Evaluation of the Canadian Centre on Substance Abuse’s Named Grant Activities 2011–2012 to 2014–2015

Prepared by
Office of Audit and Evaluation
Health Canada and the Public Health Agency of Canada

January 2016
List of Acronyms

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<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>CADUMS</td>
<td>Canadian Alcohol and Drug Use Monitoring Survey</td>
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<td>CCD</td>
<td>Cross Country Dialogues</td>
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<tr>
<td>CCSA / CCLT</td>
<td>Canadian Centre on Substance Abuse</td>
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<td>CACCF</td>
<td>Canadian Addiction Counsellors Certification Federation</td>
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<td>CCENDU</td>
<td>Canadian Community Epidemiology Network on Drug Use</td>
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<td>CECA</td>
<td>Canadian Executive Council on Addictions</td>
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<td>CAMH</td>
<td>Centre for Addiction and Mental Health</td>
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<td>CAR-BC</td>
<td>Centre for Addictions Research of British Columbia</td>
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<td>CFPC</td>
<td>College of Family Physicians of Canada,</td>
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<td>CIHI</td>
<td>Canadian Institutes for Health Information</td>
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<td>CIHR</td>
<td>Canadian Institutes of Health Research</td>
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<td>CMA</td>
<td>Canadian Medical Association</td>
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<td>CND</td>
<td>United Nations Commission on Narcotic Drugs</td>
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<td>DSCIF</td>
<td>Drug Strategy Community Initiatives Fund</td>
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<td>DTFP</td>
<td>Drug Treatment Funding Program</td>
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<td>EENet</td>
<td>Evidence Exchange Network</td>
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<td>EMCDDA</td>
<td>European Monitoring Centre for Drugs and Drug Addiction</td>
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<td>EWG</td>
<td>Evaluation Working Group</td>
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<td>FASD</td>
<td>Fetal Alcohol Spectrum Disorder</td>
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<td>FDNH</td>
<td>First Do No Harm</td>
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<td>FNIGC</td>
<td>First Nations Information Governance Centre</td>
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<td>FNIM</td>
<td>First Nations, Inuit, and Métis</td>
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<td>FPT</td>
<td>Federal Provincial Territorial</td>
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<td>HESA</td>
<td>House of Commons Standing Committee on Health</td>
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<td>CICAD</td>
<td>Inter-American Drug Abuse Control Commission</td>
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<td>LCBO</td>
<td>Liquor Control of Ontario</td>
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<td>LRDGs</td>
<td>Low Risk Drinking Guidelines</td>
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<td>MHCC</td>
<td>Mental Health Commission of Canada</td>
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<td>NADS</td>
<td>National Anti-Drug Strategy</td>
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<td>NAS</td>
<td>National Alcohol Strategy</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<td>NASAC</td>
<td>National Alcohol Strategy Advisory Committee</td>
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<td>NGO</td>
<td>Non-Governmental Organization</td>
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<td>NHTSA</td>
<td>National Highway Traffic Safety Administration</td>
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<td>NIDA</td>
<td>National Institute on Drug Abuse</td>
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<td>NNAPF</td>
<td>National Native Addictions Partnership Foundation</td>
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<td>PHAC</td>
<td>Public Health Agency of Canada</td>
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<td>PRA Inc.</td>
<td>Prairie Research Associates Inc.</td>
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<td>SIAST</td>
<td>Saskatchewan Institute of Applied Science and Technology</td>
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<tr>
<td>SBIR</td>
<td>Screening, Brief Intervention, and Referral</td>
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<td>SIS</td>
<td>supervised injection sites</td>
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<tr>
<td>SMART</td>
<td>Specific, Measurable, Achievable, Results-focused, Time-bound</td>
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<tr>
<td>SPSS</td>
<td>Statistical Package for the Social Sciences</td>
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<td>SWOT</td>
<td>Strengths, Weaknesses, Opportunities, Threats</td>
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<td>UNGASS</td>
<td>United Nations General Assembly on the World Drug Problem</td>
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<td>VNGOC</td>
<td>Vienna Non-Government Organization Committee</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Executive Summary

The Canadian Centre on Substance Abuse (CCSA) hired PRA Inc. to conduct an outcome evaluation of activities funded through a Named Grant from Health Canada, covering the period from 2011–2012 to 2014–2015. Although the evaluation of the Named Grant funded activities was the primary focus, a broader evaluation scope was used and included an examination of CCSA’s prevention and treatment activities which are an integral part of CCSA’s work. Recent outcome evaluations from both the Drug Treatment Funding Program (DTFP) and the Drug Strategy Community Initiatives Fund (DSCIF) were used to help inform the evaluation of these activities. The evaluation was scheduled for 2015–2016, as per the Public Health Agency of Canada/Health Canada approved Five-Year Evaluation Plan 2015–2016 to 2019–2020, and fulfills the requirements of the Financial Administration Act.

The evaluation piloted a new, joint, collaborative approach to evaluating national organizations funded by Health Canada. In the past, many national organizations conducted their own evaluations outside of the scope of Treasury Board requirements. Additionally, all initiatives had to be evaluated under the Departmental Five-Year Evaluation Plan. In an effort to be more deliberate and consistent in the approach to evaluating national organizations as well as respond to concerns regarding efficiency when there is duplication of effort, Health Canada and CCSA agreed to pilot this new collaborative approach. As part of this approach, the evaluation was jointly planned, implemented, and reviewed. Work was guided by an Evaluation Working Group (EWG) comprised of representatives from CCSA, Health Canada and the Office of Audit and Evaluation, to ensure the needs of both groups were addressed. The evaluation addresses key questions of interest to senior management within CCSA and Health Canada and aligns with Treasury Board of Canada’s 2009 Policy on Evaluation.

The evaluation used multiple lines of evidence, including a literature review, a review of documents and administrative data, key informant interviews, a survey of CCSA stakeholders, a focus group with provincial/territorial stakeholders, and two case studies. This report integrates the findings from all lines of evidence, draws conclusions based on themes identified, and makes recommendations.

Findings

Relevance

Continued need

The available data show that while the prevalence of illicit drug use is relatively low and has decreased or remained stable over the past decade, many Canadians use alcohol at rates exceeding the national low risk drinking guidelines for chronic and acute health effects. Furthermore, use and misuse of prescription opioids, as well as related harms, have become increasingly common in Canadian society. Overall, the available data suggest a continued need to take action to address substance abuse and related harms.
There is widespread support among stakeholders for addressing substance abuse and related issues at the national level, as well as support for a national approach that is distinct and independent from the federal government. Perceived benefits of a national approach include the ability to gather and share information and expertise across jurisdictions; the ability to leverage resources; the ability to coordinate stakeholders working in similar areas to avoid duplicating effort; and the ability to produce pan-Canadian resources that can be adopted or adapted by stakeholders based on their own needs and contexts.

**Alignment with federal roles and responsibilities**

CCSA’s legislated mandate aligns\(^1\) with federal roles and responsibilities, and in particular, with Health Canada’s mandate under the *Department of Health Act*. Furthermore, CCSA’s activities and expected outcomes are consistent with CCSA’s legislated mandate, as described in Section 3 of the *CCSA Act*.

**Alignment with federal priorities**

There is generally strong alignment among CCSA and federal priorities. However, there are some perceptions that CCSA is too well-aligned with the federal government, as a result of which it can be vulnerable to shifting focus on short notice or reluctant to take a different position from the federal government or challenge it on controversial topics, particularly harm reduction. Notwithstanding funding realities, ensuring that CCSA has the flexibility, when warranted by the evidence, to adopt an independent position vis-à-vis the federal government would be consistent with CCSA’s legislated mandate as an arm’s length organization that exists to serve the diverse interests of stakeholders in the substance abuse field.

**Alignment with other stakeholder priorities**

CCSA’s activities are generally responsive to gaps and needs in the field and well-aligned with the priorities of stakeholders. Areas that some stakeholders identified as meriting greater focus or allocation of resources by CCSA include prevention, harm reduction, and linkages and coordination between substance abuse and mental health services.

**Value-added**

CCSA’s unique value-added is its ability to bring together a diverse range of stakeholders, reconcile conflicting views, and work toward a solution that has broad acceptance by the field. This ability is seen as particularly valuable given the strong viewpoints and highly charged debate that characterize this policy area, and was attributed in part to CCSA’s position outside of the hierarchical structure of responsibility within which governments must operate. As a third-party agency with a broadly defined mandate and no real legislative authority, CCSA has the ability to interact in a non-threatening way with multiple partners and jurisdictions.

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\(^1\) For the purpose of this evaluation, alignment was interpreted as being both reflective of and complementary to federal roles, responsibilities, and priorities.
CCSA’s ability to gather and disseminate information is also widely seen as one of its key strengths and a unique value-added. This ability is seen as particularly valuable by smaller jurisdictions or organizations that may not have the capacity to research and/or generate such information and materials on their own. The availability of well-researched, credible information and standardized, evidence-informed resources provides a starting point that can be adopted or adapted to suit the unique contexts and circumstances of stakeholders.

In the absence of CCSA, stakeholders believe that there would be fewer evidence-informed resources available in the substance abuse field and less coordination/collaboration among sectors on substance abuse issues. Furthermore, stakeholders doubted whether, in the absence of CCSA, other organizations would step in and do the same work. Key informants agreed that no other organization shares CCSA’s national mandate or scope of activity, nor the network of contacts and credibility that it has established as a result of its more than 25 years of work in the substance abuse field.

**Performance**

**Implementation**

During the current Grant period, CCSA implemented most of its planned activities relating to its priority areas. A small number of planned projects were not undertaken due to funding constraints, data availability, and other factors. Specifically in the case of the First Do No Harm (FDNH) Strategy, CCSA responded to challenges in maintaining momentum in moving the recommendations in the strategy forward by adjusting its approach to implementation. The new approach has been endorsed by FDNH stakeholders.

The evidence available to this evaluation suggests that there may be different expectations and interpretations among Health Canada and CCSA representatives regarding the meaning of ‘implementation’, the limits of CCSA’s role and the extent and level to which it should be involved in changing policy, programs, and practice, suggesting a need to clarify CCSA’s role in this regard.

**Achievement of outcomes**

**Partnerships and coordination of effort**

There is general agreement among key informants that CCSA’s partners have increased in number and diversity since the 2010 evaluation of the Named Grant. However, quantitative comparisons were not possible due to changes in CCSA’s approach to tracking partnership information. Nonetheless, CCSA’s partners represent a diverse range of stakeholders and interests and are involved in a range of Named Grant, Drug Strategy Community Initiatives Fund (DSCIF) and Drug Treatment Funding Program (DTFP) funded activities. Further adjustments to CCSA’s contact database could enhance CCSA’s ability to report on the nature and extent of its partnerships.

There is evidence that coordinated action is taking place to address the harms of substance abuse. While direct financial contributions by external partners were lower in this Grant period as compared to the previous Grant, in-kind contributions were substantial: partners and stakeholders contributed over 28,000 hours of engagement time to CCSA activities between 2011–2012 and 2014–2015. Furthermore, activities are underway or have been implemented by stakeholders to address 39 of 41 National Alcohol Strategy recommendations, and 23 of 58 FDNH recommendations.
External key informants and two-thirds of survey respondents agree that the work of CCSA has improved coordinated action in the substance abuse field, and about half of survey respondents believe their own organization is more likely to work together with other stakeholders because of CCSA. While many stakeholders reported having worked together on joint initiatives with connections to CCSA, 41% reported that they have collaborated with other stakeholders on a joint initiative with no connection to the organization. Overall, these data suggest that while coordination can and does occur without any involvement by CCSA, CCSA is an important impetus for coordinated action.

**Recognition of CCSA as a leader**

CCSA is generally regarded by stakeholders as an important leader in the field of substance abuse, and in particular, as a credible source of information and a trusted expert. Among survey respondents, 83% consider CCSA to be an important leader in the field, compared to 77% who agreed with a similar statement in 2010. In particular, CCSA was identified as a top five choice of information by 87% of survey respondents, followed by academic journals/databases (82%), international sources (68%), Health Canada (63%), and the Centre for Addiction and Mental Health (CAMH)/Evidence Exchange Network (EENet) (62%). Based on average ranking, CCSA is survey respondents’ second choice for information, after academic journals/databases.

CCSA is also seen as a trusted expert in the field, and has been called on by some stakeholders to provide advice, conduct research and other projects, and deliver presentations on a variety of topics at events in Canada and around the world. During the current Grant period, CCSA received over 230 communiques from stakeholders acknowledging and thanking it for its work in all priority areas.

However, CCSA is not necessarily seen as embodying all dimensions of leadership. More specifically, some key informants noted that CCSA is neither innovative nor on the cutting edge of public policy, especially with respect to harm reduction. Stakeholders disagreed over whether it would be appropriate for CCSA to take on such a role, with some expressing concern that by taking too strong a position CCSA may lose relevance in the eyes of some stakeholders and jurisdictions.

**Awareness and application of evidence-informed products**

CCSA actively promotes awareness of its products through a variety of approaches to knowledge dissemination and exchange. Visitors to the CCSA website and downloads of CCSA documents have both increased over the evaluation period. While most stakeholders are aware of and have used at least one of the major products published by CCSA, awareness and use varies considerably by product. These differences may be due in part to the target audience for specific products (some are likely to have a broader appeal than others) and the recency of publication. Awareness is greatest for the Low Risk Drinking Guidelines (LRDGs), the Workforce Competencies, and the FDNH Strategy, and these products, along with the Canadian Community Epidemiology Network on Drug Use (CCENDU) bulletins and drug alerts, are also the most often used or applied by stakeholders.
Awareness and understanding of substance abuse as a health issue
A majority of stakeholders (69%) report increased awareness and understanding of substance abuse because of CCSA, and large majorities of those who have read specific CCSA products – ranging from 74% of those who have read the LRDGs to 97% of those who have read the CCENDU bulletins – report that they have gained new knowledge as a result. Key informants believe that gains in awareness and understanding due to CCSA’s work have been achieved particularly with respect to prescription drug misuse and alcohol, as well as mental health and substance abuse, impaired driving, the effects of cannabis and other drugs on brain development and cognitive function, and the contribution of substance abuse to other disease.

A majority of stakeholders (58%) see substance abuse primarily as a health issue. Many external key informants believe that progress, albeit slow, is being made in this area, but observed that CCSA’s work is only one factor contributing to evolving conceptions of substance abuse. There is some evidence at the federal and provincial/territorial levels of initiatives and investments in substance abuse based on CCSA’s work. To the extent that all of CCSA’s work is based on recognition of substance abuse as health issue, it is reasonable to assume that stakeholder initiatives based on that work reflect a similar understanding.

More effective policies, programs, and practices
Although CCSA has been in existence since 1988, the specific products and activities that are the focus of this evaluation have been implemented much more recently. The evidence available to this evaluation suggests that although policies, programs and practices based on some of CCSA’s evidence-informed products have begun to be implemented, it is premature to draw conclusions about their effectiveness. Ongoing monitoring and evaluation are needed to support valid conclusions.

Efficiency and economy

Over the current Grant period, CCSA has been funded almost entirely by the federal government. External funding has ranged from a high of 13% of CCSA’s total budget in 2013–2014 to less than 1% the following year. While the federal government is likely to remain as its major funder, diversifying its funding sources while recognizing the potential constraints and limitations of non-Health Canada funding could help CCSA to better position itself as an organization that exists to serve the diverse interests of stakeholders in the substance abuse field.

Despite expending 97% of Named Grant funds over the current Grant period, CCSA experienced some variances in the ratio of planned to actual spending on priority areas, spending more than planned on international relations (due in part to participation in international events that were not anticipated at the time of budget preparation) and less than planned, for various reasons, on mental health and substance abuse, impaired driving, and First Nations, Inuit and Métis, as well as workforce development. Notably, mental health and substance abuse was an area identified by stakeholders as meriting greater focus by CCSA, suggesting that CCSA could explore opportunities to pursue more work in this priority area in the future.

CCSA has taken steps to optimize the quantity, quality and blend of products and services delivered under the Named Grant, including using SMART objectives and methodology to develop annual strategic directions and activities; responding to emerging priorities identified through consultations with stakeholders; building project management capacity to improve
planning and tracking timelines and resource implications associated with project outputs;
pursuing and securing non-Health Canada funding for some priority areas; and obtaining
substantial in-kind support from partners to produce, disseminate and promote products. The
willingness of partners to contribute in-kind is seen as the most important factor enabling the
efficient production of high quality outputs.

While the evaluation evidence supports continued third-party delivery of the activities currently
delivered by CCSA, there are opportunities for CCSA to clarify its role in the substance abuse
landscape. CCSA is widely seen and valued by stakeholders as a collaborator, facilitator, trusted
expert, and knowledge broker, and there is a strong rationale for the organization to continue in
these roles, but in other respects, CCSA’s role is less clear. The extent to which CCSA should be
independent from the federal government or position itself as innovator or advocate are questions
that remain to be resolved, and over which stakeholders expressed differing opinions.

The current funding model, based on three distinct funding streams, creates administrative
burden for both CCSA and Health Canada in proposal development and assessment, financial
monitoring, progress reporting, and performance measurement and evaluation. While moving to
a consolidated funding model is unlikely to reduce overall costs to CCSA, it would create
efficiencies that could increase CCSA’s capacity to undertake substantive work in its priority
areas. Health Canada, CCSA and other external key informants emphasized an arrangement that
would continue to give CCSA the flexibility to undertake work in areas that may not necessarily
align with the priorities of the government of the day, for example alcohol.

Finally, with respect to CCSA governance, provincial/territorial stakeholders noted that although
Section 8 of the CCSA Act requires CCSA’s Board of Directors to consult with the governments
of the provinces with respect to at-large appointments to the Board, their own jurisdiction has
not, to the best of their knowledge, been consulted. Evidence provided by CCSA indicates that
provincial/territorial representatives, including members of the FPT Committee on Problematic
Substance Use, the business community, enforcement, and other key stakeholders positioned to
provide information on potential candidates, were informally consulted regarding the
appointment of some of the eight current Board-appointed Directors. Given the requirements of
the CCSA Act, a more formal process for engaging the provinces and territories with respect to
Board appointments may be warranted.

RECOMMENDATIONS

This evaluation confirmed an ongoing need for action to address substance abuse and related
harms, as well as widespread support for CCSA, as an independent, arm’s length organization, to
coordinate national efforts to address these issues. Furthermore, the evaluation found that
progress has been made toward CCSA’s expected outcomes and the organization has taken steps
to ensure that it operates in an efficient and economical manner. The following recommendations
identify opportunities for improvement based on the evaluation findings.
The evaluation proposed seven recommendations directed at CCSA and one recommendation directed at Health Canada. Overall the CCSA recommendations cover communication, opportunities to respond to priority areas and performance measurement.

**Health Canada Recommendation 1:**

The Office of Audit and Evaluation has an additional recommendation which is directed at Health Canada:

- HC should work with CCSA to identify the recommendations that directly impact the work funded by Health Canada and work with CCSA accordingly to monitor their implementation.

**CCSA Recommendation 1:**

CCSA should clarify its role in accordance with fulfilling its legislated mandate as an independent arm’s length agency and, with due consideration of available resources, clarify the appropriate approaches and mechanisms through which that role can be executed.

**CCSA Recommendation 2:**

CCSA should clearly communicate to partners and stakeholders its role and the execution and scope of that role according to the clarification outlined in Recommendation 1.

**CCSA Recommendation 3:**

CCSA should explore opportunities to focus more resources on priorities identified by stakeholders, including prevention, harm reduction, and promoting linkages and coordination between substance abuse and mental health services.

**CCSA Recommendation 4:**

Recognizing that the federal government is likely to remain as its major funder, CCSA should explore opportunities to diversify its funding sources as a prudent risk management measure.

**CCSA Recommendation 5:**

Given anticipated efficiencies that could be redirected toward CCSA’s substantive work in its priority areas, CCSA and Health Canada should proceed with current plans to transition to a consolidated funding model that retains CCSA’s ability to undertake work in areas that may not necessarily align with the priorities of the government of the day.

**CCSA Recommendation 6:**

CCSA should review and enhance its current approach to performance measurement in order to track progress toward outcomes; for example through improved data collection and management; and to move toward demonstrating impact at both project and organizational levels within short, intermediate, and long-term timeframes.
CCSA Recommendation 7:

CCSA should explore opportunities to implement a formal, transparent process for consulting with provinces and territories and other relevant stakeholders with respect to at-large appointments to the CCSA Board of Directors, pursuant to Section 8 of the CCSA Act.
# Management Response and Action Plan for Health Canada
## Evaluation of the Canadian Centre on Substance Abuse’s Named Grant Activities

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<thead>
<tr>
<th>Recommendations</th>
<th>Response</th>
<th>Action Plan</th>
<th>Deliverables</th>
<th>Expected Completion Date</th>
<th>Accountability</th>
<th>Resources</th>
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<td>HC should work with CCSA to identify the recommendations that directly impact the work funded by Health Canada and work with CCSA accordingly to monitor their implementation</td>
<td>Agree</td>
<td>HC will identify the recommendations that directly impact the work funded by HC and work with CCSA accordingly to monitor their implementation.</td>
<td>Identification of relevant recommendations. Revisions to CCSA deliverables made in the contribution agreement and monitored accordingly. Letter to be sent to CCSA CEO.</td>
<td>December 2015</td>
<td>Executive Director of HPSI and SPB ADM in collaboration with CCSA</td>
<td>Existing FTEs within the Drugs Program will be used.</td>
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<td>HC will send CCSA a letter outlining HC’s expectations for the recommendations and how they will be implemented and establish regular meetings between the Executive Director, HPSI and the CEO of CCSA to monitor progress.</td>
<td></td>
<td>January 2016</td>
<td>Executive Director of HPSI</td>
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1.0 Evaluation purpose

The Canadian Centre on Substance Abuse (CCSA) hired PRA Inc. to conduct an outcome evaluation of activities funded through a Named Grant from Health Canada, covering the period from 2011–2012 to 2014–2015. The evaluation was scheduled for 2015–2016, as per the Public Health Agency of Canada/Health Canada approved Five-Year Evaluation Plan 2015–2016 to 2019–2020, and fulfills the requirements of the Financial Administration Act.

The evaluation piloted a new, joint, collaborative approach to evaluating national organizations funded by Health Canada. In the past, many national organizations conducted their own evaluations outside of the scope of Treasury Board requirements. Additionally, all initiatives had to be evaluated under the Departmental Five-Year Evaluation Plan. In an effort to be more deliberate and consistent in the approach to evaluating national organizations as well as respond to concerns regarding efficiency when there is duplication of effort, Health Canada and CCSA agreed to pilot this new collaborative approach. As part of this approach, the evaluation was jointly planned, implemented, and reviewed. Work was guided by an Evaluation Working Group (EWG) comprised of representatives from CCSA and Health Canada to ensure the needs of both groups were addressed. The evaluation addresses key questions of interest to senior management within CCSA and Health Canada and aligns with Treasury Board of Canada’s 2009 Policy on Evaluation.

The evaluation used multiple lines of evidence, including a literature review, a review of documents and administrative data, key informant interviews, a survey of CCSA stakeholders, a focus group with provincial/territorial stakeholders, and case studies. This report integrates the findings from all lines of evidence, draws conclusions, and makes recommendations.

1.1 Outline of the report

Section 2.0 of this report provides a profile of CCSA, while Section 3.0 describes the evaluation. Section 4.0 presents the evaluation findings and Section 5.0 concludes and provides recommendations. The Appendix 1 contains the list of references and Appendix 2 contains the logic model and Appendix 3 contains the Summary of Findings.

2.0 Profile of CCSA

2.1 Origins and mandate

CCSA is an arm’s-length, not-for-profit organization that works to reduce the health, social, and economic harms associated with substance abuse and addictions. CCSA was established on August 31, 1988, by the passage of the Canadian Centre on Substance Abuse Act (hereafter the “CCSA Act” or the “Act”). The mandate of CCSA is set out in Sections 3 and 4 of the Act:
The purpose of the Centre is to promote increased awareness on the part of Canadians on 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 cooperation 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 efforts to reduce alcohol and drug abuse and supporting Canada’s participation in those efforts.

Pursuant to its legislated mandate under the Act, CCSA aims to provide national leadership and evidence-informed analysis and advice to mobilize collaborative efforts to reduce alcohol- and other drug-related harms. Although CCSA’s core mandate as outlined in the Act has not changed since 1988, the scope of its work has changed over the years as funding has varied. Furthermore, although the approach that CCSA takes to its work has evolved over time (e.g., to focus increasingly on knowledge exchange), the organization takes its core direction to reduce the harms associated with substance use from the CCSA Act.

### 2.2 National Framework for Action and priorities for action

Since 2005, much of CCSA’s work has been organized around priorities for action identified in the National Framework for Action to Reduce the Harms Associated with Alcohol and other Drugs and Substances in Canada (hereafter the “National Framework” or “the Framework”). The National Framework is the outcome of a series of consultations led by Health Canada and CCSA in 2004 with stakeholders across the country, which culminated in a national meeting with over 100 participants at which a consensus on the priority areas was reached.

The Framework is intended to be a national, collaborative call to action to address the estimated $40 billion spent, per year, on the public health and safety issue of substance abuse. The Framework is intended to provide a strategic national asset for identifying how multi-sectoral resources can be best applied to maximize use of funding and to achieve the greatest good for Canadian society. Centred on 13 national priorities for action, the Framework provides targeted recommendations aimed at producing cohesive and decisive action to reduce the harms of alcohol and other drugs. The First Edition of the National Framework was released in early 2006 and Framework priorities were revalidated in a National Forum held in 2008.
In addition to the National Framework priorities, over the years CCSA has identified additional priority areas for action in response to environmental trends and stakeholder needs. CCSA’s priority areas during the period of the evaluation, and the process used to identify them, are discussed later in this report.

2.3 Activities

CCSA’s activities fall into the following two broad categories:

1) **Promoting and supporting consultation, consensus, and cooperation through working with stakeholders and partners through the following:**
   - developing annual partnership plans for each active National Framework Priority area
   - identifying and developing Canadian and international partnerships
   - conducting outreach to identified organizations
   - facilitating and assisting cooperative efforts among stakeholders in respect of policy and program initiatives
   - establishing national advisory groups composed of partners representing various sectors and geographic areas, which are engaged in the development and/or implementation of strategies
   - providing project management support to national advisory groups
   - developing national strategies and recommendations for action
   - developing implementation plans for national strategies and recommendations for action
   - working with partners and stakeholders toward recommendation actions

2) **Promoting and supporting knowledge development, synthesis, exchange and application in the substance abuse field through the following:**
   - initiating, conducting, promoting and contributing to new research
   - analyzing and critically appraising existing research
   - synthesizing existing research
   - reviewing and providing informed comment on policies and programs related to substance abuse
   - monitoring and surveillance of trends in the use of substances and their harms
   - publishing and disseminating associated findings
   - translating knowledge and tailoring format for specific audiences
   - providing training and mentoring to support knowledge application
   - initiating, sponsoring and supporting conferences, seminars and meetings, and supporting and assisting those of stakeholders, to support knowledge application
   - raising awareness with addiction workers, addiction program planners and managers, and health and public health professionals
On an annual basis, CCSA develops a Strategic Directions Workplan for approval by Health Canada that describes its planned activities within each priority area and links these activities to its four strategic directions. CCSA’s current strategic directions are to create and sustain partnerships to mobilize individual and collective efforts; foster a knowledge exchange environment where evidence and research guide policy and practice; develop evidence-informed actions to enhance effectiveness in the field; and foster organizational excellence and innovation.

2.4 Program Narrative

The activities and outputs of the Named Grant are expected to result in various immediate, intermediate, and long-term outcomes. The immediate and intermediate outcomes are closely linked and inter-related; each of the expected immediate outcomes is expected to influence the achievement of the other immediate outcomes, as well as the achievement of the intermediate outcomes.

**Immediate outcomes** are the external consequences that are the direct result of the activities and outputs of the Named Grant, and that are expected to take place over the short-term (i.e., within one to two years). The expected immediate outcomes of the Named Grant include:

- Increased and more diverse partnerships.
- Increased recognition of CCSA as a leader in the substance abuse field
- Increased awareness among stakeholders of evidence-informed products
- Increased awareness and understanding among stakeholders of the nature, extent and harms of substance abuse

**Intermediate outcomes** refer to the external consequences that flow from the immediate outcomes and that are expected to occur over the medium term (i.e., within three to five years). The following intermediate outcomes are anticipated:

- Increased coordination of effort to address the harms of substance abuse
- Increased application of evidence-informed products to inform policies, programs, and practices
- Increased recognition of substance abuse as a health issue by stakeholders
Long-term outcomes are the external consequences to which the intermediate outcomes contribute, along with other factors beyond the control of CCSA. These are expected to occur over the long-term (i.e., within five years or more). In the long-term, the following outcome is expected:

- More effective policies, programs and practices to address the harms of substance abuse

The ultimate outcome is the external consequence to which the long-term outcomes contribute, along with other factors beyond the control of CCSA. This represents CCSA’s raison d’être and is the highest-level change that can reasonably be attributed to CCSA. The following ultimate outcome is expected:

- Reduced rates of substance abuse among Canadians

A logic model depicting the relationship among the activities, outputs, and expected outcomes is presented in Appendix 2.

2.5 Resources

CCSA’s main source of funding is a Named Grant from Health Canada, which to date has been renewed for five-year periods. The current Named Grant totals $18.1875 million over the period 2011–2012 to 2015–2016. CCSA’s activities to date under the current Named Grant are the focus of this evaluation.

In addition to the Named Grant, CCSA also receives funding from Health Canada through two additional funding streams; namely, the Drug Strategy Community Initiatives Fund (DSCIF) and the Drug Treatment Funding Program (DTFP), both of which are components of the federal government’s National Anti-Drug Strategy.2 CCSA’s DSCIF and DTFP activities have been subject to separate evaluations, in accordance with the terms of the relevant funding agreements with Health Canada, and are not examined in detail in this evaluation.3

In 2014–2015, CCSA’s total annual budget from all sources was $7.2 million, and included $3.6 million in Named Grant funding, $0.9 million in DTFP funding and $2.3 million in DSCIF funding. A small proportion of CCSA’s budget comes from other sources or is paid out of CCSA’s reserves.

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2 In December 2014, the DSCIF and the DTFP were merged under the new Anti-Drug Strategy Initiative (ADSI).

3 The CCSA DSCIF project interim evaluation was completed in 2009, and the outcome evaluation was completed in 2012. The CCSA DTFP interim evaluation was completed in 2011, and the outcome evaluation was completed in 2013. An outcome evaluation for the CCSA DTFP II project is planned for 2016.
3.0 Evaluation description

An evaluation matrix was developed to address key questions of interest to senior management within CCSA and Health Canada and to align with the Treasury Board’s 2009 Policy on Evaluation. The evaluation considered the five core Treasury Board issues under the two themes of relevance and performance (effectiveness, efficiency and economy). Corresponding to each of the core issues, specific questions were developed based on program considerations, and these guided the evaluation process. Although this report is structured according to the key evaluation issues required by Treasury Board, it goes beyond the minimum Treasury Board requirements by also responding to areas of interest to CCSA and Health Canada.

3.1 Data collection and analysis methods

The evaluation drew on multiple lines of evidence, including a literature review, a review of documents, files, and administrative data, key informant interviews, a survey of CCSA stakeholders, a focus group with provincial/territorial stakeholders, and case studies.

3.1.1 Literature, document and file/data review

The literature review addressed evaluation questions relating primarily to relevance (i.e., continued need). The document, data and file review provided historical and contextual information for CCSA’s activities and responded directly to virtually all of the evaluation questions. Relevant literature, documents and data were provided by CCSA and Health Canada and/or were accessed from publically available sources.

3.1.2 Key informant interviews

A total of 33 individuals were interviewed. Interviews were conducted with CCSA staff and Board members (n=7); Health Canada (n=6); and external stakeholders (n=20). External key informants represented provincial/territorial governments and organizations (n=6), research and academia (n=5), federal government departments (n=2), and non-governmental organizations (NGOs) and other stakeholder organizations including Aboriginal, student, health, and international organizations (n=7).

Key informants were selected for their knowledge of and experience with CCSA and/or the substance abuse field. Prior to being contacted by PRA, key informants received a letter from CCSA advising them that the evaluation was taking place and inviting them to participate in an interview. The interviews were conducted in the preferred official language of key informants and digitally recorded with their permission. The notes were returned to them for review and approval.

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4 To obtain a copy of the Technical Report on Evaluation Matrix, use the following e-mail “Evaluation Reports HC - Rapports Evaluation@hc-sc.gc.ca”.

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3.1.3 Survey of CCSA stakeholders

A bilingual, web-based survey of CCSA stakeholders was conducted (for more details on the survey, use the following e-mail “Evaluation Reports HC - Rapports Evaluation@hc-sc.gc.ca” to obtain a copy of the Technical Report on Supplementary Data). CCSA supplied the survey sample based on contacts within its contact database. For the purpose of the survey sample, all contacts within the database were included, with the exception of contractors and CCSA personnel. The sample included three distinct groups, defined as follows by CCSA:

- **Partners** — groups, networks, or organizations that actively collaborate and exchange information with CCSA to achieve a common goal of mutual benefit to the organizations.

- **Stakeholders** — groups, networks, or organizations that affect or are affected by CCSA’s actions, products, and objectives. The relationship with stakeholders is direct, informal, and infrequent (less than quarterly), and it may occur for the purpose of increasing awareness or obtaining input on products.

- **Other contacts** — individuals that have contact with CCSA, but who do not meet the criteria to be considered partners or stakeholders.

The original sample provided by CCSA consisted of 2,120 email addresses. After cleaning, the final loaded sample consisted of 2,113 email addresses, including 338 partners, 1,139 stakeholders, and 636 other contacts.

Prior to the survey launch, CCSA sent potential respondents an initial letter describing the survey and advising them that they would receive an invitation to complete the survey from PRA in the near future. PRA followed up with an email, including the link to the survey, two days later.

The survey was launched on May 5, 2015 and closed on May 28, 2015. Two reminders were issued to increase the response rate. Overall, the survey achieved 343 completions, representing a completion rate of 18%. Completion rates were 24% for partners, 18% for stakeholders, and 14% for other contacts.

The survey results were analyzed using SPSS. Cross-tabulations were performed, where feasible based on sample size, to analyze differences among various groups of respondents; results are reported only when significant differences were found.

Comparing survey respondents against the sample as a whole indicates that the respondent population is quite similar to the original sample along a number of dimensions. Partners are slightly overrepresented, other contacts are slightly underrepresented, and stakeholders are represented among respondents in exact proportion to their presence in the sample. Furthermore,

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This compares with 27% achieved for stakeholder survey for the previous Grant evaluation and 22% achieved for a web-based survey of youth drug prevention and health promotion stakeholders, conducted by PRA for CCSA in 2010 and 2014, respectively. Completion rates for web-based surveys are highly variable depending on the specific nature and purpose of the survey, the target population, and the number of times the target population has been asked to participate in surveys in recent years, among other factors. As a result, it is challenging to assess rates achieved by particular surveys.
most provinces and territories are represented among respondents in similar proportion to their presence in the sample, although Alberta and British Columbia are slightly overrepresented and Ontario is slightly underrepresented.

A majority of respondents (57%) identified themselves as working primarily in a health-related sector. Of these, almost one-third (30%) identified the addictions sector as the primary sector in which they work, while another 14% indicated that they work primarily in the health sector (including public health and primary care); 7% work primarily in mental health; 4% work primarily in mental health and addictions/concurrent disorders; and 2% identified themselves as working in drug prevention or harm reduction. The remaining 43% of respondents identified themselves as working primarily in other fields.

One-third of respondents (33%) represent provincial/territorial governments, while 23% work for not-for-profit organizations and 11% each work for federal government and academic/research institutions. Respondents are involved in a variety of types of work, most commonly capacity building/knowledge exchange (37%), frontline work (32%), research (30%), policy/planning (25%), and executive (25%) and management (23%) work.

3.1.4 Focus group with provincial/territorial representatives

One teleconference focus group was completed with provincial/territorial stakeholders recruited from among a list of 13 potential participants identified by CCSA and Health Canada. Potential participants received a letter from CCSA advising them that the evaluation was taking place and inviting them to participate. PRA then followed up by telephone to recruit individuals to participate. Individuals were asked to indicate the availability on three possible dates and times. In some cases, alternate participants were identified through this process. Ultimately, seven individuals, representing seven provinces/territories, participated in the focus group. In addition, two of the potential participants, representing two provinces/territories, were unable to take part in the focus group and instead each participated in a key informant interview. These two provincial/territorial representatives are counted among the provincial/territorial key informants. The focus group discussion focused primarily on two key areas: uptake and use of CCSA products in the provinces and territories, and provincial/territorial perspectives on the contribution and ongoing relevance of CCSA. The focus group was digitally recorded with participants’ permission.

3.1.5 Case studies

Two case studies were conducted by CCSA (for more details on the case studies, use the following e-mail “Evaluation Reports HC - Rapports Evaluation@hc-sc.gc.ca” to obtain a copy of the Technical Report on Case Study Reports). The case studies were intended to illustrate how CCSA leverages partnerships to achieve impact; to provide concrete reference points to more clearly communicate complex information; and to tell the story of CCSA’s work in a way that is approachable to a broad range of stakeholders. Two of CCSA’s evidence-based products, the Low Risk Drinking Guidelines (LRDGs) and the Canadian Community Epidemiology Network on Drug Use (CCENDU) were selected by the EWG for case study, based on criteria developed by the EWG.
CCSA prepared the case studies based on consultations with project leads and a review of project documentation including terms of reference, published reports and knowledge exchange products, and stakeholder feedback. CCSA circulated drafts to the members of the EWG and incorporated their feedback to ensure that the information was clearly presented and met the case study objectives.

Information from the case studies has been integrated into this report.

### 3.2 Limitations and mitigation strategies

Like all evaluations, this evaluation faced constraints that may have implications for the validity and reliability of evaluation findings and conclusions. A summary of these limitations, their impacts, and mitigation strategies is provided below. In all cases, the limitations associated with specific data collection methods were mitigated through triangulation, i.e., using the findings in conjunction with those from other lines of evidence.

<table>
<thead>
<tr>
<th>Limitation</th>
<th>Impact</th>
<th>Mitigation strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of relevant performance measurement information was limited for certain indicators, particularly ones that imply a comprehensive inventory or count of outputs. The evaluation budget was insufficient to undertake data collection activities to fill these gaps.</td>
<td>Certain indicators in the evaluation framework could not be fully addressed in reporting.</td>
<td>The available performance measurement data, including examples of outputs where comprehensive inventories and counts were not available, are reported, along with information from other lines of evidence.</td>
</tr>
<tr>
<td>Although a “census” approach was taken to the survey, (i.e., all eligible partners, stakeholders, and other contacts were included in the sample), respondents self-selected into the survey.</td>
<td>The survey results represent the views of respondents, and should not be generalized to the entire sample or to the substance abuse community at large.</td>
<td>Survey findings are used in conjunction with other lines of evidence. No conclusions are drawn solely on the basis of the survey results.</td>
</tr>
<tr>
<td>As in all web-based surveys, some technical constraints and difficulties were experienced. An unknown number of survey invitations were likely diverted by spam filters, reducing the potential pool of survey respondents. In addition, an unknown number of potential respondents experienced technical difficulties while attempting to complete the survey.</td>
<td>Technical constraints and difficulties likely reduced the original sample and/or affected the completion rate.</td>
<td>PRA provided assistance to those experiencing technical difficulties, to the extent that these individuals brought these difficulties to PRA’s attention. Beyond acknowledging these limitations inherent in all web-based surveys, no further mitigation strategies were undertaken.</td>
</tr>
<tr>
<td>External key informants were identified based on purposive sampling. Budget considerations constrained the number of external key informant interviews that could be completed.</td>
<td>External key informant interview findings cannot be interpreted as representing the views of all stakeholders.</td>
<td>Interview findings, particularly views expressed by a minority of key informants, are used in conjunction with other lines of evidence. No conclusions are drawn solely on the basis of interview data.</td>
</tr>
<tr>
<td>Two case studies were selected based on specific criteria. The case study findings are not necessarily representative of all CCSA initiatives.</td>
<td>Case study findings cannot be interpreted as being relevant to all CCSA initiatives.</td>
<td>Case study findings are used in the report for illustrative purposes only and in conjunction with other lines of evidence. No conclusions are drawn solely on the basis of the case study data.</td>
</tr>
</tbody>
</table>

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6 For example, Number and nature of references to citations of evidence-informed products in federal, provincial/territorial, and other stakeholders’ policy and practice documents
4.0 Findings

4.1 Relevance

4.1.1 Continued need

There is a continued need to address substance abuse and related harms in Canada, as well as widespread support among stakeholders for addressing these issues at the national level.

Broadly speaking, substance abuse or substance abuse problems are patterns or methods of substance use that result in harms at the individual, family, community, or social level. These harms include negative impacts on physical health and on other domains of life. Physical harms attributable to alcohol abuse include various mental and behavioural disorders, such as alcohol dependence, as well as other conditions such as cirrhosis, pancreatitis, diabetes, cardiovascular disease, some forms of cancer, and fetal alcohol spectrum disorder (FASD) (CCSA, 2015a; PHAC, 2012; WHO, 2014). Similarly, drug abuse is associated with weakened immune system, adverse cardiovascular effects, neurological damage, and cognitive impairment, and can be linked to risky behaviours like needle sharing, which greatly increases the likelihood of acquiring HIV-AIDS, hepatitis B, and hepatitis C (NIDA, 2012). Long-term abuse of drugs can lead to long-lasting changes in the brain, which may lead to paranoia, depression, aggression, and hallucinations. In addition to physical harms, the harms associated with substance abuse can extend to friendships and social life; financial position; home life or marriage; and work, studies, or employment opportunities; and can include legal problems, difficulty learning, and housing problems (Healthy Canadians, 2015a).

Recent data and analysis indicate that substance abuse and related harms are ongoing issues in Canadian society.

Illicit drugs

National survey data (shown in Table 2) indicate that rates of use of various illicit drugs, including cannabis, cocaine/crack, crystal meth, hallucinogens, ecstasy, and salvia, remained steady or decreased between 2004 and 2013. However, while overall prevalence rates were relatively low, rates of illicit drug use among youth ages 15 to 19 and older youth ages 20 to 24 were three times higher in 2013 than rates reported by adults, and youth reported harms related to illicit drug use at a rate four times that of adults. Canadian youth also had the highest rates of cannabis use (28%) when compared to youth in other developed countries.

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7 This broad working definition was provided by CCSA. It was beyond the scope of this evaluation to explore the ongoing debate concerning appropriate use of terms such as substance use, substance abuse, substance misuse, problematic substance use, and addiction.

8 The Public Health Agency of Canada (PHAC) reports that FASD is the leading cause of developmental disability among Canadian children, with nine out of every 1,000 babies in Canada being born with FASD (PHAC, 2012).
Table 2: Illicit substance use trends among Canadians aged 15 and older, 2004–2013 – past year use

<table>
<thead>
<tr>
<th>Type of drug</th>
<th>2004</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis</td>
<td>14.1%</td>
<td>11.4%*</td>
<td>10.6%*</td>
<td>10.7%*</td>
<td>9.1%*</td>
<td>10.2%*</td>
<td>10.6%</td>
</tr>
<tr>
<td>Cocaine/crack</td>
<td>1.9%</td>
<td>1.6%</td>
<td>1.2%</td>
<td>0.7%</td>
<td>0.9%</td>
<td>1.1%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Speed</td>
<td>0.8%</td>
<td>1.1%</td>
<td>0.4%</td>
<td>0.5%</td>
<td>0.5%</td>
<td>0.2%</td>
<td>S</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>1.1%</td>
<td>1.4%</td>
<td>0.9%</td>
<td>0.7%</td>
<td>0.7%</td>
<td>0.6%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Hallucinogens*</td>
<td>0.7%</td>
<td>N/A</td>
<td>0.7%</td>
<td>0.9%</td>
<td>0.6%</td>
<td>0.9%</td>
<td>0.6%</td>
</tr>
</tbody>
</table>

* These rates exclude use of salvia.
** Significant difference between reporting year and 2004
N/A- In 2008, the list of substances under hallucinogens included salvia and “magic mushrooms”; as a result the estimate is not comparable to 2004, 2009-2012.
S – Estimate suppressed due to high sampling variability.
Q – Estimate qualified due to moderate-high sampling variability
Sources: (Health Canada, 2009, 2012, 2013b; Healthy Canadians, 2015d)

**Prescription drugs**

Prescription drugs with potential for misuse include opioid analgesics (e.g., codeine, oxycodone, and fentanyl), sedative-hypnotics (e.g. benzodiazepines and barbiturates), and stimulants (e.g., amphetamine and dextroamphetamine, methylphenidate). Rates of prescription opioid and stimulant use in Canada are among the highest in the world, and have increased substantially in the past decade (Okanagan Research Consultants, 2015). Although national data are lacking, the available data indicate prescription opioid use and misuse has become increasingly common among the general adult and student populations, street drug users, First Nations/Aboriginal peoples, and correctional populations, and related harms and costs have grown significantly with increased prescribing and consumption (Okanagan Research Consultants, 2015). The following data highlight the link between increased opioid prescribing, misuse, and related harms.

- One recent study reported that there were 5,935 deaths from opioid-related causes in Ontario between 1991 and 2010 (Gomes et al., 2014). During this period, rates of opioid-related deaths increased 242%, from 12.2 deaths per million in 1991 to 41.6 deaths per million in 2010. Deaths in the later five years of the study accounted for over 40% of all opioid-related deaths in the 20 years examined, and by 2010, nearly one of every eight deaths among individuals aged 25 to 34 years was opioid-related.

- Despite the publication of clinical practice guidelines in 20109 and the delisting of OxyContin and OxyNeo from most provincial drug plans in 2012, opioid prescribing has continued to increase in Canada. According to one recent analysis of IMS Brogan data, opioid prescriptions increased 18.6% between 2012 and 2014, reaching 21.7 million prescriptions in the latter year (The Globe and Mail, 2015). Prescriptions for other long-acting opioids such as Hydromorph Contin, BuTrans, and Targin have all increased over this period.

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9 Increased prescribing has occurred despite the publication in 2010 of The Canadian Guideline for Safe and Effective Use of Opioids for Non-Cancer Pain.
• Similarly, over the period 2010–2013, fentanyl dispensing rose by nearly 16% (CBC News, 2015). Between 2009 and 2014, at least 655 Canadians died as a result of fentanyl (CCSA, 2015f). Fentanyl is available by prescription, but is also illegally manufactured and sold on the street.

• Between 1997 and 2010, more than 1 in 10 Ontarians who were prescribed opioids for noncancer pain for the first time became chronic users (Kaplovitch et al., 2015). Men were more likely than women to escalate to high-dose therapy and to die from opioid-related causes.

**Alcohol**

National survey data indicate that alcohol is widely used by Canadians, with just over three-quarters of Canadians aged 15 and over reporting any use between 2004 and 2013. Over this period, as shown in Table 3, rates of drinking associated with acute and chronic health effects have been in the range of 19% and 14%, respectively, of Canadians aged 15 and over, with a recent, though not statistically significant, increase between 2012 and 2013.

| Table 3: Alcohol use trends among Canadians in the past year aged 15 and older, 2004–2013 |
|----------------------------------------|--------|--------|--------|--------|--------|--------|--------|
| Level of use                           | 2004   | 2008   | 2009   | 2010   | 2011   | 2012   | 2013   |
| Exceeds LRDG guideline 1 (chronic)*   | 18.0%  | 19.8%  | 19.1%  | 19.1%  | 18.7%  | 18.6%  | 21%    |
| Exceeds LRDG guideline 2 (acute)*     | 12.9%  | 14.3%  | 15.5%  | 13.8%  | 13.1%  | 12.8%  | 15%    |

* These rates exclude the non-drinking population. Health Canada defines LRDG guideline 1 (chronic) as drinking “no more than 10 drinks a week for women, with no more than two drinks a day most days and 15 drinks a week for men, with no more than three drinks a day most days. Plan non-drinking days every week to avoid developing a habit”. Health Canada defines the LRDG guidelines 2 (acute) as drinking “no more than three drinks (for women) and four drinks (for men) on any single occasion. Plan to drink in a safe environment. Stay within the weekly limits outlined in guideline 1”

Sources: (Health Canada, 2012, 2013a, 2013b; Healthy Canadians, 2015b)

One recent study based on national survey data provides evidence that these rates may actually be much higher (Zhao, Stockwell, & Thomas, 2015). After correcting for under-reporting, the study found that nearly 40% of Canadian drinkers are exceeding the guidelines for acute effects (i.e., exceeding daily limits), and 27% are exceeding the guidelines for chronic effects (i.e., exceeding weekly limits). The study also found that binge drinking to be particularly widespread among young people, suggesting that as many as 60% of youth aged 18 to 24 are consistently drinking above the daily consumption guidelines.

Furthermore, despite higher rates of abstinence from alcohol and less frequent alcohol use among First Nations than the general population, there are higher levels of heavy alcohol use, including binge drinking, among First Nations. The 2008/10 First Nations Regional Health Survey found

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10 Rates of drinking associated with acute and chronic health effects are based on the Low Risk Drinking Guidelines (LRDGs), a product developed by CCSA in partnership with various stakeholders and discussed in more detail later in this report. For acute effects, the guidelines recommend no more than three drinks per day for women and four for men. For chronic effects, the guidelines recommend no more than 10 drinks per week for women and 15 for men.
that although over one-third of First Nations adults abstained from alcohol over the past 12 months (a higher abstinence rate than the general Canadian population), almost two-thirds of those who drink engage in heavy consumption (FNIGC, 2012).

**Costs and harms associated with substance use/abuse**

In a major, though now dated, study completed in 2006 and based on 2002 data, CCSA estimated that abuse of alcohol and illegal drugs contributed to nearly 9,800 deaths in Canada in 2002, with most (83%) being alcohol related (Rehm et al., 2006, p. 4). The leading causes of alcohol-related deaths were cirrhosis, motor-vehicle collisions, and alcohol-attributable suicides, while the leading causes of illegal drug-related deaths included overdose, drug-attributable suicide, and drug-attributable diseases, including hepatitis C and HIV infections (Rehm et al., 2006, p. 7). In the same study, CCSA estimated the social costs of substance abuse in Canada in 2002 at around $39.8 billion, of which alcohol accounted for about $14.6 billion (37%) and illegal drugs accounted for $8.2 billion (21%)11 (Rehm et al., 2006, p. 1). These costs included costs to the health care system, law enforcement, and employers and workplace productivity, as well as costs related to accidents from impaired driving, but did not include costs associated with the abuse/misuse of pharmaceuticals (Rehm et al., 2006, p. 6), which in the interim has emerged as a significant health and public policy concern.

More recent studies have confirmed that abuse of alcohol and drugs continues to generate substantial harms as well as costs to individuals and society.

- National survey data show that in 2013, 3% of Canadians aged 15 and older experienced harms related to illicit drug use, and as might be expected, these rates are much higher among drug users (20%) and users of multiple drugs (44%) (Healthy Canadians, 2015d). For survey purposes, harm was defined as encompassing physical health; friendships and social life; financial position; home life or marriage; work, studies, or employment opportunities; legal problems; difficulty learning; and housing problems.


- Between 2009 and 2014, there were at least 655 deaths in Canada where fentanyl was determined to be a cause or a contributing cause, and, during the same period, at least 1,019 drug poisoning deaths where post-mortem toxicological screening indicated the presence of fentanyl (CCSA, 2015f).

- CCSA’s 2014 study on the impact of substance use disorders on hospital use found that 1.2% of all hospital stays were due to a primary diagnosis of substance use disorder and that these hospitalizations cost approximately $267 million in 2011 (an increase of 22% since 2006) (CCSA, 2014a, p. 2).

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11 Tobacco accounted for the largest cost at $17 billion (43%).
• In Canada in 2011, 56% of all hospital departures via discharge or death that involved substance abuse were related to alcohol (CCSA, 2015a, p. 8).

• The cost of acute care hospital use attributable to FASD was estimated at approximately $3.4 million in 2011 (Popova, Stade, Lange, & Rehm, 2012, p. 60).

• The average annual cost of impaired driving, including fatalities, injuries, and property damage, is estimated to be about $20.5 billion (Pitel & Solomon, 2013, p. 13).

This brief overview of the harms and costs associated with substance abuse suggest an ongoing need for intervention to address them.

Among key informants, there is unanimous agreement that there is a continued need to address substance abuse at the national level. Furthermore, 90% of survey respondents agreed that there is a need for a national organization to play a leadership role in the field of substance abuse. Perceived benefits of a national approach include:

• the ability to gather and share information and expertise across jurisdictions;
• the ability to leverage resources;
• the ability to coordinate stakeholders working in similar areas to avoid duplicating effort and “reinventing the wheel;” and
• the ability to produce pan-Canadian resources that can be adopted or adapted by stakeholders based on their own needs and contexts.

Several key informants remarked specifically on the ongoing need for a national approach that is distinct and independent from the federal government, and that is informed by and representative of a range of stakeholder interests from across Canada.

4.1.2 Alignment with federal roles and responsibilities and the CCSA Act

CCSA’s legislated mandate aligns with federal roles and responsibilities, and in particular, with Health Canada’s mandate under the Department of Health Act. Furthermore, CCSA’s activities and expected outcomes are consistent with CCSA’s mandate, as described in section 3 of the CCSA Act.

Pursuant to the Constitution Act, 1867, health is a matter of shared jurisdiction between the federal and provincial governments. The federal government has jurisdiction relating to the promotion and preservation of the health of the people of Canada, including disease prevention, knowledge sharing, funding research, and ensuring access to health care for specific populations. Health Canada’s funding to CCSA helps fulfil the federal government’s roles with respect to funding research and promoting overall health.

Health Canada funding to CCSA through the Named Grant is provided pursuant to its mandate under the Department of Health Act. Section 4 of the Act defines the Minister’s duties to include the promotion and preservation of the physical, mental and social well-being of Canadians; their protection against risks to health and the spreading of diseases; investigation and research into
public health; the establishment and control of safety standards and safety information on requirements for consumer products; and the collection, analysis, interpretation, publication and distribution of information relating to public health. More broadly, the Minister’s jurisdiction covers all matters related to the health of Canadians that have not otherwise been assigned by Parliament to any other department, board or agency of the Government of Canada.

Under the CCSA Act, CCSA’s mandate is to “promote increased awareness on the part of Canadians on 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.” As such, CCSA’s mandate is well-aligned with Health Canada’s mandate to promote and preserve the physical, mental and social well-being of Canadians, as described in the Department of Health Act.12

The evaluation also found that CCSA’s activities and expected outcomes are consistent with the broad mandate of the organization, as laid out in the CCSA Act. CCSA’s activities and expected outcomes align explicitly with the Act. More specifically CCSA’s plays a role in promoting partnerships and coordination; facilitating the development, exchange and application of knowledge; and promoting and assisting in the development of more effective policies and programs to reduce alcohol and drug abuse. In practice, virtually all of CCSA’s activities have involved partnerships and knowledge development, exchange and application, with a view to influencing and improving policies, programs, and practices.

4.1.3 Alignment with federal priorities

There is generally strong alignment between CCSA and federal priorities. Ensuring that CCSA has the flexibility, when warranted by the evidence, to adopt an independent position vis-à-vis its main funder would be consistent with CCSA’s mandate as an arm’s length organization that exists to serve the diverse interests of stakeholders in the substance abuse field.

CCSA priorities

Over the period covered by this evaluation, CCSA’s work has been based largely on the priorities identified in the 2005 National Framework, which were revalidated through a stakeholder consultation process in 2008.

CCSA priority areas for action

- Alcohol
- Workforce development

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12 Two other federal Acts administered by Health Canada are related to substance use and abuse issues. These are the Controlled Drugs and Substances Act (CDSA), which provides the cornerstone of a legislative framework that prohibits and penalizes illegal activities with controlled substances and precursor chemicals; and the Food and Drugs Act (FDA), which defines the parameters of a drug and gives legislative support to Health Canada’s role in regulating the use of human drugs and taking actions to enforce compliance with those regulations. These federal Acts are not directly relevant to CCSA.
• Canada’s North and First Nations, Inuit and Métis
• Mental health and substance abuse
• Prescription drug misuse
• Impaired driving
• Monitoring and surveillance
• Cannabis
• International activities
• Knowledge exchange and research
• Treatment (DTFP)
• Prevention (DSCIF)

Some of CCSA’s priority areas directly mirror Framework priorities, including research and knowledge transfer, alcohol, prescription drug misuse, workforce development, treatment, and Canada’s North and First Nations, Inuit, and Métis. Several Framework priorities, including increasing awareness and understanding of problematic substance use and modernizing legislative, regulatory, and policy frameworks, are addressed by CCSA through multiple priority areas for action, and the Framework priority of children and youth is addressed through CCSA’s prevention priority.

CCSA has also identified a number of priority areas that were not explicitly identified as Framework priorities, including monitoring and surveillance, impaired driving, international activities, mental health and substance abuse, cannabis, and most recently, recovery and family violence. However, most of these priorities with the exception of cannabis emerged from and/or are linked to Framework priorities, or, in the case of international activities, from CCSA’s mandate under the CCSA Act. CCSA representatives indicated that cannabis was identified as a priority area based on Canadian prevalence data, feedback from partners and stakeholders, and federal government (bureaucratic and political) priorities.

The National Framework represents a collective vision and is not owned by CCSA or any other single organization. Although CCSA has taken on a leadership role to promote that vision, there are areas in which other stakeholders have been positioned to take on that role. There are three Framework priorities that CCSA has not explicitly identified as priority areas for action during the current Grant period, namely addressing FASD; addressing enforcement issues; and responding to offender-related issues. Nevertheless, CCSA has been actively collaborating with partners leading activities in these areas during the period of the evaluation.13

13 CCSA has addressed enforcement- and offender-related issues through submissions to and appearances before various Parliamentary Committees. CCSA is also a member of the Canadian Association of Chiefs of Police’s Drug Advisory Committee and in November 2014, made a presentation to the Federal/Provincial/Territorial Heads of Corrections on substance abuse among offenders. Subsequently, CCSA entered into a Memorandum of Understanding with the Correctional Service of Canada (signed in June
Federal priorities

The federal government’s priorities with respect to substance abuse are reflected in the National Anti-Drug Strategy (NADS), which was launched in 2007. Through the Strategy, which involves 12 federal departments and agencies led by the Department of Justice, the federal government “contributes to safer and healthier communities by helping prevent use, treat dependency and reduce production and distribution of illicit drugs as well as by addressing prescription drug abuse” (Government of Canada, 2014).

Although at its launch the Strategy focused specifically on illicit drugs, the federal government has since (in 2013) expanded the Strategy to address the problem of prescription drug abuse (Government of Canada, 2013). Other federal priorities include ongoing surveillance and monitoring of drug use; supporting the Parliamentary process for the Respect for Communities Act regarding the establishment of supervised injection sites14 and continuing to implement the Marihuana for Medical Purposes Regulations, among other priorities related to monitoring and enforcement for controlled substances (Health Canada, 2015). The federal government also expressed commitments in relation to First Nations and Inuit through implementation of the Honouring Our Strengths Addictions Framework, the Mental Wellness Continuum Framework, and a five-year Prescription Drug Abuse Plan.

While the most recent federal budget did not make any mention of substance use/abuse issues, mental health, including support for the Mental Health Commission of Canada (MHCC) and for mental health services in First Nations communities, was highlighted as a priority (Government of Canada, 2015). The federal government has also recently highlighted actions being taken on cannabis and drug-impaired driving through a variety of initiatives funded through the NADS and/or through the Named Grant to CCSA (Parliament of Canada, n.d.).

Within Health Canada, CCSA supports the Program Alignment Architecture (PAA) under Strategic Outcome #2 “Health risks and benefits associated with food, products, substances, and environmental factors are appropriately managed and communicated to Canadians.”

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14 In the October 2013 Speech from the Throne, the federal government highlighted commitments to “re-introduce and pass the Respect for Communities Act to ensure that parents have a say before drug injection sites open in their communities” and to “close loopholes that allow for the feeding of addiction under the guise of treatment.” It is unclear from the Speech what loopholes this commitment refers to, and what plans the federal government intended, or intends to, pursue in relation to them.
Alignment of CCSA and federal priorities

Comparing recent and current CCSA and federal priorities suggests numerous areas of alignment, including treatment, youth drug prevention, prescription drug misuse, First Nations and Inuit, and monitoring and surveillance, as well as cannabis, drug-impaired driving, mental health and substance abuse, and workforce development. Conversely, beyond some interest in impaired driving, alcohol is not a current focus for the federal government. In a recent pre-budget submission to the Standing Committee on Finance, CCSA urged the Government of Canada to expand the NADS to include alcohol (CCSA, 2014b).

Enforcement is a significant focus of the federal government under the NADS and as a result of its responsibilities under various acts of legislation, but has not been identified by CCSA as one of its priority areas for action in the current Grant period. Nevertheless, CCSA has addressed enforcement- and offender-related issues in several submissions to and appearances before Parliamentary Committees. Although not always in line with the federal government's position, CCSA provided evidence-informed input and suggestions related to the issues at hand.

Health Canada key informants believe that CCSA and federal priorities are well-aligned. However, a minority of stakeholders who participated in this evaluation, including representatives of Health Canada, the provinces and territories, and other stakeholder groups, suggested that they may be too well-aligned. Health Canada key informants, for example, noted that because of its strong alignment with federal priorities, CCSA is vulnerable to shifting focus on short notice and taking on work in many different areas. These key informants wondered if CCSA may be “spreading itself too thin”, thereby jeopardizing its ability to take on bigger agendas relating to fewer topics. It was suggested that CCSA could potentially achieve greater impact by focusing its efforts in fewer areas. CCSA representatives, however, noted that CCSA takes many factors into consideration when pursuing a new activity, including stakeholder input and priorities, available resources, and anticipated impact, as outlined in section 4.1.4.

Other stakeholders (including representatives of Health Canada, the provinces and territories, and other organizations) believe that CCSA has a close relationship with the federal political

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15 Workforce development is currently a federal priority with respect to First Nations and Inuit under the Honouring Our Strengths framework. In addition, the federal government is currently prioritizing the improvement of treatment systems under the DTFP; arguably, CCSA’s focus on workforce development is complementary to this effort.

16 These submissions addressed the federal government’s proposed legislative amendments relating to mandatory minimum penalties for drug offences (Bill C-10, the Safe Streets and Communities Act), supervised injection sites (Bill C-2, the Respect for Communities Act) and penalties for drug use for offenders on parole (Bill C-12, the Drug Free Prisons Act).

17 CCSA representatives emphasized that the organization’s focus is remaining true to its mandated role of providing evidence-informed information and advice, rather than the degree to which the evidence supports a given position.

18 In the past year, CCSA has begun work in two new areas (recovery and family violence). Although work in these areas was initiated through collaborations with other partners (i.e. colleagues at the Commission on Narcotic Drugs involved in the drafting of a resolution on Recovery; FAVOR Canada, and the Sheldon Kennedy Centre) and was not initiated at the request of the Minister of Health, CCSA indicated that Ministerial support played a role in moving it forward.
leadership, as a consequence of which it can be hesitant to take a different position than the federal government or challenge it on controversial topics. External key informants indicated, for example, that CCSA did not challenge the government on the exclusion of harm reduction from the NADS and has not taken a resolute position, in their view, in favour of supervised injection sites (SIS), despite a considerable body of scientific evidence attesting to their public health benefits. CCSA’s work on cannabis was also cited as an instance in which CCSA has demonstrated close alignment with the federal government.\footnote{As part of its work on cannabis, CCSA has advised Health Canada on the evidence base for messaging regarding harms associated with marijuana. In August 2014, the College of Family Physicians of Canada (CFPC), the Canadian Medical Association (CMA), and the Royal College of Physicians and Surgeons of Canada issued a joint statement indicating that they had been invited by Health Canada to “co-brand and provide expert advice” on an upcoming anti-drug educational campaign targeted at young Canadians, but noted that the campaign “had become a political football on Canada’s marijuana policy and for this reason” they would not be participating (The College of Family Physicians of Canada, 2014).}

CCSA representatives acknowledged that the organization did not challenge the federal government on the exclusion of harm reduction from the NADS, but indicated that doing so would have meant taking on a public advocacy role that in their view is better suited to other organizations. From CCSA’s perspective, one aspect of its value-added is its ability to keep dialogue open with a range of stakeholders, including stakeholders at the political level.

With respect to SIS, CCSA indicated that the organization has spoken to their value as an evidence-informed part of the treatment continuum in its testimony on Bill C-2 and Bill C-12. More generally, CCSA representatives indicated that although CCSA has not identified harm reduction as an explicit priority area for action, harm reduction is embedded in its work as one component of a range of interventions needed to address substance abuse. They noted that this approach is consistent with the National Framework, which likewise does not single out harm reduction as an explicit priority.

Nevertheless, some stakeholders believe adopting a more independent position vis-à-vis the federal government would be more consistent with CCSA’s mandate as an arm’s-length organization, echoing similar concerns raised by a minority of key informants in the previous Grant evaluation. At the same time, external key informants recognized that CCSA is in a delicate position, since its Chief Executive Officer (CEO) and four of its Board members are appointed by the Governor-in-Council and it is funded almost entirely by the federal government.

4.1.4 Alignment with other stakeholder priorities and responsiveness to needs and gaps

CCSA’s activities are generally responsive to gaps and needs in the field and well-aligned with the priorities of stakeholders. CCSA could explore opportunities to focus more resources on priorities identified by stakeholders, including prevention, harm reduction, and linkages and coordination between substance abuse and mental health services.

To help ensure that its work reflects the priorities of stakeholders and responds to gaps and needs in the substance abuse field, CCSA uses a variety of planning and consultative processes. On an annual basis, CCSA’s senior leadership team, with input from staff, completes a strategic planning
session that includes a strengths, weaknesses, opportunities, threats (SWOT) analysis. CCSA incorporates input from partners and stakeholders obtained through the mechanisms outlined below into this planning process through the SWOT analysis. External context, including partner priorities and environmental patterns and trends are the key considerations in the “opportunities and threats” component of the analysis. The final strategic directions are submitted to CCSA’s Board for approval. CCSA key informants reported that through this process, certain areas come to the fore and are identified as new priorities. Often, these are areas that CCSA had already been working in for some time (e.g., impaired driving and cannabis). By identifying these areas as priorities, CCSA indicates its intention to devote additional resources to them.

In addition to the annual strategic planning process, since 2012, CCSA has used Cross Country Dialogues (CCDs) as a forum for communication and knowledge exchange with leaders and decision makers in Canadian jurisdictions. CCDs are used to discuss provincial/territorial priorities and activities on substance abuse, as well as share lessons learned and explore future opportunities to collaborate on issues related to substance abuse. During each leg of the CCDs, CCSA consults with stakeholders and partners with whom it has worked in the jurisdictions. This facilitates CCSA’s understanding of local issues and priorities as well as its introduction to key contacts within the ministries. Overall, CCD outreach has focused on sectors most concerned with addressing issues related to substance abuse. Participants have included government health and education ministries and officials, corrections and police services, public health, as well as NGOs in the health, mental health, addictions, and education sectors. As of August 2015, stakeholders in all provinces and territories with the exception of Quebec have been reached through the process; consultations with Quebec are planned for the fall of 2015.

Most recently, CCSA consulted with its partners to gain input on priority areas and its role for the next few years, in order to support planning for the next Named Grant. Board members, advisory groups and committees, and members of the Federal/Provincial/Territorial Liaison Committee on Problematic Substance Use were consulted through this process.

Overall, CCSA representatives indicated that in setting priority areas for action, consideration is given to input from stakeholders, the nature of identified gaps and needs, the expertise available to address them, the existence of opportunities for collaboration, internal capacity within CCSA, the availability of funding to support work in the area, the nature and extent of other work being done in the field (i.e. to avoid duplication of effort), and fit with CCSA’s other activities and mandate.

A majority of participants in this evaluation perceive CCSA’s activities as well-aligned with their priorities and responsive to gaps and needs in the substance abuse field. As shown in Table 4, two-thirds of survey respondents (69%) believe that CCSA’s activities are well-aligned with the priorities of their organization, and just over half (55%) believe that CCSA’s activities are well-aligned with the priorities of their province or territory when it comes to substance abuse. In the latter case, only 4% disagreed, while a substantial proportion was either neutral (25%) or did not know (17%).
Among the sub-group of respondents who work for provincial/territorial government departments or agencies, a larger proportion – 71% – agree that CCSA’s activities are well-aligned with the priorities of their province or territory. \(^{20}\) Furthermore, two-thirds of survey respondents (67%) agree that CCSA’s activities address identified gaps and needs in the substance abuse field; only 4% disagreed, while 20% were neutral, and 10% did not know. Similarly, most external key informants and provincial/territorial focus group participants agreed that CCSA’s priorities are aligned with those of their organization as well as responsive to gaps and needs in the field.

Table 4: Level of agreement among survey respondents with statements about CCSA’s alignment and responsiveness to gaps and needs (n=343)

<table>
<thead>
<tr>
<th>Statements</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alignment</strong></td>
<td></td>
</tr>
<tr>
<td>CCSA’s activities are well-aligned with my organization’s priorities in the substance abuse field</td>
<td>69% 18% 4% 8%</td>
</tr>
<tr>
<td>CCSA’s activities are well-aligned with the priorities of my province/territory when it comes to substance abuse</td>
<td>55% 25% 4% 17%</td>
</tr>
<tr>
<td><strong>Responsiveness to gaps and needs</strong></td>
<td></td>
</tr>
<tr>
<td>CCSA’s activities address identified gaps and needs in the substance abuse field</td>
<td>67% 20% 4% 10%</td>
</tr>
<tr>
<td>There are gaps and needs in the substance abuse field that CCSA should address</td>
<td>34% 38% 3% 26%</td>
</tr>
</tbody>
</table>

Note: Row percentages may not add to 100% due to rounding.

Some participants in this evaluation indicated that there are gaps and needs that CCSA should address. For example, just over one-third of survey respondents (35%) believe there are gaps and needs that CCSA should address; 38% were neutral and 26% did not know. Some key informants and focus group participants also identified gaps and needs. The most commonly identified areas were linkages between substance abuse and mental health and integration of mental health and substance abuse services, including evidence on their effectiveness; harm reduction; and prevention. \(^{21}\) Notably, while some provincial/territorial focus group participants acknowledged that harm reduction is woven into some of CCSA’s work, all agreed that it is sufficiently important to merit attention on its own. At the same time, it was also observed that if it takes too strong a position on harm reduction, CCSA may not be seen as relevant by some stakeholders or jurisdictions (for more information on perceived gaps and needs, use the following e-mail “Evaluation Reports HC - Rapports Evaluation@hc-sc.gc.ca” to obtain a copy of the Technical Report on Supplementary Data).

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\(^{20}\) This compares with 47% of all other respondents (a significant difference).

\(^{21}\) By identifying these areas as gaps and needs, stakeholders were not necessarily implying that CCSA has done no work in these areas. Indeed, some acknowledged the work that CCSA has done. Rather, stakeholders were identifying these as areas for increased focus by CCSA.
4.1.5 Value-added

CCSA brings unique value-added to the substance abuse field in Canada, as demonstrated by its ability to bring together a diverse range of stakeholders, reconcile conflicting views, and work toward a solution that has broad acceptance by the field.

There is general agreement among key informants that CCSA brings a unique value-added to the substance abuse field in Canada: its ability to bring together a diverse range of stakeholders, reconcile conflicting views, and work toward an outcome or solution that has broad acceptance by the field. This ability is seen as particularly valuable given the strong viewpoints and highly charged debate that characterize this policy area. Several key informants pointed to the First Do No Harm (FDNH) Strategy as an example of CCSA’s ability to manage the conflicting perspectives and priorities of diverse partners in order to bring all stakeholders to a consensus and a shared vision for a way forward.

Several stakeholders suggested that CCSA’s ability to broker different perspectives stems in part from its position outside of the hierarchical structure of responsibility within which provincial/territorial and federal government organizations must operate. As a non-regulatory entity with a promotional mandate, these key informants noted that CCSA has the ability to interact in a non-threatening way with multiple partners and jurisdictions. As one external key informant put it: “By not being empowered to act, CCSA is empowered to see that action does occur.”

In general, key informants also agreed that the result of CCSA’s collaborative approach is a higher quality final product. However, for a minority of key informants, the emphasis that CCSA places on partnerships and collaboration can have a downside. In particular, these key informants were concerned that collaborating with stakeholders who have a commercial interest in the outcome or final product may be detrimental from a public health perspective. Specific concerns were raised about the impact of the alcohol industry’s involvement in the National Alcohol Strategy (NAS) and more specifically in the development of the LRDGs; it was noted that the industry does not have public health expertise and is arguably in a conflict position due to its commercial interests. That said, industry was not in fact part of the Working Group tasked with the development of the LRDGs, although three industry associations were among the organizations that provided feedback on a draft version of the report summarizing the evidence and recommending the LRDGs. However, the evaluation did not obtain any specific, concrete evidence that the involvement of industry in this process resulted in weaker guidelines or activities to promote them.

In addition to its collaborative approach, many participants in this evaluation see CCSA’s ability to gather and disseminate information as one of its key strengths and a unique value-added. This is seen as particularly valuable by smaller jurisdictions that may not have the capacity to research and/or generate such information and materials on their own. Several provincial/territorial representatives indicated that the availability of well-researched, credible information and standardized, evidence-informed resources provides a starting point that can be adopted or adapted to suit the unique contexts and circumstances of the provinces and territories and other stakeholders. CCSA’s systems-related work is particularly appreciated, as program development issues are not always addressed in the peer-reviewed literature or by provincial/territorial governments.
Asked to imagine a hypothetical situation in which CCSA did not exist, a majority of survey respondents agreed that:

- there would be fewer evidence-informed resources available in the substance abuse field (71%);
- there would be less coordination/collaboration among sectors on substance abuse issues (64%); and
- substance abuse policies, programs, and practices would be negatively affected (61%).

Relatively few respondents believe there would be no significant impact on the substance abuse field if CCSA did not exist (15%), while 56% disagreed. Similarly, relatively few believe that other organizations would step in and do the same work (20%), compared with 42% who disagreed. It is important to note that for all of these questions, a substantial proportion of respondents was either neutral or did not know.²² See Table 5.

Table 5: Level of agreement among survey respondents with statements about likely consequences if CCSA did not exist (n=343)

<table>
<thead>
<tr>
<th>Statements</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>There would be fewer evidence-informed resources available in the substance abuse field</td>
<td>71%</td>
<td>15%</td>
<td>6%</td>
<td>8%</td>
</tr>
<tr>
<td>There would be less coordination/collaboration among sectors on substance abuse issues</td>
<td>64%</td>
<td>18%</td>
<td>6%</td>
<td>12%</td>
</tr>
<tr>
<td>Substance abuse policies/programs/practices would be negatively affected</td>
<td>61%</td>
<td>20%</td>
<td>5%</td>
<td>15%</td>
</tr>
<tr>
<td>There would be no significant impact for the substance abuse field</td>
<td>15%</td>
<td>19%</td>
<td>56%</td>
<td>10%</td>
</tr>
<tr>
<td>Other organizations would step in and do the same work</td>
<td>20%</td>
<td>19%</td>
<td>42%</td>
<td>19%</td>
</tr>
</tbody>
</table>

Note: Row percentages may not add to 100% due to rounding.

While key informants agreed that various other organizations do some similar work as CCSA,²³ most doubted whether, in the absence of CCSA, similar activities would be carried out or similar products developed by other organizations. A few speculated that some similar work might occur (for example, through the federal government funding a variety of organizations to carry out specific activities, or doing some similar work itself), but would likely be more fragmented. Key informants generally agreed that no other organization shares CCSA’s national mandate or scope of activity, nor the network of contacts and credibility that it has established as a result of its more than 25 years of work in the substance abuse field.

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²² It is difficult to know how to interpret the large proportion of “neutral” and “don’t know” responses to these questions. One possible explanation is that respondents had difficulty imagining a hypothetical situation in which CCSA did not exist, given that the organization has been in existence for over 25 years.

²³ Key informants cited several examples of organizations that do some similar work as CCSA, most notably the Centre for Addiction and Mental Health (CAMH) and the Centre for Addictions Research of British Columbia (CAR-BC). However, it was observed that both are provincial organizations and do not have CCSA’s national mandate.
4.2 Implementation

During the current Grant period, CCSA implemented most of its planned activities and in one case, responded to challenges in maintaining momentum in promoting the implementation of national strategy recommendations by adjusting its approach. A small number of planned projects were not undertaken due to funding constraints and other factors. Given differing expectations expressed by key informants, and recognizing CCSA’s mandate and available resources, the nature and extent of CCSA’s role in promoting and influencing policies, programs, and practice could be clarified.

During the current Grant period, CCSA implemented most of its planned activities in its various priority areas. Key activities are summarized below.

- **Alcohol.** CCSA is a member and co-chair of the National Alcohol Strategy Advisory Committee (NASAC), responsible for the implementation of the NAS recommendations identified in the 2007 *Reducing Harm Related to Alcohol in Canada* report (National Alcohol Strategy Working Group, 2007). As of 2014, activities were underway to implement 39 of 41 NAS recommendations. Key activities include ongoing distribution and uptake of the LRDGs; the online launch of Screening, Brief Intervention, and Referral (SBIR) tool in partnership with the College of Family Physicians of Canada; and initiatives relating to national alcohol price policy, standard drink labelling, post-secondary campuses and alcohol, and municipal alcohol policies. An evaluation of the NAS is currently being planned, which will report more extensively on progress in implementing its recommendations, as well as outcomes achieved.

- **Workforce development.** During the Grant period, CCSA continued to develop, refine, and update its Competencies for Canada’s Substance Abuse Workforce, a resource that is now available on CCSA’s website in six parts. Several organizations are integrating the Competencies into their work. CCSA has established a Certification Task Force to promote addiction counselling certification. An Accreditation Network involving all six Canadian accreditation bodies has recently been established to encourage accreditation of residential treatment facilities.

- **Canada’s North and First Nations, Inuit, and Métis (FNIM).** CCSA implemented a knowledge exchange plan for the Meeka Manuals, a series of four documents that provide culturally-relevant Inuit approaches to health and wellness, including recovery from substance abuse. CCSA also partnered with the National Native Addictions Partnership Foundation (NNAPF) to adapt existing resources to specifically apply to First Nations and Inuit populations and communities.

- **Mental health and substance abuse/concurrent disorders.** In partnership with the Canadian Executive Council on Addictions (CECA) and the Mental Health Commission of Canada (MHCC), CCSA developed and hosted a Transformational Leaders Forum, resulting in a Best Advice report that identifies the essential key considerations for enhancing collaboration between mental health and addiction services. CCSA also undertook a variety of other initiatives in collaboration with the MHCC and other partners, including, for example, contributing to the development of two CIHR Transformational Research in
Adolescent Mental Health proposals related to developing a national network for youth and mental health services and collaborating with the University of British Columbia to organize a second Lost in Translation symposium with speakers from Canada, the US, and Australia, focused on forming connections between mental health and substance use services.

- **Prescription drug misuse.** CCSA led the development of the pan-Canadian FDNH Strategy, in collaboration with stakeholders from a diverse range of sectors. The Strategy, which consists of 58 recommendations to address the harms associated with prescription drugs, was launched in March 2013. Various activities have been carried out pursuant to the Strategy, including two National Prescription Drug Drop-Off Days and establishment and annual meetings of the Canadian Prescription Drug Use Surveillance Task Force. CCSA has also completed a variety of literature reviews, environmental scans, and other research projects relating to prescription drug misuse, including several funded by Alberta Health. To date, activities are underway by stakeholders to address 23 of the 58 strategy recommendations.24

- **Impaired Driving.** CCSA co-hosted the 2011 International Symposium on Drug-Impaired Driving in Montreal, completed a major research project assessing the predictive validity of Drug Evaluation and Classification Program Tests for the National Highway Traffic Safety Administration (NHTSA) in the U.S., conducted a study of the validity of the Standardized Field Sobriety Test in detecting impairment due to drugs other than alcohol, and published various reports on the topic of impaired driving.

- **Monitoring and Surveillance.** Recognizing the monitoring and surveillance work led by Health Canada’s Office of Research and Surveillance, CCSA conducted projects in this area that fill gaps and complement this work. CCSA worked on developing a new strategy for monitoring novel psychoactive substances by monitoring media, revitalized and expanded the Canadian Community Epidemiology Network on Drug Use (CCENDU) — a national network sharing information and issuing alerts and bulletins on trends in drug-related harms — by including more sites and collaborating with more partners. CCENDU currently is comprised of nine community-based networks located throughout Canada. CCSA also produced a pan-Canadian report on student substance use in partnership with student drug use surveys in nine provinces, produced a report on the impact of substance use disorders on hospital use, and initiated a stakeholder collaboration aimed at preventing alcohol and drug-related harms at music festivals.

- **Cannabis.** CCSA published the fifth report in the Clearing the Smoke on Cannabis series on the medical use of cannabis and cannabinoids, and updated the evidence on the report focussed on the maternal use of cannabis during pregnancy. CCSA also undertook and published numerous reports on cannabis use, held a Government Caucus on marijuana, and most recently, established an Expert Advisory Group on Cannabis. CCSA provided advice to Health Canada on the evidence base for messaging regarding marijuana harms, participated in the Minister’s Roundtable on Cannabis and Health Harms for Youth in April 2014, and provided testimony on the health risks of cannabis to the House of Commons Standing Committee on Health (HESA) in May 2014.

24 Many of the FDNH recommendations have multiple sub-recommendations. This figure represents a count at the level of the main recommendations, based on a status update provided by CCSA on August 28, 2015.
• **International activities.** CCSA lead the Vienna Non-Government Organization Committee (VNGOC), which was established to create a centralized link between NGOs and international bodies in drug policy and control, until the departure of its CEO in 2014. In 2013, CCSA chaired the first national drug conference in New Zealand, and has taken various opportunities to support international connections and knowledge exchange, such as advising the International Narcotics Control Board on key NGO stakeholders to meet with in a series of national visits and participating in the 2013 World Health Assembly in Switzerland. CCSA is also a member of the Canadian delegation to the Commission on Narcotic Drugs as well as a member of World Health Organization-led initiatives looking at impaired driving, cannabis, and standards for the prevention of youth drug use.

• **Knowledge exchange and research.** In addition to knowledge exchange and research activities carried out under the above priority areas, CCSA hosted the fourth and fifth Issues of Substance conferences, used CCDs as a forum for discussing provincial/territorial priorities and activities on substance abuse, as well as sharing lessons learned and exploring future opportunities to collaborate on issues related to substance abuse, and produced three Substance Abuse in Canada reports.

While CCSA documents indicate that most planned activities in the last two fiscal years (2013-2014 and 2014-2015) have been implemented or are in the process of being implemented, there is evidence that a small number of planned activities were not pursued or were suspended, often for reasons related to availability of resources such as funding and data. For example, a project on drug-impaired driving harms among seniors using CADUMS and crash fatality data was not completed because CCSA did not receive the latter data from the Canadian Council of Motor Transport Administrators as expected. In addition, several Alberta Health-funded projects on prescription drug misuse did not proceed as planned, since provincial funding became unavailable due to the economic downturn in that province. Finally, a project on the costs of prescription drug misuse, which was intended to explore health, social and enforcement costs associated with prescription drug use/misuse and produce a research report with related knowledge exchange products, was suspended in 2014–2015 due to lack of funding. In this context, it is important to note that several external key informants highlighted the usefulness of the 2006 cost study to their own work and emphasized the urgent need for it to be updated\(^{25}\).

However, funding and data availability were not the only reason that planned activities were not undertaken. For example, planned inaugural meetings of the Canadian Prescription Drug Use Surveillance Task Force and the Canadian Network of Prescription Drug Monitoring Programs were not held as planned; Health Canada has assumed the leadership role for these activities and is working directly with the FPT Ministers of Health. A planned Chair Event on the topic of risky drinking on campus was replaced with a formal partnership with Acadia University on a research and knowledge exchange collaboration that will support Acadia’s leadership of a Campus and Alcohol initiative.

\(^{25}\) According to CCSA, a comprehensive substance abuse cost study was initially considered for inclusion in their current Grant proposal. However, it was agreed that this study was beyond the scope of the 2.5 year funding period. CCSA will instead be working with partners to explore potential methods, feasibility, and resources for a comprehensive study in the future.
Beyond evidence of funding constraints and other issues that affected specific projects, two main issues emerged from the evaluation related to the completion of planned activities. First, some key informants observed that it can be difficult to ensure that momentum follows the work that is put into the development of a strategy or resource. For example, some external key informants noted that they have heard little regarding the status of implementation of the recommendations of the FDNH Strategy, and wondered what has been accomplished to date.

CCSA representatives indicated that CCSA has committed to monitoring and reporting on the status of the FDNH recommendations, as it has also committed to reporting on the status of the NAS recommendations. During the development of the FDNH Strategy, regular updates were provided to NAC members. One year post launch, CCSA produced an annual report that was distributed to 242 individuals. CCSA also facilitated monthly teleconference meetings of the implementation teams involved in moving the Strategy recommendations forward (see discussion below), as well as meetings of the FDNH Executive Council. As per the FDNH knowledge mobilization approach, all NAC members are expected to share updates with their organizations and networks to facilitate broad communication.

CCSA key informants acknowledged that challenges were encountered in moving FDNH recommendations forward under the original approach, under which implementation teams were responsible for implementing the recommendations associated with each of the strategic streams of action. They attributed these challenges to the natural lifecycle of projects, suggesting that it is not uncommon for stakeholder commitment to wane following the initial time and energy devoted to strategy development. To address this challenge, smaller, project-based teams have been established, which are responsible for implementing specific projects selected by the National Advisory Council from among a group of submissions. The original implementation teams have become communities of practice and continue to be consulted. CCSA key informants reported that this new approach has been endorsed by FDNH stakeholders.

Second, based on the key informant interviews, there appears to be different expectations regarding the limits of CCSA’s role and the extent to which it should be involved in promotion or implementation of policies, programs, and practices. From CCSA’s perspective, its role is to promote and facilitate implementation through, for example, collaborating on funding proposals, knowledge exchange materials, letters of support, or strategic meetings with key decision makers. Views were also expressed by Health Canada key informants that CCSA could more actively champion strategy or resource implementation or, conversely, that CCSA is being pushed into an implementation role that is more extensive than it is equipped, resourced, or intended to play. These differing views suggest a need to clarify what implementation means to different stakeholders, and the nature and extent of CCSA’s role in promoting changes to policy, programs, and practice in order to achieve a common understanding.

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26 Six out of eight projects will be seed funded under this new process. For example, one project aims to standardize data collection in death investigations related to opioids.
4.3 Achievement of outcomes

4.3.1 Partnerships and coordination of effort

CCSA’s partners represent a diverse range of stakeholders and interests and there is evidence that coordinated action is taking place to address the harms of substance abuse. While coordination can and does occur without any involvement by or connection to CCSA, CCSA is an important impetus for coordinated action and most stakeholders agree that there would be less coordination of effort in its absence.

Increased and more diverse partnerships

While key informants believe that CCSA’s partners have increased in number and diversity over the period covered by this evaluation, quantitative comparisons against the 2010 Grant evaluation were not possible due to changes in CCSA’s approach to tracking partnership information. Prior to that evaluation, CCSA considered both “partners” and “stakeholders” to be partners, which likely overstated the true extent of its partnerships.27

Following the recommendation of the 2010 evaluation, CCSA began distinguishing between “partners” and “stakeholders”.28 This shift in definitions has resulted in a nominal drop in the number of CCSA’s “partners”. However, it provides a more accurate portrayal of the number and range of organizations actively engaged in CCSA-led activities.

Currently, CCSA’s contact database contains 340 partners (representing 194 organizations) and 1,820 stakeholders (representing 859 organizations). The large majority of CCSA’s partners (93%) are located in Canada and represent all Canadian provinces and territories, while 7% are international partners located outside of Canada. Although a large proportion of Canadian partners (44%) are located in Ontario, it is important to recognize that many federal government employees as well as national organizations are located in that province; thus this is not necessarily indicative of overrepresentation by Ontario. Conversely, relative to its population, Quebec appears to be underrepresented among CCSA’s partners (5%). For more information on the geographic distribution of CCSA’s partners, use the following e-mail “Evaluation Reports HC - Rapports Evaluation@hc-sc.gc.ca” to obtain a copy of the Technical Report on Supplementary Data.

27 Under the tracking system used at the time of the previous evaluation, CCSA counted a total of 6,897 national stakeholders and 216 international stakeholders. Of these, CCSA considered 919 to be “partners” in Grant-funded activities, which it defined as those who have been involved in those activities by either providing financial or in-kind support; participating in consultations or collaborating in the development of resources; or otherwise engaging in activities.

28 Partners are now defined as “groups, networks, or organizations that actively collaborate and exchange information with CCSA to achieve a common goal of mutual benefit to the organizations”; while stakeholders are defined as “groups, networks or organizations that affect or are affected by CCSA’s actions, products, and objectives. The relationship with stakeholders is direct, informal, and infrequent (less than quarterly) and may occur for purpose of increasing awareness or obtaining input on products.”
CCSA’s partners are involved in Named Grant, DSCIF, and DTFP funded activities. Those involved in Named Grant activities (n=263) are most often involved with prescription drug misuse (n=79), alcohol (n=60), workforce development (n=44) and monitoring and surveillance (n=40), as well as mental health and substance abuse (n=24), international activities (n=18), First Nations, Inuit and Métis (n=14), impaired driving (n=10), and cannabis (n=5) (CCSA, 2015d). An additional 77 partners are involved only in DSCIF or DTFP activities.

Partner organizations include national and regional NGOs, health professional organizations, academic institutions, provincial/territorial government health departments, provincial agencies, regional health authorities, Aboriginal organizations, federal government departments, industry, municipal governments, local organizations, and international organizations. Based on information contained in CCSA’s contact database, the four largest sectors represented by CCSA’s partners are provincial/territorial government (19%); health promotion (11%), federal government (11%), and research (10%). However, because organizational and sectoral information about partners is not captured consistently within the database, these results may not be reliable. While CCSA has made clear progress in tracking its partners since the last Grant evaluation, further adjustments to the structure of the contact database could enhance its ability to report partnership information.29

CCSA representatives reported that in the current Grant period, CCSA has altered its approach to engaging partners in several ways.

- CCSA has become more systematic in its engagement of new stakeholders and partners through a variety of tactics. In addition to the CCDs, these include annual as well as ongoing, ad hoc stakeholder mapping to identify key organizations that can plan a role in moving forward work in the priority areas; regular review of membership and recruiting for its advisory groups and implementation teams; and regular scanning for new organizations that are undertaking work that aligns with its own.

- CCSA has made a conscious effort to diversify its partnerships and to strengthen links to the health sector at the national and provincial levels with organizations such as the College of Family Physicians and the Canadian Nurses Association (among others). New partnerships have also been established with pharmacists, coroners, accreditation bodies, recovery organizations, and sport organizations that did not exist at the time of the last Grant evaluation.

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29 Currently, the “sector” field within CCSA’s contact database captures two types of information: information about the organization type (e.g. federal government, provincial/territorial government) and information about fields or domains of activity (e.g., health promotion, education). Within the database, partners may be associated with multiple “sectors”, including both types of organization and fields or domains of activity. Furthermore, relevant characteristics of a given partner are not consistently tracked (e.g., many NGOs are not identified as NGOs, producing under-counting of NGO partners). Separating “organization type” and “sector” into two distinct database fields and ensuring consistent coding would resolve these shortcomings.
• CCSA has adopted an integrated approach to knowledge transfer according to which the needs and issues of end users are identified and incorporated into projects from the outset through a process of consultation. Through this approach, CCSA solicits and incorporates input from relevant stakeholders throughout project lifespans, resulting in final products that are more appropriate to stakeholders’ needs. Key informants outside of and within CCSA observed that this change has been positive for all of CCSA’s work, and has been particularly relevant to projects serving the needs of Aboriginal Canadians.

**Coordination of effort**

In the intermediate term, increased and more diverse partnerships are expected to produce increased coordination of effort to address substance abuse and related harms. An important measure of coordinated effort is the extent to which partners and stakeholders contribute financially and in-kind to joint initiatives. The available evidence indicates that:

• Direct financial contributions to CCSA-led activities by partners other than Health Canada were considerably lower during the period covered by this evaluation as compared to the last Grant evaluation. Financial contributions totalled just over $800,000 between 2011–2012 and 2014–2015, compared to approximately $3.1 million between 2006–2007 and 2009–2010. Both the current and previous Grant evaluation found considerable variability from year to year in the level of direct financial contributions from external partners. Overall, these patterns highlight the unpredictability of non-Health Canada funding to CCSA; many of CCSA’s partners and stakeholders almost certainly face resource constraints that limit their ability to provide direct financial support to CCSA.

• While financial contributions were relatively low, partners and stakeholders contributed 28,000 hours of engagement time, or an average of 13 hours per partner or stakeholder, to CCSA activities (Named Grant, DSCIF, and DTFP) between 2011–2012 and 2014–2015 (CCSA, 2015e).\(^{30}\) Using a conservative estimate of $30 per hour for in-kind time, this translates into $840,000 in partner contributions over this period, or $389 per partner or stakeholder.

• Partners and stakeholders contributed approximately 63% of the total in-kind hours (17,500 hours) to Named Grant activities. Among Named Grant priority areas, partners and stakeholders combined spent the most time on prescription drug abuse/misuse (4,864 hours), the NAS (3,693 hours), monitoring and surveillance (2,801 hours), workforce development (2,633 hours) and impaired driving (2,105 hours), reflecting areas of shared priority.

• 26 working/advisory groups and committees were active during the current Grant period, of which more than half were either co-chaired by CCSA and an external partner (n=17) or chaired by an external partner supported by CCSA (n=3), demonstrating the commitment of some external stakeholders to support coordinated action.

\(^{30}\) Comparisons of in-kind contributions against the previous Grant evaluation were not possible, since these were not tracked at that time for all Grant-funded activities.
Beyond financial and in-kind contributions of partners, the extent to which actions are being taken by stakeholders to address the recommendations of national strategies and action plans is an important indicator of coordinated effort. At present, activities are underway or have been completed to implement 39 of 41 NAS recommendations, and are underway to implement 23 of 58 FDNH recommendations. Table 6 provides some examples.\(^{31}\)

<table>
<thead>
<tr>
<th>Strategy/action plan</th>
<th>Examples of actions</th>
</tr>
</thead>
</table>
| National Alcohol Strategy               | • Development of the national LRDGs to encourage a culture of moderation and provide clarity and consistency of messaging, and subsequent uptake and promotion of the LRDGs by stakeholders  
• Collaboration between CCSA and the College of Family Physicians of Canada to develop an SBIR tool for alcohol  
• Collaboration between CARBC, CCSA, and the Canadian Institutes for Health Information (CIHI) to develop a project to estimate and report annual rates of alcohol, tobacco and illicit drug use-attributable morbidity and mortality for Canadian provinces and territories |
| First Do No Harm Strategy               | • Ongoing work of the FPT Ministers of Health to establish prescription monitoring programs and a national surveillance framework for pharmaceutical abuse  
• Agreement between the Canadian Association of Chiefs of Police and Public Safety Canada to host an annual prescription drug drop-off event for the next three to five years, following on the success of the first national Prescription Drug Drop-Off Day in May 2013  
• Ongoing work to update the existing Canadian Guideline for Safe and Effective Use of Opioids for Non-Cancer Pain  
• Numerous collaborative projects related to opioid prescribing, overdose prevention, death investigations, care pathways, prescriber training, and safe storage and disposal, among other topics |

In addition to actions taken in response to national strategy/action plan recommendations, the evaluation also found other examples of coordinated action, including an initiative led by CCSA and the Canadian Executive Council on Addiction (CECA) to explore current accreditation services for residential facilities and improve the overall level of accreditation in Canada; an agreement between CCSA and the Canadian Addiction Counsellors Certification Federation (CACCFC) to develop a certification process for regulated addiction counselling in Canada, and subsequent establishment of a Workforce Certification Taskforce; and establishment of Memoranda of Understanding with CECA and the MHCC to organize a Transformational Leaders Forum and produce a report on a Collaboration for Addiction and Mental Health Care: Best Advice to assist the field in moving forward on collaborative practice.

External key informants agreed that the work of CCSA has improved coordination of action in the substance abuse field, and similar views emerged from the stakeholder survey.

\(^{31}\) It was beyond the scope and budget of this evaluation, which is focusing on CCSA in general and not on particular action plans and strategies, to compile an exhaustive inventory of actions taken by partners and stakeholders to implement national action plan/strategy recommendations. Therefore, examples are provided to the extent that the information was available in the available documents or known to CCSA. In future, the task of compiling a comprehensive inventory could be completed on an ongoing basis as part of CCSA’s performance measurement strategy, or appropriately resourced as one aspect of evaluations focused on specific national strategies.
• Two-thirds of survey respondents (66%) agree that the work of CCSA has improved coordination of action in the field of substance abuse. This compares favourably with survey results from the previous (2010) Grant evaluation, when 59% of respondents agreed with a similar general statement that overall, collaboration and coordination among stakeholders in the field of substance abuse had increased because of CCSA.

• Just over half of survey respondents (51%) believe their own organization is more likely to work together with other stakeholders to address substance abuse issues and related harms because of CCSA. This is considerably higher than in 2010, when 39% of survey respondents agreed with a similar statement that their organization was more likely to collaborate with other stakeholders as a result of CCSA. Although this proportion may seem low, it is important to recognize that undertaking partnerships and collaborative work is time-consuming, and most stakeholder organizations are likely not specifically funded for this purpose.

• 82% of survey respondents reported having worked together with other stakeholders in substance abuse or related fields in the last five years. This includes many who reported having done so as a result of some connection to CCSA:
  • 66% have networked with other stakeholders at a CCSA-led event
  • 50% have collaborated with other stakeholders on an initiative coordinated by CCSA
  • 33% have contacted other stakeholders following an introduction facilitated by CCSA
  • 26% have collaborated with other stakeholders on a joint initiative, following an introduction facilitated by CCSA

Notably, a sizeable proportion of survey respondents (41%) have collaborated with other stakeholders on a joint initiative with no connection to CCSA.

Overall, these findings suggest that while coordination can and does occur without any involvement by or connection to CCSA, CCSA is an important force behind coordinated action. As reported earlier, 64% of survey respondents believe there would be less coordination and collaboration among sectors on substance abuse issues if CCSA did not exist.

4.3.2 Recognition of CCSA as a leader

CCSA is generally regarded by stakeholders as an important leader in the field of substance abuse, and in particular, as a credible source of information and a trusted expert.

Virtually all key informants, as well as a large majority of survey respondents, consider CCSA to be an important leader in the substance abuse field. Among survey respondents, 83% consider CCSA to be an important leader in the field, compared to 77% of respondents in 2010 who agreed that

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32 The 2010 and 2015 survey results are not directly comparable due to differences in question wording and sample, but nonetheless provide some basis for comparison. It should be noted that unlike the 2010 survey, the 2015 survey targeted all stakeholders in CCSA’s contact database regardless of their level of involvement with the organization.
CCSA plays an important leadership role in the field. In particular, CCSA is widely regarded as a top choice among stakeholders for credible, evidence-informed information; see Table 7A, Table 7B and Table 7C.

- CCSA was identified as a top five choice of information by 87% of survey respondents. By comparison, academic journals/databases were among the top five for 82% of respondents, followed by international sources (68%), Health Canada (63%), and CAMH/EENet (62%).
- Academic journals/databases were most often chosen as respondents’ first choice of evidence-informed information (48% of respondents), followed by CCSA (27%).
- Average ranking of various sources of information confirms academic journals/databases as respondents’ top choice, followed closely by CCSA.

Table 7A: Perceptions of CCSA as a source of information among survey respondents (n=343)

<table>
<thead>
<tr>
<th>Respondents identifying various sources of evidence-informed information as a top five choice</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCSA</td>
<td>87%</td>
</tr>
<tr>
<td>Academic journals/databases</td>
<td>82%</td>
</tr>
<tr>
<td>International sources</td>
<td>68%</td>
</tr>
<tr>
<td>Health Canada</td>
<td>63%</td>
</tr>
<tr>
<td>Centre for Addiction and Mental Health (CAMH)/Evidence Exchange Network (EENet)</td>
<td>62%</td>
</tr>
<tr>
<td>Public Health Agency of Canada</td>
<td>34%</td>
</tr>
<tr>
<td>Centre for Addictions Research of British Columbia (CAR-BC)</td>
<td>31%</td>
</tr>
<tr>
<td>Canadian Institutes for Health Information (CIHI)</td>
<td>23%</td>
</tr>
<tr>
<td>Health Systems Evidence</td>
<td>12%</td>
</tr>
<tr>
<td>Other</td>
<td>38%</td>
</tr>
</tbody>
</table>

Table 7B: Perceptions of CCSA as a source of information among survey respondents (n=343)

<table>
<thead>
<tr>
<th>Respondents identifying CCSA among their top five choices</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>First choice</td>
<td>27%</td>
</tr>
<tr>
<td>Second choice</td>
<td>26%</td>
</tr>
<tr>
<td>Third choice</td>
<td>12%</td>
</tr>
<tr>
<td>Fourth choice</td>
<td>12%</td>
</tr>
<tr>
<td>Fifth choice</td>
<td>10%</td>
</tr>
<tr>
<td>Not a top five choice</td>
<td>13%</td>
</tr>
</tbody>
</table>

33 For the purpose of this analysis, respondents’ first choices were given a value of 5, their second choices were given a value of 4, and so on to their fifth choices, which were given a value of 1. An average score was then calculated for each source of information and the sources were ranked based on the average, with higher scores indicating more popular choices.
Table 7C: Perceptions of CCSA as a source of information among survey respondents (n=343)

<table>
<thead>
<tr>
<th>Average ranking of information sources</th>
<th>Average ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic journals/databases</td>
<td>3.25</td>
</tr>
<tr>
<td>CCSA</td>
<td>3.08</td>
</tr>
<tr>
<td>CAMH/EENet</td>
<td>1.95</td>
</tr>
<tr>
<td>International sources</td>
<td>1.85</td>
</tr>
<tr>
<td>Health Canada</td>
<td>1.71</td>
</tr>
<tr>
<td>CAR-BC</td>
<td>0.83</td>
</tr>
<tr>
<td>Public Health Agency of Canada</td>
<td>0.76</td>
</tr>
<tr>
<td>CIHI</td>
<td>0.51</td>
</tr>
<tr>
<td>Health Systems Evidence</td>
<td>0.28</td>
</tr>
<tr>
<td>Other</td>
<td>0.78</td>
</tr>
</tbody>
</table>

In addition to being a top source of evidence-informed information about substance abuse, CCSA is regarded as a trusted expert in the substance abuse field by stakeholders, some of whom have called on the organization to provide advice, conduct research and other projects, and deliver presentations on a variety of topics.

- Beyond its successful proposals for Named Grant, DTFP, and DSCIF funding, CCSA received funding through 12 contracts and/or research grants to undertake work for other stakeholders during the period of this evaluation. For example:
  - Alberta Health requested CCSA’s support in developing a clinical network for alcohol and contracted CCSA to conduct a series of projects over a three year period related to prescription drug misuse. However, a second three-year term has been placed on hold, as funding become unavailable due to the economic downturn in that province.
  - CCSA has been contracted by Manitoba to inform the development of an alcohol strategy for the province, which will build on the efforts of the NAS.
  - The National Highway Traffic Safety Administration (NHTSA) in the United States funded CCSA to undertake a major research project from September 2010 to December 2013 that assessed the predictive validity of Drug Evaluation and Classification Program tests.
  - CCSA has advised Health Canada on the evidence base for key messages regarding marijuana harms. In February 2014, CCSA held a Government Caucus on marijuana to provide Conservative Members of Parliament and Senators with an opportunity to become more informed on the issue. In April 2014, CCSA was invited to participate in the Minister of Health’s Roundtable on Marijuana Health Harms for Youth, and in May 2014, CCSA participated in the House of Commons Standing Committee on Health’s (HESA) examination of the health risks and harms of marijuana.
  - Health Canada has also requested CCSA’s input on challenges, gaps, and improvements in the CDSA. In addition, CCSA developed advice briefs on Zohydro and Naloxone.
  - The Ontario Ministry of Transportation invited CCSA to participate in its internal Expert Working Group on drug-impaired driving.
• The Cross Country Dialogue process has resulted in numerous invitations for collaboration being extended to CCSA, signifying stakeholder recognition of the organization’s expertise and leadership role as well as new opportunities for knowledge sharing, partnership development, and further engagement. For example, CCSA’s CEO was invited to sit on the Minister’s Advisory Committee on Mental Health and Addictions in Newfoundland following the CCD in that province.

• During the period covered by the evaluation, CCSA staff were invited to present at conferences, panels and meetings in Canada and around the world. Topics included cannabis, novel psychoactive substances, and the impact of substance use disorders on hospital use. Some of these invitations have come from major international organizations such as the WHO and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Furthermore, CCSA is part of the Canadian delegation attending meetings of the Inter-American Drug Abuse Control Commission (CICAD) and the Special Session of the United Nations General Assembly on the World Drug Problem (UNGASS), as well as the United Nations Commission on Narcotic Drugs (CND).

• During the current evaluation period, CCSA received over 230 communiqués from stakeholders acknowledging and thanking it for its work in all priority areas, particularly in relation to the development of the LRDGs (n=29 messages), action on prescription drug misuse (n=29), international work (n=15), and workforce development/competencies (n=13), as well as cannabis, drugs and driving, and the Youth Standards (n=12 each). This was up from 75 reported in the interim evaluation.

Overall, the evidence available to this evaluation clearly indicates that CCSA is regarded by stakeholders as a leader in the substance abuse field, when leadership is defined as being a top source of information and trusted expert and adviser. However, some key informants observed that the organization does not necessarily embody all dimensions of leadership. In particular, they noted that CCSA is neither innovative nor on the cutting edge of public policy, for example with respect to work in the area of harm reduction. However, these key informants disagreed on whether it would be appropriate for CCSA to take on such a role.

4.3.3 Awareness and application of evidence-informed products

CCSA actively promotes awareness of its products through a variety of approaches to knowledge dissemination and exchange. While most stakeholders are aware of and have used at least one of the major products published by CCSA, awareness and use varies considerably by product.

CCSA actively promotes awareness of its knowledge products by disseminating them through a variety of approaches, ranging from traditional media outlets (via Internet, broadcast and print), conferences, small-scale online meetings, social media, email subscriptions, and publishing documents on its website. Awareness is greatest for the LRDGs, the Competencies, and the FDNH Strategy, and these products, along with the CCENDU bulletins and drug alerts, are also the most often used.
- Since 2010, CCSA has accumulated nearly 4,000 subscriptions (unique subscribers) through its email subscription-based products, including Action News (English), Action Nouvelles (French), Addiction News, and CCENDU bulletins and drug alerts.


- There has been a large increase in the number of CCSA documents downloaded per year, rising from an average of 1,171 per year in 2011–2012 to 2,202 per year in 2014–2015. Together, the top 10 downloaded documents were downloaded 212,881 times during this period. To obtain a copy of the Technical Report on the Supplementary Data, use the following e-mail “Evaluation Reports HC - Rapports Evaluation@hc-sc.gc.ca”.

- CCSA publications and evidence-based products are being cited in peer-reviewed journals and referenced in stakeholders’ policy and practice documents. For example, 12 CCSA publications spanning various topic areas were cited a total of 54 times in peer-reviewed journals during the period covered by this evaluation (between one and 12 times each), and 26 stakeholder reports and policy documents contained references to a CCSA product.34

Results from the stakeholder survey show variable awareness and use among respondents of specific evidence-based products produced by CCSA, as shown in Table 8.35 Overall, almost all (98%) survey respondents were aware of at least one of the eleven products named in the survey, and 74% have used or implemented at least one of them. However, awareness and use varies considerably depending on the product. These differences may be attributable in part to the different types of products published (some are likely to have a broader appeal than others) and the recency of publication.

- Respondents were most familiar with the LRDGs, the Competencies, and the FDNH Strategy. More than three-quarters of respondents (77%) were aware of the LRDGs prior to the survey, while 67% were aware of the Competencies and 60% were aware of the FDNH Strategy. Somewhat fewer respondents, but still over half, were aware of the Drug Summaries (56%), the Clearing the Smoke on Cannabis series (55%), the Policy Briefs on Impaired Driving (54%), the CCENDU bulletins and drug alerts (53%), and the SBIR tool (52%). Fewer than half were aware of the Alcohol Pricing Policy (43%), The Impact of Substance Use Disorders on Hospital Use report (32%), and the Meeka Manuals (13%).

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34 It was beyond the scope and budget of this evaluation to conduct a bibliometric analysis to provide comprehensive data pertaining to these indicators. Therefore, the evaluation reports available performance measurement information provided by CCSA. In future, maintaining this information could be completed on an ongoing basis as part of CCSA’s performance measurement strategy, or appropriately resourced as one task in a future evaluation.

35 Due to length considerations, the stakeholder survey did not assess awareness and uptake of all of CCSA’s knowledge products, but rather focused on 11 major products selected by CCSA.
- Respondents were most likely to have read the LRDGs (54%), the FDNH Strategy (42%), the Competencies (39%), the Drug Summaries (37%), and the CCENDU bulletins and drug alerts (33%). The remaining products have been read by fewer than 30% of respondents.

- Survey findings showed that between 74% and 97% of respondents who had read the CCSA products listed had in fact used them. Respondents were most likely to have used or implemented the LRDGs (41% of all respondents, or 75% of those who have read them), followed by the CCENDU bulletins and drug alerts (27% of all respondents, or 81% of those who have read them), the Competencies (26% of all respondents, or 67% of those who have read them), and the FDNH Strategy (21% of all respondents, or 51% of those who have read it).

- The remaining products have been used or implemented by fewer than 20% of all respondents. However, all of the remaining products have been used or implemented by more than one-quarter of those who have read them. In the case of the Clearing the Smoke on Cannabis series, 72% of readers have used or implemented this product.

Table 8: Awareness and use of evidence-informed products among survey respondents (n=343)

<table>
<thead>
<tr>
<th>Product</th>
<th>Aware prior to survey</th>
<th>Have read</th>
<th>Have used/implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>All respondents</td>
</tr>
<tr>
<td>LRDGs</td>
<td>77%</td>
<td>54%</td>
<td>41%</td>
</tr>
<tr>
<td>Competencies</td>
<td>67%</td>
<td>39%</td>
<td>26%</td>
</tr>
<tr>
<td>FDNH Strategy</td>
<td>60%</td>
<td>42%</td>
<td>21%</td>
</tr>
<tr>
<td>Drug Summaries</td>
<td>56%</td>
<td>37%</td>
<td>17%</td>
</tr>
<tr>
<td>Clearing the Smoke on Cannabis series</td>
<td>55%</td>
<td>26%</td>
<td>18%</td>
</tr>
<tr>
<td>Policy Briefs on Impaired Driving</td>
<td>54%</td>
<td>26%</td>
<td>8%</td>
</tr>
<tr>
<td>CCENDU bulletins and drug alerts</td>
<td>53%</td>
<td>33%</td>
<td>27%</td>
</tr>
<tr>
<td>SBIR tool</td>
<td>52%</td>
<td>29%</td>
<td>11%</td>
</tr>
<tr>
<td>Alcohol Pricing Policy</td>
<td>43%</td>
<td>23%</td>
<td>6%</td>
</tr>
<tr>
<td>The Impact of Substance Use Disorders on Hospital Use</td>
<td>32%</td>
<td>18%</td>
<td>6%</td>
</tr>
<tr>
<td>Meeka Manuals</td>
<td>13%</td>
<td>6%</td>
<td>2%</td>
</tr>
</tbody>
</table>

The specific ways in which some of CCSA’s knowledge products have been used and applied by stakeholders are described below.

**LRDGs**

Of CCSA’s knowledge products, the LRDGs are the most widely known and used. Shortly after the release of the LRDGs in 2011 they were officially supported by 33 organizations. According to data provided by CCSA, since 2011, the LRDGs have been promoted, used, or implemented by 160 organizations. The actual number of organizations that have used the LRDGs may well be higher, since this figure only reflects use known to CCSA.
implemented the LRDGs, most commonly by promoting them within or outside of their organizations; using them to initiate conversations with clients, patients, students, or others about their drinking behaviours; and adapting the format of the LRDGs to use with their own materials.

Specific examples of use of the LRDGs, based on the LRDG case study and other sources of evidence, include the following:

- Éduc’alcool in Quebec promoted awareness of the LRDGs through a series of campaigns using digital, television, radio, and print media to convey creative messaging about the LRDGs.
- The Liquor Control Board of Ontario undertook a mass production and distribution of LRDG-informed brochures through its 624 stores and Ontario’s 36 health units.
- The Liquor and Gaming Authority of Manitoba launched an awareness campaign based on the LRDGs (It’s Not How, It’s How Many) which targets young adults.
- Healthy Child Manitoba is using the LRDGs in its work with prenatal and postpartum mothers who may be at risk of drinking.
- The Liquor Distribution Branch of British Columbia disseminated the LRDG brochure in its stores.
- CAMH redesigned its alcohol-related resources to incorporate the LRDGs.
- Canada’s Department of Defence distributed the LRDGs to all 20 of its bases and wings, incorporated the LRDGs into military medical screening protocol, and included information on the LRDGs in the official Canadian Forces magazine.
- Nine health units in southern Ontario launched the Rethink Your Drinking campaign to increase awareness/education of LRDGs.
- A university campaign was launched asking students to reflect on their drinking behaviour: What’s Your Cap?
- The LRDGs have been incorporated into training materials for medical and nursing students at several universities.
- The distillery Lucky Bastard has added an LRDG label to its bottles.

Workforce Competencies

Twenty-six percent of all survey respondents report having used the Competencies, and according to CCSA, in 2014, the Competencies were in use by 24 communities/regions across 10 provinces/territories (CCSA, 2014c). Common uses of the Competencies reported by survey respondents include incorporating some behaviour indicators from some Competencies into training/professional development processes; incorporating some behaviour indicators from some Competencies into performance assessment processes; using the Competencies interviewing tools in the hiring process; using the generic questions in the interview process;
using the Competencies tools in the performance management process; using the Competencies to improve their own skill level or job performance and incorporating use of the Competencies into human resource policies. Specific examples of the use of the Competencies include the following:

- The Saskatchewan Institute of Applied Science and Technology (SIAST) integrated the Competencies into its addictions counselling diploma program. SIAST indicates the diploma program now exceeds CCSA’s Workforce Competencies (SIAST, n.d).

- Veterans Affairs Canada, Newfoundland and Labrador Health and Community Services, and Alberta Health Services worked with CCSA to incorporate the Technical and Behavioural Competencies into their standards of practice, training, and hiring (CCSA, 2011b). Most recently, Veterans Affairs used and adapted the Competency Dictionary for behavioural and technical competencies to create competency profiles for positions making up its client service teams, and competencies were embedded in clinical guidelines for Operational Stress Injury Clinics across Canada. Key informants reported that multiple organizations in Nova Scotia have also been integrating the competencies into their standards of practice, training and hiring.

- McMaster University integrated the Competencies into its curriculum for the Social Worker, Alcohol, Drug and Gambling Services Program.

- In Manitoba, some addiction service providers are using the Competencies in developing job descriptions and in interviewing.

**Other knowledge products**

Examples of the use and application of other products produced by CCSA are given below.

- **Meeka Manuals.** The Truth and Reconciliation Committee ordered 500 sets of Meeka Manuals for its second national event and invited Meeka Arnakaq to conduct training workshops and/or healing circles with the resources.

- **Policy Briefs on Impaired Driving.** The Ontario Ministry of Transportation considered CCSA’s three Policy Briefs on Impaired Driving while drafting Bill 31, the *Transportation Statue Law Amendment Act (Making Ontario’s Roads Safer)*.

- **SBIR tool.** Manitoba is in the process of selecting five pilot sites for implementation of the SBIR tool as part of its DTFP project. In addition, SBIR videos are being adapted for case managers at Veterans Affairs to use for training, and SBIR is being integrated as part of an addiction toolkit to be launched in late 2015 as part of CAMH Education.

- **CCENDU bulletins and drug alerts.** In its announcement of its intention to include methylenedioxypyrovalerone (MDPV), an amphetamine-type drug commonly referred to as “bath salts”, as a Schedule I substance, Health Canada referred to CCENDU’s June 5, 2012 alert as the most up-to-date, reliable source of information on the topic. Most recently, CCENDU’s alerts and bulletins related to fentanyl brought significant media and stakeholder
attention to the issue, including a joint statement from Health Canada and the PHAC warning the public about the dangers of illicit fentanyl (see case study excerpt below for more information).

**Use and application of evidence-based products: The role of CCENDU in the early detection and dissemination of information on the fentanyl crisis**

CCENDU first detected and advised network members and subscribers of the dangers of non-pharmaceutical fentanyl in June 2013. This was followed by a second alert in February 2014 warning of the dangers of the increasing availability of counterfeit oxycodone tablets containing fentanyl, and a third in February 2015 notifying CCENDU subscribers that, as predicted, fentanyl deaths in British Columbia, Alberta and Saskatchewan had increased. Collectively, these alerts have been accessed from the CCSA website a total of 32,773 times. They have also provided source material for the 2013 International Narcotics Control Board (INCB) Report as well as public alerts issued by the Agence de la santé et des services sociaux de Montréal, Alberta RCMP, and others and are featured on the home page of the Canadian Association of Poison Control Centres.

When CCSA first issued the alert in 2013, CCENDU alerts had less than 100 subscribers. As of August 2015, there are almost 700 people receiving these alerts and communicating relevant information to their networks. The quote below illustrates that not only is this increased reach is having an impact, it is saving lives:

*I am a paramedic in a large urban city and I just did a male pt [patient] that OD [overdosed] on what his friend described to us was this pill. Thanks to your bulletin we knew what we were dealing with immediately. This is the 3 pt I have had that has used these particular pills. Even with early intervention the pt I had today went into cardiac arrest but we did manage to resuscitate him but he remains in critical condition due to aspiration while he was unconscious.* (Email sent to ccendu@ccsa.ca).

By May 2015, deaths from fentanyl were being referred to as a “death epidemic” in Alberta and British Columbia. Given increasing concerns about harms associated with fentanyl from both illicit and pharmaceutical sources, and the lack of national data on deaths involving fentanyl, the CCENDU network decided to collect and collate the number of deaths involving fentanyl from across Canada to better understand this evolving situation and assist jurisdictions to plan appropriate interventions, as needed.

In August 2015 CCSA released a CCENDU Bulletin on Deaths involving fentanyl. The release of the bulletin in conjunction with media outreach by partners in B.C., Québec, and elsewhere brought a great deal of attention to the issue. Between August 11 and August 18 there were almost 700 media stories released that referred to the bulletin including several high-profile editorials and commentaries from the Globe and Mail, statements from the Canadian Pharmacists Association, and news conferences held by Toronto Police Services as well as Winnipeg Police Services.

Health Canada and the Public Health Agency of Canada issued a joint statement warning the public about the dangers of illicit fentanyl, and Health Canada indicated that it was reviewing the prescription-only status of the opioid overdose treatment Naloxone on an urgent basis.
The majority of respondents who had read CCSA’s products reported gaining knowledge or actively using them. However, the rate of awareness for some products was relatively low. Recognizing that CCSA’s products are targeted to specific audiences, this indicates that there may be an opportunity for CCSA to explore ways in which to promote awareness of their products.

Among survey respondents who had read the LRDGs, the Competencies, the Clearing the Smoke on Cannabis series, and the CCENDU bulletins and drug alerts, the most common reasons for not using or implementing them (either at all or more fully) were a lack of resources and a lack of relevance to their work. Much less commonly, respondents indicated that they were unsure how to use or apply the products, that they lacked the opportunity to use them, or that they were concerned about the quality. Specifically in the case of the LRDGs, a minority reported that they have not used the guidelines because, in their view, they are not appropriate for youth. To obtain a copy of the Technical Report on the Supplementary Data, use the following e-mail “Evaluation Reports HC - Rapports Evaluation@hc-sc.gc.ca”.

Similar and related concerns about the LRDGs were raised by some participants in the provincial/territorial focus group, and are discussed in Section 4.3.5. Some participants in the provincial/territorial focus group noted, in addition, that while they are interested in the Competencies, they are not yet at the stage in system development where implementation could occur. However, focus group participants agreed that limited resources and capacity was the main factor inhibiting use or application of the Competencies and CCSA products in general.

4.3.4 Awareness and understanding of substance abuse and recognition of substance abuse as a health issue

A majority of stakeholders report increased awareness and understanding of substance abuse because of CCSA, and consider substance abuse to be primarily a health issue. There is some evidence at the federal and provincial/territorial levels of initiatives and investments in substance abuse reflecting a health perspective.

Awareness and understanding of substance abuse

Dissemination of CCSA’s evidence-based knowledge products should, in theory, contribute to increased awareness and understanding of the nature, extent and consequences of substance abuse among stakeholders. Short of administering a pre/post knowledge test, however, it is challenging to objectively assess the extent to which CCSA’s activities may have produced this outcome. Findings from the stakeholder survey show that 69% of respondents believe they are more aware of the nature, extent, and/or consequences of substance abuse because of CCSA — roughly the same as in 2010, when 67% of those surveyed agreed with a similar statement. Furthermore, large majorities of survey respondents who have read specific CCSA products reported that they have gained new knowledge as a result, including 74% of those who have read the LRDGs, 84% of those who have read the Clearing the Smoke on Cannabis series, 94% of those who have read the Competencies, the 97% of those who have read the CCENDU bulletins and drug alerts. To obtain a copy of the Technical Report on the Supplementary Data, use the following e-mail “Evaluation Reports HC - Rapports Evaluation@hc-sc.gc.ca”.
Key informants believe that gains in awareness and understanding have been achieved particularly with respect to prescription drug misuse and alcohol, as well as mental health and substance abuse, impaired driving, the effects of cannabis and other drugs on brain development and cognitive function, and the contribution of substance abuse to other diseases.

- **Prescription drug misuse.** Key informants noted that the process leading to the creation of the FDNH Strategy drew public attention to issues that had previously been ignored, and in many jurisdictions, focused policy attention on the issue for the first time. Key informants indicated that as a result there is greater awareness of issues related to prescription drug misuse, such as the harms of opioid prescribing practices in primary care, the need for improved access to naloxone, and the need for improved monitoring and surveillance.

- **Alcohol.** Many key informants perceived that CCSA had, through the LRDGs, translated knowledge about risks and safe practices for alcohol consumption into an accessible form for consumers, enabling them to take action to better preserve their own health. More generally, key informants indicated that the work that CCSA has led on the NAS has helped to create and foster public dialogue about the health risks associated with alcohol.

- **Mental health and substance abuse.** A few key informants noted that CCSA’s work in the area of mental health and substance abuse has contributed to a more common understanding of the linkages between substance abuse and mental health issues, and the realization that they must be addressed simultaneously and collectively.

- **Other areas.** A few key informants observed that in general, there is greater awareness of drug-impaired driving, of the effects of cannabis and other drug use on brain development and cognitive function, and of the contribution of substance abuse to other diseases. However, key informants noted that these have been growing areas of research worldwide, and that it is difficult to know the extent to which increased awareness is due to CCSA’s activities.

**Recognition of substance abuse as a health issue**

In the intermediate term, increased awareness of the nature, extent, and consequences is expected to lead to increased recognition of substance abuse primarily as a health issue, rather than a justice, law enforcement, or public safety issue. Results from the survey of stakeholders indicate that a majority (58%) of survey respondents sees substance abuse primarily as a health issue, while a sizeable minority (39%) sees it primarily as a social issue. Very few (3%) believe it is primarily a justice, law enforcement, or public safety issue. Just over one-third of survey respondents (35%) reported that because of CCSA, their organization is collecting and using information about addictions and substance abuse, while 32% were neutral, 28% disagreed, and 7% did not know.  

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For both survey questions, the number of survey respondents was insufficient to compare responses based on primary sector. Cross-tabulations were performed comparing respondents who worked primarily in health-related sectors and those in all other sectors. This analysis revealed no significant differences in responses to these questions.
Many external key informants perceive that progress, albeit slow, is being made in stakeholder understanding of substance abuse. From their perspective, diverse groups of stakeholders have gained a more comprehensive understanding of how substance abuse functions (i.e., its causes and impacts) and how it is most effectively addressed as a result of specific initiatives led by CCSA, particularly the FDNH Strategy and the NAS. However, external key informants also noted that CCSA’s work is not the only factor contributing to evolving understanding of substance abuse; indeed, public dialogue and discussion is occurring on a global scale in relation to issues such as the legal status of marijuana, medical marijuana, and opioids.

At the federal and provincial/territorial level, there is some evidence of initiatives and investments based on CCSA’s work. For example:

- In 2013, following up on the work on the FDNH Strategy, the federal government announced that the NADS would be expanded with $44.9 million in additional funding specifically to address misuse of prescription drugs.

- The recommendations of the FDNH Strategy informed the decision of the federal/provincial/territorial ministers of health to establish prescription monitoring programs and a national surveillance framework for pharmaceuticals. Other provincial/territorial activities address specific smaller-scale issues, such as updates to opioid guidelines and methadone maintenance programs that focus on balancing the need for treatment with the potential risk of addiction or other health impacts.

- Health Canada is consulting with CCSA on addressing challenges, gaps, and improvements in the CDSA.

- Key informants indicate that most (though not all) provincial alcohol strategies are well-aligned with the NAS. The Government of Manitoba is currently consulting with CCSA to develop a new provincial alcohol strategy based on the LRDGs.

- Québec, Alberta, and British Columbia have made changes to impaired driving limits and suspensions, and Alberta and British Columbia have increased the use of alcohol interlock systems to prevent prior offenders from driving while impaired.

- The Ontario Ministry of Transportation considered CCSA’s three Policy Briefs on Impaired Driving while drafting Bill 31, the Transportation Statue Law Amendment Act (Making Ontario’s Roads Safer).

- Key informants and focus group participants indicated that most provinces now have strategies in place or are developing strategies to address the intersection of substance abuse and mental health issues in treatment and rehabilitation.

To the extent that all of CCSA’s work is based on recognition of substance abuse as a health issue, it can be reasoned that stakeholder initiatives based on that work reflect a similar understanding. However, it was well beyond the scope of this evaluation to determine what understanding of substance abuse underlies various stakeholder initiatives, and it is possible that alternate views underpin some of them. Furthermore, while key informants noted that discussions and policies have begun to reflect an understanding of substance abuse as a health issue, they also observed that the overall level of investment in substance abuse has been largely
steady. Some key informants were of the view that despite some progress in the area of prescription drugs, some federal initiatives related to substance abuse are inconsistent with a health perspective.

4.3.5 More effective policies, programs, and practices

Although policies, programs and practices based on CCSA’s evidence-informed products have begun to be implemented, it is premature to draw conclusions about their effectiveness. Ongoing monitoring and evaluation are needed to support valid conclusions.

The preceding sections of this report have shown that policies, programs and practices based on CCSA’s evidence-informed knowledge products have begun to be implemented by stakeholders. In theory, because these products are informed by evidence, the resulting policies, programs and practices should be more effective at addressing and reducing substance abuse-related harms. Although CCSA has been in existence since 1988, the specific products that are the focus of this evaluation have been created much more recently. Given that stakeholder implementation of these products is, in most cases, still in the early stages, it is premature to draw conclusions about the extent to which specific ones may have contributed to more effective policies, programs, and practices. Furthermore, ongoing monitoring and evaluation of the new policies, programs and practices are needed to support valid conclusions about effectiveness.

The LRDGs are an example of a product that was developed earlier on that can now be followed through to determine longer-term impact. This product, which was published in 2011, appears to be the most widely disseminated and used of CCSA’s knowledge products.

In Quebec, where Educ’alcool has invested $1.5 million annually in the dissemination and promotion of the LRDGs, survey data show that more Quebecers than other Canadians were familiar with the LRDGs in 2012 (43% versus the national average of 26%). Furthermore, in 2013, Quebec was the province where the greatest proportion of drinkers followed the LRDGs for both chronic effects (more than 80%) and acute effects (more than 86%). Quebec is the only province in Canada where the proportion of drinkers who follow the LRDGs for chronic effects increased (rather than decreased) between 2011 and 2013, and although the percentage of drinkers in Quebec who follow the LRDGs for acute effects declined over this period, as it did elsewhere in Canada, this decline was lower than in Canada as a whole. While these data are encouraging, attributing these outcomes to Educ’alcool’s LRDG campaign versus other factors (such as, for example, pre-existing societal/cultural attitudes toward alcohol consumption) is challenging without a rigorous evaluation.

Data collected through the current evaluation further support the need for evaluation of the LRDGs and/or related initiatives undertaken by stakeholders. For example, some participants in the provincial/territorial focus group expressed concern that the LRDGs were not developed in consultation with primary care physicians in the provinces/territories who are best positioned to
understand local drinking patterns and issues; were higher than they were expecting; conveyed an inappropriate message to youth (i.e., that it is ok to drink); and overlooked that for some people, no amount of alcohol is safe. One jurisdiction reported that implementation of the LRDGs had the opposite effect than what was intended; that is, they promoted drinking among some high risk segments of the population — though it was acknowledged that the way in which the LRDGs were delivered may have contributed to this unexpected result. Focus group participants suggested that the LRDGs may be appropriate for the moderate user group, but not necessarily for heavy users of alcohol and those at risk of heavy use, such as youth.

4.3.6 Reduced rates of substance abuse

Trends in the use of illicit drugs, prescription drugs, and alcohol, as well as related harms, were described at some length in Section 4.1.1 of this report, and that discussion is not repeated here. Overall, the available data show that while the prevalence of illicit drug use is relatively low and has decreased or remained stable over the past decade, many Canadians use alcohol at rates exceeding the national LRDGs for chronic and acute health effects. Furthermore, use and misuse of prescription opioids, as well as related harms, have become increasingly common in Canadian society. Overall, these data suggest that work is still needed toward CCSA’s ultimate outcome.

4.4 Efficiency and economy

4.4.1 Overall budget profile and sources of funding

Over the current Grant period, CCSA has been funded almost entirely by the federal government. While the federal government is likely to remain as its major funder, CCSA may want to consider diversifying its funding sources in order to support the ability to respond to emerging stakeholder interests.

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38 It should be noted that the guidelines were intended to be national in scope rather than regionally or locally specific. The Canadian Low-Risk Alcohol Guidelines Expert Advisory Panel was in fact chaired by a physician representing the College of Family Physicians of Canada.

39 The LRDGs recommend no more than 10 drinks a week for women, with no more than two drinks a day most days, and 15 drinks a week for men, with no more than three drinks a day most days. By comparison, within Canada, the Canadian Partnership Against Cancer and the Canadian Cancer Society recommend two drinks per day for men and one drink per day for women to reduce the risk of cancer (Canadian Cancer Society, n.d.; Canadian Partnership Against Cancer, 2011). Internationally, the U.S. Federal Dietary Guidelines for Americans recommend up to one drink per day for women and two drinks per day for men. Heavy or high risk drinking is defined as consumption of more than three drinks on any day for women OR more than seven per week; and more than four drinks on any day for men, or more than 14 per week (U.S. Office of Disease Prevention and Health Promotion, 2010). Australia recommends no more than two drinks a day for both men and women (Australian Government National Health and Medical Research Council, 2015).

40 Focus groups with youth aged 18 to 24, recently completed by PRA for the Liquor and Gaming Authority of Manitoba (LGA) in order to test advertising on the LRDGs, similarly found that the guidelines may not be sufficient to encourage youth to change their drinking behaviour (PRA Inc., 2015).
A high-level budget profile for CCSA for the period 2011–2012 to 2014–2015 is provided in Table 9. As shown in the table, CCSA has been funded primarily by the federal government during the current Grant period, as was also the case during the previous Grant period. Between 2011–2012 and 2014–2015, an average of 93% of CCSA’s annual budget consisted of Health Canada funding.

Health Canada funding is delivered through three funding streams: the Named Grant, the DSCIF, and the DTFP. In 2014–2015, CCSA’s budget included $3.56 million in Named Grant funding (50% of its overall budget), $2.3 million in DSCIF funding (32% of its overall budget), and $0.9 million in DTFP funding (13% of its overall budget).

A relatively small proportion of CCSA’s annual budget comes from other sources, and this amount varies considerably by year, ranging from a high of 12% of CCSA’s total budget in 2013–2014 to less than 1% the following year due to varying timelines for non-Health Canada funding streams. Notably, the previous Grant evaluation also found considerable variability from year to year in non-Health Canada funding to CCSA. During the period covered by this evaluation, other sources of funding supported specific projects in the areas of impaired driving, prescription drug misuse, mental health and substance abuse, alcohol, and knowledge exchange and research. CCSA also received non-Health Canada funding for projects related to gambling, although this is not currently one of its priority areas.

Table 9: CCSA budget profile, $, 2011–2012 to 2014–2015

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<tr>
<td>Named Grant</td>
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<td>Total – All sources</td>
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<td>7,069,867</td>
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<tr>
<td>Health Canada as % of total funding</td>
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<td>96%</td>
<td>84%</td>
<td>94%</td>
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<tr>
<td>Other sources as % of total funding</td>
<td>12%</td>
<td>2%</td>
<td>12%</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

Source: CCSA.
Notes: “Other sources” represents non-Health Canada sources of funding. “Unfunded” represents expenses not covered by a non-Health Canada funder, which are paid out of CCSA’s reserves at the discretion of the Board of Directors.

While the source of CCSA’s funding may not seem relevant to a discussion of efficiency and economy, it is pertinent to the extent that it may affect how CCSA uses resources (i.e., for which priority areas or activities), as well as the nature of the outputs produced and, eventually, the outcomes achieved. As described earlier in this report, CCSA is perceived by some stakeholders as being too closely aligned with the federal government, which they attributed in part to the fact that it is funded almost exclusively by the federal government. The CCSA reports to Parliament through the Minister of Health who also exercises in respect to the Centre specific responsibilities set out in the Canadian Centre on Substance Abuse Act. As a result, it is
appropriate for the federal government to constitute a major source of CCSA’s funding. That said, diversifying its funding sources is advisable from a strictly risk management perspective, and also has the potential to better position CCSA as an organization that exists to serve the diverse interests of the substance abuse field, consistent with its legislated mandate.

At the same time, it is important to recognize the potential constraints and limitations of sources of funding beyond Health Canada. Given the resource constraints faced by many public and non-governmental organizations, these sources are unlikely to constitute a significant source of CCSA funding in the foreseeable future. Furthermore, as has been CCSA’s experience to date, non-Health Canada funding is likely to be given for specific projects of interest to the funder, which may or may not prove to be relevant to the wider substance abuse field, and is unlikely to be given to cover CCSA’s general operating expenses. Finally, private sector funding, if pursued, could lead to perceptions of conflict of interest and inappropriate influence on CCSA’s work.41

4.4.2 Comparison of planned and actual spending

CCSA expended 97% of Named Grant funds over the current Grant period, but has experienced variances in the ratio of planned to actual spending for certain priority areas.

Between 2011–2012 and 2014–2015, CCSA spent 97% of Named Grant funds. Detailed information provided below and in Table 10.

- Administrative costs are by far the largest category of spending in relation to the Named Grant. Over the four-year period, administrative costs totalled approximately $12.1 million, accounting for 78% of budgeted funds over this four-year period. This category of spending includes staff salaries, which is CCSA’s most significant cost.

- Funding allocated to specific priority areas totalled approximately $1.87 million, accounting for approximately 12% of budgeted funds over this period.42 However, because staff salaries are captured under administration, these figures do not reflect the total resources that CCSA has devoted to its priority areas.43

- Based on budgeted amounts, over the past four years, CCSA planned to focus Named Grant resources primarily on knowledge exchange and research; prescription drug misuse; alcohol; and workforce development. However, based on actual spending, the four largest areas of spending have been knowledge exchange and research; international relations; prescription drug misuse; and alcohol. The greatest difference in planned versus actual spending is on international relations; spending on this priority area was higher than planned every year and

41 Such perceptions may also arise even in the absence of direct funding by industry, as evidenced by concerns raised about the alcohol industry’s involvement in the NAS and the LRDGs.
42 Two of the priority areas discussed in this evaluation are funded through other sources than the Named Grant. Cannabis is funded through the DSCIF and recovery is funded through the DTFP. Therefore, these priority areas are not reflected in the table.
43 While this must be acknowledged as a limitation of CCSA’s approach to financial reporting, it is one that is shared by many much larger organizations within the federal public sector. Accounting for staff time at the priority and activity level would require an investment in information technology that may be difficult to justify for an organization of CCSA’s size.
250% higher than budgeted overall during this period. CCSA representatives indicated that the variance was due in part to CCSA’s participation in international events that had not been planned or confirmed at the time of budget preparation, including invited research presentations at international events as well as participation in international policy and best practice dialogue at United Nations and World Health Organization events. These events include activities associated with a number of priority areas including monitoring and surveillance, knowledge exchange and research, and alcohol.

- Named Grant spending on monitoring and surveillance slightly exceeded what was planned (108%), and was approximately as planned for alcohol (101%), prescription drug misuse (99%), and knowledge exchange and research (91%).

- Named Grant spending was less than planned for workforce development (85%), First Nations, Inuit and Métis (67%), impaired driving (61%), and mental health and substance abuse (42%). CCSA reported that:
  
  - In the case of mental health and substance abuse, planned activities were reliant on a planned collaboration with external partners, who were unable to commit to move the work ahead due to competing priorities, resulting in lower expenditures in this area. The lower-than-planned spending in this area is notable, given that it was identified by stakeholders as an area of potential greater focus for CCSA.
  
  - In the case of impaired driving, non-Health Canada funding and DSCIF funding were leverage to complete the planned work, resulting in savings in the Named Grant spending envelope.
  
  - In the case of First Nations, Inuit and Métis, significant project delays were encountered as a result of working within the timelines of the collaborating partners and ensuring that proper engagement and consultation were conducted.
  
  - With respect to workforce development, a planned survey was delayed in order to conduct groundwork intended to better identify scope and purpose. CCSA has plans to conduct the survey in the future.

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44 It should also be noted that International Relations accounted for a relatively small component of the overall budget; at 0.9% of planned and 2.3% of actual spending.
Table 10: Overview of planned and actual spending, $, Named Grant-funded activities, 2011–2012 to 2014–2015

<table>
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<td>Administration</td>
<td>3,159,214</td>
<td>2,986,317</td>
<td>2,848,704</td>
<td>2,836,649</td>
<td>2,994,139</td>
<td>2,857,400</td>
<td>3,063,554</td>
<td>2,858,678</td>
<td>12,065,612</td>
<td>11,629,444</td>
<td>96%</td>
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<tr>
<td>Board of Directors and Board Alumni</td>
<td>109,725</td>
<td>138,582</td>
<td>109,725</td>
<td>101,682</td>
<td>109,725</td>
<td>101,682</td>
<td>109,725</td>
<td>121,093</td>
<td>438,900</td>
<td>474,517</td>
<td>108%</td>
</tr>
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<td>National Relations</td>
<td>47,670</td>
<td>103,577</td>
<td>57,055</td>
<td>99,603</td>
<td>61,500</td>
<td>86,671</td>
<td>216,125</td>
<td>343,152</td>
<td>605,029</td>
<td>433,679</td>
<td>159%</td>
</tr>
<tr>
<td>Information Technology</td>
<td>79,827</td>
<td>67,914</td>
<td>111,286</td>
<td>69,869</td>
<td>204,263</td>
<td>139,818</td>
<td>209,653</td>
<td>156,078</td>
<td>605,029</td>
<td>433,679</td>
<td>72%</td>
</tr>
<tr>
<td>Annual Report</td>
<td>10,000</td>
<td>24,394</td>
<td>20,000</td>
<td>17,823</td>
<td>20,000</td>
<td>21,744</td>
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<td>23,179</td>
<td>78,000</td>
<td>87,140</td>
<td>112%</td>
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<tr>
<td>Monitor Research and Trends</td>
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<td>21,705</td>
<td>19,500</td>
<td>32,603</td>
<td>41,500</td>
<td>30,782</td>
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<td>43,335</td>
<td>119,800</td>
<td>128,425</td>
<td>107%</td>
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<td>International Relations</td>
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<td>41,186</td>
<td>25,580</td>
<td>67,690</td>
<td>35,580</td>
<td>116,124</td>
<td>50,000</td>
<td>117,112</td>
<td>136,740</td>
<td>342,111</td>
<td>250%</td>
</tr>
<tr>
<td>First Nations, Inuit and Métis</td>
<td>50,500</td>
<td>18,341</td>
<td>18,239</td>
<td>57,064</td>
<td>40,000</td>
<td>3,000</td>
<td>11,500</td>
<td>1,930</td>
<td>120,239</td>
<td>80,335</td>
<td>67%</td>
</tr>
<tr>
<td>Impaired Driving</td>
<td>50,000</td>
<td>37,064</td>
<td>103,113</td>
<td>54,907</td>
<td>7,000</td>
<td>7,945</td>
<td>11,800</td>
<td>5,132</td>
<td>171,913</td>
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</tr>
<tr>
<td>Prescription Drug Misuse</td>
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<td>156,666</td>
<td>233,257</td>
<td>10,000</td>
<td>10,640</td>
<td>148,000</td>
<td>25,826</td>
<td>324,666</td>
<td>319,898</td>
<td>99%</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse</td>
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<td>-</td>
<td>55,000</td>
<td>36,068</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>85,000</td>
<td>36,068</td>
<td>42%</td>
</tr>
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<td>Workforce Development</td>
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<td>73,683</td>
<td>102,000</td>
<td>76,583</td>
<td>28,000</td>
<td>17,628</td>
<td>25,000</td>
<td>30,826</td>
<td>233,500</td>
<td>198,720</td>
<td>85%</td>
</tr>
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<td>Alcohol</td>
<td>55,900</td>
<td>50,600</td>
<td>49,920</td>
<td>25,117</td>
<td>32,000</td>
<td>55,745</td>
<td>89,800</td>
<td>122,201</td>
<td>227,620</td>
<td>229,918</td>
<td>101%</td>
</tr>
<tr>
<td>Knowledge Exchange and Research</td>
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<td>124,955</td>
<td>77,184</td>
<td>99,631</td>
<td>173,620</td>
<td>132,863</td>
<td>70,000</td>
<td>59,678</td>
<td>501,554</td>
<td>457,884</td>
<td>91%</td>
</tr>
<tr>
<td>Monitoring and Surveillance</td>
<td>61,000</td>
<td>57,568</td>
<td>12,333</td>
<td>21,867</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>73,333</td>
<td>79,435</td>
<td>108%</td>
</tr>
</tbody>
</table>
4.4.3 Optimization of outputs and demonstration of value

CCSA has taken steps to optimize the quantity, quality and blend of products and services delivered under the Named Grant. The willingness of partners to contribute in-kind is seen as the most important factor enabling the efficient production of high quality outputs.

CCSA has taken a number of steps to optimize the quantity, quality and blend of products and services delivered under the Named Grant. These include:

- Improving focus and ensuring manageability of project scope by implementing evidence-based approaches to planning such as:
  - Using CCSA’s legislated mandate and high-level strategic directions as the fundamental basis for all of its work
  - Using SMART (specific, measurable, achievable, results-focused, time-bound) objectives and methodology to develop annual strategic directions and associated activities, which are translated into project and employee work plans
  - Building project management capacity to improve planning and tracking the timelines and resource implications associated with producing project outputs (i.e., through project charters, events and deliverables calendar, and quarterly project status updates)
- Responding to emerging priorities identified through consultations with stakeholders to ensure that CCSA’s work aligns with stakeholder needs (e.g., prescription drugs, recovery, and family violence as priority areas)
- Enhancing access to resources through
  - pursuing and securing non-Health Canada funding for some priority areas (e.g., prescription drugs, impaired driving)
  - obtaining substantial in-kind support from partners to produce, disseminate and promote products
- Addressing challenges in implementing the FDNH strategy by establishing small, project-based teams charged with implementing specific projects

CCSA representatives noted that the willingness of partners – many of whom are experts in their given field – to donate their time to joint initiatives has been a critical factor enabling the production of high quality products in an efficient manner. Moreover, external key informants highlighted CCSA’s ability to leverage in-kind contributions for joint initiatives as evidence of stakeholders’ belief in the value of these activities in the context of their own organizational objectives and missions.

Virtually all key informants and focus group participants agreed that CCSA’s activities and outputs have demonstrated value, citing as evidence their own and other stakeholders’ use of CCSA products such as the LRDGs, the Competencies, and the CCENDU bulletins and drug alerts, among others. As noted elsewhere in this report, many organizations and smaller jurisdictions do not have the capacity to independently undertake the kind of work that CCSA does, and most key informants doubted whether similar collaborative work would be done by
other organizations in the absence of CCSA. From this perspective, the availability of credible, evidence-informed resources that can be adopted or adapted to suit the unique contexts and circumstances of stakeholders is seen as having significant value.

4.4.4 Alternatives

While the evaluation evidence supports continued third-party delivery of the activities currently undertaken by CCSA, there are opportunities for CCSA to clarify its role in the substance abuse field, particularly its degree of independence from the federal government. Moving to a consolidated funding model would create efficiencies that could increase CCSA’s capacity to undertake work in its priority areas, and should be accompanied by a review of CCSA’s current approach to performance measurement.

The evaluation considered alternatives to achieving CCSA’s Named Grant objectives, with a view to assessing the relative efficiency of these approaches versus the current model.

The evaluation found strong stakeholder support for continued third-party delivery of the activities currently delivered by CCSA under the Named Grant and other sources of funding. As already reported, among key informants and survey respondents there is widespread agreement on the need for a national organization to play a leadership role in the field of substance abuse, as well as support for a national approach that is distinct and independent from the federal government. Key informants noted that as a third-party organization positioned outside of the hierarchical structure of authority that constrains government, CCSA is able to bring together diverse stakeholders, reconcile conflicting views, and work toward an outcome or solution that has broad acceptance by the field. Key informants doubted whether government would be able to achieve similar results.

The evaluation evidence suggests that the existence of multiple Health Canada funding streams for CCSA’s activities creates administrative and financial burden for both organizations in terms of proposal development and assessment, fund/financial monitoring, progress reporting, and performance measurement and evaluation, (to obtain a copy of the Technical Report on the Supplementary Data, use the following e-mail “Evaluation Reports HC - Rapports Evaluation@hc-sc.gc.ca”). There was agreement among CCSA staff and Board members and Health Canada key informants that moving to a consolidated funding model would eliminate some of the administrative and financial burden for both organizations.

A consolidated model has in fact been agreed to by Health Canada and began in September, 2015. It consolidates CCSA's three funding agreements under one arrangement, leading to less reporting overall by reducing semi-annual reports from three to one, and aligning reporting under one process and template. One evaluation report will be required instead of three as required under the existing structure. Overall, the consolidation of funding is expected to give CCSA the flexibility to take a more cohesive approach to undertaking and reporting on its activities while at the same time creating administrative and financial efficiencies. While overall costs to CCSA are unlikely to change, the efficiencies gained as a result of the move to a consolidated funding model should free CCSA staff to undertake additional work in relation to the organization’s
priority areas. To support the move toward a consolidated funding model, CCSA should undertake a review of its current logic models and approaches to performance measurement for the Named Grant, the DTFP, and the DSCIF, and take steps to consolidate these into a single logic model and performance measurement strategy (to obtain a copy of the Technical Report on the Supplementary Data, use the following e-mail “Evaluation Reports HC - Rapports Evaluation@hc-sc.gc.ca”).

With respect to the specific nature of the funding model, both Health Canada and CCSA key informants emphasized the need to ensure that CCSA retains the flexibility to work in areas that may not necessarily align with the priorities of the government of the day (although Health Canada key informants also identified a need for Health Canada to more clearly articulate its expectations of CCSA). From CCSA’s perspective, a grant would be preferable to a contribution agreement, since it provides a greater degree of flexibility, stability and certainty that in CCSA’s view is important to be more responsive to changing needs and to its ability to attract high calibre staff.

Finally, with respect to CCSA’s mix or range of program activities, CCSA is widely seen and valued by stakeholders as a collaborator, facilitator, trusted expert, and knowledge broker, and there is a strong rationale for the organization to continue in these roles. In other respects, however, CCSA’s role is less clear. For example, the extent to which CCSA, as an arm’s length organization, should be independent from the federal government or position itself as innovator or advocate are questions that remain to be resolved.

4.4.5 Governance

Although CCSA has consulted informally with the provinces and territories with respect to at-large appointments to the CCSA Board pursuant to Section 8 of the CCSA Act, a more formal process for their engagement in Board appointments may be warranted.

A strong Board of Directors is an important part of ensuring that an organization functions in an efficient and effective manner. Although the evaluation did not include specific questions related to governance, two issues arose that are worth noting, given the importance of strong governance to effective organizational functioning. First, several external key informants remarked upon the length of time it has taken thus far for a new CEO to be identified. Key informants emphasized that CCSA’s effectiveness as an organization depends on putting in place a permanent leader as soon as possible. However, since the CEO and four directors are appointed by the Governor-in-Council, this is not a matter over which CCSA has control (to obtain a copy of the Technical Report on the Evaluation Matrix, use the following e-mail “Evaluation Reports HC - Rapports Evaluation@hc-sc.gc.ca”).

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Assuming that staffing levels are not affected.
Second, participants in the provincial/territorial focus group noted that although Section 8 of the CCSA Act requires the Board to appoint up to eight directors, after consultations with the governments of the provinces and with any individuals and organizations representative of the business community and labour, professional and voluntary organizations having a particular interest in alcohol and drug abuse, their own jurisdiction has never, to their recollection, been consulted with respect to Board appointments. According to information provided by CCSA, provincial/territorial representatives as well as representatives from the business, professional, and other stakeholder groups noted in the Act were in fact consulted regarding the appointment of the eight current Board-appointed Directors. However, these consultations were relatively informal (i.e., conducted by telephone). Given the requirements of the CCSA Act, a more formal process for engaging the provinces and territories with respect to Board appointments may be warranted.

5.0 Conclusions and recommendations

Relevance

Continued need

The available data show that while the prevalence of illicit drug use is relatively low and has decreased or remained stable over the past decade, many Canadians use alcohol at rates exceeding the national LRDGs for chronic and acute health effects. Furthermore, use and misuse of prescription opioids, as well as related harms, have become increasingly common in Canadian society. Overall, the available data suggest a continued need to take action to address substance abuse and related harms.

There is widespread support among stakeholders for addressing substance abuse and related issues at the national level, as well as support for a national approach that is distinct and independent from the federal government and that is informed by and representative of a range of stakeholder interests from across Canada. Perceived benefits of a national approach include the ability to gather and share information and expertise across jurisdictions; the ability to leverage resources; the ability to coordinate stakeholders working in similar areas to avoid duplicating effort; and the ability to produce pan-Canadian resources that can be adopted or adapted by stakeholders based on their own needs and contexts.

Alignment with federal roles and responsibilities

CCSA’s mandate aligns with federal roles and responsibilities, and in particular, with Health Canada’s mandate under the Department of Health Act. Furthermore, CCSA’s activities and expected outcomes are consistent with CCSA’s mandate, as described in Section 3 of the CCSA Act.
Alignment with federal priorities

There is generally strong alignment among CCSA and federal priorities. However, there are some perceptions that CCSA is too well-aligned with the federal government, as a result of which it may be vulnerable to shifting focus on short notice or reluctant to take a different position from the federal government or challenge it on controversial topics, particularly harm reduction. Notwithstanding funding realities, ensuring that CCSA has the flexibility, when warranted by the evidence, to adopt an independent position vis-à-vis the federal government would be consistent with CCSA’s mandate as an arm’s length organization that exists to serve the diverse interests of stakeholders in the substance abuse field, as it has done with topics such as prescription drug abuse and alcohol.

Alignment with other stakeholder priorities

CCSA’s activities are generally responsive to gaps and needs and well-aligned with the priorities of stakeholders. Areas that some stakeholders identified as meriting greater focus or allocation of resources by CCSA include prevention, harm reduction, and linkages and coordination between substance abuse and mental health services.

Value-added

CCSA’s unique value-added is its ability to bring together a diverse range of stakeholders, reconcile conflicting views, and work toward a solution that has broad acceptance by the field. This ability is seen as particularly valuable given the strong viewpoints and highly charged debate that characterize this policy area, and was attributed in part to CCSA’s position outside of the hierarchical structure of responsibility within which governments must operate. As a third-party agency with a broadly defined mandate and no real legislative authority, CCSA has the ability to interact in a non-threatening way with multiple partners and jurisdictions.

CCSA’s ability to gather and disseminate information is also widely seen as one of its key strengths and a unique value-added. This ability is seen as particularly valuable by smaller jurisdictions or organizations that may not have the capacity to research and/or generate such information and materials on their own. The availability of well-researched, credible information and standardized, evidence-informed resources provides a starting point that can be adopted or adapted to suit the unique contexts and circumstances of stakeholders.

In the absence of CCSA, stakeholders believe that there would be fewer evidence-informed resources available in the substance abuse field and less coordination/collaboration among sectors on substance abuse issues. Furthermore, stakeholders doubted whether, in the absence of CCSA, other organizations would step in and do the same work. Key informants agreed that no other organization shares CCSA’s national mandate or scope of activity, nor the network of contacts and credibility that it has established as a result of its more than 25 years of work in the substance abuse field.
Performance

Implementation

During the current Grant period, CCSA implemented most of its planned activities relating to its priority areas. A small number of planned projects were not undertaken due to funding constraints, data availability, and other factors. Specifically in the case of the First Do No Harm Strategy, CCSA responded to challenges in maintaining momentum in promoting the implementation of national strategy recommendations by adjusting its approach. The new approach has been endorsed by FDNH stakeholders.

The evidence available to this evaluation suggests that there may be different expectations and interpretations among Health Canada and CCSA representatives regarding the meaning of ‘implementation’, and the limits of CCSA’s role and the extent to which it should be involved in promoting and influencing policy, programs, and practice, suggesting a need to clarify CCSA’s role in this regard.

Achievement of outcomes

Partnerships and coordination of effort

There is general agreement among key informants that CCSA’s partners have increased in number and diversity since the 2010 evaluation of the Named Grant. However, quantitative comparisons were not possible due to changes in CCSA’s approach to tracking partnership information. Nonetheless, CCSA’s partners represent a diverse range of stakeholders and interests and are involved in a range of Named Grant, DSCIF and DTFP funded activities. Further adjustments to CCSA’s contact database could enhance CCSA’s ability to report on the nature and extent of its partnerships.

There is evidence that coordinated action is taking place to address the harms of substance abuse. While direct financial contributions by external partners were lower in this Grant period as compared to the previous Grant, in-kind contributions were substantial: partners and stakeholders contributed over 28,000 hours of engagement time to CCSA activities between 2011–2012 and 2014–2015. Furthermore, activities are underway or have been implemented by stakeholders to address 37 of 41 NAS recommendations, and 23 of 58 FDNH recommendations.

External key informants and two-thirds of survey respondents agree that the work of CCSA has improved coordination of action in the substance abuse field, and about half of survey respondents believe their own organization is more likely to work together with other stakeholders because of CCSA. While many stakeholders reported having worked together on joint initiatives with connections to CCSA, 41% reported that they have collaborated with other stakeholders on a joint initiative with no connection to the organization. Overall, these data suggest that while coordination can and does occur without any involvement by CCSA, CCSA is an important impetus for coordinated action.
Recognition of CCSA as a leader

CCSA is generally regarded by stakeholders as an important leader in the field of substance abuse, and in particular, as a credible source of information and a trusted expert. Among survey respondents, 83% consider CCSA to be an important leader in the field, compared to 77% who agreed with a similar statement in 2010. In particular, CCSA was identified as a top five choice of information by 87% of survey respondents, followed by academic journals/databases (82%), international sources (68%), Health Canada (63%), and CAMH/EENet (62%). Based on average ranking, CCSA is survey respondents’ second choice for information, after academic journals/databases.

CCSA is also seen as a trusted expert in the field, and has been called on by some stakeholders to provide advice, conduct research and other projects, and deliver presentations on a variety of topics at events in Canada and around the world. During the current Grant period, CCSA received over 230 communiques from stakeholders acknowledging and thanking it for its work in all priority areas.

However, CCSA is not necessarily seen as embodying all dimensions of leadership. More specifically, some key informants noted that CCSA is neither innovative nor on the cutting edge of public policy, especially with respect to harm reduction. Stakeholders disagreed over whether it would be appropriate for CCSA to take on such a role.

Awareness and application of evidence-informed products

CCSA actively promotes awareness of its products through a variety of approaches to knowledge dissemination and exchange. Visitors to the CCSA website and downloads of CCSA documents have both increased over the evaluation period. While most stakeholders are aware of and have used at least one of the major products published by CCSA, awareness and use varies considerably by product. These differences may be due in part to the target audience for specific products (some are likely to have a broader appeal than others) and the recentness of publication. Awareness is greatest for the LRDGs, the Competencies, and the FDNH Strategy, and these products, along with the CCENDU bulletins and drug alerts, are also the most often used or applied by stakeholders.

Awareness and understanding of substance abuse as a health issue

A majority of stakeholders (69%) report increased awareness and understanding of substance abuse because of CCSA, and large majorities of those who have read specific CCSA products – ranging from 74% of those who have read the LRDGs to 97% of those who have read the CCENDU bulletins – report that they have gained new knowledge as a result. Key informants believe that gains in awareness and understanding due to CCSA’s work have been achieved particularly with respect to prescription drug misuse and alcohol, as well as mental health and substance abuse, impaired driving, the effects of cannabis and other drugs on brain development and cognitive function, and the contribution of substance abuse to other disease.

A majority of stakeholders (58%) see substance abuse primarily as a health issue. Many external key informants believe that progress, albeit slow, is being made in this area, but observed that CCSA’s work is only one factor contributing to evolving conceptions of substance abuse. There is some evidence at the federal and provincial/territorial levels of initiatives and investments in
substance abuse based on CCSA’s work. To the extent that all of CCSA’s work is based on recognition of substance abuse as health issue, it is reasonable to assume that stakeholder initiatives based on that work reflect a similar understanding.

**More effective policies, programs, and practices**

Although CCSA has been in existence since 1988, the specific products and activities that are the focus of this evaluation have been implemented much more recently. The evidence available to this evaluation suggests that although policies, programs and practices based on some of CCSA’s evidence-informed products have begun to be implemented, it is premature to draw conclusions about their effectiveness. Ongoing monitoring and evaluation are needed to support valid conclusions.

**Efficiency and economy**

Over the current Grant period, CCSA has been funded almost entirely by the federal government. Non-Health Canada funding has ranged from a high of 13% of CCSA’s total budget in 2013–2014 to less than 1% the following year. While the federal government is likely to remain as its major funder, diversifying its funding sources while recognizing the potential constraints and limitations of non-Health Canada funding could help CCSA to better position itself as an organization that exists to serve the diverse interests of stakeholders in the substance abuse field.

Despite expending 97% of Named Grant funds over the current Grant period, CCSA experienced some variances in the ratio of planned to actual spending on certain priority areas, spending more than planned on international relations (due in part to participation in international events that were not anticipated at the time of budget preparation) and less than planned, for various reasons, on mental health and substance abuse, impaired driving, and First Nations, Inuit and Métis, as well as workforce development. Notably, mental health and substance abuse was an area identified by stakeholders as meriting greater focus by CCSA, suggesting that CCSA could explore opportunities to strengthen work in this priority area going forward.

CCSA has taken steps to optimize the quantity, quality and blend of products and services delivered under the Named Grant, including using SMART objectives and methodology to develop annual strategic directions and activities; responding to emerging priorities identified through consultations with stakeholders; building project management capacity to improve planning and tracking timelines and resource implications associated with project outputs; pursuing and securing non-Health Canada funding for some priority areas; and obtaining substantial in-kind support from partners to produce, disseminate and promote products. The willingness of partners to contribute in-kind is seen as the most important factor enabling the efficient production of high quality outputs.

While the evaluation evidence supports continued third-party delivery of the activities currently delivered by CCSA, there are opportunities for CCSA to clarify its role in the substance abuse landscape. CCSA is widely seen and valued by stakeholders as a collaborator, facilitator, trusted expert, and knowledge broker, and there is a strong rationale for the organization to continue in these roles, but in other respects, CCSA’s role is less clear. The extent to which CCSA should position itself as innovator or advocate is a question that remains to be resolved.
The funding model covered by the current evaluation, based on three distinct funding streams, creates administrative burden for both CCSA and Health Canada in proposal development and assessment, financial monitoring, progress reporting, and performance measurement and evaluation. While moving to a consolidated funding model is unlikely to reduce overall costs to CCSA, it would create efficiencies that could increase CCSA’s capacity to undertake substantive work in its priority areas. Both Health Canada and CCSA key informants emphasized the need for an arrangement that would continue to give CCSA the flexibility to undertake work in areas that may not necessarily align with the priorities of the government of the day, as was done with prescription drugs and alcohol.

Finally, with respect to CCSA governance, provincial/territorial stakeholders noted that although Section 8 of the CCSA Act requires CCSA’s Board of Directors to consult with the governments of the provinces with respect to at-large appointments to the Board, their own jurisdiction has never, to the best of their knowledge, been consulted. Evidence provided by CCSA indicates that provincial/territorial representatives were informally consulted regarding the appointment of some of the eight current Board-appointed Directors. Given the requirements of the CCSA Act, a more formal process for engaging the provinces and territories with respect to Board appointments may be warranted.

RECOMMENDATIONS

This evaluation confirmed an ongoing need for action to address substance abuse and related harms, as well as widespread support for CCSA, as an independent, arm’s length organization, to coordinate national efforts to address these issues. Furthermore, the evaluation found that progress has been made toward CCSA’s expected outcomes and the organization has taken steps to ensure that it operates in an efficient and economical manner. The following recommendations identify opportunities for improvement based on the evaluation findings.

The evaluation proposed seven recommendations directed at CCSA and one recommendation directed at Health Canada. Overall the CCSA recommendations cover communication, opportunities to respond to priority areas and performance measurement.

Health Canada Recommendation 1:

The Office of Audit and Evaluation has an additional recommendation which is directed at Health Canada:

- HC should work with CCSA to identify the recommendations that directly impact the work funded by Health Canada and work with CCSA accordingly to monitor their implementation.

CCSA Recommendation 1:

CCSA should clarify its role in accordance with fulfilling its legislated mandate as an independent arm’s length agency and, with due consideration of available resources, clarify the appropriate approaches and mechanisms through which that role can be executed.
CCSA Recommendation 2:

CCSA should clearly communicate to partners and stakeholders its role and the execution and scope of that role according to the clarification outlined in Recommendation 1.

CCSA Recommendation 3:

CCSA should explore opportunities to focus more resources on priorities identified by stakeholders, including prevention, harm reduction, and promoting linkages and coordination between substance abuse and mental health services.

CCSA Recommendation 4:

Recognizing that the federal government is likely to remain as its major funder, CCSA should explore opportunities to diversify its funding sources as a prudent risk management measure.

CCSA Recommendation 5:

Given anticipated efficiencies that could be redirected toward CCSA’s substantive work in its priority areas, CCSA and Health Canada should proceed with current plans to transition to a consolidated funding model that retains CCSA’s ability to undertake work in areas that may not necessarily align with the priorities of the government of the day.

CCSA Recommendation 6:

CCSA should review and enhance its current approach to performance measurement in order to track progress toward outcomes; for example through improved data collection and management; and to move toward demonstrating impact at both project and organizational levels within short, intermediate, and long-term timeframes.

CCSA Recommendation 7:

CCSA should explore opportunities to implement a formal, transparent process for consulting with provinces and territories and other relevant stakeholders with respect to at-large appointments to the CCSA Board of Directors, pursuant to Section 8 of the CCSA Act.
Appendix 1 – References


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Appendix 2 – Canadian Centre on Substance Abuse – Logic Model

**Vision**
All people in Canada live in a healthy society free of alcohol- and other drug-related harm

**Ultimate Outcome**
Reduced rates of substance abuse

**Long-term Outcome**
More effective policies, programs and practices to address the harms of substance abuse

**Intermediate Outcome**
Increased coordination of effort to address the harms of substance abuse

**Outputs**
- Increased application of evidence-informed products to inform policies, programs and practices
- Increased recognition of CCSA as a leader in the substance abuse field
- Increased awareness among stakeholders of evidence-informed products

**Mission**
- Provide national leadership and advance solutions to address alcohol- and other drug-related harm

**Reach**
- Reach to stakeholders
- Promote and support consultation, consensus and cooperation
- Promote and support knowledge development, synthesis, exchange and application

**CCSA Act**
A) Promoting and supporting consultation and co-operation in matters relating to alcohol and drug abuse
B) Contributing to the effective exchange of information on alcohol and drug abuse
C) Facilitating and contributing to the development and application of knowledge and expertise in the alcohol and drug abuse field
D) Promoting and assisting in the development of realistic and effective policies and programs aimed at reducing the harm associated with alcohol and drug abuse
E) 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
Appendix 3 – Summary of Findings

Rating of Findings

Ratings have been provided to indicate the degree to which each evaluation questions and issues have been addressed.

Relevance Rating Symbols and Significance:

A summary of Relevance ratings is presented in Table 1 below. A description of the Relevance Ratings Symbols and Significance can be found in the Legend.

Table 1: Relevance Rating Symbols and Significance

<table>
<thead>
<tr>
<th>Questions</th>
<th>Indicators</th>
<th>Overall Rating</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Continued Need for the Program</td>
<td>Is there a continued need to address substance abuse at the federal level?</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Evidence in documents/literature regarding ongoing need to address substance abuse</td>
<td></td>
<td>While the prevalence of illicit drug use is relatively low and has decreased or remained stable over the past decade, many Canadians use alcohol at rates exceeding the national LRDGs for chronic and acute health effects. Furthermore, use and misuse of prescription opioids, as well as related harms, have become increasingly common in Canadian society. Overall, the available data suggest a continued need to take action to address substance abuse and related harms. There is widespread support among stakeholders for addressing substance abuse and related issues at the national level, as well as support for a national approach that is distinct and independent from the federal government and that is informed by and representative of a range of stakeholder interests from across Canada.</td>
</tr>
<tr>
<td></td>
<td>• Stakeholder assessment of ongoing need to address substance abuse at the federal level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Alignment with Government Priorities</td>
<td>Do Named Grant activities address stakeholder priorities (including provincial/territorial priorities) and gaps/needs in the substance abuse field?</td>
<td></td>
<td>CCSA’s activities are generally responsive to gaps and needs and well-aligned with the priorities of stakeholders. Areas that some stakeholders identified as meriting greater focus or allocation of resources by CCSA include prevention, harm reduction, and linkages and coordination between substance abuse and mental health services.</td>
</tr>
<tr>
<td></td>
<td>• Comparison of stakeholder priorities and gaps/needs against CCSA’s activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Stakeholder perceptions of extent to which Named Grant activities address stakeholder priorities and gaps/needs in the substance abuse field</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Legend - Relevance Rating Symbols and Significance:

High      There is a demonstrable need for program activities; there is a demonstrated link between program objectives and (i) federal government priorities and (ii) departmental strategic outcomes; role and responsibilities for the federal government in delivering the program are clear.

Partial   There is a partial need for program activities; there is some direct or indirect link between program objectives and (i) federal government priorities and (ii) departmental strategic outcomes; role and responsibilities for the federal government in delivering the program are partially clear.

Low       There is no demonstrable need for program activities; there is no clear link between program objectives and (i) federal government priorities and (ii) departmental strategic outcomes; role and responsibilities for the federal government in delivering the program have not clearly been articulated.
<table>
<thead>
<tr>
<th>Questions</th>
<th>Indicators</th>
<th>Overall Rating</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>To what degree do the objectives of the Named Grant align with federal priorities?</td>
<td>Extent to which Named Grant objectives are linked to federal government priorities and Health Canada’s strategic outcomes and priorities</td>
<td>High</td>
<td>There is generally strong alignment among CCSA and federal priorities. However, there are some perceptions that CCSA is too well-aligned with the federal government, as a result of which it may be vulnerable to shifting focus on short notice or reluctant to take a different position from the federal government or challenge it on controversial topics, particularly harm reduction.</td>
</tr>
<tr>
<td>3. Alignment with Federal Roles and Responsibilities</td>
<td>Extent to which Named Grant objectives, activities and expected outcomes are consistent with the CCSA Act and CCSA’s legislated mandate</td>
<td>High</td>
<td>CCSA’s legislated mandate aligns with federal roles and responsibilities, and in particular, with Health Canada’s mandate under the Department of Health Act. Furthermore, CCSA’s activities and expected outcomes are consistent with CCSA’s legislated mandate, as described in Section 3 of the CCSA Act.</td>
</tr>
<tr>
<td>To what extent do the objectives, activities, and expected outcomes of the Named Grant align with the CCSA Act and CCSA’s legislated mandate?</td>
<td>Extent to which Named Grant objectives, activities and expected outcomes are consistent with the CCSA Act and CCSA’s legislated mandate</td>
<td>High</td>
<td>CCSA’s legislated mandate aligns with federal roles and responsibilities, and in particular, with Health Canada’s mandate under the Department of Health Act. Furthermore, CCSA’s activities and expected outcomes are consistent with CCSA’s legislated mandate, as described in Section 3 of the CCSA Act.</td>
</tr>
<tr>
<td>To what degree do the objectives of the Named Grant align with federal roles and responsibilities?</td>
<td>Extent to which Named Grant objectives are consistent with the legislative framework of the federal government</td>
<td>High</td>
<td>CCSA’s unique value-added is its ability to bring together a diverse range of stakeholders, reconcile conflicting views, and work toward a solution that has broad acceptance by the field. This ability is seen as particularly valuable given the strong viewpoints and highly charged debate that characterize this policy area, and was attributed in part to CCSA’s position outside of the hierarchical structure of responsibility within which governments must operate. CCSA’s ability to gather and disseminate information is also widely seen as one of its key strengths and a unique value-added. This ability is seen as particularly valuable by smaller jurisdictions or organizations that may not have the capacity to research and/or generate such information and materials on their own. The availability of well-researched, credible information and standardized, evidence-informed resources provides a starting point that can be adopted or adapted to suit the unique contexts and circumstances of stakeholders. In the absence of CCSA, stakeholders believe that there would be fewer evidence-informed resources available in the substance abuse field and less coordination/collaboration among sectors on substance abuse issues. Furthermore, stakeholders doubted whether, in the absence of CCSA, other organizations would step in and do the same work. Key informants agreed that no other organization shares CCSA’s national mandate or scope of activity, nor the network of contacts and credibility that it has established as a result of its more than 25 years of work in the substance abuse field.</td>
</tr>
<tr>
<td>What is CCSA’s unique value-added as a national organization?</td>
<td>Unique outputs produced/activities undertaken as a result of Named Grant activities/extent of duplication in activities and outputs</td>
<td>High</td>
<td>CCSA’s unique value-added is its ability to bring together a diverse range of stakeholders, reconcile conflicting views, and work toward a solution that has broad acceptance by the field. This ability is seen as particularly valuable given the strong viewpoints and highly charged debate that characterize this policy area, and was attributed in part to CCSA’s position outside of the hierarchical structure of responsibility within which governments must operate. CCSA’s ability to gather and disseminate information is also widely seen as one of its key strengths and a unique value-added. This ability is seen as particularly valuable by smaller jurisdictions or organizations that may not have the capacity to research and/or generate such information and materials on their own. The availability of well-researched, credible information and standardized, evidence-informed resources provides a starting point that can be adopted or adapted to suit the unique contexts and circumstances of stakeholders. In the absence of CCSA, stakeholders believe that there would be fewer evidence-informed resources available in the substance abuse field and less coordination/collaboration among sectors on substance abuse issues. Furthermore, stakeholders doubted whether, in the absence of CCSA, other organizations would step in and do the same work. Key informants agreed that no other organization shares CCSA’s national mandate or scope of activity, nor the network of contacts and credibility that it has established as a result of its more than 25 years of work in the substance abuse field.</td>
</tr>
</tbody>
</table>

Legend - Relevance Rating Symbols and Significance:

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>There is a demonstrable need for program activities; there is a demonstrated link between program objectives and (i) federal government priorities and (ii) departmental strategic outcomes; role and responsibilities for the federal government in delivering the program are clear.</td>
</tr>
<tr>
<td>Partial</td>
<td>There is a partial need for program activities; there is some direct or indirect link between program objectives and (i) federal government priorities and (ii) departmental strategic outcomes; role and responsibilities for the federal government in delivering the program are partially clear.</td>
</tr>
<tr>
<td>Low</td>
<td>There is no demonstrable need for program activities; there is no clear link between program objectives and (i) federal government priorities and (ii) departmental strategic outcomes; role and responsibilities for the federal government in delivering the program have not clearly been articulated.</td>
</tr>
</tbody>
</table>
Performance Rating Symbols and Significance:

A summary of Performance Ratings is presented in Table 2 below. A description of the Performance Ratings Symbols and Significance can be found in the Legend.

Table 2: Performance Rating Symbols and Significance

<table>
<thead>
<tr>
<th>Questions</th>
<th>Indicators</th>
<th>Overall Rating</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have Named Grant activities been implemented as planned and have</td>
<td>• Degree of match between planned and actual activities/outputs and spending</td>
<td>Achieved</td>
<td>During the current Grant period, CCSA implemented most of its planned activities relating to its priority areas. A small number of planned projects were not undertaken due to funding constraints, data availability, and other factors. Specifically in the case of the First Do No Harm Strategy, CCSA responded to challenges in maintaining momentum in promoting the implementation of national strategy recommendations by adjusting its approach. The evidence available to this evaluation suggests that there may be different expectations and interpretations among Health Canada and CCSA representatives regarding the meaning of ‘implementation’, and the limits of CCSA’s role and the extent to which it should be involved in promoting and influencing policy, programs, and practice, suggesting a need to clarify CCSA’s role in this regard.</td>
</tr>
<tr>
<td>planned outputs been produced? If not, why not? What, if any, challenges</td>
<td>• Reasons for any observed variance between planned and actual activities/outputs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>have been encountered in implementation and how have these been addressed?</td>
<td>• Challenges encountered in implementation and CCSA’s response</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To what extent have Named Grant activities led to increased and more</td>
<td>• Change in number of Canadian and international partners</td>
<td>Achieved</td>
<td>There is general agreement among key informants that CCSA’s partners have increased in number and diversity since the 2010 evaluation of the Named Grant. However, quantitative comparisons were not possible due to changes in CCSA’s approach to tracking partnership information. Nonetheless, CCSA’s partners represent a diverse range of stakeholders and interests and are involved in a range of Named Grant, DSCIF and DTFP funded activities.</td>
</tr>
<tr>
<td>diverse partnerships?</td>
<td>• Change in nature of Canadian and international partners, based on size, scope, sector, target population, geographic area/region, partnership type (consultative, cooperative, coordinated, collaborative), other relevant variables</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Key informant perceptions of changes in number and nature of partners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To what extent have Named Grant activities led to increased recognition</td>
<td>• Number and type of documents expressing stakeholder support/recognition of</td>
<td>Progress Made; Further Work</td>
<td>CCSA is generally regarded by stakeholders as an important leader in the field of substance abuse, and in particular, as a credible source of information and a trusted expert. Among survey respondents, 83% consider CCSA to be an important leader in the field, compared to 77% who agreed with a similar statement in 2010. In particular, CCSA was identified as a top five choice of information by 87% of survey respondents. CCSA is also seen as a trusted expert in the field, and has been called on by some stakeholders to provide advice, conduct research and other projects, and deliver presentations on a variety of topics at events in Canada and around the world. However, CCSA is not necessarily seen as embodying all dimensions of leadership. More</td>
</tr>
<tr>
<td>of CCSA as a leader in the substance abuse field?</td>
<td>• Number and type of successful CCSA proposals for contracts, research grants, and contribution agreements</td>
<td>Warranted</td>
<td></td>
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<tr>
<td></td>
<td>• Number and type of invitations for CCSA to participate in key domestic and international events on substance abuse</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Proportion of stakeholders who identify CCSA as leader in the substance abuse field</td>
<td></td>
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</tbody>
</table>

Legend - Performance Rating Symbols and Significance:

Achieved: The intended outcomes or goals have been achieved or met.
Progress Made; Further Work Warranted: Considerable progress has been made to meet the intended outcomes or goals, but attention is still needed.
Little Progress; Priority for Attention: Little progress has been made to meet the intended outcomes or goals and attention is needed on a priority basis.
<table>
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<tr>
<th>Questions</th>
<th>Indicators</th>
<th>Overall Rating</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>To what extent have Named Grant activities increased awareness among stakeholders of evidence-informed knowledge products?</td>
<td>- Proportion of stakeholders who turn to CCSA as a primary source of information</td>
<td>- CCSA product metrics</td>
<td>CCSA actively promotes awareness of its products through a variety of approaches to knowledge dissemination and exchange. Visitors to the CCSA website and downloads of CCSA documents have both increased over the evaluation period. While most stakeholders are aware of and have used at least one of the major products published by CCSA, awareness and use varies considerably by product. These differences may be due in part to the target audience for specific products (some are likely to have a broader appeal than others) and the recency of publication. Awareness is greatest for the LRDGs, the Competencies, and the FDNH Strategy, and these products, along with the CCENDU bulletins and drug alerts, are also the most often used or applied by stakeholders.</td>
</tr>
<tr>
<td>To what extent have Named Grant activities increased awareness and understanding among stakeholders of the nature, extent, and consequences of substance abuse?</td>
<td>- Level of reported awareness and understanding among stakeholders of the nature, extent, and consequences of substance abuse</td>
<td>- Level of reported awareness among stakeholders of evidence-based products</td>
<td>A majority of stakeholders (69%) report increased awareness and understanding of substance abuse because of CCSA, and large majorities of those who have read specific CCSA products – ranging from 74% of those who have read the LRDGs to 97% of those who have read the CCENDU bulletins – report that they have gained new knowledge as a result. Key informants believe that gains in awareness and understanding due to CCSA’s work have been achieved particularly with respect to prescription drug misuse and alcohol, as well as mental health and substance abuse, impaired driving, the effects of cannabis and other drugs on brain development and cognitive function, and the contribution of substance abuse to other disease.</td>
</tr>
<tr>
<td>To what extent have Named Grant activities led to increased coordination of effort to address the harms of substance abuse?</td>
<td>- Level and nature of financial and in-kind contributions to joint initiatives by partners</td>
<td>- Number and nature of actions undertaken by partners and stakeholders based on national strategy/action plan recommendations</td>
<td>There is evidence that coordinated action is taking place to address the harms of substance abuse. While direct financial contributions by external partners were lower in this Grant period as compared to the previous Grant, in-kind contributions were substantial: partners and stakeholders contributed over 28,000 hours of engagement time to CCSA activities between 2011–2012 and 2014–2015. External key informants and two-thirds of survey respondents agree that the work of CCSA has improved coordination of action in the substance abuse field, and about half of survey respondents believe their own organization is more likely to work together with other stakeholders because of CCSA.</td>
</tr>
</tbody>
</table>
### Questions

<table>
<thead>
<tr>
<th>To what extent have Named Grant activities increased the application of evidence-informed products to inform policies, programs and practices?</th>
<th>Indicators</th>
<th>Overall Rating</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Number of citations of evidence-informed products in peer-reviewed journals</td>
<td></td>
<td>Progress Made; Further Work Warranted</td>
<td>While most stakeholders are aware of and have used at least one of the major products published by CCSA, awareness and use varies considerably by product. These differences may be due in part to the target audience for specific products (some are likely to have a broader appeal than others) and the recency of publication. Awareness is greatest for the LRDGs, the Competencies, and the FDNH Strategy, and these products, along with the CCENDU bulletins and drug alerts, are also the most often used or applied by stakeholders.</td>
</tr>
<tr>
<td>• Number and nature of references to/citations of evidence-informed products in federal, provincial/territorial, and other stakeholders’ policy and practice documents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Extent of use/application of evidence-informed products to inform policies, programs, and practices</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>To what extent have Named Grant activities increased stakeholder recognition of substance abuse as a health issue?</th>
<th>Indicators</th>
<th>Overall Rating</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Stakeholder perceptions of extent to which substance abuse is a health issue</td>
<td></td>
<td>Progress Made; Further Work Warranted</td>
<td>A majority of stakeholders (58%) see substance abuse primarily as a health issue. Many external key informants believe that progress, albeit slow, is being made in this area, but observed that CCSA’s work is only one factor contributing to evolving conceptions of substance abuse.</td>
</tr>
<tr>
<td>• Number/proportion of stakeholders in the health sector having incorporated collection, analysis, reporting, and/or use of addictions or substance abuse-related information into their activities</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>To what extent have Named Grant activities led to more effective policies, programs, and practices to address the harms of substance abuse?</th>
<th>Indicators</th>
<th>Overall Rating</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Stakeholder reports of impact of using/applying evidence-informed products on effectiveness of policies, programs and practices</td>
<td></td>
<td>Little Progress; Priority for Attention</td>
<td>Although CCSA has been in existence since 1988, the specific products and activities that are the focus of this evaluation have been implemented much more recently. The evidence available to this evaluation suggests that although policies, programs and practices based on some of CCSA’s evidence-informed products have begun to be implemented, it is premature to draw conclusions about their effectiveness. Ongoing monitoring and evaluation are needed to support valid conclusions.</td>
</tr>
<tr>
<td>• Documented evidence of more effective policies, programs and practices</td>
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</tbody>
</table>

#### 5. Demonstration of Economy and Efficiency

<table>
<thead>
<tr>
<th>What are the costs in relation to delivery of the Named Grant?</th>
<th>Indicators</th>
<th>Overall Rating</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Ratio of costs to outputs by priority areas</td>
<td></td>
<td>Progress Made; Further Work Warranted</td>
<td>Over the current Grant period, CCSA has been funded almost entirely by the federal government. Non-Health Canada funding has ranged from a high of 13% of CCSA’s total budget in 2013–14 to less than 1% the following year. While the federal government is likely to remain as its major funder, diversifying its funding sources while recognizing the potential constraints and limitations of non-Health Canada funding could help CCSA to better position itself as an organization that exists to serve the diverse interests of stakeholders in the substance abuse field.</td>
</tr>
</tbody>
</table>

Despite expending 97% of Named Grant funds over the current Grant period, CCSA experienced some variances in the ratio of planned to actual spending on certain priority areas, spending more than planned on international relations (due in part to participation in international events that were not anticipated at the time of budget preparation) and less than planned, for various reasons, on mental health and substance abuse, impaired driving, and First Nations, Inuit and Métis, as well as workforce development. Notably, mental health and substance abuse was an area identified by stakeholders as meriting greater focus by CCSA, suggesting that CCSA could explore opportunities to strengthen work in this priority area going forward. |

### Legend - Performance Rating Symbols and Significance:

- **Achieved**: The intended outcomes or goals have been achieved or met.
- **Progress Made; Further Work Warranted**: Considerable progress has been made to meet the intended outcomes or goals, but attention is still needed.
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<th>Overall Rating</th>
<th>Summary</th>
</tr>
</thead>
</table>
| How has CCSA optimized the overall quantity, quality, and blend of products/services to facilitate the achievement of outcomes? | • Measures taken/changes made to improve the quantity, quality, and blend of outputs (e.g., changes in approach to program delivery, flexibility in funding allocations by program area, responsiveness to emerging issues and changing priorities)  
• Key informant perceptions of factors that inhibit/promote efficient production of outputs | **Achieved** | CCSA has taken steps to optimize the quantity, quality and blend of products and services delivered under the Named Grant, including using SMART objectives and methodology to develop annual strategic directions and activities; responding to emerging priorities identified through consultations with stakeholders; building project management capacity to improve planning and tracking timelines and resource implications associated with project outputs; pursuing and securing non-Health Canada funding for some priority areas; and obtaining substantial in-kind support from partners to produce, disseminate and promote products. The willingness of partners to contribute in-kind is seen as the most important factor enabling the efficient production of high quality outputs. |
| How have the activities and outputs demonstrated value in terms of expenditures to achieve results? | • Dollar value of in-kind and direct financial investments by partners and amount leveraged  
• Partners’ perceptions of their likelihood of making similar investments in absence of CCSA  
• Key informant perceptions regarding the value of program outputs relative to their costs  
• Perceived capacity (in terms of resources and expertise) of partners and CCSA to produce outputs of similar scope, magnitude, and quality by acting independently | **Achieved** | CCSA representatives noted that the willingness of partners – many of whom are experts in their given field – to donate their time to joint initiatives has been a critical factor enabling the production of high quality products in an efficient manner. Moreover, external key informants highlighted CCSA’s ability to leverage in-kind contributions for joint initiatives as evidence of stakeholders’ belief in the value of these activities in the context of their own organizational objectives and missions. Virtually all key informants and focus group participants agreed that CCSA’s activities and outputs have demonstrated value, citing as evidence their own and other stakeholders’ use of CCSA products such as the LRDGs, the Competencies, and the CCENDU bulletins and drug alerts, among others. |
| Are there alternative methods to achieving CCSA’s Named Grant objectives? What would be the relative efficiency of these approaches versus the current model? | • Alternative methods/approaches for program delivery:  
• third-party vs. government delivery  
• grants vs. contribution agreements  
• multiple funding agreements versus consolidated funding arrangement  
• mix/range of program activities  
• Key informant/expert assessment of other options for program delivery | **N/A** | While the evaluation evidence supports continued third-party delivery of the activities currently delivered by CCSA, there are opportunities for CCSA to clarify its role in the substance abuse landscape. CCSA is widely seen and valued by stakeholders as a collaborator, facilitator, trusted expert, and knowledge broker, and there is a strong rationale for the organization to continue in these roles, but in other respects, CCSA’s role is less clear. The extent to which CCSA should position itself as innovator or advocate is a question that remains to be resolved.  
The funding model covered by the current evaluation, based on three distinct funding streams, creates administrative burden for both CCSA and Health Canada in proposal development and assessment, financial monitoring, progress reporting, and performance measurement and evaluation. While moving to a consolidated funding model is unlikely to reduce overall costs to CCSA, it would create efficiencies that could increase CCSA’s capacity to undertake substantive work in its priority areas. Both Health Canada and CCSA key informants emphasized the need for an arrangement that would continue to give CCSA the flexibility to undertake work in areas that may not necessarily align with the priorities of the government of the day, as was done with prescription drugs and alcohol. |