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

JUSTIFICATION

A1. Circumstances of Information Collection

The Substance Abuse and Mental Health Services Administration (SAMHSA) is requesting approval from the Office of Management and Budget (OMB) for revisions to the previously approved instrument and data collection activities for the Government Performance and Results Act (GPRA) Center for Substance Abuse Treatment (CSAT) Client/Participant Outcome Measure (OMB No. 0930–0208) which expires on February 28, 2022. SAMHSA is requesting approval to modify its existing CSAT Client-level GPRA instrument by removing 48 questions and adding 42 questions to its existing CSAT Client-level GPRA instrument, for a net decrease of six questions.

In revising the CSAT-GPRA tool, we sought to improve functionality while also eliciting programmatic information that demonstrates impact at the client level. In this way, data from the revised GPRA tool can be used to assess resource allocation and to delineate who we serve, how we serve them, and how the program impacts clients from entry to discharge. The tool reflects CSAT's desire to elicit pertinent client and program level data that can be used to not only guide future programs and practice, but to also respond to stakeholder, congressional and agency enquiries.

This information is collected using a client-level instrument that provides SAMHSA with the capacity to report on the performance and outcomes for all of its discretionary programs, including:

- Demographic characteristics of individuals served;
- Clinical characteristics of individuals served before;
- During, and after receipt of services;
- Numbers of individuals served; and
- Characteristics of services and activities provided.

To be fully accountable for the spending of federal funds, SAMHSA requires all discretionary programs to collect and report data on all clients served to ensure program goals and objectives are being met (for a complete list of programs, see appendix I). Data collected as part of this package will be used to monitor performance through the grant period and to ensure appropriate spending of federal funds.

Approval of this information collection will allow SAMHSA to continue to meet the Government Performance and Results Modernization Act of 2010 (GPRMA) reporting requirements that quantify the effects and accomplishments of its discretionary grant programs which are consistent with OMB guidance.

To carry out section 1105(a) (29) of the GPRA, SAMHSA is required to prepare a performance plan for its major programs of activity.

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

All SAMHSA's programs and activities are geared toward the achievement of goals related to reducing the impact of substance use and mental health disorders. GPRA performance monitoring is a collaborative and cooperative aspect of this process.

This request represents a first step in SAMHSA's efforts to improve its ability to assess the impact of its programs, and to use data collected from its discretionary grant portfolio to enhance grantee performance and to improve the lives of Americans with mental health and substance use disorders. To help accomplish these goals, SAMHSA is undertaking an effort to enhance and modernize its data collection efforts over the next two years. The current request seeks approval to revise the current data collection tools to remove 48 questions and add 42 questions for a net decrease of six questions.

A2. Purposes and Use of Information

SAMHSA uses this measure to report on the performance and outcomes of its discretionary services grant programs. The information is used by individuals at three different levels: the Assistant Secretary and SAMHSA staff, the Center administrators, and Government Project Officers (GPOs), and grantees:

> **Assistant Secretary Level** – The information is used to inform the Assistant Secretary for Mental Health and Substance Use of the performance and outcomes of the programs funded through the Agency. The performance is based on the goals of the grant program. This information serves as the basis of the annual GPRA report to Congress contained in the Justifications of Budget Estimates.
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> **Center Level** – In addition to providing information about the performance of the various programs, the information is used to monitor and manage individual grant projects within each program. The information is used by GPOs to identify program strengths and weaknesses, to provide an informed basis for providing technical assistance and other support to grantees, to inform funding decisions, and to identify potential issues for additional evaluation.
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> **Grantee Level** – In addition to monitoring performance and outcomes, the grantee staff uses the information to improve the quality of treatment and recovery services provided to clients within their projects.

SAMHSA and its Centers will use the data for annual reporting required by GPRA to describe and understand changes in outcomes from baseline to follow-up to discharge. GPRA requires that SAMHSA's report for each fiscal year include actual results of performance monitoring for

the three preceding fiscal years. The information collected through this revised data collection process allows SAMHSA to report on the results of performance and outcomes in a manner that is consistent with SAMHSA specific performance domains, and to assess the accountability and performance of its discretionary and formula grant programs.

Outcomes data reflect the Agency's desire for consistency in data collected across the Agency. These domains represent SAMHSA CSAT's focus on the factors that contribute to the success of substance use disorder treatment. The CSAT Client/Participant Outcome Measure will address the following performance domains:

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

Proposed Changes to Data Collection Tool

SAMHSA is proposing the revision of this data collection instrument (OMB No. 0903-0208) to improve performance monitoring and outcome measurement of its programs. SAMHSA is removing 48 questions and adding 42 questions to its existing CSAT Client-level GPRA instrument, for a net decrease of six questions. The 42 new questions added to this data collection instrument were developed by SAMHSA to monitor national outcomes and specific outcomes of each grant program. Individual respondents will only be required to respond to a subset of these additional questions based on the client's level of need.

SAMHSA and its Centers will use the data for annual reporting required by GPRA and comparing baseline with discharge and follow-up data. GPRA requires that SAMHSA's fiscal year report include actual results of performance monitoring for the three preceding fiscal years. The additional information collected through this process will allow SAMHSA to: 1) report results of these performance outcomes; 2) maintain consistency with SAMHSA-specific performance domains, and 3) assess the accountability and performance of its grant programs including a focus on health equity.

In revising the CSAT-GPRA tool, we sought to improve functionality while also eliciting programmatic information that demonstrates impact at the client level. In this way, data from the revised GPRA tool can be used to assess resource allocation and to delineate who we serve, how we serve them, and how the program impacts clients from entry to discharge. Beyond this, much of the tool has been restructured to make its administration flow with greater ease, while also eliciting information that speaks to a client's experience with substance misuse, the concurrent use of substances and mental health. This is most apparent in Section B (Substance Use and Planned Services), where questions have been updated and restructured to elicit important

aspects of a client's use of substances, namely the frequency of use and combinations of misused substances. This speaks to an emerging and urgent need to appropriately manage polysubstance misuse[1], and the questions allow for evidence of change as the tool is readministered at different intervals. These questions do not rely on ICD-10 codes, so as to create a dialogue between the client and the individual administering the tool. Restructuring the tool has also included:

- Placing many questions from the general GPRA Tool, that have previously been viewed as being specific to patient populations or grants, in the menu items found in Section H. This section allows Program Officers the opportunity to introduce grant specific questions as needed;
- Removing or substantially altering existing questions viewed as being potentially traumatizing or incentive to clients;
- Removing questions that have not been used in program evaluation at the federal level; and
- Incorporating evidence-based questions from tools such as the Addiction Severity Index to better address program performance.

The tool reflects CSAT's desire to elicit pertinent client and program level data that can be used to not only guide future programs and practice, but to also respond to stakeholder, congressional and agency enquiries. For details on items that have been deleted and added see appendix II: Item changes.

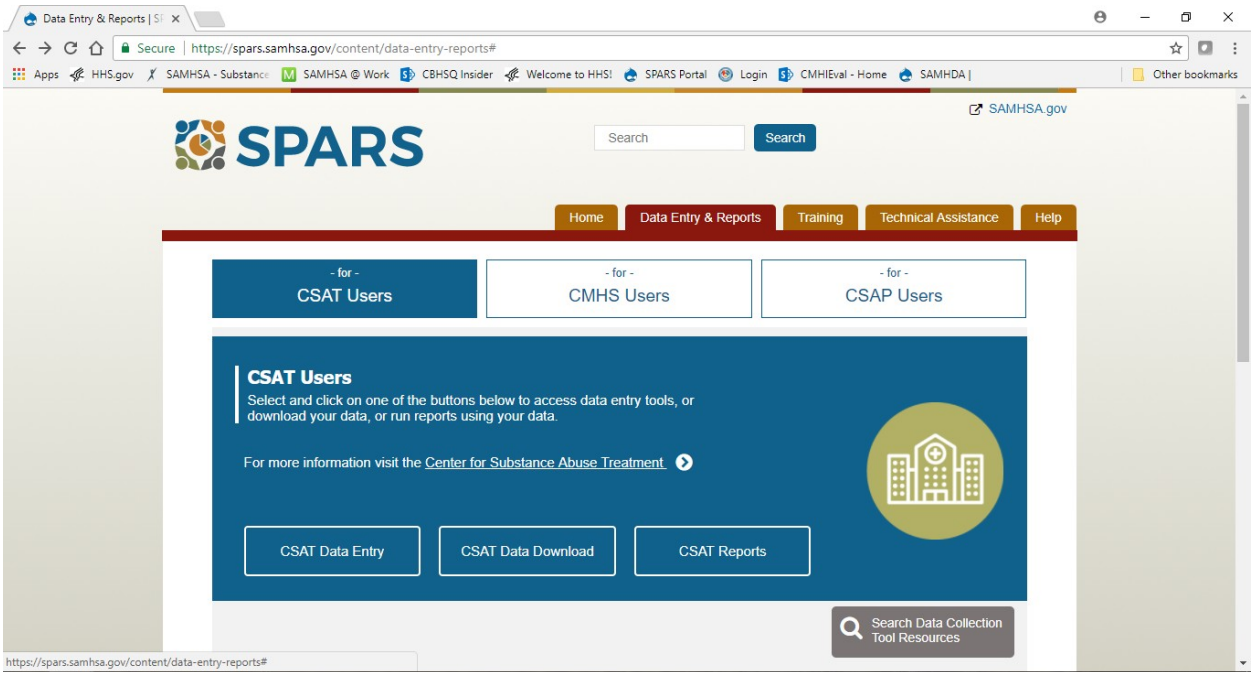
All of CSAT's data collection activities are intended to promote the use of consistent measures among CSAT-funded grantees and contractors. These measures are a result of extensive examination and recommendations, using consistent criteria, by panels of staff, experts, and grantees. Wherever feasible, the measures are consistent with or build upon previous data development efforts within CSAT. These data collection activities are organized to reflect and support the National Outcome Measures domains specified for SAMHSA's programs providing direct services.

A3. Use of Improved Information Technology

Programs collect client information using a variety of methods, including paper-and-pencil and electronic methods. This project will not interfere with ongoing program collection operations that facilitate information collection at each site.

A web-based data collection and entry system, SAMHSA's Performance Accountability and Reporting System (SPARS), has been developed and is currently used and available to all programs for data collection. This web-based system allows for easy data entry, submission, and reporting to all those who have access to the system. Levels of access have been defined for users based on their authority and responsibilities regarding the data and reports. Access to the data and reports is limited to those individuals with a username and password. A screenshot of the data entry screen on SPARS is below:

[1] Substance Abuse and Mental Health Services Administration (SAMHSA): Treating Concurrent Substance Use Among Adults. SAMHSA Publication No. PEP21-06-02-002. Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2021.



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

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

A4. Efforts to Identify Duplication

The items collected are necessary to assess grantee performance. CSAT is promoting the use of consistent performance and outcomes measures across all programs; this effort will result in less overlap and duplication and will substantially reduce the burden on grantees that results from data demands associated with individual programs.

A program-level review of current measures and methods of data collection was conducted to identify duplication of these data collection efforts. With the goal of creating questions for more precise monitoring of grantee performance across the Center, existing questions were considered for use where appropriate. Each of the proposed questions was reviewed and approved by CSAT senior leadership as meeting the performance monitoring and management needs of individual programs and the Center.

SAMHSA will work closely with the grantees to identify whether other data are being collected by the grantee, which may be redundant to the GPRA instrument. When duplication is

identified, SAMHSA and the grantees will identify a priority action plan to reduce the duplicative efforts and streamline the data items to reduce client burden.

A5. Involvement of Small Entities

Individual grantees vary from small entities to large provider organizations. Every effort has been made to minimize the number of data items collected from all programs down to the least number of items necessary to accomplish the objectives described within and meet GPRA reporting requirements. Therefore, there is no significant impact to small entities.

A6. Consequences if Information Collected Less Frequently

Substance use disorder treatment programs collect data at three time points: intake, six-month follow-up, and discharge. Of note, the six-month follow-up data collection may occur after the client has been discharged from the program. These times points are part of regular program activity.

These data collection points are generally accepted intervals for client assessment and the participants will be asked to respond to the items according to this schedule. The grantees for adolescent substance use disorder treatment programs are required to collect information additionally at three months follow-up due to the transitory 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 August 2, 2021 (86 FR 41491). SAMHSA received public comments from 27 entities that were subdivided into 249 comments for response. CSAT obtained feedback and consultation regarding the availability of data, methods and frequency of collection, and the appropriateness of data elements.

A9. Payment to Respondents

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

Survey research literature suggests that monetary incentives have a strong positive effect on response rates and no known adverse effect on reliability. In particular, individuals with substance use disorder research has shown improved response rates when remuneration is offered to respondents. Individuals with substance use disorder are typically a harder-to-reach population for whom out-of-pocket costs of participation (e.g., transportation, childcare) are significant barriers.

A10. Assurance of Confidentiality

The information from Grantees and all other potential respondents will be kept private through all points in the data collection and reporting processes. However, SAMHSA cannot ensure complete confidentiality of client data. SAMHSA will work with each grantee to prepare an impact assessment protocol. All data will be closely safeguarded, and no institutional or individual identifiers will be used in reports. Only aggregated data will be reported. SAMHSA and its contractors will not receive identifiable client records. Provider-level information will be aggregated to, at least, the level of the grant/cooperative agreement-funding announcement.

SAMHSA has statutory authority to collect data under the GPRA (Public Law 1103(a), Title 31) and is subject to the Privacy Act for the protection of data. Federally assisted substance abuse treatment providers are subject to the federal regulations for alcohol and substance abuse patient records (42 CFR Part 2) (OMB No. 0930-0092) which govern the protection of patient identifying data. In some cases, these same providers meet the definition of a Health Insurance Portability and Accountability Act covered entity and are additionally subject to the Privacy Rule (45 CFR Parts 160 and 164) for the protection of individually identifiable data.

A11. Questions of a Sensitive Nature

SAMHSA's mission is to improve the quality and availability of prevention, early intervention, treatment, and rehabilitation services for mental and substance use disorders, including co-occurring disorders, to improve health and reduce illness, death, disability, and cost to society. In carrying out this mission, it is necessary for service providers to collect sensitive items such as experiences with violence and trauma, legal involvement, use of alcohol or other drugs, as well as issues of mental health. The data that will be submitted by each grantee will be based in large part on data that most of the programs are already routinely collecting. This primarily includes data on client demographics, substance abuse and treatment history, services received, and client outcomes. These issues are essential to the service/treatment context. Grant projects use informed consent forms as required and as viewed appropriate by their individual organizations. They also use the appropriate forms for minor/adolescent participants requiring parental approval. Client data are routinely collected and subject to the Federal Regulations on Human Subject Protection (45 CFR Part 46; OMB No. 0925-0404). Alcohol and drug abuse client records in federally supported programs are also protected by 42 CFR Part 2. The informed consent forms usually contain the following elements:

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

A12. Estimates of Annualized Hour Burden

The time to complete the instruments is estimated in Table 1. These estimates are based on current funding and planned fiscal year 2021 notice of funding announcements and the number of consumers served in fiscal year 2019; the amount of time required to complete the new questions is based on an informal pilot and prior SAMHSA/CSAT experience in collecting similar data.

Table 1: Estimates of Annualized Hour Burden

SAMHSA Tool	Number of Respondents	Responses per Respondent	Total Number of Responses	Burden Hours per Response	Total Burden Hours	Hourly Wage [1]	Total Hour Cost
Baseline Interview Includes SBIRT Brief TX, Referral to TX, and Program-specific questions	179,668	1	179,668	0.6	107,801	$24.78	$2,671,309
Follow-Up Interview with Program-specific questions[2]	143,734	1	143,734	0.6	86,240	$24.78	$2,137,027

Hourly Wage [

Discharge Interview with Program-specific questions[3]	93,427	1	93,427	0.6	56,056	$24.78	$1,389,068
SBIRT Program – Screening Only	594,192	1	594,192	0.13	77,245	$24.78	$1,914,131
SBIRT Program – Brief Intervention Only Baseline	111,411	1	111,411	0.2	22,282	$24.78	$552,148
SBIRT Program – Brief Intervention Only Follow-Up[2]	89,129	1	89,129	0.2	17,826	$24.78	$441,728
SBIRT Program – Brief Intervention Only Discharge[3]	57,934	1	57,934	0.2	11,587	$24.78	$287,126
CSAT Total	**1,269,495**		**1,269,495**		**379,037**		**$9,392,537**

[1] The hourly wage estimate is $21.23 based on the Occupational Employment and Wages, Mean Hourly Wage Rate for 21-1011 Substance Abuse and Behavioral Disorder Counselors = $24.78/hr. as of May 11, 2021. (http://www.bls.gov/oes/current/oes211011.htm. Accessed on May 11, 2021.)

[2] It is estimated that 80% of baseline clients will complete this interview.

[3] It is estimated that 52% of baseline clients will complete this interview.

Note: Numbers may not add to the totals due to rounding and some individual participants completing more than

Discharge Interview with Program-specific questions[

[2]

[3]

one form.

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

A13. Estimates of Annualized Cost Burden to Respondents

There are no capital or startup costs, nor are there any operation and maintenance costs.

A14. Estimates of Annualized Cost to the Government

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

The estimated annualized cost for a contract for the GPRA mandate is $7.2 million and the cost of one full-time equivalent staff (25% for the midpoint of one GS-14 $34,372.75 and 75% for one GS-12 $73,386) responsible for the CSAT data collection effort is approximately $107,758.00/year.

A15. Changes in Burden

Currently, there are 379,037 burden hours in the OMB-approved inventory. SAMHSA is not requesting additional hours. The program changes to the tool between additions and deletions has remained the same. The estimated time to complete the client interview with the revised tool has been also remained the same 36 minutes.

A16. Time Schedule, Publication and Analysis Plans

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

Analysis/Publication Plans

Client outcome data will be collected through the web site. Data will be used to report to Congress regarding the GPRA as specified in the SAMHSA Annual Justifications of Budget

Estimates. The data might also be used for specific comparisons relative to the Office of National Drug Control Policy's National Drug Control Strategic Goals, especially for some of the secondary treatment outcomes (e.g., homelessness).

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

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

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

There will also be program-specific analysis of these data because each program may have unique programmatic and performance goals. The data items collected will be analyzed and presented in GPRA reports using basic descriptive statistics. On key outcomes (e.g., drug use, criminal involvement, and employment), the proportion of individuals showing improvement from baseline to discharge and follow-up (baseline to discharge, baseline to six months) will be calculated and aggregated at the program level (e.g., discretionary services). If deemed necessary for CSAT specific issues, the data will be examined at the individual activity level. The results will be examined for subpopulations of interest within individual activities (e.g., by age, by gender, by race/ethnicity, etc.).

A17. Display of Expiration Date

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

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.

Appendix I: Discretionary Program Required to Collect GPRA Data

	Program short name	Programs
1	DCT-FA	SAMHSA Treatment Drug Courts
2	DR-AD20	Disaster Response Grant Program – Services for Adults
3	CORC20	Comprehensive Opioid Recovery Centers
4	COVID-19	Emergency Grants to Address Mental and Substance Use Disorders During COVID-19
5	PPW-PLT	State Pilot Grant Program for Treatment for Pregnant and Postpartum Women
6	MAT-PDOA	MAT-PDOA
7	PPW	Pregnant Postpartum Women
8	TREE	Enhancement and Expansion of Treatment and Recovery Services for Adolescents, Transitional Aged Youth, and their Families
9	TRWS20	Treatment Recovery and Workforce Support-Services
10	SYT-I	State Youth Treatment-Implementation
11	ORP	Offender Reentry Program
12	SOR/TOR	State Opioid Response/Tribal Opioid Response
13	TCE-SPECIAL	Targeted Capacity Expansion: Special Projects
14	TCE-HIV-MW	Targeted Capacity Expansion HIV: Substance Use Disorder Treatment for Racial/Ethnic Minority Women at High Risk for HIV/AIDS (TCE-HIV: Minority Women)
15	FTDC	Family Treatment Drug Courts
16	TCE/PTP	Targeted Capacity Expansion- Peer to Peer
17	GBHI	Grants for the Benefit of Homeless Individuals
18	DCT-AD	Adult Treatment Drug Courts
19	TCE-HIV-High Risk	Targeted Capacity Expansion-HIV Program: Substance Use Disorder Treatment for Racial /Ethnic Minority Populations at High Risk for HIV/AIDS
20	TCE-HIV	Targeted Capacity Expansion-HIV
21	BCOR	Comprehensive Addiction and Recovery Act: Building Communities of Recovery
22	SBIRT	Screening Brief Intervention Referral and Treatment
23	RCSP	Recovery Community Services Program – Services

Appendix II: Additions and Deletions

Section		Added		Removed	Comment
A – Records Management					
	1	A5 – Language spoken at home	1	A1 (but kept 1a)	Changes to demographic questions in this section were made in consultation with the Center of Behavioral Health Statistics and Quality (CBHSQ) and Center of Mental Health Services (CMHS) as part of the Cross-Center Workgroup. Detailed questions about military deployment and family military involvement were removed to decrease burden, and because such questions might be triggering to clients. Moreover, data from these questions do not form part of routine analysis. Questions from other sections of the current CSAT-GPRA tool, namely those questions about children, were moved from Section C to Section A to complete the client profile.
	1	A6 - Sexual Orientation	1	A2 (but kept 2a)	
	1	A7 - Relationship Status	1	A5b - Military Deployment	
	1	A9c - Reunited with children previously removed	1	A5a - Active Military Involvement	
	1	A11 - Time travelled to receive Services	1	A6 - Family Military Involvement	
			1	A6a	
			1	A6b	
			1	A6c	
			1	A6d	
B – Substance Use And Planned Services					
			1	B1 - Past 30 day activity	Grantee and GPO feedback revealed that existing questions around substance misuse were difficult to follow and potentially uninformative. To overcome this, while also maintaining information on treatment progression, questions were altered to allow clients to respond with their own substance use categories, and to provide the number of days used and route of administration (Question 1). The list of substances that are commonly prone to misuse were updated. Questions 4 and 5 were added to better assess whether clients enter treatment already on FDA Approved or evidence-based treatment for substance use disorders and/or tobacco misuse. Questions 6 and 7 were added to assess if the client has suffered a recent overdose, and if treatment was required. Further to this, two questions (8 and 9) were added to understand previous engagement with treatment. Based on feedback, the table of mental health illnesses was simplified. Moreover, feedback revealed a need to update subheadings in the table of planned services.
	2	B4 - Treatment for stimulant use disorder	1	B1a	
	2	B5 - Treatment for tobacco misuse	1	B1b	
	1	B6 - Need for assistance after overdose	1	B1c	
	1	B7 - Type of post overdose assistance needed	1	B1d	
	1	B8 - Previous Treatment Engagement	1	B2 - Drug Use	
	1	B9 - Timing of previous treatment engagement	1	B2a	
	1	B11b - Referred for further screening	1	B2b	
			1	B2c	
			1	B2d	
			1	B2e	
			1	B2f	
			1	B2g	

			1	B2h	
			1	B2i	
C - Living Conditions					
			1	C3 - Drug Use and Emotional Stress	Questions in this section were removed as they are largely duplicated in Section F (Mental and Physical Health). Additionally, questions involving removal of children or loss of parental rights were removed as they were viewed as being traumatizing to clients.
			1	C2 - Satisfied with Current Living Space	
			1	C4 - Drug Use and Apathy	
			1	C5 - Drug Use and Emotional Problems	
			1	C7c - Children not living with you	
			1	C7d - Lost parental rights	
D - Education, Employment, And Income					Question 3 was added to assess the ability of the client to purchase everyday necessities with their current income. Question 4 was adapted from an existing question to be less burdensome.
	1	D3 - Enough money to purchase necessities			
E - Legal					
	1	E4 - participation in a drug court program or other	1	E2 - Arrests for drug related offences	Based on TOR and grantee feedback, Questions E2, E3 and E4 were removed as they were viewed as being self-incriminating and potentially stigmatizing. A question about involvement in drug court programs or deferred prosecution agreements was added to capture this information.
			1	E3 - Nights spent in prison	
			1	E4 - How many times have you committed a crime?	
F - Mental And Physical Health Problems And Treatment/Recovery					
	1	F4 - Source of Care	1	F1 - Self report quality of overall health status	Questions pertaining to violence and PTSD associations with violence and trauma were removed to create a more trauma-informed set of questions, and to avoid triggering vulnerable clients. Further questions added to this section seek to understand a client's usual source of care and insurance status.
	2	F5 and 5a - Medical Insurance Status	1	F2 - Past 30 days assistance need	
			1	F6 - Satisfied with health	
			1	F7 - Enough energy	
			1	F8 - Ability to perform daily activities	
			1	F9 - Satisfied with self	
			1	F12 - Violence and Trauma	
			1	F12a	

			1	F12b	
			1	F12c	
			1	F12d	
G - Social Connectedness					
	1	G4 - Needed to change friendships or places	1	G2 - Attendance at Faith-Based Self-Help	Client-level questions pertaining to personal relationships and supportive contacts have not been used in program analysis and were removed. Questions around involvement in self-help groups were combined in the final tool to reduce burden. A question that seeks to understand behavior modification as a result of treatment (Question 4) was added.
			1	G3 - Self-Help Other	
			1	G5 - Supportive contacts	
			1	G6 - Personal relationships	
H – Program Specific Questions					
H7	1	H7ai - First HIV Test?			Based on GPO feedback, detailed questions about HIV testing and treatment were added. Additional questions about hepatitis were also added. This provides information pertinent to many SAMHSA grants. Additionally, questions pertaining to risky sexual activity (found in section F) were moved to this section so that such questions will only be asked if required by the grant.
	1	H7aii - Where was HIV Test Performed?			
	1	H7aiii - Type of Location Test Performed?			
	1	H7av - Confirmatory Testing?			
	1	H7avi - Result?			
	1	H7aviii - Where Referred For Ongoing Treatment?			
	1	H7aix - Test Offered to Partner?			
	1	H7ax - How Many Partners Screened?			
	1	H7axii – Referred for treatment?			
	1	H7.3b - Follow up to Rapid HCV testing?			
	2	H7.3c - Vaccination for HBV/HAV			
H8	1	H8.1 Do you offer peer mentoring?			Based on GPO feedback, a question about whether a program offers peer mentoring was added. Peer mentoring is an important treatment modality.
H11		New Section			Questions in this Section Moved From Section A (SBIRT Specific)
I - Follow-Up Status					

	1	J1 - Was the client contactable?			To delineate whether a client was contactable at the time of follow up, one question was added to this section.
J - Discharge Status					
	1	J5 - Provided harm reduction			To assess harm reduction strategies at the program-level, a question about Naloxone and Fentanyl Test Strips (FTS) was added. Additionally, a question about the client's COVID-19 vaccination status was added.
	1	J6 - COVID Vaccination Status			
K – Services Received					
	1	K1 - Attendance at Services			Services, counseling and education criteria were added to the Services Received Table to match the corresponding table found in Section B (Planned Services). To assess program engagement, questions that assesses client attendance and the use of telehealth were added. Questions K5 and K6 were added to assess
	1	K2 - Use of telehealth			
	2	K5a and b - Stimulant Treatment and Compliance			
	2	K6a and b - Tobacco Treatment and Compliance			
TOTAL	**42**		**48**	**Overall, 6 Questions Removed**	