Initial Report to the MA Treatment Study Committee of the Nebraska Community Corrections Council:

MOVING PAST THE ERA OF GOOD INTENTIONS: METHAMPHETAMINE TREATMENT STUDY

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List of Acronyms & Abbreviations

ASI.....Addiction Severity Index
Ax..... Assessment
CADAC ..... Certified Alcohol/Drug Abuse Counselor
CASA..... National Center on Addiction and Substance Abuse at Columbia University
CASI ..... Comprehensive Adolescent Severity Inventory
COMET .....Co-occurring Methamphetamine Expanded Treatment
CSAT..... Center for Substance Abuse Treatment
DARE ..... Drug Abuse Resistance Education
DATCAP..... Drug Abuse Treatment Cost Analysis Program
DCS.....Department of Correctional Services
HCC.....Hastings Correctional Center
HHSS.....Nebraska Health and Human Services System
HRC..... Hastings Regional Center
JCAHO.....Joint Commission on Accreditation of Health Care Organizations
JSAT.....Justice Substance Abuse Subcommittee
LADAC ..... Licensed Alcohol and Drug Abuse Counselor
LMHP..... Licensed Mental Health Professionals
LOC.....Levels of Care
MA..... Methamphetamine
NIDA .....National Institute on Drug Abuse
N-SSATA ..... National Survey of Substance Abuse Treatment Services
PSI ..... Pre-Sentence Investigation
PTSD ..... Post Traumatic Stress Disorder
SAMHSA ..... Substance Abuse and Mental Health Services Administration
SAO ..... Substance Abuse Officer
SICA..... State Incentive Cooperative Agreement
STD.....Sexually Transmitted Diseases
TASC..... Treatment Accountability and Safer Communities
TEDS..... Treatment Episode Data Set
TIP.....Treatment Improvement Protocol
Tx.....Treatment
WEC..... Work Ethic Camp
WIC.....Women, Infants and Children Program

Executive Summary

Rodger McDaniel is the Director of the Wyoming Department of Family Services and one of the co-authors of *Reclaiming Wyoming: A Comprehensive Blueprint for the Prevention, Early Intervention and Treatment of Substance Abuse.* In an article entitled, "Solving the Meth Problem: The Wyoming Plan" he says, "we [now] have enough available research to end the era of "good intentions" and invest dollars in programs with a likelihood of success, the ability to measure the outcomes and the opportunity to make mid-course corrections." (McDaniel, 2004: 34) It took more than three years from the time Wyoming started its substance abuse reform effort to reach the point McDaniel notes above.

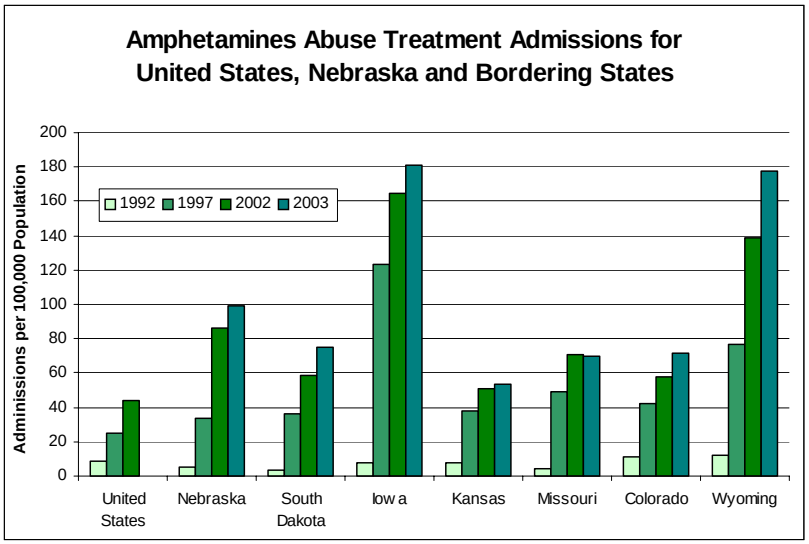
With LB 425, the Nebraska Legislature declared its readiness to also reconfigure the state's philosophy and response to methamphetamine abuse ("MA"). Specifically, the Legislature wanted the MA Treatment Study to identify the policy and implementation issues which must be resolved to create a coordinated system for the treatment of chemical dependency related to methamphetamine.

Having spent the last three months deeply immersed in the study of these questions, the MA Treatment Study Research Team has reached the point where it can now begin to outline the actions Nebraska must take to move beyond its era of good intentions. The findings and recommendations contained in the Initial Report are the initial steps required to hold methamphetamine users accountable for their actions and obligations, as well as the means by which the State can finally progress in promoting the long-term recovery of its chemically dependent citizens.

The Scourge of Methamphetamine

In 1992, admissions for methamphetamine abuse totaled 5.5 per one hundred thousand persons; by 2003, this rate increased nearly twenty-fold to 99.1 per one hundred thousand. In 1992 and 1997, Nebraska's methamphetamine treatment admission rate was lower than any of its neighbors; by 2002 and 2003 Nebraska's rate was exceeded only by Iowa and Wyoming.

As the accompanying figure illustrates, Nebraska's admission rate (per hundred thousand population) for amphetamine abuse treatment has been increasing faster than the United States and most of its neighbors since 1992.



The Continuum of Assessment, Treatment and Recovery

The recipe for recovery from methamphetamine addiction does not require Nebraska to develop innovative strategies. Put plainly, the continuum of successful drug and alcohol treatment services is as follows:

1. A standardized, validated assessment of the nature and severity of a person's chemical dependency;
2. The design of a case-plan which accounts for the person's substance abuse factors within the context of their individual lives and legal constraints;
3. The provision of treatment services matching the person's short-term, individualized treatment needs; and,
4. The provision of recovery and relapse prevention services which support the person's life-long effort to remain clean and sober.

The challenge facing Nebraska lies not in the complexity of the response needed to combat methamphetamine addiction, but in manifesting the will to establish a complete continuum of assessment, treatment and recovery. Alcoholics are taught that recovery is a life-long process. As a state, however, Nebraska has been slow to accept that not only is it a long-term process for the individual, it also demands a long-term commitment from society. Once the sobriety of an addict has been stabilized through initial treatment, their continued abstinence will always depend on the accessibility of recovery support and relapse prevention services.

Nebraska's Existing Capacity

Ultimately, the recommendations for the State turn not on the prevalence of methamphetamine users in any given justice or social service system, but on the State's ability to establish the continuum of assessment, treatment and recovery as needed beneath methamphetamine users. Among the key questions the Legislature has directed to be answered by the MA Treatment Study, are those related to where Nebraska might invest money and resources to obtain the best results against the methamphetamine problem.

The surprising findings from the research reveal that the State cannot buy its way out the biggest obstacle to substance abuse reform, at least not very quickly. Nebraska presently faces such a severe shortage of substance abuse clinicians and treatment professionals that every level of service within the continuum of care has a waiting list. Justice and treatment professionals from all over Nebraska report that regardless of an individual's personal financial resources, obtaining even the initial assessment on which so many critical legal and treatment decisions depend can be delayed for weeks. Similarly, once an assessment has been obtained, the addict faces more delay as they wait for admission to the most appropriate level of treatment, if it exists at all.

The ramifications of this shortage are fairly obvious in terms of treatment for methamphetamine abuse. The impact on the justice and social service process is equally profound, though more subtle. The primary mission for justice and social services is to hold substance abusing offenders accountable for their crimes and/or the family crises they have caused as a result of abuse or neglect. When criminal rehabilitation and the restoration of parental responsibility turn on the elimination of a person's substance abuse problem, these waiting lists and gaps in the continuum of assessment, treatment and recovery become part of the transactional calculus offenders and neglectful parents use to avoid the compelled surrender of

addiction. Addicts play justice professionals, social service workers, and treatment providers against each other by exploiting these gaps and shortages as excuses for their lack of recovery progress.

It would seem that the solution to this dilemma turns on the State's ability to quickly develop a cadre of clinicians and treatment specialists to fill these gaps. Increasing reimbursement levels might motivate more people to complete the rigorous education and training requirements to become treatment professionals and possibly improve Nebraska's ability to recruit and retain them from other states. As other Nebraska studies have shown, however, this strategy provides only a partial remedy. While the State must seriously consider the incentives it can create to grow the number of treatment specialists, the payoffs from this effort are likely to be years in the making.

Intersecting Treatment Needs With Justice/Social Service Process

When one considers the specific missions, separate budgets and differing philosophies of Nebraska's Social Service and Justice Systems, it is easy to see how these agencies are viewed as silos of command rather than an integrated network. At the same time, the State's response to the methamphetamine problem requires it to recognize that all of these agencies are actually points within the flow of the justice and legal process. Viewed as a stream of decisions and response rather than administrative units, one sees the vast potential of this stream to quickly and dramatically alter the course of methamphetamine abuse for individual offenders/parents and the State as a whole. When earlier stages of the justice process successfully intervene in the offender/parent's substance abuse problem, more expensive, intensive levels of supervision or incarceration are avoided.

The trick, of course, is to develop levels of service and treatment beneath all points of the HHSS and justice systems which are appropriate to their statutory authority and inherent structure. These strategies must seal the gaps, shorten the delays, and remove the explicit barriers to recovery now found in Nebraska's present substance abuse system. To reduce methamphetamine abuse, an infrastructure must be laid which enforces a state-wide response to the problem and channels addicts into a fast-flowing stream of recovery in which it is easier to succumb than escape.

The main recommendations for changing or expanding the infrastructure for Nebraska's methamphetamine response system include:

- ***Legislative action and incentives to develop more methamphetamine treatment professionals throughout the state;***
- ***Incentives for treatment providers to expand and develop localized methamphetamine abuse treatment programs;***
- ***Funding and legislative action to establish and staff day/night reporting centers across Nebraska in support of Probation, Parole, drug courts, and diversion programs;***
- ***An increased utilization of the WEC as a methamphetamine treatment facility for those offenders whose crimes and risk to others do not warrant incarceration by DCS;***
- ***A centralized substance abuse treatment facility for medium and low risk offenders committed to the custody of the Department of Correctional Services;***
- ***Expanding the use of ASI/CASI evaluations and the standardized reporting format throughout all of justice and HHSS;***

- ***A centralized database where substance abuse evaluation results and treatment summaries are kept and accessed by social service, justice, and treatment providers;***
- ***Ongoing research to drive targeted capacity expansion for treatment and recovery services;***
- ***Ongoing research to monitor the effectiveness of treatment programs; and***
- ***Creating an office which can coordinate the implementation of any recommendations which may be adopted and report to the Governor, Legislature, and Supreme Court on the progress being made***

Conclusion

Recovery is like a long trip up a steep hill: if the support pushing a methamphetamine user falters, they risk not only stalling, but a rapid plunge back into the valley of addiction from which they had begun to emerge.

The State may not be perfectly positioned to resolve the problems of methamphetamine abuse, but the concerted efforts of many agencies, committees, and treatment providers has laid a solid foundation on which additional reforms can take hold as Nebraska strides ahead to a more hopeful future.

Background

Nebraska's Movement toward Community-Based Services

In recent years, justice and treatment professionals throughout Nebraska have seen substance abuse treatment and mental health care shift to community based services. This shift has been affect by the Legislature in several ways: the creation of the Substance Abuse Task Force and subsequent implementation of the Best Practices Model (LB 685), the creation of the Community Corrections Council (LB 46) and Behavioral Health Reform (LB 1089).

The Standardized Model

The movement toward standardization of substance abuse treatment within the criminal justice system grew from a grassroots group of criminal justice professionals who began meeting informally in 1995 to document problems related to identification and treatment of substance abuse among offenders. As a result, LB 865 was introduced in the 1999 Legislative Session (Herz 2003). The bill was passed, creating the Substance Abuse Task Force that was charged with examining adult and juvenile offenders' need for and access to substance abuse treatment.

When examining gaps in the criminal justice system applying to chemical dependence, the Task Force was disheartened to learn that "limited evaluation results render an assessment of Nebraska 'best practices' almost impossible" (Herz 2000). The Task Force uncovered a wide disparity in criminal justice system and juvenile justice system responses to substance abuse. Standardization was determined to be the key to addressing gaps in funding, training, and the criminal justice system's continuum of care, so the Task Force recommended that professionals from these disciplines collaborate in identifying a standardized level of care.

When researching the most effective treatment modalities the Task Force found that the best practices literature supported the establishment of community-based services.
Based upon these findings, recommendations were made to expand treatment programs by incorporating the concepts in the best practice literature.

The result of the Task Force's work was the development of the *Standardized Model for Assessing Substance Abusing Offenders* illustrated in *Figure 1* below. The *Model* requires screening of all offenders for substance abuse as early in the justice system process as possible. If a potential problem is identified, the justice agencies must provide a risk assessment to the treatment providers who are conducting substance abuse/chemical dependency evaluations. The treatment providers then develop a diagnostic impression and recommendations for the proper level of care for the individual.

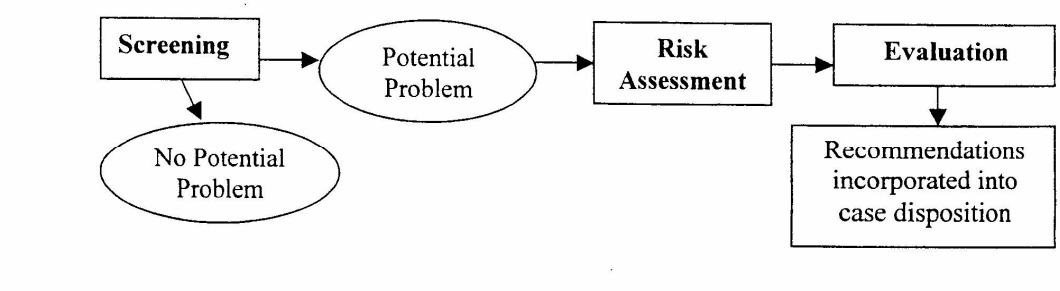


Figure 1. Nebraska's Standardized Model for Assessing Substance Abusing Offenders, 2001.

In support of this *Model*, the Task Force also drafted the *Standardized Risk Assessment for Substance Abusing Offenders* and the *Standardized Risk Assessment for Substance Abuse Offenders Reporting Form* to ensure uniform collection of information from adult and juvenile justice agency risk assessment tools. By standardizing the risk assessment tools used among Nebraska's justice agencies, the *Model* intends to ensure that relevant information on offenders' prior history and risk levels is consistently shared by justice agencies with evaluators (Herz 2003).

The original idea behind the *Nebraska Standardized Model* was to rethink the criminal justice system's process for identifying and treating substance abuse. The *Model* has succeeded in this effort and evolved to incorporate many justice and treatment best practices. As the concept solidified, focus shifted to the vital role that partnership between treatment and justice professionals plays in resolving potential conflicts. These stakeholders worked together on these issues on a daily basis to deliver this *Model* to administrators; in effect, producing a product to be "handed up", rather than "handed down" by agency administrators. Representing cutting-edge responses to problems plaguing the criminal justice system for decades, the *Model* relies on practical, reasonable solutions to pave the way for Nebraska's current shift to consider a community-based services delivery model.

Formation of the Community Corrections Council

In the Fall of 2000, the Vera Institute conducted a study of community corrections in Nebraska, recommending that the State form a working group to study community corrections, define community corrections, share criminal justice data, and develop a plan for community corrections. The recommendations of the working group are found in the Community Corrections Act (LB 46). By enacting the Community Corrections Act, the Legislature demonstrated its intent that community based services be utilized as an alternative to incarceration in Nebraska. Through this Act, the Community Corrections Council was created to assist the state's justice system in establishing community based correctional programs intended to divert felony offenders from the prison system. Among its duties, the Community Corrections Council was charged with developing standards for community correctional facilities and programs and developing and implementing a plan for establishing programs and facilities statewide.

Behavioral Health Reform (LB 1089)

In 2004 Nebraska Legislature passed the Nebraska Behavioral Health Services Act (LB 1089) to implement the intent of LB 724 passed in 2003 for the reform on the state's behavioral health system. The primary focus of this bill was to develop community-based services allowing persons with mental illness to be served closer to their home communities. LB 1089 proposes to provide a multi-level system of services for individuals requiring mental healthcare in Nebraska. The new behavioral health system will make better use of scarce resources, ensuring that citizens in need of behavioral health services will receive care at an appropriate level of service with documented outcomes.

Objectives of LB 1089 include restructuring the existing fragmented system of mental health services by moving from state-owned regional centers to a community-based system that includes many levels of services and developing community-based behavioral health services enabling individuals to be closer to home communities and live more independent lives with more community support. Individuals will have access to health care providers, support groups,

family and friends in the least restrictive environment that still provides safety and protection for the individual and community. These efforts provide the potential for 60% match of Medicaid funds.

To ensure delivery of its intent, LB 1089 created the Behavioral Health Implementation Plan. Phase I of the plan replaces current inpatient services provided at the Regional Centers. Resident populations will be decreased through discharges to appropriate community-based services. Each of the six behavioral health regions in Nebraska has been directed to assess its needs and develop a proposal outlining the community-based services needed to meet the behavioral health needs of that particular region. Phase 2 addresses the gaps identified during Phase I and promotes the long-term expansion of community-based services.

Levels of Care Model

To determine the best practices for treating methamphetamine addiction, it is necessary to base the findings upon a continuum of care. A hallmark of community based services is the practice of matching an individual's treatment to his or her unique treatment needs. A one-size-fits-all approach is not effective in treating methamphetamine addiction. Therefore, it becomes necessary to consider all of the potential treatment options, or the continuum of care, when assessing the best treatment practices. The continuum of care is comprised of levels of care (LOC) ranging from assessment to treatment to recovery support.

Unfortunately, review of the literature and community practices revealed that LOC were inconsistently defined and varied depending upon the source. Before recommendations could be made addressing the state's treatment needs, it was necessary to establish what LOC actually comprise the continuum of care. In an attempt to clarify what LOC exist, researchers reviewed several groups' definitions of LOC including the Nebraska Standardized Model for Assessing Substance Abusing Offender updated January 2005 which is included as *Appendix A* of this report, and the American Society of Addiction Medicine Patient Placement Criteria. However, researchers struggled to find a consistent definition for each LOC.

The difficulty of condensing the diverse LOC criteria into a standard form underscored one of the reasons why treatment for methamphetamine addiction is at times ineffective. Before the continuum of care can be utilized it must be understood by the treatment and justice professionals accessing it. An attempt to overcome this difficulty revealed that LOC are driven by treatment requirements and staffing concerns, not reimbursement guidelines, an organization's individualized criteria or any other system that is currently governing establishment of the definitions of LOC. In an attempt to illustrate this idea, the research team has generated a standardized continuum of care based upon the state of Nebraska's current LOC. In addition to providing standardized definitions to be utilized when making recommendations, this continuum of care also illustrates the particular staffing needs of each LOC.

LEVEL OF CARE	STAFF												
	Physician	Nurses	Med. Tech	Psyc. Tech	Psychology	Mental Health	Substance Abuse	Case Mgmt	Probation/ Corrections	Transportation	Community Support	Compulsory	Voc. Rehab
Assessment Services						XX	XXX	XXX					
Emergency Substance Abuse Evaluation													
Substance Abuse Evaluation													
Screening													
Emergency Services	XXXX	XXX	XXX	XXX		XXX	XXX	XXX		XXX			
Crisis Phone Line													
Mobile Crisis Response Team													
Emergency Protective Custody (EPC)													
Civil Protective Custody(CPC)													
Medical Detox													
Emergency Stablization and Treatment													
Substance Abuse Emergency Shelter or Respite													
Social Detox													
Emergency Community Support													
Residential Services													
Residential	XX	XX	XX	XXX	XXX	XXX	XXX	XXX	as needed	XX		X	
Methamphetamine Detox													
Short Term Residential													
Extended Residential													
Dual Residential													
Transitional Residential	as needed	as needed	as needed	XX	as needed	X	X	X	X	XX	XXX	X	X
Theraputic Community													
Halfway House													
Non-Residential Services													
Out-Patient	as needed	X	?	?	X	XXX	XXX	XX	XX	X	X	X	
Partial Care													
Intensive Outpatient													
Counseling													
Community Support													
Outpatient Counseling													
Recovery Support and Relapse Prevention	as needed		as needed	XX	as needed	XX	X	XX	X	XX			
Care Monitoring													
Methadone Maintenance													

Table 1. Staffing needs at each level of care for substance abusers in Nebraska.

All of the LOC have specific staffing needs based on the specific intents of each LOC. Each column of the Continuum of Care represents a type of professional staff. The "X's" found in each column represents the necessary staffing for each area of expertise or training. Please be aware that the "X's" are not an exact ratio for the actual number of staff needed, but illustrate the approximate number staff needed in relation to one another and the other LOC.

The LOC have been broken up into four broad types of services. The specific LOC provided under each of these services are listed below it. The LOC have been listed in chronological order from the most intensive to the least intensive within each category of services. It is important to note that the following Assessment Services are not to be confused with the current standardized assessment that is currently required by justice professionals.

The first type of treatment that needs to be provided to methamphetamine addicts is Assessment Services.

- Emergency Substance Abuse Evaluation.
  - An in-depth evaluation of the individual's substance abuse history and treatment needs.
  - Completed within 24 hours of being requested.

  - Takes into consideration not only the user's habits with regards to methamphetamine use, but also any other illicit drugs or alcohol.
  - Clinician will begin formulating a treatment plan based on the individual's specific needs.
- Substance Abuse Evaluation.
  - Differs from the emergency evaluation only in that it does not have to be completed within the first 24 hours.
- Screening
  - Identifies substance abuse, mental health and gambling problems.
  - Serves as a referral for more comprehensive evaluation.

The second type of services that should be provided to methamphetamine users is Emergency Services.

- Emergency Protective Custody (EPC).
  - Involuntary commitment of an individual when he or she is experiencing a substance abuse or mental health crisis causing him or her to be dangerous to self or others.
  - Takes place in a medical facility where the individual can receive the necessary medical treatment to address all of their immediate needs.
- Civil Protective Custody (CPC).
  - Involuntary commitment that lasts only 24 hours, allowing an individual to detox.
  - Takes place in a residential setting, not a medical facility.

There are two types of detox available under Emergency Services.

- Medical Detox.
  - Medically supervised.
  - Available 24 hours a day to address the medical needs of the individual as they go through detox.
- Social Detox.
  - Occurs in a residential setting where there is limited nursing coverage.
  - Unable to address the medical needs of the individual.
- Emergency Stabilization and Treatment.
  - Stabilizes an individual who is experiencing withdrawal or intoxication symptoms and then returns him or her to the community.
  - Primary treatment can be started during this LOC.
  - Receives limited nursing care.

The final four LOC under Emergency Services are provided to an individual while he or she is residing within the community.

- Emergency Community Support.
  - Provides services once an individual has been stabilized.
  - Services are on-call 24 hours a day.
- Substance Abuse Emergency Shelter or Respite
  - Provides short-term placement for an individual in crisis.
  - The individual must be medically stable as there is limited or on-call nursing coverage.

- Mobile Crisis Response Teams.
  - Provides in-home screenings when an individual is in crisis and makes referrals to appropriate services.
- Emergency Service is the Crisis Phone Line.
  - Provides 24 hour a day, seven day a week intervention and referral services.

The next type of services appearing on the continuum of care is Residential Services. Researchers found it difficult, if not impossible, to categorize all Resident Services into a single category. Therefore, the continuum of care divides Residential Services into two categories, Residential and Transitional Residential. Both provide services when the individual receiving treatment lives at the treatment facility. The difference between the two is apparent in the goal of the treatment provided at each. Residential Facilities focus on treating the substance abuse problem while Transitional Residential focus on equipping the individual to re-enter his or her community. None of the Residential Services provide medical treatment as they all require the individual to be medically and psychiatrically stable. Services are provided by addiction specialist instead of medical professionals.

Residential Services

- Short Term Residential.
  - Provided for the individual who is unable to remain drug-free in a non-residential setting
  - 24 hour a day, short-term, comprehensive rehab services.
  - Addresses mental health concerns.
- Extended Residential.
  - Provides non-medical treatment for chronic individuals who are at a high risk for relapse and are often unable to perform daily activities and may have cognitive defects.
  - Provides less intensive services for a longer period of time to accommodate the needs of the individuals seeking this LOC.
- Dual Residential.
  - Simultaneously treats substance abuse and mental health issues in individuals that have a dual diagnosis.
  - Requires dually accredited clinicians.

Transitional Residential

- Therapeutic Community.
  - Utilizes highly structured, peer-oriented activities
  - Focus on building psychosocial skills.
  - Staff secure.
- Halfway House.
  - Assists individuals in moving from more intensive treatment to independent living.
  - The least restrictive type of Residential Services.

The final type of services provided on the continuum of care is Non-Residential Services. Individuals seeking Non-Residential Services live within the community. They do not live in the treatment facility. As in the case of Residential Services, Non-Residential Services have also been divided into two categories, Outpatient and Recovery Support and Relapse Prevention. Outpatient is treatment services provided through day treatment, therapy groups or other similar

means. Recovery Support and Relapse Prevention no longer focuses on treatment, but rather on sobriety maintenance.

Outpatient

- Partial Care.
  - A very intensive treatment program run by licensed clinicians.
  - Medical back-up is provided.
  - Services are generally provided 5 days a week for 6-8 hours a day.
- Intensive Outpatient Counseling.
  - Offers groups and individual counseling averaging 10-15 hours of therapy per week.
- Community Support.
  - Provides one to one staff to client ratio
  - Focuses on rehabilitating social and relationship skills.
  - Provides 24 hour a day, seven day a week on-call availability
  - Often works in conjunction with other Non-Residential Services.
- Outpatient Counseling.
  - Provides individual and group therapy designed to develop the skills to prevent relapse.
  - Less intensive than Intensive Outpatient Counseling.

Recovery Support and Relapse Prevention

- Care Monitoring.
  - For individuals who have made significant progress in recovery and community living.
  - Monitors the individual's success in the community.
  - Works with the individual to plan to prevent relapse.

For comprehensive and successful MA treatment to occur, the State of Nebraska must strive to provide the above LOC to MA users in the community and at each level of the justice and social service system.

Methodology

The MA Treatment Study Research Team's first step toward identifying the policy and implementation issues linked to creating a coordinated system for the treatment of MA dependency was to scour the related literature, including treatment methods and best practices nationwide. The literature review provided a foundation for developing interview questions asked at four site visits (Hastings Correctional Center, Hastings Regional Center, Norfolk Regional Center, and McCook Work Ethic Camp). The site visits were conducted to determine what would be necessary from an organizational, financial, and cultural standpoint to provide MA treatment at each facility.

During the same timeframe as the site visits were being conducted, two Roundtable Discussions were held to develop a picture of practitioners' views of best practices for MA treatment in Nebraska. The first session was held on August 29, 2005 in Bridgeport and the second session was held on September 16, 2005 in Lincoln. Researchers invited representatives from the justice professionals, treatment providers and community support providers. While community support providers were invited to the Lincoln meeting, none attended. *Table 2* below illustrates the breakdown by profession of the attendees. A list of attendees is included in *Appendix B.*

	Community Support Providers	Treatment Providers	Justice Professionals
Bridgeport	10	10	5
Lincoln	0	20	21
Totals	10	30	16

Table 2. Breakdown by Profession of 2005 MA Treatment Best Practice Roundtable Discussions.

Because the existing circumstances surrounding MA use and treatment in Nebraska dictate the parameters for construction of a best practices model for MA treatment that meet the specific needs of Nebraskans, researchers presented a snapshot of Nebraska's current state of affairs regarding MA use to participants in the Best Practices Roundtable Discussions. Prior to forming breakout groups, participants considered a series of contributing factors with statewide implications, including the impact of substance abuse on the Nebraska state budget, admissions rates linked to MA abuse, and Nebraska's treatment capacity, as well as a generic treatment response model. The researchers drew from their review of the literature regarding best practices for MA treatment to develop a generic treatment model to serve as the foundation for the Round Table Discussions. The generic treatment model, drawing liberally from the Substance Abuse and Mental Health Services Administration (SAMHSA) *Treatment Improvement Protocol, Series 33 (TIP #33)* (Rawson 1999), was presented to the discussion participants. Topics included treatment engagement, assessment and orientation, treatment plan, treatment initiation, abstinence initiation and maintenance, and medical aspects. Upon conclusion of the researchers' presentation, the participants divided into smaller breakout groups according to profession. The Bridgeport session broke into three small groups: the Western Nebraska Justice Professionals, Treatment Providers and Community Support Providers. Due to the lack of Community Support Providers, the Lincoln session supported only two groups: the Eastern Nebraska Justice Professionals and Treatment Providers. Following the breakout sessions, the participants reconvened as a large group to review findings. The *Best Practices Roundtable Discussions* section represents the data gathered at the Eastern and Western Nebraska sessions, organized by

the generic treatment model headings. Responses to the *Best Practices Roundtable Discussions* are included in this report.

Research to identify Nebraska's existing capacity for MA treatment drew heavily from three sources: the SAMHSA March 31, 2003 *National Survey of Substance Abuse Treatment Services,* the *Roster of Substance Abuse Treatment Center Roster* (updated October 11, 2005) by the Nebraska Health and Human Services System (HHSS), and *Substance Abuse Treatment Facility Locator Lists* (updated April, 2005) by SAMHSA. By combining and cross-referencing these sources, researchers were able to draw a picture of the number of beds and facilities, as well as mental health practitioners and drug and alcohol counselors available in each of Nebraska's Behavioral Health Regions.

The cost study was been guided from the outset by a series of research questions developed to systematically identify existing unmet needs in methamphetamine/amphetamine-related treatment services in Nebraska and to provide cost estimates for programs and facilities to meet identified needs. *Table 3* summarizes the major research questions, as well as the data sources and published reports consulted in their investigation.

Major Study Areas	Research Questions	Published/Internal Reports & Data Sources (National/States)
Substance- Abuse Treatment Needs and Costs	1. What is the total prevalence (population) of illicit-drug, stimulant-related and meth-amphetamine related substance abusers in NE? a. Of these, how many are receiving treatment (met demand)? b. How many need but are not in treatment? c. How many want or would seek treatment if it was available (unmet demand)? 2. What are the average costs for drug treatment by level of treatment (e.g., for residential and outpatient levels)? 3. What levels/types of treatment are most cost-effective for high-, moderate- and low-need/risk stimulant- and meth/amphetamine-related substance abusers/dependent? What are the estimated costs of a comprehensive program to meet the unmet demand of those who are not receiving treatment, but want or would seek treatment?	1. "State Estimates of Substance Use from the 2002-2003 National Surveys on Drug Use and Health," SAMHSA (2004). [*Figure 5, Appendix D: Tables VIII-XVII*] "Substance Abuse Treatment Admissions by State and Primary Substance of Abuse," SAMHSA (2003). [*Figure 5, Appendix D: Tables VIII-XVII*] "Analysis of Substance Abuse Prevalence, Treatment Resources and Gaps in Colorado," State of Colorado (2002). [*Figure 5, Appendix D: Tables VIII-XVII*] 2. DATStats: Results from 85 studies using the Drug Abuse Treatment Cost Program Analysis (DATCAP), by M.C. Roebuck et al, Journal of Drug Abuse Treatment (2003). [*Table 24*] "The Cost and Benefits of Substance Abuse Treatment: National Treatment Improvement Study," by Lane Koenig et al. (1999). 3. "Economic Benefits of Drug Treatment: A Critical Review of the Evidence for Policy Makes," by Steven Belenko et al. (2005). "Wyoming Methamphetamine Treatment Initiative," State of Wyoming (1998), Office of Justice Programs (2001), and Citizens Education Project (2004)
Substance-Abuse Treatment Facility Costs	1. What types and how many facilities currently provide substance abuse treatment in NE? a. What are the fixed costs for these types of treatment facilities? b. What are the combined fixed and variable (treatment program) costs for each type?	1. "National Survey of Substance Abuse Treatment Services (N-SSATS) State Profile Nebraska," SAMHSA (2003). a. (Pending master budgets, audited facility, performance reports to be provided by the State of Nebraska.) b. "DATStats: Results from 85 studies using the Drug Abuse Treatment Cost Program Analysis (DATCAP), by M.C. Roebuck et al, Journal of Drug Abuse Treatment (2003).

Impacts of Substance-Abuse Treatment on State Budgets	1. What portion of the Nebraska State Budget is currently devoted to dealing with the impacts of substance abuse? a. What are the major areas of state spending that are most impacted by substance abuse? b. What portion of state spending is devoted to substance abuse treatment and prevention? c. How does this compare to surrounding states? d. How does this compare to the national average?	1. "Shoveling Up: The Impact of Substance Abuse on State Budgets," National Center on Addiction and Substance Abuse at Columbia (CASA), (2001). [*Appendix C: Tables I-VII*]
	2. What levels of treatment (and associated costs) are available at Nebraska Department of Corrections facilities?	2. "Nebraska Department of Correctional Services (DCS) FY-2004 Annual Report and Statistical Summary."

Table 3. Methamphetamine Treatment-Facility Cost Research Questions and Data Sources/Published Reports Consulted

To develop policy and implementation recommendations, the researchers performed an analysis of the current service distribution system in place for MA users in Nebraska. The following section illustrates the flow of offenders through the justice system, highlighting the points of contact where MA users are likely to encounter criminal justice and HHSS providers, along with the assessment and treatment options available to each provider.

Problem Statement: Methamphetamine Addicts in Nebraska

Substance Abuse and Dependence

A review and analysis of the SAMHSA report "State Estimates of Substance Use from the 2002-2003 National Surveys on Drug Use and Health"[1] reveals the following key findings:

- **A total of 180,412 persons 12 years of age and older (12.71% of that population) were estimated to be dependent on or abused alcohol or illicit drugs in Nebraska in 2003.**[2] *(Appendix D, Tables VIII-XVI show the estimated ranges of drug dependence and treatment needs in Nebraska and the state's Behavioral Health regions).*

- Of these, **49,113 were identified as illicit drug dependent/abusers,** of which **32,709** (66.6% based on SAMHSA admissions data)[3] **were estimated to be stimulant-related** and **22,396** (45.6%) **were methamphetamine or amphetamine dependent or abusers.**

Substance Abuse Admissions

A review and analysis of 2003 SAMHSA substance abuse treatment admissions data for Nebraska[4] reveals the following key findings:

- There were a total of 10,609 admissions for substance abuse treatment; of these, 4,320 were for alcohol only treatment, while 6,289 (64.4%) were for primary substances other than alcohol or alcohol as a primary substance in combination with a secondary illicit drug.

- Of these 6,289 non-alcohol only admissions, **4,188 (66.6%) were linked to methamphetamines, amphetamines or other stimulants;**[5] and after eliminating primary and secondary cocaine and other stimulant abusers from this population, **2,869 (45.6%) were linked to methamphetamines or amphetamines.**

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[1] This SAMHSA report presents state estimates on substance use based on the combined findings of the 2002 and 2003 National Surveys on Drug Use and Health (NSDUHs), formerly called the National Household Survey on Drug Abuse (NHSDA).

[2] This estimate uses 2002-2003 survey results rates applied to 2000 U.S. Census data.

[3] NSDUH survey findings are further refined by using SAMHSA treatment admissions data for Nebraska including estimates of the proportions of "alcohol w/secondary drug" and "other/unknown" classifications that were stimulant- and methamphetamine/amphetamine-related (see Substance Abuse Admissions footnote _).

[4] See *Appendix F* for a description of the Treatment Episode Data Set (TEDS) and the National Survey of Substance Abuse Treatment Services (N-SSATS) data and their limitations.

[5] This total includes estimates of the number of "alcohol w/secondary drug" and "other/unknown" classifications which were stimulant-related (cocaine, amphetamines and other stimulants). Alcohol w/secondary drug estimates were based on the proportion of primary drug admissions which were stimulant-related (70.5%), while a somewhat more conservative estimate of 50% stimulant-related was used for "other/unknown" classifications.

- Altogether, the **2,869 admissions linked to methamphetamines and amphetamines comprise 27.0% of admissions for substance abuse treatment (alcohol only + non-alcohol only) in Nebraska.**

Impacts of Substance Abuse on the Nebraska State Budget

A review and analysis of Nebraska state budget information conducted in 2001 by the National Center on Addiction and Substance Abuse at Columbia University (CASA)[6] reveals the following key findings (which *do not* include any Federal or local spending):

- **The state government of Nebraska spent about $291 million or 8.2% of the entire annual state budget ($3.5 billion) dealing with the impacts, regulation/compliance functions and problems of substance abuse. Of this amount, only about $9 million or .3% was spent by the state on substance abuse treatment, prevention and research.** *(See Tables I-VII in Appendix C for Nebraska and six surrounding states).*

Figure 2 below uses two columns to summarize Nebraska's state spending on substance abuse. The taller stack represents the total substance abuse dollars spent ($291 million), highlighting the $8,946,000 directed toward treatment, $17,492,000 directed to regulation/compliance, and a total of $264,665,000 burdening public programs. The shorter column addresses only those expenses burdening public programs, illustrating the areas of state spending in Nebraska most heavily impacted by substance abuse.

- The $66.4 million spent on the criminal justice system breaks down to $57.6 million for adult corrections and $8.8 million for juvenile justice.
- The $51.5 million spent on education includes both elementary and secondary levels.
- $72.8 million was spent on health.
- $35.6 million was spent on child/family assistance.
- $29.9 million was spent on mental health/developmental disability.
- $6.3 million was spent on public safety.

[6] "Shoveling Up: The Impact of Substance Abuse on State Budgets," by the National Center on Addiction and Substance Abuse at Columbia (2001) is based on detailed budget data for 1998 submitted by Nebraska and 46 other state budget officials.

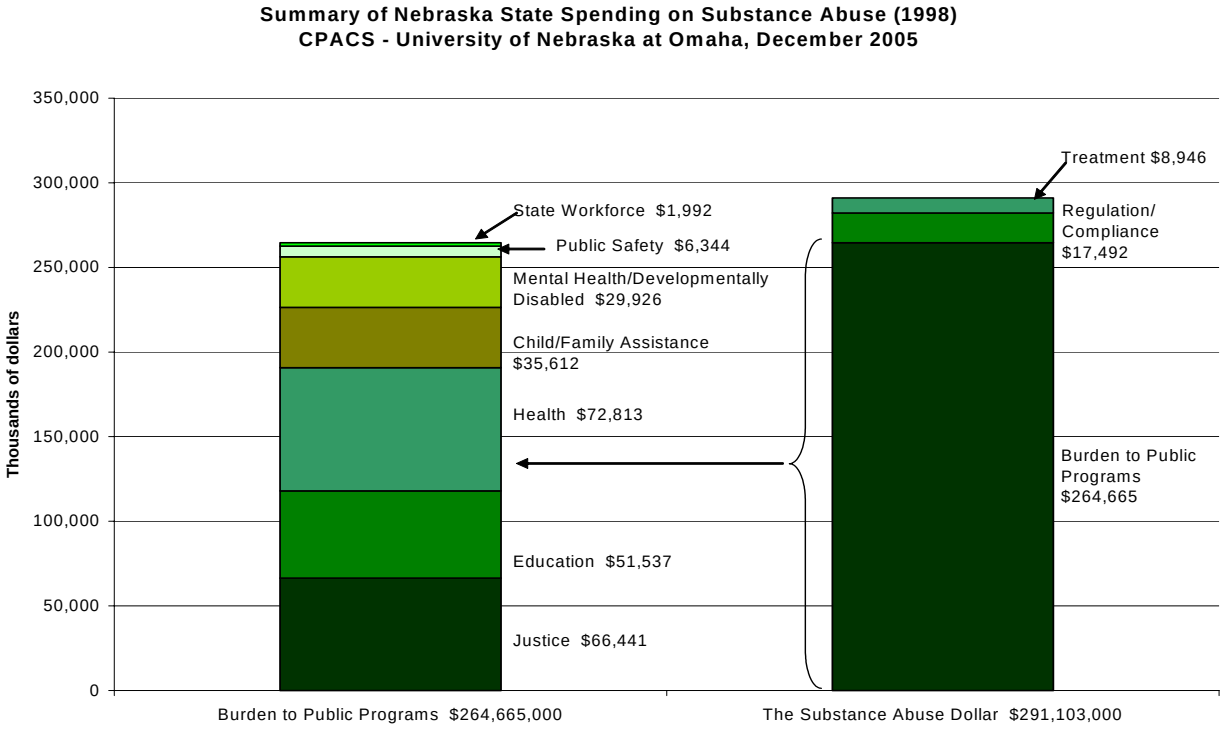


Figure 2. Summary of Nebraska State Spending on Substance Abuse (1998).

- For every dollar the state of Nebraska spends on substance abuse:

  - **91 cents goes to pay for the burden of this problem on public programs in the affected areas of criminal justice, elementary/secondary education, health, child/family assistance, mental health/developmental disability, public safety and the state workforce.**

  - **Only 3.1 cents goes to fund prevention, treatment and research programs aimed at reducing the incidence and consequences of substance abuse.**

  - The remaining 5.8 cents goes for regulation/compliance of alcohol and tobacco licensing, control and collection of taxes (compared to a national average of only .5 cents).[7]

    (Appendix C: Table I shows the total spending in each category in Nebraska, the amount and percentage related to substance abuse and the per capita amount spent for each person in the state).

- Even though **state spending on substance abuse** cannot be disaggregated by type of drug (e.g., methamphetamines), **nationwide results show that 78.2% is related to a**

[7] This proportion, amounting to .5% of the state budget, is the highest of all reporting states, matched only by Alabama and Washington.

combination of both illicit drugs and alcohol, while only 11.3% could be attributed to alcohol only, 9.1% to tobacco only and 1.4% to illicit drugs only.

- Based on these findings, **the estimated amount of state spending in Nebraska linked to abuse of illicit drugs (in combination with and without alcohol) is about $232 million** (79.6% of $291 million). **Of this amount, approximately $225 million goes toward cleaning up the wreckage of illicit drug abuse, while only about $7 million is applied to illicit drug prevention and treatment.**[8]

- The CASA study examining state spending on substance abuse provides an important context for the other findings and recommendations of the current Methamphetamine Treatment Facility Feasibility Study. These findings strongly suggest that a relatively modest increase in illicit drug prevention and treatment spending is the greatest opportunity for the State of Nebraska to reduce or curb the enormous amounts already being spent on dealing with and cleaning up the effects and wreckage of substance abuse.

This recommended increase in funding of an additional $8-16 million per year for illicit drug treatment and prevention generally matches the cost estimates for unmet demand in Nebraska (presented below under *Unmet Treatment Need and Demand)* for alternative modalities of treatment for high-, moderate- and low-need/risk clients and offenders.

Interaction between Substance Abuse and the Criminal Justice and Social Service Systems

Research suggests a small population of MA users is ready to receive treatment. The continued development of community based services at all levels of care and the recruitment of professional staff will help to ensure that this population receive treatment. However, many MA users initially pursue treatment as a result of their involvement with the justice or social service systems. Because of an arrest, allegation of neglecting their children or mental illness, a large number of MA users are forced into treatment as a condition their sentencing or case plan with Health and Human Services. Therefore, it is not enough for the State of Nebraska to provide treatment at each level of care, it must also understand how the LOC interact with the varying status of individuals within the justice and social service systems.

To aid in this understanding, *Figure 3* illustrates the movement of a MA user through the justice system. At each level of the system a MA user has the opportunity to avail himself to the services provided at that level. If, However, the MA user fails to utilize those services, he or she will continue to progress to the next level within the justice system. For example, a MA user sentenced to probation may fulfill the conditions of his/her probation, one of which is likely to be some type of substance abuse treatment, at which point the MA user would be released from the justice system and, ideally, continue to pursuer treatment in the community. In contrast, an

[8] As all regulation and compliance substance abuse spending is alcohol and tobacco only, the breakdown of the $232 million illicit-drug (in combination with and without alcohol) spending estimate is based on the total substance abuse spending ratio of 97:3 affected-program spending to treatment, prevention and research spending.

individual who violates the conditions of his/her probation will be remanded to the custody of the Department of Corrections, thereby continuing to the next level of services within the justice system. The practical application of this phenomenon is that MA treatment must be available at all levels within the justice system because there will continue to be a residual number of MA users who will either volitionally or non-volitionally fail to avail themselves to the treatment services available at the previous level. Additionally, MA users involved with Health and Human Services may or may not have contact with the justice system Therefore, it is equally necessary for treatment options to be available to MA users in that setting as well.

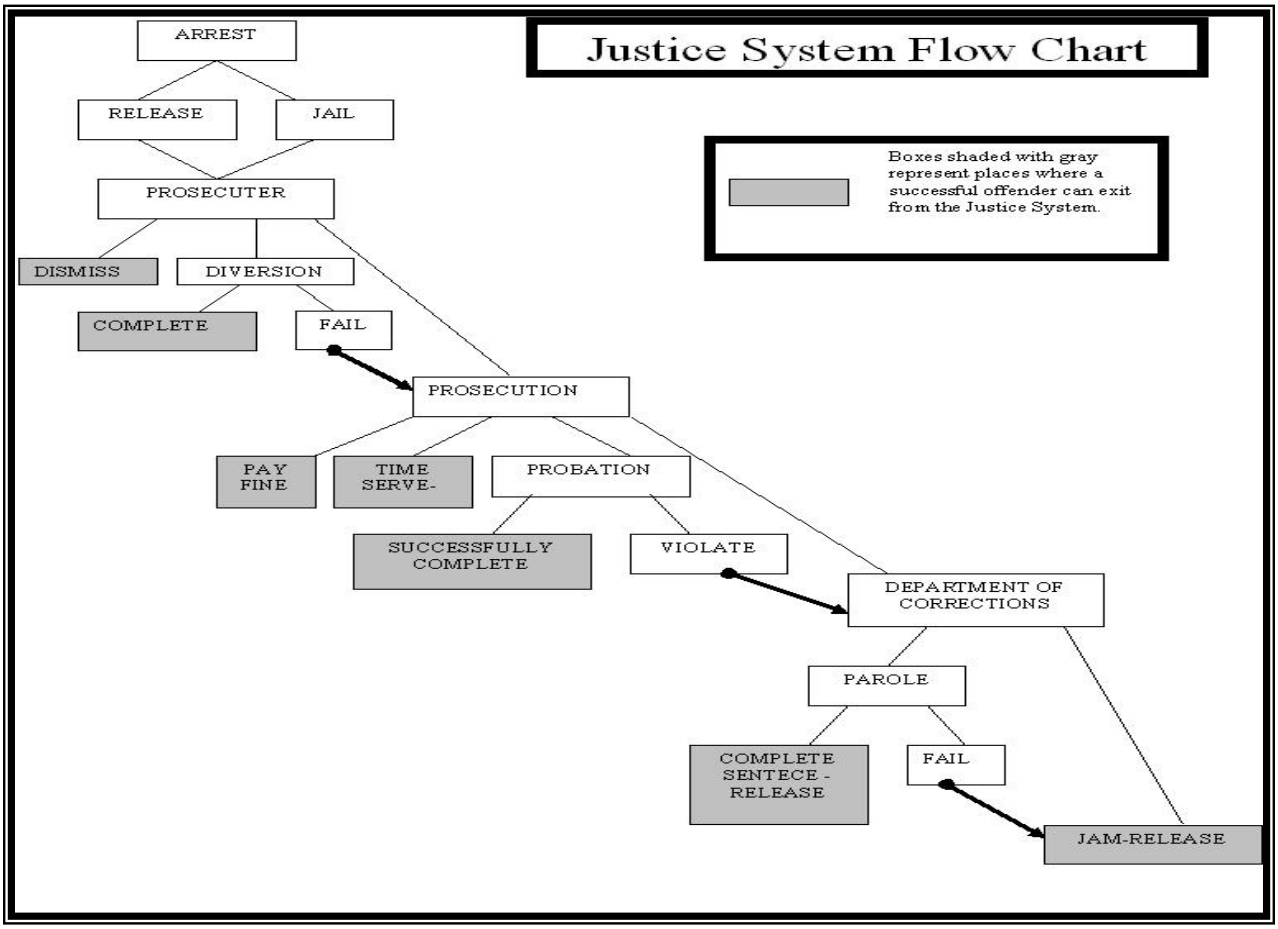


Figure 3. Flow of Offenders through Nebraska's Justice System.

Once we begin to understand the natural progression through the justice and social service systems, we are able to begin to identify at what terminal status a particular level of care can be maximized. Terminal status describes the last point that a MA user has contact with the justice or social service systems. *Figure 4* demonstrates the point in the progression through the system a particular service entity would have the most contact with a user. For example, the police will have the most contact with an arrestee.

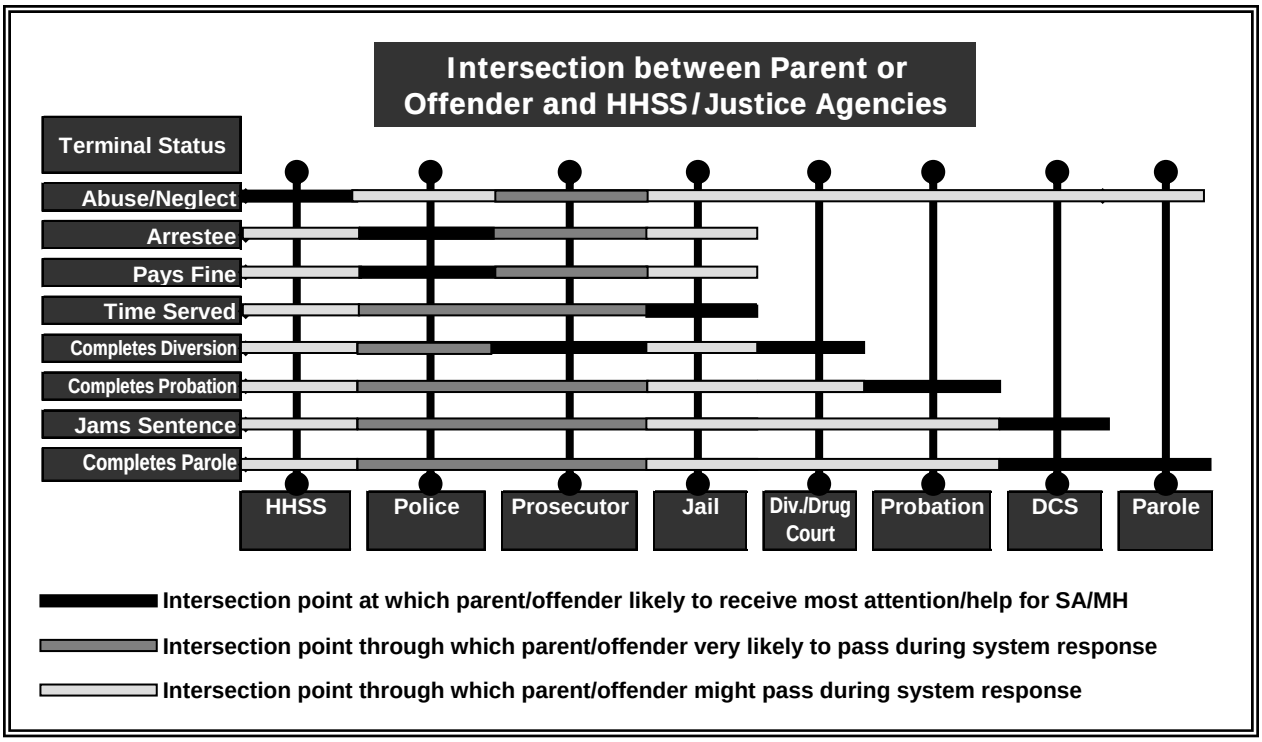


Figure 4. Intersection between Parent or Offender and HHSS/Justice Agencies.

Before proceeding to the discussion of specific recommendations, it is necessary to look at the current capacity within the state of Nebraska today. The beds and facilities described below serve not only users voluntarily seeking treatment, but also users who were involuntarily admitted as a condition of probation or drug court requirements.

Capacity: Nebraska Methamphetamine Treatment Services

Unmet Treatment Need and Demand

Table 4 summarizes the levels of drug dependence, drug dependence or abuse, and numbers of persons needing but not receiving treatment in Nebraska, Behavioral Health Regions.

STATE/Behavioral Health Region	Total 2000 Population (Persons 12 yrs. and over)	Drug Dependence (Persons in Past Year)	Drug Dependence or Abuse (Persons in Past Year)	User Needing/ Not Receiving Treatment (Persons in Past Year)
NEBRASKA	1,419,450			
Any Illicit Drug		34,635	49,113	45,990
Stimulant-Related Drug		23,067	32,709	30,629
Meth/Amphetamine-Related		15,793	22,396	20,972
Region 1	76,085			
Any Illicit Drug		1,856	2,633	2,465
Stimulant-Related Drug		1,236	1,753	1,642
Meth/Amphetamine-Related		847	1,200	1,124
Region 2	85,206			
Any Illicit Drug		2,079	2,948	2,761
Stimulant-Related Drug		1,385	1,963	1,642
Meth/Amphetamine-Related		948	1,344	1,259
Region 3	186,125			
Any Illicit Drug		4,541	6,440	6,030
Stimulant-Related Drug		3,025	4,289	4,016

Meth/Amphetamine-Related		2,071	2,937	2,750
Region 4	178,553			
Any Illicit Drug		4,357	6,178	5,785
Stimulant-Related Drug		2,902	4,115	3,853
Meth/Amphetamine-Related		1,987	2,817	2,638
Region 5	348,720			
Any Illicit Drug		8,509	12,066	11,299
Stimulant-Related Drug		5,667	8,036	7,525
Meth/Amphetamine Related		3,880	5,502	5,152
Region 6	544,761			
Any Illicit Drug		13,292	18,849	17,650
Stimulant-Related Drug		8,853	12,553	11,755
Meth/Amphetamine Related		6,061	8,595	8,049

Table 4. Illicit Drug-Related Dependent/Abusers Needing But Not Receiving Treatment in Nebraska and Behavioral Health Regions (2003).

- **A total of 45,990 persons 12 and over** (3.24% of the state population) **needed but did not receive treatment for an illicit drug use problem in 2003.**[9]

- Of these, **30,629 stimulant-related** (66.6% based on SAMHSA admissions data) and **20,972** (45.6%) **methamphetamine or amphetamine-related problem users needed but did not receive treatment.** *(See Appendix D: Table XVII for age group estimates.)*

It is important to distinguish between treatment need and treatment demand. "Treatment need" refers to those illicit drug-related dependent/abusers needing but not receiving treatment, although not necessarily requesting treatment. "Treatment demand "refers to those users seeking treatment, whether voluntarily or involuntarily as a condition of probation or drug court requirements. "Unmet treatment demand" refers to those persons who are drug dependent or

[9] Persons "needing treatment" are defined as those who are classified as either drug dependent or abusers. The status of these are based on the criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) (American Psychiatric Association, 1994), indicators of which are included in the survey questions. Those "not receiving treatment" did not receive any during the past 12 months.

abusers that "needed but did not receive treatment" and also "wanted, would seek or are ready for" treatment if it was available.

- Of the 45,990 persons who needed but did not receive treatment**, there is an estimated unmet treatment demand in Nebraska of 2,300 illicit drug, 1,531 stimulant-related and 1,049 methamphetamine- or amphetamine-related problem users.** [10]

The estimated gaps in substance abuse treatment services in Nebraska are illustrated by type of drug in four bar graphs in *Figure 5* below, which shows total prevalence of substance abuse/dependence, met demand (in treatment), those needing but not receiving treatment (not in treatment) and unmet demand (would seek, wanted or ready for treatment).

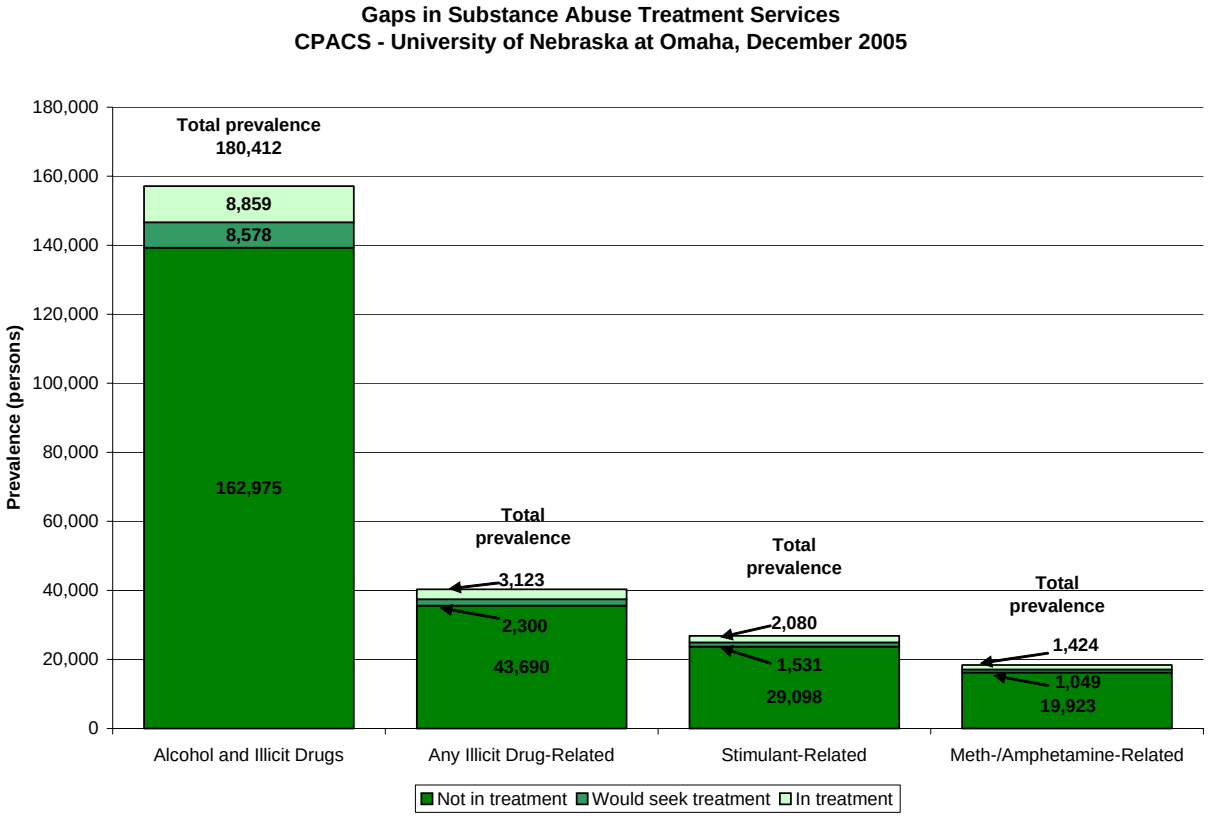


Figure 5. Comparison of Nebraska's total prevalence of substance abuse, met demand, unmet need and unmet demand by type of drug.

[10] As with the substance abuse/dependence estimates, the extent to which models used in other states accurately portray conditions in Nebraska is uncertain. A State of Colorado model (see "Analysis of Substance Abuse Prevalence, Treatment Resources and Treatment Gaps in Colorado," by Bruce Mendelson, 2002) used integrated survey findings to determine that 2.7% of problem users who did not receive treatment, wanted or would seek treatment if it was available. Similarly, data in correctional settings reveals relatively low levels of inmate unmet demand or "readiness," with about 10-13% of inmates (70-85% classified as needing treatment) involved in any form of treatment, despite such services being available in 90% of the facilities studies (U.S. Dept. of Justice, Office of National Drug Control Policy, 1998; Camp and Camp, 1997). To estimate overall unmet treatment demand in Nebraska, we use a conservative estimation rate of 5.0%.

Number of Beds

The SAMHSA March 31, 2003 *National Survey of Substance Abuse Treatment Services,* provided the number of beds and utilization rate for residential facilities and hospital inpatient facilities shown in *Table 5* below. Based on reporting facilities only, 34 residential facilities had 620 beds designated for substance abuse clients with a utilization rate of 100 percent. The two reporting hospitals had 14 designated beds with a utilization rate of 86 percent.

	Residential	Hospital inpatient
No. of facilities*	34	2
Designated beds	620	14
Utilization rate	100%	86%
Designated beds per facility (average)	18	7

*Excludes facilities not reporting both client counts and number of beds, facilities whose client counts were reported by another facility, and facilities that included client counts from other facilities.
Source: SAMHSA, "National Survey of Substance Abuse Treatment Services," March 31, 2003.

Table 5. Nebraska Substance Abuse Treatment Facility Capacity and Utilization Rate on March 31, 2003.

Since the SAMHSA report referenced above contains only summary information, it does not list the facilities by Behavioral Health Region of the state. For this information we looked at two sources:

Roster of Substance Abuse Treatment Center Roster (updated October 11, 2005) by the Nebraska HHSS, and
Substance Abuse Treatment Facility Locator Lists (updated April, 2005) by SAMHSA.

A problem with these two sources is that they list different facilities. The HHSS source lists 71 facilities while the SAMHSA source lists 86 facilities. Furthermore there were some facilities on one list but not the other—46 facilities were on both lists, 40 were on the SAMHSA list and not the HHSS list, and 25 were on the HHSS list and not the SAMHSA list.

Number of Facilities

Figure 6 below combines the two lists to show a total of 111 facilities statewide broken down by region. Based on this information roughly one-third (33) of Nebraska's counties had a substance abuse treatment facility.

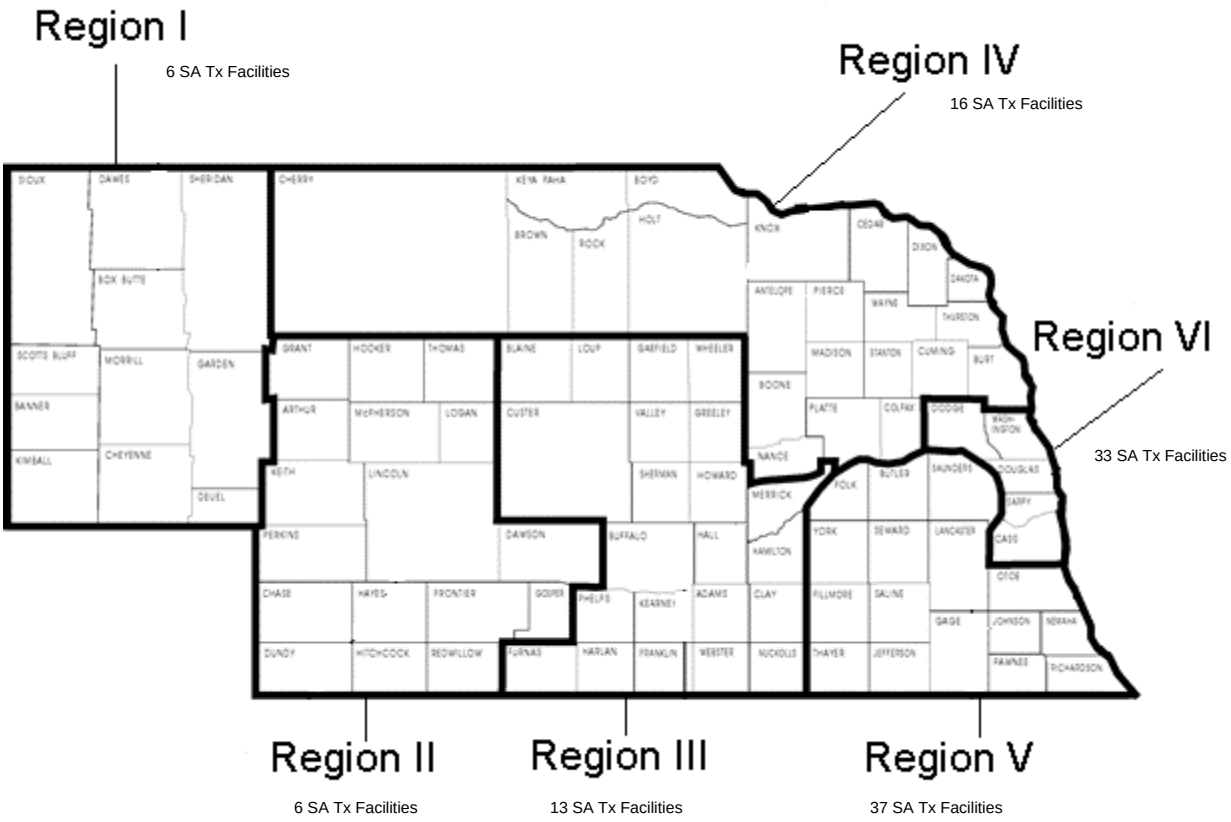


Figure 6. Nebraska Substance Abuse (SA) Treatment (Tx) Facilities by Region.

The most comprehensive description of substance abuse treatment facilities is the National Survey of Substance Abuse Treatment Services(N-SSATA) conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA). The most recent reported information is for March 31, 2003. There were 107 substance abuse treatment facilities that responded to the survey and reported that there were 4,573 clients in treatment. *Table 6* shows the distribution of the facilities and clients by type of care. There were 84 facilities with outpatient services with 3,879 clients; 35 facilities with residential services with 634 clients; and 5 facilities with hospital inpatient services with 60 clients.

	Facilities*		Clients in treatment on March 31, 2003		
	Number	Percent	Number	Percent	Median no. of clients per facility
Outpatient	**84**	**79**	**3,879**	**85**	**31**
Regular outpatient	82	77	3,081	67	24
Intensive outpatient	37	35	541	12	12
Day treatment/partial hospitalization	11	10	46	1	--
Detoxification	5	5	30	1	1
Methadone/LAAM maintenance	2	2	181	4	91
Residential	**35**	**33**	**634**	**14**	**16**
Short term	16	15	216	5	10
Long term	26	24	378	8	13
Detoxification	8	7	40	1	4
Hospital inpatient	**5**	**5**	**60**	**1**	**2**
Rehabilitation	3	3	58	1	10
Detoxification	3	3	2	0	--
Total	**107**		**4,573**		**29**

*Facilities may be included in more than one category.
Source: SAMHSA, "National Survey of Substance Abuse Treatment Services," March 31, 2003.
Table 6. Nebraska Substance Abuse Treatment Facilities and Clients in Treatment on March 31, 2003, by Type of Care.

A relatively new type of facility is the Substance Abuse Recovery Home. These homes are communal-living, mutual-help settings for persons in recovery of alcohol and substance abuse. Currently these homes exist in three of Nebraska's counties: Hall, Lancaster, and Douglas. *Table 7* shows the distribution of these homes and the number of beds by gender and county. In those three counties there are 42 facilities with beds for 244 men, 42 women, and 31 women and children.

	Facilities	Beds		
		Men	Women	Women and children
Hall	4	12	6	7
Lancaster	9	58	12	0
Douglas	29	174	24	24
Total	**42**	**244**	**42**	**31**

Source: Nebraska Health and Human Services System, Nebraska Substance Abuse Recovery Homes, updated 6/16/05
Table 7. Nebraska Substance Abuse Recovery Homes

The bed and treatment facility shortages revealed in this analysis reflect that Nebraska's existing capacity to treat addicts is overburdened at each level of care. The *Best Practices Roundtable Discussions* confirm this bed and facility scarcity, identifying among the primary barriers to implementing a best practices model for MA treatment in Nebraska that the waiting

list for all levels of treatment is too long, and that greater accessibility is needed to treatment facilities across Greater Nebraska.

Professional Capacity

One natural reaction to learning of Nebraska's bed and treatment facility deficiencies would be to redirect resources to create more beds. However, further analysis into Nebraska's professional capacity reveals a severe lack of professional capacity to staff new facilities. *Table 8* shows that the 1,949 mental health practitioners and the 348 alcohol and drug counselors were distributed throughout Nebraska's Behavioral Health Regions. However, 18 counties lacked a mental health practitioner, and 48 counties did not have an alcohol and drug counselor. (*Note: the map from which these numbers were derived [source: State of Nebraska, Credentialing Division, data updated 3/30/05] lists the total number of mental health practitioners as 1,953 and alcohol and drug counselors as 346. The numbers in the table are summarized from the county numbers listed in the map.)*

	Mental Health Practitioners	Alcohol and Drug Counselors
Region 1	64	19
Region 2	70	11
Region 3	247	56
Region 4	122	37
Region 5	536	99
Region 6	910	126
Total[11]	**1,949**	**348**

Table 8. Mental Health Practitioners and Alcohol and Drug Counselors by Nebraska Behavioral Health Region.

Developing Nebraska's capacity of behavioral health professionals plays a pivotal role in the success of any statewide response to the MA problem. The addition of new treatment facilities and new beds will be ineffective without adequate staff to provide those corresponding services. Unfortunately, the *Best Practices Roundtable Discussions* reveal that creating beds is less difficult than attracting qualified staff.

Average Duration at Level of Care

The average duration for each level of care used in the cost analysis section was determined by a review of the cost findings in the study, "Results from 85 studies using the Drug Abuse Treatment Cost Analysis Program (DATCAP)," by M.C. Roebuck and other economists supported by the National Institute on Drug Abuse (NIDA). *Table 9* below illustrates average durations by level of care with breakdowns to compare residential and outpatient programs.

[11] The map from which these numbers were derived list the total number of mental health practitioners as 1,953 and alcohol and drug counselors as 346. The numbers in the table are summarized from the county numbers listed in the map. Source: State of Nebraska, Credentialing Division. Data updated 3/30/05

LEVEL OF TREATMENT	PROGRAM TYPE	AVERAGE DURATION
RESIDENTIAL		
	Adult Residential	13 weeks
	Adolescent Residential	8 weeks
	Therapeutic Community	33 weeks
	Therapeutic Community (Prison)	28 weeks
OUTPATIENT		
	Standard Adult Outpatient	17 weeks
	Standard Adolescent Outpatient	13 weeks
	Intensive Outpatient	7 weeks
	Drug Court	46 weeks

Table 9. Durations by level of care comparing residential and outpatient programs.

Site Visits

The research team was directed to investigate the current facilities and capacity at several existing facilities across the state. Site visits were conducted at Hastings Correctional Center, Hastings Regional Center, Norfolk Regional Center, and McCook Work Ethic Camp to assess whether any of these sites could be utilized as a treatment facility. During each site visit, researchers toured the existing facilities and spoke with staff and administration to determine whether any of the existing facilities would be an appropriate venue for administering MA treatment. Table 10 below summarizes a comparison of the three site interviews.

Staff	
McCook WEC	82; 70 staff pd by Dept of Corrections; 70 medical staff; 70 staff from Metro College (altogether 210); staff-to-patient ratio nearly 1:1
Norfolk RC	@ 300+
Hastings RC	73
Number of Admissions	
McCook WEC	259
Norfolk RC	527
Hastings RC	NA
Number of Beds	
McCook WEC	75 male, 25 female (100 altogether)
Norfolk RC	208 bed psychiatric hospital
Hastings RC	156 beds
Cost per admission per year	
McCook WEC	$15,948
Norfolk RC	$180/;day; crisis center $500/day. HHSS pays $600 for first 6 days per patient; $340/day after that.
Hastings RC	HHSS pays $600 for first 6 days per patient; $340/day after that.
Eligibility	
McCook WEC	First-time non-violent male & female offenders; offenders must be convicted as an adult of a felony offense (offenders must be medically and physically fit to the program. 16-20 PSI; >29=prison)
Norfolk RC	Patients with mental health problems, specifically adults in need of inpatient psychiatric treatment.
Hastings RC	1. General psychiatric residential services provide treatment to all uninsured, under-insured, and indigent individuals needing residential psychiatric care 2. Adolescent residential substance abuse treatment center for males ages 13-19 years of age
Minimum/Max. Stay	
McCook WEC	120 days/180 days
Norfolk RC	Varied according to patients needs.
Hastings RC	41% of patients stay 1-30 days; 26.2% stay 31-89 days; 11.5% stay 90-180 days; 11.5% stay 181-165 days; 4.9% stay 336-370 days; and 4.9% stay 731-1460 days.
Chemical Dependence	

McCook WEC	94% chemically dependent; 28% MA abuse; 42% marijuana abuse, 60% dual diagnosis
Norfolk RC	25% MA abuse, 60% dual diagnosis
Hastings RC	NA
Treatment Focus	
McCook WEC	Altering criminal thinking and making rational choices, oriented toward the offender & the family
Norfolk RC	Acute inpatient mental health. Secure residential mental health. Intermediate residential mental health. Non-residential mental health (day treatment & medication management).
Hastings RC	Intermediate Residential Mental Health; Neuro-geriatric Outreach (clinical support to 200+ nursing homes statewide); Adolescent Substance Abuse Residential Treatment (Boys); Non-Residential Mental Health; Day Treatment; Medication Management; Assertive Community Treatment (ACT)
Treatment Phases	
McCook WEC	Step-down program. Ph1 "Thinking for a Change" cognitive restructuring; Ph2 Victim empathy, problem solving; Ph3 Job skills; Ph 4 Life skills (e.g., anger mgt.)
Norfolk RC	Acute inpatient mental health; secure residential mental health; intermediate residential mental health; non-residential mental health (day treatment & medication mgt).
Hastings RC	Intermediate Residential Mental Health; Neuro-geriatric Outreach (clinical support to 200+ nursing homes statewide); Adolescent Substance Abuse Residential Treatment (Boys); Non-Residential Mental Health; Day Treatment; Medication Management; Assertive Community Treatment (ACT)
MA Treatment Options	
McCook WEC	1. Set aside beds in existing facility for MA-specific offenders; develop MA-Detox wing in split housing unit. 2. Build new bldg to house @ 100 offenders in MA-Detox/Intensive O/Patient program
Norfolk RC	1. If NRC closes on schedule, State may start MA-tx pilot for DCS low-security inmates; 2. State should commission Program Statement for 225-250 bed tx facility for DCS medium/low security inmates
Hastings RC	None
Biggest Hurdles	
McCook WEC	1. Recruiting tx staff
Norfolk RC	1. Protecting cache of professional staff in Norfolk area during transition period b/n NRC closing and DCS tx facility opening
Hastings RC	1. No current capacity to provide MA-tx

Table 10. Site Visit Comparison for Hastings Correctional Center, Hastings Regional Center, Norfolk Regional Center, and McCook Work Ethic Camp, 2005.

Hastings Regional Center

The first site visit was conducted on September 27, 2005 at the Hastings Regional Center (HRC) and the Hastings Correctional Center (HCC). The researchers began by touring HRC. As a result of the State's decision to close the regional centers in Hastings and Norfolk and transition to community-based services, HRC is no longer operating as a regional center. HRC

has begun to shift to other uses for the facility. Because HRC is currently operating at capacity in this way, it cannot be considered as a possible resource for a treatment facility. As the services at HRC were curtailed, professionals left the facility and took jobs in other places.

Hastings Correctional Center

Researchers also toured HCC which is currently empty at this time. While this facility was in the possession of DCS, it was used as a medium security correctional facility. Most recently DCS contracted with the federal government and HCC was used as a detention center for illegal aliens, however that contract has expired. While in operation, this facility received high ratings from the agencies accrediting the facility. When HCC was transferred from the Department of Corrections to Health and Human Services in mid 2005, most of the security equipment in the facility was removed by DCS. The facility is now empty and, therefore, researchers did not conduct staff interviews. During the tour the researchers learned that a sprinkler system would have to be installed before it could be used as a MA treatment facility. Additionally, if the facility were to be used as a centralized treatment facility for DCS, all of the security features that were previously removed from the facility would have to be reinstalled.

There is an extensive campus surrounding HRC and HCC in Hastings. This land could possibly be utilized as a building site for the construction of a centralized treatment center for DCS. However, a program statement would have to be conducted before a determination could be made regarding whether this location would be the most cost effective site for such a facility.

Work Ethic Camp

On September 28, 2005, the team conducted a site visit at the McCook Work Ethic Camp (WEC). WEC has only been operating since April of 2001 and is a minimum/community secure facility. Individuals sentenced to WEC are there as a condition to their probation. The facility is in excellent condition and the environment is surprisingly pleasant. The atmosphere lacks the institutional feeling found in many correctional facilities. WEC has a capacity of 100 beds and has been consistently functioning at about 75 % of capacity. Administrators offered several explanations for this including the fact that judges are unfamiliar with the benefits of sentencing an individual to WEC. Researchers believe that by adjusting the pre-sentencing criteria used in placing probationers at WEC and educating judges on the exceptional services provided by this facility, WEC could be operating at 100% capacity in a short amount of time.

Several factors support utilizing WEC as a MA treatment facility. Researchers learned that 92% of the individuals admitted to WEC since its opening have been chemically dependent. Researchers also found that WEC staff are currently offering substance abuse treatment that is very similar to the MATRIX model. Staff members were confident that the MATRIX model could easily be implemented into their treatment program. Residents currently stay at WEC for 120 days (or approximately 16 weeks). This is the exact amount of time recommended for administering the MATRIX model. And finally, WEC has the ability to house MA addicts who need more intensive services in a separate unit. The dormitories at WEC are currently divided into four 25 bed units. One of these units is also divided into two smaller sections, one with 12 beds and one with 13 beds. Women are currently being housed in this unit, but administrators at WEC stated that this unit could be utilized for more intensive MA treatment.

In addition to these factors, WEC's working relationship with probation bolsters the assessment that WEC could be used to MA treatment. The literature is adamant that effective MA treatment requires that individuals continue to receive support services after completing the initial treatment. WEC has established a excellent working relationship with probation officers across the state ensuring that individuals leaving WEC benefit from much needed follow-up. Before an individual leaves WEC, staff develops a plan for transitioning from WEC to the community. That plan is then implemented by probation. The existence of follow-up resources will benefit individuals receiving MA treatment at this facility.

WEC is not without drawbacks. Because of its remote location, the facility has had difficulty attracting qualified staff to work there. A mental health position was posted for two years and never filled. To maximize WEC as a treatment facility, incentives may need to be implemented to attract the necessary professionals to work that the facility. This concern could also be addressed by utilizing the Telehealth capabilities that already exist at WEC to capitalize on professionals who may reside in other portions of the state.

Were WEC to excel as a treatment facility, expansion is possible at a reasonable expense.

Norfolk Regional Center

On October 5, 2005, the team visited the Norfolk Regional Center (NRC). NRC serves patients with mental health problems. Some of the patients housed in this facility have lived the majority of their lives there and would unable to function when released into the community. In fact, many of the patients at NRC thwart attempts at transition into the community because they fear leaving NRC. Like HRC, NRC is slated to close as Nebraska begins to rely more heavily on community-based services.

At this time, there are no plans to utilize NRC in another capacity. This suggests that, if HHS does in fact close NRC, the building and the existing staff could be utilized as a MA treatment facility. However, a recent JCAHO audit revealed the facility to be in violation of 1971 Fire & Safety Code Regulations. Although a different accreditation body would likely assess the facility for DCS treatment, the building will still require some sort of improvement. A new sprinkler system is estimated to cost $500,000.

When researchers broached the subject of HHS closing NRC, staff expressed support for the idea of converting the existing facility, personnel and resources into a substance abuse treatment facility. The presence of existing staff at NRC weighs heavily in its favor as a potential site for a MA treatment facility. Unlike HRC where staff dispersed to other jobs, the bulk of the staff from NRC remains. In light of the scarcity of treatment professionals in the state of Nebraska, this is viewed as a great resource.

The campus at NRC could also be utilized as a potential site for the construction of a new treatment facility. The State of Nebraska already owns this land, which reduces the overall cost of constructing the facility. The Norfolk community has consistently demonstrated support for the facility and the work that is done there. As at HRC, a program statement would have to be conducted before a determination could be made regarding whether this location would be the most cost effective site for such a facility. When comparing the costs of remodeling the current facility or constructing a new one, it will be important to consider the long-term costs of operating the facility in relation to the cost of construction. The out-dated infrastructure at NRC is inefficient when compared with current technology. A portion of the cost associated with constructing a new facility will be offset by the savings of a more energy efficient facility.

Best Practices

Review of Treatment Methods and Best Practices Literature

Review of Treatment Methods Literature

Methamphetamine (MA) abuse has reached epidemic proportions in the Midwest and continues to spread (Maxwell 2005) (Caulkins 2003). The Substance Abuse and Mental Health Services Administration (SAMHSA) study of national amphetamine treatment admissions from 1992-1999, ranked Iowa as the third highest state in the nation for admission for treatment of MA abuse at 118 per 100,000 population. In 1996, Iowa's rate of MA admissions was 250% times higher than that of the next highest state, California, which showed 92 admissions per 100,000 (2001). The Iowa Department of Public Health's *Iowa Substance Abuse Report* (1998) documents admissions to Iowa treatment facilities for MA abuse escalating from 1% of admissions in 1992 to 12% in 1998 – an increase of 1,100%. A report submitted to the Iowa Governor's Alliance on Substance Abuse (Havel 1997) affirms MA's infiltration of the Midwest, with the incidence of MA use among incarcerated Iowa adults rising from 4% to 30% from 1994 to 1997. The same report also reflects a shift from inhalation to intravenous use of MA among this population.

A review of the literature on treatment for methamphetamine dependence reflects the resourcefulness of drug abuse professionals as they strive to respond to the constant fluctuation of trends in substance abuse. Limited by severe budget constraints, scarce community resources, the blink-of-an-eye shifts of abusers' drugs of choice and preferred intake methods, and the geographic migrations of methamphetamine abuse, researchers and clinicians turn to the existing methodologies considered successful for stimulant use disorders.

Treatment methods dominating the literature include psychosocial and behavioral approaches adapted from experience with treatment of cocaine dependence, efforts to develop effective medication therapies, emergence of replacement pharmacotherapies, supplementation of treatment interventions with comprehensive case management outreach, and application of aversion therapy using both chemical aversion and electrical stimuli. The abundance of research devoted to the Matrix Model merits an in-depth discussion of this particular psychosocial and behavioral approach. Other programs are reviewed as the literature permits. Evaluations of treatment programs are presented, with particular attention to the Matrix Model. Finally, literature regarding development of treatments for MA users involved in the criminal justice system is reviewed.

Psychosocial and Behavioral Approaches

At this time psychosocial and behavioral interventions demonstrate the most empirical support for treatment of MA dependence (1998) (Rawson R A 2002) (Rawson R A 2000) (Huber A 1997). The cognitive-behavioral approach focuses on how thought affects feelings and actions, preparing patients for lifelong recovery by coaching them to identify and plan for triggers associated with substance abuse. The National Institute on Drug Abuse calls cognitive behavioral interventions "the most effective treatments for methamphetamine addiction" in their *Principles of Drug Addiction Treatment, A Research-based Guide* (1999), singling out the Matrix Model as the only specific treatment featured. The Matrix Model is an example of a cognitive-behavioral protocol adapted for stimulant use disorders in general, and MA

dependence specifically, from interventions successfully treating cocaine abusers in the early eighties (Obert J 2000). This application of cognitive-behavioral therapy is consistent with evidence suggesting that cocaine and MA users respond similarly to such strategies (Huber A 1997) (Rawson R A 2000) (Rawson R A 2002) . Huber et al. (Huber A 1997) reviewed the charts of 500 MA- and 224 cocaine-abusing patients treated at the Matrix Clinic in Rancho Cucamonga, CA between 1988 and 1995 to compare the two groups' responses to the Matrix Model treatment. With cocaine users remaining in treatment an average of 18.0 weeks compared to 17.1 weeks for MA-users and with 13.3% of cocaine users showing positive urinalyses compared to 19.3% for MA users (this difference was not significant), the Matrix model was concluded to be equally well-received by cocaine and MA users.

Matrix Model

Introduction

In 1986, with funding from a Small Business Innovative Research grant through the National Institute on Drug Abuse (NIDA), the Matrix Institute in Los Angeles instituted an outpatient treatment model for stimulant abusers. The developers integrated techniques and materials from numerous disciplines including the cognitive behavioral therapy models, relapse prevention and skill training into treatment protocols (Rawson R A 2004) (Obert J 2000). The result was a manualized, intensive 16-week outpatient treatment program, grounded in "user friendly" practical utility (Obert J 2005). The model has been continuously revised over the years to incorporate the most recent evidence-based practices pointing to long-term recovery from drug and alcohol dependence (2005). In 1999 SAMHSA commenced an effort to expand and evaluate the Matrix Model, and in 2003 the Center for Substance Abuse Treatment (CSAT), a division of SAMHSA, tested the Matrix Model through the *Methamphetamine Treatment Project*, the largest randomized clinical trial of treatments for methamphetamine dependence to date (Rawson R A 2004). Results of the *Methamphetamine Treatment Project* are presented below under the *Evaluations of the Matrix Model* section.

Empirically-Based Behavioral Change

To equip patients with daily skills and structures leading to a long-term drug-free recovery, the Matrix Model focuses on behavior change, rather than underlying causes or presumed psychopathology. Empirical support in scientific literature and application provide the foundation for the program's elements and schedule (Obert J 2000). The *National Institute on Drug Abuse* identifies several tested treatment approaches utilized in developing Matrix Model treatment materials, including relapse prevention and relapse analysis, drug education, 12-step programs, urine testing, and a number of specialized therapy groups (family education, early recovery skills, relapse prevention, social support, et al.) (1999). Each therapy session is topic-focused, guided by a user-friendly patient handout that is bound into a notebook for each client (Obert J 2005). Simple exercises, materials, and psychoeducational lectures are purposefully delivered in terms appropriate for the patient's stage of recovery, since in-depth concepts cannot be understood or tolerated during the first few days of MA abstinence (Obert J 2000).

The Therapist as Coach and Teacher

The Matrix Model very explicitly defines the therapist's role to function as teacher and coach. In this role, the therapist cultivates a positive relationship with the patient, using encouragement and a nonjudgmental demeanor to reinforce positive behavior change. Particular

attention is given to training the therapist in client-centered, motivational interviewing style to that builds the patient's self-esteem, self-worth and dignity. The model calls for therapist-patient interaction that is realistic and direct, cautioning against falling into confrontational or parental tones. Literature evaluating the Matrix Model attributes the relationship between the patient and therapist as being a vital component in determining engagement and retention success (Obert J 2000) (1999).

Patient Goals

Rawlins et al. (2002) describes the Matrix Model as a comprehensive approach, relying on cognitive-behavioral principles and five basic goals:

1. *stop drug use*
2. *learn issues critical to addiction and relapse*
3. *receive education for family members affected by addiction and recovery*
4. *become familiar with self-help programs*
5. *receive weekly monitoring by urine toxicology and breathalyzer alcohol testing*

Obert et al. (2000) point to the importance of time scheduling in creating structure in recovering addicts' lives. The Matrix Model teaches patients to use a paper schedule to chronicle their plans for each portion of their day, but never for more than 2-3 days at a time. The structuring concept is based on the notion that stressful or dangerous periods can be weathered more successfully when patients don't find themselves with idle chunks of time. Therapists use the schedule to enhance treatment by teaching patients to evaluate the proposed activities in terms of their potential for triggering relapse and their contribution to a safe, balanced lifestyle. By following up, therapists determine whether the patient could abide by the plan. The schedule also gives therapists a picture of the individual's day-to-day life.

Group Therapy Modality

Patients attend therapy sessions three times a week for at least four months. The Matrix Model reduces the cost of treatment by limiting individual sessions to three 45-minute sessions in the 16-week engagement. If an individual experiences a time of crisis, the patient may attend an additional individual session(s) to conduct relapse analysis, a specific exercise in the Matrix protocol assisting the therapist and patient to identify issues and events that preceded the relapse (Obert J 2000).

Obert et al. (2000) describes the specialized group settings wherein the majority of treatment is conducted. During Weeks 1-4 patients participate in Early Recovery Groups twice a week to learn craving deterrence, time scheduling techniques, secondary substance abuse avoidance, and community support utilization. Individuals attend Relapse Prevention Groups at the beginning and end of each week for all 16 weeks of treatment, covering the 32 manualized topics of the protocol. Weeks 5-13 feature Family Education Sessions where patients and their families engage in a group setting to address topics pertaining to substance abuse through slide presentations, videotapes, panels and group discussions. Patients enter Social Support Groups during the last month of treatment, to establish new nondrug-related friends and activities. Matrix model protocols require patients to attend "Introduction to 12-Step Meetings" held on site one night each week, to familiarize newcomers to the meetings in a more comfortable environment. Patients are encouraged to attend outside 12-Step meetings throughout the 16

weeks of treatment and to continue to access this community resource for support after graduating from the Matrix program.

Urinalysis/Breath Testing

The nonjudgmental character of the Matrix Model offers no consequences for positive results from urine tests that are conducted randomly on a weekly basis. Rawson (Rawson 1999) emphasizes the role that urinalysis plays in establishing accountability for slips and relapses, but warns therapists to respond without incrimination, as this may lead to full-blown relapse. Obert et al. (Obert J 2000) suggest that positive urine tests be viewed as sign posts for adjusting the treatment plan and an opportunity to discuss coping strategies to prevent a complete relapse. Both Rawson and Obert recommend additional testing (e.g. Breathalyzer®) in light of the fact that stimulant users tend to struggle with secondary alcohol or marijuana use. Negative drug tests provide tangible proof for the patient, family and therapist that the patient is clean and sober (Obert J 2000).

Evaluations of the Matrix Model

A number of projects have demonstrated statistically significant reductions in drug and alcohol use by subjects treated with the Matrix Model(1999). The CSAT *Methamphetamine Treatment Project* represents the largest trial to date on treatments for MA dependence (Huber A 2000) (2005). Funded by SAMHSA and CSAT, researchers from the Matrix Institute on Addictions and the UCLA Integrated Substance Abuse Programs implemented and evaluated the Matrix Model in comparison to the "treatments as usual" implemented at the seven study sites in three western states (CA, MT, and HI) (Huber A 2000) (Herrell J 2000). Each site recruited 150 MA-dependent patients who were randomly assigned to receive either the Matrix Model or the "treatment as usual" for each individual site (Huber A 2000). Findings demonstrated that MA-dependent individuals responded positively to the Matrix Model's treatment protocols (Rawson R A 2004) (2005). The study indicated that patients assigned to the Matrix treatment were 38% more likely to stay in treatment, 27% more likely to complete treatment, and 31% more likely to have negative MA urine test results, compared to patients participating in the "treatment as usual" protocols (Rawson R A 2004). Rawson et al. (Rawson R A 2004) observed that the significantly improved in-treatment performance of Matrix clients represents an advancement in the field, although discharge and follow-up outcomes did not demonstrably differ from those of the control group. Zweben suggests that the *Methamphetamine Treatment Project* findings support the value of integrated treatment for co-occurring conditions, emphasizing the vital role that training counseling staff to handle psychotic symptoms plays in successful treatment for MA dependence (Zweben J 2004) (Maxwell 2005).

Further study of the *Methamphetamine Treatment Project* has been devoted to address the gap between substance abuse research and practice, with particular attention to issues pertaining to the effective transfer of a new comprehensive treatment protocol into the community drug treatment system. Approximately half-way through the *Methamphetamine Treatment Project,* Brown conducted individual interviews at all 7 sites of all principal investigators, evaluators, clinical supervisors, Coordinating Center personnel, agency directors and CSAT personnel (n = 35), and conducted 15 focus groups to interview the clinical and research staffs (n = 50) (Brown 2004). Participants were asked about research-to-practice issues that they encountered during the project. Brown (Brown 2004) reports the participants' suggestions for integrating research and practice in community-based treatment organizations:

- *Continue to have a bridging mechanism or third party like the Coordinating Center;*
- *Address recruitment early and hire personnel specifically for recruitment purposes*
- *Conduct a more extensive initial investigation of sites, perhaps even before the sites are selected to receive the grant monies;*
- *Make efforts to build relationships and establish roles early in the research project by having retreats and similar, relationship-building activities*

Using Brown's qualitative study (Brown 2004), Obert et al. (Obert J 2005) analyzed *Methamphetamine Treatment Project* counselors' responses to the practitioner concerns regarding manual-based psychotherapies compiled by Addis (Addis M 1999). Counselors did not indicate that the Matrix Model's manual-based treatment protocols interfered with their ability to develop a therapeutic bond. Obert et al. (Obert J 2005) suggested possible Matrix protocols that may have contributed to stronger therapeutic alliances, including the frequency of visits (3x per week), the philosophy of nonjudgmental counselor as coach and teacher, and the consistency of having a single counselor.

Initial concerns regarding the manual-based Matrix Model were recorded. Clinical supervisors observed that new counselors and counselors trained in standard treatment modalities that used techniques involving confrontation, labeling, and the client's need to "bottom out", reported difficulty adjusting to the Matrix Model. Many counselors objected to the Matrix Model's lack of consequences for clients who were not compliant, doubting that the treatment would work with their populations. Counselors also reported trouble concentrating on their client while concentrating on the presentation of the manual-based material. After the project was underway, counselors reported becoming more and more at ease with the material with each successive 16-week rotation, allowing them to refocus on their nonjudgmental relationship with the client. The qualitative interviews conducted a year and a half into the project reflected counselors' appreciation for how "empowering", "client-driven" and "respectful to clients" the Matrix Model proved to be (Obert J 2005).

Personnel at six out of seven study sites criticized the Matrix Model for being inattentive to mental health issues and co-occurring disorders. Personnel at four out of seven study sites criticized the Matrix Model for giving inadequate attention to cultural, socioeconomic, and gender issues such as domestic violence and sexual abuse. (Obert J 2005) These complaints are consistent with the three problems that Addis et al. (1999) identified in relation to clients' needs: (1) manual-based treatments ignore individual client differences; (2) manual-based treatments cannot meet the needs of multi-problem clients; and (3) manual-based treatments ignore clients' emotions. Addis et al. (1999) suggest that researchers and trainers give special attention to personalizing manual-based approaches and methods for dealing with emotional issues within the framework of structured therapy.

Counselors reported greatly increased job satisfaction during the course of the study. The Matrix Model's easy to learn format was credited for increasing counselors' sense of competence. The supervision component of the study was also recognized as a factor contributing to job satisfaction. Supervisors with strong backgrounds in both the Matrix Model and clinical supervision consciously worked to promote feelings of self-efficacy within the therapist group, using tools like weekly teleconferences to deliver frequent supervision. Obert et al. (Obert J 2005) concluded that a manualized treatment program will increase its chance of succeeding by requiring concerted supervision efforts, at least at the introduction of the problem.

Counselors from three sites reported that they felt free to improvise when components of the model did not fit their client population. Counselors from two sites felt restricted by the Matrix Model. These two sites also had more negative attitudes toward the model, the clinical training and oversight (Obert J 2005). Counselors and researchers from four sites found that the manual and lessons were written at a level beyond comprehension for their obviously impaired clients, detracting from therapy sessions with translations, interpretations and explanations. Counselors from two sites reported difficulty implementing the manualized sessions with "clients who had little or no clean time" (Obert J 2005).

Below is a list of "lessons learned" about delivering manual-based treatment in community drug treatment settings, derived from Obert at al.'s study of implementation of the Matrix Model during the *Methamphetamine Treatment Project* (Obert J 2005):

- *Importance of strong, frequent supervision*
- *Longer learning curve required to achieve proficiency in delivering a manual-based protocol*
- *New ways to shorten the training required to master the materials are needed*
- *Research on personalization and individuation of a manual-based treatment approach*
- *Understanding the culture of a clinic before new methodologies are introduced*
- *Get buy-in of personnel at all levels of the organization before the project commences*

Relapse Prevention

Relapse Prevention is another example of a cognitive-behavioral therapy that has evolved to address multiple populations of substance abusers. Originally developed as a treatment for alcoholism, the model was later tailored for cocaine abuse. Relapse prevention techniques are adapted for MA addiction and incorporated into the Matrix Model (1999).

The National Institute on Drug Abuse's *Principles of Drug Addiction* (1999) identifies a collection of cognitive-behavioral strategies designed to teach individuals to identify and correct problematic behaviors:

- *Exploring the positive and negative consequences of continued use*
- *Self-monitoring to recognize drug cravings early on and to identify high-risk situations for use*
- *Developing strategies for coping with and avoiding high-risk situations and the desire to use*
- *Central element is anticipating the problems patients are likely to meet and helping them develop effective coping strategies*

Studies show that individuals retain the skills they learn through relapse prevention therapy after treatment. One unidentified research study listed in *Principles* (1999) reported that throughout the year following treatment most individuals participating in relapse prevention therapy still maintained the progress gained.

Co-Occurring Methamphetamine Expanded Treatment (COMET)

SAMHSA recently announced funding of a program for 2004-2007 to reduce MA abuse among seriously mentally ill individuals in Clark County, WA. The Co-Occurring Methamphetamine Expanded Treatment (COMET) Program targets individuals dually diagnosed with MA addiction and serious mental illness by integrating two best practice models of treatment. The Matrix Model will address stimulant abuse and Assertive Community Treatment

will provide intensive case management services. The Regional Research Institute of Portland State University is conducting the 3-year evaluation (Herinch 2004).

Medication Therapy

Rawson et al. observes that research to develop medications to treat MA-related disorders is in its infancy (Rawson R A 2002). The literature is in agreement that there are currently no pharmacological treatments with demonstrated value for MA dependence (Rawson R A 2002) (1998). The National Institute on Drug Abuse's *Principles of Drug Addiction* (1999) notes that the current pharmacological approach, adapted from treatments for cocaine abuse, has not been successful. Clinical studies have yet to isolate a single agent that proves to be efficacious.

Rawson and Brethen state that no medications exist for quick, safe reversal of life-threatening MA overdoses (Rawson R A 2002). *Principles (1998)* reports that the established protocols used by emergency room physicians for potentially fatal complications of MA overdoses focus on the immediate physical symptoms, commonly relying on ice baths to treat hyperthermia and anticonvulsant drugs for convulsions (1998).

Rawson and Brethen also state that there are no drugs that reliably reduce the paranoia and psychotic symptoms (Rawson R A 2002). *Principles (1998),* however, recommends antianxiety agents such as benzodiazepines as helpful in cases of extreme excitement or panic, and short-term use of neuroleptics for MA-induced psychoses. *Principles* also reports that antidepressant medications can be helpful in reducing depressive symptoms for recently abstinent MA-users (1998).

Hopeful that antidepressant medication could improve retention in drug treatment and lead to better outcomes, Galloway and colleagues hypothesized that imipramine, a tricyclic antidepressant, would reverse the possible dampening affect that repeated exposure to cocaine may have on the brain's reward systems (Galloway G 1994). Their study administered either 10 or 150 mg/day of imipramine to 183 male and female volunteers who were cocaine or MA abusers resulted in subjects treated with the larger amount of imipramine staying in treatment longer, averaging 34 days compared with 17 days for those in the control group. The imipramine therapy was supplemented with access to psychiatric and medical care, along with intensive drug abuse group counseling. The common body of research suggests that more treatment is tied to better outcomes; this is in opposition to this study's results, wherein subjects that received the larger dose stayed in treatment longer. Therefore, the use of imipramine for MA abuse is not supported by the data.

Shoptaw et al. (Shoptaw S 2005) recently reported significant reductions in MA use and sexual risk behaviors in a randomized controlled trial of MA-dependent gay and bisexual males. These promising results indicate that drug treatment may serve as an HIV prevention strategy for these populations.

Replacement Pharmacotherapies

Rawson et al. (Rawson R A 2002) also report that there are currently no pharmacotherapies that are reliably successful in treating MA dependence. To further research in this area, the Methamphetamine Clinical Trials Group (established by NIDA) is conducting double-blind, placebo-controlled trials of promising pharmacotherapies at sites in geographic areas where MA use has been deemed a major health problem. A coordinating center at UCLA manages a network of sites in San Diego and Costa Mesa, CA, Honolulu, HI, Des Moines, IA, and Kansas City, MO. (Rawson R A 2002)

Maxwell (Maxwell 2005) identifies replacement/agonist-like pharmacotherapy as an emerging treatment for stimulant dependence. Researchers are working to adapt treatments from successful experiences with nicotine and opioid dependence. *Principles of Drug Addiction (1999)* describes opiate addicts stabilized on sustained dosages of long-acting synthetic opiate medication as being able to function normally, engaging more readily in counseling and other behavioral interventions. *Principles* recommends supplementation of opiate agonist maintenance programs with individual and/or group counseling, along with medical, psychological and social services as needed.

Maxwell (Maxwell 2005) envisions an MA agonist-type pharmacotherapy combined with behavioral therapy components. Volkow et al. call for therapeutic approaches that include both pharmacological and behavioral interventions. They support a model combining pharmacological and behavioral treatments to increase sensitivity to natural reinforcers and establish alternative reinforcing behaviors, essentially increasing the value of the nondrug reinforcers. (Maxwell 2005) ** (Volkow N 2003). Obert et al. (Obert J 2000) express hope for the combination of a soon-to-be-determined medication with psychosocial therapy for MA dependence, anticipating improved retention in the Matrix model thanks to the therapy's effects on cognitive function, mood elevation, and craving reduction. In an examination of the status of preclinical agonist pharmacotherapy strategies pertaining to the use of stimulant medications in cocaine dependence and amphetamine replacement strategies for amphetamine dependence, Grabowski et al. (Grabowski J 2004) reinforces the integration strategy, recommending integration of a potent stimulant with quality behavioral therapy and appropriate monitoring procedures.

Comprehensive Case Management

Maxwell observed that comprehensive case management was found to be an effective intervention for MA abusers (Maxwell 2005), with Cretzmeyer et al. (Cretzmeyer CM 2003) specifically noting comprehensive case management's success in improving employment status and lowering the incidence of depression.

In the Iowa Case Management Project, treatment interventions were supplemented with outreach activities, including visiting clients in their homes, assisting with transportation to and from services, and providing limited emergency funds. Cretzmeyer (Cretzmeyer CM 2003) identified five functions as broad clinical guidelines for service delivery:

1. *contracting and negotiating;*
2. *assessment and monitoring;*
3. *brief solution-based counseling;*
4. *planning and referral;*
5. *evaluation of process and outcomes.*

To determine the effectiveness of case management in improving outcomes of substance abuse treatment, Hall et al. (1999) investigated a sample of 422 clients admitted to the Mideastern Council on Chemical Abuse, a facility in rural Iowa. Of these 422 subjects, 41 reported amphetamines as their primary addiction. 90% (36) of the 41 amphetamine abusers participated in a residential program and the remaining 5 amphetamine abusers participated in an outpatient program. Through random assignation, three-fourths of the 422 clients received case management through one of three conditions, all following the Iowa Case Management model. The remaining one-fourth served as the control group, receiving standard substance abuse

treatment services. Hall et al. interviewed participants on their status in several life domains for a period of 12 months. Overall, clients who received Iowa Case Management saw employment increase from a mean of 6.3 days at baseline to 18.5 days at the 12 month follow-up, while the clients in the control group saw an increase in employment from a mean of 5.6 days to 13.4 days. At follow-up interviews, the amphetamine abusers receiving Iowa Case Management reported a nearly significant lower incidence of depression than clients in the control group (p=.07). Clients in all 4 conditions, including the control group, saw a significant decrease in drug use. Iowa Case Management was not deemed to impact drug use or other key outcomes beyond that provided by standard treatment. Hall et al. concluded that MA abusers did not respond differently to comprehensive case management from the subjects reporting primary abuse of other drugs.

Aversion Therapy

Volkow et al. suggest interventions to decrease the rewarding value of drugs, such as pharmacological treatments that interfere with the drug's reinforcing effects / treatments that make the effects unpleasant (Volkow N 2003) (Maxwell 2005). An earlier study by Frawley and Smith (1992) integrated aversion therapy into a multi-modal treatment program. Patients received therapeutic counseling in educational groups, individual sessions, family sessions and aftercare planning. The researchers obtained follow-up data on 156 of 214 patients who had completed the initial inpatient treatment program at one of four hospitals. 58% of the subjects tested positive for cocaine use, 38% were positive for marijuana, and 6% (n = 9) tested positive for amphetamines on admission into treatment. The program attempted to pair an aversive stimulus with the act of using a particular stimulus. Nausea caused by oral emetine was associated with the act of snorting the substance (chemical aversion), while irritating, but not painful electric shocks on the forearm were associated with the act of using cocaine or MA (faradic/electrical aversion). According to data from phone interviews, 53% of patients who abused either or both cocaine or MA remained abstinent 12 months after treatment. The study was marred by a lack of standardized assessment procedures for outcomes (i.e., drug use) and the lack of a comparison group or random assignment to research conditions. Researchers, however, considered their results promising (Cretzmeyer CM 2003) (Frawley P 1992).

Outpatient Drug-Free Treatment

Principles of Drug Addiction Treatment identifies Outpatient Drug-Free Treatment as a less expensive alternative to residential or inpatient treatment, particularly applicable for employed individuals or individuals with extensive social supports. The patient's characteristics and needs dictate the best choice of programs ranging from low-intensity treatment (offering drug education and admonition) to high-intensity day treatment (comparable to residential programs). Group counseling is emphasized by many outpatient programs. Some outpatient programs treat patients with medical or mental health problems co-existing with their drug disorder (1999).

Coerced Treatment Research

The literature reflects a public outcry for policymakers, legal officials, and service providers to address the personal and societal effects of MA abuse (Rawson 1999). One response is the Comprehensive Methamphetamine Control Act of 1996, which strengthens law enforcement initiatives, tightens regulatory powers, and mandates research initiatives (Rawson

1999). Cretzmeyer observes the severe legal sanctions that MA users can now incur, citing Iowa's $1 million fine and up to life in prison for MA users (Cretzmeyer CM 2003).

The effect of habitual offender laws on prison admissions and populations is relatively unknown. Some research suggests that habitual offender laws have increased prison admissions at the state level, yet other research has not. These mixed findings most likely result from one key issue, the degree to which habitual offender laws are used by criminal justice professionals. The most consistent finding across the literature is that habitual offender laws are rarely used for charging offenders thereby making them mostly symbolic in nature. They appear to be a way for politicians to demonstrate a "get tough" stance on crime, while at the same time not actually affecting criminal justice operations. To the degree that these laws become popular among prosecutors, they do appear to have the ability to increase prison admissions. More importantly, to the degree that offenders are aware of habitual offender statutes, some research suggests that these laws may actually promote violent crime and exacerbate a state's homicide rate. At the very least, most scholars suggest that these laws will have very little or no impact on crime.

The increasing cost of incarceration and the demonstrated link between crime and substance abuse have led to the development of strategies using criminal justice system sanctions to require offenders to enter substance abuse programs (Brecht M 2005). Rawson et al. (Rawson R A 2002) observes the critical importance of developing treatments for MA users involved in the criminal justice system (Rawson R A 2002) (Maxwell 2005). The quest to explore what role the criminal justice system can play in the treatment of drug addiction makes the topic of coerced treatment of particular interest in the literature.

Outcomes and Concerns

There has been much conjecture regarding whether individuals under legal coercion can achieve positive outcomes to MA treatments similar to those enjoyed by individuals not under legal pressure. Wild attributes the controversy surrounding coerced treatment to its potential conflicts with the psychological processes involved in treatment (i.e., motivation, engagement, and compliance). Other researchers refer to the belief that lack of internal motivation may obstruct successful outcomes (Brecht M 2005) (Rosenthal 1988) (Platt 1994).

Principles of Drug Addiction Treatment (1999), however, counters these objections with research demonstrating that individuals entering treatment under pressure achieve outcomes as positive as those who enter treatment without pressure. In a study by Brecht et al. (Brecht M 2005), 350 Los Angeles County MA users were evaluated, comparing background and treatment characteristics and selected treatment outcomes across groups defined by existence of coerced treatment for MA. The pressured and nonpressured MA users saw no statically significant difference in outcome successes. The chief difference observed was a greater percentage of pressured respondents relapsing within 6 months of treatment (59% vs. 49% for non-pressured. p = 8).

Farabee et al. (Farabee 1998)observed that just because clients enter treatment under pressure, the treatment may not be involuntary. In fact, several studies suggest that criminal justice coercion may increase patients' internal motivation to produce more successful treatment outcomes (De Leon 1994) (Joe 1999) (Simpson 1993). Coerced Treatment research points to positive results for criminal offenders in general, with specific studies exhibiting success with heroin abusers (McGlothlin WH 1977; Brecht M 1993; Prendergast M 1995; Anglin MD 1998; Hiller M 1998; Miller N 2000).

Benefits

Principles of Drug Addiction Treatment (1999) makes a compelling case for integration of substance abuse treatment with the criminal justice system. Research indicates that combining criminal justice sanctions with drug treatment during, after or in lieu of incarceration can interrupt or shorten a career of drug use, since drug users often encounter the criminal justice system at an earlier stage than other health or social systems; encourage drug abusers to stay in treatment for a longer period of time; and reduce the risk of recidivism to drug-related criminal behavior.

A number of studies support the idea that coerced treatment helps recovering MA addicts stay out of jail:

- A study of inmates enrolled in a therapeutic treatment program in the Delaware State Prison that continued to receive treatment in a work-release program after prison were shown to be 70% less likely than nonparticipants to experience a drug relapse and incur rearrest. (1999)

- Recidivism numbers from the *Iowa Adult Methamphetamine Treatment Project – Final Report, 2003* indicated that 90.4% of MA clients had not been arrested 6 months after treatment and 95.7% of MA clients interviewed one year after treatment had not been arrested during the previous 6 months (Roth 2003).

- The Year Six Report of the *Iowa Project Outcomes Monitoring System* 2004 recidivism numbers indicated no arrests in the six months after treatment for 86% of MA users; 90.7% of alcohol users; 79.2% of cocaine users; and 86.8% of marijuana users. These rates are compared to 30.9% of clients who had not been arrested in the 12 months prior to treatment. (Johnson A 2004)

Models

A number of community-based treatment programs for criminal justice populations offer offenders with substance abuse dependencies alternatives to incarceration. Examples listed in *Principles* include limited diversion programs, pretrial release conditional on entry into treatment, and conditional probation with sanctions. (1999)

Treatment Accountability and Safer Communities (TASC) offers offenders one such alternative to prison. The TASC model represents a comprehensive approach to address the needs of drug-addicted offenders in an outpatient, community setting. By providing drug treatment in tandem with the criminal justice system, personnel can identify drug-involved offenders at an earlier stage, conduct assessments and refer the addicts to appropriate community services. Offenders may be monitored for drug use through mandatory drug testing and legal sanctions are used as inducement for offenders to remain in treatment.

The Drug Court model is proving effective in decreasing costs, improving treatment program retention, and decreasing recidivism for drug-addicted offenders (Belenko 1998; 1999; Terry 1999; Guydish 2001; 2002). In the Drug Court model, participants undergo long-term treatment, counseling, sanctions, incentives and frequent court appearances. Participants exhibiting the desired behaviors, as monitored through treatment attendance and mandatory urine tests, can earn rewards of reduced sentences and even dismissal of charges (Rawson R A 2002).

To date, however, the literature reflects little but anecdotal data on drug outcomes pertaining to offenders who abuse MA (Zweben 1999).

For treatment of incarcerated addicts, there is a body of empirical data supporting the effectiveness of the Therapeutic Community model in reducing drug use and recidivism to criminal behavior. This model segregates substance abuse patients from the general prison population, to ensure that the "prison culture" won't obstruct recovery progress. Returning inmates to the general prison population after treatment endangers the patients' progress achieved through therapy. Continuation of treatment after release from prison significantly decreases the chance for relapse to drug use and return to crime. (1999)

The Prison-Based Treatment Program model delivers treatment based on the Therapeutic Community or Residential Milieu Therapy models and includes didactic drug education classes and self-help programming. *Principles of Drug Addiction Treatment* describes the most effective Prison-Based Treatment Program models as those that integrate criminal justice and drug treatment systems and services. Counselors work together with criminal justice personnel to create a system of sanctions and rewards for inmates receiving drug rehabilitation treatment. The treatment and criminal justice personnel also combine their efforts to develop and implement screening, placement, testing, monitoring, and supervision plans. Like the Therapeutic Community model, the Prison-Based Treatment Program extends beyond release from prison with continuing care, monitoring, and supervision during parole and reentry into the community (1999).

Review of Best Practices Literature

Principles of Drug Addiction Treatment (1999) outlines a set of overarching principles for effective substance abuse treatment:

- No single treatment is appropriate for all individuals
- Treatment needs to be readily available
- Effective treatment attends to multiple needs of the individual, not just his or her drug use
- An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs
- Remaining in treatment for an adequate period of time is critical for treatment effectiveness
- Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction
- Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies
- Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way
- Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use
- Treatment does not need to be voluntary to be effective
- Possible drug use during treatment must be monitored continuously
- Treatment programs should provide assessment for HIV/AIDS, Hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help patients modify or change behaviors that place themselves or others at risk of infection
- Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment

Keeping these recommendations in mind, careful attention must be given to understanding the MA addict's needs when developing a set of Best Practice recommendations for treatment of MA abuse. Simon and colleagues (Simon S 2002) found startling differences in the patterns of abuse for MA and cocaine. Although both substances are considered stimulants, typical use patterns for MA reflected habits more closely resembling administering medication than using a drug for pleasure, with the MA typically using the drug upon waking each morning, and taking doses every 2-4 hours throughout the day. However, cocaine abusers reported that they would begin taking the drug in the evening and continue binging until all supplies were exhausted. The study, conducted through the Los Angeles Addiction Research Consortium, examined the typical use patterns of 120 MA and 63 cocaine users by means of self-report measures. Simon et al. expressed their hope that understanding of the patterns of use for MA and cocaine will help treatment providers and drug users identify triggers, times and places when the recovering abuser is most vulnerable to relapse (Simon S 2002).

In the November/December 1996 edition of NIDA Notes, recommendations were given to improve the focus on MA abuse by evaluating current NIDA programs to identify existing research that can be supplemented or adapted, rather than becoming dependent upon new research initiatives (Lukas 1996). To this effect, a best practice recommendation should be built firmly on experience and knowledge of clinicians, researchers, and administrative experts specializing in the MA abuse treatment field. The most credible guidelines dominating the MA abuse literature are in SAMHSA's *Treatment Improvement Protocols* (TIP) series. SAMHSA's *TIP #33* describes approaches that are effective and appropriate for treating stimulant use disorders, including recommendations on practical application of treatment strategies specific to cocaine and MA dependence problems (2005). For the purposes of this best practice recommendation, *TIP #33* (Rawson 1999) will serve as the framework.

Maximizing Treatment Engagement

Tip #33 (Rawson 1999) prescribes the following to maximize treatment engagement:

Make Treatment Accessible

- *Having treatment programs in areas convenient to clients is associated with lower attrition rates*
- *Provided on hours and days convenient for clients*
- *Located near public transportation*
- *Safe part of town for evening visits*

Provide Support for Treatment Participation

- *Address clients' concrete needs (transportation, housing, finances)*
- *Address logistical barriers with onsite services (onsite child care services, referrals to temporary shelters, vouchers for lunches, targeted financial assistance, assistance with paperwork regarding insurance, or filing for disability benefits)*

Respond Quickly and Positively to Initial Telephone Inquiries

- *Ambivalence about treatment is common among treatment-seeking stimulant users*
- *Initial interview scheduled within 24 hours after the client initially contacts the program*

Assessments and Orientations

Tip #33 (Rawson 1999) prescribes the following for assessments and orientations:

Keep Initial Assessments Brief

- *Initial assessments should be brief, focused, and nonrepetitive*

Provide Clear Orientations

- *Clear, thorough, realistic orientation about stimulant use disorder treatment*
- *Clients acquire good understanding about the treatment process, rules of the treatment program, expectations about their participation, and what they can expect the program to do for them and in what time frame.*

Offer Client Options

- *Addiction treatment is more effective when a client chooses it from among alternatives than when it is assigned as the only option.*
- *Negotiate with clients regarding treatment approaches and strategies that are the most acceptable and promising.*

Convey Empathetic Concern

- *Counselors should be warm, friendly, engaging, empathetic, straightforward, and non-judgmental.*
- *Authoritarian and confrontational behavior by the staff can substantially increase the potential for violence.*

Involve Significant Others

- *Family and significant others who support the treatment goals should be involved in the treatment process whenever possible.*

Obert et al. (Obert J 2000) echo the importance of family involvement in the treatment process, noting that assessing the attitudes and involvement of the patient's significant friends and family members will help the therapist determine whether their influence will enhance or interfere with the therapy. When family members are engaged and understand the addiction recovery process, their attitudes and expectations will be more realistic. Obert et al. (Obert J 2000) state that therapists can optimize the chance of a successful recovery by integrating the family in appropriate parts of the treatment program.

Planning Treatment

TIP #33 (Rawson 1999) recommends treatment for 12 to 24 weeks followed by some type of support group participation. A written schedule should be given to clients so they are aware of expected attendance and may share the schedule with family members to encourage their involvement in treatment.

TIP #33 (Rawson 1999) organizes the treatment process into four phases:

- *Treatment initiation period*
- *Abstinence attainment period*

- *Abstinence maintenance phase*
- *Long-term abstinence support plan*

Initiating Treatment

TIP #33 (Rawson 1999) sets the following priorities for the first several weeks of treatment:

- *Establish treatment attendance (multiple weekly visits are best during the first 2-3 weeks, even if only limited to 30 minutes or less)*
- *Discontinue use of psychoactive substances and initiate urinalysis schedule (mandatory urine samples taken every 3-4 days, but not to exceed the sensitivity limits of standard laboratory testing)*
- *Encourage participation in self-help groups (not required)*
- *Assess psychiatric comorbidity and initiate appropriate treatment*
- *Assess stimulant-associated compulsive sexual behaviors*
- *Remediate stimulant "withdrawal" symptoms*

TIP #33 (Rawson 1999) characterizes the initial period of stimulant abstinence with symptoms of depression, difficulty concentrating, poor memory, irritability, fatigue, craving for MA, and paranoia. The duration of these symptoms are generally 10-15 days for MA-users, but vary from case to case. During MA use, addicts often do not associate their feelings of paranoia, anger, impulsiveness, hostility, sexual compulsiveness or cognitive impairment with the drug use, so the therapist's role in disseminating information can provide enlightenment. This information may be particularly welcome, as the cravings usually result in patients feeling completely out of control of their lives (Obert J 2000). *TIP #33* advises therapists to encourage proper sleep and nutrition, to allow the neurology of the brain to "recover" (Rawson 1999).

TIP #33 (Rawson 1999) emphasizes the importance at this treatment initiation stage of discussing issues regarding compulsive sexual behaviors in an open, nonjudgmental manner. MA users report a loss of control over their sexual expression, describing sex as 'compulsive' and 'obsessive' (Maxwell 2005) (Reback C 2004). *TIP #33* (Rawson 1999) lists compulsive sexual behaviors for MA abusers as promiscuous sex, AIDS-risky behaviors, compulsive masturbation, compulsive pornographic viewing, and homosexual behavior for otherwise heterosexual individuals. The disinhibitory affects of MA (and Ice in particular) have been strongly associated with sexual behaviors that put men at high risk of sexually transmitted and blood-borne disease, including HIV infection (Maxwell 2005) (Kurtz S 2003). The need to connect addicts with these diseases to medical resources make the assessment of stimulant-associated compulsive sexual behaviors a critical activity in the initial treatment phase. Therapists must take care to build a nurturing, open rapport with patients to encourage disclosure of these behaviors.

Initiating Abstinence

Tip #33 (Rawson 1999) notes that there is no clear distinction between clients who are initiating abstinence and clients who are *maintaining* abstinence, estimating that the initiating abstinence period occurs roughly from 2-6 weeks into treatment.

Tip #33 (Rawson 1999) prescribes the following goals and objectives for initiating abstinence:

<u>Establish Structure and Support</u>

- *Immediately set short-term goals that are reasonably achievable*
- *Reinforce short-term goal of immediate abstinence with brief, frequent counseling sessions*
- *Establish therapeutic alliance between the client and counselor, reviewing events of the past 24 hours each session and recommendations for navigating the next 24 hours.*
- *Enlist family participation*
- *Establish social support systems*

Address Secondary Drug Use
- *Help clients identify the connections between the use of other substances and their stimulant addiction.*
- *Clients throw out all substance-related items; family members, sober friends of 12-Step sponsors help*

Initiate Avoidance Strategies
- *Clients develop specific action plans to break contacts with dealers and other stimulant users, and to avoid high-risk places that are strongly associated with stimulant use.*
- *Identify cues and triggers*
- *Develop action plan for cues and triggers*

Provide Client Education
- *Educate clients about learning and conditioning factors associated with stimulant abuse*
- *Educate clients about the impact of stimulants and other substances on the brain and behavior*

Respond to Early Slips
- *Treat early slips as simple mistakes*
- *Counselors respond by making a verbal or behavioral contract with clients with short-term achievable goals.*

Simon et al. (Simon S 2004) suggest that during the first 3 months of abstinence MA users may benefit from strategies to compensate for cognitive problems, as during this initial abstinence period neuro-cognitive performance drops, often affecting attention/psychomotor speed, gross and fine motor skills, short-term memory, and fluency (Simon S 2004).

Maintaining Abstinence

Tip #33 (Rawson 1999) prescribes the following goals and objectives for maintaining abstinence:

Teach Functional Analysis of Stimulant Use
- *Teach clients to examine the types of circumstances, situations, thoughts and feelings that increase the likelihood that they will use stimulants*
- *Counsel clients to examine the positive, immediate, but short-term consequences of their stimulant use*
- *Encourage clients to review the negative and often delayed consequences of their stimulant use*

Teach Relapse Prevention Techniques

- *Psychoeducation about the relapse process and how to interrupt it*
- *Identification of high-risk situations and relapse warning signs*
- *Developing coping and stress management skills*
- *Enhancing self-efficacy in dealing with potential relapse situations*
- *Counteracting euphoric recall and the desire to test control over use*
- *Developing a balanced lifestyle including healthy leisure and recreation activities*
- *Responding safely to slips to avoid escalation into full-blown relapse*
- *Establishing behavioral accountability for slips and relapse via urine monitoring and/or Breathalyzer® testing*

Enhance Self-Efficacy Regarding High-Risk Situations

- *Role-playing and other therapeutic techniques*

Counteract Euphoric Recall and Desire to Test Control

- *Discourage selective memory and "war stories" in recovery groups*
- *Stories can be powerful relapse triggers*

Relapse Prevention

Research shows that recovering MA addicts require a longer and more intense outpatient program, with the most effective programs lasting at least 3 months to a year in duration. (http://www.ag.state.il.us/methnet/subpages/treatment.html). Brecht and colleague's study of predictors for relapse in 98 MA abusers in Los Angeles County identified shorter length of treatment as one of the predictors of shorter time to relapse (Brecht M 2000).

MA addicts experience physiological changes that often lead to relapse around 45-120 days into MA treatment. This compulsion to return to old behaviors, known as "The Wall" is a critical consideration when developing strategies for relapse prevention for MA addicts (Obert 2004).

TIP #33 (Rawson 1999) recommends the following approach for use with stimulant users:

> *Relapse prevention systemically teaching clients:*
> - *How to cope with substance craving*
> - *Substance refusal assertiveness skills*
> - *How seemingly irrelevant decisions may affect the probability of later substance use*
> - *General coping and problem solving skills*
> - *How to apply strategies to prevent a full-blown relapse should an episode of substance use occur*

Medical Aspects

*TIP #33 (*Rawson 1999) includes recommendations for medical personnel, including the broad categories bulleted below:

- *Management of stimulant intoxification*

- *Management of potentially lethal overdose*
- *Management of stimulant withdrawal*
- *Management for medical and psychiatric disorders that frequently accompany stimulant abuse and dependence*

Studies have confirmed some of the medical complications arising from MA abuse. In HIV-infected patients complications include hypertension, hyperthermia, rhabdoymyolysis, and stroke, and some researchers suggested that dopaminergic systems are vulnerable to the combined neurotoxity of HIV infection and methamphetamine (Maxwell 2005) (Urbina 2004).

Psychiatric disorders arising from MA abuse were confirmed in a study of 405 methamphetamine users in Taipei. MA users with pre-morbid schizoid/schizotypical personality were found to be predisposed to developing psychoses (Maxwell 2005) (C. Chen 2003). A study among MA psychotic patients in a multi-country study involving Australia, Japan, the Philippines and Thailand indicated that persecutory delusion was the most common lifetime psychotic symptom, followed by auditory hallucinations, strange or unusual beliefs, and thought reading (Maxwell 2005) (M. Srisurapanont 2003).

Additional medical complications include the affects of MA use on the developing fetus, as well as children and adults exposed to toxic chemicals at laboratory sites (Maxwell 2005).

Dental complications also arise from MA abuse, with studies showing patients taking amphetamines at increased risk of gingival enlargement (Maxwell 2005) (Hasan A 2004), and studies revealing chewing and grinding movements associated with MA abuse (bruxism) (Maxwell 2005) (See S 2003).

TIP #33 (Rawson 1999) also recommends preparations for violence associated with MA abuse:

<u>Reducing the risk of violence</u>

- *Keep the client in touch with reality by identifying him/her, using the client's name, and anticipating his/her concerns*
- *Place the client in a quiet, subdued environment with only moderate stimuli; ensure sufficient space so that the client does not feel confined. Have the door readily accessible to both the client and the interviewer, but do not let the client get between the interviewer and the door*
- *Acknowledge agitation and potential for escalation into violence by reassuring the client that they are aware of his distress; asking clear, simple questions; tolerating repetitive replies; and remaining nonconfrontational.*
- *Foster confidence by listening carefully, remaining nonjudgmental, and reinforcing any progress made.*
- *Reduce risk by removing objects from the room that could be used as weapons and discreetly ensuring that the client has no weapons*
- *Be prepared to show force if necessary by having a backup plan for help and having chemical and physical restraints immediately available.*
- *Train all medical or emergency staff to work as a team in managing volatile clients.*

A body of empirical research ties the MA user with violence, both as a victim and as a perpetrator (Cretzmeyer CM 2003). Cohen et al. found that the majority of MA addicts pursuing treatment reported past and current interpersonal violence as a characteristic of their lifestyles (Maxwell 2005) (J. Cohen 2004). In the *Methamphetamine Treatment Project*, 80% of the

women and 26% of the men reported abuse or violence from their partner, with men more likely than women to report experiencing violence from friends and others. (Maxwell 2005) (Cohen J 2004).

TIP #33 (Rawson 1999) notes the association of stimulant use with paranoia, aggression, and violence, and is supported by substantial evidence found in the literature that amphetamine use is associated with violence (Maxwell 2005) (Boles S 2003). Maxwell points out the increase in presentations of MA-associated aggression and violence in emergency rooms (Maxwell 2005). The importance of training counseling staff to handle psychotic symptoms is demonstrated by Zweben et al. (Zweben J 2004) in a story of the *Methamphetamine Treatment Project* where MA abusers reported high levels of difficulty with controlling anger and violent behavior, combined with a correspondingly high frequency of assault and weapons charges. Participants were found to have anxiety, psychotic symptoms, depression and attempted suicide.

Special Groups and Settings

TIP #33 (Rawson 1999) recommends the following in regard to cultural sensitivity:

- *Understanding the mores of groups bound together by gender, age, geography, sexual preferences, criminal activity, substance use, and medical and mental illnesses*
- *Training counselors in cultural sensitivity and cultural competency issues*
- *Educating counselors working with gay men about the sexual and social behaviors that are common among this population (including the widespread use of MA), as well as the stigma associated with substance abuse in the gay community*
- *Implementing contingency management approaches for addressing clients in narcotic replacement treatment when cocaine use is a major clinical problem*
- *Implementing close coordination of psychiatric and stimulate use disorder treatments for clients with co-occurring psychiatric disorders*
- *Requiring longer stays under medical/psychiatric supervision and ongoing treatment with antipsychotic medications for patients whose psychiatric symptomatology is not quickly resolved*
- *Expanding treatment for individuals in the criminal justice system, since stimulant users represent a substantial portion of the individuals in the court and prison treatment population.*
- *Forming linkages for rural populations between social service agencies, providing flexible treatment services and using nontraditional outreach sites (such as mobile or satellite offices)*
- *Making counselors aware of the special needs of women and adolescents including domestic issues, medical problems, child care needs, academic performance, and so on. Gender-specific treatment groups and school-based clinics can be helpful in reaching these particular groups.*

In a later study, Rawson (Rawson R A 2002) notes that discussion in mixed patient groups with heterosexuals frequently results in very poor treatment engagement and early treatment dropout.

Best Practices Roundtable Discussions

Following is an examination of the Best Practices Roundtable Discussions. Topics are organized according to the Best Practices Model (*TIP #33)* (Rawson 1999). The discussions are analyzed for barriers to implementing best practices, with obstacles rank ordered in charts following each topic.

Maximizing Treatment Engagement

Treatment Accessibility

TIP #33 (Rawson 1999) emphasizes the vital role that accessibility plays in maximizing treatment engagement. Research supports the premise that Nebraska can reduce attrition rates by locating MA treatment programs in convenient places (Rawson 1999). Participants in both the Eastern and Western Nebraska roundtable discussions agreed that the treatment facilities scattered geographically across Greater Nebraska need to be more accessible to the people living in the surrounding communities.

Centralized Treatment Services

All roundtable discussion groups addressed the question of whether centralized treatment services would be effective in Nebraska. Treatment Providers from both Eastern and Western Nebraska alluded to the field of evidence supporting a move from centralized to community-based treatment for MA users. Concerns were voiced that use of a central treatment center for MA treatment would reverse the progress that communities have been making towards community-based care. Treatment Providers were particularly concerned that clients receiving treatment in a centralized location would be isolated from their community and the associated support systems awaiting them upon release, including access for family treatment, mechanisms appropriate for the local continuum of care, and resources for long-term support. Currently, Lincoln and Omaha have long-term abstinence support; such services are lacking in a number of other communities. Smaller regional facilities that can develop community-based treatment were proposed. At the very least, participants agreed that there needed to be transition centers to help eliminate the concerns raised regarding a central treatment center.

The Western Nebraska Treatment Providers were overwhelmingly opposed to a centralized treatment center, cataloging the following objections:

- Transportation to and from a central location is burdensome for both the patient and treatment provider, who is usually responsible for transporting the user to and from the treatment center. MA users cannot be put on public transportation when going through withdrawal.
- The Western Nebraska Treatment Providers discussed the challenges in holding “family days” at centralized facilities when family members must travel from 200-300 miles away. Because of time, transportation or other issues, the family members do not attend.
- Treatment providers have observed a higher rate of relapse during the 2-4 week acclimation period that recovered MA addicts experience when returning to their communities after having been away at a treatment facility. Absence from the community forces the patient to reestablish relationships with family, counselors and primary care providers. Much of the treatment provider’s time is monopolized with handling the case management aspect of this

transition process, detracting from the time that the treatment provider could be delivering direct services to other clients.

- By the time a MA user is sent to a central location, he has often exhausted all of the resources available to him in the community. When he reenters that community he cannot get help because there is no program that is willing to work with him. Treatment providers find that local providers are more often willing to work with one another and allow users a second chance.
- A central location provides an artificial environment. When the user returns to his community, he finds that he has not developed the skills necessary for dealing with his addiction in the environment where he will be living and maintaining sobriety. If a user is not sent to a central treatment facility, then treatment providers are able to attach the recovery process to the community, and hopefully alleviate any inability to function in the community after leaving treatment. The MA user needs to learn how to function in his home community.
- By sending a user to a central location for treatment, the possibility of involving the user's family in the treatment process is eliminated. This adversely affects both the user and the family: The user does not benefit from having the support of his family, and the family suffers because there is no support for the family in their community if the treatment is being provided at a central location. This is especially important for single parents with children. The treatment providers reported that parents, especially mothers, who were able to see their children, were more likely to enter into treatment.
- Moving treatment out of the local community and into a central location would interfere with interactions with the legal system. Interactions with local law enforcement provide a higher degree of accountability. MA users do well in the more structured environment this creates. Locally there is a better rapport with parole and the legal system. The MA user sees all of the treatment providers and law enforcement working together towards the same goal.
- Cultural sensitivity, especially with Native American customs such as sweats and journaling, would not be present at a central location.
- The individualized treatment at the local level is very important. The size of the treatment groups are smaller, so the user is unable to blend into group of 30 people as he might be able to do at a central location.
- Western Nebraska Justice Professionals also objected to a centralized facility, questioning whether centralized care would effectively impact the offender population on a long-term basis, beyond initial stabilization.

Community-Based Treatment Services

The Eastern Nebraska Treatment Providers pinpointed the barrier to community-based treatment to be funding. They pointed out the difficulty in obtaining reimbursement for community programs. Instead, treatment providers are forced to follow the money, shipping MA users to where the services are and estranging them from their families. Setting aside the funding issues, the Eastern Nebraska Treatment Providers identified a number of benefits supporting a community-based model for MA treatment:

- It is easier to move a MA user up and down through the continuum of care.
- Community-based services reduce travel time and cost for the MA users and families getting to treatment. Windshield time is reduced, freeing up more time for treatment providers to spend on direct services.

- Community-based services allow the MA user to access a support system within his community. Otherwise, MA users have difficulty coping within their community upon their return from treatment.
- Community-based services increase the likelihood of family involvement which increases the chances of successful recovery. Educating the family about the recovery process helps change the family's behavior to support the MA user's recovery. Since there is often more then one addict in family, community-based services facilitate access to treatment for family members, as well.
- The MA user is exposed to risk factors within the home environment while in treatment and is better prepared to deal with them.
- Because community-based treatment is not a one-time service, the MA user is more likely to access services throughout the continuum of treatment.
- Community-based services allow the community to be responsible for the recovery of its citizens.
- Because the user's employer is in the community, the treatment provider can work with the employer, increases the likelihood of the employer in rehiring the employee.

With the majority of urban offenders receiving treatment within their own cities, the Eastern Nebraska Treatment Providers stressed the importance of locating assessment facilities in the communities where people who need them can access them. The group was apprehensive about relying on private funding for these facilities. The Eastern Nebraska Justice Professionals proposed that each district within a city should contribute financially to the treatment centers to ensure service delivery for patients.

Client Convenience

Other accessibility barriers cited in the roundtable discussions coincided with *TIP #33*'s call to locate treatment services in safe areas near public transportation and to be open at times convenient for clients. Roundtable participants identified this scheduling issue as particularly applicable for people in rural areas, who may have to travel considerable distances to reach MA treatment services. Rural clients with day jobs are challenged to fit their working hours around an intensive out-patient schedule. Community Support Providers in Western Nebraska suggested satellite offices as an option. Eastern Nebraska Justice Professional proposed installing one or two intensive out-patient centers in Omaha, offering multiple levels of service. Justice Professionals from both Eastern and Western Nebraska saw a tremendous opportunity to have a day and night reporting center. Western Nebraska Justice Professionals noted that only 2 or 3 areas have day and night reporting systems. One Substance Abuse Officer (SAO) in Lexington offers night and day reporting centers (some contract and some probation). The Western Nebraska Justice Professionals would like to see out-patient care in a day reporting center, suggesting that college students be tapped for personnel support. They particularly liked the idea of a "one-stop shop" where clients can check in for probation, counseling and treatment support.

Clients' Concrete Needs

To minimize barriers to treatment participation, research points to first addressing clients' concrete needs, including transportation, housing and finances (Rawson 1999).

Transportation

Across the board, all roundtable discussion groups identified a deficit in transportation options as a primary obstacle for both urban and rural clients. Participants agreed that multiple solutions would be necessary to address the transportation problems across the state. The Justice Professionals from Eastern Nebraska observed clients' chief reasons for lacking transportation as not having a driver's license, and being unable to afford reliable transportation (a car/gas). The Eastern Nebraska Justice Professionals supported the idea of a mobile treatment center relying on part-time employees. A prototype program in urban Milwaukee was cited, where probation officers and Treatment Providers work together using a bookmobile that runs until 11:00 p.m. The Western Nebraska Justice Professionals also proposed the mobile reporting center concept, citing fewer personnel required and wireless access to HHSS as advantages.

Treatment Providers from Western Nebraska discussed the lack of public transportation in rural areas. In some communities the Handibus is available for substance abusers. In the northern part of the panhandle, Native American Outreach provides limited transportation assistance to Native Americans. When transportation to and from treatment is not available, the Treatment Providers indicated that they work with the client to problem solve and look for informal supports that could be utilized to provide transportation. These informal supports include family members, friends or volunteers from within the community that would be able to provide transportation to and from treatment. Unfortunately, these informal supports are not always reliable. The Western Nebraska Treatment Providers agreed that they would rather install resources to provide transportation than to rely on community supports. It was suggested that the Treatment Providers be allowed to use flex funding to compensate volunteers to transport users to and from treatment if they are meeting their treatment goals. This type of reimbursement will be particularly beneficial as fuel costs continue to rise.

Housing

The Western Nebraska Community Support Providers voiced grave concerns regarding the lack of housing available for MA users. Public housing authorities do not allow MA users or manufacturers to use public housing. While MA users who have documentation of successful treatment completion can appeal to the public housing authority, these Community Support Providers indicated that they have never seen a successful appeal.

Another concern expressed by the entire Western Nebraska roundtable group was the clean-up expenses associated with buildings that have been used as methamphetamine labs. Once the lab has been shut down, owners are unable to resell the buildings. No training is available on how to deal with these contaminated buildings. Parents are considered neglectful if they continue to reside in a contaminated house. Therefore, there has been an increase in the number of children entering foster care because they live in buildings that were used as MA labs. A related outcome may be a shortage of foster care homes for these children.

All focus groups called for an increase in transitional housing facilities. The Eastern Nebraska Justice Professionals pointed out how MA users normally share housing. A MA user who has successfully completed treatment may return to a high-risk living environment, where housemates are using MA or other drugs. Both Eastern and Western Nebraska Justice Professionals would like to see transitory programs including half-way houses, three-quarter houses, and after-care services. Western Nebraska Justice Professionals revealed a need for half-way house reporting centers for MA users to use for transitioning between prison and returning into the community, since the half-way house in North Platte has closed, leaving no half-way

houses west of Kearney. The Eastern Nebraska Treatment Providers pointed out how the current system doesn't allow housing for relapse patients; relapsing MA addicts end up in the emergency room.

Finances

Both the Eastern and Western Nebraska roundtable groups agreed that too often money dictates treatment options. The Eastern Nebraska Treatment Providers related how the working poor and even middle class clients who do not qualify for Medicaid cannot afford to pay for treatment. Many times their best course of action seems to be quitting their jobs in order to get the state to pay for treatment. Evaluation fees were a treatment barrier identified by the Eastern Nebraska Justice Professionals. MA users who are unable to pay the fees for the evaluation to the treatment consequently do not receive treatment. The cost for an evaluation is $180 in Omaha, ranging from $70-$120 in other areas. Standardizing prices across the state was suggested, as was allowing patients to pay installments.

Patients with private insurance also face challenges in paying for treatment. Some insurance companies are not willing to cover MA treatment or will only cover a portion of the costs. Some contracts won't pay for outpatient care. The Eastern Nebraska Treatment Providers noted that even people with insurance requiring relatively inexpensive co-pay have difficulty paying for a co-pay of $10 per visit, four times a week, plus transportation expenses.

Both the Eastern Nebraska Justice Professionals and the Western Nebraska Community Support Providers gave anecdotal evidence of how the judicial system seems to consider finances in sentencing and parole: A judge may set a bond very high so that a person with low income cannot afford it and must stay in prison for treatment. Or a juvenile offender from a low-income family may be incarcerated rather than sent to a treatment program.

On-Site Services

The best practices model suggests addressing logistical barriers with onsite services (Rawson 1999). The Eastern Nebraska Justice Professionals favored a treatment center model that provides transportation and child care services. Eastern Nebraska Treatment Providers echoed the need for child care, citing the growing awareness of the need for parent-child treatment at all levels of treatment.

The Eastern Nebraska Treatment Providers stressed the importance of discreet funding for discreet services. A voucher system was proposed for individuals to use for individualized services.

Quick Response

Because ambivalence about treatment is a common attitude among even those MA users seeking treatment, the best practices model recommends a quick, positive response to initial telephone inquiries (Rawson 1999), calling for the initial interview to be scheduled within 24 hours after the client initially contacts the program. All Treatment Providers participating in the roundtable discussions labeled the waiting list for all levels of treatment as "too long". The Eastern Nebraska Justice Professionals observed that the less expensive the program is, the longer the waiting list.

The Western Nebraska Treatment Providers would like to see intake completed on the same day that the user approached the treatment provider regarding services. Completing intake on the same day was more likely to occur if the MA user was able to work with the intake

worker who was on call at the treatment center. Intake workers are usually Licensed Alcohol and Drug Abuse Counselors (LADACs). These intake workers identify the essential functioning including medical needs, emotional needs, mental health needs, motivation, family support and the 13 Medicaid requirements. Patients needing to access the services of an intake worker with a specialty may be required to wait a day or two before intake can be completed, because these appointments are limited.

The Western Nebraska Treatment Providers outlined the routes through which MA users access treatment services. In the southern portion of the Panhandle, MA users generally access treatment services through their primary care physician. In the northern portion of the Panhandle, access usually begins through the law enforcement agency. The treatment facility there has a contract with the state for Native American beds. Rarely receiving walk-ins, most referrals come by phone contact with medical providers, law enforcement officers or counselors. Response time is particularly impeded through the law enforcement referral route. An individual must be arrested to receive a referral for treatment services. Since the goal of law enforcement is to stabilize a situation, no arrest (and no referral) is made if the situation stabilizes. The Eastern Nebraska Justice Professionals echoed frustrations around offenders whose offense is not severe enough to receive imprisonment not receiving treatment, noting that the recidivism rates among this populations, for either drug offenses or other offenses, are very high. The Western Nebraska Treatment Providers suggested introducing the MA user to a community worker prior to returning to the community.

The Eastern Nebraska Treatment Providers gave a snapshot of their intake process. MA users are rarely seen within 24 hours of requesting assistance. Treatment providers must qualify to be accredited, licensed, a provider through Medicaid and in compliance with the patient's contract back to the region so that they can get paid once services have been provided. All contracts have differing requirements that must be met. Ensuring that each MA user's contract qualifies under all these requirements is time consuming and often detrimental to the user because he is not receiving the care that he needs.

The Eastern Nebraska Treatment Providers broke down the time barriers that they are currently experiencing: a 3-4 week wait time before an assessment, followed by a 4-6 week wait time for screening. Because of the wait list to enter services at another agency, there is often a period of time when the user is not getting the level of care needed. The MA user's ambivalent attitude surrounding MA treatment often leads the patient to believe that a higher level of care is not necessary. Access to step-down services is also impacted by wait times. The Eastern Nebraska Treatment Providers identified a 10-12 week wait for intensive outpatient services at this time.

A solution proposed by the Eastern Nebraska Treatment Providers to allow users quicker access to individualized treatment would be a 5-10 day pre-treatment period, much like the detox period. This would allow users to restore their bodies, as treatment providers determine the patient's needs in a variety of domains by assessing each level of service. A pre-treatment period would prevent half of the treatment period from being eaten up with assessments. Treatment providers could identify environmental problems and safety concerns and remove the MA user from the environment if necessary.

The Eastern Nebraska Justice Professionals suggested that quicker turn-around times could be facilitated through more coordination among the justice system, treatment professionals and insurance companies.

Barrier to Implementing Best Practices	Justice Professionals		Treatment Providers		Community Support Providers
	E. Neb	W. Neb.	E. Neb.	W. Neb.	W. Neb.
Greater accessibility needed to treatment facilities across Greater Nebraska	•	•	•	•	•
Burdensome transportation costs and travel time	•	•	•	•	•
Treatment facilities and services need to be open on days and at times convenient to clients (i.e., rural clients with day jobs who must travel to site)	•	•	•	•	•
Waiting list for all levels of treatment is too long	•	•	•	•	•
Lack of transitional housing facilities	•	•	•	•	•
Money dictating treatment options	•	•	•	•	•
Clean-up expenses associated with buildings used as MA labs		•		•	•
Judicial system considers finances in sentencing and parole	•	•			
Lack of child care services	•		•		
Family needs access to MA user in treatment facility			•	•	
Removal from home community creates an artificial environment, isolating MA user from opportunities to practice avoidance strategies			•	•	
Offenders whose offense is not severe enough to receive imprisonment not receiving treatment	•				
Differing requirements of all MA user's contracts must be met			•		
Lack of transportation in rural areas				•	
Moving treatment out of local community interfering with interactions with local law enforcement				•	
Sensitivity to local culture, particularly Native American customs				•	
Treatment groups too large				•	
Difficulty in obtaining reimbursement for community programs			•		
Alienation from support system within MA user's community			•		
Lack of housing available for MA users					•
Working poor/middle class who don't qualify for Medicaid can't afford treatment			•		
Some insurance companies unwilling to cover MA treatment or only cover a portion of cost			•		
Even low co-pays of $10/visit add up at 4 visits/week			•		
Evaluation fees too high	•				

Table 11. Barriers to Implementing Best Practices in Maximizing Treatment Engagement, as identified by Eastern and Western Nebraska Justice Professionals, Treatment Providers, and Community Support Providers, 2005.

Assessments and Orientations

Brief Initial Assessments

TIP #33 (Rawson 1999) prescribes a brief, focused initial assessment. The Eastern Nebraska Treatment Providers validate this practice, calling for a brief screening to enable the MA user to enter a safe, stabilizing environment, followed by a comprehensive assessment during treatment. They protested that funding sources will not allow this approach. The current assessment mandated by the justice system involves an expensive comprehensive assessment that eats into the patient's allowed treatment time, leaving little time to focus on treatment. Currently, a MA user could be two weeks into treatment and still be undergoing assessment. A

suggestion arose to have a paraprofessional conduct the screening and a treatment professional conduct the assessment at a later time. This solution increases the accuracy of the comprehensive assessment, because the MA user has stabilized.

The Eastern Nebraska Treatment Providers described the current assessment tool as "a step backward". They'd like to see an assessment outline rather than a required tool. The assessment outline would allow more patient individualization and provide direction for accessing more detailed information. To ensure collection of quality information, the assessment outline would include standard headings required by the criminal justice system.

The Western Nebraska Treatment Providers and Justice Professionals singled out affordable assessment as a critical issue to be addressed by a set of best practices. Both the Eastern and Western Nebraska groups stressed the need for money for more comprehensive assessment. The Western Nebraska Justice Professionals noted that weaknesses in the pre-sentence investigation (PSI) being relied upon now leaves some risks not fully identified. The Western Nebraska Community Support Providers blamed high assessment costs for parolees' inability to access drug treatment. Discussion ensued on the likelihood of felons to recidivate without access to treatment services.

Clear Orientations

Research indicates more successful outcomes when clients receive clear, realistic information on their MA treatment process, including program rules, expectations for their participation, and anticipated outcomes and timetables (Rawson 1999). Research also shows that addiction treatment is more effective when clients may negotiate with the treatment providers regarding treatment strategies to arrive at an individualized program, rather than being assigned a standard plan (Rawson 1999).

Empathetic Concern

Authoritarian and confrontational staff demeanors increase the potential for violence. *TIP #33* advocates empathetic, nonjudgmental, straightforward counselors to engage patients (Rawson 1999). The Western Nebraska Justice Professionals' comments support this aspect, suggesting that staff members act in a manner that reflects genuine care about their patients.

Family Involvement

Assessment of the attitudes and involvement of the patient's significant friends and family members helps the treatment provider gauge whether their influence will enhance or interfere with treatment goals. Research also shows that appropriate family involvement optimizes chances for a successful recovery (Obert J 2000) (Rawson 1999).

Barrier to Implementing Best Practices	Justice Professionals		Treatment Providers		Community Support Providers
	E. Neb	W. Neb.	E. Neb.	W. Neb.	W. Neb.
Affordable assessments needed	•	•	•	•	•
Time-consuming initial assessments eat into patient's treatment time			•		
PSI leaves some risks not fully identified		•			
Staff need to act in caring manner		•			

Table 12. Barriers to Implementing Best Practices in Assessments and Orientations, as identified by Eastern and Western Nebraska Justice Professionals, Treatment Providers, and Community Support Providers, 2005.

Planning Treatment

The best practices model for planning treatment for MA use follows *TIP #33's* 12-24 weeks of treatment, followed by a form of support group participation (Rawson 1999). Patients are provided with a written schedule to solidify attendance expectations and facilitate family member involvement in treatment.

Time Period

The Eastern Nebraska Justice Professionals indicated that a longer time is needed for the whole treatment process. Six months of treatment was considered, with the duration of treatment to last at least 18 month to 2 years, but the Justice Professionals observed that few patients are able to complete the whole process. Reasons identified for treatment centers losing patients included the patient's inability to complete the treatment program, patient financial problems, and prohibitively long waiting lists. Even in prisons where the offenders volunteer for treatment, the waiting list is long.

The Eastern Nebraska Justice Professionals suggested that the state definition be changed to allow for longer treatment. The group strongly felt that treatment providers should be providing the appropriate level of treatment based on the individual's personal MA use. The Eastern Nebraska Treatment Providers built on this concept of individualized treatment plans, noting that treatment providers cannot treat MA users like other drug users. Since it can take up to three weeks for MA to clear a user's system, MA users cannot be treated in a short amount of time. Because most methamphetamine users are also using alcohol, marijuana or other drugs, treatment plans must also address secondary drug use.

The Eastern Nebraska Justice Professionals observed that MA users need a minimum of 4 to 6 months to clear their minds to be receptive for treatment. The group outlined the current timeline for treatment at 4 to 5 contacts per week, continuing for 5 to 6 weeks for the whole treatment. They consider the current outpatient schedule of one or two contacts per week as inadequate, calling for more contacts per week to facilitate patients' stability. There is no after-care following the treatment.

Conflicting System Requirements

The Eastern Nebraska Treatment Providers observed that the regional treatment centers appear not to value outpatient treatment, instead funding residential programs even though more people could be treated on an outpatient basis for the same dollars. The Eastern Nebraska Justice Professionals proposed moving patients to residential facilities so that they can complete their treatment. However, long waiting lists prohibit patients from getting into the treatment programs

that they need. The Western Nebraska Justice Professionals pointed out how other system requirements conflict with one another. Other system requirements also conflict with one another. It can take a couple of weeks to get a user placed into residential treatment. However, if the user remains sober for two weeks then he no longer qualifies for residential care. Of course, if the user continues to use while waiting for a bed, treatment becomes more difficult. Health and Human Services and Probation's recommendations often override tax provider recommendations.

The Western Nebraska Justice Professionals said that even the Matrix Model that is being used extensively by treatment providers is in direct conflict with state's minimum mandate for the number of treatment hours required each week. The Matrix Model of intensive outpatient treatment requires six-eight hours of treatment, while the state's minimum mandate is 10 hours of treatment. Both of these requirements conflict with the standards set by the behavioral health system and the Medicaid system which requires nine hours per week divided among three specific components. Participants all expressed frustration with attempting to tailor treatment so that it meets the criteria set forth by each group.

The Western Nebraska Treatment Providers stated that the guidelines set forth by Behavioral Health Services, Criminal Justice, Medicaid, Primary Care Providers, and Managed Care Providers require different levels of care, making it difficult for a MA user to access care. If the guidelines of a particular group are not met, then funding for treatment can be removed. The Eastern Nebraska Treatment Providers cautioned that a set of best practices for Nebraska will only be followed if there is money available to implement the recommended protocol.

Planning Treatment

Barrier to Implementing Best Practices	Justice Professionals		Treatment Providers		Community Support Providers
	E. Neb	W. Neb.	E. Neb.	W. Neb.	W. Neb.
Longer time needed for treatment process	•		•		
Treatment providers cannot treat MA users like other drug users	•		•		
Regional treatment centers fund residential programs, not outpatient treatment			•		
Conflicting system requirements		•		•	

Table 13. Barriers to Implementing Best Practices in Planning Treatment, as identified by Eastern and Western Nebraska Justice Professionals, Treatment Providers, and Community Support Providers, 2005.

TIP #33 (Rawson 1999) organizes the treatment process into four phases:

- *Treatment initiation period*
- *Abstinence attainment period*
- *Abstinence maintenance phase*
- *Long-term abstinence support plan*

Initiating Treatment

Treatment Schedule

The first priority for initiating treatment is to develop expectations for the first weeks of treatment. *TIP #33* recommends setting a schedule of multiple weekly visits during the first 2-3 weeks, even if the sessions are for 30 minutes or less (Rawson 1999). As discussed above in the

Planning section, current treatment protocols are too often dependent on the patients' contracts, rather than dictated by individuals' needs.

Urinalysis Schedule

To confirm that the patient has discontinued use of MA and any other drugs, a urinalysis schedule is set. *TIP #33* advises taking mandatory urine samples every 3-4 days, but cautions against exceeding the sensitivity limits of standard laboratory testing. The Western Nebraska Justice Professionals indicated that the current practice is twice weekly mandatory urine testing, and are in favor of sharing positive tests with others.

Self-Help Groups

While not required by *TIP #33,* the model encourages patient participation in self-help groups (Rawson 1999). Eastern Nebraska Treatment Providers found Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) to be useful forms of community support. One Eastern Nebraska Treatment Provider cautioned against adopting a model that could undermine the 12-Step program that is currently working in Nebraska. Both Eastern and Western Nebraska Treatment Providers were not as impressed with the 12-Step programs available in Western Nebraska, referring to the AA chapter as being "alcohol only" and questioning the reputations of the Sydney and Chappell NA programs. The Western Nebraska Treatment Providers singled out the 12-Step program in Torrington as an example for other chapters to emulate.

Dual Diagnosis Assessment

TIP #33 assigns the diagnosis of psychiatric comorbidity in the *Initiating Treatment* phase (Rawson 1999). The Eastern Nebraska Treatment Providers devoted much discussion to the challenges in diagnosing mental disorders. The group suggested standardizing definitions for the terms "dual diagnosis" and "co-occurring conditions". Because the service definitions do not match, the common interchanging of the terms makes it difficult to navigate the different levels of care.

The Eastern Nebraska Treatment Providers called for a working relationship across the systems. Under the current system, Medicaid will not allow two authorizations for both mental health and chemical dependency open at the same time. Treatment providers are challenged to choose between mental health care and substance abuse care. Ways of manipulating the system were described that are often destructive to the family. Treatment providers must label a MA user "mentally ill" to receive funding from Medicaid or even private insurance companies. The mental health diagnosis is necessary to obtain treatment for family members with substance abuse problems. Then the MA user is burdened by the stigma that is attached to mental illness.

Safety Issues

When asked to describe an ideal process for initiating treatment, Western Nebraska Treatment Providers identified safety issues as their primary concern. Treatment providers must first determine immediate medical concerns, ensure the MA user's personal safety, and determine if detox is necessary. The Eastern Nebraska Treatment Providers confirmed that environmental and safety concerns apply to users of MA. Once safety issues are addressed, treatment providers can determine the appropriate level of care for medical care and psycho-social needs.

Compulsive Sexual Behaviors

Because MA users report a loss of control over their sexual expression, describing sex as 'compulsive' and 'obsessive' (Reback C 2004; Maxwell 2005), *TIP #33* (Rawson 1999) emphasizes the importance of assessing stimulant-associated compulsive sexual behaviors in an open, nonjudgmental manner. Compulsive sexual behaviors for MA abusers include: promiscuous sex, AIDS-risky behaviors, compulsive masturbation, compulsive pornographic viewing, and homosexual behavior for otherwise heterosexual individuals (Rawson 1999). Because these behaviors are associated with high risks of sexually transmitted and blood-born disease, including HIV infection (Kurtz S 2003; Maxwell 2005), treatment providers must assess these dangers during the *Initiating Treatment* phase in order to connect addicts who may have these diseases to medical resources.

Eastern Nebraska Treatment Providers expressed concern over the sexual addition associated with MA use and the spread of HIV. The group indicated that they vigilantly watch for this addiction in MA users. Treatment Providers would like to require a nursing assessment to test for STD's at the time of referral.

Withdrawal Symptoms

For the first 10-15 days of MA abstinence, patients report symptoms of depression, difficulty concentrating, poor memory, irritability, fatigue, craving for MA, and paranoia. Therefore, *TIP #33* prescribes remediation of stimulant "withdrawal" symptoms during the *Initiating Treatment* phase (Rawson 1999). These symptoms leave patients feeling completely out of control of their lives, because they are unable to associate their symptoms with drug use (Obert 2004). Research suggests that during the first 3 months of abstinence MA users may benefit from strategies to compensate for cognitive problems, as during this initial abstinence period neuro-cognitive performance drops, often affecting attention/psychomotor speed, gross and fine motor skills, short-term memory and fluency (Simon S 2004). The treatment provider informs the patient about these symptoms, offers remedial options, and encourages proper sleep and nutrition to allow the neurology of the brain to recover (Rawson 1999).

The Western Nebraska Treatment Providers discussed the accessibility, skill and knowledge of physicians regarding detox and substance abuse issues. Since treatment providers can only provide social detox treatment, they must rely on primary care physicians and emergency room doctors to deliver medical detox services. There is no medical model protocol for detox, so physicians are not required to deliver a standardized level of care. The Western Nebraska Treatment Providers stated that in some communities the doctors are unwilling to deal with MA users.

	Justice Professionals		Treatment Providers		Community Support Providers
Barrier to Implementing Best Practices	E. Neb	W. Neb.	E. Neb.	W. Neb.	W. Neb.
Current treatment protocols dependent on patients' contracts, rather than dictate by individuals' needs	•	•	•	•	•
AA chapters in Western Nebraska described as "alcohol only"			•	•	
Environmental and safety concerns must be addressed prior to determining appropriate level of care			•	•	
Sexual addictions must be assessed			•	•	
No medical model protocol for detox for physicians and emergency room doctors				•	
Doctors unwilling to deal with MA users				•	
Medicaid will not allow 2 authorizations for both mental health and chemical dependency open at the same time			•		
Conflicting service definitions for "dual diagnosis" and "co-occurring conditions"			•		
Mental health diagnoses employed in order to secure funding from Medicaid or private insurance companies			•		

Table 14. Barriers to Implementing Best Practices in Initiating Treatment, as identified by Eastern and Western Nebraska Justice Professionals, Treatment Providers, and Community Support Providers, 2005.

Initiating Abstinence

TIP #33 (Rawson 1999) notes that there is no clear distinction between clients who are initiating abstinence and clients who are *maintaining* abstinence, estimating that the initiating abstinence period occurs roughly from 2-6 weeks into treatment.

Structure and Support

The first order of business in the *Initiating Abstinence* phase is to set reasonable short-term goals with the patient. The first short-term goal should be immediate abstinence. Frequent brief counseling sessions help reinforce MA abstinence. The *TIP #33* format for these sessions is to review events of the past 24 hours and develop a plan of action for the next 24-hour period. Family and social support systems are established to fortify these goals (Rawson 1999)

Secondary Drug Use

As MA users initiate abstinence, abstinence from all drugs is required. *TIP #33* advises treatment providers to help clients identify the connections between the use of other substances and their stimulant addiction. Family members, sober friends, and 12-Step sponsors can be enlisted to help the MA user throw away all substance-related items. (Rawson 1999)

Eastern Nebraska Treatment Providers and Justice Professionals validated the best practices' literature's reports that MA users abuse other substances as well. The Eastern Nebraska Treatment Providers called for a substance abuse treatment focus over a MA treatment focus, noting that without addressing the other substances, MA users will turn to alcohol or marijuana.

Discussion ensued regarding limited funding. Both the Eastern Nebraska Treatment Providers and Justice Professionals raised the issue of focusing funding on MA abuse by shifting it away from alcohol and other substance abuse programs. The Eastern Nebraska Treatment Providers warned that while the majority of drug problems are currently associated with MA, marijuana use is still prevalent, and possibly seen as more accepted. The group also

recommended that funding still needs to focus on alcohol because it serves as a gateway drug. Another barrier for allocating specific MA dollars was identified in how focusing on the number of MA-specific beds complicates funding for treatment facilities.

The Eastern Nebraska Justice Professionals pointed out how the number of general drug abusers is always greater than that of MA abusers. They proposed a general drug treatment which includes MA and other substances.

Avoidance Strategies

To initiate avoidance, treatment providers work with clients to plan strategies to respond to cues and triggers. *TIP #33* specifically requires treatment providers to help clients develop action plans to break contacts with dealers and other stimulant users, as well as to avoid high-risk places that are strongly associated with stimulant use (Rawson 1999).

Client Education

TIP #33 describes a client education program where clients learn about conditioning factors associated with stimulant abuse and the impact of stimulants and other substances on the brain and behavior (Rawson 1999).

Early Slips

TIP #33 is very explicit about avoiding judgmental reactions to MA users' early slips, suggesting that they be treated as simple mistakes. Treatment providers are directed to respond by making a verbal or behavioral contract with the client, stating short-term achievable goals.

	Justice Professionals		Treatment Providers		Community Support Providers
Barrier to Implementing Best Practices	E. Neb	W. Neb.	E. Neb.	W. Neb.	W. Neb.
Doctors unwilling to deal with MA users			•	•	
MA users abuse other substances as well	•		•		
Consequences of shifting funding away from alcohol and other substance abuse programs in order to focus on MA	•		•		
Focusing on number of MA-specific beds complicates funding for treatment facilities			•		

Table 15. Barriers to Implementing Best Practices in Initiating Abstinence, as identified by Eastern and Western Nebraska Justice Professionals, Treatment Providers, and Community Support Providers, 2005.

Maintaining Abstinence

Functional Analysis

TIP #33 (Rawson 1999) suggests that treatment providers teach clients to examine the types of circumstances, situations, thoughts and feelings that increase the likelihood that they will use stimulants. Clients can then weigh the positive, short-term effects of their MA use against the negative and often delayed consequences.

Relapse Prevention Techniques

TIP #33 (Rawson 1999) prescribes the following relapse prevention techniques:

- *Psychoeducation about the relapse process and how to interrupt it*
- *Identification of high-risk situations and relapse warning signs*
- *Developing coping and stress management skills*
- *Enhancing self-efficacy in dealing with potential relapse situations (i.e., role-playing)*
- *Counteracting euphoric recall and the desire to test control over use*
- *Developing a balanced lifestyle including healthy leisure and recreation activities*
- *Responding safely to slips to avoid escalation into full-blown relapse*
- *Discouraging selective memory, euphoric recall, and "war stories" in recovery groups*
- *Restraining desires to test control*
- *Establishing behavioral accountability for slips and relapse via urine monitoring and/or Breathalyzer® testing*

Both the Eastern and Western Nebraska Justice Professionals discussed the need for more drug testing. Technologies are in place, but not as effective as expected, including sweat bud/patches, electronic monitoring (which was deemed expensive in terms of officers' time), and urinalysis (which is not accurate if the user drinks too much water). Strategies for counteracting inaccurate urinalysis include waiting to test until the water level drops or conducting the test in the field where the incident occurred.

The Eastern Nebraska Justice Professionals noted that the levels of testing results are important for some drugs. If the result is only "negative" or "positive", it is not specific enough for further actions to be taken by the Substance Abuse Officers, e.g., the level of marijuana test result can tell whether the offenders are continuous users or increased users. In the drug court, the abusers are tested over 3 times a week. If the result shows positive, there is a need for a urinalysis test, which reveals drugs in general, not just MA. If the result shows negative, then no urinalysis is necessary.

	Justice Professionals		Treatment Providers		Community Support Providers
Barrier to Implementing Best Practices	E. Neb	W. Neb.	E. Neb.	W. Neb.	W. Neb.
More frequent and more specific/reliable drug testing needed	•	•			

Table 16. Barriers to Implementing Best Practices in Maintaining Abstinence, as identified by Eastern and Western Nebraska Justice Professionals, Treatment Providers, and Community Support Providers, 2005.

Relapse Prevention

Techniques

MA addicts experience physiological changes that often lead to relapse around 45-120 days into MA treatment. This compulsion to return to old behaviors, known as "The Wall" is a critical consideration when developing strategies for relapse prevention for MA addicts (Obert

2004). Research shows that recovering MA addicts require a longer and more intense outpatient program, with the most effective programs lasting at least 3 months to a year in duration. One study of predictors for relapse in 98 MA abusers in Los Angeles County identified shorter length of treatment as one of the predictors of shorter time to relapse (Brecht M 2000).

The Western Nebraska Treatment Providers discussed the need for ongoing support services to prevent relapse. Identifying a specific person to be available to assist the MA user when he was tempted to relapse was suggested. Self help groups were also a solution. The Western Nebraska Treatment Providers said that RESPITE provides good intervention services in Scottsbluff for mental health patients. However, this service is primarily for mental health patients and would require additional funding if it were to be widely available to substance abusers. In Alliance, users fearing relapse can call a 24-hour hotline manned by an LADAC who is able to provide counsel over the phone. In addition, a residential stay is available at the Alliance facility as long as the user is current and paid. However, due to transportation problems, some users are not able to return the next day if a bed is unavailable.

The Eastern Nebraska Treatment Providers did not like the term “after care”, believing it implies that the real treatment has stopped and the “after care” might no longer be necessary. The trend in the profession is to use the term “continued care”. Long-term continued care addresses continuing medical issues, dental issues, chronic pain, cognitive damage, and vocational rehabilitation. To remedy the problem of support mechanisms disappearing immediately with the discontinuance of treatment, the Western Nebraska Treatment Providers were in favor of a gradual step-down treatment continuum, ranging from residential treatment to intensive outpatient treatment to general outpatient treatment.

Evaluation of Treatment Outcomes

The Western Nebraska Justice Professionals expressed their discouragement by the low percentage of success after treatment for MA addiction. The success rate is highest for juveniles who move to another place. Evaluation of treatment outcomes was analyzed. To evaluate treatment outcomes, the Western Nebraska Treatment Providers often collect their data through a post discharge survey given at discharge and again 90 days to six months after discharge. The group agreed that a good time to evaluate recovery would be six to nine months after discharge. The Eastern Nebraska Treatment Providers pointed out difficulties in following up on treatment. When questionnaires are dispatched, they are often not returned. Once clients leave treatment, they are often hard to find. Western Nebraska Justice Professionals proposed instituting a tracker service for adults similar to that for juveniles. Right now there is only one tracker service left in northwest Nebraska, with agencies meeting trackers once or twice a month to listen to their reports. The justice professionals wondered whether trackers and treatment professionals could work together. It was suggested that college students could serve as trackers, supervising, testing and interviewing clients. A concern was raised regarding sending trackers to dangerous places.

	Justice Professionals		Treatment Providers		Community Support Providers
Barrier to Implementing Best Practices	E. Neb	W. Neb.	E. Neb.	W. Neb.	W. Neb.
Difficult to follow-up on treatment	•	•	•	•	
Ongoing support services necessary to prevent relapse				•	
Term "after care" implies that real treatment has stopped			•		
Long-term continued care needed for medical issues, dental issues, chronic pain, cognitive damage, and vocational rehabilitation			•		
Support mechanisms disappear immediately after treatment discontinued				•	
Step-down services needed, ranging from residential treatment to intensive outpatient treatment to general outpatient treatment				•	
Low percentage of success after treatment for MA addiction		•			

Table 17. Barriers to Implementing Best Practices in Relapse Prevention, as identified by Eastern and Western Nebraska Justice Professionals, Treatment Providers, and Community Support Providers, 2005.

Medical Aspects

Management of Medical Complications

Studies have confirmed some of the medical complications arising from MA abuse (including hypertension, hyperthermia, rhabdoymyolysis and stroke in HIV-infected patients) (Maxwell 2005) (Urbina 2004), as well as psychiatric disorders arising from MA abuse (including psychoses, persecutory delusion, auditory hallucinations, strange or unusual beliefs, and thought reading) (Maxwell 2005) (C. Chen 2003; Srisurapanont M 2003) . Use of MA causes medical complications on developing fetuses (Maxwell 2005). Children and adults exposed to toxic chemicals at MA laboratory sites also require medical treatment (Maxwell 2005). Dental complications arriving from MA abuse include gingival enlargement, and bruxism (Maxwell 2005) (Hasan A 2004) (See S 2003).

Medical Barriers

Doctor Reluctance

The roundtable discussions indicated that MA users cannot concentrate on treatment when their medical and dental needs have not been addressed. Eastern Nebraska Treatment Providers observed that doctors and dentists do not want to work on MA users. There is a stigma associated with MA users, perhaps compounded by the police having to accompany the MA user due to contamination risks. The treatment providers would like to see hospital staff educated about safety precautions with MA users, so they will no longer be afraid of touching their MA patients due to the "shock and awe" education tactics. Some of the medical providers' reluctance stems from the lack of funding. Eastern Nebraska Treatment Providers would like to see funds for immediate medical care, covering expenses like dental work and anti-depressants. In urban areas, medical providers are overwhelmed by the need for medical resources.

The Western Nebraska Treatment Providers observed that the problem of poor medical care is compounded by the fact that MA users are not forthright with their doctors. Taking medications is not a priority for MA users. A physician cannot expect a direct response when inquiring whether medications are being taken.

Long-Term Care

Continuing care for MA users entering long-term abstinence encounters medical issues such as diabetes, dental problems, and chronic back pain. Users are often afraid to treat chronic back pain because of the concerns of becoming hooked on prescription drugs. Resources to receive this care, the cost of the medical care and the education of medical providers regarding the unique treatment issues for MA users are some of the issues that prevent users from getting the medical care that they need. Low-cost prescriptions are also difficult to attain. This issue is going to deteriorate in Norfolk, since the hospital can no longer give samples (a source of medicine for many).

Dental Problems

Both Eastern and Western Nebraska Treatment Providers concurred that finding resources to address the dental problems created by MA use represents a significant challenge. In Western Nebraska the community health center is unable to handle the dental problems created by methamphetamine use. Dentists do not want to take Medicaid patients because they are already over their limit providing dental care for children on Medicaid. There is no way to obtain dental care for the user because there are no funding resources. A participant from North Platte noted that dentists in the North Platte area have put on a free dental clinic, either annually or semiannually, to provide methamphetamine users with needed dental care.

Medical Coverage

The Western Nebraska Community Support Providers identified an insistent need for Panhandle residents to secure financial help for prescriptive medication. The community support providers can attain assistance with obtaining psychotropic drugs, but not for pain killers. Nearly all of the MA users that rural community support providers work with do not have medical coverage other than Medicare. Many people do not meet the criteria for Medicaid. The Eastern Nebraska Treatment Providers suggested funding free and reduced-cost clinics.

Risk of Violence

A body of empirical research associates stimulant use with anxiety, psychotic symptoms, depression, attempted suicide, paranoia, aggression, and violence (Maxwell 2005) (Boles S 2003) (Zweben J 2004). *TIP #33* (Rawson 1999) recommends preparations for violence associated with MA abuse. MA users describe with a lifestyle of violence with the user in both victim and perpetrator roles (Cretzmeyer CM 2003) (Maxwell 2005) (J. Cohen 2004). In the *Methamphetamine Treatment Project*, users reported abuse or violence from their partner, friends and others. (Maxwell 2005) (Cohen J 2004). ER staff need to be prepared for presentations of MA-associated aggression and violence in emergency rooms (Maxwell 2005). Counseling staff must also be trained to handle psychotic symptoms (Zweben J 2004).

	Justice Professionals		Treatment Providers		Community Support Providers
Barrier to Implementing Best Practices	E. Neb	W. Neb.	E. Neb.	W. Neb.	W. Neb.
MA users cannot concentrate on treatment when their medical & dental needs are unmet	•	•	•	•	•
Doctors reluctant to treat MA patients			•	•	
Hospital staff afraid of touching MA patients			•	•	
No funding resources for dental care			•	•	
Lack of medical coverage			•		•
Many MA users do not meet the criteria for Medicaid					•
MA users are not forthright with their doctors				•	
MA users fear becoming hooked on pain relievers, so are afraid to treat chronic back pain				•	
Long-term continued care needed for medical issues, dental issues, chronic pain, cognitive damage, and vocational rehabilitation			•		
Dentists reluctant to take Medicaid patients (already over their limit providing dental care for children on Medicaid)				•	
Financial help needed for prescriptive medication					•

Table 18. . Barriers to Implementing Best Practices in Medical Aspects, as identified by Eastern and Western Nebraska Justice Professionals, Treatment Providers, and Community Support Providers, 2005.

Special Groups and Settings

The roundtable discussions identified the following impressions of special groups and settings in Nebraska.

Co-occurring Diagnosis

The Eastern Nebraska Treatment Providers would like to see wet houses to accommodate the high needs of MA users with co-occurring diagnoses.

Juvenile MA Users

The Western Nebraska Community Service Providers stated their goal to intervene and treat juveniles while they have an acute problem, before it becomes a chronic problem. The Western Nebraska Justice Professionals observed that juveniles start using MA between 12-15 years of age. Many of them learn it from their siblings. The Eastern Nebraska Treatment Providers noted that MA use at ages 16-19 diminishes juveniles' cogitative abilities, placing a burden on the school district. In Sidney, roughly 60% of the youth and young adults requesting services are not under court orders, although they may be ordered by another agency.

The Western Nebraska Community Support Providers were disillusioned by the lack of swift interventions for first-time juvenile offenders. Delays in court prevent juveniles from receiving treatment the day that they are picked up. Eastern Nebraska Treatment Providers expressed frustration regarding securing treatment for gang members and other dangerous/high-risk juveniles. The Western Nebraska Justice Professionals suggested hiring Substance Abuse Officers who can also work with juveniles.

The Western Nebraska Community Support Providers turned their attention to the barriers to securing treatment for juvenile MA users. Limited money and services are available in Western Nebraska for youth MA programs. Contract reimbursement policies interfere with

securing individualized treatment. Magellan was used as an example, because it will not pay for inpatient treatment unless the juvenile MA user has failed an outpatient treatment program. There is a wait time as long as a year to enter residential programs. Once a juvenile is in treatment, contracts will not pay for drugs for youth in residential settings. The distance of treatment centers separates juveniles from their families, presenting another hurdle for transporting and involving the juvenile's family in treatment.

Sexual Addicts

Most Easter Nebraska Treatment Providers indicated that they treat sexual addiction as a cross-addiction, relying on an addiction model. Continuing care for sexual addicts should include medical evaluation and care for co-occurring diseases. In addition to HIV, the spread of HEP C is seen in many MA users. The group noted that HIV patients are moved to the top of any waiting list. Treatment providers must also be alert for signs of Post Traumatic Stress Disorder (PTSD) and eating disorders. If available, a sexual addiction counselor would play a significant part in the continued care program.

Homeless Population

The Eastern Nebraska Treatment Providers pointed out that all treatment services most appropriate for the homeless population are waitlisted.

Language Barriers

The Eastern Nebraska Justice Professionals emphasized that receipt of equal services is a constitutional right. However, because insurance providers do not provide translation services, people who speak other languages cannot receive appropriate treatment. Eastern and Western Nebraska Justice Professionals see a high demand for bilingual treatment providers and certified interpreters. In some communities near Lexington, it was estimated that 75-80% of probation contacts are non-English speaking. This language barrier creates difficulties when addressing MA issues.

The Eastern Nebraska Justice Professionals were aware of only one treatment facility in Omaha that provides services for people who speak Spanish. Even so, the need is not only for Spanish-language interpreters and providers. The Eastern Nebraska Treatment Providers identified a high need to fund interpreters for Spanish and Sudanese and deaf MA users.

Criminal Justice System Population

Both Eastern and Western Nebraska Justice Professionals would like to see a change in judges' philosophies regarding MA abusers away from the "nail 'em and jail 'em mentality". The judges seem to be relying upon the jail/prison systems to stabilize MA users. To make a good impression on the judge at parole hearings, the majority of offenders volunteer for MA treatment. This practice clogs the system when the offender is not in urgent need of treatment, wasting limited opportunities that could help MA users who are in need. Eastern Nebraska Justice Professional voice concerns that treatment may not be effective when offenders have such a casual attitude regarding it.

To combat their inability to respond to MA users' needs quickly, the Eastern Nebraska Justice Professionals recommended coordination with all agencies, including treatment and justice professionals.

The Eastern Nebraska Justice Professionals also pointed that the current system is set up so few felony drug offenders can receive treatment for MA addiction.

Native Americans

The Western Nebraska Justice Professionals revealed that many Native Americans have a MA problem but cannot afford treatment. The system is also overloaded, making it impossible to send all 400 Native American MA users for treatment.

Women MA Users

The need for treatment tailored to women's needs, specifically with a parent/child focus, was discussed by the Eastern and Western Nebraska Treatment Providers. The Western Nebraska Community Support Providers pointed out women fear entering a 30-day treatment center because they don't want to put their children in foster care. Many female MA users do not have a healthy support network to care for their children while they're in treatment, since their peers often are also MA users. Community support providers would like to see funding for day, evening and weekend child care.

Other issues pertaining to female MA users were identified by the Eastern Nebraska Treatment Providers. Eating disorders are a common co-occurrence in women. Family treatment is often necessary, since women's significant others tend to also be MA users. The Western Nebraska Treatment Providers and Justice Professionals reported an increase in the number of pregnant mothers who are using MA. Eastern Nebraska Treatment Providers stated that pregnant MA users are bumped to the top of waiting lists for services.

Rural Communities

The Western Nebraska Community Support Providers described the attraction of rural communities for MA users and producers. Small communities provide lower housing costs, a chance to fly under the radar of sparse law enforcement personnel, and a large transient population.

The transitory nature of rural communities in Western Nebraska includes an influx of Native Americans, along with people from the neighboring states of Wyoming and Colorado. MA users come to one town for a few months, but once they get into trouble or have contact with the authorities, they move to a different town. Many times Western Nebraska Community Support Providers see a MA user once and the individual moves without receiving the chance to go to treatment. All of the professionals representing Western Nebraska noted that this transient lifestyle makes it difficult to gauge the scope of MA problems in any given town. Oshkosh, Chappell, Morrill County, Kimball County, Deuel County, Sioux County, Garden County, Dawes County, and the western edge of Scotts Bluff were identified as counties facing the problem of transient populations and limited ability to get them to treatment.

Small communities try to decrease the problem of chronic MA use among 21-40 year olds where long-term treatment is required, by targeting the acute cases, the juveniles age 19 and under who need immediate help. However the isolated, rural communities offer very few treatment options for those who seek assistance.

Western Nebraska Community Service Providers highlighted the need for a more structured referral base, involving collaboration among all agencies including doctors, psychologists and the justice system. This would be particularly beneficial for individuals completing treatment and returning to their home community.

Race-Ethnic Differences

Eastern Nebraska Justice Professionals observed that Omaha is a multi-cultural city. Race and ethnic differences among MA users were discussed. The Eastern Nebraska Justice Professionals reported an increasing number of African American MA users. In Eastern Nebraska, Hispanic MA users are more likely to be suppliers/dealers.

The Western Nebraska Justice Professionals, Treatment Providers and Community Support Providers said that not all areas reported that MA use was racially related. In Sidney, MA use tends to be associated with a lower socioeconomic class.

	Justice Professionals		Treatment Providers		Community Support Providers
Barrier to Implementing Best Practices	E. Neb	W. Neb.	E. Neb.	W. Neb.	W. Neb.
High demand for bilingual treatment providers and certified interpreters	•	•	•		
Judges relying on jail/prison systems to stabilize MA users	•	•			
Increase in pregnant MA users		•		•	
Need for parent/child focus for MA treatment programs			•	•	
High needs of MA users with co-occurring diagnoses			•		
Reduced cognitive abilities of juvenile MA users places burden on school district			•		
Delays in court prevent juveniles from receiving treatment the day that they are picked up				•	
Difficulty in securing treatment for gang embers and other dangerous/high-risk juveniles			•		
Limited funds and contract reimbursement policies interfere with treatment for juvenile MA users					•
Wait time as long as a year to enter juvenile residential programs					•
Continuing care for sexual addicts should include medical evaluation and care for co-occurring diseases			•		
All treatment services most appropriate for homeless persons are waitlisted			•		
Insurance providers do not provide translation services	•				
Offenders volunteering for MA treatment to impress judge at parole hearing clogs system	•				
Few felony drug offenders can receive treatment for MA addiction	•				
Many Native Americans have a MA problem but cannot afford treatment		•			
Women won't enter 30-day treatment center because they don't want their children in foster care				•	
Eating disorders common among female MA users			•		
Transitory nature of rural communities in Western Nebraska limits treatment contact					•
Isolated, rural communities offer very few treatment options					•
More structured referral base needed					•
Increasing number of African American MA users	•				

Table 19. Barriers to Implementing Best Practices for Special Groups and Settings, as identified by Eastern and Western Nebraska Justice Professionals, Treatment Providers, and Community Support Providers, 2005.

Education, Training & Staffing

Health Professionals

The Eastern Nebraska Treatment Providers made a plea for educating doctors, nurses and psychiatrists in identifying addiction. The Western Nebraska Treatment Providers thought that it would be of value to train emergency personnel on how to deal with MA addicts, including how to implement safety precautions and how to interact with the police to determine contamination risks. Home health professionals were also singled out as potentially benefiting from training in dealing with MA addicts and how to react to the environment. The Eastern Nebraska Treatment Providers were in favor of requiring mandatory continuing education units for doctors, dentists and nurses.

Business Leaders

The Western Nebraska Treatment Providers discussed the need to educate business leaders regarding MA's effects on people in the community. Real estate agents and merchants could be trained to notice signs that suggest methamphetamines are being used. Some community education programs have had positive results. An effort to educate farmers in the central portion of the state regarding signs that MA labs are being operated nearby was well attended by farmers. Farmers have subsequently provided law enforcement officials with information that has resulted in the shut-down of several labs.

Friends & Family

The Western Nebraska Treatment Providers reported that 85% of MA users are brought into treatment by someone else. Community education can address the topic of how to get help for someone who is using MA. Parental and family education is also vital for prevention and identification efforts. The DARE Program was praised for their efforts.

Legislators

The Eastern Nebraska Treatment Providers would like to educate legislators so that they understand the full issue, rather than just seeing a piece of legislation. They thought that this is especially relevant with the term limits that now exist.

Schools

Input from teachers and school professionals is essential to early identification of MA users. Eastern Nebraska Treatment Providers said that teachers and principals may be reluctant to report MA use, because the school doesn't want to shoulder the financial burden. Recommendation was made for continuing education on MA for teachers, and staff in-service training on what to look for to recognize drug use and guidelines in what to do once drug use is identified.

Prevention efforts were addressed by the Western Nebraska Treatment Providers. They were impressed by the efforts of SICA (State Incentive Cooperative Agreement), a regional prevention group working to promote prevention efforts in Greater Nebraska. The group's focus has been elementary school prevention, using a model that allows each community to adopt their own strategy based on areas of need (for instance, alcohol use may be the forerunner drug of choice in one community, while MA or marijuana may be another community's chief issue).

The Eastern Nebraska Treatment Providers singled out Gretna's Parent Call Line for recognition as a model drug prevention program.

Research

Linking research, policy making & treatment can give researchers and policy makers insight into the reactions of consumers and treatment providers to programming (Blumenthal 2005). The academic institutional infrastructure in place today, however, inhibits collaboration across departments, institutions and professions (Boust 2005). Higher effectiveness and efficiencies can be obtained by partnering Nebraska State and Regional officials with academic institutions for their research needs (Boust 2005).

In addition, practitioners need training tools that can keep them abreast of the best practice models and cutting-edge treatment protocols, like teamwork and collaborative care training which are needed in Nebraska (Boust 2005). Nebraska's training repertoire is also sorely deficient in interdisciplinary approaches for practitioners (2003) (Boust 2005).

Criminal Justice Professionals

The Western Nebraska Justice Professionals noted that the current focus on policing is to trace MA dealers more than users in possession. The Eastern Nebraska Treatment Providers perceived conflicting theories among law officials regarding how to treat MA users. They suggested that requiring judges, lawyers, probation officers and court personnel to take continuing education regarding MA would help develop a unified, client-centered approach. A consistent response to MA offenses was considered particularly important, since MA users experience numerous contacts with the justice system because of numerous infractions with the law as offenders recidivate because of MA use.

The Western Nebraska Justice Professionals were concerned with retention and recruitment of criminal justice professionals. The chief barrier to recruiting people to work for the justice department is the lack of an adequate salary to permit professionals to move their family with them.

The Eastern Nebraska Justice Professionals addressed the issue of losing Substance Abuse Officers (SAOs) to other states. While the SAOs are highly trained professionals, working with law enforcement officers, taking high risk assignments that deal with parole, intensive supervision and the drug court population, they are overloaded and do not receive overtime pay. Compared to Iowa, Nebraska's SAOs make $10,000 less per year. It was also asserted that the reimbursement rate for education and training certifications is too low.

Treatment Providers

Lack of Professionals

In *The Nebraska Academic Health Centers Plan for Excellence in Behavioral Health*, the University of Nebraska Medical Center, Creighton University and the State of Nebraska (working together as the Behavioral Health Reform Academic Support Work Group) determined that:

> *People with substance abuse and mental illness should have access to needed services within their communities or as close to home as possible* (2003).

A survey of the workforce supply in Nebraska, however, does not support this possibility. In fact, the lack of behavioral health care professionals in Nebraska has reached crisis proportions, reflecting a scarcity of mental health and substance abuse professionals particularly in rural Nebraska. The Nebraska Office of Rural Health and Primary Care has designated Regions 1 through 5 as mental health professional shortage areas.

Compared to the national average of 31.2 psychologists per 100,000 population, in 1998 Nebraska had only 26.5 psychologists per 100,000 population. Nebraska was also below the national 1998 average for social workers, with only 205.3 social workers per 100,000 population, compared to the national average of 216.0 (2003). *Table 20* below reflects the number and location of psychologists, substance abuse counselors (CADAC), and Licensed Mental Health Professionals (LMHP) certified by HHSS.

	CADAC	Prov. CADAC	LMHP	Prov. LMHP	Psychologists	TOTALS
Region 1	21	8	64	22	8	123
Region 2	11	7	65	17	5	105
Region 3	60	21	213	63	28	385
Region 4	20	22	114	61	21	249
Region 5	89	59	493	183	129	963
Region 6	110	63	815	329	137	1454
Multi-Region	24	5	152	9	20	210
Total	346	185	1916	684	348	3479

Table 20. Locations of Psychologists, CADAC, and LMHP's by Nebraska Region; UNMC Health Professions Tracking Center. (2003)

Nebraska ranked 27th among states in psychiatrists per capita in 1998, with 6.7 psychiatrists per 100,000 population, compared to the national average of 11.1. (2003). Of Nebraska's 93 counties, 21 have no licensed psychiatrists, psychologists, social workers, counselors, or marriage and family therapists; while only one mental health professional is reflected in 24 Nebraska counties (2003). *Table 21* below illustrates the locations of these mental health professionals.

	Psychiatrists		Child/Adol. Psychiatrists		Nurse Practitioners		Physician Assistants		TOTALS	
	#	%	#	%	#	%	#	%	#	%
Region 1	5	4%	1	5%	1	5%	0	0%	7	4%
Region 2	4	3%	1	5%	0	0%	0	0%	5	3%
Region 3	16	13%	3	14%	3	15%	0	0%	22	13%
Region 4	7	6%	0	0%	0	0%	2	40%	9	5%
Region 5	23	18%	3	14%	4	20%	1	20%	31	18%
Region 6	72	57%	13	62%	12	60%	2	40%	99	57%
Totals										

Table 21. Locations of Mental Health Professionals by Nebraska Region; UNMC Health Professions Tracking Center. (2003)

Maintaining qualified practitioners is another topic for concern relating to Nebraska's lack of treatment professionals. In fact, the Academic Support Work Group (2003) labeled education as a critical mission in their needs assessment. They recommended varied training programs relevant to Nebraska's local populations, as well as an area of special focus to train public sector behavioral health professionals. Enhancing interaction among clinicians, policy experts and public mental health advocates was proposed in order to provide clinician trainees with exposure to health care systems, research and outreach.

Treatment providers in Nebraska have raised the issue that the least trained people are working with highest risk clients. While not unique to Nebraska, the state appears to be suffering symptoms similar to the treatment provider education paradoxes identified by the Annapolis Coalition:

- *Graduate programs have not kept pace with the dramatic changes wrought by managed care and subsequent health care reforms, leaving students unprepared for contemporary practice environments*
- *Continuing education models persist in using passive, didactic models of instruction that have been proven ineffective in controlled research*
- *Non-degreed and bachelor-degreed direct care providers, who may have the most contact with consumers, receive very little training.*
- *Consumers and families, who play an enormous care giving role, typically receive no educational support*. (Boust 2005)

The Behavioral Health Reform Academic Support Work Group identified the need statewide for practitioners at all levels (2003). In a later report, the Academic Support Work Group emphasized the projected need for behavioral health providers in all areas of the state, addressing the full continuum of care including emergency services, long term care, rehabilitation and community support (Boust 2005). The State was advised to find ways to recruit and retain providers representing all disciplines of behavioral health (2003).

The roundtable discussion groups called attention to the shortage of workers, counselors, tech staff, case managers, and dual diagnosis professionals. Western Nebraska faces a challenge in importing quality staff because the rural areas offer limited job opportunities for spouses. The Western Nebraska Community Support Providers speculated that retired nurses might provide potential pool of workers. Cross-training local people to identify and work with MA users was proposed to increase saturation.

Research indicates that peer specialists are seldom employed in Nebraska and that education activities are needed to support the emerging concept of consumers as providers (Boust 2005). The Eastern Nebraska Treatment Providers suggested that treatment providers draw upon the alumni base from 12-step programs to assist MA transition from one level to the next. The Eastern Nebraska Treatment Professionals also suggested that agencies draw not only from their alumni, but create working relationships across different treatment settings.

The Behavioral Health Reform Academic Support Work Group called for education activities that broaden service coverage in underserved geographic areas (Boust 2005). Outreach training and services, such as telephone or tele-video consultation would particularly support local needs in outlying Nebraska, but remain uncommon and rare (2003). It appears that the tradition of face-to-face contact between patients and clinicians tends to suppress spontaneous innovation with such practices. Support is also needed for rural rotations (Boust 2005). The Western Nebraska Community Service Providers endorsed the concept of creating local networks. Telehealth medicine was one option. Developing virtual AA/NA support groups was another. Virtual training was mentioned as an opportunity to secure education credentials without transportation costs.

Transportation costs pose a significant challenge for staff. The Eastern Nebraska Treatment Providers indicated that the current system for reimbursement is not compensatory for treatment providers. The Western Nebraska Community Service Providers indicated that there

is no payment for team meetings. The Western Nebraska Community Service Providers were particularly concerned about the reimbursement issue, noting that they don't break even on the driving reimbursement rates. The reimbursement system for HHSS won't reimburse mileage for family services unless travel of 25 miles or more is required. In addition, the system does not support windshield time – community service providers are not paid for being in a car.

As gas prices increase, the Western Nebraska Community Providers predicted that MA users' access to services will decrease, unless a local solution is in place. Satellite offices staffed on a weekly basis were suggested. Another idea was to refer MA users to local facilities staffed at an hourly reimbursement wage. The community service providers agreed that seeing people in the community rather than in a centralized office would provide a better continuum of support for MA users.

Case Management

The Western Nebraska Treatment Providers expressed a need for case managers who can handle the outcomes, record keeping, etc. The Eastern Nebraska Treatment Providers validated this claim, saying that the case management positions that currently exist are given too many clients. Users without case managers are not receiving services. The Eastern Nebraska Treatment Providers' ideal model would assign a case manager to the client at pre-assessment who would follow the MA user all the way through the client's continuum of care, even assisting with employment, finances and life skills. At this time, case management is being performed by community support providers because the treatment providers are concentrating on treatment. Many agencies rely on practicum students for this help.

The Western Nebraska Treatment Providers described a case manager/liaison model based on what is being done in Michigan, South Carolina, Texas and Arizona. A local liaison serves in a case management/peer advocate capacity as the client's long-term care provider, connecting the MA user with his home while in treatment. Before the MA user leaves for treatment, the liaison meets with the MA user and commences paving the way toward the long-term recovery process. Because the liaison is a part of the community where the MA user resides, even if the treatment facility is far from the MA user's community, the liaison works to engage the family in the treatment process. The liaison guides the MA user through the continuum of treatment services. The liaison holds a discharge conference with the MA user and assists the recovering addict through a step-down process, connecting the patient to community support services after leaving treatment.

Substance Abuse Education

Research points to a current state of crisis in the education system for behavioral health professionals. The educational system has not kept pace with the accelerating changes in behavioral health care, lagging behind in translating current research into training (Hoge 2002; Daniels 2005). Nebraska's Behavioral Health Reform Academic Support Work Group characterized a lack of statewide coordination for academic and education efforts as the cause of fragmented service delivery (Boust 2005).

Accreditation requirements, board examinations, and state licensing requirements currently dictate Nebraska's training and continuing education opportunities (Boust 2005). Training curricula need the flexibility to adjust to changing treatment methods, while retaining credibility for licensure (Boust 2005). Public-sector behavioral health specialists need specialized training, accompanied by mandatory clinical training (2003).

The Eastern Nebraska Treatment Providers attributed the limited number of qualified treatment professionals in the state to the high level of education required in exchange for a relatively low rate of pay. A prime example can be found in the licensing and certification requirements for LADACS. In order to meet the 6,000 hours of supervised clinical experience required, applicants can substitute an associate's degree in addictions or chemical dependency for 1,000 hours, a bachelor's degree for 2,000 hours, and a master's degree for 4,000 hours (Neb. Rev. Stat. Sec. 71-1,357). The state requires 270 hours of alcohol and drug counseling plus 300 hours of supervised practical training just to obtain a *provisional alcohol and drug counselor* license (Neb. Rev. Stat. Sec. 71-1,355). Not only does this demand a high degree of commitment from potential counselors, the thousands of hours of supervised clinical experience tax the capacity of the State's professionals required to deliver this oversight.

The Eastern Nebraska Treatment Providers observed that to implement a best practices model, staff will require an even higher level of dually credited training. As a trade off for higher pay, treatment professionals proposed that agencies require licensures and certificates. More substance abuse and MA training opportunities, a certificate for co-occurring disorders, and mandatory continuing education credits were identified to prepare the level of professional staff necessary to implement the best practices model.

Training barriers include finances, the time required, and lack of professionals with dual credentials. Masters level professionals' reluctance to work with MA addiction was another obstacle, since funding sources like Medicaid won't accept LADACs or those working toward their license.

More substance abuse licensing programs and criminal justice training at the collegiate level were suggested by the Eastern Nebraska Treatment Providers. They also favored combining LADAC and LMHP licensure. They agreed that students would benefit from training in dealing with dual diagnoses that are common with MA users. The Western Nebraska Community Support Providers suggested combining training with agencies and creating a training academy for substance abuse professionals.

	Justice Professionals		Treatment Providers		Community Support Providers
Barrier to Implementing Best Practices	E. Neb	W. Neb.	E. Neb.	W. Neb.	W. Neb.
Shortage of workers, counselors, tech staff, case managers and dual diagnosis professionals	•	•	•	•	•
Current system for reimbursement does not adequately compensate treatment providers			•	•	•
Case managers have too many clients			•	•	
Doctors, nurses & psychiatrists need to learn how to identify addiction			•		
Emergency personnel need training on safety precautions for MA addicts and interaction with police to determine contamination risks				•	
Home health professionals need training in dealing with MA addicts and how to react to the environment			•		
Business leaders need education regarding MA's effects on people in the community				•	
Parents and family need education for prevention and identification				•	
Legislators need to understand full issue			•		
Teachers and principals reluctant to report MA user, because school doesn't want to shoulder the financial burden			•		
Need to focus on elementary school prevention				•	
Conflicting theories among law officials regarding how to treat MA	•				

users					
Judges, lawyers, probation officers and court personnel need continuing education regarding MA	•				
Lack of adequate salary hinders recruitment and retention of criminal justice professionals		•			
Losing Substance Abuse professionals to other states	•				
Reimbursement rate for education and training certifications is too low	•				
Low rate of pay hinders recruitment and retention of treatment providers			•		
Lack of finances and time bar treatment professionals from training			•		
More substance abuse licensing programs and criminal training is needed at the collegiate level			•		
More training needed for dual diagnoses			•		
Rural areas offer limited job opportunities for spouses				•	
Need to draw from alumni base			•		
Need to create local networks for telehealth, virtual AA/NA groups, and virtual training				•	

Table 22. Barriers to Implementing Best Practices for Education, Training & Staffing, as identified by Eastern and Western Nebraska Justice Professionals, Treatment Providers, and Community Support Providers, 2005.

Community Support

Wrap Around Support

The Western Nebraska Community Support Providers favored wrap-around support utilizing the Strength-Based Model. Community education would educate groups on prevention and identification of MA abuse, reaching out to doctors, pharmacists, parole and probation officers, HHSS, hospital, EMS, law enforcement officials, psychiatrists, churches, parish nurses, public health resource nurses, schools, rural bus drivers, college student health services, foster care providers, HIV- HEP C clinics, the Nebraska AIDS Project, WIC family planning teams, Child Protective Services, child abuse teams, community centers, and recipients of 21st Century Grants. Telehealth resources would be employed to reach management teams.

Informal supports provide vital resources as MA users' numerous needs strain the system. MA users repeatedly cycle through the system due to relapse. Without proper referrals and an established continuum of care, MA and general substance abuse resources are spent inefficiently in this recurring cycle.

A flaw in the current system was pointed out by the Eastern Nebraska Treatment Providers: because community support staff members are undervalued, the least experienced employee is working with the highest risk clients. Because there is not enough staff, some participants rely on practicum students.

The Eastern Nebraska Treatment Providers encouraged training community support staff to work in the client's home environment, where they can give assistance in specialty and acute areas. Working with the client within his/her own community was emphasized, providing valuable life skills lessons including budgeting, cleaning, cooking, job hunting, and securing transportation.

Both the Eastern Nebraska Treatment Providers and Western Nebraska Community Support Providers discussed the challenges in linking recovering MA users to jobs. The Western Nebraska Community Support Providers posed the problem bluntly: "If they didn't want to work before…why should they want to work now?" Without a job, the MA addict may return to selling drugs and incur a felony charge. Barriers to employment include the applicant's physical

appearance associated with MA use, as well as cognitive damage that interferes with the applicant's ability to hold a job. Surgery and medical costs associated with long-term treatment compound the problem. The Eastern Nebraska Treatment Providers recommended vocational rehabilitation for MA users.

Regional Support

The Eastern Nebraska Treatment Providers saw an opportunity for treatment providers to network to services in other regions. However, funding issues drive regions to first address their own region, creating pockets that are competing for the money with other regions within Nebraska. The Western Nebraska Treatment Providers gave an example of how this regionalism complicates the system. Law enforcement will not bring someone into emergency protective custody without the approval of the county attorney. Because the county attorney does not want to expend money for someone from a different county, approval will often not be granted if the individual is not a resident.

The Western Nebraska focus group said that the natural linkages for their referrals don't go east; they go west to South Dakota, Wyoming, and Colorado. Denver, Rapid City, Fort Collins, Cheyenne, Hot Springs, and Torrington were named as alternatives to Nebraska treatment shortages. Barriers to intra-state referrals are primarily financial. To access the sliding fee scale, a MA user must be a Nebraska resident. Medicaid coverage does not cross state lines. Intrastate protocols also interfere with Indian Health Services and prescription drug coverage.

The Western Nebraska Treatment Providers proposed intrastate collaboration for meeting education and training needs. All Western Nebraska participants expressed a willingness to work with whomever necessary, regardless of the state, to ensure that their clients received the best care possible.

Drug Court

The Eastern Nebraska Justice Professionals discussed the advantages and disadvantages of drug courts.

Advantages:

- Things happen faster. The patients can receive treatment 3 to 4 weeks after the test.
- Probation officers conduct regular spot checks and reports.
- Success rate for treatment in the drug court is 80%.
- Drug court can provide many services.
- Most drug courts are financially supported locally, and a few receiving funding from both the state and local government.

Disadvantages:

- Due to drug courts' tight budgets, they don't provide primary treatment.
- A shortage of supervisors may leave patients on their own at night.
- The drug court may take resources away from other programs.

The Eastern Nebraska Justice Professionals suggested that the drug court coordinate with other departments to share data, use standardized definitions, etc.

Work Ethic Camp

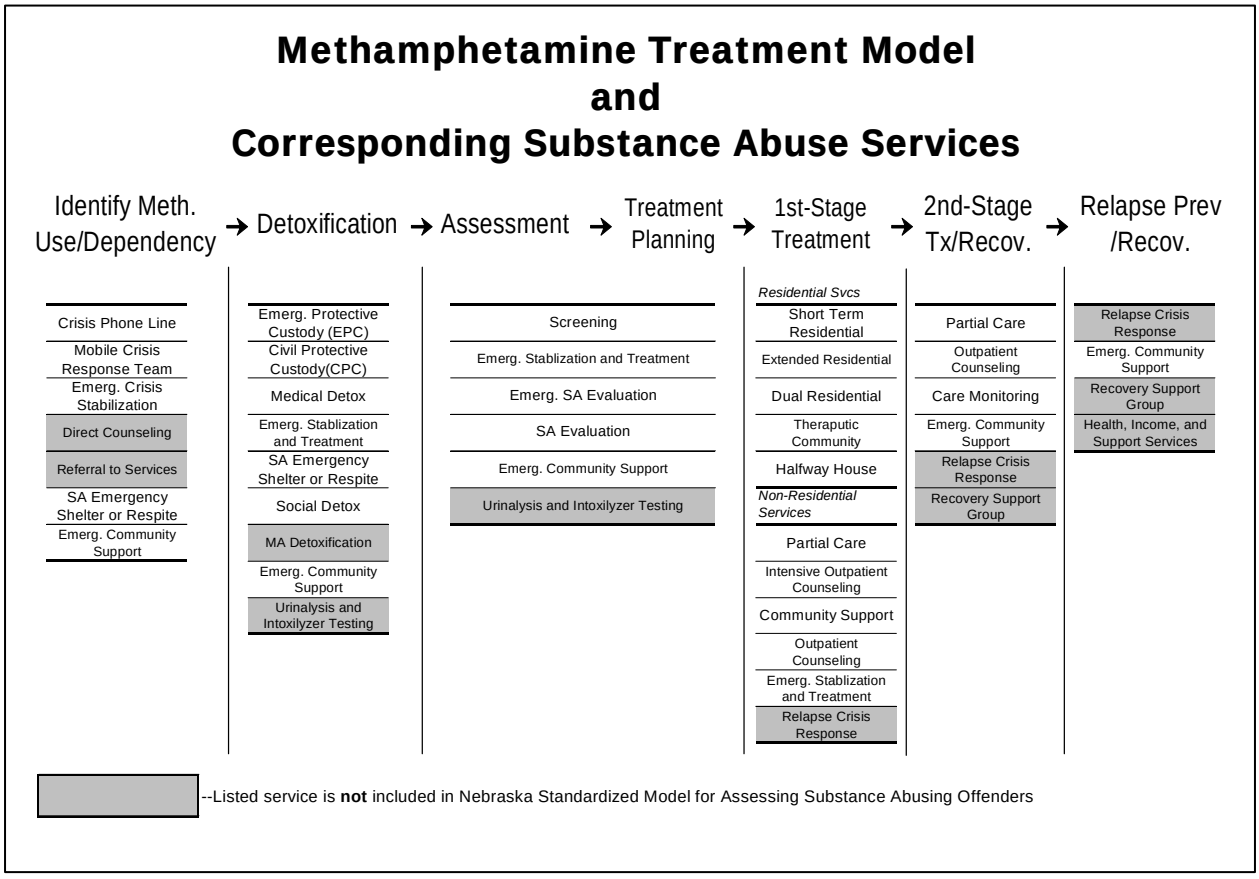
The Western Nebraska Justice Professionals saw work ethic camp as a good treatment option. The Eastern Nebraska Justice Professionals pointed out that the misdemeanor offenders cannot go to the work ethic camp. The treatment beds at the work ethic camp are for drug abusers in general. The Eastern Nebraska Justice Professionals proposed stipulating beds for MA abusers.

	Justice Professionals		Treatment Providers		Community Support Providers
Barrier to Implementing Best Practices	E. Neb	W. Neb.	E. Neb.	W. Neb.	W. Neb.
Natural linkages for services in Western Nebraska go west to South Dakota, Wyoming and Colorado		•		•	•
MA users' numerous needs strain the system				•	•
Challenges in linking MA users to jobs			•		•
Medicare won't cross state lines				•	•
Wrap-around support needed to educate community groups on prevention and identification of MA abuse					•
Least experienced community support providers working with highest risk clients			•		
Regions competing for funding discourages collaboration			•		
To access the sliding fee scale, a MA user must be a Nebraska resident					•
Intrastate protocols interfere with Indian Health Services and prescription drug coverage					•
Drug courts tight budgets	•				
Misdemeanor offenders cannot go to the work ethic camp				•	

Table 23. Barriers to Implementing Best Practices for Community Support, as identified by Eastern and Western Nebraska Justice Professionals, Treatment Providers, and Community Support Providers, 2005.

Recommendations

With a treatment model, cost and prevalence data, site-visit data, and feedback from treatment, social service, and justice providers, a foundation has been laid for final recommendations. The Figure below, illustrates the general MA treatment response model and those substance abuse services which correspond to the different phases of treatment.



A model and service array does not make a treatment and recovery strategy, however. Both the model and services listed above are already implemented to some degree throughout Nebraska. The problem is that gaps, delays, and explicit barriers exist in Nebraska's present substance abuse system which hinder motivated addicts' pursuit of recovery and allow un-motivated addicts to slip between the cracks. To reduce methamphetamine abuse, an infrastructure must be laid which enforces a state-wide response to the problem and channels addicts into a fast-flowing stream of recovery to which it is easier to succumb than escape.

This infrastructure includes three core components beyond the model and service array: people, buildings, and data. The main recommendations for changing or expanding the infrastructure for Nebraska's methamphetamine response system include:

- ***Legislative action and incentives to develop more methamphetamine treatment professionals throughout the state;***
- ***Incentives for treatment providers to expand and develop localized methamphetamine abuse treatment programs;***

- ***Funding and legislative action to establish and staff day/night reporting centers across Nebraska;***
- ***Promoting an increased utilization of the WEC as a methamphetamine treatment facility for those offenders whose crimes and risk do not warrant incarceration by DCS;***
- ***A centralized substance abuse treatment facility for medium and low risk offenders committed to the custody of the Department of Correctional Services;***
- ***Expanding the use of ASI/CASI evaluations and the standardized reporting format throughout all of justice and HHSS;***
- ***A centralized database where substance abuse evaluation results and treatment summaries are kept and accessed by social service, justice, and treatment providers;***
- ***Ongoing research to drive targeted capacity expansion for treatment and recovery service;s***
- ***Ongoing research to monitor the effectiveness of treatment programs; and***
- ***Creating an office which can coordinate the implementation of any recommendations which may be adopted and report to the Governor, Legislature, and Supreme Court on the progress being made.***

The next section discusses in detail each of these recommendations and other recommendations which will contribute to Nebraska's reform effort. To illustrate how these recommendations actively promote a best practices model for methamphetamine treatment, they are organized according to the methamphetamine treatment protocols contained in *Treatment for Stimulant Use Disorders: Treatment Improvement Protocol, Series #33* (Rawson, 1999).

Maximizing Treatment Engagement

Methamphetamine users must be able to easily initiate the treatment process. Rawson says telephone inquiries about treatment must be handled quickly and positively. Treatment locations must be within easy reach of users and accommodate a variety of schedules. The administrative burden of accessing treatment must be minimal and support services such as on-site child-care, targeted financial assistance, and food or shelter vouchers need to be in place.

To maximize treatment engagement for methamphetamine users within Nebraska, the following recommendations need to be implemented.

1) *Improve methamphetamine addicts' ability to link up with assessment and treatment services when they are willing to do so*
   a) *Widely publicize a hotline service by which addicts and families can identify assessment and treatment resources (similar to the gambling addiction hotlines)*
   b) *Educate all justice and social service providers about where to refer addicts and families for assessment and treatment services (tip cards, in-services, dispatcher trainings)*

While detoxification and treatment services exist throughout the state, there is no prominent hotline or referral resource which has been widely marketed to the general public. Compare, however, the numerous television and radio advertisements which identify similar referral services for gambling and other social issues such as pregnancy assistance. If a methamphetamine addict is actually motivated enough to reach out for help, they must know where to call to find out about recovery options. Even when local services are unavailable for

special populations, such as non-English speaking minorities, multi-lingual public service announcements could provide a starting point for addicts and their families.

One of the greatest frustrations for program directors is the inability to match their services with clients who would benefit most. Police officers, dispatchers, social workers, community support specialists, medical doctors, and, in the case of methamphetamine use, dentists can constitute a formidable network of referral sources. Ideally, they should have training on how to provide direct counseling to methamphetamine addicts and families in crisis when the factual circumstances of a situation do not permit official action to be taken. Giving these front-line professionals the means by which they can provide concrete information about available services, though, is a major step towards activating a powerful, but untapped resource in the fight against methamphetamine abuse.

2) *The state must address the scarcity of methamphetamine treatment providers.*
   a) *Immediately develop and implement methamphetamine-specific training for Nebraska mental health and chemical dependency counselors which includes use of the MATRIX Model of methamphetamine treatment*
      i) *Condition state-reimbursement for methamphetamine treatment services on the completion of the state-provided training*
   b) *Re-examine certification and licensure qualifications of LADACs and provisional LADACs to ensure that education and clinical requirements are in accord with the minimal competencies required and are not an artificial disincentive to students and professionals who would otherwise make effective substance abuse treatment counselors*
   c) *Create a degree track within Nebraska schools by which a pool of chemical treatment professionals can be developed; completion of degree, clinical work, and passing of an exam should suffice for licensing and certification requirements*
      i) *Actively recruit students for these programs from the minority populations in Nebraska and establish support mechanisms beneath them as encouragement for them to adopt substance abuse counseling as a viable career*
   d) *Improve financial incentives for people to pursue a career in substance abuse treatment and agencies to provide substance abuse treatment*
      i) *Increase reimbursement rates for substance abuse treatment to reflect the education level and financial/time expenses of becoming a substance abuse treatment specialist*
      ii) *Conduct a salary study to improve the state's ability to attract out-of-state providers, maintain our current base of Nebraska providers, and identify critical positions for which premium salaries are required in order to meet the State's needs*
      iii) *Establish tuition reimbursement and student loan re-payment programs for LADACs who remain in Nebraska*

One of the more surprising findings from the research is that the Nebraska cannot buy its way past the biggest hurdle to establishing effective methamphetamine treatment, at least not very quickly. The State presently faces such a severe shortage of substance abuse clinicians, treatment professionals, and support facilities that every level of service for every type of substance abuse within the continuum of care has a waiting list. Justice and treatment professionals from across Nebraska report that regardless of an individual's personal financial resources, even the initial assessment on which so many critical legal and treatment decisions depend is often delayed for weeks. Similarly, once an assessment has been obtained, addicts

face more delays waiting for admission to the most appropriate level of treatment, if it exists at all. This delay threatens to destroy addicts' motivation as frustration over the lack of services builds. Worse, it increases the likelihood that users and offenders who wish to avoid treatment will escape it: a particularly important concern since most methamphetamine users come to treatment reluctantly. (Rawson, 1999)

The impact of this shortage on individual methamphetamine users is fairly obvious. The impact on the justice and social service process is more subtle, but equally profound. The primary mission for justice and social services is to hold substance abusing offenders accountable for their crimes and/or the family crises of child-abuse or neglect related to their methamphetamine use. When criminal rehabilitation and the restoration of parental responsibility turn on eliminating a person's substance abuse problem, these waiting lists and gaps in the continuum of assessment, treatment and recovery become part of the transactional calculus offenders and parents use to avoid the compelled surrender of addiction. Addicts play justice professionals, social service workers, and treatment providers against each other, exploiting these gaps and shortages as excuses for their lack of recovery progress.

At first blush, it seems the State could solve this dilemma by simply increasing reimbursement rates to entice substance abuse professionals to migrate from other states. As other Nebraska studies have shown, however, this strategy provides only a partial remedy. Unless all substance abuse rates are increased across the board, Nebraska treatment professionals will simply shift around to fill the more lucrative positions and those jobs which rely on state-reimbursed case-loads will remain less financially attractive to out-of-state chemical dependency counselors.

Increasing reimbursement levels would motivate more people to complete the rigorous education and training requirements to become treatment professionals and possibly improve Nebraska's ability to recruit and retain them from other states. The forgiveness of student loans and tuition reimbursement programs for students serving as interns while working on their degree would also make the pursuit of such a career more appealing.

If clinicians are in short supply generally, the scarcity of culturally and linguistically competent providers is even worse. The measures discussed above must be combined with active recruitment, mentoring networks, and the promise of quick jobs upon the completion of prerequisite training to motivate Spanish, Sudanese and members of Nebraska's other minority populations to fill the gaps in treatment services for non-English speaking addicts and offenders.

While it may take years for these types of efforts to pay off, the State must act quickly to fill the current void of methamphetamine expertise in Nebraska. At best practices meetings, participants repeatedly spoke of poor outcomes when treatment specialists tried to apply alcohol and marijuana-related treatment strategies to methamphetamine addicts. The confrontational dynamics of most alcohol recovery programs have proven to be ineffective responses to methamphetamine addicts struggling to maintain sobriety. Although it will shift some treatment capacity away from alcohol and other illicit drug programs until new providers enter the market, the State has little choice but to motivate some existing providers to acquire a specialized expertise in methamphetamine treatment.

In a similar vein, Nebraska must seize this opportunity to establish standardized treatment requirements and documentation regarding methamphetamine. The State is moving towards the widespread adoption of a standardized assessment process with the ASI/CASI and it is not unreasonable to condition reimbursements and contracts on the use of a standardized, evidence-based treatment program for methamphetamine. The MATRIX treatment model has been the

most scrutinized and successful methamphetamine addiction program of the past ten years. It is a manualized, 16 week program designed for outpatient settings, but can easily be adapted and applied within the therapeutic community program of a correctional or treatment facility. Until a more successful treatment model for methamphetamine emerges, Nebraska should aggressively push providers to utilize the MATRIX as the prevailing treatment strategy.

3) *The State must address the scarcity of treatment and supervision locations across Nebraska.*
   a) *Improve financial incentives for local health agencies to provide substance abuse treatment and recovery-support services*
   b) *Fund multiple treatment and recovery hubs across Nebraska's regional population centers*
      i) *Create mobile reporting centers from which supervision and treatment services can be remotely delivered*

The primary obstacle to wide-spread implementation of community-based treatment services is that too few providers are scattered across the State to make this goal feasible. As the recommendations under section 1, above, gradually increase the pool of treatment professionals, hospitals, clinics, and treatment facilities must have an economic basis for recruiting these new professionals. Reimbursement rates need to be differentially structured to account for the situational difficulties of recruiting treatment staff to Greater Nebraska. Policy makers have to realize that many providers require additional work to be located for spouses before they can move to the less populated areas around the State. Financial incentives in the recruitment of treatment providers alleviate the strain on these families and compensate for the diminished income their husbands and wives face. Facility administrators have repeatedly stated these dynamics render the present profit potential from state-reimbursed contracts insufficient to operate chemical dependency programs on the scale needed to meet the State's needs.

One way Nebraska can solve several problems with one stroke is to establish at least one twenty-four hour reporting center in every Probation District or Mental Health Region across the State. Staffed by probation officers, parole officers, LADACS, psychologists/mental health providers, and social workers/community support specialists, these centers would become a hub for all the substance abuse services, supervision, and drug and alcohol testing which will sustain methamphetamine recovery over time. The supervisory powers of probation and parole officers can compensate for less than ideal levels of direct treatment. The centers' physical space will become a venue through which intensive outpatient, individualized counseling, group counseling, and relapse crisis response can be administered and ease the transportation and logistical challenges methamphetamine users face during recovery. The availability of multiple counseling group options and recovery support services will allow offenders to continue their pursuit of sobriety even after they have been discharged from drug courts, probation, or parole.

Day/night reporting centers also provide policy makers with one more way to lure treatment professionals into practice. Free or subsidized office space with telephone, photocopying, and computer networking and internet services comes at a relatively modest cost to the State, but can be a lucrative benefit to contract and private treatment providers delivering services to the offender and HHS populations. To the extent that cities and counties desire the placement of reporting centers in their locations, local government should be able to partner with the State in bearing some of the costs associated with the buildings in which the reporting centers are housed. Alternatively, private/commercial agencies may be willing to provide probation and

parole officers space and support in order to secure convenient access to offender populations for their staff counselors and psychologists who are delivering treatment services.

Obviously, day/night reporting centers cannot be built or staffed in every place in Nebraska so that all transportation and accessibility obstacles are eliminated for every offender. Justice officials from around the state strongly support the creation of mobile reporting centers. Staffed with a probation officer and a treatment specialist, these vehicles could travel between communities with significant numbers of methamphetamine users and serve many of the same functions as the day and night reporting centers. As mobile units, however, they could reduce the practical transportation problems that offenders face when work and residences are removed from population centers within the state and the loss of driving privileges make it illegal for them to drive themselves to a regional center.

4) *Increase utilization of the WEC as a methamphetamine treatment facility for those offenders whose crimes and risk do not warrant incarceration by DCS*
   a) *Judges need to better appreciate Probation's ability to provide offenders with intensive treatment services at the WEC*
   b) *WEC should be allowed salary and/or reimbursement premiums to improve its ability to recruit treatment providers*
      i) *WEC should be granted license to pilot video-conference treatment strategies*

Last year Probation supervised 1250 cases in which the offender had been convicted of methamphetamine possession or some other methamphetamine-related charge. If the full capacity of the WEC had been dedicated strictly to methamphetamine offenders, approximately 300 Probation clients could have rotated through the program. One of the main obstacles to keeping the WEC even half-full of methamphetamine users, though, is that judges do not fully appreciate WEC's ability to provide offenders with intensive, quality substance abuse treatment. It is unclear how these perceptions can be altered, but attempts must be made to do so.

During the research team's site visit, the WEC was revealed to be a bright, comfortable facility, well-equipped with the technological capacity to implement a number of innovative pilot projects. Perhaps the best example of this flexibility is the video-conference system. To compensate for treatment staff shortages, a pilot program using a remote therapist for group or individual counseling should be designed and implemented. To improve the re-integration of WEC residents in their home community, a pilot project in which community-based probation officers remotely confer with the residents on re-entry case planning should be attempted and evaluated. To ensure that supportive family members remain connected with WEC residents during their stay, an experiment which allows video-conferenced visitations may prove an effective alternative to expensive, time-consuming trips. These examples and others illustrate that the WEC possesses untapped potential for providing Probation and the justice system with a wider array of options for rehabilitating methamphetamine-dependent offenders whose recovery progress requires a brief removal from their home community until abstinence can be established.

Efforts of this nature instituted and evaluated over the next twelve to fourteen months will reveal whether expanding WEC's capacity for a larger residential population is justified. Using WEC as a lab where innovative treatment strategies exploit modern communication technology holds the potential for developing discovering even more ways by which the State can attack its overall shortage of treatment professionals.

Assessments and Orientations

Rawson says assessments should be focused, orient the addict to realistic expectations about treatment, provide them with different treatment options to consider, and involve family and friends who support the treatment and recovery process. For methamphetamine users, the person conducting the assessment should be warm, straightforward and non-judgmental. Confrontational tactics can not only diminish a methamphetamine user's motivation for treatment but may also provoke violence.

An evidence-based, standardized assessment process is important to developing effective treatment plans for individual methamphetamine users. It is critical, however, to developing accurate data about Nebraska's treatment services needs on which policy makers can rely while mapping out future capacity expansion strategies and appropriations. To reap the full benefit of assessing methamphetamine users, the State needs to adopt and implement the following recommendations.

1) Methamphetamine detoxification must be managed as part of the assessment process

Methamphetamine addicts undergo two stages of detoxification after they have stopped using. In the first stage, the intense symptoms of methamphetamine intoxication typically resolve by the user going through a long period of sleep. Complications are rare and the only medical responses reported in the literature relate to monitoring the user for hyperthermia and treating it with ice-baths if it becomes severe. This stage of detoxification does not pose any particular problem for assessment.

However, the assessment of methamphetamine users in the second stage of detoxification can be compromised by lingering effects the drug has on an addict's cognitive and psychological capacity. During the site-visit to the Norfolk Regional Center, it was learned that many of the methamphetamine users committed to NRC exhibit signs of psychosis and neurological deficits which suddenly clear 45 to 60 days following the cessation of methamphetamine use. The treatment research literature also reports that methamphetamine addicts experience physiological changes that can produce sudden episodes of psychosis, violence without any prior warning signs, and lead to relapse as many as 45 to 120 days into treatment. This phenomenon, commonly known as "The Wall" is a critical consideration when developing strategies for treatment and relapse prevention for methamphetamine addicts (Obert 2004).

These characteristics of methamphetamine detoxification must be managed in order for a reliable drug abuse assessment to be completed. Unlike most other drugs, assessment results for a methamphetamine user can be dramatically distorted during the 45 to 60 days after their last use. Failure to account for these possibilities can lead to treatment decisions which become inappropriate for the methamphetamine user's new state of mind. The manifestation of severe symptoms in a treatment setting can put staff, family, and other recovering addicts at risk of harm.

For these reasons, it is recommended that the assessment process for methamphetamine users include explicit plans for addressing these potential changes in the addict. At a minimum, methamphetamine addicts should have access to the resources required to obtain two or three assessments as needed during the initial four months after drug use has stopped. Meth-amphetamine users should also have access to services during this time period which can best be described as "Methamphetamine Detox". These services would help the addict manage the

temporary cognitive and neurological deficits, anticipate and avoid violent behavior, and guard against relapse.

2) *All justice agencies should immediately work to implement the Standardized Model for Assessing Substance Abusing Offenders*
3) *All social service and treatment providers should move towards adopting the ASI/CASI for their initial substance abuse assessment tool*

Thanks to the leadership of the Supreme Court, Probation Administration, and the Department of Corrections, most state-level justice officials are actively striving to implement the Standardized Model for Assessing Substance Abusing Offenders. While it is expected that local justice agencies will eventually follow suit, county attorneys and drug courts need to be particularly mindful of adopting these assessment protocols. General diversion and drug courts must work to incorporate ASI/CASI results as part of the criteria by which candidates are selected.

Similarly, it is unclear to what extent, if any at all, HHSS plans to utilize the ASI in assessing the substance abuse treatment needs of parents whose methamphetamine use has interfered with their ability to properly care for children. Adopting the Standardized Model as a key part of reunification planning and/or family counseling would convey the same benefits to juvenile court proceedings for abuse and neglect that are expected in criminal matters. If HHSS is reluctant to utilize this assessment model in all chemical dependency cases, it would greatly contribute to the State's overall methamphetamine reform effort if the ASI could at least be used with parents who are methamphetamine users. The data produced by these assessments would provide a common platform from which the relative treatment service needs of HHSS and justice agencies could be evaluated.

4) *Collect assessment results to a centralized data-base within State government*
   a) *Ensure that all justice, social service and treatment providers can access and review assessment results as needed for treatment and supervision case-planning*
   b) *Ensure that assessment results obtained on juveniles are included in the data system*
   c) *Utilize assessment results and treatment histories to identify which treatment providers and treatment models promote the best recovery outcomes*
      i) *Ensure that researchers have access to the data for evaluation purposes*

Many of the planning questions the Legislature raised in crafting this study have proven impossible to answer more definitively than the estimates reported earlier in the report. For example, despite the Legislature's obvious interest in expanding treatment services which are underdeveloped in the State's present substance abuse response system to ensure that methamphetamine users have all the levels of treatment and recovery services which are needed to ensure success, answering these questions depends on access to standardized assessment results which have been collected throughout justice and HHSS. This data does not exist. This data will not exist even if the ASI/CASI are used for every methamphetamine addict assessed over the next five years—if those results are not collected in a centralized database.

A small group within the JSAT subcommittee of the Community Corrections Council has been working to develop a modest application in which ASI/CASI results can be amassed and accessed by justice and treatment providers. Since this effort has largely relied on the time and resources which its members can string together on an ad hoc basis, progress has been slow.

Uncertainties about funding resources have also constrained design expectations and an implementation schedule. The possible purchase and implementation of similar systems from other states has been explored, but issues related to cost and development schedules have essentially foreclosed this strategy.

That said, a good deal of discussion and planning for the database has already been completed and the group is well-acquainted with most of the design and deployment issues. Mike Overton of the Crime Commission and Dave Wegner of State Probation have provided critical leadership in the process. If funding were made available for the creation of such a database, much of this planning could be harnessed towards a final design and implementation.

For Nebraska to move towards an evidence-based system for substance abuse treatment, however, collecting assessment results is only the first step. A comprehensive data-system would also include treatment summaries which would enable the effectiveness of different services to be evaluated. Accordingly, if the recommendation for a centralized database is adopted, sufficient resources must be provided to grow the application beyond the concept on which the JSAT group has concentrated its energy.

Planning Treatment

Rawson recommends treatment for 12 to 24 weeks followed by some type of support group participation. The MATRIX model of methamphetamine treatment lasts 16 weeks. Simon et al. (Simon S 2004) suggest that during the first 3 months of abstinence MA users may benefit from strategies to compensate for cognitive problems, as during this initial abstinence period neuro-cognitive performance drops, often affecting attention/psychomotor speed, gross and fine motor skills, short-term memory, and fluency (Simon S 2004).

1) *All points of the justice system must commit to substance abuse treatment as an effective deterrent to methamphetamine users' future offending.*
   a) *Criminal sanctions must be structured to balance punitive considerations against the rehabilitative potential of substance abuse treatment.*
   b) *Except when public safety and/or moral outrage demand otherwise, justice planning should be driven by an offender's substance abuse treatment needs.*

When treated offenders and neglectful parents quickly re-enter society and the lives of their families, far from being treated soft-heartedly, they are being held accountable for their acts in the most appropriate way society can design: they are being forced to daily assume responsibility for repairing the damage left in the wake of their substance abuse and offending. With sufficient recovery support and relapse prevention services in place, methamphetamine addicts can resume their role as a contributing member of society and the web of social involvement which keeps them from succumbing to their old habits strengthens.

The first step in treatment planning depends, therefore, on those justice providers who possess the greatest discretion—prosecutors and judges—to prioritize recovery over sanctions or punishments which are unlikely to resolve the central factor contributing to recidivism, methamphetamine use. At most, prosecutors and judges can ensure that the legal constraints placed on an offender contribute to the addict's recovery; at the least, they have the power to see that legal controls do not detract from it.

2) *Treatment should be community based and non-residential except for addicts with significant, persistent mental health issues*

People who suffer from serious mental health problems *and* methamphetamine addiction present treatment management issues which may not be amenable to outpatient treatment models. As explained above, symptoms from methamphetamine use can mask or distort the perceived mental health of even those people who actually have no psychological or cognitive impairments. Upon the discovery of a methamphetamine user's history for recurring mental health problems, the detoxification process demands a strict abstinence from additional use so that treatment providers can observe and document the user's true state of mental disease. In these instances, residential detoxification during the early stages of recovery may be the only way for clinicians to separate the two.

3) *Treatment should be community based and non-residential except for offenders at a high risk of continued criminal behavior or whose crimes require incarceration*
    i) *A centralized treatment facility with 225 to 250 beds should be developed for the Department of Correctional Services*
    ii) *Assuming the State closes the Norfolk Regional Center, the DCS facility should be located in Norfolk, Nebraska*
    iii) *If the State accepts this recommendation, a Program Statement prepared by an architecture or engineering firm should be commissioned to more accurately estimate the construction, staffing, and operational expenses of the proposed facility*

One of more pressing questions for which the Legislature has sought an answer is whether Nebraska needs to develop a centralized facility for methamphetamine treatment and, if so, where, for how many, and for how much. As the literature review of the Initial Report indicates, the most effective treatment models for the majority of methamphetamine addicts actually focuses on outpatient treatment as the primary intervention strategy. This is good news given Nebraska's desire to develop alternatives to incarceration founded on community based correction and treatment options and fits perfectly with the State's efforts to grow community based mental health services.

A group of offenders will always exist, however, whose resistance to treatment and recovery will outpace even the most complete system of intervention services available at stages prior to incarceration within the Department of Corrections Services. Last year alone, more than five hundred men and women were admitted to the custody of DCS with evidence of a methamphetamine problem. Though the sentences for these offenders vary, all will be reviewed as possible parolees and all will eventually return to society. The question is whether they will have obtained the level of substance abuse treatment and recovery services that are required to keep them from falling back into old patterns of use and offending.

DCS requires a centralized, secure facility in which those offenders who have proven unamenable to the justice and social service system's alternative interventions can finally be forced to initiate aggressive, non-negotiable treatment for their methamphetamine abuse problems. The research shows that while methamphetamine users' are overwhelmingly ambivalent about seeking treatment, they also tend to do just as well in coerced treatment as those who pursue it voluntarily. (Brecht M., 2005)

The potential for a DCS treatment facility to be effective would be greatly enhanced if two more slight changes were made in the justice process points around sentencing an individual to prison. First, to the extent that other security and risk factors permit, all offenders committed to the custody of DCS should go immediately from the DEC to the centralized treatment facility. This practice would enable DCS to detoxify prisoners, identify the degree to which serious, persistent mental health problems emerge upon the remission of drug-related symptoms, deliver the complex array of treatment strategies and structure required for this resistant population, and better orient these inmates for the transfer to regular prison life, transitional incarceration such as OCC, or even parole.

Granted, some inmates may fail and be removed from this treatment facility, but DCS is no worse off for it—they were going to have to place and manage these prisoners eventually. When the strategy succeeds, however, the benefits to DCS and society are tremendous. DCS now has an inmate whose withdrawal and substance abuse-related problems have already been given the maximum response the State of Nebraska can provide. Not only will this minimize potential management problems of the inmate within prison facilities, it positions the offender to better avail him or herself of the vocational, educational, and other therapeutic services DCS provides. This practice shifts DCS focus from simply having to house and manage inmates, and makes them an active, positive force in preparing an inmate to return to society. The strides taken as part of the prisoner's DCS custody establish a solid foundation on which Parole can build re-entry case-plans which optimize the offender's likelihood of success. Similarly, with the treatment gains achieved under DCS custody, HHSS can begin the crucial process to reconnect offender-parents with their children and change the chance of re-unification from a remote possibility to a reality.

The second change required to maximize the effective reach of a centralized treatment facility within DCS is to transplant a few key drug court concepts into Nebraska's criminal courts. Wyoming pursued this strategy and passed legislation which now requires every offender convicted of a felony to receive a comprehensive substance abuse evaluation regardless of their actual crime. Given Nebraska's severe shortage of substance abuse providers, this sort of legislation may not be immediately feasible, but Courts can change the way in which an offender approaches his or her sentence.

Nebraska law allows judges to set both a minimum and maximum period in their sentencing decisions. If DCS had a comprehensive treatment facility in which the court could be confident that offenders would receive aggressive interventions against their substance abuse problem, judges could structure sentence minimums as an incentive for offenders to abide by treatment recommendations and pursue their recovery. Offenders whose primary offenses relate to drug and alcohol use, could even transition directly from the treatment facility to less secure, re-entry oriented facilities like OCC.

Last year DCS admitted 418 men and 109 women who were confirmed methamphetamine users. DCS believes commitment practices to the York Correctional Facility can be adjusted to implement the above treatment protocols for women without a separate facility. The substance abuse treatment program that DCS presently operates runs for ten months. As resources and staff permit, DCS intends to create and implement individualized, evidence-based methamphetamine treatment strategies in which treatment duration is determined by the pace of an addict's recovery progress. Under these circumstances, a male inmate's average length of stay at a centralized treatment facility is expected to be approximately six

months. Assuming that methamphetamine users enter DCS custody at a fairly even rate, the treatment facility will require capacity for 225-250 beds.

In discussions with DCS about a centralized treatment facility, it was determined that methamphetamine users who were classified as requiring a maximum security institution would receive their treatment from within one of the State's maximum security facilities. Methamphetamine users who met medium or low security classification criteria would be sent to the centralized treatment facility.

The total capital cost per bed for the maximum security, 960 bed Tecumseh Correctional Facility was approximately $77,000 per bed. (Carter Goble Associates, 1997) The minimum security, 100 bed Work Ethic Camp cost approximately $65,000 per bed to complete. Since the centralized treatment facility would require only medium security, its costs are expected to be somewhere between the two; factoring in inflation places its per bed estimate at $70,000, with an estimated final expense of $15.8 million to $17.5 million. If the Legislature and Governor adopt this recommendation, the State will need to commission an architecture/engineering firm to complete a detailed Program Statement projecting the specific construction, staffing and operational costs.

Assuming that the State remains committed to closing the Norfolk Regional Center, the centralized treatment facility for DCS should be built in Norfolk, Nebraska. In addition to the considerable amount of land which the State already owns at the NRC, upon NRC's closure, Norfolk will become the only city in Nebraska with at least a temporary surplus of alcohol and drug counselors, LMHP's, and psychologists. Every county, including Madison county, faces an overall scarcity of treatment providers, but none of the other counties have a significant population of treatment specialists who are about to become unemployed. Though other counties, such as Adams, Douglas, and Lancaster, have a larger ratio of treatment providers than Madison County, there are no events pending which will require a large number of them to find alternative employment in the foreseeable future. Though the planned closure of the NRC is only six months away, information gathered during the site visit indicated that the overall staff remained intact.

DCS could build a centralized treatment center anywhere in the state; however, the staffing needs for such a facility would have a devastating effect on most Nebraska cities' community-based service capacity. There are already waiting lists for treatment resources throughout the State. A facility the size of the one recommended for DCS would draw heavily from the local pool of community based treatment providers and simply exacerbate treatment shortages for the surrounding, non-incarcerated substance abuse population. Opening a DCS treatment facility in Norfolk should have little more effect than simply leaving the NRC open.

Among the factors that figure in Norfolk's favor is that DCS may be able to utilize the current NRC facility as an interim treatment center pending the planning and construction of a new building. Though security, fire-code compliance and a complete re-hiring process would have to be managed, the effort would help to keep a core of treatment providers and facility support together and enable DCS to quickly implement its new front-end treatment strategy at least on a more modest scale.

Other factors which point to Norfolk being the most appropriate place in which to locate a DCS treatment facility include:

- A 50+ year success rate in recruiting and maintaining the professional clinical staff required for such a facility

- Extremely strong, vocal, community support for sustaining a treatment facility like NRC and the DCS project
- An established relationship with State educational institutions as a teaching hospital—the maintenance of which will be a crucial element in Nebraska's effort to grow its state-wide pool of treatment providers
- The population of methamphetamine users who are to receive treatment at the facility are not particularly inconvenienced by its Norfolk location because they are there for a relatively short time and they will ordinarily transition from the center into other DCS institutions before returning to their home community

b) Every case plan should encompass both the initial stages of substance abuse treatment and a long-term strategy for recovery and maintaining abstinence

While this recommendation would improve treatment planning from a clinical perspective, it is really aimed at promoting the State's need to understand where gaps in the service array exist. Case-plans which encapsulate only the immediate and short-term treatment needs of the methamphetamine user lack the documentation Nebraska policy makers require to evaluate whether sufficient services are in place to maintain the progress of recovery over time. It is easy to say that support and relapse prevention services are an integral part of an addict's recovery, but debates over funding priorities turn on hard data, not theoretical concepts. The collection of full course treatment plans provides a source from which responsible analyses can be conducted to isolate the extent these late term services demand and deserve funding.

4) Treatment case plans and progress reports must be collected at centralized database within State government

a) Ensure that all justice, social service and treatment providers can access and review treatment plan and progress notes as needed

b) Ensure that treatment plans and progress notes for juveniles are included in the data system

c) Utilize assessment results and tx histories to identify which treatment providers and treatment models promote the best recovery outcomes

i) *Ensure that researchers have access to the data for evaluation purposes*

The outcome indicators buried in the assessment and treatment histories of methamphetamine offenders are the only pathway by which Nebraska will be able to eventually determine which treatment models and funding strategies are consistently effective in reducing the toll of substance abuse on the state's citizens and resources.

Initiating Treatment and Managing Withdrawal

There is no single point in the justice or social services process where policy makers can fix funding decisions or capacity expansion. Instead, every agency and justice provider possesses some lever which can be used to press methamphetamine addicts to seek help or maintain the recovery process.

1) *Initiate assessment/treatment at all stages of the justice/social service process*
   a) *Capitalize on addict's contact with any stage of the justice/social service process*
   b) *Make voucher funds available at all stages of the justice/social service process*
   c) *Fund substance abuse capacity expansion within those stages of the justice/social service system with the potential to impact addiction*

Whether it is the police, HHSS case-workers investigating abuse/neglect allegations, judges making sentencing decisions, parole officers supervising offenders' re-entry programs, or any of the other justice and social service providers executing their official duties, each of these contacts with an addict is one more opportunity to steer offenders to treatment. When these efforts are successful, additional barriers have been erected to keep the methamphetamine user from pushing on to more expensive, intensive systems of punishment.

To promote the conversion of all justice and social service system points into portals for engaging treatment, voucher funds must be available. Flexible funding for assessments and treatment services are the best way to transform these possibilities into genuine opportunities.

Policy makers may debate what priority, if any should be given to the distribution of voucher funds. For example, since the children of HHSS clients are facing the devastating loss of their parents, should these parents receive greater priority for voucher resources than Probation clients who face prison if they violate the terms of their supervision or re-offend? If carefully designed and implemented, the voucher program could eliminate the need for the Legislature to somehow anticipate which agency will require what levels of funding on an annual basis, by simply distributing funds on a first come, first served basis until the support is exhausted.

This type of funding strategy also holds offenders more accountable for their progress in recovery. Consider the example of a newly convicted methamphetamine user. As part of the PSI process, Probation requests the person to complete a substance abuse evaluation. When the offender demonstrates they lack the $75 to $155 for the evaluation, a voucher can issue for the assessment. If the offender continues to follow-through with the treatment paid for by the voucher program, they should remain eligible to receive voucher funds in support of their recovery progress. If the user resists treatment, then voucher funds would not be issued and the user is left to the legal consequences that may result. Similarly, parents involved with HHSS for whom methamphetamine treatment is required, would be motivated to incrementally pursue recovery one step at a time in order to capitalize on the chain of funding support as they seek reunification and the restoration of their family.

2) *Fund urinalysis at all stages of the justice/social service process and collect the results in a centralized database*

One way for the social service and justice systems to monitor the sincerity of a methamphetamine user's efforts to take advantage of these treatment opportunities is the regular use of urinalysis tests. Funding or a State-sponsored testing program need to be created so that the financial impact to state and local agencies for testing is not a disincentive for it to be used as often as necessary. If these agencies are to bear increasing responsibility for intercepting and diverting methamphetamine users from higher levels of justice involvement, they must have all the tools they need to achieve success.

Maintaining Treatment Progress and Abstinence

1) *Establish information exchange required to advance addict's progress through the continuum of recovery.*
    a. *The centralized data base must provide assessment, treatment plans, urinalysis test result and progress notes to treatment, justice and social/service providers at every stage.*
2) *Establish the financial resources required to advance an addict's progress through the continuum of recovery.*
    a. *When addicts continue to satisfy treatment expectations, financial resources must be available to obtain any services reasonably related to long term recovery.*
3) *Leverage justice and social service resources in support of substance abuse treatment.*
    a. *Use justice related supervision to monitor, promote and enforce abstinence, treatment participation and community reintegration.*
    b. *Use prosecution, incarceration and release decisions as incentives for offenders to complete treatment and remain abstinent.*

The familiar ring of these statements demonstrates that the recommendations advanced above constitute elements in a true system of methamphetamine treatment response. Just as these recommendations secured the solid initiation and engagement of treatment earlier, they now extend the addict's journey towards eventual recovery.

Relapse Prevention

1) *The historical neglect of long-term recovery support and relapse crisis services must be rectified*
    a. *Make voucher funds available for health, employment, and general support services*
    b. *Provide methamphetamine addicts with access to recovery support groups and other substance abuse treatment services even after they have been discharged from the oversight and control of justice and social service systems.*

The State's commitment to the end of the recovery process must match its commitment to the initiation of treatment. Once the sobriety of an addict has been stabilized through initial interventions, their continued abstinence will always depend on the accessibility of recovery support and relapse prevention services. Recovery is like a long trip up a steep hill: if the support pushing a methamphetamine user falters, they risk not only stalling, but a rapid plunge back into the valley of addiction from which they had emerged. This fails the methamphetamine user, but it betrays social service, justice, and treatment providers by squandering the time, energy, and resources they already expended.

As with the earlier stages of treatment, the State's best appropriation strategy for promoting life-long abstinence is a pool of flexible voucher funds which can be accessed as the recovered methamphetamine user requires. The availability of these funds will catalyze the expansion of such services. Provided addicts have demonstrated an ability to capitalize on these investments by the state, eligibility should be maintained even though no formal link between Nebraska's social service and justice agencies remains.

Integrating the Implementation of These Recommendations

While this final recommendation does come from *TIP #33* (Rawson, 1999), it provides pivotal support to the State's efforts to implement the recommendations discussed above.

1) *Create an office which can coordinate the implementation of any recommendations which may be adopted and report to the Governor, Legislature, and Supreme Court on the progress being made*

The recommendations of the Initial Report fall across many points of the social service and justice systems and require the coordinated efforts of state and local agencies to keep time from being lost and money from being wasted. A Coordinator with sufficient support staff to organize meetings, promote inter-agency agreements, monitor overall progress, and serve as a liaison to the Governor, Legislature and Supreme Court will be necessary. The overall process cannot be adequately managed by the agencies charged with actually designing and deploying the variety of reforms envisioned. For these reasons, it is recommended that some point of oversight be established within State government.

Summary

As Nebraska attempts to address the MA crisis which it is currently facing, both practitioners and clients will require tools to ensure progress. Some of these tools will be MA-specific; others will be more system specific. The state must develop solutions which address the long term challenge of recovery. The practice of recycling MA addicted offenders through the justice system until they are incarcerated must stop.

Cost Study

A detailed description of the processes used to calculate the estimates included in the cost study is included in the *Methodology* section of this report. The cost estimates are presented as a model to estimate unmet needs in substance abuse treatment services (especially related to MA abuse) in Nebraska and the variable (program) and fixed (facility) costs to address them.

A review and application of the cost findings in the study, "Results from 85 studies using the Drug Abuse Treatment Cost Analysis Program (DATCAP)," by M.C. Roebuck and other economists supported by the National Institute on Drug Abuse (NIDA) reveals the following key findings:

Residential and Outpatient Treatment Costs

According to National Survey of Substance Abuse Treatment Services (N-SSATS) data for 2003, about 85% of clients in treatment in Nebraska received outpatient, 14% received residential and 1% hospital inpatient. Due to the lack of standardized assessments and data collection the proportions of unmet demand at each level of treatment are currently unknown. However, it is possible to illustrate alternative unmet demand cost estimates through a combination of residential and outpatient treatment options as is done in the tables below by relying on the estimated unmet demand.

The estimated costs of providing treatment to meet the unmet demand in Nebraska (those who did not receive, but wanted or would seek treatment if it was available) varies widely according to the level of treatment or program type. *Table 24* shows the estimated costs to meet the unmet demand[12] by type of drug **at any single level of residential or outpatient treatment** (i.e., if all persons needing and wanting treatment were treated at the same level and only at that level).

LEVEL OF TREATMENT/ PROGRAM TYPE (Average Duration)	Average Cost per Treatment Episode	18 Years or Older **($ Millions)**	Ages 12-17 **($ Millions)**	**Total* Age 12+ ($ Millions)**
Meth/Amphetamine-Related **[Persons]**		[818]	[231]	**[1,049]**
RESIDENTIAL				
Adult Residential (13 weeks)	$9,426	$7.7	---	
Adolescent Residential (8 weeks)	$9,347	---	$2.2	
Total Adult and Adolescent Residential				**$9.9**
Therapeutic Community (33 weeks)	$18,802	$15.4	$4.3	**$19.7**

[12] Developing cost estimates for alternative levels of treatment is for illustrative purposes and provides a basic cost range. These estimates are not based on specific data or assumptions about the proportions of unmet demand for treatment at particular levels, nor do they address the issues of determining the most appropriate forms of treatment to meet the unmet demand.

Therapeutic Community (Prison) (28 weeks)**	$1,534	$1.2	$.4	**$1.6**
OUTPATIENT				
Standard Adult Outpatient (17 weeks)	$1,944	$1.6	---	
Standard Adolescent Outpatient (13 weeks)	$2,678	---	$.6	
Total Adult and Adolescent Standard Outpatient				**$2.2**
Intensive Outpatient (7 weeks)	$4,445	$3.6	$1.0	**$4.7**
Drug Court (46 weeks)	$3,463	$2.8	$.8	**$3.6**

Table 24. Cost Estimates for Unmet Demand by Level of Treatment in Nebraska (2003)
* Unmet demand estimates are based on 2003 National Surveys on Drug Use and Health and cost estimates shown in 2001 dollars. Columns may not add due to rounding.
**Does not include incarceration or aftercare costs.

The estimated costs to meet the unmet demand in Nebraska in a comprehensive approach for MA related drug treatment are shown in *Table 25*[13] In other words, *Table 25* illustrates the estimated cost of treatment assuming that the treatment needs of the users are divided evenly between the levels of care. Intensive Outpatient would be utilized instead of Drug Court by someone who has not been accepted into that program. Treatment modalities presented are In-Prison Therapeutic Community (high-moderate need/risk incarcerated offenders), Drug Court (moderate need/risk offenders not incarcerated), Adult and Adolescent Residential (low-moderate abusers/dependent not in the criminal justice system) and Intensive Outpatient treatment.

LEVEL OF TREATMENT/ PROGRAM TYPE (Average Duration)	Average Cost per Treatment Episode	Total Age 12+ (Persons)	Total Cost Unmet Demand ($ millions)
Meth/Amphetamine-Related		**1,049**	**$5.0**
RESIDENTIAL			
Therapeutic Community (Prison)** (28 weeks)	$1,534	350	**$.5**
Adult & Adolescent Residential (13 weeks)	$9,386	350	**$3.3**
OUTPATIENT			
Drug Court (46 weeks)	$3,463	350	**$1.2**
Intensive Outpatient (7 weeks)	$4,445	350	**$1.6**

Table 25. Cost Estimates for Unmet Demand of Meth/Amphetamine-Related Users for Residential and Outpatient Levels of Treatment in Nebraska (2003)*.
* Unmet demand estimates are based on 2003 National Surveys on Drug Use and Health and cost estimates shown in 2001 dollars. Columns may not add due to rounding.

[13] Unmet demand figures by type of drug are divided into approximately thirds for each alternative treatment modality.

**Does not include incarceration or aftercare costs

The cost estimates in *Table 24* and in *Table 25* do not include aftercare (which is an essential element of In-Prison Therapeutic Community) (Belenko, 2005) or incarceration costs, nor do they include other possible modalities in a comprehensive treatment program, such as those incorporated into Probation Department day/night reporting centers.

Estimated Cost of MA Treatment in Nebraska

As demonstrated by the above tables, the cost of providing MA treatment varies greatly depending on the type treatment needed by an individual and the number of individuals requiring that level of care. Until standardized assessments can be administered and the results collected into a central data base, we are unable to accurately pinpoint exactly how many people will need treatment at a particular level of care and estimate the cost. However, given the enormity of the MA problem, it would be imprudent to delay in allocating funds to MA treatment until after the assessment results have been collected.

Although it would be ideal to provide every MA user with treatment, it is understood that some users are not yet to the point that treatment is a consideration to them. The literature review and the best practice meetings both indicated that users often seek treatment once they have become involved with the justice system. Research also shows that coerced MA treatment that takes place as a result of involvement with the justice system is highly effective. Since users involved with the justice system are often motivated to seek treatment and receptive to receiving it, providing treatment to this population is beneficial.

Table 26 below reflects the estimated need for treatment in the State based strictly on those who have become involved with the justice system by being convicted for methamphetamine-related charges or those who tested positive for methamphetamine at the time of their arrest.

	Number of MA-related Offenders	Source
DCS-Men	418	Nebraska Dept. of Corrections (2004)
DCS-Women	109	
Probation	1,250	Nebraska State Probation (2004)
Arrestees	17,269	Estimated from 2003 Arrestee Drug Abuse Monitoring Program results for Nebraska
Total	19,046	

Table 26. Estimated Need for Treatment in Nebraska Based on MA-related Offenders.

In 2004, HHSS reported that 88 abuse/neglect cases were opened involving allegations that parents had chemical dependency problems. Based on these data, *Table 27* below illustrates cost estimates for the levels of treatment services recommended in support of each agency. The cost estimates were calculated by multiplying the cost of treatment at that particular level of service by the estimated need as illustrated in *Table 26*. The cost of treatment is set forth in *Tables 24* and *25*. The cost of an assessment is $75 to $125. This estimate was based on the higher amount to ensure adequate funding.

Estimated Methamphetamine Treatment Costs (2006)	
DCS: Men	
Therapeutic Treatment Community[14]	$641,212
DCS: Women	
Therapeutic Treatment Community	$167,206
Probation:	
Assessments (1,250)	$156,250
Outpatient Treatment (950)	$1,846,800
WEC (300)	$0
Drug Court:	
Across NE (400)	$1,385,200
All other MA-related Offenders:	
Assess 33% (5,600)	$700,000
Outpatient Treatment (1,120)	$2,177,280
HHSS:	
Assessments (88)	$11,000
Outpatient Treatment (88)	$171,072
Total	**$7,256,020**

Table 27. Estimated Methamphetamine Treatment Costs per Nebraska Agency for 2006.

The estimated cost relies heavily on funding assessment costs. By allocating funds for assessment, the state is increasing its potential for cost effectiveness in the future, while beginning to get necessary treatment services to those who will benefit from them. The estimated costs allow every individual entering DCS or probation to be assessed and also provide funds for assessments for arrestees and parents involved with HHSS. Once the results of these assessments have been collected, the state can adjust treatment allocations to address the actual need, not the projected need.

It is assumed that the funds allocated should first be used for their designated purpose. If, however, a portion of the funds allocated for a certain purpose are not utilized, then the residual funds can be utilized to pay for any other service approved for treatment or recovery support. For example, funds are provided for all probationers to receive an assessment. However, if one probationer can pay for the assessment through his private insurance, then those funds might be used by a parent involved with HHSS to obtain an assessment or to provide for another treatment need for the probationer such as dental expenses.

It is proposed that the treatment recommendations be implemented in phases. During Phase I, the emphasis will be spent on treatment services that make the biggest difference in preparing for Phases II and III, such as assessment and outpatient treatment. The information generated by the assessment will determine where missing levels of treatment are needed. Then, during Phase II, the state will be able to redistribute funding to the treatment levels where it is known to be needed. The results of the assessments will continue to show where services are needed but not being received. By Phase III the state will be structuring the appropriation

[14] The Cost of Therapeutic Treatment Community includes the cost of an assessment.

process on actual consumption. At this stage the state will be able to determine what resources are needed from year to year to promote recovery.

Cost Comparison at Existing Facilities

DCS Treatment Costs

A review of sections of the 2004 Nebraska Department of Correctional Services (DCS) annual report related to substance abuse programming and treatment services reveals the following:

- The DCS provides four general levels of care: Residential, Non-Residential, Assessment and Evaluation and Emergency. *Table 28* shows DCS facilities that offer services at the residential, non-residential and assessment/evaluation levels and the annual costs per inmate at each facility.

Level of Care	NE DCS Facility	NE DCS Substance Abuse Program	Total Annual Cost per Inmate
Long-Term Residential and Residential	1. Nebraska State Penitentiary (100 minimum custody males at RTC)	1. Residential Treatment Community (10 months) Parole Violator Program (90-120 days intensive)	1. $27,834
	2. Omaha Correctional Center (72 minimum custody males at SAU)	2. Substance Abuse Unit (10 months)	2. $23,389
	3. Tecumseh State Correctional Institution (32 minimum custody males at SAU)	3. Substance Abuse Unit (10 months)	3. $30,923
	4. Nebraska Correctional Center for Women (28 minimum custody females at SAU)	4. Substance Abuse Unit (10 months) Parole Violator Program (90-120 days intensive)	4. $27,423
Non-Residential	1. Nebraska State Penitentiary	1. Education, Intensive Outpatient, Aftercare	1. n/a
	2. Omaha Correctional Center	2. Education, Intensive Outpatient, Aftercare	2. n/a
	3. Tecumseh State Correctional Institution	3. Education, Intensive Outpatient, Aftercare	3. n/a
	4. Nebraska Correctional Center for Women	4. Intensive Outpatient, Aftercare	4. n/a
Non-Residential (continued)	5. McCook Work Ethic Camp	5. Education, Intensive Outpatient	5. $15,948 (based on number of annual admissions)
	6. Community Corrections Center-Lincoln	6. Education, Outpatient, Aftercare	6. $15,996
	7. Community Corrections Center-Omaha	7. Education, Outpatient, Aftercare	7. $14,705

	8. Lincoln Correctional Center	8. Education, Intensive Outpatient, Aftercare	8. $32,123
	9. Nebraska Correctional Youth Facility	9. Education, Intensive Outpatient, Aftercare	9. $68,275
Evaluation and Assessment	1. Diagnostic and Evaluation Center	1. Diagnosis, Evaluation, Assessment, Classification and Facility Assignment	1. $30,977
	2. Nebraska Correctional Center for Women	2. Diagnosis, Evaluation, Assessment, Classification and Facility Assignment	2. n/a
	3. Nebraska Correctional Youth Facility	3. Diagnosis, Evaluation, Assessment, Classification and Facility Assignment	3. n/a

Table 28. Nebraska Department of Correctional Services Substance Abuse Levels of Care and Costs by Facility

Facility	Annual Cost Per Person	Daily Cost Per Person	Annual Amount Allocated for Treatment*	Annual Average Treatment Amount Per Inmate
Tecumseh	**$30,923.00**	**$91.44**	**$4,254,499**	**$5311**
Penitentiary	**$27,834.00**	**$75.46**	**$6,101,510**	**$5311**
LCC	**$32,123.00**	**$89.96**	**$2,558,891**	**$5311**
York	**$27,423.00**	**$80.60**	**$1,490,408**	**$5311**
Work Ethic Camp	**$15,948.00**	**$45.42**	**$398,398**	**$5311**

* Treatment includes medical care, mental health care, and substance abuse treatment.

Table 29. Cost Comparison by Facility for Tecumseh, Penitentiary, LCC, York, and Work Ethic Camp.

Total Cost Estimates

Development and construction of a centralized, medium security, MA treatment center for DCS is estimated to cost between $15.8 million and $17.5 million. The final cost will ultimately depend upon the total number of beds which are estimated to cost $70,000 per bed. A Program Statement for the treatment facility is estimated to cost $30,000 to $35,000.

The cost of funding the voucher program for Phase 1 is $7,256,020. This expense will provide voucher funds to ensure that those MA users who have contact with the justice and social service systems can have access to assessment and treatment.

The cost associated with creating 24-hour, day and night reporting centers will primarily be in the salaries of those people who are staffing the centers. Ideally each center should house three probation officers with each manning an eight hour shift, a parole officer and a substance abuse counselor. The total expense for this recommendation will depend upon how many day/night reporting centers are created and the final staffing configuration.

The cost for the creation of a data base to compile all of the assessment and treatment data ultimately depends upon the applications that the design team decides to build into the application. Other factors affecting the cost include how comprehensive of a system is created and whether the chosen applications will be able to piggyback on existing computer systems or computer systems that are currently being developed.

The cost associated with reducing the scarcity of treatment professionals likewise depends on the degree to which this recommendation is implemented and the size of the incentives that are ultimately offered to attract new professionals to the state.

Implementation of the MA treatment recommendations will require the creation of a full-time coordinator to oversee the implementation process. This position should be salaried as a coordinator within the Human Resources classification system. This position will require support staff, specifically a secretary, for at least the first year of the implementation process.

The total cost to implement all the recommendations of the MA Treatment Study is estimated to be $30-35 million.

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Appendices

SUBSTANCE ABUSE SERVICES FOR JUVENILE JUSTICE CLIENTS

The terms listed are for use by all substance abuse providers and justice entities in referring justice system clients to substance abuse services provided in Nebraska.

LEVEL OF CARE (LOC): General category that includes several similar types of services.
Substance Abuse Services: The specific service name that more specifically identifies the type of actual substance abuse service a consumer will receive.
Children/Youth: Age 18 and below (note that Medicaid SA services apply for ages 21 and below).

NOTE: Not all of these services are available in Nebraska; some services may be available in some areas but not in others. This service array is intended to be a balanced array of substance abuse services that could meet various needs at different levels of severity.

LOC: EMERGENCY SERVICES
(very short term, unscheduled service availability in time of crisis in a variety of settings)

Crisis Phone Line	Clinician on-call for early intervention/screening/referral; available 24/7.
Mobile Crisis or Crisis Response Team	A two-member team that offers on-site crisis stabilization, SA and MH screening usually at the crisis location, brief interventions to stabilize the crisis, and referrals for SA Crisis Respite and thorough SA evaluation; available 24/7; includes access to a LADC.
Emergency Crisis Stabilization	Supportive services therapy, brief SA assessment, and coordination of srvcs to help a child and/or family to alleviate a crisis and facilitate involvement in ongoing services; services may be provided in a variety of settings (I.e. residential or non-residential, dependent on severity of crisis).
SA Emergency Shelter or SA Respite	Residential or home based service for a short term placement of a youth or child in a substance abuse crisis; program has capability to supervise alcohol/drug social setting detoxification (non-medical); length of stay varies by legal status, but emphasis is short term (less than 14 days); 24/7 availability of on-site clinically managed and monitored services; medically stable; limited nursing coverage.
Medical Detox	24-hr medically supervised alcohol/drug detoxification where severe medical issues are involved; 24/7; medical staff coverage.

LOC: ASSESSMENT SERVICES
(screening or evaluation tools used to determine the level of a SA problem & make appropriate service referral; generally provided in a non-residential setting)

Screening	General preliminary screening by provider to identify a substance abuse problem and refer for a complete SA evaluation and early intervention or treatment; includes a screening for mental health and gambling issues. **For Justice referrals**, the Simple Screening Instrument (SSI) that indicates the need for a further evaluation is completed by the criminal justice system and is sent to the SA provider.
Emergency SA valuation	SA evaluation needed on an urgent and unscheduled basis; a provider is available within 24 hours to do a complete evaluation; ***all evaluations completed for justice clients must be completed by a clinician licensed by the State of Nebraska to assess and treat substance abuse problems and who has completed the Standardized Model requirements, and the state approved CASI training and the criminal justice behaviors/thinking training;*** available from any licensed SA service provider; Evaluation Tool Required: Comprehensive Adolescent Severity Inventory (CASI); Approved State Reporting Format: SA Evaluation results are required to be provided in a state approved format only.
SA Evaluation	SA evaluation ***for justice clients must be completed by a clinician licensed by the State of Nebraska to assess and treat substance abuse problems and who has completed the Standardized Model requirements, and the state approved CASI training and the criminal justice behaviors/thinking training;*** available at any state approved SA service provider; Evaluation Tool Required: Comprehensive Adolescent Severity Inventory (CASI); Approved State Reporting Format: SA Evaluation results are required to be provided in a state approved reporting format only.

LOC: NON-RESIDENTIAL SERVICES

(least intensive services based on clinical need offered in a variety of community settings; youth/child lives independently with family, guardian, relatives, or other).

NON-RESIDENTIAL SERVICES: A range of services for youth at risk of developing or who have substance abuse problems, specific functional deficits, problems with intoxication or withdrawal, but few biomedical complications. Youth may have significant deficits in the areas of readiness to change, relapse, continued use or continued problem potential or recovery environment and thus is in need of interventions directed by addiction specialists rather than medical or psychiatric personnel in a variety of non residential settings. Level 1 is the most intensive and Level 5 is the least intensive service level f care.

Lv 5	Prevention and Education	Education and other activities designed to prevent abusing substances.
Lv 5	Intervention	Intervention counseling and education for persons experimenting or currently using substances but who are NOT abusing or dependent; staff supervised EDUCATION programs are very structured with a specific outcome for the client; LoS varies (i.e., minimally one staff supervised 6 or 8 hr class; other options might include eight one-hour sessions, 3-4 four-hour sessions, or other); includes support group or self help referrals.
Lv 5	Care Monitoring SA/MH	Monitoring service designed for youth eligible under the definition for Community Support Substance Abuse, who have made significant progress in recovery and stable community living, or for those youth unwilling to accept the more intensive and rehabilitative community support service; this service monitors youth progress in community living, provides crisis/relapse intervention/prevention as needed, provides oversight and follow-up functions as identified in the youth's monitoring plan (i.e., services, appointments, reminders), and intervenes to protect current gains and prevent losses or decompensation/relapse; contact with youth as needed.
Lv 4	Outpatient Counseling	Individual and/or group counseling/therapy by a licensed addiction specialist for a variety of substance use disorders which disrupt a client's life; treatment focus is on permanent change of behaviors and modifying thought patterns, coping with problems, improving functioning, and other services to achieve successful outcomes and prevent relapse. LoS varies depending on individual illness and response to treatment (i.e., may average 10-12 sessions at 1-4 hrs per week but treatment frequencies and duration will vary); includes brief therapy model (3-5 sessions); group therapy sessions include approx 3-8 persons; family counseling is included.
	Community Support	Support for a children and youth with chemical dependency, habitual use/abuse, and functional deficits; 1:1 staff to client support in school, residence or other non-office location to ensure child's focus on rehabilitating his/her social and relationship skills; aiding the child in using appropriate coping skills; child, guardian, and family relationship building; relapse and recovery mgmt and skill teaching; provides client advocacy; assistance with schooling, housing, accessing transportation, and a variety of other case management activities; ensure attendance at medical appointments or SA non-residential treatment services; coordination of a care/case plan and services; 24/7 on call availability of community support worker; often provided concurrently with another SA non-residential service.
Lv 2	Intensive Outpatient Counseling	Intensive group and individual therapy and counseling for persons with substance abuse disorders or chemical dependence; provide essential education and treatment counseling components while allowing clients to apply new skills within real world environments; counseling provided by a licensed addiction specialist; offered in day or evening, before or after work or school; more intensive than Outpatient Therapy and less intensive than partial care; service includes a combination of group sessions 3-5 times/week plus individual sessions 1-3 hrs/week; total services to the client average 10-15 hours per week; hours per week are tapered to a prescribed schedule or client need as the client transitions to the less intensive Outpatient Therapy or other service; LoS varies with individual response to treatment but the intensity of the service averages 5-6 weeks in duration.
Lv 1	Partial Care	Very intensive day treatment program by licensed addiction specialists under supervision for clients with substance abuse disorders or chemical dependence problems; medical backup; includes individual and group counseling, medication monitoring services; services may occur during school hours, but education must be available through other resources; client needs are of higher intensity need than Intensive Outpatient; services are provided 5 days per week at 6-10 hours daily including minimum of 4 hrs daily of primary SA treatment; LoS varies but averages 5-6 weeks; highest intensity, non-residential service.

LOC: RESIDENTIAL SERVICES

(treatment services provided in a 24 hr community based residential setting)

CLINICALLY MANAGED RESIDENTIAL SERVICES: An array of residential services for youth who need a safe living environment to develop recovery skills; have specific functional deficits; minimal problems with intoxication or withdrawal and few biomedical complications; youth may have significant deficits in the areas of readiness to change, relapse, continued use or continued problem potential or recovery environment and thus is in need of interventions directed by addiction specialists rather than medical or psychiatric personnel. Level 1 is the most intensive and Level 3 is the least intensive service level of care.

Lv 3	Halfway House or SA Group Home	CLINICALLY MANAGED, LOW INTENSITY: Non-medical transitional residential program of substance abuse treatment for youth who are transitioning from more intensive treatment to family/independent living; structured living environment and semi-structured activities designed to develop/support recovery living and relapse prevention skills; maintaining the skills necessary for a life free from substance abuse outside of residential treatment; service has ability to arrange for services or support/coordinate access to school, work, concurrent emotional/behavioral/other treatment activities; staffing must include LADC; treatment plan must include relapse prevention planning (crisis); LoS varies but averages 3 - 6 months.
Lv 2	Therapeutic Community or SA Therapeutic Group Home	CLINICALLY MANAGED, MEDIUM INTENSITY: Non-medical residential program of substance abuse treatment for youth with chronic substance use, repeated relapse &/or resistance to treatment whose substance use recovery efforts are effected by emotional, behavioral or cognitive problems; 24 hour structured therapy to promote sustained focus on recovery tasks; program relies on a treatment community or milieu as the agent of change for acquiring recovery and basic life skills; skills are built through a longer term, highly structured set of peer oriented activities; services include individual & group counseling/therapy, relapse prevention (crisis), education, vocational & skill building; treatment goals include motivation to change, anger management, conflict resolution, values clarification & limit setting; program facilitates integration into the community; treatment services are directed by addiction specialists and access to medical/other consultation; program is staff secure & has ability to arrange for services or support/coordinate access to school, work; LoS varies from 6 -18 months. TC or SA-TGH programs specialize in serving youth in the justice system, many with conduct or personal
Lv 2	SA Extended Residential or SA Residential Treatment Center	CLINICALLY MANAGED, MEDIUM-HIGH INTENSITY: Non-medical longer term, medium intensity residential service for adolescents who are chemically dependent and who are at high risk for relapse &/or potential harm to self or others; clients have significant deficits in ability to perform activities of daily living &/or cognitive deficits; skills training emphasizes impulsive behavior change & other behavior deficits; service may be combined for chemically dependent youth transitioning from Short Term Res who need longer term structured treatment; LoS ranges from 4 - 24 months; service has capability to address mental health issues; staffing includes LADCs; program is staff secure.
Lv 1	Short Term Residential	CLINICALLY MANAGED, HIGH INTENSITY: Enhanced non-medical residential program of primary substance abuse treatment for youth with an entrenched dependency pattern of usage and an inability to remain drug free outside of a 24 hour care; highly structured, intensive, shorter term conprehensive addiction recovery service including group counseling/therapy and relapse prevention; that is of shorter duration but at a higher intensity level; access to medical evaluation and consultation available 24/7; significant emphasis is on readiness to change and treatment engagement; experience induces the adolescent into a peer group; promote coordination of the multiple systems surrounding the youth and implement strategies for ongoing engagement in treatment; physician monitoring and nursing care observation available as needed; addiction treatment by licensed addiction specialists/LADCs; interdisciplinary staff including LMHP, psychologists as needed; administer/monitor medications; program is staff secure. LoS varies but averages 30 - 45 days.

SUBSTANCE ABUSE SERVICES FOR ADULT CRIMINAL JUSTICE CLIENTS

The terms listed are for use by all substance abuse providers and criminal justice entities in referring criminal justice system clients to substance abuse services provided in Nebraska.

LEVEL OF CARE (LOC): General category that includes several similar types of services.
Substance Abuse Services: The specific service name that more specifically identifies the type of actual substance abuse service a client will receive.
Adult: Age 19 and above.

NOTE: Not all of these services are available in Nebraska; some services may be available in some areas but not in others. This service array is intended to be a balanced array of substance abuse services that could meet various needs at different levels of severity.

LOC: EMERGENCY SERVICES

(very short term, unscheduled service availability in time of crisis in a variety of settings)

Crisis Phone Line	Clinician on-call for early intervention/screening/referral; available 24/7.
Mobile Crisis / Crisis Response Teams	Teams of professional and/or paraprofessionals that offer on-site screening usually in the home; brief interventions to stabilize the crisis and refer for SA Crisis/Crisis Respite or other appropriate service, and a thorough SA evaluation; available 24/7; includes access to a LADC.
SA Emergency Shelter or SA Respite	Residential or home based service for a short term placement of a individual in a substance abuse crisis; most clients are not intoxicated but program has capability to supervise alcohol/drug social setting detoxification (non-medical); length of stay varies by legal status, but emphasis is very short term (less than 7 days); 24/7 availability of on-site clinically managed and monitored services as needed; client is medically stable; very limited nursing coverage/can be on-call.
Emergency Community Support	Support service for persons once a MH or SA crisis has been stabilized; 1:1 staff to client work to ensure client focuses on relapse and recovery mgmt, and skill teaching, assistance with housing, ensure attendance at medical appointments or SA non-residential treatment services; coordination of a care plan; coordinating services, transportation; 24/7 on call; service is very short term; often provided concurrently with another SA service to ensure client stays connected with services; LoS varies but not longer than 30-90 days.
Emergency Stabilization & Treatment	Service to stabilize acute withdrawal and/or intoxication symptoms and return person to independent living in the community or engage & refer the person to a recovery program; supportive services therapy, brief SA assessment, primary clinical treatment for substance abuse disorder implemented, and coordination of services to help the client alleviate a substance abuse crisis; LoS varies but not longer than 14 days; on site clinically managed and monitored; medically stable; limited nursing coverage.
Social Detox	Residential service for the short term placement for an adult needing alcohol/drug detoxification (non-medical); length of stay varies but usually not more than 5-7 days depending on the drugs involved; 24/7 on-site availability of clinically managed and monitored; medically stable; limited nursing coverage.
Medical Detox	24-hr medically supervised alcohol/drug detoxification where severe medical issues are involved; 24/7; medical staff coverage.
Emergency Protective Custody (EPC)	Crisis Center services provided in a medical facility to stabilize a person in psychiatric and/or substance abuse crisis; clinically managed detox with legal hold; 24/7; admission on involuntary basis by EPC legal hold because of alleged dangerousness to self or others; generally 7 day or less stay to stabilize, begin emergency treatment & referral to most appropriate service to meet client's need; LoS not longer than 7 days, or if the client is on an EPC hold may continue to a commitment hearing.
Civil Protective Custody (CPC)	Residential services; 24 hr legal hold to keep someone involuntarily in a social detox service.

LOC: ASSESSMENT SERVICES

(screening and evaluation tools used to determine the level of a SA problem & make appropriate service

Screening	General screening by provider to identify a substance abuse problem and refer for a complete SA assessment, early intervention or treatment; includes screen for mental health and gambling issues. Criminal Justice referrals will have had an SSI screen done by criminal justice system staff.
Emergency SA Evaluation	SA evaluation needed on an unscheduled basis and completed within 24 hours of request; ***all evaluations completed for justice clients must be completed by a clincian licensed by the State of Nebraska to assess and treat substance abuse problems and who has completed the Standardized Model requirements and state approved ASI and criminal justice behaviors/thinking training; available from any state licensed SA service provider;*** Evaluation/Assessment Tool Required: Addiction Severity Index (ASI); Approved State Reporting Format: SA Evaluation/Assessment results are required to be provided in the state approved reporting format only.
SA Evaluation	***All SA evaluations completed for justice clients must be completed by a clincian licensed by the State of Nebraska to assess and treat substance abuse problems and who has completed the Standardized Model requirements and state approved ASI and criminal justice behaviors/thinking training; available from any state licensed SA service provider;*** Evaluation/Assessment Tool Required: Addiction Severity Index (ASI); Approved State Reporting Format: SA Evaluation/Assessment results are required to be provided in the state approved reporting format only.

LOC: NON-RESIDENTIAL SERVICES

(least intensive services based on clinical need offered in a variety of community settings; client lives independently)

NOTE: Persons MUST be psychiatrically and medically stable to be admitted to the non-residential services.

NON-RESIDENTIAL SERVICES: A range of services for persons at risk of developing, or who have substance abuse problems, specific functional deficits, problems with intoxification or withdrawal, but few biomedical complications. Clients may have significant deficits in the areas of readiness to change, relapse, continued use or continued problem potential or recovery environment, and thus is in need of interventions directed by licensed addiction specialists rather than medical or psychiatric personnel in a variety of non residential settings. Level 1 is the most intensive and Level 5 is the least intensive service in this level of care.

Lv 5 **Prevention and Education**	Education and other activities designed to prevent abusing substances.
Lv 5 **Intervention**	Intervention counseling and education for persons experimenting or currently using substances but who are NOT abusing or dependent; staff supervised EDUCATION programs are very structured with a specific outcome for the client; LoS varies (i.e., minimally one staff supervised 6 or 8 hr class; other options might include eight one-hour sessions, 3-4 four-hour sessions, or other); includes support group or self help referrals.
Lv 5 **Methadone Maintenance**	Administration of methadone medication to enable an opiate addicted person to be free of heroin; methadone replacement for heroin is a lifetime maintenance program; counseling therapy interventions are included in the service.
Lv 5 **Care Monitoring SA/MH**	Monitoring service designed for persons eligible under the definition for Community Support Mental Health or Substance Abuse, who have made significant progress in recovery and stable community living, or for those clients unwilling to accept the more intensive and rehabilitative community support service; this service monitors a client's progress in community living, provides crisis/relapse intervention/prevention as needed, provides oversight and follow-up functions as identified in the client's monitoring plan (i.e., services, appointments, reminders), and intervenes to protect current gains and prevent losses or decompensation/relapse; contact with client as needed.
Lv 4 **Outpatient Counseling**	Individual and/or group counseling/therapy by a clinician licensed in Nebraska to treat substance use disorders that disrupt a client's life; treatment focus is on changing behaviors, modifying thought patterns, coping with problems, improving functioning, and other services to achieve successful outcomes and prevent relapse. LoS varies depending on individual illness and response to treatment (i.e., may average 10-12 sessions at 1-4 hrs per week but treatment frequencies and duration will vary); includes brief therapy model (3-5 sessions); group therapy sessions include approx 3-8 persons; family counseling is included.
Lv 3 **Community Support**	Support for a persons with chemical dependency and functional deficits; 1:1 staff to client support (face to face) in residence or other non-office location to ensure client focus on rehabilitating his/her social and relationship skills; aiding client in use of appropriate coping skills; active relapse and recovery mgmt and skill teaching; provides client advocacy; assistance with housing, accessing transportation, and a variety of other case management activities; ensure attendance at medical appointments or SA non-residential treatment; coordination of a care plan and services; 24/7 on call availability of community support worker; often provided concurrently with another non-residential SA non-residential service.
Lv 2 **Intensive Outpatient Counseling**	Intensive group and individual counseling for persons with substance abuse disorders or chemical dependence; counseling provided by a clinician licensed in Nebraska to treat substance abuse disorders; offered in day or evening, before or after work; more intensive than Outpatient Therapy and less intensive than Partial Care; service includes a combination of group sessions 3-5 times/week plus individual sessions 1-3 hrs/week; total services to the client averages 10-15 hours per week; hours per week are tapered to a prescribed schedule or client need as the client transitions to the less intensive Outpatient Therapy or other service; LoS varies with individual response to treatment but the intensity of the service averages 5-6 weeks in duration.
Lv 1 **Partial Care**	Very intensive day treatment program by clinician licensed in Nebraska to treat substance abuse disorders for clients with substance abuse or dependence problems; medical backup; includes individual and group counseling and medication monitoring services; services are provided 5 days per week at 6-8 hours of daily including a minimum of 4 hrs daily of primary SA treatment; LoS varies but average is 5-6 weeks; highest intensity, non-residential service.

LOC: RESIDENTIAL SERVICES

(treatment services provided in a 24 hr community based residential setting)

NOTE: Persons MUST be psychiatrically and medically stable to be admitted to the residential services.

CLINICALLY MANAGED RESIDENTIAL SERVICES: An array of residential services for persons who need a structured, safe living environment to develop recovery skills; have specific functional deficits; minimal problems with intoxification or withdrawal and few biomedical coomplications; client may have significant deficits in the areas of readiness to change, relapse, continued use or continued problem potential or recovery environment, and thus is in need of interventions directed by addiction specialists rather than medical or psychiatric personnel. Level 1 is the most intensive and Level 3 is the least intensive service in this level of care.

Lv 3 **Halfway House**	CLINICALLY MANAGED, LOW INTENSITY: Non-medical transitional residential program for persons who as with chemical dependency or substance abuse disorder who are successfully moving from more intensive treatment to independent living and seeking to re-integrate into the community; structured living environment and semi-structured activities designed to develop recovery living and relapse prevention skills; assistance in maintaining or accessing employment and developing the skills necessary for an independent life free from substance abuse outside of residential treatment; service has capacity to address mental health issues; counseling is provided by a clinician licensed in Nebraska to treat substance abuse disorders; LoS varies but is usually not longer than 3-6 months.
Lv 2 **Therapeutic Community**	CLINICALLY MANAGED, MEDIUM INTENSITY: Non-medical transitional residential treatment for persons with chemical dependency; treatment includes psychosocial skill building through a longer term, highly structured set of peer oriented activities incorporating defined phases of progress; services include individual and group counseling/therapy, relapse prevention, education, vocational and skill building; service has the capacity to address mental health issues; counseling is provided by a clinician licensed in Nebraska to treat substance abuse disorders; program is staff secure; LoS varies but is usually not longer than 10-18 months.
Lv 2 **Dual Residential (MH/SA)**	CLINICALLY MANAGED, MEDIUM-HIGH INTENSITY: Non-medical, simultaneous, integrated substance abuse and mental health residential treatment for persons with co-occurring primary chemical dependence **AND** primary major mental illness (schizophrenia, bi-polar, major depression, major psychosis); structured, supervised service includes addiction recovery counseling & activities, medication management and education, and psychosocial rehabilitation services; focus on mental functioning, not psychiatric care; staff include dually credentialed clinicians (LADC/LMHP) and/or both LMHPs and LADCs; LoS varies but is usually not longer than 4-8 months.
Lv 2 **Extended Residential**	CLINICALLY MANAGED, MEDIUM-HIGH INTENSITY: Non-medical longer term, medium intensity residential service for chronic chemically dependent persons who are at a high risk for relapse and/or potential harm to self or others; clients have significant deficits in ability to perform activities of daily living and/or cognitive deficits; counseling is provided by a clinician licensed in Nebraska to treat substance abuse disorders; program is staff secure; LoS ranges from 8-24 months; service has capability to address mental health issues.
Lv 1 **Short Term Residential**	CLINICALLY MANAGED, HIGH INTENSITY: Non-medical residential community treatment for persons with a primary chemical dependency, an entrenched dependency pattern of usage and an inability to remain drug-free outside of a 24 hr care; highly structured, intensive, shorter term comprehensive addiction recovery service including individual, group counseling/therapy and relapse prevention; medication monitoring; service has the capacity to address mental health issues; counseling is provided by a clinician licensed in Nebraska to treat substance abuse disorders; program is staff secure; LoS varies but is usually not longer than 14-30 days.

Appendix B: Attendance List for Best Practice Roundtable Discussions

Attendance at the Bridgeport
August 29, 2005, Best Practices Meeting

Orpha Peterson	Panhandle Community Services
Bonnie Lockhart	PMHC
Dan Witko	District 10 Probation
Lonnie Folchert	ISP Region B
Juanita Rodriguez	Addiction Counseling/Consultation Services
Barb Jolliffe	Panhandle Substance Abuse Counseling
Gary Cotton	PMHC
Don Douglas	ISP Region A
Melody Lisin	PPHD
Sandy Roes	WCHR
Pat Anderson	HHSS
Michelle Chance	PMHC-Community Services
Glenda Luay	Human Services, Inc.
Colleen Houd	Human Services, Inc.
Doug Watson	District 9 Probation
Trish Davison	GCHS
Russ Allie	GCHS
Pamela Richardson	PMCH Region I
Katherine McGowen	PMHC
Jim Young	SCSI
Jane Morgan	NEPSAC
Trina Janis	NEPSAC
Sandra Babin	PMHC Region I
Kim Engel	PPHD

Attendance at the Lincoln
September 16, 2005, Best Practices Meeting

Ellen Brokofsky	Probation/Sarpy, Cass, Otoe
Carroll Brown	Probation/Hall, Howard
Pamela Lewis	Region E ISP
Therese Voboril	Region D ISP
Rich Chisholm	Dist. 3 Probation
Bob Horton	Dist. 7 Probation
Ron Broich	Dist. 4 Probation
Tim Perry	Dist. 6 Probation
Kent Lilly	Dist. 17 Probation
Dick Brown	Dist. 2 Probation
Tom Rathbun	Lancaster Co. Drug Ct.
Christina Lyons	Dist. 12 Probation
Creston Ashburn	Dist. 5 Probation
Pam Butler	Northeast NE Drug Ct.
Judi Brenamow	Douglas County Drug Ct.
Tim Sprakel	Region E ISP
Howard Kensinger	Supreme Court
Derek Vaughn	Douglas County Attorney's Office
Beverly Lueshen	Norfolk Regional Center
Susan Krome	NAMI-NE
Connie Barnes	Behavioral Health Specialists
Cindy Oltmer	Behavioral Health Specialists
Julie Hippen	Lutheran Family Services
Kent Kretz	The Link, Inc.
Connie Stuckey	Cornhusker Place
Shawn Schutz-Long	Cornhusker Place
Melva Denholm	Alegent Health
Jim Swallow	The Link, Inc.
John Wells	BHS
Rita Burke	n/a
Lewis Burke	Heartland Counseling
Brad Shay	Bryan LGH Independence Center
Scott Halverson	Alegent Health
Mike Ryan	Valley Hope
Mike Phillips	Catholic Charities
Ida-Marie Hebrant	Catholic Charities
Marti Wilson	Lutheran Family Services
Kathie Repp	HHSS R&L
Jeff Beaty	Legislature
Jim McKenzie	Corrections
Jessica Watson	Legislature
Doug Koeberack	Legislature
Julie Rogers	Community Corrections Council

Appendix C: Tables on State SA Spending for Nebraska and 6 Surrounding States

Appendix C: Table I. Summary of State Spending on Substance Abuse (1998)*: Nebraska

	State Spending by Category ($000)	Spending Related to Substance Abuse Amount	%	% S/Bdgt	Per Capita
Afftected Programs:	***1,967,751.16***	***264,665.40***		***7.4***	***$159.82***
Justice	**87514**	**66440.8**		**1.9**	**40.12**
Adult Corrections	73451	57624.6	78.5		
Juvenile Justice	14063	8816.1	62.7		
Judiciary (Courts)	NA	NA	NA		
Education (Elem/Secondary)	**594625**	**51537.4**	**8.7**	**1.5**	**31.12**
Health	**308145**	**72813.4**	**23.6**	**2.1**	**43.97**
Child/Family Assistance	**64297**	**35612.1**		**1**	**21.5**
Child Welfare	51489	34284.9	66.6		
Income Assistance	12808	1327.2	10.4		
Mental Health/Dev Disabled	**112833**	**29925.8**		**0.8**	**18.07**
Mental Health	53286	25076.4	47.1		
Development Disabled	59547	4849.4	8.1		
Public Safety	**23053**	**6343.6**	**27.5**	**0.2**	**3.83**
State Workforce	**777284.6**	**1992.5**	**0.3**	**0.1**	**1.2**
Regulation/Compliance:	***17492***	***17492***	***100***	***0.5***	***10.56***
Licensing & Control	720	720			
Collection of Taxes	16772	16772			
Prevention, Treatment, Resrch:	***8945.7***	***8945.7***	***100***	***0.3***	***5.4***
Prevention	NA	NA			
Treatment	8945.7	8945.7			
Research	0	0			
Total		***$291,103.10***		***8.2***	***$175.78***

*Nebraska state budget data compiled by National Center on Addiction and Substance Abuse (CASA) at Columbia University (2001)

Appendix C: Table I. Summary of State Spending on Substance Abuse (1998)*: Nebraska

	State Spending by Category ($000)	Spending Related to Substance Abuse Amount	%	% S/Bdgt	Per Capita
Afftected Programs:	***$5,708,737***	***$845,374.50***		***12.4***	***$217.25***
Justice	**462593**	**379297.9**		**5.6**	**97.47**
Adult Corrections	370000	303932.3	82.1		
Juvenile Justice	NA	NA	NA		
Judiciary (Courts)	92593	75365.7	81.4		
Education (Elem/Secondary)	**1884000**	**201704.5**	**10.7**	**3**	**51.83**
Health	**827000**	**201797.4**	**24.4**	**3**	**51.86**
Child/Family Assistance	**91670**	**8434.2**		**0.1**	**2.17**
Child Welfare	**135**	**96.6**	**71.6**		
Income Assistance	**91535**	**8337.6**	**9.1**		
Mental Health/Dev Disabled	**124652**	**46042.6**		**0.7**	**11.83**
Mental Health	78663	41612.5	52.9		
Development Disabled	45989	4430.1	9.6		
Public Safety**	**651**	**595.1**	**91.4**	**<.01**	**0.15**
State Workforce	**2318171**	**7502.7**	**0.3**	**0.1**	**1.93**
Regulation/Compliance:	***NA***	***NA***	***NA***	***NA***	***NA***
Licensing & Control	NA				
Collection of Taxes	NA				
Prevention, Treatment, Resrch:	***548***	***548***	***100***	***<.01***	***0.14***
Prevention	340	340			
Treatment	208	208			
Research	0	0			
Total		***$845,922.50***		***12.4***	***$217.39***

*Colorado state budget data compiled by National Center on Addiction and Substance Abuse (CASA) at Columbia University (2001)

**Colorado did not report any spending for highway safety or local law enforcement

Appendix C: Table III. Summary of State Spending on Substance Abuse (1998)*: Iowa

	State Spending by Category ($000)	Spending Related to Substance Abuse Amount	%	% S/Bdgt	Per Capita
Afftected Programs:	***$3,678,682.40***	***$720,839.40***		***9.2***	***$252.54***
Justice	**360526**	**289077.2**		**3.7**	**101.27**
Adult Corrections	222200	179754.3	80.9		
Juvenile Justice	36845	24373.5	66.2		
Judiciary (Courts)	101481	84949.3	83.7		
Education (Elem/Secondary)	**1714014**	**170379.3**	**9.9**	**2.2**	**59.69**
Health	**404148**	**91781.4**	**22.7**	**1.2**	**32.15**
Child/Family Assistance	**190824**	**106105.1**		**1.4**	**37.17**
Child Welfare	143892	100523.4	69.9		
Income Assistance	46932	5581.7	11.9		
Mental Health/Dev Disabled	**165066**	**50616.8**			
Mental Health	85586	43506.8	50.8		
Development Disabled	79480	7110.1	8.9		
Public Safety	**41271**	**10487.1**	**25.4**	**0.1**	**3.67**
State Workforce	**802833.4**	**2392.6**	**0.3**	**<.01**	**0.84**
Regulation/Compliance:	***1589***	***1589***	***100***	***<.01***	***0.56***
Licensing & Control	1589	1589			
Collection of Taxes	NA	NA			
Prevention, Treatment, Resrch:	***11428.8***	***11428.8***	***100***	***0.2***	***4***
Prevention	1654	1654			
Treatment	9774.8	9774.8			
Research	0	0			
Total		***$733,857.20***		***9.4***	***$257.10***

*Iowa state budget data compiled by National Center on Addiction and Substance Abuse (CASA) at Columbia University (2001)

Appendix C: Table IV. Summary of State Spending on Substance Abuse (1998)*: Kansas

	State Spending by Category ($000)	Spending Related to Substance Abuse Amount	%	% S/Bdgt	Per Capita
Afftected Programs:	***$4,982,580.80***	***$575,085.30***		***9.3***	***$219.81***
Justice	**248616.2**	**185153.2**		**3**	**70.77**
Adult Corrections	190233	148758.3	78.2		
Juvenile Justice	58383.2	36394.9	62.3		
Judiciary (Courts)	NA	NA	NA		
Education (Elem/Secondary)	**1885227.8**	**161167**	**8.5**	**2.6**	**61.6**
Health	**372045**	**88488.7**	**23.8**	**1.4**	**33.82**
Child/Family Assistance	**153999**	**67672.9**		**1.1**	**25.87**
Child Welfare	84100	55717.6	66.3		
Income Assistance	69899	11955.3	17.1		
Mental Health/Dev Disabled	**252113**	**61207.5**		**1**	**23.39**
Mental Health	107703	50281.9	46.7		
Development Disabled	144410	10925.6	7.6		
Public Safety	**40600**	**6269.9**	**15.4**	**0.1**	**2.4**
State Workforce	**2029979.8**	**5126.1**	**0.3**	**0.1**	**1.96**
Regulation/Compliance:	***1073***	***1073***	***100***	***<.01***	***0.41***
Licensing & Control	968	968			
Collection of Taxes	105	105			
Prevention, Treatment, Resrch:	***8376.2***	***8376.2***	***100***	***0.1***	***3.2***
Prevention	1512.5	1512.5			
Treatment	6863.6	6863.6			
Research	0	0			
Total		***$S584534.4***		***9.4***	***$223.42***

*Kansas state budget data compiled by National Center on Addiction and Substance Abuse (CASA) at Columbia University (2001)

Appendix C: Table V. Summary of State Spending on Substance Abuse (1998)*: Missouri

	State Spending by Category ($000)	Spending Related to Substance Abuse Amount	%	% S/Bdgt	Per Capita
Afftected Programs:	***$6,928,833.90***	***$1,325,790.90***		***12.5***	***$245.19***
Justice	**864448.3**	**699253.3**		**6.6**	**129.32**
Adult Corrections	750662.2	612361.1	81.6		
Juvenile Justice	52649.9	35349.7	67.1		
Judiciary (Courts)	61136.2	51542.5	84.3		
Education (Elem/Secondary)	**3062755.2**	**316876.2**	**10.3**	**3**	**58.6**
Health	**28603.2**	**8903**	**31.1**	**0.1**	**1.65**
Child/Family Assistance	**219745.6**	**67164.7**		**0.6**	**12.42**
Child Welfare	59620.9	42205.3	70.8		
Income Assistance	160124.7	24959.4	15.6		
Mental Health/Dev Disabled	**515624.8**	**201864.5**		**1.9**	**37.33**
Mental Health	358411.5	186180.9	51.9		
Development Disabled	157213.3	15683.6	10		
Public Safety	**144887**	**25209.3**	**17.4**	**0.2**	**4.66**
State Workforce	**2092769.8**	**6519.9**	**0.3**	**0.1**	**1.21**
Regulation/Compliance:	***4536.8***	***4536.8***	***100***	***<.01***	***0.84***
Licensing & Control	4150	4150			
Collection of Taxes	386.7	386.7			
Prevention, Treatment, Resrch:	***41670.9***	***41670.9***	***100***	***0.4***	***7.71***
Prevention	NA	NA			
Treatment	41670.9	41670.9			
Research	0	0			
Total		***$1,371,998.50***		***12.9***	***$253.74***

*Missouri state budget data compiled by National Center on Addiction and Substance Abuse (CASA) at Columbia University (2001)

Appendix C: Table VI. Summary of State Spending on Substance Abuse (1998)*: South Dakota

	State Spending by Category ($000)	Spending Related to Substance Abuse Amount	%	% S/Bdgt	Per Capita
Afftected Programs:	***$680,795.60***	***$125,216.40***		***10.6***	***$171.33***
Justice	**57516**	**46021.6**		**3.9**	**62.97**
Adult Corrections	32992	27149.2	82.3		
Juvenile Justice	11693	7974.3	68.2		
Judiciary (Courts)	12831	10898.1	84.9		
Education (Elem/Secondary)	**265045.7**	**28631.2**	**10.8**	**2.4**	**39.17**
Health	**109080**	**26131.8**	**24**	**2.2**	**35.76**
Child/Family Assistance	**11395**	**4790.5**		**0.4**	**6.55**
Child Welfare	5403	3878.1	71.8		
Income Assistance	5992	912.4	15.2		
Mental Health/Dev Disabled	**50931.6**	**17318.2**		**1.5**	**23.7**
Mental Health	27549.2	14642.2	53.1		
Development Disabled	23382.4	2676	11.4		
Public Safety	**11164.7**	**1748.8**	**15.7**	**0.2**	**2.39**
State Workforce	**175662.6**	**574.2**	**0.3**	**0.1**	**0.79**
Regulation/Compliance:	**NA**	***NA***	***NA***	***NA***	***NA***
Licensing & Control	NA	NA			
Collection of Taxes	NA	NA			
Prevention, Treatment, Resrch:	3768.6	3768.6	100	0.3	5.16
Prevention	256.7	256.7			
Treatment	3511.9	3511.9			
Research	0	0			
Total		***$128,985***		***10.9***	***$176.49***

*South Dakota state budget data compiled by National Center on Addiction and Substance Abuse (CASA) at Columbia University (2001)

Appendix C: Table VII. Summary of State Spending on Substance Abuse (1998)*: Wyoming

	State Spending by Category ($000)	Spending Related to Substance Abuse Amount	%	% S/Bdgt	Per Capita
Afftected Programs:	***$830,172.40***	***$111,296***		***7.5***	***$231.85***
Justice	**56154**	**43531.3**		**2.9**	**90.68**
Adult Corrections	32127	26121.9	81.3		
Juvenile Justice	16109	10752.6	66.7		
Judiciary (Courts)	7918	6656.8	84.1		
Education (Elem/Secondary)	**326265**	**33223.3**	**10.2**	**2.2**	**69.21**
Health	**79228**	**18447.3**	**23.3**	**1.2**	**38.43**
Child/Family Assistance	**19697**	**8959.5**		**0.6**	**18.66**
Child Welfare	10025	7059.8	70.4		
Income Assistance	9672	1899.8	19.6		
Mental Health/Dev Disabled	**16227**	**3411.5**		**0.2**	**7.11**
Mental Health	4629	2384.1	51.5		
Development Disabled	11598	1027.4	8.9		
Public Safety	**12583**	**2743.5**	**21.8**	**0.2**	**5.72**
State Workforce	**320018.4**	**979.6**	**0.3**	**0.1**	**2.04**
Regulation/Compliance:	***1148***	***1148***	***100***	***0.1***	***2.39***
Licensing & Control	NA	NA			
Collection of Taxes	1148	1148			
Prevention, Treatment, Resrch:	***2790***	***2790***	***100***	***0.2***	***5.81***
Prevention	379	379			
Treatment	2411	2411			
Research	0	0			
Total		***$115,234***		***7.8***	***$240.06***

*Wyoming state budget data compiled by National Center on Addiction and Substance Abuse (CASA) at Columbia University (2001)

Appendix D. Drug Dependence-Abuse Estimates

Appendix D: Table VIII. Drug Dependence/Abuse Estimates in Nebraska & Regions* (2003) (Alcohol or Any Illicit Drug in Past Year)**

State/Regions	Population (12+) (Total Persons)	Alcohol [11.83% SAMSHA]	Any Illicit Drug [3.46%]	Alcohol or Ilicit# [12.71%]
Nebraska	**1,419,450**	**167,921**	**49,113**	**180,412**
Male	694,156	**82,119**	**24,018**	**88,227**
Female	725,294	**85,802**	**25,095**	**92,185**
Region 1	**76,085**	**9,001**	**2,633**	**9,670**
Male	36,626	**4,333**	**1,267**	**4,655**
Female	39,459	**4,668**	**1,365**	**5,015**
Region 2	**85,206**	**10,080**	**2,948**	**10,830**
Male	41,860	**4,952**	**1,448**	**5,320**
Female	43,346	**5,128**	**1,500**	**5,509**
Region 3	**186,125**	**22,019**	**6,440**	**23,656**
Male	90,710	**10,731**	**3,139**	**11,529**
Female	95,415	**11,288**	**3,301**	**12,127**
Region 4	**178,553**	**21,123**	**6,178**	**22,694**
Male	87,983	**10,408**	**3,044**	**11,183**
Female	90,570	**10,714**	**3,134**	**11,511**
Region 5	**348,720**	**41,254**	**12,066**	**44,322**
Male	172,019	**20,350**	**5,952**	**21,864**
Female	176,701	**20,904**	**6,114**	**22,459**
Region 6	**544,761**	**64,445**	**18,849**	**69,239**
Male	264,958	**31,345**	**9,168**	**33,676**
Female	279,803	**33,101**	**9,681**	**35,563**

*Estimates based on total populations 12 years of age and older according to 2000 U.S. Census

** Estimates are based on results of 2002 and 2003 National Surveys on Drug Use and Health (NSDUHs) as reported by SAMHSA in "State Estimates of Substance Use" (2003). The percentages shown are the upper range of the .95 confidence level, results of which were more consistent with SAMSHA admissions data for 2003.

Respondents to the survey questions may have indicated that they were both alcohol and illicit drug dependent/abusers, but such respondents were only counted once as alcohol OR illicit drug dependent/abusers. Alcohol only dependent/abusers are 9.47%, illicit drug only are .88% and both alcohol and illicit are 2.36% of the total of 12.71%.

Appendix D: Table IX. Drug Dependence/Abuse Estimates in Nebraska & Regions* (2003)
(Stimulant-Related [SAMHSA Admissions = 66.6%] Illicit Drug in Past Year)

State/Regions	Population (12+) (Total Persons)	Stimulant Related [3.46% x .666]
Nebraska	**1,419,450**	**32,709**
Male	694,156	15,996
Female	725,294	16,713
Region 1	**76,085**	**1,753**
Male	36,626	844
Female	39,459	909
Region 2	**85,206**	**1,963**
Male	41,860	965
Female	43,346	999
Region 3	**186,125**	**4,289**
Male	90,710	2,090
Female	95,415	2,199
Region 4	**178,553**	**4,115**
Male	87,983	2,027
Female	90,570	2,087
Region 5	**348,720**	**8,036**
Male	172,019	3,964
Female	176,701	4,072
Region 6	**544,761**	**12,553**
Male	264,958	6,106
Female	279,803	6,448

*Estimates based on total populations 12 years of age and older according to 2000 U.S. Census

** Estimates are based on results of 2002 and 2003 National Surveys on Drug Use and Health (NSDUHs) as reported by SAMHSA in "State Estimates of Substance Use" (2003). The percentages shown are the upper range of the .95 confidence level, results of which were more consistent with SAMSHA admissions data for 2003.

Respondents to the survey questions may have indicated that they were both alcohol and illicit drug dependent/abusers, but such respondents were only counted once as alcohol OR illicit drug dependent/abusers. Alcohol only dependent/abusers are 9.47%, illicit drug only are .88% and both alcohol and illicit are 2.36% of the total of 12.71%.

Appendix D: Table X. Drug Dependence/Abuse Estimates in Nebraska & Regions* (2003)
(Meth/Amphetamine-Related [SAMHSA Admissions = 45.6%] Illicit Drug in Past Year)

State/Regions	Population (12+) (Total Persons)	Meth/Amphetamine Related [3.46% x .456]
Nebraska	**1,419,450**	**22,396**
Male	694,156	10,952
Female	725,294	11,443
Region 1	**76,085**	**1,200**
Male	36,626	578
Female	39,459	623
Region 2	**85,206**	**1,344**
Male	41,860	660
Female	43,346	684
Region 3	**186,125**	**2,937**
Male	90,710	1,431
Female	95,415	1,505
Region 4	**178,553**	**2,817**
Male	87,983	1,388
Female	90,570	1,429
Region 5	**348,720**	**5,502**
Male	172,019	2,714
Female	176,701	2,788
Region 6	**544,761**	**8,595**
Male	264,958	4,180
Female	279,803	4,415

*Estimates based on total populations 12 years of age and older according to 2000 U.S. Census

** Estimates are based on results of 2002 and 2003 National Surveys on Drug Use and Health (NSDUHs) as reported by SAMHSA in "State Estimates of Substance Use" (2003). The percentages shown are the upper range of the .95 confidence level, results of which were more consistent with SAMSHA admissions data for 2003.

Respondents to the survey questions may have indicated that they were both alcohol and illicit drug dependent/abusers, but such respondents were only counted once as alcohol OR illicit drug dependent/abusers. Alcohol only dependent/abusers are 9.47%, illicit drug only are .88% and both alcohol and illicit are 2.36% of the total of 12.71%.

Appendix D: Table XI. Drug Dependence Estimates in Nebraska* (2003)
(Alcohol or Any Illicit Drug in Past Year)

State/Regions	Population (12+) (Total Persons)	Any Illicit Drug [2.44% SAMHSA]
Nebraska	**1,419,450**	**34,635**
Male	694,156	**16,937**
Female	725,294	**17,697**
		0
Region 1	**76,085**	**1,856**
Male	36,626	**894**
Female	39,459	**963**
		0
Region 2	**85,206**	**2,079**
Male	41,860	**1,021**
Female	43,346	**1,058**
		0
Region 3	**186,125**	**4,541**
Male	90,710	**2,213**
Female	95,415	**2,328**
		0
Region 4	**178,553**	**4,357**
Male	87,983	**2,147**
Female	90,570	**2,210**
		0
Region 5	**348,720**	**8,509**
Male	172,019	**4,197**
Female	176,701	**4,312**
		0
Region 6	**544,761**	**13,292**
Male	264,958	**6,465**
Female	279,803	**6,827**

*Estimates based on total populations 12 years of age and older according to 2000 U.S. Census

** Estimates are based on results of 2002 and 2003 National Surveys on Drug Use and Health (NSDUHs) as reported by SAMHSA in "State Estimates of Substance Use" (2003). The percentages shown are the upper range of the .95 confidence level, results of which were more consistent with SAMSHA admissions data for 2003.

Respondents to the survey questions may have indicated that they were both alcohol and illicit drug dependent/abusers, but such respondents were only counted once as alcohol OR illicit drug dependent/abusers. Alcohol only dependent/abusers are 9.47%, illicit drug only are .88% and both alcohol and illicit are 2.36% of the total of 12.71%.

Appendix D: Table XII. Drug Dependence Estimates in Nebraska* (2003)
(Stimulant-Related [SAMHSA Admissions = 66.6%] Illicit Drug in Past Year)

State/Regions	Population (12+) (Total Persons)	Stimulant-Related [2.44% x .666]
Nebraska	**1,419,450**	**23,067**
Male	694,156	11,280
Female	725,294	11,786
Region 1	**76,085**	**1,236**
Male	36,626	595
Female	39,459	641
Region 2	**85,206**	**1,385**
Male	41,860	680
Female	43,346	704
Region 3	**186,125**	**3,025**
Male	90,710	1,474
Female	95,415	1,551
Region 4	**178,553**	**2,902**
Male	87,983	1,430
Female	90,570	1,472
Region 5	**348,720**	**5,667**
Male	172,019	2,795
Female	176,701	2,871
Region 6	**544,761**	**8,853**
Male	264,958	4,306
Female	279,803	4,547

*Estimates based on total populations 12 years of age and older according to 2000 U.S. Census

** Estimates are based on results of 2002 and 2003 National Surveys on Drug Use and Health (NSDUHs) as reported by SAMHSA in "State Estimates of Substance Use" (2003). The percentages shown are the upper range of the .95 confidence level, results of which were more consistent with SAMSHA admissions data for 2003.

Respondents to the survey questions may have indicated that they were both alcohol and illicit drug dependent/abusers, but such respondents were only counted once as alcohol OR illicit drug dependent/abusers. Alcohol only dependent/abusers are 9.47%, illicit drug only are .88% and both alcohol and illicit are 2.36% of the total of 12.71%.

Appendix D: Table XIII. Drug Dependence Estimates in Nebraska* (2003)
(Meth/Amphetamine-Related [SAMHSA Admissions = 45.6%] Illicit Drug in Past Year)

State/Regions	Population (12+) (Total Persons)	Meth/Amphetamine-Related [2.44% x .456]
Nebraska	**1,419,450**	**15,793**
Male	694,156	7,723
Female	725,294	8,070
Region 1	**76,085**	**847**
Male	36,626	408
Female	39,459	439
Region 2	**85,206**	**948**
Male	41,860	466
Female	43,346	482
Region 3	**186,125**	**2,071**
Male	90,710	1,009
Female	95,415	1,062
Region 4	**178,553**	**1,987**
Male	87,983	979
Female	90,570	1,008
Region 5	**348,720**	**3,880**
Male	172,019	1,914
Female	176,701	1,966
Region 6	**544,761**	**6,061**
Male	264,958	2,948
Female	279,803	3,113

*Estimates based on total populations 12 years of age and older according to 2000 U.S. Census

** Estimates are based on results of 2002 and 2003 National Surveys on Drug Use and Health (NSDUHs) as reported by SAMHSA in "State Estimates of Substance Use" (2003). The percentage shown are the upper range of the .95 confidence level, results of which were more consistent with SAMSHA admissions data for 2003.

Respondents to the survey questions may have indicated that they were both alcohol and illicit drug dependent/abusers, but such respondents were only counted once as alcohol OR illicit drug dependent/abusers. Alcohol only dependent/abusers are 9.47%, illicit drug only are .8 and both alcohol and illicit are 2.36% of the total of 12.71%.

Appendix D: Table XIV. Drug Use Treatment Need Estimates in Nebraska & Regions* (2003)**
(Needing But Not Receiving Treatment for Any Illicit Drug Use in Past Year)

State/Regions	Population (12+) (Total Persons)	Any Illicit Drug [3.24% SAMSHA]
Nebraska	**1,419,450**	**45,990**
Male	694,156	**22,491**
Female	725,294	**23,500**
		0
Region 1	**76,085**	**2,465**
Male	36,626	**1,187**
Female	39,459	**1,278**
		0
Region 2	**85,206**	**2,761**
Male	41,860	**1,356**
Female	43,346	**1,404**
		0
Region 3	**186,125**	**6,030**
Male	90,710	**2,939**
Female	95,415	**3,091**
		0
Region 4	**178,553**	**5,785**
Male	87,983	**2,851**
Female	90,570	**2,934**
		0
Region 5	**348,720**	**11,299**
Male	172,019	**5,573**
Female	176,701	**5,725**
		0
Region 6	**544,761**	**17,650**
Male	264,958	**8,585**
Female	279,803	**9,066**

*Estimates based on total populations 12 years of age and older according to 2000 U.S. Census

** Estimates are based on results of 2002 and 2003 National Surveys on Drug Use and Health (NSDUHs) as reported by SAMHSA in "State Estimates of Substance Use" (2003). The percentages shown are the upper range of the .95 confidence level, results of which were more consistent with SAMSHA admissions data for 2003.

Respondents to the survey questions may have indicated that they were both alcohol and illicit drug dependent/abusers, but such respondents were only counted once as alcohol OR illicit drug dependent/abusers. Alcohol only dependent/abusers are 9.47%, illicit drug only are .88% and both alcohol and illicit are 2.36% of the total of 12.71%.

Appendix D: Table XV. Drug Use Treatment Need Estimates in Nebraska & Regions* (2003)**
(Needing But Not Receiving Treatment for Stimulant-Related Illicit Drug Use in Past Year)

State/Regions	Population (12+) (Total Persons)	Stimulant-Related [3.24% x .666]
Nebraska	**1,419,450**	**30,629**
Male	694,156	14,979
Female	725,294	15,651
Region 1	**76,085**	**1,642**
Male	36,626	790
Female	39,459	851
Region 2	**85,206**	**1,839**
Male	41,860	903
Female	43,346	935
Region 3	**186,125**	**4,016**
Male	90,710	1,957
Female	95,415	2,059
Region 4	**178,553**	**3,853**
Male	87,983	1,899
Female	90,570	1,954
Region 5	**348,720**	**7,525**
Male	172,019	3,712
Female	176,701	3,813
Region 6	**544,761**	**11,755**
Male	264,958	5,717
Female	279,803	6,038

*Estimates based on total populations 12 years of age and older according to 2000 U.S. Census

** Estimates are based on results of 2002 and 2003 National Surveys on Drug Use and Health (NSDUHs) as reported by SAMHSA in "State Estimates of Substance Use" (2003). The percentages shown are the upper range of the .95 confidence level, results of which were more consistent with SAMSHA admissions data for 2003.

Respondents to the survey questions may have indicated that they were both alcohol and illicit drug dependent/abusers, but such respondents were only counted once as alcohol OR illicit drug dependent/abusers. Alcohol only dependent/abusers are 9.47%, illicit drug only are .88% and both alcohol and illicit are 2.36% of the total of 12.71%.

Appendix D: Table XVI. Drug Use Treatment Need Estimates in Nebraska & Regions* (2003)**
(Needing But Not Receiving Treatment for Meth/Amphetamine-Related Illicit Drug Use in Past Year)

State/Regions	Population (12+) (Total Persons)	Meth/Amphetamine-Related [3.24% x .456]
Nebraska	**1,419,450**	**20,972**
Male	694,156	10,256
Female	725,294	10,716
Region 1	**76,085**	**1,124**
Male	36,626	541
Female	39,459	583
Region 2	**85,206**	**1,259**
Male	41,860	618
Female	43,346	640
Region 3	**186,125**	**2,750**
Male	90,710	1,340
Female	95,415	1,410
Region 4	**178,553**	**2,638**
Male	87,983	1,300
Female	90,570	1,338
Region 5	**348,720**	**5,152**
Male	172,019	2,541
Female	176,701	2,611
Region 6	**544,761**	**8,049**
Male	264,958	3,915
Female	279,803	4,134

*Estimates based on total populations 12 years of age and older according to 2000 U.S. Census

** Estimates are based on results of 2002 and 2003 National Surveys on Drug Use and Health (NSDUHs) as reported by SAMHSA in "State Estimates of Substance Use" (2003). The percentages shown are the upper range of the .95 confidence level, results of which were more consistent with SAMSHA admissions data for 2003.

Respondents to the survey questions may have indicated that they were both alcohol and illicit drug dependent/abusers, but such respondents were only counted once as alcohol OR illicit drug dependent/abusers. Alcohol only dependent/abusers are 9.47%, illicit drug only are .88% and both alcohol and illicit are 2.36% of the total of 12.71%.

Appendix D: Table XVII. Drug Dependence/Abuse Estimates in Nebraska by Age Cohorts* (2003)**
(Illicit Drugs in Past Year)

	Population (12+) (Total Persons)	**Age 12-17** (Total Persons)	**Age 18-25** (Total Persons)	**26 or older** (Total Persons)
NEBRASKA	**1,419,450**	**158,429**	**197,185**	**1,063,836**
Male	694,156	81,191	100,729	512,236
Female	725,294	77,238	96,456	551,600
DEPENDENT/ABUSERS				
Any Illicit Drug	**49,113**	**10,936**	**16,089**	**22,088**
[% Total Population]	**[3.46%]**	**[4.60-7.58%]**	**[5.50-8.96%]**	**[1.11-2.28%]**
Stimulant-Related* **	**32,709**	**7,283**	**10,715**	**14,711**
Meth/Amphetamine-Rel* **	**22,396**	**6,930**	**10,242**	**12,603**

*Estimates based on population by age group and the proportions of male and female persons in each
according to 2000 U.S. Census. Columns may not add due to rounding.

**Estimates of drug dependent/abusers are based on results of 2002 and 2003 National Surveys on Drug Use and Health (NSDUHs) as reported by SAMHSA in "State Estimates of Substance Use" (2003) using Alternative Estimate B. (see Tables 11-13), a mid-point (not exact due to rounding) between Base Estimate A. and Alternative Estimate C.

***Based on 2003 SAMHSA data 66.6% of non-alcohol only admissions were stimulant-related and 45.6% were Methamphetamine/Amphetamine-related.

Appendix E: Explanation of the TEDS and NSSATS

THE TREATMENT EPISODE DATA SET

The Treatment Episode Data Set (TEDS) is maintained by the **Office of Applied Studies, Substance Abuse and Mental Health Services Administration (SAMHSA)**. The TEDS system includes records for some 1.5 million substance abuse treatment admissions annually. While TEDS does not represent the total national demand for substance abuse treatment, it does comprise a significant proportion of all admissions to substance abuse treatment, and includes those admissions that constitute a burden on public funds.

TEDS comprises data that are routinely collected by States in monitoring their individual substance abuse treatment systems. In general, facilities reporting TEDS data are those that receive State alcohol and/or drug agency funds (including Federal Block Grant funds) for the provision of substance abuse treatment. However, differences in State systems of licensure, certification, accreditation, and disbursement of public funds affect the scope of facilities included in TEDS. Treatment facilities that are operated by private for-profit agencies, hospitals, and the State correctional system, if not licensed through the State substance abuse agency, may be excluded from TEDS. TEDS does not include data on facilities operated by Federal agencies (the Bureau of Prisons, the Department of Defense, and the Veterans Administration).

The data reported below represent the latest full calendar year data available for each State from the TEDS system. Total numbers and percent distribution are reported by sex, age, and race/ethnicity for each of 15 categories of primary substance of abuse.

Limitations of TEDS data

TEDS is an exceptionally large and powerful data set. Like all data sets, however, care must be taken that interpretation does not extend beyond the limitations of the data. Limitations fall into two broad categories: those related to the scope of the data collection system, and those related to the difficulties of aggregating data from the highly diverse State data collection systems. Limitations to be kept in mind while analyzing TEDS data include:

- TEDS is an admission-based system, and TEDS admissions do not represent individuals. An individual admitted to treatment twice within a calendar year would be counted as two admissions. Most States cannot, for reasons of confidentiality, identify clients with a unique ID assigned at the State level. Consequently TEDS is unable to follow individual clients through a sequence of treatment episodes.

- TEDS attempts to enumerate treatment episodes by distinguishing the initial admission of a client from his/her subsequent transfer to a different service type (for example, from residential treatment to outpatient) within a single continuous treatment episode. However, States differ greatly in their ability to identify transfers; some can distinguish

transfers within providers but not across providers. Some admission records may in fact represent transfers, and therefore the number of admissions reported probably overestimates the number of treatment episodes.

- The number and client mix of TEDS admissions does not represent the total national demand for substance abuse treatment, nor the prevalence of substance abuse in the general population.

- The primary, secondary, and tertiary substances of abuse reported to TEDS are those substances which led to the treatment episode, and not necessarily a complete enumeration of all drugs used at the time of admission.

- In reporting TEDS data, SAMHSA must balance timeliness of reporting with completeness of the data set. States rely on individual facilities to report in a timely manner. States then bundle the data and report them to SAMHSA at regular intervals. Admissions from facilities that report late to the States may appear in a later data submission to SAMHSA. However, the additional submissions are unlikely to have a significant effect on the percentage distributions that are the basis of these tables.

- States continually review the quality of their data processing. When systematic errors are identified, States may revise or replace historical TEDS data files. TEDS continues to accept data revisions for admissions occurring in the previous five years. While this process represents an improvement in the data, the numbers of admissions reported here may differ slightly from those in earlier or subsequent reports and tables.

Considerations specific to these tables include:

- The tables include admissions records that were received and processed by SAMHSA through the date noted at the bottom of each table.

- The tables focus on treatment admissions for substance abusers. Thus admissions for treatment as a codependent of a substance abuser are excluded. Records for identifiable transfers within a single treatment episode are also excluded.

- Records with partially complete data have been retained. Where records include missing or invalid data for a specific variable, that record is excluded from tabulations of that variable. The total number of admissions on which a percentage distribution is based is reported in each table.

- Primary alcohol admissions are characterized as Alcohol only or Alcohol with secondary drug. Alcohol with secondary drug indicates a primary alcohol admission with a specified secondary or tertiary drug. All other alcohol admissions are classified as Alcohol only.

- Cocaine admissions are classified according to route of administration as Smoked and Other route. Smoked cocaine primarily represents crack or rock cocaine, but can also include cocaine hydrochloride (powder cocaine) when it is free-based. Non-smoked

cocaine includes cocaine admissions where the route of administration is not reported, and thus the TEDS estimate of the proportion of admissions for smoked cocaine is conservative.

- Methamphetamine/amphetamine admissions include admissions for both methamphetamine and amphetamine, but are primarily for methamphetamine. Four States (Arkansas, Connecticut, Oregon, and Texas) do not distinguish between methamphetamine and amphetamine admissions. However, for the States that make this distinction, methamphetamine constitutes about 95 percent of combined methamphetamine/amphetamine admissions.

Source: http://wwwdasis.samhsa.gov/webt/information.htm

THE NATIONAL SURVEY OF SUBSTANCE ABUSE TREATMENT SERVICES

The National Survey of Substance Abuse Treatment Services (N-SSATS) is maintained by the **Office of Applied Studies, Substance Abuse and Mental Health Services Administration (SAMHSA)**. The N-SSATS is designed to collect data on the location, characteristics, services offered, and number of clients in treatment at alcohol and drug abuse facilities (both public and private) throughout the 50 States, the District of Columbia, and other U.S. jurisdictions.1

N-SSATS is designed to collect information from all facilities2 in the United States, both public and private, that provide substance abuse treatment. N-SSATS includes some 13,000 facilities with about 1.1 million clients in treatment on the survey reference date.

N-SSATS provides the mechanism for quantifying the dynamic character and composition of the U.S. substance abuse treatment delivery system. The objectives of N-SSATS are to collect multipurpose data that can be used to:

- assist SAMHSA and State and local governments in assessing the nature and extent of services provided in State-supported and other treatment facilities and in forecasting treatment resource requirements;
- update SAMHSA's Inventory of Substance Abuse Treatment Services (I-SATS), which includes all known drug and alcohol abuse treatment facilities;
- analyze general treatment services trends and conduct comparative analyses for the nation, regions, and States; generate the National Directory of Drug and Alcohol Abuse Treatment Programs, a compendium of facilities approved by State substance abuse agencies for the provision of substance abuse treatment; and update the information in SAMHSA's Substance Abuse Treatment Facility Locator, a searchable database of facilities approved by State substance abuse agencies for the provision of substance abuse treatment. The Facility Locator is available on the Internet at: http://findtreatment.samhsa.gov

Limitations of N-SSATS

As with any data collection effort, certain procedural considerations and data limitations must be taken into account when interpreting N-SSATS data. Some of these are outlined below.

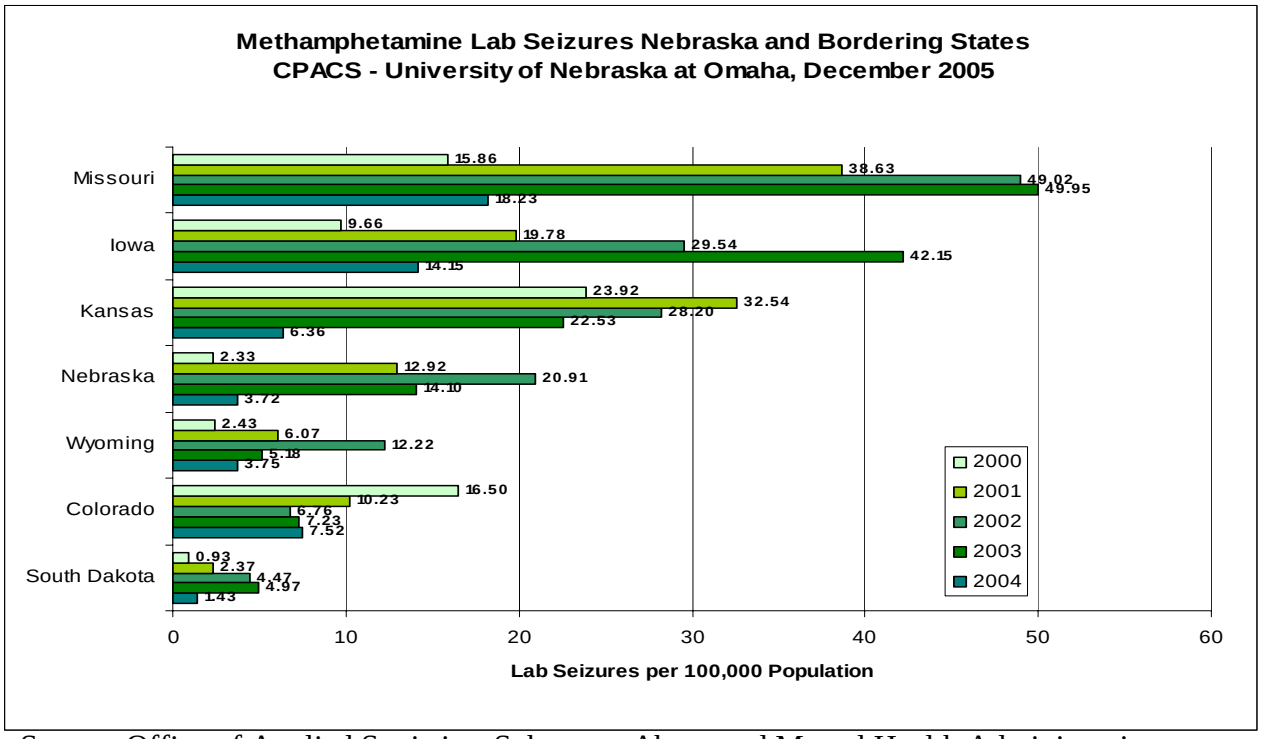
- N-SSATS attempts to obtain responses from all known treatment facilities, but it is a voluntary survey. There is no adjustment for the approximately 4 percent facility non-response.
- N-SSATS is a point-prevalence survey. It provides information on the substance abuse treatment system and its clients on the reference date. Client counts reported here do not represent annual totals. Rather, N-SSATS provides a "snapshot" of substance abuse treatment facilities and clients on an average day.
- Multiple responses were allowed for certain variables (e.g., services provided and specialized programs). Tabulations of these variables include the total number of facilities reporting each response.

1 The jurisdictions include the territories of American Samoa and Guam, the Federated States of Micronesia, the Republic of Palau, the Commonwealth of Puerto Rico, and the Virgin Islands of the United States.

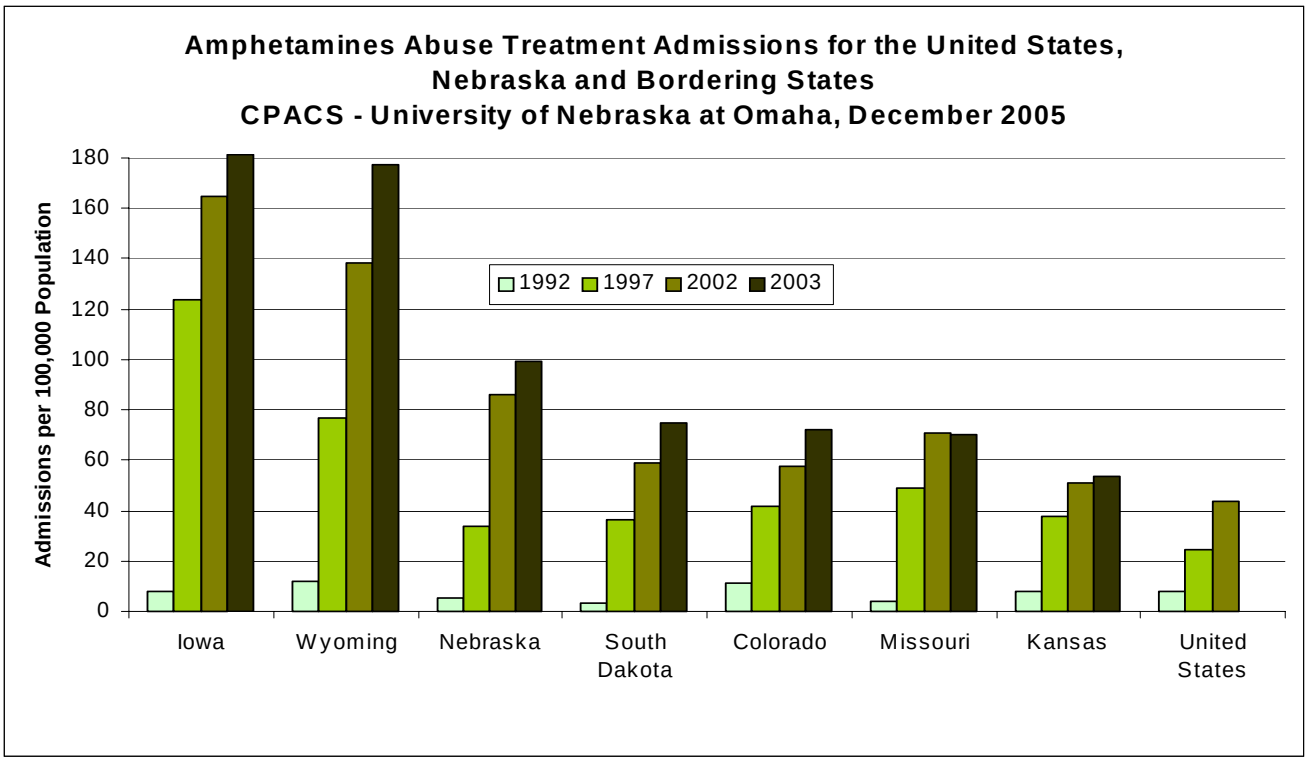
2 In this report, entities responding to N-SSATS are referred to as "facilities". A "facility" may be a program-level, clinic-level, or multi-site respondent.

Source: http://wwwdasis.samhsa.gov/webt/nssatsinfo.htm

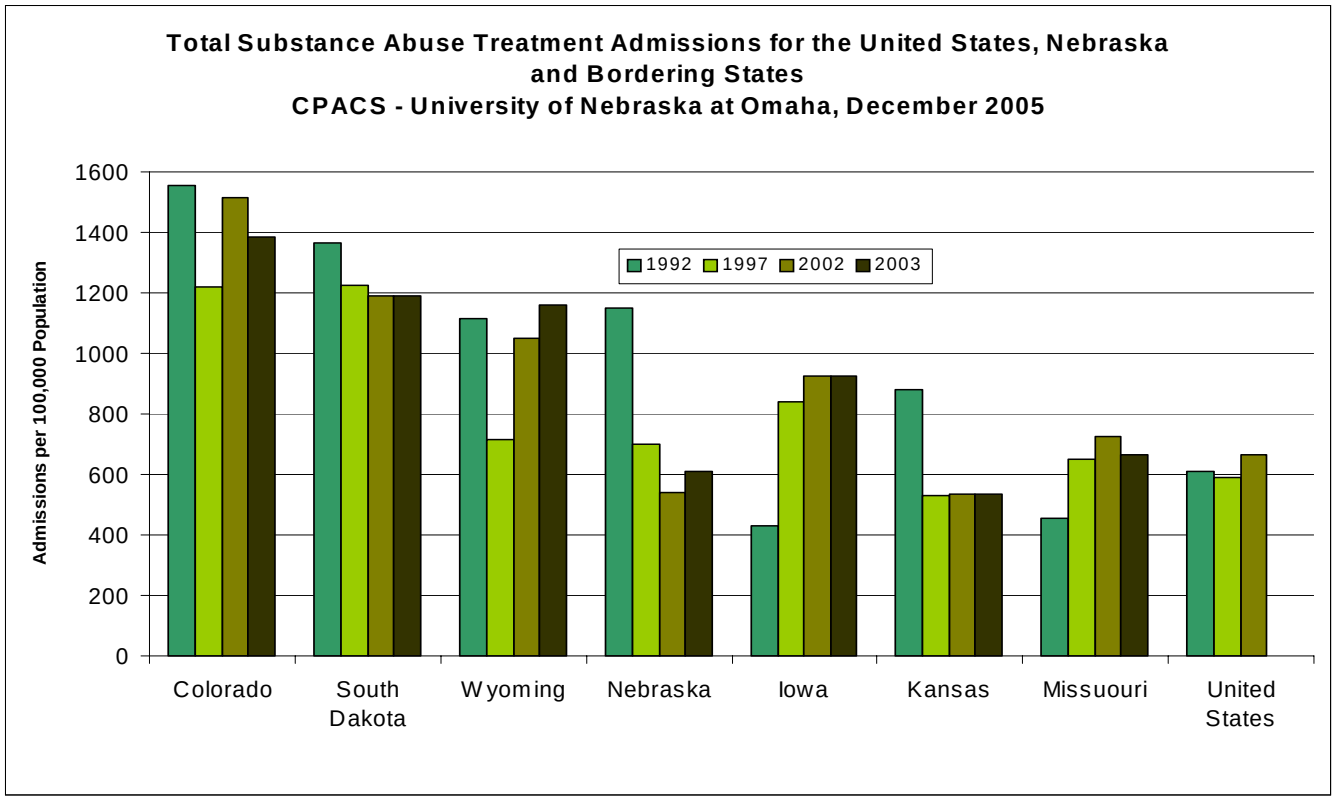
Appendix F: Graphs Regarding Methamphetamine in Nebraska



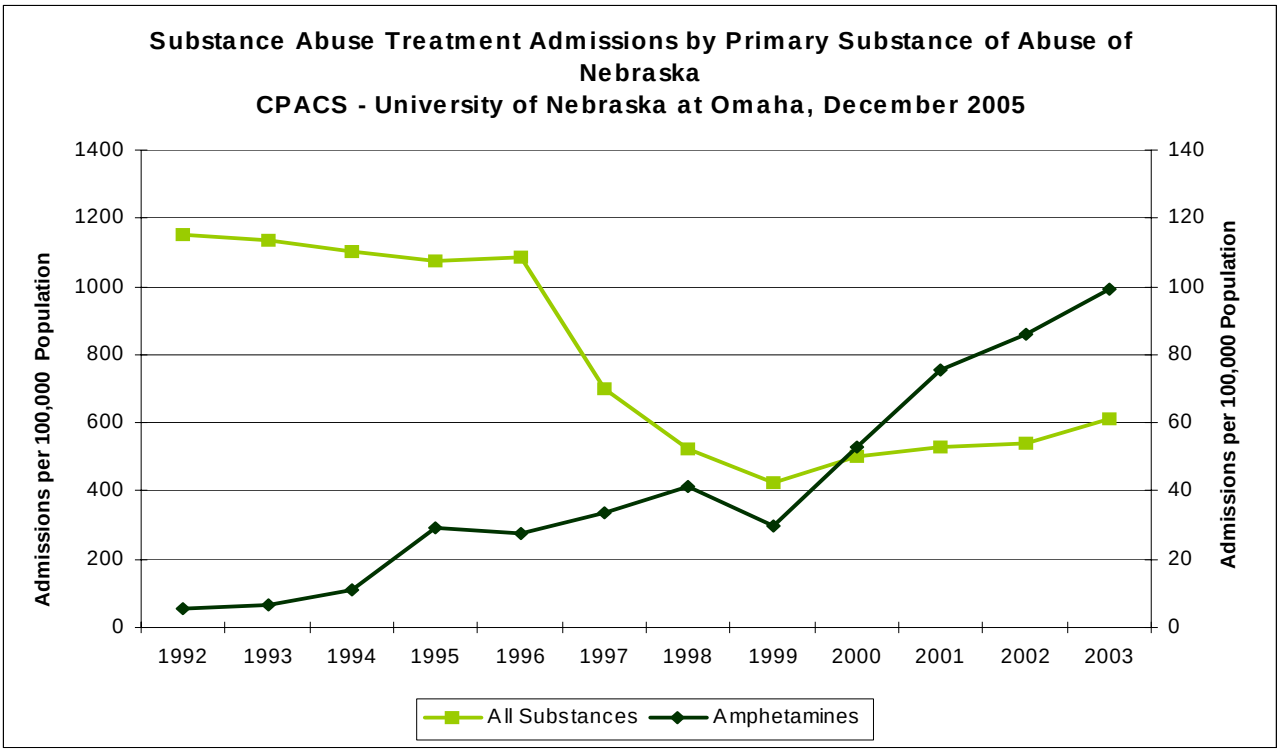
Source: Office of Applied Statistics; Substance Abuse and Mental Health Administration, Treatment Episode Data Set (TEDS)



Source: Office of Applied Statistics; Substance Abuse and Mental Health Administration, Treatment Episode Data Set (TEDS)



Source: Office of Applied Statistics; Substance Abuse and Mental Health Administration, Treatment Episode Data Set (TEDS)



Source: Office of Applied Statistics; Substance Abuse and Mental Health Administration, Treatment Episode Data Set (TEDS)

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