

SUPPORTING STATEMENT
National Outcome Measures for Substance Abuse Prevention (NOMs)

JUSTIFICATION

A1. Circumstances Making the Collection of Information Necessary

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention (CSAP) is requesting from the Office of Management and Budget (OMB) approval to add six items for adults and three items for youth that address SAMHSA's Strategic Initiative #3 - Military Families. SAMHSA has made it a priority to support "America's service men and women—Active Duty, National Guard, Reserve, and Veteran—together with their families and communities by leading efforts to ensure that needed behavioral health services are accessible and that outcomes are positive." Monitoring the number of military personnel and their families served by funded programs, whether specifically targeted or not, and monitoring their outcomes is an important step in addressing this priority. This entails a revision of data collection activities for the National Outcome Measures (OMB No. 0930-0230) that expire on April 30, 2012 and include the following four forms:

1. Adult Community Form
2. Youth Community Form
3. Adult Programs Form
4. Youth Programs Form

Approval of this information collection will allow SAMHSA to continue to meet the Government Performance and Results Act of 1993 (GPRA) reporting requirements that quantify the performance and accomplishments of its programs, which are consistent with OMB guidance. The findings are used for reporting on program performance in the annual Congressional Justifications, as well as in other performance related documents such as the MAI report for HHS, and the ONDCP Drug Budget.

In order to carry out section 1105(a) (29) of GPRA, SAMHSA is required to prepare a performance plan for its major programs of activity. This plan must:

- a) Establish performance goals to define the level of performance to be achieved by a program activity;
- b) Express such goals in an objective, quantifiable, and measurable form;
- c) Briefly describe the operational processes, skills and technology, and the human, capital, information, or other resources required to meet the performance goals;
- d) Establish performance indicators to be used in measuring or assessing the relevant outputs, service levels, and outcomes of each program activity;
- e) Provide a basis for comparing actual program results with the established performance goals; and
- f) Describe the means to be used to verify and validate measured values.

SAMHSA's legislative mandate is to increase access to high-quality prevention and treatment services and to improve outcomes. Its mission is to reduce the impact of substance use and mental illness on our communities.

All of SAMHSA's programs and activities are geared toward the achievement of goals related to reducing the impact of substance use and mental health disorders. GPRA performance monitoring is a collaborative and cooperative aspect of this process. SAMHSA is striving to coordinate the development of these goals with other ongoing performance measurement development activities (for example, the development of performance measures for reporting of activities). This information collection is needed to provide objective data that demonstrate SAMHSA's monitoring and achievement of its mission and goals.

The NOMS initiative emerged as a result of multiple, converging Federal events, including: the advent of GPRA; SAMHSA's agency-wide cross-cutting GPRA tools in 1999 (OMB No. 0930-0208); the Office of National Drug Control Policy's (ONDCP) Performance Measures of Effectiveness (PMEs); Healthy People 2010; the Children's Health Act of 2000; and the general emphasis on accountability at all levels. As a result, the NOMs include GPRA and HP2010 and 2020 measures and further support these efforts by promoting common measures in the prevention field. A number of NOMs are also now consistent with ONDCP's Drug Free Community core measures.

A2. Purpose and Use of Information

SAMHSA uses the performance measures to report on the performance of its discretionary services grant programs. As detailed below, performance measures information is used by individuals at three levels: the SAMHSA administrator and staff; the Center administrators and government project officers; and grantees.

SAMHSA Level—The information is used to inform the administration of the performance of Agency-funded programs. The performance is based on the goals of the grant program and includes the NOMs. This information serves as the basis of the annual GPRA report to Congress contained in the Justifications of Budget Estimates.

Center Level—In addition to exploring the performance of the various programs, the information is used to monitor and manage individual grant projects within each program, informing the government project officers of the project staff's abilities to meet their individual goals. This information has been used by government project officers to make funding continuation decisions.

Grantee Level—In addition to monitoring performance outcomes, the grantee staff uses the information to improve the quality of treatment and prevention services that are provided to clients within their projects.

SAMHSA and its Centers will use the data for annual reporting required by GPRA and for NOMs to compare program participants' behavior prior to program entry with their outcomes following participation. GPRA requires that SAMHSA's report for each fiscal year include actual results of performance monitoring for the three preceding fiscal years. The additional information collected with the NOMs will allow SAMHSA to report on the results of these performance outcomes, to maintain consistency with the specific performance domains that SAMHSA is implementing as the NOMs, and to assess the accountability and performance of its discretionary and formula grant programs.

Performance Monitoring data reflect the Agency's desire for consistency across its data collection efforts. SAMHSA has implemented specific performance domains called NOMs to assess the accountability and performance of its discretionary and formula grant programs.

SAMHSA/CSAP would like to improve its ability to address questions from Congress and the public regarding the types of prevention programs that work best and for whom, including military families. Through the use of common, psychometrically sound measures across its many grant programs, SAMHSA/CSAP is able to compare results and assess performance across data sets. The NOMs reduce the number of measures to those most critical to prevention and provide the best items for capturing those constructs as defined by experts in the field. With approval of this revision, SAMHSA/CSAP will continue to look across all of its programs to determine which are having the greatest impact on prevention outcomes and modify programs accordingly. This type of cross-program information is vital to understanding the types of interventions that work, for which populations, and under what circumstances. Such information informs SAMHSA/CSAP's future budget allocation and program development decisions, and allows SAMHSA/CSAP to address various information requests and queries.

Proposed Changes to Data Collection Tool

CSAP has increased the number of questions in the form to satisfy reporting needs. These questions will be contained in a new section in the NOMS form. The following paragraph present a description of the changes made to the information collection.

CSAP added six items for adults and three items for youth that addresses SAMHSA's Strategic Initiative #3 (Military Families). SAMHSA is interested in collecting data on active duty and veteran military members. Collection of these data will allow CSAP to identify the number of veterans served, deployment status and location, and family veteran status in conjunction with the types of services that military individuals and their families receive. Identifying a client's veteran status and deployment area allows CSAP and the grantees to monitor the needs of these clients and explore whether special services or programs are needed to treat them for substance abuse and other related issues. Identification of veteran status and/or military family status will also allow coordination between SAMHSA and other Federal agencies to provide a full range of services to veterans. CSAP will also be able to monitor military family outcomes through the NOMS.

CSAP Substance Abuse Prevention NOMs

Abstinence from Drug Use/Alcohol Abuse

- Past 30-day Substance Use (non-use/reduction in use)
- Age of First Substance Use
- Perception of Disapproval/Attitude
- Perceived Risk/Harm of Use

Increased/Retained Employment or Return to/Stay in School

- Perception of Workplace Policy
- Substance Abuse-Related Suspensions and Expulsions (developmental)
- School Attendance and Enrollment

Decreased Criminal Justice Involvement

- Driving Under the Influence (DUI)
- Alcohol-Related Traffic Fatalities
- Alcohol and Drug-Related Crime

Increased Access to Services (Service Capacity)

Number of Persons Served by Age, Gender, Race

Based on current funding and budget proposals, the CSAP programs that will use these measures include the Fetal Alcohol Spectrum Disorders (FASD) Center for Excellence, Strategic Prevention Framework State Incentive Grants (SPFSIG), Partnerships for Success (PFS), and Minority Aids Incentive (HIV) grantees. Prevention Prepared Communities (PPC) were included for FY 2012 and FY 2013 based on their inclusion in budget proposals.

A3. Use of Improved Information Technology and Burden Reduction

SAMHSA/CSAP has developed a web-based data entry tool to assist grantees in submitting their data electronically. This data entry tool, available through CSAP’s Prevention Management Reporting and Training System (PMRTS), will reduce the burden on those grantees that do not have the capacity to submit large batch files. These tools will be made available to grantees through CSAP’s PMRTS web portal. The tools are designed to reflect the structure of the forms and to allow the entry of data from completed forms directly into the system through the use of radio buttons corresponding to response options. The system automatically quantifies the selected response options and stores the numeric codes in a SQL server for subsequent extraction, cleaning, and analysis.

PMRTS is maintained by CSAP’s Data Information Technology Infrastructure Center (DITIC). The data entered online by grantees are periodically extracted by DITIC and transmitted in encrypted form to CSAP’s Data Analysis Coordination and Consolidation Center (DACCC) for cleaning, record linkage, and analysis. Grantees have two options for accessing the data they enter online: 1) grantees can download, in spreadsheet form, the raw data they have entered online as soon as it is submitted; and 2) grantees can access their data from the cleaned analysis files prepared by DACCC, which are posted on PMRTS under password protection.

Grantees that prefer to create their own data files have the option of uploading complete data files to PMRTS. A grantee choosing this data submission method is required to use a standard codebook while preparing the data, thus ensuring that uploaded data files have the same numeric coding and variable naming conventions as the data entered using the online tools.

Grantees' NOMs data are submitted to CSAP's DITIC in May and November (or annually as appropriate), which in turn are submitted to the DACCC. The DACCC uses these data for secondary analysis to aid SAMHSA/CSAP in responding to GPRA, ONDCP, and other Federal reporting requirements, and to inform SAMHSA/CSAP policy and program planning.

Electronic submission of the data promotes enhanced data quality. With built-in data quality checks and easy access to data outputs and reports, users of the data can feel confident about the quality of the output. The electronic submission also promotes immediate access to the data set. Once the data are put into the web-based system, it is available for access, review, and reporting by all those with password protected access to the system – from Center staff to the grantee staff.

A4. Efforts to Identify Duplication

The items collected are necessary to assess grantee performance. SAMHSA is promoting the use of NOMs across all programs; this effort will result in less overlap and duplication for grantees and will substantially reduce the burden on grantees that results from data demands associated with individual programs. Thus, if an organization has more than one grant, it uses the standard NOMS items across grants instead of each grant having its unique measures for the same indicator. For example, key NOMS are included in ONDCP's DFC data collection tool to reduce duplicative data collection for grantees who also have SAMHSA's STOP Act and SPFSIG sub recipient community funds.

A5. Involvement of Small Entities

Individual grantees vary from small entities to large provider organizations. Every effort has been made to minimize the number of data items collected from programs to the least required to accomplish the objectives of the effort and to meet GPRA and NOMs reporting requirements; therefore, there is no significant impact involving small entities.

A6. Consequences If Information Is Collected Less Frequently

The data collection points remain unchanged from the previous submission. Direct service grantees usually collect the required data (e.g., previously approved GPRA measures) from participants before services are initiated, at the end of services, and 6 months after services end. Discharge and follow-up data collections are necessary to generate outcome data. Infrastructure and indirect service grantees submit data annually. Grantees submit NOMs data to coincide with GPRA data submissions. SAMHSA/CSAP requires all grantees and contractors to submit data to the CSAP DITIC for cross-program analysis twice per year (May and November). These submission dates are necessary for SAMHSA/CSAP to provide the most current performance reporting for requirements such as GPRA. If these data are submitted to SAMHSA/CSAP less

frequently, SAMHSA/CSAP will not be able to meet reporting requirements. The data will be reported to SAMHSA on an annual basis in keeping with the GPRRA requirements for annual reporting.

A7. Consistency With the Guidelines in 5 CFR 1320.5(d) (2)

This information collection fully complies with 5 CFR 1320.5(d) (2).

A8. Consultation Outside the Agency

The notice required by 5 CFR 1320.8(d) was published in the Federal Register on June 15, 2011 (Vol. 76, p. 35002). No comments were received in response to this notice.

A9. Payment to Respondents

Grantee organizations may decide to provide in-kind incentives to respondents (such as gift certificates from local vendors not to exceed \$20) for completing the data forms. Literature suggests that monetary incentives have a strong positive effect on response rates and no known adverse effect on reliability. In particular, substance abuse research has shown improved response rates when remuneration is offered to respondents. SAMHSA programs typically target a high risk population for whom out-of-pocket costs of participation (e.g., transportation, child care) are significant barriers.

A10. Assurance of Confidentiality

SAMHSA has statutory authority to collect data under the Government Performance and Results Act (Public Law 1103(a), Title 31) and is subject to the Privacy Act for the protection of this data. As part of its grant application process, SAMHSA/CSAP requires grantees to describe the procedures they will use to ensure the privacy and protection of participant data. These include by whom and the methods by which data will be collected; how data collection forms will be administered; where data will be stored; who will/will not have access to information; and how the identity of participants will be safeguarded. Consent forms will include language about privacy and that the data collection is voluntary and will not affect participation in direct service programs. Data are collected through self report

The information from grantees and all other potential respondents will be kept private through all points in the data collection and reporting process. All data will be closely safeguarded, and no institutional or individual identifiers will be used in reports. Only aggregated data will be reported. SAMHSA and its contractors will not receive identifiable client records. Provider-level information will be aggregated to, at the least, the level of the grant/cooperative agreement-funding announcement.

A11. Questions of a Sensitive Nature

SAMHSA's mission is to improve the quality and availability of prevention, early intervention, treatment, and rehabilitation services for substance abuse and mental illnesses, including co-occurring disorders, in order to improve health and reduce illness, death, disability, and cost to society. In carrying out this mission it is necessary for service providers to collect sensitive items such as use of alcohol or other drugs. The data that will be submitted by each grantee will be based in large part on data that most programs are already routinely collecting. This primarily includes data on client demographics, substance abuse history, services received, and outcomes in order to understand the needs of participants and to measure the impact of services. Grantees are required to have adequate consent procedures in place, and these procedures include obtaining and documenting active parental/guardian consent when necessary. SAMHSA review committees will not approve nor will SAMHSA fund a site without adequate provisions for meeting Federal policies regarding consent. Review committees consider the following participant protection (PP) criteria:

1. Protect participants from potential risks,
2. . Fair selection of participants,
3. Absence of coercion,
4. Data collection,
5. Privacy and confidentiality, and
6. Adequate consent procedures.

Applications are coded: no PP concerns or comments; PP comments or PP concerns. Before an application can be funded, the applicant must address in writing any PP comments or concerns raised to the CSAP's participant protection officer's satisfaction. Until this is done, they are barred from funding especially if the application is coded with "concerns". The CSAP participant protection officer reviews their response to issues raised by the peer review committee. If they respond to the protection officer's satisfaction, the bar on funding is lifted.

SAMHSA follows procedures similar to those used by CDC and DoEd regarding parental consent for youth: adherence to state and local regulations.

A12. Estimates of Annualized Hour Burden

A typical grantee implementing direct service programs will collect NOMs data at the participant level by administering the NOMs forms at program entry, exit, and 6 months following exit. This request for OMB approval to collect a set of national outcome measures for prevention is an umbrella request; that is, this request covers all SAMHSA/CSAP grantees. The estimated annual hour burden is provided in the table below. This estimate is based on SAMHSA/CSAP's projected new and active grantees for FY 2011 through FY 2013 that target individuals. These estimates represent data collection primarily at the program level, although this may also be applicable for some community-level measures wherein data are only collected once per year. Estimated hours are broken out by programs within divisions.

It is estimated that the average annual number of respondents over three years will be 19,316. The average annual hour burden will be 14,488 hours. There will be no direct cost to youth or

adults for participating in the study. The value of adult time was assumed given the prevailing minimum wage rate in California, the state chosen since it is often the leading indicator for setting precedents later adopted by other states.

ESTIMATES OF ANNUALIZED COST BURDEN

SAMHSA/CSAP program	Number of grantees	Number of respondents	Responses per respondent	Hours/response	Total hours	Hourly Wage	Total Hour Cost†
FY 11							
Science/Services:							
Fetal Alcohol	23	4,800	3	0.4	5,760	\$8.00	\$27,187
Capacity:							
HIV/Targeted Capacity	122	31,964	3	0.4	38,357	\$8.00	\$181,044
SPF SIG	51		0				
SPF SIG/Community Level *		44,288	1	0.4	17,715	\$8.00	\$83,615
SPF SIG/Program Level *		13,575	3	0.4	16,290	\$8.00	\$76,889
PFS	5		0				
PFS/Community Level *		5,250	1	0.4	2,100	\$8.00	\$9,912
PPC	N/A	N/A	N/A	N/A		N/A	N/A
FY 12							
Science/Services:							
Fetal Alcohol	23	4,800	3	0.4	5,760	\$8.00	\$27,187
Capacity:							
HIV/Targeted Capacity	122	31,964	3	0.4	38,357	\$8.00	\$181,044
SPF SIG	35		0				
SPF SIG/Community Level *		29,925	1	0.4	11,970	\$8.00	\$56,498
SPF SIG/Program Level *		9,100	3	0.4	10,920	\$8.00	\$51,542
PFS	10		0				
PFS/Community Level *		10,500	1	0.4	4,200	\$8.00	\$19,824
PPC	50	25,000	1	0.4	10,000	\$8.00	\$47,200
FY 13							
Science/Services:							
Fetal Alcohol	23	4,800	3	0.4	5,760	\$8.00	\$27,187
Capacity:							
HIV/Targeted Capacity	122	31,964	3	0.4	38,357	\$8.00	\$181,044
SPF SIG	35		0				
SPF SIG/Community		29,925	1	0.4	11,970	\$8.00	\$56,498

SAMHSA/CSAP program	Number of grantees	Number of respondents	Responses per respondent	Hours/response	Total hours	Hourly Wage	Total Hour Cost†
Level *							
SPF SIG/Program Level *		9,100	3	0.4	10,920	\$8.00	\$51,542
PFS	15		0				
PFS/Community Level *		15,750	1	0.4	6,300	\$8.00	\$29,736
PPC	50	25,000	1	0.4	10,000	\$8.00	\$47,200
Annual Average		19,316			14,488		\$70,717

†Total hour cost based on the percentage of adults served by SAMHSA/CSAP programs in FY 2010, which was 59%.

* The Strategic Prevention Framework State Incentive Grant (SPF SIG) has a three-levels of data collection: The Grantee, Community, and Program Level; Partnerships for Success (PFS) has two-levels : The Grantee and Community Level. The Grantee level data is pre-populated by SAMHSA. The use of the Community Level form is optional as they relate to targeted interventions implemented during the reporting period. We estimated at the community level that 25% of state/jurisdiction grantees are using the community level form. Across these grantees, we estimate that approx. 14 communities are using the form to collect data from 300 people per community. Among tribal grantees, we estimate that 75% of grantees are using the forms with approx. 5 communities per tribal grantee. We estimate that each of these communities is including 150 people per community. At the program level, we estimated that each state/jurisdiction grantee would have approx. 14 communities with 25 program participants and each tribal grantee would have approx. 5 communities with 25 program participants.

A13. Estimates of Annualized Cost Burden to Respondents

There are neither capital nor startup costs, nor are there any operation and maintenance costs.

A14. Estimates of Annualized Cost to the Government

The estimated annualized cost to the government is \$184,320. NOMs data collection is part of SAMHSA/CSAP's ongoing data collection and reporting activities, and the Center has allocated sufficient resources for the efficient and effective management and use of the information to be collected. It is anticipated that the Contract Officer Technical Representative (COTR) who oversee the projects will expend time assisting the DITIC, the DACCC, and grantees in appropriately responding to the measures. The COTR overseeing the DACCC will expend a portion of time overseeing the analysis of the NOMs data, as well as working to revise the measures as they are developed. It is anticipated that cross-program analysis will be conducted by the DACCC. Data analysis activities include processing the data received from the various programs, as well as conducting statistical analysis. These costs are broken out in the table below. Annual hours are based on a 40-hour work week for 48 weeks per year.

Estimated Annualized Cost to the Government

POSITION	PERCENT FTE	ANNUAL HOURS	RATE	TOTAL ANNUAL COST
DACCC GPO	10%	192	\$40	\$7,680
DITIC GPO	5%	96	\$40	\$3,840
FASD GPO	2.50%	48	\$40	\$1,920
SPF SIG GPO	2.50%	48	\$40	\$1,920
HIV GPO	2.50%	48	\$40	\$1,920
PFS GPO	2.50%	48	\$40	\$1,920
PPC GPO	2.50%	48	\$40	\$1,920
DACCC Senior Analyst*	25%	480	\$80	\$38,400
DACCC Data Analyst*	50%	960	\$65	\$62,400
DACCC Data Manager*	50%	960	\$65	\$62,400
	Totals	2,928		\$184,320

* Rate for DACCC staff includes fringe and overhead.

A15. Changes in Burden

Currently there are 19,523 hours in the CSAP NOMs OMB package. SAMHSA is requesting a total of 14,488 burden hours, an overall decrease of 5,035 hours in the inventory. The change is due to a decrease in the number of responses based on the type of data collection (communities do not do pre, post, follow-up) and that the burden hours for completion of the form were reduced. Therefore, the burden for data collection is decreasing despite SAMHSA/CSAP’s request for the addition of 6 items for adults and 3 for youth.

A16. Time Schedule, Publication and Analysis Plans

Publication and Analysis Plans. SAMHSA/CSA utilizes the NOMs data on an ongoing basis to respond to GPRA and other Federal reporting requirements, as well as to address questions from Congress and the public regarding the types of prevention programs that work best and for which participants. Further, these data are used to provide SAMHSA with data to document the overall Center performance requirements via cross-program analyses and analyses of individual programs to provide information that will assist CSAP in planning and monitoring SAMHSA/CSAP’s success in meeting its goals. The table below provides examples of the various analyses and reports for which the NOMs data are used and provides approximate dates as to when these activities take place.

Time Frame for Analytic Activities

Activity	Date
GPRA findings in budget justifications	May September, December
Conducting analyses to support CSAP budget proposals to Congress	Spring of each year
Responding to ad hoc requests for analysis from CSAP staff, other Federal agencies, and the public regarding prevention effectiveness	Ongoing

The analyses of NOMs data is descriptive, and, where suitable, inferential. Basic statistics are calculated to derive frequency distributions, means, and other measures of central tendency. National outcome data are also examined by demographics to allow comparisons of program effectiveness between gender and other subpopulation groups.

A17. Display of Expiration Date

The expiration date for OMB approval will be displayed on all data collection forms for which approval is being sought.

A18. Exceptions to Certification Statement

This collection of information involves no exceptions to the Certification for Paperwork Reduction Act Submissions.

B. COLLECTIONS OF INFORMATION EMPLOYING STATISTICAL METHODS

B1. Respondent Universe and Sampling Methods

Direct service grantees use a census approach and administer the NOMs form to all participants receiving services covered by grant funds. State grantee level data collection uses sampling. These proposals are reviewed by a peer review group that assesses the adequacy and appropriateness of the study design and methods. Only those applicants having technically sound proposals are funded. In the SPFSIG and PFS programs, state grantees then fund community level sub recipients to implement interventions and community level data collection. As the communities are funded by the state, the state works with the communities on sampling design. Often, the NOMs items are added to existing surveys, such as the YRBS or BRFSS, with existing sampling frames. In addition, SAMHSA/CSAP provides technical assistance as necessary to monitor grantee adherence to the proposal. SAMHSA/CSAP's response universe for the NOMs renewal includes all active grantees (with relevant participants and objectives) and those initially funded at the end of FY 2011 and beyond that provide direct services to

participants. In order to ensure accountability for the spending of federal funds, CSAP has employed the use of these data as a performance management tool to ensure that grantees are meeting the goals and objectives of the program. Data are used to monitor performance throughout the grant period. The Public Health Service Act Sec. 501 [290aa] (d) (13) with respect to grant Programs authorized under this title, assure that *all grants that are awarded for the provision of services are subject to performance and outcome data collections*. SAMHSA has operationalized these requirements to indicate the need for data to be collected on all clients served.

B2. Information Collection Procedures

Each grantee also has its own plan for data collection, processing, data cleaning, control, and retention. Each plan describes how uniform data collection will be ensured, the time frame for conducting the assessments over the course of the project, and how participant protection will be assured. As mentioned above, these plans undergo peer review to ensure the adequacy and appropriateness of the study design and methods. The precise manner in which data will be collected and used depends on the specific grant program.

The SPF SIG and PFS program. sub recipient communities are given the option of using the Community NOMs forms to track changes across time in the NOMs at the community level. Starting with Cohort 3 grantees, sub recipients implementing direct service programs will collect NOMs data at the participant level by administering the NOMs forms at program entry, exit, and 6 months following exit.

The Fetal Alcohol Spectrum Disorder (FASD) Center for Excellence program integrates prevention and intervention approaches into existing service delivery systems. In addition, it identifies and disseminates state-of-the-art information for the prevention of FASD and increases functioning and quality of life for those impacted by it.

The Minority Aids Initiative (MAI) develops local capacity to provide substance abuse prevention services for individuals living with and affected by HIV/AIDS. These funds assist with outreach and training, addressing the special needs of racial and ethnic minorities, and studying the costs associated with delivering integrated care.

The Prevention Prepared Communities (PPC) program will assist states and communities in developing and implementing effective mental illness and substance abuse prevention practices, strategies, and policies that will promote the wellness of individuals ages 9 through 25 and the communities in which they live. The program builds on scientific evidence that a common set of risk and protective factors contributes to a range of mental, physical, and behavioral problems, including substance abuse and other unhealthy behaviors. The goal of Prevention Prepared Communities is to improve community- and individual-level wellness and health promotion outcomes in a comprehensive, collaborative way.

Most measures are administered by pencil and paper; see Attachment B for example NOMs forms.

Web-Based Data Entry Upload System: The DITIC has created CSAP's Prevention Management and Training System (PMRTS), an online data entry system that provides prevention information, data collection tools, documents, data entry functions, and access to reporting statistics and tracking. All forms can be found in the "Tools" section of this website. Common forms are available in both Microsoft Word and PDF format for individual grant sites to download and make copies for administration to participants. Site evaluators or data collectors are expected to enter client or participant responses through the PMRTS website. Sites will also be able to upload response databases through PMRTS that use the appropriate variable/value numbering (Questionnaire codebooks are also available on the "Tools" section of the PMRTS site). SAMHSA/CSAP's DACCC will be responsible for conducting logic checks on the data, and will communicate with the grantees to clarify questions about the data.

B3. Methods to Maximize Response Rates

Each grantee will have established its own follow-up procedures as part of the original protocol. Issues related to response rates, as well as other data collection issues, are discussed at grantee meetings in order for GPOs to identify problems and provide technical assistance. In addition, GPOs monitor data collection efforts and provide technical assistance to individual grantees as necessary. Because collection of the NOMs is a stipulation of the grants, it is anticipated that all grantees will comply (as appropriate). The participants at each site to whom these measures will be administered are all voluntary respondents; therefore, grantees cannot guarantee full cooperation on the part of participants. Historically, however, participant response rates across grantee sites have averaged 80%.

As part of the terms and conditions of the grant award, sites are required to use the NOMs data system, available through the PMRTS website.

B4. Tests of Procedures

All measures on the NOMs are either part of the National Household Survey or measures from existing databases. As a result, all are well-tested and proven useful; no further pre-testing is needed.

B5. Statistical Consultants

The measures submitted here for OMB approval renewal are a result of lengthy consultation and discussion among SAMHSA personnel, state representatives, the DCC staff and a panel of outside experts. Furthermore, these measures were presented and discussed with members of the grantee community, and at various meetings and conferences. The final selection of these measures was made by SAMHSA and CSAP senior officials. See Attachment A for staff and consultants involved.

List of Attachments

<u>Attachment</u>	<u>Description</u>
A	NOMS Review: Outside Experts
B	NOMS Forms (Adult Community, Youth Community, Adult Program, Youth Program)