Overdose Data to Action: Limiting Overdose through Collaborative Actions in Localities (OD2A: LOCAL)

Community Needs Assessment (CNA)

Marion County, Indiana

INDIANA UNIVERSITY INDIANAPOLIS
FAIRBANKS SCHOOL OF PUBLIC HEALTH

MARION COUNTY PUBLIC HEALTH DEPARTMENT
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This Community Needs Assessment (CNA) was conducted by the IU Richard M. Fairbanks School of Public Health (FSPH) in Indianapolis and supported by the Centers for Disease Control and Prevention (CDC) of the U.S. Department of Health and Human Services (HHS) as part of Overdose Data to Action: LOCAL (CDC-RFACE-23-0003). The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, CDC/HHS or the U.S. Government.

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Executive Summary

In the fall of 2023, the Marion County Public Health Department (MCPHD) was awarded the federal *Overdose Data to Action: Limiting Overdose through Collaborative Actions in Localities (OD2A: LOCAL)* grant. This 5-year initiative by the Centers for Disease Control and Prevention (CDC) supports local jurisdictions in addressing the overdose crisis through surveillance and evidence-based prevention and harm reduction strategies, with the overarching goal to reduce drug overdoses and health inequities. To achieve this goal, MCPHD funds and collaborates with 16 community organizations (sub-awardees).

One requirement of the initiative is the completion of a Community Needs Assessment (CNA) to identify the primary needs and challenges of people who use drugs in Marion County. The enclosed report details the findings of our thorough assessment, with this section specifically highlighting the key findings from the study.

Based on prevalence rates from the 2021-2022 National Survey on Drug Use and Health, we estimated that in Marion County nearly 80,000 adults had a drug use disorder in the past year, this included almost 15,000 adults who qualified as having an opioid use disorder. Furthermore, over 62,000 adults needed but did not receive treatment at a specialty facility for their illicit drug use (Substance Abuse and Mental Health Services Administration, 2024).

The MCPHD conducts ongoing surveillance of drug overdose incidents. Recent data from 2023 indicates a concerning trend, with 701 deaths attributed to drug intoxication, 80% of which involved opioids, predominantly fentanyl. These figures position drug intoxication as the leading cause of death in the community, exceeding even cardiovascular deaths for the third consecutive year.[1] Additionally, the county faced over 6,100 non-fatal drug overdose cases (Marion County Coroner's Office, 2023).

To assess the essential needs and challenges of people who use drugs, we conducted surveys and focus groups, gathering insights from 168 participants. This included 140 responses from people who use drugs and 28 responses from community service providers, offering a comprehensive perspective on the issues at hand. The primary

[1]Drug intoxication is the leading cause of death among deaths investigated by the Marion County Coroner's Office (MCCO), but not necessarily for all of Marion County. MCCO investigates nearly all deaths due to overdoses in the county, but there are many deaths that occur among Marion County residents that do not result in an investigation.

insights from our community-engaged research can be categorized into three main areas: (1) access to services and barriers to care, (2) needed resources, and (3) experiences of stigma.

Access to services and barriers to care:

Participants highlighted significant concerns regarding the accessibility of essential services for people who use drugs (PWUD), identifying a notable gap between community needs and available resources. They emphasized that the involvement, inclusion, and transparency of community providers are crucial in facilitating access to services for PWUD, whether through direct care or by connecting them to necessary services. Additionally, participants stressed the importance of providing immediate assistance and a "warm handoff" to capitalize on the "window of willingness" when individuals are ready to seek help.

Major barriers to obtaining care included factors related to people's social determinants of health such as financial constraints, lack of transportation, housing and employment instability. Many participants stated that even if services are available in the community, PWUD are frequently not aware of them. Furthermore, limited treatment capacity and mistrust in the health system were also mentioned as significant obstacles. Inconsistent rules and regulations across treatment facilities can create confusion and hinder access. Participants identified several vulnerable populations, including justice-involved individuals, single parents, and people of color, who may face additional challenges.

Needed resources:

Many respondents indicated a need for stable housing. Other common issues included physical violence, food insecurity, and lack of transportation. There is a strong need for support services addressing social determinants of health, for example, governmental support and employment assistance/training, but also mental health counseling and peer support are necessary.

Not only PWUD but also the community organizations serving them require additional resources, particularly funding to sustain and expand services, and training to enhance the peer recovery workforce and service capacity. At the community level, increased

education and awareness about substance use disorders[2], along with greater support from politicians and law enforcement, were considered essential.

Experiences of stigma:

Stigma is a significant barrier to care. Participants indicated that encountering stigma reduced their willingness to seek services and affected their sense of belonging. The experience of stigma was especially pronounced among certain groups, such as PWUD who are experiencing homelessness or who are part of the LGBTQ+ community.

The majority of our PWUD respondents felt that they could trust the local health department and community organizations to provide harm reduction services. However, many reported feeling stigmatized by medical providers because of their drug use. Stigma is frequently purported by law enforcement and can even occur within the recovery community, where individuals may have differing opinions about harm reduction and what "sober living" means. Additionally, PWUD may internalize stigmatizing language themselves, negatively impacting their recovery. Participants highlighted the need for education and awareness to reduce stigma in the community.

[2]Substance use disorder refers to the clinical diagnosis of having an alcohol use or drug use disorder.

Introduction

In the fall of 2023, the Marion County Public Health Department (MCPHD) was awarded the federal *Overdose Data to Action: Limiting Overdose through Collaborative Actions in Localities (OD2A: LOCAL)* grant. This 5-year initiative by the Centers for Disease Control and Prevention (CDC) supports local jurisdictions in addressing the overdose crisis through surveillance and evidence-based prevention and harm reduction strategies, with the overarching goal to reduce drug overdoses and health inequities. Key aspects of *OD2A: LOCAL* include:

- Continuous collection of data to inform programs and prevention strategies.
- Implementation of culturally relevant interventions and the equitable delivery of prevention services.
- Maintenance and expansion of multisectoral partnerships to strengthen the local overdose response.

The MCPHD contracted researchers from the Indiana University Richard M. Fairbanks School of Public Health (FPSH) in Indianapolis to assist with the evaluation of the initiative. One of the requirements of *OD2A: LOCAL* is conducting a community needs assessment (CNA). This report contains the findings of this comprehensive assessment.

Methodology

The CNA was conducted from January to June 2024, and involved the collection of secondary (already existing) and primary (new) data.[3] This report contains the following sections:

1. **Background.**
   We reviewed the existing literature to see what overdose related issues had already been identified in Marion County and defined the priority populations.
2. **Marion County population profile.**
   To provide a community context, we listed the demographic and social risk factors of Marion County residents. This is important because these factors generally have a tremendous impact on health outcomes and are often referred to as social determinants of health.

[3]The study protocol for the CNA was submitted to the Indiana University Institutional Review Board (IRB) and deemed exempt (Protocol #21170).

3. **Drug use and consequences.**
   We reported the rate of drug use in Indiana and estimated the number of people who use drugs in Marion County. We also analyzed overdose surveillance data.
4. **Findings from surveys and focus groups.**
   We surveyed the community to gather information of the needs and challenges that people who use drugs (PWUDs) experience. These surveys were given to PWUDs and community partners who serve PWUDs. Furthermore, we conducted focus groups on these issues to get a more in-depth understanding.

Background

We conducted a literature review to identify relevant studies on overdose-related issues and existing health inequities in Marion County. Each report was carefully reviewed, and the most pertinent information was extracted.

Prioritized populations

One of the primary objectives of the OD2A: LOCAL grant is to reduce health inequities among people who use drugs. Based on current data, the Marion County Public Health Department has identified the following priority groups for the initiative: Black or African American residents, Spanish-speaking and/or Hispanic/Latinx residents, unhoused residents, and residents living in zip codes with high overdose death rates (46201, 46204, and 46225).

Rationale for selecting prioritized populations: Data were collected through the Emergency Department Syndromic Surveillance Database, Emergency Medical Services Data, public safety data, census data, and overdose fatality data from the Marion County Coroner's Office. Based on the findings, the rate of suspected overdoses seen in emergency departments across Marion County is higher among White individuals. However, between 2022 and 2023, the suspected non-fatal overdose rate among White individuals decreased by 16%. During the same period, the rate among Black/African Americans decreased by 9%, while the rate among Hispanics saw a smaller decrease of 3% (Marion County Public Health Department, 2024). Additionally, data from the Marion County Coroner's Office revealed similar trends. From 2021 to 2022, there was a 5% increase in overdose fatalities among Black/African American decedents, but a decline of 5% among White decedents. Furthermore, a special report was included in the Coroner's annual report on unhoused individuals, highlighting the need to enhance data collection due to an increase in deaths among unhoused individuals. In 2023, unintentional drug intoxication deaths among unhoused individuals accounted for 86%

of all deaths in this group (Marion County Coroner's Office, 2023).

Stigma

A 2023 report identified five major challenges to the behavioral health system in Marion County including: No sustainable funding for community mental health centers; workforce shortages; limited access to services, especially for some populations; a complex and fragmented behavioral health system; and stigma. Stigma is a considerable barrier to accessing mental health and substance use services, especially in communities of color (Greene et al., 2023). A study by Seo et al. (2023) examined how racism affects Black residents' fatality reduction behaviors, such as calling 911 or administering naloxone, following an opioid overdose. Findings from the study suggest that Black individuals often experience stigmatization from first responders and medical institutions, leading to strong feelings of mistrust and fear. These experiences may explain Black individuals' low motivation to call 911 or administer naloxone to prevent overdose deaths (Seo et al., 2023).

The MCPHD surveyed and interviewed several healthcare workers in major hospitals and emergency medical services (EMS) first responders in Marion County. Overall, the survey results conveyed three major themes among participants: (i) a lack of knowledge among healthcare professionals regarding substance use disorders (SUD) and harm reduction, (ii) a "hidden curriculum" (informal and unintended passing of knowledge between generations of staff), and (iii) compassion fatigue (a decline in the ability to feel sympathy or empathy). MCPHD was able to identify common stigmatizing and harmful beliefs held by participants that can affect the quality of healthcare that patients with SUD receive (Marion County Public Health Department, 2023).

Marion County Population Profile

Marion County is located centrally in Indiana. It is the most populous county in the state with 969,466 residents. Three-fifths of residents are white, and African Americans represent about a third of the county's population. In terms of ethnicity, 12% are Hispanic or Latino (U.S. Census Bureau, 2023).

Social determinants of health

Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. They also

contribute to health disparities and inequities. These SDOH can be grouped into five domains including:

1. Economic stability.
2. Education access and quality.
3. Healthcare access and quality.
4. Neighborhood and built environment.
5. Social and community context (U.S. Department of Health and Human Services, n.d.).

The following statistics are key SDOH indicators in Marion County (U.S. Census Bureau, 2023):

Economic status: 68% of residents aged 16 and older were in the civilian labor force; the median household income was $59,504; and 16% of residents lived in poverty.

Education: 87% of residents aged 25 and older had a high school degree or higher, and 33% had a bachelor's degree or higher.

Healthcare: 10% of residents under the age of 65 were without health insurance.

Housing: 56% lived in a house they owned.

According to the *County Health Rankings*, Marion County ranked 86 out of 92 Indiana counties on health outcomes. This means that the county is among the bottom 25% in the state, making it one of the least healthy communities. An estimated 18% of residents considered themselves to be in poor or fair health (Indiana: 15%). On average, Marion County residents experienced 3.7 days of poor physical health and 5.3 days of poor mental health in the past month (Indiana: 3.3 days and 4.9 days respectively). The ratio of population to mental health providers was 290:1, meaning there was one mental health provider per 290 people registered in Marion County. On this statistic, Marion County fared better than the state overall, which had one mental health provider per 530 Indiana residents (University of Wisconsin Population Health Institute, 2023)

Furthermore, 4.4% of people aged 16 and older were unemployed but seeking work, and 21% of children lived in poverty in Marion County (Indiana: 3.6% and 16% respectively). Additionally, 13% of Marion County residents experienced food insecurity (Indiana: 11%). Violent crime is another major concern in the community. There were 20 homicide

deaths per 100,000 people, almost three times higher than the rate for all of Indiana (7 per 100,000) (University of Wisconsin Population Health Institute, 2023).

Of all the households in Marion County (n=404,259), 8.4% are Spanish-speaking, 3.6% speak other Indo-European languages, 2.3% speak Asian and Pacific Island languages, and 2.8% speak other languages. Also, 3.9% of households in Marion County have limited English proficiency (LEP), meaning that English is not their primary language, and they have difficulty communicating effectively in English (U.S. Census Bureau, 2022).

Of the households with LEP (n=15,928), 23.1% speak Spanish, 19.6% speak other Indo-European languages, 20.4% speak Asian and Pacific Island languages, and 29.4% speak other languages. The percentage of LEP households in Marion County (3.9%) is more than twice as high as the state's percentage (1.8%) (U.S. Census Bureau, 2022)

Indiana 211

Indiana 211 is a free service that connects Hoosiers with health and human service agencies and resources in their local communities. Data from this hotline indicates the level of social need among residents. The program is sponsored by the State of Indiana Family and Social Services Administration (Family and Social Services Administration, n.d.-a).

During calendar year 2022, 66,665 calls were made to Indiana 211 by Marion County residents, representing 42,120 distinct callers. The top five needs categories reflected in these calls were:

1. Housing (19,954 callers)
2. Utility assistance (10,994 callers)
3. Individual/family/community support (10,900 callers)
4. Food/meals (10,054 callers)
5. Legal/consumer/public safety services (9,845 callers)

Out of all the distinct callers, 94% spoke English and 3% spoke Spanish. Demographic data such as race, age, gender, and education level were asked of the callers, but the majority declined to answer (Family and Social Services Administration, n.d.-b).

Drug Use and Consequences

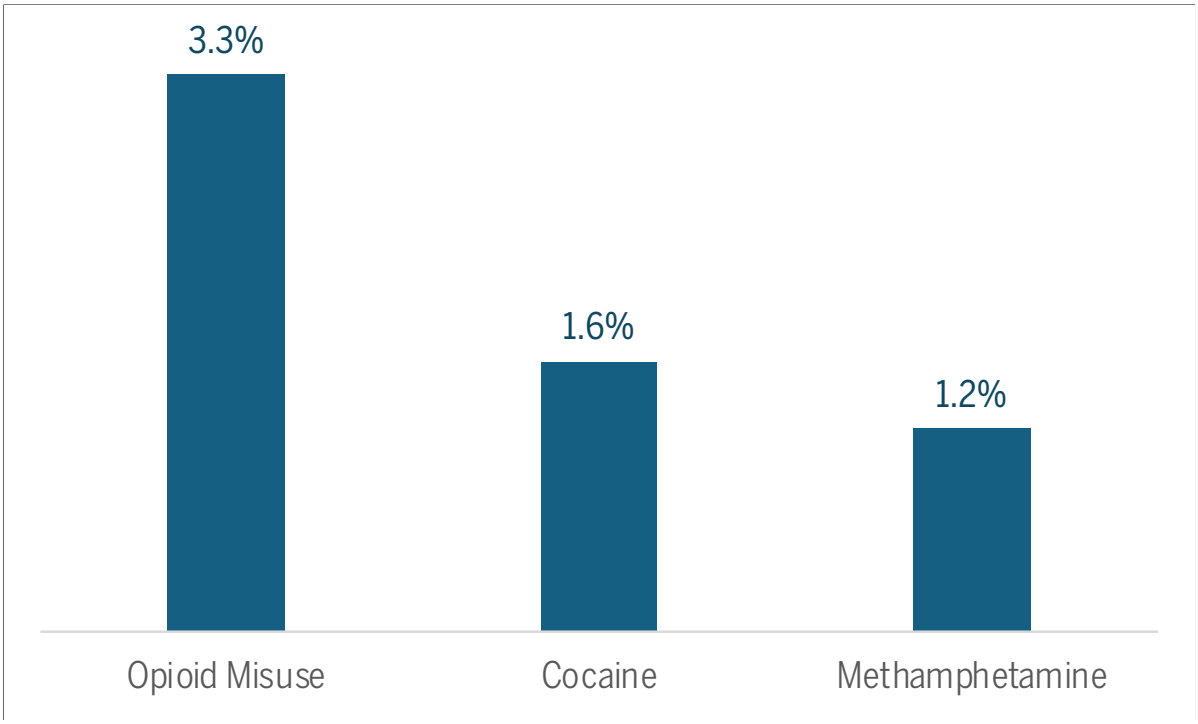
Prevalence of drug use in Indiana

According to the most recent state-level estimates from the 2021-2022 National Survey on Drug Use and Health (NSDUH), an estimated 14% of Indiana's population aged 18 or older reported using an illicit drug in the past month. More specifically:

- 3.3% reported past-year opioid misuse.
- 1.6% reported past-year cocaine use.
- 1.2% reported past-year methamphetamine use.

(Substance Abuse and Mental Health Services Administration, 2024) (See **Figure 1.**)

Figure 1. Estimates of opioid misuse, cocaine use, and methamphetamine use in the past year, among Indiana residents aged 18 and older (NSDUH, 2021-2022)



Nearly 11%, or approximately 1 out of every 10 Indiana residents aged 18 or older, reported having a drug use disorder in the past year[4], and 2% had an opioid use disorder[5]. Furthermore, close to 9% of Indiana adults reported needing but not receiving treatment at a specialty facility for illicit drug use in the past year (Substance Abuse and Mental Health Services Administration, 2024).

In 2019, untreated mental illness cost the state of Indiana an estimated $4.2 billion in societal costs. This includes $3.3 billion in indirect costs (e.g., unemployment, workplace productivity losses due to absenteeism and presenteeism, all-cause mortality, suicide, caregiver direct health care, caregiver productivity losses, and missed primary education), $708.5 million in direct health care costs (i.e., disease-related health care expenditures), and $185.4 million in non-health care costs (e.g., criminal justice system, homeless shelters) (Taylor et al., 2023).

Drug use estimates in Marion County

We applied state level prevalence rates provided by the 2021-2022 NSDUH (referenced in the previous section) to estimate the number of adults in Marion County affected by substance use.[6] We estimated that in the past year in Marion County:

Substance misuse

- 25,356 adults misused some type of opioid. This included the misuse of prescription pain relievers (23,899 adults) and heroin (2,186 adults).
- 11,877 adults used cocaine.
- 8,379 adults used methamphetamine.

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[4]Drug use disorders are based on the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) criteria and includes disorders for the use of marijuana (including vaping), cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine in the past year or any use (i.e., not necessarily misuse) of prescription pain relievers, tranquilizers, stimulants, or sedatives in the past year.

[5]Opioid use disorder (OUD) estimates are based on Diagnostic and Statistical Manual of Mental Disorders, 5th edition criteria. OUD is defined as meeting the criteria for heroin or pain reliever use disorder.

[6]According to the U.S. Census Bureau, the estimated adult population aged 18 and older in Marion County was 730,956 in 2021.

Substance use disorders

- 149,151 adults had a substance use disorder. Of these, 77,526 adults had a drug use disorder, and more specifically, 14,573 adults had an opioid use disorder.

Needing but not receiving treatment

- 62,152 adults needed but did not receive treatment at a specialty facility for illicit drug use.

Overdose surveillance

Fatal Overdoses

In 2023, there were 701 deaths due to drug intoxication, either as a direct cause or contributing factor, across all manners of death in Marion County. Most of these deaths (669 or 95%) were classified as accidental. Of the drug intoxication deaths across all manners, 80% (555 deaths) involved opiates, primarily fentanyl (543 deaths). These fatalities mostly involved residents who were white (469 deaths), male (500 deaths), or individuals ages 40 to 49 (191 deaths). In Marion County, drug intoxication was the top cause of death in 2023, even surpassing cardiovascular fatalities (460 deaths) for the third consecutive year. On average, the Marion County Coroner's Office investigated 1.9 drug intoxication deaths per day in 2023. Additionally, 1,890 substances were detected in drug intoxication deaths across all manners. Opioids were detected in 561 (80%) deaths with 543 (97%) of those deaths involving fentanyl (Marion County Coroner's Office, 2023).

Non-fatal Overdoses

In 2023, Marion County reported 6,347 suspected non-fatal overdoses, mostly affecting males (58.8%), individuals who are white (63.1%) or ages 30-39 (28.5%). Trends from 2022 and 2023 show that Marion County Emergency Departments (EDs) typically experience an increase in visits for non-fatal overdoses starting in March, coinciding with warmer weather, and peaking in August. Conversely, non-fatal overdoses hit their lowest point in November (see **Figure 2**). These trends were consistent with EMS (Emergency Medical Services) Naloxone runs for the same period. The rate of suspected non-fatal overdoses was higher for white residents, compared to Black or those of Hispanic origin (see **Figure 3**), and also higher among males compared to

females (see **Figure 4**) (Marion County Public Health Department, 2024).

Figure 2: Number of suspected non-fatal overdoses in Marion County by Month, 2023

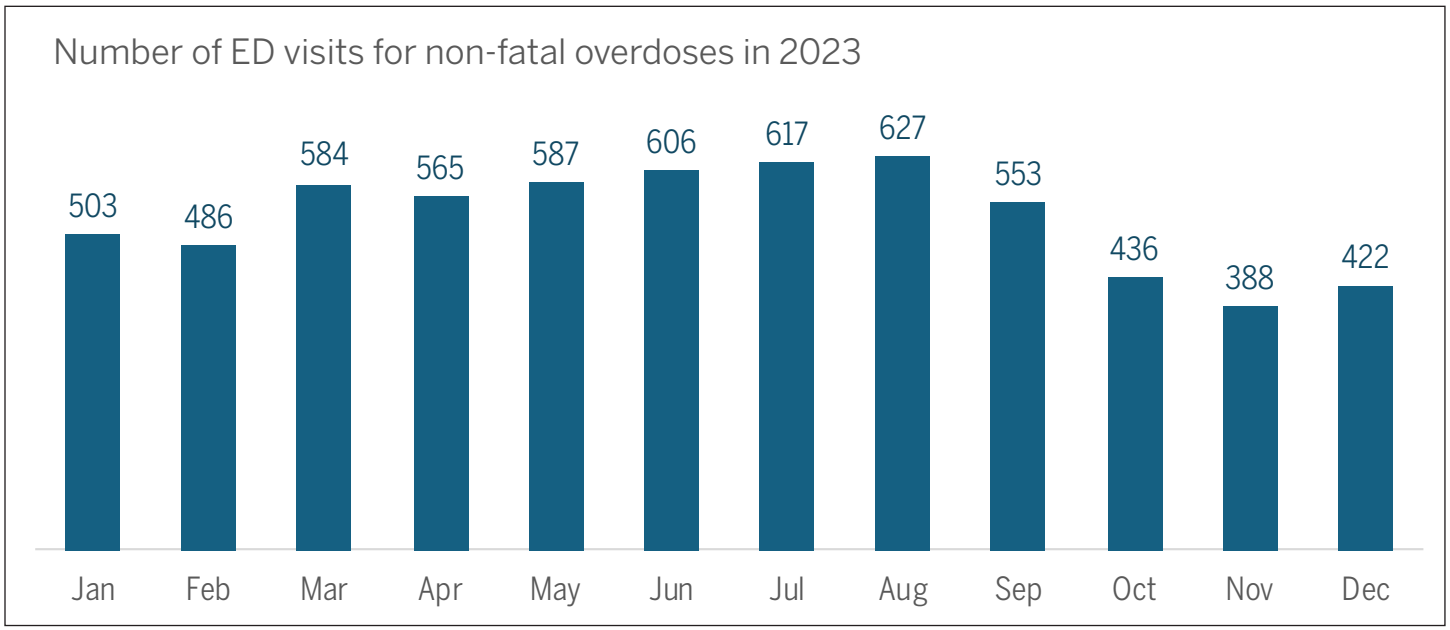


Figure 3: Rate of suspected non-fatal overdoses in Marion County, by race, 2022-2023

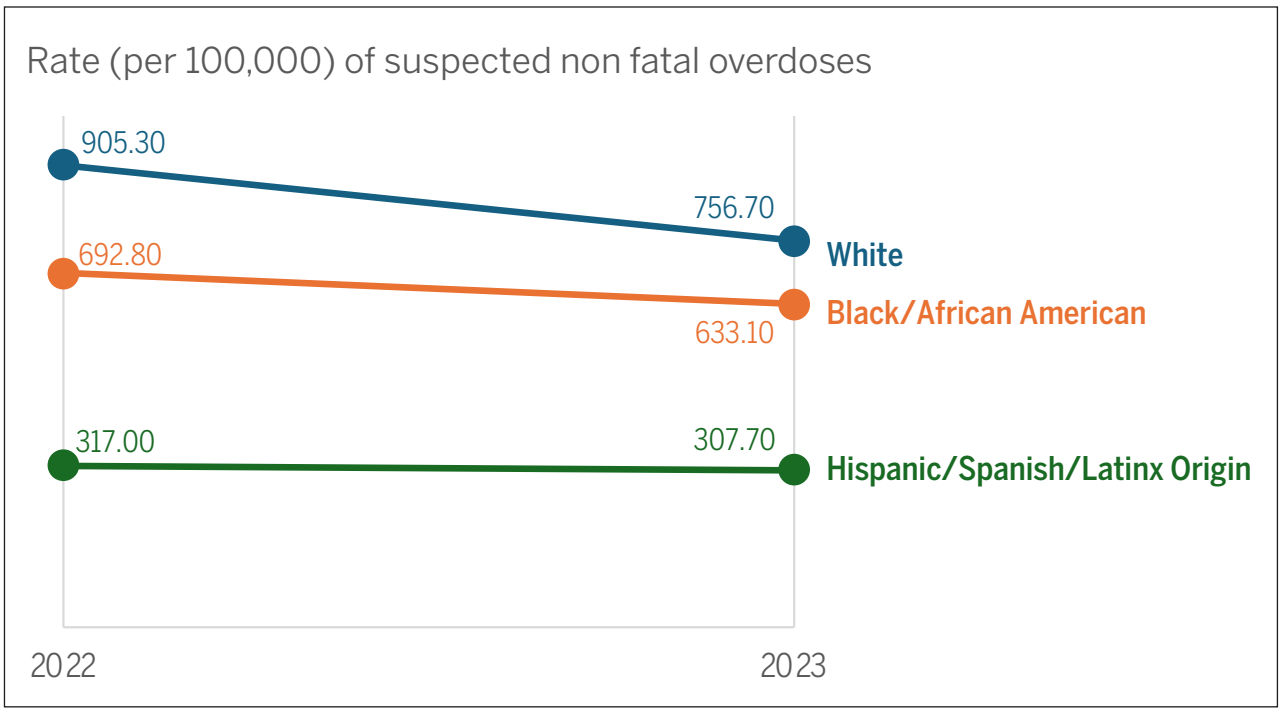
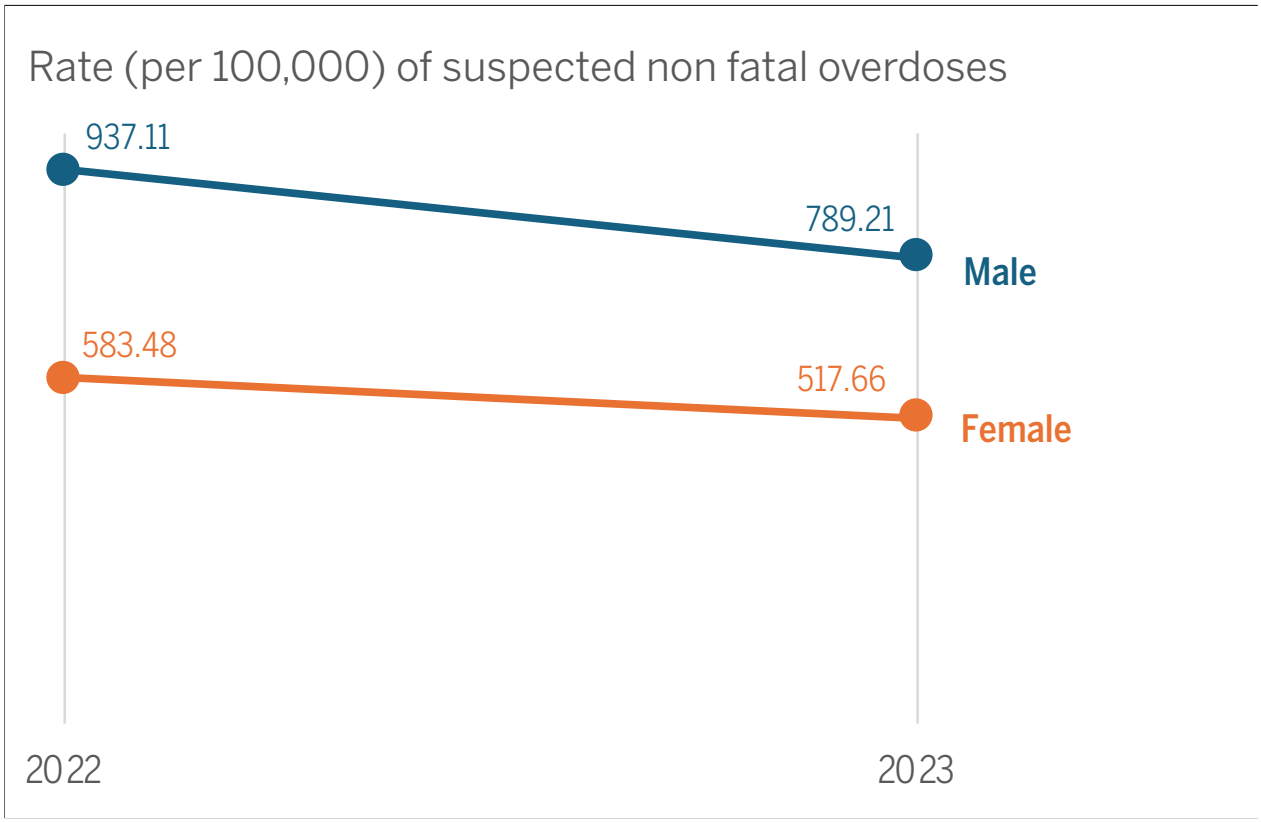


Figure 4: Rate of suspected non-fatal overdoses in Marion County, by gender, 2022-2023



Data from figures 2-4 provided by Marion County Public Health Department, Epidemiology DR5708, 06SEPTEMBER2024. Source: Inductive Health ESSENCE.

Findings from Surveys and Focus Groups

To identify the needs and challenges of the community as they relate to drug use, we collected data through surveys and focus groups. Special emphasis was given to people with lived experiences and organizations providing services to people with lived experiences.
The survey and focus groups were conducted between March and June 2024. We received feedback from 168 participants in Marion County.

Survey of community partners

Community organizations who provide services, either directly or indirectly, to people who use drugs were invited to complete a 15-minute online survey. The focus of the survey was to understand the types of services provided by the organizations, the estimated number of clients reached, the barriers clients face in accessing care (from the perspective of the organization), and the services and resources needed to provide adequate care.

Organizational information

We received 25 responses from 24 different community organizations (for one organization, two staff members completed the survey). Nearly half of the responses (11 or 46%) came from partners who are funded by the MCPHD as part of the OD2A: LOCAL initiative. Eleven more responses (46%) were completed by organizations not funded through this grant and two responses (8%) indicated that they do not know if their organization is funded through OD2A: LOCAL.

The estimated number of SUD clients served by the surveyed organizations ranged from 0 (no direct client contact or service) to 25,000 clients per year.

The organizations reported being engaged in various harm reduction programs and related services. Linkage to services was offered by most, 88% of organizations reported linking clients to treatment or support services and 80% of organizations reported linking clients to social services. Furthermore, overdose prevention, education, and distribution of naloxone was reported by 76% of organizations. [For further details see **Table 1**].

Table 1: Type of harm reduction and related services provided by community organization in Marion County

Harm reduction and related services (n=25, missing=0)	Number	Percentage
Referral/linkage to treatment or support services	22	88%
Referral/linkage to social services	20	80%
Naloxone (Narcan)	19	76%
Overdose prevention and education	19	76%
Anti-stigma awareness	17	68%
Fentanyl test strips	16	64%
Peer coaching	13	52%
Xylazine test trips	10	40%
HIV/hepatitis screening and counseling	10	40%
Health professional training	10	40%
Medications to treat opioid use disorder[1]	7	28%
Sterile syringes/injection equipment	3	12%
Other drug use equipment such as cookers and pipes	2	8%
Other[2]	1	4%

[1]Medications to treat opioid use disorders (e.g., buprenorphine, methadone, or naltrexone).
[2]Other services include promoting collaboration and best practices between organizations serving people who use drugs.

The community organizations surveyed reported providing care to several vulnerable, at-risk populations. Nearly two-thirds of organizations work with justice-involved individuals (64%), members of the LGBTQ+ community (60%), and persons with unstable housing (60%). Furthermore, over half of the organizations provide special programming for pregnant or postpartum women and survivors of sexual abuse. [For further details see **Table 2**].

Table 2: Care provided to special populations (specialized care) in Marion County

Specialized Care (n=25, missing=0)	Number	Percentage
Justice-involved individuals	16	64%
LGBTQ+ individuals	15	60%
Persons with unstable housing	15	60%
Pregnant/Postpartum women	14	56%
Survivors of sexual abuse	14	56%
People living with HIV/AIDS	13	52%
Persons who are Black/African American	12	48%
Survivors of domestic violence	12	48%
Youth	12	48%
Veterans	11	44%
Persons who are Latino/Latina	10	40%
Persons with limited English proficiency	9	36%
Other vulnerable or minoritized groups[1]	5	20%

[1]*Other vulnerable or minoritized groups mentioned: BIPOC (black, indigenous, and other people of color); persons who are homeless, hearing impaired; persons who inject drugs; women with substance use disorder; individuals with serious mental illness (SMI) and serious emotional disturbance (SED).*

Perceived barriers to care

Over two-thirds (68%) of respondents felt that not having access to services because of financial reasons was a significant to very significant barrier for people who use drugs. Similarly, lack of transportation (64%) and not knowing about available services (60%) were also endorsed as significant to very significant barriers. Many survey respondents felt that limited treatment capacity leading to a lack of access to care as well as clients not trusting the medical/health system were significant to very significant barriers. [For further details see **Table 3**].

Table 3: Perceived barriers to care in Marion County

Barriers (n=25, missing=0)	Perceived as a significant to very significant barrier	Perceived as a minor to moderate barrier	Not perceived as a barrier
Lack of access to services because of financial reasons	68%	24%	8%
Lack of transportation	64%	36%	0%
Lack of knowledge about available services	60%	32%	8%
Lack of access to services because of treatment capacity	56%	36%	8%
Lack of trust in the medical or healthcare system	56%	40%	4%
Fear of legal consequences	52%	44%	4%
Having a co-occurring mental health and substance use disorder	52%	44%	4%
Discrimination or stigma due to substance use	48%	44%	8%
Lack of trust in the health department, grassroots, or community organizations	44%	48%	8%
Lack of family or social support	40%	60%	0%
Political climate (state or local laws and policies related to substance use and harm reduction)	40%	44%	16%
Language and cultural barriers	32%	64%	4%

Needed services and resources

A large percentage of survey respondents felt that support services addressing clients' social determinants of health are needed to engage them into care. This includes the need for transportation, housing, governmental support (e.g., Medicaid, food stamps), and employment assistance and training. Additionally, mental health counseling and peer support were endorsed by many of the respondents as needed support services. [For further details see **Table 4**].

Table 4: Support services needed for clients to engage in care in Marion County

Needed support services (n=25, missing=0)	Number	Percentage
Transportation	21	84%
Mental health counseling	21	84%
Finding housing	19	76%
Peer support services	19	76%
Governmental support[1]	16	64%
Employment assistance and training	15	60%
Family services (e.g., marriage counseling, parenting training)	14	56%
Grief counseling/peer grief support	14	56%
Childcare	13	52%
Help with food	12	48%
Education (e.g., GED courses)	12	48%
Legal aid	12	48%
Church or spiritual services support	11	44%
Domestic violence services	10	40%
Other	1	4%

[1]*Governmental support included Medicaid, WIC (Special Supplemental Nutrition Program for Women, Infants, and Children), Food stamps, SSI (Supplemental Security Income) or SSDI (Social Security Disability Insurance).*

We also asked respondents about resources that their organization needs to sustain and expand the reach of their programs and services. The most frequent response, by far, was the need for additional funding (92%). [For further details see **Table 5**].

Table 5: Additional resources needed to sustain and expand the reach of services and programs in Marion County

Needed resources (n=25, missing=0)	Number	Percentage
Additional funding	23	92%
Services offered in additional languages	13	52%
More staff	12	48%
Additional training for current staff	12	48%
Services offered at non-traditional hours	10	40%

Survey of People Who Use Drugs

We surveyed people who use drugs (PWUDs) in Marion County, to better understand their needs and challenges in accessing services. The term "services" here is broadly defined and includes treatment, harm reduction, and/or other support services designed to help PWUDs.

People who use drugs were invited to complete a 15-minute survey, either online or on paper. Our community partners with direct client contact helped recruit participants. Participation was completely voluntary, and participants received a small gift package (consisting of a water bottle, tote bag, cooling towel, lip balm, sunscreen, and band-aids) as an incentive. A total of 133 respondents completed the survey (for demographic information, see **Table 6**).

Table 6. Respondents' demographics

Demographics (n=133, missing=8)	Number	Percentage
Gender		
Male	55	44.0%
Female	64	51.2%
Transgender	2	1.6%
Other[1]	1	0.8%
Don't know/refuse to answer	3	2.4%
Race		
American Indian/Alaska Native/Indigenous	5	4.0%
Asian or Asian American	0	0.0%
Black/African American or African	23	18.4%
Native Hawaiian or Pacific Islander	0	0.0%
White	93	74.4%
Other	3	2.5%
Don't Know/refuse to answer	4	3.2%
Ethnicity		
Hispanic/Latino/Spanish Origin	6	4.8%
Burmese	1	0.8%
Congolese	1	0.8%
Haitian	2	1.6%
Do not belong to any of the groups listed	86	68.8%
Don't know/refuse to answer	30	24.0%

[1]*Other gender such as non-binary, gender fluid, agender, culturally specific gender, or questioning.*

Table 6. Respondents' demographics (continued)

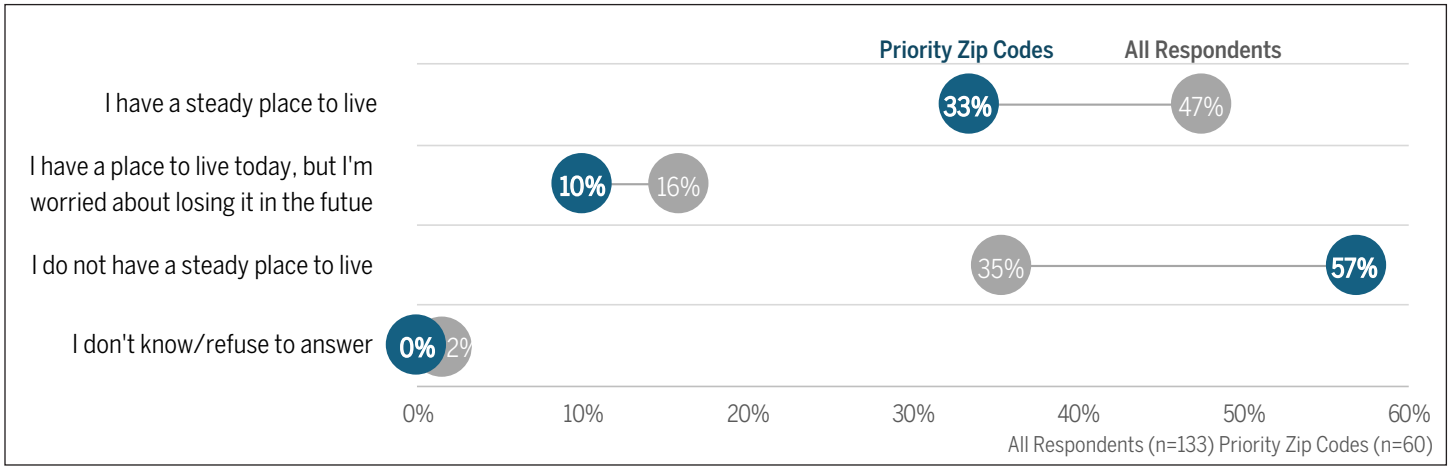
Demographics (n=133, missing=8)	Number	Percentage
Age group		
18-24	3	2.4%
25-34	30	24.0%
35-44	49	39.2%
45-54	32	25.6%
55-64	9	7.2%
65 or older	0	0.0%
Don't know/refuse to answer	2	1.6%
Veteran status		
Veteran	6	4.8%
Non-veteran	116	92.8%
Don't know/refuse to answer	3	2.4%
Sexual orientation		
Heterosexual or straight	98	78.4%
Gay	5	4.0%
Lesbian	0	0.0%
Bisexual	15	12.0%
Questioning	1	0.8%
Don't know/refuse to answer	6	4.8%
Residence zip code		
Priority zip codes[2]	60	48.0%
Other zip code	62	49.6%
Don't know/refuse to answer	3	2.4%

[2]*The priority zip codes included 46201, 46204, and 46225.*

Social needs

Housing was a need indicated by many survey respondents, especially those living in the priority zip codes. Respondents from the priority zip codes were more likely to lack stable housing compared to all respondents combined (see **Figure 5**).

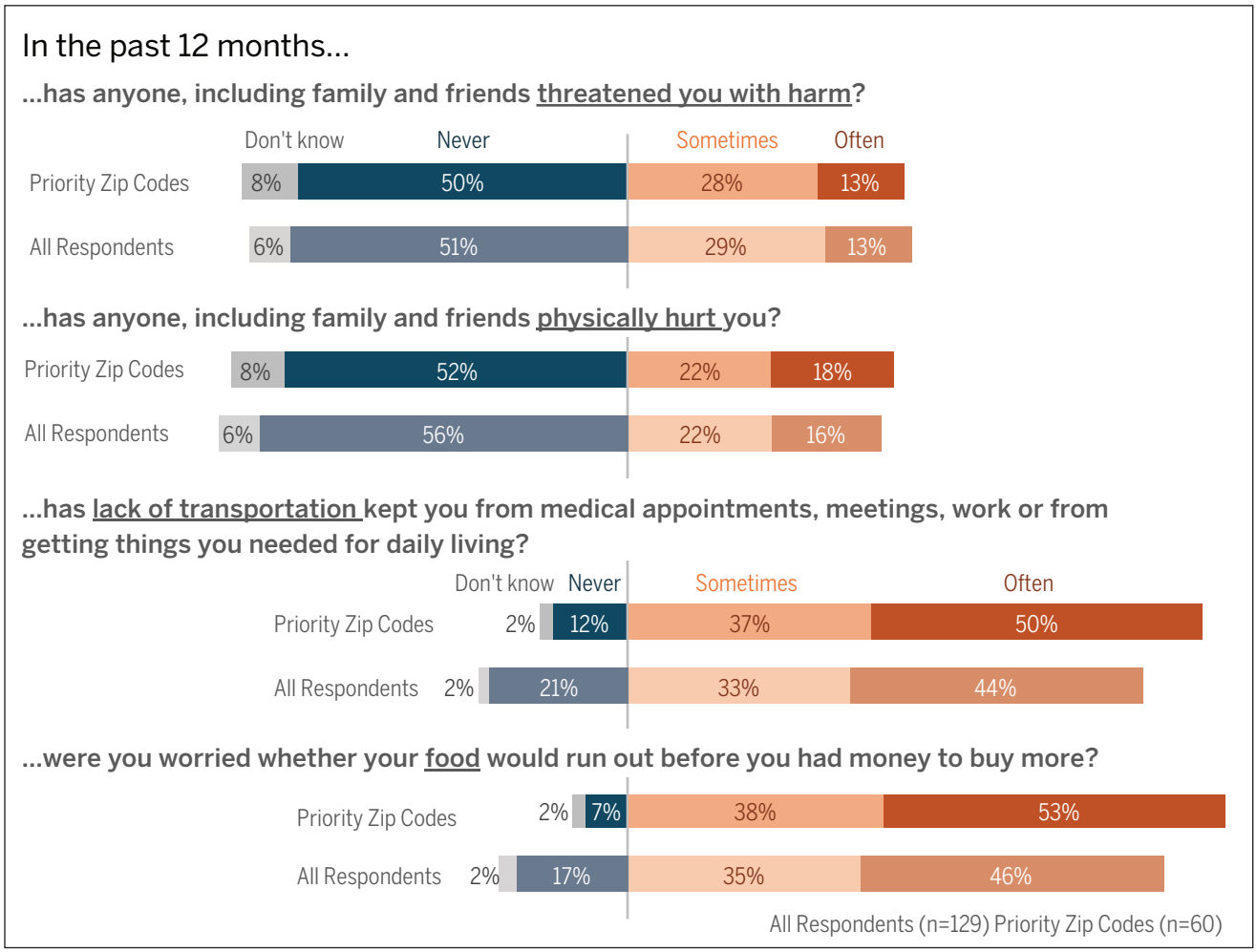
Figure 5: Housing status as reported by survey respondents



Note: "I do not have a steady place to live" includes; I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, in a car, abandoned building, bus or train station, or in a park.

Approximately 4 in 10 respondents indicated that they have experienced physical violence or have been threatened with harm, regardless of whether they lived in a priority zip code or not. However, respondents from the priority zip codes were more likely to have experienced food insecurity and a lack of transportation (see **Figure 6**).

Figure 6. Social needs experienced within the past 12 months among survey participants



Note: Response options ranged from "Never" to "Often". For easier comparison between the two groups, "Priority Zip Codes" and "All Respondents," we aligned the graphs on neutral, as indicated by the grey line.

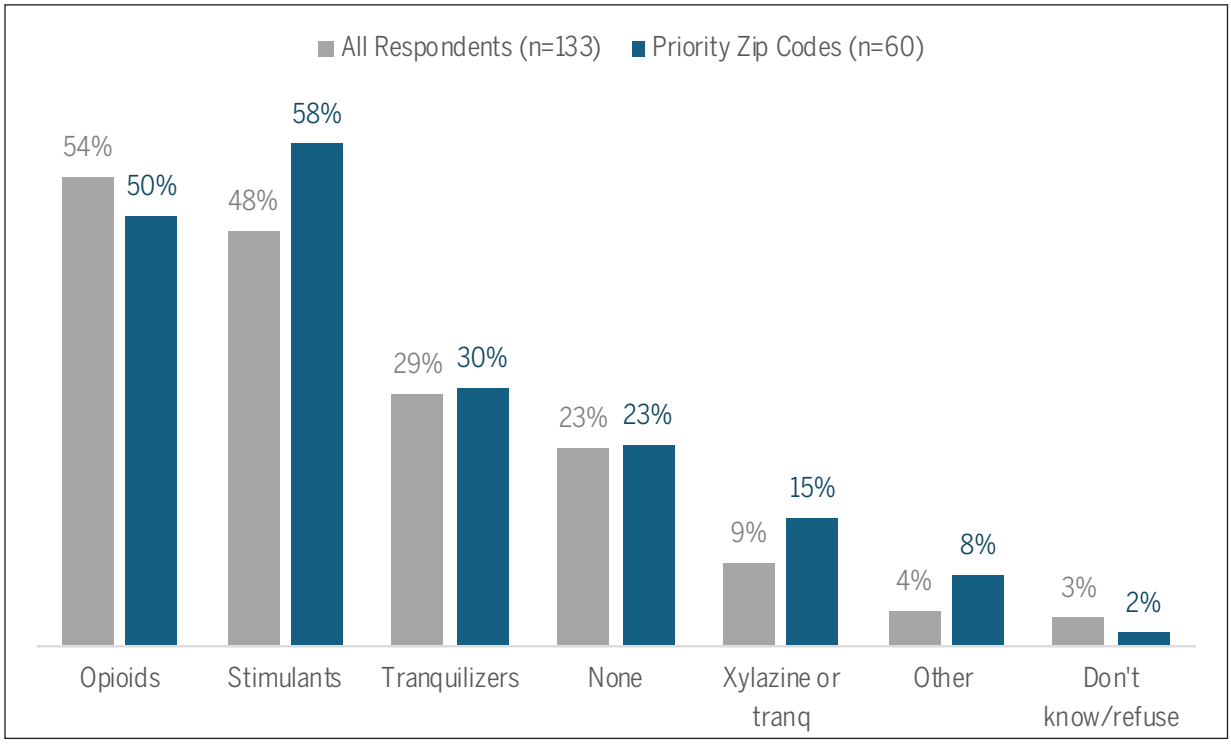
Drug use

Survey respondents were asked to indicate all substances they had used in the past month. Approximately half of the respondents reported using opioids and/or stimulants during this period. Overall, opioid use was the most frequently reported substance, with 54% of all respondents indicating use. However, among respondents from the priority zip codes, stimulants were the most commonly reported drug category, with 58% indicating use. For details, see **Figure 7**.

Out of the 94 individuals who reported using drugs (opioids, stimulants, tranquilizers,

xylazine/tranq, or other), 61% indicated they had taken more than one of these drug categories in the past month (polysubstance use).

Figure 7: Substances used in the past month for nonmedical purposes by participants



Drug overdoses

Among the 94 individuals who responded to the question "have you experienced an overdose in the past 12 months", 17 individuals (18%) stated that they had. Of those, the majority (82%) reported receiving naloxone. Furthermore, 87 respondents (69%) reported that they regularly carry naloxone, which they obtain primarily from syringe exchange or other harm reduction programs (33%) and drug treatment facilities (31%). Some also reported receiving naloxone from family and friends (21%) or community organizations (20%). For more locations, see **Table 7**.

The reasons why respondents do not regularly carry naloxone (37 respondents) included:

- Not using opioids (30%)
- Don't know where to get it (19%)

- It costs too much (8%)
- Don't think I'm at risk for an overdose (8%)
- Don't feel comfortable/don't know how to use it (5%)
- Have used it and not replaced it yet (5%)
- Worry about law enforcement (5%)
- Don't want others to know that I'm using drugs (3%)

Table 7. Locations where respondents obtained naloxone (Narcan)

Where do you get naloxone/Narcan? (n=87, missing=0)		
	Number	Percentage
Syringe exchange or other harm reduction program	29	33.3%
Drug treatment facility	27	31.0%
Friend/family	18	20.7%
Community organization	17	19.5%
Hospital or emergency room	13	14.9%
Local Health Department	13	14.9%
Doctor or other health clinic	10	11.5%
Jail or prison	7	8.0%
Pharmacy or drug store	7	8.0%
Other[1]	1	1.1%
I don't know/refuse to answer	3	3.4%

Treatment and support services

Among all survey respondents, 39 reported being currently engaged in treatment and/or support services to help them modify, reduce, or stop their drug use. This may be an underestimation, because of a technical design error in the electronic survey, this

[1]*One person reported that they found naloxone in a public area.*

question was not shown to participants who selected only opioids as their substance used in the past 30 days. As a result, 28 records were missing.

Most respondents who indicated receiving treatment or other services, stated that they are receiving medications for opioid use disorder (MOUD, 30 respondents or 83%). (See **Table 8**). Of the 30 respondents receiving MOUD, 24 reported being on methadone; the other 6 respondents did not know or did not respond to the question. There were 34 respondents who said they are currently not engaged in treatment or support services and half of them stated that they were interested in receiving those services, especially MOUD (35%), but also counseling, inpatient/outpatient rehabilitation, and support groups (see **Table 8**).

Table 8. Treatment/support services reported by respondents

	Services that are currently utilized by respondents. (n=36, missing=3)		Services that respondents are interested in using. (n=17, missing=0)	
	Number	Percentage	Number	Percentage
Medication for Opioid Use Disorder	30	83.3%	6	35.3%
Counseling (Group or one-on-one)	8	22.2%	4	23.5%
Outpatient Rehabilitation	6	16.7%	4	23.5%
Support Group (e.g., Narcotics Anonymous)	5	13.9%	4	23.5%
Detox	2	5.6%	2	11.8%
Inpatient Rehabilitation (staying overnight)	1	2.8%	4	23.5%
Peer Recovery Coaching	1	2.8%	3	17.6%
Other (please specify)[1]	1	2.8%	0	0.0%
Don't know/refuse to answer	0	0.0%	1	5.9%

[1]*The respondent noted "spirituality, self-meditation" as other treatment.*

We asked participants if there was ever a time, in the past year, when they tried to get into a program to modify, reduce, or stop their drug use but were not able to. Of the 94 individuals who responded to the question, nearly half (n=46) reported they were unable to access the program. Challenges to getting into a program included primarily transportation (22%), not being able to get through on the phone (22%), and not being ready to stop using drugs (22%). For additional information, see **Table 9**.

Table 9. Challenges to accessing treatment or support services among respondents

Do any of these statements help to explain the challenges that got in the way of your treatment or support services? (n=46, missing=0)		
	Number	**Percentage**
Transportation was difficult and/or the treatment program was too far away	10	21.7%
I could not get through on the telephone	10	21.7%
I was not ready to stop using drugs	10	21.7%
I had health care coverage, but it didn't cover treatment or didn't cover the full cost	8	17.4%
I was treated poorly by staff	8	17.4%
I did not know where to go for treatment and/or what type of treatment to start with	6	13.0%
I don't know/refuse to answer	6	13.0%
I don't understand the system	5	10.9%
The hours were inconvenient	4	8.7%
I did not have childcare or eldercare	3	6.5%
I do not have health care coverage and could not afford the cost	2	4.3%
Lack or translation services/language barriers	1	2.2%
Other (please specify)[1]	5	10.9%

[1]*Respondents noted having a pre-existing health condition; worries about medical withdrawal.*

We then followed up with the question "what would make getting treatment or support services easier for you." Many respondents indicated reasons related to social factors such as stable employment (40%), housing (33%), and transportation (32%). For additional information, see **Table 10**.

Table 10. Making treatment/support access easier

Would anything from the list make getting treatment or support services easier for you? (n=94, missing=0)		
	Number	**Percentage**
Help maintaining stable employment while in treatment	38	40.4%
Help with finding or maintaining housing while in treatment	31	33.0%
Help with transportation to appointments	30	31.9%
Help paying for treatment	27	28.7%
Peer support	24	25.5%
Help with getting a phone	22	23.4%
Virtual options (e.g., telehealth)	21	22.3%
Help with getting a new ID	15	16.0%
Fewer rules/requirements while in treatment	15	16.0%
Help with childcare/eldercare	9	9.6%
Translation or bilingual staff	2	2.1%
Other (please specify)[1]	9	9.6%
Don't know/refuse to answer	13	13.8%

[1]*Other suggestions included: "Not having my phone taken, being able to do school in treatment, finding a detox treatment that is less intense physically as just using comfort meds is; trying to find a new house; More comfortable environment and being able to have cigarettes caffeine and maybe communication with the outside world while in detox it would help to not stop everything that's helpful while tryna quite the huge ones; clothes & hygiene; less judgeful people; help getting insurance, mileage payments for people w no insurance; Getting Medicaid cab set up; Support from family; some place closer."*

Harm reduction services

In addition to treatment, we were also interested in learning more about respondents' use of and need for harm reduction services. About one-third of respondents (31%) received services from the Safe Syringe Access and Support program, 20% accessed services from the local health department, 14% utilized Overdose Lifeline, and 6% reported getting services from other organizations. Also, 25% stated that they are not receiving services from any of these organizations.

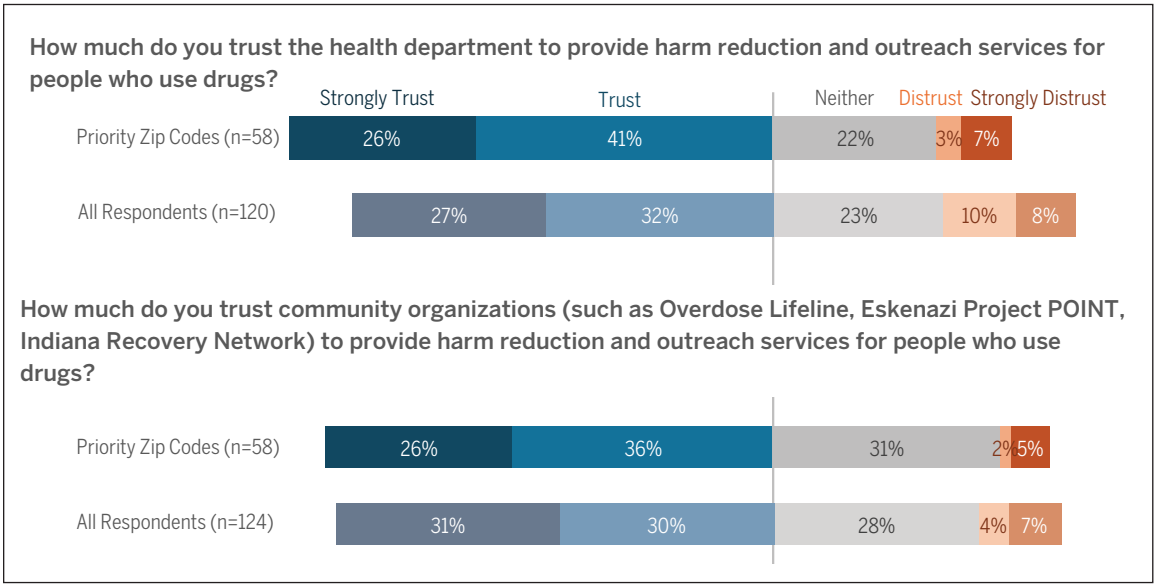
Respondents could mark the resources they believed would be helpful if included in naloxone kits. Nearly half indicated that information about the syringe exchange program (48%) and about Overdose Lifeline and where/how to get naloxone and fentanyl test strips (47%) would be of value. Furthermore, 32% stated that information about hotlines such as the Never Use Alone, 211 and 988 hotlines, or the Indiana Recovery Network would be beneficial.

Nearly half (47%) of respondents said they would be interested in having syringes, paraphernalia, or drugs tests to ensure they are not contaminated.

Trust and stigma

Over half of our respondents reported trusting or strongly trusting the health department and community organizations to provide harm reduction and outreach services to people who use drugs. Only between 7% and 18% stated that they distrust or strongly distrust these organizations (see **Figure 8**).

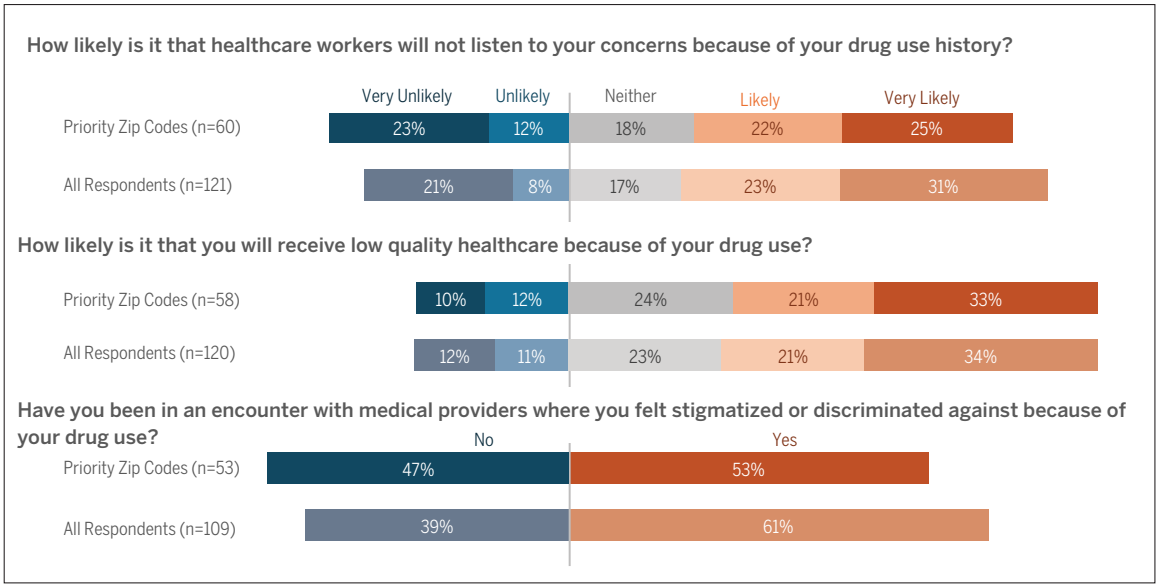
Figure 8. Perceived trust in outreach services



Note: Response options ranged from "Strongly Trust" to "Strongly Distrust". For easier comparison between the two groups, "Priority Zip Codes" and "All Respondents," we aligned the graphs on neutral, as indicated by the grey line.

A majority of respondents indicated that they have been stigmatized by a medical provider because of their drug use. Furthermore, many felt that healthcare workers may not listen to their concerns or provide low quality healthcare because of their drug use history (see **Figure 9**).

Figure 9. Perceived likelihood of stigmatization in the healthcare system



Note: Response options ranged from "Very Unlikely" to "Very Likely". For easier comparison between the two groups, "Priority Zip Codes" and "All Respondents," we aligned the graphs on neutral, as indicated by the grey line.

Survey participants were asked about the specific type of stigma or discrimination they had experienced with medical providers; responses were collected with a free-text response box. Based on 39 responses, certain themes emerged. Participants frequently reported not only the types of stigma or discrimination they had encountered, but occasionally offered reasons why they felt they were being stigmatized (see **Table 11**).

Table 11. Types of stigma experienced by respondents around medical providers

Types of stigma (n=39)	Count	Percentage	Example
General judgement	9	23%	"They treat you like ur no good or nasty."
Dismissal of symptoms	6	15%	"I was not believed and dismissed by 12 doctors over a 7 month period!!!"
Specific reason for stigma	6	15%	Reasons for stigma included: Drug use, addiction, pregnancy, methadone, sexuality, chronic pain management, and mental health.
Being treated differently and/or poorly	5	13%	"Once you tell someone or anyone your an addict they look down: I told the emergency room I was a heroin addict they then brought a camera in the room to watch me."
Denial of medication	4	10%	"I been in the emergency room with an injury that was real painful. And was treated with no pain medication."
Accusation of drug-seeking	4	10%	"I can't go to the doctor without them thinking I'm there only for drugs even if I'm not asking for anything."
Refusal of services	3	8%	"I have been at a Obgyn and turned away and told to go to rehab because of my addiction."
Other reasons	4	10%	"Too much to write down." "I felt bad about myself."

Note: Some comments covered multiple themes

Participants were then asked what medical providers could change to improve interactions in the future with people who use drugs. Forty-three (43) responses were collected using a free-text response box. Responses were again tallied by theme, with many responses mentioning multiple themes. Overwhelmingly, participants suggested that medical providers should stop discriminating or judging patients for their drug use (49%) and receive some sort of training to address stigma/discrimination (47%). Participants suggested a range of training topics for medical providers (see **Table 12**).

Table 12. Recommendations made by respondents for addressing stigma and discrimination amongst medical providers

Recommendations (n=43)	Count	Percentage
Stop discrimination/ judgement	21	49%
Training/education	20	47%
Training, recognize addiction as a disease	5	12%
Training, empathy	5	12%
Training, recognize people as people	5	12%
Training, improve bedside manner	3	7%
Training, trauma informed care	1	2%
Listen more	4	9%
Provide guideline concordant care	3	7%
Unsure	2	5%
Termination	1	2%
Provide housing	1	2%
Everything	1	2%
Nothing	1	2%

Note: Some comments covered multiple themes.

A few quotes suggesting how medical providers could improve interactions with people who use drugs can be found below.

- "Realize that I still contribute to my community – I'm not just a user."
- "Treat us the same as anyone else. They took an oath to help anyone and everyone that needs medical attention."
- "Remember that people live with a lot of trauma."
- "Be less judgmental and more understanding."
- "Be more like the people at the needle exchange."

Focus Groups

To provide context to the survey data and enrichen our understanding of the challenges faced by people who use drugs (PWUD), we conducted two focus groups with key stakeholders: (1) Community members who use drugs and receive harm reduction services, and (2) certified peer recovery coaches who work with PWUD. The focus groups took place in June 2024.

People who use drugs

Participants were recruited by a local syringe exchange program and included people who use/inject drugs. The focus group was held at the same time and location where clients collect supplies and attend harm reduction services to ensure convenience for participants. Informed consent was obtained verbally from all participants, who were compensated with a $50 gift card for their contribution. Seven community members participated.

Participants were asked about their usage of treatment and harm reduction services, access to services and barriers to care, type of stigma they experienced, and the resources needed to improve access to services.

Usage of treatment and harm reduction services

Focus group participants listed various services they utilize in Marion County that support health-related social needs. We have categorized these services and listed the specific community-based organizations mentioned by the focus group participants:

- *Behavioral health services* (e.g., Sandra Eskenazi Mental Health Center, a community mental health center that provides comprehensive services regardless of individuals' ability to pay)·
- *Housing services* (e.g., Horizon House or the Homeless Initiative Program)
- *Re-entry services* (e.g., Public Advocates in Community Re-Entry to help individuals

transition from incarceration into the community)
- *Multi-service centers* (e.g., Damien Center or Brookside community church; centers that address multiple needs and provide access to food, transportation, and medical and mental health/substance use services)

Focus group participants specifically appreciated community-based organizations that provide comprehensive services with high impact. For example:

> *"If, you know, if you're on paper [on parole or probation], they give you full services. Or if you are a family member or anybody that's ever been incarcerated, then they'll give you partial."*

> *"...you can just call them on the phone and talk to them. If you show them a pay stub, they'll pay, they'll pay for your rent or they'll, they'll get you housing."*

Access to services and barriers to care

Focus group participants expressed concerns about access to services and indicated a significant **gap between the community's needs and the available resources.**

> *"I would say a lot of times the need is far greater than the what's available."*

Moreover, focus group participants believed that some community resources might exist, but they are **not aware of these resources**:

> *"...there are services like that that we just don't know about."*

> *"Everything that is available to you isn't always available to you because you don't know about it."*

Several participants identified the need for **community-based organizations to be more inclusive and transparent** when providing services, especially eligibility criteria and who gains access seemed, at times, arbitrary. Further, there was a sense that people who use drugs are excluded from receiving certain services due to stigma. As one participant noted, when asked about barriers to accessing services:

> *"I would say a lot [of organizations] won't [provide services] because I do drugs. So, they're like, we don't want you to squander."*

Stigma

Focus group participants reported having encountered stigma, which can reduce one's willingness to seek services and affect a person's sense of belonging. Due to stigma,

participants felt judged and less connected to their community. The burden of **stigma was particularly pronounced among those who also experience homelessness or belong to the LGBTQ+ community.**

> *"When I'm in public, people automatically assume that I'm going to steal something."*

> *"If I go into a Burger King or something with my backpack, I'm told they don't have a working restroom because they assume I'll do drugs in there."*

> *"If I need something, I'm not the type that's going to steal, but it's like there's so much limiting of resources to those they choose, so it's like what do you want us to do? Do you want us to shake a cup? That's the normal. What, you think we'll kill, steal from, or rob people? No, most have good intentions. So, it's like they prejudge us before getting to know the whole story."*

As a result of stigma, participants reported **difficulties accessing resources and services** for their social and healthcare needs. As an example, one participant described how some community-based organizations interact with people who use drugs:

> *"We don't want you. You have a need that we can't provide for. So, like we're gonna give it to somebody else that doesn't have a drug addiction problem."*

All focus group participants felt that community members had limited understanding of addiction. As one participant noted: "*...there's a lot of people in society that have never had a drug addiction problem and don't know anything about it. So, like, they don't understand what we're going through.*"

Participants mentioned that stigma was often based on the type of substance used. For example, when describing a person drinking alcohol, one participant said: "*...they got an addiction problem too. It's just alcohol and it's legal, like mine's illegal. That's the only difference. But a lot of people don't see it like that.*" This **limited understanding** contributes to negative attitudes and a lack of empathy toward people who use drugs. Conversely, there was an overall sense that medical providers are less likely to stigmatize people who use drugs. Participants observed that medical providers were generally inclusive and accepting of individuals who use drugs and their addiction journey.

Participants provided insights on how the community could better respond to people who use drugs and be less stigmatizing. One person stated the importance of unbiased

decision-making by leaders, considering "*all available options and perspectives, without letting stigma affect their decision-making.*" To diminish stigma, it was suggested that the public **engage with individuals "as they are,"** acknowledging everyone's humanity.

> *"...meet us for who we are, see us for who we are."*

Needed resources

Participants offered various ideas on how the community might better serve people who use drugs. They discussed the importance of **resources that address people's social, physical, and mental health needs**. Particularly, the need for safe and stable **housing** and **access to transportation and legal counsel** was frequently mentioned. Participants highlighted access to housing resources as a key concern, affecting their ability to function and obtain other resources. For example:

> *"...once you're thrown into this position, regardless of the reason, it's very hard to get out because you're constantly in survival mode. How will you safely get sleep? Or store all your life's belongings and not get robbed or raped? Or what are you going to have in your stomach so you can satisfy the hunger pain enough to get to sleep? It's so hard to get other things back in order that are out in dysfunction."*

> *"It's not what you don't have when you're homeless, it's what you do have, its everybody wanting to take from you."*

> *"When we're getting high, it's a numbing sensation against the homelessness problem."*

Furthermore, some participants listed access to **psychiatric services**, including **medications**, and **supervised injection sites** as necessary resources.

Having **multi-service centers** that offer various resources in a single location was recommended. Such hubs streamline access to essential services, therefore, reducing time spent and minimizing exposure to drug-use triggers. One participant provided the following example, and the rest of the group nodded emphatically in agreement:

> *"...rather than individual little pick and poke for help here and there, all at one central location. You can spend all day trying to get help. Then you've wasted your entire day trying to get assistance when you could've applied it somewhere else. You get just enough to get you through the day, and you feel the temptations. But if you had somewhere that was safe, where you could sustain yourself and get the things you needed to restart, it would be more beneficial. It would keep you from encountering the faces, the places, the memories and give you a fresh start. "*

Since many participants felt that needed community resources might exist but are not well-known to them, the group suggested employing **more peer navigators** to help connect people who use drugs with available resources. Participants stated a preference for peer navigators **with lived experiences** (e.g., peer recovery coaches) and familiarity with the local community. There also was a desire for more outreach to the addiction community at large to spread awareness of existing resources and programs.

Certified peer recovery coaches

Participants for this focus group were recruited by one of the community organizations that is supported through the OD2A: LOCAL initiative. The focus group comprised three certified peer recovery coaches (CPRC) and was held at the above referenced community organization during working hours to ensure convenience for participants. Verbal informed consent was secured from all CPRCs.

Participants provided insights into their clients' access to care (facilitators and barriers), the kind of stigma that exists within medical and treatment facilities, and the resources needed to improve service accessibility.

Access – facilitators and barriers to care

Facilitators to accessing care are the conditions that encourage individuals to seek and receive healthcare services. CPRCs highlighted the idea of a ***"window of willingness"***, where individuals often have only a brief period when they are ready to accept help. During this critical time, the importance of a warm handoff and immediate assistance becomes apparent. As one coach explained:

> *"There is a very small window for willingness when somebody is ready to get help, and you have to jump on that. So, when they are reaching out, we need people equipped with knowledge, awareness, resources, and tools. If they're not, they should at least be able to point people in the right direction for help, facilitating that warm, soft handoff."*

Involved community organizations play a crucial role in facilitating care. They can engage individuals "where they are" and provide immediate resources to overcome barriers which otherwise might prevent people who use drugs from seeking help. Many individuals may not be aware of the resources available to them, or they may feel overwhelmed by the prospect of change. In-person events, like resource fairs, provide an opportunity to **connect with support services** and offer a starting point for those

who might otherwise not know where to begin.

As an example, Overdose Lifeline was mentioned, a local harm reduction organization that effectively mobilizes resources based on emerging trends and needs in the community. A CPRC described their efforts:

> *"Overdose Lifeline sends out a text alert when they're going to have a pop-up, often triggered by the results of a drug raid or multiple reported overdoses, whether fatal or not. They will send out a text alert about where they'll be setting up to provide supplies, which I love. It's fantastic because they will go anywhere."*

This proactive approach ensures that essential resources are available where they are needed most, further supporting individuals during their critical window of willingness.

Barriers to care are the obstacles and challenges individuals face when attempting to access healthcare services. The CPRCs identified several barriers to care that they had experienced personally, as well as the clients they serve. One of the largest issues discussed was the **inconsistency of rules and regulations across treatment facilities**. Each treatment facility is allowed to set its own regulations on who can enter treatment and how.

> *"Each place is totally [different], it is their prerogative to come up with different stipulations, different requirements, different determination of what is, or is not recovery."*

This leads to confused clients, difficulties transferring to different treatment facilities, and inconsistencies in what is and is not allowed in terms of harm reduction activities during treatment. One CPRC noted that certain sober living centers will not allow Vivitrol (naltrexone) or Suboxone as a medication to treat opioid use disorder; or they will only allow one type of medication but not the other. Facilities are often **siloed** and are not aware of what others are doing. There were also concerns that the facilities were taking a **capitalistic approach to treatment**.

> *"We're seeing more people really take a capitalist approach to popping up these sober living homes. And they are, they are co-opting our certification title and like, you know, changing one word of it. And then those people are their 'peer coaches / house manager.' The point of a peer coach is so we can relate. We don't have a punitive obligation. We don't have, we don't dictate how their recovery should look."*

Multiple participants noted there are certain populations that due to their circumstances are denied care or have trouble accessing services without additional support. For example, **individuals with justice involvement**, i.e., those with an active warrant or with certain criminal (especially sexual) convictions face additional obstacles when attempting to get services.

> *"The men and women who have any type of sexual offenses. They're also limited. Um, they can go, there is one place in Indianapolis in this big city that I know that will take [them], but listen, that's inpatient."*

Also, **single parents** often are concerned about who will take care of their children while they are in treatment, or they worry that their children will be taken away from them. Furthermore, **people of color** often face barriers different from those that are encountered by white individuals. As one CPRC noted:

> *"This is just an estimate, but it would not, it would not be an overestimate to say 85% of my participants were black men coming out of re-entry, which tells you everything to know."*

Other challenges and barriers mentioned during the group included:

- Inability to gain/keep **employment** when in care (struggling to find employment with a criminal record, lack of insurance access without a steady job, lack of identification to apply for a job).

- **Societal obstacles** (affordable/available housing, lack of trust/shared experiences between clients and healthcare staff, PWUD do not share in decision-making processes).

- **Lack of community access** (struggling to find accessible treatment within the community they currently live in, including logistical/transportation issues).

Stigma

Stigma refers to the negative attitudes, beliefs, and perceptions that society holds towards people with certain conditions or characteristics, such as mental health or substance use disorders. It is often difficult for individuals to remove the shame and stigma associated with substance use, especially injection drug use. One CPRC participant described stigma as "*this horrible umbrella and it's really hard to get out from under.*" Older generations were told to pull themselves out of it or sweep issues

under the rug, especially men. There is also **stigma within the recovery community**, regarding what is considered the best recovery route, what is considered detoxification, and what is considered "sober." People who use substances may themselves internalize stigmatizing language.

> *"I have a friend of mine who takes the Delta 8 THC gummies and initially for anxiety and she looked right at me and said, if that was my sponsor, we'd be talking about a new start date. A start over day, right? They weren't drinking...And I wanted to go. Yeah. Did you pop your Lexapro this morning... and did you drink your 10 pots of coffee before 10 a.m.? Because if you think those aren't mind- and mood-altering substances, you are sadly mistaken."*

CPRCs also pointed out **stigma from healthcare providers and law enforcement**, two groups that interact regularly with people who use drugs. One participant described having seen syringe exchange participants turn and walk away from the exchange if they notice law enforcement nearby. Healthcare providers have been known to change their behavior towards patients who inject drugs, compared to patients who use other modes of drug administration.

> *"You'll see a lot of police come by, which is great. But when they do, I have seen, we have seen participants start to walk up and then they go the other way. Um, and, and those police may not even be coming. They may just be driving by and unaware that we're even there, but it's the association, right?"*

CPRCs also mentioned that certain populations may face additional stigma, for example, **single parents** and **justice-involved individuals**, especially if they had been convicted of a **sexual offense**.

> *"And if you were a mom that didn't have your children, not only did the other patients there judge you and stigmatize you...just because you work in behavioral health doesn't mean that you don't stigmatize them and the same with the sexual offenders...Absolutely."*

Needed Resources

When asked which community resources would be necessary to assist people who use drugs, CPRCs listed several supports and services required for effective recovery, while emphasizing the need for a **holistic approach to care**. Increasing **education and awareness** about substance use disorders, especially in schools, is crucial. It was mentioned that education is the most consistently proven method to reduce recidivism, particularly when individuals attain higher levels of education while incarcerated. As

one CPRC stated:

> *"We just need more compassionate, empathetic and active, actively educated and aware professionals, professionals in the health care space."*

CPRCs emphasized the need for integrating peer recovery coaches—individuals with personal recovery experience—to mentor others on their recovery journey and offer personalized support. They recommended **increasing the availability of trained peer recovery professionals**. Furthermore, CPRCs stated the importance of making resources or services more **easily accessible** for people who use drugs.

Greater **buy-in from the community**, especially politicians and law enforcement, was also mentioned as necessary to improve the lives of people who use drugs. As one CPRC described a positive encounter with law enforcement:

> *"...there was a gal who is a participant of the [syringe exchange program] who was pulled over... and the officer was very good to her and, and she showed them her [syringe participant] card. He confiscated the syringes...she did not get arrested. She did not get any type of citation to get summons...he just literally confiscated her, her, um, used [needles] and they weren't even sterile, they were used. So that is really good, and she did not get in trouble."*

Summary of survey and focus group findings

We synthesized the findings from the surveys and focus groups and categorized them into three main areas: (1) access to services and barriers to care, (2) needed resources, and (3) experiences of stigma.

Access to services and barriers to care:

Participants highlighted significant concerns regarding the accessibility of essential services for people who use drugs (PWUD), identifying a notable gap between community needs and available resources. They emphasized that the involvement, inclusion, and transparency of community providers are crucial in facilitating access to services for PWUD, whether through direct care or by connecting them to necessary services. Additionally, participants stressed the importance of providing immediate assistance and a "warm handoff" to capitalize on the "window of willingness" when individuals are ready to seek help.

Major barriers to obtaining care included factors related to people's social determinants of health such as financial constraints, lack of transportation, and housing and

employment instability. Many participants stated that even if services are available in the community, PWUD are frequently not aware of them. Furthermore, limited treatment capacity and mistrust in the health system were also mentioned as significant obstacles. Inconsistent rules and regulations across treatment facilities can create confusion and hinder access. Participants identified several vulnerable populations, including justice-involved individuals, single parents, and people of color, who may face additional challenges.

Needed resources:
Many respondents indicated a need for stable housing. Other common issues included physical violence, food insecurity, and lack of transportation. There is a strong need for support services addressing social determinants of health, for example, governmental support and employment assistance/training, but mental health counseling and peer support are also necessary.

Not only PWUD but also the community organizations serving them require additional resources, particularly funding to sustain and expand services, and training to enhance the peer recovery workforce and service capacity. At the community level, increased education and awareness about substance use disorders, along with greater support from politicians and law enforcement, were considered essential.

Experiences of stigma:
Stigma is a significant barrier to care. Participants indicated that encountering stigma reduced their willingness to seek services and affected their sense of belonging. The experience of stigma was especially pronounced among certain groups, such as PWUD who are experiencing homelessness or who are part of the LGBTQ+ community.

The majority of our PWUD respondents felt that they could trust the local health department and community organizations to provide harm reduction services. However, many reported feeling stigmatized by medical providers because of their drug use. Stigma is frequently purported by law enforcement and can even occur within the recovery community, where individuals may have differing opinions about harm reduction and what “sober living” means. Additionally, PWUD may internalize stigmatizing language themselves, negatively impacting their recovery. Participants highlighted the need for education and awareness to reduce stigma in the community.

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