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Staged Screening and Assessment Virtual Discussion with AMHO Members
Summary Notes

Background

A comprehensive research project through Health Canada's Drug treatment Funding Program, along with evaluation, pilot testing, and broad, sector-wide consultation led to the recommendation to adopt Staged Screening and Assessment (SS&A) as a common suite of tools across the province. In 2015, the Ministry of Health mandated SS&A across all publicly funded addictions organizations and contracted the Provincial System Support Program (PSSP) at the Centre for Addiction and Mental Health (CAMH) to support the sector to implement the tools.

On October 15, 2020, Addictions and Mental Health Ontario (AMHO) and PSSP co-hosted a virtual discussion on SS&A with AMHO members. The goal was to review commonly noted implementation barriers, share successful mitigating strategies (including from a panel of four AMHO members), and discuss opportunities to further support SS&A implementation across the province.

These notes summarize SS&A implementation barriers and strategies reviewed and discussed on October 15. Barriers are summarized into key themes: system and leadership challenges, disconnect between administration and practical application, scope limitations, and restrictions in use of data for decision-making. The panel summary includes mitigating strategies related to training and selection, entry and service matching, linking clinical administration and practical application, and building buy-in. Also included are participant suggestions for completing the GAIN Q3 MI ONT with clients with complex needs.

System and Leadership Challenges

A system shift, including a consistent level of support and regional collaboration, is required from all levels of government and organizational leadership to back the use of standardized tools such as SS&A, acknowledge gaps in the effectiveness of these tools, and address system barriers such as waitlists and service availability.

- The SS&A tools are mandated in the addiction sector and included in Multi-Service Accountability Agreements. SS&A, however, is not prioritized to the same extent by all levels of government across the province, and ***accountability to the mandated process is inconsistent***. This creates conflicting messages for staff and organizations regarding the importance of standardization and makes it difficult to identify true gaps in the effectiveness of the tools.
- There is an ongoing need for communication and reinforcement of the ***value of the staged process*** for screening and assessment, specifically the need for screening to be widespread

(used for all) and, when clinically indicated, certain individuals to have a comprehensive addiction assessment. *refer to *Building Buy-In* mitigation strategies in panel summary

- Organizations often ***need to adjust their clinical pathways*** and operations to implement SS&A, but may ***lack the resources or support*** to make these changes. Because it is not simply a matter of replacing previously used tools (such as the ADAT), there may not be enough dedicated time or resources to review and adjust internal processes to support successful implementation of the SS&A tools. In addition, lack of infrastructure to support electronic administration may reduce the efficiency of administration and the ability to use the reports.
- Local systems may also need adjustment to support efficient implementation of the common tool and staged process, requiring ***system collaboration***. Examples include the widespread use of screening tools, centralized assessment centre, and regional training plan. Centralized assessment centres add a new contact, another point of transition, potential delays related to the back and forth between agencies, and possible issues with clients needing to return to a specific organization for an assessment where they may have previously had a harmful experience and/or introduce language and cultural barriers. Without adjusting processes, local systems, agencies and clinicians may find workarounds to support their clients' needs.
- Substantial ***resource investments*** (by organizations, clinicians, and trainers) are required to accommodate SS&A's comprehensive training process. This can be overwhelming for staff and management who have many ***competing priorities***. Many agencies do not have the capacity to offer staff as quality assurance trainers, resulting in high attrition rates, regional capacity limitations for training, and staff having to wait for training (delaying onboarding and client access to assessments). High turnover in the sector also means resource investments are required on an ongoing basis. *refer to *Training and Selection* mitigation strategies in panel summary
- There are ***pressures to reduce long waitlists***, which do not match well with what some consider a ***long assessment***. Some clinicians report a percentage of their clients find the assessment length intolerable. In particular, the use of the grids, with its focus on timeframes, can be stressful and overwhelming for clients and add frustration when memory impairments and inconsistencies arise. The recommendation to complete the assessment over multiple visits does not always allow the clinician to receive results and/or the client to access treatment in a timely manner.
- The ***limited range of services available*** in some regions restricts the applicability of a tool that provides a level-of-need assessment. This can result in clinician and client frustration when they complete the assessment and there are few treatment options available. Further, clinicians may need to spend time modifying the recommended referral summary to reflect regional realities.

Disconnect between administration and practical application

The SS&A tools are multi-faceted and not consistently used for clinical purposes

- The online training and quality assurance ***(certification) process is substantive and resource intensive***. It also ***focuses on the administration of the tool and not on its clinical use***. It takes time and use of the tool to gain clinical mastery in its administration. Clinicians' need to build

confidence and capacity in using their clinical skills while administering the assessment (building rapport and trust, use of trauma-informed and culturally-appropriate care, motivational interviewing techniques, adapting to the client). In-house coaching and clinical supervision are known to be beneficial to support the practical application of the tools, including the use of the clinical reports and development of treatment plans. These supports, however, are not always available within implementing agencies, particularly in smaller community agencies. *refer to *Linking Clinical Administration and Practical Application* in mitigation strategies in panel summary

- There can be a disconnect between what clinicians or others (e.g. courts, Children's Aid Society, family members) feel is the required need for a client and what the GAIN Q3 MI ONT recommends. For example, some court systems are reluctant to accept a pathway that does not result in residential care, but this may not match GAIN Q3 MI ONT recommendations.
- The GAIN Q3 MI ONT is often ***used for referral purposes only***. In this sense, the assessment is viewed as a data collection process, rather than a valuable support for clinical decision-making and guide to match the client to the right level of care for their needs. Without a comprehensive assessment first, clients may not be matched to appropriate treatment, affecting their experience as well as the treatment experience and access for others. *refer *to Entry and Service Matching* mitigation strategies in panel summary

Scope limitations

Scope limitations create barriers to effective implementation and sustainability, as well as barriers for clients

- Programs and individuals selected to participate in training are not always those who will use the tools regularly. Clinicians who do not regularly conduct assessments may be trained on SS&A, but then not actually administer the tool after training. This may be because of the clientele they serve; for example, if they primarily provide mental health supports rather than addiction services. This does not allow clinicians to build the ***efficiency and added competency known to come with practice***. Because of the complex nature of the training, the commitment required, and the need for practice with the tools, it can be frustrating for clinicians, trainers and organizations if the right trainees are not selected from the start and/or if the they do not have the opportunity to practice sufficiently with the tool.
- It is recognized that the ***tools are challenging with some client populations*** and can be seen as a barrier to equitable and accessible services for all. Specifically, uncertainty exists regarding the appropriateness of the GAIN Q3 MI ONT for clients who are in crisis, actively in withdrawal or under influence, those with significant cognitive impairment, and/or clients with complex social situations demanding primary attention in other areas – e.g. homeless; language barriers; lower education levels; trauma. While various mitigation strategies have been identified to respond to client scope issues, uptake is variable. In addition, there is a need to be able to indicate why a client was not assessed using the GAIN Q3 MI ONT to help make statistics meaningful. *refer to mitigation strategies for clients with *complex needs*

Restrictions in use of data for decision-making

Information from the GAIN Q3 MI ONT is not available and/or used consistently to support decision-making

- It is not always clear how agencies use the assessment information from the GAIN Q3 MI ONT. Some residential providers have their own intake packages that need to be completed, which can result in ***duplicate data collection***. This may be, in part, because the GAIN Q3 MI ONT Recommendation Referral Summary (RRS) is not routinely edited. To be most useful, the RRS should be reviewed to ensure the context is appropriate and specific, and necessary information is collected. Some providers indicate editing the RRS is time consuming.
- Decision-makers do not always have access, or the capacity, to review data to support decision-making. Quality, ***easily accessible data are essential to support needs-based planning*** at both the system and agency-level (e.g. to inform quality improvement efforts, support staff and client buy-in, help regions identify what types/intensities of services are needed locally and across the province). It is recognized that easy access to SS&A data is a work in progress across the system. In addition, not all electronic systems integrate well, meaning GAIN Q3 MI ONT data (reports) that are available are not always easily transferable or accessible.

PANELIST PRESENTATIONS

Peel Addiction Assessment Referral Centre (PAARC) – Training Selection & Leadership

Challenge: can't get all clinicians trained quickly, not all appropriate for training

- Prioritize who needs training based on scope of work and system focus (internal planning as well as with regional partners)
- Select based on capacity and clinician flexibility (clinicians who can provide assessments outside their own program, interest in championing)
- Strong leadership and support critical for successful uptake

Thunder Bay Counselling Centre (TBCC) – Entry and Service Matching

Challenge: client arrives "needing a GAIN assessment", or clinician says, "I've done a referral to residential treatment, now need an assessment"

- All-staff involvement and overhaul of entry process to assessment - receptionist and entry group facilitators explain process of screening first, assessment if appropriate; counsellor explains all treatment options and discusses fit based on need
- Extensive education to third parties regarding purpose of and need for assessment

CMHA Muskoka Parry Sound – Linking Administration and Clinical Application

Challenge: staff resistant to make big shift from ADAT to SS&A, need to link administration and practical application

- Lots of education on importance of comprehensive assessment (which includes items not captured on ADAT); and that tool is a complement to clinical judgement
- In-house trainers supporting staff and regular SS&A refreshers helpful
- Use of reports for treatment planning, clinical supervision, advocacy for why clients with complex needs should have a comprehensive assessment

Cochrane District Detox Centre – Building Buy In

Challenge: clinicians not using assessment tool previously; new process, more work

- Started training with interested clinicians, who then became champions
- Worked with champions on who should and should not receive an assessment (e.g. in withdrawal management – assessing those interested in treatment and who have detoxed)

Mitigating Strategies Suggested by Participants Regarding Administering the GAIN Q3 MI ONT with Clients with Complex Needs

- Clients with higher needs should be matched to clinicians with more experience/ comfort with tool and clinical expertise (better able to use clinical judgement to support tool administration)
- Lunch and learns and refreshers (by champions) help staff who need additional support for working with complex clients
- Complex clients need more case management and often need to have other issues addressed before assessment is completed (right time)
- Need to address many social determinants of health before recommending complex clients for residential services (impacts relapse risk, motivation for change, etc.)
- Work with community partners to stabilize client before recommending for treatment. Advocating for clients when GAIN Q3 MI ONT cannot be completed.