Building Healing Systems (BHS)

Behavioral Health Provider Survey

Behavioral Health Administration & Universities Partnership

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SCHOOL OF MEDICINE

UM SOM Psychiatry Department

- Division of Child and Adolescent Psychiatry (DCAP)
- Systems Evaluation Center (SEC)

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- Department of Behavioral Sciences and Services

Key Take Aways

- **Provider Estimates of Prevalence**
  - 97% of the individuals served experience one or more Adverse Childhood Experience (ACE) with 63% having four or more ACEs.
  - 75% of individuals served experience one or more Positive Childhood Experience (PCE) which can counterbalance the impact of ACEs
- **Screening**
  - While many providers screen for ACEs and PCEs, only 59% or providers screen all individuals
  - Screening happens most frequently for child abuse and neglect (42-47%). Other ACEs are screened less frequently including school-related ACEs (13-31%), community ACEs (14-29%) and household ACEs (13-25%)
- **Trauma Symptom Checklists are used by 35% of providers, and 87% of providers use one or more evidence-based trauma-focused intervention**
- **Providers have most frequently received training in ACE awareness or theories (62%), and they are most interest in future trainings on implementing evidence-informed practices for individuals (60%), with providers expressing interest in trainings for special populations.**

Surveys

- **The BHBS surveys aim to gain an understanding of**
  - The prevalence of ACEs and trauma exposure within the Maryland Public Behavioral Health System (PBHS) and associated outcomes or experiences
  - ACEs and trauma screening procedures currently in use by behavioral health providers
  - Provider training and support needs when working with individuals with ACEs
  - Other information to inform BHBS Initiative activities
- **The results will be used to:**
  - understand the impact of childhood trauma and ACEs on associated health and behavioral health outcomes
  - to develop strategies aimed at supporting the integration of trauma informed approaches at the state, local, and provider levels

Surveys

- **The panel surveys will include a similar set of items asked across three target populations within the Maryland PBHS, with one survey conducted during each of the three years of the BHBHS initiative:**
  - Year 1: Behavioral health service providers
  - Year 2: Caregivers of youth receiving services
  - Year 3: Transition Age Youth receiving services
- **This approach will enable the collection of prevalence information from three different perspectives, providing a multi-faceted estimation of ACEs prevalence within the system.**

Provider Survey

The goals of this survey are to:

1. Assess provider perceptions of lifetime ACEs prevalence for youth, transitional age youth, and adults served by the Maryland PBHS
2. Assess provider perceptions of Positive Childhood Experiences (PCEs)
3. Identify ACEs screening procedures used by service providers
4. Understand the extent to which providers feel knowledgeable and comfortable screening for ACEs
5. Identify provider training and support needs to enable them to successfully screen for ACEs and treat individuals who have experienced ACEs

Building Healing Behavioral Health Systems:

Provider Survey Methods

Methods: Survey Development

- **This project has Institutional Review Board approval.**
- **BHBHS developed a web-based survey tool in collaboration with BHA**
  - Topics from the Brief Risk Factor Surveillance Survey (BRFSS) and the Youth Behavioral Risk Survey / Youth Tobacco Survey (YRBS/YTS) were included
    - This allowed comparisons with Maryland and national data.
  - A literature review was conducted to inform questionnaire development, sources included:
    - Primary care pediatric surveys regarding ACEs prevalence and screening (Bright, Thompson, Esemio-Jenssen, Alford & Shenkman, 2015)
    - Impact of ACEs (Quizhpi et al., 2019)
    - Positive Childhood Experiences (Bethell, Jones, Gombojay, Linkenbach & Sege, 2019)
    - Other questions developed by the BHBHS team as needed to capture information needed to address project goals

Methods: Sample

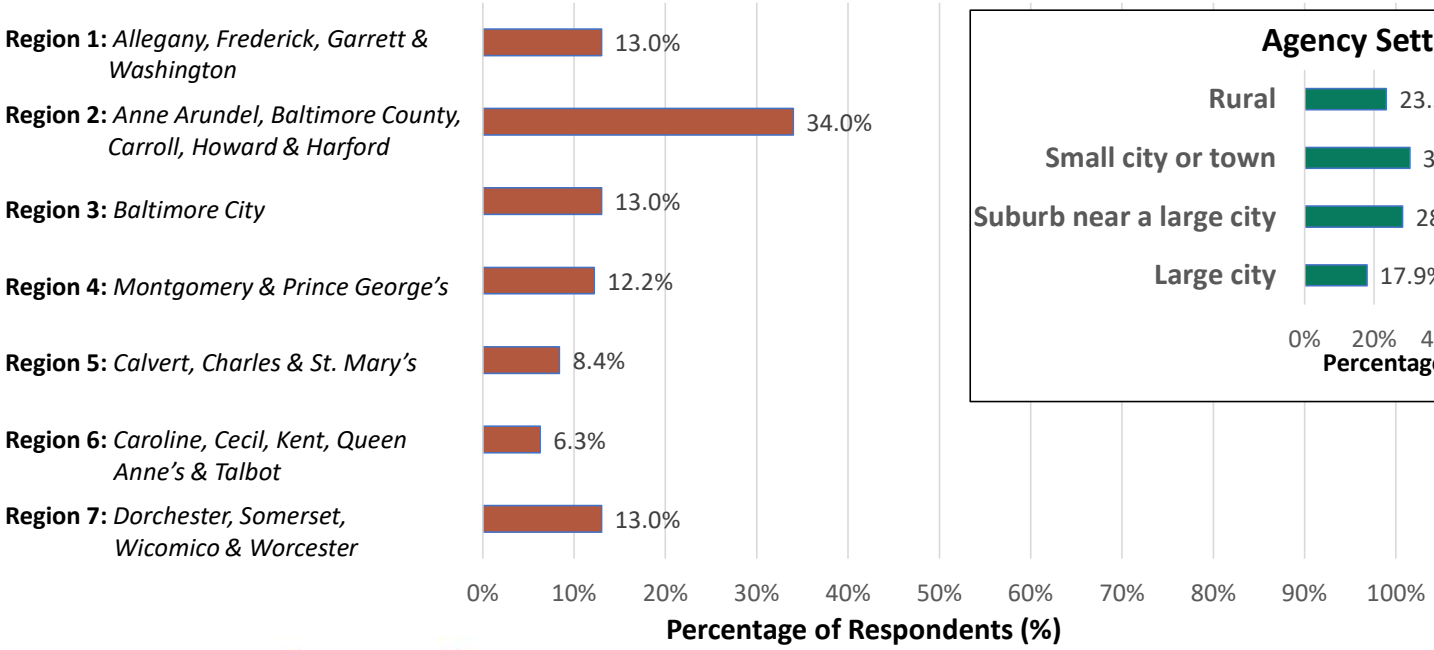
- **369 Survey responses were received. The following responses were dropped from the analysis:**
  - 87 responses from administrators (not an eligible group to participate)
  - 43 responses from providers not serving any individuals in the PBHS
- **239 responses from PBHS providers included in the analysis**
- **Four open ended questions were included in the qualitative analysis. Topics included:**
  - Barriers to successfully screening individuals for ACEs (n=145)
  - What can BHA do to better support:
    - screening individuals with Adverse Childhood Experiences (n=124)
    - providing services or supports to individuals with Adverse Childhood Experiences (n=78)
  - Anything else you think BHA should know about how you or your agency provides services or supports to individuals with Adverse Childhood Experiences? (n=30)
- **Additional Methods for Eligibility, Invitation, Data Collection and Analysis, and Survey distribution can be found in the Appendix.**

Building Healing Behavioral Health Systems:

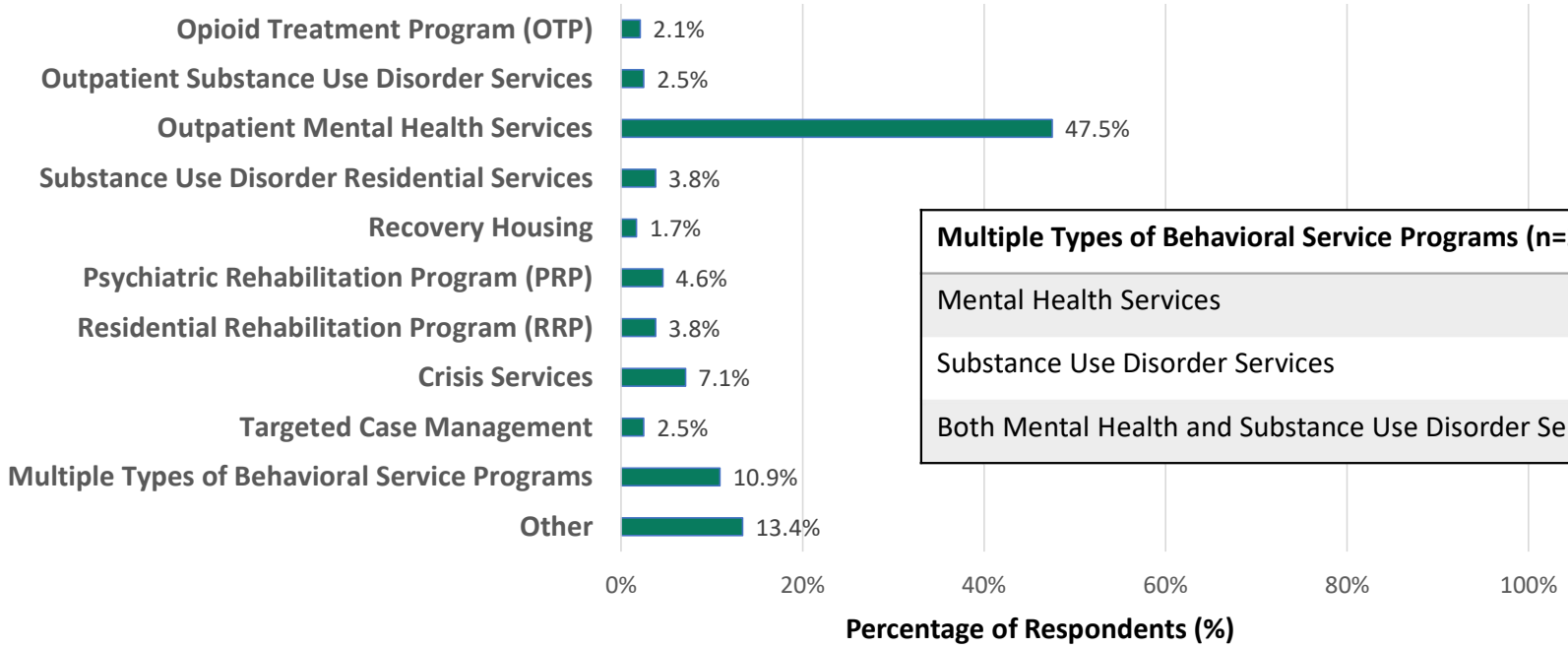
Respondent Characteristics

Agency Location

By Region

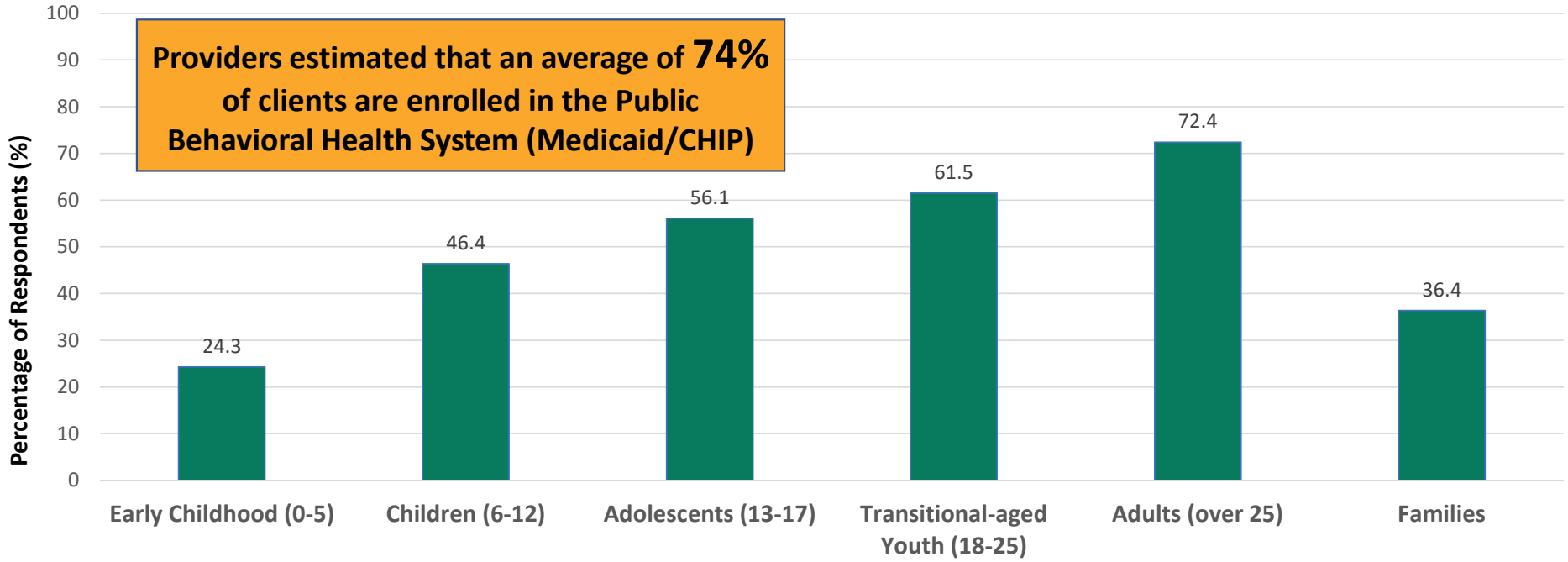


Provider Behavioral Health Settings



Multiple Types of Behavioral Service Programs (n=26)	%
Mental Health Services	6.3
Substance Use Disorder Services	0.8
Both Mental Health and Substance Use Disorder Services	3.8

Populations Primarily Served



Note: *Providers could choose more than one population*

Building Healing Behavioral Health Systems:

Positive Childhood Experiences, Adverse Childhood Experiences, and Screening Processes

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Impact of Positive Childhood Experiences

- PCEs can counteract the impact of ACEs
- Research comparing adults with high numbers of PCEs to those who reported low or no PCEs. Adults reporting more PCEs:
  - had 72 percent lower levels of adult depression and/or poor mental health
  - were 3.5 times more likely to get the social and emotional support they need as an adult (Bethell, et al, 2019)
- When parents share ideas and talk about things that matter with their child, the child had a 1,200 percent greater chance of flourishing compared to those who did not have this type of communication (Bethell, Gombojav & Whitaker, 2019)

Bethell, C., Jones, J., Gombojav, N., Linkenbach, J., & Sege, R. (2019). Positive Childhood Experiences and Adult Mental and Relational Health in a Statewide Sample. *JAMA Pediatrics published online* 2019 Sep 9.
Bethell, C. D., Gombojav, N., & Whitaker, R. C. (2019). Family resilience and connection promote flourishing among US children, even amid adversity. *Health Affairs*, *38*(5), 729-737.
Positive Childhood Experiences source: https://www.childandadolescent.org/positive-childhood-experiences/

Impact of Positive Childhood Experiences

- PCEs can come from the family; however, some children live in homes where they don't feel emotionally safe. PCEs involving friends and communities can counterbalance the effect of ACEs, even if household PCEs are not available.

Household PCEs

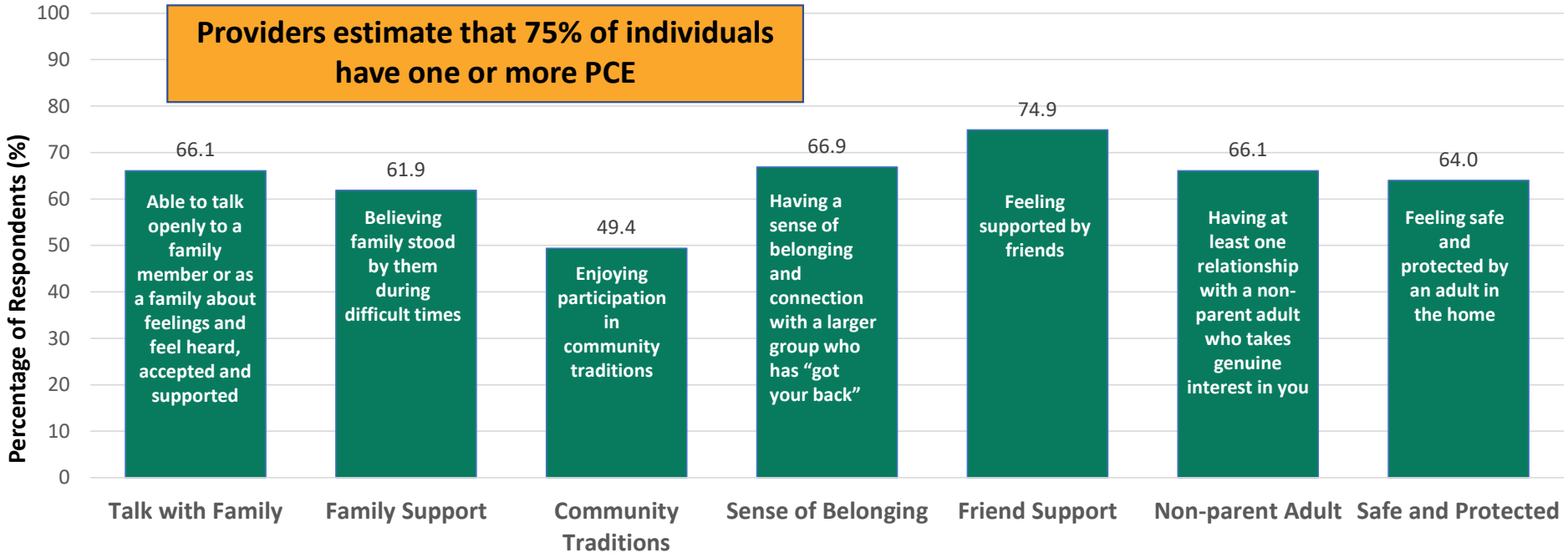
- Being able to talk openly to a family member or as a family about feelings and feel heard, accepted and supported.
- Belief that family stood by them during difficult times.
- Feeling safe and protected by an adult in the home.

Community PCEs

- Feeling supported by friends.
- Having a sense of belonging and connection with a larger group who has "got your back" (e.g. school, church, clubs, neighborhood, etc.).
- Enjoyment of participation in community traditions.
- Relationship with at least one non-parent adult who takes genuine interest in you.

Bethell, C., Jones, J., Gombojav, N., Linkenbach, J., & Sege, R. (2019). Positive Childhood Experiences and Adult Mental and Relational Health in a Statewide Sample. *JAMA Pediatrics published online* 2019 Sep 9.
Positive Childhood Experiences source: https://www.childandadolescent.org/positive-childhood-experiences/

Positive Childhood Experiences (PCEs)



BHBHS Study of Maryland High School Students

- **More students with behavioral health challenges experience all ACEs than students without behavioral health challenges.**
- **Positive Childhood Experience mitigate the impact of ACEs** on behavioral health challenges by 18-69% and are associated with reducing risk from specific ACEs by 18-83%
- **Having three or more ACEs is associated with increased behavioral health risks** including mental health challenges (3.3.times), substance use (2.8 times), and both mental health and substance use challenges (3.3 times). 3+ ACEs are associated with increased risk for
  - Mental health indicators, such as depression or suicide attempt (2.0-3.5 times)
  - Current alcohol or marijuana use (2.2-3.0 times) and
  - Ever using other illicit substances (2.4-3.7 times)

Data from 2021 Maryland High School Youth Risk Behavior / Youth Tobacco Survey (YRBS/YTS)

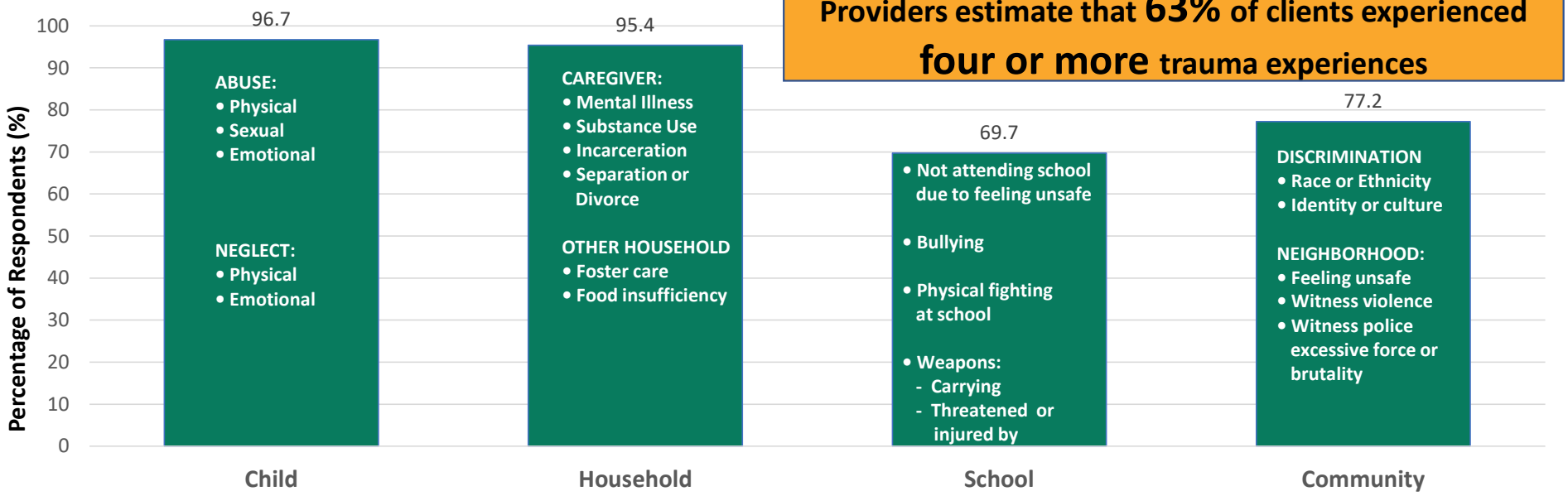
Nurturing Positive Childhood Experiences

- **Check in**. Ask the child to share their thoughts, feelings and concerns about what is going on. If the child gives a superficial response like "I'm fine" share some of your own thoughts, feelings and concerns to show that it is acceptable to talk openly about these things. Don't assume that a child is doing fine just because he or she is not showing obvious signs of distress.
- **Listen carefully**. Put the electronics down. Give your full attention.
- **Make time**: Some children and most teenagers aren't comfortable maintaining eye contact when talking about their innermost fears and hurts. They're more likely to bring these things up at times when they don't have to look directly at you, like when riding in the car. Don't dismiss the topic because it is not a good time. Make time, even if it means you have to drive extra laps around the block while you do.
- **Offer compassionate empathy rather than solutions**. Many of us are uncomfortable hearing another person's fears, especially if we don't know how to fix the situation that is causing them. Showing that the child's emotions aren't too frightening for you to handle helps the child to feel safer, less out of control and genuinely connected.
- **Do something together** – play a game, do a craft or look at pictures and share memories. Breathing in the same room is not the same as connecting.
- **Let the child's questions guide you**. Children will let you know what is on their mind and what concerns them most through the questions they ask. A great way to start a conversation with the child is to ask, "What questions do you have about what is happening?"
- **Keep your traditions and rituals** going as much as possible. This can be elaborate and formal as decorating for and making traditional foods for a holiday. It can be as simple and informal as greeting each other with a certain phrase or making up a secret handshake.
- **Say the words**. Don't assume they know you care. Every human being needs to hear that he or she is loved. Everyone deserves to hear it when they do a good job. It won't give them a swelled head if you tell them that you proud of them. It helps them feel connected and appreciated.

Child & Adolescent Behavioral Health https://www.childandadolescent.ort/positive-childhood-experiences/

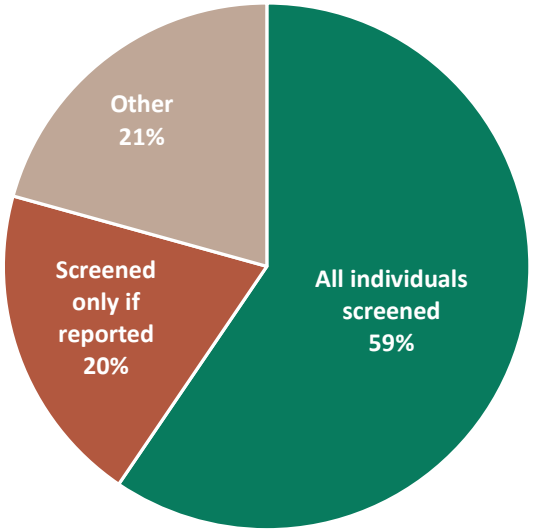
Types of Childhood Trauma Experienced

Providers estimate that 63% of clients experienced four or more trauma experiences



Agency Screening

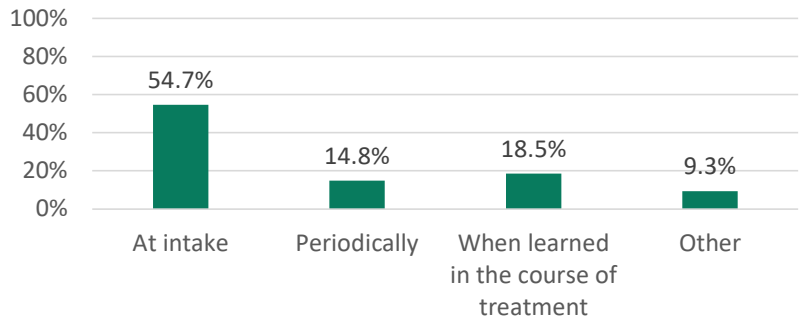
Screening Process



Other screening processes include:

- *customized items embedded in intake*
- *informal screening during treatment*
- *screening at the therapist's discretion*

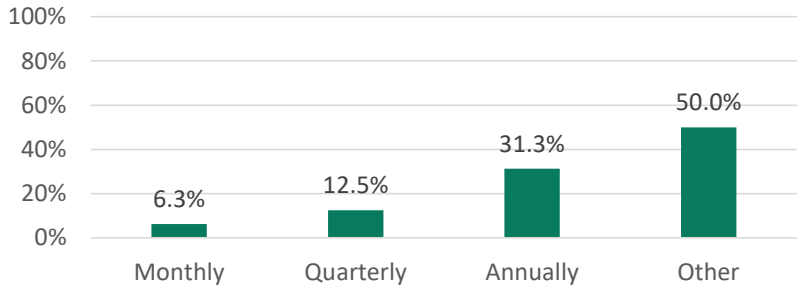
Screening Frequency



Other screening frequency includes:

- *annually*
- *ongoing*
- *when clinicians learn of trauma in the course of treatment*

Periodic Screening occurs



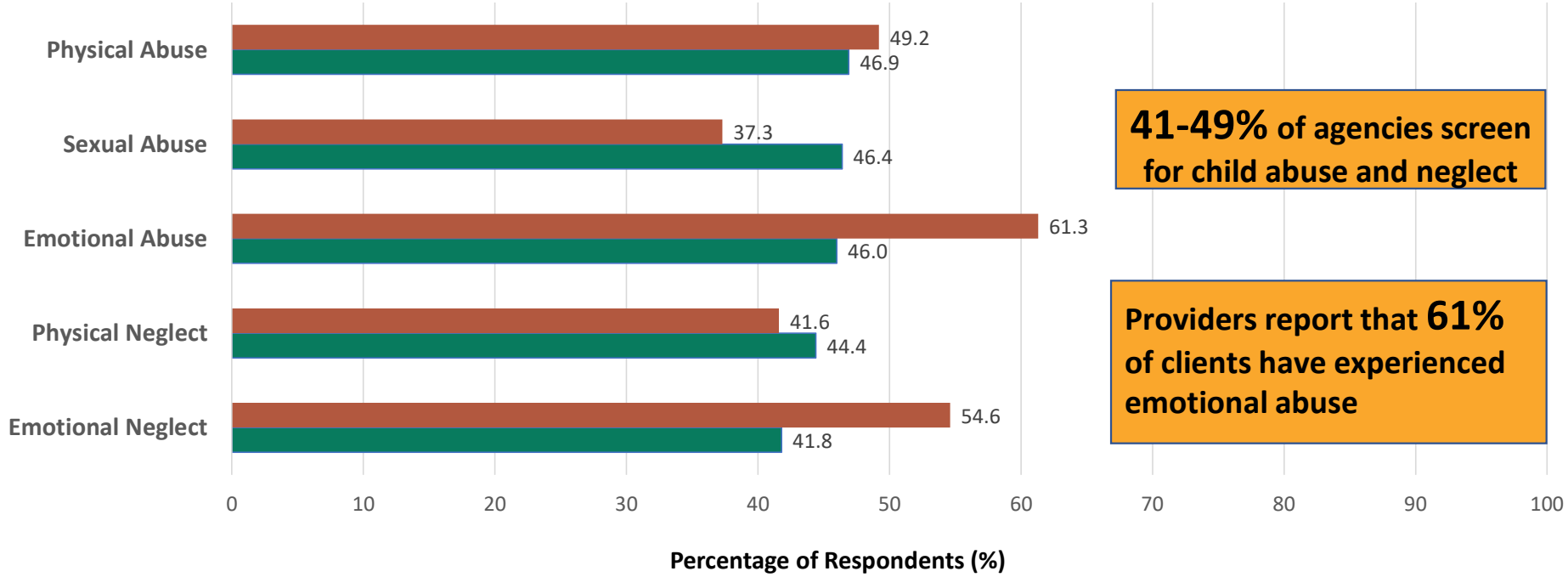
Other periodic screening includes:

- *At every session*
- *6 months*
- *As needed*

Building Healing Behavioral Health Systems:

Estimated Client Prevalence and Agency Screening

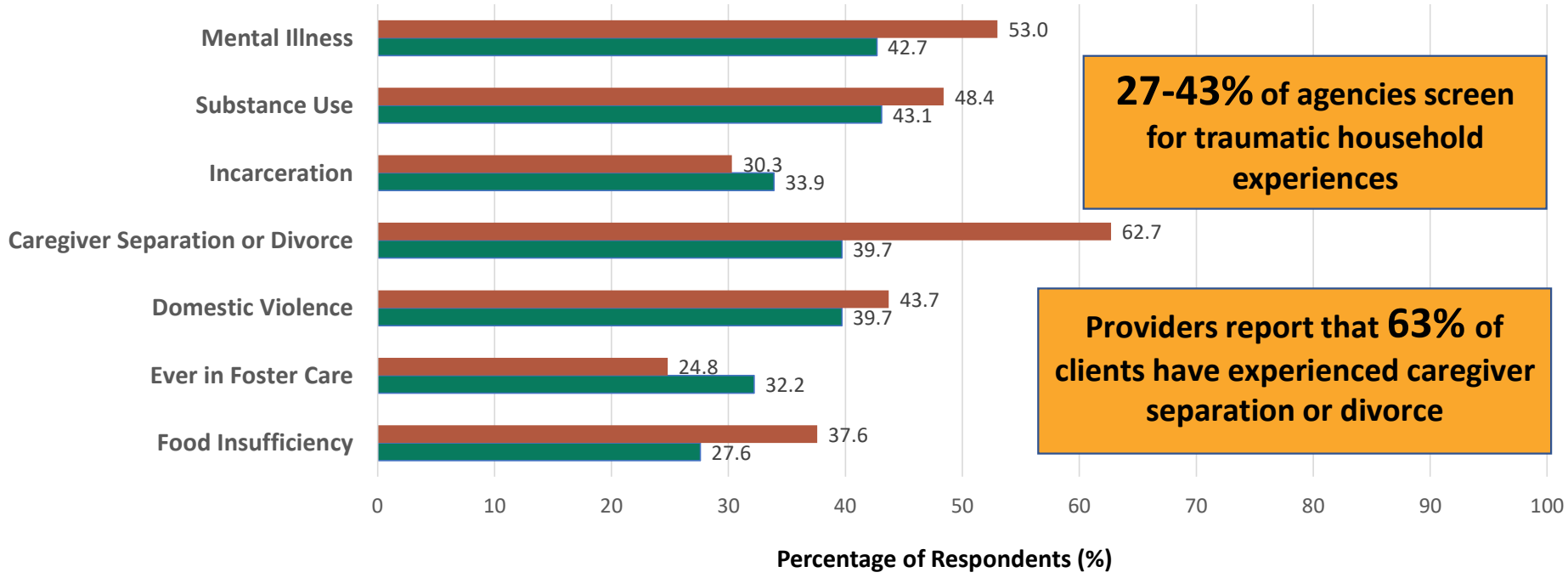
ACE Screenings and Prevalence: Child Abuse and Neglect



41-49% of agencies screen for child abuse and neglect

Providers report that **61%** of clients have experienced emotional abuse

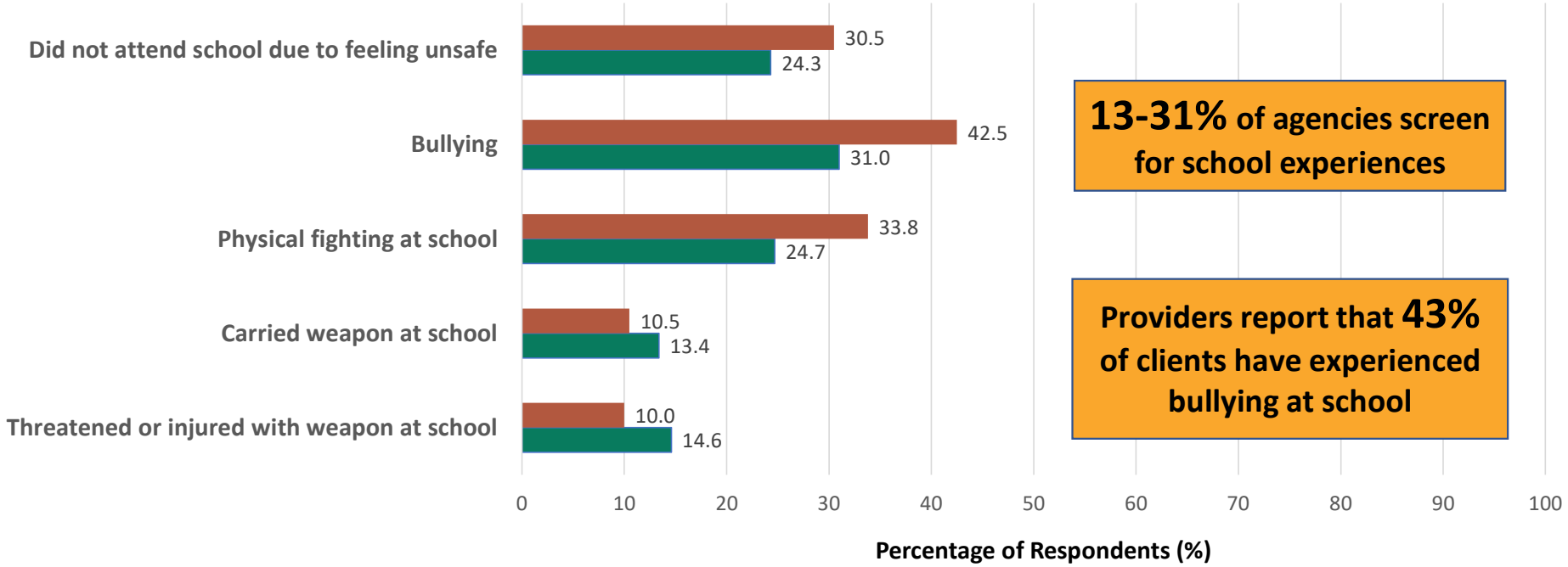
ACE Screenings and Prevalence: Household



27-43% of agencies screen for traumatic household experiences

Providers report that **63%** of clients have experienced caregiver separation or divorce

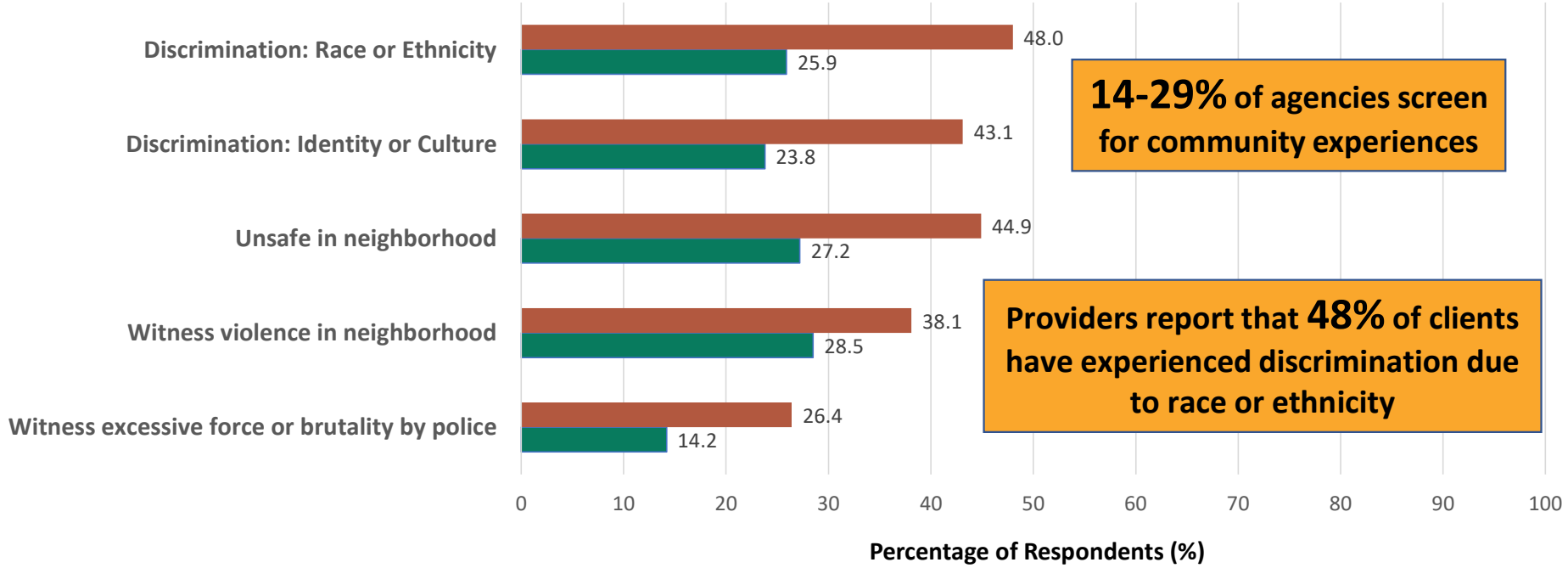
ACE Screenings and Prevalence: School



13-31% of agencies screen for school experiences

Providers report that 43% of clients have experienced bullying at school

ACE Screenings: Community



14-29% of agencies screen for community experiences

Providers report that 48% of clients have experienced discrimination due to race or ethnicity

Supports Requested for Screening (n=124)

The top two requested supports for screening:

- **Training (n=52)**
  - Includes requests for special populations including adults who are parents, corrections, dual diagnosis, and low-income individuals
  - Several individuals emphasized need for free / low-cost trainings (n=7)
- **Provide screening tools for agencies (n=13)**

"A training on next steps would be great. I feel there are a lot of wonderful trainings on ACE's and screening tools, but not so much on the "what's next?"

"Recommend validated and electronic, non-proprietary screeners"

"Additional training in mandated reporting requirements. i.e. What meets the threshold for required reporting and what does not. "

"I am in a Supported Employment program…we still encounter many individuals who have suffered from ACEs. It would be beneficial to engage in training opportunities to understand how those effects impact the consumers we work with and maybe how that could impact them in searching for work, or within the workplace."

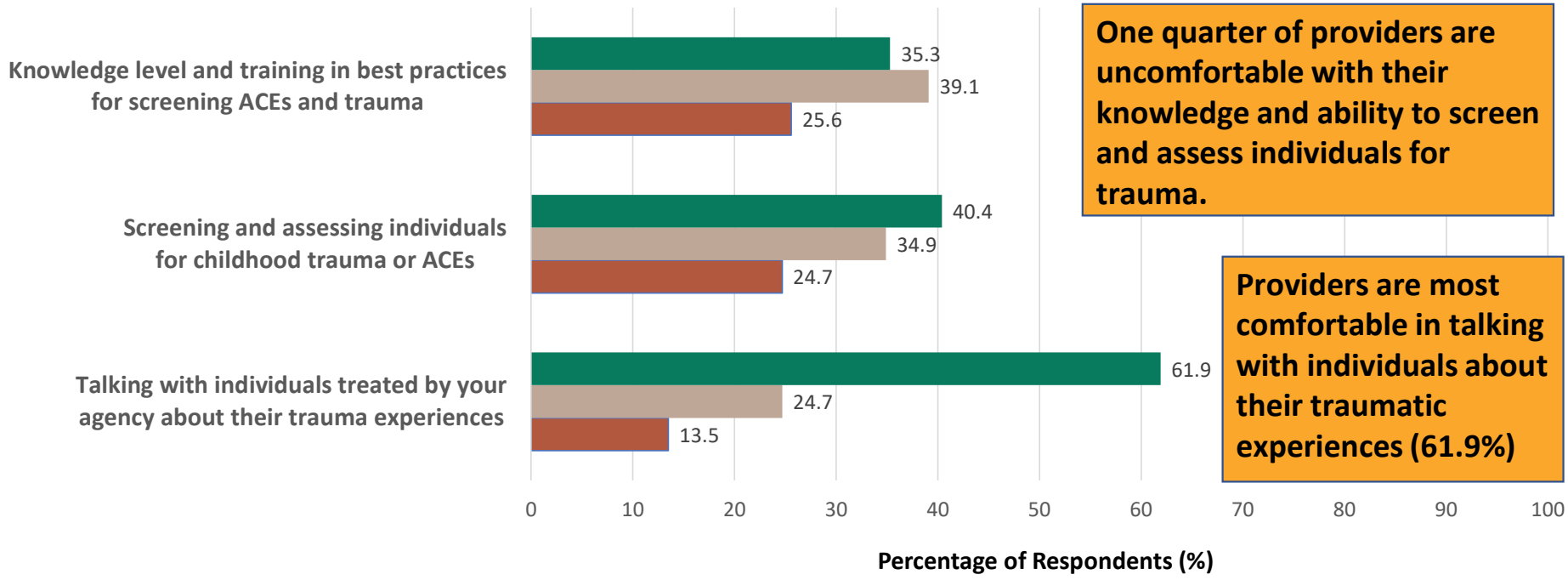
Building Healing Behavioral Health Systems:

Experiences with Screening:

Client and Provider Comfort

Barriers

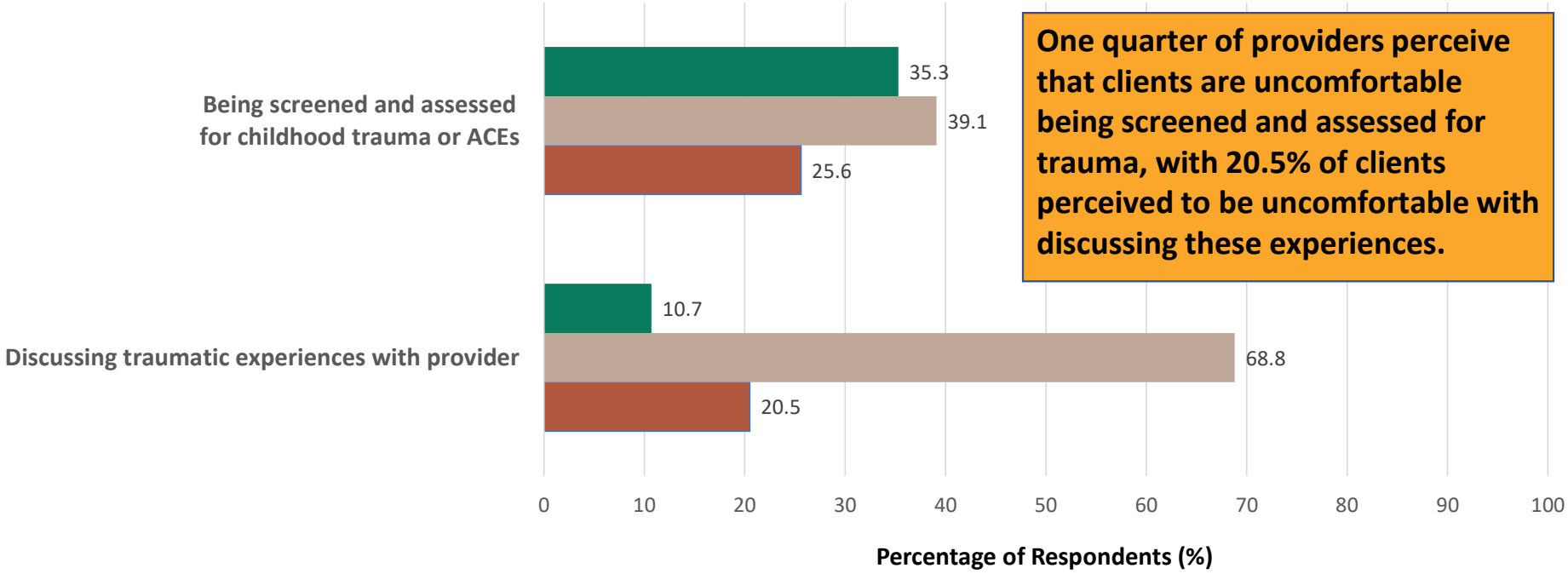
Provider Comfort with ACEs and Trauma



One quarter of providers are uncomfortable with their knowledge and ability to screen and assess individuals for trauma.

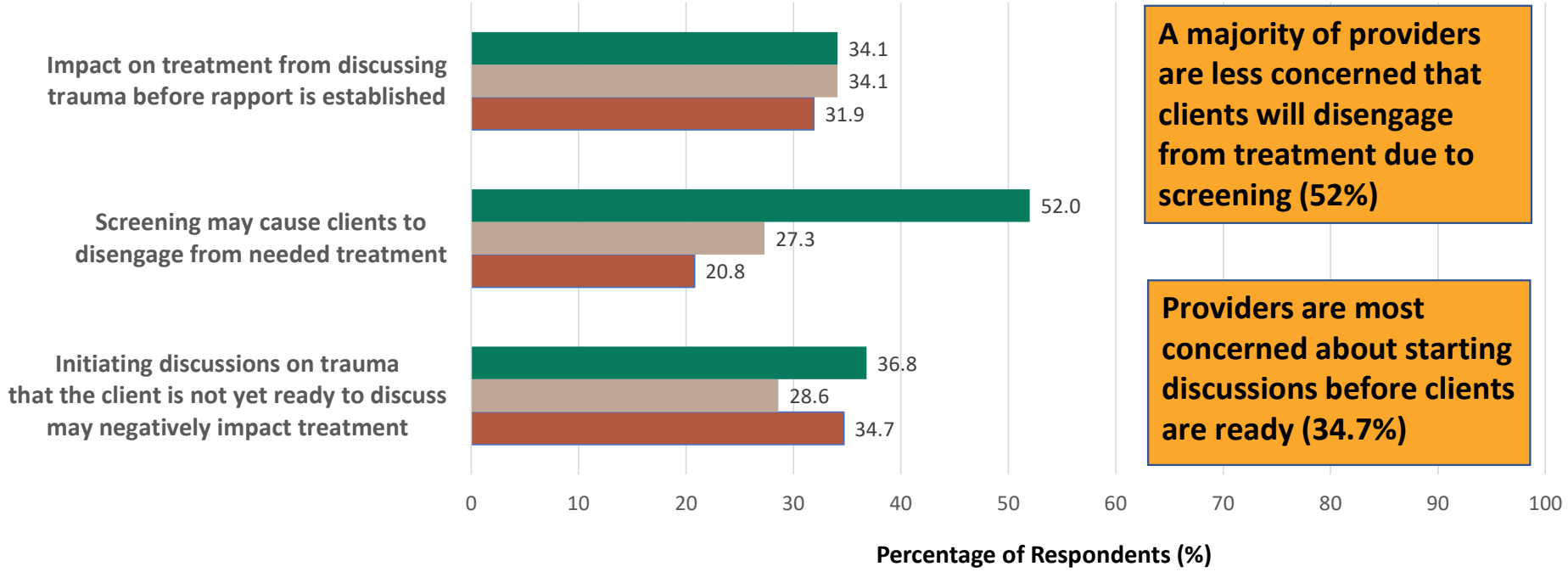
Providers are most comfortable in talking with individuals about their traumatic experiences (61.9%)

Perceived Client Comfort with ACEs and Trauma



One quarter of providers perceive that clients are uncomfortable being screened and assessed for trauma, with 20.5% of clients perceived to be uncomfortable with discussing these experiences.

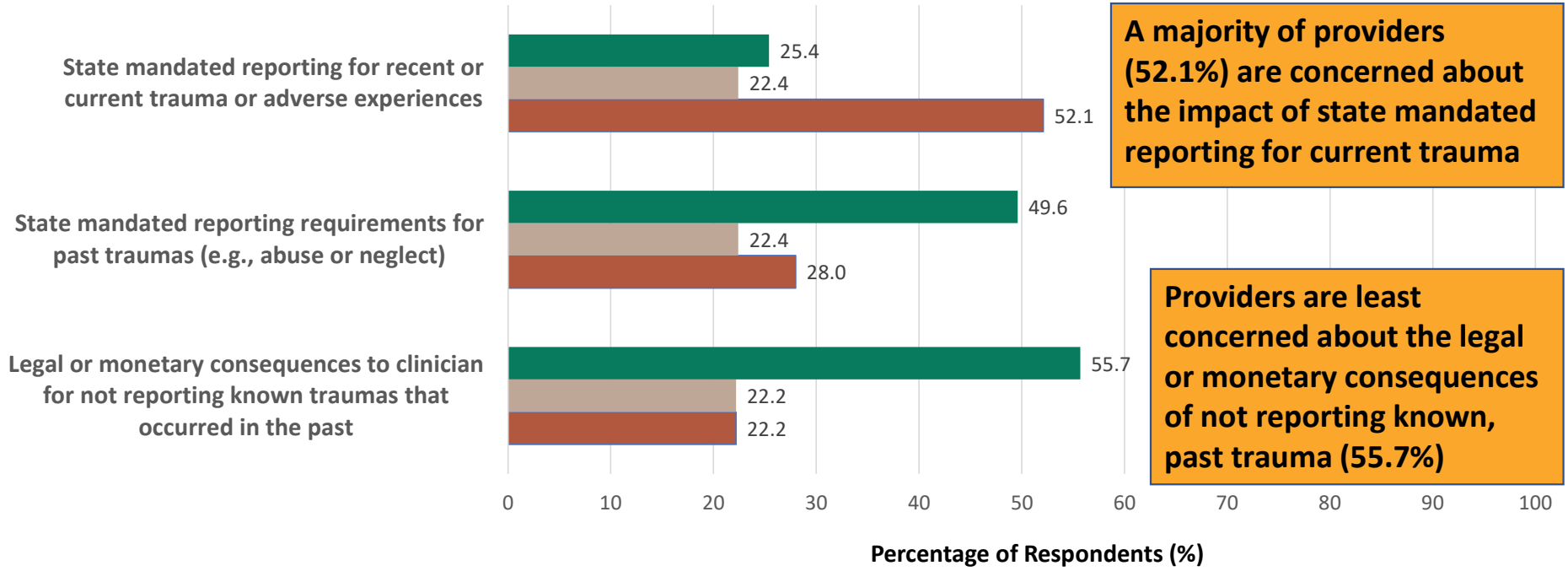
Concerns for impact of trauma screening and assessment on individuals in treatment



A majority of providers are less concerned that clients will disengage from treatment due to screening (52%)

Providers are most concerned about starting discussions before clients are ready (34.7%)

Mandated Reporting and Legal/Monetary Concerns



A majority of providers (52.1%) are concerned about the impact of state mandated reporting for current trauma

Providers are least concerned about the legal or monetary consequences of not reporting known, past trauma (55.7%)

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Top Barriers to Screening (Clients) (n=145)

- Client Transparency / Trust (n=43)
- Insufficient Client Rapport (n=37)
- Client Readiness to Discuss Trauma (n=30)
- Mandated Reporting (n=25)
- Negative Impact on Client in Probing for Prior Trauma (n=18)
- Not Enough Time (n=15)
- Client Definition of Trauma (n=10)
- Client Protecting Family or Fearing Retaliation (n=10)

"If a rapport is not built prior to screening, that can do cause a significant negative impact on the individual being assessed as well as the success of treatment."

"Consumers often feel hesitant to disclose once understanding mandated reporting, especially if the individual is still involved in their lives. Although the person may have had a negative impact on the individual, it is often still one of the few supports in their lives. In my experience, people [would] rather have a negative support in their lives rather than no supports at all."

Top Barriers to Screening (Agency) (n=145)

- **Timing of screenings (e.g. crisis response at intake, structure of agency) (n=19)**

> *"I work at a community agency that offers short-term counseling, with some leeway. A major barrier is sticking to a proposed short-term timeframe and initiating discussions around trauma without adequate time to fully treat the individual. Another barrier - screening may result in dysregulating the client so early on in the treatment process."*

- **Lack of available, appropriately trained clinicians (n=13)**

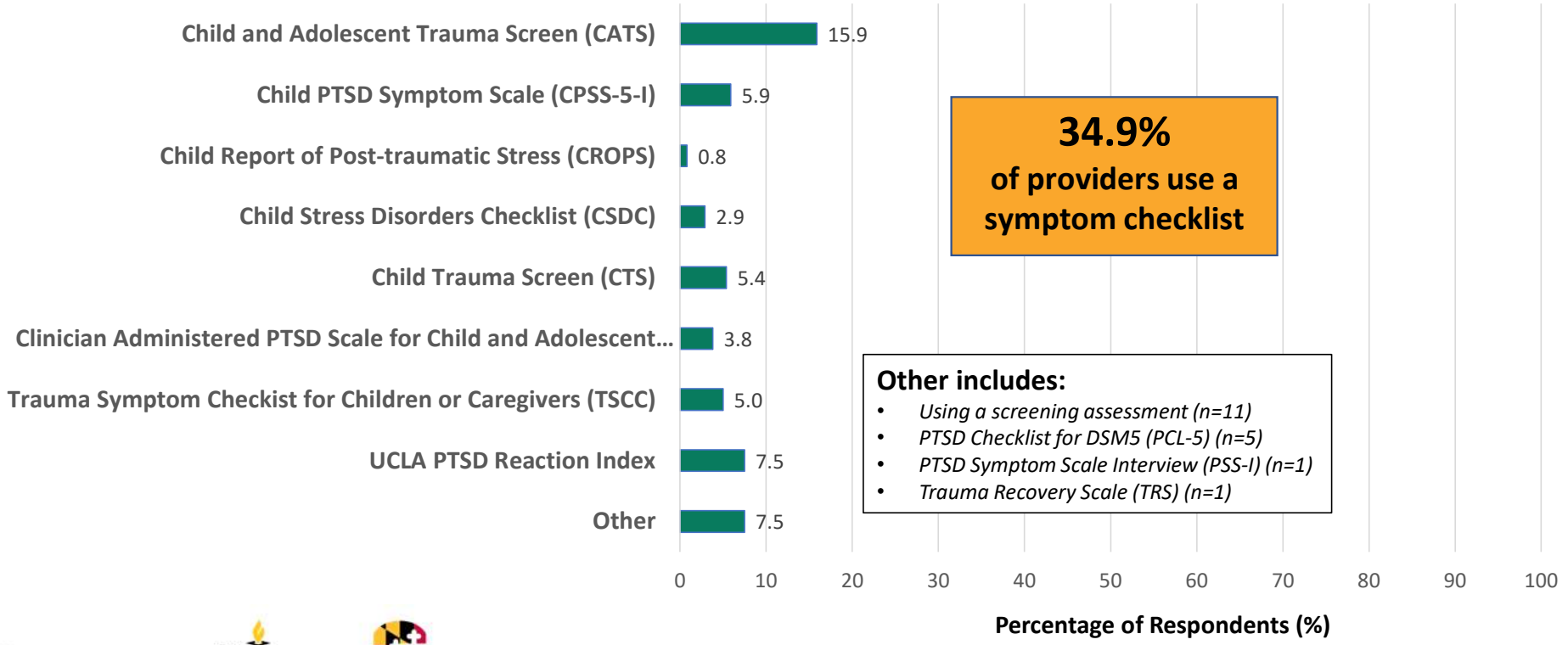
> *"Lack of specialized local resources to aid in treating trauma and related issues (such as lack of psychiatrists, specialized therapists, and substance use disorder treatment)."*

> *"In SUD, this is outside of a SUD counselor's scope and is generally conducted [by] licensed clinicians. SUD counselors are not trained in college, and other counselors believe its is not part of their job. It's perception of the counselors."*

Building Healing Behavioral Health Systems:

Trauma-informed Clinical Activities

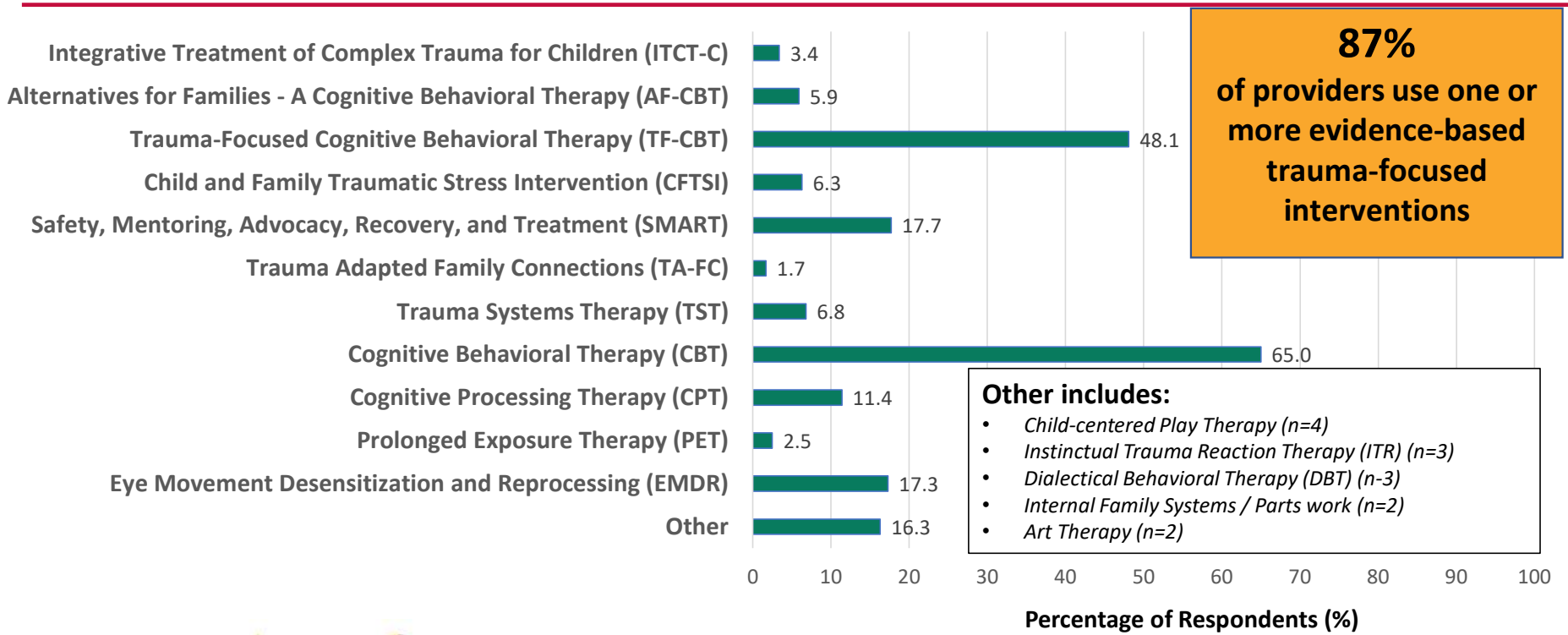
Trauma Symptom Checklists Used



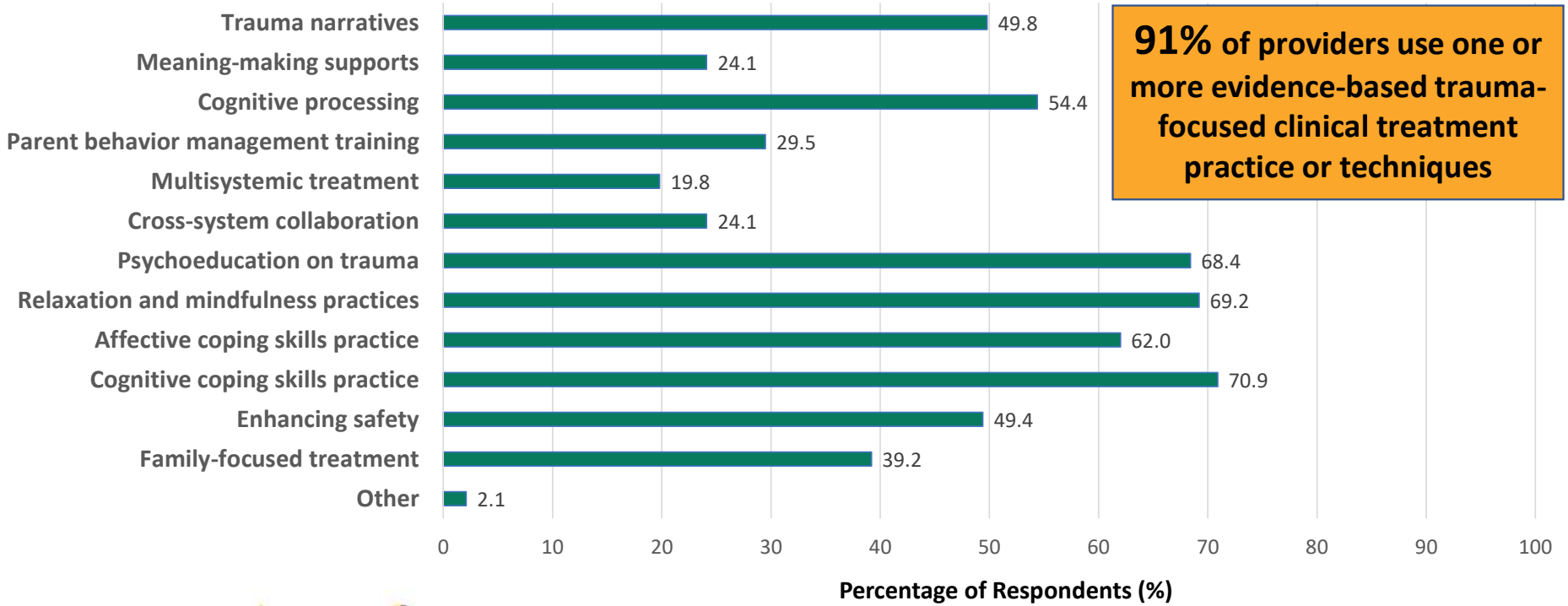
34.9%
of providers use a symptom checklist

Other includes:
- *Using a screening assessment (n=11)*
- *PTSD Checklist for DSM5 (PCL-5) (n=5)*
- *PTSD Symptom Scale Interview (PSS-I) (n=1)*
- *Trauma Recovery Scale (TRS) (n=1)*

Evidence-Based Trauma-Focused Interventions



Evidence-Based Trauma-Focused Clinical Treatment Practices or Techniques



91% of providers use one or more evidence-based trauma-focused clinical treatment practice or techniques

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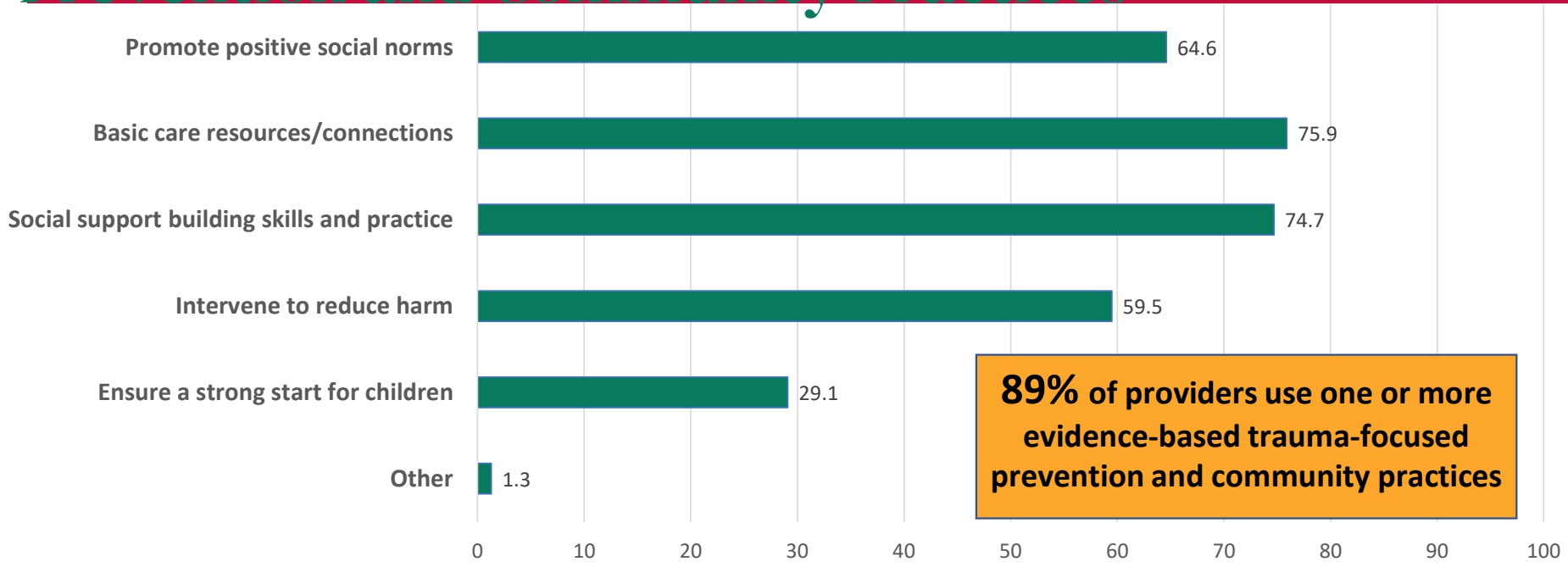
Evidence-Based Trauma-Focused Prevention and Community Practices



89% of providers use one or more evidence-based trauma-focused prevention and community practices

Supports Requested for Interventions (n=78)

The top two requested supports for interventions:

- **Training (n=61)**
  - Several individuals again emphasized need for free / low-cost trainings (n=14)
- **Resources (n=13)**

"Free resources and trainings on trauma-informed approaches for health systems."

"Virtual or in-person trainings that don't cost an arm and a leg, or are free. Substance abuse counselors do not make a lot of money even though we provide a much needed service to trauma survivors."

"Offering of trainings around assessments, treatment interventions, especially when working with intersecting minority identities like immigrant children and families, transgender/gender non-conforming, Autism. Working with intergenerational trauma, and chronic traumatic experiences. Running trauma groups. More training including self-paced ones."

Building Healing Behavioral Health Systems:

Trainings: Past and Future

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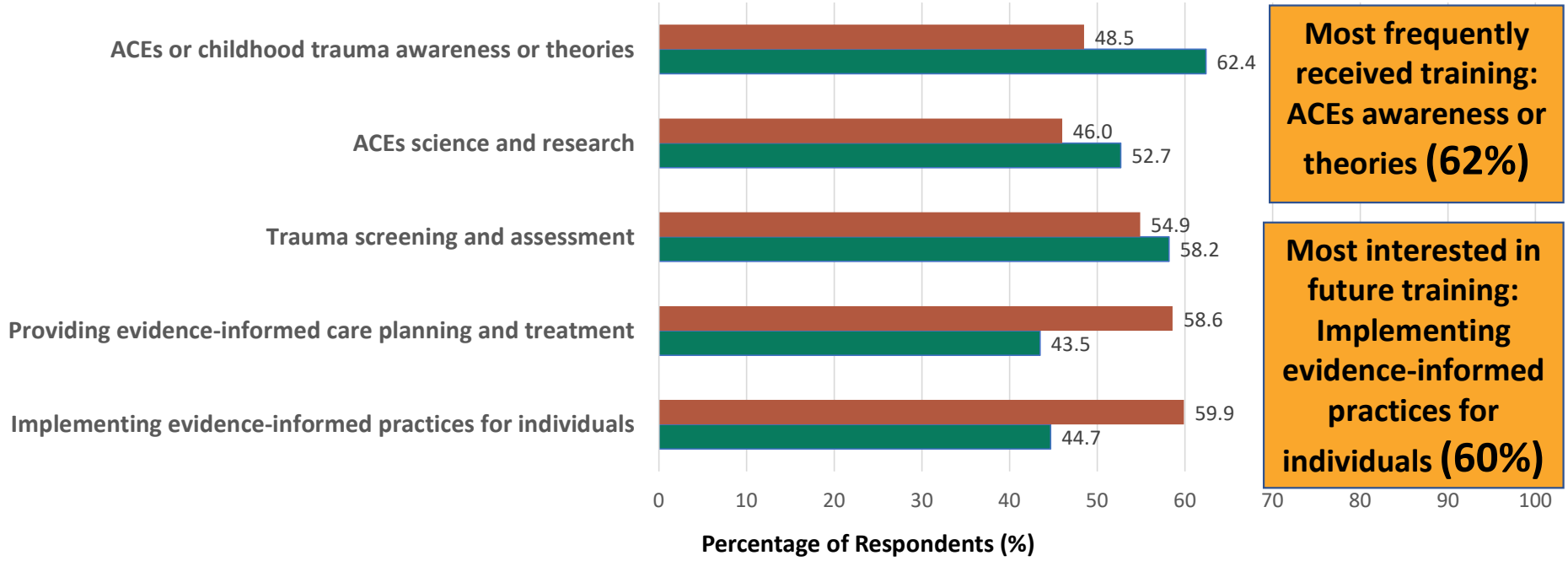
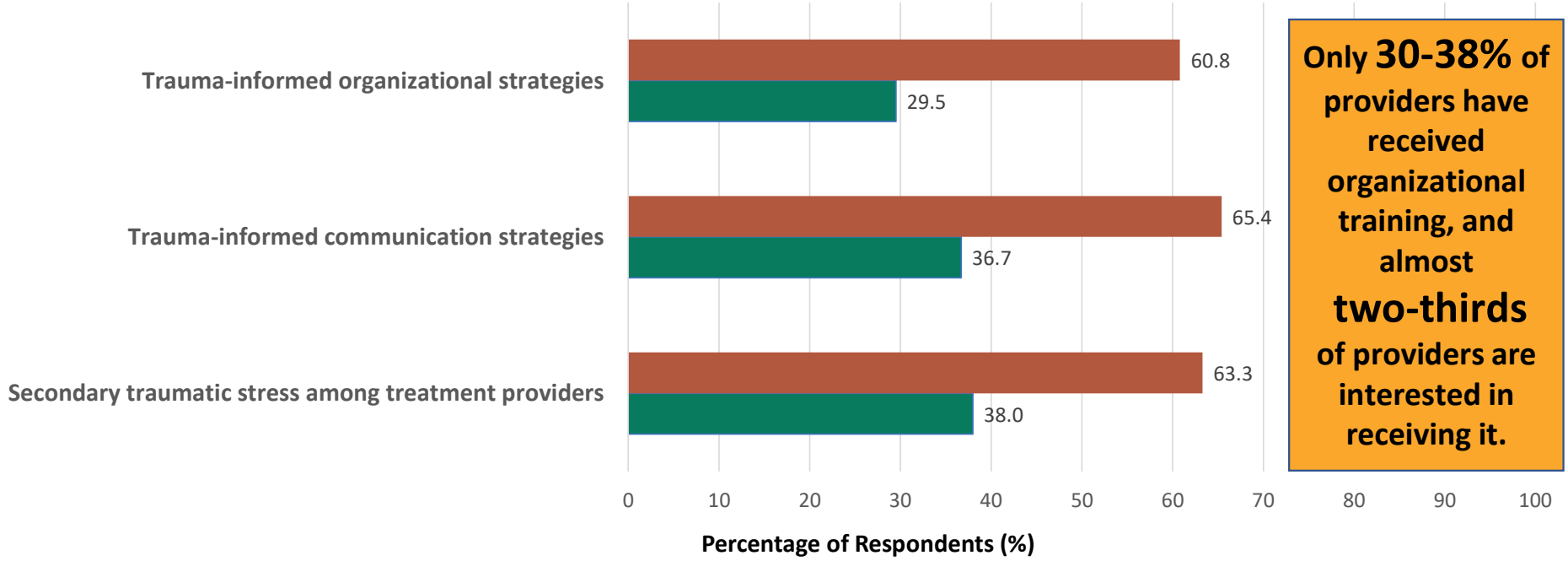
Trainings: General and Individual



Most frequently received training: ACEs awareness or theories (62%)

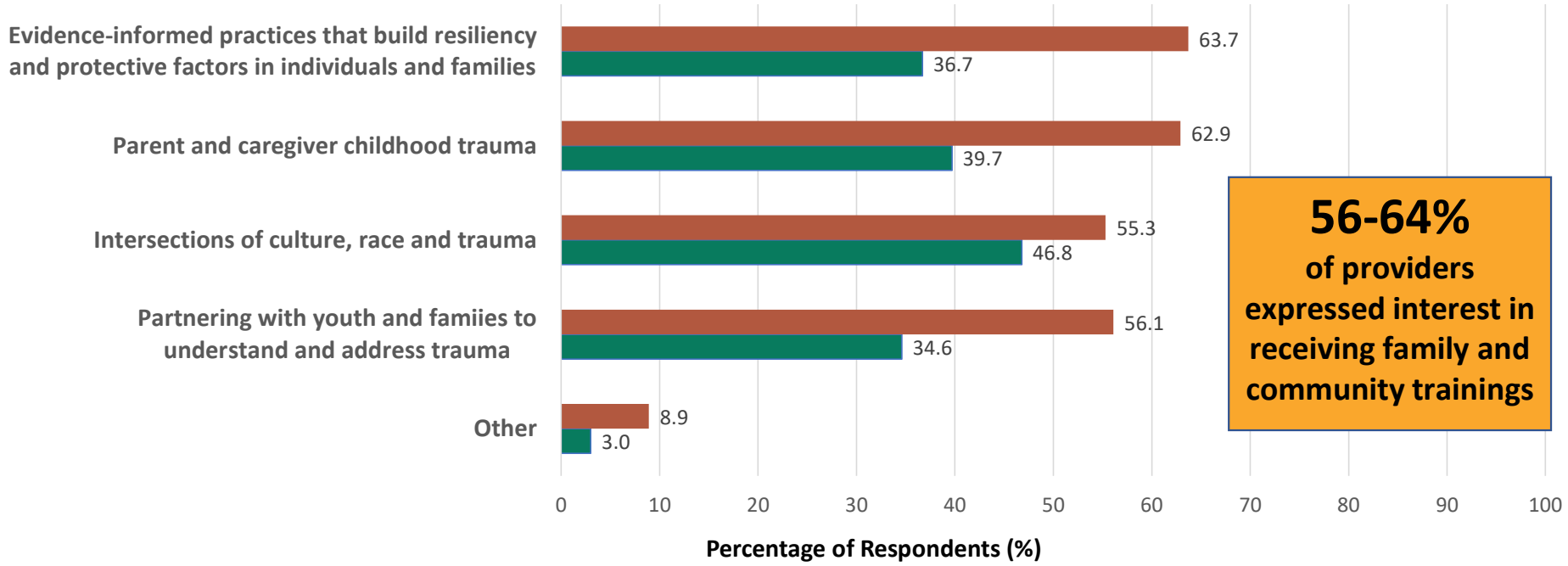
Most interested in future training: Implementing evidence-informed practices for individuals (60%)

Trainings: Organizational and Provider



Only 30-38% of providers have received organizational training, and almost two-thirds of providers are interested in receiving it.

Trainings: Family & Community



56-64%
of providers expressed interest in receiving family and community trainings

Anything else? (n=30)

- **Training (n=12), especially with**
  - special populations (n=4)
  - Treating adults with severe childhood trauma and children with current childhood trauma (n=5)

"We tend to focus on building coping skills for the present, but I notice that individuals with severe childhood trauma often are unable to do this. We need more help."

- **Immediate treatment needs and insufficient time or agency resources prevent addressing childhood experiences in adults (n=4)**

"I find it very challenging for us to try to create a new beginning for each resident with our very limited resources. Many are extremely traumatized either from family, friends, foster care, jail, homeless to name a few and to "start" living in an apt either alone or with a roommate without having essential life skills. Yes we try our best to provide a warm, safe, nurturing place but unfortunately lack of trust is huge. this takes a tremendous amount of time and in our program, time is limited. The World ahead of them can be very intimidating and overwhelming. Many of them make extremely poor decisions for many reasons."

Trainings for Special Populations

- Co-occurring disorders and dual diagnosis
- Deaf and Hard of Hearing
- Intersecting minority identities like immigrant children and families, transgender/gender non-conforming
- Autism
- Intellectual Disability
- Adults and children with severe childhood trauma
- Individuals with multiple, comorbid conditions that require stabilization
- Cultural training on how trauma presents in people from different backgrounds
- Immigrant families with English as an other language

Other Salient Comments

Training in higher education

"… about the content of behavioral health degrees, internships. Almost all trainings are basic and are not practiced with or in front of trainers and supervisors. . . For example, The Masters in Social Work degree does not have any practicum for working with children but the majority of the jobs when you graduate are working with children. We are not experienced or equipped. Especially with children with childhood trauma."

Training for individuals with multiple behavioral and health challenges

"How to incorporate this with individuals diagnosed with Intellectual Disabilities, Developmental Disabilities and severe & persistent mental illness (often all three in one individual)…"

Training to understand cultural differences in trauma

"Cultural training and how trauma presents in people from different backgrounds, especially immigrant families. Ideally we would learn a bit about why people are immigrating in large numbers, how they perceive and address trauma within their cultural norms, and actual tangible supports available to people who speak a language other than English and free therapy resources and treatment providers. . . "

Building Healing Behavioral Health Systems:

Summary of Findings and Potential Action Steps

Summary of Findings

- **Providers estimate that vast majority clients are impacted by childhood trauma**
  - **97%** of their clients **experience some form of childhood trauma**
  - **63%** of clients have **four or more** trauma experiences
- **Clients also are reported to have Positive Childhood Experiences to counteract the impact of childhood trauma, with 75% feeling supported by friends**
- **Although a wide variety of screening processes are used across agencies, only 59% of agencies reporting that all clients receive screening. Agencies report screening for**
  - 41-49% Child Abuse and Neglect
  - 27-43% Household ACEs
  - 13-31% School ACEs
- **There is a gap in our identification of ACEs during treatment - virtually all PBHS clients have experienced trauma but only 59% of agencies appear to be screening all clients for trauma**

Summary of Findings: Provider and Client Comfort

- **Providers reported that they are very or extremely uncomfortable with**
  - their knowledge level and training in best practices for screening (26%)
  - screening and assessing individuals for childhood trauma or ACEs (25%)
  - talking with individuals treated by their agency about their trauma experiences (14%)
- **Providers reported that they perceive their clients to be very or extremely uncomfortable with**
  - being screened and assessed for childhood trauma or ACEs (26%)
  - discussing traumatic experiences with their provider (21%)

Summary of Findings: Provider Concerns

- **Providers are very or extremely concerned about the impact of trauma screening and assessment on individuals in treatment, including**
  - initiating discussions on trauma that the client is not yet ready to discuss that may negatively impact treatment (35%)
  - impact on treatment from discussing trauma before rapport is established (32%)
  - screening may cause clients to disengage from needed treatment (21%)
- **Providers are very or extremely concerned about mandated reporting and legal/monetary concerns, including**
  - state mandated reporting for recent or current trauma or adverse experiences (52%)
  - state mandated reporting requirements for past trauma (e.g. abuse or neglect) (28%)
  - legal or monetary consequences to clinician for not reporting known traumas that occurred in the past (22%)

Summary of Findings

- **Other Supports were requested for**
  - **Screening**: provide screening tools for agencies
  - **Intervention**: Resources on trauma informed approaches
- **35% of providers use a symptom checklist**
  - 12 different symptom checklists in use
  - Most frequently used symptom checklist is the Child and Adolescent Trauma Screen (CATS) 16%

Summary of Findings: Interventions and Practices

- **87% of providers use one or more evidence-based trauma-focused interventions**
  - 16 different interventions in use
  - Most frequently used interventions were Cognitive Behavioral Therapy (65%) and Trauma-Focused Cognitive Behavioral Therapy (48%)
- **91% of providers use one or more evidence-based trauma-focused clinical treatment practices or techniques**
  - 12 different clinical treatment practices or techniques in use
  - Most frequently used practices or techniques were Cognitive Coping Skills Practice (71%), Relaxation and Mindfulness Practices (69%) and Psychoeducation on Trauma (68%)
- **89% of providers use one or more evidence-based trauma-focused prevention and community practices**
  - 6 different community practices in use
  - Most frequently used practices were Basic care resources / connections (76%), Social Support Building Skills and Practice (75%)

Summary of Findings: Trainings

- **44-62% of providers have received general trainings or trainings on interventions with individuals on ACEs**
  - 46-60% are interested in receiving this training
- **30-38% of providers have received training regarding trauma-informed organizational approaches and provider supports**
  - 61-65% are interested in receiving this training
- **35-47% of providers have received trainings on family and community approaches for ACEs**
  - 55-64% are interested in receiving this training

Summary of Findings: Trainings

- **Most common requests for training (open-ended questions):**
  - Identifying and treating trauma in special populations, such as individuals
    - who are incarcerated, deaf, or immigrants
    - with co-occurring or comorbid conditions, such as autism, intellectual disabilities or current PTSD.
  - Providing diversity training for how trauma presents in different populations such as transgender, non-gender conforming and other intersecting minority identities
  - Understanding mandated reporting requirements and what meets threshold for reporting with ACEs
  - Emphasizing need for broadly available free or low-cost trainings with CEUs

Potential Action Steps

- **Identify reliable, comprehensive trauma screening tools and disseminate this information to providers**
- **Promote trauma-informed organizational-level approaches**
- **Further explore barriers to trauma screening, assessment and interventions and develop strategies to reduce barriers (e.g. providing educational resources regarding state mandated reporting requirements).**
- **Continue to provide resources through the BHBHS Data-to-Action Toolkit**
- **Develop resources, tools, policies/practices that help increase PCEs in Maryland systems**
- **Encourage providers to participate in self assessment to work toward becoming a more trauma informed organization**
  - Consider applying for the next cohort for the BHBHS Learning Community to learn more about using the Building Healing Systems (BHS) Trauma-Informed Organizational Assessment (TIOA) for quality improvement

Potential Action Steps

- **Offer low-cost provider training with CEUs including**
  - Overview and general information
  - Individual screening tools and how to use them
  - Trauma-informed treatment approaches, including considerations for special populations
  - Trauma-informed organizational approaches and provider supports
  - Community approaches for ACEs

- **Evaluation Activities**
  - Continue with a similar survey for youth and caregivers
  - Once data is available, compare prevalence estimates from a variety of sources (BRFSS, YRBS, providers, caregivers, service recipients) to refine our understanding of service and support needs in Maryland

Appendix - Methods: Eligibility and Invitation

- **Eligibility**
  - The survey targeted individuals providing clinical or rehabilitative services within the Maryland PBHS, including those working for an agency or in private practice.
  - Individuals serving only in an administrative capacity were *not* eligible to participate. Respondents who identified themselves as administrators were exited from the survey.
- **The following methods were used to invite providers to participate in the survey**
  - SEC and/or BHA contacted several entities that have provider representation
    - Each entity distributed the invitation to their provider distribution list, requesting that it be forwarded to staff providing direct services
  - Information and a link to the survey were included in a Provider Alert disseminated to agency administrators and service providers throughout the state.

Appendix - Methods: Data Collection and Analysis

- **Because individuals were likely to receive the survey link via multiple emails, interested participants were asked to complete the survey only once.**
- **Data were collected from April 5- June 19, 2023**
  - Approximately 2-4 weeks after the initial survey distribution, a reminder email with the invitation survey was sent with a request to redistribute.
  - To boost response rates, additional organizations and email listservs were added to the distribution in May and June .
- **Quantitative Data Analysis**
  - General descriptive statistical information were calculated for all quantitative variables
  - Cross-tabulations for relevant variables were used to understand the patterns in the results
- **Qualitative Data Analysis**
  - Qualitative items were analyzed using an emergent theme approach..

Appendix – Methods: Survey Distribution

The provider survey was distributed to the following organizations:

- The Community Behavioral Health Association of Maryland (MDCBH)
- Maryland Association of Behavioral Health Authorities (MABHA)
- Mental Health Association of Maryland (MHAMD)
- Maryland Addictions Directors Council (MADC)
- Maryland Association for the Treatment of Opioid Dependence (MATOD)
- National Council on Alcoholism and Drug Dependence of Maryland (NCADD-MD)
- Maryland Network Against Domestic Violence
- Maryland Coalition Against Sexual Assault

The survey was also distributed using email lists from the following:

- UMB Training Center
- UMB Evidence Based Practice Center

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