DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

January 18, 2013

TO: Daryl Kade
Director
Office of Financial Resources
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 2012 Performance Summary Report for National Drug Control Activities and Accompanying Required Assertions (A-03-13-00352)

This report provides the results of our attestation review of the Substance Abuse and Mental Health Services Administration (SAMHSA) Performance Summary Report for National Drug Control Activities and accompanying required assertions for fiscal year (FY) 2012.

Each National Drug Control Program agency must submit to the Director of the Office of National Drug Control Policy (ONDCP) an annual evaluation of the progress by the agency with respect to drug control program goals using the performance measures established for that agency (21 U.S.C. § 1703(b)(13)). The Federal statute authorizes ONDCP to "monitor implementation of the National Drug Control Program, including – (A) conducting program and performance audits and evaluations." ONDCP may request "assistance from the Inspector General of the relevant agency in such audits and evaluations" (section 1703(d)(7)). Section 7 of the ONDCP Circular entitled *Drug Control Accounting,* dated May 1, 2007, provides the reporting requirements to comply with section 1703(b)(13). Section 8 of the ONDCP Circular requires that each report defined in section 7 must be provided to the Office of Inspector General to express a conclusion about the reliability of each assertion made in each Performance Summary Report for National Drug Control Activities.

As authorized by section 1703(d)(7) of the Federal statute, and in compliance with the Circular, ONDCP requested that we perform this review. Accordingly, we reviewed the attached SAMHSA report entitled "FY 2012 Performance Summary Report for National Drug Control Activities" and accompanying required assertions, dated November 30, 2012. 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. A 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.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION PERFORMANCE SUMMARY REPORT

SAMHSA's report included assertions for four measures for National Drug Control Program activities. The four measures were (1) percent of clients reporting no drug use in the past month at discharge, (2) percent of States showing an increase in State-level estimates of survey respondents (aged 12–17) who rate the risk of substance abuse as moderate or greater, (3) percent of adults receiving services who had no involvement with the criminal justice system (no past-month arrests), and (4) percent of program participants (aged 18 and up) who rate the risk of substance abuse as moderate or great.

In accordance with ONDCP requirements, SAMHSA made the following assertions:

- SAMHSA's performance reporting system was sufficient;
- SAMHSA's explanations for not meeting performance targets, and plans and recommendations for meeting targets, were reasonable;
- SAMHSA's methodology to establish performance targets was reasonable; and
- performance measures exist for all significant drug control activities.

We performed review procedures on the performance summary report and accompanying required assertions. In general, we limited our review procedures to inquiries and analytical procedures appropriate for our attestation review.

OFFICE OF INSPECTOR GENERAL CONCLUSION

Based on our review, nothing came to our attention that caused us to believe that SAMHSA's performance summary report for FY 2012 and management's assertions accompanying its report were not fairly stated, in all material respects, based on the ONDCP Circular.

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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. Please refer to report number A-03-13-00352 in all correspondence.

Attachment

ATTACHMENT

Substance Abuse and Mental Health Services Administration
SAMHSA
1 Choke Cherry Road • Rockville, MD 20857
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

MEMORANDUM TO: Director
Office of National Drug Control Policy

NOV 30 2012

THROUGH: Norris Cochran
Deputy Assistant Secretary, Budget

FROM: Director, Office of Management, Analysis and Coordination
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 "Drug Control Accounting," I make the following assertions regarding the attached Performance Summary Report for National Drug Control Activities:

Performance Reporting System

I assert that SAMHSA has a system to capture performance information accurately and that this system was 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.

Shelly K. Hara
Director, Office of Management, Analysis, and Coordination

Attachment:
FY 2012 Performance Summary Report for National Drug Control Activities

FY 2012 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 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2012 Target	FY 2012 Actual	FY 2013 Target
75.7%	70.3%	76.8%[1]	70.3%	TBR 12/2012	70%	To be reported Nov. 2013	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 relates directly to a key goal of the Block Grant Program, that is, to assist clients in achieving abstinence through effective substance abuse treatment. This measure allows SAMHSA to gauge the extent to which this program addresses its key objective. This measure reflects program emphasis on reducing demand for illicit drugs by targeting chronic users. Project Officers review and monitor data on a regular basis, which serves as a focus of discussion with the States, as well as utilizing it in management of the program.

(2) The target for FY 2010 has been exceeded with 76.8% reporting abstinence from drug use at discharge.

(3) The performance targets for FY 2011 and FY 2012 were both set at approximately 70%. Changing economic conditions, especially at the State level, can be expected to negatively impact substance abuse treatment programs throughout the country, thus stability in program outcomes and outputs is somewhat questionable. SAMHSA will continue to work with States to monitor progress in accomplishing treatment goals and will provide technical assistance as needed. The FY 2010 target was exceeded.

(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 reviewing the quality of their data. Each State is responsible for ensuring that each record in the data submission contains the required key fields, that all fields in the record contain valid codes, and that no duplicate records are submitted. States are also responsible for cross-checking data items for consistency across data fields. The internal control program consists of a rigorous quality control examination of the data as they are received from States. They are examined to detect values that fall out of the expected range based on the State's historical trend. If such outlier values are detected the State is contacted to validate the value or correct the error. Detailed instructions governing data collection, review, and cleaning are available at the following links:

[1] Previous figures for the FY 2010 actual were revised during November 2012 using additional data.

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 greater (age 12-17)

Table 2: Measure 2

FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2012 Target	FY 2012 Actual	FY 2013 Target
58.8%	45.1%	17.6%	47.1	Not Available until at least 12/2012	47.1	Not available yet	47.1

(1) Measure 2, for Decision Unit 1 (SAPTBG) 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. The measure of "perceived risk of harm from substance use" has been used to inform prevention policy and programming since the 1960s[2],[3] as it remains a significant predictor of substance use behaviors[4,5]. For example, "Monitoring the Future, 2008" tracks the trends in perceived risk with substanace use since the 1970s[6]. 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[7]. In brief, tracking and monitoring levels of "perceived risk of harm" remains critical for informing prevention policy and programming as it can assist with understanding and predicting changes in the prevalence of substance use behaviors nationwide.

This measure represents the percentage of States that reported improved rates for perceived risk, aggregated for alcohol, cigarettes, and marijuana. This is not the same as the average rate in those States. Rather, it reflects the percentage of States who improved from the previous year on the composite perceived risk rate. Data shows that the percentage of States who improved on this measure increased from 45.1% to 56.9% during FY 2007 – FY 2009 and then dropped to 17.6% during FY 2010. This change is best understood by examining the measure definition. This measure is not the same as the average rate in those States but is the *percentage of States* that improved from the previous year (using the composite perceived

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[2] Cuijpers, Pim. (2003). Three decades of drug prevention research. Drugs: Education, Prevention and Policy 10:7–20.
[3] Bjarnason, T. & Jonsson, S. (2005). Contrast Effects in Perceived Risk of Substance Use. *Substance Use & Misuse*, 40:1733–1748.
[4] 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.
5 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.
[6] 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.
[7] 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.

risk rate). It is not unexpected that a ceiling will sometimes be reached in a measure of this kind. The FY 2010 decline is also consistent with national trends. For example, according to the FY 2010 NSDUH data, the proportion of youths aged 12 to 17 who reported perceiving great risk from smoking one or more packs of cigarettes per day increased from 63.1% during FY 2002 to 69.7% during FY 2008 then declined over the next two years. A similar phenomena was seen with SAMHSA's NSDUH measurements for the percentage of youths aged 12 to 17 at great risk for smoking marijuana once or twice per week also decreased from 54.7 percent in FY 2007 to 47.5% in FY 2010.

Despite the solitary FY 2010 decline, perceived risk over the past ten years has remained stable or increased for most substances. Rather than reduce the target to align with the lowest (possibly aberrant) performance report, CSAP has chose to slightly increase the target to 47.1% as a reflection of the positive trend from the three previous years. Because NSDUH and state estimates have not been reported yet, SAMHSA will maintain the 47.1% target for FY 2012 and FY 2013.

(2) Unfortunately, 2011 State estimates will not be available until December, 2012, at the earliest. Therefore, FY 2011 results cannot be provided at this time. SAMHSA did not reduce the target based on FY 2010 results because it appeared that these results mimicked national trends. SAMHSA did not want to reduce the target if this was also an aberrant result. SAMHSA is confident that the FY 2011 results will return to previous levels. If not, future targets will be reconsidered. All opportunities for understanding and overcoming the FY 2010 decline are being explored. Right now, there is no obvious programmatic change that would dramatically influence performance. Analysis will be strengthened as soon as the FY 2011 Actuals are reported.

(3) The FY 2014 Justification will include five GPRA measures reflecting alcohol and illicit drug prevalence rates and Synar violation rates. The perceived risk measures have been eliminated as GPRA measures, but will continue to be collected as a valid indicator of performance.

(4) Data for levels of perceived risk of harm from substance use are obtained annually from the National Survey on Drug Use and Health State estimates (NSDUH; SAMHSA, 2012). The NSDUH is sponsored by the 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[8]. For purposes of measuring SAPT Block Grant 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:

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

[8] Information on the data collection and validation methods for the NSDUH can be found at http://www.oas.samhsa.gov/nhsda/methods.cfm.

Decision Unit 2: 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

FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2012 Target	FY 2012 Actual	FY 2013 Target
96%	95%	96%	95%	96%	95%	96.4%	96%

(1) Measure 3 is the percent of clients served by the capacity portion of the PRNS portfolio[9] who report no past month arrests. A key component of the Program is to ensure that clients receive a comprehensive array of services to achieve improvements in quality of life. This measure supports a primary objective of assisting clients to increase productivity and remain free from criminal involvement. In addition, this measure relates directly to and supports the national drug control strategy.

This measure of percentage of clients with no past month arrests is monitored routinely throughout the period of performance for the program.

(2) CSAT was able to meet the target for FY 2012 at 96.4%.

(3) The target for FY 2013 is 96%. Targets are set based on trends seen in previous performance and anticipated funding levels (i.e. in general, the number served would be expected to go up if funding increases and decline if funding decreases). Further, this decision unit incorporates several different program activities. Because the mix of programs and grantees varies from year to year, adjustments are made in the target methodology.

(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 to ensure data quality.

9 PRNS capacity programs: Targeted Capacity Expansion (TCE)/General, HIV/AIDS Outreach, Addiction Treatment for Homeless Persons, Assertive Adolescent and Family Treatment, Family Drug Courts, Juvenile Drug Courts, Adult Drug Courts, Young Offender Re-entry Program, Pregnant and Post-Partum Women, Recovery Community Services – Recovery, Recovery Community Services – Facilitating, Co-Occurring State Incentive Grants, and Child and Adolescent State Incentive Grants.

Decision Unit 3: CSAP Programs of Regional and National Significance (PRNS)

Measure 4: Percent of program participants (age 18 and up) that rate the risk of substance abuse as moderate or great[10]

Table 4: Measure 4

FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2012 Target	FY 2012 Actual	FY 2013 Target
95.3%	93%	95.8%	95%	96.3%	95%	Not available yet	

(1) Measure 4 for Decision Unit 3 reflects the goals of CSAP's Programs of Regional and National Significance (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 from the MAI 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[11] as it remains a significant predictor of substance use behaviors[12,13,14]. For example, Monitoring the Future, 2008 tracks the trends in perceived risk with substance use since the 1970s. This depicts a consistent pattern for a leading indicator[15]. 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[16]. In brief, tracking and monitoring levels of "perceived risk of harm" remains critical for informing prevention policy and programming as it can assist with understanding and predicting changes in the prevalence of substance use behaviors nationwide.

(2) The MAI grant program continues to successfully impact participants resulting in observed increases in levels of perceived risk of harm from substance use among adults. As a result, the program has been able to meet or exceed its annual performance targets. Based on performance results from the MAI grantees, data show that perceptions of risk are significantly influenced by age, race, and individual-level experiences with substance

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

[11] Cuijpers, Pim. (2003). Three decades of drug prevention research. Drugs: Education, Prevention and Policy 10:7–20.

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

[13] 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.

[14] 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.

[15] 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

[16] 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.

use—findings that are directly aligned with previous research[17]. Additional findings suggest that service types (e.g., individual-level counseling, group-level workshops) may also affect perceived levels of risk of harm between baseline and exit. For example, the "Brief Alcohol Screening and Intervention for College Students (BASICS)" program emerged as the most successful intervention for minorities across substance use and HIV prevention outcomes and resulted in a 37% increase in participants who perceive great risk, especially regarding unprotected sex. Additionally, examination of follow-up data for the grant program revealed continued improvements after the cessation of services. For example, the percentage of participants perceiving moderate or great risk of harm from binge drinking increased from 81.5% at baseline to 87.7% at exit and 89.8% at follow-up. Similarly, the percentage perceiving the same level of risk of harm from marijuana use increased from 67.6% at baseline to 77.5% at exit and 80.1% at follow-up. In both cases, the improvement between program exit and follow-up was statistically significant.

(3) At the request of the Office of Management and Budget (OMB), and the Office of the Assistant Secretary for Financial Resources (HHS/ASFR), SAMHSA underwent a GPRA reduction in an attempt to decrease the total number of GPRA measures. As part of this exercise, the measure for perceived levels of risk of harm among adults was replaced with a more global measure that does not separate out age groups (i.e. youth vs. adults) and is limited to those reporting only great perceived risk.

(4) Data for the MAI are collected by the grantees through OMB approved survey instruments. Measures used in these instruments include items from other validated instruments such as Monitoring the Future and NSDUH. Grantees typically collect data and enter these into an online data entry system. Data received have been processed, cleaned, analyzed and reported by the Data Analysis Coordination and Consolidation Center (DACCC). The DACCC reviewed the data for completeness and accuracy using a set of uniform cleaning rules. Information on any data problems identified is transmitted to the COR and task lead, who work with the program Government Project Officers and grantees to identify a resolution. Grantees also receive instruction on the data collection protocols at grantee meetings and through survey administration guides. This function will be continued under the Data Collection Analysis and Reporting contract (DCAR).

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. The formula is shown below:

$$\frac{Number\ of\ MAI\ participants\ improved}{Total\ Number\ of\ MAI\ participants\ with\ matched\ data} = Performance\ Result.$$

[17] Elekes, Z., Miller, P., Chomynova, P. & Beck, F. (2009). Perceived risks of alcohol and illicit drugs: relation to prevalence of use on individual and country level. *Journal of Substance Use, 14*: 250-264.