Drug Overdose Prevention Needs Assessment

Healthcare and First Responders

April 30, 2019

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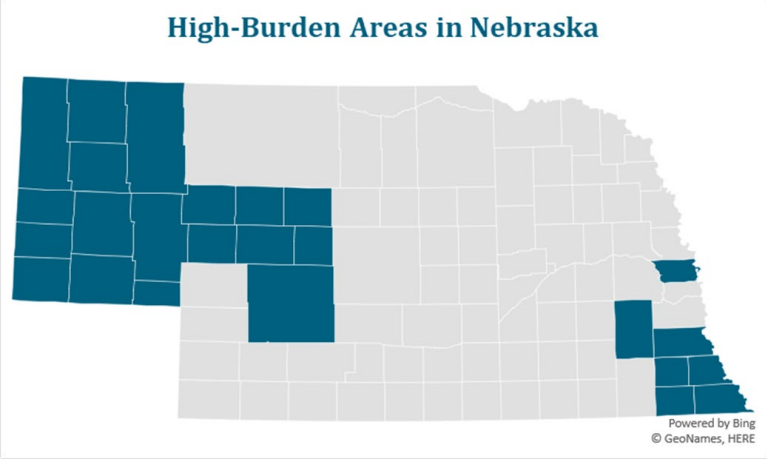


The counties in blue were identified by Nebraska DHHS as high-burden for drug overdose fatalities.

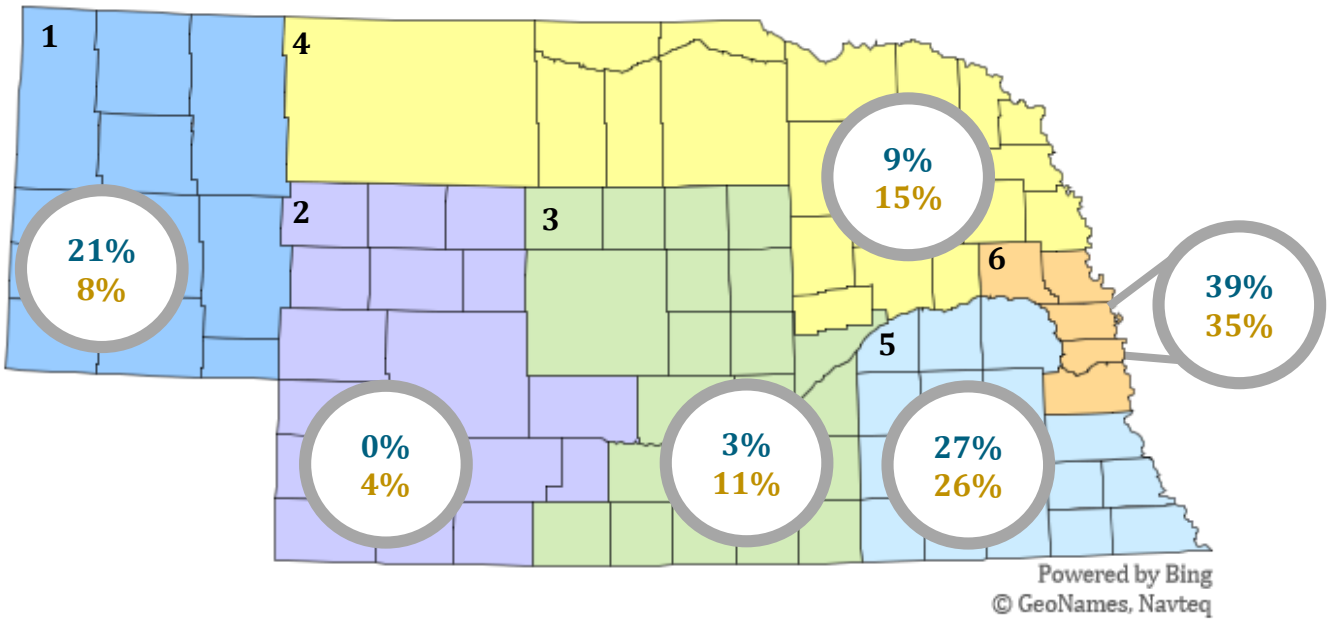
Purpose and Background

The Nebraska Department of Health and Human Services (DHHS) partnered with Support and Training for the Evaluation of Programs (STEPs) at the University of Nebraska at Omaha, Grace Abbott School of Social Work, to complete a statewide needs assessment between October 2018 and April 2019. **The purpose of this needs assessment was to gauge the capacity of statewide systems in Nebraska to respond to surges or clusters of intentional, unintentional, and unknown drug overdoses, especially in high-burden areas and with a focus on opioids.** The hope of the results from this needs assessment is to inform DHHS on the development of incident management for crisis response. The needs assessment included a literature review, quantitative surveys, and qualitative focus groups and interviews.

The results of the literature review can be found in the Drug Overdose Prevention Needs Assessment: *Promising Practices* report submitted by STEPs to DHHS in December of 2018. Please contact DHHS to request access to this report.

Participants by Region

STEPs collected qualitative and quantitative data in each of the six health regions across the state. 247 EMTs and firefighters, and 133 health care professionals responded to quantitative surveys; STEPs conducted 33 focus groups and interviews with healthcare professionals, EMTs and firefighters, and law enforcement. Below is a representation of the percentage of overall responses from each health region with **blue** text indicating the percentage of focus group and interview participants and **gold** text indicating the percentage of quantitative survey responses. (For example, 21% of all focus groups and interviews were conducted in Region 1, and 8% of all survey responses were from Region 1.)



Findings by Participant Groups

Healthcare Findings

Healthcare professionals reported **alcohol** as the substance most involved in overdoses, followed by **methamphetamine**. In the focus groups and interviews, healthcare participants discussed how opioid overdoses were not as much as a concern compared to other substances such as methamphetamine. They also reported they did not think many people in the community knew about the standing order for naloxone.

Almost all healthcare respondents indicated they felt confident in their ability to administer naloxone if needed and felt their department had sufficient resources to respond to opioid overdoses. Nearly three out of four respondents reported they had received sufficient training about opioid use and around response to an opioid overdose. Focus group and interview participants also noted they utilized the Prescription Drug Monitoring Program (PDMP) and found it helpful.

Survey respondents indicated increased training on overdose symptoms, overdose prevention, alternative methods of pain management, and resources for drug overdose were needed in their facilities and communities in order to better prepare for a surge in opioid use. Focus group and interview participants also spoke of the need for safe ways for the community to dispose of unused medications. Most significantly, healthcare professionals spoke of the need for mental health and substance abuse treatment for patients.

"You know, opiate overdoses, it's a relatively rare thing in the ER. I mean, you see it enough, you know how to handle it, but it's not like a daily occurrence where we have to give Narcan."

EMS and Fire Findings

Similarly to healthcare professionals, EMTs and firefighters reported **alcohol** as the substance most often involved in overdoses. **Fentanyl** was the only substance noted as causing overdoses in all six regions. Survey respondents also reported they are responding to about the same number of overdose situations now as they were two years ago.

In focus groups and interviews, EMTs and firefighters reported having enough naloxone and feeling confident in their ability to administer it. Participants also discussed an awareness of naloxone's impact on the overdosing individual. However, in survey responses, first responders indicated a need for more departmental resources such as naloxone, response vehicles, and funding.

During focus groups and interviews, safety emerged as a consistent theme with EMTs. Almost all participants mentioned "scene safety" as one of the first things they attended to. As a result, some EMTs reported that, when medical indicators were stable, they controlled the dosing of naloxone so as to reduce the risk of combative reactions.

Notable Regional Differences

- Unlike in the other five regions, opioids were reported as the primary overdose-related drug in Region 6.
- All regions felt their department was relatively prepared to respond to a surge in opioid overdoses, but a need for more staff and more naloxone kits were noted in Regions 2 and 5.
- While the majority of Region 6 respondents felt there was sufficient substance use treatment in their community, much fewer respondents in the other five regions felt there was sufficient treatment options, especially in Region 1.

"If we had a surge in opioid use, we would need to have more naloxone kits. We also wouldn't have enough staff if we had a surge in calls."

Executive Summary

Law Enforcement Findings

Focus group participants often noted that opioids were not as prevalent and concerning as compared to **methamphetamine** use.

Participants reported a strong need for **safety equipment**, especially if there was a surge in opioid overdoses.

Jurisdictions were commonly concerned about the limited availability of **naloxone** and the two-year shelf life.

Common Findings Across Groups

Overall, both healthcare professionals and EMS reported they are responding to fewer overdose situations now than they were 2 years ago, except for small increases in Region 6.

Also, most respondents did not think members of their communities were aware they could access naloxone without an individual prescription, and over half thought members of their communities were not aware of the Good Samaritan law.

Nearly all respondents felt the communities they served supported their departments, and most felt they were making a positive impact on their communities through their work. Additionally, almost all respondents felt supported by their departments, felt a sense of connection to their co-workers, and had peer support to process highly stressful experiences.

"It's frustrating, I think sometimes for health care providers as well, for the whole care team, you know, you see it redundant, and you kinda get fatigued. A lack of empathy."

Overall Recommendations

1. Substance abuse and mental health treatment.
   a. Make substance abuse and mental health treatment more widely available and accessible across Nebraska.
   b. Assist healthcare professionals and first responders in connecting individuals and families to needed services and resources.
   c. Improve collaboration and communication for healthcare professionals and first responders on substance abuse and mental health treatment services.

2. Training.
   a. Provide training and educational materials to the community on opioids, opioid abuse, prevention of opioid overdoses, proper disposal of unused medications, and the availability of naloxone through the standing order.
   b. Provide training for first responders on naloxone administration and further clarification of the Good Samaritan Law.

3. Develop communication materials for healthcare and first responders on treatment options and community support groups that can be given directly to individuals and families involved in overdose situations.

4. Ensure availability of naloxone for first responders, including appropriate storage methods.

5. Enhance resources for healthcare and first responders including training, support, and incentives to improve physical and mental wellness.

6. Increase the amount of safety and medical equipment for EMTs and law enforcement (see specific sections in full report for specific types of equipment).

7. Consider a secondary analysis of qualitative data that would allow for examining differences by region. This would then allow for the qualitative data to further explain the quantitative findings.

Acknowledgements

We wish to thank the many healthcare professionals and first responders across Nebraska who trusted us with their responses in regards to drug overdoses. We came to admire their skill, knowledge, professionalism, and commitment to the work of assisting and caring for people in their times of need. We also wish to thank Felicia Quintana-Zinn and her colleagues in the Nebraska DHHS Drug Overdose Prevention Program for inviting us to conduct this needs assessment. We appreciate Felicia's competent leadership and responsive assistance in our conducting this study.

- UNO STEPs

Drug Overdose Prevention Needs Assessment

Healthcare Professionals

Survey

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Healthcare: Quantitative–Sample Description

Between January 30 and March 27, 2019, **133 healthcare professionals across Nebraska submitted valid responses to our online survey.** **The largest number of respondents were healthcare professionals who served Douglas county** (n=22, 17%). Over half (n=75, 56%) indicated they had been in their current healthcare role for 10 years or less.

133
Total Responses

In addition, 40 individuals provided demographic responses only. Of these 40, 24 (71%) were nurses, 4 (12%) were physicians, and 6 (18%) were in other roles. Also, 10 (29%) were in each Douglas and Lancaster county, and the remaining 20 (41%) were in other counties.

Profession

115
Nurses or other nursing roles

12
Physicians

6
Other healthcare professionals

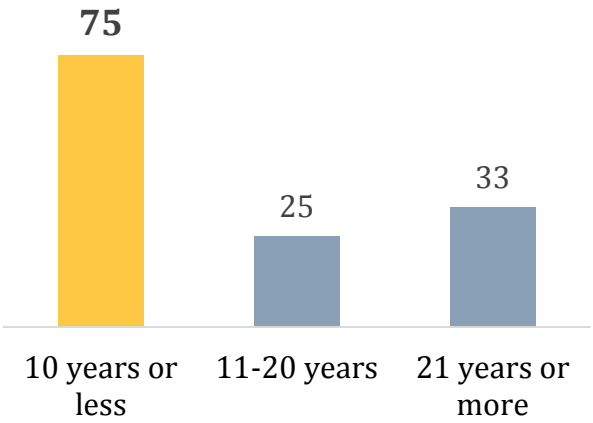
Nursing Role	#	%
Nurse	109	95%
Other role	4	3%
Nurse DON/CNO	2	2%
Total	115	100%

Physician Role	#	%
Physician	10	83%
Physician Assistant	2	17%
Total	12	100%

Other Role	#	%
Paramedic	3	50%
Case Manager	1	17%
Pharmacist	1	17%
Social Work or Mental Health	1	17%
Total	6	100%

Length of Time in Role

Over half of respondents indicated they had been in their current role for 10 years or less.



Gender and Age

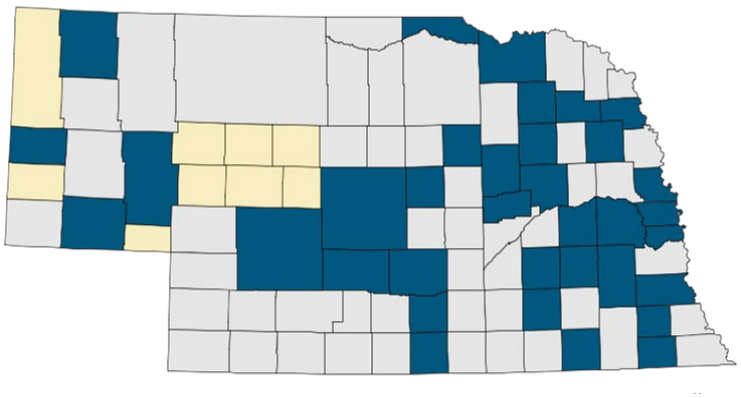
The majority of respondents identified as female and 25-44 years old (n=28 missing).

Female Age	#	%
18-24	2	2%
25-34	**31**	**34%**
35-44	26	29%
45-54	13	14%
55-64	16	18%
65-74	3	3%
Total	91	100%

Male Age	#	%
18-24	0	0%
25-34	4	29%
35-44	**5**	**36%**
45-54	1	7%
55-64	3	21%
65-74	1	7%
Total	14	100%

Healthcare Professional Service Area by County and Region

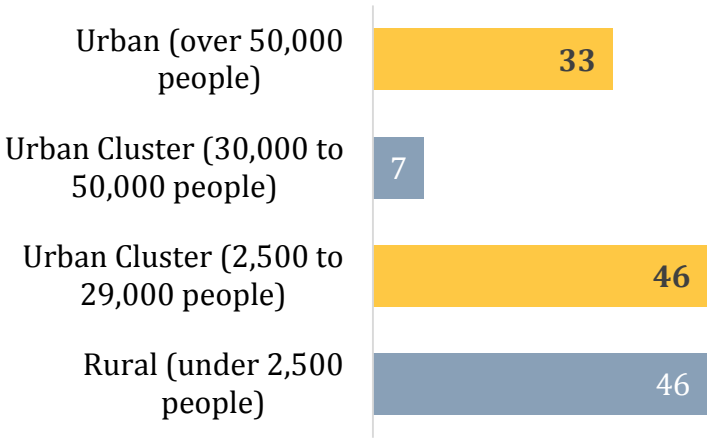
At least 1 healthcare professional from each of 34 Nebraska counties responded to the survey (indicated in **blue** on the map below) (n=130, n=3 unknown). We received no responses from 59 counties (indicated in **gray** on the map below), six of which were considered to have a higher burden of drug overdose fatalities[1]. Respondents indicated they most frequently served Douglas county (n=22, 17%), followed by Lancaster county (n=14, 11%), and Saunders and Seward counties (n=9, 7%, each). The remaining 30 counties had eight respondents or less. Though the majority of respondents indicated they served Douglas county in Region 6, Region 5 had the highest number of responses (n=66, 38%). The map areas shaded in **yellow** represent the nine counties that did not contain a hospital at the time of this needs assessment.



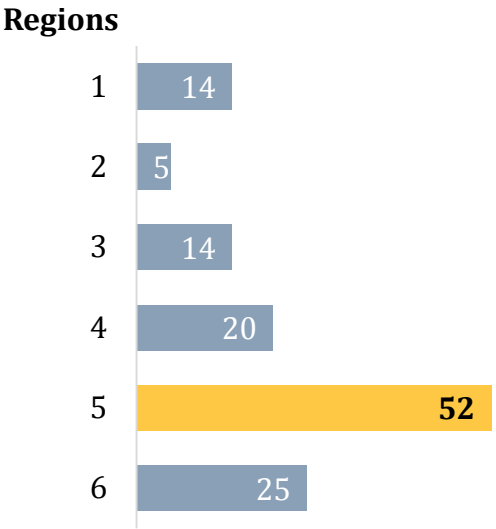
Respondent by Region		
Region 1	14	11%
Region 2	5	4%
Region 3	14	11%
Region 4	20	15%
Region 5	52	39%
Region 6	25	19%
Unknown	3	2%
Total	133	100%

Healthcare Professional Service Area by Population

Over two-thirds of respondents indicated they served areas with populations under 30,000 people (n=92, 70%), **with fewer** (n=33, 25%) **serving urban areas.**



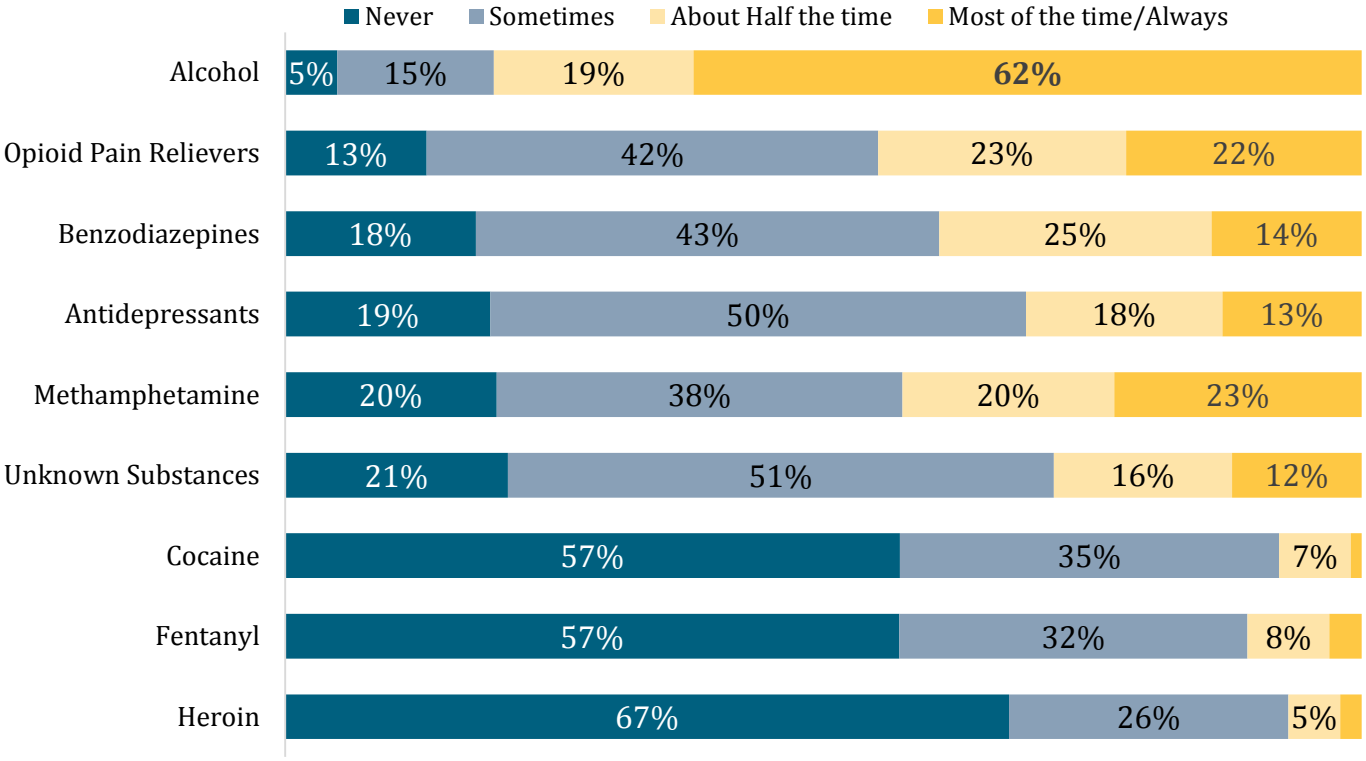
Nearly half (40%) **of respondents worked in Region 5** (n=3 missing).



General Drug Overdoses

Please indicate how frequently you suspect each of the substances listed below were involved in overdoses you responded to in the past 12 months.

By far, **alcohol was the substance most often involved in overdoses**, followed by methamphetamine, opioid pain relievers, and benzodiazepines. Respondents indicated heroin, fentanyl, and cocaine were least involved in overdoses. Of the 133 responses, **54 (41%) said opioids are involved in overdoses at least half the time.** (The n's ranged from 97-124.)



Alcohol is a significant concern in two of the regions, and opioids are a concern in three of the regions. Methamphetamine is a concern in all regions. (See specific data in Appendix F.)

Region	Alcohol	Opioids	Methamphetamine
1	***		*
2			**
3		**	**
4		**	*
5			*
6	***	**	**

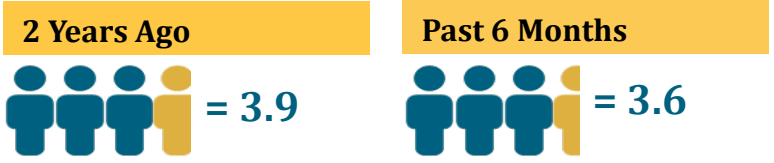
(The more *s, the more concern healthcare respondents had about individuals overdosing on this substance in their region.)

General Drug Overdoses

A. On average per month, how many situations involved responding to a drug overdose two (2) years ago?
B. On average per month, how many situations involved responding to a drug overdose in the most recent six (6) months?

On average, respondents said they are responding to fewer overdose situations now than they were 2 years ago. Two years ago, they were responding to an average of **3.9 overdoses** a month (range=0-20, SD=4.91, n=116), compared to **3.6 overdoses** a month over the last 6 months (range=0-23, SD=4.62, n=119).

Healthcare survey respondents are responding to about the same number of overdose situations now as they were 2 years ago ago.



Healthcare staff reported fewer overdoses per month in all regions, except for a small increase in Region 4. (See specifics in Appendix F.)

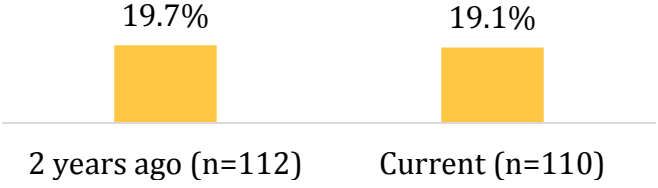
Region	n	Rate of Change
Region 1	11	- 0.5
Region 2	5	- 4.6
Region 3	14	- 0.9
Region 4	18	+ 0.4
Region 5	45	- 0.4
Region 6	19	0.0

Opioid-Related Overdose

A. Of the overdoses you were responding to two (2) years ago, approximately what percentage do you suspect involved opioids?
B. Of the overdoses you were responding to six (6) months ago, approximately what percentage do you suspect involved opioids?

On average, respondents said overdose situations involve opioids about as often now as they did 2 years ago. Two years ago, **20% of overdose situations involved opioids** (range 0-100%, SD=30.64, n=112) compared to **19%** in the 6 months prior to this data collection (range=0-100%, SD=30.80, n=110).

Overdose situations involved opioids less than 20% of the time, and this has stayed steady over the last 2 years.



Overall, healthcare professionals reported a decrease in the percentage of overdoses that involved opioids, except in Region 6 which increased 5%. (See specifics in Appendix F.)

Region	n	Rate of Change
Region 1	10	- 6.9%
Region 2	3	*
Region 3	13	- 0.6%
Region 4	15	- 7.4%
Region 5	39	- 3.2%
Region 6	17	+ 5.2%

*sample size too small

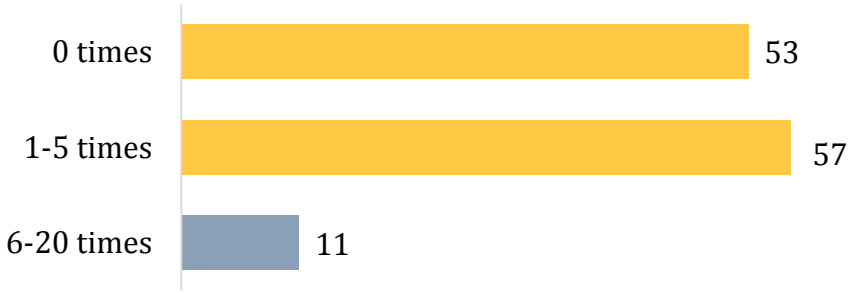
Naloxone

Within the past 12 months, approximately how many times have you (you individually, not your department) administered naloxone?

On average, respondents reported they **administered naloxone 2.6 times in the last 12 months** (range=0-70, SD=6.99, n=122). **Just under half of the respondents had not administered naloxone in the previous 12 months, and about the same amount had administered it 5 or fewer times.**

Respondents in Regions 5 and 6 had administered naloxone 3.6 and 4.6 times in the past 12 months, respectively, as compared to respondents in other regions who had administered naloxone fewer times.

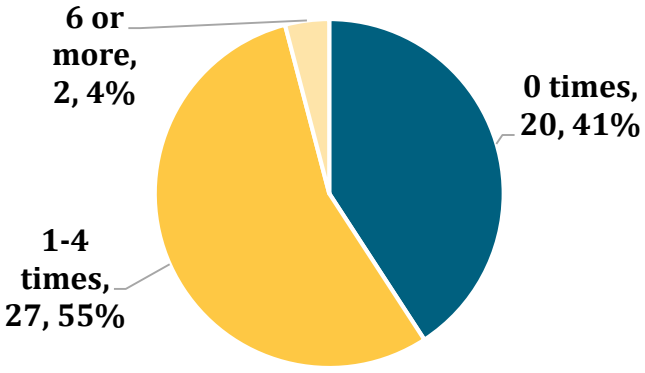
Nearly all respondents had administered naloxone five or fewer times in the previous 12 months.



In the past 12 months, approximately how many times did you administer naloxone to the same person on separate occasions?

Of the 69 survey respondents who had administered naloxone at least once within the past 12 months, **nearly half** (n=29, 42%) **had administered naloxone to the same person on different occasions**. Most of these 29 respondents had returned to the same person 1-4 times, while 2 had returned to the same person 10 times (n=21 missing).

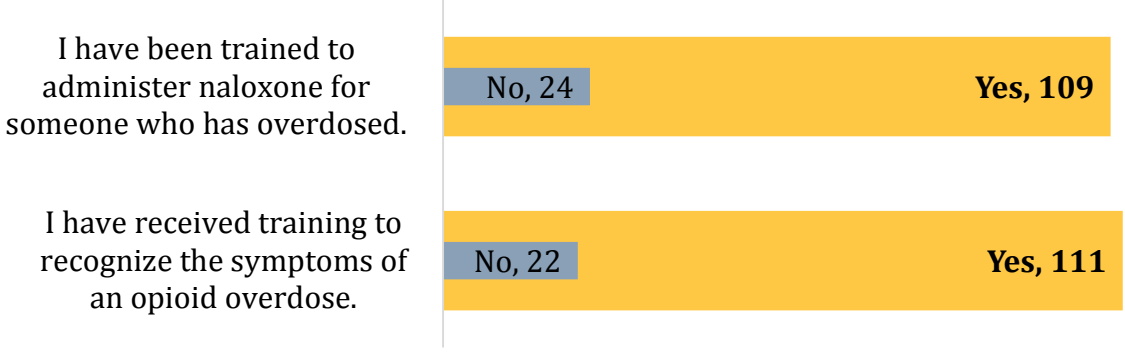
Over half of respondents who had administered naloxone within the past 12 months had also administered naloxone to the same person on a different occasion.



Naloxone

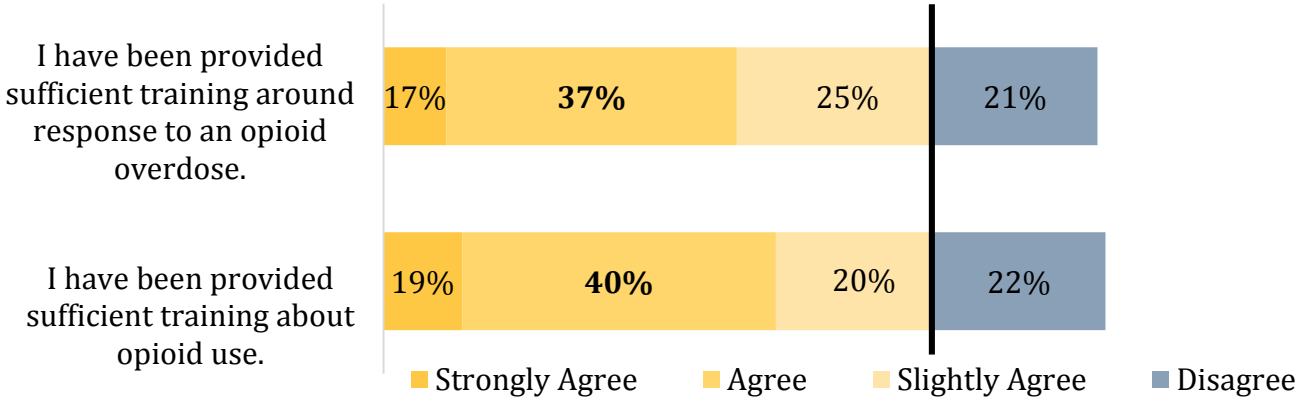
This next section is about the (naloxone) training you've received.

Of the 133 respondents, **the majority indicated they had received training to administer naloxone for an overdose** (n=109, 82%) **and to recognize the symptoms of an opioid overdose** (n=111, 83%).



Please indicate your level of agreement with the following statements regarding naloxone use and availability.

Nearly three-fourths of respondents indicated they had received sufficient training about opioid use, and on response to an opioid overdose (n=112 and 110, respectively, 79%).



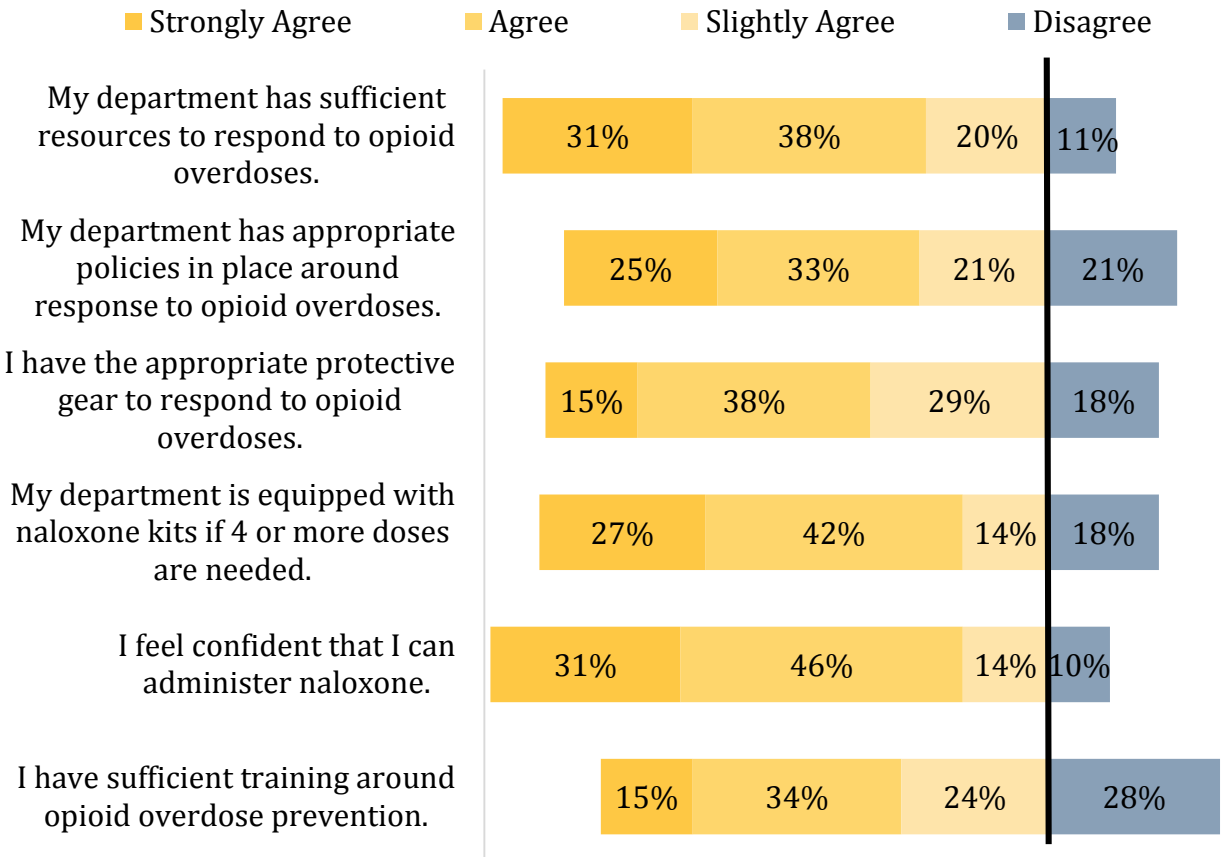
Whereas nearly all (96%) of respondents in Region 6 indicated they had received training to administer naloxone, fewer had received such training in other regions. Just over half of respondents in Region 2 (60%) had received training to administer naloxone (although there were only five responses from this region). (See Appendix F for specifics.)

Naloxone

Please indicate your level of agreement with the following statements regarding naloxone use and availability.

Nearly all respondents felt confident they could administer naloxone, if needed (91%) **and felt their department had sufficient resources to respond to opioid overdoses** (89%). Similarly, respondents thought their department was equipped with naloxone kits if 4 or more doses were needed to revive a victim (83%), they had the appropriate protective gear to respond to opioid overdoses (82%), and thought their department had appropriate policies and procedures in place to respond to opioid overdoses (79%).

The biggest area of need among these items is **the need for training around opioid overdose prevention**, expressed by 28% of respondents (n's ranged from 108-112). Respondents in Region 4 indicated they were less confident they had received sufficient training around opioid overdose prevention.

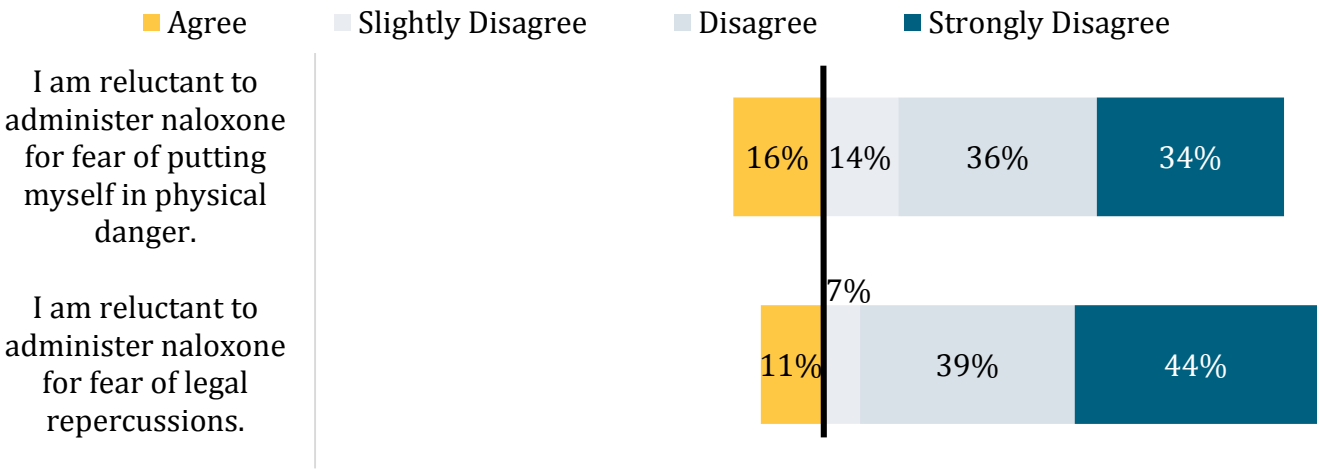


"Disagree" includes "slightly disagree," "disagree," and "strongly disagree."

Naloxone

Please indicate your level of agreement with the following statements regarding naloxone use and availability.

Very few respondents expressed reluctance to administer naloxone for fear of putting themselves in danger (n=17, 16%) or in fear of legal repercussions (n=11, 11%).
More respondents in Region 1 expressed reluctance.



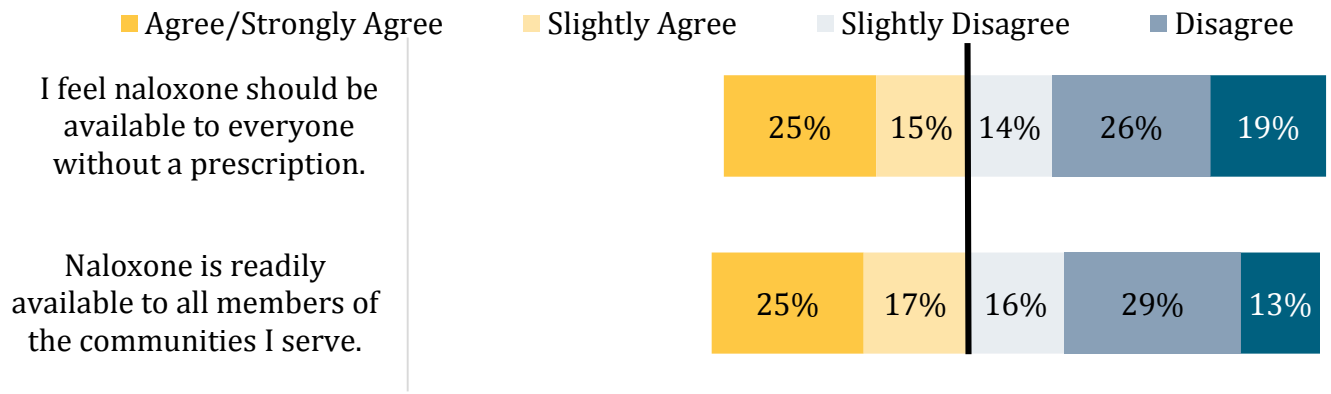
Region 6 consistently stood out from other regions in nearly all areas of resources and training.

- More had received training on opioid use, recognizing the symptoms of an opioid overdose, how to respond to an opioid overdose, how to administer naloxone, and on opioid overdose prevention.
- Most thought they had sufficient naloxone kits, protective gear, and other resources to respond to opioid overdoses.
- More thought their department had the appropriate policies and procedures in place around response to opioid overdose.
- More felt confident they could administer naloxone, if needed.

Naloxone

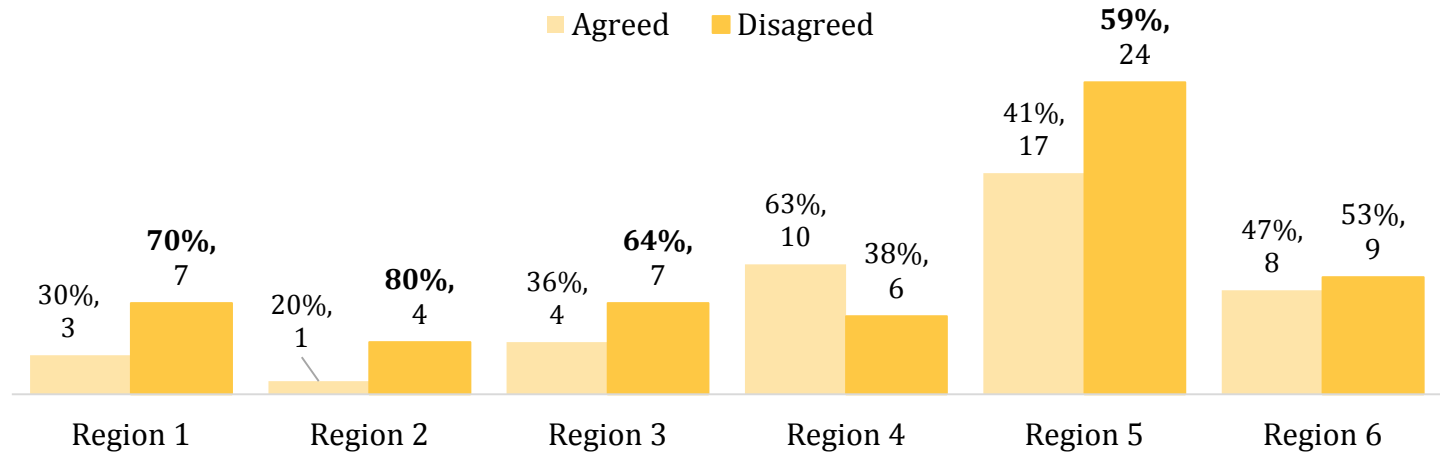
Please indicate your level of agreement with the following statements regarding naloxone use and availability.

Respondents were split on whether naloxone is readily available to all members of the communities they serve with 42% saying it is available, and 58% saying it is not (n=103). Similarly, **respondents were split with 40% saying naloxone should be available to everyone without a prescription**, and 59% saying it should not (n=111).



The majority of respondents from Regions 1, 2, 3, and 5 did not agree that naloxone was readily available to the communities they served (n=100).

Naloxone is readily available to all members of the communities I serve.



"Agreed" includes "strongly agree," "agree," and "slightly agree." "Disagreed" includes "slightly disagree," "disagree," and "strongly disagree."

Healthcare: Quantitative–Results

The table below summarizes how healthcare professionals in Nebraska regions differed from one another on training, resources, policies, opinions/attitudes, and availability of naloxone in the communities they served.

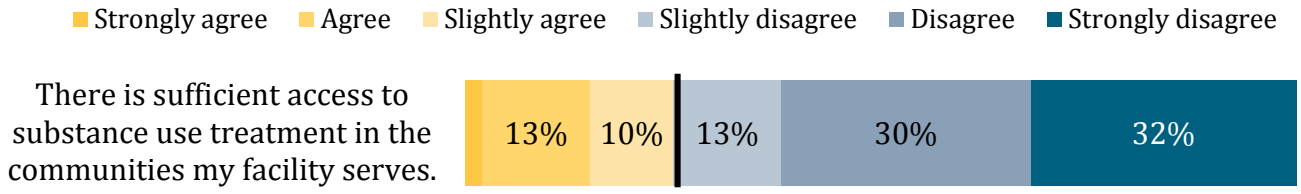
Region	Training	Resources/Policies	Opinions/Attitudes
Region 1	Fewer had received sufficient training on opioid use.	-	More felt reluctant to administer naloxone for fear of putting themselves in physical danger.
Region 2	Fewer had received training on how to administer naloxone.	More thought they did not have sufficient resources to respond to opioid overdoses, including appropriate protective gear.	Fewer felt confident they could administer naloxone if needed.
Region 3	More had received training on recognizing the symptoms of an opioid overdose, and on opioid overdose prevention.	More thought they did not have sufficient resources to respond to opioid overdoses, and that their department did not have appropriate policies and procedures in place around response to opioid overdoses.	More disagreed that naloxone should be available to everyone without a prescription.
Region 4	Fewer had received sufficient training on opioid use, how to respond to an opioid overdose, or on opioid overdose prevention.	Fewer thought they had sufficient naloxone kits available. More thought their department did not have appropriate policies and procedures in place around response to opioid overdoses.	-
Region 5	Fewer had received sufficient training on opioid use.	-	-
Region 6	More had received training on opioid use, recognizing the symptoms of an opioid overdose, how to respond to an opioid overdose, how to administer naloxone, and on opioid overdose prevention.	Most thought they had sufficient naloxone kits, protective gear, and other resources to respond to opioid overdoses. More thought their department had the appropriate policies and procedures in place around response to opioid overdose.	More felt confident they could administer naloxone if needed.

In addition to the above, more respondents in Regions 1, 2, and 3 did not think naloxone was readily available to members of the communities they served.

Community Resources

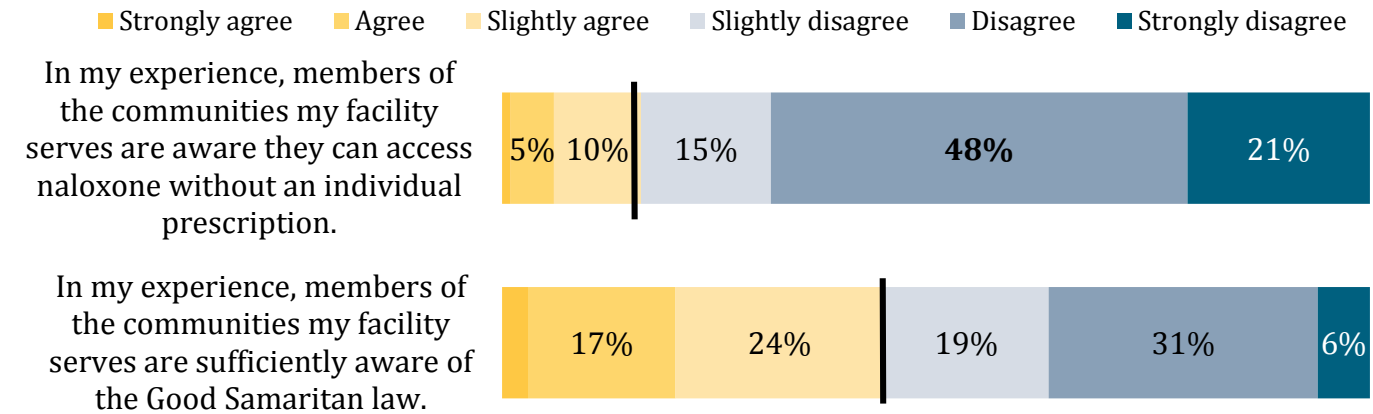
Please indicate your level of agreement with the following statements regarding substance use in your community.

Three-fourths of respondents expressed that there is not sufficient access to substance use treatment in the communities they serve (n=113, 75%).



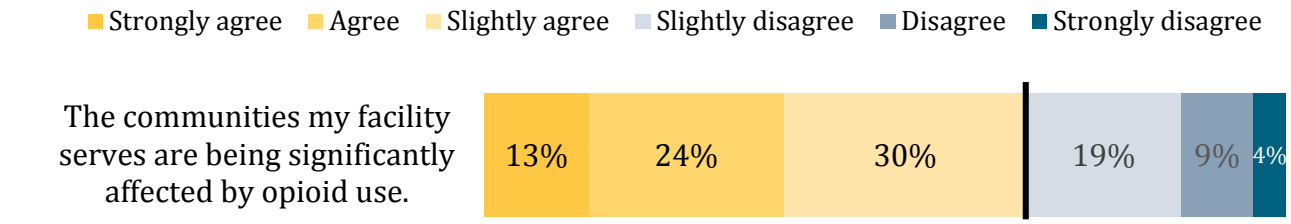
Nearly all of respondents did not think members of their communities were aware they could access naloxone without an individual prescription (n=112, 84%), **and just over half thought members of their communities were not aware of the Good Samaritan law** (n=113, 56%).

This awareness was especially lacking in Regions 1, 2, and 4.



Two-thirds (67%) of respondents thought their communities were being significantly affected by opioid use.

Regions 2, 4, and 5 did not think their communities were being significantly affected. Most respondents in Region 6 thought their communities were being significantly affected.

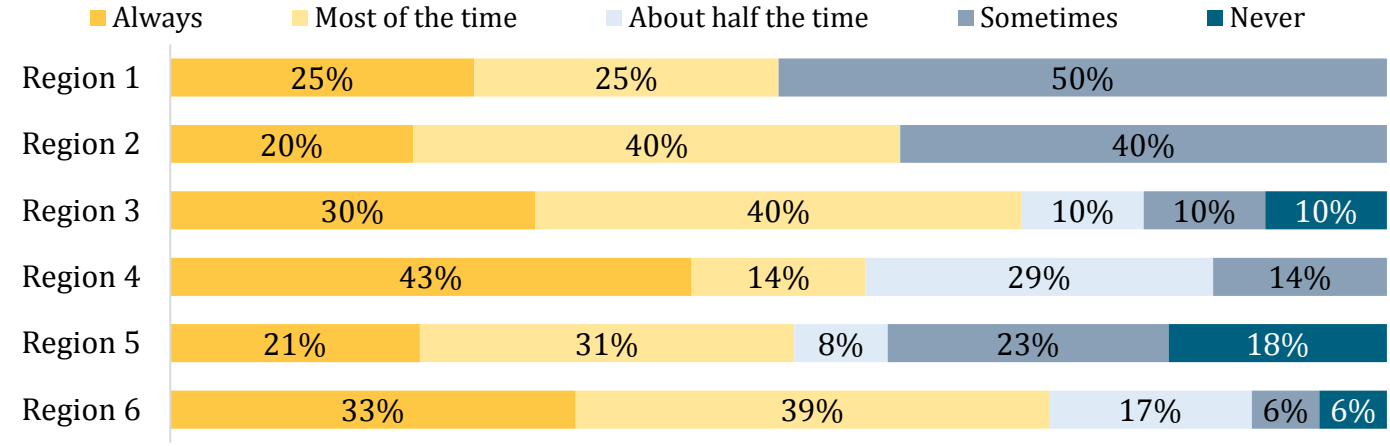


Community Resources

We are interested in knowing about resources and information that are provided to the person who overdosed and their families and friends. These resources can be provided by anyone in the community, including your department or other systems.

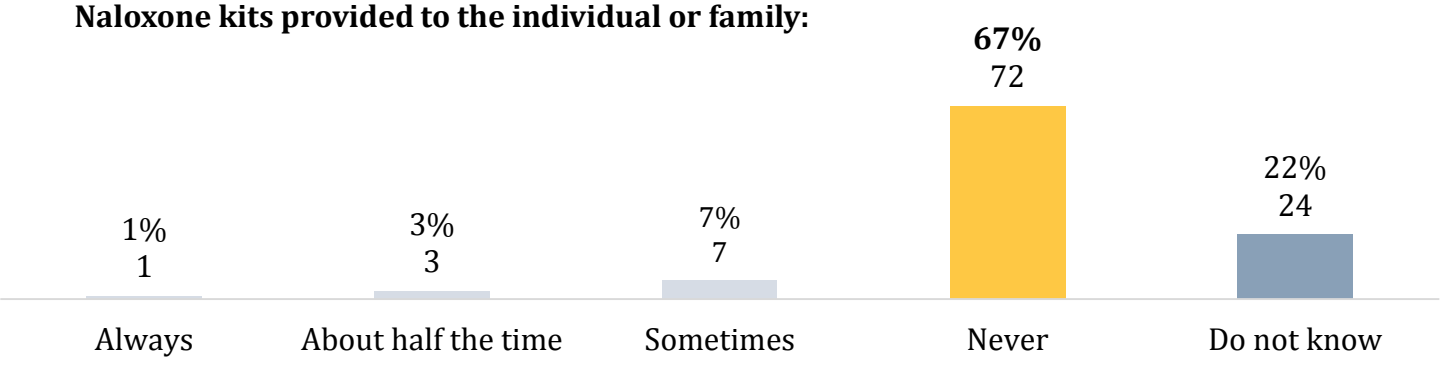
Over half of respondents indicated that information regarding treatment options were provided at least half of the time (n= 67, 63%).
Almost half of respondents from Region 4 indicated they always provided information about treatment options (43%, n=6).

Provided information regarding treatment options:



The majority of respondents indicated that naloxone kits were never provided to individuals who overdosed or to their families (n=72, 67%) and almost one quarter of respondents did not know if naloxone kits were provided (n=24, 22%).

Naloxone kits provided to the individual or family:



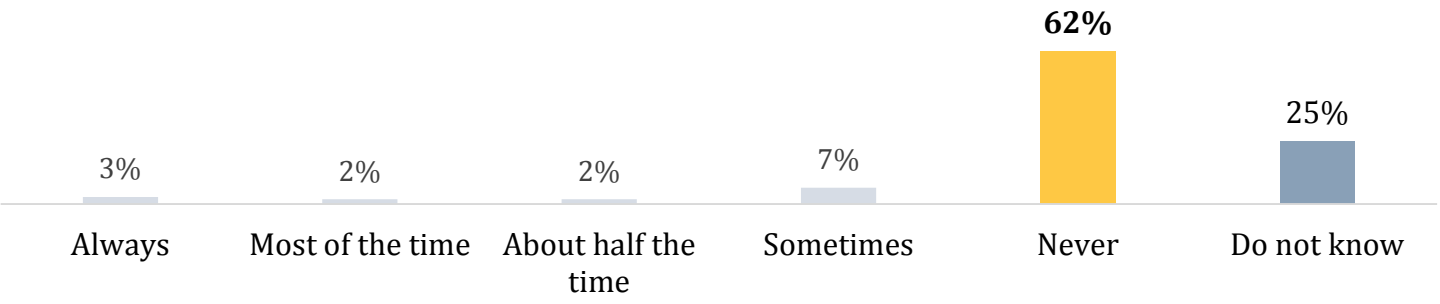
Community Resources

We are interested in knowing about resources and information that are provided to the person who overdosed and their families and friends. These resources can be provided by anyone in the community, including your department or other systems.

Similar to responses about providing naloxone kits after an overdose situation, **over half of respondents indicated that information on accessing naloxone kits to keep at home were never provided to individuals who overdosed or to their families and friends** (n=66, 62%). Additionally, 25% of respondents (n=27) indicated they did not know whether or not this information was provided.

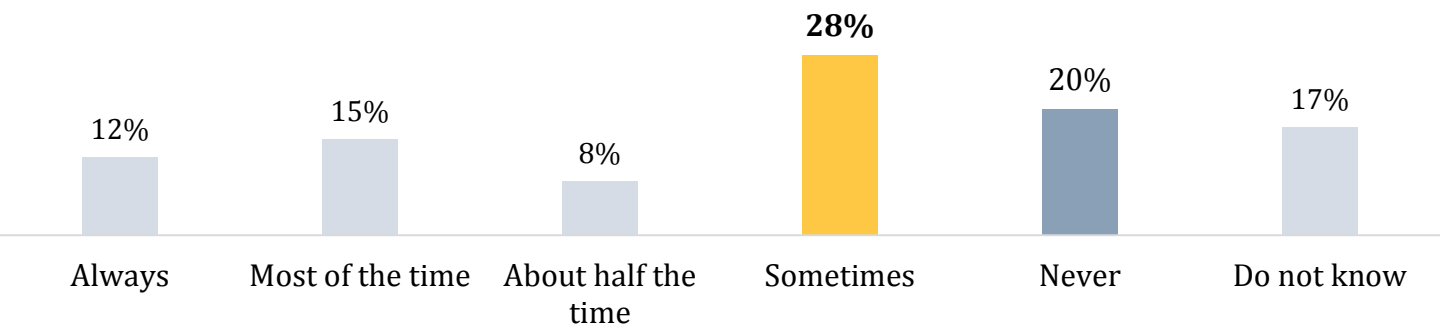
Approximately half of respondents who never provided this information served communities in Region 5.

Provided information on how to access naloxone kits to keep at home:



Responses as to whether information on support groups in the community were provided to individuals who overdosed and to their families and friends were more evenly distributed. **Most respondents indicated that information on support groups was provided sometimes** (n=30, 28%), while some (n=21, 20%) indicated it was never provided, and fewer (n=18, 17%) did not know if this information was provided.

Provided information on support groups in the community:

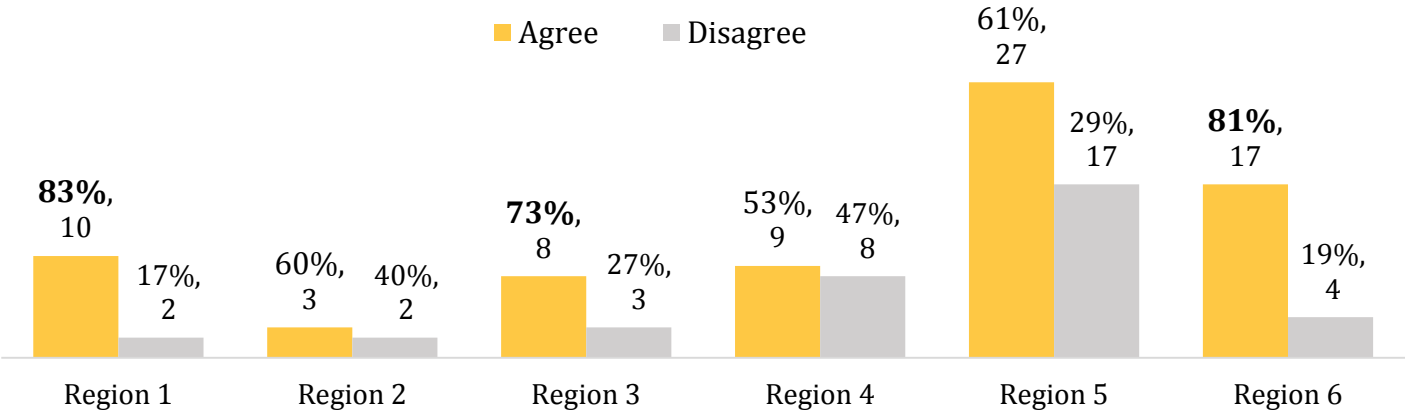


Healthcare Professional Resources

Please indicate your level of agreement with the following statements regarding substance use in your community.

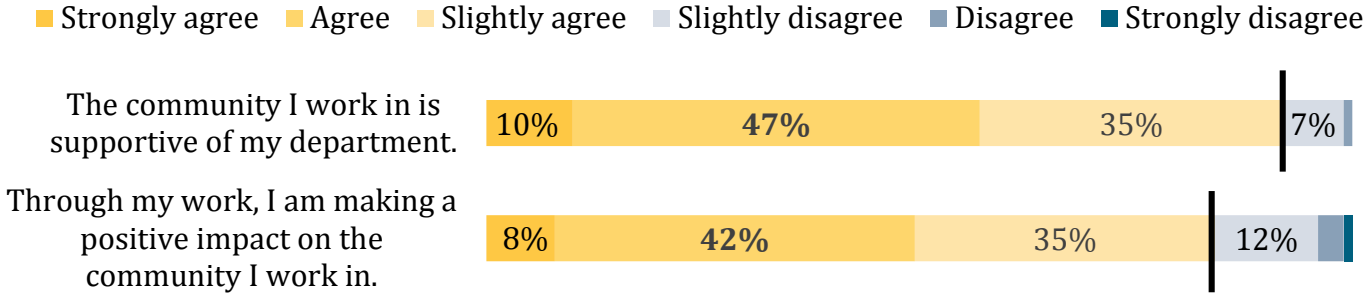
At least half of respondents from each region indicated their communities were being significantly affected by opioid use (n=110). Regions 1, 6, and 3 had the highest percentage of agree responses (n=10, 83%; n=17, 81%; and n=8, 73%, respectively).

The communities my facility serves are being significantly affected by opioid use.



"Agree" includes "slightly agree," "agree," and "strongly agree." "Disagree" includes "slightly disagree," "disagree," and "strongly disagree."

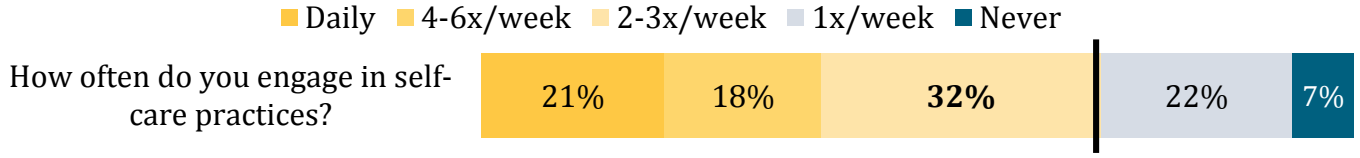
Nearly all respondents (92%) **stated that they felt the communities they serve are supportive of their department, and most** (85%) **also felt they were making a positive impact on their communities through their work** (n=113 for both).



Healthcare Professional Resources

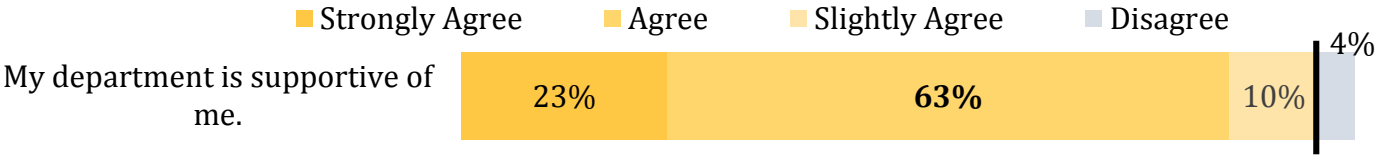
How often do you engage in self-care practices? Examples of self-care practices include meditation, journaling, spending quality time with a loved one, stretching, taking a walk, doing something new, limit work hours.

The highest number of respondents indicated they practiced self-care at least 2-3 times a week (n=35, 32%), 22% practiced once a week (n=24), 21% practiced daily (n=23), 18% practiced 4-6 times a week (n=20), and 7% indicated they never engaged in self-care practices (n=8).

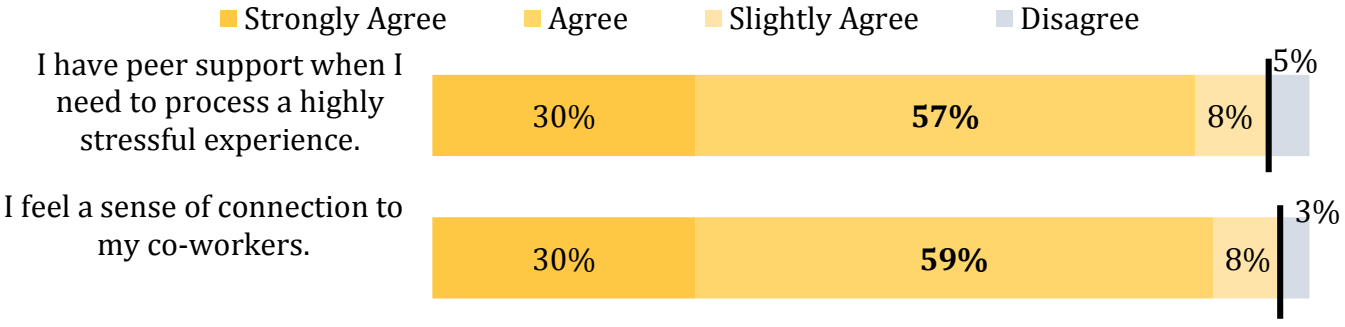


Please indicate your level of agreement with the following statements regarding work-related stress.

Fortunately, **nearly all respondents felt their department was supportive of them** (97%).



Similarly, **nearly all respondents felt a connection to their co-workers, and they had peer support when needing to process a highly stressful experience.**



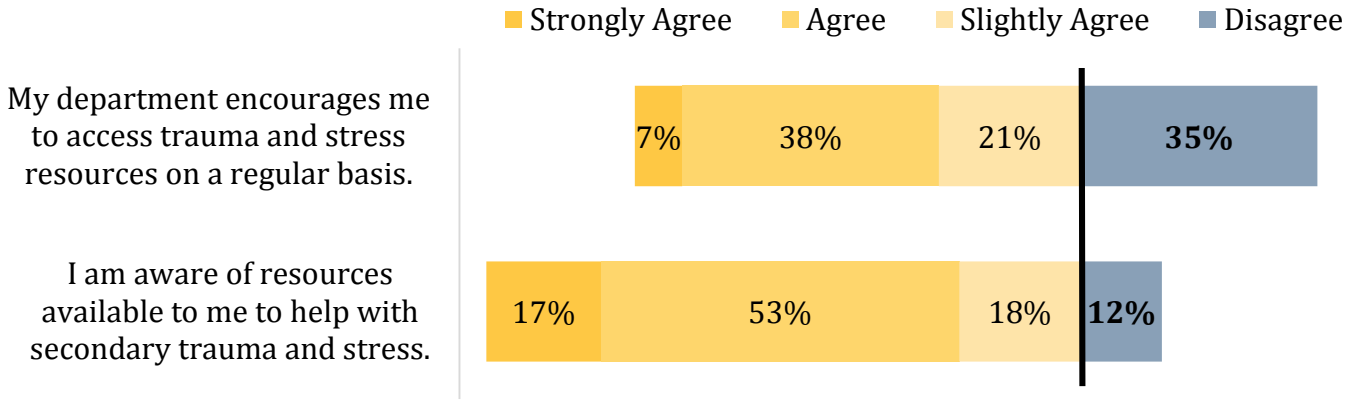
"Disagree" includes "slightly disagree," "disagree," and "strongly disagree."

Compassion Fatigue

Please indicate your level of agreement with the following statements regarding work-related stress.

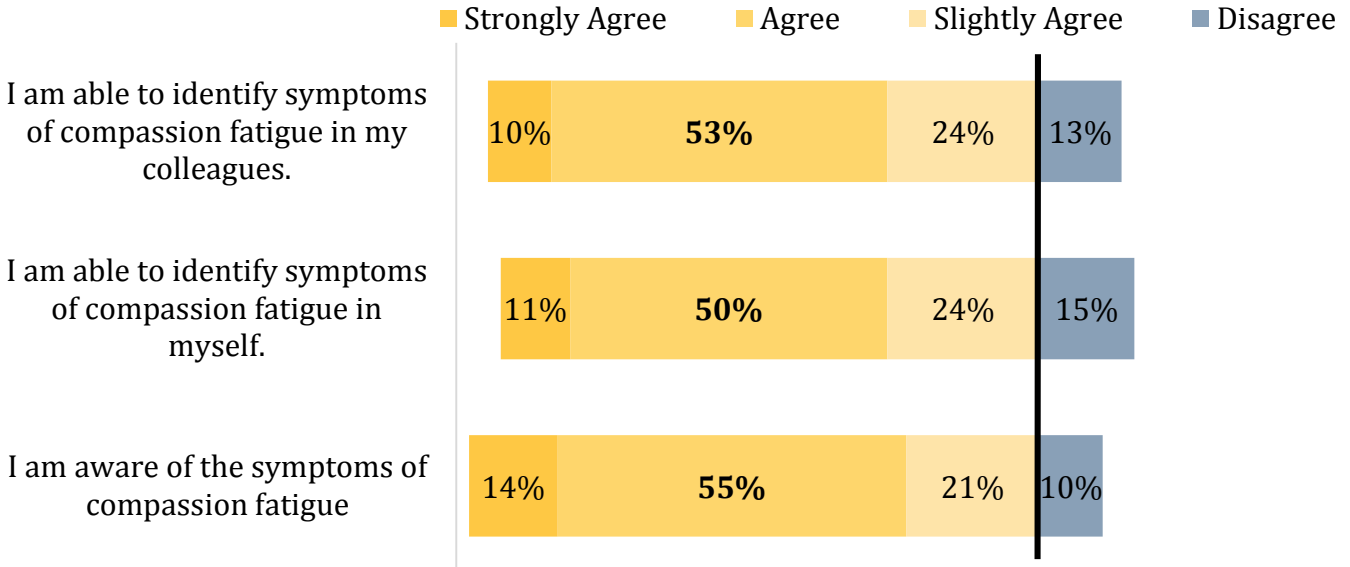
While **nearly all respondents were aware of resources available to help them with secondary trauma and success** (n=98 agreed, 88%), **they were not quite as sure about whether their department encouraged them to utilize these resources** (n=39 disagreed, 35%).

Respondents from Regions 2 and 3 indicated they received less encouragement from their departments. Respondents from Region 3 were also less aware of resources available to them.



"Disagree" includes "slightly disagree," "disagree," and "strongly disagree."

Overall, **respondents thought they knew what the symptoms were of compassion fatigue, and were able to identify symptoms of compassion fatigue in themselves and their colleagues**. Region 1, overall, was less able to identify symptoms of compassion fatigue.



"Disagree" includes "slightly disagree," "disagree," and "strongly disagree."

Open-Ended Survey Questions

1 What specific stressors do you experience in your role as a healthcare staff member in regards to overdose situations?

The most commonly occurring responses about specific stressors were related to burnout and compassion fatigue, coping with traumatic patient deaths, and a lack of mental health and substance abuse treatment facilities. Respondents frequently mentioned frustration related to the lack of treatment resources for patients upon discharge from the healthcare facility and when dealing with drug overdoses of unknown origin.

2 What resources does your facility need to better prepare for a surge in opioid use?

Respondents most often mentioned the need for increased training and education on overdose symptoms, alternative therapies for pain management, and resources and supplies for treating overdoses and substance abuse within the facility. Respondents also mentioned a need for patient education on pain management expectations and resources available once the patient is discharged.

3 What resources does your community need to better prepare for a surge in overdoses?

The two most mentioned community needs were for increased mental health treatment and substance abuse treatment options. Respondents frequently mentioned lack of treatment referral options for both mental health and substance abuse. Another need noted was for increased availability of naloxone at common locations in the community.

4 What else would you like to say in regards to the capacity of healthcare facilities across Nebraska in responding to a surge in overdoses?

Overall, respondents mentioned a need for treatment facilities in both urban and rural areas. In particular, there is a great need for facilities that are able to treat dual diagnoses (mental health/substance use) patients across the state of Nebraska.

Healthcare: Quantitative–Summary and Recommendations

According to healthcare professionals' survey responses, **alcohol was the substance most often involved in overdoses** in the previous 12 months, followed by methamphetamine, opioid pain relievers, and benzodiazepines. Respondents indicated heroin, fentanyl, and cocaine were least involved in overdoses. Alcohol was a significant concern in Regions 1 and 6, and opioids were a concern in Regions 3, 4, and 6. **Methamphetamine was a concern in all regions.**

On average, **respondents said they are responding to fewer overdose situations now than they were 2 years ago.** Respondents said overdose situations involved opioids about as often now as they did 2 years ago. Respondents in Region 6 indicated that over the last 6 months one-third of overdose situations involved opioids.

Respondents reported they administered naloxone an average of 2.6 times in the last 12 months. Just under half of the respondents had not administered naloxone in the previous 12 months, and about the same amount had administered it one to five times. Of those who had administered naloxone at least once within the past 12 months, over half had administered naloxone to the same person on different occasions.

Nearly three-fourths of respondents reported they had received sufficient training about opioid use and around response to an opioid overdose. Most respondents had received training to administer naloxone for an overdose and to recognize the symptoms of an opioid overdose. Almost all respondents felt confident they could administer naloxone, if needed and felt their department had sufficient resources to respond to opioid overdoses. Similarly, respondents thought their department was equipped with naloxone kits if 4 or more doses were needed to revive a victim. They also had the appropriate protective gear to respond to opioid overdoses, and thought their department had appropriate policies and procedures in place to respond to opioid overdoses. Very few respondents expressed reluctance to administer naloxone for fear of putting themselves in danger or fear of legal repercussions.

Recommendations

In response to healthcare professionals' responses on our online survey, STEPs recommends that NE DHHS consider the following:

1. Make substance abuse and mental health treatment more widely available and accessible across Nebraska.
2. Provide support and other forms of resources to healthcare facilities on alcohol and methamphetamine overdoses in addition to opioid overdoses.
3. Communicate the availability of naloxone to communities, and provide training on how to use naloxone.
4. Offer training to healthcare professionals on the availability of naloxone in their communities, and how to talk with patients and their families about the use of naloxone.
5. Provide materials on opioids and naloxone that healthcare facilities can disseminate to their patients and in their communities.

Healthcare: Quantitative–Summary and Recommendations

Respondents were split on whether naloxone was readily available to all members of the communities they served and whether naloxone should be available to everyone without a prescription. Nearly all respondents did not think members of their communities were aware they could access naloxone without an individual prescription, and over half thought members of their communities were aware of the Good Samaritan law. **The biggest area of need among these items was the need for training around opioid overdose prevention.**

Three-fourths of respondents stated there was not sufficient access to substance use treatment and two-thirds thought their communities were being significantly affected by opioid use. Responses to survey items concerning whether resources and information were provided to an individual who had experienced an overdose or their families and friends showed over half of respondents provided information at least half the time. The majority of respondents indicated they never provided naloxone kits or information on accessing naloxone kits to keep at home.

Recommendations
(continued)

6. Offer trainings and materials in communities about prevention of opioid overdose.
7. Increase healthcare management's awareness of their staff's needs for support and emotional well-being when providing care in difficult situations. Ensure resources are available for them to offer to staff.
8. Offer healthcare staff training and information on methods of pain management other than opioids.

Nearly all respondents felt the communities they served supported their departments, and most felt they were making a positive impact on their communities through their work. Additionally, almost all respondents felt supported by their departments, felt a sense of connection to their co-workers, and had peer support to process highly stressful experiences. While nearly all respondents were aware of resources available to help them with secondary trauma and stress, they were less sure about whether their department encouraged them to utilize these resources. Overall, respondents thought they knew what the symptoms were of compassion fatigue, and were able to identify symptoms of compassion fatigue in themselves and their colleagues.

When asked to list the specific stressors experienced in their role as a healthcare professional, most respondents mentioned burnout and compassion fatigue, coping with traumatic deaths, and frustration at the lack of mental health and substance use treatment resources, particularly treatment facilities that accept patients who needed treatment for both mental health and substance use issues in their communities. Respondents indicated increased training on overdose symptoms, alternative methods of pain management, and resources for drug overdose were needed in their facilities and communities in order to better prepare for a surge in opioid use.

Healthcare: Quantitative–Limitations

1. **Low response rate:** Completed surveys were received from respondents who served 34 of the 93 counties in Nebraska.

2. **Incomplete survey responses:** 40 survey respondents provided demographic data only or did not respond to any survey items.

3. **Regional response rate:** There were only 5 respondents from Region 2. Comparing the respondents from other regions may misrepresent the experience of Region 2 respondents. We tried to compensate this discrepancy by providing a regional breakdown of responses in an appendix.

4. **Convenience sampling:** Survey invitations were sent based on the availability of facility contact information and each individual's willingness to participate. Healthcare professionals whose contact information was not available did not receive a link to the survey from their facility, or who were not willing to participate due to time constraints, the overdose topic, or previous interactions with the public may have offered a consistently different perspective.

5. **Survey construction:** Some of the survey items, particularly those that asked respondents to reflect on certain time periods (6 months, 12 months, 2 years) may have been confusing for the respondent to conceptualize. Similarly, some of the survey items that asked for a percentage may have also been hard for them to answer.

6. **Survey dissemination:** STEPs relied on hospital administrators to distribute the survey to appropriate healthcare employees. It is unknown if every hospital did this. The contact information for some hospital administrators was outdated, and it was difficult to obtain accurate contact information. This delayed survey distribution or inhibited it altogether.

Drug Overdose Prevention Needs Assessment

Healthcare Professionals

Focus Groups and Interviews

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES
DRUG OVERDOSE PREVENTION

UNIVERSITY OF NEBRASKA AT OMAHA
SUPPORT AND TRAINING FOR THE EVALUATION OF PROGRAMS

Healthcare: Qualitative–Sample Description

STEPs conducted 8 focus groups and 3 individual interviews with medical facility staff across Nebraska. Limited demographics were gathered from the participants to respect confidentiality.

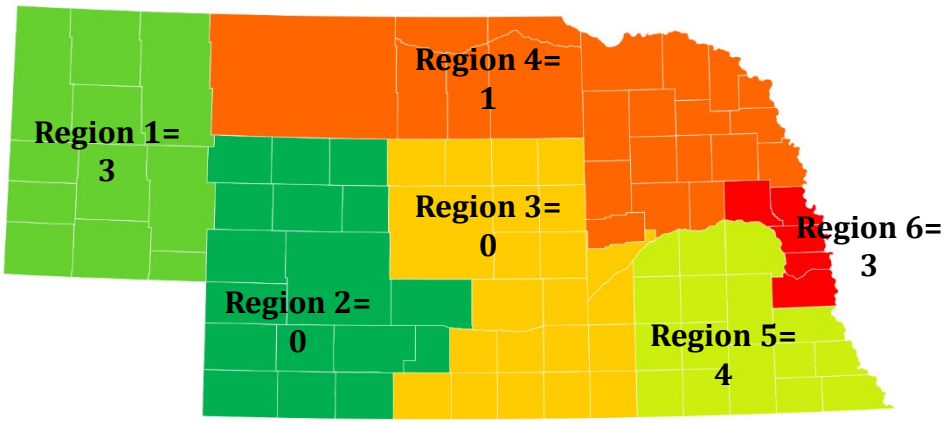
The majority of the participants were nurses in hospital Emergency Departments. However, other participants worked in pharmacy, hospitalist, administration, physician, and social work departments. The average length participants had been in their respective roles was 8 years.

8 focus groups

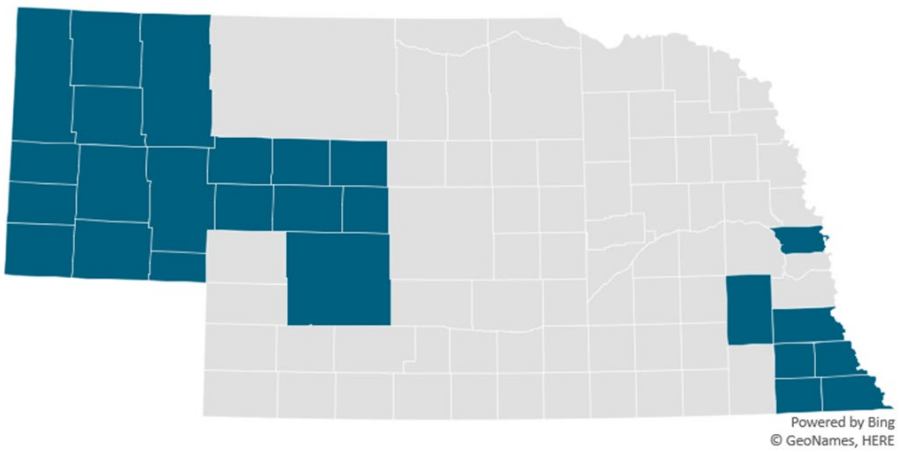
3 interviews

8 years on average the participant had worked in their role

Number of Focus Groups/Interviews by Region



High-Burden Areas in Nebraska



At the conclusion of the healthcare qualitative analyses, four overarching themes emerged: **Facility Impact, Staffing Impact, Patient Impact, and Responding to the Impact.** Within these overarching themes, several subthemes were also identified. Each theme and subtheme is described in detail below along with supporting quotations.

Facility Impact

Participants described how opioids have impacted their facility in a general sense. They shared on topics such as the **Number of Overdoses, Small Community, Surge Needs, Policies and Procedures, and Naloxone.**

Number of Overdoses

Participants were asked how many opioid overdoses they typically encountered in a given period of time. This was a difficult question for most participants, and responses varied from 0 to 20 opioid overdoses per month. One facility estimated 1 per week while another estimated 10 per week.

> *"I mean, but, specific overdoses we'll call six. I mean, we just had, I think, two in the last couple weeks."*

> *"We have at least 10 a week."*

Several facilities said they did not think Nebraska, in general, had experienced prevalent opioid overdose situations. Facilities stated there are patients who are using opioids but they had not seen overdose situations yet.

> *"I just don't think we have an overabundance of this havoc."*

> *"Well, I think that Nebraska has been relatively spared compared to those from other states, surrounding states even as well."*

> *"You know, opiate overdoses, it's a relatively rare thing in the ER. I mean, you see it enough, you know how to handle it, but it's not like a daily occurrence where we have to give Narcan."*

Instead, facilities discussed how other substances were more of an issue including mentions of methamphetamine, K2, and fentanyl.

> *"But right now we have a methamphetamine problem more than we have an opiate problem."*

Small Community

Due to several smaller communities being included in this research, several participants discussed how being in a small community impacted their facility's work. Knowing members of the community can, at times, both negatively and positively impact the facility's interaction with certain patients.

> *"…most of the nurses know the people in the community and who may be at risk for an overdose."*

> *"The disadvantage of that is that we may jump to assumptions and overlook something medical because you make an assumption that because of who they are and where they came from."*

Surge Needs

Participants were asked if they felt their facility was capable of handling a surge of opioid overdose situations if one were to occur. Participants were encouraged to share in terms of staff and supplies. Most of the facilities felt unsure if they could handle a surge of overdoses such as a large party. They discussed the lack of staff and the lack of individualized acute treatment that would be necessary. They said a lot would depend on the amount of naloxone a facility had on hand as well. However, several facilities discussed how they would do everything possible to meet the needs including calling in extra staff, contacting other facilities, and utilizing other floors.

> *"We don't because they need one-on-one care, they need a bed, they need a dedicated therapy staff, none of which we have on staff to provide that care."*

> *"I think it would really depend on what we're talking as far as numbers goes and what else is going on in the ER. No matter what, we find a way to make do. We call in extra help, or whatever we've gotta do, but we make do. It would depend on really the numbers and what else was going on that day."*

Policies and Procedures

Participants were asked if their facility had specific policies or protocols for responding to an opioid overdose. Most facilities stated they did not have a specific policy for an opioid overdose but had more general policies for overdose situations. Many facilities said they do not always know what a patient is overdosing on. They know it is an overdose situation but are unsure what the substance is. In these situations, they said, it is trial and error to see which drug or treatment the patient appropriately responds to.

> *"I mean, I know, Narcan's on a bunch of different order sets but I'm not sure if there's one that's titled 'opioid overdose.' "*

"There's just so many things that we're trying to narrow down. And it might be worth looking at maybe, just reviewing our current policy and procedures, order sets, just to make sure that we're kind of prepared for somebody that comes in."

Naloxone

Participants were invited to share their current experiences with naloxone, which is a drug that treats a narcotic overdose. The discussion around naloxone often involved how much of the drug a facility had on hand. Most facilities carried various forms of naloxone including nasal and injection. Most facilities felt they had ample supply of naloxone on hand at the time of interview.

"I can say though in my five years here, anytime I've needed Narcan, it was readily accessible for me. I've never had a circumstance where it wasn't on the floor and I thought it was, or we ran out of it. I mean, I've never once had any issues obtaining it in my five years."

All facilities discussed how they had experience administering naloxone and felt confident in their abilities. Participants felt they received adequate training.

"I think everybody is competent and knowledgeable about Narcan, that it's used for narcotics in the Emergency Department."

There was discussion about the effects of naloxone. A few facilities discussed how there was a fine line of how much naloxone to give in order to balance patient reaction.

"And so then, what's the patient gonna do if I take that high away, or if I take that pain control away, are they going to sit up in the bed and start swinging at me?"

"There seems to be a kind of sweet spot, I guess. Yeah, you can give too much Narcan and make someone have a really bad reactions."

Some participants discussed how knowing the option of naloxone has a negative impact on the patient and how patients may end up abusing naloxone in an overdose situation.

"It's a false sense of security if somebody gets it, 'Well, I'll just, somebody'll bail me out if I O.D.' "

"...now these kids, you know, you hear, at these parties, they're taking themselves to the absolute brink of death with opioids because they know they can bring them back."

Naloxone is offered as a standing order across the state, meaning anyone can obtain naloxone. Some participants said that they did not think this was well-known in the community and that there was an opportunity to provide more education on this available resource.

"I think there's a lot of people that don't have a clue that they can go get it."

"I don't know how the physicians feel on this, but I wouldn't be opposed to the physicians writing prescriptions for Narcan, in our department and giving those to people that come in with that. I mean, I kind of equate it to having an EpiPen for an allergy. It's life saving. I do think they need to have, be educated, they need to be, they need to know what their treatment options are, to get help, but, you know."

Staff Impact

Participants described how opioids have impacted themselves as staff members in a medical facility. The subthemes consisted of **Burnout, Self Care, the Prescription Drug Monitoring Program (PDMP), and Prescribing Practices.**

Burnout

After discussing at length about participants' experiences with overdose situations, they were asked how this impacted their work. Some participants shared how they felt an elevated level of stress or burnout in response to their work.

"It's frustrating, I think sometimes for health care providers as well, for the whole care team, you know, you see it redundant, and you kinda get fatigued. A lack of empathy at some point."

Self-Care

In response to participants discussion on burnout, participants were asked how they gained support to continue doing their job. Participants discussed resources such as EAP sessions, yoga classes, debriefing sessions, allowing time off from work, and in-house trainings. Most of the discussion revolved around how coworkers acted as personal support systems as well. There were comments made about the opportunity for improvement or for the facility to offer more support.

"I think we all have our own personal supports systems. That's helpful, as an institution, I don't know if... they really understand kind of what we as nurses in the ER see and go through. Because there are definitely days where you just don't think you can come back."

"I think the hospital would be supportive of people if they needed a day off from work because of something that happened at work."

"We do critical incident debriefing, and the staff needs to have had a couple of all… after every code in our organization, and often debriefing is offered. The time I've only taken them is after a pediatric death, or something of that sort, but, um... There's structured stuff to offer that."

"A lot of it, I think, is just the informal human nature of being with your coworkers, of being… We all tend to gravitate towards those who have shared that experience, as nasty as it is, no matter if you're a cop, or a fireman, or an ambulance driver."

Some participants recognized how burnout progresses, meaning they felt they were a different provider when they first started their job compared to where they are today. In these honest discussions, it was more difficult to articulate how the facility could provide support.

"I think what is more difficult is just the smaller things that kind of continually nick, and nick, and nick away at you that are harder for us. And we don't, I don't think people recognize it in themselves… And over time, I think all these hinders to their work have gone with them, and now they're just, they show up to work crabby… They go to see patients, and every patient's stupid, or dumb, or what are they doing here? …And I see it a lot in our providers, as well. I mean, every shift I work, providers are saying, 'This is an emergency room. People are here without emergencies...'"

Prescription Drug Monitoring Program (PDMP)

Participants were asked if they had personally used or had coworkers that used the Prescription Drug Monitoring Program or PDMP. The majority of respondents had used PDMP and found it to be very helpful. Participants who were not familiar with PDMP were often not given access to the program so they did not have personal experience to attest to. Those that were using PDMP particularly appreciated the ability to access a patient's current prescription list and use this to provide better care.

"*I love it, it's an amazing tool and now with the state where all the medications fall under there, it's really helpful. Especially in your confused patients where they're like, 'I don't know what I take. I take a little white pill.' Or, 'A little green pill' or like 'Oh, that's the one' when they've taken 1,000 drugs. I think it's useful, very useful."*

"I have personally seen preventative use of databases frequently actually call out patients that have had multiple prescriptions elsewhere, and you simply call them out. 'I'm not refilling this, here's why, I see this refill here, here, and here, and you're not gonna get from me…'"

"A lot of the times they'll just tell the patient, 'I see you got a prescription for this, this date. Why is it gone already?...I think they are very upfront with patients, because I think that patients think that we don't know, we can't tell where they've been, you know."

Although the discussion around PDMP was mostly positive, there were some issues or concerns brought up. Participants discussed issues related to the program having limited connection to other states or systems, being time consuming, not including directions on how a patient is prescribed to take the medication, not being user friendly, and not interfacing with current electronic medical records systems.

"You know, and the only thing you don't get on there is if somebody's gotten medication through the V.A…or out-of-state."

"And one problem with PDMP, it doesn't put the directions on, it just puts quantity, fill date, days supplied, it needs directions sometimes, I wished it would put those on."

"It's usually time consuming, to go into a completely different system and then you run into, you know, do the queries. It goes, looking at it from an isolated view of this person in acute pain in front of you, it is a time, labor for staff."

"…which that's another problem is that you have to use it on certain web browsers that you could integrate it into your EMR, 'cause that's what we use is an EMR."

Another common barrier or issue related to PDMP revolved around access. Many nurses shared frustrations that they were unable to access PDMP due to their credentials and felt that it would be beneficial if they did have access. Another issue many participants discussed was that the system was difficult to access, meaning required trainings or resetting passwords were an additional barrier at times hindering access to PDMP.

"…but it breaks a lot, and…I don't even know how to get access to PDMP now, but it's not switching my password…So, I think you have to do training now, and there's online stuff, and so I don't understand that, why that's the case."

"And so, if it was easier to access, I think people would routinely access it before they wrote any prescription."

Prescription Practices

As participants began to describe how the opioid crisis was or was not impacting their work, discussions around how medications are being prescribed often came up. Participants reflected on how there have been changes over the years on how medications are prescribed. Many participants felt that physicians are prescribing less compared to several years ago, particularly for pain medications, narcotics, or opioids. Emergency Department physicians were described to not want to interfere with whomever was prescribing these pain medications originally such as a designated pain specialist. Other trends noted were that physicians are not prescribing as many medications as they had in the past, only a few doses to get the patient through the immediate days. A few participants described differences in acute pain versus chronic pain.

> *"I say in our primary care practice we used to give that stuff out like candy. And I think in the last 10 years, last, even last 7 years it has substantially dropped. And then with the advent of PDMP and some of those other things, it's easier to spot the drug seekers coming through."*

> *"I think in recent years there has been, but I do think that it's, there's a push now to stop prescribing. When I started in the ER 10 years ago, I feel like we gave narcotics to everybody. And now it's definitely, we don't do that."*

> *"I think whatever a decision points him to is trying to determine whether the patient came in for was acute pain or chronic pain, and if it's a chronic pain then they're less likely to treat it. But if it's acute pain, a new problem, then they're more likely to see you kinda, sometimes those patients might have a care plan or advice from their primary care provider, and the docs are looking at them like, but this seems like a different problem today or this acute pain so they'll treat it. It's complicated, because sometimes people come in and really commit to it's acute pain when it's not."*

> *"I have seen a dramatic change in the last few years. The awareness of opioids and how they're prescribed…I think it holds people accountable for their prescribing practices and their dispensing practices."*

Participants sometimes said it was difficult trusting what a patient shared about their pain; they had concerns about manipulation.

> *"There could be worse consequences for cutting their medication off than just continue it, and that's terribly sad… the patients work the system too. They know what to say. They know, I mean, it's frustrating."*

However, some participants noted frustration that physicians sometimes give in to the pressure and do write a prescription.

> *"Yeah, it depends on the day, and the provider, and the kind of day that they're having, and the kind of month that they've had. Sometimes, you know, the providers won't give in because they'll say, 'This patient doesn't need it. We're gonna give them something else. It's still a strong pain medication. It's non-narcotic and they can take this,' and that's that. And some days, you get tired of arguing, and you don't want a scene. So, I mean, I hate to say it, but I think sometimes they just do it to make the patient happy."*

Patient Impact

Participants described how changes in opioid use and practices around opioids have impacted patients themselves. These discussions were categorized into the subthemes of **Patient Emotion, Medications, Referrals, and Treatment Facilities.**

Patient Emotion

Participants shared how they had seen patients react to changes in opioid-prescribing practices. They described patients as getting angry, frustrated, becoming combative, confused on what care they are receiving, and "working the system." This dissatisfaction can sometimes directly impact provider or facility satisfaction scores.

> *"It's created really a volatile environment and sometimes a dangerous environment in the Emergency Department, a lot of anger, a lot of hostility."*

> *"...and then at the same time then you've got the patient saying, 'Well, I thought, you know, you guys were supposed to control my pain, and you don't believe me that I'm in pain.' "*

> *"...let's say that somebody comes in and sees Dr. [name removed for confidentiality], and he refuses to give them a prescription for Percocet. I have heard them say that those are the type of people that'll go immediately when they get home to Health Grades, and give him a failing grade. And that is unfair to the professional, to the doctors who are trying to take care of them."*

Medications

General concerns about medications were discussed. Participants had varying concerns on how medications are handled by patients. For example, patients often hold onto medications for years even if it is expired. This poses a danger for stealing, selling, or mishandling. There were several conversations about the fear of patients selling their medications as opposed to taking them as prescribed.

> *"And you have people walking into other people's houses and going through their drug cabinets and that happens. It happens."*

"Yeah, yeah, scary thing is that it's in Grandma's cupboard, so when the experimental teenager who's in Grandma's house goes in the bathroom and sees this great big bottle, the risks are too great to have that kind of stuff sitting around."

"Street value of them don't help either. Think that, these pills that were given to him, either insurance or Medicaid's paying for them, and they get $3 a pill in the street. That's good income."

Referrals

Healthcare staff discussed how common practice in working with people with an opioid or other substance concern, is to refer for additional substance abuse treatment or mental health services. Patients have mixed feelings about such referrals. Sometimes they are open to them but most of the time they are not. Common concerns surrounding this topic were a major lack of services in both substance abuse and mental health treatment (see further discussion in this report). Participants described how this lack of resources is frustrating for patients and how it impacts patients.

"They do not get Naloxone kits. People who have self-harm behavior do get a referral to Behavioral Health Services [and] substance abuse, if they're interested in that–most of the times, they're not."

"…there'll be some patients who will say, 'Can you just keep me in the hospital?' And there's no medical need to keep them here, so we can't make something up to admit them to the hospital. But people are asking, 'Can I just stay here?'"

Sometimes the issues revolved around the barriers in transferring a patient to an appropriate treatment facility or treatment centers not being willing to admit certain patients.

"For law enforcement, can take someone to a facility for 72 hours, and then they have to be seen by the Board of Mental Health, and so all that is expensive, and the county doesn't wanna pay for it is my, what I've been told. It's a lot of money and time…On one occasion, we actually called state patrol, and the state patrol came down and said, 'Oh, yeah, obviously,' and made the things happen."

"[Facility name removed for confidentiality] does have a behavioral health unit…but they tend not to take or accept people where addictions, I don't mean this lightly, or a drug use or abuse is the only identified issue, although we all know that there probably are more. But it's more of an acute, short term, quell-the-fire kind of a unit. And for addiction-related issues…we hand them the usual and standard listing of AA meetings, and outpatient counselors, and it really is, honestly speaking, virtually worthless…It's the rare few that are really ready to be willing to cooperate and accept the services that we are willing to. And it would be different if we were able to transfer a patient immediately to an inpatient treatment facility. I think it would make a world of difference. But when they have to leave our facility, face the world that they are accustomed to, and all that triggers, and everything that is related to that, it just is not successful. It is a horrendous let down to them, and our society."

A few facilities discussed how they do have good resources or processes in place.

"We have what, 12 providers here in town? I mean there's a lot of us. So there's plenty of access to the educational piece and supports, but we've gotta get people to a place where they're not scared of the backlash from the stigma of seeking support."

"We're pretty lucky at [facility name removed for confidentiality], where we have Mental Health Emergency right next door to us and we work so well with them. So, if we have issues like this, I can just call over there and say, 'Hey, I've got a patient over here who has substance abuse, or is looking for treatment,' or this or that, and they'll come over, and they completely take care of all those resources…"

Treatment Facilities

The majority of participants said there is a dire need for more mental health and substance abuse treatment. This was true for both rural and metropolitan areas. Some participants acknowledged there are treatment facilities or providers in the area, but the availability is limited. Some discussed how inpatient mental health facilities were also lacking which directly impacted Emergency Departments.

"I think we know how to manage these patients, and we know how to take care of them in the acute moment…I think the problem is, is that there are few resources in terms of treatment facilities. I think, even just kind of knowing where we can refer these people to, to prevent that reoccurrence."

"We certainly don't have enough resources out in the community. When we have a… our psych patients that, a lot of them, I would say most of them, have drug problems too. There's just nowhere to transfer them to, that's appropriate, everybody's either full, or there's no place the would take them because they are violent or whatever the reason. So they can sit in the ER for 4 to 5 days. So to be cooped up in one room, that's not helping anybody. They're not getting any treatment in the ER. They're not seeing anybody, they're just… they're getting their meals and getting their meds, and that's it, it's not helping anyone."

Participants discussed how it could be difficult determining if a patient required mental health services or substance abuse treatment. This dilemma sometimes made the referral process even harder.

"Well and, as far as mental health stuff goes, I've… we've had it happen where I'm not kidding you, we've called 7 or 8 facilities for one, to try and get one patient transferred, because they were suicidal or they'd overdosed… I mean…[is it] the substance abuse problem or is it a mental health or, I mean, is it both, which perpetuates what? It's a vicious cycle."

"I can look in our ED right now, and we probably have 8 to 10 people. We have a quarter of our beds being held up by mental health patients that can't go anywhere. They're pouring in the ED for 24 or 48 hours, 2 or 3 days, we've had people up here over a week in a 9x9 room not getting any therapy because there's nowhere for them to go…mental health support is an absolute keystone you need in order to fix these other drug problems. Giving people Narcan kits is not fixing the problem. It just is giving somebody Narcan for a short term 'cause they'll go back and use again."

Participants shared their concerns about the impact of the lack of treatment options for patients and how that can cause patients to keep returning to the Emergency Department. Participants also speculated on other barriers patients might have.

"We can't even get people into treatment for alcohol, hospital-issued treatment. There's a void there. There's no bridge therapy available, and it creates that cycle in the emergency room where they're back, and they're back, and they're back."

"And there's not enough places for people to safely sober up in order to get into any treatment facility. So, people are trying to sober up at home, and I mean, we all understand that's not gonna happen because that's where they have their addiction problem. So, several times I've had to… We send people out saying, 'Good luck. We don't have any beds available anywhere. Everywhere's full.' And they feel defeated 'cause the system's now failed them in a way. And so, there is not enough resources out there for people who are genuinely trying to get help, get over this addiction they have, whatever it is, and they can't."

"And a lot of people just can't, you know, most of them want gobs of money, and so I meant that's our system that's broken...a lot of the people who have drug problems do not have health insurance. Therefore, they have no help available to them at all."

Responding to the Impact

Participants were directly asked what type of support, training, or resources they would like to see from Nebraska DHHS in regards to the opioid crisis. Participants offered feedback throughout the focus groups and interviews that alluded to recommendations. These recommendations were categorized as **Community Training, Provider Training, System Changes, and Resource Development.**

Community Training

Participants shared ideas on how the community would benefit from training on what opioids are, and when and how they are acceptable to use.

> *"You hear the 'Opioid, opioid, opioid,' but I think there's a lot of people out in the general population that don't have a clue what an opioid is… You don't realize that Norco they have is an opioid… Or you have the ones that are, have heard it and it been beat into their head, and they're so scared they don't wanna take anything, because I've heard that more from older people, mostly. They're like, 'I, no I don't want any of that, because I don't wanna be addicted to that.'"*

> *"Just teach these people, that we're not the enemy. We're not just not giving them their opioids because we wanna be mean, and, it kinda has to start at the ground zero again with patients knowing… I mean, sorry, 'It's not just us being mean, it's the way medicine is practicing now, it's not best practice to give you all of this narcotic medication.'"*

> *"And they think they're supposed to use them all. Now, if you could get them to use all their antibiotics, you would be happy, but not all of their narcotics. And sometimes they don't understand the 'as needed,' and it's best not to use them. Only use them when absolutely necessary. So, again, there's a lot of education and managing expectations that we need to continue to do as care providers."*

Participants also had a lot to say about the community's need for training on how to dispose of expired or unneeded medications. They also want more flexibility in how to assist people with disposing of medications.

> *"And for the public to clean out their cabinets. We did a waste disposal presentation here which wasn't very well-attended, but just getting the awareness out there for people to get rid of their unused prescription medicine, because a lot of it's being diverted, taken by grandkids, or teenagers… And they've got, like, Xanax in their cabinet for 10 years."*

"I don't think you should have to have a retail pharmacy license in order to be able to take back medications… But we've had so many people cross our threshold, that we cannot take their meds back."

"…That can be hardwired into every patient we send home. The full blue of 'Lock 'em up and then dispose of 'em. When you're done with this, when you're done, you need to go to this for disposal, okay?' And give 'em references, and we have planned dates, that is a drug collection day on this day and this day and this day of this year, and we do it the same day every year just so it's an annual thing… And we don't even have to pick dates anymore. I mean you can drop it off at the police station any day of the week."

Participants also expressed the need for training on opioids for children and youth both in schools and through parents.

"…It used to be, everybody was worried about, are they drinking and smoking. And now it's like, how many Loritab do you have in your coat pocket?... So it needs to start young too… There's more, actually it probably happens a lot in small towns, 'cuz they don't have as much stuff to do… 'Why not go through the medicine cabinet, see what happens?...'"

"And we need to educate 'em before they need the information… And we don't want to admit how young they need the information… At grade school… We need to start it in kindergarten… Basic stuff."

"…there are so many families that are not teaching life skills, and parents maybe already have those mental health issues, or abuse issues, or whatever, and they don't have a clue how to guide their children. They don't understand the importance of it, or what that means for them as adults, and I think that's just gonna perpetuate the issue long term for not just for us, but in general, for our country."

Provider Training

Participants discussed ways to improve education to providers including both physicians and nursing staff. Ideas varied but participants noted wanting up-to-date, consistent, and useful training.

"I would say, the physicians I work with are very motivated to not contribute to the opioid crisis…like they're actually hungry for something that they can do to help sort of reverse this."

"Sometimes I wonder too if the problem is that some of these patients for their chronic pain are seeing their primary provider. And their primary provider is probably managing it the way that's not best practice."

"I think there's a lot of opportunities there for education…so I'd say people have a lot of variability and practice, with regard to how many pills they prescribe at a time. I think some guidance, like what number of pills is appropriate would be very helpful for providers, or something along that line, like a duration of time or something would be helpful."

"We go to all these specific trainings for these specific situations, but we don't train for overdoses and we don't train for, and they don't happen that often. So then, like you get one maybe every 6 months on a night shift when it's just you and two other nurses here and that's it, which is usually what happens."

"And I think they need to teach more how to be… how do our providers be more empathetic, instead of being sympathetic."

"The programs and trainings for nurses, especially... You know, very new nurses, I think kind of over time you develop those skills, in terms of resiliency but it's very hard for the new nurses..."

Some participants discussed how it would be helpful if there were a more useful health information exchange system, similar to the PDMP but with more features and accessibility across state lines.

"It would be nice to have a health information exchange system that worked, I think it's a good idea… and some of the barriers they create are not specific for providers that access the system. I think that is a huge frustration, and I think it limits people from engaging because of that."

"Especially out here in the Panhandle… The other states don't do the non-scheduled medications I don't think but at least the controlled substances, it's nice to be able to see because you could do kind of a whole area in one fell swoop instead of having to log into each state's site."

"It would be nice if it could be integrated into, like our EMR."

System Changes

At various points in the focus groups and interviews, participants shared creative ideas for system changes such as adjusting the role of paramedics, increasing the number of primary care physicians (especially those who accept Medicaid), and attaching walk-in clinics to emergency departments.

"Some of the communities in the country are doing paramedic, the paramedics are going to people's homes, and they're doing the interventions, so they're not actually putting them in the ambulance and taking them to the ER.."

"…So we're trying to get access to primary care physicians, make it easier for these people to get to these. Problem is is that for Medicaid, it pays out so little that there's only a couple of providers that are willing to even accept Medicaid or it's such a small percentage that they will accept… If there was some way to incentivize to get more primary care physicians. And most people, when they go to med school, they don't go in it to want to be a primary care doctor. If there was some way to subsidize that, to get more primary care physicians out there and get them to help accept Medicaid, try to get people to go to the primary care physicians versus the ER where the medicine and the costs are so much more expensive… If there was even a copay that, it's free to go to your primary care doctor, but you pay $10 to come to the ER. Not some huge exorbitant fee, but anything as a deterrent to get them to not use the ER for these things where they really should be seeing a primary care physician I think would be good… I mean, even if there was…a whole separate walk-in clinic attached to the ER that people could come to… Maybe less acute…"

Some participants said they were frustrated with how pain became a key indicator for hospital ratings or doctor ratings. Participants voiced frustration on how this impacts how they provide care.

"Pain was one of those top things that was our quality indicators, so people more thoroughly addressed their pain when they left. So the government keeps that open, and it's frustrating."

"But I feel like a lot of providers feel like their hands have just been tied a little bit, and they haven't really been given alternatives to use instead, until, I think especially when we talk about acute pain, most people feel, if they're in emergency, these people, in pain for the most part. There are some people who it isn't, that there are narcotics they need. But for the most part, they still have some very little pain, and so what we're gonna do to identify that, and address that, instead of using the, you know… I know that the country in general, and I know we kind of adopted it here, is everybody, you know, asked, when I came here, and I continued on for years of practice, because that was the standard of practice. It was 'We don't want you to have any pain, no pain. We want you to have zero pain.' Well the culture now is that we have to train the people that if you come in for surgery, you can't expect to not have pain. 'You're going to have pain. We want to manage your pain, but we can't totally take your pain totally away…' And that was probably one of the worst things that they could do for patients, have staff thinking that one of our quality indicators was our pain controls. And so I think that that measure of our own encouraged people to increase their use of pain medication, because it was directly correlated to our reimbursement, how we are as a hospital."

Resource Development

Participants often stated they wished they had a comprehensive list of resources, including mental health and substance abuse treatment options, and resources from other neighboring states. Other participants discussed how they wished they had better treatment alternatives for pain to offer patients besides using an opioid.

> *"I would like the DHHS to at least query the providers here, the mental health counselors and providers, to determine their willingness, and if they have had special training to deal with opioid-abusing clientele, and provide us with a list of folks, willing and able and trained to work with us."*

> *"I think also, just better treatment alternatives too. People who have pain… Yeah, I think that would be one thing to talk about resources for us, and training for us, that would be a good thing for us to know. Things that we can refer them to or us learning new things to teach them to do at home. To try to deal with their pain in other ways. I think that's more of the key to controlling, especially chronic pain, is getting to like the, out of the western medicine."*

> *"Give 'em the good coping strategies early, they may not reach into the cabinet."*

> *"…So there isn't a lot of good education on what to do for them instead…just to kind of replace the opioid in the first category, I'll preface it with alternatives. What are we gonna use instead, because this person is experiencing real pain, and I can't just take away the opioids and not replace it with something…"*

Healthcare: Qualitative–Summary

Facility Impact

- **Number of Overdoses:** Participant responses varied significantly on the rate of overdoses in general, and opioid overdoses more specifically. Staff were sometimes more concerned about methamphetamine, K2, and fentanyl.
- **Small Community:** Healthcare staff in small communities often know patients which can be both negative and positive, especially in regards to assessment.
- **Policies and Procedures:** Most facilities stated they did not have a specific policy for an opioid overdose but had more general policies for overdose situations.
- **Naloxone:** Most facilities stated they had ample supply of naloxone. They felt confident in knowing how and when to administer naloxone, but were a little uncertain on the appropriate dosage. Some participants feared that patients may abuse naloxone in an overdose situation, and some didn't think that many people in the community know about the standing order for naloxone.

Staffing Impact

- **Burnout:** Some participants felt an elevated level of stress or burnout in response to their work.
- **Self-Care:** Most participants expressed how coworkers provided them with support. Other self-care practices included EAP sessions, yoga classes, debriefing sessions, allowing time off from work, and in-house trainings. Some participants acknowledged that burnout progresses and can affect their work.
- **Prescription Drug Monitoring Program (PDMP):** While the majority of respondents had used PDMP and found it to be very helpful, others were not familiar with PDMP or did not have access to it. Participants discussed issues related to PDMP having limited connection to other states or systems, being time consuming, not including directions on how a patient is prescribed to take the medication, not being user-friendly, and not interfacing with current electronic medical records systems.
- **Prescribing Practices:** Participants frequently said that physicians are prescribing less pain medications, narcotics, and opioids compared to several years ago. They also expressed uncertainty in knowing when patients really need strong pain medications, and some inconsistency in when physicians prescribe them.

Healthcare: Qualitative–Summary

Patient Impact

- **Patient Emotion:** Participants shared how they had seen patients react emotionally to changes in opioid-prescribing practices, including dissatisfaction with healthcare services and specific physicians.
- **Medications:** Participants expressed the fear of patients holding onto expired medications which make them susceptible to further abuse.
- **Referrals:** Healthcare staff wish to refer patients for substance abuse treatment or mental health services, but often services are not available or patients do not accept a referral. Also, appropriate treatment centers may not be willing to admit certain patients. In contrast, a few facilities discussed how they have good resources and referral processes in place.
- **Treatment Facilities:** The majority of participants in both rural and metropolitan areas said there is a dire need for more mental health and substance abuse treatment. They also spoke of not knowing whether to refer someone for mental health or substance abuse treatment, and the centers bouncing them back and forth. When patients do not get the treatment they need, they frequently return to the emergency department.

Responding to the Impact

- **Community Training:** Participants shared ideas on how the community would benefit from training on what opioids are, and when and how they are acceptable to use. They also had a lot to say about the community's need for training on how to dispose of expired or unneeded medications. Participants also expressed the need for training on opioids for youth both in schools and through parents.
- **Provider Training:** Participants discussed ways to improve up-to-date, consistent, and useful education to physicians and nurses. Some participants discussed how it would be helpful if there were a more useful health information exchange system, similar to the PDMP but with more features and across state lines.
- **System Changes:** Participants shared creative ideas for system changes such as adjusting the role of paramedics, increasing the number of primary care physicians (especially those who accept Medicaid), and attaching walk-in clinics to emergency departments. Some said they were frustrated with how pain became a key indicator for hospital or doctor ratings.
- **Resource Development:** Participants stated they wished they had a comprehensive list of resources, including mental health and substance abuse treatment options, and resources from other neighboring states. Other participants discussed how they wished they had treatment alternatives to offer patients besides using an opioid to manage chronic pain.

Healthcare: Qualitative–Limitations

As with all qualitative research efforts, STEPs did encounter limitations. The research team made valid efforts to reduce limitations that could impact conclusions and results. It is important to note the potential limitations to provide richer context to the research. The limitations are listed as follows:

1. Members of the STEPs team contacted hospital administrators directly to invite participation in focus groups or interviews. The STEPs team was most likely an unknown contact and response rate could have been negatively impacted by this factor.
2. Many hospital contacts were hesitant to participate in a focus group because it would require staff to be off the floor and/or staff would need to participate on unpaid time. This was expressed through email conversations between the researchers and hospital staff when trying to coordinate a focus group.
3. The overall project was on a limited timeline and coordinating numerous focus groups and interviews within several weeks was difficult.
4. The risk of bias is involved in all qualitative research. STEPs utilized two coders to limit bias. The coders utilized writing memos to capture ideas, thoughts, and definitions. The coders worked with all researchers using a team approach.
5. Due to a short timeline, geographic distance, and a particularly hard winter, STEPs engaged with the Panhandle Public Health District (PPHD) to conduct three focus groups in the western portion of the state. STEPs prepared the consent and script, and spent time training PPHD facilitators. Collaborating with the PPHD limited the amount of control in conducting focus groups.
6. A mix of both focus groups and interviews may have hindered the amount of in-depth conversations or the quality of discussion.
7. There were no focus groups or interviews conducted with participants from Regions 2 and 3.

Healthcare: Qualitative–Recommendations

In summary of all qualitative analyses of the healthcare professionals' responses, STEPs recommends DHHS:

1. Continue efforts to increase the number of and access to behavioral health and substance abuse treatment facilities.
2. Create comprehensive lists of resources including both mental health and substance abuse treatment. This list may need to include surrounding states' resources depending on the location.
3. Provide education to the general public regarding best practices for opioid use, pain management, and proper medication disposal.
4. Provide prevention and awareness education to youth, as young as elementary or middle school.
5. Increase access to PDMP.
6. Eliminate interface and login barriers to PDMP.
7. If possible, include other states' information into the PDMP.
8. Provide consistent education opportunities to healthcare staff on pain management and appropriate naloxone dosages.
9. Encourage in-house burnout training or encourage practice of peer support.
10. Review policies and procedures with hospitals to include specifics on how to handle opioid overdose situations, possibly providing templates or examples of policies.
11. Develop a list of better treatment alternatives to pain management.
12. Revisit the need for pain to be a quality indicator in hospital ratings or physician satisfaction.
13. Provide public or community education on how to appropriately dispose of unwanted or expired medications, possibly allowing healthcare facilities more capability in receiving these medications.

Drug Overdose Prevention Needs Assessment

EMS and Firefighters

Surveys

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES
DRUG OVERDOSE PREVENTION

UNIVERSITY OF NEBRASKA AT OMAHA
SUPPORT AND TRAINING FOR THE EVALUATION OF PROGRAMS

Survey Demographics

Between January 30 and March 27, 2019, 247 firefighters and EMTs participated in a statewide online survey. Responses were received from all six regions, with the majority of responses from Region 6. Ages of participants ranged from 18 to over 64 years with the majority (30%) in the 45-54 year old bracket. 80% of respondents had more than 10 years of experience.

247
Total Responses

The survey was started by 311 individuals, but only 247 respondents completed both the demographic questions and at least one other item. Therefore, survey results are based on the 247 completed surveys. The demographics of the other 64 participants can be found in Appendix G.

Profession (n=236)

More participants identified as EMTs than firefighters. Nearly 30% of participants (n=72) indicated they serve in both firefighter and EMT roles.

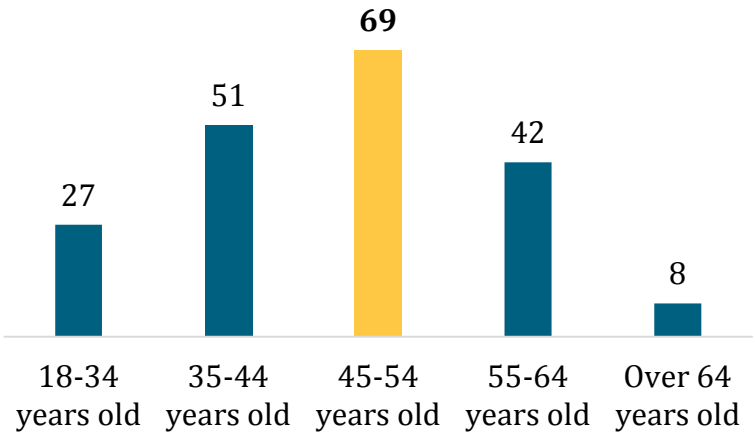
115 EMTs

49 Firefighters

72 Both Firefighters and EMTs

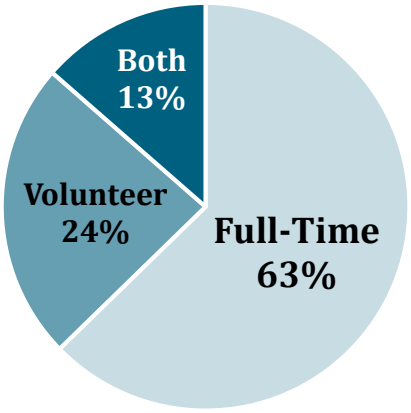
Age (n=197)

The majority of respondents were in the 35-64 age range. Few participants (n=8) were over 64 years old, which may be related to retirement or comfortability accessing the online survey.



Capacity (n=236)

The majority of participants were full-time first responders (n=148). Some participants (n=32, 13%) served in both a full-time and volunteer capacity.



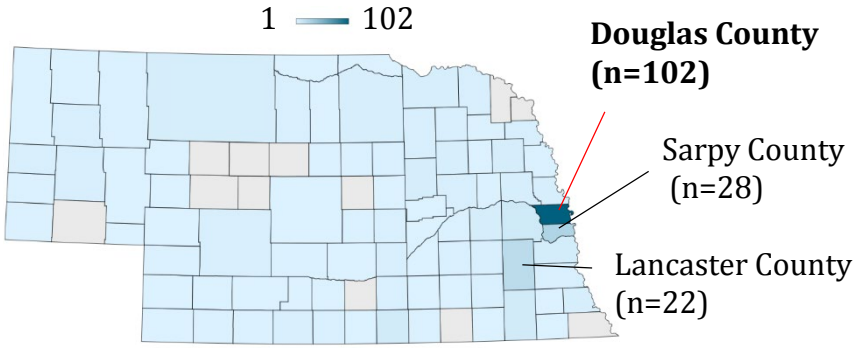
Experience (n=247)
The majority of participants had been a first responder for over 10 years (n=197). This includes 53 participants who had served for over 26 years.

Gender (n=198)
The majority of participants (74%) identified as male (n=146).

Service Area by County and Region (n=247)

The majority of responses were received from Douglas county (n=102), Sarpy county (n=28), and Lancaster county (n=22). There were less than five respondents for 66 of the counties. Counties in gray indicate areas in which no survey responses were received (n=13). 158 of responses were from high-burden counties for drug overdoses. The six high-burden counties with no survey respondents included Cheyenne, Hooker, Logan, McPherson, Richardson, and Thomas Counties. Many respondents listed more than one service county, which is why the Region 6 is listed as only having 109 respondents, while Douglas and Sarpy County had a combined total of 130. Region 6 had significantly more respondents than any other region (n=109), while Region 2 had the lowest response rate with only 10 respondents.

At least 1 first responder from 80 Nebraska counties responded to the survey, with Region 6 having a higher response rate than any other region.

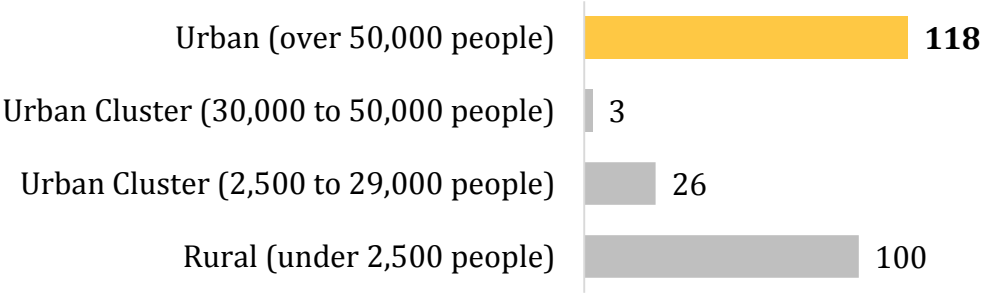


Participants by Region	
Region 1	15
Region 2	10
Region 3	28
Region 4	38
Region 5	47
Region 6	109

Service Area by Population (n=247)

Consistent with the county map above, more participants indicated serving an urban area than a rural area. In Nebraska, urban areas with over 50,000 residents include Omaha, Lincoln, Bellevue, and Grand Island. With the exception of Grand Island, these cities lie in counties with particularly high response rates. Those who indicated serving a rural area were dispersed throughout the state.

Slightly more participants served in an urban area with over 50,000 residents compared to a rural area with under 2,500 people.

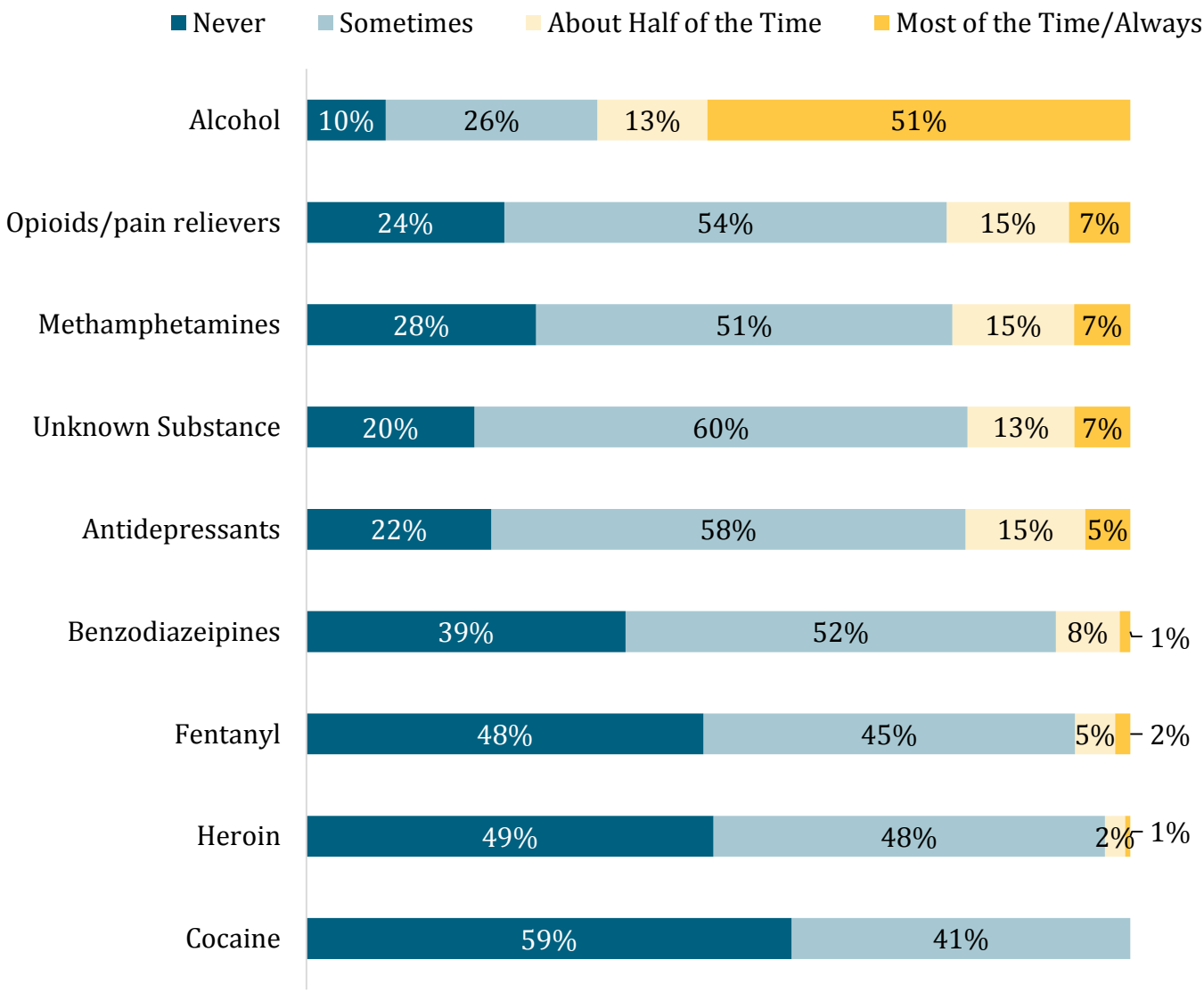


General Drug Overdoses (n=196)

Please indicate how frequently you suspect each of the substances listed below were involved in overdoses you responded to in the past 12 months.

Respondents identified alcohol, opioids, and methamphetamines as being most frequently involved in overdose calls. In contrast, heroin and cocaine were the least frequently overdose-involved substances. Over half of respondents identified cocaine as being "never" involved in overdose calls.

Alcohol was identified as being involved in overdose calls more than any other drug.



Due to small percentages, "Most of the Time" and "Always" were combined in the graph above.

General Drug Overdoses (n=206)

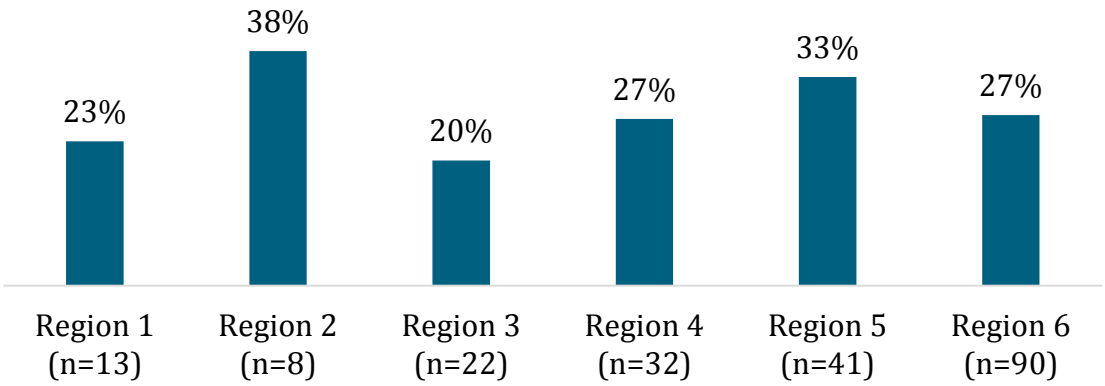
Please indicate how frequently you suspect each of the substances listed below were involved in overdoses you responded to in the past 12 months.

In order to look at regional opioid-overdose differences, the percentages of respondents who identified opioids as being involved in overdose calls at least half the time are displayed below. "About Half the Time," "Most of the Time," and "Always" were combined due to the low number of responses for "Most of the Time" and "Always" in Regions 1, 2, and 3.

Fentanyl was the only drug identified by at least 1 respondent in all regions as being involved "Most of the Time" or "Always" in overdose calls. At least two respondents from Regions 3, 4, 5, and 6 identified **methamphetamines** as being involved "Most of the Time" or "Always" in overdoses. Only Region 6 respondents identified opioids as being more often involved in overdoses than methamphetamines or fentanyl.

Percentage of Respondents Who Reported Overdose Calls Involving Opioids At Least Half the Time

Region 2 respondents most frequently indicated opioids being involved in overdose calls at least half the time.



"I would like to know what Nebraska's issues are in regard to this problem … and what we need to do for the fentanyl exposures that seem to be increasing."
- Thurston County

Participants rated this item on a six-point Likert scale from "Strongly Disagree" to "Strongly Agree." "Slightly Agree," "Agree," and "Strongly Agree" were combined to show only the percentage of respondents who agreed with the statement.

General Drug Overdoses (n=202)

A. Think back to the calls you were responding to two (2) years ago. On average per month, how many of these calls involved responding to a drug overdose?

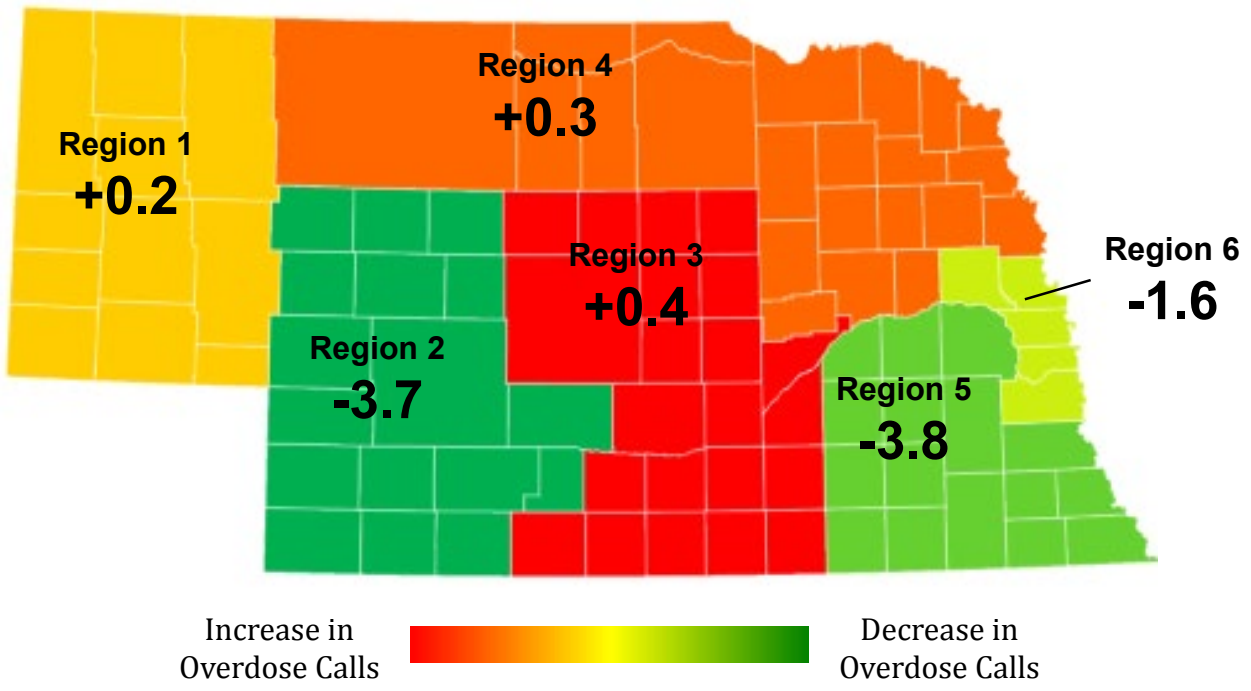
B. Think back to the calls you've responded to in the most recent six (6) months. On average per month, how many calls involved responding to a drug overdose?

Region 5 first responders, closely followed by Region 2, reported the most improvement (decrease) in drug overdose calls when comparing 2 years ago to the past 6 months. In contrast, Region 3 participants reported an average 0.4 call increase in drug overdose calls per month. Region 1 and Region 4 also reported a slight increase in drug overdose calls.

It is important to note that these numbers are reported based on perceived number of drug-related calls, which may differ from the actual calls received. The regional perceived rate of change was calculated using the average number of drug overdose calls reported 2 years ago and in the past 6 months.

Region	Rate of Change
Region 1	+ 0.2
Region 2	- 3.7
Region 3	+ 0.4
Region 4	+ 0.3
Region 5	- 3.8
Region 6	- 1.6

Region 5 reported the most improvement in perceived drug overdose-related calls in the past 6 months compared to 2 years ago.



General Drug Overdoses (n=202)

A. Of these overdoses you were responding to two years ago, approximately what percentage (%) do you suspect involved opioids?

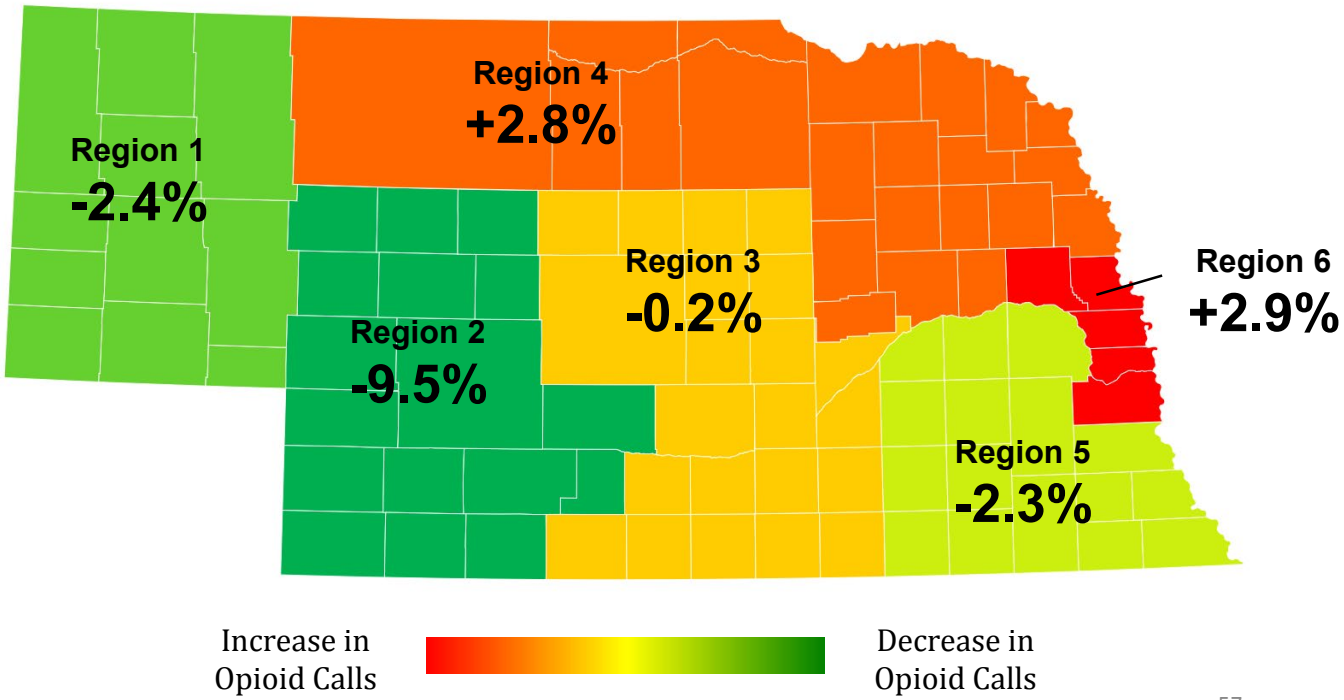
B. Of these overdoses you were responding to 6 months ago, approximately what percentage (%) do you suspect involved opioids?

Region 2 first responders reported the largest average decrease in opioid-involved calls. Participants in Region 6 indicated an overall increase of 2.9% in opioid-related calls. There was a corresponding increase in Region 4 with a 2.8% increase. Respondents in the other four service areas indicated a decrease in the number of opioid related calls in the past 6 months, with the major decrease occurring in Region 2.

The regional perceived rate of change was calculated using the average percentage of opioid-involved calls reported 2 years and in the past 6 months. It is important to note that these numbers are reported based on perceived percentage of opioid-related calls, which may differ from the actual calls received.

Region	Rate of Change
Region 1	- 2.4%
Region 2	- 9.5%
Region 3	- 0.2%
Region 4	+ 2.8%
Region 5	- 2.3%
Region 6	+ 2.9%

Region 2 reported the most improvement in the perceived percentage of opioid-involved calls in the past 6 months compared to 2 years ago.



Naloxone Administration (n=172)

Within the past 12 months, approximately how many times have you (you individually, not your department) administered naloxone?

Only EMTs or those who are both firefighters and EMTs were included in this analysis due to policies preventing firefighters from administering naloxone when an EMT or paramedic is present. **Regions 2, 3, and 4 participants reported rarely administering naloxone in the past year. Region 6 had double the EMT respondents as Region 5, but nearly five times the naloxone administrations over the past year.**

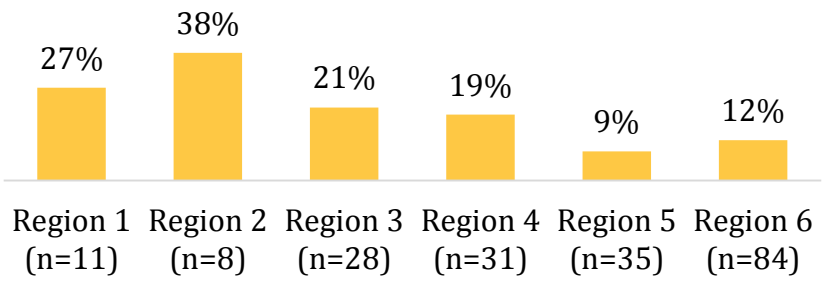
Number of Naloxone Administrations in the Past Year (EMTs only)

Region 6 EMTs reported administering naloxone most often in the past year.

Region	0 times	1-3 times	4-6 times	7-10 times	11-15 times	16-20 times	21-25 times	Total Naloxone Administrations
Region 1 (n=12)	10	1	0	0	1	0	0	14
Region 2 (n=6)	6	0	0	0	0	0	0	0
Region 3 (n=21)	20	1	0	0	0	0	0	2
Region 4 (n=31)	28	3	0	0	0	0	0	6
Region 5 (n=33)	18	7	5	2	1	0	0	70
Region 6 (n=69)	18	15	17	9	7	2	1	349

When taking into account both firefighters and EMTs, Region 2 respondents most frequently agreed they were hesitant to administer naloxone due to fear of legal repercussions. This may be correlated to no Region 2 respondents, including firefighters and EMTs, administering naloxone in the past year.

Percentage of Respondents with Fear of Administering Naloxone due to Fear of Legal Repercussions



Participants rated this item on a six-point Likert scale from “Strongly Disagree” to “Strongly Agree.” “Slightly Agree,” "Agree," and “Strongly Agree“ were combined to show only the percentage of respondents who agreed with the statement.

Naloxone Administration

In the past 12 months, approximately how many times did you administer naloxone to the same person on separate calls?

Only EMTs or those who are both firefighters and EMTs were included in this analysis due to policies preventing firefighters from administering naloxone when an EMT or paramedic is present. Regions 1, 2, 3, and 4 participants reported rarely administering naloxone to the same person on separate calls in the past year. Region 5 and Region 6 respondents reported administering naloxone to the same person at approximately the same rate in the past year.

Number of Naloxone Administrations to the Same Person on Separate Calls (EMTs only)

Region 5 and Region 6 EMTs averaged approximately the same number of repeated naloxone administrations in the past year.

Region	0 times	1 time	2 times	3 times	Total Repeated Naloxone Administrations
Region 1 (n=9)	8	0	0	1	**3**
Region 2 (n=6)	6	0	0	0	**0**
Region 3 (n=16)	16	0	0	0	**0**
Region 4 (n=26)	24	1	1	0	**3**
Region 5 (n=27)	23	2	1	1	**7**
Region 6 (n=49)	39	5	4	1	**16**

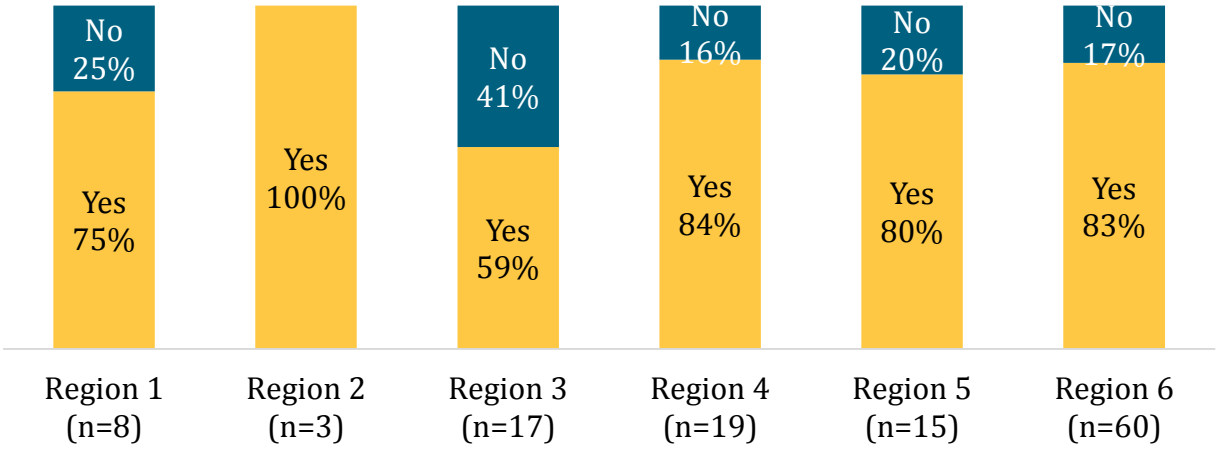
"If we had a surge in opioid use we would need to have more naloxone kits. We also wouldn't have enough staff if we had a surge in calls."
- Nemaha County

Naloxone Administration

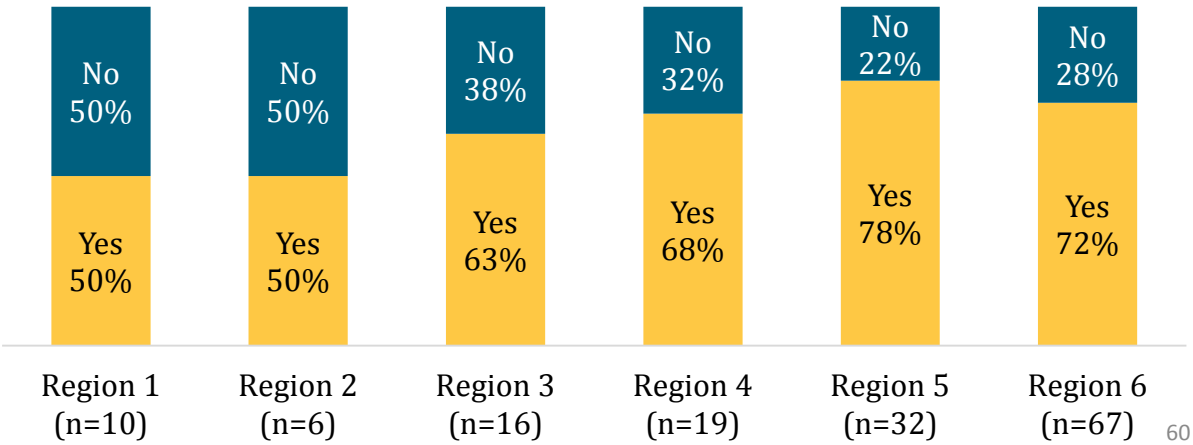
This next section is about the training you've received.

The majority of Regions 4, 5, and 6 respondents were both trained to recognize the symptoms of an opioid overdose and to administer naloxone. Except for Region 3, respondents from all regions were more likely to have been trained to recognize the symptoms of an opioid overdose than they were to have been trained to administer naloxone. While Region 1 and 2's low response rate must be taken into account, only half of respondents reported being trained to administer naloxone.

Trained to Recognize Opioid Overdose Symptoms (n=122)
Region 3 respondents were the least trained to recognize opioid overdose symptoms.



Trained to Administer Naloxone (n=150)
Region 5 and Region 6 respondents were most often trained to administer naloxone.

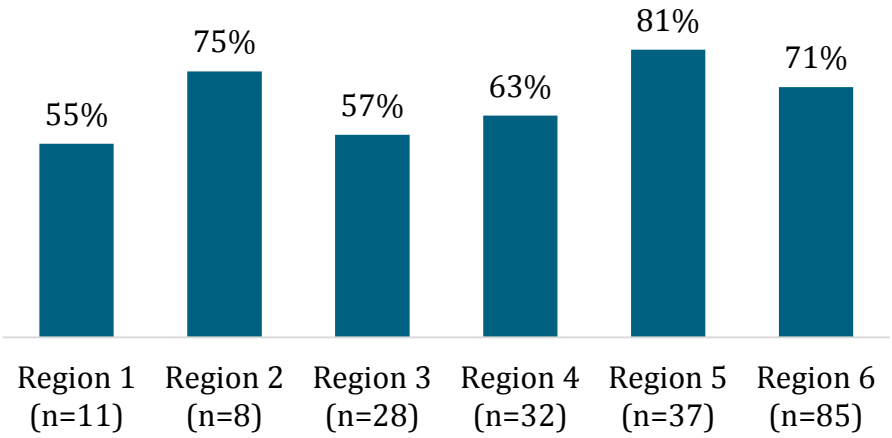


Naloxone Administration

Please indicate your level of agreement with the following statements regarding naloxone use and availability.

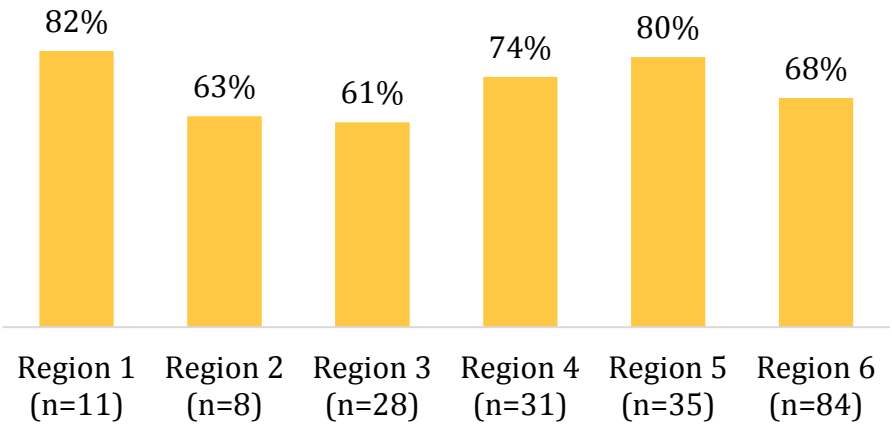
Except for Region 5, a higher percentage of participants in each region indicated being trained in recognizing opioid overdose symptoms than the percentage of participants who felt they had received sufficient opioid use training. Region 1 participants indicated the least agreement they had received sufficient opioid use training.

Percentage of Respondents Who Felt They Had Received Sufficient Opioid Use Training (n=201)



The majority of respondents in each region felt they had sufficient naloxone administration training. Except for Region 3, these percentages are slightly higher in each region than the percentage of respondents who indicated being trained in naloxone.

Percentage of Respondents Who Felt They Had Received Sufficient Naloxone Administration Training (n=197)



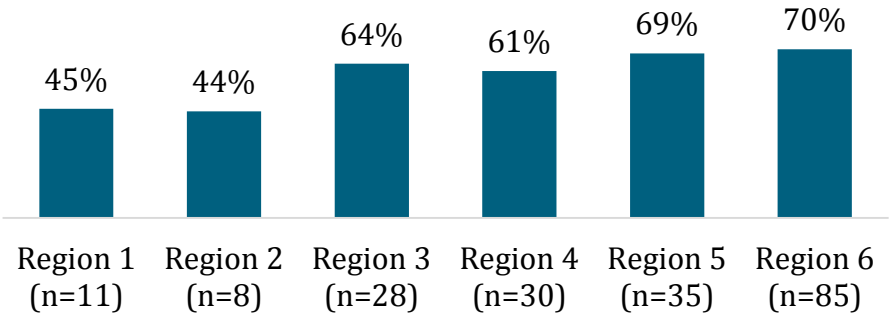
Participants rated these items on a six-point Likert scale from “Strongly Disagree” to “Strongly Agree.” “Slightly Agree," "Agree," and “Strongly Agree“ were combined to show only the percentage of respondents who agreed with the statement.

First Responder Resources

Please indicate your level of agreement with the following statements regarding first responder resources.

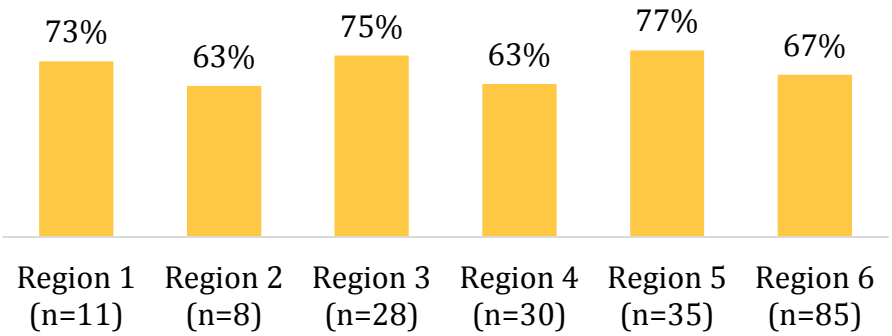
Regions 5 and 6 participants had the highest rate of agreement that their department had sufficient resources. Less than half of respondents from Region 1 and 2 felt their department was well-equipped.

Percentage of Respondents Who Felt They Had Sufficient Opioid Response Resources (n=197)



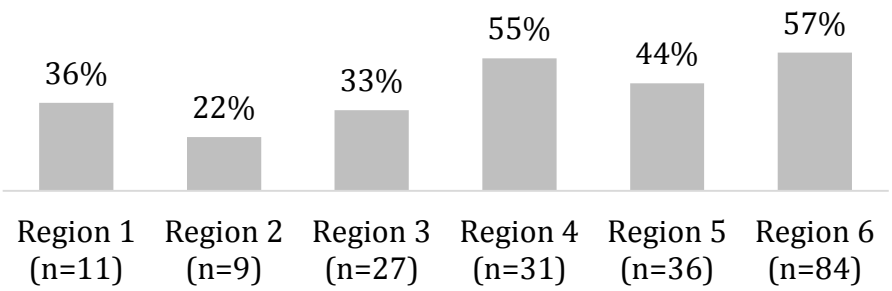
The majority of all regions' participants agreed they had appropriate protective gear. A higher percentage of Regions 1, 3, and 5 participants felt their department had sufficient protective gear.

Percentage of Respondents Who Felt They Had Appropriate Protective Gear (n=197)



Just over half of Regions 4 and 6 participants claimed their emergency vehicles had at least four doses of naloxone. In contrast, only two of the nine Region 2 participants agreed their vehicles had sufficient naloxone.

Percentage of Respondents Whose Emergency Vehicles Had Four or More Doses of Naloxone (n=198)



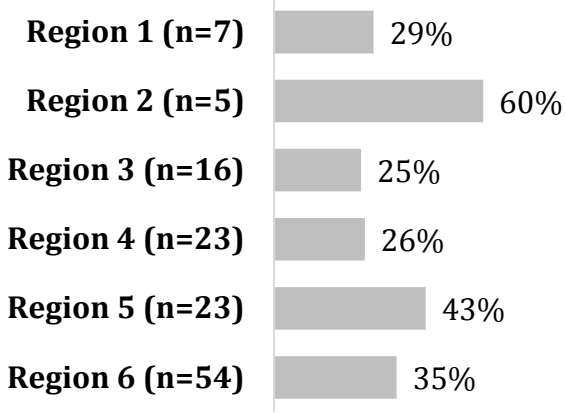
Participants rated these items on a six-point Likert scale from "Strongly Disagree" to "Strongly Agree." "Slightly Agree," "Agree," and "Strongly Agree" were combined to show only the percentage of respondents who agreed with the statement.

First Responder Resources (n=128)

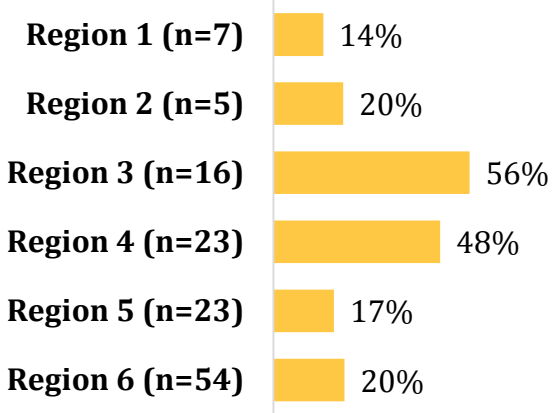
What resources does your department need to better prepare you for a surge in opioid use?

A need for more resources, such as naloxone, response vehicles, and funding, was the most common departmental needs mentioned. The majority of Region 2 respondents identified a need for additional resources. Training was the second most common identified need, particularly in Regions 3 and 4. Approximately one in four respondents, and the majority of respondents in Region 1, identified no additional needs.

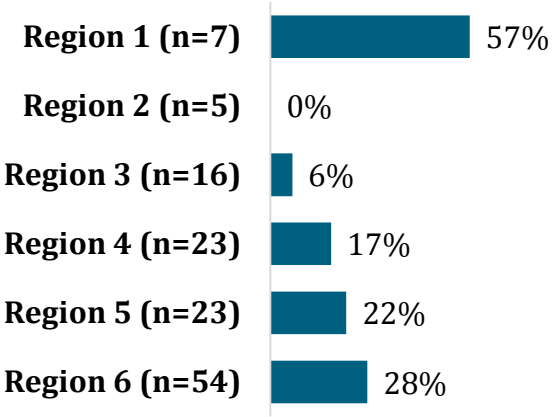
Resources (e.g. Naloxone, Response Vehicles, Supplies, and Funding)



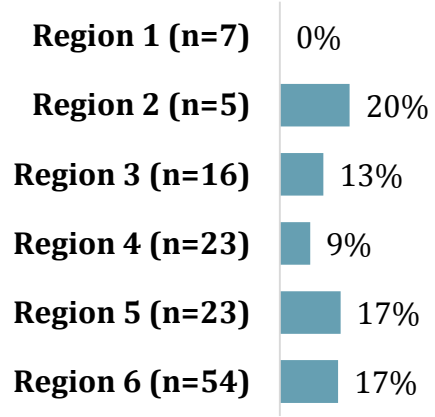
Training



No Resources Needed



Staff Support (e.g. Scene Safety, Community Outreach, More Staff)



"We are very well prepared as a department for the opioid problems."
"Narcan prices are high for EMS agencies so we have limited supplies."
"Convey to the members that fire administration will be supportive when we have to use self-defense as a mechanism to protect ourselves and fellow crew members."
- Douglas and Sarpy counties

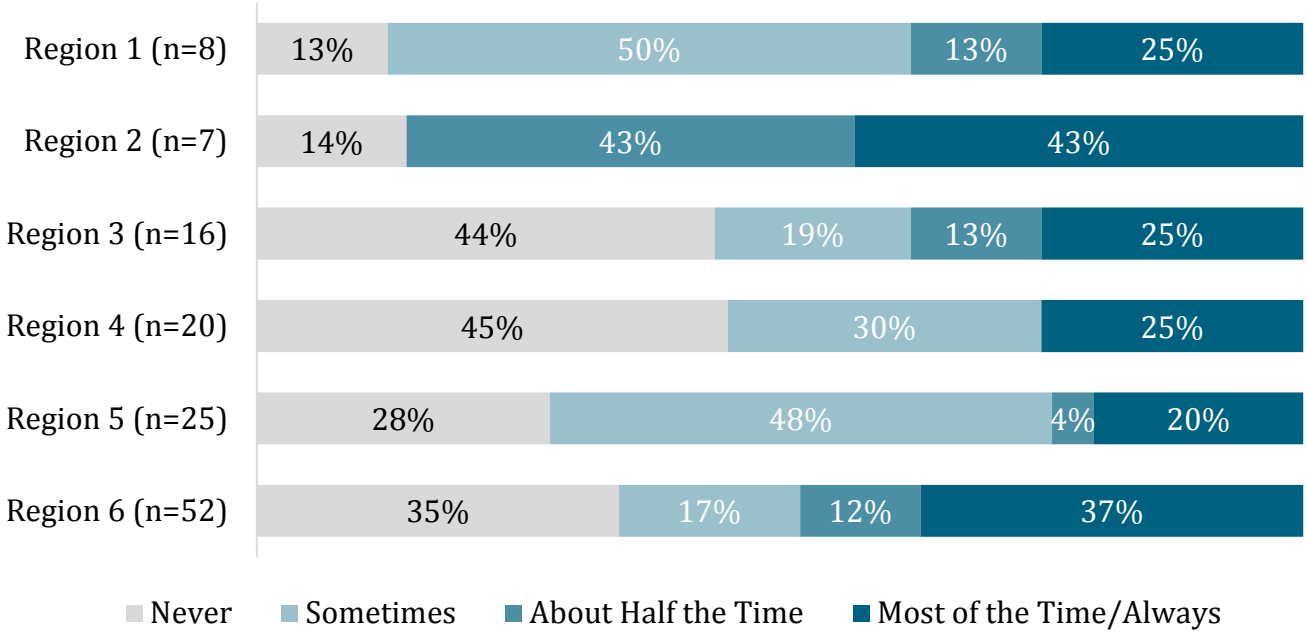
First Responder Resources (n=128)

We are interested in knowing about resources and information that are provided to the person who overdosed and their families and friends.

Regions' 2 and 6 responders most frequently provided information to the individual or their families regarding treatment options on overdose calls. Regions 3 and 4 rarely provided information regarding treatment options.

"Most of the Time" and "Always" were combined due to the low number of responses in Regions 1 and 2.

Information Regarding Treatment Options Provided to the Individual or Their Families



"I relate overdose to suicide attempts so knowing how much to counsel them bothers me. And with being a border state, it's hard to get them to the proper place for help."

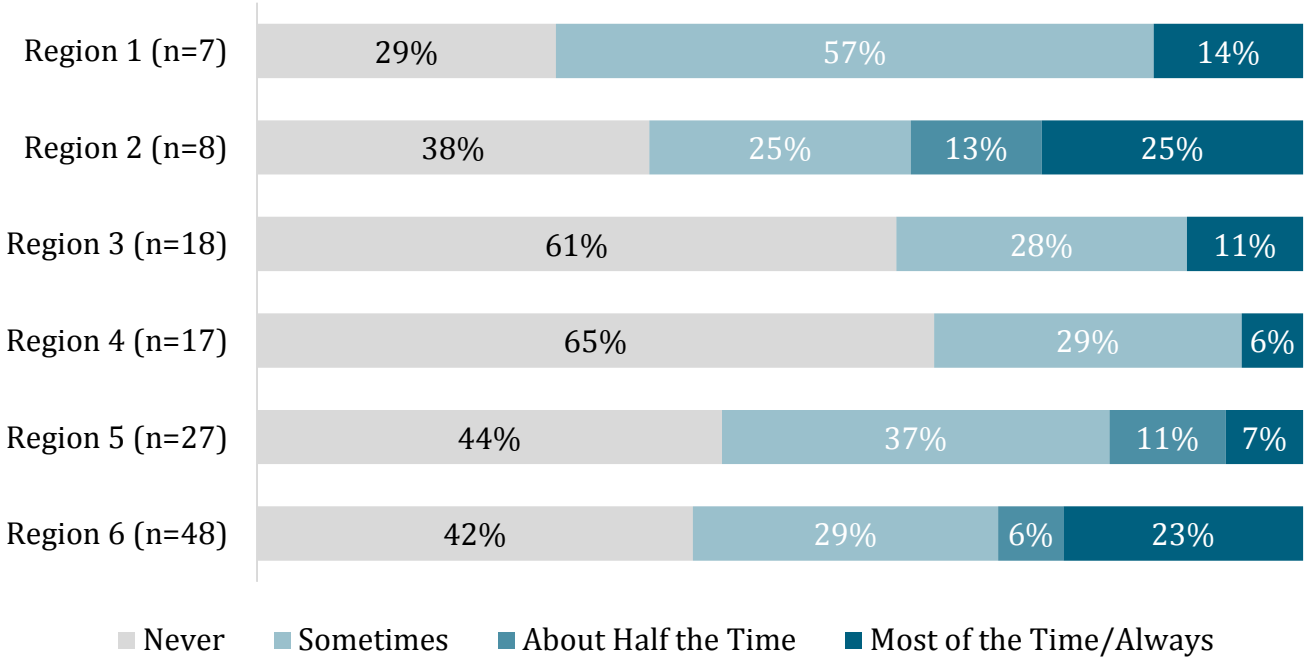
- Cedar, Knox county

First Responder Resources (n=125)

We are interested in knowing about resources and information that are provided to the person who overdosed and their families and friends.

The majority of respondents from Regions 3 and 4 said they "never" share information regarding community support groups with the individual or their family on the scene of an overdose. Approximately one in four respondents from Regions 2 and 6 provide community support group information "Most of the Time" or "Always." Region 4 respondents were most frequently reported "never" providing information around community support groups or information regarding treatment options.

Information Regarding Support Groups Provided to the Individual or Their Families



"I'd like to see more information about recovery tools when we encounter an overdosed individual."
- Douglas, Sarpy, and Saunders counties

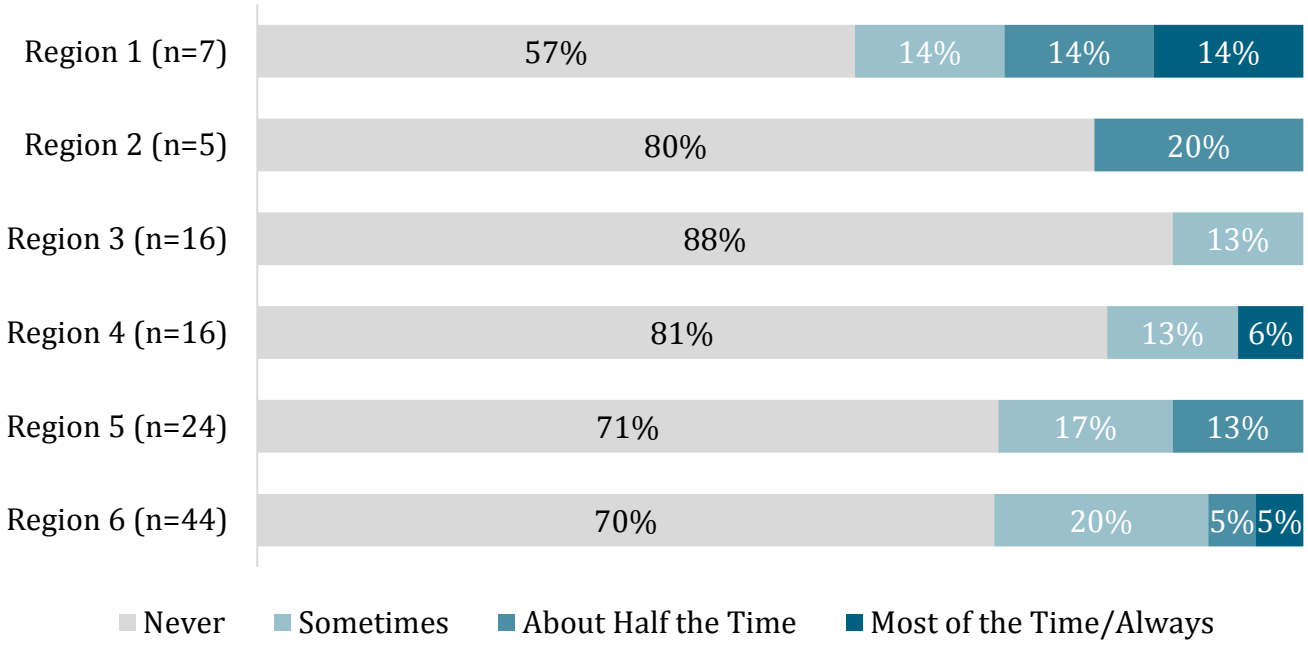
"Most of the Time" and "Always" were combined due to the low number of responses in Regions 1 and 2.

First Responder Resources (n=112)

We are interested in knowing about resources and information that are provided to the person who overdosed and their families and friends.

The majority of all regions' respondents reported they have "never" provided take-home naloxone kits to the individual or their families. This may be related to first responder departments lacking sufficient naloxone access themselves, as was mentioned by respondents in the open-ended question about their departmental needs. Furthermore, some respondents in both the open-ended survey items and the qualitative focus groups expressed disagreement that naloxone should be publicly available due to the risk of misuse or prolonging a necessary call to emergency services. At least one respondent from Regions 1, 4, and 6 reported providing naloxone kits to the individual or their families "Most of the Time" or "Always."

Naloxone Kits Provided to the Individual or Their Families



"It just seems incredibly wrong to send home Narcan with these families or patients without excessive training..."
- Adams, Clay, Nuckolls, and Webster counties

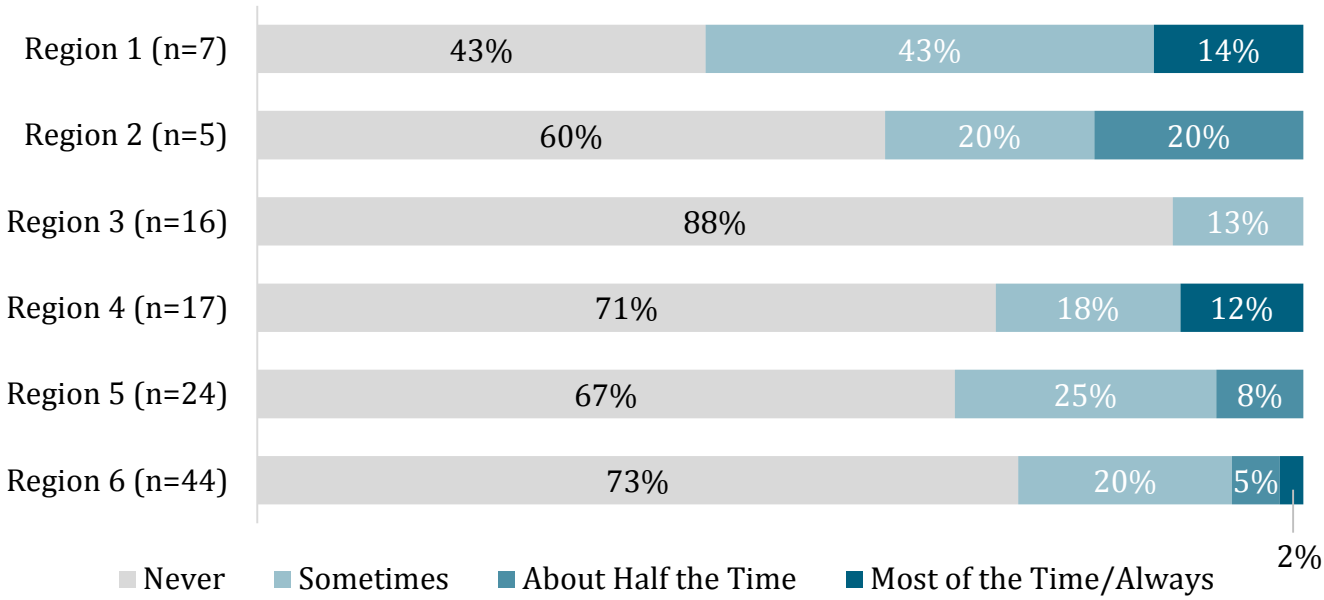
"Most of the Time" and "Always" were combined due to the low number of responses in Regions 1 and 2.

First Responder Resources (n=113)

We are interested in knowing about resources and information that are provided to the person who overdosed and their families and friends.

No region consistently provided information regarding the standing order for naloxone to the individual or their families. Region 1 respondents were the most likely to provide information regarding public naloxone access to the individual or their families. Regions 1, 2, 4, and 5 respondents were more likely to provide information regarding public access to naloxone than they were to provide naloxone kits. Regions 3 and 6 respondents were the least likely to provide information regarding the standing order for naloxone.

Information on Public Naloxone Access Provided to the Individual or Their Families



"More has to be done to educate people on the long turn problems of drug use. Giving Narcan to everyone gives the false sense that this "miracle" drug will save everyone."
- Douglas and Sarpy counties

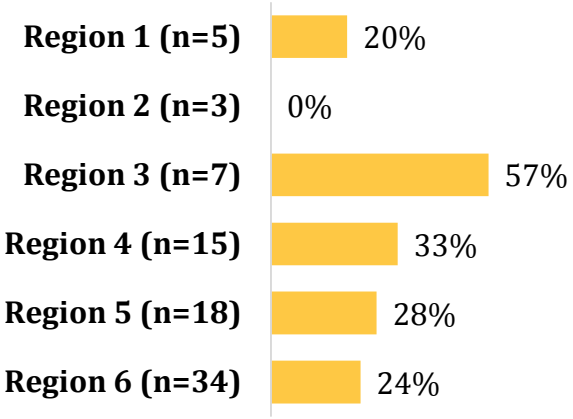
"Most of the Time" and "Always" were combined due to the low number of responses in Regions 1 and 2.

First Responder Resources (n=82)

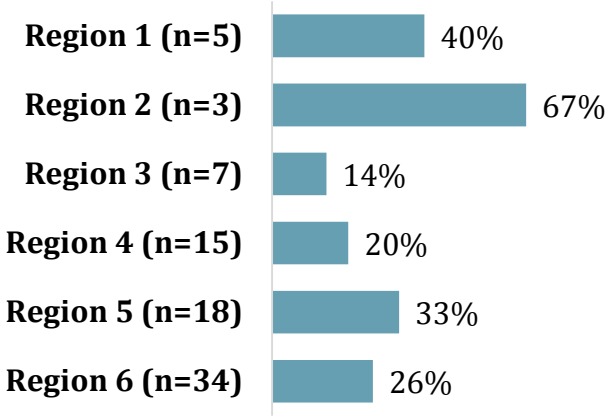
What else would you like to say in regards to the capacity of first responders across Nebraska in responding to a surge in overdoses?

A need for more training, for both community members and first responders, was the most common need mentioned. First responder support and community support were also identified as the primary themes of this item. Regions 4, 5, and 6 respondents were relatively split between all four themes. While keeping in mind their low response rate, Regions 1 and 2 respondents most often identified a need for additional first responder support.

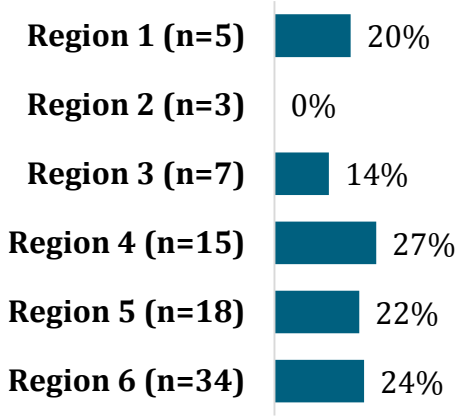
Training (e.g. First Responder and Community Training)



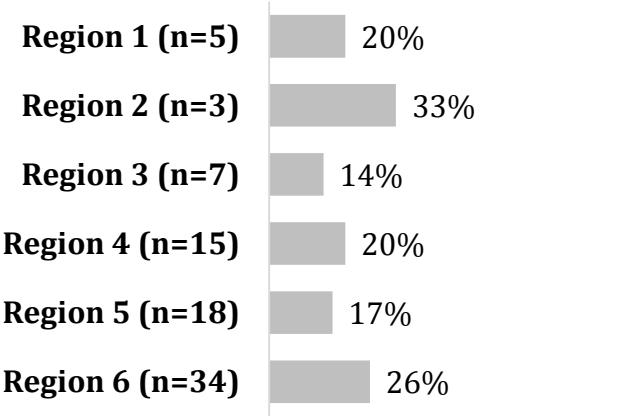
First Responder Support (e.g. Staff, Funding, Safety, Mental Health)



None



Community Support (e.g. Treatment and Prevention Efforts)

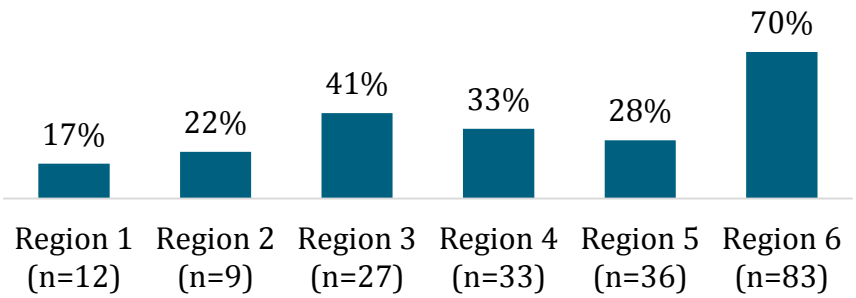


Community Resources

Please indicate your level of agreement with the following statements regarding substance use in your community.

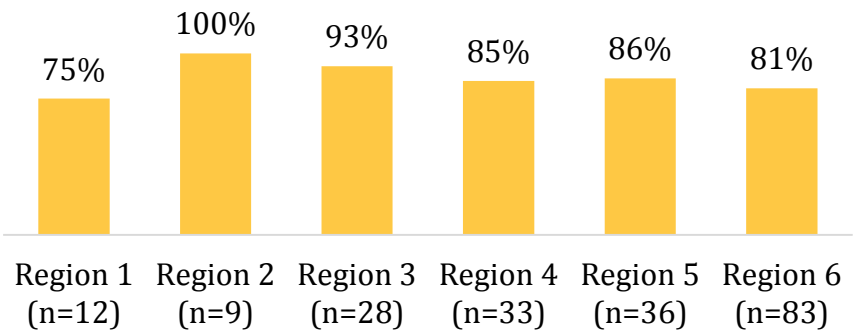
The majority of Region 6 respondents felt there was sufficient substance use treatment in their community. In contrast, less than a quarter of Regions 1 and 2 respondents felt there was sufficient treatment options.

Percentage of Respondents Who Felt There was Sufficient Substance Use Treatment in Their Community (n=200)



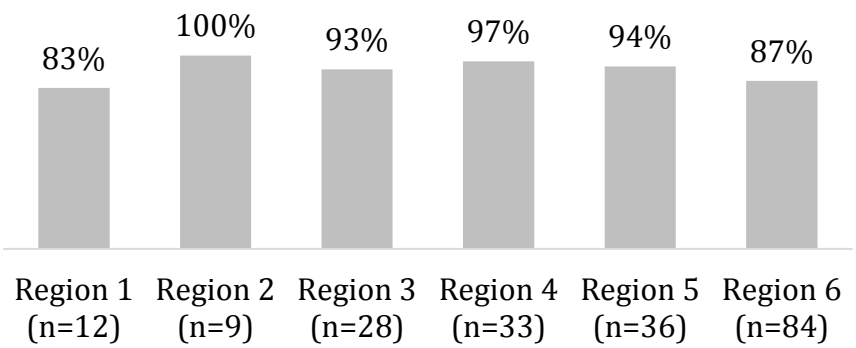
The majority of respondents from all regions felt they were making a positive impact on their community. Regions 1 and 6 respondents had the lowest rate of agreement that they were a positive force in their community.

Percentage of Respondents Who Felt They Were Making a Positive Impact in Their Community (n=201)



The majority of respondents from all regions felt their community was supportive of their department. Regions 1 and 6 had the lowest rate of agreement that their community was supportive of their department.

Percentage of Respondents Who Felt Their Community was Supportive of Their Department (n=201)



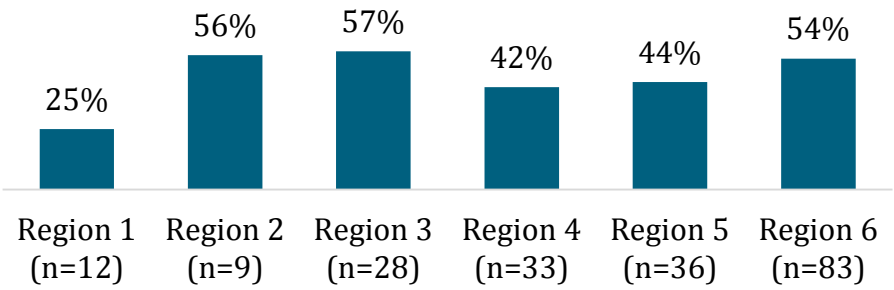
Participants rated these items on a six-point Likert scale from "Strongly Disagree" to "Strongly Agree." "Slightly Agree," "Agree," and "Strongly Agree" were combined to show only the percentage of respondents who agreed with the statement.

Community Resources

Please indicate your level of agreement with the following statements regarding substance use in your community.

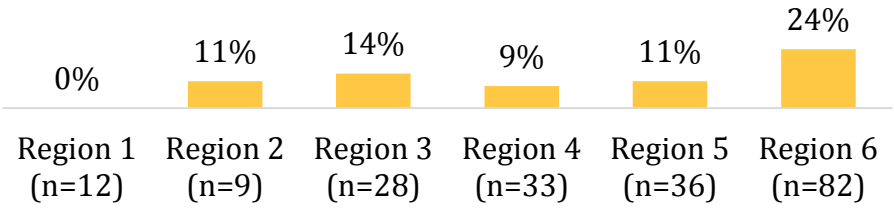
Only one in four Region 1 respondents felt their community members were aware of the Good Samaritan Law. At least half of respondents in Regions 2, 3, and 6 felt there was community awareness of the Good Samaritan Law.

Percentage of Respondents Who Felt Community Members Were Aware of the Good Samaritan Law (n=201)



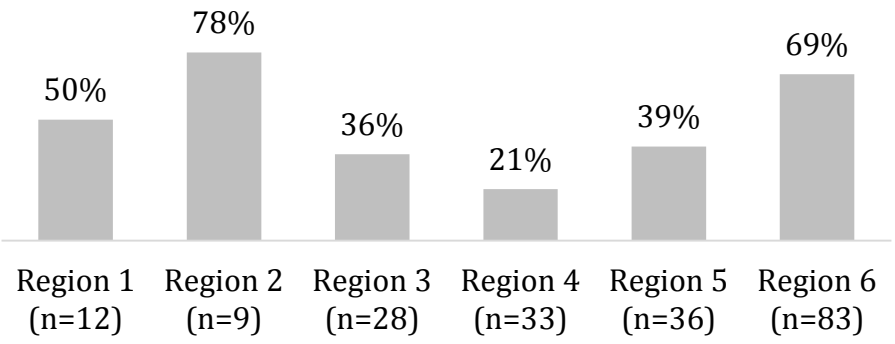
Few respondents across all regions felt their community members were aware of the standing order for naloxone. No respondents in Region 1 felt there was community awareness of the standing order.

Percentage of Respondents Who Felt Community Members Were Aware of Public Naloxone Access (n=200)



At least half of Regions 1, 2, and 6 respondents felt their community was being affected by opioids. Only one in five respondents from Region 4 felt their community was being affected by opioid use.

Percentage of Respondents Who Felt Their Community Was Significantly Affected by Opioid Use (n=201)



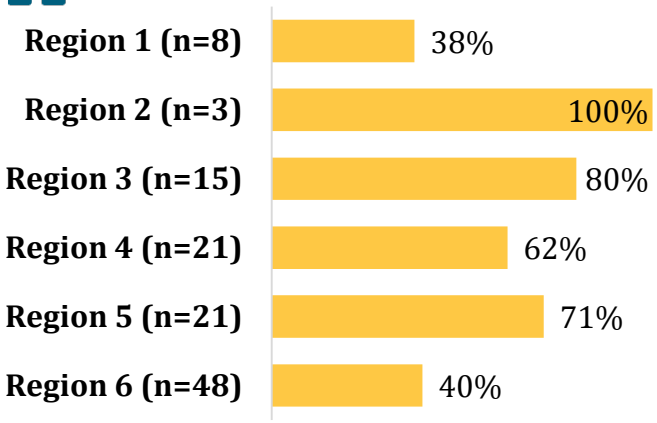
Participants rated these items on a six-point Likert scale from "Strongly Disagree" to "Strongly Agree." "Slightly Agree," "Agree," and "Strongly Agree" were combined to show only the percentage of respondents who agreed with the statement.

Community Resources (n=116)

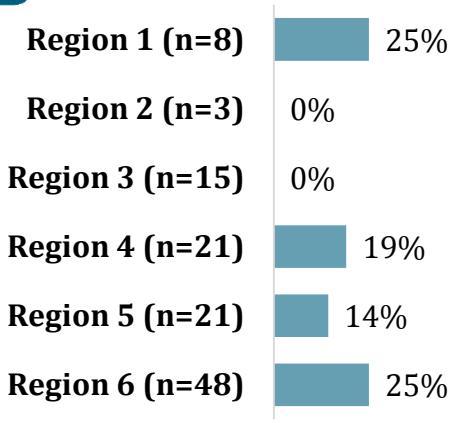
What resources does your community need to better prepare first responders for a surge in overdoses?

A need for increased community awareness and education around drug overdoses and opioid use was the most common community need mentioned across nearly all regions. All three participants from Region 2 indicated a need for increased awareness and education. Respondents in Regions 2, 3, 4, 5, and 6 mentioned a need for community awareness and education more than any other need. No respondents from Regions 2 or 3 mentioned a need for treatment and prevention efforts. No respondents from Regions 1, 2, or 6 mentioned a need for additional first responder support.

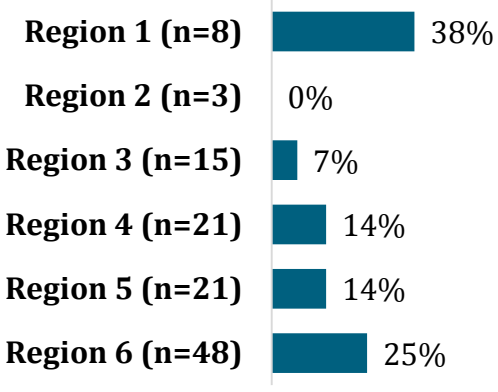
Awareness and Education



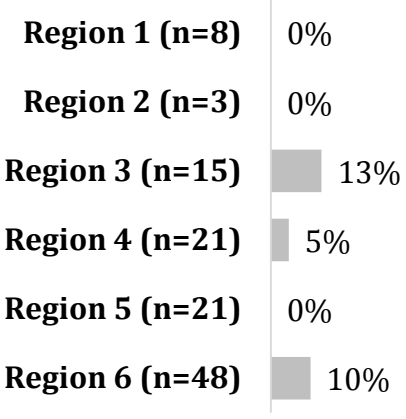
Treatment and Prevention (e.g. Epi-pens, naloxone, etc.)



No Resources Needed



First Responder Support (e.g. Increase staff and funding)

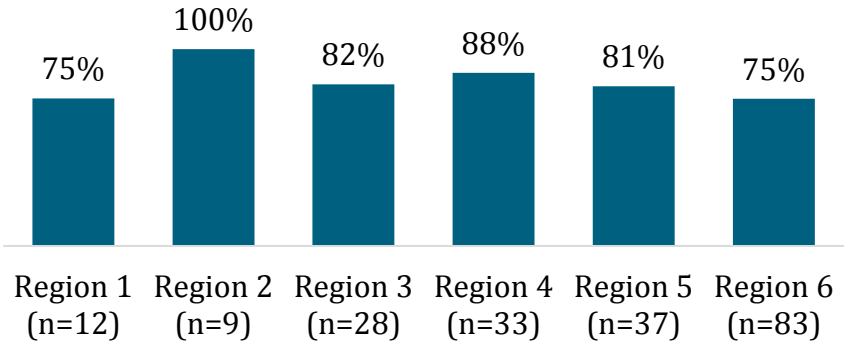


Compassion Fatigue

Please indicate your level of agreement with the following statements regarding work-related stress.

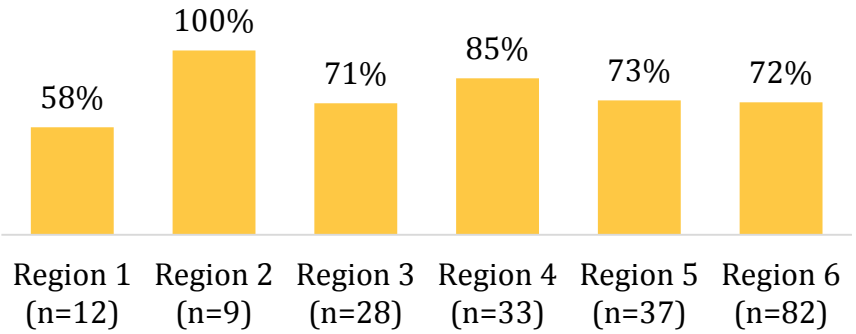
The majority of respondents from all regions felt they were aware of the symptoms of compassion fatigue. All Region 2 participants felt they were aware of the symptoms of compassion fatigue.

Percentage of Respondents Who Felt Aware of Compassion Fatigue Symptoms (n=202)



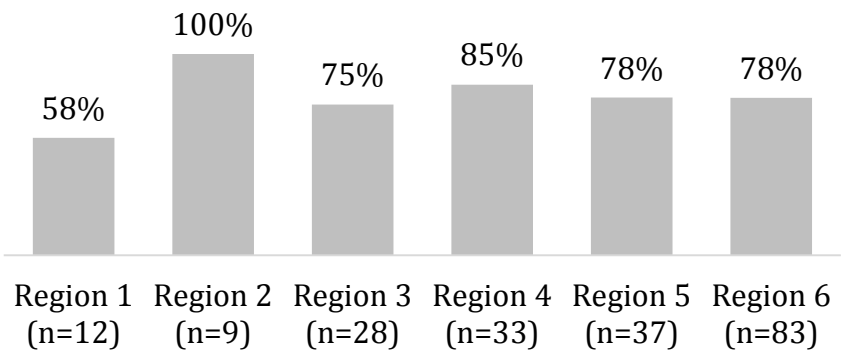
Compared to the above item, a slightly lower percentage of respondents from Regions 1, 3, 4, 5, and 6 felt they could identify compassion fatigue symptoms in themselves. Regions 2 and 4 had the highest percentage of respondents who felt they were aware of compassion fatigue in themselves.

Percentage of Respondents Who Felt Aware of Compassion Fatigue Symptoms in Themselves (n=201)



In congruence with the two above items, Regions 1 and 3 respondents had the lowest percentage of respondents who felt aware of compassion fatigue symptoms in their colleagues.

Percentage of Respondents Who Felt Aware of Compassion Fatigue Symptoms in Their Colleagues (n=202)



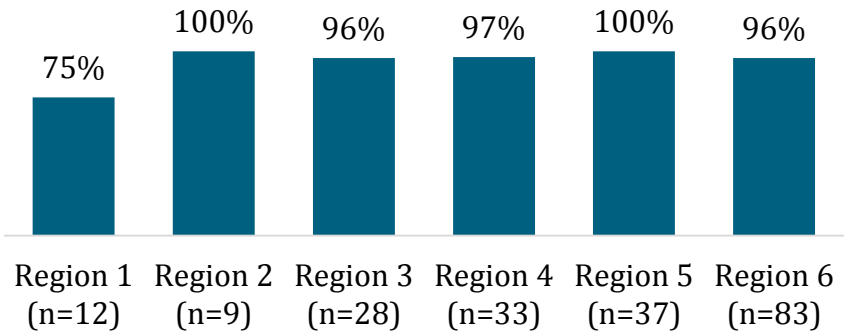
Participants rated these items on a six-point Likert scale from "Strongly Disagree" to "Strongly Agree." "Slightly Agree," "Agree," and "Strongly Agree" were combined to show only the percentage of respondents who agreed with the statement.

Compassion Fatigue

Please indicate your level of agreement with the following statements regarding work-related stress.

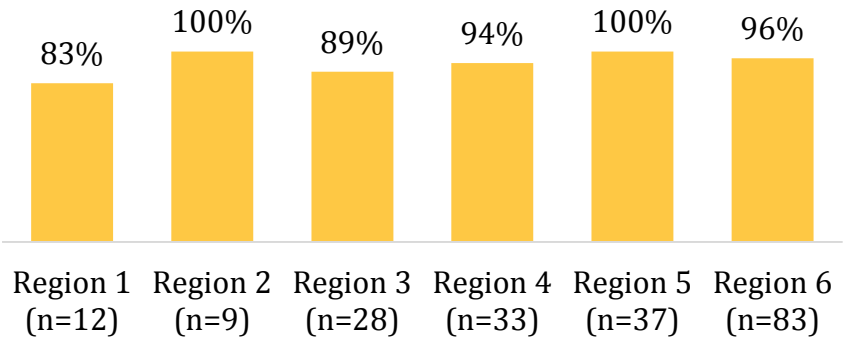
Nearly all respondents from every region felt aware of mental health resources for themselves. Region 1 respondents had the lowest percentage of awareness of mental health resources.

Percentage of Respondents Who Felt Aware of Mental Health Resources (n=202)



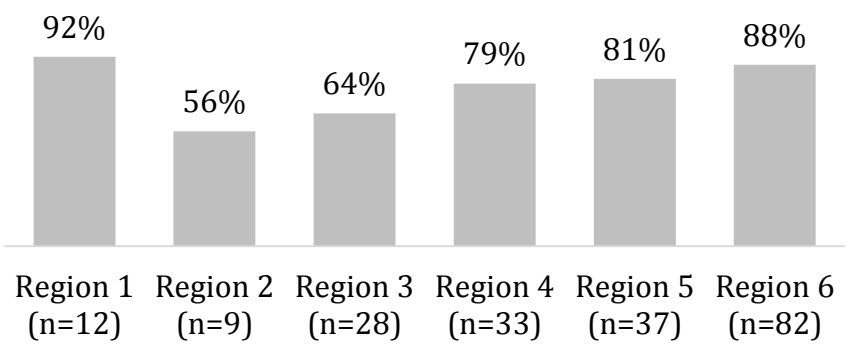
In congruence with the above item, Region 1 respondents were the least likely to feel they had peer support to process highly stressful experiences. All respondents from Regions 2 and 5 felt they had peer support.

Percentage of Respondents Who Felt They Had Peer Support to Process Highly Stressful Experiences (n=202)



While all Region 2 respondents felt aware of mental health resources, just over half felt encouraged by their department to access these resources. Regions 1 and 6 respondents felt the most encouraged to access mental health resources.

Percentage of Respondents Who Felt Encouraged To Access Mental Health Resources (n=201)



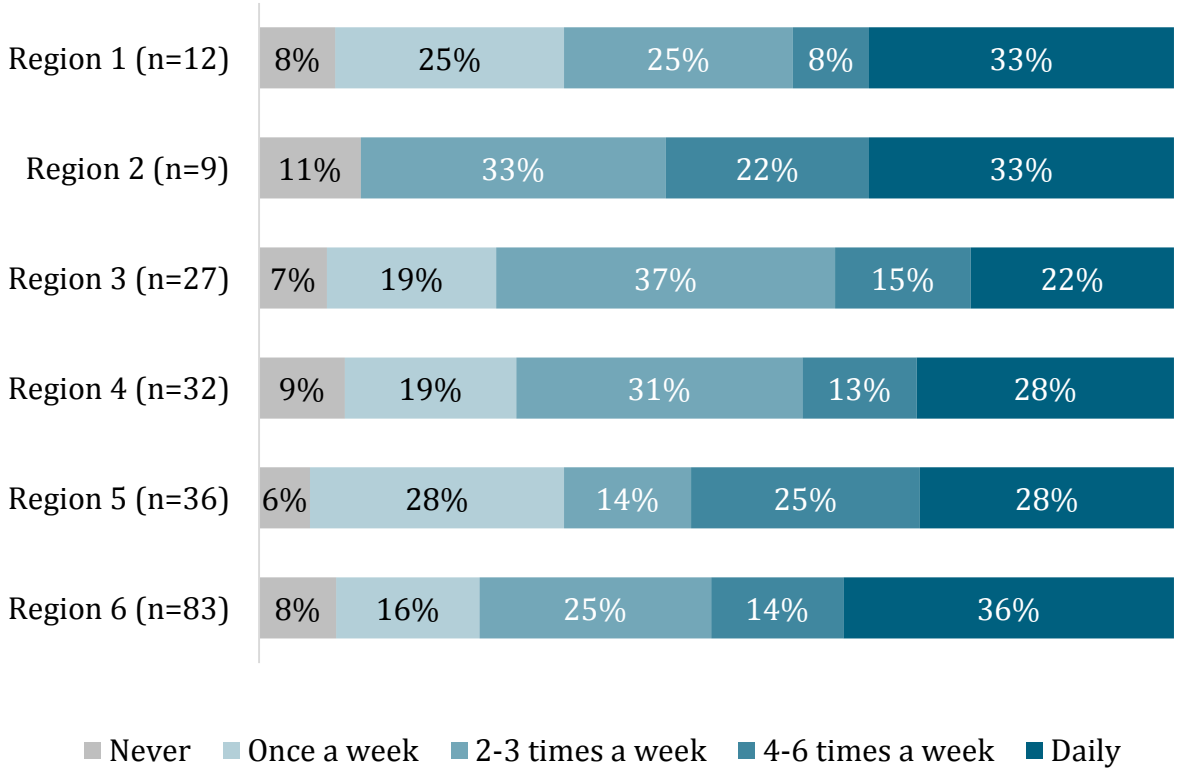
Participants rated these items on a six-point Likert scale from “Strongly Disagree” to “Strongly Agree.” “Slightly Agree,” "Agree," and “Strongly Agree" were combined to show only the percentage of respondents who agreed with the statement.

Compassion Fatigue (n=199)

How often do you engage in self-care practices?

Region 6 respondents were the most likely to engage in self-care on a daily basis, while Region 3 participants were the least likely. **Few respondents from any region reported never engaging in self-care practices.** Region 2 participants had the highest rate of never practicing self-care, which may be related to being the region with the lowest rate of feeling encouraged to access mental health resources.

Number of Times Respondents Engaged in Self-Care Per Week
Regions 2, 5, and 6 respondents were the most likely to practice self-care at least four times a week.



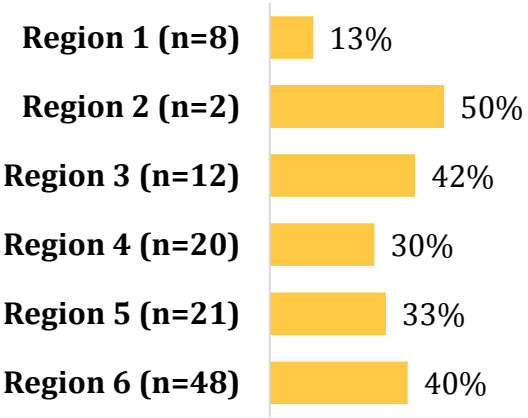
"Overwhelming surge of overdoses has my coworkers and I strained."
- Douglas county

Compassion Fatigue (n=111)

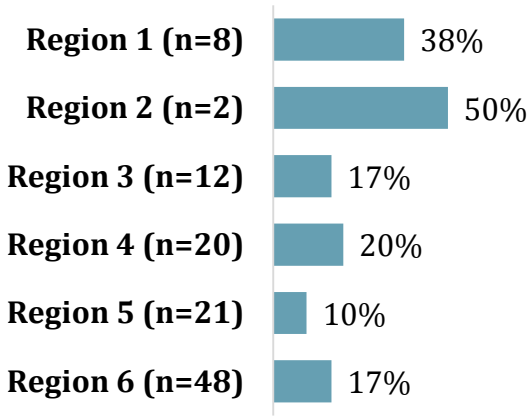
What specific stressors do you experience in your role as a first responder in regards to overdose calls? Please use the comment box below:

Interactions with the overdose scene environment, which includes interactions with patients, their family, and providing medical care, were the most common stressors mentioned. There were only two participants from Region 2, one whom identified stress due to the scene environments, and one whom identified stressful emotions. Region 1 respondents indicated emotions and no stressors most often. Region 1 being a primarily rural region may influence the decreased stress of scene environments. In contrast, Region 6 respondents, the most urban region, were among the most often stressed by the scene environment. Of all the regions, Region 5 respondents were the most frequently stressed by factors related to their team's competence and preparedness.

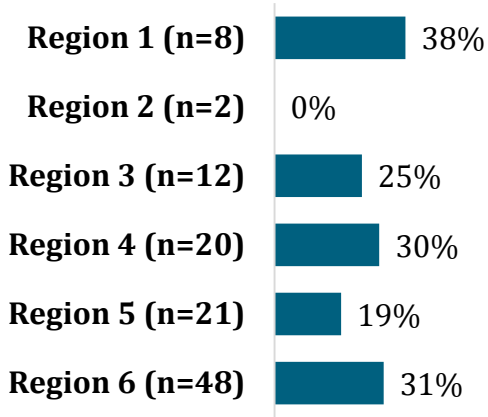
Scene Environment (e.g. patients, family, treatments)



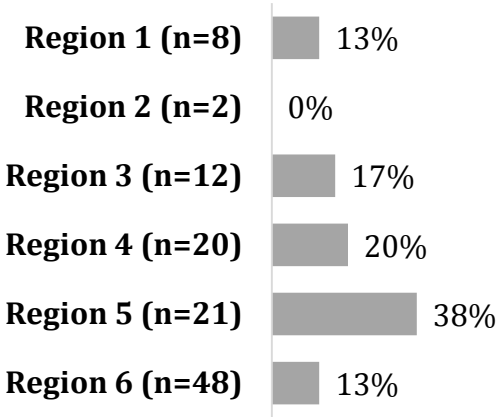
Emotions (e.g. frustration, concern, compassion fatigue)



None



Team Safety, Competence, and Preparedness



EMS and Fire: Quantitative–Summary

Demographics:

Between January 30 and March 27, 2019, 247 firefighters and EMTs submitted valid responses to the online quantitative survey. Most respondents were EMTs (n=115) or both EMTs and firefighters (n=72). Region 6 had more respondents than any other region (n=109), followed by Region 5 (n=47). Slightly more respondents (n=118) reported serving an urban area with over 50,000 people compared to those who served a rural area (n=100).

Summary:

According to first responder survey responses, **alcohol was the substance most often involved in overdoses** in the previous 12 months. Overall, respondents reported **opioids were involved in overdoses about 25-33% of the time. Fentanyl was the only drug identified by at least one respondent in all regions as being involved** "Most of the Time" or "Always" in overdose calls.

On average, respondents said they are responding to about the same number of overdose situations now than they were 2 years ago, with three regions indicating a slight increase, and three regions indicating a decrease (especially a decrease in Regions 2 and 5). Of the overdose situations they are responding to, fewer involve opioids than did 2 years ago, especially in Region 2, but also in Regions 1, 3, and 5; more overdose calls involve opioids in Regions 4 and 6 now.

By far, respondents in Region 6 reported administering naloxone the most frequently. Respondents in Regions 5 and 6 reported higher numbers of repeated naloxone administrations than other regions. Overall, **most respondents were not fearful of administering naloxone due to fear of legal percussions, although the fear was a bit higher in Region 2.**

The majority of Regions 4, 5, and 6 respondents were both trained to recognize the symptoms of an opioid overdose and to administer naloxone; only half of respondents in Regions 1 and 2 reported being trained to administer naloxone.

About two-thirds of respondents in Regions 3, 4, 5, and 6 thought they had sufficient opioid response resources, while less than half did in Regions 1 and 2. **Across the state, about two-thirds of respondents thought they had appropriate protective gear.** Except for higher rates in Regions 4 and 6, less than half of respondents said their emergency vehicles had four or more doses of naloxone on board. **A need for more resources, such as naloxone, response vehicles, and funding, was the most common departmental needs mentioned.** The majority of Region 2 respondents identified a need for additional resources. Training was the second most common identified need, particularly in Regions 3 and 4.

Summary: (continued)

Most responders said they provided information to the individual or their families regarding treatment options and community support groups on overdose calls. However, responders in Regions 3 and 4 did so less often. **The minority of responders provide naloxone kits to the individual or their families**, with more so doing it in Region 1. No region consistently provided information regarding the standing order for naloxone to the individual or their families with this being especially true in Region 3. While the majority of Region 6 respondents felt there was sufficient substance use treatment in their community, much fewer respondents in the other five regions felt there was sufficient treatment options, especially in Region 1.

Nearly all respondents felt they were making a positive impact in their community and felt their community was supportive of them, with slightly lower numbers in Region 1. About half of respondents felt their community members were aware of the Good Samaritan Law, with only a quarter of respondents feeling this way in Region 1. **Almost none of the respondents thought their community members were aware of the standing order for naloxone**, with none thinking so in Region 1.

Responses across the state varied significantly in regard to their thoughts on the community being significantly affected by opioid use. Most than two-thirds of respondents in Regions 2 and 6 thought their community was significantly affected, only half of those in Region 1, and fewer in Regions 3, 4, and 5.

Training for both community members and first responders was the most common need expressed by respondents. A need for increased community awareness and education around drug overdoses and opioid use was the most common community need mentioned across nearly all regions.

The majority of respondents from all regions felt they were aware of the symptoms of compassion fatigue, and would be able to identify it in themselves and their colleagues, with lower numbers in Region 1. Nearly all respondents from every region felt aware of mental health resources for themselves, and felt they had peer support to process highly stressful experiences, with lower numbers in Region 1. Most respondents in Regions 1 and 6 felt encouraged by their department to access mental health resources, if they were needed, with many echoing this in Regions 3, 4, and 5, and just over half in Region 2. Nearly all respondents engage in self-care practices a minimum of once a week.

Interactions with the overdose scene environment, which includes interactions with patients, their family, and providing medical care, were the most common stressors mentioned. Region 6 respondents, the most urban region, were among the most often stressed by the scene environment, and Region 5 respondents were the most frequently stressed by factors related to their team's competence and preparedness.

Summary by Regions

Region 1 (n=15)

Respondents reported an average of 2.4 drop in opioid-involved calls in the past 6 months compared to 2 years ago. Only half of respondents (n=10) were trained to administer naloxone, though 82% of respondents (n=11) felt they had received sufficient naloxone administration training. However, none of the respondents (n=12) felt their community members were aware of public naloxone access. Furthermore, Region 1 respondents (n=12) had the lowest rates of awareness of compassion fatigue (75%), both in themselves (58%) and in their colleagues (58%). They also had the lowest rate of awareness of mental health resources (75%) and feeling of peer support during stressful situations (83%). Though 41% of respondents (n=12) practiced self-care at least four times a week, 38% (n=8) identified their emotions as the greatest stressor.

Region 2 (n=10)

Respondents reported an average of a 3.7 decrease in overdose calls and a 9.5 decrease in opioid-related overdoses in the past 6 months compared to 2 years ago. In congruence with the reported decrease, no EMT respondents reported administering naloxone in the past year. Less than half of respondents felt they had sufficient opioid response resources (44%), and even fewer reported having at least four doses of naloxone on their emergency vehicles (22%). Additional resources, such as naloxone, response vehicles, and funding, was the most frequently identified departmental need (60%). The majority of participants (78%) felt their community was significantly affected by opioid use. All respondents noted a need for increased community awareness and education surround drug overdoses. All respondents also felt aware of mental health resources, such as peer support, but just over half of respondents felt encouraged by their department to access these resources (56%).

Region 3 (n=28)

Respondents reported an average of 0.3 decrease in opioid-related overdose calls in the past 6 months compared to 2 years ago. Only 1out of 20 respondents reported administering naloxone in the past year. The majority of respondents (63%) reported being trained in naloxone administration, and 61% felt their training was adequate. Furthermore, the majority of respondents felt their department had sufficient opioid response resources (64%). Yet, less than half reported having at least four doses of naloxone on their emergency vehicles (33%). Despite the high levels of reported training, additional training was the most commonly identified departmental need (56%). The majority of respondents felt aware of mental health resources (96%), but only 64% felt encouraged by their department to access these resources. In addition, only 22% of respondents reported practicing self-care daily, the lowest percentage of all regions.

Region 4 (n=38)

Respondents reported an average 2.8 increase in opioid-related overdose calls in the past 6 months compared to 2 years ago, which was the largest reported increase of any region. Respondents reported a relatively high rate of satisfaction with both the opioid overdose and naloxone administration trainings they received. Regardless, additional training was the most frequently identified departmental need (48%). Only 21% of participants felt their community was significantly affected by opioid use, which was the lowest percentage of any region. The majority of respondents felt confident in their ability to recognize compassion fatigue (85%) and felt aware of mental health resources (97%), but slightly less respondents felt encouraged by their department to access these resources (79%). Region 4 respondents reported experiencing stress as a result of the overdose scene environment (30%), but the same percentage of respondents reported experiencing no stressors (30%).

Region 5 (n=47)

Respondents reported an average 3.8 drop in general overdose calls and an average 2.3 drop in opioid-related overdose calls in the past 6 months compared to 2 years ago, the largest reported decrease of any region. Region 5 respondents administered naloxone at the second highest rate, behind Region 6. Respondents also reported the lowest frequency of fearing legal repercussions when administering naloxone. This may be related to respondents reporting the highest frequency of naloxone administration training (78%) and the majority (80%) feeling this training was sufficient. The majority of respondents felt they had sufficient opioid response resources (69%) and adequate protective gear (77%), but less than half reported having at least four doses of naloxone on emergency vehicles (44%). A need for additional resources, such as naloxone, was the most commonly identified departmental need. Less than half of respondents felt their community was significantly affected by opioid use. Region 5 respondents reported experiencing the most stress as a result of their team's safety, competence, and preparedness (38%).

Region 6 (n=109)

While respondents reported an average 1.6 drop in overdose calls, they also reported an average 2.9 call increase in opioid-related drug overdoses in the past 6 months compared to 2 years ago. Respondents administered naloxone at over twice the rate of any other region and had the second highest rate of naloxone administration training (72%), but a slightly lower percentage thought this training was adequate (68%). Respondents reported the highest confidence their departments had sufficient opioid response resources (70%) and they had access to sufficient naloxone (57%). Respondents were more likely to provide information regarding treatment options than any other resource, but rarely provided naloxone kits or information about the public naloxone access. Additionally, 70% of respondents felt their community had sufficient substance use treatment options, which was nearly double that of the next region. Most respondents indicated their community was significantly affected by opioid use (69%). The majority of respondents felt aware of mental health resources (96%) and encouraged by their department to access these resources (88%). A higher percentage of respondents reported practicing self-care daily compared to any other region (36%). Region 6 respondents reported experiencing the most stress as a result of the overdose scene environment (40%).

EMS and Fire: Quantitative– Limitations

1. **Incomplete survey responses:** The survey was started by 311 individuals, but only 247 respondents completed both the demographic questions and at least one other item. Therefore, survey results are based on the 247 completed surveys.

2. **Regional response rate:** Comparing the 109 respondents from Region 6 to regions such as Region 2 with only 10 responders may misrepresent the experience of Region 2 responders. There were only 15 responders from Region 1. While we reported regional percentages, a higher response rate from Regions 1-5 may produce considerably different findings.

3. **Inconsistent responses**: Some quantitative responses were inconsistent with qualitative responses. In the quantitative survey, for example, five urban firefighters in Douglas county reported administering naloxone 84 times in the past year. However, in each of the three focus groups, EMTs were the only personnel who reported administering naloxone due to departmental policy.

4. **Quantifying qualitative items:** To assist in the synthesis of data, we chose to quantify the open-ended questions from the online survey. Some researchers discourage quantifying qualitative data because of the risk of losing the narrative context. We accounted for this concern with the addition of related quotes.

5. **Convenience sampling:** Survey invitations were sent based on a list of emails for statewide emergency medical technicians and firefighters. EMT's or firefighters whose contact information was not available did not receive a link to the survey, or who were not willing to participate due to time constraints, the overdose topic, or previous interactions with the public may have offered a consistently different perspective.

6. **Survey dissemination:** STEPs emailed the anonymous survey link to each first responder from a STEPs email account. This email may have inadvertently been sent to a spam or junk folder or recipients may not have recognized the sender and ignored the email. This may have impacted survey response rate.

EMS and Fire: Quantitative–Recommendations

Region 1

- Provide compassion fatigue trainings to increase awareness of both compassion fatigue symptoms and mental health resources. This may result in emotions being a less significant stressor for Region 1 first responders.

Region 2

- Conduct additional research to determine the current barriers to naloxone access and other requested resources. Implementing strategies, such as incentives, to increase the sample size will improve the validity of Region 2 results.

Region 3

- Offer naloxone administration training to meet the most frequently identified departmental need. Encourage staff to practice self-care regularly as this region was the least likely to practice daily.

Region 4

- Share strategies to first responder department administrators to encourage their staff to access mental health resources. Increase first responder and community training as this was the most commonly identified departmental need.

Region 5

- Further identify those departments who are in need of additional doses of naloxone. The high rate of naloxone administration and lower rate of reported naloxone doses on emergency vehicles support the most commonly identified departmental need of additional resources.

Region 6

- Make information packets, brochures, or cards on treatment resources available for first responders to provide to the patient or their family on the scene of an overdose.

Evaluation Recommendations

1. Conduct a secondary analysis on the quantitative EMT and firefighter data. Further analyses dividing responses by profession, county, and years of experience would provide a fuller picture of overdose calls, naloxone administration, and training.

2. In future evaluation of first responders, consider only including EMTs and paramedics in medical-related questions. In Douglas county focus groups, only EMTs were permitted to administer naloxone, while firefighters assisted in monitoring scene safety.

Community Recommendations

1. Increase public awareness of the standing order for naloxone across Nebraska through media campaigns. Most first responders across all regions disagreed that their community was aware of their access to naloxone.

2. Increase public awareness of naloxone access and community naloxone training. Most first respondents disagreed that their community was aware of naloxone access in the quantitative survey. Some also indicated concern at community members accessing naloxone without being trained.

Drug Overdose Prevention Needs Assessment

EMS and Firefighters

Focus Groups and Interviews

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES
DRUG OVERDOSE PREVENTION

UNIVERSITY OF NEBRASKA AT OMAHA
SUPPORT AND TRAINING FOR THE EVALUATION OF PROGRAMS

EMS and Fire: Qualitative–Sample Description

Thirteen focus groups and interviews were conducted across 10 Nebraska counties between February 13 and March 30, 2019, and were selected due to their area's high-burden of drug overdoses.

Seven focus groups and six individual interviews were conducted with Fire/EMT units. Limited demographics were gathered from the participants. Nearly all participants were either fire or EMT personnel working in a fire department. At least one focus group in Region 1 had law enforcement participation as well. There was a large range in experience with participants being in their roles for 1-40 years, with an average of 14 years of experience. Ten participants had over 20 years experience.

42 First Responders

Capacity

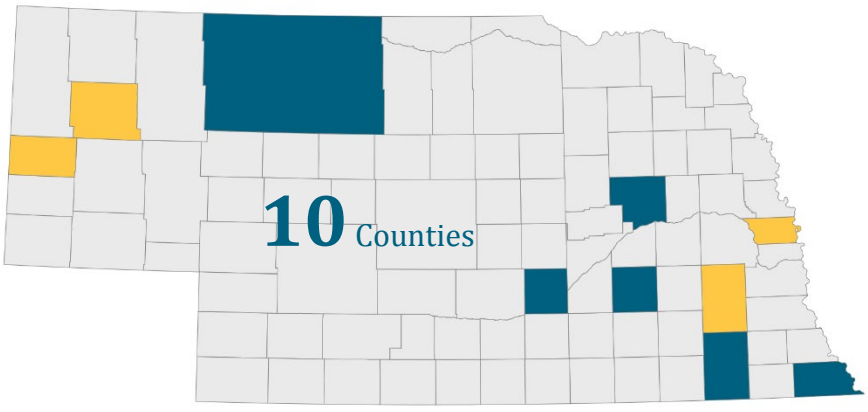
34 Full-time

8 Volunteer

Profession

1 Police officer
2 Paramedics
9 EMTs
9 Firefighters
21 Both

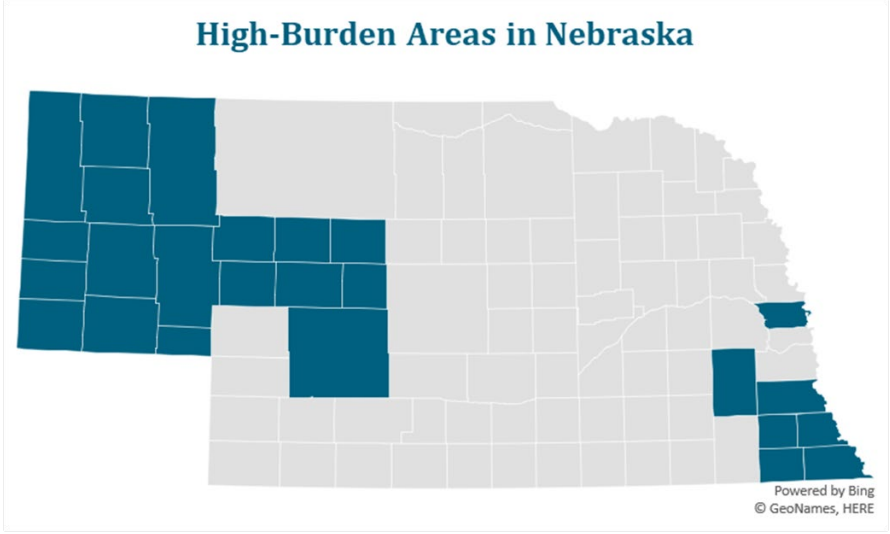
Interview counties (n=6) Focus group counties (n=32)



7 focus groups

Focus Group Locations

Box Butte County (2)
Douglas County (3)
Lancaster County (1)
Scotts Bluff County (1)
Three in Region 1, three in Region 6, and one in Region 5.



6 interviews

Interview Locations

Cherry County
Gage County
Hall County
Platte County
Richardson County
York County
Three in Region 5, two in Region 4, and one in Region 3.

At the conclusion of the first responder qualitative analyses, five overarching themes emerged: 1) Drug Overdose Trends; 2) Call Responses; 3) Naloxone and Other Surge Needs; 4) Policies, Training, and Services that Would Help; and 5) Compassion Fatigue: Support and Strategies. Within these overarching themes, several subthemes were also identified. Each theme and subtheme is described in detail below along with supporting quotations.

1) Drug Overdose Trends

Focus groups and interviews began with questions on first responders' views on drug overdose trends in the communities they served. Subthemes that emerged were Opioid Overdoses, Involvement of Other Known or Unknown Substances, Geographic Differences, and Generational Differences.

Opioid Overdoses

The overall response to questions regarding drug overdoses generally and opioids specifically was that opioid overdose calls were not the majority of their calls. When asked about the frequency of overdose calls specific to opioids, nearly all units stated the number of opioid-related calls was higher 2 years ago, and the number overall appears to have stabilized. Notably, there were two units that stated they did not have any opioid-related overdose calls in the past year–both units were in the more rural area of Region 5.

> *Abuse of meth and alcohol are still far more prevalent than opioid abuse in this area."*

> *"Mostly the overdose that we get called to is an intentional prescription overdose and mixed with alcohol."*

Many of the units indicated that although there was not necessarily an increase in opioid use, the severity of the opioid calls they are seeing has increased.

> *"I think what we've seen more is just the severity of it. As far as respiratory arrests, I don't think the numbers per se though have really changed. I think when fentanyl started coming around a little bit more frequently, it seems like the level of, I guess, interventions we have to do has increased."*

> *"I think that the level of intervention that we've had to do, like the severity of the overdose has been more critical, the ones that we do see."*

Participants were asked how many opioid overdoses they typically encountered in a given period of time. This was a difficult question for most participants and responses varied since opioid overdoses were mixed in with other substances. Many of the participants indicated that it was difficult to know whether the overdose was opioid related and that many of the calls they responded to had multiple drugs in their system. When asked to provide a range for overall overdose calls, and then try and identify which of those were related to opioid use, responses ranged from 0 to 12 overdoses per month.

"You might find a young kid who may have an opioid addiction who went to the bar and got way too drunk on top of that and so they're down. Their friends don't know what's wrong with them or they won't tell ya… But at no point do we ever know that there was an opioid or actual prescription at the time. All you know is obviously this isn't just alcohol, but it doesn't matter what they were on to us."

"Most of ours out here, on the intentional side, are multi-drug overdoses, so they just took a whole bunch and, yeah, like recreational or abuse, like the non-mental health side, I would say... mostly in the opioid category. Opioid and alcohol are our two big ones out here."

Involvement of Other Known or Unknown Substances

Many of the units discussed how substances other than opioids were more of an issue. **Nearly all units stated that alcohol was nearly always a factor.** Although opioids are still part of the landscape, many participants remarked that the drugs they see seem to come in waves or cycles. Of the units indicating exposure with opioid overdose, they all mentioned seeing an **increase in fentanyl use**, both intentional and unintentional.

"There are a lot of the accidents with the fentanyl patches."

"When fentanyl started coming around a little bit more frequently, it seems like the level of, I guess, interventions we have to do has increased."

"Where we see the problems usually is if they put more than one fentanyl patch on and don't take the—'Cause your supposed to take one off, and then put a new one on, and if they don't, they can get an excess of build up."

"We had a short spurt of fentanyl X, which is like all of our calls. It comes in spurts. Like, you get three or four suddenly in a set, and then next few sets, you won't have any, and then there it goes again, whether it's just the area that you're in, or what."

"…inserting the fentanyl patches in their butts or vagina."

They also named methamphetamine, over-the-counter drugs, and heroin being involved in many of their calls.

"We see probably more over-the-counter overdoses like Benadryl and cough medicine and the Coricidin. Just prescribed medication overdoses, unintentionally, Tylenol, I mean, we see that more frequently than we do opioid stuff."

"Two of the overdoses that I've talked about, that we had that I know were heroin."

"I don't know if you'd call it an epidemic or not, but we've seen several overdoses on Xanax, not necessarily opioids, but we've seen a couple opioid cases, but recently, it's been Xanax, or benzo."

"We have meth. And the problem is you don't know what, they say meth, you don't know what they're chasing it with."

"We may have some with heroin and meth that's mixed together, and so you may get there because they've overdosed on a heroin, for example. However, if that gets reversed, now the meth is the dominant drug in their system. So now they are fighting, because you've taken away their opioid, but they've also got, you know, a stimulant in their system that makes it even worse, so the heroin in that aspect is actually our friend because it's keeping them manageable as a patient on the flipside. So that's what we kind of see a lot of, in a lot of areas, the mix and match."

Quite often, participants said that other people around do not know what substance the patient may have taken. A common expression stated was that there was a lot of "mix and matching" of substances and that opioids may or may not be involved.

"And I see it as trying to identify what the overdose is. So that's… you never know what, potentially it... I guess you shouldn't say you never know… If they've been prescribed something, it's one thing."

"It's more of a cocktail: drugs, alcohol, prescriptions, illegal stuff, you name it. From marijuana and cheap booze to Xanax and shrooms. And meth has been big."

"There can be three different kinds of drugs you know. They're sitting right there, doesn't mean any of those are the ones they're taking. It could have been a pill bottle they stole out of a purse. So honestly, unfortunately, to get back to… doesn't really matter what they've done."

"Well I'd say the biggest challenge like we've always said is not knowing. There's a rare occasion when the dispatchers will tell us, took a whole bottle of Tylenol or whatever, so we know exactly what they took, but that's pretty rare."

Geographic Differences

The number of overdose calls depended on location with the more urban units indicating they responded to 20-30 overdose calls per month compared to the units in more rural areas where they indicated about 8 calls per month.

> *'So if every crew, if every shift is doing 2 or 3 a month, you know that's 9, about 8 to 10 a month for our station (not including alcohol overdoses).*

> *"Not breaking it down to like opioids or alcohol, but I'd say every day, we have at least one overdose."*

Within counties, there was a difference in overdose calls as well. One unit in Douglas county indicated the majority of overdose calls were due to alcohol and substances other than opioids, and another unit indicated opioids and methamphetamine were more frequent in their region. This did not seem to be specific to Douglas county as other interviews also mentioned the variability in drug type across their regions.

What became apparent was the geographic differences in calls. Even within the same county, the prevalence of different drugs presenting as the drug of choice was apparent. In one Omaha station, the unit stated that opioids were not a prevalent concern in that location and that overdoses in general represented less than 5% of their calls. Further west in Omaha, opioid overdoses were more common.

> *"I would say meth was more prevalent in southeast Omaha."*

> *"We still do see meth, but I think opioids is probably more common, and that might depend on parts of town too."*

> *"And it's a little bit different out here than it is at some stations, because we see more prescription abuse than we do the street-level drug use out here."*

> *"Mostly our problem would be meth. We're on the northeast side of town which we see those types of calls for sure, but not probably to the extent possibly that the downtown medic crews might be experiencing."*

> *"We're the second slowest medic unit, yeah. But our clientele is different than other parts of town too."*

Due to rural communities being included in this research, several participants discussed how **being in a small community both positively and negatively impacted their department's work.** Comments included potential challenges that can be emotionally draining are related to distance, collaboration with law enforcement, knowing members of the community.

"The smaller your community, probably, the longer you have for the potential response."

"Just that in a small community you know a lot of your patients, which can be tougher. You know, when you're treating a total stranger sometimes it doesn't hit you as hard as when it's somebody you know."

"*Having an officer there is definitely helpful. A lot of times, being in a small town and stuff, they know these people. One time the officers came to the call, and they would just kind of like stop by.*"

"I think we're very passionate and very responsive to the calls that we have, and I think we give good quality service because of that, because it's a friend, a neighbor."

Generational Differences

Most units mentioned a generational difference in the calls they are getting and also mentioned seeing an uptick in the number of medication-related calls–not necessarily an overdose, but calls regarding a concern with the reaction to medication. A common sentiment was that accidental overdoses occurred most frequently with the older population (age 50 and over) where people would forget when they took their last dose and would end up taking too much. In addition to prescription opioid overdoses, they also mentioned that fentanyl patches were creating problems with people not removing the patch and then putting on new patches.

"80-year old woman that's on an opioid-type medication that her doctor prescribed to her, but he's also got her on a diuretic, and she doesn't drink water. Now, she's dehydrated and that amplifies the strength of the drug."

"Potential overdoses, but actually on the end it turning out not to be true overdose? It's not actually, but you see an increase in overall, we're getting, responding to, you know, drug-related calls."

Many of the first responders mentioned this may be due to an awareness of what to look for and having medical personnel caution patients about the risks of the medications they are taking. At the same time, there are still the unintentional overdose calls they are responding to, especially with the older population.

"What the dispatcher gets… we're getting notified for medication reactions. So we get there, and it's antibiotic or we just have no idea until we get there and evaluate… that it's more so, the awareness that there's an issue. They pick up their prescription. They get a list of symptoms and stuff to watch for and if you have any symptoms call 911, and so that's what they're doing. So yeah, I would say that's the awareness issue, it's just made people pay attention."

Overdoses with the younger population also present challenges as they generally are not due to one substance.

2) Call Responses

Focus group participants and interviewees spoke of their experiences in responding to calls when not knowing the nature of the call nor the drug or combination of drugs that may be involved. They also shared their opinions on the Safe Stations and Paramedics as Recovery Partners programs in responding to community needs.

One of the challenges most units mentioned was going on a call and not knowing the true nature of the call. For example, they could be called for an apparent heart attack only to find that the issue is an overdose. Or if it is an overdose, understanding what substance, or combination of substances, were used.

"They thought she was having a stroke, and she accidentally overdosed on her prescriptions."

"We have to be a detective 'cause what we get calls for it's not usually necessarily an overdose. It's that they're unconscious, they're having trouble breathing in another way."

"Identifying it can be hard. You know, once you've identified that this is probably what's happening, or you're in the game of this doesn't make sense and you're going, 'Ok, well maybe this is an opiate overdose.'"

"We've went on calls where people have gotten shot and not mentioned it. So that's the biggest issue, is not knowing. They got chest pain, and they did a pound of cocaine and didn't tell you."

In cases where EMTs do not know what drug, or combination of drugs, the individual took, they **treat the symptoms by controlling the respirations and breathing; and they provide naloxone if they suspect an opioid may have been involved.** The uncertainty of what has been taken provides an uncertainty regarding the administration of naloxone. A common sentiment was that providing naloxone will not hurt the patient so they might administer it to see if that has an impact. Because of the uncertainty, the EMT has to treat the prevalent symptoms.

"And that's what we see too, with a lot of drug use, is the person that's there with them, doesn't know anything, not sharing, you know, they're not giving anything up, so what's the harm in using Narcan, you know? I think maybe that's why we use it quite a bit. They're mixing so much, to where the Narcan probably can hit on something."

"And it's coming now to the point where it's if you got an altered mental status, and you have any inclination that maybe this person could have overdosed, well, what the heck, we'll push Narcan."

"We had basically like a Nerd's candy-sized pill that basically incapacitated a gal, put her into cardiac arrest, where Narcan worked, it reversed it really fast, but it was just like such a small amount of some unknown substance."

We asked respondents about the **Safe Stations** concept in Nebraska where fire stations can be designated as a place where anyone can walk in, be checked by firefighters for any medical issues that might require a ride to the hospital, and be connected to a nearby nonprofit, such as Hope for New Hampshire Recovery. In the first three months of the program, 370 people have used the "Safe Station" program and been connected to a recovery center, outpatient program, or other nonprofit resource (Kamp, J. (2016, Aug 30). Fire stations open their doors to addicts: New Hampshire city hit by opioid crisis takes a novel approach to getting people help. *Wall Street Journal*.)

12 out of 13 groups did not support the Safe Stations concept. In the western part of the state, many mentioned they were understaffed or staffed by volunteers so this would not be a good option. In the eastern part of the state, there was concern regarding abuse of the fire station and what you would do with someone when you had a call. Several people mentioned this sounded like a satellite hospital unit or would turn into the need of an emergency shelter where people would come for a meal and a bus ticket.

"We don't have enough paramedics anyway, the way it is you know, we're pretty understaffed."

"It would figure out a way to get a free shower or meal or get out of the cold for 30 minutes and get a free coffee or a cookie. And you'd have 50 people down here on a snowy afternoon for the Safe Station."

"I don't think any of our fire stations have the resources to be able to do this."

There are programs, such as **Paramedics as Recovery Partners**, that are implemented in other states where community paramedics and recovery specialists are able to visit recovering addicts in their homes to provide medical support and assistance in non-emergent situations. This relieves the resource strain on EMS caused by addicts unnecessarily using 911 services to receive healthcare. Nearly all interview groups discouraged this except for one unit in the eastern part of the state and one interviewee in central Nebraska.

"Private ambulance services doing that, that would be a great follow-up type of thing, home visits. And I know other cities are doing that. I think we were just talking about this today with somebody in Milwaukee, maybe? That does… they have like a BLS squad, Milwaukee Fire, and that's what they do. They go around elderly, or frequent, frequent 911 callers. That's what it was. It was people who called 911 X amount of times in a year. They would go do home checks on them and help them make sure that their meds are straightened out and just once in a while checking in on them and it cut back on the 911 calls. It was a several year long study that they have implemented this now."

"I think if it were a program that was separate from the, the everyday ambulances that were responding to 911 calls. You know, an additional program, people that, you know, community paramedicine program. I think that would be beneficial, keeping 'em out. For sure, as long as it's, like I said, separate from people that run in at 911 every day 'cause I don't think that's going to be possible or practical. But there's been community para-medicine programs that have been very successful around the country for that type of stuff, so I think that's great."

One of the fire stations in Region 6 was quite frustrated with the abuse of the 911 system and responding to non-emergency calls on a frequent (several times/shift) basis. This station did not endorse this concept.

"Now 1 out of every 25 calls might be something that is actually a 911 emergency. And that goes for everything, not just overdoses. Somebody with asthma, they'll call because their inhaler has been out for two days and they're not having difficulty breathing, because they're talking to you. They just want to go to a hospital so they can get their inhaler refilled. That's probably as frustrating, and that covers everything. Especially the guys that end up taking care of people who have the big things like overdose, you know."

3) Naloxone and Other Surge Needs

In response to questions about their ability to respond to a potential surge, first responders spoke of the Availability of Naloxone, Naloxone Use, their Perception of Naloxone, and their need for Training on Naloxone.

Availability of Naloxone

Several questions were posed regarding naloxone, including the availability, training, and experience with using naloxone. With respect to availability, **every unit indicated they had enough naloxone on hand to handle current demands** and most thought they had enough on hand to handle the need for multiple uses with several units mentioning they had both injectable and intra-nasal units available. Many mentioned they could call for other units for back-up supplies if needed.

"No, we go through… that's like the one drug we have that isn't like a national shortage. I don't think we'll run out."

"I have never run out."

"And if we do use it, we have the ability to just restock after every call. So if we do use it, we just go and get another one."

"It's a plentiful drug right now, and I think, that's fine. So, I can't think that I would have any problems right now."

Several units across Nebraska also said they felt comfortable in managing overdose calls without naloxone and would not necessarily need naloxone to treat all patients.

"I can manage a narcotic overdose without Narcan. I mean, you manage your respirations. It doesn't affect their cardiac system per se, it affects their respiratory site."

"Naloxone is not needed if they are breathing adequately."

Rural responses were different than urban responses with several respondents indicating that personnel would be a concern should there be a surge.

"Most first responders are volunteers and a surge in calls could easily overwhelm the available responders."

"If we had a surge in opioid use, we would need to have more naloxone kits. We also wouldn't have enough staff if we had a surge in calls."

Naloxone Use

Questions were asked regarding the ease, frequency, and comfort in using naloxone as well as their perceptions of using naloxone to reverse an overdose**. Those who had experience with naloxone were quite comfortable in using it,** and there were a few units that were very experienced in that they were using naloxone weekly.

"In the last couple years, we've used Narcan just as often as D50 or D25 (common diabetes medication), you know, sometimes more so."

Other comments made were with respect to **dosing speed** where, those with a lot of experience with administering naloxone, may sometimes try to control the dosing speed so the patient does not 'wake up' immediately and become combative and disoriented. The more experienced medics talked about being able to do this fluidly so once the patient was on the ambulance and appropriately restrained, they could then complete the dosing.

"We'll give them a little bit so they start breathing again. You don't want to slam the whole thing, and bring them out of it quickly."

"If it's obvious it's an opioid and their vitals are stable and they're stable, then yeah, we'll slowly push it because it's taking away that high and you've got other issues that you're gonna have to deal with."

Of the 13 interviews, 3 units said they had not used naloxone within the past 12 months, or at all.

"I've actually only seen Narcan used once in the eight years that I've been on the squad."

"We have no history of overdoses requiring Narcan."

Perceptions of Naloxone

Respondents were invited to share their perceptions on the use of naloxone and reversing an overdose as the literature indicates a negative perception of naloxone as a 'get out of jail free card' for people who abuse opioids. **Every response was positive with respect to the use of naloxone.**

"I think we have to do, as medical professionals, we have to do everything we can to, to try and keep people alive. That's the oath we take, that's the… the… the role that we play."

"I think that anytime that you have an opportunity to save a life and maybe turn that person's life around, it would not definitely, I mean I would think that that's what we're supposed to do and why we're in EMS and are first responders."

"It's no different than giving Benadryl to somebody that's having an allergic reaction or epinephrine if somebody's heart stopped. You're giving them another shot at life, and they have to deal with the consequences, I think, regardless."

Training on Naloxone

With respect to training, **most groups indicated they had been trained in using naloxone several years ago and continue to receive refresher trainings.** Overall, the general sense was that training was adequate in the use and administration of naloxone, as well as in the identification of when to use naloxone.

"I think we're pretty well trained in recognizing it, recognizing signs and symptoms."

"We've had a couple of, about once a year, we have someone come in, whether it be the local chief of police, police, or one of the medical providers come in, and we kind of have our refresher on the scene safety using the Narcan just to kind of remind us all. So I would say definitely once a year at a minimum, we have that opportunity."

"We do like a quarterly training. Our training division, they're pretty good about getting us information like with fentanyl and the morphine, just kind of showing us the differences in strength between those and kind of what it may look like if you encounter it as far as like pill form goes. Yeah, I think they do a pretty good job of keeping us informed on that stuff here in our trainings."

However, there were some differences in the more rural counties where they indicated that training had just been rolled out and **not everyone in their units had been trained.** It is worth noting that this was mentioned by the volunteer EMT respondents.

"Our squad was just trained last week on the use of Naloxone."

"I have taken the Narcan extra training for it, but for the majority of the squad it's… we haven't. But it's something that we're looking to do in the future."

4) Policies, Training, and Services that Would Help

The theme of policies, training, and services that would help first responders in performing their professional duties emerged from the focus groups and interviews. The subthemes are Follow-up with the Medical Community, Updated Protocols on Naloxone, Availability of Resources for Patients, and Training Needs.

Follow-up with Medical Community

Although we did not ask specific questions regarding policies and procedures, a number of the respondents provided some insight regarding their needs. Nearly every participant spoke of the challenges of identifying what substances might have been taken and then taking the patient to the emergency room with no follow up regarding the substance that was used. They uniformly stated, in one way or another, that **it would be beneficial to know what the substance was so they would know how to respond to future cases that present similarly.**

"Sometimes you find out later, when you go back with another patient, and they say, 'Oh yeah, that guy was on whatever.' But usually we don't know, we never know what they were on."

"That's one thing that we don't get on our end is if somebody overdoses on some unknown medication or pill or whatever, we have no way to go back and follow-up as to what was it?"

"No, we're not able to follow-up because what was told to me, I guess the last time, is they run that stuff through a field lab or a lab with police or with state patrol to do it, but it never comes back to us in regards to what it actually was and what the concentration was or anything like that. As soon as we drop the patient off at the hospital, then pretty much that's it."

Updated Protocols on Naloxone

Several respondents indicated a **need for updated naloxone protocols** as they are having to provide more than one dose at times and this is not currently indicated in their protocol.

"But if it is just, like, if fentanyl, 'cause fentanyl is a super-strong opioid, that if more Narcan is required, but that's a level way above us to make that decision."

When asked about having to give patients more than one dose of naloxone, the response we received was the following:

"That's not in our protocol though either."

"What are we supposed to do? 'Cause it's not in our protocol to give multiple doses of Narcan."

Availability of Resources for Patients

We asked respondents to describe the resources available in their communities for people who are abusing opioids as well as their thoughts about what resources might be helpful in their community for treatment, recovery, or prevention. With respect to resources, many of the EMS/fire participants did not know what resources were being provided to the patients they take to the emergency room. They often mentioned they get the patients to the emergency room, and they presume there might be some resources being provided at the hospital.

"I mean, there's some counseling, some drug counseling services. I couldn't give you a specific one, but I imagine that there's a drug use counselor or substance abuse counselor that would be available."

"I've told people before that don't know what to do, they can request a social worker at the hospital."

"We don't have enough of the mental health help for the drug abusers. Especially when it gets to the point where they need to be EPC'd because they're a danger to themselves or others."

"Nothing in our community that I know of."

Many people talked about the resources that were available, generally, within their communities with some indicating there was little or few resources available and others indicating a number of different resources. These differences seemed to be geographic with more resources available in Regions 5 and 6 than in the other regions.

"I think there's counselors, and I think there is an active group of people that are working towards identifying problems in the community through the hospital, and how to address those issues and what services need to be provided. So, I think that community is very active and very aware of the issues that the nation's facing. I think they're trying to address them, and figure out how to address them in our smaller community."

"I think there's an immense amount of resources out there."

When asked about the resources their department could potentially provide, many of them felt they did not know what the resources might be primarily due to the brief interaction they have with the patient.

"Once we dump them off at the ER, we don't do anything else. But it would be nice to know options that we have here."

"It's all cyclical, that without treating the problem then you keep doing the same thing. You treat 'em and get them to the ER, the ER treats them, they send them on their way, and then nothing."

"It's just a such a short period that we deal with them. We're talking minutes, maybe 20 minutes at the most that we're even around them, and then we dump them off, and we're on to the next patient. And the time we spend with them… we're probably not going to change the pattern, 'cause if Joe can't talk to 'em heart to heart to make them change, then nobody can."

"You can refer somebody to anything, and they can go, 'Thanks,' and go back over to their dealer and buy some more. So I don't… I think they refer a lot of people, but I don't think they… I mean, you can't force behavior change."

Many of the first responders seemed concerned about the patients who needed something more than an emergency room visit, but felt as though there were no other options.

"It seems like we get the question… A lot of times, these constant overdoses like alcohol, and what the step is, taking 'em to the ER is not what they need. They need some kind of treatment, but they don't seem like we have, like we don't really know any way to really steer people towards like… if we had any resource like, here's somebody to contact."

"'Cause the shelters, they're not gonna take 'em to the shelter because they can't go in if they're under the influence of anything."

"And a lot of times, we're seeing the same people over and over, and they're banned and barred… We end up taking them to the ER, and we feel like, in 6 hours, they're gonna be out on the same boat they're in now. And the ER's tired of seeing them."

Training Needs

All participants were asked what additional training needs they would like with respect to opioid overdoses. **Most thought the current training curriculum and the training venue through company school was sufficient.** However, if they were to have a "wish list" of sorts, they did mention wanting to get more **current information on the street names of drugs being used and having more information on when it is appropriate to use more than one dose.**

"Training on what's out there… example is fentanyl and having the facts and not going by what you hear in social media. Need factual information in order to respond appropriately and not freak out over white powdery substances; also knowing how patients are abusing."

"More recognition. I think we can always have more training on what to recognize in symptoms of hallucinogens, other intoxicating substances so we know what we're getting into after we make contact with a patient, and if they're already breathing, and it's not necessarily a case for Narcan. "

In addition, other training needs were related to **personal safety.** A majority of all respondents mentioned having to subdue combative patients. This was particularly true of patients who accidently overdosed on an opiate and were angry that their "high" was just taken away.

"Watch your back, just 'cause, you know, they might be laying there one second, next thing you know, they're up wanting to fight you."

"We always preach safety because you might take away that high, and they come out swinging once you've taken that away. And you've probably seen, it but it's just so fast, how fast that Narcan changes."

If respirations are ok… I'm not gonna give it to them because you give someone a dose of Narcan, and you could take somebody that's very sedentary, maybe even sleepy-like and a lot of times they're gonna be exceptionally angry that that high that they tried so hard to go on."

5) Compassion Fatigue: Support and Strategies

Participants were asked about Community Support. They also shared Role Challenges and Remedies. Their opinions were also invited on Compassionate Fatigue-related Strategies implemented in other fire stations nationally.

Community Support

Every station felt supported by their community and readily provided examples of how the community showed their appreciation.

"I think we have pretty strong support around the community. Every year, it seems like they do polls and stuff and what's the one thing you want to see supported? And it's always police and fire at the top of the list. So I think a lot. But I think we do a great job creating that and getting enough support by being professional and doing the small things that we're not really even there for. You know there's bringing in your newspaper

off the driveway or scooping up a sidewalk when it's covered in ice and snow, and just those little small things I think go along way in our public perception. There's people out there that don't like what we do obviously, but I think the vast majority really are supportive of the things we need and if we come at them with facts and figures saying this is what we need."

"We're really lucky here at this station, we've got a great group of people and everybody gets along so it makes it easy to come to work. It makes it easier to deal with things, you know we can have our own little briefing sessions whenever we need to."

"They'll give donations, thanks in the papers, thanks personally, and even just like some follow ups if we may have had a call. And we might see somebody, and they'll let us know how their family member is doing, if it was somebody that knows we were there."

Role Challenges and Remedies

Nearly all focus group interview participants talked about **the challenges of their job.** Below are some of the challenges they face which contribute to compassion fatigue.

"With the advent of the cell phone and everyone recording and doing things, I think there's a lot less of us in public, being less compassionate than we should be, because you never know who's got a cell phone anymore. So I think it's keeping people in check of being professional and doing what we're supposed to do, no matter if we've seen this person 12 times in the last month or not. And I know I was just as guilty younger on, 'cause you start seeing… When you start realizing how many people's full name, full address, I know your birthday, I know what medicines you're on, and I don't know what to say to my mom or my dad, but I've got all this different information stored on so many people that it's like… it's easy to be fatigued, and you're no longer as compassionate for that person."

There were other comments as well about **what contributes to compassion fatigue.**

"They gotta understand 911 is for something more important. Knowing when a real emergency problem is. It just burns a hole. First responders… it just brings you out of it. You get tired, and you could spend more time actually helping somebody that actually needs help."

"I mean, just continuous call volume, and then sleep fatigue, when your sleep cycle is interrupted. You're not having good overnight sleeps, even on your off days. If you're not having good sleep, you're not gonna be fresh. You're not gonna have the emotional mental capacity to deal with the continuous… and the compassion fatigue just builds up over time."

Oftentimes, the conversation veered to what first responders were doing to recharge and how compassion fatigue was being recognized by the department. There were many positive statements made about this.

> *"And I think some of the narrative is changing in the fire department of, 'I'm allowed to seek help.' Like recognizing… 'I'm not myself right now, I should go talk to somebody,' and realizing that that's not a bad thing, and that should be okay."*

> *"Find your routine that kind of resets you, whether it's working out an hour a day, or traveling, whatever it is that makes you happy. Make sure you're doing it on your day off to reset, and get away. Find whatever works for you. There are a thousand different ways to deal with stress. Find what works for you. Surround yourself with people who have good attitudes. And we all have bad days, but surround yourself with those who are gonna pick you up, and can handle being told, 'Hey, you're kind of being a jerk today, and you should fix it.' And find those that have no problem with you telling them that same thing, would be my advice."*

Compassion Fatigue Strategies

We asked each focus group/interviewee about possible strategies mentioned in the literature with respect to compassion fatigue and working with drug overdoses on a regular basis. There was consistency in the responses across the 13 focus groups and interviews.

When asked about **meditation** as a compassion fatigue strategy, there was a mixed response to this with five groups indicating this would be a good idea, the majority coming from the central part of the state. At least one station had already implemented this.

> *"I think guided meditation would be an awesome option."*

> *"We actually have that. That counselors group I was talking about earlier in our family assistance program actually has come in and has given us a couple meditation classes.*"

When asked about a **yoga** class, there was limited enthusiasm. Many seemed to know this was being done in other states, but did not think it would work well here. Some of the women indicated they would prefer not to do this with the men from their unit and some mentioned they were already doing their own yoga on video. A few people thought this would be a great idea. When yoga was mentioned in the interviews, a lot of the respondents indicated they had their exercise regimes at the station already. One person offered that perhaps a fitness instructor assigned to each station would be more palpable.

> *"I like the idea of yoga, personally. But I think there's a lot of that. It's hard. And if you get a group of macho personalities together. No, it's a terrible idea."*

"You have to be in a good mental place to get the benefits from yoga, and if you're thinking about the tone's gonna go off, and you're not in full uniform, so you gotta get dressed to go make the call, it's not as relaxing, I don't think."

"I think everybody has their own way of dealing with stress. I like to workout. I wouldn't do yoga. I like to run. I like to do all kinds of other stuff. Doug likes to do weights, and if they do push-ups when they get back from a call, maybe that's your stress relief."

"We do circuits in the morning, out in the bay, a lot of times together, and more times than not, we get interrupted by a call, so yeah, we do try to work out."

"Just don't think it would really apply here although other stations do it."

We also asked about having **support groups.** There was a generally positive response to this although most stated they had a similar resource available to them already. Many talked about the peer support system that was in place.

"The peer support group has some referral partners in place."

"We have a peer support team which is where it starts for us. Two guys that are trained in talking to guys and helping them work through their feelings or concerns. If it needs to be, they refer them up a ladder to an employee assistance program with trained counselors. The trained counselors can send them up even further if there's a need be. As long as the people ask for help, hopefully we can get it to them."

The last strategy we asked about were **massages**, and respondents thought that was a great idea!

"I can take as many massages as I can get."

"They're great!"

"Oh, I bet they would be all for that!"

EMS and Fire: Qualitative–Summary

Drug Overdose Trends

- **Opioid overdoses:** The overall response to questions regarding drug overdoses generally and opioids specifically was that opioid overdose calls were not the majority of their calls. Responses ranged from 0 to 12 opioid overdoses per month.
- **Involvement of other known or unknown substances:** Many of the units discussed how substances other than opioids were more of an issue. Nearly all units stated that alcohol was nearly always a factor. They also named fentanyl, methamphetamine, over-the-counter drugs, and heroin. Other times respondents said they did not know the substance that was involved or it was a mix of substances.
- **Geographic differences:** The number of overdose calls depended on location with the more urban units indicating they responded to more overdose calls per month compared to the units in more rural areas. Several participants said being in a small community both positively and negatively impacted their department's work.
- **Generational differences:** Most units mentioned a generational difference in the calls they are getting and mentioned seeing an uptick in the number of medication-related calls–not necessarily an overdose, but calls regarding a concern with the reaction to medication. Overdoses with the younger population also present challenges as they generally are not due to one substance.

Call Responses

- Focus group participants and interviewees spoke of their experiences in responding to calls when not knowing the nature of the call nor the drug or combination of drugs that may be involved. They also shared their opinions on the Safe Stations and Paramedics as Recovery Partners programs in responding to community needs.

Naloxone and Other Surge Needs

- **Availability of Naloxone**: Participants indicated they had enough naloxone on hand to handle current demands and most thought they had enough on hand to handle the need for multiple uses. Several units across Nebraska also said they felt comfortable in managing overdose calls without naloxone. Rural responses were different than urban responses with several respondents indicating that personnel would be a concern should there be a surge.
- **Naloxone use:** Those who had experience with naloxone were quite comfortable in using it. Other comments made were with respect to dosing speed where, those with a lot of experience with administering naloxone, may sometimes try to control the dosing speed so the patient does not become combative.
- **Perception of Naloxone**: Participants perceived naloxone positively.
- **Training on Naloxone:** Overall, the general sense was that training was adequate in the use and administration of naloxone. However, personnel in rural communities felt less trained.

EMS and Fire: Qualitative–Summary

Policies, Training, and Services that Would Help

- **Follow-up with medical community:** Participants stated, that it would be beneficial to know what substance was involved so they would know how to respond to future cases that present similarly.
- **Updated protocols on Naloxone:** Several respondents indicated a need for updated naloxone protocols as they are having to provide more than one dose at times and this is not currently indicated in their protocol.
- **Availability of resources for patients:** Many participants did not know what resources were being provided to the patients they take to the emergency room. Some indicated there were few resources available and others indicated a number of resources. Many seemed concerned about patients who needed something more than an emergency room visit, but felt as though there were no other options.
- **Training needs:** Most thought the current training curriculum and the training venue through company school was sufficient. Some wished to get more current information on the street names of drugs being used or for more training related to personal safety.

Compassion Fatigue: Support and Strategies

- **Community Support:** Every station felt supported by their community and readily provided examples of how the community showed their appreciation.
- **Role challenges and remedies**: Participants talked about the challenges of their job, what contributes to compassion fatigue, and what they were doing to recharge and how compassion fatigue was being recognized by the department.
- **Compassion fatigue strategies:** Participants shared their opinions about possible strategies mentioned in the literature with respect to compassion fatigue including meditation, yoga, support groups, and massages.

EMS and Fire: Qualitative–Limitations

As with all qualitative research efforts, STEPs encountered limitations. The research team made concerted efforts to reduce limitations that could impact conclusions and results. These potential limitations provide richer context to the research. The limitations are listed as follows:

1. Members of the STEPs team contacted fire administrators in each of the high burden areas to invite participation in focus groups or interviews. Attempted contacts were made both by phone and email; however, we had very limited success. The STEPs team was most likely an unknown contact and response rate could have been negatively impacted by this factor.
2. The overall project was on a limited timeline and coordinating numerous focus groups and interviews within several weeks was challenging. At least two of the scheduled focus groups or interviews were cancelled due to weather conditions or having to take an emergency call.
3. The risk of bias is involved in all qualitative research. STEPs utilized two coders to limit bias in the coding of the data. The coders utilized writing memos to capture ideas, thoughts, and definitions. The coders worked with all researchers using a team approach.
4. Due to a short timeline, geographic distance, and a particularly hard winter, STEPs engaged with the Panhandle Public Health District (PPHD) to conduct three focus groups in the western portion of the state. STEPs prepared the consent and script, and spent time training PPHD facilitators. Collaborating with the PPHD limited the amount of control in conducting focus groups.
5. A mix of both focus groups and interviews may have hindered the amount of in-depth conversations or the quality of discussion.
6. No focus groups or interviews were conducted with participants from Regions 2.
7. Much data was obtained, but because of our constricted timeframe, STEPs was not able to analyze the data as deeply as would be possible with more time. For example, there appears to be differences between urban and rural communities that merit additional attention.
8. More in-depth conversations regarding opioid-specific concerns would be beneficial in understanding the depth and breadth of the concern in Nebraska, with a particular focus on the stations that respond to the most opioid-related calls in each region.

EMS and Fire: Qualitative–Recommendations

In summary of all qualitative analyses of the Fire/EMS professionals, STEPs recommends DHHS:

1. Developing a process of follow up with EMT personnel regarding the drugs that were taken once a patient is dropped off at the emergency room.
2. Increase communication with Fire/EMT personnel regarding the trends in the community regarding current drug use to help with better on-scene assessments.
3. Assess current protocols regarding naloxone administration to provide guidance on when multiple doses may be needed.
4. Review dispatch protocol to determine if additional information could be obtained from the caller regarding the substance used.
5. Because the names of street drugs change so rapidly, update and provide the current street lingo to EMTs.
6. Provide training to EMTs on working with combative patients.
7. Increase collaboration with law enforcement when responding to possibly dangerous situations.
8. Tailor the provision of training and resources across the state as the experiences and needs are disparate.
9. Although most respondents indicated they had mechanisms in place to help with compassion fatigue, it was evident in the responses that some of the stations are involved in many "non-emergency" calls which is taking away from the ability, both physical and mental, to respond to emergency calls. Strategies should be identified with collaboration of the various fire stations to determine the best response.
10. There appears to be different needs for volunteer and non-volunteer stations as well as for those stations in urban and rural areas. A secondary analysis with this data might provide additional insights.

Drug Overdose Prevention Needs Assessment

Law Enforcement

Focus Groups and Interviews

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES
DRUG OVERDOSE PREVENTION

UNIVERSITY OF NEBRASKA AT OMAHA
SUPPORT AND TRAINING FOR THE EVALUATION OF PROGRAMS

Interview Participants

During the first quarter of 2019, STEPs conducted semi-structured interviews with law enforcement officials in nine Nebraska jurisdictions. Participating jurisdictions included eastern Nebraska local and county level law enforcement (e.g., police and sheriff's departments) that represented urban, suburban, and rural jurisdictions. A single jurisdiction in western Nebraska was responsive to the request for study participation although multiple contacts were made to several departments.

9

jurisdictions

The majority of qualitative interview respondents were Caucasian males, which is typical of law enforcement command leadership in the state of Nebraska at this time. The interviews utilized the Law Enforcement Focus Group Questions (see Appendix E).

Region	# of participating agencies
1	1
2	0
3	0
4	0
5	1
6	7
Total	9

Results from the qualitative interviews with law enforcement are summarized in the pages that follow according to these themes:

1. **Prevalence of opioids in your community.**
2. **Perceived capacity to respond to opioid overdoses: Existing training resources for law enforcement officers on opioids and opioid overdoses and ongoing need.**
3. **Perceived capacity to respond to opioid overdoses: Existing material resources and ongoing needs.**
4. **Stress.**

1) Prevalence of opioids in your community.

Opioid use is less prevalent and concerning to law enforcement as compared to methamphetamine use.

Participating law enforcement agencies in Nebraska noted that while opioids are one of the substances they are handling on calls for service, the most concerning and pressing narcotics issue in Nebraska has been, and continues to be, use of methamphetamine. The exception is in jurisdictions on the I-80 corridor where calls for service related to opioids and overdoses have risen in the past few years and deemed problematic.

Officers noted that opioid use tends to garner a disproportionate amount of media and other public attention because small quantity use and exposure can result in overdose and death, and opioid users come from a broader range of socioeconomic background as compared to other drugs. Without prompting, officers from urban areas consistently noted that methamphetamine prevalence is "as big as its been" in their communities, and much more common than opioid use or crack cocaine. One participant specified opioids in its various forms is the least problematic narcotic indicating, "We're on an island and have taken preventative measures" to avoid surges through legislation and other measures. Participants in general felt strong laws were in place to prevent opioids from becoming a major issue in Nebraska as is seen in other areas.

The drug trafficking pattern of opioids and methamphetamine is experiencing a change. Both drugs are being produced cheaply in mass quantities outside of the U.S. and trafficked into the country. **Officers noted that methamphetamine labs are no longer an issue.**

Anecdotally, officers find drug users are transitioning to methamphetamine or heroin because they can no longer access prescription drugs. A continued negative aspect of this drug class is users are frequently involved in property crimes and robberies. These changes in drug trafficking patterns have resulted in officers encountering opioids during traffic stops in jurisdictions along the I-29 and I-80 corridors.

Statistical information available to law enforcement on opioid use and opioid overdoses varies by agency.

Agencies interviewed varied in the extent to which information was available to officers regarding opioid use and overdoses in their jurisdiction. All calls for service (including non-arrests) and incident reports are cataloged in Computer Aided Dispatch systems and/or Record Management Systems. In many cases, these systems do not document drug use information in a format that can be easily aggregated in intelligence reports. To obtain such data for intelligence reports, an agency must review call records and extract the information, sometimes manually. Jurisdictions large enough to have a data analysis unit might conduct this type of research for the department. This action may also be taken by any jurisdiction if a spike in drug use is detected anecdotally by the narcotics officer. The information would then be used to enhance officer training or for other enforcement purposes, but these actions may be beyond the capacity of smaller agencies.

Command staff in larger jurisdictions have monthly meetings at which managers and certain unit commanders attend. Meetings are comprised of data analysis predictions of what the jurisdiction might expect in the upcoming months. For example, data analysis units may track the number of overdoses that have already occurred and based on that information will project trends expected.

Uniquely, in the western part of Nebraska where individual county level law enforcement agencies tend to be small, drug task forces such as the Western Nebraska Intelligence and Narcotics Group (WING) have been developed. WING agents are drawn from the ranks of the Alliance Police Department, Chadron Police Department, Cheyenne County Sheriff's Office, Gering Police Department, Kimball Police Department, Nebraska State Patrol, Scottsbluff Police Department, Scotts Bluff County Sheriff's Office, and the Sidney Police Department to form the collaborative. Eastern Nebraska jurisdictions noted that they rely on these types of tasks force groups to house intelligence field analysts who work for the Nebraska State Patrol. WING provides alerts and information to officers by emails and phone alerts.

Smaller jurisdictions reported the prevalence of overdoses was low. One suburban jurisdiction noted that in the last six months, only a single opioid overdose incident occurred. In contrast**, urban jurisdictions reported a much higher prevalence rate of overdoses in the past year.** Importantly, law enforcement agencies noted the overdoses could be resulting from aspirin to hardcore drugs, and they do not have detailed information. It is also common to find people overdosing with poly-pharmacy situations where the individual has consumed a mix of drugs.

Strongly emphasized throughout the interviews was that law enforcement officers do usually consider any call for service specifically as an "opioid-related" call. Patrol officers "99% of the time" will not know they are responding to an opioid-involved call and similarly may not be aware they are responding to an opioid-related overdose call for service.

Responding officers treat all scenes involving drug overdoses similarly, regardless of drug type that may have been used by individuals including administration of naloxone. Participants consistently indicated that having information about the type of drug on which an individual overdosed would not be substantially beneficial to the officers on the scene. Most often, dispatch does not provide officers detailed information about the situation to which they are responding. For example, typically an officer is responding to a "disturbance" call, but he or she does not receive information about drugs involved or health situation of individuals on scene; however, the other first responders (e.g., fire and EMS) may receive this information.

The primary role in responding to a known overdose call is to assist in transport as needed for medical reasons to a nearby hospital. Even in these cases, law enforcement often does not know which drugs are involved and may never know the outcome of a situation after the individual is handed off to medical personnel. The only working information that may be garnered by officers is from "bad overdose calls" that stem from the same set of addicts. Overdoses among these known users may help officers know there is a new type of drug (or drug mix) in the market. The WING's intelligence field analyst keeps track of all the overdose reports and may help develop this type of knowledge as well.

2) Perceived capacity to respond to opioid overdoses: Existing training resources for law enforcement officers.

Strong training resources are currently available to law enforcement in Nebraska.

No concerns or needs regarding the availability of training materials on opioids existed or were identified. Many jurisdictions felt very adequately prepared regarding knowledge of opioids, and from a knowledge standpoint were prepared for potential spikes or surges in opioid use or overdoses. The various modalities of existing resources are discussed next.

Training Bulletins. Information is shared with officers through law enforcement training bulletins, or Information Orders, produced by their agency. Some bulletins include information on prevalence of various forms of drugs and legal statutes. **More timely dissemination of current knowledge on opioids as it develops could be shared with law enforcement.**

Officers perceived drug-related knowledge (e.g., trends, prevalence, knowledge about a drug) to evolve quickly and they want to be up to date. Agencies with training bulletins create their own bulletin, or rely upon other sources for information (e.g., DEA, FBI, and other local, state, and federal agencies) and incorporate that information within their training bulletins. In some jurisdictions, officers electronically review training bulletins and "sign off" to indicate they read the bulletin. Crime Analysis Units may also gather and report on opioid use and abuse, best practices, and intelligence reports.

Training academy. A major resource for transmitting current knowledge to patrol officers is during the officer training academy. While in the academy, officers typically receive training on legal aspects of liabilities (e.g., Good Samaritan law). The training officers teaching the academy curriculum may rely on past data, reports from the local physicians, DEA, Nebraska Information Analysis Centre (NIAC), and State Patrol Fusion center to refine their presentations and knowledge. Some departments have special, designated training officers to provide training or have Subject Matter Experts (SME) provide training and overdose information.

The training academy is very intensive and does not allow for many new additions of content areas even though knowledge on topics such as opioid and overdoses continues to evolve quickly. Participants discussed a variety of other existing methods for disseminating knowledge to their officers as discussed next.

Online videos. Both in the training academy and beyond the training academy, law enforcement agencies indicated the high value of video resources that were available to the officers. An online system in some larger law enforcement agencies stores information and videos on various opioid-related topics such as proper administer of naloxone. In other smaller jurisdictions, the Public Health Department is leading efforts to develop training videos and make these resources available to local Sheriff' **These types videos are one example of a useful training resource that could be developed by entities and provided to law enforcement agencies in Nebraska.**
s departments.

Roll call training. Another existing opportunity for training is during roll call. Participants noted that during line up/shift change, individuals may be briefed about relevant drug-related information. This is the ideal time to provide officers with updated knowledge on relevant topics through verbal or written format. **Particularly encouraged by participants was the development of brief videos (5-10 minute) that could be shown at roll call.**

Annual/recurrent training. Annual training is required and scheduled regularly for sworn law enforcement officers. In some jurisdictions, the law enforcement agency works closely with the fire department who takes the initiative on opioids or related drug training. Opioid and drug training in general is typically part of in-service trainings in which a minimum requirement of 20 hours per year is required by the state. In actuality, a higher number of training hours across the various departments was targeted, varying from 24 to 80 hours per year.

20
hours
Minimum hours of recurrent training required

All jurisdictions were interested in additional training opportunities that were low cost.

Counties are willing to send their officers for training if more were available. Some officers are able to attend conferences and trainings, specifically noted the Midwest Counter Drug Training, but resources are limited.

K2 training was suggested as a training resource. This is a (K2) Person Borne (PB) Handler Course including 8 weeks of specialized instruction. The course is designed to ensure the K9 handler is teamed with a highly trained PB canine that can work in all operational environments.

80
hours
Highest number hours of recurrent training targeted by participating agencies

At times during the interviews, participants engaged in brainstorming efforts to think of different types of training from which their officers might benefit. Some options included **having individuals who have experienced overdose situations to come over and talk about their problems and experiences with the drugs**. These individuals could also share with the department their experiences while being involved in treatment activity.

Participants also indicated an openness to having more subject matter experts come in to their agencies and discuss the latest developments in the field about new drugs, and ways to handle those drugs.

In summary, law enforcement officials feel their organizations had the knowledge to handle opioids in their community including overdoses, spikes, and potential surges. They were committed to expanding training given the appropriate resources, and recognized the existing knowledge base was ongoing in evolution.

3) Perceived capacity to respond to opioid overdoses: Existing material resources and ongoing needs.

Officer safety concerns surrounding opioids stem from inhalation risk of drugs such as fentanyl, more so that contact exposure. Inhalation risk extends to concern for K-9s and their handlers. Officers are able to administer naloxone to officers and/or K-9 in the event of exposure or inhalation. Officers are trained to take safety precautions on scene where exposure risk exists. Precautions include use of N-95 masks, in addition to safety gloves and goggles. An added prevention measure is that drugs no longer field tested by officer to avoid exposure; instead, substances are lab tested including, in some jurisdictions, testing at the precinct. Unfortunately, participants noted that in some **jurisdictions safety equipment is lacking, and they are under resourced should a spike or surge in opioid-related overdoses occur in their community.**

Naloxone. The vast majority of law enforcement agencies have had naloxone available for officer use in their department for one to two years. In these jurisdictions, the vast majority (nearly 100%) of officers are trained on the administration of naloxone under statute 28-405. Some jurisdictions have Naloxone Administration Procedures developed, while others are still working to develop formal policies. In larger departments, it is a challenge to ensure that all sworn officers who should be equipped with naloxone at all times have access, and are sufficiently trained. All departments required officer training before officers are able to carry naloxone kits. **The two-year shelf life and resulting lack of funds to replace naloxone kits was a concern among larger departments in Eastern Nebraska.**

Jurisdictions were commonly concerned about the limited availability and accessibility of naloxone. These limitations are problematic because law enforcement officers are first responders. In some jurisdictions, all officers had access to naloxone (e.g., "Every officer always has one dose of naloxone on them."); yet, in other jurisdictions only specialty officers such as school resource officers, or specialty units had consistent access to kits.

While officers have confidence they have sufficient naloxone on hand to address an average call, in the event that a spike or surge occurs, some departments felt they would be unprepared. One officer provided an example that in a case with multiple victims due to a "bad batch," an officer would not have enough naloxone on hand meaning "they have to pick and choose whom to administer the naloxone first. It becomes a judgment call."

In discussing the preparedness of local law enforcement for a surge, the importance of collaborative relationships between law enforcement and the local fire department became apparent regarding accessibility and supply of naloxone. Commonly, the Fire Department or EMT arrives before patrol and administers naloxone (about 10% of time police administer). If given an option, officers would also defer to EMT to administer naloxone because their agency has so fewer kits and perceived that Fire/EMT had a larger supply for utilization.

Access to obtain naloxone varied by jurisdiction. Some agencies obtained naloxone directly from the manufacturer, while others obtained kits from various state sources or the local fire department. If a spike in overdoses happened, agencies that had a strong relationship with their Fire Department perceived they would be able to respond accordingly because they can get kits fairly quickly (within 10 days or so). Jurisdictions that did not partner as closely with their fire department (e.g., obtaining naloxone through other sources) felt less adequately prepared.

One reason for the under resourcing of naloxone kits in some jurisdictions is because naloxone kits were originally obtained so that officers could administer the drug to themselves or other officers if they were exposed to fentanyl. Current practices include officers carrying a P-100 respirator for protection against inhalation risk during vehicle searches. Moreover, if an officer believes they were exposed to fentanyl, they are advised to call the EMS rather than self administering the naloxone. Naloxone kits are more often used on civilians suspected to be overdosing.

Toxicology reporting. Toxicology is very expensive for agencies, so it is rarely used as an investigative tool. If additional funding for toxicology reports became available, some jurisdictions felt they could use this information for drug trend analysis to identify new drugs in the area, but that, toxicology screens would not provide any other assistance beyond drug pattern analysis.

Smaller counties in Nebraska receive funding through DHHS for toxicology screens. In case of death, they follow the coroner's policy. In cases of overdose death, post mortem is conducted and toxicology screens are done by default. If there is a suspicion of an overdose in a death, then the toxicology screen will alsobe conducted. For overdose deaths, the county attorney gets involved too.

If this funding was available to other urban jurisdictions, they would be able to conduct more toxicology screens to figure out what drugs are being mixed together and whether there are new drugs being used/distributed in the area. Knowledge about new drugs could lead to more trainings/ staying on top of trends.

4) **Stress and wellness.**

Officers expressed concerned about opioid use and abuse in communities and take substance use and abuse very seriously. While substance use is a concerning matter, participants did not perceive opioid use, abuse, overdoses, or the potential for a spike or surge in these factors to be particularly stressful. Instead, the potential for violence that officers face regularly in responding to calls for service takes higher importance and causes more stress on a regular basis.

Interestingly, participants discussed a different concerning aspect of opioids as it related to officer stress and wellness. It is common knowledge that law enforcement officers experience stress as a result of their job as noted. It is also common for officers to experience injuries on the job as the result of violence encounters experienced while on duty or due to other job-related hazards (e.g., prolonged sitting in patrol car, heavy duty belt). Sometimes when officers experience injuries (e.g., back or shoulder injuries), the injury results in the prescription of opioids for pain management. The combination of a stressed workforce population and prescription of opioid based medication to that population presents a non-zero risk of addiction.

In an effort to support officer well-being, law enforcement agencies typically have an employee assistance program (EAP), where officers can meet and discuss any issue they are facing, and receive a referral if the representative cannot adequately assist them. For their physical health matters, officers have gyms inside the department where the officers are encouraged to go regularly to maintain their fitness. In some departments, more formalized training officers will disseminate information about current and upcoming training sessions through bulletin boards or electronic notices.

Larger departments tend to have a representative on city wellness committees that contact officers often about wellness opportunities or are engaging in efforts to develop Wellness Programs. Wellness efforts promoted by the departments might include diet and fitness challenges, opportunities for blood panels, fun runs, or partnerships with local fitness centers. Officers might be offered various incentives to ensure their physical and mental wellness.

Law Enforcement: Limitations

1. The research team engaged in significant efforts to ensure regional representation from western Nebraska law enforcement agencies; however, participation was limited in smaller jurisdictions. Although the participating agencies from Region 1 and Region 5 were knowledgeable about their region in general, additional agency participation would enhance the robustness of our conclusions.

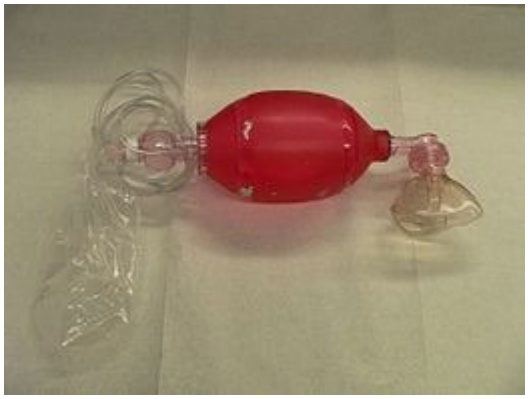
2. Similar to other qualitative components of this report, responses are subject to bias. The majority of participants in the qualitative interviews were command staff with significant levels of experience. Their career length and "birds eye" view of their law enforcement agency and jurisdiction may bias their responses such that they differ from entry level patrol officers who have less experience.

3. Due to the law enforcement context, qualitative data was captured in a manner different from the healthcare and other first responder qualitative data. Data collection was completed in a more conversational manner, and notes were taken rather than the interaction being audio recorded and then transcribed verbatim. While this manner of qualitative method was more conducive for the context, it runs a higher risk of introducing bias into the findings.

In summary, jurisdictions that participated felt sufficiently trained on opioid-related knowledge and well prepared from a knowledge perspective to respond to a surge or spike in opioid-related overdoses. That said, the vast majority of departments felt they did not have sufficient material resources to respond to a surge or spike. In discussion, the material needs were clearly outlined by interview participants. Recommendations for supporting these resources are outlined next.

Recommended items needed to support law enforcement resource needs:

1. Resource Needed: Bagging valve masks and associated training.



Patrol officers were concerned about violence when reviving a person who has overdosed. The concern with violence may distract the officer from other things in the immediate surrounding that could be dangerous to their own health, e.g., needles and other drugs they could potentially come into contact with. If officers were equipped with bagging valve masks and were sufficiently trained in usage, some interview participants felt that administering naloxone would not be required.

Instead, a potential policy is to advise to bag the individual "patient" and wait for EMS to arrive. One officer noted that even with 4 milligrams of naloxone, the individual can be combative and that can become a safety issue for the officer and others in the immediate area.

2. Resource needed: Heat and cold protective bags for naloxone kits. Based on interviews, a clear need aside from resources to ensure an adequate supply of naloxone were items related to safely storing naloxone. The naloxone kits are temperature controlled and are never left in the police cars overnight but heat and cold protective bags are required.

3. Resource needed: Respirators. During a potential spike or surge of opioids in the community, to avoid officer exposure to dangerous contaminants during vehicle searches, some jurisdictions felt they would benefit from additional resources including P-100 respirator kids.

4. Resource needed: Protective gear–Fume Hoods for substance testing. During a potential spike or surge of opioids in the community, to avoid officer exposure to dangerous contaminants during vehicle searches, some jurisdictions felt they could continue to avoid field testing of drugs and enhance officer safety by purchasing fume hoods to facilitate in-house examination of drugs.

5. Resource needed: Interdiction support. Agencies would like to have more patrol officers and K-9 units dogs dedicated to highway interdiction for crime and drug prevention efforts. Highway interdiction with patrol dogs have a higher impact for drug use prevention given the inflow of opioids on the Nebraska corridors. Yet, this is an expensive undertaking ($100,000 for patrol car and $7,000 for purchase of the drug dog). Officers believe if they were able to use patrol dogs for highway stops, drug-related calls, focused patrols more often, the word would spread and drug trafficking would decrease.

6. Resource Development: Training Aids. Aid in more timely dissemination of current knowledge on opioids as it develops could be shared with law enforcement. Ideally, information would be developed in video format, in short increments, which could be provided for use in any of the information dissemination modalities currently used by law enforcement as discussed earlier in this report (e.g., roll call, available online).

7. Subject matter experts. Support subject matter experts visiting with law enforcement agencies to discuss the latest developments in the field about new drugs, and ways to handle those drugs.

Appendixes

Appendix A: Healthcare–Quantitative Survey

Surveys

To achieve feedback from a large scope of medical professionals, STEPs developed quantitative surveys to be administered through Qualtrics. Qualtrics is an online survey software that assists in the design and distribution of surveys.

Sample

In mid-January of 2019, a short survey was sent through Qualtrics to the administrators of relevant healthcare facilities requesting the email addresses of staff members. The purpose of this survey was to collect a comprehensive list of email addresses from all relevant parties for STEPs to use in sending out the quantitative surveys.

However, multiple healthcare administrators responded to this request stating that it was time consuming to input each staff member's email address, some of which were confidential, into Qualtrics. Because of this feedback, STEPs disseminated the survey by sending an anonymous Qualtrics link to healthcare administrators, who then forwarded the link via email to their staff members. This survey was provided to personnel in medical facilities and emergency departments in Nebraska counties, including physicians, nurses, social workers and mental health therapists, case managers, administrators, and other medical facility staff.

Survey Items

The survey introduction informed the respondent that the purpose of the survey was to better understand the capacity of healthcare professionals to respond to a surge in opioid use. The introduction also explained that responses would be anonymous and would be used by STEPs, in combination with qualitative results, to create a final report for the Nebraska Department of Health and Human Services (DHHS). They were told DHHS would use the final report to inform their allocation of grant funds and resources, in addition to the development of statewide crisis response plans.

The 18-item survey was a combination of closed-ended and open-ended questions. These items focused on four areas:

- *Demographics*: role, service area population, service area county, age range, and gender.
- *Naloxone*: training, current and past administration frequency, availability.
- *Service area*: perceptions of substance use, treatment options, resources needed.
- *Compassion fatigue:* work-related stressors, self-care.
- *Overdose emergencies*: frequency, substances responsible, training, protocols.

Survey questions were developed in collaboration between STEPs and Nebraska DHHS.

Introduction

Thank you for taking part in this important survey to gauge the capacity of first responders across Nebraska in responding to increased opioid use.

This survey is part of a statewide needs assessment by the Nebraska Department of Health and Human Services' Division of Public Health to assess the capacity of systems in Nebraska to respond to surges or clusters of intentional, unintentional, and unknown drug overdoses, especially in high-burden areas and with a focus on opioids. This survey is administered by STEPs (Support and Training for the Evaluation of Programs) through the University of Nebraska at Omaha. Aggregate responses to this survey will be used to allocate grant funds, resources, and develop crisis response plans.

We expect this survey to take 5 to 10 minutes to complete. Responses will be analyzed collectively by STEPs and individuals will remain anonymous. The STEPs team will then provide a final report with recommendations to DHHS using your invaluable feedback.

Q1 What is your role or position at your medical facility?

- ☐ Physician
- ☐ Nurse
- ☐ Social Worker or Mental Health Therapist
- ☐ Case Manager
- ☐ Administrator
- ☐ Other. Please specify: _____

Q2 How many years have you served in this capacity?

- ○ Less than 1 year (1)
- ○ 1-5 years (2)
- ○ 6-10 years (3)
- ○ 11-15 years (4)
- ○ 16-20 years (5)
- ○ 21-25 years (6)
- ○ More than 26 years (7)

Q3 What is the population of your typical service area?

- ☐ Rural (under 2,500 people) (1)
- ☐ Urban Cluster (2,500 to 29,000 people) (2)
- ☐ Urban Cluster (30,000 to 50,000 people) (3)
- ☐ Urban (over 50,000 people) (4)
- ☐ Other (5) _____

Q4 Which county is your facility located in? (check all that apply)

- ☐ Adams
- ☐ Antelope
- ☐ Arthur
- ☐ Banner
- ☐ Blaine
- ☐ Boone
- ☐ Box Butte
- ☐ Boyd
- ☐ Brown
- ☐ Buffalo
- ☐ Burt
- ☐ Butler
- ☐ Butler
- ☐ Cass
- ☐ Cedar
- ☐ Chase
- ☐ Cherry
- ☐ Cheyenne
- ☐ Clay
- ☐ Colfax
- ☐ Cuming
- ☐ Custer
- ☐ Dakota
- ☐ Dawes
- ☐ Dawson
- ☐ Deuel
- ☐ Dodge
- ☐ Dixon
- ☐ Douglas
- ☐ Dundy
- ☐ Fillmore
- ☐ Franklin
- ☐ Frontier
- ☐ Furnas
- ☐ Gage
- ☐ Garden
- ☐ Garfield
- ☐ Gosper
- ☐ Grant
- ☐ Greeley
- ☐ Hall
- ☐ Hamilton
- ☐ Harlan
- ☐ Hayes
- ☐ Hitchcock
- ☐ Holt
- ☐ Hooker
- ☐ Howard

Q4 What county is your facility located in? (check all that apply) (continued)

- ☐ Jefferson
- ☐ Johnson
- ☐ Kearney
- ☐ Keith
- ☐ Keya Paha
- ☐ Kimball
- ☐ Knox
- ☐ Lancaster
- ☐ Lincoln
- ☐ Logan
- ☐ Loup
- ☐ McPherson
- ☐ Madison
- ☐ Merrick
- ☐ Morrill
- ☐ Nance
- ☐ Nemaha
- ☐ Nuckolls
- ☐ Otoe
- ☐ Pawnee
- ☐ Perkins
- ☐ Phelps
- ☐ Pierce
- ☐ Platte
- ☐ Polk
- ☐ Red Willow
- ☐ Richardson
- ☐ Rock
- ☐ Saline
- ☐ Sarpy
- ☐ Saunders
- ☐ Scotts Bluff
- ☐ Seward
- ☐ Sheridan
- ☐ Sherman
- ☐ Sioux
- ☐ Stanton
- ☐ Thayer
- ☐ Thomas
- ☐ Thurston
- ☐ Valley
- ☐ Washington
- ☐ Wayne
- ☐ Webster
- ☐ Wheeler
- ☐ York
- ☐ not applicable

Q5 This question is in reference to the most recent **12 months** and is specific to you individually, not your department.

	0 10 20 30 40 50 60 70 80 90 100
a) Within the past 12 months, approximately how many times have you *(you individually, not your department)* administered naloxone? If you have not administered naloxone select 0.	
b) Of the overdoses you responded to in the past 12 months, approximately how many times did you administer naloxone to the same person on separate occasions? If you have not administered naloxone select 0.	

Q6 Think back to the overdose situations you were responding to **two (2)** years ago. On average per month, how many situations involved responding to a drug overdose?

	0 10 20 30 40 50 60 70 80 90 100

Q6b Of these overdoses you were responding to two years ago, approximately what percentage (%) do you suspect involved opioids?

0 10 20 30 40 50 60 70 80 90 100

Q7a For this question think back to the situations you've responded to in the most recent **six (6)** months. On average per month, how many situations involved responding to a drug overdose?

0 10 20 30 40 50 60 70 80 90 100

Q7b Of these overdoses you were responding to six months ago, approximately what percentage (%) do you suspect involved opioids?

0 10 20 30 40 50 60 70 80 90 100

Q8 Please indicate how frequently you suspect each of the substances listed below were involved in overdoses you responded to in the past **12 months**.

	Never	Sometimes	About half the time	Most of the time	Always	Do not know
Alcohol	○	○	○	○	○	○
Opioid pain relievers	○	○	○	○	○	○
Fentanyl	○	○	○	○	○	○
Heroin	○	○	○	○	○	○

Q8 Please indicate how frequently you suspect each of the substances listed below were involved in overdoses you responded to in the past 12 months.

	Never	Sometimes	About half of the time	Most of the time	Always	Do not know
Cocaine	○	○	○	○	○	○
Methamphetamine	○	○	○	○	○	○
Benzodiazepines	○	○	○	○	○	○
Antidepressants	○	○	○	○	○	○
unknown substances	○	○	○	○	○	○

Q9 This next section is about the training you've received.

	Yes	No
I have been trained to administer naloxone for someone who has overdosed.	○	○
I have received training to recognize the symptoms of an opioid overdose.	○	○

Q10 Please indicate your level of agreement with the following statements regarding naloxone use and availability.

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree	Not Applicable
I have been provided sufficient training about opioid use. (1)	○	○	○	○	○	○	○

Q10 Please indicate your level of agreement with the following statements regarding naloxone use and availability.

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree	Not Applicable
I have been provided sufficient training around response to an opioid overdose. (2)	○	○	○	○	○	○	○
I have been provided sufficient training around opioid overdose prevention (3)	○	○	○	○	○	○	○
Through my training, I feel confident that I can administer naloxone if needed. (4)	○	○	○	○	○	○	○
I have confidence that my department is equipped with sufficient naloxone kits if four or more doses are needed to revive the overdose victim. (5)	○	○	○	○	○	○	○
I am reluctant to administer naloxone for fear of legal repercussions. (6)	○	○	○	○	○	○	○

Q10 Please indicate your level of agreement with the following statements regarding naloxone use and availability.

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree	Not Applicable
I am reluctant to administer naloxone for fear of putting myself in physical danger. (7)	○	○	○	○	○	○	○
I have the appropriate protective gear to respond to opioid overdoses. (8)	○	○	○	○	○	○	○
I feel naloxone should be available to everyone without a prescription. (9)	○	○	○	○	○	○	○
Naloxone is readily available to all members of the communities I serve. (10)	○	○	○	○	○	○	○
My department has sufficient resources to respond to opioid overdoses. (11)	○	○	○	○	○	○	○
I feel my department has the appropriate policies and procedures in place around response to opioid overdoses. (12)	○	○	○	○	○	○	○

Q11 Please indicate your level of agreement with the following statements regarding substance use in your community.

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
There is sufficient access to substance use treatment in the communities my facility serves. (1)	○	○	○	○	○	○
In my experience, members of the communities my facility serves are sufficiently aware of the Good Samaritan law. (2)	○	○	○	○	○	○
In my experience, members of the communities my facility serves are aware they can access naloxone without an individual prescription. (3)	○	○	○	○	○	○
The communities my facility serves are being significantly affected by opioid use. (4)	○	○	○	○	○	○
Through my work, I am making a positive impact on the community I work in. (5)	○	○	○	○	○	○
The community I work in is supportive of my department. (6)	○	○	○	○	○	○

Q12 Please indicate your level of agreement with the following statements regarding work-related stress.

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
My department is supportive of me. (1)	○	○	○	○	○	○
I feel a sense of connection to my coworkers. (2)	○	○	○	○	○	○
I have peer support when I need to process a highly stressful experience. (3)	○	○	○	○	○	○
I am aware of resources available to me to help with secondary trauma and stress. (4)	○	○	○	○	○	○
My department encourages me to access trauma and stress resources on a regular basis. (5)	○	○	○	○	○	○
I am aware of the symptoms of compassion fatigue. (6)	○	○	○	○	○	○
I am able to identify symptoms of compassion fatigue in myself. (7)	○	○	○	○	○	○
I am able to identify symptoms of compassion fatigue in my colleagues. (8)	○	○	○	○	○	○

Q13 We are interested in knowing about resources and information that are provided to the person who overdosed and their families and friends. These resources can be provided by anyone in the community, including your department or other systems.

	Never Provided	Sometimes Provided	Provided about half the time	Provided most of the time	Provided always	Do not know
Information regarding treatment options	○	○	○	○	○	○
Naloxone kits provided to the individual or family	○	○	○	○	○	○
How to access Naloxone kits to keep at home	○	○	○	○	○	○
Support groups in the community	○	○	○	○	○	○
Other (please specify in comment box below)	○	○	○	○	○	○

Q14 How often do you engage in self-care practices? (Examples of self-care practices include meditation, journaling, spending quality time with a loved one, stretching, taking a walk, doing something new, limit work hours.)

- ○ Never
- ○ Once a week
- ○ 2-3 times a week
- ○ 4-6 times a week
- ○ Daily

Q15 What specific stressors do you experience in your role as a healthcare staff member in regards to overdose situations? Please use the comment box below:

Q16 What resources does your **facility** need to better prepare for a surge in opioid use?

Q17 What resources does your **community** need to better prepare for a surge in overdoses?

Q18 What else would you like to say in regards to the capacity of healthcare facilities across Nebraska in responding to a surge in overdoses?

Q19 Please indicate your gender.

- ○ Male
- ○ Female
- ○ Other, or prefer not to respond

Q20 Please indicate your age range

- ○ 18 - 24 years
- ○ 25 - 34 years
- ○ 35 - 44 years
- ○ 45 - 54 years
- ○ 55 - 64 years
- ○ 65 - 74 years
- ○ 75 or older years
- ○ Prefer not to answer

End of Survey Message

Thank you for taking the time to complete this survey. Your responses will be used to inform the work of the Nebraska DHHS Public Health Department. Responses will be analyzed collectively by STEPs and individuals will remain anonymous. The aggregate results will be shared with your department at the conclusion of the statewide needs assessment. Thank you for contributing your time, and your honest and thoughtful responses.

Sampling Plan

STEPs invited medical facilities in counties identified by Nebraska DHHS as high-burden for drug overdoses to participate in focus groups or individual interviews. DHHS provided contact information for these facilities to STEPs. In early 2019, STEPs sent hospital administrators and directors of nursing an email requesting permission to conduct small, 60-90 minute focus groups of four to six people who had direct contact with patients in their emergency departments. Each facility was offered a range of available dates and informed that STEPs evaluators would travel to their facility to conduct the focus groups. STEPs sent multiple invitations, numerous times across the state to increase participation.

The goal was to conduct 13-16 focus groups or interviews statewide. In the end, STEPs conducted eight focus groups and three individual interviews with medical facility staff. STEPs contacted Kim Engel, the director of the Panhandle Public Health District (PPHD) and offered to train and reimburse their staff to conduct focus groups at medical facilities in western Nebraska. PPHD conducted three of the focus groups in the western panhandle of the state. Compensation was not provided to any focus group or interview participant due to funding restrictions.

STEPs and Nebraska DHHS collaboratively developed all qualitative questions. Focus group and interview participants from medical facilities were invited to share their experiences with opioid overdoses; their facilities' process, policies, and protocols on responding to an opioid overdose; their knowledge and experience with naloxone; their knowledge and experience with the Prescription Drug Monitoring Program (PDMP); and their level of compassion fatigue and support.

Data Analysis Plan

The focus groups and interviews were recorded. A total of 9 hours of audio files were obtained. The audio recordings were transcribed verbatim and the transcripts were kept in password-protected files. STEPs analyzed the transcripts using two coders and MAXQDA software. The coders utilized grounded theory which included the process of writing memos to organize thoughts, definitions, and ideas.

Coders independently read through all the transcripts moving from open coding to higher level coding to form categories which eventually developed into themes. Each coder cross-coded the data by agreeing or disagreeing on coded transcripts. The coders then came together to discuss any disagreements on coding and came to an agreement.

Participants had the option to share limited demographic data prior to participating in each focus group or phone interview. Participants also provided their email addresses to STEPs to receive the state and national literature review, *Promising Practices.* The focus group consent forms and the focus group format, including questions are on the following pages.

Focus Group Consent Form

Thank you for taking the time to join our discussion about the opioid crisis in Nebraska. This focus group is conducted through the Support and Training of the Evaluation of Programs (STEPs) which is housed in the University of Nebraska at Omaha. STEPs has partnered with NDHHS to complete a needs assessment for the Drug Overdose Prevention Program. **The purpose of this project is to assess the capacity of statewide systems in Nebraska to respond to a surge of drug overdoses, with a focus on opioids.** The results will help DHHS create crisis response plans and ultimately to reduce overdoses in Nebraska. The purpose of today's discussion is to gain information about your current experiences with drug overdose situations, how you respond to such incidents, and what you need to improve your work.

There are no right or wrong answers to the questions I am about to ask. Please feel free to share your point of view even if it differs from what others have said. You may talk with one another during the group. I am here to ask questions, listen, and make sure everyone has a chance to share. Please respect each other and keep everything that is said in this group to stay in this group. We will be recording the focus group because we do not want to miss any of your comments, but the transcripts will only be reviewed by the researchers on this project. We will keep the things that you say confidential. That means your name won't be connected to what you said. When we report the results of this assessment, names will not be used. The only exception is if you share something that indicates that you, or someone else, is in danger.

The STEPs team has already created a Promising Practices report for DHHS. An executive summary of this report can be available to you if you wish. Please leave us your email address and it will be emailed directly to you. This report will also be available on the Drug Overdose Prevention website resources page soon (DHHS.ne.gov).

If you have any questions after this focus group is completed. Please contact the STEPs office at:

STEPs
UNO Barbara Weitz Community Engagement Center
6001 Dodge Street, CEC 223-A
Omaha, NE 68182
Phone: 402.554.3663
Email: steps@unomaha.edu

Medical Facility Staff Focus Group Script

Introduction:

Participants will be given a hard copy of the consent form that they will be invited to keep.

Hello and welcome.

Thank you for taking the time to join our discussion about the opioid crisis in Nebraska. This focus group is conducted through the Support and Training for the Evaluation of Programs (STEPs) which is housed in the University of Nebraska at Omaha. STEPs has partnered with NDHHS to complete a needs assessment for the Drug Overdose Prevention Program. The purpose of this project is to assess the capacity of statewide systems in Nebraska to respond to a surge of drug overdoses, with a focus on opioids. The results will help DHHS create crisis response plans and ultimately to reduce overdoses in Nebraska. The purpose of today's discussion is to gain information about your current experiences with drug overdose situations, how you respond to such incidents, and what you need to improve your work.

There are no right or wrong answers to the questions I am about to ask. Please feel free to share your point of view even if it differs from what others have said. You may talk with one another during the group. I am here to ask questions, listen, and make sure everyone has a chance to share. Please respect each other and keep everything that is said in this group to stay in this group. We will be recording the focus group because we do not want to miss any of your comments, but the transcripts will only be reviewed by the researchers on this project. We will keep the things that you say confidential. That means your name won't be connected to what you said. When we report the results of this assessment, names will not be used. The only exception is if you share something that indicates that you, or someone else, is in danger.

The STEPs team has already created a Promising Practices report for DHHS. An executive summary of this report can be available to you if you wish. Please leave us your email address and it will be emailed directly to you. This report will also be available on the Drug Overdose Prevention website resources page soon (DHHS.ne.gov)

Does anyone have any questions before we begin?

Icebreaker

- What is your name, role, and how many years have you worked in this role?

Current experience with opioid overdose

- How has the opioid crisis affected your facility?
- What is a typical number of overdoses that your facility would experience in a week/month/quarter?
- To what degree is your facility prepared to respond to a surge or spike in opioid overdoses? Explain. (Probe: Do you have enough staff?)

Medical Facility Staff Focus Group Script (continued)

Process and policies, protocol, resources/availability of naloxone

- Does your facility have protocols for responding to an opioid overdose?
    - Is the protocol sufficient in addressing an opioid overdose situation?
        - If yes: What are the barriers to following the protocol?
        - If no: What needs to be changed to the protocol?
- When you have a patient who has experienced an overdose, do you provide resources such as referrals to mental/behavioral health services, treatment, naloxone kits, etc.?

Naloxone administration

- How many doses of naloxone do you have on hand?
- What have been your experiences with naloxone or naloxone? (*Probes: Do you have enough on hand? Has your facility provided training for staff? Do you know how to use naloxone or Narcan? Have you ever administered it to a patient? How has naloxone affected your work?*)

Mental health, compassion fatigue, support

- Your job can no doubt be difficult at times, responding to various crises, specifically overdose situations. How does your facility provide support to you? (*from community, higher ups, peers*)
- What resources or trainings provided by Nebraska DHHS do you or your facility need in regard to opioid abuse? (*public health, behavioral health, etc.*)

Closing

- We have covered a lot of information today, is there anything else that you think would be helpful for DHHS to know or additional considerations you feel need to be addressed?

*****Extra questions, only if there is time*****

Prescription Drug Monitoring Program

- Do you or your coworkers use the Nebraska PDMP-Prescription Drug Monitoring Program?
    - What are the barriers to using PDMP?
    - What needs to be changed? Or what would help you to use the PDMP more?

Focus Group Demographic Questions

Healthcare Focus Group/DHHS DOP/STEPs

Please complete the following questions. Your names will remain confidential and this will be used for data purposes only. Thank you.

Position: _____

How long have you worked in this position: _____

Email address (optional, only if you want the Promising Practices report sent to you):

_____

Appendix C: EMS and Fire–Quantitative Survey

Surveys

To achieve feedback from a large scope of first responders, we developed quantitative surveys to be administered through Qualtrics. Qualtrics is an online survey software that assists in the design and distribution of surveys.

Sample

In mid-January of 2019, a short survey was sent through Qualtrics to the administrators of relevant fire departments and emergency medical services departments requesting the email addresses of staff members. The purpose of this survey was to collect a comprehensive list of email addresses from all relevant parties for STEPs to use in sending out the quantitative surveys.

A comprehensive list of emails for statewide emergency medical technicians and firefighters was provided to STEPs by Felicia Quintana-Zinn, Drug Overdose Prevention Epidemiologist with the Nebraska Department of Health and Human Services. This list was used to send the anonymous Qualtrics link to each first responder from a STEPs email account.

Survey Items

The survey introduction informed the respondent that the purpose of the survey was to better understand the capacity of first responders to respond to a surge in opioid use. The introduction also explained that responses would be anonymous and would be used by STEPs, in combination with qualitative results, to create a final report for the Nebraska Department of Health and Human Services (DHHS). They were told DHHS would use the final report to inform their allocation of grant funds and resources, in addition to the development of statewide crisis response plans.

The 18-item survey was a combination of closed-ended and open-ended questions. These items focused on four areas:

- *Demographics*: role, service area population, service area county, age range, and gender.
- *Naloxone*: training, current and past administration frequency, availability.
- *Service area*: perceptions of substance use, treatment options, resources needed.
- *Compassion fatigue:* work-related stressors, self-care.
- *Overdose emergencies*: frequency, substances responsible, training, protocols.

Survey questions were developed in collaboration between STEPs and Nebraska DHHS.

Introduction

Thank you for taking part in this important survey to gauge the capacity of first responders across Nebraska in responding to increased opioid use.

This survey is part of a statewide needs assessment by the Nebraska Department of Health and Human Services' Division of Public Health to assess the capacity of systems in Nebraska to respond to surges or clusters of intentional, unintentional, and unknown drug overdoses, especially in high-burden areas and with a focus on opioids. This survey is administered by STEPs (Support and Training for the Evaluation of Programs) through the University of Nebraska at Omaha. Aggregate responses to this survey will be used to allocate grant funds, resources, and develop crisis response plans.

We expect this survey to take 5 to 10 minutes to complete. Responses will be analyzed collectively by STEPs and individuals will remain anonymous. The STEPs team will then provide a final report with recommendations to DHHS using your invaluable feedback.

Survey Questions

Q1 What is your role as a first responder? (We understand that you may be involved in more than one role as first responder. If you are involved in multiple roles please indicate which role you consider as your primary first responder role and the other first responder roles you hold as secondary. Note: This survey is focused specifically on first responders who are not in law enforcement. If you are also in law enforcement, please answer these questions as a fire/EMT first responder.)

	Primary	Secondary	Not Applicable
Firefighter	○	○	○
Emergency Medical Technician (all levels) or Emergency Medical Responder	○	○	○
Volunteer Firefighter	○	○	○
Volunteer Emergency Medical Technician or Volunteer Emergency Medical Responder	○	○	○
Other (please specify)	○	○	○

Q2 How many years have you served as a first responder in the capacity you indicated in Question 1?

- ○ Less than 1 year (1)
- ○ 1-5 years (2)
- ○ 6-10 years (3)
- ○ 11-15 years (4)
- ○ 16-20 years (5)
- ○ 21-25 years (6)
- ○ More than 26 years (7)

Q3 What is the population of your typical service area?

- ☐ Rural (under 2,500 people) (1)
- ☐ Urban Cluster (2,500 to 29,000 people) (2)
- ☐ Urban Cluster (30,000 to 50,000 people) (3)
- ☐ Urban (over 50,000 people) (4)
- ☐ Other (5) _____

Q4 In which counties are you a first responder? (check all that apply)

- ☐ Adams
- ☐ Antelope
- ☐ Arthur
- ☐ Banner
- ☐ Blaine
- ☐ Boone
- ☐ Box Butte
- ☐ Boyd
- ☐ Brown
- ☐ Buffalo
- ☐ Burt
- ☐ Butler
- ☐ Butler
- ☐ Cass
- ☐ Cedar
- ☐ Chase
- ☐ Cherry
- ☐ Cheyenne
- ☐ Clay
- ☐ Colfax
- ☐ Cuming
- ☐ Custer
- ☐ Dakota
- ☐ Dawes
- ☐ Dawson
- ☐ Deuel
- ☐ Dixon
- ☐ Dodge
- ☐ Douglas
- ☐ Dundy
- ☐ Fillmore
- ☐ Franklin
- ☐ Frontier
- ☐ Furnas
- ☐ Gage
- ☐ Garden
- ☐ Garfield
- ☐ Gosper
- ☐ Grant
- ☐ Greeley
- ☐ Hall
- ☐ Hamilton
- ☐ Harlan
- ☐ Hayes
- ☐ Hitchcock
- ☐ Holt
- ☐ Hooker
- ☐ Howard

Q4 In which counties are you a first responder? (check all that apply) (continued)

- ☐ Jefferson
- ☐ Johnson
- ☐ Kearney
- ☐ Keith
- ☐ Keya Paha
- ☐ Kimball
- ☐ Knox
- ☐ Lancaster
- ☐ Lincoln
- ☐ Logan
- ☐ Loup
- ☐ McPherson
- ☐ Madison
- ☐ Merrick
- ☐ Morrill
- ☐ Nance
- ☐ Nemaha
- ☐ Nuckolls
- ☐ Otoe
- ☐ Pawnee
- ☐ Perkins
- ☐ Phelps
- ☐ Pierce
- ☐ Platte
- ☐ Polk
- ☐ Red Willow
- ☐ Richardson
- ☐ Rock
- ☐ Saline
- ☐ Sarpy
- ☐ Saunders
- ☐ Scotts Bluff
- ☐ Seward
- ☐ Sheridan
- ☐ Sherman
- ☐ Sioux
- ☐ Stanton
- ☐ Thayer
- ☐ Thomas
- ☐ Thurston
- ☐ Valley
- ☐ Washington
- ☐ Wayne
- ☐ Webster
- ☐ Wheeler
- ☐ York
- ☐ not applicable

Q5 This question is in reference to the most recent 12 months and is specific to you individually, not your department:

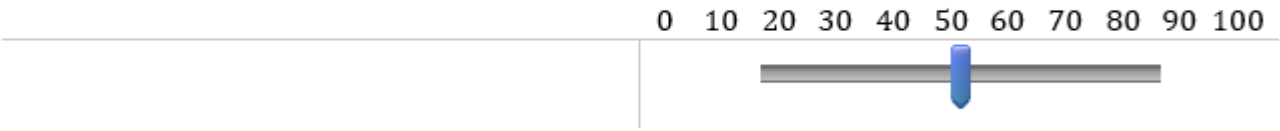
	0 10 20 30 40 50 60 70 80 90 100
a) Within the past 12 months, approximately how many times have you (*you individually, not your department*) administered naloxone? If you have not administered naloxone select 0.	
b) Of the overdoses you responded to in the past 12 months, approximately how many times did you administer naloxone to the same person on separate calls? If you have not administered naloxone select 0.	

Q6a

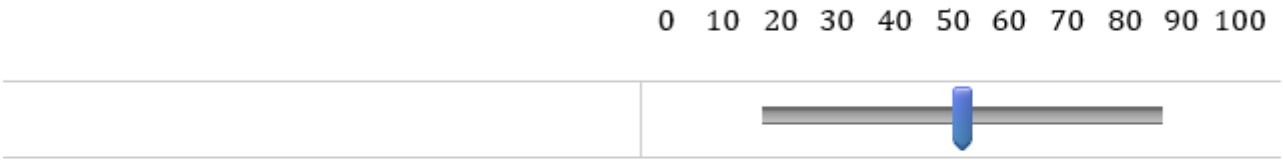
Think back to the calls you were responding to **two (2)** years ago. On average per month, how many of these calls involved responding to a drug overdose?

	0 10 20 30 40 50 60 70 80 90 100
On average per month, how many of these calls involved responding to a drug overdose?	

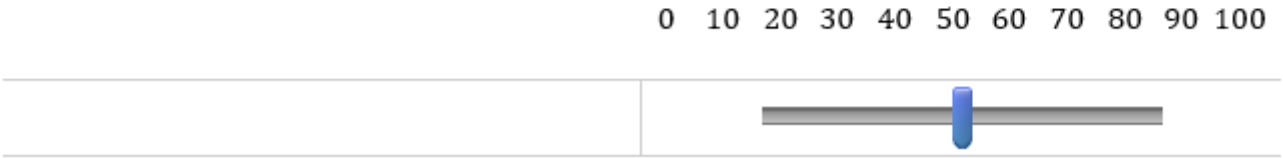
Q6b Of these overdoses you were responding to two years ago, approximately what percentage (%) do you suspect involved opioids?



Q7a For this question think back to the calls you've responded to in the most recent **six (6)** months. On average per month, how many calls involved responding to a drug overdose?



Q7b Of these overdoses you were responding to 6 months ago, approximately what percentage (%) do you suspect involved opioids?



Q8 Please indicate how frequently you suspect each of the substances listed below were involved in overdoses you responded to in the past **12 months.**

	Never	Sometimes	About half of the time	Most of the time	Always	Do not know
Alcohol	○	○	○	○	○	○
Opioid pain relievers	○	○	○	○	○	○
Fentanyl	○	○	○	○	○	○
Heroin	○	○	○	○	○	○

Q8 Please indicate how frequently you suspect each of the substances listed below were involved in overdoses you responded to in the past 12 months.

	Never	Sometimes	About half of the time	Most of the time	Always	Do not know
Cocaine	○	○	○	○	○	○
Methamphetamine	○	○	○	○	○	○
Benzodiazepines	○	○	○	○	○	○
Antidepressants	○	○	○	○	○	○
unknown substances	○	○	○	○	○	○

Q9 This next section is about the training you've received.

	Yes	No
I have been trained to administer naloxone for someone who has overdosed.	○	○
I have received training to recognize the symptoms of an opioid overdose.	○	○

Q10 Please indicate your level of agreement with the following statements regarding naloxone use and availability.

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
I have been provided sufficient training around opioid use. (1)	○	○	○	○	○	○
I have been provided sufficient training around response to an opioid overdose. (2)	○	○	○	○	○	○
I have been provided sufficient training around opioid overdose prevention. (3)	○	○	○	○	○	○
Through my training, I feel confident that I can administer naloxone if needed. (4)	○	○	○	○	○	○
I have confidence that my ambulance or fire engine is equipped with sufficient naloxone kits if four or more doses are needed to revive the overdose victim. (5)	○	○	○	○	○	○
I am reluctant to administer naloxone for fear of legal repercussions. (6)	○	○	○	○	○	○

Q10 Please indicate your level of agreement with the following statements regarding naloxone use and availability.

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
I am reluctant to administer naloxone for fear of putting myself in physical danger. (7)	○	○	○	○	○	○
I have the appropriate protective gear to respond to opioid overdoses. (8)	○	○	○	○	○	○
I feel naloxone should be available to everyone without a prescription. (9)	○	○	○	○	○	○
Naloxone is readily available to all members of the community I work in. (10)	○	○	○	○	○	○
My department has sufficient resources to respond to opioid overdoses. (11)	○	○	○	○	○	○
I feel my department has the appropriate policies and procedures in place around response to opioid overdoses. (12)	○	○	○	○	○	○

Q11 Please indicate your level of agreement with the following statements regarding substance use in your community.

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
There is sufficient access to substance use treatment in the community I work in. (1)	○	○	○	○	○	○
In my experience, members of the community I work in are sufficiently aware of the Good Samaritan law. (2)	○	○	○	○	○	○
In my experience, members of the community I work in are aware they can access naloxone without an individual prescription. (3)	○	○	○	○	○	○
The community I work in is being significantly affected by opioid use. (4)	○	○	○	○	○	○
Through my work, I am making a positive impact on the community I work in. (5)	○	○	○	○	○	○
The community I work in is supportive of my department. (6)	○	○	○	○	○	○

Q12 Please indicate your level of agreement with the following statements regarding work-related stress.

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
My department is supportive of me. (1)	○	○	○	○	○	○
I feel a sense of connection to my coworkers. (2)	○	○	○	○	○	○
I have peer support when I need to process a highly stressful experience. (3)	○	○	○	○	○	○
I am aware of resources available to me to help with secondary trauma and stress. (4)	○	○	○	○	○	○
My department encourages me to access trauma and stress resources on a regular basis. (5)	○	○	○	○	○	○
I am aware of the symptoms of compassion fatigue. (6)	○	○	○	○	○	○
I am able to identify symptoms of compassion fatigue in myself. (7)	○	○	○	○	○	○
I am able to identify symptoms of compassion fatigue in my colleagues. (8)	○	○	○	○	○	○

Q13 We are interested in knowing about resources and information that are provided to the person who overdosed and their families and friends. These resources can be provided by anyone in the community, including your department or other systems.

	Never Provided	Sometimes Provided	Provided about half the time	Provided most of the time	Provided always	Do not know
Information regarding treatment options	○	○	○	○	○	○
Naloxone kits provided to the individual or family	○	○	○	○	○	○
How to access Naloxone kits to keep at home	○	○	○	○	○	○
Support groups in the community	○	○	○	○	○	○
Other (please specify in comment box below)	○	○	○	○	○	○

Q14 How often do you engage in self-care practices? (Examples of self-care practices include meditation, journaling, spending quality time with a loved one, stretching, taking a walk, doing something new, limit work hours.)

- ○ Never
- ○ Once a week
- ○ 2-3 times a week
- ○ 4-6 times a week
- ○ Daily

Q15 What specific stressors do you experience in your role as a first responder in regards to overdose calls? Please use the comment box below:

Q16 What resources does your department need to better prepare you for a surge in opioid use?

Q17 What resources does your community need to better prepare first responders for a surge in overdoses?

Q18 What else would you like to say in regards to the capacity of first responders across Nebraska in responding to increased surge in overdoses?

Q19 Please indicate your gender.

- ○ Male
- ○ Female
- ○ Other, or prefer not to respond

Q20 Please indicate your age range

- ○ 18 - 24 years
- ○ 25 - 34 years
- ○ 35 - 44 years
- ○ 45 - 54 years
- ○ 55 - 64 years
- ○ 65 - 74 years
- ○ 75 or older years
- ○ Prefer not to answer

End of Survey Message

Thank you for taking the time to complete this survey. Your responses will be used to inform the work of the Nebraska DHHS Public Health Department. Responses will be analyzed collectively by STEPs and individuals will remain anonymous. The aggregate results will be shared with your department at the conclusion of the statewide needs assessment. Thank you for contributing your time, and your honest and thoughtful responses.

Sampling Plan

Fire department units in counties identified as high-burden for drug overdoses by Nebraska DHHS were invited by STEPs to participate in focus groups or individual interviews. The goal was to conduct 13-16 focus groups or interviews statewide. Contact information for these facilities was provided to STEPs by DHHS.

In early 2019, STEPs sent fire administrators an email requesting permission to conduct 60-90 minute hour focus groups of four to six fire/EMS personnel at their location. In addition, STEPs called several other contacts. STEPs received no responses to these requests. STEPs enlisted the help of several people in the western and eastern regions of the state to help facilitate these contacts. STEPs contacted Kim Engel, the director of the Panhandle Public Health District (PPHD) and offered to train and reimburse their staff to conduct focus groups at medical facilities in western Nebraska. PPHD conducted three of the focus groups in the western panhandle of the state. Compensation was not provided to any focus group or interview participant due to funding restrictions.

In the eastern area, STEPs enlisted the help of a University of Nebraska Omaha instructor who had recently retired as a Omaha fireman. With his help, STEPs was able to schedule three focus groups in the Omaha area. STEPs was successful in conducting one focus group in Lancaster county with the assistance of a STEPs team member who had a personal contact. Efforts were made to conduct focus groups over interviews, but scheduling challenges resulted in having to schedule phone interviews when necessary. In the end, STEPs team conducted seven focus groups and six individual interviews with fire departments.

STEPs and Nebraska DHHS collaboratively developed all focus group questions. Focus group and interview participants were asked to share their experiences with opioid overdoses; their departmental process, policies, and protocols on responding to an opioid overdose; knowledge and experience with naloxone; compassion fatigue and support; suggestions for better coordination or needs regarding opioid responses; and reactions to other resources and strategies being implemented in other regions of the U.S.

Data Analysis Plan

All interviews and focus groups were recorded and transcribed with transcripts saved in password-protected files. The audio recordings, totaling 12 hours, were transcribed verbatim and the transcripts were kept in password-protected files. STEPs analyzed the transcripts using two coders and MAXQDA software. The coders utilized grounded theory which included the process of writing memos to organize thoughts, definitions, and ideas. Coders independently read through all the transcripts moving from open coding to higher level coding to form categories which eventually developed into themes. Each coder cross-coded the data by agreeing or disagreeing on coded transcripts. The coders then came together to discuss any disagreements on coding and came to an agreement.

Participants had the option to share limited demographic data prior to participating in each focus group or phone interview. Participants also provided their email addresses to STEPs to receive the state and national literature review, *Promising Practices*. The focus group consent forms and the focus group format, including questions, can be found on the following pages.

Coders independently read through all the transcripts moving from open coding to higher level coding to form categories which eventually developed into themes. Each coder cross-coded the data by agreeing or disagreeing on coded transcripts. The coders then came together to discuss any disagreements on coding and came to an agreement.

Participants had the option to share limited demographic data prior to participating in each focus group or phone interview. Participants also provided their email addresses to STEPs to receive the state and national literature review, *Promising Practices.* The focus group consent forms, and the focus group format, including questions, can be found in Appendix D.

Focus Group Demographics

STEPs conducted seven focus groups within Douglas, Lancaster, Box Butte, and Scotts Bluff counties. Each focus group lasted approximately 90 minutes and included three to six first responders with a range of 1 to 29 years of experience Six of the seven focus groups consisted of all full-time personnel. The one focus group with volunteer personnel was in Box Butte county and all participants were volunteers. One of the focus groups conducted in Scotts Bluff county consisted of one firefighter, one police officer, and two paramedics not associated with a fire department.

Interview Demographics

STEPs completed six phone interviews with EMT/fire individuals within Cherry, Gage, Hall, Platte, Richardson, and York counties. Each interview lasted approximately 1 hour and was conducted with a first responder who had been in their position for at least 5 years. Five of the interviews were conducted with EMTs and two interviews were conducted with firefighters. The interviews with EMTs included two interviews with an ambulance service, and three interviews with EMTs associated with a fire department.

Region	Focus Group	Interview	Volunteer	Full-time
1	3	-	5	9
2	-	-		
3	-	1		1
4	-	2	2	
5	1	3	1	6
6	3	-		18

Focus Group and Interview Locations

Focus Group Locations	
Box Butte County	Hemingford Fire Department
Box Butte County	Alliance Fire Department
Douglas County	Omaha Fire Department: Station 1
Douglas County	Omaha Fire Department: Station 42
Douglas County	Omaha Fire Department: Station 77
Lancaster County	Lincoln Fire Department
Scotts Bluff County	Scottsbluff Emergency Medical Services

Interview Locations	
Cherry County	Cherry County Ambulance Service
Gage County	Beatrice Fire and Rescue
Hall County	Grand Island Fire Department
Platte County	Humphrey Rescue Unit
Richardson County	Falls City Volunteer Ambulance Service
York County	York Fire Department

Focus Group Script

Introduction:
Participants will be provided a hard copy of the consent form for their records.

Hello and welcome.

Thank you for taking the time to join our discussion about the opioid crisis in Nebraska. This focus group is conducted through the Support and Training of the Evaluation of Programs (STEPs) which is housed in the University of Nebraska at Omaha. STEPs has partnered with NDHHS to complete a needs assessment for the Drug Overdose Prevention Program. The purpose of this project is to assess the capacity of statewide systems in Nebraska to respond to a surge of drug overdoses, with a focus on opioids. The results will help DHHS create crisis response plans and ultimately to reduce overdoses in Nebraska. The purpose of today's discussion is to gain information about your current experiences with drug overdose situations, how you respond to such incidents, and what you need to improve your work.

There are no right or wrong answers to the questions I am about to ask. Please feel free to share your point of view even if it differs from what others have said. This is a group format and you are encouraged to talk with one another during the group. I am here to ask questions, listen, and make sure everyone has a chance to share.

We ask that everyone respect each other's opinions and to keep everything said in this group here. We will be recording the focus group because we do not want to miss any of your comments, but the transcripts will only be reviewed by the researchers on this project. We will keep what you say confidential. That means your name won't be connected to what you said. When we report the results of this assessment, names will not be used. The only exception is if you share something that indicates that you, or someone else, is in danger.

The STEPs team has created a Promising Practices report for DHHS and an executive summary of this report can be available to you if you wish. Please leave us your email address, and it will be emailed directly to you. This report will also be available on the Drug Overdose Prevention website resources page soon (DHHS.ne.gov)

Does anyone have any questions before we begin?

Icebreaker
What is your name, role, and how many years have you worked in this role? (we will want to capture role and numbers of year in the role as a data point)

Interviewer Notes:

Number of fire personnel (not EMT):
Number of EMTs:
Other (describe):
Number of people in the focus group:
Other:

Introductory Statement: Responding effectively to the opioid epidemic

The opioid epidemic has been a problem nationally, as well as here in Nebraska. We are wanting to have a conversation about how opioid overdoses have had an impact on first responders in NE. We are conducting a series of focus groups statewide with medical first responders, law enforcement, and fire departments. Your responses to these questions will help to determine the needs we have in our state which will provide guidance to the public health department regarding grants and programs.

We have a series of questions that are grouped by topic area. We'd like for this to be a conversation.

Our first topic is about opioid overdoses in general.

Talk to us about your experiences with responding to overdose calls in general and your general thoughts about this.

Prompts for General Questions

As you think about the overdose calls you've responded to, we want to ask some specific questions regarding opioids.

Are you seeing/experiencing an increase in the frequency of overdose calls in general?

- With opioids specifically?
- Approximately how many calls are your responding to in a month that involve an overdose?
  - How is this different from a year or two ago?
- If yes, help us understand the type of overdose calls you find yourself responding to more frequently.
  - Anything with opioids in particular?
- What is the impact this increased frequency has on you as a first responder?

Think about someone who is new to the job. What would your advice be to them regarding overdose calls?

- What would you say to them about opioids in particular?
- Is there another drug you would mention?

Training

Talk to us about the type of training you've received about responding to opioid overdoses in general.

- How long ago was the training?
  - In person or online?
  - Stand alone or as part of another training?
  - Mandatory or optional?
  - Annual or one time only?

These next few questions are specifically about training related to opioid overdoses. Think about your responses to an overdose call where you suspected opioid involvement.

In what respects did the training you received:

Prepare you for responding?

Leave you feeling a little uncertain about what to do?

What did you like most about the training you received?

What did you like least about the training you received?

What type of opioid training would you recommend for new members of your unit?

What advanced training would be useful for your unit?

This next set of questions is about your experience with using naloxone

<u>Experience with naloxone or Narcan</u>

Describe to us some of your experiences with naloxone or Narcan.

Prompts:

Ease of use.

Comfort with using it.

Knowing when to use it.

Describe to us your experience with naloxone or Narcan.

Prompts:

Have you been trained to use it?

Experiences with administering it:

First time using it.

Over time using it.

Talk to us about the availability of naloxone on your unit:

Prompts:

How much naloxone do you generally have on hand in your unit?

Does it meet the need?

Do you ever run out?

How often does it take to get more?

What do you do when you don't have any?

We have a few very specific questions about the use of naloxone.

Do you generally enough on hand if:

More than one person at the scene needs it?

More than two doses are needed onsite?

Additional doses are needed enroute to the hospital?

What is your opinion on the use of naloxone to reverse an opioid overdose? (in lit review, some said it was a "get out of jail free card").

<u>This next section is about the challenges you may have experienced when responding to overdose calls</u>

What are some of the challenges your unit has experienced in responding to an opioid overdose call?

Prompts:

- Naloxone availability.
- Initial response time to the call.
- Availability of the right resources.
- Preparedness in providing the right treatment.
- Time it takes to get to the nearest hospital.
- Challenges in transporting to the hospital.
- Interaction with the patient and/or friends/family of the patient:
  - While treating.
  - During treatment.
  - Enroute to the hospital.
- Once at the scene of an overdose, what are the challenges your unit has experienced to treating someone who has overdosed?

This next section is about resources

Describe the type of resources that are available in your community, or nearby, for people who have, or are, abusing opioids?

What resources would be helpful to have in in your community for:

Treatment, recovery, or prevention.

Have you heard of any the following resources, and if so, do you think this would be useful in your community:

Safe Stations – fire stations designated to provide assistance to individuals looking for addiction treatment.

Paramedics as Recovery Partners – community paramedics who provide assistance to patients in addiction recovery at home.

What resources does your unit typically provide to a patient that has overdosed, if any?

E.g. naloxone kits, treatment referrals, pamphlets.

Safety Practices

Describe for us some of your main safety concerns when responding to an overdose call.

What are some of the things you do to keep yourselves safe when responding to the scene of an overdose?

Prompts:

- Protective gear.
- Training.
- Protocols used.
- Combative patients after naloxone administration.

What advice would you give to a new member of your unit about how to keep themselves safe when responding to a potential overdose call?
What safety resources do you wish you had that you don't?

This last section is about compassion fatigue related to your role as a first responder

Your job can no doubt be difficult at times, responding to various crises, specifically overdose situations. Talk to us about some of the stressors that first responders experience that contribute to compassion fatigue.

Prompts

- Big and small events.
- Recurring events.
- Lack of control.
- Lack of respect for the patient.
- Recurring themes (generally negative) in responding to the calls.
- How do repeat overdose calls to the same address/person affect first responders?

Describe the ways in which your department has supported your unit or individuals in your unit to alleviate the effects of compassion fatigue.

Prompt:

- Can you tell me about a time when you saw the stress involved in being a first responder impact someone you know/someone in your department?

Describe the ways your department/unit is supported by:

- The community.
- Your peers.
- Your bosses.
- Your family.
- Other.

There is a growing body of literature about ways to help with compassion fatigue for first responders. Below is a list of some of them. What do you think of these?

Yoga or other on-site exercise classes.
Support groups.
Counseling.
Meditation.
Online trainings on compassion fatigue (signs, symptoms, prevention).
Massages.

What advice would you give to a new member of your unit about compassion fatigue and some of the strategies they can use.

Closing

We have covered a lot of information today, is there anything else that you think would be helpful for DHHS to know or additional considerations you feel need to be addressed?

Focus Group Cheat Sheet

An **opioid** is a substance that is a prescription medication (pill, liquid, patch) and prescribed for pain relief. Heroin is also an opioid.

Common opioid prescription pain relievers include OxyContin, Vicodin, and Percocet or Hydrocodone and Oxycodone. Opioids are from a family of drugs used therapeutically to treat pain, that also produce a sensation of euphoria (a "high") and are naturally derived from the opium poppy plant (e.g., morphine and opium) or synthetically or semi-synthetically produced in a lab to act like an opiate (e.g., methadone and oxycodone). Chronic repeated use of opioids can lead to tolerance, physical dependence, and addiction.

The Nebraska Prescription Drug Monitoring Program (PDMP) is a unique statewide tool that collects dispensed prescription information and is housed on the Health Information Exchange platform. The Nebraska PDMP is a public health model focusing on patient safety. Starting January 1, 2018, all dispensed prescriptions drugs (supplies and medical devices are not reported) were reported to the PDMP. The PDMP stores the information in a secure database and makes it available to healthcare professionals as authorized by law.

First Responder Focus Group/DHHS DOP/STEPs

Please complete the following questions. Your names will remain confidential and this will be used for data purposes only. Thank you.

Position: _____

How long have you worked in this position: _____

Email address (optional, only if you want the Promising Practices report sent to you):

_____

Interview Participants

During the first quarter of 2019, we conducted semi-structured interviews with law enforcement officials in 9 Nebraska jurisdictions. Participating jurisdictions included eastern Nebraska local and county level law enforcement (e.g., police and sheriff's departments) that represented urban, suburban, and rural jurisdictions. A single jurisdiction in western Nebraska was responsive to our request for study participation although multiple contacts were made to several departments.

The majority of interviews were comprised of face-to-face focus groups with law enforcement command staff (i.e., leadership) in each agency at their administrative offices. Focus groups tended to be comprised of 3-4 individuals who had responsibility for uniform patrol bureau, narcotics units, or other forms of leadership.

Two interviews were conducted by phone using the same semi-structured approach. As needed, follow-up information was provided to the research team from other sources within these agencies. Interviews typically lasted 1.5 hours.

The majority of qualitative interview respondents were Caucasian males, which is typical of law enforcement command leadership in the state of Nebraska at this time. The interviews utilized the Law Enforcement Focus Group Questions (see next page).

Appendix F: Law Enforcement–Qualitative

Interview Consent Form

Thank you for taking the time to be interviewed regarding the opioid crisis in Nebraska. This interview is conducted through the Support and Training for the Evaluation of Programs (STEPs) which is housed in the University of Nebraska at Omaha. STEPs has partnered with NDHHS to complete a needs assessment for the Drug Overdose Prevention Program. **The purpose of this project is to assess the capacity of statewide systems in Nebraska to respond to a surge of drug overdoses, with a focus on opioids.** The results will help DHHS create crisis response plans and ultimately to reduce overdoses in Nebraska. The purpose of today's interview is to gain information about your current experiences with drug overdose situations, how you respond to such incidents, and what you need to improve your work.

There are no right or wrong answers to the questions I am about to ask. We will be taking notes during the interview because we do not want to miss any of your comments, but the notes will only be reviewed by the researchers on this project. We will keep the things that you say confidential. That means your name won't be connected to what you said. When we report the results of this assessment, names will not be used. The only exception is if you share something that indicates that you, or someone else, is in danger.

The STEPs team has already created a Promising Practices report for DHHS. An executive summary of this report can be available to you if you wish. Please leave us your email address and it will be emailed directly to you. This report will also be available on the Drug Overdose Prevention website resources page soon (DHHS.ne.gov).

If you have any questions after this focus group is completed. Please contact the STEPs office at:

STEPs
UNO Barbara Weitz Community Engagement Center
6001 Dodge Street, CEC 223-A
Omaha, NE 68182
Phone: 402.554.3663
Email: steps@unomaha.edu

Law Enforcement Leadership Interview Script

Thank you for taking time to meet with us today. Our organization, STEPs, has been contracted by DHHS to conduct a ***statewide needs assessment*** *as part of the Prescription Drug Overdose Prevention Program. The purpose of this* ***needs assessment*** *is to determine the* ***current capacity*** *of first responders and medical professionals to respond to a surge in* ***opioid overdoses****. Our team will be interviewing and surveying other sheriffs, fire chiefs, paramedics, and hospital staff throughout Nebraska as part of this assessment. We are sharing feedback with DHHS on law enforcement agency experience regarding* ***opioid overdoses and related policies****,* ***needs****, and* ***existing resources****.*

Rachel will be taking electronic notes throughout the session, which will be incorporated into our final report to DHHS. All efforts to maintain anonymity of respondents will be taken when reporting back to DHHS. This report will then help inform DHHS as they develop statewide and local crisis response plans. To provide additional follow-up information pertaining to this interview, contact Dr. Gaylene Armstrong, Director, UNO School of Criminology and Criminal Justice, GArmstrong@UNOmaha.edu, 402.554.3615.

Do you have any questions before we begin?

A. Prevalence of opioids in your community

1. To what extent are your officers/agency handling call outs related to opioids and opioid abuse? (*referring to overdoses*, *in general*)
2. What statistics or knowledge regarding opioid use and abuse does your agency collect or make available to patrol officers?
3. How is that information gathered and documented? How is that information disseminated?
4. What are the policies related to ordering toxicology reports on individuals?
    1. Are toxicology reports a useful investigative tool?
5. To what extent is opioid-specific prevention efforts occurring in the community?
    1. Who is leading these efforts?
    2. What feedback have you received about these programs from the community (e.g., appropriateness, effectiveness)?

B. Development and transmission of opioid-related knowledge for patrol officers

1. What information, generally, has been disseminated to patrol officers regarding opioids, such as prescription opioids and fentanyl?
2. What information has been disseminated to patrol officers regarding the legal liability of overdose calls, specifically regarding the administration of naloxone?
3. What modalities does your organization use to communicate knowledge regarding opioids generally to patrol officers?
    1. What opioid-specific trainings are patrol officers provided?
    2. What other types of drug related trainings are patrol officers provided?

4. How frequently has opioid-specific knowledge been disseminated within your agency to patrol officers in the past 12 months?
    1. Is this frequency any different from other topics in the past 12 months? If so, why?
5. What resources do your training officers typically rely on to develop knowledge on the opioid topic?
    1. What resources or training aids exist within your agency related to opioids?
6. Recognizing that your agency has been providing opioid-related training, would patrol officers could benefit from additional trainings or supporting materials (e.g., resources) on this topic at this time?
7. What new resources or training aids would be helpful related to opioids?

C. <u>Capacity to respond to opioid overdoses</u>

1. What level of access does your department currently have to naloxone?
    1. Is the number of kits on hand sufficient for current usage rates of naloxone?
2. Are patrol officers trained to administer naloxone?
    1. Do officers carry naloxone in a professional capacity?
        1. Kits for administration to fellow officers or self?
        2. Kits for administration to citizens?
        3. When on overdose scene, do your officers defer to EMS for naloxone administration?
3. What are your agency's policies regarding administration of naloxone pertaining to:
        1. Response to person overdosing?
        2. Response to officer exposed?
        3. Process for documenting naloxone administration?
            1. Are overdose reports available?
4. Do officers have concerns with their ability to respond?
5. Are you aware of barriers officers perceive to exist in the administration of naloxone/ Narcan?
6. Does your agency find important differences in responding to opioid-related calls? If so, what is important for DHHS to know?
7. Is your agency/department sufficiently prepared for a potential spike or surge in opioid related overdoses?

<u>Other areas of discussion and concern regarding ability to respond or opioid use and abuse in the community</u>

1. Are officers stressed about opioids in the community? To what extent are officers concerned about contact exposure to opioids?
2. In general, how confident are officers about their opioid training?
3. Can you tell me about some wellness programs from your department?
    1. How is information disseminated to officers about these programs?

Healthcare Professional Respondents who Provided Demographic Data Only

40 survey respondents provided demographic data only. These respondents were not included in the analysis, but the information they gave is provided below.

Position	Count	Percentage
Nursing	27	79%
Physician	4	12%
Other Healthcare Professional	3	9%

Years in Position	Count	Percentage
Less than 1 year	4	12%
1-5 years	7	21%
6-10 years	13	38%
11-15 years	2	6%
16-20 years	1	3%
21-25 years	4	12%
More than 26 years	3	9%

Service Area Population	Count	Percentage
Rural (under 2,500 people)	4	12%
Urban Cluster (2,500 to 29,000 people)	7	21%
Urban Cluster (30,000 to 50,000 people)	3	9%
Urban (over 50,000 people)	20	59%

Service Area, County	Count	Percentage
Douglas	10	29%
Lancaster	10	29%
Scotts Bluff	2	6%
Saunders	2	6%
Sarpy	2	6%
Wayne	2	6%
Kearney	1	3%
York	1	3%
Seward	1	3%
Lincoln	1	3%
Custer	1	3%
Madison	1	3%

Healthcare Professional Quantitative Survey Responses by Region

Characteristics of Respondents

Nurses were 84% (n=108) of the respondents, and they worked in each of the six regions. 1-4 physicians responded from each of the regions, except no physician responded from Region 3. The largest group of respondents was 44 nurses in Region 5, which represents 34% of the total responses.

Region	#	Nurse	Other Nursing role	Physician	Other Physician role	Other healthcare professional	Total %
1	14	86%	-	7%	7%	-	100%
2	5	60%	-	20%	-	20%	100%
3	14	100%	-	-	-	-	100%
4	19	74%	5%	5%	-	16%	100%
5	52	85%	6%	4%	2%	4%	100%
6	25	84%	-	16%	-	-	100%

Overall, respondents in Region 2 were younger (80% were under 45 years old), whereas respondents in Regions 3 and 4 were older (40% and 36%, respectively, were 55-64 years old).

Region	#	18-24 years old	25-34 years old	35-44 years old	45-54 years old	55-64 years old	65-74 years old	Total %
1	12	-	25%	42%	17%	8%	8%	100%
2	5	20%	-	60%	20%	-	-	100%
3	10	-	20%	30%	10%	40%	-	100%
4	14	-	21%	36%	7%	36%	-	100%
5	41	-	39%	22%	20%	12%	7%	100%
6	21	5%	48%	24%	-	24%	-	100%

Most respondents in Regions 1 and 2 worked in urban clusters, whereas those in Region 4 worked primarily in rural areas. Respondents in Region 4 worked in both rural areas and urban clusters. Region 5 had respondents in all areas, and Region 6 respondents worked primarily in large urban areas (n=130).

Region	#	Rural (under 2,500)	Urban cluster (2,500-50,000)	Urban (over 50,000)
1	14	28%	71%	-
2	5	-	100%	-
3	14	71%	29%	-
4	20	55%	45%	-
5	52	37%	37%	27%
6	25	8%	12%	79%

Please indicate how frequently you suspect each of the substances listed below were involved in overdoses you responded to in the past 12 months.

Alcohol is the primary concern in Regions 1 and 6.

Region	#	Never	Sometimes	About half the time	Most of the time/Always	DNK
1	13	-	15%	-	77%	8%
2	5	-	40%	-	60%	-
3	13	-	31%	23%	46%	-
4	20	15%	15%	15%	50%	5%
5	51	6%	10%	27%	51%	6%
6	24	-	8%	13%	79%	-

Opioids are more of a concern in Regions 3, 4, and 6.

Region	#	Never	Sometimes	About half the time	Most of the time/Always	DNK
1	13	23%	31%	23%	16%	8%
2	5	40%	60%	-	-	-
3	12	17%	50%	-	25%	8%
4	19	16%	32%	21%	26%	5%
5	49	12%	45%	22%	18%	2%
6	24	-	38%	38%	25%	-

Methamphetamine is a concern in all regions, but especially in Regions 2, 3, and 6.

Region	#	Never	Sometimes	About half the time	Most of the time/Always	DNK
1	13	31%	31%	23%	8%	8%
2	5	-	60%	40%	-	-
3	14	21%	50%	21%	29%	-
4	19	21%	32%	11%	21%	5%
5	50	24%	45%	14%	16%	6%
6	24	-	38%	29%	21%	4%

Fentanyl is not a concern in any of the regions; it is somewhat of a concern in Regions 4, 5, and 6.

Region	#	Never	Sometimes	About half the time	Most of the time/Always	DNK
1	13	54%	23%	-	-	23%
2	5	60%	40%	-	-	-
3	10	70%	20%	-	-	10%
4	18	44%	50%	-	-	6%
5	46	54%	22%	9%	2%	13%
6	23	30%	35%	17%	9%	9%

For this question, think back to the situations you've responded to in the most recent six (6) months. On average per month, how many situations involved responding to a drug overdose?

Respondents in Region 6 indicated that over the last 6 months they had responded to an average of 5.5 overdose situations a month. Respondents in Regions 1, 2, and 5 responded to 3-4 overdose situations a month, and respondents in Region 3 responded to just 1.5 overdose situations a month.

Region	#	Mean	SD
1	13	3.5	3.38
2	5	3.2	2.28
3	13	1.5	1.61
4	19	2.1	1.82
5	43	3.9	6.28
6	23	5.5	3.89

F=1.79, df=5, p=0.12

Of the overdoses you were responding to six (6) months ago, approximately what percentage do you suspect involved opioids?

Respondents in Region 6 indicated that over the last 6 months 33% of overdose situations involved opioids. This number was 18% for Regions 3 and 4, and 11% for Region 1. (Sample in Region 2 was too small to include.)

Region	#	Mean	SD
1	11	10.8%	19.69
2	2	*	*
3	11	18.9%	40.11
4	19	18.8%	34.67
5	33	11.6%	21.15
6	19	33.4%	39.59

F=1.36, df=5, p=0.24 *sample size too small

Within the past 12 months, approximately how many times have you (you individually, not your department) administered naloxone?

Respondents in Regions 5 and 6 had administered naloxone 3.6 and 4.6 times in the past 12 months, respectively, as compared to respondents in other regions who had administered naloxone fewer times.

Region	#	Mean	SD
1	14	1.6	2.70
2	5	0.6	0.89
3	14	0.6	0.84
4	19	0.9	1.43
5	43	3.6	10.78
6	23	4.6	5.04

F=1.09, df=5, p=0.36

This next section is about the training you've received.
- I have been trained to administer naloxone for someone who has overdosed.

Whereas nearly all (96%) of respondents in Region 6 indicated they had received training to administer naloxone, fewer had received such training in other regions. Just over half of respondents in Region 2 (60%) had received training to administer naloxone (although there were only 5 responses).

Region	#	% had received training to administer naloxone
1	14	71%
2	5	80%
3	14	93%
4	20	70%
5	52	83%
6	25	96%

p=0.24

- I have received training to recognize the symptoms of an opioid overdose.

Nearly all respondents in Regions 3 and 6 (93% and 96%, respectively) had received training to recognize the symptoms of an opioid overdose. Nearly three-fourths of respondents in all other regions had also received similar training.

Region	#	% had received training to recognize the symptoms of an opioid overdose
1	14	71%
2	5	80%
3	14	93%
4	20	70%
5	52	83%
6	25	96%

p=0.17

- I have been provided sufficient training about opioid use.

More than 60% of respondents in Regions 2, 3, and 6 indicated they had received sufficient training about opioid use, with Region 6 at 72%. Not as many respondents in Regions 1, 4, and 5 thought they had received sufficient training about opioid use.

Region	#	Strongly agree	Agree	Slightly agree	Disagree	N/A
1	13	8%	38%	38%	15%	-
2	5	-	60%	20%	20%	-
3	11	27%	36%	9%	27%	-
4	17	18%	35%	18%	30%	-
5	44	7%	45%	20%	22%	5%
6	21	48%	24%	14%	15%	-

- I have been provided sufficient training around response to an opioid overdose.

Nearly three-fourths (71%) of respondents in Region 6 indicated they had been provided sufficient training about response to an opioid overdose. More than half of respondents in Regions 2 and 3 also indicated they had been provided sufficient training about response to an opioid overdose.

Region	#	Strongly agree	Agree	Slightly agree	Disagree	N/A
1	13	8%	38%	31%	23%	-
2	5	-	60%	20%	20%	-
3	11	18%	45%	18%	18%	-
4	17	12%	29%	24%	30%	6%
5	43	5%	40%	28%	23%	5%
6	21	52%	19%	19%	10%	-

- I have been provided sufficient training around opioid overdose prevention.

About 60% of respondents in Regions 3 and 6 indicated they had been provided sufficient training around opioid overdose prevention. Nearly half of respondents in Region 4 indicated they had not.

Region	#	Strongly agree	Agree	Slightly agree	Disagree	N/A
1	13	8%	38%	38%	15%	-
2	5	-	40%	40%	20%	-
3	11	27%	36%	9%	27%	-
4	17	6%	24%	29%	42%	-
5	42	10%	36%	21%	29%	5%
6	21	33%	29%	14%	24%	-

- Through my training, I feel confident that I can administer naloxone if needed.

More than 60% of respondents in all regions felt confident they could administer naloxone if needed, with Region 6 respondents at 95%. Nearly half (40%) of respondents in Region 2 did not feel confident that they could do so.

Region	#	Strongly agree	Agree	Slightly agree	Disagree	N/A
1	13	8%	62%	15%	15%	-
2	5	40%	20%	-	40%	-
3	11	45%	36%	18%	-	-
4	17	18%	47%	29%	6%	-
5	43	16%	53%	14%	11%	5%
6	21	62%	33%	-	5%	-

- I have confidence that my department is equipped with sufficient naloxone kits if four or more doses are needed to revive the overdose victim.

Nearly all respondents in Region 6 (95%) had confidence their department was equipped with sufficient naloxone kits if four or more doses were needed to revive the overdose victim. Fewer respondents in Region 4 had confidence their department was equipped with sufficient naloxone kits.

Region	#	Strongly Agree	Agree	Slightly Agree	Disagree	N/A
1	12	8%	50%	25%	8%	8%
2	5	20%	40%	-	20%	20%
3	11	27%	36%	18%	18%	-
4	17	18%	35%	24%	24%	-
5	43	12%	47%	12%	25%	5%
6	21	62%	33%	5%	-	-

- I am reluctant to administer naloxone for fear of legal repercussions.

Very few of respondents in any of the regions felt reluctant to administer naloxone for fear of legal repercussions.

Region	#	Agree	Slightly disagree	Disagree	Strongly disagree	N/A
1	12	16%	33%	25%	25%	-
2	5	-	-	-	80%	20%
3	11	9%	9%	55%	27%	-
4	17	12%	6%	47%	35%	-
5	42	12%	5%	40%	38%	5%
6	21	5%	-	29%	67%	-

- I am reluctant to administer naloxone for fear of putting myself in physical danger.

Over half of respondents in all regions except Region 1 did not feel reluctant to administer naloxone for fear of putting themselves in physical danger. Almost half of respondents in Region 1 (45%) felt reluctant to administer naloxone for fear of putting themselves in physical danger.

Region	#	Agree	Slightly disagree	Disagree	Strongly disagree	N/A
1	12	45%	18%	9%	27%	-
2	5	20%	-	-	60%	20%
3	11	18%	9%	55%	18%	-
4	17	13%	13%	50%	25%	-
5	42	14%	16%	37%	28%	5%
6	21	5%	14%	29%	52%	-

- I have the appropriate protective gear to respond to opioid overdoses.

Half or more of the respondents in Regions 1, 2, 3, and 6 expressed they had the appropriate protective gear to respond to opioid overdoses, including 81% of Region 6 respondents. Only a third of respondents in Regions 4 and 5 expressed they had the appropriate protective gear. While 60% of respondents in Region 2 thought they had the needed gear, 40% thought they did not.

Region	#	Strongly Agree	Agree	Slightly agree	Disagree	N/A
1	12	8%	42%	42%	8%	-
2	5	-	60%	-	40%	-
3	11	9%	45%	36%	9%	-
4	17	12%	24%	53%	6%	6%
5	43	7%	35%	28%	28%	2%
6	21	43%	38%	5%	15%	-

- I feel naloxone should be available to everyone without a prescription.

Most respondents in Regions 1, 4, 5, and 6 felt naloxone should be available to everyone without a prescription. Respondents in Region 3 were not in favor of this, and respondents in Region 2 had a variety of feelings on this.

Region	#	Agree	Slightly Disagree	Disagree	Strongly Disagree	N/A
1	12	25%	25%	25%	25%	-
2	5	20%	20%	40%	20%	-
3	11	18%	-	18%	64%	-
4	17	48%	18%	29%	6%	-
5	43	47%	14%	23%	14%	2%
6	21	48%	10%	29%	14%	-

- Naloxone is readily available to all members of the communities I serve.

Region 4 is the only region where more than half of respondents stated that naloxone was readily available to all members of the communities they served. More than half of respondents in Regions 1, 2, and 3 did not think that naloxone was available in their communities.

Region	#	Agree	Slightly Disagree	Disagree	Strongly Disagree	N/A
1	11	27%	9%	36%	18%	9%
2	5	20%	20%	40%	20%	-
3	11	36%	-	36%	27%	-
4	17	59%	18%	18%	-	6%
5	43	39%	16%	30%	9%	5%
6	20	40%	15%	15%	15%	15%

- My department has sufficient resources to respond to opioid overdoses.

Nearly all respondents in Region 6 stated their departments had sufficient resources to respond to opioid overdoses. About one-fifth of respondents in Region 2 and 3 stated they did not have sufficient resources.

Region	#	Strongly Agree	Agree	Slightly Agree	Disagree	N/A
1	12	17%	33%	42%	8%	-
2	5	-	80%	-	20%	-
3	11	36%	36%	9%	18%	-
4	17	18%	59%	18%	6%	-
5	43	19%	37%	30%	13%	-
6	21	76%	19%	-	5%	-

- There is sufficient access to substance use treatment in the communities my facility serves.

Across the board, respondents did not think there was sufficient access to substance use treatment in their community, especially in Regions 1 and 6 (83% and 65%, respectively).

Region	#	Strongly Agree/Agree	Slightly Agree	Slightly Disagree	Disagree	Strongly Disagree
1	12	8%	8%	-	33%	50%
2	5	20%	-	20%	40%	20%
3	11	-	-	27%	45%	27%
4	17	12%	18%	18%	24%	29%
5	44	18%	14%	14%	34%	20%
6	21	24%	5%	5%	19%	48%

- In my experience, members of the communities my facility serves are sufficiently aware of the Good Samaritan law.

Only in Regions 4 and 5 did more than 50% of respondents think community members were sufficiently aware of the Good Samaritan law. Nearly all (80%) of respondents in Region 2 did not think their community members were aware of the law.

Region	#	Strongly Agree/Agree	Slightly Agree	Slightly Disagree	Disagree	Strongly Disagree
1	12	-	25%	-	42%	-
2	5	20%	-	20%	60%	20%
3	11	27%	9%	9%	36%	9%
4	17	24%	35%	6%	12%	6%
5	44	21%	27%	5%	30%	5%
6	21	19%	24%	5%	33%	5%

- In my experience, members of the communities my facility serves are aware they can access naloxone without an individual prescription.

All of the respondents in Regions 1 and 2, and nearly all the respondents from Region 4 did not think members of their communities were aware they could access naloxone without an individual prescription.

Region	#	Strongly Agree/Agree	Slightly Agree	Slightly Disagree	Disagree	Strongly Disagree
1	12	-	-	25%	75%	-
2	5	-	-	-	80%	20%
3	11	18%	9%	9%	36%	27%
4	17	-	6%	29%	53%	12%
5	43	7%	19%	9%	42%	23%
6	21	10%	5%	19%	43%	24%

- The communities my facility serves are being significantly affected by opioid use.

Most respondents in Region 6 (80%) thought their communities were being significantly affected by opioid use. Over a third of respondents in Regions 2, 4, and 5 did not think their communities were being significantly affected by opioid use.

Region	#	Strongly Agree	Agree	Slightly Agree	Slightly Disagree	Disagree	Strongly Disagree
1	12	25%	17%	42%	17%	-	-
2	5	20%	40%	-	-	20%	20%
3	11	18%	27%	27%	18%	9%	-
4	17	6%	18%	29%	29%	12%	6%
5	44	7%	16%	39%	25%	11%	2%
6	21	24%	48%	10%	10%	5%	5%

- Through my work, I am making a positive impact on the community I work in.

Most respondents in Regions 1, 2, and 4 felt they were making a positive impact on the community they worked in (84%, 80%, and 88%, respectively).

Region	#	Strongly Agree/Agree	Slightly Agree	Slightly Disagree/Disagree	Strongly Disagree
1	12	42%	42%	17%	-
2	5	80%	-	-	20 %
3	11	54%	18%	27%	-
4	17	47%	41%	12%	-
5	44	45%	41%	13%	-
6	21	53%	33%	15%	-

- The community I work in is supportive of my department.

Most all respondents thought their community was supportive of their department, although a few respondents in Regions 2 and 5 disagree.

Region	#	Strongly Agree	Agree	Slightly Agree	Slightly Disagree/Disagree/ Strongly Disagree
1	12	-	50%	50%	-
2	5	-	80%	-	20%
3	11	9%	73%	18%	-
4	17	12%	41%	41%	6%
5	44	9%	41%	36%	14%
6	21	19%	33%	43%	5%

Please indicate your level of agreement with the following statements regarding work-related stress.

Nearly all respondents thought their department was supportive of them, felt a sense of connection to their co-workers, and felt they had peer support when they needed to process a highly stressful experience.

- I am aware of resources available to me to help with secondary trauma and stress.

All respondents (n=5) in Region 2 were aware of resources available to them to help with secondary trauma and stress. More than one-third of respondents in Region 3 were not aware of resources available to them to help with secondary trauma and stress.

Region	#	Strongly Agree	Agree	Slightly Agree	Slightly Disagree/Disagree/ Strongly Disagree
1	12	-	67%	25%	8%
2	5	60%	20%	20%	-
3	11	9%	45%	9%	36%
4	17	18%	76%	-	6%
5	43	9%	58%	23%	9%
6	21	38%	24%	24%	15%

- My department encourages me to access trauma and stress resources on a regular basis.

More than half of respondents in Regions 2 and 3 (60% and 54%, respectively) did not think their department encouraged them to access trauma and stress resources on a regular basis.

Region	#	Strongly Agree	Agree	Slightly Agree	Slightly Disagree	Disagree/Strongly Disagree
1	12	-	33%	42%	8%	17%
2	5	40%	-	-	40%	20%
3	11	18%	18%	18%	18%	36%
4	17	24%	59%	18%	24%	-
5	43	26%	42%	16%	26%	12%
6	21	19%	33%	24%	19%	10%

- I am aware of the symptoms of compassion fatigue.

A few respondents in Regions 1 and 3 were not aware of the symptoms of compassion fatigue.

Region	#	Strongly Agree	Agree	Slightly Agree	Slightly Disagree	Disagree/Strongly Disagree
1	12	-	58%	17%	17%	8%
2	5	60%	40%	-	-	-
3	11	9%	36%	36%	18%	-
4	17	6%	65%	24%	-	6%
5	43	12%	55%	24%	7%	2%
6	21	29%	52%	14%	-	5%

- I am able to identify symptoms of compassion fatigue in myself.

One-third of respondents in Region 1, and a few respondents in Regions 3 and 5 did not think they were able to identify symptoms of compassion fatigue in themselves.

Region	#	Strongly Agree	Agree	Slightly Agree	Slightly Disagree	Disagree/Strongly Disagree
1	12	-	58%	8%	25%	8%
2	5	40%	20%	40%	-	-
3	11	9%	45%	27%	18%	-
4	17	6%	65%	24%	-	6%
5	43	9%	47%	28%	12%	4%
6	21	19%	48%	24%	-	10%

- I am able to identify symptoms of compassion fatigue in my colleagues.

One-fourth of respondents in Region 1 did not think they were able to identify symptoms of compassion fatigue in their colleagues.

Region	#	Strongly Agree	Agree	Slightly Agree	Slightly Disagree/Disagree/ Strongly Disagree
1	12	-	58%	17%	25%
2	5	40%	40%	20%	-
3	11	9%	36%	45%	9%
4	17	6%	65%	24%	6%
5	43	9%	51%	26%	14%
6	21	14%	52%	19%	15%

- How often do you engage in self-care practices?

Respondents in Regions 1 and 6 engaged in self-care practices a bit less than respondents in other regions. (Examples of self-care practices listed in the survey item included meditation, journaling, spending quality time with a loved one, stretching, taking a walk, doing something new, limit work hours.)

Region	#	Daily	4-6x/week	2-3x/week	1x/week	Never
1	12	17%	8%	50%	17%	8%
2	5	20%	20%	40%	20%	-
3	11	30%	10%	40%	10%	10%
4	17	19%	19%	38%	25%	-
5	43	21%	23%	33%	14%	9%
6	21	19%	19%	14%	43%	5%

Quantitative Demographics for Incomplete Responses

Forty-two survey participants responded only to the demographic questions. These respondents were not included in the analysis, but their position, capacity, and years in the position frequencies are provided below.

Position (n=35)	**Count**	**Percent**
Firefighter	10	29%
EMT/Paramedic	8	23%
Both	17	49%
Capacity (n=35)		
Professional	32	91%
Volunteer	2	6%
Both	1	3%
Years in Position (n=42)		
Less than 1 year	1	2%
1-5 years	7	17%
6-10 years	11	26%
11-15 years	5	12%
16-20 years	5	12%
21-25 years	9	21%
More than 26 years	4	10%

Service Area Region (n=41)

	Count	Percent
Region 1	1	2%
Region 2	2	5%
Region 3	4	10%
Region 4	3	7%
Region 5	5	12%
Region 6	26	63%

Service Area Population (n=42)	**Count**	**Percent**
Rural (under 2,500 people)	6	14%
Urban Cluster (2,500 to 29,000 people)	4	10%
Urban (over 50,000 people)	31	74%
Other	1	2%
Service Area County (n=41)		
Brown	2	5%
Douglas	21	51%
Douglas, Sarpy	5	12%
Furnas	1	2%
Hall	1	2%
Hall, Hamilton, Howard, Merrick	1	2%
Lancaster	3	7%
Lancaster, Saline, Seward	1	2%
Lincoln	1	2%
Nemaha	1	2%
Platte	1	2%
Red Willow	1	2%
Scotts Bluff	1	2%
Webster	1	2%

Unused Quantitative Items

The following eight items were not included in the analysis due to the prioritization of other items. The first five items relate to naloxone use and availability. The final two items relate to compassion fatigue.

Survey Items	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
I have been provided sufficient training around response to an opioid overdose.	15%	12%	6%	10%	32%	25%
I have been provided sufficient training around opioid overdose prevention.	15%	21%	9%	19%	23%	14%
I am reluctant to administer naloxone for fear of putting myself in physical danger.	31%	41%	6%	13%	5%	4%
I feel naloxone should be available to everyone without a prescription.	16%	24%	13%	16%	21%	10%
Naloxone is readily available to all members of the community I work in.	15%	37%	19%	13%	8%	7%
I feel my department has the appropriate policies and procedures in place around response to opioid overdoses.	16%	12%	6%	13%	36%	18%
I feel a sense of connection to my coworkers.	3%	1%	1%	18%	42%	36%
My department is supportive of me.	3%	2%	2%	24%	40%	28%