Summary of Implementation Evaluation Report

Executive Summary

Background System Context

Ontario's addictions sector has historically experienced substantial variation in the screening and assessment processes used by addiction services across the province. Local agencies and programs developed over time in response to local needs, but the larger system has lacked clarity and consistency in the tools and processes used for gathering the right amount of information from clients, and how to best use that information to optimize services. Ontario's Ministry of Health began funding addiction agencies for assessments and needs-based treatment planning in the 1970's, but there was significant regional variation that emerged in the administration of tools, care pathways, protocols, and system entry points.

A Brief History of Standardized Tools in Ontario's Addictions Sector

A number of initiatives have taken place over the past four decades in an attempt to consolidate and standardize the administration of tools, care pathways, and protocols. Tools such as the *ASIST - A Structured Addictions Assessment Interview for Selecting Treatment* (1985) and the *ADAT - Admission and Discharge Criteria* (2000) were implemented in addiction programs across the province. Despite these efforts, an evaluation conducted by Rush and Martin in 2006[1] found significant variation in the tools used to assess individuals accessing service and in the length of time taken to complete the assessments. The evaluation 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 involving a rational, evidence-informed basis for treatment planning and matching to the appropriate type and level of service.

The Staged Screening and Assessment (SS&A) process is the most recent effort to enhance the consistency and quality of care for people accessing addictions services by implementing a standardized suite of screening and assessment tools.

Overview of SS&A

The SS&A approach was mandated in 2015 after a five-year review, development, and piloting phase. SS&A is based upon the following four principles: 1) comprehensiveness; 2) efficiency; 3) supportive of treatment and referral planning; and 4) supportive of agency and program planning by identifying system-wide patterns of service needs.

[1] 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

The SS&A process consists of four main tools; three screeners (Stage 1: GAIN-SS; Stage 2: MMS or POSIT) and one assessment (the GAIN Q3 MI ONT). These tools are intended to be used in combination, following a staged approach. The reason for the staged approach is to enable providers to quickly spot key areas of concern in need of immediate attention, identify co-occurring mental health issues, and to save time by reserving the more resource-intensive substance use assessment tool (GAIN Q3 MI ONT) until screening confirms it is required. At the agency, program, and system levels, SS&A data can be used to identify trends in service use and to make data-informed planning decisions to support quality improvement efforts.

The Current Evaluation

After six years of SS&A implementation, PSSP engaged the addiction sector in a comprehensive evaluation to assess the implementation of the SS&A process across the sector. 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. Based on the information shared in this evaluation, a list of recommendations was prepared, which take into account the historical context associated with prior attempts to introduce standardized assessment tools into the addiction sector, as outlined above.

Overall findings are summarized below. Full results can be found in the full Implementation Evaluation Report - a comprehensive 83-page document which includes important context, additional detail, and nuanced interpretation and discussion of the results. Please email ssa@camh.ca to have the full report sent to you.

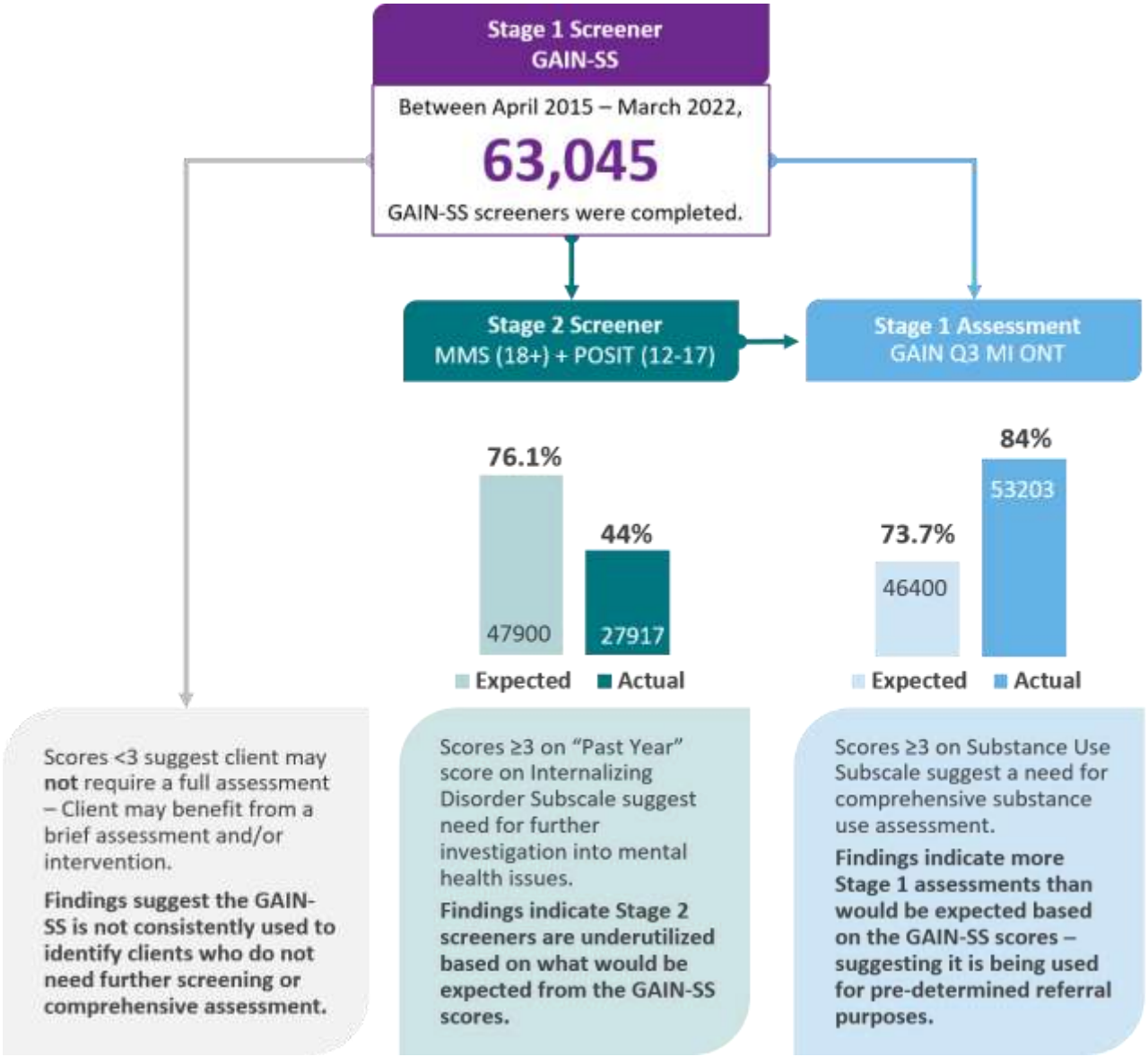
Methods

The evaluation was completed using a mixed-methods approach, gathering data through a survey (n=118), ten focus groups (n=48), and three key informant interviews.

Findings

Five evaluation questions informed the data collection activity. The evaluation questions and key findings are summarized below. Overall findings show that the intended benefits of the Staged Screening and Assessment process are not yet being realized.

Figure 1 – Summary of expected and actual tool usage based on the total number of GAIN-SS screeners completed since SS&A implementation began in 2015.



Evaluation Question 1: To what extent are the screeners (GAIN-SS, MMS, POSIT) and assessment tool (GAIN-Q3 MI ONT) being used?

Key findings:

- The SS&A process is underutilized across Ontario.
- The total volume of Stage 1 screeners (63,045), Stage 2 screeners (27,917), and assessments (53,203) relative to established tool cut-off scores reflects a lack of adherence to the staged protocol.
- Data suggest the tools are completed administratively to facilitate service access once a treatment destination has been determined (e.g. for referral to bed-based services), and not to guide the treatment decision itself.
- Variation in tools used across service types suggests a lack of clarity around when different components of the staged protocol should be administered.
- SS&A is most reliably implemented by a small number of clinicians who work for an equally small number of organizations relative to the entire scope of SS&A implementation.

Evaluation Question 2: Are the tools and process being used as intended?

Key findings:

- Data reflect significant variation in SS&A implementation processes across the province. 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. This was followed by clients not being receptive or finding the process burdensome, and the SS&A process takes too long to complete.
- The theme “disconnect between practice and policy” emerged, which included variability in agency-level implementation, purpose of the assessment, and system-level mandates.
- 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.
- A theme emerged suggesting that the assessment tool (the GAIN Q3 MI ONT) is perceived as a barrier to clinical practice. 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.

Evaluation Question 3: What has been the impact of introducing the SS&A process (to agencies and the broader sector)?

Key findings:

- Few impacts were mentioned regarding the impacts of SS&A on the broader sector. This suggests that the intended 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.

Evaluation Question 4: What has been the experience with respect to training, competency, and ongoing support?

Key findings:

- 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.
- Participants suggested developing more complicated mock training interviews, as the existing ones lacked complexity to apply all the of the required skills.
- 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). Health service providers are not able to link client records in Catalyst with the same client's assessments in GAIN ABS. As a result, any outcome or progress monitoring must be performed manually and individually by comparing two or more point-in-time assessments.
- Because the GAIN Q3 MI ONT assessments are not linked or cross-referenced with screener results or other client health information, treatment destinations recommended by the GAIN Q3 MI ONT assessment cannot currently be compared to actual program admissions.

Evaluation Question 5: Are there any modifications to the tools or the implementation process that could be made to maximize uptake and sustainability going forward?

Key findings:

- Participants spoke to the benefits of having supportive leadership, who recognized and supported the time for training and for the process.
- 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.

Recommendations

The following recommendations are based on the information provided by participants in this evaluation, subject to the limitations noted in the next section.

1. Revisit the implementation scope criteria for SS&A and re-state the mandate letter that was originally issued by the Ministry of Health and Long-Term Care in 2015 for all publicly funded addiction services. Additional language should clearly communicate the expectation for agencies to use the staged process and any associated accountability mechanisms. Acceptable exceptions and related alternative measures should be clearly articulated in order to achieve a shared and consistent understanding of expectations.

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 who support 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 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. 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 due to low sample size. Recommend working with implementing organizations to reprise the client engagement activity of 2017 to complement the clinician perspectives and concerns gathered in this evaluation; namely, 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.

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.

Limitations:

Sampling strategy:

- This evaluation did not obtain a representative sample, as the sampling strategy led to an overrepresentation of some organizations and underrepresentation of others relative to their size, assessment volume and geographic location across the province.
- 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.
- Recruitment and data collection tools were not translated into French, so it is possible that participation by this group was limited.
- 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 because these 10 organizations collectively administer 46% of all assessments in Ontario, but were the minority among the total number of evaluation respondents. Therefore, while the overall sentiment throughout this evaluation was negatively skewed, it is worth recognizing that input from the organizations with the most demonstrated experience in administering assessments, were not proportionally represented in this evaluation.

Potential bias:

- As the intermediary program responsible for SS&A implementation, there was a risk of bias due to PSSP also leading this evaluation. Two evaluators co-led all aspects of the evaluation in order to mitigate actual or perceived bias.

COVID-19 effect:

- The survey launch and initial focus group recruitment both occurred during the COVID-19 pandemic. This may have limited respondents' capacity to participate in the evaluation.