Health Canada Santé Canada

Alcohol and Drug Treatment and Rehabilitation Program

FINAL EVALUATION REPORT

Presented to

Health Canada
Departmental Audit and Evaluation Committee

October 14, 2004

Canada

Alcohol and Drug Treatment and Rehabilitation Program
Final Evaluation Report
PROGRAM RESPONSE

Background

The Alcohol and Drug Treatment and Rehabilitation (ADTR) Program is an A-base component of Canada's Drug Strategy and represents an intervention-type program which supports treatment and rehabilitation programs and services. It provides $14 million per year in cost-shared contribution funding to participating provinces and territories.

An evaluation of the ADTR Program was undertaken by the Departmental Program Evaluation Division (DPED, Information, Analysis and Connectivity Branch (IACB) in 2003. This was the first formal evaluation of the ADTR Contribution Program since its inception in 1987 and addressed both summative and formative types of questions. The evaluation focussed on the relevance, impact and cost-effectiveness of the Program. The evaluation was required because the terms and conditions of the ADTR Program were up for renewal by Treasury Board in 2004.

Evaluation Findings

1. General Findings/Conclusions

The evaluation process pursued four lines of evidence including a literature review, a document review, key informant surveys and two case studies. The findings from the evaluation were primarily inconclusive, mainly because of the lack of performance measurement data and outcome monitoring. The evaluation consequently could make no conclusions with respect to the Program's impacts and the extent to which progress has been made towards program objectives. The available financial and client information renders the cost-effectiveness of the ADTR Contribution Program difficult to assess at this time. To a limited degree, the findings of the evaluation supported the relevance of the Program mainly because of the considered but anecdotal opinions of stakeholders and evidence obtained from professional literature.

What the Branch can do

The findings from the ADTR evaluation reflect the conclusions and recommendations of recent reports of the Auditor General, the Senate Committee and the Special House Committee, all of which call for enhanced federal investment in leadership and information on drug use and abuse. To this end, the Drug Strategy and Controlled Substances (DSCS) Programme as part of its Canada's Drug Strategy (CDS) RMAF and the enhanced consultative processes associated with CDS Renewed is putting in place processes to deal with the lack of information on ADTR programming. These processes and associated timetable were outlined in the Treasury Board Submission to renew the Terms and Conditions (T&C) for the ADTR Contribution Program and

subsequently approved, with conditions, by Treasury Board on April 21, 2004. The conditions relate to the need to report to TBS on progress to enhance the ADTR component of the CDS RMAF.

2. Findings/Conclusions in Three Key Areas

2.1 Performance Measurement Strategy/Gathering of Performance Information

Findings

The evaluation study evidenced weaknesses with respect to the performance measurement and program evaluation context in which the ADTR Program operates. The Program did not implement performance measurement and evaluation strategies at the outset of the Program, nor was a baseline study conducted or performance information collected throughout the duration of the Program. Consequently it is not possible to measure the extent to which progress has been made toward program objectives.

Conclusions of the Evaluation Team

The ADTR Program design and implement a performance measurement strategy and an evaluation strategy, to monitor and measure the impacts of the Program. To support this, the ADTR Program will allocate additional resources into its performance measurement and program evaluation activities.

The ADTR Program should play an enhanced role in fostering a coordinated and centralized approach to collecting and managing data and outcome monitoring.

What the Branch can do

The DSCS Programme, as part of CDS Renewed, will work collaboratively with provinces and territories to improve ADTR performance measurement and data collection. This work will accord with the horizontal CDS Renewed RMAF and the enhanced governance structures put in place as a result of CDS Renewed (e.g. the Federal/Provincial/Territorial (FPT) Committee on Canada's Drug Strategy and the ADTR FPT Working Group). A key element of this will be the development of a common analytical framework and definitions to assist in data collection and output analysis with respect to substance abuse.

The timetable to enhance the ADTR component of the CDS RMAF, and as outlined in the ADTR submission approved by Treasury Board, includes:

- Consultations to Improve Measurement, Data Collection, and Provincial Reporting - 2004-05
- Implementation of Action Plan (e.g. Data Collection) - 2005-06

- Mid Term Evaluation as per RMAF - 2006-07
- Final Evaluation as per RMAF - 2008-09

2.2 Relevance of target group

Findings

The stakeholder interviews and the most recent information available on alcohol and drug use in Canada provide evidence that there is still a need for the federal government to support substance use treatment and rehabilitation programming in the P/Ts. Also, evidence from the literature review and the stakeholder interviews suggest that targeting high-need populations, especially women and youth, is an effective strategy for substance use programming and is consistent with programming in the P/Ts.

Conclusions of the Evaluation Team

The ADTR Program continue to provide targeted funding to P/Ts to support initiatives that strengthen alcohol and drug treatment and rehabilitation for high-need populations. A literature review should be conducted to verify if women and youth are still relevant target populations for the ADTR Program and if additional target populations have emerged across the country.

What the Branch can do

The DSCS Programme will undertake more in-depth literature reviews and examine varying data sources in assessing the continued relevancy of the target population, women and youth, and in identifying other target populations as the evidence indicates.

2.3 Review of Program Objectives

Findings

To Program's main objective is to ensure innovative, accessible and effective alcohol and drug treatment and rehabilitation services and programs. Program stakeholders and the document review revealed that when the ADTR Program was implemented in 1987 and in the first year of the contribution agreements, the funding provided an initial incentive for the creation of new initiatives or the expansion of existing programs. Since then, the effect of the funding as an incentive to ensure new and innovative programming has diminished.

Conclusions of the Evaluation Team

The ADTR Program objective that seeks "to ensure innovative, accessible and effective alcohol and drug treatment and rehabilitation services and programs" be re-examined since most ADTR contribution funds now"support the delivery of ongoing alcohol and drug treatment and rehabilitation services within provinces and territories."

What the Branch can do

The DSCS Programme revisited the objectives during the renewal of the ADTR Program T&C to bring them more in line with what the Programme wants to accomplish through this funding mechanism. Appropriate, meaningful and achievable performance indicators against the objectives have been identified in the CDS RMAF.

From a broader policy perspective, as work on the national framework for substance use and abuse unfolds and collaborative priorities emerge, the federal "value-added" role in substance abuse treatment services will continue to be assessed. As well, an internal program expenditure review exercise, if implemented, would provide an opportunity to examine the ADTR Program against specified criteria, federal objectives and consideration of the best instrument to advance these.

Action Plan

A response and detailed action plan to respond to each of the recommendations in the evaluation report is attached.

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Approved by: Halina Cyr

Date: June 8, 2004

PROPOSED ACTION PLAN IN RESPONSE TO THE ALCOHOL AND DRUG TREATMENT AND REHABILITATION PROGRAM EVALUATION REPORT

RECOMMENDATION	RESPONSE	KEY ACTIVITIES	ACCOUNTABILITY	TIMEFRAME
1.0 As the ADTR Program moves forward with its renewed and revised Terms and Conditions (T&C), the ADTR Program will design and implement a performance measurement strategy and an evaluation strategy to monitor and measure the impacts of the Program. To support this, the ADTR Program will allocate additional resources to its performance measurement and program evaluation activities.	Agree. The performance measurement and evaluation strategies for the ADTR Program will accord with the horizontal CDS Renewed RMAF and the enhanced governance structures put in place as a result of CDS Renewed.	• The DSCS Programme will be seeking Treasury Board Secretariat approval of Canada's Drug Strategy (CDS) Renewed horizontal Results-Based Management and Accountability Framework (RMAF) that identifies CDS Renewed objectives, including ADTR Program objectives, and the chain of activities, outputs and outcomes contributing to the achievement of these objectives. The horizontal RMAF includes a comprehensive evaluation strategy which will be used for the purposes of continuing to monitor, report on and integrate into subsequent decision-making the impacts and lessons learned from the implementation of CDS renewed, including the ADTR Program. • Consistent with the conditions attached to TB's approval of the ADTR Program T&C on April 21, 2004, the DSCS Programme will undertake and report to TBS on the following activities to enhance the ADTR component of the CDS RMAF : • Consultations with provinces/territories to improve measurement, data collection and provincial reporting • Implementation of Action Plan (e.g. data collection) • Mid-Term Evaluation as per RMAF • Final Evaluation as per RMAF	• Office of CDS Secretariat and Strategic Policy, DSCS Programme and • Office of Demand Reduction, DSCS Programme • Office of Demand Reduction, DSCS Programme	September 2004 FY 2004-05 FYs 2004-06 FY 2006-07 FY 2008-09

RECOMMENDATION	RESPONSE	KEY ACTIVITIES	ACCOUNTABILITY	TIMEFRAME
1.1 Identify ADTR Program objectives, outcomes, indicators and baseline information that can be measured, attributed to the Program, and reasonably expected to occur within the four to five-year time period.	Agree.	• ADTR Program objectives, outcomes and indicators have been identified and incorporated into the horizontal CDS RMAF. Some baseline information is available as a result of the 2003 ADTR Program Evaluation; other baseline information to be collected in FY 2005-06 as per actions identified under 1.0 above.	• Office of Demand Reduction, DSCS Programme	FY 2005-06
1.2 Develop an evaluation strategy that would outline the evaluation issues and questions for formative and summative evaluation studies.	Agree.	• Evaluation issues and questions identified in the 2003 ADTR Program Evaluation have been incorporated into the comprehensive evaluation strategy for CDS Renewed.	• Office of CDS Secretariat and Strategic Policy, DSCS Programme and • Office of Demand Reduction, DSCS Programme	September 2004
1.3 Report annually on progress towards ADTR objectives in a streamlined and standardized manner.	Agree.	• The DSCS Programme will report to TBS on progress to enhance the ADTR component of the CDS RMAF per timetable outlined under 1.0 above.	• Office of Demand Reduction, DSCS Programme	FY 2004-05 and ongoing

RECOMMENDATION	RESPONSE	KEY ACTIVITIES	ACCOUNTABILITY	TIMEFRAME
1.4 Formally integrate evaluation requirements into the ADTR program design. This includes revising the annual reporting template for provinces and territories and assist the provinces and territories with their annual reports. Also, all ADTR-funded initiatives, as a condition of funding would be required to explicitly allocate a portion of their resources to project evaluation, using a standardized reporting format to be developed by the ADTR Program	Partially agree. While Health Canada is responsible for the overall management of the ADTR Program, provinces and territories are responsible for the administration, design, delivery and evaluation of their treatment and rehabilitation programs.	• Evaluation requirements will be formally integrated into the ADTR Program's design per actions identified under 1.0 above. • To address limitations in data, the DSCS Programme will work collaboratively with provinces and territories to improve ADTR performance, data collection and P/T reporting. This work will accord with the horizontal CDS Renewed RMAF and the enhanced governance structures put in place as a result of CDS Renewed (e.g. the rejuvenated FPT Committee on CDS and the ADTR FPT Working Group). A key element of this will be the development of a common analytical framework and definitions to assist in data collection and output analysis with respect to substance abuse.	• Office of Demand Reduction, DSCS Programme • Office of Demand Reduction, DSCS Programme	September 2004 2004-05 and ongoing
2. The ADTR Program should play an enhanced role in fostering a coordinated and centralized approach to collecting and managing data and outcome monitoring. This would entail providing a leadership role in data collection and management, including developing an analytical framework, common definitions and standards, and a central data set that provinces and territories would use to input their data.	Agree.	• As per 1.4 above, the DSCS Programme is putting in place processes to deal with the lack of information on ADTR programming. These actions are designed to address provincial comments that the federal government needs to play and enhanced role in terms of national leadership with respect to ADTR and in facilitating data collection, management and program evaluation.	• Office of Demand Reduction, DSCS Programme	2004-05 and ongoing

RECOMMENDATION	RESPONSE	KEY ACTIVITIES	ACCOUNTABILITY	TIMEFRAME
3. ADTR Program should continue to provide targeted funding to provinces and territories to support initiatives that strengthen alcohol and drug treatment and rehabilitation for high-need populations. A literature review should be conducted to verify if women and youth are still relevant target populations for the ADTR Program and if additional target populations have emerged across the country.	Agree.	• Program guidelines reflect youth and women as the prime high-need target groups for services funded under the ADTR Program. Other at risk groups requiring specialized services can also be served. • A literature review and varying data sources in building and supporting emerging evidence on the continued relevancy of the target population, women and youth will be conducted.	• Office of Demand Reduction, DSCS Programme • Office of Demand Reduction, DSCS Programme	Completed FY 2005-06
4. The ADTR Program objective that seeks "to ensure innovative, accessible and effective alcohol and drug treatment and rehabilitation services and programs" be re-examined since most ADTR contribution funds now support the delivery of "support the delivery of ongoing alcohol and drug treatment and rehabilitation services within provinces and territories."	Partially agree. Established in 1987, the ADTR Program served as the federal incentive to provinces and territories to invest in innovative/ specialized treatment services for at risk populations such as women and youth. The ADTR Program will be examined during the Program Expenditure Review exercise. It is anticipated that this review will examine the federal role in the area of substance abuse treatment services.	• The ADTR Program objective has been revised as follows: "to assist in ensuring access for Canadians to effective alcohol and drug treatment and rehabilitation services and programs". Per the revised Program guidelines, new and innovative programs and services will continue to be considered as eligible programming under ADTR along with enhanced or, if established on or after April 1, 1987, ongoing programs and services. • Participate in the Program Expenditure Review exercise as it relates to the ADTR Program and link to CDS national priority setting framework.	• Office of Demand Reduction, DSCS Programme • Office of Demand Reduction, DSCS Programme	Completed Summer 2004

RECOMMENDATION	RESPONSE	KEY ACTIVITIES	ACCOUNTABILITY	TIMEFRAME
5. The ADTR Program should strengthen linkages with relevant federal departments, provinces and territories, and relevant stakeholders to develop an enhanced level of cooperation and collaboration. This should include consulting with the ADTR F/P/T Working Group to discuss strategies to ensure meaningful and appropriate engagement and implementing mechanisms to facilitate communication and the exchange of information between the ADTR Program and stakeholders.	Agree. Good collaboration exists between the ADTR Program and the ADTR F/P/T Working Group on issues related to the research component of the Program.	• Processes will be put in place to strengthen provincial/territorial engagement in performance measurement discussions per actions identified under 1.0 above.	• Office of Demand Reduction, DSCS Programme	2004-05 and ongoing

RECOMMENDATION	RESPONSE	KEY ACTIVITIES	ACCOUNTABILITY	TIMEFRAME
6. Alcohol and drug treatment and rehabilitation issues continue to be a Health Canada priority and dedicated funding remain available to assist in developing and disseminating research information to the provinces and territories and relevant stakeholders. Also, increased documentation of the key dissemination mechanisms and strategies for best practises information should be introduced into the research component of the ADTR Program to assess how these activities are conducted and their effectiveness in terms of achieving the objectives of the ADTR Program research agenda.	Agree.	• Dedicated funding identified in the 2004-05 operational plan to finalize two best practices documents and undertake one new best practices. In addition, funding identified to support dissemination activities of research information including holding one workshop to disseminate best practices information on treatment issues related to people who drive while impaired. • An ADTR Best Practices Uptake Survey will be developed and implemented to determine level of use and uptake of ADTR research materials among program planners, policy makers and health professionals in the substance abuse service delivery sector.	• Office of Demand Reduction, DSCS Programme • Office of Demand Reduction, DSCS Programme	2004-05 2004-05 and ongoing

Health Canada Santé Canada

ALCOHOL AND DRUG TREATMENT AND REHABILITATION PROGRAM

FINAL EVALUATION REPORT

June 2004

DEPARTMENTAL PROGRAM EVALUATION DIVISION

Applied Research and Analysis Directorate
Information, Analysis and Connectivity Branch

Canada

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- Renee Pilon, Project Officer

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- Kevin McKenzie, Evaluation Manager
- Michael Willox, Analyst
- Jennifer Cote, Analyst
- Michael King, Analyst
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EXECUTIVE SUMMARY

BACKGROUND

Under the auspices of Canada's Drug Strategy (CDS), the Alcohol and Drug Treatment and Rehabilitation (ADTR) Program was established in 1987 by Health and Welfare Canada, to stimulate innovative alcohol and drug treatment and rehabilitation programs and services, with a focus on women and youth. In 1993, the Program was transferred to Human Resources Development Canada and then back to Health Canada in 1997. Presently, the ADTR Program falls under the management of the Treatment and Rehabilitation Division, Office of Demand Reduction, Drug Strategy Controlled Substances Programme, Healthy Environments and Consumer Safety Branch (HECS).

The objectives of the ADTR Program are:

- to ensure innovative, accessible and effective alcohol and drug treatment and rehabilitation services and programs;
- to assist in ensuring access for all Canadians to alcohol and drug treatment and rehabilitation services;
- to reduce the harm to individuals, families, and communities arising from the abuse of alcohol and other drugs; and
- to assist provinces and territories through a cost-sharing plan to increase and expand alcohol and drug treatment and rehabilitation programming within the provinces and territories, and to do so in a fashion that builds on the current cooperation of the two orders of government in this field, and which supports provincial/territorial efforts to plan and deliver alcohol and drug services.

Of the $15.5 million currently allocated to the ADTR Program annually, $14 million is used to support the Federal/Provincial/Territorial cost-sharing agreements (contribution component); $1.0 million is converted to operating funds to support treatment and rehabilitation research and information dissemination activities (research component) with the provinces and territories (P/Ts) and to administer the Program; the $500,000 balance is made to the Canadian Centre on Substance Abuse (CCSA) to develop and disseminate knowledge on substance use issues, to create new knowledge on treatment and rehabilitation, and to expand its dissemination networks.

PROGRAM EVALUATION

An evaluation of the ADTR Program was conducted to meet the requirements of the 1997 Treasury Board submission. The objectives of the evaluation study were to:

- to assess the relevance, impact, and cost effectiveness of the ADTR Program since it was transferred to Health Canada in 1997;
- to assess the extent to which the ADTR Program has made progress on the achievement of its identified objectives; and
- to facilitate the development of a Performance Measurement Strategy that will be included as part of the Results-Based Management and Accountability Framework to be presented to Treasury Board Secretariat for purpose of renewing the ADTR Program's Terms and Conditions.

The evaluation included an examination of program design, implementation, and impacts in an effort to respond to the following evaluation questions:

- ❑ Is there a continued need for the ADTR Program?
- ❑ To what extent has the ADTR Program made progress on the achievement of its identified objectives?
- ❑ To what extent were best practices adopted by service providers?
- ❑ Were contribution arrangements the most efficient and effective means of achieving the ADTR Program objectives?
- ❑ What was the cost effectiveness of the program?

The methodology included the following components:

- a literature review on evaluations of substance use treatment and rehabilitation programs focussed on women and youth, to assess the continuing need and relevance of the ADTR Program;
- a document review to determine the extent to which planned ADTR Program activities were carried out and to address the evaluation questions with respect to the impacts and cost effectiveness of the Program;
- interviews with 21 stakeholders, including Health Canada representatives from the National Capital Region and Regional Offices, provincial representatives, CCSA representatives, ADTR-funded project proponents; and representatives from non-funded jurisdictions. The objective of the interviews was to determine the relevance of the Program in terms of its objectives and target populations and to assess the extent to which the ADTR Program has made progress toward its objectives and the overall strengths and weaknesses of the Program; and

- case studies with 2 sites, to assess the extent to which the ADTR Program made progress toward its objectives and to determine the cost effectiveness of the sites.

While evaluators took every measure to conduct a thorough and methodologically sound study, the following limitations must be considered:

- lack of performance management and outcome monitoring;
- inability to develop valid cause and effect inferences;
- limited extent to which the evaluation questions could be addressed; and
- inability to conduct a cost effectiveness analysis.

CONCLUSIONS

This evaluation study evidenced some weaknesses with respect to the performance measurement and program evaluation context in which the ADTR Program operates. The Program did not implement performance measurement and evaluation strategies at the outset of the Program, nor was a baseline study conducted or performance information collected throughout the duration of the Program. Consequently, it is not possible to measure the extent to which progress has been made toward program objectives. This does not imply that the ADTR Program did not have an impact on the outcomes, but due to lack of evidence available, an assessment of this type was not possible. As a result, the findings presented in this report are based primarily on the activities and outputs of the ADTR Program and on the opinions of ADTR Program stakeholders.

Relevance

The stakeholder interviews and the most recent information available on alcohol and drug use in Canada provide evidence that there is still a need for the federal government to support substance use treatment and rehabilitation programming in the P/Ts. Also, evidence from the literature review and the stakeholder interviews suggest that targeting high-need populations, especially women and youth, is an effective strategy for substance use programming and is consistent with programming in the P/Ts.

Impacts

To achieve the Program's main objective, to ensure accessible and effective alcohol and drug treatment and rehabilitation services and programs, the ADTR Program must rely on P/Ts to deliver funded services. Available evidence suggests that ADTR-funded initiatives, by virtue of its contribution funding, contribute to facilitating accessible and effective services.

However, stakeholders indicated that while there was an initial increase in access in the first year of the Program, due to the fact that there have not been additional increases in ADTR Program contribution funding, there have not been additional increases in ensuring access.

In terms of ensuring innovative, accessible, and effective substance use treatment and rehabilitation, program stakeholders and the document review revealed that when the ADTR Program was implemented in 1987 and in the first year of the contribution agreements, the funding provided an initial incentive for the creation of new initiatives or the expansion of existing programs. Since then, the effect of the funding as an incentive to ensure new and innovative programming has diminished. In terms of facilitating new and innovative services under the research component of the ADTR Program, through the development and dissemination of best practices documents and workshops, there is little information which provides an assessment of this type. However, stakeholders reported a high level of satisfaction with best practices activities, which can be interpreted as a proxy measure for success.

Available evidence suggests that the ADTR Program has been successful in increasing the cooperation and collaboration between various levels of government, through supporting several working groups and through the development of best practises projects and workshops. Program stakeholders indicated a high level of satisfaction with these relations, which can be interpreted as a proxy measure for cooperation and collaboration. However, it should be noted that a minority of stakeholders indicated some dissatisfaction with the lack of cooperation and communication between Health Canada and the regional offices, provincial representatives, F/P/T working group, and funded initiatives.

The ADTR Program has been successful in carrying out its responsibilities to provide funding to develop and facilitate the dissemination of research information to P/Ts. A considerable amount of information was produced and developed to a range of stakeholders as a result of the ADTR Program funding and overall, stakeholders indicated a high level of satisfaction with these activities. While this level of satisfaction can be interpreted as a proxy measure of the usefulness and quality of the information developed and disseminated, there is little outcome evidence available to assess the extent to which the best practises information led to increased expertise and changes to the provisions of services.

Preliminary analysis indicates that there is some inefficiency in terms of the renewal/approval process of the contribution agreements; however, given the current level of information available, it is not possible to draw any definitive conclusions on the efficiency of the process. Available evidence suggests that the program stakeholders perceive the contribution agreements and annual reporting requirements as rigid.

Cost Effectiveness

Objective outcome research on the cost effectiveness of the ADTR Program is not available at this time, due to the inconsistency and incompleteness of information provided in the ADTR Program Annual Reports as well as the inability to determine the cost effectiveness of the ADTR Program contribution funding in relation to provincial substance use treatment and rehabilitation budgets. Accordingly, it is not possible to assess the cost effectiveness of the ADTR Program

RECOMMENDATIONS

Based on the evaluation findings, it is recommended that:

1. As the Program moves forward with its renewed Terms and Conditions, it is recommended that the ADTR Program design and implement a performance measurement strategy and an evaluation strategy, to monitor and measure the impacts of the Program. To support this, it is recommended that the ADTR Program allocate additional resources into its performance measurement and program evaluation activities. This recommendation entails that:
   - ADTR Program objectives, outcomes, indicators, and baseline information be identified that can be measured, attributed to the Program, and reasonably expected to occur in the five-year time period.
   - An evaluation strategy be developed to outline the evaluation issues and questions for formative and summative evaluation studies.
   - Progress towards ADTR objectives be reported annually in a streamlined and standardized manner.
   - Evaluation requirements be formally integrated into the ADTR program design. This includes revising the annual reporting template for P/Ts and to assist the P/Ts with their annual reports. Also, all ADTR-funded initiatives, as a condition of funding, should be required to explicitly allocate a portion of their resources to project evaluation, using a standardized reporting format to be developed by the ADTR Program.

2. The ADTR Program should play an enhanced role in fostering a coordinated and centralized approach to collecting and managing data and outcome monitoring. This recommendation would entail providing a leadership role in data collection and management, including developing an analytical framework, common definitions and standards, and a central data set that P/Ts would use to input their data.

3. The ADTR Program continue to provide targeted funding to P/Ts to support initiatives that strengthen alcohol and drug treatment and rehabilitation for high-need populations. A literature review should be conducted to verify if women and youth are still relevant target populations for the ADTR Program and if additional target populations have emerged across the country.

4. The ADTR Program objective that seeks "to ensure innovative, accessible and effective alcohol and drug treatment and rehabilitation services and programs" should be re-examined, as most ADTR contribution funds support the delivery of ongoing alcohol and drug treatment and rehabilitation services in the P/Ts. Instead, the ADTR Program should seek to "support the delivery of ongoing alcohol and drug treatment and rehabilitation services in P/Ts."

5. The ADTR Program strengthen linkages with relevant federal departments, P/Ts, and relevant stakeholders to develop an enhanced level of cooperation and collaboration. This recommendation should include consulting with the F/P/T Working Group to discuss strategies to ensure meaningful and appropriate engagement and implementing mechanisms to facilitate communication and the exchange of information between the ADTR Program and stakeholders.

6. Alcohol and drug treatment and rehabilitation issues continue to be a Health Canada priority and dedicated funding remain available to assist in developing and disseminating research information to the P/Ts and relevant stakeholders. Also, increased documentation of the key dissemination mechanisms and strategies for best practises information should be introduced into the research component of the ADTR Program to assess how these activities are conducted and their effectiveness in terms of achieving the objectives of the ADTR Program research agenda.

INTRODUCTION

This report is a summary of the findings of an evaluation conducted on the Alcohol and Drug Treatment and Rehabilitation Program (herein after referred to as the ADTR Program or the Program).

This report is based on information provided in the evaluation process, which was completed for the ADTR Program by staff from Health Canada's Departmental Program Evaluation Division and a consultant. Evaluators relied on information and input from Health Canada staff and a wide array of Program stakeholders; their input to this study is gratefully acknowledged.

To begin, the report describes the issue of substance use in Canada, including statistics on alcohol and drug use and estimates of the costs of substance abuse in Canada. Following this, a brief description of the ADTR Program, its history, and the Program logic model is presented. Then, details on the evaluation study are presented, including information on the purpose, evaluation issues and questions, and the methodology employed; a discussion of the limitations of the study is also included. The final section of the report presents the evaluation findings. This section is organized by evaluation issue, beginning with continuing relevance, program impacts, best practises, contribution agreements, and cost effectiveness. Finally, the conclusion presents the overall analysis, conclusion, and resulting recommendations related to the evaluation of the ADTR Program.

SUBSTANCE USE IN CANADA

The following section presents the most recent information on alcohol and drug use in Canada and situates the ADTR Program in the environment in which it operates.[1] To understand the relevance of alcohol and drug programming in Canada, it is necessary to define the issue and describe the prevalence of alcohol and drug use in society. Statistics on alcohol and drug use in Canada are presented along with the numbers of deaths and hospitalizations attributable to substance use; in addition, the costs of substance use in Canada are outlined.

ALCOHOL USE

According to the 1999 National Population Health Survey (NPHS), the majority of adult Canadians (78%) are considered current drinkers, having used alcohol at least once in the past year; 13% have used alcohol in their lifetime but not in the past year; and almost 10% are abstainers.[2] While many Canadians drink moderate levels of alcohol, there are considerable numbers who drink immoderately. According to the 2000-2001 Canadian Community Health Survey (CCHS), 29% of males and 11% of females reported heavy drinking patterns, consuming five or more drinks on a single occasion 12 or more times in the past year.

It has been found that alcohol consumption patterns are highly correlated with several socio-demographic factors, such as age, gender, education levels, social isolation and employment status. For instance, men are more likely than women to have reported exceeding the low-risk drinking guidelines and young adults in their 20's reported the highest rates of consumption and high-risk drinking patterns.[3] Also pertaining to age, according to a paper released by the Organisation for Economic Co-operation and Development (OECD), over 30% of Canadian 13 year-olds drank alcohol in the past year; close to 20% of Canadian youth reported drinking weekly, 42% of whom reported drinking heavily; and there was a 29% prevalence of high-risk drinking among Canadian youth.[4]

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1 Subsequent to the completion of the literature review, more recent statistics on alcohol and drug use were released; wherever possible, the most recent statistics are included in this report.

2 Unless otherwise referenced, all statistics in this section are derived from: 2002: National Report, Drug Trends and the CCENDU Network. 2003. Canadian Centre on Substance Abuse.

3 The low risk drinking guidelines are 14 drinks a week for men and 9 drinks a week for women, with no more than two drinks on a single day. Single, Eric. 1999. Substance Abuse and Population Health. Canadian Centre for Substance Abuse. Workshop on Addiction and Population Health, Edmonton.

4 Bennett, Jan. 2003. Investment in Population Health in 5 OECD Countries. Organisation for Economic Co-operation and Development. OECD Health Working Papers, Directorate for Employment, Labour and Social Affairs.

DRUG USE

Many Canadians use illicit drugs and Canada ranks among the highest countries in the world in terms of illicit drug use rates. According to data from the 1994 Canada's Alcohol and Other Drugs Survey (CADS), almost one in four Canadians reported the using illicit drugs at least once in their lifetime; 19 % reported having used cannabis, 4% LSD, speed or heroin, and 3% cocaine.[5] At the same time, approximately one in 12 Canadians (approximately 8 %) reported using an illicit drug in the last year; the rates of use were 7% for cannabis, 1% for LSD, speed or heroin, and less than 1% for cocaine.[6]

Across Canada, the rates of illicit drug use varied significantly by region, and in most instances, drug use was highest in British Columbia and lowest in Newfoundland. As is the case with alcohol, drug use is associated with a variety of socio-demographic characteristics, including age, gender, marital status. According to the data from CADS, the typical profile of an illicit drug user is a young, unattached male.[7] In contrast to alcohol, illicit drug use patterns are not clearly related to education or income, but is more common among unemployed individuals. However, the mixed relationship between income, education and occupation to illicit drug use patterns "should not be interpreted to mean that the problems associated with use are not related to the underlying determinants of health.[8]

MORBIDITY AND MORTALITY

Statistics are also available that provide evidence of the negative impacts of alcohol and drug use in Canadian society. In 1999, it was estimated that 3,139 Canadians lost their lives as a result of alcohol, which does not include motor vehicle accidents. Of these deaths, the leading cause for both females and males was cirrhosis of the liver (581 females and 1,205 males).

In 2000, there were 981 alcohol-related motor-vehicle accidents, which resulted in 1,096 deaths; of these deaths, the majority were male (82 %).

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5 One time cannabis users are not included in this statistic.

6 Single, Eric, Robson, Lynda, Xie, Xiaodi, and Rehm, Jurgen. 1996. The Costs of Substance Abuse in Canada - Highlights of a Major Study of the Health, Social and Economic Costs Associated with the Use of Alcohol, Tobacco and Illicit Drugs. Canadian Centre on Substance Abuse. Online at: http://www.ccsa.ca.

7 Ibid.

8 Ibid.

In 1999, there were 517 deaths in Canada attributable to illicit drugs (250 females and 267 males); this represents a slight increase from the previous year (4%). Among these deaths, almost all could be attributed to suicide and self-inflicted poisoning (249 females and 262 males); 1 female and 5 males died as a result of cocaine-type drug dependence.

In terms of alcohol and drug related morbidity, there were an estimated 56,161 hospital separations (both live and dead) in Canada in 2000-2001, where alcohol and drug use was the most responsible diagnosis. In the same time period, there were a further 137,429 hospital separations where alcohol and drug use were responsible to some extent.

THE COSTS OF SUBSTANCE ABUSE IN CANADA[9]

In 1992, alcohol and drug abuse in Canada was estimated to have resulted in $8.89 billion worth of costs to the economy, which encompasses health care, social welfare, criminal justice and lost productivity costs.[10]

As part of these total costs, alcohol accounted for $7.5 billion in costs, or $265 per capita.[11] Alcohol related costs included $4.1 billion for lost productivity due to morbidity and premature mortality, $1.36 billion for law enforcement, and $1.3 billion in direct health care costs.

In 1992, alcohol and drug abuse cost the Canadian economy an estimated $8.89 billion in health care, social welfare, criminal justice, and productivity costs.

At the same time, drugs accounted for $1.4 billion of total economic costs of substance abuse, or $48 per capita.[12] Drug related costs included $823 million for lost productivity due to morbidity and premature mortality, $400 million for law enforcement, and $88 million in direct health care costs.

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[9] The term "use" is used predominantly by the ADTR Program and throughout this document to refer to substance use patterns, substance use treatment, substance use programming, etcetera. However, in cases where the literature specifically used the term "abuse," as is the case with the substance abuse costs, the term has not been altered.

[10] Single et. al., 1996.

[11] Ibid.

[12] Ibid.

THE ALCOHOL AND DRUG TREATMENT AND REHABILITATION PROGRAM

CONTEXT

Launched in 1987, Canada's Drug Strategy (CDS) represents the federal government's commitment to reducing the supply of and demand for drugs, and consists of seven components:

- research and knowledge development;
- knowledge dissemination;
- prevention programming;
- treatment and rehabilitation;
- legislation, enforcement and control;
- national coordination; and
- and international cooperation.

Under the auspices of CDS, the ADTR Program was established in 1987 by Health and Welfare Canada to stimulate innovative alcohol and drug treatment and rehabilitation programs and services, with a focus on women and youth. In the period 1988 - 1990, the first set of cost-shared agreements was negotiated with provinces and territories (P/Ts) and annual funding was allocated on an ongoing basis.

Following the second set of agreements negotiated by the ADTR Program and the P/Ts (1990 - 1993), the federal government undertook a major reconstruction of federal departments which resulted in the ADTR Program being transferred to the newly formed department, Human Resources and Development Canada (HRDC). The Program continued to be administered by HRDC and another set of funding agreements was negotiated with the P/Ts.

In 1996, HRDC underwent a program review and refocused its programs to concentrate on employment issues and consequently, the ADTR Program was transferred to Health Canada (HC). The official transfer occurred in October 1997 at which time the Program was positioned under the Office of Alcohol, Drugs and Dependency Issues, Health Promotion and Programs Branch. HRDC staff responsible for the ADTR Program were not transferred to HC.

Presently, the ADTR Program falls under the management of the Treatment and Rehabilitation Division, Office of Demand Reduction, Drug Strategy Controlled Substances Programme (DSCSP), Healthy Environments and Consumer Safety Branch (HECS).

PROGRAM OBJECTIVES

The overall objectives of the ADTR Program are:

- to ensure innovative, accessible and effective alcohol and drug treatment and rehabilitation services and programs;
- to assist in ensuring access for all Canadians to alcohol and drug treatment and rehabilitation services;
- to reduce the harm to individuals, families and communities arising from the abuse of alcohol and other drugs; and
- to assist provinces and territories through a cost-sharing plan to increase and expand alcohol and drug treatment and rehabilitation programming within the provinces and territories, and to do so in a fashion that builds on the current cooperation of the two orders of government in this field, and which supports provincial/territorial efforts to plan and deliver alcohol and drug services.

ADTR TARGET POPULATION

The primary target population for P/T services supported by the ADTR Program is any individual, who in the opinion of the P/T, requires alcohol and drug treatment and rehabilitation services, particularly women and youth.

ADTR PROGRAM FUNDING

The ADTR Program was one of several programs included in the 1999 Treasury Board (TB) submission for programs supported by the Promotion of Population Health A-based funding mechanism. As stated in the TB submission, transfer payments were to be made from the Population Health contributions and grants programs with generic Terms and Conditions as of April 1, 1999. The allocation of resources for the 1997 and 1999 TB submissions by activity and vote is presented in Table 1.

Table 1: ADTR Program Allocation of Resources				
	1997 Treasury Board Submission		**1999 Treasury Board Submission**	
Vote 1	Full-time Equivalents	6	Full-time Equivalents	6
	Salary $ (including Employee benefits package)	$0.35 m	Salary $ (including Employee benefits package)	$0.4
	Operations and Management	$0.65 m	Operations and Management	$0.6
Vote 10	Grants and Contributions	$14.0 m	Grants and Contributions	$14.0 m
	Maintenance of core capacity of CCSA	$0.5 m	Maintenance of core capacity of CCSA	$0.5 m
	Total	**$15.5 m**	**Total**	**$15.5 m**

Of the $15.5 million currently allocated to the ADTR Program annually, $14 million is used to support the federal/provincial/territorial cost-sharing agreements (contribution component); these funds are intended to support new and innovative alcohol and drug treatment and rehabilitation programs and services in the P/Ts. The federal contribution allocated to each P/T is calculated using a base amount ($250,000), plus a percentage of population formula. The total base amount for distribution for all P/Ts is $3 million and $11.5 million is available for the percentage of population amount. The percentage of population formula is based on Statistics Canada data related to the number of individual in each province/territory between the ages of 7 and 24, as indicated in the most recent *Age, Sex and Marital Status Census*.[13]

At the end of each fiscal year, any unspent ADTR funds are redistributed to the P/Ts whose actual shareable expenses are greater than their allocation and who wish to receive a portion of the funds available for redistribution. Once the total amount available for redistribution is known, the amounts are based on the eligible jurisdiction's initial allocation for the fiscal year as a percentage of the total initial allocations for all P/Ts with shareable over-expenditures, as a ratio of the total amount available in surplus funds.

The federal government reimburses fifty percent of the eligible costs of P/Ts in providing alcohol and drug treatment and rehabilitation services. The types of services funded include detoxification services, early identification and intervention, assessment and referral,

[13] The percentage of population formula is calculated by dividing the provincial/territorial population by the total Canadian population, multiplying this by 100, and then multiply this percentage by the base amount available for all provinces and territories.

counselling/case management, therapeutic intervention, special access services, continuing care/clinical follow-up, awareness and development, research and evaluation and knowledge dissemination.

In addition, a yearly contribution in the amount of $500,000 is made to the Canadian Centre on Substance Abuse (CCSA). These funds enable the CCSA to develop and disseminate knowledge on substance use issues, to create new knowledge on treatment and rehabilitation and to expends its dissemination networks.[14]

Also, $1.0 million is converted to operating funds to support treatment and rehabilitation research and information dissemination activities with P/Ts (research component) and to administer the Program. The research agenda establishes a framework for the development and dissemination of information on alcohol and drug treatment and rehabilitation issues. The objective of the agenda is to create new knowledge on treatment and rehabilitation use through literature reviews and knowledge dissemination and to widely disseminate the information to a range of stakeholders.

LOGIC MODEL

The ADTR Program logic model was developed by DPED in collaboration with DSCSP and P/T government representatives (Figure 1). This logic model is a diagram used to describe and communicate the important elements of the Program and is the primary focus of the current evaluation. To address substance use issues in treatment and rehabilitation and research, the ADTR Program consists of four inter-related activities:

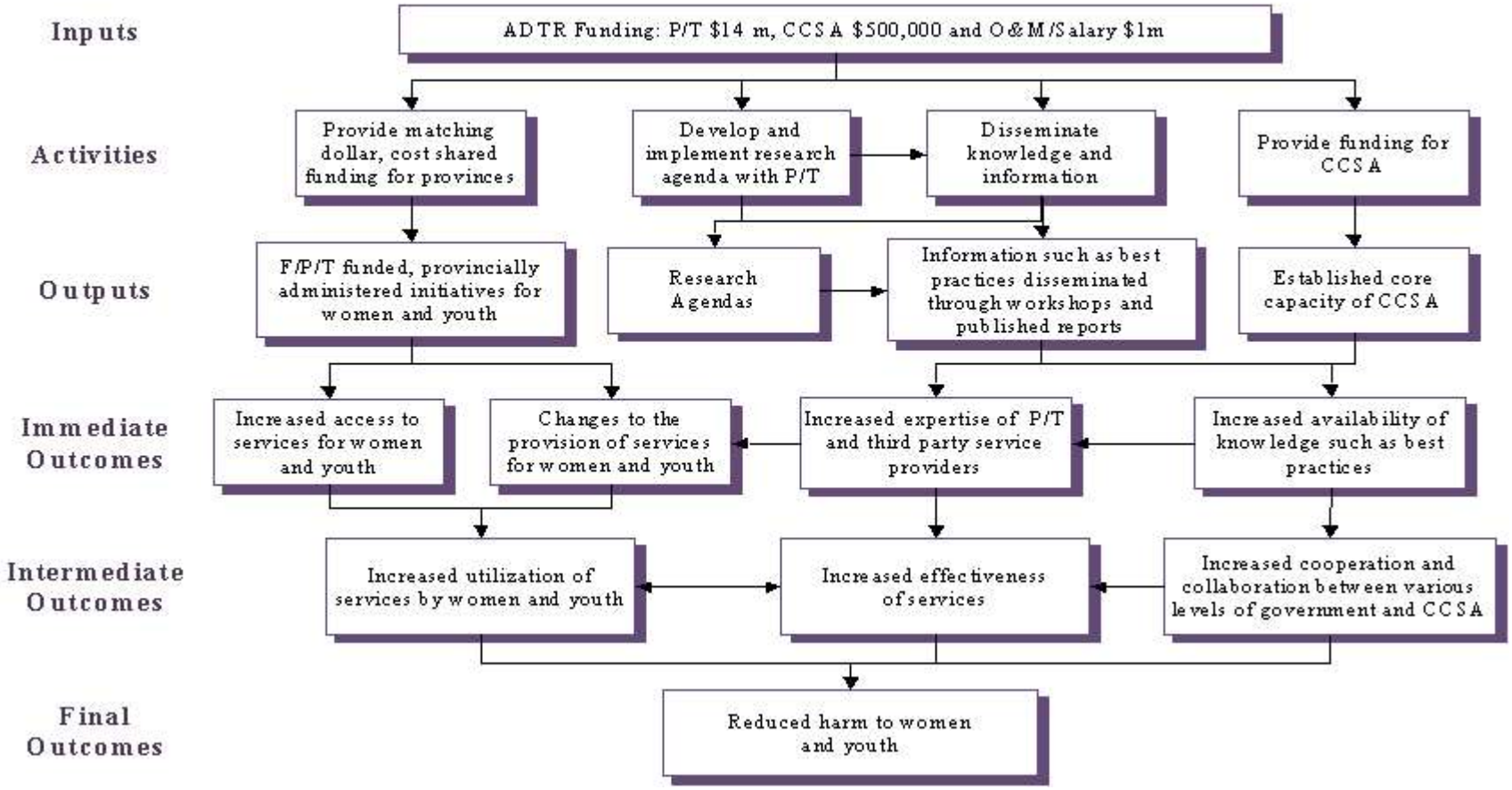
- provide cost-shared funding to P/Ts for substance use treatment and rehabilitation;
- develop and implement research agenda with P/Ts;
- disseminate knowledge and information; and
- provide funding to CCSA.

In addition to describing the main components of the Program, the logic model describes the linkages between the main activities, the outputs and the immediate, intermediate, and final outcomes.

[14] Effective 2003-2004, the CCSA received enhanced funding under Canada's Drug Strategy Renewed and contributions for 2004-2005 and ongoing will be made pursuant to new T&C more appropriate for supporting the CCSA operations.

Figure 1

ADTR Program Logic Model



PROGRAM EVALUATION

PURPOSE

In the 1997 Treasury Board submission, which outlined the permanent transfer of funds for the ADTR Program from HRDC to Health Canada (HC), and in the 1999 Treasury Board submission which outlined the implementation of population health programming under which the ADTR Program was subsumed, HC committed to conducting an evaluation of the ADTR Program. In April of 2004, HC will be seeking Treasury Board approval for renewed Terms and Conditions for the contribution component of the ADTR Program under the CDS Renewed Treasury Board submission.

The evaluation study serves three major purposes to facilitate HC in meeting its commitments made in these Treasury Board submissions:

- to assess the relevance, impact, and cost effectiveness of the ADTR Program since it was transferred to HC in 1997;
- to assess the extent to which the ADTR Program has made progress on the achievement of its identified objectives; and
- to facilitate the development of a performance measurement strategy that will measure the performance of the ADTR Program on a continuing basis; this strategy will be included as part of the Results-Based Management and Accountability Framework to be presented to Treasury Board Secretariat for purpose of renewing the ADTR Contribution Program's Terms and Conditions.

The evaluation report will facilitate the development of the Results-Based Management and Accountability Framework and will also contribute to improved decision-making and provide recommendations for program improvement.

APPROACH

The present study employed a participatory approach to evaluation, where the key focus of the evaluation was to ensure that the ADTR Program was involved at all stages of the process. The objective of using this approach was to foster collaboration between the evaluators (DPED) and the ADTR Program and to enhance the use of the evaluation results by the Program.

EVALUATION ISSUES AND QUESTIONS

The evaluation was national in scope and focussed on addressing three key issues: relevance, impacts, and cost effectiveness. More specifically, the evaluation attempted to answer a series of evaluation questions, presented in Table 2.

Table 2: ADTR Program Evaluation Issues and Questions

Relevance	
1. Is there a continued need for the ADTR Program?	1.1 Are women and youth still a relevant target population for the Program?
	1.1.1 How much demand by women is there for ADTR services? a. Should prevention activities be considered? b. What other program services are important to accessing the impact of the ADTR Program? For example, mental health services.
	1.1.2. How much demand by youth is there for ADTR services? a. Should prevention activities be considered? b. What other program services are important to accessing the impact of the ADTR Program? For example, mental health services.
Program Impacts	
2. To what extent as the ADTR Program made progress on the achievement of its identified objectives?	2.1 To what extent has the ADTR Program contributed to increased access? 2.1.1 To what extent has the ADTR Program increased access to the number of clients served. 2.1.2 To what extent has the ADTR Program increased the volume and variety of services per client. 2.2 How many new and innovative services has the ADTR Program facilitated? 2.2.1 How should concepts such as new and innovative be defined? 2.2.2 To what extent has the ADTR Program facilitated the development and dissemination of best practices and information? 2.2.3 To what extent has the ADTR Program facilitated the increased expertise of provinces and other service providers? 2.3 To what extent has the ADTR Program contributed to increased cooperation and collaboration between various levels of government? 2.3.1 To what extent has targeted ADTR funding to CCSA contributed to increased cooperation and collaboration between various levels of government, the business community, professionals and voluntary organizations in matters related to alcohol and drug abuse?
3. To what extent were best practices adopted by service providers?	3.1 What were the catalysts/barriers to best practice uptake?

Table 2: ADTR Program Evaluation Issues and Questions	
4. Were contribution arrangements the most efficient and effective means of achieving the ADTR Program objectives?	4.1 What was the optimal agreement duration to achieve outcomes? 4.1.1 What was the optimal agreement duration to maximize accountability by provinces and service providers?
Cost Effectiveness	
	5. What was the cost effectiveness of the program?

METHODOLOGY

TIMING

Planning for this evaluation began in June, 2003, when a Terms of Reference was developed for both the present study and the ADTR Evaluation Working Group (EWG).[15] Data collection was conducted from July, 2003 to December, 2004. The final report was drafted in January 2004, completed in May, and is expected to be submitted to the Departmental Audit and Evaluation Committee in June, 2004.

Table 3: Timing of ADTR Program Evaluation Activities

Activity	Time
Evaluation Terms of Reference approved	June 2003
Evaluation Working Group Terms of Reference approved	June 2003
Evaluation work begins	July 2003
Field work completed	December 2003
Draft evaluation report	January 2004
Final evaluation report	May 2004
Final evaluation report submitted to Departmental Audit and Evaluation Committee	June 2004

MULTIPLE LINES OF EVIDENCE

The methodology used in the study is described briefly in the proceeding paragraphs. A more detailed description of the methodology employed in each line of evidence is included in each of the technical reports.[16]

[15] Please refer to Appendix A and B for the Evaluation Terms of Reference and the EWG Terms of Reference, respectively.

[16] Please refer to Appendix C for the list of technical reports related to this evaluation study.

The following lines of evidence were conducted for this study:

- literature review;
- document review;
- stakeholder interviews (n=21); and
- case studies (n=2).

Overall responsibility for the evaluation was with DPED, with the exception of the analysis of the case study data, which was contracted to an independent consultant. The methodological approach relied on multiple lines of evidence, both qualitative and quantitative in nature, to discern the most comprehensive, valid, and reliable results. All component reports of the evaluation were reviewed at several key points by the ADTR Program and the ADTR EWG and relevant feedback was incorporated into the documents as necessary. Once all components reports were complete, the findings were analysed and synthesized and form the basis of this ADTR Program evaluation report.

Document Review

The purpose of this component of the evaluation was to review all program-related documents to provide contextual information about the ADTR Program and its activities, from the time it was transferred from HRDC to HC in 1997 to present. In particular, the document review captured the extent to which planned ADTR Program activities were carried out and addressed the evaluation questions with respect to the impacts and cost effectiveness of the Program.

The document review proceeded in a sequence of three steps. The first step involved determining which documents were to be included as part of the review. Then, the documents were reviewed and ADTR Program activities were assessed to the extent to which they addressed the broad objectives of the Promotion of Population Heath program funded under the A-Based framework as they are described in the Treasury Board submission and the Report on Plans and Priorities. Finally, the documents were analysed and the evaluation questions were addressed to the extent possible.

Some of the key program documents reviewed include:

- Treasury Board submissions;
- ADTR Program Operations and Procedures Manual;
- contribution agreements;
- annual reports;
- meeting minutes and agendas;
- accountability and evaluation frameworks;

- provincial annual and financial reports; and
- draft Results-Based Management and Accountability Framework (RMAF).

Literature Review

A literature review was conducted to describe the context in which the ADTR Program operates and present the most recent literature on the evaluation issues pertaining to alcohol and drug treatment and rehabilitation programming. More specifically, this component of the evaluation established the relevance of and need for the ADTR Program; described the range of alcohol and drug treatment and rehabilitation programs and services across the country, including a description of relevant target groups; provided a best practises example in performance measurement; and provided information on common approaches, methodological challenges, and recommendations for evaluating substance use treatment and rehabilitation programming.

Relevant Canadian and international literature was located through the following means:

- Health Canada Departmental Library catalogue and Carleton University Library catalogue, using various subject and keyword search terms.[17]
- A comprehensive search of several electronic databases using various subject and keyword search terms, including MEDLINE, SilverPlatter databases, Canadian Research Index, Business Source Premier, and ISI Web of Science.
- Internet search, including Health Canada, Canadian Centre of Substance Abuse, and Australian Department of Health and Ageing websites.
- A search of several databases on the Internet, including Database of the Canadian Centre of Substance Abuse, National Clearinghouse on Substance Abuse, and Canadian Substance Abuse Information Network.
- Journals accessible electronically at Health Canada's Departmental Library and through inter-library loans, including Journal of Substance Abuse Treatment, Evaluation Review, Addictive Behaviours, Journal of Drug Issues, and Millbank Quarterly.

To ensure the compatibility of the literature being reviewed with the ADTR Program, the screening criteria for selecting documents included:

- credibility of source (e.g. peer reviewed journal articles and edited compilations);
- relevant to the ADTR Program and program objective(s);
- at least three of the following four document characteristics to apply: provides background information on the context in which the ADTR Program operates; provides descriptive information on alcohol and/or drug programming in Canada; provides

[17] Library searches were both manual and computerised and the expertise of the librarians was frequently called upon. Health Canada librarians also assisted in searching the various databases.

information for evaluation purposes such as performance measurement and evaluation studies of alcohol and/or drug programming; and provides information on outcomes and indicators for alcohol and/or drug programming.

Interviews with Key Stakeholders

A series of interviews were conducted to gather the opinions of ADTR Program stakeholders on various evaluation issues. More specifically, respondents determined the Program relevance in terms of its objectives and target populations; assessed the extent to which the ADTR Program has made progress toward its objectives; and assessed the overall strengths and weaknesses of the Program. In total, 21 interviews were completed with Program stakeholders between July 28 and August 18, 2003. Stakeholders represented the following categories of respondents:

- Health Canada representatives from both the National Capital Region and Regional Offices;
- provincial representatives;
- CCSA representatives;
- ADTR-funded project proponents; and
- representatives from non-funded jurisdictions.

The ADTR Program provided a comprehensive list of Program stakeholders from which evaluators selected which individuals were to be interviewed, based on a pre-determined set of criteria; respondents were selected to reflect a broad range of perspectives and experiences based on their specific involvement with the ADTR Program, to ensure representation from all levels of government, and to ensure representation from across the country, including funded and non-funded jurisdictions. When initial contact was made, potential interviewees were assured that all information emanating from the interviews would remain confidential and findings would only be used in an aggregated manner.

Interview guides were designed to address all of the evaluation issues and all questions were open-ended. These guides were reviewed by the ADTR Program and the EWG prior to being sent to respondents in preparation for the interview. Interviews ranged from 45 minutes - 2 hours in length and detailed notes were taken by the interviewer. Once complete, the interview notes were sent to the respondent to be validated.

Case Studies

Case studies were conducted to provide a more in-depth examination of ADTR funded initiatives. Two treatment centres were selected on the basis of willingness to participate and data availability. In both cases, evaluators relied on both qualitative and quantitative information and the corresponding analysis was based on primary client data and interviews with key stakeholders.

Appropriate measures were taken to ensure the confidentiality of project level and client level information. Prior to conduct of the case studies, a protocol was established with each of the provinces and sites pertaining to confidentiality issues and the requirements for data management and reporting. Health Canada analysts entered into signed confidentiality agreements, as per provincial privacy regulations and where there was inconsistency between federal and provincial privacy regulations regarding the minimal sample size that must be present in order for results to be presented, the more conservative number was chosen. Also, all information with the potential to directly or indirectly identify individual clients was removed from the data before it was received by Health Canada.

Once the data was analysed, a technical report was developed for each of sites and was submitted only to the province and the site which supplied the data; site reports were not shared with other P/Ts or the ADTR Program. Once these reports were reviewed by their respective jurisdictions, the data was sent back to sites and the two individual reports were used to synthesize the information and develop a technical report on the case studies.

SYNTHESIS OF MULTIPLE LINES OF EVIDENCE

The fact that findings from multiple lines of evidence were synthesized to form the basis of this study reduces the potential for bias and enhances the opportunity for a balanced picture of the Program; addressing evaluation issues from different perspectives lends greater credibility to the findings. Evaluators took steps to ensure a lack of bias by balancing stakeholder information with program documentation wherever possible.

LIMITATIONS

Even though evaluators made every attempt to conduct a thorough and rigorous study, several limitations and their potential impacts on the findings should be acknowledged.

Lack of performance management and outcome monitoring

After reviewing the findings from all lines of inquiry, there is little evidence available relating to the immediate, intermediate, and final outcomes of the ADTR Program. This is not to say that the ADTR Program did not have an impact on the outcomes, but due to lack of evidence

available, an assessment of this type was not possible. As such, the findings presented in this report are based primarily on the activities and outputs of the ADTR Program and on the opinions of ADTR Program stakeholders. Based on these findings, a series of recommendations are presented to enhance the performance management and outcome monitoring of the ADTR Program.

Inability to develop valid cause and effect inferences

Due to lack of performance measurement and outcome monitoring, the research design employed in the present study was based on a post-intervention, non-experimental design. This evaluation strategy is limited in the extent to which it can test the hypotheses and examine the research questions and consequently, this study was unable to assess program impacts in terms of assessing causal relationships.

Extent to which the evaluation questions could be addressed

The evaluation study relied on multiple lines of evidence to produce a balanced and comprehensive assessment of the ADTR Program's progress towards its objectives. The ADTR Program provided well-organized documents that were critical to the present study and were willing to accommodate all of the data collection requirements. However, due to significant gaps in performance measurement and outcome monitoring, the extent which some of the evaluation questions could be addressed is limited.

Inability to conduct a cost effectiveness analysis

Due to incomplete information provided in annual reports and wide variations in reporting, evaluators were unable to determine the cost effectiveness of the ADTR Program. Although it was possible to generate some information from the cost effectiveness analysis, the information was inconsistent and was not substantiated by other lines of evidence and consequently are excluded from the findings in this report.

Attribution

Because the P/Ts have jurisdictional responsibility for the delivery of alcohol and drug treatment and rehabilitation programming, the ADTR Program allocates contribution funding to the P/Ts for their respective treatment and rehabilitation budgets. P/Ts then use these monies, along with the various other funding resources, for their respective substance use programming. Accordingly, it is difficult to attribute results to the ADTR Program, or to one particular funding stream, per se.

Considering these limitations and building on the evidence that is currently available, the present evaluation study makes a series of recommendations for the ADTR Program. The findings presented in this report is a starting point from which the ADTR Program can improve its performance measurement and program evaluation context, which can in turn lead to more outcome evidence being collected, a stronger evidence-base for making assessments of impacts, and ultimately increase its accountability to the Canadian public.

EVALUATION FINDINGS

In this section, the evaluation findings related to the ADTR Program's progress toward achievement of the objectives are reported. As indicated in the methodology, the findings are based on multiple lines of evidence which have been synthesized to form the basis of this report.

ISSUE 1: CONTINUING RELEVANCE

Is there a continued need for the ADTR Program? Are women and youth still a relevant target population for the Program?

Program Objectives

The objectives of the ADTR Program are:

- to ensure innovative, accessible and effective alcohol and drug treatment and rehabilitation services and programs;
- to assist in ensuring access for all Canadians to alcohol and drug treatment and rehabilitation services;
- to reduce the harm to individuals, families and communities arising from the abuse of alcohol and other drugs; and
- to assist provinces and territories through a cost-sharing plan to increase and expand alcohol and drug treatment and rehabilitation programming within the provinces and territories, and to do so in a fashion that builds on the current cooperation of the two orders of government in this field, and which supports provincial/territorial efforts to plan and deliver alcohol and drug services.

Overall, federal and provincial representatives and funding recipients alike believe that the Program objectives are fairly accurate and continue to be relevant, with one exception. Stakeholders indicated that in the first year of the contribution agreements, the ADTR Program (contribution component) did provide funding that facilitated new and innovative treatment rehabilitation programming. However, since then, this objective no longer holds true. This is confirmed by evidence from the document review, which indicated that when the Program was created, it provided an initial incentive for the creation of new or expansion of

older programs through its contribution funding. However, no stipulation was made that those new initiatives or enhanced portions of initiative were to provide evidence as to how they are innovative. Over time, this incentive has diminished and the Program is limited with respect to how much it is able to increase innovation through its cost-shared funding.

Role of the Federal Government

Program stakeholders perceive the need for an ongoing federal role in substance use treatment and rehabilitation programming. Health Canada representatives believe the federal government should continue to play a leadership role in the area of substance use and provide funding to assist the P/Ts with the delivery of their programming. This funding is perceived by federal representatives to be encouraging a provincial investment in substance use programming. A few Health Canada representatives also indicated that the federal government should play an enhanced role in terms of facilitating data collection and management, which would in turn improve the ADTR Program's ability to engage in evidence-based decision making.

Provincial representatives and funded recipients alike support the ongoing role of the federal government in providing funding to support alcohol and drug treatment and rehabilitation. However, the majority of provincial representatives indicated that the federal funding is limited in terms of its impact, which is in turn exacerbated by the fact that funding has not increased over time. Provincial representatives also noted that the federal government should play an enhanced role in terms of national leadership and facilitating data collection, data management, and program evaluation.

Coordination with Other Federal and Provincial Programs

Program stakeholders indicated that the ADTR Program complements the work of other federal programs and programming in the P/Ts. Provincial representatives indicated that the ADTR Program is well-aligned with their provincial substance use programming in terms of having consistent mandates and objectives. Furthermore, provincial representatives do not perceive the ADTR Program as an intrusion into their jurisdiction. In addition, some federal and provincial representatives indicated that the ADTR Program complements the work of other federal programs including the Employee Assistance Program, the Crime Prevention Strategy, and the Homelessness Strategy.

Target Populations

In terms of the target populations, substance use literature has consistently identified women and youth as target populations whose alcohol and drug use, treatment needs, and treatment outcomes differ from the general population. Despite some criticism and limitations being acknowledged, the majority of literature suggests the need to distinguish certain segments of

the population in substance use programming and substantial evidence has been provided to support the use of target populations in such programming. Studies conducted in Canada and internationally have yielded results which provide evidence to confirm this fact and accordingly, both the United States and Australia have designed their national drug strategies (i.e. substance use treatment and rehabilitation programming) to provide specialized treatment to women and youth. That being said, research has also identified additional target populations that have unique barriers to treatment, treatment needs, and treatment outcomes. Target populations identified consistently throughout the literature include individuals with cognitive impairments, individuals with comorbid mental health disorders, Aboriginals, seniors, individuals with HIV/AIDS, homeless persons, and street youth.

Based on experiences in their respective jurisdictions or programs, all program stakeholders indicated that youth were still a relevant target population for the ADTR Program, and the majority of the same indicated that women were still relevant.

Evidence from the case studies suggests that women and youth are still relevant target populations in alcohol and drug treatment and rehabilitation programming.[18] Information from the client analysis of one site indicates that women and youth continue to report substance usage that creates problems; on average, youth and women reported 2.4 and 3.7 substance addictions at registration, respectively. Also, the number of addictions have remained constant over the five-year period examined. However, client follow-up and outcome monitoring were not conducted so it is not possible to draw any conclusions on program impacts.

Stakeholders were divided in terms of expanding the reach of the ADTR Program to include additional target populations. While some interviewees indicated that the focussed approach to targeting is appropriate and effective, approximately half of the stakeholders, particularly provincial representatives, indicated that additional flexibility is needed to provide support to under-serviced and marginalised populations in their respective jurisdictions. Additional target groups raised in the interviews include seniors, Aboriginals, and homeless youth. Finally, program stakeholders identified the need for current research to be conducted to verify which segments of the population are in highest need of substance use treatment and rehabilitation across the country.

[18] Findings from the case studies can not be generalized to all ADTR-funded initiatives and the ADTR Program. Accordingly, findings should be considered as facilitating an understanding of how and to what extent the objectives of the ADTR Program may be achieved.

Territorial Non-Participation in the ADTR Contribution Program

While the Northwest Territories did receive ADTR Program funding in 1997-1998 and 1998-1999, since that time, the territories do not partake in contribution portion of the ADTR Program. While evidence from the interviews provided a few possible reasons for territorial non-participation, these explanations were not substantiated by any other line of evidence and accordingly, the evaluation did not yield any conclusive findings as to why the territories do not partake in that part of the ADTR Program.

Available information provides evidence that the territories do participate in the research component of the ADTR Program; there is territorial representation on the F/P/T Committee on Alcohol and Other Drug Issues and the Working Group on the Accountability and Evaluation Framework and Research Agenda for the ADTR Program. Also, there was territorial participation in the stakeholder interviews conducted for this study

Canadian Centre on Substance Abuse

The CCSA is an arms-length organization to the federal government that provides leadership and support on substance use issues in Canada. As per the 1988 Act of Parliament in which the CCSA was created, its purpose is to "promote increased awareness on the part of Canadians of matters relating to alcohol and drug abuse and their increased participation in the reduction of harm associated with such abuse, and to promote the use and effectiveness of programs of excellence that are relevant to alcohol and drug abuse by:

- promoting and supporting consultation and co-operation among governments, the business community and labour, professional and voluntary organizations in matters relating to alcohol and drug abuse;
- contributing to the effective exchange of information on alcohol and drug abuse;
- facilitating and contributing to the development and application of knowledge and expertise in the alcohol and drug abuse field;
- promoting and assisting in the development of realistic and effective policies and programs aimed at reducing the harm associated with alcohol and drug abuse; and
- promoting increased awareness among Canadians of the nature and extent of international alcohol and drug abuse efforts and supporting Canada's participation in those efforts."[19]

Program stakeholders indicated that the role of the CCSA is to develop and disseminate information on substance use issues. While stakeholders indicated they understood the overall mandate of the CCSA, some stakeholders indicated that they were unclear as to the role of the CCSA in the ADTR Program. In fact, the CCSA representative was the only stakeholder who was able to articulate this role, by indicating that the ADTR Program facilitates HC to fulfill

[19] Canadian Centre on Substance Abuse. 1988. CCSA Act, 1998. Online at: www.ccsa.ca.

its commitment to the CCSA Act. While the majority of stakeholders were satisfied with CCSA's efforts to develop and disseminate information, a few stakeholders indicated that it would be useful if the CCSA reached a broader audience; one respondent indicated that this could be achieved through a more effective dissemination/promotion strategy.

Overall, stakeholders perceive the CCSA to be valuable resource and source of expertise on issues related to substance use for provinces, programs, and service providers. Program stakeholders indicated they use information from CCSA for various purposes, including program development and to assist with assessing their respective initiatives.

ISSUE 2: PROGRAM IMPACTS

The evaluation questions in this category were aimed at determining the effectiveness of the ADTR Program in terms of making progress toward the achievement of its identified objectives.

To what extent has the ADTR Program contributed to increased access?

To achieve the ADTR Program's main objective, to ensure accessible and effective alcohol and drug treatment and rehabilitation programs and services, the Program must rely on P/Ts to deliver funded services. The available evidence suggests that the P/T delivered, ADTR-funded initiatives contribute to facilitating accessible and effective services by virtue of its cost-shared funding ($14.0 million). While program stakeholders consider the above-mentioned objective to be important and relevant, they were not able to provide any outcome evidence to determine the extent of this progress. Based on the interviews, approximately half of the federal and provincial representatives stated that in the first year of the contribution agreements, the ADTR Program (contribution component) led to an initial increase in access to alcohol and drug programs and services. However, since the first year, there has not been any additional increased in funding; therefore, there has not been any additional increases in access.

Information from stakeholder interviews indicates that relapse can be considered an indicator of the degree to which clients have reduced their harm. The case studies analysis used re-registration as a proxy for relapse or change in the addiction status of a client. This measure can be useful when considered in combination with other indicators such as program completion, client satisfaction, access rates, and global functioning. Evidence from one case study site found that Aboriginal status was the only client characteristic to have a statistically

significant association with relapse.[20] Findings from both sites illustrated a downward trend in re-registration rate over the five-year period examined. However, this can not be considered as an indication of improvement in program effectiveness because a comparison group was not examined. Consequently, the lack of information on client outcomes and a comparison group precludes an evaluation of program effectiveness in reducing harm in the client populations.

At this time, while there is evidence of Program outputs in terms of the cost-shared funding, there is no outcome evidence available to assess the extent to which the ADTR Program increased access to services for women and youth, increased utilization of services by women or youth, or reduced harm.

How many new and innovative services has the ADTR Program facilitated?

As per the document review, "new and innovative" programs are defined as programs commencing operations on or after April 1, 1987; the enhanced or expanded portion, commencing on or after April 1, 1987 of a previously operational program; and/or previously existing but non-provincially funded program, where provincial funding commences on April 1, 1987 or after. Due to the fact that performance measures were not identified at the outset of the program and performance information was not collected, there is little documented evidence to assess the extent to which the Program has made progress on the objective that seeks "to ensure innovative, accessible and effective alcohol and drug treatment and rehabilitation services and programs."

Program stakeholders were unable to determine how many new and innovative services that were facilitated as a result of the ADTR Program. However, stakeholders did indicate that in the first year of the contribution agreements, there was an initial increase in new and innovative services as a result of the contribution funding provided by the ADTR Program. This is consistent with the findings of the document review, which revealed that when the ADTR Program was implemented in 1987 and in the first year of the contribution agreements, it provided incentive for the creation of new initiatives or the expansion of existing program. Since then, the ADTR Program has provided ongoing funding to P/Ts using a base amount and a percentage of population formula. Consequently, while the ADTR Program might be encouraging P/Ts to develop new and innovative programming through its contribution funding, the extent to which the ADTR Program can directly contribute to the achievement of

[20] Findings from the case studies can not be generalized to all ADTR-funded initiatives and the ADTR Program. Accordingly, findings should be considered as facilitating an understanding of how and to what extent the objectives of the ADTR Program may be achieved.

the objective is limited. It should also be mentioned that a few stakeholders expressed concern on the use of the term "innovative" as there is some ambiguity about its meaning on how it relates to ADTR Program funding.

To what extent has the ADTR Program contributed to increased cooperation and collaboration between various levels of government?

There are several mechanisms through which the ADTR Program contributes to increased cooperation and collaboration between the various levels of government:

- **the F/P/T Working Group on Accountability and Evaluation Framework and Research Agenda**: The F/P/T Working Group consists of both federal and provincial representatives and works to provide recommendations on mechanisms to measure the impacts and outcomes of programs funded by the ADTR Program. Also, this group provides advice and guidance to inform the development of the best practices research agenda, documents and workshops;
- **the F/P/T ADTR Evaluation Working Group** (EWG): The EWG consists of federal and provincial representatives and works to provide advice and guidance to inform the evaluation study;
- **the F/P/T Committee on Alcohol and Other Drugs**;[21] and
- **funding support to the Canadian Centre on Substance Abuse**: One of the objectives related to the contribution in support of CCSA is to promote and support consultation and cooperation among governments, the business community and labour, professional and voluntary organizations in matters relating to alcohol and drug abuse.

The evidence required to determine the extent of increased cooperation and collaboration as a result of the ADTR is limited. It is a challenge to assess the extent of increased cooperation and collaboration because cooperation and coordination measures were not outlined at the outset of the Program. As a result, there is little outcome evidence available to make such an assessment. Available evidence suggests that the ADTR Program has been successful in increasing the cooperation and collaboration between various levels of government through supporting the above-mentioned working groups, funding to the CCSA, and the best practices projects. These activities have provided the opportunity for a range of partners to meet for the purpose of sharing and exchanging information and learning from experiences.

[21] Following the renewal of Canada's Drug Strategy, this Committee has been replaced with a rejuvenated F/P/T Committee on Canada's Drug Strategy.

In terms of the stakeholder interviews, some divergence was noted when asked about cooperation and collaboration. Approximately half of all interviewees, at both the provincial and federal levels, highlighted a positive working relationship between the ADTR Program and provincial government representatives, especially relating to the F/P/T Committee, the ADTR EWG, and the best practises workshops. Program stakeholders viewed the collaboration and cooperation as a contributing factor to the ADTR Program's success; the ADTR Program has promoted dialogue between the levels of government and encouraged provincial investment in substance use treatment and rehabilitation. In addition, all provincial representatives and half of the federal representatives referenced the research agenda and the best practices documents and workshops as specific examples that illustrate that the ADTR Program has facilitated cooperation between the levels of government. The high level of satisfaction noted by Program stakeholders can be interpreted as a proxy measure for cooperation and collaboration.

However, despite these responses, a small group of stakeholders stated that there has been a lack of collaboration not only between the federal and provincial levels, but also between Health Canada staff at the national level and regional offices.[22]

ISSUE 3: BEST PRACTICES

To what extent were best practices adopted by service providers?

Information from the document review indicates that the research component of the ADTR Program has been successful in carrying out its responsibilities to provide funding to develop and facilitate the dissemination of research information to P/Ts and key stakeholders. The ADTR Program has contributed to the development of new knowledge on substance use issues and filled the gaps in current knowledge levels. In 2001 and 2002, best practises documents were published on different target groups and issues, including women, youth, persons with concurrent mental health disorders, seniors, cocaine use, fetal alcohol syndrome/fetal alcohol effect, and methadone maintenance treatment.

[22] It should be noted that the ADTR Program is a centrally managed program. While HECS Regional Offices were established in 2001 as a result of departmental realignment, only three of the six Regional Offices have DSCSP regional coordinators in place.

The key mechanisms in place to disseminate these best practises documents included a communications strategy, targeted mail-outs, web-sites, conferences, and workshops. Best practises documents were distributed to a range of stakeholders, including:

- federal and provincial governments, including Health Canada, all federal departments/agencies participating in Canada's Drug Strategy, F/P/T committees that address substance use issues, national level committee that address substance use issues, P/T health ministries, P/T law enforcement, justice, and correctional ministries, and P/T community service departments.
- national clearinghouses,
- national substance use organizations, most notable the CCSA,
- professional bodies and associations, substance use treatment agencies, clinics, or organizations,
- non-profit organizations,
- health care providers, and
- clients.

While there appears to be considerable diversity in the range of stakeholders who received the best practises information, there is little information available which facilitates an assessment of the effectiveness of the dissemination strategy. In addition to the documents, four best practises workshops were conducted between November 2001 to March 2003 that each focussed on specific target group: women, youth, persons with concurrent mental health and substance use disorders, and seniors.

Evidence from the interviews suggests that Program stakeholders perceive that the ADTR Program has contributed to the development of new knowledge on substance use issues and have indicated a high level of satisfaction with the best practises documents and workshops. Federal and provincial officials, as well Program stakeholders, view collecting and disseminating information on substance use as an effective and relevant role for the federal government. While this level of satisfaction can be interpreted as a proxy measure of the usefulness and quality of the information developed and disseminated, there is little outcome evidence available to assess the extent to which the ADTR Program made progress toward this objective. Furthermore, while there is evidence of Program outputs in terms of the research agenda and the best practises documents and workshops, there is no outcome evidence available to assess the extent to which the ADTR Program increased the expertise of P/T and third-party service providers, increased effectiveness of services, or reduced harm.

ISSUE 4: CONTRIBUTION AGREEMENTS

Were contribution agreements the most efficient and effective means of achieving the ADTR Program objectives?

Preliminary analysis indicates that there is some inefficiency in terms of the renewal/approval process of the contribution agreements; however, given the current level of information available, it is not possible to draw any definitive conclusions on the efficiency of the contribution agreements.

Evidence from the interviews suggests that the program stakeholders are of the opinion that the contribution agreements and reporting requirements are rigid. Another finding from the interviews is that stakeholders do not have a solid understanding of the contribution agreements in terms of appropriateness of design and selection criteria.

ISSUE 5: COST EFFECTIVENESS

What was the cost effectiveness of the ADTR Program?

Objective outcome research on the cost effectiveness of the ADTR Program was not available at the time of the study, due to the inconsistency and incompleteness of information provided in the ADTR Program Annual Reports. In addition, the interviews did not facilitate a cost effectiveness analysis and provincial representatives were unable to determine the cost effectiveness of the ADTR Program contribution funding in relation to their respective provincial addictions treatment and rehabilitation budgets.

The documentation required to support a cost effectiveness analysis is stipulated as a requirement in the contribution agreements and the P/T Annual Reports. As per the contribution agreements, P/Ts are required to submit annual reports to the ADTR Program. However, annual reports have been inconsistently submitted to the extent that most provinces have failed to submit a report in at least one year since 1997 and in the most extreme case, one province has never submitted a report. Of the reports that have been submitted, while in some cases large amounts of information have been provided, there is little if any information on

impacts and the extent to which progress has been made on Program objectives. Accordingly, it is not possible to assess the cost effectiveness of the ADTR Program.

In addition, evidence provided by the stakeholder interviews did not support a cost effectiveness analysis. While provincial representatives were asked to determine the cost effectiveness of ADTR funding in relation to their total provincial alcohol and drug treatment and rehabilitation budgets, they were unable to do so. Program stakeholders did express some concern about assessing the cost effectiveness of substance abuse programming. Overall, this stemmed from the perceived inability to place a monetary value on societal benefits derived from substance use programming, such as reduced harm. When asked to provide recommendations on how future cost effectiveness studies of the ADTR Program should be conducted, stakeholders indicated they should be conducted over the long-term because significant behaviour changes can only be seen over time. Also, stakeholders indicated that a set of national indicators related to alcohol and drug treatment and rehabilitation is needed to determine the cost effectiveness of the ADTR Program.

ISSUE 6: PROGRAM STRENGTHS AND WEAKNESSES

Based on the multiple lines of evidence, the following themes emerged in terms of the strengths and weakness of the ADTR Program.

Key Strengths

- The ADTR Program provides targeted cost-shared funding to support and facilitate the delivery of substance use treatment and rehabilitation services in the P/Ts, which is perceived to be a relevant role for the federal government.
- The focus on substance use treatment and rehabilitation and reduced harm is an upstream effort which is well-aligned with the programs in the P/Ts and is consistent with the international substance use literature.
- Development of the research agenda and the best practises documents and workshops as well as the funding to the CCSA are considered particularly effective program activities.
- The ADTR Program encourages an ongoing cooperation and collaboration between the levels of government on substance abuse issues.

Key Weaknesses

- While the ADTR funding is considered a strength, it is also perceived by stakeholders to be a weakness as the level of funding is considered limited in terms of its impact and has not increased over time. For example, one interviewee stated that ADTR funding has not increased on an annual basis, as per increases in inflation.
- Based on the inability of the present study to make an assessment of progress on objectives, it is evident that there is a lack of performance measurement, outcome monitoring, and evaluation activity relating to the ADTR Program. This is consistent with what Program stakeholders stated in the interviews; some federal representatives indicated that a weakness of the Program is that the criteria for program funding is not linked to program evaluation; also, several provincial representatives indicated that the lack of targeted funding to enhance data collection is a weakness of the Program.

CONCLUSION AND RECOMMENDATIONS

This report is based on the findings in the various component reports and recommendations are made on the analysis and integration of all lines of evidence.

PERFORMANCE MANAGEMENT AND PROGRAM EVALUATION

This evaluation study evidenced some weaknesses with respect to the performance management and program evaluation context in which the ADTR Program operates. Measurement of ADTR Program success was not possible for most of the program objectives due to the fact that performance measurement and evaluation strategies were not implemented for the ADTR Program. In addition, because this is the first time that the ADTR Program has been formally evaluated since it was transferred back to HC in 1997, it is the first time that issues pertaining to design and implementation, which would typically be examined and addressed in a formative evaluation, were examined.

Recommendation

Based on the evaluation findings, it is recommended that:

1. As the Program moves forward with its renewed Terms and Conditions, it is recommended that the ADTR Program design and implement a performance measurement strategy and an evaluation strategy, to monitor and measure the impacts of the Program. To support this, it is recommended that the ADTR Program allocate additional resources into its performance measurement and program evaluation activities. This recommendation entails that:
    - ADTR Program objectives, outcomes, indicators, and baseline information be identified that can be measured, attributed to the Program, and reasonably expected to occur in the five-year time period.
    - An evaluation strategy be developed that would outline the evaluation issues and questions for formative and summative evaluation studies.
    - Progress towards ADTR objectives be reported annually in a streamlined and standardized manner.
    - Evaluation requirements be formally integrated into the ADTR program design. This includes revising the annual reporting template for P/Ts and to assist the P/Ts with their annual reports. Also, all ADTR-funded initiatives, as a condition of funding, should be required to explicitly allocate a portion of their resources to project evaluation, using a standardized reporting format to be developed by the ADTR Program.

2. The ADTR Program should play an enhanced role in fostering a coordinated and centralized approach to collecting and managing data and outcome monitoring. This recommendation would entail providing a leadership role in data collection and management in the following areas:
    - The ADTR Program should work to develop common definitions and standards with respect to alcohol and drug treatment and rehabilitation. These definitions should be mutually agreed upon and used by all P/Ts in their annual reporting. Possible concepts to be defined include "access" to and "effective" alcohol and drug treatment and rehabilitation.
    - The ADTR Program should work to develop an analytical framework which would assist both the Program and the P/Ts with their data collection and management and outcome monitoring. Development of this framework could be initiated by building on the work already completed by the case study component of the present study.
    - The ADTR Program should work to develop a central data set that P/Ts would use to input their data. This data set would facilitate individual programs monitoring their effectiveness and would also facilitate monitoring the impacts of the ADTR Program. This data set should not be used for interprovincial comparisons.

RELEVANCE

Based on stakeholder's opinions and the most recent statistics available on alcohol and drug use in Canada, there is still a need for the federal government to support alcohol and substance treatment and rehabilitation programming in the PTs. Given the level of ADTR Program funding available to support treatment and rehabilitation services, in relation to the costs of substance use in Canada and the multiple funding streams that support such programming, it is reasonable to expect that the ADTR Program plays a minor role in directly affecting the desired outcomes.

At present, there is no objective outcome research available to assess the extent to which women and youth are still relevant target populations for services funded under the ADTR Program. However, findings from the present study suggest that targeting high-need populations, particularly women and youth, is an appropriate and effective mechanism for substance use treatment and rehabilitation. Also, ADTR program stakeholders support the continued targeting of women and youth for such programming. However, many provincial representatives indicated that the ADTR Program should allow for sub-targeting based on provincial/territorial/regional circumstances.

Recommendation(s)

Based on the evaluation findings, it is recommended that:

3. The ADTR Program continue to provide targeted funding to P/Ts to support initiatives that strengthen alcohol and drug treatment and rehabilitation for high-need populations.
    - A literature review should be conducted to verify if women and youth are still relevant target populations for the ADTR Program and if additional target populations have emerged across the country.
    - A series of indicators related to the relevance of the ADTR Program and baseline data be included in the ADTR Performance Measurement strategy.

ACCESS

To achieve the Program's main objective, to ensure accessible and effective alcohol and drug treatment and rehabilitation services and programs, the ADTR Program must rely on P/Ts to deliver funded services. While program stakeholders consider the above-mentioned objective to be important and relevant, there is no outcome evidence available to assess the extent to which the ADTR Program has made progress on this objective.

Available evidence suggests that ADTR-funded initiatives (delivered by the P/Ts) contribute to facilitating accessible and effective services. Federal and provincial representatives alike have indicated that the ADTR Program facilitates access to substance use treatment and rehabilitation, by virtue of its funding. However, stakeholders indicated that while there was an initial increase in access in the first year of the Program, due to the fact that there have not been additional increases in ADTR Program funding, there have not been additional increases in ensuring access.

Recommendation(s)

Based on the evaluation findings, it is recommended that:

- As per Recommendation # 1, a series of indicators related to accessible and effective alcohol and drug treatment and rehabilitation and baseline data be included in the ADTR Performance Measurement strategy. Possible indicators could include: relapse, number of clients registered, size of the population served, number of and wait lengths for clients on waiting lists.

New and Innovative Services

There is little documented evidence to assess the extent to which the ADTR Program has made progress on the objective that seeks "to ensure innovative, accessible and effective alcohol and drug treatment and rehabilitation services and programs."

Program stakeholders and the document review revealed that when the ADTR Program was implemented in 1987 and in the first year of the contribution agreements, the contribution funding provided incentive for the creation of new initiatives or the expansion of existing programs. Since then, the effect of this funding incentive has diminished and accordingly, the extent to which the ADTR contribution funding as currently allocated can contribute to achievement of this objective is limited. However, the ADTR Program does encourage new and innovative programming through the development and dissemination of its best practices documents.

Recommendation(s)

Based on the evaluation findings, it is recommended that:

4. The ADTR Program objective that seeks "to ensure innovative, accessible and effective alcohol and drug treatment and rehabilitation services and programs" should be re-examined, as most ADTR contribution funds support the delivery of ongoing alcohol and drug treatment and rehabilitation services in the P/Ts. Instead, the ADTR Program should seek to "support the delivery of ongoing alcohol and drug treatment and rehabilitation services in provinces and territories."
    - A series of indicators related to supporting alcohol and drug treatment and rehabilitation programming and baseline data should be included in the ADTR Performance Measurement Strategy.

Cooperation and Collaboration

The main mechanisms for cooperation and collaboration include the F/P/T Working Group on Accountability and Evaluation Framework and Research Agenda, the F/P/T ADTR Evaluation Working Group, and the F/P/T Committee on Alcohol and Other Drug Issues. However, it is a challenge to assess the extent of increased cooperation and collaboration as a result of the ADTR Program because no cooperation and coordination measures were officially outlined at the outset of the Program and there is limited outcome evidence available.

Available evidence suggests that the ADTR Program has been successful in increasing the cooperation and collaboration between various levels of government through supporting the above-mentioned working groups and the best practises projects. Also, program stakeholders indicated a high level of satisfaction with these relations, which can be interpreted as a proxy

measure for cooperation and collaboration. However, a minority of stakeholders noted some dissatisfaction with the lack of cooperation and communication between Health Canada and the regional offices, provincial representatives, F/P/T working group, and funded initiatives.

Recommendation(s)

Based on the evaluation findings, it is recommended that:

5. The ADTR Program strengthen linkages with relevant federal departments, P/Ts, and relevant stakeholders to develop an enhanced level of cooperation and collaboration. Communication of priorities, directions, and the exchange of information is pivotal to improve understanding and knowledge of the ADTR Program activities, intended impacts, and key outcomes.
    - The Program should consult with the F/P/T Working Group to discuss strategies to ensure meaningful and appropriate engagement.
    - The ADTR Program should consult with territorial representatives and other federal government departments with similar cost-shared funding agreements to explore options for possible involvement in the contribution component of the Program.
    - The ADTR Program implement mechanisms to facilitate communication and the exchange of information between the ADTR Program and regional offices, P/Ts, and ADTR-funded initiatives. One possible mechanism could be the development of a ADTR Program newsletter to be disseminated to all relevant stakeholders, including ADTR-funded initiatives.
    - A series of objectives and indicators related to cooperation and collaboration and baseline data be included in the ADTR Program Performance Measurement strategy. Potential indicators could include: number of conferences, seminars, and meetings supported or assisted by the ADTR Program and number of F/P/T working group meetings.

BEST PRACTICES

The ADTR Program has been successful in carrying out its responsibilities to provide funding to develop and facilitate the dissemination of research information to P/Ts. A considerable amount of information was produced and developed to a range of stakeholders as a result of the ADTR Program funding, including best practises documents that focussed on various target groups and issues including women, youth, persons with concurrent mental health disorders, seniors, cocaine use, fetal alcohol syndrome/fetal alcohol effect, and methadone maintenance treatment. Overall, stakeholders indicated a high level of satisfaction with the best practises documents and workshops.

While this level of satisfaction can be interpreted as a proxy measure of the usefulness and quality of the information developed and disseminated, there is little outcome evidence available to assess the extent to which the best practises information led to increased expertise and changes to the provisions of services. Federal and provincial representatives, as well Program stakeholders, view collecting and disseminating information on substance use as an appropriate and relevant role for the federal government.

Recommendation(s):

Based on the evaluation findings, it is recommended that:

6. Alcohol and drug treatment and rehabilitation issues continue to be a Health Canada priority and dedicated funding remain available to assist in developing and disseminating research information to the P/Ts and relevant stakeholders.
    - A series of indicators related to the development and dissemination of best practises and baseline data be included in the ADTR Program performance measurement strategy.
    - Increased documentation of the key dissemination mechanisms and strategies for best practises information should be introduced into the research component of the ADTR Program to assess how these activities are conducted and their effectiveness in terms of achieving the objectives of the ADTR Program research agenda.
    - An ADTR Information Uptake Survey should be designed and implemented in collaboration with the P/Ts to determine: who uses the information, how the information is used, and to understand if and how such information are incorporated into alcohol and drug treatment and rehabilitation programming. It will also attempt to measure the extent to which professional expertise has increased over time due to these activities and reports.

Contribution Agreements

Preliminary analysis indicates that there is some inefficiency in terms of the renewal/approval process of the contribution agreements; however, given the current level of information available, it is not possible to draw any definitive conclusions on the efficiency of the contribution agreements.

Available evidence suggests that the program stakeholders believe that the contribution agreements and reporting requirements are excessively rigid. Evidence also suggests that the F/P/T Working Group and the F/P/T Committee on Alcohol and Other Drug Issues has contributed, both indirectly and directly, to the development of contribution agreements.

Recommendation(s)

- As per Recommendation # 1, the ADTR Program should develop an evaluation strategy, including a formative and summative evaluation. The formative evaluation should address issues related to program design and implementation, and an in-depth examination of the funding mechanism should be conducted.

Cost Effectiveness

Objective outcome research on the cost effectiveness of the ADTR Program is not available at this time, due to the inconsistency and incompleteness of information provided in the ADTR Program Annual Reports as well as the inability to determine the cost effectiveness of the ADTR Program funding in relation to provincial substance use treatment and rehabilitation budgets. Accordingly, it is not possible to assess the cost effectiveness of the ADTR Program.

Recommendation(s)

- As per Recommendation # 1, an evaluation strategy should be developed, including a formative and summative evaluation. The summative evaluation should address the issue of cost effectiveness and ongoing performance measurement should ensure information is being collected that will facilitate this analysis.

APPENDIX A

ALCOHOL AND DRUG TREATMENT AND REHABILITATION PROGRAM EVALUATION

TERMS OF REFERENCE

Health Canada Santé Canada

THE ALCOHOL AND DRUG TREATMENT AND REHABILITATION PROGRAM EVALUATION

TERMS OF REFERENCE

Prepared by:

Departmental Program Evaluation Division
Applied Research and Analysis Directorate
Information, Analysis and Connectivity Branch
&
Alcohol and Drug Treatment and Rehabilitation Program
Office of Demand Reduction
Drug Strategy and Controlled Substances Programme
Healthy Environments and Consumer Safety Branch

August 8, 2003
(Revised Dates)

Canada

TABLE OF CONTENTS

Alcohol and Drug Treatment and Rehabilitation Program Evaluation
Terms of Reference

1.0 Purpose

The purpose of this document is to present the Terms of Reference for the Alcohol and Drug Treatment and Rehabilitation (ADTR) Program evaluation. This document describes the scope of the evaluation, questions to be examined, potential evaluation methods and the respective roles of Departmental Program Evaluation Division (DPED) and the Office of Canada's Drug Strategy (since renamed the Office of Demand Reduction), Drug Strategy and Controlled Substances Programme (DSCSP). The projected work plan and costs of the evaluation are also outlined.

2.0 History

The ADTR Program was established in 1987 by Health and Welfare Canada under the auspices of Canada's Drug Strategy, to stimulate innovative alcohol and drug treatment and rehabilitation programs and services, with a focus on women and youth. In the period 1988 - 1990, the first set of cost-shared agreements was negotiated with provinces and territories (P/Ts) and annual funding was allocated on an ongoing basis.

Following the second set of agreements negotiated by the ADTR Program and the P/Ts (1990 - 1993), the federal government undertook a major reconstruction of federal departments which resulted in the ADTR Program being transferred to the newly formed department, Human Resources and Development Canada (HRDC). The Program continued to be administered by HRDC and another set of funding agreements was negotiated with the P/Ts.

In 1996, HRDC underwent a program review and refocused its programs to concentrate on employment issues and consequently, the ADTR Program was transferred to Health Canada (HC). The official transfer occurred in October 1997 at which time the Program was positioned under the Office of Alcohol, Drugs and Dependency Issues, Health Promotion and Programs Branch. HRDC staff responsible for the ADTR Program were not transferred to HC.

The 2000 realignment exercise of HC resulted in the ADTR Program falling under the management of the Treatment and Rehabilitation Division, Office of Demand Reduction, DSCSP, Healthy Environments and Consumer Safety Branch (HECS).

As a result of the ADTR Program's frequent movement and changing of staff since its inception, the Program has never been formally evaluated. This will be the first evaluation of the ADTR Program and will focus on the life of the Program since it was transferred to HC in 1997. Examining this time frame is the most promising in terms of availability of data and information, particularly with respect to corporate memory.

3.0 BACKGROUND

The ADTR Program is one element that supports the federal government's efforts to reduce the harm associated with the abuse of alcohol and other drugs to individuals, families and communities. The ADTR Program is a cost-shared program that funds provinces and territories to expand innovative treatment and rehabilitation programs related to alcohol and other drugs. Youth and women are the prime target groups for services funded under the program.

The overall objectives of the ADTR Program are

- to ensure innovative, accessible and effective alcohol and drug treatment and rehabilitation services and programs;
- to assist in ensuring access for all Canadians to alcohol and drug treatment and rehabilitation services;
- to reduce the harm to individuals, families and communities arising from the abuse of alcohol and other drugs; and
- to assist provinces and territories through a cost-sharing plan to increase and expand alcohol and drug treatment and rehabilitation programming within the provinces and territories, and to do so in a fashion that builds on the current cooperation of the two orders of government in this field, and which supports provincial/territorial efforts to plan and deliver alcohol and drug services.

Of the $15.5 million currently allocated to the ADTR Program annually, $14 million is used to fund new and innovative substance abuse treatment and rehabilitation programs and services. The federal government reimburses fifty percent of the eligible costs of P/Ts in providing alcohol and drug treatment and rehabilitation services. The types of services funded include detoxification services, early identification and intervention, assessment and referral, counselling/case management, therapeutic intervention, special access services, continuing care/clinical follow-up, awareness and development, research and evaluation and knowledge dissemination. A yearly contribution in the amount of $500,000 is made to the Canadian Centre on Substance Abuse (CCSA).[1] The remaining $1 million of Program funding is used to administer the Program, develop and implement a research agenda with the P/Ts and disseminate knowledge and information such as best practices.

[1] Funding to the CCSA was increased to $1.5 million in 2002 - 2003 and for the next two fiscal years.

The management of the ADTR Program is the responsibility of the Office of Demand Reduction, DSCSP. P/Ts are responsible for the administration, design and delivery of their respective alcohol and drug treatment and rehabilitation programs.

3.1 Alcohol and Drug Treatment and Rehabilitation Program Logic Model

The ADTR Program logic model was developed by DPED in collaboration with DSCSP and P/T government representatives (Figure 1). This logic model is a diagram used to describe and communicate the important elements of the Program and is the primary focus of the current evaluation. In addition to describing the main components of the Program, the logic model describes the linkages between the main activities, the outputs and the immediate, intermediate and final outcomes. The Program logic model has three main components that are summarized in Table 1.

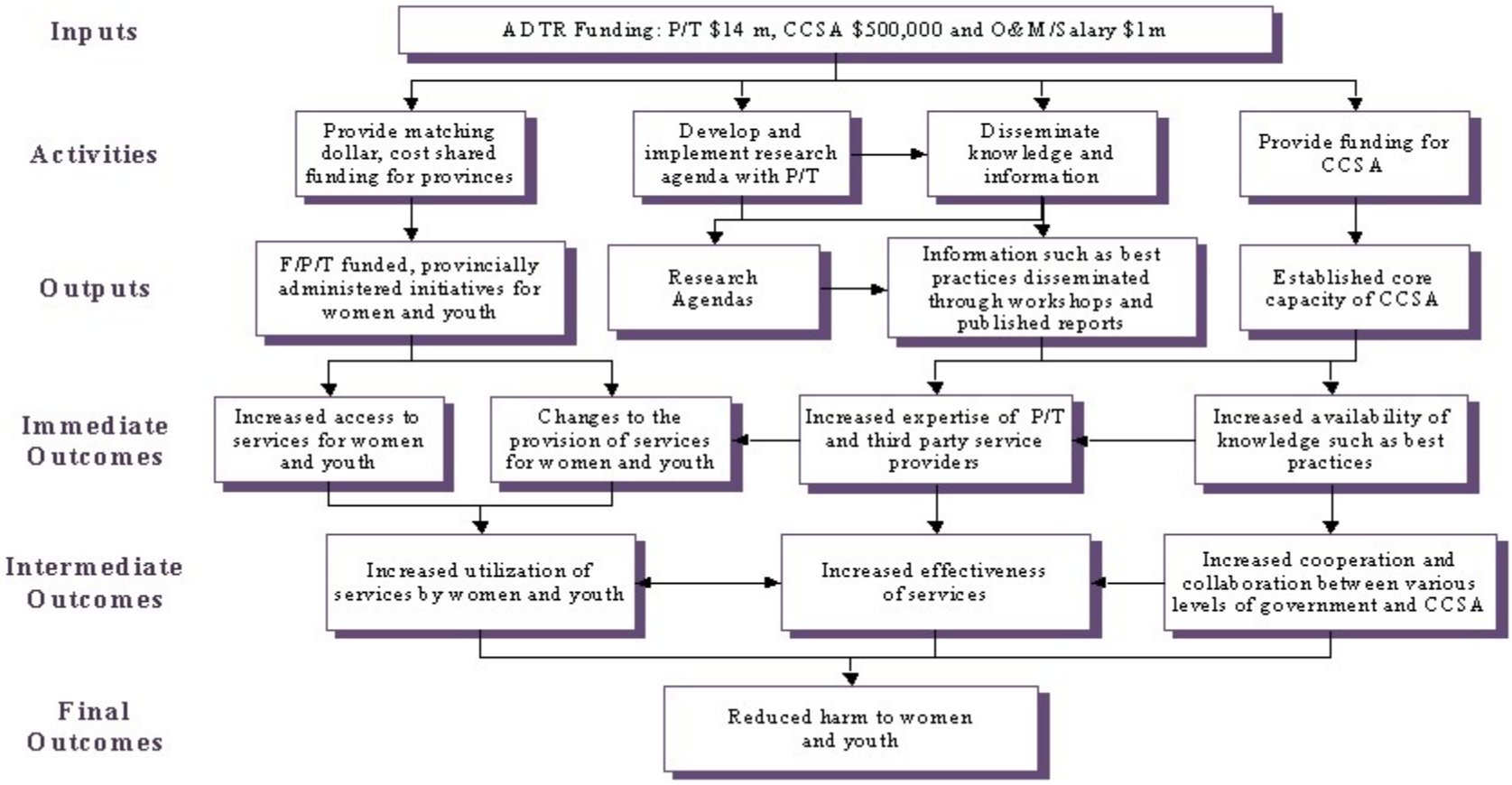
Table 1: Elements of the ADTR Program Evaluation Logic Model

Logic Model Component	Definition
Activities	The main operations or actions that produce a good or service.
Outputs	The goods and services produced or directly controlled by the Program.
Outcomes	The consequences of the Program that can be attributed to activities and outputs. Outcomes are stated as immediate, intermediate and long-term.

The relationships identified in the model by arrows represent the strongest causal relations, though there may be more. It should be noted that the Program exercises diminishing levels of control and influence as one moves down the logic model toward the final outcomes. The Program has direct control over activities and outputs and direct influence over the immediate outcomes. However, the achievement of the intermediate and long-term outcomes is influenced by a variety of factors, including the Program, other HC activities, the activities of P/T governments and service providers, as well as other environmental factors.

Figure 1

ADTR Program Logic Model



4.0 The Alcohol and Drug Treatment and Rehabilitation Program Evaluation

This section describes the purpose, scope and focus and the issues and questions proposed for the evaluation.

4.1 Purpose of Evaluation

In the 1997 Treasury Board Submission, which outlined the permanent transfer of funds for the ADTR Program from HRDC to HC, and in the 1999 Treasury Board Submission which outlined the implementation of population health programming under which the ADTR Program was subsumed, HC committed to conducting evaluation studies of the ADTR Program. In the fall of 2003, HC will be seeking Treasury Board approval for renewed Terms and Conditions for this contribution program.

The evaluation will serve three major purposes to facilitate HC in meeting its commitments made in these Treasury Board Submissions:

- to assess the relevance, impact and cost effectiveness of the ADTR Program since it was transferred to HC in 1997;
- to assess the extent to which the ADTR Program has made progress on the achievement of its identified objectives; and
- to facilitate the development of a strategy to measure the performance of the ADTR Program on a continuing basis. This Performance Measurement strategy will be included as part of the Results-Based Management and Accountability Framework to be presented to Treasury Board Secretariat for purpose of renewing the ADTR Program's Terms and Conditions.

The evaluation report will also contribute to improved decision-making and provide recommendations and an action plan for continuous program improvement.

4.2 Scope and Focus

The evaluation will be national in scope and will focus on validating and answering the evaluation questions outlined in this document. More specifically, the evaluation will focus on three key areas: program relevance, impact and cost-effectiveness.

4.3 Issues and Questions

The evaluation will examine, but not be limited, to the following questions:

1) Is there a continued need for the ADTR Program?

2) To what extent has the ADTR Program made progress toward the achievement of its identified objectives?
3) To what extent were best practices adopted by service providers?
4) Were contribution arrangements the most efficient and effective means of achieving the ADTR Program objectives?
5) What was the cost effectiveness of the ADTR Program?

A detailed list of potential evaluation questions is provided in Annex A.

5.0 Evaluation Methodology

To effectively answer the questions, the evaluation will draw on information from primary (such as the Program and other stakeholders) and secondary sources (such as Statistics Canada and CIHI), and will rely on a combination of quantitative and qualitative methods to analyse and synthesize the information. The specific evaluation methods are described in more detail below.

Document Review

As part of the evaluation methodology, a review of key documents related to the ADTR Program will be conducted. The document review will focus on information related to the ADTR Program after the Program moved to HC from HRDC in 1997. Documents to be reviewed will include, but will not be limited, to the following:

- departmental documents related to HC business line and its components;
- Reports to Parliament and Treasury Board Secretariat, including Treasury Board Submissions;
- ADTR Program files, including accepted and rejected initiative proposals and signed agreements;
- key internal documents, including minutes of meetings and correspondence between HC and ADTR-funded initiatives;
- other relevant documents which provide information on the ADTR Program, the dissemination of Program information, relationships with key stakeholders; and
- relevant documentation provided by P/Ts relating to the planning, delivery and evaluation of their alcohol and drug treatment and rehabilitation services.

The document review will provide the evaluator(s) with an in-depth understanding of program background and activities. In addition, the document review will assist in validating the evaluation issues and questions outlined for the study.

Literature Review

The literature review will serve several purposes related to the evaluation. First, information gathered will provide background information on the environment in which the ADTR Program operates including the context of alcohol and drug programming in Canada. In addition, the literature review will assist in identifying logic models and indicators that have been used for similar programs and will validate the ADTR Program logic model and indicators. Also, it will allow the evaluator(s) to compare the results of the study with other programs/initiatives that have similar objectives. Finally, to the extent possible, the literature review will examine similar alcohol and drug programming across jurisdictions to document best practises in funding strategies, delivery models and achievement of intended outcomes.

Case Studies

Up to four ADTR-funded initiatives from various regions will be selected as case studies to assess the efficiency and efficiency of the ADTR Program. Evaluator(s) will make site-visits and conduct in-depth examinations of the selected initiatives, relying on both qualitative and quantitative information. In examining project level data, and where possible client level data, the case studies will assess the feasibility of a baseline study and, most importantly, will facilitate the development of a performance measurement system for the ADTR Program.

Selecting the appropriate case studies is essential to collecting information and validating methods of analysis. At minimum, the initiatives selected should

- reflect the range of diversity of ADTR-funded initiatives;
- receive a significant portion of its funding through the ADTR Program;
- have objectives that are consistent with the ADTR Program objectives and be targeted to women and/or youth;
- have and be willing to share information including data for evaluation purposes, that is both valid and reliable; and,
- be willing to commit various resource requirements. More specifically, selected initiatives must have staff available to respond to requests for information on program documentation, reports related to program operations and when available, client and financial data. Also, staff must be willing to participate in stakeholder interviews.

Appropriate measures will be taken to ensure the confidentiality of project level and client level information. Data and analysis in the site report will not contain any identifying information on program participants and findings will be fed back to sites for accuracy before they are completed.

Depending on the complexity of the case study analysis, a peer review panel might be formed to analyze and provide an expert review of the overall quality of the case studies.

Interviews

A series of interviews, by telephone and in person, will be carried out with a variety of stakeholders to provide information on the more qualitative aspects of the evaluation questions. Interviews should yield information that will validate the evaluation questions, logic model and indicators.

As part of this information collection method, a structured interview guide will be developed for each group of key informants that will provide the template for asking interview questions. It will also facilitate the collection and analysis of information generated from the interviews. The following key informants may be asked to participate in the evaluation survey:

- ADTR Program representatives (DSCSP - NCR and Regions);
- provincial government representatives;
- service providers and clients;
- alcohol and drug programming experts;
- representatives from territories and non-ADTR funded initiatives; and
- representatives of non-governmental organizations.

See Annex B for the evaluation methodology and information collection matrix.

6.0 Roles and Responsibilities

DPED will lead the development and conduct of the evaluation, in collaboration with DSCSP staff. The Evaluation Project Team will consist of a manager from the Office of Demand Reduction, DSCSP and an evaluation manager and two analysts from DPED.

An Evaluation Working Group (EWG), consisting of selected federal and provincial government representatives, will be formed to provide feedback on the development and conduct of the evaluation. A terms of reference for the EWG will be developed at the time the group is formed.

The responsibilities of DPED will include the following:

- oversight of the evaluation study;
- developing the terms of referencesfor the Evaluation and EWG;
- chairing EWG meetings;
- developing the overall design of the evaluation study;
- conducting the document review, literature review, case studies, interviews and peer review; managing the work of individuals outside of DPED who will assist in conducting evaluation activities;
- producing draft and final evaluation documents and interim evaluation products in a timely fashion;
- assisting in data collection as required; and,
- providing expertise as necessary to ensure the success of the evaluation;

The responsibilities of DSCSP will include the following:

- providing funding for evaluation activities conducted outside of DPED (i.e. site visits to case studies, data analysis, peer review);
- approving the Terms of Reference;
- providing timely access to documents as needed for the conduct of the evaluation (files, records, lists of funded projects, databases, evaluations of projects, etc.);
- reviewing all draft, interim and final evaluation documents and providing comments/feedback in a timely fashion;
- providing relevant information about the program to both DPED and EWG;
- assisting in the selection of initiatives for the case studies and key stakeholders for the interview component; and,
- acting as a liaison for DPED and provincial representatives.

7.0 Costs

The budget for operations and materials of this evaluation is $80,000. The cost of evaluation activities conducted outside of DPED, which are anticipated to include the analysis of data for the case studies and possibly a peer review, will be the responsibility of DSCSP. The peer review will likely cost in the range from $15,000 to $20,000. The quantity and quality of data and information to be analysed will determine the extent of the involvement of individuals or groups outside of DPED (such as Statistics Canada or the Canadian Institute for Health Information) and thereby will determine the cost of the analysis for the case studies. DPED has committed a manager and two evaluation analysts for the duration of this project.

8.0 TIME FRAMES

The ADTR Program evaluation consists of several steps. These are summarized on the following page in Table 2.

Table 2: ADTR Program Evaluation Time Frames

Step	Completion Date*	Task
1	August 2003	Approval of Evaluation Terms of Reference
2	June 2003	Finalized Evaluation Working Group Terms of Reference
3	August 2003	Completed first draft of logic model with indicators
4	September 2003	Finalized literature review
5	September 2003	Finalized document review
6	August 2003	Finalized stakeholder interviews
7	September 2003	Completed first draft of case studies
8	October 2003	Completed final draft of logic model with indicators
9	October 2003	Completed final draft of case studies
10	October 2003	Completed first draft of evaluation report
11	October 2003	Completed final draft of RMAF

*_Note_: The completion dates listed above assume that all activities occur in a timely manner. If slippages occur with a particular completion date, many or all of the subsequent completion dates will have to slip accordingly, as there are minimum times needed for certain steps.

APPROVAL

_____ _____

Cathy Airth Date
Director, Alcohol and Drug Treatment and Rehabilitation Program
Healthy Environments and Consumer Safety Branch

_____

Ken Lee Date
Director, Departmental Program Evaluation Division
Information, Analysis and Connectivity Branch

ANNEX A
POTENTIAL EVALUATION QUESTIONS

Relevance

1. Is there a continued need for the ADTR Program?

    1.1 Are women and youths still a relevant target population for the Program?
        1.1 How much demand by women for ADTR services?
            1.1.1 Should prevention activities be considered?
            1.1.2 What other program services are important to accessing the impact of the ADTR Program? For example, mental health services.

        1.2 How much demand by youths for ADTR services?
            1.2.1 Should prevention activities be considered?
            1.2.2 What other program services are important to accessing the impact of the ADTR Program? For example, mental health services.

Impact

2. To what extent has the ADTR Program made progress on the achievement of its identified objectives?

    2.1 To what extent has the ADTR Program contributed to increased access?
        2.1.1 To what extent has the ADTR Program increased access to the number of clients served.
        2.1.2 To what extent has the ADTR Program increased the volume and variety of services per client.

    2.2 How many new and innovative services has the ADTR Program facilitated?
        2.2.1 How should concepts such as new and innovative be defined?
        2.2.2 To what extent has the ADTR Program facilitated the development and dissemination of best practices and information?
        2.2.3 To what extent has the ADTR Program facilitated the increased expertise of provinces and other service providers?

    2.3 To what extent has the ADTR Program contributed to increased cooperation and collaboration between various levels of government?
        2.3.1 To what extent has targeted ADTR funding to CCSA contributed to increased cooperation and collaboration between various levels of government, the business community, professionals and voluntary organizations in matters

related to alcohol and drug abuse?

3. To what extent were best practices been adopted by service providers?

   3.1 What were the catalysts/barriers to best practice uptake?

4. Were contribution arrangements the most efficient and effective means of achieving the ADTR Program objectives?

   4.1 What was the optimal agreement duration to achieve outcomes?

   4.1.1 What was the optimal agreement duration to maximize accountability by provinces and service providers?

Cost Effectiveness

5. What was the cost effectiveness of the program?

ANNEX B
EVALUATION METHODOLOGY AND INFORMATION COLLECTION MATRIX

Evaluation Question	Document Review	Literature Review	Case Studies	Stakeholder Interviews	Peer Review
1. Is there a continued need for the ADTR Program?		●	●	●	●
2. To what extent has the ADTR Program contributed to the achievement of its identified objectives?	●		●	●	●
3. To what extent were best practices adopted by service providers?			●	●	●
4. Were contribution arrangements the most efficient and effective means of achieving the ADTR Program objectives?	●	●		●	
5. What was the cost effectiveness of the ADTR Program?	●		●		●

APPENDIX B

EVALUATION WORKING GROUP
TERMS OF REFERENCE

APPENDIX B

Alcohol and Drug Treatment and Rehabilitation Program Evaluation Evaluation Working Group Terms of Reference

PURPOSE

The purpose of this document is to present the Terms of Reference for the Alcohol and Drug Treatment and Rehabilitation Program Evaluation Working Group (EWG). The EWG will facilitate the development and conduct of the Alcohol and Drug Treatment and Rehabilitation (ADTR) Program evaluation.

CONTEXT

The ADTR Program is one element that supports the federal government's efforts to reduce the harm associated with the abuse of alcohol and other drugs to individuals, families and communities. The ADTR Program is a $15.5 million program, of which $14.0 million is cost-shared with provinces and territories to expand innovative treatment and rehabilitation programs related to alcohol and other drugs. Youth and women are the prime target groups for services funded under the program.

In collaboration with the ADTR Program of the Office of Canada's Strategy (since renamed the Office of Demand Reduction), Drug Strategy and Controlled Substances Programme (DSCSP), the Departmental Program Evaluation Division (DPED) is leading the Health Canada Evaluation of the ADTR Program.

Conduct of this evaluation will rely on multiple lines of evidence and focus on assessing the relevance, impact and cost-effectiveness of the ADTR Program. The final evaluation of the ADTR Program is intended to be completed by September, 2003.

MANDATE

The mandate of the EWG is to provide advice on the design, implementation and completion of the various components of the evaluation. More specifically, the EWG will:

- assist in the development of the Program logic model, performance indicators, evaluation products and tools, and Terms of Reference for the Evaluation;

- provide feedback on the work of the evaluation consultant(s);
- provide information useful to the development and conduct of the evaluation; and
- review draft and final evaluation reports.

MEMBERSHIP

The EWG will have seven members:

- Departmental Program Evaluation Division, (two members including chair);
- ADTR Program, DSCS, (two members including one from the Regions); and
- Provincial Representatives (three members).

ROLES AND RESPONSIBILITIES

Departmental Program Evaluation Division

- oversight of development and conduct of evaluation;
- chairing the EWG meetings;
- provide assistance and information about information and data collection requirements; and
- provide information about progress on evaluation activities.

ADTR Program, Drug Strategy and Controlled Substances Programme representatives

- provide relevant information about the program to the evaluation working group;
- provide assistance and advice in the development of program indicators and evaluation products and tools;
- regularly report progress on evaluation activities to all provinces;
- review draft and final evaluation reports; and
- act as a liaison for DPED and provincial representatives.

Provincial representatives

- provide provincial input and perspective in evaluation activities;
- provide information regarding the availability of and access to information and data;
- provide assistance and advice in the development of program indicators and evaluation products and tools;

- provide contact information for people who may provide information to facilitate the evaluation; and
- review draft and final evaluation reports.

EWG members will attend all meetings to the extent possible to ensure a range of perspectives is brought to the table.

MEETINGS

The EWG will meet as needed to review progress and fulfil its responsibilities. All meetings will be carried out via teleconference. The organization of conference calls will be carried by the ADTR Program, DSCS representative.

SECRETARIAT

The organization of and note taking from the meetings will be carried out by DPED.

APPENDIX C

LIST OF TECHNICAL REPORTS

APPENDIX C

LIST OF TECHNICAL REPORTS

Alcohol and Drug Treatment and Rehabilitation Program, Literature Review. December 1, 2003. Prepared By: Department Program Evaluation Division

Alcohol and Drug Treatment and Rehabilitation Program, Summary Report on Stakeholder Interviews. December 1, 2003. Prepared By: Department Program Evaluation Division

Alcohol and Drug Treatment and Rehabilitation Program, Document Review. December 10, 2003. Prepared By: Department Program Evaluation Division

Alcohol and Drug Treatment and Rehabilitation Program, Case Study Report. February 16, 2004. Prepared By: Department Program Evaluation Division