Rapid Access Models for Substance Use Services

The Canadian Centre on Substance Use and Addiction recently commissioned a rapid review of published literature to analyze models of rapid access for substance use services and supports and examine the extent to which they are achieving their goals. The objectives of the review were to identify what program components facilitate access to and engagement in substance use treatment services and the extent to which the models have resulted in improved access to services. This report at a glance summarizes the key findings of the full technical report.

Key Messages

- Responses to the COVID-19 pandemic have amplified existing gaps in the continuum of services and supports for substance use treatment. Models that increase treatment access and engagement across the full spectrum of risk and problem severity, and include access to effective self-management tools, are more critical than ever.
- The high rates of substance use and related harms, and reports by the majority of those with substance use disorders of unmet needs and waiting times, require innovative responses to expand the breadth and depth of service and support options, outreach and effective engagement with those who need services, including members of vulnerable populations.
- A rapid review of the literature identified five models of rapid access for substance use services and supports and their core components of effectiveness to address client need for support and access: Hospital-affiliated models; mobile and assertive outreach models; screening, assessment, brief intervention and referral to treatment models; integrated youth services models; and centralized and coordinated access models.
- Common features of the models that contribute to effectiveness and positive outcomes include co-design with and tailoring to the needs of the target populations, flexibility in access and delivery, outreach capability, support for transitions among services, multi-disciplinary teams, and integration of evidence-based practices and evaluation.

Substance Use in Canada

Substance use, substance use disorders and related mental and physical health challenges cost Canadians almost $46 billion in 2017 (Canadian Substance Use Costs and Harms Scientific Working Group, 2020).[1] Some estimates classify as much as one-fifth of the Canadian adult population at risk of experiencing problems related to substance use (Rush, Tremblay, & Brown 2019), and as many as one in ten adolescents may be experiencing high risk and problematic substance use. (Tremblay et al., 2019). While about one-quarter of Canadian adults with substance use disorders report unmet

1 This estimate excludes costs associated with inpatient hospitalization, day surgery and emergency departments in the province of Quebec. It is expected that this omission led to an underestimation of approximately $857 million or 1.9% of total cost.

needs for support (Sunderland & Findlay, 2013), only about one in 10 of those have accessed substance use services or supports.

Many factors contribute to low treatment coverage, including individuals' belief they can manage their substance issue on their own, the stigma associated with seeking help and disclosing challenges related to substance use, and past negative experiences with seeking help (McQuaid et al., 2017; Urbanoski, Inglis, & Veldhuizen, 2017). Availability of services varies across the country in terms of location, supply, options for services and supports, populations served, cultural appropriateness and length of wait times. The locations or hours of service can present practical challenges such as transportation, childcare and cost (Urbanoski, 2017).

Gender differences are critical to consider when designing and implementing rapid access models. Men and women differ in terms of prevalence rates for substance use (Statistics Canada, 2012), rates of help seeking (Harris et al., 2016), rates of hospitalizations and emergency department visits related to substance use (Canadian Institute for Health Information, n.d.), trajectories from non-problematic substance use to hazardous use (Poole & Dell, 2005), severity of clinical profiles, and barriers to accessing treatment (Canada FASD Research Network, 2014). The differences related to gender are not always the same for adolescents and adults.

Rapid Access to Care and the Pandemic Response

Canadians' substance use has been significantly impacted by the response to the COVID-19 pandemic and there has been an increase in overdose deaths and calls to emergency medical services related to opioids during this time (Kapelos, 2020, June 14; Rose et al., 2020). Prior to the pandemic, telemedicine and other technology-based services for treatment of substance use was limited. There is some evidence that technology-based services and supports may even be more effective than in-person treatment for retaining in care individuals with opioid use disorder (Eibl et al., 2017) and for increasing physician engagement in substance use treatment (Komaromy et al., 2016).

In response to the pandemic, many agencies across Canada quickly adopted technology to ensure continued delivery of substance use treatment and supports. This adoption has been supported by national guidelines from the Canadian Research Initiative in Substance Misuse on the use of telemedicine in the delivery of substance use services, which include, for example, modifications to prescription rules to allow for virtual witnessing of dosing (Bruneau et al., 2020).

Models that increase treatment access and engagement across the full spectrum of risk and problem severity and include access to effective self-management tools are more critical than ever. The response to the pandemic has amplified existing gaps in the continuum of services and supports for those with a substance use disorder or who are experiencing the harms of substance use. While it is not known how the broader treatment system will be impacted by the pandemic, particularly with respect to the need for services, innovations in technology-assisted service delivery are likely to remain part of treatment and support systems into the future.

Objectives and Methods

New models to facilitate rapid access to substance use services and supports have been developed in several Canadian jurisdictions in response to ongoing concerns about access, unmet needs for support and the need for better integration in the broader health and social sector. These models are being implemented at a time when the health systems of many jurisdictions are undergoing significant transformation, while developing additional response capability to prepare for a potential surge in demand for substance use services and supports when we emerge from the pandemic.

The rapid review of published literature this report summarizes examined the extent to which these models are achieving their goals, enumerated the core components that facilitate access to and engagement in substance use treatment services, and assessed the extent to which the models have resulted in improved access to services.

Research literature for this rapid review was obtained through scholarly database searches, Internet searches, searches of reference lists of relevant documents and contact with a key expert. Five models were identified and reviewed. This report overviews the findings and summarizes the implications for policy and practice.

Five Models for Rapid Access to Substance Use Services

Hospital-affiliated Models

Substance use disorder is associated with longer hospital stays and high rates of repeat hospitalizations (Canadian Institute for Health Information, n.d.). People who have concurrent mental health and substance use issues account for almost half of frequent emergency department visits related to mental health and substance use. Contacts with the medical system provide important opportunities to identify substance use issues, intervene earlier to address risks and harms, and refer to more specialized and intensive services when needed.

Features of hospital-affiliated models, of which Rapid Access to Addiction Medicine (RAAM) programs are a recognized example, include facilitating access to treatment through referrals from service providers working in hospitals and emergency departments, self-referrals and referrals from other services such as primary care and withdrawal management services. They include access to addiction medicine services and pharmacotherapy, and supports to help people experiencing substance use issues to transition to community-based substance use services. The supports provided can include discharge planning, referrals and referral pathways, liaison "in-reach" workers and bridging medication prescriptions.

Evaluations have found rapid access models in hospital settings to be successful in engaging and retaining patients in ongoing substance use treatment and in reducing emergency department visits and inpatient care. Early research also suggests they are cost-effective.

Defining Rapid Access

Factors that pertain to **access** include: approachability (ease of identifying that services exist, can be reached and will impact health), acceptability, availability and accommodation, affordability and appropriateness (services fit needs and can match clients to services).

Factors related to **rapid** access include length of time it takes to receive a service, swift access to a meaningful intervention after the first point of contact, and rapid transition to a treatment service or service network after receipt of services.

The literature review identified two additional considerations as relevant to models designed to enhance rapid access to substance use services and supports. The first pertains to the degree to which individuals recognize the need for support and are motivated to make the first contact with a service. This consideration points to the importance of engagement strategies such as outreach that are designed to bring more people in need into service. Secondly, innovations to facilitate motivation and retention once a client is engaged in a service are critically important, since retention is a key indicator of treatment success.

Mobile and Assertive Outreach Models

Outreach models deploy specialized mobile response clinicians or teams to the home or community location of individuals at high-risk of substance use issues (Langabeer et al., 2020). Mobile clinics typically involve regular, brief and assertive contacts and can serve either as an alternative to

traditional office-based care or as a gateway to connect clients to these services These multidisciplinary services have a comprehensive and intensive focus on health and social care needs, and service delivery over an extended period of time. They offer material resources and coping skills, aim to engage clients in treatment and prioritize low client caseloads to facilitate intensive support (Fincham-Campbell et al., 2018; Drummond et al., 2017).

Mobile health units have been found effective in reaching high-risk or stigmatized populations and in attracting different sectors of society to engage in screening for various illnesses. They can be cost-effective, due to earlier engagement in health care, improved ability for clients to self manage health conditions, reduced emergency department visits and hospital admissions, and improved quality of life (Yu, Hill, Ricks, Bennet, & Oriol, 2017). Canadian practice standards require teams focused on people with severe and persistent mental illness to include a substance use specialist who will conduct assessments for substance use issues and deliver services as appropriate (Ministry of Health Services, 2008; Ministry of Health and Long-Term Care, 2005). However, the capacity to meet this guideline for concurrent disorders varies.

Screening, Assessment, Brief Intervention and Referral to Treatment Models

Screening, assessment, brief intervention and referral to treatment (SBIRT) models aim to screen all individuals presenting for services in a variety of healthcare settings, allowing professionals to identify and address risky or problematic substance use, even if these individuals are not actively seeking an intervention or treatment (Substance Abuse and Mental Health Services Administration, 2013). The goals of the model are to reach a higher percentage of people in need, potentially at an earlier point in their trajectory of substance use and potential harm, and to increase engagement in well-matched substance use interventions. SBIRT involves three components. Clients are first screened to identify at-risk substance use and related problems using a brief validated instrument. Those identified to be at risk are provided a brief intervention (Substance Abuse and Mental Health Services Administration, 2013). Finally, clients identified as needing more intensive treatment are referred to specialty substance use treatment providers. While there has not been much research undertaken to date about technology-supported service delivery, what has been done has found it has the potential to engage with a broader range of people and to be feasible and acceptable among patients.

The effectiveness and feasibility of SBIRT in primary care settings has been largely demonstrated in highly controlled research trials for individuals with mild to moderate substance use issues. However, there is some question as to whether these results can be generalized to current primary care settings. Some researchers have proposed that a chronic disease management model might be more appropriate and effective in identifying substance use issues and providing timely access to a broader range of services and supports. Such a model would treat substance use like any other chronic health condition, with the provider conducting regular checks for substance use, providing advice for behavioural interventions in the case of risky use and offering pharmacological support when needed (McCambridge & Saitz, 2017; Rehm et al., 2016).

Integrated Youth Services Models

Integrated Youth Services (IYS) aim to enhance access to and engage youth and their families in integrated and evidence-based services that respond to their needs and preferences and address known barriers to service access and engagement. Common principles that guide the development and implementation of these models include:

- A one-stop-shop model of care in easily identifiable, low-barrier, youth-friendly locations;
- Co-design, delivery, governance and evaluation of programming and services with the involvement of youth, their families, community partners and other stakeholders;
- Evidence-based or evidence generating services;
- Youth-centred and developmentally appropriate services;
- Use of consistent branding to convey the breadth of wellness services delivered; and
- Ensuring organizational capacity and skills to create equitable, inclusive, culturally specific sites through self-assessment, considering local data and engaging with stakeholders.

IYS models have generally been successful in engaging large numbers of young people in services, including youth from marginalized groups that have been traditionally underserved and youth who report they would not have otherwise accessed care in the absence of these services. Some sites have challenges with wait times and so may not be facilitating *rapid* access to services and supports.

Centralized and Coordinated Access Models

Centralized access typically involves a central intake and assessment process after which clients are referred to the level of care that fits their needs. *Coordinated* access typically ensures commonality in key intake, screening and assessment processes across participating service providers, as well as agreements on pathways and protocols for referral and transitions among the providers and beyond. Both these models aim to reduce wait times and to:

- Facilitate more effective screening through clear, well-documented, low-threshold, consistent and transparent criteria, screening tools and processes to triage referrals, reduce assessment time and authorize direct admission into required services (Mohr & Bourne, 2004);
- Use common, validated assessment tools and procedures that match individual strengths and needs to available resources;
- Facilitate treatment retention and continuity of care, and support navigation among services (Canadian Medical Association, 2011);
- Have infrastructure for the transfer of health information to facilitate transitions and for ongoing communication and planning among the community partners; and
- Use routinely collected indicators to measure performance and make continuous improvements.

Coordination can be implemented through call centres that provide information and referral services, with no screening, assessment or other clinical component, or with crisis services that may provide those services along with safe and timely linkage to services for managing immediate crises. Measuring the extent to which these services improve access to treatment and support is challenging, but some evaluations have shown large numbers of calls and contacts to these services and significant numbers of requests for information fulfilled (Wighton, 2009).

In Canada, Stepped Care 2.0, a systems model encompassing both mental health and substance use services, organizes services such that interventions of the lowest intensity warranted by the initial assessment are implemented first and then clients are either stepped up or down depending on their level of distress or need. Stepped Care offers:

- 24/7 web portal access to community service directories;

- Navigation strategies;
- Information about mental health in general and access to self-help tools;
- Phone or text access to peer support or, if urgent, professional crisis counsellors;
- Same day single-session walk-in clinics that offer solutions immediately with only minimal assessment and a fail-forward strategy to engage in more in-depth assessment if needed;
- A range of technologies including web- and mobile-based apps; and
- Ongoing outcome monitoring to signal the need for transitions to more or less intense interventions.

Stepped Care has shown some indications of success in improving access, while highlighting the need for more dedicated resources.

Barriers to implementing centralized or coordinated access models include making the scope too broad, underestimating needs and resources, and lack of understanding and collaboration among the engaged service providers. Needs-based planning models may be helpful in estimating community needs and in ensuring the capacity of different service pathways for each level of severity (Rush, Tremblay, & Brown, 2019; Rush & Furlong, 2017). These models offer an efficient approach to service matching when implemented with standardized processes and tools and monitored with appropriate performance indicators. However they have not been sufficiently evaluated from the perspective of clients and families and do not necessarily yield better treatment outcomes.

Further Research Considerations

More research and evaluation of these models would be useful to investigate the following issues:

- Whether they represent best practices and enhance capacity for substance use services along the continuum of care;
- The extent to which they improve rapid access to and engagement in treatment and early intervention;
- Whether the quality of treatment, types of services and system capacity are appropriate for and meet the needs of the overall population and its most vulnerable subgroups;
- What the core components of specific initiatives are and which components are most responsible for improved access-related outcomes, as well as for whom;
- The role, effectiveness and impacts of technology both on those who were switched from face-to-face care and on those who accessed care for the first time due to the increased stresses of the pandemic or the availability of a virtual platform;
- Which technology-assisted options are best viewed as adjuncts versus alternatives to face-to-face service delivery and how the digital information resulting from these options is integrated into client records and performance measurement;
- Their ultimate benefits in terms of client and family outcomes and return on investment; and
- The impact of changes in access to substance use services resulting from the move to virtual service delivery in response to the COVID-19 pandemic, along with gauging the sustainability of virtual service delivery and identifying which population groups do better with it and why.

More research and population-level surveillance are needed to evaluate the rapid responses to pandemics from a treatment systems perspective (Rose et al., 2020). In addition, consultations with experts and key stakeholders would contribute a more nuanced perspective on rapid access models.

Summary and Implications

Identification of the core components of the models is challenging given the variation among them, their implementation context, populations served, measured outcomes and critical gaps in the research with respect to sex, gender and diversity. A high-level list of the **critical features** across rapid access models that improve access to substance use treatment services and supports includes:

- Consideration of the target population to be served to ensure that the full range of severity and complexity of substance use concerns are being addressed;
- Flexibility in the way in which people access services and supports;
- Outreach capability, especially for those with the most severe and complex challenges;
- A focus on transition supports and the overall coordination of the network of services surrounding the access focal point, including transitions that will support needs beyond the substance use concern itself;
- Multi-disciplinary team capacity within the models;
- Inclusion of core principles and evidence-based practices of screening, assessment and stepped care to maximize opportunities for early intervention, as well as access to relevant services that will contribute to optimal outcomes based on the initial assessment;
- Inclusion of both access and outcome indicators in performance measurement frameworks, with built-in ongoing quality improvement processes; and
- Active meaningful engagement of people with lived and living experience and other key stakeholders in design, implementation and ongoing evaluation.

These rapid access models have either clearly demonstrated a positive impact on access to services or have the potential to increase access. They hold significant promise for engaging people in substance use services who might not otherwise seek assistance. There is also emerging evidence of the cost-effectiveness of some of these models.

Whether any given rapid access model will be successful in engaging and connecting individuals with substance use problems to appropriate services and supports will always be limited by the extent to which those services and supports, and the competencies of the workforce to deliver them, are locally available in the broader continuum of care. Developing and implementing rapid access models will require a systems approach that is grounded in a solid understanding of the demand for services along a continuum of risks, acuity, complexity and chronicity of substance use for different populations, the range and availability of these services, the competencies, training and supports required to deliver them, and the barriers to timely access in a local community.

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ISBN 978-1-77178-697-3

Canadian Centre on Substance Use and Addiction

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CCSA activities and products are made possible through a financial contribution from Health Canada. The views of CCSA do not necessarily represent the views of Health Canada.