On July 28, 2016, a focus group was held with consumers and family members at the Hope for Holyoke Recovery Center in Holyoke, MA. There were 17 participants – 11 consumers and 3 family members. 4 attendees had a history of overdose. Questions were posed in both English and Spanish given linguistic preferences of attendees. The discussion lasted 2 ½ hours. Key discussion themes were:

* Wraparound services should be centralized and easily accessible for people pursuing recovery. It becomes very difficult to secure housing, employment, education, and more when one has to go to various offices and agencies to apply for assistance.
* Recovery coaches can be helpful at various stages of the process – when someone is trying to get into treatment, immediately after detoxification in order to connect to the next step, and to provide support throughout recovery thereafter.
* Inadequate aftercare after detoxification often leads to relapse. Participants have experienced long waits for outpatient treatment, have been unable to get to treatment due to lack of transportation, and at times have not been connected to further treatment.
* A phone call from a recovery coach after detoxification would mitigate the risk of relapse and help clients connect to the next step in treatment
* Treatment capacity in Western Massachusetts is a barrier – it is difficult to get a bed through the Helpline after 10am, and it is difficult to start methadone due to waiting lists.

On July 28, 2016, a focus group was held with consumers at the Gandara Addiction Recovery Program in Springfield, MA. There were 13 participants – all male consumers. 4 attendees had a history of overdose. Questions were posed in both English and Spanish given linguistic preferences of attendees. The discussion lasted 1 ½ hours. Key discussion themes were:

* Nonsmoking rules at addiction treatment centers are challenging for some clients and sometimes cause people to be discharged from facilities for violating such rules.
* Immediate connection to treatment after detoxification is critical; those with smooth transitions tended to do better in their recovery.
* Methadone withdrawal after detoxification can increase risk of relapse. It would be helpful to start medication-assisted treatment in detox or be connected to other treatment centers immediately to reduce risk of relapse while withdrawing from methadone or other medications.
* Medication-assisted treatment is difficult to access and stigmatized at some treatment centers. It would be easier and less stigmatizing if MAT were offered on-site at treatment centers, rather than needing to go elsewhere.
* Overdoses are more likely after a period of sobriety, especially after treatment or incarceration. Several participants were released from jail or prison without a connection to treatment and experienced overdose shortly thereafter.

On August 1, 2016, a focus group was held with family members of individuals with substance use disorders at a meeting of the Cambridge chapter of Learn to Cope. There were 23 participants – all family members of individuals with substance use disorders. The discussion lasted one hour. Key discussion themes were:

* Stigma in emergency rooms (ERs) is highly prevalent and requires intervention with all members of emergency room staff, not just clinicians. Individuals in recovery and their family members may be best suited to conduct trainings.
* Many people go to ERs as their entry point into treatment. As such, ERs should be equipped with addiction specialists who can provide stigma-free care, support the clinical team, and help patients connect to treatment.
* Additionally, other entry points to treatment, such as primary care offices and BSAS resources, should be available and equipped with sufficient support to help someone reach the appropriate level of care.
* Few participants were familiar with mabhaccess.com and the BSAS helpline, though almost all said such a resource would be helpful for them.
* Different pathways to recovery work for different people, so it is important to offer a variety of treatment options, including making medication-assisted treatment available while still providing quality care to those who decline it

On August 11, 2016, a focus group was held with pregnant and postpartum women with substance use disorders at Gandara Recovery Services for Women. There were 12 participants

– all women with substance use disorders. The discussion lasted one hour. Key discussion themes were:

* Access to care is a major barrier. In particular, there are few treatment beds for women with young children, and policies regarding eligibility make it difficult to navigate the system.
* More supportive transportation options are needed to help women reach appointments.
* Long waiting lists for public housing make it difficult to transition from a residential program into stable community housing, and unstable housing leads to difficulty retaining custody of one’s children.
* Limited case management resources for women in correctional facilities is a barrier to connecting to treatment upon release.
* Women often face significant stigma from Labor and Delivery care providers, though providers with more education and experience treating SUDs are often less stigmatizing.
* The postpartum period can carry high risk for relapse; recovery coaches may help navigate this challenging time.

On August 11, 2016, a focus group was held with family members of individuals with substance use disorders representing the three Western Massachusetts chapters of Learn to Cope. There were 14 participants – all family members of individuals with substance use disorders. The discussion lasted one hour. Key discussion themes were:

* Some detoxes do not accept new patients on weekends due to inability to verify insurance; this poses a barrier to care for people who need urgent treatment.
* It would be helpful to have a guide to navigating the treatment system for those who have a family member newly diagnosed with an SUD
* Long waiting lists inhibit continuity of care in Western Massachusetts – it can be difficult to get into an intensive outpatient program or methadone maintenance program directly after detoxification.
* Published information on facility quality, including staff qualifications, case load, programming, and rates of program completion would guide families in choosing a treatment facility for their loved one.
* Stigma around MAT has significant consequences – participants related stories of family members who lost jobs after testing positive for methadone or buprenorphine on a drug screen, and one who was fired after being seen by her employer waiting in line for methadone dosing.

Additional comments were submitted by family members who could not attend this focus group in person. Their comments included:

* One client who was at a treatment facility but was not given her prescription medications until her primary care physician called the facility directly.
* Inadequate education of providers, leading to a pregnant women being administered buprenorphine/naloxone instead of buprenorphine by a nurse at an ATS facility
* Strict policies that interrupt continuity of care, such as one client who moved from Philadelphia to Massachusetts but would not be administered methadone at a Massachusetts clinic because she arrived one day later than the clinic expected her.
* Additionally, a pregnant woman and her partner were discharged from a CSS facility for failing to identify themselves as a couple.
* Homelessness can serve as an obstacle for treatment, such as a homeless client who was precluded from being admitted to an ATS facility because they would have no address to discharge him to.
* Some facilities reportedly do not permit clients to have naloxone.
* Lifelong bans from private MAT providers for diverting buprenorphine are perceived as stigmatizing and impeding access to treatment for clients who later wish to make another

attempt at recovery. 6

On August 11, 2016, a focus group was held with adolescents at the Young Adult Resource Network in Dorchester. There were 15 participants, ages 12 to 26. The discussion lasted 1 hour. Key discussion themes were:

* Participants identified long waitlists, scheduling during school hours and no provider continuity as a barrier to care. A more clear treatment enrollment process would aid patient adherence.
* Diversity in age, life experience, culture and ethnicity were discussed as factors that help participants feel at ease and develop trust with therapists.
* A lack of clarity in treatment expectations was identified as a barrier to patient’s continuity of care.
* Stigma was a significant barrier to care, particularly coming from treatment providers.

Participants felt this as a lack of respect which discouraged them from treatment.

* Participants identified that extra supports in the form of family involvement and engagement through music and sports would increase motivation to participate in treatment.

On August 11, 2016, a focus group was held with consumers at The Boston Public Health Commission’s PAATHS (Providing Access to Addictions Treatment, Hope, and Support) program. There were 8 participants of which we observed 2 Females and 6 Males with a total of 7 participants of color and 1 white participant. All attendees shared a history of substance use. Questions were posed in English, however, resources were on hand for translation in the even of a Spanish linguistic preferences. Key discussion themes were:

* **Creating a welcoming and stigma free environment needs to include opportunities that promote freedom of dialogue without fear of judgement, access to staff with both academic and lived experience, a framework rooted in empathy, meeting people at respective stages of recovery, services specific to dual-diagnosed individuals, and increased opportunities for community engagement.**
* **Specific to treatments received during periods right before or during incarceration, clients shared having access to recovery support opportunities only if the individual was motivated and committed to utilizing available resources, such as access to Narcan training.**
* **Regarding policies related to residential discharge, there was unanimous feedback that peers typically experience a downward spiral in their recovery process as a result.**
* **Mixed experiences relevant to primary care identified some consumers with inconsistent care due to stigma related to pain management and limited addiction related knowledge.**
* **With regard to Medicated Assisted Treatment, consumers carry personal biases depending on individual experiences that stressed the importance of proper dosing and monitoring, utilizing effective methods of screening candidates, and ensuring providers are strongly educated on the recovery tool.**

# Focus Group 8: Consumers, BHCHP

On August 11, 2016, a focus group was held with patients at The Barbara McInnis House at the Boston Healthcare for the Homeless Program. There were 5 participants of which we observed 2 Females and 3 Males with a total of 1 participant of color and 4 white participants. All attendees shared a history of substance use. Questions were posed in English, however, resources were on hand for translation in the even of a Spanish linguistic preferences. Key discussion themes were:

* **Multiply diagnosed consumers continue to face layered and complex barriers across the healthcare system that further exacerbate the severity of their conditions. Specific to detox, accessing facilities that will accept such individuals is extremely limited, especially for those with complicated medication regimens, anticoagulation needs, insurance barriers, and even for people who must break sobriety in order to enter programs. Consumers emphasized that while in detox, needs related to other diagnoses were not acknowledged.**
* **Related to transitioning into extended treatment programs, the desire is there, however, medical complications and needs greatly reduce rates of admission. Many consumers credited the Barbara McInnis house for opening their doors to them for receipt of care. Note, with regard to adhering to program rules, consumers did not take issue.**
* **If housing was stable, consumers shared their willingness to engage with outpatient programs that were accessible.**
* **Consumers shared common experiences of being turned away from primary care due to stigma related to drug seeking behavior, co-occurring conditions that overwhelm providers, and having to work through myths and stigma related to Medicated Assisted Treatment, including one that did not recognize sobriety while on such a treatment**
* **When asked to identify ideal methods of treatment, consumers highlighted the need for cocaine related treatment, increased medical interventions, alignment between law and health related to substance use, stronger support for sober living people who are disabled, increased funding for those committed to sober living.**

**Focus Group 9: Meeting with Providers Regarding Mental Health Integration**

On August 11, 2016, the Commission held a working meeting with stakeholders about regulatory reforms to promote integration of mental health and substance use disorder treatment. There were 25 attendees, representing EOHHS, MassHealth, DPH, DMH, the Association for Behavioral Healthcare, families of individuals with substance use disorders, and 8 treatment centers across the Commonwealth. Key discussion themes were:

* + Mental health outreach services, as outlined in 105 CMR 140.560, are a valuable tool for addiction treatment facilities to provide on-site mental health services, and MassHealth is working to clarify and address barriers to delivering and billing for such services.
	+ Lengthy and redundant credentialing processes delay onboarding and affect access to care. Delegating credentialing to providers can streamline this process.
	+ Patient transportation is a barrier to care in both rural and urban communities. Providers have struggled to obtain PT-1 authorization for some patients in need of transportation.
	+ Reimbursement rates are the biggest disincentive for dual diagnosis treatment in the inpatient and outpatient settings, though increased collaboration between DMH and BSAS on licensing dual diagnosis facilities may be helpful. Rates for a new level of care – residential dual diagnosis treatment – could build capacity.
	+ Further education of consumers and providers is necessary to reduce stigma around MAT and improve medical and mental health treatment for patients on MAT.