

# Drug Use Behaviors

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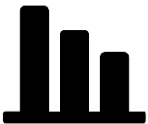


## Purpose

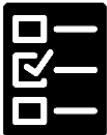
**The goal of this needs assessment is to better understand individuals' drug-use behaviors in Nebraska through the lens of treatment providers.**

The results of this study will aid the Drug Overdose Prevention (DOP) program in providing training and other resources to treatment centers, focusing prevention efforts, and informing the statewide crisis response plan and future studies. Ultimately, this study will support DOP's efforts to reduce opioid-involved fatal and non-fatal overdoses in Nebraska.

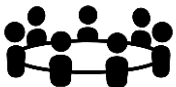
Support and Training for the Evaluation of Programs (STEPs) at the University of Nebraska at Omaha is a leader in conducting evaluations of and needs assessments for social service programs and policies. The Nebraska Department of Health and Human Services (DHHS) contracted with STEPs in the summer of 2019 to complete a needs assessment that included an analysis of secondary data from national and state datasets, a survey of treatment providers, and focus groups with treatment providers.



**Community Datasets:** Secondary analysis of two datasets: the Treatment Episode Data Set (TEDS), and the Nebraska Risk and Protective Factor Student Survey (NRPFS) as a components of the Student Health and Risk Prevention Surveillance System (SHARP).



**Treatment Provider Surveys:** Online survey of administrators in residential inpatient treatment facilities and methadone clinics in Nebraska.



**Treatment Provider Focus Groups:** Focus groups with medication-assisted treatment facilities in Omaha and Lincoln, Nebraska.

## Operationalization of "Treatment Providers"

The primary data in this report was collected from substance use treatment facilities. These facilities are most commonly independent of other healthcare facilities (i.e. hospitals or clinics) and specialize in the treatment of substance use disorders. They are generally staffed by individuals trained in behavioral health, such as counselors, psychologists, and social workers.

The focus of treatment tends to be directed at the psychological healing of addiction and trauma through modalities such as individual and group therapy delivered by behavioral health professionals, with a particular expertise in treating addictions. While some facilities may employ medical staff, such as nurses and psychiatrists, these professionals tend to serve as a compliment to psychological treatment, addressing the biological components of addiction and other commonly occurring health concerns of clients in treatment (Center for Substance Abuse Treatment, 2004).



## Research Questions

The following research questions were developed in collaboration with DHHS and guided STEPs' analyses:

1. What are the demographic characteristics of people in Nebraska who use drugs?
2. What drugs are people in Nebraska using?
3. How do people in Nebraska initiate drug use?
4. At what point do people in Nebraska seek intervention or treatment?
5. What are the needs of treatment providers?
6. What are the needs of individuals receiving treatment for substance use disorders?
7. What are providers' perceptions of current DHHS prevention efforts?
8. What databases do we recommend for further data mining?

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### 1. What are the demographic characteristics of people in Nebraska who use drugs?

Findings from TEDS and SHARP indicate that misuse of substances is disproportionately affecting persons of color in Nebraska, especially those identifying as American Indian or Black.

Most striking, American Indians were significantly over represented in the Nebraska data as they accounted for 2% of the Nebraska population, but 7% of substance abuse treatment admissions in 2017.

Both Asians and Caucasians were under-represented nationally and in Nebraska. African Americans, however, were over-represented. According to TEDS, African Americans represented 13% of the U.S. population, but 18% of admissions. In Nebraska, African Americans represented 5% of the population, but 11% of admissions.

With respect to gender, males were more frequently represented in both the U.S. (65%) and Nebraska (68%) samples. The most common age category both for the U.S. and Nebraska was 25-34 years old, representing 35% of the sample. Overall, Nebraska trends mirrored national trends with the exception of the 18-24 year olds with Nebraska showing a 17% admission compared to the U.S. admission rate of 13%.

### 2. What drugs are people in Nebraska using?

According to TEDS, opiates were the most common primary substance identified nationally in 2017, accounting for 34% of all admissions in 2017. In Nebraska, opiates accounted for less than 4% of all admissions, according to TEDS. In contrast, according to TEDS, the most common substances for Nebraska were alcohol (42% compared to 17% nationally) and methamphetamines (23% compared to 10% nationally).



## Executive Summary (cont'd)

These findings are consistent with survey results from treatment providers in inpatient facilities in Nebraska as they also reported a high prevalence of alcohol and methamphetamine as primary substances in addition to marijuana. Survey results drawn from three of the four methadone clinics in Nebraska showed their clients most commonly present with opiate use disorder, including prescription pain relievers, heroin, and fentanyl.

According to TEDS, DSM diagnosis data was strikingly different between Nebraska and nationally. Opioid abuse was more common as a diagnosis nationally than in Nebraska (33% compared to 4%). Consistent with the primary substances used at admission, DSM diagnoses of Alcohol Intoxication and Alcohol Dependence were much higher in Nebraska (20% and 26% respectively) than nationally (4% and 19% respectively). In addition, “other substance abuse” was much higher in Nebraska than nationally (26% compared to 8%) and might be related to the high incidence of methamphetamine use in Nebraska. Because the TEDS data is focused on those who are admitted to treatment, it is quite possible that the true prevalence of opiates and other substances is much higher.

7% of youth responding to the SHARP survey indicated that they had used marijuana in the previous 30 days. Nearly one-fourth of youth who self-reported marijuana use said they started at the age of 15 years, with 16% saying they started as 12 years or younger. A very small percentage (4%) of youth reported using prescription drugs without a doctor telling them to take them.

Less than 2% of youth in the SHARP survey indicated use of LSD, methamphetamines, cocaine/crack, or heroin.

### **3. How do people in Nebraska initiate drug use?**

According to TEDS and survey findings, first use of alcohol and marijuana most commonly occurs during adolescence, and is provided by a friend or relative. In contrast, these sources plus focus group findings show that opioid misuse most commonly begins in adulthood, and with a doctor’s prescription.

### **4. At what point do people in Nebraska seek intervention or treatment?**

Individuals are most likely to seek treatment if mandated by a court or other source (i.e. employer). Clients experience many barriers to treatment, especially MAT. There is a large geographic void in access to inpatient treatment facilities, and an even greater void in treatment facilities able to prescribe MAT for either opioid misuse or alcohol dependence. As such, the most common barriers to clients accessing treatment are their ability to pay for treatment, and related expenses such as transportation and childcare.



## Executive Summary (cont'd)

According to TEDS, individual or self-referrals account for 43% of referrals. Trends in referrals are very different in Nebraska with only 20% of referrals being from individuals or self-referrals. Rather, the largest referral source in Nebraska was the courts/criminal justice system (58% compared to 28% nationally).

### **5. What are the needs of treatment providers?**

Very few treatment providers have the capacity to prescribe MAT for OUD or alcohol addiction, according to survey results; only slightly more refer clients for MAT. In survey and focus group findings, treatment providers reported their greatest needs are for training on evidence-based practices (especially related to trauma and MAT), and funding for the workforce to increase their capacity to provide MAT, mental health care, and access to rural communities.

They also expressed a need for education for the general public and medical professionals on MAT to reduce stigma and unethical prescribing practices. Additionally, they noted a dearth of funding for staff in three distinct areas: 1) Support staff needed to ethically provide MAT; 2) Staff to address mental health needs of clients; and 3) Staff to provide services in rural locations of Nebraska.

### **6. What are the needs of individuals receiving treatment for substance use disorders?**

Those seeking a path to recovery need financial support including assistance paying for substance treatment (including MAT) as well as transportation and childcare assistance to be able to access treatment. Survey and focus group participants also indicated a need for clients to receive more holistic care, especially related to their mental health needs.

### **7. What are provider perceptions of current DHHS prevention efforts?**

In survey and focus group findings, treatment providers indicated a disconnect between DHHS efforts and their current needs. On the survey, relatively few providers were informed about DHHS' current prevention efforts; even fewer utilized current resources, despite expressing a need for such programming. They indicated a greater need for funding related to mental health and the misuse of substances other than opioids.



## Executive Summary (cont'd)

### 8. What databases do we recommend for further data mining?

STEPs recommends continued data mining with the Treatment Episode Data Set (TEDS) and the Nebraska Risk and Protective Factor Student Survey (NRPFSS) as part of the Student Health and Risk Prevention Surveillance System (SHARP). In dialogue with DHHS to identify research questions, STEPs could dig more deeply into these datasets to answer more specific questions about Nebraska. In addition, data is updated annually or biannually so identified trends need to be monitored.

In addition, STEPs anticipates approval to receive the Monitoring the Future (MTF) data. TEDS provides vital data from treatment admissions and discharges, whereas SHARP and MTF provide data on youth, which informs youth usage of substances as well as informs prevention efforts.

These datasets also show promise in informing substance abuse treatment and prevention in Nebraska:

1. National Survey of Substance Abuse Treatment Services (N-SSATS). This dataset originates through an annual survey administered by SAMHSA regarding substance use treatment facilities and their clients.
2. National Survey on Drug Use and Health (NSDUH). The NSDUH is administered by SAMHSA and surveys individuals in all 50 states and provides valuable information on substance use and mental health.
3. Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is a telephone survey which collects data on the health-related risk behaviors, chronic health issues, and use of preventative services for United States residents. According to DHHS, beginning in 2018, BRFSS has eight questions regarding substance use.

### Additional Key Findings

According to TEDS, 71% of all discharges are due to treatment completion compared to 41% nationally.

In SHARP results, students generally viewed taking prescription drugs as more wrong and more risky than using marijuana. Students thought their parents were more against their using marijuana than prescription drugs. Students indicated a high likelihood they would go to their parents if they needed help with a drug or alcohol problem; they would also likely go to their friends.

**Recommendations can be found at the end of each section.**

# Community Datasets







## Treatment Episode Data Set (TEDS): Key Findings



### Primary Substance

Nationally, opiates were the most common primary substance identified in 2017, accounting for 34% of all admissions in 2017. In Nebraska, **opiates accounted for less than 4% of all admissions**. The most common substances for Nebraska were alcohol (42% compared to 17% nationally) and methamphetamines (23% compared to 10% nationally). The admissions data indicates **alcohol and methamphetamines are the most prevalent substance issues Nebraska is facing**. Because TEDS only reports those admitted to treatment, the true prevalence of opioid use may be much higher.



### Race

Asians and Caucasians were under-represented both nationally and in Nebraska, while Blacks were over-represented. Nationally, Black individuals represented 18% of admissions and 13% of the population; in Nebraska, Black individuals represented 11% of admissions and 5% of the population. Most strikingly though, **American Indians were significantly over-represented in Nebraska admissions** (2% of the Nebraska population compared to 7% of admissions).



### Treatment

**People admitted in Nebraska were more likely to have no prior treatment episodes than U.S. admissions** (67% compared to 36% nationally).



### Income and Employment at Admission

**Over half of people admitted in Nebraska reported having no income source at admission** (54%) compared with 35% of U.S. admissions. However, people admitted in Nebraska also reported being employed more frequently and receiving public assistance less frequently than U.S. admissions.



### Referral

The largest referral source in Nebraska was the courts/criminal justice system (54% compared to 28% nationally).



### Age at First Use

Most people admitted in Nebraska reported using their primary substance for the first time before age 18 (66% compared to 49% nationally).



### Discharge and MAT

Discharge data shows that 71% of all discharges were due to treatment completion in Nebraska compared to only 41% of U.S. discharges. **Nebraska admissions were nearly five times as likely to complete MAT** (67% compared to 13% nationally). Only 4% of Nebraska discharges planned to receive MAT at discharge compared to 12% of U.S. discharges. **Nebraskans are more likely to successfully complete treatment in general and after receiving MAT, but utilize MAT less often than U.S. discharges.**



## Treatment Episode Data Set (TEDS)



The Treatment Episode Data Set is a compilation of client information from substance use treatment admissions nationwide. Data from approximately 1.5 million treatment admissions across the U.S. are recorded annually through TEDS. This database provides administrative data on admissions to, and discharges from, substance use facilities. This data provides an opportunity to understand admission and discharge trends including characteristics associated with admissions and successful discharges.

### Admission Demographics

#### Gender

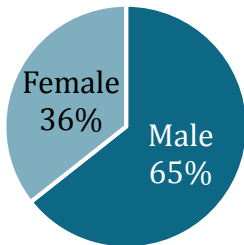
The majority of treatment admissions were male, both nationally and in Nebraska.



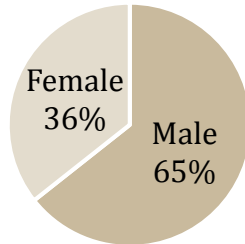
#### Pregnancy Status

Pregnancy status for individuals admitted to substance use treatment was consistent between U.S. (4% pregnant, 96% not pregnant) and Nebraska (3% pregnant, 97% not pregnant).

Nebraska Admissions  
(n=13,357)

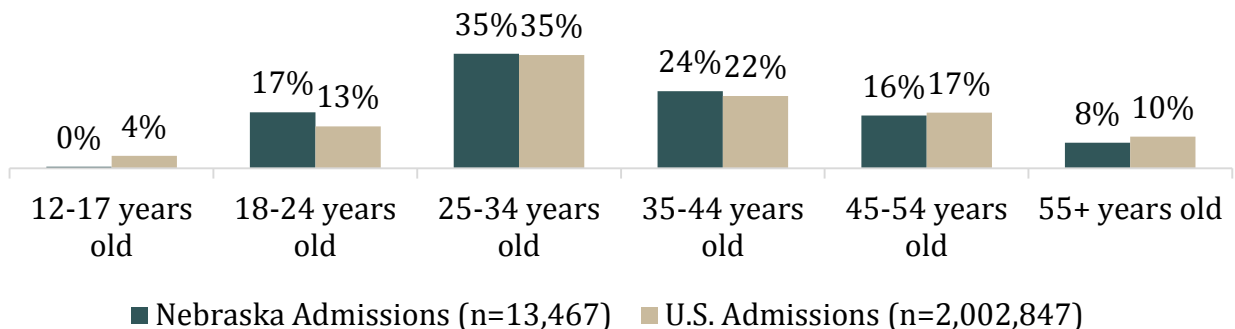


U.S. Admissions  
(n=2,004,329)



#### Age

The average age for U.S. admissions was 36 years, with 25-39 year-olds accounting for 35% of all admissions both nationally and in Nebraska. Nebraska data was consistent with U.S. trends, with a slightly higher percentage of admissions for 21-24 year-olds (12% compared to 10%) and for 12-20-year-olds (6% compared to 4%).



\*Nebraska Census data based on 5-year population estimates for ages 18 and older in 2017.



**Race/Ethnicity**



Racial disproportionality for admissions was observed across several race types compared to U.S. and Nebraska census data.

Both Asians and Caucasians were under-represented nationally and in Nebraska; African Americans were over-represented both in the U.S. and in Nebraska. Most striking though, American Indians were significantly over-represented in the Nebraska population (7% of Nebraska admissions compared to 2% of the Nebraska population). The majority of Nebraska admissions (92%) indicated they were not Hispanic or Latino (n=12,315). U.S. admissions indicated nearly double (14%) those of Hispanic or Latino origin compared to the Nebraska percentage (n=2,002,847).

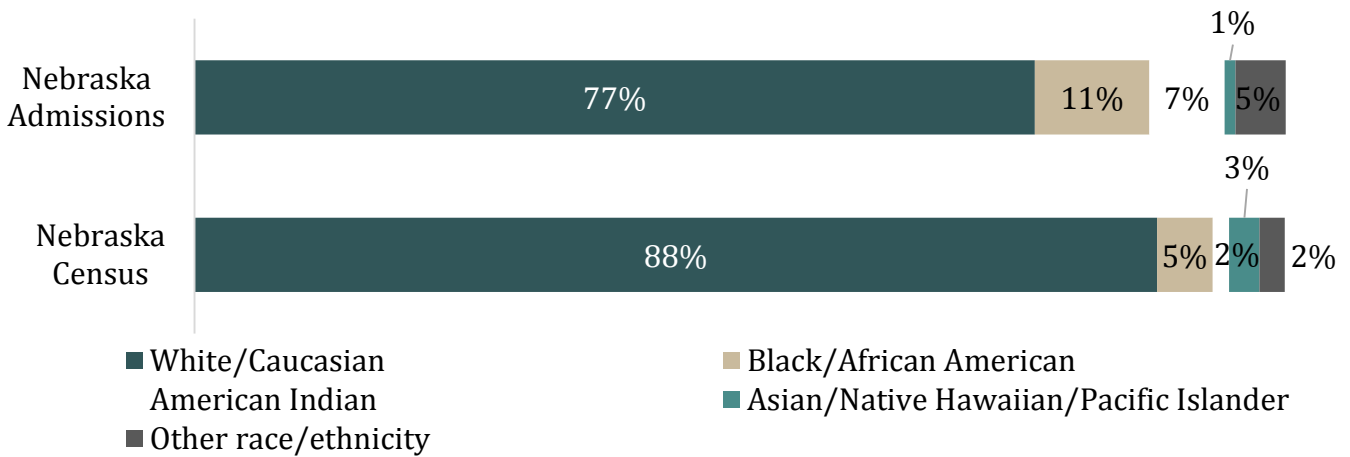
**8%**

Nebraska admissions identified as Hispanic or Latino.

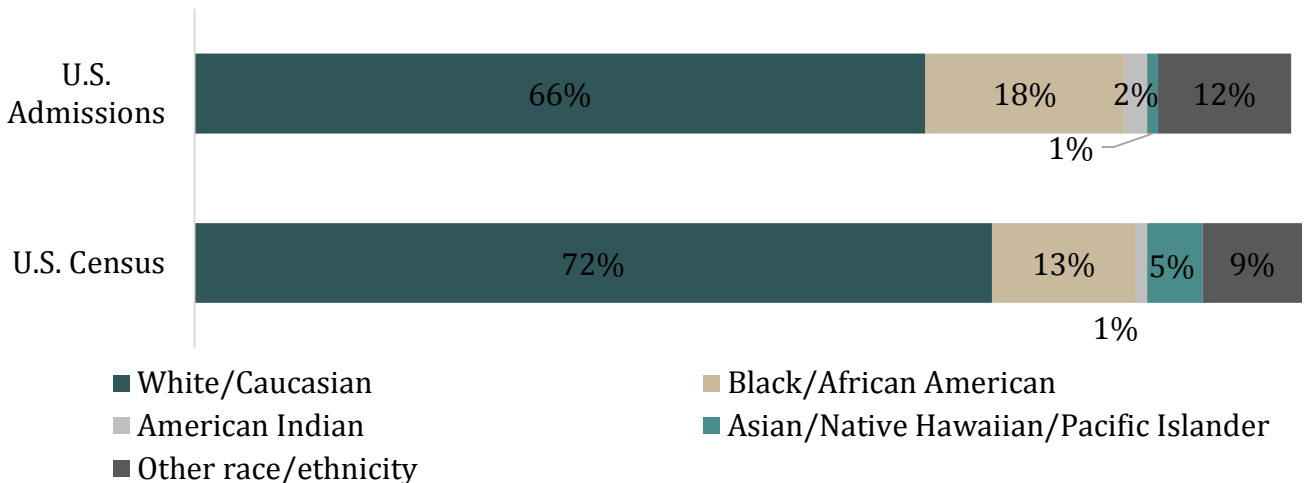
**14%**

U.S. admissions identified as Hispanic or Latino.

**Nebraska Data for 2017**



**U.S. Data for 2017**



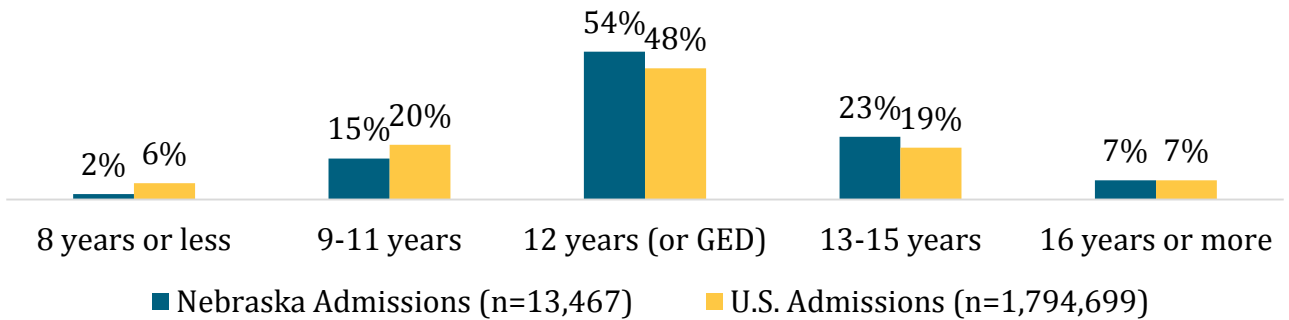


### Years of Education at Admission



Compared to the U.S. population, individuals admitted in Nebraska were more likely to have a high school degree or more (84% compared to 74%).

Years of Education	U.S. Admissions	Nebraska Admissions
8 years or less	6%	2% (183)
9-11 years	20%	15% (1,514)
12 years/GED	48%	54% (5,520)
13-15 years	19%	23% (2,392)
16 years or more	7%	7% (665)
Total	1,794,699	13,467

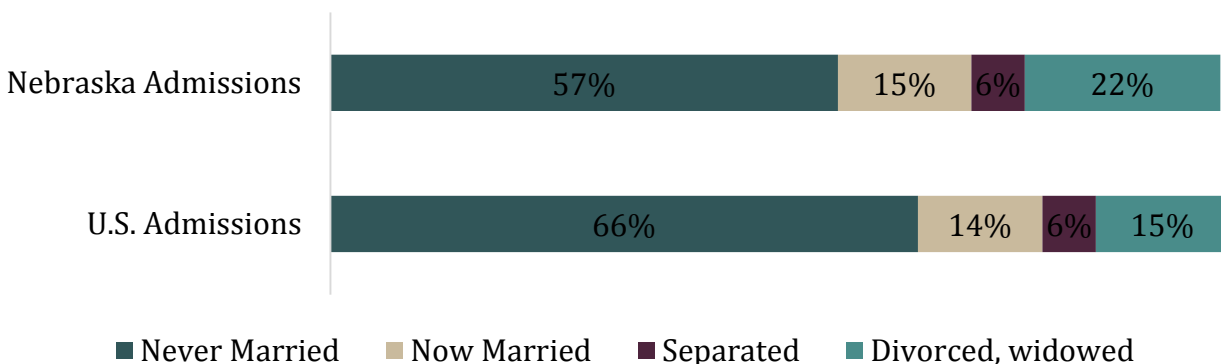


### Marital Status at Admission



Compared to U.S. admissions, individuals admitted in Nebraska were more likely to have never been married or divorced/widowed.

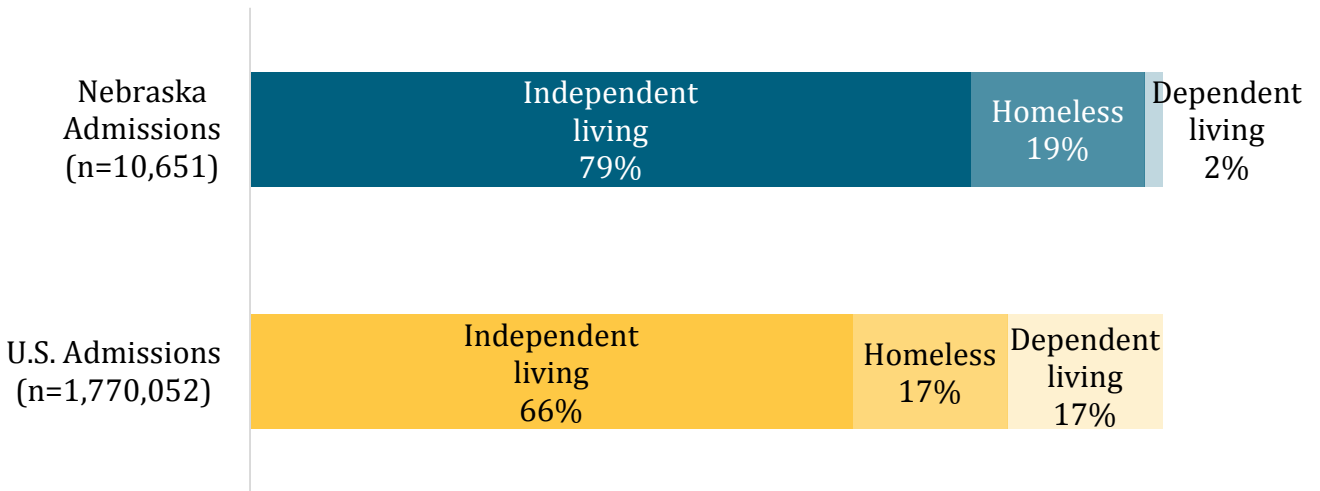
2017	U.S. Admissions	Nebraska Admissions
Never married	66%	57% (4,369)
Now married	14%	15% (1,169)
Separated	6%	6% (472)
Divorced, widowed	15%	<b>22%</b> (1,642)




**Living Arrangements at Admission**


The most striking differences within this variable were that fewer participants were in a dependent living environment and a significant number were living independently.

<b>2017</b>	<b>U.S. Admissions</b>	<b>Nebraska Admissions</b>
Homeless	17%	19% (1,981)
Dependent living	17%	<b>2%</b> (236)
Independent living	66%	<b>79%</b> (8,434)
<b>Total</b>	<b>1,770,052</b>	<b>10,651</b>



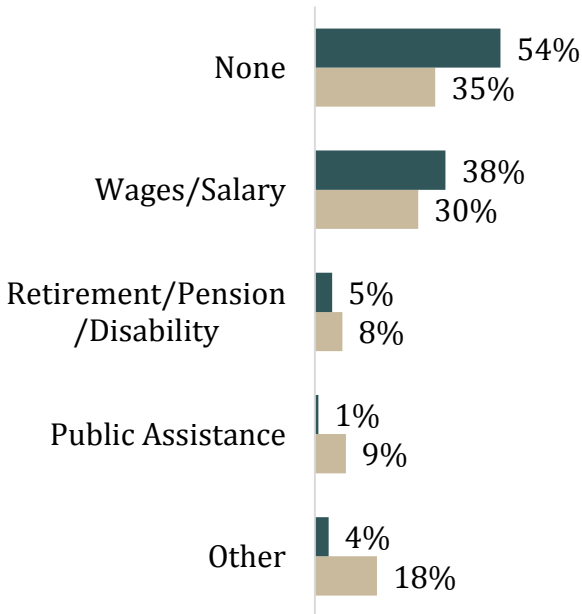


## Income Characteristics



### Income Source at Admission

Fewer Nebraskans were receiving public assistance at admission compared to the national data, and significantly more indicated they did not have an income source.



Income Source	U.S. Admissions	Nebraska Admissions
Wages/salary	30%	38% (4,143)
Public assistance	9%	<b>1%</b> (84)
Retirement/pension/disability	8%	5% (495)
Other	18%	4% (393)
None	35%	<b>54%</b> (5,926)
<b>Total</b>	<b>1,794,699</b>	<b>11,261</b>

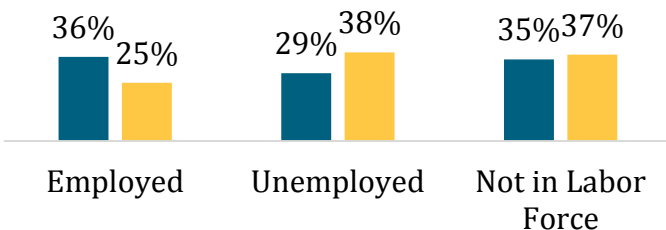
■ Nebraska Admissions (n=11,261)

■ U.S. Admissions (n=1,794,699)



### Employment Status at Admission

Fewer individuals who were admitted in Nebraska were unemployed (29% compared to 38%) and more were employed (36% compared to 25%) than in the U.S.



Employment Status	U.S. Admissions	Nebraska Admissions
Employed	25%	<b>36%</b> (4,045)
Employed full-time	18%	25% (2,813)
Employed part-time	7%	11% (1,232)
Unemployed	38%	<b>29%</b> (3,242)
Not in labor force	37%	35% (5,926)
<b>Total</b>	<b>1,794,699</b>	<b>11,261</b>

■ Nebraska Admissions (n=11,261)

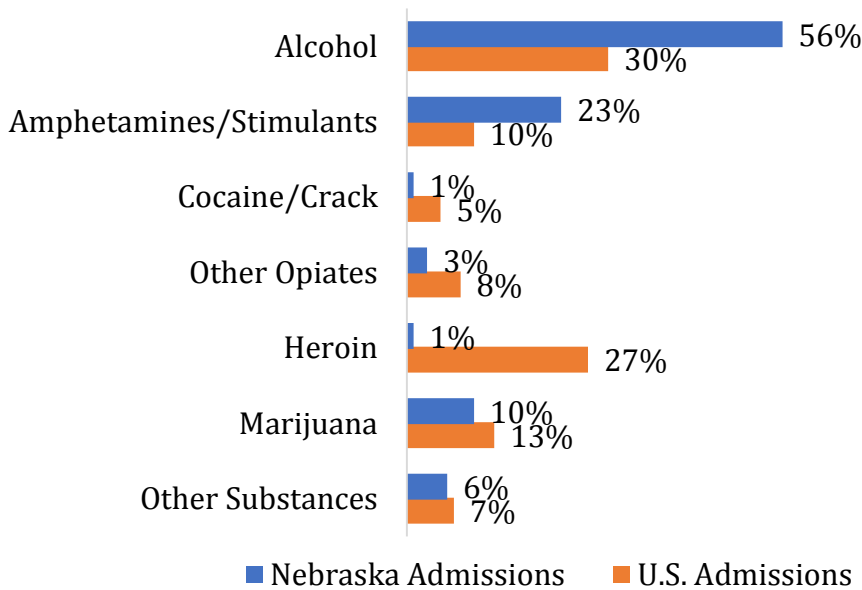
■ U.S. Admissions (n=1,794,699)



## Primary Substance Used at Admission



There were striking differences between Nebraska admissions data compared to national data with respect to alcohol use, opiate use, and methamphetamine use. Nationally, opiate use (34%) was the most common substance identified at admission. In contrast, opiates accounted for less than 4% of all admissions in Nebraska. Nebraska's most common substance was alcohol (42%) compared to 17% nationally, and methamphetamine (23% compared to 10% nationally).



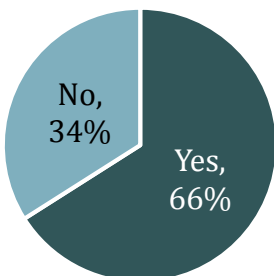
## Age at First Use of Primary Substance



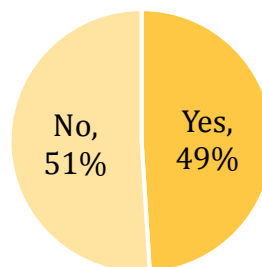
Generally, Nebraska youth appear to use substances much earlier than youth nationally. The majority of admissions in Nebraska (66%) indicated they first used the primary substance they received treatment for when they were under the age of 18 compared to 49% nationally. Most striking though is that nearly 9% indicated they were 11 years or younger in Nebraska and 5% nationally. (See [Appendix A](#) for full table of age at first use of primary substance).

### First Use Younger than 18 Years Old

Nebraska Admissions



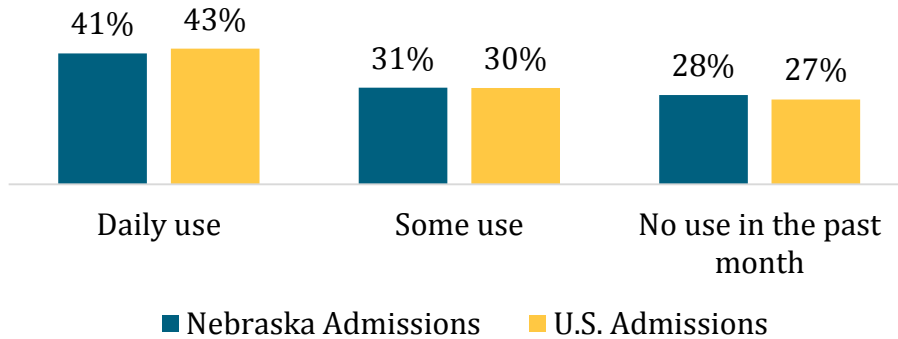
U.S. Admissions





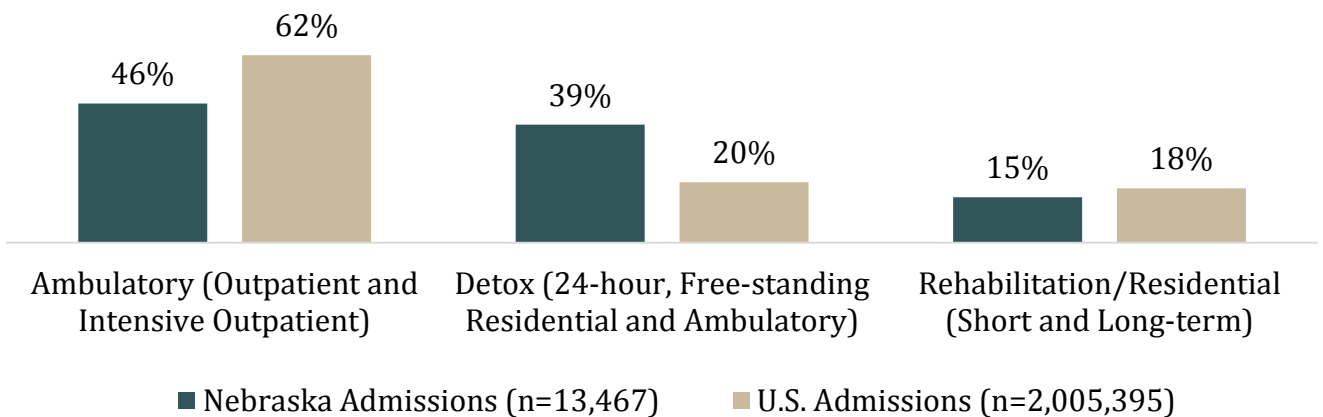
### Frequency of Primary Substance Use at Admission

U.S. and Nebraska admissions reported approximately the same frequency of primary substance use, with more than 70% of all admissions reporting some use or more at the time of their admission to treatment.



### Treatment Service Type

Nebraska admissions receiving detox services (39%) nearly doubled those of U.S. admissions (20%). More U.S. admissions (62%) received treatment within an ambulatory service setting than did Nebraska admissions (46%). U.S. admissions showed more frequent use of both non-intensive outpatient treatment (48% U.S. and 40% NE) and significantly higher frequency of intensive outpatient treatment (12% U.S. and 6% NE). (See [Appendix A](#) for all admission treatment service types and service setting at discharge.)

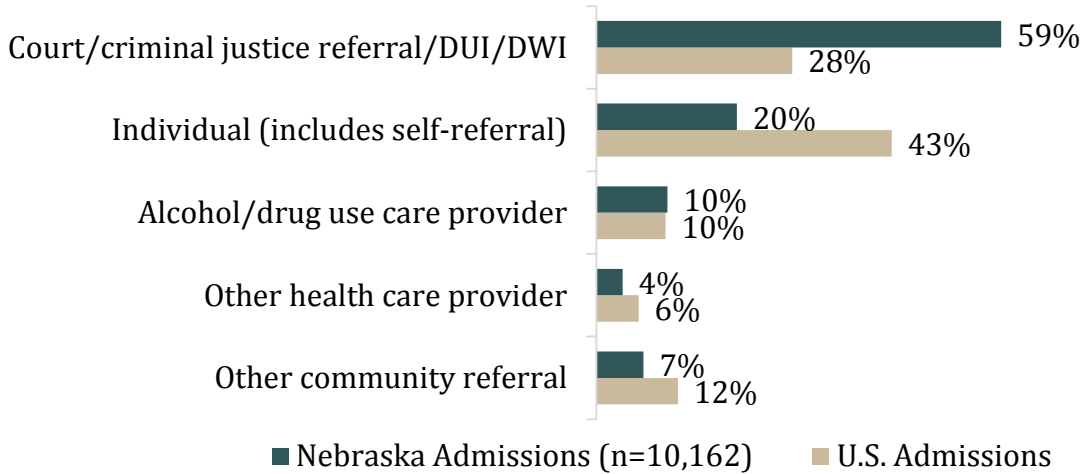






### Treatment Referral Sources

The most common referral source nationally was self-referrals (43% U.S. compared to 20% in Nebraska) whereas the most common referral source in Nebraska was from the criminal justice system (59% in NE compared to 28% nationally).

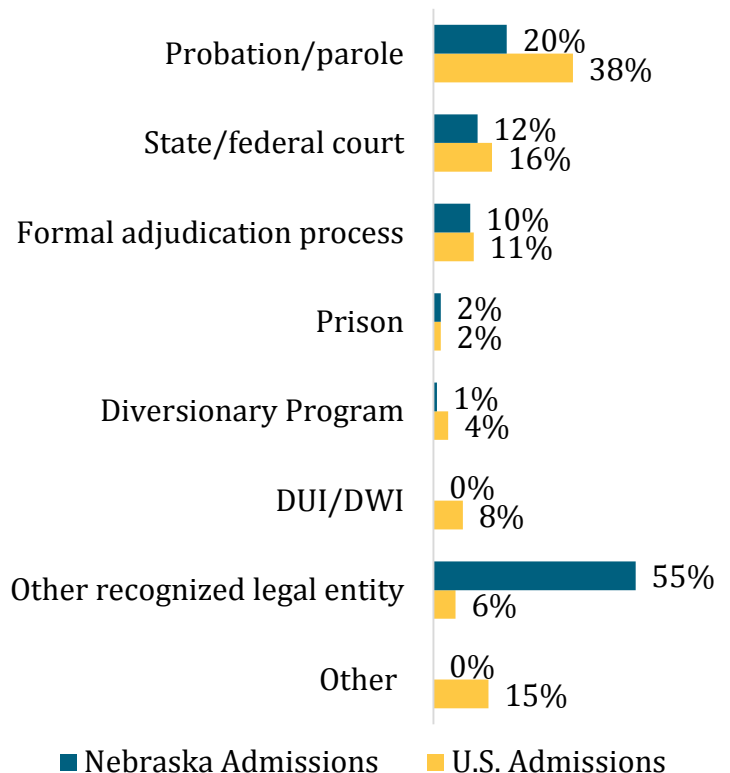


\* There were no admission data for Employer/EAP referrals from Nebraska or nationally. Admissions data showed no referrals to treatment from schools or other educational sources in Nebraska, and less than 1% nationally.

### Criminal Justice Referral Sources



Referrals from the criminal justice system show that the majority come from an "other recognized legal entity" (55%) compared to 6% nationally. Given this high percentage in the "other," category it is difficult to discern where the criminal justice referrals are coming from.



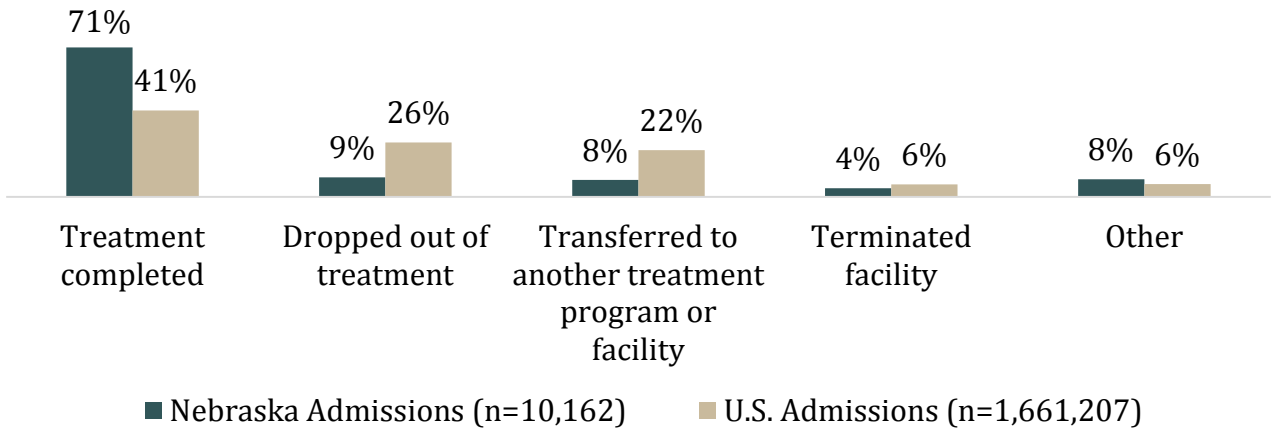
\*Detailed criminal justice referral is a Supplemental Data Set item. Supplemental Data Set items are reported at each state's option. Not all states report on this item



## Treatment Discharges

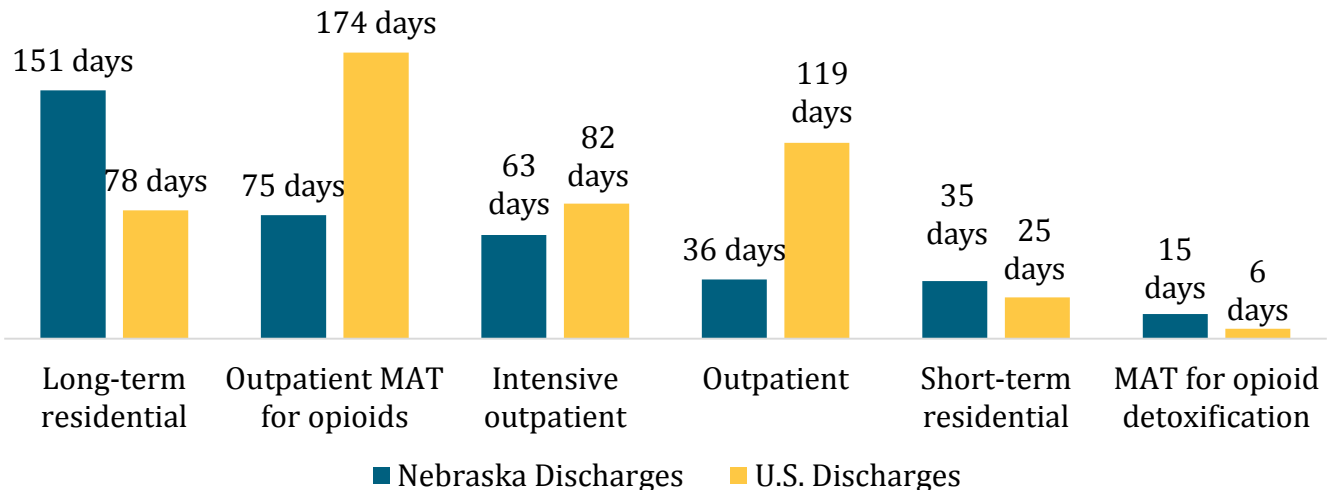
### Reason for Discharge

In 24 of 49 states and jurisdictions, treatment completion rates were less than 41%. Nebraska data shows that 71% of discharges were due to treatment completion, in sharp contrast to national data (41%). Nebraska had a much lower percentage of dropping out of treatment (9% compared to 26%) or transferring to another treatment program or facility (8% compared to 22%).



### Median Length of Stay

There were several differences in the median length of stay for participants who had completed treatment. Overall, outpatient treatments in Nebraska had a much shorter length of stay than nationally. Residential treatment lengths of stay were longer, especially for long-term residential and for MAT opioid detoxification. (See [Appendix A](#) for length of stay at discharge.)



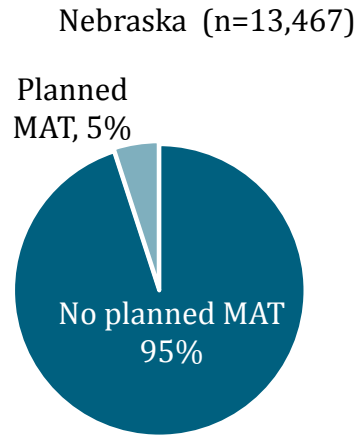
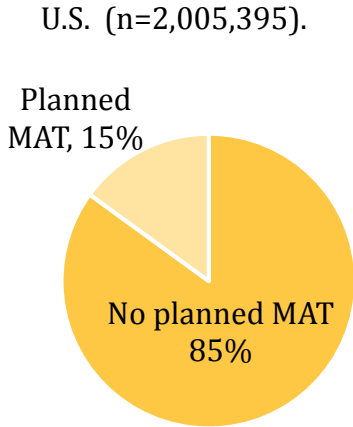
\* There were no Hospital Residential treatment days reported in Nebraska data.



## Treatment Discharges

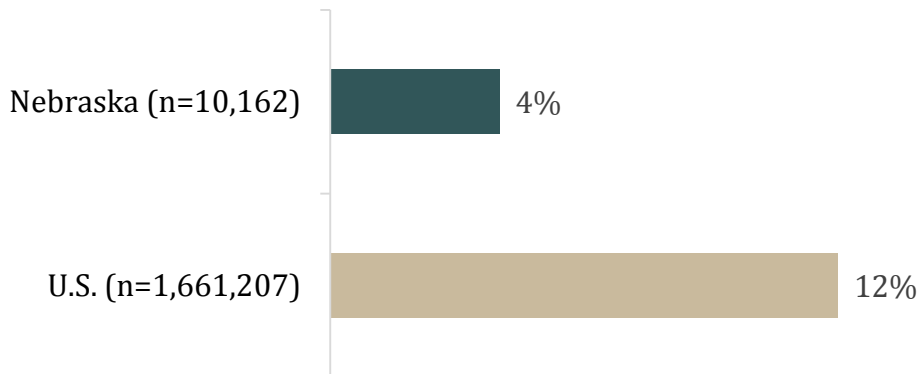
### Planned MAT for Opioid Use at Admission

MAT is not a treatment modality used frequently in Nebraska compared to other states. Nationally 15% of all admissions included planned MAT compared to 5% in Nebraska.



### Discharges from Treatment that used MAT

Nationally nearly 12% of all discharges from treatment were from a MAT treatment service compared to less than 4% of all discharges in Nebraska.

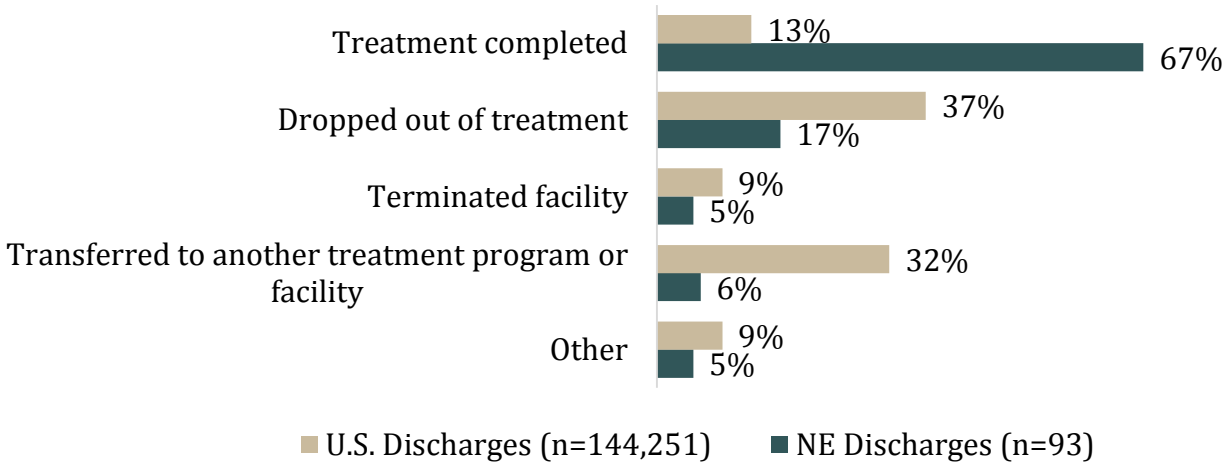




## Treatment Discharges

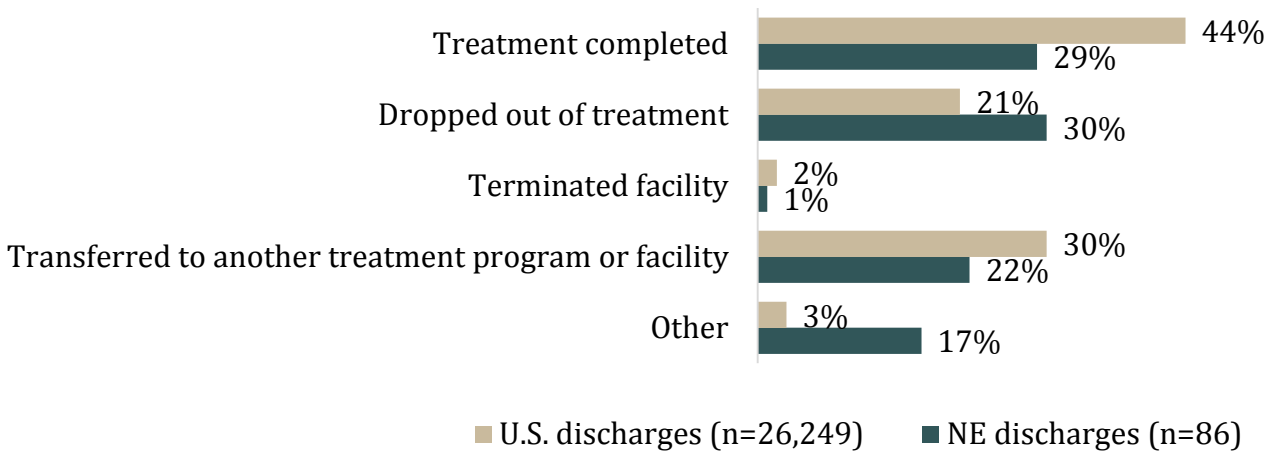
### Medication Assisted Treatment Discharge: Outpatient

Although not frequently used in Nebraska, when MAT is used there appears to be good success with the treatment. When used in an outpatient setting, treatment was completed 67% of the time compared to 13% of U.S. outpatient discharges.



### Medication-Assisted Treatment Discharge: Detoxification

In contrast to the outpatient success with MAT, only 29% of people admitted in Nebraska successfully completed MAT when used in detox settings (compared to 44% in the U.S.) and there was a higher percentage of dropouts from treatment (30% in NE compared to 21% in the U.S.).

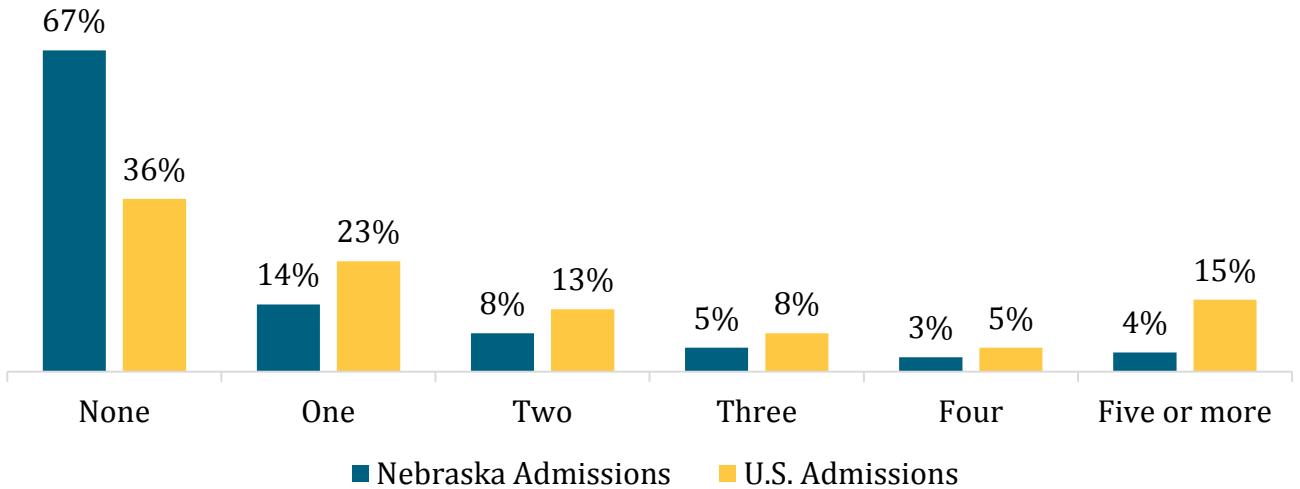




## Treatment Discharges

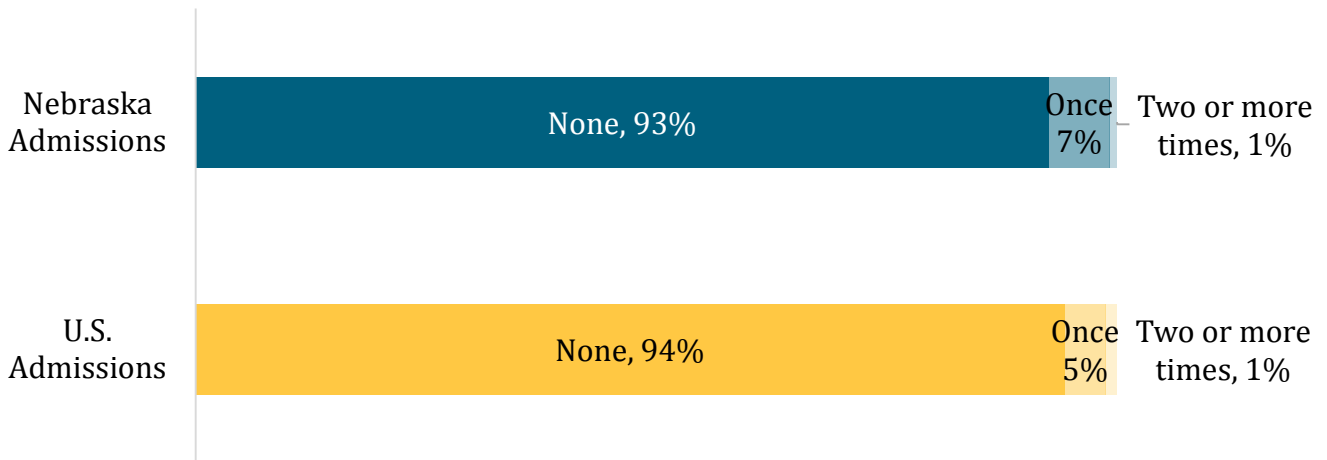
### Number of Previous Treatment Episodes

The majority of U.S. admissions had received substance use treatment previously (64%) whereas only 33% of Nebraska admissions reported receiving prior substance use treatment.



### Arrests 30 Days Prior to Discharge

Number of arrests within the past 30 days among treatment discharges were consistent across national and Nebraska data.

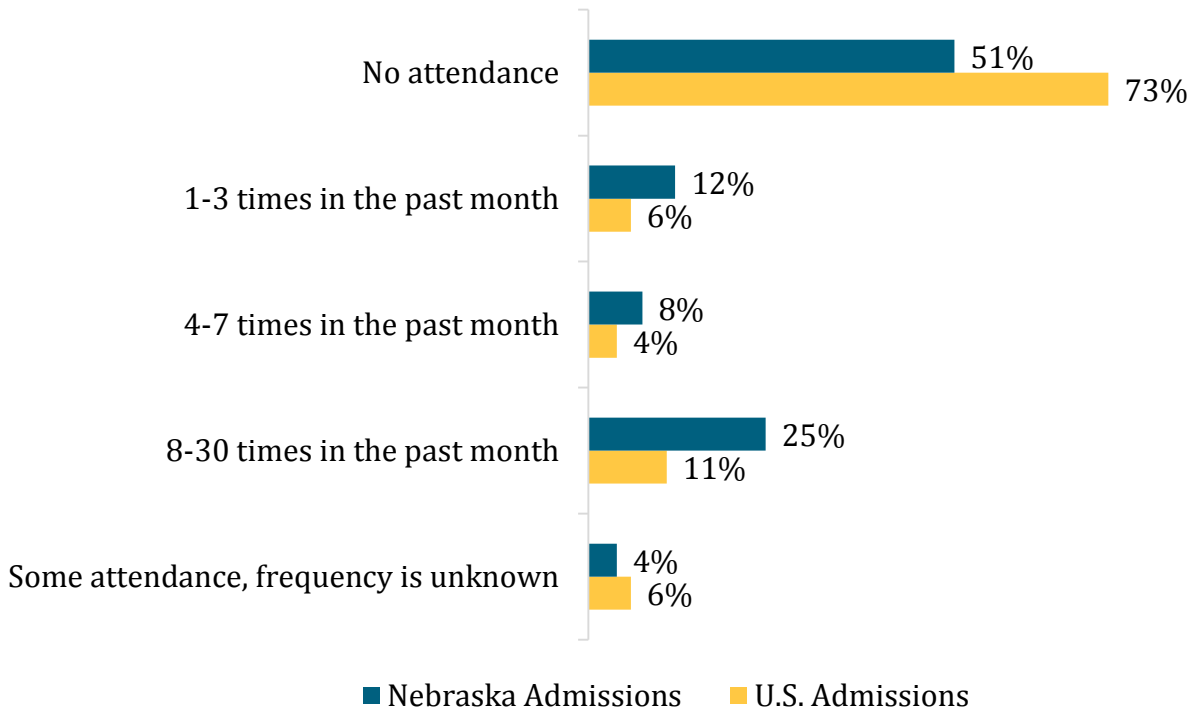




## Treatment Discharges

### Self-Help Group Attendance Prior to Discharge

There appears to be a greater frequency in self-help group attendance by Nebraskans prior to discharge than in other parts of the U.S.





## Treatment Episode Data Set (TEDS): Limitations



### 1. Representativeness

TEDS reports information on admissions to treatment facilities, not individuals.

Someone who is admitted to treatment twice in one year, therefore, may represent two data points. A client transferring from one service type to another (such as inpatient to outpatient) may be recorded as an additional admission depending on the facility, even if the services were provided within the span of one treatment episode.



### 2. Disproportionate Representation from Urban Areas

Most substance use treatment facilities in Nebraska are located within Douglas and Lancaster counties. TEDS data may disproportionately represent an urban demographic due to their proximity to treatment facilities and subsequent ease of access to treatment.

### 3. Small Sample Size

The sample size of Nebraska admissions and discharges was significantly smaller than U.S. admissions. The difference in sample size is important to consider when looking at percentages throughout this report.

### 4. Incomplete Data on Admissions

Not all treatment admissions are captured by TEDS. While TEDS collects data from facilities receiving state funds, private treatment facilities and those operated by hospitals or correctional systems may not be included.

### 5. State Variation

Some states vary on their data collection processes, which limits the U.S. admissions data available. Other differences between states, such as the availability of MAT or the states' definition of "admission," may also affect the validity of certain measures within TEDS.



## TEDS: Recommendations

1. Target American Indian and Black youth in alcohol- and methamphetamine-focused prevention efforts.
2. Discover how beds are being allotted, whether enough beds are available to meet the need, and characteristics and experiences of individuals on waiting lists.
3. Increase implementation of MAT as it appears to be successful in outpatient settings.
4. Provide treatment providers evidence-based and culturally appropriate tools to better serve racially diverse populations.
5. Examine TEDS data:
  - a. Longitudinally to identify trends in primary substance use, treatment modalities, and treatment outcomes by demographic characteristics.
  - b. To analyze nearby states' primary substance use over time to determine possible trends. Assess those characteristic differences between Nebraska and other states that may affect Nebraska's primary substance use patterns in the future.
  - c. To determine the risk factors influencing the higher rates of substance use among American Indians and Black or African American individuals.
  - d. Through the lens of survey and focus groups results.
6. Utilize data sources other than TEDS to:
  - a. Determine the characteristics of those individuals not receiving treatment and the services needed to support their access to treatment.
  - b. Determine the untreated prevalence of opioid use and misuse in Nebraska.
  - c. Discover protective factors for American Indians and Black individuals, and utilize these factors for improving prevention and treatment efforts targeted at these populations.
  - d. Further assess how the urban-rural divide influences the initiation of substance use and treatment need to support future prevention and intervention efforts.
  - e. Examine income sources of Nebraskans (TEDS shows 54% of admissions have no income).





## Student Health and Risk Prevention Surveillance System (SHARP)



Since 2010, the SHARP Surveillance System has encompassed three school-based surveys in Nebraska, including the Nebraska Risk and Protective Factor Student Survey (NRPFSS). The NRPFSS includes a census of students in participating public and non-public high school in 8<sup>th</sup>, 10<sup>th</sup>, and 12<sup>th</sup> grades. All Nebraska schools are invited to participate and all students in eligible grades are asked to complete the survey. For those schools who choose to participate, a school district report and optional individual school report may be provided at no cost.


### Key Findings

1. Most students perceived illegal drug use and prescription drug misuse as wrong.
2. 16% of students self-reported as having used marijuana at some point in their life, and 7% reported that they had used in the past 30 days. Nearly half (42%) of those who had used marijuana in the past 30 days, reported they had used it 10 or more times.
3. One-fourth of students who self-reported as having used marijuana said they started at age 15.
4. Over one-fourth of students said it is relatively easy to get marijuana.
5. Although the number of responses from students who self-identified as American Indian, Alaska Native, and Pacific Islander was very low compared to students in other racial groups, their responses indicated that these minority race groups have unique perceptions and needs. They are less likely to view illegal drug use or prescription drug misuse as problematic, and they are more likely to have used illegal drugs or to have misused prescription drugs than students in other racial groups.
6. Students identifying as Black reported a higher use of marijuana than White or Asian.
7. Students generally viewed taking prescription drugs as more wrong and more risky than using marijuana.
8. Students indicated a high likelihood they would go to their parents if they needed help with a drug or alcohol problem; they would also likely go to their friends.
9. Over one-third of students did not perceive prescription drug misuse as a great risk.
10. Drug use perceptions and behaviors are similar for male and female students.
11. Students self-reported a very low rate of misusing prescription drugs or using LSD, cocaine/crack, methamphetamines, heroin, or synthetic drugs. They also reported a low likelihood of using inhalants.
12. If students thought they needed help for a drug or alcohol problem, most would turn first to parents or caregivers and many would turn to friends. The 12- and 19-year-old students had a higher likelihood of turning to a counselor or other adult in school.



## Student Health and Risk Prevention Surveillance System (SHARP)

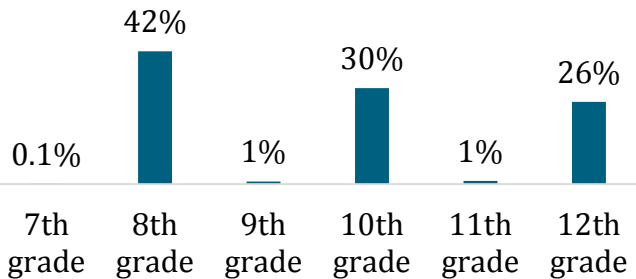
### Sample Description

 In 2018, 24,847 students completed the Nebraska Risk and Protective Factor Student Survey (NRPFSS) in Nebraska. Most students were in 8th (42%), 10th (30%), or 12th (26%) grades, which correlates to about 13, 15, and 17 years old. Over two-thirds of students (84%) self-reported as White.



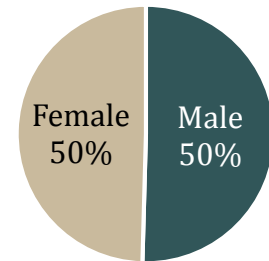
#### Grade (n=24,785)

Students most often identified as being in the 8th, 10th, or 12th grade, with nearly half of respondents being in 8th grade.

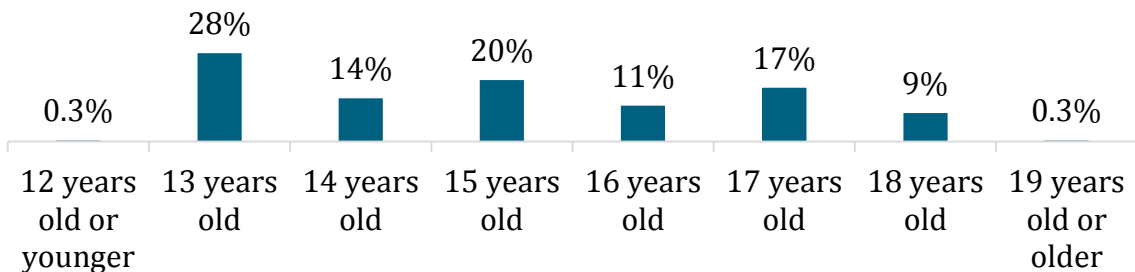


#### Gender (n=24,781)

Half of students identified as female and the other half identified as male.



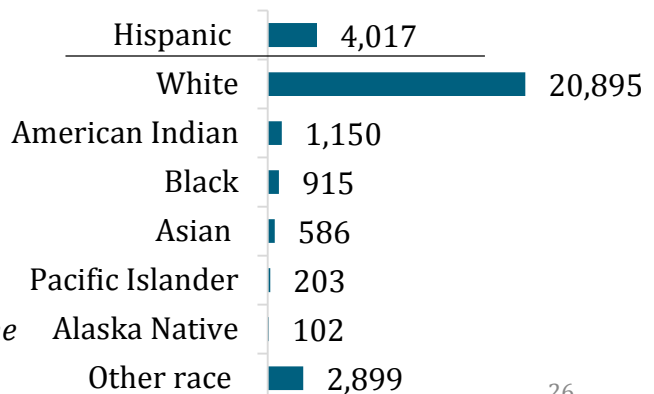
#### Age (n=24,825) Students most often identified as being 13, 15, or 17 years old.



#### Race/Ethnicity

Most students reported "White" as at least one of their racial identities. One in five students identified themselves as Hispanic or Latino. (According to the U.S. census, 86-87% of youth ages 10-19 years old in Nebraska are white.)

*Students were able to identify more than one racial category. The number shown is representative of the number of responses each race/ethnicity category received. A sample size for this item is not available.*



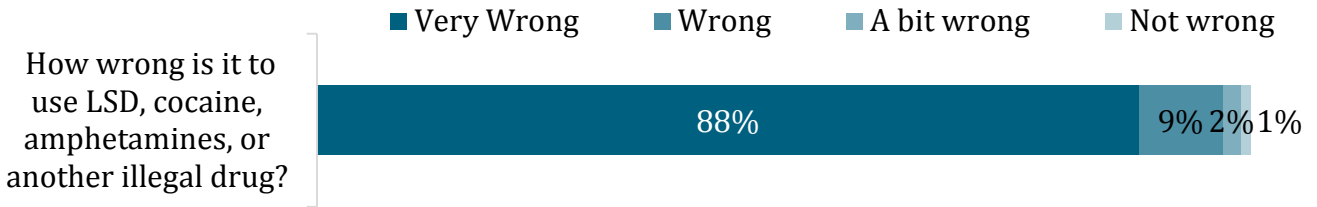


## Illegal Drugs



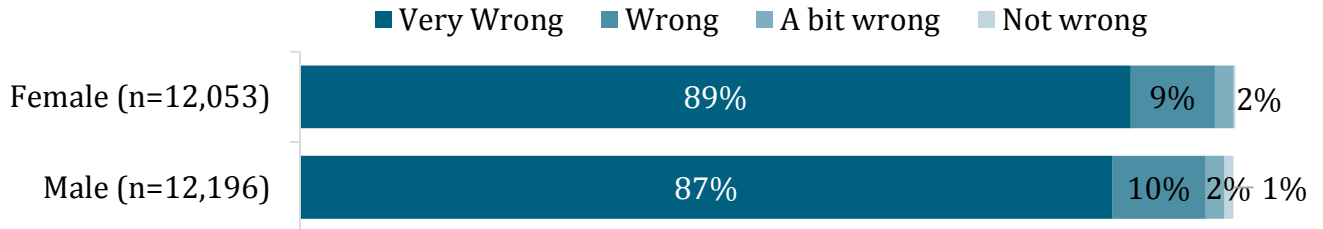
### Perception of Illegal Drug Use (n= 24,484)

When asked, "How wrong is it to use LSD, cocaine, amphetamines, or another illegal drug," 88% of students responded "very wrong."



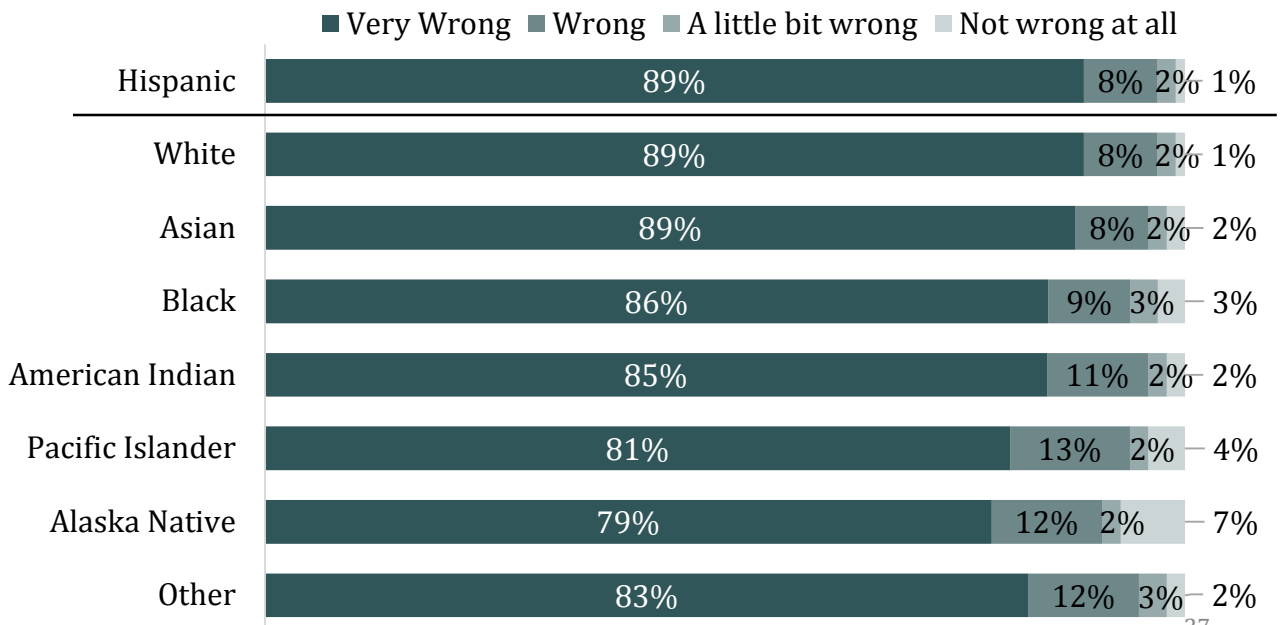
### Perception of Illegal Drug Use by Gender

The majority of both female and male students reported illegal drug use as "very wrong".



### Perception of Illegal Drug Use by Race/Ethnicity

Slightly fewer students who identified as Pacific Islander and/or Alaska Native students thought illegal drug use was "very wrong."



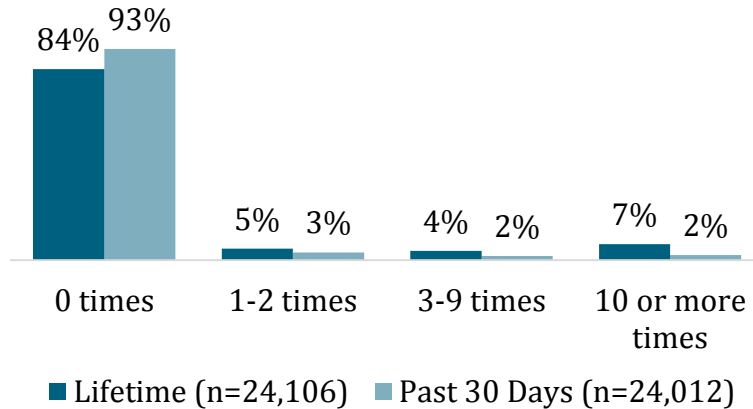


## Marijuana



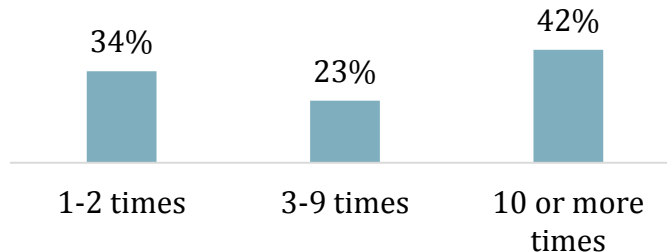
### Marijuana Use: Lifetime and Past 30 Days

16% of students (3,765) self-reported using marijuana at some point in their lifetime, and 7% (1,743) reported using marijuana in the past 30 days.



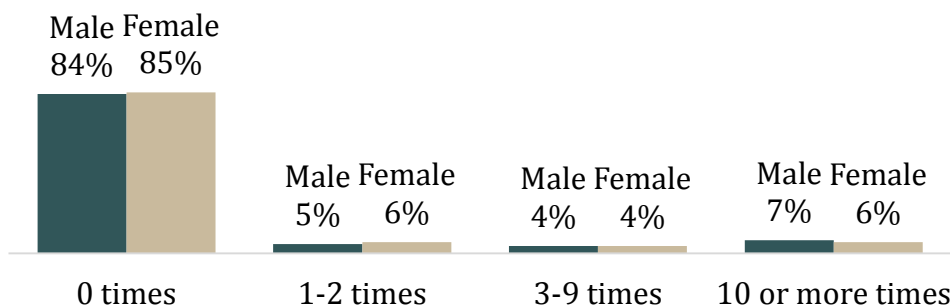
### Frequency of Use in the Past 30 Days (n=3,792)

Of those who reported using marijuana in the past 30 days, 34% said they had used marijuana 1 or 2 times, 23% said 3 to 9 times, and nearly half (42%) said they had used marijuana more than 10 times.



### Marijuana Use by Gender (male, n=12,045; female, n=11,932)

Nearly identical proportions of male and female students reported using marijuana.



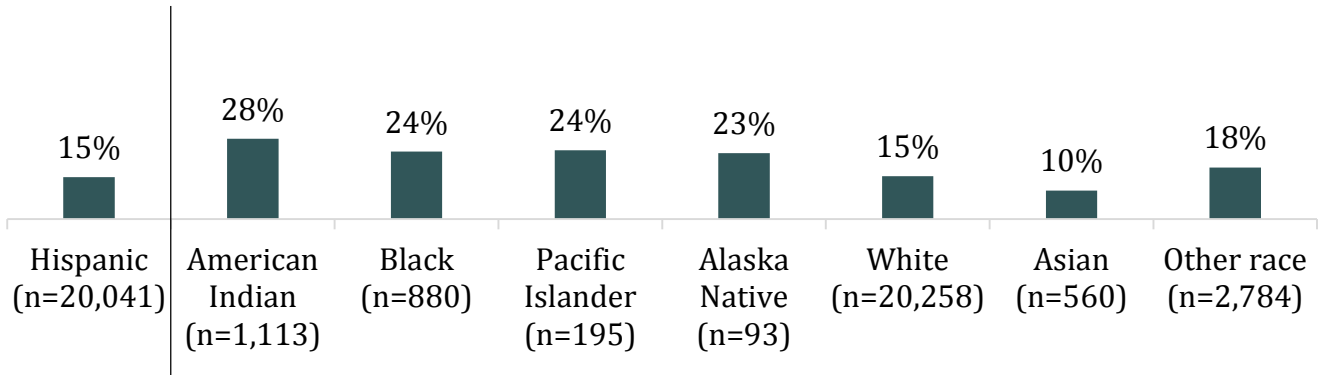


## Marijuana



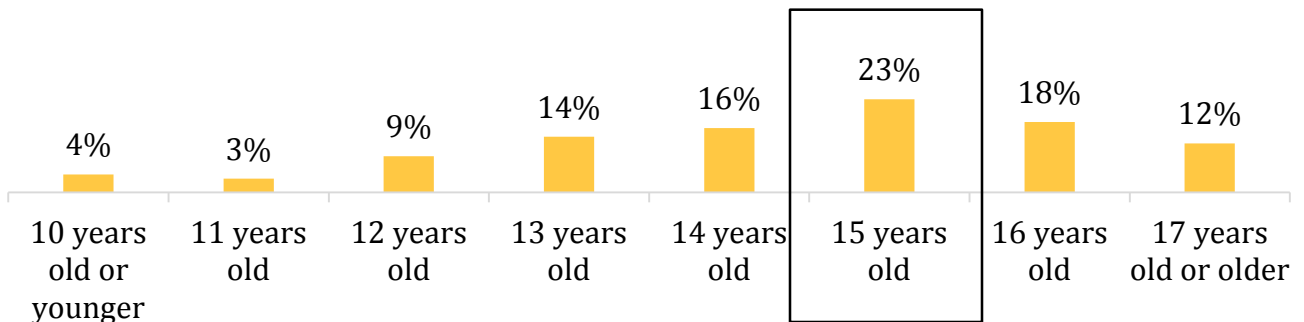
### Marijuana Use by Race/Ethnicity

Although there were much fewer students represented, students in these racial groups reported much higher rates of marijuana use: American Indians (28%), Black (24%), Pacific Islander (24%), and Alaska Native (23%).



### Age of First Marijuana Use (n=3,565)

Of the 3,565 students who self-reported as using marijuana, nearly one-fourth started at the age of 15. A small number (16%) started at 12 years or younger.



### Ease of Access to Marijuana (n=23,434)

Over one fourth of all students (28%) responded it is "sort of" or "very" easy to get marijuana.





## Marijuana



### Perception of Marijuana Use (n=24,384)

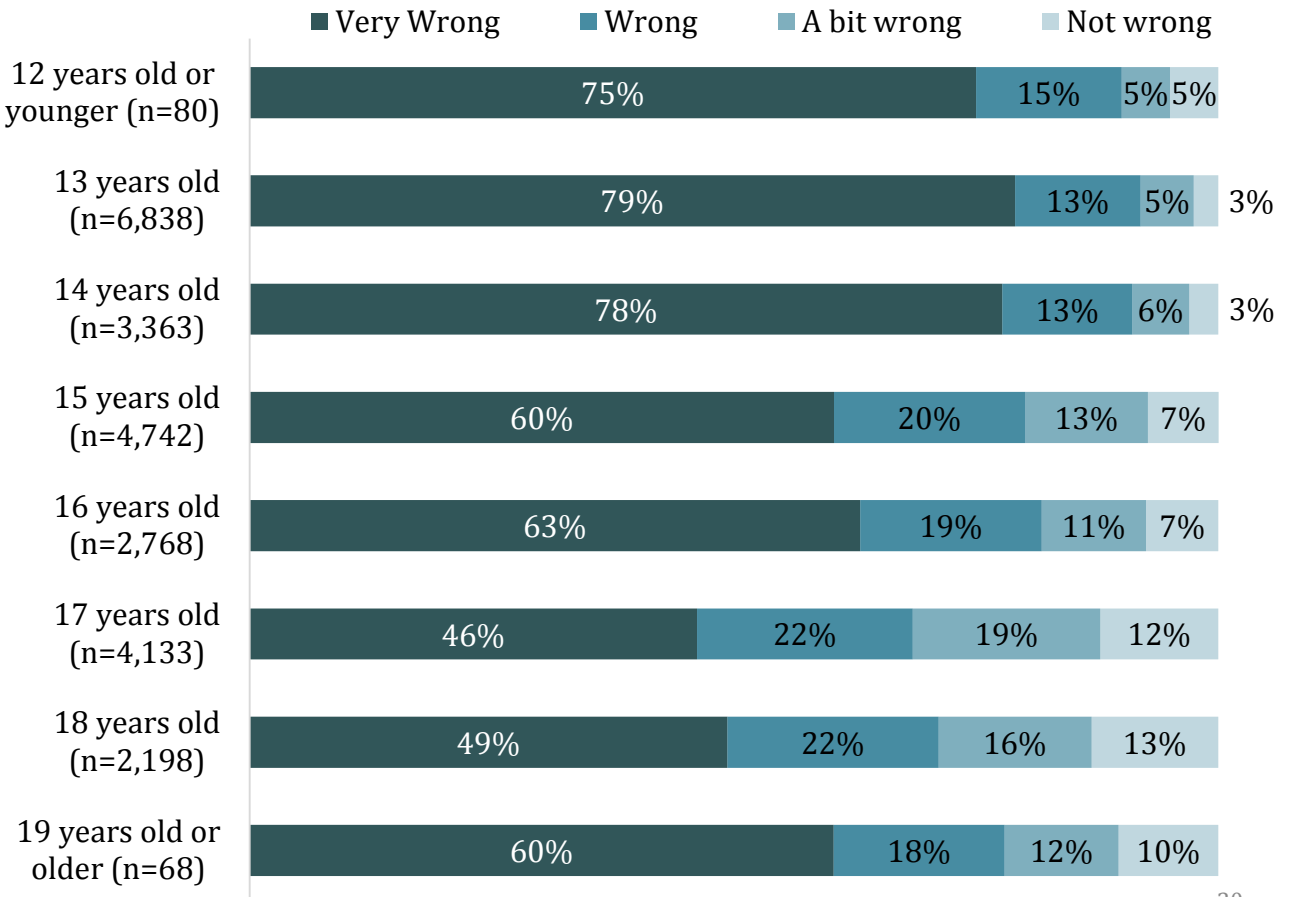
Two-thirds of students indicated their belief that using marijuana was "very wrong."

How wrong do you think it is for someone your age to smoke marijuana?



### Perceptions of Marijuana Use by Age

More students 14 years and younger felt marijuana use was "very wrong" than did older students. Less than half of 17-year-old students thought using marijuana was "very wrong."



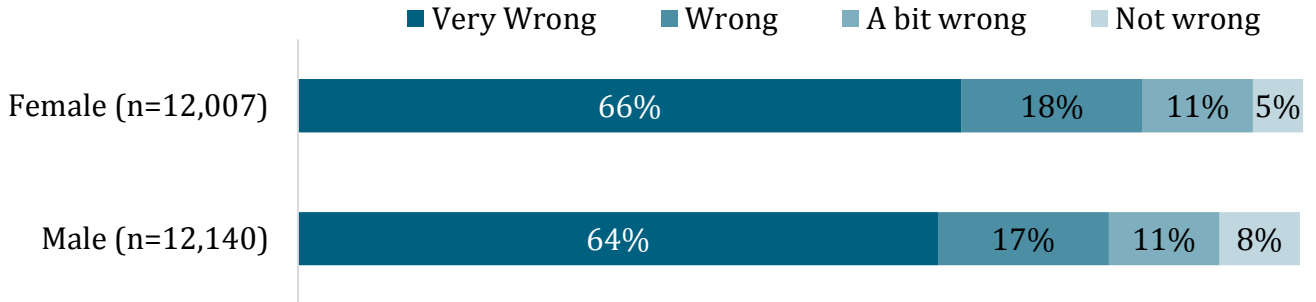


## Marijuana



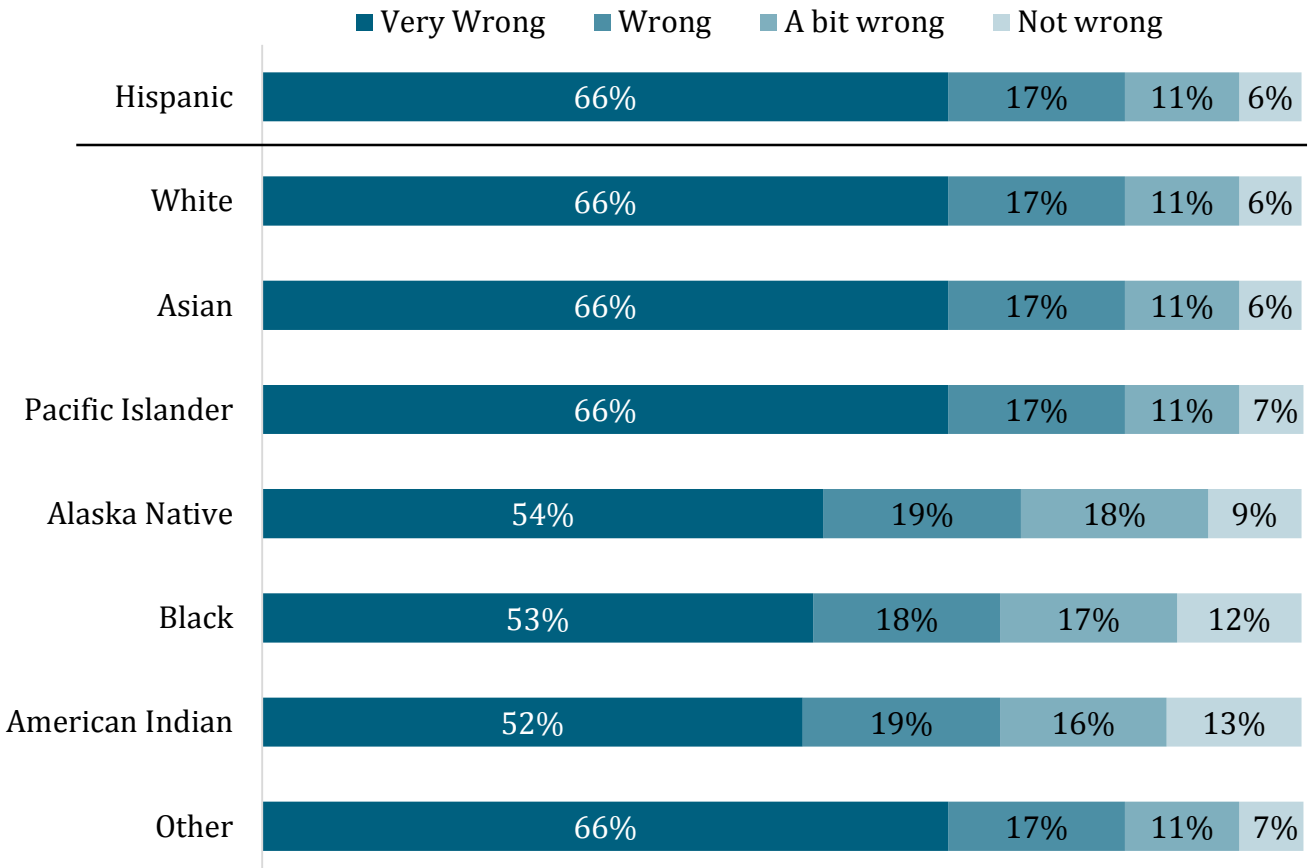
### Perception of Marijuana Use by Gender

Male and female students responded similarly in regards to marijuana use being right or wrong.



### Perception of Marijuana Use by Race/Ethnicity

Students of various races responded similarly, although somewhat fewer Black, American Indian, and Alaska Native students had the perception of marijuana use being wrong.



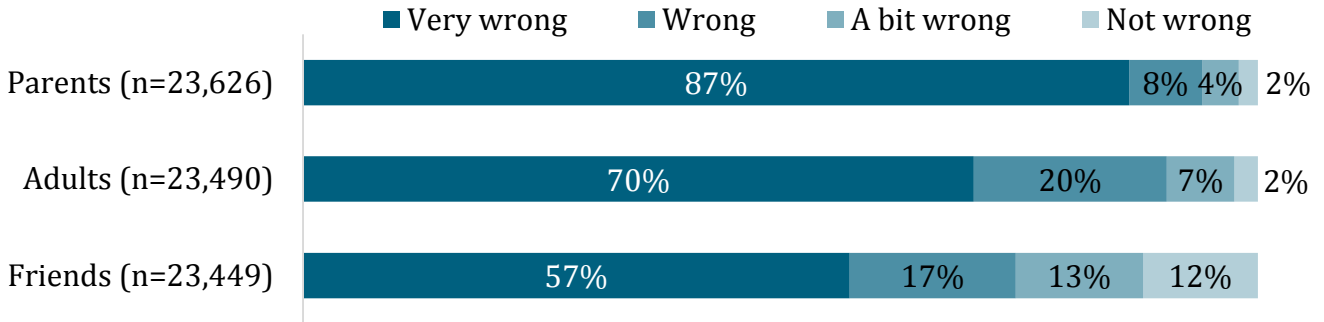


## Marijuana



### Youth's Perceptions of How Parents, Adults, and Friends View Marijuana Use

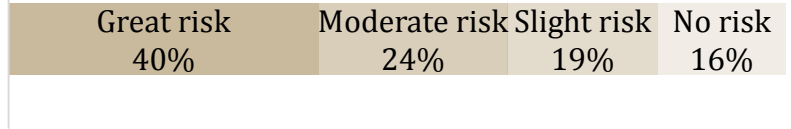
While 65% of students thought using marijuana was "very wrong," many more indicated their parents viewed marijuana use as "very wrong" (87%), and slightly more thought the adults in their neighborhood would as well (70%). Students' perceived that just over half of their friends saw smoking marijuana as "very wrong" (57%).



### Perceived Risk of Marijuana Use (n=24,310)

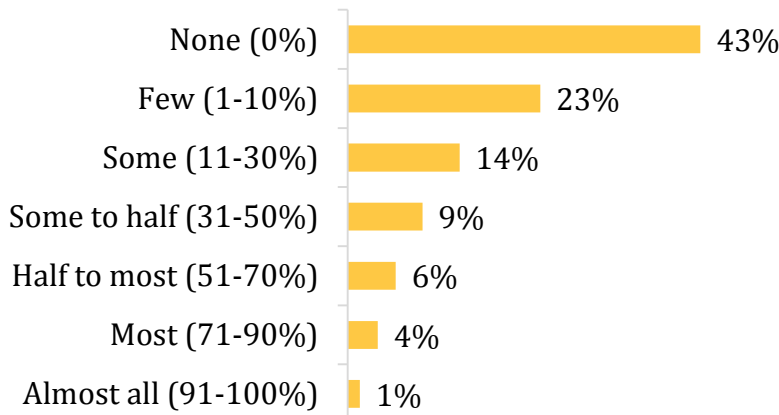
One-fourth of students (25%) assessed the risk of smoking marijuana as a slight risk or no risk at all, while under half (40%) thought it was a great risk.

How much do you think people risk harming themselves if they smoke marijuana once or twice a week?



### Perception of Marijuana Use by Peers in Past 30 Days (n=24,352)

Over half of students (57%) believed their peers had smoked marijuana in the past 30 days.





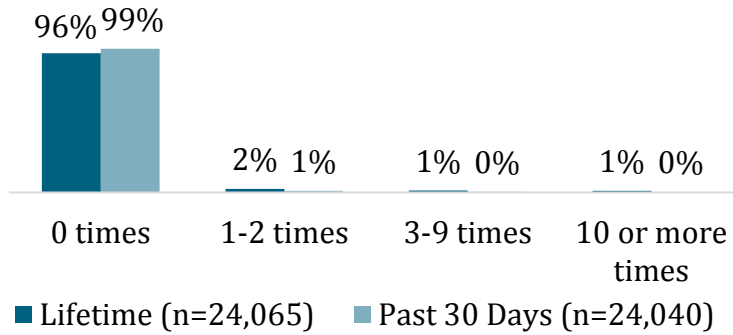


## Prescription Drugs



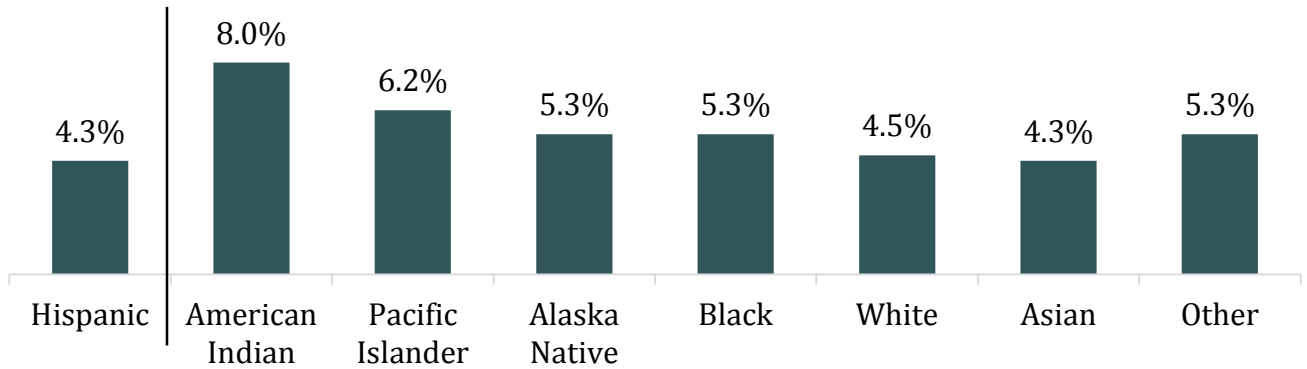
### Prescription Drug Misuse: Lifetime and Past 30 Days

1,076 (4%) of students reported using prescription drugs (such as Valium, Xanax, Ritalin, Adderall, OxyContin, Vicodin, or Percocet) without a doctor’s instructions to take them; 349 students reported doing this in the past 30 days.



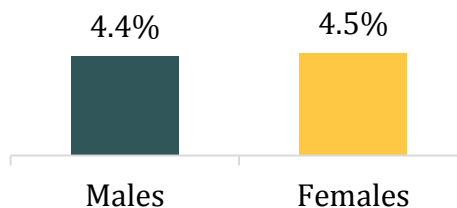
### Lifetime Prescription Drug Misuse by Race (n=24,065)

Students who identified as American Indian reported a slightly higher rate of misuse.



### Lifetime Prescription Drug Misuse by Gender (n=24,065)

Male and female students reported approximately the same rate of misuse.

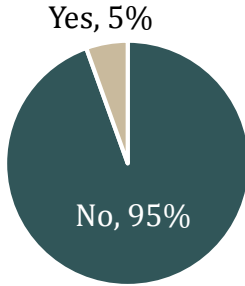




## Prescription Drugs

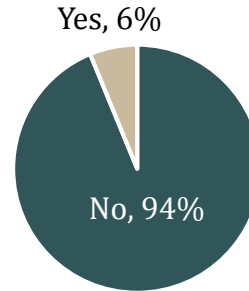
### Request to Borrow or Buy Prescription Medication (n=11,649)

670 students (5%) indicated someone else asked to borrow or buy some of their medication the last time a doctor prescribed them a pain medication.



### Higher Use than Directed by Prescriber (n=12,187)

722 students (6%) reported using prescription pain medications more frequently or at a higher dose than their doctor directed.



### Ease of Access to Prescription Drugs (n=23,396)

One-fourth of students (24%) said it's "sort of " or "very" easy to get prescription drugs.

How easy would it be for you to get some prescription drugs for non-medical use?



### Perception of Prescription Drug Misuse (n=24,377)

Over three-fourths of students overall indicated their belief that someone their age misusing prescription drugs without a doctor telling them to was "very wrong."

How wrong is it for someone your age to use prescription drugs?



### Risk of Harm in Misuse of Prescription Drugs (n=24,378)

Just over one-third of students (35%) assessed the risk of misusing prescription drugs as a risk, while under two thirds (64%) thought it was a great risk.

How much do people risk harming themselves if they use prescription drugs not prescribed to them?



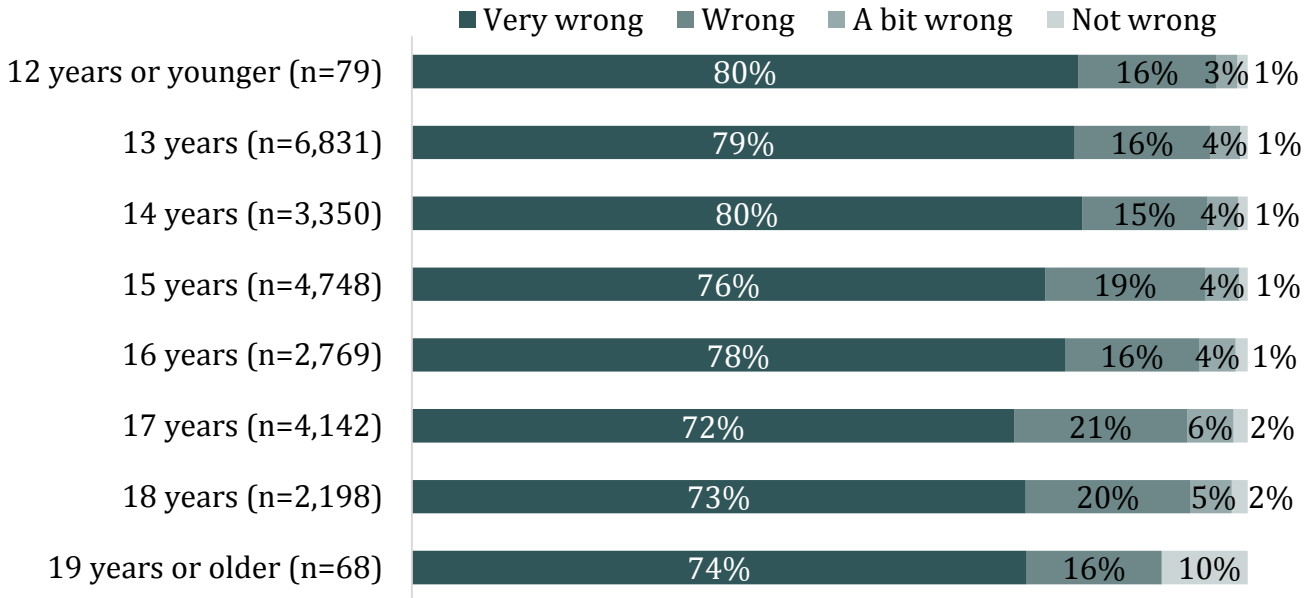


## Prescription Drugs



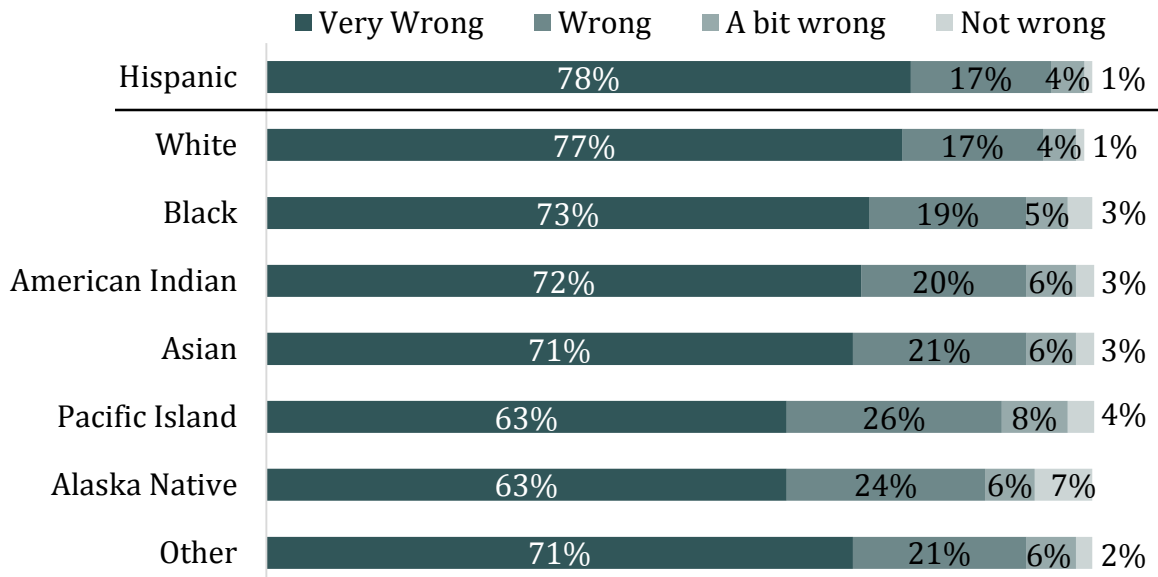
### Perception of Prescription Drug Misuse by Age (n=24,377)

The majority of students perceived the misuse of prescription drugs as “very wrong” regardless of age.



### Perceptions of Prescription Drug Misuse by Race/Ethnicity (n=24,377)

The majority of students perceived the misuse of prescription drugs as “very wrong” regardless of age.

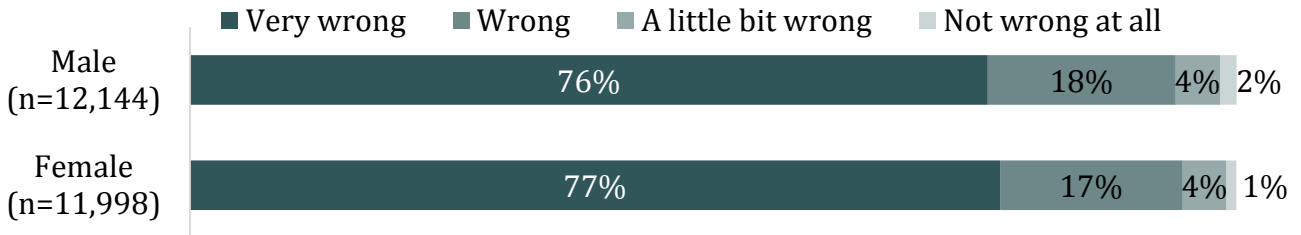




## Prescription Drugs

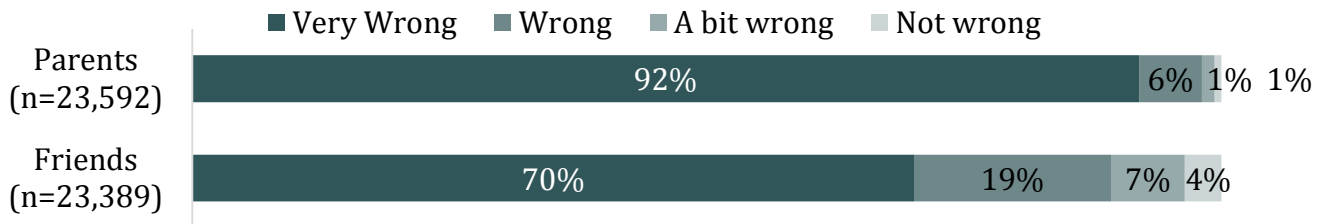
### Perceptions of Prescription Drug Misuse by Gender (n=24,377)

Male and female students reported approximately the same perception of prescription drug misuse.



### Perceptions of Prescription Drug Misuse of Parents and Friends

While nearly all (95%) of students thought misusing prescription drugs was "very wrong" or "wrong," 98% thought their parents shared that view. Students' perceived that over two thirds students in their schools saw using prescription drugs as "very wrong" (70%).



### Perceptions of Marijuana Use Compared to Prescription Drug Misuse

Students generally viewed taking prescription drugs as more wrong and more risky than using marijuana. Students thought their parents were more against their using marijuana than their misusing prescription drugs.



## LSD and Other Psychedelic Drugs



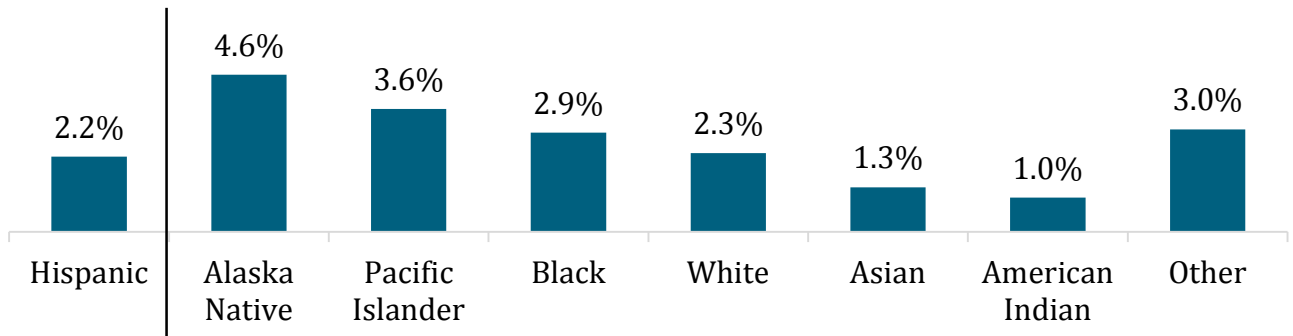
### Lifetime LSD or Other Psychedelic Drug Use (n=24,007)

579 (2.7%) of students reported using LSD or other psychedelic drugs in the past 30 days.

**98%** Nearly 100% of students reported never using LSD or other psychedelic drug.

### Lifetime LSD or Other Psychedelic Drug Use by Race (n=24,007)

Students who identified as American Indian (4.6%) and/or Pacific Islander (3.6%) reported a slightly higher rate of use.



## Cocaine and Crack



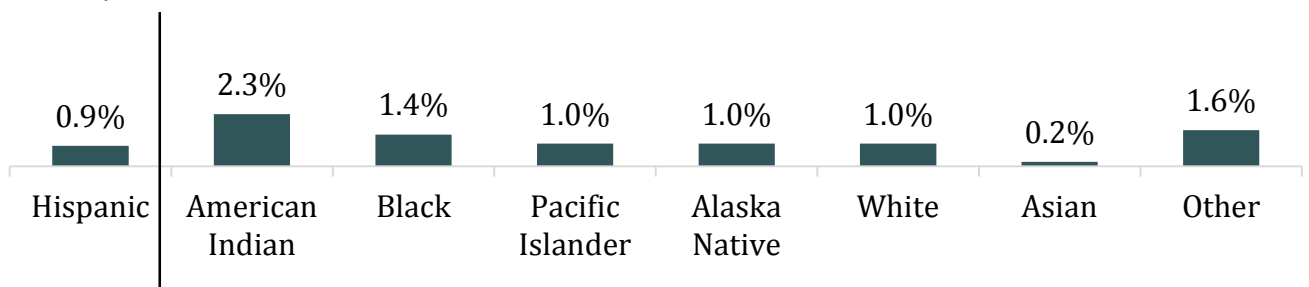
### Lifetime Cocaine/Crack Use (n=23,958)

246 (1%) of students reported using cocaine or crack.

**99%** Nearly 100% of students reported never using cocaine or crack.

### Lifetime Cocaine/Crack Use by Race/Ethnicity (n=23,958)

Students who identified as American Indian (2.3%) reported a slightly higher rate of cocaine/crack.



Nearly equal proportions of male and female students reported use of these drugs.



## Methamphetamines



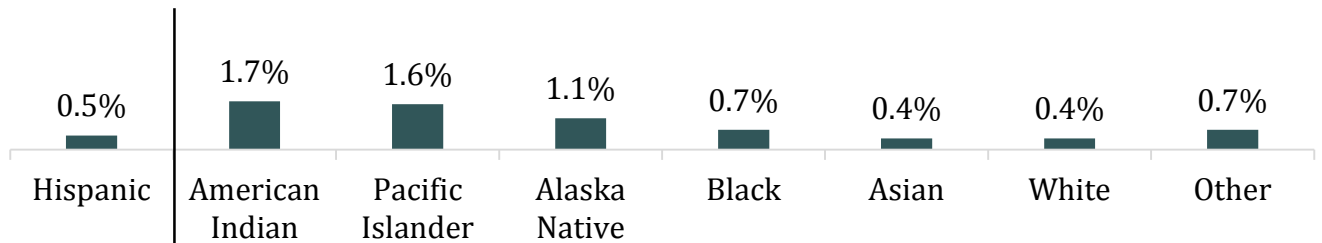
### Lifetime Methamphetamine Use (n= 24,062)

118 (less than 1%) of students reported using methamphetamines, which included speed, crank, crystal meth, or ice.

**100%** Nearly 100% of students reported never using methamphetamine drugs.

### Lifetime Methamphetamine Use by Race/Ethnicity (n=24,062)

Students who identified as American Indian (1.7%) and/or Pacific Islander (1.6%) reported a slightly higher rate of methamphetamine use.



## Heroin



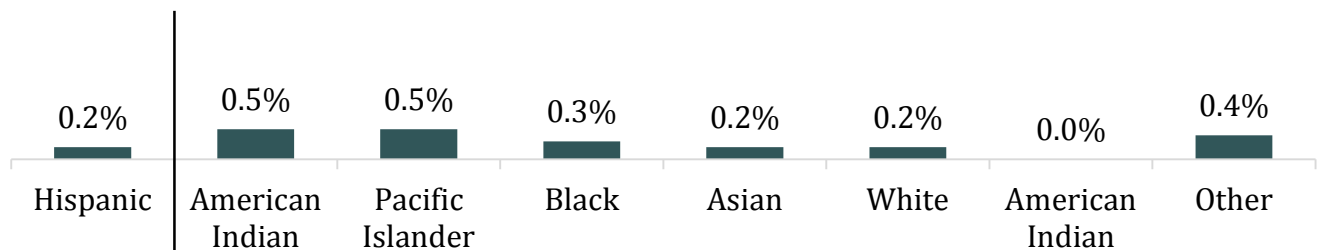
### Lifetime Heroin Use (n= 24,086)

44 (less than 1%) of students reported using heroin, which included smack, junk, or China White.

**100%** Nearly 100% of students reported never using heroin.

### Lifetime Heroin Use by Race/Ethnicity (n=24,086)

Students who identified as American Indian and/or Pacific Islander reported a slightly higher rate of heroin use.



Nearly equal proportions of male and female students reported use of these drugs.



## Synthetic Drugs



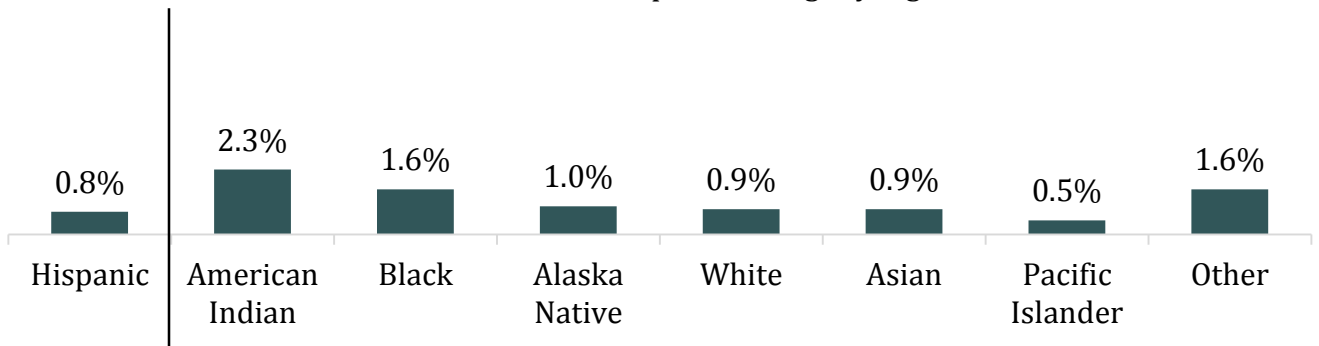
### Lifetime Synthetic Drug Use (n= 24,097)

236 (0.01%) of students reported using synthetic drugs, which included man-made drugs such as K2, Bath Salts, Spice, fake weed, King Kong, Yucatan Fire, or Skunk.

**100%** Nearly 100% of students reported never using synthetic drugs.

### Lifetime Synthetic Drug Use by Race/Ethnicity (n=24,097)

Students who identified as American Indian reported a slightly higher rate of use.



## Inhalants



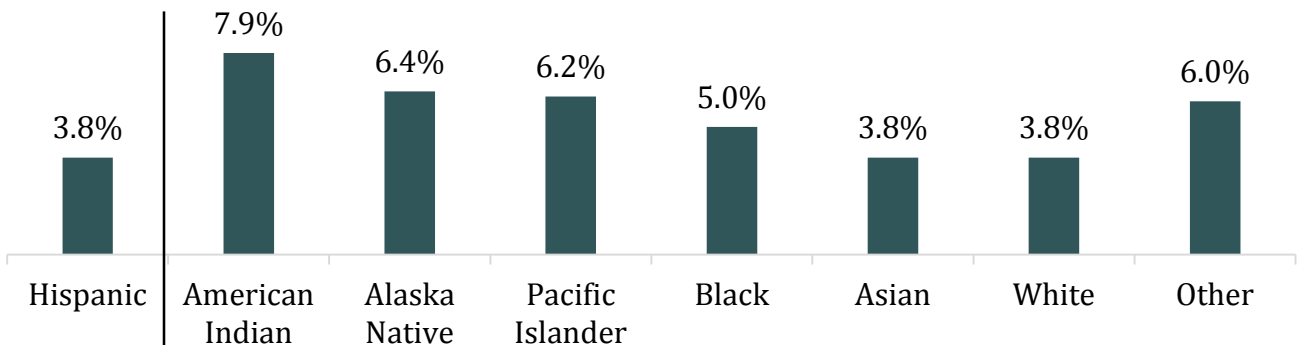
### Lifetime Inhalant Use (n=24,121)

957 (4%) of students reported using inhalants like sniffed glue, breathed the contents of an aerosol spray can, or inhaled other gases or sprays in order to get high.

**96%** Nearly 100% of students reported never using inhalants.

### Lifetime Inhalant Use by Race/Ethnicity (n=24,121)

Students who identified as American Indian reported a slightly higher rate of use.



Nearly equal proportions of male and female students reported use of these drugs. 39

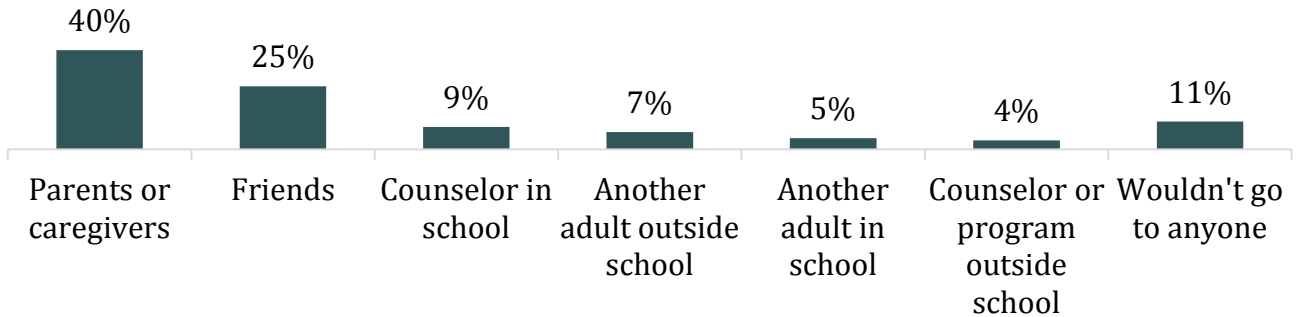


## Seeking Help



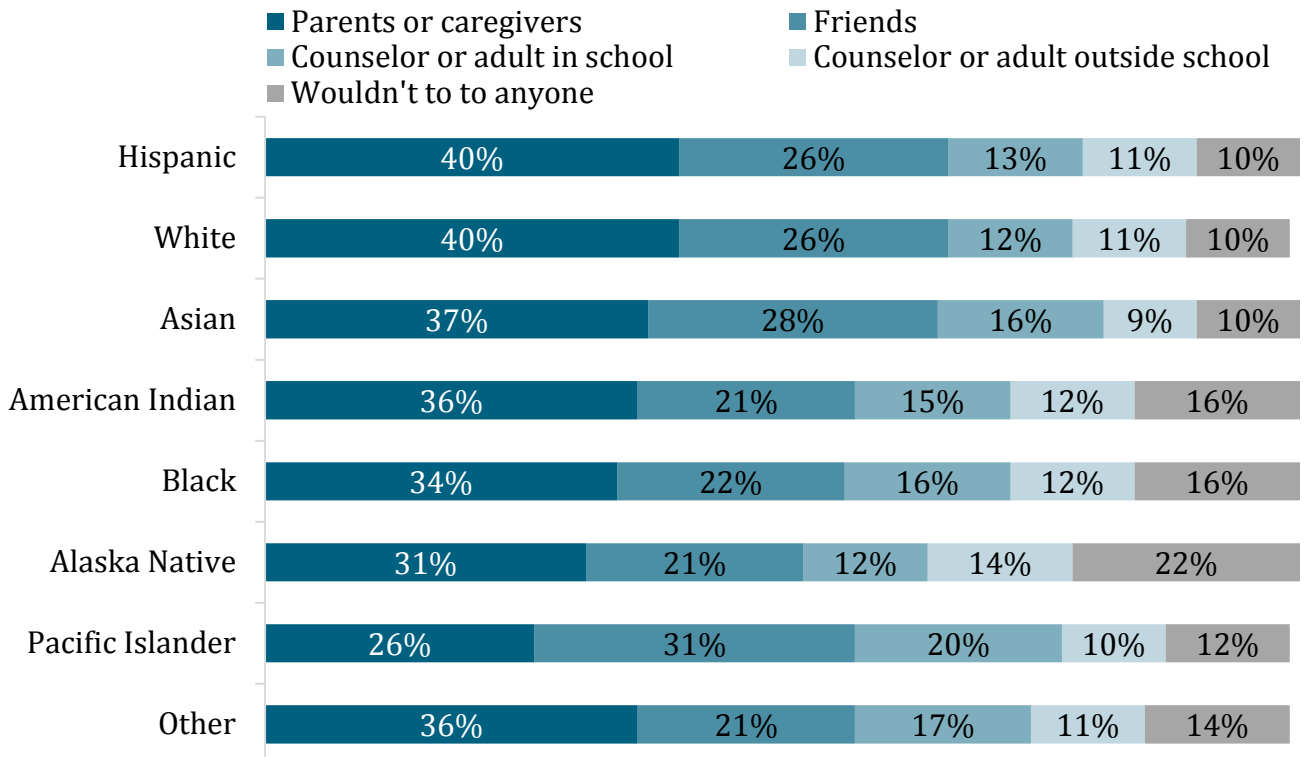
### First Contact Person in Seeking Help (n=23,617)

When asked, "If you had a drug or alcohol problem and needed help, who is the FIRST person you would go to," over one-third of students (40%) said parents or caregivers. One-fourth of students said they would go to friends, with fewer going to counselors or other adults. 11% said they would not go to anyone for help.



### First Contact Person in Seeking Help by Gender (n=23,617)

Students of all races were likely to turn to their parents, except Pacific Islanders who had a higher likelihood of turning to friends.



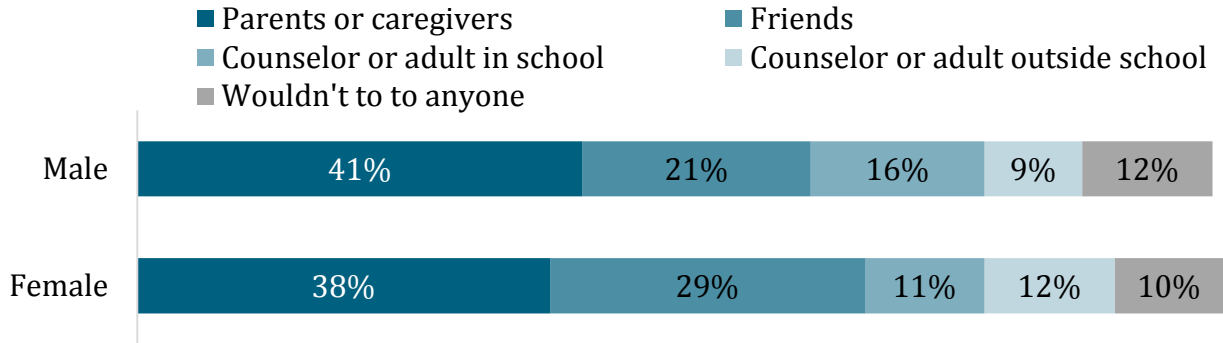




## Seeking Help

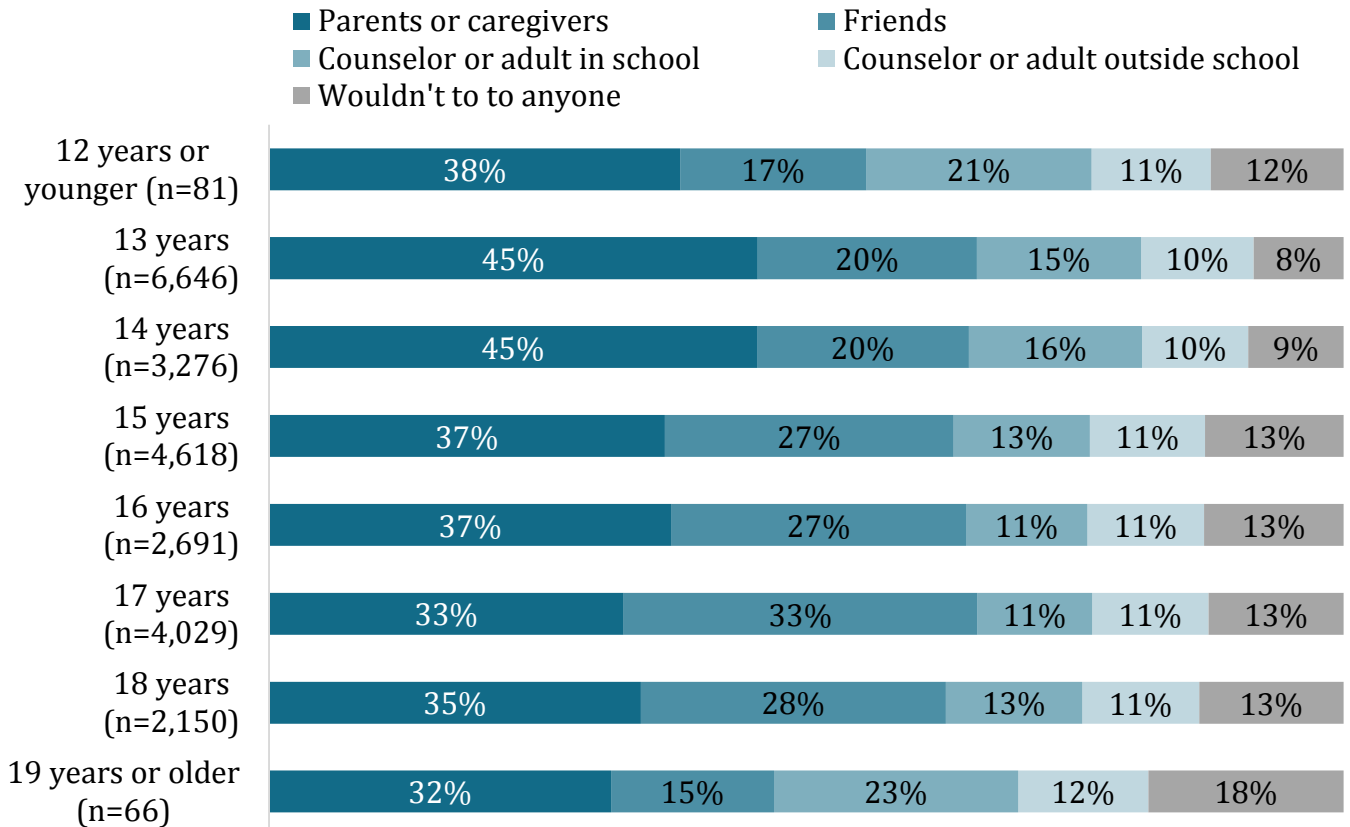
### First Contact Person in Seeking Help by Gender (n=23,617)

Female students were somewhat more likely to go to friends, and male students to parents in seeking help.



### First Contact Person in Seeking Help by Age (n=23,617)

Students ages 14 years and under had a higher likelihood of turning to parents, and 17- and 18-year-old students had a higher likelihood of turning to friends. 12-year-old students were more likely to turn to another adult in the school, and 19-year-old students were much more likely to either turn to a school counselor or not turn to anyone.





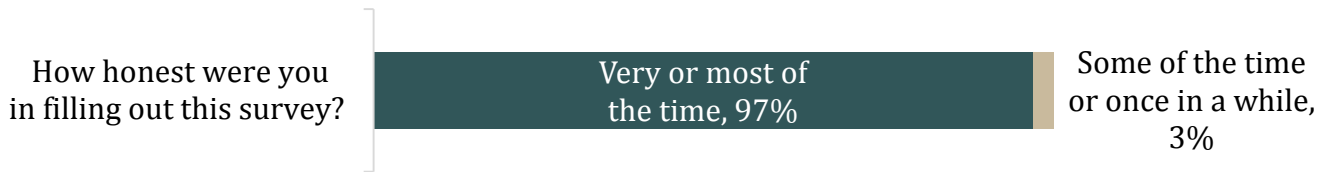
## Seeking Help

### Anti-Alcohol and Anti-Drug Messages (n=23,175)

**74%** Three-fourths of students (74%) recalled seeing or hearing an anti-alcohol or anti-drug message in the past 12 months.

### Honesty in Survey Completion (n=23,562)

97% of students indicated they were "very honest" or "honest most of the time" in responding to survey items.





## Limitations

1. Data is for Nebraska as a whole and cannot be applied to any specific geographic area of Nebraska, including rural or urban areas. School-identifying information is not available.
2. Responses were based on students self-report and are only as valid as students were able and willing to respond accurately. Given the sensitivity and stigma of topics in the survey, students may have over- or under-reported their drug use.
3. Nearly half of responses were from students in 8<sup>th</sup> grade, so results are most representative of that age group.
4. Parental consent is required for student participation in the survey. Data was not collected from students from whom parental consent was not received.
5. Results are drawn from a random sample of students in public and non-public schools in Nebraska. Students being homeschooled are not sampled. Also not represented are those students who may have been absent from school on the day the survey was administered.

## Recommendations

1. Direct prevention and intervention services at students of all ages and genders, with additional attention to students who identify as African American, American Indian, Alaska Native, or Pacific Islander.
2. Provide education and materials to parents for use in talking with their children about drug use.
3. Identify curriculum and messaging for schools to aid students in talking with their peers about healthy behaviors in regards to drug use.
4. Continue to direct social media and other sources of messaging at students on drug use prevention and intervention.



## Monitoring the Future (MTF)

Since 1975, the annual Monitoring the Future (MTF) survey has tracked national substance use among U.S. adolescents. Each year, MTF surveys a random sample of approximately 50,000 students in 8<sup>th</sup>, 10<sup>th</sup>, and 12<sup>th</sup> grades in 420 public and non-public schools. A small sample of high school seniors is also chosen to participate in longitudinal, follow-up surveys for multiple years after graduating from high school. MTF is conducted by the University of Michigan and funded by the National Institute on Drug Abuse.



**Students chosen to participate in the MTF survey are asked about their drug-use behaviors in the past month, the past year, and over their lifetime.** Survey items regarding drug-use prevention programming and their attitudes around substance use may be useful variables for this study.

The Monitoring the Future data is a nationally based dataset housed by the Inter-University Consortium for Political and Social Research (ICPSR) at the University of Michigan. **Since the information is not publicly available, STEPs has not yet been able to ascertain any Nebraska-specific data or findings.**

Several steps and formal reviews are required to obtain access to the Monitoring the Future data. First, individuals applying for data access must be preapproved through their university's institutional review board. STEPs prepared an application, submitted it to the institutional review board at the University of Nebraska Medical Center via their electronic portal system, and received the needed approval.

Second, individuals are required to submit the IRB approval along with a specific data request demonstrating prior experience with confidential data sources. STEPs submitted this data request and accompanying documentation and is currently awaiting ICPSR's review and final determination on access to the Monitoring the Future data.

# Treatment Provider Surveys





## Key Findings

### Drug Use Behaviors

**Type of Treatment:** While only three methadone providers responded to the survey, their responses regarding all drug use behaviors were starkly different than inpatient providers. Those seeking treatment from methadone clinics varied significantly from those seeking treatment in other inpatient facilities.



#### Methadone Clinics

Methadone providers identified that **100% of their clients had an opioid use disorder and were using a combination of prescription pain relievers, heroin, and fentanyl**. Methadone providers reported that **the first substance misused by their clients was prescription pain relievers obtained from a doctor, often as adults**. Methadone providers did not report other substances used by their clients.



#### Inpatient Facilities

In contrast to methadone providers, inpatient providers reported their clients had a higher **usage of methamphetamines, often paired in combination with alcohol and marijuana**. Inpatient providers identified relatively **low use of opioids in their clients**. According to inpatient providers, **their clients' first misused substance was typically alcohol, obtained from a friend or family member when they were 14 years old or younger**.

### Medication-Assisted Treatment (MAT)



**Few inpatient facilities indicated an ability to prescribe for MAT, especially for those medications indicated exclusively for opioid use disorder**. Only half of inpatient providers referred for any opioid-indicated MAT. **Both the ability to prescribe and reports of referrals occurred more often among providers located in the eastern third of Nebraska**.

However, there was an inverse relationship between providers with Opioid Use Disorder (OUD) beds in Lancaster County, and their reports of prescribing or referring for MAT. **Despite the majority of beds for OUD being in Lancaster county, these facilities seemed to prescribe or refer for OUD-related MAT less often than other providers**. Across providers, buprenorphine is more commonly referred or prescribed than methadone. Naltrexone (indicated for the treatment of both opioid and alcohol use disorders) is the pharmacotherapy most inpatient providers refer out for or prescribe. Many needs arose for both clients and providers related to MAT, as discussed on the following page.



## Key Findings

### Client Needs



**Medication-Assisted Treatment:** Providers indicated a need for **financial assistance to be able to give clients MAT**. Some providers also identified the **stigma around MAT as a barrier to clients** and suggested that **public education around MAT would be a potentially helpful prevention effort**.



**Treatment Access:** The geographic location of current inpatient treatment facilities leaves a huge gap in service in terms of access to treatment and MAT, especially in central and southwestern Nebraska. **Individuals in need of inpatient treatment may have to travel up to 3 hours to locate the nearest inpatient treatment facility**. Additionally, **the only methadone treatment facilities are in Lincoln and Omaha, leaving the central and western sections of Nebraska completely devoid of this vital treatment**.



**Children:** In multiple questions, providers identified a **lack of long-term childcare and the fear of children being removed from the home as some of the most common external factors that prevent clients from seeking treatment**. Some providers reported a need for residential treatment programs that incorporate dependent children to increase access to treatment and address generational substance use.



**Financial Barriers:** Some providers identified their clients' finances as a significant barrier to both entering and completing treatment. According to providers, financial concerns impact a myriad of factors related to treatment access, including the ability to afford residential inpatient treatment, MAT, long-term childcare, and transportation to treatment.

### Treatment Provider Needs



**Training on Evidence-Based Practices:** When asked about helpful training received in the past and interesting training topics for the future, providers consistently identified evidence-based practices as the most common need. Providers specifically demonstrated an interest in trauma-informed care (especially evidence-based trauma treatments), motivational interviewing, and MAT.



**Funding:** Providers indicated a need for additional funding for a variety of services, particularly to create or expand the workforce to better meet the demand for MAT, clients' mental health needs, and expanded services in rural areas.



## Key Findings

### Current Prevention Efforts



**Disconnect between Prevention and Providers:** Although there are many prevention efforts that have the potential to directly assist individuals currently seeking treatment, and those that provide substance abuse treatment for them, **relatively few providers indicated a knowledge or utilization of current efforts.** Further illustrating this disconnect, sometimes providers listed the need for a service that already exists. For example, several providers indicated a need for financial assistance to clients accessing buprenorphine and an increase in MAT workforce capacity, despite these being resources that currently exist.



**Most Helpful Prevention Efforts:** In addition to providers supporting public education concerning MAT, medically based prevention efforts were identified as being among the most helpful or current efforts. Providers indicated prescriber education and addiction screening at primary care facilities as being particularly helpful. Educational outreach, especially to middle school age children, was identified as an area of need.





## Methodology

### Treatment Provider Survey Purpose

The purpose of the quantitative survey with treatment providers was to discover clients' drug use behaviors, providers' needs, and providers' perceptions of DHHS prevention efforts. The goal of this needs assessment was to better understand individuals' drug use behaviors through the lens of treatment providers.

### Survey Administration

Between June 26 and July 23, 2019, STEPs administered the survey by sending a Qualtrics link to one provider at each of the 25 inpatient substance use treatment facilities licensed by Nebraska DHHS, in addition to the 4 methadone clinics in Nebraska. STEPs received 20 total responses. Respondents' identities were not requested.

## Sample Description

### Program Type

Providers most often indicated their program to be residential inpatient treatment, either long-term (40%) or short-term treatment (n=19, 40%).



**16**

#### Inpatient Facilities

- 8 long-term (more than 30 days)
- 8 short-term (30 days or less)



**3**

#### Methadone Clinics

### Rural vs. Urban

Based on the counties indicated by providers, most of the facilities were located in urban counties (Douglas and Lancaster counties) (n=19).



**14**

#### Urban Providers



**6**

#### Rural Providers

### Provider Comparisons

For certain questions, the responses of inpatient facilities and methadone clinics were significantly different and are thus reported separately to illustrate the distinction.

It is important to keep in mind three of the four methadone clinics in Nebraska responded to the survey. The methadone clinic sample size, therefore, is significantly smaller than the inpatient facility sample size.

Evaluators examined any potential disparities between urban (Lancaster and Douglas counties) and rural providers (all other counties). However, there was generally little distinction between the two groups.

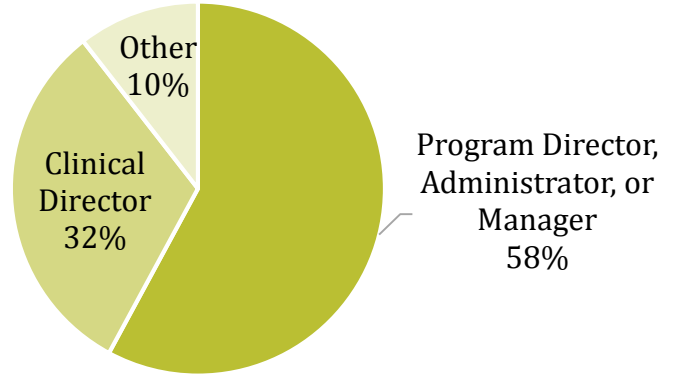


## Sample Description

### Role in Facility



Approximately half of respondents serve as the program administrator, director, or manager (n=19, 55%) at their facility. Of the two respondents who chose “other,” one indicated they serve as the “director of nursing,” and one indicated “bookkeeping and payroll.”

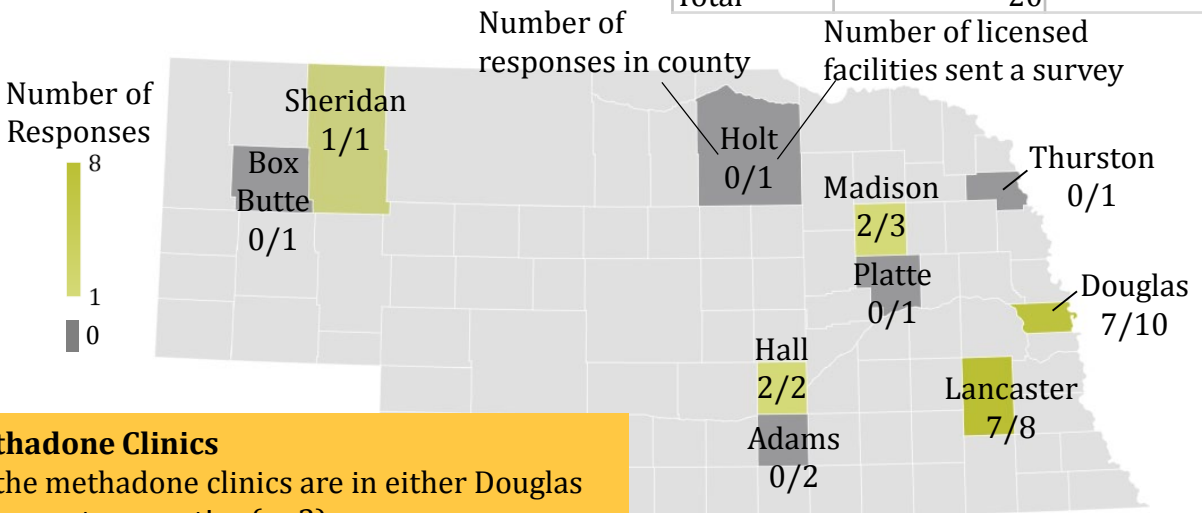


### Facilities by County

The treatment provider survey was sent to all 29 licensed inpatient substance misuse facilities in 10 counties. 20 providers from six counties responded to the survey. Most of the respondents were in Douglas or Lancaster counties, both of which are in the eastern part of Nebraska. The survey results, therefore, are a more accurate reflection of treatment providers in urban areas in the eastern third of Nebraska.

Facilities by County		
County	Responded	Sent a Survey
Douglas	7	10
Lancaster	7	8
Madison	2	3
Hall	2	2
Sheridan	1	1
Adams	0	2
Box Butte	0	1
Holt	0	1
Platte	0	1
Thurston	0	1
<b>Total</b>	<b>20</b>	<b>29</b>

*Map note: The first number below the county name indicates the number of providers who responded. The second number indicates how many providers were sent a survey (all licensed providers). This information is also reflected in the table at right.*



### Methadone Clinics

All the methadone clinics are in either Douglas or Lancaster counties (n=3).



## Substance Use Trends

For the remainder of this section, the survey question will be stated in full inside the box, followed by the relevant analysis.

### Intravenous (IV) Drug Use

Thinking about clients served in your program over the past year, approximately what PERCENT of these clients were considered IV drug users?

#### Inpatient Facilities (n=15)



Inpatient facilities reported a median of 30% of clients who used drugs intravenously in the past year. Five inpatient providers reported at least half of their clients used IV drugs. Fewer inpatient providers indicated their clients using IV drugs in comparison to methadone clinics.

#### Percent of clients who were IV drug users

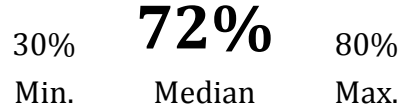


#### Methadone Clinics (n=3)



Methadone clinics reported a median of 72% of clients who used drugs intravenously in the past year. Two of the three methadone providers reported their clients used IV drugs.

#### Percent of clients who were IV drug users

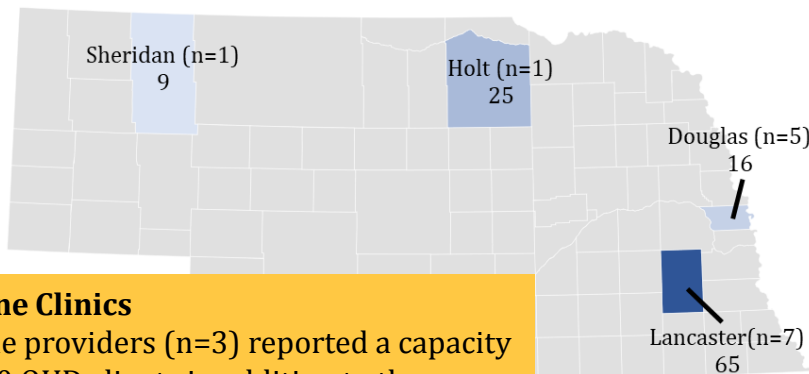


### Total Opioid Use Disorder (OUD) Beds



Six inpatient facilities reported having OUD beds. 115 OUD beds were reported across the six facilities, the majority of which were reported in Lancaster county. Survey results indicated both a lack of treatment providers and OUD beds in the southwestern part of Nebraska. It is unknown if these beds are filled with clients presenting with OUD.

Number of OUD Beds



#### OUD Beds by County

County	Total OUD Beds
Lancaster	65
Holt	25
Douglas	16
Sheridan	9
<b>Total</b>	<b>115</b>

#### Methadone Clinics

Methadone providers (n=3) reported a capacity to serve 50 OUD clients in addition to those OUD beds indicated by inpatient facilities.



## Substance Use Trends

### Substances Used by Clients

Thinking about clients served in your program over the past year, approximately what PERCENT of these clients have presented needing treatment for the misuse of:

Note: Providers responded to each substance independently. Thus, since many clients present with multiple substance use, the cumulative percentage generally exceeded 100%.

#### Inpatient Facilities (n=15)



Inpatient providers indicated a higher average percent of clients presenting for treatment related to methamphetamines (66%), followed by alcohol (65%), and marijuana (55%). Fewer inpatient providers indicated their clients sought treatment for opioids, benzodiazepines, or cocaine compared to methadone providers.

#### Methadone Clinics (n=3)

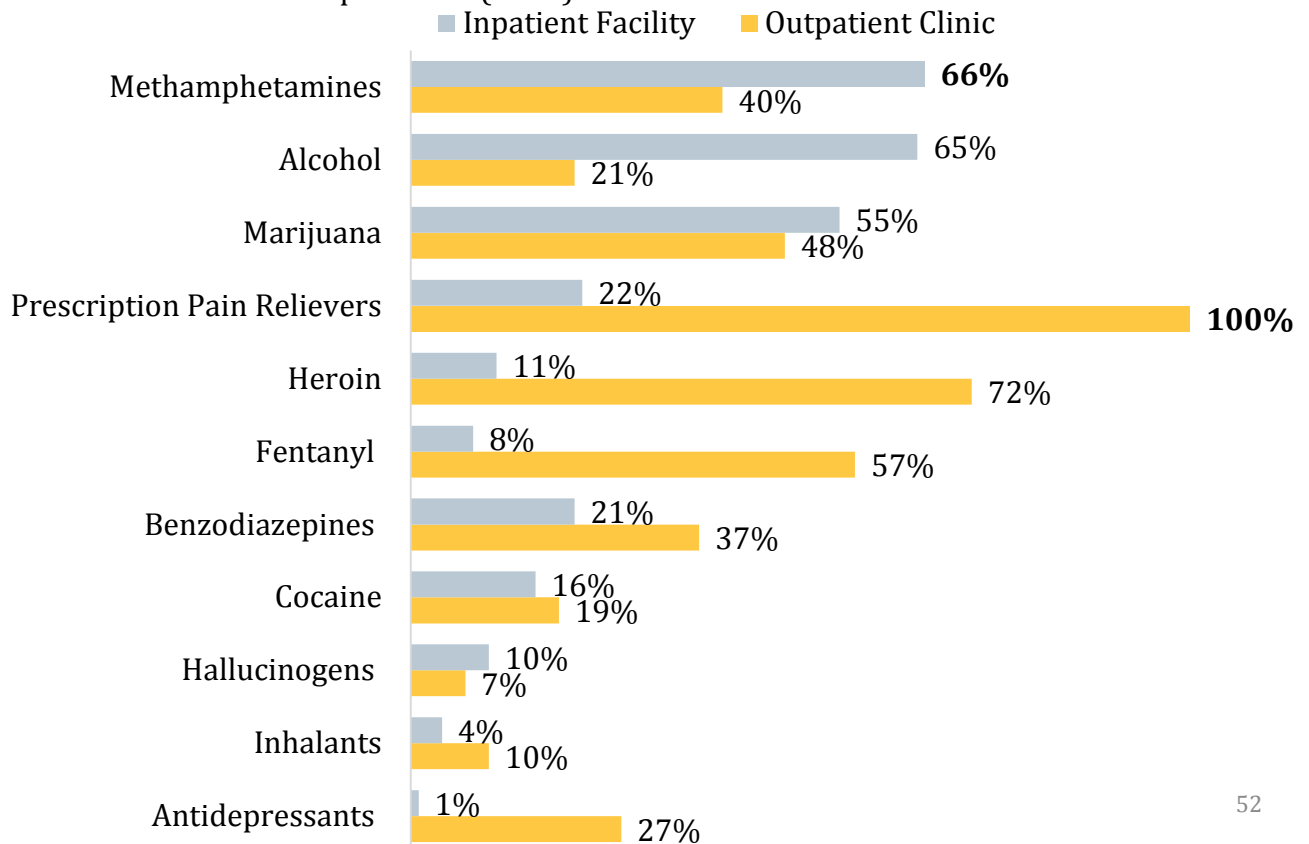


All three methadone providers indicated 100% of their clients use prescription pain relievers. Most methadone providers also indicated their clients commonly use heroin (72%) and fentanyl (57%). Methadone providers indicated nearly half of clients use marijuana (48%) and methamphetamines (40%).



#### Percent of Clients Needing Treatment by Substance

Relatively few inpatient providers reported their clients use opioids in comparison to methadone providers (n=18).





## Substance Use Trends

### Primary Drug of Choice

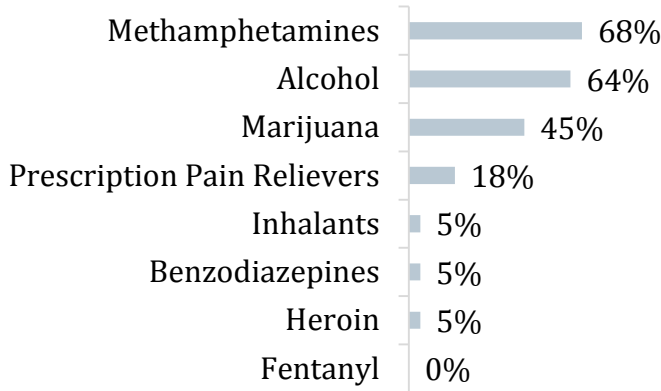
Thinking about clients served in your program over the past year, what have been their most common primary drugs of choice? (select all that apply)

#### Inpatient Facilities (n=15)



Most respondents (68%) listed methamphetamines as one of the most common primary drugs of choice. Alcohol (64%) and marijuana (45%) were also common primary drugs listed. This is consistent with the common substances reported by inpatient providers on the previous page.

#### Percent of clients by primary drug of choice



#### Methadone Clinics (n=3)



**100%**

All three methadone clinics reported their clients' primary drugs of choice in the past year were "prescription pain relievers, heroin, and fentanyl."

### Percent of Clients with Opioid Use Disorder (OUD)

What PERCENT of your clients have an opioid use disorder (prescription pain relievers, fentanyl, heroin)?

#### Inpatient Facilities (n=15)



Providers generally reported less than one-third of clients (23%) have an OUD.

#### Percent of clients with OUD



#### Methadone Clinics (n=3)



**100%**

All three methadone clinics reported 100% of their clients have an OUD.



## Substance Use Trends

### Primary Drug of Choice

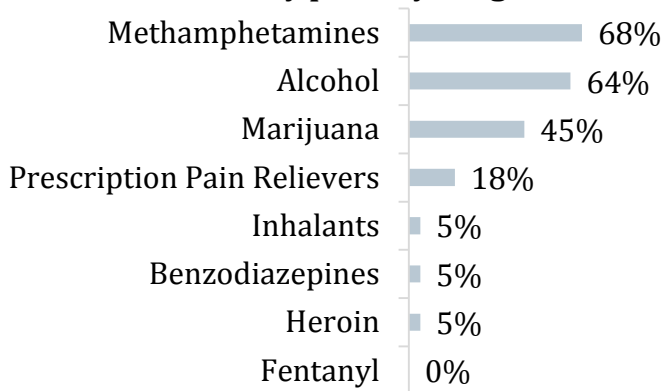
Thinking about clients served in your program over the past year, what have been their most common primary drugs of choice? (select all that apply)

#### Inpatient Facilities (n=15)



Most respondents (68%) listed methamphetamines as one of the most common primary drugs of choice. Alcohol (64%) and marijuana (45%) were also common primary drugs listed. This is consistent with the common substances reported by inpatient providers on the previous page.

#### Percent of clients by primary drug of choice



#### Methadone Clinics (n=3)



# 100%

All three methadone clinics reported their clients' primary drugs of choice in the past year were "prescription pain relievers, heroin, and fentanyl."

### Percent of Clients with Opioids Use Disorder (OUD)

What PERCENT of your clients have an opioid use disorder (prescription pain relievers, fentanyl, heroin)?

#### Inpatient Facilities (n=15)



Providers generally reported less than one-third of clients (23%) have an OUD.

#### Percent of clients with OUD



#### Methadone Clinics (n=3)



# 100%

All three methadone clinics reported 100% of their clients have an OUD.



## Substance Use Trends

### Clients Who Are Polysubstance Users

In the past year, what PERCENT of clients in your program were dependent on multiple substances? (polysubstance or multiple substance dependent)

#### Inpatient Facilities (n=15)



Providers reported a median 80% of clients as dependent on multiple substances. **14 of the 15 inpatient providers indicated over half their clients are polysubstance users.**

**Percent of clients who are polysubstance users**

20%	<b>80%</b>	100%
Min.	Median	Max.

#### Methadone Clinics (n=3)



Providers reported a median 40% of clients as dependent on multiple substances. Two methadone providers indicated 40% of clients are polysubstance users.

**Percent of clients who are polysubstance users**

40%	<b>40%</b>	85%
Min.	Median	Max.



## Substance Use Trends

### Most Common Polysubstance Drug Pairings

We would like to know about trends you are seeing in the use of multiple substances. For each of the primary substances listed below, please indicate the drug or drugs that you commonly see paired with each substance.

#### Inpatient Facilities (n=15)



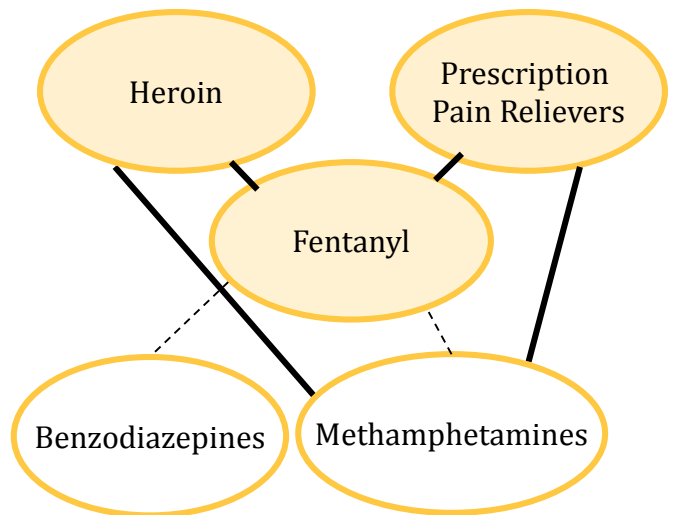
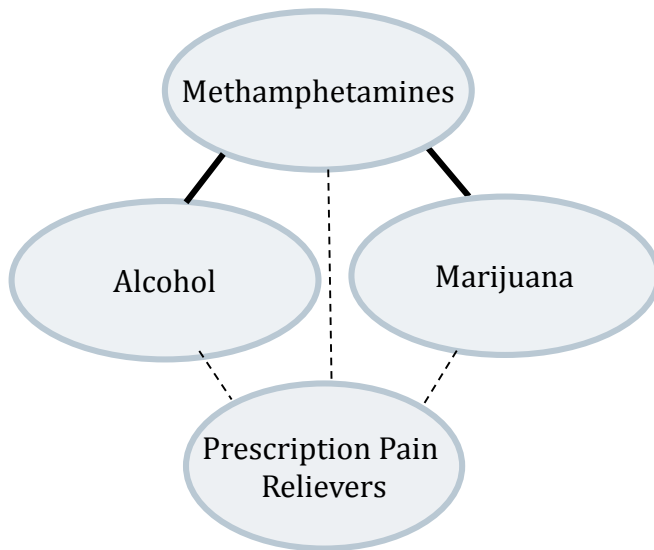
**Inpatient providers consistently indicated the pairing of methamphetamines, marijuana, and alcohol.** Providers indicated methamphetamines as the primary substance paired with alcohol and marijuana more than any other combination. Fewer providers indicated that when prescription pain relievers were the primary substance, marijuana, methamphetamines, and alcohol were paired with prescription pain relievers.

#### Methadone Clinics (n=2)



**Methadone providers indicated heroin, fentanyl, and prescription pain relievers as being primary substances paired with other drugs.** Both methadone providers indicated heroin and prescription pain relievers being paired with methamphetamines and benzodiazepines. One methadone provider indicated fentanyl as a primary substance, paired with methamphetamines and benzodiazepines.

### Most Common Polysubstance Drug Pairings



#### Diagram Key

- Some providers reported pairing
- Most providers reported pairing
- Primary drug of choice and paired drug
- Paired drug only

The full results are provided in a table in [Appendix C](#).





## Drug Use Initiation

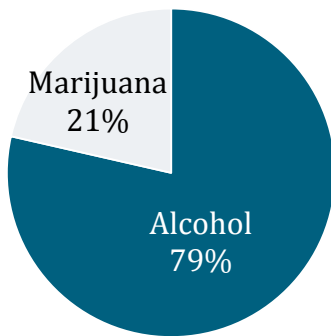
### Most Common Substance First Misused

What is your perception of the most common substance that is first misused by your clients?

#### Inpatient Facilities (n=14)



Most inpatient providers indicated alcohol was the first substance misused by clients (n=11, 79%). A few inpatient providers also indicated marijuana was the first substance misused (n=3, 21%).



#### Methadone Clinics (n=2)



Methadone providers reported prescription pain relievers were the first substances misused by clients.



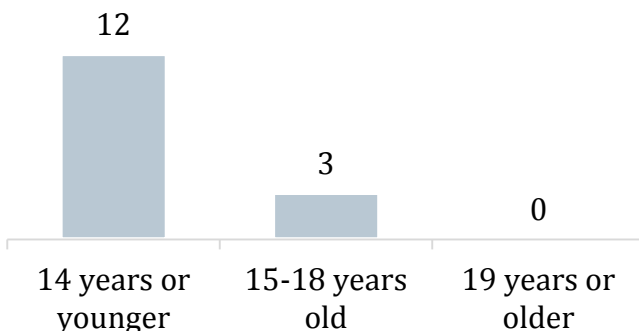
### Age at First Misuse

What age do most clients served in your program report as their first misuse?

#### Inpatient Facilities (n=14)



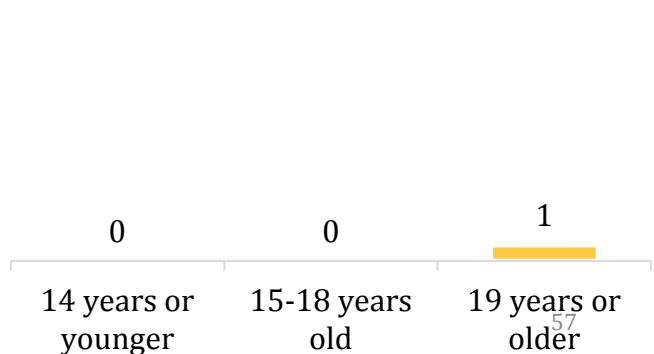
Most inpatient providers indicated their clients first misused a substance at age 14 or younger (n=12). A few inpatient providers also indicated their clients began using between ages 15 and 18 years old (n=3).



#### Methadone Clinics (n=1)



One methadone provider indicated most clients in their program began misusing at age 19 or older (n=1). (Only one methadone provider answered this question.)





## Drug Use Initiation

### Most Common Reason for First Misuse

In your opinion, what are the most common reasons for clients' first substance misuse? (check all that apply)

#### Response Options

- Peers encouraged them to
- Experiment/see what it's like
- Feel good/get high
- Help with feelings or emotions
- Parents or other family members encouraged them to
- Pain relief
- Relax or relieve tension
- Help with sleep
- Help be alert or stay awake
- Help study
- Help concentrate
- Help lose weight
- Unknown
- Other \_\_\_\_\_

#### Inpatient Facilities (n=15)



Providers indicated the top two most common reasons for their clients' first substance misuse was "peer pressure" or the desire to "experiment/see what it's like." No providers indicated clients' first misuse was due to help being alert or staying awake, studying, concentrating, or losing weight.

#### Methadone Clinics (n=1)

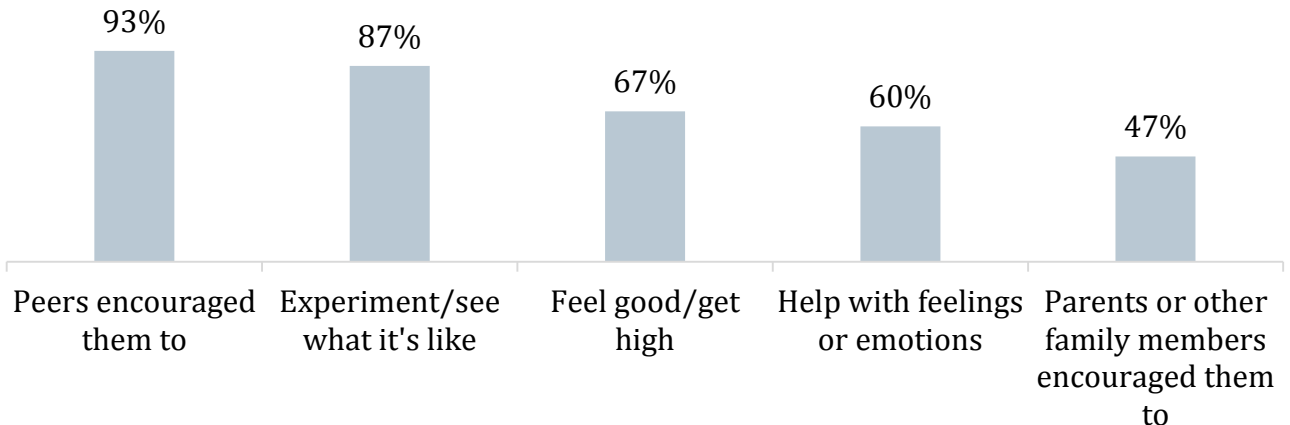


Only one methadone provider responded to this question. The methadone provider was the only respondent who indicated "pain relief," help with sleep, and relax or relieve tension as reasons for clients' first substance misuse. This methadone provider also indicated clients first misuse substances to "feel good/get high" and "help with feelings or emotions."



#### Top Five Reasons for First Misuse (n=16)

Inpatient providers most often indicated clients first misused substances due to peers' encouragement.





## Drug Use Initiation

### Source of First Misuse

Where did clients most commonly get the substance they first misused?

#### Response Options

- Got from friend or relative for free
- Took from friend or relative without asking
- Bought from friend or relative
- Got from a doctor
- Stole from doctor's office, clinic, hospital, or pharmacy
- Bought from drug dealer or other stranger
- Other \_\_\_\_\_

#### Inpatient Facilities (n=15)



According to most inpatient providers, clients most commonly obtained their first misused substance “from a friend or relative for free.” All inpatient providers indicated their clients’ source was a friend or relative, whether the substance was given for free, purchased, or stolen.

No providers indicated the source of their clients’ first misuse was from a drug dealer or stranger (n=16).

#### Methadone Clinics (n=1)

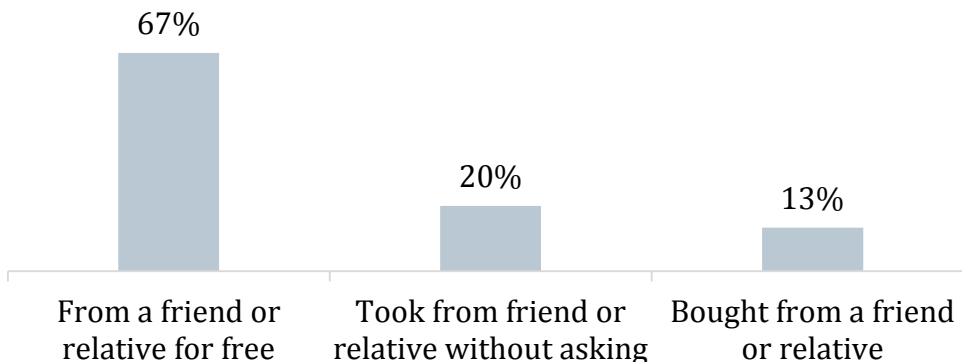


One methadone provider responded to this item indicating the source of their clients’ first use was “from a doctor.”



#### Clients’ Sources of First Misuse

Most inpatient providers indicated their clients first misused substance was obtained “from a friend or relative for free” (n=15).





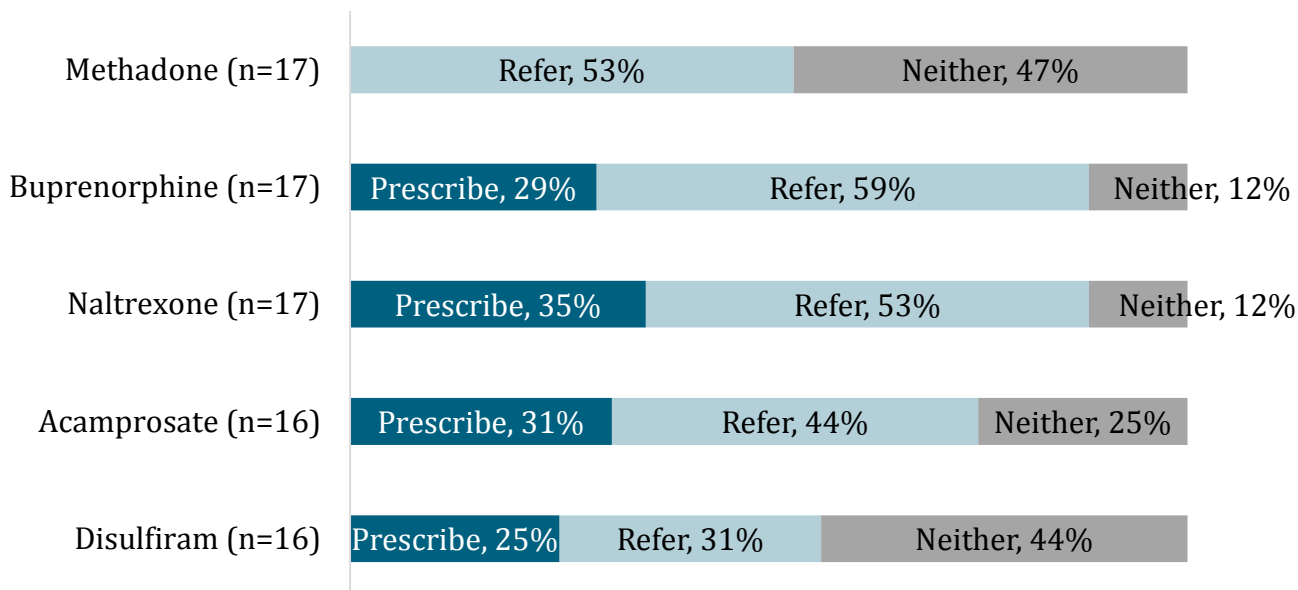
## Medication-Assisted Treatment



Respondents indicated whether they 1) prescribe, 2) refer, or 3) neither prescribe nor refer for a variety of different medications for substance abuse treatment. Providers indicated this for all major pharmacotherapies indicated for both opioid and alcohol dependency as well as a general statement related to medications for psychiatric disorders. 17 providers responded to questions surrounding MAT; 18 providers responded to questions regarding medications for psychiatric disorders.

Overall, buprenorphine, naltrexone, and acamprosate were favored as pharmacotherapies over methadone and disulfiram. Significant differences, however, emerged based on provider location and the pharmacotherapy's indication.

### Pharmacotherapy Involvement by Inpatient Facilities



### Pharmacotherapy Treatment Use

The table to the right outlines the MAT medications and the corresponding substance dependencies they treat.

Target Addiction	MAT Medication
Opioid Use Disorder	Methadone
	Buprenorphine
Opioid Use Disorder and Alcohol Use Disorder	Naltrexone
Alcohol Use Disorder	Acamprosate
	Disulfiram



## Medication-Assisted Treatment for Opioid Use Disorder

### Methadone

Only about half of inpatient providers (n=9, 53%) reported providing referrals for methadone, making it the least commonly referred pharmacotherapy.



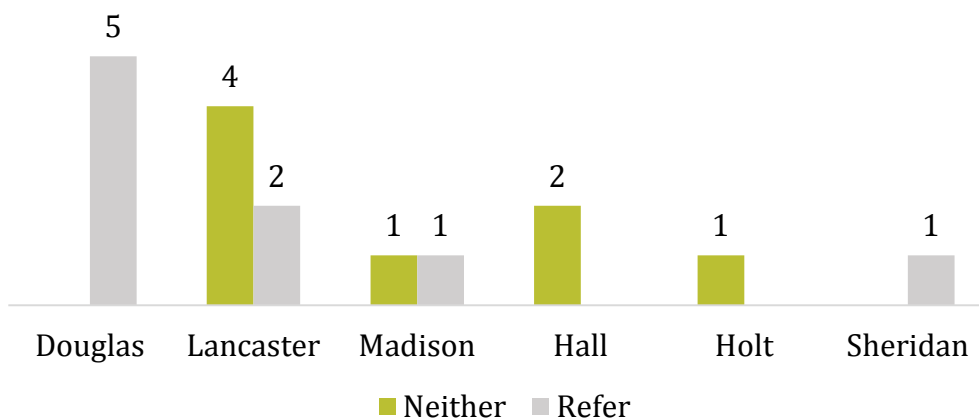
There seemed to be a disparity related to methadone referrals based on geographic location. Only two rural inpatient providers, located in Madison and Sheridan counties, indicated referring for methadone treatment. Additionally, only two facilities in Lancaster county indicated they refer for methadone treatment, despite having a methadone clinic being in the same county.

Given that respondents also indicated elsewhere on the survey that a relatively small number of their clients need treatment for OUD, and methadone clinics are often located far from the inpatient treatment facility (with the exception of the Lancaster county respondents), it is unclear if the lack of methadone referral is due to a lack of client need for methadone treatment, lack of client access to methadone treatment providers, a lack of provider knowledge surrounding methadone treatment, or some other reason.

### Methadone Clinics

As expected, only methadone clinics reported prescribing methadone (n=3). One methadone clinic also reported prescribing buprenorphine, and one reported referring for psychiatric medications.

**Inpatient Facility Methadone Referral by County (n=17)**





## Medication-Assisted Treatment for Opioid Use Disorder

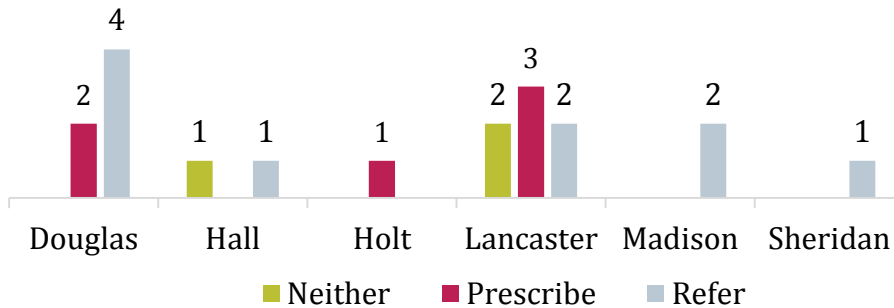
### Buprenorphine



While treatment providers (including methadone clinics, n=19) **more commonly reported either prescribing or referring for buprenorphine more than any other pharmacotherapy**, there was one provider in Hall county and two providers in Lancaster county that neither prescribe nor refer clients for buprenorphine.

Despite more providers indicating they prescribe or refer buprenorphine more than any other pharmacotherapy, **only inpatient and methadone providers in three counties indicated they are able to prescribe buprenorphine.**

**Inpatient Facility Buprenorphine Prescription and Referral by County (n=17)**



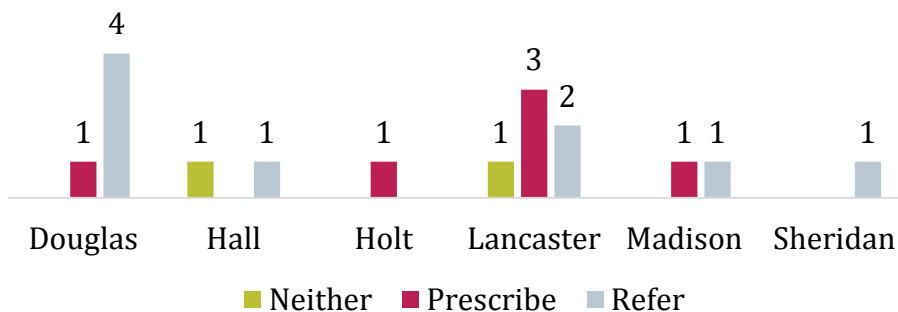
### Naltrexone



**All but two inpatient facilities indicated they either prescribe or refer for naltrexone, making it, together with buprenorphine, the medication more inpatient facilities prescribe or refer for than any other pharmacotherapy.**

Methadone clinics were excluded from this analysis as naltrexone seemed to be outside of the scope of their services (two methadone providers did not answer, and one indicated they neither prescribe nor refer for naltrexone). Since naltrexone is indicated for the use of both opioid and alcohol dependence, it is unknown for which substance providers prescribe or refer this pharmacotherapy.

**Inpatient Facility Naltrexone Prescription and Referral by County (n=17)**





## Medication-Assisted Treatment for Opioid Use Disorder

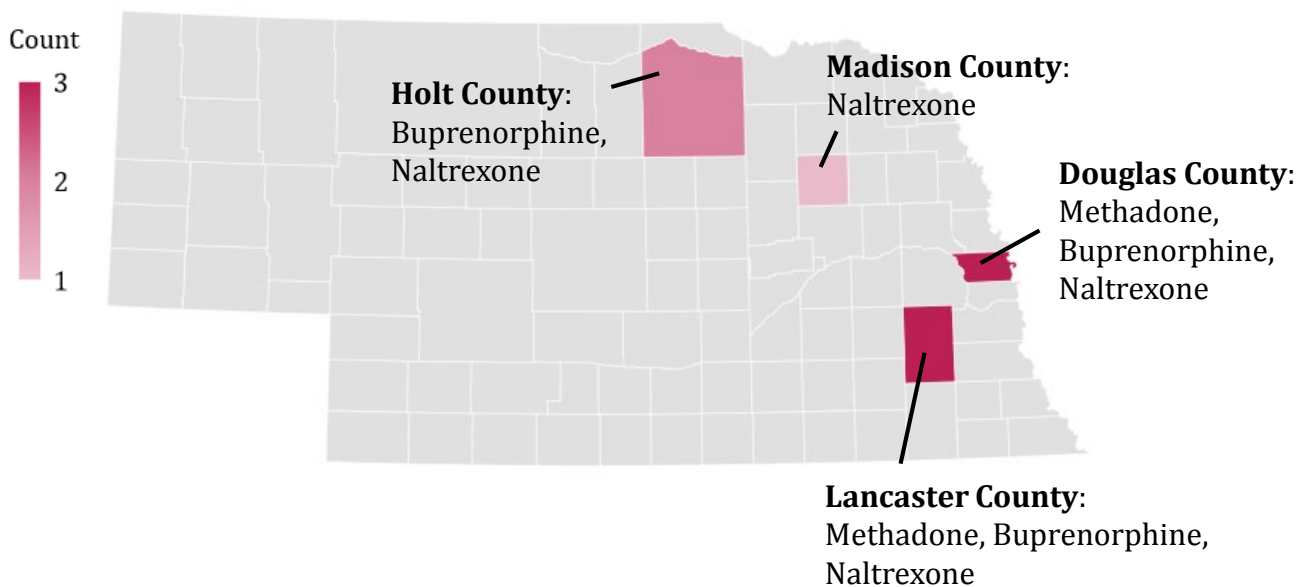
### MAT Availability for Opioid Use Disorder



Providers identified four counties that prescribe at least one MAT pharmacotherapy to treat OUD. Because naltrexone can be used to treat OUD or Alcohol Use Disorder, it is unclear whether Madison county has a MAT prescriber for clients with OUD. No providers indicated a MAT prescriber in western Nebraska for clients with OUD.

### MAT Pharmacotherapies Prescribed by County for Clients with OUD

Providers identified Douglas and Lancaster as the only counties that prescribe all three MAT pharmacotherapies used to treat OUD.



### Lancaster County (n=8)



Since providers indicated that most beds in the state for OUD are in Lancaster county, evaluators noted a relationship between those inpatient providers with OUD beds in Lancaster county and their reports of prescribing or referring for MAT, particularly for those pharmacotherapies indicated for OUD. Three inpatient facilities in Lancaster county indicated they reserve 65 beds for OUD (two facilities have 25 beds each; one facility reported 15 beds). **Of these three facilities, none of them indicated they refer or prescribe for methadone. Two of these facilities indicated the ability to prescribe for buprenorphine and naltrexone. The remaining facility indicated they neither refer nor prescribe for any pharmacotherapy medication listed on the survey, including those for psychiatric disorders.**



## Medication-Assisted Treatment for Alcohol Use Disorder

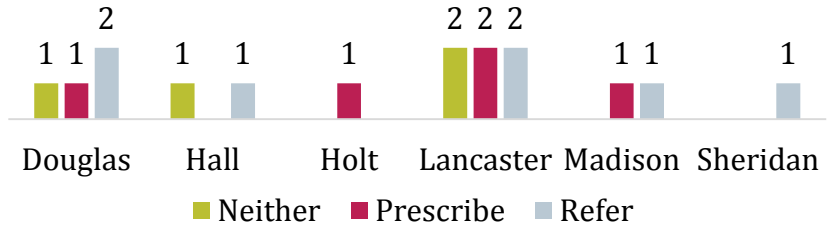
### Acamprosate



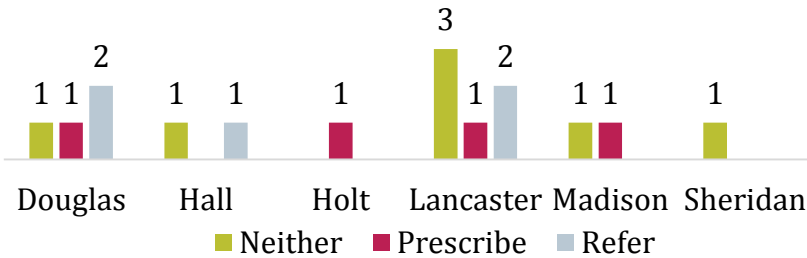
**Most inpatient facilities indicated they either prescribe or refer for**

**acamprosate.** Four inpatient facilities indicated they neither prescribe nor refer for acamprosate. Interestingly, three of those facilities are located in the metropolitan areas of Lancaster and Douglas counties. Methadone clinics were not included in this analysis as this pharmacotherapy is outside of their scope of service.

**Inpatient Facility Acamprosate Prescription and Referral by County (n=16)**



**Inpatient Facility Disulfiram Prescription and Referral by County (n=16)**



### Disulfiram



**Fewer inpatient facilities prescribe or refer for disulfiram than any other pharmacotherapy (n=8, 50%), except methadone.** Only three facilities indicated they prescribe disulfiram, while five indicated they refer for the medication. Methadone clinics were excluded from this analysis as disulfiram seemed to be outside their scope of service.

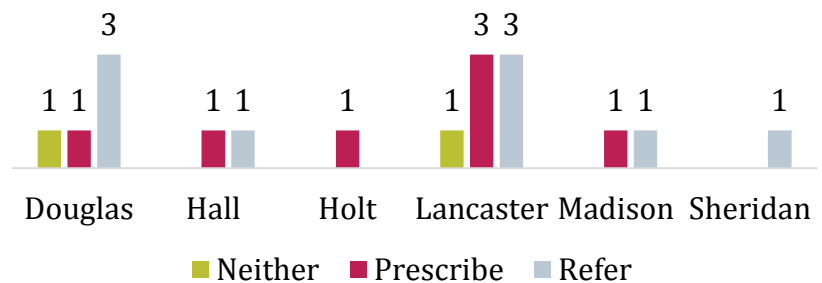
### Medication for Psychiatric Disorders



**All but two providers prescribe or refer for psychiatric**

**medications (n=18).** Seven providers prescribe medications for psychiatric disorders and nine providers indicated they refer out for this medication. Both methadone clinics and inpatient facilities were included in this analysis.

**Psychiatric Prescription and Referral by County (n=18)**







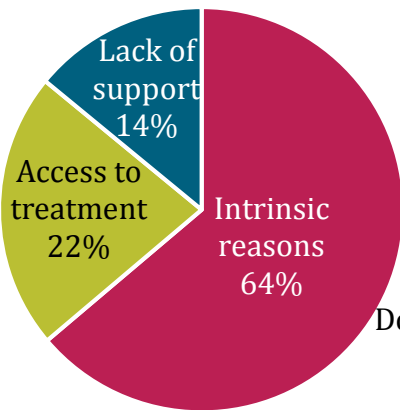
## Treatment

### Reasons to Not Seek Treatment

What are the most common reasons people do NOT receive treatment? (select all that apply)  
 The full list of response options are provided in [Appendix B](#).

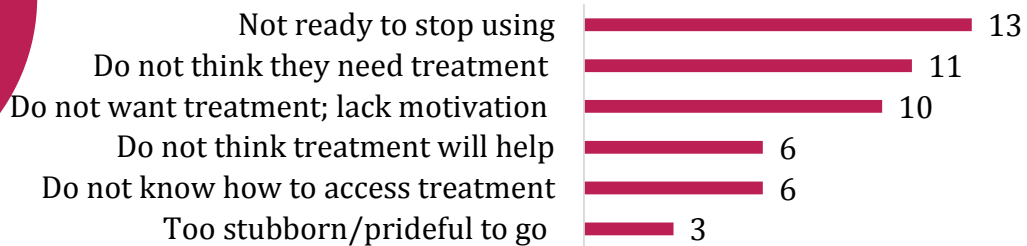
For this item, providers could list an unlimited number of reasons why their clients did not seek treatment. Providers gave a collective total of 83 responses (n=17). Of those 83 responses, 64% were categorized as “intrinsic reasons,” 22% were deemed “access to treatment” issues, and 14% were classified as “lack of support.”

#### Reasons to Not Seek Treatment (n=17)



#### Intrinsic reasons

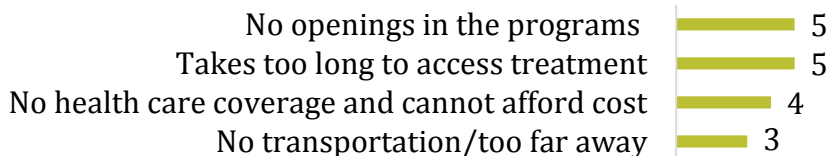
Most providers indicated clients do not seek treatment due to intrinsic reasons. **Over half of providers reported clients do not seek treatment because they are not ready to stop using, do not think they need treatment, or do not want to seek treatment.**



#### Access to Treatment

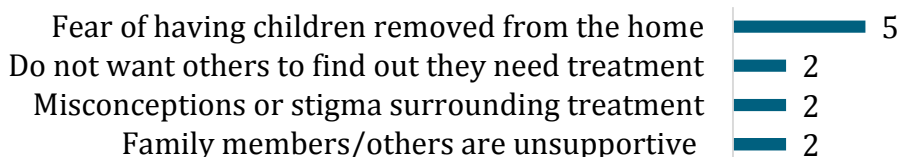


Some providers reported systemic barriers to clients seeking treatment. **The most common barriers involved availability of treatment beds.** One methadone provider from Douglas County and two inpatient providers from rural counties reported clients have difficulty seeking treatment due to transportation.



#### Lack of Support

Few providers reported that people do not seek treatment due to reasons related to lack of support. Within this category, providers most frequently identified clients' barriers to treatment as the fear of their children being taken from the home.





## Treatment

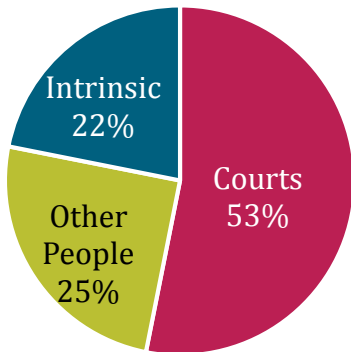
### Catalysts for Treatment

Which of these statements best describes how your clients were prompted to get treatment?  
(select all that apply)

The full list of response options are provided in [Appendix B](#).

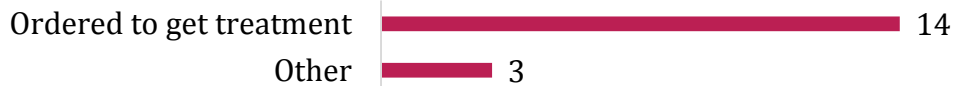
For this item, providers could list an unlimited number of reasons why their clients do not seek treatment. Providers gave a collective 32 responses (n=17). Of those 32 responses, 53% were categorized as “courts” (including other legal entities), 25% were related to “other people” supporting clients, and 22% were classified as “intrinsic.”

#### Catalyst for Treatment (n=16)



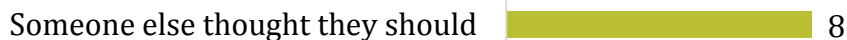
#### Courts

Providers indicated their clients were prompted to get treatment due to court-related incidents more than any other catalyst (n=14). Of the three providers who indicated “other,” one stated “legal issues; trying to look good before sentencing” and the other stated that “probation, employer” prompted their clients to seek treatment.



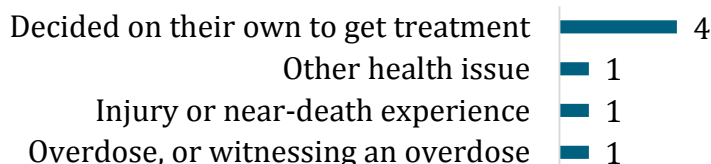
#### Other People

8 of the 17 providers stated their clients sought treatment because “someone else thought they should.” Six of the providers who identified other people as the catalyst for their clients’ treatment also reported their clients were ordered to get treatment.



#### Intrinsic

Approximately one-fourth of providers (n=7) identified intrinsic reasons as a catalyst for their clients to seek treatment. Of the intrinsic options, providers most often stated their clients “decided on their own to get treatment.”





## Needs of Providers

### Helpful Training Received

What training have you received that has been helpful to your work?

#### Themes (n=10)



#### 1. Evidence-Based Practices

Providers most often indicated that training on evidence-based practices (EBPs) was helpful. EBPs specifically mentioned were medication-assisted treatment (MAT), eye movement desensitization and reprocessing (EMDR), dialectic behavioral therapy (DBT), and motivational interviewing, among others.



#### 1. Trauma-Informed Care

Four respondents indicated trauma-related trainings such as trauma-informed care and adverse childhood experiences (ACEs) have been beneficial.



#### 1. Substance Trends

Four respondents reported training on substance use trends were useful to staff, including the one methadone provider who responded to this question.

*"We do consistent monthly trainings with staff on new controlled substances and how the public are using them."*

- Methadone Provider



#### 1. Crisis intervention

Two respondents also indicated crisis intervention trainings were helpful. Providers specifically mentioned trainings on de-escalation, suicide prevention, and co-occurring disorders have been helpful.



## Needs of Providers

### Needs of Treatment Providers

What additional resources or training do you or other staff at your facility need?

#### Themes



#### 1. Funding

Three participants reported a need for funding to expand their workforce capacity. More specifically, they noted a need for case managers to assist MAT prescribers, professional staff to provide mental health services, and additional support for rural treatment providers (n=4).

*“Our program urgently needs funding to meet the mental health needs of our clients. Access to mental health services is nonexistent.”*

- Inpatient Provider

*“Our prescribers in our outpatient office are open to prescribing MAT, but they will not do it without supportive staff in place to help manage these clients... We currently do not have funding for this, so we have not been able to implement MAT with our prescribers in our outpatient facility.”*

- Inpatient provider



#### 1. Evidence-Based Practices

The providers who indicated a need for EBP training specifically mentioned MAT training and American Society of Addiction Medicine (ASAM) criteria training.

*“ASAM Criteria needs to be taught to private and State funded providers in rural areas.”*

- Inpatient Provider

*“I do not believe DHHS knows anything about our clients or our work.”*

- Inpatient Provider



## Needs of Providers

### Future Training Topics

Which of the below topics would be useful for future training for yourself or other staff at your facility? (select up to 5)

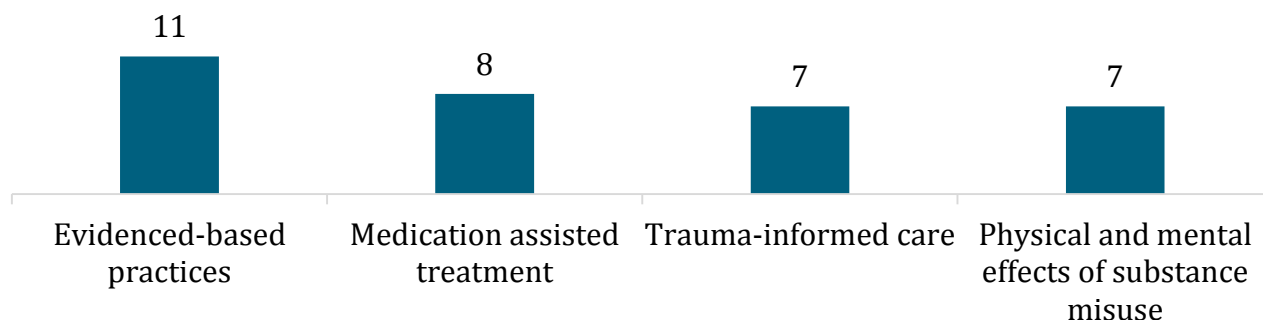
The full list of response options are provided in [Appendix B](#).

Providers most often indicated interest in receiving training on evidence-based practices (n=11). Nearly half of providers replied that future training on medication-assisted treatment, trauma-informed care, and the effects of drug use would be useful.



#### Future Training Topics

Providers most often indicated interest in receiving training on evidence-based practices (n=11).



### Needs of Clients

What additional resources do your clients need? (select up to 5)

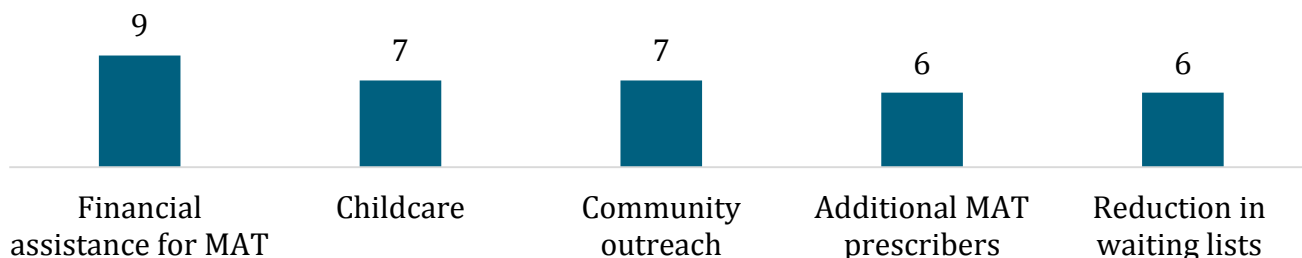
The full list of response options are provided in [Appendix B](#).

Over half of providers (two of whom are methadone providers) identified financial assistance for MAT as the most common need for their clients. Providers also identified childcare as a client need in this item and in the following open-ended item.



#### Needs of Clients

Providers most often indicated interest in receiving training on evidence-based practices (n=11).





## Treatment

### Information for DHHS

What would you most like DHHS to know about your clients, and your work?

Three primary themes were identified from the responses of providers:

1. Client Finances,
2. Care of Children, and
3. Mental Health.

Providers included other concerns such as the importance of harm reduction interventions, the effects of MAT stigma, and difficulties that rural providers face due to a small workforce.

### Themes (n=11)



#### 1. Client Finances

Of the 11 providers who responded, 4 providers shared client finances are a significant concern. According to these providers, financial limitations lead to clients leaving treatment too early and resorting to illicit ways of making money. Financial concerns prevent clients from being able to afford MAT and from being able to afford the transportation to access treatment.

*"In the panhandle we do not have the resources to help all clients."*

- Inpatient Provider

*"We have so many patients who discontinue treatment early due to a lack of funds. Most go back onto the street for drugs as they can get drugs by selling other drugs and using their bodies."*

- Methadone Provider

#### 1. 2. Care of Children



Two providers indicated concerns about childcare for parents who are seeking treatment. One shared the desire to see fathers eligible for reunification with children at the same rate as mothers after receiving substance use treatment. Another provider conveyed the need for residential treatment facilities equipped to house both mothers and their dependent children in order to increase the accessibility of treatment for mothers.

*"One of the primary factors preventing mothers from getting treatment is lack of long-term childcare and an unwillingness to leave their children... DHHS must prioritize residential treatment for mothers with their children to break the cycle of addiction in families."*

-Inpatient Provider

#### 1. 3. Mental Health



Two providers identified a lack of accessible mental health services. One of these providers shared that mental health providers are particularly hard to access in rural areas.



## Prevention

### Most Helpful Prevention Efforts

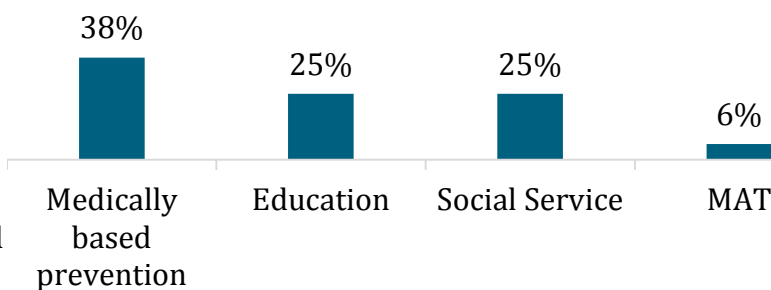
In your opinion, what prevention efforts are most helpful? (Select up to 3 in each category)  
 The full list of response options are provided in [Appendix B](#).



Providers reported that “medically based prevention” efforts,

specifically prescriber education, are the most helpful, followed by “education,” “social service efforts,” and “MAT.” Providers indicated that school-based prevention education for middle school students was the most helpful education intervention. Providers rated mental health services and counseling as the most helpful interventions within the “social service” category.

**Helpfulness of Prevention Efforts by Category (n=17)**



### Prevention Efforts included in Categories

*Note: Prevention efforts are listed below the categories in order of the helpfulness as rated by providers.*

#### Medically based prevention

- Prescriber education.
- Addiction screening at primary care facilities.
- Use of Prescription Drug Management Program (PDMP) before prescribing controlled substances.
- Addiction screening for those presenting for early refills.

#### Education

- School-based substance misuse prevention programs—middle school students.
- School-based substance misuse prevention programs—elementary students.
- PSA and media campaigns for general public.
- Public education about MAT.
- School-based substance misuse prevention programs—high school students.

#### Social Service

- Increased access to mental health treatment.
- Mandatory counseling and services with buprenorphine or naltrexone administration.
- Increased access to 12-step programs.
- Increased access to and training on naloxone.
- Education about safe injection practices.

#### MAT

- Methadone treatment.
- Buprenorphine treatment.
- Naltrexone treatment.



## Prevention

### Populations in Need of Prevention Efforts

In your opinion, what populations are most in need of additional substance abuse prevention efforts? (select up to 5)

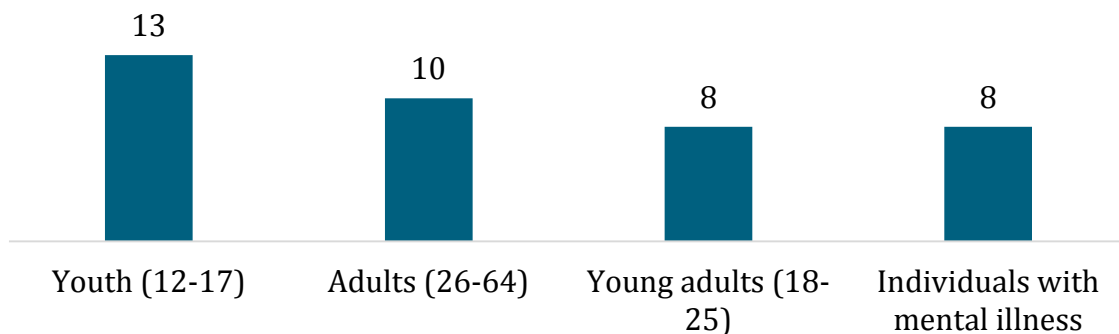
The full list of response options are provided in [Appendix B](#).



Providers reported youth ages 12 to 17 years are most in need of prevention efforts, followed by adults and young adults. Out of all the categories not based on age group, providers considered “individuals with mental illness” to be the most in need. Few providers indicated older adults age 65 years and over, persons in urban areas, and specific racial groups were in need of targeted prevention.

#### Populations Most in Need of Prevention Efforts

Providers indicated youth ages 12 to 17 years are most in need of prevention efforts (n=17).



Populations in Need	Responses
Youth (ages 12-17)	13
Adults (ages 26-64)	10
Young adults (ages 18-25)	8
Individuals with mental illness	8
Families living in poverty	7
Incarcerated individuals	7
Persons who lack a stable residence	7
Persons in rural areas	6
American Indians/Alaska Natives	5
Current substance users	4
Children (ages 5-11)	3

Populations in Need	Responses
Women of child-bearing age	3
Individuals experiencing food insecurity	3
LGBT individuals	3
Older adults (ages 65+)	2
Persons in urban areas	2
Latinos/Latinas	2
English Language Learners	1
Asian/Pacific Islanders	1
Other	0





## Prevention

### Prevention Resources



Following is a list and description of prevention efforts DHHS is currently involved with. Please rate your degree of knowledge about the program, and the degree to which you find the program helpful. We would also like to know the degree to which you have utilized the information and resources provided by these programs and initiatives for yourself or for your clients.

#### Response Options:

##### Knowledge

- I have no knowledge of this initiative
- I have heard of the initiative, but don't know much about it
- I have some knowledge of the initiative and its activities
- I am well-informed about the initiative

##### Helpfulness

- Unsure
- Not helpful
- Somewhat helpful
- Very helpful

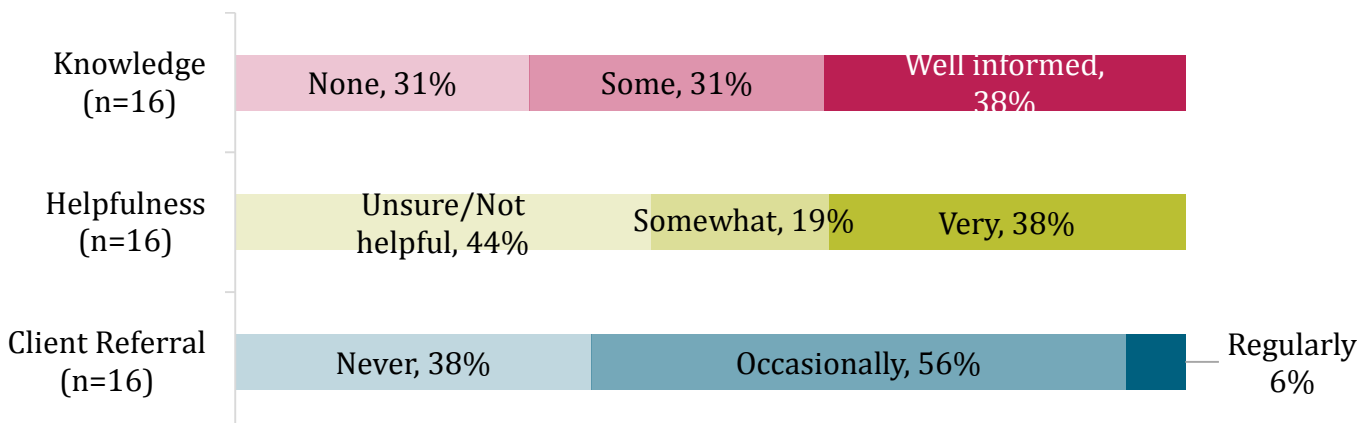
##### Client Referral

- We never refer clients to this resource
- We occasionally refer clients to this resource
- We refer clients to this resource regularly
- We sometimes refer clients to this resource

### Funding for Buprenorphine



While most providers indicated at least some knowledge of funding for buprenorphine, approximately one third of providers neither had knowledge nor ever referred clients to this resource. Almost half of providers reported they are unsure about the helpfulness of this resource or that the resource is not helpful. One inpatient provider from Lancaster county indicated their program is well informed about funding for buprenorphine, regularly refers clients to this resource, and the resource is very helpful.





## Prevention

### Prevention Resources



Following is a list and description of prevention efforts DHHS is currently involved with. Please rate your degree of knowledge about the program, and the degree to which you find the program helpful. We would also like to know the degree to which you have utilized the information and resources provided by these programs and initiatives for yourself or for your clients.

#### Response Options

##### Knowledge

- I have no knowledge of this initiative
- I have heard of the initiative, but don't know much about it
- I have some knowledge of the initiative and its activities
- I am well-informed about the initiative

##### Helpfulness

- Unsure
- Not helpful
- Somewhat helpful
- Very helpful

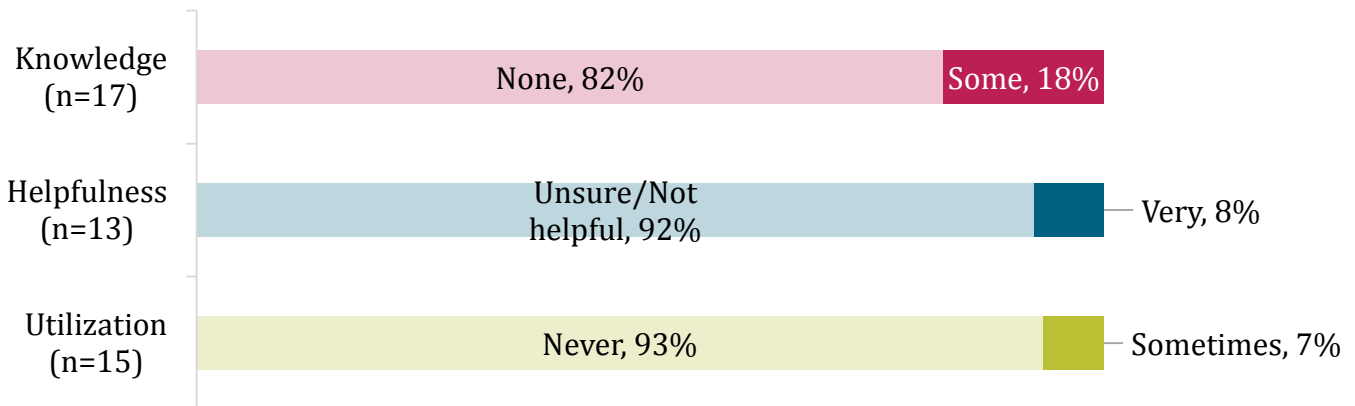
##### Utilization

- We never use this resource
- We sometimes utilize this resource
- We occasionally use this resource
- We utilize this resource regularly

### OpiRescue Phone Application



Nearly all providers reported no knowledge or utilization of the OpiRescue Phone application. Of the 13 providers who rated the helpfulness of the OpiRescue Phone application, 11 reported uncertainty about the helpfulness of the resource. One inpatient provider from Douglas county indicated the phone application is "very helpful" (n=13).





## Prevention

### Prevention Resources



Following is a list and description of prevention efforts DHHS is currently involved with. Please rate your degree of knowledge about the program, and the degree to which you find the program helpful. We would also like to know the degree to which you have utilized the information and resources provided by these programs and initiatives for yourself or for your clients.

#### Response Options

##### Knowledge

- I have no knowledge of this initiative
- I have heard of the initiative, but don't know much about it
- I have some knowledge of the initiative and its activities
- I am well-informed about the initiative

##### Helpfulness

- Unsure
- Not helpful
- Somewhat helpful
- Very helpful

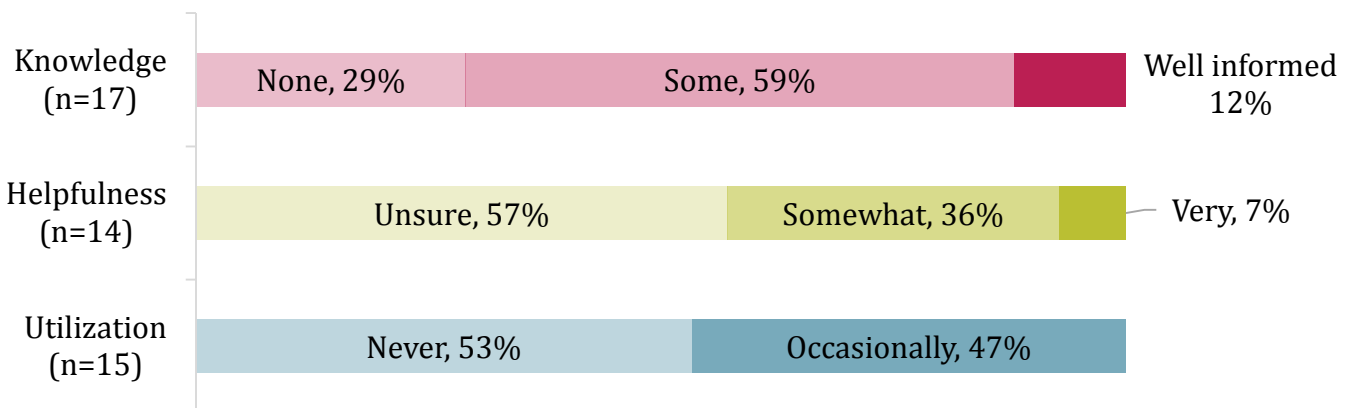
##### Utilization

- We never use this resource
- We sometimes utilize this resource
- We occasionally use this resource
- We utilize this resource regularly

### Increase Medication-Assisted Treatment (MAT) Workforce Capacity



Most providers indicated at least some knowledge of this MAT resource. Though less than half of providers replied they utilized it, more providers specified using this resource than any other on the survey, except for referring clients to funding for buprenorphine (n=17). Over half of providers, however, reported being unsure of its helpfulness (n=14).





## Prevention

### Prevention Resources



Following is a list and description of prevention efforts DHHS is currently involved with. Please rate your degree of knowledge about the program, and the degree to which you find the program helpful. We would also like to know the degree to which you have utilized the information and resources provided by these programs and initiatives for yourself or for your clients.

#### Response Options

##### Knowledge

- I have no knowledge of this initiative
- I have heard of the initiative, but don't know much about it
- I have some knowledge of the initiative and its activities
- I am well-informed about the initiative

##### Helpfulness

- Unsure
- Not helpful
- Somewhat helpful
- Very helpful

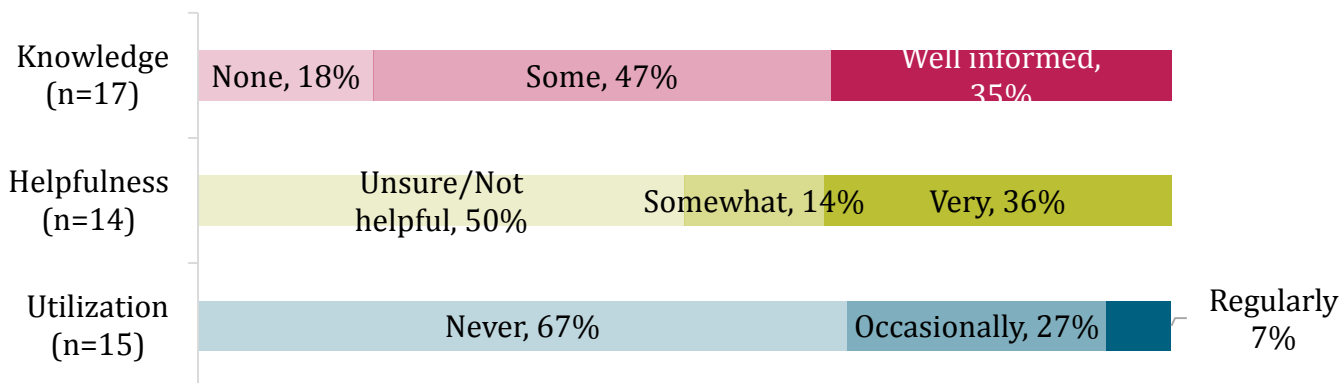
##### Utilization

- We never use this resource
- We sometimes utilize this resource
- We occasionally use this resource
- We utilize this resource regularly

### Naloxone Distribution



**Despite indications that providers had more knowledge about naloxone distribution than any other resource on the survey, only about one third of them reported occasionally or regularly utilizing this resource.** One Douglas county inpatient provider reported regularly using naloxone distribution and indicated it as very helpful in their program. Half of providers found naloxone distribution to be at least somewhat helpful, while the other half reported they were unsure of its helpfulness. One provider reported naloxone distribution as not helpful.





## Limitations



### 1. Response Rate

STEPS emailed the anonymous survey link to one administrative contact, provided by DHHS, per treatment facility or clinic. The email may have inadvertently been sent to a spam folder or recipients may not have recognized the sender and ignored the email, so STEPS used follow-up emails and phone calls to increase the survey response rate. Some providers were never reached which negatively impacted the response rate.



### 2. Incomplete Survey Responses

24 providers started the survey, but only 20 respondents completed both the demographic questions and at least one other item. Several others did not complete many of the survey items (as noted by total n in each survey item throughout the report).



### 3. Disproportionate Representation from Urban Counties

Relatively few treatment facilities outside of Douglas and Lancaster counties replied. Even fewer responses were received from the western two thirds of Nebraska, and thus we know very little about rural substance misuse behaviors, especially how those in central and western Nebraska might differ from the eastern third of the state.



### 4. Limited Scope of Services Sampled

This report covers only inpatient facilities and methadone clinics in Nebraska. The perspectives of other treatment providers may differ substantially from our available sample. Particularly for MAT, it is plausible that these services may be provided in facilities outside of the scope of this survey's sample.



### 5. Inpatient Versus Methadone Providers

Due to a difference in sample size, comparing 17 inpatient providers to 3 methadone providers may be misleading. There are only 4 methadone clinics in Nebraska, so for many of the questions the survey results represent 75% of methadone providers.



### 6. Provider Self-Report

The measurement instrument asked providers to reflect on their perceptions of their clients' experiences and behaviors. This is may be less valid than asking individual clients about their own experiences.



### 7. Aggregate Data

This survey asked providers to estimate the percentage of clients they see engaging in various drug use and treatment behaviors in aggregate form. This does not reflect an actual count of providers referring clients for MAT or clients engaging in a specific drug use behavior. From this survey, it is unknown at which rate clients actually engage in particular behaviors or access services such as MAT and prevention efforts. Similarly, when providers reported OUD beds, we do not know if those beds are actually filled by clients with OUD.



## Recommendations

1. Target prevention efforts to meet unique audiences.
  - a. Aim the prevention of alcohol, marijuana, and methamphetamine at youth, and incorporate parents and peers into these efforts.
  - b. Aim the prevention of opioids misuse at prescribers and the medical community, along with clients and family members of those being treated for chronic or acute pain with narcotics.
2. Revisit current methods of communicating with treatment providers about prevention efforts. Assess how these efforts relate to the realized needs of treatment providers and their clients.
3. Provide education to increase knowledge about MAT and to reduce stigma. Education should be aimed at prescribers, substance abuse treatment providers, clients and their families, and the general public.
4. Assist treatment providers with training on evidence-based practices, especially those related to the treatment of trauma and MAT.
5. Provide or coordinate funding for:
  - a. Treatment providers to increase workforce capacity, especially related to MAT, mental health care, and rural access.
  - b. Clients to pay for treatment, transportation to access treatment, and childcare to facilitate their participation in treatment.

# Treatment Provider Focus Groups





## Key Findings

Mental health professionals in medication-assisted treatment (MAT) facilities in Nebraska shared their experiences in providing treatment to individuals seeking treatment for substance abuse during three focus groups. They were also invited to express their current needs as well as the needs of their clients.

### Drug Initiation

According to focus group participants, their clients with OUD are typically first introduced to opioids by friends or family or through doctors' prescriptions. Most of their patients are also struggling with trauma, like sexual violence, which makes them particularly vulnerable toward opioid misuse.

### Education

Participants called for education on MAT targeting three distinct groups: professionals, clients and their families, and the general public.

#### Professionals:

- Education for medical professionals should focus on how methadone works. Many medical professionals seem to be engaging in an array of unethical prescribing practices, assumingly due to lack of knowledge.
- Some mental health professionals seem to need increased knowledge of MAT as a treatment option.
- Education for criminal justice professionals should focus on the range of substance use treatment options, especially those other than 12-stop programs and the use of MAT as a viable component of treatment. . According to participants, the criminal justice system does not seem intentional or invested in patients' recovery.

#### Clients and Their Families:

- Patients and their families could benefit from an increased understanding surrounding the length of treatment, and the role of medication as part of a holistic approach to treatment.

#### General Public:

- The public seems to have many misconceptions surrounding substance misuse. From the perspective of MAT providers, the public lacks knowledge surrounding the presence of opioid misuse in their communities and about addiction, treatment, and recovery.

### Ethical Prescribing

Focus group participants also described prescribing practices that have harmed their clients. They spoke of medical doctors pursuing MAT when they are not licensed to do so. While some medical professionals are over-prescribing pain medications, others are abruptly discontinuing long-term pain medications—both harmful practices, according to MAT providers.





## Key Findings (cont'd)

### Stigma

Treatment providers identified stigma regarding substance use disorders and MAT options as barriers to their clients' recovery. Too often, clients are viewed negatively by professionals and the general public due to their addiction struggles which is hard for providers to see when they work so hard to empower their clients.

### Financial Barriers

Many clients experience significant barriers to entering into treatment including the cost of treatment and the distance they must travel.

### Treatment Silos

Finally, focus group participants lamented the disconnect between educational requirements and treatment options for mental/behavioral health and substance use disorder. This results, they shared, in treatment silos which are detrimental to client recovery.



## Methodology

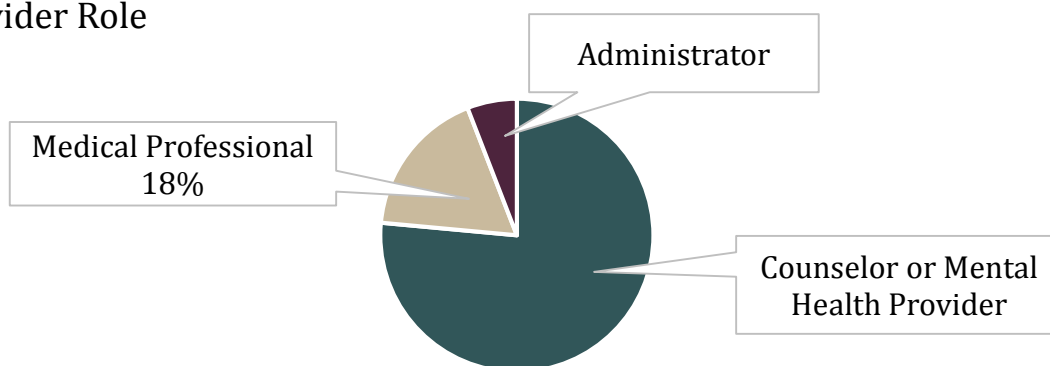
STEPs conducted three focus groups with treatment providers at medication-assisted treatment (MAT) facilities in Nebraska. The purpose of these focus groups was to explore the experiences of mental health professionals and to understand more about the supports they and their clients need. The intention was also to build relationships with professionals in the treatment community.

The focus groups followed an intentional format of questioning to gain insight into opioid treatment and substance misuse trends. Due to time constraints for the participants, the focus groups lasted an average of 90 minutes. (See consent and script in [Appendix D](#).)

## Sample Description

STEPs collected limited demographic information to respect confidentiality and encourage candid discussion. Most focus group participants indicated they were counselors or mental health practitioners with an average of 6 years' experience.

### Provider Role



## Data Analysis

STEPs utilized thematic analysis (Riessman, 2008) with *in vivo* coding (Saldana, 2016) to gain insight into participants' experiences, with a focus on story and lived experience. The emphasis in this form of coding is the participants' word choices. Since focus group participants represented a microculture of mental health providers, this form of coding highlighted their voices and stories and relied on them to give the data meaning (Saldana, 2016). STEP's coders included one graduate student staff and one Ph.D. project lead. Coders co-facilitated two focus groups, and the project lead completed one focus group.

STEPs coded all interviews separately and then the two coders met together to reach consensus on emerging themes for each focus group. Coders then compared across focus groups to derive overall themes from the transcripts. In this study, reflexivity is critical to provide trustworthiness to findings (Morrow, 2005). In coding separately and then comparing themes in this manner, STEP's was able to practice reflexivity and strengthen findings. Participant quotes played an integral role in deriving and presenting themes through their voice.



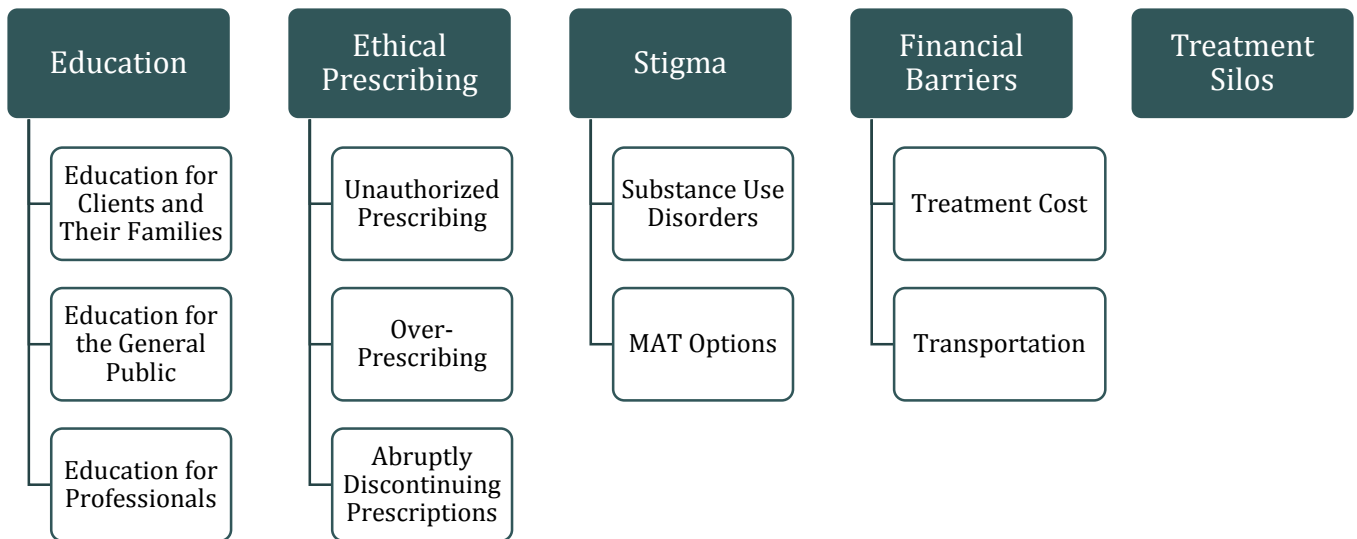
## Results

At the close of qualitative data analysis, several themes emerged concerning the barriers to recovery experienced by individuals seeking treatment for substance misuse and substance use disorders at Nebraska MAT facilities. Treatment providers identified specific barriers to recovery as:

1. **Education;**
2. **Ethical Prescribing;**
3. **Stigma;**
4. **Financial Barriers;** and
5. **Treatment Silos.**

Themes and subthemes discovered during analysis are shown in the figure and detailed below with supporting quotes from focus group participants.

### Focus Group Themes and Subthemes





## Education

Participants identified a need for education with three subthemes:

**Education for Clients and Their Families;**  
**Education for the General Public;** and  
**Education for Professionals.**

### Education for Clients and Their Families

STEPS asked participants what services their facilities provided. One common response was to provide information about recovery to clients and their families. Participants noted that many clients and their families believed that recovery could be achieved quickly. Many held their own beliefs and biases on the use of medication in recovery. The importance of a holistic approach to recovery, including psychoeducation for both the clients and their families, emerged in the focus groups.

*“The reason why the education piece is so critical here is because there is a lot of stigma. So, a lot of times, you’ll have pushback from family members: ‘Oh, you’re on that methadone.’ And so for us, to kind of help create a healthy environment for our patients, a lot of times it is bringing in their significant other, or their parent, or even sometimes their children to help them understand the process, and what the program is really about.”*

Participants shared that they often provide education to all involved in the client’s life. Through their holistic approach, they said they provide education on both physical and mental components.

*“We utilize methadone to help with people who are struggling with opioid addiction. If they do counseling, those who are qualified get approval for, like, couples counseling, if needed. We provide patient education. We provide education to the public, too, and the spouses, significant others, family members. We provide education, we provide drug screens, we provide blood work, physicals.”*

*“I’ve done sessions with the patient’s mom and the partner, and they said, ‘Oh, we’re here to understand what methadone is, how it affects them, how the aspects of treatment work.’ It’s not a quick fix. You can’t come and dose for a week and be done.”*

### Education for the General Public

STEPS asked participants to discuss their view on the education level regarding medication-assisted recovery (MAR). Focus group participants expressed a general lack of understanding of what is involved in MAR. Participants also noted a connection between the general public’s misconceptions of individuals who struggle with opioid addiction and the media’s portrayal of them. These misconceptions lead to their clients’ dehumanization and allow the general public to stay removed from the issue. Despite increasing media campaigns on opioid misuse in recent years, many Nebraskans hold onto the belief that it is not happening in our state.



## Education (cont'd)

*“It's amazing what you see, like heroin... the people that are dependent on heroin that come in here, because you don't really honestly realize that there is heroin out there. Yeah, there's quite a bit. There's a lot, and it's just, because we hide it so well here in Nebraska 'cause we're such a conservative state, it's kind of, I don't know... it's humbling when you come into a practice like this, and you see people off the streets and what they're struggling with and it's like, wow, I had no idea this was a serious issue up here.”*

STEPS found that there is a misunderstanding of how methadone treatment works. The providers spend a lot of time educating and reeducating on how the treatment process works.

*“It's not harmful to be on (methadone) for an extended period of time, so we would rather have someone be on this and be successful than feel pressured to have to get off of it... and then continue to fail.”*

*“Two to five years is how long it takes the brain to heal, so we recommend them to stay at the therapeutic dose, once they get to it, for at least 18 months before they start to decrease, because that gives them time to learn the coping skills. It gives their brain a chance to heal, and creates further stability in their lives, before they start adding another stressor of decreasing the methadone, and eventually getting off.”*

The providers' ability to fulfill multiple roles is also vital to the success of the client.

*“We are also kind of the go-between for the patients. Part of our role is the case management aspect of the patient... so we process through a lot of what that means to the patient, how they're doing on their (methadone) dose. If they're needing any kind of adjustments, then we pass the word on to the doctor, and he makes the adjustments as need be.”*

Providers expressed frustration with past prevention efforts and how the “Just Say No” approach is still a trend. A common theme was that providers' clients will use substances illicitly to cope with the trauma they have experienced. Prevention is not as easy as “just saying no”—providers were adamant about mental health being a factor.

*“All of us know that mental health and addiction go hand in hand, and, like, the whole DARE program when we were younger... It never talked about anything except what a drug is, and how it works on your body, and why not to do it... saying, 'Just say no,' doesn't really work if you have anxiety and depression, and you're trying to get rid of all of those other things. Going back to the mental health aspect, is huge. I think that's one of the ways to help, 'cause if you have a healthy person, a healthy person's not gonna want to escape with drugs.”*



## Education (cont'd)

### Education for Professionals

Participants struggled with the lack of education and awareness surrounding MAR in the medical community. They related how clients experienced doctors and nurses calling them “junkies” for using methadone in recovery, among other instances of verbal abuse. Participants were particularly passionate about the lack of understanding of MAR in the mental health community. Clinicians in Nebraska may not know that such treatment options exist in the state, and therefore cannot refer their clients to a potentially helpful treatment.

**Medical professionals** lack an understanding of how methadone works, often jeopardizing recovery by refusing to give needed medication to those seeking treatment at a hospital.

*“(Clinic) patients go to the ER for... I had one, had been injured at work, and he went to the ER, and they're like, ‘Well, you're on methadone, you don't need any painkillers.’”*

*“(Clinic patients) are like, ‘Well, I went to the ER, but I won't say I'm on methadone because the methadone isn't covering my pain. It's keeping me from misusing opiates, but then I won't get opiates if I tell them I'm on methadone.’”*

*“When we're talking to parole officers, when we're dealing with courts, when we're dealing with (a treatment center), trying to get people in to get off of other things, they are so uneducated when it comes to methadone and even suboxone or buprenorphine. Anything that we use to help people get off of opioids.”*

Additionally, many **mental health professionals** do not realize that MAT is a treatment option in Nebraska. Providers related how often Alcoholics Anonymous (AA) is considered the sole option for treatment.

*“(Alcoholics Anonymous, AA) was less effective. (AA's) 5-10% success rate in a year's time was equal to zero treatment at all, AA by itself. And so, I think we're... Times are changing but we're not going to remove (AA) from culture because it's been there for so long... I'm not against it, but it's not treatment, and it's not going to be a one size fits all. It's not going to work for everyone.”*

The providers gave many examples of how their interactions with suggested **criminal justice departments** had a frustrating lack of focus on recovery.

*“Sometimes probation officers mandate that people go to 12-step programs. And that's great for some people, but that's not... that doesn't work for everybody.”*

*“But it's not treatment, you know, 12-step recovery is not. Unless it's facilitation in addition to therapy.”*



## Education (cont'd)

Often, it seems the system sets up clients to fail when it orders those seeking treatment to complete tasks they do not have the resources for.

*"(Patients are) court ordered to go to treatment and sometimes they can't afford it to begin with. Sometimes the state helps. But then there's also the piece of the state—if you can't afford it, they don't pay for medication. They don't pay for mental health appointments or medication. And so you're left with some gaps, especially if you're working with someone who has been used to this dopamine overload in their brain or whatever else, from the meth or whatever else drug they've been using, and now you're just pulling them off of it."*

The providers struggled with how the criminal justice system did not seem intentional or invested in clients' recovery.

*"(Patients) don't need to be held captive. They need long-term recovery."*

*"When people go to jail, whether on work release or whatever else, there is... It depends on the medication, sometimes there is just a lapse... There are other medications they just flat won't allow inmates to take. And sometimes that's the very thing that's helped them stay clean and sober, and to be able to survive or do well... It makes me question what the expectation really is. To make them pay? Well how... What are we doing to them and to our culture and our society, our community in the long run, by just yanking them off of those things, and expecting them to just tough it out? I think that's insane."*

*"I just got into an argument with (staff at jail) for like... 'This person can bring in their benzos (to jail), but they can't bring in their methadone.' 'Well explain to me why they can have their benzos but not their methadone?' 'Well we just don't do that there.' 'Okay, well this person's gonna have their dose. If you medically feel that you can trump my doctor, please write me a letter stating that you're gonna take care of 'em and you think this is the best for him and whatever outcome.' So finally, they're like, 'Just have them bring it' and they got it."*

## Ethical Prescribing

Participants indicated clients have issues with prescribing practices at their treatment facilities. These issues included:

**Unauthorized Prescribing of Medications for Opioid Use Treatment;**  
**Over-Prescribing Pain Medication;** and  
**Abruptly Discontinuing Long-Term Opioid Prescriptions** without providing treatment or referrals.



## Ethical Prescribing (cont'd)

### Unauthorized Prescribing of Medications for Opioid Use Treatment

According to participants, medical doctors are pursuing MAT when they are not licensed to do so. This problematically continues the stigma and legitimate MAT clinics are dealing with the aftermath.

*“(Patients) need to be in a medication-assisted treatment facility. Now, methadone is prescribed for pain, but when you're treating opioid addiction, it needs to be in a setting like this.”*

*“There are physicians that are prescribing methadone for patients when they're not supposed to. You have to be a buprenorphine provider to prescribe methadone for anyone. So, we've... a couple times ran into doctors that are writing methadone scripts anyhow and then, I mean, then you have the DEA go in and they're closing down the clinics.”*

### Over-Prescribing Pain Medication

Unethical prescribing was a recurring concern in the focus groups, and several providers shared how these practices have harmed clients. According to participants, doctors are part of the reason people are struggling with addiction to opioids.

*“That's the commonality... The doctors prescribing all thism and then before they know it, these guys can't stop. 'I couldn't stop on my own,' 'I ran out before I was supposed to.' That's a big commonality.”*

*“I had one client who ended up actually OD-ing. She had been put on opioids at age 11 for some problems with cramps and just terrible pain. And so the doctor put her on opioids for that and they refused, no matter how much she begged throughout her years, to have a hysterectomy... they said, 'You're too young, we won't don't that.' But they did some other things for her. But then she escalated into stealing a prescription pad.”*

*“I had a client come in the other day... And she had done karate and broke her toe, her little toe. Went to the emergency room and because she was urged to do so, not because she necessarily felt that she was in so much pain, so they did what they needed to do, double wrapped her toe to the next one, blah blah blah. And then (the physician) writes her a prescription for 10 Hydrocodone or something like that. And she said, 'I don't need these.' He said, 'Well just don't fill it then.' But he gave her the prescription. It's crazy. It's BS.”*

*“But I would say, the ones who've strictly used the opiates are the ones that got addicted to it because of the doctor. Some didn't even start their addiction 'til they're in their 30s.”*





## Ethical Prescribing (cont'd)

Providers are now seeing how it has become common practice for doctors to prescribe anxiety medication without a thorough assessment of awareness of the danger, leading to a trend in this type of opioid addiction.

*"I'd say another big trend that I've noticed within the last year is benzos, benzos and opioids combined, we are seeing a ridiculous amount of people who are getting prescribed benzos."*

*"Of the 300 (patients), I think 140 of them had benzos in them (drug screens). And out of the 140, only 10 of them were illicit. And that was a huge jump from the prior year, and so I may... I know our patients are getting benzo scripts, or at least coming in with benzo scripts more often than previously."*

*"(Clinic patients can) easily say, 'These are the symptoms I'm having,' and, 'It's not being controlled by non-medical means,' or whatever, and most doctors are kind of like, 'Okay, whatever, here's a benzo script,' not knowing that they're also taking methadone, or street drugs."*

## Abruptly Discontinuing Long-Term Opioid Prescriptions

According to many providers, doctors are abruptly stopping long-term prescriptions which leaves clients to deal with withdrawal and recovery without proper support. Providers consider this sudden discontinuation of medication unethical. In the mental health field, providers have to follow certain procedures to properly discharge a client from therapy, and participants wondered why doctors are not held to the same standard.

*"Well, I think it's great that they're having doctors cut people off from their opiates, but they're not providing them with treatment."*

*"I have a patient that was prescribed two different opiates for 12 years and then one day they (the prescribing doctor) just decided they were done. You were cut off, you were kicked out, no more, and ended up here."*

*"I'd say a lot of it was when restrictions came too. The doctors started cutting people off. They were first going out onto the streets before coming into treatment."*

*"Or (new patients will) come in 'cause every so often the state patrol monitors, and so if they eventually go into a practice and say, 'Well, okay, you've been prescribing this medication for this individual for X amount of years and why,' so they may get scared and then it's like 'Uh oh, no more. This is your last script.' So, they're just left hanging."*



## Ethical Prescribing (cont'd)

*“And the doctors do make them feel like second rate, like they're a loser, and they may have legitimately had a health issue, chronic, you know, they talk about back pain has a huge, huge effect on people, and you can't get away, it's very hard to treat it. And so, they're chronically dealing with this pain. Well, if you have somebody who's chronically in pain, all they want to do is escape that. And so, then they get in this cycle, where it's over and over, and how are they... Where are they supposed to go now that they don't have any pain medicine?”*

## Stigma

Treatment providers identified stigma as a barrier to recovery, specifically related to:

**Substance Use Disorders;** and  
**MAT Options.**

### Substance Use Disorders

Patients are often viewed negatively due to their addiction struggles. This is frustrating for providers, who view people as more than their addiction. The providers see the side of clients that is often covered by the stigmas of addiction.

*“I would say, again, people are not bad, their behaviors can be unhealthy. So keep in mind that that's a person—no matter what they're struggling with, whether it's opiate addiction, meth, whatever it may be... and not dehumanizing it.”*

*“They are a person. They have a mother, they have a father, they have a life to live, too, that could be a healthy, fun, active life.”*

Participants from one MAT facility spoke very passionately spoke of the level of commitment they have to their clients and how they work to empower them.

*“We just show that we care and they're human beings and if they need something, we're gonna help them. We'll go above and beyond if need be and it just shows that it gives them value as a human being. Other places that they've dealt with treat them (that) way, that they're beneath their feet. And to get treatment from somebody that gets to their level and respects them on that level as a human being, you tend to see them really fight for it and push for it. If you fight for them, then they learn to fight for themselves.”*

Their wishes included finding ways for DHHS to address stigma.

*“I think they (DHHS) should lessen the stigma 'cause everybody has that judgment factor that they don't know much about addiction so with that stigma comes along.”*



## Stigma (cont'd)

Another area of concern was the lack of resources for individuals trying to seek treatment or to detox in a safe way. Often there is a lack of space for clients, and the MAT providers are left to pick up the pieces of an overdose, or see their clients with no place to detox use again.

*"(A local detox center) will not take anyone detoxing off of opiates. They are our biggest detox center, and they will not take anyone for detoxing from heroin, methadone, or anything."*

*"(Referring clients to treatment) is a little more difficult just because with methadone... not all the treatment facilities wanna deal with people on methadone."*

## MAT Options

The providers indicated inconsistencies and stigma within their own practices. They also acknowledged stigma in the mental health community regarding what they actually do for clients.

*"We're a methadone clinic, but there's this branding of Suboxone, and there can be misunderstandings about what each one of them can do, how each one of them work... I sure hear an awful lot of Suboxone commercials. I don't ever hear anything about methadone. Then I get that, part of it is the stigma, and I think that that. If we don't... if we close the door on one avenue that may, Suboxone may not work for somebody, and this may be the key, that if they didn't have that opportunity, or if they weren't aware of that opportunity, we just left somebody out there to dry."*

*"There are still substance abuse therapists and staff I know that just say, 'Oh no, you're just cross-addicting. You're just using a substance to cure a substance, and that's just not okay.' And I would, I would beg to differ. Yeah, that's just, that's ridiculous."*

A particular area of concern for providers was the stigma against pregnant women utilizing MAT. According to providers, these women are treated in an unethical way which has an impact on their mental health.

*"(A pregnant client) went in and (nurses) found out that she was on methadone because of an addiction that she's trying to take care of that was produced by a doctor, okay. She was treated like crap. She was in tears. She even came back and on her paperwork, it said, 'methadone dependent' and it's like that's not what it is, honey, because they're miseducated."*

*"They immediately, you know, they (nurses) have to treat the babies if they're having withdrawals, and so, then the nurses' kind of, 'Oh, you're just a junkie... They're not because she's in recovery, and that's what she should say, 'I'm not, I'm in recovery.'"*



## Stigma (cont'd)

An experienced provider stated that they have seen a shift in how methadone is perceived in different settings. Their observation was that methadone stigma has been increasing.

*"(In) the late 60s, early 70s, the jails allowed you to bring methadone in. You can take it down there. They would come pick it up or they would bring the patient. And then as time evolved, they got new personnel in, and they had a different view of what methadone was and it was all of a sudden... it's like nope, you can't do it anymore. I mean... and they (jails) did it for years, they allowed them to do that with no problem. They got new personnel in with different views and ideas and stigma about methadone, and we even had one nurse say, 'Well we don't give alcohol to alcoholics.'"*

## Financial Barriers

Focus group participants expressed frustration with how policy changes regarding treatment funding have impeded recovery success for clients, and related significant financial barriers that their clients face when seeking recovery:

**Treatment Cost;** and  
**Transportation.**

### Treatment Cost

Providers repeatedly talked about treatment cost as a barrier, and changes in policy and funding is concerning for MAT providers.

*"Again, back to the late 60s, 70s, and all that, when methadone first came to Nebraska, when the first methadone clinic was opened, the government gave grants and paid for the methadone because people could not afford it. It had a big impact to stop people from, the crime rate went down, homelessness went down. They (patients) got it free. As the years evolved, all that was taken away. They cut this, they cut that, and pretty soon it was not available anymore, but we still had all those people that were out there addicted and needed the help."*

*"You think about the person that is struggling with addiction or substance abuse. If they have insurance, great. But the majority of them, they can't afford insurance. They are your average Joe. Or their insurance doesn't cover that type of stuff. So, the funding to help them get their life back together isn't fair and that's such a disservice, and it's just disgusting, sorry. I keep on saying that, but it's disgusting. It's gross."*

Providers were adamant that DHHS hear the stories of the people impacted by insufficient resources to help with drug addiction in our state. They find it very disheartening for clients to be unable to utilize resources that would aid in their recovery.



## Financial Barriers (cont'd)

*"And that's where I see a big lapse as far as helping people in their recovery progress. There's not enough options for people that don't have the coverage... not enough beds out there for inpatients. You have people on waitlists for three months, and you have to literally be homeless, suicidal, IV user, in order to get a bed right away."*

*"What's really frustrating about the Nebraska system and why I think it's so broke, is because we are cutting back on the mental health issues and that's the stuff that needs to be addressed. I mean there's so many people that need help and that goes beyond just substance abuse. That is just really frustrating on our behalf because we try so hard for these guys. We try and it's just shut door after shut door after shut door."*

*"I've got a patient right now who's been trying to get into treatment for more than two months, and Saturday she overdosed."*

*"A lot of people don't have the money for the fees and stuff, and Nebraska doesn't pay for treatment for adults for drug treatment. There needs to be monies available to help these people when they do come in for treatment that can assist them with the fees, with the housing, medical stuff, and it's just not there."*

Methadone clinic costs are also a deterrent for recovery success. Providers gave several examples of how they have seen this play out with their clients.

*"One of the biggest things is, is it's patients being able to afford (methadone treatment) ongoing. We have patients come in here, and they'll have enough to get the program started, and then, nothing. They can't afford the cost of it. And so we find with the insurance providers, that sometimes be a little bit difficult to work with, or to get reimbursement for that. The money is probably one of the biggest deterrents, or complications for patients to be able to be successful in treatment."*

*"(Clinic patients) can be on the program for two months. They're doing really well, then they run out of money, and then they just stop coming. And it's sad for us to see because they were doing so well, and the only reason they quit was because of money."*

*"We had an admit today who wanted to come last week, but she didn't have the money, and then she came today, but she doesn't have a job, so we have no idea how she's gonna continue with the program."*

*"Family members always volunteer to help, but most of them stop after a couple months because they're tired of forking over \$400 a month (for methadone medication) for them to be well."*



## Financial Barriers (cont'd)

### Transportation

Clients' ability, or lack thereof, to get to the clinic was another frequent theme. The large amount of time and resources, including a car and gas money, are significant barriers to recovery. The lack of MAT clinics in rural Nebraska requires clients to drive.

*"(Methadone clients) are all over. I have one that drives from South Dakota."*

Even if clients have Medicaid, coverage for a ride to treatment is not guaranteed. Providers stated provisions for transportation depends on their worker.

*"We have a few (clients) that have Medicaid, for example, and I guess we're not Medicaid-billable, but they won't transfer them to any methadone clinic, so they get stuck without medication. They can be transported to a grocery store, but they can't be transported to treatment."*

Providers also related how applying for a federal exemption delays the treatment process, and often has the client waiting for a long time to get the medication they need.

*"(Methadone clients come from) Kansas, Grand Island, Hastings. And they make that trip daily, until we can get them a federal exemption. In order to get a federal exemption, you have to have two, at least two drug screens in a row. With the new ways, we write an order, or I write an order up on the computer in the federal website, and there's no identifying information, it's just their admit date, what they need the exemption for, what their UAs look like. And then it's either denied or approved. Usually if it's a travel exemption, they'll approve it. But in order for them to get those two clean UAs, it can take a while, especially if their dose isn't therapeutic, and they're still abusing street drugs, they can be taking that hour and a half journey every day for two months."*

### Treatment Silos

When STEPs asked participants about training on substance abuse treatment, many shared about their degree program course requirements. They spoke about a disconnect between mental/behavioral health and substance use disorder educational requirements for licensure or certification. According to participants, this disconnect leads to treatment silos which are detrimental to client recovery. Providers are seeking connections within the disciplines to reveal addiction's root cause, and hope this clarity will lead to a more comprehensive treatment plan that is more collaborative in application.

*"Everything's so siloed in our field."*



## Financial Barriers (cont'd)

*“(In the providers degree program,) we had pharmacology, biological bases of behavior, but I don't think we had a specific chemical dependency course, which is a problem. I think things are too separated. ‘Well that's chemical dependency over here, and this is mental health over here.’ Well wait a minute, like, when do you see chemical dependency without trauma? I don't see it without trauma. I don't think I've ever seen it without trauma.”*

Providers are treating the whole person, not just the addiction. This is paramount to successful treatment.

*“Our (methadone treatment facility's) main focus is on the opioid addiction. However, in order for patients to be successful, all aspects of life have to be taken into consideration. We focus on more than simply just the addiction itself. We focus on the relationships that they have with others, or their finances, or their employment, or their mental health.”*

*“I think educating (the public) on what it means to have anxiety, and what it actually is, is huge, and various aspects, in regards to getting prescribed medications, coping skills, educating yourself and your family members.”*

## Additional Messages from Providers

While many of the providers' perspectives have already been covered, several additional items worthy of reporting emerged.

Providers expressed enthusiasm in sharing stories with STEPs. They also appreciated DHHS's genuine interest in their work and are glad DHHS wants to hear their voices, yet remain apprehensive that it will have an impact.

In narratives of how their clients first misused a substance, providers said their clients are either introduced to opioids by friends or family or through doctors' prescriptions. There was a connection in the data between the theme of mental health and interpersonal struggles to the stories of how clients first misused a substance.

*“I would say at least 50% have started with prescriptions, taking prescriptions from the doctor, and getting hooked that way.”*

Additionally, all the providers talked about trauma being a part of most their clients' lived experiences. One clinic specifically related that all their clients, both male and female, reported sexual assault as a part of their history. This is important when looking at trends in the opioid crisis because providers thought the media have made the crisis out to be something different than it is. In looking at prevention efforts, trauma must be a major part of the conversation.



## Additional Messages from Providers (cont'd)

One clinic gave this demographic report:

*“90% of our people are Caucasian. The majority of the people in age are between the age of 35 and 44, and then our second highest one, at 23%, are the 25 to 34-year-olds. And currently, we have 14 patients over the age of 60. Most of them, we have 16% of our patients are disabled, and 69% of them are employed.”*

Providers also wanted DHHS to limit the amount of resources and energy the department focuses on prevention instead of treatment. Providers were very committed to their current clients and wanted them to have a say in how DHHS moves forward. They did not believe it was too late for their clients to achieve successful recovery, and were weary of how many systems in Nebraska dehumanized individuals who struggle with addiction.

*“They're not thinking or considering all the people already addicted to opiates, the ones that got cut off from their doctor, the ones that are out on the streets using heroin 'cause they don't have the money to come here, they don't have the resources, or they don't know that we exist.”*

The providers wanted the opportunity to share an accurate view of their treatment approach and how holistic it is, and encouraged DHHS to visit MAT clinics to speak directly with treatment providers. As one provider said:

*“It needs to be an all-encompassing scope because it is an all-encompassing problem. Like, one thing isn't gonna fix it.”*





## Limitations

1. While qualitative research is conducive to small sample sizes, more focus groups might have revealed themes not yet discovered in this analysis.
2. Focus groups were conducted in treatment programs in two of the larger cities in Nebraska and do not necessarily represent most treatment providers in Nebraska.
3. Focus groups were conducted only in medication-assisted treatment programs and do not represent the views of inpatient or other outpatient programs.
4. Time constraints on the length of focus groups may have limited participants from offering a full exploration of the topics.
5. STEPs was unable to conduct a focus group with one key treatment provider despite several efforts to schedule one.
6. The risk of bias is involved in all qualitative research. STEPs utilized two coders to limit bias in the coding of the data.



## Recommendations

In light of the qualitative analysis of focus group responses from treatment providers, STEPs makes the following recommendations:

1. Create a pathway for increased communication and coordination between DHHS and treatment providers, as well as between mental health providers and the continuum of substance abuse treatment providers, ensuring seamless and holistic treatment to individuals seeking recovery.
2. Reduce stigma for individuals who have misused, or are misusing substances.
  - a. Provide psychoeducation on MAT (MAR) to clients and their families, the general public, and professionals. Education for professionals is critical in healthcare, mental health, and criminal justice settings.
  - b. Be diligent about using language that aids in reducing stigma (i.e. “Medication Assisted Recovery” rather than “Medication Assisted Treatment”), and communicate with treatment providers about this language.
3. Increase access to treatment options, including MAT (MAR), inpatient and outpatient programs, detox, and trauma-informed mental health care. Reduce financial barriers to these services, specifically related to healthcare coverage and transportation.
4. Promote ethical prescribing practices among medical professionals, including unauthorized prescribing, over-prescribing, and abruptly discontinuing prescriptions for those who have been on long-term opioid pain medication.

**In addition, focus group participants invited DHHS to their programs to hear directly from them about their experiences in providing treatment and other care to individuals affected by substance misuse.**



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# Appendices





## TEDS: Additional Findings

### Age at First Use of Primary Substance

2017	U.S. Admissions	Nebraska Admissions
11 years old and younger	5%	9% (1,124)
12-14 years old	18%	23% (2,938)
15-17 years old	26%	34% (4,347)
18-20 years old	19%	18% (2,238)
21-24 years old	12%	9% (1,107)
25-29 years old	9%	5% (492)
30 years and older	11%	3% (555)
	100%	101%

### Treatment Facility Type

Admitting Facility	U.S. Data	Nebraska Data
<b>Ambulatory</b>	62%	47% (6,334)
Outpatient	48%	40% (5,416)
Intensive outpatient	13%	6% (825)
Detoxification	1%	1% (93)
<b>Rehabilitation/residential</b>	18%	15%
Short-term (<31 days)	9%	10% (1,278)
Long-term (31+days)	8%	5% (705)
Hospital (non-detox)	0.4%	-
<b>Detoxification (24-hour service)</b>	20%	38% (5,150)
Free standing residential	16%	38% (51,50)
Hospital	4%	-


**TEDS: Additional Findings (cont'd)**
**Length of Stay at Discharge**

<b>2017</b>	<b>U.S. Admissions</b>	<b>Nebraska Admissions</b>
1 day	11%	27%
2-10 days	23%	19%
11-20 days	8%	5%
21-30 days	8%	7%
31-45 days	7%	10%
46-60 days	5%	6%
61-90 days	9%	7%
91-120 days	7%	5%
121-180 days	8%	6%
181-365 days	9%	6%
>365 days	5%	3%
	100%	100%

**Service Setting at Discharge**

<b>2017</b>	<b>U.S. Admissions</b>	<b>Nebraska Admissions</b>
Ambulatory, detoxification	12%	1%
Ambulatory, non-intensive outpatient	39%	44%
Ambulatory, intensive outpatient	13%	7%
Rehab/residential, long term (more than 30 days)	9%	6%
Rehab/residential, short term (30 days or fewer)	9%	12%
Detox, 24-hour, free standing residential	18%	30%
	100%	100%



## TEDS: Additional Findings (cont'd)

What additional resources do your clients need? (select up to 5)

Response options identified by at least three providers:

- Condom distribution
- Facilities that accommodate women with dependent children
- Funding for rural area
- Education about MAT
- Naloxone kits
- Information on how to access treatment

The full list of response options can be found in the Appendices ([link to appendices](#)).

What are the most common reasons people do NOT receive treatment? (select all that apply)

Response Options:

- No health care coverage and cannot afford cost
- No transportation/too far away
- Takes too long to access treatment
- There are no openings in the programs
- Family members/others are unsupportive
- Fear of having children removed from the home
- Misconceptions or stigma surrounding treatment
- Do not want others know they need treatment
- Do not know how to access treatment
- Do not want treatment; lack motivation
- They are not ready to stop using
- They are too stubborn/prideful to go
- They do not think they need treatment
- They do not think treatment will help
- Hours inconvenient
- Too embarrassed, ashamed
- Stopped using, treatment not indicated
- Other problems to deal with
- Conflict of interest



## Appendix B: Treatment Provider Survey

*\*Note: Brand name pharmaceuticals were used in the survey to increase recognition of pharmacotherapies by treatment providers. This in no way reflects support or endorsement by DHHS or STEPs of any particular company, medication, or therapeutic intervention.*

Thank you for taking part in this important survey to gauge drug-use behaviors, treatment needs, and prevention efforts through the lens of treatment providers across Nebraska.

This survey is part of a statewide needs assessment by the Nebraska Department of Health and Human Services' (DHHS) Division of Public Health to focus prevention efforts, provide training and other resources to treatment centers, prepare for a more in-depth study in the near future, and inform the statewide crisis response plan.

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 by DHHS to allocate grant funds, resources, and develop crisis response plans.

We expect this survey to take 10-12 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.

### Program Information

We would like to know about your program and/or facility, and the services that your program offers.

1. What is your role within your facility?

*We understand that you may be involved in more than one role at your organization. If you are involved in multiple roles please indicate which role you consider as your primary role.*

- Treatment Therapist/Counselor
- Community Outreach Liaison
- Program Director/Administrator/Manager
- Clinical Director
- Director of Nursing
- Volunteer
- Other (please specify): \_\_\_\_\_





2. Which of these best describes your program? (Select only one)

- Residential short-term treatment (similar to ASAM Level III.5, clinically managed high-intensity residential treatment, typically 30 days or less)
- Residential long-term treatment (similar to ASAM Levels III.3 and III.1, clinically managed medium- or low-intensity residential treatment, typically more than 30 days)
- Outpatient methadone/buprenorphine maintenance or naltrexone treatment
- Outpatient day treatment or partial hospitalization (similar to ASAM Level II.5, 20 or more hours per week)
- Intensive outpatient treatment (similar to ASAM Level II.1, 9 or more hours per week)
- Regular outpatient treatment (similar to ASAM Level I, outpatient treatment, non-intensive)

For all of the remaining questions, please answer thinking about the specific program indicated above (even if your organization has multiple programs, or you work in multiple programs).

3. Which of the following pharmacotherapies does your program either prescribe on site, or refer out for a prescription?

Prescribe, Refer, Neither			
	Prescribe on site	Refer out for prescription	Our program does NOT prescribe or refer for this medication
Disulfiram (Antabuse®)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Naltrexone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acamprosate (Campral®)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medications for psychiatric disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methadone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Buprenorphine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. How many beds or spots do you have dedicated to individuals with opioid use disorder? (Drop down with numbers, and option for comments)



5. In which county is your program located?  
(Listing of all counties, can select multiple)

6. In which counties do your clients typically reside?  
(Listing of all counties, can select multiple)

For this section, we are interested in hearing your perceptions of substance use trends. We are examining the most common and most recent trends in substance use among the clients you serve, as we recognize these may be different from national trends.

7. Thinking about clients served in your program over the past year, approximately what percentage of these clients have presented needing treatment for the misuse of:  
*Misuse refers to any use of the substance other than that which is intended. The substance need not be their primary drug of choice.*

(Choose % for each on a slider)

- Alcohol
- Prescription Pain Relievers (i.e. hydrocodone, oxycodone, Demerol®, Percocet®, Vicodin®, etc.)
- Heroin
- Fentanyl (Duragesic®, Abstral®, Ionsys®, Subsys®)(including prescription or illicit)
- Methamphetamines
- Benzodiazepines (i.e. Valium®, Xanax®, etc.)
- Antidepressants (i.e. Wellbutrin®, etc.)
- Marijuana
- Hallucinogens (i.e. LSD, PCP)
- Inhalants
- Cocaine/Crack
- Other (please specify) \_\_\_\_\_

8. Thinking about clients served in your program over the past year, approximately what percentage of these clients were considered IV drug users?  
(Choose % on a slider)

9. Thinking about clients served in your program over the past year, what have been their most common primary drugs of choice? (Select all that apply)

- Prescription Pain Relievers (i.e. hydrocodone, oxycodone, Demerol®, Percocet®, Vicodin®, etc.)
- Heroin
- Fentanyl (Duragesic®, Abstral®, Ionsys®, Subsys®)
- Methamphetamines
- Benzodiazepines (i.e. Valium®, Xanax®, etc.)



9. Thinking about clients served in your program over the past year, what have been their most common primary drugs of choice? (Select all that apply)

- Antidepressants (i.e. Wellbutrin®, etc.)
- Marijuana
- Alcohol
- Hallucinogens (i.e. LSD, PCP)
- Inhalants
- Cocaine/Crack
- Other (please specify) \_\_\_\_\_

10. What percentage of your clients have an opioid use disorder (prescription pain relievers, fentanyl, heroin)?

(Choose % on a slider)

11. In the past year, what percentage of clients in your program were polysubstance dependent?

*Polysubstance dependence refers to a type of substance dependence disorder in which an individual uses at least three different classes of substances indiscriminately and does not have a favorite drug that qualifies for dependence on its own. (Encyclopedia of Mental Disorders, 2019).*

(Choose % on a slider)

12. We would like to know about trends you are seeing in the use of multiple substances. For each of the primary substances listed below, please indicate the drug or drugs that you commonly see paired with each substance.

(open ended box after each option)

- Alcohol
- Prescription Pain Relievers (i.e. hydrocodone, oxycodone, Demerol®, Percocet®, Vicodin®, etc.)
- Heroin
- Fentanyl (Duragesic®, Abstral®, Ionsys®, Subsys®)
- Methamphetamines
- Benzodiazepines (i.e. Valium®, Xanax®, etc.)
- Antidepressants (i.e. Wellbutrin®, etc.)
- Marijuana
- Hallucinogens (i.e. LSD, PCP)
- Inhalants
- Cocaine/Crack
- Other (please specify) \_\_\_\_\_



### Drug-Use Initiation

For this section, we would like to hear your perceptions about your clients' experiences of initiation to drug use. For the purposes of this survey, "drug-use initiation" is defined as the first *misuse* of a substance. For example, the first time binge drinking, rather than the first time tasting alcohol.

13. What is your perception of the most common substance that is first misused by your clients? For example, choosing alcohol would convey that most clients first began their misuse of substances by using alcohol, regardless of the current substances they misuse.

- Prescription Pain Relievers
- Heroin
- Fentanyl
- Methamphetamines
- Benzodiazepines
- Antidepressants
- Alcohol
- Marijuana
- Other (please specify) \_\_\_\_\_

14. What age do most clients served in your program report as their first misuse?

- 14 years or younger
- 15-18 years old
- 19 years or older

15. In your opinion, what are the most common reasons for clients' first substance misuse?  
(Check all that apply)

- Pain relief
- Relax or relieve tension
- Experiment/see what it's like
- Feel good/get high
- Help with sleep
- Help be alert or stay awake
- Help study
- Help concentrate
- Help with feelings or emotions
- Help lose weight
- Parents or other family members encouraged them to
- Peers encouraged them to
- Unknown
- Some other reason (please provide reason) \_\_\_\_\_



### Treatment Barriers and Facilitators

For this section, we would like to hear your perceptions about your clients' treatment experiences. We are interested to hear about what motivates clients to enter treatment (facilitators) and what prevents them from seeking treatment (barriers).

16. Where did clients most commonly get the substance they first misused?
- Got from a doctor
  - Stole from Dr office, clinic, hospital, or pharmacy
  - Got from friend or relative for free
  - Bought from friend or relative
  - Took from friend or relative without asking
  - Bought from drug dealer or other stranger
  - Got some other way (please provide source) \_\_\_\_\_
17. What are the most common reasons people do NOT receive treatment?
- No health care coverage and cannot afford cost
  - No transportation/too far away
  - Hours inconvenient
  - They are not ready to stop using
  - There are no openings in the programs
  - They do not think they need treatment
  - They do not think treatment will help
  - They do not want others to find out they need treatment
  - Too embarrassed, ashamed, afraid/do not want to ask
  - Do not want treatment; lack motivation
  - Stopped using, treatment not indicated
  - Other problems to deal with (emotional, family, etc.)
  - They are too stubborn/prideful to go
  - Family members/others are unsupportive
  - Conflict of interest
  - Do not know how to access treatment; do not know where to start
  - Takes too long to access treatment; window of motivation closes before program has an opening
  - Misconceptions or stigma surrounding treatment
  - Fear of having children removed from the home
  - Other (please specify) \_\_\_\_\_



18. Which of these statements best describes how your clients were prompted to get treatment?

- They decided on their own to get treatment
- They got treatment because someone else thought they should
- They were ordered to get treatment
- Injury or near-death experience
- Overdose, or witnessing an overdose
- Other health issue
- Other (please specify) \_\_\_\_\_

### Prevention Efforts

For this section, we would like to hear your experiences and ideas related to current and future prevention efforts. We would also like to know what needs your program has, and what needs your clients have, that DHHS may be able to fill in the future.

Below is a list and description of prevention efforts DHHS is currently involved with. Please rate your degree of knowledge about the program, and the degree to which you find the program helpful. We would also like to know the degree to which you have utilized the information and resources provided by these programs and initiatives for yourself or for your clients. Please also indicate any comments or feedback you may have about any of these initiatives.

#### **OpiRescue Phone application**

A FREE phone application designed to walk individuals through what to do in the event that they witness an overdose, provide resources to anyone on treatment, recovery, and where to get naloxone. Information at: <https://opirescue.com/> [Download through the Google Play Store or the Apple App Store.](#)

I have no knowledge of this initiative	I have heard of the initiative, but don't know much about it	I have some knowledge of the initiative and its activities.	I am well informed about the initiative
We have never referred clients to this resource in our program.	We have occasionally referred clients to this resource in our program.	We sometimes refer clients to this resource in our program.	We refer clients to this resource regularly in our program.
Not helpful	Somewhat helpful	Very helpful	Unsure



<b>Funding for Buprenorphine</b>			
Provides funding for medication and associated costs for clients with Opioid Use Disorder. Information at: <a href="http://dhhs.ne.gov/Pages/State-Opioid-Response.aspx">http://dhhs.ne.gov/Pages/State-Opioid-Response.aspx</a>			
I have no knowledge of this initiative	I have heard of the initiative, but don't know much about it	I have some knowledge of the initiative and its activities.	I am well informed about the initiative
We have never referred clients to this resource in our program.	We have occasionally referred clients to this resource in our program.	We sometimes refer clients to this resource in our program.	We refer clients to this resource regularly in our program.
Not helpful	Somewhat helpful	Very helpful	Unsure

<b>Increase Medication Assisted Treatment (MAT) workforce capacity</b>			
Provides education and support for DATA waiver certification of providers. Information at: <a href="http://dhhs.ne.gov/Pages/State-Opioid-Response.aspx">http://dhhs.ne.gov/Pages/State-Opioid-Response.aspx</a>			
I have no knowledge of this initiative	I have heard of the initiative, but don't know much about it	I have some knowledge of the initiative and its activities.	I am well informed about the initiative
We have never utilized this resource in our program.	We have occasionally utilized this resource in our program.	We sometimes utilize this resource in our program.	We utilize this resource Regularly in our program.
Not helpful	Somewhat helpful	Very helpful	Unsure

<b>Naloxone Distribution</b>			
Distributes naloxone (Narcan®) to individuals at high risk of overdose through providers, law enforcement, first responders, and EMS. Information at: <a href="http://dhhs.ne.gov/Pages/State-Opioid-Response.aspx">http://dhhs.ne.gov/Pages/State-Opioid-Response.aspx</a>			
I have no knowledge of this initiative	I have heard of the initiative, but don't know much about it	I have some knowledge of the initiative and its activities.	I am well informed about the initiative
We have never utilized this resource in our program.	We have occasionally utilized this resource in our program.	We sometimes utilize this resource in our program.	We utilize this resource Regularly in our program.
Not helpful	Somewhat helpful	Very helpful	Unsure



22. In your opinion, what prevention efforts are most helpful? (Select up to 3 in each category)

<b>Primary Prevention</b> (Targeted at non-users and general public)	
Prescriber education	<input type="checkbox"/>
PSA and media campaigns for general public	<input type="checkbox"/>
Public education about medication assisted treatment (MAT)	<input type="checkbox"/>
School-based substance use prevention programs—ELEMENTARY STUDENTS	<input type="checkbox"/>
School-based substance use prevention programs—MIDDLE SCHOOL STUDENTS	<input type="checkbox"/>
School-based substance use prevention programs—HIGH SCHOOL STUDENTS	<input type="checkbox"/>
<b>Secondary Prevention</b> (targeted at early use, before serious complications)	
Addiction screening for those presenting for early refills (to refer for treatment and services)	<input type="checkbox"/>
Use of Prescription Drug Management Program before prescribing controlled substances	<input type="checkbox"/>
Addiction screening at primary care facilities (similar to ways in which they might screen for mental health)	<input type="checkbox"/>
<b>Tertiary Prevention</b> (rehabilitation strategies after addiction is established, targeted at heavy users)	
Methadone treatment	<input type="checkbox"/>
Naltrexone treatment	<input type="checkbox"/>
Buprenorphine treatment	<input type="checkbox"/>
Mandatory counseling and services with buprenorphine or naltrexone administration (similar to methadone requirements)	<input type="checkbox"/>
Increased access to 12-step programs	<input type="checkbox"/>
Increased access to mental health treatment	<input type="checkbox"/>
Increased access to and training on naloxone	<input type="checkbox"/>
Education about safe injection practices (i.e. how to clean needles, how to use a “taster shot”)	<input type="checkbox"/>





23. Based on your experience, what populations are in need of additional substance abuse prevention efforts? (Select up to 5)

- Older adults (65+)
- Adults (26-64)
- Young adults (18-25)
- Youth (12-17)
- Children (5-11)
- Women of child-bearing age
- English Language Learners
- Persons in rural areas
- Persons in urban areas
- Families living in poverty
- Incarcerated individuals
- Current substance users
- Individuals with mental illness
- Individuals experiencing food insecurity
- Persons who lack a stable residence
- LGBT individuals
- American Indians/Alaska Natives
- Latinos/Latinas
- Asian/Pacific Islanders
- Other (please specify)\_\_\_\_\_

### **Training and Resources for Treatment Providers**

For this section, we would like to know about any needs you have for training or resources, both for yourself as a provider, and for your clients.

24. What training have you received that has been helpful to your work?  
(open ended)



25. Which of the below topics would be useful for future training for yourself or other staff at your facility? (Select up to 5)

- Medication assisted treatment (methadone, buprenorphine, naltrexone)
- Client assessments (i.e. trauma screening tools, addiction screening tools, etc.)
- Trauma-informed care
- Evidenced-based treatments (i.e. EMDR, DBT, TF-CBT, etc.)
- Treatment for opioid addiction
- Naloxone (Narcan®) use and/or administration
- Co-occurring disorder
- Safe injection practices
- Harm reduction
- Methamphetamine treatment
- Clinical supervision
- Documentation/record keeping
- Treatment planning
- Human growth and development
- Medical and psychosocial aspects of drug and alcohol use and addiction
- LGBT health issues
- Prescription Drug Management Program (PDMP)
- Domestic violence
- Gambling addiction
- Internet addiction
- Other addition (non-substance addiction)
- Suicide screening
- Medicaid, Medicare, and health insurance
- Compassion fatigue, stress, and burnout
- Cultural competency
- Ethics and boundaries
- Working with homeless population
- Alternative pain management strategies
- Other (please specify) \_\_\_\_\_

26. What additional resources or training do you or other staff at your facility need?  
(open ended)



27. What additional resources do your clients need? (Select up to 5)

- Naloxone kits
- Condom distribution
- Financial assistance for medication assisted treatment (MAT)
- Childcare
- MAT prescriber
- Funding for rural area
- Education about MAT
- Information on how to access treatment
- Reduction in waiting lists and wait time
- Facilities that accommodate women with dependent children
- Community Outreach
- Other (please specify) \_\_\_\_\_

28. What would you most like DHHS to know about your clients, and your work?  
(open-ended)

29. DHHS is committed to hearing directly from providers about needs and trends as we develop future programming. Would you be willing to participate in a follow-up study on drug-use behaviors?

- Yes (if yes, please provide email address) \_\_\_\_\_
- No



## Appendix C: Treatment Provider Survey Drug Pairing Tables

### Methadone Clinic Drug Pairings

Note: No methadone provider indicated a drug pairing for alcohol, antidepressants, marijuana, hallucinogens, inhalants, or cocaine. As such, they are not included in the below table as a drug pairing or primary drug. Methadone providers indicated drug pairings for heroin, fentanyl, and prescription pain relievers as primary drugs, but not as drug pairings. They are included in the below table only as primary drugs.

Primary Drugs (n=3)						
Drug Pairings	Prescription Pain Relievers	Heroin	Fentanyl	Methamphetamines	Benzodiazepines	
Benzodiazepines	2	2	1	0	-	
Methamphetamines	2	2	1	-	0	
Opioids	0	0	0	1	1	

### Inpatient Facility Drug Pairings

Note: No inpatient provider indicated inhalants as a drug pairing for the first table of primary drugs. Therefore, it is not included in the table below. No inpatient provider indicated inhalants, fentanyl, or benzodiazepines as a drug pairing for the second table of primary drugs. Therefore, it is not included in the second table.

Primary Drugs (n=20)						
Drug Pairings	Alcohol	Prescription Pain Relievers	Heroin	Fentanyl	Methamphetamines	Benzodiazepines
Alcohol	-	9	4	3	12	7
Benzodiazepines	2	1	0	1	0	-
Cocaine	1	1	1	1	3	1
Fentanyl	0	0	2		0	0
Hallucinogens	0	0	0	0	1	0
Heroin	0	1	-	4	0	0
Marijuana	7	4	2	2	12	4
Methamphetamines	11	4	3	1	-	1
Opioids	2	1	0	1	1	1
Prescription pain relievers	0	-	4	3	1	0

Primary Drugs (n=20)					
Drug Pairings	Antidepressants	Marijuana	Hallucinogens	Inhalants	Cocaine
Alcohol	1	10	2	3	7
Cocaine	1	1	2	1	-
Hallucinogens	0	0	-	1	1
Heroin	0	0	0	0	1
Marijuana	1	-	4	5	5
Methamphetamines	1	9	1	2	5
Opioids	0	1	0	0	1
Prescription pain relievers	0	0	0	1	0



## Appendix D: Treatment Provider Consent Form and Script

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 the DOP Drug Use Behaviors project is to equip DHHS with the information to develop effective drug use prevention plans.**

The results will help DHHS to focus on the needs of treatment providers and ultimately to reduce overdoses in Nebraska. The purpose of today's discussion is to gain information about your experiences with clients, how the DHHS prevention campaign impacts you, 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](tel:402.554.3663)  
Email: [steps@unomaha.edu](mailto:steps@unomaha.edu)



## Treatment Provider 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 prevention and treatment of drug overdoses in Nebraska. This focus group is conducted by the Support and Training of the Evaluation of Programs (STEPs) which is a program of the Grace Abbott School of Social Work at the University of Nebraska at Omaha.

NE DHHS invited STEPAs to complete a research study for the Drug Overdose Prevention Program. **The purpose of the DOP Drug-Use Behaviors project is to equip DHHS with information to develop effective drug-use prevention plans and provide any needed training and resources for treatment providers.** The results will help DHHS to focus on the needs of treatment providers and ultimately to reduce drug misuse, substance use disorder and overdoses in Nebraska.

**The purpose of today's discussion is to gain information about your services and clients, to hear your thoughts on prevention, and to assess your training and other resource needs.**

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; the transcripts will only be reviewed by the researchers on this project. We will keep what you say confidential. The only exception is if you share something that indicates that you or someone else is in danger.

The STEPAs 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/pdmp](http://DHHS.ne.gov/pdmp)).

Does anyone have any questions before we begin?

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



As you know, drug misuse, substance use disorder and overdoses are a problem nationally as well as here in Nebraska. We are wanting to have a conversation about the therapeutic services provided in NE. We are conducting a series of focus groups with inpatient providers in the Lincoln and Omaha area. Your responses to these questions will help to determine the needs we have in our state which will provide guidance to DHHS 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 generally about the services provided at your center and the clients you serve.

2. What services are provided at your center?

- Are any of these services specifically for methamphetamine? For opioids?

3. What drugs are most of your clients in treatment for?

- Approximately what percent of clients have opioids as their main issue (as compared to other drugs)?

4. How is any of this different from a couple of years ago?

5. What are the gaps in service you are seeing?

Next, let's talk about your current training, and your needs, if any, for additional training and other resources.

6. Talk to us about the type of training you've received about drug use. When was the training (years)?

- Was it in person or online?
- Stand alone or as part of another training?
- Mandatory or optional?
- Annual or one time only?
- What did you like most about the training you received?
- What did you like least about the training you received?
- What further training would be useful for you as a provider?
- Tell me about the training provided by your current agency to all staff.
- What other resources do you need in providing quality treatment for clients?
- What role do you see DHHS having in providing training and other resources?



**This next set of questions is a closer look at the clients you serve. This is all general information on things you have observed as a provider.**

7. How would you describe your typical client?

- Age, SES, race, geographics (are clients traveling large distances for treatment)
- Typical risk factors *including trauma, ACE scores*
- Typical protective factors such as family, community
- How is this different from a couple of years ago?

8. What do you hear about how your clients started using drugs? (*prompts: access, age, prescription or party*)

- How and where did your clients access drugs? Have you noticed changes in availability?
- How is this different from a couple of years ago?

9. What do you think could be done to keep young people from first starting to use drugs?

10. For the clients you have seen that have relapsed, Under what circumstances does it seem clients relapse?

11. Based on what clients tell you, what do you think drives overdose?

**This next section is about prevention of drug overdoses.**

12. What are prevention efforts you are aware of in your community?

13. Is there anything that you think is working well to prevent drug overdoses? Opiate misuse?

14. What prevention efforts do you think should be targeted for youth?

- Literature shows that 70% of clients who reported a history of drug treatment, did not access treatment until about age 20, which is about 3 years after initiation of nonmedical prescription opioid use.

15. If you could design a prevention plan, what would you be sure to include?

16. Is there anything about this community that you think makes it more or less likely for people to use drugs? Specifically opiates?

17. What do you wish the public understood about drug use, misuse and use disorders? About opioid use, misuse and use disorders?





18. What do you wish policymakers understood about drug use, misuse and use disorders?  
About opioid use, misuse and use disorders?

**This next set of questions is a closer look at the clients you serve. This is all general information on things you have observed as a provider.**

7. How would you describe your typical client?

- Age, SES, race, geographics (are clients traveling large distances for treatment)
- Typical risk factors *including trauma, ACE scores*
- Typical protective factors such as family, community
- How is this different from a couple of years ago?

8. What do you hear about how your clients started using drugs? (*prompts: access, age, prescription or party*)

- How and where did your clients access drugs? Have you noticed changes in availability?
- How is this different from a couple of years ago?

9. What do you think could be done to keep young people from first starting to use drugs?

10. For the clients you have seen that have relapsed, Under what circumstances does it seem clients relapse?

11. Based on what clients tell you, what do you think drives overdose?

**This next section is about prevention of drug overdoses.**

12. What are prevention efforts you are aware of in your community?

13. Is there anything that you think is working well to prevent drug overdoses? Opiate misuse?

14. What prevention efforts do you think should be targeted for youth?

- Literature shows that 70% of clients who reported a history of drug treatment, did not access treatment until about age 20, which is about 3 years after initiation of nonmedical prescription opioid use.

15. If you could design a prevention plan, what would you be sure to include?

16. Is there anything about this community that you think makes it more or less likely for people to use drugs? Specifically opiates?



17. What do you wish the public understood about drug use, misuse and use disorders? About opioid use, misuse and use disorders?

18. What do you wish policymakers understood about drug use, misuse and use disorders? About opioid use, misuse and use disorders?

### **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?