to the community and their families.

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http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/hepatitis-b-virus-infection-screening-2014

[2] *Final Recommendation Statement: Hepatitis C: Screening*. U.S. Preventive Services Task Force. December 2014. http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/hepatitis-c-screening

[3] *Final Recommendation Statement: Hepatitis B in Pregnant Women: Screening*. U.S. Preventive Services Task Force. October 2014. http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/hepatitis-b-in-pregnant-women-screening

In order to effectively address the expansion and/or enhancement of treatment and recovery services to the population of focus, applicants are expected to demonstrate a collaborative partnership between the institutional corrections agency(ies) and the community-based organization.

The following represents a comprehensive but not exhaustive range of systems linkage coordination activities to be provided, and for which funds may be used:

- Systems coordination planning and developmental activities that bring all the key stakeholder agencies/organizations together;

- The development of systems linkages and referral sources in the community for offenders/ex-offenders, to include housing;

- Efforts to increase treatment capacity to provide immediate entry for offenders/ex-offenders into substance abuse treatment; and

- Assistance in paying for Department of Labor bonding for employment of the substance-abusing offender (access information at http://www.bonds4jobs.com).

Grantees are encouraged to provide HIV rapid preliminary antibody testing as part of their treatment regimen. Grantees providing HIV testing must do so in accordance with state and local requirements. Up to 5 percent of grant funds may be used for HIV rapid testing. [Note: Grant funds may be used to purchase such services from another provider.]

All clients who have a preliminary positive HIV test result must be administered a confirmatory HIV test result. Post award, grantees must develop a plan for medical case management of all clients who have a preliminary positive HIV and confirmatory HIV test result. As appropriate, SAMHSA will provide technical assistance to: train grantee staff in HIV rapid testing; obtain required state certification to conduct on-site testing; develop, as may be required, agreements with state and local health departments regarding HIV testing activities, and develop a case management system for monitoring and tracking.

SAMHSA and the U.S. Department of Justice (DOJ), Bureau of Justice Assistance (BJA) share a mutual interest in supporting and shaping offender reentry-treatment services, as both agencies fund “offender reentry” programs. SAMHSA and BJA have developed formal agreements to further encourage and engage in mutual interests and activities related to criminal justice-treatment issues. In order to reduce duplication of federal funds and to increase federal programs efficiencies, SAMHSA’s ORP grantees will be expected to seek out and coordinate with any local federally-funded offender reentry initiatives including “Second Chance Act” offender reentry programs, as appropriate. Applicants are encouraged to review the National Criminal Justice

Initiatives Map of all current federal offender reentry and criminal justice grants by state. This may be accessed by visiting the National Reentry Resource Center, a project of the Council of State Governments supported by BJA. (http://www.nationalreentryresourcecenter.org/national-criminal-justice-initiatives-map).

2.3 Allowable Activities in Institutional Correctional Settings

Because the focus of ORP is on the return of the offender to the community, the expectation is that most proposed treatment and related reentry services will be provided in the community. [NOTE: Grant funds may not be used to provide substance use disorder treatment services within the correctional facilities. See Part II: Appendix D - Funding Restrictions.]

However, recognizing that effective offender reentry requires assessment and release planning while the offender is incarcerated, limited funds may be used for certain activities inside adult institutional correctional settings for:

- Systems coordination planning and developmental activities that bring together all the key stakeholder agencies/organizations to form partnerships that will plan, develop, and provide substance abuse treatment and related reentry services in the community;

- The development of systems linkages and referral processes in both institutional and communities settings;

- Purchase and/or administration of brief diagnostic and screening tools for identification of substance abuse issues for the targeted offender population;

- Purchase and/or administration of substance abuse assessment instruments for the targeted offender population;

- Intake and/or case management staff with substance abuse treatment expertise to administer assessment instruments and to assist correctional staff in developing the individual offender transition plans for reentry into the community; and

- Community-based organizations, including faith-based groups, to go inside the correctional institution to begin wrap around transition planning activities such as, but not limited to, jobs skills planning, building connections to social support structures or educational program planning for community follow-up upon release.

[Note: These activities are considered infrastructure development (see Section I-2.7 Infrastructure Development); up to 15 percent of the total grant award may be used for infrastructure development activities.]

2.4 Using Evidence-Based Practices

SAMHSA's services grants are intended to fund services or practices that have a demonstrated evidence base and that are appropriate for the population(s) of focus. An evidence-based practice (EBP) refers to approaches to prevention or treatment that are validated by some form of documented research evidence. In Section B of your project narrative, you will need to:

- Identify the evidence-based practice(s) you propose to implement for the specific population(s) of focus.
- Identify and discuss the evidence that shows that the practice(s) is (are) effective for the specific population(s) of focus.
- If you are proposing to use more than one evidence-based practice, provide a justification for doing so and clearly identify which service modality and population of focus each practice will support.
- Discuss the population(s) for which the practice(s) has (have) been shown to be effective and show that it (they) is (are) appropriate for your population(s) of focus.

  [Note: See PART II: Appendix D – Funding Restrictions, regarding allowable costs for EBPs.]

SAMHSA recognizes that EBPs have not been developed for all populations and/or service settings. See Appendix I of this document for additional information about using EBPs.

2.5 Data Collection and Performance Measurement

All SAMHSA grantees are required to collect and report certain data so that SAMHSA can meet its obligations under the Government Performance and Results (GPRA) Modernization Act of 2010. You must document your ability to collect and report the required data in Section E: Data Collection and Performance Measurement of your application. Grantees will be required to report performance on the following performance measures: number of individuals served; client's substance use, family and living condition, employment status, social connectedness, access to treatment, retention in treatment, and criminal justice involvement. This information will be gathered using a uniform data collection tool provided by SAMHSA. The current tool is being updated and will be provided upon award. An example of the type of data

collection tool required can be found at https://cdp.samhsa.gov/**.** In addition to these measures, grantees will be expected to collect and report data on the frequency and type of substance use 90 days prior to incarceration. Grantees will be required to collect data via a face-to-face interview using this tool at three data collection points: intake to services, six months post intake, and at discharge. Grantees will be expected to do a GPRA interview on all clients in their specified unduplicated target number and are also expected to achieve a six-month follow-up rate of 80 percent.

The collection of these data will enable SAMHSA to report on key outcome measures relating to substance use. In addition to these outcomes, data collected by grantees will be used to demonstrate how SAMHSA's grant programs are reducing disparities in access, service use and outcomes nationwide.

Performance data will be reported to the public, the Office of Management and Budget (OMB) and Congress as part of SAMHSA's budget request.

2.6 Local Performance Assessment

Grantees must periodically review the performance data they report to SAMHSA (as required above) and assess their progress and use this information to improve management of their grant projects. The assessment should be designed to help you determine whether you are achieving the goals, objectives and outcomes you intend to achieve and whether adjustments need to be made to your project. Performance assessments also should be used to determine whether your project is having/will have the intended impact on behavioral health disparities. You will be required to report on your progress achieved, barriers encountered, and efforts to overcome these barriers in a performance assessment report to be submitted at least annually.

At a minimum, your performance assessment should include the required performance measures identified above. You may also consider outcome and process questions, such as the following:

Outcome Questions:

- What was the effect of the intervention on key outcome goals?
- What program/contextual/cultural/linguistic factors were associated with outcomes?
- What individual factors were associated with outcomes, including race/ethnicity/ sexual identity (sexual orientation/gender identity)?
- How durable were the effects?

- Was the intervention effective in maintaining the project outcomes at 6-month follow-up?

As appropriate, describe how the data, including outcome data, will be analyzed by racial/ethnic group or other demographic factors to assure that appropriate populations are being served and that disparities in services and outcomes are minimized.

Process Questions:

- How closely did implementation match the plan?
- What types of changes were made to the originally proposed plan?
- What types of changes were made to address disparities in access, service use, and outcomes across subpopulations, including the use of the National CLAS Standards?
- What led to the changes in the original plan?
- What effect did the changes have on the planned intervention and performance assessment?
- Who provided (program staff) what services (modality, type, intensity, duration), to whom (individual characteristics), in what context (system, community), and at what cost (facilities, personnel, dollars)?
- What strategies were used to maintain fidelity to the evidence-based practice or intervention across providers over time?
- How many individuals were reached through the program?

The performance assessment report should be a component of or an attachment to the biannual progress report of each grant year.

Up to 20 percent of the total grant award may be used for data collection, performance measurement, and performance assessment, e.g., activities required in Sections I-2.5 and 2.6 above.

2.7 Infrastructure Development (maximum 15 percent of total grant award)

Although services grant funds must be used primarily for direct services, SAMHSA recognizes that infrastructure changes may be needed to implement the services or improve their effectiveness. You may use up to 15 percent of the total services grant award for the following types of infrastructure development, if necessary to support the

direct service expansion of the grant project, and describe your use of grant funds for these activities in Section A of the Project Narrative.

- Developing partnerships with other service providers for service delivery.

- Adopting and/or enhancing your computer system, management information system (MIS), electronic health records (EHRs), etc., to document and manage client needs, care process, integration with related support services, and outcomes.

- Training/workforce development to help your staff or other providers in the community identify mental health or substance abuse issues or provide effective services consistent with the purpose of the grant program.

- Conducting specified activities outlined in this RFA under Section I-2.3 -Allowable Activities in Institutional Correctional Settings.

2.8 Grantee Meetings

Grantees must plan to send a minimum of three people to at least one joint grantee meeting in each year of the grant. It is anticipated that during the three-year grant period, grantees will alternate between physical, on-site grantee meetings and "virtual" grantee meetings on an alternating year basis. There will be two onsite meetings and a virtual grantee meeting is slated for FY 2017. In years when on-site grantee meetings are held, applicants should plan to send the Project Director, Clinical Supervisor and Evaluator. You must include a detailed budget and narrative for this travel in your budget. If the grantee is a community-based treatment agency instead of a local or state corrections agency the grantee is encouraged to send a key representative of the corrections agency involved in the ORP partnership. At these meetings, grantees will present the results of their projects and federal staff will provide technical assistance. Each meeting will be 3 days. These meetings are usually held in conjunction with the annual National TASC Conference and attendance is mandatory. Grantees may determine the current conference location by going to the national TASC website at http://www.nationaltasc.org. Applicants should budget per diem costs for a higher cost geographic region such as Washington, D.C., in order to adequately cover travel and per diem expenses. In addition to travel and per diem costs, you should include funds in your budget to cover any applicable conference registration fees since grantees will attend a joint grantee meeting and the national conference.

II. AWARD INFORMATION

Funding Mechanism: Grant

Anticipated Total Available Funding: $13.6 million

Estimated Number of Awards: Up to 18 awards

Estimated Award Amount: Up to $400,000 per year

Length of Project Period: Up to 3 years

Proposed budgets cannot exceed $400,000 in total costs (direct and indirect) in any year of the proposed project. Annual continuation awards will depend on the availability of funds, grantee progress in meeting project goals and objectives, timely submission of required data and reports, and compliance with all terms and conditions of award.

III. ELIGIBILITY INFORMATION

1. ELIGIBLE APPLICANTS

Eligible applicants are domestic public and private nonprofit entities. For example:

- State and local governments
- Federally recognized American Indian/Alaska Native (AI/AN) tribes and tribal organizations
- Urban Indian organizations
- Public or private universities and colleges
- Community- and faith-based organizations

Tribal organization means the recognized body of any AI/AN tribe; any legally established organization of American Indians/Alaska Natives which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of American Indians/Alaska Natives in all phases of its activities. Consortia of tribes or tribal organizations are eligible to apply, but each participating entity must indicate its approval.

In order to reduce duplication of federal efforts, the Federal Bureau of Prisons (BOP) institutions, and it's various correctional/community corrections facilities and programs are not eligible to apply for an ORP grant. Additionally, if you propose to serve offenders who are currently in the BOP, or its various correctional/community corrections institutions and programs, your application will not be reviewed and will not be considered for an award.

2. COST SHARING and MATCH REQUIREMENTS

Cost sharing/match is not required in this program**.**

3. EVIDENCE OF EXPERIENCE AND CREDENTIALS

SAMHSA believes that only existing, experienced, and appropriately credentialed organizations with demonstrated infrastructure and expertise will be able to provide required services quickly and effectively. You must meet three additional requirements related to the provision of services.

The three requirements are:

- A provider organization for direct client substance abuse treatment services appropriate to the grant must be involved in the proposed project. The provider may be the applicant or another organization committed to the project. More than one provider organization may be involved;

- Each mental health/substance abuse treatment provider organization must have at least 2 years experience (as of the due date of the application) providing relevant services in the geographic area(s) in which services are to be provided (official documents must establish that the organization has provided relevant services for the last 2 years); and

- Each mental health/substance abuse treatment provider organization must comply with all applicable local (city, county) and state licensing, accreditation and certification requirements, as of the due date of the application.

[Note: The above requirements apply to all service provider organizations. A license from an individual clinician will not be accepted in lieu of a provider organization's license. Eligible tribes and tribal organization mental health/substance abuse treatment providers must comply with all applicable tribal licensing, accreditation, and certification requirements, as of the due date of the application. See Appendix II, Statement of Assurance, in this document.]

Following application review, if your application's score is within the funding range, the government project officer (GPO) may contact you to request that the following

documentation be sent by overnight mail, or to verify that the documentation you submitted is complete:

- a letter of commitment from every mental health/substance abuse treatment provider organization that has agreed to participate in the project that specifies the nature of the participation and the service(s) that will be provided;

- official documentation that all mental health/substance abuse treatment provider organizations participating in the project have been providing relevant services for a minimum of 2 years prior to the date of the application in the area(s) in which the services are to be provided;

- official documentation that all participating mental health/substance abuse treatment provider organizations: 1) comply with all applicable local (city, county) and state requirements for licensing, accreditation and certification; OR 2) official documentation from the appropriate agency of the applicable state, county or other governmental unit that licensing, accreditation and certification requirements do not exist; and

- for tribes and tribal organizations only, official documentation that all participating mental health/substance abuse treatment provider organizations: 1) comply with all applicable tribal requirements for licensing, accreditation and certification; OR 2) documentation from the tribe or other tribal governmental unit that licensing, accreditation and certification requirements do not exist.

If the GPO does not receive this documentation within the time specified, your application will not be considered for an award.

IV. APPLICATION AND SUBMISSION INFORMATION

In addition to the application and submission language discussed in PART II: Section I, you must include the following in your application:

1. ADDITIONAL REQUIRED APPLICATION COMPONENTS

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

  The Supporting Documentation provides additional information necessary for the review of your application. This supporting documentation should be

provided immediately following your Project Narrative in Sections G through H. There are no page limits for these sections except for Section G, Biographical Sketches/Job Descriptions. Additional instructions for completing these sections are included in PART II-V: Supporting Documentation. Supporting documentation should be submitted in black and white (no color).

- Applicants for this program are required to complete the Assurance of Compliance with SAMHSA Charitable Choice Statutes and Regulations Form SMA 170**.** This form is posted on SAMHSA's website at http://www.samhsa.gov/grants/applying/forms-resources.

- **Attachments 1 through 5** – Use only the attachments listed below. If your application includes any attachments not required in this document, they will be disregarded. Do not use more than a total of 30 pages for Attachments 1, 3 and 4 combined. There are no page limitations for Attachments 2 and 5. Do not use attachments to extend or replace any of the sections of the Project Narrative. Reviewers will not consider them if you do. Please label the attachments as: Attachment 1, Attachment 2, etc.

  - **Attachment 1**: (1) Identification of at least one experienced, licensed mental health/substance abuse treatment provider organization; (2) a list of all direct service provider organizations that have agreed to participate in the proposed project, including the applicant agency, if it is a treatment or prevention service provider organization; (3) letters of commitment from these direct service provider organizations; **(Do not include any letters of support – it will jeopardize the review of your application if you do.)** (4) letters of commitment from community corrections, law enforcement, and judges that states their involvement in the development and plan for ongoing collaboration during implementation of the opioid overdose prevention program;(5) the Statement of Assurance (provided in Appendix II of this announcement) signed by the authorized representative of the applicant organization identified on the first page (SF-424) of the application, that assures SAMHSA that all listed providers meet the 2-year experience requirement, are appropriately licensed, accredited and certified, and that if the application is within the funding range for an award, the applicant will send the GPO the required documentation within the specified time.

  - **Attachment 2**: Data Collection Instruments/Interview Protocols – if you are using standardized data collection instruments/interview protocols, you do not need to include these in your application. Instead, provide a web link to the appropriate instrument/protocol. If the data collection instrument(s) or

interview protocol(s) is/are not standardized, you must include a copy in Attachment 2.

- **Attachment 3**: Sample Consent Forms

- **Attachment 4**: Letter to the SSA (if applicable; see PART II: Appendix C – Intergovernmental Review (E.O. 12372) Requirements).

- **Attachment 5**: A letter from the SSA Director or designated representative indicating that the proposed project addresses a state- or county-identified priority. Tribal applicants must provide similar documentation relating to tribal priorities. Also, include memoranda of agreement (MOAs) demonstrating linkages with appropriate treatment providers for all clients testing positive for viral hepatitis (B or C) in **Attachment 5**.

2. APPLICATION SUBMISSION REQUIREMENTS

Applications are due by **11:59 PM** (Eastern Time) on **May 26, 2015.**

3. FUNDING LIMITATIONS/RESTRICTIONS

- Up to 15 percent of the total grant award may be used for developing the infrastructure necessary for expansion of services.

- Up to 20 percent of the total grant award may be used for data collection, performance measurement and performance assessment, including incentives for participating in the required data collection follow-up.

- Up to 5 percent of grant funds may be used for HIV rapid testing. [Note: Grant funds may be used to purchase such services from another provider.]

- Up to 20 percent of the annual grant award may be used to pay for FDA-approved medications for the treatment of substance use disorders (e.g., methadone, buprenorphine products including buprenorphine/naloxone combination formulations and buprenorphine mono-product formulations, naltrexone products including extended-release and oral formulations, disulfiram, and acamprosate calcium) when the client has no other source of funds to do so.

- Up to $5,000 of grant funds per year (when no other funds are available) may be used for viral hepatitis (B and C) testing, including purchasing test kits and other required supplies (e.g., gloves, bio hazardous waste containers, etc.) and training for staff related to viral hepatitis (B and C) testing.

Be sure to identify these expenses in your proposed budget.

SAMHSA grantees also must comply with SAMHSA's standard funding restrictions, which are included in PART II: Appendix D – Funding Restrictions.

Note: Please disregard the following funding restriction listed in Part II Appendix D – Funding Restrictions (2nd bullet). ORP grantees may use funds to provide services to incarcerated populations, as explained in Section I-2.3 of this RFA.

SAMHSA grant funds must be used for purposes supported by the program and may not be used to:

- Provide services to incarcerated populations (defined as those persons in jail, prison, detention facilities, or in custody where they are not free to move about in the community).

V. APPLICATION REVIEW INFORMATION

1. EVALUATION CRITERIA

The Project Narrative describes what you intend to do with your project and includes the Evaluation Criteria in Sections A-F below. Your application will be reviewed and scored according to the quality of your response to the requirements in Sections A-F.

- In developing the Project Narrative section of your application, use these instructions, which have been tailored to this program.

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

- You must use the six sections/headings listed below in developing your Project Narrative. **You must indicate the Section letter and number in your response or it will not be considered, i.e., type "A-1", "A-2", etc., before your response to each question.** Your application will be scored according to how well you address the requirements for each section of the Project Narrative.

- Although the budget and supporting documentation for the proposed project are not scored review criteria, the Review Group will consider their appropriateness after the merits of the application have been considered. (See PART II: Section V and Appendix F).

- The number of points after each heading is the maximum number of points a review committee may assign to that section of your Project Narrative. Although scoring weights are not assigned to individual bullets, each bullet is assessed in deriving the overall Section score.

Section A: Population of Focus and Statement of Need (10 points)

1. Provide a comprehensive demographic profile of your population of focus in terms of race, ethnicity, federally recognized tribe, language, gender, age, socioeconomic characteristics and sexual identity (sexual orientation, gender identity).

2. Discuss the relationship of your population of focus to the overall population in your geographic catchment area and identify sub-population disparities, if any, relating to access/use/outcomes of your provided services, citing relevant data. Demonstrate an understanding of these populations consistent with the purpose of your program and intent of the RFA.

3. Describe the nature of the problem, including service gaps, and document the extent of the need (i.e., current prevalence rates or incidence data) for the population(s) of focus based on data. Identify the source of the data. Documentation of need may come from a variety of qualitative and quantitative sources. Examples of data sources for the quantitative data that could be used are local epidemiologic data, state data (e.g., from state needs assessments, SAMHSA's National Survey on Drug Use and Health), and/or national data [e.g., from SAMHSA's National Survey on Drug Use and Health or from National Center for Health Statistics/Centers for Disease Control and Prevention (CDC) reports, and Census data]. This list is not exhaustive; applicants may submit other valid data, as appropriate for your program, including offender reentry program specific data.

4. If you plan to use grant funds for infrastructure development, describe the infrastructure changes you plan to implement and how they will enhance/improve service effectiveness. If you do not plan to use grant funds for infrastructure changes, indicate so in your response.

5. Describe how you will utilize 3rd party and other revenue realized from the provision of substance abuse treatment services to the extent possible and use SAMHSA grant funds only for services to individuals who are ineligible for public health insurance programs, individuals for whom coverage has been formally determined to be unaffordable, or for services that are not sufficiently covered by an individual's health insurance plan (co-pay or other cost sharing requirements are an acceptable use of SAMHSA grant funds).

Section B: Proposed Evidence-Based Service/Practice (25 points)

1. Describe the purpose of the proposed project, including its goals and objectives. These must relate to the intent of the RFA and performance measures you identify in Section E: Data Collection and Performance Measurement.

2. Describe the Evidence-Based Practice (EBP) that will be used and justify its use for your population of focus, your proposed program, and the intent of this RFA. Describe how the proposed practice will address the following issues in the population(s) of focus: demographics (race, ethnicity, religion, gender, age, geography, and socioeconomic status); language and literacy; sexual identity (sexual orientation, gender identity); and disability. [See Appendix I: Using Evidence-Based Practices (EBPs).]

3. If an EBP does not exist/apply for your program, fully describe the practice you plan to implement, explain why it is appropriate for the population of focus, and justify its use compared to an appropriate existing EBP. Describe how the proposed practice will address the following issues in the population(s) of focus: demographics (race, ethnicity, religion, gender, age, geography, and socioeconomic status); language and literacy; sexual identity (sexual orientation, gender identity); and disability.

3. Explain how your choice of an EBP or practice will help you address disparities in service access, use and outcomes for subpopulations.

4. If applicable, describe any modifications that will be made to the EBP or practice and the reasons the modifications are necessary.

5. Identify any residential treatment services that will be funded within this project. Please include the number of individuals that you propose to serve with residential treatment slots.

Section C: Proposed Implementation Approach (30 points)

1. Provide a chart or graph depicting a realistic time line for the entire project period showing key activities, milestones, and responsible staff. These key activities should include the requirements outlined in Section I-2: Expectations. Be sure to show that the project can be implemented and service delivery can begin as soon as possible and no later than 4 months after grant award. [Note: The time line should be part of the Project Narrative. It should not be placed in an attachment.]

2. Indicate whether your proposed project will expand (i.e., increase access and availability of services to a larger number of clients) and/or enhance offender reentry program services (i.e., improve the quality and/or intensity of services).

3. Describe how the proposed activities will be implemented and how they will adhere to the National Standards for Culturally and Linguistic Appropriate Services (CLAS) in Health and Health Care. For additional information go to http://ThinkCulturalHealth.hhs.gov.

4. Describe how you will screen and assess clients for the presence of co-occurring mental and substance use disorders and use the information obtained from the screening and assessment to develop appropriate treatment approaches for the persons identified as having such co-occurring disorders.

5. Describe how you will identify, recruit and retain the population(s) of focus. Discuss how the proposed approach to identify, recruit and retain the population(s) of focus considers the language, beliefs, norms, values and socioeconomic factors of this/these population(s).

6. Identify any other organization(s) that will participate in the proposed project, including the institutional corrections agency(ies). Describe their roles and responsibilities and demonstrate their commitment to the project. Include letters of commitment from these organizations in **Attachment 1** of your application.

7. State the unduplicated number of individuals you propose to serve (annually and over the entire project period) with grant funds, including the types and numbers of services to be provided and anticipated outcomes. Explain how you arrived at this number. You are required to include the numbers to be served by race, ethnicity, and gender.

8. Since reentry must begin in the correctional institution, describe the allowable activities you plan to conduct in adult institutional correctional settings (see Section I-2.3 - Allowable Activities in Institutional Correctional Settings of this RFA)**.**

9. Describe how the proposed service(s) or practice(s) to be implemented will address the impact of violence and trauma by integrating trauma-informed approaches delivered to clients. [Information for SAMHSA's Strategic Initiative on Trauma and Justice is available at http://www.samhsa.gov/traumaJustice.]

10. Describe your plan to implement the use of the required RNR tools.

11. If you plan to provide HIV rapid testing, describe your process for offering this service.

12. If you plan to use funds to provide MAT, describe your plan to offer this treatment.

13. Describe your plan for providing referrals to viral hepatitis testing (if applicable), and to treatment for all clients testing positive for viral hepatitis (B or C).

14. Provide a per-unit cost for this program. Justify that this per-unit cost is providing high quality services that are cost effective. Describe your plan for maintaining

and/or improving the provision of high quality services that are cost effective throughout the life of the grant.

[NOTE: One approach might be to provide a per-person or unit cost of the project to be implemented. You can calculate this figure by: 1) taking the total cost of the project over the lifetime of the grant and subtracting 20 percent for data and performance assessment; 2) dividing this number by the total unduplicated number of persons to be served. Another approach might be to calculate a per-person or unit cost based upon your organization's history of providing a particular service(s). This might entail dividing the organization's annual expenditures on a particular service(s) by the total number of persons/families who received that service during the year. Another approach might be to deliver a cost per outcome achieved.]

Section D: Staff and Organizational Experience (10 points)

1. Discuss the capability and experience of the applicant organization and other participating organizations with similar projects and populations. Demonstrate that the applicant organization and other participating organization have linkages to the population(s) of focus and ties to grassroots/community-based organizations that are rooted in the culture(s) and language(s) of the population(s) of focus.

2. Provide a complete list of staff positions for the project, including the Project Director and other key personnel, showing the role of each and their level of effort and qualifications.

3. Discuss how key staff have demonstrated experience and are qualified to serve the population(s) of focus and are familiar with their culture(s) and language(s).

4. Describe how your staff will ensure the input of clients in assessing, planning and implementing your project.

Section E: Data Collection and Performance Measurement (20 points)

1. Document your ability to collect and report on the required performance measures as specified in Section I-2.5 of this RFA. Describe your plan for data collection, management, analysis and reporting. If applicable, specify and justify any additional measures or instruments you plan to use for your grant project.

2. Describe the data-driven quality improvement process by which sub-population disparities in access/use/outcomes will be tracked, assessed and reduced.

3. Describe your plan for conducting the local performance assessment as specified in Section I-2.6 of this RFA and document your ability to conduct the assessment.

Section F: Opioid Overdose Prevention Program (5 Points)

1. Describe your plan to deliver an opioid overdose prevention program to soon-to-be released and recently released offenders.

2. Describe your collaboration with community corrections, law enforcement, and judges in the development of the opioid overdose prevention program, and the plan for ongoing collaboration during implementation. Letters of commitment from community corrections, law enforcement, and judges, must be included in Attachment 1 of your application.

SUPPORTING DOCUMENTATION

Section G: Biographical Sketches and Job Descriptions

See PART II: Appendix E – Biographical Sketches and Job Descriptions, for instructions on completing this section.

Section H: Confidentiality and SAMHSA Participant Protection/Human Subjects

You must describe procedures relating to Confidentiality, Participant Protection and the Protection of Human Subjects Regulations in Section H of your application. See Appendix III of this document for guidelines on these requirements.

VI. ADMINISTRATION INFORMATION

1. REPORTING REQUIREMENTS

In addition to the data reporting requirements listed in Section I-2.5, grantees must comply with the reporting requirements listed on the SAMHSA website at http://www.samhsa.gov/grants/grants-management/reporting-requirements. SAMHSA will provide grantees with reporting guidelines and requirements at the time of award and at the initial grantee orientation meeting after the award.

VII. AGENCY CONTACTS

For questions about program issues contact:

Jon D. Berg
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Room 5-1002
Rockville, Maryland 20857
240-276-1609
jon.berg@samhsa.hhs.gov

For questions on grants management and budget issues contact:

Eileen Bermudez
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Room 7-1091
Rockville, Maryland 20857
(240) 276-1412
eileen.bermudez@samhsa.hhs.gov

Appendix I – Using Evidence-Based Practices (EBPs)

SAMHSA recognizes that EBPs have not been developed for all populations and/or service settings. For example, certain practices for American Indians/Alaska Natives, rural or isolated communities, or recent immigrant communities may not have been formally evaluated and, therefore, have a limited or nonexistent evidence base. In addition, other practices that have an established evidence base for certain populations or in certain settings may not have been formally evaluated with other subpopulations or within other settings. Applicants proposing to serve a population with an practice that has not been formally evaluated with that population are required to provide other forms of evidence that the practice(s) they propose is appropriate for the population(s) of focus. Evidence for these practices may include unpublished studies, preliminary evaluation results, clinical (or other professional association) guidelines, findings from focus groups with community members, etc. You may describe your experience either with the population(s) of focus or in managing similar programs. Information in support of your proposed practice needs to be sufficient to demonstrate the appropriateness of your practice to the individuals reviewing your application.

- Document the evidence that the practice(s) you have chosen is appropriate for the outcomes you want to achieve.

- Explain how the practice you have chosen meets SAMHSA's goals for this grant program.

- Describe any modifications/adaptations you will need to make to your proposed practice(s) to meet the goals of your project and why you believe the changes will improve the outcomes. We expect that you will implement your evidence-based service(s)/practice(s) in a way that is as close as possible to the original service(s)/practice(s). However, SAMHSA understands that you may need to make minor changes to the service(s)/practice(s) to meet the needs of your population(s) of focus or your program, or to allow you to use resources more efficiently. You must describe any changes to the proposed service(s)/practice(s) that you believe are necessary for these purposes. You may describe your own experience either with the population(s) of focus or in managing similar programs. However, you will need to convince the people reviewing your application that the changes you propose are justified.

- Explain why you chose this evidence-based practice over other evidence-based practices.

- If applicable, justify the use of multiple evidence-based practices. Discuss how the use of multiple evidence-based practices will be integrated into the program. Describe how the effectiveness of each evidence-based practice will be quantified in the performance assessment of the project.

- Discuss training needs or plans for training to successfully implement the proposed evidence-based practice(s).

Resources for Evidence-Based Practices:

You will find information on evidence-based practices at http://store.samhsa.gov/resources/term/Evidence-Based-Practice-Resource-Library. SAMHSA has developed this website to provide a simple and direct connection to websites with information about evidence-based interventions to prevent and/or treat mental and substance use disorders. The *Resource Library* provides a short description and a link to dozens of websites with relevant evidence-based practices information – either specific interventions or comprehensive reviews of research findings.

In addition to the website noted above, you may provide information on research studies to show that the services/practices you plan to implement are evidence-based. This information is usually published in research journals, including those that focus on minority populations. If this type of information is not available, you may provide information from other sources, such as unpublished studies or documents describing formal consensus among recognized experts.

[Note: Please see PART II: Appendix D – Funding Restrictions, regarding allowable costs for EBPs.]

Appendix II – Statement of Assurance

As the authorized representative of [*insert name of applicant organization*] _____, I assure SAMHSA that all participating service provider organizations listed in this application meet the two-year experience requirement and applicable licensing, accreditation, and certification requirements. If this application is within the funding range for a grant award, we will provide the SAMHSA Government Project Officer (GPO) with the following documents. I understand that if this documentation is not received by the GPO within the specified timeframe, the application will be removed from consideration for an award and the funds will be provided to another applicant meeting these requirements.

- a letter of commitment from every mental health/substance abuse treatment service provider organization listed in **Attachment 1** of the application that specifies the nature of the participation and the service(s) that will be provided;

- official documentation that all mental health/substance abuse treatment provider organizations participating in the project have been providing relevant services for a minimum of 2 years prior to the date of the application in the area(s) in which services are to be provided. Official documents must definitively establish that the organization has provided relevant services for the last 2 years; and

- official documentation that all mental health/substance abuse treatment provider organizations: 1) comply with all local (city, county) and state requirements for licensing, accreditation and certification; OR 2) official documentation from the appropriate agency of the applicable state, county or other governmental unit that licensing, accreditation and certification requirements do not exist.[4] (Official documentation is a copy of each service provider organization's license, accreditation and certification. Documentation of accreditation will not be accepted in lieu of an organization's license. A statement by, or letter from, the applicant organization or from a provider organization attesting to compliance with licensing, accreditation and certification or that no licensing, accreditation, certification requirements exist does not constitute adequate documentation.)

- for tribes and tribal organizations only, official documentation that all participating mental health/substance abuse treatment provider organizations: 1) comply with all applicable tribal requirements for licensing, accreditation and certification; OR

[4] Tribes and tribal organizations are exempt from these requirements.

2) documentation from the tribe or other tribal governmental unit that licensing, accreditation and certification requirements do not exist.

_____ _____

Signature of Authorized Representative Date

Appendix III – Confidentiality and SAMHSA Participant Protection/Human Subjects Guidelines

Confidentiality and Participant Protection:

Because of the confidential nature of the work in which many SAMHSA grantees are involved, it is important to have safeguards protecting individuals from risks associated with their participation in SAMHSA projects. All applicants (including those who plan to obtain IRB approval) must address the seven elements below. Be sure to discuss these elements as they pertain to on-line counseling (i.e., telehealth) if they are applicable to your program. If some are not applicable or relevant to the proposed project, simply state that they are not applicable and indicate why. In addition to addressing these seven elements, read the section that follows entitled "Protection of Human Subjects Regulations" to determine if the regulations may apply to your project. If so, you are required to describe the process you will follow for obtaining Institutional Review Board (IRB) approval. While we encourage you to keep your responses brief, there are no page limits for this section and no points will be assigned by the Review Committee. Problems with confidentiality, participant protection, and the protection of human subjects identified during peer review of the application must be resolved prior to funding.

1. Protect Clients and Staff from Potential Risks

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

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

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

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

2. Fair Selection of Participants

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

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

- Explain the reasons for including or excluding participants.

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

3. Absence of Coercion

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

- If you plan to compensate participants, state how participants will be awarded incentives (e.g., money, gifts, etc.). Provide justification that the use of incentives is appropriate, judicious and conservative and that incentives do not provide an "undue inducement" which removes the voluntary nature of participation. Incentives should be the minimum amount necessary to meet the programmatic and performance assessment goals of the grant. Applicants should determine the minimum amount that is proven effective by consulting with existing local programs and reviewing the relevant literature. In no case may the value if an incentive paid for with SAMHSA discretionary grant funds exceed $30.

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

4. Data Collection

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

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

- Provide in **Attachment 2**, “Data Collection Instruments/Interview Protocols,” copies of all available data collection instruments and interview protocols that you plan to use (unless you are providing the web link to the instrument(s)/protocol(s)).

5. Privacy and Confidentiality

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

   - Describe:

     - How you will use data collection instruments.

     - Where data will be stored.

     - Who will or will not have access to information.

     - How the identity of participants will be kept private, for example, through the use of a coding system on data records, limiting access to records, or storing identifiers separately from data.

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

6. Adequate Consent Procedures

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

   - State:

     - Whether or not their participation is voluntary.

     - Their right to leave the project at any time without problems.

     - Possible risks from participation in the project.

     - Plans to protect clients from these risks.

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

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

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

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

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

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

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

7. Risk/Benefit Discussion

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

Protection of Human Subjects Regulations

SAMHSA expects that most grantees funded under this announcement will not have to comply with the Protection of Human Subjects Regulations (45 CFR 46), which requires Institutional Review Board (IRB) approval. However, in some instances, the applicant's proposed performance assessment design may meet the regulation's criteria for research involving human subjects.

In addition to the elements above, applicants whose projects must comply with the Human Subjects Regulations must fully describe the process for obtaining IRB approval. While IRB approval is not required at the time of grant award, these grantees will be required, as a condition of award, to provide documentation that an Assurance of Compliance is on file with the Office for Human Research Protections (OHRP). IRB approval must be received in these cases prior to enrolling participants in the project.

General information about Human Subjects Regulations can be obtained through OHRP at http://www.hhs.gov/ohrp or (240) 453-6900. SAMHSA–specific questions should be directed to the program contact listed in Section VII of this announcement.

Appendix IV – Background Information

SAMHSA's Interest in Offender Reentry Issues

SAMHSA recognizes that there is a significant disparity between the availability of treatment services for persons with alcohol and drug use disorders and the demand for such services. According to the 2010 National Survey on Drug Use and Health (NSDUH), 23.1 million individuals needed treatment for an alcohol or illicit drug use problem. Only 11 percent of these individuals received treatment at a specialty facility in the past year. This disparity is also consistent for criminal justice populations, as estimates show only 8.3 percent of individuals involved with the criminal justice system who are in need of substance abuse treatment receive it as part of their justice system supervision. Approximately one-half of the institutional treatment provided is educational programming (Taxman, NIDA CJDATS, 2007).

Furthermore, a 2007 study by NIDA's Criminal Justice Drug Abuse Treatment Study indicates that offenders have a much higher rate of psycho-social dysfunction, including substance abuse disorders, than the general population. By providing needed treatment services, the ORP program is intended to reduce the health and social costs of substance abuse and dependence to the public, and increase the safety of America's citizens by reducing substance abuse related crime and violence.

Over the past decade, awareness of the need for a continuing care system for adult offenders has grown as states and local communities have struggled with the increasing number of these individuals returning to the community after release from correctional confinement. Reentry into the community and reintegration into the family are risky times for these offenders and their families. Substance abuse treatment for offenders in prison and in the community has been extensively studied and evaluated over the past several years, and the results are consistent and clear – treatment works at reducing crime and recidivism.

SAMHSA/CSAT recognizes the need to successfully return and reintegrate these individuals into the community by providing substance abuse treatment and other related reentry services, while also ensuring public safety for the community and family. This program builds on previous and ongoing SAMHSA/CSAT criminal justice program initiatives (e.g., SAMHSA/CSAT FY 2009, 2010, 2012, and 2013 ORP grant programs), incorporating lessons learned to improve program effectiveness. ORP is one of SAMHSA's services grant programs. SAMHSA's services grants are designed to address gaps in substance abuse treatment services and/or to increase the ability of states, units of local government, American Indian/Alaska Native Tribes and tribal organizations, and community- and faith-based organizations to help specific populations or geographic areas with serious, emerging substance abuse problems.

Appendix V – Allowable Substance Abuse and/or Co-Occurring Treatment and Recovery Support Services

Applicants must propose to **expand** substance abuse treatment and recovery support services, to **enhance** substance abuse treatment and outreach and recovery support services, or do both.

1) **Service Expansion:** An applicant may propose to **increase access and availability of services to a larger number of clients**. Expansion applications should propose to increase the number of clients receiving services as a result of the award. For example, if a treatment facility currently serves 50 persons per year and has a waiting list of 50 persons (but no funding to serve these persons), the applicant may propose to expand service capacity to be able to admit some or all of those persons on the waiting list. **Applicants must clearly state in "Section C: Proposed Implementation Approach" of the application the** unduplicated number of individuals you propose to serve, including sub-populations, (annually and over the entire project period) with grant funds, including the types and numbers of services to be provided and anticipated outcomes.

2) **Service Enhancement:** An applicant may propose to improve **the quality and/or intensity of services,** for instance, by adding state-of-the-art treatment approaches, or adding a new service to address emerging trends or unmet needs. For example, a substance abuse treatment project may propose to add a co-occurring treatment intervention to the current treatment protocol for a population being served by the program. **Applicants proposing to enhance services must clearly state in "Section C: Proposed Implementation Approach" of the application the number of clients who will receive the** unduplicated number of individuals you propose to serve, including sub-populations, (annually and over the entire project period) with grant funds, including the types and numbers of services to be provided and anticipated outcomes.

Substance Abuse and/or Co-Occurring Services:

The following represents a comprehensive but not exhaustive range of services/treatment to be provided, and for which funds may be used:

- Screening and a comprehensive individual assessment for substance use and/or co-occurring mental disorders, case management, program management and referrals related to substance abuse treatment for clients

- Alcohol and drug (substance abuse) treatment in outpatient, day treatment (including outreach-based services) or intensive outpatient, or residential treatment programs.

- Wrap around services supporting the access to and retention in substance abuse treatment or to address the treatment-specific needs of clients during or following a substance abuse treatment episode (See below under "Recovery Support Services")

- Individualized services planning

- Drug testing as required for supervision, treatment compliance, and therapeutic intervention

Recovery Support Services:

Community Linkages

Applicants must demonstrate that they have developed linkages with community-based organizations with experience in providing services to these communities.
Examples of possible community linkages include, but are not limited to:

- Primary health care.
- Substance abuse treatment services and where appropriate integrated mental health treatment services for individuals with co-occurring disorders.
- Private industry-supported work placements for recovering persons.
- Faith-based organizational support.
- Mentoring programs.
- Community service.
- Support for the homeless.
- HIV/AIDS community-based outreach projects.
- Opioid treatment programs.
- Health education and risk reduction information.
- Access/referral to STD, hepatitis B (including immunization) and C, and TB testing in public health clinics.

Examples of Recovery Support Services

Recovery support services (RSSs) are non-clinical services that assist individuals and families to recover from alcohol or drug problems. They include social support, linkage to and coordination among allied service providers, and a full range of human services that facilitate recovery and wellness contributing to an improved quality of life. These services can be flexibly staged and may be provided prior to, during, and after treatment. RSSs may be provided in conjunction with treatment, and as separate and distinct services, to individuals and families who desire and need them. RSSs may be delivered by peers, professionals, faith-based and community-based groups, and others. RSSs are a key component of recovery-oriented systems of care.

Recovery support services are typically provided by paid staff or volunteers familiar with how their communities can support people seeking to live free of alcohol and drugs, and are often peers of those seeking recovery. Some of these services may require reimbursement while others may be available in the community free of charge.
Examples of recovery support services include the following:

- Transportation to and from treatment, recovery support activities, employment, etc.

- Employment services and job training.
- Case management/individual services coordination, providing linkages with other services (legal services, TANF, social services, food stamps, etc.).
- Outreach.
- Relapse prevention.
- Referrals and assistance in locating housing.
- Child care.
- Family/marriage education.
- Peer-to-peer services, mentoring, coaching.
- Life skills.
- Education.
- Parent education and child development.
- Substance abuse education.

Definitions for Recovery Support Services

Transportation: Commuting services are provided to clients who are engaged in treatment- and/or recovery support-related appointments and activities and who have no other means of obtaining transportation. Forms of transportation services may include public transportation or a licensed and insured driver who is affiliated with an eligible program provider.

Employment Services and Job Training: These activities are directed toward improving and maintaining employment. Services include skills assessment and development, job coaching, career exploration or placement, job shadowing or internships, résumé writing, interviewing skills, and tips for retaining a job. Other services include training in a specific skill or trade to assist individuals to prepare for, find, and obtain competitive employment such as skills training, technical skills, vocational assessment, and job referral.

Case Management: Comprehensive medical and social care coordination is provided to clients to identify their needs, plan services, link the services system with the client, monitor service delivery, and evaluate the effort.

Relapse Prevention: These services include identifying a client's current stage of recovery and establishing a recovery plan to identify and manage the relapse warning signs.

Referrals and Assistance in Locating Housing: This includes referral to local sober houses, access to housing databases, and assistance in locating housing.

Child Care: These services include care and supervision provided to a client's child(ren), less than 14 years of age and for less than 24 hours per day, while the client is participating in treatment and/or recovery support activities. These services must be provided in a manner that complies with state laws regarding child care facilities.

Family/Marriage Counseling and Education: Services provided to engage the whole family system to address interpersonal communication, codependency, conflict, marital issues and concerns, parenting issues, family re-unification, and strategies to reduce or minimize the negative effects of substance abuse use on the relationship.

Peer-to-Peer Services, Mentoring, and Coaching: Mutual assistance in promoting recovery may be offered by other persons who have experienced similar substance abuse challenges. These services focus more on wellness than illness. Peer mentoring or coaching refers to a one-on-one relationship in which a peer leader with more recovery experience motivates, supports, and encourages another peer in establishing and maintaining his/her recovery. Mentors/coaches may help peers develop goals and action plans, as well as helps them find resources. Recovery support includes an array of activities, resources, relationships, and services designed to assist an individual's integration into the community, participation in treatment and/or recovery support services, and improved functioning in recovery.

Life Skills: Life skills services address activities of daily living, such as budgeting, time management, interpersonal relations, household management, anger management, and other issues.

Education: Supported education services are defined as educational counseling and may include academic counseling, assistance with academic and financial applications, and aptitude and achievement testing to assist in planning services and support. Vocational training and education also provide support for clients pursuing adult basic education, i.e., general education development (GED) and college education.

Parent Education and Child Development: An intervention or treatment provided in a psycho-educational group setting that involves clients and/or their families and facilitates the instruction of evidence-based parenting or child development knowledge skills. Parenting assistance is a service to assist with parenting skills; teach, monitor, and model appropriate discipline strategies and techniques; and provide information and advocacy on child development, age appropriate needs and expectations, parent groups, and other related issues.

Appendix VI – The Risk, Needs, and Responsivity Simulation Tool

Applicants are expected to implement a Risk, Needs, and Responsivity (RNR) Simulation Tool that was developed by George Mason University's Center for Advancing Correctional Excellence (ACE!) with support from SAMHSA and the Bureau of Justice Assistance. The model has three main features: 1) Individual Assessment, 2) Program Assessment, and 3) Jurisdiction Capacity Assessment.

RNR Background Information

For people involved in the criminal justice system, assessment and programming should involve not only behavioral health needs but also criminal justice-related issues. Addressing both behavioral health needs/risks and risks of criminal justice involvement in assessment and treatment services is an evidence-based practice (Taxman, 2006; Taxman & Marlowe, 2006; Lowenkamp, Latessa, & Hostlinger, 2006; Andrews & Bonta, 2010.) The notion is that by assessing for criminal and behavioral health factors (i.e. substance abuse, mental health, HIV/AIDS risk factors, trauma, and so forth), the criminal justice system and/or treatment system can be better informed as to the most effective treatment and recovery interventions and criminal justice controls to reduce reoffending and to improve the behavioral health of the individual. The assessment should also include other factors that are referred to as criminogenic needs such as antisocial peers, antisocial cognitions, and, antisocial values/thinking. This evidence-based practice is referred to as the Risk-Need-Responsivity Model (RNR) since it is grounded in evidence that targeting people with certain criminal justice risk and behavioral health needs for certain programs is more likely to improve outcomes. (Taxman, Perdoni, & Caudy, 2012; Lowenkamp & Latessa, 2005)

Another component of the evidence-based practice model for those involved in the justice system is the nature of the program and interventions offered to the individual. Essentially, effective programs must be able to address the criminal justice, behavioral health, and criminogenic needs to achieve more positive results. Good quality programs should focus on: Identifying a primary target behavior for cognitive behavioral interventions; increasing the dosage based on the criminal justice risk factors; increasing the dosage and intensity of the intervention based on the criminogenic needs and behavioral health needs; using cognitive behavioral therapy and social learning interventions that focus on assisting with restructuring prosocial thinking; creating an environment where individuals can change; collaborating with justice agencies to ensure that the controls are integrated into the treatment programming; emphasizing motivation to change to build up the individual's commitment to the treatment programming; providing feedback to individuals in the program to ensure long-term success; offering programs and interventions that adhere to the core model, using an evidence-based treatment curriculum, and having staff that are skilled in delivering the services. A good program also has access to reports on process and outcomes. Effective, well-run programs are important to achieving better outcomes.

RNR Framework

The RNR framework focuses on improving outcomes by ensuring that people involved in the justice system are handled in a manner that is likely to yield better outcomes. The framework basically builds on good practices. It requires that individuals involved in the justice system are screened and assessed for criminal justice risk factors, behavioral health needs, and other criminogenic factors. (Most of these criminogenic factors include factors that are clinically relevant that affect how well the person functions in the community such as peer or family issues, substance abuse, housing stability, etc.) It requires that programs should be targeted to certain profiles of individuals with core components. The programs also need to be implemented well. In total, the RNR framework also reinforces the need for jurisdictions to have a range of programs to meet the overall needs of the justice-involved population. The gaps in services need to be identified in order to develop a program and/or system that are responsive. The implementation of all three components of the RNR framework—individual screening and assessment, program quality, and gap analysis—can reduce recidivism and improve behavioral health outcomes. Effective programs can reduce recidivism but systems that offer quality programming and have a variety of programming to meet the risk-needs profiles can be even more effective in reducing recidivism than a single program.

RNR Simulation Model

To help jurisdictions and programs use the RNR framework, George Mason University's Center for Advancing Correctional Excellence (ACE!) with the support of the federal Substance Abuse and Mental Health Services Administration and the Bureau of Justice Assistance developed a decision support system—the RNR Simulation Model--for line staff, supervisors, administrators, and jurisdictions overall. The model has an underlying database of over 100,000 profiles that includes how changes in programming can affect recidivism outcomes. That is, the system tries to meet the full needs of justice and behavioral health agencies (either government or non-profit organizations) by integrating the science around effective screening, assessment, programs, and treatment matching (responsivity) to reduce offending.

This model draws from criminal justice and behavioral health information with three main features:

- **Individual Assessment: What type of programming would this person benefit from?** That question is addressed in this component. Here, the emphasis is using data from criminal justice and behavioral health screening and assessment to determine the most effective intervention to reduce recidivism. If your organization does not have certain information, then the underlying database can be integrated with your own data to make a better decision as to the program of "best fit". The programming recommendations for individual offenders are based on inputted information about the risk, criminogenic needs, and other clinically relevant factors. It estimates a percent reduction in recidivism that may be expected if the offender is matched to the level of programming that

is consistent with their unique needs. This assessment is to be administered to clients; it can be done either as an interview or as a summary of the interview. It is advisable that organizations use their own screening and assessment procedures (and instruments). The 17 item screener uses information from clinical interviews or screening tools. If an organization does not have a tool, then they can use these 17 questions in lieu of the existing tool(s) or it can be used to supplement these tools for any criminogenic needs or clinically relevant factors that are important in supporting treatment matching decisions. That is, the tool uses the underlying data base to complete a risk-need profile. With support from SAMSHA, the tool also includes pertinent questions about reentry and assessment of reentry needs. It takes about 10 minutes to complete and enter into a data base.

- **Program Assessment: What type of individual is more likely to have better outcomes from this program? Does this program embrace evidence-based practices? In what way can implementation of this program be improved to achieve better outcomes?** This 30 minute program assessment tool examines the services/treatments offered, program content, quality, dosage, and other factors. Jurisdictions input information about a specific program and the tool rates the program's overall quality according to the RNR principles. When applicable, the tool provides recommendations for how the program can be refined to better achieve responsivity. The three main goals of the program tool are: (1) to classify programs to facilitate treatment matching, (2) to explore how programs currently target the risk level and criminogenic needs of their clients, and (3) to asses programs on their use of evidence-based practices. The tool is intended to help criminal justice and behavioral health agencies better understand the treatment resources that are available to them and to foster responsivity to specific risk-need profiles. .

- **Jurisdiction Capacity Assessment: Does your program have capacity for the individuals that would benefit from the individual? Does the jurisdiction or system have an array of evidence-based programming to meet the needs of individuals in that jurisdiction?** This portal uses data to assess a jurisdiction's capacity to be responsive. Based on data about the prevalence of risk and needs of individuals and then the available programs in your jurisdiction, this portal identifies system-level gaps in the capacity to provide responsivity and estimates expected recidivism reductions when programming is matched to risk and needs at the jurisdictional level. Additionally, this portal makes recommendations regarding what levels of programming jurisdictions may need to augment in order to better respond to the needs of their population.

Implementation of the RNR Simulation Tool

What does it take to implement The RNR Simulation Tool? For each component of the tool, there is a need for a staff member to be trained (2 days) with three booster sessions. Jurisdictions will need to have access to a computer and an Internet browser.

- Individual Assessment is designed for line staff. Line staff will need to be trained to use the tool and then to use the reports. An intake staff member will need to use assessment and screening data available in the system.
- Program Assessment is designed for program administrators or managers. This staff member will need some assistance from a data person or clinical person to provide information about the program.
- Assessment of the Jurisdiction or Capacity is designed for administrators or managers. A data person from the organization will need to gather data. A committee or workgroup can review the data from the system for system planning efforts.

To implement the RNR Simulation Model, applicants should budget for additional staff time for screening and assessment and review of reports. The assessment tool is public domain and grantees will access the GMU website for information, data collection, and reporting.

Additional Resources:

For programmatic questions related to the RNR Simulation Model requirements contact Jon Berg, the Programs Contact, listed in this RFA.

For additional information about the Risk, Needs, and Responsivity Model and implementation in behavioral health and correctional settings applicants are referred to the Council of State Governments' Justice Center Report: '"Adults with Behavioral Health Needs Under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery" at http://consensusproject.org/jc_publications/adults-with-behavioral-health-needs.

Applicants are also referred to the following site for additional information about the RNR Simulation Model: http://www.gmuace.org/tools/

Other additional research citations of interest on RNR concepts and models related to substance abuse treatment and criminal populations include:

Andrews, D. A. & Bonta, J. (2010). *The psychology of criminal conduct* (5th ed.). Cincinnati, OH: Anderson Publishing Co.
Bonta, James and D. A. Andrews. 2007. *Risk-Need-Responsivity Model for Offender Assessment and Rehabilitation*. Ottawa: Public Safety Canada, June. Available at: http://www.publicsafety.gc.ca/res/cor/rep/risk_need_200706-eng.aspx .
Lowenkamp, C.T. & Latessa, E.J. (2005). Increasing the effectiveness of correctional programming through the risk principle: Identifying offenders for residential placement. *Criminology and Public Policy,* 4(2), 263-290.

Lowenkamp, C.T., Latessa, E.J. & Holsinger, A.M. (2006). The risk principle in action: What have we learned from 13,676 offenders and 97 correctional programs? *Crime & Delinquency,* 52(1), 77-93.79.
Lowenkamp, C.T., Latessa, E.J. & Smith, P. (2006). Does correctional program quality really matter? The impact of adhering to the principles of effective intervention. *Criminology and Public Policy,* 5(3), 575-594.
Osher, F., D'Amora, D.A., Plotkin, M., Jarrett, N., & Eggleston, A (2012). *Adults with Behavioral Health Needs under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery*. New York: Council of State Governments.
Taxman, F.S. (2014). Second Generation of RNR: The Importance of Systemic Responsivity in Expanding Core Principles of Responsivity. *Federal Probation.* http://www.uscourts.gov/uscourts/FederalCourts/PPS/Fedprob/2014-09/rnr.html
Taxman, F.S., Pattavina, A., & Caudy, M. (2014). Justice Reinvestment in the US: The Case for More Programs. *Victims & Offenders*, 9(1): 50-75.
Taxman, F.S., Perdoni, M.L., & Caudy, M. (2012). The Plight of Providing Appropriate Substance Abuse Treatment Services to Offenders: Modeling the Gaps in Service Delivery. Victims & Offender, 8(1): 70-93. Taxman, F. S. (2006). Assessment with a flair. *Federal Probation*, 70(2): 3-15.
Taxman, F. S., & Marlowe, D. M (2006). Risk, needs, responsivity: In action or inaction. *Crime and Delinquency*, 52(1): 3-7.