White Paper – Mental Health and Addictions Care in the Community Intersecting with Patient Medical Homes and Primary Care Networks

Working/Living Document – Last updated July 9, 2021

COVID-19: Impacts and influences

While completing the consultation and final writing process of this white paper, COVID-19 became a worldwide pandemic. Amongst its impact is changes to health care delivery and access, which reinforces the importance of the vision outlined below. It is in the Recommended Actions section where we have made most reference to COVID-19, noting that we believe new or better opportunities for change exist.

Overview

The Vancouver Division of Family Practice ("the Vancouver Division") and its members are leading the work towards the implementation of important primary care changes. It involves the development of Patient Medical Homes (PMHs) and wider Primary Care Networks (PCNs). Details about the change toward a more team-based and networked approach to primary care can be found on our dedicated website www.vancouverdivision.com. Additionally, it contains information on the Vancouver Division's strategic priorities available here[1].

Although the development of Vancouver PMHs and PCNs are still in their infancy, the goal is to create a comprehensive primary care system with family physicians (FPs) and nurse practitioners (NPs) at its core, supported by nurses (RNs and LPNs) and complementary allied health professionals so patients have access to holistic care across the lifespan continuum. Initial PCNs are being established utilizing a hub model of centralized but limited Inter-Professional Teams, which include allied health with one priority being supporting mental health and substance use.

The Vancouver Division's Mental Health and Addictions (MHA)[2] Committee (along with the Vancouver Division's Maternity Care and Frail Elder Care Committees) has undertaken a visioning process to highlight the resources that are available in Vancouver. The committee will leverage these system changes to improve the conditions and delivery of MHA primary care in the city. This white paper documents the outcomes of the process and informs the work of the committee and the Vancouver Division in the coming years.

[1] The full link to the strategic priorities document is https://vancouverdivision.com/static/e60f7edfa2007715d4297862a3a1f54f/Strat-Priorities-2021.pdf

[2] A note about terminology: Although the prevailing terminology is Mental Health and Substance Use (MHSU), the term and abbreviation most utilized in this white paper will be Mental Health and Addictions (or MHA), as covered within addictions care is both substance use addictions (such as opioids) as well as process addictions (such as gambling).

What Current Is: Mental Health and Addictions Care in Vancouver Today

The Data

Mental health can be defined as 'the state of your psychological and emotional well-being. Poor mental health can lead to mental and/or physical illness[3]. It is important to note here that mental health and illness are on a spectrum with varying degrees of acuity and complexity. Addictions can be defined as 'a compulsive, chronic, physiological or psychological need for a habit-forming substance, behavior, or activity having harmful physical, psychological, or social effects and typically causing well-defined symptoms (such as anxiety, irritability, tremors, or nausea) upon withdrawal or abstinence'[4]. The following data provides some context to mental health and addictions care as it can be experienced today.

As reported by the Canadian Mental Health Association (CMHA), in any given year, 1 in 5 people in Canada will personally experience mental health concerns or illness. Only 1 out of 5 children who need mental health services receives them.[5]

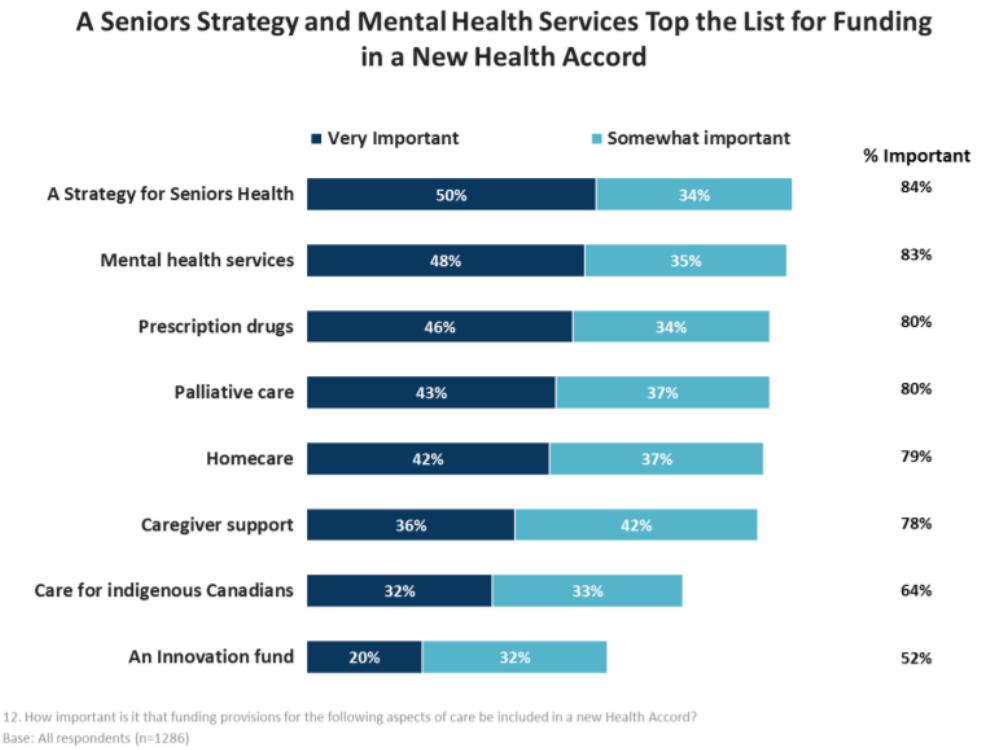

Figure 1: Survey respondents from the CMA's 16th Annual Report Card on Heath Care (2016) ranks investing in mental health services a top priority.

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[3] From the Government of Canada: https://www.canada.ca/en/public-health/services/about-mental-health.html
[4] Marriam-Webster Dictionary definition: https://www.merriam-webster.com/dictionary/addiction
[5] From the CMHA Fact Sheet, which draws from the Mental Health Commission of Canada (2013) report: "Making the case for investing in mental health in Canada"

As Figure 1 illustrates, Canadians recognize the need and fully support investments in increased mental health services.[6] The prolonged and continuing COVID-19 pandemic has only amplified the impacts and need for MH supports. Anecdotally, this has become clear from media reports as well as firsthand experiences from FPs and NPs across the city.

There have also been specific impacts on addictions and substance misuse. The most visible is the ongoing opioid crisis, with January 2021 reporting 165 deaths in BC due to overdoses from toxic illicit drugs. This is a 104% jump from the number of deaths reported in January 2020.[7] In April 2021, the 176 deaths in the province represented a 43% jump from the same month in 2020 and the 14th consecutive month where over 100 people have died.[8]

Many Canadians (58%) say they would socialize with a friend who has a mental illness. However, when focusing on addictions, the proportion who say they would socialize with a friend who has alcohol (32%) or drug addiction (26%) is significantly lower. This suggests that the stigma of addictions is significantly greater than that associated with mental illness.[9]

The pandemic has added a concentrated focus towards mental health and addictions. In addition to what members have reported anecdotally, research is starting to emerge to add or reinforce the impacts of the pandemic on patients. Research published in July 2020 in the Journals of Gerontology looked at the experience of Canadian and U.S. residents in the early stage of the pandemic. The study suggests that those 60+ have fared the best so far, with middle-aged and younger adults being more likely to struggle. Younger adults (18 to 39) are at greater risk for loneliness and psychological distress during the pandemic. Researchers suggest that part of the difference in ability to cope may be age-related stressors. Younger adults and middle-aged adults have had to manage one or a combination of: unemployment, working from home, childcare, and homeschooling.[10]

COVID-19 has worsened mental health inequities for those who were already experiencing challenges. During the pandemic mental health has declined in 44% of women, 32% of men, and there has been a significant rise in suicidal thoughts. For example, 1 out of 20 people in the general population has suicidal thoughts and 1 in 5 who already had mental health concerns or illness experience suicidal thoughts.[11] As vaccination rollout continues, the contemplation of the long-term consequences of COVID-19's collective trauma will continue to emerge and require support.

The system in Vancouver

As clearly articulated in the Centre for Addictions and Mental Health policy framework on mental health and primary care, most health and medical services are provided in primary care settings. "Primary care is

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[6] 16th Annual Report Card on Health Care, Canadian Medical Association (August, 2016)
[7] 165 people died of an illicit drug overdose in B.C. in January, coroner reports, CBC News (Mar 2, 2021)
[8] 176 people died due to illicit drugs in B.C. in April: coroner, CBC News (Jun 1, 2021)
[9] 8th Annual Report Card on Health Care, Canadian Medical Association (August, 2008)
[10] The Ups and Downs of Daily Life During COVID-19: Age Differences in Affect, Stress, and Positive Events, Patrick Klaiber, MSc, Jin H Wen, BA, Anita DeLongis, PhD, Nancy L Sin, PhD, *The Journals of Gerontology: Series B*, gbaa096 (July, 2020)
[11] 2020 CMHA Impact Report.

the fundamental building block of effective health care delivery and is key to the sustainability of the health care system. When chronic physical and mental health concerns and illnesses are treated in primary care settings, instead of in emergency rooms and hospital inpatient settings, the cost burden on the system is reduced." [12]

Having undertaken similar visioning processes for other specialized populations that are a priority for the Vancouver Division, it is clear that each one is informed by its own distinct culture and contexts. For the mental health and addictions care system, a sense of scarcity clearly informs how the system has evolved and continues to operate. From primary care providers we spoke to, the reports and studies reviewed, and the existence of a patchwork of supports offered across the City (particularly low or no cost options where there are a number) are all indicators that there is not enough, or the right supports needed for the "demand" from the public. It is important to acknowledge this existing deficit perspective in the system as we look forward toward making improvements and sparking sustainable change.

To create the most useful description of the current system for this white paper, the Vancouver Division held focus groups with members before the pandemic started to capture the realities they face in the system as it is[13]. Here are the key themes:

- *Consolidating and mobilizing knowledge may be challenging* – For FPs with only a small portion of their practice involving MHA care, knowledge gained through Continuing Medical Education (CME) and other means is hard to consolidate and access when not put to practice on an ongoing basis. For example, "there is a difference between addictions and overuse," said one participant. "We are good at identifying diabetes, but not necessarily good at identifying addictions."
- *Navigating patient resources is difficult* – Regardless of the level of MHA care that an FP provides, many have found it hard to support their patients in navigating the resources available within the system.
- *Acting as counsellors beyond their scope of practice* – FPs often act as counsellors for patients. Although there are some billing codes to compensate for these longer and important clinical encounters, they are limited and often run out. Especially if unplanned, they can impact workflow and cause delays for other same day scheduled fee for service (FFS) appointments.
- *When things get beyond what is capable* –FPs who shared their experience and perspectives described a variety of scenarios when they felt challenged or at their capacity to provide MHA care. Some conditions or patient scenarios that were common included supporting patients with alcohol use disorder (AUD), adult Attention-deficit/hyperactivity disorder (ADHD), and Opioid Agonist Therapy (OAT) prescriptions. FPs expressed that they felt particular distress when their patient's condition was chronic and longstanding, and every intervention they had prescribed was not or no longer working. Co-morbidity of conditions (for example, the addition of ADHD as a secondary condition was mentioned multiple times as challenging) often makes providing care

[12] Mental Health and Primary Care Policy Framework, Centre for Addictions and Mental Health (March, 2016)
[13] The focus groups were held on March 3, 2020 with two groups of Vancouver Division members, all providing fee-for-service primary care with invitations sent to a randomized sample of the membership: 1) 6 FPs with established practices and 2) 5 FPs who are in the first 10 years of practice.

and referring to other services difficult. Lastly, the age of the patient can also add complexity, with some complexities being around consent (younger) or frailty (older).

- These additional scenarios are also worth noting from the focus groups:
    - *Not complex enough for VCH services* - If a patient's condition is beyond what is possible within the FFS context, referrals to VCH services (for example VCH Mental Health Team or MHSU Outpatient Services) are often declined because the patient does not meet their mandate. This gap is reflected in the conceptual diagram below.
    - *Stopping the decline* – The issue of decompensation has clearly started. There is a need for temporary but timely psychiatric care. This could help stabilize a patient for the FP to continue their treatment. FPs described the potential benefit of a temporary (and the hope would be timelier) support option for their patients that would help stop a clear decline they see in their patient.
    - *A quick referral versus a call for help* – FPs expressed a clear difference between needing a quick referral ("the easy button"), as opposed to when all options have been exhausted and they need a call for help. Work could be done to further describe the spectrum of scenarios between these two points and what can be supported through existing resources (the RACE Line or eCase) versus what might remain a gap in support that could be explored.
- *Patients find themselves in between systems of support* – Unattached patients (i.e. patients without a primary care provider) who present within the health authority system (often in *high acuity circumstances)* was identified as a key concern. Often patients in these situations are not yet appropriate for longitudinal care in community (e.g. fee-for-service care through an FP or NP) and often get "stuck" in this gap of service – a "missing middle". Through our engagement work, we have identified key places in the healthcare system where patients in this gap are identified, which would be ideal initial collaborators to explore ways to address this gap.

When combining the data and statistics with the lived experience of our members, the following description of the current MHA system emerges. It is important to note, we have intentionally left out definitions for mild, moderate, and severe mental health concerns as there is so much fluidity within the spectrum for each individual and diagnoses.

Intensity of MHA concern	Mild <-> Moderate <-> Severe		
	Family Physicians and Primary Care Providers	"Missing Middle" Gap	VCH
Medical system support - the current state	Many patients with mental health complexities receive care exclusively from the primary care system. When a patient's MHA concerns grow, FPs often do not have the proper supports to provide more enhanced care within their practice and often there are no publicly funded		Pathways to acute services are clear and available. There is, however, a lack of publicly funded or affordable options towards the middle of the spectrum of care; and options that exist have long wait-times. VCH has a suite of MHSU Specialized Community Service Programs (SCSPs). But

	options to refer to. Alternatively, the patient's condition does not meet eligibility for the services that are publicly available.		they do not bridge the gap in care and often have more demand than they can accommodate
Community support	There is a mosaic of community services available. However, the ever-changing landscape is hard for patients and FPs to keep up with. Although system navigators do exist, the need for such supports outpaces what is available.		

What should be: describing optimal MHA primary care in the community

Guided by values

The Vancouver Division's visioning process engaged members in focus group discussions. They were aimed at describing the characteristics and contours of optimal primary care for several specialized populations. In all discussions, six critical values surfaced that are universal across family practice. However, these values need to manifest in unique ways when providing MHA care. The table below summarizes the broad value and how they should look within an optimal MHA care system in Vancouver.

Value 1: *Timely*		
Patients receive the right care at the right time with the right provider. In terms of MHA care, waiting for treatment is not a neutral endeavor and can lead a patient's condition to transition from mild-to-moderate or moderate-to-severe.		
For Patients	**For Family Physicians**	**For the System**
Patients are triaged directly to appropriate care, ideally within 2 weeks.	There is a spectrum of care (one-on-one and groups or online) readily available to offer.	Would reduce inappropriate use of emergency systems.
Value 2: *Accessible*		
Care is easily navigated and centered on the needs of the patient, family, and community.		
For Patients	**For Family Physicians**	**For the System**
Travel is minimal, and access points are also available closer to home.	FPs have non pharmacologic options to offer alongside pharmacological ones.	There is a spectrum of care options that are appropriate for the patient demographic of the Community Health Area (CHA).
Value 3: *Safe and inclusive*		
Care is adaptive to a patients circumstances and empowers patients in their own self-management, and in contributing to the development and assessment of their own care. Important considerations inform the design and delivery of care, including social determinants of health, culture, language, and other aspects of oppression and marginalization.		
For Patients	**For Family Physicians**	**For the System**

Patients receive care that is trauma-informed and culturally inclusive.	FPs confidently draw on MHA skills and training and continue to grow their capacity.	Training in areas such as culturally sensitive care, trauma-informed care, and addictions care are readily available. The system has appropriate incentives to ensure education is effectively translated into practice.

Value 4: *Longitudinal and Relational*

Patients have greater access to continuous, comprehensive, and coordinated primary care. FPs are working in a supportive environment that facilitates them to do what they do best – know the patients and their families over a longer time and care for them in a holistic way. This puts FPs in a privileged position to understand and support the patients with MHA diagnoses.

For Patients	For Family Physicians	For the System
Patients do not have to tell their story again and again.	FPs are drawing from their relational strengths and the wider perspective of knowing their patient's family. They have appropriate training to provide counselling supports and follow-up as appropriate and possible given the current fee codes.	Trained and experienced community FPs have confidence in accepting MHA patients who are appropriate for longitudinal care in community. FPs draw on appropriate VCH services (SCSP, AAC, available addictions program, etc.).

Value 5: *Informed, Connected, and Good Communication*

FPs need to be up to date on the appropriate options for their patients. They also need to be aware of and connected to MHA providers to allow seamless and timely transfer of information and care.

For Patients	For Family Physicians	For the System
Patient education is clear for them to know where to go. "Every door is the right door to care."	Timely and thorough communication and referrals between FPs and external providers (mental health clinicians, psychiatrists, etc.).	Strong communities of practice exist for peer and specialized support.

Value 6: *Sustainable*

FPs have the capacity both clinically (appropriate education and training) and operationally (the right clinic systems and procedures), so they are well supported and thriving in their practice of medicine. Providing MHA care can be a stressful part of an FP's practice. It is equally important to ensure there are systemic measures in place to support the health and well-being of providers.

For Patients	For Family Physicians	For the System
Allied health services are fully funded at no cost to the patient.	FPs are drawing from their relational strengths and the wider perspective of knowing their patient's family. They have appropriate training to provide counselling supports and follow-up as appropriate	Wrap-around teams are accessible (including formal connections to specialists like FFS psychiatrists that have traditionally not been in place) based on the patient panel and the patient demographics within the PMH network and PCN.

	and possible given the current fee codes. Adjustments of payment structure to facilitate greater number of counseling sessions or mix of blended and FFS funding to provide flexibility for FPs who can utilize this additional time. Physician wellness and resiliency opportunities are easily accessible.	

The Future State We Need

There are several opportunities for the development of PMHs and PCNs in Vancouver as it relates to primary MHA care. As the PCNs come into development, there is already efforts to bring additional mental health clinicians to support patient care. There are also efforts to create more localized access to appropriate MHA SCSPs. These are offered by VCH and are appropriate for patients more complex and/or acute in the MHA spectrum of care.

However, there will continue to be a structural ***'missing middle' gap*** in care for patients. For our members, this will be for patients whose MHA concerns have grown beyond what FPs and NPs can support in their clinical encounters but do not meet the official mandate of available health authority options. Some patients may have the means to access private or extended health options like counselling. However, this is not accessible for all patients, leaving some without support.

Visually, we see a future state that looks like this:

Intensity of MHA Concern	Mild <-> Moderate <-> Severe		
Medical system support	**Family Physicians and Primary Care Providers**	**Filled Gap**	**VCH**
	FPs continue to provide MHA care as appropriate to their patient panel. They have timely communication with MHA experienced colleagues for advice, resulting in an increase in capacity to provide care within their practice. When needed, FPs have clear and trusted referral pathways for their patients to appropriate supports that are publicly funded or offered on a sliding scale.	The missing middle gap has narrowed, and there are appropriate new options for patients –within or facilitated by PCNs, nurtured by the Vancouver Division and/or collaborative partners.	VCH acute and tertiary care continues to be effective and timely. Mental Health Teams and other MHSU services are readily available when needed. MHSU outpatient services are available to meet the demand. Redeployment of MHSU SCSPs into each of the six CHAs that offer "closer to home" access for patients.
Community support	Consistently updated and expert navigation of the mosaic of community services available will be available to patients and providers – so patients are directed to the right option(s) at the right time from the right person/supports.		

As you can see from the above visual, moving from the current system of scarcity to one of optimal care requires more than simply identifying and creating new patient care options. Given the scarce resources, many social services and non-profits offer important MHA supports and programs as part of helping to "fill the gap". Navigation and awareness need to be easier to make them more accessible. Without dependable funding, availability and capacity of these services vary constantly. VCH also regularly reviews and adjusts their offerings. Altogether, this creates an ever changing and patchwork of options that

patients, their families, and primary care providers find troublesome to navigate. An optimal system would ideally create a simpler system of care to navigate. But as we work towards that, a trusted navigation infrastructure is needed.

With scarcity also comes the potential for provider burnout. The focus group of community FPs clearly articulated the toll on their own wellbeing as they struggle to support patients that fall within the "Missing Middle". In addition to more and expanded supports for their patients, they also see an optimal primary care system as one that fosters ***stronger connections and deeper relationships with more experienced FPs and specialist colleagues***. Often when caring for patients with more complex MHA concerns, FPs experience some anxiety when they do not have the resources to help these patients. Having access to collegial support would be one way in reduce this anxiety.

Leveraging the Best of What Currently Is

There are strengths in the system that should be leveraged early on to jumpstart efforts to get to an optimal state. Some of these assets are:

- Members who provide specialized care, have a focused practice, and who provide MHA care confidently have a wealth of knowledge and experience in delivering MHA primary care. This should be leveraged to support their fee-for-service colleagues in community.
- Programs like the CBT Skills Group Program are examples of how initiatives can be launched that leverage the publicly funded system. They provide much-needed preventative and early interventions. The CBT Skills Group Program teaches patients mindfulness and cognitive behavioral therapy skills and concepts. It teaches patients valuable tools to address patterns of thinking, feelings, and behaviors. The Program is made accessible to patients thought MSP funding, making it accessible.
- The Vancouver Division has the processes and tools in place to collate, identify, and spread resources and information to members (e.g. Pathways, FastFacts, etc.).
- Efforts are already underway within VCH to review and reorganize their SCSP. As a result, SCSP will align with the PMH and PCN structures being put in place within Vancouver.
- The Vancouver Division has strong established relationships that can support MHA collaborations across the city – through the Vancouver Adult MHSU Partnership Table (with VCH and Providence Health Care) as well as the Child and Youth Mental Health and Substance Use Collaborative – Vancouver Local Action Team (which represents a cross section of stakeholders including the Vancouver School Board, Parks and Recreation, and numerous community social service agencies).
- The Patient Attachment Initiative (PAI) at the Vancouver Division continues to match unattached patients to primary care providers. At the time of writing, PAI is close to reaching 20,000 patients matched. PAI is a crucial part of the current system, matching patients to primary care providers close to their home. As the PCNs and PMHs continue to develop, PAI will continue to serve their mandate matching patients to the appropriate PCNs.

- Continue to utilize services like the RACE line (and eCase), Pathways, and the BCCSU line to receive help with system navigation, making referrals to the right place, and getting support for tougher to solve cases.

Recommended actions

Work is required to bridge the gap in the healthcare system currently being provided to patients dealing with mental health and addictions challenges. Focus should move towards team-based holistic care that includes community-based non-clinical supports, as well as better connections amongst providers in support of their patients. Concrete areas of action are outlined in the following table.

Recommended actions	
Supporting data collection and analysis for data-driven quality improvement	As PMHs and PCNs begin to develop, there is an emphasis being made on data infrastructure (aggregated, but specific to the six key areas of the city) to inform ongoing planning and development within each PCN. There is an opportunity for the MHA Committee to support and inform development. The committee can help make sense of the aggregate data for Vancouver and utilize data to inform any quality improvement work that should be done. They can specifically look at what can be improved in the system of care in Vancouver – particularly addressing the "missing middle" gap in care.
Committing to Equity, Diversity and Inclusion	The impact of systemic racism and discrimination cannot be overstated as it relates to MHA. It will be critical at the start of designing and implementing new initiatives with an EDI lens to listen, unlearn, and relearn. This will facilitate system changes toward an optimal MHA primary care system for all. Existing healthcare approaches such as being trauma informed and cultural safe are current strengths in the system to build on.
Developing and growing Communities of Practice (CoP)	Communities of Practice (CoPs) provide a framework in which more intentional and stronger connections can be made. As networks based on geographical CHAs are developed, it will be equally as important to have CoPs (whether distinct or connected to PMH networks) focused on MHA. These CoPs will provide the supportive environment for: 1) Enabling FPs to consult with experienced and expert peers which currently does not exist; and 2) Supporting ongoing learning which, will result in increasing the overall MHA capacity for FPs. Specific areas of opportunity are: • Further support the growth of the nascent CoP for OAT prescribers. • Explore how a CoP approach could help FPs provide care for other areas of substance use – particularly alcohol and stimulants.

	• A CoP to support the developing model of team-based care, where multiple care providers work together in a joint decision-making process including the patient or substitute decision-maker[14].
Exploring and addressing the "missing middle" gap in MHA patient care	Energy and efforts continue to be needed to bridge the gap in care that still exists for many patients. Their mental health complexities go beyond what can be provided within a family practice setting. However, they do not meet the mandate for current MHSU services provided by VCH. Any efforts in this area need to be informed and connected to work done to create PMHs and PCNs as well as ongoing efforts within VCH. The work to create this white paper has helped to describe and clarify the gap. Options to address and fill these gaps are numerous. The work of the Division, through the MHA Committee should be to explore what options are viable and sustainable for the system in Vancouver. Specific areas of opportunity are: • Stay connected with the initial pilot efforts to provide new mental health supports as part of the PCN service plan and understand how they impact the gap. • PCNs will have mental health supports (such as counselling) available that patients for limited visits. Explore how these new supports can be best structured to effectively serve the need that FPs expressed for MH supports when a patient decompensates but could return for additional temporary support with the same clinician if the patient relapses. • Explore infrastructures or systems that could be housed or centralized within each PCN that strengthens connections to services. Areas to consider include: o Means to connect with fellow FPs who are experts or experienced that are ready to provide peer support; o Similar means to connect with providers and specialists within appropriate VCH services for quick consultations, improve efficiency and accuracy of referrals, or avoid unnecessary referral; and, o Offer ways for FPs to provide focused care to fellow primary care providers (e.g. further increasing OAT prescribing capacity in areas outside of the Downtown East Side through PCN support, as we continue to support increasing the number of FPs who provide OAT prescribing within their clinics.) • PCNs could be a facilitative home for mild-moderate programs like the CBT Skills Group Program. Alternatively, they could help spark other group medical visits on topics such as how to live with chronic

[14] A literature review of team-based models focused on MHA was conducted in the early stages of developing this white paper and could serve as a starting point for ideas and energy.

	conditions, learning self-healing strategies (e.g. de-medicalize mental health complexities and support patient self-management).
Easing system navigation	Ongoing and repeated efforts will be needed to ensure FPs have access to up to date information on programs and services available. This would in turn help patients view their PMHs as the "one-stop-shop" for their primary care needs. FPs would benefit from staying up to date on the following: • Services and wait-times for VCH run programs such as MHSU Outpatient services, detox programs, Mental Health Teams (for adults and child and youth), and the Older Adult and Mental Health Substance Use (OAMHSU) program • Changes to VCH's Specialized Community Services Programs as it unfolds • MHSU and wellness programs run by community nonprofit and social service agencies • Ensuring that patient information and consult notes are easily accessible and shared in a timely manner With navigation of the MHA system, an optimal approach would have navigators working alongside patients as their service approach, not just simply providing referral options.
Enhancing education and training	Work should be undertaken to curate and facilitate specific training opportunities, through collaborations and partnerships with existing providers. By receiving adequate training, FPs would be more confident in providing care in their practice and clinic. Topics likely include: • Social determinants of health impacting mental health and addictions • Trauma informed care • Increasing cultural competencies and understanding impacts of system racism and colonization • Self-care and mindfulness skills that can be introduced in a typical clinical encounter • Addictions care training (building on OAT prescribing, alcohol and stimulants use, etc.) • Explore practical ways that experienced and expert FPs can support the learning of their colleagues (informal shadowing, mentorship, etc.) • Explore options for FFS FPs to gain exposure within VCH owned and operated MHSU programs and services in a way that would benefit both the FPs and VCH. • Clinic management training that supports the inclusion of addictions care within the workflow of a fee-for-service clinic (similar to the training around the concept of advanced access).
Further supporting patient attachment	The Vancouver Division's established PAI can be leveraged and further supported to improve the attachment rates of MHA patients to primary care providers): • One of the benefits of the PAI is attaching patients to the primary care provider that would balance their patient panel. This, partnered with the Division's focus on physician wellness may increase the primary

	care providers capacity. This should be communicated with the PAI to increase the number of unattached patients that can be matched. • Continued referral education work to ensuring appropriate patients are being referred to PAI.
Supporting or sparking the development of programs	Like the Vancouver CBT Skills Group Program, the Vancouver Division has a history of collaborating on new programs and initiatives. The Vancouver Division provides strategic support for the continued growth and sustainability of the CBT Skills Group Program. Moreover, we encourage the Vancouver Division to consider additional initiatives that can further bridge the gap in care within the "missing middle".