RAAM Clinic Best Practices

April 11, 2018

Access to the RAAM clinic

Best practice: RAAM clinics will be open to community members with any substance use disorder. Patients may be referred from any hospital, clinic, or community agency, or they may be self-referred. Patients will be seen within seven days and ideally in under three.

Rationale: Patients with substance use disorders are often struggling with multiple health and social challenges. This makes it difficult for them to cope with long waiting lists, or to engage in lengthy intake interviews and questionnaires. Other barriers to addiction treatment include geographical catchment areas, restrictive admission and discharge criteria, and costs.

RAAM clinics are part of the general health care system, and services are covered by OHIP. RAAM clinics see patients without referrals or booked appointments; patients are seen on a walk-in basis during specified hours (with a suggested minimum of one half-day per week). The walk-in model gives patients the flexibility to attend when they are able to, without the pressure of having to make and keep a scheduled appointment.

The RAAM clinic is intended to be part of an integrated addiction care pathway. It is open to everyone who wishes to address their substance use.

Staffing

Best practice: Clinical staff should include at least one physician or nurse practitioner who is able to prescribe buprenorphine and anti-craving medications, and one counsellor, case manager, or nurse who can provide assessment and brief counselling interventions and time-limited case management.

Rationale: The clinicians will provide medication-assisted treatment along with counselling, case management, and links to community services. This interprofessional team approach is best suited to meet the patients' medical and psychosocial needs.

Counselling

Best practice: Clinical staff will provide counselling as necessary at each office visit. The counselling will be trauma informed and based on principles of motivational enhancement and solution-focused therapy.

Rationale: Counselling is critical in early recovery. The goals of counselling are to (a) give patients hope and encouragement, (b) address the guilt and shame that commonly accompany addiction, (c) educate patients on cognitive strategies for coping with cravings, (d) give practical guidance on relationships, housing, and finances, and (e) encourage patients to seek help from community resources such as self-help groups and mental health services.

Management of alcohol use disorder

Best practice: The RAAM physician or NP will offer anti-craving medications such as naltrexone or acamprosate on the first visit when indicated. The physician will manage mild to moderate alcohol withdrawal on site with lorazepam or diazepam when it is safe to do so; patients in more severe alcohol withdrawal will be referred to the emergency department. Patients with comorbid depression or anxiety will be treated concurrently for both conditions.

Rationale: The dominant view in many psychosocial and primary care settings is that alcohol use disorder is entirely a psychological disorder despite strong evidence that anti-craving medications reduce alcohol use and decrease ED visits and hospitalizations. Mild to moderate withdrawal does not necessarily require an ED visit; in many cases it can be managed in the office with a follow up visit at the RAAM within a day or two.

Management of opioid use disorder

Best practice: On the initial visit, the RAAM physician or NP will prescribe buprenorphine/naloxone if indicated, and will give information on take-home naloxone and on overdose prevention strategies. Methadone may be an appropriate alternative to buprenorphine/naloxone for some patients, however this requires that a physician with appropriate training be on staff**.** The care provided will be flexible and patient-centered. The frequency of follow-up visits and urine drug screens will be based on clinical need, and will take into account the patient's resources and work and family responsibilities. Clinical visits will address the patient's use of opioids and other substances, necessary medication adjustments, and their daily mood and functioning.

Rationale: Most patients on methadone or buprenorphine receive care in high-volume methadone clinics. Patients are typically required to attend these clinics 1-2 times per week on average to leave a urine drug screen and get a prescription, even after the patient's medication and dosing is stable. These frequent visits are usually clinically unnecessary after the first few months, and are highly disruptive for patients' lives. Ontario methadone clinics have a very high dropout rate: 50–60% of patients drop out after one year, much higher than in comprehensive clinics. Patients who drop out of methadone treatment are at very high risk of overdose death due to high relapse rates combined with loss of opioid tolerance. By rejecting this approach and providing flexible, patient-centered care, RAAM clinics will have much higher treatment retention rates and lower rates of relapse and overdose death.

Management of concurrent mental disorders and connection with psychosocial programs

Best practice: The RAAM clinic will provide counselling and medical treatment for anxiety, depression, PTSD and drug-induced psychosis. The clinic will refer patients to psychiatry and to community agencies for more intensive, formal treatment when warranted.

Rationale: Many patients use substances in part to cope with symptoms of an underlying psychiatric disorder. These patients are at high risk for relapse if their psychiatric disorder is not treated. Given the time-limited nature of RAAM clinic services, connection to longer-term community services are essential. Community referrals made early on in RAAM treatment allow clinics to provide the patient with immediate support while they are moved up the wait lists of community programs.

Connection with community programs

Best Practice: The RAAM clinic will refer patients to community agencies when appropriate. Beyond psychosocial treatment programs, patients will be referred to social service agencies as required for assistance in managing issues around housing, income support, Children's Aid, legal help, etc.

Rationale: RAAM clinics are intended to be a single component of a broader, integrated care pathway. To ensure the RAAM model is sustainable, patients will be referred to community agencies as required rather than offering all services 'in house.' This way clinics can stay accessible to new, walk-in patients.

Connection with primary care

Best practice: RAAM clinics will transfer patients' care back to their primary care provider when they are stable (ideally within 3-9 months). Patients who do not have a primary care provider will be connected to one through the RAAM clinic. The primary care provider will take over prescribing addiction medications and general management, with the RAAM clinician's ongoing support through phone calls, e-mails, and reassessments as required.

Rationale: There is evidence that addicted patients are more likely to receive screening and chronic disease identification and management in a primary care setting than in a specialized setting. There is also good evidence that patients who receive buprenorphine or anti-craving treatment have as good or better outcomes in a primary care setting than in a specialized setting. Transferring patients to primary care after stabilization also ensures that there is adequate clinic outflow that the walk-in model is sustainable.

Capacity building

Best practice: The RAAM clinic staff will work with local ED and hospitals to (a) establish a simple, clear pathway from the ED, inpatient wards, and other hospital units to the RAAM clinic; (b) train hospital staff in symptom-triggered treatment of alcohol withdrawal, prescribing anti-craving medication for patients with alcohol use disorder, prescribing buprenorphine for patients with opioid use disorder, and dispensing harm reduction materials and advice; (c) add buprenorphine to the hospital formulary, and (d) create and implement pre-printed orders for treatment of alcohol and opioid withdrawal.

Rationale: Evidence suggests that initiating buprenorphine or anti-craving medications in the hospital markedly improves treatment retention and engagement. These medications are safe and effective, and do not require expertise in addiction treatment. Using symptom-triggered withdrawal protocols ensures that patient withdrawal is resolved before leaving the hospital, which eliminates the need to send patients home with high doses of benzodiazepines and, when paired with medication and follow-up, reduces the likelihood that patients will use again upon discharge.