Summary from STR/SOR Qualitative Interviews

This document provides a summary of the SOR Year 2 qualitative evaluation. The purpose of this evaluation was to gain a better understanding of the barriers and successes that SUD treatment centers that receive public funding encountered while implementing the Medication First (Med First) approach through the STR grant in Missouri.

Methods:

- Interviewed 21 individuals (e.g. executive directors, program coordinators, prescribers, peer support specialists, nurses, and people formerly in treatment under the STR grant) across seven STR/SOR-funded agencies in the St. Louis region.
    - Please Note: Interviews for this project were cut short due to COVID-19. Our sample currently lacks perspectives from individuals who had success with treatment under the STR/SOR grant as well as client perspectives from people of color. We hope to conduct more interviews to broaden our sample in the future.
- Conducted in-person, semi-structured interviews which lasted between 30 and 60 minutes.
- Used an automated transcription service to transcribe audio files from the interviews. Transcripts were reviewed for accuracy and edits were made as needed.
- Used Atlas.TI software to code and analyze the data. Two research staff independently coded each interview. Interrater-agreement was higher than 80%.
- We analyzed 65 codes across 10 overarching themes (see Table 1 in Appendix). ***The contents of this document provide a summary of each of the 10 themes as well as quotes to illustrate the sub-themes (i.e. codes).***

System Factors Group Summary

Collaboration among providers and across systems (outside of DMH) has increased since the beginning of the STR grant; however, any positive changes gained under STR/SOR will not be sustained if the financial reimbursement system does not change. Project EPICC has played a crucial role in connecting individuals to treatment and in increasing collaboration among agencies. Although moving to an evidence-based medical model for the treatment of OUD has resulted in positive treatment outcomes, costs related to medications and qualified staff remain a challenge for agencies. Providers recognize and are used to working within a financially strained system, but the shift to the MedFirst approach required unprecedented changes in both clinical practice and business model. Indeed, most agencies are currently NOT operating under a “true” medication first model due to lack of funding. To a certain degree, agencies were never able to go back to the way they were operating before the STR budget crisis in 2018.

Communication and leadership are key to successful implementation of these grants. Interviewees consistently mentioned challenges regarding lack of transparent communication from DMH and understanding the roles of different entities within the context of the grant. Further, there must be clear and united messaging from DMH and MIMH.

People had a lot of ideas about what future grants should address:

- More consultation with treatment agencies before decisions are made
    - Everyone from medical providers to financial staff should be consulted
- More funding for housing and transportation
- Increased methadone access (clear treatment deserts for methadone)
- More medication money
- Funding priority for high-need areas
- Improved aftercare
- Continued support for peers
    - EPICC expansion for non-OUD related inclusion

- Study milestones that “ring true with external validity around flourishing in recovery” (in other words, how do we get people to thrive, not just survive?)
- Continuation and expansion of Dr. Turner’s work
- Grant positions and roles must be thoughtfully assigned and defined (as to not create conflict of interest)
- Financial incentives for best practices across the system (not just within one grant program)
- Must continue working to improve the system through data-driven decision making and collaboration across care systems

Code Quotes

DMH “I think there was more communication cause we were all traveling together, right? For a year and a half. But without us being together and people communicating, I think there's times where each silo forgets with the other one does, and then the message becomes, well there is no clear definition or distinction of what Agency X does or MIMH or DMH or this program or this project. Some way of continuing to have some sort of, as painful as it may be, not an SUD work group, not a Coalition meeting, a SOR stakeholders meeting, just like in the one-on-ones, maybe have a quarterly or twice a year meeting to say, every agency, you get to bring two or three people, but just to keep us all in contact just to make...I feel like that's one thing, we've all gone back to our silos, as messy as it was in the beginning, it forced us to all be talking and working and thinking and figuring out things. Now that it's, it is what it is. Everyone's kind of back in their own silo, and how you break that down and how we get people reconnected. That'll be the push. Cause I don't believe the funding's going anywhere.” - Provider

Sustainability: “I cannot emphasize enough how important the sustainability factor is because we're not the only place that experienced that. It's been honestly a battle to kind of keep the doors open and keep the program functioning ever since. We had to let go of staff, we had to transfer somebody to another program. It's just, it's been tough. Yeah. And I think that trickles down to the clients because they can feel that it's sort of a, I don't wanna say a hopeless situation, but it was not at all how it was the first year.” - Provider

Care System “Communication between agencies maybe. Yeah, there's, I don't wanna use the word ego, but I think that maybe agencies could work better together. I was speaking with my boss about this yesterday too, is like there's, there's not a lot of communication between us coaches, for example, like us coaches and their actual treatment teams in the agencies. I send somebody to my [partner agency], I have much more access. I can get into our files and actually read notes and things like that. If I send somebody to say Treatment Agency X or Treatment Agency Y or something like that, it's all dependent on me being able to reach my coworker coach who works at that agency and ask them what's going on, you know? And they've got their own case load and that too. I think that's probably one of the big things is communication. Sure. It would be able to help a lot just in my own agency, is to be able to have more of a relationship with the, the wherever, CSS, whatever counselor or therapist at the actual agency about what's going on with the clients, you know?” - Peer

STR: “I think that lower barriers to treatment are super important because a lot of people previously would over-report things and be like, I am the worst ever. Um, but people would also divert a lot because they were like, I'm going to get cut off from my medication if I have a positive UA, which is not the case now, but previously it was. And so people were not correctly reporting to their doctors what was actually going on, just out of fear of losing treatment. So I think with STR and with SOR, people are more comfortable being honest with their doctors was is huge because a doctor can't help someone if they don't know what kind of help they need.” - Person in Recovery

Future grants: “This may sound overly negative, but I don't want it to be taken as such. I feel that there needs to be more leaders from medicine and the medication pieces of any grant coming forward….I mean, I love a good randomized trial, and I love a good Cochrane database cause it's good. But when we're extrapolating what we learned from that to how things work in the US or how it works in an underserved population or how it works in St. Louis from things we've talked about already, we need to make sure we're having not only the right message but the right messenger providing that message.” - Provider

Agency Protocol Group Summary

Protocols, both at the agency and program (STR/SOR) level, impact client experiences and outcomes. Protocols are complicated to develop and may not be well received by agencies or clients; education can help improve acceptance of and adherence to protocols. Specific areas STR/SOR protocols have developed:

- UDS
    - Are used as conversation-starters and to adjust dosages
    - Are seen as improving client outcomes by:
        - Increasing honesty about substance use
        - Increasing medication compliance
- Intake
    - Is highly connected to access to care & a source of frustration due to lack of capacity
        - EPICC helps by giving faster access to the highest risk clients
- Discharge
    - Financial concerns underlie many discharges and clients' anxiety about discharge
    - Planned discharges are considered successful, while unplanned discharges are considered unsuccessful
        - Reasons listed for unsuccessful discharge include dropping out of the program and not having the prescribed medication test positive on several UDSs
- Eligibility
    - Is mentioned when discussing problems transferring between programs (CSTAR to STR)
- Telehealth
    - Expands capacity both in STL and statewide
    - Is an opportunity for agencies to collaborate
    - May not produce the same quality of relationships between clients and providers as in-person visits but is still a necessary and growing component to the care system

Code Quotes

UDS: "And that's one of the things too, that when you create a respectful environment, people's brains, okay. One is environment and people's comfort with their provider and their team and knowing that we got your back and we're not going to kick you out for pot in your urine or whatever. Um, and if you have a positive screen, we're going to talk with you about it." - Provider

Intake: "We were getting 6,000 calls a week and that's like, within the last month, and just the screening, you know, of 6,000 incoming calls. And when you have services that don't carry a large margin, already we have three dedicated people that simply answer calls, try to return calls, enter in manual paper screenings by getting that information via email to try to increase efficiencies. It's, this is like a total focus point of ours and a priority all the time." – Provider

Discharge: "And then in December it was like, no, just kidding. There is a budget and by the way, we're going to make it retroactive for two months. Well, we'd been operating budgetless for all that time. We'd spent 50% of the budget we didn't know we had before the end of the calendar year. So we had to make 10 months' worth of treatment last on what was essentially supposed to be, what, six months' worth of money. Um, so we ended up transferring a ton of clients. Um, a bunch of clients who were being maintained on Vivitrol went off Vivitrol. A lot of clients were disengaged as a result of that. We had one client after it, he had been, transferred to [another agency] just for his Vivitrol. I'm not sure what happened that he was not maintained on Vivitrol after we discharged him. But anyways, six or eight weeks after everybody lost their money, he died of an overdose." - Provider

Eligibility: "As a peer and as a recovery coach, you can offer the immediate access because we have these allocated spots at all these different treatment agencies that no one has. You can't do that. You can't just call up, you know, your friend, unless it's, you know, the CEO of a major, uh, treatment agency and say, I need help now. Doesn't happen. It does with EPICC. EPICC is a golden ticket, so to speak, for lack of a better term. And it's a, you know, it's a, it's, I don't want to

say it's like a way of cutting in line, but it's a way of, uh, you know, recognizing the urgency, uh, for immediate stabilization using MAT from people that have just overdosed." - Peer

Telehealth: "We partner with over 30 sites around the state. What's been so exciting about this work is with this model, we can respond pretty quickly to the request for the medication piece. But then we work hand in glove with our partnering agencies, usually community mental health centers around the state. They can do the wraparound services like we mentioned earlier, the housing, the therapy, the, um, the social determinants piece. And what's been nice about this is it's really given a lot of agencies some time to ramp up services along a medication first model." - Provider

Agency Factors Group Summary

- STR and Medication First shifted some agencies' identities from one focused on abstinence only to one with more of a harm reduction mindset
    - Some agencies that cater to specific populations benefitted from this shift, while others are still struggling with it
- Hiring
    - Need for diverse workforce with culturally relevant knowledge of the population
    - Education and training begin in the interview for some agencies (should be the case for all agencies)
    - Difficulty finding potential employees with the necessary qualifications
    - Staff equipped to work with the population require higher salaries and frequently leave to take higher-paying jobs
- Workplace challenges
    - Continued stigma against MOUD and/or naloxone
    - High client mortality rate
    - Burnout
    - Staff turnover
    - Relapse of clients and colleagues
    - Shortage of waivered prescribers
- Characteristics of the typical population providers encounter
    - Those who are housing insecure, using multiple substances, co-occurring mental health disorders, IV drug use, more White than prior to STR
- Staff Training
    - Training is ongoing at most agencies
        - Provided through whomever they contract with for their EHR
        - Some agencies bring in local organizations for specific content trainings
        - Some agencies send staff to conferences (if they have room in the budget)
        - EPICC coaches can typically utilize training opportunities through their partner treatment agency
        - For peers in particular, self-care trainings are needed
    - Some agencies are collaborating with universities to educate future generations of healthcare providers
    - BASIC has a very comprehensive cultural competency training for their staff that other agencies could potentially benefit from
- Quality Improvement
    - Varies between agencies
    - Some larger agencies employ data analysts
    - Some smaller agencies have little to no capacity for quality improvement activities
    - Agencies tend to look at overall outcomes such as treatment engagement for their entire treatment population or occasionally for specific programs (i.e. STR)
    - Agencies often do not have the capacity to look at treatment outcomes based on specific diagnoses or demographics

- System factors
    - Lack of funding, particularly since December 2018, has resulted in capacity issues
        - Not everyone who wants treatment gets treatment
        - There are longer wait times for people seeking treatment (no longer immediate access)
        - Agencies have had to cut staff
    - Telemedicine helps expand capacity to communities with little or no access to a waivered prescriber
    - The larger population brought into treatment by STR/SOR have reduced community outreach because agencies are overwhelmed and have no need to seek out clients
        - People who are not aware of their treatment options or who face barriers like transportation are less likely to receive treatment
    - Data sharing across systems is limited despite frequent sharing and transferring of clients between systems
        - Agencies each have their own electronic health record that may or may not be compatible with other agencies' systems. This is a huge barrier for care coordination.
    - Need capacity to collect patient satisfaction data
        - Currently only seem to be collected from individuals who successfully complete treatment

Code Quotes

Hiring Practices: "We ask about beliefs, about philosophy. We ask beliefs about addiction in general and, and we try to minimize the risk of stigma associated with addiction and kind of start that education process even in the interview. And, you know, even we've started introducing stress mindset because when you have the high turnover and people find out this is stressful, what people do every day and serving this population, and now, when they're reversing overdoses and that's not what they went to be a therapist for…it's stressful. And so, so learning about how do we help shape and change the workforce's beliefs and thrive in that culture and that atmosphere then versus get beat up and burned out." - Provider

Capacity: "I think the impact was felt when, at least in the Eastern district, when we went from a two day waiting list to a three week waiting list. And that's not just us. That's everyone. And so that's when I think the impact started being felt as people were in the community, you know, how it goes, chirp, chirp, chirp, chirp, and then, in the recovery community. So everyone started talking quickly saying there's nothing we can do. There's nowhere to go" - Provider

Workforce Challenges: "And unfortunately, the people that need to be hired are very expensive, high licensed individuals who they just cost a lot of money and they want benefits. And we're competing with hospitals. We're competing with, uh, universities. I mean all these places that hire these high licensed individuals and when we're struggling to compete, so we have to offer salaries that compete with that, benefit packages that compete with that. So they want to come here and, and treat and we want the best of the best treating these people. We don't just want the people who barely survived med school, and they're coming through, and they don't know what they're prescribing." - Provider

Non- Medical Treatment Group Summary

- Transportation and housing cited as two of the most critical factors in success of harm reduction; treatment is only as successful as someone's ability to get there and maintain stable housing or shelter.
- People seeking to enter the STR program because they are housing insecure (not because they have OUD); providers express this creates issues when you have folks entering into recovery housing when "they aren't ready" and get cyclically kicked out of recovery housing and referred to another
- Need enhanced coordination between providers and partner agencies on client care coordination.
- Utilizing the client or patient's naturally built-in support system (friends, family, environment, etc.) is a way to build relationship with clients and maintain contact; peers and coaches serve as middle person between client and staff and are helpful in figuring out what each person's barriers to access are.

Spotlight on Housing:

- Housing and transportation are listed as the two biggest needs
- 2018 budget crisis created chaos in housing and lost clients/people kicked out of recovery housing
- Medication treatment is only as effective as the ability to maintain stable housing
- People dropping Medicaid to qualify for STR housing
- People utilizing recovery housing to address housing insecurity – people not ready to stop using, cycle of being kicked out of multiple houses → "burning bridges at recovery houses"
- Tension on provider's thoughts about time limits on housing (tied to finite resources between treatment and recovery budgets)
- Perceptions of people overusing housing and staying in STR housing too long/taking up housing for people "who really need it" vs perceptions of people needing a place to stay and recovery housing filling that need
- Safety in administering bupe; tension in abstinence only housing or agonist only housing → tapering of medications.

Code Quotes

Housing "I mean, SOR, a majority or I don't have an exact number, but I would guesstimate over 50% of our clients are in desperate need of housing situations. And so in that particular instance, when you are told, here's your Suboxone, here's your medication, go home and be sober, you're going to a park bench and trying to say sober on a park bench. And that is next to impossible. Um, so it obviously goes in hand in hand. Everybody already knows that the dollars seem to be supporting a lot of people. Um, but then again, it's just, it's not enough dollars." - Provider

Transportation: "I don't think there are enough services provided within, directly within the communities where it's needed. There's a lot that are sort of peripheral. Um, you know, but I have, we had clients at [our agency] who were by car 20 minutes away and by bus an hour and a half. And I cannot reasonably expect a client to get on public transportation in active withdrawal and go an hour and a half, one way, to sit at the doctor for five hours. It's just not going to happen. There has to be services within the communities that need them." - Provider

Peer Support "And the way that we fit into the overall system of care coordination is, is you're somewhat of a translator or a middleman between a client and a staff. And it's like, well, he's saying, or she is saying this to me, the client, and this might translate a little bit better if I, if I can speak clinically to these, uh, the people that they're working with. So you're kind of a glue that holds the client and the treatment team together in the same arena of, uh, care coordination." - Peer

Outreach: "I would rather go in and say like, here's this to stay safe for now. I'm like, when you're ready for treatment, let me know. And then building up those relationships and building that trust slowly with the people in the neighborhoods and things like that. Because it's not comfortable to be a person from a oppressed group going into a different space and a neighborhood, you know, nothing about to ask for help. And I know that that's overwhelming. So I would rather go meet people in the areas that they've already grown up in, that they already know where they feel safe. Um, and I don't see it as me like encroaching on other people's territory because no one else is doing this kind of work. So I'm perfectly fine with it. And it is literally a life and death matter." - Peer

Medications for Opioid Use Disorder (MOUD) Group Summary

Clients and providers had differing perspectives on medication for opioid use disorder (MOUD). Most former clients seemed to view buprenorphine as something to taper off of into abstinence, while most providers were receptive to MOUD as a long-term treatment. For many participants, MOUD was a necessary first step in treatment, stabilizing clients and enabling them to engage in other treatment modalities. Some commented that quick access to MOUD gave clients hope for recovery.

- Clients
    - Expressed ambivalence about MOUD, which many saw as another drug they were dependent on
    - Often sought detox rather than MOUD at admission but returned to opioid misuse after detoxing to treat withdrawal symptoms
    - Felt that too many comfort meds were prescribed and that, in housing, the visible effects of the medications induced cravings in those not taking them, damaging others' recovery efforts
    - Indicated that more methadone clinics are needed, as are treatment agencies providing MOUD access in north St. Louis City and County, for improved access
    - Questioned the benefit of buprenorphine for those primarily using fentanyl; one person suggested that methadone may work better for this population
    - Suggested that precipitated withdrawals might lead people to leave treatment and resume drug misuse
    - Mentioned that accountability (such as from drug courts or to meet requirements to maintain custody of their children) helped keep them motivated in treatment
- Providers
    - Indicated that most people working in the field support MOUD, but that there is the need for ongoing education about it
    - Discussed the distrust African Americans have of the healthcare system and indicated that Blacks do not want to be the guinea pigs used to find out the long-term consequences of using buprenorphine
    - Saw MOUD as enabling people to do the things they need to in order to live full lives
    - Found inadequate funding and staffing to be barriers to access
    - Stated that some housing managers are advocating for antagonist-only MOUD for residents
    - Expressed differing opinions about diversion, with some continuing to be concerned about diversion and others indicating that concerns about diversion have been overblown.
    - Were concerned with clients who only want the medication without psychosocial services; some felt clients should not be allowed to do so, and others were concerned with financing treatment for these clients
    - Acknowledged the importance of partnering with pharmacies with the ability to respond flexibly to clients' needs and to buy in bulk and provide lower medication prices
    - Advocated for policy changes at the state level to ensure that all providers are choosing to work with more affordable pharmacies

Code Quotes

"We need the medication money. I mean, we need it in meds. We need it in, um, the access to the, the medical providers. Um, you know, that that is what gets the person showing up for anything and not competing with the constant cravings to walk right out your door and not do anything different. So, you know, so that all serves as the foundation." Provider

MOUD Access: "I think for people to have more access to methadone clinics, um, this isn't really as much an SOR thing as just like a general St. Louis thing. But having a methadone clinic on the south side or within St. Louis city limits would be super helpful because there are so many people I know, um, that I interact with regularly who aren't on methadone because it's just too much of a hassle to get to the clinic." - Peer

Medication Initiation: "Induction is really pretty easy for the most part. And most of the patients here are familiar with precipitated withdrawals. They've done it before, the subs are out there on the street. You and I both know that it's flooded the streets, which is part of the reason for this program is getting buprenorphine products on the streets as opposed to the full agonist opioids." - Prescriber

Antagonist: "So those are kind of some things that I think have been very interesting is finding out how culture is among different programs because there's still too many either abstinence only transition housing or I call it antagonists only housing because sometimes I think the term antagonist and abstinent get conflated and nobody wins there either." - Provider

Agonist: "I think the biggest struggle that they seem to have faced is how do they ensure that people who are on bupe are taking their medication as prescribed, that it's not being diverted, that it's not being stolen. Um, like there were a lot of issues that I observed as a treatment provider with Suboxone and housing. Um, you know, people would lose their housing because they were caught selling their medication, things like that. Um, and I don't really know what the solution to that is cause you have to reasonably expect a certain amount of diversion is going to happen. But I know that that complicated things, and housing providers have struggled to figure out a system so that they're not obviously not taking people, but that they can have some degree of control over that" - Provider

Medication First Model: "The message that was received, by people in terms of the, the Med Only, which we know wasn't what we said, but I think the idea of the Med Only was a bit of a challenge. Being in the community and working with the stakeholders, I think there was also a lot of, uh, I don't want to say frus—frustration's a good word. There was a frustration that the only thing we were doing was bupe. And we came from PDOA, which was Vivitrol, Vivitrol, Vivitrol, Vivitrol, to all of a sudden flipping over to this bupe, bupe, bupe, bupe, bupe, which was fine for people who understood it. The rest of the community didn't get it. They had no idea why this was happening, who it was coming from. We went from a very robust Vivitrol program, which was fine, to this bupe only type of program, that's what people were hearing. – Provider

Withdrawal: "Yeah, I can't do the Suboxones or the Subutex. Subutex put me on the withdrawal, but not as bad as the Suboxones. But yeah, it's because of the fentanyl, I'm thinking. So I'm thinking it doesn't, I don't think it goes well with it at all. Cause most people, I've heard of them now that's been taking it, they went into early withdrawals and even waiting five days after, you know, not doing anything. So I don't think it works well with fentanyl. They need to find a different medication, methadone maybe. I don't know." - Person Formerly in Treatment

Taper: "It was, and that was the thing that was terrifying, to ever be just cold turkey off of methadone. I mean the horror stories were right and I didn't want to have to go through that, um, and so I made a conscious decision to go back to using rather than go through that hell." - Person Formerly in Treatment

Diversion: "You know, the dark side of this, the underbelly of this situation also, something we don't really like to think about or talk about, but it's, the reality is there, there's a fair amount of abuse of the situation, there just is….buprenorphine products are a vehicle of commerce, they are. And that's how some people afford their world out there, you know, and it's, it's discouraging when that happens, you know, that we're being used, we're being duped, providing, you know, we're just giving stuff away here. Um, so, uh, it can be a little bit frustrating when that, that happens. Um, but I suppose that's the price of price of, you know, being in this field, right. It's gonna happen. It's human nature. Right. Um, and if we can help more people than we harm, uh, in particular, we can help a great number more people than we harm. Uh, then it's, it's worth it." - Provider

Long-term medication: "Early on it was, okay, we really want you to do this for a four week rapid taper. Then you get to a washout week essentially. And then you get on Vivitrol and…or Naltrexone, and that's it. Now you're sober. Um, and so now, it's sort of trending of like, okay, well you're gonna take bupe for as long as you feel it's appropriate, and we're gonna, we're gonna consider that as you being sober." - Provider

Detox: "A lot of our calls are detox, they want detox. They think that's where you have to start. So our access specialists do a good job of, well no, let's, you know, we can get you in to see a doctor start you in outpatient. And that's really kind of where we've gone anyway, which is let's start you in outpatient, let's assess you, start you in outpatient, unless there's an all-out crisis. Because we do know just from history that people get better. They don't always believe that, you know what I mean? Um, and so no, they, they are pretty well-versed on that and trying to deter people from, you know, naming their own level of care or, you know, I can only do this many services or I can't do this on this day. Well, okay. You know, but we're not there anymore, so let's evaluate you and figure out, yeah, you go." - Provider

Pharmacy: "And I think a lot of agencies, at least in the Eastern district, have definitely made the move. Um, the $4 pharmacies are really the way to go. They're the ones who provide the max flexibility. They're the ones who have the

Saturday hours. They're the ones who have the ability to deliver if they need to. They're the ones who can bulk order. So the purchasing price is substantially lower." - Provider

Racial Inequities Group Summary

- **Barriers to access to care**
    - Current treatment/housing/RCC desert in North St. Louis – need to be meeting people where they're at – literally – because people who have been oppressed are less likely to feel safe/comfortable seeking resources outside their community. On the flip side, interviewees also discussed the prevalence of drug use in predominately Black communities and how people often feel they must leave their community to stay in recovery because there are too many barriers otherwise.
    - A major venue for access to care is through EPICC's emergency department outreach program. However, the cohort of individuals referred to treatment agencies are predominately White, likely because Black individuals may be less likely to call 911 for an overdose for fear of the punitive retribution. When the STR budget crisis happened, many agencies were only taking new STR clients through EPICC referrals, which thus directly impacts and disadvantages the Black community's access to care.
    - Outreach
        - Many people who have engaged in street outreach services mentioned that they didn't know help was available.
        - Wait times are already long, so they do not feel the need to outreach specific populations despite acknowledging there is a need.
        - Dr. Kanika is amazing and has been an invaluable addition to the consultant team, but she cannot be everywhere at once. Further, training to raise awareness about resources in predominately Black communities can only do so much when structural barriers remain in place (i.e. treatment deserts, wait times, etc.).
- **Treatment Provider's Role**
    - Hire more Black providers at treatment agencies
    - Agencies should use data to assess if treatment outcomes are equitable across all of the populations they serve (not just look at overall outcomes across their entire treatment population).
    - Provider Education: It may be that interviewers did not press interviewees to explain themselves; however, there seems to be a surface level understanding of the impact that racism plays in the Black community. When we asked about racial inequities, many people discussed the socioeconomics challenges in the Black community in St. Louis. However, for the most part people did not talk about structural and institutional racism that led to these inequities in the first place. Although many providers have attended trauma-related trainings, it seems there may be a gap in trainings specifically related to racism.
    - BASIC plays a unique role in the city of St. Louis. Their curricula, which focuses on Black identity and pride, is something that should be further explored. They are not part of the SUD coalition, and it seems they feel disconnected from the system in general.

Code Quotes

"I think hiring more black people at treatment providers, like at treatment agencies would be a start. Because the majority of the treatment providers are run by white people." - Person in Recovery

"And the people are suffering from survival fatigue... You got the people who are suffering, lack of cultural origin, not knowing who they are. Fighting every day, wake up in the morning, tired, go to bed, tired…. But they've got to be given an opportunity to see that there's hope. And, and they have to have mentors. They need mentors... you know, if we ask the person how you feel about you being Black man. Um, and I feel great. Tell me something about it. Duh. That's all we

get. Our job is to put on the videos, put on the tapes and start the dialogue so they can start developing a pride culture." - Provider

"It's not comfortable to be a person from an oppressed group going into a different space and a neighborhood, you know nothing about to ask for help. And I know that that's overwhelming. So I would rather go meet people in the areas that they've already grown up in, that they already know where they feel safe. Um, and I don't see it as me like encroaching on other people's territory because no one else is doing this kind of work. So I'm perfectly fine with it. And it is literally a life and death matter. So, you know, we can talk politics after you are revived, but like right now, here's what you need. Um, and all of the participants that I've met with mobily are like eternally grateful and are so thankful, and it's really rewarding, and it's really cool to be able to help people who feel like, and this is mostly true, that like they don't have resources available to them. Um, and as White people, I feel like it is our responsibility to provide the services that we already have for the people that we're taking care of to the people who are most vulnerable. And right now that's Black men." - Person in Recovery

"Each agency, inside and outside of the DMH umbrella, has their specific types of outreach they do. Some organizations distribute food and clothing, some spread religion. Because my role is purely as a harm reductionist and person in recovery, I provide treatment resources, harm reduction supplies and naloxone to places where I know they are needed. I can give people supplies they need to stay safer and information about treatment and the way Good Sam works, but I also have to recognize what I am not capable of. I will never understand what it's like to be a black person seeking recovery, and because I'm forthcoming about that with black participants, we have a mutual understanding for what I'm capable of. It takes time to build trust, but with trust, people tell their friends and loved ones about what services I can provide, and the numbers grow. Part of me not being a part of the neighborhoods that I enter is being seen as an expert or authority figure, regardless of what how much I tell people otherwise. I use that perception to tell people about how to use naloxone and what to expect after an overdose." - Person in Recovery

"Um, and part of it is, I hate to say this, when the demand for something is higher than those supplying it, you just kind of sit back. I didn't have to go and do any marketing work. I had to internally make sure everything was running well. We actually had to go pull marketing. We had to shut down marketing for recovery housing, to shut down marketing. So that's part of the issue. When we're we, we, we're all just kind of trying to figure out how we manage this line that's outside of our door. We weren't concerned about who is in the line. Um, again, I don't know if that takes a, a reallocation of dollars to say, these, this subset of dollars is specifically used to serve X. Um, but I think it's education. It's making a more concerted effort to reach out to those people in those communities. That's what we've heard. We're isolated. We're not met." - Provider

Client Experiences Group Summary

- Listening to clients and opening up trust between clients and providers is essential for getting people to be open and upfront about what is going on. Building provider trust and addressing the fear that being honest about using or life circumstances will result in being kicked out of treatment or recovery is important to making client feel genuinely supported.
- Provider Trust: Having trust in providers results in patients being more upfront and honest with them and being able to talk about what is going on versus being more afraid of testing positive and being kicked out.

  Note: More details from "Client Experiences" included under the MOUD Group Summary

Code Quotes

"Yeah, yeah. It was either, well honestly, I didn't even have a choice. Get sober. Kill myself. I didn't have enough balls to kill myself or enough dope. So yeah." Person Formerly in Treatment

SUD Trends Group Summary

- Increased presence of fentanyl, particularly perceived to be in “inner city” areas
- Fentanyl is being laced in multiple substances, not just heroin—large increase in the amount of meth laced with fentanyl (both knowingly and unknowingly by users)
- Significant increase in naloxone usage as well as education and training; however, some resistance and pushback from hospitals and EMS workers in prescribing and utilizing it based on the perception that prescribing folks Naloxone, especially frequently, is giving a “free pass” for people to use
- Meth use is on the rise again, in both rural and urban areas, and the medication first/harm reduction approach is not as developed for meth use as opioid use. More need for mental health/psychiatric treatment

Codes Quotes

Overdose/Naloxone: “We do overdose education and Naloxone distribution where we can, um, we've had a lot of pushback from hospitals for whatever reason. Politics, uh, make strange bedfellows. It might be the, the pharmacies in the hospitals or, or whoever, executives, who knows. But, uh, we have people also in NCAA and MIMH that are pushing back and, you know, going back to these top level decision makers and saying, what's going on? The only, I think 16 out of 18 hospitals we're partnered with do not allow us to distribute Narcan on campus.” - Peer

Fentanyl: “I don't know so much that the way people here are using it impacts that. I think what impacts it more is how those people use, like how long they've been using, how much they're using. We're starting to get a lot more people that are using a lot of fentanyl. So it's really hard to convince them to go through that withdrawal process. Cause everyone's afraid of those withdrawals. You never know what they're going to do. Am I going to be sick for two weeks and I going to be sick for a day? And it's hard to judge in those people to when they should start the Suboxone because we don't want to throw them into worst withdrawals and send them back to the streets.” - Prescriber

Meth: “For the people who are meth users, for instance, that's like another big population that we see. A lot of them are like, I don't need Narcan. I don't want Narcan. And they are very against keeping Narcan. They look down on opioid users as like, why are you using something that could kill you? But then there's also a much higher level of mental health needs going on with people who are using meth. Um, and it's kind of a, which came first, chicken or the egg kind of thing. Because if people aren't sleeping, obviously they're not going to be doing their best. Um, but we run into a lot of people who are new to meth use, who think that there are bugs in their meth that are crawling out of their skin. And like a lot of that is psychosis.” - Peer

Naloxone: “For people to know how to use Narcan, like especially people in early recovery who are still around people who might be using, having that knowledge and like actually physically having Naloxone on them, can be really helpful. In terms of anxieties around like, this person might die and making someone super anxious and then that person won't be like, okay, well I'm feeling horrible. What am I going to do to cover that up, I'm going to use. And so instead of that happening, like being able to provide real education around like how to stay safe, what laws are, things like that.” - Peer

Harm Reduction Group Summary

Acceptance of harm reduction practices has come a long way since the beginning of the STR grant in 2017. Initially, the biggest challenge for many agencies was getting on board with naloxone. However, now that naloxone is more accepted, some agencies have moved towards conversations about syringe exchange and safe injection. Many people still associate harm reduction solely with naloxone based on their answers to our question. We should further explore how to expand the conversation of harm reduction among treatment providers in Missouri. Expanding the scope of harm reduction may be challenging. One provider mentioned that it actually made sense that everyone got behind harm reduction because we have to keep people alive first and foremost; however, treatment agencies are inherently not interested in furthering the conversation around people who are not interested in treatment. Providers are interested in how to move beyond the conversation of “just keeping people alive” to how people can “thrive in recovery.”

As mentioned under the "RCC" summary, MoNetwork has been a leader in harm reduction in St. Louis and Missouri. Individuals who utilize the syringe exchange program talk about how it is much more common to see people using sterile syringes now they have access to the exchange program.

Code Quotes

"We support it [harm reduction], you know, I mean, I think that there's pockets of different beliefs about it, but I mean, from a Naloxone, I think that was a very early on year one, much larger challenge, in that. And I just can't, I couldn't even count the conversations I had with staff because there is a difference between saving a life, harm reduction, and treatment. And I think people wanted, they wanted both for every single person. And so I think that, the conversations, oh, my gosh, I mean it was, it was brutal, honestly, initially, on helping people understand that you can't ever get to treatment if you don't save the life first. You know what I mean? And so, I think today, it's much better than it was…Um, you know, and works with people where they're meeting them where they are, and our doc was fantastic with that, honestly. Um, but internally it was, I mean, people were like, you know, well that doctor, he's just enabling blah, blah. I mean, it was an interesting time. Um, and I don't hear those things so much anymore, so I know that's died down quite a bit." Provider

Recovery Group Summary

We heard the sentiment of "you have to want it" from a variety of providers, prescribers, and people in recovery. Due to capacity issues in both treatment and housing settings, there is a common theme about wanting to admit individuals who "really want to get better." How much of this sentiment is driven by capacity/funding issues?

The people most likely to talk about 12-step programs in a positive way are the people for whom it has been successful. Other than the people for whom it has been successful, most acknowledge that it's just one of many paths to recovery often used in conjunction with other treatment services. Some people mentioned that talking about drug use during meetings made them want to use again, and others talked about how some 12-step programs are not MOUD friendly.

RCCs have become valuable institutions for people in recovery and people in active use in the St. Louis area. They provide a safe, warm place with internet and food for some people to meet basic needs. While people are there, they learn about and start to engage in other services. MoNetwork specifically has provided an invaluable referral network to treatment providers, which did not exist to the extent it did before the STR grant began. The major challenge related to RCCs is the lack thereof in high need locations like North County. Although MoNetwork has begun mobile outreach in those areas, more work is needed to spread the word about resources and availability of treatment for the uninsured.

Code Quotes

RCCs - "I had no idea the impact and the reach, that harm reduction, that those in the harm reduction space and those with a harm reduction message could, the people they could touch…..that partnership with these guys has been unreal. So the RCCs, I think, are phenomenal. Their ability, at least what these guys have done [Mo Netowork], their ability to reach those that traditional treatment providers could never reach. I'm blown away by it." - Provider

Have to want it "I feel like wherever someone is the most successful, they're like, that was the best treatment center I went to regardless of what treatment center it is. Um, and I have been to a lot of different treatment centers, and I feel like it doesn't really matter where you go, like when you're ready, you're ready." – Person in Recovery

12-Step "Um, I've never been a real big NA/AA person. That just isn't my path. I don't know if it's because I was forced to do it through so many judges and courts and things like that, that I just, I don't know if it's the negative feeling that they have against people on MAT, or it's just sitting around me sitting around talking about getting high and get talking about drugs for hours on end. First thing I want to do when I get out of class is going to get high, you know? Um, but for thousands of people it does help and it does work for them. It just, that was just never mine. And that's one thing I like about this program is there are different options and, you know, there are different, different types of treatment." - Peer

Appendix:

Table 1. Codes		
Code	**Code Count**	**Group Total**
System factors	**5**	**243**
DMH	27	
MIMH	10	
CSTARs	18	
Sustainability	12	
Fiscal Viability	57	
Care System	43	
Pre-STR	8	
STR	34	
Future grants	29	
Agency Protocol	**22**	**82**
UDS	20	
Intake	15	
Discharge	11	
Eligibility	6	
Telehealth	8	
Agency Factors	**0**	**175**
Quality Improvement	7	
Staff Training	33	
Typical pop	11	
Typical day	7	
SUD field entry	3	
Hiring practices	3	
Agency Identity	42	
Capacity	35	
Workforce challenges	34	
Non-Med Tx Service	**38**	**282**
Housing	65	
Transportation	24	
Care Coordination	38	
Peer Support	49	

Employment	16	
Tx Planning	7	
Outreach	45	
MOUD	**24**	**234**
MOUD Access	17	
Medication Initiation	14	
Antagonist	26	
Agonist	33	
Prescribers	15	
Prescribing Barriers	2	
Medication First Model	16	
Withdrawal	11	
Taper	14	
Diversion	16	
Role of medications	4	
Long-term treatment	14	
Detox	25	
Pharmacy	3	
Racial Inequities	**53**	**78**
Cultural Competency	25	
Client Experiences	**38**	**60**
Provider trust	7	
Previous treatment experience	1	
Stigma	14	
Substance Use Trends	**11**	**115**
Overdose	30	
Fentanyl	28	
Meth	19	
Naloxone	27	
Harm Reduction	**26**	**26**
Recovery	**14**	**57**
RCC	16	
Have to want it	13	
12 Step	14	
New codes since we started:		
Stigma		
Telehealth		
Pharmacy		
Detox		