SAMHSA 2023–2026 Data Strategy

SAMHSA

Substance Abuse and Mental Health
Services Administration

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MESSAGE FROM THE ASSISTANT SECRETARY FOR MENTAL HEALTH AND SUBSTANCE USE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

As the Assistant Secretary for Mental Health and Substance Use in the United States Department of Health and Human Services (HHS), and the leader of the Substance Abuse and Mental Health Services Administration (SAMHSA), I am pleased to present SAMHSA's 2023–2026 Data Strategy.

SAMHSA's mission is to lead public health and service delivery efforts that promote mental health, prevent substance misuse, and provide treatments and supports to foster recovery while ensuring equitable access and better outcomes. The 2023–2026 SAMHSA Strategic Plan highlights key guiding principles and presents new priorities, goals, and objectives. To achieve its mission, SAMHSA has identified five priority areas to better meet the behavioral health needs of individuals, communities, and service providers. In the wake of the COVID-19 public health emergency, this is more important than ever. SAMHSA works to prevent substance use and overdose; enhance access to suicide prevention and mental health services; expand access to crisis care; promote behavioral health resilience and emotional health for children, youth, and families; integrate primary care and behavioral health and physical health care; and strengthen the behavioral health workforce. This work is guided by the principles of equity, trauma-informed approaches, recovery, and a commitment to data and evidence. SAMHSA's data strategy details our agency's commitment to data and evidence, which is only possible through robust systems of data collection, analysis, and dissemination.

In fall 2022, SAMHSA held over 20 listening sessions with stakeholders from a variety of interest groups, including grantees; federal partners; organizations representing diverse racial, ethnic, cultural, and sexual minority communities; substance use and mental health professional councils and associations; youth-serving organizations; entities representing persons with lived experience; state and provider associations; researchers; and tribal partners, as well as internal stakeholders.

This data strategy is predicated upon our learnings from these sessions and is outlined across four key goals: (1) enhance SAMHSA's ability to collect, capture and maintain high-quality data; (2) conduct robust performance monitoring, evaluation, and surveillance; (3) strengthen access to, utilization of, and dissemination of SAMHSA data; and (4) expand and strengthen SAMHSA's workforce capacity.

In addition to these goals, six core principles emerged that serve as guidelines for implementation of this data strategy. First, SAMHSA must focus its data efforts across the lifespan, with special attention to children and youth and older adults. Second, SAMHSA must incorporate measures that are recovery-oriented, trauma-informed, and culturally and linguistically appropriate. Third, implementation must prioritize evidence-based and validated measures. Fourth, we must minimize the data burden for SAMHSA grantees and those they serve. Fifth, implementation of this data strategy must promote collaboration among SAMHSA Centers and Offices so that expertise is leveraged to the fullest extent possible. Finally, SAMHSA must align its data strategy with the Foundations for Evidence-Based Policymaking Act.

In the more than 15 years since SAMHSA published its last such strategy, systems of and approaches to data collection and performance monitoring have evolved. I am excited about the direction this data strategy will take SAMHSA as we modernize our approach to data collection, analysis, and dissemination, and I am committed to dedicating sufficient resources towards its implementation. Fulfillment of this data strategy will bring SAMHSA closer to achieving our vision that people with, affected by, or at risk for mental health and substance use conditions receive care, thrive, and achieve well-being. I encourage you to join us in better using data to create stronger, healthier communities.

Miriam E. Delphin-Rittmon, Ph.D.
Assistant Secretary for Mental Health and Substance Use
U.S. Department of Health and Human Services

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EXECUTIVE SUMMARY

SAMHSA's mission is to lead public health and service delivery efforts that promote mental health, prevent substance misuse, and provide treatments and supports to foster recovery while ensuring equitable access and better outcomes. To support this mission and strengthen SAMHSA's activities across its five priority areas, the organization needs a well-designed data strategy that enhances SAMHSA's ability to collect, analyze, and disseminate high-quality data, from both quantitative and qualitative sources, while also leveraging that data and evidence to inform programs and policies.

The following data strategy, which covers all of SAMHSA's data collections, was created after extensive consultation with stakeholders from across SAMHSA, the federal government, local governments, academia, grantee representatives, national organizations representing behavioral health and the interests of minority populations, and those with lived experience. As a result of this consultation, in the form of stakeholder listening sessions, six core principles emerged that serve as guidelines for the development and implementation of SAMHSA's data strategy:

1. SAMHSA must focus its data efforts across the lifespan, with special attention paid to children and youth and older adults.

2. SAMHSA must incorporate measures that are recovery-oriented, trauma-informed, and culturally and linguistically appropriate.

3. SAMHSA must prioritize evidence-based and validated measures.

4. SAMHSA must minimize the data burden for SAMHSA grantees and those they serve.

5. SAMHSA must promote collaboration between and across Centers and Offices so that expertise and knowledge are fully leveraged.

6. SAMHSA must align its data strategy with the Foundations for Evidence-Based Policymaking Act.

These six core principles underpin the four key goals that were identified through stakeholder consultation. The strategy outlines the objectives, strategies, and actions to be undertaken to achieve these four goals.

1. Goal 1: Enhance SAMHSA's ability to collect, capture, and maintain high-quality data.

    a. Objective 1: Expand and/or leverage data on recovery, social determinants of health (SDOH), race and ethnicity, and sexual orientation and gender identity (SOGI).

        i. Strategy 1: Integrate recovery and SDOH measures.

        ii. Strategy 2: Standardize collection of demographic information regarding race and ethnicity and SOGI information.

    b. Objective 2: Streamline performance data collection tools.

        i. Strategy 1: Implement a low-burden performance data collection strategy that ensures both compliance and high-quality performance data on SAMHSA's grants.

    ii.   Strategy 2: Establish a SAMHSA-led collaborative process to support ongoing development/updates of tools.

    iii. Strategy 3: Create resource materials that improve understanding and high-quality collection of performance measures.

2.   Goal 2: Conduct robust performance monitoring, evaluation, and surveillance.

   a.   Objective 1: Modernize data storage and data systems.

      i.   Strategy 1: Implement integrated and interoperable data platforms.

      ii.   Strategy 2: Leverage secondary data sources that collect metrics that facilitate performance monitoring and program evaluation.

      iii. Strategy 3: Invest in data literacy/capacity for SAMHSA-funded entities.

   b.   Objective 2: Assess the impact of SAMHSA's funds using existing block grant and client services data.

      i.   Strategy 1: Create mechanisms for regular cross-SAMHSA review and analysis of grantee data.

   c.   Objective 3: Promote performance monitoring and evaluation at the grantee and state levels.

      i.   Strategy 1: Promote continuous quality improvement among grantees and states.

      ii.   Strategy 2: Strengthen local performance monitoring and evaluation.

3.   Goal 3: Strengthen access to, utilization of, and dissemination of SAMHSA data.

   a.   Objective 1: Enhance utility of SAMHSA's data files (both public and restricted use files).

      i.   Strategy 1: Assess the value of SAMHSA's data.

      ii.   Strategy 2: Establish internal and/or external data dashboards (i.e., National Survey on Drug Use and Health [NSDUH], Treatment Episode Data Set [TEDS], National Substance Use and Mental Health Services Survey [N-SUMHSS], Mental-Health Client-Level Data (MH-CLD), Establish internal and/or external data dashboards.

      iii. Strategy 3: Support access to data by subset (in line with usual best practices pertaining to privacy, etc.).

   b.   Objective 2: Enhance utility of SAMHSA's data deliverables.

      i.   Strategy 1: Assess the value of SAMHSA's data products.

      ii.   Strategy 2: Establish a data communications strategy with a focus on improving/advertising/promoting SAMHSA data products and ensuring broad usability.

4. Goal 4: Expand and strengthen SAMHSA's data workforce capacity.

    a. Objective 1: Realign human capital to promote timely and actionable data collection, analysis, and dissemination.

        i. Strategy 1: Promote focused and responsive performance monitoring and evaluation through investments in human capital.

    b. Objective 2: Enhance in-house capacity as it relates to data collection and analysis.

        i. Strategy 1: Hire staff who possess education and experience in the following core areas: data visualization, data linkage, data science, and mixed-methods research.

        ii. Strategy 2: Enhance SAMHSA-wide staff data literacy.

A commitment to data quality, greater transparency in data collection and analysis, reduction in the burden of data collection, integration of diverse data sources, and robust dissemination of data underpin this data strategy. The strategy calls not only for a commitment to these principles, but also recognizes the importance of its human resources, and advocates for promoting each Center and Office's data needs as well as the hiring and training of SAMHSA staff to enhance skills in data analysis, data science, and predictive analytics

INTRODUCTION

In the more than 15 years since publication of SAMHSA's last data strategy, there has been an expansion in the scope and breadth of programs supported by SAMHSA as well as a global pandemic that highlighted the significant behavioral health issues facing the nation. The nature of data collection, analysis, and dissemination have also evolved, and there is an increasing need to demonstrate programmatic impact and routinely incorporate data in planning and policy decision making.

"Having a Chief Data Officer and a data-management function is a start, but neither can be fully effective in the absence of a coherent strategy for organizing, governing, analyzing, and deploying an organization's information assets."

Cross-industry studies show that on average, "less than half of an organization's structured data is actively used in making decisions—and less than 1% of its unstructured data is analyzed or used at all;"[1] and "having a Chief Data Officer and a data-management function is a start, but neither can be fully effective in the absence of a coherent strategy for organizing, governing, analyzing, and deploying an organization's information assets."[2] Further to this, we have learned from our prior work and current listening sessions that we need to update and solidify our data strategy. For these reasons, SAMHSA spent the past 18 months developing this data strategy.

By leveraging evidence and data, from both quantitative and qualitative sources, a well-designed data strategy can strengthen SAMHSA's activities across its five priority areas and support the organization's overall mission and vision (further details in SAMHSA's

Strategic Plan). This agency-wide data strategy is designed to advance the work of each Center and Office while leveraging the functions and expertise of its Center for Behavioral Health Statistics and Quality (CBHSQ). SAMHSA's Center and Office data collections are unique to their roles in the agency, and analytic needs vary accordingly. By recognizing the importance of collaboration in implementing needs-based and evidence-driven data collection, rigorous analysis, and widespread dissemination of results, the capacity of each Center and Office, particularly CBHSQ's role as an Office of Management and Budget (OMB)-recognized Federal Statistical Unit, will be fully realized.

In spring 2022, SAMHSA's Data Strategy Working Group was established, and it was comprised of members from each Center and Office (Appendix A). This Working Group supported and advised the Data Strategy Leadership Team, which was co-led by staff from the Office of the Assistant Secretary (OAS), CBHSQ, and the Center for Substance Abuse Treatment (CSAT). The Working Group developed a list of internal and external stakeholders, which resulted in over 20 listening sessions regarding SAMHSA's data collection, analysis, and dissemination efforts (Appendix B). The Working Group also conducted an environmental scan of data strategies from across government: The Federal Data Strategy; HHS's 2018 Data Strategy; SAMHSA's FY 2019–FY 2023 Strategic Plan; the National Center for Health Statistics' Data Modernization Plan; the Centers for Disease Control and Prevention's (CDC) Data Modernization Plan; and the National Institutes of Health's Strategic Plan for Data Science.

These listening sessions revealed a broad array of topics and highlighted the need for SAMHSA to implement data collection strategies that decrease administrative or respondent burden, provide specialized analysis of data, and share metrics and results with grantees, researchers, federal partners, and the general public. This SAMHSA data strategy lays the foundation for this work, while also recognizing that implementation of new systems and paths of collaboration should be done in a thoughtful manner.

CORE PRINCIPLES

As a result of the listening sessions, six core principles emerged that serve as guidelines for development and implementation of SAMHSA's data strategy.

1. SAMHSA must focus its data efforts across the lifespan, with special attention paid to children and youth and older adults.

2. SAMHSA must incorporate measures that are recovery-oriented, trauma-informed, and culturally and linguistically appropriate.

3. SAMHSA must prioritize evidence-based and validated measures.

4. SAMHSA must minimize the data burden for SAMHSA grantees and those they serve.

5. SAMHSA must promote collaboration between and across Centers and Offices so that expertise and knowledge are fully leveraged.

6. SAMHSA must align its data strategy with the Foundations for Evidence-Based Policymaking Act.

An overarching focus across these six core principles is a commitment to data quality. A key part of developing any data collection system is prioritizing the routine examination, and subsequent reporting, of an entity's data quality. Through this data strategy, SAMHSA reaffirms its continuing commitment to examining and transparent reporting of data quality by following OMB's "Guidelines for Ensuring and Maximizing the Quality, Objectivity, Utility, and Integrity of Information Disseminated by Federal Agencies; Republication," based on the Information Quality Act (IQA) passed by Congress in 2000.[3,4] Appendix C details the Federal Committee on Statistical Methodology (FCSM) recommendations on examining data quality for official statistics.

Overall, it is imperative that these principles and SAMHSA's commitment to data quality be applied across SAMHSA's discretionary, block grant, national, and financial data collection efforts.

BUILDING ON THE ROLE OF SAMHSA'S CBHSQ AS A FEDERAL STATISTICAL UNIT

Within the HHS, SAMHSA leads public health efforts around substance use and mental health information, services, prevention, and data. Data collected by SAMHSA are used to inform programs and funding for prevention, early intervention, treatment, and recovery support services, all of which are funded via SAMHSA's discretionary and block grant programs. The collection, analysis, and dissemination of these data are often led by CBHSQ, whose organization, function, and delegations of authority within SAMHSA were detailed in a 2018 Federal Register Notice[5] (FRN); (Appendix D).

CBHSQ serves as the lead federal government center for behavioral health data. It is designated as an OMB-recognized Federal Statistical Unit, whose principal function is the collection, analysis, and dissemination of information for statistical purposes. As with other federal statistical units and agencies, CBHSQ embraces five fundamental principles as established by the Committee on National Statistics (part of the National Academies)[6]:

- Principle 1: Relevance to Policy Issues and Society

- Principle 2: Credibility Among Data Users and Stakeholders

- Principle 3: Trust Among the Public and Data Providers

- Principle 4: Independence from Political and Other Undue External Influence
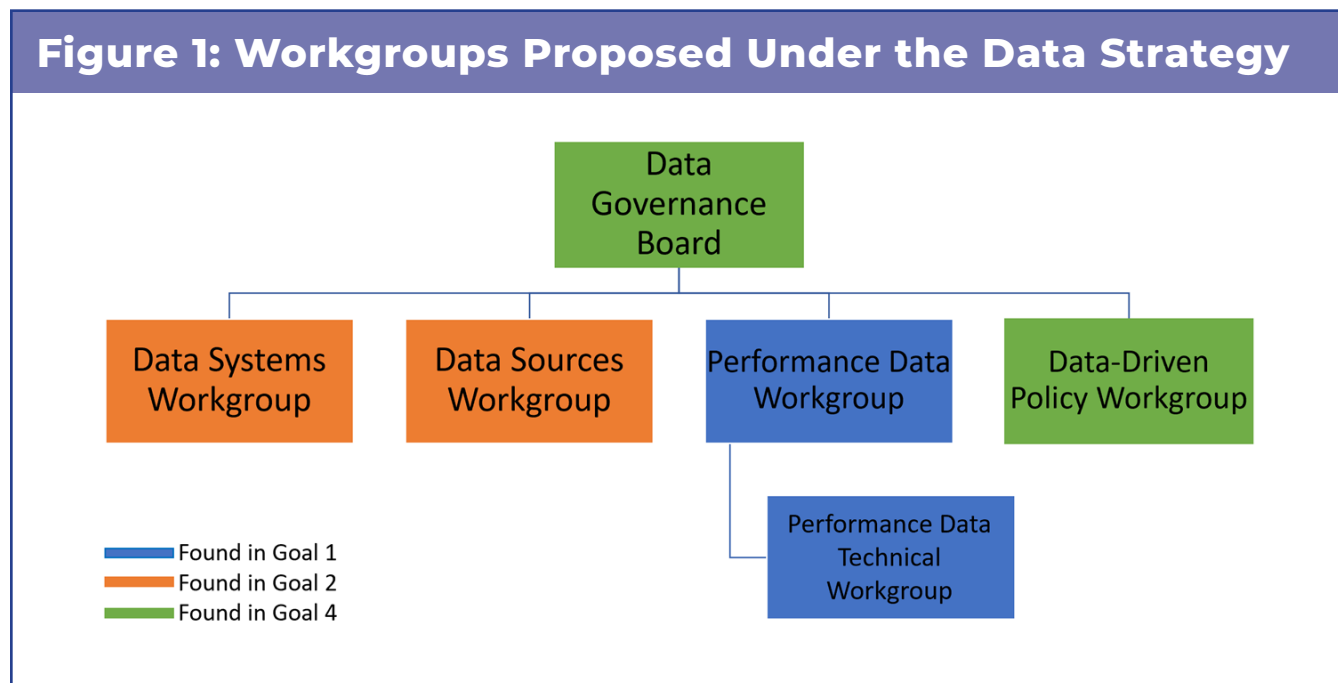
- Principle 5: Continual Improvement and Innovation

The goals and core principles of this data strategy align with CBHSQ's principles and functions, and the strategies and actions detailed here will leverage CBHSQ's role and expertise at SAMHSA.

DATA GOVERNANCE BOARD

To ensure the success of this data strategy, it is crucial that sufficient resources (both staff and financial) are dedicated to systems improvement, human capital investments, and infrastructure support. As such, SAMHSA will charter a Data Governance Board (DGB) charged with implementing and monitoring the success of the data strategy. The DGB will be led by CBHSQ, with membership comprised of subject matter experts in data collection, analysis, and dissemination from each of SAMHSA's Centers and Offices. The DGB will implement the strategy in alignment with SAMHSA's Strategic Plan, HHS' Strategic Plan, HHS' draft Data Strategy, as well as congressional statutes and White House Executive Orders (EOs). The goal of the DGB will be to improve the accessibility, quality, and reliability of SAMHSA's data.
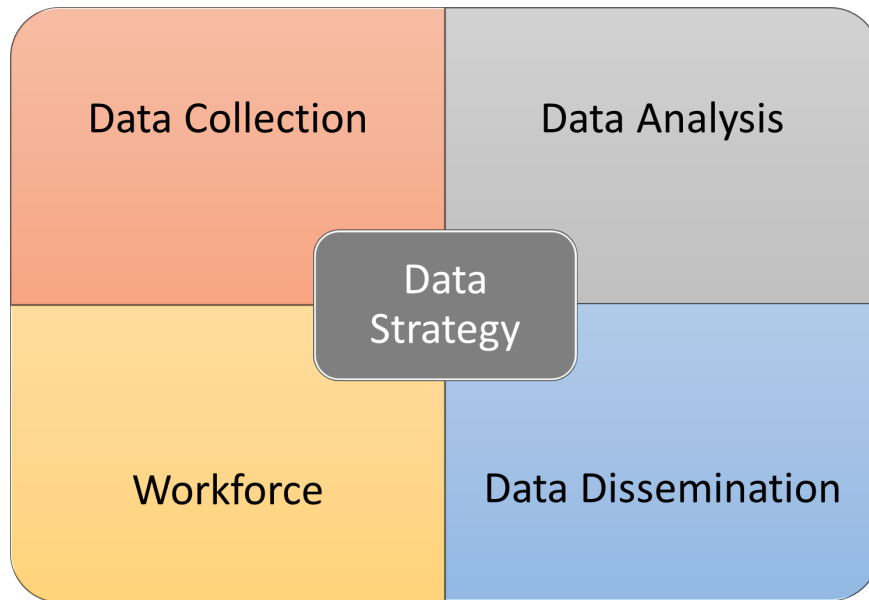
The guiding principle of SAMHSA's DGB is to promote intra-agency collaboration and innovation to promote the optimal use of, and investment into, agency data resources. Greater detail about the responsibilities, membership, meetings, decision model, and reporting are in Appendix E.

Additional Workgroups: There are five additional workgroups recommended in this strategy: a Performance Data Technical Workgroup under a Performance Data Workgroup; a Data Systems Workgroup; a Data-Driven Policy Workgroup, and a Data Sources Workgroup. The lead of each workgroup will be a standing member of the DGB to allow for greater coordination across SAMHSA's Offices and Centers. More information about each is detailed under the data strategy goals.

Figure 1: Workgroups Proposed Under the Data Strategy

The DGB's first charge will be to develop a charter detailing its membership, roles and responsibility, and workplan for implementing this data strategy. The value of this Board cannot be overstated, as careful monitoring of the data strategy implementation is crucial to successfully effectuating the goals and actions detailed on the following page.

Figure 2: SAMHSA's Data Strategy Goals

Data Collection	Data Analysis
Data Strategy	
Workforce	Data Dissemination

GOAL 1—ENHANCE SAMHSA'S ABILITY TO COLLECT, CAPTURE, AND MAINTAIN HIGH-QUALITY DATA

To support its mission and fulfill congressional mandates, SAMHSA collects data from a wide variety of populations, including hospital emergency departments[7]; individuals receiving mental health treatment services provided or funded through state mental health agencies (SMHAs)[8]; public and private substance use and mental health treatment facilities[9]; civilian, noninstitutionalized population ages 12 or older in the United States[10]; substance use treatment admissions and discharges from state agency data systems[11]; state mental health authorities to support the Community Mental Health Services Block (MHBG) Grant program[12]; individuals served via SAMHSA's discretionary and demonstration programs; and individuals served via the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS BG, formally known as SABG).[13]

SAMHSA must expand its existing data collections to help programs measure emerging public health needs. This will involve including, revising, and/or updating recovery, SDOH, race/ethnicity, and sexual orientation and gender identity (SOGI) items, as well as streamlining the performance data collection approach.

Objective 1: Expand and/or leverage data on recovery, social determinants of health (SDOH), race and ethnicity, and sexual orientation and gender identity (SOGI).

SAMHSA has already initiated efforts to develop a common data set for race and ethnicity within its discretionary grant portfolio and is committed to identifying common metrics for key demographic and outcome measures for the MHBG and SUPTRS BG. SAMHSA is also working to identify common metrics related to SOGI by participating in the FCSM Measuring Sexual Orientation and Gender Identity Research Group.

LISTENING SESSION TAKEAWAYS:

- *Recovery statistics:* Participants indicated that SAMHSA does not consistently collect data on recovery, except for NSDUH, TEDS, the Uniform Reporting System, and N-SUMHSS.

- *SDOH:* Respondents commented that SDOH are important correlates of resilience and recovery, and yet SAMHSA data collections only measure certain social drivers, including housing stability, education level, and criminal justice involvement.

- *Race/ethnicity and SOGI:* Listening session participants voiced that across SAMHSA data collections, there is inconsistency in the measurement of race/ethnicity and SOGI.

(Greater detail of themes found during the listening session can be found in Appendix F.) This feedback aligns with a number of policy directives that reinforce the importance of recovery, SDOH, race/ethnicity, and SOGI data, including:

- SAMHSA's newly launched Office of Recovery[14];

- HHS's Office of Disease Prevention and Health Promotion definition of SDOH for Healthy People 2030[15];

- EO 13985: "Advancing Racial Equity and Support for Underserved Communities Through the Federal Government"[16]; and

- EO 14075: "Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals."[17]

Strategy 1: Integrate recovery and SDOH measures.

Action 1: Work with the Office of Recovery and Office of Behavioral Health Equity (and other stakeholders, when appropriate) to identify evidence-based recovery and SDOH measures.

> *This action will result in an inventory of possible recovery and SDOH items, as well as what is currently used across SAMHSA.*

Action 2: Publish a Request for Information soliciting inputs on a proposal for incorporating specific recovery and SDOH measures across SAMHSA's data collection modalities.

> *This action will result in a comprehensive list of recovery and SDOH items to be considered for use.*

Action 3: Incorporate feedback and develop/implement a recovery/SDOH data collection plan.

> *This action will result in more robust collection of recovery and SDOH measures.*

Strategy 2: Standardize collection of demographic information regarding race and ethnicity and SOGI information.

Action 1: Inventory race/ethnicity and SOGI data collection best practices across HHS, the federal government, and state/local/tribal areas.

> *This action will help SAMHSA create a comprehensive best practices list.*

> "We need guidance on data collection for sexual orientation and gender identity organized at the Agency level, especially given differing rules at the state and local level." – Listening Session Participant

Action 2: Inventory of SAMHSA's current race/ethnicity and SOGI measurement.

> *This action will result in a list of all race/ethnicity and SOGI items used by SAMHSA.*

Action 3: Propose and implement a cross-SAMHSA demographic data collection tool.

> *This action will result in implementation of more unified race and ethnicity and SOGI data collection across SAMHSA.*

Objective 2: Streamline performance data collection tools.

Collecting data can be a time-consuming and resource-intensive process, and it is important to ensure that the burden on those being served is minimized as much as possible. Listening sessions revealed the importance of simplifying data collection processes and reducing the number of data points being collected.

> Data collection is prohibitively burdensome.
> – Listening Session Participant

> "This degree of data collection disrupts engagement with the person we're trying to serve."– Listening Session Participant

LISTENING SESSION TAKEAWAYS:

SAMHSA held multiple listening sessions with performance tool stakeholders (Appendix B) and a number of themes emerged (Appendix F). At a high level, SAMHSA found that different grantees have different data needs, are overwhelmed by respondent and administrative burden, and saw value in a thorough examination of the fitness-for-use of data collection items and materials describing the utility of data collection for respondents. Tribes had unique concerns, including data sovereignty.

Strategy 1: Implement a low-burden performance data collection strategy that ensures both compliance and collection of high-quality performance data on SAMHSA's grants.

Action 1: Assess common themes and questions across tools and categorize measures by evidence-base, data quality, redundancy, and other variables of interest.

> *This action will result in an inventory of common themes and measures across SAMHSA Government Performance and Results Act (GPRA) tools.*

Action 2: Develop a performance monitoring approach that prioritizes decreased burden and high-quality performance data for FY25 OMB approval.

> *This action will result in changes implemented across SAMHSA to the various GPRA packages.*

The CDC Program Performance and Evaluation Office (PPEO) manages a central process for proposing, revising/replacing, and retiring measures from their data collection packages. The PPEO coordinates an annual such process, where all proposed measure changes must be included in a "measures change spreadsheet," which asks programs to provide summaries of their plans before completing a more robust template. This spreadsheet helps determine which proposed measure changes meet certain criteria necessary to move forward with the requested measure change. Proposed measures changes should be limited to **"big ticket"** items based on changes in the budget; program strategy or design (including new NOFOs); and/or data source, availability, or validation issues.

Missingness: Missing data, meaning records that were intended to be obtained but for some reason were not, is a common issue in data analysis.

(via https://eprints.ncl.ac.uk/file_store/production/250524/36BF769F-9085-461B-9B9F-50A0E25063FC.pdf)

Strategy 2: Establish a SAMHSA-led collaborative process to support ongoing development/updates of the agency's performance management approach.

Action 1: Convene a Performance Data Technical Workgroup inclusive of national bodies, states, territories, Tribes, grantees, community-based organizations, and other key stakeholders (including those from under-resourced populations and those with lived experience).

This action will (1) result in a workgroup able to provide perspective on measure change from the grantee, state, and evaluator perspective, and (2) create and implement an engagement plan for continuous and meaningful feedback from internal and external (selected states, Tribes, and discretionary grantees) stakeholders.

Action 2: Create a specific workplan that reflects the importance of tribal sovereignty in the collection, management, and the use of tribal data.

This action will result in an actionable workplan to be used by the Performance Data Working.

Strategy 3: Create resource materials that improve understanding and high-quality collection of measures.

Action 1: Develop and maintain client-facing frequently asked questions (FAQs) describing performance tools, associated data collection training protocols, purpose of the collected data, and how SAMHSA maintains confidentiality.

This action will result in FAQs that will ultimately support improved quality of the responses, including unit and item missingness.

Action 2: Create guidance on the way SAMHSA performance data should be collected, recorded, and represented.

This action will be informed by data on how grantees currently collect discretionary grant data and will lead to the development of a set of best practices that is stakeholder led.

GOAL 2 – CONDUCT ROBUST PERFORMANCE MONITORING, EVALUATION, AND SURVEILLANCE

Performance Monitoring, Evaluation, and Surveillance

Performance monitoring encompasses the ongoing collection, monitoring, review, and reporting of data on preselected measures related to specific activities, and services delivered. Quantitative data assists in measuring progress toward pre-established goals and targets, while also determining whether an activity is achieving its stated output/outcome objectives.

Evaluation is an assessment using systematic data collection and analysis of one or more programs, policies, and organizations intended to assess their effectiveness and efficiency. An evaluation indicates how well all or part of a program, intervention, policy, regulation, or other government activity is working.

Surveillance pertains to the systematic collection and analysis of data related to a specific aspect of public health or social welfare, such as tracking geographic distribution, monitoring the prevalence of a particular risk factor, and evaluating the effectiveness of public health interventions.

Adapted from https://www.cdc.gov/evaluation/index.htm; https://www.evaluation.gov/assets/resources/Performance-Measurement-and-Evaluation.pdf; and 'The Evidence Act' (Public Law No: 115-435).

To ensure the successful operation and ongoing improvement of any organization, program, or the U.S. public health system, the application of comprehensive performance monitoring, evaluation, and surveillance systems is crucial. These systems involve the continuous collection and analysis of data, with the aim of tracking progress, ensuring that resources are used effectively, identifying areas for improvement, and informing programmatic and policy development. By providing accurate and up-to-date information, these systems will enable SAMHSA to make informed decisions and allocate resources effectively, ultimately leading to improved outcomes for the communities that SAMHSA serves.

In this way, evaluation and performance monitoring play important yet distinct roles in the management of public programs. Evaluation provides periodic, methodical assessment using social science techniques to judge the overall effectiveness of a program model and identify ways to enhance outcomes going forward.[18] Performance monitoring involves the routine, ongoing tracking of key aspects of program operations and service delivery activities.[19]

While evaluation is focused on understanding the results and impacts of a program, performance monitoring examines the implementation and process elements. As Poister (2003) explains, performance monitoring provides managers with continuous feedback to determine whether program activities and workflows are being executed as originally planned and designed, and if resources such as staffing and budgets are being utilized in an efficient and appropriate manner.[20] Typical performance metrics that would be monitored include counts of clients served or visits completed, staffing ratios and caseloads, resource utilization rates, and spending against budget. These implementation-focused metrics allow managers to ensure day-to-day activities are aligned with program objectives.[21]

While useful for oversight, the operational insights from performance monitoring have limitations for comprehensive, evidence-based program evaluation. As Newcomer et al. (2015) point out, performance monitoring data provide observational snapshots of internal workflows but cannot credibly establish causal relationships between a program and its intended impacts over time, or answer evaluative questions about improvements in end outcomes.[22] For example, simply tracking the number of clients served or visits completed does not provide insights into whether or how those program activities or services influenced any changes in well-being or behaviors among the target populations.

In contrast, program evaluation employs social science methodologies centered on establishing causal connections between a program model and its intended impacts or outcomes. Common techniques include randomized controlled trials, pre–post assessments, comparison group studies, longitudinal surveys, qualitative interviews, and rigorous document analysis.[23] For instance, a SAMHSA-funded program evaluation may examine, through statistical modeling of multiple years of data, whether the introduction of an intervention was associated with any significant changes in key outcome measures, such as rates of substance misuse within a community or employment rates and economic stability among individuals receiving services.

This focus on determining clear, attributable relationships between programs and their stated goals is what distinguishes in-depth evaluation from the more superficial monitoring of operational dynamics. While useful for oversight, performance data alone cannot provide meaningful answers to the fundamental evaluative questions about true outcomes, results, and impact that high-quality program evaluation is designed to investigate.[24] In this way, performance monitoring offers real-time insights into the implementation of program processes, whereas evaluation provides rigorous, evidence-focused assessment of whether intended outcomes are being achieved. Together, these complementary approaches give stakeholders a comprehensive understanding of both program operations and effects to guide effective management of public resources.

SAMHSA's performance monitoring, evaluation, and surveillance systems must possess certain characteristics. They should continue to be comprehensive, covering all aspects of the program or organization's work.[25] They should also be timely, providing regular updates on progress and allowing for judicious course correction as needed.[26] In addition, they should always be accurate and reliable, with ongoing use of high-quality data sources and robust statistical methods.[27]

Objective 1: Modernize data storage and data systems.

To improve its ability to serve the needs of target populations, SAMHSA must modernize its data systems. By implementing integrated and interoperable data platforms, SAMHSA seeks to improve the quality and accessibility of its data, which could in turn facilitate more informed decision making and enhance program effectiveness. By leveraging secondary data sources and investing in predictive analytics, SAMHSA might gain more rapid and valuable insights into the needs and preferences of its target populations, which can help the agency respond proactively to emerging challenges and opportunities. Finally, by investing in data literacy and capacity building, SAMHSA seeks to ensure that grantees and the behavioral health workforce more broadly have the skills and resources they need to manage and analyze data effectively, which could lead to more informed decision making and improved program outcomes.

LISTENING SESSION TAKEAWAYS:

Need for updated systems: There is a need to consider extensive and well-planned upgrades to data platforms (i.e., SAMHSA's Performance Accountability and Reporting System, Web-Block Grant Application System, eRA Commons, etc.), as current systems are outdated, segregated, and lack interoperability.

- ***Center and Office independence to analyze their own data:*** Internal stakeholders expressed a desire for increased SAMHSA Center and Office independence in the analysis of performance data, proposing that program analysis units be given additional resources and be staffed with skilled employees. This will allow Centers and Offices to address their individual data and assessment needs in a timely and mission-focused way.

- ***Reduce burden:*** There is a desire to reduce the burden of data collection by using existing secondary data to augment analytic potential. Grantees also reported a need to implement technical assistance that promotes data literacy and analysis as well as facilitates grantee-level data analysis and use in organization-level planning decisions.

Strategy 1: Implement integrated and interoperable data platforms for the collection, storage, and analysis of discretionary and formula grants, financial information, national data sets, and other data collected by SAMHSA.

Action 1: Establish a cross-SAMHSA Data Systems Workgroup charged with modernizing applications and technology to improve SAMHSA operations and ensure alignment of investments in software/platforms.

> *This action will result in a workgroup composed of SAMHSA experts in data management and analysis responsible for identifying and evaluating potential upgrades to SAMHSA's information technology (IT) systems.*

Action 2: Assess and develop recommendations for immediate or future actions that promote functional IT systems that are interoperable and capable of collecting, storing, and analyzing data.

This action will result in a series of recommendations to the OAS on how to promote functional and integrated IT systems that can collect, store, and analyze data in an effective and sophisticated manner.

Action 3: Procure integrated and interoperable data platforms for the collection, storage, and analysis of discretionary and formula grants, financial information, national data sets, and other data collected by SAMHSA.

This action will result in integrated and interoperable data platforms that help lead to more informed decision making and enhanced program analysis.

Strategy 2: Leverage secondary data sources that collect real-time and/or pertinent metrics that facilitate performance monitoring and program evaluation.

Action 1: Assess options for leveraging secondary data sources to augment analysis of SAMHSA's data sets.

This action will result in a workgroup composed of SAMHSA staff that will source data sets that can be used to augment current data collection, or to provide additional information.

Action 2: Establish interagency connections to leverage secondary data sources, including real-time metrics, surveillance, and programmatic data.

This action will provide valuable insights into the effectiveness of SAMHSA's programs as well as the populations that they serve.

Action 3: Explore use of proprietary and government data sets to expand analytic potential, reduce collection burden, and enhance program analysis.

This action will result in robust data sets that can help inform SAMHSA policy and program decisions.

Action 4: Assess feasibility of using SAMHSA and secondary data to support active forecasting and predictive data analytics.

This action will result in more robust data-driven policy, while also allowing SAMHSA to respond to emerging patterns of behavioral health concern.

Strategy 3: Invest in data literacy/capacity for SAMHSA-funded entities.

Action 1: Explore mechanisms to fund organizational-level data coordinators (i.e., data management experts who organize data for use by analysts).

The DGB will explore mechanisms to fund organizational-level data coordinators, who will be responsible for organizing data for use by analysts and help to improve the overall quality and accessibility of data.

Action 2: Explore the feasibility of awarding data infrastructure grants to support capacity around state/tribal-level grant data collection.

If reestablished, this action will help recipients improve their data management systems and infrastructure, which would in turn enhance their ability to collect, analyze, and utilize data related to SAMHSA's programs.

Action 3: After performing a gap and needs analysis, explore the feasibility of increasing caps on the use of grant funds for data collection, evaluation, and continuous quality improvement at the grantee level.

This action will help grantees allocate more resources towards data management and analysis, which could lead to improved data quality and utilization.

Action 4: Re-establish State Epidemiological Outcomes Workgroups across all jurisdictions.

This action will result in recommendations to the OAS exploring mechanisms and funding to appropriately support the State Epidemiological Outcomes Workgroups.

Objective 2: Assess the impact of SAMHSA's funds using existing block grant and client services data.

SAMHSA needs to use its existing data sets to engage in rigorous program analysis and to critically appraise the impact of grants at the individual and community level. Block grants have collected extensive metrics over many years, creating a rich longitudinal data set that can be used to assess outcomes, look for gaps in current interventions, and to consider emerging needs. Similarly, SAMHSA's Office of Financial Resources collects reliable financial, cost, and performance information. This data is not routinely used for grants management purposes or other programmatic/policy development.

LISTENING SESSION TAKEAWAYS:

- Use of current and historical data: SAMHSA's client-level longitudinal data, particularly from the block grants, should be rigorously analyzed to assess programmatic and client-level impacts, as appropriate, over time.

- Lack of transparency: Grantees and academic stakeholders request regular reporting of client-level data and publicly available analysis and reports.

- A need to effectively use SAMHSA's data: The assessment of block grant and client services data can help to better understand the effectiveness of SAMHSA's programs and to identify areas for improvement.

Strategy 1: Create mechanisms for regular, cross-SAMHSA review and analysis of grantee.

Action 1: Analyze current and historical block and discretionary grants data as they relate to access to, use of, and outcomes from services, with a focus on equity.

This analysis will form the basis of a report that identifies trends and patterns in program and client-level data, while also ensuring that services are delivered equitably to all target populations.

Objective 3: Promote performance monitoring and evaluation at the grantee and state levels.

Consistent with healthcare activities across the continuum of care, there is a need for SAMHSA to foster continuous quality improvement at the grantee and state levels. Grantees collect a significant amount of data on SAMHSA's behalf, and SAMHSA must provide the resources for grantees to use this data appropriately and in a manner that drives person-centered innovation and positive outcomes. This collaborative process is supported by activities described throughout this objective.

LISTENING SESSION TAKEAWAYS:

- Training and technical assistance opportunities: Grantees, particularly Tribal Nations and other under-resourced populations, reported an interest in using the data they collect to inform their programs and practices, while also working with SAMHSA to review metrics and contribute to data-driven policy.

Strategy 1: Promote continuous quality improvement among grantees and states.

Action 1: Support enhanced sharing and analysis of grantee-level metrics in a manner that promotes positive change and structural reform.

This action will result in recommendations for facilitating this work in accordance with associated legal protections of confidentiality.

Action 2: Host annual Grantee Data Users Conferences.

This action will result in annual state, tribal, and grantee-level data users conferences that provide a forum through which grantees can share information with one another and SAMHSA, while also promoting dialog and action around potential barriers or facilitators to data collection.

Action 3: Invest in technical assistance to grantees.

This action will help grantees establish continuous performance monitoring and evaluation using their own data.

Strategy 2: Strengthen local performance monitoring and evaluation.

Action 1: Identify and implement best practices that rigorously protect individuals' identity when returning data to grantees.

The DGB will assess and implement evidence-based, universal procedures to rigorously protect individual identity when sharing data, in accordance with associated legal protections of confidentiality.

Action 2: Determine the types of metrics to share with grantees and the format for sending/sharing data.

The Data Performance Workgroup will coordinate with grantees to curate those metrics that will be regularly shared, and to determine how they will be shared.

GOAL 3 – STRENGTHEN ACCESS TO, UTILIZATION OF, AND DISSEMINATION OF SAMHSA DATA

SAMHSA's ability to capture and maintain high-quality data that results in robust analysis is incomplete without an accompanying focus on enhancing access to and dissemination of SAMHSA's data. There are a variety of ways to define data dissemination. Bauman, et al., define data dissemination as "the process of communicating information through defined channels and media in order to reach various target groups (e.g., national policymakers, researchers, health professionals, or consumers)."[28] The University of Michigan took this a step further, saying that, "an additional aspect of dissemination is how to share research findings with interested parties. Determining who is using the data and why is important to consider as part of a comprehensive dissemination strategy."[29] Bauman, et al., created a framework for how to successfully disseminate data, as follows: (1) develop clear and evidence-based resources or innovations; (2) define the target audience; (3) select communication channels; (4) engage decision makers; and (5) develop evaluation frameworks around dissemination.

CBHSQ adheres to OMB's "Statistical Policy Directive No. 4: Release and Dissemination of Statistical Products Produced by Federal Statistical Agencies, Notice."[30] It discusses the nature of how recognized statistical units embargo data, perform outreach to media, and states:

> "To further support the quality and integrity of Federal statistical information, OMB is issuing a new Statistical Policy Directive designed to preserve and enhance the objectivity and transparency, in fact and in perception, of the processes used to release and disseminate the statistical products of Federal statistical agencies. The procedures in the directive are intended to ensure that statistical data releases adhere to data quality standards through equitable, policy-neutral, and timely release of information to the general public... The timing of the release of statistical products, including statistical press releases, regardless of physical form or characteristic, shall be the sole responsibility of the statistical agency or unit that is directly responsible for the content, quality, and dissemination of the data."

As part of its efforts in dissemination of data, over the past decade, the federal government has invested heavily in development of data dashboards. These can help capture, track, analyze, and visualize important key performance indicators and metrics while letting people see information in near-real time. Data dashboards can also visualize massive amounts of information pulled from different sources. Dashboards can let agencies see trends, challenges, and successes in an ongoing manner that would be challenging to achieve with traditional data analysis methods.

Objective 1: Enhance utility of SAMHSA's data files (both public and restricted-use files).

LISTENING SESSION TAKEAWAYS:

- ***Challenges accessing and utilizing SAMHSA's data and data products***: While listening session participants lauded SAMHSA for the ability to access certain data sets, such as NSDUH, TEDS, and N-SUMHSS, we also heard about the challenges in accessing and/or maximizing use of other data sets. Suggestions were provided about how to make the data easier to access, use, and connect with other available data sources, as well as how to clarify the intended use of a given data set.

- ***Using SAMHSA data:*** Large data sets like those collected via the state block grants have largely gone unused. Creating access points to SAMHSA's discretionary and block grant data could offer the opportunity for robust analysis and help inform policymaking at the state or national level.

- ***Lack of reciprocity:*** Many respondents mentioned a lack of reciprocity with data ("nothing in return"), where data is only sporadically reported back to grantees for performance improvement.

- ***Modernize SAMHSA's data dashboards:*** Participants consistently mentioned the need for SAMHSA to modernize its approach to data dissemination, namely via establishing public-facing data dashboards.

- ***Importance of understanding underserved populations:*** SAMHSA received ongoing feedback that there is profound interest in being able to understand more about traditionally underserved populations and/or communities, but statistical suppression within a given data set can pose challenges. Relatedly, SAMHSA also received feedback that it is no longer of value to understand a given population from just one perspective (aka variable); in fact, people are multifaceted, and creating mechanisms to apply an intersectional lens to data analysis would better serve our communities.

Goal 3 seeks to enhance the value and use of SAMHSA's data by creating processes that extend access to a broad array of users as a means of ultimately encouraging innovation in the field of behavioral health. This can be done by focusing on SAMHSA's data and data deliverables, with attention to the audiences (both current and future) and their needs.

Strategy 1: Assess the value of SAMHSA's data.

Action 1: Develop recommendations for improving use of SAMHSA's data sets.

This action will result in a series of recommendations for how to improve the usability of SAMHSA's data sets.

> "NSDUH and TEDS data are unrivalled in the field. How does SAMHSA ensure this data stays relevant?" – Listening Session Participant

Goal 3: Strengthen Access to, Utilization of, and Dissemination of SAMHSA Data

Action 2: Leverage a unified data use agreement for release of data sets to outside entities, as appropriate and permissible.

> As defined by HHS, a "data use agreement (DUA) is a legal binding agreement between the OPDIV [HHS Operating Division] and an external entity (e.g., contractor, private industry, academic institution, other Federal government agency, or state agency), when an external entity requests the use of personal identifiable data that is covered by a legal authority... The agreement delineates the confidentiality requirements of the relevant legal authority, security safeguards, and the OPDIV's data use policies and procedures. The DUA serves as both a means of informing data users of these requirements and a means of obtaining their agreement to abide by these requirements.[31]

This action will result in a consistent SAMHSA approach to sharing data with external parties and minimize confusion and misinformation on how and when data can be shared.

Action 3: Explore development of external access to block grant and/or discretionary grant data.

This action will set the stage for broader plan for SAMHSA to include block grant and discretionary data as part of its public and/or restricted use files, with the goal of leveraging these robust data sets to better inform policy and program development.

Strategy 2: Establish internal and/or external data dashboards (i.e., NSDUH, TEDS, N-SUMHSS, MH-CLD, DAWN, performance data.

Action 1: Develop meaningful and easy-to-navigate dashboards.

This action will result in a plan that assesses which data sets lend themselves to dashboard development, determines the audience/s for such dashboards (both internal and external to SAMHSA), and estimates costs of development and maintenance. Timely updates can be ensured by starting with single-use cases, pilot testing, user testing, and building application programming interfaces. In addition, this action will result in a better understanding of the financial, technological, and staffing requirements needed to support development and maintenance of the dashboard/s.

> "There are lots of data visualization contractors out there, but it's crucial to invest in your own internal capacity by training data analysts to do this type of work." – Listening Session Participant

> "Build your dashboards around the questions that answer the problems you're trying to solve." – Listening Session Participant

Strategy 3: Support access to data by subset (in line with usual best practices pertaining to privacy, etc.).

Action 1: Facilitate access to cross-SAMHSA metrics that can be stratified by sub-state, county, and/or local jurisdictions.

This action will result in the ability to drill down by geographic area given the added power of data available from across SAMHSA, as opposed to just one program/data set.

Action 2: Facilitate access to cross-SAMHSA metrics that can be stratified by race, ethnicity, and SOGI.

This action would result in the ability to drill down by race and ethnicity and SOGI variables, while balancing disclosure risk and privacy concerns.

Action 3: Facilitate access to cross-SAMHSA metrics that can be stratified by age, specifically children/youth and older adults (65+).

This action would result in the ability to drill down by age while balancing disclosure risk and privacy concerns.

> **Data Suppression**
> According to the U.S. Census Bureau, data suppression "refers to the various methods or restrictions that are applied to…estimates to limit the disclosure of information about individual respondents and to reduce the number of estimates with unacceptable levels of statistical reliability."
>
> https://www2.census.gov/programs-surveys/acs/tech_docs/data_suppression/ACSO_Data_Suppression.pdf

Action 4: Facilitate the ability to examine intersectionality when conducting research and analysis with SAMHSA's data.

> **Intersectionality**
>
> Bauer, et al, defines intersectionality as, "a theoretical framework rooted in the premise that human experience is jointly shaped by multiple social positions (e.g. race, gender), and cannot be adequately understood by considering social positions independently." In their "Advancing Equity by Incorporating Intersectionality into Research," HHS' Office of the Assistant Secretary for Planning and Evaluation notes that "Embedding an equity and intersectionality framework in research and analysis is an essential means to achieve the goal of advancing people's well-being through research, evaluation, and analysis activities," and go on to explain that "Quantitative analysis might go beyond examining the effect of a single factor or aspect of a person's identity (such as race) to highlighting how two or more factors (such as race and gender) interact to produce an outcome. For example, in regression models, researchers can use interaction terms to probe how the effect of an intervention differs for Asian American and Black LGBTQI+ adults."
>
> https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8095182/
>
> https://aspe.hhs.gov/sites/default/files/documents/80123172bbe4458a06259535dc3fcfc3/Intresectionality-Resrch-Anlysis.pdf

This action will result in a more comprehensive analysis accounting for structural barriers, recognizing that only looking at outcomes by one variable can produce misleading results.

Objective 2: Enhance utility of SAMHSA's data deliverables.

Every year, SAMHSA publishes a wealth of materials related to the data it collects. These may take the form of national reports, short or long reports, data snapshots, state profiles, infographics, and fact sheets. Often these resources are not widely accessed by SAMHSA's stakeholders, notwithstanding the time, effort, and resources dedicated to their development. This strategy focuses on assessing the relative value of SAMHSA's major data deliverables, with the goal of working to improve accessibility of these products.

LISTENING SESSION TAKEAWAYS:

- ***Need more investment in targeted communication of findings:*** Listening session members expressed that while SAMHSA invests a significant amount of time and money on data collection and analysis, it has dedicated less resources towards communicating said analyses in a meaningful way to a diverse array of stakeholders.

- ***Need to improve the ability for stakeholders to use SAMHSA's data:*** Participants reflected that SAMHSA's data must be communicated such that there is broad understanding of the data, and the messages reach the intended audiences and promote active use of findings in support of people with mental health and/or substance use disorders.

> "SAMHSA can drive the narrative using its data." – Listening Session Participant

- ***Enhancing usability of SAMHSA's data is important internally and externally:*** Stakeholders explained that it can be challenging for the SAMHSA workforce to absorb and integrate key findings into a given workstream and thereby limit improvements on the impact of SAMHSA's efforts. Good internal communication is as crucial as good external communication and can play a key role in forming a data-driven culture.

Strategy 1: Assess the value of SAMHSA's data products.

Action 1: Inventory all SAMHSA data deliverables.

This action will result in a comprehensive record of SAMHSA's data deliverables that will serve to inform subsequent stakeholder engagement.

Action 2: Review website analytics pertaining to SAMHSA's data deliverables.

This action will result in a quantitative review of access to SAMHSA's data deliverables, which will serve as a proxy for what data products are of most value to different types of stakeholders.

Action 3: Evaluate methods to engage a broad range of stakeholders.

This action will result in a series of recommendations for how to improve the accessibility of SAMHSA's data products.

Strategy 2: Establish a data communications strategy with a focus on improving/advertising/promoting SAMHSA data products and ensuring broad usability.

Action 1: Hire a data communications team.

> "It's so important to get the story right." – Listening Session Participant

This action will result in a small team of individuals trained in communication and data, nested within SAMHSA's CBHSQ, that will be charged with framing SAMHSA's data findings in a manner that is digestible to a variety of audiences.

Action 2: Conduct user experience research.

This action will inform development of a CBHSQ data communications strategy.

Action 3: Develop and implement a data communications strategy, which would work collaboratively with SAMHSA's Office of Communications.

This action will produce an actionable strategy that frames SAMHSA's key audiences, recognizes why these audiences are of importance to SAMHSA, assesses how and when communication with various audiences should occur, describes what form that communication should take, and defines by what mechanisms said communication should be provided.

Action 4: Develop recommendations on parameters of a possible publication vehicle within SAMHSA.

This action will result in an assessment and evaluation of implementing a "voice of SAMHSA" which can serve as the agency's primary vehicle for scientific publication of timely, reliable, authoritative, accurate, objective, and useful behavioral health information and recommendations.

GOAL 4 – EXPAND AND STRENGTHEN SAMHSA'S DATA WORKFORCE CAPACITY

Improving data literacy and skills among SAMHSA's workforce is crucial for the effective collection, analysis, and dissemination of data in support of the agency's mission. An appropriately skilled workforce has the potential to increase productivity and efficiency, foster innovation and adaptability, and effectively contribute to work that improves outcomes for those served by SAMHSA.

Strategic investments in human capital with data expertise not only facilitate activities within SAMHSA, but also invigorate data-driven initiatives and learning. Having a skilled workforce in data-related areas can lead to more accurate and reliable data being collected, analyzed, and disseminated. This, in turn, can improve decision making within SAMHSA and support the organization's efforts to better serve those with substance misuse and mental health conditions.[32] A skilled workforce can also improve transparency and accountability, while supporting SAMHSA's grant-making and programmatic efforts.[33] Ultimately, investing in human capital through the expansion and improvement of a skilled workforce can contribute to the overall goal of improving access to care and improving the lives of those served by SAMHSA.

Objective 1: Realign human capital to promote timely and actionable data collection, analysis, and dissemination.

SAMHSA can establish focused and responsive performance monitoring by defining the roles and responsibilities of the Centers/Offices and appropriating funding for them to hire skilled staff and maintain coordinated data platforms that address their data needs, while also closely coordinating with CBHSQ on SAMHSA-wide data-related activities that may have an effect on the agency as a whole.

LISTENING SESSION TAKEAWAYS:

- *Facilitate collaboration between Centers (including CBHSQ) and Offices in data collection and analysis pertinent to their needs:* Many SAMHSA components have established program analysis units to assess their data and to design client-level collection tools, and there is a desire to augment these units through allocation of resources and skilled staff.

- *Align data roles and responsibilities:* Internal listening sessions revealed specific functions set out for CBHSQ in a 2018 FRN. Centers and Offices reported a desire to better collaborate with CBHSQ to take greater responsibility for the collection and analysis of performance data where appropriate.

- *Grantees seek focused and responsive feedback:* Listening sessions revealed a high level of interest among grantees to receive timely feedback on progress and performance measures.

This objective is crucial for the organization to effectively improve access to care for those with substance use and mental health conditions. This also aligns with the reported desire to enhance data literacy among SAMHSA staff and grantees, and to do this in a collaborative manner. This not only leverages existing skills, but also provides numerous benefits, including increased productivity and efficiency, as well as fostering innovation. Further to this, investing in human capital can improve job satisfaction and engagement, while also improving employee retention.

Strategy 1: Promote focused and responsive performance monitoring and evaluation through investments in human capital.

Action 1: Provide resources and staffing to Center/Office program analysis units that collaborate with CBHSQ.

This action will allow Centers and Offices to conduct timely analysis and reporting, while balancing privacy concerns and confidentiality protections mandated of the federal government.

Action 2: Align the data roles and responsibilities of SAMHSA's Centers and Offices.

This action will allow CBHSQ to focus on its roles and responsibilities more intentionally as defined in this FRN (See Appendix D). Center and Office program analysis units will be able to assume greater responsibility for the collection, analysis, and dissemination of client and program level data, as appropriate.

Action 3: Appropriate funding for Centers and Offices to hire skilled staff and to maintain coordinated program-specific data platforms, in close consultation and coordination with the Chief Information Officer and CBHSQ.

This funding will allow the Centers/Offices the necessary resources to support staff efforts towards effectively collecting, analyzing, and disseminating data pertinent to their mission and grantees.

Action 4: Create a SAMHSA-wide Data-Driven Policy Working Group to promote data-driven decision making that includes qualitative data collected from project officers.

The DGB will make recommendations to the OAS based on the advice of this working group.

Objective 2: Enhance in-house capacity as it relates to data collection and analysis.

LISTENING SESSION TAKEAWAYS:

- *Challenges in hiring new staff:* Listening sessions within SAMHSA and the federal government highlighted the need to hire staff with skills that support data-driven initiatives and emphasized potential difficulties in identifying appropriate skills and attributes during the hiring process.

- ***Investing in staff experienced in data visualization, data linkage, data science, etc.:*** It is essential to invest in human capital with education and experience in data visualization, data linkage, data science, mixed-methods research, data collection/survey methodology, and data architecture.

- ***Training existing staff:*** Across SAMHSA, there is a desire for education and training in data analysis, linkage, and dissemination for all staff, particularly those who administer grants and who have regular contact with grantees. SAMHSA stakeholders expressed a desire to receive training in-house, particularly in the use of intuitive software and collaborative learning as well as to participate in data groups that promote new skills.

SAMHSA's objective of enhancing in-house capacity as it relates to data collection, analysis, and dissemination is crucial for the organization to effectively support its mission and to improve access to care for those with substance use and mental health conditions. To achieve this objective, SAMHSA has outlined two strategies: hiring staff with education and experience in data-related areas and enhancing staff data literacy.

Strategy 1: Hire staff who possess education and experience in the following core areas: data visualization, data linkage, data science, and mixed-methods.

Action 1: Perform a gap analysis of skills assessment for Centers and Offices around data visualizations, data linkage, data science, and data collection/survey methodology.

This action will result in an analysis that identifies areas for improvement and guide any future hiring decisions.

Strategy 2: Enhance wide staff data literacy.

Action 1: After performing a skills analysis and a staff survey, the DGB will coordinate data-related training for all staff.

This action will result in more consistent and high-quality professional development trainings on data for staff, particularly for those who are not otherwise part of Center and Office data units.

Action 2: Support applications to HHS's Data Science CoLab Program.

Engagement in such training will enhance the skills of participants and create new data user networks.

Action 3: Establish ongoing learning opportunities for staff, including data affinity groups and support for attendance at courses and conferences related to data collection, analysis, and dissemination.

Such learning opportunities will help staff stay up to date on the latest data-related developments and best practices, while also inspiring data-driven discussions and analysis.

CONCLUSION

This data strategy provides a comprehensive and forward-looking approach to improving SAMHSA's data capabilities. By recognizing the crucial role that data plays in providing knowledge and informing decision making, this strategy demonstrates SAMHSA's ongoing commitment to ensuring that data are used in a way that is relevant, meaningful, and of value to those it serves. To this end, no part of the strategy is intended to be aspirational— it has been developed after extensive consultation with stakeholders, and there is an expectation that the new SAMHSA DGB will implement and monitor the success of this data strategy.

Investments in human capital and IT systems are a key component of this strategy, as they provide long-term savings and enhanced flexibility in data analysis and application. Recognition of the urgent need to redesign how data is collected and disseminated highlights the importance of taking a strategic and proactive approach to improving data capabilities. SAMHSA also recognizes that expanding the collection of certain data elements, such as SDOH, is key to improving and tracking key issues that pertain to the public's health.

Strategic elements pertaining to workforce and human capital are designed to improve workflow and ensure that SAMHSA has the skills and capacity it needs to effectively collect, analyze, and disseminate data. This will help SAMHSA to meet its goals and better serve those in need. Similarly, supporting technical assistance for grantees facilitates decision making, improves outcomes, and has positive impacts on communities.

Additionally, by engaging internally and externally, and taking a responsive approach to stakeholder needs, SAMHSA is demonstrating its commitment to transparency, accountability, and collaboration. This approach will not only help to ensure that data is being used in the most effective and meaningful way possible, it will also foster trust and confidence in SAMHSA's data and analytic capabilities.

This document represents a significant step forward for SAMHSA and its mission to improve access to services for those with substance misuse and mental health conditions. The investments in human capital and IT systems, the focus on improving workflow and data capabilities, and the commitment to engaging with stakeholders and using data in a meaningful and relevant way, represent the importance that SAMHSA places on collaboration in advancing the behavioral health of vulnerable populations.

APPENDIX A: Data Strategy Workgroup Members

Name	Center/ Office	Role
Brendan Gudenburr	Center for Substance Abuse Prevention (CSAP)	Member
Carter Roeber	National Mental Health and Substance Use Policy Laboratory (Policy Lab)	Member
Darren Fulmore	Center for Behavioral Health Statistics and Quality (CBHSQ)	Member
Dona Dmitrovic	Office of Recovery	Member
Gary Blau	Office of the Assistant Secretary (OAS)	Member
Ingrid Donato	CSAP	Member
Kathryn Bistline	Center for Mental Health Services (CMHS)	Member
Kathy Piscopo	CBHSQ	Co-Lead and author
Kimberly Nelson	Office of Intergovernmental and Public Affairs (OIPA)	Member
Molly Sanborn	Policy Lab	Member and writing contributor
Naomi Tomoyasu	CBHSQ	Member and writing contributor
Perry Chan	Office of Behavioral Health Equity	Member
Robert Baillieu	Center for Substance Abuse Treatment (CSAT)	Co-Lead and author
Robert Day	OIPA	Member
Roger George	Office of Financial Resources	Member
Talisha Searcy	CSAT	Member
Tenly Biggs	CMHS	Member
Trina Dutta	OAS	Co-Lead and author
William Longinetti	Office of Tribal Affairs and Policy	Member

APPENDIX B: Listening Session Participants

Agency for Healthcare Research and Quality, Center for Financing, Access, and Cost Trends	Indian Health Service
American Academy of Child & Adolescent Psychiatry (AACAP)	Individual researcher(s)
Assistant Secretary for Planning and Evaluation, Office of Behavioral Health, Disability, and Aging Policy	National Association of State Alcohol and Drug Abuse Directors (NASADAD)
Bureau of Indian Affairs, Office of Justice Services	NASADAD Board of Directors
Centers for Disease Control and Prevention (CDC), Center for Surveillance, Epidemiology, and Laboratory Services	National Association of State Mental Health Program Directors (NASMHPD)
CDC, National Center for Injury Prevention and Control (NCIPC)	NASMHPD Children, Youth, Families Division
Children's Hospital Association	NASMHPD Research Institute, Inc. (NRI)
Centers for Medicare & Medicaid Services (CMS), Center for Clinical Standards and Quality for the Centers	National Asian American Pacific Islander Mental Health Association (NAAPIMHA)
CMS, Office of Enterprise Data & Analytics	National Council for Mental Wellbeing
CMS, Office of Minority Health, Director of the Data and Policy Analytics Group	National Latino Behavioral Health Association (NLBHA)
Community Anti-Drug Coalitions of America (CADCA)	National Institutes of Health, Office of the Director, Sexual & Gender Minority Research Office, Division of Program Coordination, Planning, and Strategic Initiatives
Department of Justice, Bureau of Justice Assistance	National Institute of Mental Health, Division of Services and Intervention Research, Services Research and Clinical Epidemiology Branch
Young People in Recovery (YPR)	Office of the National Coordinator for Health Information Technology (ONC)
Federation of Families for Children's Mental Health	SAMHSA Block Grant staff

APPENDIX B: Listening Session Participants, Continued

SAMHSA Data Strategy Working Group	U.S. Census Bureau, Population Division
SAMHSA Regional Administrators	Youth MOVE
Tribal Epidemiology Centers	

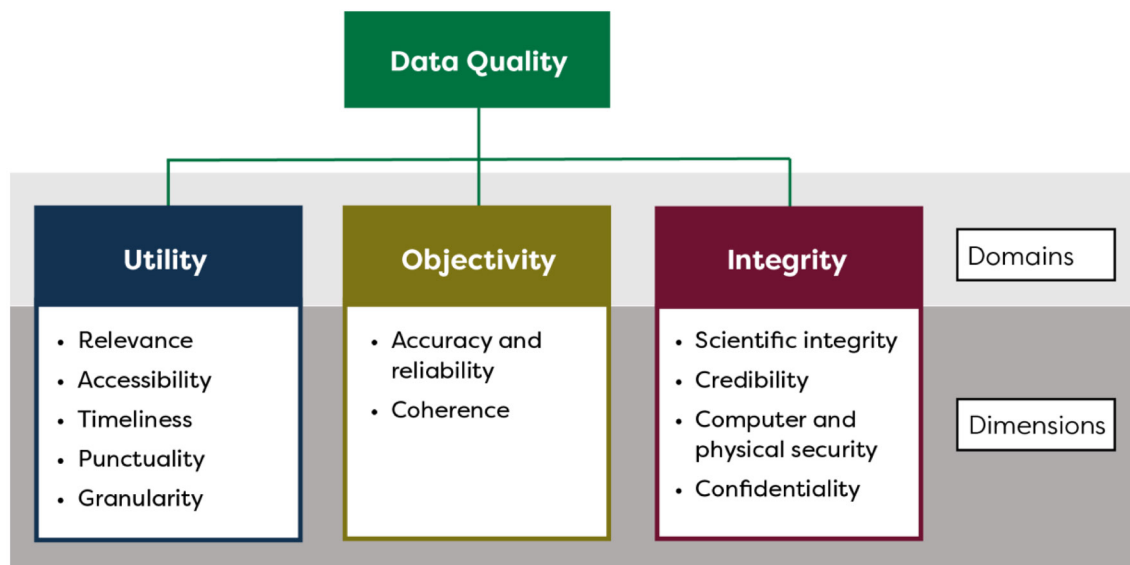| Grantees	
Behavioral Health Equity Center of Excellence	Grants to Expand Substance Use Disorder Treatment Capacity in Adult and Family Treatment Drug Courts
Capacity Building Initiative for Substance Abuse (SA) and HIV Prevention Services for At-Risk Racial/Ethnic Minority Youth and Young Adults (HIV CBI)	Medication-Assisted Treatment – Prescription Drug and Opioid Addiction (MAT-PDOA)
Certified Community Behavioral Health Clinics-Expansion (CCBHC-E)	State Opioid Response (SOR)
Enhancement and Expansion of Treatment and Recovery Services for Adolescents, Transitional Aged Youth, and their Families grant program (Youth and Family TREE)	Targeted Capacity Expansion-HIV Program: Substance Use Disorder Treatment for Racial/Ethnic Minority Populations at High-Risk for HIV/AIDS (TCE-HIV: High Risk Populations)
Garrett Lee Smith State/Tribal Youth Suicide Prevention and Early Intervention	

APPENDIX C: FCSM Data Quality Framework

Given the Information Quality Act[34], HHS's Chief Information Officer (CIO) was to adopt specific quality standards and ensure that quality reviews occur before dissemination. In response, HHS published its quality standards in 2002.[35] The Office of Science and Data Policy, in the Office of the Assistant Secretary for Planning and Evaluation (ASPE), manages the Information Quality process in HHS.

The Federal Committee on Statistical Methodology (FCSM), created by OMB, has extensively researched and provided recommendations on data quality. Their 2020 report[36] emphasizes "fitness for use" as a metric (see text box). For more details regarding the FCSM Data Quality Framework please go to https://www.fcsm.gov/assets/files/docs/FCSM.20.04_A_Framework_for_Data_Quality.pdf.

The FCSM data quality framework found in the report is summarized in Figure ES1 below. Definitions of terms are in the subsequent Table ES1.

"A clear, documented understanding of the strengths and weaknesses of data assures attention to ameliorating the weaknesses, enables appropriate uses of the data, and reinforces the credibility of the data and their use…Data users who understand the fitness-for-use of data are more likely to use them appropriately, whether for secondary use in developing other data products, for conducting data analysis, or when using data outputs for decision making…These activities all support appropriate and effective use of data"

Figure ES 1. The FCSM Data Quality Framework

APPENDIX C: FCSM Data Quality Framework, Continued

Within the three domains, there are eleven dimensions of data quality, as shown in Table ES 1 below, also from the report.

Table ES 1. Dimensions of Data Quality

Domain	Dimension	Definition
Utility	Relevance	Relevance refers to whether the data product is targeted to meet current and prospective user needs.
	Accessibility	Accessibility relates to the ease with which data users can obtain an agency's products and documentation in forms and formats that are understandable to data users.
	Timeliness	Timeliness is the length of time between the event or phenomenon the data describe and their availability.
	Punctuality	Punctuality is measured as the time lag between the actual release of the data and the planned target date for data release.
	Granularity	Granularity refers to the amount of disaggregation available for key data elements. Granularity can be expressed in units of time, level of geographic detail available, or the amount of detail available on any of a number of characteristics (*e.g.* (demographic, socio-economic).
Objectivity	Accuracy and reliability	Accuracy measures the closeness of an estimate from a data product to its true value. Reliability, a related concept, characterizes the consistency of results when the same phenomenon is measured or estimated more than once under similar conditions.
	Coherence	Coherence is defined as the ability of the data product to maintain common definitions, classification, and methodological processes, to align with external statistical standards, and to maintain consistency and comparability with other relevant data.
Integrity	Scientific integrity	Scientific integrity refers to an environment that ensures adherence to scientific standards and use of established scientific methods to produce and disseminate objective data products and one that shields these products from inappropriate political influence.
	Credibility	Credibility characterizes the confidence that users place in data products based simply on the qualifications and past performance of the data producer.
	Computer and physical security	Computer and physical security of data refers to the protection of information throughout the collection, production, analysis, and development process from unauthorized access or revision to ensure that the information is not compromised through corruption or falsification.
	Confidentiality	Confidentiality refers to a quality or condition of information as an obligation not to disclose that information to an unauthorized party.

Reports on data quality by agencies should ultimately be tied to the intended use and users of the information. Users should be told about any threats and any trade-offs to fitness-for-use in the eleven domains above so that they can use the data appropriately. For example, data quality for the intended use may differ from that for its original purpose. (For more information, please see the presentation slides[37] and recording[38] of the "Leveraging the Data Quality Framework Workshop".)

The "Foundations for Evidence-Based Policymaking Act of 2018", or "Evidence Act," codified several important Federal initiatives. It established an "Advisory Committee on Data for Evidence Building," which was charged with promoting the use of Federal data for evidence building. The Evidence Act also called upon the head of each agency to designate a civil servant as the Chief Data Officer of the agency, who in turn supports the Performance Improvement Officer, Evaluation Officer, and the CIO.

APPENDIX D: Background of Legislative Mandates

Health surveillance activities are authorized under Sections 501 and 505 of the Public Health Service Act (PHSA[39]). Prior to this, "[i]n the 1990s, the legislation that created SAMHSA in 1992, Public Law 102321, the Alcohol Drug Abuse Mental Health Administration Reorganization Act, required that SAMHSA develop a definition of adults with "serious mental illness" and that this definition be operationalized and applied to the Community Mental Health Services Block Grant Program."[40]

PHSA Title V, Section 505, states that CBHSQ performs activities that: (1) coordinate SAMHSA's integrated data strategy, including collecting data each year; (2) provide statistical and analytical support for SAMHSA's activities; (3) manage a core set of performance metrics to evaluate activities supported by SAMHSA; (4) coordinate with the Assistant Secretary, the Assistant Secretary for Planning and Evaluation (ASPE), National Mental Health and Substance Use Policy Lab, and SAMHSA's Chief Medical Officer, as appropriate, to improve the quality of data collection services and evaluations of SAMHSA activities.[41]

PHSA Title V, Section 505 also outlines the CBHSQ Director's duties to include coordinating an integrated data strategy: collecting data on the incidence and prevalence of mental illness and substance use (the National Survey on Drug Use and Health [NSDUH]), the number of individuals seeking treatment for mental illness and substance use issues (NSDUH), and the number of individuals admitted to emergency rooms as a result of substances (the Drug Abuse Warning Network [DAWN]). Duties of the Director further include collecting data on mental health and substance use treatment programs (National Substance Use and Mental Health Services Survey [N-SUMHSS]) and making recommendations for performance monitoring metrics to evaluate SAMHSA activities. PHSA Section 505 specifies that summaries and analyses of data collected shall be made available to the public in addition to using "best practices" in the collection of the data. In 2016, Congress passed the 21st Century Cures Act[42] (PL 114-255, Sec. 6031; "Cures Act") in response to the opioid crisis. PHSA Title V, Section 505 was reauthorized and amended by Section 6004 of the Cures Act. SAMHSA's Opioid State Targeted Response (STR) grant program, the National Mental Health Policy Laboratory, and the position of the Assistant Secretary for Mental Health and Substance Use were created by the Cures Act.[43]

The HHS Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) was additionally established on March 15, 2017, in accordance with the Cures Act.[44] One main goal of the ISMICC is to establish priorities in measuring Serious Mental Illness (SMI) in the general population. Also, HHS's 5-Point Opioid Strategy[45] prioritizes "strengthening public health data reporting and collection" as strategy three.

In 2018, the reorganization of SAMHSA was advertised in an FRN.[46] Within that, CBHSQ was again charged with several responsibilities, particularly "recommends a core set of performance metrics to evaluate activities supported by the Administration… improves access to reliable and valid information on evidence based programs and practices, including information on the strength of evidence associated with such programs and practices, related to mental and substance use disorders; (7) compiles,

APPENDIX D: Background of Legislative Mandates, Continued

analyzes, and disseminates behavioral health information for statistical purposes."[47] The creation of the Office of Evaluation (OE) within CBHSQ ensured compliance with these requirements.[48]

The 2018 FRN[49] detailed the organization, function, and delegations of authority within SAMHSA and further defined CBHSQ's role, as follows:

1. Coordinates the Assistant Secretary for Mental Health and Substance Use's (ASMHSU) integrated data strategy, which includes collecting data each year on the national incidence and prevalence of the various forms of mental illness and substance abuse;

2. Provides statistical and analytical support for activities of the ASMHSU, and the Secretary of HHS;

3. Recommends a core set of performance metrics to evaluate activities supported by the Administration;

4. Coordinates with the ASMHSU, ASPE, and SAMHSA's Chief Medical Officer, as appropriate, to improve the quality of services provided by programs and the evaluation of activities carried out by the Administration;

5. Works with the National Mental Health and Substance Use Policy Laboratory to collect, as appropriate, information from grantees under programs to evaluate and disseminate information on evidence-based practices, including culturally and linguistically appropriate services, as appropriate, and service delivery models;

6. Improves access to reliable and valid information on evidence-based programs and practices, including information on the strength of evidence associated with such programs and practices, related to mental and substance use disorders;

7. Compiles, analyzes, and disseminates behavioral health information for statistical purposes.

The "Foundations for Evidence-Based Policymaking Act of 2018"[50], or "Evidence Act," codified several important federal initiatives. It established an "Advisory Committee on Data for Evidence Building," which was charged with promoting the use of federal data for evidence building. The Evidence Act also called upon the head of each agency to designate a civil servant as the Chief Data Officer of the agency who in turn supports the Performance Improvement Officer, Evaluation Officer, and the Chief Information Officer.

In addition to its statutory authority, CBHSQ is a Recognized Statistical Unit (RSU) by OMB, as listed in OMB's Statistical Policy Directive 1, or "SPD 1"[51]. (Recognition was given in 2006.) SPD 1 is also called the "Trust" Directive because it heavily emphasizes the impacts of data integrity on public trust:

APPENDIX D: Background of Legislative Mandates, Continued

"Any loss of trust in the accuracy, objectivity, or integrity of the Federal statistical system and its products causes uncertainty about the validity of the measures the Nation uses to monitor and assess its performance, progress, and needs by undermining the public's confidence in the information released by the Government."[52]

SPD 1 also states that:

"It is the responsibility of Federal statistical agencies and recognized statistical units to produce and disseminate relevant and timely information; conduct credible, accurate, and objective statistical activities; and protect the trust of information providers by ensuring confidentiality and exclusive statistical use of their responses as described below."[53]

More specifically, the four roles and key responsibilities of a Recognized Statistical Unit (RSA) or RSU are to:

- Produce and disseminate relevant and timely information. (Responsibility 1)

  - "The core mission of Federal statistical agencies and recognized statistical units is to produce relevant and timely statistical information to inform decision-makers in governments, businesses, institutions, and households."

  - Requires communication and coordination among agencies and within and across departments when planning information collection and dissemination activities

  - Must seek input regularly from the data users

- Conduct credible and accurate statistical activities. (Responsibility 2)

  - "Federal statistical agencies and recognized statistical units apply sound statistical methods to ensure statistical products are accurate."

  - Apply against Information Quality Act standards

  - Includes transparency on limitations and data quality

  - Improve efficiencies in data collections

  - Must cite external data and how it is used

- Conduct objective statistical activities. (Responsibility 3)

  - "It is paramount that Federal statistical agencies and recognized statistical units produce data that are impartial, clear, and complete and are readily perceived as such by the public."

  - Equitable, policy-neutral, transparent, timely, and punctual basis

APPENDIX D: Background of Legislative Mandates, Continued

- Conduct statistical activities autonomously when determining what information to collect and process, and how to process it

    - Avoid even the appearance that agency design, collection, processing, editing, compilation, storage, analysis, release, and dissemination processes may be manipulated

    - Must maintain and develop in-house staff who are trained in statistical methodology

- Protect the trust of information from providers by ensuring the confidentiality and exclusive statistical use of their responses. (Responsibility 4)

    - "Maintaining and enhancing the public's trust in a Federal statistical agency's or recognized statistical unit's ability to protect the integrity of the information provided under a pledge of confidentiality is essential for the completeness and accuracy of statistical information as well as the efficiency and burden of its production."

    - Maintain consistent and effective protection to enhance trust

    - Fully adhere to legal requirements and follow best practices for protecting the confidentiality of data

As an RSU, CBHSQ adheres to the "Principles and Practices" outlined by the Committee on National Statistics (CNSTAT).[54] This Principles and Practices report was recently updated for 2021. The principal statistical agencies embrace the five fundamental principles:

1. Principle 1: Relevance to Policy Issues and Society

2. Principle 2: Credibility Among Data Users and Stakeholders

3. Principle 3: Trust Among the Public and Data Providers

4. Principle 4: Independence from Political and Other Undue External Influence

5. Principle 5: Continual Improvement and Innovation

To support these five principles, RSAs and RSUs use 10 practices or guidelines:

1. A Clearly Defined and Well-Accepted Mission

2. Necessary Authority and Procedures to Protect Independence

3. Commitment to Quality and Professional Standards of Practice

4. Professional Advancement of Staff

APPENDIX D: Background of Legislative Mandates, Continued

5. An Active Research Program

6. Strong Internal and External Evaluation Processes for an Agency's Statistical Programs

7. Coordination and Collaboration with Other Statistical Agencies

8. Respect for Data Providers and Protection of Their Data

9. Dissemination of Statistical Products That Meet Users' Needs

10. Openness About Sources and Limitations of the Data Provided

It is important to note that through the President's Memorandum on the Preservation and Promotion of Scientific Integrity (2009)[55], the heads of executive departments and agencies were asked to detail in writing how each would support the scientific integrity of the RSUs or RSAs that were housed within them. In other words, parent agencies publicly committed to support the scientific integrity and autonomy of the RSU or RSAs.[56]

APPENDIX E: Data Governance Board

Core Responsibilities:

- **Oversight and Decision-making:** Provides a forum for executive oversight and management of the agency's data strategy. The DGB will make recommendations to the OAS regarding data management principles and policies that apply to all phases of the data lifecycle (including its collection or creation, integration, storage, validation, analysis, dissemination, and destruction or archiving).

- **Resource Allocation:** In collaboration with financial officers and other interested parties, makes recommendations to OAS regarding funding and other data-related priorities to maximize the utility of agency data and fully leverage its potential within the agency.

- **Assessment and Prioritization of Needs:** Continually assesses the analytic and reporting needs of the agency and reflects these needs in policy development and funding recommendations. Supports stakeholder access to and delivery of SAMHSA data resources.

- **Strategic Alignment:** Ensures that investments into data-related initiatives, and the principles, policies, and practices established to govern them, align with the agency's mission and strategic objectives and initiatives as well as current privacy and security protocols. This should include the involvement of people with lived experience, while also considering issues related to diversity, equity, and inclusion.

- **Issue Resolution:** Serves as mediator for data-related issues and needs. Makes recommendations to OAS on issues related to data access, architecture, and precedent-setting data requests.

- **Facilitation of Knowledge Sharing:** Ensures OAS-approved policies, procedures, and related decisions are documented and made available to agency employees and, where appropriate, external entities. This transparency enables performance measurement and progress toward data governance goals.

Accountability: The DGB may sponsor creation of ad hoc agency working groups to focus on specific tasks. The DGB will review and approve charters that specify the tasking, relationship between, and reporting requirements of these entities, and will continually assess progress by receiving updates from these bodies at DGB meetings.

Membership: The DGB will be comprised of members, as designated by Center and Office leadership, where voting members must be familiar with data and support program development and/or implementation. DGB voting members will include the following:

- Center for Behavioral Health Statistics and Quality (n=2)

- Center for Mental Health Services (n=2)

- Center for Substance Abuse Prevention (n=2)

APPENDIX E: Data Governance Board, Continued

- Center for Substance Abuse Treatment (n=2)

- 988 and Behavioral Health Crisis Coordinating Office (n=1)

- National Mental Health and Substance Use Policy Laboratory (n=1)

- Office of Behavioral Health Equity (n=1)

- Office of Communication (n=1)

- Office of Financial Resources (n=1)

- Office of Legislative Affairs (n=1)

- Office of Intergovernmental and Public Affairs (n=1)

- Regional Offices (n=1)

- Office of Recovery (n=1)

- Office of the Chief Medical Officer (n=1)

- Office of Tribal Affairs and Policy (n=1)

The DGB will be chaired by a CBHSQ representative, with a rotating co-chair from a Center or Office separate to CBHSQ, who is responsible for:

- Liaising between the DGB and the Immediate Office of the Assistant Secretary (IOAS)

- Chairing and facilitating DGB meetings

- Defining meeting agendas

Meetings: The DGB will meet on a regular basis and as needed, depending upon the type and urgency of issues that arise.

The DGB shall have administrative support, responsible for:

- Scheduling meetings and disseminating materials

- Taking meeting minutes and disseminating them for review and approval

- Managing DGB artifacts

Decision Model and Dispute Resolution: The DGB will function as a decision-making body that strives for consensus when making decisions. Each member has one vote in the voting process, and decisions will be made by simple majority. Members have the right to abstain from voting. The DGB Chair will capture and record member votes (including abstentions and cases where the member is not present to vote). Disagreements or disputes will be settled in the following manner: recognition by

APPENDIX E: Data Governance Board, Continued

the chair that disagreement has arisen; and a call for interested parties to discuss the issues at hand for 3 minutes each. The chair will then summarize the disputed issue and propose a resolution upon which a vote is called. Voting will be carried out in the manner described above, and the dispute will be resolved by a majority vote.

Reporting: The IOAS will review and approve all major decisions made by the DGB. In consultation with DGB leadership, the IOAS retains the right to overturn decisions made by the DGB.

APPENDIX F: Themes from Listening Sessions

Below are the major themes found during the listening sessions, along with some quotations from participants (that are in addition to quotes in the body of the report). The themes are organized by Data Strategy Goal.

GOAL 1—ENHANCE SAMHSA'S ABILITY TO COLLECT, CAPTURE, AND MAINTAIN HIGH-QUALITY DATA

- **Recovery statistics:** Participants appreciated the utility and value of SAMHSA data resources such as the National Survey on Drug Use and Health (NSDUH), the National Survey of Substance Abuse Treatment Services (N-SSATS), the National Mental Health Services Survey (N-MHSS), and the Treatment Episode Data Set (TEDS). However, participants indicated that SAMHSA does not collect statistics on recovery, with the exception of NSDUH's perceived recovery estimates.

> *Quotation*: "Collect data on recovery rates for MH and SUD conditions so that the field has a better sense of how effective individuals believe treatment is and how many people are recovering without formal treatment." – Listening Session Participant

- **Social determinants of health:** Respondents commented that SDOH are important predictors of resilience and recovery and yet SAMHSA data collections only measure certain social drivers, including housing stability, education level, and criminal justice involvement.

- **Race/ethnicity and SOGI:** Listening session participants voiced that across SAMHSA data collections, there is inconsistency in the measurement of race/ethnicity and SOGI.

- **Government Performance and Results Act (GPRA)-specific feedback:**

  - **Different Needs:** There are different data needs for discretionary grants versus formulary or block grants. The current GPRA measures could pose a threat to engaging clients, particularly for low-barrier programs (such as SAMHSA's Harm Reduction grant portfolio[57]) that prioritize immediate access to a given service. Participants associated with SAMHSA's training and technical assistance (T/TA) centers voiced concern that their respective GPRA measures have little bearing on understanding the value of their efforts and are most focused on process measures versus outcome measures.

  - **Respondent Burden:** The number of items in the GPRA tools have significantly increased, and there is no clear path or decision-making processes to reduce burden for grantees. Some participants stated there were too many data being collected, especially when so little is reported back to grantees or to the field at large.

APPENDIX F: Themes from Listening Sessions, Continued

■ **Administrative/Grantee Burden:** Due to both the number of questionnaire items and data collection instruments,[58] and data collection systems (such as SAMHSA's Performance Accountability and Reporting System[59] or "SPARS"), data entry for grantees is extremely burdensome. One participant remarked that a standard services grant program requires a full-time staff person dedicated just to GPRA data collection, and the GPRA tools take 30 to 60 minutes to complete. Additionally, grantees mentioned SAMHSA considering technologic methods to improve data collection and entry.

> "Determine how much information and improvement in BH outcomes each data collection effort is yielding. If it is not yielding much, determine how to make it more useful or eliminate it." – Listening Session Participant

■ **Validity of Items:** The validity of the measures must be examined. Only those with evidence of validity and prior questionnaire testing should be used, and all items should be trauma-informed and culturally and linguistically appropriate. Furthermore, national bodies representing state authorities and professional organizations should be consulted during the development phase to align with state metrics.

■ **Data Dictionaries:** Participants mentioned that states have varying interpretations of the data elements; as such, cross-state data dictionaries would be helpful in establishing a common language for SAMHSA data collection.

■ **Consistency:** Participants expressed frustration over SAMHSA "constantly changing measures," and suggested that changes only be proposed when specific codified change criteria are met.

■ **Information for Respondents:** A few participants mentioned that many times grantees or program participants don't know why they are asked these questions, and this impacts data quality. Many SAMHSA data collections, such as NSDUH,[60] create respondent materials that answer common questions, such as the importance and utility of the data collected. However, these are lacking for most GPRA tools.

■ **Lack of Grantee Training:** Participants noted that many grantees are not trained in data collection best practices, which can negatively impact data quality. Grantees also suffer from a lack of data infrastructure.

■ **Special Concerns for Tribes:** The concept of tribal "data sovereignty" was discussed, where some Tribes have written data sovereignty agreements with federal agencies like the Department of Justice. Tribal nations want to be able to measure their progress; however, these procedures need to be explicitly written into the grants. Also, Tribes should be involved in developing measures as they might have specific data needs (such as intersectionality), and items should be based on "cultural humility." Additionally, participants stated that SAMHSA should better leverage Tribal Epidemiology Centers (TECs) and its own Tribal Technical Advisory Committee.

APPENDIX F: Themes from Listening Sessions, Continued

- **Cross-Government Coordination:** Staff from other agencies expressed desire for better coordination across the government related to data collections, particularly with the Indian Health Service and Centers for Disease Control and Prevention.

GOAL 2 – CONDUCT ROBUST PERFORMANCE MONITORING, EVALUATION, AND SURVEILLANCE

- **Need for updated systems:** Stakeholders highlighted a need to consider extensive and well-planned upgrades to data platforms. Current systems are outdated, segregated, and lack interoperability, which often leads to duplication of tasks, delays in performance assessment, or an inability to seamlessly link financial and programmatic data. Capital improvements should be coordinate and funded at the agency level. Interoperability must be enhanced, such as linking SPARS, eRA, and Stop Act funds data.

- **Center and Office autonomy:** Internal stakeholders expressed a desire for increased SAMHSA Center and Office autonomy in the evaluation of data, proposing that data units be given additional resources and be staffed with skilled employees. This would allow Centers and Offices to assume leadership in the collection, analysis, and dissemination of client-level data.

- **Reduce respondent and grantee burden:** Across internal and external listening sessions, there was a desire to reduce the burden of data collection with the use of existing secondary data to augment analytic potential and reduce burden among grantees. In support of this, feedback from grantees and their representatives revealed a need to implement technical assistance that promotes data literacy and analysis. Grantees also reported a desire to use client-level data to better understand the impact of their programs, and to make organization-level planning decisions.

- **Use of current and historical data:** Internal and external stakeholders highlighted the need for SAMHSA to better use historical and current data for analysis of grantee program impact. Discussions revealed several decades of data, particularly from block grants, that has not been adequately interrogated.

- **Lack of transparency:** Grantees and academic stakeholders reported a lack of transparency (or "bidirectionality") in how SAMHSA uses the grantee data it collects. Listening session participants reported frustration in the lack of regular reporting or publicly available analysis of collected data. This overlaps with Goal 3 on dissemination.

APPENDIX F: Themes from Listening Sessions, Continued

- **Training and technical assistance opportunities:** Grantees, particularly Tribal Nations, reported an interest in using the client-level data they collect to inform their programs and practices and in working with SAMHSA to review metrics and contribute to data-driven policy. This represents an opportunity for grantees to constructively interrogate data, and it requires SAMHSA to invest not only in technical assistance that facilitates analysis, but to also consider robust methods to share data and to promote discussion.

GOAL 3 – STRENGTHEN ACCESS TO, UTILIZATION OF, AND DISSEMINATION OF SAMHSA DATA

- **Challenges accessing and utilizing SAMHSA's data and data products:** While listening session participants lauded SAMHSA for the ability to access certain data sets, such as NSDUH, TEDS, and N-SSATS, we also heard about the challenges in accessing and/or maximizing use of other data sets. Suggestions were provided about how to make the data easier to access, use, and connect with other available data sources, as well as how to clarify the intended use of a given data set. Participants also mentioned using active forecasting and predictive data analytics when data allows.

- **Using the data SAMHSA has:** Large data sets like those collected via the state block grants have largely gone unused. Creating access points to SAMHSA's discretionary and block grant data could offer the opportunity for robust analysis and help inform policy-making at the state or national level. There was also feedback on the value of SAMHSA's performance data if properly mined.

- **Lack of reciprocity:** Many respondents mentioned a lack of reciprocity with data ("nothing in return"), where data is only sporadically reported back to grantees for performance improvement.

- **Modernize SAMHSA's data dashboards:** Participants consistently mentioned the need for SAMHSA to modernize its approach to data dissemination, namely via establishing public-facing data dashboards.

- **Importance of understanding underserved populations:** SAMHSA received ongoing feedback that there is profound interest in being able to understand more about traditionally underserved populations and/or communities, but statistical suppression within a given data set can pose challenges. Relatedly, we also received feedback that it is no longer of value to understand a given population from just one perspective (aka variable); in fact, people are multifaceted, and creating mechanisms to apply an intersectional lens to data analysis would better serve our communities. "Summary sheets" for certain populations would be helpful.

APPENDIX F: Themes from Listening Sessions, Continued

- **Provide more analyses by state or county:** Akin to analyses by demographic characteristics, many internal and external stakeholders expressed needing geographical granularity to improve their programmatic planning or evaluation. Again, statistical suppression within a given data set can pose challenges.

- **Leverage the National Mental Health and Substance Use Policy Laboratory (Policy Lab):** The Policy Lab should be a data-driven policy hub, bringing together Center data teams and representatives to inform publications, guidance, and policy.

- **Explore data linkages:** Participants mentioned that linking SAMHSA datasets with each other or external data would be helpful. For example, financial and programmatic data are often not linkable. Some highlighted that there may be privacy and CIPSEA (Confidential Information Protection and Statistical Efficiency Act of 2002) concerns associated with certain datasets.

- **Framing "stories":** Participants also mentioned that SAMHSA should publicize data that shows successes, not just deficits. Framing the data is an important part of data dissemination that must be examined.

- **Usability of reports and publications:** Quite a few people mentioned that while SAMHSA has a great amount of data, it is very difficult to know and digest the current reports SAMHSA has released. Just as website developers conduct usability testing with potential users of a website to determine whether users can complete tasks and have positive experiences, SAMHSA should talk to potential report users about how to make SAMHSA documents more digestible for certain audiences.

GOAL 4 – EXPAND AND STRENGTHEN SAMHSA'S DATA WORKFORCE CAPACITY

- Facilitate collaboration between Centers, Offices and CBHSQ in data collection and analysis pertinent to their needs: Many Centers and Offices have established program analysis units to assess their data and to design client-level collection tools. There is a desire across SAMHSA to expand these units through allocation of resources and skilled staff. This will allow the Centers and Offices to promote data-driven decision making pertinent to their unique mission, while more closely collaborating with data experts in CBHSQ.

- Align data roles and responsibilities: Facilitate CBHSQ and Centers/Offices meeting their goals and objectives through realignment of data roles and responsibilities. Internal listening sessions revealed specific functions set out for CBHSQ in a 2018 Federal Register Notice. Centers and Offices will collaborate with CBHSQ to take greater responsibility for the collection and analysis of client-level data where appropriate.

APPENDIX F: Themes from Listening Sessions, Continued

- Grantees seek focused and responsive feedback: Listening sessions revealed a high level of interest among grantees to receive timely feedback on progress and performance. This is achieved when Centers and Offices have full access to their client-level data and have appropriate skills and knowledge in data analysis.

- Challenges in hiring new staff: Listening sessions within SAMHSA and the federal government highlighted the need to hire staff with skills that support data-driven initiatives and emphasized potential difficulties in identifying appropriate skills and attributes during the hiring process. Other agencies mentioned resources for potential hiring such as HHS Tech Transfer Offices, the CDO Playbook, assessments current environment and training needs , tips on writing job positions , and learning agendas.

- Investing in staff experienced in data visualization, linkage, science, etc.: Listening sessions highlighted the importance of investing in human capital with education and experience in data visualization, data linkage, data science, mixed-methods research, data collection/survey methodology, and data architecture. It was proposed that this be guided by a gap analysis and skills assessment that can help identify areas for improvement. Dashboards should be developed in open-source programs.

- Training existing staff: Across SAMHSA, there is a desire for education and training in data analysis, linkage, and dissemination for all staff, particularly those who administer grants and who have regular contact with grantees. Enhancing data literacy of SAMHSA staff supports grantees who seek greater involvement in data analysis. SAMHSA stakeholders expressed a desire to receive training in-house, particularly through the use of intuitive software and collaborative learning, as well as to participate in data groups that promote new skills. Some centers mentioned needing more statisticians for analytic needs.

- Communication of scientific data: Listening sessions revealed that other agencies have dedicated resources, such as the Morbidity and Mortality Weekly Report, to dedicate agency scholarly research to a broad audience and that SAMHSA should explore this, as well as more public outreach of analytic findings and creating a "brand."

- Incentives for retention: Other agencies discussed how to make "intangible payments" to retain staff—authorship to their code, deliverables, data briefs, and data visualizations, and more availability to present across agencies.

ENDNOTES

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SAMHSA

Substance Abuse and Mental Health
Services Administration

SAMHSA's mission is to lead public health and service delivery efforts that
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