Integrating Services for People Who Use Opioids in a Rural Primary Care Setting: The ROOT Program

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ABSTRACT

In response to an emerging substance use crisis in rural Ontario, a Family Health Team initiated the Rural Outpatient Opioid Treatment program. This program includes access to an interdisciplinary team, opioid agonist therapy, counselling, and peer support. Patients report they appreciate the "seamless" integration of medical, social, and peer support.

Keywords: substance use, harm reduction, outpatient treatment, rural primary care, interdisciplinary

RÉSUMÉ

En réponse à une nouvelle crise provoquée par la consommation de substances illicites dans les zones rurales de l'Ontario, une équipe de santé familiale a mis en place un programme de soins ambulatoires contre la dépendance aux opiacés en milieu rural (*Rural Outpatient Opioid Treatment*). Ce programme comprend l'accès à une équipe interdisciplinaire, une thérapie aux agonistes opioïdes, des services de consultation et des activités de soutien par les pairs. Les patients disent apprécier l'intégration « transparente » des services de soutien médical, social et par les pairs.

Mots clés : consommation de substances illicites, réduction des préjudices, traitement ambulatoire, soins primaires en milieu rural, services interdisciplinaires

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In early 2018, the Rural Outpatient Opioid Treatment (ROOT) program emerged from collaboration between a registered nurse system navigator (second author) and a family physician (third author) with an interest in addictions. We envisioned the integration of group recovery work, primary care, harm reduction, peer support, smoking cessation, opioid agonist therapy, screening and treatment for hepatitis C and HIV, and longitudinal follow-up. These services would be coordinated and barrier-free for people who use drugs. We clarified and coordinated existing services and requested a small pocket of additional funding from the South East Local Health Integration Network (LHIN). We developed a monitoring and evaluation plan that included biochemical and self-reported outcomes. To assist in evaluation of the ROOT program, we invited a nurse researcher from Trent University (first author) to join the team.

Bancroft and its surrounding rural communities lie in the county of North Hastings, just south of Algonquin Park and equidistant between Toronto and Ottawa. While this area was once known for its mining and lumber industries, a shift toward a tourism economy means many residents have difficulty finding year-round, full-time employment. With a low-income rate of 25% and one-third of children living in poverty (Statistics Canada, 2017), the social determinants of health such as housing, food security, social inclusion, and transportation are often lacking. When combined with trauma and mental illness, this social and economic context frequently lies at the root of substance use disorder (Morin, Eibl, Franklyn, & Marsh, 2017). While the larger population of Hastings and Prince Edward counties has higher rates of emergency department visits, hospitalizations, and deaths from substance use compared to the Ontario average (Bergeron, Cheyne, Schultz, & Vance, 2019), local data regarding the prevalence of substance use is limited. However, service providers and community members of North Hastings have observed an increase in discarded needles in public parks, drug seizures by police, and patients seeking opioid replacement therapy, indicating a substance use crisis has emerged in recent years.

Rural geography can exacerbate the social and economic challenges that contribute to substance use. Treatment for substance use disorders is often difficult to access in rural regions with limited infrastructure, transportation challenges, and a shortage of qualified staff; at the same time, rural residents may be unaware of the services that exist or are afraid to access these services due to lack of anonymity in small towns that can lead to being labelled a "user" (Thomas, van de Ven, & Mulrooney, 2019). It has been recommended that substance use disorders be managed in primary care due to their chronic nature and limited availability of specialty services, particularly in rural areas (Runyan, Hewitt, Martin, & Mullin, 2017). Yet there is a significant gap in the literature regarding how to manage substance use disorders in primary care settings of rural communities.

To support people who wanted to make changes to their substance use while acknowledging this unique social, economic, and geographic context, the Bancroft Community Family Health Team (BCFHT) created the ROOT program. The goals of the ROOT program are to reduce non-prescribed opioid use, reduce the harms associated with drug use, and improve the quality of life for people who use drugs. The program provides wrap-around treatment programming, including medical supports, one-to-one clinical support, group counselling, and peer-based programming. At the outset, all participants meet with a primary care physician to assess for medical issues, including infectious disease screening, need for opioid agonist therapy, and other medical conditions that may be affecting their substance use. Participants are invited to become

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permanent patients of the physician and can access all services provided by the BCFHT. Intake interviews are also conducted by peers who have lived experience with substance use.

When five to seven participants are enrolled, the program begins with 12 weeks of intensive programming followed by nine months of monthly aftercare. On a typical intensive programming week, participants meet twice in a clinician-led group setting: Mondays are a Structured Relapse Prevention Program and Wednesdays are a Mindfulness-Based Relapse Prevention Program. On Tuesdays, a peer-led group is offered and on the other days, participants may meet with their physician and/or opioid agonist therapy prescriber, nurse, or addictions counsellor. There are often additional phone calls throughout the week to check in with participants, as well as occasional fitness sessions. Participants provide weekly urine drug screens (UDS), participate in monthly questionnaires, and complete the standardized research instruments every six months. Services are not all housed in the same building; however, the BCFHT office has been the clear focal point for participants.

One unique aspect of the ROOT program is its interdisciplinary nature. Over the three program cycles that have run to date, the BCFHT has collaborated with four other community organizations, including addiction and mental health services, a local violence-against-women prevention organization, an anti-poverty organization, and a peer support program. Having several providers and organizations allows for multiple entry-points for clients, shares the burden of care among service providers, and acknowledges that the complexity of substance use and its treatment means participants benefit from the diverse expertise of many disciplines. In-kind funding from all partner organizations also increases the program's feasibility. In addition, the program uses a harm reduction, rather than abstinence-based, approach; participants must want to make a change in their substance use, but abstinence does not need to be that goal. Many participants in the ROOT program are poly-substance users, and the program is open to people who want to make changes in *any* of their substances. With weekly UDS, we were clear with participants that there are no results that would lead to consequences or affect their ability to participate in the program. Harm reduction supplies such as safe use materials and naloxone kits are accessible all over town at the pharmacies, partner organizations, hospital, public health, and the BCFHT. In order to further reduce barriers to participation, coordination of the local non-profit community transportation system to get to ROOT groups and appointments are provided by the system navigator, participants are given a $5 gift card for attendance at each session, and peer support workers engage in outreach activities to help participants with ongoing attendance. Participants are also provided with support to attend to their affairs, including health card and ID renewal, Ontario Disability Support Program (ODSP) submissions, appointments with child services workers, and lawyers.

Within three separate sessions that have run to date, 14 participants have completed or are engaged in aftercare in the ROOT program. We are evaluating the ROOT program by analyzing trends in UDS, addiction severity, quality of life, and other qualitative and quantitative metrics. Preliminary findings show that opioid use has decreased while use of methamphetamines has increased over time. This increase is concurrent with our observation of an increase in the use of methamphetamine within our geographic area, and further research is needed to better understand its causes and what supports may be needed. Qualitative interviews and focus groups have shed light on the participant experience, including an appreciation of the "seamless" nature of the program, the access to a physician that program participation brings, integration of peers who

understand what they are going through, and the social support system gained through group participation. A more detailed analysis will be published in a second paper.

In the future, we plan to continue the ROOT program with a number of intake points throughout the year and programming that participants can access on a more open basis. We have identified that there is a cohort of potential participants who are interested in a treatment program like ROOT but do not have the stability in their lives to attend regular programming. Expansion to provide mobile services, as well as access to employment, education, or housing supports may better serve our clients. Finally, peer involvement has been a core component of the ROOT program and we hope to expand by bringing prior participants into peer roles.

The ROOT model emphasizes community-based interdisciplinary care, harm reduction, and peer support for people who are interested in making changes to their substance use. This collaboration among multiple organizations demonstrates how a rural community can make a difference in the lives of people using substances in a collaborative, cost-effective manner.

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