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Health Canada and the Public
Health Agency of Canada

Santé Canada et l'Agence
de la Santé publique du Canada

Evaluation of the Drug Treatment Funding Program

Prepared by
Evaluation Directorate
Health Canada and the Public Health Agency of Canada

December 2013

List of Acronyms

| | |
|---------|--|
| DTES | Vancouver's Downtown Eastside |
| DTFP | Drug Treatment Funding Program |
| HC DTFP | Health Canada's Drug Treatment Funding Program |
| NADS | National Anti-Drug Strategy |
| NIDA | National Institute on Drug Abuse |
| PT | Provincial/Territorial |
| RPP | Report on Plans and Priorities |
| WHO | World Health Organization |

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Executive Summary

The National Anti-Drug Strategy (NADS) was launched by the Government of Canada in 2007. Its goal is to contribute to safer and healthier communities through coordinated efforts to prevent use, treat dependency and reduce production and distribution of illicit drugs. It encompasses three action plans: Prevention, Treatment and Enforcement.

Health Canada's Drug Treatment Funding Program (DTFP), which falls within the Treatment Action Plan of the NADS, is a federal contribution program, created in 2007 to replace the Alcohol and Drug Treatment and Rehabilitation Program (1987–2007). The DTFP supports the NADS ultimate outcomes of healthier individuals, fewer problematic behaviours and safer communities.

The DTFP was established to provide approximately \$118M in contribution funding over five years to provinces, territories and other key stakeholders under two key components:

Strengthening Treatment Systems - projects that lead to sustainable improvements in the quality and organization of substance abuse treatment systems. The bulk of the treatment systems funding was allocated to provinces and territories, with the balance of funds set aside to support national and/or multi-jurisdictional initiatives. Three priority investment areas were identified: (i) implementation of evidence-informed practices; (ii) strengthening evaluation and performance measurement; and (iii) multi-jurisdictional linkage and exchange of initiatives to strengthen treatment systems.

Support for Treatment Services - time limited funding (ended in March 2013, as planned) for the delivery of treatment services to meet the critical treatment needs of at-risk youth, and those living in Vancouver's Downtown Eastside (DTES).

The evaluation of the DTFP is part of the Public Health Agency of Canada/Health Canada's Five-Year Evaluation Plan. The evaluation was conducted to provide senior management with evaluative information for the renewal of the program's Terms and Conditions (renewed end of March 2013). It also fulfilled the *Treasury Board Policy on Evaluation, 2009* and *Financial Administration Act* requirements. The focus of the evaluation was to assess the relevance and performance (effectiveness, efficiency and economy) of the DTFP. The evaluation covered activities carried out during the period 2008-2009 to 2012-2013.

The evaluation used multiple lines of evidence including literature and jurisdictional review, document and administrative file review, key informant interviews and an online survey.

Findings

Relevance

All of the lines of evidence confirmed the ongoing relevance of the DTFP. The evaluation found evidence that the rates of illicit drug use continue to be highest amongst youth (15-24 years of age) and marginalized groups (Aboriginal and street-involved/homeless youth) compared to the general population. Illicit drug use is linked to a range of legal, social and health problems which can be costly to individuals and society. Such impacts represent a drain on Canada's economy, both directly and indirectly. The benefits from substance abuse treatment extend beyond the reduction in substance abuse, to areas such as reduced crime, reduced risk of infectious diseases and improved social function.

The DTFP supports two of Health Canada's strategic priorities: "Canadians are informed of and protected from health risks associated with food, products and substances and environments, and are informed of the benefits of healthy eating" and "A Health System Responsive to the Needs of Canadians". The DTFP is also aligned with Government of Canada priorities as a key partner under the National Anti-Drug Strategy.

The federal role in the DTFP stems from the *Department of Health Act*. It includes policy levers, such as grants and contributions, where the federal government provides funding to provinces, territories or other organizations to pursue particular policy commitments, promote innovative practices and generally provide federal leadership on health-related issues. Health Canada was seen by most DTFP stakeholders as having a national coordinating role in supporting more effective drug abuse treatment systems. Some interviewees indicated that Health Canada was uniquely positioned to make connections across jurisdictions by supporting the exchange of knowledge between key stakeholders. They also suggested that connecting across jurisdictions was a way to reduce duplication because of the opportunity to share best practices and lessons learned.

Performance – Effectiveness

The DTFP has made progress in achieving its expected outputs and outcomes. The evaluation confirmed that DTFP-funded projects support collaboration across treatment systems and that the majority of systems projects have led to enhanced collaboration among key stakeholders and jurisdictions/regions. The national systems projects were viewed positively as effective mechanisms for encouraging a national perspective through an inter-jurisdictional approach.

The evaluation found PT commitment to system level changes, as evidenced by the level of support for the DTFP, and found that systems projects have led to the creation and dissemination of evidence-informed practice information. Those consulted agreed that they have been able to easily access drug treatment support and resources provided by the projects.

A majority of both systems and services projects indicated an increased capacity to evaluate substance abuse systems and services. The program provided additional supports to funding recipients to help them meet the Program requirements for evaluation planning and logic models.

The evaluation found evidence of both an increased availability of, and access to, evidence-informed early intervention programs and services. Survey respondents and interviewees indicated that projects had successfully increased the availability of evidence-informed drug treatment programs and made it easier for at-risk individuals in their region to access drug treatment programs.

Issues related to performance measurement were identified. The evaluation found that although common indicators were developed, performance information was not collected consistently by projects. Project representatives cited problems with reporting systems and templates, for which steps were taken to address in summer 2012 by the program. DTFP did invest resources in the development of a performance reporting system, but further investment in the system was put on hold. According to program staff, this was due to a departmental decision to use a new system being introduced for grants and contributions for performance measurement. As a result, the program lacked a national database/system to support performance monitoring and reporting.

There was limited evidence that the research, best practices and knowledge products from the DTFP-funded projects were being analysed or synthesized to feed back into the projects, other than through a national project that was funded to share information across projects. According to the program, this was explained in part because some projects were not yet complete. Some interview respondents indicated the program could do more in this area.

Performance – Efficiency and Economy

The demonstration of efficiency and economy, according to the Treasury Board *Policy on Evaluation* (2009), is based on the assumption that departments have standardized performance measurement systems and that financial systems link information about program costs to specific inputs, activities, outputs and expected results. The type of financial information provided for DTFP did not facilitate the assessment of whether program outputs were produced efficiently, or whether expected outcomes were produced economically. There was, however, some evidence of efficiencies gained and less duplication of effort (e.g., sharing best practices, tools and lessons learned across projects, and leveraging of funds). In addition, the literature review suggested that drug treatment programs are good value-for-money and that the resulting savings to society can be well in excess of funds invested.

Actual spending on contributions was about 67% of planned. The remainder of the contribution budget was lapsed and returned to Treasury Board (14%) or transferred to other programs within Health Canada (19%). While lapses occurred in the early years, primarily due to delays in project approvals, there have been no significant lapses since 2011-2012.

Recommendations

Recommendation 1

Health Canada should strengthen its role of synthesizing, analysing and disseminating information regarding the DTFP project results.

Recommendation 2

Health Canada should ensure that the DTFP implements an effective performance measurement strategy that includes financial data tracking and monitoring to ensure consistent performance reporting.

Management Response and Action Plan

Evaluation of the Drug Treatment Funding Program

| Recommendations | Management Response | Management Action Plan | Deliverables | Expected Completion Date | Responsibility/Accountability |
|--|---------------------|---|--|--|--|
| 1. Health Canada should strengthen its role of synthesizing, analysing, and disseminating information regarding the DTFP project results. | Agree | DTFP will implement a more systematic approach to conducting analysis and sharing results from projects both internally and with external stakeholders (e.g. analysis of project reports, presentations at conferences). | <p>Presentation of key findings and lessons learned from project data mining exercises at the Issues of Substance Conference.</p> <p>Formation of the Drugs Program Knowledge Exchange and Translation Working Group to promote Health Canada's role in the analysis and dissemination of information.</p> <p>Updated data mining report based on project results.</p> | <p>November 2013</p> <p>Fall 2013</p> <p>March 2014</p> | Director, Drugs Program, Strategic Policy Branch |
| 2. Health Canada should ensure that the DTFP implements an effective performance measurement strategy that includes financial data tracking and monitoring to ensure consistent performance reporting. | Agree | <p>DTFP will revise its Performance Measurement Strategy (PMS) to reflect findings of the Evaluation, and implement the PMS accordingly.</p> <p>The Department has implemented a new system to improve financial reporting (GCIMS), which the program will adopt accordingly.</p> | <p>Revised DTFP PMS.</p> <p>Annual performance report that includes relevant performance and efficiency/economy indicators.</p> <p>Use of GCIMS for the Drugs Program.</p> | <p>Summer 2013</p> <p>May/June 2014</p> <p>Within 6 months of GCIMS coming into force.</p> | Director, Drugs Program, Strategic Policy Branch |

1. Introduction

The evaluation of the Drug Treatment Funding Program (DTFP) is part of the Public Health Agency of Canada/Health Canada's Five-Year Evaluation Plan. The evaluation assesses the relevance and performance (effectiveness, efficiency, and economy) of the DTFP for the period 2008-2009 to 2012-2013. This evaluation is conducted in accordance with the Treasury Board of Canada's *Policy on Evaluation (2009)* requirements and standards. It is also required by the *Financial Administration Act*.

The report is organized into several sections. Section 2 provides a brief profile of the DTFP. Section 3 describes the evaluation. Section 4 contains the evaluation findings pertaining to relevance and performance. Section 5 concludes the report and offers recommendations for consideration.

2. Program Description

2.1 Program Context

The National Anti-Drug Strategy (NADS) was launched by the Government of Canada in 2007. Its goal is to contribute to safer and healthier communities through coordinated efforts to prevent use, treat dependency and reduce production and distribution of illicit drugs. It encompasses three action plans: Prevention, Treatment and Enforcement.

Health Canada's DTFP, which falls within the Treatment Action Plan of the NADS, is a federal contribution program, created in 2007 to replace the Alcohol and Drug Treatment and Rehabilitation Program (1987–2007). The DTFP supports the NADS ultimate outcomes of healthier individuals, fewer problematic behaviours and safer communities.

Health Canada consulted extensively with key stakeholders regarding substance abuse issues and priorities. These consultations identified the need to address key service gaps, and revealed general agreement that systemic change was needed to move treatment systems towards more evidence-informed practices, while increasing systems' capacity to evaluate practices for their efficiency and effectiveness.¹ These consultations informed the development of the federal DTFP. The DTFP responds to the need to fundamentally strengthen provincial and territorial substance abuse treatment systems, with particular focus on evidence-informed practice, linkage and knowledge exchange within and among jurisdictions and communities of practice, and performance measurement and evaluation. The DTFP draws on a knowledge exchange model, and focuses on five key action areas: knowledge management; knowledge movement; implementation; evaluation; and linkage and exchange.² In addition, the DTFP addresses the need for new or enhanced treatment services funding in order to support provincial/territorial governments in addressing treatment gaps for at-risk youth as well as those living in Vancouver's Downtown Eastside.

2.2 Program Components and Resources

The DTFP was established to provide approximately \$118M in contribution funding over five years to provinces, territories and other key stakeholders under two key components:

Strengthening Treatment Systems - \$66M in on-going seed funding to initiate projects that lead to sustainable improvements in the quality and organization of substance abuse treatment systems. The bulk of the treatment systems funding was allocated to provinces and territories, with the balance of funds set aside to support national and/or multi-jurisdictional initiatives. Funding was available to provinces, territories and non-governmental organizations. Three priority investment areas were identified: (i) implementation of evidence-informed practices; (ii) strengthening evaluation and performance measurement; and (iii) multi-jurisdictional linkage and exchange of initiatives to strengthen treatment systems.

Support for Treatment Services- \$52M in five-year time limited funding (ended March 2013, as planned) for the delivery of treatment services to meet the critical treatment needs of at-risk youth, and those living in Vancouver's Downtown Eastside. Under this component only provinces and territories were eligible for funding. There were two sub-components of this funding stream:

- \$42M to fill critical gaps in treatment through investments in early intervention treatment initiatives designed to reduce and eliminate the progression and severity of illicit drug use among youth. This stream was intended to focus on early intervention treatment services to support at-risk youth aged 15 to 24, and to assist in strengthening the quality of drug treatment services.
- \$10M as a special funding allotment to deliver critical treatment services and programs for Vancouver's DTES that target the most vulnerable groups in this neighbourhood, such as women engaged in the survival sex trade. The funding supported: 1) an Assertive Community Treatment Team for those with concurrent disorders; and 2) a Residential/Day Program for female survival sex workers.

2.3 Expected Outcomes

The following table presents a summary of the expected outcomes of the DTFP.

Table 1: Expected Outcomes of the DTFP

| | Strengthening Treatment Systems | Support for Treatment Services (ending in March 2013) |
|------------------------------|--|--|
| Immediate Outcomes | 2008-2009 <ul style="list-style-type: none"> ▪ Enhanced collaboration on responses to treatment systems issues within and among jurisdictions and stakeholders ▪ Enhanced provincial/territorial (PT) commitments to effect system change in DTFP treatment systems investment areas | 2008-2009 to 2009-2010 <ul style="list-style-type: none"> ▪ Enhanced PT capacity to deliver evidence-informed early intervention treatment programs and services to at-risk youth in high-needs areas 2008-2009 <ul style="list-style-type: none"> ▪ Enhanced capacity to deliver drug treatment services and support for people residing in DTES Vancouver |
| Intermediate Outcomes | 2009-2010 to 2011-2012 <ul style="list-style-type: none"> ▪ Increased access to evidence-informed practice information ▪ Increased PT capacity to evaluate substance abuse treatment systems performance ▪ Increased understanding of effective treatment systems performance | 2010-2011 to 2011-2012 <ul style="list-style-type: none"> ▪ Increased availability/access to sustainable, evidence-informed early intervention treatment programs and services for at-risk youth in high-needs areas 2009-2010 to 2011-2012 <ul style="list-style-type: none"> ▪ Increased availability/access to drug treatment services and supports for people residing in DTES Vancouver |
| Long-term Outcome | 2012-2013 Strengthened evidence-informed substance abuse treatment systems and services | |

Below is the logic model depicting the linkages between activities, outputs and expected outcomes.

2.4 Drug Treatment Funding Logic Model

| Program Activities | HC DTFP Coordination & Leadership | HC/DTFP Funding |
|---|---|---|
| Program Outputs/Inputs to Projects | <ul style="list-style-type: none"> • DTFP Framework & Priorities • Syntheses/dissemination of DTFP knowledge • DTFP Performance & Evaluation Results | <ul style="list-style-type: none"> • Funding agreements, MOUs • DTFP Reports, Briefings |
| Project Activities | PT/Key Stakeholders DTFP Planning & Implementation | |
| Outputs | <ul style="list-style-type: none"> • Strengthening Treatment Systems <ul style="list-style-type: none"> - Proposals - Projects, Reports | <ul style="list-style-type: none"> • Support for Treatment Services <ul style="list-style-type: none"> - Proposals, - Projects, Reports |
| | <ul style="list-style-type: none"> • Opportunities for linkages & exchange of knowledge | |

| Program Activities | HC DTFP Coordination & Leadership | HC/DTFP Funding | |
|------------------------------|---|---|---|
| Immediate Outcomes | 2008-2009 <ul style="list-style-type: none"> Enhanced collaboration on responses to DTFP treatment systems' issues within and among jurisdictions & stakeholders Enhanced PT commitments to effect system change in DTFP treatment systems' investment areas | 2008-2009 <ul style="list-style-type: none"> Enhanced PT capacity to deliver evidence-informed early intervention treatment programs & services to at-risk youth in high-needs areas | 2008-2009 <ul style="list-style-type: none"> Enhanced capacity to deliver drug treatment services & support for people residing in Downtown Eastside Vancouver |
| Intermediate Outcomes | 2009-2010 to 2011- 2012 <ul style="list-style-type: none"> Increased access to evidence-informed practice information Increased PT capacity to evaluate substance abuse treatment systems' performance Increased understanding of effective treatment systems' performance | 2010-2011 to 2011-2012 <ul style="list-style-type: none"> Increased availability/access to sustainable, evidence-informed early intervention treatment programs & services for at-risk youth in high-needs areas | 2009-2010 to 2011-2012 <ul style="list-style-type: none"> Increased availability/access to drug treatment services & supports for people residing in Downtown Eastside Vancouver |
| Long-term Outcome | 2012-2013 Strengthened evidence-informed substance abuse treatment systems and services | | |

2.5 Responsibilities

Health Canada

Health Canada has overall responsibility for the development and implementation of the DTFP. This includes engaging partners (provincial/territorial governments and other key stakeholders) to establish common objectives, priorities and outcomes for the DTFP. Health Canada is also responsible for ensuring that funding is appropriately allocated and spent according to established criteria and guidelines, that government procedures are adhered to, and that reporting and accountability standards are met.

The DTFP is situated within Health Canada's Drugs Program¹, Programs Directorate of the Strategic Policy Branch. The program area within the Strategic Policy Branch is responsible for: reviewing and approving proposals; providing oversight and support throughout the implementation of projects; approving final reports (including interim and final evaluations); and analysing, synthesizing and disseminating best practices, knowledge products/tools and evaluation results. The program is also required to report annually on program performance as part of the government performance reporting process, and to provide annual performance updates to meet NADS reporting requirements.

Funding Recipients

PT governments are responsible for the planning and delivery of substance abuse treatment within their jurisdictions. PT governments are the predominant funding recipients; other funding recipients include non-profit organizations. Funding recipients are responsible for developing and submitting proposals consistent with DTFP objectives and priorities, providing general oversight/project management of the funded project and complying with established reporting

¹ Previously called the Drugs and Tobacco Initiatives Program.

requirements. Proposal process requirements are consistent across all contribution agreements, with the exception of Quebec², and include the need for an evaluation plan to support interim and final evaluations of project activities and outcomes based on ‘common’ (i.e. identical) performance measures and indicators. DTFP reporting requirements for funding recipients include: the submission of semi-annual financials; semi-annual progress reports; final project reports; an interim evaluation report and final evaluation report.³ Additionally, funding recipients, with the exception of Quebec, are required to provide input into any federal evaluation of the DTFP.

3. Evaluation Description

3.1 Scope of the Evaluation

The evaluation focuses on DTFP activities undertaken during the period of 2008-2009 to 2012-2013.

3.2 Evaluation Issues and Questions

Five core issues are outlined in Treasury Board of Canada’s *Policy on Evaluation (2009)*. The evaluation issues and questions in Table 2 guided the development of the evaluation’s data collection instruments and collection of data. Key findings for each question were synthesized into broader conclusions.

Table 2: Evaluation issues and questions

| Evaluation issues | Evaluation questions |
|---|--|
| Relevance - Continued Need | To what extent does Health Canada’s DTFP continue to address a demonstrable need? |
| Relevance - Alignment with Government Priorities | How do DTFP objectives and priorities support the achievement of current Government of Canada priorities and align with Health Canada’s strategic priorities and outcomes? |
| Relevance - Alignment with Federal Roles and Responsibilities | Are DTFP activities aligned/congruent with Health Canada’s jurisdictional, mandated and/or legislated role in a federated system? |

² Under Section 11 of Quebec’s contribution agreement there are no requirements to conduct an interim and final evaluation and the Province is only required to submit data that is currently on hand and of public record.

³ The original intent in planning DTFP was that all projects would have to do an interim and final evaluation. However, due to the delays in getting some contribution agreements signed, funding released and projects staffed, the Program decided to eliminate the requirement to conduct an interim evaluation for some projects where these delays were experienced.

| Evaluation issues | Evaluation questions |
|-------------------------------------|--|
| Performance – Effectiveness | <p>Did DTFP produce outputs, as per the evaluation matrix, for systems and services projects?</p> <ul style="list-style-type: none"> • Have knowledge exchange products and tools been produced? • Have there been opportunities for linkages and exchanges of knowledge? • Have evaluations of substance abuse treatment systems projects been conducted? • Is there evidence of new or enhanced early intervention services? <p>Did DTFP systems projects achieve the expected immediate outcomes?</p> <ul style="list-style-type: none"> • Is there evidence of enhanced collaboration? • Is there evidence of enhanced PT commitment to effect systems change? <p>Did DTFP services projects achieve the expected immediate outcome?</p> <ul style="list-style-type: none"> • Was there evidence of enhanced PT capacity to deliver evidence-informed early intervention services? <p>Did DTFP systems projects achieve the expected intermediate outcomes?</p> <ul style="list-style-type: none"> • Is there evidence of increased availability of and access to evidence-informed practice information? • Is there evidence of increased PT capacity to evaluate the performance of substance abuse treatment systems? <p>Did DTFP services projects achieve the expected intermediate outcome?</p> <ul style="list-style-type: none"> • Is there evidence of increased availability/access to evidence-informed early intervention treatment programs and services? <p>Did DTFP achieve the expected long-term outcome?</p> <ul style="list-style-type: none"> • Is there evidence of strengthened evidence-informed substance abuse treatment systems and services? |
| Performance -Efficiency and Economy | <p>Were DTFP resources used effectively and efficiently to maximize the achievement of outcomes?</p> <ul style="list-style-type: none"> • What were the costs in relation to DTFP delivery? • Was there evidence of efficiencies gained? • Was there evidence of leveraged funds? |

3.3 Evaluation Methodology

The evaluation incorporated multiple lines of evidence, as described in Table 3, combining qualitative and quantitative information to ensure a balanced analysis of the relevance and performance of the Program. The data from each line of evidence were summarized under the appropriate evaluation issue and question, and then triangulated to substantiate the findings and conclusions.

Table 3: Lines of evidence and information sources

| Line of evidence | Sources |
|---|--|
| Literature and jurisdictional review | Over 90 documents were reviewed including academic and grey literature. In addition, an international jurisdictional review was conducted of four other countries' drug treatment strategies (Australia, Denmark, USA, and Switzerland). The purpose of the review was to compare and contrast Canada's activities with similar countries in order to assess relevance of the DTFP. |
| Document and administrative file review | <p>This review addressed the evaluation issues related to relevance and performance. Two categories of program documents were reviewed:</p> <ul style="list-style-type: none"> • Program-specific documents provided information on the rationale of the DTFP and its alignment with government priorities, as well as information on program implementation. Moreover, the review of these documents informed evaluation issues concerning effectiveness, efficiency and economy. • Project-level documents provided information on specific details of the funded projects. The review of project documents included: <ul style="list-style-type: none"> - project database review where randomly selected files were assessed to provide a profile of the projects/recipients funded under the DTFP; and - project file review of randomly selected projects including: proposals; situational analyses/environmental scan reports; progress reports; project-level performance measurement and evaluation plans; project progress reports; key financial and management documents; and available project-level interim evaluations. <p>In addition, the review included documents such as the <i>Canada Health Act</i>, <i>Department of Health Act</i>, <i>Controlled Drugs and Substances Act (1996)</i>, 2003 Health Accord, federal budgets, Speeches from the Throne, Reports on Plans and Priorities (RPP), Departmental Performance Reports, and Health Canada's Program Alignment Architecture (PAA).</p> |
| Key informant interviews | <p>The interviews addressed evaluation questions related to relevance and performance. The breakdown of interviewees by type of key informant is as follows:</p> <ul style="list-style-type: none"> • Six program representatives. • 47 project representatives (funding recipients – PT representatives and project coordinators) from all provinces and territories, with the exception of Quebec, and from 3 national projects. 23 project representatives were from systems projects and 24 were from services projects. These interviewees represented 12 systems projects (including 3 national projects) and 14 services projects (including 2 closed⁴ projects). • Five academics/experts in the field of drug treatment. |
| Online survey | <p>The online survey included DTFP stakeholders⁵ (e.g., knowledge exchange and product users, participants in collaborative working arrangements, front-line service providers). Purposive/judgement sampling and snowball sampling techniques were used. The approach relied upon the opinions of knowledgeable individuals to determine who should be invited to participate in a survey. Fifteen primary contacts were asked to prepare a contact list of relevant individuals for their specific project(s). Nearly all primary contacts opted to send out the survey invitations directly, rather than providing the list of individuals to the evaluators.</p> <p>A total of 276 participants completed the survey. The response rate was 31% based on approximately 881 survey invitations.</p> |

3.4 Limitations of the Data

In considering the evaluation findings, the limitations described below should be considered.

Limitation:

A program-specific central database/system to support program-wide performance monitoring and reporting was not available. While a departmental Grants & Contributions database did exist, the level of information contained in this database was not sufficient to inform the evaluation at the level required by the DTFP's evaluation matrix.

⁴ "Closed" projects were developmental projects that provided funding for the creation of DTFP funding proposals. As a result, these projects were not required to produce an evaluation plan or evaluation report.

⁵ The ultimate target group for the DTFP, illicit drug users, was not surveyed.

Additionally, there were some differences in outputs and indicators in the Program's Results-based Management and Accountability Framework (RMAF), developed in 2009, compared to the evaluation matrix developed for this evaluation. As a result, some data specified in the evaluation matrix had not been collected.

Mitigation:

The evaluators worked with program representatives to create a database using Excel in an attempt to create a performance measurement story at the project level. The evaluators also undertook a detailed file review of 20 of the 27 projects.

Limitation:

The evaluators were not able to use a probability sampling method to obtain a representative sample for the online survey.

Mitigation:

Survey data were triangulated with other lines of evidence to ensure greater confidence in the findings.

Overall, the findings presented in this evaluation can be relied upon.

4. Findings

This section of the report presents the evaluation findings on relevance and performance, organized according to the evaluation issues.

4.1 Relevance

4.1.1 Continued Need for the Program

The evaluation confirmed a continued need for the Program – rates of illicit drug use continue to be highest amongst youth and marginalized groups in Canada, and illicit drug use is linked to a range of legal, social and health problems which can be costly to individuals and society.

Across Canada the rate of 'past year' illicit drug use is 11% nationally, ranging from 8% in Saskatchewan to 14% in Nova Scotia.³ Rates of illicit drug use continue to be highest among youth (15-24 years of age) and marginalized groups (e.g., Aboriginal people and street-involved/homeless youth) compared to the general population.⁴ Interviewees, particularly those from northern and remote areas, noted that prior to DTFP there were limited treatment resources targeted at youth and marginalized groups.

Illicit drug use is linked to a range of legal, social and health problems which can be costly to individuals and society.⁵ Some impacts can be subtle, indirect and long term, for example, a health disorder or deteriorating work performance after years of chronic use. Other effects are often dramatic and acute, for example, domestic violence, alcohol or drug impaired driving collisions, or injection drug use in public places. Canadians view criminal activity as the area most impacted by drugs⁶ with research both in Canada and internationally showing that a significant proportion of those apprehended for a range of criminal offences are frequently illicit drug users.⁷ Many crimes are committed by those who are under the influence of drugs and/or alcohol. For example, one study found that 30% of federal inmates committed their most serious crime at least under the partial influence of drugs.⁸ Additionally, certain crime, particularly property-related crime, is often committed to obtain money to purchase drugs.⁹ Moreover, drug offences have been linked to organized crime, street gang activity¹⁰ and prostitution.¹¹

In terms of health impacts, there are numerous and potentially serious health consequences associated with drug abuse. Some of these can occur when drugs are used at high doses or after prolonged use. Others, however, may occur after just one use including, for example, a variety of infectious illness (e.g. blood borne infections such as hepatitis C and HIV/AIDS), health issues affecting the cardiovascular, respiratory and gastrointestinal systems, as well as liver and kidney damage.¹²

Such effects represent a significant drain on Canada's economy in terms of both its direct impact on the health care and criminal justice systems, and its indirect impact on productivity as a result of premature death and ill health. The Department of Justice Canada's 2008 report *Costs of Crime in Canada* estimated the annual social and economic costs associated with illicit drug use at \$8.6 billion, with the biggest losses being related to productivity (at \$5.3 billion in productivity losses in the workplace or at home resulting from premature death and disability), followed by \$2 billion in justice-related⁶ costs¹³.

The benefits from substance abuse treatment have been found to extend beyond the reduction in substance abuse, to areas that are important to society such as reduced crime, reduced risk of infectious illness/diseases, and improved social function. Government-funded projects targeted at reducing the use of illicit drugs through health and social programs, such as those designed to prevent and treat substance abuse, achieve greater financial and social benefit for their communities than those focussing on supply reduction and law enforcement activities.^{14,15}

Recent research conducted by the World Health Organization (WHO) indicates that drug abuse is a result of a complex multi-factorial interaction between repeated exposure to drugs, and biological and environmental factors.¹⁶ The National Institute on Drug Abuse (NIDA) found that more than half of people who have drug problems also have a mental health problem, which includes conditions such as depression, anxiety, bipolar disorder, attention-deficit/hyperactivity disorder, or antisocial personality disorder.¹⁷ The literature review and interviews revealed that the focus of drug treatment programs in Canada and in other developed countries is shifting

⁶ Includes expenses for police, courts and correctional services.

away from treating drug use as an isolated problem and moving towards treating drug addiction in relation to other concurrent issues such as alcohol use along with mental health issues, homelessness, prostitution, etc. The shift in treatment programs was corroborated by stakeholders who indicated that many of the funded projects attempted to address drug use/abuse within a broader spectrum of co-occurring issues – in particular mental health.

4.1.2 Alignment with Government of Canada and Health Canada priorities

The evaluation found that DTFP objectives are aligned with Federal Government priorities and Health Canada strategic priorities.

Several corporate documents outlined the importance of drug treatment funding, supporting DTFP's alignment with the priorities of the Government of Canada and Health Canada. In addition, stakeholders consulted as part of the evaluation agreed that DTFP was consistent with federal and departmental priorities.

Government of Canada

The 2007 Speech from the Throne stated: “Our Government will implement the National Anti-Drug Strategy (NADS) giving law enforcement agencies powers to take on those who produce and push drugs on our streets. In addition to tougher laws, our Government will provide targeted support to communities and victims. It will help families and local communities in steering vulnerable youth away from a life of drugs and crime, and the Anti-Drug Strategy will help to treat those suffering from drug addiction”.¹⁸

In October 2007, the Federal Government unveiled the NADS with the goal of introducing more effective measures to combat drugs and promote safer and healthier communities. Along with other partners under the NADS, the DTFP supports the priorities of the Government of Canada in relation to illicit drugs.

Stakeholders consulted as part of the evaluation indicated that DTFP was viewed as the Federal Government's key commitment to treating and supporting Canadians with drug addiction issues.

Health Canada

A review of previous Health Canada Reports on Plans and Priorities (RPP) supported the importance of drug treatment funding. For example, the 2012-2013 RPP states: “Health Canada will work with the Department of Justice and other partners under the National Anti-Drug Strategy (NADS) and will support the treatment and prevention of substance abuse...”¹⁹

DTFP is aligned with two key departmental strategic outcomes: “Canadians are informed of and protected from health risks associated with food, products and substances and environments, and are informed of the benefits of healthy eating” and “A Health System Responsive to the Needs of Canadians”.²⁰ DTFP is also consistent with the Health Canada organizational priority “Promote Health System Innovation”; it aims to work with partners, including provinces, territories and other health care partners, to improve the effectiveness and efficiency of the health system.²¹

4.1.3 Alignment with Federal Roles and Responsibilities

Health Canada has a national coordinating role in supporting more effective drug abuse systems and services.

While the provinces and territories are primarily responsible for the delivery of health care, the Federal Government supports that provincial/territorial role through providing transfer payments, establishing national standards through the *Canada Health Act*, and undertaking other health-related functions outlined in the *Department of Health Act*, such as conducting public health research and cooperating with provinces and territories on efforts to improve public health.²² The federal role in supporting other health-related functions includes several types of policy levers, such as grants and contributions programming, where the Federal Government provides funding to provinces, territories or other organizations to pursue particular policy commitments, promote innovative practices and generally provide federal leadership on health-related issues. Health Canada is the department responsible for administering these federal activities.²³ Therefore, as a targeted contribution initiative, the DTFP is aligned with the federal role in health care by providing leadership, promoting health care system innovation, and supporting federal/provincial/territorial coordination and collaboration to improve the health care system.

Further, the NADS Implementation Evaluation (2010) found that provinces and territories tended to be focused on substance abuse in general rather than abuse of illicit drugs.²⁴ As such, it could be argued that there was a role for the Federal Government under the NADS, including DTFP, to target illicit drugs more specifically.

A majority of the stakeholders consulted agreed that Health Canada had a national coordinating role to play in supporting more effective drug abuse treatment systems and services. Some interviewees indicated that Health Canada was uniquely positioned to make connections across jurisdictions by supporting the exchange of knowledge between key stakeholders. They also suggested that connecting across jurisdictions was a way to reduce duplication because of the opportunity to share best practices and lessons learned.

4.2 Performance – Effectiveness

The findings of this evaluation, as well as those from the 2011 DTFP Implementation Evaluation, indicated that there were delays in implementing some projects, primarily due to the time required to obtain approvals at both the federal and PT level. In spite of these delays, the evaluation found evidence that DTFP had made progress in producing outputs and outcomes.

4.2.1 Achievement of Expected Outputs

The findings related to project outputs from both systems and services projects are provided in the following section.

(i) Knowledge exchange products and tools (Systems output)

The evaluation found evidence that a variety of knowledge exchange products and tools were developed as the result of DTFP-funded projects.

The project file review found evidence that a wide variety of knowledge exchange products and tools had been developed by the DTFP-funded projects. Although this output related to the systems projects, there was evidence that a number of services projects had also produced knowledge exchange products and tools. For systems projects, knowledge products and tools included: standardized models/tools, and evidence-based practice guidelines for identification, knowledge promotion, referral and treatment of individuals with drug abuse issues. For services projects, the file review found evidence of knowledge products and tools related to training and capacity building (for example training manuals, programs and curriculum), as well as new policies and procedures for service delivery based on evidence-informed knowledge and practice, and new competency-based HR models for treatment services.

All but one interview respondent provided details on the knowledge products and tools that were developed by the project in which they were involved. The knowledge products and tools described were consistent with what was found in the file review. Over 80% of the survey respondents agreed that the DTFP funding enabled them to increase the number of knowledge products and tools available to them or to their organization and strongly agreed or agreed that the knowledge products and tools were "useful" and "appropriate".

With an emphasis on specific products and tools, respondents indicated that a range of products and tools were useful or will be useful when they are complete, for example:

- Services respondents tended to be most interested in training curriculum (64%), evaluation planning tools (57%) and evidence-based reports (50%).
- Almost three-quarters of PT systems respondents (73%) have used or will use evidence-based reports, and 66% indicated they have used or will use standards, manuals and guidelines.
- A majority of respondents from national projects indicated that they will use or have used evidence-based reports (66%), as well as standards manuals, guidelines and strategic plans (61%).

The majority of experts were aware of knowledge products and/or tools produced through the DTFP, and several had also used them. One of the experts indicated that the Program had not done enough to disseminate knowledge products and tools.

(ii) Opportunities for linkages and exchange of knowledge (Systems output)

The evaluation findings indicated that both the systems and services projects have resulted in increased opportunities for linkages and exchanges of knowledge.

The review of selected files found evidence of a wide variety of opportunities for linkages and exchanges of knowledge within and across DTFP-funded projects. All of the systems projects, including national projects, involved collaboration among a number of key stakeholders in order to create more integrated drug treatment systems and to support the dissemination of evidence-based practices to improve the delivery of substance abuse treatment.

Approximately 85% of survey respondents indicated that DTFP projects had increased opportunities for knowledge exchange and developing linkages, either for themselves or for their organization. The most common types of linkages identified were partnerships, collaborations, networks and cross-sectorial consultations. Respondents also reported widespread use of knowledge exchange meetings, training opportunities and communities of practice.

More than 80% of survey respondents felt that they had benefited from opportunities for linkages and exchanges of knowledge either “extensively” or “occasionally”. Most survey respondents who indicated having benefited from these opportunities were “very satisfied” with the overall quality and relevance of the information being exchanged, and the range of subject matters covered. Of the five experts consulted, three had participated in knowledge exchange initiatives/networks that were funded by DTFP and all of them indicated that it was a positive experience.

Although this output relates primarily to systems projects, the evaluation found that services projects had also created opportunities for linkages and exchanges of knowledge outputs. These included workshops and working groups, protocols, partnerships with other agencies and services, collaborations with school systems and other jurisdictions, and training programs which had been developed and delivered.

In terms of barriers to this output, some interview respondents noted that the program could have done more to facilitate the exchange of information and findings across the projects. The DTFP funded the Canadian Centre on Substance Abuse project (CCSA) in order to assist in this regard. According to interview respondents, while the CCSA had done some work to share findings across projects, the program could have taken a stronger role in summarizing and disseminating information from DTFP projects.

(iii) Evaluations of substance abuse treatment systems (Systems output)

DTFP-funded projects are producing evaluations of substance abuse treatment systems.

DTFP has evaluation requirements throughout the project phases including an evaluation plan and logic model, an interim evaluation and a final evaluation. All required⁷ DTFP projects submitted evaluation plans as part of the proposal process. The review of project files found that five of the ten systems projects⁸ had completed and submitted interim evaluation reports. Those projects that did not submit an interim evaluation report were exempted from the requirement in

⁷ Under Section 11 of Quebec’s contribution agreement there are no requirements to conduct an interim and final evaluation and the Province is only required to submit data that is currently on hand and of public record.

⁸ This output relates specifically to systems projects. Seven of the eight services projects reviewed, however, had also completed interim evaluation reports.

their contribution agreement due to the late start of their project. At the time of conducting this evaluation, no final evaluations had been completed, given that all but two⁹ projects were still in progress.

In terms of evaluation planning, early on in the proposal review process the program identified a common need, among the majority of DTFP-funded projects, for more support in evaluation planning. Responding to this need, the program hired an evaluation consultant to support project leads. In these instances, the program allowed the projects to submit their evaluation plans after the proposal approval but prior to the release of funding. These efforts and supports were reviewed positively by those consulted for this evaluation.

Some of the interview respondents from DTFP-funded projects described difficulties with evaluating performance and tracking outcomes. Several project representatives indicated that they lacked dedicated human resources and/or expertise in evaluation. Some projects addressed this by hiring third party firms to conduct evaluations. Almost all projects (both systems and services) experienced significant difficulty using the reporting templates provided by the program.

In terms of evaluation results, in its leadership role, the DTFP program was responsible for identifying common issues and best practices emerging from project evaluation results (for both systems and services), then synthesizing and disseminating the information. According to DTFP program staff, there had been limited evaluation results to share and disseminate since none of the projects have been completed.

(iv) New or Enhanced Early Intervention Services (Services output)

DTFP-funded projects resulted in new or enhanced treatment services in regions across Canada, as well as in Vancouver DTES.

Early intervention refers to specific measures or interventions undertaken to reach at-risk populations or populations already engaged in harmful behaviours or practices. Intervening early is essential for decreasing the psychosocial consequences that accompany substance abuse and that can ultimately disrupt the educational, occupational and social development of youth.²⁵

Services projects are focused on improving service delivery (including improved early intervention services) and providing those in need with better access to available treatment. All of the services files reviewed contained evidence that projects had led to either the enhancement of existing services or introduction of new services as a result of DTFP funding. A number of projects however, had not been able to expand their services and/or reach as planned given delays in implementation and an overall shortage of resources, according to project representatives. Examples of new or enhanced services included:

- Creation of mobile early intervention teams offering services to at-risk youth.
- Placement of outreach workers in new regions.

⁹ The two completed projects were 'developmental projects' that provided funding for the creation of the DTFP project proposals, therefore, these projects were not required to do evaluations.

- Expansion of outreach services.
- Increasing the number of hours that trained addictions counsellors spend in early treatment intervention for youth in high school settings.
- Hiring additional staff and creating inter-professional health teams.

According to survey results:

- Over two-thirds of respondents (67%) indicated that the project was successful in improving or expanding pre-existing drug treatment programs/services for at-risk individuals in their region.
- Almost two-thirds of respondents (64%) believed the project was successful in introducing new drug treatment programs for at-risk individuals in their region.

Services for Vancouver Downtown East Side:

The evaluation found evidence that DTFP funding had helped to increase the provision of services to highly marginalized and vulnerable populations in DTES:

- Burnaby Centre Assertive Community Treatment Team – This project served clients with concurrent disorders, prioritizing those with the greatest demand for health services--in particular, those with tertiary, acute or emergency mental health issues. The type of treatment services and related supports included: psychiatric intervention and treatment, assertive case management, psycho-social rehabilitation, outreach contact, crisis intervention, some primary care, vocational drug treatment, and peer support.
- Residential Program/Day Program for the Female Survival Sex Workers (‘The Rainier’) Project – This project focused on women involved in the survival sex trade¹⁰ in Vancouver as well as on individuals who have multiple and severe risks to their well-being. Integrated services included community engagement, facilitating connections with medical services, aboriginal services, and community recreation. In addition, the project facilitated mentorship, training and employment opportunities through community work placements in a variety of local organizations.

4.2.2 Achievement of Expected Outcomes

In the following section, systems and services projects are described separately.

4.2.2.1 Systems Projects

Immediate Outcomes

(i) Enhanced Collaboration

Many DTFP projects have created, and are benefiting from, opportunities for enhanced collaboration.

¹⁰ Including Aboriginal women as a target population, although the scope of eligibility is all women currently involved in the sex trade in the DTES.

The 2012 Evaluation of the NADS stated that the DTFP was one of the components that had placed the greatest emphasis on collaboration as a means to improve responses and share knowledge regarding treatment issues.

A review of program documents found that the DTFP was built on a collaborative approach and placed considerable emphasis on funding projects that support collaboration across treatment systems to encourage sharing knowledge and best practices. Even in the program planning stage, stakeholders across jurisdictions had actively collaborated in the design of the Program. Stakeholders consulted as part of this evaluation indicated that collaborative planning had been an effective mechanism for encouraging an inter-jurisdictional approach.

In terms of DTFP-funded projects, the evaluation found evidence that they were enhancing collaboration among key stakeholders and jurisdictions/regions within PTs, and across PTs in the case of national projects. A majority of survey respondents and interviewees indicated that opportunities for collaboration had increased as a result of the DTFP, and they had benefited from them. Almost three quarters of survey respondents (73%) indicated that collaborative opportunities have been made available through the DTFP. According to those consulted through the survey and interviews, the national systems projects were viewed positively as an effective mechanism for encouraging a national perspective through an inter-jurisdictional approach.

The review of project files found that many DTFP-funded projects had developed knowledge exchanges to collaborate in sharing evidence-based practices in relation to the identification, referral and provision of addiction treatment services. In many cases, partnerships were being explored and systems examined in relation to co-dependency/co-occurring issues. Additionally, all systems projects that were reviewed as part of the evaluation had developed a working/reference group or steering committee to bring together key partners and stakeholders across sectors and organizations as part of project implementation.

(ii) Enhanced PT Commitment to Effect Systems Change

There was PT involvement in systems projects, including investments of time, infrastructure and support for implementation.

The evaluation found some evidence of PT commitment to effect systems change. The project file review found evidence of PT involvement in the projects in terms of time invested and infrastructure provided (e.g., office space). This included work in relation to oversight, forming and supporting networks, and dissemination of information, best practices and lessons learned. There were also some instances of PTs and partner organizations providing supplementary financial resources to support projects. For example, one provincial government funded the development of an outcome monitoring system (providing approximately 38% of the funding), and a non-governmental organisation working with another project committed to raising additional funds.

The interviews, however, revealed mixed views on PT commitment to effect system change in DTFP treatment systems investment areas. Representatives of six systems projects indicated that they did not have confirmation of a PT commitment – particularly if DTFP were to discontinue funding. Representatives of three systems projects indicated that they had PT commitment which they measured by one or more of the following: the provision of additional financial resources and in-kind support, supporting the formation of and participation in knowledge exchange networks/working groups, and a willingness to implement the outcomes of the project including new systems, standards and tools.

Intermediate Outcomes

Although none of the systems projects had been completed at the time of this evaluation, many had advanced far enough to show evidence of the achievement of intermediate outcomes.

(i) Increased Availability of and Access to Evidence-Informed Practice Information

There was evidence that availability of and access to evidence-informed practice information has increased.

The evaluation found evidence of the creation and dissemination of evidence-informed practice information. The project file review found that evidence-informed practice information had been produced including: literature reviews, research on best practices for intake, concurrent disorders and treatment/withdrawal management, revised policies, procedures, guidelines and standards, training programs and tools in evidence-based decision-making and change management and needs-based planning tools/models. Practice information was disseminated using vehicles such as knowledge exchange websites, web-based networks and knowledge exchange working groups/forums.

These findings were supported by the interview and survey results. The majority of program representatives interviewed as part of the evaluation indicated that DTFP funding led to an increased availability of research and innovative/best practices in drug treatment. Representatives of two systems projects described how evidence from research had been used to inform pilots that were subsequently introduced into practice. Another respondent described how culturally informed best practices were used to develop workshops and toolkits for improving outreach and services to Aboriginal communities.

Most interviewees agreed that the drug treatment resources developed through the projects were easily accessible and that evidence-informed practice information was more readily available. Many project informants noted that networks, communities of practices and renewed systems had helped to increase the availability and access to evidence-informed services and systems and, overall, had improved system response. At the national level, it was felt that DTFP funding had resulted in improved information on treatment systems. Project representatives indicated that DTFP had made it possible to use evidence to inform practice and strengthen services and to provide more innovative and targeted services to highly marginalized and hard-to-reach groups.

Over 75% of survey respondents agreed that the DTFP project had been either very successful or somewhat successful in: increasing the availability of evidence-informed practice information; making it easier to access evidence-informed practice information; and improving the quality of evidence-informed practice information.

(ii) Increased PT Capacity to Evaluate the Performance of Substance Abuse Treatment Systems

There was evidence that PT capacity to evaluate the performance of substance abuse treatment systems has increased

As discussed above, the program supported funding recipients in the preparation of their evaluation plans and logic models through a contracted evaluation resource. Some project representatives indicated that this support was a positive contribution to developing their capacity to evaluate systems projects. In addition, the project file review identified a number of activities that related to evaluation and performance measurement in the area of drug treatment. These included: standardized performance measurement and evaluation tools, establishment of baseline measures and provincial benchmarks for treatment and systems-wide changes, staff training in evaluation and performance measurement, and the establishment of project databases to support ongoing monitoring. DTFP has built in requirements at the proposal stage for funded projects to dedicate resources to monitoring and evaluation, and the approval of funding requires an approved logic model and evaluation plan.

At the time of this evaluation, interim evaluations had been produced for half of the systems projects examined in the project file review. Based on the number, as well as the overall quality of the interim evaluation reports reviewed (assessed based on the level of rigor and the use of multiple lines of evidence as is consistent with current evaluation best practices), there is evidence of increased evaluation capacity. Feedback obtained through interview consultations supported this finding; project representatives indicated that, as a result of DTFP funding, there was improved capacity to create logic models and evaluation frameworks, and to undertake performance measurement and evaluations. Several project representatives noted that DTFP's evaluation planning and conduct requirements had led to a better understanding of the linkages between program activities and outcomes, as well as an improved ability to track and report on performance.

Survey results indicated that 75% of respondents from systems projects (87% for national projects specifically) believed that the project was either very or somewhat successful in improving understanding of how to measure the quality or impact of activities. While the outcome referred to treatment systems specifically, the majority of respondents from services projects also indicated that the capacity to evaluate substance abuse services had increased.

4.2.2.2 Services Projects

Immediate Outcome

(i) Enhanced PT Capacity to Deliver Evidence-Informed Early Intervention Services

DTFP funding has helped to build capacity to deliver evidence-informed early intervention treatment programs and services.

Some project representatives interviewed as part of the evaluation described how they had built their own internal capacity to deliver services, while others indicated that their focus had been on developing ‘front-line’ capacity to deliver early intervention services. These projects targeted front-line staff most likely to come into contact with youth (such as youth outreach workers, counsellors and staff at youth drop-in centres and shelters).

The review of project files found that DTFP had contributed to enhancing PT capacity to deliver evidence-informed early intervention treatment programs and services. Examples included:

- Delivery of a mentorship program providing youth service professionals with practical hands-on knowledge on how to intervene and appropriately refer youth through the continuum of care to ensure seamless access to services.
- Brief Intervention Training sessions to approximately 70 front-line workers in child and family services and community health services. Post-training survey results indicated that, on average, participants had moved from a self-reported “no ability” (0%) to implement an early intervention program regarding youth and substance abuse, to 60-75% ability at the conclusion of the five-day training. Participants were also tracked so they could receive support to further develop their skills.
- Development of an information package of youth services including screening, brief intervention and referral that was based on a needs assessment and review of best practices.
- Issue specific training sessions for front-line workers including substance abuse screening, fetal alcohol spectrum disorder, therapeutic relationships, critical incident stress management, navigating government systems, building cultural competency, substance abuse and concurrent disorders.

The 2012 evaluation of the National Anti-Drug Strategy supported these findings, indicating that the DTFP had enhanced the capacity of PTs to plan and deliver a range of treatment services and programs across Canada.

The survey conducted as part of this evaluation found that 84% of services respondents believed their ability to deliver evidence-informed drug treatment programs or services had been improved as a result of the DTFP.

Intermediate Outcome

(ii) *Increased Availability/Access to Evidence-Informed Early Intervention Treatment Programs and Services*

The evaluation found evidence of increased availability of and access to evidence-informed early intervention programs and services.

The evaluation matrix developed for the evaluation identified “New or Enhanced Early Intervention Services” as an output for the services component of the DTFP. The Program’s RMAF presented “Increased Availability/Access to Evidence-Informed Early Intervention Treatment Programs and Services” at the outcome level. As a result, there is some repetition in reporting in this section and section 4.2.1.

The project file review found that the availability of, and access to, evidence-informed early intervention programs and services had increased. For example:

- Enhancements to a school-based early intervention program that targeted youth who were at the beginning stages of substance involvement in remote communities. It has been delivered to over 40 community service providers, including 20 from First Nation communities. The program used a community development approach to engage other community partners. In addition, 9 communities delivered the first round of the 10 week/10 module in-school program to selected students.
- Delivery of evidence-informed early intervention services and the development of substance-use youth outreach/counsellors in three communities, two of which now offer outreach programming that did not exist before.
- Creation of five mobile teams to provide enhanced, early intervention and improve the offering of services to at-risk youth, including young men and street youth with concurrent disorders.
- An increase (by 56%) in the number of hours that trained addictions counsellors spend in early treatment intervention for youth in high schools. This was equivalent to over 600 hours per week of addictions counsellor time across 55 schools. Over 1,000 individual students have been or were being treated and over 400 parents have been seen in the context of their child’s treatment. Additionally, funding allowed one non-traditional academic setting to more than double the number of addictions counselling hours attached to its schooling program for young mothers to two days per week.
- Services in Vancouver’s DTES (as described in section 4.2.1).

Representatives of approximately two-thirds of the services projects indicated that their PT was delivering new services which had not been provided prior to DTFP and that their focus on horizontal integration and capacity building among front-line workers has led to enhanced service delivery. They also stated that increasing the availability of evidence-informed drug treatment programs has made it easier for at-risk individuals in their region to access drug treatment programs.

A number of services projects reported that they were able to use their evidence-based practice knowledge to assist in the development of operational policies and procedures, competency-based HR tools, and standardized program policies and procedures (including assessment tools and intake processes). Representatives of one services project noted that enhancements in capacity and services have led to an increase/improvement in referrals and a reduction in their wait-list. Three services project representatives indicated that DTFP had enabled projects to use evidence to inform practice and strengthen service delivery models and overall services while also providing more innovative and targeted services to highly marginalized and hard-to-reach groups. It was suggested that these services need to be expanded into more communities/regions.

These findings are supported by the survey evidence in which two-thirds of services respondents (67%) indicated that the project was successful in improving or expanding pre-existing drug treatment programs for at-risk individuals in their region. Similarly, 65% of respondents believed that the project was successful in helping at-risk individuals in their region more easily access drug treatment programs.

Long-term Outcome

(i) *Strengthened evidence-informed substance abuse treatment systems and services*

Given the status of project implementation it is largely premature to assess achievement of the long-term outcome. Interview respondents indicated that projects are not far enough along in the implementation process to be able to assess the long-term outcome. However, DTFP's program theory appears to be consistent with findings from the literature and jurisdictional review – particularly the system based approach to increase capacity, encourage national and multi-jurisdictional collaborative initiatives, facilitate the sharing and implementation of evidence-informed practices into treatment systems, develop capacity of front-line workers to identify persons with co-occurring disorders and those with drug use issues, and address immediate treatment delays and gaps for at-risk individuals.

DTFP was viewed by some interviewees as giving national support to mental health and addictions issues which had helped change provincial perspectives. A number of funding recipients noted that DTFP should expand its definition of drugs to include alcohol and prescription drugs.

4.2.3 Performance Measurement

Although there is some performance information available, several issues related to performance measurement were identified.

The evaluation found that some performance indicators defined in the evaluation matrix were not consistent with the common indicators developed at the outset of the DTFP. Additionally, performance indicators were not always reported consistently across projects. For example, some project reports referred to common indicators, some reported indicators consistent with the

evaluation matrix, and others reported progress through alternative metrics. Project representatives expressed dissatisfaction with, and difficulty in using, DTFP reporting systems and templates, including the inability to manipulate primarily qualitative information in an Excel template. According to program staff, an alternative Microsoft Word version of the template was made available as of summer 2012. The evaluation also found that the program lacks a central database/system to support program-wide performance monitoring and reporting. According to program staff, the Excel template was intended only as a temporary measure while a formal performance measurement system was under development. DTFP did invest resources in the development of an Integrated Planning and Performance Reporting System (IPPRS). This was meant to be a database of performance information for DTFP as well as other Health Canada programs. At present, however, further investment in IPPRS has been put on hold. According to program staff, a departmental decision was made to use a new system being introduced for grants and contributions which includes a module for performance measurement as well. The performance measurement aspect of this system is to be developed as part of phase 2 starting in 2014.

As a result of these performance measurement issues, although the evaluation was able to report on examples of outputs and outcomes, it could not provide quantitative assessments (e.g., number of target groups reached, number of knowledge products and tools created).

4.3 Performance – Efficiency and Economy

The evaluation found that actual spending on contributions was approximately \$79M (67% of planned). There was some evidence of efficiencies gained and less duplication of effort through sharing of best practices and tools across projects, and leveraging of funds.

The demonstration of efficiency and economy is defined by the Treasury Board *Policy on Evaluation* (2009) as an assessment of program resource utilization in relation to the production of outputs and progress toward expected outcomes. This assessment is based on the assumption that departments have standardized performance measurement systems and that financial systems link information about program costs to specific inputs, activities, outputs and expected results.

The type of financial information provided for DTFP did not facilitate the costing of outputs. Consequently, an assessment of whether program outputs were produced efficiently, or whether expected outcomes were produced economically, was not possible. As a result, the evaluation provides observations on efficiency and economy based on findings from the key informant interviews, literature review, and available financial data.

DTFP had an overall budget of \$124.5M including a \$118M contribution budget.¹¹ Table 4 shows the planned versus actual spending for DTFP's contribution funding. The program reported that the unspent contribution budget was lapsed and returned to the Treasury Board (14%) or transferred to other program areas within Health Canada (19%). The program noted

¹¹ In 2009-2010 approximately \$2.5M in contribution funding was converted to Operations and Maintenance and then transferred to help establish the Health Canada Emergency Preparedness and Occupational Health Directorate.

that although lapses occurred in the early years, primarily due to delays in project approvals, some funds were re-profiled to future years and there have been no significant lapses since 2011-2012.

Funding by component area was consistent with planned expenditures; services projects received approximately 44% of DTFP contribution funding and systems projects received approximately 56%.

Actual operating expenditures for DTFP were the same as planned, although details related to the operating budget could not be disaggregated from the total budget of the Drugs Program since resources are allocated across its various programs in an effort to improve management efficiency.

Table 4: DTFP Planned versus Actual Contribution Funding

| DTFP | 2008-2009 | 2009-2010 | 2010-2011 | 2011-2012* | 2012-2013* | Total |
|---------|--------------|--------------|--------------|--------------|--------------|---------------|
| Planned | \$28,743,911 | \$29,250,088 | \$25,855,434 | \$17,113,123 | \$13,200,000 | \$118,098,748 |
| Actual | \$1,386,807 | \$5,942,719 | \$16,623,961 | \$27,902,174 | \$27,647,027 | \$79,502,688 |

* actual amounts include unspent funding from 2008-2010 that was re-profiled into 2011-2012 and 2012-2013.

Although efficiency and economy could not be quantitatively assessed, there was some qualitative evidence. Decreased duplication of effort was cited as a result of improved sharing of best practices and lessons learned. The national CCSA project was identified by the majority of project representatives as being a critical mechanism for connecting teams across the various projects in order to share information, best practices and lessons learned across jurisdictions from the DTFP projects. Other exchange networks were primarily focused on sharing information within the jurisdiction in which the project was located.

There was, however, limited evidence that research, best practices and knowledge products from the DTFP-funded projects were being analyzed or synthesized to feed back into the projects. Some interview respondents indicated that the program should be doing more in this area. The program noted, that in part, this is explained by the fact that projects have not yet been completed.

As discussed above (section 4.2.1), the program developed reporting templates and hired an evaluation consultant to assist project representatives in completing evaluation plans. DTFP interviewees agreed that this had been an efficient use of time and resources.

Some evidence was found that DTFP-funded projects (three systems projects and two services projects) had leveraged funds. These were primarily from the PT government and key partners and stakeholders such as non-profit organizations. Additionally, six projects provided examples of in-kind contributions such as infrastructure resources/office space, staff time and cost-sharing to support technology/systems development.

The literature review suggested that drug treatment programs are good value-for-money and that the resulting savings to society can be well in excess of funds invested.²⁶ Research indicates that treatment has a benefit-cost ratio of 7:1, with the largest amount of savings coming from reduced cost of crime and increased earnings (as well as reduced absenteeism, reduced tardiness, lowered on-the-job injuries, fewer mistakes and disagreements with supervisors).²⁷

5. Conclusions and Recommendations

The analysis of the information gathered for this evaluation resulted in conclusions about the relevance and performance of the DTFP which led to two key recommendations.

5.1 Relevance

The DTFP continues to address a demonstrable need. The objectives of the DTFP are aligned with Government of Canada priorities as a key partner under the National Anti-Drug Strategy. Health Canada is well positioned for its national coordinating role in supporting more effective drug treatment systems, and the DTFP supports two of Health Canada's strategic priorities.

The DTFP assisted in addressing issues related to illicit drug use both directly through funding of services, as well as indirectly through support for treatment systems. There is an ongoing need for action related to illicit drug use. Rates of use continue to be highest amongst youth (15-24 years of age) and marginalized groups (Aboriginal and street-involved/homeless youth) compared to the general population. Illicit drug use is linked to a range of legal, social and health problems which can be costly to individuals and society. The benefits from substance abuse treatment extend beyond the reduction in substance abuse, to areas such as reduced crime, reduced risk of infectious diseases and improved social function.

There is a legitimate role for the federal government in the DTFP, which stems from the *Department of Health Act*. It includes policy levers, such as grants and contributions, where the federal government provides funding to provinces, territories or other organizations to pursue particular policy commitments, promote innovative practices and generally provide federal leadership on health-related issues. Health Canada is uniquely positioned to make connections across jurisdictions by supporting the exchange of knowledge between key stakeholders. Connecting across jurisdictions reduces duplication because of the opportunity to share best practices and lessons learned.

5.2 Performance – Effectiveness

The DTFP has made progress in achieving its expected outputs and outcomes. Health Canada can, however, do more to facilitate the achievement of outcomes by moving beyond the role of funder, towards its coordination and leadership role. Additionally, improved monitoring and measurement of the program’s achievements would better enable the program to report on results.

The DTFP-funded projects are making progress in producing planned outputs and achieving outcomes. Projects have supported collaboration across treatment systems and the majority of systems projects have led to enhanced collaboration among key stakeholders and jurisdictions/regions. The national projects encourage a national perspective through an inter-jurisdictional approach. Systems projects have led to the creation and dissemination of evidence-informed practice information, and led to accessible drug treatment supports and resources.

DTFP services projects have led to increased availability of, and access to, evidence-informed early intervention programs and services. Additionally, both systems and services projects have improved capacity to evaluate substance abuse systems and services.

The achievement of these objectives could, however, have been better facilitated by the program moving beyond its role as project funder and taking on greater responsibilities in coordination and leadership. This would include more actively synthesizing, analysing, and disseminating the research, best practices and knowledge products from DTFP-funded projects to feed back into the projects.

Recommendation 1

Health Canada should strengthen its role of synthesizing, analysing and disseminating information regarding the DTFP project results.

A key barrier to reporting on the success of the program was the lack of consistent performance measurement data. Although common indicators were developed, performance information was not consistent across projects and the program lacked a national database/system to support performance monitoring and reporting. The program has taken steps to improve reporting systems and templates but further improvements to performance measurement would enable the program to better report on progress.

Recommendation 2

Health Canada should ensure that the DTFP implements an effective performance measurement strategy that includes financial data tracking and monitoring to ensure consistent performance reporting.

5.3 Performance – Efficiency and Economy

Although the available data did not facilitate a quantitative assessment of DTFP’s efficiency and economy, there were examples of operational efficiencies and less duplication of effort. In addition, the literature review suggested that drug treatment programs are good value-for-money and that the resulting savings to society can be well in excess of funds invested.

The demonstration of efficiency and economy, according to the Treasury Board *Policy on Evaluation* (2009), is based on the assumption that departments have standardized performance measurement systems and that financial systems link information about program costs to specific inputs, activities, outputs and expected results. The type of financial information provided for DTFP did not facilitate the assessment of whether program outputs were produced efficiently, or whether expected outcomes were produced economically. There was, however, some evidence of efficiencies gained and less duplication of effort (e.g., sharing best practices, tools and lessons learned across projects, and leveraging of funds). Additionally, the literature reviewed indicated that drug treatment programs are good value-for-money and that the resulting savings to society can be well in excess of funds invested.

Endnotes

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