OVERDOSE DATA TO ACTION:

Dallas County 2024 Community Needs Assessment

About the Dallas County Health and Human Services and Recovery Resource Council Partnership

Dallas County Health and Human Services (DCHHS) is the public government entity charged with promoting and protecting the health of Dallas County's diverse population of over 2.6 million people across 31 cities. Recovery Resource Council (RRC) is North Texas' largest non-profit organization dedicated to prevention, intervention and treatment of alcohol, substance use disorders and behavioral health issues. DCHHS and RRC partnered under the *Overdose Data to Action (OD2A)* grant from the Centers for Disease Control and Prevention (CDC) to conduct a community needs assessment specific to substance use and misuse to better capture the needs, gaps, and barriers that exist for stakeholders and people with lived or living experience in Dallas County to guide future intervention and programmatic efforts.

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DCHHS
Dallas County Health and Human Services
Healthy People Healthy Communities
Health and Social Equity

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Executive Summary

Located within the heart of the North Central Texas region, Dallas County is the second-largest county in Texas with a population of 2.6 million people. The 2022 Dallas County Community Health Needs Assessment (CHNA) indicates continued health disparities in prevalence rates for people who use drugs (PWUD) and opioid/stimulant use disorder (OUD/StUD) across the county. Dallas County hospitals reported a substantial increase in drug-related overdoses including non-fatal overdoses, from 2,419 in 2018 to 3,818 in 2023. Notably, Dallas County presents a complex socio-political environment that significantly impacts both opioid use and prevention efforts, and the Social Determinants of Health (e.g., healthcare, education, economic stability, built environment, and community context) significantly impact the use of drugs and the ability and accessibility of treatment, support groups, and other holistic services designed to support people who are seeking recovery or are actively in recovery.

The primary data collected during this needs assessment in addition to secondary trends indicate an urgent need to invest and prioritize increased federal, state and local funding for expanded treatment options and wraparound services for Dallas County residents. Stakeholder focus groups and PWLE interviews revealed a complex web of services with notable gaps, needs, and stigmatizing, outdated policies that create significant challenges for stakeholders providing services and PWLE seeking services. Notably, primary data findings indicate an urgent need for the investment in adolescent services and inclusive services for LGBTQIA+ groups, immigrant communities, people experiencing homelessness, and people living with disabilities. Furthermore, primary data collection affirmed the well-known need for cross-sector collaboration to bridge the gaps in services across stakeholders and to build a strong, unified stance against stigma. Efforts to include PWLE within decision-making processes for opioid prevention is imperative for ensuring inclusive, relevant, and accessible services.

Targeted and unified advocacy efforts to increase the availability and access of harm reduction services within the state, such as fentanyl test strips and syringe exchange programs, must take precedent if we are to achieve positive and sustainable changes for people with lived and living experience. Furthermore, data findings confirmed that trauma-informed wraparound services are paramount to effective treatment and support for PWLE. Moving forward, efforts to internally educate employees and staff who work within organizations that support PWLE on the harmful effects of stigma and the importance of a trauma-informed approach is critical and must be employed immediately. The implementation of trauma-informed care will ensure that PWLE feel safe, heard, and valued in their recovery efforts and journey and thus has a substantial impact for mitigating relapse and overdose.

The first step of many for the DCHHS-RRC assessment team will be to convene a consortium that will include a vast number of organizations and individuals across stakeholder groups including, public safety and criminal justice, healthcare providers, peer support specialists, community-based organizations, people with lived and living experience, and parents of children with lived or living experience. This platform will allow for connection and collaboration across sectors and ensure a continued, long-lasting commitment to mitigating opioid-related morbidity and mortality in Dallas County.

Background

Socio-political Landscape

Dallas County presents a complex socio-political environment that significantly impacts both opioid use and prevention efforts. One key factor is the state's strict stance on drug control. Texas has some of the harshest penalties for drug possession in the nation. This can create a climate of fear and stigma around addiction, discouraging people from seeking help. Additionally, laws restricting access to clean syringes, a harm reduction strategy proven to curb the spread of infectious diseases among people who inject drugs, are still in place. This lack of access can exacerbate the negative consequences of opioid use. Furthermore, Texas also has broad drug paraphernalia laws prohibiting fentanyl test strips (FTS), a harm reduction tool that empowers people who use drugs to make informed decisions about their safety. This creates a significant barrier to preventing opioid-related fatalities. Without access to FTS, people who use drugs are less likely to know if their supply is contaminated with fentanyl, a powerful synthetic opioid that can be deadly in even small doses.

On the other hand, there are positive political developments. Dallas County has seen a growing movement towards harm reduction strategies, despite the limitations imposed by state-level restrictions. Increased funding for medication-assisted treatment (MAT) programs, which combine medication with therapy, offers a more evidence-based approach to opioid use disorder. Additionally, community outreach programs run by social service organizations and faith-based groups are working to destigmatize addiction and connect people with resources.

However, these efforts are often strained due to the lack of access to substance use treatment in Dallas County. Despite the positive strides in funding MAT programs, Dallas County still faces a shortage of state-funded in-patient treatment beds and qualified providers. This lack of access creates a bottleneck for people seeking help, leaving them vulnerable to continued opioid use and overdose risks. The ongoing tension between public health needs and traditional "war on drugs" policies, coupled with limited access to treatment, shapes the landscape of opioid use and prevention in Dallas County. There's a clear need for a more comprehensive approach that prioritizes harm reduction strategies, expands access to treatment options, and dismantles the stigma surrounding addiction.

Community Overview

Located within the heart of the North Central Texas region, Dallas County is the second-largest county in Texas with a population of 2.6 million people. As the only county in the North Texas region with a majority non-white population, Dallas County’s communities boast a vastly diverse blend of cultures. According to the U.S. Census Bureau, the population is 27.4% White, 22.2% Black or African American, 41% Hispanic or Latino, 6.7% Asian, Native Hawaiian, and Other Pacific Islander, 0.2% American Indian and Alaskan Native, 2.3% Two or More Races, and 0.3% Some Other Race. Notably, 40% of Dallas County households speak a language other than English, and approximately 1 in 5 of those households have limited-English proficiency, the highest percentage in the region. Of those with limited-English proficiency, about 81% are Spanish speakers. Dallas County is also home to several higher education institutions, such as the University of Texas at Dallas and Dallas College, which is reflected in its large population of youth. By age, 25.6% of Dallas County residents are below the age of 18, 9.9% are 18-24 years old, 30.2% are 25-44 years old, 23.3% are 45-65 years old, and 11.2% are 65 years or older. About half of the population resides within the county seat and urban center: the city of Dallas. (U.S. Census Bureau).

Dallas County Health Profile

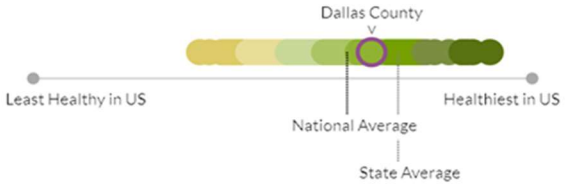
Overview

The U.S. Department of Health and Human Services' Healthy People 2030 defines the Social Determinants of Health (SDOH) as the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. There is growing recognition that health disparities significantly impact the prevalence of substance use in a community, though there is much work to be done in combatting social stigmas for individuals struggling with substance use and misuse. In the long term, building awareness of the upstream factors that create these public health issues and efforts to mitigate them will benefit the outcomes for our society as a whole.

Figure 1: Social Determinants of Health, U.S. Department of State Health Services

Overall, according to the County Health Rankings and Roadmaps, Dallas County fares worse than the average county in the state of Texas but in comparison to the United States, fares better than the average county.

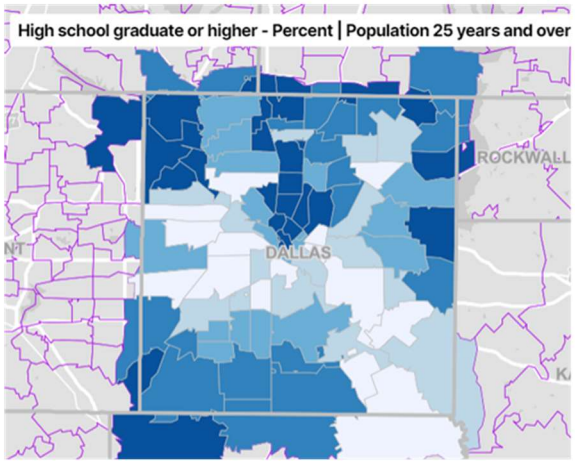
Figure 2: County Health Rankings



Education Access and Quality

Educational attainment is a significant predictor of an individual's ability to access employment opportunities and subsequent resources such as healthcare. There is a higher prevalence of economic hardship among individuals without at least a high school diploma. In Dallas County, about 1 in 5 people do not have a high school diploma. This population is concentrated mostly within southern Dallas.

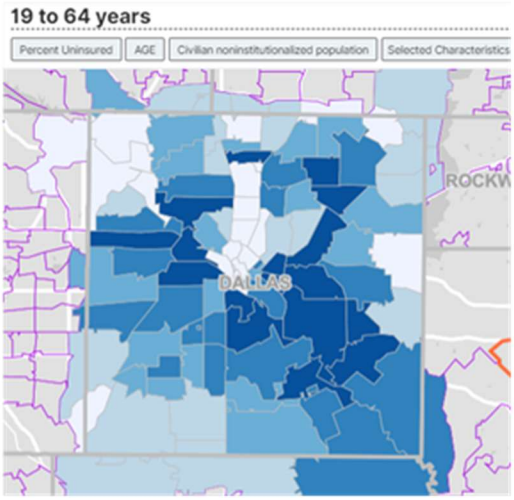
Figure 3: Percent of Population with a High School Diploma or higher, Age 25 or older, U.S. Census Bureau



Healthcare Access and Quality

Access to healthcare is essential to not only maintain physical health and screen for preventable diseases, but it is critically necessary for accessing affordable mental health and substance abuse services. According to the U.S. Census Bureau, Texas has the highest percentage of uninsured residents in the nation at 17%, which is more than twice the national average of 8%. In comparison, Dallas County surpasses the state percentage with approximately 22% of its residents being uninsured; a relatively high percentage compared to the state. By zip code, large swaths of the uninsured adult population are concentrated in southern Dallas. Furthermore, according to the CDC's Behavioral Risk Factor Surveillance System (BRFSS), approximately 29% of adults in Dallas County did not have a routine checkup with a doctor in 2021, 46% did not visit the dentist, and 12% of adults in Dallas County reported chronic issues with their physical health. (CDC).

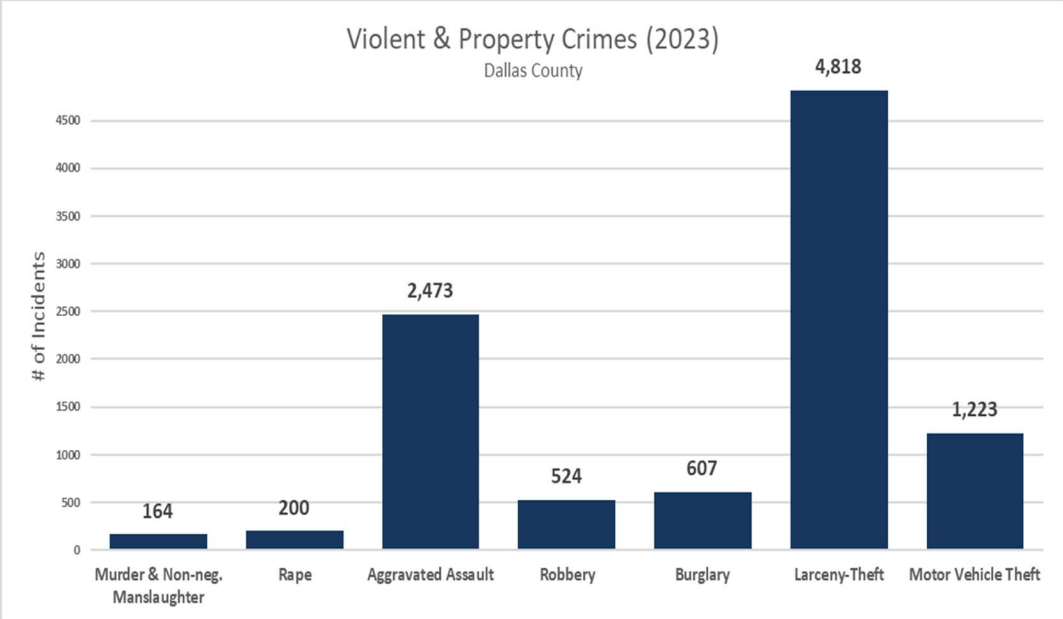
Figure 4: Percent of Uninsured Population, Age 19-64, U.S. Census Bureau



Neighborhood and Built Environment

It is crucial for people to feel safe in their environment. This isn't always the case for many underserved communities. In addition to a high prevalence of violent crime in Dallas County, 1 in 17 children in the region report not feeling safe in their neighborhood and 1 in 9 children report not feeling safe at school, according to the 2022 Texas School Survey (TSS).

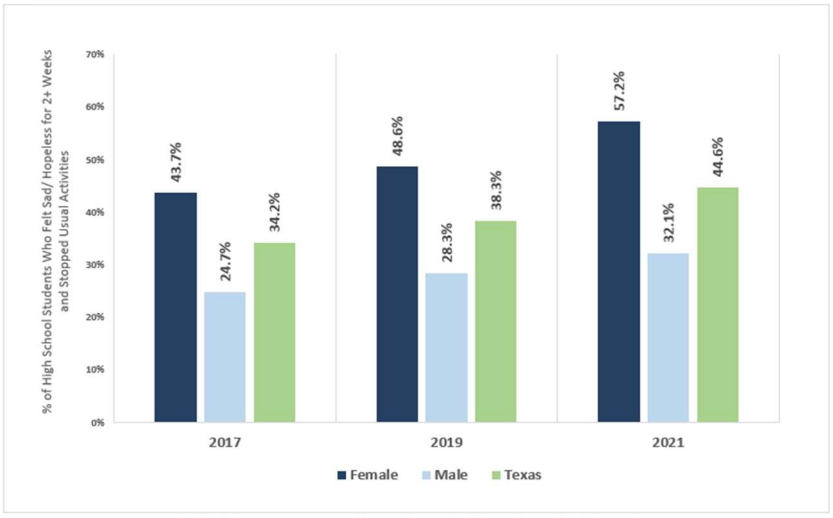
Figure 5: Violent & Property Crimes in Dallas County, Dept. of Public Safety



Social and Community Context

In many cases, adults and especially children have no control over their environment. Having the support of trusted friends, family, or other community members can often serve as a protective factor for individuals facing difficult life circumstances. However, since the COVID-19 pandemic, communities have suffered from an increasing sense of isolation. According to the CDC, 21% of adults in Dallas County reported being depressed. Furthermore, there is a significant increase in adolescent depression rates. Female students in Texas saw a 31% increase from 2017 to 2021. (YRBSS). And according to the Region 3 Prevention Resource Center, the percentage of students who report that they would not seek help if they had a substance use problem increased from 17.7% in 2018 to 22.1% in 2022. (Texas School Survey).

Figure 6: Adolescent Depression in Texas, by Sex, 2017-2021, YRBSS

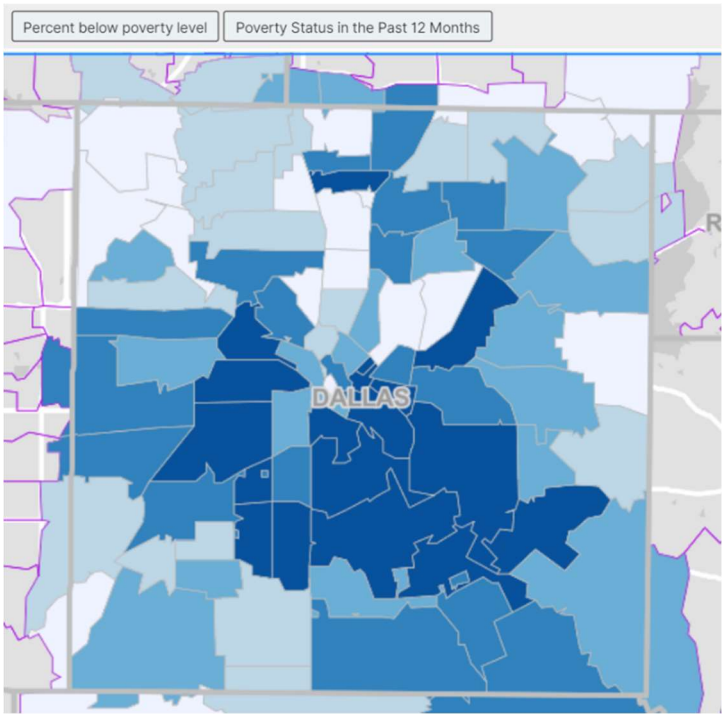


Region 3 Prevention Resource Center, Centers for Disease Control and Prevention

Economic Stability

The concept of economic stability underlies all the aforementioned aspects of the Social Determinants of Health. It is no surprise, as the ability to have one's needs met is almost completely dependent on one's financial health. From primary needs such as food and shelter to secondary needs such as safety, mental/emotional health, and life fulfillment, money is often a barrier to economically disadvantaged communities' ability to access resources to fulfill these needs. In Dallas County, 14% of the population is below the poverty line. However, the vast majority of impoverished communities are concentrated in southern Dallas, an area primarily occupied by Black and Latino communities.

Figure 7: Percent of Population Below Poverty Line, U.S. Census Bureau

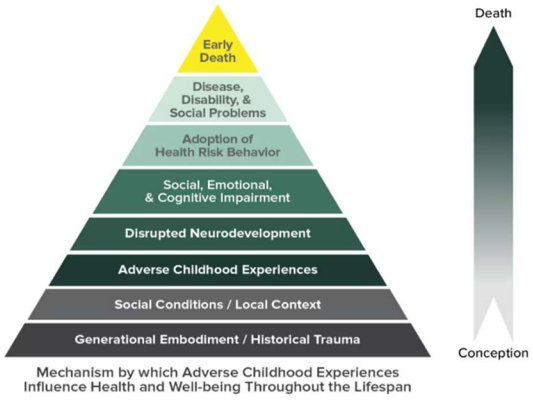


Risk Prevalence

Risk Prevalence for Trauma Survivors

The CDC-Kaiser Adverse Childhood Experiences Study (ACEs) has gained widespread notoriety as one of the largest studies with findings emphasizing the link between childhood trauma and early adversity to poor future health outcomes. Those that reported higher instances of childhood trauma and early adversity were found to be more susceptible to various poor health outcomes such as depression, suicide, chronic disease, and risky behaviors including unprotected sex and substance use and misuse. Further, the study found that children may be more vulnerable to experiencing adverse childhood experiences due to the social and economic conditions in which they live. (CDC). This is particularly relevant due to the prevalence of generational trauma in many historically underserved communities within Dallas County.

Figure 8: The ACE Pyramid, CDC

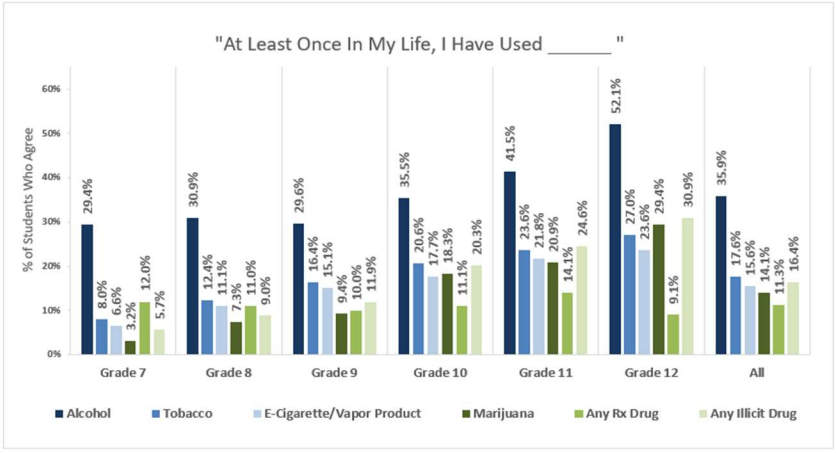


In Texas, about 1 in 7 children reported not having an adult at home who tried to meet their basic needs. 30% of children reported living with someone who had a substance use problem and 33% reported living with someone who was depressed or suicidal. Furthermore, 1 in 6 children reported experiencing mental or emotional abuse at home, 1 in 30 children reported experiencing physical abuse at home, and 1 in 10 children reported experiencing sexual abuse. About 1 in 6 children reported being separated from their parent due to the parent's incarceration. (Texas Youth Behavioral Risk Surveillance System).

Risk Prevalence for Youth

According to the Texas Education Agency (TEA), 75% of students in Dallas County were designated as economically disadvantaged in the 2023-2024 school year, compared to Texas at 62%. Additionally, TEA reported that in Dallas County, there were 9,479 students experiencing homelessness as well as 1,020 children in foster care for the same school year. 64% of all students were identified as "at risk," compared to the state at 53%. (TEA). Without adequate access to resources and opportunities for healthy coping strategies, these extenuating circumstances present a challenge to the youth's ability to abstain from unhealthy coping methods such as substance use. This is particularly alarming given the steadily increasing rate of adolescent depression and increased youth fatalities due to the presence of fentanyl in substances. In Dallas County's largest school district, Dallas ISD, TEA reported 1,733 students were referred to a Disciplinary Alternative Education Program

Figure 8: Region 3 (Dallas Fort-Worth) Youth Substance Use, Lifetime Use, By Substance, By Grade Level, TSS, 2022



Region 3 Prevention Resource Center, Texas School Survey

(DAEP) and 259 students were referred to in school suspension (ISS) for substance use-related infractions in the 2023-2024 school year.

Risk Prevalence for the LGBTQ+ Community

Figure 9: Lesbian, Gay, and Bisexual Behavioral Health, NSDUH, SAMHSA

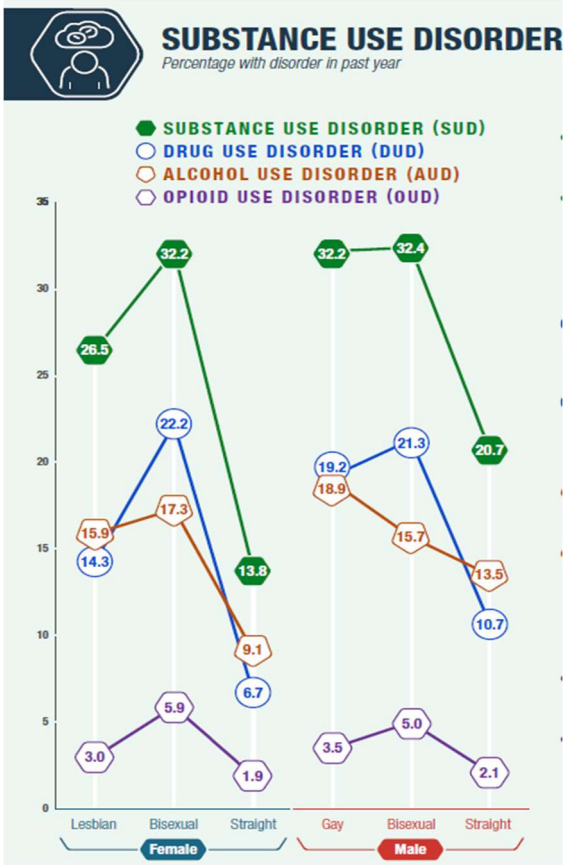
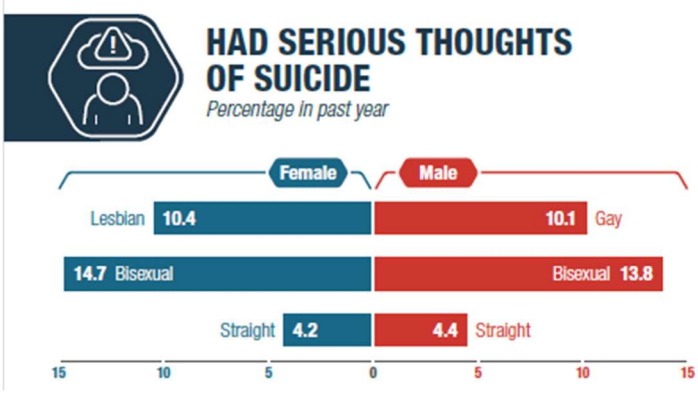


Figure 10: Lesbian, Gay, and Bisexual Behavioral Health, NSDUH, SAMHSA



According to the UCLA Williams Institute, there are approximately 1.1 million LGBTQIA+ adults in the state of Texas alone. In 2023, the Substance Abuse and Mental Health Administration (SAMHSA) published a report using 2021 and 2022 results from the National Survey on Drug Use and Health (NSDUH) to study the prevalence of substance use trends in lesbian, gay, and bisexual adults. Though the results noticeably exclude transgender individuals, the findings are prominent. Results indicate that lesbian, gay, and bisexual adults were often two to three times "more likely than straight adults to use substances, experience mental health issues including major depressive episodes, and experience serious thoughts of suicide." (SAMHSA). Though the report does not delve into causation, the high prevalence is no surprise as LGBTQ+ adults and youth are at a higher risk of experiencing ostracization from their family and community. According to the 2021 Survey on LGBTQ+ Youth Mental Health, 28% of LGBTQ+ youth reported experiencing homelessness or housing instability at some point in their lives. Furthermore, the report emphasized that homelessness and housing instability were reported at higher rates among transgender and nonbinary youth, including 38% of transgender girls/women, 39% of transgender boys/men, and 35% of nonbinary youth." (The Trevor Project).

Risk Prevalence for the Disability Community

The CDC estimates that about 30% of all adults in Dallas County have a disability of some kind. The intersection of substance use and disability is a vastly under-researched subject in public health. However, the few studies in existence suggest that individuals with disabilities are at a higher risk for substance misuse than their able-bodied counterparts (Mills, 2022; Reif, Lee, & Ledingham, 2023). Additionally, despite having a higher prevalence rate, individuals with disabilities are also less likely to enter addiction treatment. A 2023 study found that "attitudes, discriminatory policies or practices, communications, and physical constraints reflect ableism and affect the ability of people with disabilities to enter addiction treatment." (Reif, Lee, & Ledingham,

2023). Similarly, a 2022 study found that the increased likelihood of individuals with disabilities to use substances is caused by the chronic stress of having an environment that is inaccessible to them, not the impairment itself. (Mills, 2022). Therefore, the success of addiction treatment for individuals with disabilities is possible but is dependent on a provider's ability to meet specific disability-related needs. (Reif, Lee, & Ledingham, 2023).

Risk Prevalence for Incarcerated Individuals

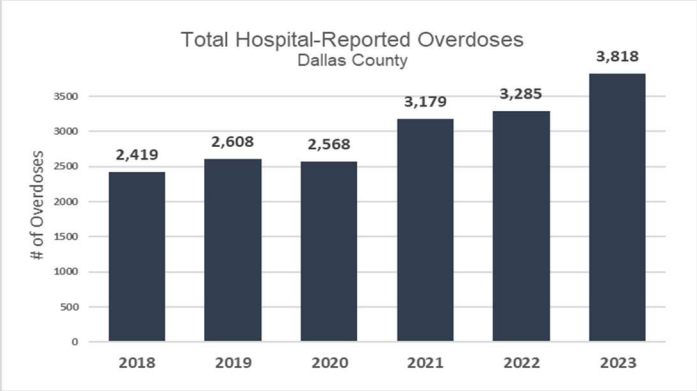
According to the U.S. Census Bureau, there are 249,293 incarcerated adults in Texas. Notably, 33% of those adults do not have a high school diploma, and only 3% have a bachelor's degree or higher. Furthermore, 29% of the population has a disability of some kind, 12% of the incarcerated population do not speak English "very well," and a total of 25,113 incarcerated adults are foreign-born immigrants without citizenship. (U.S. Census Bureau).

Notably, incarceration is linked to an increased risk of overdose poisonings and deaths. This is especially true upon release from prisons as they people have limited access to MAT, a loss of tolerance to substances, and upon release, have significant disruptions in access to healthcare and other social support services (Carson and Cowhig, 2020). These trends suggest an urgent need to bolster and develop wraparound services and improve linkage to care for incarcerated individuals upon their release.

Opioid Use and Misuse in Dallas County

Overview

Figure 11: Total Hospital-Reported Overdoses in Dallas County, DCHHS

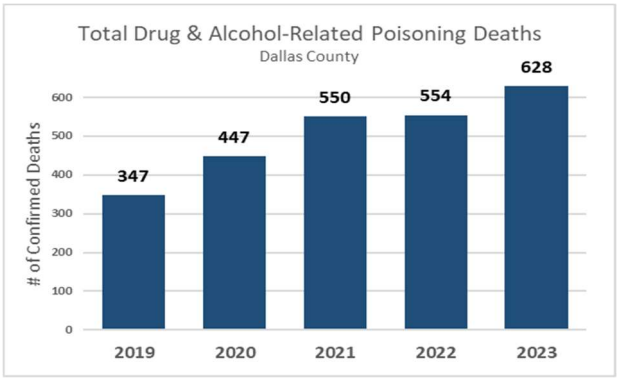


The opioid epidemic is a pressing public health issue in the United States, and Dallas, Texas, is no exception. Substance use disorder (SUD) is among the top growing health concerns for the residents in the county. The 2022 Dallas County Community Health Needs Assessment (CHNA) indicates continued health disparities in prevalence rates for people who use drugs (PWUD) and opioid/stimulant use disorder (OUD/StUD) across the county. Dallas County hospitals reported a substantial increase in drug-related overdoses including non-fatal overdoses, from 2,419 in 2018 to 3,818 in 2023. Still, this count underestimates the true count of drug overdoses, as it does not include unreported overdoses or those that are not transported to the hospital. Individuals and families living in neighborhoods in the southern region of Dallas County have been identified as being at a high risk for untreated SUD, and more likely to have limited income, limited access to healthcare, and limited resources to get treatment. Furthermore, this area is populated with historically underserved populations such as Black and Latino residents.

Drug-Related Poisoning Deaths

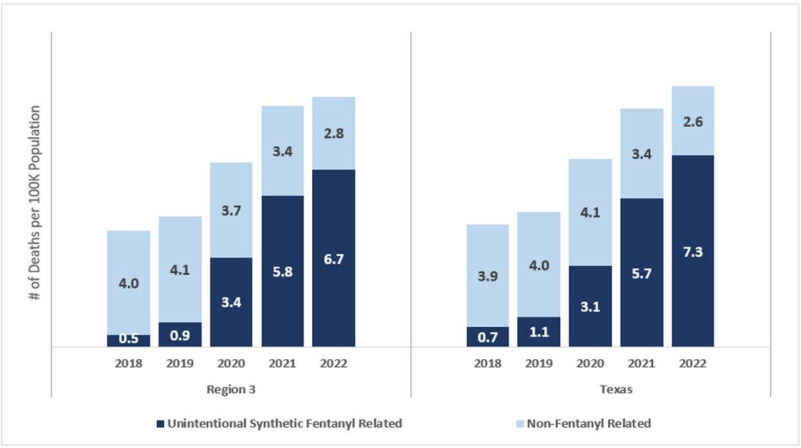
In addition to ranking as the second-highest Texas county in overdose deaths, Dallas County has witnessed a sharp rise in overdose fatalities. The overall drug & alcohol overdose death rate in Dallas County has drastically increased in recent years. In 2019, there were 347 overdose deaths but in 2023, the number of overdose deaths in the county surged to 628, indicating an approximately 81% increase in overdose deaths from 2019 to 2023. (Dallas County Health & Human Services).

Figure 12: Total Drug & Alcohol-Related Poisonings, 2019-2023, DCHHS



Notably, the Texas Department of State Health Services (DSHS) reported an alarming 87.5% increase in fentanyl-related overdose deaths in Dallas County from 2019 to 2020, which represents a substantial rise in the number of overdose deaths involving this highly potent opioid. In 2018, synthetic fentanyl was responsible for 11.4% of all opioid-related poisoning deaths in Public Health Region 3 (DFW Metroplex) per the Region 3 Prevention Resource Center's Regional Needs Assessment (RNA). In 2022, unintentional synthetic fentanyl poisoning deaths are now responsible for 70.5% of all opioid poisoning deaths. While Dallas County has followed the national trend in reducing opioid prescriptions, the rate of overdose deaths involving fentanyl has continued to rise, leading to a concatenate rise in synthetic opioid overdoses.

Figure 13: Total Opioid-Related Poisoning Deaths (per 100k Population), Region 3, By Synthetic Fentanyl Status, 2018-2022



Region 3 Prevention Resource Center, Centers for Disease Control and Prevention

From 2016-2023, Dallas County experienced a sharp increase in fentanyl-related deaths but a notable decline in heroin, highlighting the lethal potency of fentanyl and the corresponding increase in mortality in recent years. Furthermore, data shows that overwhelmingly, overdose deaths are by accidental rather than intentional.

Figure 14: Dallas County Drug-Related Poisoning Deaths, by Substance, DCHHS

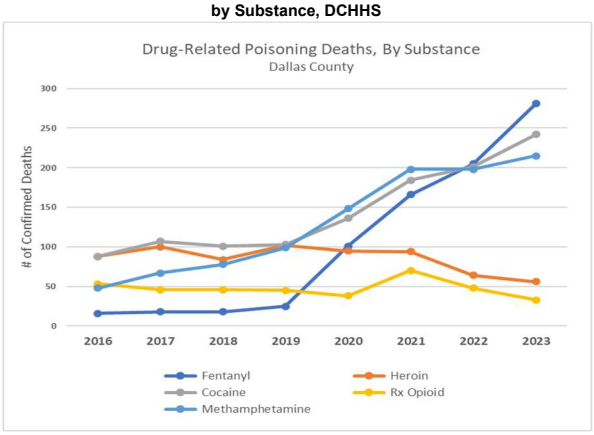
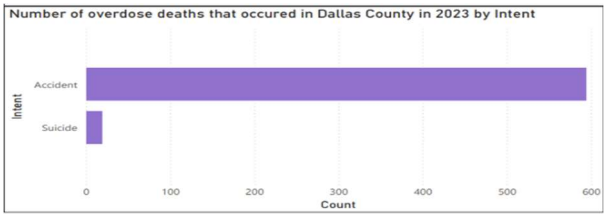
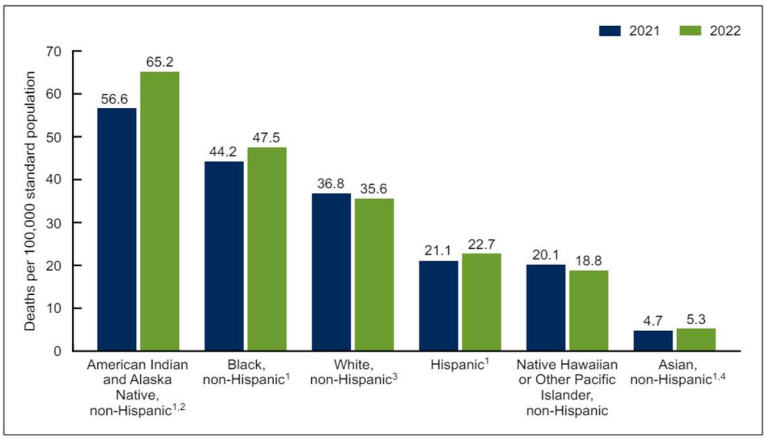


Figure 15: Dallas County Overdose Deaths, by Intent, 2023, DCHHS



According to the National Center for Health Statistics, American Indian and Alaskan Native (AI/AN) and Black or African American individuals have been disproportionately impacted by drug overdose poisonings. This fact is significant considering Texas-level and Dallas County-level data for the AI/AN population are often unavailable. This underrepresentation in data is crucial to keep in mind given the 16,535 AI/AN individuals who call Dallas County home.

Figure 16: Age-adjusted Rate of Drug Overdose Deaths, by Race/Ethnicity, United States, NCHS



Methods for Primary Data Collection

From January 2024-April 2024, DCHHS completed a two-tiered Community Needs Assessment (CNA) in partnership with RRC that involved focus groups across three stakeholder groups: public safety and criminal justice, health systems, and community-based organizations. Following the focus groups, 14 semi-structured interviews were conducted: six with additional stakeholders and eight with people with lived experience (PWLE) with substance use.

Focus Group Methodology

The DCHHS-RRC community assessment team conducted three focus groups sessions amongst key stakeholders working within the fields of public safety and criminal justice, health systems, and community-based organizations. The assessment team developed nine discussion questions to facilitate the focus groups that included introductions, experiences with the opioid epidemic, barriers to carrying out their work, experiences with partnerships and cross-sector collaboration, and policy level factors that influence their ability to provide support and services to Dallas County community residents.

The public safety and criminal justice focus group had 11 participants, the health systems group had 7 participants, and the community-based organization group had 8 participants. An introduction and guidelines script were read verbatim for each focus group to ensure continuity across groups and to inform them of their rights as participants in the CNA. Each focus group was recorded via company cell phones, transcribed using Otter.ai software, and stored securely on VPN private drives.

Transcripts were reviewed and edited in Otter.ai prior to codebook development. Line by line coding and reflexive thematic analysis was used to identify key themes in the focus group transcripts. Two members of the DCHHS-RRC assessment team reviewed transcripts and developed a working codebook separately. Codes were reviewed, combined, and a finalized codebook was developed. From there, codes were categorized by recurring themes by both assessment team members.

Semi-Structured Interview Methodology

The DCHHS-RRC team conducted six semi-structured interviews with additional stakeholders from the public safety and criminal justice field, the peer support specialist field, and parents of

children with experience with substance use. These interviews were intended to bolster the qualitative data collected during the focus groups and to gain deeper context surrounding specific circumstances and experiences of the opioid epidemic in Dallas County.

Eight semi-structured interviews were conducted with people with lived experience (PWLE) with substance use and misuse to better understand the experiences of those directly impacted by the opioid crisis and weave together a story of lived experiences through data. The DCHHS-RRC team sought to understand the current landscape of navigating services, recovery, and support from the community's perspective within Dallas County, as well as barriers and needs currently left unaddressed. Following a phenomenological methodology, these semi-structured interviews prioritized understanding the holistic lived experiences of PWLE from the beginning of their journey to where they are today.

The majority of PWLE recruited came from one peer working within one organization, and all were in varying stages of recovery. According to the PWLE pre-screening survey:

- 7 of 8 participants identified as Female
- 1 of 8 participants identified as Transgender Male
- 37.5% identified as White
- 25% identified as Black or African American
- 25% identified as Hispanic or Latino/a
- 12.5% identified as White and Hispanic or Latino/a
- 1 of 8 participants identified with the disability community
- 1 of 8 participants identified with the LGBTQIA+ community
- 3 of 8 participants identified as trauma survivors

Transcripts were reviewed and edited in Otter.ai prior to codebook development. Line by line coding and reflexive thematic analysis was used to identify key themes in the focus group transcripts. Two members of the DCHHS-RRC assessment team reviewed transcripts and developed a working codebook separately. Codes were reviewed, combined, and a finalized codebook was developed. From there, codes were categorized by recurring themes by both assessment team members.

Results of Primary Data Collection

Stakeholder Focus Groups and Interviews

The stakeholder focus groups and stakeholder interviews were analyzed together and the PWLE interviews were analyzed separately. Thematic results for both groups are summarized below.

Stakeholder Themes: Five overarching themes emerged from the stakeholder focus groups: 1) Stakeholder Experiences with the Opioid Epidemic, 2) Cultural Challenges, 3) Challenges to Providing Services, 4) Partnerships & Collaboration, and 5) Policy & Law. See Table 1 below for the breakdown of codes by theme.

Table 1: Themes and Codes from Stakeholder Focus Groups and Interviews

Theme	Codes
Stakeholder Experiences with Opioid Epidemic	Personal Experiences
	Environment of Drug Use
	Personal Accountability
	Prompt Support (previously willingness to change)
	Eager to Learn
Cultural Challenges	Stigma
	Resistance to Change
	Discrimination
	Emotional Impacts to PWLE
	Emotional Impact to Stakeholders
	Denial/Head in the Sand
Challenges to Providing Services	MAT Hesitancy & Misconceptions
	Message from the Wrong People
	Difficulties in Navigating the System
	Resources
	Stakeholder Power Dynamics
	Dual Diagnoses/Holistic Treatment
	Loss of Trust in Treatment Providers
	Lack of Education and Understanding
	Cross-Sector Connectivity

Partnerships & Collaboration	The Importance of Continuity of Care
	Programmatic Sustainability
Policy & Law	Competition for Funding
	Data
	Insurance

Stakeholder Experiences with the Opioid Epidemic

Conversations with stakeholders throughout the focus groups and interviews expressed common experiences with the opioid epidemic in Dallas County. Stakeholders described in detail the environment of drug use in the area, sharing the impact of fentanyl and how the landscape of drug use and addiction has shifted because of it. Most strikingly, participants stated that fentanyl has changed the "face of addiction." Where the primary concern was once people becoming addicted after using a substance once, now, fentanyl has shifted the primary concern to people using once and dying as a result.

Within these descriptions of the opioid crisis in Dallas County, sentiments in recognizing the importance of providing immediate support to people with lived and living experience when they decide to seek help were made apparent. A participant summarized this sentiment by saying:

> *"And it's like, really, this is like the Eclipse, right? It's gonna happen for four minutes on April 8th. And when somebody, like wants help, needs help, we want to be right there."*

Additionally, there was consensus on the acknowledgement that stakeholder groups had more to learn in this space and were eager to meet that need. Conversely, stakeholder groups also acknowledged the gaps associated with the hardships of navigating support, treatment, and care for PWLE and noted that there is an element of personal accountability that PWLE must carry. Medical professionals in the focus groups noted that there is a "certain onus" on the person to seek treatment after coming to an emergency room (ER) that cannot be forced. However, the system and linkage to care within Dallas County is complex, and often times there are not clear "next steps" for PWLE upon leaving the ER, and if there are clear next steps, there is often an availability issue with bed space in residential treatment centers.

Lastly, stakeholders shared some of their personal stories about addiction and substance use, and several had lost family, friends, and colleagues. One participant shared that his personal experience gave him empathy to relate and have compassion for PWLE. These comments within this theme paint a picture of what the opioid crisis in Dallas County is like from the stakeholder perspective.

Cultural Challenges

This theme encompasses patterns pertaining to cultural and societally held beliefs surrounding substance use and PWLE that make it challenging for stakeholders to provide optimum care and support, and even causes issues within stakeholder partnerships leading to significant gaps in support for PWLE groups. Stigma was a significant contributing factor to these cultural challenges, with many stakeholders commenting and reaffirming the well-known evidence that stigma often triggers relapses. Many stakeholders shared their personal experiences where they witnessed someone seeking help face stigma, with one sharing:

"And the doctor said, 'what is it you're trying to get from me?'"

Resistance to change was another pattern that emerged within stakeholder discussions, where they shared frustrations surrounding the slow nature of change and changing people's minds. For example, one stakeholder shared a story regarding the pushback they received during discussions for expanding their treatment services and said, *"and I got a call from the neighborhood association president, and he just blindly said, 'we really don't want your people here in our neighborhood.'"* These sentiments were prevalent within stakeholder administrations as well, with many commenting on how it takes time for leadership to change the culture of their departments and for it to trickle down into the lower ranks. These scenarios were described as "head in the sand" moments, referring to situations where community members refused to acknowledge the problem, with one participant stating specifically that often schools in Dallas County will not acknowledge there is a drug use problem with our youth, despite well publicized opioid overdoses occurring on school campuses. Another shared this head in the sand mentality is often seen in parents as well, sharing that many parents do not believe it can happen to their children, despite the increasing drug poisonings and deaths in our youth in Dallas County.

Stakeholders also commented on the role of discrimination against specific groups, like people of color and LGBTQIA+ individuals within the substance use and misuse space. One participant noted that many of their clients refuse to identify their sexuality for fear of discrimination, while another noted the inconsistent messaging around substance use leads to more stigma and discrimination. A participant emphasized this point by stating *"well when it crosses racial lines,"* referring to a story another participant shared regarding the media's changeability when describing overdoses and overdose deaths, stating that sometimes reports are worded as though someone were killed from 'fentanyl poisoning,' while another article about the same person says, 'an addict overdose.' These discriminatory instances regarding substance use and misuse compound the challenges PWLE already experience.

Lastly, recurring sentiments within the theme of cultural challenges was the emotional impact to stakeholders and PWLE alike. Stakeholders commented on the emotional toll that PWLE experience as they interact with various checkpoints through the system. Participants discussed instances where PWLE experienced stigma during their efforts to seek help which re-traumatized them and often times, led them back to drug use. On the stakeholder side, some participants also shared that there is a personal emotional toll that comes with working in this space that often leaves them drained and mentally exhausted.

Challenges to Providing Services

Stakeholders experienced a wide variety of common challenges that persisted across the varying fields of public safety and criminal justice, health systems, and community-based organizations. Misconceptions around medicated-assisted treatment (MAT) for substance use and misuse were discussed across every stakeholder interview and focus group. MAT consists of a select number of medications that can be prescribed to help treat SUD and are used to treat symptoms of opioid withdrawal, but do not cause a euphoric high, allowing people to take it long-term and to function effectively within society

The most common misconception was relating to the notion that someone on MAT is simply replacing one drug with another. This hesitancy towards MAT may exist because these medications are also opioids, but without the euphoric "high" that other opioids cause. However, MAT is approved for long-term treatment by the FDA. Notably, sentiments and hesitancy towards MAT also exist within PWLE groups per stakeholders.

"[T]here's a huge disconnect in the recovery community about what MAT is and how it can help them, why these people are on MAT, that they're kind of fighting the battle within their own community recovery. So, it's a real struggle for them."

Additionally, stakeholders pointed out that individuals who have undergone treatment (either residential or outpatient) and are seeking sober living arrangements to prevent returning to environments that may have initially facilitated their drug use often encounter obstacles because many sober living facilities do not permit entry for those on MAT. These facilities are usually abstinence-based and follow programs in line with Alcoholic Anonymous (AA) or Narcotics Anonymous (NA). This reality leads to real gaps in services for PWLE groups, with some even starting their own MAT-based groups so they can access the steps and methods of other groups like AA or NA, but without the stigmatizing beliefs that they are trading one drug for another.

MAT misconceptions also include logistical barriers for stakeholders. A focus group participant commented on an intersectional barrier where sober livings that do accept people on MAT are often financially inaccessible. Yet another participant discussed the challenges with having to balance the diverse rules that vary from sober living facility to sober living facility. Ultimately, stakeholders asserted that while the more traditional approach to treatment like AA and NA is the right path for some, it is not the only path, and that people who are on MAT long-term still need and deserve safe places to continue their recovery journey post-treatment.

Generally, other challenges to providing care were a lack of resources across the board for stakeholders. Many noted that they were often understaffed, underfunded, and had limited space for the number of people who needed care and treatment. The lack of beds for inpatient treatment centers was especially a concern, with many participants noting the importance of connecting someone to treatment as soon as possible. This lack of space within residential treatment centers lead to long wait lists and makes it challenging for those who are perhaps detoxing and in significant pain to not have a place to receive attention, care, and support, which often leads people to using once more. Another limited resource was the availability of housing, with many stakeholders pointing out that people are often discharged from residental treatment centers and put right back in the environment that may have led them to use substances in the first place. These conversations led to comments regarding the significance of dual mental health diagnosis and holistic treatment to provide wraparound services from the beginning of someone's journey all the way through long-term recovery to address these significant gaps in providing comprehensive care to PWLE groups.

Notably, one participant commented on the egregious gap in services, treatment, and support systems for those who speak Spanish. This participant shared that there are no inpatient facilities that offer services in Spanish in Dallas County. When 1 in 5 of our residents have limited English proficiency, and of those that have that limited proficiency, 81% are Spanish speaking, this is a significant and harmful gap in our ability to provide holistic care to all Dallas County residents.

Yet another limited resource and thus a notable gap for Dallas County is not only the availability of bed space and safe housing, but treatment centers for adolescents. Dallas County does not have a single residential treatment center outside of the juvenile justice program for teenagers with substance use disorders. As the system exists today, the only way someone under the age of 18 can receive in-patient treatment is if they commit a crime and are sent to jail, where Parkland Hospital will provide treatment and MAT within the jail itself.

Notably, participants also discussed the reality of an existing power dynamic between themselves and the communities they serve and the impact this dynamic has on providing care and earning the trust of PWLE. Some stakeholders shared their experiences of PWLE working through treatment centers that were too rigid and forced, while others mentioned sober livings not always

following sobriety rules – both scenarios ultimately leading to unsafe spaces for those who are seeking to recover from substance use and abuse.

Stakeholders also commented on the importance of education and ensuring the message is communicated by a peer. Many stakeholders acknowledged that within their own organizations and systems there were often people who lacked education surrounding substance use and misuse. For example, a participant in law enforcement noted that there is a lack of understanding in the scope of opioid use in Dallas County law enforcement agencies and acknowledged that fentanyl is only the beginning, emphasizing the need to provide internal education. Ultimately, stakeholders believed there was much to do internally in addition to externally to appropriately and effectively address the opioid crisis in Dallas County and close the gaps in education within stakeholder groups.

Partnerships & Collaboration

All stakeholder discussions included comments surrounding the criticalness of cross-sector collaboration and partnership. Many noted the duplication of services within the county. Stakeholders discussed that coming together to discuss, collaborate, and determine each other's priority services (what they do best), funding sources, and needs would help to ensure that the network of support services across Dallas County are intentional, intersectional, and begin to build connectivity and move away from a zero-sum game system. However, many noted that a significant barrier to these collaborations is a lack of awareness of one another.

Within discussions of the role of partnerships and collaboration, stakeholders expressed the necessity for their connectivity to improve and ensure continuity of care. This is especially significant in areas with limited resources for harm reduction efforts, such as Dallas County. Cross-sector collaborations not only allow for a de-duplication of efforts and maximization of resources but promotes optimum care and support for people seeking services for drug use and abuse. The spectrum of continuity of care is vast and includes the social determinants of health, such as the housing, education, finances, and healthcare access which are critical to be healthy and lead healthy lifestyle. Despite this necessity, many do not have access to these determinants which not only contribute to drug use in the first place, but also make accessing treatment and recovery resources extremely difficult. It then expands into the services and stakeholders that first interface with people who use drugs, such as emergency rooms or police officers. From there, if people need residential treatment, the criticality of having bed space is most significant, as the window when someone admits to needing help and is ready to follow through is incredibly small. Furthermore, if someone were to receive treatment and graduate from their program, having a place they can go to live and maintain sobriety is critical. Cross-sector partnerships can facilitate a more holistic approach to providing services and linking organizations that provide varying services across the stages of recovery to one another. Stakeholders discussed how partnerships can then foster programmatic sustainability across the continuity of care spectrum and have significant implications for closing service gaps within Dallas County.

Policy & Law

The last major theme across stakeholder focus groups and interviews discussed was the impact of policy and law in Dallas County on providing services to PWLE. A heavily discussed concern amongst stakeholders was the reality that they are forced to compete against one another for limited federal and state funding.

This competition between organizations and across stakeholder groups creates challenges in providing wraparound services and holistic treatment across the continuity of care spectrum. Instead, stakeholders emphasized the need for them to continue to connect so they can develop

comprehensive, collaborative plans to bolster wraparound services and availability of holistic treatment.

A significant barrier to providing optimum treatment services were also the challenges surrounding insurance. Many stakeholders expressed varying challenges dealing with insurance, ranging from a lack of coverage for those who need their services most, the requirement of prior authorizations for MAT, low reimbursement rates for individuals on Medicaid, and how all of these policy-level issues create barriers to PWLE to access their services, but also for stakeholders and their organizations to continue to provide services.

> *"Our most expensive youth to treat were the lowest reimbursement rates and our highest reimbursement rates are least expensive to treat."*

Stakeholders felt strongly that policies needed to be updated to reflect modern standards for substance use and misuse treatment and education. Currently, policies that exist require treatment providers to connect education of drug use to hepatitis or use outdated reference manuals rather than focus on overdose prevention. These outdated policies create barriers and create notable gaps in providing comprehensive, evidence-based education, care, and holistic services for community members in Dallas County.

People with Lived Experience Interviews

People with Lived Experience Themes: Three primary themes emerged from conversations with people with lived experience of drug use and misuse during interviews. Within each theme are three subthemes that characterize the nuance within each theme. See table below:

Table 2: Themes and Sub-themes from People with Lived Experience Interviews

Theme	Sub-Themes
Understanding the Impact of Trauma	Childhood Experiences/Trauma
	Contradicting Needs for Authenticity and Attachment
	Generational Trauma
Importance of Safety	Understanding Safety-Seeking Behaviors
	The Need for Comprehensive Care
	Creating Safe Spaces
Promoting Resiliency	Intrinsic Motivation
	Building Self-Efficacy
	The Need for Community

The semi-structured interview questions with PWLE followed a phenomenological methodology that prioritized lived experience. Thus, participants were asked to walk the interviewers through their story, from the beginning to where they are now. Themes that were generated (understanding the impact of trauma, importance of safety, and promoting resilience) identified three broad areas of need for PWLE: acknowledgment of root causes of substance use, usage of

holistic and safety-centered approaches in every sector, and opportunities to build self-efficacy and sustainability for long-term recovery.

Understanding the Impact of Trauma

A common analogy within the field of prevention describes the process of addressing complex public health issues as similar to a parable of villagers discovering babies repeatedly floating down a river and, instead of continually pulling babies out of the river, deciding to go upstream to find out who was throwing babies into the river in the first place. The principle of the story alludes to the crucial need to identify the root causes of these complex issues. In conversations with stakeholders, the word "stigma" was often used to refer to harmful stereotypes they believed needed to be addressed, but the question remained: what would that really look like in practice?

Across countless hours of conversation, PWLE lamented on the fact that among people in their lives, and others that they encounter in various contexts, it is often an uphill battle to be treated humanely, often due to a lack of understanding of the context of their substance use. Nearly every participant shared stories of adverse experiences (often in childhood, but some well into adulthood), whether that was physical abuse, sexual abuse, emotional abuse, or neglect. Participants reported that these adverse experiences impacted them in various ways including damage to their sense of self-worth and increased social isolation.

It is important to note each participant related to these experiences with various degrees of attachment. This is significant because among stakeholders who may encounter PWLE, it is crucial to note that PWLE may reflect on these experiences in a more subtle manner, or some may not mention them at all due to the fact they had to emotionally detach to survive. The development of these involuntary instincts has long-lasting effects on their lives. Many participants noted difficulties in being able to recognize what they needed or struggled to act on those needs early on in their recovery. Although a survival instinct, this lack of physical, mental, and emotional awareness puts individuals at higher risk for substance misuse due to the detachment of an individual from the ability to recognize their physical, mental, and emotional needs.

> *"Because at home I wasn't getting the attention, the love, the care. You know, all I got was a lot of depression, a lot of anxiety, a lot of abuse. And so I found comfort in drugs and in my new drug family. [...] they were giving me the comfort and the attention and you know, I thought they were giving me love, but you find out later on, it's really not love. They were giving me the things that I needed that I was missing at home. So I actually found myself not going back home one day. And I stayed in the streets for seven years after that."*

Many participants mentioned that they were exposed to substances from their parents or caregivers. Although a few participants noted that their parents or caregivers were not intentionally trying to harm them, it was still clear that the environment of substance use created early adversity for those participants. Growing up in those circumstances can make it even more difficult for those individuals to maintain hope and break the cycle.

> *"[...] in the end me and my mom did drugs together. And I feel like me stepping back into my kid's life [now that I'm sober], I kind of stopped that generational [cycle]. Because my grandma gave me pain pills all the way until the day she died. I was always high off Vicodin and my mom always made sure I had meth. I never went without. So I feel like if I would've stayed in my kids lives [back then], they would be getting high with me now at this point, and it would have just kept going."*

These sentiments highlight the urgent need for the acknowledgement of root causes of substance use, but in practice, this theme emphasizes the need for trauma-informed practices in every sector

that interfaces with PWLE. Although it cannot be definitively stated that all PWLE experience trauma, there is a high prevalence of trauma survivors among PWLE. Whether traumatic stress symptoms are present or not, the simple action of approaching each individual with the intent to truly understand and create a safe space, even in a 10-minute interaction, has profound benefits and increases the likelihood of that individual to engage in services and improve their long-term outcomes.

Importance of Safety

Participants across the board expressed a desire to be understood. Although the group unanimously agreed that if someone doesn't want help, there is nothing that can be done, a majority also agreed that truly understanding and respecting someone's need for safety and building upon that sense of safety is most effective in bridging that gap. As stakeholders ponder effective approaches to reaching PWLE, it is crucial they understand the safety-seeking nature of substance use, the importance of comprehensive services, and what it means to create a safe space for those struggling with substance misuse.

> *"[…] communication is very, very limited when you're deep in addiction […] because the entire addiction is surrounded by defense walls that are like 'no this is the only thing I can do, like this is literally the only way I can be alive and survive anything because to not numb my emotions would be worse than death.' And I think for people with like really like intense trauma like that, that can be almost true. Sometimes it does feel worse than death."*

Conceptually, substance use is widely recognized as a coping mechanism, but the practical application of this knowledge in real-life circumstances often leaves much to be desired. For instance, the degree of empathy extended to someone who is not ready to begin recovery is often significantly less than those actively in recovery.

When participants were asked to expand on the factors that impact their reluctance to begin recovery, it became clear that, for many, substance use is a safety-seeking behavior. Although unhealthy, substances often have been the best coping tool PWLE have had for a long time. Without replacing that tool with another way to cope, the thought of facing recovery is often riddled with intense fear. In fact, many participants reported that their recovery journey only began after they had a pivotal moment of intense distress in their life that gave them the temporary momentum to overcome their previous fear, such as the death of a loved one to substances or a near-death scare themselves. Therefore, a crucial first step is acknowledging the dignity and humanity inherent in every person with lived experience.

The second step, then, is understanding the holistic nature of substance use issues. A major concern of all three stakeholder groups was the lack of accessible, high quality transitional housing and affordable wraparound services. This issue was echoed by PWLE participants who discussed the importance and impact of accessible resources like education, jobs, mental health services, and other services they may need to heal and build self-efficacy. In particular, access to transitional housing with the appropriate level of therapeutic care was nearly impossible for those who searched on their own. One participant noted that the only housing they were able to access required them to abide by an Alcohol Anonymous program, but the nature of the program itself did not address healing from trauma at all and left them feeling more traumatized. Another participant expressed frustration that their court-appointed attorney pressured them to accept charges without informing them of the impact it will have on their ability to access housing.

Logistical barriers encountered by participants, such as getting a driver's license, their birth certificate, or other important documents needed to succeed in life were also troublesome and

contributed to feelings of hopelessness, loneliness, and their dependency on substances. While those who had access to comprehensive, wraparound services lauded the impact it had on their ability to succeed in their recovery, others who were either unable to access or were unaware of those comprehensive services reported increased difficulty in struggling to support themselves and stay sober without better resources. This seems to indicate that while successful wraparound services may exist within Dallas County, there is a need to expand those services to be accessible to more of the of the population. As mentioned in stakeholder discussions, this would require increased collaboration with other sectors of the community, increased funding and capacity, and further education and awareness of such available resources.

Many participants encountered the criminal justice system, healthcare systems, and community-based organizations on multiple occasions. The feedback was mixed, depending on the quality of interpersonal interactions experienced by the participant. Those who reported negative interactions felt those they encountered did not value their lives, weren't willing to take the time or effort to listen and truly understand or weren't interested in their holistic needs. This was evident in multiple instances where participants shared that healthcare providers they encountered either completely rejected their request for help or spent so little time trying to understand that they misdiagnosed their patients and provided them medications that further exacerbated their mental health issues.

> *"You know, I literally asked them for help in the hospital for rehab. And they told me no, they ended up discharging me and told me to go back to Dallas [...] So at that point from me wanting to get sober, I just wanted to get back to Dallas and get high at that point because I was in so much pain."*

Conversely, however, participants described vastly more positive experiences with service providers and practitioners who had lived experience and those who PWLE perceived as advocates who understand and highly value their lives and holistic needs. Participants shared that these individuals advocated for them in various settings whether it was regularly speaking with the district attorney on their behalf or taking the time to sit with them at the courthouse. Some even mentioned a particularly compassionate case worker or a therapist who shared their personal experiences with trauma. Many reported that these providers and advocates immensely improved their ability to feel safe, build trust, and truly engage in their healing journey and recovery process. This finding further emphasizes the efficiency of holistic, safety-centered approaches in improving long-term outcomes for PWLE.

The third and final step of this section explores what it means to create a safe space for PWLE. Although participants had differing opinions on what recovery should look like, the unanimous opinion among participants is there is no "one size fits all" solution when it comes to recovery, contrary to mainstream opinion. Participants emphasized that each journey to recovery has its unique challenges and is rarely linear. Most participants experienced a relapse at some point in their journey. Some expressed certain MAT medications worked for them, while others realized they needed to try several medications before finding one that worked for them. Some found comfort in sober living communities, while others found themselves ostracized for not following socially accepted rules for recovery. However, nearly all participants agreed that the current structures of recovery are seldom concerned about allowing PWLE to have a say in what works best for them. Participants stressed that this intense pressure from rigidly structured recovery systems often created an environment in which unrealistic expectations led to feelings of shame and further isolation, hindering recovery rather than aiding it. Recovery is a recursive process. Therefore, the prioritization of making space for all PWLE's to share what their unique needs are, and to honor and meet those needs, is essential in creating safe spaces.

> *"In rehab [...] I told them, like, 'Hey, I need a certain amount [of time] a week alone.' Because their whole thing was like, 'busy, busy, busy, keep them busy, so they don't relapse,' you know? And like I would relapse if you did that to me, because I literally cannot function if something is always happening and penetrating my everything"*

Participants also unanimously agreed that if someone is not ready for recovery, there is no way to force them that will ultimately result in long term success. However, participants also reflected that there were a few ways to bridge that gap with higher levels of success. These methods all require being willing to meet PWLE where they are. In practice, this refers to the necessity of individuals who are willing to unconditionally express compassion, nurture a safety-centered environment, respect PWLE's autonomy, and assist with what PWLE expresses to be their high priority needs. This process requires stakeholders to invest a great deal of time, energy, and effort, but participants insist that building upon this foundation of safety and trust will be most effective in the long term.

> *"[He] knew my language and cared enough to speak my language, exactly as I needed to hear it. […] he didn't pressure me in any way, or try to make any decisions for me, or make any ultimatums, […] It was just planting seeds, watering them in my language specifically, which is hard to explain. But you just have to get to know somebody. You have to care for them and show unconditional love. So that they know that no matter what they do, you're not going to judge them and that they're safe..."*

Lastly, it is prudent to note that within every effort to create safe spaces, it is crucial to have awareness of populations that are adversely impacted by systemic barriers to recovery, such as the LGBTQIA+ population, disability community, limited-English speaking populations, immigrants, and others. Participants who identified with these groups expressed struggling with compounded layers of stigma not only regarding their substance use, but also the intersection of the other facets of their identity. These intersections of their identity make them particularly vulnerable to trauma and, subsequently, substance use.

Only one PWLE participant identified with the disability community. However, despite the limited representation, the experience they shared as an autistic adult revealed a glimpse into the elevated risk the disability community has in developing a substance use disorder, particularly those with "invisible" or non-apparent disabilities. The participant expressed frustration that because they appear "high functioning" and do not have the obvious characteristics of what most consider a disability, they did not receive support either as a child or as an adult, causing them to be further isolated and reliant on substances as their only constant in life. For autistic adults that have some ability to work and communicate, these misconceptions put them at an exacerbated risk of substance use because although they may be able to "blend in" or "mask," this comes at a steep cost as these individuals must constantly endure an onslaught of painful sensory input and are often seen as misbehaving or being disobedient, uncompliant, or otherwise difficult due to communication barriers.

It is no surprise, then, that living in this reality puts autistic children and adults at a high risk of substance use to cope with their inaccessible environment. This participant also highlighted that those same communication and sensory needs directly excluded him from being able to effectively take part in treatment, recovery communities and support, and other recovery-related programs because most relied on structures and tasks that were too overwhelming for this participant. The vast diversity of impairments in the disability community reflects a challenge to service providers in ensuring their services are accessible. Several factors including limited funding, logistical support, and disability awareness impact the ability of providers to address these disparities and represent an area of needed improvement.

”I’m very proud of myself for [surviving] but I really weep for all those that didn’t because we are not even thinking of them. We’re not putting any resources towards them. We are not thinking that they even exist. And then that makes me really sad because it’s like unmarked graves […] We exist and we are dying because no one thinks we exist. Autistic adults exist. Autistic adults in addiction exist, and we are completely void [of] help. And we need it.”

As discussed in stakeholder discussions, LGBTQIA+ individuals are at a higher risk for experiencing trauma related to their gender identity or sexual orientation. One participant who identified as transgender male shared the isolation he experienced and its subsequent effect on his substance use. He shared his traumatizing experience coming out to his parents as queer and transgender, during which they opted to call him “it” as opposed to using his “he/him” pronouns and asking if he would be having sex with dogs next. This response, while dehumanizing and vulgar, is sadly not uncommon for LGBTQ+ youth and adults. The participant emphasized that this especially was isolating because his other source of social support was his religious community who, after discovering his queer identity, ostracized him because he was not “*pure or holy enough to be around or affiliated with.”* These traumatic experiences on top of the social alienation directly led to him relying on substances to cope. However, there are limited resources that not only accept LGBTQ+ individuals but are truly affirming. There is a difference in simply allowing an individual to participate in services and being truly committed to not further perpetuating cycles of trauma by using intentional language and being cognizant of these traumas in therapeutic approaches for these individuals. These stories echo countless others in the LGBTQ+ community, corroborated by the clear data trends from both the Trevor Project and SAMHSA’s aforementioned reports.

Additionally, immigration status often plays a similar role. One participant recounted how her experience as an immigrant had a similarly damaging effect on her self-worth and ability to find a job to support herself, despite living the majority of her life in Texas. Those who are non-citizens, especially in a political environment that deems their existence to be illegal, are prone to experiencing violence and prejudice in their daily lives and face significant barriers to education, healthcare, and gainful employment. Further, these individuals must overcome many administrative and financial barriers during the lengthy process to get legal residency or citizenship.

This now familiar sense of “being stuck between a rock and a hard place” places these individuals at a high risk for substance use. The participant also explained how she was led to believe that if she asked for help, she would put herself at risk of being deported. These sentiments impact these individuals’ ability to feel safe enough to reach out or receive care and are a significant barrier to treatment and recovery for immigrant communities. Further, these participants experienced a higher prevalence of encountering service providers who were judgmental, which only served to cultivate an environment of fear and distrust, further isolating them from resources, and creating an aversion to seeking help.

Stakeholders in the criminal justice sector previously lamented that there was an absence of services they could use for Spanish speakers who needed inpatient treatment services. They noted that usually send people to Hidalgo, TX, but they were unable to do so for undocumented individuals. These gaps in care are detrimental to PWLE who are already vulnerable to higher rates of morbidity. Addressing these gaps in care for those who often fall between the cracks is essential in giving these PWLE hope.

"The system is designed to make sure there is no space for people like me. That there is no hope for people like me, that there is no success for people like me. And that if we have any success, that we pull ourselves up by our non-existent bootstraps, from the

boots that we don't carry. [...] When I say the system didn't fail me, it's because [it] succeeded in what it planned to do, which was completely, completely make my existence futile."

Notably, a majority of the participants who reported positive experiences with recovery mentioned the Nexus Recovery Center – a non-profit organization that offers a wide range of substance use treatment and wraparound services for women in the North Texas area. While many participants reflected on the comprehensive support they received from the Nexus Recovery Center, it was also noted in stakeholder focus group discussions that the organization only serves women and – to their knowledge – there were no comparable programs for men in Dallas County. Furthermore, the only male PWLE participant reported a lack of accessible comprehensive support services and long-term care options, sharing that he was constantly told to *"be a man [and] get over it,"* hinting at unique stigmas men may experience in seeking help.

Despite a limited sample, it is apparent that an already difficult journey to recovery is made particularly debilitating for our most vulnerable populations. It is imperative to note that the participants represented in this assessment are only a small representation of countless stories, each with their own distinct experiences and adversities. However, while the dissonance that exists between vulnerable populations and more privileged populations is not a new concept in the field of public health, it is apparent that there is an urgent need to address the systematic barriers to accessible, quality care for every member of our community. These findings support the need for additional supports and resources for those struggling with substance use and misuse who are also a part of our most vulnerable populations. Just as PWLE experience increased success with those who inherently understand their struggles, it is perhaps best practice to not only include these communities in decision-making processes, but also to make intentional efforts to integrate members of these populations into services that aim to serve PWLE.

Promoting Resiliency

As many in the recovery community will tell you, recovery is a lifelong journey. Although the path to recovery is seldom as simple as one would hope it to be, many PWLE shared the sentiment that recovery often starts with *"[being] sick and tired of being sick and tired."* However, PWLE often struggle with dismantling years and years of living with substances as a deeply ingrained survival mechanism, easily triggered by life stressors and triggers, especially in the early stages of recovery. Thus, the final piece in the process of healing must be to focus on building resiliency to face life's inevitable adversities. This section focuses on the importance of finding intrinsic motivation, building self-efficacy, and the need for community to ensure long-term sustainability of every PWLE's recovery journey.

As previously stated, many participants discussed experienced a pivotal moment in their lives that kicked off their journey in recovery; these events often were moments of extreme distress or fear whether it was a death of a loved one who also used substances, or a moment where their own life was in danger. Regardless of the cause, participants shared that these moments of momentum were seldom long-lasting. This echoes stakeholder sentiments that it is crucial to offer intervention options and resources in these short critical windows. Overdose Response Teams, for example, aim to make contact with individuals that experience an overdose within 72 hours. Both stakeholders and PWLE participants recognized that these moments are fleeting, and someone may change their mind on pursuing recovery after a few days of no progress. Although unfortunate, this phenomenon is unsurprising because fear-based motivation and other external motivators are short term by nature. Justice-involved participants, for example, noted that they may have been court-mandated to go through treatment multiple times, but every single person emphasized that the only time it stuck was when they found internal motivation to do so. This

essential evolution in motivation must occur from the beginning stages of the recovery journey to take root.

> *"I think I was at the point where it was like, 'Well what do I have to lose? Like, I don't care about myself enough to care.' […] [But my friend] just planted seeds, and he wouldn't be like, 'Oh, you need to help, like, you need to do this, you need to do that, you're fucking up' […], he would just be like, 'hey, you know, we have really, really deep conversations, I wouldn't ever want to lose that with you. And I'm afraid that one day you won't be able to connect with me anymore, because it will have taken its toll on your brain. And you wouldn't be able to have these deep spiritual conversations with me anymore. And that would make me really sad.' And that stuck out to me."*

While this intrinsic motivation is crucial in the early stages of recovery, it is not enough to stop there. Most participants shared that they often struggled with self-love and the overall concept of valuing their lives in the beginning, hence the need to often find intrinsic motivation through a loved one. However, an essential step in healing for PWLE lies in self-acceptance, self-forgiveness, and self-love. PWLE shared that, in the long term, it wasn't sustainable to be in recovery for others. Eventually, they had to heal for themselves. Eventually, they had to believe that they deserved to live healthy, whole lives, and believe that they had the ability to achieve that.

> *"When I actually got into school, and they accepted me, that was a good feeling for me. [...] this kid, my classmate, he was like, 'oh, you should fill out for honors,' [...] And I was like, 'I don't think I'm gonna get it.' So, I did it anyways, like, he stood there with me. And I filled it out. And I actually got it. You know, so it was like, 'wow, I can do these things.' And I had more hope in myself. And I just hope that I can show that to other people. And that they can see like, you can turn yourself around because I've been homeless. I've been a prostitute. I've been on the street. I've done all that. But I'm not that today. And I'm not that type of person today. I try my best to be better every day."*

While this is an internal process that must happen organically, stakeholders and loved ones can help facilitate this process by creating opportunities for PWLE to achieve success and build self-efficacy. In practice, this echoes earlier mentions of holistic services and includes eliminating barriers to wraparound services that support PWLE on their path to becoming self-sufficient. A few examples of support participants deemed helpful were: help getting job experience, help learning how to interview, help getting interview clothes, help getting their GED, help applying for college, help applying for financial aid, help getting their drivers license, birth certificate, and other important documents, help finding affordable housing, help finding a high quality, trauma-informed therapist, and more. For justice-involved PWLE, navigating the criminal justice system is often overwhelming and disheartening, so facilitating self-efficacy in this space involves ensuring that PWLE have a reasonable path to being reintroduced to society.

The concept of hope is strong in this theme and was perhaps the most important piece of every PWLE's journey. The ability to hope, to find purpose and meaning in life, these concepts and the search to find them are universal to not only every person with lived experience, but also every human being in this world. Participants all noted that isolation from social support often is a stressor, and subsequently emphasized that an essential part of their ongoing success in facing adversities lies in finding community. This may not necessarily mean a support group, this often refers to a social support network of various "safe" individuals or groups whom a person trusts and provides a safe space to share experiences, to feel connection, and to feel love and compassion.

Summary of Key Findings

Though efforts were made to include diverse perspectives, the DCHHS-RRC team acknowledges that the participant sample is not directly representative of the population due to recruitment constraints. Thus, there are certain limitations in the generalizability of the results, as is the nature of qualitative data. The minimal male participation and complete absence of cisgender male and non-binary participants is one such notable limitation. The absence of American Indian and Alaska Native (AI/AN) individuals is another crucial limitation.

Table 3: Summary of Key Issues Experienced by Stakeholders and PWLE

Stakeholders Key Issues	PWLE Key Issues
• Lack of Funding • Logistical Constraints • Cultural Resistance • Lack of Cross-Sector Communication/Collaboration • Fragmented Continuity of Care • Outdated Policies • Lack of Education/Awareness • Political Resistance • Insurance Infrastructure • Limited Resources for Special Populations • Delays in Care • Prevalence of Fentanyl • Communication Barriers with PWLE • Limited Knowledge of Available Resources • Shortage of Resources (Accessible Transitional Housing, Residential Adolescent Treatment, etc.) • Data Sharing Challenges	• Cross-Sector Trauma-Informed Practices • Usage of Holistic and Safety-Centered Approaches in Every Sector • Opportunities to Build Self-Efficacy and Sustainability for Long-Term Recovery • Access to Comprehensive Wraparound Services • Accessible Housing • Holistic Care • Reasonable Path to Reintroduction to Society • Flexibility in Recovery • Quality of Services • Accessibility Challenges for Vulnerable Populations (LGBTQ+, Disability, Limited-English Minorities, etc.) • Access to Social Support • Integrating PWLE peer specialists into cross-sector services

Overall, stakeholders and PWLE participants both provided rich context to the rapidly evolving environment in Dallas County. Although there were notable differences between participants, there was significant agreement in several areas: the need for high quality transitional housing, increased accessibility to holistic wraparound services, and the need to address stigma surrounding people with lived and living experience.

Participants across the board agreed that in addition to the need to increase the availability of transitional housing, there is also a need to ensure these housing options are treating both substance use and mental health, are accessible to PWLE recovering in non-traditional ways, and have systems of quality control in place to prevent re-traumatizing PWLE. The expansion of holistic wraparound services was also discussed in detail, and those who had access to current services such as Nexus Recovery Center gave overwhelmingly positive feedback in the support they received in their recovery, but others who did not have access to these services expressed frustration and hopelessness and noted difficulties in accessing resources and support. Stakeholders also expressed frustration with the fragmented nature of the current structure, sharing that there were too many barriers to improving the quality of life of PWLE.

Furthermore, stakeholders across the board emphasized the barriers they face in their work due to stigma and how it creates a cultural resistance to change both externally with service providers and the general community, as well as internally within recovery communities. PWLE participants expanded on the nuance and lamented that many in the recovery community and other stakeholders reliant on traditional recovery paths were too rigid and created an environment that perpetuated shame. This ultimately indicates that safety-centered approaches across every sector are the best way to counter that stigma, that the integration of trauma-informed practices are needed across sectors, and that collectively, in practice, we must emphasize the use of peer support specialists in these various settings to foster trust and connection. As indicated in discussions surrounding the harmful effects of unregulated environments for PWLE recovering in non-traditional ways, it is crucial to pair the safety-building aspect of utilizing lived experience with the therapeutic aspect of evidence-based interventions to ensure high-quality care for PWLE.

The biggest issue identified across stakeholder groups was poor funding and its impact on the quality of service they were able to give, and the reach they were able to have with their services. This issue highlights the need for advocacy with local, state, and federal policymakers who can create systemic change. Specifically, funding must be increased and made sustainable at the federal, state, and local levels for treatment and linkage to care. There is a need to educate these decision makers on the current environment of substance use and work to update outdated language that hinders the ability of providers to provide holistic care to PWLE. However, it was also noted that having advocates that can “speak the language” of these decision-makers is crucial. Therefore, cross-sector collaboration to ensure both the accuracy of the message and the reception of said message are addressed by the relevant experts of that sector. Furthermore, several stakeholders, particularly in the criminal justice sector, explained that although there were many passionate advocates for improvements in current systems in place for PWLE, there are often logistical barriers to ensuring that changes are being implemented correctly on the ground level by those who have direct contact with PWLE. It is imperative to make a conscious effort to adjust these systems to ensure services are working as intended.

Among PWLE participants, there was less emphasis on macro-level issues than there was on issues surrounding interpersonal interactions. PWLE participants acknowledge that traditional systems of recovery may work for many people, but there is a growing urgency to address the lack of quality resources for individuals who do not fit the traditional recovery path. This includes those on medically assisted treatment as well as vulnerable populations such as the LGBTQIA+ population, the disability community, limited-English minorities, and other marginalized groups. Conversations with PWLE participants repeatedly circled back to the same three broad needs: acknowledgment of the root causes of substance use, usage of holistic and safety-centered approaches in every sector, and opportunities to build self-efficacy and sustainability for long-term recovery. These needs, in combination with the urgent need to adjust recovery systems that have long been reliant on traditional paths of recovery to be more inclusive and flexible for all PWLE, are the most pressing priorities for this group.

Recommended Strategies

"If you don't want help with something, then you can't be helped in that area. But everyone wants help with something, I think. I think everyone wants help with something, and maybe we're just too afraid to ask."

This CNA revealed a variety of important findings across stakeholder groups and people with lived experience in Dallas County. The stakeholders discussed key gaps that create challenges in their ability to provide services to PWLE and the impact of stigma within their own organizations. The narratives provided by the PWLE participants painted a picture of adversity and hope and contextualized stakeholder experiences, bringing humanity to the subject of substance use and misuse in Dallas County. Unanimously, all participants agreed that there was significant need for increased funding and investment in all treatment and support services, holistic wraparound services, accessible treatment centers for youth and adults, a creative and collaborative approach to developing a network of services to de-duplicate efforts and bolster resources, and a clear and unified stance against stigma internally and externally. See our recommended strategies for mitigating morbidity and mortality due to the opioid crisis below.

Capacity Building and Expansion through Increased Funding:

- ***Increased Federal, State, and Local Funding for Treatment and Recovery Programs*:** In Dallas County, the established shortage of treatment and recovery facilities creates a significant barrier to care. Increased funding is needed to expand access to evidence-based treatment, improve the quality of care, and provide greater support for individuals in recovery. These investments have the potential to save lives, reduce healthcare costs, and strengthen communities.
- ***Increased Funding for Youth Treatment Centers*:** There are no treatment facilities available to people under 18 who are struggling with substance use or misuse in Dallas County. This lack of resources leaves young people vulnerable, jeopardizing their health, education, and futures. Investing in sustainable funding for youth treatment centers would allow us to build, staff, and operate these centers, providing a safe space for adolescents to heal, receive professional treatment, and begin their journey to recovery.
- ***Invest in Spanish-Language Treatment Programs:*** In Dallas County, there are no inpatient facilities that offer services in Spanish. In a county where 1 in 5 residents have limited English proficiency, prioritizing funding for Spanish-language treatment programs is crucial to bridge the gap and provide effective, culturally competent care for all.
- ***Expansion of Bed Capacity for Existing Treatment Centers*:** A critical first step in addressing the addiction crisis is ensuring access to treatment when individuals seek help. Stakeholders and people with lived experience (PWLE) have consistently highlighted this need. No one in Dallas County should be denied treatment due to a lack of beds. Targeted funding for immediate capacity expansion at existing treatment centers is essential to mitigate current service gaps. Increased capacity will also reduce wait times, allowing PWLE to access care when they are most receptive to treatment, ultimately leading to more positive long-term outcomes.
- ***Invest in Outpatient Treatment Services to Close Gaps*:** Investment in bolstering, staffing, and expanding outpatient treatment centers is needed to create a comprehensive recovery ecosystem. While inpatient facilities address immediate needs, long-term recovery often thrives in outpatient settings with continued support and access to therapy. Additionally, ongoing outpatient support after residential treatment helps PWLE reintegrate into society and manage their recovery. Increasing outpatient treatment services will help to close gaps in recovery resources and will ensure PWLE have continued access to treatment once they've completed a residential stay.

- ***Increased Funding or Opioid Response Team Programs*:** Building on the success of the City of Dallas' existing Overdose Response Team (ORT), a county-wide expansion is warranted. The current program's collaboration between Recovery Resource Council and Dallas Fire-Rescue has proven effective in connecting individuals with resources and reducing overdose deaths. Dallas County Health and Human Services and Recovery Resource Council have partnered to expand the existing ORT Program to the other municipalities in Dallas County, but further investment is needed for increased personnel, training, and outreach efforts. This comprehensive expansion would ensure a more robust response across the entire county, ultimately saving more lives and offering a stronger safety net for those struggling with addiction.
- ***Expansion of MAT Services and Increasing Access to MAT*:** Expanding MAT services and increasing access to MAT (medication-assisted treatment) is a crucial step in addressing the addiction crisis in Dallas County. MAT, which combines medication with counseling and behavioral therapy, has proven highly effective in helping people with lived experience (PWLE) of substance use disorder achieve and maintain recovery. By streamlining access through initiatives like training more healthcare providers to prescribe MAT, advocating for broader insurance coverage, and addressing the stigma surrounding MAT we can ensure this effective treatment reaches a wider population in Dallas County, ultimately saving lives and strengthening our community.
- ***Expansion of Diversion Drug Courts*:** Expanding diversion drug courts in Dallas County is a critical investment in both public safety and individual well-being. These programs offer early intervention for those struggling with addiction, diverting them from the criminal justice system and setting them on a path to recovery. Studies show diversion courts significantly reduce recidivism rates, leading to safer communities. By increasing capacity and funding, Dallas County can serve more individuals and achieve higher success rates, making diversion courts a cost-effective solution for a healthier future.
- ***Accessible Transitional Housing:*** Transitional housing with expanded services bridges the gap to permanent housing, reduces homelessness, and improves recovery for those struggling with substance use and mental health. Accessibility is key, ensuring these programs welcome individuals on non-traditional paths and serve the needs of vulnerable populations. By providing a safe, supportive environment with tailored services, we empower individuals, strengthen communities, and create a more equitable society.
- ***Accessible Wraparound Services:*** To effectively mitigate the morbidity and mortality of opioid use and misuse in Dallas County, we must expand the availability of holistic wraparound services through cross-sector collaboration, communication, and partnerships and advocacy efforts involving relevant policymakers. By working together, policymakers, healthcare providers, and community organizations can create a comprehensive support system for individuals struggling with addiction.
- ***Cross-Sector Integration of Recovery Support Specialists:*** Expanding the use of recovery support specialists (RSS) in healthcare, criminal justice, and social services can significantly benefit people with lived experience (PWLE). RSS, such as peer navigators and recovery coaches, can provide unique understanding, advocacy, and system navigation support, all while reducing stigma and increasing engagement with crucial services. This cross-sector integration is key to building a more supportive recovery ecosystem.

Intersectional Changes to Implement Immediately:

- ***Intersectional Supports for Vulnerable Populations:*** The PWLE testimonies revealed the nuanced impact varying marginalized identities, such as those with disabilities or immigrant communities, have on those who are also experiencing addiction or working through their recovery. Thus, incorporating intersectionality in opioid treatment and recovery is imperative to ensure we are including our most vulnerable populations in our expansion of capacity and services. By acknowledging and addressing the unique challenges faced by vulnerable populations, we can ensure all individuals have access to the comprehensive support they need for recovery.
- ***Involvement & Integration of Vulnerable Populations:*** To ensure collective impact and collaboration, organizations in the opioid use and misuse space must create opportunities for members of vulnerable populations (LGBTQIA+, disability community, limited-English minorities, etc.) to provide input on priorities and initiatives. Additionally, service providers should prioritize hiring or collaborating with members of these communities to ensure those making direct contact with PWLE are better able to build rapport.
- ***Integrating Mental Health Services in All Stages of the Continuum of Care:*** Often, mental health and substance use are intricately woven together, so addressing both simultaneously is crucial. Mental health services must be integrated within the entire addiction treatment continuum, from initial detox to ongoing recovery support groups. Additionally, efforts to effectively address underlying mental health issues that contribute to substance use and also increasing the access to affordable mental health treatment in tandem with substance use treatment is paramount. This comprehensive approach will empower individuals to heal and build a strong foundation for long-term recovery.
- ***Sober Living Facilities Should Allow Residents on MAT:*** Generally, sober living facilities operate within their own rules, but there should be efforts to unify and develop one standardized regulation. All facilities should allow people on MAT into their facilities. While there are still conflicting views on MAT, it's an evidence-based and scientifically backed treatment for opioid use and misuse disorder. Denying entry based on outdated beliefs harms individuals seeking recovery. By allowing MAT in sober living facilities, we can create a unified system that supports all paths to long-term sobriety.
- ***Addressing Internal Communication Barriers:*** All organizations should identify and implement strategies to address the implementation of trauma-informed practices and eliminating stigma within their workplaces. By actively monitoring and enforcing these practices, we can ensure people with lived experience (PWLE) feel safe, respected, and empowered to seek the treatment and support they deserve.
- ***Cross-Sector Implementation and Enforcement of Trauma-informed Practices:*** Organizations must identify environments that PWLE frequently encounter (i.e., criminal justice, hospitals, etc.) and collaborate with PWLE and relevant stakeholders to develop and implement trauma-informed protocols. Monitor and enforce implementation of these changes to ensure PWLE have a safe and supportive experience throughout their recovery journey.

Policy Changes and Advocacy – the Long Game:

- ***Modification of State Laws that Ban Evidence-Based Harm Reduction Strategies:*** Overwhelming evidence supports harm reduction strategies such as fentanyl test strips and syringe service programs. By removing outdated laws that hinder access to these life-saving measures, Texas can empower local organizations to provide more comprehensive care and support for people with lived experience (PWLE).

- ***Modification of the Texas Good Samaritan Law***. While the Texas Controlled Substances Act (Health & Safety Code Ch. 481) offers an affirmative defense for those calling 911 during a potential overdose, significant limitations restrict its effectiveness. These limitations exclude people with past drug convictions, those who've previously used the defense, and individuals who've called 911 for a possible overdose within the past 18 months. Consequently, the current Texas Good Samaritan Law discourages overdose intervention by peer support specialists and people with lived experience (PWLE) due to restrictions on past drug convictions and limitations on using the defense. Broadening this law would empower more people to intervene in overdoses without fear of legal repercussions, potentially saving lives.
- ***Update Medicaid Reimbursement Rates for Substance Use Disorder:*** Many facilities offering substance use disorder treatment rely on Medicaid funding. Facilities should not be forced to reduce or eliminate their ability to offer substance use disorder treatment due to a lack of effective reimbursement rates for their services. To ensure long-term sustainability and accessibility of treatment options, Medicaid reimbursement rates for substance use disorder treatment must be re-evaluated and updated to appropriately reflect the cost of care for these services.
- ***Political Advocacy:*** Identify representatives with established rapport with policymakers and other local decision makers to collaborate with PWLE and other relevant stakeholders to advocate for necessary policy changes that address the current needs and gaps for PWLE in Dallas County. By working together, this powerful coalition can advocate for evidence-based solutions that address the current gaps and unmet needs of PWLE.

Immediate Action Strategy

Cross-Sector Consortium: The overwhelming feedback for stakeholders was the need for cross-sector awareness, collaboration, and de-duplication of services. Essentially, they agreed there is a need to get creative in efforts to optimize services for people who use drugs. Thus, Dallas County Health and Human Services (DCHHS) will convene a consortium across all sectors that will meet quarterly to organize, share perspectives, foster understanding, and develop future plans to collaboratively address the opioid crisis and sharing of resources. The consortium will bring representatives from public safety and criminal justice, healthcare, community-based organizations, people with lived experience, and parents of children with SUD. The consortium will identify a purpose statement, objectives, and goals and some key topic areas that will be included are:

- ***Addressing Stigma:*** The consortium will work to develop an official, unified statement and stance against stigma and commit publishing this statement on their websites to represent a unified front. Additionally, shifting language to person-first terms and promoting responsible media portrayals can foster a more respectful dialogue. Building trust involves increasing access to resources, training healthcare providers, and partnering with faith-based organizations to create a network of support.
- ***Accessibility of Resources:*** The consortium will commit to identifying barriers to resources for vulnerable populations and regularly consult with members of vulnerable populations in the decision-making process.
- ***Broadening Communication:*** The consortium will discuss openly (within their organizational restraints) what organizational resources they provide, the gaps and needs they have as an organization and discuss ways other organizations may help support them. Consortium members will commit to collaborative efforts to support one another to provide optimum services to PWLE.

- ***Data Sharing:*** The Consortium will prioritize data sharing across organizations to better understand each other's services and to minimize duplication of services. Furthermore, the Consortium will organize data use agreements amongst organizations when deemed necessary to ensure competent wraparound services.
- ***Educational Resources:*** The Consortium will analyze existing educational resources within their organizations and identify the most effective and ensure these educational resources are available across all organizations. Furthermore, if the need is there, the Consortium will work collaboratively to develop new educational resources and materials that focus on cross-sector collaborations and wraparound services. These materials should be spearheaded by PWLE to ensure that the messages are relevant, impactful, and useful to the communities we are trying to reach. These educational resources would then be posted on each organization's website and shared by PWLE and parents of PWLE when appropriate. Partnerships with relevant stakeholders will be necessary to ensure the receptiveness of corresponding audiences.
- ***Funding Collaboration:*** Consortium members will communicate (within their organizational restraints) the grants they are applying for and any additional funding they are seeking openly to mitigate unnecessary competition. When appropriate, organizations can apply for funding together and DCHHS and RRC can help facilitate any grant writing needs they may have.
- ***Commitment to Grow:*** It may go without saying, but despite a diverse participant pool, not everyone was represented. Thus, the consortium will agree and commit to continuing to bring people to the table and ensure the development of a network that spans all of Dallas County.
- ***Advocacy:*** The consortium will work to advocate for increased funding for treatment services, harm reduction activities, revising of outdated state laws, and any other identified barriers.
- ***Workforce Capacity:*** DCHHS will use the OD2A grant dollars to hire a position that will oversee and organize the consortium. This person will also oversee tasks and duties detailed in the strategic work plan that will be developed for the county based on this assessment and ensure goals and priorities set by the consortium are met in a timely manner. DCHHS will also use OD2A funding to staff peer support specialists at local hospital systems, where they can interface with people who recently overdosed. Though this was a goal prior to the assessment, this intervention is supported by the PWLE interviews, as they discussed the criticalness of having peers disseminate information and resources rather than someone who does not understand their lived experiences.

Conclusion

Dallas County is home to an incredibly diverse population that is not immune to the harmful and negative health outcomes associated with the opioid crisis, and our most marginalized communities often disproportionately bear the brunt of this burden. The primary data collected during this needs assessment in addition to secondary trends indicate an urgent need to invest and prioritize wraparound services and additional treatment options for Dallas County residents. Stakeholder focus groups and PWLE interviews revealed a complex web of services with notable gaps, needs, and stigmatizing, outdated policies that create significant challenges for stakeholders providing services and PWLE seeking services. Notably, primary data findings indicate an urgent need for the investment in adolescent services and inclusive services for LGBTQIA+ groups, immigrant communities, people experiencing homelessness, and people living with disabilities.

Cross-sector collaboration is integral and necessary to bridge the gaps in services across stakeholders and a strong, unified stance against stigma must be taken by all organizations. Efforts to include PWLE within decision-making processes for opioid prevention is imperative for ensuring inclusive, relevant, and accessible services. Furthermore, PWLE should be involved in the creation of educational materials to ensure messaging is communicated ethically and effectively. Targeted and unified advocacy efforts to increase the availability and access of harm reduction services within the state, such as fentanyl test strips and syringe exchange programs must take precedent if we are to achieve positive and sustainable changes for people with lived and living experience.

Trauma-informed wraparound services are paramount to effective treatment and support for PWLE. Moving forward, efforts to internally educate employees and staff who work within organizations that support PWLE on the harmful effects of stigma and the importance of a trauma-informed approach is critical and must be employed immediately. The implementation of trauma-informed care will ensure that PWLE feel safe, heard, and valued in their recovery efforts and journey and thus has a substantial impact for mitigating relapse and overdose. Efforts to educate staff and employees, update internal policies, and collaboration to advocate for external policies, like at the state level, to view people with lived or living experience as a whole human and employ the SDOH is imperative for future progress and positive health outcomes for our most vulnerable populations.

The first step of many for the DCHHS-RRC assessment team will be to convene a consortium that will include a vast number of organizations and individuals across stakeholder groups including, public safety and criminal justice, healthcare providers, peer support specialists, community-based organizations, people with lived and living experience, and parents of children with lived or living experience. This platform will allow for connection and collaboration across sectors and ensure a continued, long-lasting commitment to mitigating opioid-related morbidity and mortality in Dallas County.

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Appendices

Appendix 1: Focus Group Questions

Criminal Justice/Public Safety Focus Group:

Research Question: What are the assets, needs, and gaps in mitigating morbidity and mortality due to opioid/fentanyl use in Dallas County across stakeholder groups?

1. **Micro-level: Current Environment & Needs**
    a. Please walk us through the work you do and the services you provide.
    b. What has been your experience with the opioid epidemic?
    c. Thinking of the instances where your work intersected with substance use/misuse, what were some barriers you faced in carrying out your work?
        i. **Probe**: What are some ways you'd like to see those barriers addressed?
    d. Within Dallas County, what gaps in knowledge do you think need to be addressed, if any?
        i. **Probe**: What gaps in data need to be addressed, if any?
        ii. **Probe**: How could closing these gaps help support your work?
2. **Meso-level: Local Community Partnerships**
    a. In regard to substance use/misuse, in what ways have you partnered with other organizations?
    b. What would improve your ability to partner with other stakeholders or organizations?
        i. **Probe**: What would improve your ability to partner with healthcare organizations or community-based organizations?
        ii. **Probe:** What assets or resources do you possess, or know of, that you feel others here should be aware of?
3. **Macro-level: Prevention Policies & Programs**
    a. How have policies (changes in policy; or lack thereof) related to substance use/misuse impacted public safety and criminal justice work?
    b. What policies can be implemented to support your work as it pertains to the opioid epidemic?
        i. **Probe:** Harm reduction is a set of strategies and ideas (e.g., naloxone distribution, drug test strips) aimed at reducing negative health consequences from substance use/misuse – such as overdosing or contracting infectious diseases (I.e., Hep C, Hep B, HIV). In regard to Dallas County, what are your thoughts on harm reduction strategies? (CDC)
4. **Wrapping Up**
    a. Is there anything else you think we should talk about that we haven't discussed already?

Health Systems:

Research Question: What are the assets, needs, and gaps in mitigating morbidity and mortality due to opioid/fentanyl use in Dallas County across stakeholder groups?

1. **Micro-level: Current Environment & Needs**
    a. Please walk us through the work you do and the services you provide.
    b. What has been your experiences with the opioid epidemic?

c. Thinking about instances where your work intersected with substance use/misuse, what are some barriers you faced in carrying out your work?
    i. **Probe:** In your experience, and with the specific groups you support in mind, what are some factors that contribute to substance use?
d. Within Dallas County, what gaps in knowledge do you think need to be addressed, if any?
    i. **Probe:** What areas in the overall process of connecting people to care can be improved?
    ii. **Probe:** How could closing these gaps help support your work?

2. **Meso-level: Local Community Partnerships**
    a. In regard to substance use/misuse, in what ways have you partnered with other organizations?
    b. What would improve your ability to partner with other stakeholders or organizations?
        i. **Probe**: What would improve your ability to partner with public safety and criminal justice stakeholders or community-based organizations?
        ii. **Probe**: What assets or resources do you possess, or know of, that you feel others here should be aware of?
3. **Macro-level: Prevention Policies & Programs**
    a. How have policies (changes in policy; or lack thereof) related to substance use/misuse impacted your ability to provide care for people who use drugs?
    b. What policies can be implemented to support your work as it pertains to the opioid epidemic?
        i. **Probe:** Harm reduction is a set of strategies and ideas (e.g., naloxone distribution, drug test strips) aimed at reducing negative health consequences from substance use/misuse – such as overdosing or contracting infectious diseases (I.e., Hep C, Hep B, HIV). In regard to Dallas County, what are your thoughts on harm reduction strategies? (CDC)
4. **Wrapping Up**
    a. Is there anything else you think we should talk about that we haven't discussed already?

Community-Based Organization Focus Group:

Research Question: What are the assets, needs, and gaps in mitigating morbidity and mortality due to opioid/fentanyl use in Dallas County across stakeholder groups?

1. **Micro-level: Current Environment & Needs**
    a. Please walk us through the work you do and the services you provide.
    b. What has been your experience with the opioid epidemic?
        i. **Probe**: In your experience, and with the specific groups you support in mind, what are some factors that contribute to substance use?
        ii. **Probe**: What areas in the overall process of connecting people to care can be improved?
    c. Thinking about instances where your work intersected with substance use/misuse, what were some barriers you faced in carrying out your work?
    d. Within Dallas County, what gaps in knowledge do you think need to be addressed, if any?
        i. **Probe**: What gaps in data need to be addressed, if any?
        ii. **Probe**: How could closing these gaps help support your work?

2. **Meso-level: Local Community Partnerships**
    a. In regard to substance use/misuse, in what ways have you partnered with other organizations?
    b. What would improve your ability to partner with other stakeholders or organizations?
        i. **Probe:** What would improve your ability partner with healthcare organizations or public safety and criminal justice stakeholders?
        ii. **Probe**: What assets or resources do you possess, or know of, that you feel others here should be aware of?
3. **Macro-level: Prevention Policies & Programs**
    a. How have policies (changes in policy; or lack thereof) related to substance use/misuse impacted your work?
    b. What policies can be implemented to support your work as it pertains to supporting people who used drugs or people living with substance use disorder?
        i. **Probe**: Harm reduction is a set of strategies and ideas (e.g., naloxone distribution, drug test strips) aimed at reducing negative health consequences from substance use/misuse – such as overdosing or contracting infectious diseases (I.e., Hep C, Hep B, HIV). In regard to Dallas County, what are your thoughts on harm reduction strategies?
4. **Wrapping Up**
    a. Is there anything else you think we should talk about that we haven't discussed already?

Appendix 2: Interview Questions

Parents of People with Lived Experience Semi-Structured Interview Questions
Objective: To understand the holistic experience of parents of people with lived experience with substance use/misuse in Dallas County.

1. In regard to substance use or misuse, could you walk me through your journey as a parent of a child with substance use/misuse lived experience?
2. In your understanding of your child's journey, what factors do you think influenced their path, positive or negative?
3. In your understanding of your child's journey, what are some ways you would have wanted them to be supported, or would like them to be supported currently?
    a. **Probe:** What kind of support did they look for in the past?
    b. **Probe:** What kind of support did they experience that didn't seem helpful or didn't meet their expectations?
4. What were the most pivotal moments during your journey?
5. What were some barriers you encountered?
    a. **Probe:** Where do you think the system failed you?
6. What are some ways you personally would have wanted to be supported, or would like to be supported currently?
7. How have other people's perceptions impacted your journey?
8. In your opinion, and in regard to substance use or misuse, what gaps in knowledge do you think need to be addressed, if any, in Dallas County?
9. Is there anything else you think we should talk about that we haven't discussed already?

People With Lived Experience Semi-Structured Interview Questions
Objective: To understand the holistic experience of people with lived experience with substance use/misuse in Dallas County.

1. In regard to your journey with substance use, could you walk me through where you feel this journey started for you?
2. What were factors that influenced your path, positive or negative?
3. What were the most pivotal moments during your journey?
    a. **Probe**: What were some moments you felt you were at a crossroad of decisions?
4. Reflecting on the journey you've shared, and thinking of where you are right now, what would you say you want **most** out of life?
5. What were some barriers you have encountered, or are encountering now, in achieving this goal, if any?
    a. **Probe**: Where do you think the system failed you, if at all?
6. With your whole journey in mind, what are some ways you would have wanted to be supported or would like to be supported currently?
    a. **Probe**: What kinds of support have you needed or looked for, either in the past or currently?
    b. **Probe**: What kinds of support have you experienced that weren't helpful or didn't meet your expectations?
    c. **Probe**: What do you look for when considering whether or not to try a support service?
7. With your whole journey in mind, how have other people's perceptions of you impacted your journey?

8. In your opinion, what is the best way to support someone who is not ready to begin treatment or discuss recovery?
9. Is there anything else you think we should talk about that we haven't discussed already?

Focus group questions were recycled for stakeholder interviews based on their career field, so there are no separate stakeholder interview questions.

Appendix 3: Additional Quotes from Interviews and Focus Groups by Theme

This section includes additional quotes from focus groups and interviews that the joint assessment team believed were powerful and necessary to include to provide additional voice and human context to the data collected.

Stakeholder Quotes by Theme:

Theme 1: Stakeholder Experiences with Opioid Epidemic

> *"I think the scary thing is that the face of addiction has changed. It used to be 'use once and you'd get addicted' now to 'use once and you're dead.'"*
>
> *"...there's a certain onus on the patient themselves to pursue that follow up [treatment]."*
>
> *"and so I just think about that a lot, is, what does that take for that person to navigate the system?*

Theme 2: Cultural Challenges

> *"Stigma. There's huge stigma... and I think the shame, judgement, guilt, is what makes somebody relapse."*
>
> *"and one of the things is over 10% of our individuals that come to our rooms will not identify what their sexuality is. And that is very fear-based on them being discriminated against."*
>
> *"So, it's not only an impact on the family, but my staff have an impact dealing with these families, because they are their resources at that point in time."*

Theme 3: Challenges to Providing Services

> *"There's a real disconnect with the abstinence, which is with AA, NA, that the MAT group have started their own kind of MAT, MA or whatever, they have their own group."*
>
> *"...so I keep a list of places that do – that will accept them on buprenorphine, the list of maybe 10 places, and the ones that are accepting of it are costing over $1,000 a month."*
>
> *"Its overloading the residential drug treatment center…"*
>
> *"…it's an issue of not having enough physical beds."*
>
> *"I think individuals prefer to talk to someone who has been there, that they can identify with*

Theme 4: Partnerships & Collaboration

"On that end I would like to see the agencies continue to work together, we have a horrible duplication of effort."

"I would say awareness, because there is so many out there that like, I have to google [other organizations] sometimes."

Theme 5: Policy & Law

"…like the granting organizations could look across applicants and say, there, we don't need duplication of services, right, rather than making us compete with one another for the same dollars."

"...it's just really unstable and rocky [referring to funding], and then we're all going to compete for these exact same opioid dollars."

"One thing we'd want to make sure that after a point, there is a certain limited pot of money, you don't all want to be competitive toward that pot, because then you just ended up fighting each other. So, working together is the way to do it."

"So can we talk about Medicaid plans in Texas requiring prior authorization for buprenorphine?"

"And so, with Texas, ranking number one in the country for uninsured children, what we've noticed is that a lot of these young people are thinking that they're taking the Adderall's, the Xanax's, things of that nature, to help cope with anxiety, that they're having depression. And so, if you don't have insurance, it's easier and cheaper now to get it off the street or from your friends."

"there's just so many barriers that still exist from just outdated policies. The outdated language in the Texas Administrative Code, outdated requirements as far as what we should be focusing on as far as curriculum and education […]"

People with Lived Experience Quotes by Theme:

Theme 1: Understanding the Impact of Trauma

Sub-theme 1: Childhood Experiences/Trauma

"I used to self-medicate. I suffered, you know, from depression, anxiety. I came from a dysfunctional family. And I didn't know how to cope with what I was going through at all. I did endure, you know, sexual abuse as a child and nobody ever taught me how to cope with anything […] so I found a way to self-medicate. And so, I justified my drug addiction, you know, by saying that was how I coped with that."

"This journey started for me after I got married. I had a real good husband. He was real caring [...] and then after we got married he became very controlling, very abusive. I don't know he just flipped the script on me and changed. I actually started using drugs to escape what I was going through at home."

Sub-theme 2: Contradicting Needs for Authenticity and Attachment

"Ever since I was a young little girl [being] abused since I can remember […] and all times being controlled […] I was a little girl. Like, that little girl never grew [up], you know,

and still here, now, I am fighting for that little girl to like, [be] here. […] I haven't overpassed those traumas, you know, and, and that too, had a lot to do with all the addictions."

"I spilled my guts [to my parents]. I spilled everything that I wanted. I wanted connection with them. Like I wanted a relationship with them. I wanted to feel like secure. I wanted some kind of consistency in my life. And they just sat there stone faced and didn't really respond in any way."

Sub-theme 3: Generational Trauma

"And I would have to say it would have been my mom, and possibly who my dad was- they were both active drug users. And I think that's what really introduced me to it [...] my mom not being around, me knowing why she wasn't around, and then just following in her footsteps."

"I just wanted my kids to have me be the mom that I didn't have. And in the end, I ended up not being the mom because I ended up leaving my kids for the street, which was crazy."

Theme 2: Importance of Safety

Sub-theme 1: Understanding Safety-Seeking Behaviors

"It would have been life changing. Just to have my mother, my siblings, to just hear me. They just saw a drug addict. That's all they saw, was a drug addict. […] a lot of people don't want to listen to somebody who is not in the right mind, I guess. I think I just wanted somebody to listen and not give up on me."

"I used to say that I didn't really care what people thought about me, but that's absolutely not true. I care a lot. And back when I was active using it bothered me that I felt that I was a disappointment to certain people, or that they couldn't trust me or, you know, they didn't want me to be around. […] it just made me in my head want to be like, 'screw it, I'm gonna go get high, I'm gonna get higher now and y'all don't want me around' and [that] kept me in a hole and then a dark place. You know, drugs are just, they're miserable. You think they're helping; they're making things worse, they drain you physically, mentally, emotionally, financially."

"When I was first fresh in recovery, I went to a department store. And I heard these little kids, you know how kids run through the clothes at the store? And I heard the kids say, 'Mom! Mom!' Immediately I just started crying. […] you know why? Because I wasn't there for my kids to call for me. And if they were calling for me, I was nowhere around. So that made it worse. And now I'm like, 'you know what, give me more dope,' you know? 'Give me more dope'. […] you try to stay numb when you're an addict. You want to stay numb. Because you don't want to feel nothing. You don't want reality to set in."

"Coming off of drugs, you have a lot of like mental problems that affect you, you know, like schizophrenia and all this stuff. [...] so when I went to go get the medication, and I was realizing [...] I was gonna go to rehab. I was terrified. I was so scared. I didn't know what to expect or what to think or how to act. It was terrifying."

Sub-theme 2: The Need for Comprehensive Care

"I spent two years living in an Oxford house. And if you don't know about Oxford houses, they're ran completely by people [...] in addiction. [...] there's not really any like therapeutic

aspect of it, [...] and their main fundamental program that they abide by is AA. And AA- I believe that there are some helpful things about it. [...] But since [the Oxford house] is not actually therapeutically ran or have like any kind of system of accountability, it's very easy for people to manipulate the system […]"

"To be honest with you, like the court appointed attorney I got convinced me to sign for some of my charges and told me that it would be just like a parking ticket and it actually stopped me from getting an apartment. It was more than a parking ticket, you know? [They] aren't really for your best interest. They're just trying to get, you know, enough cases where they can graduate from that so I would probably change some of their dedication into actually helping their clients instead of just getting a checkmark on their, you know, on their caseload. […] it made me feel kind of played."

"They diagnosed me as being bipolar [and] I started taking these psych meds, you know, which helped. But also the psych meds hurt. They helped one way, and they hurt the other way. And the reason I say they helped me with the depression and the anxiety, but I started that grinding of my teeth. [...] I was having tics, I gained so much weight, [...] and then they caused me severe depression, because I'm so fat now. You know, even though I'm okay, I'm in recovery. But [...] I'm so depressed, until the depression medicine is not working anymore."

"At the time, I just wanted to just kill [my abusive husband] because I'm blaming everything on him, you know, and then I'm like crying. And then I'm so mad. And then they're like, 'oh, yeah, she's bipolar. Because she's manic-y and now she's depressed.' […] And then when I ended up going to another psychiatrist, [...] he says 'you've been off your medicine a month. Well, have you had any manic episodes? Have you been screaming?' [I said], 'no. I left my husband though. And I feel much better.' You know, so then it was like, 'we don't think you're bipolar. I think was your situation. You know?' He says, 'I don't see you being bipolar at all, you're the sweetest thing ever […].' So the more I kept coming, the more they kept seeing me without this bipolar medicine, and they kept seeing me and they're like, 'girl you are not bipolar. That was the wrong diagnosis.' […] all they could see was a lot of depression. A lot of anxiety, a lot of PTSD, you know, no bipolar."

"If you're an addict [...] you have a lot of complex trauma, there's just no way around that. [...] I have not met a more deeply traumatized group of people. [...] I really wanted to connect with these people, but I also noticed that there was a very shallow connection that I could have because empathy was not something that a lot of them had access to yet because of their lack of support in the area of healing from trauma. Because AA does not focus on healing trauma [...] when I went to rehab it was very like, 'okay go to AA do 1000 meetings and if you step wrong, you just failed,' you know, like 'you relapsed, it's your fault.'"

"They care about their clients. We're not just like a number. [My recovery coach] has a really large caseload, but she will still take time out of her day to go down to the courthouse [and] sit there with me. She communicated with the DA every month, even when I don't know she's doing it. I just couldn't ask for more."

"I remember the counselor in that group, when she mentioned that she was in recovery, I was like, wait a minute, hold on. You can live this life of addiction and still be successful and still have a life after that? Still get an education? And I'm like, 'I'm gonna try that.'"

"The only thing I would have changed was when I went through rehab the first time. Having somebody with my shared experience really does make a difference. And it matters a lot.

Because it's no longer - you don't look at your therapist like, 'okay, they're just here for a paycheck.' You look at your person, like they know what they're talking about. They've done it before."

Sub-theme 3: Creating Safe Spaces

"[In the Oxford house] it was like, 'oh, that's just your job, like, go pee test someone and tell them that they're homeless now and have no resources and that we all don't care about them anymore.' [...] I had to tell my friend Hayden, [...] but I just felt really bad because I saw why he relapsed. I saw him doing his best. And I saw them tormenting him in ways that were 'socially acceptable' [...] completely uprooting this guy who's [...] just coming off the streets trying to get his life together.[...] uprooting the space that he's in over and over again and not giving him any say in the matter because, 'oh, we have to do it this way because it's the house necessity' [...] But when you don't have any safety or stability where you live, how are you not going to relapse when literally people don't care about your needs, much less your wants, and don't want to hear anything about it?"

"There's people, even here, that are like, 'well, you're not cool because you're on pills.' But I feel like that if the government says it's okay [to be on medically assisted treatment] and I'm not breaking any laws, I'm doing really good in life, and I feel good. I say to my heart, you know, I honestly do, I love myself [...] I wake up every morning and have a purpose. And I love that. I love that I have a purpose."

"I would go [to the methadone clinic] early in the morning. And by lunchtime, I was wanting to get high. Like it was weird, [...] it wasn't helping me at all [...] I could just get heroin because the methadone wasn't taking my pain at all for me. Suboxone has really saved me. Like, that's what, my pain, it helps me maintain. I don't take more than what I need. Like, I don't hurt [in] the afternoon."

"[Oregon] had a MAT clinic out of this world. They had a MAT clinic that was connected to the shelter that was connected to housing. And inside of this place, there was the mental health clinic, there was the health clinic itself. There was the psychiatrist, there was a therapist, […] they even had acupuncture room […] So their MAT clinic not only was about medication, it was about meditation. It was about therapy. It was about counseling, it was about people understanding the addiction, it was about offering them a choice, you know, do you want to do this cold turkey, and we help you along that hard struggle? Or do you want us to help out with some Suboxone? […] Methadone? […] Naltrexone? What do you want to do? You know, because they did it in a group setting where the people live there. You live here. So, your recovery all around the clock, 24 hours a day was recovery."

"I think [with] somebody who just doesn't want help with something that's killing them, I think the only thing you could help them with is something that they wanted help with. You would have to put resources into finding out what they actually want help with. And in that safety of them feeling like you're helping something they actually want help with, then over time, you can develop a little bit more familiarity with their language, and perhaps they will open up to the care that they're being given."

"[…] my needs as a person, even just as a child as like any kid would, but also as an autistic person […] I had no support in that area. So, I think I was really like triple isolated in so many different ways that caused me to reach out for really any kind of relief I could find. And when that relief proved to be consistent, it's addicting. I mean, it's extremely hard to let go of something that has been the only constant in your life."

"There's this big assumption, like, 'Oh, you're high-functioning, so you can work well,' but I'm actually really suffering because most of my jobs were penetrating my eyeballs, and my ears, and my everything constantly, which also had a huge influence on use because I would drink heavily working in places where [...] I was able to do my job, but [only] if I was drunk. Because then I wasn't in agonizing pain from the job that I was performing that took every single ounce of my energy to just do sufficiently."

*"I said [to my parents] that I wanted to be a dad and I want to use he/him pronouns. And [my mom] said, 'Well, I'd sooner call you 'it' first'. And when I was younger, and they thought that I was gay, they said 'Well, are you gonna like **** dogs next?'"*

"I felt really isolated, I think, as a queer person in Texas. I was part of a religious organization that had basically all decided that I was not like pure or holy enough to be around or affiliated with. And so my heart was broken. And I also had a lot of trauma from moving around a lot as a kid. And that kind of compounded into feeling like there was really no consistency in my life and support and that's what nicotine offered to me in that way. It was like [...] you have something that will get you outside, make you feel a little bit better for a moment, and it's always there because no one else is."

I've been dropped by every single sponsor that I had because I couldn't go to enough meetings or go to enough [hospitals] and [institutions]. [They] admit that I put in a ton of effort into finishing my steps and doing everything correctly. But it was just at this point where I would be like, 'I can't actually keep following [the 12-step program] because it's destroying me'. And they would just go 'Oh, you're just not trying hard enough. Go find somebody else' or like 'I can't work with you.'"

"I just felt really demonized. [...] I didn't really see [Christian counseling] to be extremely helpful [as a queer person] because of their religious leanings. [...] Because in order to have a therapeutic alliance, you have to feel safe and build trust and it's really hard for a kid to build trust with somebody who, in your mind, stands with everything that has labeled you broken."

"She decided to go to [college]. And [...] I wish it would have been me because I graduated from high school, and I wanted to go. But I always had this obstacle that I'm an immigrant. I'm not from here, you know? And that was hard because I always told myself, 'you can't do it, you're not smart enough.'"

"I want to go back to school, too. [...] I want to have a good job [...] I have always been in the minimum wage because I don't have papers, or like hiding myself because I don't have papers."

"I was like, 'who's going to help me?' [...] I'm not from here. I can't ask for so many things. That was my fear because they told me if you ask for things, immigration's gonna be like, 'you're asking for things you cannot. You cannot get a visa, or you cannot get anything.' So that's why I was scared of asking for help [...] because I thought [...] I was never gonna get help."

"I'm very proud of myself for [surviving] but I really weep for all those that didn't because we are not even thinking of them. We're not putting any resources towards them. We are not thinking that they even exist. And then that makes me really sad because it's like unmarked graves, you know. Like we exist and we are dying because no one thinks we exist. Autistic adults exist. Autistic adults in addiction exist, and we are completely void [of] help. And we need it."

Theme 3: Promoting Resiliency

Sub-theme 1: Intrinsic Motivation

> *"In the latter part of my addiction, I really wanted to get out. I, I was tired, […] I wanted to reconnect with my children and my family. And my youngest children, they had been with CPS for a few years already. […]. I was in a county jail when I asked for a Bible. And it was during that time that I started to find myself again. I found it a spiritual awakening […] my higher power [told] me that I need to really sit down and listen and, you know, make some different choices in my life."*

> *"I didn't know if I would be able to do it. Like I said, I thought I was destined to be a drug addict. I thought like, that was my life. I didn't know that I was worthy. Like, you know how even though you stand up tall, you really don't feel tall. You feel like really, really small in this big old world. […] I knew that if I didn't go, and I didn't follow through that I would never see anybody in my family again, ever. And that scared me. Because even though I said, I tried to act tough, I was lonely, and I was scared. I just knew that I had to make a change."*

Sub-theme 2: Building Self-Efficacy

> *"I wish that I had safe adults when I was a kid. Like just one. But I am that adult for me now."*

> *"I have faced my fears with going to court, I'm no longer on the run, I'm getting my driver's license, I have a job. I am in church as many times a week as I can be the relationships with my children, my grandkids, everything is coming back in order the way it's supposed to."*

> *"Now my kids call me just, just to talk. They don't need anything, they just want talk. You know, I've gotten everything God promises, like double to triple if that makes sense. Everything has been promised, all the blessings they said will come will come. People trust my opinion now, you know, and, I've only been at my job seven months, and they already want to have me relocated at a different location as the assistant manager."*

Sub-theme 3: The Need for Community

> *"Hearing other people's story really helped me. Like it made me feel that I was not alone in this world, that I was not the only one going through depression and, you know, battling addiction, and fighting for their kids, and that there was a community, you know, that like to stick together and be there for each other."*

> *"I can reach out if I have a desire to use, I can always pick up the phone and call somebody. My top one, the people on the top fives list. They going to be very supportive. When I go to my NA group, someone, always even the newcomers helped me to stay strong as well."*