



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



January 15, 2021

TO: Krishnan Radhakrishnan
Director, Center for Behavioral Health Statistics and Quality
Substance Abuse and Mental Health Services Administration

Deepa Avula
Chief of Staff/Director
Office of Financial Resources
Substance Abuse and Mental Health Services Administration

FROM: /Amy J. Frontz/
Deputy Inspector General for Audit Services

SUBJECT: Independent Attestation Review: Substance Abuse and Mental Health Services Administration Fiscal Year 2020 Detailed Accounting Report, Performance Summary Report for National Drug Control Activities, Budget Formulation Compliance Report, and Accompanying Required Assertions (A-03-21-00353)

This report provides the results of our review of the attached Substance Abuse and Mental Health Services Administration (SAMHSA) Office of National Drug Control Policy (ONDCP) Detailed Accounting Report, which includes the table of Drug Control Obligations, related disclosures, and management's assertions for the fiscal year ended September 30, 2020. We also reviewed the Performance Summary Report, which includes management's assertions and related performance information for the fiscal year ended September 30, 2020. Lastly, we reviewed the Budget Formulation Compliance Report, which includes budget formulation information for the fiscal year ending September 30, 2022, and the Chief Financial Officer's or accountable senior executive's assertions relating to the budget formulation information. SAMHSA management is responsible for, and submitted, the Detailed Accounting Report, Performance Summary Report, and Budget Formulation Compliance Report, which were prepared in accordance with the ONDCP Circular *National Drug Control Program Agency Compliance Reviews*, dated October 22, 2019 (ONDCP Compliance Reviews Circular). It is our responsibility to express a conclusion about the reliability of management's assertions based on our review.

We performed this review as required by 21 U.S.C. § 1704(d)(1) and as authorized by 21 U.S.C. § 1703(d)(7) and in compliance with the ONDCP Compliance Reviews Circular.

We conducted our review in accordance with attestation standards established by the American Institute of Certified Public Accountants and the standards applicable to attestation engagements, as described in the U.S. Government Accountability Office (GAO) publication, *Government Auditing Standards* (July 2018). Those standards require that we plan and perform the review to obtain limited assurance about whether any material modifications should be made to management's assertions to be in accordance with the criteria. A review is substantially less in scope than an examination, the objective of which is to obtain reasonable assurance and express an opinion about whether management's assertions are in accordance with the criteria in all material respects. Accordingly, we do not express such an opinion. We believe that our review provides a reasonable basis for our conclusion.

Based on our review, we are not aware of any material modifications that should be made to SAMHSA's Detailed Accounting Report and Performance Summary Report for fiscal year 2020 and SAMHSA's Budget Formulation Compliance Report for fiscal year 2022 for them to be in accordance with the ONDCP Compliance Reviews Circular.

SAMHSA's Detailed Accounting Report, Performance Summary Report, and Budget Formulation Compliance Report assertions¹ are included as Attachments A, B, and C, respectively.

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. It is not intended to be, and should not be, used by anyone other than those specified parties. If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Carla J. Lewis, Assistant Inspector General for Audit Services, at (202) 205-9125 or at Carla.Lewis@oig.hhs.gov. Please refer to report number A-03-21-00353 in all correspondence.

Attachments

¹ Only the Budget Formulation report assertions are included as Attachment C since the report contains prospective information.



Substance Abuse and Mental Health
Services Administration

5600 Fishers Lane • Rockville, MD 20857

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DATE: December 14, 2020

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: Detailed Accounting Report

In accordance with the requirements of the *ONDCP Circular: National Drug Control Program Agency Compliance Reviews*, dated October 22, 2019, 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.

Material Weaknesses or Other Findings

I assert there are no material weaknesses or other findings from previous years reporting.

Methodology Modifications

I assert there are no methodology modifications for reporting drug control resources from previous year's reporting.

Reprogramming or Transfers

As of Oct 1, 2020, The Office of National Drug Control Policy Drug Free Communities Programs have been transferred to the Centers for Disease Control and are no longer managed by SAMHSA.

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 2020 Drug Control Obligations
- FY 2020 Exhibit A – Drug Control Methodology

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
FY 2020 Drug Control Obligations
(Dollars in millions)

Drug Resources by Decision Unit and Function

Programs of Regional and National Significance (PRNS)

<i>Prevention</i> ¹	206.4
<i>Treatment</i> ¹	1,979.60
Total, PRNS	\$2,186.0

Substance Abuse Prevention and Treatment Block Grant (SABG)

<i>Prevention</i> ²	371.6
<i>Treatment</i> ²	1,486.40
Total, SABG	\$1,858.0

Health Surveillance and Program Support (HSPS)

<i>Prevention</i> ³	22.81
<i>Treatment</i> ³	91.24
Total, HSPS	\$114.1

Total Funding	\$4,158.1
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Drug Resources Personnel Summary

<i>Total Full Time Equivalents (FTEs)</i> ⁴	428
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Drug Resources as a Percent of Budget

Total Agency Budget ⁵ (in billions)	\$5.9
Drug Resources Percentage	70.7%
Drug Free Communities Program ⁶	\$18.5

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 PHS evaluation fund. Treatment include State Opioid Response Grants.

² Substance Abuse Prevention and Treatment Block Grant 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. Substance funds to SAMHSA. HSPS obligations include funds provided to SAMHSA from the PHS evaluation fund.

⁴ SAMHSA's FY 2020 final FTE (606) * Drug Resources Percentage (70.7%) = 428 Drug Resources FTE.

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

⁶ Drug Free Communities Program funding was provided to SAMHSA/Center of Substance Abuse Prevention (CSAP) via Interagency Agreements. This amount represents the final FY 2020 obligations.

Exhibit A

1) Drug Methodology - Actual obligations of 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 October 22nd, 2019. 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-CSAT/CSAP; and
- Health Surveillance and Program Support ¹ – SAMHSA.

Included in this Drug Control Accounting report for FY 2020 are 100 Percent of the actual obligations for these four budget decision units, minus reimbursements. Obligations against funds provided to SAMHSA from the PHS evaluation fund are included.

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 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;
- Of the portion from SAMHSA HSPS funds, including obligations related to receipt of PHS evaluation funds and Prevention 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;
 - 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;

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

- 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
- Behavioral Health Workforce Data and Development 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
 - Behavioral Health Workforce Data and Development split 50/50 between SA and MH and 80 percent of the SA portion is considered Treatment.

2) Methodology Modifications – None.

3) Reprogramming or Transfers - As of Oct 1, 2020, The Office of National Drug Control Policy Drug Free Communities Programs have been transferred to the Centers for Disease Control and are no longer managed by SAMHSA.

4) Other Disclosures – None.



Substance Abuse and Mental Health
Services Administration

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DATE: October 27, 2020

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 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 from 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.

In order to effectively manage SAMHSA's grant portfolio and provide timely, accurate information to stakeholders and to Congress, SAMHSA utilizes a unified data collection reporting system, SAMHSA's Performance Accountability and Reporting System (SPARS). SPARS provides unified data entry, data validation and verification, data management, data utilization, data analysis support, and automated reporting for discretionary grants.

In accordance with the requirements of the Office of National Drug Control Policy Circular *National Drug Control Program Agency Compliance Reviews*, dated October 22nd, 2019, and consistent with the assertions made by Center for Substance Abuse Treatment (CSAT) and Center for Substance Abuse Prevention (CSAP) to the Office of Financial Resources (OFR), I make the following assertions regarding the attached Performance Summary Report for National Drug Control Activities:

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 Exhibit A.

Explanations for Not Meeting Performance Targets

I assert that the explanations offered in the attached report for failing to meet a performance targets 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.



Deepa Avula
Chief Financial Officer

Attachment:

Exhibit A- FY 2020 Performance Summary Report for National Drug Control Activities

Exhibit A

FY 2020 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	FY 2017 Actual	FY 2018 Target	FY 2018 Actual	FY 2019 Target	FY 2019 Actual
74.0%	74.8% ¹	74.0%	72.9%	74.0%	71.6%	74.0%	69.6%	74.0%	69.3%	69.3%	57.0%	74.0%	55.7%

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 serve as a focus of discussion with the states, and aids in the management of the program.

2. The targets for FY 2016 through FY 2019 were 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. In particular, behavioral health worker shortages and shorter lengths of stay by clients in substance abuse treatment programs may be contributing factors to the decreasing proportion of clients reporting no drug use in the past month at discharge. The findings will increase our awareness of the opioid epidemic and the corresponding lagging response in the use of medicated assisted treatment (MAT) in response to the rising opioid use disorder (OUD) epidemic.

3. 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 and 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 (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 crosscheck 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: http://www.dasis.samhsa.gov/dasis2/manuals/teds_adm_manual.pdf

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

Decision Unit 2: 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	FY 2017 Actual	FY 2018 Target	FY 2018 Actual
47.1%	19.6%	47.1%	35.3%	N/A*	N/A*	N/A*	N/A*	35.0%	37.3%	37.3%	33.3%

*2015 and 2016 data not available due to break in trend with NSDUH data.

1. Measure 2 for Decision Unit 2 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 1960s², as it remains a significant predictor of substance use behaviors³. For example, “Monitoring the Future,” tracks the trends in perceived risk with substance use since the 1970s⁴. 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 22⁵. 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% of states reported increased rates of moderate or great perceived risk of two or more substances. Although the actual did not meet the target in FY 2014, the perceived risk (actual) is higher than FY2012 or FY2013. Given that a break in trend occurred in the 2015 NSUDH data and estimates are generated from over a two-year period, CBHSQ has not been able to report data in recent years. Although data for FY 2018 suggests that targets for this measure are still not being met.

²Morgan, 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.

³Elekes, 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.

⁴Johnson, 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.

⁵Adalbjarnardottir, 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.

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 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.

Another consideration is that state estimates are based on two years of pooled 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.

4. 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 closely monitored the data during FY 2011 – FY 2015. 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.

5. Data for levels of perceived risk of harm from substance use are obtained annually from the 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 States⁶. 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:

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

Decision Unit 3: 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

FY 2015 Target	FY 2015 Actual	FY 2016 Target	FY 2016 Actual	FY 2017 Target	FY 2017 Actual	FY 2018 Target	FY 2018 Actual	FY 2019 Target	FY 2019 Actual	FY 2020 Target	FY 2020 Actual
93.0%	96.7%	93.0%	97.9%	97.5%	97.6%	97.5%	98.0%	92.0%	95.5%	95.5	98.2%

1. Measure 3 is the percent of clients served by the capacity portion of the PRNS portfolio⁸ 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.
2. This measure relates directly to and supports the national drug control strategy. The results are monitored routinely throughout the period of performance.
3. Programs included in this measure are HIV/AIDS Outreach, Pregnant Postpartum Women, Recovery Community Services Program, State Adolescent Treatment Enhancement and Dissemination (SAT-ED), Targeted Capacity Expansion (TCE), TCE/HIV, Targeted Capacity Expansion- Technology Assisted Care, and Crisis Support programs.
4. CSAT is able to ensure the accuracy and completeness of this measure as all data are submitted via the **SAMHSA Performance Accountability and Reporting System (SPARS)**, a web-based data entry and reporting system. The system has automated built-in checks designed to assure data quality. The SPARS 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 4: 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)

Table 4: Measure 4

FY 2015 Target	FY 2015 Actual	FY 2016 Target	FY 2016 Actual	FY 2017 Target	FY 2017 Actual	FY 2018 Target	FY 2018 Actual	FY 2019 Target	FY 2019 Actual	FY 2020 Target	FY 2020 Actual
88.0%	90.6%	93.0%	89.4	88.0%	84.7%	84.7%	76.7%	76.7%	68.7%	68.7%	60.8%

1. Measure 4 for Decision Unit 4 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 Sober Truth on Preventing Underage Drinking Act (STOP Act) grants 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 1960s⁹ as it remains a significant predictor of substance use behaviors. For example, "Monitoring the Future," tracks the trends in perceived risk with substance use since the 1970s¹⁰. 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. 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 2017, 84.7% of program participants rated the risk of substance abuse as great. This is slightly lower than the FY 2016 result of 89.4%. One possible explanation for the slight reduction in FY 2017 is the changing laws around marijuana use, which may be decreasing perceived risk. Previously, SAMHSA reported the percent of program participants (age 18 and up) who 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.

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. Reykjavík: Félagsvísindastofnun Háskóla Ísland

2. 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, who works 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. Starting in FY 2018 this data has been collected and stored within SPARS. The new instrument captures cigarette use under a broader measure of tobacco use. Therefore, data reported in 2018 and 2019 reflects those who report perceiving a great risk-of-harm in engaging in at least one of the following behaviors: binge drinking, regular tobacco use, or regular marijuana use.

3. The FY2018, FY2019, and FY2020 numbers are lower than previous years. As mentioned above, the survey instruments were updated including a change from a measure of cigarettes to a more general question about tobacco use. In recent years, there have also been tremendous changes in the status of marijuana with states making this substance legal potentially impacting the level of risk associated with its use.



Substance Abuse and Mental Health
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December 15, 2020

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: SAMHSA Budget Formulation Compliance Report for FY 2022

In accordance with the requirements of the ONDCP Circular: National Drug Control Program Agency Compliance Reviews, dated October 22, 2019, I make the following assertions regarding the attached Budget Formulation Compliance Report:

Timeliness of Summer Budget Submission

I assert that the summer drug budget submitted to ONDCP under the cover letter provided in response to Section 6.a.(1) in response to ONDCP Circular: Budget Formulation, Section 9.a.(1) was provided to ONDCP at the same time as the budget request was submitted to our superiors in accordance with 21 U.S.C. § 1703(c)(1)(A). (See Exhibit A)

Funding Levels Represent Bureau-Level Request

I assert that the funding request in the submission provided in Section 6.a.(2) of this circular represent the funding levels in the budget submission made by the bureau to the Department without alteration or adjustment by any official at the Department.

A handwritten signature in black ink, appearing to read "Deepa Avula".

Deepa Avula
Chief Financial Officer

Attachment

- Exhibit A- FY 2022 Performance Budget Submission to DHHS