



Residential Recovery Services in Massachusetts
Voices from the Field

Commonwealth of Massachusetts
Department of Public Health
Bureau of Substance Abuse Services (BSAS)

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Presenter Disclosures

Jane Moore

The following personal financial relationships with commercial interests relevant to this presentation existed during the past 12 months:

No relationships to disclose.

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BACKGROUND

DPH/BSAS Supports Residential Recovery Services in MA:

- Annual BSAS Expenditure:** \$32,825,191
- Number of Contracts:** 67; 2022 beds
- FY2013 Admission:** 6,753
- Last procurement:** 2003
- 2008:** MGL Chapter 257 requires provider and consumer input for all new procurements

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BSAS **BACKGROUND**

BSAS determined to conduct a transparent process with opportunities for input from providers, consumers and stakeholders:

- 11 focus groups
- Reported back to focus group participants with opportunity to comment on findings
- Developed Model for Residential Recovery Services integrating BSAS-defined elements and focus group findings
- Sought input on Model via Commonwealth procurement website

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BSAS **BSAS DEFINED PRINCIPLES & BASIC ELEMENTS**

- Recovery happens in a social context, i.e. in relationships and in a community. THEREFORE, a residential program should provide:**
 - A safe environment with a physical layout that facilitates interaction of residents, including:
 - Morning meetings at least 5 times a week;
 - One communal meal each day;
 - One house meeting each week;
 - 24/7 awake staff, one per building.

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BSAS **BSAS DEFINED PRINCIPLES & BASIC ELEMENTS**

- Development of life skills is critical to successful recovery. THEREFORE, a residential program should provide:**
 - Attention to teaching self care;
 - Daily schedule;
 - Wellness Groups;
 - Recovery Counseling and Coaching;
 - Process for teaching and facilitating conflict resolution skills;
 - Defined process for accommodating different resident abilities;
 - Mechanism for ensuring aftercare and transition plans are in place before a resident leaves;
 - Recovery support group, at least once each week.

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BSAS **BSAS DEFINED PRINCIPLES & BASIC ELEMENTS**

A residential program should model best practices and quality improvement. THEREFORE, programs should:

- Maintain mechanisms for quality improvement;
- Maintain mechanisms for consumer input and feedback to consumers;
- Ensure staff receive supervision from individuals with demonstrated competence in the twelve core functions of addictions counseling;
- Maintain active, integrated links with health care, mental health and other services.

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BSAS **FOCUS GROUPS**

Groups: 11 Groups

- Three groups with providers
- One group with criminal justice partners
- One group with family members and partners of current or former residents
- One group with the BSAS Consumer Advisory Board
- One group with BSAS Licensing Inspectors
- Four groups with current and former residents

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BSAS **FOCUS GROUPS**

All groups were recorded and all recordings transcribed.

- In Provider and Criminal Justice groups, speakers were identified.
- In family-partner and consumer groups, numbers were used instead of names

Transcriptions were analyzed to identify topics and themes.



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 **FOCUS GROUP FINDINGS** 

In the current system, who is served well?

- 1. People who are motivated** (9 groups)
- 2. Homeless Individuals** (6 groups)
- 2. Those served in specialized programs, e.g. young adults, women with kids, linguistic/ethnic groups** (6 groups)
- 3. Individuals involved in the criminal justice system** (5 groups)



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 **FOCUS GROUP FINDINGS** 

Who could we serve better?

- 1. Persons with co-occurring disorders** (whether or not they are on medication) (9 groups)
- 2. Persons on any kind of medication, especially if not stabilized** (8 groups)
- 2. Young Adults** (8 groups)
- 2. Persons specifically on methadone or suboxone** (8 groups)
- 3. Gay Men & Transgender Individuals** (7 groups)



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 **FOCUS GROUP FINDINGS** 

How does the system account for the different needs of different consumers, and how could it do better?

- 1. Thorough, individual assessment** (8 groups)
- 2. Skilled and available staff** (7 groups)
- 2. Goals and plan developed by resident** (7 groups)
- 3. Flexibility re: length of stay** (6 groups)



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 **FOCUS GROUP FINDINGS** 

How can admissions and discharge criteria and processes be designed to balance fairness and equal access with needs of program milieu?

1. **'Applicant' should have thorough information about the program before intake/admission** (8 groups)
2. **Specialized programs improve fairness** (5 groups)
3. **Providers should have a well established network/continuum of care linkages** (5 groups)



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 **FOCUS GROUP FINDINGS** 

In addition to competencies for clinical supervisors, what skill sets and competencies are needed? Should specific credentials be required?

1. **Credentialed supervisor should be part of Model** (8 groups)
2. **Professional development should be in place for all staff** (7 Groups)
3. **Staff should include some people in recovery but professional development and supervision are critical** (4 groups)

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 **FOCUS GROUP FINDINGS** 

Cross Question Theme:

Case Management: (9 groups)

- Supports serving everyone well, especially considering the multiple needs many consumers have
- Plays a role in improving services by speeding referrals
- Improves ability to meet different needs of different consumers
- Consumers should expect assistance in referrals for services, and case managers help to do this
- Improves coordination
- Improves building of links and networks

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BSAS **FOCUS GROUP FINDINGS**

All participants in focus groups were invited to an afternoon forum where findings were presented and discussed. Participants agreed that findings represented their input and experience.

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BSAS **FOCUS GROUP OUTCOME**

Residential Recovery Services Model Specified:

- Individualized assessment
- Provisions regarding medication
- Aftercare Planning
- Case management
- Clinical supervision by a Master's level clinician
- Professional development plan for all staff
- Descriptive information for applicants

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BSAS **REQUEST FOR INPUT**

BSAS posted the Model on Web, soliciting additional feedback through an RFI:



Comments Received:

- Requested differentiation by 'model' (e.g. therapeutic community, social model, recovery home) **and by population** (e.g. co-occurring disorders)
- Clarify staffing ratio
- Overall feedback:

-The model is quite comprehensive and the focus on serving individuals with co-occurring issues and providing trauma informed care is critical.

-I feel it is fine just the way it is.



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 **REQUEST FOR INPUT** 

BSAS Response:

- Declined to differentiate 'Models' since these are treatment philosophies to which the BSAS Model was equally applicable;
- Incorporated proportional staffing ratios;
- Provided detailed report of RFI comments and BSAS response.

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 **OUTCOME** 

- The Final Model incorporated the thoughts, suggestions and experience of consumers, their families and partners, and service providers, through multiple 'feedback loops'.
- Final Model submitted to Massachusetts Center for Healthcare Information and Analysis. The Model, regulatory requirements and provider Uniform Financial Reports are the basis for determination of rate.

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