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**Adult Mental Health and Substance Use**

**Final Evaluation Report**

**February 2022**

**Surrey North Delta
 Division of Family Practice**

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# Acronyms and Abbreviations

|  |  |
| --- | --- |
| **FP** | Family Physician |
| **MHSU** | Mental Health and Substance Use |
| **MOA** | Medical Office Assistant |
| **SNDDFP** | Surrey-North Delta Division of Family Practice |

# Introduction

This report provides a review of the Surrey-North Delta Division of Family Practice (SNDDFP) “Adult Mental Health and Substance Use” (AMHSU) Project which operated between February 2021 and February 2023. This project aimed to increase Family Physician (FP) knowledge of Mental Health best practices, increase FP and MOA awareness of specialized services, and troubleshoot existing communication gaps between FPs, Specialists (SPs), MOAs and specialized services. The project aimed to support high quality care for patients with mild to moderate mental health challenges.

# About the Project

Project documents highlight that while Surrey-North Delta already has higher than the provincial average incidence of MHSU cases, the COVID-19 pandemic further increased the number of people seeking help for MHSU concerns. For many individuals with mental health needs, primary care settings are the first point of contact with the health care system. However, FPs often report feeling unequipped to support their patients mental health needs.

In the EOI phase, the project team identified the following existing gaps:

* FP lack of knowledge about best practices in MHSU care
* FP lack of awareness of MHSU resources Lack of skills to screen for MHSU concerns
* FP lack of confidence and comfort to provide quality MHSU care for patients with mild to moderate concerns
* FP feeling isolated in their ability to provide care, and unable to access appropriate support if MHSU concerns escalate to more severe and acute circumstances
* FP feeling overwhelmed by the volume of patients needing MHSU support

## Goals of the Project

As stated in the project proposal, the objectives of the project were to:

1. Improve provider **confidence in skills and abilities** to provide quality mental health care in primary care settings (family doctors comfort and confidence in managing their patients with MHSU issues).
2. Improve **communication and collaboration** between family doctors, psychiatrists, addictions medicine specialists and mental health professionals.

## Key Stakeholders

Key project stakeholders were FPs, community psychiatrists, addiction medicine specialists, mental health and substance use professionals (FH MHSU team), the Surrey-North Delta Division of Family Practice, and Fraser Health Authority.

# About the Evaluation

## Evaluation Approach

The evaluation is intended to provide feedback on the implementation, operation, and potential outcomes of the project. The evaluation was designed to be participatory and developmental. The following questions guided the evaluation:

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| Process Questions | 1. To what extent has the project been implemented as planned?
2. To what extent has the project been able to identify and engage the necessary stakeholders?
 |
| Outcome Questions | 1. To what extent is the project achieving its planned results?
2. What lessons does the project provide that could be used to improve patient care and efficiencies in other populations or locations?
3. To what extent are the outputs/outcomes sustainable?
 |

## Methods

The evaluation incorporated the following data collection methods:

Document/ Admin Data Review. The evaluation team reviewed relevant project documentation including the project planning documents (i.e. funding proposals, meeting minutes, etc.) and project administrative data (i.e. event attendance, etc.).

Key Stakeholder Interviews. A total of 9 semi-structured interviews were conducted with FPs to assess the transition process for clients returning back to primary care from specialized Mental Health services and to gather feedback on and experience using the Transition Guideline for Adult Community Health and Substance Use Services. MOA’s (n=2) were also interviewed to better understand how they support physicians at their clinic when a patient is transitioning back to their office (i.e. primary care) from specialised Mental Health services. The evaluation used these findings to help inform potential next steps on ways in which client transitions or the Transition Guideline may be improved in the future.

In addition, a total of 6 semi-structured telephone interviews were also conducted with working group members These interviews gathered information on what was implemented, project team challenges and successes, overall project impacts, project sustainability and next steps.

**Pre-event survey.** Pre-event Surveys were administered preceding 2 learning and engagement sessions hosted for physicians and MOA’s (Table 1)**.** Pre-event surveys provided the evaluation with timely qualitative and quantitative information from a variety of perspectives as well as allowed the evaluation to compare pre and post event data and assess changes in attendees learning.

Post-event survey**.** Post-event surveys were administered following all five learning and engagement sessions hosted by the project (Table 1) to assess attendees’ perspectives on whether the event and learning objectives were met. Post-event surveys provided the evaluation with timely qualitative and quantitative information from a variety of perspectives.

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| **Table 1. Overview of Learning and Engagement Sessions Hosted as part of the AMHSU Shared Care Project** |
| **Event** | **Date** | **# pre-event survey responses** | **# post-event survey responses** |
| **Adult Mental Health CME Event** intended to increase physician knowledge and awareness of the patient journey through adult mental health services in SND. | Jan 17, 2022 | 25 FPs | 29 FPs |
| **MOA Learning and Engagement Session** intended to increase MOA health literacy and comfort in supporting physicians with their adult mental health patients | Feb 22, 2022 | 12 (9 MOAs & 2 management staff) | 47\* 100% response rate |
| **AMHSU CME: Management of OCD- Beyond the Basics** | Oct 11, 2022 | N/A | 38 (FPs & Specialists)100% response rate |
| **AMSHU CME: Mental Health Medication Management During Pregnancy** | Nov 16, 2022 | N/A | 43 (FPs & Specialists)90% response rate |
| **AMHSU CME:** Sleep Disorders: The Effects of Depression & Antidepressants on Sleep | Jan 24, 2023 | N/A | 10 FPs 83%% response rate |

\**Note: A small number of event attendees completed the event feedback survey twice, by mistake. Because we did not collect personal data to ensure respondent confidentiality, we were not able to remove duplicate data from this dataset*.

Contextual Analysis**:** All evaluation information was analysed within the context of the program’s stated goals and objectives.

## Limitations

A potential limitation associated with using semi-structured interviews is participants not being able to recall all experiences. In order to mitigate this, participants were sent the interview guides well in advance to their interview date, allowing them time to review questions and reflect on their experiences. By doing this, it was less likely that participants were caught off guard or surprised by any questions that were asked within the interview itself.

# Evaluation Findings | Organization and Operation

The following section summarizes the operation and activities of the project, or the process component of the evaluation.

## Organization and Operation

The AMHSU project was implemented by a working group consisting of local FPs, community psychiatrists, addiction medicine specialists, a Fraser Health director, and a Surrey-North Delta Division of Family Practice Project Manager.

## Activities and Outcomes

The project focused on the following activities:

### Physician Education and Engagement

**About**

Four learning and engagement sessions were hosted for FPs, psychiatrists, and addiction medicine specialists and MHSU professionals (Fraser Health MHSU team) as part of this project. The first session was hosted in January of 2022 and the goal of the session was to increase physician knowledge and awareness of the patient journey through adult mental health services in SND.

The other three learning and engagement sessions were a part of a Learning Series on Medication Management. The goal of the education sessions was to:

* To increase knowledge and confidence levels of FP’s with treating MHSU patients
* To increase knowledge and confidence of secondary care in the community – not just baseline medicine – whilst waiting for specialist care. So, GP’s feel more confident and comfortable with using 2nd or 3rd line treatments/mood stabilising. Providing integrated care. Starting early treatment before specialist support.
* To increase knowledge of alarming signs and symptoms in patients – what makes patients different to typical population?
* To increase awareness of what happens once referral accepted by MH services – understanding patient journey. Including services jargon and acronyms. What does it mean to care plan?
* To increase awareness of services that provide chronic care/ residential treatment – who would be accepted?

**Participant Satisfaction**

Overall, participants indicated that they were satisfied with the organization of the sessions and that it was a valuable use of their time. Participants indicated that there was enough time in the session to ask questions and have their questions responded to (Figures 1 & 2**).**

*“…the CMEs…for medication management and they have been very, very well received. On average, when we do a physician CME, we usually expect to get about 20 to 25 physicians in attendance. Our first session we had 37 and our second session 50. Usually, the numbers go down, our numbers have gone up”* – Working Group Member

**Impacts/ Outcomes**

**Generally, attendees of the January 2022 learning and engagement session indicated that after the session, they were **more knowledgeable about the patient journey using adult mental health services in SND as well as their journey following their discharge from these services.** (Figure 3)

*“I am noticing that FPs are understanding what happens when they refer the client to mental health team. Because previously they had this frustration that when they refer the patient, they don't know what's going on. Now they have a better understanding of things and they have been referring some clients which are more in line with the services that we are able to provide. Rather than previously not even referring them because they were not aware that these services were available.”* – Working Group Member

Session attendees also indicated **improved knowledge of community resources and services available to support patients dealing with mental health concerns.** For example, attendees of the January 2022 learning and engagement session **indicated improved confidence in navigating resources related to related to various mental** health concerns following session (Figure 4) and some attendees also indicated that as a result of the session, they were more likely to refer to or contact the UCRC (n=4), to confidently discuss what services are available with patients (n=1), and use other referral centres when needed (n=1).

*\*Note: N=27 for Depression on the post-event survey*

*\*\*Note: N=23 for Generalized Anxiety Disorder/ Panic Disorder and Personality Disorder on the pre-event survey*

*\*\*\*Note: Provider confidence navigating ADHD resources was not assessed pre-event.*

Attendees of the learning and engagement sessions indicated that the sessions **improved their knowledge around medication management** of various mental health issues that their patients may be dealing with, as well as improved their **confidence in their ability to treat and manage these issues** (Figure 5). In addition, attendees also agreed that they were confident in their understanding of the 2021 NICE guidelines (93%, n=40) and that they had a good understanding of the guidelines for management and treatment of patients with OCD (97%, n=37), following the learning and engagement sessions.

Finally one working group interviewee indicated how these learning and engagement sessions supported communication between primary care and the mental health team.

*“One thing was having better understanding of how the mental health team works for the primary care. Similarly, from primary care perspective, what is expected from the mental health. The gaps, one of the main things was the communication and how to fill that gap and being more practical about it rather being idealistic about it.”* – Working Group Member

### MOA Education and Engagement

**About**

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| **Classroom with solid fill** | One learning and engagement session was hosted with MOA’s in February of 2022 as part of this project. The goal of this session was to **improve MOA’s health literacy and comfort in supporting physicians with their adult mental health patients.**  |

**Participant Satisfaction**

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| --- | --- |
| All or nearly all event attendees who attended the session and completed a post-event survey agreed that session was a **valuable use of their time** (100%), that the **content of the presentation was relevant to their work** (100%), that the **event was well organized** (98%), and that there were **adequate opportunities to interact with event attendees and to ask questions of service providers** (100%). | Thumbs up sign with solid fill*“Thank you again for arranging this session and providing detailed explanation of UCRC referral process, plan G and SA forms”* – Session Attendees |
| *“Thank you so much for the effort to put together this learning event”* – Session Attendee |

**Impact/ Outcomes**

All or nearly respondents indicated that after the session, they **understood or were knowledgeable on how they can support the physicians they work with regarding their mental health patients** (Figure 6). Generally, respondents also indicated that they were **more knowledge about community services and resources for adult mental health patients** (98%, n= 46) as well as indicated **having higher confidence in their understanding of how to refer patients to the UCRC and with connecting with the UCRC team** , after the session (Figure 7).

### Creation of Education Videos

**About**

|  |  |
| --- | --- |
| **Presentation with media with solid fill** | Six education videos were created as post-education session clinical resources providers. Four were on the topic of OCD and two were on the topic of perinatal depression. These videos have been distributed to primary care providers and will continue to be available via Youtube.  |

**Impacts/ Outcomes**

|  |  |
| --- | --- |
| **Idea with solid fill**Several working group interviewees (n=4) indicated that the education videos created were **valuable resources made available for physicians and supported their learning and overall management of mental health patients.**  | *“We also created videos of clinical content that are just snapshots of what was inside the CMEs. Sometimes with the CME even though you send out the recording, a physician is not going to go back and rewatch the whole 60 min or 90 min recording... So, we have little snippets of what the working group felt were key prescribing 'golden nuggets' that are a couple of minutes long… we have been able to send those out as some follow-up resources for FPs in our community…I think the value add for the FPs is that they have a tangible resource that can help them with medication management for diagnosis that are typically very complicated…it is a tangible resource. It's relevant and it's also current.”* – Working Group Member |
| *“I think the value add for the FPs is that they have a tangible resource that can help them with medication management for diagnosis that are typically very complicated… it is a tangible resource. It's relevant and it's also current.”* – Working Group Member |

The video that was created on the topic of OCD has received 352 views as of March 9, 2023.

### Assessment of the Transition Process

**About**

****Semi-structured interviews were conducted with FPs to assess the transition process for clients returning back to primary care from specialized Mental Health services and to gather feedback on and experience using the Transition Guideline for Adult Community Health and Substance Use Services. Semi-structured interviews were conducted with MOAs to supplement the FP interview and to better understand how their support physicians at your clinic when a patient is transitioning back to their office (i.e. primary care) from specialised Mental Health services.

**Assessment Findings**

**FPs described experiencing challenges in the following transition stages** (Appendix A):

1. **While the patient is accessing their services as well as is continuing to access services of the MHSU services. Specifically, they described:**
	1. Having limited 1:1 communication with clinicians at the MHSU centre
	2. Having difficulties getting in touch with clinicians at the MHSU service centre when they have tried to reach out.
	3. Receiving patient transition letters via fax which was not ideal as the fax system does not integrate with their EMR and sometimes malfunctions.
2. **After the patient has been discharged from the MHSU service. Specifically, they described:**
	1. Experiencing long wait-times when trying to get patients re-referred to MHSU service centres.
	2. A need for more support with the care of their MHSU patients, particularly ones with complex MHSU health needs.

A**ll but one FP indicated that they did not know about the guideline**. However, upon having the opportunity to review the transition protocol prior to and during the interview, FPs had **positive comments about the recommended processes and the suggested transition forms included in the guideline**.

*‘We don't apply cookie cutter approaches. That's the reason we use the term Guideline…It was good to know that the physicians found that information to be helpful…I also heard people say they like the guideline.”* - Working Group Member

**Impacts/ Outcomes**

A one-page summary (Appendix A) highlighting assessment findings was created and shared with Fraser Health as a means by with the aim of **supporting future decision making and next steps related to improving these transition processes and the transition guideline itself**. In addition, this summary was identified as an **opportunity to connect FPs with MHSU resources and services in the community,** including the UCRC, Surrey Mental Health and the RACE line.

*“Now that there is an identified person in Fraser Health …we were able to create that one-pager … [it] has been taken back to the Fraser Health team...Just having a tangible almost to-do list or a recommendation list was valuable because it was a representation of voices, right? So, that was helpful.”* – Working Group Member

### Development of the OCD Care Pathway

**About**

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| **Route (Two Pins With A Path) with solid fill** | An OCD Care Pathway was developed as part of this project in order to better support physicians in managing and coordinating care of patients who have OCD and navigating appropriate resources. |

**Impacts/ Outcomes**

# Summary of Findings

|  |  |
| --- | --- |
| **Project Goal** | **Progress Made Toward the Goal**  |
| Improve provider **confidence in skills and abilities** to provide quality mental health care in primary care settings (family doctors comfort and confidence in managing their patients with MHSU issues). | * FPs, psychiatrists, addictions medicine specialists and/ or mental health professionals indicated that as a result of the sessions they attended, they:
	+ Improved their knowledge around medication management of various mental health issues that their patients may be dealing with, as well as improved their confidence in their ability to treat and manage these issues
	+ Were more knowledgeable about the patient journey using adult mental health services in SND as well as their journey following their discharge from these services.
	+ Improved their knowledge of community resources and services available to support patients dealing with mental health concerns
	+ Had improved confidence in navigating resources related to related to various mental as well as improved their confidence in their ability to treat and manage these issues
 |
| Improve **communication and collaboration** between family doctors, psychiatrists, addictions medicine specialists and mental health professionals. | * FPs, psychiatrists, addictions medicine specialists and mental health professionals attended 3 learning and engagement session hosted as part of the project providing an opportunity to improve their communication.
* Several FP attendees also indicated that as a result o of the January 2022 learning and engagement sessions, they were more likely to refer to or contact the UCRC, and use other referral centres when needed.
* A one-page summary highlighting the challenges FPs experience with the transition process when clients are returning back to primary care from specialized Mental Health services was created This summary was identified as an opportunity to connect FPs with MHSU resources and services in the community, including the UCRC, Surrey Mental Health and the RACE line.
* One-page summary identified as an opportunity to connect FPs with MHSU resources and services in the community, including the UCRC, Surrey Mental Health and the RACE line.
 |

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# Evaluation Findings | Discussion

The following section outlines the lessons learned, including facilitators of success and challenges faced. It also reviews the sustainability of the project and its outcomes.

## Facilitators of Success

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| --- | --- | --- |
| Cheers with solid fill | Working group interviewees indicated that having a **dedicated team that shared a common agenda** facilitated project progress and success. They also highlighted that the **right people and key stakeholders were involved** providing valuable input from varied perspectives the project. | *“Commitment and common shared goals, I think these were the two main things that just basically made it possible for us to accomplish it.”* – Working Group Member |
| *“They were all supportive and quite synchronized. Everyone was on the same page. That was what actually worked well.”* – Working Group Member |

One working group interviewee identified **strong project management and coordination** as an important facilitator of overall project progress and success. They highlighted that the project managersending reminders, preparing meeting agendas and meeting minutes was helpful and ultimately supported the team’s success. This same interviewee highlighted that meeting logistics, **such as meeting early the morning and having virtual meetings** made it easier for them to consistently attend meeting.

*“Because if it was any other time, in the middle of the day, I would have had to block of my schedule or it would have been a lot harder to access. So, that was useful and then the fact that we were meeting virtually was also... it made things easier as well. If I had an early clinic, I could just take my laptop and have our meeting right before clinic.”* – Working Group Member

## Challenges

Challenges Related to Project Management and Logistics

The primary project challenge highlighted by working group interviewees were the **impacts of staff turnover** amongst both Fraser Health and Division team members. Interviews highlighted that regular staff turnover affected project momentum and team cohesiveness.

*“We have 3 changes on the Fraser Health side for the lead person there…So, it kind of loses the impact because the new person doesn't know what the other... even if they transfer the notes. All the discussion and everything isn't there.* *And then similarly on our side we changed the [manager]...we had 3 changes on that side as well. The working group became less cohesive for lack of a better word. So, that was my concern with the whole project.”* – Working Group Member

Another challenge highlighted by working group interviewees was inconsistent meeting attendance. They highlighted that **at times, meeting attendance was low**, leading to meeting cancellations which impacted team communication and project progress. Finally, a working group interviewee indicated that challenges brought on as a result of the **COVID-19 pandemic** impacted the projects team’s availability and ultimately delayed project progress.

Challenges Related to Project Activities

Several interviewees highlighted challenges surrounding their work with the **Transition Guideline for Adult Community Health and Substance Use Services.** An interviewee noted that they were unclear about the teams’ goals and expected outcomes were related to the work that was done with the guideline. For example, because the guideline is owned by Fraser Health, the project was not in a position to make changes directly to the guideline or promote the guideline.

“But it's not ours, so, we can't do any kind of communication roll out, we can't do any marketing for it... we have to wait….” – Working Group Member



Finally, one working group interviewee highlighted some challenges that the team experienced in the development of the **OCD care pathway**. They highlighted that they were not clear how to develop the pathway and what would be valuable to include within it.

## Sustainability

There were mixed reports on the sustainability of project outcomes amongst working group interviewees. For example, one interviewee indicated that the education videos that were created and posted on YouTube are available for wide-spread and longer-term physician access and reference, making this a sustainable project activity. Another interviewee, however indicated that these videos are only sustainable for as long as the video content and information l is up-to-date. Interviewees did generally agree that education that was provided for current physicians on how to use the Surrey Mental health services was valuable, however, an interviewee highlighted the importance of considering provider turnover and the need to consider the upkeep and continued education of new providers entering the system.

*“But will that impact be long-lasting? I am not sure about it. I think soon enough the new people will come into the system and the old will leave and even what we have done, maybe after a while people won't even remember we did anything like that.”* – Working Group Member

Generally, interviewees highlighted that **long-term follow-up on project activities** would be necessary in order to determine the projects sustainability.

# Recommendations and Next Steps

While progress has been made towards the goals of the project working group interviewees noted that there is **still work to be done.** For example, one interviewee indicated that they would like to have an **ongoing forum that would allow for continued communication collaboration amongst team members and key stakeholders** in order to keep thinking about future directions and goals. In addition, several interviewees highlighted that **long-term follow-up** would be necessary to better assess project success.

 *“After all the education seminar and everything we delivered…a post-delivery review to say, hey, has this made a difference in your practice, how has that helped you, how has that not helped you, what would you like to see?”* – Working Group Member

“*I think just the implementation of the transition protocol, and then just seeing the outcomes is what we still have to see*.” – Working Group Member



As per interviewee report, including **continued physician education and skill-building** would be necessary to build upon the project successes. One interviewee highlighted that continuing to improve primary care physician skills and confidence in managing mild to moderate mental health and substance use cases would be beneficial.

*“The next step should be doing some practical problem solving…. if we just have a system where we discuss some clinical scenarios…How it has been done and how it can be improved that is where you get more confidence and that is where you get more practical information.”* – Working Group Member

Interviewees had feedback regarding the **Transition Guideline for Adult Community Health and Substance Use Services**. For example, several interviewees highlighted how the guidelines are **too complicated and suggested creating a shortened version of them.**,. Another interviewee highlighted that it would be important to **spread awareness of the guideline** amongst physicians, including ease of finding the document.

Another indicated that it would be **beneficial to assess outcomes related to the implementation of the transition protocol**.

 “*I think they are too complicated, and I don't think the physicians are going to read that. And I think from your survey, kind of got the same kind of thing that they were a little bit tedious and whatever... they didn't even know that they existed. So, to get them out to the physicians would be great but in a shorter format*” – Working Group Member

*“… how to make it more realistic and practical because in my opinion they are too idealistic…. Achieving them I don't think it would be easier, so it's better to be more practical than idealistic. It is a work in progress but its going in the right direction now.” –* Working Group Member

FP interviewees also indicated that they would like to see the following changes made in order to better support their MHSU patients transitioning back to primary care from the specialized mental health services:

* More communication between FPs and clinicians at MHSU service centres
* FPs to have more direct, easy and quick access to psychiatrists, psychologists, or other MHSU clinicians
* Improved familiarity and relationships between FPs and clinicians at the MHSU service centre
* Preferred to have electronic transfer of communication documents vs fax

Similarly, one interviewee highlighted that it may be beneficial to cerate a **“hotline phone number” for physicians** to help them better navigate Fraser Health and Community resources, programs, and services.

# Appendix

## Appendix A

