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GAO

Report to Congressional Requesters

March 2013

OFFICE OF NATIONAL DRUG CONTROL POLICY

Office Could Better Identify Opportunities to Increase Program Coordination

GAO-13-333

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GAO Accountability * Integrity * Reliability

Highlights

Highlights of GAO-13-333, a report to congressional requesters.

Why GAO Did This Study

ONDCP is responsible for coordinating implementation of drug control policy across the federal government to address illicit drug use. ONDCP developed the 2010 Strategy, which sets forth a 5-year plan to reduce illicit drug use through programs intended to prevent or treat drug abuse or reduce the availability of drugs. GAO was asked to review Strategy implementation and drug abuse prevention and treatment programs. This report assesses, among other things, the extent to which progress has been made toward achieving Strategy goals; ONDCP has mechanisms in place to monitor progress; fragmentation, overlap, and duplication exist across prevention and treatment programs; and ONDCP and federal agencies coordinate efforts to reduce the potential for unnecessary overlap or duplication. GAO analyzed the Strategy and its updates, available data on progress toward achieving Strategy goals, and documents about ONDCP's monitoring mechanisms. GAO also analyzed data from questionnaires sent to the 15 federal agencies that administer prevention and treatment programs that collected information on services provided and coordination efforts.

What GAO Recommends

GAO recommends that ONDCP assess the extent of overlap and the potential for duplication across federal programs engaged in drug abuse prevention and treatment activities and identify opportunities for increased coordination. ONDCP concurred and stated that it will work with agencies administering these programs to further enhance coordination.

View GAO-13-333. For more information, contact Eileen Larence at (202) 512-8777 or larencee@gao.gov or Linda Kohn at (202) 512-7114 or kohnl@gao.gov.

What GAO Found

The Office of National Drug Control Policy (ONDCP) and federal agencies have not made progress toward achieving most of the goals articulated in the 2010 National Drug Control Strategy (the Strategy), but are reported to be on track to implement most Strategy action items intended to support these goals. ONDCP established seven Strategy goals related to reducing illicit drug use and its consequences by 2015. As of March 2013, GAO's analysis showed that of the five goals for which primary data on results are available, one shows progress and four show no progress. For example, no progress has been made on reducing drug use among 12- to 17-year-olds by 15 percent. This is primarily due to an increase in the rate of reported marijuana use, offset by decreases in the rates of reported use of other drugs. Nevertheless, ONDCP reported that 107 of the 112 action items in the Strategy are complete or on track. ONDCP officials stated that implementing these action items is necessary but may not be sufficient to achieve Strategy goals.

ONDCP primarily intends to address the extent of progress in achieving Strategy goals through its new Performance Reporting System (PRS)—a monitoring mechanism intended to provide specific, routine information on progress toward Strategy goals and help identify factors for performance gaps and options for improvement. ONDCP officials stated that they plan to report on PRS results for the first time in 2013. They also said that they plan to assess the system's reliability and effectiveness. This could help increase accountability for improving results and identify ways to bridge the gap that currently exists between the lack of progress toward Strategy goals and the strong progress made on implementing Strategy actions.

Drug abuse prevention and treatment programs are fragmented across 15 federal agencies and provide some overlapping services, which could increase the risk of duplication. Specifically, GAO identified overlap in 59 of the 76 programs included in its review. These programs could provide or fund one or more drug abuse prevention or treatment service that at least one other program could also provide or fund, either to similar population groups or to reach similar program goals. Such fragmentation and overlap may result in inefficient use of resources among programs providing similar services.

GAO's prior work has found that inefficiencies created by fragmentation and overlap can be minimized through coordination. However, many prevention and treatment programs that GAO surveyed did not report coordination efforts, and ONDCP has not assessed the extent of overlap, duplication, and coordination. Agency officials who administer the 21 programs that GAO reviewed in detail—programs for youth and offenders—reported making various efforts to coordinate program activities, but 29 of 76 (about 40 percent) surveyed programs reported no coordination with other federal agencies on drug abuse prevention or treatment activities. Moreover, ONDCP has not assessed all drug abuse prevention or treatment programs to identify the extent of overlap and potential duplication and any opportunities for coordination. Such an assessment would better position ONDCP to help ensure that agencies better leverage and more efficiently use limited resources.

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Abbreviations

AOUSC	Administrative Office of the United States Courts
BOP	Bureau of Prisons
DEA	Drug Enforcement Administration
DOD	Department of Defense
DOJ	Department of Justice
DOT	Department of Transportation
ETA	Education and Training Administration
FAA	Federal Aviation Administration
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
HUD	Department of Housing and Urban Development
IHS	Indian Health Service
NHTSA	National Highway Traffic Safety Administration
OJP	Office of Justice Programs
ONDCP	Office of National Drug Control Policy
PRS	Performance Reporting System
SAMHSA	Substance Abuse and Mental Health Services Administration
SUD	substance use disorder
VA	Department of Veterans Affairs
VHA	Veterans Health Administration

GAO
Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

March 26, 2013

The Honorable Dianne Feinstein
Chairman
The Honorable Charles Grassley
Co-Chairman
Caucus on International Narcotics Control
United States Senate

Illicit drug use endangers public health and safety and depletes financial resources, and the scale of the problem has not improved over the past decade. An estimated 22.5 million Americans aged 12 or older were illicit drug users in 2011, representing 8.7 percent of this population, according to the National Survey on Drug Use and Health.[1] In addition, illicit drug use rates among Americans aged 12 and older from 2009 through 2011 were among the highest since trend data were available in 2002. Abuse of illicit drugs results in significant public health, social, and economic consequences for the United States. For example, the Department of Justice's (DOJ) National Drug Intelligence Center estimated that the economic impact of illicit drug use, including the costs of health care, crime, and lost productivity, was more than $193 billion in 2007.[2]

The Office of National Drug Control Policy (ONDCP) is responsible for, among other things, overseeing and coordinating implementation of national drug control policy across the federal government to address illicit drug use.[3] In this role, ONDCP is required annually to develop a National Drug Control Strategy (the Strategy),[4] which sets forth a comprehensive plan to reduce illicit drug use through programs intended

[1]Illicit drug use includes the use of marijuana (including hashish), cocaine (including crack), heroin, hallucinogens, and inhalants, as well as the nonmedical use of prescription drugs, such as pain relievers and sedatives. The 22.5 million represents individuals who reported that they used an illicit drug during the month prior to the survey interview. See Department of Health and Human Services Substance Abuse and Mental Health Services Administration, *Results from the 2011 National Survey on Drug Use and Health: Summary of National Findings* (Rockville, Md.: September 2012).

[2]See Department of Justice National Drug Intelligence Center, *The Economic Impact of Illicit Drug Use on American Society* (Washington, D.C.: April 2011). According to the report, 2007 is the most recent year for which data are available.

[3]21 U.S.C. § 1702(a)(2).

[4]21 U.S.C. §§ 1703(b), 1705(a).

to prevent or treat drug use or reduce the availability of illegal drugs, as well as to develop a National Drug Control Program Budget proposal for implementing the Strategy.[5] ONDCP reported that about $25.2 billion was provided for drug control programs in fiscal year 2012. Of this, $10.1 billion, or 40 percent, was allocated to prevention and treatment programs.[6] Specifically, these programs are intended, in all or in part, to prevent the initiation of illicit drug use or treat the abuse, or problematic use, of illicit drugs and provide or fund such services as outreach efforts to discourage first-time drug use and assessment and intervention to assist regular users to become drug-free.

Nineteen federal departments, agencies, and components (collectively referred to as agencies) funded a range of drug abuse prevention and treatment programs included in the fiscal year 2013 Drug Control Budget. As we previously reported, the range of programs across federal agencies could result in a fragmented service system, with more than one federal agency involved in the same broad area of national interest.[7] Such a system could lead to some programs offering similar services and serving similar populations, and thus to inefficiencies in program administration and service delivery across the federal government. In light of the rate of illicit drug use among Americans and the nation's current budgetary constraints, efforts to oversee progress toward achieving national drug policy goals, coordinate drug control program activities to mitigate potential inefficiencies, and conduct evaluations of program effectiveness become increasingly important.

You asked us to review an array of issues related to the Strategy and drug abuse prevention and treatment programs. In July 2012, we issued a

[5]21 U.S.C. § 1703(c). ONDCP prepares a budget proposal it refers to as the National Drug Control Budget Summary. For the purposes of this report, we refer to this proposal as the Drug Control Budget.

[6]The remaining $15.1 billion was allocated to domestic law enforcement, interdiction, and other programs intended to reduce the availability of illegal drugs.

[7]GAO, *Opportunities to Reduce Potential Duplication in Government Programs, Save Tax Dollars, and Enhance Revenue,* GAO-11-318SP (Washington, D.C.: Mar. 1, 2011).

report with the results of our initial review of these issues.[8] This final report reflects our completed work and addresses the extent to which (1) progress has been made toward achieving Strategy goals and ONDCP has mechanisms in place to monitor progress; (2) fragmentation, overlap, and duplication exist across drug abuse prevention and treatment programs, and ONDCP and federal agencies coordinate efforts to reduce the potential for overlap or duplication; and (3) federal agencies that have drug abuse prevention and treatment programs conduct evaluations of these programs, including assessments of program effectiveness. We also reviewed what available research suggests about the potential effect of societal factors, such as state laws allowing the use of marijuana for medical purposes, on youth drug use. Appendix I summarizes the results of this work.

To address the first objective, we analyzed the 2010 Strategy and 2011 and 2012 annual updates; ONDCP documentation about its Performance Reporting System and associated performance measures, which are intended to measure progress toward achieving Strategy objectives; and implementation plans and reports from selected federal drug control agencies. Specifically, we selected the following seven agencies to include in our assessment of Strategy implementation and performance measures: within the Department of Health and Human Services (HHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), National Institutes of Health, and Centers for Disease Control and Prevention; within DOJ, the Office of Justice Programs (OJP) and the Drug Enforcement Administration; within the Department of Homeland Security, Customs and Border Protection; and the Department of Education (Education).[9] We selected these agencies to reflect a range in the number of Strategy activities for which agencies are responsible, the size of agency drug control budgets, and prevention, treatment, and

[8]GAO, *Drug Control: Initial Review of the National Strategy and Drug Abuse Prevention and Treatment Programs*, GAO-12-744R (Washington, D.C.: July 6, 2012). We reported that ONDCP established a process to monitor progress on implementing the Strategy and described agency funding for drug abuse prevention and treatment programs, among other things.

[9]The National Institutes of Health includes the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism. OJP includes the Bureau of Justice Assistance, Bureau of Justice Statistics, National Institute of Justice, and Office of Juvenile Justice and Delinquency Prevention.

supply reduction missions.[10] While these seven agencies are not representative of all drug control agencies, they are responsible for implementing a majority of activities in the Strategy and provided a range of perspectives about its implementation and progress. We also interviewed officials from ONDCP and these agencies to obtain information about progress on the Strategy's goals, implementation of the Strategy, and mechanisms to monitor progress. We compared these documents and information with criteria for performance management indentified in our prior work.[11] Finally, we interviewed seven drug policy experts to discuss their perspectives on the Strategy and performance management. We selected these experts based on our review of drug policy literature, their expertise in drug policy issues and work conducted in this area, and recommendations from these and other researchers. The information we obtained cannot be generalized to other experts; however, they provided us with a range of views about the Strategy and ONDCP's monitoring mechanisms.

To address the second objective, we assessed 76 drug abuse prevention and treatment programs that provide or fund prevention and treatment services, such as education and outreach activities, drug testing, and intervention. We excluded programs that, for example, exclusively conduct research, fund overhead costs, or reimburse services as part of a health benefit plan.[12] These 76 programs are administered by 15 of the 19 agencies that are included in the fiscal year 2013 Drug Control

[10]Supply reduction includes any activity or program conducted by a National Drug Control Program agency that is intended to reduce the availability or use of illegal drugs in the United States or abroad. See 21 U.S.C. § 1701(11). This includes, for example, activities to enforce drug control laws and reduce the production or trafficking of illicit drugs. Also, under 21 U.S.C. § 1701(7), the term "National Drug Control Program agency" means any agency that is responsible for implementing any aspect of the National Drug Control Strategy, including any agency that receives federal funds to implement any aspect of the National Drug Control Strategy, subject to certain exceptions regarding intelligence agencies.

[11]See for example GAO, *Tax Administration: IRS Needs to Further Refine Its Tax Season Performance Measures*, GAO-03-143, (Washington, D.C.: Nov. 22, 2002).

[12]We excluded, for example, programs such as those administered by HHS's National Institutes of Health, which funds and disseminates scientific research on drug abuse prevention and treatment but does not provide direct services to individuals. We also excluded the Department of Defense's Health Program, which includes military health benefit plans.

Budget.[13] We distributed a questionnaire to program officials at these 15 agencies to collect information on program activities in fiscal year 2011, such as program purpose, allowable services provided, and population served.[14] We received responses to all the questionnaires we distributed, for a 100 percent response rate, and analyzed information for 76 prevention and treatment programs. To assess the reliability of the information we received, we incorporated questions about the reliability of data on the programs' obligated funds, performed internal reliability checks, and conducted follow-up as necessary with agency officials. As a result, we determined that the data used in our report were sufficiently reliable for our purposes. We analyzed responses to identify potential fragmentation, overlap, or duplication based on criteria established in our previous work.[15] To assess coordination efforts, we analyzed questionnaire responses regarding agency efforts to coordinate drug abuse prevention and treatment program activities. We also analyzed the 2010 Strategy and interviewed ONDCP and agency officials about actions taken to coordinate these activities. We compared these reported actions with criteria for coordinating interagency efforts identified in our prior work.[16]

[13]We excluded 4 of the agencies included in the budget for varying reasons. For example, we excluded HHS's Centers for Medicare and Medicaid Services, which accounted for almost $4.5 billion of the $10.1 billion allocated to prevention and treatment programs in fiscal year 2012, because it administers federal health benefit programs that reimburse drug prevention and treatment services but does not directly provide them. We also excluded the Court Services and Offender Supervision Agency for the District of Columbia because it was created to supervise District of Columbia code offenders and functions primarily as a local agency. Federal agencies we included may administer programs through a variety of means, including, but not limited to, grants to state, local, tribal, and nonprofit entities; contracts with services providers; or services directly provided to beneficiaries by the federal agency itself.

[14]We collected information on activities conducted in fiscal year 2011 because it was the most recently completed fiscal year at the time we administered the survey. In addition, we collected information on all services that programs may provide, not just those that are currently provided.

[15]GAO-11-318SP and GAO, *2012 Annual Report: Opportunities to Reduce Duplication, Overlap and Fragmentation, Achieve Savings, and Enhance Revenue*, GAO-12-342SP (Washington, D.C.: Feb. 28, 2012).

[16]For example, GAO, *Results-Oriented Government: Practices That Can Help Enhance and Sustain Collaboration among Federal Agencies*, GAO-06-15 (Washington, D.C.: Oct. 21, 2005) and GAO-12-1022.

To address the third objective, we analyzed documents, such as completed program evaluations and agency policies and procedures, and interviewed officials from the 15 agencies who are responsible for overseeing the programs included in the second objective to identify the number of program evaluations completed, under way, or planned since 2007.[17] We selected 2007 as the starting point for our review in order to provide a long enough time frame to include evaluations that may take multiple years to complete. We reviewed completed evaluations to determine whether these evaluations included assessments of effectiveness (i.e., determining the extent to which a program is achieving its objectives) described in our prior work in this area.[18] We also interviewed ONDCP officials responsible for Strategy implementation to obtain their perspectives on how program evaluations were used to inform policy and resource allocation decisions. In addition, through our review of agency documents and interviews, we identified other ways in which agencies are attempting to ensure that programs are effective.

Finally, to describe the available research about the potential effect of societal factors on drug use among youth—individuals 17 years old and under—we conducted a literature search to identify studies, published as of June 2012, that addressed the following: (1) state laws allowing the use of marijuana for medical purposes, (2) marijuana decriminalization, and (3) the favorable portrayal of drugs in the media on youth drug use.[19] We reviewed the studies on medical marijuana laws and decriminalization from our initial search results and identified those that met our established criteria for these factors, such as using comparison groups or statistical analysis to assess their effects. We selected the studies on medical marijuana laws and marijuana decriminalization to include in this report based on the sufficiency of their methodologies; therefore, our results cannot be generalized to all research about the potential effect of these factors on youth drug use. The media studies we identified did not assess the effect of prodrug messages on youth drug use, but we included them because they provide useful context regarding the portrayal of drugs in

[17]We define "program evaluations" as individual, systematic studies to assess how well a program or programs are working.

[18]GAO, *Designing Evaluations: 2012 Revision*, GAO-12-208G (Washington, D.C.: January 2012).

[19]Marijuana decriminalization refers to the reduction in penalties for marijuana possession.

the media. Additional information about our scope and methodology is included in appendix II.

We conducted this performance audit from July 2012 to March 2013 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Office of National Drug Control Policy

ONDCP was established by the Anti-Drug Abuse Act of 1988 to, among other things, enhance national drug control planning and coordination and represent the drug policies of the executive branch before Congress.[20] In this role, the office is responsible for (1) developing a national drug control policy, (2) developing and applying specific goals and performance measurements to evaluate the effectiveness of national drug control policy and National Drug Control Program agencies' programs, (3) overseeing and coordinating the implementation of the national drug control policy, and (4) assessing and certifying the adequacy of the budget for National Drug Control Programs.[21]

[20]ONDCP was created and authorized through January 21, 1994, by the National Narcotics Leadership Act of 1988 (codified at 21 U.S.C. 1501 et seq.), in title 1 of the Anti-Drug Abuse Act of 1988, Pub. L. No. 100-690, 102 Stat. 4181. ONDCP has continued to operate since the conclusion of its first authorization through multiple reauthorizations or as a result of legislation providing continued funding.

[21]21 U.S.C. § 1702(a). We reported on the Drug Control Budget process in GAO, *Office of National Drug Control Policy: Agencies View the Budget Process as Useful for Identifying Priorities, but Challenges Exist*, GAO-11-261R (Washington, D.C.: May 2, 2011). Agencies included in the Drug Control Budget are required to follow a detailed process in developing their annual budget submissions. Agencies submit to ONDCP the portion of their budget requests dedicated to drug control. ONDCP provides annual budget recommendations to these agencies that are intended to specifically delineate what priorities each agency is expected to fund in the coming year submission. Each fiscal year, ONDCP assesses agency budget submissions to implement the Strategy and certifies them if deemed adequate, or otherwise decertifies them.

The 2010 Strategy is the inaugural strategy guiding drug policy under President Obama's administration. According to ONDCP officials, it sought a comprehensive approach to drug policy, including an emphasis on drug abuse prevention and treatment efforts and the use of evidence-based practices or interventions—approaches to prevention or treatment that are based in theory and have undergone scientific evaluation.[22] For the 2010 Strategy, ONDCP changed its approach and moved from publishing a 1-year Strategy to publishing a 5-year Strategy, which ONDCP is to update annually. The annual updates, which ONDCP has issued for 2011 and 2012, are to provide an implementation progress report as well as an opportunity to make adjustments to reflect policy changes.

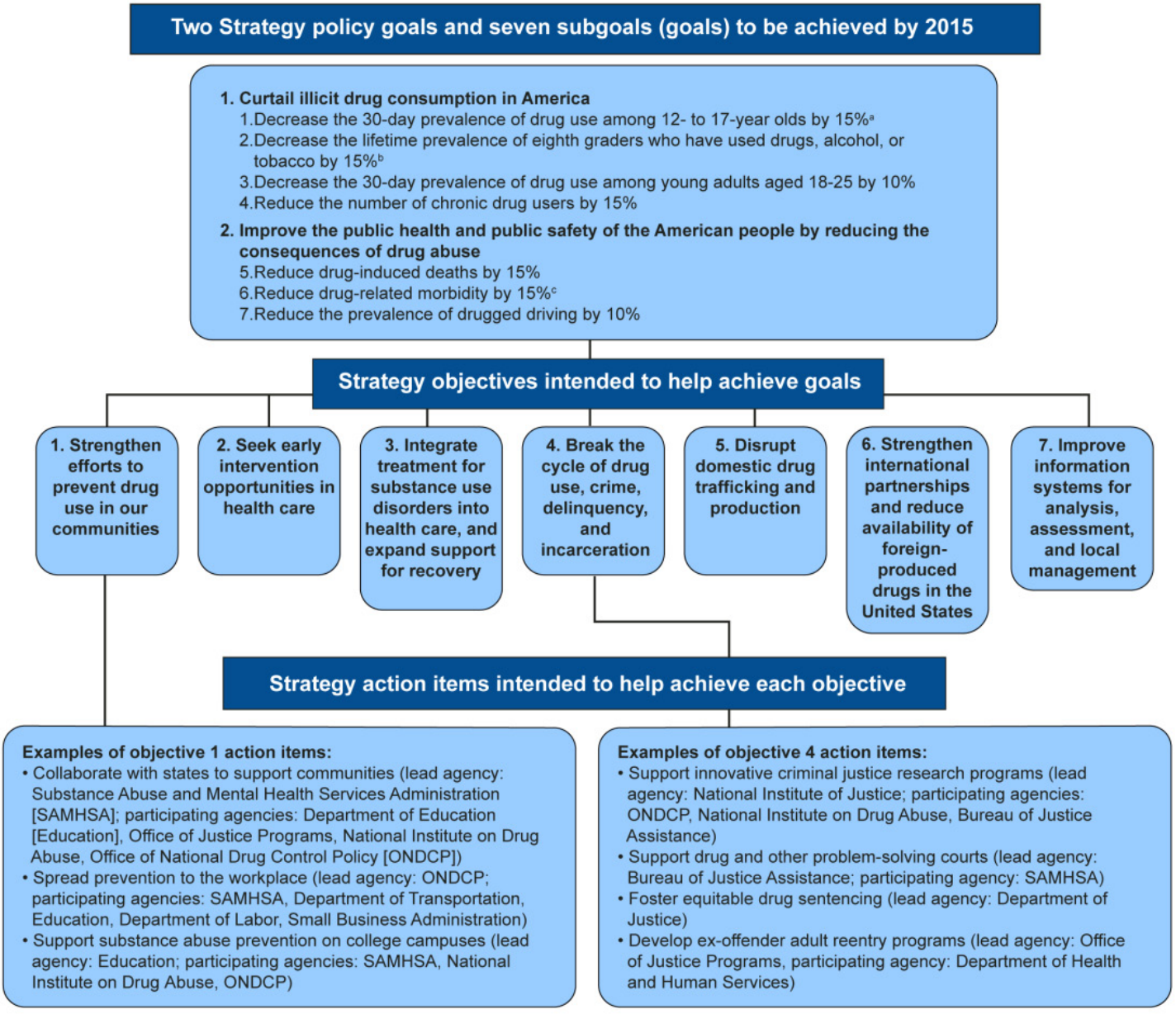
ONDCP established two overarching policy goals in the 2010 Strategy for (1) curtailing illicit drug consumption and (2) improving public health by reducing the consequences of drug abuse, and seven subgoals under them that delineate specific quantitative outcomes to be achieved by 2015, such as reducing drug-induced deaths by 15 percent.[23] To support the achievement of these two policy goals and seven subgoals (collectively referred to as goals), the Strategy and annual updates include seven strategic objectives. These objectives are to be achieved by implementing 112 action items, with lead and participating agencies designated for each action item.[24] See figure 1 for additional details.

[22]ONDCP also developed several supplemental strategies to complement the Strategy, including the 2011 Prescription Drug Abuse Plan, the 2011 National Southwest Border Counternarcotics Strategy, the 2012 National Northern Border Counternarcotics Strategy, and the 2011 Strategy to Combat Transnational Organized Crime. We focused on the 2010 National Drug Control Strategy and annual updates because they are the primary documents that comprehensively outline the administration's drug control policy and goals.

[23]When developing the Strategy, ONDCP identified data sources for each of the seven subgoals, such as SAMHSA's National Survey on Drug Use and Health.

[24]ONDCP developed 106 action items for the 2010 Strategy and combined 2 action items and added 8 action items in the 2011 Strategy update. In July 2012, ONDCP officials reported that they combined 2 additional action items.

Figure 1: 2010 National Drug Control Strategy Goals, Objectives, and Action Items



Source: GAO analysis of 2010 Strategy and 2011 and 2012 updates.

[a]Thirty-day prevalence is defined as having used within the past 30 days.

[b]Lifetime prevalence is defined as having ever used.

[c]Morbidity refers to incidence of disease.

We previously reported that ONDCP developed the objectives and action items in the Strategy through a consultative process with drug control agencies and other stakeholders because these agencies have primary responsibility for implementing them.[25] The objectives represent broad policy areas, such as prevention, treatment, and domestic law enforcement, and collectively contribute to all of the Strategy's goals. The action items under each objective represent the activities needed to accomplish the objective and may highlight specific drug control program activities or call for agencies to perform a specific task, such as preparing a report on the health risks of youth drug abuse.

Drug Abuse Prevention and Treatment Programs

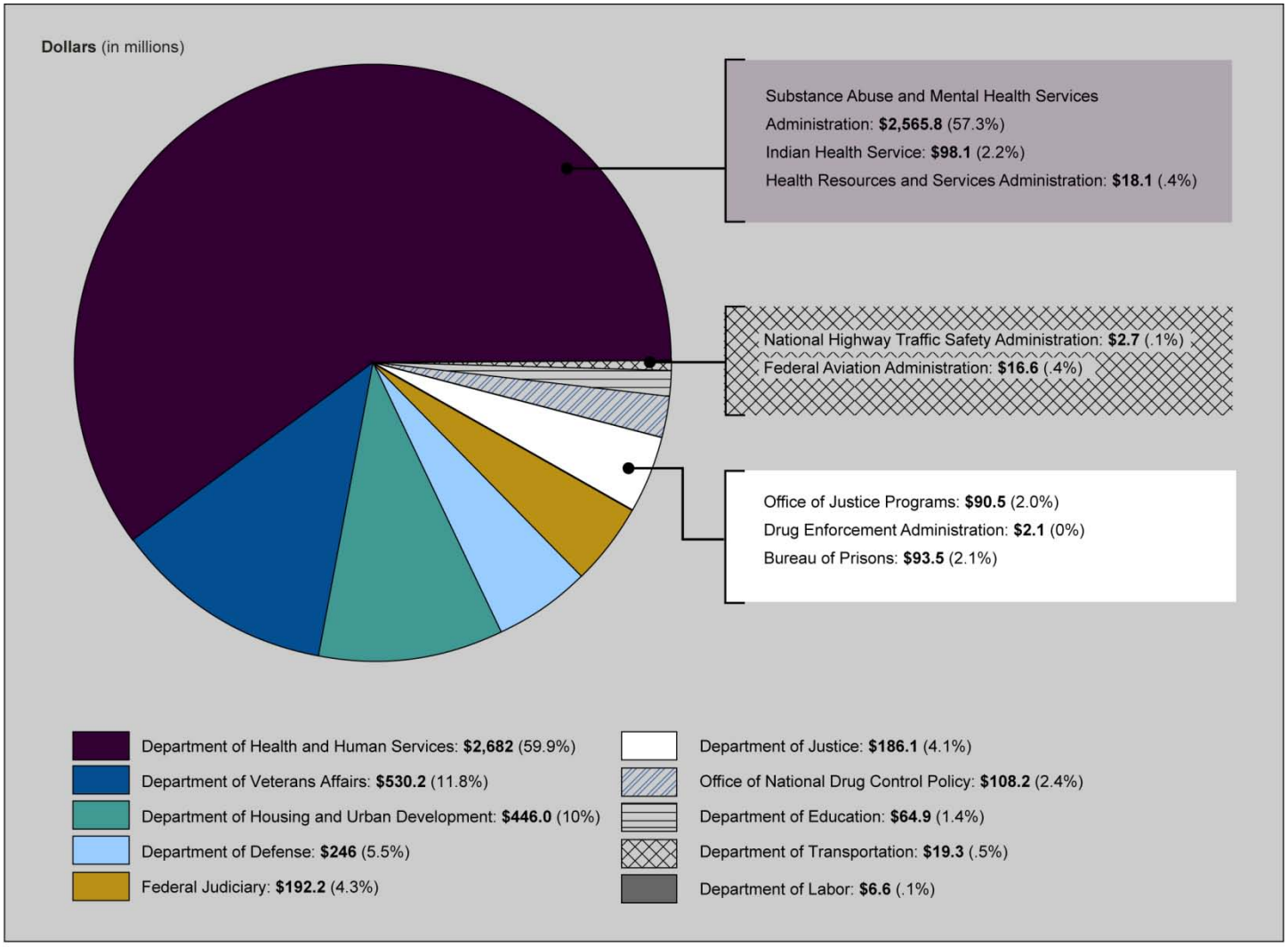
The Strategy's drug abuse prevention and treatment objectives are supported by action items implemented through programs across multiple agencies. Specifically, the 15 federal agencies we selected to include in our review collectively allocated about $4.5 billion in fiscal year 2012 to programs that provide drug abuse prevention and treatment services (drug abuse prevention and treatment programs)[26] as shown in figure 2.[27]

[25]See GAO-12-744R for additional information on the Strategy development process.

[26]Specifically, on the basis of ONDCP guidance, we defined a drug abuse prevention program as a federal program that provides services, allocates funding, or allows for activities focused on discouraging the first-time use of controlled substances—specifically illicit drugs and the problematic use of alcohol—and encouraging those who have begun to use controlled substances to cease their use. We defined a drug abuse treatment program as a federal program that provides services, allocates funding, or allows for activities focused on identifying and assisting users of controlled substances—specifically illicit drugs and the problematic use of alcohol—to become drug-free and remain drug-free.

[27]Seventy-six prevention and treatment programs within these 15 agencies were included in our review of fragmentation, overlap, and duplication. We did not include supply reduction programs in this review.

Figure 2: Federal Funding Allocated to Drug Abuse Prevention and Treatment Programs by 15 Selected Agencies, Fiscal Year 2012



Source: GAO analysis of fiscal year 2012 allocated funding reported in the fiscal year 2013 Drug Control Budget.

Note: ONDCP refers to these funds as enacted funding in the Drug Control Budget, while in this report we use the term "allocated funding." At the beginning of a fiscal year, agencies may allocate certain amounts from available appropriations for specific programs. However, to the extent that an appropriation has not identified a particular amount for a specific program, an agency may reallocate unobligated funds from that program to another during the course of a fiscal year. The amounts represent fiscal year 2012 funding that these agencies allocated to their prevention and treatment programs as reported in the fiscal year 2013 Drug Control Budget and include funding for programs that were excluded from our review. For example, Department of Defense funding includes $90.4 million for the Defense Health Program, which we excluded from our review because it reimburses for services as part of a military health benefit. The 15 agencies include both departments and components, based on how funding was reported in the Drug Control Budget. For example, within the Department of Justice, the Office of Justice Programs, the Drug Enforcement Administration, and the

Bureau of Prisons were counted as 3 agencies and the Department of Veterans Affairs was counted as 1 agency. Percentages represent the proportion of the total $4.5 billion that these agencies allocated to prevention and treatment activities. See appendix III for descriptions of programs within each of the agencies.

Our Work on Fragmentation, Overlap, and Duplication

In 2010, Congress directed us to conduct routine investigations to identify programs, agencies, offices, and initiatives with duplicative goals and activities within departments and government wide and report annually to Congress.[28] In March 2011 and February 2012, we issued our first two annual reports to Congress in response to this requirement.[29] On the basis of the framework established in these reports, we used the following definitions for assessing drug abuse prevention and treatment programs:

- *Fragmentation* occurs when more than one federal agency (or more than one organization within an agency) is involved in the same broad area of national interest.
- *Overlap* occurs when fragmented agencies or programs have similar goals, engage in similar activities or strategies to achieve them, or target similar beneficiaries.
- *Duplication* occurs when two or more agencies or programs are engaged in the same activities or provide the same services to the same beneficiaries.

[28]Pub. L. No. 111-139, § 21, 124 Stat. 8, 29-30 (2010) (codified in 31 U.S.C. § 712 Note).

[29]See GAO-11-318SP and GAO-12-342SP.

Results Show Lack of Progress on Strategy Goals, although Implementation of Most Action Items Is Complete or On Track; ONDCP Established a New Mechanism to Monitor Progress

Our analysis indicates that ONDCP and federal agencies have not made progress toward achieving four of five goals established in the 2010 Strategy for which primary data are available. However, ONDCP reported strong progress in implementing most of the action items in the Strategy intended to support achievement of these goals. ONDCP officials stated that implementing these action items is necessary but may not be sufficient to achieve Strategy goals. ONDCP's Performance Reporting System (PRS) is a new monitoring mechanism intended to provide more specific, routine information on progress and help identify causal factors for performance gaps and options for improvement. According to ONDCP officials, the office plans to report on PRS results for the first time in 2013 and assess the system's reliability and effectiveness, which could help increase accountability for improving results and identify ways to bridge the gap between the lack of progress toward Strategy goals and the strong progress on implementing actions in the Strategy.

Results Show Lack of Progress toward Achieving Strategy Goals

ONDCP officials responsible for overseeing the development of the 2010 Strategy stated that they established the Strategy's seven quantitative goals based in part on the availability and quality of data sources to measure the effects of drug control policy and what they considered could realistically be achieved within designated time frames, among other things.[30] Nonetheless, these officials said that the goals are aggressive given that drug use trends for some of the measures were increasing prior to their establishment. As of March 2013, our analysis indicates that of the five goals for which data on results were available, one shows progress and four show either no change or movement away from the 2015 goals—for example, drug-induced deaths have increased, instead of decreased, from the 2009 baseline, as shown in table 1.[31]

[30]The 2010 Strategy notes that the seven goals do not capture some highly important effects of drug policy, such as reducing drug-motivated robberies and assaults, because current information systems are not sufficient to measure whether goals are being achieved. The Strategy includes an objective to improve information systems for analysis, assessment, and local management to address this issue.

[31]As of March 2013, 2009 baselines and results for 2010 to 2012 were not available for two of the goals because information from primary data sources was not available. ONDCP officials stated that 2015 results for all measures are to be available in 2016 to determine if the Strategy met its goals.

Table 1: 2010 National Drug Control Strategy Goals and Progress toward Meeting Them, as of March 2013

2010 Strategy goals	2007	2008[a]	2009 (baseline)	2010 (new Strategy)	2011	2012	2015 (goal)[b]	Progress from baseline to goal
Goal 1: Curtail illicit drug consumption in America								
1. Decrease the 30-day prevalence of drug use among 12- to 17-year-olds by 15 percent	9.6%	9.3%	10.1%	10.1%	10.1%		8.6%	No change
2. Decrease the lifetime prevalence of eighth graders who have used drugs, alcohol, or tobacco by 15 percent								
Illicit drugs	19.0%	19.6%	19.9%	21.4%	20.1%	18.5%	16.9%	Movement toward goal
Alcohol	38.9%	38.9%	36.6%	35.8%	33.1%	29.5%	31.1%	Met goal
Tobacco	22.1%	20.5%	20.1%	20.0%	18.4%	15.5%	17.1%	Met goal
3. Decrease the 30-day prevalence of drug use among young adults aged 18-25 by 10 percent	19.8%	19.7%	21.4%	21.6%	21.4%		19.3%	No change
4. Reduce the number of chronic drug users by 15 percent[c]								No data available
Goal 2: Improve the public health and public safety of the American people by reducing the consequences of drug abuse								
5. Reduce drug-induced deaths by 15 percent	38,371	38,649	39,147	40,393			33,275	Movement away from goal[d]
6. Reduce drug-related morbidity by 15 percent								
Emergency room visits for drug misuse and abuse	1,883,280	1,999,877	2,070,451	2,301,050			1,759,883	Movement away from goal
HIV infections attributable to drug use	7,600	6,400	5,300	5,500			4,505	Movement away from goal
7. Reduce the prevalence of drugged driving by 10 percent[e]	16.3%						14.7%	No data available

Source: GAO analysis of data from the following sources for these measures: (1) Substance Abuse and Mental Health Administration's (SAMHSA) National Survey on Drug Use and Health; (2) National Institute of Drug Abuse's Monitoring the Future; (3) What America's Users Spend on Illegal Drugs; (4) Centers for Disease Control and Prevention's National Vital Statistics System; (5) SAMHSA's Drug Abuse Warning Network drug-related emergency room visits; (6) Centers for Disease Control and Prevention data on HIV infections attributable to drug use; and (7) National Highway Traffic Safety Administration's National Roadside Survey.

[a]Data from 2007 and 2008 are included to show trends for these measures prior to the 2009 baselines.

[b]Goals for 2015 were established by calculating 10 to 15 percent decreases, as applicable, from the 2009 baselines.

[c]The data source for this measure is a report entitled *What America's Users Spend on Illegal Drugs*, which is sponsored by ONDCP. The most recent report was released in June 2012 and provides data

from 1998 through 2006. According to ONDCP officials, the baseline for this measure will be established when updated results through 2010 are available in May 2013.

[d]Strategy goals call for decreases in the prevalence or numbers of drug use, drug users, or consequences of drug use. Movement away from goals indicates that the results for these measures have increased from the 2009 baseline or are trending in the opposite direction of the 2015 goals.

[e]According to ONDCP officials, the primary data source for this measure is the National Roadside Survey conducted by the National Highway Traffic Safety Administration. The most recent survey in 2007 was the first to include an estimate of the prevalence of drugged driving. It found that 16.3 percent of weekend, nighttime drivers tested positive for the presence of at least one illicit drug or medication (with the ability to impair). Results of the next survey are expected in 2014. Accordingly, ONDCP officials stated that 2007 is the baseline year for this measure. These officials said that SAMHSA's National Survey on Drug Use and Health, which also measures the prevalence of drugged driving, serves as a secondary data source to the National Roadside Survey.

ONDCP and federal drug control agencies have made progress toward achieving the goal for decreasing the lifetime prevalence of eighth graders who have used drugs, alcohol, or tobacco, which consists of three separate measures.[32] In addition, while results from the primary data source for the goal to reduce drugged driving are not available, results from ONDCP's secondary data source indicate progress toward achieving this goal.[33] However, progress has not been made on the other four goals for which primary data are available. For example, the 30-day prevalence of reported drug use among 12- to 17-year-olds has not changed from the 2009 baseline to 2011. According to the data source for this measure—SAMHSA's National Survey on Drug Use and Health—this is due primarily to an increase in the rate of reported marijuana use, offset by decreases in the rates of reported non-medical use of prescription drugs and inhalants. The survey indicates that marijuana accounts for almost 80 percent of illicit drug use among 12- to 17-year-olds. In addition, drug-related morbidity, as measured by the number of emergency room visits for drug misuse and abuse and HIV infections attributable to drug use, increased from 2009 to 2010 and is higher than the established goals for these measures. The data source for the number of emergency room visits for drug misuse and abuse—

[32]Specifically, as of 2012, they have met the 2015 goals for reducing alcohol and tobacco use and made progress toward the goal for reducing illicit drug use.

[33]The secondary data source for this measure—the National Survey on Drug Use and Health—indicates a reported decrease in driving under the influence of illicit drugs during the past year from 4.2 percent in 2009 to 3.7 percent in 2011 (about a 12 percent reduction). These rates are based on self-reported responses. In contrast, ONDCP's primary data source for this measure—the National Roadside Survey—is based on either oral fluid or blood tests of nighttime drivers.

SAMHSA's Drug Abuse Warning Network—indicates that misuse and abuse of prescription drugs accounted for the majority of these visits in 2010 (58 percent).[34]

ONDCP Monitors Progress on Implementing Strategy Action Items and Reported That Most Are Complete or on Track

In August 2010, ONDCP instituted a process to track the implementation status of action items established to achieve the objectives, and ultimately the goals, of the Strategy.[35] Agencies that have lead responsibility for implementing action items submit progress reports to ONDCP on an annual basis. The office reviews these updates and information from other sources, such as interagency meetings and agency budget submissions, and classifies action items into five categories—complete, on track, delayed but progressing, facing budget issues, and at risk.[36] Despite the lack of progress we found toward meeting the Strategy's goals, ONDCP reported in its most recent publication of results in July 2012 that 96 percent (107 of 112) of the action items are complete or on track, as shown in figure 3.[37]

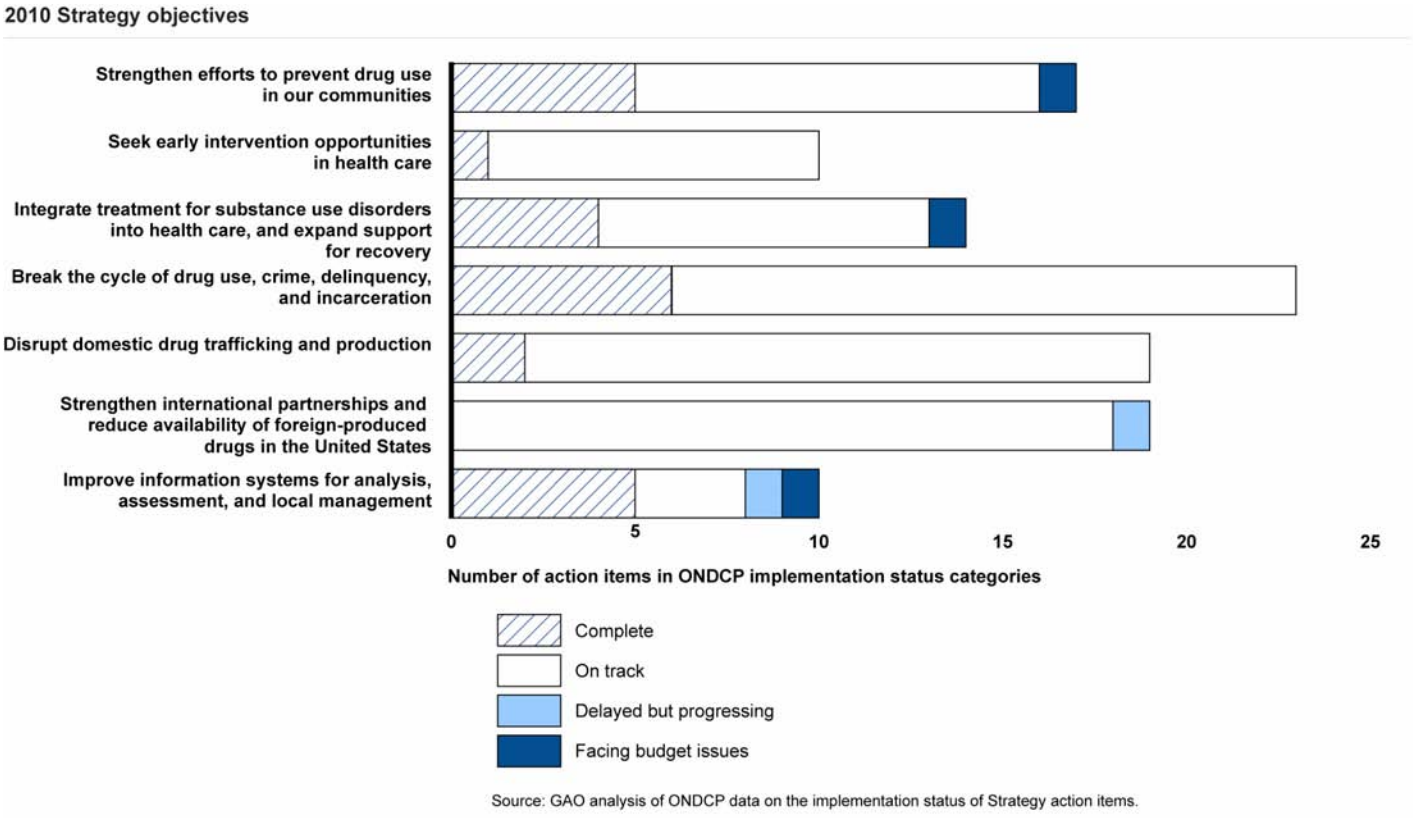
[34]According to one of the drug policy experts we interviewed who stated that he was involved in the development of the Strategy's goals, each goal generally targets reductions in the use of specific drugs. The expert stated, for example, that the goals related to youth and young adult drug use primarily target marijuana use, while the goals related to drug-related deaths and morbidity primarily target the use of cocaine, heroin, and prescription drugs.

[35]We previously reported on ONDCP's process to determine the implementation status of action items in GAO-12-744R.

[36]We reviewed ONDCP's categorizations for a nonprobability sample of 24 out of 82 action items led by ONDCP and our seven selected agencies. Although we cannot generalize the results to all action items led by these agencies, we generally agreed with ONDCP's characterization of the implementation statuses of the action items we reviewed.

[37]ONDCP officials stated that in order to better support the development of the annual Strategy update by providing the latest information about the progress of the action items, the next published review of action items will be released in April 2013, prior to the Strategy being released. They said that they continuously monitor the implementation status of action items between publication dates.

Figure 3: Number of Action Items in Office of National Drug Control Policy (ONDCP) Implementation Status Categories by National Drug Control Strategy Objective, as of July 2012



Source: GAO analysis of ONDCP data on the implementation status of Strategy action items.

Note: ONDCP defines the implementation status categories as follows: (1) *Complete*. The work specifically directed by the Strategy has been fulfilled. It does not imply that the larger goals the item supports have been entirely achieved or that work in progress in support of those goals should be halted. (2) *On track*. Implementation is under way, and the work being done is consistent with the fulfillment of the action item within the time frame specified. (3) *Delayed but progressing.* Work has started but has slowed or stalled, or the work being done is not ambitious enough to fulfill the action item in the time frame specified. (4) *Facing budget issues.* Work has stopped or been significantly impeded by funding shortfalls. (5) *At risk*. Work has never begun or has ceased.

We previously reported in July 2012 that ONDCP monitors and reports on the implementation status of action items to, among other things, help hold agencies accountable for implementing the action items; give credit to agencies for progress made; and motivate them, if needed, to take

steps to address delays.[38] Officials we interviewed from all seven agencies we selected stated that Strategy action items reflect their already existing priorities or activities. According to ONDCP officials, this alignment helps facilitate implementation. ONDCP officials stated that the implementation of Strategy action items is necessary to achieve Strategy goals but may not be sufficient. According to these officials, a variety of factors could affect achievement of these goals, such as worsening economic conditions, changing demographics, or changing social or political environments; the passage of state laws that decriminalize marijuana use or allow its use for medical purposes; failure to obtain sufficient resources to address drug control problems; insufficient commitment from agency partners; and the need for new action items that include initiatives or activities beyond those that are under way or planned.[39] ONDCP officials stated that the PRS is to provide more specific information about where the Strategy is on or off track and prompt diagnostic reviews to identify causal factors contributing to any problems identified, as discussed below.

ONDCP Has a New System in Place to Monitor Progress toward Goals and Plans to Define How the System Will Be Used to Assess Progress and Review Its Effectiveness

In April 2012, ONDCP established the PRS to monitor and assess progress toward meeting Strategy goals and objectives, and the office issued a report (the PRS report) describing the system with the 2012 Strategy update. The PRS includes interagency performance measures and targets under each Strategy objective.[40] For example, one of the six performance measures under the objective to strengthen efforts to prevent drug use in our communities is the average age of initiation for all illicit drug use, which has a 2009 baseline of 17.6 years of age and a 2015 target of 19.5 years of age. Similarly, one of the four performance measures under the objective to seek early intervention opportunities in health care is the percentage of respondents, aged 12 to 17, who have used prescription-type drugs nonmedically in the past year. This measure has a 2009 baseline of 7.7 percent and a 2015 target of 6.5 percent. According to ONDCP officials, the PRS augments ONDCP's current

[38]See GAO-12-744R for more information about how ONDCP shares and uses information regarding the implementation status of Strategy action items.

[39]See app. I for our review of available research on the effect of medical marijuana laws and marijuana decriminalization on youth drug use.

[40]ONDCP refers to the measures as interagency measures because they were developed to reflect the contributions of more than one agency.

method of examining performance by allowing the office to assess the effectiveness of interagency efforts to achieve the Strategy's objectives.[41] ONDCP officials stated that they plan to release the results of the PRS measures for the first time in 2013. According to the PRS report, system information is to be used to inform budget formulation and resource allocation, Strategy implementation, and policy making, among other things.

We assessed PRS measures and found them to be generally consistent with attributes of effective performance management identified in our prior work as important for ensuring performance measures demonstrate results and are useful for decision making.[42] For example, the PRS measures are clear, have limited overlap, and have measurable targets. Specifically, the measures are clearly stated, with descriptions included in the 2012 PRS report, and all 26 of them have or are to have numerical targets. In addition, the measures were developed with input from stakeholders through an interagency working group process, which included participants from Education, DOJ, and HHS, among others.[43] According to the PRS report, the working groups brainstormed candidate performance measures for each Strategy objective and assessed them based on criteria such as being clear, quantifiable, and valid indicators for the objective. The groups also identified data sources, such as national surveys on drug use and treatment services, to use to report on these measures and evaluated the data sources to determine if they were unbiased and collected data routinely, among other things.

The PRS report states that the system is to provide early warning about progress toward achieving Strategy objectives. However, it does not clearly define how progress toward 2015 targets for PRS measures is to be assessed and what actions are to be taken if intermediate results are not on track to meet these targets. ONDCP officials stated that they plan to provide information about the process to assess intermediate

[41]ONDCP's current method of assessing performance relies primarily on ONDCP's review of data agencies report for performance metrics that they established for individual drug control programs, as well as program budget justifications and evaluations, among other things.

[42]See GAO-03-143.

[43]The PRS report stated that five working groups were established and assigned Strategy objectives. Each working group held meetings to develop and refine measures and targets for the objectives.

performance results in the PRS report that is to be issued in 2013. These officials said that the report is still in development, but that for each PRS measure, they plan to compare the linear trend line from the baseline to the 2015 target with results to date; examine auxiliary data sources, such as other relevant national surveys, to refine the assessment; and work with interagency subject area experts to arrive at a final assessment.[44] ONDCP officials stated that when results are determined to not be on track to meet 2015 targets, the PRS is to serve as a trigger for an interagency review of potential causes of performance gaps and options for improvement. These proposed actions are consistent with leading practices that we have previously identified regarding using intermediate goals and measures to show progress or contributions to intended results and clearly documenting significant events to help ensure that management directives are carried out.[45]

According to ONDCP officials, information collected through the PRS is to provide valuable insights to help identify where the Strategy is on track and when further problem solving and evaluation are needed. However, the system is still in its early stages and, as of March 2013, operational information is not available to evaluate its effectiveness. ONDCP officials stated that as part of the annual process to assess PRS results, they plan to review the measures to determine the extent to which they reliably capture agency performance and whether there is a need to modify them.[46] Further, the 2012 PRS report states that ONDCP plans to continue to improve measures as better data sources become available. Officials said that they plan to address any modification of the measures in the 2013 PRS report. According to these officials, ONDCP plans to assess the effectiveness of the PRS more comprehensively to determine

[44]ONDCP officials stated that they plan to refine the trend lines used to assess progress as more data become available in future years. ONDCP officials stated that they are still developing their assessment process and did not wish to provide additional details because the 2013 PRS report has yet to be issued.

[45]GAO, *Agency Performance Plans: Examples of Practices That Can Improve Usefulness to Decisionmakers,* GAO/GGD/AIMD-99-69, (Washington D.C.: Feb. 26,1999), and *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999). According to these standards, the documentation should appear in management directives, administrative policies, or operating manuals.

[46]ONDCP officials stated that they are still developing how they specifically plan to review the measures and did not wish to provide additional details because the 2013 PRS report has yet to be issued.

how well it is working and whether any adjustments need to be made after the system has been operational for a longer period of time. Such actions are consistent with *Standards for Internal Control in the Federal Government* which calls for reviewing established performance measures to validate their propriety and integrity.[47]

ONDCP's plans to clearly define and document its performance assessment process and evaluate how well the PRS and its measures are working should help increase accountability for improving results and enhance the system's effectiveness as a mechanism to monitor progress toward Strategy goals and objectives and assess where further action is needed to improve progress. These actions could also help ONDCP identify ways to bridge the gap between the lack of progress toward Strategy goals and the reported strong progress agencies are making in implementing action items intended to facilitate the achievement of those goals.

Drug Abuse Programs Are Fragmented and Overlapping; Many Reported That They Did Not Coordinate, and ONDCP Has Not Assessed Extent of Overlap and Coordination Opportunities

Drug abuse prevention and treatment programs are fragmented across 15 federal agencies that funded or administered 76 programs in fiscal year 2011, and we identified overlap in 59 of these programs. Agency officials who administer programs in two areas that we reviewed in detail—that is, programs for youth and programs for offenders—reported making various efforts to coordinate program activities, which, according to our previous work, can minimize the risk of duplication. However, 29 of 76 (about 40 percent) surveyed programs reported no coordination with other federal agencies on drug abuse prevention or treatment activities. ONDCP has not assessed all drug abuse prevention or treatment programs to identify the extent of overlap and potential duplication and opportunities for coordination.

[47] GAO/AIMD-00-21.3.1.

Drug Abuse Programs Are Fragmented across 15 Federal Agencies, and Many Are Overlapping, Which May Result in Inefficiencies

Federal drug abuse prevention and treatment programs are fragmented across 15 federal agencies that administered 76 programs in fiscal year 2011. Agencies reported that they administered four types of programs, specifically:

- 22 programs were drug abuse prevention programs;
- 21 programs were drug abuse treatment programs;
- 13 programs were both drug abuse prevention and treatment programs; and
- 20 programs were neither drug abuse prevention nor treatment programs, but programs that may provide or fund drug abuse prevention or treatment services to support other program objectives.[48]

Table 2 provides the number of these types of programs within the 15 federal agencies, and appendix III provides additional information on the programs each agency administered in fiscal year 2011.

[48]For the purpose of our review, we collectively refer to these programs as drug abuse prevention and treatment programs. This includes those 20 programs that may provide or fund drug abuse prevention or treatment services to support other program objectives.

Table 2: Drug Abuse Prevention or Treatment Programs or Activities Administered by Selected 15 Federal Agencies in Fiscal Year 2011, by Type of Program

		Number of programs, by type of program				
Department	**Agency**	**Drug abuse prevention program**	**Drug abuse treatment program**	**Drug abuse prevention and treatment program**	**Neither, but program may include drug abuse prevention or treatment activities**	**Total number of programs**
DOD		5	1	1		7
DOJ	BOP		3	1		4
	DEA				1	1
	OJP	1	4		1	6
DOT	FAA				3	3
	NHTSA				1	1
Education		1			2[a]	3[b]
Executive Office of the President	ONDCP	2			1	3
Federal Judiciary	AOUSC		1			1
HHS	HRSA				2	2
	IHS			5		5
	SAMHSA	13	10	6	5	34
HUD					3	3
Labor	ETA				1	1
VA	VHA		2			2
	Total	**22**	**21**	**13**	**20**	**76**

Source: GAO analysis of questionnaire responses from 15 federal agencies.

AOUSC = Administrative Office of the United States Courts
BOP = Bureau of Prisons
DEA = Drug Enforcement Administration
DOD = Department of Defense
DOJ = Department of Justice
DOT = Department of Transportation
ETA = Education and Training Administration
FAA = Federal Aviation Administration
HHS = Department of Health and Human Services
HRSA = Health Resources and Services Administration
HUD = Department of Housing and Urban Development
IHS = Indian Health Service
NHTSA = National Highway Traffic Safety Administration
OJP = Office of Justice Programs
ONDCP = Office of National Drug Control Policy
SAMHSA = Substance Abuse and Mental Health Services Administration
VA = Department of Veterans Affairs
VHA = Veterans Health Administration

Notes: For the purpose of our review, we defined a drug abuse prevention program as a federal program that provides services, allocates funding, or allows for activities focused on discouraging the first-time use of controlled substances—specifically illicit drugs and the problematic use of alcohol—

and encouraging those who have begun to use controlled substances to cease their use. We defined a drug abuse treatment program as a federal program that provides services, allocates funding, or allows for activities focused on identifying and assisting users of controlled substances—specifically illicit drugs and the problematic use of alcohol—to become drug-free and remain drug-free.

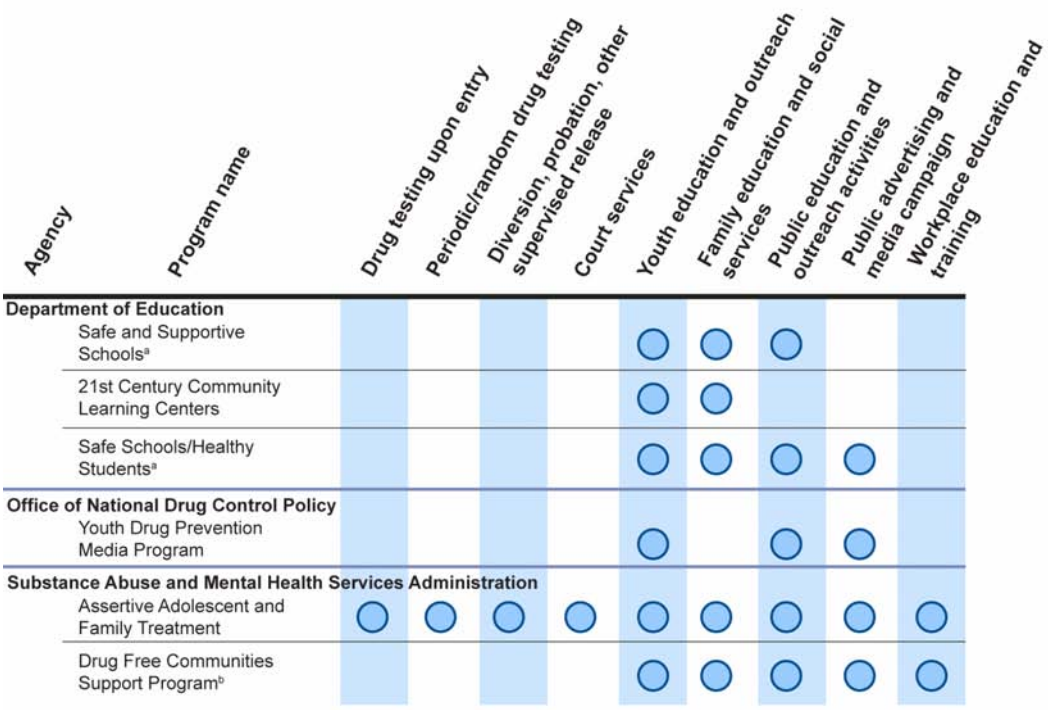
[a]Under 20 U.S.C. § 7164, funds may not be used for medical services, drug treatment, or rehabilitation, except for pupil services or referral to treatment for students who are victims of, or witnesses to, crime or who illegally use drugs with regard to Safe and Drug-Free Schools and Communities. Under 20 U.S.C. § 7175, with regard to 21st Century Community Learning Centers, each eligible entity that receives an award may use the award funds to carry out a broad array of before and after school activities that advance student academic achievement that are listed in the statute.

[b]For the purpose of our review, we assessed the activities of Education's Safe and Supportive Schools and Safe Schools/Healthy Students programs separately; according to officials from Education, they are considered to be activities within a single program—the Safe and Drug-Free Schools and Communities National Activities.

Furthermore, we identified overlap among the prevention and treatment programs we reviewed. As we have previously reported, overlapping programs can lead to target populations being eligible for similar services through multiple programs. However, overlapping programs are not necessarily duplicative, if the services provided and the populations served differ in meaningful ways.[49] Of the programs we reviewed, 59 of the 76 programs (nearly 80 percent) are overlapping because they can provide or fund at least one drug abuse prevention or treatment service that at least one other program can provide or fund, either to similar population groups or to reach similar program goals. For example, six programs reported that they can provide or fund drug abuse prevention services for students and youth in order to support program goals of preventing drug use and abuse among young people. All six of the programs reported that they can provide or fund services to conduct outreach and educate youth on drug use. In addition, all of these programs also reported that they can provide or fund other similar services—such as public advertising and media campaigns or workplace education and training—with at least one other program. (See fig. 4.)

[49]See GAO, *Science, Technology, Engineering, and Mathematics Education: Strategic Planning Needed to Better Manage Overlapping Programs across Multiple Agencies,* GAO-12-108 (Washington, D.C.: Jan. 20, 2012).

Figure 4: Overlapping Prevention Services Provided to the Student and Youth Population, Fiscal Year 2011



Source: GAO analysis of questionnaire responses from 15 federal agencies.

Notes: We defined "drug abuse prevention services" as activities focused on discouraging the first-time use of controlled substances—specifically illicit drugs and the problematic use of alcohol—and encouraging those who have begun to use controlled substances to cease their use. Programs included in this table reported providing drug abuse prevention services to support program goals of preventing drug use and abuse among young people. Other drug abuse programs included in our review may also provide drug abuse prevention services to students and youths to achieve the program's primary objectives. For example, the Department of Labor's Job Corps program provides prevention services to students and youths for the purpose of workforce development.

[a]Education and the Substance Abuse and Mental Health Services Administration (SAMHSA) jointly fund and manage the Safe Schools/Healthy Students program. In addition, for the purpose of our review, we assessed the activities of Education's Safe and Supportive Schools and Safe Schools/Healthy Students programs separately; according to officials from Education, they are considered to be activities within a single program–the Safe and Drug-Free Schools and Communities National Activities.

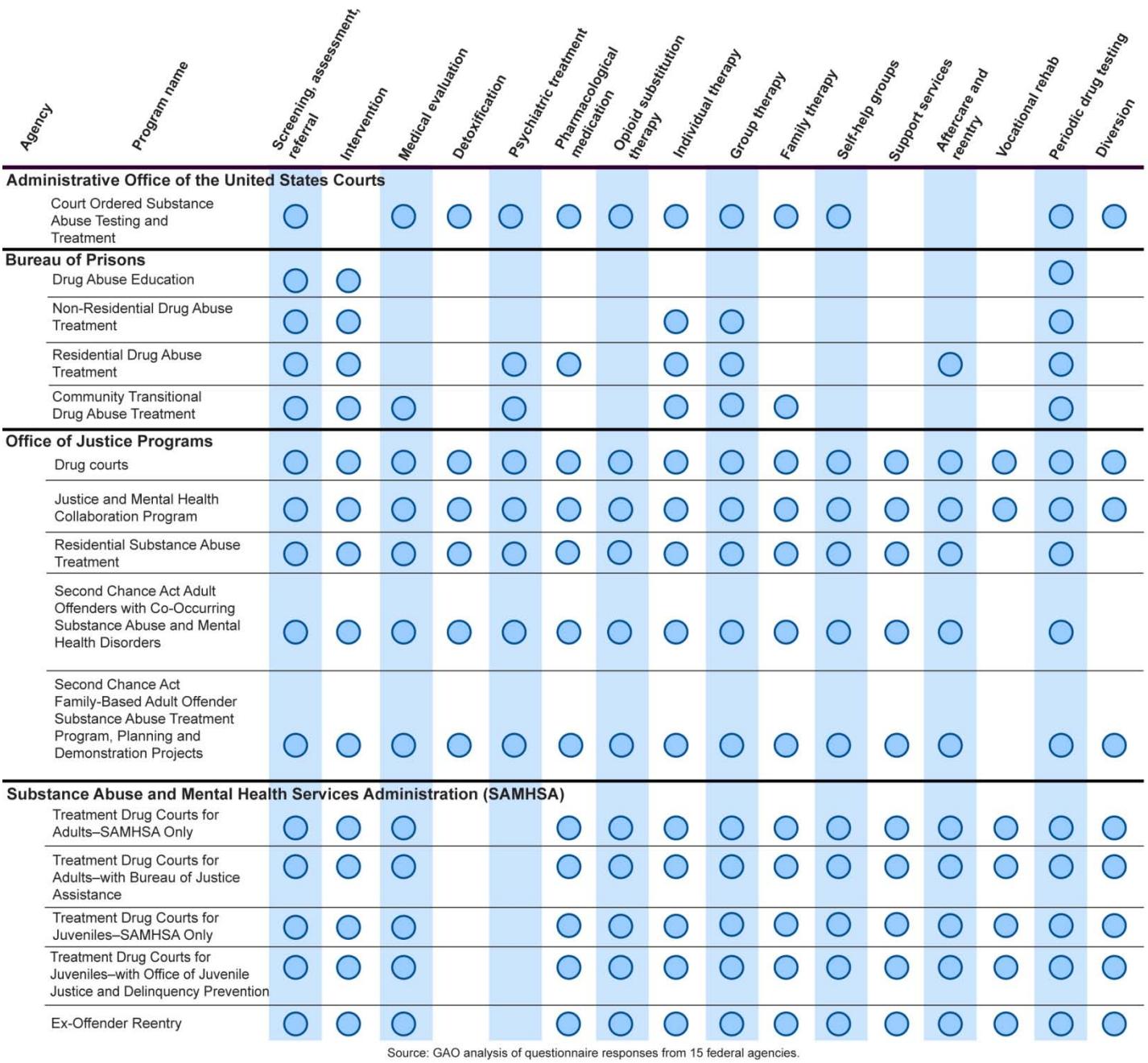
[b]This program is managed by SAMHSA and funded by the Office of National Drug Control Policy (ONDCP). According to ONDCP officials, Drug Free Communities coalitions are allowed to participate in and provide media on drug abuse prevention, but the program itself is not a public advertising or media campaign.

In addition, 15 programs reported that they can provide or fund many of the same prevention and treatment services provided to the offender

population, that is, those individuals involved in the criminal justice system. Specifically, these programs reported that they can provide or fund many of the same treatment services in order to support similar program goals of identifying and meeting the treatment needs of offenders and providing services to reduce recidivism and facilitate reentry.[50] For example, 12 of the 15 programs can provide or fund medical evaluations and different forms of therapy, including individual and family therapy, as shown in figure 5.

[50]The term "recidivism" generally refers to the act of committing new criminal offenses after having been arrested or convicted of a crime. See GAO, *Adult Drug Courts: Studies Show Courts Reduce Recidivism, but DOJ Could Enhance Future Performance Measure Revision Efforts*, GAO-12-53 (Washington, D.C.: Dec. 9, 2011).

Figure 5: Overlapping Treatment Services Provided to the Offender Population, Fiscal Year 2011



Source: GAO analysis of questionnaire responses from 15 federal agencies.

Note: We defined "drug abuse treatment services" as activities focused on identifying and assisting users of controlled substances, specifically illicit drugs and the problematic use of alcohol, to become drug free and remain drug free.

In addition, programs with the goals of (1) expanding state and community capacity to prevent drug abuse and (2) addressing underage drinking also demonstrated overlap. For example, 9 programs reported that they can provide or fund drug abuse prevention and treatment services to almost all population groups listed in our survey in support of program goals to expand the capacities of state- and community-level entities to prevent drug abuse. Prevention services that could be provided by these programs included youth education, family education and support services, and public outreach activities. Furthermore, 4 programs with the goal of reducing underage drinking also reported providing similar types of prevention services, including youth education and public outreach activities.

Fragmentation and overlap in some programs have resulted from agency efforts to meet specific areas of national need, among other things. For example, SAMSHA officials told us that DOJ's and states' expansion of funding for drug courts in the 1980s resulted in a strain on the number of community substance abuse treatment services available to drug courts. SAMHSA recognized the need for additional funding in this area and began to fund the expansion and enhancement of substance abuse treatment services specifically available to drug courts. In addition, having multiple programs that can provide similar services to similar beneficiaries can help to fill gaps in services for beneficiaries. However, this fragmentation and overlap could also make it challenging to develop a coordinated federal approach to providing drug abuse prevention and treatment services because of the number of different federal agencies involved, and could result in potential inefficiencies among programs providing similar services. Specifically, our body of work on fragmentation and overlap has found that agencies often can realize a range of benefits, such as improved customer service and decreased administrative burdens and cost savings from addressing issues related to fragmentation and overlap, as we discuss below.[51]

[51]See GAO-11-318SP and GAO-12-342SP.

Many Programs Reported That They Do Not Coordinate, and ONDCP Has Not Assessed the Extent of Overlap and Identified Coordination Opportunities to Help Improve Efficiencies

Coordination Efforts in Two Areas with Overlap Helped Minimize Risk of Duplication, but Not All Programs Reported Such Efforts

Agency officials who administer programs in two areas that we reviewed in more detail—specifically, programs for youth and programs for offenders—reported making various efforts to coordinate overlapping program activities or services, which can serve to minimize the risk of duplication.[52] However we found that not all programs surveyed reported coordinating with other federal agencies on drug abuse prevention or treatment activities in the year prior to our survey. For those areas that we reviewed in more detail, we found the following:

- *Prevention services for student and youth:* While 6 programs that provide services to youth are overlapping, the risk of potential duplication among these programs may be low because of interagency coordination efforts.[53] Officials overseeing these programs from Education, ONDCP, and SAMHSA reported that the agencies coordinate to improve program efficiencies. For example, using an interagency agreement, Education jointly administers the Safe Schools/Healthy Students program with DOJ and HHS to provide complementary educational, mental health, and law enforcement services to help prevent youth violence and drug use. Similarly, SAMHSA and ONDCP maintain an interagency agreement to jointly administer the Drug Free Communities Support program. Officials from SAMHSA said that the agreement defines the roles and

[52]See GAO, *Managing for Results: GPRA Modernization Act Implementation Provides Important Opportunities to Address Government Challenges*, GAO-11-617T (Washington, D.C.: May 10, 2011).

[53]These programs included 2 programs administered by Education; 1 program administered by SAMHSA; 1 program administered by ONDCP; 1 program administered jointly by Education, SAMHSA, and DOJ; and 1 program administered jointly by SAMHSA and ONDCP.

responsibilities of the two agencies, and establishes agreed-upon standard operating procedures.

In addition, officials from Education, ONDCP, and SAMHSA reported that some programs and the services they can provide or fund are distinct because they target specific subgroups among students and youth, or they differ in scope. For example, the 21st Century Community Learning Center program allows for additional uses of funds that are not related to drug abuse prevention, like tutoring and mentoring, and does not require that grantees include drug abuse prevention as a program component. Officials from Education said that this indicates a difference in scope from the Safe Schools/Healthy Students program, which requires grantees to include drug abuse prevention services as a main program component. These officials also reported taking steps to identify opportunities for increasing efficiencies. For example, in its fiscal year 2013 budget justification, Education proposed consolidating several existing programs that seek to help schools provide programs and activities including alcohol, drug, and violence prevention. According to Education officials, the consolidation would more effectively target resources and address the needs of grantees.

- *Prevention and treatment services for offenders*: Officials from the four agencies overseeing the programs that can provide or fund treatment and prevention services to the offender population also said that the agencies conduct coordination efforts to help ensure that programs provide complementary services to this population, which can minimize the risk for potential duplication.[54] OJP and SAMHSA officials reported that both agencies coordinate to ensure that these programs provide funding for different program elements. For example, according to OJP and SAMHSA officials, SAMHSA funding for drug courts is used for treatment services, while OJP funding for drug courts is used for administrative or case management purposes. While OJP is not restricted from funding the same treatment services SAMHSA can fund, officials from both agencies said that they use multiple coordination mechanisms to help minimize the risk of potential duplication. For example, OJP and SAMHSA jointly administer two drug court programs. For the agencies' other programs

[54]These programs included 5 programs administered by OJP, 4 programs administered by the Bureau of Prisons, 3 programs administered by SAMHSA, 2 programs jointly administered by OJP and SAMHSA, and 1 program administered by the Administrative Office of the United States Courts.

serving offenders that are not jointly administered, SAMHSA officials told us they share requests for grant applications and information on potential awardees with OJP officials to ensure that grants are not awarded to the same grantee for the same purpose. We also previously reported that program overlap is minimal and the risk of potential duplication is low among OJP's and SAMHSA's offender programs that assist former inmates or inmates preparing for release from federal, state, and local correctional facilities.[55]

Additionally, officials from OJP and SAMHSA reported that their programs specifically serve offenders in the state and local justice systems, while the Bureau of Prisons and the Administrative Office of the United States Court's programs specifically serve offenders who are or were incarcerated in federal prisons, which results in these programs having a low risk for duplication. In addition, these officials reported that the two agencies regularly share information and coordinate on prerelease planning for inmates in federal prisons and on transitioning inmates from prison to court-ordered drug testing and treatment after release, or vice versa.

Coordination efforts among the programs included in the two areas we reviewed in detail were consistent with practices that we have previously reported federal agencies use to implement collaborative efforts.[56] These efforts could address crosscutting issues that may reduce potentially duplicative, overlapping, or fragmented efforts. However, 29 of the 76 programs (about 40 percent) surveyed reported no coordination with other federal agencies on drug abuse prevention or treatment activities. As we have previously reported, because fragmentation across agencies can create an environment in which programs are not delivered as efficiently and effectively as possible, coordination across government is essential.[57] Therefore, there may be additional opportunities to implement interagency coordination efforts among the programs that did not report

[55]Services funded by these programs included substance abuse, housing, and mental or behavioral health. GAO, *Inmate Reentry Programs: Enhanced Information Sharing Could Further Strengthen Coordination and Grant Management,* GAO-13-93 (Washington, DC: Dec. 14, 2012).

[56]See GAO, *Managing for Results: Key Considerations for Implementing Interagency Collaborative Mechanisms,* GAO-12-1022 (Washington, D.C.: Sept. 27, 2012).

[57]See GAO, *Homelessness: Fragmentation and Overlap in Programs Highlight the Need to Identify, Assess, and Reduce Inefficiencies*, GAO-12-491 (Washington, D.C.: May 10, 2012).

any of these efforts, to identify potential efficiencies that better leverage available resources and minimize overlap and potential duplication.

ONDCP Has Not Assessed the Extent of Overlap and Duplication among Drug Abuse Programs and Identified Agency Opportunities for Coordination

While ONDCP has identified activities related to the development and implementation of the Strategy and Drug Control Budget that promote coordination, it has not systematically assessed all drug abuse prevention or treatment programs to examine the extent of overlap and potential for duplication and identified opportunities for coordination among programs to more efficiently use limited resources. According to ONDCP officials, the office's current processes are sufficient to determine the extent of overlap and potential for duplication. Specifically, officials from ONDCP and other agencies with whom we spoke reported that they have made efforts to promote coordination through the Strategy, which emphasizes the importance of agencies collaborating on the Strategy's goals.[58] In addition, ONDCP officials stated that as part of the office's annual process for developing the National Drug Control Budget submission, they review prevention and treatment programs for which funding is requested to verify that the programs serve unique needs and populations. ONDCP officials stated that their familiarity with the programs and information obtained from outreach at the programmatic level and interagency meetings, among other things, help in this review.

However, the purpose of the interagency meetings and other efforts to facilitate coordination is to develop and implement the Strategy and not to identify overlap or potential duplication. Furthermore, the purpose of the budget process is to develop a consolidated funding request to implement the Strategy and help ensure that the Strategy is adequately resourced rather than to identify overlap or potential duplication across all programs. Accordingly, ONDCP has not conducted a systematic assessment of all federal drug abuse prevention and treatment programs, including those not captured in the budget, and the services they are allowed to provide to determine the extent to which they overlap and where opportunities exist to pursue coordination strategies in order to more efficiently use

[58]For example, ONDCP designates lead and partner agencies for each of the activities in the Strategy and discusses the use of interagency working group meetings, both of which are used to coordinate Strategy implementation.

limited resources.[59] Further, ONDCP officials stated that there is no overlap among these programs, but our analysis of prevention and treatment services identified overlap in 59 of them. *Standards for Internal Control in the Federal Government* highlights the importance of having access to operational and other data to determine whether programs are meeting goals for accountability and efficient use of resources.[60] Additionally, *The Standard for Project Management* states that to ensure related projects are managed to achieve more benefits than could be achieved with stand-alone efforts, management should coordinate common activities or programs and the efficient use of resources across activities.[61] This can include such efforts as mapping out how various activities across organizations are to achieve desired benefits.

Further, our previous work on characteristics of effective national strategies states that such strategies should include mechanisms for coordinating agency implementation efforts, which could entail the identification of specific processes for coordination.[62] As discussed earlier, officials from 29 of the 76 programs (about 40 percent) surveyed reported that they did not participate in any coordination efforts over the

[59]Some of the programs included in our review of 76 programs are not included in the Drug Control Budget. For example, Education's 21st Century Community Learning Centers program is not included in the Drug Control Budget because Education officials told us that the drug abuse prevention is one of a large number of authorized uses of these funds. Officials also said that the agency does not have a viable, cost-effective methodology for compiling the data that would be used to estimate the amount of funds spent on drug abuse prevention in this program. ONDCP reviews the budget requests of drug control agencies to determine if the agencies have acceptable methodologies for estimating their drug control budgets, and includes those that do in the National Drug Control Budget. An acceptable methodology relies on availability of empirical data at the agencies for estimating their drug control budgets. These data include determining which portion of an agency's funding is for drug control programs or activities versus nondrug control programs. See GAO-11-261R. ONDCP officials also told us that they are working with officials from Education to develop additional information on drug prevention activities in the 21st Century Community Learning Centers program including (1) the number of local centers that provide drug prevention activities, (2) the number of students served by those centers, and (3) the amount of 21st Century Community Learning Centers funds received by those centers.

[60]GAO/AIMD-00-21.3.1.

[61]The Project Management Institute, *The Standard for Program Management* (Newtown Square, PA: 2008).

[62]See GAO, *Combating Terrorism: Evaluation of Selected Characteristics in National Strategies Related to Terrorism*, GAO-04-408T (Washington, D.C.: Feb. 3, 2004).

past year. Additionally, there may be other opportunities for improved efficiencies among agencies that have some coordination efforts in place. For example, while SAMHSA and OJP officials have made efforts to provide complementary drug court services, a SAMHSA official stated that a drug court awardee using SAMHSA funds to provide treatment services and OJP funds to administer the drug court still must meet complex, separate reporting requirements to each agency for such things as budget and performance management information. Our previous work has shown that fragmented services with separate agency requirements can be burdensome, difficult, and costly for service providers.[63] ONDCP is uniquely situated to conduct an assessment across the 76 programs engaged in drug abuse prevention and treatment activities to identify the extent of overlap and potential for duplication and prospective processes for coordination. ONDCP could use the results of our analysis as a starting point for conducting this assessment. Such actions would better position ONDCP to help ensure that federal agencies undertaking similar prevention and treatment efforts identify opportunities for increased efficiencies, such as using coordination mechanisms to mitigate the risk of duplication and reducing administrative burdens on grantees, and better leverage available resources. These mechanisms could include, for example, joint program administration established through interagency agreements, sharing requests for grant applications, or joint performance measurement reporting among programs serving the same grant or cooperative agreement awardees.[64]

[63]See GAO, *Homelessness: Fragmentation and Overlap in Programs Highlight the Need to Identify, Assess, and Reduce Inefficiencies*, GAO-12-491 (Washington, D.C.: May 10, 2012).

[64]For more information on the mechanisms that the federal government can use to lead and implement interagency coordination, see GAO-12-1022.

Agencies We Reviewed Have Completed Few Program Evaluations, with Three Looking at Program Effectiveness, but Have Taken Other Steps to Ensure Programs Are Effective

While agencies in our review had completed few program evaluations since 2007, in part because of funding constraints, more are under way or planned. ONDCP officials stated that because few programs have completed program evaluations, they rely on a range of available performance information, including agency performance metric data, to inform development and implementation of the Strategy. In addition, agency officials said that they have taken other steps to help ensure that programs supporting the Strategy are effective, such as requiring or encouraging the use of interventions—drug abuse prevention or treatment practices—in their programs for which there is research or evidence that the interventions work.

Agencies in Our Review Have Completed Few Program Evaluations, but More Are Under Way or Planned

Program evaluations allow for comprehensive assessments of whether programs are achieving desired results to help allocate scarce resources to effective interventions, among other things.[65] Program evaluation is closely related to performance measurement and reporting;[66] evaluations have been used to supplement performance reporting by measuring results that are too difficult or expensive to assess annually or by exploring why program goals were not met. Program evaluations can tell agencies how well their programs are working, suggest options for improving program performance, and assist in program management. However, the drug control agencies in our review had completed few program evaluations since 2007, although more are under way or planned. Specifically, we found that 3 of the 15 agencies had completed evaluations of 6 programs since 2007, which accounts for about 8 percent of the 76 drug abuse prevention and treatment programs included in our review, and 8 agencies had started or planned 22 additional program

[65]For more information about program evaluations, see GAO-12-208G.

[66]Performance measurement is the systematic ongoing monitoring and reporting of program accomplishments, particularly progress toward preestablished goals or standards. Performance measures or indicators may address program staffing and resources, the type or level of program activities conducted, the direct products or services delivered by a program, or the direct results of those products and services.

evaluations.[67] See table 3 for the 9 agencies with program evaluations for one or more of their programs.

Table 3: Drug Control Agency Programs with Evaluations Completed, Under Way, or Planned since 2007, as of November 2012

Program	Program type[a]	Status of evaluation		
		Completed	Under way	Planned
Administrative Office of the United States Courts				
Court Ordered Substance Abuse Testing and Treatment	Treatment			X
Department of Defense				
Substance Abuse Rehabilitation Program	Treatment			X
Navy Alcohol and Drug Abuse Prevention	Prevention			X
Department of Education				
Safe Schools/Healthy Students[b]	Prevention			X
Indian Health Services				
Methamphetamine Suicide Prevention Initiative	Prevention and treatment			X
Substance Abuse and Mental Health Services Administration				
Substance Abuse Prevention and Treatment Block Grant	Prevention and treatment	X		
Underage Drinking Prevention Education Initiative	Prevention	XX[c]		X
State Screening, Brief Intervention, and Referral to Treatment	Prevention and treatment			X
Targeted Capacity Expansion General—Grants to Expand Care Coordination Using Health Information Technology	Neither prevention nor treatment, but may include prevention or treatment activities			X
Assertive Adolescent and Family Treatment	Prevention and treatment	X		
Homeless Grants for the Benefit of Homeless Individuals	Treatment			X
Minority AIDS Initiative Targeted Capacity Expansion	Prevention and treatment			X

[67]We examined program evaluations conducted by agencies in our review or on behalf of these agencies. An agency, through a program office or a research, policy, or evaluation office, may conduct studies internally, or it may direct or fund a study to be conducted externally by an independent consulting firm, research institute, or independent oversight agency or an agency's inspector general.

Program	Program type[a]	Status of evaluation		
		Completed	Under way	Planned
Minority HIV/AIDS[d]	Prevention		X	
Minority HIV Prevention				
Capacity Building Initiative				
Ready to Respond				
Strategic Prevention Framework State Incentive Grants	Prevention		XX[c]	
Fetal Alcohol Spectrum Disorders Center of Excellence	Prevention		X	
Bureau of Prisons				
Residential Drug Abuse Treatment	Treatment			X
Office of Justice Programs				
Drug Courts	Treatment	X	XX[c]	X
Enforcing Underage Drinking Laws	Prevention		X	X
Residential Substance Abuse Treatment	Treatment			X
Office of National Drug Control Policy				
Drug Free Communities Support Program[e]	Prevention		X	
Department of Veterans Affairs				
Substance Use Disorder Outpatient Program and Substance Use Disorder Residential Program[f]	Treatment	X		
Total		**6**	**18**	**4**

Source: GAO analysis of agency information.

Notes: We define a completed evaluation as one that has been published, while an evaluation that is under way is one that is currently being conducted or has been published as an interim report with the intention of publishing a final version in the future. We define a planned evaluation as one that will begin at a future date.

[a]Program type is prevention, treatment, prevention and treatment, or neither prevention nor treatment, but may include prevention or treatment activities.

[b]Education and SAMHSA jointly fund and manage the Safe Schools/Healthy Students program. SAMHSA funds and has the lead on implementing the evaluation.

[c]Indicates two evaluations completed or under way for the same program.

[d]SAMHSA is conducting one cross-site evaluation of the Minority HIV/AIDS program, which includes the Minority HIV Prevention, Capacity Building Initiative, and the Ready to Respond programs.

[e]SAMHSA manages this program, but ONDCP funds it. ONDCP is funding and managing the program evaluation.

[f]Indicates one evaluation was completed for both programs.

Some evaluations' results may be used to assess a programs' effectiveness, while other results may examine the quality or progress of program implementation. In reviewing the six completed evaluations, we found that three directly examined program effectiveness: OJP's Drug Courts Program, the Department of Veterans Affairs' Substance Use

Disorder Outpatient Program and Substance Use Disorder Residential Program, and SAMHSA's Substance Abuse Prevention and Treatment Block Grant Program.[68] The three other evaluations assessed aspects of how the programs were implemented, and were SAMHSA's Underage Drinking Prevention Education Initiative (2008 evaluation and 2010 evaluation), and SAMHSA's Assertive Adolescent and Family Treatment Program.[69] Appendix IV provides more information about these six evaluations.

SAMHSA, the HHS agency that administers 34 of the 76 programs (45 percent) that were included in our review, is developing guidelines for conducting standard program evaluations across the agency.[70] Under the new guidelines, program evaluation will consist of three phases: (1) conceptualization and planning prior to making a funding announcement for grants or other types of awards, in which evaluation planning and resource allocation will occur; (2) evaluation design and implementation; and (3) postevaluation dissemination and closeout activities. Additionally, SAMHSA has tasked an agency evaluation team with establishing criteria to determine who should conduct program evaluations. SAMHSA officials said that they expect to fully implement the new guidelines in 2014, and they will apply to all programs being evaluated after this date.

Officials from five of the six agencies that had not conducted evaluations—HHS's Health Resources and Services Administration (HRSA), the Department of Housing and Urban Development, the Department of Labor, and the Federal Aviation Administration and National Highway Traffic Safety Administration within the Department of Transportation—said they did not conduct them largely because drug

[68]ONDCP has conducted an assessment of its High Intensity Drug Trafficking Areas program. However, analysis of drug abuse prevention and treatment activities was not the focus of this assessment and, therefore, we did not include it in our review.

[69]Agency officials noted that for some programs that provide grants, individual grantees may conduct small-scale evaluations as a condition of the grant to examine how well a specific grantee is implementing a program at a specific site. For example, Education's Safe Schools/Healthy Students grantees are required to complete an evaluation as a condition of the grant. We did not review program evaluations conducted by individual grantees, as this was outside the scope of our work.

[70]SAMHSA describes itself as the nation's lead agency for information on behavioral health services—including drug abuse prevention and treatment. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

abuse prevention and treatment were not the main focus of the program, or funding was not available for an evaluation.[71] Officials from three of the agencies said that while program evaluations may be conducted that look at other features of the programs, the evaluations may not examine any drug abuse prevention and treatment activities. For example, officials from the Department of Labor's Job Corps program and from the Department of Housing and Urban Development said that since their programs focus on other areas, namely employment and homelessness, drug abuse prevention and treatment were not included in any program evaluation activities.

Officials from four agencies also cited the lack of funding or other resources as another reason why program evaluations have not been completed, started, or planned. For example, officials from HRSA's Ryan White HIV/AIDS program said that the program's evaluation requirement and its associated funding were eliminated when the program was reauthorized in 2006. As a result, HRSA officials said the agency has not conducted an evaluation of the entire Ryan White HIV-AIDS program since 2006.[72]

ONDCP and Agencies Have Taken Other Steps to Help Ensure That Programs Supporting the Strategy Are Effective

ONDCP and agency officials said that they have collected and analyzed other program performance information or required or encouraged the programs to use evidence-based interventions, which are approaches to prevention or treatment that are based in theory and have undergone scientific evaluation. ONDCP officials responsible for implementing the Strategy said that the agency uses the results of program evaluations, when available, to help develop and implement the Strategy and budget. Because few programs have completed program evaluations, they also use a range of available performance information, including agency performance data collected to meet GPRA Modernization Act of 2010

[71]One of the six agencies, DOJ's Drug Enforcement Administration, said that it did not conduct evaluations because its program was a small education program designed to increase awareness about the dangers associated with using illegal drugs.

[72]While HRSA has not conducted a program evaluation of the entire program, HRSA officials stated that the agency initiates two to three studies each year about various aspects of the Ryan White HIV-AIDS program. For example, officials said that the agency is currently conducting a study to assess factors that affect enrollment and management of the program's AIDS Drug Assistance Program in light of waiting lists for AIDS Drug Assistance Program services.

requirements, and other agency data when developing and implementing the Strategy and budget.[73] Additionally, we reported in July 2012 that agencies may either require grantees to demonstrate the effectiveness of the interventions they plan to use in drug abuse prevention and treatment programs or give preference to grant applicants that include interventions for which there is evidence of effectiveness in their grant applications.[74] For example, we reported that SAMHSA officials said that as a condition of funding, the agency requires, as part of its grant application process, that most grantees show that they will use evidence-based interventions in their programs.

Officials from seven agencies with whom we spoke said that they do not prescribe the specific evidence-based interventions that must be used in their grant programs, but rather rely on grantees to identify the most appropriate evidence-based interventions based on client needs. For example, Indian Health Service officials noted that there are many evidence-based practices that would be appropriate, depending on various characteristics, such as the population being served or a community's specific alcohol or drug abuse problem, and grantees must be able to use the interventions most suited for their specific situations. Additionally, HRSA officials said that because their Health Center and Ryan White HIV/AIDS programs are not direct drug abuse prevention or treatment programs, they rely on professionals in their delivery care settings to provide the appropriate services for drug abuse prevention or treatment. Other agencies that directly offer prevention or treatment services said that they require those programs to incorporate specific, evidence-based interventions in their services. For example, according to a Department of Veterans Affairs official, the department's treatment guidelines for its substance use disorder inpatient and outpatient treatment programs incorporate the elements of evidence-based

[73]Pub. L. No. 111-352, 124 Stat. 3866 (2011). The GPRA Modernization Act of 2010 amends the Government Performance and Results Act of 1993, Pub. L. No. 103-62, 107 Stat. 285 (1993), which established a statutory framework for performance management and accountability, including the requirement that federal agencies set goals and report annually on progress toward these goals and program evaluation findings.

[74]GAO-12-744R.

treatment that are outlined in a national consensus standards report published by the National Quality Forum.[75]

Conclusions

The public health, social, and economic consequences of illicit drug use, coupled with the constrained fiscal environment of recent years, highlight the need to ensure that federal programs efficiently and effectively use their resources to address this problem. ONDCP has developed a 5-year Strategy to reduce illicit drug use and its consequences, but our analysis shows lack of progress toward achieving four of the Strategy's five goals for which primary data are available. ONDCP established the PRS in April 2012 to monitor progress toward the Strategy's goals and objectives and provide information to guide efforts to meet these goals. While this is promising, ONDCP does not plan to report on results until later in 2013, and until then, operational information is not available to evaluate its effectiveness.

A wide range of federal drug abuse prevention and treatment programs support the achievement of the Strategy's goals. While some fragmentation and overlap of program services may be beneficial, they also entail potential inefficiencies that programs may not be able to afford in this era of resource constraints. Because of its responsibility for coordinating implementation of national drug control policy across the federal government, ONDCP is uniquely situated to conduct an assessment to identify overlap and potential duplication among prevention and treatment programs and coordination opportunities. Our work has identified specific areas of fragmentation and overlap of services among these programs that could be used by ONDCP, along with other information such as results from agencies' program evaluation efforts, to help agencies begin or improve coordination efforts to help reduce or eliminate potential inefficiencies. For example, ONDCP could identify the causes for the lack of coordination among the 29 agencies that reported conducting no coordination and further examine the overlap we identified in programs focused on capacity building and underage alcohol use, as a starting point for a broader assessment across federal agencies. Such an assessment would better position ONDCP to identify opportunities for increased efficiencies, such as using coordination

[75]See National Quality Forum, *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence Based Treatment Practices* (Washington, D.C.: 2007).

mechanisms to mitigate the risk of duplication, and help ensure that federal agencies undertaking similar prevention and treatment efforts better leverage available resources to achieve Strategy goals.

Recommendation for Executive Action

To identify opportunities to increase efficiencies and therefore better leverage agency prevention and treatment resources, we recommend that the Director of ONDCP assess the extent of overlap and potential for duplication across federal programs engaged in drug abuse prevention and treatment activities and identify opportunities for increased coordination. ONDCP could use our work as a starting point for this assessment.

Agency Comments and Our Evaluation

We provided a draft of this report to ONDCP; the Departments of Health and Human Services, Justice, Education, Defense, Housing and Urban Development, Labor, Transportation, Veterans Affairs, and Homeland Security; and the Federal Judiciary for review and comment. ONDCP provided written comments, which are reprinted in appendix V and summarized below. ONDCP concurred with our recommendation, and also provided perspectives on overlap among drug abuse prevention and treatment programs and progress toward achieving Strategy goals.

In its comments, ONDCP reiterated that we reported finding overlap but not actual instances of duplication among the drug prevention and treatment programs we reviewed. The office also made the points, with examples, that some overlapping programs (1) may not serve identical populations and may target different specific subgroups of a large population category, such as different types of youth age groups, and (2) may provide distinct services. We acknowledged these factors in our report, and maintain that this is why it is important to systematically review the extent of overlap among prevention and treatment programs, taking into account targeted subgroups and allowable services, to help ensure that they efficiently use limited resources to deliver these important services. ONDCP also reiterated, as we stated, that overlapping programs may provide positive benefits, such as reinforcing key prevention messages. Further, the office agreed that coordination efforts among programs can help avoid duplication and maximize program effectiveness. This is consistent with our report, which noted that overlap and fragmentation may not necessarily lead to duplication, but can create an environment in which programs are not delivered as efficiently and effectively as possible, and that coordination among programs helps to reduce the risk of duplication and increase efficiencies.

ONDCP stated that while extensive coordination of prevention and treatment programs is already taking place, there is always room for improvement, and that it will work with agencies administering these programs to further enhance coordination.

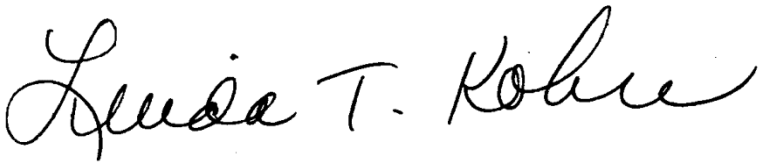
With regard to progress toward achieving Strategy goals, ONDCP stated that it is important to analyze trends for each drug category separately and noted that we recognized this in our discussion of ONDCP's goal to reduce drug use among 12- to 17-year-olds by 15 percent by 2015. As the report states, marijuana accounts for almost 80 percent of drug use in this age group, and the lack of progress on this goal is due primarily to an increase in the rate of reported marijuana use, offset by decreases in the rates of other drug use. We also state that misuse and abuse of prescription drugs is the primary factor for one of the measures for the goal to reduce drug-related morbidity by 15 percent, which also shows lack of progress. Finally, ONDCP noted, as we did in the report, that while results from the primary data source for the goal to reduce drugged driving by 10 percent are not available, results from ONDCP's secondary data source indicate progress.

ONDCP and the Departments of Health and Human Services, Justice, Education, Defense, Transportation, and Housing and Urban Development provided technical comments on this report that we incorporated as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to selected congressional committees; the Director of ONDCP; Secretaries of Health and Human Services, Education, Defense, Housing and Urban Development, Labor, Transportation, Veterans Affairs, and Homeland Security; Attorney General; Director of the Administrative Office of United States Courts; and other interested parties. In addition, the report will be available at no charge on GAO's website at http://www.gao.gov. If you or your staff have

any questions about this report, please contact Eileen R. Larence at (202) 512-8777 or larencee@gao.gov or Linda T. Kohn at (202) 512-7114 or kohnl@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Key contributors to this report are listed in appendix VI.

Eileen R. Larence
Director, Homeland Security and Justice



Linda T. Kohn
Director, Health Care

Appendix I: Relatively Few Studies Have Assessed the Effect of Societal Factors on Youth Marijuana Use, and These Studies Had Limitations

Prior studies have found that a number of factors may affect marijuana use among youth, that is, individuals 17 years old and under. For example, we reported in 1993 that several risk factors were associated with marijuana use based on our review of a national longitudinal survey.[1] Specifically, we found that young people who had reported that they engaged in delinquent activities, such as running away from home, truancy, fighting, and theft, were more likely to have used marijuana; however, we also noted that underlying factors may be associated with both drug use and delinquent activities. More recently, in 2000, a meta-analysis of 101 longitudinal studies from around the world identified a number of risk factors that predicted future marijuana use, including the availability of illicit drugs and guns, family history of antisocial behavior, positive attitudes toward substance use, low perceived risk of drug use, and rebelliousness.[2]

Review of Studies on the Effect of Societal Factors on Youth Marijuana Use

Other factors, including state laws and changing attitudes and social norms regarding drugs, may also affect drug use. We examined studies on three of these other factors, which we refer to as societal factors, which may affect youth marijuana use. Specifically, we examined studies that addressed: (1) the passage of laws allowing for the use of marijuana for medical purposes (medical marijuana laws); (2) the reduction in penalties for marijuana possession (decriminalization); and (3) the favorable portrayal of drugs in the media (prodrug media), such as movies, television, music, and music videos. For instance, a number of states have passed varying degrees of laws related to the production,

[1]GAO, *Drug Use Among Youth: No Simple Answers to Guide Prevention*, GAO/HRD-94-24 (Washington, D.C.: Dec. 29, 1993). Our review included a multivariate analysis of the National Longitudinal Study of Youth.

[2]According to this study, a meta-analysis is a method of combining findings from many studies and allows researchers to use similar results from many studies to gain an understanding of an issue, in this case, the strength of the relationship between proposed risk factors and marijuana use. The majority of the data in this meta-analysis (73 of 101) came from studies conducted in the United States. The remaining studies were conducted internationally, such as in Canada, Great Britain, Australia, and New Zealand. See W. Hansen, S. Giles, and M. Fearnow-Kenney (Eds.*). Improving Effectiveness*. Greensboro, NC: Tanglewood Research, Inc (2000).

possession, or use of marijuana for varying purposes.[3] In addition, separate from laws that may allow for the use of marijuana for certain medical purposes, some states and local governments have taken actions to reduce or eliminate certain criminal penalties for the possession of small amounts of the drug. Finally, some speculate whether media depictions of illicit drugs influence youth drug use. For example, according to one study, frequent viewing of media messages may increase the likelihood of the adoption of ideas or beliefs reflected in the media portrayals, which may influence subsequent behaviors, such as the use of illicit substances.[4]

Through searches of databases, Internet websites, and other sources available as of June 2012, we identified 476 documents that addressed possible factors relating to youth drug use, including the societal factors described above, as well as others such as alcohol use and mental illness.[5] We reviewed these documents to determine if the studies met our literature review criteria, which required that the study (1) address one of the three societal factors included in our review, specifically medical marijuana laws, decriminalization, or prodrug media; (2) report results on U.S. youth (age 17 and under); (3) have a national or multiple state scope; and (4) assess the effect of the factor on youth marijuana use through the use of methods such as comparison groups or statistical analyses. We identified 10 studies that assessed the effect of medical marijuana laws or decriminalization. We also identified 10 studies on prodrug media that focused on U.S. youth; however, 4 of the latter 10 studies did not have a national or multiple state scope, and none of these

[3]According a report issued on November 2012 by the Congressional Research Service, 18 states and the District of Columbia have enacted provisions that, in various ways, exempt qualified individuals from state criminal prosecution and various state civil penalties for marijuana-related offenses. See Congressional Research Service, *Medical Marijuana: The Supremacy Clause, Federalism, and the Interplay between State and Federal Laws.* (Washington, D.C.: Nov. 9, 2012).

[4]Enid L. Gruber et al. “Alcohol, Tobacco, and Illicit Substances in Music Videos: A Content Analysis of Prevalence and Genre.” *Journal of Adolescent Health*, vol. 37 (2005): 81-83.

[5]Specifically, we (1) conducted key word searches of social science research databases, such as Academic One File, Education Resources Information Center, Dissertation Abstracts Online, the National Academies, Social Sciences Abstracts, ProQuest, and WorldCat; (2) searched public health-related and think tank websites, such as those of the American Public Health Association and RAND; (3) reviewed bibliographies; and (4) asked public health researchers to identify potential studies for our review, as well as any potential challenges in reviewing these studies.

10 studies assessed the effect of media on youth marijuana use. Specifically, 4 assessed the association between media and youth marijuana use, and 6 provide descriptive statistics on, for example, the prevalence of drugs and prodrug representations in various forms of media. While these studies may not assess the effect of media on youth marijuana use or include a national or a multiple state scope, we included them because they provide useful context regarding the portrayal of drugs in the media. Two social scientists and, as applicable, a statistician reviewed each of the 20 studies to determine whether the design, implementation, and analyses of the study were sufficiently sound to support the study's results and conclusions based on generally accepted social science principals.[6] On the basis of these reviews, we excluded 3 studies on medical marijuana laws and 1 study on decriminalization. Below, we provide information on 2 medical marijuana studies, 4 decriminalization studies, and the 10 media studies from our review.[7] We selected these studies on medical marijuana laws and marijuana decriminalization to include in this report based on the sufficiency of their methodologies; therefore, our results cannot be generalized to all research about the potential effect of these factors on youth drug use.

Medical Marijuana Laws Studies

The studies that assessed the effect of medical marijuana laws that met our review criteria found mixed results on effects of the laws on youth marijuana use. These studies are described in table 4 below. One potential limitation to these studies may be the variation in implementation of medical marijuana laws across states. We discuss this and other potential limitations, as well as the ways that some studies addressed this issue, later in this appendix.

[6]Social science research standards are discussed in the scientific literature. For example, see Thomas D. Cook, and Donald T. Campbell, *Quasi-experimentation: Design and Analysis Issues for Field Settings* (Boston: Houghton Mifflin, 1990); William R. Shadish, Thomas D. Cook, Donald T. Campbell, Experimental and *Quasi-Experimental Designs for Generalized Causal Inference* (Boston: Houghton Mifflin, 2002); and GAO, *Design Evaluations: 2012 Revision,* GAO-12-208G (Washington, D.C.: January 2012).

[7]The Substance Abuse and Mental Health Services Administration (SAMHSA) is conducting an examination of marijuana use rates and the differences between states with and without medical marijuana laws or lenient enforcement or prosecution of marijuana possession. SAMHSA expects to release the report in 2013.

Table 4: Medical Marijuana Laws Studies and Their Findings Regarding Effect on Youth Marijuana Use

Study title, author(s), and source	Overall finding and summary of study[a]
Title: "Adolescent Marijuana Use from 2002 to 2008: Higher in States with Medical Marijuana Laws, Cause Still Unclear." Author(s) and source: Melanie M. Wall et al. *Annals of Epidemiology*, vol. 21, no.9 (September 2011): 714-716.	Overall finding: Higher use and lower perceived risk Years: 2002-2008 Scope: National Data source: National Survey on Drug Use and Health[b] The study found that between 2002 and 2008, adolescent marijuana use was higher and perception of its riskiness lower in states with medical marijuana laws compared with states without such laws.
Title: "Do Medical Marijuana Laws Increase Marijuana Use? Replication Study and Extension." Author(s) and source: Sam Harper, Erin C. Strumpf, and Jay S. Kaufman. *Annals of Epidemiology*, vol. 22, no.3 (March 2012): 207-212.	Overall finding: Little or no effect Years: 2002-2009 Scope: National Data source: National Survey on Drug Use and Health The study found that after controlling for unmeasured state characteristics, such as differences in social norms regarding drug use, there was little evidence that passing medical marijuana laws in the 16 states that had passed such laws at the time of the study increased marijuana use among youths in those states.

Source: GAO analysis.

[a]Year refers to the years during which the data were collected.

[b]The National Survey on Drug Use and Health is an annual nationwide survey involving interviews with approximately 70,000 randomly selected individuals aged 12 and older. The Substance Abuse and Mental Health Services Administration (SAMHSA), a component of the U.S. Department of Health and Human Services, funds and oversees the project.

Decriminalization Studies

Three of the four studies that assessed the effect of marijuana decriminalization that met our review criteria found little to no effect of the laws on youth marijuana use. These studies, as well as one study that found an increase, are described in table 5. One potential limitation to these studies is that all four studies contained data on marijuana use that had been collected in 1990 or earlier, which may mean that their findings are not applicable to current youth drug use patterns; however, we included them in our review because they provide useful information regarding the previous effects of decriminalization. We discuss this and other potential limitations later in this appendix.

Table 5: Decriminalization Studies and Their Findings Regarding Effect on Youth Marijuana Use

Study title, author(s), and source	Overall finding and summary of study[a]
Title: "Decriminalization of Marijuana and the Demand for Alcohol, Marijuana, and Cocaine." Author(s) and source: Clifford F. Thies and Charles A. Register. *The Social Science Journal*, vol. 30, no. 4 (1993): 385-399.	Overall finding: Little or no effect Years: 1984-1988 Scope: National Data source: National Longitudinal Survey of Youth 1979[b] On the basis of its review of a national longitudinal survey, this study found no strong evidence that the decriminalization of marijuana in 11 states affected the reported frequency of marijuana use as compared with the frequency of use by individuals in states that had not decriminalized marijuana.
Title: *Marijuana Decriminalization: The Impact on Youth 1975-1980.* Author(s) and source: Lloyd D. Johnston, Jerald G. Bachman, and Patrick M. O'Malley. Ann Arbor, Michigan: Institute for Social Science Research, 1981.	Overall finding: Little or no effect Years: 1975-1980 Scope: National Data source: Monitoring the Future Survey[c] This study found that decriminalization had virtually no effect either on marijuana use or on related attitudes and beliefs about marijuana use among high school seniors in the 7 states that had decriminalized the possession of small amounts of marijuana at the time of the study.
Title: *The Demand for Cocaine and Marijuana by Youth.* Author(s) and source: Frank J. Chaloupka, Michael Grossman, and John A. Tauras. Cambridge, Massachusetts: National Bureau of Economic Research, 1998.	Overall finding: Little or no effect Years: 1982-1989 Scope: National Data source: Monitoring the Future Survey Based on its review of a nationally-representative survey of high school seniors, this study found that, for youth residing in states that had eliminated criminal sanctions for the possession of small amounts of marijuana, decriminalization appeared to have no effect on either the probability of past month marijuana use or on the number of occasions marijuana users consumed marijuana in the past year or month.
Title: *Marijuana Decriminalization: What Does It Mean in the United States?* Author(s) and source: Rosalie Liccardo Pacula, Jamie F. Chriqui, and Joanna King. Cambridge, Massachusetts: National Bureau of Economic Research, 2003.	Overall finding: Increase Year: 1990 Scope: National Data source: National Education Longitudinal Study of 1988[d] This study found that being from a state that had decriminalized marijuana was a statistically significant factor in whether the high school sophomores in a nationally representative survey reported using marijuana in the past month.

Source: GAO analysis.

[a]Year refers to the years during which the data were collected.

[b]The National Longitudinal Survey of Youth 1979 consists of a nationally representative sample of approximately 12,000 youths who were 14 to 22 years old when they were first surveyed in 1979. Individuals were surveyed annually through 1994 on a variety of topics, including education, employment, and alcohol and drug use.

[c]Monitoring the Future is an ongoing annual survey of approximately 50,000 American middle and high school students funded from grants from the National Institutes of Health.

[d]The National Education Longitudinal Study of 1988, administered by the National Center for Education Statistics, included a nationally representative sample of eighth graders first surveyed in the spring of 1988. This study based its findings off a 1990 follow-up survey.

Media Studies

None of the studies we identified on prodrug media assessed whether exposure to prodrug media caused changes in marijuana or other drug use. Of the 10 studies we identified that address prodrug media, 4 assessed the association between such media and youth marijuana use (see table 6). Three of the four studies found that exposure to various forms of media (e.g., rap music, music, and media depicting the positive aspects of marijuana use) were associated with higher rates of marijuana or other drug use. The fourth study found that information obtained from the Internet changed reported drug-using behavior, but did not determine whether marijuana or other drug use increased or decreased as a result.

Table 6: Studies on the Association between Media and Youth Marijuana Use

Study title, author(s), and source	Summary of study
Title:" A Prospective Study of Exposure to Rap Music Videos and African-American Female Adolescence." Author(s) and source: Gina M. Wingood et al. *American Journal of Public Health*, vol. 93, no. 3 (March 2003): 437-439.	This 2003 study, based on a group of 522 African-American adolescent females, found that after controlling for other factors, such as age and employment status, participants who had greater exposure to rap music videos were 1.5 times more likely to report that they had used drugs over the 12-month follow-up period, but the study did not examine causality. The results of this study cannot be generalized to any larger population.
Title: "Media Exposure and Marijuana and Alcohol Use Among Adolescents." Author(s) and source: Brian A. Primack et al. *Substance Use & Misuse*, vol. 44, no. 5 (2009): 722-739.	This 2009 study, based on high school students at one school, found that, after controlling for multiple demographic and environmental factors, self-reported marijuana use was independently associated with, but not necessarily caused by, increased music exposure. The results of this study cannot be generalized to any larger population.
Title: "Media and Marijuana: A Longitudinal Analysis of News Media Effects on Adolescents' Marijuana Use and Related Outcomes, 1977-1999. Author and source: Jo Ellen Stryker. *Journal of Health Communication*, vol. 8 (2003): 305-328.	This 2003 study used a nationally representative survey of high school students, but included data from 1977 through 1999, which may not reflect the current content of media. This study found that media depicting the negative aspects of marijuana use were related to higher rates of drug abstinence (and therefore, lower rates of drug use). The study also found, but to a lesser extent, that media depicting the positive aspects of marijuana use were related to lower rates of drug abstinence (and therefore higher rates of drug use).[a]
Title: "The Internet and Psychoactive Substance Use Among Innovative Drug Users." Author(s) and source: Edward W. Boyer, Michael Shannon, and Patricia L. Hibberd. *Pediatrics*, vol. 115, no. 2 (February 2005): 302-305.	This 2005 study, which included 12 youths, found that participants reported that reviewing information obtained from the Internet changed their drug-using behavior, such as using drugs they believed to be "safe" or avoiding drugs they believed to be addictive, but the study did not determine whether marijuana or other drug use increased or decreased as a result. The results of this study cannot be generalized to any larger population.

Source: GAO analysis.

[a]Specifically, the study found that media coverage (as measured by the number of news stories on marijuana from the Associated Press) accounted for approximately 3 percent of variation in drug abstinence rates. However, while significant, the small percentage of variance explained in the statistical tests may be indicative of the limited effect of media on self-reported drug use behaviors and attitudes.

Six of the 10 studies that addressed prodrug media provided descriptive statistics on, for example, the prevalence of drugs and prodrug representations in various forms of media. Five of these studies described

the nature and frequency of illicit drugs in various forms of media, including movies, television, music videos, and music. The media content from these studies ranges from 1996 through 2005, and may not reflect the current content of media. Some of the findings from these descriptive studies are described in table 7.

Table 7: Descriptive Studies on Media and Youth Marijuana Use

Media type	Study findings
Movies	Illicit drugs, including marijuana, cocaine, and heroin, among others, appeared in 22 percent of the 200 most popular movie rentals in 1996 and 1997, of which 26 percent showed explicit, graphic portrayals of their preparation or ingestion. Of the movies showing illicit drugs, marijuana appeared most frequently (51 percent of movies).[a]
Television	Illicit drugs, which included controlled substances such as marijuana, cocaine, and heroin, among others, were mentioned or seen in 20 percent of all episodes of the 42 top-rated television shows during October and November 1998. However, illicit drug use was seen in only 3 percent of these episodes overall.[b]
Music videos	One study found that substances of one kind or another, such as alcohol, marijuana, and prescription medications, were found in 45 percent of 258 music videos included in a 6-week period across three cable television channels in 2000.[c] A more recent study, conducted in 2001, found that illicit substances, along with drug paraphernalia and abusable substances such as glue or spray canisters, were present in 13 percent of the 359 music videos included in a 3-week random sample from two cable television channels. The study also found that substance use was more often seen in rap and hip hop music videos.[d] While illicit substances were absent in pop music videos, they were at least three times as likely to be present in rap and hip hop videos as compared with rock and rhythm and blues videos.
Music	One hundred and sixteen of the 279 (or 41 percent) most popular songs in 2005 included a reference to substance use, including alcohol, marijuana, tobacco, and other illicit, prescription, or nonspecific substances. Alcohol was the most frequently referenced (24 percent), followed by marijuana (14 percent).[e]

Source: GAO analysis.

[a]Donald F. Roberts et al. *Substance Use in Popular Movies and Music*. Washington, D.C.: Office of National Drug Control Policy and Department of Health and Human Services, 1999.

[b]Peter G. Christenson, Lisa Henriksen, and Donald F. Roberts. *Substance Use in Popular Prime Time Television*. Washington, D.C.: Office of National Drug Control Policy, 2000.

[c]Donald F. Roberts et al. *Substance Use in Popular Music Videos*. Washington, D.C.: Office of National Drug Control Policy, 2002.

[d]Enid L. Gruber et al. "Alcohol, Tobacco, and Illicit Substances in Music Videos: A Content Analysis of Prevalence and Genre." *Journal of Adolescent Health*, vol. 37 (2005): 81-83.

[e]Brian A. Primack et al. "Content Analysis of Tobacco, Alcohol, and Other Drugs in Popular Music." *Archives of Pediatrics and Adolescent Medicine*, vol. 162, no. 2 (February 2008): 169-175.

The sixth study assessed the perceived value of "the media" and other sources as credible providers of drug information, based on anonymous interviews with 223 high school students across two states. This study found that adolescents reported listening to their parents and teachers the most about drugs and alcohol, as compared with movie, television, music,

or sports celebrities, but the results of this study cannot be generalized to a larger population.[8]

Study Limitations and Inherent Challenges

We identified several challenges related to inherent difficulties in analyzing this subject matter or with the study designs that may limit the generalizability of these studies. For example, a study's design may have been sufficiently sound to support the study's results and conclusions, but it could have used old data, which may mean that the study's findings are not applicable to current youth drug use patterns. We describe these limitations below:

- **Variation in implementation of medical marijuana laws**: Office of National Drug Control Policy (ONDCP) officials stated that states implement medical marijuana laws differently and that these differences may influence the effect of the laws on youth marijuana use. For example, according to these officials, some states enacted laws where medical marijuana has had a very visible presence throughout the state, while other states' laws have low visibility or have not been implemented yet. Further, ONDCP officials stated that some studies incorrectly looked at the changes in marijuana use before and after medical marijuana laws are passed instead of before and after such laws are implemented. The officials noted that this is an important distinction because the implementation of medical marijuana laws after passage can be a lengthy process. ONDCP officials also noted that the states that eventually passed medical marijuana laws tended to have higher rates of youth marijuana use before such laws were passed. However, some of the studies we reviewed attempted to account for these issues in their study designs. For example, one study used a model that controlled for unmeasured state characteristics that do not change over time, such as differences in social norms, and that might affect marijuana use and the likelihood of a state passing a medical marijuana law.[9]
- **Self-reported data**: As we have previously reported, research about drug use among youth is limited, in part, because most studies rely on

[8]Daniel M. Mayton, Elizabeth A. Nagel, and Reese Parker. "The Perceived Effects of Drug Messages on Use Patterns in Adolescents." *Journal of Drug Education*, vol. 20, no. 4 (1990): 305-318.

[9]Sam Harper, Erin C. Strumpf, and Jay S. Kaufman. "Do Medical Marijuana Laws Increase Marijuana Use? Replication Study and Extension." *Annals of Epidemiology*, vol. 22, no.3 (March 2012): 207-212.

self-reported data, and low estimates are likely because drug use is illegal. [10] For example, youth may be unlikely to report their drug use in the survey for fear of negative repercussions, regardless of whether the results of the survey are shared with law enforcement. For our analysis, all of the 6 studies on the effects of medical marijuana laws or decriminalization on youth marijuana use as well as the 4 studies on the association between media and youth marijuana use employ self-reported data.

- **Use of historical data**: While 4 of the 10 studies on the effect of or association between societal factors and youth marijuana use data collected since 2000 (2 medical marijuana and 2 media studies), the remainder of the studies used older data (the oldest being collected in 1975). In particular, all 4 studies on decriminalization, as well as 2 of the media studies, contained data on marijuana use that had been collected before 2000, which may mean that their findings are not applicable to current youth drug use patterns.

[10] GAO/HRD-94-24.

Appendix II: Objectives, Scope, and Methodology

This report addresses the following objectives:

1. To what extent has progress has been made toward achieving Strategy goals and does ONDCP have mechanisms in place to monitor progress?
2. To what extent does fragmentation, overlap, and duplication exist across drug abuse prevention and treatment programs, and do ONDCP and federal agencies coordinate efforts to reduce the potential for unnecessary overlap or duplication?
3. To what extent do federal agencies that have drug abuse prevention and treatment programs conduct evaluations of these programs, including assessments of program effectiveness?

In addition, we provide information on what the available research suggests about the potential effect of societal factors, such as state laws allowing the use of marijuana for medical purposes, on youth drug use.

Assessing Progress toward Strategy Goals and Mechanisms to Monitor Progress

To assess progress toward Strategy goals and the extent to which ONDCP has mechanisms in place to monitor progress, we analyzed the 2010 Strategy and 2011 and 2012 annual updates, the National Drug Control Budget, and ONDCP documentation about its Performance Reporting System and associated performance measures. We also analyzed ONDCP documents on the implementation status of Strategy action items and implementation plans and reports from selected federal drug control agencies. In addition, we analyzed agency budget justifications and strategic plans. We also reviewed information provided by ONDCP and publicly available data sources, such as the National Survey on Drug Use and Health, to determine progress toward Strategy goals.

On the basis of such factors as the number of Strategy action items for which agencies are responsible, the size of agency drug control budgets, and inclusion of a balance of drug prevention, treatment, and supply reduction missions, we selected the following seven agencies to focus on in our review:

- within the Department of Health and Human Services (HHS), the Substance Abuse and Mental Health Services Administration, National Institutes of Health—specifically, the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism—and Centers for Disease Control and Prevention;

- within the Department of Justice (DOJ), the Office of Justice Programs (OJP)— specifically, the Bureau of Justice Assistance, Bureau of Justice Statistics, National Institute of Justice, and Office of Juvenile Justice and Delinquency Prevention—and Drug Enforcement Administration;
- within the Department of Homeland Security, U.S. Customs and Border Protection; and
- the Department of Education (Education).

While these seven agencies are not representative of all federal drug control agencies, they are responsible for implementing a majority of activities in the Strategy and provide a range of perspectives about Strategy implementation and progress. Specifically, our selected agencies and ONDCP have lead implementation responsibilities for approximately 70 percent of the 112 action items in the Strategy. We also interviewed officials from ONDCP and these agencies to obtain information about progress on the Strategy's goals, the Performance Reporting System, how ONDCP monitors progress on Strategy objectives and action items, the implementation status of these action items, and the effect of the Strategy on agencies' drug control activities. We compared the information we obtained from documents and agency officials about the Strategy and ONDCP's monitoring mechanisms with criteria for performance management identified in our prior work.[1] We also reviewed ONDCP's categorizations for a nonprobability sample of 24 out of 82 action items led by ONDCP and our seven selected agencies to validate ONDCP's characterization of their implementation statuses. Although we cannot generalize the results to all action items led by these agencies, this allowed us to determine the extent to which we agreed with ONDCP's categorizations of the action items we reviewed. Finally, we interviewed seven drug policy experts to discuss their perspectives on the Strategy and performance management. We selected these experts based on our review of drug policy literature, their expertise in drug policy issues and work conducted in this area, and recommendations from these and other researchers. The information from these seven policy experts cannot be generalized to other experts; however, they provided us with a range of views about the Strategy and ONDCP's monitoring mechanisms.

[1]See for example GAO-03-143 and GAO/GGD/AIMD-99-69.

Assessing Fragmentation, Overlap, and Duplication across Drug Abuse Prevention and Treatment Programs and Agency Coordination Efforts

Identifying Programs

To identify federal drug abuse prevention and drug abuse treatment programs, and programs that include drug abuse prevention or treatment activities, we developed a preliminary list based on the agencies included in our previous work in this area and a review of ONDCP and agency information, such as the fiscal year 2013 National Drug Control Budget, the 2010 National Drug Control Strategy, and publically available information on agency websites.[2] We also reviewed the *Catalogue of Federal Domestic Assistance*. On the basis of ONDCP guidance, we defined a drug abuse prevention program as a federal program that provides services, allocates funding, or allows for activities focused on discouraging the first-time use of controlled substances—specifically illicit drugs and the problematic use of alcohol—and encouraging those who have begun to use controlled substances to cease their use. We defined a drug abuse treatment program as a federal program that provides services, allocates funding, or allows for activities focused on identifying and assisting users of controlled substances—specifically illicit drugs and the problematic use of alcohol—to become drug-free and remain drug-free.[3]

We focused our review on programs that directly administer or fund drug abuse prevention or treatment programs, or programs that include these activities, and therefore excluded programs that, for example, exclusively focus on law enforcement or policy, conduct research, or fund overhead costs. In addition, we also excluded programs that reimbursed drug abuse treatment services as part of a health benefit plan, such as HHS's Medicare and Medicaid programs and the Department of Defense's

[2]See GAO-12-744R.

[3]See ONDCP Circular: Budget Formulation, May 2007. ONDCP issued this circular to the heads of executive departments and establishments, and it provides instructions for preparing agency drug control budgets to be submitted to ONDCP for review and inclusion in the consolidated National Drug Control Budget.

Defense Health Program, which includes military health benefit plans like TRICARE.[4] Our initial review determined that 3 of 19 agencies included in the National Drug Control Budget for funding drug abuse prevention and treatment programs did not administer programs that met our scope of review. As a result, we excluded these agencies from our review. In total, our initial search identified 91 potential programs that 16 federal agencies administered.

Next, we shared our preliminary list of programs with agency officials and asked them to verify that the included programs met our criteria and if any should be added or deleted. During initial meetings with agency officials, we asked them to clarify program names, descriptions, and services offered. We used the information obtained to make additional refinements to the list of agencies and programs included in our review. For example, some programs were removed from the list because they were no longer in operation in fiscal year 2012 or were part of a larger program already listed, and other programs were added. We also excluded one additional agency from our review. Specifically, we excluded the Court Services and Offender Supervision Agency for the District of Columbia because its programs are primarily for residents of the District of Columbia. Thus the number of agencies in the scope of this study decreased from 16 to 15. After completing these refinements our list identified a total of 95 programs.

To obtain program-specific information, we sent a total of 95 web-based questionnaires to the 15 agencies included in our review.[5] These questionnaires are described in detail below. We included several screening questions in the questionnaire to further verify that programs met our definition of a drug abuse prevention program, drug abuse treatment program, or a program that includes these activities, and were in operation in fiscal year 2012. Fourteen programs did not pass our screening questions and therefore were excluded from our analysis. We also removed 4 programs from our analysis after reviewing the responses and determining that the program did not meet one or more of our criteria

[4]TRICARE is the health care program serving military service members, retirees, and their families.

[5]Seven of these programs were jointly administered by two or more federal agencies. For these programs, we sent the agency that is primarily responsible for the day-to-day operations of the program the questionnaire for completion

for inclusion, and consolidated the responses of 1 program at the request of agency officials. In total, 76 programs were included in our final analysis of questionnaire responses.

Developing and Administering the Questionnaire on Federal Drug Abuse Prevention and Drug Abuse Treatment Programs

We developed a web-based questionnaire to collect detailed information on federal drug abuse prevention and drug abuse treatment programs, and programs that include these activities, for fiscal year 2011. The questionnaire included questions on program objectives, target groups served, services provided, and coordination activities with other federal agencies. We also collected data on program obligations—defined as definite commitments that create a legal liability of the government for the payment of goods and services ordered or received—as available, for fiscal year 2011. Specifically, we asked programs to provide the amount of federal funds obligated specifically for their drug abuse prevention or treatment activities, and the total amount of federal funds obligated for all program activities in fiscal year 2011. In many cases, programs were not able to provide data on funds obligated specifically for their drug abuse prevention or treatment activities because agency officials told us that they did not report budgetary data at this level, among other reasons.[6]

To minimize errors arising from differences in how questions may be interpreted and to reduce variability in responses, we conducted pretests with four agencies and 6 programs from July to August 2012. To ensure that we obtained a variety of perspectives on our questionnaire, we selected programs that differed in program scope, services provided, and target groups served. We included budget staff as well as program officials in the pretest to ensure budget-related terms in the survey were understandable. An independent reviewer also reviewed a draft of the questionnaire prior to its administration. After completing the pretests, we administered the survey to 95 programs. We received completed surveys for 95 programs, for a 100 percent response rate.[7] We also made telephone calls to officials and sent them follow-up e-mail messages, as necessary, to clarify their responses or obtain additional information.

[6]As a result of not having complete data at this level, when reporting this information, we noted which programs were not able to provide this information by marking it as “not available.”

[7]We consolidated questionnaire responses for SAMHSA’s Substance Abuse and Mental Health block grant program at the request of agency officials. As a result, we ultimately received responses for 94 unique programs.

We used standard descriptive statistics to analyze responses to the questionnaire. Because this was not a sample survey, there were no sampling errors. To minimize other types of errors, commonly referred to as nonsampling errors, and to enhance data quality, we employed survey design practices in the development of the survey and in the collection, processing, and analysis of the survey data. For instance, as previously mentioned, we pretested the questionnaire with federal officials to minimize errors arising from differences in how questions might be interpreted and to reduce variability in responses. We further reviewed the questionnaire to ensure the ordering of sections was appropriate and that the questions within each section were clearly stated and easy to comprehend. To reduce nonresponse, another source of nonsampling error, we sent out e-mail reminder messages to encourage officials to complete the questionnaire. In reviewing the questionnaire data, we performed automated checks to identify inappropriate answers. We further reviewed the data for missing or ambiguous responses and followed up with agency officials when necessary to clarify their responses. To assess the reliability of obligations data, we incorporated questions about the reliability of the programs' data systems and if there were any limitations to reporting the data. On the basis of our application of recognized survey design practices and follow-up procedures, we determined that the data were of sufficient quality for our purposes. All data analysis programs were also independently verified by a data analyst for accuracy.

Determining the Extent of Fragmentation, Overlap, and Duplication

To determine the extent of fragmentation, overlap, and duplication, we compared data from the 76 drug abuse prevention and treatment programs to review the types of services offered across the federal government and used the following definitions from our prior work:

- *Fragmentation* occurs when more than one federal agency (or more than one organization within an agency) is involved in the same broad area of national interest.
- *Overlap* occurs when fragmented agencies or programs have similar goals, engage in similar activities or strategies to achieve them, or target similar beneficiaries.

- *Duplication* occurs when two or more agencies or programs are engaged in the same activities or provide the same services to the same beneficiaries.[8]

To determine the extent of fragmentation, we used the questionnaire data to identify the number of agencies that deliver similar types of drug abuse prevention and treatment programs. To determine the potential for overlap, we identified the number of programs with similar goals that provided similar services to similar populations. We also conducted an in-depth analysis of two areas—prevention services for students and youths and treatment services for the offender populations—to further assess the potential for overlap among these programs. We selected these areas because of the number of programs and extent of overlap in these areas. For those areas in which we completed our in-depth review, we also determined the potential for duplication by reviewing programmatic information and holding meetings with program staff to determine whether the programs were providing the same services to the same beneficiaries.

To assess coordination efforts to reduce the potential for unnecessary overlap or duplication, we analyzed questionnaire responses from the 76 programs regarding agency efforts to coordinate drug abuse prevention and treatment program activities. We also analyzed the 2010 Strategy and interviewed ONDCP and agency officials about actions taken to coordinate activities. We compared these reported actions with criteria for coordinating interagency efforts, internal controls, and desirable characteristics of effective national strategies identified in our prior work.[9]

Assessing Evaluations of Drug Abuse Prevention and Treatment Programs

To identify which of the 76 drug abuse prevention and treatment programs at the 15 agencies included in our review had program evaluations, including assessments of effectiveness, we first conducted Internet and library searches to identify any reports or other documents that described evaluations that had been completed or for which interim

[8]Specifically, we used these definitions for assessing drug abuse prevention and treatment programs based on the framework established in two previous reports, GAO-11-318SP and GAO-12-342SP.

[9]See GAO, *Results-Oriented Government: Practices That Can Help Enhance and Sustain Collaboration among Federal Agencies*, GAO-06-15 (Washington, D.C.: Oct. 21, 2005), GAO-12-1022, GAO/AIMD-00-21.3.1, and GAO-04-408T.

reports had been issued since 2007.[10] We then interviewed or received written responses from agency officials responsible for administering the 76 programs, in which they confirmed the evaluations that we found through our searches and identified additional evaluations of the programs that had been completed, were under way or had interim reports completed, or were planned since 2007. We selected 2007 as the starting point for our review in order to provide a long enough time frame to include evaluations that may take multiple years to complete. We obtained copies of all completed program evaluations and reviewed each to determine whether these evaluations included assessments of effectiveness (i.e., determining the extent to which a program is achieving its objectives) as described in our *Designing Evaluations: 2012 Revision*, which provides guidance on evaluation methodologies.[11] For each program evaluation, we reviewed its objectives, scope, and any description of how its findings were used by the agency. Furthermore, we interviewed agency officials about factors affecting the lack of program evaluation. We also reviewed agency documents and interviewed agency officials to identify whether the agencies took other steps to help ensure that their programs are effective, such as requiring programs or their grantees to use evidence-based interventions, and whether the agencies prescribed specific evidence-based interventions that must be used in their programs. We also interviewed ONDCP officials to determine how program evaluations were used to inform policy and resource allocation decisions.

We conducted this performance audit from July 2012 to March 2013 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that

[10]We define "program evaluations" as individual, systematic studies to assess how well a program or programs are working. Program evaluations can be designed to answer a range of questions about programs to assist decision making by program managers and policymakers. An evaluation can assess an entire program or focus on an initiative within a program. Although evaluation of a federal program typically examines a broader range of activities than a single project, agencies may evaluate individual projects to seek to indentify effective practices or interventions.

[11]GAO, *Designing Evaluations: 2012 Revision*, GAO-12-208G (Washington, D.C.: January 2012).

the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix III: Fiscal Year 2011 Obligations for Drug Abuse Prevention and Treatment Programs in Our Review

Agency or subagency	Program name	Program description[a]	Fiscal year 2011 obligations for drug abuse prevention and treatment activities
Department of Defense (DOD)	Drug Demand Reduction Program	[b]	$118,078,000 [b]
DOD civilian agencies	Civilian Employee Drug-Free Workplace Program	Prevention	[b]
National Guard Bureau	National Guard Bureau Prevention, Treatment, and Outreach Program	Prevention	[b]
U.S. Air Force	Air Force Drug Demand Reduction	Prevention	[b]
U.S. Army	Army Substance Abuse Program	Prevention and treatment	[b]
U.S. Marine Corps	Marine Corps Community Services Substance Abuse Program	Prevention	[b]
U.S. Navy	Navy Alcohol and Drug Abuse Prevention	Prevention	[b]
	Substance Abuse Rehabilitation Program	Treatment	Not available[c]
Department of Justice			
Bureau of Prisons			$92,500,000[d]
	Community Transitional Drug Abuse Treatment	Treatment	Not available[d]
	Drug Abuse Education	Prevention and treatment	Not available[d]
	Non-residential Drug Abuse Treatment	Treatment	Not available[d]
	Residential Drug Abuse Treatment	Treatment	Not available[d]
Drug Enforcement Administration	Demand Reduction Program	Neither a prevention nor a treatment program, but may include prevention or treatment activities	$2,085,000[e]
Office of Justice Programs	Drug Courts	Treatment	Not available[c]
	Enforcing Underage Drinking Laws	Prevention	$16,968,000
	Justice and Mental Health Collaboration Program	Neither a prevention nor a treatment program, but may include prevention or treatment activities	Not available[c]
	Residential Substance Abuse Treatment	Treatment	Not available[c]
	Second Chance Act Adult Offenders with Co-Occurring Substance Abuse and Mental Health Disorders	Treatment	Not available[c]
	Second Chance Act Family-Based Adult Offender Substance Abuse Treatment Program, Planning, and Demonstration Projects	Treatment	Not available[c]

Agency or subagency	Program name	Program description[a]	Fiscal year 2011 obligations for drug abuse prevention and treatment activities
Department of Transportation			
Federal Aviation Administration	Employee Drug and Alcohol Testing Program	Neither a prevention nor a treatment program, but may include prevention or treatment activities	$469,241
	Flight Attendant Drug And Alcohol Program	Neither a prevention nor a treatment program, but may include prevention or treatment activities	$269,241
	Human Intervention Motivation Study	Neither a prevention nor a treatment program, but may include prevention or treatment activities	$200,000
National Highway Traffic Safety Administration	Drug Impaired Driving Program	Neither a prevention nor a treatment program, but may include prevention or treatment activities	$2,688,000
Department of Education			
	21st Century Community Learning Centers	Neither a prevention nor a treatment program, but may include prevention or treatment activities[f]	Not available[c]
	Safe and Supportive Schools[g]	Neither a prevention nor a treatment program, but may include prevention or treatment activities[f]	Not available[c]
	Safe Schools/Healthy Students[g]	Prevention	Not available[c]
Executive Office of the President			
Office of National Drug Control Policy	Anti-Doping Activities	Prevention	$8,982,000
	High Intensity Drug Trafficking Areas	Neither a prevention nor a treatment program, but may include prevention or treatment activities	$2,848,424
	Youth Drug Prevention Media Program	Prevention	$39,000,000[e]
Federal Judiciary			
Administrative Office of the United States Courts	Court Ordered Substance Abuse Testing and Treatment	Treatment	$48,053,914
Department of Health and Human Services			
Health Resources and Services Administration	Health Center Program	Neither a prevention nor a treatment program, but may include prevention or treatment activities	Not available[c]
	Ryan White HIV/AIDS	Neither a prevention nor a treatment program, but may include prevention or treatment activities	Not available[c]

Agency or subagency	Program name	Program description[a]	Fiscal year 2011 obligations for drug abuse prevention and treatment activities
Indian Health Service	Urban Indian Health Program Title V 4-in-1 grants	Prevention and treatment	$4,500,000
	Alcohol and Substance Abuse Self Determination Contracts	Prevention and treatment	$194,409,000
	Methamphetamine and Suicide Prevention Initiative	Prevention and treatment	$16,358,000
	Youth Regional Treatment Centers	Prevention and treatment	$18,450,189[e]
	Tele-behavioral Health Activities	Prevention and treatment	Not available[c]
Substance Abuse and Mental Health Services Administration (SAMHSA)	Access to Recovery	Treatment	$98,954,000
	Assertive Adolescent and Family Treatment	Prevention and treatment	$4,198,000
	Capacity Building Initiative	Prevention	$8,097,080
	Center for the Application of Prevention Technologies	Prevention	$10,977,264
	Community-based Coalition Enhancement Grants	Prevention	$4,912,052
	Drug Free Communities Mentoring Program	Prevention	$2,391,168
	Drug Free Communities Support Program	Prevention	$83,845,306
	Ex-Offender Reentry	Treatment	$16,373,000
	Fetal Alcohol Spectrum Disorders Center for Excellence	Prevention	$9,830,206
	Grants to Serve Young Children and Families Affected by Methamphetamine	Prevention and treatment	$4,148,000
	Historically Black Colleges and Universities Grant	Neither a prevention nor a treatment program, but may include prevention or treatment activities	$300,000
	Homeless Grants for the Benefit of Homeless Individuals	Treatment	$35,946,000
	Minority AIDS Initiative Targeted Capacity Expansion	Prevention and treatment	$53,934,000
	Minority HIV Prevention	Prevention	$20,048,037
	National Adult Oriented Media Public Service Campaign	Prevention	$1,096,735
	Native American Center for Excellence	Prevention	$1,031,475
	Partnership for Success	Prevention	$11,500,000

Agency or subagency	Program name	Program description[a]	Fiscal year 2011 obligations for drug abuse prevention and treatment activities
	Physician Clinical Support System Project—Buprenorphine	Neither a prevention or treatment program, but may include prevention or treatment activities	$494,000
	Physician Clinical Support System Project—Opioid	Neither a prevention or treatment program, but may include prevention or treatment activities	$500,000
	Residential Treatment for Pregnant and Post Partum Women	Prevention and treatment	$14,377,000
	Ready to Respond	Prevention	$10,435,218
	Recovery Community Services Program	Treatment	$5,236,000
	Screening, Brief Intervention, and Referral to Treatment—Medical Schools/Residency	Neither a prevention nor a treatment program, but may include prevention or treatment activities	$6,152,000
	State Screening, Brief Intervention and Referral to Treatment	Prevention and treatment	$44,141,000
	Strategic Prevention Framework State Incentive Grants	Prevention	$53,872,449
	Substance Abuse Prevention and Treatment Block Grant	Prevention and treatment	$1,441,962,000
	Targeted Capacity Expansion General—Grants to Expand Care Coordination Using Health Information Technology	Neither a prevention nor a treatment program, but may include prevention or treatment activities	$8,033,000
	Targeted Capacity Expansion General—Recovery Oriented Systems of Care	Treatment	$4,380,000
	Targeted Capacity Expansion General—Technology Assisted Care	Treatment	$2,291,000
	Treatment Drug Courts—Adults (SAMHSA only)	Treatment	$4,897,000
	Treatment Drug Courts—Juvenile (SAMHSA only)	Treatment	$3,355,000
	Treatment Drug Courts—Adult (joint with the Bureau of Justice Assistance)	Treatment	$7,282,000
	Treatment Drug Courts—Juvenile (joint with the Office of Juvenile Justice and Delinquency Prevention)	Treatment	$398,000
	Underage Drinking Prevention Education Initiative	Prevention	$3,039,738

Agency or subagency	Program name	Program description[a]	Fiscal year 2011 obligations for drug abuse prevention and treatment activities
Department of Housing and Urban Development			
	Emergency Solutions Grants	Neither a prevention nor a treatment program, but may include prevention or treatment activities	Not available[c]
	Supportive Housing Program	Neither a prevention nor a treatment program, but may include prevention or treatment activities	Not available[c]
	Housing Opportunities for Persons with AIDS	Neither a prevention nor a treatment program, but may include prevention or treatment activities	Not available[c]
Department of Labor			
Employment Training Administration	Job Corps	Neither a prevention nor a treatment program, but may include prevention or treatment activities	$6,600,000
Department of Veterans Affairs			
Veterans Health Administration	Substance Use Disorder Outpatient Program	Treatment	$581,646
	Substance Use Disorder Residential Program	Treatment	$68,132

Source: GAO analysis of agency data.

[a]For the purpose of our review, we identified a drug abuse prevention program as a federal program that provides services, allocates funding, or allows for activities focused on discouraging the first-time use of controlled substances—specifically illicit drugs and the problematic use of alcohol—and encouraging those who have begun to use controlled substances to cease their use. We defined a drug abuse treatment program as a federal program that provides services, allocates funding, or allows for activities focused on identifying and assisting users of controlled substances—specifically illicit drugs and the problematic use of alcohol—to become drug-free and remain drug-free.

[b]The Drug Demand Reduction program funds, at least in part, the National Guard Bureau Prevention, Treatment, and Outreach program; the Air Force Drug Demand Reduction program; the Army Substance Abuse Program; the Marine Corps Substance Abuse Program; and the Navy Alcohol and Drug Abuse Prevention program, as well as drug testing for the department's civilian employees. The military services use Drug Demand Reduction program funds to provide drug abuse prevention services, including drug testing, education, and outreach. The Drug Demand Reduction Program does not fund drug abuse treatment services or services related to the prevention or treatment of alcohol abuse. However, the military services may use other funding sources to provide those services. For example, the U.S. Army uses funds from its Operations and Maintenance Account to provide some drug abuse treatment services.

[c]We requested that surveyed programs provide the total amount of federal funds obligated specifically for drug abuse prevention and treatment activities in fiscal year 2011. For those agencies that were unable to provide this information, we reported that this information was not available. Program officials reported that they were unable to provide the total amount of federal funds obligated specifically for their program's drug abuse prevention or treatment activities in fiscal year 2011 for a variety of reasons, such as that the programs do not collect this type of budgetary data.

[d]The Bureau of Prisons reported obligations for its drug abuse prevention and treatment programs in total, but was not able to report obligations for individual programs.

[e]Agency officials reported these figures as estimated obligations.

[f]Under 20 U.S.C. § 7164, funds may not be used for medical services, drug treatment, or rehabilitation, except for pupil services or referral to treatment for students who are victims of, or witnesses to, crime or who illegally use drugs with regard to Safe and Drug-Free Schools and Communities. Under 20 U.S.C. § 7175, with regard to 21st Century Community Learning Centers, each eligible entity that receives an award may use the award funds to carry out a broad array of before and after school activities that advance student academic achievement that are listed in the statute.

[g]For the purpose of our review, we assessed the activities of Education's Safe and Supportive Schools and Safe Schools/Healthy Students programs separately; according to officials from Education, they are considered to be activities within a single program–the Safe and Drug-Free Schools and Communities National Activities.

Appendix IV: Information about Completed Program Evaluations Conducted by Agencies in Our Review

We found that the agencies included in our review have completed six evaluations of drug abuse prevention and treatment programs since 2007, three of which examined effectiveness and three of which examined program implementation. The completed program evaluations that included assessments of effectiveness examined the following:

- *Office of Justice Program's (OJP) Drug Courts Program*.[1] The study examined 23 adult drug courts across the United States and compared them with 6 sites in the same geographic areas. The evaluation focused on four main issues: (1) whether drug courts reduce drug use and other problems associated with drug abuse, (2) how drug courts work, (3) how offender attitudes and behaviors change when they are exposed to drug courts and how these changes help explain the effectiveness of drug courts, and (4) whether drug courts generate cost savings. OJP officials told us that as a result of the study, the major findings of the evaluation were translated into seven evidence-based design features that OJP is including in drug court grant solicitations. When making awards, OJP gives priority to applicants that include the seven design features in their proposals, as OJP considers these design features to be indicators of an effective program. The seven design features are (1) screening and assessment, (2) target population (3) procedural and distributive justice, (4) judicial interaction, (5) monitoring, (6) treatment and other services, and (7) relapse prevention, aftercare, and community integration.
- *The Department of Veterans Affairs' (VA) Substance Use Disorder Outpatient Program and Substance Use Disorder Residential Program*.[2] The study looked at the quality of VA substance abuse and mental health care for veterans diagnosed with substance use disorder (SUD) or one or more other mental health conditions. The evaluation asked the following questions: (1) To what extent is VA achieving the program outcomes for veterans with SUD or other mental health conditions? (2) How do the outcomes for VA patients

[1]Urban Institute Justice Policy Center, *The Multi-Site Adult Drug Court Evaluation: Executive Summary,* a report prepared for the Department of Justice (November 2011). GAO assessed this evaluation in GAO-12-53 and found it to be well done analytically and one of the most comprehensive studies of drug courts to date. For more information about drug court program evaluations and effectiveness, see GAO-12-53.

[2]Altarum Institute and RAND Health, *Veterans Health Administration Mental Health Program Evaluation Capstone Report*, a report prepared for the Department of Veterans Affairs (2011).

compare with outcomes for comparable veterans treated in non-VA-funded care? (3) How does the availability of care compare across Veterans Health Administration medical centers? (4) When there is a diagnosis of SUD and a mental health condition, are both conditions being managed? (5) What factors influence the use of VA specialty mental health services by veterans whose condition is a result of or aggravated by their service? (6) How widespread is the use of the strongest evidence-based models of care for SUD and the other mental health diagnoses? The study identified areas for further research and recommended strategies to improve SUD and mental health care in VA.

- *Substance Abuse and Mental Health Services Administration's (SAMHSA) Substance Abuse Prevention and Treatment Block Grant Program*.[3] The study assessed the extent to which this program is effective, functioning as intended, and achieving desired outcomes. The program provides funds to 50 states, nine territories (including the District of Columbia), and one Indian tribe for activities to prevent and treat substance abuse. The evaluation examined (1) the processes and activities by which states implement the legislative and policy requirements of the Substance Abuse Prevention and Treatment Block Grant program, (2) activities associated with the federal administration of the program and how they support program implementation and accountability, (3) state system processes and capacity for the collection and submission of data on block grant-funded activities, (4) specified outcomes associated with states' treatment and prevention services, and (5) the ways in which states used and leveraged program funds. The study identified program successes, as well as challenges and areas for improvement.

The other completed program evaluations examined:

- *SAMHSA's Underage Drinking Prevention Education Initiative*.[4] Two evaluations examined implementation and perceived outcomes of

[3]Altarum Institute, *Independent Evaluation of the Substance Abuse Prevention and Treatment (SAPT) Block Grant (BG) Program Final Evaluation Report,* a report prepared for SAMHSA (2009).

[4] ICF Macro, *2008 Town Hall Meetings: Mobilizing Communities to Prevent and Reduce Underage Alcohol Use Evaluation Report,* a report prepared for the Substance Abuse and Mental Health Services Administration (2009), and ICF Macro and University Research Company, LLC, *2010 Town Hall Meetings: Mobilizing Communities to Prevent and Reduce Underage Alcohol Use,* a report prepared for the Substance Abuse and Mental Health Services Administration (2011).

2008 and 2010 Town Hall meetings intended to raise public awareness of underage drinking and engage communities in its prevention. The evaluation also reviewed the barriers and challenges in planning and convening the Town Hall meetings. The evaluations reviewed, among other things, changes over time in the numbers of Town Hall meetings held and participation by community-based organizations. The evaluations also examined Town Hall attendees and presenters and the settings, formats, and contents of the Town Halls. Officials from SAMHSA, which administers the program, said they would use the evaluation results to shape future program proposals and inform and improve technical assistance and training activities. SAHMSA plans to share the results with participants and use the results in presentations on best practices.

- *SAMHSA's Assertive Adolescent and Family Treatment Program*.[5] The study focused on the third cohort of Assertive Adolescent and Family Treatment Program grant recipients and had two overarching goals: (1) to document the program implementation process, and (2) to explore how implementation supports, such as training and technical assistance for the clinical and assessment components of the project, guide how the funded programs evolve. The report findings addressed the characteristics of agency, staff, and clients and their relationship with program implementation, grantees' use of implementation activities, implementation barriers, strategies used and lessons learned, and the overall impact of the program on program sites and their clients.

[5]Advocates for Human Potential, Inc. Program Evaluation for the Assertive Adolescent and Family Treatment (AAFT) Program, Final Report, a report prepared for SAMHSA (September 14, 2012).

Appendix V: Comments from the Office of National Drug Control Policy

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

March 8, 2013

Eileen Larence
Director, Homeland Security and Justice
Government Accountability Office
441 G Street, NW
Washington DC 20548

Subject: GAO Report on Drug Abuse Prevention and Treatment Programs (GAO-13-333)

Dear Ms. Larence:

ONDCP appreciates the work which GAO has done examining drug abuse prevention and treatment programs. These programs are important to the health and wellbeing of millions of Americans, and we are always interested in identifying ways to enhance their effectiveness.

There are two issues raised in the report that we believe require further clarification:

Firstly, in order to fully understand the progress that has been made toward the five year goals for reducing illicit drug use that were set in the 2010 National Drug Control Strategy, it is important to analyze trends for each drug category separately. The apparent lack of progress reflected in the aggregate data is, as GAO recognizes in its report, "due primarily to an increase in the rate of reported marijuana use, offset by a decrease in the rates of reported [use of other drugs]" The uptrend in marijuana use dominates the aggregate data because marijuana accounts for approximately eighty percent (80%) of overall illicit drug use. With the exception of marijuana use, illicit drug use is trending down, consistent with ONDCP goals, especially prescription drug abuse and use of cocaine, hallucinogens, inhalants, and methamphetamine. The rate of illicit drug use other than marijuana is tracked by the NSDUH. In 2009, this rate for youth was 4.6%; by 2015 a 15% reduction would result in a rate of 3.9%. In 2011, this rate was 4.1%--well on track for achieving the target. Among young adults this rate was 8.4% in 2009; by 2015 a 10% reduction would result in a rate of 7.6%. In 2011, this measure, at 7.0% had already been achieved. Additionally, progress appears to have been made in reducing drugged driving. Since the National Roadside Survey is being conducted only once prior to 2015, ONDCP also is tracking progress toward achieving this measure with data from the NSDUH on the prevalence of having driven under the influence of illicit drugs in the past 12 months. In 2009, this rate was at 4.2 percent; a 10% reduction by 2015 would result in a target rate of 3.8%. In 2011, this target was already achieved with a rate of 3.7%.

Secondly, GAO identified 76 programs in the report that provide some prevention and/or treatment services, and concluded that there was "overlap" amongst 59 of them. This potential for overlap exists, in GAO's words "because they can provide or fund at least one drug abuse prevention or treatment service that one or more other programs can also provide or fund.." It is important to note the distinction between "overlap" and "duplication". As GAO has explained: "overlapping programs are not necessarily duplicative, if the services provided and the populations served differ in meaningful ways." Some potentially overlapping programs may in fact target different specific subgroups of a large population category, and there may also be significant distinctions in the specific services provided. GAO's report did not identify any actual duplication of prevention and treatment services to beneficiaries.

For example, one of the population groups examined for potential program overlap - "the student and youth population" - contains over 100 million people. Many of the programs identified serve relatively small subgroups of youth, making actual overlap amongst them unlikely, and in some cases, impossible. For example, an 18-24 year old enrolled in Job Corps cannot also be a 6th or 8th Grade middle school student in an afterschool setting (21st Century Learning Centers) nor can they be in active substance abuse treatment (Assertive Adolescent and Family Treatment) nor can they be in any of the school based programs as they must have graduated or dropped out to be eligible for Job Corps. Similarly, one program providing prevention and treatment services to offenders may target those in the federal criminal justice system while another targets those in state criminal justice systems. One may serve offenders who are incarcerated while another serves offenders in the community.

It is also important to recognize that "overlap" can be positive, such as when it reinforces key prevention messages. Evidence shows that there is a broad range of risk factors that can lead youth into abusing drugs. Therefore, it is important to have multiple prevention programs that are focused on addressing these different risks factors and at different stages of development. The fact that a student who participates in a school based prevention program also hears about the danger of illegal drugs in an afterschool setting or in the media increases the likelihood that our goal of deterring youth drug use will be achieved.

ONDCP and its agency partners recognize the importance of coordinating the administration of potentially overlapping programs in order to avoid duplication and maximize program effectiveness. The National Drug Control Strategy designates lead and partner agencies for each of its action items, and ONDCP works to facilitate coordination amongst them throughout the course of implementation. The annual process of developing the National Drug Control Budget involves a systematic review of prevention and treatment programs to allocate limited resources most effectively. Avoiding duplication is a key consideration in this process. Additionally, there is ongoing dialogue amongst the agencies directly administering these programs to coordinate the delivery of services.

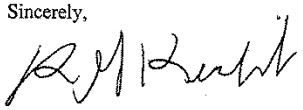
GAO recognizes that substantial coordination of prevention and treatment programs is already taking place. As GAO stated in the summary of this report that it drafted for its "2013 Annual Duplication Report":

> "A more in-depth analysis of two areas (prevention services for students and youth, and prevention and treatment services for offenders) found that all the agencies administering these programs took various efforts to coordinate overlapping programs or services where the programs had similar objectives, reducing the risk of duplication."

For example, GAO found "the risk of potential duplication" among six prevention programs for youth that it examined "may be low due to interagency coordination efforts" taken by the administering agencies to improve efficiencies. It also found that officials from the key agencies involved in delivering prevention and treatment services for offenders "use multiple coordination mechanisms to help minimize the risk of potential duplication."

GAO is right to emphasize the importance of coordination. When programs are examined in depth, the apparent overlap that appears on paper often disappears in practice due to well-coordinated administration. While there is already extensive coordination of prevention and treatment programs taking place, there is always room for improvement. ONDCP accepts GAO's recommendation for an assessment to identify opportunities for increased coordination amongst drug control agencies, and we will work with those agencies to further enhance program coordination.

Sincerely,



R. Gil Kerlikowske
Director

Appendix VI: GAO Contacts and Staff Acknowledgments

GAO Contacts

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