Journal of Substance Abuse Treatment 107 (2019) 1–7

Contents lists available at ScienceDirect

Journal of Substance Abuse Treatment

journal homepage: www.elsevier.com/locate/jsat

Patient experiences with a transitional, low-threshold clinic for the treatment of substance use disorder: A qualitative study of a bridge clinic

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ARTICLE INFO

Keywords:
Substance use disorders
Low threshold
Transitional clinic
Bridge clinic
Harm reduction
Patient experience in treatment
Outpatient services

ABSTRACT

Background: A minority of patients with substance use disorder (SUD) receives treatment, indicating the need for innovation in care for individuals with SUD. Transitional and low threshold models of care for SUD are utilized to address this treatment gap, but there is limited evidence about their effectiveness or patient perspectives on these models.

Methods: Patients participated in semi-structured interviews (N = 29) which explored their experience in a transitional, low threshold, Bridge clinic for the treatment of SUD. In order to reach a diverse patient population across age, gender, housing status, type of SUD, length of stay, and patient status in the clinic, researchers employed maximum variation sampling. Interviews were conducted until no new central concepts emerged. Codes were developed and assigned using an inductive as well as a mixed inductive-deductive approach.

Results: Patients identified flexibility and accessibility of services, compassionate approach of providers and staff, use of peers in recovery, and the emphasis on harm reduction as positive features of the model. Patients struggled with transitioning out of the clinic.

Conclusion: Patients reported positive experiences in a transitional, low threshold clinic for SUD, comparing it favorably to other programs. Patients maintained sobriety more consistently and increasing motivation to adhere to treatment. Patients almost universally appreciated the flexible and harm reduction-oriented model of treatment. Future quantitative research is needed to further examine the effects of low threshold programs on treatment outcomes, including ongoing substance use, treatment retention and overdose mortality, as compared to traditional treatment programs.

1. Introduction

In 2017, there were 19.7 million Americans with a substance use disorder (SUD); in 2017, over 70,000 individuals died from an overdose and 90,000 individuals died from an alcohol-related cause (National Institute on Drug Abuse, 2019; Substance Abuse and Mental Health Services Administration, 2017). Despite the existence of effective treatment for SUD, a minority of affected individuals receives care each year. Factors contributing to this treatment gap include stigma, disparities in access to care, a history of criminalizing behaviors associated with addiction, and the design of traditional treatment programs which may be unwelcoming to certain patient populations. Most importantly, individuals at highest risk of harm and death may be least able to access care (Blevins, Rawat, & Stein, 2018; Center for Health Information and Analysis, 2015; Kulesza, Ramsey, Brown, & Larimer, 2014; National Institute on Drug Abuse, 2019). Lower threshold care models are needed to fill these gaps.

Low threshold addiction treatment models emphasize engagement and harm reduction rather than abstinence (Strike, Millson, Hopkins, & Smith, 2013). These models aim to reduce barriers to access and to make care easily available to individuals who are unable to engage with higher threshold services (Edland-Gryt & Skatvedt, 2013). Features of lower threshold models include providing medication for opioid use disorder (MOUD) or alcohol use disorder without requiring counseling,

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https://doi.org/10.1016/j.jsat.2019.09.003
Received 29 April 2019; Received in revised form 29 August 2019; Accepted 9 September 2019

performing unobserved medication inductions, and offering walk-in services that do not require an appointment (Bhatraju et al., 2017).

Transitional treatment models for SUD, which provide immediate, short-term access to pharmacotherapy and evidence-based psychosocial treatment, are primarily designed to the fill the treatment gap between inpatient and outpatient care. Patients are initiated on treatment immediately while awaiting linkage to ongoing care in the community (Shanahan, Beers, Alford, Brigandi, & Samet, 2010). Transitional treatment models have been effective in managing serious mental illness (Abbas et al., 2014; Lorenzo-Luaces et al., 2017). Post-discharge "bridge" clinics have also been used successfully for chronic medical conditions such as heart failure (Hale et al., 2017). In the context of the overdose crisis specifically, there is a growing recognition of the urgency to initiate MOUD immediately, including in the hospital or emergency department setting (D'Onofrio et al., 2015; Rubin, 2018). This has highlighted the need for transitional, bridge clinics for patients to be connected immediately to care given the difficulty accessing pharmacotherapy for SUD in behavioral health and primary care settings (Hostetter & Klein, 2017; Ross, Lo, McKim, & Allan, 2008; Townley & Dorr, 2017). Despite the increase in providers calling for low-threshold and transitional services, there is limited evidence about their overall effectiveness (Babor et al., 2007; Fox, Chamberlain, Frost, & Cunningham, 2015; Haugum, Iversen, Bjertnaes, & Lindahl, 2017; Resnick & Griffiths, 2012).

Patient experience in treatment is an important aspect of health care quality and is linked to clinical effectiveness as well as patient satisfaction and safety (Drainoni et al., 2014; Gilburt, Drummond, & Sinclair, 2015). Though the collection of patient experience as part of quality measurements has become widespread in healthcare generally, it is relatively new to evaluation of SUD treatment (Gilburt et al., 2015; Haugum et al., 2017). To our knowledge, this is the first study to examine patient experience within a transitional, low threshold SUD treatment program. We selected a qualitative approach because we recognized that patient perspectives on recovery and recovery services are complex and multi-faceted and may be best explored through qualitative interviews in which patients can direct the conversation toward what is important to them. A qualitative study allows for the formation of hypotheses for future quantitative exploration of low threshold, transitional treatment programs and may inform further development of patient-centered models.

2. Materials and methods

We conducted semi structured interviews with 29 current and former patients from the Massachusetts General Hospital (MGH) Bridge Clinic between January and June of 2018. We used an inductive approach as well as a mixed inductive-deductive approach (Bradley, Curry, & Devers, 2007; Strauss & Corbin, 1998). The study was approved by the Partners Healthcare Institutional Review Board.

2.1. Participants

Inclusion criteria were: 1) 18 years or older; 2) diagnosis of SUD; 3) being either a current or former (no longer a patient for > 30 days) patient of the MGH Bridge Clinic; and 4) being fluent in English. Patients were recruited from the MGH Bridge Clinic after being given a diagnosis of SUD by a provider, which was noted in the medical record. A list of eligible patients was created using maximum variation sampling. Patients were identified to maximize selection across age, gender, housing status, type of SUD (alcohol vs opioids vs multiple substances such as cocaine, benzodiazepines, or methamphetamine), length of stay at the clinic (< 90 days or > 90 days), and whether the patient was a current or former patient (Teddlie & Yu, 2007). The study was described to clinic staff who were given the list of eligible patients and called the study staff when an eligible patient came to clinic and was amenable to hearing more about the study.

2.2. Setting

The MGH Bridge clinic is a flexible, low-threshold model of integrated SUD care, which offers on-demand treatment with a focus on access and retention. An interdisciplinary team of providers work at the clinic, including addiction medicine physicians, nurse practitioners, a clinical pharmacist, a medical assistant, a resource specialist (a staff employed to assist with patients' discharge to further addiction treatment and ensure successful transition), patient services coordinators, and a recovery coach (a staff in recovery from SUD employed to provide support to patients) (Jack, Oller, Kelly, Magidson, & Wakeman, 2018). The clinic provides a range of services, including medication for addiction treatment, peer support groups, recovery coaching, and resource specialist support assisting with issues regarding insurance, transportation, clothing, and other barriers to recovery. Patients are referred to the clinic by providers within the academic medical center and its satellite clinics, including providers from the inpatient addiction consult team, emergency department, and primary care. Patients may also self-refer. Appointments are not required, and the clinic offers walk-in services during weekdays and weekends. Between its opening in 2016 and the time of this study, over 800 patients have had at least one clinic visit. Fifty percent of visits were not scheduled in advance. The median time in care was 73 days, however despite the transitional design of the clinic 25% of patients remained in care at the clinic for longer than one year highlighting that a significant minority of patients may find it difficult to transition to other care settings.

2.3. Data collection

A trained interviewer obtained verbal consent and conducted face to face interviews lasting approximately 1 h in a private space within the MGH Bridge Clinic. Because the study presented minimal risks to participants and involved no procedures for which written consent is normally required outside of the research context, verbal consent was approved by the Partners Healthcare Institutional Review Board for this study. All interviews were audiotaped and professionally transcribed. Participants were compensated with a $15 gift card. Patients were selected to theoretical saturation when no new concepts emerged from subsequent interviews. Despite the breadth of the patient pool, researchers believed that they reached saturation after 29 interviews. Research staff met to discuss the progress of the interviews and generated themes throughout the recruitment phase. Upon completion of 29 interviews, researchers met to discuss and generate themes and codes and agreed that responses to the semi-structured interview questions, which were asked to each participant, were similar and that theoretical saturation had been reached (Glaser & Strauss, 1967).

No patients declined to participate. However, after expressing initial interest in the study and verbally consenting to being contacted at a later time to complete the interview, four patients were unable to be reached for an interview. The interviewer attempted to reach each patient over a two-week period from the verbal consent date by both phone call and meeting the patient in the clinic at their appointment time, and these four patients were either not able to be reached, did not show for their appointment, or did not have time to meet with the interviewer during this two-week period.

2.4. Interviews

We developed a semi-structured interview guide, which addressed themes around patient experience with initiating, receiving care at, and transitioning out of the clinic (Appendix A). The interview guides used open-ended questions to explore these themes in a participant guided approach, using specific follow-up probes to get further detail about specific experiences. A single interviewer (R.L.S.), who was trained and had experiences in qualitative interviewing technique and had no prior clinical relationship with any of the participants, conducted and

recorded all the interviews (McCracken, 1988).

2.5. Data analysis

Both inductive and mixed inductive-deductive approaches were used to develop and assign codes (words or phrases that are given to distinct ideas) (Bradley et al., 2007; Glaser & Strauss, 1967; Strauss & Corbin, 1998). First, four researchers (D.O., H.E.J., R.E.S., R.L.S.) separately reviewed four randomly selected transcripts, assigning codes (labels) to key concepts in the transcripts and then applying the same codes to other similar concepts. After each researcher read the four transcripts and developed their own list of codes, they met to discuss and reconcile their codes, coming to agreement around a single set of codes that captured all the important themes from the data.

Two coders (R.E.S., R.L.S.) then separately coded each transcript using the code list. One coder was an internal medicine resident and the other a clinical research coordinator who both had training in qualitative methods and experience working with patients with SUD. After each transcript was separately coded by the two coders, they met to discuss and reconcile their codes to come to a final consensus for each transcript.

Following coding, the coded transcripts were inputted into ATLAS.ti (version 8.2.34.0 Scientific Software Development GmbH, Berlin, Germany), a qualitative analysis software system, to organize the data. All codes present throughout the transcripts were examined to further analyze the data. The researchers examined the data to identify central codes that expressed ideas independent of other codes, combine codes to create a broader group of themes, and identify specific themes that encompassed more detailed concepts, which were present throughout the data (Morse, 2008). Ideas that emerged while examining and analyzing the data were then used to guide discussion for further analysis among the coders, until a final list of central themes was established (Bradley et al., 2007).

3. Results

The 29 participants were 66% male and 90% non-Hispanic white. More than a quarter were former patients and 72% were current patients. Patients identified a range of primary types of substance use disorder, with 10% reporting alcohol only, 38% opioids only, and 45% multiple substances (Table 1).

The central themes included (1) accessibility and flexibility of services, (2) emphasis on harm reduction, (3) provider-patient relationship, (4) role of peers in recovery, and (5) transitional care. Table 2 displays quotes illustrating the central themes.

Table 1
Characteristics of patients interviewed.

Characteristic	Number of participants (N = 29)
Gender	Male: 19 Female: 10
Race/ethnicity	White: 29 Hispanic: 2 Non-Hispanic: 26 Unknown: 1
Patient status at time of interview	Current patient: 21 Former patient: 8
Duration as patient at time of interview	< 90 days: 7 > 90 days: 22
Primary substance	Alcohol: 3 Drugs: 17 Opioids: 11 Opioids and other drug: 4 Both: 9 Alcohol and opioids: 5 Alcohol, opioids, and other drug: 4
Housing status	Housed: 20 Not housed: 9

3.1. Accessibility and flexibility of services

Patients valued the clinic's walk-in policy, describing how they could come to the clinic without an appointment and be seen, which was a feature different from past treatment programs. One patient commented, "*I was happy because it can be difficult to get into Suboxone clinics…and there's usually a long wait, and he [recovery coach] told me I could come the next day*." Patients expressed frustration with prior experiences at other treatment programs, which had long waitlists and required multiple evaluations prior to initiating treatment. Some patients described the walk-in policy as especially beneficial when they were experiencing social and financial difficulties, such as unstable housing or homelessness, inability to pay for transportation to and from the clinic, or incarceration, as these life factors made making an appointment difficult or impossible. Some patients also described how the walk-in option was helpful for them when they were experiencing strong cravings to use or were in withdrawal. They appreciated having a place they could go to stay safe. As one patient described it, "*I can come up here anytime*."

Patients valued the flexibility in making appointments and attending groups in the clinic. Several expressed gratitude that if they missed an appointment at this clinic, they would not be reprimanded or penalized, such as being denied medication or the ability to make another appointment; a common experience for many in other treatment models where they had sought care. Additionally, patients appreciated that group sessions were optional, reflecting the clinic's emphasis on patient autonomy and understanding of treatment as an individualized process: "*they allow you to heal however you have to*." One patient said,

> "*I went to a lot of the groups after I had done detoxes or some sort of program so I already knew a lot about what they were saying. But I wasn't forced to do these groups. You are forced to do those [outside services] ones. There's a difference. This is participating on your own free will…their groups are helpful.*"

Patients highlighted the benefits of the accessibility and flexibility of services as compared to past treatment experiences. As one patient explained:

> "*[This clinic] doesn't make you feel like the other places do. They don't bombard you. Instead, it's just such a relief and a help. They allow you to heal and don't try to bring rules and make things mandatory*".

Patients universally reported that the lack of a "controlling environment" in this clinic helped them stay engaged, emphasizing that "*many addicts feel out of control…and I think they need a little less control, just to decide something on their own. This clinic allows you to do that.*"

3.2. Emphasis on harm reduction

Patients valued the clinic's emphasis on harm reduction. Some reported that a relapse was not viewed by the clinic as an action that required punishment which brought relief to many, as they initially expected to be "kicked out" if they used rather being "allowed" to return to the clinic.

Additionally, patients emphasized providers' knowledge, professionalism, and acceptance, expressing relief that they were "accepted the way they were" and would not be withheld medication or care if they relapsed or missed an appointment, as many experienced in past programs:

> "*…they were practical about it, they didn't withhold medication because you had done something that you shouldn't have, or forced you to sit and go to AA…or NA meetings…they didn't make your medication contingent upon you either being successful or some other type of treatment, that oftentimes I have found, personally, to have the opposite effect,*

Table 2
Central themes of the clinic.

Theme	Participant quotes
Accessibility and flexibility of services	"I [patient] found out about the [clinic] about six months ago. I overdosed, and after that…I decided I'm going to do something to get clean. And the very next day, I was referred to the clinic…and I came the very next day. And I've been clean ever since, off the heroin, because of the Suboxone." "I [patient] was happy because it can be difficult to get into Suboxone clinics…and there's usually a long wait, and he [recovery coach] told me I could come [to the clinic] the next day." "I [patient] went to a lot of the groups after I had done detoxes or some sort of program so I already knew a lot about what they [staff] were saying. But I wasn't forced to do these groups. You are forced to do those [outside services] ones. There's a difference. This is participating on your own free will…their [groups] are helpful."
Emphasis on harm reduction	"I [patient] don't feel like they'll [staff] yell at me or get mad because I'm using. They actually talk to me and help me. It's not like, 'oh, you used. Goodbye.' They understand you make mistakes." "I [patient] walk out of here and I feel good about myself…Instead of getting chastised for relapsing, and feeling bad about it, we actually talked about it…. I take something away from it positive instead of just feeling bad about it. Like how I screwed up again…then I just feel bad and then how do I deal with feeling bad? I end up using drugs." "…I've [patient] been caught dirty for different substances and she [provider] talks about it and she doesn't threaten. She takes an approach which is logical and makes sense to a person in the situation such as I'm in. And you feel more apt to say exactly what's going on and not have to think in advance of how you're going to talk your way out of something in order to be able to continue."
Provider-patient relationship	"…You [patients] can speak honestly and in that way, that you can actually get to the bottom of other problems that may be playing a role in the whole thing. And I [patient] also get a feeling of safety with her that she's [provider] not going to… withhold treatment or make you go somewhere else or force you to do something that you know that you're not going to do and end up not coming back." "She [provider] surprised me [patient] with her knowledge and wisdom. And not just about the medications, but the lifestyle that comes with the addiction of heroin, the stigma and all that" "They [staff] treat you like you're a person, and trying to make your life better, and encourage that. And I [patient] think that's an awesome thing instead of not believing that you can even do it." "…no one's [staff] going to judge you or give you a hard time. You'll [patients] find that everyone is really understanding. It's hard for me [patient] to open up, honestly…I keep everything to myself…but it's easy here…it's just nice to be able to talk about things." "…it's nice to be able to just walk in somewhere [immediately post incarceration], and they [staff] are understanding, and accepting, and willing to help still." "…and coming here [clinic], there was something redeeming about it. I [patient] felt safe. I felt warm. In fact, I felt nurtured, I think would be the best word." "…they [staff] say, 'help yourself [patients] to…'. Sometimes they have different things on the table, like books and snacks…there's coffee that you can make. And they just seem to want to make you comfortable. So that's always nice."
Role of peers in recovery	"[Staff] used to help me [patient] a lot. She used to come to court with me. Everything. And [staff] helps me with getting into Access to Recovery and setting up appointments and all of that…I need help because I can't read that good, but they help me with a lot of things." "…she's [recovery coach] like a teacher. Like somebody is trying to teach you [patients] but yet not…forcing into you. But they've been there. And they know so they know all the tricks and con artists and all that…they've been through it. They've done it. So… to come here, you got to be straight up truthful." "…and here she [recovery coach] is, a year and a half, two years later, she's working for the recovery team…That's a pretty inspirational story…She used to sleep in the same clothes for seven days like I [patient] did…It helps when you can relate to the person who's helping you and you know they've been through a little."
Transitional care	"I [patient] feel like if I'm not ready, they're [staff] not going to force me out the door, and that's a good feeling to have. You don't want to feel like you're being pushed out because then what's the point of coming if you're just pushing me out the door." "I [patient] think they [clinic] should stay open. I think that they should get a bigger grant or whatever they need and just stay. Stay. Everybody [patients] likes it here. Everybody's doing good. Why toss everybody out? I know they don't want to and that's not what their goal is, but if something's working why."

actually. And they didn't link caveats to being treated."

Patients reported the lack of "punishment" in this clinic for relapsing or coming into the clinic after using substances as therapeutic and unique compared to experiences in other treatment programs. One patient reflected feeling that he "*can say whatever I need to say in there and not have to worry about what the repercussions are…and it allows you the safety of being able to actually treat whatever the problem is instead of having to worry about being punished*." Another patient reported feeling cared for and accepted despite relapsing while attending the clinic, describing staff "*seeing that I was relapsing while I was going there…but they knew I had addiction really bad. And they still accepted me either way. They didn't kick me off. They still accepted me the way I was*."

"Unconditional acceptance" and "nonjudgment" were phrases used to describe the clinic, in large part when reflecting upon the emphasis on harm reduction. Patients expressed confidence that "*there was no stigma up there. everybody knew what they were there for*."

3.3. Provider-patient relationship

3.3.1. Medical providers

Participants received medical care from an internal medicine physician (MD), a nurse practitioner (NP), or a clinical pharmacist at the clinic. Though patients mostly used "provider" interchangeably, when specified, most patients reflected on their interactions with the "MD provider." Regardless, data displayed similar results across all provider types: providers were described as "compassionate", "supportive," "encouraging," and "committed to help people." MDs, in particular, were described as educating patients about the diagnosis, natural history and treatment of substance use disorders: "*She helped me positively reinforce not doing drugs…the health reasons not to do it…the social and responsibility issues that are involved*." Another patient said, "*She surprised me with her knowledge and wisdom. And not just about the medications, but the lifestyle that comes with the addiction of heroin, the stigma and all that*."

Patients also viewed providers as "accepting" and "safe", especially when it came to individual medication and treatment needs. One patient reflecting on his provider noted that he "*got a feeling of safety with her that she's not going to… withhold treatment or make you go somewhere else or force you to do something that you know that you're not going to do and end up not coming back*."

3.3.2. Non-clinical staff

Non-clinical staff (i.e., front desk, practice manager) play an integral part of this clinic and frequently interact with patients. Patients described the staff as being respectful, supportive and compassionate. One patient remarked,

"*They treat you like you're a person, and trying to make your life better,*

and encourage that. And I think that's an awesome thing instead of not believing that you can even do it."

After a positive initial experience in the clinic, all patients interviewed returned for a second appointment. According to some patients, the supportive environment influenced their motivation to continue to seek the clinic's services. Many patients emphasized the comfort and acceptance in speaking with staff members. One patient commented,

"*…no one's going to judge you or give you a hard time. You'll find that everyone is really understanding. It's hard for me to open up, honestly…I keep everything to myself…but it's easy here…it's just nice to be able to talk about things.*"

Another patient noted that the treatment and body language of staff affected their decision return and stay engaged in care, describing that

"*[staff] treat you like you're a person and try to make your life better… they make everybody here feel welcome. So, if you've got somewhere to go where people are happy to see you, you'll probably keep going.*"

Some patients highlighted that this contrasted their experiences at outside services, where patients were reportedly told, "*you're just a drug addict…you're lucky you're getting this treatment.*"

Overall, patients described staff as encouraging and supportive of their recovery. One patient reported "*they don't make you feel like you're doing something wrong and you have to do it this way or you're not going to succeed. They never say that.*" Another patient described the clinic overall, saying "*in this type of treatment, there's a combination of very high levels of competency, of great culture and values…high level of compassion and caring. Those all are really powerful things put together. Unconditional.*"

Patients also commented on the welcoming physical environment of the clinic, including the availability of free coffee and food and having a warm, communal space to wait for their appointment and socialize with others. One patient said, "*…they say, 'help yourself to…'. Sometimes they have different things on the table, like books and snacks…there's coffee that you can make. And they just seem to want to make you comfortable. So that's always nice.*" Many of the patients who experience homelessness or unstable housing appreciated the food vouchers and assistance with transportation.

3.4. Role of peers in recovery

Some patients noted the benefit of both the resource specialist and recovery coaches. The resource specialist, who similar to the recovery coach is a person in recovery, assisted them with logistics of care, specifically connecting them to outpatient or inpatient facilities, or helping them transition to another program. One patient noted the resource specialist was "*calling all day for me trying to find a detox.*" Patients described the recovery coach helping them with social, financial, and legal challenges connected to their SUD, such as accompanying them to court appointments, helping them get a state ID, and visiting them when they were in the hospital. Patients remarked on the benefit of the recovery coach's accessibility, particularly outside of clinic hours through calling or texting. One patient noted, if they needed to talk to their recovery coach, "*he'd be on the phone right then and there.*" Other patients mentioned how the recovery coach helped them obtain basic necessities, such as clothes, food, and transportation vouchers.

Patients specifically valued working with staff in remission from SUD because they felt these staff members could truly relate to their experience and were "powerful examples of recovery." One patient described working with a recovery coach,

"*…and here she is, a year and a half, two years later, she's working for the recovery team. That's a pretty inspirational story…She used to sleep in the same clothes for seven days like I did…It helps when you can relate to the person who's helping you and you know they've been through a little.*"

Another patient described working this same recovery coach, who had both OUD and AUD, saying, "*she told me alcohol was the hardest to kick. Because it's everywhere. It was so helpful to me that'd she been through it too.*" Some patients expressed being more truthful because they "*didn't feel so different around them.*"

3.5. Transitional care

Patients did not like that the clinic was transitional, stating they wished to stay permanently because they trusted and felt comfortable with the clinic staff. A few did not mind being transitioned to care closer to home. Former patients described the transition process itself with mixed feedback. While some said they worked with the resource specialist to transition out smoothly, others said they felt like they were "stepping on hot coals" when coming to clinic follow-up, wondering if this would be the week "*that they'd - throw me out.*" Patients reported hoping the clinic would expand the length of time people can stay in the program to receive services beyond a transitional model, saying "why toss everybody out?" In the current model, some patients do stay past the temporary time period, but patients with less severe SUD are transitioned on to community-based care. Patients expressed a wish to be able to remain in this clinic because the model was helping their recovery.

4. Discussion

This study explored the experiences of patients with SUD within a low threshold, transitional clinic at a large urban teaching hospital. Patients perceived the clinic as a safe, welcoming space staffed by a compassionate, knowledgeable, and nonjudgmental care team which they reported increased their motivation to seek and stay in treatment. Patients perceived the clinic's flexible structure and emphasis on harm reduction as effective at meeting their needs and the acceptance of staff, including providers, peers, and non-clinical staff, as increasing their desire to remain in treatment. Furthermore, patients reported enhanced motivation to seek and stay engaged in care, as well as to adhere to treatment for SUD generally, compared to previous experiences in treatment models that do not employ a low-threshold, patient-centered, flexible approach.

Participants' perspectives that their positive experiences in the clinic contributed to their long-term recovery are consistent with prior research showing the impact on treatment retention of patients' experience of care, particularly related to staff encouragement and support (Teruya et al., 2014). Many patients in this study had difficult experiences with past treatment programs for SUD, which some patients noted contributed to lower expectations of treatment effectiveness at their initial clinic visit. This finding is consistent with the literature linking past treatment experiences to future expectations of treatment effectiveness (Greenberg, Constantino, & Bruce, 2006). In this study, after a positive initial experience in the clinic, many patients began to think that treatment could be effective. Positive expectancies of treatment effectiveness have been shown predict greater treatment engagement and a higher likelihood of returning for future treatment for other mental health and medical disorders (Nock & Kazdin, 2001; Snippe et al., 2015). More research is needed to explore how patient perceptions of low threshold services affect future treatment participation and outcomes as compared to higher threshold models. Our findings allow us to hypothesize that positive patient experiences in treatment may lead to greater patient engagement and better recovery outcomes.

Patients highlighted that staff were influential in their motivation to engage in treatment. In particular, patients praised the ability of the staff to develop positive rapport and speak in a non-judgmental manner. This finding underscores the importance of ensuring both staff and providers at low-threshold clinics receive the education and skills training necessary to incorporate non-judgmental approaches into their interactions with patients. Patients also discussed the benefit of working with staff in SUD recovery, as seen in previous studies (Bassuk, Hanson, Greene, Richard, & Laudet, 2016; Jack et al., 2018). The accessibility, relatability, assistance with logistics, and motivational

support provided by these staff members reportedly helped many patients continue to come to the clinic for treatment.

In addition to provider-patient interactions, the low threshold treatment model which included on demand MOUD initiation was an important feature of this clinic. Patients commented that the ability to immediately access medication and to continue on medication despite ongoing struggles with substance use was an important feature of the model. This harm reduction approach, which included MOUD on demand, may be important to more rapidly engage patients at highest risk of overdose, foster patient comfort with providers, and diminish patient fear of having treatment withheld for ongoing use.

Several features of this clinic, such as accessibility and flexibility, focus on harm reduction, and compassionate providers and staff, while enhancing treatment retention for some patients, also contributed to the difficulty patients faced in navigating the transition process out of the clinic. Some patients expressed not wanting to leave in part due to these beneficial components. Healthcare transitions are considered a universal challenge; poor transitions can increase the risk of hospital readmission and poorer clinical outcomes, as seen in mental illness and diabetes (Garnica, 2017; Peters & Laffel, 2011; Singh, 2009; Viggiano, Pincus, & Crystal, 2012). There may be some high-risk patients who need longitudinal engagement in a low-threshold clinic. Future research could examine patient and clinic characteristics to identify subgroups of patients who may need to continue in low threshold treatment, those who can successfully transition into other care settings, and ideal transition plans to support successful connections into long-term care.

4.1. Limitations

This study had several limitations which need to be considered when interpreting the data. First, all the patients interviewed voluntarily remained at the clinic or returned thirty days later for an interview, suggesting that they were more likely patients who had positive experiences at this clinic. Second, social desirability bias may have affected how the patients described their experiences at the clinic (may have described it more positively as they thought the interviewer wanted to hear that), emphasizing the need for further study. Third, the relative homogeneity of the study sample may mean that our findings are not fully applicable to the general population. Despite our attempt to interview a diverse demographic sample, most patients interviewed were white. Fourth, because this study was conducted at a large academic medical center that provided financial support for this clinic, the findings may not be generalizable to other settings.

5. Conclusions

Our findings indicate that patients viewed this low-threshold, transitional clinic model favorably. Patients identified the flexible and harm reduction-oriented model of treatment, the compassionate approach of providers and staff, and the use of peers in recovery as key features of the model. Because these attributes may differ from standard SUD care, more research is needed to examine the effect of low threshold, transitional treatment programs on clinical outcomes, including reductions in ongoing substance use, treatment retention, and overdose mortality.

Funding

This work was supported by a small amount of internal funding from Massachusetts General Hospital to provide gift cards for participant remuneration. This study was approved by the Partners Human Research Committee (Protocol 2017P002398/MGH).

Declaration of competing interest

Dr. Wakeman received research support from OptumLabs.

Appendix A. Interview guides

Current patients	Former patients
How did you find out about the clinic and end up coming here?	How did you find out about the clinic and end up coming here?
What did you expect the clinic to be like?	What did you expect the clinic to be like?
Tell me about the first time you came to the clinic.	Tell me about the first time you came to the clinic.
Why did you come back to the clinic after your first visit? What happened next?	Why did you come back to the clinic after your first visit? What happened next?
What providers did you see at the clinic?	What providers did you see at the clinic?
Did you attend any of the groups?	Did you attend any of the groups?
Did the clinic affect your life and health in any way? If so, how?	Did the clinic affect your life and health in any way? If so, how?
Tell me about a moment of frustration you had at the clinic.	Tell me about a moment of frustration you had at the clinic.
Tell me about the best moment that you had at the clinic.	Tell me about the best moment that you had at the clinic.
Are you going to stop coming to the clinic? If so, when?	Are you going to stop coming to the clinic? If so, when?
What could the clinic have done to serve you better?	How did you get along with the people working at the clinic?
What advice would you have to patients who are new to the clinic?	Are you getting addiction care now?
How did you get along with the people working at the clinic?	What happened to get you from the clinic to where you are now?
Who are the people who are helping you in your recovery?	Would you ever come back to the clinic?
	What could the clinic have done to serve you better?
	What advice would you have to patients who are new to the clinic?
	Who are the people who are helping you in your recovery?

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