DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

January 10, 2017

TO: Daryl W. Kade
Director
Center for Behavioral Health Statistics and Quality
Substance Abuse and Mental Health Services Administration

Deepa Avula
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 2016 Detailed Accounting Submission and Performance Summary Report for National Drug Control Activities and Accompanying Required Assertions (A-03-17-00353)

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, 2016. We also reviewed the Performance Summary Report, which includes management's assertions and related performance information for the fiscal year ended September 30, 2016. 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 2016 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 Amy J. Frontz, Assistant Inspector General for Audit Services, at (202) 619-1157 or through email at Amy.Frontz@oig.hhs.gov. Please refer to report number A-03-17-00353 in all correspondence.

Attachments

Substance Abuse and Mental Health Services Administration
SAMHSA
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NOV 10 2016

To: Director
Office of National Drug Control Policy (ONDCP)

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

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

Subject: Assertions Concerning Drug Control Accounting

In accordance with the requirements of the ONDCP Circular *Accounting of Drug Control Funding and Performance Summary*, dated January 18, 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 that 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 SAMHSA's financial plan to include funds received from ONDCP in support of the Drug Free Communities Program. SAMHSA had no reportable reprogramming in FY 2016.

Fund Control Notices

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

Deepa Avula
Chief Financial Officer

Attachments

- FY 2016 Drug Control Obligations
- FY2016 Exhibit A – Drug Control Methodology

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

FY 2016 Drug Control Obligations

(Dollars in millions)

Drug Resources by Decision Unit and Function	
Programs of Regional and National Significance (PRNS)	
Prevention [1]	*210.7*
Treatment [1]	*334.2*
Total, PRNS	**$544.9**
Substance Abuse Prevention and Treatment Block Grant (SABG)	
Prevention [2]	*371.6*
Treatment [2]	*1,486.5*
Total, SABG	**$1,858.1**
Health Surveillance and Program Support (HSPS)	
Prevention [3]	*20.5*
Treatment [3]	*82.0*
Total, HSPS	**$102.5**
Total Funding	**$2,505.5**
Drug Resources Personnel Summary	
Total Full Time Equivalents (FTEs) [4]	*411*
Drug Resources as a Percent of Budget	
Total Agency Budget [5] *(in billions)*	*$3.8*
Drug Resources Percentage [6]	*66.3%*
Drug Free Communities Program [7]	**$91.2**
Total with Drug Free Communities	**$2,596.7**

Footnotes:

[1] 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 Public Health Services (PHS) evaluation fund.

[2] SABG obligations include funds provided to SAMHSA from the PHS evaluation fund.

[3] 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.

*[4] SAMSHA's FY 2016 final FTEs (620) * Drug Resources Percentage (66.3%) = 411 Drug Resources FTE.*

[5] Total Agency Budget does not include Drug Free Communities Program funding.

[6] Not precise due to rounding to 1,000s.

[7] Drug Free Communities Program funding was provided to SAMHSA/Center of Substance Abuse Prevention (CSAP) via Interagency Agreements.

Exhibit A

1) **Drug Methodology** - Actual obligations of prior-year drug control budgetary resources are derived from the SAMHSA Unified Financial Management System (UFMS), Program Support Center (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 18th, 2013. These units are:

- PRNS-Prevention (CSAP);
- PRNS-Treatment (Center of Substance Abuse Treatment (CSAT));
- SABG-CSAT/CSAP; and
- HSPS[1] - 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 2016 are 100 percent 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 UFMS, PSC Status of Funds by Allotment and Allowance Report.

b. **Obligation 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 PRNS direct funds, excluding reimbursable authority obligations;
- 20 percent of the actual obligations of the SABG funds, including obligations related to receipt of PHS evaluation funds;
- Drug Free Communities Program funds provided by Interagency Agreements with ONDCP[2]; and,
- Of the portion from SAMHSA HSPS funds, including obligations related to receipt of PHS evaluation funds and Prevention and Public Health Funds (PPHF), 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 percent of the SA portion is considered Prevention;

[1] The HSPS appropriation funded activities are split between MH and SA as follows: Program Support, Health Surveillance, and Performance and Quality Information Systems (PQIS) are split the same percentage split as between MH and SA appropriations. PAS and Agency-wide are split 50/50 between MH and SA. The subsequent SA amounts are then divided into 20 percent for Prevention and 80 percent for Treatment.

[2] The Drug Free Communities 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.

- PQIS funds were split between MH and SA, the same percentage split as between the MH and SA appropriations and 20 percent of the SA portion is considered Prevention;
- Program Support funds were split between MH and SA, the same percentage split as between the MH and SA appropriations and 20 percent of the SA portion is considered Prevention;
- Health Surveillance funds were split between MH and SA, the same percentage split as between the MH and SA appropriations and 20 percent of the SA portion is considered Prevention; and
- Agency-wide initiatives were split 50/50 between SA and MH and 20 percent of the SA portion is considered Prevention.

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

- CSAT's PRNS direct funds, excluding reimbursable authority obligations, but including obligations related to receipt of PHS Evaluation funds;
- 80 percent of the actual obligations of the SABG funds, including obligations related to receipt of PHS Evaluation funds; and,
- Of the portion from SAMHSA HSPS funds, including obligations related to receipt of PHS evaluation funds and PPHF, the assumptions are as follows:
  - PAS funds were split 50/50 between SA and MH and 80 percent of the SA portion is considered Treatment;
  - PQIS funds were split between MH and SA, the same percentage split as between the MH and SA appropriations and 80 percent of the SA portion is considered Treatment;
  - Program Support funds were split between MH and SA, the same percentage split as between the MH and SA appropriations and 80 percent of the SA portion is considered Treatment;
  - Health Surveillance funds were split between MH and SA, the same percentage split as between the MH and SA appropriations and 80 percent of the SA portion is considered Treatment; and
  - Agency Wide initiatives were split 50/50 between SA and MH and 80 percent of the SA portion is considered Treatment.

2) **Methodology Modifications** – None.

3) **Reprogrammings or Transfers** – SAMHSA had no reportable reprogramming in FY 2016.

4) **Other Disclosures** – None.

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NOV 30 2016

TO: Director, Office of National Drug Control Policy

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

SUBJECT: Assertions Concerning Performance Summary Report

Information regarding SAMHSA's drug control performance efforts is based on data collected as part of agency GPRMA reporting requirements and other information that measures the agency's contribution to the Strategy. When possible, analyses integrate performance data with evaluation findings and other evidence. The tables in the summary reports include performance measures the latest year for which data are available.

In collaboration with state agencies, SAMHSA defined a core set of standardized National Outcome Measures (NOMs) that are monitored across SAMHSA programs. NOMs have been identified for both treatment and prevention programs. NOMS share common methodologies for data collection and analysis. SAMHSA continues to use online data collection and reporting systems.

In addition to centralized GPRMA reporting at the agency level, each SAMHSA program center currently operates its own data management system. Each system includes methodologies for ensuring the reliability and validity of the data for measures reported. In order to effectively manage SAMHSA's grant portfolio and provide timely, accurate information to stakeholders and to Congress, SAMHSA will begin utilizing a unified data collection reporting system, otherwise known as the SAMHSA Performance Accountability Reporting System (SPARS) in February 2017. SPARS is intended to provide a unified data entry, data validation and verification, data management, data utilization, data analysis support, and automated reporting system for discretionary grants.

In accordance with the requirements of the Office of National Drug Control Policy Circular *Accounting of Drug Control Funding and Performance Summary*, dated January 18th, 2013, consistent with the assertions made by the Center for Substance Abuse and Treatment (CSAT) and the Center for Substance Abuse and Prevention (CSAP) to the Center for Behavioral Health, Statistics and Quality (CBHSQ), I make the following assertions regarding the attached Performance Summary Report for National Drug Control Activities:

NOV 30 2016

Performance Reporting Systems

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
Director,
Center for Behavioral Health Statistics and Quality

Attachment:
FY 2016 Performance Summary Report for National Drug Control Activities

FY 2016 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

FY 2013 Target	FY 2013 Actual	FY 2014 Target	FY 2014 Actual	FY 2015 Target	FY 2015 Actual	FY 2016 Target	FY 2016 Actual	FY 2017 Target
74%	74.8%[1]	74%	72.9%	74%	TBR 11/2016	74%	TBR 11/2017	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 2014 was not met. The results are being monitored closely to provide necessary technical assistance to states and jurisdictions as the impact of national policy changes is better understood. The target for FY 2013 was also exceeded with 74.8 percent reporting no drug use at discharge. Because of the lag in the reporting system, actual data for FY 2015 will not be available until November 2016 and the FY 2016 data will not be available until November 2017.

(3) The performance targets for FY 2016 and FY 2017 were set at 74 percent. 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.

[1] Revised slightly from what was previously reported as data was cleaned and updated.

(4) The data source for this measure is the **Treatment Episode Data Set (TEDS)** 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 links: http://wwwdasis.samhsa.gov/dasis2/manuals/teds_adm_manual.pdf and http://wwwdasis.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

FY 2013 Target	FY 2013 Actual	FY 2014 Target	FY 2014 Actual	FY 2015 Target	FY 2015 Actual	FY 2016 Target	FY 2016 Actual	FY 2017 Target
47.1%	19.6%	47.1%	35.3%	19%	TBR 12/2016	19%	TBR 12/2017	19%

(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 increased 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,[2] as it remains a significant predictor of substance use behaviors.[3] For example, "Monitoring the Future, 2008" tracks the trends in perceived risk with substance use since the 1970s.[4] 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.[5] 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.

(2) In FY 2014, 35.3 percent of states reported increased rates of moderate or great perceived risk in two or more substances. Although the actual did not meet the target in FY 2014, the percentage of perceived risk (actual) is higher than FY2013.

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 rate 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.

[2]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.

[3]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.

[4] Johnson, L.D., O'Malley, P.M., Bachman, J.G. and Schulenberg, J.E. (2009) Monitoring the Future national results of adultescent drug use: Overview of key findings 2008 (NIH Publication No. 09-7401), Bethesda MD: National Institute on Drug Abuse; p.12.

[5]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. Reykjav´ık: F´elagsv´ısindastofnun H´ask´ola ´Islands.

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 2015 historical actual results for this measure are not yet available and FY 2016 won't be reported until December 2017.

(3) The general trend of lower numbers associated with perceived risk (not meeting targets) may be associated with recent contextual factors, such as marijuana legalization and decriminalization. Future targets take into account this change in environment which may be associated with lower rates of perceived risk. The updated historical actual data for FY 2015 is due at the end of December, 2016.

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 2015. The targets for FY 2015, FY 2016, and FY 2017 were set based on the historical actual data reported. We anticipate future targets will be met as they better align with the changing environment due to marijuana laws. Right now, it is too early to know how the changing marijuana laws will impact future targets, so no changes are being proposed.

(4) **Data for levels of perceived risk of harm from substance use are obtained annually from National Survey on Drug Use and Health (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.[6] 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:

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

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)

[6] Information on the data collection and validation methods for the NSDUH can be found at http://www.samhsa.gov/data/sites/default/files/NSDUH-RedesignChanges-2015.pdf

Table 3: Measure 3

FY 2013 Target	FY 2013 Actual	FY 2014 Target	FY 2014 Actual	FY 2015 Target	FY 2015 Actual	FY 2016 Target	FY 2016 Actual	FY 2017 Target
96%	96.5%	93%	96.5%[7]	93%	TBR 12/2016	93%	TBR 12/2017	93%

(1) Measure 3 is the percent of clients served by the capacity portion of the PRNS portfolio[8] 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 96.5 of adults receiving services had no involvement with the criminal justice system. CSAT anticipates that data for FY 2015 and FY 2016 will be available in December 2016 and 2017 respectively, for reporting actual results.

(3) The targets for FY 2014, FY 2015, FY 2016, and FY 2017 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 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) Programs of Regional and National Significations (PRNS)

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

[7] Revised from what was previously reported as data was cleaned and verified.

[8] PRNS capacity programs: HIV/AIDS Outreach, Pregnant Postpartum Women, Recovery Community Services Program - Services, Recovery-Oriented Systems of Care, SAT-ED, TCE/HIV, Targeted Capacity Expansion, Targeted Capacity Expansion- Health Information Technology, Targeted Capacity Expansion- Peer to Peer, Targeted Capacity Expansion- Technology Assisted Care, and Crisis Support programs.

Table 4: Measure 4

FY 2013 Target	FY 2013 Actual	FY 2014 Target	FY 2014 Actual	FY 2015 Target	FY 2015 Actual	FY 2016 Target	FY 2016 Actual	FY 2017 Target
88%	88.1%	88%	87.3%	88%	90.6%	88%	TBR 2/2017	88%

(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,[9] as it remains a significant predictor of substance use behaviors[10]. For example, "Monitoring the Future, 2008" tracks the trends in perceived risk with substance use since the 1970s. [10] 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[11]. Because it can assist in understanding and predicting changes in the prevalence of substance use behaviors nationwide, tracking and monitoring levels of "perceived risk of harm" remains important. It informs prevention policy and programming.

(2) 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 2014, 87.3 percent of program participants rated the risk of substance abuse as great. This is a slight but not significant decrease from the 2014 target of 88%. One possible explanation for the slight reduction in FY 2014 is the changing laws around marijuana use, which may be decreasing perceived risk. However, the 2015 actual, 90.6%, slightly exceeds the target of 88% showing the perceived risk is more in alignment with earlier years in terms of meeting targets. The increased perceived risk may be associated with stronger prevention efforts to demonstrate the risk of substance misuse.

[9] Bjarnason, T. & Jonsson, S. (2005). Contrast Effects in Perceived Risk of Substance Use. *Substance Use & Misuse*, 40:1733–1748.

[10] 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.

[11] 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. Reykjav´ık: F´elagsv´ısindastofnun H´ask´ola ´Islands.

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 and provides more meaningful feedback.

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.

(3) The performance targets for FY 2016 and FY 2017 were set at 88% for each year. Performance targets were set using analysis of the results from previous years combined with expected resources.

(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 entered, processed, cleaned, analyzed and reported under the **Program Evaluation for Prevention Contract (PEP-C)**. 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.