Terry S. Clark,
Asst Information Collection Clearance Officer.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Agency Information Collection Activities: Proposed Collection; Comment Request

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Comments are invited on: (a) Whether the proposed collections of information are necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology.

Proposed Project: Children's Mental Health Initiative National Evaluation—NEW

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS) is requesting approval from the Office of Management and Budget (OMB) for the new collection of data for the Children's Mental Health Initiative (CMHI) National Evaluation.

Evaluation Plan and Data Collection Activities. The purpose of the Children's Mental Health Initiative (CMHI) National Evaluation is to assess the success of the CMHI grants in expanding and sustaining the reach of SOC values, principles, and practices. These include maximizing system-level coordination and planning, offering a comprehensive array of services, and prioritizing family and youth involvement. In order to obtain a clear picture of CMHI grant activities, this longitudinal, multi-level evaluation will measure activities and performance of grantees essential to building and sustaining effective Systems of Care (SOC)'s.

Data collection activities will occur through four evaluation components. Each component includes data collection activities and analyses involving similar topics. Each component has one or more instruments that will be used to address various aspects. The four components with their corresponding data collection activities are as follows:

(1) The Implementation Assessment is designed using a strategic framework that provides five analytic dimensions: (1) Policies, (2) services/supports, (3) financing, (4) training/workforce, and (5) strategic communications. These dimensions cut across the State System, Local System and Service Delivery levels and together link to a range of proximal and distal outcomes. The evaluation will identify and assess the mechanisms and strategies employed to implement and expand systems of care, and explore the impact on system performance and child and family outcomes. Evaluation activities are framed by the five strategic areas to examine whether specific mechanisms and strategies lead to proximal and distal outcomes. System of care principles are woven throughout the framework at both the State and Local levels. Data collection activities include: (A) *Key Partner Interviews* with high-level administrators, youth and family representatives, and child agencies to organize qualitative data collection into these five areas and to allow within and across grantee evaluation of the implementation and impact of activities in these areas; and (B) the *System of Care Expansion and Sustainability Survey (SOCESS),* a self-report survey administered to representatives from grantee organizations, family and youth organizations, child-serving sectors, advocacy organizations for diverse populations, provider organizations, and financial officers, among others. The SOCESS is designed to capture self-report implementation data in the five analytic dimensions adopted by the 2015 CMHI National Evaluation.

(2) The Network and Geographic Analysis Component will use *Network Analysis Surveys* to determine the depth and breadth of the SOC collaboration across agencies and organization. *Geographic Information Systems (GIS*) will measure the geographic coverage and spread of the SOC, including reaching underserved areas and populations. At the child/youth and family level, Census block groups (derived from home addresses) will be used to depict the geographic spread of populations served by SOCs.

(3) The Financial Component involves the review of implementation grantees' progress in developing financial sustainability and expansion plans. The *Financial Mapping Interview and Financing Plan Survey and Interviews* will be conducted with financial administrators of Medicaid Agencies, Mental Health Authorities, mental health provider trade associations, and family organizations. The Financial Plan Interview will focus on how the financial planning process supported or hindered attainment of sustainable financing. The *Benchmarking Analysis* will compare relative rates of access, utilization, and costs for children's mental health services using the Benchmarking Tool and administrative data requested from financial administrators and personnel working with Medicaid Agency and Mental Health Authority reporting and payment systems.

(4) The Child and Family Outcome Component will collect longitudinal data on child clinical and functional outcomes, family outcomes, and child and family background. Data will be collected at intake, 6-months, and 12-months post service entry (as long as the child/youth is still receiving services). Data will also be collected at discharge if the child/youth leaves services before the 12-month data collection point. Data will be collected using the following scales for youth age five and older: (A) A shortened version of the Caregiver Strain Questionnaire, (B) the Columbia Impairment Scale, (C) the Pediatric Symptom Checklist-17, and (D) background information gathered through SAMHSA National Outcomes Measures (NOMS). Data for youth age 0–4 will be collected using the: (A) Baby Pediatric Symptom Checklist; (B) Brief Infant and Toddler Emotional Assessment; (C) Pre-School Pediatric Symptom Checklist and d) background information from the NOMS.

Estimated Burden. Data will be collected from 69 grantee sites. Data collection for this evaluation will be conducted over a 4-year period. The average annual respondent burden estimate reflects the average number of respondents in each respondent category, the average number of responses per respondent per year, the average length of time it will take to complete each response, and the total average annual burden for each category of respondent for all categories of respondents combined. Table 1 shows

the estimated annual burden estimate by instrument and respondent. Burden is summarized in Table 2.

TABLE 1—ESTIMATED ANNUAL BURDEN

Instrument/data collection activity	Respondent	Number of respondents	Responses per respondent	Total number of responses	Hours per response	Total annual burden hours
Implementation Assessment						
Key Partner Interviews	Project Director	84	2	168	1.5	252
	Family Organization Representative.	54	2	108	1.5	162
	Youth Organization Representative.	54	2	108	1.5	162
	MH Agency Director	54	2	108	1.5	162
	Core Agency Partners [b]	162	2	324	0.75	243
	Quality Monitor	54	2	108	0.33	36
SOCESS	Project Director	84	4	336	0.5	168
	Family Organization Representative.	108	4	432	0.5	216
	Youth Organization Representative.	108	4	432	0.5	216
	Core Agency Partners	432	4	1,728	0.5	864
	Practitioners	690	4	2,760	0.5	1,380
Network Analysis Survey						
Network Analysis Survey	Key Agency Partners	690	2	1,380	0.5	690
Financial Mapping and Benchmark Components						
Financial Mapping Interview	Financial administrators at: Medicaid Agencies & MH Authorities	108	2	216	0.75	162
	Financial administrators at: Trade associations & Family organizations.	108	2	216	0.5	108
	Tribal Financial Administrators.	9	2	18	0.75	14
Benchmark Tool	Payment personnel at Medicaid Agencies & MH Authorities.	12	2	24	40	960
Financial Plan Interviews	Financial Planning Directors	54	3	162	0.6	97
Child and Family Outcome Component						
Administrative Measures	Caregivers of clients age 0–17 [c].	4,136	1	4,136	0.05	207
	Clients age 11–26	1,685	1	1,685	0.05	84
Client Functioning	Caregivers of clients age 0–17 [c].	4,136	3	12,408	0.15	1,861
	Clients age 11–26 [d]	970	3	2,910	0.15	437
Caregiver Strain Questionnaire.	Caregivers of clients age 0–17 [c].	4,136	3	12,408	0.15	1,861
Columbia Impairment Scale	Caregivers of clients age 5–17 [e].	2,859	3	8,577	0.08	686
	Clients age 11–26 [d]	2,655	3	7,965	0.08	637
Pediatric Symptom Checklist-17.	Caregivers of clients age 5–17 [e].	2,859	3	8,577	0.05	429
	Clients age 11–26 [d]	2,655	3	7,965	0.05	398
New Tools in 2015						
Brief Infant and Toddler Emotional Assessment (BITSEA).	Caregivers of children and youth 0 to 5 years of age [f].	1,277	3	3,831	0.08	306
Baby Pediatric Symptom Checklist (BPSC).	Caregivers of children and youth for ages 1 month to 18 months [f].	638	3	1,914	0.05	96
Preschool Pediatric Symptom Checklist (PPSC).	Caregivers of children and youth for ages 18 months to 66 months [f].	639	3	1,917	0.05	96

TABLE 1—ESTIMATED ANNUAL BURDEN—Continued

Instrument/data collection activity	Respondent	Number of respondents	Responses per respondent	Total number of responses	Hours per response	Total annual burden hours
Total Annual Burden						
All	All [g]	12,107		36,354		12,990

[a] Based on the average hourly wages for Community and Social Service Specialists, All Other (21–1099; $22.47) and Social Workers (21–1020; $29.83) from the May 2015 National Industry-Specific Occupational Employment and Wage Estimates, 621330—Offices of Mental Health Practitioners; the Federal minimum wage of $7.25; and an estimated average hourly wage of $11.60 for a family of four living 25% below poverty level.
[b] Core agency partners include (1) representatives from MH, child welfare, and juvenile justice and (2) CMHI quality monitors.
[c] Assumes 81% of clients will be age 0 to 17.
[d] Assumes 52% of clients will be age 11 to 26.
[e] Assumes 56% of clients will be age 5 to 17.
[f] Assumes 25% of clients will be age 0 to 5, with 12.5% of clients age 0 to 2.5, and 12.5% age 2.6 to 5).
[g] Sums shown indicate unduplicated respondents and responses per respondent.

TABLE 2—TOTAL ESTIMATED ANNUAL BURDEN

Instrument/data collection activity	Number of respondents	Total number of responses	Average annual burden (hours)
Key Partner Interview	462	924	339
SOCESS	1,422	5,688	948
Network Analysis Survey	690	1,380	230
Financial Mapping Interview	225	450	95
Benchmark Tool	12	24	320
Financial Planning	54	162	32
Child and family instruments	9,242	27,726	2,366
Total	12,107	36,354	4,330

Send comments to Summer King, SAMHSA Reports Clearance Officer, 5600 Fishers Lane, Room 15E57–B, Rockville, Maryland 20857, *OR* email a copy to *summer.king@samhsa.hhs.gov.* Written comments should be received by February 21, 2017.

Summer King,

Statistician.

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Proposed Project: 2017–2020 National Survey on Drug Use and Health: Methodological Field Tests (OMB No. 0930–0290)—Extension

The National Survey on Drug Use and Health (NSDUH) is a survey of the U.S. civilian, non-institutionalized population aged 12 years old or older. The data are used to determine the prevalence of use of tobacco products, alcohol, illicit substances, and illicit use of prescription drugs. The results are used by SAMHSA, the Office of National Drug Control Policy (ONDCP), federal government agencies, and other organizations and researchers to establish policy, direct program activities, and better allocate resources.

Methodological tests will continue to be designed to examine the feasibility, quality, and efficiency of new procedures or revisions to existing survey protocol. Specifically, the tests will measure the reliability and validity of certain questionnaire sections and items through multiple measurements on a set of respondents; assess new methods for gaining cooperation and participation of respondents with the goal of increasing response and decreasing potential bias in the survey estimates; and assess the impact of new sampling techniques and technologies on respondent behavior and reporting. Research will involve focus groups, cognitive laboratory testing, customer satisfaction surveys, and field tests.

These methodological tests will continue to examine ways to increase data quality, lower operating costs, and gain a better understanding of sources and effects of nonsampling error on NSDUH estimates. Particular attention will be given to minimizing the impact of design changes so survey data continue to remain comparable over time. If these tests provide successful results, current procedures or data collection instruments may be revised.

The number of respondents to be included in each field test will vary,