Landscape Analysis

TEXAS OVERDOSE DATA TO ACTION (TODA)

December 2024

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ACKNOWELDGEMENTS

Thank you to all the individuals who participated in the interviews and focus groups. The input was invaluable, and we appreciate the time and effort it takes to share your experiences. Also thank you to DSHS and HHSC for sharing their programmatic connections and information about the work being done in Texas.

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EXECUTIVE SUMMARY

To support the development of prevention programming for the Department of State Health Services (DSHS), we conducted a landscape analysis of opioid-related issues in Texas. We rely on publicly available data, previous programming reports and studies, and conversations with those in the community to fully understand what are the issues Texas faces, what are communities doing to address the issues locally, and what challenges are these communities encountering. All towards the end goal of developing recommendations on the best design for prevention interventions going forward.

Prescriptions for opioids are decreasing across Texas. Unintentional overdoses are driving the number of overdose-related deaths in Texas. Trends related to emergency department visits and non-fatal overdoses are less clear. While these trends shed light on what is happening in Texas, there are limitations. For one the publicly available data stops at 2022 and may not reflect current trends. Two, youth-related outcomes, poly-drug and fentanyl contamination, and drug trafficking patterns are not detailed in these datasets, but our community conversations highlighted that these areas are important to address.

Our community conversations also described the complexities around the stigma of opioids and how it can impact an individual from receiving care or treatment. We heard anecdotes on stigma arising from the community, law enforcement and first responders, healthcare, schools, families, and even from other individuals who use opioids. Some fear the stigma is so bad it leads to discrimination. Others suggest that in some cases, there is not enough stigma, as youth seem to have no fear of using opioids and even utilize it as a moment to brag.

Challenges to address these issues revolve around accessing quality, comprehensive, timely data; the realities of implementing new policy; gaps in education and providing services to youth, those in criminal justice system and other hidden populations; and combatting misinformation on opioids. Recent shifts, like increased attention, funding, and access to Naloxone/Narcan, are helping these communities overcome these challenges. Yet perhaps, the biggest asset is the countless passionate individuals in the communities and across the state are dedicated to addressing the needs of those who use opioids.

To address these issues and challenges, while leveraging the supports that exist, we propose the following recommendations for DSHS and other state agency leads.

1. Create guidance materials on how to genuinely engage and outreach local partners
2. Increase marketing and promotion of existing resources related to Naloxone/Narcan
3. Combine access to Naloxone/Narcan with education
4. Consider the additional infrastructure needed to increase Naloxone/Narcan
5. Develop a network infrastructure for navigators

6. Utilize statewide contacts to better connect navigators to court systems and schools
7. Maintain a model of navigators being a truly holistic linkage to care
8. Consider communities for expansion of navigator program based on community characteristics
9. Consider giving specific attention to youth and criminal justice involved populations through the TODA program
10. Use data to study seasonal and geographic trends
11. Promote statewide data sources including training on how to use them
12. Create a centralized list of opioid-related services and centers in Texas
13. Develop a Texas Opioid Workgroup for DSHS, HHSC, agency partners, university partners, and service providers

In the future, we hope to build off the foundation set in this landscape analysis to become a useful tool in the project. We would like to disseminate the findings, continue to capture feedback from stakeholders, and conduct additional analysis.

LIST OF ABBREVIATIONS

CDC	Center for Disease Control and Prevention
DSHS	Texas Department of State Health Services
ED	Emergency Department
EMSTR	Texas Emergency Medical Services and Trauma Registries
HHSC	Texas Health and Human Services Commission
HSR	Health Service Region
ORS	Opioid Response Strategy
PPRI	Public Policy Research Institute at Texas A&M University
SAMHSA	Substance Abuse and Mental Health Services Administration
SHAC	School Health Advisory Council
THCIC	Texas Health Care Information Collection
TODA	Texas Overdose Data to Action
TTOR	Texas Target Opioid Response
VSTAT	Texas Vital Statistics

INTRODUCTION

Texas, like many other states, is facing a drug poisoning epidemic. Deaths related to drug poisoning have increased more than 75% in the past 5 years with certain populations facing worst outcomes than others. To address this, the Texas Department of State Health Services (DSHS) launched the Texas Overdose Data to Action (TODA) program funded by the Center for Disease Control and Prevention (CDC).[1] In 2024, the Public Policy Research Institute (PPRI) at Texas A&M University was contracted DSHS by the to conduct an evaluation of the TODA program, focusing on the prevention related strategies.

The team at PPRI has designed a comprehensive evaluation strategy that incorporates outcome and process evaluation phases plus a landscape analysis to guide programming decisions. This report documents the landscape analysis results from the first phase of the project (March 21, 2024 – December 30, 2024). The report guides the next steps of planning for the TODA program. We start with our methods for conducting the landscape analysis. Then we describe our results around common themes – scope of opioid issues, stigma of opioid use, challenges and successes in addressing opioid issues. From here, we describe recommendations for TODA program prevention services and overall conclusions.

METHODS

The landscape analysis has three main objectives:

- To understand the current state of opioid use across Texas,
- To identify partners and stakeholders for future study activities, and
- To shape future prevention strategies.

Figure 1 illustrates the steps of the process. We started with identifying and organizing relevant publicly available data. We aimed for data at the county level to pinpoint specific areas to study more closely. We also looked at other opioid programs in Texas focusing on their results, challenges and successes. Based on these steps, we narrowed our focus to specific counties or areas to conduct interviews and focus groups with individuals who understand the opioid concerns in each community. In future updates to the landscape analysis, we will supplement this qualitative data with survey data. All of this data together provides an in-depth information related to opioids in Texas and what is and what is not working in Texas.

[1] Texas Overdose Data to Action: https://www.dshs.texas.gov/injury-prevention/texas-overdose-data-action

Figure 1: Steps of the landscape analysis.

Publicly available data

For our landscape analysis, we utilized several key indicators to assess opioid-related health impacts across Texas (Table 1). Two of these indicators were obtained from datasets provided by the Texas Department of State Health Services, both standardized per 100,000 population. The first dataset focuses on opioid-related emergency department (ED) visits, providing rates for various substances, including all opioids, fentanyl, heroin, non-heroin opioids, and synthetic opioids from the Texas Health Care Information Collection (THCIC).[2] The second dataset details drug poisoning-related death rates across a range of substances, such as all drugs, opioids, benzodiazepines, cocaine, commonly prescribed opioids, heroin, psychostimulants, synthetic opioids, and fentanyl, reflecting statistics sourced from Texas Vital Statistics (VSTAT).[3]

Next, we examined data from the Texas Emergency Medical Services and Trauma Registries (EMSTR), specifically focusing on rates of opioid-related non-fatal overdoses and Naloxone administration.[4] Managed by the Texas Department of State Health Services, this system collects and maintains comprehensive data on EMS responses, trauma incidents, and patient outcomes across the state.[5] Finally, we analyzed opioid prescription dispensing rates, which reflect the number of opioid prescriptions dispensed by retail pharmacies per 100 people. This data, obtained from the CDC includes a variety of opioids such as buprenorphine (commonly

[2] Texas Health Data - Opioid-Related Emergency Department Visits
[3] Texas Health Data - Drug-Related Deaths
[4] Rates were constructed using population estimates from the 2018 Texas Demographer State Projection 1.0 Migration Scenario Projections
[5] EMSTR Data Requests | Texas DSHS

prescribed for pain), codeine, fentanyl, hydrocodone, hydromorphone, methadone, morphine, oxycodone, oxymorphone, propoxyphene, tapentadol, and tramadol.[6]

Table 1: Publicly Available Data Sources

Data	Data source	Download/request source
Drug related death rates	DSHS Vital Statistics	https://www.dshs.texas.gov/vital-statistics-data
Opioid-related ED visit rates	THCIC	https://healthdata.dshs.texas.gov/dashboard/drugs-and-alcohol/opioids/opioid-related-emergency-department-visits
Opioid dispensing rates	IQVIA Xponent	https://www.cdc.gov/overdose-prevention/data-research/facts-stats/opioid-dispensing-rate-maps.html
Emergency Medical Services and Trauma Registries (EMSTR)	Texas DSHS	https://www.dshs.texas.gov/injury-prevention/ems-trauma-registries/data-requests
Substance use services locations	Texas HHSC	https://txdshsea.maps.arcgis.com/apps/webappviewer/index.html?id=f2fb359d9a4249f289cd8d241c3b78de
Opioid treatment program directory	SAMHSA	https://dpt2.samhsa.gov/treatment/directory.aspx (through TX Cope - https://www.txcope.org/home)
Other service providers	Google searches	

Additionally, we wanted to determine how many service providers were available across the state of Texas. Our goal was to identify where services are being provided, and what types are available. Outpatient treatment, residential treatment, and medically assisted treatment are the most prevalent, with different locations catering to specific populations (men, women, youth, etc.). Secondary data sources include substance use service locations, obtained from Texas Health and Human Services Commission (HHSC), an Opioid treatment program directory, obtained from Substance Abuse and Mental Health Services Administration (SAHMSA), and other service providers, such as nonprofit organizations, through google searches. After compiling this data into a master spreadsheet, it allowed us to identify concentrated

[6] Opioid Dispensing Rate Maps | Overdose Prevention | CDC

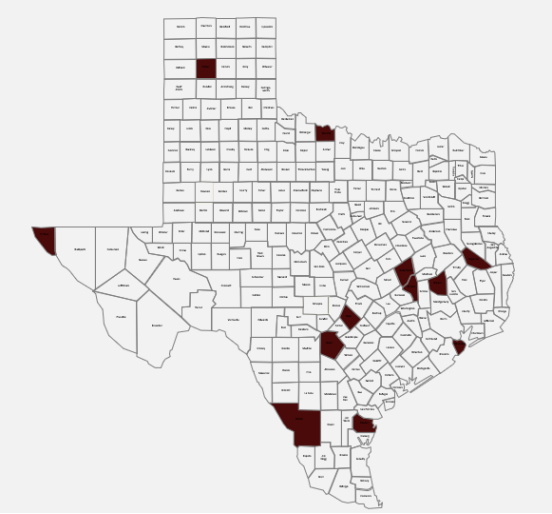
areas of providers, versus areas that are minimally resourced. It was the first steppingstone of our landscape analysis, and helped paint a picture of where our efforts should be targeted for interviews and follow-up conversations.

Document review

We searched for reports and programmatic documents around previously conducted opioid related programs in Texas. The intent is to understand what strategies have already been attempted, how successful they have been, and what challenges they faced. This will help guide us on making recommendations to shape the TODA programming. We found a few documents, relying heavily on previously conducted programs from HHSC.

Counties selected for further study

We wanted to identify a group of counties that we could talk to community stakeholders to better understand what opioid issues are most concerning and how to address them. We compared counties on their primary opioid outcomes and how many services are available to them in the area utilizing the publicly available data sources. We also wanted to achieve a variety of county sizes and geography. More detail on our rationale for selecting counties is included in the Appendix.



We initially selected the following counties and shared them with DSHS and partners who suggested additional counties.

Initial Counties:

- Potter
- Wichita
- Angelina
- Galveston
- Hays
- Brazos
- Roberston
- Bexar
- El Paso
- Nueces

Requested additions:

- Walker
- Webb

These contacts also included representatives from the Opioid Response Strategy (ORS) Program.[7] These individuals offer a more regional discussion of opioid issues in Texas (as opposed to a county-specific perspective).

Community conversations completed

We reached out to the contacts provided to us and other known contacts in the specific counties to participate in interviews or focus groups called community conversations. All conversations were conducted virtually to reduce the burden on

[7] For more information on Opioid Response Strategy - https://orsprogram.org/

participants. We utilize a semi-structured interview guide to guide our discussion. (See appendix for the list of questions.) Conversations were recorded for note-taking purposes. Researchers also utilized a debrief form to capture notes on the most salient themes.

We initially reached out to 49 individuals, representing 15 counties and 4 regions of Texas. Ultimately 26 individuals (53%) agreed to participate, and we conducted conversations with 34 individuals.[8] Some individuals could speak on experiences in multiple counties, a region, or the whole state. Table 2 provides insight into how counties and areas in Texas were represented. The exact individuals and organizations that participated are absent to maintain confidentiality, but we had representatives from community liaisons, treatment providers, DSHS and HHSC grantees, non-profits, law enforcement agencies, and university professors.

Table 2: Counties and regions of Texas represented in community conversations

County	Number of individuals
Bastrop	1
Bexar	7
Brazos	3
Caldwell	3
El Paso	4
Galveston	3
Hays	10
Jefferson	1
Other Focus Areas	**Number of individuals**
ORS Region	2
Statewide Perspective	3

Analysis

We analyzed our conversations and documents via a thematic approach – looking for specific issues, successes, challenges, and recommendations that most closely tie to the TODA program. For the quantitative data, we rely mainly on descriptive statistics to help paint the landscape of Texas opioid issues in recent years.

RESULTS

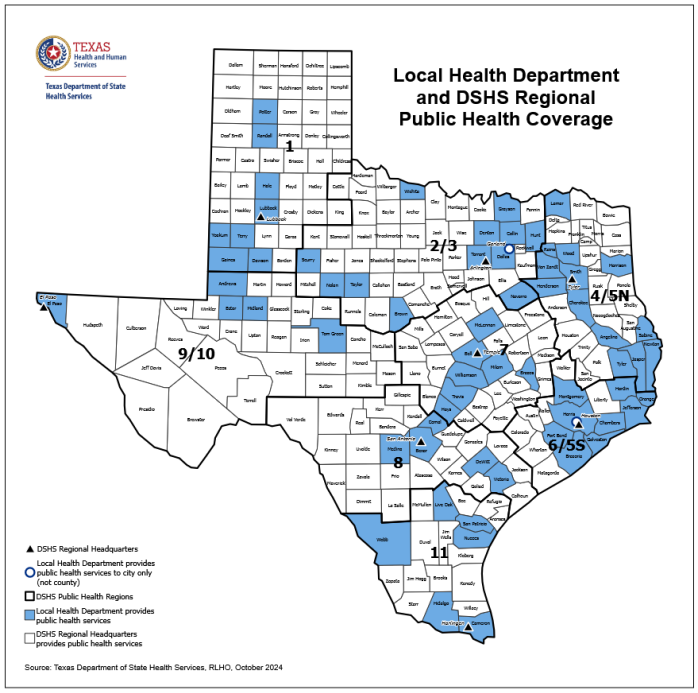
We hope to continue to build this landscape analysis by regularly updating it through the life of the project. We will look at different counties and stakeholders, do additional data analysis on the available quantitative data, and add surveys to the data collection methods. We also intend to incorporate feedback from those with

[8] In some conversations, the initial contact would bring additional people to the call.

lived experience more intentionally in upcoming years[9]. As such, the results provided in the following sections should be seen as a foundational piece for future analysis.

Scope of opioid issues

To provide foundation for many of the challenges and solutions discussed, it's helpful to begin with data that illustrates the problem. The following analysis explores trends in opioid prescription dispensing, opioid-related non-fatal overdoses, opioid-related ED visits, and opioid-related drug poisoning deaths across Health Service Regions (HSRs) from 2019 to 2022 (see map). The publicly available data provides perspective on how opioid-related outcomes have changed over time, offering insight into how the landscape is changing. We aggregated the data to regional level to analyze differences in geographical areas. Qualitative data from the community conversations gives additional perspective on areas that quantitative data does not cover. Together, this draws attention to the most significant opioid-related issues and provides the scope of the overall problem that Texas faces.

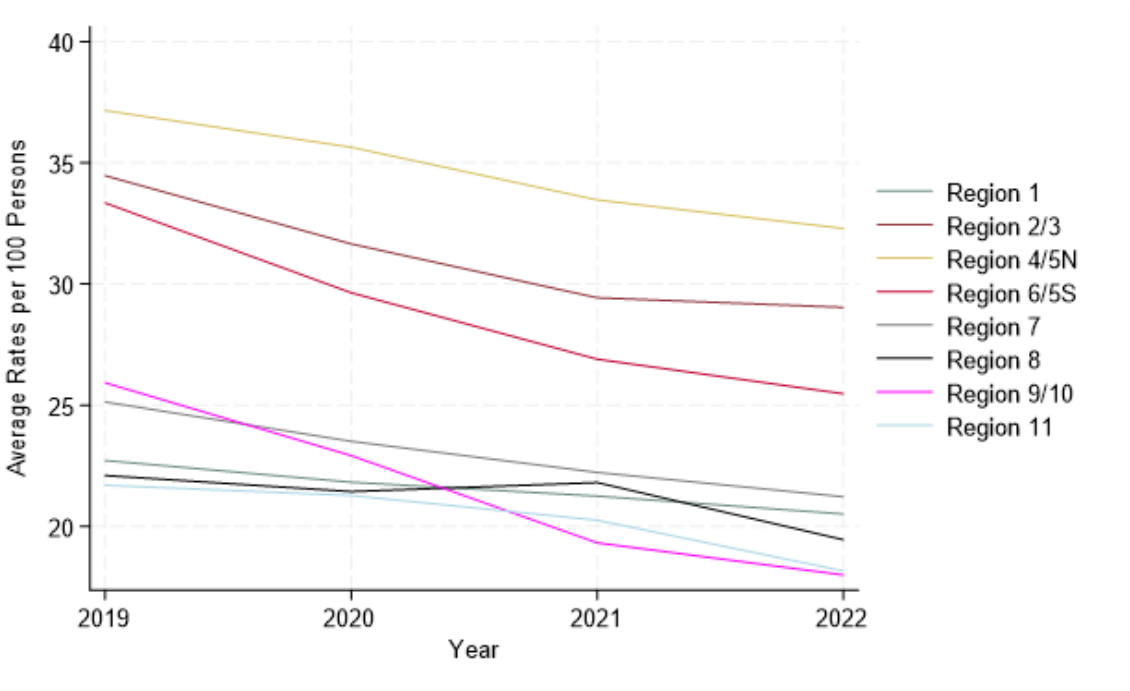


Prescription dispensing rates

Average opioid prescription dispensing rates by HSR, depicted in Figure 2, are evaluated using data from the CDC.[1] This dataset reflects the average number of opioid prescriptions dispensed by retail pharmacies per 100 people from 2019-2022 and includes a variety of opioids, such as buprenorphine, codeine, fentanyl, hydrocodone, methadone, and oxycodone. While all regions experienced a decline in opioid dispensing rates, the rate and magnitude of the decrease varied. Region 1 showed a steady and modest downward trend, whereas Regions 6/5S and 2/3 experienced sharper reductions, particularly early in the period. Despite these declines, Region 2/3 maintained higher dispensing rates throughout the observed years. These changes in dispensing rates reflect recent shifts in policy and professional guidance on how to prescribe opioids.

[9] It should be noted that multiple individuals who participated in the conversations volunteered information about their previous experiences with opioid use.

Figure 2: Average opioid prescription dispensing rates



Emergency department visit rates

Figure 3 depicts the average ED visit rates using data from THCIC. This dataset provides opioid-related ED visit rates for substances such as all opioids, fentanyl, heroin, and synthetic opioids. Trends in ED visits are less clear but most regions experienced increases between 2019 and 2021. For example, Region 1 saw a substantial rise from 28.9 visits per 100,000 in 2019 to 36.2 in 2021. Conversely, Region 4/5N and 6/5S have seen decreases in the same period, suggesting potential differences in healthcare utilization, reporting practices, or the underlying prevalence of opioid-related emergencies across regions.

Overdoses/drug poisonings

We evaluate the data on overdoses or drug poisonings from two different data sources. First, to understand trends in opioid-related non-fatal overdoses, we utilized data from the EMSTR. These registries, managed by the Texas Department of State Health Services, provide comprehensive data on EMS responses and trauma incidents. Referring to Figure 4, the analysis of opioid-related non-fatal overdoses revealed a sharp rise in non-fatal overdose counts between 2019 and 2020, followed by a stabilization or slight decline in subsequent years for most regions, the exception being Regions 2/3, 8 and 9/10 that have consistently increased. It should be noted that unlike our other data sources, this is count data and therefore does not consider differences in population sizes of the region. We can compare a region to itself over time, but

it may not be accurate to compare across regions as more populated regions are more likely to have higher counts based on populations alone.

Figure 3: Average opioid-related ED visit rates

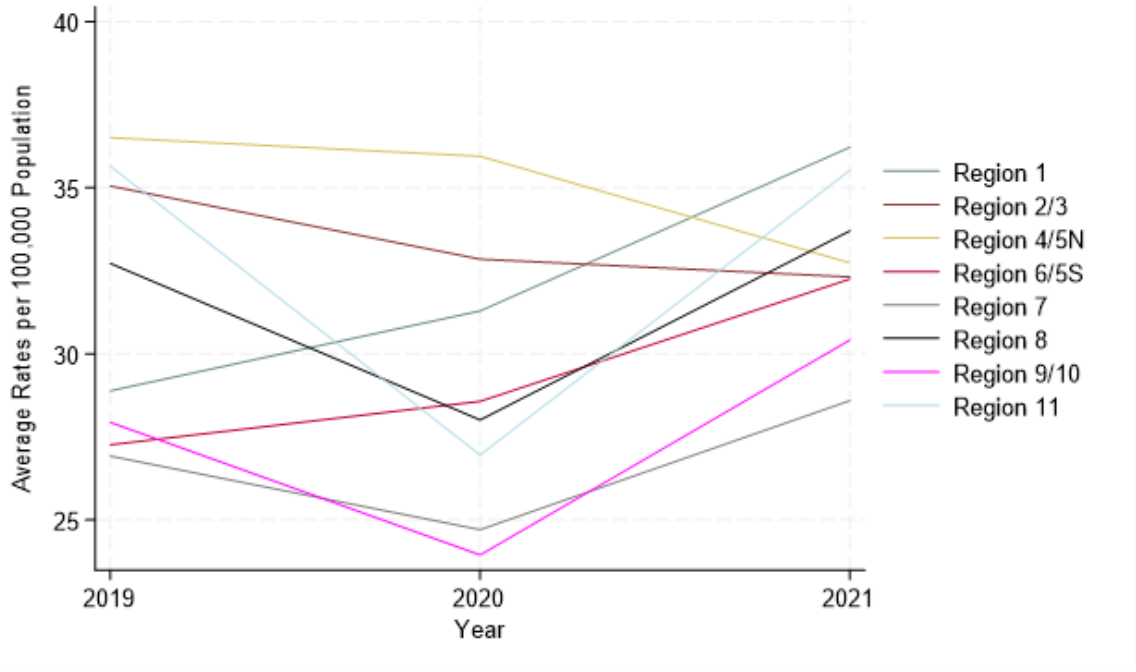
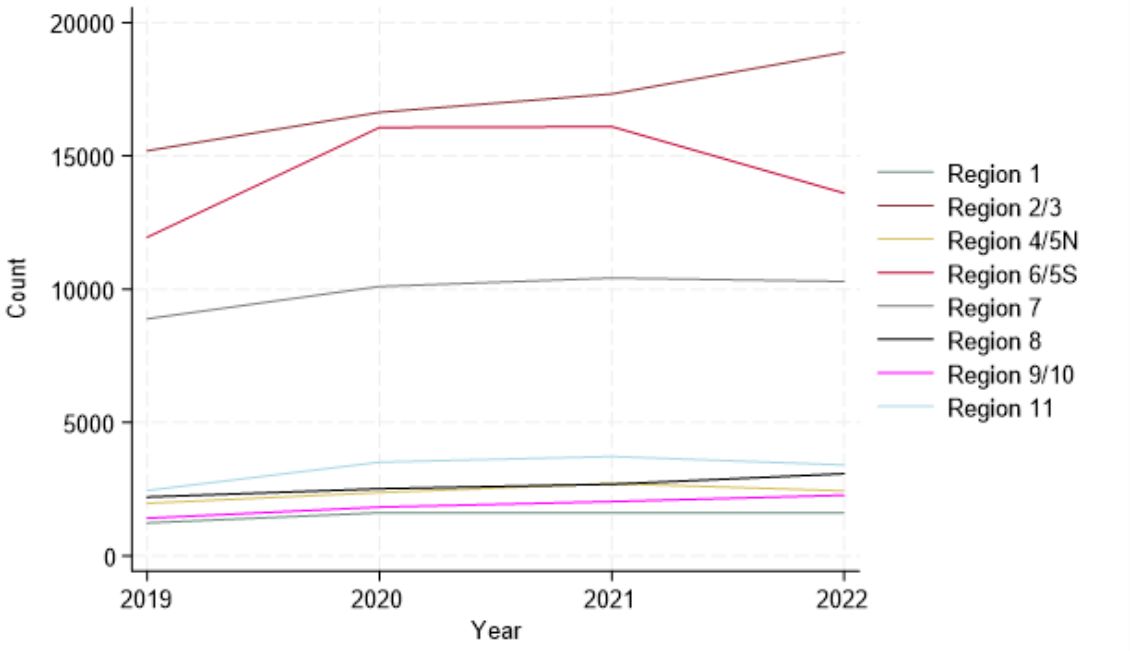
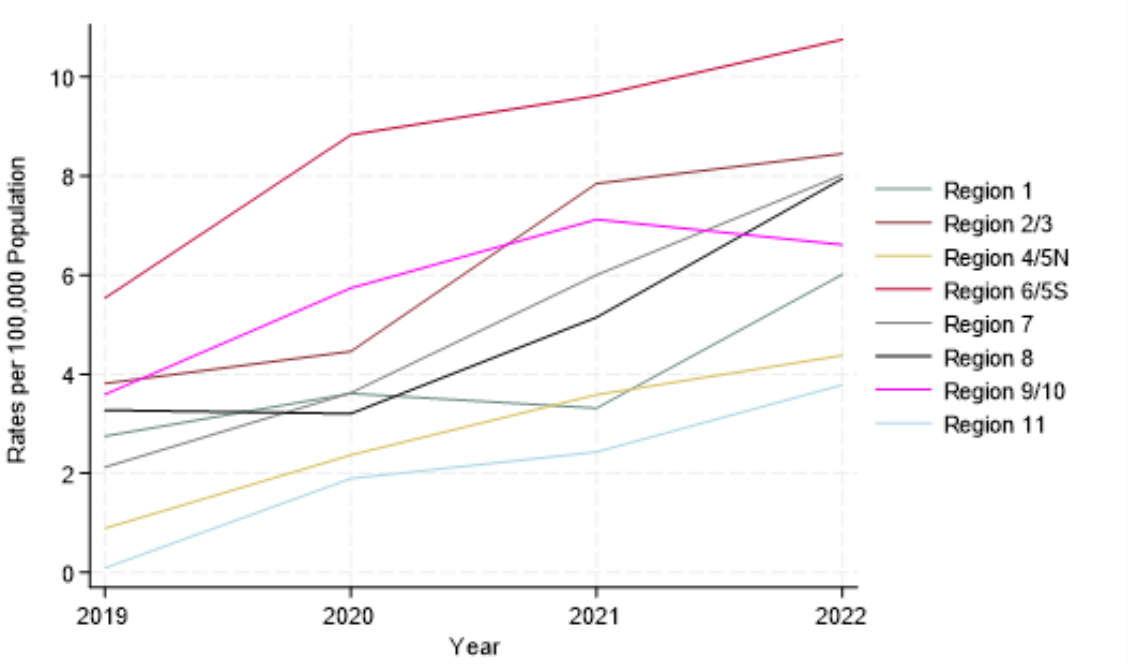


Figure 4: Opioid-related non-fatal overdoses



Next, we analyze the opioid drug poisoning-related deaths with data from Texas Vital Statistics. This dataset captures deaths related to a range of substances, including opioids, heroin, synthetic opioids, and fentanyl, and further differentiates between all, intentional, and unintentional deaths. Across all opioid-related poisoning deaths, rates steadily increased from 2019 to 2022. As shown in Figure 5, Region 6/5S exhibited the highest mortality rates, peaking above 10 deaths per 100,000 in 2022, followed closely by Regions 9/10 and 7. Meanwhile, Regions 4/5N and 11 reported comparatively lower rates.

Figure 5: All opioid-related drug poisoning-related deaths



For intentional opioid drug poisoning-related deaths (Figure 6), trends remained relatively stable but low throughout the period. Regions 6/5S and 2/3 recorded slightly elevated rates, peaking just above 0.4 deaths per 100,000 in 2019 before experiencing gradual declines in subsequent years. Other regions maintained consistently minimal rates that was suppressed in the dataset, indicating that intentional poisonings represent a smaller but persistent portion of opioid-related mortality. In contrast, unintentional opioid drug poisoning-related deaths (Figure 7) emerged as the primary driver of overall opioid-related mortality. These deaths exhibited steady increases across most regions, with Region 6/5S surpassing 11 deaths per 100,000 in 2021 and maintaining this elevated level into 2022. Significant increases were also observed in Regions 2/3 and 9/10, while Regions 4/5N and 11 reported comparatively lower mortality rates.

Figure 6: Intentional opioid-related drug poisoning-related deaths

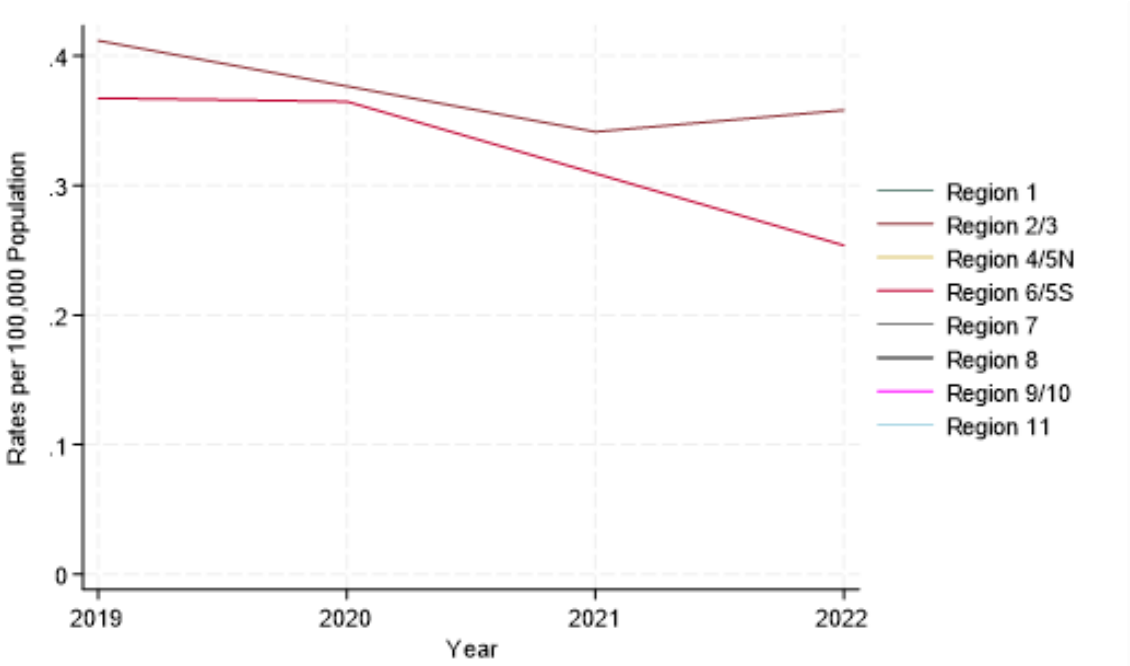
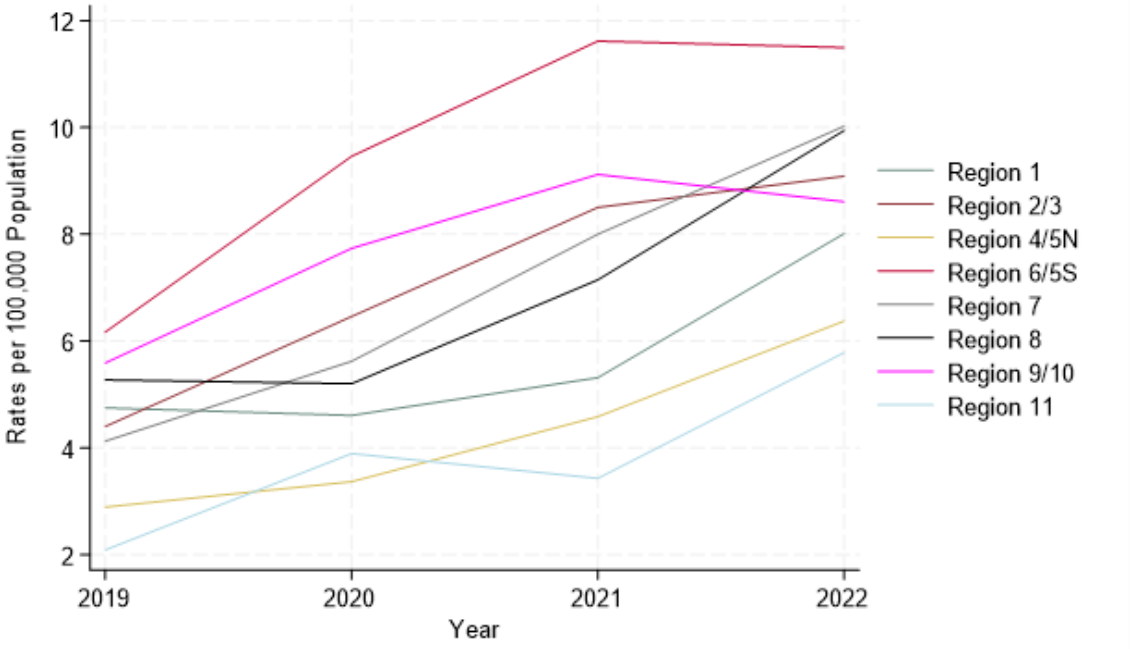


Figure 7: Unintentional opioid-related drug poisoning-related deaths



Youth

Our focus group and interview participants brought attention to other significant opioid-related issues in Texas that are not captured well in the quantitative data. The first being youth and their use of opioids. One issue was youth not taking the risk of overdose seriously. Participants reported that there is a lack of concern from adolescents in terms of drugs being contaminated, and the repercussions of using them in the event of an overdose. One focus group described how drug use is "glorified by teenagers" in their communities. Youth post videos using substances on their social media channels. Drug use is seen as exciting, and teens even mock individuals for how they act when under the influence or for being afraid to try the substance. Organizations are seeing repeated overdoses from youth, many times due to teens not knowing what they are actually taking. One organization disclosed that 3 teenagers in their community recently died from Fentanyl poisoning, because the individuals believed they were taking Percocet.

Participants explained the perceived causes of youth using opioids. Organizations that work in the mental health sector stated that youth who are having to provide for their families or lack support seem to be at risk for using opioids and other drugs to cope with these stressors. This is exacerbated by the fact social media portrays drug use as fun and exciting. Another participant contends: *"they're just bored because they don't have a place in the county"*, elaborating that most social supports are aimed at younger children or adults.

Poly-drug use and fentanyl contamination

One group provided insight on what they are seeing individuals overdose on and described what was being observed on tox screens that they review. Due to poly-drug use, they are seeing a dramatic increase in seizures, spiked blood sugars, and other life-threatening side effects.

The interviewee detailed:

> *"there's a big trend with poly-drug use... With cocaine and fentanyl mixed together on the street, we see the same thing with methamphetamine and fentanyl now being mixed together. We have a lot of Xylazine, which is another veterinarian tranquilizer being mixed. So... unfortunately we can't say it's just one drug threat now."*

Toxicology reports are showing Fentanyl, Heroin, Cocaine, and Benzodiazepines being in one's system at the same time. Additionally, law enforcement is now seeing pills with a mixture of the above mentioned drugs. This is causing EMS to give multiple doses of Narcan, sometimes 10 or more, to bring individuals back from an overdose.

Both adults and youth are becoming victims of Fentanyl contamination. Kratum, which can be purchased in smoke shops and gas stations, has been contaminated by Fentanyl and led to a series of overdoses in the Houston and the Bay area. A variety of pills being sold as Percocet or other stimulants have also been contaminated in the area. Several organizations stated that individuals who use drugs were comfortable using Fentanyl because they had been told their tolerance would be similar to that of other opioids. It was reported that other toxic materials, such as toxic plastics, are being found in the contaminated pills. It is unsure if it is intentional, or just a product that is used in the mixture.

Drug trafficking

Various organizations from across the state discussed their concerns with the trafficking of drugs through major corridors, like Interstate 35, Interstate 10, and State Highway 290. Some stated that drugs used to pass through the communities, but did not seem to settle or have a large impact on community health. Now, they feel that drugs are being sold and staying within the communities. This has led to major increases in drug use, especially in areas of west Texas. Some participants think there needs to be more emphasis placed on identifying traffickers, and more security at border crossings to stop the drugs from crossing into the U.S.

Stigma

Stigma directed towards opioids is one reason for slow progress in substance use prevention and addiction. Stigma significantly hinders harm reduction efforts, creating barriers for individuals who use drugs. It comes from various communities and can cause substandard medical care, be punitive for individuals receiving treatment with law enforcement and first responders, and alienating even within the community of other individuals who use substances. Many interviewees discussed several forms of stigma they have encountered working in and around substance abuse, substance treatment and prevention. We documented the sources of stigma along a socioecological framework (Figure 8). We included only the sources which were described to us during the interview process; so our figure is missing the policy level that is traditional in most socioecological models. However, the influence on policy is discussed in the challenges section.

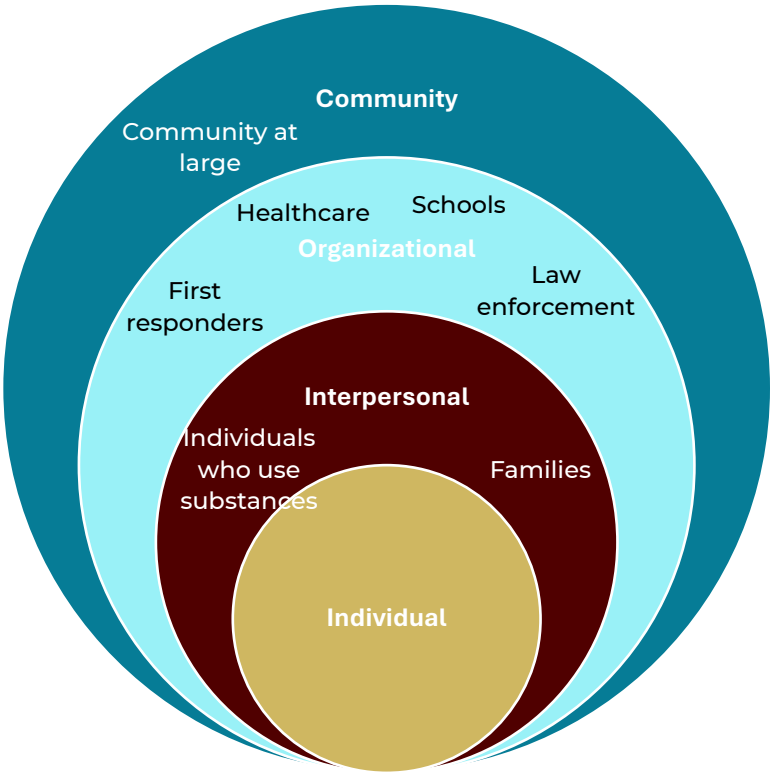
Family

There was lots of discussion around families and parents who do not want drugs and opioid issues discussed with youth. Organizations said that many parents do not feel it is necessary to have trainings or educational events at schools, because their children are not impacted by the epidemic. However, over half of the organizations said their biggest concern is adolescent use of opioids.

Other individuals who use substances

We heard stories about people who smoke, snort, and use needles can look down on and discriminate against each other based on the mechanism of opioid use. The thinking is "at least I am not that bad". When treatment providers attend meetings to provide Narcan, Naloxone or treatment options, others can refuse these options because they do not consider themselves "one of those people" who needs help.

Figure 8: Sources of stigma directed at those who use opioids



Healthcare

Interviewees pointed out multiple moments of potential stigma when individuals engage with healthcare organizations. Some providers do not want to treat or have negative attitudes towards individuals who use substances. We heard stories of providers prioritizing other patients first. One participant claimed it can be so severe it should be considered discrimination.

From our document review, we heard many individuals avoid emergency departments due to fear of judgment and past negative experiences, including inadequately treated withdrawal and confrontational interactions. Despite the potential of EDs to provide harm reduction resources, stigma from

both patients and clinicians remains a major obstacle. Clinicians' discomfort with opioid agonist treatments like methadone further exacerbates the issue.

Law enforcement and first responders

Similar to healthcare organizations, law enforcement agencies and first responder organizations can hinder access to treatment via their held beliefs and stigma towards opioids and individuals who use substances. We heard about being reluctant to serve and having negative attitudes.

Schools and education System

Organizations frequently discussed the lack of support they receive from school districts. Schools are afraid to discuss the opioid epidemic with students and teachers, mostly from fear of pushback. Additionally, many school districts do not want to admit that there is an Opioid issue in their area. However, some organizations say schools become much more likely to hop on board with training and educational events *after* they have students suffer an overdose. Additionally, teachers may not feel like they have the skills or expertise to help address these kinds of problems in their classroom.

Community

Communities can believe or be in denial that there is a substance issue in their area. Citizens may believe “other areas have those problems but not our area”. They view drug use as a moral failing instead of a disorder that needs to be treated. Many believe falsely that if a person is prescribed a medication, it cannot become addictive.

One interesting counterpoint we heard is that some participants feel there is *not enough* stigma surrounding opioids, especially around youth using opioids in their social circles. When discussing stigma around opioids and other substances, youth have “no fear.” Per organizations, youth find it fun and consider it acceptable among their friend groups. They felt if there was more stigma or fear surrounding use of drugs that there would be less overdoses. Instead, they describe opioids and other substances being readily available through social media channels, and adolescents are often observed bragging about using, or posting videos of themselves and peers under the influence. There is a positive stigma or belief around opioids in adolescent circles.

Interviewees maintained that substance abuse education, access to fentanyl testing strips and Naloxone/Narcan, as well as treatment facilities were the best ways to combat stigma for all demographics.

Challenges

Addressing these opioid issues is not straightforward. Strategies must be multi-faceted and address challenges that can complicate the issues laid out above. We asked our participants to detail some of these challenges for us. We also considered

the challenges we encountered while utilizing the publicly available data and the challenges we reviewed in our documents. The common challenges revolve around accessing data, addressing policy changes, incorporating comprehensive education, lack of services, and misinformation about opioids. Some county- and organization-level solutions to these challenges are discussed in the success and recommendations sections.

Data challenges

The opioid crisis continues to pose significant challenges, and addressing it effectively requires reliable, timely, and transparent data. However, several persistent issues undermine the ability to make informed decisions, intervene promptly, and develop impactful prevention strategies. These issues became apparent to the research team through conversations with key stakeholders. The following lists the main barriers and their impact.

Primary data challenges

- Lack of trust in data
- Limited data or lack of awareness of data
- Delays in data and interventions
- Lack of youth data
- Suppressed rural data
- Discontinued or deprioritized data tools

Lack of trust in data

A pervasive mistrust of overdose data stems from inaccuracies and misclassifications. Many overdose deaths are reported under other medical emergencies rather than being identified as overdoses. This lack of transparency obscures the true magnitude of the opioid crisis, leading to a disconnect between the actual severity of the issue and public awareness. Communities struggle to fully understand the impact of opioid use, which hinders collective efforts to address the crisis effectively.

Limited data or lack of awareness of data

The availability of comprehensive data remains a critical barrier. Many organizations depend on sources from state and federal agencies, yet this data is often outdated by the time it is accessed. Furthermore, despite innovative tools like the overdose map and data from entities like DSHS, awareness of these resources is limited. As one participant noted: “I only found a dataset because it happened to be at the bottom of a newsletter. Otherwise I would not know it existed.”

Delays in data and interventions

Delays between when data is collected and when it becomes actionable further exacerbate the crisis. For instance, organizations often find themselves operating with outdated information, which reduces the effectiveness of training and educational programs. Timely data sharing, especially at local and regional levels, is critical to ensuring that intervention strategies are relevant and impactful.

Lack of youth data

Youth data is particularly sparse, leaving a critical gap in understanding the crisis's impact on younger populations. This lack of insight into youth-specific issues prevents the development of targeted educational and intervention programs. Youth are often unaware of available resources, highlighting the need for better outreach and tailored strategies to engage this vulnerable demographic.

Suppressed rural data

In rural areas, data is often suppressed due to small population counts, which can result in underreporting or gaps in understanding regional needs. This creates significant challenges for organizations trying to implement effective policies and procedures.

Discontinued and deprioritized data tools

One concern raised in the documents we reviewed is that even when data tools exist, they are reliant on specific programmatic funding. When that funding ceases to exist, the tools are no longer maintained or discontinued altogether. Not only does this hinder program in the short-term, it can also hinder the program from seeking additional funds as they lack the data to support their cause.

Challenges addressing new policy

Participants described how recent legislative and other policy changes affect how they address opioid issues in their schools and communities. The discussions surrounding these policies underscore the reality of strategy implementation, that even well-meaning and potentially successful interventions can create additional challenges during real-world implementation.

Policies impacting opioid strategies

- Texas SB 629 (2023) concerning access to Naloxone/Narcan in schools
- Texas HB 3908 (2023) concerning education on fentanyl (and other substance use issues) in schools
- Texas HB 253 and SB 362 (if passed in 2025) concerning legality of fentanyl testing strips.
- Texas HB 1694 (2021) concerning protections to prosecution when calling 911 for overdose

School districts and concerns about Naloxone/Narcan access

In interviewing multiple participants, a topic that continued to come up was that schools are a place to connect with kids, but also a place where youth overdosing on campus is a reality. Interviewees discussed the need to provide Naloxone/Narcan on campus to prevent overdose deaths. However, the schools have concern of potential liability by administering the medication to students. Some school principals keep the medicine in their office instead of the nurse's office because of this

concern. This concern became a larger question when Texas SB 629 became effective June 2023. This hesitation comes from section 38.227(f):

> "An act or failure to act by school personnel or a school volunteer under this subchapter, including an act for failure to act under related policies and procedures, is the exercise of judgement or discretion on the part of the school personnel or school volunteer and is considered to be a ministerial act for purposes of liability of the school district…"

While section 38.227(a) protects the person who might administer the Naloxone/Narcan and states:

> "a person who in good faith takes, or fails to take, any action under this subchapter is immune from civil or criminal liability or disciplinary action resulting from that action or failure to act…"

Additionally, the bill requires Texas school districts to have a policy for maintenance, administration, and disposal of "opioid antagonists" frequently known as Naloxone/Narcan on school campuses serving grades 6-12. Incidence of administration of the opioid antagonist must be reported within 10 days of the incident occurring. Each campus is responsible for training employees and volunteers in how to administer the medication. Schools were expected to comply with the bill by January 1, 2024.[10]

Not all schools in Texas have complied with SB 629 though, and the official total number of schools is unknown at this time. Some interviewees discussed concern over the cost of opioid antagonists for schools. SB 629 allows physicians to prescribe Naloxone/Narcan to schools, however schools can also obtain it at no cost from one of the free providers in Texas as several interviewees stated. While this policy is meant to increase access to Naloxone/Narcan, how schools and communities overcome the barriers in education, stigma, and resources remains to be seen.

Tucker's Law (HB 3908)

Tucker's Law (HB 3908), named after Tucker Roe, a 19-year-old who died from a Percocet laced with fentanyl, came into effect in June 2023. This law outlines new duties for the School Health Advisory Council (SHAC) regarding recommending curriculum instruction on the dangers of opioids, synthetic opioids, and fentanyl for grades 6-12. Additionally, the law requires a designated week dedicated to fentanyl poisoning awareness education in public schools with evidence-based education provided. Instruction required under section 38.040 includes:

[10] https://capitol.texas.gov/tlodocs/88R/billtext/html/SB00629F.htm; https://www.cnhinews.com/cnhi/article_e9967584-fcb7-11ed-89f0-0b6bdb7c2d09.html

> "Suicide prevention, prevention of the abuse and addiction to fentanyl; awareness of local school and community resources and any processes involved in accessing those resources; and health education that includes information about substance use and abuse, including youth substance abuse and use."

Interviewees stated they were pleased that such a law now existed, and education on addiction prevention is important, but the requirements do not go far enough. Recommending there should be more an emphasis on harm reduction in drug use rather than abstinence from drugs all together. Interviewees felt abstinence was unrealistic and more tools should be given for youth to avoid addiction and overdose but will experiment with drugs, as well as tools for youth who are living with addiction.[11]

Legality of fentanyl testing strips

Interview participants recommend making fentanyl strips legal in Texas and providing them to individuals would prevent accidental overdoses and deaths due to fentanyl laced in other drugs. In Texas, the road to legalizing fentanyl strips has been bumpy. Texas House Bill 362 went to vote April 11, 2023, and passed. HB 362 was then sent to the Texas Senate where it stopped without being voted on.[12] If passed in the State Senate, the bill would have allowed for individuals to test drugs to ensure they were not tainted by fentanyl before using them. Detractors of the bill believe the test strips would only test a portion of the drug intended for use and not the whole drug rendering the tests unreliable.

In the upcoming 2025 Texas legislative session HB 253 will again attempt to make the testing strips legal.[13] Additionally, Texas SB 362 has been filed to also aim to make the testing strips legal.[14] These bills will be something to monitor in the coming year.

Lack of comprehensive Good Samaritan Law

One study we found highlighted significant challenges in implementing harm reduction strategies due to macro-level issues like restrictive policies and funding structures. They expressed concerns that the lack of a comprehensive Good Samaritan Law discourages people who use drugs from seeking help during overdoses, fearing legal repercussions. While Texas passed a partial Good Samaritan Law in 2021, participants criticized its limited protections,

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[11] https://capitol.texas.gov/tlodocs/88R/billtext/pdf/HB03908H.pdf, https://tea.texas.gov/about-tea/news-and-multimedia/correspondence/taa-letters/implementation-of-fentanyl-related-legislation

[12] https://journals.house.texas.gov/hjrnl/88r/pdf/88RDAY38FINAL.PDF#page=17, https://www.texastribune.org/2023/04/10/texas-house-fentanyl-testing-strips/

[13] https://capitol.texas.gov/BillLookup/History.aspx?LegSess=89R&Bill=HB253

[14] https://capitol.texas.gov/Reports/Report.aspx?LegSess=89R&ID=senatefiled

poor dissemination, and confusing language, which hinder its practical effectiveness.[15]

Challenges related to educating youth

One of the debates around substance abuse education for youth is to teach abstinence from drugs or harm reduction from drugs. Abstinence drug education programs have been employed in schools since D.A.R.E. was established in the early 1980s. Abstinence programs tend to focus on avoiding drugs all together, understanding the risks of taking drugs, as well as identifying unsafe situations. Interviewees stated that youth have difficulty connecting with these messages because the messaging is out touch and not resounding with the daily realities youth see in their lives.[16]

Harm reduction refers to the education strategy of reducing the safety issues common with drug use including HIV, Hepatitis C, and overdose. Interviewees commented that youth can and do use harm reduction to help friends and family members living with addiction by having Narcan or Naloxone on hand for them and knowing where to help them find treatment. Further, interviewees recommended including education in schools regarding harm reduction for youth who are or may become addicted to drugs to reduce the longer-term consequences of drug use.[17]

Many interviewees discussed the availability of training and education programs that are designed to enlighten youth and adults regarding Naloxone/Narcan, fentanyl contamination, and other opioid dangers. Simultaneously, the CDC, SAMHSA, and multiple states have created education programs for schools to follow regarding drug avoidance and harm reduction. However, for multiple reasons messaging is slow to reach users. Some of the reasons discussed in interviews were combating misinformation on the streets about the lethality of fentanyl, generational drug and alcohol use in families, combating misinformation on social media, and stigma in communities disallowing education regarding substance abuse to be disseminated in areas of the state. However, persistence by advocates and

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[15] Claborn, K., Samora, J., McCormick, K. *et al.* "We do it ourselves": strengths and opportunities for improving the practice of harm reduction. *Harm Reduct J* **20**, 70 (2023). https://doi.org/10.1186/s12954-023-00809-7

[16] https://dare.org/, https://www.apa.org/monitor/2024/03/new-approaches-youth-substance-misuse,https://drugpolicy.org/resource/safety-first/, https://www.avenuesrecovery.com/understanding-addiction/abstinence-vs-harm-reduction-the-complete-guide/

[17] https://nida.nih.gov/research-topics/harm-reduction, https://www.hhs.gov/overdose-prevention/harm-reduction,https://www.avenuesrecovery.com/understanding-addiction/abstinence-vs-harm-reduction-the-complete guide/, https://www.samhsa.gov/find-help/harm-reduction, https://www.samhsa.gov/find-help/harm-reduction/framework

their messaging is cited by interviewees as one of the main factors in pushing information forward over time and reaching more people.[18]

Gaps and barriers to service provision

A common theme that arose during our discussions is the challenges of providing services to those who use opioids. While these discussions often centered around treatment options, much can be learned and applied to structuring preventative efforts.

Primary barriers in access to services
• Lack of services for youth • Challenges to those in criminal justice system • Connecting hidden populations to right services • Cost • Transportation

Lack of youth services

Our participants highlighted several populations that can use more support and services. The most frequently mentioned population was youth. Connecting youth to treatment facilities, especially inpatient care, was one concern. As one participant noted: "every single day we get a new e-mail that says this treatment has closed and isn't taking new clients". Other challenges cited included: education that does not connect with youth and needs to be updated, a lack of evidence-based treatment and curriculum options; difficulty scheduling treatment around school hours; and gathering buy-in from parents, teachers, and school staff that more services are needed. Youth themselves are unaware of the services that are available. Feedback suggested that youth rely primarily on social connections to learn about resources (as opposed to more traditional models of education or outreach).

Challenges to serving those in the criminal justice system

We also heard during multiple conversations about the challenges that can arise when serving individuals who are in the criminal justice system. For one, there is a lack of services and treatment providers that will go into jails leaving those populations often without services. Other respondents felt addressing the needs of individuals in the pretrial stage was especially difficult. Often a judge will add conditions that an individual can be released into the community (as opposed to jail) if they obtain treatment. The individual may not know where to go to get this court-mandated support and is reliant on knowledge of court staff who are not specialists in this field. Many services are not available locally or can be difficult to schedule around work schedules and other release conditions. For this population, not getting treatment can have legal consequences.

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[18] https://adai.uw.edu/pdfs/YouthODHarmReduction202402.pdf, https://www.samhsa.gov/sites/default/files/harm-reduction-framework.pdf, https://www.cdc.gov/stop-overdose/about/index.html

Connecting hidden populations to right services

Our participants also described challenges to serving populations that are more likely to fly under the radar. Finding service options for individuals with comorbid mental health conditions or poly-drug use is difficult, specifically treatment centers that can address all the person's needs.

One of the studies we found contends that there is a pressing need to improve equity in harm reduction services, as many vulnerable populations, including women, people of color, LGBTQ individuals, rural residents, and youth, remain underserved. Outreach to hidden populations, such as individuals who are unhoused and veterans with PTSD, also poses significant challenges, highlighting the need for targeted strategies to expand access and support.[19]

Furthermore, one participant made note of the critical timing of serving someone who was just released from inpatient services. In their experience, this is a prime time to offer comprehensive supports (including addressing basic needs such as transportation, food, housing as well as drug issues) to avoid relapse.

Cannot afford service

Most respondents made note of a lack of treatment centers across the state. They told stories of often sending clients 2 to 3 hours away, sometimes closer to 7 or 8 hours away to receive services. An individual is often sent further away because they are unable to pay for a closer option. Many providers will only take insurance or have clients pay out of pocket. Providers that are state or federally funded tend to have long waitlists and limited space.

Transportation

Even if the service does exist locally, transportation can be a major barrier in a participant obtaining that service. Service providers will often work to get bus passes or rideshare credits to those who do not have a car. Individuals may need to drive to larger cities and there is a lack of publicly available transportation between cities. In some cases, a dedicated provider will drive the client themselves, even to these locations that are 7 hours away, but there are safety concerns related to this strategy.

Misinformation

Our participants also drew attention to the misinformation surrounding fentanyl and other opioids. Many of which can be addressed by wider spread education and outreach. Common myths we heard about during our conversations include:

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[19] Claborn, K., Samora, J., McCormick, K. *et al.* "We do it ourselves": strengths and opportunities for improving the practice of harm reduction. *Harm Reduct J* **20**, 70 (2023). https://doi.org/10.1186/s12954-023-00809-7

- Fentanyl is not deadly if someone also uses heroin,
- Individuals who use opioids are usually living on the streets,
- Opioid addiction only comes from drugs available on the street, addictions do not happen from opioids received in healthcare settings.

Successes

While organizations made it clear there is work to be done to address the drug epidemic, there are organizations and people who are dedicated to making their communities safer and healthier. Successes include passionate partnerships between organizations and city departments, agency collaborations, the increasing availability of Narcan and Naloxone, as well as the drug epidemic gaining attention and increased funding for research. Moreover, as we have discussed in previous sections, strides are being made in reducing opioid prescriptions and passing beneficial legislation.

Passionate community partnerships

While there is much work to be done to decrease opioid use, there are hundreds of people in communities across Texas that are passionate about making their homes safer and healthier. At least 10 of the organizations we spoke with are connected to other providers and have a known presence in their communities. They provide assistance and services to those who need them, but also find their ways into schools and community spaces to educate people on opioids and how to navigate a world that is impacted by drug use. They attribute their success to attending community events, networking with city councils and police departments, and building relationships with the citizens in their area. There are well established coalitions all across Texas that are working towards providing Narcan to their citizens, designing trainings for schools, and working with law enforcement to provide care to individuals who need it, rather than receiving a jail sentence.

While they are not common, peer support partnerships are highly recommended by communities with established bonds. Organizations that work to establish peer supports believe it helps individuals stay sober, connects them to pertinent resources (like housing, insurance, and social connection), and makes the transition to sober living, or entering rehabilitation, easier to accomplish. We received recommendations on how these can be better established, which will be covered later in the report.

Naloxone/Narcan availability

Many communities are taking advantage of free Naloxone/Narcan, and feel they are well equipped with Naloxone/Narcan availability. Several groups noted Narcan vending machines were placed in areas that individuals who use drugs may congregate. Groups have learned how to obtain more Narcan, whether that is through the police department or groups that are registered

suppliers. Many groups also hand out Narcan at events, during trainings, and to individuals who may be getting out of jail. While some noted that availability still needs to improve, it seems that groups are learning how to obtain it and sharing the resource with their community.

Increased attention and funding

Several groups that we spoke with were building partnerships with city governments and law enforcement offices. This may allude to the fact that opioid and other drug issues are gaining attention, and communities are becoming more aware of the negative impact it can have on public safety. Additionally, we spoke with university professors who said funding for research projects related to opioids is increasing. They felt this shows the commitment to finding solutions and providing resources to people who use opioids and other drugs.

Agency collaborations

With Texas being a large state and the variability in populations and geography, solving the opioid epidemic cannot be tasked to just one agency. Through this study, we have found numerous state agencies and their programs – DSHS, HHSC, TTOR, ORS – willing to connect and share. These agencies and programs recognize the benefits of addressing problems together and the value of collaboration. This bodes well for the future as we attempt to maximize impact and share resources.

RECOMMENDATIONS

To develop our list of recommendations, we asked our interview and focus group participants their feedback on addressing three of the main prevention strategies that are incorporated into the TODA program. Given the knowledge and experiences of the participants in our community conversations, we focused on the prevention strategies related to public safety partnerships/interventions, harm reduction, and community-based linkages to care (aka navigators). We also included additional recommendations based on our overall findings from the community conversations, secondary data, and document review. These recommendations are primarily directed at DSHS on how to shape the TODA program from a statewide level and keeping in mind their specific role in implementation of TODA program. However, practitioners, community leaders, and other agencies may still find value here. The recommendations are a mix of practice recommendations and decision-points for DSHS to consider as they develop the next steps of the program. They are organized according to the main prevention strategies, followed by overall recommendations.

Public Safety Partnerships

Interview and focus group participants described their experiences with local public safety and multi-sector partnerships. They emphasize creativity and genuine

connections to support partnerships. While DSHS and TODA work on public safety partnerships statewide, local partnerships can also be encouraged.

Create guidance materials on how to genuinely engage and outreach local partners

Participants proposed a wide range of potential partners. Mental health organizations and emergency medical services formed the foundation. Criminal justice organizations and schools were also suggested as key partners. Some creative ideas on how to partner included creating mobile units with mental health professionals to respond to overdoses and comprehensive diversion programs that include substance use care. Whatever the strategy, participants stressed that each collaborator has to be authentically engaged. This typically includes finding a champion at the organization who is actively involved in decision-making. We suggest materials be developed for local communities on how to engage and collaborate with partners including providing ideas and outreach strategies to connect with these partners and develop strategies. Then tracking and documenting their activities and successes to use as models to be scaled up across the state.

Harm Reduction

Participants had varying opinions on whether to increase Narcan or Naloxone in their communities. Some were open, others felt they had plenty and did not need more. Still others felt that increasing access to would increase opioid use in their community. For those in support of using Naloxone/Narcan, the consensus was to make it easily available and reduce the stigma around using it.

Increase marketing and promotion of existing resources related to Naloxone/Narcan

We heard from participants that while resources to access Naloxone/Narcan (such as https://naloxonetexas.com/) exist but are not well-known. Additionally, as DSHS and TODA complete the Texas Naloxone locator map, a robust outreach campaign will be needed, especially targeting priority areas such as youth, those in the criminal justice system, and areas that have a need.

Combine access to Naloxone/Narcan with education

Any Naloxone/Narcan doses given out as part of TODA should also include access to education and local resources available to the individual themselves. Larger-scale partnerships - for instance, if hundreds of doses are given to law enforcement, courts, and schools among others - should also include education and resources aimed at the organization. As one interviewee described: it is often assumed these organizations are educated on opioids,

but they are not. Education and resources tied to access to Naloxone/Narcan should also address stigma related to opioid and Naloxone/Narcan use.

Consider the additional infrastructure needed to increase Naloxone/Narcan

Feedback from one organization was that while additional Naloxone/Narcan doses would be great, they did not have the capacity to store more. It's important to think about the surrounding infrastructure when considering increasing doses and associated access. Physical space, storage opportunities, and staff to distribute doses are important considerations.

Community-Based Linkage to Care

Support for increasing access to community-based linkages to care via navigators was very high. Many of our participants felt this hands-on, holistic approach was critical to preventing additional overdoses. Some of our interview participants have heavily engaged with their local navigators or act in a navigator role themselves, offering a detailed look into the experience.

Develop a network infrastructure for navigators

As one participant said, "[navigators] need education, outreach, and resources". Similar sentiments were echoed by other participants, as well. Navigators rely on connections and outreach to services and organizations in their communities to make referrals. They must be aware of what exists and when these services have changed or are at capacity. As the number of navigators grows in Texas, creating a community of practice for navigators to meet regularly and share knowledge about services or the best ways to connect in the community can help all. Guest speakers from statewide service providers or statewide data resources can assist the navigators in their mission. Additionally, we heard about the emotional and mental burden that may arise in the opioid service provision field. Having education and sharing resources on self-care, burnout, and related topics should be one of the topics covered.

Utilize statewide contacts to better connect navigators to court systems and schools

Two populations that were repeatedly highlighted as critical to address are youth and those in the criminal justice system. Service providers' connections to these systems are variable depending on personal connections and support from the local systems. Additionally, the knowledge of these localized systems about opioid issues, treatment options available, and potential alternatives can also vary even as they are often mandated to address them. We suggest building out connections at the state level with related agencies - such as Texas Behavioral Health and Justice Technical Assistance Center, Texas

Association of Pretrial Services, Texas Juvenile Justice Department, SHACs, School Nurses Associations and others - to reinforce spread of information to the local communities. Also materials related to navigator services can be created and distributed at these agencies' conferences, at agency wide meetings, or through their networks.

Maintain a model of navigators being a truly holistic linkage to care

Service providers stress that they not only assist on opioid- and drug-related care, but help individuals address housing, food, clothing, and hygiene needs whenever possible. This is critical to the health of individuals and promotes longer-term success. One participant suggested that peer support also be included in this holistic approach to reinforce other care strategies. As partners in this intervention, DSHS and HHSC should continue to support the navigators in this holistic linkage to care model and ensure the philosophy is incorporated into any education and resources for navigators.

Consider communities for expansion of navigator program based on community characteristics

Before the navigator program is expanded to new counties, an assessment is done that considers opioid-related outcomes and resources in the area. Our discussions with service providers have uncovered additional characteristics that can be useful for the success of the program. First, is the presence of a local coalition of non-profits and service providers in the community. Participating in these coalitions have been critical for navigators to stay on top of what is available to support individuals. Second, is identifying where previous navigator-like programs have recently closed doors due to loss of funding. In these communities, many of the resources including personnel are still available and it could potentially be an easier ask to get started on the program. Information about existing infrastructure is not readily available or centralized and will require internet searches and continued conversations with local providers to gather details. A next step of the landscape analysis can include such activities. We will rely on support from DSHS, HHSC, and other partners to help share this information when it becomes known to them.

Other Recommendations

Through our study, we have developed additional recommendations that do not fit within the specific prevention strategies.

Consider giving specific attention to youth and criminal justice involved populations through the TODA program

A recurring theme was these two populations needing more support in terms of opioid services. Special attention and resources – including funding, access

to data, and education – should be given to prevention strategies addressing these areas. We should also consider creating specific measures for these populations to track involvement in the program.

Use data to study seasonal and geographic trends

We heard multiple perspectives on the seasonality of opioid overdose and service use. Moreover, some participants felt the opioid epidemic was getting worse in their county, others felt it was getting better, and still others felt it had not arrived in their county yet (but would be given trends they have seen in neighboring counties). Utilizing the data available to better understand potential shifts of opioid-related outcomes can help community leaders anticipate and react.

Promote statewide data sources including training on how to use them

Addressing these challenges requires a multifaceted approach, including improving the accuracy and transparency of overdose data, increasing data sharing between agencies, and creating centralized, up-to-date resources. Better outreach and data-sharing practices are essential to empower organizations with the information needed to craft timely interventions. As one participant noted: “I only found a dataset because it happened to be at the bottom of a newsletter. Otherwise, I would not know it existed.” Other participants repeated a similar sentiment surrounding awareness and understanding of data available to them. We suggest promoting the available data dashboards and other potential data sources when also promoting the TODA program services.

Create a centralized list of opioid-related services and centers in Texas

Currently, lists of treatment centers or services are specific to one program or agency. A comprehensive database that cross - references these and also includes care need organizations such as food banks, housing facilities, etc. would support navigators and other service providers in their missions. Ideally the information would be kept current to know when the organization is taking new clients or at capacity. To do so, it would have to be a database open to providers to update and include that information as necessary. Without centralized, accessible databases or better communication, organizations are left under-resourced and unable to fully leverage the supports at their disposal.

Develop a Texas Opioid Workgroup for DSHS, HHSC, agency partners, university partners, and service providers

Resource sharing can maximize the reach of opioid services. We propose setting up a workgroup (or joining one if it already exists) to connect these organizations on a regular basis. Sharing program updates, data sources, and other information can address many of the above recommendations.

CONCLUSIONS AND NEXT STEPS

This landscape analysis sheds light on some of the largest concerns related to opioid use in Texas. Across Texas, we need to address stigma, education, service gaps, and increase access and use of data. More resources and support need to be specifically developed for our youth and criminal justice involved populations.

This analysis also highlights what is going well. One important takeaway is that there are many motivated and passionate people across Texas eager to help individuals who use opioids. We heard countless stories of connecting people to services they would not have otherwise received. It's clear that the best way to address opioid-related issues relies on substantial collaboration between state and community partners.

Next Steps in Evaluation

One limitation is that we were unable to speak to participants in every public health region like we wanted. In these areas, we have to rely more on secondary data. We hope that in future years, as the evaluation team makes more connections, we can update this landscape with those perspectives.

The next steps in the evaluation include:

- Talking to agency leads about implementing the program incorporating many of the themes laid out in this report
- Conducting additional analysis on the data we already have and collecting additional data to better understand the trends and patterns discussed
- Continuing to capture the feedback of all stakeholders via surveys and community conversations to contextualize program and state performance.

APPENDICES

APPENDIX A: SELECTING COUNTIES FOR LANDSCAPE ANALYSIS SITE VISITS (PRELIMINARY)

Explanation

We compiled various data points: opioid related deaths, opioid related EMS data, opioid dispensing rates, and opioid related ED visits, and number of service provider in the county. We also included contextual data to review including size of the county, DSHS PHR, healthcare shortage social vulnerability index, ICON site, etc. A summary of a few of these data points is provided below.

We narrowed our list to include the counties that repeatedly show up as the highest and/or lowest in each of these variables. We decided we wanted at least 1 county from each DSHS Public Health Region (PHR) and that we wanted to include different sizes of counties for variety.

We chose some counties because of their opioid-related outcomes. For example, Potter and Wichita Counties are high in providers and opioid-related outcomes and are mid-size counties in their respective PHRs. Nueces County is also high on opioid-related outcomes but has a larger population, is on the opposite side of the state and has a middle level ranking of providers.

Other sites were chosen because of their status as an ICON site. Galveston County was chosen as it currently an ICON site, is high in opioid-related outcome, and low in providers. Similarly, Hays is also an ICON site and ranks high in some opioid-related outcomes. Interestingly, in our data we are unable to find any providers in Hays, so this will be something to more closely investigate through discussion. El Paso County was chosen because of its future status as an ICON site and its varying ranking in opioid outcomes.

We chose two additional counties in PHR 7 as they are local to PPRI and we have strong networks to connect with. We would like to test site visit procedures here. Robertson county was chosen as a small county that ranks high in providers and low in many opioid-related outcomes. Brazos County is mid-size and low in providers but also low or middle in opioid-related outcomes.

And then our final sites round the geographic and size variability. Angelina County provides representation for PHR 4/5N and offers a smaller size county perspective who also is low in many opioid-related outcomes. Bexar County is a large county in PHR 8 that is high in opioid-related deaths but not many more opioid – related outcomes (which is surprising given its size).

This list is a starting point, we may have to adjust with new data or based on conversations with stakeholders. We may also seek input from Dallas County or omit 1 of the counties in PHR 7. Altogether, these counties should provide us with a good foundation on what is working and not working in Texas and how to guide the TODA programming.

Details on the counties chosen

Based on this we are planning to connect with the following:

- Potter County (PHR 1)
  - 100,001-250,000 people
  - Ranks high number of providers
  - Ranks high in opioid related ED, non-fatal opioid poisonings, and dispensing
- Wichita County (PHR 2/3)
  - 100,001-250,000 people
  - Ranks high number of providers
  - Ranks high in opioid related ED, opioid-related death, and dispensing
- Angelina County (PHR 4/5N)
  - 50,000-100,000 people
  - Ranks high in providers
  - Ranks lower in associated opioid-related outcomes except high in dispensing
- Galveston County (PHR 6/5S)
  - Current ICON site
  - 250,000+ people
  - Ranks low in providers
  - Ranks high in opioid-related deaths and opioid-related ED visits
- Hays County (PHR 7)
  - Current ICON site
  - 100,001-250,000 people
  - Unable to find any providers
  - Ranks high in opioid-related deaths, lower in other outcomes
- Robertson County (PHR 7)
  - Local to PPRI with strong network
  - <50,000 people
  - Ranks high in providers
  - Low in many opioid-related outcomes like dispensing
- Brazos County (PHR 7)
  - Local to PPRI with strong network
  - 100,001-250,000 people
  - Ranks low in providers
  - Ranks low to middle in most opioid-related outcomes.
- Bexar County (PHR 8)
  - 250,000+
  - Ranks low in providers
  - High in opioid – related deaths
- El Paso County (PHR 9/10)
  - Future ICON Site
  - 250,000+

    - Mid rank on number of providers
    - Varying opioid outcomes (sometimes high/sometimes low)
- Nueces County (PHR 11)
    - 250,000+
    - Mid rank on number of providers
    - High in many opioid related outcomes including deaths, ED and dispensing.

APPENDIX B: GENERAL INTERVIEW QUESTIONS

Questions

1. Tell us about yourself, what is your role in the community, especially as it relates to opioid issues.
2. Tell us about opioid issues in your community/area. What are some of your biggest concerns?
    a. [stigma probe] How are opioids perceived in this community?
    b.
3. How has your program or county addressed these issues? What is working? What is not working?
    a. [if they provide services directly, ask about the services – what types of services do they offer? For how long? How many people can they serve? How long do they serve individuals? What else do they need to better serve community?]
    b. Are you aware of any programs in your community that offer peer supports? Can you tell me about them?
4. What could be improved upon? What do you need to be more effective?
5. The program has certain prevention strategies that DSHS will need to incorporate. Part of our job is to help them understand how to build out these strategies to be most effective.
    a. One of the strategies is public safety/public health partnerships – have you worked in such a partnership? How do those look in your community? What advice would you give DSHS to building out such partnerships?
    b. Another strategy is increasing access to naloxone or Narcan. What does access to naloxone/Narcan look like in your community? What recommendations would you suggest to DSHS on how to do this?
    c. Another strategy is a navigator where someone like a community health worker supports connects an individual who uses opioid to services/supports directly. Are you aware of such a program in your community? How do you think this would look? What advice would you give to DSHS about doing this?
6. Anything else you want to tell us about opioid issues in your community?

Closing

- Thank you again and if you think of anything else you would like to share, please don't hesitate to reach out.