AN ANALYSIS OF THE BEHAVIORAL HEALTH LANDSCAPE

Wichita-Sedgwick County

May 2024

STEADMAN GROUP, LLC

Introduction

Kansas, alongside numerous other states, has reached settlements with various entities involved in the production, distribution, and marketing of prescription opioids to resolve thousands of lawsuits nationwide linked to their involvement in the opioid epidemic. The agreements include a broad and non-exhaustive list of eligible opioid remediation expenditures and also mandate the establishment of an advisory committee in each state to oversee the allocation of settlement funds. In 2021, the state of Kansas and 205 local government units within Kansas endorsed and became part of these nationwide settlements. The Kansas Fights Addiction Act (KFA) was enacted by the Kansas Office of the Attorney General (AGO) to ensure that funds recuperated from opioid litigation are channeled toward addressing the opioid epidemic effectively in communities across the state.

The Act stipulates that Kansas opioid settlement dollars should be allocated into two distinct funds: 75% are directed to the Kansas Fights Addiction Fund (KFAF), while the remaining 25% are allocated to the Municipalities Fight Addiction Fund (MFAF). As of December 2023, the Kansas AGO has recovered or anticipates recovery of more than $340 million from litigation settlements. Settlement payments, many of which will be frontloaded, will be made to the state for as many as 18 years. Sedgwick County received $1,307,221.44, and Wichita received $1,315,025.75 through the MFAF in 2023. Combined, the city and county expect to receive ~$15,500,000.00 over the duration of the settlement (Sunflower Foundation, 2023).

Excitingly, Sedgwick County and Wichita have joined forces to tackle the opioid crisis within their communities. As the first city and county in the state to collaborate in this way, the local governments are pooling their funds to develop a strategic plan for spending their allocations of the settlement dollars. In early 2024, the city and county formed the Wichita-Sedgwick Opioid Settlement Consortium (WS-OSC), including elected officials, subject matter experts from across the behavioral health continuum, and people with lived experience of substance use in the community. The purpose of this review is to equip the WS-OSC with the information needed to identify gaps and effectively address substance use disorder (SUD) treatment, recovery, and prevention in their communities. Insights provided through rich qualitative analysis in conjunction with a secondary data analysis of available quantitative information offer a comprehensive understanding of the current opioid landscape in Sedgwick County and facilitate informed strategic planning for the WS-OSC.

Methods

For this data analysis, Sedgwick County and the city of Wichita contracted with The Steadman Group, a woman-owned health and social services consultancy tenaciously improving people's health and well-being. All research, findings, and recommendations hereafter are representative of the work of the Steadman Group and do not represent the perspective of the City and County.

This data analysis utilizes a mixed methods approach and provides a comprehensive understanding of the behavioral health landscape, with a particular focus on Opioid Use Disorder (OUD) in Sedgwick County, Kansas. Triangulating qualitative and quantitative data sources allows for a comprehensive interpretation of the findings that captures the complexity of SUD in Sedgwick County. The report includes recommendations based solely on findings from this analysis. The recommendations will provide the foundation for a WS-OSC opioid settlement strategic plan, which WS-OSC members will build upon using their subject matter expertise and experience in the community. This process will result in an evidence-based and locally tailored plan for addressing the opioid epidemic to be submitted to City and County elected officials by the end of 2024.

Quantitative Secondary Data Analysis

The Steadman Group collected secondary data from existing sources relevant to the SUD landscape in Sedgwick County, Kansas, such as dashboards, reports, and databases. This information provided context and supplemented the primary qualitative data. The decision to use Johnson County as a comparison for quantitative analysis stemmed from its similarities to Sedgwick County in population makeup, size, and geographic location in Southern Kansas. Utilizing Johnson County as a comparison enriches the understanding of SUD dynamics within Sedgwick County by revealing insightful parallels and contrasts. Quantitative secondary data were examined from the following sources:

- Kansas Overdose Data Dashboard from the Kansas Department of Health and Environment
- Prescription Opioid Dashboard from K-TRACS Database
- Sedgwick County Drug Misuse Statistics Dashboard from the Sedgwick County Health Department
- NORC's Recovery Ecosystem Mapping Tool
- Oxford House Lists for Recovery Residences
- Kansas Department for Aging and Disability Services (KDADS) data

Qualitative Data Analysis

From February through April of 2024, a total of four focus groups and 15 key informant interviews were conducted with the following population groups:

1. People who use drugs (PWUD) and those with lived experience of substance use (PWLE)
2. Peer recovery specialists or nonclinical behavioral health providers
3. Clinical behavioral health providers
4. Law enforcement, EMS, Fire, and Judicial
5. Community Providers such as social workers and family service providers

The Steadman Group conducted two focus groups at the WSU Community Engagement Institute, and another two at the HealthCore Clinic. All focus groups took place in person. Five focus groups and 15 interviews were conducted, with participants self-identifying across the five populations mentioned above. We conducted interviews in various settings, depending on the participant's preference, including in person, a phone call, or a virtual meeting over Zoom. All participants with lived experience who were not city or county employees received a $30 incentive for their time.

We asked interview and focus group participants ten questions, each with a few additional probes and minor tailoring to the specific population. Questions focused on the following topics or themes:

- Existing resources and gaps in the community about behavioral health
- Common barriers faced by those seeking services
- Aspects of the behavioral health system that are working well
- Aspects of the system that need improvement
- The most disproportionately impacted and underserved populations
- The most immediate needs to address and issues that should be prioritized
- Potential challenges to the successful development and implementation of the strategic plan
- The best ideas for addressing the gaps and challenges mentioned above

Using a deductive analysis approach, we annotated all conversations and analyzed data for key insights per theme. Findings were first organized by population group and then consolidated to reveal the most relevant, repetitive, and important takeaways across all populations per theme.

Quantitative Findings

Demographics

Sedgwick County, home to Kansas' most populous city, Wichita, boasts a resilient and diverse community that urgently needs increased investment in behavioral health. Data from the latest US Census and American Community Survey for the county indicate elevated levels of adverse health determinants, heightening the risk of SUD and overdoses.

Residents of Sedgwick County are exceptionally uninsured (12.5%), impoverished (15.7%), and Hispanic/Latino (16.1%) compared to the state averages (10.3%, 12%, and 13%, respectively). Based on ACS 2015-2022 data, almost one-fifth (15.1%) of this region's households are "linguistically isolated," meaning that these homes have no proficient English-speaking adults. The majority of these families speak Spanish at home.

Sedgwick County is the home of Kansans who are significantly more likely to lack insurance coverage, have a history of justice system involvement and incarceration, identify as

Hispanic/Latino, be uninsured, and experience poverty. All these demographic characteristics indicate that City and County residents are at high risk of substance use disorder (SUD), mental health conditions, and overdose.

Social Determinants of Health in Wichita - Sedgwick County

When examining the unique social determinants of health across communities in Sedgwick County and Wichita, inequities in access to insurance, housing, race, healthcare access, transportation, and economic opportunities are unveiled. These disparities not only impact general health outcomes but also exacerbate challenges in addressing substance use disorder (SUD) effectively within these communities.

According to the annual Point-In-Time (PIT) Homeless Count for Wichita-Sedgwick County in January 2023, 702 persons were identified as homeless (living in emergency shelters, transitional housing, a safe haven, or on the street), highlighting that homelessness affects children (18%) and adults (75%). Considering gender, race, and ethnicity, the majority of homeless individuals identified as male (70%), white (64%), and non-Hispanic/Latino (77%). Important to note, the PIT count found Black/African Americans as the second most common unhoused race, at 25% of all surveyed. Yet only 9.6% of the total population of Wichita identifies as Black, representing a massive overrepresentation among the unhoused population. Since 2019, the number of unsheltered persons, those who don't have access to any shelter, has nearly tripled - from a count of 57 in 2019 to 150 persons in 2023. The United Way Social Determinants of Health Dashboard attributes 14% of households in Wichita to severe housing conditions (overcrowding, high housing costs, or a lack of kitchen and plumbing facilities). Furthermore, the median household income in Wichita (~$56K) is significantly less than that of the state (~$64K).

Exasperated by the rates of homelessness in the City and County, in 2023, the annual average daily population (ADP) of individuals jailed in Sedgwick County was 1,312. Correctional facility data trends suggest that in recent years, the total jail population has been decreasing (down 37% since 2018). However, 39.87% of released people are rearrested within 180 days, and 60.36% are rearrested within two years of release. These statistics underscore the complex challenges facing Sedgwick County and emphasize the importance of strengthened support systems to address issues of homelessness and recidivism effectively.

An analysis by the Kansas Health Institute (KHI) of data from the 2018 American Community Survey by the U.S. Census Bureau reveals that racial and ethnic minorities in Kansas face higher uninsured rates (15.2% compared to white Kansans (6.6%). Notably, Hispanics exhibit the highest likelihood of being uninsured, at 21.7 percent. In a more recent estimate of uninsured rates for the population, from the US Census in 2021, approximately 10.1% to 15.0% of individuals in Sedgwick County are uninsured.

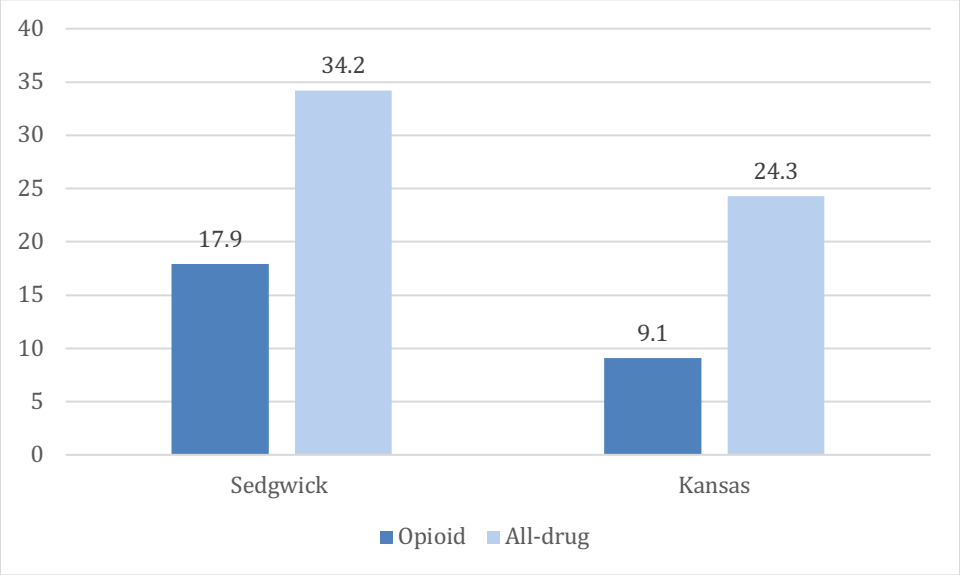
According to United Way (2023), the infant mortality rate in Wichita (7.3 per 1,000 births) and the rate of food insecurity (11%) are comparable to that of the state (6 per 1,000 births and

10%, respectively). An estimated 6% of households in Wichita do not have a vehicle, and 18% of adults in Wichita do not have access to exercise opportunities. High school graduation rates in Wichita are far below the state average - with 20% of students not graduating in Wichita compared to 11% in the state. Social support and community engagement are critical for improving the health and well-being of people with SUD - 14% of the population in Wichita is living independently with a disability, which can cause financial, physical, and social limitations.

These rates reflect quality and access to care, public health practices, and socioeconomic conditions. When risk factors are analyzed concurrently, it is identified that 20% of individuals in Wichita experience three or more risk factors related to demographics, socioeconomic status, and housing. This highlights a pressing need for comprehensive interventions addressing the interconnected challenges of SUD, poverty, housing instability, and other social determinants of health.

Behavioral Health Needs

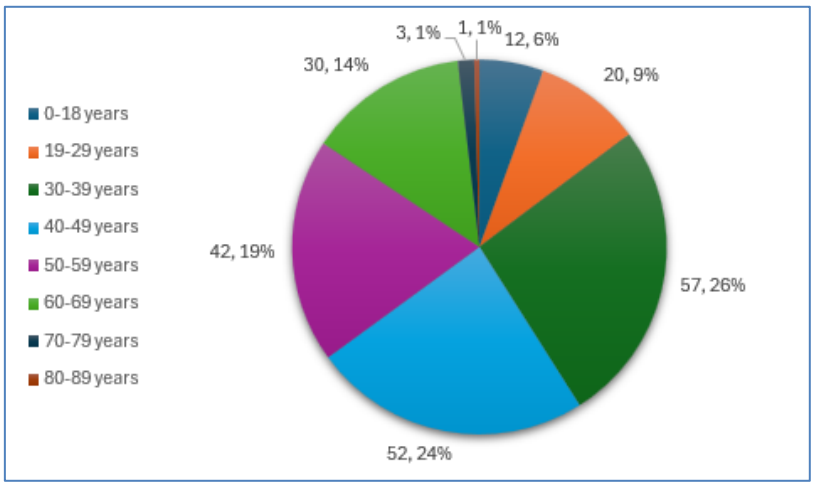
Recent data from Kansas in 2022 discloses that the age-adjusted rate of overdoses involving all drugs across the state was 26.2 per 100,000, while for opioid-related overdoses, it was 17.3. County-level data (Graph 1) reveals that Sedgwick County experiences higher rates of both all drug overdose deaths (34.2) and opioid-associated[1] overdose deaths (17.9) when compared to the state (24.3 and 9.1, respectively). Shockingly, from 2015 to 2020, drug-associated[2] deaths by Sedgwick County residents increased by 91%.



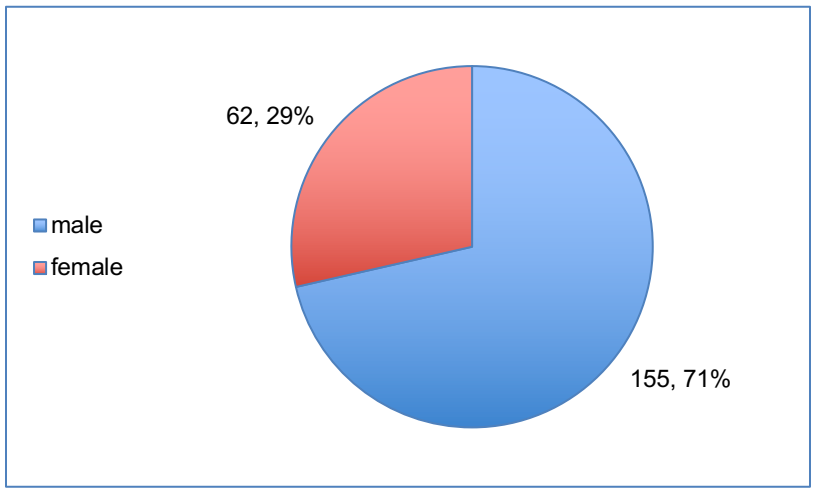
Graph 1: Age-adjusted rate of all-drug and opioid overdose deaths per 100,000 (2020-2021)

Graphs 2, 3, and 4 represent the demographics in Sedgwick County that are most affected by substance use disorder (SUD).

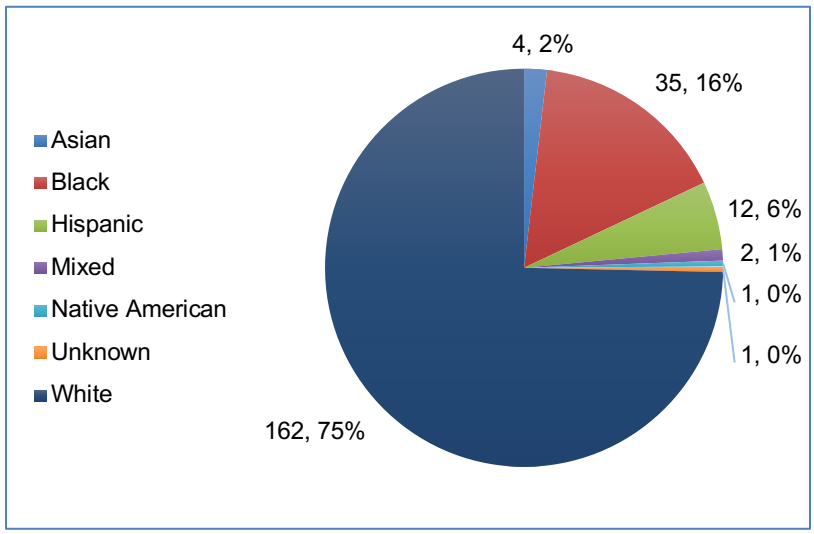
[1] KDHE defines 'opioid-associated' as deaths or emergency visits for illicit and prescription opioids.
[2] KDHE defines 'drug-associated' as deaths or emergency visits for cocaine and stimulants.



Graph 2: 2023 Counts of Drug Overdose Death by Age



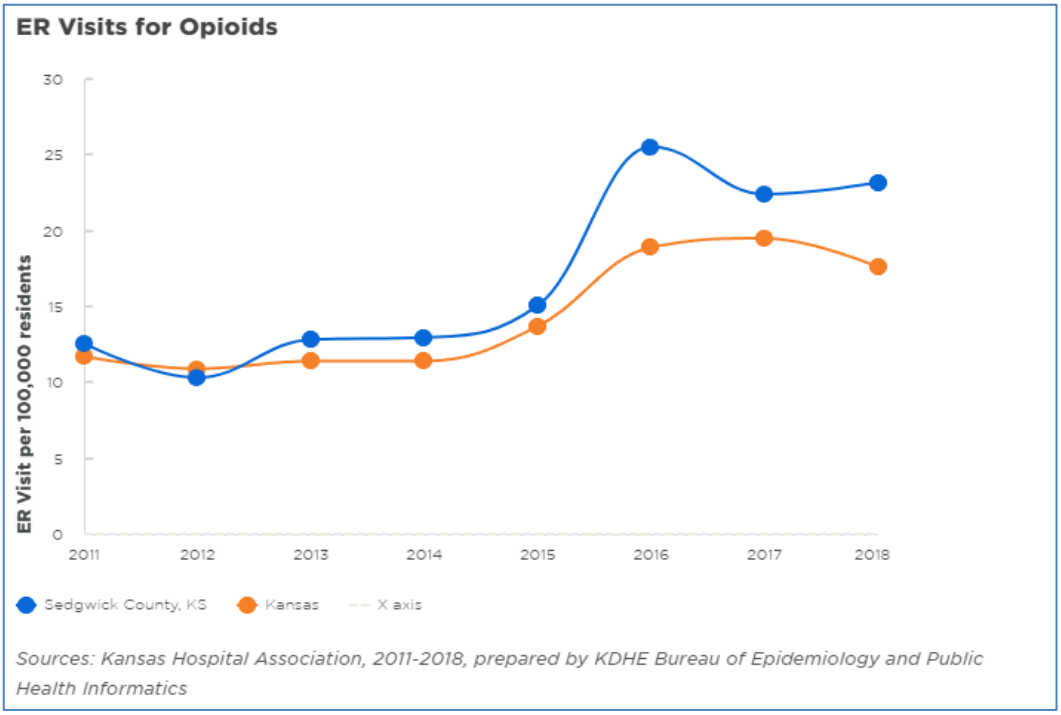
Graph 3: 2023 Counts of Drug Overdose Death by Gender



Graph 4: 2023 Counts of Drug Overdose Death by Race

Accordingly, those aged 30-49, males (71.4%), and white individuals (74.6%) experience the highest rates of opioid overdose in the region. Black individuals (16.1%) and people between the ages of 40 and 49 also experienced notably higher rates of overdoses than other population groups.

In 2023, Sedgwick County saw much higher overdose emergency department admissions for all drugs (140) and any opioid (32) compared to Johnson County (83 and 13, respectively) per 100,000 population. Data from KDHE's Overdose Data Dashboard (2022) highlight that 70% of all non-fatal drug overdose emergency department visits were by people between the ages of 14 and 44, with the highest rates in the 14-24 age group.



Graph 5: Emergency Department Visits over time for Opioids

Data from 2022 highlights a concerning trend in Sedgwick County, where the rate of opioid prescribing per 100 individuals was substantially higher at 73.91 compared to 39 in Johnson County and 61 across the state. This elevated rate indicates a potentially risky prescribing environment within Sedgwick County, which can significantly amplify the risk of overdose morbidity and mortality in the region.

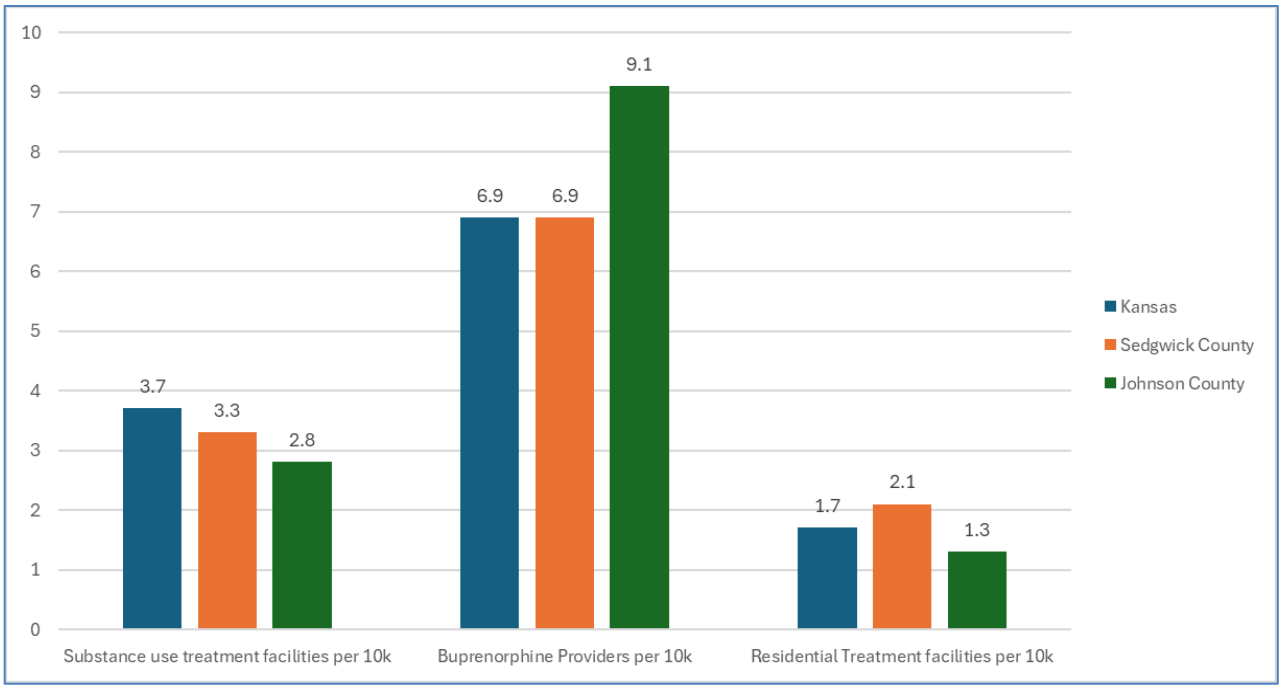
Disparities in ER visits, prescribing behavior, and high rates of opioid-associated deaths in Sedgwick County highlight an intense need for effective and evidence-based behavioral health interventions for SUD.

Behavioral Health Resources and Gaps

Sedgwick County needs increased community-based capacity for behavioral health, harm reduction, and recovery resources, as Graph 6 below illustrates. One measure of treatment

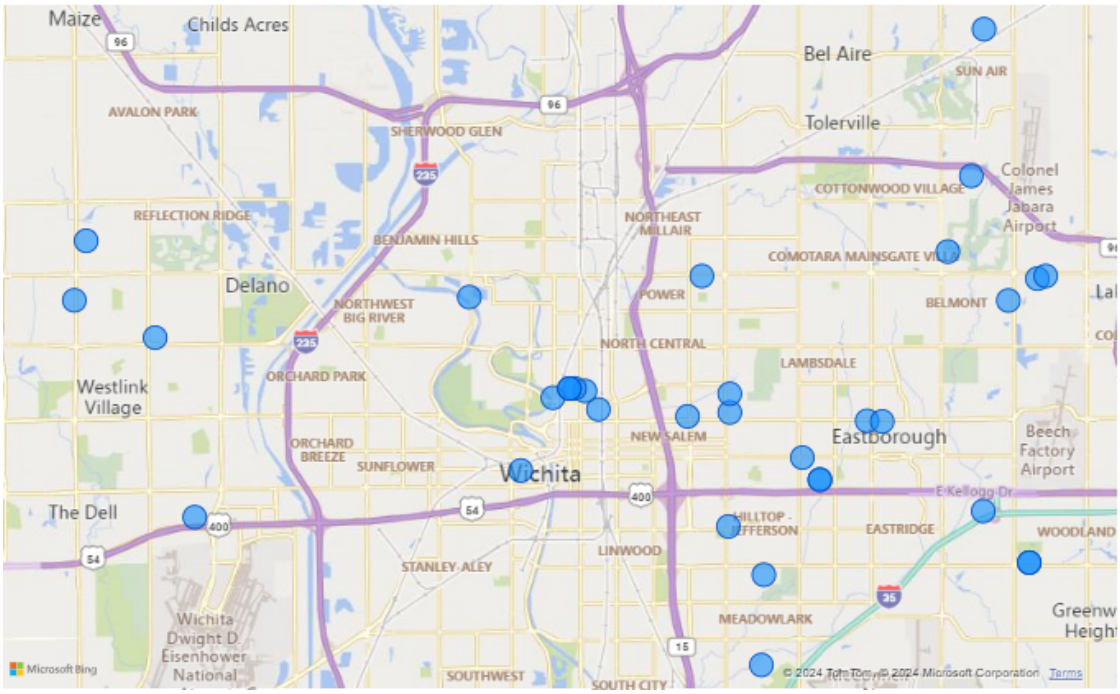
availability is the number of buprenorphine prescribers. Buprenorphine is one of the two most effective medications for opioid use disorder. Despite being the second-most populous county in Kansas, there are significantly fewer buprenorphine providers in Sedgwick County (6.9 providers per 10K population) than in Johnson County (9.1). The average distance to the nearest syringe services program (SSP) in Sedgwick County is 177.7 miles.

Graph 6: Substance use treatment facilities, buprenorphine providers, and residential treatment facilities per 10K in Kansas, Sedgwick, and Johnson Counties, 2023

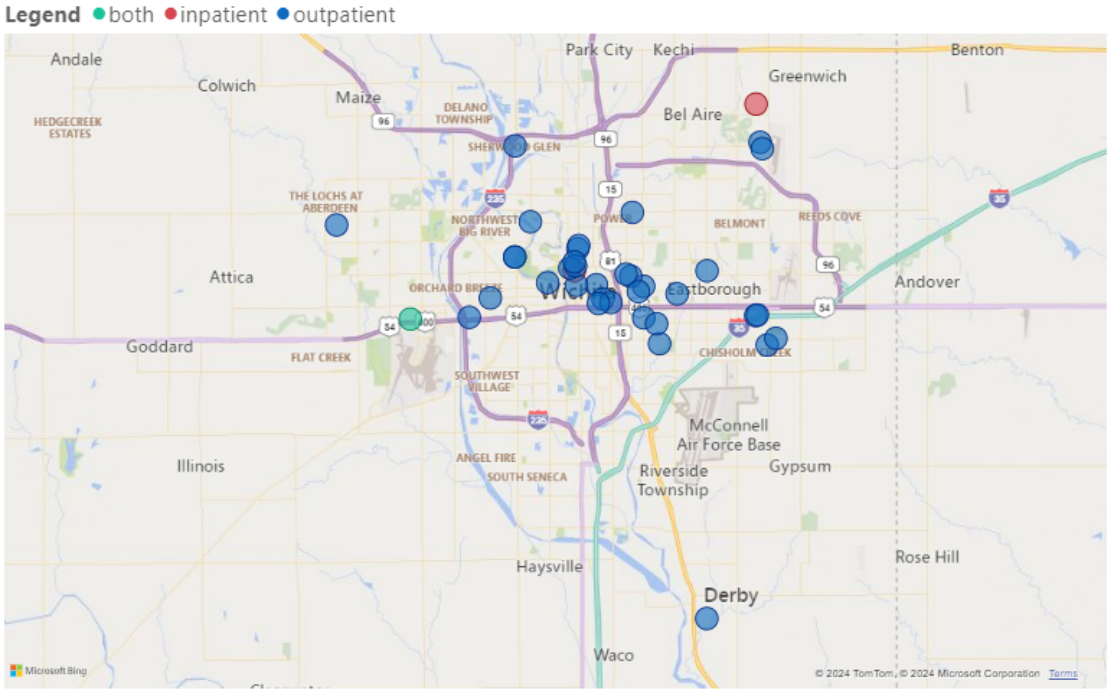


The other effective medication for OUD is methadone, which is only available for OUD treatment at facilities called opioid treatment programs (OTPs). Notably, Sedgwick County houses only three opioid treatment programs (OTP), all concentrated closely together in Wichita. Unsurprisingly, most of the counties' SUD program locations are also concentrated in Wichita (Maps 1 and 2). SUD programs include both inpatient and outpatient programs. Given that surrounding counties lack any providers of medication for opioid use disorder (MOUD), it's likely that people from these areas are also seeking services in Sedgwick County, further intensifying the demand for comprehensive SUD treatment resources across the county.

Map 1: Methadone (OTP) & Buprenorphine Treatment Locations, Sedgwick County



Map 2: Substance Use Disorder (SUD) Programs, inpatient and outpatient



Qualitative Findings

Demographics:

Demographic information of focus group and interview participants were collected retroactively and are not a complete or accurate representation of all individuals involved in this effort. Nonetheless, of the demographic information collected, ~63% of participants identified as male, while 37% identified as female. ~63% of participants were white, 19% were Black, and the remaining 18% selected unknown as their race. Ages ranged from 33 to 65, with an average age of about 48. Lastly, 36% of participants self-identified as being in recovery from substance use disorder. Nearly 55% shared they had lived experience to substance use, either themselves or through a family member or friend.

Results:

Six key themes emerged from the eight topics discussed across all focus groups and interviews. Key insights from each theme are outlined in detail below. Following the qualitative results are recommendations based entirely on findings from the report for WS-OSC to consider as the foundation for their strategic plan.

Theme One – Aspects of the System Working Well

Multiple population groups identified seven different areas or aspects of the system as working well. The first and most commonly referenced strength of the current behavioral health system in Wichita and Sedgwick County were **"recovery groups,"** or supportive programs run by people in recovery from SUDs. Mentioned across all population groups, participants shared multiple specific options available to people seeking or in recovery throughout the community, including AA, NA, Unity Recovery, and The Phoenix. Most groups mentioned provide non-clinical peer recovery support and sober social activities.

The clinical and nonclinical providers and justice system/crisis response groups also cited **Sober Living** or recovery housing as a strength. Two of the three groups referenced a strong network of Oxford Houses throughout the community. The Oxford House Model provides housing and rehabilitative support for adults who are recovering from alcohol or drug use and who want to remain abstinent. Each house is self-governed and does not employ professional treatment staff. In addition, clinical providers discussed a unique communication channel created and utilized by recovery housing staff and peers called "Reaching out," which uses a group phone chat to allow staff from all sober living communities to share resources and experiences.

Although cited as a gap in the community, interview and focus group participants across three population groups (PWUD, nonclinical providers, and community providers) also expressed that **harm reduction** was working well. The grassroots organizations Safe Streets and Positive Directions were explicitly called out as doing good work and increasing access to overdose

reversal medications, harm reduction education, and testing strips. Community providers also commended law enforcement for commonly carrying naloxone.

Cited with the same frequency as harm reduction, **high-quality treatment providers** also emerged as a strength of the current system. Specifically, participants shared that the current treatment providers serving the community are dedicated, creative, and resourceful. Clinical and non-clinical providers gave residential treatment providers additional credit. Important to note here is that the majority of high-quality providers are only accessible to insured or high-income individuals, leaving a major gap for the uninsured and low-income populations.

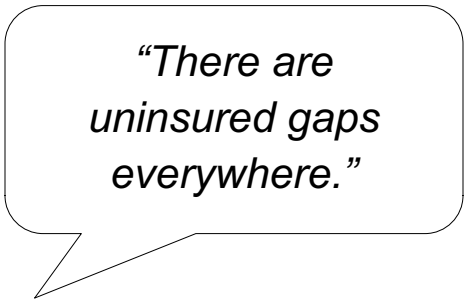
60% of population groups mentioned a **willingness to collaborate** as an additional strength or positive of the current system. Clinical providers highlighted that coalitions in the community are robust in different areas and work well together. They also said that law enforcement and the government are willing to come to the table alongside behavioral health subject matter experts and discuss solutions. One provider said it best when they stated, *"We are not afraid to get together and try to figure out a problem."* Additionally, community providers highlighted the strength of community organizing across Wichita. At the same time, justice system/crisis response discussed how community groups and coalitions are coming together to address the silos common across the behavioral health system in Wichita and Sedgwick.

Two final strengths highlight specific programs within the community that are working well, although only two population groups shared them. The first is the **Substance Abuse Center of Kansas (SACK)**, which received praise from clinical providers and community partners for their post-discharge support. Likewise, **Integrated Care Teams (ICT)** were discussed by clinical providers and justice system/crisis response as a strength. ICT is a co-responder program aimed at providing resources to those in the community experiencing a mental health crisis. The team is a collaborative effort between Sedgwick County and the City of Wichita. It includes a Qualified Mental Health Professional, a Law Enforcement Officer, and a Paramedic who respond to emergent mental health crises in the community, identified through 911 and COMCARE.

Theme Two – Aspects of the System that Need Improvement

Participants were asked various questions to better understand the areas of the behavioral health system that are not working well, including what resource gaps exist, the barriers faced by those seeking services, and current resources and services that aren't functioning as they should. The following key insights emerged from these questions.

Healthcare coverage emerged as the most common issue discussed across populations. One person with lived experience who is currently working as a peer recovery specialist noted, *"There are uninsured gaps everywhere."* In most cases, participants expressed challenges with the cost of treatment for uninsured individuals. Justice system participants discussed the "revolving door" common among uninsured individuals.



The revolving door phenomenon refers to a cycle in which individuals who use substances repeatedly enter and exit treatment programs, the emergency department, or the justice system without achieving sustained recovery. A lack of health insurance or adequate coverage for behavioral health services often exacerbates the cycle. Although there are many vital treatment programs in the community, they are costly and thus inaccessible to those without insurance coverage or adequate financial resources. As a result, many individuals may delay or forgo treatment altogether. Even when people without insurance manage to access treatment, they may encounter limitations in the length or intensity of care they receive. Many insurance plans have restrictions on the duration or types of treatment covered, leading to premature discharge from programs before individuals have fully addressed their substance use issues. Lack of insurance also impacts the continuity of care and the ability to access the necessary follow-up services and support for sustained recovery. For many interview and focus group participants, funding specifically for Medications for Opioid Use Disorder (MOUD) for uninsured individuals was the most significant gap.

In addition to healthcare coverage specifically, **treatment costs and funding sustainability** surfaced as primary issues needing improvement**.** Most participants discussed this issue in the context of ongoing funding to cover the cost of MOUD for uninsured and low-income populations. Many folks shared that a daily MOUD dose is ~10 dollars. Often, organizations find grant funding to cover the cost for those who can't afford it, but when grant funding ends, the individuals supported usually discontinue treatment and return to use. Others discussed the common challenge of nonprofits competing with one another for funding rather than working together to address the same issues. Community providers explained further that other funding sources for treatment, like Medicaid and Block Grants, are limited in the community and do not adequately address the issue, sharing that Medicaid doesn't cover social detox as an example. Lastly, clinical providers also discussed funding limitations related to billing restrictions, highlighting that care coordination is not billable since you cannot bill two providers simultaneously.

Importantly, all population groups also discussed the **social determinants of health, most prominently transportation**, as a major barrier for people navigating the behavioral health system in the region. Clinical providers explained that three of the four methadone clinics in the region exist in one area of Wichita and require daily visits. Justice system/crisis response talked about the limited bus schedule in the community, stating that the bus schedule is too limited, especially for people who live outside the city and work regular business hours. This population

group also discussed housing and employment as additional social determinants serving as barriers for SUD populations. Importantly, when asked about services for rural populations outside Wichita, all population groups mentioned transportation as a major issue. The bus system is limited, and services are concentrated in the most urban areas. Lastly, non-clinical providers discussed childcare as a barrier, especially for those seeking residential care.

The revolving door issue explained above also emerged in the context of **withdrawal management** or "detox," which participants also listed as a significant gap. People who use drugs (PWUD) shared that it's easy to access the social withdrawal management facility, commonly known as detox, at the Substance Abuse Center of Kansas (SACK), but *"they just sober you up, and then you are out"* with no follow-up care or connections. Participants from the justice system/crisis response group and clinical providers felt the withdrawal management gap was especially prevalent among indigent and uninsured individuals. Nearly all population groups discussed this gap. Importantly, there is still no medical withdrawal management in Wichita or Sedgwick County, where medical providers monitor and manage medication to assist individuals through the withdrawal process. With a serious substance use disorder, it is important to be medically supervised throughout the withdrawal process, as symptoms can be dangerous and even life-threatening. The process may last between 5 and 10 days and vary depending on multiple factors. Currently, individuals who become very ill while detoxing are managed at the hospital with no intervention to assist or connect them with services once they are medically stable.

Intimately connected to withdrawal management challenges, the **prevalence and associated complications of fentanyl** emerged as an additional aspect needing improvement. This was discussed at length by clinical providers, who shared that stabilizing people on fentanyl can be extremely difficult and is different from other opioids. Law enforcement highlighted the sheer volume of clients they see addicted to fentanyl in the jails. In fact, during the period of time Steadman was conducting focus groups and interviews, a total of four inmates overdosed at the Sedgwick County Detention Facility in one day. PWUD discussed how methadone is generally preferable for people using fentanyl since you don't need to wait for withdrawal symptoms to initiate treatment. Yet, there are often more difficulties with accessing methadone treatment than other forms of MOUD like buprenorphine since it has to be administered daily in a clinic.

All population groups mentioned the need for more **stigma reduction, education, and training** in the community. PWUD discussed pushback from the community when new SUD services are proposed, stating things like *"we don't want them here"* when referring to people with substance use challenges. PWUD also talked about experiencing stigma from providers across the continuum of care, including outpatient service providers, MOUD providers, and pharmacists. Interestingly, clinical providers also highlighted the prevalence of stigma towards people with SUDs from the medical community, sharing that additional training and education are needed. The justice system/crisis response groups reiterated the need for more education to reduce MOUD misconceptions.

Moreover, clinical and nonclinical providers discussed stigma in the context of MOUD specifically, sharing that recovery housing often doesn't allow residents on MOUD, and many medical providers are still hesitant to prescribe MOUD despite barriers such as the DATA Waiver getting removed. The DATA waiver was initially created under the Addiction Treatment Act of 2000 to allow certain qualified providers to treat patients with buprenorphine outside of an opioid treatment program (OTP). Community providers felt that the general public, policymakers, providers, justice system professionals, and law enforcement needed more education and stigma reduction to serve and support individuals with SUDs effectively. Both PWUD and justice system/crisis response also discussed the need for more education and training for law enforcement. Both groups commented, *"We cannot arrest our way out of this."* When expressing a desire for more education for law enforcement, PWUD felt that the education should center around how to properly treat people with substance use and mental health issues so they can better work with the community. It is crucial to note that stigma was shared explicitly as a primary issue to be addressed when discussing rural populations, as it remains highly prevalent in rural areas.

Workforce issues emerged as another key insight, discussed as a gap or barrier by most population groups. Many participants expressed that the behavioral health field isn't attractive due to lower pay or reimbursement rates than other areas the medical field. Both clinical and non-clinical providers shared that private, for-profit, or out-of-state entities often pay more, reducing the number of people willing to work in agencies that serve low-income or uninsured populations. As a potential consequence, fewer people are seeking a licensed addiction counselor career. People with lived experience discussed burnout among existing substance use staff, saying, *"We have good people, but we work them so hard they leave."* Likewise, community partners discussed how workforce shortages are particularly evident when examining providers' lack of diversity representation.

"We have good people, but we work them so hard they leave."

Four out of five groups expressed the **availability of residential and inpatient treatment beds** as a primary gap. Importantly, participants shared that beds are often available for people with insurance, but uninsured, underinsured, or low-income individuals can wait upwards of two months for an available bed. Clinical providers mentioned that beds are the most difficult to secure for uninsured men, as there are at least eight Designated Women's Substance Abuse Treatment Programs that give priority admission to pregnant women, women with dependent children, and women who inject drugs, in response to various state and federal mandates. Participants with lived experience with substance use discussed competition for beds, sharing that it wasn't uncommon for people to claim to inject drugs since they often receive priority access.

Support for people transitioning from one level of care to another emerged as another critical issue mentioned as frequently as workforce issues and the availability of treatment beds. Community partners and justice system/crisis response professionals

discussed the need for more warm handoffs to treatment and reentry programs to help individuals with substance use issues successfully return to the community from incarceration. Similarly, clinical providers expressed a dire need for increased support after discharge from the emergency department, treatment facilities, and jails, as the likelihood of fatal overdose is significantly increased during such transitions. In addition, non-clinical providers discussed a shortage of non-abstinence-based recovery programs for people seeking recovery but not entirely sober yet. People with lived experience shared it can be challenging to know where to go or how to get help once you enter the justice system. Participants also discussed this in the context of SACK's social detox.

Related to this issue is another key insight that emerged: **the complex nature of the behavioral health system in Wichita and Sedgwick County makes it difficult to access and navigate.** Non-clinical providers shared how difficult same-day access to services can be, mainly because things are ever-changing and difficult to track. Clinical providers shared that it is extremely challenging to know what resources are available for those seeking services and providers due to the complexities and need for a more organized service structure. Similarly, community partners shared that resources are difficult to identify because there is no communication across providers and provider types. Lastly, the justice system/crisis response group highlighted nuances in process that complicate the situation even further, such as medical clearance needed to access certain beds. All populations expressed the need for additional resource navigation for those providing care and seeking services.

Another key issue discussed by all populations except PWUD is the lack of **available treatment, prevention, and recovery support for young people.** Clinical providers, the justice system/crisis response group, and community providers discussed youth treatment specifically. In contrast, non-clinical providers highlighted the gap in all SUD services and care for youth, including wraparound services. Similarly, youth prevention was discussed by the majority of groups. The Justice System/Crisis Response group talked about this extensively, highlighting the total lack of prevention education for youth outside of urban Wichita and limited prevention efforts even within the city. Participants shared multiple reasons for the lack of prevention programming in schools. This includes the need for more buy-in among school principals who independently decide whether or not their school offers any prevention education and a limited awareness among parents and caregivers regarding the current context and risks related to substance use. Likewise, Community Providers discussed the need for buy-in and funding for youth prevention among relevant stakeholders more generally.

In addition to the above-mentioned gaps, **harm reduction** surfaced as a crucial missing link. Even though harm reduction emerged as an aspect of the system working well, Clinical and nonclinical providers mentioned the need for naloxone—the antidote for opioid overdoses-- for high-risk individuals within hospitals or MOUD clinics. Peers discussed the need for more street outreach with harm reduction supplies and education. At the same time, community providers expressed the need for more testing, both in the context of testing the substances themselves for potentially harmful added substances such as fentanyl, and the individuals' using substances for the infectious diseases common among active drug users. From a substance standpoint, an

increase in fentanyl testing strips – a low-cost method of determining what a substance(s) is-- is needed throughout the community. Regarding infectious diseases, more providers should be conducting tests for hepatitis C and HIV, skin and soft tissue infections, and infective endocarditis to reduce the negative impacts associated with drug use.

The final common gap shared by the majority of groups was the **lack of treatment and support for people with co-occurring mental health and substance use disorders**. Clinical providers highlighted that while some outpatient options can adequately address co-occurring issues, there are no residential or crisis options for this population. PWUD discussed COMCARE as a potential option for mental health services but shared it is *"so backed up they can't get people in…"* Valley Hope was also referenced as a co-occurring provider. However, the services are inaccessible for many individuals due to their location outside of Wichita.

Theme Three – Disproportionately Impacted and Underserved Populations

All focus group and interview participants were asked about populations throughout Wichita and Sedgwick that are underserved or disproportionately impacted by the current behavioral health system. Nine populations were shared among population groups and are listed below, in no particular order.

- Uninsured/underinsured
- LGBTQ+
- People Of Color
- Non-English speakers
- Unhoused persons,
- Youth
- Disabled individuals
- People with co-occurring issues
- Those without transportation

These populations should be more heavily considered throughout the development and implementation of the strategic plan.

Theme Four – Most Immediate Needs and Priorities

Participants were asked what they felt were the most immediate needs the strategic plan should address and if any issues they felt should receive priority funding. Across both questions, a total of eight key insights emerged. The most commonly discussed issue, shared enthusiastically by all population groups, was the need for **sustainable funding to support treatment and care for those who can't afford it**. This includes funding for MOUD, treatment for people with co-occurring issues, and scholarships or another specific pathway to support people

without insurance. In addition, participants discussed the desire to move away from fee-for-service payment models and towards value-based care. In a few cases, participants mentioned the need for sustainable funding, specifically for grassroots organizations with difficulty identifying institutionalized or longer-term funding opportunities. On a related note, all population groups agreed that the strategic plan should prioritize settlement dollars for **MOUD** specifically, suggesting the creation of no-cost MOUD beds, as well as Medically Assisted Detox, in the community and ensuring that funding goes directly to MOUD providers to support their clients.

In addition to sustainable funding and MOUD, there was universal consensus among population groups that **navigation or coordination for people in transitions** is an immediate need that should be prioritized. Specifically, participants spoke about the need for more peers in hospital settings to support resource navigation and connections to care for individuals following an overdose. Others suggested funding for reentry programs to help people with SUDs successfully transition into the community from jail. Lastly, participants discussed more broadly the positive impact that an increase in behavioral health care coordination could make across the community.

Harm reduction and overdose prevention emerged as another need to prioritize, shared among 60% of population groups. People who use drugs felt that syringe service programs, or SSPs, should be supported. SSPs are community-based prevention programs that usually offer a range of services, including links to treatment; access to and disposal of sterile syringes and injection equipment; and vaccination, testing, and even treatment for infectious diseases. Alternatively, Community Partners discussed the need for an Overdose Fatality Review group to better understand the risk factors and circumstances that lead to fatal overdoses while identifying opportunities to prevent future overdoses. Other participants discussed the need for more naloxone throughout the community, especially among high-risk populations.

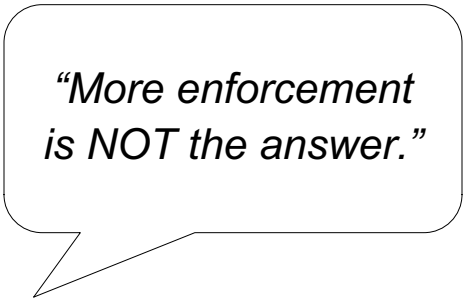
Addressing the workforce was another key insight that 60% of the population groups felt was necessary to prioritize. Clinical providers and justice system/crisis response participants felt that settlement dollars should be used to address staff retention and burnout issues specifically. PWUD and Community Partners discussed workforce shortages more broadly, hoping to increase access to care by increasing the number of providers (including clinical and non-clinical) throughout the system.

Lastly, **primary prevention and education**, shared by ~84% of population groups, emerged as an immediate need to prioritize. PWUD expressed the need to reduce misconceptions in the medical field regarding substance use. Additionally, they shared that more training is needed for law enforcement professionals to better address people with SUDs when they encounter them throughout the community. The remaining population groups, non-clinical and clinical providers, and justice system/crisis response shared that supporting evidence-based school-based prevention and prevention with settlement dollars is crucial.

Theme Five – Anticipated Challenges for the Strategic Plan

All interview and focus group participants were also asked what potential challenges they foresee with developing and implementing the Wichita Sedgwick Opioid Settlement Strategic Plan. Of all the questions asked, this saw the most agreement across population groups, with six key insights emerging from the data.

Importantly, all population groups expressed concerns with **funding going to organizations, agencies, and strategies that are not appropriate or evidence-based.** 60% of the population groups discussed issues with the amount of money going to law enforcement specifically, including participants from the justice system/crisis response group. One law enforcement professional stated, "More enforcement is NOT the answer. Law enforcement already gets grants and money to enforce." Others were more concerned with the power of law enforcement in developing the plan in general. Clinical Providers and Community Partners heavily emphasized the need to fund only evidence-based approaches to combating OUD and SUD. 40% of population groups shared concerns about money going to outside (nonlocal) agencies that don't intend to stick around to support individuals and communities for the long term. Lastly, another 40% of groups were worried that too much funding would be utilized to support for-profit organizations, staff administrative time, or "middlemen," rather than going directly to the people and populations most impacted by the epidemic to support MOUD or other crucial services.



Nearly all population groups (80%) felt that **transparency, sustainability, and evaluation** would be another challenging aspect of developing and implementing the strategic plan. Many participants expressed the dire need for data to inform the development and ongoing implementation. Similarly, others discussed the importance of a transparent process with trustworthy oversight of funds. Lastly, multiple groups discussed concerns with how to sustain services, not only once the settlement dollars run out but also throughout the settlement as other funding sources like the American Rescue Plan Act (ARPA) run dry. Some participants felt that a robust evaluation approach to the strategic plan could help combat these issues.

Another primary concern, shared by 80% of population groups, was **ensuring collaboration, coordination, and communication across all involved sectors** throughout the development and implementation of the plan. One participant highlighted this well when stating, *"Everyone wants their hands in it [the funding],"* and another when sharing, *"I don't know if anyone is going to work together on this."* Others expressed concerns that politics or *"red tape"* might get in the way of good work and that it will be necessary to *"focus on needs, not politics."* Moreover, Clinical Providers discussed the importance of ensuring small providers and grassroots organizations have a seat at the table so that the largest providers aren't the only voices and recipients of funds. Despite slight differences in the focus of this discussion across groups, it was clear that participants are deeply concerned with the communities' ability to work together to address this epidemic.

Only 40% of population groups shared the final two anticipated challenges, but they remain important to discuss. First, PWUD and Community Partners felt that **workforce shortages** would be a challenge, particularly as people burn out or retire and the number of individuals interested in working in the SUD field continues to decrease. Lastly, both Non-Clinical Providers and Community Partners feared that the process would not be inclusive enough towards people with lived experience with substance use and other behavioral health issues or those who are "boots on the ground," actually doing the hard work. Likewise, a few participants expressed concerns that people with lived experience would be exploited throughout the process. This is particularly important when highlighting that the PWUD and those with lived experience interviewed in this process shared that "the people who make decisions don't get us" and that some providers and community members make them feel like *"they aren't people."*

Theme Six – Best Ideas for Addressing Current Challenges

The final question asked of all interview and focus group participants was their best ideas for addressing the identified gaps, barriers, and challenges. Participants shared many excellent and robust ideas, and there was significant overlap among population groups and suggestions. Below, the nine key insights from this question are outlined in greater detail.

First, 80% of population groups suggested a **platform for behavioral health providers to effectively share data and resources** to improve communication and collaboration between various organizations and provider types. As one provider shared, *"We don't know what each other are doing."* An online platform of this kind could help address the duplication of efforts among providers.

Another 80% of population groups felt that increasing **resource navigation and connections to care** would profoundly benefit individuals seeking treatment and recovery, especially for people transitioning from one point of care to another. Specifically, participants suggested an increase in peer recovery specialists or case managers in hospital settings to support people post-overdose. Others mentioned reviving an old program through SACK that provided case management to individuals receiving MOUD. Lastly, 60% of population groups also discussed resource navigation specifically to help address the social determinants of health like housing, transportation, and vocational support. Interestingly, as Clinical Providers, Justice System/Crisis Response, and Community Providers suggested, transportation emerged as a key insight here. Participants mentioned funding for bus passes and discussed the need to address restricted licenses often placed on people with SUDs.

Youth prevention was shared by 60% of population groups, with most participants suggesting the inclusion of SBIRT (Screening, Brief Intervention, and Referral to Treatment) programs directly in schools. Others highlighted the importance of including youth in developing youth prevention programs for them to be effective. On a related note, a **community awareness and education campaign** also emerged as a strong idea for addressing the

challenges mentioned above, stated by 60% of population groups. Participants felt this is crucial for combating the stigma and misconceptions among providers, law enforcement, and the greater community.

To address the significant barriers to seeking SUD treatment and recovery for rural populations outside Wichita, 60% of population groups suggested an increase in **telehealth services**. Likewise, Clinical Providers and Community Partners felt that a **behavioral health career pipeline** is necessary to increase the workforce and ensure that organizations are adequately staffed.

The final key insight regarding potential solutions, shared by Non-clinical and Clinical Providers and Justice System/Crisis Response, was a **"one-stop shop"** or facility with co-located care. Clinical participants discussed the need to include services like residential and IOP in one place to support clients beyond outpatient needs. Other participants felt it was crucial to include recovery services, housing services, and employment resources.

Recommendations

Based on the above findings and themes, with specific attention to Theme Six – Most Immediate Needs and Priorities, Theme Seven – Anticipated Challenges for the Strategic Plan, and Theme Eight – Best Ideas for Addressing Current Challenges.

The recommendations aim to address the complex challenges in Wichita/Sedgwick County and provide strategic approaches for utilizing settlement funds to support comprehensive and equitable solutions to the opioid epidemic. By prioritizing evidence-based practices, community engagement, and collaboration, the Wichita-Sedgwick Opioid Settlement Consortium can make significant strides toward improving outcomes for individuals and communities affected by substance use disorders.

Finally, these recommendations also provide the framework for the Wichita-Sedgwick Opioid Settlement Strategic Plan, with additional planning for sustainability and communication. They generally follow a chronological order for implementation.

1. **Community Outreach and Education**: Develop comprehensive community outreach and education programs aimed at raising awareness about the risks of opioid misuse and providing information on available resources for prevention, treatment, and recovery. Ensure that these programs are accessible to all communities, including rural areas, and are culturally sensitive and linguistically appropriate.
2. **Stigma Reduction and Education**: Allocate funding for stigma reduction efforts and education campaigns aimed at reducing misconceptions about substance use disorders and promoting empathy and understanding. Prioritize initiatives that involve community members, healthcare providers, law enforcement, and policymakers in destigmatizing substance use and advocating for evidence-based approaches to treatment and support.

3. **Collaborative Partnerships**: Foster collaborative partnerships between local government agencies, healthcare providers, community organizations, and individuals with lived experience to develop and implement the Wichita Sedgwick Opioid Settlement Strategic Plan. Ensure that decision-making processes are transparent and inclusive and prioritize the needs of communities most affected by the opioid epidemic.
4. **Workforce Development**: Invest in workforce development initiatives to address staffing shortages and burnout in the behavioral health field. Provide funding for training and education programs for healthcare professionals, peer recovery specialists, and law enforcement personnel on evidence-based practices for opioid prevention, treatment, and support.
5. **Integrated Care Mode**l: Implement an integrated care model that fosters collaboration between healthcare providers, social service agencies, law enforcement, and community organizations to address the complex needs of individuals with substance use disorders, mental health issues, and social determinants of health. Prioritize funding for programs that provide warm handoffs between different levels of care and support individuals in transitions.
6. **Enhanced Access to Behavioral Health Services for Underserved Populations**: Allocate funding to expand access to behavioral health services, including SUD treatment and mental health support, mainly targeting underserved populations in Sedgwick County.
7. **Prevention and Harm Reduction Initiatives**: Invest in evidence-based prevention and harm reduction initiatives, such as syringe service programs (SSPs), naloxone distribution, overdose prevention education, and testing for infectious diseases. Support grassroots organizations and community partnerships that focus on harm reduction efforts tailored to the needs of vulnerable populations.
8. **Expansion of Treatment Capacity**: Allocate resources to expand the capacity of addiction treatment facilities, including increasing the availability of buprenorphine providers, opioid treatment programs (OTPs), and residential treatment beds in Sedgwick County. Prioritize funding for programs that offer wraparound services and support for individuals with co-occurring disorders.
9. **Culturally Competent Services**: Ensure that behavioral health services and support programs are culturally competent and responsive to the needs of diverse communities in Sedgwick County, including Hispanic/Latino populations. Provide funding for initiatives that offer language access services and culturally tailored interventions to reduce stigma and improve access to care.
10. **Data Monitoring and Evaluation**: Establish a robust system for monitoring and evaluating the impact of opioid prevention and treatment programs in Sedgwick County. Prioritize funding for data collection, analysis, and reporting to track outcomes, identify service gaps, and inform continuous quality improvement efforts.

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