A Guide to Rapid Access Addiction Medicine (RAAM) Clinics

1. What is a RAAM clinic?

RAAM clinics are intended to fill a void in the addiction treatment system by providing patients with immediate access to evidence-based addiction care. Historically, accessing treatment for addictions in Ontario has been challenging, if not impossible, for patients who suffer from the disease. Long and complicated intake procedures, lengthy waiting lists, and costly rehabilitation programs have prevented many people looking to address their substance use disorders from accessing the services they need. Conversely, RAAM clinics are accessible to patients without appointments or medical referrals. They offer both medication and psychosocial interventions from the first visit, ensuring a holistic approach to addressing the patient's substance use. The goal of the RAAM clinic is to meet patients where they are at and work with them to create a care plan that fits with their goals.

2. How do RAAM clinics work?

The RAAM clinic model is very flexible and can be adjusted to suit a variety of contexts. At its essence, the model is intended to be (a) low-barrier, (b) walk-in, and (c) patient-centred.

Low-barrier

Patients with substance use disorders are often struggling with multiple health and social challenges. These challenges can make it very difficult for them to engage in the procedures that are often required to start a treatment program, such as intake interviews, questionnaires, and long waiting lists. Other barriers to addiction treatment include geographical catchment areas, lists of criteria, and prohibitive costs. RAAM clinics are part of the general health care system, and services are covered by OHIP. They are open to anyone who wants help addressing their substance use.

Walk-in

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). In Ontario, specialist appointments require a physician referral and are usually booked weeks or months in advance; if a patient misses their appointment, they must start the process over again. 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. This model eliminates the problem of no-shows, which are frustrating for clinicians and have negative consequences for patients.

Patient-centred

There is no single approach to substance use disorder treatment; different types of care work for different patients. The RAAM clinic model is intended to give each patient a voice in their own care, allowing them to set their own goals and co-develop a treatment plan with the clinician. The role of the clinician is to give the patient a range of options (including pharmacotherapy, harm reduction advice, counselling, and referrals to psychosocial treatments) and help them decide what would work best for them. There is no limit to the duration of patients' engagement with the clinic; treatment lasts until the patient is stable and ready to be transferred back to primary care for long-term management.

3. Who works at a RAAM clinic?

Medical services at RAAM clinics can be provided by several different types of clinicians, including family physicians, psychiatrists, internists, or nurse practitioners. Some clinics are also staffed by case managers, counsellors, and/or nurses, who can provide medical assistance, additional counselling, and links to community services.

4. Where do RAAM clinic patients come from?

The RAAM clinic is intended to be part of an integrated addiction care pathway. Because patients with substance use disorders access treatment in several settings (emergency departments, hospital inpatient wards, withdrawal management, primary care), clinicians in all of these settings should know about the services that the RAAM clinic offers so that they can give interested patients the relevant information (including location and hours). RAAM clinicians should work with care providers in these settings to implement evidence-based interventions for addiction (e.g., screening for problematic alcohol use in primary care, buprenorphine/naloxone treatment of opioid withdrawal in the emergency department).

5. What services does a RAAM clinic provide?

The core responsibilities of a RAAM clinic include the following:

- Diagnose substance use disorders and concurrent mental health disorders
- Initiate pharmacotherapy when indicated
    - Alcohol use disorders: naltrexone, acamprosate, gabapentin, disulfiram
    - Opioid use disorders: buprenorphine/naloxone, methadone
- Provide harm reduction interventions and advice
    - Overdose prevention guidance
    - Take-home naloxone kits
- Provide brief solution-focused counselling
- Provide trauma-informed care
- Make appropriate links to community services for addiction, psychosocial, and social services
- Link patients back to primary care when stable
- Connect patients to primary care providers if unattached
- Educate and support emergency department and hospital clinicians, and primary care providers about addiction treatment
- Provide advice and support to primary care physicians who have referred patients

The following services are outside the scope of a RAAM clinic:

- Management of acute/severe withdrawal
- Management of acute psychiatric illness
- General primary care
- Long-term psychotherapy

6. What does a typical RAAM clinic visit look like?

During their first visit to the RAAM clinic, patients first receive a brief assessment: they are asked about their history of substance use, what brought them to treatment, and what their goals are. The clinician will provide brief psychotherapy and, if indicated, pharmacotherapy: patients with an alcohol use disorder may be prescribed naltrexone, acamprosate, or another anti-craving medication, and patients with an opioid use disorder may be prescribed buprenorphine/naloxone or methadone. The patient can follow up with the RAAM clinic for as long as is necessary to be stabilized on an optimal medication dose, form connections to psychosocial supports, and establish a lifestyle that helps them achieve their treatment goals. At that point, the patient's care is typically transferred back to their primary care provider; patients who do not have a primary care provider are connected to one through the RAAM clinic. The primary care provider takes over prescribing addiction medications and general management, with the RAAM clinician's ongoing support through phone calls, e-mails, and reassessments as required.

7. How do I start a RAAM clinic?

Starting a RAAM clinic requires the following things:

- Support from organizational leadership
- Space (i.e., a private office and a waiting room)
- Office support
- A clinician who is able to spend at least one half-day per week seeing patients on a walk-in basis
- Relationships within the health care system (hospitals, emergency departments, primary care) and with community services (addiction treatment programs, withdrawal management services)

There are several steps to developing a RAAM clinic as part of an integrated addiction care pathway:

(a) Develop a team
    - Engage local leadership (e.g., hospital VP, department chiefs from emergency, psychiatry, acute care, and pharmacy, withdrawal management services director, family health team executive director, etc.)
    - Leverage personal connections with service providers (e.g., emergency physicians and nurses, family physicians, community counsellors)

(b) Develop a plan
    - Decide on local priorities
    - Make logistical decisions (clinic location, hours, staffing, etc.)
    - Set definite timelines and clear stakeholder deliverables
    - Decide on evaluation (how will the success of the project be measured?)

(c) Engage with partners
    - Communicate with representatives of all parts of the care pathway
    - Ask partners for feedback on their challenges

(d) Ongoing evaluation
    - Continuous measuring of processes and outcomes
    - Get patient feedback
    - Collect data from hospital on changes in addiction practices and patient outcomes