**Provider Perceptions of Medication for Opioid Use Disorder (MOUD) in Allegheny County Pennsylvania**

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**Highlights:**

* Community healthcare and social service providers have differing views on MOUD.
* Providers view MOUD as: 1) a transition to abstinence or 2) a long-term treatment.
* Providers have concerns about the quality of MOUD treatment.
* Further studies are needed to inform MOUD treatment protocols and clinical practice.

**Abstract:
Background:** Medication for Opioid Use Disorder (MOUD) has been shown to be a safe, cost-effective intervention that successfully lowers risk of opioid overdose. However, access to and use of MOUD has been limited. Our objective was to explore attitudes, opinions, and beliefs regarding MOUD among healthcare and social service providers in Allegheny County, PA, highly impacted by the opioid overdose epidemic.

**Methods:** As part of a larger ethnographic study examining neighborhoods in Allegheny County with the highest opioid overdose death rates, semi-structured qualitative in-person and telephone interviews were conducted with forty-five providers treating persons with opioid use disorders in these communities. An open coding approach was used to code interview transcripts followed by thematic analysis.

**Results:** Three major themes were identified related to MOUD from the perspectives of our provider participants. Within a variety of healthcare roles and settings, provider reflections revealed: 1) different opinions about MOUD as a transition to abstinence or as a long-term treatment; 2) lack of uniformity and quality control of MOUD, permitting discrepancies in care, and 3) barriers to entry and navigation of MOUD, including referrals as a “word-of-mouth insider system” and challenges optimizing timing of MOUD service access with patient motivation.

**Conclusions:** Even in communities hard hit by the opioid overdose epidemic**,** providers have differing views on the function and duration of MOUD. Understanding providers’ beliefs and current structural barriers can inform efforts to improve MOUD treatment and access in clinical practice.

**Keywords:** opioid, buprenorphine, methadone, naltrexone, MOUD, providers, urban, qualitative, community assessment

**Abbreviations:** Opioid Use Disorder (OUD), Medication for Opioid Use Disorder (MOUD)

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**1. INTRODUCTION:**

 The United States is in the midst of a fatal opioid overdose epidemic; nearly 70% of the 67,367 drug overdose-related deaths in 2018 involved opioid use (Centers for Disease Control and Prevention, 2020). Medication for opioid use disorder (MOUD), specifically buprenorphine and methadone treatment, has been found to improve multiple outcome measures, including lower rates of other opioid use, better treatment retention rates, and reduced all-cause and opioid-related mortality (Larochelle et al., 2019; Mattick et al., 2014; Schuckit, 2016). Naltrexone has also demonstrated lower rates of opioid use as compared to placebo (Jarvis et al., 2018; Krupitsky et al., 2011).

Although methadone, buprenorphine, and injectable naltrexone were approved by the U.S. Food and Drug Administration for the treatment of opioid use disorder (OUD) in 1972, 2002, and 2010, respectfully, wide-spread access has been challenging to implement. Of the greater than 2 million identified individuals with OUD in the U.S., it has been estimated that less than 7% initiate MOUD treatment. Moreover, of those started on MOUD, retention is only about 30-50% (Blanco and Volkow, 2019; Williams et al., 2018). Distribution of MOUD providers, healthcare engagement of those identified with OUD, and insurance restrictions are some of the reasons thought to contribute to the under-utilization of MOUD treatment (Blanco and Volkow, 2019; Mojtabai et al., 2019; Rosenblatt et al., 2015; Williams et al., 2018).

Prior qualitative work has demonstrated a multitude of barriers to MOUD treatment including access, environment, knowledge, and stigma (Finlay et al., 2020; Jacobson et al., 2020; Rawson et al., 2019). These studies have explored patient and provider opinions regarding MOUD in the context of specific healthcare settings, such as a hospital system (e.g., Veterans Affairs) or other healthcare organizations. Although other research has examined physician perceptions of MOUD, less is known about how urban community providers who provide services for persons with OUD -- in domains ranging from healthcare to social services -- perceive the benefits and detractors to patient treatment with MOUD (Livingston et al., 2018; Louie et al., 2019; Vogel et al., 2016). We set out to examine this issue in Allegheny County, Pennsylvania, a County that has experienced high opioid-related overdose rates (Allegheny County Department of Human Services, 2018b). Allegheny County, Pennsylvania contains the city of Pittsburgh and is home to two large healthcare delivery systems, over 20 hospitals, and many outpatient centers and clinics that serve patients with OUD (Simpson, 2015; U.S. General Services Administration, 2018). Many provide MOUD services. The objective of this study was to qualitatively explore attitudes, opinions, and beliefs of MOUD among healthcare and social service providers within the urban communities of Allegheny County, Pennsylvania.

**2. METHODS:**

2.1 STUDY DESIGN:

This study was conducted as part of a larger rapid-cycle assessment ethnographic study (Fitch et al., 2004; Stimson et al., 2006) of communities with disproportionately high opioid overdose death rates (Allegheny County Department of Human Services, 2018b; Spencer et al., 2020). The study was approved by the University of Pittsburgh IRB in June 2018 and a waiver for written consent was obtained. Eight communities in Allegheny County were selected for participation in the study based on opioid overdose death rates, geographic variation, and demographic diversity. Data collection consisted of interviews with community stakeholders (including local MOUD providers) and observations of community meetings and events addressing opioid use. An interview guide included the open-ended questions: what has been tried in your community to deal with opioid use and overdose, and what do you think is needed? A specific question was also added to interviews with healthcare/social service providers (See Appendix 1 for full interview guide): “When you identify a patient with a substance use disorder, what are the next steps?” The interviews were recorded and transcribed verbatim, and participants were given a study ID number and categorized by general community role/position to maintain anonymity.

In 73% of healthcare/social service provider interviews, this question led to further discussion about MOUD. This manuscript focuses on analysis of healthcare/social service providers’ interviews that mentioned MOUD and their related opinions, perspectives, experiences, concerns, and suggestions regarding MOUD.

2.2 SAMPLE:

Interview participants were recruited first by contacting individuals suggested and introduced by the parent study leadership team and then via snowball sampling (Patton, 2002). The leadership team was composed of representatives from community service organizations, the Allegheny County Health Department, the Allegheny County Department of Human Services, the City of Pittsburgh Mayor’s Office, and a collaborative partnership among several municipalities focusing on the opioid crisis. Interviews took place between 7/03/2018 and 5/03/2019. Participants self-identified in one or more of the following stakeholder categories: person who uses or used illicit opioids in the present or past, family member of a person who uses illicit opioids, government official, law enforcement official, school official, community member, or healthcare/social service provider. Among interview participants who identified as “healthcare/social service provider” were individuals who had medical, nursing, behavioral, social service, counseling, advocacy or other treatment/intervention expertise. For this analysis, we focused on interviews with 45 of these healthcare/social service provider participants which explicitly contained discussions regarding MOUD. All interviews were in-person or by telephone and used a semi-structured, open-ended format to allow participants to lead the conversation.

Most interviews were one-on-one with the interviewer and participant. There were three group interviews that included two to six participants, and these groups spontaneously formed due to the location and availability of participants (e.g. two healthcare providers from the same organization participated in the same interview). In sum, a total of 45 providers participated in 38 interviews used in this analysis.

2.3 DATA ANALYSIS:

For the parent ethnographic study, team members developed general preliminary codes from topic areas in the interview guide and applied these broad codes to all interview transcripts (Thomas, 2006). These codes were used to identify and categorize key topics/concepts addressed in the interviews. The team created a coding rulebook with definitions, rules, and examples for each code. Among these topical codes was MOUD which was applied to any mention of pharmacologic treatment of opioid use disorder broadly or naming of specific medications used to treat opioid use disorder such as methadone or buprenorphine. For the analysis presented in this paper, we focused on transcripts from healthcare and service providers that contained discussions of MOUD, and more detailed coding was performed using an open coding approach (Cascio, 2019; Glaser, 2016). Two research team members separately coded the first 3 transcripts included in our analysis, compared codes, and then altered, merged, and added codes to create a preliminary coding rulebook. This process was repeated with a new set of 3 transcripts until saturation -- no new codes related to content topics or categories were created. The final MOUD coding rulebook was reviewed with the larger study team and applied to all remaining provider participant interviews. We utilized Atlas.ti 8 as our data management and analysis software.

Once coding of all transcripts was completed, we performed thematic analysis to methodically explore and capture the meaning of the collected data (Braun, 2006; Vaismoradi et al., 2013). The codes were reviewed by the same two research team members to uncover patterns and categories, and relationships and interactions between categories were subsequently identified by four research team members to generate themes. These themes were longitudinally reviewed and refined by the study team. These themes were presented to the leadership teams in the context of the ethnographic data collected and members of the team noted that they rang true with their own observations and perceptions.

**3. RESULTS:**

 3.1 DEMOGRAPHIC CHARACTERISTICS

 A total of 45 healthcare and social service providers who provide services for persons with OUD participated in 38 interviews which specifically contained discussions of MOUD, and these 38 interviews were included in our analysis (see Table 1). Twenty-one participants identified as serving the entire county. Eleven participants indicated additional stake-holder categories including: a member of the community they serve, person with former opioid use/currently in treatment, and parent/spouse/child/family member of a person with OUD. The average age of participants was 43 years old.

3.2 QUALITATIVE THEMES

The following three themes were identified: 1) Disagreement in provider views regarding MOUD as a transition to abstinence or as long-term treatment; 2) Lack of uniformity and quality control of MOUD; 3) Barriers to entry and navigation of MOUD care.

* 1. **Disagreement in Provider Views of MOUD as a Transition to Abstinence or as Long-Term Treatment**

Throughout discussions of MOUD in clinical practice, an overlying theme emerged surrounding diverging views of the function and intent of MOUD. Providers often took a strong standpoint on two differing ideologies, and rarely did they discuss a more nuanced perspective on the central purpose and overall endpoint of MOUD. One perception of the role of MOUD was that it is a preliminary step to assist patients in reaching a primary objective -- to achieve abstinence from all opioid medications.

“I think [MOUD is] a good way to help somebody get through a process until they realize ‘wait a minute, this isn’t the right thing, it’s more negative than positive for me.’ It’s kind of a, keeps them in a neutral mode, so they’re at least surviving, they’re not OD-ing, and, that as long as they’re using it properly, okay, then, then when they’re ready, really ready for recovery, then they can move forward, and they have to do it cold turkey, they have to do it with meetings, peers that have been through it can help them through it, that’s the way it seems to be, the most sustainable is really been.”

In this perception, MOUD should be used for only a temporary and as short period of time as needed. Thus, continuation on MOUD is viewed as not ideal or even as a problem. This is illustrated in the following statement:

“Sometimes this medication becomes a curse...you have to take that Sub every morning…go to the doctors every month…you just want to live your life without these things every day…like [diabetics] have to take their insulin [every day].”

The other perception of MOUD’s role was that MOUD could be considered as a life-long treatment for a chronic disorder. Providers discussed their perceived views of patients’ opinions with respect to treatment goals and duration. Perceptions of patients’ beliefs and experiences almost always paralleled participants’ respective clinical practice ideologies.

“It’s a very individualized treatment. I have one guy who has been on it for 8-9 years and is doing really well. He doesn’t want to get off. He’s successful, and has a great life, but is afraid. He says, “I’m not sure I quite trust myself. If I got a really bad urge, would I, or wouldn’t I? Why risk it?”…There’s a move to viewing addiction as any other chronic illness. You would never cut off treatment for another chronic illness.”

With this perspective, providers worried that expecting MOUD to be temporary or only serving as a bridge to abstinence resulted in poor patient outcomes.

“They need to be on as long as they need to be on. If you push people off of methadone, or buprenorphine, they die. You do not push these patients off. You don’t.”

**3.4 Lack of Uniformity and Quality Control of MOUD**

Many participants perceived disparities in the quality of MOUD treatment within the community. The majority of participants attributed these discrepancies in care to differences among MOUD facilities and specific providers. They also acknowledged that differences in the pharmacological properties and regulations among methadone, buprenorphine, and naltrexone influenced variations in MOUD delivery. When comparing treatment centers (whether generalizing or specifically naming facilities) participants often cited perceived informal quality measures such as suspected physician profits and patient volume, insurance coverage, engagement in care, mental health treatment requirements, and licensure status of the facility. Overall, the lack of standardization among MOUD treatment centers and providers was believed to produce worse outcomes for patients.

“How many licensed facilities do [different areas] have? How many all-cash Subutex facilities do they have, and what are the overdoses in that ZIP code? If your treatment is different, in an area versus another treatment, then your outcomes are going to be different…But we tend to not talk about the treatment side, and it being related to the epidemic.”

Additionally, participants frequently mentioned the lack of a centralized, trustworthy, and freely accessible source to access information about MOUD providers and treatment programs. As a result, participants believed it was difficult for patients to assess the quality of different centers and providers, as well as discern which treatment option would be the best for their personalized needs.

“So, trying to help get a clear direction on how to take care of addiction is often -- there’s a lot of static that comes from on-line groups. So, I think it’s hard for a patient to understand: what I have; where do I go to get help; what’s the best help; and who’s made it? Who’s a good example for me? I don’t know how to clear that up, but that static makes it tough.”

Information available on the internet was not only viewed as challenging to navigate; it was also repeatedly perceived as unreliable.

““So, um, you know, the internet’s not updated…um, to prescribe Suboxone, you have to have the data waiver, and it’s public record who has that data waiver on their medical license. Um so anybody on the internet can find that, and post it, and say “Here’s the number on their license” that they’re prescribing this medication, but that’s not accurate.”

**3.5 Barriers to Entry and Navigation of MOUD**

Participants also described concern regarding numerous barriers to patients getting MOUD when they need it. The most commonly perceived barriers to starting MOUD care included “word-of-mouth” referral system and challenges relating to timing of treatment initiation. Participants discussed that MOUD centers/providers and patients were often connected with one another via informal recommendations. Although participants described various initiatives to develop a systematic referral process, they repeatedly returned to informal dissemination of information as the most effective means of patient outreach and initiation of care.

““We track things to determine where our marketing dollars should go and have found that word-of-mouth is the most common way that folks hear of us.”

Some participants perceived the unofficial system to be sufficient for community knowledge of MOUD treatment. However, others mentioned that the current system allowed for gaps in care because of its dependence on individual healthcare professionals who, in contrast to organizations, are more likely to have limited hours or change positions.

“You need to have…really knowledgeable case managers that have worked in this area before. Because you may not get that person on the phone again. You may not get them in front of you again. So having really knowledgeable staff, really knowledgeable about what resources are out there for them, being able to do things rapidly, intervene rapidly, because their window of wanting [help] might close too. So, you kind of have to [pause] get them when they are ready too. Yeah, so I think that is, that takes a lot of work.”

“I don’t think we are doing a good job of getting people into treatment and I don’t know where that comes, but somehow they are out there and they are not coming in and we don’t have a centralized way of getting them to the appropriate place. I don’t know if it is because the appropriate place doesn’t exist or we don’t do a good job of outreaching these people, but even now, with our Suboxone clinic, there was a change in the person who is the coordinator for the drug and alcohol program that we talk to, and they had a couple of therapists that changed, so I don’t know if that is why it has been slow.”

Participants also emphasized time-sensitive challenges of connecting patients to MOUD. Among obstacles discussed, participants mentioned the non-emergent structure of initiating MOUD within the medical system, as well as a critical period for treatment initiation that was largely dependent on patient motivation and engagement. Due to the limitations of regular clinic hours, many participants believed that the available services within the community did not fully correlate to increased patient access, as illustrated by the following statements:

“So I can give a patient a list of twelve methadone clinics, Suboxone clinics to call, and they can call and make an appointment in any one of them, they’re gonna get them in and they’re eventually gonna get treatment, but when they show up to our door, in withdrawal, struggling, wanting something immediately, I can’t always get them into detox, I can’t always get them something that’s gonna make them feel better and become invested in treatment.”

“It is being able to have services available for them when they need the services. Again, if someone has a heart attack at 4:00 pm on Friday afternoon, we send them to the cath lab and everybody comes in and does a cardiac catherization but if someone says at 4:00 pm on a Friday afternoon, I finally want to stop using, you know we are just like well, come back Monday. You know? We have the whole weekend we gotta get through now.”

**4. DISCUSSION**

In this qualitative study to examine providers’ perceptions about MOUD and challenges to implanting MOUD, we identified several important issues that may create obstacles for patients. First, providers had differing opinions about how to utilize MOUD: some felt it was a step on the road to sobriety and others felt it could be used as long-term treatment. In addition, there was a variety of concerns raised about the quality of MOUD treatment itself and the challenges inherent in entry into MOUD services.

 Our findings highlight that providers’ views on MOUD are similar to views on OUD services in general. Numerous studies have shown a long-standing cultural bias against treatment for OUD within the medical and non-medical system (Kennedy-Hendricks et al., 2017; Sells, 1977; Zweben and Payte, 1990). Negative perceptions of MOUD have also been shaped by a medical delivery system that fosters skepticism and mistrust of MOUD by the public, patients, and providers; this includes a lack of well-trained providers, regulatory barriers, and a societal preference for abstinence from all opioid containing medications (Hunt et al., 1985; Volkow et al., 2014). Although efforts have been made to address barriers to MOUD, treatment gaps are still prevalent and MOUD remains underutilized (Blanco and Volkow, 2019; Centers for Disease Control and Prevention, 2019). Our study expands on this literature base by demonstrating similar findings regarding MOUD.

Our participants’ differing views regarding duration of MOUD reflect a shifting opinion within the medical community concerning best clinical practices for patients on MOUD, and more specifically, buprenorphine (Bentzley et al., 2015; Fiellin et al., 2014; Martin et al., 2018; Substance Abuse and Mental Health Services Administration, 2018). Our interviews began less than four months following the release of the Substance Abuse and Mental Health (SAMHSA) Treatment Improvement Protocol (TIP) 63, which advised against arbitrary time limits on MOUD treatment duration and reported that “patients who discontinue OUD medication generally return to illicit opioid use” (Substance Abuse and Mental Health Services Administration, 2018). While TIP 63 acknowledged that treatment length could vary, the report emphasized that optimal results occur with maintenance treatment -- meaning as long as the medication “provides a benefit.” This is in contrast to previous approaches that utilized MOUD (most commonly buprenorphine) as a short-term treatment to be prescribed as tapered dosages (Martin et al., 2018). In fact, only two years prior to the release of TIP 63, an opioid treatment review article stated: “universal agreement on how long a patient should continue to receive maintenance therapies is lacking” and that physicians tend to vary from goals of one year to lifelong treatment (Schuckit, 2016).

In line with treatment review protocols during the time of our study, the majority of our participants did not readily identify a central source to dictate and regulate a “gold standard” of care. Instead, they frequently discussed differences in clinical practice and quality control. Prior studies have shown that provider education has influenced access to and use of MOUD (Huhn and Dunn, 2017; Levin et al., 2016; Sorrell et al., 2020). This suggests that broader dissemination of updated MOUD recommendations among a variety of healthcare and social service providers may promote better understanding of current guidelines and development of more uniform treatment practices.

While translation of evidence-based practices is essential, the cultural components of using MOUD as a long-term treatment versus a tool for abstinence should not be neglected. A recent study examining perceptions of MOUD in rural Appalachia found that abstinence-based treatment was more predominant in this “‘conservative’ culture,” and only a small subset of healthcare providers supported long-term use (Richard et al., 2020). The views of participants in our study may have been shaped by their urban environment and associated values, which may partially account for some providers in our study favoring MOUD as an indefinite treatment (Meyers 2009; Weinstein et al., 2018).

 Rather than focusing on the availability of MOUD services, participants in our study emphasized structural challenges for patients to enter and navigate MOUD care. Other studies have highlighted both limited MOUD services and infrastructure constraints as a significant challenge; however, our focused findings on organizational barriers may reflect the abundant healthcare landscape of the community we studied (Blanco and Volkow, 2019; Huhn et al., 2020; Jacobson et al., 2020; Matusow et al., 2013). Barriers discussed by our participants included the challenges of a “word-of-mouth” referral system; this “insider” system has been described elsewhere, as well (Hoffman et al., 2019; Jacobson et al., 2020; Saunders et al., 2019). Additionally, participant views regarding the time-sensitive introduction of MOUD reflect a larger discussion about critical periods for MOUD intervention and the need to develop healthcare initiatives to address this problem (D'Onofrio et al., 2015; Trowbridge et al., 2017).

 Our study had limitations. As with many qualitative studies, the sample likely did not represent all viewpoints. It is possible that healthcare and social service providers in other communities and regions would share different perspectives. Also, our healthcare and social service provider category was comprised of individuals with wide-ranging roles, and it is conceivable that specific subsets of this group (e.g., physicians compared to peer support specialists) may have different viewpoints that were not appreciated by analyzing their perspectives as a cohort. Even so, the points of view were consistent with other elements of our ethnographic observations and with other county initiatives describing barriers to accessing OUD treatment in the county (Allegheny County Department of Human Services, 2018a). Additionally, since the interview questions were broad and did not specifically focus on one type of MOUD, it was not possible to discern if the treatment modality (i.e., methadone, buprenorphine, and naltrexone) may have influenced participants’ opinions, and it is likely the different treatment modalities contain nuances that are not fully generalizable to all types of MOUD.

 Given the disagreement among study participants in the midst of evolving MOUD treatment recommendations, our findings provide a starting point for discussions among a variety of providers regarding differences in MOUD treatment in clinical practice, as well as highlight the need for broader dissemination of updated MOUD treatment protocols. Additionally, our work reveals limitations within some MOUD referral and delivery systems, which may be applicable to future clinical design and policy reform. Overall, our findings set the stage for larger studies within various geographic regions to better inform MOUD treatment protocols, policies, and clinical practice.

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**Contributors:** ST, JC, and KH designed the study and organized the leadership team. ST led data collection and interview conduction, and NP also conducted interviews. NP and AK coded and analyzed data with input from ST, JC, and KH. NP prepared the first draft of the paper; revisions were made by AK, ST, JC, and KH.

**Conflict of Interest:** None of the authors have any conflict of interest.

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| **Table 1: Participant Demographics** |
| Characteristic | Sample, N (%) |
| N | 45 |
| Age, years (median) | 43 |
| Female | 31 |
| Provider Groups |  |
|  Physician | 9 |
|  Nurse | 6 |
|  Administrator | 10 |
|  Peer Support Specialist | 3 |
|  Care Manager/Social Worker | 6 |
|  Counselor  | 3 |
|  Other\* | 8 |
| \*This category includes housing supervisors and paramedics. It also includes office staff members who were included in a group interview with non-specified clinical roles. |

**Appendix 1**

Interview Questions: Healthcare and Social Service Professionals

Please tell me a little bit about yourself.

Why were you interested in participating in this study?

How has the opioid epidemic impacted you, as a healthcare professional?

How long have you lived here?

Tell me a little bit about the community you serve.

What is the best thing about this community?

How have the patients you serve changed over time? (generally: jobs, demographics etc…)

What are your patients struggling with?

**What is going on in your patients in terms of opioid use and opioid overdose? (How has the opioid epidemic affected the patients and their communities?)**

Tell me what you have heard or think is contributing to the current problem of heroin and other narcotic use in the community you serve.

What has changed in the communities you serve due to opioid use?

What has been the impact on your patients and their communities of opioid use and opioid overdoses?

Other communities around the country are also struggling with this issue, what—if anything—makes the communities you serve different than other communities?

**What has been tried and what is needed?**

What has been done in the community to deal with the opioid epidemic? How is that working?

Is there anything else that has been tried, and how did it work/is it working?

What would you like to see addressed and how? (Where should efforts be targeted?)

What services do you think are needed?

How do people in your community get treatment for opioid addiction? (Can they get treatment when they need it? Explain)

Where do people in your community go to get treatment for opioid addiction? (How do they find out about where to go?)

**When you identify a patient with a substance use disorder, what are the next steps? Can you walk me through the process?**

**Follow up:**

**How do you asses the patient to determine what treatment options might be best for him/her?"**

**How do you introduce options (Inpatient, outpatient, medication-assisted treatment, etc.)?**

**Do you limit options based on certain factors such as employment or housing?**

**Who does the assessment for treatment options?**

**Do you use American Society of Addiction Medicine (ASAM) or the PA Client Placement Criteria (PCPC)?**

**Now, I want to talk with you about what other communities are trying in dealing with the opioid epidemic and how you think these could work.** There are several programs some communities are trying out to try to prevent overdose deaths from heroin and other opioids.

One is the program to make naloxone—which the medicine that reverses the action of narcotics and thus can save people who have overdosed on opioids from dying—easy for everyone to get. What are your thoughts about this? What are your concerns? How would this something like this work in your community?

Another program allows addicts to exchange used syringes for new ones, as well as receive wound care and resources about treatment and other services. In some communities Prevention Point has a site that provides these services, while other communities are reached by a mobile outreach van at set times. What are your thoughts about this? What are your concerns? How would this something like this work in your community?

Another program focuses on creating sites that folks are calling “safe use sites” where addicts can get clean needles, use where there is naloxone right there in case of overdose, and where addiction treatment resources and information can be provided. What are your thoughts about this? What are your concerns? How would this something like this work in your community?

What other ideas for dealing with this problem have you heard about? What ideas do you have for this?

**Perceived barriers** (e.g., legal or policy) and are they actual or perceived barriers. (For example, perception that if you go for treatment, you will be reported, and your kids will be removed.)

What do you think are barriers to dealing with the opioid epidemic in your community?

**Perceived facilitators**

What help do users need while they get treatment?

What else can be done for individuals who are not in treatment?

What is needed to prevent overdose?

What is needed to prevent initiation of use/addiction?

What other things should we know about this topic that we have not yet discussed?