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

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

DRUG USE BEHAVIORS

Final Report

Jeanette Harder, Ph.D., CMSW
December Lange Treacy, MS
Liam Heerten-Rodriguez, Ph.D., MSW, CSE
Jodi Gabel, MSW
Daniel Kreuzberg, MSW/MPA Student
Rachel Lubischer, MSW, MPA
Jennifer L. Smith, MPPA, CMHC Student

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Report Background

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) Drug Overdose Prevention (DOP) program contracted with STEPs in the fall of 2019 to complete a needs assessment that included an identification and analysis of quality datasets, a survey of outpatient treatment providers, and focus groups with treatment providers.

STEPs wishes to acknowledge the contributions of many organizations and professionals in the preparation of this report:

- *The DOP staff, especially Davidson Wissing*
- *The Department of Behavioral Health data team*
- *The Nebraska Hospital Association*
- *The many survey and interview participants*

Purpose Statements

STEPs collaborated with the NE DHHS Drug Overdose Prevention (DOP) program to prepare a purpose statement for the overall project, as well as each of its contained sub-projects.

The purpose of this needs assessment is to deepen DOP's understanding of individuals' drug use behaviors in Nebraska through the lens of treatment providers.

The results of this study will aid DOP in providing training and other resources to treatment centers, focusing prevention efforts, and informing their strategic plan and future studies. Ultimately, this study will support DOP's efforts to reduce opioid-involved fatal and non-fatal overdoses in Nebraska.

Report	Purpose
Survey Report	The purposes of the survey of treatment providers are to discover current patterns in clients' drug use behaviors, and the unique needs of both substance users and treatment providers in the state of Nebraska.
Dataset Report	The purpose of the dataset analysis is to provide data on who is receiving treatment, who is referring people to treatment, and people's age at first use. The current report includes analysis of quality datasets that can be useful now and in future evaluations.
Interview Report	The purpose of the qualitative component of the Drug Use Behaviors project was to provide NE DHHS with rich and in-depth information regarding the professional experiences and needs of drug treatment providers in Nebraska. Through the perspectives and insights of drug treatment providers, NE DHHS can better understand the experiences and needs of people with substance use disorders in Nebraska.
Final Report	The purpose of the final report is to integrate the results of evaluation activities to provide a comprehensive summary, including recommendations for next steps in the study of individuals' drug use behaviors in Nebraska.

Orientation to This Report

This Drug Use Behaviors: Final Report provides a comprehensive summary of the results of three individual reports: a survey report, dataset report, and interview report; it offers overall recommendations. Each of these reports, whether they represent primary or secondary data, quantitative or qualitative methods, can inform NE DHHS' Drug Overdose Prevention (DOP) program in a unique way. Brought together, this use of multiple methods lends validity to the overall findings and recommendations.[1]

Primary Data

Primary data is collected directly from study participants by members of the research team to address a specific question or hypothesis. Primary data collection is often time consuming and expensive,[2] especially with the challenge of achieving large and representative samples.

As shown in the table below, the survey and interview reports represent primary data, as STEPs prepared the procedures and questions specifically for this project and collected data from treatment providers in Nebraska.

	Primary Data	Secondary Data	Qualitative Methods	Quantitative Methods
Survey Report	√		(√)	√
Dataset Report		√		√
Interview Report	√		√	

Important note: Substance use treatment providers include social workers, counselors, and case managers who provide therapy, crisis counseling, and case management and make referrals to medical providers for physical health needs. (Click this text box to navigate to a comparison between substance use treatment providers and medical providers.)

Secondary Data

Secondary data is often publicly available and may be collected routinely through large ongoing surveillance systems.[3] Since secondary data typically has a large sample size, it is likely more generalizable to an overall population. However, since secondary data was collected for other reasons and under other conditions than the current study, the data collection cannot be tailored to the current study. Also, data may be masked to protect confidentiality, which impacts usefulness for a rural state like Nebraska.

Secondary data utilized in the dataset report came from 3,330 inpatient and 7,712 emergency department discharges from 2016 to 2019, as collected by the Nebraska Hospital Association; and from 53,605 discharges from substance use treatment facilities in Nebraska from 2013 to 2017, as collected in the Treatment Episodes Database-Discharge system. STEPs located, cleaned, and analyzed the data for the purposes of this project, but did not design the items nor collect the data. (STEPs also worked with the NE DHHS Division of Behavioral Health Data Team to receive data from the Nebraska Risk and Protective Factor Student Survey from 2010 to 2018.)

Orientation to This Report (cont.)

Qualitative Methods

Another important consideration in reading this report is the differentiation between quantitative and qualitative research methods. Qualitative research methods provide insight into the perceptions, values, and opinions of a target audience, with data typically collected through interviews and focus groups. This kind of open-ended inquiry method is essential for exploring phenomena that do not fit neatly into predefined categories and offers voice to participants. Qualitative data can provide a rich source of insight and is often bulky and time consuming to code and analyze.[4]

The interview report represents qualitative methods like the survey report's open-ended items. For both the survey and interview projects, STEPs worked with NE DHHS to develop open-ended questions and posed them to treatment providers. In this way, participants could openly share their perceptions and experiences in providing substance use treatment.

Quantitative Research

Quantitative research, in contrast, captures numerical data that can be statistically analyzed. Ideally, the sample size is large enough to allow results to be more reliably generalized to an overall population. By design, quantitative data is consistent and precise, but it may be fraught with challenges related to instrumentation, response rates, and sampling.[5]

Comprehensive Summary

This final report includes individual reports in entirety, including key findings, methodology, results, and recommendations. (Click on the symbol to navigate to that section.)

Report	Key Findings	Recommendations
Survey report		
Dataset report		
Interview report		

The results of the survey, dataset, and interview reports are summarized here in response to six research questions:

1. What are the characteristics and needs of individuals receiving substance use treatment in Nebraska?
2. What are current trends in substance use in Nebraska?
3. What are current trends and needs in substance abuse treatment in Nebraska?
4. What is needed for prevention of substance use and overdose in Nebraska?
5. What are expressed issues/needs specific to NE DHHS?
6. What are possible next steps for research and evaluation in Nebraska?

1. What are the characteristics and needs of individuals receiving substance use treatment in Nebraska?

Individuals receiving treatment in their 30s and 40s typically initiated substance use before age 18.

Across all report data sources, the majority of individuals receiving substance use treatment in Nebraska initiate substance use at age 18 or younger. In survey results, just over half of providers indicated most of their clients first misused a substance at age 14 or younger with the overwhelming majority of providers indicating first use at the age of 18 years or younger. Similarly, in the Treatment Episodes Discharge Dataset (TEDS-D) data, one-third of clients reported the first use of their primary substance at age 14 or younger and two-thirds of clients reported the first use of their primary substance at age 17 or younger.

While Nebraska Risk and Protective Factor Student Survey (NRPFSS) data suggests a relatively small percentage of youth reporting substance use, the percentage of those who reported using a substance in their lifetime increased as the students' grade level increased. This suggests a need for primary prevention efforts targeting youth.

Comprehensive Summary (cont.)

While clients may have first used substances at a young age, the majority of those receiving treatment are older. According to Nebraska Hospital Association (NHA) data, the average age of inpatient patients with a diagnosis related to a substance was 41 years (median of 39) and the average age of emergency department patient with diagnoses related to a substance was 34 (median of 31). Similarly, TEDS-D data indicates most clients were between the ages of 21 and 49 years in 2013 to 2017.

According to NRPFSS and NHA data, males and females tended to use substances at similar rates. However, according to the TEDS-D data, most clients receiving treatment identified as male. The gender gap between those using and those receiving treatment may be explained in part by interview responses indicating women disproportionately experience financial and childcare barriers to treatment.

The American Community Survey's 2018 5-year race estimates for Nebraska found 5% of Nebraskans identified as Black or African American. However, according to TEDS-D, 9% of those in treatment for substance use identified as Black or African American. Similarly, 1% of Nebraskans identified as American Indian or Alaska Native but accounted for 8% of those in treatment as per TEDS-D data. These trends, along with NRPFSS findings that suggest a higher percentage of Alaska Native and American Indian youth report substance use, indicate a disproportionate impact on these communities.

Participants in the treatment provider interviews primarily defined the typical client by shared experiences, rather than demographic characteristics. Almost all of the participants explicitly identified a trauma history as something that all or most of their clients have in common. Most participants identified childhood trauma and several participants specified complex trauma, which refers to trauma that is chronic and long-term.

2. What are current trends in substance use in Nebraska?

Use of alcohol, methamphetamines, and drug combinations are the biggest concerns in Nebraska. Opioid misuse is growing.

Depressants, including alcohol, are a primary concern in Nebraska. Outpatient providers indicated in their survey responses that over half of their clients presented for treatment related to alcohol, followed by marijuana and methamphetamines; TEDS-D data validates this. Analysis of NHA data showed the most common substances related to emergency department and inpatient treatment diagnoses were depressants, stimulants, and narcotics. NHA data indicated 4% of inpatient and 11% of emergency department patients with substance-related diagnoses were associated with cannabis and cannabis derivatives. (Data on alcohol was not requested.) In the interviews, providers confirmed that while a growing number of individuals seek treatment for opioids, a much higher number of individuals seek treatment for methamphetamines, alcohol, and drug combinations.

Comprehensive Summary (cont.)

Providers indicated in their survey responses that about 25% of their clients in the past year had an opioid use disorder. Similarly, the NHA discharge data showed that 25% of inpatient patients and 21% of emergency room patients with substance-related diagnoses had diagnoses related to narcotics. In contrast, TEDS-D data from 2013 to 2017, showed that 4-5% of clients each year reported opioids as their primary substance. Participants interviewed in 2020 spoke of opioid abuse as a growing problem in Nebraska, which may account in part for this difference in primary and secondary data sources.

According to the NRPFSS, youth in Nebraska were more likely to report using prescription drugs at least once in their lifetime than any other substance; inhalants were the second most reported substance used.

Based on NHA and census data, Region 6 had a higher percentage of discharged patients (both inpatient and emergency room) with substance use disorders than expected based on population. Regions 3 and 4 had higher rates of stimulants related to inpatient treatment diagnosis compared to other regions where depressants are more common. Treatment providers did not indicate unique trends or needs for particular regions, although prevention services and treatment delivery methods need to be adapted to overcome geographic barriers.

3. What are current trends and needs in substance abuse treatment in Nebraska?

Criminal justice makes a high proportion of treatment referrals for individuals.

Survey respondents indicated many of their clients were prompted to receive treatment through court-related incidents more than any other catalyst. Similarly, TEDS-D 2017 data showed that 54% of patients were referred from courts, criminal justice entities, and DUI/DWIs. Of criminal justice referrals, the greatest percentage (27%) of criminal justice referrals came from law enforcement.

On average, providers indicated in survey responses that this was the first treatment experience for 33% of their clients. 2017 TEDS-D data showed that twice as many clients (62%) had no prior treatment episodes, which had increased from 44% in 2013.

Interview participants discussed significant barriers to individuals' ability to access substance abuse treatment, especially higher levels of care such as inpatient and residential treatment. In their survey responses, providers identified many systemic barriers to treatment and called for policy and funding changes to improve individuals' ability to access needed treatment.

Barriers to accessing treatment are not evenly distributed across populations. Clients who are already vulnerable or marginalized often experience more barriers and experience them more intensely. For example, some participants identified that women need residential treatment options that allow them to be with their children. Interviewees identified finances as an

Comprehensive Summary (cont.)

especially high burden for women seeking treatment. They also discussed specific barriers to accessing treatment for clients who are undocumented, experiencing homelessness, or are currently or were previously incarcerated. Barriers for vulnerable or marginalized populations are often unique and especially burdensome.

Women and vulnerable populations experience significant barriers to substance abuse treatment and have unique treatment needs.

Interview participants explained that clients also need access to housing, healthcare, and employment for substance abuse treatment to be effective. They indicated that wraparound services would increase both access to and effectiveness of treatment.

While the survey results show that 75% of outpatient providers reported referring for some type of medication assisted treatment (MAT) for alcohol or opioid substance use disorder, TEDS-D data from 2013 to 2017 in Nebraska show that 2–5% of clients received planned MAT treatment for opioid substance use disorder. This discrepancy is rectified in part as providers shared in interviews a newer trend towards harm reduction and MAT approaches.

In their survey responses, treatment providers indicated their interest in training in these areas: co-occurring disorders, trauma-informed care, evidence-based practices, and drug use trends. In interviews, treatment providers expressed the need for training related to reducing overprescribing for prescribers; promoting safe use, raising awareness, and reducing stigma for communities; and naloxone access for treatment providers.

4. What is needed for prevention of substance use and overdose in Nebraska?

All data sources for this report indicated primary prevention strategies aimed at middle and high school students, rather than other populations, are the most needed.

Prevention strategies aimed at middle and high school students are especially important.

Responses to the survey and interviews clearly showed that treatment providers do not understand what NE DHHS is doing to prevent drug overdoses. Survey responses also showed that providers view NE DHHS' public service announcements as the least helpful of all prevention tools. Treatment providers also do not view the Prescription Drug Monitoring Program (PDMP) to be as helpful as other potential strategies (perhaps, in part, because they are not prescribers and do not have reason to access or use PDMP).

Providers indicated their belief that substance abuse treatment plays a significant role in overdose prevention. In interviews, participants discussed getting clients into treatment immediately after evaluations as a way of reducing overdoses.

Comprehensive Summary (cont.)

Stigma remains a barrier to prevention and intervention.

Interview participants spoke of the need for policies to increase access to naloxone as crucial for overdose prevention; survey responses indicate that treatment providers do not uniformly value the use of naloxone as a helpful strategy for preventing fatal overdoses.

Many survey respondents were very concerned with stigma related to substance use. They viewed this stigma as a barrier to clients' ability to seek and maintain sobriety. Interviewees shared their concern that when political leaders believe addiction is a choice, these leaders are less interested in funding and addressing substance abuse issues. They also expressed the need to decrease individuals' fears of criminalization as crucial in preventing overdoses. Work is needed to reduce stigma and to humanize interventions for people with substance use disorders by providing an accurate understanding of who is at risk and the strengths they possess.

5. What were expressed issues/needs specific to NE DHHS?

Providers do not have a clear understanding of what NE DHHS does and does not do, and how DOP is differentiated from other DHHS programs.

Interview participants and some providers' responses to the open-ended survey items indicated they view Child and Family Services/Child Protective Services as synonymous with NE DHHS. A few providers alluded to clients' lack of trust in DHHS due to the fear of NE DHHS taking away their children.

Treatment providers shared the stigmatizing experiences of their clients from NE DHHS as well as from other organizations.

Interview participants called on DOP to partner with stakeholders in drug overdose prevention. In addition, they suggested that DOP engage treatment providers in a way that honors their expertise, facilitates ongoing communication, and includes them as partners in this important work.

6. What are possible next steps for research and evaluation in Nebraska?

Research participants are eager for this final report to be made available to them as evidence that their perspectives were represented and for use in advocating for changes in practice and policy. They also look forward to continued opportunity to offer their expertise and feedback in shaping drug overdose prevention.

Comprehensive Summary (cont.)

According to NHA, hospitals are currently not collecting data related to race and ethnicity consistently. The collection of this data should be encouraged as it would allow for an examination of health disparities and barriers to access to care based on race.

Overall Recommendations for Practice

STEPs offers the following overall recommendations for DOP's consideration.

1. Provide training to policymakers, treatment providers, other community professionals, and the general public as outlined in the table below.

Training Topics	Policy-makers	Treatment Providers*	Other Community Professionals	General Public
Drug use trends	√	√	√	√
Anti-oppressive and intersectional approaches	√	√	√	
Treating co-occurring disorders (substance misuse and mental health)		√		
Medication Assisted Treatment (MAT)	√	√	√	√
How to access and use naloxone		√	√	√
Reducing overprescribing	√		√ (prescribers)	
Reducing stigma	√		√	√

*Substance use treatment providers include social workers, counselors, and case managers who provide therapy, crisis counseling, and case management, and make referrals to medical providers for physical health needs. (A comparison between substance use treatment providers and medical providers can be found in the survey report.)

2. Focus prevention strategies toward middle and high school students.

3. Continue to expand access to naloxone.

4. Reduce barriers to treatment through:
   a. Reviewing treatment programs' geographic locations, eligibility criteria, payment options, and levels of care, and then addressing gaps.
   b. Advocating for funding for treatment.
   c. Ensuring availability of residential treatment, especially for women with children.

5. Communicate the role of DOP as distinct from other NE DHHS programs.

6. Create, maintain, and make available a database of statewide resources to help treatment providers make appropriate referrals and connect clients to the needed level of treatment. The database should include items like levels of care, pay sources, and eligibility criteria. The database could also serve as an environmental scan that informs stakeholder assessment and strategic planning.

Overall Recommendations for Practice (cont.)

7. Regularly convene a roundtable with treatment providers (perhaps meeting quarterly) to increase collaboration and understanding of trends in substance use and treatment, and to inform effective prevention and treatment.

8. Improve communication and collaboration among NE DHHS divisions and programs to maximize efficiency of existing programming and to share research data and results.

Overall Recommendations for Evaluation and Research

Based on all work completed for the DOP program to date, STEPs offers the following evaluation and research recommendations to allow for continued use of evidence in planning and decision-making.

1. Create a logic model for the DOP program that shows activities, outcomes, and impacts. This logic model can inform DOP's planning and work, enhance communication with stakeholders, and inform ongoing evaluation and research.

2. Utilize primary, mixed methods research methods to assess the impact of the current pandemic on all areas of DOP's work.

3. Evaluate DOP's prevention efforts to allow the use of data to inform prevention and outreach and to showcase efforts and outcomes to treatment providers and others.

4. Conduct an environmental scan to identify and remedy gaps in drug treatment services. This scan could lead to an interactive resource assisting in linkages to care. Elements to assess and show include geographic locations of services, referral criteria, payment types, levels of care, and treatment modalities.

5. Seek the perspectives of prescribers, local health departments, and other community professionals, as well as other DHHS programs, on substance use trends, prevention, treatment access, and stigma.

6. Discover the effectiveness of mandated treatment compared to voluntary treatment in the professional literature and consider applicability to Nebraska.

7. Continue to consider how to ethically collect data directly from individuals who may be using or misusing substances to learn about substance use trends, prevention, treatment access, and stigma.

8. Evaluate the effectiveness of DOP's consumer awareness campaigns, including the effectiveness and acceptability of public service announcements for specific populations.

9. Synthesize findings from STEPs' 3 years of reporting to identify commonalities and reinforce trends and highest priorities in Nebraska.

References: Comprehensive Summary

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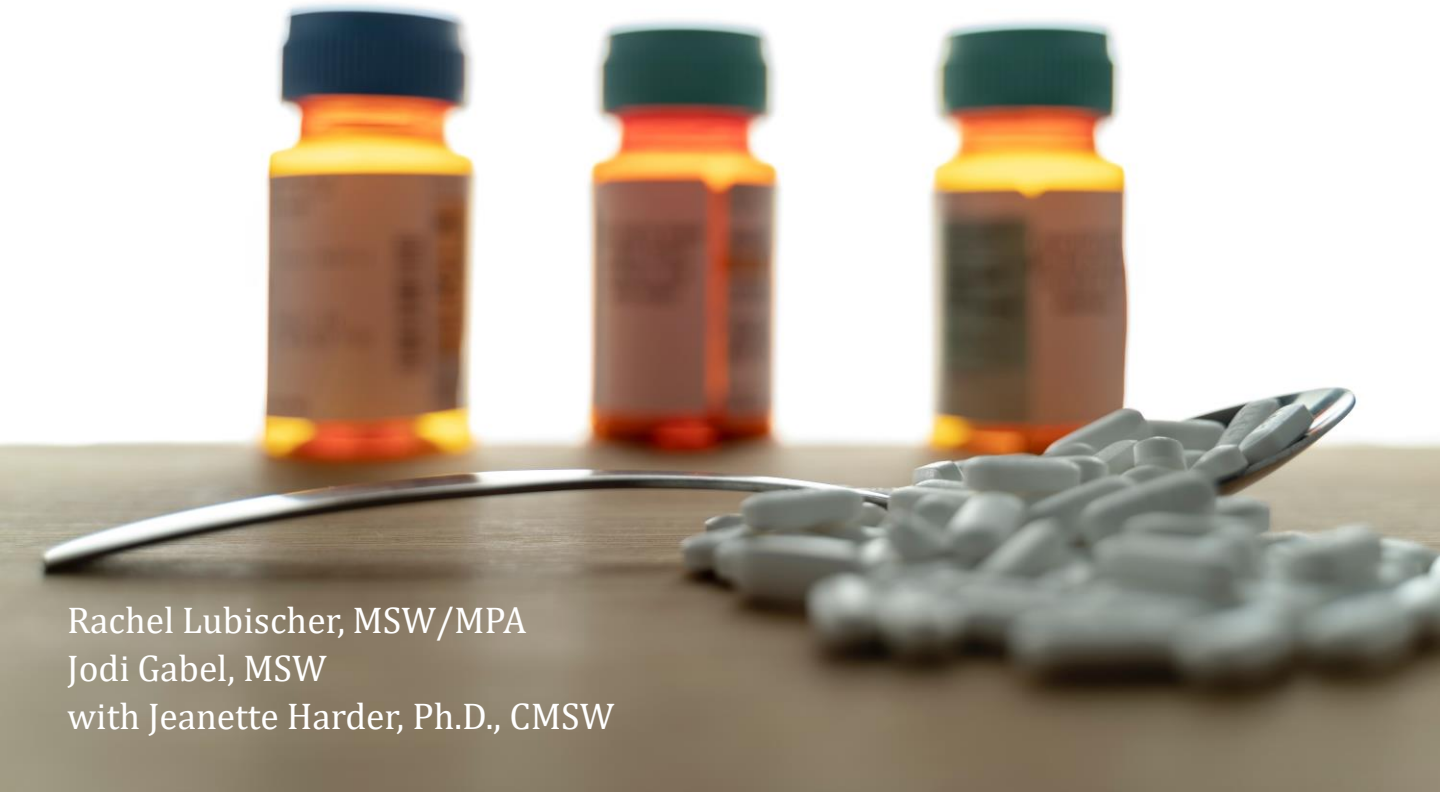
DRUG USE BEHAVIORS

LADC/PLADC Quantitative Survey

May 2020



Rachel Lubischer, MSW/MPA
Jodi Gabel, MSW
with Jeanette Harder, Ph.D., CMSW

Drug Use Behaviors Background

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) Drug Overdose Program (DOP) contracted with STEPs in the fall of 2019 to complete a needs assessment that included an identification and analysis of quality datasets, a survey of Licensed and Provisionally Licensed Alcohol and Drug Counselors (LADCs and PLADCs), and focus groups with treatment providers.

STEPs developed the survey administered to treatment providers using valid and reliable measurement tools for the 2018-2019 DOP Drug Use Behaviors (DUB) report.[1-6] STEPs administered the same survey, with slight changes in language, to Nebraska LADCs and PLADCs for the current needs assessment. The 2018-2019 DOP DUB report and other STEPs reports can be found on Digital Commons.

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Purpose

The goal of this needs assessment is to deepen DOP's understanding of individuals' drug use behaviors in Nebraska through the lens of treatment providers.

The results of this study will aid DOP in providing training and other resources to treatment centers, focusing prevention efforts, and informing their strategic plan and future studies. Ultimately, this study will support DOP's efforts to reduce opioid-involved fatal and non-fatal overdoses in Nebraska.

Key Findings

Medication Assisted Treatment: Most providers indicated referring clients for at least one medication used in medication assisted treatment (MAT). Rural providers indicated providing referrals for MAT medication less often than urban providers. This may be due to a lack of access to MAT providers or a lower percentage of substance use disorders requiring MAT. Across regions, providers indicated clients need financial assistance to receive MAT more often than any other resource option.

Common Substances Used: Providers indicated alcohol is the most common substance used, followed by marijuana and methamphetamines. For polysubstance users, providers reported these three drugs are consistently paired with each other. Across multiple items, providers reported approximately 25% of their clients have an opioid use disorder.

Adolescence: Most providers indicated adolescence as a key age during which many clients initiated substance use. Many providers also identified middle school and high school students as a population in need of prevention efforts, and indicated school-based prevention programs as helpful.

Systemic Barriers: Providers consistently identified insufficient health care coverage and wait times to access services as significant barriers to treatment. Providers shared that insufficient health care coverage prevents clients from accessing necessary services, especially MAT, detoxification, and chemical dependency evaluations. For those clients possessing resources and motivation to access treatment, providers indicated treatment wait lists can be a deterrent. These wait lists point to a gap in treatment availability and were the second most commonly indicated resource need. In addition, many providers reported clients' access to substance use treatment is limited by the gap in support services, such as transportation, childcare, and housing.

Future Training Topics: Many providers indicated interest in receiving training on evidence-based practices. Evidence-based practice topics specifically mentioned by providers included Cognitive Behavioral Therapy, Dialectical Behavior Therapy, standardized assessment instruments, and trauma-informed care.

Focused Efforts: While national trends call for efforts targeting women of child-bearing age, Native American populations, naloxone distribution, and prescription drug monitoring, providers indicated these efforts were among the least needed. It is unknown if providers do not find these current efforts helpful, or rather, if the need in the community has already been filled by existing programming. Providers indicated access to mental health treatment as a helpful prevention effort more often than any other effort.

Regional Differences: Most providers, regardless of geographic area, indicated similar substance use trends and needs among their clients. Additionally, systemic barriers and training interests were also fairly consistent across the state.

Survey Purpose

The purposes of the quantitative survey of treatment providers are to discover current patterns in clients' drug use behaviors, and the unique needs of both substance users and treatment providers in the state of Nebraska.

Sample Description

Substance use treatment providers support individuals' ability to understand and overcome their substance use disorder and maintain recovery.

Providers offer

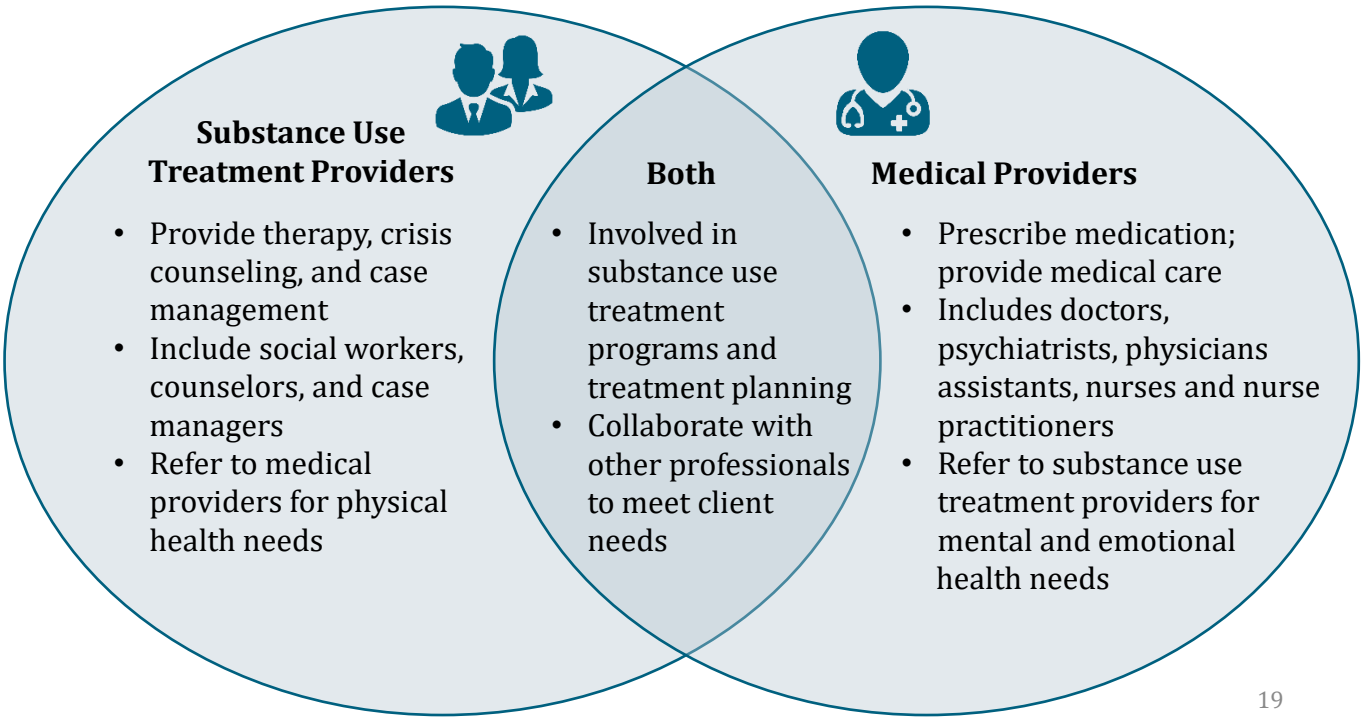
- Intake, assessment, and treatment planning,
- Counseling for individuals, groups, and significant others,
- Case management and crisis intervention, and
- Referrals to medical providers and other professionals when appropriate.

Providers support

- Individuals with substance use, mental health, or co-occurring disorders, and
- Clients in self-help recovery groups, outpatient treatment, intensive outpatient treatment, residential or inpatient treatment, or continuing care.

Common Licenses Held by Providers

- Licensed or Provisionally Licensed Alcohol and Drug Counselor (LADC/PLADC)
- Licensed Mental Health Practitioner (LMHP)
- Licensed Independent Clinical Social Worker (LICSW)



Sample Description

Survey Administration

DHHS partnered with STEPs in the fall of 2019 to survey outpatient treatment providers, specifically Licensed Alcohol and Drug Counselors (LADCs) and Provisional Licensed Alcohol and Drug Counselors (PLADCs) in the state of Nebraska. On February 5, 2020, STEPs emailed a Qualtrics survey link to the 1,131 registered LADCs and PLADCs in Nebraska.

Sample Size (n=193)

Of the 1,131 registered LADCs and PLADCs contacted, 213 treatment providers responded to the survey for a 19% response rate. However, 20 providers answered only the demographic questions and identified the medications they refer for, but did not answer any additional questions. These 20 individuals were included in the analyses for medication referral, but were removed from all other analyses. Thus the sample size for the majority of this report equates to 193 substance use treatment providers.

193

Survey participants

Missing Data

Missing data was handled using pairwise deletion in which participant responses were included in analysis regardless of whether the participant responded to all 24 items. The number of participant responses for each item is shown by the "(n=)" in the item headings.

Comparisons

STEPs analyzed the responses to each survey item by provider region and by the provision of outpatient provision. STEPs indicated any notable differences, where applicable, in the analyses. For the majority of items, no differences were found.

Outpatient Treatment (n=191)

The majority of providers (85%) indicated providing outpatient treatment. Since the survey did not specify any treatment types, no conclusions can be drawn regarding the type of service provided (if any) by the remaining 15% of respondents.

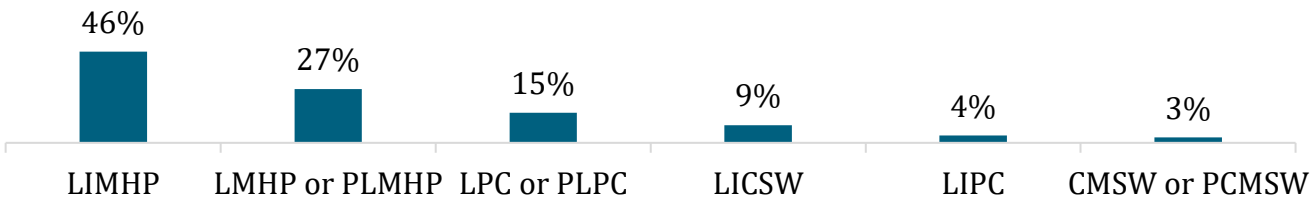
85%

Provided outpatient treatment

Sample Description

Other Licenses or Certificates (n=193)
Most providers (72%) indicated holding other licenses or certificates in addition to their LADC or PLADC. Nearly half of providers (47%) indicated also being a Licensed Independent Mental Health Provider (LIMHP) and approximately one in four providers indicated being a Licensed or Provisionally Licensed Mental Health Provider (LMHP or PLMHP). **Just over one in four (28%) providers indicated only holding a LADC or PLADC license.** The percentages in the below graph do not sum to 100% because providers could indicate holding multiple other licenses or certificates. An acronym index can be found in Appendix C.

Other Licenses or Certificates Held by LADCs and PLADCs



Grouping Nebraska Regions
Providers responding to this survey indicated serving 66 of Nebraska's 93 counties. In order to compare trends by similar geographic regions, STEPs grouped Nebraska counties according to four regions with similar characteristics, including public health region, size and location of cities and towns, relative population, and primary economic forces (i.e. agricultural v. other service industries). These four regions also allowed for sample sizes to be more comparable between regions for the purpose of statistical analyses. The four regions include:

1. Lancaster County;
2. Omaha Metro, including Douglas County and Sarpy County;
3. Rural East, including all eastern counties, with the exclusion of Lancaster County and Omaha Metro areas; and
4. West, including all counties west of Knox County.

A detailed table of all 93 counties according to these four regions is provided in Appendix D.

Location of Services

When asked to identify the county or counties in which they provide substance use treatment, 39 providers identified more than one county. In these cases, providers were categorized according to the following criteria.

- Providers who listed both rural and urban counties were categorized according to the urban county listed (e.g. "Hall County, Lancaster County" = Lancaster).
- If a provider listed both an Omaha Metro county and Lancaster County, they were categorized into the Omaha Metro region (e.g. "Douglas County, Lancaster County" = Omaha Metro).
- Providers listing counties in multiple rural regions were categorized into the region in which they indicated serving more counties (e.g. "Scotts Bluff, Banner, Pierce" = West).

Sample Description

Providers by Region (n=189)

As indicated in the table below, the majority of providers served counties in the Omaha Metro (42%) and Lancaster regions (24%). Only 24 providers (13%) reported serving Western Nebraska.

125 Providers indicated serving at least one urban county

64 Providers indicated serving only rural counties

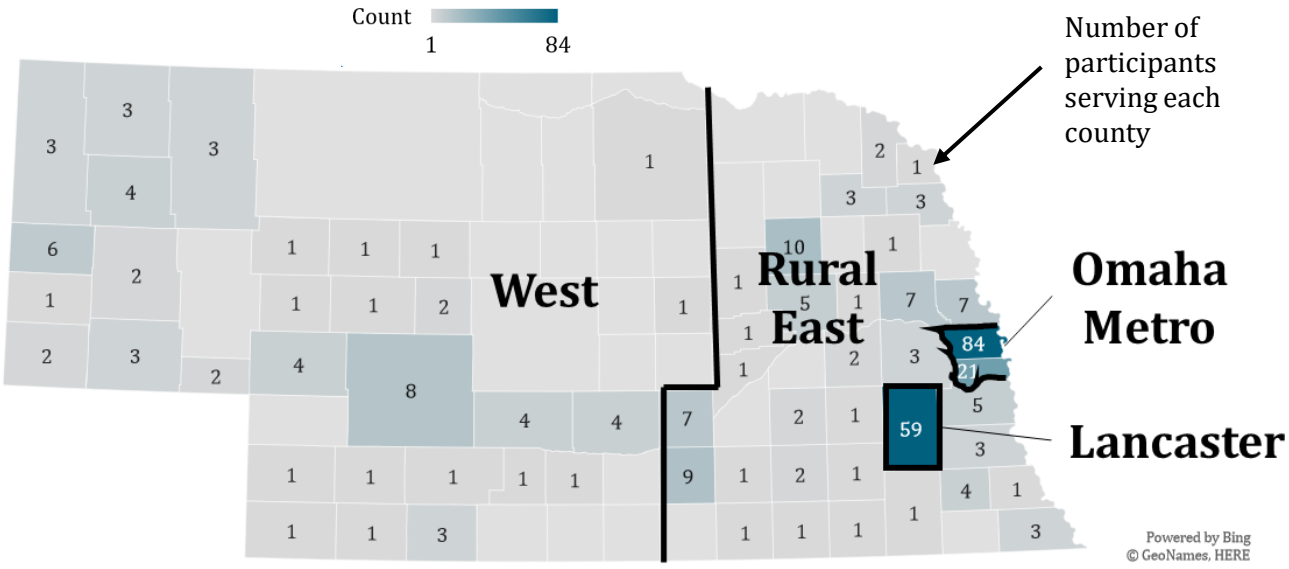
Number of Providers by Region

Region	Count	Percentage
Omaha Metro	80	42%
Lancaster	45	24%
Rural East	40	21%
West	24	13%

Note: Providers could identify providing treatment in more than one county.

Providers by County (n=189)

The below map of Nebraska is divided into the four geographic regions used for analysis: West, Rural East, Omaha Metro, and Lancaster. The number in the middle of each county represents the number of providers who indicated serving that county. Those counties with a higher count of providers are shaded in a darker blue. Over 80 providers indicated serving Douglas County, which is included in the Omaha Metro region and shaded a dark blue.



Referral for Medications

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

Referral for Medications (n=129)

Do you refer clients for any of the following medications? (select all that apply)

- Disulfiram
- Naltrexone
- Acamprosate
- Methadone
- Buprenorphine
- Suboxone
- Medications for psychiatric disorders
- Other

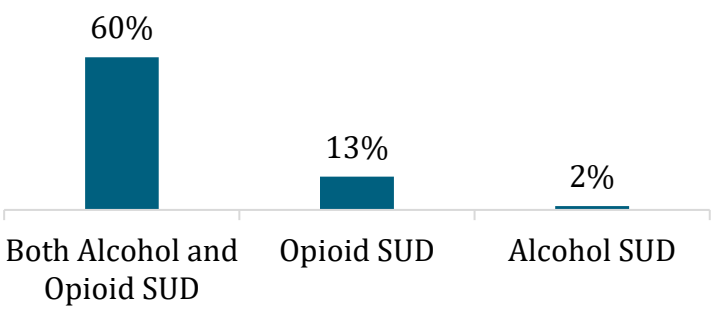
MAT Referral by Outpatient Providers

In preliminary analyses, STEPs discovered that providers who indicated providing outpatient treatment had a higher rate of MAT referral than those who did NOT indicate providing outpatient treatment. Because the survey cannot assure that providers working in other settings are providing direct care (which would be the setting appropriate for medication referral), STEPs excluded non-outpatient providers from all analyses for this item, in order to give a more accurate picture of medication referral.

Most outpatient providers (75%) referred for some type of MAT. Over half of providers (60%) indicated they referred for one or more medications used in MAT to treat both alcohol and opioid SUDs, whether that be naltrexone or a combination of other medications.

75%
Providers refer for MAT

MAT Referral by Outpatient Providers



MAT Medications by SUD Treated	
Alcohol SUD	**Opioid SUD**
Naltrexone	Naltrexone
Disulfiram	Methadone
Acamprosate	Buprenorphine
	Suboxone

Specifically, over half of providers (60%) referred clients for naltrexone, a medication indicated for use in both alcohol and opioid use disorders. Fewer providers referred for disulfiram (22%) or acamprosate (16%), medications used only for treatment of alcohol use disorder. Only 17 providers (12%) referred clients for methadone, a medication used in treating opioid use disorder.

25%
Providers do not refer for any MAT medication

Referral for Medications

Regional Differences in MAT Referral (n=129)

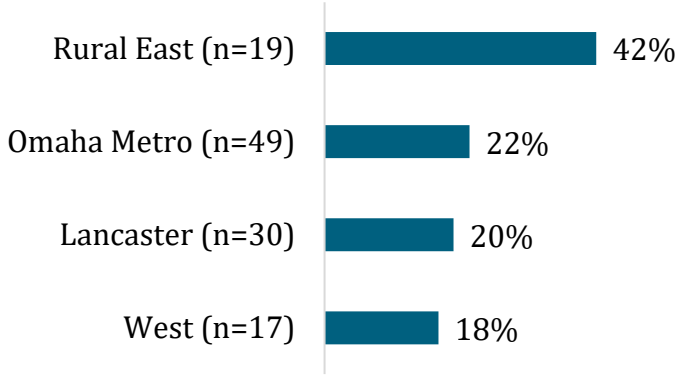
Slightly more providers from the West region indicated only referring for MAT medications used in treating alcohol use disorder (12%). Providers serving the West region were also less likely to referred for medications used in MAT for opioid use disorder (6%). However, STEPs noted little difference in substance use trends between regions.

No MAT Medication Referrals by Region (n=115)

A greater percentage of outpatient providers serving Rural East counties indicated providing no referrals for MAT medications (42%). Approximately 20% of outpatient providers from the Omaha Metro, Lancaster, and West regions indicated providing no referrals for MAT medications.

Only 115 outpatient providers indicated answers for both the county(ies) served and medication referral items.

No MAT Medication Referrals by Region



Outpatient Psychiatric Medication Referral (n=129)

The majority of outpatient providers (85%) indicated providing referrals for psychiatric medication. **However, 15% of outpatient providers did not indicate providing referrals for psychiatric medication**.

85%

Providers refer for psychiatric medication

Substance Use Trends

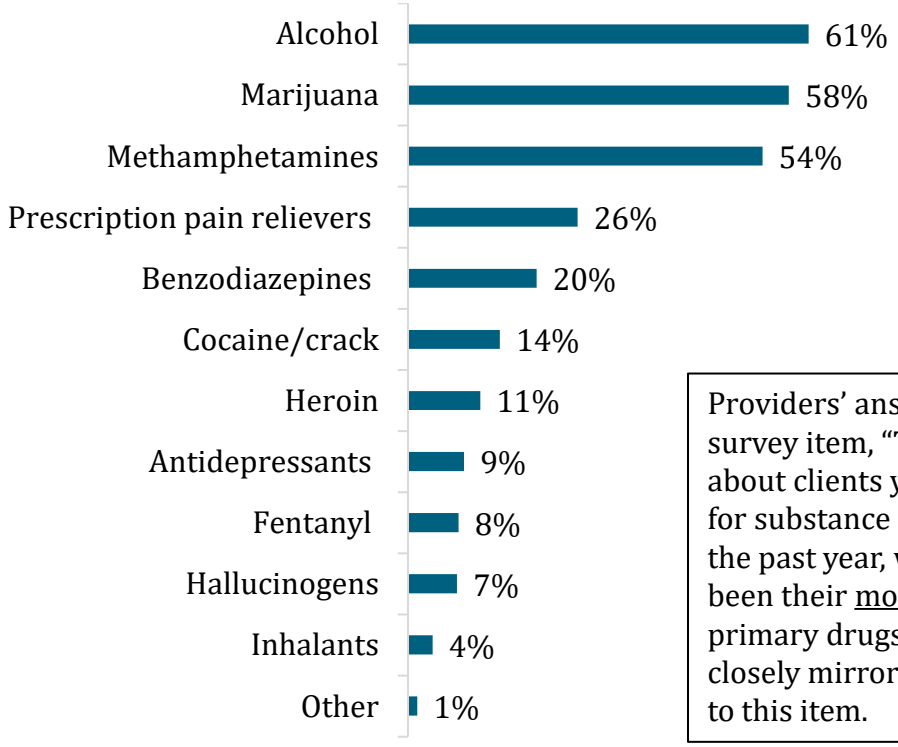
Substances Used by Clients (n=193)

Thinking about clients presenting for substance use over the past year, approximately what percentage of these clients have presented needing treatment for the use of:

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

Clients Needing Treatment by Substance

Providers indicated over half of their clients presented for treatment related to alcohol (61%), followed by marijuana (58%), and methamphetamines (54%) in the past year. Providers from different regions indicated similar substance use trends.



Providers' answers to the survey item, "Thinking about clients you treated for substance use over the past year, what have been their most common primary drugs of choice?" closely mirrored answers to this item.

Clients with Opioid Use Disorder (n=180)

In the past year, what percentage of your clients have had an opioid use disorder (prescription pain relievers, fentanyl, heroin)?

On average, providers indicated 25% of their clients in the past year had an opioid use disorder. However, answers to this item ranged from 0% to 100%. Providers indicated little difference between the rates of opioid use disorder by region.

25%

Clients with an Opioid Use Disorder

Substance Use Trends

Clients Who Are Polysubstance Dependent (n=184)

In the past year, what percentage of your clients were polysubstance dependent?

On average, providers indicated 59% of their clients in the past year were polysubstance dependent. Providers' responses to this item ranged from 0% to 100%. Providers indicated little difference in the rates of polysubstance dependence by region.

59%

Clients who were polysubstance dependent

Most Common Polysubstance Drug Pairings (n=177)

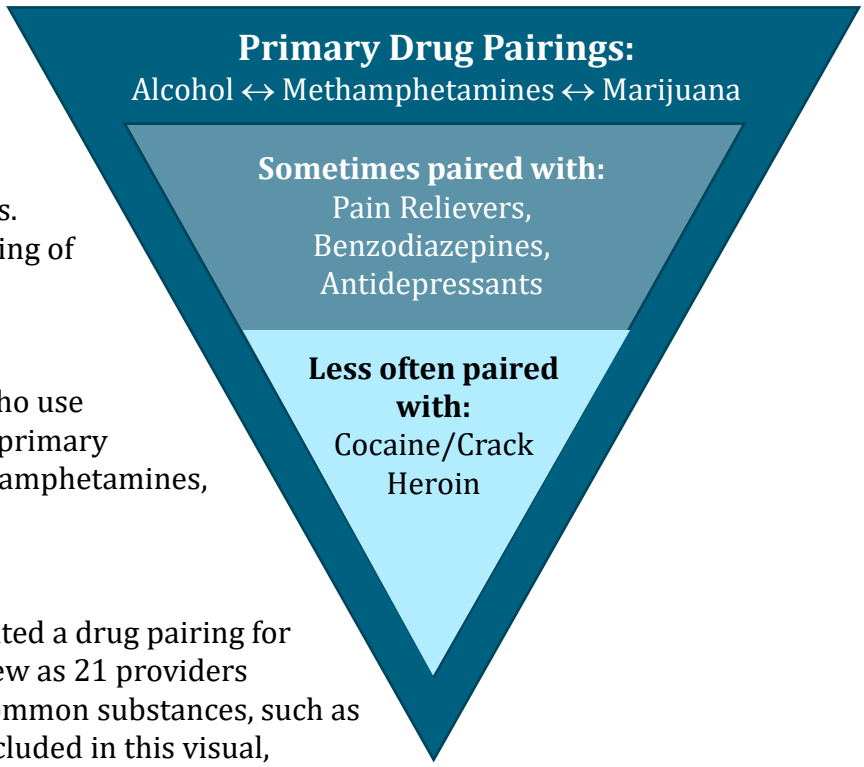
We would like to know about trends you are seeing in the use of multiple substances. For each of the primary substances listed below, please indicate the drug or drugs that you commonly see paired with each substance.

Primary Drug Pairings

Providers indicated alcohol, methamphetamines, and marijuana are the primary drugs being used, and are often paired with each other, particularly alcohol and marijuana. While providers reported a variety of other drugs also being paired with these three main drugs, other pairings were reported much less often.

Secondary Drug Pairings

Some providers indicated clients pair pain relievers and benzodiazepines with alcohol or marijuana, and slightly less often with methamphetamines. Other providers indicated the pairing of antidepressants with alcohol.



Tertiary Drug Pairings

A few providers indicated those who use cocaine/crack and heroin as their primary drug pair these with alcohol, methamphetamines, and marijuana.

Variation in Substance Pairings

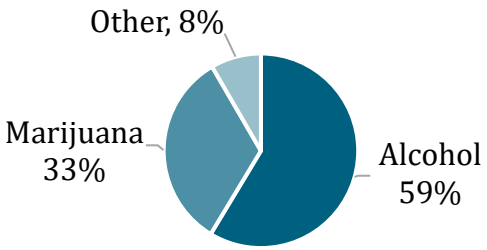
For this item, 177 providers indicated a drug pairing for at least one primary drug, but as few as 21 providers indicated a drug pairing for less common substances, such as inhalants. For those substances included in this visual, responses ranged from 168 providers indicating a drug paired with alcohol to 55 providers indicating a drug paired with heroin. Providers from different regions indicated little difference in substance use trends.

Drug Use Initiation

Most Common Substance First Misused (n=191)

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

Across regions, providers indicated alcohol (59%), followed by marijuana (33%), to be the most common substances first misused. However, **1 in 10 providers serving the Rural East region indicated their clients used methamphetamines first,** which is substantially more than those in any other region.

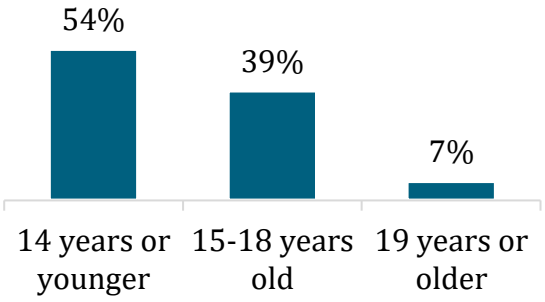


Age of First Use (n=189)

What age do most clients you serve indicate as their first misuse?

Just over half of providers indicated most of their clients first misused a substance at age 14 or younger. **1 in 10 providers from the Rural East and Omaha Metro regions indicated their clients first misused a substance at age 19 or older**, compared to few providers from the Lancaster (2%) or the West regions (0%). Because opioid use can be related to a later age of first misuse, STEPs compared rates of opioid use between regions and found a slightly higher rate of prescription pain relievers being the first misused substance for clients in Rural East and Omaha Metro regions. The slightly elevated rate of prescription pain relievers as the first misused substance and the later age of first misuse in the Rural East and Omaha Metro region are consistent with findings from the 2018-2019 DOP DUB survey of inpatient facility administrators.[7]

Age of First Misuse



Drug Use Initiation

Most Common Reason for First Misuse (n=191)

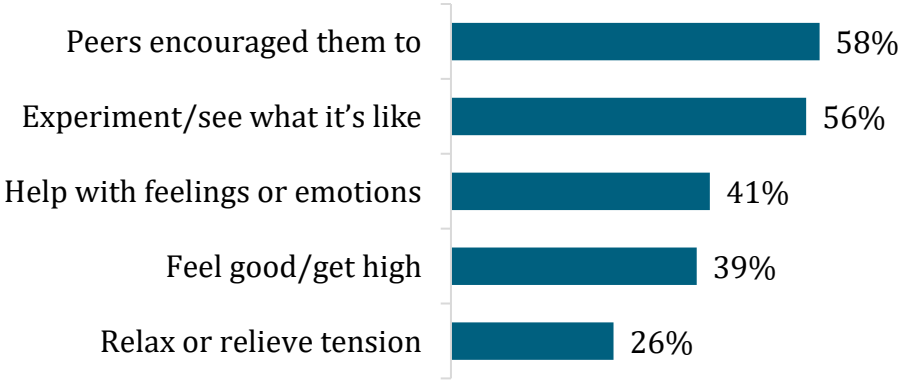
In your opinion, what are the most common reasons for clients' first substance misuse?

Response Options

- 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 or concentrate
- Help with feelings or emotions
- Help lose weight
- Parents or other family members encouraged them to
- Peers encouraged them to
- Other reason

Providers indicated the top two most common reasons for their clients' first substance misuse was peer pressure or their desire to "experiment/see what it's like." The top four answers were consistent with those of inpatient administrators from the 2018-2019 DOP DUB survey.[7] However, inpatient administrators from the 2018-2019 survey rated "parents or other family members encouraged them to" as the fifth most common reason for clients' first misuse, compared to LADC and PLADC providers who indicated clients first used to "relax or relieve tension" as more common. Providers' responses differed little across regions.

Top Five Reasons for First Misuse



Drug Use Initiation

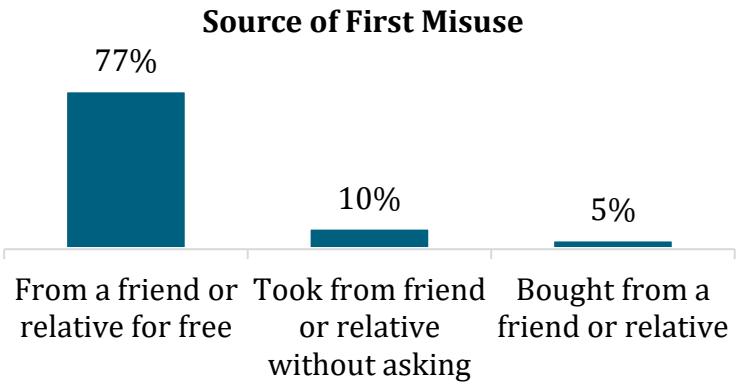
Source of First Misuse (n=191)

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

Response Options:

- From a doctor
- Stole from doctor's office, clinic, hospital, or pharmacy
- 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
- Some other way

According to the majority of providers, clients most commonly obtained their first misused substance "from a friend or relative for free." The top three answers for providers all related to the source being a friend or relative. These responses closely mirror those of inpatient administrators from the 2018-2019 DOP DUB report.[7] Providers' answers differed little across regions.

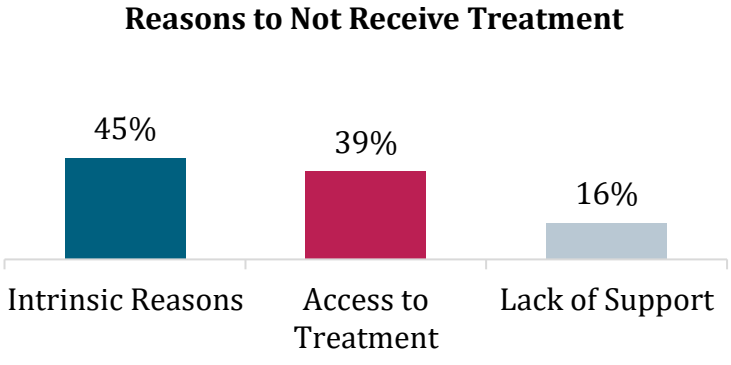


Treatment Barriers and Facilitators

Reasons to Not Receive Treatment (n=191)

What are the most common reasons people do NOT receive treatment?
The full list of response options are provided in Appendix B.

For this item, providers could choose multiple reasons from the list provided as to why clients did not seek treatment. Providers gave a collective total of 937 responses (n=191). Of those 937 responses, STEPs classified 45% as "intrinsic reasons," 39% were deemed "access to treatment" issues, and 16% were classified as "lack of support."



This breakdown resembles that of the inpatient administrators from the 2018-2019 DOP DUB survey.[7] However, in the previous survey, 64% of the responses were categorized as "intrinsic reasons" and only 22% were categorized as "access to treatment."

Intrinsic Reasons

Most providers indicated clients did not seek treatment due to intrinsic reasons. One in four responses related to clients not wanting treatment or not thinking they needed treatment (28%).

72%

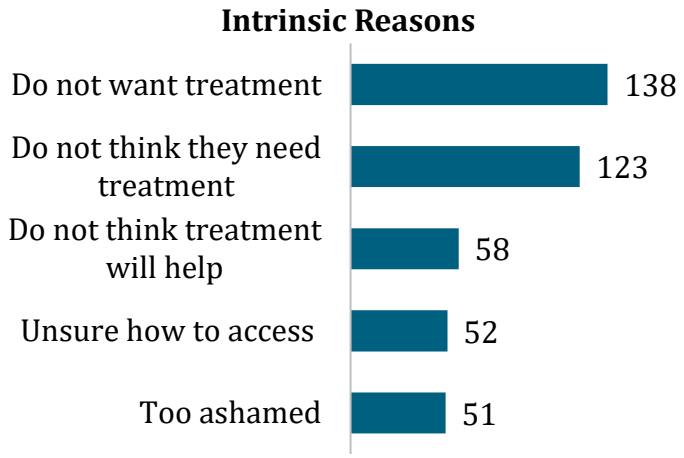
Providers indicated individuals did not seek treatment because they did not want treatment

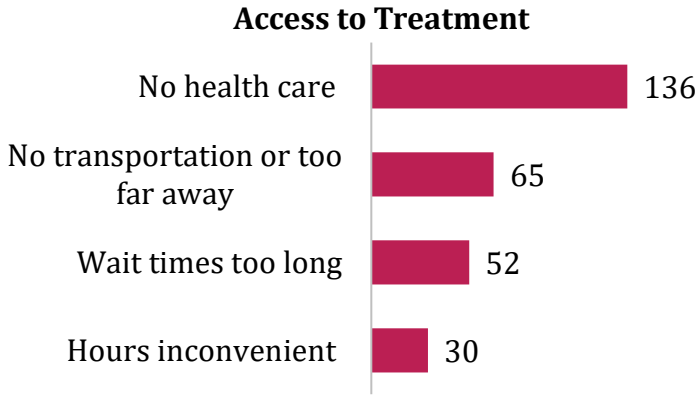
Access to Treatment

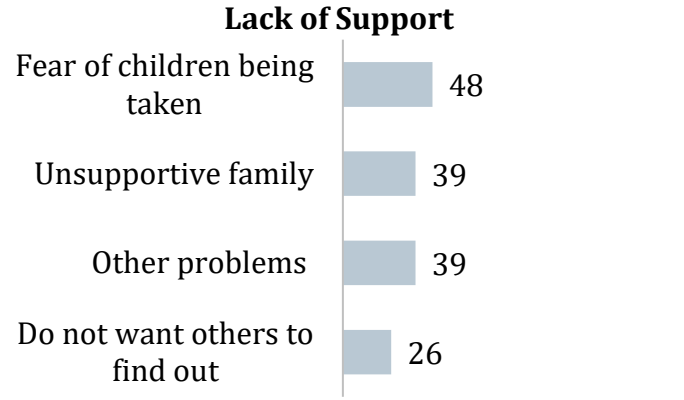
Nearly 40% of responses related to systemic barriers to accessing treatment. The most common systemic barrier related to individuals' lack of health insurance. In contrast, the most common barriers reported by inpatient administrators from the 2018-2019 survey[7] involved the availability of treatment beds.

Lack of Support

Few providers reported a lack of support as a treatment barrier for people. The most common "lack of support" barrier indicated by providers related to fear of children being removed from the home.







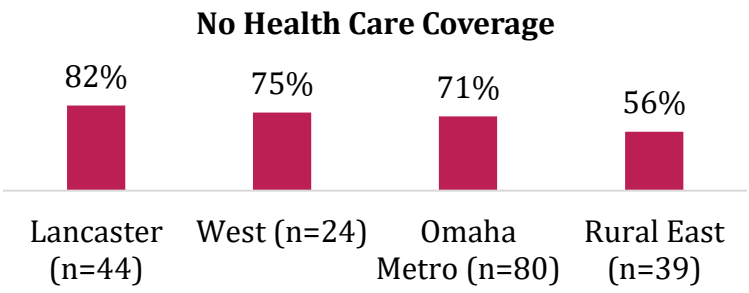
Treatment Barriers and Facilitators

Reasons for Not Receiving Treatment by Region (n=187)
Providers from the **Lancaster region** (n=44) most often indicated a lack of health care coverage as a treatment barrier (82%), followed by "do not think they need treatment" (70%). The majority of providers serving the **West region** (n=24) also indicated no health care coverage as a primary treatment barrier (75%), followed by "takes too long to access treatment" (71%). **Rural East** (n=39) providers most often identified "takes too long to access treatment" (82%) and "do not think they need treatment" (77%). Finally, providers from the **Omaha Metro region** (n=80) indicated a lack of health care coverage and the wait time for accessing treatment were barriers to treatment at the same rate (71%).

Providers indicated "no health care coverage" and "takes too long to access treatment" as treatment barriers more often than any other option. While "no transportation/too far away" was not the most common answer for any region, providers' answers did vary significantly by region. The regional breakdown for these three notable barriers is shown in the graphs below.

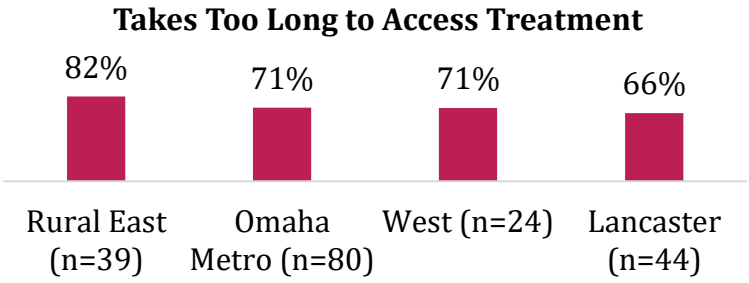
No Health Care Coverage

As indicated in the graph to the right, most providers from the Lancaster, West, and Omaha Metro regions indicated lacking health care coverage impeded individuals from receiving treatment. However, fewer providers in the Rural East indicated health care as a barrier.



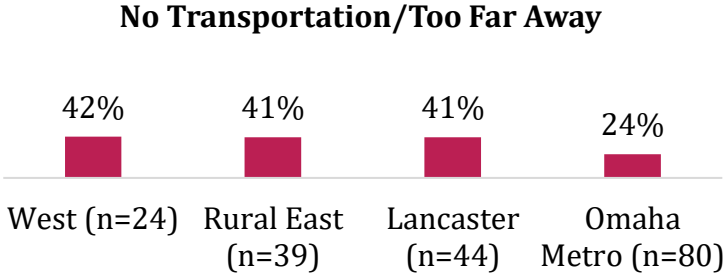
Takes Too Long to Access Treatment

While wait times were a significant factor for clients not receiving treatment in all areas, more providers in the Rural East indicated wait times as a notable barrier.



No Transportation/Too Far Away

Approximately 40% of providers in the West, Rural East, and Lancaster regions indicated transportation as a barrier to accessing treatment, in contrast to only 24% of providers serving the Omaha Metro region.



Treatment Barriers and Facilitators

Information for DHHS (n=100)

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

When given an open-ended opportunity to reflect on the most important issues impacting their work, providers passionately described service gaps and access barriers. Four primary themes emerged from providers' responses:

1. Description of clients and reduction in stigma
2. Gaps in services
3. Barriers to service, and
4. Relationships between gaps and barriers.

Theme 1: Description of clients and reduction in stigma

Many providers viewed this question as an opportunity to "set the record straight" regarding **the humanity and personhood of their clients**. At times, this message seemed to be pointedly addressed toward stigma they perceived coming from DHHS. Those provider responses categorized into Theme 1 varied little across region.

"They are not just another number or problem on [the DHHS] caseload."
"[DHHS is] not willing to help clients."
"[Clients] don't trust DHHS."
"Nobody is a monster!"

Providers articulated the many hardships and barriers their clients encounter, especially the **rigorous and sometimes conflictual requirements required by multiple systems** in which their clients are involved (i.e. child protective services, courts, public assistance, schools, etc.).

"They have an illness. Not every family looks the same. Do not set a standard for them to live up to that is not realistic."

In light of these difficulties, many providers described **practices they have found to be more effective than many current practices**, which they described as being shame-inducing and stigmatizing. Those practices most often identified by providers as beneficial included:

- Partnering and establishing a relationship with the client,
- Reducing or eliminating waiting lists to ensure treatment is accessible when they are ready,
- Meeting basic needs (i.e. housing, food, childcare) so clients are able to focus on treatment, and
- Carefully reconsidering mandated treatment, because it is often NOT helpful.

"There needs to be treatment available when clients are ready, waiting list [sic] are death sentences for some and cruel to the rest."
"Court ordering treatment does not work [sic] The client needs to want this for themselves, or it is just a waste of state monies."

Treatment Barriers and Facilitators

Information for DHHS (n=100)

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

Theme 2: Gaps in services

Many providers pointed to **systemic gaps which often acted as barriers** to clients overcoming substance use disorders. While a few gaps appeared to be community specific, the most prominent gaps described seem to exist across the state, regardless of the provider's location.

The **most common gaps** noted across the state included:

- Adequate provider reimbursement from public insurance,

"NE total Care and Wellcare suck in regards to everything this survey is seeking data on. Wellcare and NTC pretend like they do, but we see their patients every day with nowhere else to go and are forced to turn them away. Despite repeatedly expressing concern [NTC and Wellcare] just don't care. This is probably how they make a 15% profit on their contracts with the state despite being capped at 3% by contract. NTC and Wellcare provide profit for their shareholders and limit patient access to care. That has been our only experience and persists to this day."

"I quit taking Medicaid."

- Necessary services are often not covered by insurance, most notably chemical dependency evaluations and detoxification,
- Services to assist with basic needs (i.e. transportation, childcare, housing),
- Funding for essential services that support substance use treatment (i.e. healthcare, case management, community outreach),

"Programs are less helpful when under funded. MAT is dangerous when not appropriately monitored."

- Early prevention services (targeted at younger age groups),
- Training for professionals, especially related to trauma and co-occurring disorders, and
- Wait lists for substance use treatment services.

Additionally, providers articulated the **region-specific gaps** provided below.

Lancaster County:

- Services for adolescents
- Services for those involved in the criminal justice system
- Services for women and their children

Treatment Barriers and Facilitators

Information for DHHS (n=100)

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

Theme 2: Gaps in services

Douglas and Sarpy County:

- Recent closure of facilities resulting in significant gaps in community services and certain levels of care

"It is important that Nebraska has multiple programs that offer all of the levels of care. There have been several good substance abuse programs that closed in the last few years and it has left gaps in resources."

- Services for those involved in the criminal justice system
- Training on MAT

Rural East and West Counties:

- Availability of 12-step groups
- Availability of treatment for co-occurring disorders
- Availability of all levels of care
- Workforce capacity

"Funding is the number one concern, followed by capacity/access to treatment without extensive intake paperwork, followed by a provider workforce that understands co-occurring disorders."

Theme 3: Barriers to service

Often as a result of the gaps discussed, providers reported clients encounter significant barriers in accessing substance use treatment services, as well as services that support their recovery. Providers identified similar barriers across the state, regardless of geographic area.

The **most common barriers** noted across the state include:

- Inability to pay/lack of insurance coverage,

"Most of our patients are trying very hard to complete treatment, but have financial issues in paying for treatment."

- Extensive wait lists and lost opportunities for obtaining treatment,

"Long wait lists make it difficult to get people into treatment because substances [sic] users often change their mind as to if they want treatment or not."

Treatment Barriers and Facilitators

Information for DHHS (n=100)

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

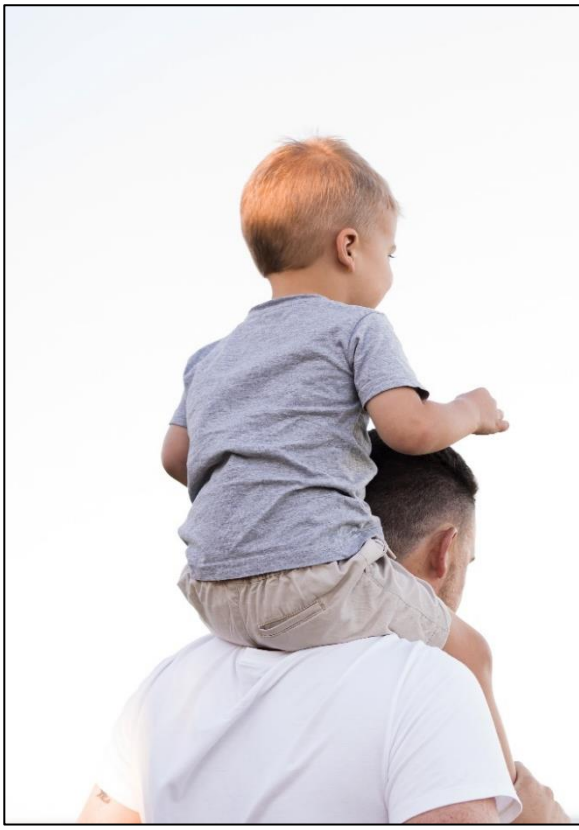
Theme 3: Barriers to service

- Unmet basic needs, especially housing, transportation, and childcare, and

"Often times the biggest barriers to someone getting the help they need is basic things like transportation, gas money, and insurance. We need more in-home providers as well."

- Fear of losing custody of children.

"Losing their children often times pushes them into deeper substance use because they can't cope with the devastating loss of their kids."



"Transportation and childcare are two significant barriers when it comes to treatment. Many are on probation or involved with DHHS and expected to attend meetings, counseling, have a job, doing family counseling, UA daily, attend parenting class, practice family activities within the home and go to probation classes all within a 7 day week and there is limited means of transportation or they have kids who can not attend probation classes or therapy with them. Many can't drive or have no car. We often have kids waiting in the waiting room which is not always ideal and parents get distracted working in sessions. There are many single parent households so when they have an AA meeting or probation class, they rely on friends or family to watch the kids because daycares are closed in the evenings."

- Outpatient Substance Use Treatment Provider

Treatment Barriers and Facilitators

Information for DHHS (n=100)

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

Theme 4: Relationship between gaps and barriers

While providers discussed both gaps in the community, as well as barriers encountered by clients, a clear connection between the two phenomena became apparent.

Gaps in the Community	Lead to	Barriers for Clients
Inadequate reimbursement to providers from public insurance	→	Lack of quality providers for low-income individuals
Lack of funding for services often not covered by insurance (i.e. detoxification, evaluations)	→	Since these services are often pre-requisites for entering treatment, clients are not able to access treatment
Inadequate services to help meet basic needs, especially transportation, housing, and childcare	→	Inhibits clients' ability to connect with, or fulfill the obligations of treatment
Lack of funding to organizations for support services, such as healthcare, case management, and outreach	→	Inhibits clients' ability to successfully complete treatment, transition to self-sufficiency, or maintain sobriety
Few treatment facility options, with long wait lists	→	Missed opportunities for clients to seek treatment within the window of opportunity in their lives

"Medicaid reimbursement for treatment doesn't sustain programs and isn't financially viable if you want to keep qualified clinicians doing the hardest work."

"Omaha and Nebraska have disgracefully few treatment alternatives for the uninsured and almost no realistic detox options."

"The more support they are provided with the better the outcomes i.e....transportation child care housing energy assistance etc..."

"My individuals are at most need for services in the community for when then [sic] transition to life."

"Our waitlist hovers around 2-6 months and often times those on the waitlist can't wait that long for treatment and get lost in the shuffle waiting for services."

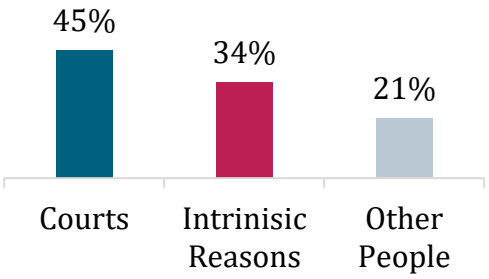
Treatment Barriers and Facilitators

Catalysts for Treatment (n=191)

Which of these statements best describes how your clients were prompted to get treatment? *The full list of response options are provided in Appendix B.*

For this item, providers could choose multiple reasons from the list provided as to why their clients seek treatment. Providers gave a collective 402 responses (n=191). Of those 402 responses, 66% were extrinsic reasons, categorized as "courts and other legal entities" (45%) and "other people" (21%), and 34% were categorized as "intrinsic reasons." Inpatient administrators from the 2018-2019 DOP DUB survey[7] also identified "courts" as the most common catalyst (53%), but identified "other people" as a catalyst for treatment slightly more often (25%) than "intrinsic reasons" (22%).[7]

Catalysts for Treatment



Courts and Other Legal Entities

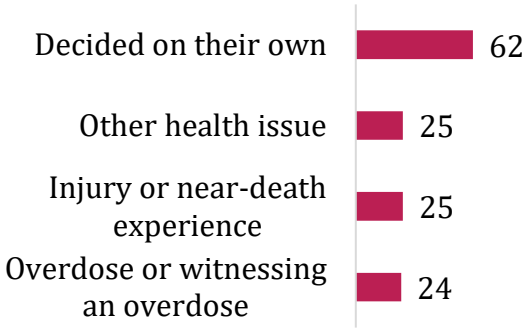
Providers indicated their clients were prompted to receive treatment due to court-related incidents more than any other catalyst.

Courts

Intrinsic Reasons

Approximately one-third of provider responses indicated clients sought treatment due to intrinsic reasons. One-third of all providers indicated their clients decided to get treatment on their own.

Intrinsic Reasons



Other People

Nearly half of providers indicated their clients sought treatment because someone else thought they should.

Other People

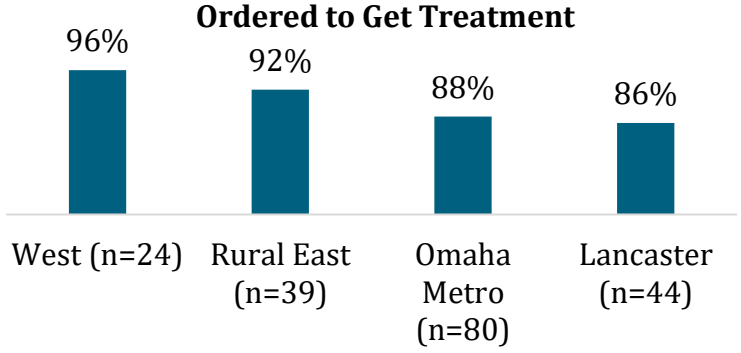
Treatment Barriers and Facilitators

Catalyst for Treatment by Region (n=187)

In each region, providers most often indicated "they were ordered to get treatment" as the reason someone sought treatment, followed by "they got treatment because someone else thought they should." The regional breakdown for these two notable treatment catalysts is included below.

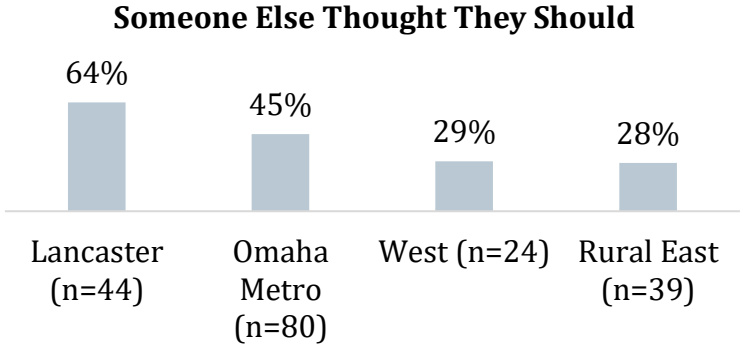
Ordered to Get Treatment

Most providers from all regions indicated clients sought treatment due to having been ordered to get treatment, but this was especially pronounced in the western half of the state.



Someone Else Thought They Should

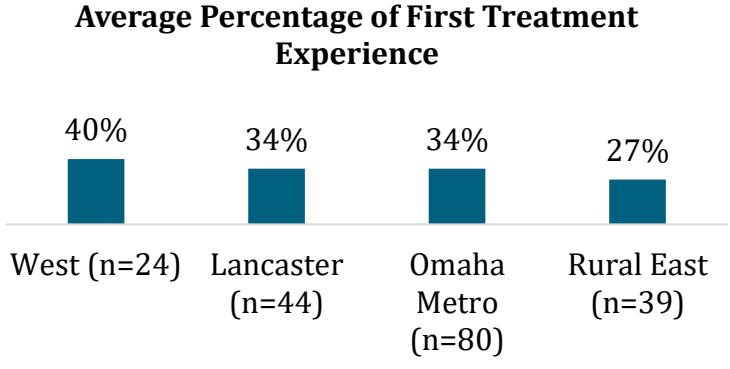
Over twice as many Lancaster providers as West and Rural East providers indicated the influence of others was a significant reason their clients sought treatment.



First Treatment Experience (n=187)

For what percentage of your clients in the past year was this their first treatment experience EVER?

On average, providers indicated it was the first treatment experience for 33% of their clients in the past year.



First treatment experience for one in three clients

Providers from the West region indicated a slightly higher percentage of their clients in the past year had never had a previous treatment experience (40%).

Prevention Efforts

Helpful Prevention Efforts (n=189)

In your opinion, what prevention efforts are most helpful?
The full list of response options are provided in Appendix B.

Most Often Indicated Prevention Efforts

Nearly half of providers (44%) indicated prevention programs targeting middle school students are helpful primary prevention efforts and just over half indicated addiction screening at primary (medical) care facilities is a helpful secondary prevention effort (52%). Nearly 80% of providers indicated increased access to mental health treatment is an effective prevention effort. **Access to mental health treatment was the most often indicated effort in the tertiary prevention category and overall.** Little difference existed in the answers of providers from different regions.

Most Often Indicated Prevention Efforts by Category

Primary Prevention	Secondary Prevention	Tertiary Prevention
School-based substance use prevention programs for middle school students	Addiction screening at primary care facilities	Increased access to mental health treatment

Least Often Indicated Prevention Efforts

Only 18 providers (9%) indicated public service announcements are helpful primary prevention efforts. In the secondary and tertiary prevention categories, use of the Prescription Drug Monitoring Program and naloxone training and access were the strategies identified least often as being helpful. This is similar to findings from the previous 2018-2019 DOP-DUB report[7], in which inpatient administrators indicated MAT treatment and increased access/ training on naloxone as helpful the least often. Few inpatient administrators from the 2018-2019 report indicated public service announcements as a helpful prevention effort and only slightly more indicated use of the Prescription Drug Monitoring Program as a helpful prevention effort.

Least Often Indicated Prevention Efforts by Category

Primary Prevention	Secondary Prevention	Tertiary Prevention
Public service announcements and media campaigns for general public	Use of Prescription Drug Monitoring Program before prescribing controlled substances	Increased access to and training on naloxone

The full chart of prevention efforts ranked from most often indicated to least often indicated is provided in Appendix E.

Prevention Efforts

Populations in Need of Prevention (n=189)

In your opinion, what populations are most in need of additional substance use prevention efforts?
The full list of response options are provided in Appendix B.

Most Often Indicated Populations

Providers most often indicated middle school students and high school students (62%), and young adults (61%) as populations in need of prevention efforts, closely followed by individuals with mental illness (58%). These answers are consistent with providers' rating of helpful prevention efforts in the previous item. Little difference existed in the answers of providers from different regions.

Least Often Indicated Populations

Approximately 10% of providers indicated American Indians/Alaska Natives and women of child-bearing age are in need of prevention efforts. Only 2% of providers indicated Latinos/Latinas are a population in need of prevention efforts.

The full chart of populations ranked from the most often indicated to least often indicated is provided in Appendix F.

Populations in Need of Prevention

Most Often Indicated

1. Middle school and high school students
2. Young adults (18-25 years)
3. Individuals with mental illness
...
...
...
11. American Indians/Alaska Natives
12. Women of child-bearing age
13. Latinos/Latinas

Least Often Indicated

Note: The darker shade of blue indicates more providers identified this population as in need of prevention efforts.

Training and Resources for Treatment Providers

Future Training (n=188)

Which of the below topics would be useful for future training for yourself or other staff at your facility?

Most Often Indicated Training Topics

Over half of providers indicated interest in trainings on co-occurring disorders (56%) and evidence-based treatments (54%). Nearly 40% of providers indicated interest in trauma-informed care and alternative pain management strategies for future training topics. Little difference existed in the answers of providers from different regions.

Least Often Indicated Training Topics

Providers indicated little interest in trainings related to naloxone use, PDMP, or treatment for methamphetamine addiction.

The full chart of future training topics ranked from most often indicated to least often indicated is provided in Appendix G.

Future Training Topics

Most Often Indicated

1. Co-occurring disorders
2. Evidence-based treatments
3. Alternative pain management strategies
4. Trauma informed care
...
...
14. Naloxone use and/or administration
15. Prescription Drug Monitoring Program
16. Treatment for methamphetamine addiction

Least Often Indicated

Note: The darker shade of blue indicates providers identified interest in this training topic more often.

Training and Resources for Treatment Providers

Additional Resources for Clients (n=178)

What additional resources do your clients need?

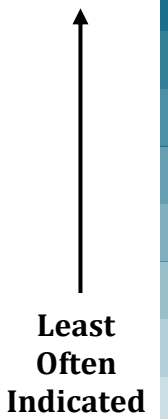
Most Often Indicated Resources

Approximately half of providers indicated financial assistance for MAT and a reduction in wait time to access treatment, both systematic barriers to treatment, are additional resources needed by clients. Nearly half of providers also indicated community outreach as a necessary resource for clients. Little difference existed in the answers of providers from different regions.

Least Often Indicated Resources

Consistent with the rating of prevention efforts and future training topics, few providers indicated clients need additional naloxone kits. Providers who indicated "other" specified a range of answers including transportation assistance, assistance with children while in treatment, and aftercare services.

The full chart of additional resource options ranked from most often indicated to least often indicated is provided in Appendix H.



Additional Resources
1. Financial assistance for MAT
2. Reduction in waiting lists and wait time
3. Community outreach
…
…
…
11. Naloxone kits
12. Condom distribution
13. Other

Note: The darker shade of blue indicates providers identified a need for this resource more often.

Training and Resources for Treatment Providers

Helpful Training Received (n=126)

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

Provider responses to this item generally mirror the same types of training they indicated they would find helpful in the future (see previous item)**.**

1. Evidence-Based Practices (other than trauma)

Providers most often indicated that training on evidence-based practices (EBPs) was helpful. This was especially true in the Rural East region, as over half of responses in this category were from this region.

EBPs specifically mentioned in this category were those NOT focused on trauma, including **Cognitive Behavior Therapy, Dialectical Behavior Therapy and training on the following standardized assessment instruments**:

- Adverse Childhood Experiences Scale
- Addiction Severity Index
- Comprehensive Adolescent Severity Index
- Substance Abuse Subtle Screening inventory

2. Trauma-Informed Care (including EBPs)

Many respondents also expressed that trainings on trauma informed care have been helpful. These included both evidence-based models (i.e. Eye Movement Desensitization and Reprocessing, Trauma-Focused Cognitive Behavioral Therapy), as well as general trauma trainings and treatment strategies.

3. Substance Use Trends

Many respondents reported training on substance use trends was useful. This was especially true for those in the Omaha Metro region, and those in the West region, with approximately 20% of responses coming from each of those regions.

4. Biological Components of Addiction

Several respondents indicated that trainings related to biological aspects of addiction have been most helpful. These include training on **MAT, psychopharmacology, and neurobiology of addiction.**

5. Co-Occurring Disorders

Several respondents indicated trainings related to co-occurring disorders have been helpful. However, **significantly more providers indicated this type of training would be helpful in the future (see previous item), than has already been helpful (current item). This may illustrate a great need in this area.**

Training and Resources for Treatment Providers

Helpful Training Received (n=126)

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

6. General Training

Many respondents indicated that, in general, participating in training is helpful. More general trainings mentioned by providers included trainings that provide continuing education credit, trainings from the American Society of Addiction Medicine, post-secondary training, and clinical experience.

7. Other

Other trainings that providers indicated as helpful included topics such as **harm reduction strategies, wholistic or alternative treatments, and special populations or issues** such as domestic violence, sexual addiction, criminal justice, and cultural competency.

Recommendations

Clarify DHHS' Role: Some providers' responses to the open-ended survey items indicated they may see Child Protective Services as synonymous with DHHS. A few providers alluded to clients' lack of trust in DHHS due to the fear of DHHS taking away their children. Clarifying the role of DHHS in supporting the provision of substance use treatment may resolve misconceptions currently held by providers.

Work to Reduce Stigma: Many providers were most concerned with stigma from organizations, including DHHS, targeted at their clients. They viewed this stigma as a barrier to their clients' ability to seek and maintain sobriety. Additional investigation into the sources and communication of this stigma may be warranted.

Evaluate Current DHHS Efforts: In the 2018-2019 DOP DUB report[7], approximately half of inpatient administrators indicated naloxone as a helpful prevention effort, but few LADC and PLADC providers found naloxone helpful. Additionally, few LADC and PLADC viewed strategies such as the Prescription Drug Monitoring Program and Public Service Announcements helpful prevention tools. Instead, providers overwhelmingly indicated prevention strategies aimed at middle and high school students, rather than other populations, are the most helpful. Additional investigation into the delivery and effectiveness of current DHHS efforts may be useful to inform outreach and prevention strategies.

Meet Training Needs: Training needs across the state include topics such as co-occurring disorders, trauma-informed care, EBPs, and drug use trends. Any offerings DHHS may be able to offer in these areas would be helpful for providers.

Target Efforts: Most results indicate that trends and needs for both clients and providers are consistent across the state. While delivery methods may need to be adapted to overcome geographic barriers, it does not appear as if DHHS needs to target most efforts to a particular area or region.

Alleviate Treatment Barriers: Providers noted many systemic barriers to treatment, both from the perspective of providers and clients. Any policy or funding changes that can be made to alleviate these barriers would greatly increase the ability of clients to access treatment.

Share Findings: Share the findings of this needs assessment with DHHS staff, community members, providers, and other stakeholders. Sharing the results of the survey with those who provided input can make participants feel heard and valued, increasing their likelihood of participation in future evaluation efforts. By sharing information from this report with the Nebraska community, DHHS can be recognized for their efforts to better understand drug use behaviors and the needs of treatment providers. Publishing this needs assessment may also contribute to the knowledge base of substance use treatment for providers, public administrators, and researchers, leading to an increase in evidence-informed decision making for a variety of practitioners.

Limitations

1. Response Rate

STEPs emailed the anonymous survey link to each registered LADC and PLADC licensed by DHHS. Some individuals did not provide an email or the email provided was no longer active. In addition, emails may have inadvertently been sent to a spam folder or recipients may not have recognized the sender and ignored the email. STEPs used multiple rounds of follow-up emails to increase the response rate. Due to these technological barriers, some providers were not reached which negatively impacted the response rate.

2. Incomplete Survey Responses

A total of 213 providers started the survey, but only 193 respondents completed both the demographic items, the medication referral item, and at least one other item. These 20 individuals may have unintentionally only completed the first page of items on the survey, without realizing there were items beyond the first page. Other providers only completed some of the survey items (as noted by total n for each survey item).

3. Disproportionate Representation from Urban Counties

Nearly twice as many urban providers responded as rural providers. Only 24 providers serving the West responded, compared to 40 providers serving the Rural East. As such, we know less about drug use behaviors and provider needs in the West region. Additionally, nearly twice as many Omaha Metro providers responded as Lancaster providers.

4. Limited Scope of Services Sampled

This report only included those individuals who hold a LADC or PLADC in Nebraska. The perspectives of those individuals who provide services to this population, but do not hold a LADC or PLADC may differ substantially from this sample.

5. Provider Self-Report

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

6. Aggregate Data

This survey asked providers to estimate the percentage of clients they see engaging in various drug use 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.

7. COVID-19

STEPs obtained survey data prior to the outbreak of COVID-19 in Nebraska. Challenges faced by both treatment providers and clients may be substantially different post-COVID.

References: LADC/PLADC Quantitative Survey

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

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

DRUG USE BEHAVIORS

Updated* Dataset Results

August 6, 2020

*Report updates are indicated with a footnote.

Rachel Lubischer, MSW, MPA,
Jennifer L. Smith, MPPA, CMHC Student,
December Lange Treacy, MS
with Jeanette Harder, Ph.D., CMSW

*Table of Contents

Click on the section headings below to navigate to that page. Click on the compass symbol in the top right-hand corner of each page to return to the overall Table of Contents.

Drug Use Behaviors Background

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) Drug Overdose Program (DOP) contracted with STEPs in the fall of 2019 to complete a needs assessment that included an identification and analysis of quality datasets, a survey of outpatient treatment providers, and focus groups with treatment providers.

Purpose

The goal of this needs assessment is to deepen DOP's understanding of individuals' drug use behaviors in Nebraska through the lens of treatment providers.

The results of this study will aid DOP in providing training and other resources to treatment centers, focusing prevention efforts, and informing their strategic plan and future studies. Ultimately, this study will support DOP's efforts to reduce opioid-involved fatal and non-fatal overdoses in Nebraska.

*Table of Contents updated on 8/6/2020

Introduction

Dataset Purpose

The purpose of the dataset analysis is to provide data on who is receiving treatment, who is referring people to treatment, and people's age at first use. The current report includes analysis of quality datasets that can be useful now and in future evaluations.

Methodology

Below is an outline of the activities STEPs completed to identify, select, and analyze quality secondary datasets.

1 STEPs conducted a review of the literature on health indicators, which found consistent references to documents published by the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Council of State and Territorial Epidemiologists (CSTE). STEPs weighed the prevalence of established substance use indicators when determining the usefulness and quality of datasets. The CSTE's *Recommended CSTE Surveillance Indicators for Substance Abuse and Mental Health* identified 10 substance use indicators recommended for use in surveillance systems (2019). Of these 10 indicators, 5 are included in the table below, and target non-alcohol drug use.

Five Recommended Substance Use Indicators
(CSTE, 2019, p. 14)

Drug overdose mortality	Hospitalization attributable to drugs with potential for abuse and dependence	Prescription opioid sales per capita	Drug or alcohol dependence or abuse in the last year	Prevalence of use of selected prescription and illicit drugs

2 STEPs identified 12 secondary datasets relevant to substance use. Utilizing the substance use indicator literature and the CDC's "Guidelines for Evaluating Public Health Surveillance Systems," STEPs selected the following datasets to be used over time: the Nebraska Risk and Protective Factor Student Survey (NRPFSS), Nebraska Hospital Association Hospital Discharge Data (HDD), and Treatment Episode Data Set (TEDS). For more information on indicators and dataset selection, please see the Drug Overdose Prevention Dataset Methodology report in Appendix I.

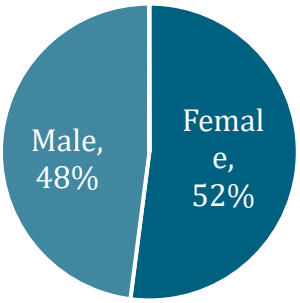
3 Following the identification of datasets, STEPs downloaded publicly available data and requested non-public data from appropriate sources including the Nebraska Hospital Association and the Nebraska DHHS Division of Behavioral Health (DBH). STEPs analyzed available data in Microsoft Excel and SPSS.*

*Section updated on 8/6/2020

Nebraska Hospital Association (NHA) Inpatient Discharges

The Nebraska Hospital Association (NHA) provided STEPs inpatient hospital discharge data for cases with diagnoses related to substance use. The dataset included information on patients' diagnosis, sex, age, home address, hospital location, and length of stay. The dataset included 3,330 discharges between January 1, 2016 and September 30, 2019.

What are the characteristics of individuals discharged from inpatient treatment with diagnoses related to substance use?



Patient Sex (n=3,329)
For the entire population of Nebraska in 2018 (n=1,904,760), 50% of the population was female (n=954,850) and 50% was male (n=949,910) (United States Census Bureau, 2018). The percentage of female and male patients discharged from inpatient treatment related to substance abuse was similar with 52% (n=1,733) patients identifying as female and 48% (n=1,596) identifying as male.

41

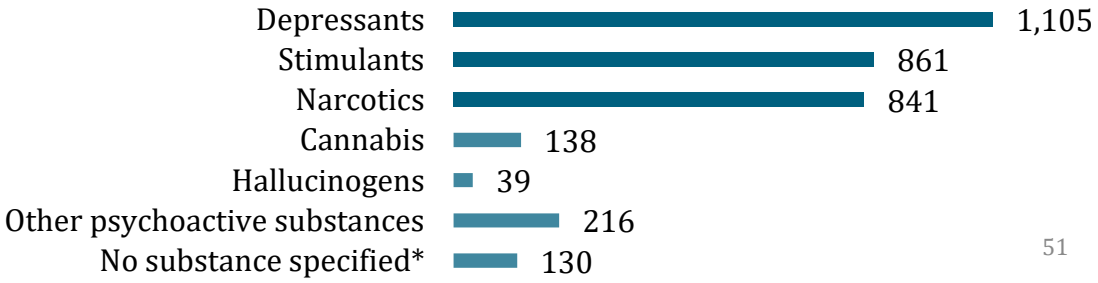
Patient Age in Years (n=3,330)
Patient ages ranged from 0 to 97 years with an average age 41 years (SD=17) and a median age of 39 years.

4

Patient Length of Stay in Days (n=3,330)
Patients' lengths of stay ranged from 1 to 45 days with an average length of 4 days (SD=4) and a median length of 2 days.

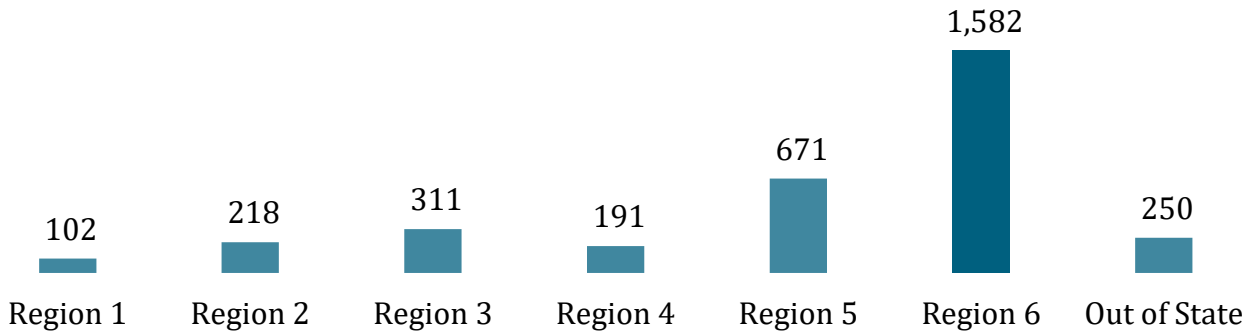
Substance Related to Patient Diagnosis (n=3,330)
The most common substances related to the inpatient diagnoses were depressants (33%, n=1,105) followed by stimulants (26%, n=861) and narcotics (25%, n=841). 130 patients (4%) did not have a substance specified in their diagnosis code. Instead, their diagnoses were related to substance use complicating pregnancy, childbirth, or puerperium.

For a sample of diagnosis codes and their related substance category, see Appendix J.



What are the characteristics of individuals discharged from inpatient treatment with diagnoses related to substance use? (cont.)

Behavioral Health Region by Patient Address (n=3,325)
The greatest proportion (48%) of all hospital inpatient discharges were for patients whose home address was in Region 6 (n=1,582). Region 5 had the second greatest proportion (20%, n=671) of residents discharged.



The table below compares the percentage of discharged patients with home addresses in each behavioral health region in Nebraska (excluding patients with missing or out-of-state home addresses, n=3,075) to the percentage of all Nebraskans residing in each region (n=1,904,760, United States Census Bureau, 2018). As shown, **Region 6 had a higher percentage of discharged patients than expected based on population (51% compared to 43%).**

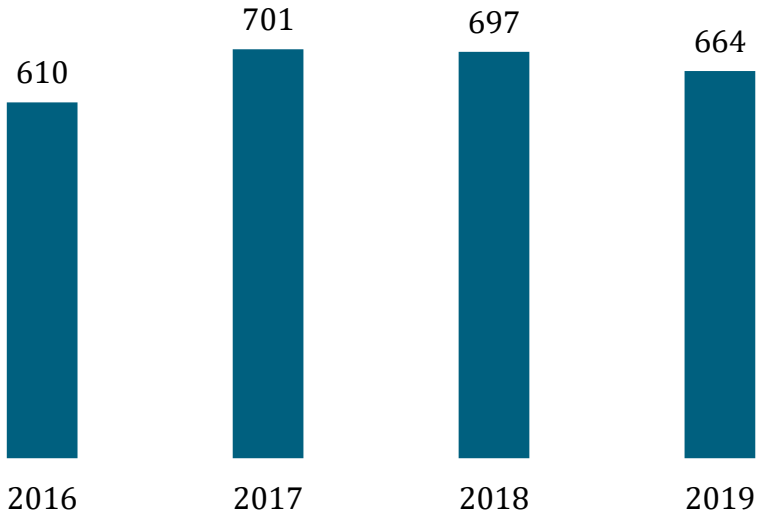
Region 4 had only 6% of inpatient discharges while comprising 11% of the population.

Behavioral Health Region	% of all discharges (n=3,075)	% of Nebraska population (n=1,904,760)
Region 1	3% (n=102)	4% (n=85,550)
Region 2	7% (n=218)	5% (n=99,028)
Region 3	10% (n=311)	12% (n=230,690)
Region 4	6% (n=191)	11% (n=205,654)
Region 5	22% (n=671)	25% (n=467,891)
Region 6	51% (n=1,582)	43% (n=815,947)

What are the trends for the characteristics of individuals discharged from inpatient treatment with diagnoses related to substance use since 2016?

Many of the characteristics of individuals discharged from inpatient treatment with diagnoses related to substance use have remained stable since 2016. Patient sex, age, and length of stay have remained consistent. See Appendix K for tables.

Number of Inpatient Treatment Discharges by Year (n=2,672)
The total number of inpatient discharges between January 1 and September 30 of each year is shown to the right. The comparison includes only discharges during this time as quarter 4 data for 2019 was not yet available at the time of this report. As shown, **the number of inpatient discharges was at its highest point in 2017 and has seen modest declines in the following 2 years.**



Substance Related to Patient Diagnosis (n=3,330)
While depressants have been the most common substances related to inpatient treatment diagnoses overall, the 4-year trend analysis shows **the percentage of diagnoses related to depressants have consistently decreased since 2016. A similar trend exists for narcotics. In contrast, diagnoses related to stimulants have been steadily increasing since 2016**. The percentage of other substances related to diagnoses has remained consistent over time. See Appendix K for information on other substances.

The percentage of depressant-related diagnoses has decreased since 2016.

The percentage of narcotic-related diagnoses has decreased since 2016.

The percentage of stimulant-related diagnoses has increased since 2016.

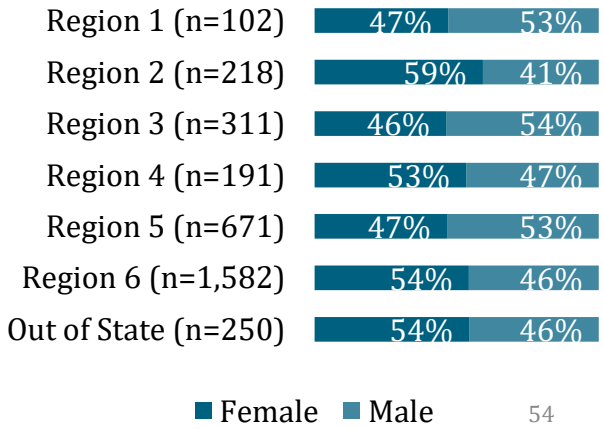
What are the trends for the characteristics of individuals discharged from inpatient treatment with diagnoses related to substance use by behavioral health region since 2016?

STEPs investigated changes in the characteristics of individuals discharged from inpatient treatment with diagnoses related to substance use behavior by behavioral health region and year. The behavioral health region was determined based on the patient's home address. Five individuals discharged were excluded from the analysis as home address information was not provided. Notable findings are summarized below with additional tables located in Appendix K.

Percentage of Patient Discharges by Behavioral Health Region and Year (n=3,325)
The percentage of individuals discharged from inpatient treatment residing in each behavioral health region stayed relatively consistent over the past 4 years. Two notable exceptions include Regions 3 and 6. **Since 2017, the percentage of individuals discharged who resided in Region 3 increased by 2 percentage points. Conversely, since 2016, the percentage of individuals discharged who resided in Region 6 decreased each year resulting in a 7-percentage-point decrease from 2016 to 2019.**

Behavioral Health Region	2016 (n=822)	2017 (n=931)	2018 (n=910)	2019 (n=662)
Region 1	3%	4%	3%	3%
Region 2	7%	6%	6%	8%
Region 3	8%	8%	10%	12%
Region 4	6%	7%	5%	5%
Region 5	18%	21%	21%	20%
Region 6	51%	48%	46%	44%
Out of State	8%	7%	8%	8%

Patient Sex (n=3,325)
The percentages of female and male patients by behavioral health region are similar to overall findings; **a higher percentage of patients discharged from inpatient treatment with diagnoses related to substance use were female compared to male.** There are some exceptions with Regions 1, 3, and 5 having a lower percentage of female patients than other health regions. Region 2 has a much higher percentage of female patients than other regions.



What are the trends for the characteristics of individuals discharged from inpatient treatment with diagnoses related to substance use by behavioral health region since 2016? (cont.)

Patient Age in Years (n=3,325)
Overall, the average age for patients does not vary greatly across behavioral health regions. The average ages ranged from 39 to 42 years old.

Patient Length of Stay in Days (n=3,325)
Overall, the average length of stay for patients does not vary greatly across behavioral health regions. The average lengths of stay ranged from 3 to 4 days.

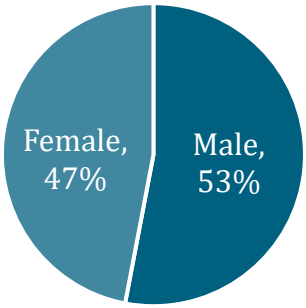
Substance Related to Patient Diagnosis (n=3,325)
For most regions, the most common substances related to inpatient treatment diagnoses were depressants. Exceptions include Region 3 and Region 4, which had stimulants and narcotics, respectively, as their most common substances. The highlighted cells indicate the most common substance for each region.

	Region 1 (n=102)	Region 2 (n=218)	Region 3 (n=311)	Region 4 (n=191)	Region 5 (n=671)	Region 6 (n=1,582)	Out of State (n=250)
Depressants	34%	31%	23%	26%	32%	36%	36%
Stimulants	20%	19%	42%	25%	28%	23%	27%
Narcotics	21%	25%	19%	27%	28%	26%	22%
Cannabis	4%	3%	3%	4%	3%	5%	5%
Hallucinogens	0%	0%	1%	1%	1%	1%	1%
Other psychoactive substances	9%	19%	5%	14%	4%	5%	4%
No substance specified	13%	2%	5%	4%	4%	3%	4%

NHA Emergency Department Discharges

NHA provided STEPs with emergency department discharge data for cases with diagnoses related to substance use. The dataset included information on patients' diagnosis, sex, age, home address, hospital location, and length of stay. The dataset included 7,712 discharges between January 1, 2016 and September 30, 2019.

What are the characteristics of individuals discharged from emergency departments with diagnoses related to substance use?



Patient Sex (n=7,709)
There was a slightly higher percentage of male than female patients discharged from emergency departments with diagnoses related to substance use with 53% (n=4,070) of patients identifying as male and 47% (n=3,639) identifying as female.

34

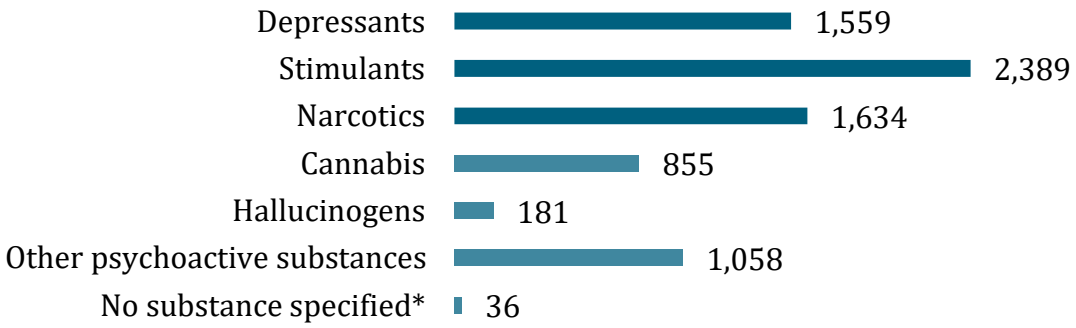
Patient Age in Years (n=7,712)
Patient ages ranged from 0 to 97 years with an average age of 34 years (SD=16) and a median age of 31 years.

1

Patient Length of Stay in Days (n=7,712)
Patients' lengths of stay ranged from 1 to 45 days with an average and median length of 1 day (SD=1).

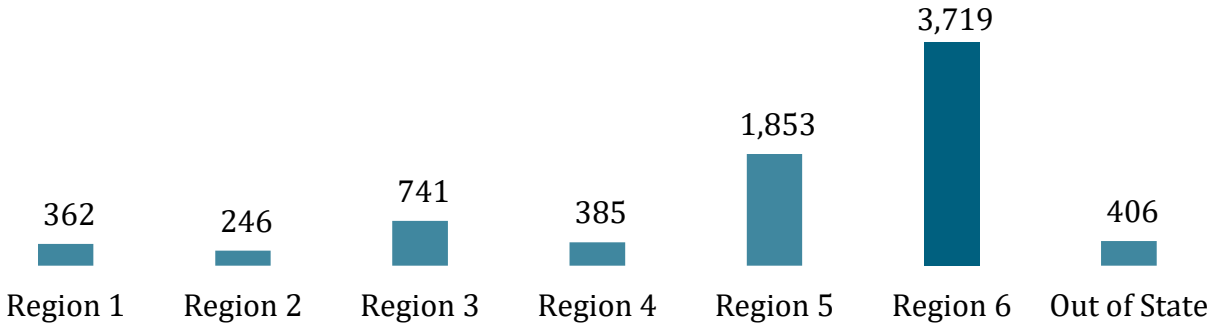
Substance Related to Patient Diagnosis (n=7,712)
The most common substances related to the emergency department diagnoses were stimulants (31%, n=2,389), followed by narcotics (21%, n=1,634) and depressants (20%, n=1,559). 36 patients did not have a substance specified in their diagnosis code. Instead, their diagnoses were related to substance use complicating pregnancy or neonatal withdrawal.

For a sample of diagnosis codes and their related substance category, see Appendix J.



What are the characteristics of individuals discharged from emergency departments with diagnoses related to substance use? (cont.)

Behavioral Health Region by Patient Address (n=7,712)
The greatest proportion of all emergency department discharges were for patients whose address was in Region 6 (48%, n=3,719). Region 5 had the second greatest proportion (24%, n=1,853) of residents discharged.



The table below compares the percentage of discharged patients with home addresses in each behavioral health region in Nebraska (excluding patients with out-of-state home addresses, n=7,306) to the percentage of all Nebraskans residing in each region (n=1,904,760, U.S. Census Bureau, 2018). As shown, **Region 6 had a higher percentage of discharged patients than expected based on population (51% compared to 43%).**

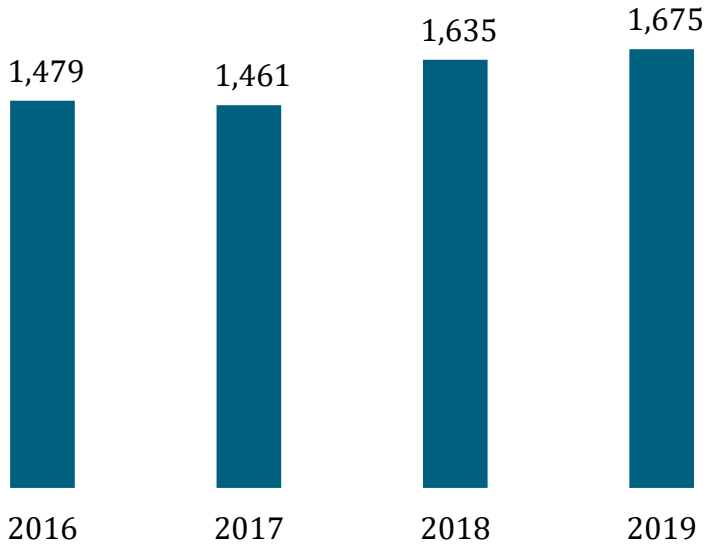
Region 4 had only 5% of inpatient discharges while comprising 11% of the population.

Behavioral Health Region	% of all discharges (n=7,306)	% of Nebraska population (n=1,904,760)
Region 1	5% (n=362)	4% (n=85,550)
Region 2	3% (n=246)	5% (n=99,028)
Region 3	10% (n=741)	12% (n=230,690)
Region 4	5% (n=385)	11% (n=205,654)
Region 5	25% (n=1,853)	25% (n=467,891)
Region 6	51% (n=3,719)	43% (n=815,947)

What are the trends for the characteristics of individuals discharged from emergency departments with diagnoses related to substance use since 2016?

Many of the characteristics of individuals discharged from emergency departments with diagnoses related to substance use have remained stable since 2016. Patient sex, age, and length of stay have remained consistent. See Appendix L for tables.

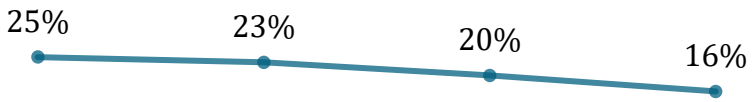
Number of Emergency Department Discharges by Year (n=6,250)
The total number of inpatient discharges between January 1 and September 30 of each year is shown to the right. The comparison includes only discharges during these months as quarter 4 data for 2019 was not yet available at the time of this report. As shown, **the number of emergency department discharges was at the lowest point in 2017 and saw increases in the following two years.**



Substance Related to Patient Diagnosis (n=7,712)
Like the trends seen in inpatient treatment, the substances related to emergency department diagnoses show **the percentage of diagnoses related to depressants and narcotics have decreased over time. In contrast, diagnoses related to stimulants have been steadily increasing since 2016**. The percentage of diagnoses related to cannabis use also increased during this timeframe. The percentage of other substances related to diagnoses have remained consistent over time. See Appendix L for information on other substances.

The percentage of depressant-related diagnoses has decreased since 2017.

The percentage of narcotic-related diagnoses has decreased since 2016.



The percentage of stimulant-related diagnoses has increased since 2016.

What are the trends for the characteristics of individuals discharged from emergency departments with diagnoses related to substance use by behavioral health region since 2016?

STEPs investigated changes in the characteristics of individuals discharged from emergency departments with diagnoses related to substance use by behavioral health region and year. The behavioral health region was determined based on the patient's home address. Notable findings are summarized below with additional tables located in Appendix L.

Percentage of Patient Discharges by Behavioral Health Region and Year (n=7,712)
The percentage of individuals discharged from emergency departments residing in each behavioral health region has stayed relatively consistent over the past 4 years except for Region 6. **Since 2017, the percentage of individuals discharged who resided in Region 6 has increased by 7 percentage points and 209 patients.**

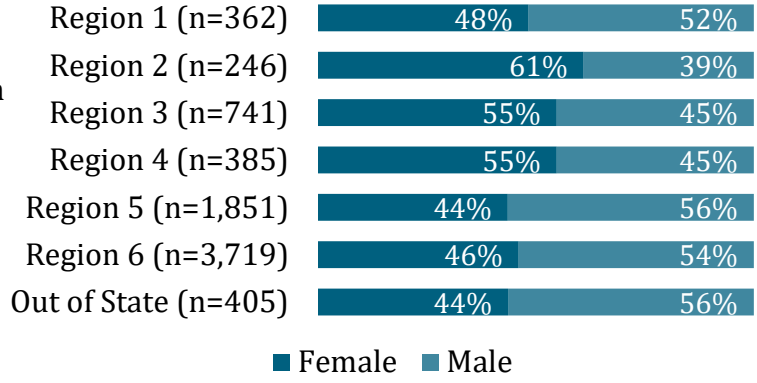
Behavioral Health Region	2016 (n=1,938)	2017 (n=1,914)	2018 (n=2,185)	2019 (n=1,675)
Region 1	6%	5%	4%	4%
Region 2	3%	3%	3%	3%
Region 3	11%	9%	9%	9%
Region 4	5%	6%	5%	5%
Region 5	24%	24%	25%	22%
Region 6	45%	49%	47%	52%
Out of State	6%	4%	6%	5%

Number of Patient Discharges by Behavioral Health Region and Year (n=6,250)
The total number of emergency department discharges between January 1 and September 30 of each year is shown to the right for each behavioral health region. The comparison includes only discharges during these months as quarter 4 data for 2019 was not yet available at the time of this report.

Behavioral Health Region	2016	2017	2018	2019
Region 1 (n=293)	85	67	78	63
Region 2 (n=192)	49	47	50	46
Region 3 (n=584)	152	131	150	151
Region 4 (n=314)	69	82	86	77
Region 5 (n=1,521)	369	368	411	373
Region 6 (n=3,023)	668	706	772	877
Out of State (n=323)	87	60	88	88

What are the trends for the characteristics of individuals discharged from emergency departments with diagnoses related to substance use by behavioral health region since 2016? (cont.)

Patient Sex (n=7,709)
The percentages of female and male patients varied across health regions with Regions 2, 3, and 4 having higher percentages of female patients and Regions 1, 4, and 6 having higher percentages of male patients.



Patient Age in Years (n=7,712)
Overall, the average age for patients did not vary greatly across behavioral health regions. The average ages ranged from 33 to 36 years old.

Patient Length of Stay in Days (n=7,712)
Overall, the average length of stay for patients did not vary across behavioral health regions. The average lengths of stay for each region was 1 day.

Substance Related to Patient Diagnosis (n=7,712)
For most regions, the most common substances related to emergency department diagnoses was stimulants. The highlighted cell indicates the most common substance for each region.

	Region 1 (n=362)	Region 2 (n=246)	Region 3 (n=741)	Region 4 (n=385)	Region 5 (n=1,853)	Region 6 (n=3,719)	Out of State (n=406)
Depressants	19%	33%	28%	22%	19%	19%	13%
Stimulants	27%	27%	28%	31%	31%	32%	34%
Narcotics	31%	26%	23%	24%	18%	20%	26%
Cannabis	12%	4%	11%	9%	9%	13%	12%
Hallucinogens	2%	0%	1%	2%	2%	3%	2%
Other psychoactive substances	11%	9%	10%	12%	21%	12%	14%
No substance specified	0%	1%	0%	0%	0%	1%	0%

Treatment Episodes Data Set–Discharges (TEDS-D)

The Treatment Episode Data Set (TEDS) is a compilation of admission and discharge data from substance use treatment facilities nationwide. TEDS–Discharges (TEDS-D) provides data from approximately 1.6 million discharges across the U.S. This data provides an opportunity to understand substance use treatment trends including demographic, substance use, and treatment episode characteristics.

Sample Size

TEDS-D includes 53,605 discharges from substance use treatment facilities in Nebraska from 2013 to 2017. Sample sizes by year ranged from 8,275 discharges in 2014, to 13,198 discharges in 2016 and 2017. TEDS-D reports information on admissions and discharges to treatment facilities, not individuals. Therefore, someone who is admitted to a treatment facility twice in one year may be included in two data points. The following analysis includes year-by-year comparisons for relevant items.

Sample Sizes by Year

Discharge Year	Sample Size
2013	10,103
2014	8,275
2015	8,831
2016	13,198
2017	13,198
Total	53,605

Missing Data

Missing data was handled using pairwise deletion in which client data were included in analysis regardless of whether that client had data for all items. The number of client data present for each item is shown by the "(n=)" in the item headings.

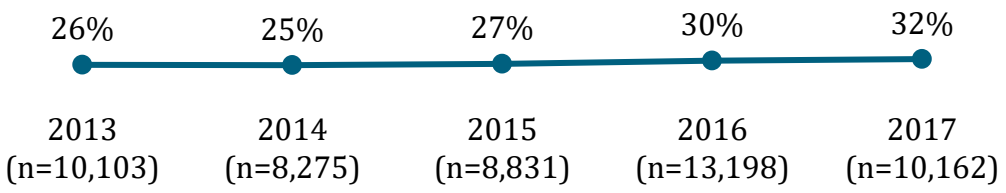
What substance use treatment trends exist in Nebraska over the past 5 years?

Client Age at Admission by Year

Between 2013 and 2017, the percentage of clients between 30 and 39 years old at admission increased slightly from 26% (n=10,103) to 32% (n=10,162). Concurrently, the percentage of clients between 40 and 49 years old and those over 50 years old decreased slightly. The percentage of clients between 21 and 29 years of age and those 20 years of age and younger stayed consistent at approximately 28% and 6% respectively. For the full Age at Admission by Year table, see Appendix M.

30-39 Years Old

The percentage of clients between 30 and 39 years old increased slightly.



Note: The y-axis ranges from 0% to 50% to emphasize the percentage increase.

What substance use treatment trends exist in Nebraska over the past 5 years? (cont.)

Client Sex by Year
Across years, approximately 69% of clients identified as male and 31% identified as female.

69% **Male**

Client Ethnicity by Year
Between 2013 and 2017, approximately 8% of clients identified as being of Hispanic or Latino origin.

8% **Hispanic or Latino Origin**

Client Race by Year

Clients who identified as White consistently made up the majority of treatment discharges, approximately 80%. Clients who identified as Black or African American made up approximately 9% of discharges and those who identified as American Indian comprised 8% of discharges between 2013 and 2017. For the full Race by Year table, see Appendix M.

Client Marital Status by Year
The percentage of clients by marital status stayed relatively consistent from 2013 to 2017. On average, 59% of clients had never married; 28% identified as either divorced, widowed, or separated; and 12% reported being married each year. For the full Marital Status by Year table, see Appendix M.

Client Pregnant at Admission by Year
Approximately 3% of clients reported being pregnant at admission between 2013 and 2017. *Due to NE DHHS' interest in drug use behaviors by women of childbearing age, STEPs requested additional data regarding client pregnancy status at admission from the DBH Data Team. Between 2013 and 2017, fewer than 0.5% of female clients were up to 6 weeks postpartum at time of admission. Overwhelmingly, female clients were neither pregnant nor within 6 weeks postpartum at time of admission.

3%
Pregnant at Admission

<0.5%
***Up to 6 Weeks Postpartum**

*Section updated on 8/6/2020

What substance use treatment trends exist in Nebraska over the past 5 years? (cont.)

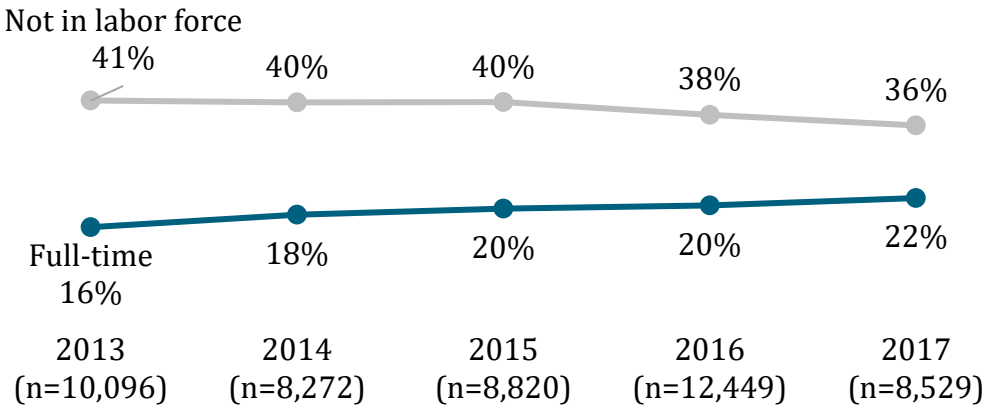
Client Education by Year

The educational attainment of discharged clients varied little between 2013 and 2017. The percentage of clients who indicated having 12 years of education or a GED increased slightly from 50% in 2013 (n=9,483) to 53% in 2017 (n=7,752). Concurrently, the percentage of clients who reported less than 12 years of education decreased slightly from 20% in 2013 to 18% in 2014 (n=7,569) through 2017 (n=7,752). For the full Education by Year table, see Appendix M.

Client Employment Status at Admission by Year

A higher percentage (22%, n=8,529) of discharged clients reported full-time employment at admission in 2017 compared to clients in 2013 (16%, n=10,096). Similarly, slightly less clients reported not being in the labor force at admission in 2017 (36%) compared to 2013 (41%). The percentage of clients who reported working part-time or being unemployed at admission stayed relatively consistent across the 4 years. For the full Employment Status at Admission by Year table, see Appendix M.

The percentage of clients reporting **full-time employment** increased between 2013 and 2017.



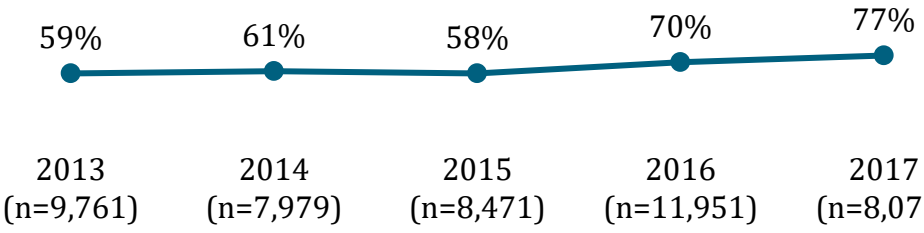
Note: The y-axis for the above graph ranges from 0% to 50% to emphasize the percentage change.

What substance use treatment trends exist in Nebraska over the past 5 years? (cont.)

Client Living Arrangements at Admission by Year

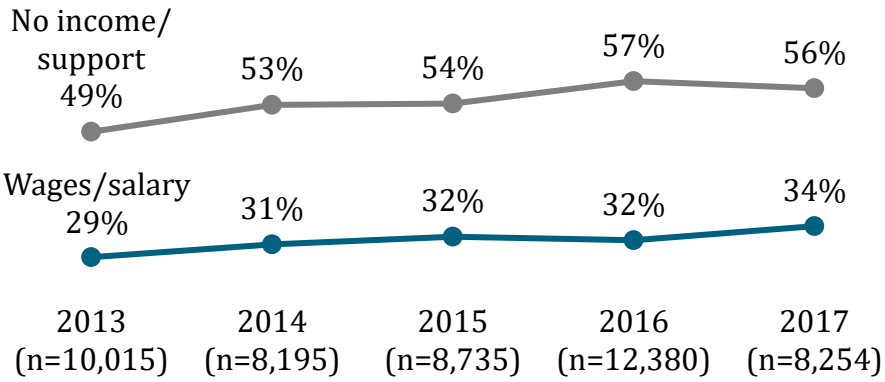
The rate of clients reporting independent living at admission increased from 59% in 2013 (n=9,761) to 77% in 2017 (n=8,072). The percentage of homeless clients and those reporting a dependent living arrangement at admission decreased at a similar rate from 2013 to 2017.

The percentage of **independent living** reported by clients increased between 2013 and 2017.



Source of Client Income/Support by Year

Both the percentage of clients indicating no income and those reporting wages or salary increased between 2013 (n=10,015) and 2017 (n=8,254). The percentage of clients receiving support from retirement, pension, or disability funding, similar to the percentage of clients indicating "Not in Labor Force," decreased from 10% in 2013 to 5% in 2017. The percentage of individuals receiving public assistance remained relatively consistent. For the full Source of Income/Support by Year table, see Appendix M.

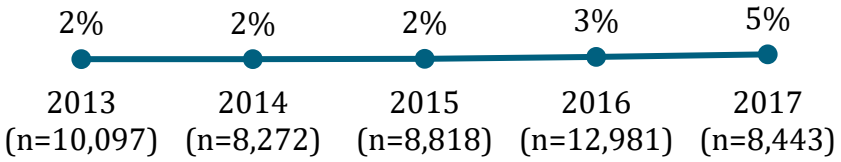


Note: The y-axis for the above graph ranges from 25% to 75% to emphasize the percentage change.

What substance use treatment trends exist in Nebraska over the past 5 years? (cont.)

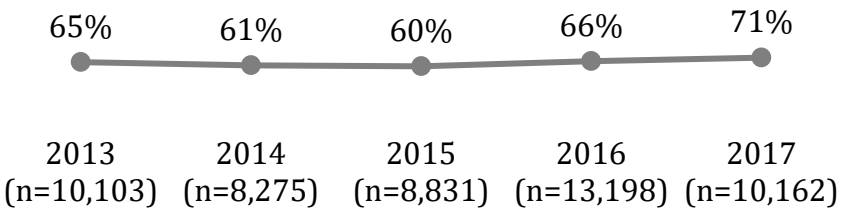
Planned Medication-Assisted Opioid Therapy by Year

The percentage of clients receiving opioid medications, such as methadone, buprenorphine, or naltrexone, as a part of their treatment plan stayed relatively constant from 2013 to 2017, increasing slightly between 2016 and 2017.



Reason for Client Discharge by Year

The percentage of clients who were discharged from treatment due to treatment completion decreased slightly between 2013 (65%, n=10,103) and 2015 (60%, n=8,831). Between 2015 and 2017, however, the rate of treatment completion rose to 71% (n=10,162).



Client Length of Stay in Treatment (Days) by Year

In 2013, 35% of discharged clients stayed in treatment for 1 day (n=10,103). This percentage decreased slightly to 27% in 2017 (n=10,162). Between 2013 and 2017, the percentage of discharged clients in treatment for 2-30 days, 31-90 days, and over 90 days all increased slightly. For the full Length of Stay by Year table, see Appendix M.

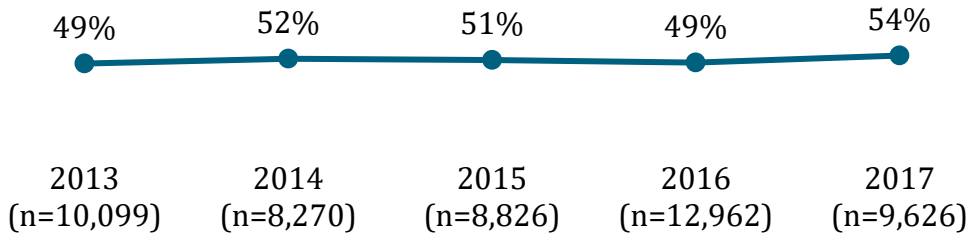
The **length of stay in treatment increased** slightly between 2013 and 2017.

What substance use treatment trends exist in Nebraska over the past 5 years? (cont.)

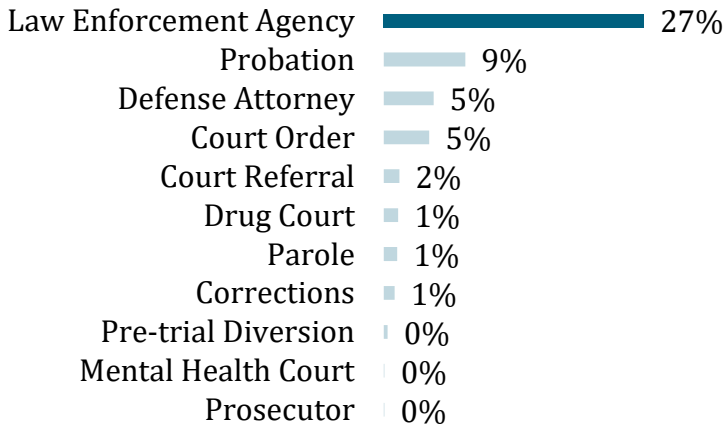
Treatment Referral Source by Year

Between 2013 and 2017, the percentage of client referrals from courts increased from 49% in 2013 (n=10,099) to 54% in 2017 (n=9,626). The other approximately half of referrals each year was split between individuals (self-referral) and other people or entities. "Other people or entities" included alcohol/drug use care providers, other health care providers, school (educational), employer/EAP, and other community referrals.

Referrals from **courts, criminal justice entities, and DUI/DWIs** increased slightly between 2013 and 2017.



*In the prior 2018–2019 drug use behavior study, STEPs found that Nebraska had a very high rate of treatment referrals from the criminal justice system compared to national referrals (59% of referrals in Nebraska; 28% nationally) in 2017. According to TEDS-A, 55% of criminal justice referrals came from an "other" source. In addition, many separate referral sources are grouped together in the TEDS-A data. For example, as shown above, referrals from courts, criminal justice entities and DUI/DWIs were grouped together in one category. To understand the specific role of the criminal justice system in referring clients to treatment in Nebraska, STEPs requested additional referral information from the DBH Data Team. **According to the DBH data, the highest percentage of criminal justice referrals come from law enforcement agencies (e.g. police/sheriff/highway patrol),** which accounted for an average of 27% of all referrals each year from 2013 to 2017. **The second highest source of referrals from the criminal justice system was probation, which accounted for an average of 9% of all referrals each year.** For the full Detailed Referral Source by Year table, see Appendix N.

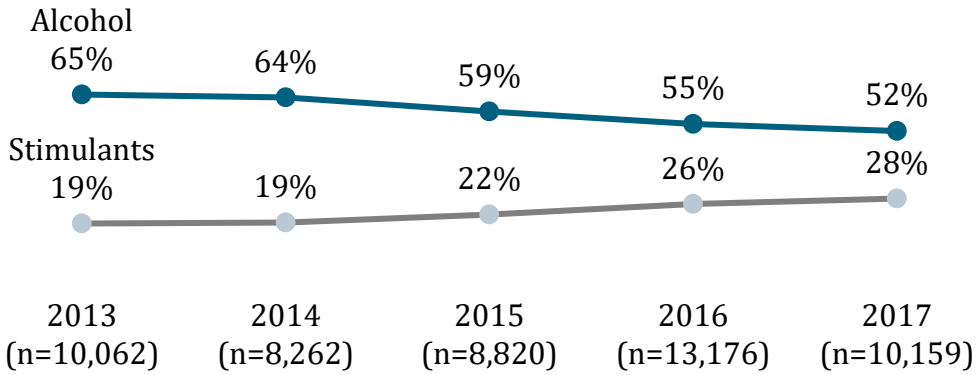


*Section updated on 8/6/2020

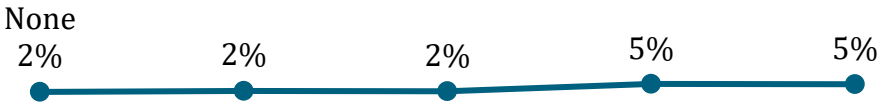
What substance use treatment trends exist in Nebraska over the past 5 years? (cont.)

Substance Use at Admission (Primary) by Year

A lower percentage of clients identified alcohol as their primary substance used at admission in 2017 (52%, n=10,159) compared to 2013 (65%, n=10,062). At the same time, the percentage of clients using stimulants at admission increased from 19% in 2013 to 28% in 2017. The percentage of clients using marijuana, opioids, depressants, hallucinogens, over-the-counter medications, and other substances stayed relatively constant across years. For the full Substance Use at Admission by Year table, see Appendix M.



Each year, a small percentage of clients identified no substance use at admission.



Frequency of Use at Admission by Year

The percentage breakdown of frequency of use remained relatively consistent across all 4 years. Nearly half of clients (44%) reported daily use, 28% reported no use in the past month and 28% reported some use. For the full Frequency of Use at Admission by Year table, see Appendix M.

What substance use treatment trends exist in Nebraska over the past 5 years? (cont.)

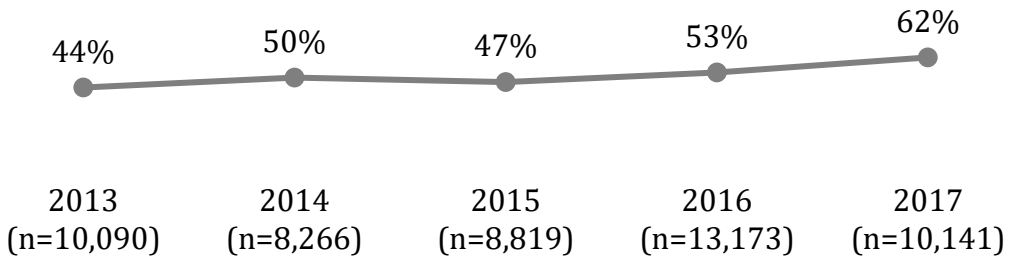
Client Age at First Use by Year

The percentage of clients by age at first use remained consistent from 2013 to 2017. One third (34%) of clients used the substance identified as their primary substance at age 14 years or younger. Another one third (32%) first used their primary substance between the ages of 15 and 17 years. The final one third of clients first used their primary substance at age 18 years or older. For the full Frequency of Use at Admission by Year table, see Appendix M.

***Number of Previous Substance Use Treatment Episodes by Year**

The percentage of clients with no prior treatment episodes increased from 44% in 2013 (n=10,090) to 62% in 2017 (n=10,141).

The percentage of clients with **no prior treatment episodes** increased nearly every year.



*Section moved from original page on 8/6/2020

*Nebraska Risk and Protective Factor Student Survey

The NRPFSS captures data on students' risk and protective factors related to substance use and other behaviors. The data is collected every other fall and made available the following spring or summer. The current report utilizes data provided to STEPs by the DBH Data Team. Respondents includes youth enrolled in 8th, 10th, and 12th grades across Nebraska in 2010, 2012, 2014, 2016, and 2018.

What trends exist for youth substance use in Nebraska?

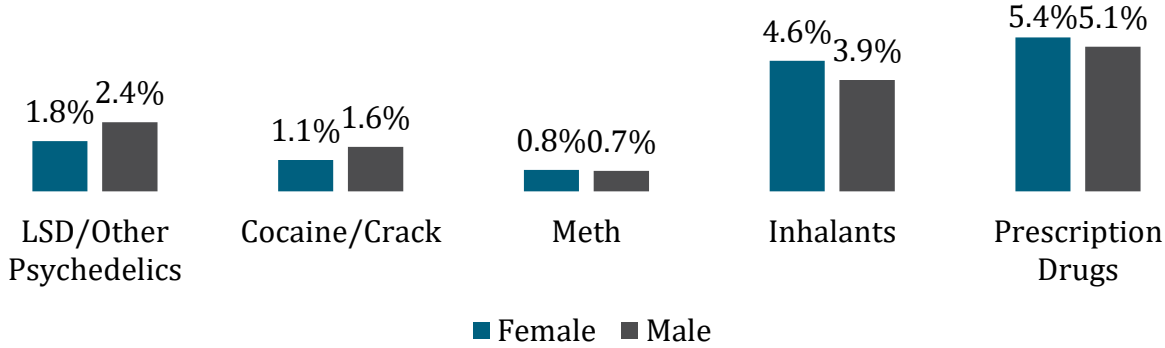
***Percentage of Youth Indicating Lifetime Substance Use by Substance and Year**

Youth were asked to indicate the frequency with which they had used each substance during their lives. The table below summarizes the percentage of youth who indicated they had used the substance at least once in their lifetime. As shown, the highest percentage of youth indicated using prescription drugs at least once in their life followed by inhalants. Over the past five administrations of NRPFSS, the percentage of youth reporting lifetime use of each substance has remained relatively stable.

Year	LSD/Other Psychedelics	Cocaine/Crack	Meth	Inhalants	Prescription Drugs
2010	2%	2%	1%	6%	7%
2012	2%	1%	1%	4%	5%
2014	2%	1%	1%	4%	5%
2016	3%	1%	1%	3%	5%
2018	2%	1%	0%	4%	4%

***Percentage of Youth Indicating Lifetime Substance Use by Substance and Sex**

Youth who identified as male had consistently higher rates of reported lifetime use of LSD/other psychedelics and cocaine/crack compared to youth identifying as female. In contrast, youth who identified as female reported higher rates of lifetime use of inhalants and prescription drugs. The reported lifetime use of meth did not vary much across sexes. For the full percentages of youth indicating lifetime substance use by substance, sex, and year, see Appendix O.



*Sections added on 8/6/2020

What trends exist for youth substance use in Nebraska? (cont.)

***Percentage of Youth Indicating Lifetime Substance Use by Substance and Grade**

On average across survey years, youth in 12th grade reported the highest percentages of lifetime use of each substance with the exception of inhalants. Youth in 8th grade reported the highest average lifetime use of inhalants across survey years. The highlighted cell indicates the most common substance for each grade level.

Substance	8th Grade	10th Grade	12th Grade
LSD/Other Psychedelics	1%	2%	4%
Cocaine/Crack	0%	1%	3%
Meth	0%	1%	1%
Inhalants	5%	4%	4%
Prescription Drugs	2%	5%	9%

***Percentage of Youth Indicating Lifetime Substance Use by Substance and Race**

On average across survey years, youth identifying as Alaska Native reported the highest percentage of lifetime use for all substances except for inhalants. Youth identifying as American Indian reported the higher percentage of lifetime use for inhalants. The highlighted cell indicates the most common substance for each racial category.

Race	LSD/Other Psychedelics	Cocaine/ Crack	Meth	Inhalants	Prescription Drugs
Black	3%	2%	1%	5%	7%
Asian	12%**	1%	1%	4%	5%
American Indian	4%	3%	2%	8%	8%
Pacific Islander	3%	2%	2%	6%	9%
Alaska Native	6%	4%	3%	6%	11%
White	2%	1%	1%	4%	5%
Other	2%	2%	1%	7%	5%

*Sections added on 8/6/2020

**The 2012 DBH data indicated 51% of youth identifying as Asian reported using LSD/Other Psychedelics. This data should be double-checked for accuracy.

Summary

Nebraska Hospital Association Discharge Data

1. The number of inpatient discharges with diagnoses related to substance use between January 1 and September 30 of the past 4 years was at its highest point in 2017 and has modestly declined in the past 2 years. An opposite trend occurred in the emergency department discharge data with the number of diagnoses related to substance use at its lowest point in 2017 and increased the following 2 years.
2. Individuals discharged from inpatient treatment with diagnoses related to substance use tended to be older than those discharged from the emergency department. The percentage of female patients was also slightly higher for inpatient discharges than emergency department discharges.
3. For both inpatient and emergency department discharges, depressants, stimulants, and narcotics were the most common substances indicated in diagnoses. However, while the percentage of depressant- and narcotic-related diagnoses decreased since 2016, the percentage of stimulant-related diagnoses increased.
4. Behavior Health Region 6 had the highest number of both inpatient and emergency department discharges. For inpatient discharges, the percentage of patients who resided in Region 6 had decreased each year since 2016. In contrast, the number of individuals residing in Region 6 discharged from emergency departments increased each year since 2016.
5. Demographic trends for individuals who were discharged from inpatient and emergency department treatment stayed relatively consistent in Nebraska since 2016.

TEDS-D

1. Between 2013 and 2017, the percentage of clients who indicated being employed full-time at admission and those who indicated receiving wages or salary increased slightly.
2. The percentage of clients who reported alcohol as their primary substance decreased between 2013 and 2017, and the percentage of clients who reported stimulant use increased.
3. Across all years, the demographics of discharged clients, such as age, race, ethnicity, and marital status varied little.
4. The increase in clients reporting independent living from 2013 to 2017 was the most significant trend indicated by the data.
5. Compared to 2013, clients in 2017 were more likely to indicate no prior treatment episodes and have a longer stay in treatment.

***Nebraska Risk and Protective Factor Student Survey**

1. Youth in Nebraska were more likely to report using prescription drugs at least once in their lifetime than any other substance. Inhalants were the second most reported substance used.
2. Youth who identified as male had consistently higher rates of reported lifetime use of LSD/other psychedelics and cocaine/crack compared to youth identifying as female. In contrast, youth who identified as female reported higher rates of lifetime use of inhalants and prescription drugs.
3. Youth in 12th grade were more likely to report having used a substance at least once in their lifetime compared to youth in 8th or 10th grades.
4. On average, youth identifying as Alaska Native reported the highest percentage of lifetime use for all substances except for inhalants.

*Section added on 8/6/2020

Directions for Future Research

Nebraska Hospital Association Discharge Data

1. **Support Additional Data Collection by Hospitals:** According to NHA, hospitals are currently not collecting data related to race and ethnicity consistently. The collection of this data should be encouraged as it would allow for an examination of health disparities and barriers to access to care based on race.

2. **Examine Differences between Inpatient and Emergency Department Patients:** This analysis provided some insight to differences between inpatient and emergency department patients with diagnoses related to substance use. However, the reasons for these differences have not yet been explored. Some areas for exploration may include comparisons of services received, health insurance information, and access and availability of treatment options. This direction for research may provide useful insight for how individuals in Nebraska are accessing and receiving treatment, as well as any health disparities that may exist. Results may potentially be used to inform outreach efforts, develop practitioner and research knowledge, support substance use disorder screening at primary care facilities, encourage collaborations across healthcare facilities and treatment providers, and design tertiary prevention efforts.

TEDS-D

1. **Continue Longitudinal Analyses:** TEDS-D presents several emerging trends in substance use treatment across Nebraska. The analysis of 2018, 2019, and future years of TEDS data will help determine the consistency of these trends and monitor any changes that arise. By continuing to analyze TEDS data as it is published, DHHS will gain additional longitudinal data, increasing the reliability of results.

2. **Conduct Additional Bivariate Analyses:** Additional bivariate analyses of the 2013 to 2017 TEDS-D data will support DHHS' understanding of substance use treatment trends. For example, an analysis of client race by primary substance used or referral source may further inform treatment and prevention efforts. This may be particularly relevant for those populations currently targeted by DHHS efforts.

***Nebraska Risk and Protective Factor Student Survey**

1. **Utilize Results to Inform Analysis of Other Datasets:** Based on the findings that youth of different gender and racial identities may utilize substances at different rates, consider examining the primary substance used by client sex and race from the TEDS-D dataset to understand if these differences persist in adulthood. This may provide insight on how to provide specific prevention messaging based on target populations.

*Section added on 8/6/2020

Limitations

Nebraska Hospital Association Data

1. Due to the timing of this report, quarter 4 discharge data for 2019 had not been finalized. This means any year-to-year comparisons for total counts excluded quarter 4 data for 2016-2018.
2. These datasets included information on hospital discharges from inpatient and emergency departments, not individuals. Someone who is discharged from inpatient or emergency department treatment may be represented more than once within the data.
3. As per the CSTE (2019), hospital discharge data "captures [information] for which drug use is the primary reason, per the admitting physician. Thus, it does not capture admissions for which drug use may be an ancillary or indirect reason, e.g., a motor vehicle crash injury caused by drug-impaired driving" (p. 33). This means additional instances of substance use resulting in inpatient or emergency department admissions are likely excluded from this dataset.
4. The diagnoses related to substance use are contingent on "the recognition, documentation and coding of drug use and drug-related diagnoses by hospital staff, all of which are known to vary" (CSTE, 2019, p. 33). This suggests diagnosis coding may vary across hospitals, which limits the ability to draw concrete conclusions across jurisdictions.
5. Because diagnosis description data included 297 unique diagnosis descriptions, diagnosis information needed to be condensed into usable categories for analysis and interpretation. This condensing may have resulted in a loss of detail on diagnoses, including specific substances and level of severity.

TEDS-D Data

1. TEDS-D reports information on admissions and discharges 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 or discharge depending on the facility, even if the services were provided within the span of one treatment episode.
2. 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. The sample sizes of variables throughout this report vary due to missing data and differences in sample sizes across years. These variations in sample size are important to consider when looking at percentages throughout the report.
4. Not all treatment admissions or discharges 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.

Limitations (cont.)

***Nebraska Risk and Protective Factor Student Survey**

1. Due to differences in survey text across years, the frequency of lifetime use by substances was analyzed using only two categories: 1) youth who reported never using a substance in their lifetime and 2) youth who reported using a substance in their lifetime at least once. The necessary condensing of categories to allow for comparisons across time may have resulted in the loss of detailed data (for example, any differences among those who have used a given substance 1-2 times compared to those who have used 10 or more times).
2. While the survey is administered to students in 6th, 8th, 10th, and 12th grade students, a different version is administered to 6th graders, and it does not include substance use variables. Therefore, conclusions cannot be drawn about substance use by youth below 8th grade.

*Section added on 8/6/2020

References: Updated Dataset Results

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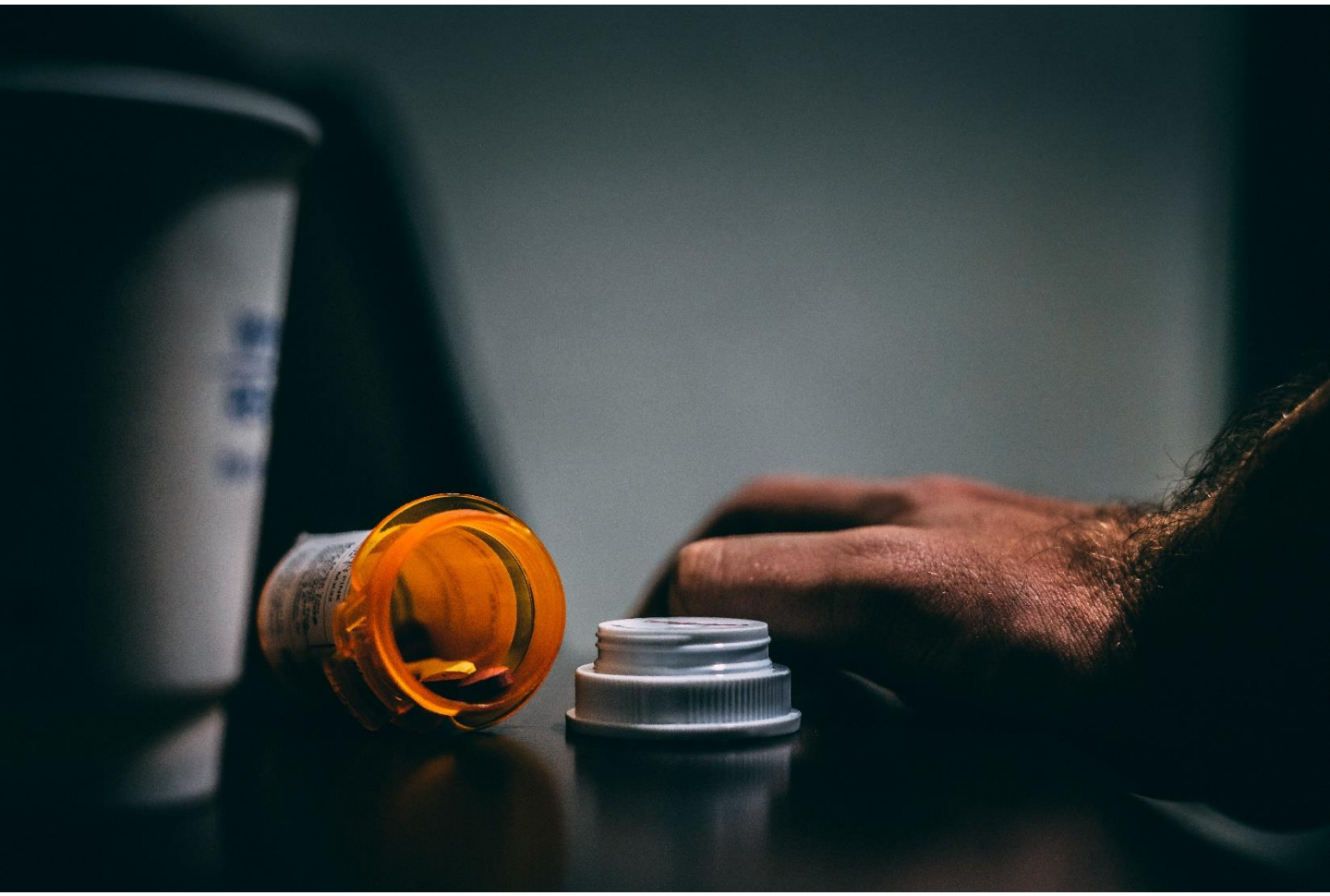
UNIVERSITY OF NEBRASKA AT OMAHA
SUPPORT AND TRAINING FOR THE EVALUATION OF PROGRAMS

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

DRUG USE BEHAVIORS

Treatment Provider Qualitative Interviews

August 2020



Liam Heerten-Rodriguez, Ph.D., MSW, CSE
Daniel Kreuzberg, MSW/MPA Student
Jennifer L. Smith, MPPA
with Jeanette Harder, Ph.D., CMSW

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Key Findings

STEPs conducted semi-structured interviews with 18 substance abuse treatment providers in Nebraska. Interviewers asked participants about the clients they serve, the field of substance abuse treatment, their professional needs, opinions on drug overdose prevention, and what they would want from a relationship with NE DHHS. STEPs engaged in several rounds of qualitative data analysis that identified important categories and relationships within the data. The following are key findings from the analysis of the data:

1. Clients are often caught in a cycle of substance abuse fueled by trauma and mental health problems but have many strengths and are determined to make positive changes in their lives.
2. While opioid use is increasing, participants described methamphetamine as the most commonly used drug in Nebraska. Some participants do not feel NE DHHS is paying enough attention to methamphetamine use.
3. Substance abuse treatment is drug overdose prevention.
4. There are significant barriers to accessing substance abuse treatment, especially in residential treatment and especially for women with children and other vulnerable and marginalized populations.
5. For substance abuse treatment to be effective, clients also need access to housing, healthcare, and employment. Wraparound services would increase access to and effectiveness of treatment.
6. When political leaders believe addiction is a choice, they are less interested in funding and addressing substance abuse issues.
7. Policies that increase access to naloxone and decrease fears of criminalization are crucial in preventing overdoses, but awareness and knowledge are inconsistent.
8. Education efforts are necessary to reduce overprescribing, promote safe use, raise awareness and reduce stigma within communities.
9. Treatment providers do not have a clear understanding of who NE DHHS is or their role in drug overdose prevention. Many defined NE DHHS by their interactions with specific divisions and sections, like CFS.
10. Participants want an ongoing relationship with NE DHHS and suggested that NE DHHS develop and maintain a statewide substance abuse treatment resource guide and facilitate quarterly roundtable discussions.

Recommendations

Based on interviews with 18 substance abuse treatment providers in Nebraska and the analysis of the data, STEPs offers the following recommendations:

1. **Prioritize Nebraska-specific data** when making decisions regarding drug overdose prevention efforts. While opioid use is a growing concern, treatment providers on the front lines are still seeing more methamphetamine use and mixed substance use, including alcohol use.
2. **Understand the needs of various stakeholders** regarding drug overdose prevention. Treatment providers have insights into the needs of people who abuse substances, other professionals, and community members, but these needs may be best identified by these groups themselves. Consider directly hearing from these voices in future evaluation and assessment efforts.
3. **Provide and advocate for education** that reduces overprescribing, promotes safe use, raises awareness, and reduces stigma within communities. Education should be targeted to the needs of specific stakeholders. Substance abuse treatment providers identified that they have educational gaps regarding naloxone access that, if filled, could help them reduce drug overdoses.
4. **Reduce stigma** associated with substance use disorders and substance abuse treatment. While stigma is widespread, intervention activities that target policy makers and political leadership for stigma reduction may be especially effective in facilitating an environment that supports treatment and reduces drug overdoses. Interventions should humanize people with substance use disorders by providing an accurate understanding of who is at risk and the strengths they possess.
5. **Establish an identity** for the Drug Overdose Prevention program that is independent of other state entities that are viewed negatively or with mistrust by treatment providers and substance use disorder clients, such as CFS and probation. Engaging treatment providers in a way that honors their expertise and facilitates ongoing communication will help treatment providers view the Drug Overdose Prevention program as a partner.
6. **Create and maintain a statewide resource guide** that helps treatment providers make efficient referrals and connect clients to the right level of treatment. The resource guide could also serve as an environmental scan that helps inform stakeholder assessment and strategic planning.

Methodology Summary

This section summarizes the methodology of the qualitative component of the Drug Use Behaviors project. The full methodology is described in Appendix P of this report.

Purpose

The purpose of the qualitative component of the Drug Use Behaviors project was to provide NE DHHS with rich and in-depth information regarding the professional experiences and needs of drug treatment providers in Nebraska. Through the perspectives and insights of drug treatment providers, NE DHHS can better understand the experiences and needs of people with substance use disorders in Nebraska.

Through semi-structured interviews with substance abuse treatment providers and qualitative data analysis, STEPs answered two primary questions:

1. What insights regarding drug use behaviors do drug treatment providers in Nebraska have that may inform drug use prevention planning?
2. What are the professional needs of drug treatment providers in Nebraska?

Sampling

Through the survey component of the Drug Use Behaviors project, STEPs developed a sample pool of 77 substance abuse treatment providers in Nebraska who were interested in participating in a qualitative interview. From this sample pool, STEPs staff interviewed 18 participants between April 29, 2020 and June 2, 2020. See Appendix Q for interview request template and Appendix R for the consent handout.

Data Collection

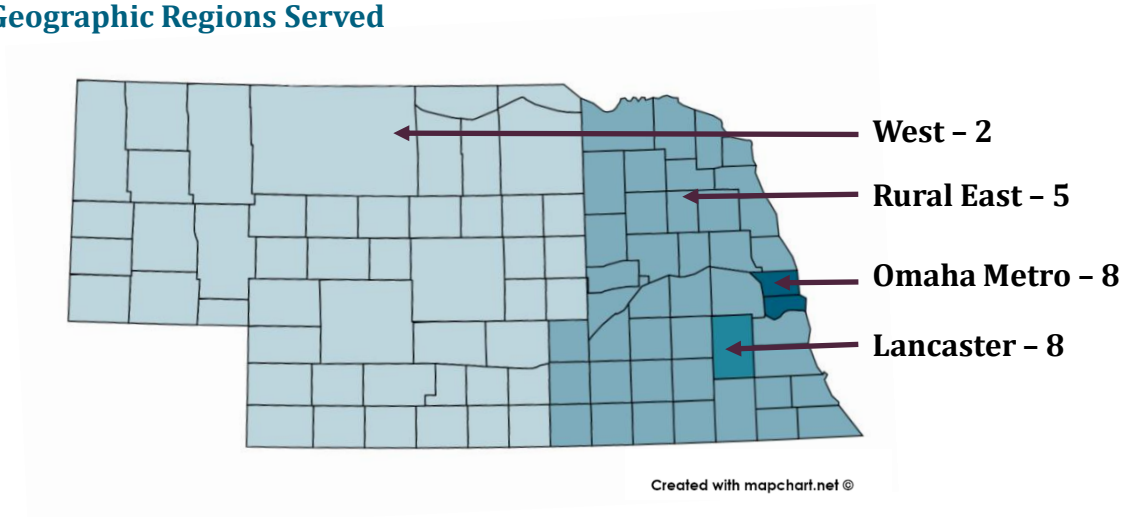
STEPs conducted semi-structured interviews over Zoom, an online videoconferencing service. STEPs staff followed an interview protocol consisting of six primary questions and multiple, flexible follow-up questions. See Appendix S for the full interview protocol.

Sample Demographics

STEPs staff collected demographic information from all participants. Participants' years of experience in the field ranged from 1 year to 33 years, with 10 years of experience on average. Participants were all licensed in Nebraska, with the most common license types being Licensed Alcohol and Drug Counselor (LADC) and Licensed Independent Mental Health Provider (LIMHP). The diversity of the sample's geographic and practice settings are summarized in the following graphics.

Methodology Summary (cont.)

Geographic Regions Served

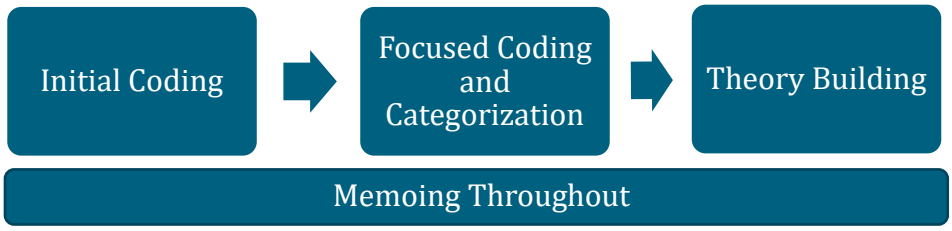


Practice Settings and Roles

Field	Practice Settings	Roles
• Substance Abuse Treatment	• Nonprofit • Private practice • Corrections • Residential treatment • Hospital	• Clinician • Clinical Director • Clinical Supervisor • Community Outreach • Intake Coordinator

Data Analysis

STEPs analyzed the data using the methods of constructivist grounded theory (Charmaz, 2014). Data analysis included multiple, iterative stages initial coding, focused coding and categorization, and theory development. The purpose was not to develop a theory in the traditional sense, but to identify meaningful relationships between the categories and codes that could tell a narrative about the data. STEPs staff also engaged in memoing throughout the data analysis process.



Results

STEPs' analysis of the data yielded seven key narratives which address the following topics:

1. Client Profile
2. Drug Use Trends
3. Treatment Trends
4. Access to Treatment
5. Funding and Stigma
6. Drug Overdose Prevention
7. Relationship with NE DHHS

Client Profile

Section highlights:

1. The typical substance use disorder client is defined by shared experiences, rather than shared identities.
2. Clients are caught in a cycle of substance abuse fueled by trauma and mental health problems.
3. Clients have many strengths and are very determined to make positive changes in their lives.
4. Women face additional challenges and stressors but are often highly motivated by their children.

As part of the qualitative interview protocol, STEPs asked all participants, "Please tell me a little bit about the clients that you serve. Would you say that there is a typical story among your clients? Or something that all or most of them have in common?" Based on the analysis of the participants' responses, STEPs developed a composite description of clients treated for substance use disorder.

While a few participants used demographic terms, **most participants defined the "typical" substance use disorder client by experiences rather than identities.** Participants were quick to point out that they see clients with a wide variety of identities and backgrounds. Several participants used similar phrasing to exemplify the variation, *"everybody from multimillionaires to homeless people."* Participants were clear that substance use disorders affect people of all ages, races, genders, and income level. As one participant stated, *"It doesn't discriminate, it picks on anyone."*

Instead of commonalities in identity, participants highlighted the shared experiences of their clients. **At the core of these shared experiences is trauma.** All but two participants explicitly identified a trauma history as something that all or most of their clients have in common.

"Experiencing trauma" was among the most frequently occurring initial codes within the analysis. Most participants identified trauma that their clients experienced in childhood and several participants specified complex trauma, which is trauma that is chronic and long-term. Participants named poverty; neglect; and physical, verbal, and sexual abuse, as well as witnessing abuse such as domestic violence, as common types of trauma that their clients have experienced.

One participant summarized the presence of trauma by saying, *"I guess the thing that I feel like everyone has in common is some form of underlying trauma. The shapes that that takes varies some, but I very rarely work with someone with a substance use disorder who does not have either complex developmental trauma or some sort of, usually, relational-based trauma."*

Client Profile (cont.)

Participants also described clients as typically **having a family history of substance abuse, which was often implicated in their trauma experiences.** As one participant put it, *"9 times out of 10 there was a substance use disorder in a close family member or a parent."*

However, there were differences in how participants made meaning of this commonality. Some participants pointed to a genetic or hereditary component to addiction, while others discussed environments where drug use was normalized, including children who began using with their parents. Other participants identified the family history of drug use as leading to children experiencing abuse, neglect, or other traumatic experiences.

Perhaps unsurprisingly, given their clients' experiences of trauma and family histories of substance abuse, participants identified that **many of their clients have co-occurring mental health problems and dual diagnoses.** There was variation in how participants described the proportions of their clients who have or qualify for a dual diagnosis, with estimates from *"50% at least"* to *"most of them"* to *"practically everyone."*

Participants brought up clients with dual diagnoses at all stages of the interview, not just when describing their typical client. In particular, participants noted the lack of substance use treatment providers and programs prepared to address the needs of dual diagnosis clients. Additional details on dual diagnoses are discussed in the "Access to Treatment" section of this report.

In the face of all of these difficulties, participants observed a severe lack of adaptive coping mechanisms and strategies among their clients, even among clients who had previous treatment experience. One participant said, *"I think again it comes down to a lot of people do not have coping skills and, even when they've been to treatment and whatnot, they just have not developed coping skills."*

In the absence of adaptive coping skills, **substance use becomes their primary mechanism.** Another participant described this saying, *"The majority of drug and alcohol clients that I [see] have a really difficult time with self-regulation, with dealing with emotion … it's kind of coping, they just have a difficult time coping and drugs or alcohol tend to be an escape for them or a way to get away."*

Some participants described these typical client experiences and characteristics without directly applying a linear, causal relationship to them. Other participants, however, identified relationships in which these experiences were connected. As one participant put it, *"There's always a reason for addiction, right? Nobody wakes up and says, 'I wanna be an addict today.'"*

Client Profile (cont.)

Participants identified these relationships as patterns, processes, or cycles. While no single participant linearly identified all of these relationships, the data taken as a whole suggests that **many substance use disorder clients are caught in cycles that generationally perpetuate substance abuse.**

The participants were clear that **their clients want to break these cycles**. A participant described this struggle saying, *"I think that [clients] want people to know that they're just regular people who happen to get caught up in that addictive process … If you don't treat the trauma, then you can't really treat the addiction. A lot of what they deal with is multigenerational trauma. And I think that most everybody I work with would really want you to know that they they're just regular people. They want to be parents, they want to live their lives like other people do, and they really find themselves struggling to not be in the middle of their addictive process."*

While attempting to break these cycles can be a significant undertaking, substance use disorder clients also possess strengths that they can leverage in this struggle. **Participants identified a number of strengths that their clients possess.**

Participants described their clients as adaptable, brave, caring, charismatic, compassionate, connected, creative, determined, driven, empathetic, entrepreneurial, hardworking, humble, intelligent, motivated, open, patient, persevering, problem-solving, resilient, resourceful, strong, supportive, survivors, vulnerable, willing, and worthy. The most commonly referenced client strength was determination**.**

Client Profile (cont.)

One participant said of her clients, *"I would say that the majority of them have great potential and drive to be successful. I think that it's very interesting that the majority of them have solid goals that they want for their life. And they want to achieve things just like everybody else, but of course, they're dealing with many barriers."* This participant also emphasized that any investment that NE DHHS makes in providing resources or help to people with substance use disorders will be used, because **clients *"want help, they need help, and with that help, they can be successful citizens."***

Gender-Based Differences

STEPs also asked participants in what ways, if any, the experiences of women, especially women of a childbearing age, were different. In general, participants expressed that **women with substance use disorders often face additional challenges and stressors.**

Participants identified finances to be a stressor for most clients, but that the burden was especially high for women. Women start at a financial disadvantage due to gender-based wage gaps, which participants suggest may be especially large for women with substance use disorders due to generally lower educational attainment and spotty work histories.

Additionally, several participants highlighted that many women with substance use disorders have been financially dependent on a man, such as a boyfriend or spouse, including for their substance use. This financial dependency can make them more vulnerable to abusive relationships and create additional barriers to leaving abusive relationships and seeking substance abuse treatment.

Women are also disproportionately responsible for childcare, which can create barriers to steady employment and additional challenges to finding and affording healthcare, housing, and supplemental childcare. **These stressors can keep women from accessing and continuing substance abuse treatment and can be triggers for women's continued substance use.**

One participant told us, *"We know that women won't go to treatment because they don't want to leave their children. So, in order to engage women and to help them get into recovery, we have to not do it the way we think it needs to be done, but we need to listen to what they're telling us, and they're telling us they need to have their kids with them."*

For women with substance use disorders who have had children removed from their care, these stressors can be magnified. Participants were clear that, while removal is sometimes necessary for the safety of the child, **disrupting families fuels substance use.**

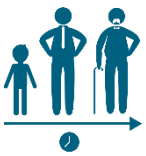
Client Profile (cont.)

One participant illustrated the dynamic as follows: *"The police or whoever has contact with the family, and there's some substance use going on there, and they automatically pull the kids out of the home. But then sometimes there's no contact for weeks, just trying to get back into the court system. I think sometimes that fuels the substance use more than it helps it."* And the burdens of Children and Family Services (CFS) or law enforcement involvement disproportionately impacts women because, as one participant told us, *"women are expected to do more to get their kids back."*

While these are significant barriers and challenges that disproportionately affect women, participants also spoke to women's strengths. In particular, participants told us that **women are highly motivated by their children to stop or manage their substance use.**

Whereas some participants felt that men were more motivated by their employment to seek treatment, women were often motivated by their children's well-being and their strong desire to be good mothers. One participant framed it like this, *"We know from the research and from my practical experience that women are more likely to recover and stay in recovery if they have their children placed back with them because the biggest motivation, the biggest driving factor, in women getting clean and staying clean is that they desperately want to be with their kids and to be really, really good moms."*

Age-Based Differences



STEPs did not directly ask about age-based differences, but several participants identified ways in which younger clients differed from older clients. Participants stated their younger clients are more commonly using marijuana and alcohol, while older clients are more commonly using methamphetamines and alcohol.

Participants also indicated that while involvement with law enforcement was a common pathway for all clients, younger clients were more likely to be in treatment due to pressure from family members. However, this dynamic is complicated by some participants reporting that it is common for younger clients to use substances around or even with their parents.

While these differences are notable, they should also be treated tentatively, as they were not discussed extensively or consistently by participants.

Drug Use Trends

Section highlights:

1. Participants identified methamphetamines as the most commonly used drug in Nebraska, but some do not feel that NE DHHS is prioritizing it appropriately.
2. Opioid use is increasing, and participants want to see interventions that address abuse and overdoses.
3. More clients are mixing drugs or using any drug type that is available to them.
4. Marijuana use has remained constant, but the marijuana has become more potent and available.

As part of the qualitative interview protocol, STEPs asked all participants to identify changes or trends they had observed within the field of substance use treatment. Almost all participants commented on the use of specific drug types, although the consensus among participants was that they are not seeing many changes in this area. According to our participants, **the drugs of choice in Nebraska have consistently been methamphetamines and alcohol.**

While many participants identified that dominant methamphetamine and alcohol use has been the case for some time, they felt that this has not been reflected in NE DHHS priorities. One participant said, *"I would say 90–95% of the folks I work with, meth is their drug of choice. And meth is still a huge problem in Nebraska, and I feel like we keep forgetting about that. So, I would just like to remind DHHS of that sometimes. And alcohol will always be one of the top two."*

Instead, some participants felt that **NE DHHS is chasing national trends that do not reflect Nebraska**, specifically opioid use. One participant encouraged NE DHHS to stay focused on the realities of drug use in Nebraska, saying *"I think it can be really easy to focus on one aspect of a problem and get a little bit of tunnel vision on it, which happens a lot in substance use treatment overall, and not just in Nebraska. There just tends to be an area of treatment where things get trendy, or things become buzzwords, and then the focus of funding and the focus of training and the focus of new initiatives becomes very pigeonholed. And that's not always in the client's best interest, you know."*

This is not to say, however, that participants were not concerned with opioid use in Nebraska. Opioids were the most frequently discussed drug type in the interviews. While participants did not view opioid use as being as widespread as methamphetamines, **many identified opioid abuse as a growing problem in Nebraska.**

Participants frequently discussed opioids in the specific context of overdose prevention, highlighting the need for greater access to naloxone and interventions to address overprescribing. These suggestions are presented in greater detail in the "Drug Overdose Prevention" section of this report.

Drug Use Trends (cont.)

In addition to increases in opioid abuse, participants identified **increases in clients mixing drug types and an increase in clients with no drug of choice** as trends that they have observed. Participants stated that abusing alcohol in addition to illicit or prescription drugs has been common for some time, with one participant saying, *"I mean alcohol seems to be a part of everything."*

Increasingly, though, participants are seeing clients abuse both methamphetamines and opioids or, in some cases, using mixtures of the two. Some participants felt that they were seeing an increasing number of clients with no drug type preferences whatsoever, indiscriminate in their abuse of drugs.

One participant stated, *"There's a lot of meth addiction, but they're combining it with other things such as alcohol and the opiates and the benzos. There's just a lot of multiple drug use. I don't know if maybe in the past if people just used one, they had a drug of choice. But now it's like just, 'Whatever's in front of me.'"*

Participants also identified marijuana use as common and consistent, but they believed that **the potency, availability, and potential negative consequences of using marijuana had increased over time**. Speaking to the potency issue, one participant stated, *"I'd also add that just the difference in marijuana from now and even 2011, when I started in the field. It's just a lot stronger now. It's just not the same marijuana that it was."*

Other participants spoke to the changes that have come with the legalization of marijuana in other states, which has changed people's perceptions of the drug. Participants also noted that legalization has made marijuana more available and available in more forms than it previously has been.

One participant pointed to the potential consequences of these changes, even without an increase in overall marijuana use, saying, *"Marijuana used to be kind of a different situation where it was just viewed as a gateway drug or that type of thing, or it's not as serious. But some of this high THC-level type things we're seeing from different dispensaries with higher THC levels, you are seeing a little bit more influx or increase in psychotic symptoms with that use and more people being hospitalized around that… You can get a lot less or not as much use with more serious consequences sometimes."*

Finally, while not speaking to any specific drug type, some participants believed that depth of individual's substance abuse has become more severe. One participant told us, *"It seems to have gotten a lot worse. People are having a lot more problems in my opinion. So, for a long time I was with the drug court and I thought I was seeing what could possibly be the worst, but it's gotten worse since then."*

Treatment Trends

Section highlights:

1. Regardless of their length of time in the field, participants have seen improvements in substance abuse treatment.
2. Diagnostic changes have led to more individualized treatment and potentially less stigma for clients.
3. The field has moved away from abstinence- and shame-based models and has largely embraced harm reduction and medication assisted treatment approaches.
4. Participants want to see even more individualization in substance abuse treatment.

As part of the qualitative interview protocol, STEPs asked all participants to identify changes or trends they had observed within the field of substance use treatment. In addition to trends in clients' drug use, participants also substantively discussed trends in substance abuse treatment.

In general, the consensus among participants was that **substance abuse treatment has improved** during their time in the field. This was true for both participants with significant tenure in the field and those who are newer practitioners, suggesting that there are ongoing positive treatment developments occurring within the field.

One positive treatment development noted by participants is **the evolution in diagnostic conceptualization, criteria, and terminology regarding substance use disorders.** Participants noted the changes that have occurred specifically between the 4th and 5th editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).

While many of the details of these changes are technical and primarily of interest to clinical audiences, participants noted that some of these changes have real impacts on clients. For example, several participants identified that previous editions of the DSM had differentiated between clients' experiences of substance abuse and substance dependence. In the DSM-5, however, there is one diagnosis of substance use disorder and a continuum of qualifiers, from mild to moderate to severe.

One participant described how this change has helped her treat her clients saying, *"So when we diagnose someone with a substance use disorder it's on a continuum rather than just, 'Oh you're abusing meth,' or 'You're addicted to meth,' which is just black and white. So that's changed a lot and helps us to kind of meet clients where they're at and match them up to the right level of care."*

Treatment Trends (cont.)

Another participant noted the change also removes the language of "dependent" or "addict" when describing the client, which can help reduce stigmatization. Another participant noted that the change in the remission criteria from 30 days sober to 90 days sober can also help clients access needed treatment options. In summary, a participant stated that these changes are not solely semantic but have *"changed the way we think"* about substance use disorders and their treatment.

Participants also noted trends of **moving away from specific treatment models, especially ones that required clients to maintain complete abstinence from all substance use and models that either explicitly or implicitly relied on shaming the client.** Participants were clear that these approaches to treatment still exist and, in some cases, individual treatment providers or clients may even prefer them, but they are less dominant than they once were.

As the dominance of these approaches wanes, there is increasing room within the field for other approaches. A participant framed this shift saying, "*I would say even 6 years ago, the 12-step model was pretty much really what was encouraged, and I feel like [now] facilities are more open to other types of models for clients in terms of their path of recovery.*" Similarly, another participant stated, *"I'd also say that substance use treatment, even before I was in the field, used to be really, I don't know if 'punitive' is the right word, but very, you know, you'd put someone in the hot seat, and you'd tell them everything that was wrong with them. And put them on the spot in group therapy and just kind of scare them into sobriety, for lack of a better word. And now we're a lot more client centered."*

A specific way that participants observed this change was in how the field has come to treat client relapses back into substance use. Many participants identified that, within these abstinence- and shame-based models, relapse was treated as a failure on the part of the client and their treatment. Participants noted that this approach was both shaming and inconducive to keeping people in treatment.

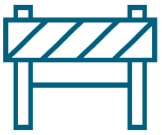
One participant described the previous way of viewing relapse as follows: "*In an abstinence-based model, with your outcomes, any type of a relapse is considered a failure sometimes. And so it's kind of looked at that way in programs or in treatment, then sometimes our clients or participants view it that way, too.*" Another participant contrasted this view of relapse with what they believed was a more contemporary understanding, "*I mean, people relapsing is not a failure. It's a learning process.*"

Treatment Trends (cont.)

In the place of these models, participants noted trends of **moving towards harm reduction and medication assisted treatment (MAT) approaches.** Participants highlighted many different treatment approaches and models that have gained greater acceptance in the decline of abstinence- and shame-based models, including motivational interviewing, eye movement desensitization and reprocessing (EMDR), and mindfulness-based therapies. However, the most commonly and frequently referenced treatment approaches were harm reduction and MAT approaches.

Participants also frequently framed this shift as one of the biggest changes that they have observed in the field. For example, one participant stated, "*Treatment has changed quite a bit as far as just focusing on relapse prevention or abstinence-type treatment, moving more into kind of harm reduction or other medication assisted treatment. That's been probably the biggest change I've seen over the past 18 years.*"

Across the board, participants acknowledged the ascent of these approaches and generally considered this a positive shift. One participant explained, "*I think sometimes it's unrealistic to think the first time that you try to stop using substances, you're going to be completely abstinent the rest of your life and that's the expectation. Sometimes, harm reduction is the goal.*" Similarly, another participant stated, "*Harm reduction is a big thing now. If I'm seeing someone and you're smoking weed, drinking on the weekends, and using IV meth daily, if I can get you to stop using IV meth daily, that's a win, you know.*"



While participants were generally supportive of these shifts, they did note **several barriers and problems associated with the move towards harm reduction and MAT.** For example, several participants noted that their ability to fully embrace harm reduction and MAT in client treatment was stifled by systems to which their clients were accountable, most notably CFS and probation.

One participant summarized the situation, stating, "*Sometimes [harm reduction] is not accepted by HHS or by probation or parole type entities. 'Cause you know you have that strict guideline of no use whatsoever. So even some appropriate use or healthy use is viewed as a violation at that point in time. And so sometimes, a treatment model of harm reduction would be more appropriate for the person you're working with, but because of their legal circumstances, you can't use it.*"

Additionally, some participants noted that they did not use harm reduction approaches in their work because their treatment setting, residential and corrections, did not allow for it. One participant stated that, in a residential setting, any drug use on the part of a client could be triggering to other clients. They also pointed out that not all clients are interested in a harm reduction approach, stating that harm reduction *"doesn't seem to be effective and a lot of our clients say if they drink one, they're all in again."*

Treatment Trends (cont.)

While not a specific shift in treatment model, several participants identified **greater use of trauma-informed practices** as a positive trend. One participant was discussing changes in the field and stated *"What really comes to mind is the focus on trauma. In the past, trauma was kind of reserved for the strictly mental health domain. And now there's much more focus on [trauma]. While you can go to substance use treatment and learn your recovery and relapse prevention skills, you really have to heal from those deeper wounds and that deeper pain in order to truly prevent returning to use in the future."*

While this participant saw greater trauma-informed care in the field, they also qualified the trend as "leveling-off" and identified a need for greater growth in this area.

Overall, participants were happy with the shifts in treatment approaches, but they were not completely satisfied with the current state of treatment. Participants identified several treatment changes that they wanted to see in the field. The most commonly and frequently identified change was a **need for greater levels of individualization within substance abuse treatment.**

Participants repeatedly referenced the need for treatment and treatment providers to *"meet clients where they are."* While participants used this sentiment to advance several changes to the current state of treatment, they most frequently expressed a need for clients to be able to **access the right level of service at the right time** and the need for **higher levels of client self-determination.**

One participant made the case for this approach by saying, *"We know that when an addict's ready to get help, they're willing in that moment. And we have to capture that willingness when it's available because we know the nature of addiction means they're going to go on a bender again, and it could have the potential for an overdose."*

While participants identified several barriers to greater levels of individualization within substance abuse treatment, **participants frequently named NE DHHS and other state agencies as significant barriers.** In some cases, this was in reference to necessary treatments not being covered by Medicaid or the regional behavioral health system. In other cases, participants were referencing actions by CFS or probation that were not client-centered or interfered with treatment in some way.

One participant spoke to this dynamic, saying, *"We have a lot of providers within the agency that don't want to take HHS cases because they're dictating the care and the level of treatment. And it just fuels that earlier concept of that, you know, the clients feel like it's a 'me versus them' mentality."*

Access to Treatment

Section highlights:

1. Substance abuse treatment is drug overdose prevention.
2. There are significant barriers to accessing treatment, especially residential treatment and especially for women with children and other vulnerable and marginalized populations.
3. For substance abuse treatment to be effective, clients need access to housing, healthcare, and employment.
4. Participants viewed NE DHHS as a barrier to meeting these basic needs.
5. Some level of wraparound services would increase access to and effectiveness of treatment.

As part of the qualitative interview protocol, STEPs asked all participants about the resources they needed, changes they believed would reduce drug overdoses, and what they would want from a partnership with NE DHHS. In response to these questions, participants mentioned the pressing need for increased access to substance abuse treatment. Participants were clear that they believe **substance abuse treatment is drug overdose prevention.**

When asked specifically about drug overdose prevention, one participant recognized the theme across many of her responses: *"I'm gonna sound like a broken record, but I would say accessibility to care. If people can get the help when they need it, then the chance of overdose decreases significantly."*

However, participants identified **significant barriers to accessing substance abuse treatment.** Many of these barriers were financial. For many people, especially those without health insurance or who are seeking services voluntarily, **substance abuse treatment can simply be out of reach financially**.

One participant said, *"I think it goes back to providing care for individuals who don't have any resources. The individuals who need the funding to be able to enter into treatment. That's pretty much all I can come up with as being the barrier. Just being able to provide that service to people in need, who don't have the resources to do it."*

However, even when financial resources are available, there can still be **significant delays in accessing the needed treatment**. Waitlists for services were a particularly frustrating barrier identified by the participants. One of them said, *"The waitlists are long–sometimes weeks. So if I think that somebody is really needing inpatient treatment and I call somewhere to try to get them on the waitlist and they'll give me a date like 6 weeks or 8 weeks or something like that. And I just sit there and I'm like, wow."*

Access to Treatment (cont.)

While participants identified financial barriers as an issue at all levels of treatment, delays in accessing treatment were most often specific to higher levels of care. **Participants identified a significant lack of inpatient, residential treatment options.**

One participant spoke of the volatility of the situation as follows: *"Where I run into problems is maybe getting somebody into an inpatient setting. A lot of times there's waiting lists and we've got, you know, kind of unstable patients that really shouldn't be sent home that end up being told there's no inpatient bed."* Another participant spoke of referring Nebraska clients to residential treatment centers in Kansas saying, *"It's easier to get someone in there than it is to get them in for treatment anywhere in Nebraska."*

For some clients, the waitlist is only one part of the delay. For example, one participant qualified her waitlist complaint saying, *"One of the hardest things is when someone needs to get into treatment, there's nothing. It's at least a 2-week wait, and that's if they're accepted on day one."*

And clients often face additional barriers to being accepted for service. One participant spoke about trying to get letters of agreement so NE DHHS would pay for services, *"but that process is very long and cumbersome so you see services get delayed by a month or two to start. You see them have delays of weeks in between while they're trying to get the payment funding going. And again, I just think it's bureaucratic, you know, it's like the caseworker does one thing, hands it off to another team, and so forth."*

While the general shortage of residential options and subsequent delays are likely to impact all clients, barriers to access rarely affect all clients equally. As a general rule, **barriers to accessing treatment are not evenly distributed.** Clients who are already vulnerable or marginalized often experience more barriers and experience them more intensely.

For example, some participants identified that **women need residential treatment options that allow them to be with their children.** While participants were able to identify programs that serve mothers and their children, the need is high and the resources severely lacking.

One participant laid out the realities of the situation saying, "*One of the biggest barriers that we run into is finding sober and safe and affordable housing. Because women who don't have children or men have wide access to halfway houses, three-quarter way houses, right? Like in Lincoln, where I'm located, I think there are twice or three times as many Oxford houses for men as there are for women. And, of the three Oxford houses that are available for women, not a single one of them will allow a woman to bring a child with her at this point in time. So, I only know of one three-quarter way house in Lincoln that takes women who need to have housing with their children, and it only has five beds available. So, there is an utter lack of safe, sober support for women who have children and want to have their children with them."*

Access to Treatment (cont.)

Similarly, **clients in rural areas of the state also face unique challenges and barriers to accessing treatment.** For substance abuse treatment providers serving rural regions, the frustrations abounded. One participant said, *"We kind of forget about all these rural areas. People don't have transportation. There are no treatment centers within a 60-mile radius. It's just not the same access of care."*

It's not only difficult accessing care, but the same participant went on to discuss how some rural clients are punished for their difficulties in accessing treatment. "*Something specific when we look at like HHS clientele, their transportation provider exists, but a lot of times they won't come to this area... If transportation cancels on them 2 hours in advance, or a day in advance, they're being consequenced* [sic] *for not following through with an appointment."*

And it's not only treatment centers that are hard to access in rural areas. Participants specifically noted the lack of rural access to detox services, AA meetings, naloxone, and even outpatient treatment.

Participants also discussed specific **barriers to accessing treatment for clients who are undocumented, experiencing homelessness, or are currently or were previously incarcerated.** These barriers are often unique and especially burdensome.

For example, one participant who worked within correctional services discussed how many entities, including insurance companies, use the date of incarceration as the start date of sobriety. Then, depending on their length on incarceration, some clients are ineligible for services upon release. The combination of forced sobriety and lack of adequate treatment can be deadly for clients after they are released. According to the same participant, "*A lot of times they've been sober for 60 days or 90 days, and they use the exact same amount they were using before coming to jail. They may be on a wait list for treatment, but it doesn't matter because if they can't get into treatment when they need it, then they're at risk of going and using, and when they use they're more likely to overdose because they don't know the amount that they can have."*

Other participants discussed the difficulties in accessing MAT while experiencing homelessness or programs that denied funding to undocumented immigrants. These examples highlighted the unequal distribution of treatment services with groups who are already vulnerable or marginalized having greater difficulties accessing substance abuse treatment.

Participants were also clear that, especially for vulnerable or marginalized clients, barriers to accessing treatment are only part of the equation. **Clients with substance use disorders often need more than just treatment.** Participants identified how a general lack of resources in a client's life can hinder their ability to consistently attend and be successful in treatment.

Access to Treatment (cont.)

For example, one participant started listing the needs and challenges that many mothers face: *"Daycare, not having enough food to eat, finding a job, adequate transportation, adequate housing. Usually, if they're in the middle of their own addictive process, they have therapy, they're expected to go to 12-step meetings. They're expected to do parenting classes. Their kids are usually in therapy, so there's just significant demands."*

A common client need that participants identified was **safe and affordable housing**. While participants mentioned housing needs in a variety of contexts, they often emphasized it in the context of women with children.

One participant told this story regarding housing: *"A lot of the moms that I work with need that long-term support where they have a place where they have safe housing and safe community with other moms, but it's not available, right? So we're sending them out into the world, often into whatever apartment they can find that accepts housing vouchers or Section 8 vouchers from the Housing Authority. Very often, those are apartments in areas of town that have very concentrated drug use. So we're sending them back out very quickly, with very little recovery time under their belts, into the very situation that we just took them out of, and expecting them to function differently in it, which doesn't just happen magically with just a little bit of treatment."*

Another need that participants consistently identified was for **general healthcare access.** Participants described accessing healthcare as a major source of stress for their clients.

One participant said, *"When you're worried about all of these things that you can't access because you don't have health insurance, it makes it really hard to focus on recovery. So I'd like to think that if folks had the resources to take care of those, what we might consider like little things - like going to your doctor's appointments, having access to your medication, having access to a dentist when you need it - then they could use all of that energy that they'd be saving on actually focusing on recovery and engaging in treatment and not having to worry about all this stuff in addition to that."*

Participants also identified **employment needs** as being important to treatment success for many clients. Not only does employment generally mean greater access to financial resources, but it can also mean greater independence for some clients.

One participant referred to this as the "domino effect," in which successful employment triggers *"a very positive effect because when you've got someone who starts over and they feel success in that and they see a future in recovery, there's going to be a huge decrease in drug overdoses because there's going to be a decrease in use."*

Access to Treatment (cont.)

In some cases, participants viewed **NE DHHS as a barrier to clients getting these basic needs met.** Participants described bureaucratic catch-22s in which clients lose important benefits when they get a job, sometimes leaving them with fewer financial resources than they had before. Participants also described caseworkers with unrealistic, and often misguided, expectations for clients that left them with no good options for bettering their situations. One participant discussed the "unspoken rules" of caseworkers, which can leave clients frustrated and can unnecessarily prolong separation from their children.

One participant told a specific and vivid story of a system-involved woman's struggle. *"I remember a case that this lady had significant drug issues, and she struggled finding a job. She didn't have very good history with jobs. Had difficulty getting a good reference, and the only job she could find was a nights and weekends waitressing job. And she did well, it paid well enough to where she was able to get her car fixed and had transportation for everything, but it didn't work out. I mean her job interfered with visits that had to be in the afternoon because of other people's schedule that were in the case. So she ended up basically giving up the job.*

The participant felt like the situation did not need to have this outcome, stating, "*She wasn't forced to quit it, but at the same time, she wasn't given any other option for it. So it's situations like that, that I feel we need to have an open, honest discussion about what we are asking these parents to do. And how much can we expect them to do given any other constraints. You're asking them to deal with a substance use disorder while they're dealing with high stress of not having their kids, in addition to trying to find a job, and their car isn't running, but if they miss a visit, because they can't get there because their car's broken down, then it's the end of the world.*"

While participants identified many significant problems and barriers to treatment, they also discussed solutions. Participants spoke of expanding access to telehealth services to meet rural needs. One participant discussed starting a program that increased the availability of treatment for women with children. Some discussed Medicaid expansion.

Many participants discussed some version or level of **wraparound services as a solution that would significantly increase access to treatment and success within treatment.** Participants felt that a treatment team approach with coordination of care and access to a wide variety of services would significantly improve outcomes for many of their clients.

One participant discussed a stalled attempt to implement a program in Omaha to provide these services: *"We had this vision of [a program] where all the services that are needed are under one roof. So it's kind of a one-stop shop, and it actually got something like this going… and it had to do with the community taking care of its own and making services available. So easily available that there was absolutely no excuse for not using them."*

Access to Treatment (cont.)

The same participant listed the agencies and services that would be needed to meet people's needs, saying, "*And the bottom line was they put all the services, including a court room and a judge, probation, treatment, education, whatever a person needs, it was all not only located in the neighborhood where people needed it, but it was all under one roof. And this was actually discussed in Omaha a long time ago, but it never went anywhere.*" While this participant's vision was particularly comprehensive, several participants expressed a need for a similar program or services.

The most commonly and frequently referenced solution to treatment access issues was increased funding. Participants believed that many treatment access issues would be solved if there was adequate funding available, whether that be provided directly to substance abuse treatment agencies, expanded treatment subsidization, or higher reimbursement rates for treatment providers.

While directly connected to access to treatment, funding issues were both prevalent and nuanced enough to warrant their own analysis. See the "Funding and Stigma" section of this report for a full discussion of funding.

Funding and Stigma

Section highlights:

1. Funding available for substance abuse treatment is insufficient to meet the need.
2. Lack of funding is directly tied to the stigmatization of substance use and those with substance use disorders.
3. When political leaders believe addiction is a choice, they are less interested in funding and addressing substance abuse issues.
4. Community education about substance use and substance use disorders is needed to increase compassion and reduce stigma.
5. Efforts to reduce stigma and increase access to treatment would benefit entire communities.

STEPs did not ask participants about funding in the interview protocol, but participants brought up funding issues and nearly all directly discussed them. Participants mentioned funding in the context of both the financial needs of people with substance use disorders and the funding provided to agencies who support people with substance use disorders.

In both contexts, the consensus was clear: participants felt that **the funding available for substance abuse treatment was insufficient to meet the need** and that **the lack of funding is directly tied to the stigmatization of substance use and those with substance use disorders**. Without changes to the funding context, people with substance use disorders will go without substance abuse treatment and be at risk for overdose.

Participants framed **funding as a tool that helps clients access treatment and helps providers better support clients**. The participants largely see this tool as insufficient for the amount of work that needs to be done in substance abuse treatment.

Participants identified seven funding sources that support substance abuse treatment:

1. Funding through NE DHHS,
2. Funding through state and foundation grants,
3. Funding through the regional behavioral health system,
4. Insurance reimbursement,
5. Payment for service by clients,
6. Private donations, and
7. Funding through probation vouchers.

While almost all participants discussed the need for increased funding, some generally and some identifying specific funding sources that need increased, many participants also believed that funding sources are often doing the best they can with what they have.

Funding and Stigma (cont.)

While many participants discussed a general need for increased substance abuse treatment funding, some participants **identified specific changes to the current funding landscape**. For example, one participant discussed the need for coordination of care, but that most funding sources do not currently reimburse for that service.

The participant wanted *"reimbursable rates for coordination of care so you can have more wraparound services for the client. You've got your behavioral health, your medical, your medication management provider, the whole treatment team being able to collaborate, but right now that's all unbillable time."*

Another participant identified the ongoing reimbursement rate disparity between medical and mental health providers as a problem. Several participants also discussed Medicaid expansion as an improvement that would increase access to substance abuse treatment.

Participants also identified specific gaps in funding that have left some clients without the means to access substance abuse treatment. While participants recognized that substance abuse disorders do not discriminate based on socioeconomic status, access to treatment is not equal. **Clients with limited financial resources and who are not system-involved may have a particularly hard time accessing substance abuse treatment on a voluntary basis**.

One participant stated, *"If you're not involved with CPS and you're an adult, there really isn't a system out there unless you go and commit a crime and then the probation system or the judicial system kicks in. And even that's a minimal amount of support. So somebody who wants to go out there and do it alone has no financial, has no emotional, has no other support to be able to do it."*

Participants shared that agencies' use of sliding fee scales sometimes allows this population to access services but isn't a sustainable solution. Participants discussed that when agencies use sliding fee scales and are not reimbursed for the service, it impacts the available funding for other necessary services.

As one participant explained, *"So we charge them on a sliding fee scale ... but we're not getting any reimbursement for it. And so, program-wise, it is a hit to our budget. And we're deeply rooted in social work values, so I don't ever see a time when we would turn people away, but it affects our budget."*

Participants connected the insufficient funding for substance abuse treatment to the stigma attached to substance at large. Like funding, STEPs did not ask participants directly about stigma, but most brought it into their interview regardless.

Funding and Stigma (cont.)

Participants expressed that the belief of "addiction is a choice" is still prominent and is a major source of stigmatization for clients and accessing substance abuse treatment. One participant said, "*I think most of society is still in a place of wanting to punish addicts for their choices rather than trying to understand that no one chooses to be an addict. Yes, they may have chosen to use substances in the first place, but no one is choosing the utter hell that active, full-blown addiction is.*"

While some participants discussed seeing an overall increase in compassion for substance use disorder clients over the years, participants were clear that stigmatization remains a major problem.

While participants discussed stigmatization as widespread, several participants specifically identified the stigmatizing beliefs of those in positions of political leadership as having a negative impact on funding availability. According to these participants**, when political leaders believe addiction is a choice, they are less interested in funding and addressing substance abuse issues.**

Instead, substance use is framed as an issue of criminality. For example, several participants discussed what they believed to be high criminal penalties for drug offenses compared to other crimes. One participant stated, *"I think we could do a better job of educating and rehabilitating rather than throwing people in jail or prison."*

Some participants discussed decriminalizing substance use to support substance use disorder clients and reduce stigma. Other participants discussed needle exchange programs as another way to support clients, but they believe these programs are not available due to the stigma attached to them. One participant explained, *"I don't think it does us any good to act like there's a moral superiority and addicts who are dying from their addiction deserve it because they made a choice. And unfortunately, I do still see that attitude explicitly or implicitly in a lot of policy and a lot of policy makers."*

Participants discussed the need for **education in schools and communities addressing drug use and addiction**. Participants believed that education would decrease stigma and make it easier for people with substance use disorders to access treatment and support.

While participants believed that education would decrease stigma, they also believed it was not currently implemented, and in some cases unlikely to be implemented due to stigma. Several participants identified the misconception that talking about substance use will encourage substance use as a barrier to meaningful educational interventions.

Funding and Stigma (cont.)

However, some participants felt that a general mental health education intervention could be effective and accessible in ways that substance use education might not be. One participant described what mental health education should entail saying, *"You need to talk about what mental health is, what it looks like, what are symptoms, it's okay to talk to someone about those things. Reduce the stigma and then educate on where to find help."*

Some participants also discussed **research as a means of reducing stigma**. One participant discussed seeing a recent study showing a correlation between menstrual cycles and craving cocaine. The participant went on to say, *"It could be the same with the men, too. Like as they age and their testosterone goes down, we just know that older men tend to like phase out of using. Well, the belief has been for a long time, they just get, quote, 'tired of the life.' But is it connected to their testosterone levels dropping?"*

This participant believed that having access to up-to-date biological studies would enhance treatment methods and the understanding of addiction. However, the participant said studies like this are not prevalent due to stigma, the prevailing belief being, *"why would you invest in figuring out bad people?"*

Participants not only believed that efforts to reduce stigma would increase funding for substance abuse treatment and benefit people with substance use disorders, but that **the benefits would be felt by entire communities.** One participant stated, *"Bottom line, it's got to be important to everyone. The communities have to see value in treating a whole person. That there's a big investment up front for addictions recovery, but everyone has to see the long-term effects. You know, we might pay $40,000 to treat this individual, but then they're going to go get a job, they're going to pay taxes. You know, this is going to pay off down the road, it's just going to take a while."*

Drug Overdose Prevention

Section highlights:

1. Naloxone is crucial in preventing overdoses, but knowledge about how to access them is inconsistent.
2. Pain medication prescribers need more education, training, and resources to reduce opioid overprescribing.
3. Substance use disorder clients need harm reduction and safe use education in case of relapse.
4. Decriminalizing drug use behaviors in circumstances where overdoses are occurring may reduce barriers to accessing emergency services.

As part of the qualitative interview protocol, STEPs asked all participants a series of questions directly addressing drug overdose prevention. As discussed in the "Access to Treatment" section of this report, participants felt strongly that substance abuse treatment is overdose prevention.

However, participants also discussed several other strategies they believed would significantly reduce the number of drug overdoses in Nebraska. Across the board, participants believed that **increased access to naloxone was preventing overdoses, and they want access to continue to increase.**

Participants had many ideas regarding where naloxone should be distributed in order to increase access and reduce overdoses. While many participants were aware that naloxone is available at some pharmacies, they also felt it should be available at or distributed to drug treatment centers and providers, homeless shelters, law enforcement officers, emergency rooms and ambulances, hotels, stores and other public places.

Many participants emphasized the need for access not just for those who use drugs, but also family and community members. Many participants stated that they as treatment providers should have access or know where to access naloxone for their clients but did not feel properly educated. One participant stated, *"I bet if I walked around and asked three or four counselors right now, do you know where you could get some NARCAN® for no money? I don't think they would know what to say or where to go."*

Other opioid overdose prevention strategies suggested by participants focused on **increasing education, training, and resources for pain medication prescribers.** Many participants believed that increases in opioid abuse or overdoses were the result of overprescribing opioids for pain management.

Drug Overdose Prevention (cont.)

Some participants believed that prescribers were not adequately considering patients' substance abuse histories or exploring alternative forms of pain management before prescribing opioids. Some participants suggested increased education and training for prescribers on both the potential dangers of opioid abuse and the availability of alternative pain management approaches.

While participants believed that clients, medical providers, and insurance companies all have responsibility for decreasing the use of opioid pain medication, one participant specified that any educational interventions directed at physicians need to come from within the physician community in order to be effective. *"Well, I think you'd have to have people within the physicians' community do that… I think it needs to come from within their community to say, 'Okay, we need to change this.'"*

Some participants discussed utilizing alternative pain management methods as a way of reducing overdoses. While participants felt that this approach could be effective, they anticipated barriers to widespread implementation, even beyond provider education. One participant said, *"The biggest barrier I see is insurances. It's cheaper to treat somebody with one medication than it is to send them to lots of different services as a total care of that person."*

Another participant suggested that prescribers need increased resources to ensure that opioids are not overprescribed, such as access to a prescription tracking database.

In addition to providing education to prescribers, participants also suggested **education on harm reduction and safe use strategies targeting people at risk for a drug overdose**. While participants acknowledged that such an approach would be controversial and may not be politically feasible in all communities, it could be a crucial strategy in preventing overdoses.

One participant said, *"I think the education to the clients is one thing. I mean it seems odd to say, 'If you go back out, don't start at your old amount.'"* Several participants identified that overdoses occur when a client resumes use at the same amount after being sober for an extended time. Many participants felt that this strategy was not being used due to misinformation regarding harm reduction.

One participant drew a comparison between drug overdose prevention and suicide prevention strategies, stating that fear and misinformation keep people from doing what we know works. "*It's no different than like suicide. If you ask a client, are you thinking about suicide, there's this belief that that's going to plant the seed. And I can see that same kind of mindset with the drug and alcohol conversation."* The participant stated while it might feel odd to talk about, it is crucial in preventing overdoses.

Drug Overdose Prevention (cont.)

Participants also **suggested several community-based education programs**. Some participants brought up in-school and afterschool programming for young people, but participants had different visions for these programs. Some suggested drug use prevention education and safe drug use education, and others envisioned general mental health awareness education. Other participants believed that the whole community not just young people needed education. One participant felt that many people were not aware of the level of drug use occurring within their communities and, if they became aware, they would be more involved in substance use prevention.

Participants also noted the need for emergency services to be contacted in the case of an overdose but believed that clients were reluctant to call out of fear of arrest. Participants felt that **decriminalizing drug use behavior in situations where an overdose has occurred may increase the likelihood of emergency services being contacted.**

One participant stated, *"The biggest piece of that, I think, is making sure that we're decriminalizing any activity that's happening if someone were to call for help for an overdose, if that makes sense. You know, like if there's four people in a place that has a lot of paraphernalia, and one person is overdosing, and nobody wants to call 911 because they're afraid that they'll all get charged with possession charges."*

Some participants also suggested other forms of drug decriminalization, such as reducing sentencing associated with drug possession, but it was less clear that participants believed those suggestions would reduce drug overdoses.

Relationship with NE DHHS

Section highlights:

1. Treatment providers do not have a clear understanding of who NE DHHS is or their role in drug overdose prevention.
2. Many participants defined all of NE DHHS by their interactions with specific divisions and sections, like CFS.
3. Participants are interested in developing partnerships with NE DHHS if they feel that their subject matter expertise will be valued.
4. Participants had specific suggestions for actions steps they would like NE DHHS to take, including developing and maintaining a statewide substance abuse treatment resource guide and facilitating quarterly roundtable discussions.

As part of the qualitative interview protocol, STEPs asked all participants, "What would it look like if NE DHHS were to be a full partner to you in your work?" and a series of follow-up questions regarding their experiences with and expectations of NE DHHS.

While participants gave a notably diverse set of responses to these questions, several participants responded by trying to understand from the interviewer what NE DHHS' role in overdose prevention is. One participant said, *"I don't know much about how DHHS contributes to preventing overdose and getting people substance abuse treatment. Could you give me some information on how DHHS is doing that now?"* This questioning of the interviewer exemplifies **the general confusion that participants had regarding NE DHHS** and its role in preventing drug overdoses.

Another common response from participants was to **define the entirety of NE DHHS by the division, section, or subsection with which they had the most interaction**. Participants frequently associated NE DHHS with CFS or Medicaid or even with systems outside of NE DHHS, such as probation.

These associations made sense to the participants because of **the important and emotionally charged role that these state entities play** in the lives of their clients and in their own professional experiences. These associations were elevated in the analysis not only due to the number of participants who made them or the frequency with which they brought it up, but because of the intensity of the statements that they made.

Relationship with NE DHHS (cont.)

One participant for example, shared these feelings when asked about NE DHHS: *"Okay, yeah, I have strong reactions to the CPS system. I think it is a huge failure to our families that we work with … I know that their primary goal is child well-being and child safety and that absolutely should be. I don't think it has to be mutually exclusive with parental involvement. I think parents are vilified; I think they're not given chances. I think there's an automatic belief about the parents that use substances and there's an automatic alignment with the foster parents."*

The participant explained how this belief impacts clients and their treatment success. The participant shared, "*The clients want the system to know that they are not bad people. We try so hard to help them work on shame. And it's really hard to do that when there are systems that continually perpetuate their belief that they should be ashamed."*

The participant went on to discuss how this relationship with NE DHHS not only impacts clients, but also the treatment providers who work with them. "*So the therapists in my programs spend more time than what they need to be spending–because we don't get paid for this work, right?–advocating for our clients. We're happy to do it, that's what helps with the relationship, but [the therapists] shouldn't have to spend this much time advocating to a system."*

Not all participants had such intense and negative reactions to NE DHHS. Several participants **described generally good and functional relationships with NE DHHS**. One participant said, *"I've got a pretty good working relationship with our, well, what I consider DHHS, I'm talking about Child Protective Services and Adult Protective Services and then Developmental Disabilities Services that I work with."*

Many other participants simply described a neutral relationship with NE DHHS. For example, one participant discussed a primarily transactional relationship, saying, *"I see the Department of Health and Human Services as a referral source and a resource for a number of different things that I may need or that my clients may need."* The participant went on to say, though, *"As far as seeing them as a partner in things? I feel like, especially with drug overdose stuff–and maybe I just need to look a little bit harder–but I haven't seen a whole lot of trainings or different opportunities to learn about what exactly they are doing when it comes to stuff like this."*

Participants were generally interested in what NE DHHS was doing to prevent drug overdoses and how they might be a partner. Specifically, participants expressed interest in **a relationship in which NE DHHS valued treatment providers for their subject matter expertise and were actively helping treatment providers provide better services.**

Some participants expressed these interests in very general ways or described it as a feeling that they would get when it was true, but other participants had very specific ideas for how NE DHHS could help foster this sort of relationship. Participants brought up–and fleshed out with some level of detail–three specific suggestions.

Relationship with NE DHHS (cont.)

The first suggestion was for **NE DHHS to create and maintain a statewide substance abuse treatment resource guide**, which would include programs and providers, the services they offer, and accepted payment methods. One participant added, *"And even knowing what levels of care are available at what agencies and their payment sources so that we can move this along much quicker and not have gaps in service."*

Many participants discussed not knowing what levels of care are available at each agency because services change depending on available funding. One participant stated, *"It's somewhat hard to find. And when we do find–we've created a list, we're actually updating our list and looking through all the different internet sources and calling all the different places, but then levels of care change all the time or people stop providing a certain level of care or they change their referral process. And we just don't have the resources to keep updating that list every month."* Participants hoped that a resource guide like this would help them connect substance use disorder clients to appropriate resources quicker and would enhance treatment for individuals.

The next suggestion was for **NE DHHS to better support their CFS caseworkers and implement changes to improve relationships between treatment providers and caseworkers**. Some participants believed that if caseworkers were better supported through access to advanced trainings, they'd be better equipped for the difficult situations they encounter.

One participant suggested the following: *"Maybe some education and training to the HHS workers, like the people who are working with their clients around drug and alcohol needs and levels of addiction and/or levels of treatment and stuff, so that way the people who maybe are getting a call first can recognize more clearly and quickly the severity of what they're dealing with. I don't know what they receive now. And not that their training now is poor, but I would just say that the more people know, the better."*

Participants also discussed feeling their relationship with caseworkers was *"purely transactional,"* with some noting that communication between them only occurs *"right before court."* Some participants felt this lack of communication and teamwork hindered progress for their substance use disorder clients. Participants believed that having conversations between all team members on these cases would improve outcomes. One participant stated, *"I think it would just help get everybody on the same page about what perspective they're bringing that from."*

Relationship with NE DHHS (cont.)

Other participants discussed feeling that NE DHHS caseworkers did not respect their recommendations for clients. One participant said, *"So often we might make a recommendation, but we will get called by the caseworker wanting that recommendation changed based on they think it's too much treatment, or they need less treatment, right? And I just feel like a lot of times those caseworkers are making clinical decisions that they should not be."* Participants stated decisions made by both practitioners and caseworkers regarding treatment *"are incredibly impactful to these families, like lifelong impacts. And sometimes these decisions appear to be taken fairly lightly, from [the caseworker's] end. So, them trusting more the treatment providers."*

Finally, participants discussed the segmented way the system currently works, which leaves them feeling left out of the loop on issues that impact their practice. Participants felt like they did not understand what decisions were being made or how they were being made regarding issues like funding availability or the selection of priorities or the incorporation of various standards or best practices.

Participants suggested **quarterly roundtable discussions between substance abuse treatment providers and NE DHHS administrators** to help bridge this gap. Multiple participants stated participating in the interview was a good first step in improving communication.

As one participant put it, *"I think this is the first time anyone from a policy standpoint, and I know that's coming down through the lens of program evaluation in this specific situation, has ever asked me what we even need, kind of like on the ground level."* Participants would like to continue to be asked about their needs and experiences as well as informed about NE DHHS' roles and services.

Limitations

All research has limitations. The findings and recommendations within this report should be understood in the context of the following limitations:

1. STEPs made changes to the sampling procedure during the recruitment phase. In these changes, STEPs prioritized a larger sample size, which often provides more data, over the use of theoretical sampling, which often provides richer data.
2. While the sample size was well within the acceptable range for qualitative research, it may not have been fully saturated, and additional findings may have developed from additional data.
3. Participants in the qualitative study are a subsect of participants from the quantitative survey. While the results of the two studies can inform one another, overlapping results should not be interpreted as verification. It is not known if this sampling strategy restricted the range of the data.
4. STEPs used purposeful, criterion sampling. While STEPs attempted to recruit a geographically diverse sample of substance use treatment providers, the sample should not be viewed as representative of all substance use treatment providers in Nebraska.
5. STEPs conducted all interviews via Zoom, an online videoconferencing platform. While researcher and participant satisfaction with qualitative data collection via Zoom has been documented, it is unknown if the use of this platform affected the type or quality of data compared to in-person interviews.
6. STEPs conducted all interviews during the COVID-19 pandemic. It is not known if this affected the type or quality of data collected.
7. Bias exists within all research. STEPs used two coders who engaged in initial coding independently and subsequent data analysis collaboratively in an effort to reduce the impact of bias.

References: Treatment Provider Qualitative Interviews

Archibald, M. M., Ambagtsheer, R. C., Casey, M. G., & Lawless, M. (2019). Using Zoom videoconferencing for qualitative data collection: Perceptions and experiences of researchers and participants. *International Journal of Qualitative Methods, 18*, 1–8.

Charmaz, K. (2014). *Constructing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage.

Appendix A

Initial Email to Treatment Providers
Hello,

We are seeking input from outpatient substance use treatment providers throughout Nebraska. If you are not currently an outpatient treatment provider, we ask that you please forward this survey to any outpatient treatment providers at your practice or agency.

The Nebraska Department of Health and Human Services (DHHS) has contracted with the University of Nebraska at Omaha's STEPs (Support and Training for the Evaluation of Programs) to conduct a survey with treatment providers across Nebraska. Results of the survey will be used to inform DHHS on future treatment and prevention programs.

- Survey responses will be anonymous and will be sent directly to STEPs.
- We expect this survey to take 10 to 12 minutes to complete.
- The survey will remain open until a desired number of responses are gathered, so please make sure your voice is heard!

Please complete the survey by clicking below:

Click Here

Thank you for your help with this project. Your feedback is invaluable and will be used to improve Nebraska's prevention and response efforts. If you have any questions, please contact STEPs at steps@unomaha.edu.

Follow-Up Email to Treatment Providers
Hello,

You were recently invited to participate in a 10- to 12-minute treatment provider survey regarding clients' misuse of substances. Please make sure your voice is heard.

- Results will be used to inform DHHS on future treatment and prevention programs.
- Responses are confidential.
- If you have already completed the survey, please disregard this email.

Please complete the survey by clicking below:

Click Here

Thank you for your help with this project. If you have any questions, please contact STEPs at steps@unomaha.edu.

Appendix B

Treatment Providers Survey[7]

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 their strategic 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 a strategic plan.

We expect this survey to take 10-15 minutes to complete. Responses will be received and analyzed by STEPs; you will remain anonymous. The STEPs team will provide a final report with recommendations to DHHS using your invaluable feedback. The final report will be made available to you through DHHS.

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DEPT. OF HEALTH AND HUMAN SERVICES
DRUG OVERDOSE PREVENTION

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

Provider Information

We would like to know about you and the services you offer.

1. **Which professional licenses or certifications do you have?** (select all that apply)
   - Licensed or Provisionally Licensed Alcohol and Drug Counselor (LADC or PLADC)
   - Licensed Independent Mental Health Provider (LIMHP)
   - Licensed or Provisionally Licensed Mental Health Provider (LMHP or PLMHP)
   - Licensed Independent Professional Counselor (LIPC)
   - Licensed or Provisionally Licensed Professional Counselor (LPC or PLPC)
   - Licensed Independent Clinical Social Worker (LICSW)
   - Certified or Provisionally Certified Master Social Worker (CMSW or PCMSW)
   - Other (please specify): _____

2. **In which county or counties do you provide substance use treatment?** (select multiple counties by holding down **Ctrl** (on a PC) or **Cmd** (on a Mac) when clicking)

Appendix B (cont.)

Treatment Providers Survey[7]

Provider Information

3. **In which counties do your clients typically reside?** (select multiple counties by holding down **Ctrl** (on a PC) or **Cmd** (on a Mac) when clicking)

4. **Do you provide substance use treatment in an outpatient setting?**
   - Yes
   - No

5. **Do you refer clients for any of the following medications?** (select all that apply)
   - Disulfiram
   - Naltrexone
   - Acamprosate
   - Methadone
   - Buprenorphine
   - Suboxone
   - Medications for psychiatric disorders
   - Other (please specify): _____

Substance of Choice

For this section, we are interested in hearing your perceptions of the most common and most recent trends in substance use among the clients you serve. For the following questions, please give your best estimate based on the clients you have seen.

6. **Thinking about clients presenting for substance use over the past year, approximately what percentage of these clients have presented needing treatment for the use of:** (choose % on a slider)
   The substance indicated below need not be their primary drug of choice. (Total must sum to 100%)
   - Alcohol
   - Prescription pain relievers (i.e. hydrocodone, oxycodone, etc.)
   - Heroin
   - Fentanyl (including prescription or illicit)
   - Methamphetamines
   - Benzodiazepines
   - Antidepressants
   - Marijuana
   - Hallucinogens (i.e. LSD, PCP)
   - Inhalants
   - Cocaine/crack
   - Other (please specify): _____

Appendix B (cont.)

Treatment Providers Survey[7]

7. **Thinking about clients you treated for substance use over the past year, what have been their <u>most common</u> primary drugs of choice?** (select all that apply)
   - Prescription pain relievers (i.e. hydrocodone, oxycodone, etc.)
   - Heroin
   - Fentanyl
   - Methamphetamines
   - Benzodiazepines
   - Antidepressants
   - Marijuana
   - Alcohol
   - Hallucinogens (i.e. LSD, PCP)
   - Inhalants
   - Cocaine/crack
   - Other (please specify): _____

8. **In the past year, what percentage of your clients have had an opioid use disorder (prescription pain relievers, fentanyl, heroin)?** (choose % on a slider)

9. **In the past year, what percentage of your clients were polysubstance dependent?** (choose % on a slider)
   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).*

10. **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)
    For example, if a common substance combination is methamphetamines with alcohol and prescription pain relievers, please type "alcohol and prescription pain relievers" in the box next to "methamphetamines."
    - Alcohol
    - Prescription pain relievers (i.e. hydrocodone, oxycodone, etc.)
    - Heroin
    - Fentanyl
    - Methamphetamines
    - Benzodiazepines

Appendix B (cont.)

Treatment Providers Survey[7]

10. (continued)

- Antidepressants
- 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.

11. 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
- Cocaine/crack
- Other (please specify): _____

12. What age do most clients you serve indicate as their first misuse?

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

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

- Pain relief
- Relax or relieve tension
- Experiment/see what it's like
- Feel good/get high
- Help with sleep

Appendix B (cont.)

Treatment Providers Survey[Z]

13. (continued)

- Help be alert or stay awake
- Help study or concentrate
- Help with feelings or emotions
- Help lose weight
- Parents or other family members encouraged them to
- Peers encouraged them to
- Other reason (please provide the reason): _____

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

- From a doctor
- Stole from doctor's office, clinic, hospital, or pharmacy
- 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
- Some other way (please provide source): _____

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).

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

- No healthcare coverage and cannot afford cost
- No transportation/too far away
- Hours inconvenient
- Do not want treatment; lack motivation to stop using
- Takes too long to access treatment; window of motivation closes before treatment is available
- 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, or prideful
- Other problems to deal with (emotional, family, etc.)
- Family members/others are unsupportive
- Do not know how to access treatment; do not know where to start
- Fear of having children removed from the home
- Other (please specify): _____

Appendix B (cont.)

Treatment Providers Survey[7]

16. **Which of these statements best describes how your clients were prompted to get treatment?** (select all that apply)
    - 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): _____

17. **For what percentage of your clients in the past year was this their first treatment experience EVER?**
    A "treatment experience" refers to any professional help they have received for substance use, inclusive of outpatient, intensive outpatient, and residential programs. (choose % on a slider)

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 you have, and what needs your clients have, that DHHS may be able to fill in the future.

18. **In your opinion, what prevention efforts are most helpful?** (select up to three in each category)
    Primary Prevention (targeted at non-users and general public)
    - Prescriber education
    - Public service announcements (PSAs) and media campaigns for general public
    - Public education about medication assisted treatment (MAT)
    - School-based substance use prevention programs for **elementary students**
    - School-based substance use prevention programs for **middle school students**
    - School-based substance use prevention programs for **high school students**

    Secondary Prevention (targeted at early use, before serious complications)
    - Addiction screening at primary care facilities (similar to ways in which they might screen for mental health)
    - Addiction screening for those presenting for early refills (to refer for treatment and services)
    - Use of Prescription Drug Monitoring Program before prescribing controlled substances

    Tertiary Prevention (rehabilitation strategies after addiction is established, targeted at heavy users)
    - Medication assisted treatment (methadone, buprenorphine, naltrexone, suboxone)
    - Mandatory counseling and services with buprenorphine or naltrexone administration (similar to methadone requirements)

Appendix B (cont.)

Treatment Providers Survey[Z]

18. (continued)

Tertiary Prevention (rehabilitation strategies after addiction is established, targeted at heavy users)

- Increased access to 12-step programs
- Increased access to mental health treatment
- Increased access to and training on naloxone
- Education about harm reduction practices (i.e. how to clean needles, reducing the amount of the substance used)

19. In your opinion, what populations are most in need of additional substance use prevention efforts? (select up to five)

- Current substance users
- Adults (26-64 years)
- Young adults (18-25 years)
- Middle school and high school students
- Elementary school students
- Persons in rural areas
- Families living in poverty
- Persons who lack a stable residence
- Incarcerated individuals
- Individuals with mental illness
- Women of child-bearing age
- American Indians/Alaska Natives
- Latinos/Latinas
- 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.

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

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

- Medication assisted treatment (methadone, buprenorphine, naltrexone, suboxone)
- Harm reduction (i.e. safe injection practices, reducing the amount of the substance used)
- Client assessments (i.e. trauma screening tools, addiction screening tools, etc.)
- Evidenced-based treatments (i.e. EMDR, DBT, TF-CBT, etc.)
- Trauma-informed care
- Alternative pain management strategies

Appendix B (cont.)

Treatment Providers Survey[7]

21. (continued)

- Co-occurring disorders
- Compassion fatigue, stress, and burnout
- Ethics and boundaries
- Prescription Drug Monitoring Program (PDMP)
- Physical and mental effects of substance use
- Naloxone use and/or administration
- Treatment for opioid addiction
- Treatment for methamphetamine addiction
- Non-substance use addictions (i.e. gambling, internet, etc.)
- Domestic violence
- Other (please specify): _____

22. What additional resources do your clients need? (select up to five)

- Naloxone kits
- Condom distribution
- Financial assistance for medication assisted treatment (MAT)
- Childcare
- MAT prescriber
- Funding for rural area
- Education about MAT
- Reduction in waiting lists and wait time
- Facilities that accommodate women with dependent children
- Community outreach
- Other (please specify): _____

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

24. DHHS is committed to hearing directly from providers about needs and trends as they develop future programming. Would you be willing to participate in a follow-up interview or focus group on drug use behaviors?

- Yes (if yes, please provide email address or send a brief email to steps@unomaha.edu indicating your interest): _____
- No

Thank you for taking the time to complete this survey.

Your responses will be used to inform the work of the Nebraska DHHS' Division of Public Health. STEPs will analyze responses collectively, and respondents will remain anonymous.

Appendix C

Acronym Index

Acronym	Definition
CMSW or PCMSW	Certified or Provisionally Certified Master Social Worker
DHHS	Nebraska Department of Health and Human Services
DOP	Drug Overdose Prevention
DUB	Drug Use Behaviors
EBP	Evidence-based practice
LADC or PLADC	Licensed or Provisionally Licensed Alcohol and Drug Counselor
LICSW	Licensed Independent Clinical Social Worker
LIMHP	Licensed Independent Mental Health Provider
LIPC	Licensed Independent Professional Counselor
LMHP or PLMHP	Licensed or Provisionally Licensed Mental Health Provider
LPC or PLPC	Licensed or Provisionally Licensed Professional Counselor
MAT	Medication Assisted Treatment
STEPs	Support and Training for the Evaluation of Programs

Appendix D

Nebraska Region Index by County

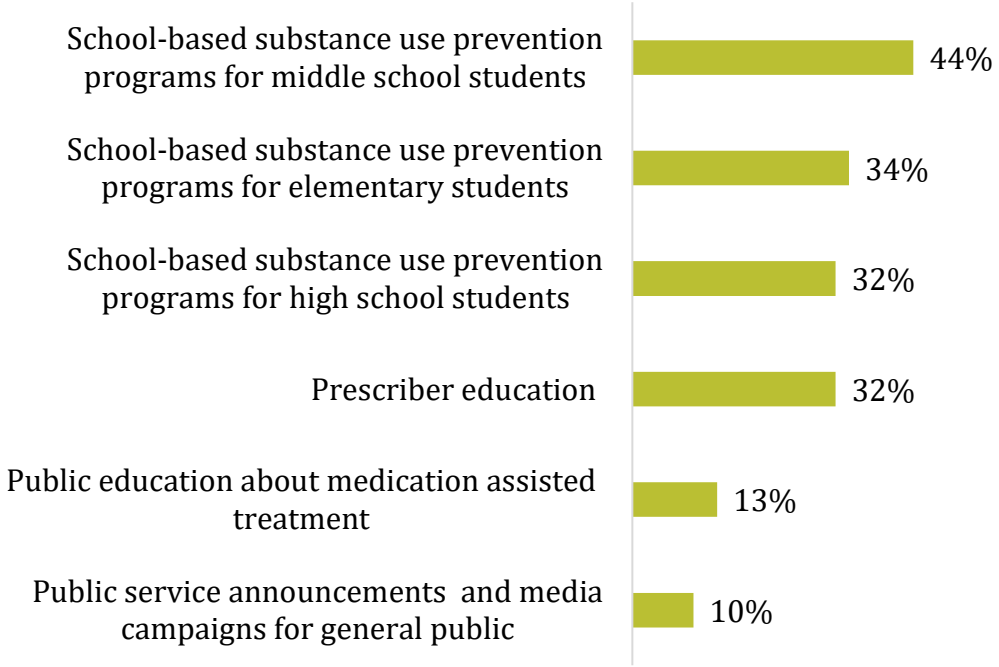
Lancaster	Omaha Metro	Rural East		West	
Lancaster	Douglas	Adams	Wayne	Arthur	Morrill
	Sarpy	Antelope	Webster	Banner	Perkins
		Boone	York	Blaine	Phelps
		Burt	Cass	Box Butte	Red Willow
		Butler		Boyd	Rock
		Cedar		Brown	Scotts Bluff
		Clay		Buffalo	Sheridan
		Colfax		Chase	Sherman
		Cuming		Cherry	Sioux
		Dakota		Cheyenne	Thomas
		Dixon		Custer	Valley
		Dodge		Dawes	Wheeler
		Fillmore		Dawson	
		Gage		Deuel	
		Hall		Dundy	
		Hamilton		Franklin	
		Jefferson		Frontier	
		Johnson		Furnas	
		Knox		Garden	
		Madison		Garfield	
		Merrick		Gosper	
		Nance		Grant	
		Nemaha		Greeley	
		Nuckolls		Harlan	
		Otoe		Hayes	
		Pawnee		Hitchcock	
		Pierce		Holt	
		Platte		Hooker	
		Polk		Howard	
		Richardson		Kearney	
		Saline		Keith	
		Saunders		Keya Paha	
		Seward		Kimball	
		Stanton		Lincoln	
		Thayer		Logan	
		Thurston		Loup	
		Washington		McPherson	

Appendix E

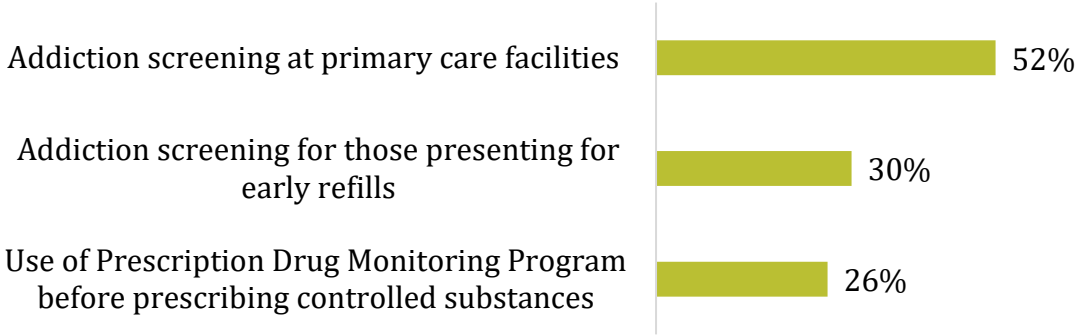
Helpful Prevention Efforts (n=189)

In your opinion, what prevention efforts are most helpful?
The full list of response options are provided in Appendix B.

Primary Prevention:
Percentage of Providers Who Indicated the Prevention Effort as Helpful



Secondary Prevention:
Percentage of Providers Who Indicated the Prevention Effort as Helpful

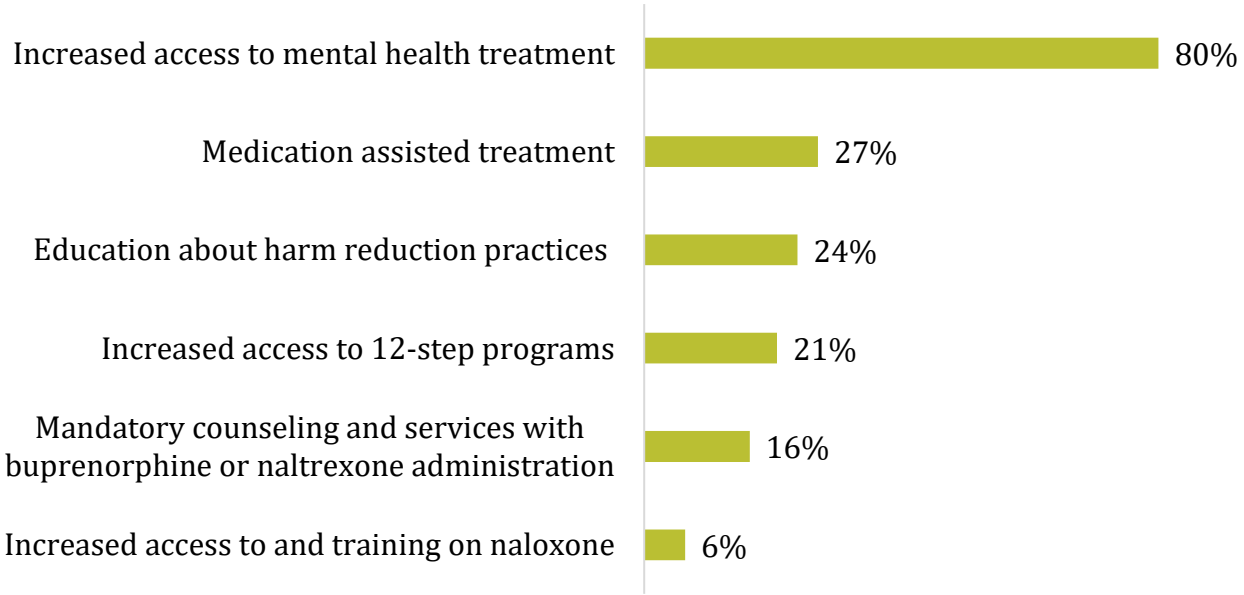


Appendix E (cont.)

Helpful Prevention Efforts (n=189)

In your opinion, what prevention efforts are most helpful?
The full list of response options are provided in Appendix B.

Tertiary Prevention:
Percentage of Providers Who Indicated the Prevention Effort as Helpful

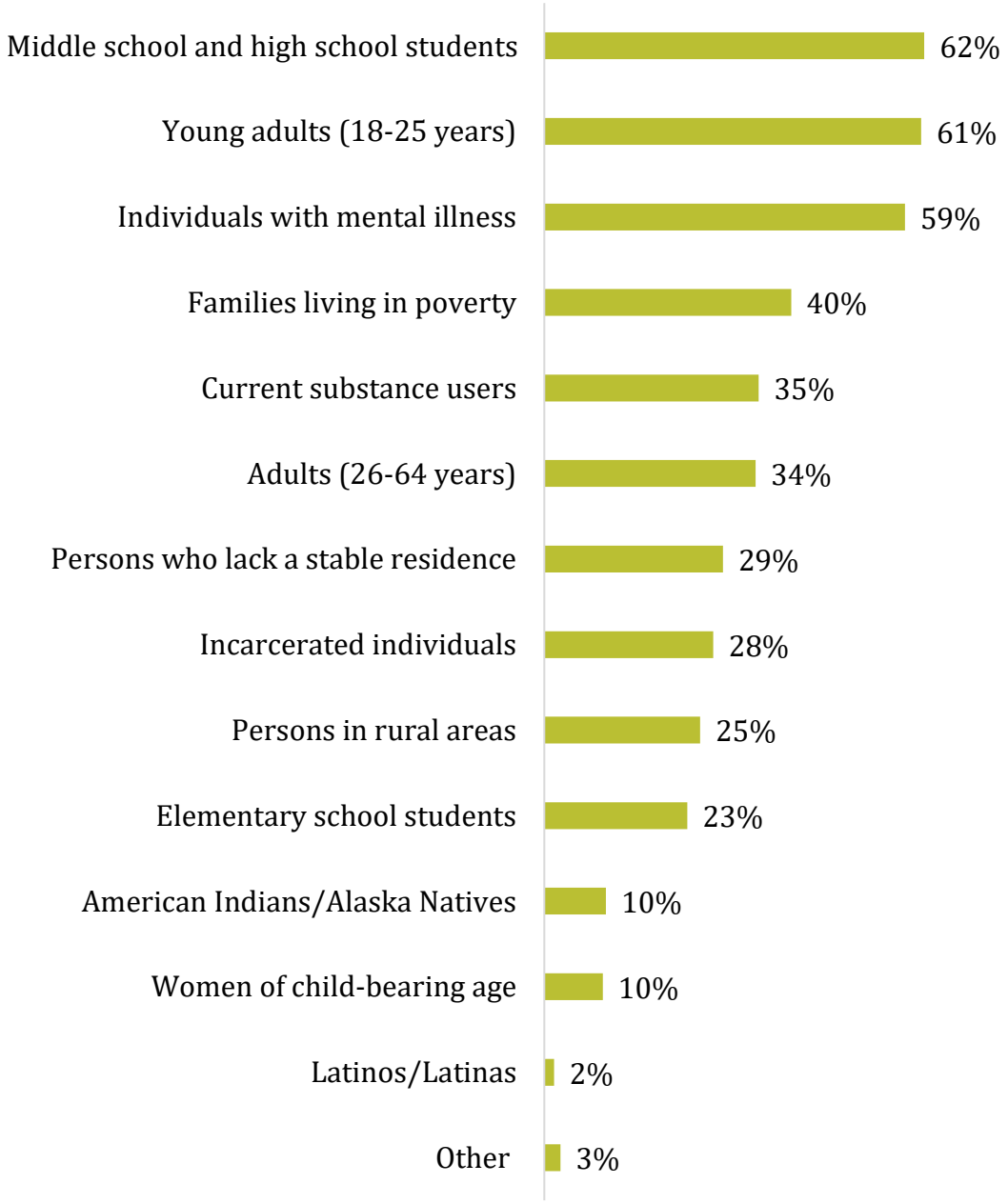


Appendix F

Populations in Need of Prevention (n=189)

In your opinion, what populations are most in need of additional substance use prevention efforts?
The full list of response options are provided in Appendix B.

Percentage of Providers Who Indicated the Population as Most in Need of Prevention

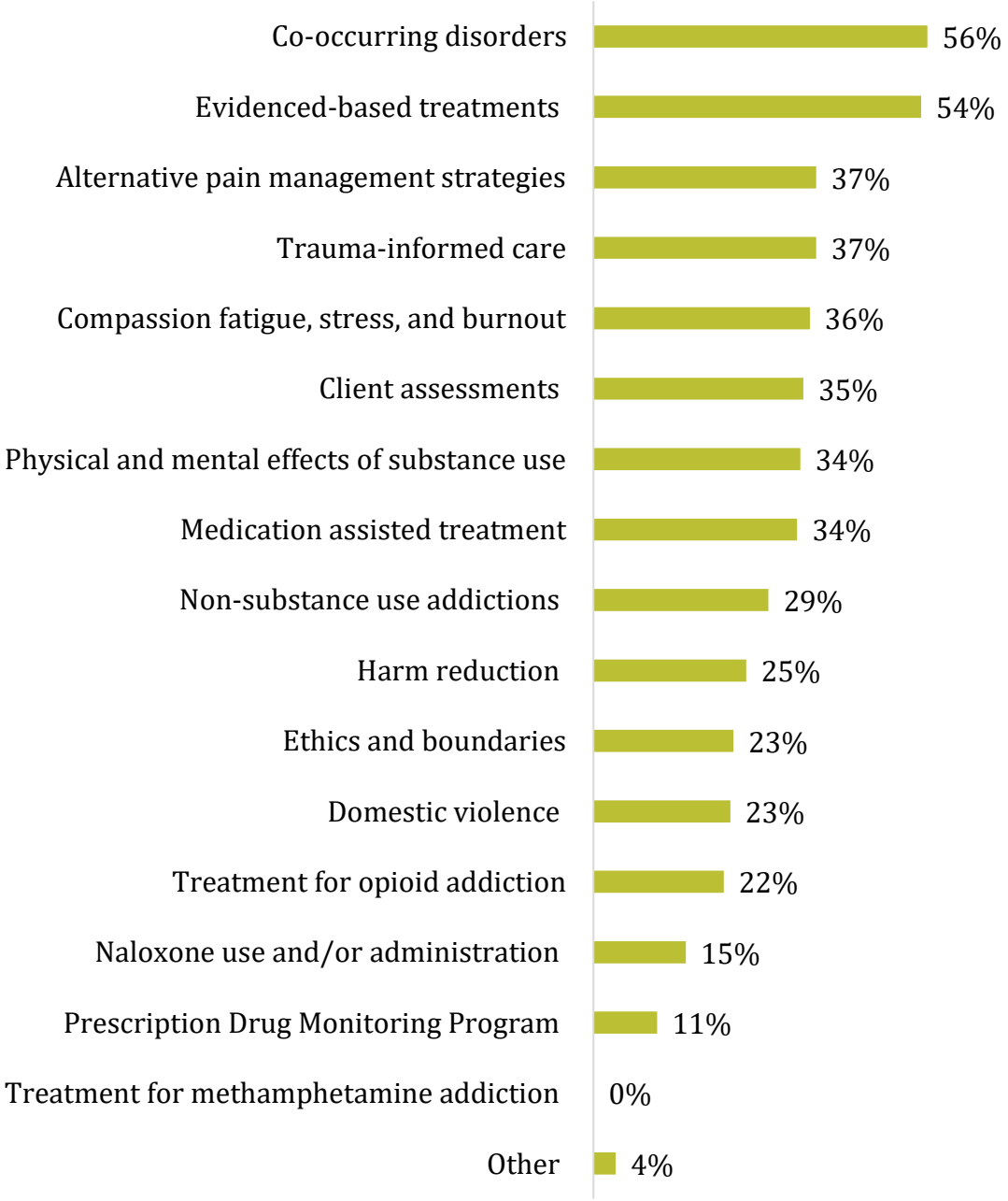


Appendix G

Future Training Topics (n=188)

Which of the below topics would be useful for future training for yourself or other staff at your facility?

Percentage of Providers Who Indicated Interest in the Topic for Future Training

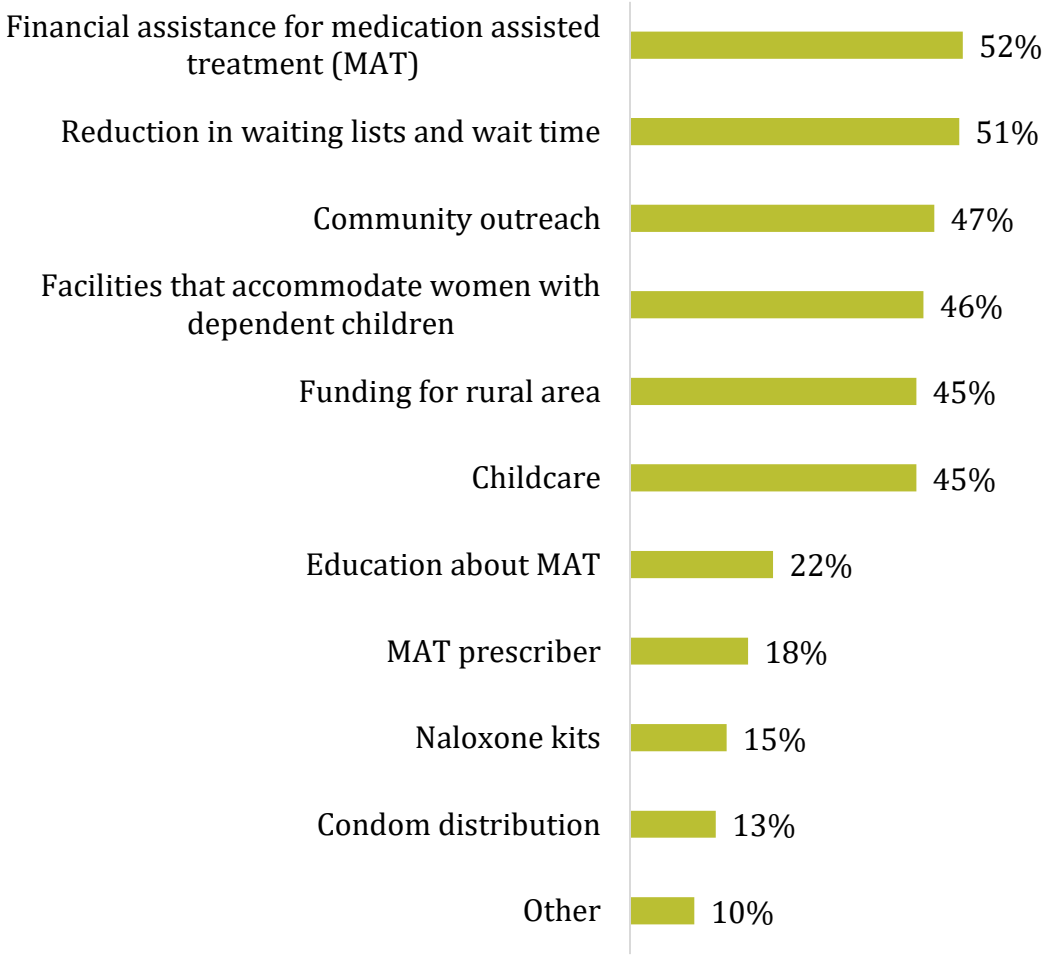


Appendix H

Additional Resources for Clients (n=178)

What additional resources do your clients need?

Percentage of Providers Who Indicated Interest in the Future Training Topic



Appendix I

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

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

DRUG USE BEHAVIORS

Dataset Methodology

April 30, 2020

Rachel Lubischer, MSW/MPA Student
Jennifer L. Smith, MPPA, CMHC Student
December Lange Treacy, MS
with Jeanette Harder, Ph.D., CMSW

Appendix I (cont.)

Table of Contents

Click on the section headings below to navigate to that page. Click on the compass symbol in the top right-hand corner of each page to return to the overall Table of Contents.

Drug Use Behaviors Background

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) Drug Overdose Program (DOP) contracted with STEPs in the fall of 2019 to complete a needs assessment that included an identification and analysis of quality datasets, a survey of outpatient treatment providers, and focus groups with treatment providers.

Purpose

The goal of this needs assessment is to deepen DOP's understanding of individuals' drug use behaviors in Nebraska through the lens of treatment providers.

The results of this study will aid DOP in providing training and other resources to treatment centers, focusing prevention efforts, and informing their strategic plan and future studies. Ultimately, this study will support DOP's efforts to reduce opioid-involved fatal and non-fatal overdoses in Nebraska.

Appendix I (cont.)
Introduction

Dataset Purpose
The purpose of the dataset analysis is to provide data on who is receiving treatment, who is referring people to treatment, and people's age at first use. The current report emphasizes identifying quality datasets that can be useful now and in future evaluations.

Literature Review of Substance Use Indicators
Prior to considering the quality of secondary datasets, STEPs identified substance use indicators commonly used by reputable public health agencies. Literature on health indicators consistently referred to documents published by the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Council of State and Territorial Epidemiologists (CSTE). STEPs weighed the prevalence of established substance use indicators when determining the usefulness and quality of datasets.

The CSTE's *Recommended CSTE Surveillance Indicators for Substance Abuse and Mental Health* identified 10 substance use indicators recommended for use in surveillance systems (2019). Five of these 10 indicators, included in the table below, target non-alcohol drug use.

Recommended Substance Use Indicators (CSTE, 2019, p. 14)				
Drug overdose mortality	Hospitalization attributable to drugs with potential for abuse and dependence	Prescription opioid sales per capita	Drug or alcohol dependence or abuse in the last year	Prevalence of use of selected prescription and illicit drugs

The CSTE document references publications by the National Institutes of Health, U.S. DHHS, and the CDC and has been endorsed by the National Public Health Surveillance System, U.S. DHHS, and SAMHSA. The sources used in the development of the document and the endorsements from other reputable organizations support the reliability of these surveillance indicators.

The United Nations Office on Drugs and Crime (2018), the Office of Disease Prevention and Health Promotion (2020), and SAMHSA (2018) utilize similar indicators, except for the hospitalization data and prescription opioid sales data. STEPs also assessed publications by the CDC for relevant surveillance indicators. However, the CDC often targeted data related to alcohol consumption and chronic diseases.

Appendix I (cont.)
Applying CDC's Guidelines for Evaluating Public Health Surveillance Systems

To determine quality datasets that can be used over time to understand drug use behavior in Nebraska, STEPs utilized the CDC's "Guidelines for Evaluating Public Health Surveillance Systems." The CDC guidelines outline nine assessment characteristics for public health surveillance systems: simplicity, flexibility, data quality, acceptability, sensitivity, predictive value positive, representativeness, timeliness, and stability. Of these characteristics, STEPs prioritized those able to be assessed using publicly available information and those most relevant to the DOP project. The selected characteristics, CDC definition, and STEPs' application of the characteristic can be found in the table below:

Applying CDC's Guidelines for Evaluating Public Health Surveillance Systems

Characteristic	CDC Definition	STEPs' Application
Simplicity	"Refers to both its structure and ease of operation. Surveillance systems should be as simple as possible while still meeting their objectives" (CDC, 2001, Section D.2.a.)	STEPs prioritized datasets with low barriers to access such as publicness of the data, cost of data access, and accessible data formats.
Data quality	"The completeness and validity of the data recorded in the public health surveillance system" (CDC, 2001, Section D.2.c.)	STEPs prioritized datasets affiliated with leaders in substance use expertise, such as the CDC and SAMHSA, as found in the literature review.
Representativeness	"Accurately describes the occurrence of a health-related event over time and its distribution in the population by place and person" (CDC, 2001, Section D.2.g.)	STEPs prioritized datasets providing place-specific data (such as those able to be desegregated by county and local health department) and demographic data.
Timeliness	"The speed between steps in a public health surveillance system" (CDC, 2001, Section D.2.h.)	STEPs prioritized datasets that publish data at least every two years.
Stability	"Refers to the reliability (i.e., the ability to collect, manage, and provide data properly without failure) and availability (the ability to be operational when it is needed) of the public health surveillance system" (CDC, 2001, Section D.2.i.)	STEPs prioritized datasets published by reputable organizations such as the Nebraska Department of Health and Human Services, as well as the CDC and SAMHSA.

In addition to these characteristics, STEPs also prioritized datasets containing data not captured in existing Nebraska DHHS reports, as well as datasets containing data closely aligned with the CSTE *Recommended Surveillance Indicators for Substance Abuse and Mental Health.*

Appendix I (cont.)
Dataset Screening

STEPs identified 12 secondary datasets relevant to current and future evaluations. Utilizing the previously outlined criteria, STEPs selected three quality datasets that can be used over time. These selected datasets include the Nebraska Risk and Protective Factor Student Survey (NRPFSS), Nebraska Hospital Association Hospital Discharge Data (HDD), and Treatment Episode Data Set (TEDS). The tables on the following pages outline the datasets examined, their purpose, and reason for inclusion or exclusion.

Dataset Screening: Excluded from Analysis

Dataset	Purpose	Exclusion Reason
State Emergency Department Databases (SEDD) (Healthcare Cost and Utilization Project, 2019a)	SEDD, sponsored by the Agency for Healthcare Research and Quality, includes information on those emergency department visits that do not result in admission to determine longitudinal trends related to emergency department visits.	An alternative provider (Nebraska Hospital Association) of emergency department discharge data was recommended by DOP; data was not publicly available.
State Inpatient Databases (SID) (Healthcare Cost and Utilization Project, 2019b)	SID, sponsored by the Agency for Healthcare Research and Quality, includes inpatient data for hospitals to determine longitudinal trends related to inpatient care.	An alternative provider (Nebraska Hospital Association) of inpatient discharge data was recommended by DOP; data was not publicly available.
Behavioral Risk Factor Surveillance System (BRFSS) (National Center for Chronic Disease Prevention and Health Promotion, 2019)	BRFSS, published by the CDC, is a collection of adult health surveys informing prevention and health promotion efforts.	The information provided by BRFSS included little direct alignment with CSTE *Recommended Surveillance Indicators for Substance Abuse and Mental Health.*
CDC WONDER (Centers for Disease Control and Prevention, 2018)	CDC WONDER, published by the CDC, is a collection of public health data available to the general public. CDC WONDER is intended to promote data-driven decisions and increase public access to public health data.	Mortality-related data is already sufficiently included in the NE DHHS' Division of Behavioral Health's Substance Use, Mental Illness and Associated Consequences in Nebraska: An Epidemiological Profile report.

Appendix I (cont.)

Dataset Screening: Excluded from Analysis (cont.)

Dataset	Purpose	Exclusion Reason
National Survey of Substance Abuse Treatment Services (N-SSATS) (Substance Abuse and Mental Health Services Administration, 2019)	N-SSATS, published by SAMHSA, is a census of substance use treatment providers. N-SSATS aims to inform SAMHSA and state administrators on the trends and resource needs of treatment services.	The information provided by N-SSATS included little direct alignment with CSTE *Recommended Surveillance Indicators for Substance Abuse and Mental Health.*
National Survey on Drug Use and Health (NSDUH) (National Survey on Drug Use and Health, 2020)	NSDUH, published by SAMHSA, determines the prevalence of substance use and mental health disorders and the receipt of care.	Much of the publicly available data is state-level only; this state-level data is already sufficiently included in the NE DHHS' Division of Behavioral Health's Substance Use, Mental Illness and Associated Consequences in Nebraska: An Epidemiological Profile report.
Pregnancy Risk Assessment Monitoring System (PRAMS) (National Center for Chronic Disease Prevention and Health Promotion, 2020)	PRAMS, published by CDC, collects data related to pre- and postnatal risk factors. PRAMS aims to identify at-risk populations and capture state changes in the health of mothers and infants.	The information provided by N-SSATS included little direct alignment with CSTE *Recommended Surveillance Indicators for Substance Abuse and Mental Health.*
Youth Risk Behavior Surveillance System (YRBS) (National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2018)	YRBS, published by the CDC, collects information on the health behaviors of youth related to causes of death and disability. The purpose of YRBS is to understand the prevalence and trends of youth health behaviors.	YRBS data is already sufficiently included in the NE DHHS' Division of Behavioral Health's Substance Use, Mental Illness and Associated Consequences in Nebraska: An Epidemiological Profile report.

Appendix I (cont.)

Dataset Screening: Included in Analysis

Dataset	Purpose	Inclusion Reason
Nebraska Risk and Protective Factor Student Survey (NRPFSS)	NRPFSS, published by BOSR-UNL, aims to assess students' risk and protective factors related to substance use and other problem behaviors.	NRPFSS data is available through request at no cost to researchers. Data is collected every other fall with reports made available the following spring/summer. Data can be disaggregated by health department district, grade, race, age, and gender. Data is related to evaluation questions regarding age of first substance use and trends in youth substance use.
Treatment Episode Data Set Admissions (TEDS-A)	TEDS-A, published by SAMHSA, captures admissions data to substance use and mental health treatment to better understand those receiving behavioral health care.	TEDS data is publicly available at no cost to researchers. Data is from trusted sources such as state-level administrative data and reported by SAMHSA, a leader in the field of substance use. Data can be disaggregated by location and demographic variable. Data is related to evaluation questions and recommended substance use indicators including access to and referrals to substance use treatment. TEDS data collection has remained relatively stable over time allowing for year-by-year analyses. Additional state-level data was requested to provide more specific information about referral sources (see Data Analysis Plan section).
Treatment Episode Data Set Discharges (TEDS-D)	TEDS-D, published by SAMHSA, captures discharge data from substance use and mental health treatment to better understand those receiving behavioral health care.	
Nebraska Hospital Association Statewide Hospital Emergency Department and Inpatient Discharge Data (HDD)	HDD, published by the Nebraska Hospital Association is used to track public health conditions and inform the development of interventions.	HDD is available on request to researchers for a small fee. This data source was referred to STEPs by DOP. Data can be disaggregated by health department district, age, length of stay, and gender. Data is related to evaluation questions and substance use indicators including hospitalizations related to substance use.

Appendix I (cont.)
Dataset Availability and Release

After identifying the quality datasets, STEPs assessed the recency of data available and the next expected release of data. The following table outlines the data availability in the past 10 years, the most recent data available, and the next release of new data.

Dataset Availability and Release

Dataset	Years of Data Availability	Most Recent Data Available	Next Expected Data Release
Nebraska Hospital Association (NHA) Inpatient Discharges	2016, 2017, 2018, partial 2019	Fall 2019 data received in March 2020	On request
Nebraska Hospital Association (NHA) Emergency Department Discharges	2016, 2017, 2018, partial 2019	Fall 2019 data received in March 2020	On request
Nebraska Risk and Protective Factor Student Survey (NRPFSS)	2010, 2012, 2014, 2016, 2018	Fall 2018 data published in 2019	Fall 2020 data will be sent from BOSR-UNL to DHHS in mid-spring 2021
Treatment Episode Data Set Admissions (TEDS-A)	2013, 2014, 2015, 2016, 2017	2017 admissions data published in June 2019	Unknown; not enough information
Treatment Episode Data Set Discharges (TEDS-D)	2013, 2014, 2015, 2016, 2017	2017 discharge data published in June 2019	Unknown; not enough information

Appendix I (cont.)
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Appendix J

The diagnosis description data provided by NHA included 297 unique diagnosis descriptions. To analyze and interpret the diagnosis data, these unique descriptions needed to be condensed into a smaller number of categories. Based on the information provided in the diagnosis description, STEPs determined the most appropriate form of categorization for the current project would be by substance classification. STEPs utilized the Drug Enforcement Administration's (2020) *Drugs of Abuse: A DEA Resource Guide* to determine drug classes for each diagnosis substance. The substances named in the diagnoses description and their associated categories are outlined in the table below.

Category	Diagnosis Description Substances
Cannabis	Cannabis, cannabis (derivatives)
Depressants	Antiepileptic and sedative-hypnotic drugs; barbiturates; benzodiazepines; sedative, hypnotic or anxiolytic
Hallucinogens	Ecstasy, hallucinogen, lysergide, other psychodysleptics, unspecified psychodysleptics
Narcotics	Heroin, methadone, opioid, opium, other narcotics, other opioids, other synthetic narcotics, unspecified narcotics
No substance specified*	Drug use complicating childbirth, drug use complicating pregnancy, drug use complicating the puerperium, neonatal withdrawal symptoms from maternal use of drugs of addiction
Other psychoactive substances	Other psychoactive substance
Stimulants	Amphetamines, caffeine, cocaine, methylphenidate, other psychostimulant, other stimulant, unspecified psychostimulants

Appendix K

Below are additional data tables for the Nebraska Hospital Association (NHA) Inpatient Discharges data.

Patient Sex by Year (n=3,329)
The trend for the percentage of female and male patients has remained relatively stable over the past 4 years. 2019 was the only year where the percentage of males (51%) was greater than that of females (49%).

Year	% of Female Patients	% of Male Patients
2016 (n=824)	53%	47%
2017 (n=931)	53%	47%
2018 (n=911)	52%	48%
2019 (n=664)	49%	51%

Patient Age in Years by Year (n=3,330)
The trend for patient age has remained stable over the past 4 years.

Year	Average Age in Years	SD
2016 (n=824)	42	18
2017 (n=931)	41	17
2018 (n=911)	41	17
2019 (n=664)	41	17

Patient Length of Stay in Days by Year (n=3,330)
The trend for patients' lengths of stay has remained stable over the past 4 years.

Year	Average Length of Stay in Days	SD
2016 (n=824)	4	4
2017 (n=931)	3	4
2018 (n=911)	4	4
2019 (n=664)	3	3

Appendix K (cont.)

Substance Related to Patient Diagnosis by Year (n=3,330)
Except for diagnoses related to depressants, narcotics, and stimulants (discussed within the body of the report), the percentage of diagnoses related to other substances has remained consistent over the past 4 years.

	2016 (n=824)	2017 (n=931)	2018 (n=911)	2019 (n=664)
Depressants	36%	34%	32%	29%
Stimulants	21%	25%	27%	32%
Narcotics	28%	26%	25%	21%
Cannabis	3%	4%	4%	6%
Hallucinogens	1%	1%	2%	1%
Other psychoactive substances	7%	6%	6%	8%
No substance specified*	3%	4%	5%	4%

Number of Inpatient Treatment Discharges by Behavioral Health Region and Year (n=2,667)
The number of inpatient discharges between January 1 and September 30 of each year is shown below for each behavioral health region. The comparison includes only discharges during this time as quarter 4 data for 2019 was not yet available at the time of this report.

Behavioral Health Region	2016	2017	2018	2019
Region 1 (n=83)	17	23	24	19
Region 2 (n=176)	37	47	38	54
Region 3 (n=250)	50	64	59	77
Region 4 (n=146)	35	49	28	34
Region 5 (n=536)	104	140	156	136
Region 6 (n=1,277)	319	330	336	292
Out of State (n=199)	46	48	55	50

Appendix K (cont.)

Percent of Female Patients by Behavioral Health Region and Year (n=3,324)
Overall, no trend related to the percentage of female patients by behavioral health region and year can be discerned in this data.

Behavioral Health Region	2016	2017	2018	2019
Region 1 (n=102)	30%	67%	30%	58%
Region 2 (n=218)	69%	60%	63%	44%
Region 3 (n=311)	52%	43%	43%	48%
Region 4 (n=191)	47%	64%	52%	44%
Region 5 (n=670)	43%	49%	47%	46%
Region 6 (n=1,582)	56%	55%	55%	51%
Out of State (n=250)	60%	46%	57%	54%

Patient Age by Behavioral Health Region and Year (n=3,325)
Overall, no trend related to the average age of patients by region and year can be discerned in this data. One trend that may be emerging in Region 3 would be the decrease in average age, which began in 2017.

Behavioral Health Region	2016	2017	2018	2019
Region 1 (n=102)	37	40	34	46
Region 2 (n=218)	45	45	40	40
Region 3 (n=311)	39	42	40	37
Region 4 (n=191)	47	39	42	40
Region 5 (n=671)	40	39	41	39
Region 6 (n=1,582)	43	41	43	43
Out of State (n=250)	39	37	39	42

Appendix K (cont.)

Patient Length of Stay in Days by Behavioral Health Region and Year (n=3,325)
Overall, no trend related to the average length of stay by region and year can be discerned in this data.

Behavioral Health Region	2016	2017	2018	2019
Region 1 (n=102)	3	3	3	5
Region 2 (n=218)	3	3	3	4
Region 3 (n=311)	5	4	4	3
Region 4 (n=191)	4	4	4	4
Region 5 (n=671)	3	3	4	3
Region 6 (n=1,582)	3	3	4	3
Out of State (n=250)	5	5	3	4

Substance Related to Diagnosis by Behavioral Health Region and Year
The tables below and on the following two pages show the percentage of inpatient discharges related to each substance by year for each health region.

Region 1

	2016 (n=23)	2017 (n=33)	2018 (n=27)	2019 (n=19)	All Discharges (n=102)
Depressants	26%	36%	22%	58%	34%
Stimulants	30%	9%	19%	26%	20%
Narcotics	22%	21%	30%	5%	21%
Cannabis	4%	3%	7%	0%	4%
Other psychoactive substances	17%	3%	15%	0%	9%
No substance specified	0%	27%	7%	11%	13%

Appendix K (cont.)

Region 2

	2016 (n=54)	2017 (n=53)	2018 (n=57)	2019 (n=54)	All Discharges (n=218)
Depressants	31%	34%	30%	28%	31%
Stimulants	11%	8%	25%	33%	19%
Narcotics	24%	32%	28%	17%	25%
Cannabis	4%	6%	2%	2%	3%
Other psychoactive substances	28%	21%	12%	17%	19%
No substance specified	2%	0%	4%	4%	2%

Region 3

	2016 (n=65)	2017 (n=77)	2018 (n=92)	2019 (n=77)	All Discharges (n=311)
Depressants	37%	26%	21%	13%	23%
Stimulants	28%	44%	37%	58%	42%
Narcotics	25%	16%	22%	16%	19%
Cannabis	2%	4%	2%	4%	3%
Hallucinogens	2%	0%	2%	1%	1%
Other psychoactive substances	5%	6%	8%	3%	5%
No substance specified	3%	4%	9%	5%	5%

Appendix K (cont.)

Region 4

	2016 (n=49)	2017 (n=64)	2018 (n=44)	2019 (n=34)	All Discharges (n=191)
Depressants	18%	27%	34%	24%	26%
Stimulants	20%	33%	23%	18%	25%
Narcotics	41%	19%	27%	21%	27%
Cannabis	2%	2%	2%	12%	4%
Hallucinogens	0%	2%	2%	0%	1%
Other psychoactive substances	16%	13%	9%	21%	14%
No substance specified	2%	6%	2%	6%	4%

Region 5

	2016 (n=150)	2017 (n=192)	2018 (n=193)	2019 (n=136)	All Discharges (n=671)
Depressants	36%	30%	34%	28%	32%
Stimulants	27%	27%	24%	38%	28%
Narcotics	26%	34%	28%	23%	28%
Cannabis	3%	2%	5%	3%	3%
Hallucinogens	1%	2%	1%	0%	1%
Other psychoactive substances	3%	3%	4%	7%	4%
No substance specified	4%	4%	4%	2%	4%

Appendix K (cont.)

Region 6

	2016 (n=418)	2017 (n=449)	2018 (n=423)	2019 (n=292)	All Discharges (n=1,582)
Depressants	38%	38%	34%	34%	36%
Stimulants	18%	22%	28%	24%	23%
Narcotics	32%	26%	24%	21%	26%
Cannabis	2%	6%	3%	9%	5%
Hallucinogens	1%	1%	2%	1%	1%
Other psychoactive substances	5%	5%	5%	7%	5%
No substance specified	4%	2%	3%	4%	3%

Appendix L

Below are additional data tables for the Nebraska Hospital Association (NHA) Emergency Department Discharges data.

Patient Sex by Year (n=7,709)
The percentage of male patients increased slightly in 2017 and 2018. The percentage of male and female patients in 2019 remained unchanged from 2018.

Year	% of Female Patients	% of Male Patients
2016 (n=1,938)	49%	51%
2017 (n=1,914)	48%	52%
2018 (n=2,185)	46%	54%
2019 (n=1,672)	46%	54%

Patient Age in Years by Year (n=7,712)
The trend for patient age has remained stable over the past 4 years.

Year	Average Age in Years	SD
2016 (n=1,938)	34	17
2017 (n=1,914)	33	16
2018 (n=2,185)	34	16
2019 (n=1,675)	34	16

Patient Length of Stay in Days by Year (n=7,712)
The trend for patients' lengths of stay has remained stable over the past 4 years.

Year	Average Length of Stay in Days	SD
2016 (n=1,938)	1	1
2017 (n=1,914)	1	0
2018 (n=2,185)	1	1
2019 (n=1,675)	1	0

Appendix L (cont.)

Substance Related to Diagnosis by Year (n=7,712)
Diagnoses related to depressants, narcotics, and stimulants, as discussed within the body of the report, have changed over time. The percentage of diagnoses related to cannabis have increased over time. The percentage of diagnoses related to other substances has remained consistent over the past 4 years.

	2016 (n=1,938)	2017 (n=1,914)	2018 (n=2,185)	2019 (n=1,675)
Depressants	22%	22%	20%	17%
Stimulants	25%	29%	33%	37%
Narcotics	25%	23%	20%	16%
Cannabis	9%	11%	12%	13%
Hallucinogens	2%	2%	2%	3%
Other psychoactive substances	17%	13%	13%	13%
No substance specified*	0%	0%	1%	1%

Percent of Female Patients by Behavioral Health Region and Year (n=7,709)
Overall, no trend related to the percentage of female patients by behavioral health region and year can be discerned in this data. However, it is worth noting Regions 2, 3, and 4 have consistently had higher percentages of female than male patients, which differs from the overall trend.

Behavioral Health Region	2016	2017	2018	2019
Region 1 (n=362)	46%	54%	47%	48%
Region 2 (n=246)	67%	69%	55%	52%
Region 3 (n=741)	53%	56%	59%	51%
Region 4 (n=385)	61%	54%	55%	49%
Region 5 (n=1,851)	48%	43%	39%	44%
Region 6 (n=3,719)	46%	47%	46%	45%
Out of State (n=405)	50%	42%	40%	41%

Appendix L (cont.)

Patient Age by Behavioral Health Region and Year (n=7,712)
Overall, no trend related to the average age of patients by region and year can be discerned in this data.

Behavioral Health Region	2016	2017	2018	2019
Region 1 (n=362)	37	35	37	35
Region 2 (n=246)	35	37	38	36
Region 3 (n=741)	35	35	35	33
Region 4 (n=385)	36	34	37	34
Region 5 (n=1,853)	33	32	34	34
Region 6 (n=3,719)	33	33	33	34
Out of State (n=406)	35	34	33	34

Patient Length of Stay in Days by Behavioral Health Region and Year (n=7,712)
The average length of stay has not varied across behavioral health regions or years for the past 4 years.

Behavioral Health Region	2016	2017	2018	2019
Region 1 (n=362)	1	1	1	1
Region 2 (n=246)	1	1	1	1
Region 3 (n=741)	1	1	1	1
Region 4 (n=385)	1	1	1	1
Region 5 (n=1,853)	1	1	1	1
Region 6 (n=3,719)	1	1	1	1
Out of State (n=406)	1	1	1	1

Appendix L (cont.)

Substance Related to Patient Diagnosis by Behavioral Health Region and Year
The tables on the following three pages show the percentage of emergency department discharges related to each substance by year for each health region.

Region 1

	2016 (n=112)	2017 (n=91)	2018 (n=96)	2019 (n=63)	All Discharges (n=362)
Depressants	17%	20%	14%	27%	19%
Stimulants	29%	31%	18%	32%	27%
Narcotics	31%	32%	34%	22%	31%
Cannabis	15%	9%	15%	5%	12%
Hallucinogens	2%	0%	1%	5%	2%
Other psychoactive substances	6%	9%	19%	10%	11%

Region 2

	2016 (n=63)	2017 (n=62)	2018 (n=75)	2019 (n=46)	All Discharges (n=246)
Depressants	41%	34%	25%	33%	33%
Stimulants	19%	32%	27%	30%	27%
Narcotics	30%	24%	28%	22%	26%
Cannabis	3%	3%	5%	7%	4%
Other psychoactive substances	6%	6%	12%	9%	9%
No substance specified	0%	0%	3%	0%	1%

Appendix L (cont.)

Region 3

	2016 (n=207)	2017 (n=179)	2018 (n=204)	2019 (n=151)	All Discharges (n=741)
Depressants	25%	31%	30%	24%	28%
Stimulants	25%	28%	26%	32%	28%
Narcotics	31%	19%	21%	18%	23%
Cannabis	7%	11%	11%	15%	11%
Hallucinogens	2%	1%	0%	1%	1%
Other psychoactive substances	11%	10%	11%	9%	10%

Region 4

	2016 (n=89)	2017 (n=109)	2018 (n=110)	2019 (n=77)	All Discharges (n=385)
Depressants	20%	18%	28%	22%	22%
Stimulants	24%	32%	30%	40%	31%
Narcotics	29%	27%	25%	12%	24%
Cannabis	8%	11%	5%	12%	9%
Hallucinogens	1%	0%	3%	4%	2%
Other psychoactive substances	17%	12%	9%	10%	12%
No substance specified	1%	0%	0%	0%	0%

Appendix L (cont.)

Region 5

	2016 (n=472)	2017 (n=460)	2018 (n=548)	2019 (n=373)	All Discharges (n=1,853)
Depressants	22%	17%	22%	15%	19%
Stimulants	26%	28%	35%	35%	31%
Narcotics	19%	22%	17%	15%	18%
Cannabis	8%	10%	9%	8%	9%
Hallucinogens	2%	2%	1%	1%	2%
Other psychoactive substances	22%	22%	16%	25%	21%
No substance specified	0%	0%	0%	1%	0%

Region 6

	2016 (n=880)	2017 (n=932)	2018 (n=1,030)	2019 (n=877)	All Discharges (n=3,719)
Depressants	21%	23%	18%	15%	19%
Stimulants	25%	28%	35%	39%	32%
Narcotics	24%	24%	18%	14%	20%
Cannabis	10%	12%	13%	17%	13%
Hallucinogens	3%	3%	3%	4%	3%
Other psychoactive substances	17%	9%	11%	9%	12%
No substance specified	0%	1%	1%	1%	1%

Appendix M

Below are additional data tables for the Treatment Episode Data Set–Discharges (TEDS-D).

Client Age at Admission by Year
Overall, no trend related to the age of clients by year can be discerned in this data. One trend that may be emerging would be an increase in clients between the ages of 21 and 39 years.

Year	20 Years and Younger	21-29 Years	30-39 Years	40-49 Years	50 Years and Older
2013 (n=10,103)	5%	26%	26%	24%	18%
2014 (n=8,275)	6%	27%	25%	21%	20%
2015 (n=8,831)	6%	28%	27%	21%	18%
2016 (n=13,198)	5%	28%	30%	20%	17%
2017 (n=10,162)	5%	28%	32%	19%	16%

Client Race by Year
Overall, no trend related to the race of clients by year can be discerned in this data. "Other" race includes clients who identified as Alaska Native, Asian or Pacific Islander, Asian, other single race, two or more races, and Native Hawaiian or Other Pacific Islander.

Year	White	Black or African American	American Indian	Other
2013 (n=10,060)	78%	10%	9%	3%
2014 (n=8,251)	82%	8%	8%	2%
2015 (n=8,831)	81%	9%	7%	2%
2016 (n=12,873)	80%	10%	7%	4%
2017 (n=9,553)	77%	10%	7%	6%

Appendix M (cont.)

Client Education by Year
Overall, no trend related to the number of school years completed by clients by year can be discerned in this data. One trend that may be emerging would be an increase in clients who have at least 12 years of education or a GED.

Year	12 Years (or GED)	Less Than 12 Years	More Than 12 Years
2013 (n=9,483)	50%	20%	30%
2014 (n=7,569)	50%	18%	32%
2015 (n=7,998)	51%	18%	31%
2016 (n=11,449)	51%	18%	31%
2017 (n=7,752)	53%	18%	29%

Client Employment Status at Admission by Year
An increase in the percentage of clients who report employment at admission may be an emerging trend.

Year	Full-time	Part-time	Unemployed	Not in Labor Force
2013 (n=10,096)	16%	9%	34%	41%
2014 (n=8,272)	18%	9%	32%	40%
2015 (n=8,820)	20%	9%	31%	40%
2016 (n=12,449)	20%	9%	33%	38%
2017 (n=8,529)	22%	10%	32%	36%

Appendix M (cont.)

Client Source of Income/Support by Year
Similar to the increase in employed clients, an increase in the percentage of clients who reported receiving an income of wages or salary may be an emerging trend.

Year	Wages/ Salary	Public Assistance	Retirement/ Pension, Disability	Other	None
2013 (n=10,015)	29%	2%	10%	9%	49%
2014 (n=8,195)	31%	2%	8%	6%	53%
2015 (n=8,735)	32%	1%	7%	6%	54%
2016 (n=12,380)	32%	1%	5%	5%	57%
2017 (n=8,254)	34%	1%	5%	4%	56%

Client Length of Stay in Treatment (Days) by Year
The length of stay in treatment remained relatively constant between 2013 and 2017. A slight decrease in clients staying in treatment for 1 day may be an emerging trend.

Year	1 Day	2-30 Days	31-90 Days	91 Days and Over
2013 (n=10,103)	35%	28%	18%	19%
2014 (n=8,275)	32%	28%	17%	23%
2015 (n=8,831)	29%	32%	18%	21%
2016 (n=13,198)	25%	29%	19%	26%
2017 (n=10,162)	27%	31%	23%	20%

Appendix M (cont.)

Substance Use at Admission (Primary) by Year
Between 2013 and 2017, the rate of clients reporting alcohol as their primary substance gradually decreased while reports of stimulant use gradually increased. The use of marijuana, opioids, depressants, and other substances stayed relatively constant. "Other" includes hallucinogens and over-the-counter medications.

Year	Alcohol	Depressants	Stimulants	Opioid	Marijuana	Other	None
2013 (n=10,062)	65%	0%	19%	4%	10%	0%	2%
2014 (n=8,262)	64%	0%	19%	4%	10%	1%	2%
2015 (n=8,820)	59%	0%	22%	5%	11%	1%	2%
2016 (n=13,176)	55%	0%	26%	4%	10%	1%	5%
2017 (n=10,159)	52%	0%	28%	4%	11%	0%	5%

*Appendix N

Below is the additional data table for the detailed referral sources, as provided by NE DHHS Division of Behavioral Health Data Centralized Data System.

Detailed Referral Source by Year

Overall, no trend related to the referral source by year can be discerned in this data. As discussed in the body of the report, the greatest percentage of referrals came from the justice system.

Referral Source	2013 (n=13,414)	2014 (n=12,586)	2015 (n=12,948)	2016 (n=12,971)	2017 (n=12,709)
Community: Community/Social Services Agency	2.9%	2.7%	2.5%	3.0%	3.7%
Community: Employer or Employee Assistance Program (EAP)	0.3%	0.3%	0.2%	0.2%	0.1%
Community: Family or Friend	3.6%	3.9%	4.0%	3.3%	2.6%
Community: Homeless Shelter	0.5%	0.9%	0.9%	0.8%	0.7%
Community: Nebraska Family Helpline	0.0%	0.0%	0.0%	0.0%	0.0%
Community: Nebraska Vocational Rehabilitation	0.0%	0.0%	0.0%	0.0%	0.0%
Community: School	0.6%	0.5%	0.4%	0.3%	0.2%
Community: Self-Help Group	0.2%	0.2%	0.1%	0.2%	0.2%
Community: Tribal Elder or Official	0.0%	0.0%	0.0%	0.0%	0.0%
Emergency/Crisis MH Services	0.2%	0.1%	0.1%	0.3%	0.7%
Emergency/Crisis SUD Services	2.6%	2.6%	2.4%	1.9%	1.4%
Justice System: Pre-trial Diversion	0.4%	0.5%	0.5%	0.3%	0.3%
Justice System: Corrections	1.0%	1.2%	1.5%	1.0%	1.0%

*Appendix added on 8/6/2020

*Appendix N (cont.)

Referral Source	2013 (n=13,414)	2014 (n=12,586)	2015 (n=12,948)	2016 (n=12,971)	2017 (n=12,709)
Justice System: Court Order	5.0%	4.5%	4.5%	5.1%	4.6%
Justice System: Court Referral	2.1%	1.8%	1.3%	1.8%	1.1%
Justice System: Defense Attorney	5.4%	5.6%	5.4%	4.7%	5.0%
Justice System: Drug Court	1.3%	1.8%	1.6%	1.6%	1.1%
Justice System: Law Enforcement Agency (e.g. Police/Sheriff/Highway Patrol)	26.8%	28.9%	27.3%	26.8%	26.2%
Justice System: Mental Health Court	0.1%	0.1%	0.1%	0.1%	0.0%
Justice System: Parole	1.0%	1.1%	1.5%	1.9%	1.5%
Justice System: Probation	7.6%	8.2%	8.2%	8.9%	9.8%
Justice System: Prosecutor	0.0%	0.0%	0.1%	0.1%	0.0%
MH Commitment Board	1.1%	0.9%	0.9%	0.7%	0.5%
Not Available	0.4%	0.5%	0.6%	3.7%	7.4%
Other	0.0%	0.0%	0.0%	1.9%	2.0%
Provider: Medical/Health Care Provider	4.0%	3.7%	3.4%	2.6%	2.5%
Provider: MH Services Provider	1.0%	0.6%	0.8%	1.1%	1.1%
Provider: SUD Services Provider	10.3%	10.6%	10.3%	9.2%	8.6%
Regional Behavioral Health Authority	0.0%	0.0%	0.0%	0.0%	0.0%
Regional Center/State Psychiatric Hospital	0.2%	0.1%	0.1%	0.3%	0.1%
Self (e.g. Self/Internet/Yellow Pages)	21.4%	18.9%	21.1%	18.2%	17.2%

*Appendix added on 8/6/2020

*Appendix O

Below are the additional data tables for the Nebraska Risk and Protective Factor Student Survey.

Percentage of Youth Identifying as Female Lifetime Substance Use by Substance and Year
Overall, no trend related to the reported lifetime use by substance and year could be discerned in this data. The greatest percentage of youth identifying as female reported using prescription drugs and inhalants.

Year	LSD/Other Psychedelics	Cocaine/Crack	Meth	Inhalants	Prescription Drugs
2010	2%	1%	1%	6%	7%
2012	1%	1%	1%	5%	5%
2014	2%	1%	1%	4%	5%
2016	2%	1%	0%	3%	6%
2018	2%	1%	1%	4%	5%

Percentage of Youth Identifying as Male Lifetime Substance Use by Substance and Year
Overall, no trend related to the reported lifetime use by substance and year could be discerned in this data. The greatest percentage of youth identifying as male reported using prescription drugs and inhalants.

Year	LSD/Other Psychedelics	Cocaine/Crack	Meth	Inhalants	Prescription Drugs
2010	2%	2%	1%	6%	7%
2012	2%	1%	1%	4%	5%
2014	2%	2%	1%	3%	4%
2016	3%	2%	1%	3%	5%
2018	3%	1%	0%	4%	4%

*Appendix added on 8/6/2020

Appendix P: Full Methodology

Purpose
The purpose of the qualitative component of the Drug Use Behaviors project was to provide NE DHHS with rich and in-depth information regarding the professional experiences and needs of drug treatment providers in Nebraska. From the perspectives and insights of drug treatment providers, NE DHHS can better understand the experiences and needs of people with substance use disorders in Nebraska.

Through semi-structured interviews, STEPs collected qualitative data from drug treatment providers in Nebraska. STEPs analyzed the data to identify information and themes relevant to the NE DHHS Drug Overdose Prevention program. The analysis answered two primary questions:

1. What insights regarding drug use behaviors do drug treatment providers in Nebraska have that may inform drug use prevention planning?
2. What are the professional needs of drug treatment providers in Nebraska?

Sampling
Through the survey component of the Drug Use Behaviors project, 77 drug treatment providers in Nebraska identified that they were willing to participate in a follow-up study and provided an email address for follow-up. These providers formed the sample pool for the qualitative component.

STEPs' initial sampling procedure called for all potential participants to be grouped by the primary behavioral health region that they serve and for potential participants to be randomly selected from each regional group for an interview request. The purpose of these sampling procedures was to maximize geographic representation within the qualitative component while providing a systematic process for contacting and scheduling interviews with potential participants. These procedures were designed to allow for theoretical sampling (Charmaz, 2014), an iterative process of simultaneous data collection and initial coding. In theoretical sampling, rounds of data collection and initial coding continue until the emergent codes and categories are saturated, at which point data collection is complete. While there can be significant variability, saturation generally occurs between 15 and 30 participants.

Using this procedure, STEPs sent out an initial interview request to 17 potential participants on April 2, 2020. After 10 days, we had received one decline and no response from the rest of the potential participants. This was a very low response rate, especially from a pool of potential participants who had recently completed another evaluation and had indicated interest in participating in future studies. Many factors may have affected potential participants' ability or willingness to respond and complete an interview. However, STEPs staff speculated that the growing threat and realities of the COVID-19 pandemic, which was emerging at the same time as participant recruitment was taking place, may have been a particularly salient factor.

Appendix P: Full Methodology (cont.)

At this point, STEPs staff judged that potential risks of the initial sampling procedure–inadequate sample size and delayed data collection–outweighed the potential benefits–maximizing geographic diversity and avoiding over-saturation. In place of the original sampling procedures, STEPs staff implemented a new procedure that called for all potential participants to be contacted with an interview request and to schedule all interviews at the participants' earliest convenience. Between April 13, 2020 and April 18, 2020, all potential participants were sent an interview request, including a follow-up request to the initial potential participant group. On May 13, 2020 all potential participants were sent a follow-up request.

After implementing the new sampling protocol, STEPs received more responses from potential participants. It may have been that the new sampling procedure was better suited to quickly identify interested participants, which the previous procedure would have slowly identified over multiple rounds of targeted recruitment. It is also possible that potential participants had better adjusted to the new realities of the pandemic at this point and had greater capacity to participate. In total, STEPs conducted 17 interviews with 18 participants between the dates of April 29, 2020 and June 2, 2020. See Appendix B for interview request template and Appendix C for the consent handout.

Data Collection

STEPs conducted semi-structured interviews to collect data for the qualitative component. STEPs conducted interviews over Zoom, an online videoconferencing service, at a time that was convenient for participants. Both qualitative researchers and research participants have found Zoom to be a highly satisfactory method of conducting interviews, highlighting its convenience and user-friendliness (Archibald, Ambagtsheer, Casey, & Lawless, 2019). STEPs scheduled all interviews for 30 minutes. Actual interview times ranged from 24 minutes to 46 minutes, with an average interview time of 34 minutes. STEPs audio recorded the interviews and all interviews were professionally transcribed to ensure accuracy for analysis.

The STEPs interviewer was guided by the interview protocol (see Appendix D). STEPs staff collaboratively developed the interview protocol, drawing on multiple conversations with the NE DHHS Drug Overdose Prevention Program staff to identify their information goals and needs. The interview protocol was designed to facilitate a conversation with participants around their professional experiences and needs, the experiences and needs of their clients with substance use disorders, the participants' thoughts and ideas on how to reduce drug overdoses in Nebraska, as well as their needs regarding and perceptions of NE DHHS. The interview protocol consisted of six primary questions and multiple, tentative follow-up questions. The STEPs interviewer engaged participants consistently with the six primary questions, but was flexible in follow-up questions in order to elicit data that was both relevant and rich.

Appendix P: Full Methodology (cont.)

Sample Description

The sample pool for the qualitative component came from a subsect of participants from the quantitative survey component of the Drug Use Behaviors project. The two samples share common parameters, such as being comprised entirely of substance use treatment providers in Nebraska. **Substance use treatment providers** support individuals' ability to understand and overcome their substance use disorder and maintain recovery.

Providers Offer

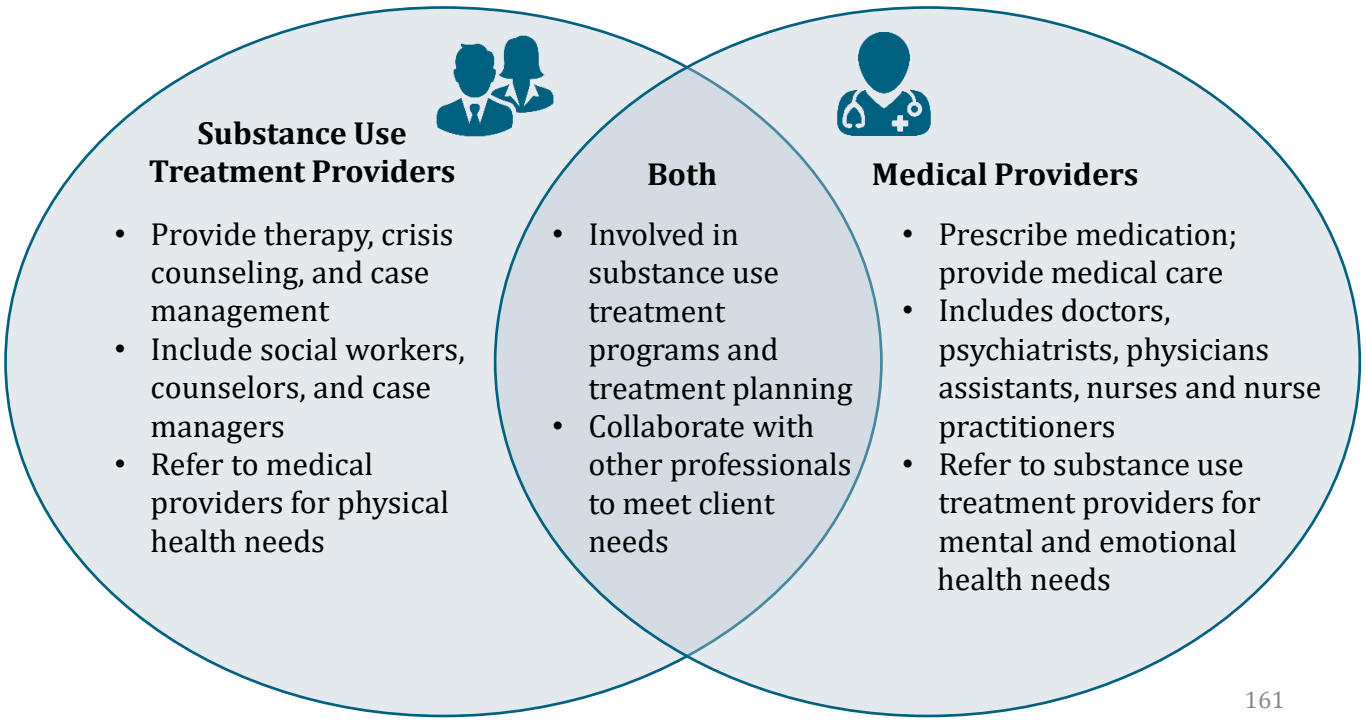
- Intake, assessment, and treatment planning,
- Counseling for individuals, groups, and significant others,
- Case management and crisis intervention, and
- Referrals to medical providers and other professionals when appropriate.

Providers Support

- Individuals with substance use, mental health, or co-occurring disorders, and
- Clients in self-help recovery groups, outpatient treatment, intensive outpatient treatment, residential or inpatient treatment, or continuing care.

Common Licenses Held by Providers

- Licensed or Provisionally Licensed Alcohol and Drug Counselor (LADC/PLADC),
- Licensed Mental Health Practitioner (LMHP), and
- Licensed Independent Clinical Social Worker (LICSW).



Appendix P: Full Methodology (cont.)

Years of Experience

Participants varied in length of experience from 1 year to 33 years. On average, participants indicated working in the field of substance abuse treatment for 10 years. In some cases, years working in the field included roles other than direct treatment provision, such as administration or case management.

Licenses Held

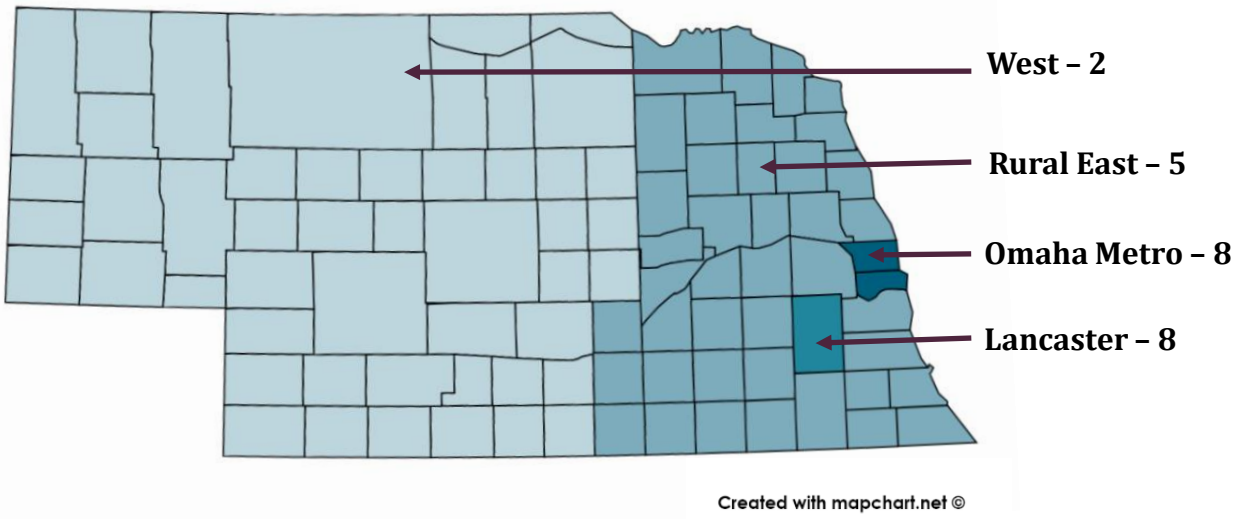
Participants held a variety of licenses. The most frequently held were Licensed Alcohol and Drug Counselor (LADC) and Licensed Independent Mental Health Practitioner (LIMHP). The table below illustrates the variety of licenses held by participants. Similar to the quantitative survey respondent demographics, LIMHP, LMHP, and LPC were the most frequently held license besides LADC and PLADC.

License Type	Total
Licensed Alcohol and Drug Counselor	11
Licensed Independent Mental Health Practitioner	10
Licensed Mental Health Practitioner	7
Provisional Licensed Alcohol and Drug Counselor	6
Licensed Professional Counselor	4
Licensed Master Social Worker	3
Provisional Licensed Mental Health Practitioner	2
Osteopathic Physician and Surgeon	1
Provisional Dispensing Practitioner Pharmacy License	1

Appendix P: Full Methodology (cont.)

Geographic Regions Served

STEPS identified four geographic regions for the purpose of the report: West, Rural East, Omaha Metro, and Lancaster. The number in each region represents the number of participants who provided services in each region. Some participants provided services in multiple regions. The most frequently served region within the sample was Lancaster County and the Omaha Metro.



Practice Settings and Roles

Participants represented a variety of practice settings and roles. These settings included nonprofits, private practice, corrections, residential treatment, and hospitals. Participants' roles in their agencies included clinical director, clinical supervisor, community outreach, outpatient therapist providing evaluations and treatment, and intake coordinator, and medical provider. Many participants played multiple roles within their agency such as clinical supervisor and outpatient therapist.

Field	Practice Settings	Roles
• Substance Abuse Treatment	• Nonprofit • Private practice • Corrections • Residential treatment • Hospital	• Clinician • Clinical Director • Clinical Supervisor • Community Outreach • Intake Coordinator

Appendix P: Full Methodology (cont.)

Data Analysis

STEPs analyzed the data using the methods of constructivist grounded theory (Charmaz, 2014). While the purpose of the project is not to develop theory, the stages of initial coding, focused coding and categorization, and theory development provided structure and rigor to the data analysis process.

In the initial coding stage, two STEPs staff independently coded the interview transcripts. The goal at the initial coding stage was to identify significant statements with tentative codes. STEPs prioritized the use of gerund coding, using verbs that end in "–ing" in order to capture action within the data. Descriptive coding, which labeled data based on the topic or theme, and in-vivo coding, which labeled data using the participants' own words, were also used when appropriate. STEPs' use of multiple coding strategies allowed a flexible approach to the data and, in combination with multiple coders, allowed the construction of a wide variety of initial codes for subsequent rounds of analysis.

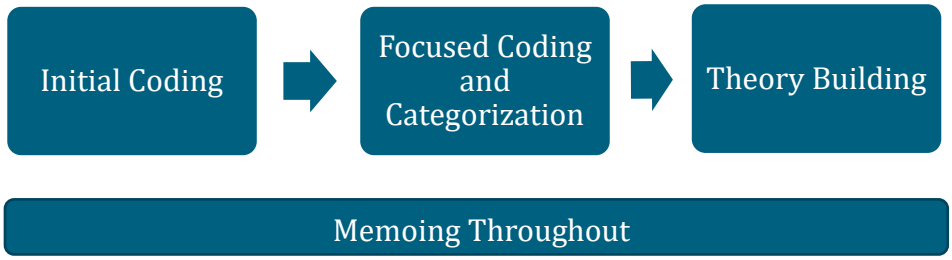
From the initial coding stage, STEPs staff progressed to focused coding and categorization. In this stage, STEPs staff identified and clustered initial codes that were conceptually similar or overlapping. Within these emergent categories, redundant initial codes were merged and new, overarching codes were developed for overlapping, but conceptually distinct, initial codes. STEPs staff then reviewed all the categories and codes and, through a consensus process, identified the categories and codes that were most crucial to telling the authentic narrative of the data. Guiding questions included, "Is this code necessary to tell the story of the data?" and "Would our report be incomplete without this code?" and "Would our participants be surprised or disappointed if they read our report and didn't see this?" These questions pushed STEPs staff to elevate categories and codes with the greatest relevance, insight, and analytic power.

After the focused coding and categorization stage, STEPs staff engaged in a theory development stage. The purpose of this stage was not to develop a theory in the traditional sense, but to identify meaningful relationships between the categories and codes that could tell a narrative about the data. Guiding questions within this stage included "What codes have led to this code?" and "What codes are caused by this code?" and "What codes could address this code?" As STEPs staff identified and developed relationships between categories and codes, disconfirming evidence and dissenting voices were identified within the data. STEPs also sought to identify how diverse identities, experiences, and contexts might affect the relationships. STEPs specifically looked for codes and data that addressed the role of race, socioeconomic status, gender and parenting status, and geography.

Appendix P: Full Methodology (cont.)

STEPs then reviewed the focused codes, categories, and relationships and elevated some, guided by similar questions as in the previous round of elevating.
Additionally, in this round, STEPs looked specifically for focused codes, categories, and relationships that may be actionable in some way by the Drug Overdose Prevention program or other stakeholders. STEPs staff developed recommendations based on these focused codes, categories, and relationships.

Throughout this process, STEPs staff used MAXQDA software to facilitate data analysis. STEPs used a two-coder system with all data initially coded independently. The two coders collaborated and sought consensus in all subsequent stages. While the data analysis involved progressive stages of analysis, the process was not strictly linear. At all stages of data analysis, STEPs staff engaged in memoing, in which they captured initial impressions and understandings of the data, including tentative ideas and hunches regarding later stages of data analysis. These memos were consulted throughout the data analysis process.



Appendix Q: Interview Request Template

Initial Email to Treatment Providers

Hello _____.

Thank you for your recent participation in the Drug Use Behaviors Treatment Provider Survey!

At the conclusion of that survey, you indicated your willingness to participate in a follow-up interview. We are excited to include you in this portion of our project, and we are thankful for your interest in sharing your time and experience with us.

The Nebraska Department of Health and Human Services (DHHS) Division of Public Health has contracted with the University of Nebraska at Omaha's STEPs (Support and Training for the Evaluation of Programs) to conduct follow-up interviews with select treatment providers across Nebraska. The purpose of these interviews is to hear directly the voices and experiences of outpatient treatment providers on issues relevant to drug overdose prevention in Nebraska. Participating in this interview is an opportunity for your agency to confidentially share your perspectives and needs with Nebraska DHHS and other relevant stakeholders.

Interviews will be scheduled at a time that is convenient for you, and they will take place over Zoom, an online videoconferencing service. Zoom is user-friendly and participants can connect via internet or phone, so there is no travel, no software, and no camera required. We anticipate the interview will take approximately 30 minutes. More information can be found in the consent document attached to this email.

If you are still willing and able to participate in the follow-up interview portion of our project, please confirm by responding to this email by XX.XX.2020. Please include in your response 2-3 dates/times that would work best for you within the date range of XX.XX.2020 to XX.XX.2020. We look forward to hearing from you.

If you have any questions, please contact steps@unomaha.edu.

Thank you,

[STEPs staff]
402.554.3663
steps@unomaha.edu

Appendix R: Consent Handout

Consenting Information

Drug Use Behaviors
Treatment Provider Interviews

Thank you for your interest in participating in a treatment provider interview. Interviews are being conducted through the Support and Training of the Evaluation of Programs (STEPs) at the University of Nebraska at Omaha. Nebraska Department of Health and Human Services (NE DHHS) Division of Public Health has contracted with STEPs to complete a needs assessment for the Drug Overdose Prevention (DOP) Program. The purpose of the DOP Drug Use Behaviors project is to equip NE DHHS with the information necessary to develop effective drug use prevention plans, as well as provide relevant trainings and resources for treatment providers. Hearing directly from treatment providers is crucial to the development of those plans.

What will happen during the interview?
The interview will last approximately 30 minutes. The interview will be scheduled at a time that is convenient for you and will take place over Zoom, an online videoconferencing service. Zoom is user friendly and participants can connect over the internet or by phone, no software or camera required. A link and phone number to connect with Zoom will be emailed to you prior to your interview. The interview will consist of several open-ended questions regarding your professional experiences and perspectives on drug use behaviors in Nebraska. You can opt out of any question or opt out of the interview at any time. STEPs will record the interview in order to best capture your perspectives and have a transcript of our conversation.

What will happen after the interview?
STEPs will analyze the transcript, along with the transcripts from other interviews, in order to develop a report. Your participation in the interview will be kept confidential and no personally identifying information will be included in the report. The report will be given to NE DHHS, who may distribute it to relevant stakeholders. At your request, a copy of the report can also be made available to you.

Why should I participate?
There are no direct, material benefits or incentives for you participating in the interview. However, by sharing your professional experiences and perspectives, you can ensure that your voice is heard by NE DHHS and other stakeholders as they develop plans relevant to your work. By including the voices of treatment providers, we hope to improve drug overdose prevention and treatment efforts in Nebraska.

Appendix R: Consent Handout (cont.)

Consenting Information (cont.)

If I have questions about the interview, who can I ask?
If you have any questions prior to or after the interview, you can contact STEPs:

Liam Heerten-Rodriguez, PhD
STEPs Faculty Affiliate
6001 Dodge Street, CPACS 206
Omaha, NE 68182
Phone: 402.554.2891
Email: lheerten2@unomaha.edu

Appendix S: Full Interview Protocol

Interview Protocol

1. Please tell me a little about your professional role involving drug treatment.
    - How long have you been doing this work?
    - How have things changed since you started in the field?
2. Please tell me a little about the clients that you serve.
    - Would you say that there's any "typical" story among your clients? Or something that all or most of them have in common?
    - When you think about your clients' strengths, what comes to mind?
    - What do you think your clients would want NE DHHS to know about them or their experiences?
    - NE DHHS is especially interested the experiences and needs of women of childbearing age. In what ways, if any, are their experiences or needs different than those of other clients?
3. Please tell me about a time when you could have done your job better if you had the resources that you needed,
    - Resources might include things like information or research, training, services, or policies.
    - What would have been different if you had had that resource?
    - Why do you think you don't have access to that resource?
4. What's one change to the current system that you believe would reduce drug overdoses?
    - Why do you think that change would be effective?
    - Who do you believe is responsible for making that change?
    - How likely do you think the change is?
    - What barriers do you think stand in the way of the change?
    - Are there any current opportunities that might make the change more likely?
5. What would it look like if NE DHHS were to be a full partner to you in your work?
    - How would that be different from how you perceive their current role?
    - What impact do you think that would have on your clients or on drug overdoses?
6. What else would you like NE DHHS to know?
    - Why do you want them to know that?
    - What do you want them to do differently because of that information?
    - How will you know that DHHS has gotten your message?

* The bulleted prompts listed after each question are meant to be flexible guides to help keep the conversation going and to dig deeper into what the interviewee is sharing. Not all prompts need to be asked. We may also need to ask prompts that are not listed here. The goal is always to dig deeper, eliciting stories, examples, and meaning from the interviewee. At any point in the interview in which the experiences or needs of women of a childbearing age might be relevant, we will ask specific follow-up questions.