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.

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
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

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.

- 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.
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.

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

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.
### FOCUS GROUP FINDINGS

#### In the current system, who is served well?

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

#### 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)
3. Young Adults (8 groups)
4. Persons specifically on methadone or suboxone (8 groups)
5. Gay Men & Transgender Individuals (7 groups)

#### 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)
3. Goals and plan developed by resident (7 groups)
4. Flexibility re: length of stay (6 groups)
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)

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)

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
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.

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

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.
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.

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.