

**STAGED SCREENING AND ASSESSMENT  
PROCESS FOR ADDICTIONS:  
IMPLEMENTATION EVALUATION REPORT**

**PREPARED BY: THE PROVINCIAL SYSTEM SUPPORT PROGRAM (PSSP) AT THE  
CENTRE FOR ADDICTION AND MENTAL HEALTH (CAMH) ©**

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## GLOSSARY

<b>Term</b>	<b>Definition</b>
ADAT	Admission and Discharge Tools
Addiction	In alignment with terminology used by the Ministry of Health and the Mental Health and Addictions Centre of Excellence at Ontario Health, the term addiction refers to problematic substance use or other similar terms
ADTC	Admission and Discharge Tools and Criteria
ASSIST	The Alcohol, Smoking and Substance Involvement Screening Test
Bed-based services	Formerly residential treatment services
Catalyst	Electronic medical record used in the addiction sector and launching pad for the GAIN Assessment Builder System
CHS	Chestnut Health Systems, the developers and owners of the GAIN suite of tools including GAIN-SS and GAIN-Q3 MI ONT
Client	The term client is used throughout this document and is respectfully intended to include all other references to service users, such as consumer, member, or patient
DATIS	Drug and Alcohol Treatment Information System, part of the Provincial System Support Program at the Centre for Addiction and Mental Health
E-QIP	Excellence through Quality Improvement Project
EMR	Electronic medical record
GAIN ABS	GAIN Assessment Builder System
GAIN-Q3 MI ONT	Global Appraisal of Individual Needs, Quick 3, Motivational Interviewing, Ontario version (the Stage 1 Assessment in the Staged Screening and Assessment process)
GAIN-SS	Global Appraisal of Individual Needs – Short Screener (Stage 1 Screener in the Staged Screening and Assessment Process)
Interface	An EMR other than Catalyst used by addiction and mental health providers, such as EMHware, Meditech, or CaseWORKS.
LHIN	A former Local Health Integration Network
MH&A	Mental Health and Addictions
MHACoE	Mental Health and Addictions Centre of Excellence at Ontario Health
MMS	Modified Mini Screener (Stage 2 screener in the Staged Screening and Assessment process)

OH	Ontario Health, a Crown agency established by the Government of Ontario to oversee provincial health care administration
OHT	Ontario Health Team
OPOC	Ontario Perception of Care Tool for Mental Health and Addictions
POSIT	Problem Oriented Screening Instrument for Teenagers (Stage 2 screener in the Staged Screening and Assessment process)
PSSP	Provincial System Support Program at the Centre for Addiction and Mental Health
PTM	Provincial Training Model for GAIN-Q3 MI ONT certification
Q3ICP	The Q3 Individual Clinical Profile lists the items that factor into a participant's scale scores according to low, moderate, and high problem severity or service utilization
Q3PFR	The Q3 Personalized Feedback Report is a summary of the participant's reported problems along with their reasons for wanting to change
Q3RRS	The Q3 Recommendation and Referral Summary, an auto-generated report that provides a narrative summary of the information provided by clients during the GAIN-Q3 MI ONT assessment
Quality Assurance (QA) Trainer	A GAIN-Q3 MI ONT certified trainer who supports trainees to achieve GAIN-Q3 MI ONT Site Interviewer certification
Site Interviewer	Service provider who has completed training and been certified to administer and use the GAIN-Q3 MI ONT assessment
SS&A	Staged screening and assessment
Trainee	A service provider pursuing training on the GAIN-Q3 MI ONT
Treatment	In this document, treatment planning refers to any type of service and not exclusively bed-based services
Validity Report	An auto-generated report that identifies inconsistencies in the participant's self-reported information for clarification at any time during or immediately after the interview

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This evaluation would not have been possible without the thoughtful participation and extensive contributions of many audience groups, including mental health and addictions service providers across the province, Ministry of Health staff, Ontario Health Mental Health and Addictions Leads, Mental Health and Addictions Centre of Excellence at Ontario Health staff, and CAMH staff at PSSP including DATIS and the SS&A implementation team, and Shkaabe Makwa. We also thank the organizations that assisted with the client engagement activity, and the clients who offered their contributions.

## EXECUTIVE SUMMARY

Ontario is striving towards a mental health and addictions system in which services are, at their core, person and family-centred. Roadmap to Wellness, the province's mental health and addictions plan, put forward a strong and clear quality improvement agenda for health care services with a focus on measuring performance and enhancing quality of care. The Staged Screening and Assessment (SS&A) process, developed through Health Canada's former Drug Treatment Funding Program, has been implemented across Ontario since 2015. The implementation team at the Provincial System Support Program (PSSP) at the Centre for Addiction and Mental Health (CAMH) has tracked risks, issues, and positive impacts related to this initiative since the beginning; however, a sector-wide evaluation activity had not been undertaken. After six years of implementation experience, a provincial scope of approximately 170 organizations, and almost 2,500 clinicians trained, PSSP engaged the addiction sector in this comprehensive evaluation.

There were two primary objectives of this evaluation: 1) to assess the acceptability and utility of the staged screening and assessment process; and, 2) to explore potential adaptations or complements to the tool package that would encourage widespread adoption across the addiction sector. Five evaluation questions informed the data collection activity:

1. To what extent are the screeners (GAIN-SS, MMS, POSIT) and assessment tool (GAIN-Q3 MI ONT) being used?
2. Are the tools and process being used as intended?
3. What has been the impact of introducing the staged screening and assessment project (to agencies and the broader sector)?
4. What has been the experience with respect to training, competency, and ongoing support?
5. Are there any modifications (to the tools or the implementation process) that could be made to maximize uptake and sustainability going forward?

This evaluation was completed using mixed-method surveys and interviews with focus group participants and key informants.

This evaluation frequently references the evaluation of SS&A's predecessor, the Admission and Discharge Tools and Criteria (ADTC). When an evaluation of ADTC was conducted in 2006, it revealed that assessments were often conducted *after* a referral decision had already been made, making the assessment an administrative activity rather than a clinical one supported by a rational, evidence-informed basis for matching the individual to the appropriate type and level of service as part of formulating an individualized treatment plan. Further, the evaluation found that a subset of addiction agencies, often the initial assessment

and referral centres, demonstrated the greatest use of the tools. Both of these findings were replicated in this current evaluation of SS&A.

SS&A aligns with current mental health and addictions (MH&A) sector initiatives that aim to create more coordinated, responsive, and client-centred services throughout the province. Additionally, it operates within a provincial database whose infrastructure is critical to providing population-level analysis and trends as well as eventual outcome monitoring. As this evaluation demonstrated, however, SS&A continues to be underutilized across Ontario, and is most reliably implemented within a small subset of addiction organizations and for referral to bed-based services. The discussions throughout this evaluation convey the administration variability, process modifications, varying perceptions of the tool itself, and divergent understandings of the purpose of assessment perpetuate an implementation environment where the full staged protocol is not being used as intended.

Other key findings from this evaluation include:

- Data reflect significant variation in SS&A implementation processes across the province.
- The total volume of screeners and assessments completed relative to established tool cut-off scores strongly suggests a lack of adherence to the staged protocol. Moreover, the variation in tools used across service types suggests a lack of clarity around when different components of the staged protocol should be administered.
- Data suggest that the tools are completed administratively to facilitate service access once a treatment destination has been determined, and not to guide the treatment decision itself.
- The vast majority of assessments completed by a relatively small number of clinicians, and these clinicians work for an equally small number of organizations relative to the entire scope of SS&A implementation.
- Both key informant and focus group participants suggested that further clarity regarding the existing SS&A mandate may be beneficial to uptake.
- Some service providers have come to view the GAIN-Q3 MI ONT assessment tool as a perceived barrier to clinical practice.
- Clinicians have divergent understandings and definitions of assessment, which impacts how and when assessment tools are administered and for what purposes. This highlights the need for system-wide definitions of screening and assessment as distinct processes.
- Although SS&A implementation efforts should continue to emphasize the role of the individual organization, focusing on increasing uptake and usage internally especially

in the context of agency administration variability, this also illustrates that system-wide benefits of SS&A are not being realized.

- A majority of respondents disagreed that the SS&A tools and process helped their organizations develop new referral pathways. Responses were mixed as to whether SS&A has a role in centralized access models, Ontario Health Teams, and regional partnerships.

The following recommendations are based on the information provided by participants in this evaluation, subject to the limitations noted at the end of this report. They also take into account the historical context associated with prior attempts to introduce standardized assessment tools into the addiction sector.

1. Revisit the implementation scope criteria for SS&A and restate the mandate with some additional language.
2. A) Target high-volume implementing organizations to identify specific factors associated with their successful uptake.  
B) Target high-volume implementing Site Interviewers to identify specific factors associated with their clinical practices and organizations that allow them to administer the tool regularly and develop proficiency.  
C) Target health service providers providing support to structurally marginalized client populations to explore if and how the SS&A tools and protocol further health inequities.
3. Reserve the need to establish a target assessment rate until the recommendation #1 is implemented.
4. A) Work with addiction sector partners to reaffirm why each component of the staged protocol exists, how they align with the original purpose and goals of SS&A, and the long-term benefits they offer to the addiction sector.  
B) Develop and provide training on use of SS&A data for quality and equity improvement opportunities
5. A) Reiterate the role of the second stage (mental health) screeners in the SS&A process, or establish legitimate exemption criteria for this stage of the protocol.  
B) The role and purpose of POSIT in the staged protocol should be re-evaluated.
6. Reemphasize that the treatment planning component, including the auto-generated reports, is an essential component of the staged process that benefits clients and clinicians when placement matching occurs as intended.
7. Work with implementing organizations to reprise the client engagement activity of 2017 to complement clinician perspectives.
8. Develop training and resources to support virtual administration of the SS&A tools and process, and provide implementation support to this effect.



9. A) Training should better emphasize the clinical applicability of information collected from the assessment rather than just the administration process.  
B) Work with organizations and Site Interviewers to reaffirm how semi-structured interviewing principles apply to the assessment.
10. Continue to raise awareness of existing SS&A resources and knowledge exchange products.

## INTRODUCTION

### SYSTEM CONTEXT

In Ontario, addiction services are delivered by a variety of health service providers. An individual in need of addiction services may receive care from primary care, hospital emergency departments, addiction treatment service providers, or specialty psychiatric hospitals. There are three main types of addiction treatment programs, primarily located in the community, delivered by almost 300 organizations across the province. Non-residential care is the most commonly accessed program type, with 170 organizations delivering individual or group counselling, or case management, during the day or evening. Residential or bed-based programs are delivered by 73 organizations, where clients live at the treatment facility and participate in structured programming. Withdrawal management programs, delivered by 49 organizations, are provided in a facility or at home, where clients receive medical care and individual or group programming while they are withdrawing or detoxing from one or more substances. The total cost of delivering these services was \$212 million in 2018/19, according to the most recent sector audit by the Auditor General of Ontario.<sup>1</sup>

The use of evidence-based tools as a foundation for effective screening, assessment, and treatment planning is a fundamental requirement for the addiction sector. As previous reviews have demonstrated,<sup>2-3</sup> the addiction sector has historically experienced substantial variation in both the frequency and quality of screening, assessment, and treatment matching. When evidence-based tools were not regularly used, it was unclear what was used in their place to inform treatment decisions.

As Ontario's Auditor General noted in 2008, "Ontario's addiction treatment services did not historically develop as part of a planned, integrated system. Rather, local agencies and

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<sup>1</sup> Auditor General of Ontario. (2019). *2019 annual report of the Office of the Auditor General of Ontario* (Chapter 3, Section 3.02: Addiction treatment programs).

[https://www.auditor.on.ca/en/content/annualreports/arreports/en19/v1\\_302en19.pdf](https://www.auditor.on.ca/en/content/annualreports/arreports/en19/v1_302en19.pdf)

<sup>2</sup> Rush, B., & Martin, G. (2006). *Report of the evaluation of the Admission and Discharge Tools and Criteria (ADTC)*. Toronto, ON: Centre for Addiction and Mental Health.

<sup>3</sup> Rush, B., Rotondi, N.K., Furlong, A., Chau, N., & Ehtesham, S. (2013). *Drug Treatment Funding Program – Best Practice Screening and Assessment Project*. Toronto, ON: Centre for Addiction and Mental Health.

<http://improvingystems.ca/img/SSA-Research-and-Development-Final-Report-2013.pdf>

programs grew over time to respond to local needs” (p. 51).<sup>4</sup> Although a comprehensive historical overview is not necessary for the purposes of this evaluation, certain milestones do relate to current discussions of assessment as a clinical practice and implementation scope. These are briefly summarized in the following section.

The Ontario government has put forward a strong and clear quality improvement agenda for health care services. *Roadmap to Wellness*, the province’s recent mental health and addictions plan, focuses on measuring performance and enhancing quality of care.<sup>5</sup> Specifically, Pillar One of *Roadmap* emphasizes improving quality and enhancing services, including with a level-of-needs approach and use of evidence-based screening, assessment, and referral tools. Within the core services framework to be developed under this pillar, expectations will be developed to promote consistent service delivery, quality improvement, and accountability. At the same time, Ontario has committed to investing \$3.8 billion over 10 years for mental health and addictions supports. It is essential that services and funding allocations be based on need and quality rather than history alone (p. 126).<sup>1</sup>

## SS&A PROCESS BACKGROUND

In the 1970s, selected communities across Ontario received funding to develop services specifically for the purpose of conducting assessments and matching a person’s needs and strengths to an individualized treatment plan, which may involve internal or external evidence-based referrals. This concept of dedicated “assessment and referral centres” was new to Ontario and followed from recommendations from an earlier comprehensive treatment system review as well as current trends in the field.<sup>6,7</sup> During the 1980s and 1990s, as the number and variability of assessment tools and practices emerged, the development of local and regional protocols challenged the appropriateness of provincial standardization for assessment and referral. The result was that clients continued to receive different options for assessment at multiple agencies in the same community and were not required to begin their treatment

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<sup>4</sup> Auditor General of Ontario. (2008). *2008 annual report of the Office of the Auditor General of Ontario* (Chapter 3, section 3.01: Addiction programs).

<https://www.auditor.on.ca/en/content/annualreports/arreports/en08/301en08.pdf>

<sup>5</sup> <https://www.ontario.ca/page/roadmap-wellness-plan-build-ontarios-mental-health-and-addictions-system>

<sup>6</sup> Rush, B.R., Ellis, K., Allen, B., Graham, K., & Ogborne, A. (1995). Ontario treatment system research 1979-1993: What have we learned about assessment and referral services in terms of the original objectives. *Contemporary Drug Problems*, 20(1), 115-136.

<sup>7</sup> Marshman, J.A. (1978). *The treatment of alcoholics: An Ontario perspective*. Report of the Task Force on Treatment Services for Alcoholics. Toronto, ON: Addiction Research Foundation.

journey at the assessment and referral centre, despite that being the *raison d'être* of the provincial program to develop these services.

In September 2000, the Ontario Substance Abuse Bureau (at the time a division of the Ministry of Health) and the Ontario Addiction Services Advisory Council released the Admission and Discharge Criteria. The criteria intended to address several known problems in the addiction sector, including treatment providers using different criteria to admit, refer, and discharge clients; and, referrals based more on available services and long-standing relationships between agencies than client need. These criteria also established common categories of services across the treatment continuum, beginning with entry (including initial contact, intake, and screening), to initial assessment/treatment planning, through to a number of service destinations (e.g., case management, community non-bed-based treatment, day/evening treatment, or bed-based treatment). The goal, when implemented as intended, was that clients could expect a common application of these criteria across all addiction agencies in the province, regardless of their entry point.

Coinciding with the adoption of these criteria, the Ministry introduced the Admission and Discharge Assessment Tools (ADAT) in 2001, which included seven core assessment tools made available to all publicly funded addiction agencies in the province. These tools were accompanied by decision-making criteria, which collectively comprise the Admission and Discharge Tools and Criteria (ADTC). When Local Health Integration Networks (LHINs) were created in 2006, they adopted these tools as the mandatory “Standardized Assessment Package” for the sector, intended to operationalize the criteria. The Admission and Discharge Criteria and Assessment Tools (ADTC) Manual<sup>8</sup> highlighted several advantages to using standardized tools, including increased efficiency and accuracy, better data, reduced duplication, and the ability to substitute new tools across the board as they become available. To the extent that a community treatment system required multiple points of entry, the concept of one centralized assessment and referral centre broadened to include commonality in the assessment tools and treatment matching processes across a wider range of service providers.

The Ministry requested Rush and Martin (2006)<sup>9</sup> evaluate the provincial Admission and Discharge Assessment Tools and Criteria. Results showed significant variation in the tools used

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<sup>8</sup> Cross, S., & Sibley, L. (2010). *Admission and discharge criteria and assessment tools manual (revised)*. Toronto, ON: Centre for Addiction and Mental Health.

<sup>9</sup> Rush, B., & Martin, G. (2006). *Report of the evaluation of the Admission and Discharge Tools and Criteria (ADTC)*. Toronto, ON: Centre for Addiction and Mental Health

to assess individuals accessing addiction services and the length of time taken to complete their assessment process. There was also considerable confusion among end-users in the terms and related tools for “screening” versus “assessment.” The evaluation also revealed that assessments were often conducted *after* a referral decision had already been made, making the assessment an administrative activity rather than a clinical one supported by a rational, evidence-informed basis for matching the individual to the appropriate type and level of service as part of formulating an individualized treatment plan. Further, the evaluation found that a subset of addiction agencies, often the initial assessment and referral centres, demonstrated the greatest use of the tools. Both of these findings were replicated in this current evaluation of SS&A. Lastly, in hindsight, that evaluation also provided an important baseline assessment of the use of standardized tools in the sector in general, which was seen as a prerequisite for a provincial outcome monitoring system and was a valuable resource during the development and execution of this evaluation.

## **SS&A TOOL AND PROCESS SELECTION**

From 2011-2013 and funded by the Drug Treatment Funding Program (DTFP), the acceptability and utility of a new common package of addiction screening assessment tools and an implementation protocol was assessed. Known as the Best Practice Screening and Assessment Project at the time, the selection and pilot testing of these various screening and assessment tools culminated in a set of recommendations to refresh or replace the current set of ADAT tools.

Following the evaluation by Rush and Martin (2006) and as part of the Best Practice Screening and Assessment Project, addiction sector partners agreed that the ADAT tools required updating, and should include a staged screening and assessment process as well as support for concurrent disorders. The SS&A tools were selected, and the environmental scan and tool selection process is described in the pilot report. The process consists of a first stage substance use screener, the GAIN-SS; two second stage mental health screeners, the MMS (ages 18+) and POSIT (ages 12-17); and, the GAIN-Q3 MI ONT assessment tool. Clients requiring a comprehensive addiction assessment are identified using the stage one screener, and clients requiring a comprehensive mental health assessment are identified using the stage two screener. The GAIN-Q3 MI ONT assessment tool is available through a partnership agreement with Chestnut Health Systems, based out of Bloomington, Illinois.

## **GOALS AND ANTICIPATED IMPACTS**

Staged Screening and Assessment (SS&A) is an evidence-based process that aims to enhance the quality of care for individuals accessing care in Ontario’s publicly funded addiction sector. It facilitates accurate identification of individuals’ needs, treatment plan development,

and recommendations for matching service users to the most appropriate level and type of care. The process is:

1. Comprehensive: SS&A provides a detailed picture of clinical concerns, including mental health and cognitive challenges;
2. Efficient: more resource-intensive screening and assessment tools are reserved for those who require them (based on first stage screening results) saving both service provider and client time;
3. Supportive of treatment and referral planning: greater support for clinical decision-making and planning of a more contextualized and individualized treatment plan; detailed reports generated through the GAIN-Q3 MI ONT are particularly helpful in this regard; and,
4. Supportive of agency and program planning by identifying system-wide patterns of service needs: GAIN-Q3 MI ONT also supports organizations in collecting standardized data regarding clients' patterns and severity of substance use, how clients use services in the addiction sector; and the proportion of clients presenting with co-occurring substance use and mental health problems.

At the beginning of implementation, the primary goals of SS&A were to:

- Implement a screening and assessment process that increases efficiency by holding the more comprehensive substance use assessment (GAIN-Q3 MI ONT) until screening confirms it is required;
- Provide better coverage of both substance use and mental health issues for treatment planning through tool selection with a concurrent disorder focus; and,
- Collect comprehensive substance use assessment information to improve referrals to and appropriate treatment placement/matching for required services.

The anticipated impacts of implementing the SS&A tools and process across the addiction treatment system were:

- Better individualized treatment planning and more appropriate placement of the client in the required level of care, including for concurrent disorders.
- Ability to generate automated reports via electronic platforms (Catalyst and GAIN ABS systems).
- Higher quality data for program planning, accountability and research purposes from state-of-the-art, standardized instruments whose validity and reliability are well established through extensive research. These data will be housed in Ontario.
- Potential to link with outcome monitoring tools, including data embedded in the GAIN-Q3 MI ONT, to calculate cost savings resulting from treatment.

- Compatibility with the GAIN-SS used in many other sectors and which is anticipated for broader provincial, and possibly national, implementation.
- Low cost of annual licensure and training relative to ADAT and infrastructure (e.g., instrument development and ABS system) already in place with DTFP funding.
- Potential for benchmarking, particularly via partnerships with other Canadian jurisdictions and benefiting from a substantial existing database of GAIN end users.

Collectively, an updated screening assessment package with increased coverage of concurrent disorder presentations, as well as automatically generated reports to support treatment planning and service matching, intend to improve client outcomes. As implementation of the SS&A tools and process and infrastructure development continues, organizations will be able to evaluate treatment outcomes through recovery monitoring.

## AUDIENCE GROUPS

### Health Service Providers

The implementation scope for SS&A included all publicly funded health service providers that conduct addiction assessments. This latter point became a frequent source of discussion between the PSSP implementation team and individual organizations, since assessment is not a standalone funding envelope in former MSAA agreements. As the former assessment and referral centres evolved to provide service across the treatment continuum, and since all organizations were expected to be able to uniformly use ADAT to apply the admission and discharge criteria, the assessment-specific funding envelope and functional centre was removed from agency funding agreements. The primary functional centre that now includes the former assessment role is Addictions Treatment-Substance Abuse 72 5 10 78 11, but it not broken down by role and also includes most of the outpatient treatment continuum. Additionally, a few exceptions were made at the request of former MH&A LHIN leads owing to regional practices (e.g., community health centres and Indigenous Friendship Centres). Although this did not align precisely with funding agreements, it still supported the intention of the admission and discharge criteria in that clients should have multiple entry points into the treatment system. Descriptions of mental health and addictions service types are available [here](#) through ConnexOntario.

### Clients

In 2017, a working group of the PSSP team undertook an evaluation activity to better understand the assessment experience from the client perspective. Seventy clients from eight agencies completed the survey, and focus groups with three to six clients each were conducted at four agencies. This project demonstrated that the assessment is fundamentally a positive, beneficial, and relevant experience for clients, but that frustrating elements (e.g., repetitive

questions or resolving inconsistencies) were strongly influenced by the therapeutic milieu and clinical skills of the administrator. This activity also validated the existence of an assessment-treatment planning gap, as only one client had seen the personalized feedback report generated by the assessment and most clients were not aware of how the reports are used.

Attempts were made to engage clients in a similar activity again for this evaluation, but due to institutional impediments, CAMH staff could not directly collect data from clients. To incorporate the perspective of this audience group, CAMH staff requested the assistance from in-scope agencies. Please see Appendix D for a description of this process.

## **Ministry of Health**

The [Ministry of Health](#) is the Government of Ontario ministry responsible for administering the health care system in the Canadian province of Ontario. The Ministry is responsible to the Ontario Legislature through the minister of health. The Ministry sets the strategic direction and priorities for Ontario's health system, and develops and enforces legislation, regulations, standards, policies, and directives. It funds the health system through various channels including hospitals, the Ontario Health Insurance Program, the Ontario Drug Benefit Program, long-term care homes, and community programs.

## **Ontario Health, including the Mental Health and Addictions Centre of Excellence**

[Ontario Health](#) is a Crown agency of the Government of Ontario that was established in June 2019 through the [Connecting Care Act](#), 2019, S.O. 2019, c. 5. The Agency's mandate is to connect and coordinate Ontario's health care system in accordance with the objects identified in the *Connecting Care Act*. Within Ontario Health, the Mental Health and Addictions Centre of Excellence (MHACoE), created through the [Mental Health and Addictions Centre of Excellence Act](#), 2019, S.O. 2019, c. 17, exists to operationalize Ontario's MH&A strategy, develop clinical, quality, and service standards for MH&A; monitor metrics related to the performance of the mental health and addictions system; and, provide resources to support MH&A health service providers.

## **Chestnut Health Systems**

[Chestnut Health Systems](#) (CHS) is a private, not-for-profit charitable organization that offers behavioural health and human services in Illinois and Missouri. The [GAIN Coordinating Center](#) provides services and support to users of the GAIN family of instruments. CHS owns the GAIN-SS screener and GAIN-Q3 MI ONT assessment, and operates the GAIN ABS database where the auto-generated Q3 reports are produced.

## **PSSP Implementation Team**



An implementation team from [PSSP](#) supported this initiative. As an intermediary organization, PSSP provided backbone support to the project that included implementation support (coordination and coaching), evaluation, administrative, and knowledge exchange activities. The implementation team provided broad implementation support, including scheduling and hosting community meetings, establishing project goals, activities, and timelines, working with former LHIN MH&A Leads (now OH MH&A Leads) to determine scope, and building partnerships through communication and engagement. In addition, they provided focused support to the SS&A process, providing agency-level implementation support including action planning.

## EVALUATION METHODOLOGY

### PURPOSE AND EVALUATION QUESTIONS

Since the initial implementation in 2015, the SS&A implementation team at PSSP tracked risks, issues, and positive impacts related to this initiative; however, neither an implementation nor an outcome evaluation has been undertaken sector-wide. After six years of implementation experience, a provincial scope of approximately 170 organizations, and almost 2,500 clinicians trained, PSSP engaged the addiction sector in this comprehensive evaluation activity.

There were two primary objectives of this evaluation: 1) to assess the acceptability and utility of the staged screening and assessment process; and, 2) to explore potential adaptations or complements to the tool package that would encourage widespread adoption across the addiction sector. Five evaluation questions informed the data collection activity.

Evaluation Question	Rationale	Related Objective(s)
1. To what extent are the screeners (GAIN-SS, MMS, POSIT) and assessment tool (GAIN-Q3 MI ONT) being used?	Establishes uptake and usage across the sector and in particular service types	1
2. Are the tools and process being used as intended?	Establishes degrees of acceptability and fidelity to the original process	1
3. What has been the impact of introducing the staged screening and assessment project (to agencies and the broader sector)?	Establishes intended and unintended outcomes resulting from adoption	1,2

4. What has been the experience with respect to training, competency, and ongoing support?	Establishes the role of select implementation drivers in this initiative	1,2
5. Are there any modifications (to the tools or the implementation process) that could be made to maximize uptake and sustainability going forward?	Establishes degree of fidelity to the original project and variations that were adopted to encourage uptake	2

This evaluation is important since the provincial context has shifted since the initial pilot work for SS&A began in 2011. This shifting landscape includes, for example, the creation of the Mental Health and Addictions Centre of Excellence at Ontario Health; Ontario Health’s ongoing development of a Data Digital Initiative, and the prioritization of standardization of core services, measurement-based care, and centralized access models; and, other assessment tools being implemented or considered for use in the mental health and addictions sector.

## METHODS

This evaluation used a mixed-methods approach, gathering data through a survey, interviews and focus groups across different audience groups. This methodology was selected to obtain widespread feedback from partners across the addiction sector, including front-line clinicians and managers at implementing organizations, implementation partners, and policymakers. All data collection tools were collaboratively developed by the two PSSP evaluators assigned to this project. In line with CAMH’s Client and Family Honoraria policy, no honorarium was offered to participants for their involvement.

Data Source	Method
Survey with health service providers	Mixed: primarily quantitative survey with open-text fields for qualitative analysis
Focus groups with health service providers, PSSP SS&A implementation and DATIS teams, and OH Regional MH&A Leads	Qualitative: transcribed focus groups coded for thematic analysis
Key informant interviews with PSSP leadership and Ministry of Health staff	Qualitative: transcribed interviews coded for thematic analysis
Secondary data produced by PSSP related to training and certification	Quantitative: primarily frequency counts and distributions
Secondary data produced by PSSP related to implementation drivers: Risks, Issues, and Positive Impact Logs (RIPILs)	Mixed: frequency count of implementation drivers over time with qualitative interpretation

Secondary data produced by PSSP: Pilot implementation reports with the Ministry of the Solicitor General and select primary care settings as part of an opioid de-implementation initiative	Mixed: frequency count of training and assessment usage data with qualitative interpretation of focus groups and interviews
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**SURVEY**

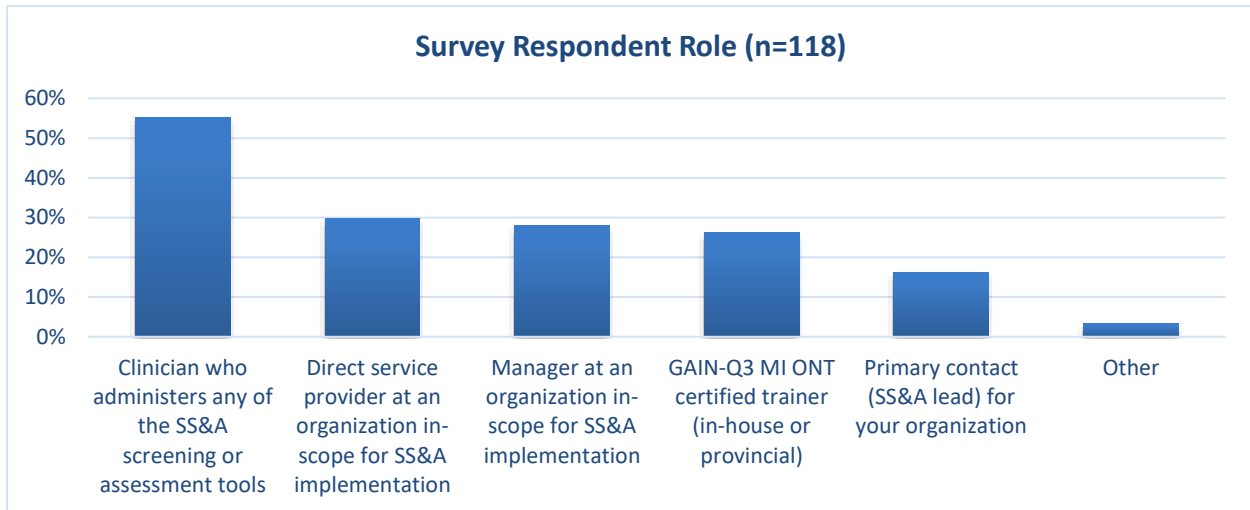
The survey was developed to obtain feedback from staff at in-scope service providing agencies. Eligible participants were identified as all staff with responsibility for the SS&A process, and included direct service providers, managers, and clinicians. The survey was designed and distributed online using the SurveyMonkey platform. It was 16 questions long, required an average of 18 minutes to complete, and included close-ended Likert-style questions as well as open-ended questions. The survey is included in Appendix C.

The data collection period was 12 weeks, with the survey launching on January 11, 2022, and remaining open until April 8, 2022. To recruit participants, PSSP Implementation Specialists emailed an electronic survey link to all SS&A Leads for organizations in their assigned regions, inviting them to participate in the survey and to share the survey information with any of their internal colleagues who are also responsible for implementing SS&A. This totaled 223 contacts. Implementation Specialists also sent two reminder emails to their SS&A contacts during the data collection period to encourage participation. To further increase awareness of this evaluation work and survey responses, a link to the survey was also shared in the January 2022 AMHO newsletter, the February 2022 SS&A newsletter distributed by PSSP, and the April 2022 newsletter distributed by the Evidence Exchange Network (EENet).

Through this recruitment method, multiple responses per agency were permitted in order to receive feedback from as many people as possible; however, only one survey per participant was accepted. A letter of information was included on the introduction page of the survey and informed consent was further implied through survey completion.

A total of 118 survey responses were received from 58 unique identifiable agencies. Six respondents did not identify their organization, and two people preferred not to answer this question. A response rate is indeterminable since agencies were permitted to forward the survey link internally to anyone with SS&A involvement. The number of organizations in scope for SS&A implementation varies by OH region, but geographic diversity occurred as follows survey respondents: 15 agencies were located in OH East, 12 in OH West, 19 in OH North, five in OH Toronto, and five in OH Central. Two agencies’ locations could not be determined based on the information provided.

Over half of all responses were from clinicians who administer the SS&A tools (n=65), followed by direct service providers (n=33) and managers at in-scope organizations (n=31). It is important to note that these roles can overlap because respondents can have multiple roles associated with SS&A implementation and administration. As a result, these 118 individuals endorsed 187 discrete roles.



## FOCUS GROUPS

Focus groups were held with three different audience groups: agency staff, policymakers/partners, and internal PSSP SS&A staff. A separate focus group guide was developed for each target audience, which are included in Appendix C. All focus groups were facilitated remotely by PSSP evaluators, recorded in [Webex](#), and then transcribed using [Sonix](#). Transcribed data was reviewed for accuracy and cleaned by the evaluators, ensuring it was consistently formatted and usable for analysis.

A letter of information and consent form was emailed in advance of the session to participants, and the focus group moderator requested verbal consent from all group participants at the outset of the focus group. Consent was further implied through participation in the focus group.

### Agency Staff Focus Groups

PSSP Implementation Specialists emailed all SS&A Leads for their respective regions, informing them of this evaluation and of the opportunity to participate in a focus group. One participant per agency, specifically the SS&A Lead, was eligible to participate and they were invited to register for a focus group session by signing up through an online form. Registered participants were emailed a remote meeting invite and consent form three to five days prior to the session by an evaluator. Six focus groups were conducted, ranging from two to five

participants. In total, 21 SS&A Leads participated in focus groups from 20 agencies. Four agencies that participated in the focus groups did not complete the survey. Focus group participants were dispersed across the province with six in OH East, six in OH Toronto, five in OH West, three in OH North, and one in OH Central.

### **PSSP Internal Staff Focus Groups**

Focus groups were held with internal PSSP staff who are involved SS&A implementation, to gather their perspective and feedback on SS&A process/tools. This included SS&A Implementation Specialists, staff from the Drug and Alcohol Treatment Information System (DATIS), and staff from [Shkaabe Makwa](#). DATIS staff were included in this evaluation to describe the implementation experience from the technology side, and Shkaabe Makwa has been supporting a separate implementation initiative with Indigenous service providers. The focus group with the PSSP SS&A Implementation Team was held during a regularly scheduled team meeting in March, with 11 staff participants. A focus group with 12 DATIS staff was held on March 30, 2022, and a focus group with four Shkaabe Makwa staff was held on April 20, 2022.

### **Ontario Health Regional Leads Meeting**

Both evaluators attended a regularly scheduled meeting with the Ontario Health Regional Mental Health and Addictions Leads on April 20, 2022. Questions were also provided following the meeting so that Leads could provide responses in writing if they wished, which they did.

## **KEY INFORMANT INTERVIEWS**

Key audience groups, including policymakers, partner agencies, and PSSP Leadership were invited to take part in key informant interviews. Key informant interview (KII) participants were identified as partners who currently worked on the SS&A portfolio and have experience with agency- or sector-implementation of the initiative. Key informant interviews included staff from the Ministry of Health and PSSP Leadership. The evaluators reached out individually to the identified contacts to schedule personal interviews. In total, three KIIs were conducted. A parallel, sector-wide evaluation of the Ontario Perception of Care (OPOC) Tool for Mental Health and Addictions was simultaneously being conducted by PSSP. For these purposes, it was relevant that the KII guide discussed both the OPOC tool and SS&A. The KII guide is included in Appendix C.

## **ANALYSIS**

Survey responses were analyzed quantitatively and qualitatively depending on the question type and level of measurement. To ensure anonymity, no identifying information was collected, although participants were asked to provide their role and organization for tracking purposes. Frequency distributions and charts were constructed using Microsoft Excel to

summarize close-ended responses, and open-text survey responses were coded alongside the focus group data.

Rigorous qualitative methods were used to centre the voices and perspectives of participants in an applied context. Qualitative data resulting from the open-text survey responses, focus groups and KII were interpreted using thematic analysis (Braun & Clarke, 2006), a structured approach to identify key themes across the dataset.

Two evaluators first reviewed the open-ended survey data to increase familiarity with the data. Together and by consensus, the evaluators assigned initial codes to the data. Codes were developed inductively, meaning that the codes were driven by the data without preconceived themes<sup>10</sup> and labelled using brief descriptions of the excerpt content. Once initial coding was complete, the evaluators reviewed the codes and data excerpts for consistency and coherence, and re-coded excerpts as needed. Patterns and similarities across the codes were iteratively and hierarchically amalgamated into broad themes and summary statements. Analyses of open-ended survey data were conducted using Microsoft Excel.

Recordings of the focus groups and KII were transcribed using Sonix. All transcriptions were reviewed by one evaluator to ensure accuracy of the transcript and to increase familiarity with the data, and then coding of the focus group and KII data was completed by this same evaluator. Given the overlap and consistency in content between the data sources, the list of codes generated through the survey analysis were applied to the focus group and KII data, with new codes developed inductively by the same method above when merited by the data. Codes were similarly reviewed and categorized into themes by both evaluators, again by consensus. With this analysis method, the open-text survey data are combined with the focus group and KII data, with the survey informing the analysis of the focus groups and KII. This resulted in themes which are evident across all qualitative data sources. The analyses of transcripts were completed using NVivo12.

Three key themes were developed to represent the implementation of SS&A in the sector:

- a) Disconnect between SS&A implementation practice and policy
- b) The GAIN-Q3 MI ONT assessment tool as a perceived barrier; and,
- c) Implementation supports and barriers.

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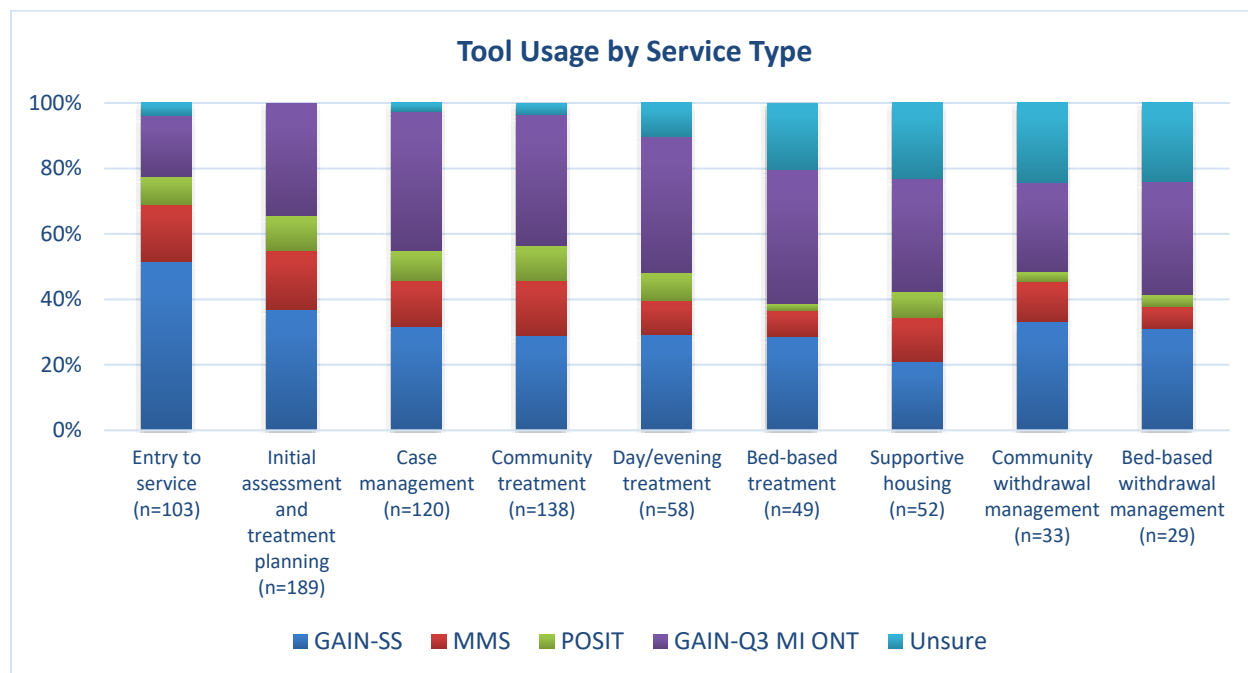
<sup>10</sup> Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, (3)2, 77-101.

Each of these themes is further elaborated on in the following results section. Each theme is reported under the evaluation question which its data aided in answering. Verbatim quotes are provided to exemplify the themes.

## FINDINGS

### EVALUATION QUESTION 1: TO WHAT EXTENT ARE THE SCREENERS AND ASSESSMENT TOOL BEING USED?

#### RESULTS



Survey participants were asked to identify which tools, if any, were used across service types delivered by their organizations. In order to standardize service types across different numbers of respondents, the above graph underrepresents the actual percentages but retains the original proportions. Actual percentages are reported in this description. Respondents indicated that the GAIN-SS was the most commonly used tool in entry to service and initial assessment and treatment planning programs, but overall, the GAIN-Q3 MI ONT was the most commonly used tool considering all service types. The stage 2 mental health screeners, MMS and POSIT, were each used less than half as often as the GAIN-SS and GAIN-Q3 MI ONT.

Survey participants were also asked to estimate what percentage of clients across their organization receive at least one of the tools, and the GAIN-Q3 MI ONT specifically. Thinking about all SS&A tool usage across their organization, respondents estimated that, on average, 72% of all clients receive at least one of the tools (n=91). Responses ranged from 0% to 100%

and were negatively skewed with a median value of 88% and a modal response of 100% (n=19). When participants were asked to estimate what percentage of clients across their organization receive the GAIN-Q3 MI ONT specifically, respondents estimated that, on average, 52% of all clients received the assessment tool (n=88). Responses ranged from 0% to 100% but were positively skewed with a median value of 51% and a modal response of 20% (n=8).

	Mean	Median	Mode
Any SS&A Tool	72%	88%	100%
GAIN-Q3 MI ONT	52%	51%	20%

## DISCUSSION

### Tool Usage by Service Type

The pattern observed in the tool usage by service type data is what would be expected in a staged screening and assessment protocol, where screener usage is more prevalent at initial entry to service and assessments become more common once the client has been triaged. **Unfortunately, as a whole, the total volume of screeners and assessments completed relative to established tool cut-off scores strongly suggests a lack of adherence to the staged protocol. Moreover, the variation in tools used across service types suggests a lack of clarity around when different components of the staged protocol should be administered.** Clients should be screened and assessed prior to beginning treatment, and yet many treatment destinations show similar rates of screening and assessment (noting that the percentage of respondents who answered unsure increased with these service types). This is further described as a sub-theme, perceived purpose of assessment, in evaluation question #3.

**Compared to admissions data, 70% of respondents overestimated how many assessments are actually completed.** In fact, a quarter of respondents estimated that 80% or more of all clients receive an assessment. As this was a self-reported estimate, it could have been influenced by each respondent's definition of an eligible client, which could also be influenced by agency practices. Another possible explanation for this discrepancy is that survey respondents represented the majority of organizations implementing the screeners across Ontario since it was not a representative sample. For example, in 2019-20, the peak administration year for the GAIN-Q3 MI ONT assessment, 13,283 assessments were created. That same year, 13,720 GAIN-SS were completed along with 85 POSIT and 5,223 MMS screeners. Using 2018-19 data as an example, if respondents estimate that 72.2% of clients receive at least one screener, there would need to be 26,355 cumulative screeners administered. This has important implications for fidelity to the SS&A process, as respondents may overestimate *how reliably* clients receive any of the tools.



## Tool Usage Provincially and Target Assessment Rate

Since 2017, the PSSP implementation team has had access to implementation status reports that were developed by DATIS. These reports allowed the team to determine how many screeners and assessments were administered during a specified reporting period, along with the number of new admissions registered. In November 2021, the GAIN-Q3 MI ONT [Assessment Report](#) was deployed to all in-scope organizations, along with a new Agency Summary Report that aggregates information from all assessments completed at a particular organization. In April 2022, [three new reports](#) were deployed allowing organizations to see their own screener usage data. Over time, several patterns emerged from this implementation usage data. Between April 1, 2015, when the earliest organizations adopted the SS&A tools during the initial rollout, and March 31, 2022, 53,203 GAIN-Q3 MI ONT assessments had been created.<sup>11</sup>

The percentage of assessments completed relative to new admissions is a more complicated topic, with rates that varied substantially across implementing organizations. Because the report captured all new client admissions regardless of program type, *it was not feasible to establish a target rate for percentage of completed assessments on this basis alone*. Initially, the PSSP team used a target of 50% during implementation discussions, but this was based on a definition of full implementation from the field of implementation science,<sup>12</sup> which did not take into account the structure of the available data and reports. As a result, implementation staff were required to have individual conversations with organizations to establish target assessment rates, which were not standardized. It should also be noted that, separate from created assessments, the data integrity of new admissions requires organizations to reliably enter, and, in the case of Interface platforms, transfer, admissions data to DATIS.

Since all former LHIN regions were onboarded in 2017-18, a consistent assessment rate of 18-22% relative to new admissions has been observed. The percentage of new clients admitted to bed-based services ranged from 13.3% to 15.6% in a study that examined Ontario's caseload distribution between the 2005-06 and 2009-10 fiscal years.<sup>13</sup> Therefore, assuming the GAIN-Q3 MI ONT assessment is being completed for the majority of clients being referred to bed-based services, this means that, conservatively, only 5% to 7% of clients are receiving the

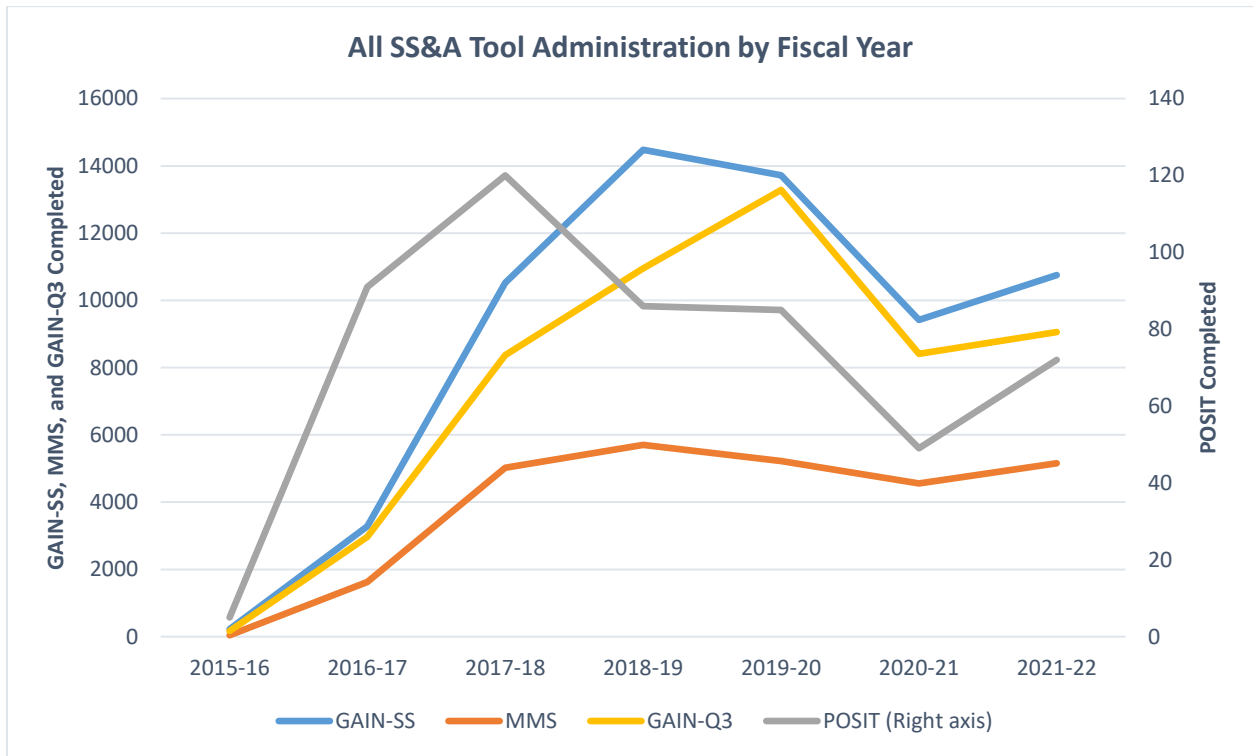
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<sup>11</sup> This includes assessments both started and completed.

<sup>12</sup> Full Implementation is reached when 50% or more of the intended practitioners, staff, or team members are using an effective innovation with fidelity and good outcomes. Source: <https://nirn.fpg.unc.edu/module-4/topic-6-full-implementation>

<sup>13</sup> Rotondi, N.K, & Rush, B. (2012). Monitoring utilization of a large scale addiction treatment system: The Drug and Alcohol Treatment Information System (DATIS). *Substance Abuse: Research and Treatment*, 6, 73-84. doi:10.4137/SART.S9617

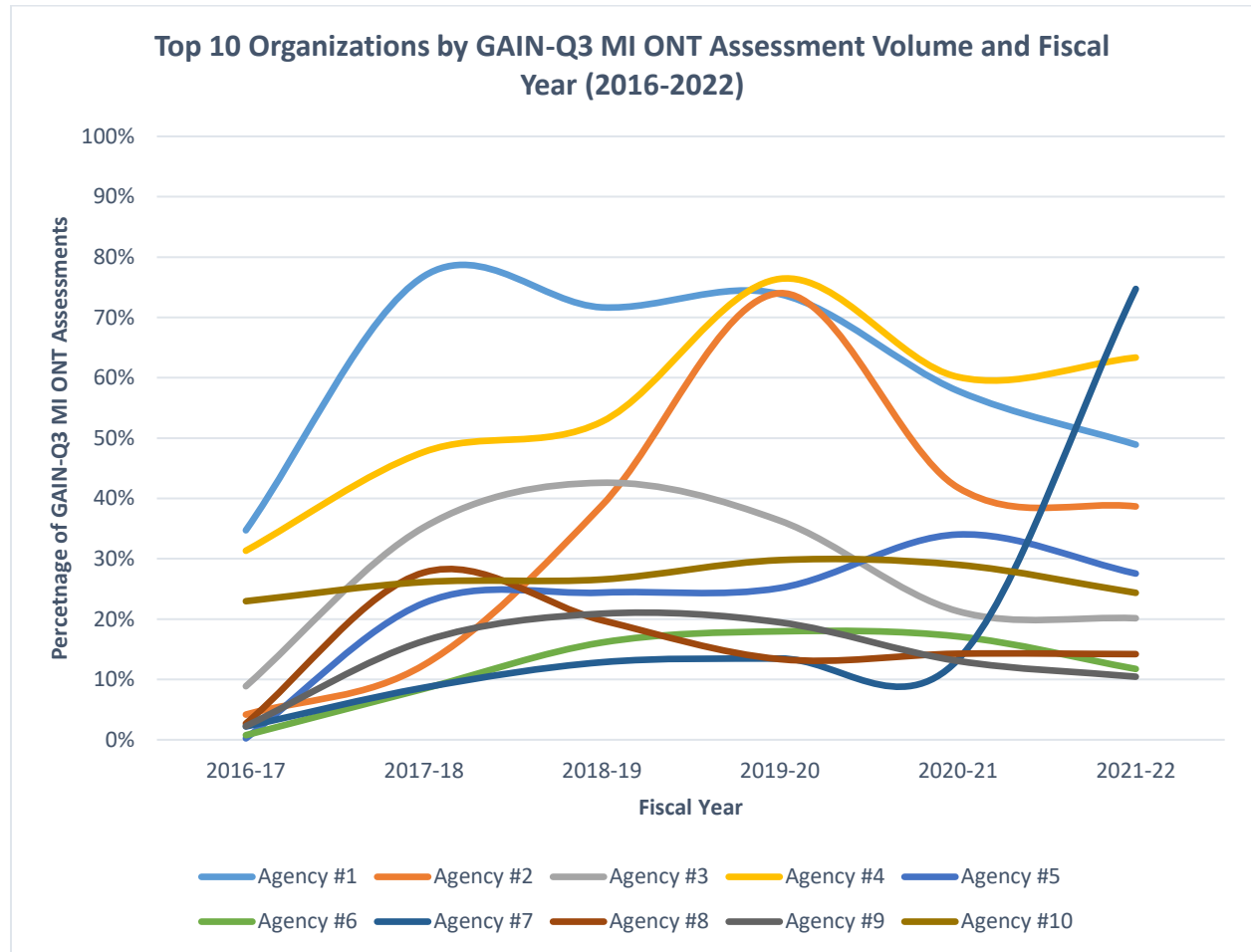
assessment for outpatient treatment planning or referral purposes. This represents a significant gap in fidelity to the intended administration process, and is consistent with observations from the 2006 ADTC evaluation; namely, **the tools are completed administratively to facilitate service access once a treatment destination has been determined, and not to guide the treatment decision itself.** Nevertheless, there is a correlation between administration of the GAIN-SS, MMS, POSIT, and GAIN-Q3 Assessment tools as shown below.



*Please note that POSIT administration is reflected on the right-hand secondary axis due to significantly smaller volume compared to the other three tools. Although the usage pattern over time is similar, it is by orders of magnitude lower.*

To further illustrate the complexity of establishing a target assessment rate across the province, the assessment rate for the top 10 implementing organizations by assessment volume was plotted on the following line chart. Although this is an arbitrary cut-off, these 10 organizations are collectively responsible for 46% of all assessments completed during the past six fiscal years. The assessment rate increased for all organizations beginning in 2016-17 when most were onboarded to the project; a few were onboarded in 2015-16 as part of early adopter LHINs. The average assessment rate during this time ranged from 12% (agency #6) to 61% (agency #1). Once these organizations were all implementing (since 2017-18), variation was noted within and between fiscal years, from a low of 8% to a high of 77%. Collectively, these

organizations peaked in 2019-20 with an average assessment rate of 38%, which coincided with peak administration across the province of 13,283 assessments.



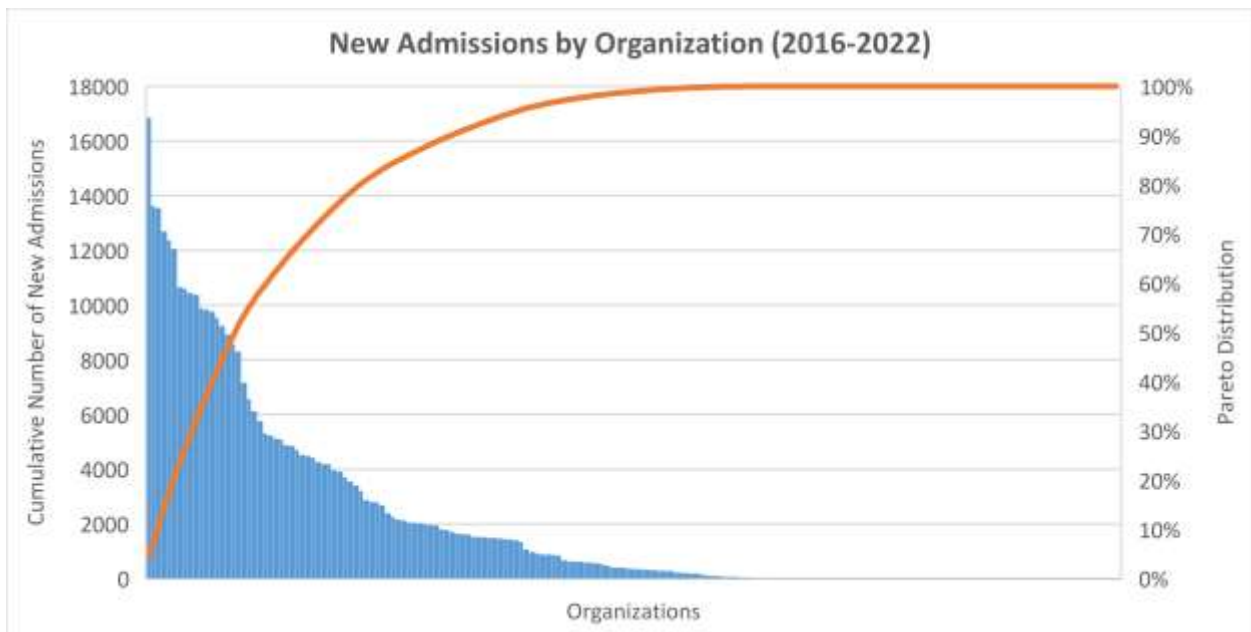
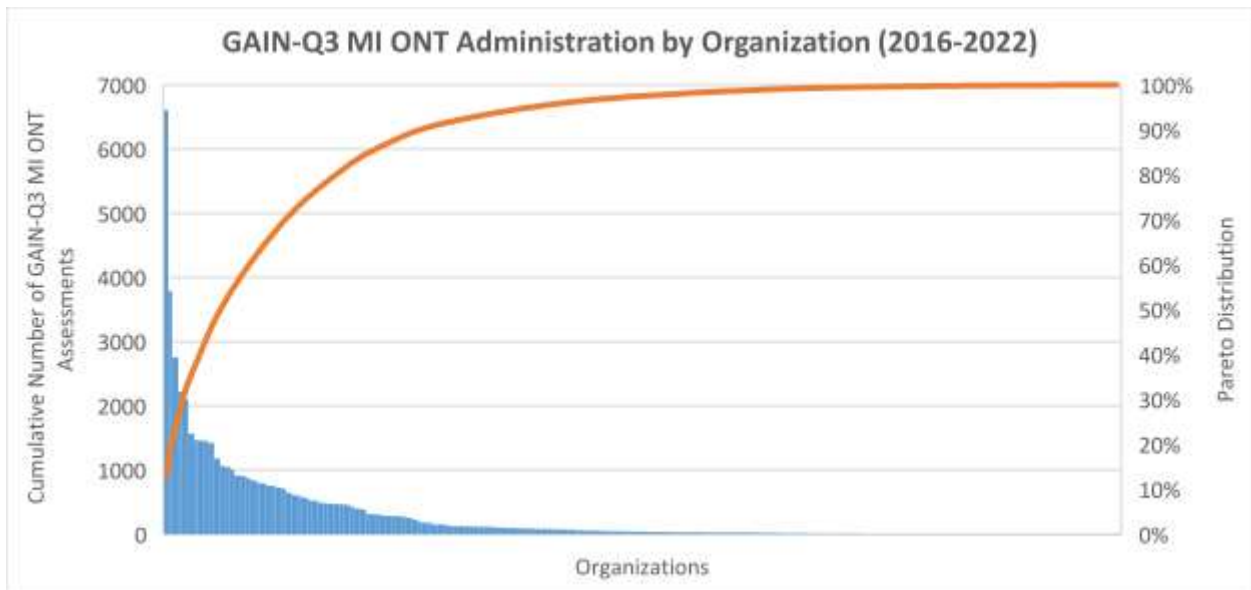
	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
<b>Agency #1</b>	34.7%	76.8%	71.7%	73.9%	57.8%	48.9%
<b>Agency #2</b>	4.2%	12.4%	38.8%	74.0%	41.8%	38.7%
<b>Agency #3</b>	8.9%	35.2%	42.6%	36.3%	21.3%	20.1%
<b>Agency #4</b>	31.3%	47.7%	52.7%	76.4%	60.1%	63.3%
<b>Agency #5</b>	0.2%	22.7%	24.4%	25.2%	34.0%	27.6%
<b>Agency #6</b>	0.8%	8.5%	16.1%	18.0%	17.1%	11.7%
<b>Agency #7</b>	2.2%	8.6%	12.8%	13.5%	13.3%	74.7%
<b>Agency #8</b>	2.7%	27.7%	19.8%	13.4%	14.3%	14.2%
<b>Agency #9</b>	2.3%	16.4%	20.9%	19.5%	13.1%	10.5%
<b>Agency #10</b>	23.0%	26.1%	26.6%	29.8%	29.0%	24.4%

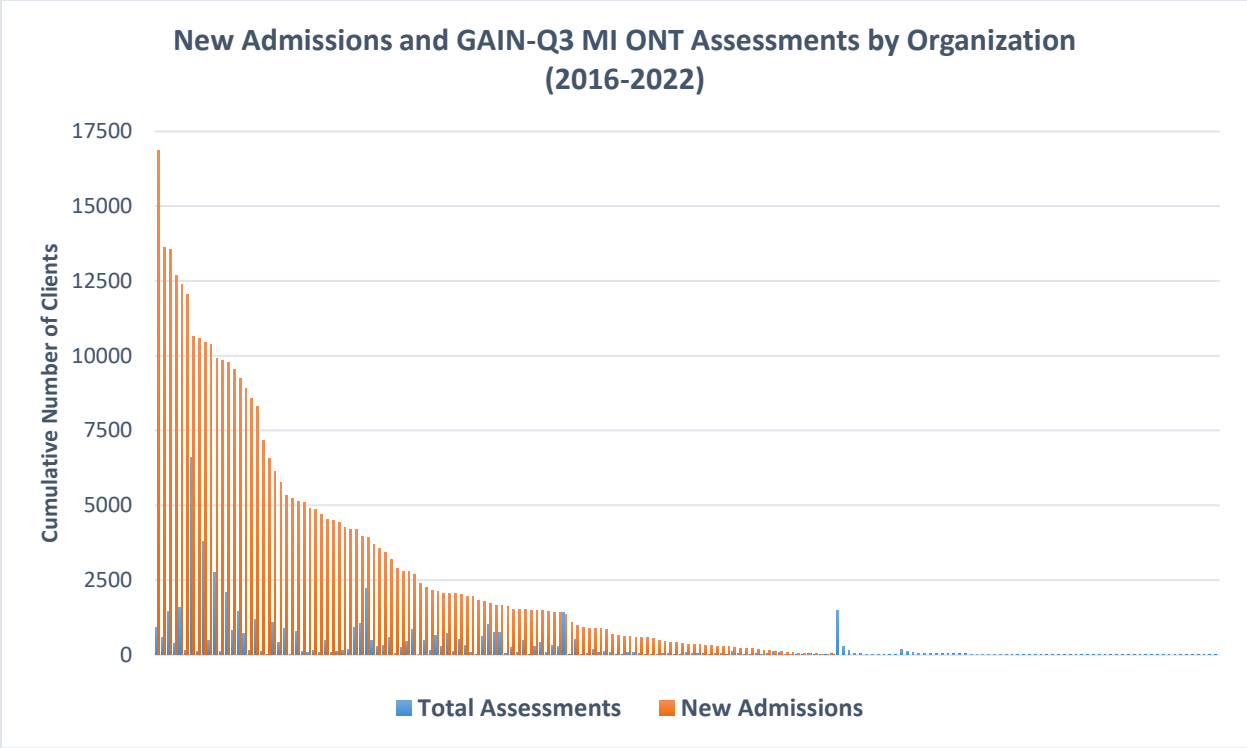
Table 1: Assessment Rate by Fiscal Year

### Implementation Usage Data by Organization

Using six years of data from April 1, 2016 to March 31, 2022, implementation usage for each organization that has completed at least one GAIN-Q3 MI ONT assessment was plotted.

This resulted in a chart with 183 organizations. A Pareto distribution emerged, with 34 organizations accounting for approximately 80% of all completed assessments. This has remained fairly consistent over time, with 32 organizations accounting for approximately 80% of all completed assessments during the last (2021-22) fiscal year. Moreover, this is remarkably similar to the distribution observed regarding new admissions, where 42 organizations account for approximately 80% of all new admissions registered in Catalyst. Plotting these values together shows the disparity between the number of clients registered as new admissions and the number of assessments completed, as well as the interagency variation subsequently addressed.





*Please note, several organizations are depicted on this chart where the number of assessments exceeds the number of new admissions. Because assessments are completed in the GAIN ABS system, organizations do not have to register clients in a program through Catalyst in order to access the GAIN-Q3 MI ONT assessment.*

Where the size of the blue line exceeds the size of the orange line, these clients may not have been registered in a program, although the mandatory data elements would have been entered. Alternatively, they could be registered in another program so their new admission is captured in another reporting line than their completed assessment. Conversely, some programs may show a large discrepancy in the other direction, with more new admissions than assessments, since they are only completing assessments for referral to bed-based services. For example, 47 organizations completed 10 or fewer assessments over the past six years.

**Implementation Usage Data by Clinician**

In fiscal year 2020-21, a review of all clinician implementation data was conducted to ascertain how frequently individual Site Interviewers were administering the GAIN-Q3 MI ONT assessment. This analysis was repeated using fiscal year 2021-22 data, which includes Site Interviewers disconnected from GAIN ABS as part of a new billing model implemented by CHS. Data for both years are similar, in that the top 250 and 256 Site Interviewers for 2020-21 and 2021-22 respectively administered 80% of all GAIN-Q3 MI ONT assessments. For 2021-22, 9,054 assessments were administered by 762 Site Interviewers. This equated to 11.9 assessments per

Site Interviewer. However, there was still an inherent positive skew in the distribution as the median value was four, meaning half of all Site Interviewers administered four or fewer assessments this fiscal year, and 167 Site Interviewers each completed only a single assessment all year.

In other words, **not only are the vast majority of assessments completed by a relatively small number of clinicians, these clinicians work for an equally small number of organizations relative to the entire scope of SS&A implementation. Framed another way, they are not randomly distributed among the addictions sector, but work for organizations or programs that either specialize in conducting assessments, or have prioritized staff or processes within the organization to ensure that they are completed as intended.**

**Implementation Variation by Region**

In September 2021, PSSP’s internal implementation status report provided by DATIS was updated to reflect the new Ontario Health Regions. (Since its inception in 2017, it was previously organized according to LHIN region.) Using population data, an analysis was conducted to determine the relative likelihood that a client admitted to any program would receive an assessment.

Ontario Health Region	Population	Assessments per 100,000	New Admissions per 100,000	New Admissions per Assessment
Central	4.5 million	39.5	292.2	7.4
East	3.3 million	110.0	473.6	4.3
North	796,300	242.6	1,740.6	7.2
Toronto	1.2 million	80.8	784.3	9.7
West	3.8 million	125.9	606.4	4.8

This analysis demonstrated that the OH Central Region had the lowest total assessment rate and the lowest new admission rate across the province. Relative to the provincial average, the assessment rate is 61% lower and the new admission rate is 47% lower. Any interpretation of this would be speculative at best. On the one hand, there could be such a lack of services that it cannot support the large population. On the other, there could be something unique about this region in terms of population demographics that are protective against substance use. In OH East Region, the rate of new admissions per 100,000 people is below the provincial average, but the rate of assessments completed is above average. As the right-hand column shows, one assessment is completed for every 4.3 new admissions, which is the highest in the province. This is likely attributed to its centralized access point, which is consistently one of the top five assessment organizations by volume.

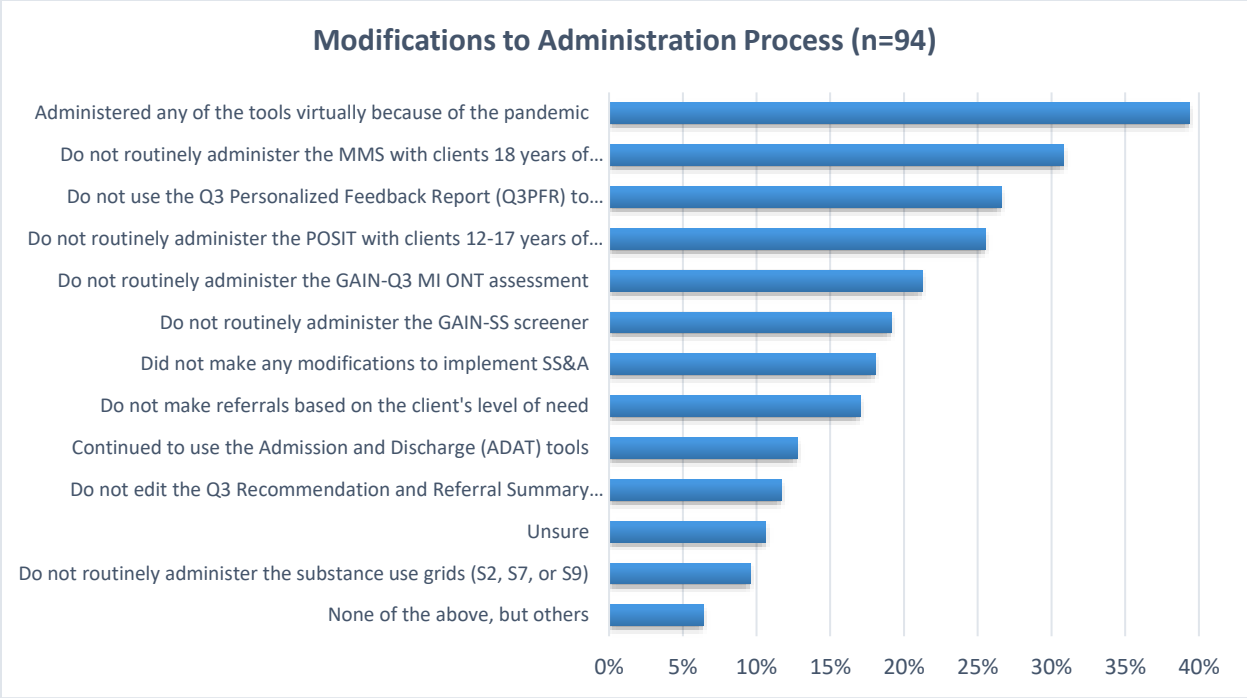
Data from the OH North Region is noticeable for a few reasons. First, the rate of assessments is 2.5 times higher than the provincial average, and the rate of new admissions is 3.2 times higher. The rate of new admissions is concerning because it could be indicative of an above-average level of substance use at the population level. However, it could also reflect greater access to service. In terms of receiving a GAIN-Q3 MI ONT assessment, this is the place in Ontario where you are most likely to receive one *on the basis of population alone*. One explanation is that, in addition to the Ministry of Health mandate letter from October 2015, the former North East LHIN established a regional go-live date for SS&A implementation in March 2019. However, these rates could also be related to the large number of bed-based treatment providers, and since they often require an assessment for admission, this could be inflating how many assessments would be completed in a treatment continuum with more of an outpatient mix or focus.

In the OH Toronto Region, the rate of assessment by population is twice as high as OH Central, but still the second lowest in the province. Notably, service providers in this region also started implementing later and a number of organizations still had not been onboarded at the beginning of the pandemic. In OH Toronto, 9.71 people need to be admitted for every created assessment, which is the highest in the province. The new admission rate is second highest, after only OH North, which could mean an above-average level of need, but those new admissions do not translate into a created assessment. Essentially then, in the OH Toronto Region, a client has the least likelihood of receiving an assessment compared to any other region in the province. This discrepancy could be explained in part by a greater number of outpatient providers, which do not require a completed assessment for admission (in contrast to bed-based services), or a higher level of client acuity that makes the assessment itself prohibitive. Lastly, of all the OH Regions, OH West most consistently resembles the provincial averages. The new admission rate is third from the top and the total assessment rate and new admissions per assessment are both second.

## **EVALUATION QUESTION 2: ARE THE TOOLS AND PROCESS BEING USED AS INTENDED?**

### **RESULTS**

Fidelity to any intervention is necessary to ensure that it is applied as intended, with adherence to its underlying evidence base. Survey participants were asked what modifications, if any, they made to the implementation process. The most frequently identified modification by survey participants was administering any of the tools virtually because of the pandemic (n=37, 39%). The next most common modifications were not using specific tools or reports, such as the MMS (n=29, 30%), Q3PFR (n=25, 27%), POSIT (n=24, 26%), the GAIN-Q3 MI ONT (n=20, 21%), and the GAIN-SS (n=18, 19%).



**Disconnect between SS&A Implementation Practice and Policy**

The theme "Disconnect between SS&A implementation practice and policy" emerged from qualitative data in this evaluation and encompasses various aspects of SS&A implementation, including variability in agency level implementation, purpose of the assessment, and system-level mandates. Together, data related to these topics speak to the second evaluation question in revealing a lack of consistency and adherence to intended practical procedures as a pattern in SS&A's implementation.

*Agency Variability*

Focus group participants described at length variations in their own program, organization, and community's implementation processes. This alongside the endorsed modifications reported by survey participants demonstrates the variability in SS&A implementation across the sector.

Focus group participants reported using different methods for delivery of the SS&A process, relaying their agencies' experiences using self-assessment and group administration models. During the focus groups, participants spoke about how switching to virtual administration during the pandemic influenced completion rates of the assessment process. For several agencies, group self-administration, where several clients complete the assessment with the assistance of one clinician/facilitator, had to be paused; in another case, an organization that previously substituted clients if they did not show for their assessment



appointment could not continue that practice. Lastly, providers in more rural locations spoke about challenges administering the assessment over the phone (“So we had to shift to a kind of a more virtual, so phone. So that poses its own challenges in the great northwest of Ontario. The phone systems in our area are not always that reliable or Internet systems are not always that reliable” (FG9)).

Another noted difference in practice, was how agencies assigned the responsibility of completing assessments to different staff roles. Some agencies identified specific staff whose primary role is to complete the screeners/assessments with clients (“GAIN Team” (FG18)), while others described that all providers in the agency are responsible for this.

Variations highlighted by participants further reflected different utilization patterns for the multiple component tools of SS&A, with more frequent use of the GAIN-SS reported and differential use of the MMS and POSIT. This also is consistent with participant descriptions of the screeners generally being more positive; participants reflected on their brevity and utility in providing “very quick snapshot” (FG7) which, in this context is “quite helpful and really sort of zeroing in on some specific information” (FG7) and “...captures some information. It's helpful with, with that kind of initial assessment screening” (FG11). In contrast, the POSIT, the Stage 2 screener used for youth, was described by participants as long and challenging to administer, and therefore completed less often. This selective usage of the tools, also reflected in the survey responses, is not consistent with the SS&A protocol.

Finally, several participants spoke to the role of their agency’s internal policies and processes, which some agencies had established. While some of these participants identified these processes as supportive to overall use, others expressed that that such policies may not followed consistently: “I can speak to what we're doing in policy and then what it actually looks like in practice. In policy, the way that we've rolled it out is upon initial intake into the program... However, in practice, neither of those are happening...” (FG20).

**Overall, data reflect significant variation in SS&A implementation processes across the province.** While they are acceptable variations based on the practice profile (included in the additional resources), they offer insights into the differential uptake of SS&A across the agencies and across the province as a whole.

#### *Purpose of Assessment*

The intended purpose of SS&A is to facilitate accurate identification of individuals’ needs, treatment plan development, and matching service users to the most appropriate level and type of care. This differs from its actual use as described by survey, focus group and KII participants, with many articulating that the GAIN-Q3 MI ONT is used primarily as necessitated for referral, or upon request by clients.

Very frequently, service providers in both the survey and focus group reported that their purpose for completing the GAIN-Q3 was for referral only and most often to bed-based services:

“So basically if you ask me, what are we doing within the agency, we've implemented it or how it's been administered, I would say pretty much we are doing the GAIN-Q3 for referral to residential treatment and that would be the purpose of us completing that.” (FG14)

Another participant echoed: “So I would say 90% of the GAIN referrals into our centralized system are referrals to [bed-based] treatment” (FG19).

Similarly, providers also often reported completing the assessment only because it is required by mandate, not to aid in clinical practice: “... but I think the only, most of the uptake you get right now is because it's mandatory” (FG16); “ [we] mostly complete the GAIN Q3 because it is a mandatory part of the referral process to residential treatment”(S47).

Furthermore, service provider participants indicated client choice often determined whether or not an assessment would be completed. For example, one participant remarked, “if a client is wanting to go to day treatment or residential treatment, then we administer the GAIN” (FG11). Another participant stated, “We only do the Q3 when individuals identify wanting to attend residential treatment” (S70). In these cases, not only is the client determining the treatment destination, but in doing so is deciding whether the assessment needs to be administered since it is a condition of entry. Providers commented that quite often clients specifically request the GAIN-Q3 by name. Reasons for this request varied, but often included requirements by the justice system, EAP programs, Child and Family Services, or because they believed it was a “ticket” (S50) into bed-based services. When used for the purposes described by these identified situations, the treatment planning and matching aspects of the SS&A are not being fulsomely utilized in clinical practice. Tellingly, one focus group participant articulated the following about the GAIN-Q3: “I think that part of it is, is sometimes people forget that there's that treatment component, they just see assessment and referral...” (FG8).

Intertwined with this misuse is the broader concept of the perception of assessment in general across the sector, with data illustrating that there are differing definitions of assessment across service providers. For example, some service providers expressed that their own tools, conversation with clients, and question prompts are effective at providing needed assessment information whereas others saw value in the standardized practice:

- “I have my own tools/screeners that are way more useful and relevant to my clinical work”(S47);

- "... the Q3 is a tool that is only useful if the client is not [an] active user, and it is almost always known information about the person. It should be as simple as a couple questions. 1 do you feel you have an addiction? 2 what do you use? 3 how often? 4 how does this impact your life? simple." [Sic] (S40);
- "...basically the assumption is... I don't want to administer this unless I have to. And I'm always like, we need to switch that to the assumption is 'I do an assessment with somebody, unless there's a good reason not to' which I think in terms of assessment, whether it's the GAIN or not, I mean, I think that's what staff should be thinking and they don't. So that's been a challenge" (FG21).

One focus group participant made commented: "... So I think part of the challenge is that the addiction system isn't consistent with understanding what needs to be done before deciding on treatment" (FG11). As SS&A is aiming to standardize the practice of assessment across the provincial sector, these varying perspectives on what constitutes adequate assessment may pose a challenge to obtaining buy-in for the tool from providers.

### *System Mandates*

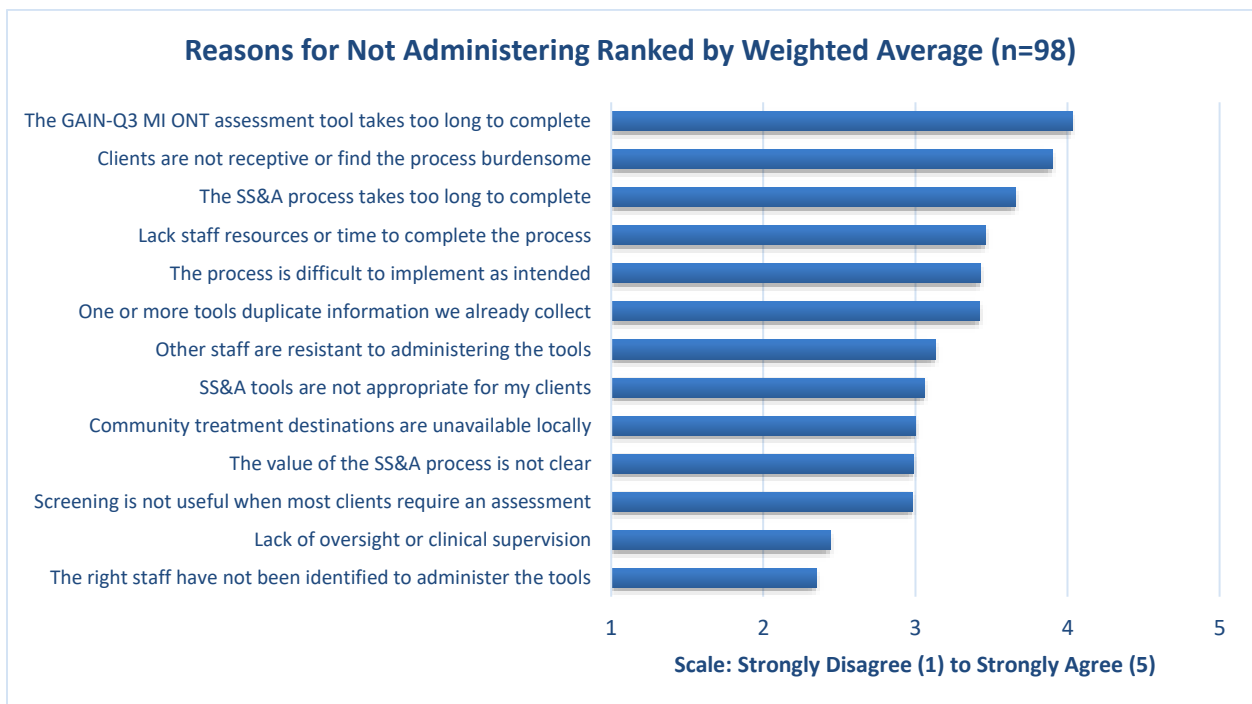
Also within the theme of *disconnect between policy and practice*, are data regarding the Ministry of Health mandate letter from October 2015. This letter identified SS&A as "a new package of staged screening and assessment tools for funded addictions services, in both hospital and community settings. These tools will replace the existing assessment tools that have been mandated in the addiction treatment system since the early 2000's." This letter is included as an additional resource at the end of this report. The demonstrated uptake across the sector depicts a misalignment with the intended practice, as defined by the mandate.

**Both KII and focus group participants did suggest that further clarity regarding this mandate may be beneficial to uptake.** This may include redefining the client groups or service types which will continue to require to receive the GAIN assessment, and to support buy-in across the sector:

- And I think around that, I think to some degree the language around the mandate, not commenting on whether the mandate stays or not, But I think the language around who is mandated specifically, maybe adding a little more detail to that mandate I think would be helpful" (KII1)
- "Probably the top of the list would be reinforcing the mandate or enforcing, depending on how you look at it" (KII2).

### **Assessment Tool as a Perceived Barrier**

Survey respondents were presented with a list of closed-ended items generated by the evaluators based on observations shared with the SS&A implementation team during the course of this initiative. They were also able to add their own responses. The most frequently identified reason survey participants gave for not administering the tools was the GAIN-Q3 MI ONT assessment tool taking too long to complete ( $\bar{X} = 4.0$ , 62% total agreement). This was followed by clients not being receptive or finding the process burdensome ( $\bar{X} = 3.9$ , 69% total agreement), and the SS&A process takes too long to complete ( $\bar{X} = 3.7$ , total agreement = 62%). Focus group participants also expressed concerns about the length of the assessment and the time required to administer it. These reasons aligned with concerns that emerged from both the survey and focus group analysis around resources, including time and staff.



Survey respondents were asked to identify if any other tools were used in addition to SS&A. Twenty-three respondents submitted open text answers, although nine stated “none,” “N/A,” or “no.” The tools identified by the remaining 12 respondents were as follows:

Tools	Frequency
Ontario Common Assessment of Need (OCAN)	4
Other (unnamed cognitive screener, unnamed proprietary tools, or tools developed in-house)	4
Admission and Discharge Assessment Tools (ADAT)	2
Columbia Suicide Screener (CSS)	1

RAI Chi [sic]	1
Problem Gambling Severity Index (PGSI)	1
Hypersexual Behavioural Inventory (HBI-19)	1
Alcohol Use Disorders Identification Test (AUDIT)	1
Drug Abuse Screening Test (DAST)	1
Fagerström Test for Nicotine Dependence	1
Unnamed screening tool for problematic technology use	1
Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)	1
Substance Abuse Subtle Screening Inventory (SASSI)	1
State-Trait Anger Expression Inventory (STAXI)	1
Trauma Symptom Inventory (TSI)	1
Tools developed by Aaron T. Beck	1
Tools developed by David D. Burns	1
GAIN-I (in addition to GAIN-Q3 MI ONT)	1

Table 2: Alternative tools submitted by respondents

Focus group participants also described additional screening/assessment tools that are required by their own agencies. These are similar to those shared by survey participants and included own internal questionnaires, additional risk assessments (suicide, overdose), and mental status exam.

Service providers in the focus groups shared that these may be used in addition to the GAIN-Q3 or may be used in lieu of. This decision for which assessment or both is made by either client preferences, depending on what treatment the client is seeking, or clinician judgement.

Based on both survey and focus group data, **an overarching theme of “assessment tool as a perceived barrier” was generated. This theme encapsulated participants’ sentiments that: a) the SS&A tools detract from therapeutic alliance/milieu; b) the SS&A tools are perceived to be a structured interview; c) a dichotomy exists between clinical judgement and tool administration; and, d) the SS&A tools are perceived to be for research and not clinical purposes. Taken together, these factors characterize how some providers have come to view the tool as a barrier to clinical practice.**

#### *Detracts from Therapeutic Alliance/Milieu*

Participants very often described the tool as “long” (FG4), “repetitive” (FG17), and not “client-centered” (FG16), with some participants describing the questions as intrusive. Some participants also raised concerns that they felt it is not in alignment with harm reduction

principles, which contradicted their programs' values. Providers in both focus groups and surveys reported feeling that the SS&A process is not useful as an engagement tool with clients and that the tool itself can negatively affect the development of the therapeutic alliance.

- “So from a client perspective coming in, I'm feeling like you're being asked the same thing multiple times and having that erode trust when you're actually trying to build a trusting relationship” (FG26 (PSSP))
- “And then the impression and the feedback that it's harmful to the therapeutic relationship for a clinician to go through the Q3 MI with their client not knowing when they already have, you know what they feel like, they need to inform treatment planning and assessment” (FG20)

As well, they discussed difficulties administering the GAIN-Q3 MI ONT with clients, expressing that clients won't tolerate the lengthy duration of the assessment and may refuse to complete it, become angry, and frustrated and feel “mistrusted” (FG20) by the repetitive nature of the questions (“Clients think, 'Oh, are you testing me?'”(FG11)). Rarely, providers also expressed concerns that the assessment tool was less appropriate, less safe, or that specific items could be potentially triggering, such as those on height/weight, risk behaviours, and trauma.

#### *Perception of Assessment as a Structured Interview rather than a Semi-Structured Interview*

The GAIN-Q3 MI ONT assessment is intended to be administered as a semi-structured interview, yet providers often used the terms “scripted” (FG20), “verbatim” (S47), and “structured” (FG10) to describe it. They perceived a difficulty with the tool, that they felt they were unable to engage clients in discussion outside of what was specified for fear that would invalidate the tool. This illustrates a held belief that the SS&A tools are to be administered using a *structured* and not semi-structured interview (“So I'd love to see it evolve into something that isn't scripted where clinicians can have discretion around how they ask the questions and how they're worded” (FG20); “But I think that there's, yes, definitely a number of issues with the very narrow structure of the tool and the questions. And you feel like you can't go off script or you're invalidating the tool. That's very frustrating for me anyways” (FG10)). This perception of the tool as a structured tool, and its practice as such, possibly contributes to the challenges experienced by service providers in using these tools.

#### *Dichotomy between Clinical Judgement and the Tool*

Through analysis of service provider statements, the notion of a dichotomy between the tool and clinical judgement became evident. Participant data reflected a sentiment that the SS&A tools do not work in tandem and are not complementary to clinician judgment. Tools

were instead described as oppositional and perceived to challenge professional skillsets. This perception may contribute to providers' views of the tool as a barrier and to a lack of its uptake.

Both survey and focus group participants placed a high value on clinician skills and clinician judgment and conveyed that clinical training and clinical judgement provide adequate skills to conduct assessments. This was further exemplified by remarks suggesting that while such a tool may be useful for less experienced providers, it is less useful for those with more expertise:

- “Standardizing treatment planning in this way - while perhaps an attempt at efficiency across the system - devalues the clinical capacity of folks who are highly skilled and educated in this sector. Perhaps it is more appropriate to value the work being done in this sector and requiring minimum standards for education and training, so that clinical staff can apply clinical judgement rather than relying on standardized processes that are cumbersome and ineffective given the dearth of resources in the system” (S33);
- “... qualifications and experience and all that kind of stuff, but, I think that that the tool then, is it's like anyone can do it. If your skill is not involved, then anyone can do it. Why even have somebody in addictions world do it? Have a robot do it!” (FG16)
- “And it [appropriate referral and back-up referral] comes from discussion - discussion and us using our skills, and our brain, and not a computer algorithm.” (FG4)
- “...Experienced addiction counselors can in ten or 15 minutes with the client pretty much tell you what level of care they need. So if they know how to do that, why don't we develop an assessment tool that is standardized across the system that uses that knowledge and experience, rather than spending an hour, 2 to 3 hours per hour doing a tool that doesn't actually answer the question because it doesn't...”(FG17)

Relatedly providers expressed a lack of understanding with how to practically incorporate the SS&A tools into their clinical practice (“But the main struggle I'm hearing is that they don't really understand how to use it clinically: 'So I've done the report, it spews out all this stuff. How do I use this clinically?’”(FG19)). One key informant interviewee also recognized this gap and attributed it to the complexity of the tool's implementation:

“... there's still a gap in understanding among service providers of the clinical value of the tool. And I think and including the reports that come out, which are if you really dig into them, they're fairly helpful. And I think what happens, just from my perception is there is before you even get to the clinical value conversation, so much sort of gets lost in what people perceive as a complexity of implementation...” (KI1)

This was also frequently identified both in the survey and focus groups as a training need, stating that the training focused primarily on administration of the tools, not their clinical application (“When I did the training (back in 2016 / 2017) it was very much focused on how to

do the tools. There was limited training on how use the tools in a clinical sense. No discussion of what the reports actually told you or how to use this data. Just "read these questions verbatim and send [off] these reports" - that was it" (S47).

### *Perception that the Tool is for Research and not Clinical Purposes*

A final topic within the tool as a barrier theme is the perception held among some providers that the tool is for research and does not meet clinical needs. Some service providers discussed the utility of the GAIN-Q3 and its output, the Q3RRS recommendations, to their practice. While some participants felt these tools were beneficial to their clinical practice, including for treatment matching and planning, others identified key limitations with it. Some participants indicated that the tool does not produce a useful or helpful care plan, and that it is not comprehensive:

"I think back to the times where, I would complete a Q3 and I go through the recommendations and essentially would be typing in tons of information to kind of like give a fuller, fuller picture of what the client was going through. And so... what this process generated was so surface level, that it really was quite meaningless in my experience like, as I thought about me being on the receiving end of one of the reports, I thought, 'Yeah, I am going to just shelf this because I'm going to have to I'm going to have to do that initial interview anyway' where I'm trying to gather that information and, and build the relationships through gathering information." (FG7)

Participants also frequently indicated that the time required to edit the auto-generated reports was excessive and created much frustration amongst themselves and colleagues. Furthermore, providers suggested that based upon their experience, they felt that report recipients were not reading or using the GAIN reports that they had labored over to produce ("all treatment centers I refer to admit to not even reading them!"(S94)). Participants also identified that the recommendations generated may not align with the availability of services locally and raised this as particularly problematic ("The recommended treatment plans are not useful or representative of the services available."(S43)).

Based upon these experiences, some participants began to suggest that the tool is aimed more for "data collection" than for clinical assessment purposes ("But then for the most part, it still does become a data collection tool, not an engagement assessment and referral tool" (FG16)).

A few providers in focus groups did note that using a provincially standardized tool provided added "credibility and legitimacy" (FG8) when communicating about clinical recommendations with external entities.



## Client Populations and Suitability

Survey respondents were asked to identify situations when the tools would not be administered with clients accessing services. A topic that emerged from these open-text responses, and during the focus groups, was client populations. Clinicians reported that the GAIN-Q3 MI ONT assessment tool was challenging to administer with certain population, such as:

- Clients with cognitive impairments (e.g., advancing age, substance-induced, neurodegenerative conditions)
- Clients with intellectual disabilities
- Clients with acquired brain injuries
- Clients with literacy issues or language barriers
- Clients who are homeless or precariously housed
- Clients actively intoxicated (altered states, withdrawal management)
- Clients registered with assertive community treatment (ACT) teams
- Clients participating in voluntary drug treatment court
- Youth (ages not specified)

Service providers described their experiences as follows:

- “Cognitive impairment like it may when you spoke and made me think of older people, but people who use drugs for so long, they are often cognitively impaired much earlier than people. And also literacy issues and sometimes language.” (FG16)
- “And then to sort of get into the nitty gritty of it, like many of my clients, couldn't remember what they did yesterday, let alone the anchoring and time and all of that piece. I think the Q3 makes an assumption about folks' capacity. And certainly some people were able to do that, but I think even recognizing the way in which substance use impacts folks' capacity for memory and being able to sort of, Like anchor what they were doing, when, and all of that. I mean I, I appreciate the need for specificity and I think that asks a lot of clients.” (FG7)

One focus group participant acknowledged that some of the difficulties experienced were “not really tool specific” (FG6) but would exist with any similar tool.

## DISCUSSION

### Adherence to the Staged Protocol

Provincial data reports can provide information about adherence to the staged protocol. In the former case, for example, there were 63,045 GAIN-SS completed between April 1, 2015

and March 31, 2022. Of these screeners, 76.1% scored 3+ on the internalizing disorder subscale in the past year, which suggests that approximately 47,900 MMS or POSIT screeners should have been administered if the process was implemented as intended. As well, 73.7% of clients scored 3+ on the substance use subscale, which means approximately 46,400 GAIN-Q3 MI ONT assessments should have been triggered. As noted above, this figure was exceeded, but it is unclear whether that was due to adherence to the staged process.

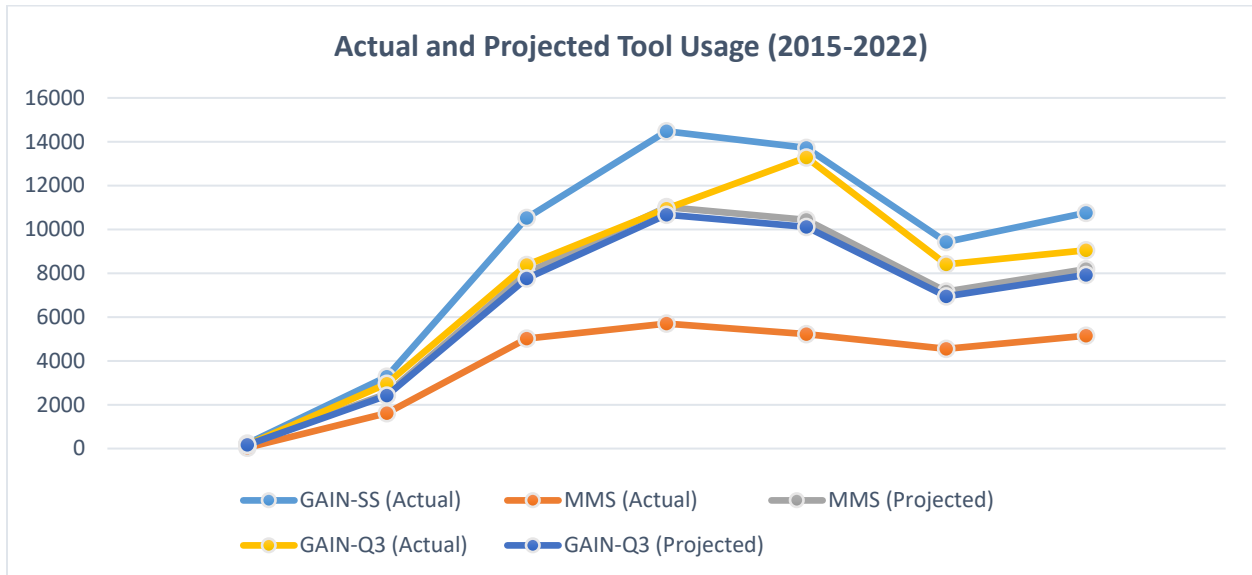
The following chart demonstrates this discrepancy between actual tool administration and projected tool administration that would be expected from adherence to the staged protocol. There are two notable observations. First, these data do suggest that stage 2 screeners have been underutilized by about 40%, as only 27,380 MMS and 537 POSIT have been administered. POSIT has been excluded in the chart due to low numbers. A possible explanation for this discrepancy is that second stage screener usage may be skipped when OCAN tools are also being administered or clients already receive mental health services, but data cannot be cross-referenced with OCAN administration to verify this possibility. Second, after 2018-19, a deviation emerges between the actual and expected number of GAIN-Q3 MI ONT assessments completed, surprisingly in favour of *actual assessments*. This could be a limitation of the projections, because they are based on the GAIN-SS as a starting point. In that case, this suggests that the GAIN-SS may also not be administered as often as intended, especially when clients are receiving the GAIN-Q3 MI ONT for referral purposes only. On the other hand, it could reflect administration of the GAIN-Q3 MI ONT in circumstances when the assessment was not indicated by the cut-off score on the GAIN-SS substance use subscale.

In the prior ADTC evaluation, the idea of a stepped approach was not considered good practice by organizations that viewed the comprehensive assessment as “a prerequisite to effective treatment matching” (p. xi). This could explain the nearly 1:1 ratio of GAIN-SS and GAIN-Q3 MI ONT completed. However, one of the benefits and intended purposes of the staged protocol was to reserve the assessment until screening indicated that it was required, thus preventing unnecessary administration:

“We need to decide if everyone needs the extreme comprehensiveness of the complete assessment or if there are, if there's a certain point in time or a certain point in time in a client's journey where it's warranted and others where something's not.” (KII3)

Unwarranted assessments may be “potentially damaging to the client when, for various reasons, the information is subsequently ignored in treatment” (p. xi). For example, one focus group participant stated, “I won't do a GAIN with somebody who's been abstinent for a period of time” (FG10), reinforcing the intention behind the staged protocol. In either case, more exploration around adherence to the staged protocol is required to determine why there is

variation in tool administration that is not supported by known cut-off scores in the provincial data.



Clinical supervision is one way to promote adherence to the staged protocol, but some organizations are inadequately resourced and structured to provide this consistently. In addition to direct clinician supervision, clinical audit procedures that cross-reference the outcome of the tools with the intended staged model (cut-off scores and matched treatment destinations in the Q3RRS) could curtail some of this widespread variability. Whose responsibility it is to develop and enforce clinical practice standards, particularly in the absence of a formal regulatory body, has been a longstanding discussion in the sector. This topic was cited in the ADTC evaluation and was also supported by a key informant. **A proper leadership mechanism is critical to monitoring, compliance, training, and resource development.**

### Disconnect Between Implementation Policy and Practice

#### *Purpose of Assessment*

As noted in the results section above, one subtheme that emerged during the survey open-text and focus group analysis was perceived purpose of assessment. This theme was also captured in the 2006 evaluation of the Admission and Discharge Tools and Criteria when the authors noted that “differences in assessment practice suggest that it would be difficult to achieve consensus about the content of an initial assessment” (p. xi).<sup>14</sup> While their observation

<sup>14</sup> Rush, B., & Martin, G. (2006). *Report of the evaluation of the Admission and Discharge Tools and Criteria (ADTC)*. Toronto, ON: Centre for Addiction and Mental Health.

was based on health service providers blending initial and ongoing assessments, it can also apply to using screening tools as assessment instruments depending on variation in the perceived purpose of assessment. For example, two alternative tools suggested above, the AUDIT and DAST, are screeners, which would render them duplicative with the GAIN-SS. If they are being used in place of the GAIN-Q3 MI ONT assessment, even though the survey question asked about supplemental and not replacement tool use, this could render the assessment inadequate. The interchangeability of screening and assessment tools was an important finding during the SS&A pilot, which also echoed the findings of the ADTC evaluation in 2006. In both instances, **participants identified the GAIN-SS, ADAT, and OCAN as both screening and assessment tools, highlighting the need for system-wide definitions and distinctions of screening and assessment as distinct processes (p. 30). As long as clinicians have divergent understandings and definitions of assessment, this will impact how and when actual assessment tools are administered and for what purposes.**

Participants noted that as long as the GAIN-Q3 MI ONT is used primarily as a referral tool, and mostly for bed-based services, the output does not justify the administration time. The auto-generated reports facilitate treatment planning and evidence-based intervention, but these reports are underutilized if the Q3RRS is only being generated as an administrative task to meet referral requirements. This aligns with endorsement of modifications that were made, in that the Q3PFR was not used for treatment planning, the Q3RRS was not edited, and referrals were not made based on the client's level of need. In this regard, the GAIN-Q3 MI ONT seems to be following a similar path to that of the ADAT suite of tools, where administration was seen as a pro forma activity that was completed *after* a decision had been made to refer the client to bed-based services. One of the key informant interviewees recalled this finding, also described in the ADTC evaluation: "... for want of a better term, people were gaming the system and essentially using the ADAT tools to get people into residential treatment because everybody thinks they need residential care, whether they do or not..." (KII2).

Related to this specific use of the Q3RRS for bed-based referral purposes only, some participants disclosed that referral recipients (treatment programs) openly admitted to not reading the edited reports. This is problematic as it reinforces the false-notion and practice that generating the Q3RRS is solely an administrative task. Addressing this longstanding sector topic could streamline referrals, especially when supplementary information is requested that is duplicative with information collected through the GAIN-Q3 MI ONT assessment and where clinicians are making multiple referrals for one client.

Administration variability, client populations and suitability, and use of alternative tools all point toward a disconnect between implementation policy and practice, which was

acknowledged by some focus group participants. One participant summarized this well as follows:

“I can speak that what we're doing in policy and then what it actually looks like in practice. In policy, the way that we've rolled it out is upon initial intake into the program. Our clients would do the [GAIN] Short Screener and then within the first few months of service, they would do the full [GAIN-Q3 MI [ONT]. However, in practice, neither of those are happening just because of the immediacy of need when folks come in, and then the impression and the feedback that it's harmful to the therapeutic relationship for a clinician to go through the [GAIN-Q3 MI [ONT] with their client... So it seems like, we're doing it just to do it, and it's not giving us anything beneficial, so in practice, we're only using it when it's required for referral to an outside service.” (FG20)

Since this participant highlighted that the need is too great when people access service to complete the SS&A process as intended, it is worth reiterating that the SS&A tools do not need to be administered during the first visit and especially not when the client is in an acute crisis. In this case, the immediate need may in fact be stabilization, but at some point, establishing an evidence-based treatment plan using the assessment, and not just for outside referrals, should be part of the client pathway.

#### *Role of Client Choice*

The role of client choice in determining a treatment destination is a theme that was identified in the 2006 ADTC evaluation. This was also identified in this evaluation, but additionally, client choice also determined whether or not an assessment would be *completed at all*. For example, as one participant remarked, “if a client is wanting to go to day treatment or residential treatment, then we administer the GAIN” (FG11). In this case, not only is the client determining the treatment destination, but in doing so is deciding whether the assessment needs to be administered as a condition of entry. Ideally, the GAIN-Q3 MI ONT assessment should be administered with all clients who are eligible in accordance with the staged screening protocol, and then the results of that assessment could inform the treatment destination, including the client’s preference. Even then, the ADTC evaluation referenced a discrepancy where two-thirds of clinicians said client choice could result in a treatment assignment to a more or less intensive treatment than the assessment tools recommended, while the other third restricted client choice to an equal or less intensive option (p. 27).<sup>15</sup> The

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<sup>15</sup> Rush, B., & Martin, G. (2006). *Report of the evaluation of the Admission and Discharge Tools and Criteria (ADTC)*. Toronto, ON: Centre for Addiction and Mental Health.

latter is more congruent with the principle of least intrusive treatment, where clients are initially referred to the least intrusive treatment that that could meet their need and then “steps up” to a more intensive treatment only if their need is not being met.

### Client Suitability

The findings identified relate to the broader topic of client suitability and whether certain populations *could* be exempt from completing the GAIN-Q3 MI ONT assessment. In 2018-19, the PSSP implementation team discussed this internally in the context of assessment rates, as previously discussed. It is important to emphasize that these client populations were not identified here in order to exempt or exclude them from participating in the SS&A process, but to acknowledge that clinicians did encounter greater administration challenges with these groups and that there is no alternative assessment tool or process available. This important topic is referenced again as a lesson learned.

In some cases, administration challenges could be temporary, as in the example of a client who attends an interview while intoxicated but is able to complete the assessment at a later time. The ADTC Manual<sup>16</sup> also mentioned the importance of addressing health and safety situations, including crises and basic needs such as shelter and food, prior to assessment or treatment planning (p. 70), and this continues to apply today. Additionally, these criteria stressed the importance of distinguishing between crisis management and treatment readiness: “If the client is in crisis and needs shelter, food or a safe environment, the criteria require that the counsellor see to these needs first, or refer the client to an agency that will. If the client is in crisis due to withdrawal management needs, then a referral is made and later the standardized assessment tools will help determine next steps” (p. 127). Moreover, clients requiring stabilization were not expected to be “physically, cognitively, or emotionally healthy enough to fully participate in completing the tools,” but they should have been completed once the client was stable and interested in pursuing treatment (p. 37). Fundamentally, “clients referred to treatment should be physically and cognitively able to participate in the treatment program” (p. 18).

The evaluators found it noteworthy that not a single survey or focus group participant referenced the GAIN Cognitive Impairment Screener (CIS), which is mentioned in PSSP’s SS&A Implementation Guide as well as CHS’ official manuals. When there are questions about a client’s ability to complete the GAIN-SS, and subsequently, the GAIN-Q3 MI ONT, this scale

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<sup>16</sup> Cross, S., & Sibley, L. (2010). *Admission and discharge criteria and assessment tools manual (revised)*. Toronto, ON: Centre for Addiction and Mental Health.

should be administered. The CIS provides non-descript evidence of impairment, which may be temporary (i.e., from current intoxication) or permanent (i.e., dementia). Results from the CIS should guide the clinician’s decision to delay the interview. The CIS is a six-item scale that rates cognitive impairment out of a possible score of 28. Higher scores indicate greater degrees of cognitive impairment. According to CHS, “As the number of errors on the CIS increase, it will be increasingly difficult to obtain reliable and valid answers from the client. In general, about 5% of a substance abuse treatment population will score 10 or higher, at which point you should consider other options” (p. 23).<sup>17</sup> If the clinician decides to proceed with the interview despite a score greater than 10, self-administration is not recommended, they should assume that the interview will take longer to complete and be more difficult in general, and they must be cautious of over-interpreting responses. Collateral information should be used to support the assessment, recognizing that the auto-generated reports may be inaccurate.

### **Tool as a Perceived Barrier and Alternative Tool Usage**

As noted in the findings, participants identified that the GAIN-Q3 MI ONT assessment and the entire SS&A process takes too long to administer. This coincided with concerns that organizations lack the staff resources and time required to administer the tools as intended. This barrier could be mitigated in some settings by using GAIN ABS self-assessment mode, where multiple clients can simultaneously complete the GAIN-Q3 MI ONT assessment under the supervision of a certified Site Interviewer, an approach that some agency representatives described successes using.

As presented in the *dichotomy between clinical judgement and the assessment tool* subtheme, many Site Interviewers viewed the assessment process as unnecessary, but acknowledged that the GAIN-Q3 MI ONT assessment may be more valuable for entry-level clinicians. They also commented that they used their clinical skills rather than the tool. This perception assumes that experienced clinicians are able to provide treatment matching and the evidence-based intervention associated with a particular diagnostic impression without the aid of standardized tools.

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<sup>17</sup> Titus, J.C., Feeney, T., Smith, D.C., Rivers, T.L., Kelly, L.L., & Dennis, M.L. (2013). *GAIN-Q3 3.2: Administration, clinical interpretation, and brief intervention*. Normal, IL: Chestnut Health Systems.  
<https://chestnut.app.box.com/v/GAIN-Q3-Materials/file/63774478953>

As noted above, 12 survey respondents provided examples of mostly validated tools that were used to supplement the SS&A process. The top three responses to this survey question, OCAN, ADAT, and various instruments developed in-house, mirror what was found during the SS&A pilot environmental scan (p. 30).<sup>18</sup> Assuming the staged process was followed, many of these could complement the SS&A tools. For example, the Ontario Common Assessment of Need (OCAN) could be used a stage 2 mental health assessment if indicated by the MMS or POSIT, as was originally contemplated but not implemented during the SS&A pilot (p. 28). Other tools do address known gaps in the GAIN-Q3 MI ONT, such as problem gambling, nicotine dependence, or compulsive sexual behaviour. Some focus group participants mentioned that they would not administer the GAIN-Q3 MI ONT assessment with process/behavioural addictions, but this practice aligns with the purpose of the assessment assuming the GAIN-SS is still being administered. The remainder of the tools are substance use tools, but the evaluators had concerns about possible duplication or interchangeability of screeners and assessments because the administration process was not described in the survey results.

For example, the AUDIT and DAST tools are screeners, which would render them duplicative with the GAIN-SS. If they are being used in place of the GAIN-Q3 MI ONT assessment, even though the survey question asked about supplemental and not replacement tool use, this could render the assessment inadequate. The interchangeability of screening and assessment tools was an important finding during the SS&A pilot environmental scan in 2011, which also echoed the findings of the ADTC evaluation in 2006. Participants identified the GAIN-SS, ADAT, and OCAN as both screening and assessment tools, highlighting the need for system-wide definitions and distinctions of screening and assessment as distinct processes (p. 30).

Lastly, the perception that the GAIN-Q3 MI ONT is a research tool could be influenced by its rigor, especially when compared to the ADAT suite of tools, because the GAIN suite of tools has been used extensively for research purposes. While the tool does collect a greater quantity of data as a multidimensional biopsychosocial assessment, this does not negate its parallel utility as a treatment planning tool. At the individual level, the auto-generated reports are designed to inform treatment planning, while the aggregate data can be used by organizations and policymakers to inform system planning.

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<sup>18</sup> Rush, B., Rotondi, N.K., Furlong, A., Chau, N., & Ehtesham, S. (2013). *Drug Treatment Funding Program – Best Practice Screening and Assessment Project*. Toronto, ON: Centre for Addiction and Mental Health. <http://improvingsystems.ca/img/SSA-Research-and-Development-Final-Report-2013.pdf>

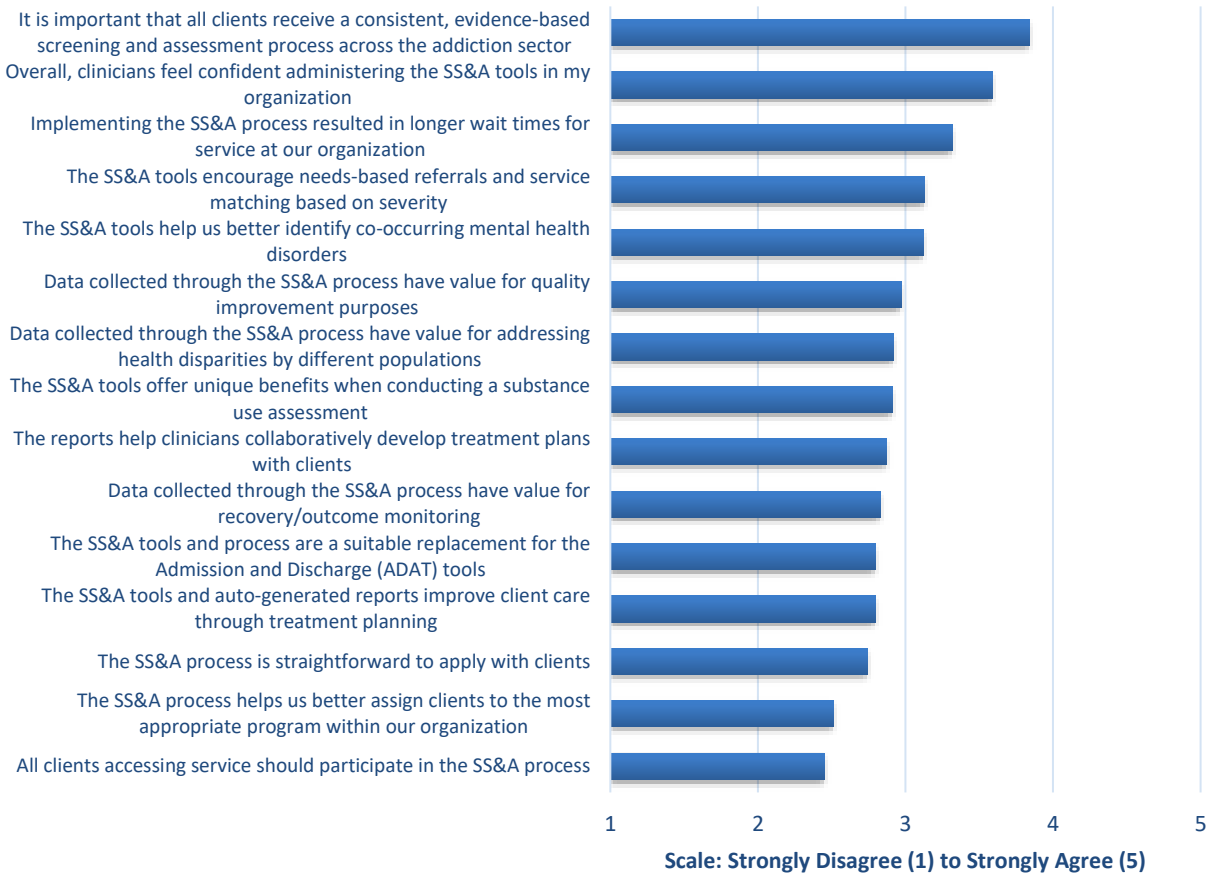


## EVALUATION QUESTION 3: WHAT HAS BEEN THE IMPACT OF INTRODUCING SS&A TO ORGANIZATIONS AND THE BROADER SYSTEM?

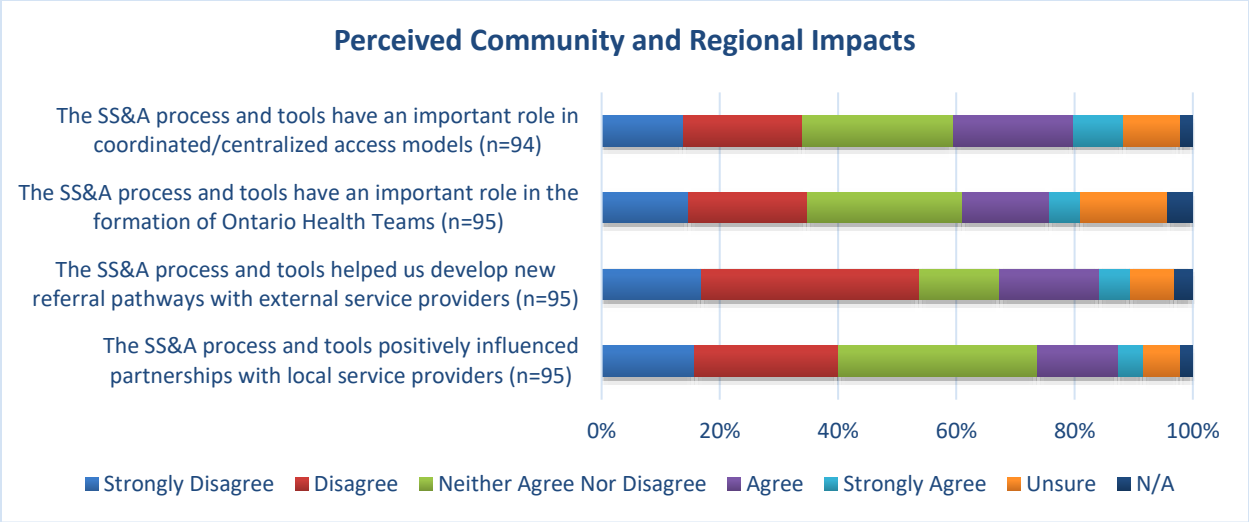
### RESULTS

Survey respondents were asked to identify if they had observed any impacts to their organization or the broader system as a result of introducing SS&A. Responses to example items were mixed, with most scoring between “neither agree nor disagree” and “agree.” As a result of implementing SS&A, respondents agreed that all clients should receive a consistent, evidence-based screening and assessment process ( $\bar{X}$ = 3.84, 69% total agreement), but scored lowest on the corresponding item, all clients accessing service should participate in the SS&A process ( $\bar{X}$ =2.45, 20% total agreement). Respondents also noted that clinicians feel confident administering the tools ( $\bar{X}$ = 3.59, 59% total agreement), but felt that implementing the SS&A process resulted in longer wait times for service ( $\bar{X}$ = 3.32, 38% total agreement). There was marginal agreement that the tools encourage needs-based referrals and service matching based on severity, and assist with identifying co-occurring mental health disorders. All other items had a weighted average below the neutral response option (3.0, “neither agree nor disagree”).

### Intended and Unintended Outcomes by Weighted Average (n=96)



In terms of community and regional impacts, responses varied considerably. Almost a quarter of respondents appraised each of these potential impacts neutrally, with one-third responding neutrally to the item about SS&A positively influencing local partnerships. The lowest scoring item was that the SS&A process and tools helped participants develop new referral pathways with external service providers ( $\bar{X}$ = 2.78, 22% total agreement). The highest scoring item pertained to SS&A having an important role in the formation of Ontario Health Teams, although it should be noted that almost 15% of respondents were unsure about that item ( $\bar{X}$ = 3.21, 20% total agreement). When this question analysis was restricted to survey respondents who identified as managers, responses remained consistent although the percentage of not applicable (N/A) responses dropped to 0% on three items, and 4% on one item. The ranked order of questions by total agreement did not change. This suggests that, despite being better positioned to respond to community or regional impacts associated with the SS&A process, managers had the same mixed response to these items as clinicians. Therefore, while these sector priorities will continue to play an important role, SS&A has not, up to this point, been well integrated into these conversations.



As an example, focus group participants described challenges to relationships with other providers and agencies, due to differing understanding of the purpose for the SS&A assessment. For instance, participants described receiving requests to complete a GAIN-Q3 only to meet a deadline for a residential treatment bed. Resulting from this practice, some participant clinicians often lamented the frustration, and a sense of being undervalued for the time and skill that is involved in completing the GAIN-Q3 MI ONT, labelling it as an “administrative” (FG12) task when completed as such. This demonstrates a broad misconception about the purpose of the assessment across the sector, as summarized by a survey participant:

“I believe an important factor in ongoing administration of the SS&A tools is ensuring that GAIN Certified people and their organizations believe in (and understand the benefits) of the SS&A process. Too many clinicians tend to lean towards seeing the process as a barrier to treatment and seeing it as an administrative task that needs to be done after having already made a treatment decision. Rather than knowing the benefits and importance of not making any treatment decisions until the recommendations of the SS&A process are generated. When organizations within a community differ in this understanding of the SS&A process, it creates challenges for ensuring a consistent SS&A process for all people accessing an assessment.”(S30)

**DISCUSSION**

As the weighted average chart of intended and unintended outcomes demonstrates, data obtained through the clinical interview were not deemed to have high value, including for treatment planning purposes. This provides a possible explanation for why the auto-generated

reports and use of the GAIN-Q3 MI ONT assessment are underutilized. If Site Interviewers do not consider the information to be of value, they are less likely to administer it, which reinforces that the information has little value because it is underutilized.

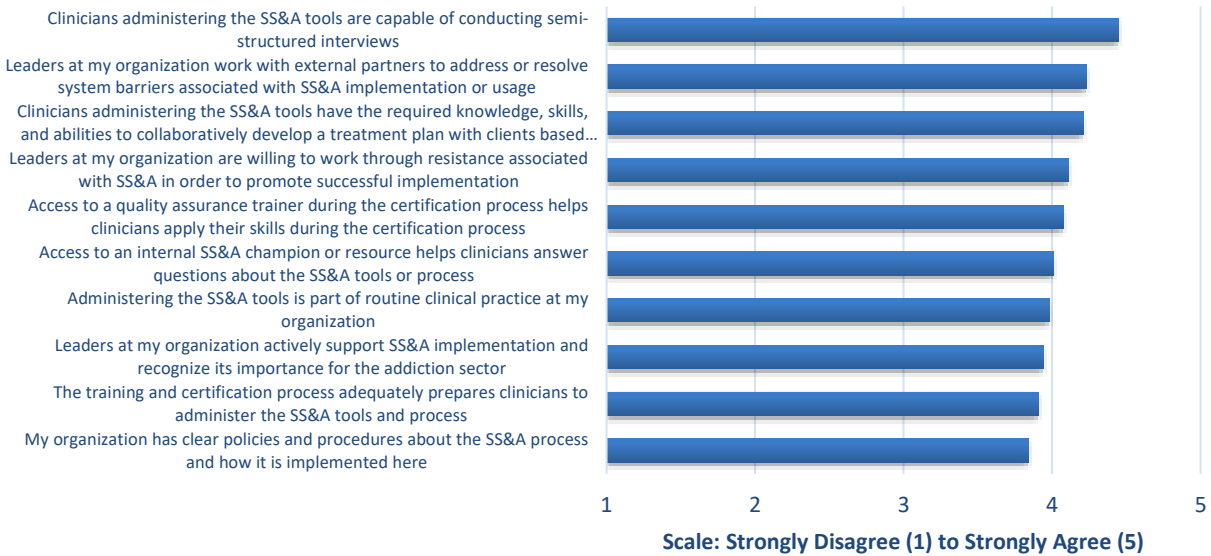
Although this evaluation question intended to explore the impact of introducing SS&A to organizations and communities, few impacts were mentioned. **A majority of respondents disagreed that the SS&A tools and process helped their organizations develop new referral pathways. Responses were mixed as to whether SS&A has a role in centralized access models, Ontario Health Teams, and regional partnerships. Although SS&A implementation efforts should continue to emphasize the role of the individual organization, focusing on increasing uptake and usage internally especially in the context of agency administration variability, this also illustrates that system-wide benefits of SS&A are not being realized.**

#### **EVALUATION QUESTION 4: WHAT HAS BEEN THE EXPERIENCE WITH RESPECT TO TRAINING, COMPETENCY, AND PSSP'S IMPLEMENTATION SUPPORT?**

##### **RESULTS**

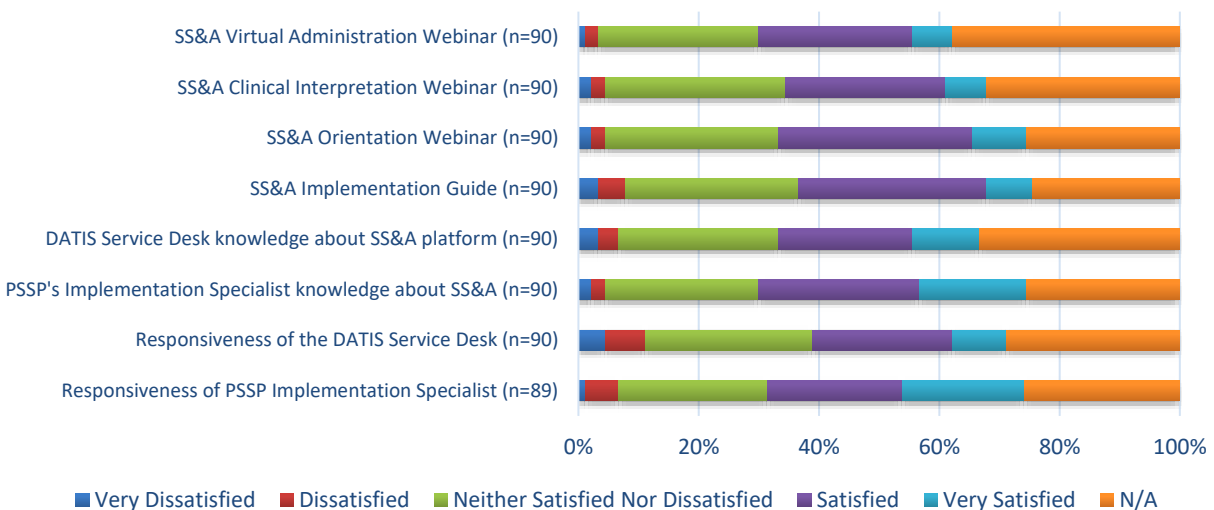
Survey respondents were asked to identify what internal factors and supports helped their organizations implement SS&A. Responses to example items were positively skewed with most respondents answering agree and strongly agree. The total agreement percentage for all items was between 60% and 80%, except for the highest ranked items where respondents ranked their own abilities. Respondents agreed that clinicians are capable of semi-structured interviewing ( $\bar{X}$ = 4.54, 81% total agreement), and have the necessary knowledge, skills, and abilities to develop a treatment plan from the assessment results ( $\bar{X}$ = 4.21, 73% total agreement). Respondents also rated their leaders positively, noting they are willing to work with external partners to resolve system barriers ( $\bar{X}$ = 4.23, 45% total agreement) and work through resistance to promote successful implementation ( $\bar{X}$ = 4.11, 63% total agreement). These two items also had the highest rate of unsure responses at 23% and 10% respectively. All other items had a weighted average below 4.0 ("agree") and none reached the cut-off for neither agree nor disagree (3.0).

### Organizational Facilitators Ranked by Weighted Average (n=95)



Survey respondents were asked to rate their level of satisfaction with implementation supports and technology-related supports provided by PSSP. A key finding from this survey question was that approximately one-quarter to one-third (24-37%) of respondents answered N/A to each response option. After excluding these N/A responses, satisfaction to each item was mixed, with a similar percentage of respondents answering “neither satisfied nor dissatisfied” and “satisfied” (all within 4%). Recognizing this, respondents were most satisfied with PSSP implementation specialists’ knowledge of SS&A ( $\bar{X} = 3.75$ , 45% total satisfaction) and their responsiveness ( $\bar{X} = 3.74$ , 43% total satisfaction).

### Satisfaction with Implementation Supports



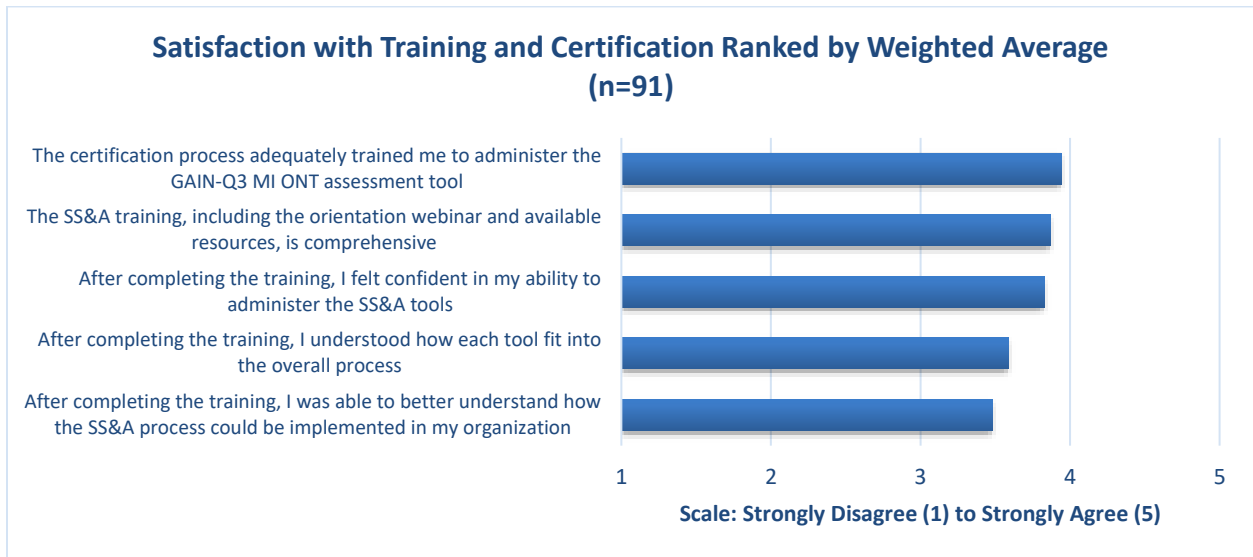
The theme of *implementation supports and barriers* details the experience of all participants (service providers, PSSP, and policymakers) in the implementation process. They articulated what had aided in implementing SS&A and what factors have posed challenges. This includes PSSP role and resources, training and certification, and technological infrastructure. Participant statements are reported descriptively.

Focus group participants also discussed PSSP's role in implementation. Many participants spoke highly of the PSSP's contributions to implementing what has been identified as a difficult and complex tool ("...the support you guys have provided has really been tremendous. And I cannot state enough how grateful I am for that, our organization is for that, because it has gone a long way in, in every time concerns come up, you guys are responsive. It's like, what can we do? Let's talk, let's understand this..." (FG8); "For all of my criticisms of the tool, PSSP has been fantastic and is not the source of the problem."(FG17); "The whole process that PSSP has done, I found to be respectful and really help us implement something that not one team member wanted to"(FG16); "And the SS&A I think what helped there was just the incredibly intensive implementation crew that ran around the province for years ... working with people"(KII2); "I don't think SS&A would be where it is without PSSP's implementation support"(KII3)).

Although participants did not speak to the many backbone responsibilities that PSSP has, nor would they necessarily be expected privy to such details, PSSP's support has been an important factor in sustainability. Some of these duties include developing, updating, and coordinating training and certification, developing and distributing knowledge exchange products and hosting engagement sessions, updating the tool language based on partner feedback, and of course, liaising with funders and policymakers to inform the overall direction and scope of the initiative. During the focus group with DATIS staff, participants spoke of the importance of and duties associated with managing the vendor relationship with CHS. In contrast to other initiatives supported by this team, being the licensee and not owner of the tool creates additional responsibilities. For example, as an organization, CAMH holds the licensing agreement and contracts and as a result, the associated liability, on behalf of the provincial sector. DATIS also has to work with CHS around technical issues that they would otherwise be able to respond to in-house.

Survey respondents were asked to rate their satisfaction with the training and certification process, including developed resources. Responses to each item were generally positive and participants expressed that the certification process adequately trained them to administer the GAIN-Q3 MI ONT assessment tool ( $\bar{X} = 3.94$ , 73% total satisfaction). Overall, participants felt that the training and certification process was comprehensive and adequately equipped them to administer the tools. The N/A response rate ranged from 10-15%. This could

be explained by respondents who completed the training several years ago, in-person, and could also be attributed to managers (n=25) who participated in the survey but may not have completed the training.



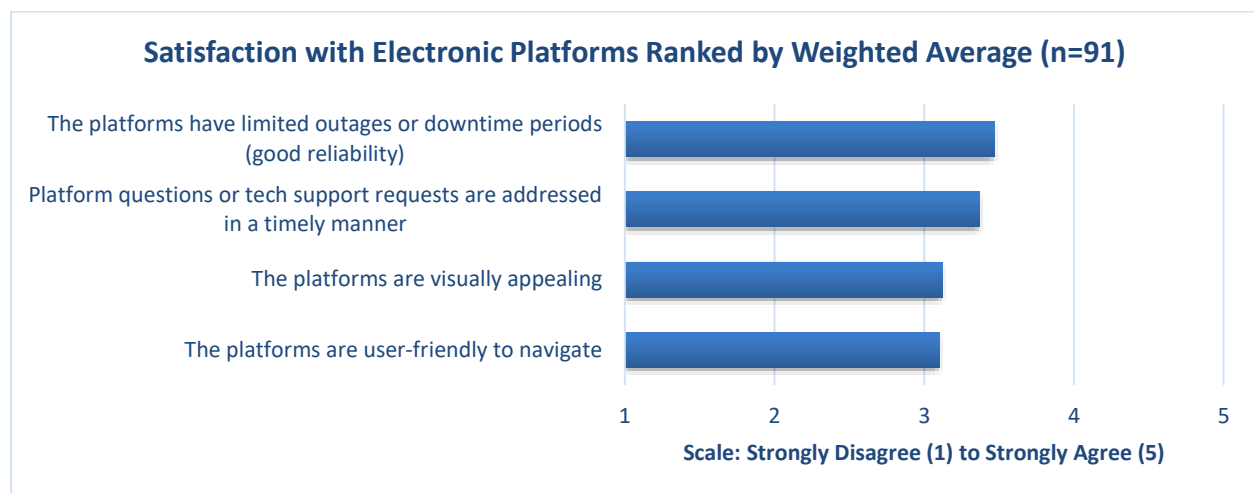
General feedback about the training and certification process was provided in both the survey open-text and focus group analysis. Some focus group participants described some challenges they had experienced with the certification process, noting it felt “cumbersome,” (FG28) “intensive” (F18), and required a substantial time-commitment (3-months). In onboarding new staff, this time period posed difficulties while awaiting completion of their certification. Additionally, some providers observed that it could be challenge to find clients for trainees to work with, as part of their training interviews.

Often, focus group participants described how their own internal training processes had “evolved” (FG8), and had become more efficient since first implementation. Some reported on structured processes they had implemented internally to support trainees through the process. As well, participants shared that they had found a helpful way to be selective with the clients who the trainees completed their mock interviews with.

**Two key suggestions for training included developing more complicated mock interviews, as the participants discussed the existing ones lacked complexity to apply all the of the required skills. Secondly, both survey and focus group participants indicated that the training focused more on using the tools administratively than how to use them clinically, and requested that this be adapted in the future (“I think something's missing with whatever the site interviewers are not getting in their training to be able to utilize the output of the tool effectively and efficiently. I think that's the biggest thing for me training wise” (FG9); “I think the training does a really great job of the actual administration of it. And then I find it ... goes**

into the other tools [sic] like the PRF, the ICP, diagnostic impressions but not necessarily implementing them into your clinical work, which I think that could be better at.”(FG15); “Back when I was trained, I felt like I learned more about the administration part of it a lot of than the actual use/interpretation of the tools” (S105)).

Survey respondents were asked to rate their satisfaction with the electronic platforms associated with SS&A administration, including Catalyst and Chestnut Health System’s GAIN Assessment Builder System (ABS). Respondents noted their satisfaction with the platforms’ reliability ( $\bar{X} = 3.47$ , 56% total satisfaction) and timely responses to support requests ( $\bar{X} = 3.37$ , 34% total satisfaction). Almost one-third of respondents to this latter question answered N/A, suggesting they have not accessed tech support.



DATIS provides HSPs with a customized software application known as Catalyst for this purpose. Some HSPs access Catalyst directly, while others use a third-party (interface) platform such as Meditech, CaseWORKS, or EMHWARE. Focus group and survey respondents provided feedback about their technological infrastructure. These comments statements reflected participants’ experiences with duplicate data entry, interface electronic medical records (EMRs), and GAIN ABS and Catalyst. A few respondents commented on the duplicate data entry associated with using Catalyst and a third-party platform. A lack of interoperability limits the transfer of existing health record data into Catalyst and vice-versa. Moreover, DATIS is no longer developing transfer mechanisms for third-party platforms. As new reports are developed by the PSSP implementation team and DATIS, organizations using interface platforms will still need to create individual Catalyst user accounts to access them, effectively contributing to the duplicate platform and multiple login issue.

- “We also have the issue of going on two different [platforms]: GAIN doesn't talk to our health record system ... Catalyst doesn't talk at all, so that's an issue.”(FG16)



- “Catalyste is double entering stats, Why can't the programe get the stats from other computer programe ex Epic.” [sic] (S13)
- “[You] should create interface between Catalyst and the large EMRs - Cerner, Meditech, EPIC. Unfortunately the tools and programs that organizations use are dependent on their history with certain technology, and programs. These relationships are difficult to reverse and are often contractual in nature. I think in the end we should endorse some variance in the specific suite of tools used. It seems like an impossible endeavor to have everyone using the same tools, so if not possible we should have electronic systems and processes that allow for some variance, while focusing on key pieces of patient information that needs to be communicated across service providers to support quality care.”(S106)

Survey respondents expressed lower levels of satisfaction with the user-friendliness of the platforms ( $\bar{X} = 3.1$ , 42% total satisfaction) and visual appeal ( $\bar{X} = 3.1$ , 37% total satisfaction). A few respondents identified that an updated user interface is needed for both GAIN ABS but especially Catalyst.

- “[You] need an updated user interface - the new GAIN Q3 refresh was nicer, but it’s still clunky. Catalyst looks like it was written in the 90s and forgotten about.” (S47)
- “I find the updated version in catalyst is much easier to use than the older version, however, we use EMHWare as an agency, so it's not as user friendly.” (S118)

A small number of respondents noted that they do have access to client health records, in which case the assessment and associated data entry were both seen as duplicative:

“[Clients are] discharged from psychiatry and referred to program. We have access to discharge summaries - Dx, tx plans, recommendations, medications. Duplication of work. Now, if we were able to just complete the substance use section - this would be helpful.” [sic] (S70)

The DATIS team at CAMH was consulted to incorporate any implementation challenges and facilitators regarding the back-end technological components. From this, the primary challenge identified was having to create an internal system for agencies that only needed access to Catalyst for SS&A.

## DISCUSSION

### Awareness of Resources

As part of PSSP’s implementation support, training and certification are provided along a continuum to in-scope organizations. Implementation Specialists develop plans with

organizations based on their client intake, assessment, and treatment pathways, and the functional roles of staff. Training is defined broadly based on providing the level of information and support needed for staff to perform their specific role well. For example, staff not administering or receiving the tools may watch a recorded [orientation](#) webinar that provides an overview of the SS&A process, while staff who regularly complete assessments will complete the 3-month Site Interviewer certification through Chestnut Health Systems. Between these ends of the training continuum, staff may watch the [GAIN-SS](#), [Clinical Interpretation](#), or [Treatment Planning](#) webinars, for example, or audit the online training without pursuing certification.

As described above, approximately one-quarter to one-third (24-37%) of survey respondents answered N/A to each response option pertaining to PSSP's implementation supports, including knowledge products and resources. This reflected the largest observed N/A rate across the entire survey. As a result, efforts should be made to promote and distribute resources to increase clinicians' awareness and familiarity with them. Greater use of these resources may mitigate implementation issues or hesitance associated with using the tools as intended. PSSP is actively responding to this finding in its current work plan.

### **Training and Certification**

Survey respondents and focus group participants positively appraised the training and certification process. The lowest ranked item reflected uncertainty with how the SS&A process could be implemented at the organizational level. This speaks to the importance of implementation planning more broadly, and the application of training content in day-to-day operations and clinical pathways.

Some participants did note that the training could better emphasize use of the clinical information collected through the tools rather than simply tool administration. Since there is a distinction between confidence to administer the tools and confidence to use the information gathered from the tools for clinical purposes, this could explain why a high proportion of participants felt confident to administer the tools while also suggesting a greater emphasis on clinical interpretation aspects. A similar finding emerged from case study interviews in the ADTC evaluation, where participants indicated that the criteria about client strengths and needs "were rarely used on a case-by-case basis" (p. ix). This could point to a broader challenge associated with clinically integrating the assessment information and linking it to treatment planning on an individual basis.

### **Data Infrastructure and Outcome Monitoring**

Participant satisfaction with the electronic platforms was not as positive as satisfaction with the implementation supports and training and certification process. Less than half of all

respondents found the platforms to be easy to navigate and visually appealing. Beyond these immediate observations about functionality, the existing data infrastructure does not support outcome monitoring to its fullest potential. Health service providers implementing SS&A that are publicly funded (e.g., through the Ministry of Health, including Ontario Health and the former LHINs) are obligated to fulfil mandatory reporting requirements with DATIS on a quarterly basis.

Client data from the SS&A screeners, including GAIN-SS, MMS, and POSIT, are all stored in Catalyst, but results from the GAIN-Q3 MI ONT assessment are stored within Chestnut Health Systems' Assessment Builder System (GAIN ABS). Although assessment data are stored in Canada in accordance with the *Personal Health Information Protection Act* (2004), HSPs are not presently able to link unique client records in Catalyst with assessments in GAIN ABS. **Although some recovery monitoring is possible by repeatedly administering the GAIN-Q3 MI ONT assessment using subsequent treatment episodes, these are not cross-referenced with screener results or other client health information. As a result, any outcome or progress monitoring must be performed manually and individually by comparing two or more point-in-time assessments. Moreover, treatment destinations recommended by the GAIN-Q3 MI ONT assessment cannot currently be compared to actual program admissions, though this is possible from a development perspective.**

## EVALUATION QUESTION 5: ARE THERE ANY MODIFICATIONS TO THE SS&A TOOLS OR PROCESS THAT COULD MAXIMIZE SUSTAINABILITY GOING FORWARD?

### PART 1: RECOMMENDED TOOL AND PROCESS CHANGES

#### RESULTS

Service providers offered specific suggestions to improve the SS&A suite of tools. Participants, in general, wanted the tool and process to be “streamlined” (FG17). They suggested being able to skip sections (specifically the School and Work sections), as they found they are not applicable to certain client demographic groups. The Substance Use Grids often arose within discussions regarding skipping sections. Overall, participant comments regarding the substance use grids were mixed, with some indicating the grids provided value, but also add to the length and the repetitiousness of the tool (“The grids are not perfect, but the absence of the grids for us was really challenging because there's such rich information in there.”(FG8)). It was also requested to reformat the online version of the substances use grids to mirror the appearance of the paper version.

As mentioned previously, participants identified concerns with the language used in the tool which could be triggering for clients (“The questions come across as judgmental and victim-

blaming.” (S43); “old judgmental language that is so stigmatizing that we don't even use in the field anymore, like we don't use the word disease to refer to a lot of these experience” (FG20)). Some participants mentioned that the tool prevents clients from identifying their preferred pronoun and requested this be rectified. Some participants also expressed discomfort with the risk behaviour section, requesting that a preamble be developed so they can explain to clients why this section is administered. Although they acknowledged that this was an improvement over the initial version of the GAIN-Q3 MI ONT where risk behaviours and trauma were consolidated into one section, there was still a high-level of discomfort with these items.

Although this evaluation question specifically inquired about factors that could promote sustainability or uptake of SS&A, few respondents offered concrete responses because most said they wanted another tool. However, one participant did make the following suggestion:

“And so what I would like to see is I would love to see us actually standardize the GAIN short screen and the second stage tool, mental health tool, I think they're excellent tools and develop a new tool that's actually about that is focused on treatment or care streaming” (FG17)

Two other participants suggested exploring the tools and criteria used by the American Society of Addiction Medicine (ASAM) and the Stepped Care 2.0© (SC2.0) model. Both of these are further described below. Lastly, another participant suggested having a tool that is used in conjunction with a narrative assessment, and matches up with available services to support system navigation or wayfinding.

Clinicians reported that validation errors could be difficult to correct expediently. They mused if it would be possible to make this more efficient.

## **DISCUSSION**

Changes to the SS&A tools, and in particular the GAIN-Q3 MI ONT assessment, are incorporated as language evolves, but changes must be made in collaboration with CHS as the tool owner. Minor updates have been made in the past to respond to feedback, and a larger tool redevelopment was undertaken in 2017-18 to separate the risk behaviours and trauma sections. Because of the sampling limitations associated with this evaluation, suggested changes above should be reviewed in consultation with the addiction sector to determine what changes, if any, should be prioritized for development.

## **PART 2: SUSTAINABILITY**

### **RESULTS**

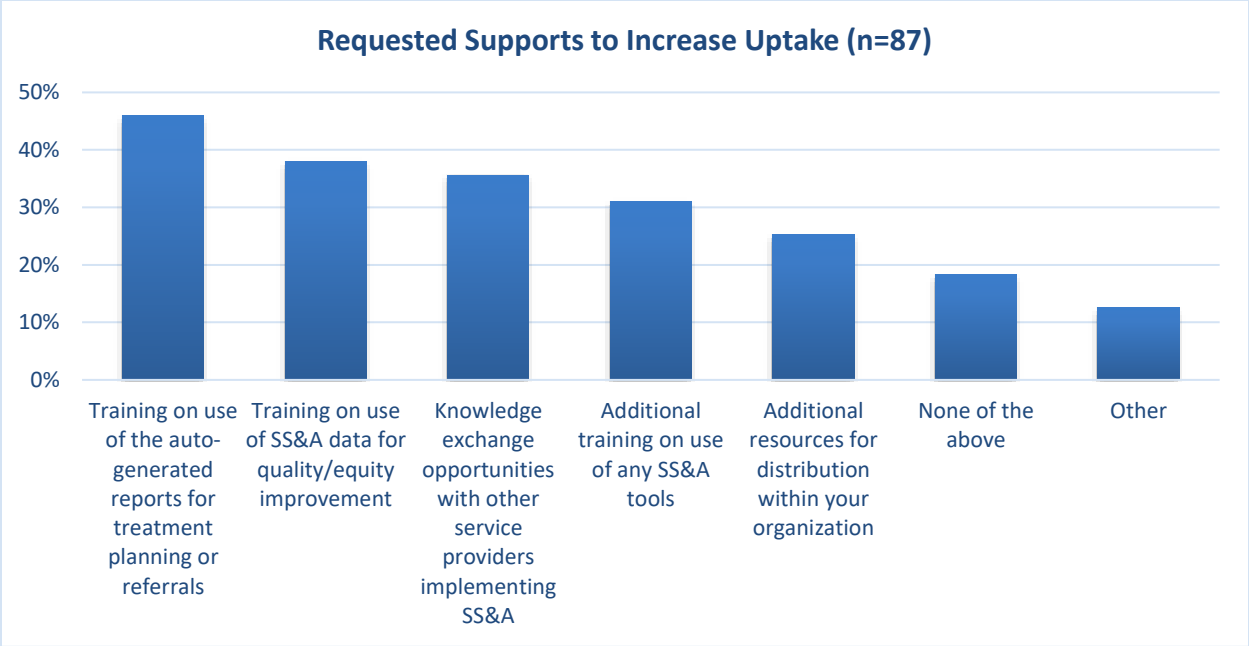
When reflecting back upon their implementation experience, service providers in focus groups discussed what had supported successes both within their agencies, and more broadly in the sector, as well as what had created challenges. They also acknowledged adaptations that had been made since initial implementation.

**Participants spoke to the benefits of having supportive leadership, who recognized and supported the time for training and for the process** (“So it's already a very high stress job and so kind of really changing the entire way you do assessment, I think it threw a lot of us for a loop and so there was a lot of patience, There is a lot of time spent for us to learn the ins and outs of the tool, A lot of times spent in supervision.” (FG15)).

**The role of champions, both internal to their own agency and external, was recognized by respondents as helpful to gaining buy-in for the SS&A process** (“... we had a couple of ... long time well-respected executive directors out in the field at two different agencies who became kind of early champions, And were good about spreading the word ...” (KII2)). Some respondents also identified that education on the rationale for SS&A would be helpful to increase buy-in.

The SS&A process also aligns with emerging sector priorities, including Ontario Health Teams and centralized/coordinated access models. For example, the screening tools could be used as part of integrated care delivery in OHTs, such as in primary care settings. Additionally, one key informant interviewee identified future opportunities for data use with system level initiatives:

“... the mental health and addiction sector is trying to move towards this idea of measurement based care. We're able to actually monitor and keep track of that client journey along the way... what [does] this measurement based care piece and the data digital work that's happening look like and how can SS&A link into that...?” (KII1)



Survey participants were asked to identify what supports would aid in increasing uptake of SS&A. The most frequently selected option, with 46% (n=40) requesting “Training on the use of auto-generated reports”, followed by “training on use of SS&A data for quality/equity improvement” (38%, n=33).

This evaluation reaffirmed many known health human resource issues in the addiction sector. Staff retention and turnover leads to frequent (re-)training and certification, and Site Interviewers may not use the tools often enough to develop proficiency in their administration.

“I guess some of the implementation challenges for us have been staff retention more so, it's a human resource management issue. So we get people trained and then they leave the job and then we can't seem to get a new person in for whatever reason.”  
(FG9)

**DISCUSSION**

While the evaluators did not expect participants to bring examples of other tools to the focus groups, it is noteworthy that other substance use assessments were not specifically mentioned during the data collection phase aside from what is discussed here. However, several other participants considered the GAIN-Q3 MI ONT duplicative as they referenced in-house biopsychosocial assessments.

One participant referenced the tools and criteria used by the American Society of Addiction Medicine (ASAM), based in Rockville, Maryland. Currently developing the fourth edition, the [ASAM Criteria](#) is a multidimensional biopsychosocial assessment that determines a

client’s level of appropriate care across a continuum of services. The assessment is administered using an electronic platform called [ASAM Continuum™](#), which produces a computer-guided, structured interview. Research related to the ASAM Criteria and its implementation spans two decades, and ASAM regularly publishes clinical guidelines on priority practice topics. As part of its [copyright](#) and fair use policy, ASAM requires that the criteria be implemented comprehensively and with fidelity to ensure adherence to the evidence-base.

A second participant referenced the [Stepped Care 2.0©](#) (SC2.0) model, which is “an innovative, evidence-informed model for organizing mental health and addictions services into a co-designed, flexible system of care.”<sup>19</sup> The SC2.0 model is organized around nine steps, ranging from self-directed access to information to acute care, case management, and systems navigation. SC2.0 is owned by Stepped Care Solutions, a not-for-profit consultancy group based in Mount Pearl, Newfoundland and Labrador, and has been implemented in Newfoundland and Labrador, Northwest Territories, and Nova Scotia in partnership with the Mental Health Commission of Canada. The participant who suggested this model encouraged the evaluators to explore with the implementation team how the SS&A tools and process could fit into a stepped care model, where the focus is on “client response and preference” rather than “symptom-based, one-size-fits all rigid treatment protocols.”<sup>20</sup>

During focus group analysis, a concern emerged that the GAIN-Q3 MI ONT assessment tool is not culturally appropriate for Indigenous clients, and one person said it is not culturally safe. This observation can be traced back to the initial SS&A pilot, specifically the one year renewal in 2013-14 where the project working group examined the data from the phase 1 pilot, refined the staged approach based on feedback, and planned for provincial scaling pending further funding. In October 2013, First Nations, Inuit, and Métis partners met with members of the project working group to discuss important considerations related to cultural appropriateness and adaptation of screening, assessment, and outcome measures. As reported in the phase 2 final report,<sup>21</sup> “the cultural adaptations of existing tools do not adequately address [First Nations, Inuit, and Métis] system needs with regards to culturally appropriate substance use and addiction treatment tools. Consequently, a proposal to develop a new

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<sup>19</sup> <https://steppedcaresolutions.com/methodology/>

<sup>20</sup> <https://steppedcaresolutions.com/methodology/>

<sup>21</sup> Rush, B., Chau, N., Tan, F., Ehtesham, S., Schell, C., & Baker, K. (2016). *Drug Treatment Funding Program 2013-14: Best Practice Screening and Assessment Project Final Report*. Toronto, ON: Centre for Addiction and Mental Health. <http://improvingystems.ca/img/SSA-Phase-2-Final-Report-2016.pdf>

trauma-informed substance use treatment screening and assessment tool for the [First Nations, Inuit, and Métis] populations was submitted and approved as part of the 2014-2016 DTFP package” (p. 39). At the time of writing, Shkaabe Makwa at CAMH continues to develop this tool, and has supported GAIN-Q3 MI ONT implementation with Indigenous organizations with amendments to the training for cultural considerations.

Rabin and Brownson (2017) defined sustainability as “the extent to which an evidence-based intervention can deliver its intended benefits over an extended period of time after external support ... is terminated” (p. 26).<sup>22</sup> Support from organizational leaders as well as system-level support for the intervention can promote sustainability, but the results of this evaluation suggest that this is occurring in limited service settings. There continues to be extensive resistance toward the SS&A tools, particularly the GAIN-Q3 MI ONT assessment, which detracts from sustainability regardless of other supports that are in place. Usage is unlikely to increase without continued implementation supports provided by PSSP. Additionally, the mandate letter issued in 2015 should be revisited by policymakers, likely by reinforcing its applicability across the sector. In its current state (in effect but not enforced), it further undermines implementation efforts and contributes to a perception that tool administration is in fact optional.

For most implementing organizations, adopting the SS&A tools and process as intended required them to evaluate their operations, clinical practices, and referral pathways and partnerships. SS&A illuminated the interconnectedness of the addiction sector. Using SS&A as a discussion point, there are opportunities to identify future cross-organization/regional partnerships and alignment with other provincial initiatives in the sector, which is timely with the development of Ontario Health Teams and coordinated access models.

## CONCLUSIONS

## RECOMMENDATIONS

The following recommendations are based on the information provided by participants in this evaluation, subject to the limitations noted at the end of this report. They also take into account the historical context associated with prior attempts to introduce standardized assessment tools into the addiction sector. Calls to implement an initial standardized assessment in Ontario’s addiction sector have existed since the Marshman Report in 1978

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<sup>22</sup> Rabin, B.A., & Brownson, R.C. (2017). Terminology for dissemination and implementation research. In R. Brownson, G. Colditz, & E. Proctor (Eds.), *Dissemination and implementation research in health: Translation science to practice* (Vol. 2, pp. 19-45). doi:10.1093/oso/9780190683214.003.0002



(cited previously), which resulted in establishing dedicated assessment and referral centres across the province in the 1980s. However, as the number of assessment centres increased, so too did the variability of assessment tools and practices. Implementation of the Assessment and Discharge Tools and Criteria in the early 2000s was the first attempt to standardize the initial assessment process across the province, and SS&A continues to expand upon this vision identified by Marshman almost 45 years ago.

The evaluation findings align with those in the prior ADTC evaluation and may reflect broader challenges associated with system barriers and/or implementing standardized assessment tools rather than the tools themselves. Historical findings associated with the perceived interchangeability of screening and assessment tools, an overreliance on clinical judgement to the exclusion of standardized tools, administering the assessment only by client request, and use of the assessment tools for administrative purposes *after* a treatment decision has been made, all warrant caution in attributing these findings solely to the SS&A tools themselves. If a decision is made to pursue alternative tools because of broader system considerations, the history of implementing standardized tools in this sector, such as with the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) and ADTC, suggest that another tool could experience similar implementation challenges and outcomes.<sup>23</sup>

Recommendation	Description
1. Revisit the implementation scope criteria for SS&A and restate the mandate with some additional language.	Owing to the substantial variation in usage across all tools, programs, service types, organizations, and regions, this is the primary recommendation as a foundation of ongoing implementation. The mandate communication should include a clear expectation to use the staged process and any associated accountability mechanisms. Acceptable exceptions and related alternative measures should be clearly articulated for a shared and consistent understanding. Consider establishing a provincial “go-live date” similar to what the former North East LHIN did in March 2019, which further bolstered certification and GAIN-Q3 MI ONT tool usage.

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<sup>23</sup> Rush, B., Ellis, K., Allen, B., & Graham, K. (1995). Ontario treatment system research 1979-1993: What have we learned about assessment and referral services in terms of the original expectations? *Contemporary Drug Problems*, 22(1), 115-136. doi:10.1177/009145099502200109

<p>2. A) Target high-volume implementing organizations to identify specific factors associated with their successful uptake.</p> <p>B) Target high-volume implementing Site Interviewers to identify specific factors associated with their clinical practices and organizations that allow them to administer the tool regularly and develop proficiency.</p> <p>C) Target health service providers providing support to structurally marginalized client populations to explore if and how the SS&amp;A tools and protocol further health inequities.</p>	<p>Considering 10 organizations are responsible for 46% of all GAIN-Q3 MI ONT assessments over the past six fiscal years, there are likely commonalities among this group of health service providers that should be elucidated to inform ongoing implementation and sustainability.</p> <p>This recommendation is based on data showing that about 10% of the clinicians trained over the lifetime of this initiative complete 80% of all assessments. These Site Interviewers may have developed unique strategies that support mastery of the tool. In addition, they may be employed in organizations identified in recommendation #2A, which will further illustrate organizational factors.</p> <p>In conjunction with recommendations #2A and B, engage service providers to identify how the SS&amp;A tools and process may further health inequities for marginalized populations, any mitigating strategies currently in use, and any remaining gaps to be addressed.</p>
<p>3. Reserve the need to establish a target assessment rate until the recommendation #1 is implemented.</p>	<p>Target implementation rates have been challenging to establish throughout this initiative for the reasons identified in that particular discussion section. However, tool usage should continue to be monitored monthly to identify trends and emerging patterns. For example, the 10 organizations identified in recommendation #2A collectively achieved a 33% assessment rate during the 2021-22 fiscal year, and peaked at 38% prior to the pandemic. This demonstrates that progress beyond the current 20% is achievable, but between-agency variation presently limits the establishment of a universal target rate.</p>
<p>4. A) Work with addiction sector partners to reaffirm why each</p>	<p>The theme <i>disconnect between implementation policy and practice</i> discussed in this report was substantial,</p>

<p>component of the staged protocol exists, how they align with the original purpose and goals of SS&amp;A, and the long-term benefits they offer to the addiction sector.</p> <p>B) Develop and provide training on use of SS&amp;A data for quality and equity improvement opportunities</p>	<p>reflecting significant deviation from the SS&amp;A protocol as originally conceptualized. It is critical that service providers recognize the value of the tools and process if broader visions for outcome monitoring and needs-based placement are to be realized.</p> <p>Respondents noted that training on this item could assist with sustainability, especially with the recent launch of the provincial SS&amp;A reports.</p>
<p>5. A) Reiterate the role of the second stage (mental health) screeners in the SS&amp;A process, or establish legitimate exemption criteria for this stage of the protocol.</p> <p>B) The role and purpose of POSIT in the staged protocol should be re-evaluated.</p>	<p>Data show that use of the MMS and POSIT is lowest among all tools in the staged protocol. This may be attributed to clients already having established mental health supports, but may also reflect an unacceptable variation from the intended SS&amp;A process. The role of the second stage screeners should be reaffirmed, based primarily on the research and development and pilot work where the need to better identify concurrent disorders was identified.</p> <p>POSIT is arguably the weakest link in the SS&amp;A protocol, and participants working with youth expressed great dissatisfaction with it. Implementation data support this sentiment, validating that it is rarely used by service providers. A literature review and environmental scan should be undertaken to identify new tools that could serve the same purpose as POSIT in the staged protocol. Partners at Youth Wellness Hubs Ontario (YWHO) could inform this work.</p>
<p>6. Reemphasize that the treatment planning component, including the auto-generated reports, is an essential component of the staged process that benefits</p>	<p>Respondents in this evaluation noted that data obtained through the clinical interview were deemed not to have high value, including for treatment planning purposes. Considering this alongside the sentiment that the tool is a data-collection exercise for research purposes, it is fundamental to reiterate its purpose for treatment</p>

<p>clients and clinicians when placement matching occurs as intended.</p>	<p>planning. Otherwise, Site Interviewers will remain stuck in a loop where the tool is only used for referral to bed-based services, which reinforces that it is unnecessarily complex for this purpose alone, where the Q3RRS is not necessarily being used to customize treatment by the referral recipients. Bed-based service providers should be included in all future discussions about SS&amp;A, as they have historically not been in their role as referral recipients only.</p>
<p>7. Work with implementing organizations to reprise the client engagement activity of 2017 to complement clinician perspectives.</p>	<p>In this evaluation, client feedback was indirectly obtained via participants from implementing organizations. All client feedback was reported through agency respondents. These respondents expressed concerns that the length of the GAIN-Q3 MI ONT assessment tool, some of its questions, and its repetitive nature all detracted from the therapeutic alliance. If exploring ways to shorten the assessment tool, an updated client perspective should be validated since efforts to obtain client feedback as part of this evaluation were not reportable.</p>
<p>8. Develop training and resources to support virtual administration of the SS&amp;A tools and process, and provide implementation support to this effect.</p>	<p>This recommendation was based on the finding that virtual administration was the most common modification made to SS&amp;A implementation. Virtual care will continue to serve a prominent role in health care delivery, and implementation support should be tailored to the unique requirements associated with implementing SS&amp;A as intended.</p>
<p>9. A) Training should better emphasize the clinical applicability of information collected from the assessment rather than just the administration process.</p>	<p>Respondents noted that this was a gap in the existing training, which emphasized administration of the tools rather than how this information could be incorporated clinically. While adding training content would increase the time commitment, it should address this observed gap in the existing training modules.</p>

<p>B) Work with organizations and Site Interviewers to reaffirm how semi-structured interviewing principles apply to the assessment.</p>	<p>Evaluation data demonstrated that many clinicians perceive that the GAIN-Q3 MI ONT assessment should be administered as a structured interview, which is not the intent. The GAIN-Q3 MI ONT assessment is not a structured interview like the Structured Clinical Interviews for DSM Disorders (SCID-5), for example, though it seems to be interpreted as such.</p>
<p>10. Continue to raise awareness of existing SS&amp;A resources and knowledge exchange products.</p>	<p>The survey question around awareness of existing implementation support resources received the highest N/A rate across the entire evaluation. These are valuable resources in variety of formats that may mitigate known implementation barriers experienced by organizations.</p>

**LESSONS LEARNED**

**Tool criticisms and recommended tool changes were variable and were provided within the context of substantial administration variability**

The tool criticisms and changes recommended by participants cannot be extrapolated from the broader context in which implementation data show they have been administered. The discussions throughout this evaluation conveyed administration variability, process modifications, varying perceptions of the purpose of assessment, and the perception that this is a data collection tool that interferes with clinical judgement, which all perpetuate an implementation environment where the full staged protocol is not being used as originally intended. This environment must be investigated further, which will occur as part of adopting the above recommendations, in order to prioritize tool or process changes.

**Certain client populations are more challenging to administer the assessment with**

This is a complex topic because participants did consistently identify populations that were more challenging to administer the GAIN-Q3 MI ONT assessment with. This is to be expected in some cases, as noted in CHS’ GAIN-Q3 manual as well as the ADTC manual. If a client is persistently unable to complete the assessment, there may be questions about their suitability for certain programs. Developing formalized exemption criteria would require extensive discussion and consultation and an alternative tool or referral process would likely be required in these circumstances.

## Duplicate data entry and lack of interoperability limits the transfer of Catalyst and GAIN ABS data to client health records

Some respondents commented on the duplicate data entry associated with using Catalyst and a third-party platform such as Cerner, Meditech, Epic, EMHWare, or CaseWORKS. A lack of interoperability limits the transfer of existing health record data into Catalyst and vice-versa. Moreover, true outcome monitoring is not feasible using the current set up since SS&A screener data are not cross-referenced with GAIN ABS assessment data, but this will be an important future direction to focus on. As these topics continue to gain a foothold as part of the health system modernization, these known issues affecting the addiction sector must be addressed, particularly related to outcome monitoring and system-level planning.

## Competing sector priorities and sustainability

Sustainability planning is critical to the long-term success of any project or initiative, especially when external implementation supports are removed. In 2019, Ontario Health Teams were announced and many health service partners are also involved in discussions or amalgamations related to this broader health system transformation. Multiple initiatives occurring at the same time can impact the engagement of, and ability for, project partners to dedicate human resources to any singular initiative. Support from organizational leaders as well as system-level support for the intervention can promote sustainability, but the results of this evaluation suggest that this is occurring in limited service settings. There continues to be extensive resistance toward the SS&A tools, particularly the GAIN-Q3 MI ONT assessment, which detracts from sustainability regardless of other supports that are in place.

## LIMITATIONS

The primary limitation of this evaluation was the sampling strategy. This was not a representative sample, and organizations were able to forward the survey to as many staff as they wanted to. This led to overrepresentation of some organizations and underrepresentation of others relative to their size and assessment volume. Coordinated access models were not represented in the sample, which may have negatively influenced responses to questions regarding community or regional impacts. This evaluation did not capture the organizations who have never implemented the SS&A process, which could have provided critical insights as to why this is the case. Additionally, because we did not translate the recruitment and data collection tools into French, it is possible that participation by this group was limited. Geographic representation among participants was unevenly distributed across OH regions, with underrepresentation in OH Central. Seven of the top 10 organizations that administer the most GAIN-Q3 MI ONT assessments by volume participated in one or both components of this evaluation. This is important to note since, as mentioned previously, these 10 organizations

collectively administer 46% of all assessments in Ontario. Therefore, while the overall sentiment throughout this evaluation was negatively skewed, it is worth recognizing that the organizations most likely to be muffled in the service provider data are also the ones administering the most assessments. Many participants acknowledged a lack of experience using the tool for purposes other than bed-based referral. These top 10 organizations, with more demonstrated experience administering the assessment, and ipso facto, greater levels of administration outside of bed-bed referrals only, were the minority.

As the intermediary program responsible for SS&A implementation, PSSP was admittedly in a position of bias by also leading this evaluation, but this was necessary because of the timeline and complexity. Two evaluators co-led all aspects of the evaluation in order to mitigate actual or perceived bias.

Lastly, it is important to acknowledge that the COVID-19 pandemic potentially affected evaluation participation. The survey launch and initial focus group recruitment both occurred in January, during Ontario's Omicron wave. As a result, this challenging and competing priority may have limited respondents' capacity to participate.

## CONTACT INFORMATION







For more information about SS&A, please visit the initiative web site at <http://improvingystems.ca/projects/provincial-screening-and-assessment>. Please direct specific questions about the initiative or this evaluation report to [ssa@camh.ca](mailto:ssa@camh.ca).

## KEY REFERENCES

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 Toronto, ON: Centre for Addiction and Mental Health.  
<http://improvingsystems.ca/img/SSA-Phase-2-Final-Report-2016.pdf>

## ADDITIONAL RESOURCES

SS&A Core Components (Practice Profile)	 SS&A Practice Profile.pdf
SS&A Mandate Letter from the Ministry of Health and Long-Term Care (October 2015)	 Memo re Mandating new adc
Opioid De-Implementation Initiative: Pilot Implementation of SS&A in Primary Care	 SSA-Opioid-Evaluation-Report.pdf
SS&A Implementation Guide (Last Revised January 2022)	 SSA Implementation Gui
SS&A Research and Development and Phase 1 Pilot Implementation Report (2013)	 SSA-Research-and-Development-Final-
SS&A Phase 2 Pilot Implementation Report (2016)	 SSA-Phase-2-Final-Report-2016.pdf



APPENDIX A: SUPPLEMENTARY CHARTS

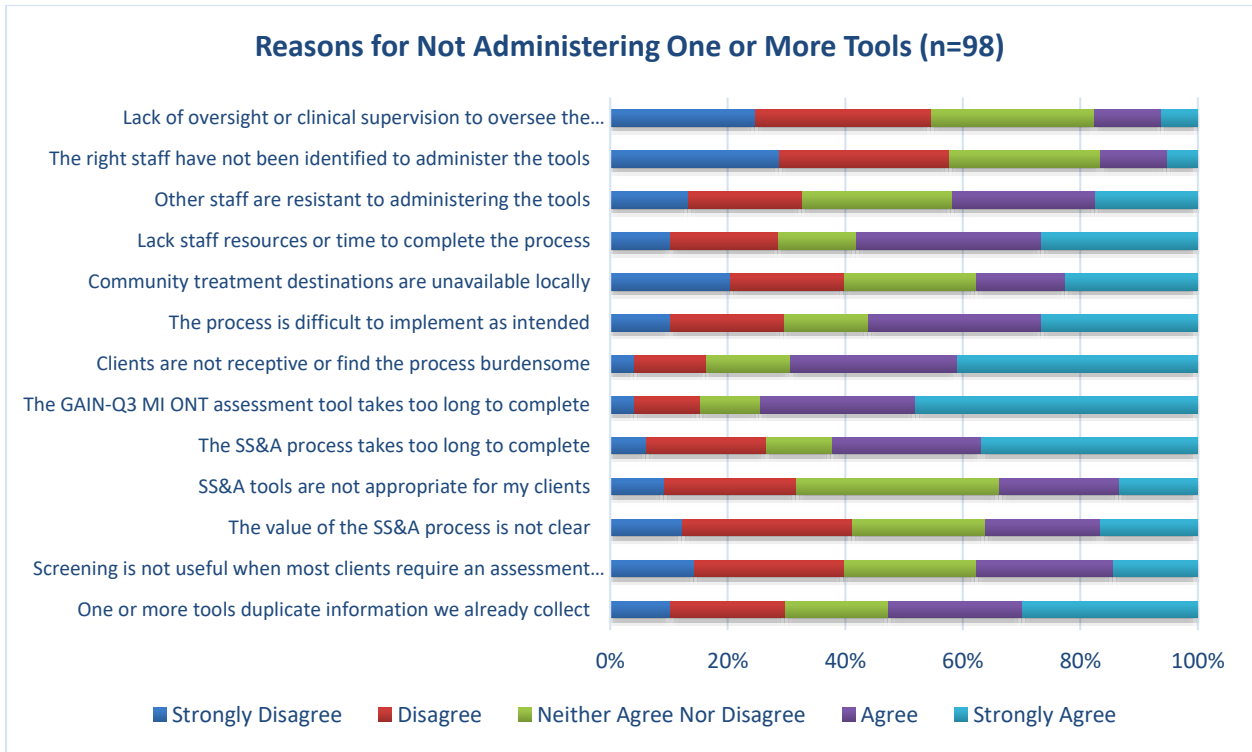


Figure 1: Stacked bar chart of reasons for not administering one or more tools

### Intended and Unintended Outcomes (n=96)

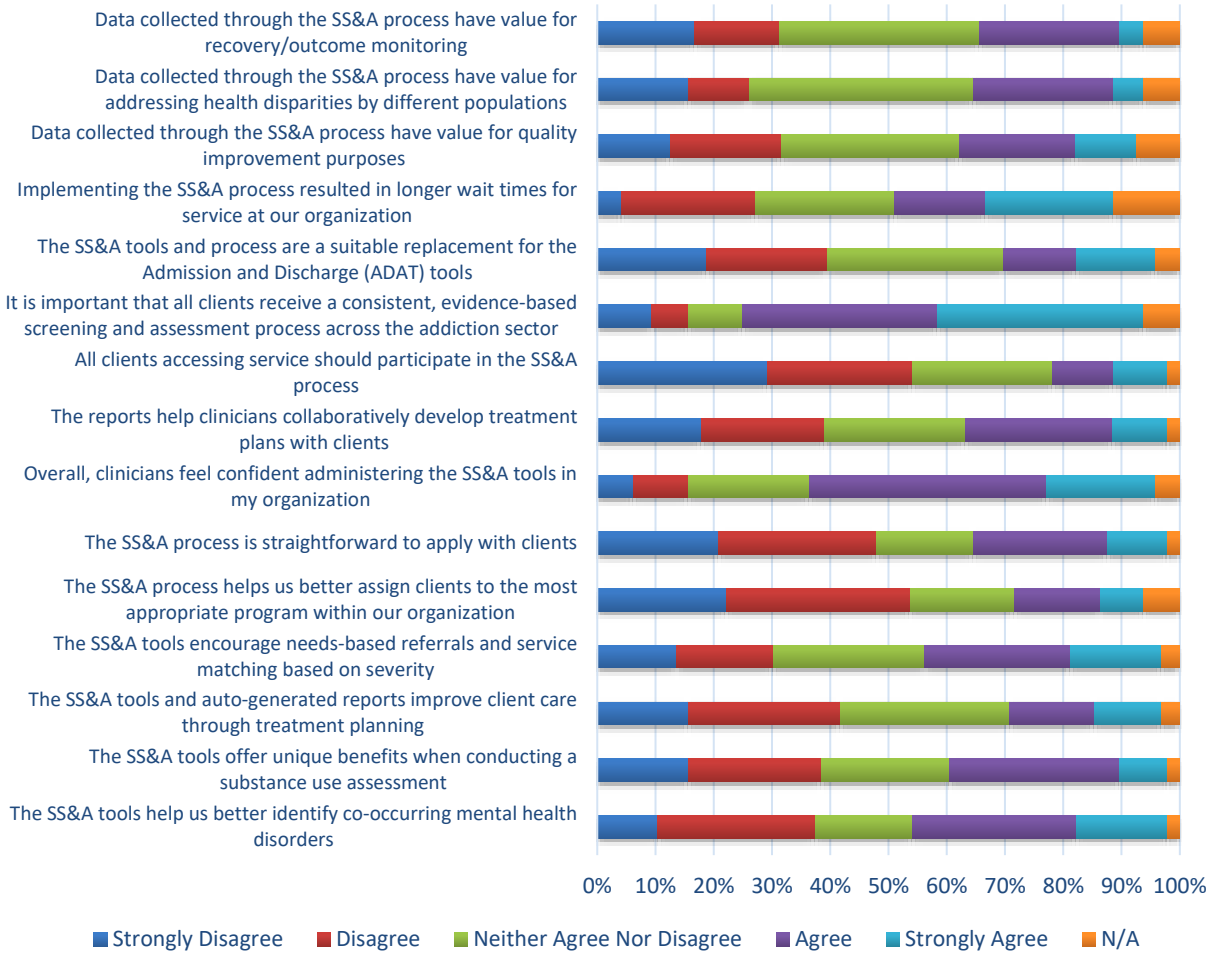


Figure 2: Stacked bar chart of impacts of introducing SS&A within organizations

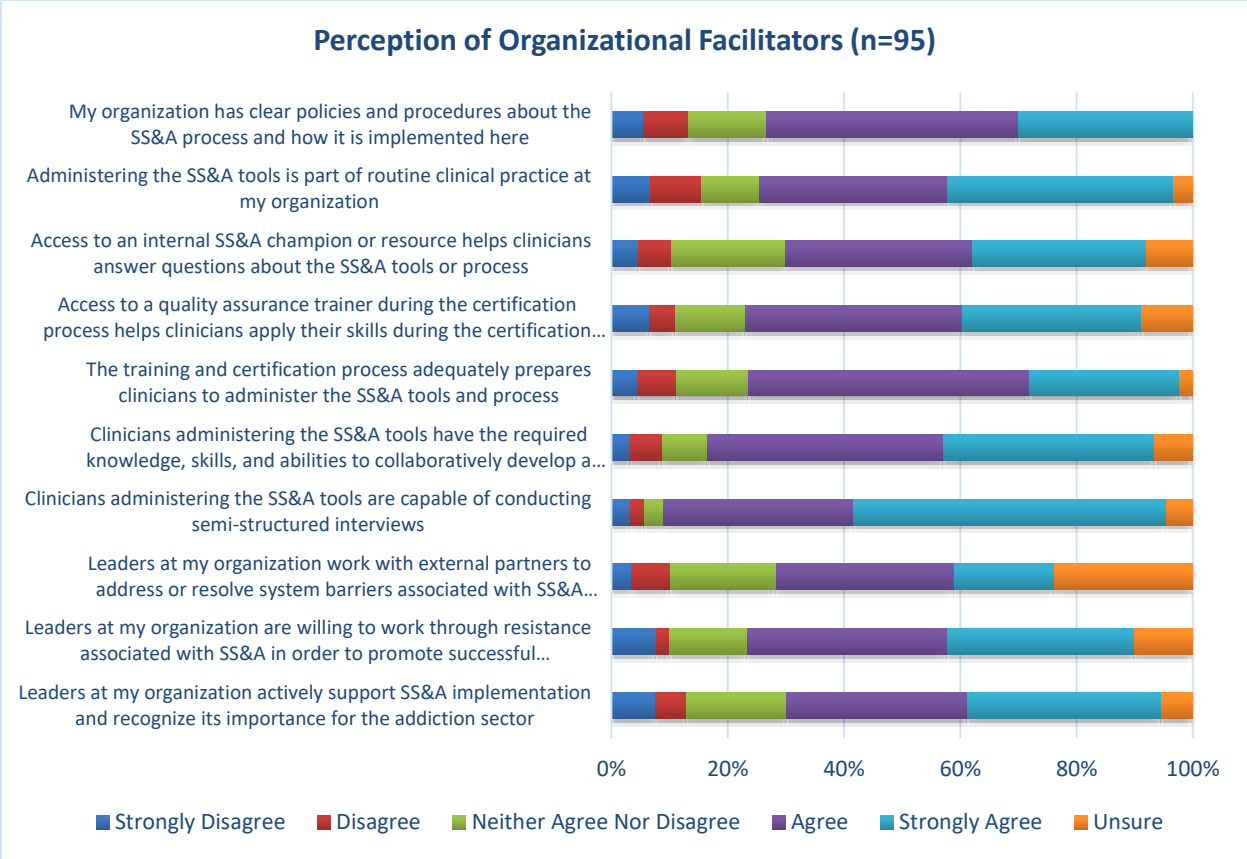


Figure 3: Stacked bar chart of organizational facilitators

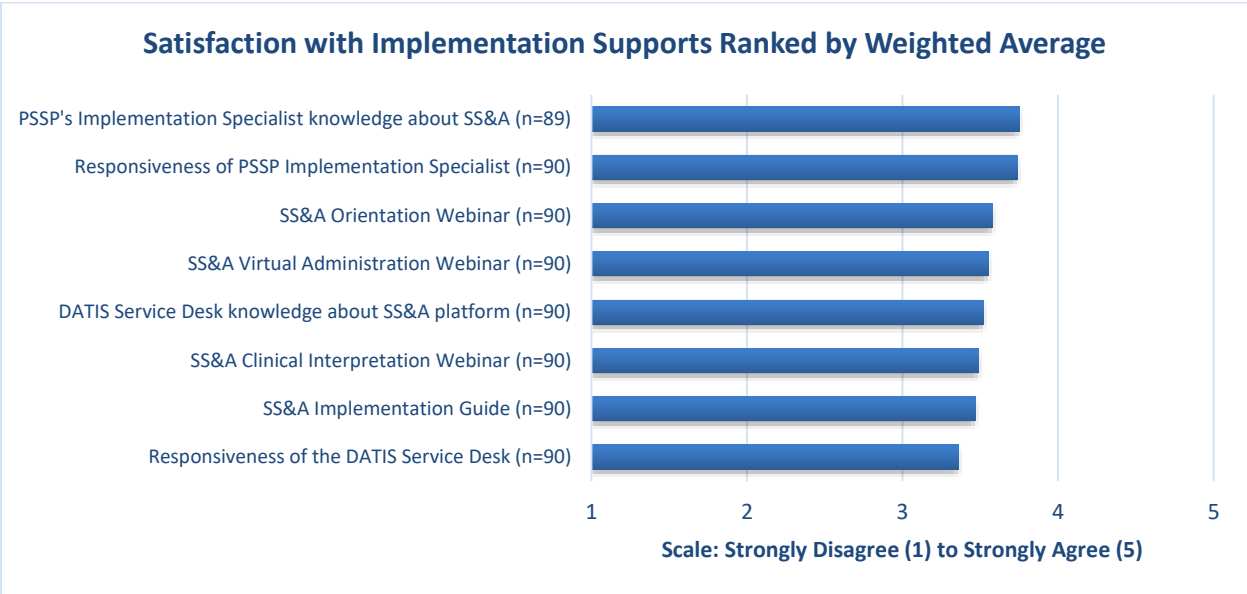


Figure 4: Weighted average of satisfaction with implementation supports

### Satisfaction with Training and Certification (n=91)

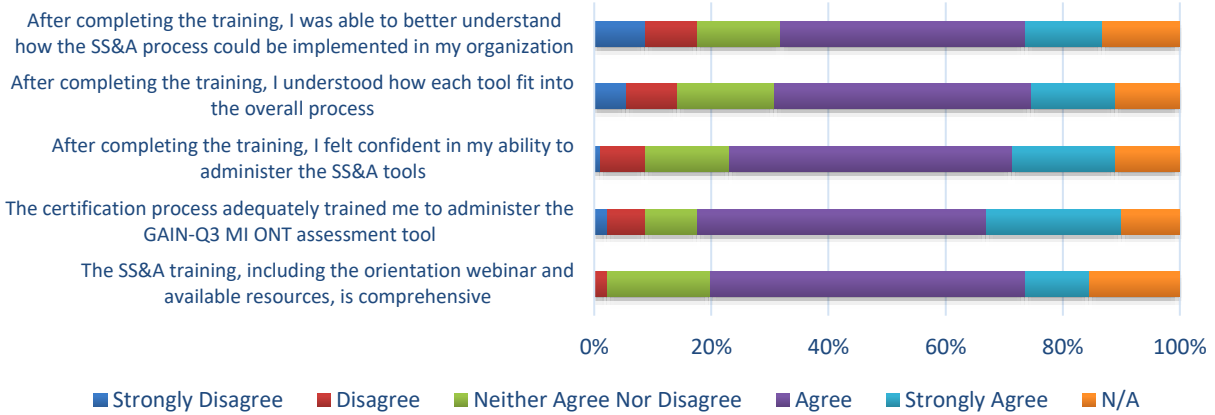


Figure 5: Stacked bar chart of satisfaction with training and certification

### Satisfaction with Electronic Platforms (n=91)

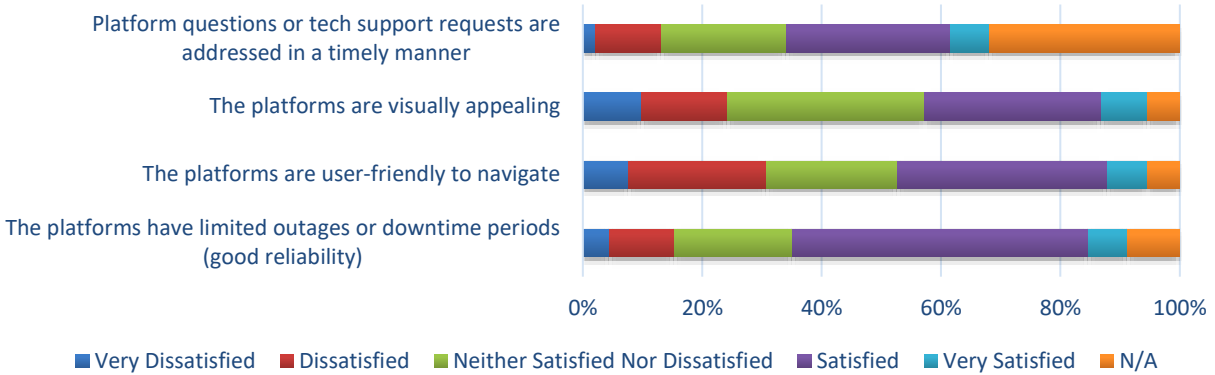


Figure 6: Stacked bar chart of satisfaction with electronic platforms

## APPENDIX B: SUPPLEMENTARY IMPLEMENTATION DATA

### IMPLEMENTATION TIMELINE

The following table highlights critical SS&A implementation milestones.

Date	Implementation Milestone
2011-2013	Health Canada's Drug Treatment Funding Program (DTFP) funded 12 projects in Ontario, including SS&A.
2011-2012	An environmental scan was conducted by approaching all publicly-funded addiction treatment agencies listed in ConnexOntario. In total, 82 different programs from 53 agencies completed the survey.
2012-2013	A broad range of audience groups were engaged in the planning stages via an overall Program Advisory Committee and a Working Group.
2012-2013	The Program Advisory Committee and Working Group selected the tools based on a literature review of existing screening and assessment tools and a site visit to Chestnut Health Systems in Illinois.
2012-2013	Five organizations participated in a pilot project to evaluate the feasibility of the new staged screening and assessment process. Across all five sites, 55 staff (including clinicians and administration) were trained. In the end, 234 clients were enrolled into the study.
2013-2014	Health Canada announced a one-year renewal of DTFP. During this time, project staff focused on refining the staged approach based on feedback and analysis from the pilot study and planning provincial implementation of the tools and protocol.
2013-2014	The research team began to work closely with PSSP to develop a provincial dissemination plan using the principles of implementation science. CAMH prepared a proposal for DTFP funding for 2014-2016 that would replace the ADAT tool package with SS&A. At the same time, infrastructure development was well underway via DATIS and Chestnut Health Systems to support tool administration.
2015-2016	A <a href="#">new round of DTFP funding</a> supported 11 projects in Ontario, including SS&A. Objectives were to implement a new staged process for screening and assessing clients receiving substance use services, and provide coaching, fidelity monitoring, evaluation, and sustainability planning as part of the implementation process. PSSP's initial implementation staff were hired and assigned. Licensing agreements were signed with Chestnut Health Systems to access the GAIN suite of tools. The first training sessions with health service providers occurred in November 2015.
2016-2017	Based on readiness assessments and planning with former LHIN Mental Health and Addictions Leads, implementation scaled across Ontario by region. LHIN regions were onboarded in stages.
March 2017	PSSP's Evidence Exchange Network hosted the final DTFP knowledge exchange event on March 13 <sup>th</sup> . Funding for future implementation support transitioned to the former Ministry of Health and Long-Term Care during the 2017-18 fiscal year via PSSP's Transfer Payment Agreement.
September 2017	After nearly two years and 116 in-person training sessions, a more sustainable web-based model was adopted in September. By this time, 1,271 clinicians had attended training and 754 clinicians were certified to administer the GAIN-Q3 MI ONT assessment tool as Site Interviewers. There were 101 certified Local Trainers across Ontario, including members of the PSSP implementation team. There were 154 organizations in scope for implementation: 76 completed implementation plans, 60 were in the planning process, and 18 were not engaged.
September 2018	As online training continued, there were now 1,004 certified Site Interviewers. The number of in-scope organizations increased to 164. Implementation plans were completed by 79, in progress by 61, and 24 organizations were not engaged in any planning with the PSSP team.

2019-2020	<p>Early indicators of Local Trainer attrition continued to compound during 2018 and the PSSP implementation team worked to develop mitigation strategies and plans.</p> <p>Citing actual and potential referral barriers from correctional facilities, representatives from the Ministry of the Solicitor General (formerly Ministry of Community Safety and Correctional Services) began discussions with the Ministry of Health and PSSP about implementing the GAIN-Q3 MI ONT assessment tool in correctional centres, jails, and detention centres. A pilot with five primary care sites as part of an initiative to de-implement low value opioid prescribing practices also occurred. As of March 31, 35,759 GAIN-Q3 MI ONT assessments had been started or completed.</p>
2020-2021	<p>In collaboration with the Ministry of the Solicitor General, implementation with four correctional institutions occurred in 2020. As of March 31, 44,184 GAIN-Q3 MI ONT assessments had been started or completed.</p>
2021-2022	<p>The Provincial Training Model (PTM) was implemented in November 2021, offering a more equitable and sustainable approach to certifying Site Interviewer candidates across Ontario. As of fiscal year end, 53,203 GAIN-Q3-MI ONT assessments had been started or completed.</p>

## PROVINCIAL TRAINING MODEL

To improve timely access to training across the province, PSSP implemented a Provincial Training Model (PTM) in November 2021. Data based on 1,643 certified Site Interviewers were analyzed to construct a baseline for a future PTM evaluation. This analysis excluded an additional 533 clinicians who discontinued the training process prior to completing certification. Results showed that 45% of all candidates achieve Site Interviewer certification before the recommended 3-month deadline, ranging from a low of 38% in the former North West LHIN region to a high of 58% in the former Erie St. Clair LHIN region. However, the percentage of certified Site Interviewers increases to 65% within four months, 75% within five months, and 99% within eight months. The median time to certification was 98 days and the mean time to certification was 119 days (approximately four months). These data are represented in the boxplot that follows. Eighteen certified Site Interviewers were excluded because of missing data. Analysis by quartiles suggests that after 250 days (approximately eight months), clinicians still achieve certification but are statistical outliers relative to their peers.



Figure 7: Box-and-whiskers plot of certification time

## RISKS, ISSUES, AND POSITIVE IMPACTS

In implementation science, “implementation drivers are the components of infrastructure needed to develop, improve, and sustain the ability ... to implement an innovation as intended as well as create an enabling context for the new ways of work.”<sup>24</sup> Since the exploration phase of implementation, the PSSP implementation team used a tracking tool known as the Risks, Issues, and Positive Impacts Log (RIPIIL) to monitor implementation barriers and successes. Individually, the RIPIILs allowed implementation staff to work with organizations to address implementation barriers as they relate to specific implementation drivers. Collectively, the RIPIILs were used by the implementation team to identify and respond to barriers commonly occurring across multiple implementation sites.

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<sup>24</sup> <https://nirn.fpg.unc.edu/module-2/implementation-drivers>

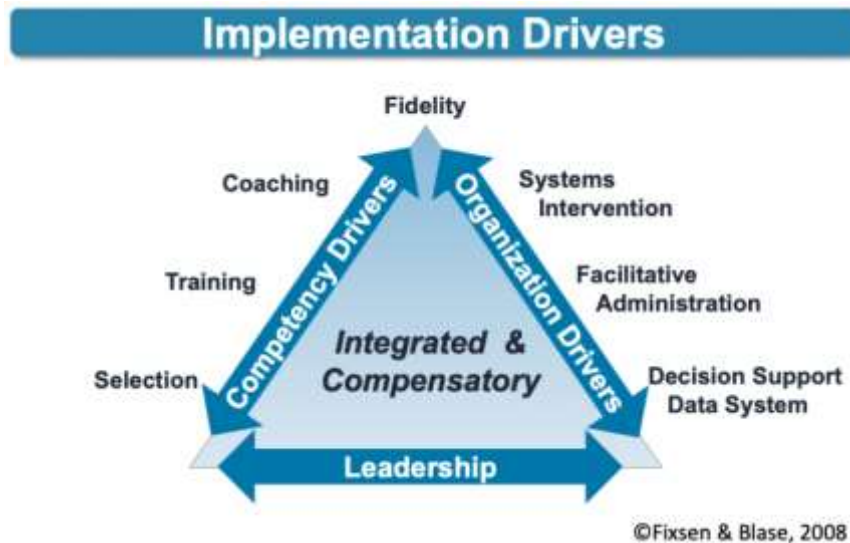


Figure 8: Implementation Drivers<sup>25</sup>

When implementation began in 2015 and 2016, RIPILs highlighted the training, selection, and decision support data systems drivers. Because training opportunities were limited and deployed in a staged fashion, organizations were supported to identify and select the right clinicians to attend. In turn, the training process was revised was PSSP iteratively in response to participant feedback. Many organizations required coaching to implement the staged protocol in Catalyst, and some were onboarded to the platform for the first time.

In 2017, RIPILs highlighted discussions around scope, potential Local Trainer attrition, and a training-implementation gap. First, several organizations indicated that the GAIN-Q3 MI OMT or the staged protocol did not apply to their operational structure or programming. As these were LHIN funded addiction organizations, they could not opt-out of the mandated process. Second, eight Local Trainers were lost across four LHINs because of conflicts between their own roles and the required time commitment. Trainers in other LHIN regions were not able to manage a full Quality Assurance caseload for the same reasons. Furthermore, capacity within Francophone services was diminished in both Champlain and North East LHINs due to limited Local Trainer availability. Lastly, organizations continued to train and certify staff but did not implement the staged protocol or assessment tool in a business-as-usual fashion. Without regular administration, certified Site Interviewers risked losing competency to conduct the assessment interview with fidelity. High staff turnover rates and a growing waiting list for training also compounded this issue.

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<sup>25</sup> <https://nirn.fpg.unc.edu/module-2/implementation-drivers>



In 2018, implementation drivers at the system level became more prominent. Local Trainer attrition continued to be an issue, and several trainers disengaged having completed the required two-years of service under the initial agreements signed with CAMH. Early discussions began around the possibility of discontinuing the ADAT suite of tools, which was met with concern among some implementing organizations because of the system implications. Because ADAT was still being used for referral to bed-based services, and PSSP had not yet achieved a critical mass of Site Interviewers in some LHIN regions, discontinuing ADAT could have imposed access-to-treatment barriers. Instead, organizations were encouraged to discontinue using ADAT once their staff had become certified to administer the GAIN-Q3 MI ONT assessment tool. Finally, implementing organizations expressed concern that many bed-based providers continued to ask for supplemental referral information even when the GAIN-Q3 MI ONT assessment was completed accurately. Bed-based service providers do not have a standardized intake and referral package,<sup>26</sup> and referring organizations found this process duplicative given the comprehensiveness of the GAIN-Q3 MI ONT Recommendation and Referral Summary.

In 2019, system intervention drivers continued to dominate implementation discussions as several LHINs were without identified Mental Health and Addictions Leads. This affected discussions related to scope, especially for multi-service organizations that were “on the fence” because of limited addiction funding. In some regions, discussions about the relationship between the mandated SS&A process and InterRAI tools hindered implementation efforts. Trainer attrition reached a critical level and PSSP began developing an alternative, more sustainable model, which became the Provincial Training Model implemented in 2021.






Most recently, the PSSP implementation team has continued to use assessment rates and the newly launched usage reports as coaching tools with organizations. The team continues to receive requests from out of scope organizations, and these discussions often focus on individual programs rather than entire organizations. In part, this is a product of recent funding announcements where addiction workers are embedded in other service types. Fundamentally, “leadership is foundational to Implementation Drivers and implementation work in general. Leadership is needed at all levels of the system to not only keep work moving forward by managing change, but also support teams and practitioners in removing barriers to implementation.”<sup>27</sup>

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<sup>26</sup> For more information, see Standard 1 of the AMHO’s *2017 Standards Manual*: <https://amho.ca/wp-content/uploads/Ontario-Provincial-Standards-Adult-Residential-Addiction-Services-2017.pdf>

<sup>27</sup> <https://nirn.fpg.unc.edu/module-1/implementation-drivers>

## APPENDIX C: DATA COLLECTION DOCUMENTS

Survey for Implementing Organizations	 <a href="#">SurveyMonkey_315 975463.pdf</a>
Focus Group Guide for Implementing Organizations	 <a href="#">SSA Focus Group Guide.pdf</a>
Focus Group Guides for PSSP Implementation Specialists and DATIS	 <a href="#">SSA Focs Group with Implementatior</a>
Focus Group Guide for Shkaabe Makwa	 <a href="#">SSA Focus Group with Shkaabe Makw</a>
Key Informant Interview Guide	 <a href="#">SSA and OPOC Key Informant Interview.</a>

## APPENDIX D: CLIENT ENGAGEMENT ACTIVITY

Due to institutional impediments, CAMH staff could not directly collect data from clients. To incorporate the perspective of this audience group, CAMH staff requested the assistance from in-scope agencies. A description of the evaluation project was shared in the AMHO and E-QIP newsletters with a request for agencies to volunteer their assistance, and PSSP staff members made a request for support during a partnership meeting.

An online survey was the sole tool used to obtain client feedback. A survey was chosen to minimize burden both on client participants, and on the volunteer agencies. PSSP evaluators developed the survey informed by previous pilot work, which could be distributed online during either in-office or virtual appointments. This survey was seven questions in length, and with Likert-type questions and open-ended response questions.

Two implementing agencies offered to support data collection with clients. PSSP evaluators provided the agencies with a short script, to be used to introduce the survey to clients and inviting their participation. PSSP also offered a recruitment poster which could be displayed. Agency staff were asked to provide the client with an electronic device to complete the survey, or the survey link, if the client was able to complete the survey using their own device.

A letter of information was included on the introduction page of the survey and informed consent was implied through survey completion. Due to further institutional impediments, CAMH did not offer a honourarium to clients for their participation.

Due to a small sample size (less than five respondents), the results are not reportable.