Mental Health and Substance Use Screening and Assessment Tools

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The core project team who led and directed this work, included:

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Lexicon

Assessment – compared to screening, assessment provides a more complete picture of an individual. Assessment can identify psychological problems and conditions, indicate their severity, and provide treatment recommendations. Screening results may be used to determine the choice of instruments for an assessment. (APA Practice Organization, 2017).

Data systems – systems that either collect and/or store structured data, and allow for information queries. Health care information systems are bound to strict privacy and confidentiality protection laws.

OAARS – Ottawa Addictions Access and Referral Services

Outcomes – although outcomes may be influenced by a variety of factors, one standard definition of 'outcome' in mental health is the 'effect of a patient's health that is contributable to an intervention by a health professional or health service' (Slade, 2002). Measuring an outcome requires that one is able to measure health status before interventions and at various points thereafter (Veillard, Fekri, Dhalla, & Klazinga, 2015).

Provider – in the context of this report, an organization or professional that provides healthcare services.

Reliability – the precision of test scores, e.g., to ensure that the repeated administration of the test would yield the same results (APA Practice Organization, 2017).

Screening – screening involves the use of evidence-based procedures and tools to identify individuals with problems, or those who are at risk for developing problems. It is intended to be an efficient way of raising a "red flag" about the possibility of a particular disorder or problem area and thereby setting the stage for a subsequent, more detailed assessment with a definite view to service planning and delivery. (Rush & Castel, 2011).

Social determinants of health – the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life (World Health Organization (WHO), 2017).

Recovery – the personal process that people with mental health conditions experience in gaining control, meaning and purpose in their lives. Recovery involves different things for different people. For some, recovery means the complete absence of the symptoms of mental illness. For others, recovery means living a full life in the community while learning to live with ongoing symptoms. (Canadian Mental Health Association Ontario, 2016).

Respondents – those that responded to the *Survey on the Current Practices in the Champlain Region for Mental Health and Substance Use Screening and Assessment Tools* for their program, organization, and/or practice.

Validity – the extent to which test scores adequately represent a test-taker's standing on the psychological variable of interest (APA Practice Organization, 2017).

Executive Summary

Project Summary

Recognizing that multiple standardized tools have a place in mental health and addictions services, this project endeavors to investigate which mental health and substance use tools are most often used within the Champlain region and what these tools are achieving for service providers and clients. Ultimately, the goal is to have a shorter and more harmonized list of screening and assessment tools be used by as many service providers as possible. Clients are foreseen to benefit from such standardization through a reduction in the number of assessments performed and in the number of times one would have to repeat their story.

Background

Clients and families across the Champlain region receive mental health and addictions services from many different organizations and programs. It is essential that these services work together to provide a consistent approach to care, which begins with a common language around screening and assessment.

Currently there is no inventory of the screening and assessment tools are in practice among various organizations and programs in Champlain. In order to address this, the Champlain Local Health Integration Network (LHIN) designated Pathways to Better Care, delivered through the Royal Ottawa Health Care Group, to conduct research on the mental health and substance use screening and assessment tools that are currently being used in Champlain. This initiative is aligned with the Champlain LHIN's Integrated Health Services Plan (2016 – 19) and through the strategic priority to better integrate mental health and addictions services.

Process

The following Champlain-LHIN funded organizations were considered in scope for this project: mental health and addictions programs in hospitals, community health centres, community mental health and addictions organizations, the Community Care Access Centre (CCAC) and its contracted agencies, and primary care professionals and services within some of these organizations. Information was gathered through an electronic survey (via SurveyMonkey®), key informant interviews, and through the literature.

An invitation to participate in the survey was sent to 121 individuals. Descriptive analyses were conducted for the survey results using SurveyMonkey® and Excel. There were nine key informant interviews that were transcribed and categorized into themes.

Findings and Conclusions

There were 69 respondents to the survey that, overall, identified 102 different standardized tools that are currently used for the screening and assessment of mental health and substance use. Tools that were identified by three or more respondents are considered the "most commonly used tools" in this report. A list of these tools and whether they were identified by respondents as being used for mental health, substance use, or both, is provided in the Executive Summary Table, below:

Executive Summary Table: Most Common Tools Identified

Standardized Tool	Identified for Mental Health, Substance Use, or Both
Alcohol Use Scale (AUS)	Substance Use
Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)	Substance Use
Alcohol Use Disorders Identification Test (AUDIT)	Substance Use
Behaviour and Symptom Identification Scale (BASIS)	Mental Health
Beck Depression Inventory (BDI)	Mental Health
Brief Psychiatric Rating Scale (BPRS)	Mental Health
CAGE Substance Use Screening Tool (CAGE)	Substance Use
Drug Abuse Screening Test (DAST)	Substance Use
Drug History Questionnaire (DHQ)	Substance Use
Drug Use Scale (DUS)	Substance Use
Generalized Anxiety Disorder Assessment (GAD-7)	Mental Health
Global Appraisal of Individual Needs – Q3 Motivational Interview Ontario (version) (GAIN-Q3 MI ONT)	Both
Global Appraisal of Individual Needs – Short Screener (GAIN-SS)	Both
Geriatric Depression Scale (GDS)	Mental Health
InterRAI Mental Health for Inpatient Psychiatry (interRAI MH)	Both
Modified Mini Screener (MMS)	Both
Montreal Cognitive Assessment (MOCA)	Mental Health
Multnomah Community Ability Scale (MCAS)	Mental Health
Ontario Common Assessment of Need (OCAN)	Mental Health
Outcome Questionnaire (OQ-45)	Mental Health
Patient Health Questionnaire (PHQ-9)	Mental Health
Problem Oriented Screening Instrument for Teenagers (POSIT)	Mental Health
Post-Traumatic Stress Disorder Checklist (PCL)	Mental Health

The findings of this project do not report on the scientific evidence base of the identified tools, however, the project does provide a starting point for further consideration and future research in this area. Further analysis of the most commonly used tools, their psychometric properties, their practicality, and their clinical utility should be performed. This report presents information

as reported by survey respondents on the following factors for each of the most commonly identified mental health and substance use screening and assessment tools:

- role of person/professional that administers each tool
- whether or not each tool is mandated
- the stage of service that each tool is used
- the length of time each tool has been in use
- the time it takes to complete each tool
- whether or not there is a cost to each tool
- the identified purposes for using each tool
- the outcomes being measured by each tool
- respondents' opinions regarding each tool's usefulness for decision making in guiding treatment and care and its ease of use

Some of the highlights of the key informant interviews and identified considerations for specific populations are as follows:

- Screening and assessment tools should serve a purpose and enhance practice.
- Tools need to be used in conjunction with a clinical assessment/interview and never in isolation.
- There are many screening and assessment tools available, but choosing which ones to use depends on specific client needs and services offered.
- Providers who serve people aged 65 and over are concerned around the limited screening and assessment tools available that have been adapted to the needs of this population.
- For the Indigenous population, screening and assessment tools should be developed through an Indigenous lens and need to be rooted in culture.
- Current tools available would be culturally inappropriate for the immigrant and refugee population and would be very difficult to translate accurately.
- For the Francophone population, it can be a challenge to find tools that have been translated and validated.

Summary of Recommendations for Further Action

1) Consider establishing an expert panel to continue work in this area and develop specific recommendations on a screening and assessment strategy.
2) Decide on a set of common indicators/outcomes that reflect the client's goals for treatment and care; define these as the key indicators to be monitored and then look at encouraging providers to use tools that are capable of measuring these.

3) Share the results of this review with provincial peers to support provincial work in this area.
4) Ensure that the considerations of all stakeholder groups are taken into account before implementing any specific tools.
5) Balance the flexibility for providers to be able to choose from a suite of tools based upon the treatment and care goals of the client.
6) Seek input from and collaborate with people with lived experience and their families when doing further work in this area.
7) Continue to explore opportunities to make information more easily accessible across different information systems.
8) Consider using electronic delivery systems for screening and assessment tools (such as computer tablets or web-based applications).
9) Coordinate the development of a screening and assessment tool strategy with the development of a common electronic medical records system.

Introduction

In January 2017, the Champlain Local Health Integration Network (LHIN) provided one-time funding for Champlain Pathways to Better Care Regional Capacity Building Program, delivered through the Royal Ottawa Health Care Group, to conduct research on the mental health and substance use screening and assessment tools currently used in the Champlain region. The following Champlain LHIN funded organizations were considered in scope for this project: mental health and addictions programs in hospitals, community health centers, community mental health and addictions organizations, the Community Care Access Center (CCAC) and its contracted agencies, and primary care professionals and services working within some of these organizations.

While LHIN-funded addictions health service providers across Ontario have been engaged in implementing a standardized set of evidence-based screening and assessment tools through the Staged Screening and Assessment (SSA) Project, LHIN-funded mental health providers and programs have not been mandated by the Ministry of Health and Long-Term Care to use these tools in the same way. The staged screening and assessment process involves an evidence-based, staged approach for screening and assessing individuals accessing services within the addiction treatment system (Centre for Addiction and Mental Health (CAMH), n.d.). The tools that are being implemented for the SSA Project include: the GAIN-SS, MMS, POSIT, and GAIN-Q3 MI ONT.

In the Champlain region, there is currently no inventory of the mental health and substance use screening and assessment tools being used in LHIN-funded mental health and addictions (MH&A) programs. Understanding the current state of screening and assessment tools being used within MH&A programs, and the impacts of these tools and processes on clients, provides one means of building a more integrated MH&A system.

Information for this project was collected through an electronic stakeholder survey, select interviews, and related background research. While the focus of this initiative is on mental health, information from addictions organizations and on substance use tools was also gathered for a more complete picture of the current practices in the Champlain region.

Objectives

The objective of this initiative is to gain an in depth, program-level understanding of the mental health and substance use screening and assessment tools that are currently being used by the Champlain LHIN-funded MH&A providers, the CCAC, and, primary care professionals and services within these organizations, by:

- Creating an inventory of the mental health and addictions screening and assessment tools that are currently being used
- Gaining a regional understanding of how the tools are being used, for what purposes, with which populations, what outcomes are being produced for providers and clients, which data systems are being used, and how information from these data systems is being used
- Analysing and documenting findings with recommendations for action to address specific client screening and assessment needs, standardization of tools and approaches (where indicated), and provide information for system planning purposes

Methodology

Data for this report was collected through an online survey and key informant interviews. The SurveyMonkey® Gold version online survey application was used for the development and dissemination of the survey. Please see Appendix A for a copy of the survey: *Survey on the Current Practices in the Champlain Region for Mental Health and Substance Use Screening and Assessment Tools.*

The survey consisted of six sections:

- Section 1: Contact and Demographic Information
- Section 2: Screening and Assessment Practices for Mental Health Disorders
- Section 3: Screening and Assessment Practices for Substance Use Disorders
- Section 4: Screening for Suicide
- Section 5: Data Systems
- Section 6: Additional Questions

MH&A programs in hospitals, community health centers, community mental health and addictions organizations, and the CCAC and its contracted agencies, as well as select LHIN-funded primary care services within these programs received an invitation to participate in the survey on February 16, 2017. An email containing a link to the survey was disseminated to 121 individuals from the above-mentioned organizations asking that someone within each program who is knowledgeable about screening and assessment practices complete the survey. A letter from the Champlain LHIN encouraging completion of the survey was sent immediately following

the original invitation and made explicit that survey participation was voluntary. Three email reminders were sent to providers to encourage completion of the survey. Data collection of the survey took place between February 16, 2017 and March 3, 2017, inclusive. Descriptive analyses of survey responses were conducted using SurveyMonkey® and Excel.

While the primary goal of this project focussed on service providers and the tools they use for screening and assessment of mental health and substance use, understanding of the process from the client's perspective is necessary and valued. Hence, discussions were conducted with clients of MH&A health service providers to increase understanding of how screening and assessment processes and tools impact those with lived experience and their family members receiving MH&A specific services.

Summary of Key Survey Findings

Findings for the online survey results are organized according to each survey section:

- Section 1: Contact and Demographic Information
- Section 2: Screening and Assessment Practices for Mental Health
- Section 3: Screening and Assessment Practices for Substance Use
- Section 4: Screening for Suicide
- Section 5: Data Systems

One of the key objectives of the online survey was to gain an understanding of the most common tools currently used in the Champlain LHIN for screening and assessing mental health and substance use. To obtain this information, respondents were asked if they currently screen and/or assess for mental health and substance use and to identify up to ten tools that they commonly use in their program. Overall, respondents identified 102 standardized tools being used for mental health and substance use screening and assessment through the survey. A complete list of these tools and their abbreviations can be found in Appendix B.

Based on the comprehensive list of tools identified by providers, a decision rule was applied to narrow the list of tools for analysis. Those tools identified by three or more survey respondents were chosen for further analysis, which are described in the following sections. It is important to note that information gathered on each tool may depend on the type and stage of service that the respondent represents. Please see Appendix D for a list of the commonly used tools, their brief descriptions, and the organizations and/or programs that currently use them.

Section 1: Contact and Demographic Information

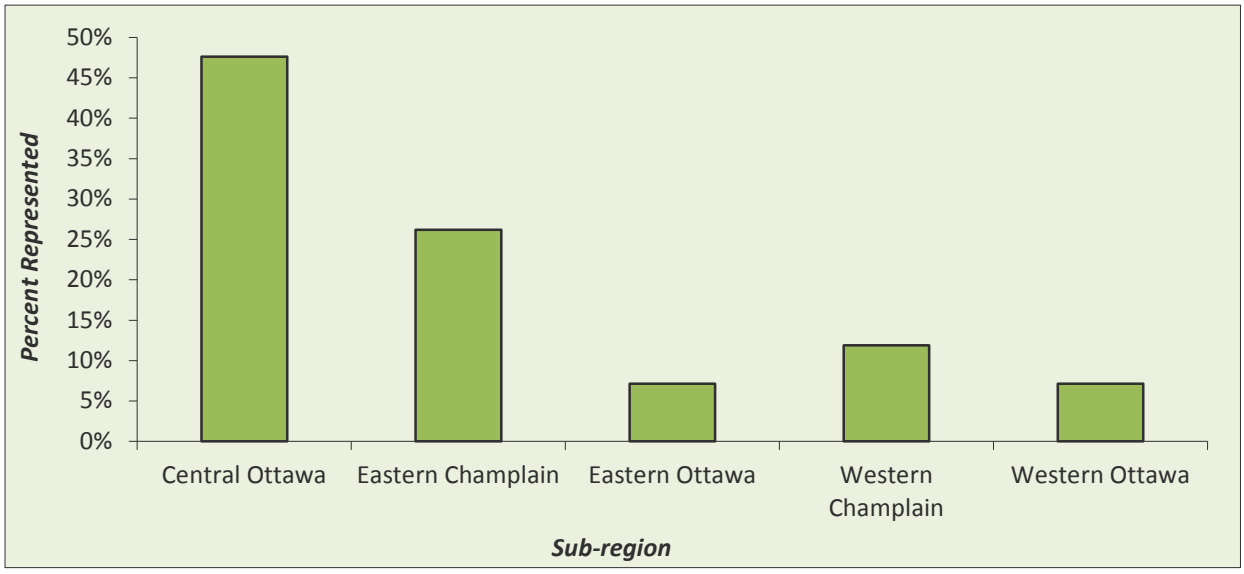
Respondents were asked to provide client contact and demographic information to identify the MH&A program/sector they represent and to better understand the characteristics of the client-base served.

Of the 69 survey respondents, representation included:

- 26 – hospital
- 16 – addiction agency
- 9 – community health centre (of which 3 respondents were from primary care programs)
- 8 – housing
- 7 – community mental health agency
- 2 – CCAC or contracted Agency
- 1 – peer support agency

Figure 1 represents the percentage of respondents working in each of the Champlain LHIN sub-regions recognizing that respondents could represent more than one sub-region (e.g., regional organizations). See Appendix C for a map of the sub-regions. The Central Ottawa and Eastern Champlain sub-regions are the most represented in this survey; the Eastern and Western Ottawa sub-regions the least.

Figure 1: Location of Survey Respondent in the Champlain LHIN by Sub-Region (n=69)

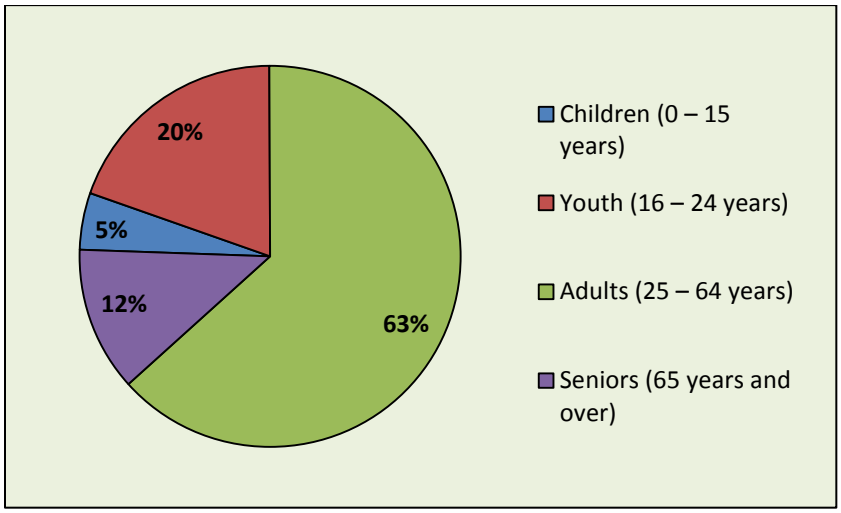


The survey asked for an estimate of the proportion of clients who request services in English, French, or another language. According to respondents, English was the most common language requested, at 81% followed by 16% in French and 3% in other languages.

Additionally, the majority of respondents reported that very few (0 – 10%) of their clients do not speak either English or French. However, 10% of respondents reported that more than 10% of their clients spoke neither English nor French and 4% of respondents reported that more than 30% of their clients spoke neither English nor French.

Figure 2 shows the approximate age of the clients served in programs represented by the respondents. Notably, 63% are between the ages of 25 – 64 years followed by 20% reporting youth 16 – 24 years, then seniors (12%), and children (5%).

Figure 2: Percentage Estimate of Age Groups Served (n=69)



As shown in Figure 3 below, respondents indicated that their program regularly serves at least one or more of the following population groups:

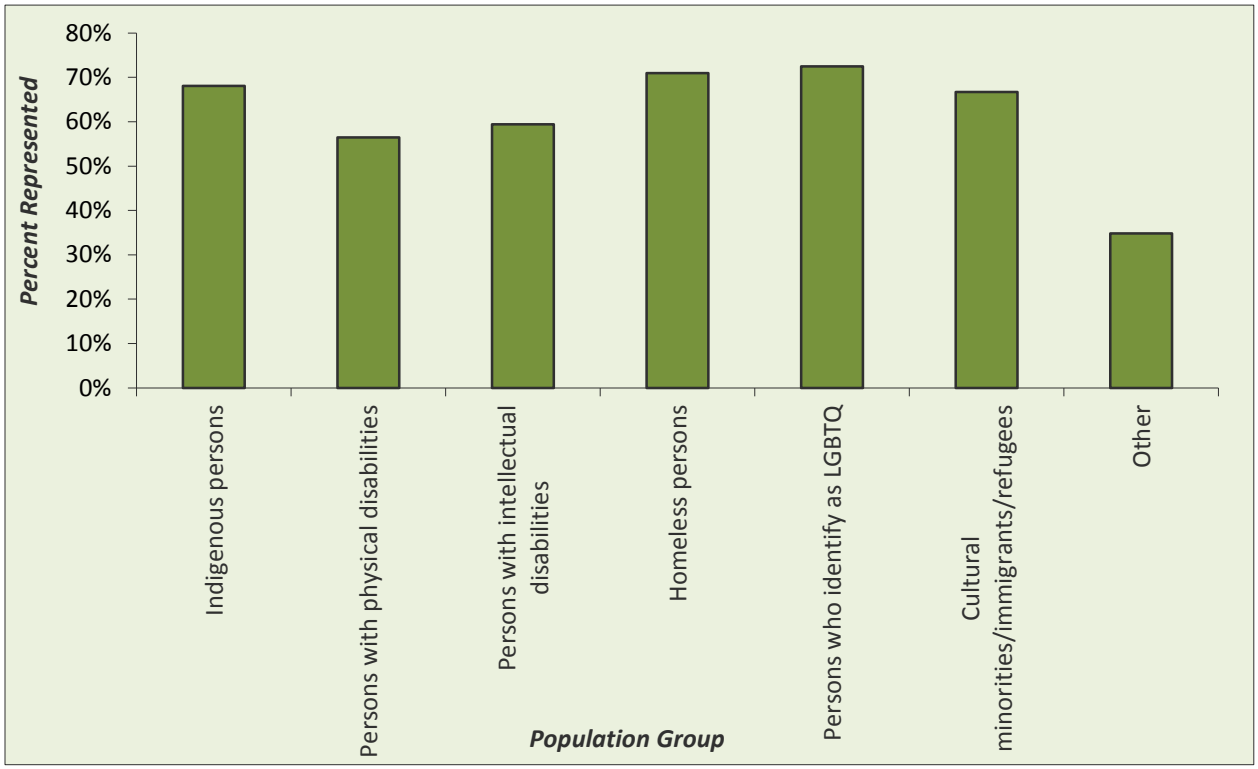
- Indigenous clients
- clients with physical and intellectual disabilities
- homeless clients
- clients who identify being within the lesbian, gay, bisexual, trans and queer (LGBTQ) community
- clients who identify being a refugee, immigrant or within a cultural minority group

Seven respondents provided additional comments emphasizing that their program does not exclude any client group and provides services to all client populations. Almost half of the

respondents (n=28) identified additional client populations served within their program, including:

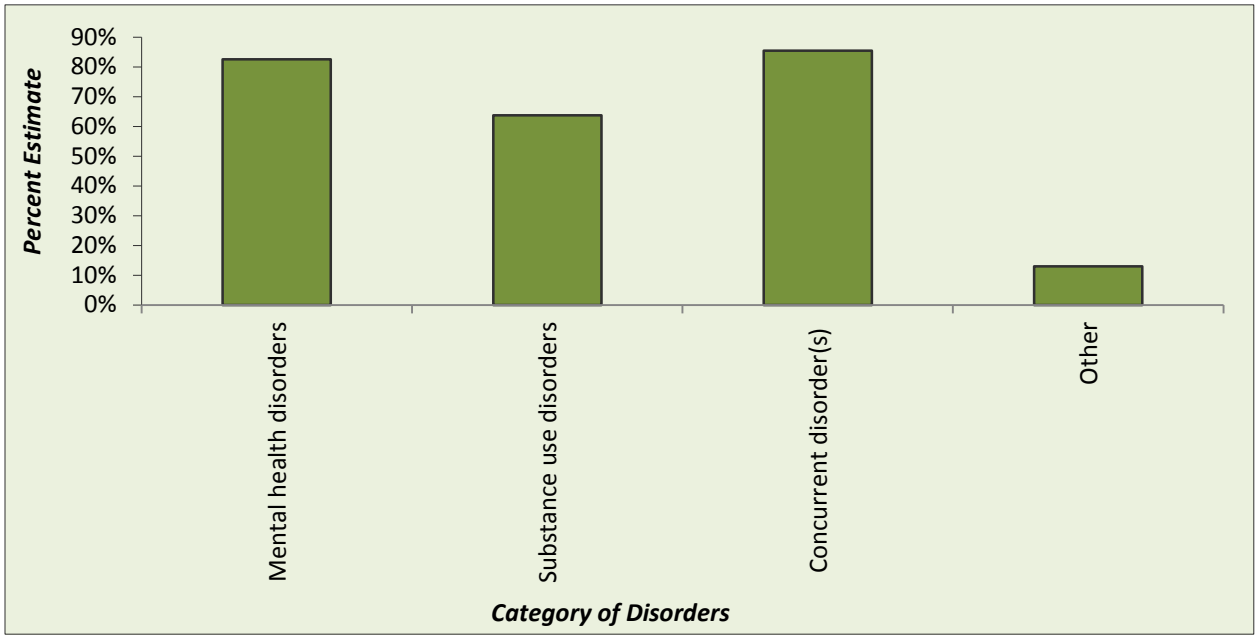
- clients with behavioural problems
- severe mental illness
- concurrent disorders
- geriatric clients
- youth
- family members and caregivers
- Francophone clients
- clients living on low income and in social housing

Figure 3: Client Populations Regularly Served (n=69)



Providers were asked to select one or more of the three most common categories of disorders affecting their client population. Figure 4 illustrates that 86% of respondents report concurrent disorders as affecting their client population, 83% mental health disorders, and 64% substance use disorders. Respondents were able to choose more than one cluster of disorders as well as add other options. Ten respondents identified other issues affecting their clients including dual diagnosis, autism spectrum disorder, first episode psychosis, and clients at risk of becoming homeless.

Figure 4: Percentage Estimate of Disorders Most Commonly Affecting Program Clients (n=69)



The following three sections will report specifically on survey respondents' opinions and understanding of screening and assessment practices for mental health, substance use, and suicide risk.

Section 2: Screening and Assessment Practices for Mental Health

Respondents were asked if they currently screen and/or assess for mental health disorders. If respondents indicated yes, they were then asked a series of questions related to the screening and assessment tools they most commonly use. Overall, 88% of survey respondents indicated they screen and/or assess for mental health disorders and 12% indicated that they do not.

Mental Health Screening and Assessment Tools

Using the decision rule described above, there are 16 tools (Table 1) that are most commonly used for mental health screening and/or assessment as identified by respondents. Table 1 also categorizes each of these tools by whether they are primarily used for screening or assessment. Note that some of these tools, such as the PHQ-9, GAD-7, DHQ, GDS, PCL, and GAIN-Q3 MI ONT, have been reported to be used for both screening and assessment purposes, however, for the purposes of this report have been categorized as either one or the other. Categorization was based on the literature and/or consultation with individuals with knowledge in this area. A portion of the analysis in this section looks at screening and assessment tools separately.

Table 1: Most Commonly Identified Tools for Mental Health (n=61)

Standardized Tool	Tool Abbreviation	Percentage of Respondents Using Tool	Category (Screening or Assessment)
Global Appraisal of Individual Needs – Short Screener	GAIN-SS	21% (n=28)	Screening
Ontario Common Assessment of Need	OCAN	14% (n=19)	Assessment
Global Appraisal of Individual Needs – Q3 Motivational Interview Ontario (version)	GAIN-Q3 MI ONT	10% (n=14)	Assessment
Modified Mini Screener	MMS	9% (n=12)	Screening
Generalized Anxiety Disorder Assessment	GAD-7	7% (n=9)	Screening
Behaviour and Symptom Identification Scale	BASIS	5% (n=7)	Screening
Beck Depression Inventory	BDI	5% (n=7)	Assessment
Patient Health Questionnaire	PHQ-9	5% (n=7)	Screening
Geriatric Depression Scale	GDS	4% (n=5)	Assessment
Montreal Cognitive Assessment	MOCA	4% (n=5)	Screening
Problem Oriented Screening Instrument for Teenagers	POSIT	4% (n=5)	Screening
Multnomah Community Ability Scale	MCAS	3% (n=4)	Assessment
Brief Psychiatric Rating Scale	BPRS	2% (n=3)	Assessment
InterRAI Mental Health for Inpatient Psychiatry	interRAI MH	2% (n=3)	Assessment
Outcome Questionnaire	OQ-45	2% (n=3)	Assessment
PTSD Checklist	PCL	2% (n=3)	Assessment

Respondents were asked if the tools they identified are mandated for use. Notably there are some differences in organizational accountabilities in relation to the use of these tools as shown in Table 2. These differences could be a result of varied accountability standards expected of programs or inconsistent levels of awareness. The tools most identified as being mandated for use include the GAIN-SS, OCAN, GAIN-Q3 MI ONT, MMS, and POSIT. The most common organizations or groups identified as mandating the use of tools are the Ontario Ministry of Health and Long-Term Care, the LHIN, physician groups, hospitals, and Accreditation Canada.

Also described in Table 2 are respondents' opinions on whether they would continue to use the tools if they were not mandated. Respondents who use the BDI, BPRS, GAD-7, GDS, MCAS, MMS, MOCA, OQ-45, PHQ-9, POSIT, and PCL all indicated that they would continue to use these

tools regardless of whether or not they are mandated. Note, however, that the number of respondents varies between tools.

Table 2: Respondents Understanding of Tools Being Mandated or Not

Standardized Tool	Not Mandated to Use	Mandated to Use	If Not Mandated Would Still Use	If Not Mandated Would Not Use
BASIS	5*	0	4*	2
BDI	5	0	5	0
BPRS	2	1	2	0
GAD-7	8	0	5	0
GAIN-Q3 MI ONT	0	14	6	4
GAIN-SS	4	22	21	4
GDS	4	0	3	0
InterRAI MH	0	3	2	1
MCAS	3	1	2	0
MMS	3	9	9	0
MOCA	6	0	4	0
OCAN	1	18	7	7
OQ-45	3	0	3	0
PHQ-9	7	0	5	0
POSIT	1	5	4	0
PCL	3	0	2	0
	n=52 **count*		*n=50* **count*	

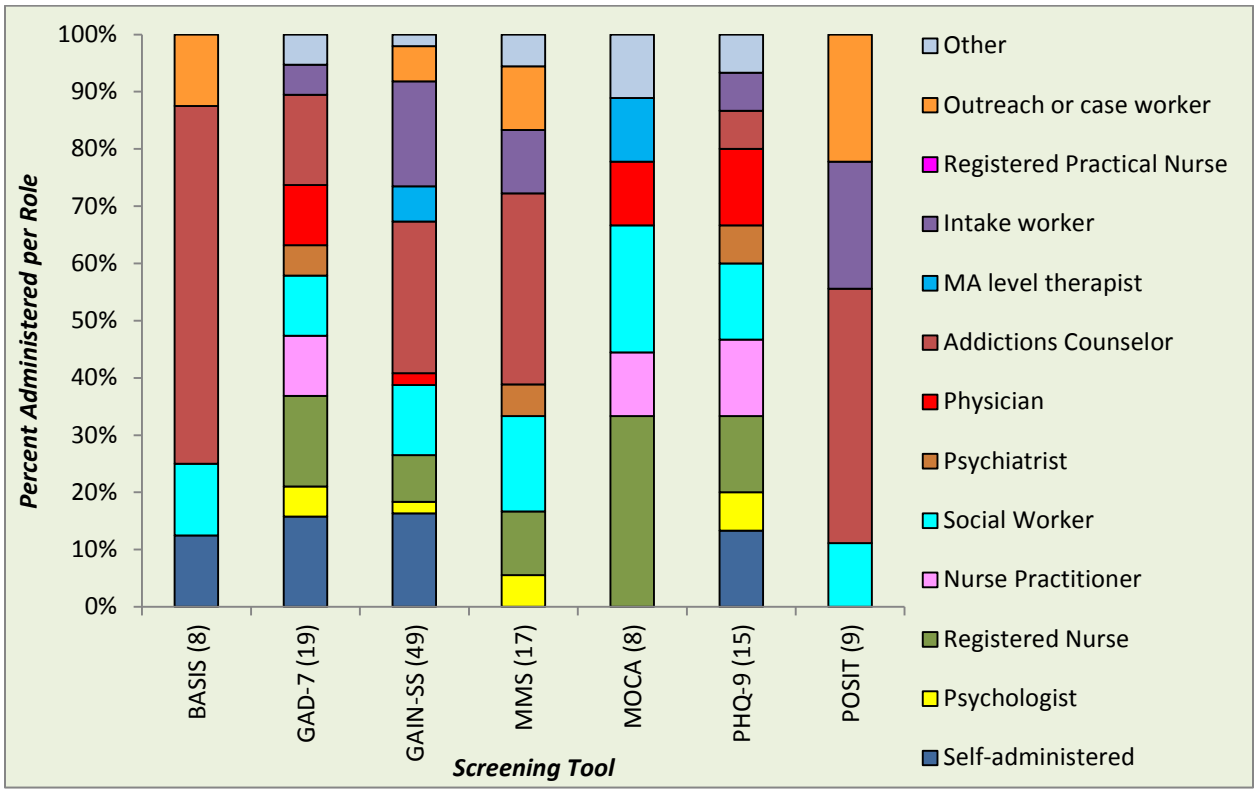
The survey asked if the tools the respondents identified are empirically validated for the population served. The majority of respondents identified all tools as empirically validated; only a small number of respondents indicated that they think the GAIN-Q3 MI ONT and OCAN are not empirically validated.

Roles of those who Administer Screening and Assessment Tools

Respondents were asked who administers each tool identified. Figure 5 and 6 provide an overview of the typical person/professional administering each of the tools according to survey respondents. Figure 5 shows that of the screening tools, the GAD-7, GAIN-SS, and PHQ-9 are administered by the most diverse group of persons/professionals. The BASIS, GAIN-SS, MMS,

and POSIT are most frequently administered by an addictions counselor. Each of these tools was reported to be administered by a social worker.

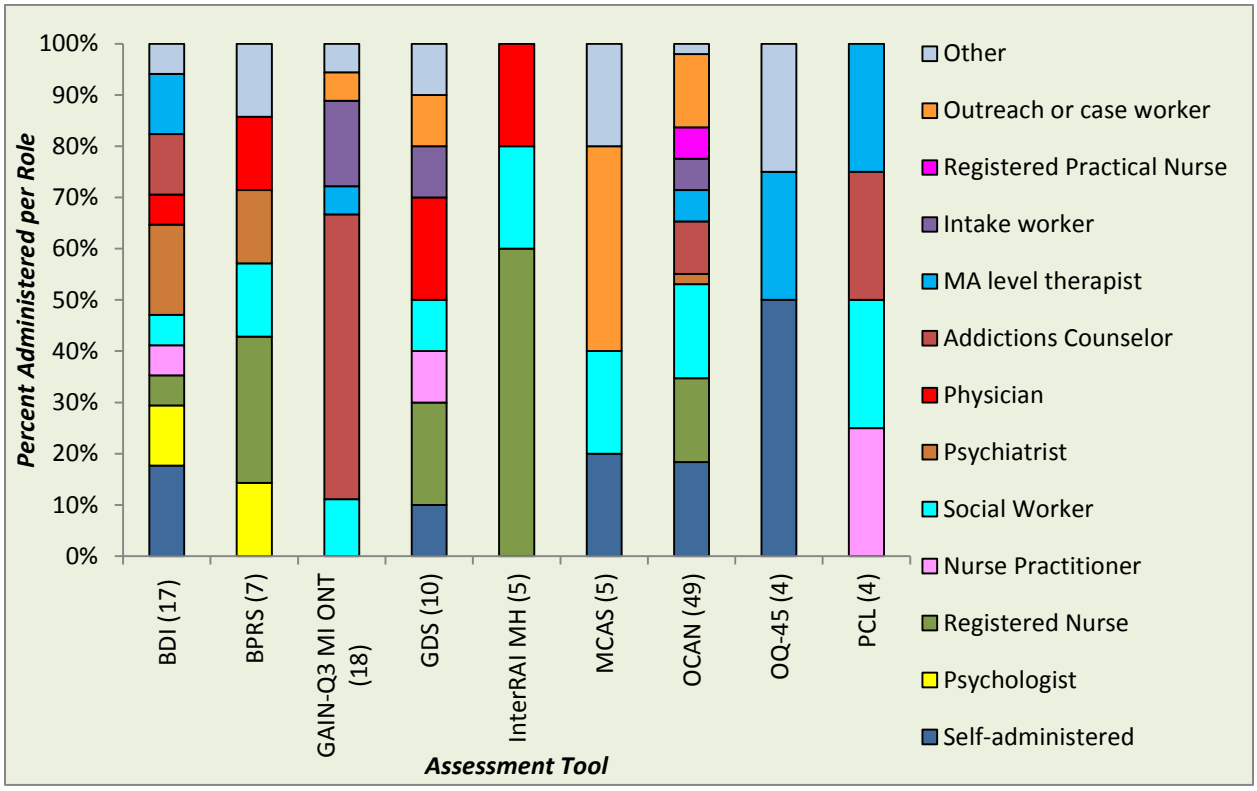
Figure 5: Role of Person who Administers Screening Tool



Note that the proportions represented in the graph are relevant to the total count for roles selected by respondents for each tool, which is the number displayed in brackets.

For the assessment tools used (Figure 6), the BDI and the OCAN are administered by the most diverse group. The interRAI MH is reported to be mostly administered by a registered nurse, and the GAIN-Q3 MI ONT mostly by an addictions counselor. The OQ-45 is largely self-administered.

Figure 6: Role of Person who Administers Assessment Tool



Note that the proportions represented in the graph are relevant to the total count for roles selected by respondents for each tool, which is the number displayed in brackets.

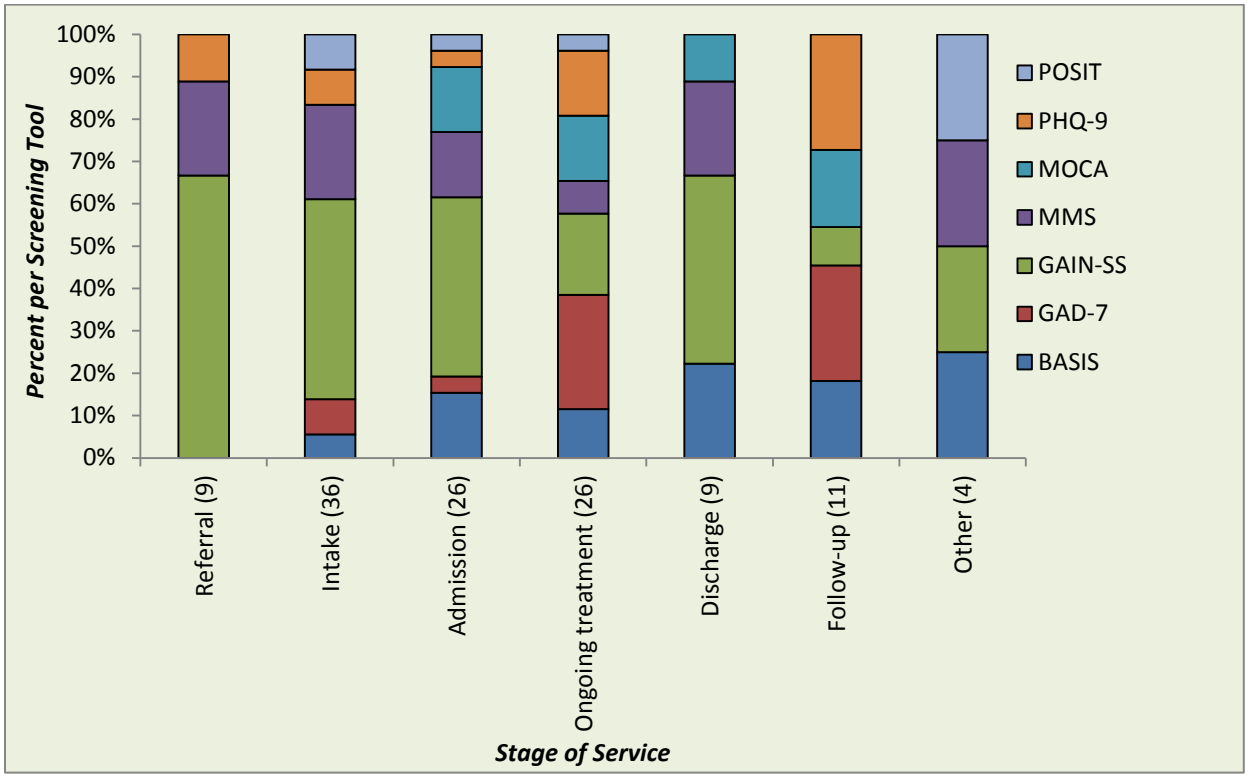
A small number of respondents provided additional comments to this survey question. One respondent shared that their program psychologist provides leadership regarding selection of screening and assessment tools. Another respondent shared that their program is amalgamating access to mental health and addictions and do not currently have a healthcare provider that can legally make a mental health disorder diagnosis. As such, they rely on anxiety/PTSD/depression screeners to refer clients for more specialized mental health services. Finally, one respondent shared that their program no longer performs screening and assessment work since the inception of the Ottawa Addictions Access and Referral Service (OAARS), a centralized access service for all addiction programs in Ottawa.

Stage of Service for Tool Administration

Figure 7 and 8 provide an overview of which stage of service each of the tools are administered according to 51 survey respondents (n=51). For all of the screening tools, as shown in Figure 7, time of administration varies across at least four stages in client service and all tools were reported to be administered during ongoing treatment. Figure 7 also shows that the GAIN-SS

and MMS are administered most often at intake followed by at admission. The GAD-7 was reported to be administered most often during ongoing treatment and the POSIT most often at intake.

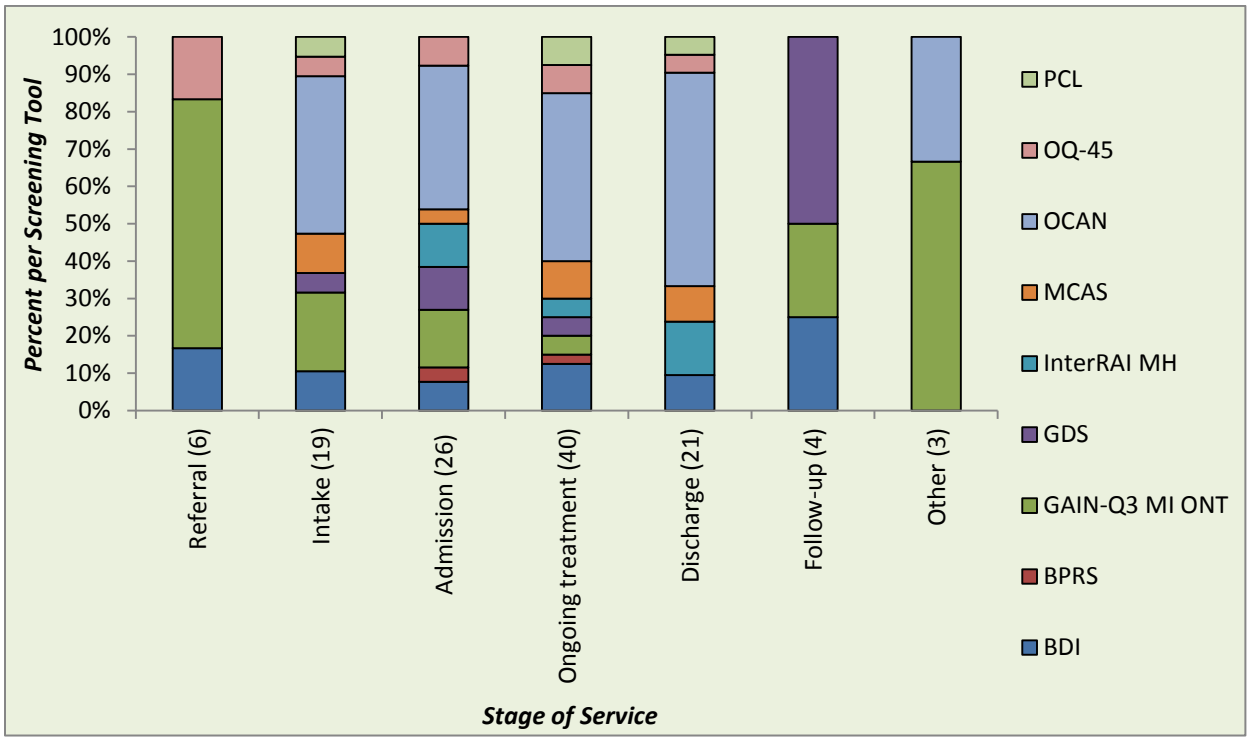
Figure 7: Stage of Service when Screening Tool is Administered



Note that the proportions represented in the graph are relevant to the frequency each stage of service was selected by respondents, which is the number displayed in brackets.

As shown in Figure 8, below, the assessment tools, like the screening tools, were all identified to be administered during ongoing treatment. The BPRS, followed by the interRAI MH and PCL were reported to be administered at the least number of stages of service while the BDI and GAIN-Q3 MI ONT were reported to be used at the most numerous stages of service (at six unique stages). Figure 8 shows that tools are least reported to be administered at referral and follow-up.

Figure 8: Stage of Service when Assessment Tool is Administered



Note that the proportions represented in the graph are relevant to the frequency each stage of service was selected by respondents, which is the number displayed in brackets.

Other suggested times for administration of screening and assessment tools included "when clinically warranted" and "every six months if a client remains in treatment." One respondent mentioned that not all programs and services serve clients throughout all of these stages, which is important to remember when interpreting this data.

Length of Time Tools have been in Use

Table 3 describes the length of time respondents report their program has been using the screening and assessment tools. The majority of respondents indicated their program has been using the tools between 1-5 years, and only a few respondents indicated using their tools more than 10 years. The highlighted cells show the most common response(s) per tool.

Table 3: Length of Time Program has Used Tool (n=48)

Standardized Tool	Less than 1 year	1-5 years	6-10 years	More than 10 years	Do not know	Response Count
BASIS	0	0	**3**	2	0	5
BDI	0	1	**3**	2	0	6
BPRS	0	**1**	**1**	**1**	0	3
GAD-7	0	**6**	1	0	0	7
GAIN-Q3 MI ONT	**9**	2	1	0	0	12
GAIN-SS	6	**14**	4	0	1	25
GDS	0	0	**3**	1	0	4
InterRAI MH	0	0	**2**	1	0	3
MCAS	**2**	0	1	1	0	4
MMS	**6**	4	0	1	0	11
MOCA	0	0	2	**3**	0	5
OCAN	1	**10**	6	0	0	17
OQ-45	0	**1**	**1**	0	**1**	3
PHQ-9	0	**2**	**2**	0	0	4
POSIT	**2**	**2**	0	0	0	4
PCL	0	**1**	0	**1**	0	2

Estimated Time to Complete Screening and Assessment Tools

Respondents were asked to estimate the average time it takes to complete each tool they identified. There were 50 respondents (n=50) to this question. Table 4 highlights the responses to this question for each of the screening tools. On average, respondents indicated that most of these tools take between 5 and 20 minutes to complete. The GAD-7 and PHQ-9 are identified as taking the shortest amount of time to administer. None of the screening tools listed were reported to take longer than 60 minutes.

Table 4: Time Estimate to Complete Screening Tools

Screening Tool	Less than 5 minutes	5-10 minutes	10-20 minutes	20-30 minutes	30-60 minutes	60-90 minutes	More than 90 minutes	Do not know	Response Count
GAIN SS	2	**11**	9	1	1	0	0	1	25
MMS	0	2	**5**	1	1	0	0	2	11
GAD-7	**3**	**3**	1	0	0	0	0	1	8
MOCA	0	1	1	**3**	1	0	0	0	6
BASIS	1	0	**4**	0	0	0	0	1	6
POSIT	0	1	1	0	**2**	0	0	1	5
PHQ-9	**2**	**2**	1	0	0	0	0	0	5

For the assessment tools (Table 5), the GAIN-Q3 MI ONT and the OCAN are identified as taking the longest to complete at typically over one hour, whereas the BDI, OQ-45, and PCL were not reported to take longer than 20 minutes.

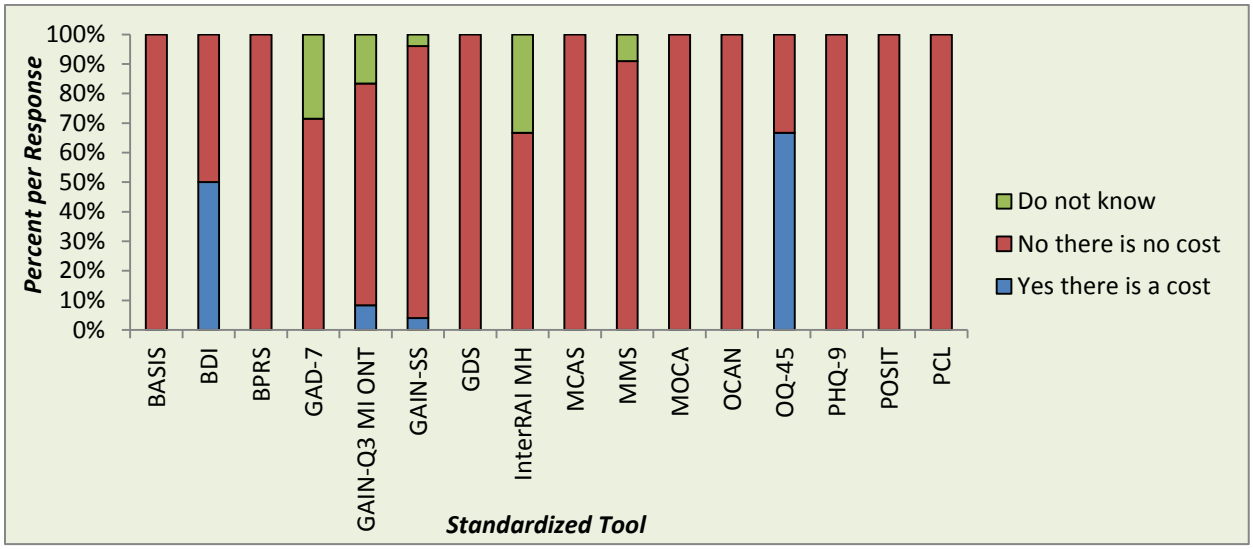
Table 5: Time Estimate to Complete Assessment Tools

Assessment Tool	Less than 5 minutes	5-10 minutes	10-20 minutes	20-30 minutes	30-60 minutes	60-90 minutes	More than 90 minutes	Do not know	Response Count
BDI	1	**3**	2	0	0	0	0	0	6
BPRS	0	0	**1**	**1**	0	0	0	1	3
GAIN-Q3 MI	0	0	0	0	0	**6**	**6**	1	13
GDS	0	1	**3**	0	0	0	0	0	4
InterRAI MH	0	0	0	**2**	1	0	0	0	3
MCAS	0	1	**2**	0	1	0	0	0	4
OCAN	0	0	0	2	**6**	4	**6**	0	18
OQ-45	**1**	0	**1**	0	0	0	0	0	2
PCL	1	**2**	0	0	0	0	0	0	3

Cost Associated with Using Tools

Respondents were also asked if there is a cost associated with using the tool (e.g., proprietary). Figure 9 describes that most respondents do not believe there is a cost associated with each of the tools. It is important to note that for some proprietary tools provided by an organization, respondents may not be aware of the associated costs. The BDI, OQ-45, GAIN-SS and the GAIN-Q3 MI ONT are the tools some respondents identified as having an associated cost.

Figure 9: Cost Associated for Using Tool (n=48)



Identified Purposes of Screening and Assessment Tools

Table 6 and 7 identify the different purposes for each of the screening and assessment tools, respectively, which represent 53 survey respondents (n=52). As shown in Table 6, each of the screening tools were identified as being used for risk identification, treatment planning, and client recovery. The GAIN-SS appears to have the most versatility for use.

Table 6: Purpose of Screening Tools

Purpose	BASIS	GAD-7	GAIN-SS	MMS	MOCA	PHQ-9	POSIT
Risk identification	3	**5**	**24**	**9**	**3**	3	**4**
Diagnosis	0	1	0	1	**3**	2	0
Service matching	**5**	1	20	**9**	0	2	**4**
Admission eligibility	3	0	12	7	0	0	3
Treatment planning	**5**	**5**	15	6	**3**	4	2
Client recovery	**5**	3	8	2	1	2	2
Treatment efficacy	3	**5**	5	2	**3**	**5**	0
Research	0	1	2	0	0	1	0
Health service planning	1	0	6	3	0	1	1
Health system planning	0	0	1	1	0	1	0
Other	0	0	1	0	1	0	0

As presented in Table 7, below, all of the assessment tools were identified as being used for treatment planning. The GAIN-Q3 MI ONT was identified as being used for the highest number of purposes, however, is mostly used for service matching.

Table 7: Purpose of Assessment Tools

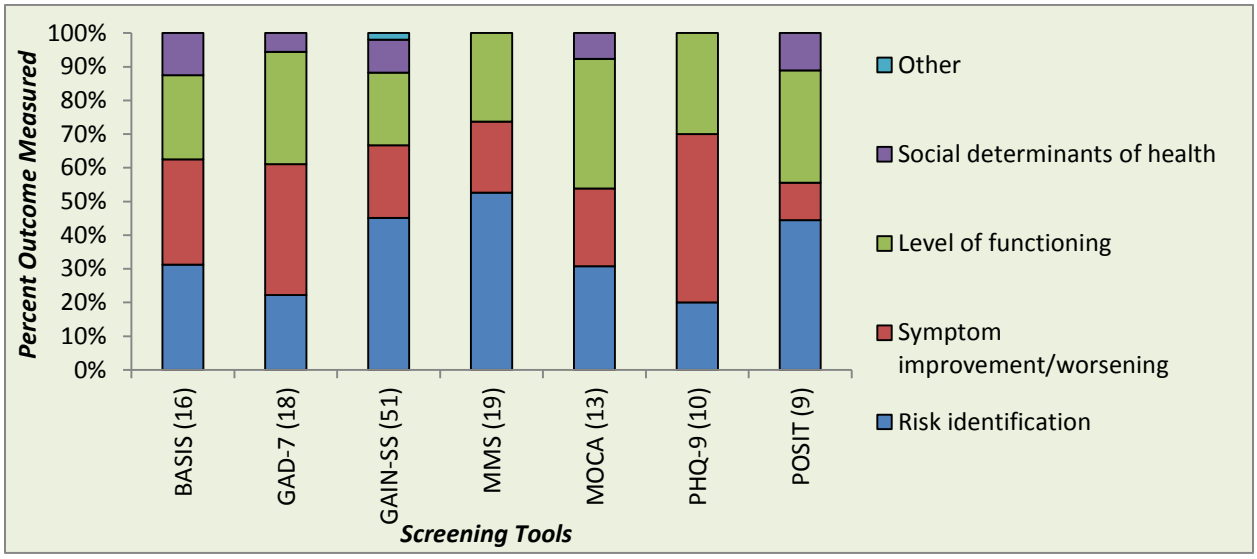
Purpose	BDI	BPRS	GAIN-Q3 MI ONT	GDS	InterRAI MH	MCAS	OCAN	OQ-45	PCL
Risk identification	**5**	1	8	1	2	1	7	1	0
Diagnosis	3	1	4	**4**	1	0	0	0	**2**
Service matching	2	0	**12**	0	1	1	8	0	**2**
Admission eligibility	1	0	7	0	0	0	0	0	0
Treatment planning	**5**	**2**	11	2	2	**2**	**14**	2	**2**
Client recovery	3	0	9	1	2	**2**	10	2	0
Treatment efficacy	3	1	8	2	2	**2**	8	**3**	0
Research	0	0	1	0	1	**2**	3	2	0
Health service planning	0	0	4	0	**3**	0	8	1	0
Health system planning	0	0	1	0	**3**	0	5	0	0
Other	0	0	0	0	0	0	1	0	0

In addition to the uses highlighted in the above tables, respondents shared that they use the screening and assessment tools for referral purposes, on follow-up to measure treatment efficacy, and to assess for employment barriers. Another respondent added that self-report questionnaires should be used for screening disorders, but only in conjunction with a clinical interview to help support diagnoses.

Outcomes Measured by Screening and Assessment Tools

The survey asked that each respondent indicate the outcomes that are being measured with each tool identified. This question also contained a definition of the social determinants of health and was completed by 51 respondents (n=51). Figure 10 shows respondents' understanding of the outcomes measured by screening tools, of which all were identified to measure risk identification, symptom improvement/worsening, and level of functioning. The MMS and PHQ-9 were the only tools that respondents indicated did not measure the social determinants of health.

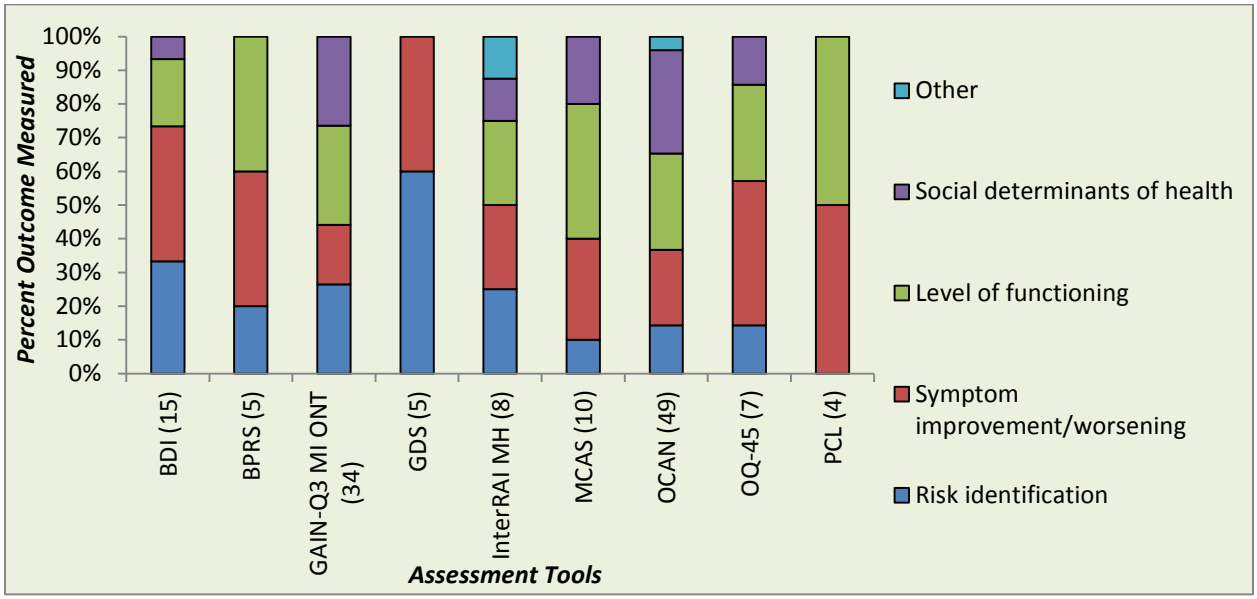
Figure 10: Outcomes Measured by Screening Tools



Note that the proportions represented in the graph are relevant to the total count for outcomes selected by respondents for each tool, which is the number displayed in brackets.

Of the assessment tools, highlighted in Figure 11, the BDI, GAIN-Q3 MI ONT, interRAI MH, MCAS, OCAN, and OQ-45 were all reported to measure outcomes in the domains of the social determinants of health, level of functioning, symptom improvement/worsening, and risk identification.

Figure 11: Outcomes Measured by Assessment Tools



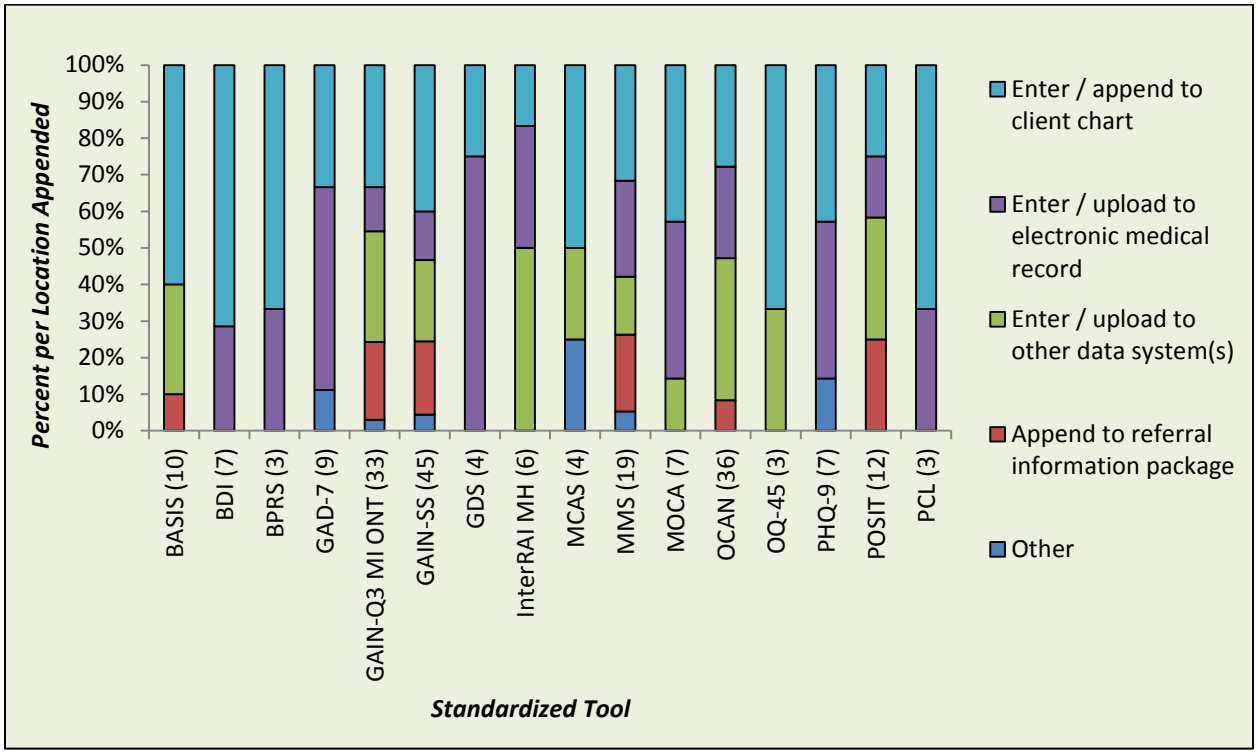
Note that the proportions represented in the graph are relevant to the total count for outcomes selected by respondents for each tool, which is the number displayed in brackets.

Other measured outcomes identified by five respondents for screening and assessment tools include caregiver coping, client needs, quality of life, and overall snapshot of a client's current situation.

Locations Information from Tools is Appended

Figure 12 below, provides an overview of respondents' understanding of the most common locations programs append the completed screening and assessment information gathered through the tool. The client chart and electronic medical record are the most common locations respondents identified. The referral information package location was identified as the least common place, although more common for the tools that many respondents reported as being mandated (GAIN-Q3 MI ONT, GAIN-SS, MMS, OCAN, and POSIT).

Figure 12: Location Tool Information is Appended (n=49)



Note that the proportions represented in the graph are relevant to the total count for locations selected by respondents for each tool, which is the number displayed in brackets.

Respondents' Ratings of Screening and Assessment Tools

The survey asked respondents to rate the tools they use based on their utility for decision making in guiding treatment and care and their ease of use. Respondents had the choice to rate tools as very poor (1), below average (2), average (3), above average (4), or excellent (5).

Table 8 and 9 describe respondents' ratings for the utility for decision making in guiding treatment and care for the screening and assessment tools used for mental health, respectively, including a column for an average rating for each tool. Please note that the response count varies between tools. It is important to note that some screening and assessment tools are intended for use with only a sub-group of clients (for example the BDI and GDS). As a result, they may be useful for guiding treatment and care for that sub-group, but not for all clients. Table 8 and 9 represent 52 unique respondents (n=52).

Table 8: Utility of Screening Tool for Decision Making in Guiding Treatment and Care

Screening Tool	Excellent	Above average	Average	Below average	Very poor	Rating Average	Response Count
PHQ-9	20*	4	3	0	0	**4.5**	6
GAD-7	25	12	3	0	0	**4.4**	9
MOCA	10	12	3	0	0	**4.2**	6
POSIT	5	4	9	0	0	**3.6**	5
GAIN-SS	30	32	30	0	0	**3.5**	26
MMS	5	16	15	0	0	**3.3**	11
BASIS	5	4	9	2	0	**3.3**	6

**Number of responses multiplied by the rating*

Table 9: Utility of Assessment Tool for Decision Making in Guiding Treatment and Care

Assessment Tool	Excellent	Above average	Average	Below average	Very poor	Rating Average	Response Count
BDI	20*	4	3	0	0	**4.5**	6
GDS	5	0	9	4	0	**4.5**	4
InterRAI MH	0	8	0	4	1	**4.3**	3
OQ-45	5	8	0	0	0	**4.3**	3
MCAS	5	8	3	0	0	**4.0**	4
BPRS	0	4	6	2	0	**4.0**	3
PCL	5	0	6	0	0	**3.7**	3
GAIN-Q3 MI ONT	10	24	3	0	2	**3.0**	13
OCAN	0	20	27	2	2	**2.7**	19

**Number of responses multiplied by the rating*

Table 10 and 11 provide an overview of how 48 respondents (n=48) rated the screening and assessment tools based on ease of use. Again, note that the response count varies between tools.

Table 10: Ease of Use of Screening Tool

Screening Tool	Excellent	Above average	Average	Below average	Very poor	Rating average	Response Count
PHQ-9	15*	12	0	0	0	**4.5**	6
GAD-7	20	16	3	0	0	**4.3**	9
BASIS	10	8	6	0	0	**4.0**	6
GAIN-SS	35	20	33	0	0	**3.8**	23
MOCA	10	4	9	0	0	**3.8**	6
MMS	10	12	15	2	0	**3.5**	11
POSIT	5	4	6	2	0	**3.4**	5

**Number of responses multiplied by the rating*

Table 11: Ease of Use of Assessment Tool

Assessment Tool	Excellent	Above average	Average	Below average	Very poor	Rating average	Response Count
MCAS	5*	8	0	0	0	**4.3**	3
OQ-45	5	8	0	0	0	**4.3**	3
BDI	10	4	6	0	0	**4.0**	5
GDS	0	8	6	0	0	**3.5**	4
BPRS	0	4	6	0	0	**3.3**	3
InterRAI MH	0	0	6	2	0	**2.7**	3
OCAN	5	0	27	12	1	**2.6**	17
GAIN-Q3 MI ONT	5	4	15	4	3	**2.6**	12
PCL	0	0	0	2	0	**2.0**	1

**Number of responses multiplied by the rating*

In the next section, the findings for the screening and assessment tools for substance use are reported in the same format as Section 2.

Section 3: Screening and Assessment Practices for Substance Use

Respondents were asked if they currently screen and/or assess for substance use disorders. If respondents indicated yes, they were directed to a series of specific questions related to the tools they commonly use. Seventy-nine percent of survey respondents indicated they do screen and assess for substance use disorders and 21% indicated that they do not.

Substance Use Screening and Assessment Tools

Using the decision rule to further analyze tools that were selected by more than three respondents, 11 tools (Table 12) are identified to be most commonly used for screening and/or

assessment of substance use. On average, respondents identified between two and three tools they commonly use. As with the tools that were presented in the mental health section of the report, the substance use tools are also categorized by whether they are primarily used for screening or assessment purposes and are presented separately in some instances. Note that some of these tools, such as the AUS, DUS, and GAIN-Q3 MI ONT may have elements of both screening and assessment, but have been placed in distinct categories.

Table 12: Most Commonly Used Tools for Substance Use (n=53)

Standardized Tool	Tool Abbreviation	Percentage Using Tool	Category (Screening or Assessment)
Global Appraisal of Individual Needs – Short Screener	GAIN-SS	45% (n=24)	Screening
Global Appraisal of Individual Needs – Q3 Motivational Interview Ontario (version)	GAIN-Q3 MI ONT	36% (n=19)	Assessment
CAGE Substance Use Screening Tool	CAGE	11% (n=6)	Screening
Alcohol Use Disorders Identification Test	AUDIT	9% (n=5)	Screening
Alcohol Use Scale	AUS	9% (n=5)	Screening
Drug Abuse Screening Test	DAST	9% (n=5)	Screening
Drug Use Scale	DUS	9% (n=5)	Screening
Modified Mini Screener	MMS	9% (n=5)	Screening
Drug History Questionnaire	DHQ	8% (n=4)	Assessment
Alcohol, Smoking and Substance Involvement Screening Test	ASSIST	6% (n=3)	Screening
InterRAI Mental Health for Inpatient Psychiatry	InterRAI MH	4% (n=2)*	Assessment

**Note that two survey respondents identified the interRAI MH, but this response represented multiple programs within a large hospital.*

Respondents were asked about their awareness of whether these tools are mandated or not; note that there are some differences in organizational accountabilities in relation to the use of these tools as shown in Table 13. These differences could be a result of different accountability standards expected of programs or inconsistent levels of awareness. The tools most identified as mandated to use include the GAIN-SS and GAIN-Q3 MI ONT. The most common organizations or groups identified as mandating use of tools are the Ontario Ministry of Health

and Long-Term Care, the LHIN, physician groups, hospitals, and Accreditation Canada. Also described in Table 13 are respondent's opinions on whether they would continue to use each of the tools if they were not mandated.

Table 13: Respondents Understanding of Tools Being Mandated or Not

Standardized Tool	Not Mandated to Use	Mandated to Use	If Not Mandated Would Still Use	If Not Mandated Would Not Use
ASSIST	3*	0	2*	0
AUDIT	5	0	2	0
AUS	3	1	3	0
CAGE	6	0	3	0
DAST	4	1	3	0
DHQ	2	2	4	0
DUS	3	1	3	0
GAIN-Q3 MI ONT	0	19	6	7
GAIN-SS	4	20	18	2
InterRAI MH	0	2	2	0
MMS	1	4	3	1
	n=41 **count*		*n=37* **count*	

Respondents were asked if the tools they use are empirically validated for the populations they serve in their programs. The majority of respondents identified all tools as empirically validated; only a small number of respondents indicated that they did not think the GAIN-SS and GAIN-Q3 MI ONT are empirically validated.

Additional comments received from respondents indicated that the screening and assessment tools they use are empirically validated but not for clients with intellectual disabilities or clients over the age of 65. One respondent shared that their program uses the GAIN-SS because it is mandated, but that it "*appears to be better suited for addiction programs that are unaware if there is a mental health issue.*"

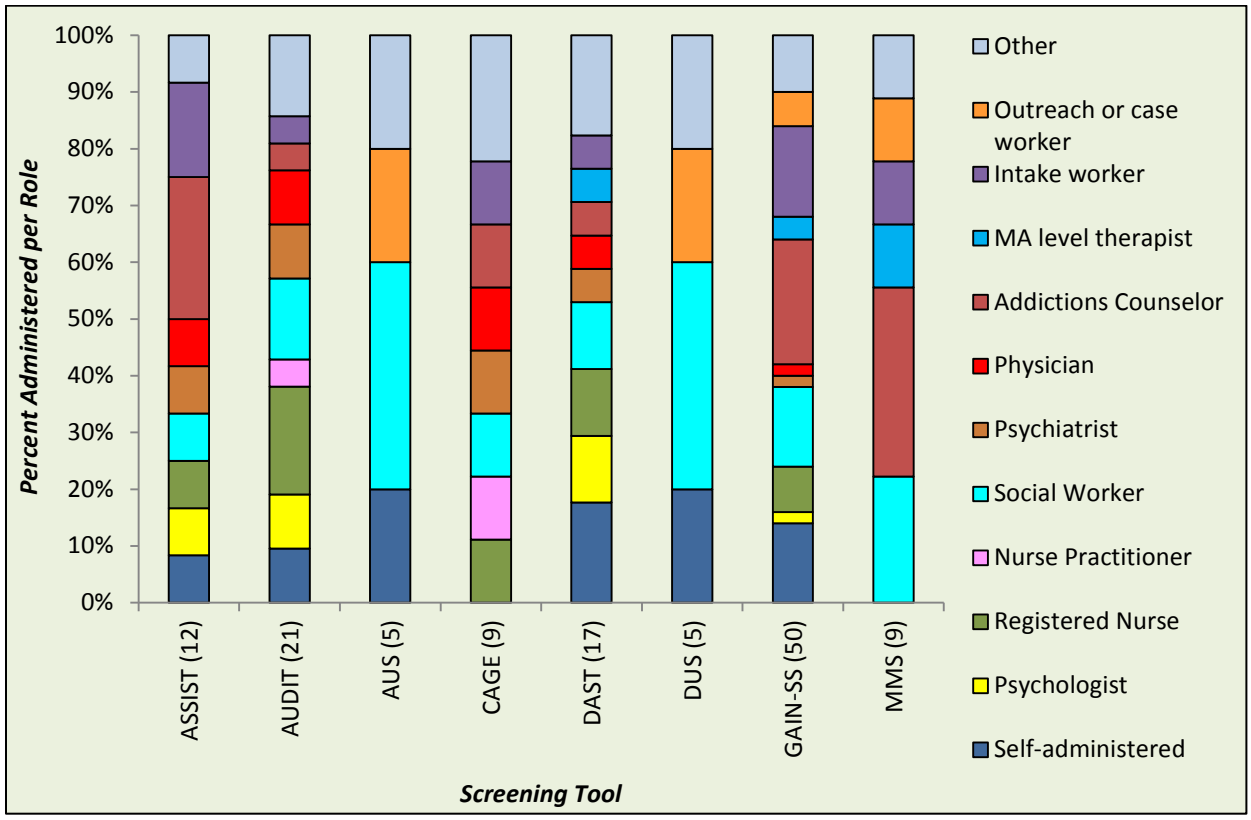
Roles of those who Administer Screening and Assessment Tools

As in the mental health section of the survey, respondents were asked to indicate who administers each tool used for substance use identified. Figure 13 and 14 provides an overview of the typical person/professional administering each of the tools according to survey respondents (n=38).

Figure 13 shows that for the commonly used screening tools, the GAIN-SS is administered by the most diverse group of people/professionals, whereas the AUS and DUS are administered by

the least diverse group, according to survey respondents. The figure also shows that social workers administer each of the screening tools.

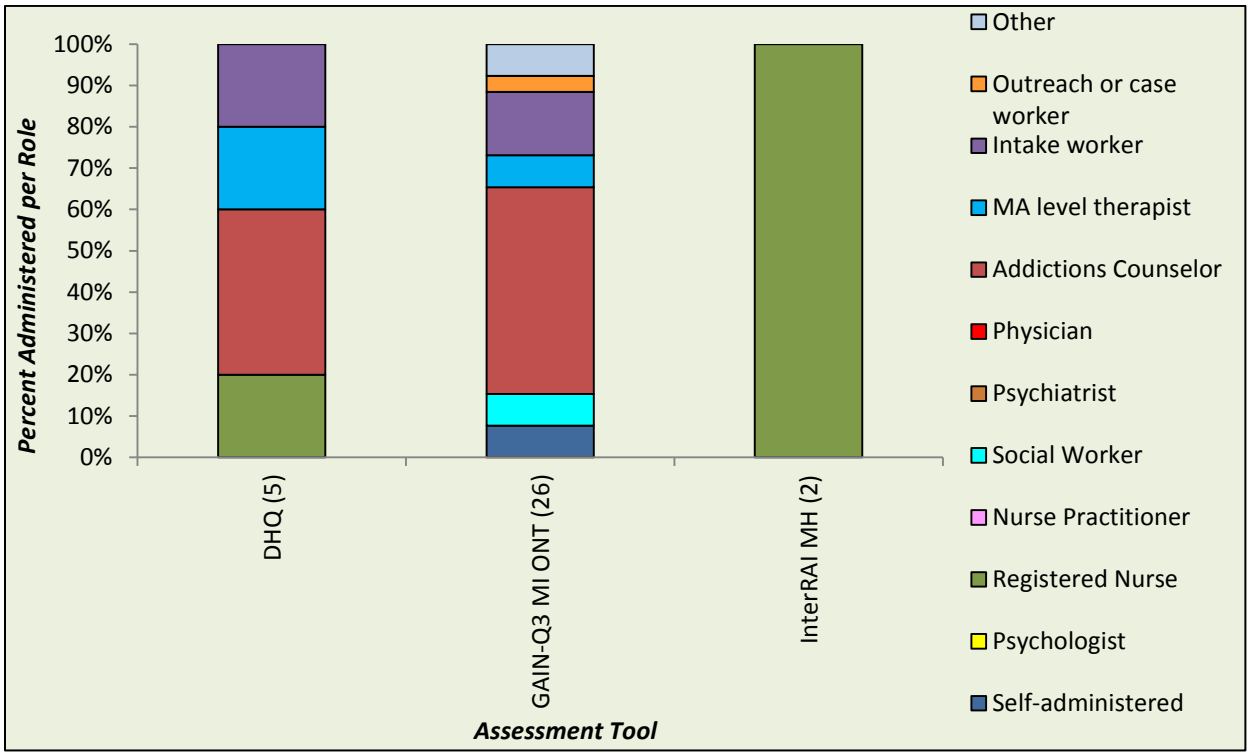
Figure 13: Role of Person who Administers the Screening Tool



Note that the proportions represented in the graph are relevant to the total count for roles selected by respondents for each tool, which is the number displayed in brackets.

Figure 13, below, shows that for the assessment tools, respondents indicated that the GAIN-Q3 MI ONT is administered by the most diverse group of people/professionals, however, this did not include being administered by a registered nurse, whereas both the DHQ and interRAI MH did.

Figure 14: Role of Person who Administers the Assessment Tool



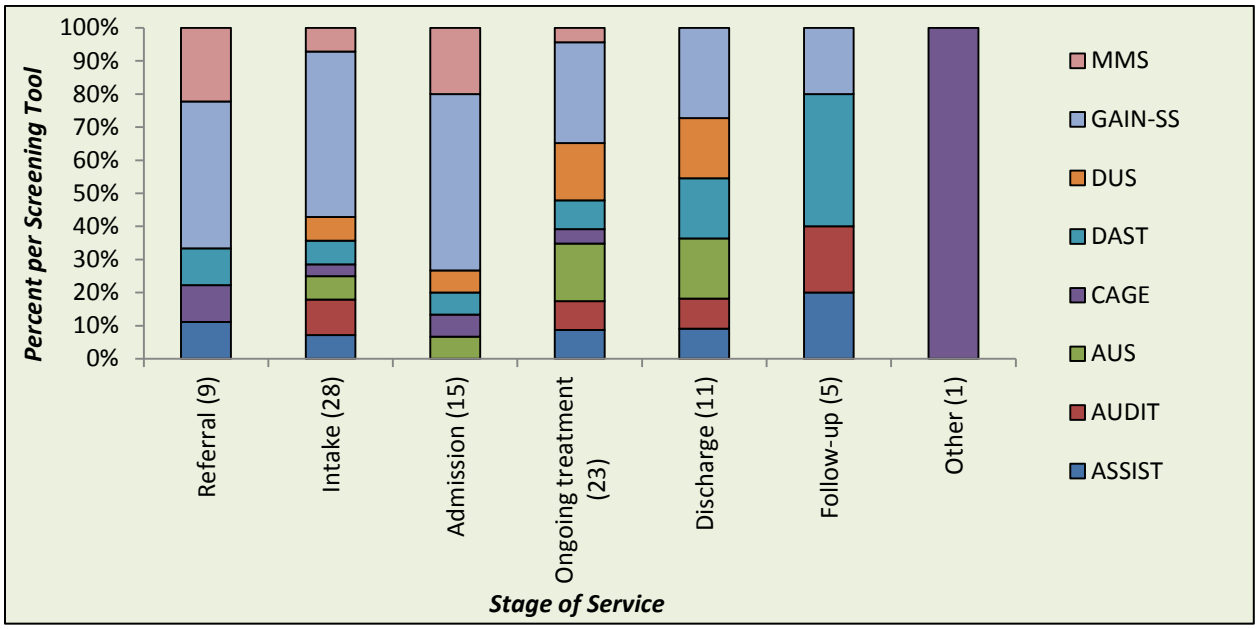
Note that the proportions represented in the graph are relevant to the total count for roles selected by respondents for each tool, which is the number displayed in brackets.

Others that were identified by eight respondents to administer tools include case managers, occupational therapists, program evaluators, psychotherapists, and OAARS team members.

Stage of Service for Tool Administration

Figure 15 and 16 provide an overview of which stages of client service each of the tools are administered according to 37 survey respondents (n=37). All of the screening tools were identified as being administered at four or more stages of client service. Additionally, all of the screening tools are reported to be administered for intake and ongoing treatment.

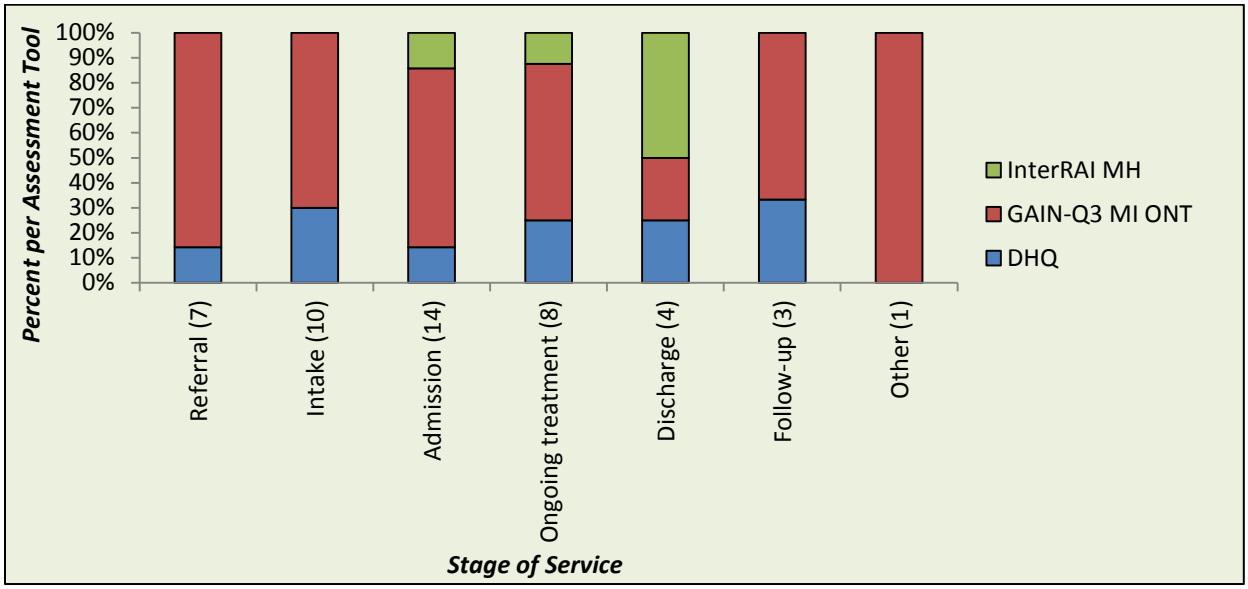
Figure 15: Stage of Service when Screening Tool is Administered



Note that the proportions represented in the graph are relevant to the frequency each stage of service was selected by respondents, which is the number displayed in brackets.

The assessment tools (Figure 16) were all reported by respondents to be used at admission, for ongoing treatment, and at discharge. The interRAI MH is used at the least stages of service according to the survey results.

Figure 16: Stage of Service when Assessment Tool is Administered



Note that the proportions represented in the graph are relevant to the frequency each stage of service was selected by respondents, which is the number displayed in brackets.

Other stages of treatment identified for tool administration include "when clinically warranted" and "every six months if a client remains in treatment."

Length of Time Tools have been in Use

Table 14 describes the length of time respondents report that their program has been using the screening and assessment tools. The majority of respondents indicated their program has been using the tools between 1-5 years, and only a few respondents indicated using their tools more than 10 years.

Table 14: Length of Time Program has Used Tool (n=36)

Standardized Tool	Less than 1 year	1-5 years	6-10 years	More than 10 years	Do not know	Response Count
GAIN-SS	3	**13**	6	0	0	22
GAIN Q3 MI ONT	**15**	2	1	0	0	18
AUDIT	1	**2**	**2**	0	0	5
DAST	1	**2**	1	1	0	5
MMS	2	**3**	0	0	0	5
CAGE	0	1	**2**	1	0	4
DHQ	0	**3**	0	1	0	4
ASSIST	0	**3**	0	0	0	3
AUS	**1**	**1**	0	0	0	2
DUS	**1**	**1**	0	0	0	2
InterRAI MH	0	0	**1**	**1**	0	2

Estimated Time to Complete Screening and Assessment Tools

Respondents were asked to estimate the amount of time each of the screening and assessment tools take to complete. Overall, 39 respondents (n=39) completed this question. Table 15 highlights how long each screening tool takes to complete. The majority of the respondents for the AUS, DUS, and CAGE indicated that these tools take the shortest time to complete. The GAIN-SS was reported as the tool with the greatest variation for time to administer, from less than 5 minutes to up to 60 minutes.

Table 15: Time Estimate to Complete Screening Tools

Screening Tool	Less than 5 minutes	5-10 minutes	10-20 minutes	20-30 minutes	30-60 minutes	60-90 minutes	More than 90 minutes	Do not know	Response Count
GAIN-SS	2	**10**	7	3	2	0	0	0	24
AUDIT	**2**	**2**	1	0	0	0	0	0	5
DAST	1	**2**	1	0	1	0	0	0	5
MMS	0	1	**2**	1	0	0	0	1	5
CAGE	**3**	0	1	0	0	0	0	0	4
DUS	**3**	1	0	0	0	0	0	0	4
ASSIST	0	**1**	**1**	**1**	0	0	0	0	3
AUS	**2**	1	0	0	0	0	0	0	3

As presented in Table 16, none of the respondents reported any of the assessment tools to take less than 10 minutes. The DHQ was reported to take the shortest time to administer, while the GAIN-Q3 MI ONT appears to take the longest.

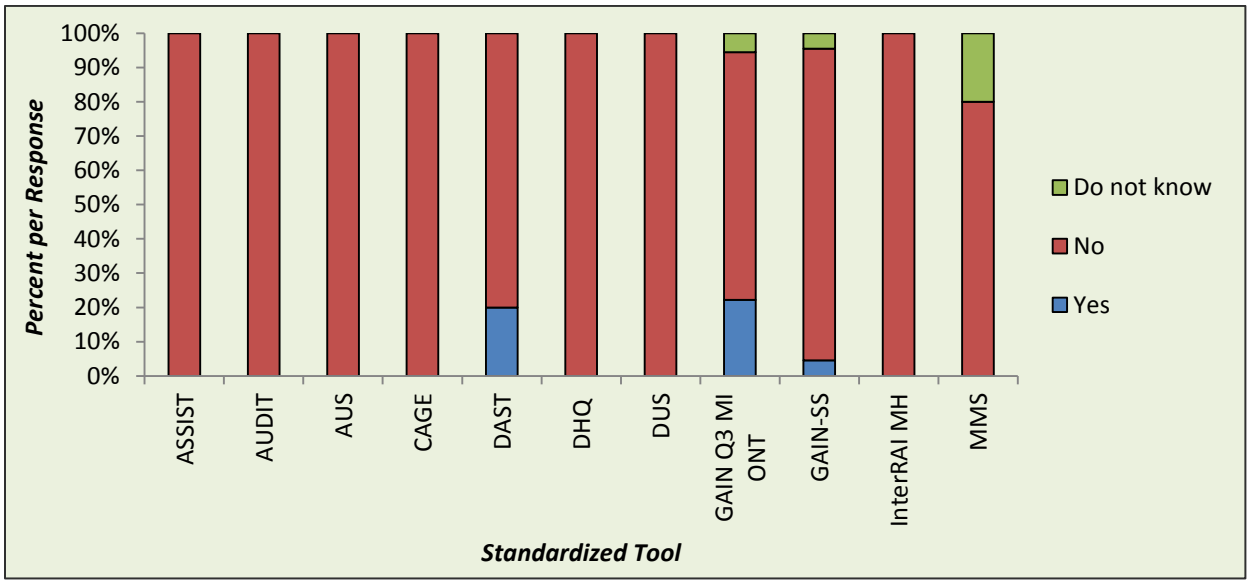
Table 16: Time Estimate to Complete Assessment Tools

Assessment Tool	Less than 5 minutes	5-10 minutes	10-20 minutes	20-30 minutes	30-60 minutes	60-90 minutes	More than 90 minutes	Do not know	Response Count
GAIN-Q3 MI ONT	0	0	0	0	0	**10**	8	1	19
DHQ	0	0	**3**	1	0	0	0	0	4
InterRAI MH	0	0	0	**1**	**1**	0	0	0	2

Cost Associated with Using Tools

Respondents were also asked if there is a cost associated with using the tool (e.g., proprietary). Figure 17 describes that most respondents do not believe there is a cost associated with the tools. It is important to note that for some proprietary tools provided by an organization, respondents may not be aware of the associated costs. The GAIN-Q3 MI ONT, GAIN-SS, and DAST are the tools some respondents identified as having an associated cost.

Figure 17: Cost Associated with Using Tool (n=36)



Identified Purposes of Screening and Assessment Tools

Respondents were asked to identify the purposes for using each screening and assessment tool. There were 39 (n=39) unique respondents for this question. Table 17 and 18 highlight the different purposes for each of the screening and assessment tools for substance use.

Table 17 highlights the purposes for which respondents identified using the screening tools. All of the screening tools were reported as being used for risk identification, treatment planning, and treatment efficacy. These tools are least commonly reported to be used for research, followed by health system planning, and diagnosis.

Table 17: Purpose of Screening Tools

	ASSIST	AUDIT	AUS	CAGE	DAST	DUS	GAIN-SS	MMS
Risk identification	2	3	**3**	**4**	2	**3**	**21**	3
Diagnosis	0	0	0	0	1	0	2	1
Service matching	0	3	**3**	2	3	**3**	20	**4**
Admission eligibility	1	1	0	0	3	0	9	3
Treatment planning	**3**	**5**	**3**	2	**4**	**3**	15	3
Client recovery	1	0	2	0	1	2	5	2
Treatment efficacy	1	2	2	1	2	2	2	1
Research	0	0	0	0	0	0	0	0
Health service planning	0	1	0	1	0	0	6	0
Health system planning	0	0	0	0	0	0	1	1
Other	0	0	0	0	0	0	1	0

Table 18 presents the purposes for using the identified assessment tools, according to respondents. All of the tools were reported to be used for risk identification, service matching, treatment planning, and client recovery.

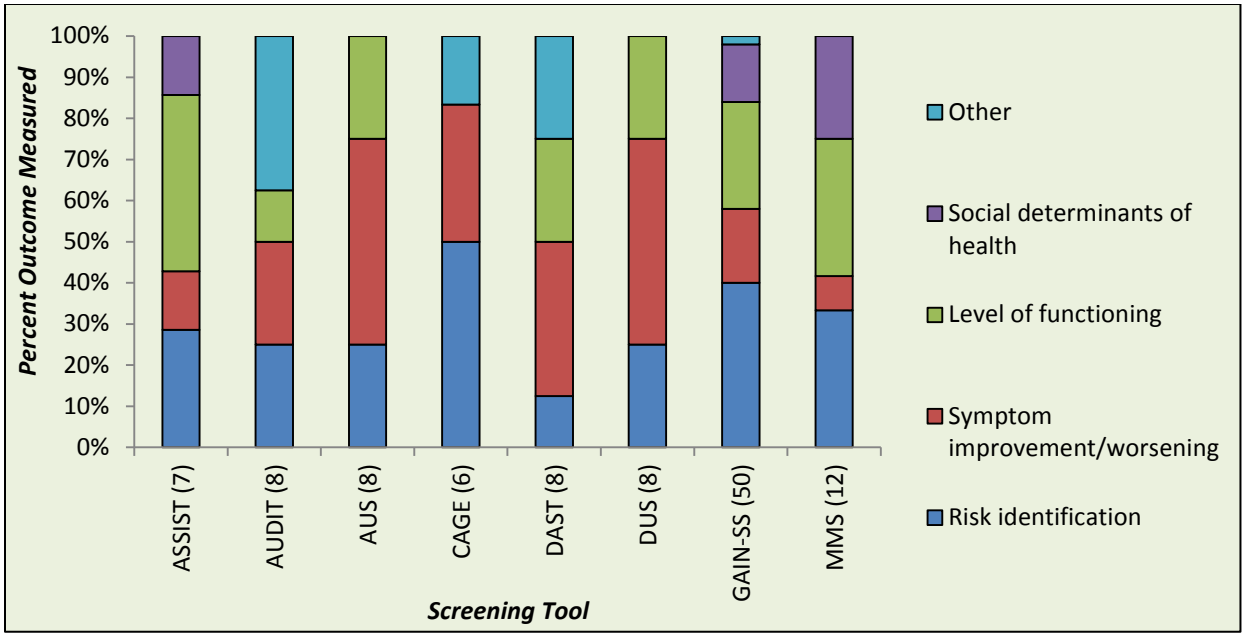
Table 18: Purpose of Assessment Tools

	DHQ	GAIN Q3 MI ONT	InterRAI MH
Risk identification	2	11	**2**
Diagnosis	0	6	0
Service matching	**3**	**17**	1
Admission eligibility	1	9	0
Treatment planning	3	16	**2**
Client recovery	2	10	1
Treatment efficacy	0	8	**2**
Research	0	0	0
Health service planning	1	6	**2**
Health system planning	0	3	**2**
Other	0	0	0

Outcomes Measured by Screening and Assessment Tools

Figures 18 and 19 display respondents' (n=39) understanding of the outcomes measured by each of the screening and assessment tools, respectively. All of the screening tools (Figure 19) are reported to measure a variety of outcomes including risk identification and symptom improvement/worsening. The CAGE was the only tool not identified to measure level of functioning.

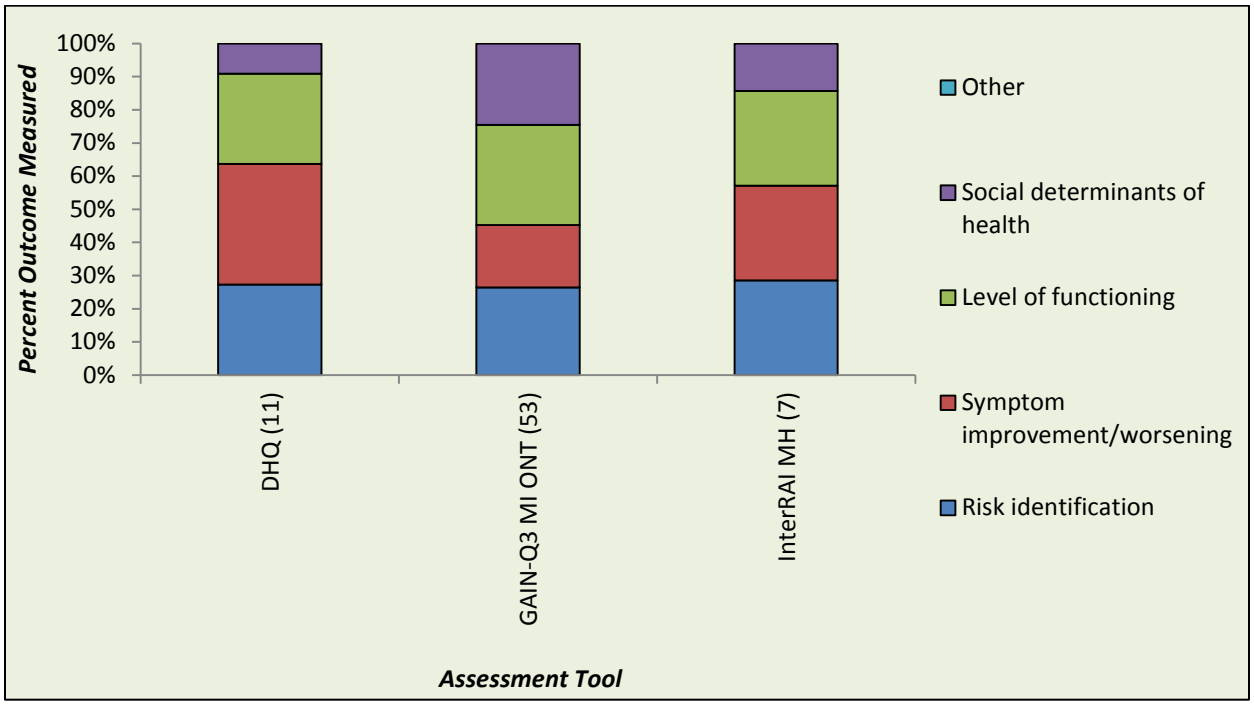
Figure 18: Outcomes Measured by Assessment Tools



Note that the proportions represented in the graph are relevant to the total count for outcomes selected by respondents for each tool, which is the number displayed in brackets.

The assessment tools (Figure 19) were all reported to measure the social determinants of health, level of functioning, symptom worsening/improvement, and risk identification.

Figure 19: Outcomes Measured by Screening Tools



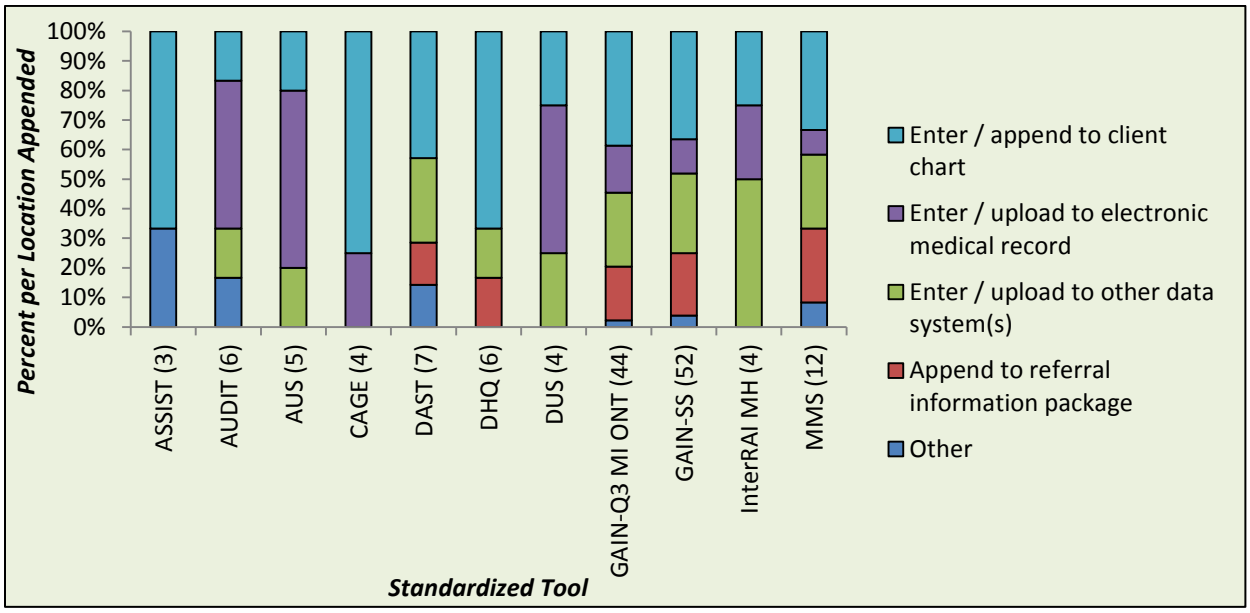
Note that the proportions represented in the graph are relevant to the total count for outcomes selected by respondents for each tool, which is the number displayed in brackets.

One other measured outcome identified by one respondent is "*functioning relative to substance use, not overall life.*"

Locations Information from Tools is Appended

Figure 20 provides an overview of respondents understanding of the most common places programs append the completed screening and assessment tool information. The client chart and electronic medical record are the most common places respondents identified to append information with referral information package identified as the least common place.

Figure 20: Areas Where Tool Information is Appended (n=39)



Note that the proportions represented in the graph are relevant to the total count for locations selected by respondents for each tool, which is the number displayed in brackets.

Respondents' Ratings of Screening and Assessment Tools

The survey asked respondents to rate the tools they use based on their utility for decision making in guiding treatment and care and their ease of use. Respondents had the choice to rate tools as very poor (1), below average (2), average (3), above average (4), or excellent (5).

Table 19 and 20 describe respondents' (n=39) ratings for the utility for decision making in guiding treatment and care for the screening and assessment tools used for substance use, respectively, including a column for an average rating for each tool. Please note that the response count varies between tools.

Table 19: Utility of Screening Tool for Guiding Decisions for Treatment and Care

Screening Tool	Excellent	Above average	Average	Below average	Very poor	Rating Average	Response Count
ASSIST	5*	8	0	0	0	**4.3**	3
DAST	10	8	3	0	0	**4.2**	5
AUDIT	10	8	3	0	0	**4.2**	5
DUS	5	0	9	0	0	**3.5**	4
CAGE	0	8	6	0	0	**3.5**	4
AUS	5	0	9	0	0	**3.5**	4
MMS	0	8	6	2	0	**3.2**	5
GAIN-SS	15	30	30	2	0	**3.2**	24

**Number of responses multiplied by the rating*

Table 20: Utility of Assessment Tool for Guiding Decisions for Treatment and Care

Assessment Tool	Excellent	Above average	Average	Below average	Very poor	Rating Average	Response Count
InterRAI MH	0*	8	0	0	0	**4.0**	2
DHQ	0	12	3	0	0	**3.8**	4
GAIN-Q3 MI ONT	20	21	12	2	3	**3.1**	19

**Number of responses multiplied by the rating*

Table 21 and 22 provide an overview of how respondents (n=35) rated the screening and assessment tools based on ease of use. Again, note that the response count varies between tools.

Table 21: Ease of Use of Screening Tool

Screening Tool	Excellent	Above average	Average	Below average	Very poor	Rating Average	Response Count
AUS	10*	0	0	0	0	**5.0**	2
DUS	10	0	0	0	0	**5.0**	2
CAGE	10	8	0	0	0	**4.5**	4
AUDIT	10	12	0	0	0	**4.4**	5
ASSIST	10	0	3	0	0	**4.3**	3
DAST	5	8	0	0	0	**4.3**	3
GAIN-SS	35	24	24	0	1	**3.8**	22
MMS	5	4	6	2	0	**3.4**	5

**Number of responses multiplied by the rating*

Table 22: Ease of Use of Assessment Tool

Assessment Tool	Excellent	Above average	Average	Below average	Very poor	Rating Average	Response Count
DHQ	5*	4	3	0	0	**4.0**	3
InterRAI MH	0	0	6	0	0	**3.0**	2
GAIN-Q3 MI ONT	5	4	15	8	6	**2.2**	17

**Number of responses multiplied by the rating*

Section 4: Screening for Suicide

Respondents were asked if they currently screen for suicide risk; if respondents indicated yes, they were asked to complete two additional questions. Figure 21 shows that 86% of respondents indicated they screen for suicide risk and 14% do not.

Figure 21: Percentage of Respondents who Screen for Suicide Risk (n=66)

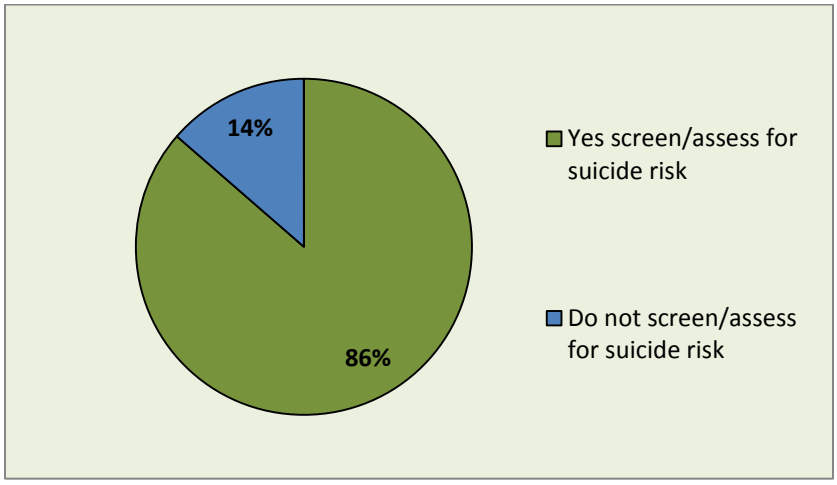
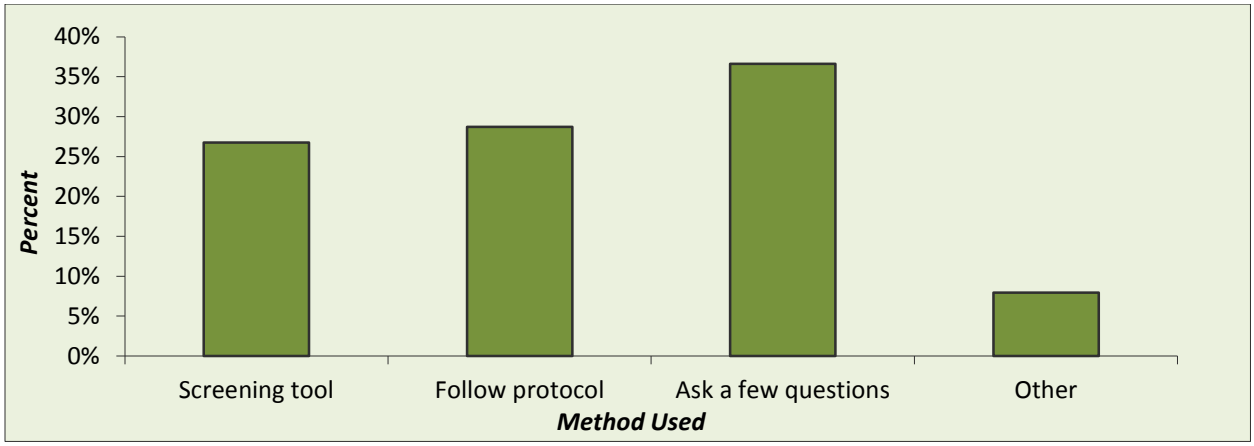


Figure 22 shows that of the three response options provided on the survey, asking a few questions to screen for suicide risk was the most common method selected (37%), followed by using an established program protocol (29%), and a screening tool (27%). Of those who selected other (n=8) the following approaches to screen for suicide were identified: Ask client questions at intake, assess client's clinical presentation, follow protocol as per Applied Suicide Intervention Skills Training (ASIST), and program planning to implement the Columbia Suicide Severity Rating Scale (C-SSRS), which is a standardized tool.

Figure 22: Method Used to Screen for Suicide Risk (n=56)



Respondents were asked to identify any tool or protocol they use to screen for suicide risk. The ten most common tools or protocols identified by 42 respondents include:

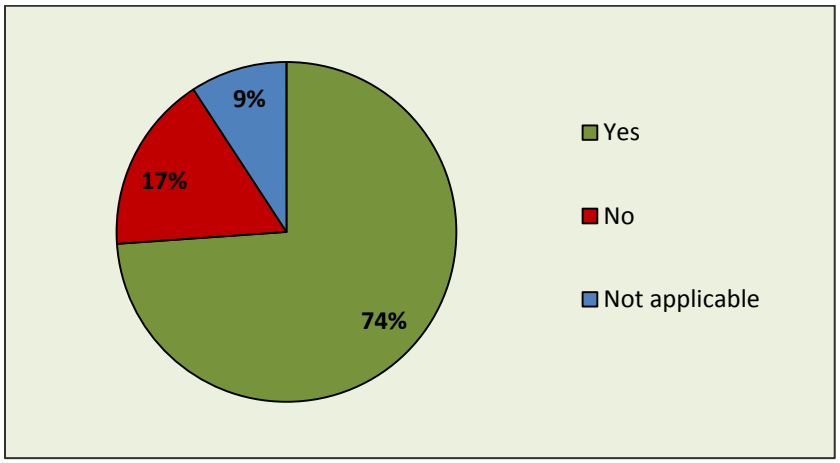
- GAIN-SS (n=9)
- ASIST (protocol) (n=8)
- Program suicide risk protocol (n=6)
- Columbia Suicide Severity Rating Scale (n=5)
- GAIN-Q3 MI ONT (n=3)
- Crisis Triangle Rating Scale (n=3)
- BASIS (n=2)

The next section of this report will address the survey findings exploring the use of data systems for entering or uploading screening and assessment tool information.

Section 5: Data Systems

Figure 23 shows that 74% (n=48) of survey respondents enter or upload information they obtain from screening and assessment tools into data systems.

Figure 23: Percentage that Tool Information into Data Systems (n=65)



Of the respondents who indicated that they upload their screening and assessment tool information into a data system, 79% indicated that they currently run reports from these data systems.

Figure 24 demonstrates that of those who create and run reports from data systems, program evaluation (25%) is the reason most frequently given for data use followed by strategic/operational planning (24%) and accountability reports (21%). Other uses for the data include performance management, program planning, clinical supervision, client management,

program management, to provide regular information to the Board of Directors about the clients served, attendance record for clients, knowledge exchange, and team dashboards.

Figure 24: Use of Screening and Assessment Tool Information (n=41)

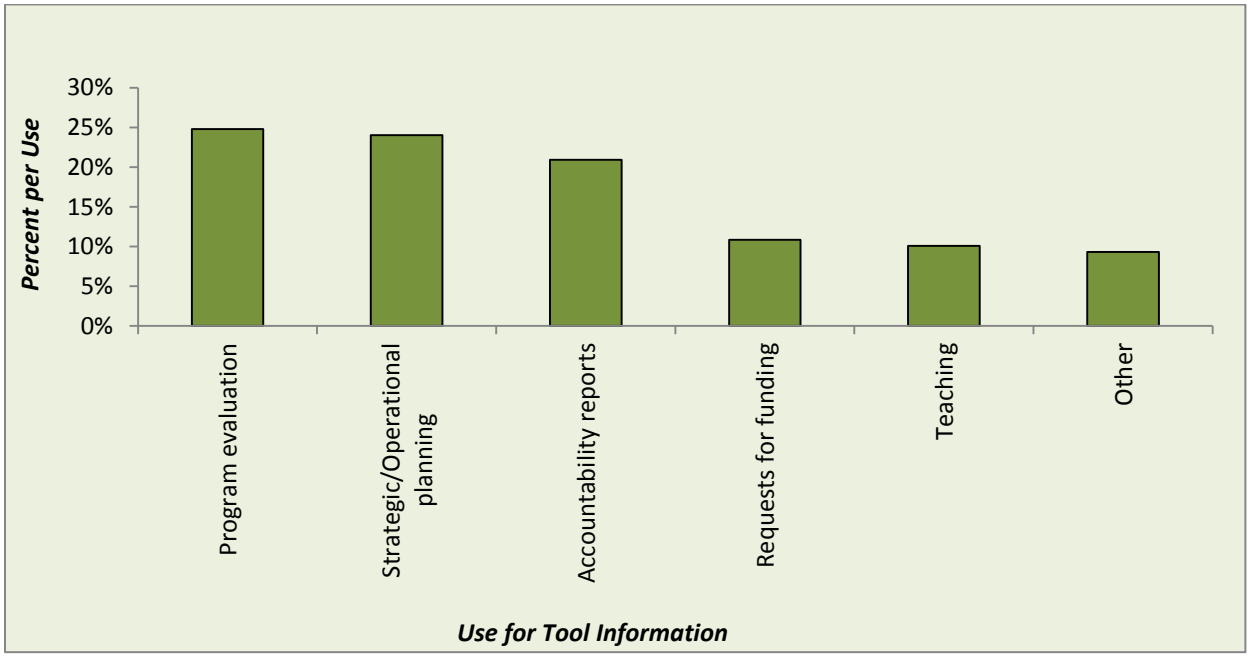


Table 23 shows the data systems that were most commonly identified by survey 47 respondents. Note that the question led many respondents to also enter the name of their electronic medical record (EMR) in this section.

Table 23: Data Systems (including databases and data software)

Data Systems	Response Count
Catalyst/DATIS (Drug and Alcohol Treatment Information System)	18
CRMS (Client Record Management System)	12
EMHware (Mental Health Software)	6
IAR (Integrated Assessment Record)	6
SPSS (Statistical Package for the Social Sciences) and Excel	4
Local/Provincial CCAC	1
WinRecs (Health Information Management Software)	1
Ontario Mental Health Reporting System	1
Other/electronic medical record/LHIN SharePoint	8

Additional information about data systems was gathered through key informant interviews. When asked about the costs of using the data systems that providers identified, many were not aware of the exact cost. One provider, however, stated that CRMS costs $8800 annually in their

adult mental health program and $4000 annually in the children's mental health program. Other providers who use CRMS reported paying an initial fee for the system and that they are charged extra for support. It was reported that DATIS/Catalyst have no cost to individual organizations, however, these are managed by the Centre for Addiction and Mental Health (CAMH) so there are costs to them.

Both benefits and challenges related to the data systems and electronic medical records used were highlighted. Benefits include that CRMS is useful because it is a full electronic health record and that Nightingale on Demand (an EMR) has very sophisticated reporting capabilities. Additionally, one provider mentioned that through the Champlain Association of Meditech Partners (CHAMP) there is capability for users to see if clients are involved with other organizations that are also part of CHAMP. One provider highlighted that SPSS is beneficial because it is capable of doing any level of statistical analysis.

Challenges related to data systems and EMRs that were reported include that there are too many data systems that do not interface well together, that much time is spent entering the same data into multiple systems, and that there is an overall lack of information sharing and communication between organizations.

Service providers had some ideas around what should be done to counteract some of the challenges mentioned. One provider suggested that if the province introduced one EMR system that everyone could use it would be very helpful. A few providers stressed the importance of having client information all in one place at one time to reduce inefficiencies. One provider stated that *"it would be very beneficial if there were a simplified process to access information."*

Summary of Findings from Key Informant Interviews and from Section 6 of the Survey

The last section (Section 6) of the survey prompted respondents to provide further comments and recommendations about screening and assessment tools.

Key informant interviews of nine service providers took place between February 27 and March 10. Ten structured questions were sent to key informants prior to the interview and guided the data collection. Some additional questions were asked on an ad hoc basis during the interviews. The structured questions were as follows:

- What training is required for using the tools you identified in the survey?
- What do the tools you use have in common and how do they differ?
- How do the screening and assessment tools that you currently use meet the needs of service providers and clients?

- What tools would you recommend be used at a centralized intake point for the screening and assessment of mental health?
- Although many programs use different screening and assessment tools, what questions or measures do you think should be common/necessary for every program?
- What challenges do you foresee for your organization if a new set of screening and assessment tools were mandated by the Ministry or LHIN?
- What supports would you need in place to successfully transition to a new suite of tools?
- Would your organization be willing to pilot new screening and assessment tools, were these to be identified?
- The survey asks about the data systems you are using. What is the cost to your organization to use this data system? What is included in those costs (e.g., licensing. annual fees, customer service support, system upgrades)?
- What are the benefits and challenges of using these data systems?

Points raised by a significant number of key informants and through comments from Section 6 of the survey were categorized into themes and documented here.

Purpose of Using Tools

In the interviews, providers gave feedback around the effectiveness of using screening and assessment tools. Screening and assessment tools were cited as being helpful for clinicians because they help monitor treatment and progress over time, give information about symptoms, and help broaden conversations. The information gathered using the tools may then benefit clients because clinicians are able to adjust treatment accordingly.

Concern was raised regarding the need for a tool and its overall purpose. It was stated that there needs to be reasons for using a specific tool at the clinical level and that mandating one single tool so that everyone is uniform does not always make sense. Some providers find that tools that are required to be completed may cause repetition. Many providers stressed the importance that tools should enhance practice rather than add an additional layer of work. One provider said:

> *"Tools that are being mandated should be to enhance practice and shouldn't decrease the amount of service that you will be providing because now you need to do this tool and it takes time to do."*

The key informants highlighted that before there is a decision made about mandating specific screening and assessment tools, it is important to know what outcomes and indicators are desired to be measured.

Using Screening and Assessment Tools According to Client Need and Service Provided

Many providers expressed that they have many tools available for use but that choosing what tools to use is based on specific client needs. Further, many providers highlighted that the services that they provide are unique and varied so the standardization of tools is a challenge. One provider said:

"Services are unique in what they provide and as such this consideration should be kept in mind when looking at standardizing screening and assessment tools that are not clinically beneficial and have no relevant outcome for the client. Assessment should be tailored to client need."

It was, however, also expressed that there is a need for harmonization of the tools that are currently in use, but a one-size-fits-all approach does not work. One person commented:

"We need to harmonize the tools used and the results transferred to instances providing follow-up or the health care for our patients."

Clinical Interviews

Many providers noted that screening and assessment tools should not be used alone, but rather should enhance a clinical interview. Used in isolation, there are concerns that tools are not very helpful and it was stated that they must be combined with a clinical interview to aid in the development of a clinical impression, diagnosis (if applicable), and treatment plan. Programs that offer specialized services also highlighted that clinicians are trained to be able to make decisions based on clinical judgement, and that standardized tools often serve to inform a clinical interview or provide diagnostic clarification. One provider said:

"The tools enhance the interview—that assessment, that one-on-one assessment."

Providers also expressed that assessment tools, particularly those being used at a central intake, need to have a space to include information about a client's presentation, such as mood, affect, and energy level.

Diverse Approaches to Care and Client Experience

Some mental health and addictions providers stressed the importance of understanding that agencies, particularly those in the community, use a resiliency model of care that focuses on the strengths of the individual. In terms of screening and assessment, it was highlighted that many tools are problem based and that there is a need for strength-based tools. It was also expressed that some tools that are mandated could actually negatively impact client experience and treatment outcomes.

Piloting New Tools and Openness to Using New Tools

When providers were asked if they would be willing to pilot a new suite of tools, most of them indicated that they would be interested in doing so but that it would really depend on timing and if the tool was suited to the services being provided. A couple of responders were early adopters or piloted the Staged Screening and Assessment tools, so at this point were not ready to pilot a new suite of tools. Those that indicated that they would be willing to test out a new tool expressed that it would depend on what the tool was and that they would like to be consulted about it prior. One provider commented:

> *"As long as it is an appropriate tool for our population, if the tool is to enhance care and service, if it is feasible, if resources are provided to be able pilot it, and if it is client centered, absolutely, but not if it takes away from care."*

A few providers also expressed interest in wanting to learn more about tools that are being used by other organizations.

Challenges around Having Tools Mandated

Some challenges and concerns that were identified by providers when asked about having a new set of tools mandated include:

- Not having the resources to sustain the use of tools and the training required.
- Concern that new tools would slow down assessment and take away from time spent with the client.
- Concern around additional databases that information from the tool would have to be uploaded to.
- Concern that tools will not adequately cover both mental health and addictions.
- Concern around having to use tools that are not appropriate for the service provided or for the client population that is served.
- Concern about ongoing isolation between mental health and addictions sectors.

Supports Needed if Tools Were Mandated

When asked what supports would be needed if a new set of screening and assessment tools were mandated, interviewed providers identified supports in three main areas: financial support, technological support, and flexibility to use tools that match service models.

In terms of financial support, providers spoke about ongoing costs for training and possible licencing fees. Technological support included: having one electronic medical record that all providers use, not to have to enter information into a new and separate data system, and

having an electronic system that would enable flow of client information throughout the system. Finally, providers would like the flexibility to be able to use tools that fit with their service model. One provider said:

> *"We need support to be able to individualize what our screening looks like."*

One provider highlighted that the support provided by the CAMH implementation team for the Staged Screening and Assessment tools was well done and that similar support would be welcome if new tools were mandated.

Client Discussions

Although the main focus of this project was on service providers and the tools they are currently using, there was some client input received as well, however quite minimal. Two clients were asked about their experiences with accessing and transitioning through the MH&A system. Both of these clients did identify having to repeat their story when they went to different service providers but that is was not excessive and was understandable. One client said that they had to go from doctor to doctor, which "*made for a lot of repetition, which would be frustrating, but [understood] it was necessary. In the moment, the process is quite numb anyway."*

Recommended Measures and Tools

Providers were asked to recommend specific screening and assessment tools that could be used in general and at a centralized intake point. Many stated that there were no specific tools they would recommend but that there were certain areas of assessment that should be common across most programs and that should be included when receiving information about a client. The areas are listed below:

- client goals
- current and past medications
- diagnosis, if available
- impact of illness or functionality
- measure of acuity
- mental health history
- sexual assault and domestic violence

- mental status and cognition
- past treatment
- risk assessment
- substance Use
- suicide Risk
- symptoms checklist
- vulnerabilities/social determinants of health

Some providers expressed the need to understand and ask questions about the broad categories of diagnosis at a central intake point and that this would give the receiving agency a heads up on the presenting issues. It was also mentioned that tools that lead to a diagnosis should not be used because the client might be matched to an inappropriate service. One provider recommended that there be a suite of tools available or to have a brief general tool available and then other tools that dig deeper into specific client needs. Another provider expressed wanting a tool that clearly indicates whether or not a client needs a psychiatric consult. Many providers recommended that tools be brief. They stated that harmonizing tools is useful, but that there also needs to be a balance between completing tools and intervening directly with clients.

The tools in the list below were identified by providers as being beneficial, tools that they would like to see more of, or tools they would recommend. Many of these tools have been identified as commonly used tools through the survey, but there are additional tools identified here as well, which are highlighted in bold print. Note that LOCUS (Level of Care Utilization System) is a tool that is designed to determine the level of care that an individual should receive (Macdonald, 2017).

- ASSIST
- AUDIT
- BASIS
- BPRS
- **C-SSRS (Columbia Suicide Severity Rating Scale)**
- DAST
- **FIM (Functional Independence Measure)**
- GAD-7
- GAIN-SS
- **InterRAI BMHS (Brief Mental Health Screener)**
- InterRAI MH
- **LOCUS (Level of Care Utilization System)**

- **MDQ (Mood Disorder Questionnaire)**
- **Mental Status Exam – RNAO**
- PHQ-9
- **PROM (Patient Reported Outcome Measure)**
- **SCARED (Screen for Child Anxiety Related Disorders)**

Training

In terms of training for screening and assessment tools, some providers emphasized that staff were regulated health professionals who have not received formal training on tools by the organization. In addition, many tools that are used come with a protocol for administration. One program provides a half-day orientation session on all standardized tools that they use.

Training for the GAIN-SS, POSIT, and MMS is a three-hour recorded webinar. Training for GAIN-Q3 MI ONT begins with one-day training followed by three months of practice and coaching, which then leads to certification.

There is training available for the MOCA and BPRS, and the OCAN has a specific training protocol that comes from Community Care Information Management (CCIM). It was reported that there is no specific training for the BDI, and providers were unsure if there is specific training for the GAD-7.

Considerations for Specific Populations

Champlain Pathways to Better Care is committed to exploring how to provide equitable health care to the residents of the Champlain LHIN. In doing so efforts are being made to identify, reduce, and avoid unfair circumstances that deprive individuals of equitable health outcomes. Information in this section regarding mental health and substance use screening and assessment was collected by organizations that primarily serve one of the following population groups: the geriatric population, Indigenous people, immigrants and refugees, and Francophones.

Geriatric Population

Several providers who serve people aged 65 years and over expressed concern around the limited tools available for the screening and assessment of mental health and substance use specific to this population. Providers highlighted that there is a significant difference between the screening and assessment needs of the geriatric population and that of the adult population. Compared to the adult population, people seeking mental health care over the age of 65 have more chronic diseases, including dementia and physical ailments, and they often do not have the capacity or stamina to complete some of the longer tools.

Providers were frustrated that screening and assessment tools, including those that are currently mandated, have not been adapted to the unique needs of the geriatric population. One provider gave the following comment:

"It is important that tools are sensitive to this population and that a tool is not embedded that has been designed for other people."

Generally, providers expressed satisfaction with the tools that are standardized for geriatrics, because they are quick and easy to administer, require minimal training, are able to be re-administered, are available in multiple languages, and are sensitive to the needs of this population. Tools that were recommended for use for the geriatric population are the MOCA, the Geriatric Depression Scale, and the Confusion Assessment Method (CAM). The CAM is a tool that can be used to help identify delirium, which can be administered quickly by non-psychiatric clinicians (Wei, Fearing, Sternberg, & Inouye, 2008). Overall, however, there are limited tools available for the geriatric population, and specifically it was identified that tools to assess anxiety are needed.

Indigenous Population

The interviewed provider explained that Indigenous culture is essentially the foundation of all the services provided at their organization. These services integrate Traditional and Western healing approaches and therapists are trained in various modalities to address the mental, physical, emotional, and spiritual aspects of a human being. It was expressed that any tools that are used must also be rooted in culture, and that these tools would ideally be developed by Indigenous people.

Current practice at the organization consists of a questionnaire that is administered at intake, which collects demographic information. Then, if a client requests services of mental wellness or case management, the GAIN Short Screener Modified Aboriginal (GAIN-SS-MA) tool is completed. The GAIN-SS-MA was adapted by the interviewee to be more culturally appropriate, but there was still concern expressed that there will always be a limitation to adapting tools that were developed for the mainstream population.

"Right now, the GAIN-SS-MA is the only tool that has been done through our lens, it's not perfect, but it's the best we have."

The provider indicated that case management assessments are not necessarily structured, but rather they are guided by a client's needs, and it is more of a conversation. Case managers at the organization know how to prompt people for information that is then recorded on the form and is translated into goals and a plan of care for each client. The interviewee expressed that

there is currently no need for another set of screening and assessment tools, and if there was, they would need to be developed from the ground up through an Indigenous lens that would focus on culture and equity.

> *"It will not work to be told what tools to use. It does not work, it cannot work. We need to own it, it needs to be culturally appropriate, it needs to service our people, it has to be client centered; and to be client centered you need to take all this into consideration."*

Information from the GAIN-SS-MA is not being uploaded to a data system; it is being used to inform clinical practice and to help clients. The organization uses Nightingale on Demand as its medical records system and the Pirouette software, which collects psychosocial information that feeds into the Common Data Set, which is the requirement of the LHIN. Concern was expressed regarding the ethics around collecting data on Indigenous people, the main concerns being around ownership of the data and the fact that this information has been misused on numerous occasions in the past.

Immigrant and Refugee Population

A key informant for the immigrant and refugee population revealed that most new immigrants and refugees come from countries that have a great deal of stigma around mental health and substance use issues. Before these issues can be discussed, a very solid long-term therapeutic relationship must first be established. The informant expressed that administering the current tools that are available would be extremely culturally inappropriate with the majority of new immigrants and refugees. It was also highlighted that within this population there are a variety of languages spoken. Many translations of the tools are not available and much of the language used in the tools would not translate in a coherent way. Further, even if mental health and/or substance use issues were identified, the informant expressed that many of these individuals would not be able to participate in community or residential treatment programs due to linguistic, cultural and/or spiritual beliefs. The informant expressed that the current system does not adequately serve newcomers who may be facing problems with regard to mental health and substance use, and that there is a need to increase awareness and competence in this area.

Francophone Population

Three key informants were able to provide some insight into considerations that should be taken for the Francophone population when using screening and assessment tools. One informant from a Francophone organization stated that all of the tools they use are translated into French and there are no particular issues with these tools. On the other hand, another individual indicated that translated and validated tools for Francophone clientele are difficult to

find. Another key informant highlighted that sometimes an issue is that the English version of a tool is available before the French version, therefore making it unavailable in French for a period of time while the English one is in use. Another aspect that was highlighted was the need to take into account the uniqueness of the Franco-Ontarian population. It was said that sometimes tools are not tested and validated in Franco-Ontarian French in particular and that it is a tendency to look for tools that are developed in Quebec. Further, it was stated that many Franco-Ontarians are brought up in French and English and use words from both languages; therefore it might be helpful to have both languages on one sheet, such as having French on the right side and English on the left side of the form.

Limitations of this Review

Some of the limitations of this review are highlighted here.

Conducting an In-depth Analysis of all Screening and Assessment Tools

- There was not sufficient time to do a thorough analysis and comparison of each common tool identified and/or recommended based on their psychometric properties, practicality properties, and clinical utility.
- There was a lot of data captured in the survey, there is potential for further analysis of the results, however this is beyond the timeframe of the current project.

Variation in Respondent Feedback

- There were technological difficulties for some respondents during survey completion, which may have impacted the thoroughness of responses.
- The respondent sample is not representative the number of individuals involved in screening and assessment (clients or providers), nor is it a balanced representation of the range of services providing screening and assessment.
    - It is known that the respondent sample is an over-representation of the addictions sector relative to the number of clients receiving mental health or substance use screening or assessment.
    - There was not enough CCAC representation to reflect the volume of mental health and substance use screening and assessment performed through that agency.
- It is difficult to come to conclusive results because the sample size for some tools is very low.
    - This report is not conclusive in comparisons between tools for their perceived utility in decision making and ease of use given range of responses for tools.
- Input was from various providers that may have interpreted the questions differently.

- Some respondents may have relied on objective counts of activity (available through their information systems), while others may have used opinions.
- Respondents were not categorized as either administrators or direct care providers, which may impact their perspective.
- There was limited client input.

Tool Restriction for Analysis

- There were tools identified by respondents that were not included in the analysis because they did not meet the decision rule.
    - Some of these tools were identified by respondents from large organizations that likely perform many assessments, and therefore may warrant further analysis. These tools include (see Appendix B for full tool name): the ASRM, BAI, C-SSRS, GAF, HAM-A, HAM-D, IDS, interRAI-BMHS, IDS, MDQ, MINI, MMPI, MSI-BPD, OASIS, PANSS, and SDS.
    - Some useful tools that can only be administered by certain disciplines may also have been missed.

Discussion

Additional Information for a few Identified Tools

There were many tools identified for mental health and substance use screening and assessment. This report highlights information gathered on tools that were identified by three or more survey respondents. Survey respondents and interview participants provided additional information for some of the identified tools, which are discussed here. Note that this is not an in depth analysis of each of these tools.

In the survey, the BDI rated the highest of the assessment tools in terms of utility for decision making in guiding treatment and care. One interview participant highlighted that the BDI is also useful in monitoring progress of depression. Two programs highlighted that despite the usefulness of the BDI, there are some people that have difficulty with this tool due to cognitive impairment or low literacy levels.

Many survey respondents and interview participants commented on the GAIN-Q3 MI ONT. Concerns reported about this tool are that it is very long and requires information that does not always seem relevant, that it does not give enough depth to appropriately assess mental health, and that some questions are inappropriate and stigmatizing. Conversely, a few providers also highlighted that the reports that are generated by the GAIN-Q3 MI ONT can be quite helpful.

The GAIN-SS was reported to have both benefits and challenges as well. One provider stated that it is a good tool, it is easy to administer and gives good information about the areas that need to be explored further. Another provider stated that it helps navigate client issues. On the down side, it was reported that the language used in the tool is difficult for clients to understand and that it does not give very much information about severity of issues. Two providers commented that it seems to be a tool better suited for addictions rather than mental health programs.

The MOCA is a tool that was identified by a few providers as being very useful for picking up cognitive changes in someone who is not already diagnosed with dementia. It was reported that this tool is sensitive to education and literacy levels, and that administering it to someone who is not cognitively impaired and who has a limited education will likely produce a false positive.

One community mental health provider particularly mentioned the OQ-45 as being an overall good tool to use. Specific commendations for this tool included that it has the ability to be re-administered to monitor progress over time and that it meets the needs of multiple funders.

Training

It is important that service providers are trained on how to properly use the screening and assessment tools that are available, as this may be a key reason why some tools are used over others. Further, without proper training and coaching for some tools, the uptake can be challenging.

Integrating Services through Common Screening and Assessment

In choosing a sub-set of screening and assessment tools to be used across the care continuum tools that were identified through this project should be further analyzed in order to determine which tools would be best suited to serve a diverse clientele, as no tool will work for all clients all of the time. Findings from this review should also be considered, as they provide important insight from the perspective of health service providers. It may be that standardization of screening and assessment tools can serve as the foundation for a common language for many clients served but any mandating agency should allow for flexibility to complement or replace these tools with those that are defined for the unique needs of each service provided.

Another step toward integrating mental health and addictions services, as revealed by the recommended measures that key informants identified (suicide risk screening, substance use screening, current medications, etc.), would be to work toward a common collaborative care planning (CCP) tool similar that being used by Ontario Health Links. Within the CCP there could

be a space to record the scores of the common screening and assessment tools, as long as this information is accompanied by clinical assessment information.

Recommendations

The findings presented in this report provide an overview of the mental health and substance use screening and assessment tools that are most commonly used in Champlain and also present a variety of valuable perspectives from health service providers. Information that has been gained through this initiative will lay the groundwork for future work in this area.

Recommendations for next steps toward the harmonization of mental health and substance use screening and assessment tools are categorized and highlighted below.

Future Direction and Next Steps

1) Decide on a set of common indicators/outcomes that reflect the client's goals for treatment and care; define these as the key indicators to be monitored and then look at encouraging providers to use tools that are capable of measuring these. Once the system knows what indicators are being monitored, then all will be in a better situation to determine which tools should be used.
2) Consider establishing an expert panel that includes, at a minimum, representation from psychology and social work, to utilize this report and other sources to continue work in this area and develop specific recommendations on a screening and assessment strategy. This panel should analyze the psychometric properties of each of the tools identified in this report, including the populations for which the tool has been validated. The costs (direct and indirect) of implementing any tools also need to be taken into consideration.
3) Share the results of this review with provincial peers to support provincial work in this area.

Client-Centred Care

4) Ensure that the considerations of all stakeholder groups are taken into account before implementing any specific tools.
5) Balance the flexibility for providers to be able to choose from a suite of tools based upon the treatment and care goals of the client.
6) Seek input from and collaborate with people with lived experience and their families during future work in this area.

Improved Data Systems and Electronic Medical Records

7) Continue to explore opportunities to make information more easily accessible across different information systems to maintain a holistic view of the client across the continuum of care and to eliminate duplication and siloed client information.
8) Consider using delivery systems (such as computer tablets or web-based applications) that will allow clients to easily interact with tools that facilitate automatic import of the tool's output into EMRs and data systems.
9) Coordinate the development of a screening and assessment tool strategy with the development of a common electronic medical records system.

Conclusion

It is hoped that the information presented in this report provides a fair picture of the screening and assessment tools for mental health and substance use that are currently being used by a variety of Champlain's mental health and addictions service providers as well as a glimpse of what is being used in a sub-set of primary care programs and the CCAC. Additional considerations around mental health and substance use screening and assessment in general were also reported.

It is clear that a more integrated system is desired, especially with regard to information sharing, however a clear path to obtaining seamless client service may not be as straightforward as implementing a one-size-fits-all approach for screening and assessment. Additional work is needed to determine how a more integrated system can be achieved through a more harmonized approach to screening and assessment.

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Appendix A: Survey

Survey on the Current Practices in the Champlain Region for Mental Health and Substance Use Screening and Assessment Tools

Section 1: Contact and Demographic Information

1. Please provide the following information:

Contact Name:
Organization Name:
Program Name:
Contact Email:
Address:
Contact Phone Number:

2. Please indicate which Champlain LHIN sub-region your program is located in.

☐ Central Ottawa
☐ Eastern Champlain
☐ Eastern Ottawa
☐ Western Champlain
☐ Western Ottawa

3. Please indicate if you regularly serve the following client populations:

☐ Indigenous persons
☐ Persons with physical disabilities
☐ Persons with intellectual disabilities
☐ Homeless persons
☐ Persons who identify as LGBTQ
☐ Cultural minorities/immigrants/refugees
☐ Other
If other, please specify:

4. Please indicate the disorders most commonly affecting your client population: (Check all that apply)

☐ Mental health disorders
☐ Substance use disorders
☐ Concurrent disorder(s) (co-occurring addiction and mental health disorders)
☐ Not applicable
☐ Other
If other, please specify:

5. For each of the age groups listed below, please indicate the approximate percentage of clients served in your program.

☐ Children (0 – 15 years)
☐ Youth (16 – 24 years)
☐ Adults (25 – 64 years)
☐ Seniors (65 years and over)

6. What percentage of your clientele requests services in the following languages?

☐ English
☐ French
☐ Other

7. What percentage of your clientele are unable to speak either English or French:

☐ 0-10%
☐ 11-20%
☐ 21-30-%
☐ Greater than 30%
☐ Do not know

Section 2: Screening and Assessment Practices for Mental Health Disorders

8. Do you currently screen and/or assess for **mental health disorders**?

☐ Yes
☐ No

Please enter the name(s) of the tool(s) you most commonly use to screen and/or assess for mental health disorders in the space(s) provided in questions 9-18. Only enter one tool per space provided; you may enter up to ten tools in total.

9 – 18 List specific tools.

Please answer the following questions about the tools you identified.

19. Is it mandated that you use this tool? If yes, please indicate by whom (e.g., Champlain LHIN, Ministry of Health and Long-Term Care, other funder, etc.)

☐ Yes
☐ No
☐ Do not know
☐ Not applicable

20. If this tool was not mandated, would you still use it?

☐ Yes
☐ No
☐ Do not know
☐ Not applicable

21. For each tool that you identified, please indicate who administers it. (Check all that apply)

☐ Self-administered
☐ Psychologist
☐ Registered Nurse
☐ Nurse Practitioner
☐ Social Worker
☐ Psychiatrist
☐ Physician
☐ Addictions Counselor
☐ MA level therapist
☐ Intake worker
☐ Registered Practical Nurse
☐ Outreach or caseworker
☐ Volunteer
☐ Other
If other, please specify for each tools you are referring to.

22. Using the drop-down menus, please respond to each question for each tool. (Choices were given for each question)

a) On average, how many minutes does it take to complete the tool?
b) How long has your program used this tool?
c) Is there a cost to use this tool?

23. Are the tools you identified empirically validated for the population you serve in your program?

☐ Yes
☐ No
☐ Do not know
☐ Not applicable

24. At what stage of service is this tool administered? (Check all that apply)

☐ Referral
☐ Intake
☐ Admission
☐ Ongoing treatment
☐ Discharge
☐ Follow-up
☐ Other
If other, please specify for each tool

25. Keeping in mind the definitions of screening and assessment, what are the purposes for using each of the tools? (Check all that apply)

☐ Risk identification
☐ Diagnosis
☐ Service matching
☐ Admission eligibility
☐ Treatment planning
☐ Client recovery
☐ Treatment efficacy
☐ Research
☐ Health service planning
☐ Health system planning
☐ Other
If other, please specify for each tool.

26. What outcomes are being measured with each of the tools? (Check all that apply)

☐ Risk identification
☐ Symptom improvement/worsening
☐ Level of functioning
☐ Social determinants of health
☐ Other
☐ If other, please specify for each tool.

27. Indicate all areas you record/append the information you collect from this tool:

☐ Enter/append to client chart
☐ Enter/upload to electronic medical record
☐ Enter/upload to other data system(s)
☐ Append to referral information package
☐ Other
If other, please specify for each tool.

28. Based on the following criteria, please rate each tool you identified using the dropdown menus. (Rate as excellent, above average, average, below average, or very poor)

a) Utility for decision making in guiding treatment and care
b) Ease of use

Section 3: Screening and Assessment Practices for Substance Use Disorders

29. Do you currently screen and/or assess for **substance use disorders**?

☐Yes
☐No

Please enter the name(s) of the tool(s) you most commonly use to screen and/or assess for substance use disorders in the space(s) provided in questions 30-39.

Only enter one tool per space provided; you may enter up to ten tools in total.

30-39 List specific tools

Please answer the following questions about the tools you identified.

40. Is it mandated that you use this tool? If yes, please indicate by whom (e.g., Champlain LHIN, Ministry of Health and Long-Term Care, other funder, etc.).

☐ Yes
☐ No
☐ Do not know
☐ Not applicable

41. If this tool was not mandated, would you still use it?

☐ Yes
☐ No
☐ Do not know
☐ Not applicable

42. For each tool that you identified, please indicate who administers it. (Check all that apply)

☐ Self-administered
☐ Psychologist
☐ Registered Nurse
☐ Nurse Practitioner
☐ Social Worker
☐ Psychiatrist
☐ Physician
☐ Addictions Counselor
☐ MA level therapist
☐ Intake worker
☐ Registered Practical Nurse
☐ Outreach or case worker
☐ Volunteer
☐ Other
If other, please specify for each tools you are referring to.

43. Using the drop-down menus, please respond to each question for each tool. (Choices were given for each question)

a) On average, how many minutes does it take to complete the tool?
b) How long has your program used this tool?
c) Is there a cost to use this tool?

44. Are the tools you identified empirically validated for the population you serve in your program?

☐ Yes
☐ No
☐ Do not know
☐ Not applicable

45. At what stage of service is this tool administered?

☐ Referral
☐ Intake
☐ Admission
☐ Ongoing treatment
☐ Discharge
☐ Follow-up
☐ Other
If other, please specify for each tool

46. Keeping in mind the definitions of screening and assessment, what are the indications for using each of the tools? (Check all that apply)

☐ Risk identification
☐ Diagnosis
☐ Service matching
☐ Admission eligibility
☐ Treatment planning
☐ Client recovery
☐ Treatment efficacy
☐ Health service planning
☐ Health system planning
☐ Other
If other, please specify for each tool.

47. What outcomes are being measured with each of the tools? (Check all that apply)

☐ Risk identification
☐ Symptom improvement/worsening
☐ Level of functioning
☐ Social determinants of health
☐ Other
☐ If other, please specify for each tool.

48. Indicate all areas you record/append the information you collect from this tool:

☐ Enter/append to client chart
☐ Enter/upload to electronic medical record
☐ Enter/upload to other data system(s)
☐ Append to referral information package
☐ Other
If other, please specify for each tool.

49. Based on the following criteria, please rate each tool you identified using the dropdown menus.

a) Utility for decision making in guiding treatment and care
b) Ease of use

Section 4: Screening for Suicide

50. Do you currently **screen** for **suicide risk**?

☐ Yes
☐ No

51. If yes, how do you screen for suicide risk? (Check all that apply)

☐ Use a screening tool
☐ Follow a protocol
☐ Ask a few questions
☐ Other
If other, please specify.

52. If you use a tool or protocol, please indicate which one(s) you use.

Section 5: Data Systems

53. Do you enter/upload the information you collect from mental health and substance use screening and assessment tools into data systems?

☐ Yes
☐ No
☐ Not applicable

54. Which data system(s) do you use? (Please list)

55. Do you create and run reports from this/these data system(s)?

☐ Yes
☐ No
☐ Do not know
☐ Not applicable
If yes, please specify which data system you are referring to.

56. If yes, how do you use the data/reports? (Check all that apply)

☐ Program evaluation
☐ Strategic/Operational planning
☐ Accountability reports
☐ Requests for funding
☐ Teaching
☐ Other
If other, please specify.

Section 6: Additional Questions

57. If applicable, please identify other tools you would like to use for screening and assessment of mental health and substance use. Please provide detail and rational.

58. Do you have any further comments regarding mental health and substance use screening and assessment tools?

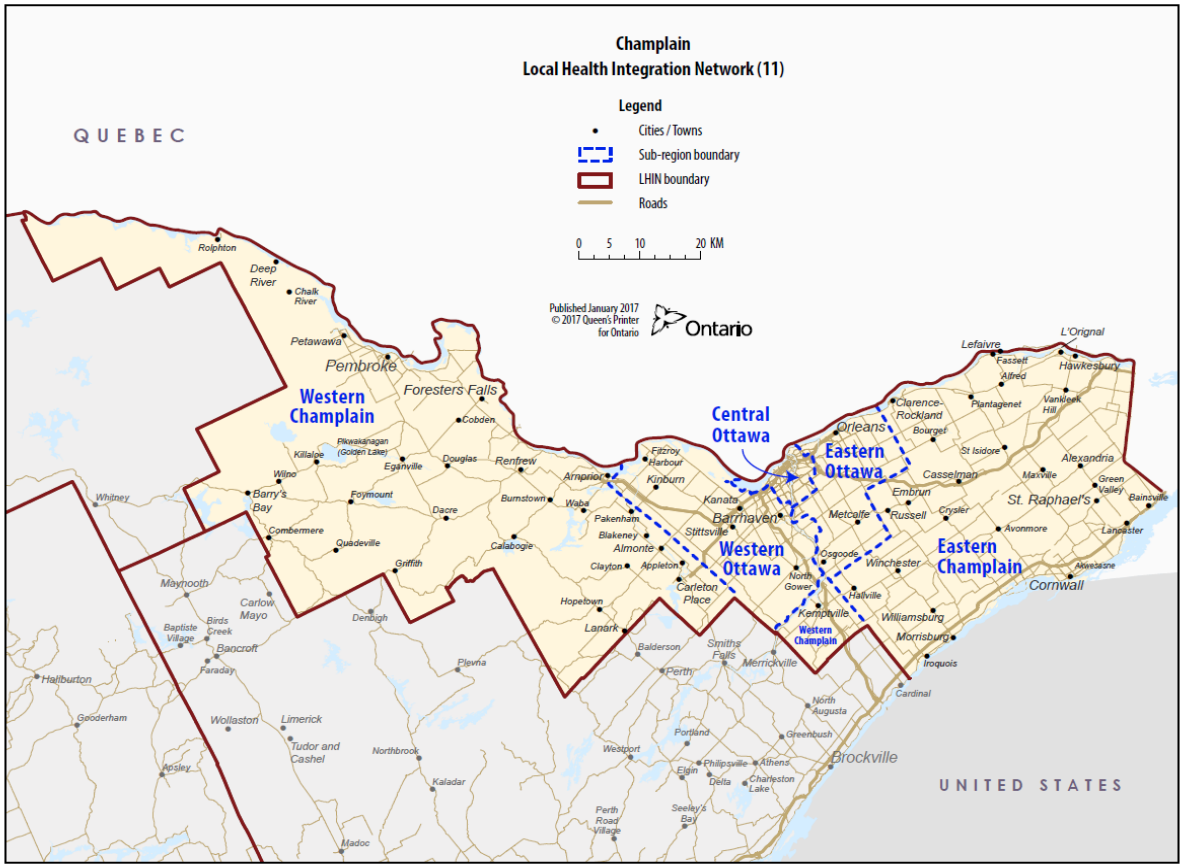
Appendix B: List of all Screening and Assessment Tools Identified

Tool Name	Abbreviation
Abnormal Involuntary Movement Scale	AIMS
Adult ADHD Self-Report Scale	ASRS
Aggressively and Hostility Scale	AHS
Alcohol Dependence Scale	ADS
Alcohol Use Disorders Identification Test	AUDIT
Alcohol Use Scale	AUS
Alcohol, Smoking and Substance Involvement Screening Test	ASSIST
Altman Self-Rating Mania Scale	ASRM
Anxiety Treatment and Research	ATR
Attention Deficit Disorder Test	ADD Test
Beck Anxiety Inventory	BAI
Beck Depression Inventory	BDI
Behavior Assessment System for Children	BASC-3
Behaviour and Symptom Identification Scale	BASIS
Brief Psychiatric Rating Scale	BPRS
Broset Violence Checklist	BVC
Burns Anxiety Inventory	BAI
Burns Depression Checklist	BDC
Child and Adolescent Needs Strengths	CANS
Child Behaviour Checklist	CBCL
Childhood Acuity of Psychiatric Illness	CAPI
Children's Depression Inventory	CDI-2
Clinical Global Impression	CGI
Clinical Institute Withdrawal Assessment for Alcohol	CIWA-re
Clinical Opiate Withdrawal Scale	COWS
Clock Drawing Test	CDT
Wechsler Adult Intelligence Scale	WAIS
Cohen-Mansfield Agitation Inventory	CMAI
Columbia Suicide Severity Rating Scale	C-SSRS
Comparative Health Information	CIA
Confusion Assessment Method	CAM
Conners 3rd Edition	Conners 3
Conners Comprehensive Behaviour Rating Scale	CBRS
Cornell Scale for Depression in Dementia	CSDD
Crisis Intensity Rating Scale	--
Substance Abuse Screening Tool (Cutdown/Annoyed/Guilty/Eye Opener)	CAGE

Dissociative Experience Scale	DES
Drug Abuse Screening Test	DAST
Drug History Questionnaire	DHQ
Drug Use Scale	DUS
Eating Disorder Examination Questionnaire	EDE-Q
Eating Disorder Inventory-3	EDI-III
Edinburgh Postnatal Depression Scale	EPDS
Empathy Construct Rating Scale	ECRS
Euro Quality of Life Scale	EQ 5D
Fagerstrom Test for Nicotine Dependence	FTND
Functional Assessment Screening Tool	FAST
Generalized Anxiety Disorder Assessment (7 item)	GAD-7
Geriatric Depression Scale	GDS
Global Appraisal of Individual Needs Q3 Motivational Interview Ontario (version)	GAIN Q3 MI ONT
Global Appraisal of Individual Needs- Short Screener	GAIN-SS
Global Assessment of Functioning	GAF
Hamilton Anatomy of Risk Management	HARM
Hamilton Anxiety Scale	HAM-A
Hamilton Depression Scale	HAM-D
Home, education, activities/ambition, drugs/drinking, sexuality, suicide and depression, and safety	HEADS-ED
Impact of Events Scale Revised	IES-R
InterRAI Brief Mental Health Screener	interRAI-BMHS
InterRAI- Child and Youth Mental Health and Adolescent	interRAI-CHMYN
InterRAI Mental Health for In-Patient Psychiatry	interRAI-MH
Kingston Standardized Cognitive Assessment	KSCA
Level of Care Utilization System for Psychiatric and Addiction Services	LOCUS
Macleans Screening Instrument for Borderline Personality Disorder	MSI-BPD
Mental Health Status Examination	MSE
Michigan Alcohol Screening Test	MAST
Mini International Neuropsychiatric Interview	MINI
Minnesota Multiphasic Personality Inventory	MMPI
Modified Mini Screen	MMS
Montreal Cognitive Assessment	MOCA
Mood Disorder Questionnaire	MDQ
Multidimensional Anxiety Scale for Children, 2nd Edition	MASC-2
Multnomah Community Ability Scale	MCAS

Nurses' Global Assessment of Suicide Risk	NGASR
Ontario Common Assessment of Need	OCAN
Opioid Manager	--
Ottawa Model for Smoking Cessation (University of Ottawa Heart Institute)	OMSC
Outcome Questionnaire	OQ-45
Overall Anxiety Severity and Impairment Scale	OASIS
Patient Health Questionnaire (9-item)	PHQ-9
Personality Assessment Inventory	PAI
Positive and Negative Symptom Scale	PANSS
Post-Traumatic Stress Disorder Checklist	PCL-C
Problem Oriented Screening Instrument for Teenagers	POSIT
Quality of Life Enjoyment and Satisfaction Questionnaire-Short Form	Q-LES-Q-SF
Quick Inventory of Depressive Symptomatology (Self-Report)	IDS
Service Prioritization Decision Assistance Tool	SPDAT
Severity of Dependence Scale	SDS
Short-term Assessment of Risk and Treatability	START
Smoking Treatment for Ontario Patients-Centre for Addiction and Mental Health	STOP-CAMH
South Oaks Gambling Screen	SOGS
Standardized Mini-Mental State Examination	SMMSE
Strength and Difficulties Questionnaire	SDQ
Substance Abuse Subtle Screening Inventory	SASSI
Substance Abuse Treatment Scale	SATS
Swanson, Nolan and Pelham Questionnaire	SNAP-IV for ADHD
Tidal Holistic Assessment	--
Vocational Assessment Tool	--
Wisconsin Quality of Life Index	W-QLI
Work and Social Adjustment Scale	WSAS
Work Rehabilitation Questionnaire	WORQ
Youth Self Report	YSR
Zarit Burden Interview	ZBI

Appendix C: Champlain LHIN Sub-Regions Map



Appendix D: Commonly Used Mental Health and Substance Use Tools

Standardized Tool	Brief Description	Currently Used by: Organization – Program (if available)
Alcohol Use Disorders Identification Test (AUDIT)	The AUDIT is a 10-item questionnaire that screens for hazardous or harmful alcohol consumption. The AUDIT is particularly suitable for use in primary care settings and has been used with a variety of populations and cultural groups. It should be administered by a health professional or paraprofessional. Source: http://www.integration.samhsa.gov/clinical-practice/screening-tools#drugs	Carlington Community Health Centre – Primary Health Care The Ottawa Hospital – Shared Care Mental Health The Royal Ottawa Health Care Group – Community Mental Health Program The Royal Ottawa Health Care Group – Mood and Anxiety Disorders Program The Royal Ottawa Health Care Group – Substance Use and Concurrent Disorders Program
Alcohol Use Scale (AUS)	The AUS is designed to rate the alcohol use of persons with severe mental illness, especially psychotic disorders. The instrument uses clinicians' ratings to classify patient alcohol use according to DSM-III-R criteria. The AUS consists of a single item that asks the clinician to "rate your client's use of alcohol over the past 6 months according to the following scale." The AUS is in the public domain, no formal permission is needed to use it, and there is no charge for its use. Source: http://bit.ly/AUS_inst	CMHA Ottawa – Concurrent Disorders Program Ottawa Salus Corporation – Case Management Ottawa Salus Corporation – Shelters to Home Ottawa Salus Corporation – SSH Upstream Ottawa – Community Mental Health Case Management
Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)	The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) is an eight-item questionnaire designed to be administered by a health worker to a client using paper and pencil, and takes about 5-10 minutes to administer. The ASSIST was designed to be culturally neutral and useable across a variety of cultures to screen for use of the following substances: tobacco products, alcohol, cannabis, cocaine, amphetamine-type stimulants (ATS), sedatives and sleeping pills (benzodiazepines), hallucinogens, inhalants,	Carlington Community Health Centre – Assertive Community Treatment Team Empathy House of Recovery – Residential Program The Royal Ottawa Health Care Group – Substance Use and Concurrent Disorders Program

ASSIST continued	opioids, and 'other' drugs. It is available in over 10 languages. Source: http://www.who.int/substance_abuse/activities/assist/en/	
Beck Depression Inventory (BDI)	The BDI is a 21-item, self-report rating inventory that measures characteristic attitudes and symptoms of depression. Source: http://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/beck-depression.aspx	Carlington Community Health Centre – Primary Health Care Hawkesbury General Hospital – Mental Health and Addictions Salvation Army – Anchorage Serenity House Inc. Serenity House Inc. – Substance Abuse Treatment The Royal Ottawa Health Care Group – Community Mental Health Program The Royal Ottawa Health Care Group – Mood and Anxiety Disorders Program
Behaviour and Symptom Identification Scale (BASIS)	The BASIS (BASIS-32) was developed as a 32-item, consumer-oriented, self-report measure of symptoms and behavioural distress. The scale consists of five subscales measuring impulsive and addictive behaviour, psychosis, relation to self and others, depression and anxiety and daily living and role functioning. Source: http://www.drugsandalcohol.ie/18266/1/NADA_A_Review_of_Screening,_Assessment_and_Outcome_Measures_for_Drug_and_Alcohol_Settings.pdf	Cornwall Community Hospital – Addictions Services Empathy House of Recovery – Residential Program Jewish Family Services – Counselling, Seniors, Homeless Renfrew Victoria Hospital – Addictions Treatment Service Rideauwood Addiction and Family Health Services – Family Program Rideauwood Addiction and Family Health Services – Youth Services Vesta Recovery Program for Women Inc. – Vesta Recovery Program
Brief Psychiatric Rating Scale (BPRS) **BPRS continued**	The BPRS is a clinician-administered scale measuring a broad range of psychiatric symptoms. It was initially devised as an instrument to assess the symptoms of schizophrenia on five subscales of thought	Carlington Community Health Centre – Assertive Community Treatment Team Cornwall Community Hospital – First Episode Psychosis

	disorder, withdrawal, anxiety/depression, hostility and activity. Source: http://www.drugsandalcohol.ie/18266/1/NADA_A_Review_of_Screening,_Assessment_and_Outcome_Measures_for_Drug_and_Alcohol_Settings.pdf	The Royal Ottawa Health Care Group – Community Mental Health Program
CAGE Substance Abuse Screening Tool (CAGE)	The CAGE (Ewing, 1984) is a four-item screening tool that is designed to identify problem drinking via four constructs (each its own question). Cutdown, Annoyed, Guilty, Eye-Opener. The CAGEAID (Adapted to Include Drugs) is an equivalent tool developed to screen for drug use disorders has been. Source: http://www.drugsandalcohol.ie/18266/1/NADA_A_Review_of_Screening,_Assessment_and_Outcome_Measures_for_Drug_and_Alcohol_Settings.pdf	Carlington Community Health Centre – Primary Health Care Centretown Community Health Centre – Primary Care Geriatric Psychiatry Community Services of Ottawa – Geriatric Psychiatry Community Services of Ottawa Mackay Manor Inc. – Community Withdrawal Management Services South-East Ottawa Community Health Centre – Primary Care The Royal Ottawa Health Care Group – Community Mental Health Program
Drug Abuse Screening Test (DAST)	DAST is a 10-item, yes/no self-report instrument that has been condensed from the 28-items and should take less than 8 minutes to complete. The DAST-10 was designed to provide a brief instrument for clinical screening and treatment evaluation and can be used with adults and older youth. Source: http://www.integration.samhsa.gov/clinical-practice/screening-tools#drugs	Salvation Army – Anchorage Maison Fraternité – Services aux adolescents et à leur famille The Royal Ottawa Health Care Group – Community Mental Health Program The Royal Ottawa Health Care Group – Mood and Anxiety Disorders Program The Royal Ottawa Health Care Group – Substance Use and Concurrent Disorders Program
Drug History Questionnaire (DHQ) **DHQ continued**	The DHQ gathers information on all psychoactive drugs used in the past 12 months, with a more detailed information on drugs used over the past 90 days. Source: Admission and Discharge Criteria and	Cornwall Community Hospital Addiction and Mental Health Center – Community Withdrawal Management Services Empathy House of Recovery – Residential Program Maison Fraternité – Services aux adolescents

	Assessment Tools Manual	et à leur famille Rideauwood Addiction and Family Health Services – Youth Services
Drug Use Scale (DUS)	The DUS is designed to rate the drug use of persons with severe mental illness, especially psychotic disorders. The instrument uses clinicians' ratings to classify patient drug use according to DSM-III-R criteria. The DUS consists of a single item that asks the clinician to "rate your client's use of drugs over the past 6 months according to the following scale." The DUS is in the public domain, no formal permission is needed to use it, and there is not charge for its use. Source: http://bit.ly/DUS_inst	CMHA Ottawa – Concurrent Disorders Program Ottawa Salus Corporation – Case Management Ottawa Salus Corporation – Shelters to Home Ottawa Salus Corporation – SSH Upstream Ottawa – Community Mental Health Case Management
Generalized Anxiety Disorder 7-item (GAD-7)	The GAD-7 is a seven-item, self-report anxiety questionnaire designed to assess the patient's health status during the previous 2 weeks. The items enquire about the degree to which the patient has been bothered by feeling nervous, anxious or on edge, not being able to stop or control worrying, worrying too much about different things, having trouble relaxing, being so restless that it is hard to sit still, becoming easily annoyed or irritable and feeling afraid as if something might happen. Source: https://academic.oup.com/occmed/article/64/3/224/1437718/The-GAD-7-questionnaire	Carlington Community Health Centre – Primary Health Care Centretown Community Health Centre – Primary Care Champlain CCAC – Mental Health and Addictions Nurse Program Sandy Hill Community Health Centre – Addictions and Mental Health Services Serenity House Inc. – Substance Abuse Treatment South-East Ottawa Community Health Centre – Primary Care The Ottawa Hospital – Shared Care Mental Health The Royal Ottawa Health Care Group – Substance Use and Concurrent Disorders Program Vesta Recovery Program for Women Inc. – Vesta Recovery Program

Geriatric Depression Scale (GDS)	The GDS (long form) is a brief, 30-item questionnaire in which participants are asked to respond by answering yes or no in reference to how they felt over the past week. The GDS may be used with healthy, medically ill and mild to moderately cognitively impaired older adults. It has been extensively used in community, acute and long-term care settings. Source: https://consultgeri.org/try-this/general-assessment/issue-4.pdf	Carlington Community Health Centre – Primary Health Care Cornwall Community Hospital – Geriatric Mental Health Services Geriatric Psychiatry Community Services of Ottawa – Geriatric Psychiatry Community Services of Ottawa Pembroke Regional Hospital – Mental Health Services Renfrew County Jewish Family Services – Counselling, Seniors, Homeless
Global Appraisal of Individual Needs Q3 Motivation Interview Ontario (version) (GAIN-Q3 MI ONT)	The GAIN-Q3 MI ONT evolved from the GAIN Q3, which was designed to identify and address a wide range of problems in clinical and general populations. The aim of the GAIN Q3 is to sort individuals into three groups: 1) those who do not appear to have problems in need of attention, 2) those who appear to have mild problems that can be addressed in a brief intervention, and 3) those whose results indicate the need for referral for a more detailed assessment or specialized treatment. The GAIN-Q3 MI ONT was developed to increase the tool's relevance to the Ontario provincial context and is used a first stage assessment. Sources: https://chestnut.app.box.com/v/GAIN-Q3-Materials/1/7515674049/63774478953/1 CAMH Provincial System Support Program	Amethyst Women's Addiction Center – Women's Day Treatment Centretown Community Health Centre – LESA Addictions Program for Older Adults Cornwall Community Hospital – Addictions Services David Smith Youth Treatment Centre – Residential and Aftercare Empathy House of Recovery – Residential Program Hawkesbury General Hospital – Mental Health and Addictions Mackay Manor Inc. – Community Withdrawal Management Services Mackay Manor Inc. – Renfrew County ASH Program Mackay Manor Inc. – Residential Program Maison Fraternité - Centre de traitement des dépendances pour adultes (hommes et femmes) Maison Fraternité – Services aux adolescents et à leur famille Pathways Alcohol and Drug Treatment

GAIN-Q3 MI ONT continued		Services – Community Treatment Renfrew Victoria Hospital – Addictions Treatment Service Rideauwood Addiction and Family Health Services – Adult Program Rideauwood Addiction and Family Health Services – Youth Services Salvation Army – Anchorage Sandy Hill Community Health Centre – Addictions and Mental Health Services Serenity House Inc. – Substance Abuse Treatment Vesta Recovery Program for Women Inc. – Vesta Recovery Program
Global Appraisal of Individual Needs Short Screener (GAIN-SS)	The GAIN-SS is made up of 20 items (four five-item subscales). The GAIN-SS subscales identify: internalizing disorders, externalizing disorders, substance use disorders, and crime/violence. Source: https://www.porticonetwork.ca/documents/489955/494758/GAIN+Short+Screener+%28GSS%29%20PDF/5006f4ae-9799-4a8e-aee7-3f2db4a1b0c6	Amethyst Women's Addiction Center – Women's Day Treatment Canadian Mental Health Association (CMHA) Champlain East – Intensive Case Management CMHA Ottawa – Concurrent Disorders Program Centretown Community Health Centre – LESA Addictions Program for Older Adults Champlain CCAC - Mental Health and Addictions Nurse Program Children's Hospital of Eastern Ontario – Transitional Mental Health Services for Youth Cornwall Community Hospital – Addictions Services Cornwall Community Hospital Addiction and Mental Health Center – Adult Mental Health Cornwall Community Hospital Addiction and Mental Health Center – Community

GAIN-SS continued		Withdrawal Management Services Empathy House of Recovery – Residential Program Hawkesbury General Hospital – Mental Health and Addictions Mackay Manor Inc.– Community Withdrawal Management Services Mackay Manor Inc. – Renfrew County ASH Program Mackay Manor Inc. – Residential Program Maison Fraternité – Centre de traitement des dépendances pour adultes (hommes et femmes) Maison Fraternité – Services aux adolescents et à leur famille Montfort Hospital – All Mental Health Programs Pathways Alcohol and Drug Treatment Services – Community Treatment Pembroke Regional Hospital – Mental Health Services Renfrew County Pinecrest Queensway Community Health Centre - Assertive Community Treatment Team Renfrew Victoria Hospital – Addictions Treatment Service Rideauwood Addiction and Family Health Services – Adult Program Rideauwood Addiction and Family Health Services – Family Program Rideauwood Addiction and Family Health Services – Youth Services Salvation Army – Anchorage

GAIN-SS continued		Sandy Hill Community Health Centre – Addictions and Mental Health Services Serenity House Inc. Serenity House Inc. – Substance Abuse Treatment The Ottawa Hospital – Eating Disorder Program The Royal Ottawa Health Care Group – Community Mental Health Program The Royal Ottawa Health Care Group – Substance Use and Concurrent Disorders Program Vesta Recovery Program for Women Inc. – Vesta Recovery Program
InterRAI Mental Health for Inpatient Psychiatry (interRAI MH)	The interRAI MH is a comprehensive standardized tool used for evaluating the needs, strengths and preferences of adults with mental illness in in-patient psychiatric settings. It allows for assessment of key domains of function, mental and physical health, social support and service use; with particular items identifying those who could benefit from further evaluation of specific problems to help prevent risk of further decline and improve functioning. Source: http://www.crms-software.com/	Cornwall Community Hospital – Psychiatric Care Unit Montfort Hospital – All Mental Health Programs The Ottawa Hospital – Inpatient Mental Health

Modified Mini Screener (MMS)	The MMS is a self-report measure that rapidly assesses for present mood, anxiety, and psychotic-spectrum disorders. Source: http://www.bhevolution.org/public/screening_tools.page	Champlain CCAC – Mental Health and Addictions Nurse Program Hawkesbury General Hospital – Mental Health and Addictions Mackay Manor Inc. – Community Withdrawal Management Services Mackay Manor Inc. – Renfrew County ASH Program Mackay Manor Inc. – Residential Program Maison Fraternité - Centre de traitement des dépendances pour adultes (hommes et femmes) Montfort Hospital – All Mental Health Programs Pathways Alcohol and Drug Treatment Services – Community Treatment Pembroke Regional Hospital – Mental Health Services Renfrew County Renfrew Victoria Hospital – Addictions Treatment Service Sandy Hill Community Health Centre – Addictions and Mental Health Services Vesta Recovery Program for Women Inc. – Vesta Recovery Program
Montreal Cognitive Assessment (MOCA)	The MOCA is a rapid screening instrument for mild cognitive dysfunction. It assesses different cognitive domains: attention and concentration, executive functions, memory, language, visuoconstructional skills, conceptual thinking, calculations, and orientation. Source: http://www.mocatest.org/	Centretown Community Health Centre – Primary Care Cornwall Community Hospital –Assertive Community Treatment Team Cornwall Community Hospital – Geriatric Mental Health Services Geriatric Psychiatry Community Services of Ottawa – Geriatric Psychiatry Community Services of Ottawa

MOCA continued		Pembroke Regional Hospital – Mental Health Services Renfrew County The Ottawa Hospital – Mobile Crisis Team
Multnomah Community Ability Scale (MCAS)	The MCAS is a 17-item standardized measure of functioning of people with mental illness living in the community. Each item is rated on a five-point ordinal scale, with a lower rating indicating poorer functioning. Source: http://evaluationcanada.ca/secure/19-3-135.pdf	CMHA Ottawa – Concurrent Disorders Program Ottawa Salus Corporation – Case Management Ottawa Salus Corporation – Shelters to Home Ottawa Salus Corporation – SSH
Ontario Common Assessment of Need (OCAN)	The OCAN is a standardized assessment tool used in the community mental health sector. OCAN supports a recovery approach by supporting conversations that capture the client's current situation, needs, strengths and service plan. Source: https://www.ccim.on.ca/CMHA/default.aspx	Carlington Community Health Centre – Assertive Community Treatment Team Causeway Work Centre – Causeway Work Centre CMHA Ottawa – Concurrent Disorders Program Cornwall Community Hospital – Assertive Community Treatment Team Cornwall Community Hospital – First Episode Psychosis CMHA Champlain East – Intensive Case Management Family Services Ottawa – Mental Health Program and Quick Response Program Hawkesbury General Hospital – Mental Health and Addictions Montfort Hospital – All Mental Health Programs Ottawa Salus Corporation – Case Management Ottawa Salus Corporation – Case Management-Francophone Team Ottawa Salus Corporation – Grove TRHP

OCAN continued		Ottawa Salus Corporation – Shelters to Home Pembroke Regional Hospital – Mental Health Services Renfrew County Pinecrest Queensway Community Health Centre - Assertive Community Treatment Team The Ottawa Hospital – First Episode Psychosis Program The Royal Ottawa Health Care Group – Community Mental Health Program Upstream Ottawa – Community Mental Health Case Management
Outcome Questionnaire (OQ-45)	The OQ-45 is a 45-item self-report instrument that requires patients to rate their functioning on a 5-point Likert scale. The OQ-45 was designed to access common symptoms across a wide range of adult mental disorders and syndromes, including stress-related illness. In addition, the OQ-45 was designed to be used as a baseline screening instrument with application in primary care for alerting physicians to the need for referral for psychological interventions. However, it was not developed for use as a diagnostic tool. Source: http://psycnet.apa.org/psycinfo/2004-14941-006	Family Services Ottawa – Mental Health Program and Quick Response Program Hawkesbury General Hospital – Mental Health and Addictions The Ottawa Hospital – Eating Disorder Program
Patient Health Questionnaire (PHQ-9) **PHQ-9 continued**	The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression. Source: http://www.cqaimh.org/pdf/tool_phq9.pdf	Carlington Community Health Centre – Primary Health Care Centretown Community Health Centre – Primary Care Empathy House of Recovery – Residential Program Geriatric Psychiatry Community Services of Ottawa – Geriatric Psychiatry Community Services of Ottawa South-East Ottawa Community Health Centre

		– Primary Care The Ottawa Hospital – Shared Care Mental Health The Royal Ottawa Health Care Group – Substance Use and Concurrent Disorders Program
Post-Traumatic Stress Disorder Checklist (PCL)	The PCL is a 17-item self-report measure reflecting DSM-IV symptoms of PTSD. The PCL has a variety of clinical and research purposes, including: screening individuals for PTSD, aiding in diagnostic assessment of PTSD, and monitoring change in PTSD symptoms Source: https://sph.umd.edu/sites/default/files/files/PTSDChecklistScoring.pdf	Centretown Community Health Centre – Primary Care CMHA Ottawa – Concurrent Disorders Program Salvation Army – Anchorage
Problem Oriented Screening Instrument for Teenagers (POSIT)	POSIT is a multidimensional tool (made up of 139 yes/no questions) intended to identify adolescents needing further assessment in problem substance use and nine other functional areas. The other nine areas are: physical health, mental health, family relations, peer relations, educational status, vocational status, social skills, leisure and recreation, and aggressive/delinquent behaviour. Source: https://www.porticonetwork.ca/web/knowledgex-archive/amh-specialists/screening-for-cd-in-youth/screening-both-mh-sud/posit	Cornwall Community Hospital – Addictions Services Hawkesbury General Hospital – Mental Health and Addictions Pathways Alcohol and Drug Treatment Services – Community Treatment Pembroke Regional Hospital – Mental Health Services Renfrew County Renfrew Victoria Hospital – Addictions Treatment Service Sandy Hill Community Health Centre – Addictions and Mental Health Services