

**SUPPORTING STATEMENT FOR THE  
GOVERNMENT PERFORMANCE AND RESULTS ACT  
CLIENT/PARTICIPANT OUTCOME MEASURES**

**JUSTIFICATION**

**A1. Circumstances Making the Collection of Information Necessary**

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) is requesting from the Office of Management and Budget (OMB) approval for the revision of data collection activities for the Government Performance and Results Act Client/Participant Outcome Measures for Discretionary Programs and Instructions (OMB No. 0930–0208) which expires on April 30, 2012.

CSAT requests approval for the following to:

Increase the number of questions in the instrument due to the agency's need for additional information from its programs to satisfy reporting needs.

This information is collected using a client tool that provides CSAT the capacity to report for all of its discretionary program: particular populations served, numbers of people served, types and locations of particular activities supported, effectiveness across programs for particular populations, the characteristics and effectiveness across programs of activities relative to national, subpopulation and geographic area data and trends. In order to be fully accountable for the spending of federal funds, SAMHSA/CSAT requires all its programs to collect and report data on all clients served as a means of ensuring that program goals and objectives are being met. Data collected as part of this package are used as a tool to monitor performance through the grant period and ensure appropriate spending of federal funds.

Approval of this information collection will allow SAMHSA to continue to meet Government Performance and Results Act of 1993 (GPRA) reporting requirements that quantify the effects and accomplishments of its discretionary grant programs which are consistent with OMB guidance.

In order to carry out section 1105(a) (29) of the 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, development of performance measures for reporting of activities. This information collection is needed to provide objective data to demonstrate SAMHSA's monitoring and achievement of its mission and goals.

## **A2. Purposes and Use of the Information Collection**

SAMHSA uses the performance measures to report on the performance of its discretionary services grant programs. The performance measures information is used by individuals at three different 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 the programs funded through the Agency. 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. The information informs the government project officers of the projects staff's abilities to meet their individual goals. The 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 comparing baseline with discharge and follow-up data. 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 through this process will allow SAMHSA to report on the results of these performance outcomes as well as be consistent with the specific performance domains that SAMHSA is implementing as the NOMs, to assess the accountability and performance of its discretionary and formula grant programs. The CSAT client-level data items were initially identified from widely used data collection instruments.

Outcome data reflect the Agency’s desire for consistency in data collected within the Agency. SAMHSA has implemented specific performance domains called NOMs to assess the accountability and performance of its discretionary and formula grant programs. These domains represent SAMHSA CSAT’s focus on the factors that contribute to the success of substance abuse treatment. The CSAT Client/Participant Outcome Measures will address the following performance domains:

- Abstinence from Drug / Alcohol Use
- Employment / Education
- Crime and Criminal Justice
- Family and Living Conditions
- Social Connectedness
- Social Consequences from Drug / Alcohol Use
- Access / Capacity
- Retention

#### **Proposed Changes to Data Collection Tool**

CSAT has increased the number of questions in the instrument to satisfy reporting needs. The following paragraphs present a description of the changes made to the information collection. These questions will be contained in new sections in the GPRA tool.

*Section H. Violence and Trauma*—CSAT added 6 items in a new section entitled “Violence and Trauma”

- **Experiences with Violence and Trauma**—One of SAMHSA’s Strategic Initiatives is *Trauma and Violence*. In order to capture this information, CSAT is adding six new questions to be asked of respondents. This information will help in SAMHSA’s overall goal of reducing the behavioral health impacts of violence and trauma by encouraging substance abuse treatment programs to focus on trauma-informed services.

*Section I. Military Family and Deployment*—CSAT added 6 new items in a new section entitled “Military Family and Deployment”

- **Veteran Family Status and Areas of Deployment** – SAMHSA is also interested in collecting data on active duty and veteran military members. Collection of these data through six new items will allow CSAT to identify the number of veterans served, deployment status and location, and family veteran status in conjunction with the types of services they may receive. Identifying a client’s veteran status and deployment area allows CSAT and the grantees to monitor 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 other military family issues will also allow coordination between SAMHSA and other

Federal agencies in order to provide a full range of services to veterans. CSAT will also be able to monitor their outcomes and activities per the NOMS.

CSAT: Substance Abuse Treatment Measures

1) Over the past year, the percentage of adults:

- a) Who were currently employed or engaged in productive activities increased for those receiving services compared to the national average or project baselines.
- b) Who had a permanent place to live in the community increased for those receiving services compared to the national average or project baselines.
- c) Who had reduced involvement with the criminal justice system increased for those receiving services compared to the national average or project baselines.
- d) Who had no past month use of illegal drugs or misuse of prescription drugs increased for those receiving services compared to the national average or project baselines.
- e) Who increased retention in the program/services compared to the national average or project baselines.
- f) Who increased social connectedness to family and friends compared to the national average or project baselines.
- g) Who increased access to services compared to the national average or project baselines.

An additional measure is for those adults:

Who experienced reduced alcohol or illegal drug related health, behavior, or social consequences (including the misuse of prescription drugs), increased for those receiving services compared to the national average or project baselines.

2) Over the past year, the percentage of children/adolescents under age 18:

- a) Who were attending school increased for those receiving services compared to the national average or project baselines.
- b) Who were residing in a stable living environment increased for those receiving services compared to the national average or project baselines.
- c) Who had no involvement in the juvenile justice system increased for those receiving services compared to the national average or project baselines.
- d) Who had no past month use of alcohol or illegal drugs (population data limited to 12 through 17 year olds) increased for those receiving services compared to the national average or project baselines.
- e) Who increased retention in the program/services compared to the national average or project baselines.
- f) Who increased social connectedness to family and friends compared to the national average or project baselines.
- g) Who increased access to services compared to the national average or project baselines.

An additional measure is for those children/adolescents under age 18:

The percentage of youth (population data limited to 12 through 17 year olds) who experienced no substance abuse related health, behavior, or social consequences increased for those receiving services compared to the national average or project baselines.

Based on current funding and planned fiscal year 2010 notice of funding announcements (NOFA), the CSAT programs that will use these measures in fiscal years 2010 through 2012 include: the Access to Recovery 2 (ATR2), ATR3, Addictions Treatment for Homeless; Adult Criminal Justice Treatment; Assertive Adolescent Family Treatment; HIV/AIDS Outreach; Office of Juvenile Justice and Delinquency Prevention – Brief Intervention and Referral to Treatment (OJJDP-BIRT); OJJDP-Juvenile Drug Court (OJJDP-JDC); Offender Re-entry Program; Pregnant and Postpartum Women; Recovery Community Services Program – Services; Recovery Oriented Systems of Care; Screening and Brief Intervention and Referral to Treatment (SBIRT), Targeted Capacity Expansion (TCE); TCE/HIV; Treatment Drug Court; and the Youth Offender Reentry Program.

### **A3. Use of Improved Information Technology and Burden Reduction**

Most programs collect their client information using a variety of methods from paper and pencil to electronic methods. This project will not interfere with ongoing program collection operations that facilitate information collection at each site.

A web-based data collection and entry system has been developed through CSAT and is available to all programs for data collection. This web-based system allows for easy data entry, submission, and reporting to all those who have access to the system. Levels of access have been defined for users based on their authority and responsibilities regarding the data and reports. Access to the data and reports is limited to those individuals with a username and password. A sample data entry screen is below:

**CSAT GPRA** Government Performance and Results Act

**CSAT** Center for Substance Abuse Treatment SAMHSA

Help Logout

User:

Home Page  
General Info  
Services Info  
Disclaimer  
Privacy Policy  
Data Collection Tools  
Data Entry  
Services  
Contact Us  
Technical Assistance  
Reports  
Data Download  
Search  
GPRA Training

**Interview Selection** [Print] [Find]

\*For more info on advanced features of the Query function, click "Help" in the upper right corner of this screen.

GFA: TCE/HV Target-to-Date: 259  
Grantee Name: Test Site 34 Intakes-to-Date: 508  
Grant #: TI00031 Coverage Rate: 196%  
Grant Target: 420  
Annual Target: 84

Client Interview Selection  
Client ID: [ ] Intake Date: [ ] Status: Show Active & Inactive Records [v]

Client Intake Records [Export List of Recently Entered Records] [Export Snapshot] [Add Client Intake]  
Last 1 day [v]

Client ID	Intake Date	Status	Intake(527)	3 Month(1)	6 Month(154)	12 Month(49)	Discharge(163)
00000126316	3/25/2008	Active	View   Edit	N/A	Add	Add	View   Edit
0008	1/29/2008	Active	View   Edit	N/A	Add	Add	View   Edit
001	10/21/2008	Active	View   Edit	N/A	Add	Add	Add
001	8/19/2008	Inactive	View   Edit	N/A	Add	Add	Add
001	3/24/2008	Inactive	View   Edit	N/A	Add	Add	View   Edit
001	9/10/2008	Inactive	View   Edit	N/A	Add	Add	Add
001	2/12/2008	Inactive	View   Edit	N/A	Add	Add	Add
002000	1/28/2008	Active	View   Edit	N/A	View   Edit	Add	View   Edit

4

SAIS: CSAT GPRA Web-Based Data Entry System Training

A few programs submit their data electronically through an upload process. This facilitates the submission of data while avoiding duplication of the data entry process. Programs that collect these data for other purposes are spared an additional collection burden.

Electronic submission of the data promotes enhanced data quality. With built-in data quality checks, 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 dataset. Once the data are put into the web-based system, it is available for access, review, and reporting by all those with access to the system from Center staff to the grantee staff.

#### A4. Efforts to Identify Duplication and Use of Similar Information

The items collected are necessary in order to assess grantee performance. SAMHSA is promoting the use of performance measures across all programs; this effort will result in less overlap and duplication, and substantially reduce the burden on grantees that results from data demands associated with individual programs. SAMSHA will work closely with the grantees to identify whether other data are being collected by the grantee that may be redundant to the GPRA instrument. When duplication is identified, SAMHSA and the grantees will identify a priority action plan to leverage the duplicative efforts, and streamline the data items to reduce client burden.

#### A5. Involvement of Small Entities

Individual grantees vary from small entities through large provider organizations. Every effort has been made to minimize the number of data items collected from programs to the least

number required to accomplish the objectives of the effort and to meet GPRA reporting requirements and therefore, there is no significant impact involving small entities.

#### **A6. Consequences of Collecting the Information Less Frequently**

The data collection points remain unchanged from the previous submission. Substance abuse treatment programs collect data at three time points: intake, discharge, and 6-months post intake, these times are part of regular program activity.

These are generally accepted intervals for client assessment and the participants will be asked to respond to the items according to this schedule. The adolescent substance abuse treatment grantees are required to collect information additionally at three months post-intake due to the migratory nature of adolescents. It is more difficult to locate adolescents than adults and, therefore, locating them more frequently and closer to their intake date should increase their follow-up rates. The data will be reported to SAMHSA on an annual basis in keeping with the GPRA requirements for annual reporting.

#### **A7. Consistency with the Guidelines in 5 CFR1320.5(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 (76 FR 35004). No comments were received in response to this notice.

#### **A9. Payment to Respondents**

Grantees are asked to budget for data collection in their grant applications and individual grantees are not prohibited from providing payments to their respondents for follow-up, which is customary practice in the field. If the grantees do provide payment for the follow-up, the maximum incentive is \$20.00 or the equivalent in coupons, transportation tokens, or other items per follow-up.

Survey research 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. Substance abusers are typically a harder-to-reach population for whom out-of-pocket costs of participation (e.g., transportation, child care) are significant barriers.

#### **A10. Assurance of Confidentiality Respondents**

The information from Grantees and all other potential respondents will be kept private through all points in the data collection and reporting processes. However, SAMHSA cannot ensure complete confidentiality of client data. SAMHSA will work with each grantee in preparing an impact assessment protocol. 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.

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 data. Federally assisted substance abuse treatment providers are subject to the federal regulations for alcohol and substance abuse patient records (42 CFR Part 2) (OMB No. 0930-0092) which govern the protection of patient identifying data. In some cases, these same providers meet the definition of a HIPAA covered entity and are additionally subject to the Privacy Rule (45 CFR Parts 160 and 164) for the protection of individually identifiable data.

#### **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 experiences with violence and trauma, criminal justice involvement, use of alcohol or other drugs, as well as issues of mental health. The data that will be submitted by each grantee will be based in large part on data that most of the programs are already routinely collecting. This primarily includes data on client demographics, substance abuse and treatment history, services received, and client outcomes. These issues are essential to the service/treatment context. Grant projects use informed consent forms as required and as viewed appropriate by their individual organizations. They use the appropriate forms for minor/adolescent participants requiring parental approval. Client data are routinely collected and subject to the Federal Regulations on Human Subject Protection (45 CFR Part 46; OMB No. 0925-0404). Alcohol and drug abuse client records in Federally supported programs are also protected by 42 CFR Part 2. The informed consent forms usually contain the following elements:

- Explanation of the purpose of the program or research.
- Expected duration of the subject's participation.
- Description of the procedures to be followed.
- Identification of any procedures which are experimental.
- Description of any reasonably foreseeable risks or discomforts to the subject.
- Disclosure of appropriate alternative procedures or courses of treatment.
- Statement describing the extent, if any, to which confidentiality of records identifying the subject will be maintained.
- Contact names & phone numbers for participants to ask questions about program, participant rights, and injury.

A typical grantee currently collects intake, or pre-intervention information at the beginning of program contact, and many also collect standard discharge and follow-up information with similar items. Data are usually collected through interviews for the programs. Across all the SAMHSA discretionary services grants to which this application applies, it is estimated that these customary and usual business practices for services and treatment take about 30 minutes



per data collection. Additional burden will only be created where grants are required to collect GPRA core measures at either intake, discharge, or follow-up points that are not customary and usual practices. In these cases the client’s time and effort are required to gather additional information that would not have been part of normal treatment or service activities.

**A12. Estimates of Annualized Hour Burden**

A typical grantee currently collects intake, or pre-intervention information at the beginning of program contact, and many also collect standard discharge and follow-up information with similar items. Data are usually collected through interviews for the programs. Across all the SAMHSA discretionary services grants to which this application applies, it is estimated that these customary and usual business practices for services and treatment take about 21 minutes per data collection. Based on a pretest of the new items in the tool, the additional 12 items results in an added 4 minutes, resulting in a total time of completion of 25 minutes (0.41 hours). Additional burden will only be created where grants are required to collect GPRA core measures at either intake, discharge, or follow-up points that are not customary and usual practices. In these cases the client’s time and effort are required to gather additional information that would not have been part of normal treatment or service activities.

The first value computed is the proportion of additional core GPRA items for a typical Center grant. This is done using the following formula:

$$\text{Proportion of Additional Burden} = \frac{\text{Total \# of items in Standard Center Instrument} - \text{Number of core GPRA items currently included}}{\text{Total \# of items in Standard Center Instrument}}$$

Additional burden is calculated by multiplying this proportion times 25 minutes for each data collection (intake or baseline, discharge, 3-month follow-up, or 6-month follow-up).

*Added Burden Proportion For Grant Programs.* There are 80 items (including record management) in the CSAT GPRA Client/Participant Outcome Measures for Discretionary Programs, which will take approximately 25 minutes per client to administer at each of the 3 or 4 data collection points. However, 42 of the items are taken from the ASI, which is used in the substance abuse treatment field by researchers and providers as a baseline and follow-up instrument, or are considered standard items in the field. The resulting Added Burden Proportion is then (80-42)/80, or .47

**Estimates of Annualized Hour Burden <sup>1</sup>**

**CSAT GPRA Client Outcome Measures for Discretionary Programs**

Center/Form/ Respondent Type	Number of Respondents	Responses Per Respondent	Total Responses	Hours Per Response	Total Hour Burden	Added Burden Proportion <sup>2</sup>	Total Annual Burden Hours	Total Hour Cost / Respondent <sup>3</sup>
<b>Clients</b>								

<b>Adolescents</b>	3,900	4	15,600	.41	6,396	.47	3,006	\$19,689
<b>Adults</b>								
General (non ATR or SBIRT)	28,000	3	84,000	.41	34,440	.47	16,187	\$106,025
ATR	53,333	3	159,999	.41	65,600	.47	30,832	\$201,949
SBIRT <sup>4</sup> Screening Only	150,618	1	150,618	.13	19,580	0	0	\$0
SBIRT Brief Intervention	27,679	3	83,037	.20	16,607	0	0	\$0
SBIRT Brief Tx & Refer to Tx	9,200	3	27,600	.41	11,316	.47	5,319	\$34,840
<b>Client Subtotal</b>	<b>272,730</b>		<b>520,854</b>		<b>153,939</b>		<b>55,344</b>	<b>\$362,503</b>
<b>Data Extract<sup>5</sup> and Upload</b>								
<b>Adolescent Records</b>	44 grants	44 X 4	176	.18	32	--	32	\$480
<b>Adult Records</b>								
General (non ATR or SBIRT)	528 grants	70 X 3	210	.18	38	--	38	\$570
ATR Data Extract	53,333	3	160,000	.16	25,600	--	25,600	\$640,000
ATR Upload <sup>6</sup>	24 grants	3	160,000	1 hr. per 6,000 records	27	--	27	\$675
SBIRT Screening Only Data Extract	9 grants	29,517 X 1	29,517	.07	2,067	--	2,067	\$31,005
SBIRT Brief Intervention Data Extract	9 grants	4,832 X 3	14,496	.10	1,449	--	1,449	\$21,735
SBIRT Brief Tx&Refer to Tx Data Extract	9 grants	1,688 X 3	5,064	.18	912	--	912	\$13,680
SBIRT Upload <sup>7</sup>	7 grants		171,639	1 hr. per 6,000 records	29	--	29	\$435
<b>Data Extract and Upload Subtotal</b>	<b>53,963</b>		<b>541,102</b>		<b>30,154</b>		<b>30,154</b>	<b>\$708,580</b>
<b>TOTAL</b>	<b>326,693</b>		<b>1,061,956</b>		<b>209,799</b>		<b>85,498</b>	<b>\$1,071,083</b>

**NOTES:**

1. This table represents the maximum additional burden if adult respondents, for the discretionary services programs including ATR, provide three sets of responses/data and if CSAT adolescent respondents, provide four sets of responses/data.
2. Added burden proportion is an adjustment reflecting customary and usual business practices programs engage in (e.g., they already collect the data items).
3. Estimate based on \$6.55 for client and program staff, \$15 for IT staff for SBIRT grants, and \$25 for more senior IT staff for ATR grants.
4. Screening, Brief Intervention, Treatment and Referral (SBIRT) grant program:

The estimates in this table reflect the maximum annual burden for currently funded discretionary services programs. The number of clients served in following years is estimated to be the same assuming level funding of the discretionary programs, resulting in the same annual burden estimate for those years.

### **A13. Estimates of Cost Burden to Respondents**

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

### **A14. Estimates of Annualized Cost to the Federal Government**

The principal additional cost to the government for this project is the cost of a contract to collect the data from the various programs and to conduct analyses which generate routine reports from the data collected. The reports examine baseline characteristics as well as the changes between baseline, discharge, and each of the follow-up periods. It is the responsibility of the contractor to work with the Government Project Officer (GPO) when preparing reports that combine the client services data with the annual reports of the project.

The estimated annualized cost for a contract for the GPRA mandate is \$7.2 million and the cost of 1 FTE staff (25% for the midpoint of one GS-14 \$25,899 and 75% for one GS-12 \$48,786) responsible for the CSAT data collection effort is approximately \$74,685/year.

### **A15. Changes in Burden**

Currently there are 66,326 hours in the OMB inventory. SAMHSA is requesting a total of 85,498 burden hours, an overall increase of 19,172 hours. The program change is due to an increase to complete the additional questions added to the current data collection activity (approximately 4 minutes for the 12 new items).

### **A16. Time Schedule, Publication and Analysis Plans**

Data for the annual GPRA plan/report are needed by SAMHSA by September of each year. The discretionary services program data are readily available through the web-based system. Data are provided for the most recently completed calendar year to SAMHSA in May in order to assure analysis in time for the annual GPRA report. The annual GPRA report must be submitted to the U.S. Department of Health and Human Services (the Department) and to OMB by September and is included in the President's annual budget request which is released to the public February 1st. Data may be refined and added to the final Presidential budget request after the Department submits its initial GPRA report.

#### Analysis/Publication Plans

Client outcome data will be collected through the web site. Data will be used to report to Congress regarding the GPRA as specified in the SAMHSA Annual Justifications of Budget Estimates. The data might also be used for specific comparisons relative to ONDCP National

Drug Control Strategic Goals, especially for some of the secondary treatment outcomes (e.g., homelessness).

In the future, the indicators for clients served under these programs might be compared to similar indicators for clients served under block grant programs as a general indicator of whether the programs are doing better than "typical" services. This could be done for discretionary services programs as a group or for specific programs.

SAMHSA and each of its Centers specifically will use the data for annual reporting required by GPRA on the previously stated items, comparing baseline with discharge and follow-up data. The GPRA dataset will consist of each element coded into the reporting categories as seen in Attachment 1. These data are at the client record level. The SAMHSA GPRA client outcome data will be aggregated at the following levels: Project/Grantee, Program/Division, and Activity. The analysis will be organized around SAMHSA's GPRA measures and the measures relating to the Family Drug Courts and the NOMs.

Baseline level analysis involves using frequency distributions and measures of central tendency to describe the populations across the GPRA client outcomes and by various demographic groups (e.g., gender, race, ethnicity, age, and level of education). The client will be followed longitudinally and the GPRA client outcome items will be re-administered again at discharge, 6 and 12 months after baseline. The follow-up data also will be described using frequency distributions and measures of central tendency. Change will be addressed by comparing the discharge and follow-up measurements with baseline data for each client. The percent of clients showing the target changes will be calculated on each of the GPRA client outcome measures that are categorical. For continuous items, mean differences will be calculated. Tables will be constructed to describe the change across projects on client outcomes.

It is important to note that each Center is responsible for its own analyses of the data. Common analyses will be used as appropriate for GPRA purposes, but control of the data rests with the Center funding the grant. The Centers submit a GPRA report to SAMHSA Office of the Administrator and SAMHSA then synthesizes results from the Centers in a descriptive manner for the GPRA report.

There also will be Center unique analysis of these data because each Center has a distinct set of programs. The data items collected will be analyzed and presented in GPRA reports using basic descriptive statistics. On the principal outcome items (e.g., drug use, criminal involvement, and employment), the proportion of individuals showing improvement from baseline to discharge and follow-up (baseline to discharge, baseline to 6 months, baseline to 12 months) will be calculated and aggregated at the program level (e.g., discretionary services). If deemed necessary for CSAT specific issues, the data will be examined at the individual activity level. Occasionally, the results will be examined for subpopulations of interest within individual activities (e.g., by age or by gender).

### **A17. Display of Expiration Date**

The expiration date for OMB approval will be displayed on all data collection instruments 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**

The data collection tool is administered to all clients receiving services covered by grant funds. The tool is administered to all clients at intake and all clients are targeted for follow-up data collection. In order to ensure accountability for the spending of federal funds, CSAT 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**

Information collection procedures will vary by type of program. The client outcome measures for most providers will be extracted from previously established databases. Intake/baseline information is obtained by intake workers and/or counselors. For clients still in treatment 6 months later, the information will be obtained in the same way. In instances where clients are no longer in direct contact with the service provider, staff from the program will locate the clients and conduct the follow-up interviews. These interviews are to be conducted face-to-face.

Some programs collect their client information using paper and pencil methods. This project will not interfere with ongoing program operations. Programs will submit their data electronically via a web-based data entry process or upload process. The data for those clients with baseline, discharge, and follow-up data are matched using a unique encrypted client identifier.

### **B3. Methods to Maximize Response Rates**

Each grantee will have established its own client follow-up procedures as part of the original protocol. At the time of intake, information is typically obtained from clients to assist with locating them later. This includes information on current residents plus information on one or

two other individuals who are likely to know where they are if they have re-located. In addition, some providers are adept at using other community resources to assist with locating clients. Clients are typically quite cooperative with provider staff because of the relationship established during treatment. Since all participating grant programs propose a census at initial intake, considerable options also exist for non-respondent analysis and associated adjustments to the data such as weighting.

Follow-up has been a challenge to some grantees given the remote locations that they serve and the challenge of locating clients as far out as 6 months. For grantees that have not been aware of the strategies they can employ to begin the follow-up process at intake, how to maintain contact with clients, and the importance of good locator forms, several strategies have been implemented to assist the grantees with followup. First, follow-up training is offered which assists grantees in learning about and conducting follow-up at their sites. This program is offered to all grantees and after the grantees are trained through the grantee orientation process, monthly follow-up trainings are offered for those that need additional training or for new project staff. Individual grantee technical assistance is also available for sites that need additional follow-up instruction. These group and individual trainings are conducted by follow-up experts. Each grantee receives a follow-up tracking manual at these trainings that may be used as a future reference. A second strategy provides the grantees with data status reports on how close they are to meeting their follow-up goals. These reports are available from the web-based system to the grantees and Government Project Officers for the grants they are responsible. A third strategy is the automatic, system generated notice of when follow-up interviews are due for each client/participant. A fourth strategy provides technical assistance at national meetings. Experts, including grantees, have been identified and asked to make presentations at national grantee meetings on how to conduct follow-up. These sessions are well attended by grantees.

#### **B4. Test of Procedures**

Most of the data elements in the data sets have been taken from established data collection instruments that have a long history of use in the substance abuse field and have already been tested for validity and reliability, (i.e., ASI).

Feedback from the grantees also indicates that they routinely collect the same information requested of this data collection tool and some have integrated this tool into other tools that they routinely use to gather information. Some grantees report that they collect information in greater detail, (i.e., more response alternatives), but these are collapsed into standard categories.

#### **B5. Statistical Consultants**

Deepa Avula,  
Government Project Officer  
Center for Substance Abuse Treatment  
SAMHSA  
1 Choke Cherry Lane  
Rockville, MD 20850  
(240) 276-2961.

Scott Novak, Ph.D.  
SAIS Associate Project Director  
RTI International  
3040 Cornwallis Road  
P.O. Box 12194  
Research Triangle Park, NC 27709-2194  
(919) 541-3129.

## **ATTACHMENTS**

Attachment 1: CSAT GPRA Client Outcome Measures for Discretionary Programs and Instructions