A Survey of the Addiction Treatment and Recovery Communities on "An Act Relative to Combating Addiction, Accessing Treatment, Reducing Prescriptions, and Enhancing Prevention"

Abstract

The Massachusetts Organization for Addiction Recovery **(MOAR)** conducted a survey of its membership to gain insight into public opinions regarding measures proposed in the Governor Baker's Legislative proposal "An Act Relative to Combating Addiction, Accessing Treatment, Reducing Prescriptions, and Enhancing Prevention" or CARE Act. With over 100 respondents representing the MA Recovery Community and treatment providers, the survey shows strong support for most measures proposed in this legislation. The vast majority of respondents' support measures to better regulate providers and insurance companies. More controversial topics include involuntary commitment and credentialing of Recovery Coaches. Detailed quantitative results are presented together with extensive and insightful comments provided by respondents with lived experience with the opioid epidemic.

About MOAR

MOAR's mission is to organize recovering individuals, families, and friends into a collective voice to educate the public about the value of recovery from alcohol and other addictions. Since 1991, MOAR has worked to advocate to improve addiction prevention, treatment, and recovery support services across the state. Today, **MOAR's** over 2,500 members represent a diverse cross section of the Massachusetts addiction recovery community as well as treatment providers, civic leaders, activists, and concerned individuals. **MOAR** envisions a society where addiction is treated as a significant public health issue and recovery is recognized as valuable to all our communities. Throughout the year, **MOAR** conducts regional meetings and statewide events to educate the public and involve our members in policymaker education.

Methodology

This survey was written by **MOAR** staff based on the information and legislative summaries made available by the Baker administration. Each of 4 major focus areas of the CARE Act were parsed into statements that respondents were asked to rate on a 5-point scale from strongly disagree to strongly agree. Respondents were also invited to provide comments on each section and demographic information.

The Survey was distributed to more than 1,800 members in **MOAR's** December electronic newsletter and as an independent email reminder. The survey was shared on **MOAR's** Social media pages on Facebook and Twitter. Responses were accepted between December 22nd 2017 and January 11th 2018. Of the 144 people who started the survey an average of 115 respondents completed most policy questions.

Please note that results do not represent the opinions of the general public. Rather, the authors sought to gain insight from the opinions of people with lived-experience in addiction and recovery as well as people working directly in the fields of addiction prevention, treatment, and peer recovery support services. As expected, most respondents were members or **MOAR** or unsure about their membership status (77%). This means that most respondents had previously shown interest in **MOAR's** mission by attending an event, signing up by mail or online, or following the organization on

social media. Of respondents, over half described themselves as people in recovery and/or friends or family of people in recovery. Other represented groups included addiction counselors (25%), recovery coaches (26%), and community activists (31%). These data fit with MOAR's expected constituency. Detailed demographics are presented in the attached Supplemental Data 1.

Please select all that best describe you

Answer	0% — 100%	Number of Response(s)	Response Ratio
Person in Recovery		56	56.0 %
Family or Friend to Recovery		50	50.0 %
Program Director		17	17.0 %
Addiction Counselor		25	25.0 %
Youth Leader		2	2.0 %
Student		4	4.0 %
Health Educator		13	13.0 %
Prevention specialist		13	13.0 %
Outreach Worker		15	15.0 %
Recovery Coach		26	26.0 %
Policymaker		5	5.0 %
Community Activist		31	31.0 %
Medical Professional		8	8.0 %
Lawyer		0	0.0 %
Mental health provider		11	11.0 %
Law enforcement		3	3.0 %
Other		18	18.0 %
	Totals	100	100%

Table 1. Constituency of respondents. Individuals were asked to select the all options to best describe themselves.

The comprehensive results presented herein were minimally curated for formatting. The opinions expressed do not necessarily represent the opinions or **MOAR**, any **MOAR** staff or **MOAR** board members.

Results

Section 1: Access to treatment

Table 2. Respondents were asked to give their reaction to three questions regarding potential measures to expand

1. Access to Treatment. One goal of the CARE Act is to expand access to and the quality of addiction treatment in our state. Please give us your opinions on these possible provisions. Please provide comments below.					
Top number is the count of respondents selecting the option. Bottom % is percent of the total respondents selecting the option.	**Strongly Disagree**	**Disagree**	**Neutral/No Opinion**	**Agree**	**Strongly Agree**
The Department of Public Health and Mental Health should be able to require new providers to treat individuals with co-occurring mental health and substance use disorders.	10 9%	2 2%	9 8%	29 25%	67 57%
Addiction treatment facilities should be required to follow effective evidence-based best practices designed by a state committee.	12 10%	12 10%	13 11%	29 25%	50 43%
Addiction treatment programs should be required to accept people regardless of whether they have private (employer provided) or public (MassHealth) insurance.	11 9%	6 5%	4 3%	9 8%	87 74%

access to addiction treatment in Massachusetts

Comments on “Access to Treatment” Section
Comment on question 2: Practices should be required that show that there is change in a positive direction. It should not be limited to specific practices.
I agree the providers should use evidence based or emerging practices but not be state mandated
Not totally confident with the "state committee" part of item 2. Maybe a state committee led by MOAR staff?
Peers meeting with persons with substance problems and doing motivational interviews, befriending the person... ie going out for a meal taking them to appropriate and good AA or NA meetings is a hopeful and successful way to help people begin considering recovery.
I don't think treatment facilities should be required to use certain practices as determined by a state committee. Treatment organizations should be allowed to innovate and try new methods, and to respond to the needs of their clients without state oversight. Basic standards of care are very important to be monitored by an outside agency, but no one should be dictating what all facilities have to use for practices because that really kills innovation and timely responses to changes in needs.
Greater collaboration between Recovery Coaches, Certified Peer Specialist, Family Support Specialists and Community Health Workers would create a grassroots, from the streets approach that would be anchored by lived experience of recovery and the knowledge to provide multiple pathways to recovery for individuals with co-occurring challenges. The intentional and ontological nature of peer support is a powerful and effective complement to medical-clinical treatment.
I agree that facilities should have regulated EBP, and that DPH/DMH funded programs should be designed in such a way that there is equal quality at each facility. But with that being said, let's remember that there is not one size fits all treatment and not all providers will be adept and talented at all practices. Additionally, 12 steps are not technically evidenced in many cases. Private facilities should be able to decide to not take public insurance, because sometimes it impacts the quality
I am not confident that a "state committee" would come up with "best practices" keep up with the latest research. Too often, state committees get bogged down with what is politically expedient and not necessarily what's best for the individual.
My concern about requiring treatment facilities to follow evidence based best practice is that best practice is often community and culturally based. It would be impossible for a state committee to have that level of knowledge and insight. In fact, this type of requirement might make treatment less effective. State supported treatment facilities should be required to provide family access and support including reasonable phone rates. The "prison phone system" is in use in many places
Evidenced based practices designed by state committee, sounds troublesome to me
Instead of requiring every program to be able to treat co-occurring disorders, programs should havethe option of entering required agreements with other providers and, if they chose that option, should be strictly monitored to make sure it is used for every person who shows up on their door. Evidence based is just another scheme for academics, and researchers to scratch each other's back to get grants and tenure.
These 3 Questions seem to place all the responsibility, for everything, on an already few and scarcely funded treatment facilities and truly qualified available professionals .Unfortunately I don't have enough space allotted here to write my answers. I would like to rate the stakeholders in charge of licensing and regulating the facilities and professional providers in all these questions. Not to rate the ones that are already doing the work with very little support and inappropriate funding.
There should be adequate providers that take all sorts of insurance, public or provide, insurance type should not be mandated.
In terms of the above statement: "Addiction treatment facilities should be required to follow effective evidence-based best practices designed by a state committee." This may limit some successful treatment facilities. I think a requirement might be best if based on poor outcomes from a facility rather than making all facilities be required to follow "best practices" designed by a state committee. Some facilities may use alternative health methods that the committee may not recommend but are use
Before one can insist that new providers are treating co-occurring disorders, graduate programs must be educating ad training them on how to do it.
When effective youth prevention programs are mentioned there are no specifics especially in the educational realm.
Transportation is needed for individuals seeking detox and continue after career treatment
Massachusetts should also have legislation that promotes life-saving measures, such as New York has had for several years, by which anyone seeking treatment for an opioid overdose nor anyone who call for help/911/goes to ER can be prosecuted. My son overdosed in our home. When my husband called and the paramedics arrived to administer narcan and bring him to the hospital, the police also arrived only to seek evidence/charge him with a crime.
Not sure if DPH / DMH can be given this authority and by whom. .

Comments on "Access to Treatment" Section
Addiction treatment and recovery support should be extended to anyone who seeks it. Although a client-centered approach and "Multiple Pathways To Recovery" is making some headway, so many suffering people continue to be alienated from support simply because they are not compatible with a 12 step program/philosophy. In theory, we have evolved beyond a one size fits all approach. In practice however, we are failing a large portion of the addicted population by trying to squeeze them into it.
They should also mandate that programs like those at MGH cannot bar someone seeking recovery from alcohol or opioid addiction from participating in their programs because they have a state issued medical cannabis card. MGH has done this at least once to at least one person seeking an outpatient alcohol treatment program.
In thinking that these practices include people who are successfully over a few years to maintain sobriety from substances. Nobody better than reviving addicts back from the gates of hell to chime in on effective treatment.
Tricky questions. Why should only new providers be required to treat co-occurring mental disorders? If you change the question removing the word new, I's say strongly agree. What State Committee? Made up of who? I think facilities should be accountable and be audited carefully, but if they have different methods that are effective they should use whatever works. As long as it does work.
My concern with Best Practice is there is none at the state level. A NEW model needs to he implemented unless and until the State is WILLING to accept something outside their predetermined box we will continue to be stuck. Places like Teen Challenge would be good even if you need to remove the religious teaching and replace it with a 12 step method would be what is needed. No more 5 days if you lucky
I question whether the State Committee should have the power to decide what practices are acceptable. If the committee was a group of recovery community representatives I'd be far more agreeable. Politicians deciding what's right and wrong concerns me. Programs that don't take tax payer money should not be mandated. Government should not be able to force a program to accept state insurance.
No one seeking treatment should ever be denied under any circumstance
There must be a payor mix but all should be required to take Mass Health
Addiction treatment facilities should be required to follow effective evidence-based best practices designed by a state committee. Although I agree with this...."What happens is so much money is spent on developing the practices that it doesn't increase capacity for treatment on demand."
Thank you for your dedication and hard work.
Yes on the use of evidence based practices but leave room for a variety of programs and approaches. A politically appointed state committee doesn't guarantee quality and would only stifle innovation.
One rigid treatment system designed by a state committee is a frightening prospect. People are individuals with unique histories and needs. While guidelines may be very useful for treatment programs, a rigid set of requirements, designed by committee, will not meet those individual needs.
I am challenged by this especially if they are not providing requirements to the funders to support the appropriate reimbursement rate
We really can't separate addiction recovery treatment and mental health any longer. This has been outdated for at least 20 years
So painfully evident that insurance is still a barrier when it comes to treatment.
Health insurance companies should be required to cover all aspects of outpatient medication-assisted treatment - therapy, urine screens, office visits, prescriptions. I was a state employee with health insurance through the GIC, and my insurance company would not pay a cent toward my required urine screens - which were initially weekly - despite the fact that the member handbook specifically stated that urine screens associated with drug treatment would be covered. This is a big issue for many.

Table 3. Respondents were asked comment on any of the statements in the "Access to treatment section"

Discussion on "Access to Treatment" Section

While there was overall support for the measures proposed in the CARE Act, opinions were more split on the statement "Addiction treatment facilities should be required to follow effective evidence-based best practices designed by a state committee." The authors are aware that the proposed legislation seeks only to study the possibility of taking this action. Many comments expressed concern about new regulations or best practices overly limiting treatment providers and stifling innovation. In addition, it should be noted that individuals also expressed concern that about the make-up of any committee that is given the task developing best practices.

The statement “Addiction treatment programs should be required to accept people regardless of whether they have private (employer provided) or public (MassHealth) insurance” was overwhelmingly supported. Many people express frustration that an individual’s insurance coverage can often dictate their access to care.

Section 2: Involuntary Commitment

2. Involuntary Commitment: The following statements reflect possible provisions of the upcoming CARE Act legislation that are written with the goal to improve involuntary commitment to treatment (section 35). Under current law a spouse, immediate family member, doctor, or law-enforcement officer can petition the court to hold someone in treatment if they can demonstrate that the person is a danger to themselves or others. Please provide your opinion on the statements and any comments related comments below.					
Top number is the count of respondents selecting the option. Bottom % is percent of the total respondents selecting the option.	**Strongly Disagree**	**Disagree**	**Neutral/No Opinion**	**Agree**	**Strongly Agree**
ED Clinical staff should be able to assess a patient and authorize involuntary transport to a treatment facility.	18 16%	7 6%	13 11%	28 25%	48 42%
Once admitted, clinicians within 72 hours should engage the person to seek voluntary treatment.	9 8%	4 4%	8 7%	30 26%	63 55%
If after 72 hours, the person still meets Section 35 criteria, the clinician must make the petition.	10 9%	6 5%	15 13%	34 30%	49 43%
Other medical/clinical professionals should be allowed to file for involuntarily commitment under section 35.	15 13%	8 7%	15 13%	28 25%	48 42%
An Advisory group should be set up to establish Section 35 evaluation criteria and guidance for medical/clinical staff.	9 8%	1 1%	11 10%	34 30%	58 51%

Table 4. Respondents were asked to give their reaction to five statements regarding involuntary commitment policies

Comments on “Involuntary Commitment” Section
LICSW can section 12 an individual if they are a danger to themselves or others. They should have the authority to sign a section 35 petition
End involuntary commitment for people who use drugs! It's unethical, unjust and unhealthy! MOAR should not be supporting section 35 at all
Who is deemed medical/clinical professional Who would make up the advisory group
Coerced treatment will increase stigma and people who use drugs even more wary of healthcare providers.
The "strongly agree" responses are dependent on adequate physician training in recognizing and treating addiction and be required to take some kind of sensitivity training related to this.
We have a responsibility to help each other sometimes this requires involuntary treatment and action.
What is presented in the course of a single ED visit is not substantial enough information to base an involuntary commitment on. Not all medical personnel are trained properly to assess SUD crises/needs. Any threat of involuntary commitment in the ED will be a massive deterrent to people with SUD from going to seek help. We'll see people who have had an overdose reversed refuse to go to the hospital afterward and then we've completely lost our opportunity to encourage them to seek help.
The civil rights of an individual are violated (unless a crime has been committed by the individual) when involuntary transport and involuntary commitment are done without the consent of the individual. The human degradation and injustices suffered by individuals with mental health disorders through involuntary commitment are legion. While the legislation is well intended, doctors, clinicians and peer workers must do everything then can to assist the individual in making a voluntary decision.
I am an ED social worker and I believe that there is so much that needs to change within EDs. I have been both a patient and obviously now an employee and the treatment leads to lack of treatment. Things need to change and there's education that needs to happen. Yes, sections would help, but there's also a problem with stigma that is an Compassionate care leads to better outcomes. If people are treated poorly, they are more likely to leave. This is part of the reason many people leave AMA

Comments on “Involuntary Commitment” Section
Involuntary commitment of any kind is very troubling. When we remove rights from people with mental health and substance addiction past history has shown that abuses and negative consequences, often severe, occur. People with behavioral health issues are already stigmatized and marginalized. It is a fine line between making decisions for people who are not able to make sound decisions for their best interests, and "criminalizing" certain behavior. Who is monitoring these facilities?
I am willing to be on any advisory board for this. As a nurse for DMH section 35 facility and person who was sectioned, I can be of good use here.
Person should be engaged by a qualified clinician well before 72 hours.
These Questions seem to place all the responsibility for everything, on an already few and scarcely funded treatment facilities and truly qualified available professionals. Unfortunately I don't have enough space allotted here to write my answers. I would like to rate the stakeholders in charge of licensing and regulating the facilities and professional providers in all these questions. Not to rate the ones that are already doing the work with very little support and inappropriate funding.
The sick don't know they are sick, professionals need to make the decision for them. It's an illness.
I strongly oppose expanding the authority to commit people for care. Deprivation of liberty on grounds of dangerousness to self or others by reason of substance use conditions should be limited to trained medical professionals, charged with implementing a narrow standard.
It is my understanding that an LICSW is now able to commit under Sec 35 but I don't think a person who has not been trained and practicing in substance abuse assessment & treatment should be doing this. I am an LICSW but I also am an LADC 1.
Usually too little too late//// this is step in right direction/ knowing it will be modified a great deal
Not sure how I feel about this since the treatment options seem to be limited to incarceration! I would be more in favor of these commitments if the placement was truly rehab rather than prison.
Social workers, nurses,psychologists, emts, lmhcs and staff in licensed addiction programs should be able to section and the 72 hour hold could help people who present outside of court hours to be evaluated for commitment
Expand to non immediate family members
Questions in the above survey are impossible for me to provide intelligent answers for without enormous clarifications. No one should be sectioned unless by being so, they are sent to a facility which provides effective, respectful, evidence-based treatment services. A prison-esque environment is not a climate which inspires someone toward recovery or has a rehabilitative impact on a human being - least of all someone who struggles with addiction.
It was just reported that this actually contributes to a greater chance of overdose in MA. There is no valid evidence based argument for this. In addition, if there is a shortage of beds for those that want them voluntarily, why would we give them away to those that do not want to even be there? Makes no sense at all. I understand the desperation of the families, but that doesn't make it worth doing against the evidence and with limited resources.
Section 35 needs to be REMOVED from the jail/prison system IMMEDIATELY! Forcing people to withdraw cold turkey wirh little to No medical help is INHUMAN
Sect 35 has killed more people than it has helped and it is more often abused than used appropriately. It has been the main tool for gentrifying neighborhoods and violates the right of users to make them disappear rather than help .
I disagree with involuntary treatment unless it is done by a family member. No other person should ever be granted that power. I will testify at the hearing on how this violates civil liberties, and quite frankly forces people against their will into a facility. I think it's disgusting , inhumane, and morally wrong. I will do everything in my power to fight against this.
Training should be mandatory for clinical and other staff involved.
I am 100%in favor of involuntarily treatment. For those unwilling to go voluntary I believe you will save lives
I hope I hit the correct button on the first page...all were STRONGLY AGREE
Section 35 saves lives. Ask those who have been sectioned, even if they are still active most will agree that "family did it because they care"
I cannot comment on this because they just unclear to me what type of clinical professionals, with what types of training and experience, would be allowed to section 35 someone. When the courts do it, this is clearly an intervention to avoid sending someone to prison in many cases. If conditions are allowed to section 35 people, just as in the old mental health system, there is a loss of individual rights that must be taken into consideration. Must be balanced with the harm reduction approach.

Comments on "Involuntary Commitment" Section
Once again should is a term that reflects ambivalence towards the expectation. This type of provision should include input from the clinical team that would be expected to participate in the process. Expecting a treatment team to support section 35 would include funding the required participation.
Section 35 needs to be more treatment oriented. It should not have a similar setting as jail.
I also believe recovery coaches and family should also be a part of the discussion since they have a better understanding of a client's history

Table 5. Respondents were asked comment on any of the statements in the "Involuntary Commitment" Section

Discussion on "Involuntary Commitment" Section

As expected, involuntary commitment proved to be one of the most controversial topics in the proposed legislation. Still, 66% either agreed or strongly agreed that Emergency Department staff should be able authorize involuntary transport to a treatment facility. Unfortunately, the survey format did not allow the authors to fully elaborate potential provisions of this legislation. Comments show that many individuals have strong feelings both for and against involuntary commitment. In addition, many individuals noted potential ongoing issues with current section 35 facilities. This concern is shared when considering any new involuntary commitment procedure. Facilities must be designed to properly and humanely treat individuals who have been civilly committed to care.

Section 3: Recovery Coaching

3. Recovery Coaches: Recovery Coach supports a person to engage in his/her own self-directed wellness plan towards recovery offering hope; while providing advocacy, guidance, motivation and knowledge. A Recovery Coach promotes recovery by serving as the "recoveree's" individual guide and mentor. This coach empowers the individual in their personal journey. Our Department of Public Health, Bureau of Substance Addiction Services currently supports a Recovery Coach training and certification process. In 2018, MassHealth will begin to cover Recovery Coaching services through a community partner program. Please give us your opinion on the following statements about recovery coaching.

Top number is the count of respondents selecting the option. Bottom % is percent of the total respondents selecting the option.	Strongly Disagree	Disagree	Neutral/No Opinion	Agree	Strongly Agree
Massachusetts should raise the profile of Recovery Coaches as important resources in the long-term management of substance use disorder.	6 5%	0 0%	6 5%	28 25%	73 65%
Recovery Coaches should go through a credentialing process similar to the one that addiction counselors must complete but without college degree requirements.	4 4%	4 4%	10 9%	38 33%	58 51%
Recovery Coaches should be licensed by the state as long as they are not required to have college degrees.	10 9%	5 4%	20 18%	30 26%	49 43%
The state should be able to revoke a recovery coach's license if they violate rules or fail to meet minimum standards.	4 3%	6 5%	10 9%	35 30%	60 52%
Most criminal records of the past should not disqualify a person from being a recovery coach	2 2%	5 4%	13 11%	27 24%	67 59%

Table 6. Respondents were asked to give their reaction to five statements regarding policies that could affect Recovery Coaches

Comments on “Recovery Coaches” Section
Comment about last question: What does "most criminal records include? And what does it exclude? When you say "most criminal records would not disqualify someone from becoming a recovery coach", would this include a Domestic violence conviction, being a sex offender, being accused of assault and or battery, stalking, physical assault to another human being, or robbery? This needs to be further defined.
Licensed or Certified? I am concerned about reimbursement rates - RC go through some training and must receive supervision and a LADC 2 requirements are even more yet the state under chapter 257 reimburses Master Level clinicians who provide supervision in RRS $50K, so what should a LADC 2 be paid verses a RC? there doesn't appear to plan for this.
Yes!
Recovery coaches are the most powerful way I have seen to help people get help.
Recovery coaches are a critical tool for success in combating SUD. I am one of the few CARC's in MA. What I do is very different than what other coaches do in other settings and there needs to be clear roles and differentiation in qualifications. Coaches volunteering in recovery centers are a critical, important and valuable tool, but they are very different than what my role provides and cannot provide the level of care that I do. All coaching should be well supported, and better understood.
If we want a peer workforce grounded in lived experience and informed by specialized recovery training and supervised practice, all of the above are necessary. The revocation of a recovery coaches' certification might best be done by a panel of senior recovery coaches and not by state officials
Recovery coaches are such a key component to treatment and help so much. I think that there absolutely should be a credentialing process but having taken the addiction counselor credentialing, I think it should be a little...easier... recovery coaches can be amazing without having the same abilities to succeed at credentialing in the way that counselors do
Credentialing is becoming recognized nation-wide. "Licensing" is a step too far in direction of professionalization. Effective Recovery Coaching depends on a multitude of factors. Coursework is an important contribution, but the integration of diverse life/recovery experiences and the ability to serve as mentor/ role model is equally important. Some of the best coaches are those who might not "qualify" under stricter licensing- culturally diverse including language, gang time, jail time, DCF..
People in recovery caring for those seeking recovery often relapse or at the very least have boundary issues. We need to have accountability for all. Licensing is a great idea.
One of the worrisome facets of recovery coaching is that the reality sometimes is; they are employed rather than qualified clinicians. If insurers can pay less, that is what they will typically opt for.
State licensing will just ruin a good idea! We want people who know the disease and community, not collect credits for attending conferences and classes.
I strongly support Recovery Coaches. But there needs to be a difference between a Clinical Qualified License Professional vs. a Recovery Coach without a master level college degree in the fields of Mental Health and Substance Abuse.
"most" criminal records - however, each case should be individually assessed.
One must examine the nature of charges that would be exempt from consideration for Recovery Coaches. Certain felonies, involving interpersonal violence and predatory behavior, should not be exempt for the protection of vulnerable people in recovery.
I think that the CORI check business needs to be case-by-case. More important is that a person be held accountable because someone newly in recovery is in a vulnerable position. I think revocation of a license is reasonable.
Haven’t experienced many long term sober individuals through traditional 12 step methodology interested at all in participating and I’m concerned why?
Made a mistake on earlier pages. Most were meant to say strongly agree.
It is essential that those with criminal records who have turned their lives around not be denied the opportunity to share their "experience, strength and hope" with the still-suffering addict.
Recovery coaching and peer support services have been proven to be an effective component of sustained, long-term recovery. I think it is vital that recovery coaches are specifically trained to support multiple pathways to recovery so they are not simply promoting their own recovery program/path. Meeting people where they are at/honoring the individual is precisely what determines a successful recovery coach/recoveree relationship. Being all-inclusive, it also reduces the alienation so common
Another major area of concern is to screen out those who are anti medication assisted treatment (Suboxone/Methadone). The evidence is more than clear that it saves many more lives than detox and then attempted abstinence and it is considered the gold standard for opioid treatment because of that. There should be no room for attempting to push step values onto non 12-step attendees either.
I think recovery coaches should be in recovery and have more thank a few years of sobriety. I think recovery coaches should go through extensive mental health screening.
Recovery coaches and college degrees have nothing to do with each other. How many addicts would listen to or want anything to do with a college educated person who had no experience with addiction? Wake Up!

Comments on “Recovery Coaches” Section
Recovery coaches must, in my opinion as a coach, be competent in all core functions that a LADC is required to be. I do not believe that a clinical training will interfere with a Recovery coach's responsibilty to their recoveree, it will prove helpful.
There needs to be more harm reduction focus in recovery coaching
The state should not be granted additional powers. Anything that increases government power I oppose. Setting guidelines from the state that are not mandatory I could live with.
I firmly believe that recovery coaches is that step that has been missing which I believe has been the missing step to get those in early recovery a fighting chance. My concern is our government will get involved and mess it up with red tape that will keep those that would be best away
And a requirement of at least a minimum of two years of their own recovery in addiction
ALL RECOVERY COACHES SHOULD HAVE A COLLEGE DEGREE. NEED TO BE MINDFUL REGARDING CRIMINAL RECORDS. DEPENDS ON THE OFFENSE
If managed properly Recovery Coaches can be an important tool for fighting to end this war.
Most of the best help I've encountered over the years were from addicts in recovery , no college degrees can beat the one on one actual live the life experience... Arrests in someone's past should not DEFINE them, that attitude towards it will only push some of the best help away ...
Once coaches are professionalized and able to receive insurance payments, then we must tighten the requirements and training. On the prior record question, again we must consider what level and types of offenses and why. For recovery coaching to be successful, we must have high ethical standards and make sure that recoverees are not being misled or otherwise misused.
There should be trainings for Recovery coaches tailored to the setting they work in. The supervision requirements for the carc need to be more stringent and all RC should have the benefit of non clinical supervision.
This all makes a lot of sense to me
Recovery coaches are an invaluable tool in the field of addiction. I do I agree that they should be held to a certain level of standards but that's someone's criminal record shouldn't prevent them from employment...providing no offenses in several years prior to beginning work.
The state should, with input from the recovery community, define the role of peer recovery specialists/recovery coaches and put in place licensing requirements. This way, insurance companies will be more likely to cover services provided by these professionals, which will allow for more coaches/specialists to be hired throughout the state.

Table 7. Respondents were asked to comment on any statements in the “Recovery Coaches” section.

Discussion on “Recovery Coaches” Section

Under most definitions, recovery coaches are not considered to provide ‘clinical services.’ Rather, Recovery Coaches seek to use their lived experience in recovery provide assistance outside the realm of the traditional addiction treatment. There is particular concern amongst members of the recovery community that recovery coaches are able to maintain this ‘peer’ role and that a credentialing process could damage the integrity or this ‘peer role’ or place undue burdens on the profession. Opinions expressed in this section indicate concern that new regulations or credentialing could exclude many individuals from becoming Recovery Coaches because of their own histories of Substance Use Disorders and criminal justice involvement. However, there is widespread recognition that Recovery Coaches need to be held to some standard in order to be taken seriously by clinicians and for their services to be reimbursed by insurers.

Section 5: Regulating Prescription Medication

4. Regulating Prescription Medication The over-prescription of opioid pain medication is often cited to be a contributing factor in the emergence of the current opioid addiction epidemic. The 2015 STEP Act included many provisions designed to curb over-prescription of opioids including limiting the number of opioid pills that can be prescribed in the Emergency Department and requiring doctors to use a statewide prescription-opioid monitoring database to prevent doctor-shopping.					
Top number is the count of respondents selecting the option. Bottom % is percent of the total respondents selecting the option.	**Strongly Disagree**	**Disagree**	**Neutral/No Opinion**	**Agree**	**Strongly Agree**
Doctors should be required to use electronic prescribing practices not just opioids but all scheduled drugs including benzodiazepines and stimulants.	6 5%	1 1%	10 9%	27 24%	67 60%
Dentists and oral surgeons should have more tightly regulated prescribing practices for opioid medication.	4 4%	4 4%	7 6%	21 19%	75 68%
People prescribed a schedule II controlled drug should have the option of initially obtaining less than the full amount of the prescribed drug while retaining the option to fill the remainder of the prescription at the same pharmacy within 30 days.	4 4%	4 4%	5 5%	26 24%	71 65%

Comments on “Regulating Prescription Medications”
Seeing a family member struggle with pain control following a fx hip makes me think we are overdoing this. The opiate regulations should be revisited in relations to treatment and hospice. No reason a person should spend their last days on earth in extreme pain because someone is afraid that a hospice patient will overdose? Some outliers need to be considered. Perhaps the legislators should all recover from hip surgery with Tylenol only or die from liver cancer with only advil.
Totally agree, just plain common sense.
I recently had shoulder surgery at a certain hospital and was prescribed50 dilauden (sp?). I only used 9 pills. When I talked to the doctors nurse about this and questioned why so many I was told this is what is always prescribed. This was at MGH this pay summer.
All prudent and preventative actions are welcomed.
Big problem with people on MAT being prescribed benzos and other altering prescriptions. Are these included in monitoring program.
Again, accountability is needed by all. If someone chooses to partially fill a prescription then they should stay with what they have and see the doctor again if pain continues. We need better alternative pain management practices.
As a clinician, and a recovering person, I am firmly against self prescribing. I believe the onus is on the prescriber, to not over, or under prescribe.
3rd Question makes me think about, the responsibility and involvement of the prescriber in the actual treatment of the client and or collaborative treatment work with the client and his other providers of treatment?
When politicians involve themselves in being doctors I strongly disagree.. a system (generic) should not be too difficult to establish to block doctor shopping and pill mills. Education of doctors is never really developed; how else could you explain one article written in the medical journal from Boston allowed pharmaceutical companies to sway a nation of doctors have absolutely no interest in addiction training themselves. Slippery slide
Years ago my son had one wisdom tooth pulled and the dentist sent him off with 24 oxycodone! When I called to inquire about this (he was a college student living at home) the assistant who spoke to me said, "Oh, is it not enough?" I thought it was excessive and she thought I was asking for MORE pain relief!!! I stopped using that dental office.
And neurontin and phernegan and clonidine
I thought we had a partial fill already in place .
There should be significant "fines" imposed to manufacturers of opioids that are put toward treatment/recovery efforts - as well as ceilings on prescription prices AND on the amount of profit they are allowed to make for opiods - and all other medications, for that matter - so that people's lives and well being doesn't present to the greedy as so insignificant when compared to the obscene profits being made today.
All that enacting a PMP before first funding greatly expanded Suboxone and Methadone access has done is push those with prescription opioid SUD to become users of street pills and/or heroin and both of those often have Fentanyl. We

Comments on “Regulating Prescription Medications”
didn't need a PMP to find and prosecute doctors who were being negligent/criminal. It was a giveaway to the tech industry at the expense of legit pain patients and those with opioid SUD.
Patients who are in recovery should have counsel from a sober professional regarding taking opioid pain medication. People don’t realize giving a drug addict pain meds is probably going to have a huge effect on their ability to maintain sobriety. Therefore council from another recovering addict professional should be mandated
The last part is strange. You can already tell a pharmacist on your own accord that you don't want them all. My father, a pharmacist, who has worked for 3 retail giants for 32 years is also confused about this as you already can. No one can force you to take them all.
A policy of monitoring every prescription should be in place asap.
The dentist, let me state , I'm in recovery for a bit now , one dentist refused to give me pain meds , result , I got my own. No way should any other practice torture you due to your addiction, not active addiction, I did seek another...now I must say I felt accepted, not like some piece of trash and I'm working w dentist to fix my issues if I didn't find this guy , I'd be suffering..left with pain on and off that would lead me to more of a chance to use more frequently. Resulting in downfall
weds
all makes perfect sense

Table 7. Respondents were asked to comment on any statements in the “Regulating Prescription Medication” section.

Discussion on “Regulating Prescription Medications” Section

This section was the least controversial of the policy topics surveyed. Most individuals believe that prescription drugs need to be more tightly regulated. In addition, many individuals expressed particular concern about dentists and oral surgeons over-prescribing opioid medications

Section 5: Opioid Epidemic Priorities

In this final section, individuals were asked to rank potential priorities in addressing the ongoing opioid epidemic.

5. Below is a list of possible priorities for addressing the opioid epidemic over the next two to five years. Using your personal knowledge and perspective please rank the priorities in order importance.

Top number is the count of respondents selecting the option. Bottom % is percent of the total respondents selecting the option.	Least Important 1	2	3	4	5	6	7
More Recovery support services like Recovery Coaches and Recovery Centers	15 15%	12 12%	18 18%	10 10%	16 16%	16 16%	15 15%
Expand capacity and access to traditional addiction treatment programs (TSS, Recovery Homes, IOPs, etc)	18 18%	12 12%	13 13%	13 13%	16 16%	14 14%	16 16%
Improve Diversion and Re-entry programs for people with addictions involved with the criminal justice system.	5 5%	13 13%	25 25%	20 20%	19 19%	10 10%	10 10%
Make medication assisted treatment more widely available	21 21%	12 12%	15 15%	17 17%	8 8%	18 18%	11 11%
Expand and improve school-based prevention programs.	14 14%	15 15%	10 10%	13 13%	13 13%	13 13%	24 24%
Improve access to Naloxone and harm reduction programs.	11 11%	24 24%	13 13%	16 16%	14 14%	14 14%	10 10%
Improve insurance coverage for inpatient and outpatient services.	18 18%	14 14%	8 8%	13 13%	16 16%	17 17%	16 16%

Discussion on Opioid Epidemic Priorities Section

Data show that opinions are widespread about the best ways to address the opioid epidemic. The priority most commonly ranked as “most important” by respondents was “Expand and improve school-based prevention programs.” Notably, “Expand capacity and access to traditional addiction treatment programs,” “More Recovery support services like Recovery Coaches and Recovery Centers” and “Improve insurance coverage for inpatient and outpatient services” were also popular choices as the most important priorities.