

The Evolution Of The Canadian Forces' Alcoholism Rehabilitation Program Evaluation System

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RÉSUMÉ

Après une brève description du Programme de Réhabilitation pour Alcoolistes des Forces canadiennes, cet article décrit l'évolution en trois étapes du système d'évaluation employé pour mesurer l'efficacité du programme. Ce cheminement peut paraître très long. Pourtant, il faut garder en tête que les ministères fédéraux ne sont habituellement pas constitués pour effectuer de la recherche ou de l'évaluation de programme, mais bien pour offrir des services à la population. L'évaluation de programme ne constitue donc pas une priorité et doit être "vendue" aux administrateurs. Il est de l'opinion des auteurs qu'une approche plus "bousculante" aurait eu pour effet de nuire à l'implantation de l'évaluation de programme comme partie intégrée au développement de nouveaux programmes.

ABSTRACT

After a brief description of the Canadian Forces Alcoholics Rehabilitation Program, this paper will describe the evolution of the evaluation system used to measure the program's effectiveness. This evolution could appear to be very long. However, one must keep in mind that the aim of federal departments is not to do research but to provide services to the population. Thus, program evaluation is not a very high priority and must be sold on a day to day basis to the administrators. It is the authors' opinion that a more hurried approach would have caused important resistance to the implementation of program evaluation as an integrated part of the development of new programs.

Introduction

For several years, the Department of National Defence (DND) has been concerned about the problem of alcohol abuse among its personnel. One

* The opinions expressed in this paper are those of the authors and do not necessarily reflect the views or policies of the Department of National Defence.

response to the problem was the development in 1980 of the Alcoholism Rehabilitation Program (ARP) to treat Canadian Forces (CF) military alcoholic. The ARP is a three phased program. During Phase I an alcohol problem is recognized by the individual or detected by the supervisor. This is the identification phase. Phase II is a four week stay in a CF Alcoholism Rehabilitation Clinic (ARC). There are six regional ARCs, five in Canada (Pacific in Victoria, Prairies in Winnipeg, Central in Kingston, Eastern in Valcartier and Atlantic in Halifax) and one, ARC (CFE) in Lahr, West Germany. The six clinics are staffed by military and civilian counsellors and administrative personnel. The mainstay of treatment is group therapy. The supervisor and the family are normally involved in the treatment process. After 28 days, the member is discharged from the ARC with an agreement concerning treatment during the 12-month Phase III follow-up. During this period regular meetings are scheduled with the Phase III Coordinator. Patients are also encouraged to attend Alcoholics Anonymous (AA) meetings and to use other appropriate facilities both on the base and in the civilian community (Brochu *et al.*, 1985).

Evaluation of the ARP has evolved over time, going from a system based primarily on descriptive statistics collected on an *ad hoc* basis to a more formal evaluation based on more scientific principles. This paper describes the evolution of this evaluation system.

First Step

During the first step of its evolution, the selection of people for treatment in the program was based only on a medical diagnosis of alcoholism. The evaluation of the patients' progress was judged at the end of Phase III by placing them in one of the following five categories;

1. total continuous abstinence;
2. one or two slips but currently abstinent;
3. returned to drinking but without problems
(i.e. no longer abusing alcohol as defined below);
4. returned to drinking with continued problems
(i.e. with resumption of abuse); or
5. released from the CF for alcohol-related problems.

According to CF policy, alcohol abuse occurs when the member's use of alcohol:

1. interferes with performance of duty or regular attendance at the place of duty
2. creates an administrative burden by causing domestic or other problems;
3. interferes with satisfactory social or economic functioning;
4. interferes with health; or
5. otherwise reflects discredit upon the CF.

It appears from a review of the literature on alcoholic treatment programs

that $\frac{1}{3}$ abstinent and $\frac{1}{3}$ improved (but not abstinent) represent reasonable estimates of short-term (12 months or less) response to treatment (Miller and Hester, 1983). Despite the fact that the results obtained were quite positive (abstinence rate: 51.4%; improvement rate: 28% (excluding abstinent), c.f. Brochu *et al.*, 1985), they must be interpreted with caution. It should be noted that the results were based on only a 12-month follow-up. Findings from different studies indicate that during this 12 month interval, variations in group data are frequent, and data from individual subjects continue to show some variability even after this period of time. According to many authors (Caddy *et al.*, 1978; Maisto *et al.*, 1980; Orford *et al.*, 1976; Sobell and Sobell, 1982), 12 months is the lowest acceptable limit for a follow-up. The results also depended solely on the subjective interpretation of part-time staff (Phase III coordinator) and no control was used.

This method considered only one variable, alcohol consumption, without evaluating the state of the patient at intake except through a medical diagnosis. It also afforded little information for improving the program. Even the basic method of data collection was of questionable validity. In spite of the above, this first step in the evaluation that took place between 1980 and 1984 was considered important because it has made it possible to lower the level of resistance from the people involved in the evaluation process and has contributed much useful descriptive data.

Second Step

During the second step, the selection of people for treatment was still based on a medical diagnosis but was also documented by a well-known alcoholism diagnostic instrument: the Alcohol Dependence Scale (ADS) (Skinner and Horn, 1984) and Michigan Alcoholism Screening Test (MAST-10) (Selzer, 1971; Skinner, 1979). The second method of evaluation is the pilot test, in the Central region (Ontario), of a scientifically more sophisticated design. The two objectives of the pilot study were to test the data-gathering procedures and to obtain some preliminary results. The pilot evaluation system used three different sources of cross-checking data:

1. Questionnaires for the:
 - a. patient;
 - b. medical personnel;
 - c. work supervisor; and
 - d. Phase III coordinator;
2. Laboratory tests: Gamma-Glutamyl Transpeptidase (GGT) and Mean Corpuscular Volume (MCV). According to previous studies (Holt, Skinner, Israel, 1981), the results of these two laboratory function tests have discriminatory power for the diagnosis of alcohol abuse.
3. Official records.

In addition to alcohol consumption, eight other variables were then measured: work performance; attendance at work; time off for illness; hospital days; general physical health; social situation; legal problems; and respon-

sibility for one's life. Data covering the one year period before the beginning of Phase II were collected retrospectively and compared with the data gathered at 6, 12, 24 and 60 months following the completion of Phase II. A pre-post design with repeated evaluations and without a control group was then used.

The results of the pilot study were released at the Banff Canadian Evaluation Society Conference (Brochu *et al.*, 1986). Suffice it to say for the moment that the results of step 2 were in line with the results of step 1. In fact, the abstinence rate was 51.5% and the improvement rate was 72.7%. The results have also contributed a better knowledge of the patients treated (young men with few alcohol-related problems).

Following this second step, the evaluation team was made aware of various sources of resistance to the new evaluation procedures. A first source of opposition came from the clinical team. In fact, they felt somewhat pressured by the evaluation project. Would they be compared to other clinicians in order to evaluate their performance? Would they be overloaded with additional tasks? It was then made clear that the objectives of the evaluation project was not to evaluate the staff (they are properly evaluated by their supervisors) but to evaluate the program in order to improve it, and to offer the best possible services. In addition, the evaluation team decided to meet the clinicians as often as needed in order to obtain their input in the development of the new evaluation procedures. This cooperation was very enriching and satisfying for both parties.

A second source of resistance emerged among the patients. They were afraid that the information collected could affect their career. In addition to the regular procedures used to protect the confidentiality of the information gathered (use of a consent form, utilization of a subject's code number, data analysis by a civilian agency, etc.), it was then decided to present the evaluation procedures as something "natural" in any rehabilitation program wanting to improve the services given to the patients. This "low key" approach has produced good results in increasing patients' cooperation.

A third source of opposition came from some staff members who were asked to report on patients' progress. There were prolonging delays before some of them sent back the information requested. The strength of the CF chain of command was then used to publicize the importance of the evaluation and its priority for every CF member.

Step 2, then, was a very important one. In fact, it would have been a big mistake to have proposed a new evaluation system to every region without the pilot study. The CF would have lost time, energy and money and could have jeopardized the future of the ARP evaluation system if the pilot phase had been deleted.

Step 3

The third step was actually to spread the improved pilot evaluation system to every region. These new procedures started in January 1986, but the data for the first three months will not be used for evaluation purposes because of the novelty of the procedures and the time required to implement the new system.

The first results of this new evaluation system will only be analyzed during the Fall of 87 but they are expected to give information that will modify Phase I in order to improve the detection of CF members who are misusing alcohol. For example, systematic screening could be done on every patient over 40 years old during their annual medical examination. Phase II could also be modified in order to be more cost-effective. Other treatment modalities could be examined (e.g. an outpatient format, giving simple advice or bibliotherapy for certain types of patients). This new evaluation system affords a close examination of all aspects of treatment.

However, step 3 is certainly not an ideal program evaluation. The absence of a control group composed of alcoholics deprived of treatment does not allow the evaluator to attribute the results observed to the treatment. It may be that, once identified, 51% of the participants would have abstained with or without the program. The scientific mind will accept the idea of using a control group in such a situation, but the clinical staff will openly protest for ethical reasons. During this step, the use of a control group was considered, then omitted for the sake of the evaluation itself.

Step 4

A fourth step is already envisaged. This step would be characterized by the use of a sound scientific evaluation approach that would aim at a match of different approaches (in-patient or out-patient programs as well as life skills education program, bibliotherapy or simple advice) for certain type of patients. One of the author's works on a success predictor model using three variables, namely, alcohol dependence, locus of control and motivation to change. This model could potentially lead to a better patient-treatment match and a better cost-effective treatment.

Conclusions

The Canadian Forces are constantly trying to improve the quality of life of their members. That is one reason why the ARP was instituted and evaluated. One can be very critical of the results obtained from the first evaluation system which was using a non-experimental design. But program evaluation must be considered differently from pure research. Program evaluation must be as extensive as possible, but also must be practicable and productive of results that decision-makers can rely on. The aim is not merely to produce a disseminable package (Campbell, 1986) that could be used in other contexts but rather to "improve programs, influence resource allocation, guide policy development and enhance accountability" (Rayner, 1986). This process also serves an educative function since program implementers must clearly define the aim of their interventions and subsequently analyze their measured impact (Albert *et al.*, 1985).

The evaluation of the CF Alcoholism Rehabilitation Program has evolved. It started with only one variable (alcohol intake) measured from only one source (Phase III coordinator) at only one point in time (12 month follow-up after Phase II). A pilot evaluation has tested the feasibility of a more sophisticated evaluation system. Presently, the evaluation is "multiple" in

character: multiple variables are measured from multiple sources and at multiple points in time. The next step will be the comparison of different approaches for different types of patients using an even sounder scientific approach.

The road which has been taken to attain a sophisticated evaluation system may seem extremely long. However, one must keep in mind that federal departments are usually not research oriented. They simply have to offer quality services to the population. Program evaluation is not an *a priori* priority and must be "sold" to the administrators. It is the authors' opinion that a more hurried approach would have been very detrimental to the implementation of program evaluation as an integrated part of new program development.

The conclusion is simple; the evolution of the evaluation system, while proportional to the decrease of the participants' resistance gradually bring more sophisticated designs and reduces the gap between program evaluation and research. In order to attain this goal, one must therefore do long-term planning.

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