



DEPARTMENT OF HEALTH AND HUMAN SERVICES

## OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



January 15, 2015

**TO:** Dan Spears  
Acting Chief Financial Officer  
Substance Abuse and Mental Health Services Administration

**FROM:** /Gloria L. Jarmon/  
Deputy Inspector General for Audit Services

**SUBJECT:** Independent Attestation Review: Substance Abuse and Mental Health Services Administration Fiscal Year 2014 Detailed Accounting Submission and Performance Summary Report for National Drug Control Activities and Accompanying Required Assertions (A-03-15-00353)

This report provides the results of our review of the attached Substance Abuse and Mental Health Services Administration (SAMHSA) detailed accounting submission, which includes the Table of Prior Year Drug Control Obligations, related disclosures, and management's assertions for the fiscal year ended September 30, 2014. We also reviewed the Performance Summary Report, which includes management's assertions and related performance information for the fiscal year ended September 30, 2014. SAMHSA management is responsible for, and prepared, the detailed accounting submission and Performance Summary Report to comply with the Office of National Drug Control Policy Circular *Accounting of Drug Control Funding and Performance Summary*, dated January 18, 2013 (the ONDCP Circular).

We performed this review as required by 21 U.S.C. § 1704(d)(A) and as authorized by 21 U.S.C. §1703(d)(7) and in compliance with the ONDCP Circular.

We conducted our attestation review in accordance with attestation standards established by the American Institute of Certified Public Accountants and the standards applicable to attestation engagements contained in *Government Auditing Standards* issued by the Comptroller General of the United States. An attestation review is substantially less in scope than an examination, the objective of which is to express an opinion on management's assertions contained in its report. Accordingly, we do not express such an opinion.

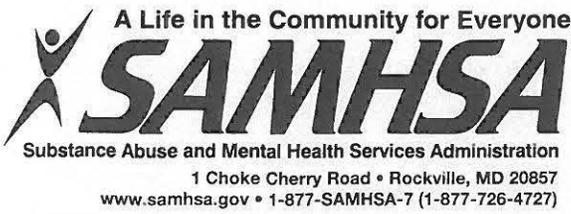
Based on our review, nothing came to our attention that caused us to believe that SAMHSA's detailed accounting submission and Performance Summary Report for fiscal year 2014 were not fairly stated, in all material respects, based on the ONDCP Circular.

SAMHSA's detailed accounting submission and Performance Summary Report are included as Attachments A and B.

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Although this report is an unrestricted public document, the information it contains is intended solely for the information and use of Congress, ONDCP, and SAMHSA and is not intended to be, and should not be, used by anyone other than these specified parties. If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Kay L. Daly, Assistant Inspector General for Audit Services, at (202) 619-1157 or through email at [Kay.Daly@oig.hhs.gov](mailto:Kay.Daly@oig.hhs.gov). Please refer to report number A-03-15-00353 in all correspondence.

Attachments



To: Director  
Office of National Drug Control Policy  
NOV 7 2014

Through: Deputy Assistant Secretary for Finance  
Department of Health and Human Services

From: Acting Chief Financial Officer  
Substance Abuse and Mental Health Services Administration

Subject: Assertions Concerning Drug Control Accounting

In accordance with the requirements of the Office of National Drug Control Policy Circular *Accounting of Drug Control Funding and Performance Summary*, dated January 18<sup>th</sup>, 2013, I make the following assertions regarding the attached annual accounting of drug control funds:

**Obligations by Budget Decision Unit**

I assert that obligations reported by budget decision unit are the actual obligations from SAMHSA's accounting system of record for these budget decision units.

**Drug Methodology**

I assert that the drug methodology used to calculate obligations of prior year budgetary resources by function for SAMHSA was reasonable and accurate in accordance with the criteria listed in Section 6b(2) of the Circular. In accordance with these criteria, I have documented/identified data which support the drug methodology, explained and documented other estimation methods (the assumptions for which are subjected to periodic review) and determined that the financial systems supporting the drug methodology yield data that present fairly, in all material respects, aggregate obligations from which drug-related obligation estimates are derived. (See Exhibit A)

**Application of Drug Methodology**

I assert that the drug methodology disclosed in Exhibit A was the actual methodology used to generate the table required by Section 6a.

**Reprogrammings or Transfers**

I assert that the data presented are associated with obligations against a financial plan that was revised during the fiscal year to include funds received from ONDCP in support of the Drug

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Free Communities Program. SAMHSA received a total of \$90,109,177 from ONDCP via Interagency Agreements to fund activities of the Drug Free Communities Program in FY 2014. SAMHSA had no reportable reprogrammings or transfers in FY 2014.

**Fund Control Notices**

I assert that the data presented are associated with obligations against SAMHSA's financial plan which complied fully with all ONDCP Budget Circulars.

A handwritten signature in black ink that reads "Dan Spears". The signature is written in a cursive style with a large initial "D".

Dan Spears  
Acting Chief Financial Officer

Attachments:

Table of Prior Year Drug Control Obligations, FY 2014  
Exhibit A - Drug Control Methodology

**SUBSTANCE ABUSE AND MENTAL HEALTH  
SERVICES ADMINISTRATION**

**Table of Prior Year Drug Control Obligations  
FY 2014  
(Dollars in millions)**

**Drug Resources by Decision Unit and Function**

<b>Substance Abuse Prevention Programs of Regional and National Significance</b>	
<i>Prevention</i> <sup>1/</sup> .....	175.2
<b>Total, Substance Abuse Prevention Programs of Regional and National Significance</b>	<b>\$175.2</b>
<b>Substance Abuse Treatment Programs of Regional and National Significance</b>	
<i>Treatment</i> <sup>1/</sup> .....	362.9
<b>Total, Substance Abuse Treatment Programs of Regional and National Significance</b>	<b>\$362.9</b>
<b>Substance Abuse Prevention and Treatment Block Grant</b>	
<i>Prevention</i> <sup>2/</sup> .....	363.0
<i>Treatment</i> <sup>2/</sup> .....	1,452.1
<b>Total, Substance Abuse Prevention and Treatment Block Grant</b> .....	<b>\$1,815.1</b>
<b>Health Surveillance and Program Support</b>	
<i>Prevention (Non-add)</i> <sup>3/</sup> .....	22.9
<i>Treatment (Non-add)</i> <sup>3/</sup> .....	91.5
<b>Total, Health Surveillance and Program Support</b> .....	<b>\$114.4</b>
 <b>Total Funding</b> .....	 <b>\$2,467.6</b>
<b>Drug Resources Personnel Summary</b>	
<i>Total FTEs (direct only)</i> .....	619
<b>Drug Resources as a Percent of Budget</b>	
<i>Total Agency Budget</i> <sup>4/</sup> (in billions) .....	\$3.6
<i>Drug Resources Percentage</i> .....	68.2%
 Drug Free Communities Program <sup>5/</sup> .....	\$90.1
 <b>Total with Drug Free Communities</b> .....	 <b>\$2,557.7</b>

**Footnotes:**

<sup>1/</sup> PRNS obligations reflect direct obligations against SAMHSA budget authority. Reimbursable obligations are not included, as these funds would be reflected in the obligations of the agency providing the reimbursable funds to SAMHSA. Substance Abuse Treatment PRNS obligations include funds provided to SAMHSA from the PHS evaluation fund.

<sup>2/</sup> SAPT Block Grant obligations include funds provided to SAMHSA from the PHS evaluation fund.

<sup>3/</sup> HSPS obligations reflect direct obligations against SAMHSA budget authority. Reimbursable obligations are not included, as these funds would be reflected in the obligations of the agency providing the reimbursable funds to SAMHSA. HSPS obligations include funds provided to SAMHSA from the PHS evaluation fund.

<sup>4/</sup> Total Agency Budget does not include Drug Free Communities Program funding.

<sup>5/</sup> Drug Free Communities Program funding was provided to SAMHSA/CSAP via Interagency Agreements.

*TOTALS MAY NOT ADD DUE TO ROUNDING*

**Exhibit A**

**(1) Drug Methodology** - Actual obligations of prior year drug control budgetary resources are derived from the SAMHSA Unified Financial Management System (UFMS), PSC Status of Funds by Allotment and Allowance Report.

**(a) Obligations by Budget Decision Unit** - SAMHSA's budget decision units have been defined by ONDCP Circular, *Budget Formulation*, dated January 18<sup>th</sup>, 2013. These units are:

- Programs of Regional and National Significance (PRNS) - Prevention (CSAP);
- Programs of Regional and National Significance (PRNS) - Treatment (CSAT);
- Substance Abuse Prevention and Treatment Block Grant (SAPTBG) – (CSAT/CSAP); and
- Health Surveillance and Program Support<sup>1</sup> - SAMHSA.

In addition to the above, the Drug Free Communities Program funds provided by ONDCP through Interagency Agreements with SAMHSA are included as a separate line item on the Table of Prior Year Drug Control Obligations.

Included in this Drug Control Accounting report for FY 2014 are 100% of the actual obligations for these five budget decision units, minus reimbursements. Obligations against funds provided to SAMHSA from the PHS evaluation fund are included. Actual obligations of prior year drug control budgetary resources are derived from the SAMHSA Unified Financial Management System (UFMS), PSC Status of Funds by Allotment and Allowance Report.

**(b) Obligations by Drug Control Function** - SAMHSA distributes drug control funding into two functions, prevention and treatment:

**Prevention:** This total reflects the sum of the actual obligations for:

- CSAP's Programs of Regional and National Significance (PRNS) direct funds, excluding reimbursable authority obligations;
- 20% of the actual obligations of the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funds, including obligations related to receipt of PHS evaluation funds;
- Drug Free Community Program funds provided by Interagency Agreements with ONDCP<sup>2</sup>; and,
- Of the portion from SAMHSA Health Surveillance and Program Support funds, including obligations related to receipt of PHS evaluation funds and Prevention and Public Health Funds, the assumptions are as follows:
  - Public Awareness and Support (PAS) funds were split 50/50 between Substance Abuse (SA) and Mental Health (MH) and 20% of the SA portion is considered Prevention;

<sup>1</sup> The Health Surveillance and Program Support Appropriation funded activities are split between Mental Health/ Substance Abuse as follows: Program Support, Health Surveillance and PQIS are split the same percentage split as between MH/SA appropriations. PAS and Agency-wide are split 50/50 between MH/SA. The subsequent Substance Abuse amounts are then divided into 20% for Prevention and 80% for Treatment.

<sup>2</sup> The Drug Free Community Program is considered part of Prevention, but is reflected as a separate line item on the Table of Prior Year Drug Control Obligations as it is a reimbursable funding amount and not part of direct funding.

- Performance and Quality Information Systems (PQIS) funds were split between MH and SA the same percentage split as between the MH/SA appropriations and 20% of the SA portion is considered Prevention;
- Program Support funds were split between MH and SA the same percentage split as between the MH/SA appropriations and 20% of the SA portion is considered Prevention;
- Health Surveillance funds were split between MH and SA the same percentage split as between the MH/SA appropriations and 20% of the SA portion is considered Prevention; and
- Agency Wide initiatives were split 50/50 between SA and MH and 20% of the SA portion is considered Prevention.

**Treatment:** This total reflects the sum of the actual obligations for:

- CSAT's Programs of Regional and National Significance (PRNS) direct funds, excluding reimbursable authority obligations, but including obligations related to receipt of PHS Evaluation funds;
  - 80% of the actual obligations of the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funds, including obligations related to receipt of PHS Evaluation funds; and,
  - Of the portion from SAMHSA Health Surveillance and Program Support funds, including obligations related to receipt of PHS evaluation funds and Prevention and Public Health Funds, the assumptions are as follows:
    - Public Awareness and Support (PAS) funds were split 50/50 between Substance Abuse (SA) and Mental Health (MH) and 80% of the SA portion is considered Treatment;
    - Performance and Quality Information Systems (PQIS) funds were split between MH and SA the same percentage split as between the MH/SA appropriations and 80% of the SA portion is considered Treatment;
    - Program Support funds were split between MH and SA the same percentage split as between the MH/SA appropriations and 80% of the SA portion is considered Treatment;
    - Health Surveillance funds were split between MH and SA the same percentage split as between the MH/SA appropriations and 80% of the SA portion is considered Treatment; and
    - Agency Wide initiatives were split 50/50 between SA and MH and 80% of the SA portion is considered Treatment.
- (2) **Methodology Modifications** – None.
- (3) **Reprogrammings or Transfers** – SAMHSA entered into Interagency Agreements with ONDCP in the amount of \$90,109,177 to fund activities of the Drug Free Communities Program in FY 2014.
- (4) **Other Disclosures** – None.



NOV 07 2014

**MEMORANDUM TO:** Director  
Office of National Drug Control Policy

**THROUGH:** Norris Cochran  
Deputy Assistant Secretary, Budget

**FROM:** Chief Financial Officer  
Substance Abuse and Mental Health Services Administration

**SUBJECT:** Assertions Concerning Performance Summary Report

In accordance with the requirements of the Office of National Drug Control Policy Circular *Accounting of Drug Control Funding and Performance Summary*, dated January 18, 2013, I make the following assertions regarding the attached Performance Summary Report for National Drug Control Activities:

Performance Reporting System

I assert that SAMHSA has systems to capture performance information accurately and that these systems were properly applied to generate the performance data presented in the attached report.

Explanations for Not Meeting Performance Targets

I assert that the explanations offered in the attached report for failing to meet a performance target are reasonable and that any recommendations concerning plans and schedules for meeting future targets or for revising or eliminating performance targets are reasonable.

Methodology to Establish Performance Targets

I assert that the methodology used to establish performance targets presented in the attached report is reasonable given past performance and available resources.

Performance Measures Exist for All Significant Drug Control Activities

I assert that adequate performance measures exist for all significant drug control activities.

Daryl W. Kade  
Chief Financial Officer

Attachment: FY 2014 Performance Summary Report for National Drug Control Activities

**FY 2014 Performance Summary Report for National Drug Control Activities**

**Decision Unit 1: Substance Abuse Prevention and Treatment Block Grant (SAPTBG)**

Measure 1: Percentage of clients reporting no drug use in the past month at discharge

**Table 1: Measure 1**

<b>FY 2011 Target</b>	<b>FY 2011 Actual</b>	<b>FY 2012 Target</b>	<b>FY 2012 Actual</b>	<b>FY 2013 Target</b>	<b>FY 2013 Actual</b>	<b>FY 2014 Target</b>	<b>FY 2014 Actual</b>	<b>FY 2015 Target</b>
70.3%	76.2% <sup>1</sup>	70%	76.2% <sup>2</sup>	74%	76.3%	74%	TBR 11/2014	74%

- (1) Measure 1 is the percent of clients in public substance abuse treatment programs who report no illegal drug use in the past month at discharge. The measure links directly to a key goal of the SAPTBG Program, which is to assist clients in achieving abstinence through effective substance abuse treatment. This measure reflects the program’s emphasis on reducing demand for illicit drugs by targeting chronic users. Project Officers monitor targets and data on a regular basis, which serves as a focus of discussion with the states, and aids in the management of the program.
- (2) The target for FY 2012 was exceeded with 76.2 percent reporting no drug use at discharge. The target for FY 2013 was also exceeded with 76.3 percent. The results are being monitored closely as the impact of national policy changes is better understood. Because of the lag in the reporting system, actual data for FY 2014 will not be available until November 2014.
- (3) The performance targets for FY 2014 and FY 2015 were set at 74 percent, which is an increase from the (exceeded) FY 2012 target. SAMHSA uses results from previous years as one factor in setting future targets. Changing economic conditions, the implementation of the Affordable Care Act, as well as Medicaid expansion may impact substance abuse treatment programs throughout the country. Fluctuations in outcomes and outputs are expected. SAMHSA continues to work with states to monitor progress and adapt to the needs of targeted groups. Technical assistance is provided as needed.
- (4) The data source for this measure is the Treatment Episode Data Set as collected by the Center for Behavioral Health Statistics and Quality. States are responsible for ensuring that each record contains the required key fields, that all fields contain valid codes, and that no duplicate records are submitted. States cross-check data for consistency across data fields. The internal control program includes a rigorous quality control examination of the data as received from states. Data are examined to detect values that fall out of the expected range, based on the state’s historical trends. If outlier values are detected, the state is contacted and asked to validate the value or correct the error. Detailed instructions governing data collection, review, and cleaning are available at the following

<sup>1</sup> Revised slightly from what was previously reported as data was cleaned and updated.

<sup>2</sup> Revised slightly from what was previously reported as data was cleaned and updated.

links: [http://www.dasis.samhsa.gov/dasis2/manuals/teds\\_adm\\_manual.pdf](http://www.dasis.samhsa.gov/dasis2/manuals/teds_adm_manual.pdf) and [http://www.dasis.samhsa.gov/dasis2/manuals/teds\\_manual.pdf](http://www.dasis.samhsa.gov/dasis2/manuals/teds_manual.pdf).

**Decision Unit 1: Substance Abuse Prevention and Treatment Block Grant (SAPTBG)**

**Measure 2: Percent of states showing an increase in state-level estimates of survey respondents who rate the risk of substance abuse as moderate or great (age 12-17)**

**Table 2: Measure 2<sup>3</sup>**

FY 2011 Target	FY 2011 Historical Actual	FY 2012 Target	FY 2012 Historical Actual	FY 2013 Target	FY 2013 Historical Actual	FY 2014 Target	FY 2014 Historical Actual	FY 2015 Target
47.1%	21.6% <sup>4</sup>	47.1%	25.5% <sup>5</sup>	47.1%	TBR 12/2014	47.1%	TBR 12/2015	19% <sup>6</sup>

(1) Measure 2, for Decision Unit 1 reflects the primary goal of the 20% Prevention Set-Aside of the SAPTBG grant program and supports the first goal of the National Drug Control Strategy: reducing the prevalence of drug use among 12-17 year olds. This measure represents the percentage of states that report improved rates for perceived risk, aggregated for alcohol, cigarettes, and marijuana. The measure of “perceived risk of harm from substance use” has been used to inform prevention policy and programming since the 1960s,<sup>7</sup> as it remains a significant predictor of substance use behaviors<sup>8,9</sup>. For example, “Monitoring the Future, 2008” tracks the trends in perceived risk with substance use since the 1970s<sup>10</sup>. This depicts a consistent pattern of a leading indicator. In addition, a longitudinal study conducted in Iceland found that levels of perceived risk of harm measured at age 14 significantly predicted substance use behaviors at ages 15, 17, and 22<sup>11</sup>. In brief, tracking and monitoring levels of “perceived risk of harm” remains important for informing prevention policy and programming as it can assist with understanding and predicting changes in the prevalence of substance use behaviors nationwide.

<sup>3</sup> Previous data revised for reasons stated in the report.

<sup>4</sup> Revised slightly from what was previously reported as data was cleaned and updated.

<sup>5</sup> Revised slightly from what was previously reported as data was cleaned and updated.

<sup>6</sup> Target revision based on trends seen in reporting of historical actual data.

<sup>7</sup> Bjarnason, T. & Jonsson, S. (2005). Contrast Effects in Perceived Risk of Substance Use. *Substance Use & Misuse*, 40:1733–1748.

<sup>8</sup> Morgan, M., Hibell, B., Andersson, B., Bjarnasson, T., Kokkevi, A., & Narusk, A. (1999). The ESPAD Study: Implications for prevention. *Drugs: Education and Policy*, 6, No. 2.

<sup>9</sup> Elekes, Z., Miller, P., Chomynova, P. & Beck, F. (2009). Changes in perceived risk of different substance use by ranking order of drug attitudes in different ESPAD-countries. *Journal of Substance Use*, 14:197-210.

<sup>10</sup> Johnson, L.D., O’Malley, P.M., Bachman, J.G. and Schulenberg, J.E. (2009) Monitoring the Future national results of adolescent drug use: Overview of key findings 2008 (NIH Publication No. 09-7401), Bethesda MD: National Institute on Drug Abuse; p.12.

<sup>11</sup> Adalbjarnardottir, S., Dofradottir, A. G., Thorolfsson, T. R., Gardarsdottir, K. L. (2003). Substance use and attitudes: A Longitudinal Study of Young People in Reykjavik from Age 14 to Age 22. Reykjavík: F’elagsv’isindastofnun H’ask’ola Íslands.

- (2) In FY 2012, 25.5 percent of states reported increased rates of moderate or great perceived risk in two or more substances. In FY 2011, this measure demonstrated progress from the result of 21.6 percent reported in FY 2011. This finding is substantially affected by perceived risk of marijuana use. Comparing the perceived risk for the three individual substances, over 41 percent of states improved on percentage of respondents reporting perceived moderate to great risk of cigarettes. In contrast, only 17.6 percent improved on the measure for perceived risk of marijuana use. The update for FY 2013 data is due at the end of December 2014.

The data trends for this measure are best understood by examining the measure definition. This measure is not the same as the average rate in those states. Rather, it is the *percentage of states* that improved from the previous year (using the composite perceived risk rate). A state is categorized as improved if it increases its rate of perceived risk on at least two of the three substances targeted (alcohol, cigarettes, marijuana). If a state's rates of moderate or great perceived risk increased for only one of the substances, it is *not* counted as improved. For example, if a state's rate of perceived risk improved for cigarettes and alcohol, it would be counted as improved. Alternatively, if only one or none of the perceived risk rates increased, the state would not be counted as improved, even if all the rates were stable.

Another consideration is that state estimates are based on two years of pooled data. For example, the 2013 estimate is pooled 2013-2014 data. There is a one year overlap which decreases the ability to reflect annual change. Data for a particular fiscal year are reported in the following year. State estimates based on the National Survey on Drug Use and Health (NSDUH) results are reported annually during December. Therefore, the FY 2013 historical actual results for this measure are not yet available. During analysis, one must consider recent contextual factors, such as marijuana legalization and decriminalization, which likely influences the perceived risk of harm from marijuana.

- (3) Program changes during FY 2011 and FY 2012 resulted in a need to monitor the data so that future targets would align with expectations. This measure was initially dropped and then added back due to its important relationship to subsequent substance use. During this lapse, no targets were calculated for future years. Rather than reduce targets to align with the lowest (possibly aberrant) performance report, SAMHSA's Center for Substance Abuse Prevention is closely monitoring the data during FY 2011 – FY 2014. The target for FY 2015 was set based on the data reported. Increased targets are anticipated after FY 2015.
- (4) Data for levels of perceived risk of harm from substance use are obtained annually from NSDUH. The NSDUH survey is sponsored by SAMHSA and serves as the primary source of information on the prevalence and incidence of illicit drug, alcohol, and tobacco use among individuals age 12 or older in the United States<sup>12</sup>. For purposes of measuring SAPTBG performance, a state has improved if levels of perceived risk of harm increase for at least two of the following substances: binge drinking, regular cigarette use, and/or regular marijuana use. Annual performance results are derived by using the following formula:

<sup>12</sup> Information on the data collection and validation methods for the NSDUH can be found at <http://www.samhsa.gov/data/NSDUH/NSDUHMethodsSIMS2012.pdf>

$$\frac{\text{Number of SAPTBG grantees improved}}{\text{Total Number of SAPTBG grantees}} = \text{Performance Result}$$

**Decision Unit 2: Center for Substance Abuse Treatment (CSAT) Programs of Regional and National Significance (PRNS)**

Measure 3: Percent of adults receiving services who had no involvement with the criminal justice system (no past month arrests)

**Table 3: Measure 3**

<b>FY 2011 Target</b>	<b>FY 2011 Actual</b>	<b>FY 2012 Target</b>	<b>FY 2012 Actual</b>	<b>FY 2013 Target</b>	<b>FY 2013 Actual</b>	<b>FY 2014 Target</b>	<b>FY 2014 Actual</b>	<b>FY 2015 Target</b>
95%	96%	95%	96.4%	96%	96.6% <sup>13</sup>	93%	96.5%	93%

- (1) Measure 3 is the percent of clients served by the capacity portion of the PRNS portfolio<sup>14</sup> who report no past month arrests. The programs are designed to help clients receive a comprehensive array of services which promote improved quality of life. This measure reflects success in increasing productivity and remaining free from criminal involvement. This measure relates directly to and supports the national drug control strategy. The results are monitored routinely throughout the period of performance.
- (2) The targets for both FY 2013 and FY 2014 were exceeded with data indicating that 96.6 and 96.5 percent respectively of adults receiving services had no involvement with the criminal justice system.
- (3) The targets for FY 2014 and FY 2015 are 93 percent, which is a slight decrease from the FY 2013 target. The target reduction reflects previous performance and anticipated funding levels. As this decision unit incorporates several different program activities, and because the mix of programs and grantees varies from year to year, adjustments are made accordingly and designed to promote performance improvement over time.
- (4) CSAT is able to ensure the accuracy and completeness of this measure as all data are submitted via the Services Accountability Improvement System (SAIS), a web-based data entry and reporting system. The system has automated built-in checks designed to assure data quality. The SAIS online data entry system uses pre-programmed validation checks to make sure that data skip patterns on the paper collection tool are followed. These validation

<sup>13</sup> Revised from what was previously reported as data was cleaned and verified.

<sup>14</sup> PRNS capacity programs: Targeted Capacity Expansion (TCE)/General, HIV/AIDS Outreach, Addiction Treatment for Homeless Persons, Cooperative Agreements to Benefit Homeless Individuals, Grants for the Benefit of Homeless Individuals-Services in Supportive Housing, Family Drug Courts, Juvenile Drug Courts, Adult Drug Courts, Pregnant and Post-Partum Women, Recovery Community Services – Recovery, Recovery Community Services-State network.

checks ensure that data reported through the online reports are reliable, clean, and free from errors. These processes reduce burden for data processing tasks associated with analytic datasets since the data being entered have already followed pre-defined validation checks.

**Decision Unit 3: Center for Substance Abuse Prevention (CSAP) PRNS**

Measure 4: Percent of program participants that rate the risk of harm from substance abuse as great (all ages)<sup>15</sup>

**Table 4:** Measure 4<sup>16</sup>

FY 2011 Actual	FY 2012 Actual	FY 2013 Target	FY 2013 Actual	FY 2014 Target	FY 2014 Actual	FY 2015 Target
87.0% <sup>17</sup>	88.8% <sup>18</sup>	88.0%	88.1%	88.0%	TBR 8/2015	88.0%

(1) Measure 4 for Decision Unit 3 reflects the goals of CSAP’s PRNS, as well as the National Drug Strategy. CSAP PRNS constitutes a number of discretionary grant programs, such as the Strategic Prevention Framework State Incentive Grants (SPF SIG), the Minority AIDS Initiative (MAI), the STOP Act grant program, and others. For this decision unit, performance on levels of perceived risk was selected to represent CSAP PRNS.

The measure of “perceived risk of harm from substance use” has been used to inform prevention policy and programming since the 1960s,<sup>19</sup> as it remains a significant predictor of substance use behaviors<sup>20, 21</sup>. For example, “Monitoring the Future, 2008” tracks the trends in perceived risk with substance use since the 1970s<sup>22</sup>. This depicts a consistent pattern of a leading indicator. In addition, a longitudinal study conducted in Iceland found that levels of perceived risk of harm measured at age 14 significantly predicted substance use behaviors at ages 15, 17, and 22<sup>23</sup>. Because it can assist in understanding and predicting changes in the

<sup>15</sup> Data from Minority AIDS Initiative (MAI): Substance Abuse Prevention, HIV Prevention and Hepatitis Prevention for Minorities and Minorities Re-entering Communities Post-Incarceration [HIV]

<sup>16</sup> Beginning in FY2013, this is a change from the previous Decision Unit 3, Measure 4 for reasons explained in the report.

<sup>17</sup> Revised from what was previously reported in budget documents as data were cleaned and updated.

<sup>18</sup> Revised from what was previously reported in budget documents as data were cleaned and updated.

<sup>19</sup> Bjarnason, T. & Jonsson, S. (2005). Contrast Effects in Perceived Risk of Substance Use. *Substance Use & Misuse*, 40:1733–1748.

<sup>20</sup> Morgan, M., Hibell, B., Andersson, B., Bjarnasson, T., Kokkevi, A., & Narusk, A. (1999). The ESPAD Study: Implications for prevention. *Drugs: Education and Policy*, 6, No. 2.

<sup>21</sup> Elekes, Z., Miller, P., Chomynova, P. & Beck, F. (2009). Changes in perceived risk of different substance use by ranking order of drug attitudes in different ESPAD-countries. *Journal of Substance Use*, 14:197-210.

<sup>22</sup> Johnson, L.D., O’Malley, P.M., Bachman, J.G. and Schulenberg, J.E. (2009) Monitoring the Future national results of adolescent drug use: Overview of key findings 2008 (NIH Publication No. 09-7401), Bethesda MD: National Institute on Drug Abuse; p.12.

<sup>23</sup> Adalbjarnardottir, S., Dofradottir, A. G., Thorolfsson, T. R., Gardarsdottir, K. L. (2003). Substance use and attitudes: A Longitudinal Study of Young People in Reykjavik from Age 14 to Age 22. Reykjavík: F’elagsv’isindastofnun H’ask’ola ‘Islands.

prevalence of substance use behaviors nationwide, tracking and monitoring levels of “perceived risk of harm” remains important. It informs prevention policy and programming.

Measure 4 has been revised to be consistent with the program’s current performance measurement efforts. It combines all ages and reports only those respondents perceiving great risk of harm. In FY 2013, 88.1 percent of program participants rated the risk of substance abuse as great.

Previously, SAMHSA reported the percent of program participants (age 18 and up) that rate the risk of substance abuse as moderate or great, which measures increased levels of perceived moderate or great risk of harm from substance use. The percentage of MAI program participants perceiving moderate or great risk of harm from cigarette, alcohol, and marijuana use increased (among those with matched baseline and exit data) by almost ten percentage points between FY 2010 and FY 2013. Because this finding remained so high over three years, SAMHSA changed the measure and now reports only perceived great risk of harm. It is believed that this change addresses the ceiling effect.

- (2) At the request of the Office of Management and Budget (OMB) and the Department of Health and Human Service’s Office of the Assistant Secretary for Financial Resources, SAMHSA underwent a performance measure reduction effort designed to decrease the total number of performance measures. As a result, the measure previously used for Decision Unit 3, Measure 4 was removed from SAMHSA’s current budget measure portfolio. SAMHSA believes that this new replacement provides a more global indicator that does not separate-out age groups (such as youth vs. adults) and only reports perceived great risk. The new measure is included in Budget and Performance Summary that accompanies the FY 2015 National Drug Control Strategy, released on July 2, 2014.
- (3) The performance targets for FY 2014 and FY 2015 were set at 88% for each year. Performance targets were set using results from previous years combined.
- (4) Data for MAI are collected by the grantees through OMB approved survey instruments. Measures used include items from other validated instruments, such as Monitoring the Future and NSDUH. Grantees collect and then enter their data using an online data entry system. The data are processed, cleaned, analyzed and reported under the Data Collection Analysis and Reporting contract. Data are checked for completeness and accuracy using a set of uniform cleaning rules. Information about any data problems or questions is transmitted to the Contracting Officer’s Representative and task lead, who work with the program Government Project Officers and grantees on a resolution. Grantees also receive instructions on the data collection protocols at grantee meetings and through survey administration guides. Other performance results reflect the proportion of matched baseline-exit surveys that show an increase in levels of perceived risk-of-harm for those engaging in at least one of the following behaviors: binge drinking, regular cigarette use and regular marijuana use.