COMMON DATA PLATFORM
CLIENT/PARTICIPANT DATA COLLECTION

SUPPORTING STATEMENT

A. JUSTIFICATION

A1. Circumstances Making the Collection of Information Necessary

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality (CBHSQ) is requesting from the Office of Management and Budget (OMB) approval for the collection of data from SAMHSA grantees. This data collection represents a combined set of elements for SAMHSA's Common Data Platform. It will replace SAMHSA's separate data collections for reporting the Government Performance and Results Act of 1993 (GPRA) measures: the TRansformation ACcountability (TRAC) Reporting System (OMB No. 0930-0285) used by the Center for Mental Health Services (CMHS); Prevention Management Reporting and Training System (PMRTS - OMB No. 0930-0279) used by the Center for Substance Abuse Prevention (CSAP); and the Services Accountability and Improvement System (SAIS - OMB No. 0930-0208) used by the Center for Substance Abuse Treatment (CSAT).

The CDP application collects and reports data and outcomes relating to treatment and prevention grants awarded by SAMHSA to its external partners. SAMHSA will review and support this data collection as appropriate for various grant programs. Partners will access the site to enter GPRA and other approved elements.

This information is collected using a client tool that provides the capacity to report for all of the discretionary programs. In particular, SAMHSA may report the following: types of populations served, numbers of people served, and number of people served by demographic characteristics; types and locations of particular activities supported; effectiveness across programs for particular populations; characteristics and effectiveness across programs of activities relative to national, subpopulation and geographic area; and trends. In order to be fully accountable for the spending of federal funds, SAMHSA 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 will be used 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 GPRA reporting requirements that quantify the effects and accomplishments of its discretionary grant programs which are consistent with OMB guidance. The data will allow SAMHSA Government Project Officers (GPOs), administrators, and policy makers to monitor grantee and program-specific progress in meeting goals and purposes of the program and impacting outcomes. 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.

The CDP represents an effort to include cross-cutting tools from 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 CDP elements include GPRAMA and Healthy People 2010 measures. A number of the measures are consistent with ONDCP's Drug-Free Community core measures. The CDP elements attempt to reduce the number of measures to those most critical to prevention and treatment as well as to provide the best items for capturing these constructs as defined by experts in the field.

In addition, this data collection supports the GPRA Modernization Act (GPRAMA) of 2010 which requires overall organization management to improve agency performance and achieve the mission and goals of the agency through the use of strategic and performance planning, measurement, analysis, regular assessment of progress, and use of performance information to improve the results achieved. GPRAMA performance monitoring is a collaborative and cooperative aspect of this process. This information collection is needed to provide objective data that demonstrate SAMHSA's monitoring of program performance. As performance measures information is used by the SAMHSA administrator and staff; the Center administrators and government project officers; and grantees, HHS, OMB and Congress.

GPRAMA requires that SAMHSA's report for each fiscal year include actual results of performance monitoring for the three preceding fiscal years. Performance Monitoring data reflect the Agency's desire for consistency across its data collection efforts.

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. To support its mission, the Agency's overarching vision is to provide leadership and devote its resources—programs, policies, information and data, contracts and grants—toward helping the Nation act on the knowledge that:

- Behavioral health is essential for health;
- Prevention works;
- Treatment is effective; and

- People recover from mental and substance use disorders.

In order to improve the lives of people within communities, SAMHSA has many roles:

- **Providing Leadership and Voice** by developing policies; convening stakeholders; collaborating with people in recovery and their families, providers, localities, Tribes, Territories, and States; collecting best practices and developing expertise around behavioral health services; advocating for the needs of persons with mental and substance use disorders; and emphasizing the importance of behavioral health in partnership with other agencies, systems, and the public.

- Promoting change through **Funding and Service Capacity Development**. Supporting States, Territories, and Tribes to build and improve basic and proven practices and system capacity; helping local governments, providers, communities, coalitions, schools, universities, and peer-run and other organizations to innovate and address emerging issues; building capacity across grantees; and strengthening States', Territories', Tribes', and communities' emergency response to disasters.

- Supporting the field with **Information/Communications** by conducting and sharing information from national surveys and surveillance (e.g., National Survey on Drug Use and Health [NSDUH], Drug Abuse Warning Network [DAWN], Drug and Alcohol Service Information System [DASIS]); vetting and sharing information about evidence-based practices (e.g., National Registry of Evidence-based Programs and Practices [NREPP]); using the Web, print, social media, public appearances, and the press to reach the public, providers (e.g., primary, specialty, guilds, peers), and other stakeholders; and listening to and reflecting the voices of people in recovery and their families.

- Protecting and promoting behavioral health through **Regulation and Standard Setting** by preventing tobacco sales to minors (Synar Program); administering Federal drug-free workplace and drug-testing programs; overseeing opioid treatment programs and accreditation bodies; informing physicians' office-based opioid treatment prescribing practices; and partnering with other HHS agencies in regulation development and review.

- **Improving Practice (i.e., community-based, primary care, and specialty care)** by holding State, Territorial, and Tribal policy academies; providing technical assistance to States, Territories, Tribes, communities, grantees, providers, practitioners, and stakeholders; convening conferences to disseminate practice information and facilitate communication; providing guidance to the field; developing and disseminating evidence-based practices and successful frameworks for service provision; supporting innovation in evaluation and services research; moving innovations and evidence-based approaches to scale; and cooperating with international partners to identify promising approaches to supporting behavioral health.

All of SAMHSA's programs and activities are geared toward achieving goals related to reducing the impact of substance use and mental health disorders. 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.

Specifically, the CDP data collection will allow SAMHSA to have the capacity to report on a consistent set of performance measures across its various grant programs that conduct each of these activities.

With approval of this data collection SAMHSA will continue to monitor its programs, review progress on meeting program goals and objectives, and ensure accountability of program funds. Such information informs SAMHSA's future budget allocation and program development decisions.

CMHS Programs

Based on current funding and planned fiscal year 2014 notice of funding announcements (NOFA), SAMHSA CMHS discretionary programs that will use these measures (See Attachment 1) in fiscal years 2015 through 2016 to collect client-level data include the following: Comprehensive Community Mental Health Services for Children and their Families (CMHI); Healthy Transitions (HT); National Child Traumatic Stress Initiative (NCTSI) Community Treatment Centers; Mental Health Transformation State Incentive Grants (MH SIG); Minority AIDS/HIV Services Collaborative Program; Primary and Behavioral Health Care Integration (PBHCI); Services in Supportive Housing (SSH); Systems of Care (SoC); and Transforming Lives Through Supportive Employment. Primary and Behavioral Health Care Integration (PBHCI) grantees will also report information through an additional data collection module focusing on health outcomes (see Attachment 2).

CMHS programs that will use the CDP to collect grantee-level IPP indicators (See Attachment 3) include: Advancing Wellness and Resiliency in Education (Project AWARE); Circles of Care; Comprehensive Community Mental Health Services for Children and their Families (CMHI); Garrett Lee Smith Campus Suicide Prevention Program; Garrett Lee Smith State/Tribal Suicide Prevention Program; Healthy Transitions Program; Linking Actions for Unmet Needs in Children's Mental Health (LAUNCH); National Suicide Prevention Lifeline; NCTSI Treatment and Service Centers; NCTSI Community Treatment Centers; NCTSI National Coordinating Center; Mental Health Transformation Grant Program; Minority AIDS/HIV Services Collaborative Program; Minority Fellowship Program; PBHCI; Safe Schools/Healthy Students; Services in Supportive Housing; State Mental Health Data Infrastructure Grants for Quality Improvement; Statewide Consumer Network Grants; Statewide Family Network Grants; Suicide Lifeline Crisis Center Follow Up; Systems of Care; Transforming Lives Through Supported Employment; Native Connections; Now is the Time: Minority Fellowship Program-Youth; Cooperative Agreements to Implement the National Strategy for Suicide Prevention, Historically Black Colleges and Universities Center for Excellence in Behavioral Health; and Statewide Peer Networks for Recovery and Resilience.

CSAP Programs

Based on current funding and planned FY 2014 NOFA , the SAMHSA CSAP discretionary programs that will use these measures (See Attachment 4 and 5) in fiscal years 2015 through 2016 include the following: HIV Minority AIDS Initiative (MAI), Strategic Prevention Framework State Incentive Grants (SPF SIG), and Partnerships for Success (PFS).

CSAT Programs

Based on current funding and planned fiscal year 2014 NOFA, SAMHSA CSAT discretionary programs that will use these measures (see Attachment 6) in fiscal years 2015 through 2016 include following: Assertive Adolescent and Family Treatment (AAFT); Access to Recovery 3 (ATR3); Adult Treatment Court Collaboratives (ATCC); Enhancing Adult Drug Court Services, Coordination and Treatment (EADCS); Offender Reentry Program (ORP); Treatment Drug Court (TDC); Office of Juvenile Justice and Delinquency Prevention – Juvenile Drug Courts (OJJDP-JDC); Teen Court Program (TCP); HIV/AIDS Outreach Program; Targeted Capacity Expansion Program for Substance Abuse Treatment and HIV/AIDS Services (TCE-HIV); Addictions Treatment for the Homeless (AT-HM); Cooperative Agreements to Benefit Homeless Individuals (CABHI); Cooperative Agreements to Benefit Homeless Individuals – States (CABHI- States); Recovery-Oriented Systems of Care (ROSC); Targeted Capacity Expansion- Peer to Peer (TCE – PTP); Pregnant and Postpartum Women (PPW); Screening, Brief Intervention and Referral to Treatment (SBIRT); Targeted Capacity Expansion (TCE); Targeted Capacity Expansion- Health Information Technology (TCE-HIT); Targeted Capacity Expansion Technology Assisted Care (TCE-TAC); Addiction Technology Transfer Centers (ATTC); International Addiction Technology Transfer Centers (I-ATTC); State Adolescent Treatment Enhancement and Dissemination (SAT-ED); Grants to Expand Substance Abuse Treatment Capacity in Adult Tribal Healing to Wellness Courts and Juvenile Drug Courts; and Grants for the Benefit of Homeless Individuals – Services in Supportive Housing (GBHI). Grantees in the Adult Treatment Court Collaborative program (ATCC) will also provide program-level data using the CSAT Aggregate Instrument (see Attachment 7)

In addition, the HIV Continuum of Care (CoC) program, funded jointly by CMHS, CSAP, and CSAT, will report both client-level and grantee-level (IPP) data through CDP as well as a program-specific form collecting information on HIV medical care (see Attachment 8).

SAMHSA programs that will be participating in this information collection in FY 2015, along with the expected number of respondents by program, are presented in Table 1.

Table 1. FY 2015 Programs Participating in the Common Data Platform and Estimated Number of Respondents by Program

SAMHSA Program Title	Estimated Number of Respondents
Client-Level Forms	
CSAP	
HIV -Minority AIDS Initiative (MAI)	18,041
SPF SIG/Community Level	122
SPF SIG/Program Level	510
PFS/Community Level	550
PFS/Program Level	111
CMHS	
Comprehensive Community Mental Health Services for Children and their Families Program (CMHI)	3,431
HIV Continuum of Care (CoC)	1,500
Healthy Transitions (HT)	1,600
NCTSI Community Treatment Centers (NCTSI)	1,856
Mental Health Transformation State Incentive Grant (MH SIG)	2,975
Minority AIDS/HIV Services Collaborative Program	2,844
Primary and Behavioral Health Care Integration (PBHCI)	14,000
Services in Supportive Housing (SSH)	4,975
Systems of Care (SoC)	1,164
Transforming Lives Through Supported Employment	1,500
CSAT	
Assertive Adolescent and Family Treatment (AAFT)	379
Access to Recovery 3 (ATR3)	33,000
Adult Treatment Court Collaboratives (ATCC)	1,348
Enhancing Adult Drug Court Services, Coordination, and Treatment (EADCS CT)	5,830
Offender Reentry Program (ORP)	2,304
Treatment Drug Court (TDC)	7,495
Office of Juvenile Justice and Delinquency Prevention - Juvenile Drug Courts (OJJDP-JDC)	490
Teen Court Program (TCP)	7,495
HIV/AIDS Outreach Program (HIV-Outreach)	5,440
Targeted Capacity Expansion Program for Substance Abuse Treatment and HIV/AIDS Services (TCE-HIV)	6,106
Addictions Treatment for Homeless (AT – HM)	13,295

SAMHSA Program Title	Estimated Number of Respondents
Cooperative Agreements to Benefit Homeless Individuals (CABHI)	3,378
Cooperative Agreements to Benefit Homeless Individuals – States (CABHI-States)	177
Recovery-Oriented Systems of Care (ROSC)	1,058
Targeted Capacity Expansion - Peer to Peer (TCE-PTP)	1,034
Pregnant and Postpartum Women (PPW)	2,149
Screening Brief Intervention Referral and Treatment* (SBIRT)	742,740
Targeted Capacity Expansion - Health Information Technology (TCE-HIT)	6,619
Targeted Capacity Expansion Technology Assisted Care (TCE-TAC)	432
Addiction Technology Transfer Centers (ATTC)	40,845
International Addiction Technology Transfer Centers (I-ATTC)	2,236
State Adolescent Treatment Enhancement and Dissemination (SAT-ED)	1,156
Grants to Expand Substance Abuse Treatment Capacity In Adult Tribal Healing to Wellness Courts and Juvenile Drug Courts	300
Grants for the Benefit of Homeless Individuals-Services in Supportive Housing (GBHI)	2,450
Total Services -- Client Level Instruments	**942,935**
CMHS Infrastructure, Prevention, and Mental Health Promotion (IPP) Form	
Project AWARE	120
Circles of Care	11
Comprehensive Community Mental Health Services for Children and their Families Program (CMHI)	69
Garrett Lee Smith Campus Suicide Prevention Grant Program	123
HIV Continuum of Care	33
Garrett Lee Smith State/Tribal Suicide Prevention Grant Program	102
Healthy Transitions (HT)	16
Historically Black Colleges and Universities Center for Excellence in Behavioral Health	1
Linking Actions for Unmet Needs in Children's Mental Health (LAUNCH)	54
National Suicide Prevention Lifeline	2
NCTSI Treatment & Service Centers	32
NCTSI Community Treatment Centers	81
NCTSI National Coordinating Center	2

SAMHSA Program Title	Estimated Number of Respondents
Mental Health Transformation Grant	30
Minority AIDS/HIV Services Collaborative Program	17
Minority Fellowship Program	9
Primary and Behavioral Health Care Integration	70
Safe Schools/Healthy Students Initiative	7
Services in Supportive Housing	5
State Mental Health Data Infrastructure Grants for Quality Improvement	2
Statewide Consumer Network Grants	42
Statewide Family Network Grants	53
Suicide Lifeline Crisis Center FUP Grants	27
Systems of Care	31
Transforming Lives Through Supported Employment	6
Native Connections	20
Now Is the Time: Minority Fellowship Program-Youth	5
Cooperative Agreements to Implement the National Strategy for Suicide Prevention	4
Statewide Peer Networks for Recovery and Resiliency	8
TOTAL IPP	**982**
CSAP Aggregate Form	
Adult Treatment Court Collaborative (ATCC)	**6**
TOTAL SAMHSA	**943,923**

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:

HHS/OMB/Congress—The GPRA information is used to help guide future program budget decisions.

SAMHSA Level— 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 outcome measures 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 to assess the accountability and performance of its discretionary and formula grant programs. The client-level data items were initially identified from widely used data collection instruments, recommended instruments from the Affordable Care and Portability Act (ACA) and from existing data collection instruments previously approved by OMB for CSAT, CMHS, and/or CSAP. SAMHSA centers engaged in a consensus-building process to reach agreement on the data collection instruments and the responses.

These proposed data activities are intended to promote the use of consistent measures among SAMHSA-funded grantees and contractors. These common measures recommended by SAMHSA are a result of extensive examination and consensus across centers. Wherever feasible, the measures are consistent with or build upon previous data development efforts within SAMHSA. These data collection activities will be organized to reflect and support the domains specified for SAMHSA's GPRA reporting for programs and infrastructure, prevention, and behavioral health promotion activities.

To fulfill GPRA requirements SAMHSA develops a report for each fiscal year that includes 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 to assess the accountability and performance of its discretionary and formula grant programs.

Client-level Data Collection

To facilitate SAMHSA-wide reporting, the agency has identified client/participant outcome measures of particular interest for accountability and performance monitoring of client-level data for programs providing direct services. Outcome data reflect the SAMHSA's desire for consistency in data collected within the agency. SAMHSA has implemented specific performance domains to assess the accountability and performance of its discretionary and formula grant programs. These domains represent SAMHSA's focus on the factors that contribute to the success of substance abuse treatment.

Data from the CDP will be used to address specific client/participant Outcome Measures for the following GPRA domains:

- Abstinence from Drug or Alcohol Use
- Access to Care
- Crime and Criminal Justice
- Employment and Education
- Evidence-Based Practices
- Functioning
- Peer Recovery Support (previously called Social Connectedness)
- Perception of Care
- Retention
- Stability in Housing
- HIV/AIDS Measures

As stated above, the SAMHSA programs that provide direct treatment to consumers, or Services programs, currently have an OMB-approved data collection in place. Consequently, this request is for approval of a replacement for those data collection instruments. SAMHSA CDP elements will be collected at baseline, at six month reassessments for as long as the consumer remains in treatment, and at discharge.

SAMHSA will provide grantees collecting these measures with Instruction Manuals that provide detail regarding the administration of all CDP measures (see Attachments 9 and 10 for draft versions of the CSAP and CMHS/CSAT versions of these manuals).

Program Level Data Collection: CMHS's Infrastructure, Prevention, and Policy Development (IPP) Indicators and CSAT's Aggregate Instrument

Some of the SAMHSA programs focus on infrastructure and policy development. A total of 29 CMHS grant programs will be using the IPP instrument. Grantees for these programs complete a form intended to capture information about the following categories and indicators: policy development, workforce development, financing, organizational change, partnership collaborations, accountability, types and targets of practice, awareness activities, training, knowledge/attitudes/beliefs, screening, outreach, referral, and access.

For example, the Policy Development indicator (PD) asks about the number of organizations or communities that demonstrate improved readiness to change their systems in order to implement specific mental health-related practices. The workforce development indicator includes the number of people in the mental health and related workforce trained in specific mental health-related practices/activities as a result of the grant.

In addition, one program (ATCC) will be using the CSAT Aggregate Instrument which collects information on policy changes, financing policy changes, resources, system links, and special needs/evidence based practices.

A3. Use of Improved Information Technology and Burden Reduction

The CDP will provide a common system for prevention and treatment centers, reducing overall costs and improving both partner experience and internal government reporting.

Information technology will be used to reduce program respondent burden. A web-based data collection and entry system has been developed through CBHSQ and is available to all programs for data collection. Most grantees and providers 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.

This web-based system allows for easy data entry, submission, and reporting to all those who have access to the system. A user's level of access to the data and reports will be defined based on his or her authority and responsibilities. Access to the data and reports is limited to those individuals with a username and password. Users are able to access the system 24 hours a day, 7 days weeks, aside from scheduled maintenance windows through the use of an encrypted username and password.

A few programs submit their data electronically through an upload process. This process 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 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 dataset. Once the data are put into the web-based system, it will be 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 multiple, individual programs. SAMSHA has worked closely with the grantees to identify whether other data are being collected by the grantee that may be redundant to the CDP instrument and has identified an action plan to leverage the duplicative efforts, and streamline the data items to reduce client burden.

A program-level review of current measures and methods of collection was conducted to identify duplication of these data collection efforts. With the goal of creating standardized indicators and methods for monitoring grantee performance across the Center, existing measures were considered for use where appropriate. However, modification of current measures was necessary in some cases to generalize across varied programs. Each of these data collection instruments was reviewed and approved by the Government Project Officers, Branch Chiefs, and SAMHSA senior leadership as meeting the performance monitoring and management needs of individual programs and the Center. Since many of the grantees engaged in infrastructure development, prevention, and mental health promotion activities already collect data for the proposed indicators, the creation of this system will provide them with a standardized method for reporting to SAMHSA.

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 previous instruments. All programs that provide direct services will collect data.

Substance abuse treatment programs collect data at three time points: intake, every six months while the consumer is receiving services and discharge; these times are part of regular program activity. Mental health programs typically collect client-level data at admission and then conduct periodic reassessments of consumers while the individual remains in services and, when feasible, at discharge. Respondents will be asked to respond to the items according to this schedule. The baseline data collection point is critical for collecting demographic information and for measuring changes. Six-month reassessments are needed to maintain contact and to update information. Extending the interval for the periodic reassessment beyond the requested intervals could lead to loss of contact with consumers, significantly diminishing the response rates, and lowering the value of the data for performance reporting use by losing measurement of intermediate effects.

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 July 14, 2014 (79 FR 40765). No comments were received.

Both external and internal stakeholders were consulted in the development of these indicators, the data collection methodology, and the associated burden. SAMHSA obtained feedback and consultation regarding the availability of data, methods and frequency of collection, and the appropriateness of data elements.

A9. Payment to Respondents

No monetary incentives are provided to grantees.

A10. Assurance of Confidentiality Respondents

SAMHSA's grantees do not collect individually identifiable information for these programs. Only aggregated data will be reported by grantees, therefore, 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.

Protection or Privacy Clause – A pledge to respondents completing the survey is included in the last page of the survey instrument. This pledge states: "the information provided will be protected to the fullest extent allowable under Section 501(n) of the Public Health Service Act (42 USC 290aa(n)) – Limitation on the Use of Certain Information. This law permits the public release of identifiable information about an establishment only with the consent of that establishment and limits the use of information to the purposes for which it was supplied. Responses will be published only in statistical summaries so that individual respondents cannot be identified."

SORN/PIA—A System of Records Notice (SORN) and HHS Privacy Impact Assessment (PIA) form have been submitted for the Personally Identifiable Information (PII) related to this data collection. This SORN was submitted to HHS on 05/14/2014, and the PIA (P-9040847-614611) was submitted 03/19/2014. The PIA will be updated as appropriate.

A11. Questions of a Sensitive Nature

No questions of a sensitive nature are asked of State or U.S. Territories grantees. However, grantees who are service providers collect information such as demographic characteristics and the use of alcohol and other drugs and mental health conditions routinely as part of the provision of services. While some of this information may appear sensitive, program participants are service recipients.

A12. Estimates of Annualized Hour Burden

These estimates are based on staff reports of the amount of time required to complete the combined data collection tool, based on an informal pilot and prior SAMHSA experience in collecting similar data. A typical grantee currently collects intake, or pre-intervention information at the beginning of program contact, and many also collect standard re-assessment and discharge 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 23 minutes (.38 hours) for the CSAP instrument, 27 minutes (.45 hours) for the CMHS basic instrument, 28 minutes (0.47 hours) for the CSAT basic instrument, 2 hours for the CMHS IPP instrument and 15 minutes for the CSAT Aggregate instrument. Additional burden will be created when specific programs are required to collect program-specific information and where grants are required to collect CDP measures at intake, discharge, or follow-up points that are not customary and not the 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. Table 2 presents the estimated annualized burden and cost for all the instruments in the CDP.

Table 2. Common Data Platform Client Outcome Measures for Discretionary Programs

SAMHSA Program Title	Number of Respondents	Responses per Respondent	Total Number of Responses	Burden Hours per Response	Total Burden Hours	Hourly Wage [1]	Total Hour Cost
Client-Level Services Forms							
CSAP							
Baseline Interview	19,334	1	19,334	0.38	7,347	$19.75	$145,103
Exit Interview [4]	15,467	1	15,467	0.38	5,877	$19.75	$116,071
First Follow-Up After Discharge [5]	12,374	1	12,374	0.38	4,702	$19.75	$92,865
Second Follow-Up After Discharge [6]	1,933	1	1,933	0.38	735	$19.75	$14,516
CSAP Subtotal	**19,334**		**49,108**		**18,661**		**$368,555**
CMHS							
Baseline Interview	35,845	1	35,854	0.45	16,130	$19.75	$318,572
Follow-Up Interview [7]	23,658	1	23,658	0.45	10,646	$19.75	$210,258
Discharge Interview [8]	10,753	1	10,753	0.45	4,838	$19.75	$95,551
PBHCI- Special Form Only Baseline	14,000	1	14,000	.08	1,120	$19.75	$22,120
PBHCI- Special Form Only Follow-Up [7]	9,240	1	9,240	.08	739	$19.75	$14,595
PBHCI – Special Form Only Discharge [8]	4,200	1	4,200	.08	336	$19.75	$6,636
HIV Continuum of Care (CSAP, CMHS, CSAT funding) -- Specific Form Baseline	200	1	200	0.33	66	$19.75	$1,304
HIV Continuum of Care Follow-Up [2]	148	1	148	.033	49	$19.75	$968
HIV Continuum of Care (CSAP, CMHS,CSAT funding) Discharge [3]	104	1	104	0.33	34	$19.75	$672
CMHS Subtotal	**35,845**		**98,157**		**33,958**		**$670,676**
CSAT							
Baseline Interview	182,153	1	182,153	0.47	85,612	$19.75	$1,690,835

SAMHSA Program Title	Number of Respondents	Responses per Respondent	Total Number of Responses	Burden Hours per Response	Total Burden Hours	Hourly Wage [1]	Total Hour Cost
Includes SBIRT Brief TX and Referral to TX							
Follow-Up Interview [2]	134,793	1	134,793	0.47	63,353	$19.75	$1,251218
Discharge Interview [3]	94,720	1	94,720	0.47	44,518	$19.75	$879,238
SBIRT Program – Screening Only [9]	594,192	1	594,192	0.13	77,244	$19.75	$1,525,569
SBIRT Program – Brief Intervention Only [10] Baseline	111,411	1	111,411	.20	22,282	$19.75	$440,070
SBIRT Program – Brief Intervention Only Follow-Up [2]	82,444	1	82,444	.20	16,489	$19.75	$325,658
SBIRT Program – Brief Intervention Only Discharge [3]	57,934	1	57,934	.20	11,587	$19.75	$228,839
CSAT Subtotal	**887,756**		**1,257,647**		**321,085**		**$6,341,427**
Infrastructure, Prevention, and Mental Health Promotion (IPP) Form (Grantee Level Data) [11]	982	4	3,928	2	7,856	$19.75	$155,156
CSAP Aggregate Tool (Grantee-Level Data) [11]	6	4	24	.25	6	$19.75	$119
TOTAL SAMHSA	**943,923**		**1,408,864**		**381,566**		**$7,535,933**

1. The hourly wage estimate is $19.75, based on the Occupational Employment and Wages, May 2013 Mean Hourly Wage Rate for 21-1011 Substance Abuse and Behavioral Disorder Counselors = $19.75/hr. as of May, 2013. (http://www.bls.gov/oes/current/oes211011.htm (Accessed on 5/23/2014).
2. It is estimated that 74% of baseline clients will complete this interview.
3. It is estimated that 52% of baseline clients will complete this interview.
4. It is estimated that 80% of baseline clients will complete this interview.
5. It is estimated that 64% of baseline clients will complete this interview.
6. It is estimated that 10% of baseline clients will complete this interview.

7. It is estimated that 66% of baseline clients will complete this interview.
8. It is estimated that 30% of baseline clients will complete this interview.
9. The estimated number of SBIRT respondents receiving screening services is 80% of the total number SBIRT participants. No further data is collected from these participants.
10. The estimated number of SBIRT respondents receiving brief intervention services is 15% of the total number SBIRT participants.
11. Grantees are required to report this information as a condition of their grant. No attrition is estimated.
Note: Numbers may not add to the totals due to rounding and some individual participants completing more than one form.

Table 3 presents the estimated annualized burden for all the instruments in the CDP by data type.

Table 3. Common Data Platform: Summary by Data Type

Data Collection Type	Number of Respondents	Average Responses per Respondent	Total Number of Responses	Average Burden Hours per Response	Total Burden Hours
CMHS Client-Level Data [12]	35,845	2.74	98,157	0.35	33,958
CSAP Client-Level Data	19,334	2.54	49,108	0.38	18,661
CSAT Client-Level Data [13]	887,756	1.42	1,257,647	0.26	321,085
CMHS Program Level Data (IPP Form)	982	4.0	3928	2.0	7,856
CSAT Program-Level Data (Aggregate Form)	6	4.0	24	.25	6
TOTAL SAMHSA	**943,923**		**1,408,864**		**381,566**

12. Includes Primary CMHS Interviews, PBHCI Form and CoC Form completed at baseline, follow-up and discharge.
13. Includes Primary CSAT interviews, and the SBIRT interviews at baseline, follow-up and discharge.

The numbers in these tables reflect the estimated 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 will be no capital, start-up, operation, maintenance, nor purchase costs incurred by the programs participating in this SAMHSA data collection, or by consumers receiving services through SAMHSA grants or cooperative agreements.

A14. Estimates of Annualized Cost to the Federal Government

The principal costs to the government for this project are $4.40 million, the cost of a contract to develop the data system, collect the data from the various programs, and conduct analyses which generate routine reports from the data collected, plus $514,000 for additional IT help desk support (e.g., passwords, data entry issues). The total annual contract award to cover all aspects of the design of the study, sampling design, data collection, and development of the data files, data tapes, and technical documentation is $4.914 million

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.

Additional costs will be incurred indirectly by the government in personnel costs of staff involved in oversight of data collection. It is estimated that 5 SAMHSA employees, at a GS Level 12 ($75,621 to $98,305) will each be involved for 100 percent of their time. Using an estimated $85,000 salary, costs of SAMHSA staff time will approximate $450,000 annually.

The estimated annualized total cost to the government will be $5.36 million.

A15. Changes in Burden

This is a new data collection.

This new data collection is requesting 381,566 burden hours. CDP will replace the following OMB approved data collections: 0930-0208, 0930-0230, and 0930-0285. These data collections have a total of 169,209 burden hours. The increase of 212,357 hours is due to a program change. CSAT now has many more funded programs that were not reflected in the previous renewals – most programs were categorized as “General” in the previous (i.e., 2012) OMB approval, but the number of funded programs since this approval has grown. From February 2012, SAMHSA was only given an extension on the current data collections each year. Due to this constraint, SAMHSA was not able to accurately reflect the new CSAT programs that were being funded. With the new CDP data collection, SAMHSA is able to accurately request/submit the true burden hours.

A16. Time Schedule, Publication and Analysis Plans

SAMHSA and the contractor collect and compile the data. SAMHSA will host the secure environment in which the CDP data will be stored.

The data will be used by SAMHSA on an ongoing basis to monitor performance, to respond to GPRAMA, to prepare Reports to Congress for selected programs, to prepare program profiles, and other Federal reporting requirements. 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

Minority AIDS Initiative (MAI) report for HHS, and the Office of National Drug Control Policy (ONDCP) Budget.

These data are used to provide the agency with information to document the overall performance requirements by program and by Center. They are used to provide information that will assist SAMHSA in planning and monitoring program goals. Descriptive information obtained from program reporting requirements will be reviewed for monitoring and program management. Information is used internally by the agency and for performance reports. There are no formal publication plans. The time frame for submission of the reporting requirements varies by grant cycle and grant program period of performance throughout the year.

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. The certifications are included in this submission.