

FAMILY TREATMENT DRUG COURT SERVICES EVALUTAION

Supporting Statement

JUSTIFICATION

A1. Circumstances of Information Collection

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), is funding 10 Family Treatment Drug Courts (FTDCs) for enhancement and/or expansion of their FTDC's capabilities to provide psycho-social, emotional and mental health services to children (0-17 years) and their families. This data collection by the FTDC program is SAMHSA's second Federal data collection effort that focuses on the needs of children whose parents have a substance use disorder and are participating in an FTDC, and on effective strategies to address their needs. The first data collection effort of this type undertaken by SAMHSA was the performance monitoring of the "Children Affected by Methamphetamine" (CAM) grant program, approved by OMB, No. 0930-0330, expiration October, 31 2014. This is a request to reinstate OMB approval through 2020 for a new cohort of grantees under the new program name of Family Treatment Drug Courts, or FTDCs.

The CAM program was designed to pilot the expansion of services to the children and the parent-child dyad of families participating in FTDC, and improve the field's knowledge base about strategies to improve family outcomes. The focus on methamphetamine was a result of the growing national concern about methamphetamine use and home lab manufacturing, as well as the impact that parental methamphetamine use was having on the lives of families and young children.

Through CAM, SAMHSA provided funding over a four-year period to 12 established FTDCs. The participants served under this program were required to be involved in an FTDC and to be receiving substance abuse treatment services. The primary focus of this grant program was to provide services directly to children and to augment supportive services for parents, caregivers, and families. Grantees were encouraged to include other caregivers (e.g., kin providers) or foster parents involved in the care of the children, as appropriate.

Emerging findings from the CAM performance monitoring system suggest that adding child-focused services with adult recovery support services appears to improve child safety and family well-being. Specifically, parents reduce substance use and extend their treatment participation when their children are engaged in services. Children seem to be subject to less neglect and abuse, stays in out of home care are shorter, families are more stable and family functioning appears to be improved as a function of extending services to both children and their caregivers. Finally, for all grantees, CAM represented a fundamental shift in focus from parent recovery to child and family well-being. Many grantees cited that identifying and addressing children's needs became "a new way of doing business" and they cannot imagine reverting back to their practice and policies prior to CAM where there was little or no intentional focus on serving children with their parents. Furthermore, lessons learned from CAM indicate that families'

complex and diverse needs across service providers is more challenging than implementation efforts within a single agency or system because such cross-systems endeavors are more demanding on staff and require aligned values, buy-in of changes being made, cooperation amongst partners and resources to launch new program components.

The information collection described in the present application will enable SAMHSA to build on what was learned through CAM and expand its influence on the expansion and improvement of FTDCs. Specifically, continued performance monitoring will inform the agency and the grantees about how to better serve families in more and diverse implementation contexts, as well as continue to assess the extent to which the promising outcomes associated with the CAM program can be extended to additional communities. SAMHSA's FTDC service grant program is authorized under 509 of the Public Health Service Act, as amended, and addresses Healthy People 2010 focus area 26 (Substance Abuse). SAMHSA's legislative mandate is to increase access to high quality prevention and treatment services and to improve outcomes. Its mission is to improve the quality and availability of treatment and prevention services for substance abuse and mental illness. To support this mission, the Agency's overarching goals are:

- 1) Accountability—Establish systems to ensure program monitoring and accountability
- 2) Capacity—Build, maintain, and enhance mental health and substance abuse infrastructure and capacity
- 3) Effectiveness—Enable all communities and providers to deliver effective services

All of SAMHSA's programs and activities are geared toward the achievement of these goals and program monitoring is a collaborative and cooperative aspect of this process. SAMHSA is striving to coordinate the development of these goals with other ongoing program development activities. The information collection for the FTDC is needed to provide objective data to demonstrate SAMHSA's monitoring and achievement of its mission and goals.

A2. Purpose and Use of the Data Collection Effort

The data elements to be collected will be used by individuals at three different levels for varying purposes:

SAMHSA Level—The information is used to inform the administration of the functioning of the programs funded through the Agency.

Center Level—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 and to make funding continuation decisions.

Grantee Level—The grantee staff uses the information to improve the quality of treatment and prevention services that are provided to clients within their projects. This

information is also used to provide information about program cost effectiveness and efficiency, and to assist grantees in sustainability planning.

The data collection needs to be standardized so that data from instruments such as the core child, parent/caregiver and family functioning outcomes can be combined across FTDC grantees. SAMHSA is requesting approval from the Office of Management and Budget (OMB) for the collection/extraction of data elements to assess the attainment of the objectives as specified above.

The proposed data collection and analysis will include use of 1) the North Carolina Family Assessment Scale (NCFAS G+R)) a staff assessment instrument regarding various domains of family functioning; and 2) extraction of data from two child welfare and one substance abuse treatment data sets, described in detail, below, that records information about the families child welfare and substance abuse treatment involvement. Information from the extraction will be entered into the FDTC Data Collection Form. Together, information from these tools will provide information about the outcomes for families participating in family treatment drug courts and will provide knowledge about the services needed and provided to these and similar families.

Family Treatment Drug Courts have been growing in number over the past decade and provide additional supervision and monitoring of parents whose substance use is a contributing factor in child welfare cases where children have been removed or remain in the home with certain court conditions stipulated. Like the CAM program, the information collected through the FTDC program will benefit SAMHSA by providing an in-depth understanding of the needs of the children and families served by FTDC and will enable SAMHSA and the grantees to monitor their performance. Findings from this program will provide SAMHSA with valuable information regarding appropriate service interventions for this population and, ultimately, inform SAMHSA on how the agency can best meet the needs of families participating in FDTCS. The results from this data collection will also support individual grantees to improve their programs and sustain program components that worked well. The FTDC project will extract and analyze data on children, parents/caregivers and family functioning. The domains specified in the Request for Applications (RFA) are: 1) Child Outcomes; 2) Parent/Caregiver Outcomes; and, 3) Family Functioning.

Background and Overall Approach

This section describes the data elements and sources. In part B we discuss data extraction methods and data collection time periods.

Data elements

The domains as specified in the Request for Applications: 1) Child Outcomes; 2) Parent/Caregiver Outcomes; and, 3) Family Functioning, have been operationalized by 18 data elements (see Table 1). To the greatest extent possible, the data elements are operationally defined using standard definitions in child welfare and substance abuse treatment. The use of standard data definitions will reduce the data collection burden on grantees as these variables are collected

through data collection procedures that currently exist through all publically funded child welfare and substance abuse treatment systems.

Most of the FTDC data elements currently collected by programs are collected as part of their normal operations (e.g., placement status in child welfare services, substance abuse treatment entry dates). Furthermore, the information utilized for the NCFAS rating (see Attachment B) is obtained during the intake interview that sites engage in when determining program eligibility and suitability. If needed, the FTDC staff member may supplement this information by obtaining information from a survey of staff who interact with the client (e.g., the social worker familiar with the family) or during interactions with participants (as this is part of their program activities).

For this project, grantees are to indicate if the adult is the index child(ren)'s primary caregiver. In general, a primary caregiver is defined as the person who has consistently assumed responsibility for the housing, health and safety of the child(ren) and who carries out and/or oversees the tasks related to the daily lives of the child(ren), which includes caring for their physical, educational, social, emotional and other needs. However, the definition should be considered flexible enough to take into account the diversity of people's lives and family structures. There can be more than one primary caregiver in a family. If there are multiple index children and the adult's primary caregiver role differs by child, the adult's primary caregiver status for the youngest child is to be used. As there is no universal definition of primary caregiver in existing Federal child welfare or substance abuse treatment data systems, the definition of primary caregiver being utilized by this study is the same definition being utilized by the ACF Regional Partnership Grant Program (OMB No.: 0970-0353).

It should be emphasized that the FTDC projects are expansions or enhancements of FTDC partnerships that currently have existing relationships (and information sharing/ confidentiality agreements) in place. It is through this existing information sharing forum that the FTDC grantees will be able to obtain the requisite child welfare and substance abuse treatment data elements.

Data Sources

The contractor and grantees will tap four data sources to collect and report the requisite data elements: a Federal substance abuse treatment data set, two Federal child welfare data sets, and the NCFAS G+R.

Federal Data Sources (N=3)

The FTDC Data Collection Form (see Attachment A) includes all of the variables extracted from the Federal data sets. Each source is described in the following subsections.

Substance Abuse Treatment Data Source (N=1). The proposed substance abuse treatment data elements involve abstracting data from an extant State automated substance abuse treatment data system. The Treatment Episode Data Set (TEDS) is an administrative data system providing descriptive information about admissions and discharges to publically funded substance abuse treatment in the United States. All States currently report the minimum required TEDS

admission data to SAMHSA and admission and discharge data are collected by State substance abuse agencies according to their own information systems for monitoring substance abuse treatment admissions. The data are typically collected during the treatment intake interview with the client using State-specific administrative forms. The data are transformed to the TEDS data elements according to an approved protocol. The data are then transmitted monthly or quarterly to a SAMHSA contractor for processing, cleaning, updating, and producing final files.

Child Welfare Data Sources (N=2). The child welfare data elements require secondary data collection and abstraction from the grantee’s State child welfare case management information system, which is often a Federally-funded Statewide Automated Child Welfare Information System (SACWIS). These automated child welfare case management systems, administered by the Administration for Children and Families (ACF), track the foster care and maltreatment status of children in the United States. These data are submitted semi-annually to ACF through two primary reporting functions: 1) The Adoption and Foster Care Analysis and Reporting System (AFCARS), which provides information on all children in foster care; and, 2) The National Child Abuse and Neglect Data System (NCANDS), which contains information on all child maltreatment reports and dispositions. All FTDC States have operational SACWIS data systems.

The NCFAS G+R

Attachment B includes all of the variables in the NCFAS G+R. The following subsection summarize this data collection activity. The NCFAS-G+R is a staff assessment instrument regarding various domains of family functioning. It is completed by staff after they have conducted assessments as part of their normal operations. The NCFAS G+ R will provide data for the following data elements: child well-being, parental capacity to care for children’s needs, family functioning/relationships and risk/protective factors. The NCFAS G+ R will also provide the project staff with data on child behaviors, developmental milestones and socio-emotional characteristics that they will use in planning family and child interventions. The information utilized for the NCFAS rating is obtained during the intake interview that sites normally engage in when determining program eligibility and suitability. If needed, the rater may supplement this information by obtaining information from other staff that interacts with the client (i.e., the social worker) or during a home visit (if this is part of their program activities).

Table 1 presents the data elements, the data sources, data collection methods and data collection time periods.

Table 1. Data elements, Data Source, Collection Method and Time Periods			
Performance Measure	Data Source	Data Collection Method	Data Collection Time Periods
1. Child Outcomes			
Children Remain at Home	NCANDS	Secondary abstraction	Baseline, every 6-months up to 24 months
Occurrence of Child Maltreatment	NCANDS	Secondary abstraction	Baseline, every 6-months up to 24 months
Length of Stay in Foster Care	AFCARS	Secondary abstraction	Baseline, every 6-

			months up to 24 months
Re-entries to Foster Care	AFCARS	Secondary abstraction	Baseline, every 6-months up to 24 months
Timeliness to Reunification	AFCARS	Secondary abstraction	Baseline, every 6-months up to 24 months
Timeliness to Permanency	AFCARS	Secondary abstraction	Baseline, every 6-months up to 24 months
Prevention of Substance-Exposed Newborns	Program Records	Secondary abstraction	Baseline, every 6-months up to 24 months
Children Connected to Supportive Services	Program Records or Child Welfare Data System	Secondary abstraction	Baseline, every 6-months up to 24 months
Child Well-Being	North Carolina Family Assessment Scale-General + Reunification (NCFAS-G+R)	Survey data collection from program staff	Baseline and discharge from the FTDC program
2. Parent/Caregiver Outcomes			
Access to Substance Abuse Treatment	TEDS	Secondary abstraction	Baseline, every 6-months up to 24 months
Retention in Substance Abuse Treatment	TEDS	Secondary abstraction	Baseline, every 6-months up to 24 months
Reduction in Substance Use	TEDS	Secondary abstraction	Baseline, every 6-months up to 24 mos.
Parents or Caregivers Connected to Supportive Services	Program Records	Secondary abstraction	Baseline, every 6-months up to 24 months
Employment / Education	TEDS	Secondary abstraction	Baseline, every 6-months up to 24 months
Criminal Behavior	TEDS	Secondary abstraction	Baseline, every 6-months up to 24 months
3. Family Functioning Outcomes			
Parental Capacity to Care for Children's Needs	North Carolina Family Assessment Scale-General + Reunification (NCFAS-G+R)	Survey data collection from program staff	Baseline and discharge from the FTDC program
Family Functioning/Relationships	North Carolina Family Assessment Scale-General + Reunification (NCFAS-G+R)	Survey data collection from program staff	Baseline and discharge from the FTDC program
Risk/Protective Factors	North Carolina Family	Survey data collection from	Baseline and discharge

	Assessment Scale- General + Reunification (NCFAS-G+R)	program staff	from the FTDC program
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A3. Use of Information Technology

It is anticipated that the grantees will have all of the child welfare and adult substance abuse treatment data available electronically (See Table 1) through the normal business operations and reporting functions to child welfare and treatment monitoring systems. Availability of existing child welfare and substance abuse treatment data will reduce burden on FTDC personnel as it will not require primary data collection and will only be abstracted twice a year.

A web-based data collection and entry system will be utilized by CSAT for collection of the data elements. This web-based system will allow for easy data entry, submission, and reporting. Levels of access will be defined for users based on their authority and responsibilities regarding the data and reports. The CSAT Data System will be password protected and grantees will only have access to their own particular data upload site. The CSAT Data System Administrator must provide grantee staff with access to the Data System in order for staff to access the CSAT Data Collection System.

The electronic submission will promote immediate access to the dataset. Once the data are put into the web-based system, it is available for access, review, and reporting by CSAT, its contractor for the FTDC program and the grantee staff.

A4. Efforts to Identify Duplication

The majority of data collection will involve secondary analysis of existing data augmented by staff administered data collection on the data elements that are not in existing data systems. New data collection is limited to data elements that do not exist in standard data collection.

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 fewest number required to accomplish the objectives of the effort and to meet reporting requirements.

A6. Consequences of Collecting the Information Less Frequently

The majority of data are collected through normal operations. The data elements involving the staff survey administration of the NCFAS will be collected at admission and discharge to FTDC. Admission data will be used for service planning for FTDC clients. Data reporting to SAMHSA will occur twice a year to keep the burden manageable for grantees and to meet reporting requirements for SAMHSA in addressing progress of grantees. The bi-annual reporting also aligns with Federal reporting timeframes for the child welfare and substance abuse treatment systems.

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 April 10, 2015 (80 FR 19331). No comments were received in response to this notice.

A9. Payment to Respondents

Respondents will not receive payment.

A10. Assurance of Confidentiality

The information from respondents will be kept private through all points in the data collection and reporting processes. Each grantee will maintain client-level data with the ability to link cases at the family level. These data will be de-identified prior to reporting to SAMHSA. SAMHSA and its contractors will not receive identifiable client records.

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. These data are submitted in de-identified format and therefore cannot be traced back by SAMHSA and its contractors to individuals, therefore the risk to clients is minimal. Data can only be accessed by SAMHSA and its contractors through a password protected system, minimizing the risk to clients' confidentiality. The system restricts access to those with a user name and password and only allows sites to access their own data. All FTDC grantees are required to obtain approval from Institutional Review Boards prior to collecting the data.

The analyses presented in SAMHSA's reports will be based on restricted analytic data files that contain the complete FTDC data set. These data files will only be available to analysts directly involved in the FTDC project. All of these analysts are responsible for using the data in accordance with the information provided to each respondent when he or she agreed to participate in the FTDC project (i.e., the data will be used only for statistical purposes), and for ensuring there is no disclosure of respondent's personal information. These responsibilities stem

from legislation that outlines severe penalties for unlawful disclosure of personal information on survey respondents. All data will be analyzed in aggregate form, which will prevent the identification of individual clients in the event of a small number of respondents within a FTDC project.

A11. Questions of a Sensitive Nature

It is necessary for service providers to collect sensitive items such as experiences with violence and trauma, criminal justice involvement, child welfare involvement, use of alcohol or other drugs, as well as issues of adult psychiatric problems. 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 and there is no primary data collection from FTDC clients. The information utilized for the NCFAS rating is obtained during the intake interview that sites engage in when determining program eligibility and suitability. 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. These data are submitted in de-identified format and therefore cannot be traced back by SAMHSA and its contractors to individuals; therefore the risk to clients is minimal.

A12. Estimates of Annualized Hour Burden

Table 2 presents the estimated annualized hour burden associated with the collection or extraction of the FTDC data elements. There are two sources of data collection burden for the performance system. First, FTDC staff extracts data from secondary sources for the child, parent/caregiver and family functioning data elements for biannual data uploads. The total number of responses is two per year; with each upload taking approximately 16 hours at each site. In addition to the data extraction, FTDC staff will complete 2 administrations (intake and discharge) of the NCFAS for each family (approximately 267 families per year based on estimates extrapolated from a similar grant program implemented by SAMHS 2010-2014). The NCFAS takes approximately .75 hours to complete per family per administration. The estimated total cost of the time FTDC staff will spend completing data collection is \$15,952 per year (total number of staff hours, 720.5 hours, multiplied by \$22.14, the estimated average hourly wages for social work professionals as published by the Bureau of Labor Statistics, 2013). See Table 2.

Table 2: Annualized Hour Burden

Form/ Instrument	Number of Records	Responses per Record	Total Responses	Hours per Response	Total Hour Burden	Hourly Wage Cost	Total Hour Cost (\$)
FTDC Form – Biannual extraction of	10	2	20	16	320	\$22.14	\$7,085

extant data x 10 grantees							
NCFAS – Administered twice for each family	267	2	534	.75	400.5	\$22.14	\$8,867
TOTAL	277		554		720.5		\$15,952

Note: The estimated response burden includes the extractions and uploads to the FTDC Form and administration the North Carolina Family Assessment Form. The term “varying number of families” was utilized as the grantees are implementing varying program models to fit their individual community’s needs. While all are expanding family drug courts, the size of their family drug court and areas to be served vary dramatically. Some of the grantees are serving very rural communities, while others are serving large urban areas.

A13. Estimates of Cost Burden to Respondents

There is no capital, start-up or operational costs for grantees.

A14. Estimates of Annualized Cost to the Federal Government

The principal cost to the government for this project is the cost of a contract to collect the data from the FTDC program and to conduct analyses which generate routine reports for SAMHSA from the data collected. The estimated annualized cost for the FTDC data collection effort is \$104,165/year for .75 FTE using loaded labor and overhead costs.

A15. Changes in Burden

This is a new data collection.

A16. Time Schedule, Publication and Analysis Plans

Data Collection Time Periods

Abstraction of child welfare, substance abuse treatment and program records will be conducted every six months and there will be no additional burden on participant families as the data are collected through normal operations of the programs. Staff administration of the NCFAS G+R will occur at intake and discharge to FTDC.

Data will be reported bi-annually corresponding with the data collection time period reflected in SAMHSA’s Bi-Annual Progress Reports, which are due April 30 and October 31 of each year. Twice yearly data submissions will include the entire current record for all of a grantee’s cases to date. The data will be reviewed for any major problems, and follow-up will be conducted as needed with grantees to resolve these issues.

SAMHSA will ensure that all disseminated information will be prepared in accordance with professional and ethical standards. They will be appropriate

for dissemination by SAMHSA and will undergo appropriate review and approval prior to release. SAMHSA adheres to the laws and regulations applying to publications, including OMB Information Quality Guidelines, the HHS Printing Handbook, and relevant SAMHSA policy issuances. SAMHSA efforts to ensure and maximize information quality begin at the preparation stage and continue through the review and approval stages. When published electronically, existing SAMHSA policies developed in concert with Federal computer security laws will provide appropriate security safeguards to ensure integrity of SAMHSA documents, i.e., that the information is protected from unauthorized access, revisions, corruption, or falsification. Each publication will be accurate, both in specific details and in general impressions, and meet accepted standards of high quality. SAMHSA documents and presentations containing text and summary data will be objective and scientifically sound. Sources will be referenced for the convenience and further information of the reader. Supporting data will have full, accurate, and transparent documentation.

Analysis Plans

Statistical Package for the Social Sciences (SPSS) software will be used for descriptive analyses of the FTDC project. A p value less than .05 will be considered statistically significant. Chi-square tests will be used to compare the distribution of client characteristics (i.e., gender, race/ethnicity). Logistic regression procedures and odds ratio (OR) estimates derived from logistic regression procedures will be used to denote the estimated magnitude of an association between a binary outcome (e.g., treatment completion) and a covariate (e.g., client gender). An OR estimate greater than 1.00 will indicate a positive association between the outcome of interest and the covariate; an OR estimate less than 1.00 will indicate an inverse association. A 95 percent confidence interval (CI) of the OR will be presented.

Initial descriptive analyses will describe the demographic characteristics of the children and parents/caregivers in the FTDC project and characteristics of FTDC families. Multivariate analyses will model the influence of child, parent/caregiver and family variables on child welfare outcomes, substance abuse treatment outcomes and receipt of FTDC services. These analyses will allow SAMHSA to accurately monitor the implementation of the FTDC program initiative.

The follow-up data also will be described using descriptive statistics including frequency distributions and crosstabs. Change will be assessed 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 client outcome measures that are categorical. For continuous items, mean differences will be calculated. Tables will be constructed to describe changes across projects on selected data elements. Once a sufficient population size is obtained, modeling will also be used to look at factors that contribute to predicting successful outcomes (e.g., decreased drug use, criminal involvement, child abuse/neglect recidivism, and increased employment). If baseline descriptive analyses reveal disparities among groups of clients and

these differences appear to be influencing results, a repeated Analysis of Covariance (ANCOVA) will be conducted on selected variables to account for these factors.

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 certificates are included in this submission.