DIVISION of STATE PROGRAMS MANAGEMENT & REPORTING TOOL

SUPPORTING STATEMENT

A. JUSTIFICATION

A.1. Circumstances of Information Collection

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention (CSAP) is seeking approval for a revised package aimed to improve oversight of federal grants from the Office of Management and Budget (OMB), to the previously approved instrument – Division of State Programs'- Management and Reporting Tool (OMB No. 0930–0354), which expires on November 30, 2021. The instrument in this current package is the Division of State Program--Management and Reporting Tool (DSP-MRT). Data collected through this instrument are necessary to ensure SAMHSA and grantees comply with requirements under the Government Performance and Results Act Modernization Act of 2010 (GPRA) that requires regular reporting of performance measures. Additionally, data collected through the DSP-MRT provide critical information to SAMHSA's Project Officers related to grant oversight, including barriers and facilitators that the grantees have experienced, and an understanding of the technical assistance needed to help grantees implement their programs. The information also provides a mechanism to ensure grantees are meeting the requirements of the grant funding announcement as outlined in their notice of grant award.

This package includes five tools including a standard set of questions used for all programs within the Division of State Programs and four specific subset questionnaires for individual programs:

- Strategic Prevention Framework (SPF)
- Partnerships for Success (PFS)
- Strategic Prevention Framework for Prescription Drugs (SPF-Rx)
- First Responders-Comprehensive Addiction and Recovery Act (FR CARA) and Grants to Prevent Prescription Drug/Opioid Overdose-Related Deaths (PDO) grants (One subset questionnaire for both programs), and
- Sober Truth on Preventing Underage Drinking Act (STOP Act) Grants (new)

SAMHSA's opioid and underage drinking prevention programs are authorized under 42 USC 290bb-22: Priority substance use disorder prevention needs of regional and national significance. This data collection effort is supported by Subsection c (1): Recipients of grants, contracts, and cooperative agreements under this section shall comply with information and application requirements determined appropriate by the Secretary.

Background.

Over the past decade, a large number of evaluation studies demonstrated that prevention interventions effectively reduce substance use, as well as delinquent behaviors; violence; and other mental, emotional, and behavioral health problems (e.g., Blow, 2020, Calear & Christensen, 2010; Lemstra et al., 2010; Ttofi & Farrington, 2011). Among 12- to 20-year-olds

from 2002 to 2019, rates of current alcohol use decreased from 28.8% to 18.5%. The rates of past month binge drinking declined from 13.4% in 2015 to 11.1% in 2019 and heavy alcohol use declined from 3.3% to 2.2% (SAMHSA, 2020). 2020 data from Monitoring the Future echo these successes, and noted teen marijuana use remains stable, but high. For example, past year marijuana use for 12th graders remains at 35% (MTF, 2020). Despite these successes, Underage Drinking (UAD) continues to be a significant public health problem. The 2019 National Survey on Drug Use and Health (NSDUH) report estimates that approximately 7 million underage people reported current use of alcohol, 4.2 million reported binge drinking, and 825,000 reported heavy alcohol use (SAMHSA, 2020). Additionally, the percentage of eighth graders who misused amphetamines, inhalants, and cough medicine over the past 12 months continues to gradually increase (MTF, 2020). UAD causes serious harm to the adolescent drinker as well as to the community as a whole (Office of Juvenile Justice and Delinquency Prevention, 2012). Alcohol use by adolescents negatively effects brain development, results in other serious health consequences (e.g., alcohol poisoning, risky sexual behaviors, and addiction), and leads to safety consequences from driving under the influence, poisonings, and other injuries. UAD places youth at increased risk for violence and victimization along with social or emotional consequences (e.g., low self-esteem, depression, anxiety, lack of self-control, stigmatization by peers), academic consequences (e.g., poor academic performance, truancy, suspension or expulsion from school), and family consequences (e.g., poor relationships with parents).

Adolescent drinking can also impose economic consequences, ranging from personal costs (e.g., payment for alcohol treatment or medical services) to familial costs (e.g., parents taking time off of work to drive children to treatment) to community costs (e.g., providing enforcement, supervision, or treatment to underage drinkers). Sacks et al. (2013) estimated that in 2006, UAD was responsible for $24.6 billion (11%) of the total cost to society of excessive alcohol consumption in the United States.

Addressing the continuing opioid epidemic is another public health crisis SAMHSA has prioritized. From 1999 to 2018, almost 450,000 people died from an opioid-involved overdose, including prescription opioids (CDC, 2020). The opioid epidemic can be described as occurring in three distinct waves. The first wave began with increased prescribing of opioids in the 1990s, with overdose deaths involving prescription opioids (natural and semi-synthetic opioids and methadone) increasing since at least 1999 (CDC, 2011). The second wave began in 2010, with rapid increases in overdose deaths involving heroin (Rudd, et al., 2014). The third wave began in 2013, with significant increases in overdose deaths involving synthetic opioids, particularly those involving illicitly manufactured fentanyl (O'Donnell, et al., 2017). In response to this, SAMHSA implemented a number of grant programs to target opioid overdose prevention. FR CARA and PDO provide funding to states and communities to purchase Naloxone, a medication designed to rapidly reverse an opioid overdose, and to train individuals on how to administer it. SPF-Rx provides funding to improve utilization of the Prescription Drug Monitoring Program (PDMP). There has been some progress: among people aged 12 or older, the number of past year initiates of prescription pain reliever misuse declined from 2.1 million people in 2015 to 1.6 million people in 2019 (SAMHSA, 2020).

A.2. Purpose and Use of Information

The DSP-MRT is a tool that enables SAMHSA Project Officers to monitor grantee activities through the SPF process. The DSP-MRT is comprised of one main instrument (Attachment #1) that contains common elements that the five grant programs are required to report on. The five grants are the Strategic Prevention Framework (SPF) Partnerships for Success (PFS), the SPF for Prescription Drugs (SPF-Rx), First Responders-Comprehensive Addiction and Recovery Act (FR CARA), and Grants to Prevent Prescription Drug/Opioid Overdose-Related Deaths (PDO) grants. We are requesting the inclusion of the grant program Sober Truth on Preventing Underage Drinking Act (STOP Act) that has data collection requirements similar to the other programs on this list.

Information that is reported into the DSP-MRT shows how grantees are progressing in implementing the five steps of the SPF: Assessment, Capacity, Planning, Implementation, and Evaluation—in the context of preventing underage drinking, opioid, or other substance misuse. The SPF is the framework that most SAMHSA prevention grants are required to adhere to as a term or condition of their grant.[1] The DSP-MRT gathers all information through a web-based data collection system that uses clickable radio buttons, check boxes, drop-down choice items, and open-ended text boxes, as relevant. It also allows grantees to upload required documents requested by their Project Officers. This web-based data collection instrument is usually completed by the grantee Project Director once each quarter or biannually, depending on the program. The instrument gathers data related to implementation of the SPF steps along with how Health Disparities are addressed through each step. Please see full instrument in Attachment #1.

Clicking the link for each step or section will direct the user to the relevant landing page. For example, the "Assessment" link will direct user to the Assessment landing page. Program specific DSP-MRT elements are included as separate attachments and include additional elements that are only required for certain grant programs. Please see the revised program specific instruments in Attachments #2 through #4 and the additional STOP Act instrument in Attachment #5.

The data from the implementation of the SPF model allows SAMHSA grantees to report on their progress and Project Officers to systematically monitor their grant program's performance along with grantee technical assistance needs. In addition to assessing activities related to the SPF steps, the performance monitoring instruments covered in this statement collect data to assess grantee-specific required performance measures. For example,

[1] *Strategic Prevention Framework:* In 2004, SAMHSA began funding programs using the Strategic Prevention Framework (SPF) to help States, jurisdictions/territories, and tribal organizations implement activities with the goals of preventing the onset and reducing the progression of substance use, reducing problems related to substance use, and building capacity and infrastructure for prevention. The SPF model consists of five steps: (1) needs assessment; (2) capacity building; (3) strategic planning; (4) implementation of programs, policies, and practices; and (5) evaluation. Grantees also considered cultural competence and sustainability at each step in the process. In 2004, the SPF was used in the State Incentive Grants and then Partnerships for Success in 2011. Currently, the SPF model is being used in both PFS and the SFP-Rx grant programs and is a driver of how these programs collect data.

Substance Abuse and Mental Health Services Administration: A Guide to SAMHSA's Strategic Prevention Framework. Rockville, MD: Center for Substance Abuse Prevention. Substance Abuse and Mental Health Services Administration, 2019.
https://www.samhsa.gov/sites/default/files/20190620-samhsa-strategic-prevention-framework-guide.pdf

- **Strategic Prevention Framework (SPF) Partnerships for Success (PFS**): This additional tool, or supplement, includes specific measures on grantee and sub-grantee implementation of evidence-based practices, policies, and programs (EBPPPs) and 30-day substance use outcomes measures that reflect the grantees' priority areas. These data are used for performance management and GPRA reporting.
- **Strategic Prevention Framework for Prescription Drugs (SPF-Rx):** This additional tool includes specific measures on how grantees are enhancing utilization of PDMPS as well as policies, regulations, and laws that affect opioid prescribing or dispensing. These data help SAMHSA understand state and local level policy decisions that impact our ability to address the opioid crisis, in addition to being requirements of the grant.
- **First Responders-Comprehensive Addiction and Recovery Act (FR CARA) and Grants to Prevent Prescription Drug/Opioid Overdose-Related Deaths (PDO) grants** (One subset questionnaire for both programs): This tool, which both programs use as they have similar grant requirements, allows grantees to report on naloxone training, distribution, and administration. In addition to being grant requirements and GPRA measures, this information also helps SAMHSA measure how efforts are progressing to address the opioid epidemic.
- **Sober Truth on Preventing Underage Drinking Act (STOP Act) Grants (new):** Similar to the PFS tool descripted above, this supplement includes measures on the implementation of EBPPPs and 30-day alcohol or other drug use required per the grant-funding announcement as well as to provide GPRA data.

The performance monitoring instrument was revised with input from grantee-level evaluators, SAMHSA management and Project Officers, and other stakeholders. Based on this feedback, minor revisions were made to clarify the instruments, and remove outdated references, and to improve the capacity for program oversight. Specifically:

- Within DSP-MRT main instrument (Attachment #1), we recommend:
    - Removal of the requirement to upload meeting minutes (page 12)
    - Updating reference from a discontinued technical support to an existing technical assistance support (page 16)
    - Removal of references to discontinued technical assistance supports (page 16)
    - The inclusion of the option "Engagement of leadership from high needs/disparity communities" in the "Accomplishments" section (page 18)
    - Revision of references of Healthy People 2020 to Healthy People 2030 (page 24)
    - The addition of the category "frontier" (pages 27 and 28)

Although these are minor changes, we feel they are important to accurately reflect the updated context in which the grantees are reporting their data.

We are also proposing the inclusion of a set of three new performance measures for both the DSP-MRT PFS tool and FR CARA/PDO tool. Specifically:

- Within the DSP-MRT PFS tool (Attachment #2), the addition of the three measures:

    - "What are the Evidence-based Practices, Policies, or Programs (EBPPs) you intend to implement through this grant?"

    - "Who is the intended audience?"
    - "What is the non-duplicated number of individuals you intend to serve each year of your grant?"
- Within the DSP-MRT FR CARA/PDO tool (Attachment #3), the addition of the three measures:
    - "What is the number of proposed trainings to be conducted by this grant?"
    - "How many individuals do you propose training through this grant?"
    - "How many kits do you plan to distribute through your grant?"

Ensuring prevention grants are achieving the intended goals of their program is critical to meeting SAMHSA's mission. The inclusion of this set of measures will allow, for the first time, a means by which GPOs can easily track the progress of the grantees they oversee. This will be a small addition of burden, but it has the capacity to improve program oversight tremendously. SAMHSA is in the process of re-assessing and strengthening how we collect, review, and use data, especially in response to the GAO Report: *GAO-21-96 Agencies Have Not Fully Identified How Grants That Can Support Drug Prevention Education Programs Contribute to National Goals* and the National Academies of Science, Engineering, and Medicine Report: *Progress of Four Programs from the Comprehensive Addiction and Recovery Act (2021*) that identified issues with aligning program measures with national measures, aligning reporting requirement with funding announcement requirements, and the need for improved oversight in grantee progress reports. The measures that currently exist in this instrument reflect grant requirements and include data that can be used to support national efforts, such as the 30-day substance use measures referenced in the GAO-21-96 report. The addition of this small set of additional measures will help improve our oversight of these important programs.

We are also requesting the ability of the STOP Act grantees to use the DSP-MRT as well as a supplemental tool to reflect their additional requirements (Attachment #5). These grants previously reported progress report data into the DFC Management and Evaluation system in conjunction with the Drug-Free Community (DFC) grants, previously managed by SAMHSA. As the DFC grants are now managed by the Centers for Disease Control Prevention, SAMHSA will need to provide a repository for STOP Act grantee data, and the DSP-MRT provides an easily adaptable structure for these data.

As noted above, data collected will include information on accomplishments and barriers for each step.

- The *Capacity* section collects information on workgroup membership and meetings to assess leveraging of partnerships; grantee-level funding and in kind resources to assess leveraging of funds from various sources; and training received by grantees and provided to subrecipients by grantees including training topics, numbers reached, delivery sources, and unfulfilled training needs.
- The *Planning* section allows grantees to upload their strategic plans as those become available.
- The *Implementation* section requests grantees to provide information on the progress of each of their community subrecipients.

- The *Evaluation* section allows grantees to upload their evaluation plans or local evaluation reports as those become available.
- The *Health Disparities* section allows SAMHSA project officers to monitor grantee efforts to fulfill requirements related to SAMHSA's mission that grantees address health disparities related to substance use risks, prevalence, and outcomes. This section allows grantees to upload required health disparities impact statements (plans for how they will address health disparities) as well as describe health disparities-related activities, accomplishments, and barriers relevant to each one of the SPF steps.

There are no changes to the SPF-Rx supplement tool (Attachment # 4).

A.3. Use of Information Technology

Grantee staff will provide information in the DSP-MRT through an online data collection system. Using a Web instrument allows for automated data checks as well as for skip procedures and prepopulated fields based on prior responses to certain questions. This will reduce the burden among respondents and data entry error, thereby increasing the efficiency of data entry and improving data quality. The automated data checks will ensure that responses follow the expected format (e.g. numbers or dates where those are expected). Similarly, once completed initially, some items are automatically pre-populated, such as when Grantees provide measure description information on baseline community outcomes data and then only need to change the time frame and outcomes values at later time points.

The Web-based system also allows SAMHSA Project Officers to review submissions conveniently, request revisions as needed, and then provide approvals to grantees on their submissions as relevant.

A dashboard and other reports will also be available to SAMHSA and the contracting team, as well as the grantees and subrecipients who submit data, so that they can monitor the overall status of data collection and monitor performance. Grantees will have access to their own data.

A.4. Effort to Identify Duplication

This monitoring tool is collecting information unique to the DSP program grantees that is otherwise not available to project officers. In addition, this data collection was cross-walked with similar instruments across SAMHSA.

A.5. Involvement of Small Entities

Participation in this data collection will not impose a significant impact on small entities. Grantees will usually consist of State agencies, tribal organizations, and other jurisdictions. Some subrecipients may be small entities; however, the System for the DSP-MRT is designed to include only the most pertinent information needed to be able to monitor the grantee's progress and to carry out the evaluation effectively, and their impact will not be significant.

A.6. Consequences If Information Collected Less Frequently

The multiple data collection points for the DSP-MRT are necessary to track and monitor grantees' and community subrecipients' progress and change over time. In addition to performance monitoring purposes, SAMHSA will use the data for the purposes of evaluation, and grantee and subrecipient communities will use these data to track their ongoing implementation. Less frequent reporting will affect SAMHSA's and the grantees' ability to do so effectively. For example, SAMHSA's federal requirements require them to report on performance and GPRA measures once each year. Federal health disparities priorities require periodic reports of the activities used to address those priorities.

SAMHSA has made every effort to ensure that data are collected only when necessary and that extraneous collection will not be conducted. For example, grantees report only outcomes required for GPRA measures on an annual basis.

A.7. Consistency With the Guidelines in 5 CFR 1320.5(d)(2)

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

A.8. Consultation Outside the Agency

The notice required by 5 CFR 1320.8(d) was published in the *Federal Register* on July 19, 2021 (86 FR 38107).

These program monitoring tools contain minor revisions on the original narrative tools completed by previous grant programs. The original tools were reviewed by SAMHSA staff, grantees, and contractors who provided feedback on each of the data collection instruments and the instruments were revised based on their feedback. Revisions are minor and include the addition of program targets, updates to reflect changes to SAMHSA programs, the removal of redundancies, and additional options to strengthen disparities reporting.

A.9. Payment to Respondents

No cash incentives or gifts will be given to respondents.

A.10. Assurance of Confidentiality

The DSP-MRT only requests personal data through the *Contact Information* section of the system. That staff role, name, e-mail, and telephone number data collected through that instrument are collected to allow contract staff to provide grantee and subrecipient login information for the system, and to facilitate contact with the grantee and subrecipient staff on their data entry, data cleaning needs, and technical assistance requests. This identifying information will be accessible only to select contractor evaluation staff and Project Officers at SAMHSA. No other personal information will be collected from respondents as the focus of the data collection is on the programmatic characteristics of the grantees and subrecipients.

No individual-level or personal data will be collected through the system. Grantee staff will provide information about their organizations and their activities, rather than information about

themselves personally. The instruments collect programmatic data at the grantee and community levels along with aggregated, non-identifying individual-level data (e.g., community outcomes data). Sensitive respondent information, such as birthdates and Social Security Numbers, will not be collected.

The contracting team takes responsibility for ensuring that the Web and data system is properly maintained and monitored. Server staff will follow standard procedures for applying security patches and conducting routine maintenance for system updates. Data will be stored on a password-protected server, and access to data in the system will be handled by a hierarchy of user roles, with each role conferring only the minimum access to system data needed to perform the necessary functions of the role.

While not collecting individual-level data, contractor staff are trained on the importance of privacy and in handling sensitive data.

A.11. Questions of a Sensitive Nature

There are no questions of a sensitive nature in this collection.

A.12. Estimates of Annualized Hour Burden

The number of burden hours has increased substantially due to significant increases in funding SAMHSA has received through legislation aimed to address the opioid epidemic and other national priorities, such as the Comprehensive Addiction and Recovery Act (P.L. 114-198) and the addition of the STOP act supplemental survey. Additionally, the number of data collection respondents will vary by year because of the varying lengths in grants, data collection time points, and each cohort's grant end dates. As such, the burden and respondent cost will also vary by year.

DSP -MRT

All programs within DSP, and all future cohorts, are expected to complete their monitoring reports between two to four times per year, depending on the grant requirements of the program. The DSP Management Reporting Tool is estimated to take 3 hours to complete per response; this includes time to look up and compile information (2.5 hours) and time to complete the Web-instrument (1.5 hour). There are no direct costs to respondents other than their time to complete the instrument. ***Table below*** provides the details of the annual burden for the DSP-MRT, which also includes attachments one through five for program specific questions. The estimate for each program specific section is 1 hour.

Burden Table: FY2021—FY2024 Annualized Burden

Instrument	Number of Respondents	Responses per Respondent	Total Number of Responses	Hours per Response	Total Burden Hours	Average Hourly Wage	Total Respondent Cost[a]
DSP -MRT	521	4	2,084	3	6,252	$44.19	$276,276
PFS Supplemental	253	1	253	1	253	$44.19	$11,180
PDO/FR CARA Supplemental	109	2	218	1	218	$44.19	$9,633
SPF Rx Supplemental	26	4	104	1	104	$44.19	$4,596
STOP Act Supplemental (new)	133	1	133	1	133	$44.19	$5,877
FY2021-FY2024 Total	**521**				**6,960**		**$ 307,562**

[a] Total respondent cost is calculated as total burden hours x average hourly wage.

A.13. Estimates of Annualized Cost Burden to Respondents

There are no respondent costs for capital or start-up or for operation or maintenance.

A.14. Estimates of Annualized Cost to the Government

The total estimated cost to the government for the data collection from FY 2021 through FY 2024 is $832,086. This includes approximately $55,602 per year for SAMHSA costs to manage/administer the data collection and analysis for 25% each of two employees (GS-14-10, $111,203 annual salary). Approximately $221,760 per year represents SAMHSA costs to monitor and approve grantee reporting in these instruments (10% time of 21 Project Officers at $105,600 annual salary). The annualized cost is approximately $277,362.

A.15. Changes in Burden

Currently there are 1,786 burden hours in the OMB inventory. The program is requesting 6,960 hours, an increase of 5,164 hours. This increase is primarily due to the significant increase in the number of grants funded, from 117 to 521, and subsequent increase in the number of respondents. The increase in burden is also attributable to the addition of the STOP act survey and the new performance metrics but these increases are partially offset with removal of requirement to submit meeting minutes.

A.16. Time Schedule, Publications, and Analysis Plan

Time Schedule

Time Schedule for Data Collection

Activity	**Time Schedule**
Obtain OMB approval for data collection	Oct. 2021
Collect data	Oct. 2021–September 2024
Analyze data --Quantitative data submitted through the biannual annual progress report	November 2021–September 2024
Disseminate of findings --Annual evaluation reports	Ongoing for monitoring purposes.

Publications

The data from the DSP-MRT will primarily be used by SAMHSA Project Officers to monitor the progress of their grantees. However, data from the monitoring reports will also be used for evaluation purposes, as the process data may inform specific outcomes. For either purpose, the objective for all reports and dissemination products is to provide user-friendly documents and presentations that help SAMHSA successfully disseminate and explain the findings to a variety of target audiences. Audiences for these reports will include Congress, SAMHSA Contracting Officer's Representatives (CORs), grantees, and the broader substance use prevention field (e.g., academia, researchers, policymakers, providers). SAMHSA recognizes that different audiences are best reached by different types of report formats. For example, reports to Congress will require materials that are concise but offer policy-relevant recommendations. Reports created for SAMHSA Centers and the CORs will require more in-depth information, such as substantive background and discussion sections, to supplement the analytic approach. Reports created for grantees will be concise handouts with helpful and easy-to-read graphics on performance data rather than lengthy text. The assortment of disseminations products developed using the data will include short and long analytic reports, congressional briefings, annual evaluation reports, research and policy briefs, ad hoc analytic reports, journal articles, best practice summaries, and conference or other presentations.

Analysis

The DSP-MRT uses a series of interdependent analysis frameworks that have been selected to maximize the coverage of key objectives of the SPF in the prevention of onset and the reduction of the progression of UAD and PDM and their consequences. PFS communities may select additional outcomes that are specific to their community (e.g. heroin). Monitoring 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 as well as for grants monitoring purposes. Data may be used in different evaluation studies for the purpose of providing contextual information to more specific outcome data.

Qualitative analyses of the monitoring data focus primarily on open ended responses grantees provide to describe their SPF step accomplishments and barriers. Preparation for coding will include developing a dictionary or codebook in which codes will be carefully defined and logged so that coders are able to follow their meaning and know when to apply the codes to text within

an interview. Codes will reflect prominent themes relevant to interpreting evaluation findings. To ensure reliability in the coding process, coders will then be assigned to work independently and concurrently on a subset of the open-ended response data. A kappa coefficient of .8 or higher will be maintained on all codes. Any discrepancies will be resolved between coders to ensure consistent application of codes. Upon completion of coding, the findings will be compiled on the basis of the prominence of codes (or themes) and organized around the major research questions and constructs. The findings that emerge will be used to examine grantee progress through the SPF steps.

A.17 Display of Expiration Date

OMB approval expirations dates will be displayed.

A.18. Exceptions to Certification for Statement

There are no exceptions to the certification statement. The certifications are included in this submission

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