2017 Situational Analysis

Substance Abuse and Prevention Treatment Agency, Bureau of Behavioral Health, Wellness and Prevention

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Acknowledgements

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The Steering Committee would like to acknowledge key informants and others that contributed to this situational analysis.

Introduction and Purpose

In January 2017, the Division of Public and Behavioral Health Behavioral (DPBH) embarked upon a strategic planning process for the Substance Abuse Prevention and Treatment Agency (SAPTA), now contained within the Bureau of Behavioral Health, Wellness and Prevention. This process is guided by a Steering Committee consisting of key community and state government stakeholders.

SAPTA's mission has been to reduce the negative impact of substance abuse in Nevada. DPBH is currently revising its mission, vision, and will develop goals to guide its work over the next three years, which will also guide SAPTA as part of the Bureau of Behavioral Health, Wellness and Prevention. While SAPTA does not provide direct substance abuse service delivery, it does serve in an administrative role, planning, funding, and coordinating statewide efforts and providing technical assistance when necessary.

The Nevada Division of Public and Behavioral Health is the Single State Authority (SSA) for federal grants issued by the Substance Abuse and Mental Health Services Administration (SAMHSA). As part of DPBH, the Bureau administers programs and activities that provide community-based prevention and treatment through the Substance Abuse Prevention and Treatment Block Grant (referred to as SABG by SAMHSA and SAPT by DPBH) (Nevada Division of Public and Behavioral Health (DPBH), n.d.). Note that "prevention and treatment" is used throughout this document to summarize a broad continuum of approaches including outreach, prevention, (early) intervention, treatment, and recovery.

The Bureau must comply with certain federal requirements in order to qualify for funding. The 2018-2019 Substance Abuse Prevention and Treatment Block Grant (SABG) application draft states that "states should identify and analyze the strengths, needs, and priorities of the state's behavioral health system." This analysis "should take into account specific populations that are the current focus of the block grants, the changing health care environment, and SAMHSA's Strategic Initiatives" (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration). Furthermore, Nevada Revised Statutes (NRS 458.025) require an assessment of the state's needs related to prevention and treatment, an assessment of professional needs for those involved in the field, and a "plan for the development and distribution of services throughout [Nevada]." Thus, in undertaking the required strategic planning process, the Bureau must first assess its internal and external environment to ensure planning is informed and relevant to the current situation.

In order to create this multifaceted understanding of the Bureau's current situation, based on these state and federal guidelines, complementary research and outreach was completed. The approach included analysis of existing state data regarding abuse incidence, prevalence, and outcomes; key informant interviews; and a review of state services systems and capacity to identify needs and gaps.

The following situational analysis summarizes the key findings of that outreach and research. Additionally, it details the methods of research; provides a description of services, systems, and capacity; identifies needs and gaps in the system; and finally, establishes potential priorities for consideration during strategic planning.

Summary of Findings

Overview

Nevada's population is growing and much of the data available indicates that more resources and better outcomes are needed for prevention and treatment of substance misuse. The current system of care appears overly reliant on emergency rooms and criminal justice settings to identify and engage individuals with substance and mental health needs. According to many key informant interviews, wait lists for services are long. Additionally, uncertainty about the Affordable Care Act (ACA) could impact already threatened provider groups struggling with workforce issues. Solutions are needed to provide access, expand the workforce, and support prevention, outreach, intervention, and effective treatment and recovery. Disproportionate representation of people with mental illness and substance issues in the criminal justice system points to lost opportunities to reach people early and intervene before additional adverse events impact their lives.

Nevada's identified issues align well with SAMHSA's strategic initiatives. Several highlights are provided below, followed by a summary of what is working, needs and issues, emerging issues, and opportunities identified through the situational analysis.

Strategic Initiative #1: Prevention of Substance Abuse and Mental Illness

➢ **Focus on high risk populations.** Key informants identified subpopulations that may have limited access and exposure to resources available for prevention and treatment. These include people speaking a language other than English, youth, and people that are lesbian, gay, bisexual, transgender and questioning (LGBTQ). Data shows that transition-age youth are particularly at risk for substance misuse in Nevada. The rate of older adults with dependence on opioids has also increased in recent years, pointing to the importance of surveillance to identify emerging populations and develop targeted prevention efforts.

Strategic Initiative #2: Health Care and Health Systems Integration

➢ **Integrate behavioral health with health promotion and health care delivery.** Continued attention and work to collaborate across behavioral health systems is important to achieve the long-term goal of successful integration. Data from the situational analysis suggests that stronger support for people with co-occurring disorders should be a priority in Nevada. Cross-sector training and education are also promising approaches to better align and integrate best practices throughout Nevada.

Strategic Initiative #3: Trauma and Justice

➢ **Reduce the involvement of individuals with trauma and behavioral health issues in the criminal and juvenile justice systems.** Data from the situational analysis suggests considerable gains are possible through attention to trauma. The state is engaged in several innovative programs around the justice system, which may shed light on additional needs and opportunities. Work through local corrections (jails) and hospitals is an important short-term strategy to address the current situation. It is important to strengthen behavioral health systems so that people are interfacing with appropriate treatment and care. Finally, 'upstream' prevention efforts, for example focusing on

reducing adverse childhood experiences and the impact of community trauma, can play an important role in addressing the root causes of some mental health and substance use disorders.

Strategic Initiative #4: Person-centered Planning and Recovery Supports

➢ **Partner with people in recovery from mental and substance use disorders and their family members to guide the behavioral health systems and promote individual, program, and system-level approaches that foster health and resilience.** Assistance with navigation and advocacy were identified as important workforce needs. Families and peers, with training and support, are an under-utilized asset. Housing and transportation are two important needs that were identified as barriers to treatment, treatment outcomes, or both. Several specific services—such as residential treatment—were identified as inadequate to meet community demand. Wraparound or continuum-of-care approaches were identified as solutions to improve outcomes for those with complex needs.

Strategic Initiative #5: Health Information Technology

➢ **Ensure that the behavioral health systems, including community providers, patients, peers, and prevention specialists can fully participate with the healthcare delivery system in the adoption of health information technology (Health IT).** Nevada has made many advancements in this regard, including expansion of electronic health records and improvements to data systems. Development of specific data, enhanced communication between state and community groups, and enhanced capacity to analyze and use data to improve outcomes, were key themes identified through this analysis.

Strategic Initiative #6: Workforce Development

➢ **Support active strategies to strengthen and expand the behavioral health workforce.** Nevada continues to face shortages of providers. Continued efforts to address reciprocity, compensation, and training/licensure issues are needed. Other opportunities include leveraging the planning and activities that are taking place at the state to address issues of reimbursement and payment for providers.

What's Working Well	
	Examples and Support for Finding
Improvements to Nevada's Behavioral Health System	➡ Nevada has successfully applied for a number of grants that are helping to improve behavioral health systems. For example, Certified Community Behavioral Health Clinics (CCBHC) will expand resources available within the state. Other programs like Community Health Workers provide an example of a grant-funded resource that helped connect hard-to-reach populations with resources. Interviewees for this report recognized progress toward a recovery-oriented system of care, including integration, inclusion, and person-centered care.
Use of Evidence-Based Practices (EBP)	➡ Many systems and organizations use EBP. There is interest in continuing or strengthening existing models and practices and promoting training so more people can benefit across systems and settings.
Local Coordination for Prevention	➡ Coalitions are locally driven and relevant within their communities. They provide information about emerging issues across providers, systems, and geographies. ➡ Coalitions that have successfully engaged local youth and school districts have high quality prevention efforts in their communities.
Substance Misuse Decreasing for Many Substances and Populations	➡ Data from surveys (e.g. National Survey on Drug Use and Health or "NSDUH" and Youth Risk Behavior Survey or "YRBS") show that for many substances and among many populations, Nevada's rates of misuse are decreasing. Significant decreases in use were observed among high school youth between 2013 and 2015 for 'ever smoking cigarettes,' 'currently used tobacco,' 'drank first alcohol before 13,' 'ever used cocaine,' 'ever used inhalants,' 'ever used methamphetamine,' 'ever used [methylenedioxy-methamphetamine, known as] MDMA, 'and 'ever used synthetic marijuana.'
Insurance Coverage	➡ Since Medicaid expansion in Nevada in 2013, the rate of people covered by Medicaid has increased dramatically, providing a source of insurance. Further, the Mental Health Parity Addiction Equity Act has helped to ensure people get the treatment they need. ➡ SAPTA is in the process of revising policies to provide treatment by functioning as a safety-net for services that are not covered by Medicaid.
State-level Improvements	➡ Administrative longevity and restructuring has started to improve the operations at the state level, including improvements to the certification system.

Issues and Challenges

Examples and Support for Finding

System Challenges	
	⇨ Emergency rooms have shown dramatic increases for behavioral health needs in recent years. Key informants also identified that jails are in contact with more people for behavioral health issues. The reasons are not fully clear. Some believe that access to insurance has driven these increases. Others are concerned that the shift to community-based providers has resulted in new access gaps.
	⇨ Services aren't well-known within the community. Online resource directories are not always up to date. Even when people know of services, they often need help navigating and advocating for services. This includes people seeking care for the first time, exiting institutions, and transitioning from treatment. Transitions from higher to lower levels of treatment were identified by key informants as contributing to higher rates of relapse and higher costs due to recurring need for more intensive services. Besides affecting community members, this information gap also affects providers' ability to refer.
	⇨ Rates of diagnosis and treatment for co-occurring disorders are lower in Nevada compared to the rest of nation. Integrated care is a best practice, and differences between Nevada and the nation for diagnosis and treatment point to the potential for improvement in this area.
	⇨ There are long wait times for people seeking services within their communities. A lack of services to meet demand, especially residential programs, was noted as a key challenge across the state.
	⇨ Providers struggle to collaborate to provide the best care to community members, and seek to better understand resources that are available and reliable within their community to improve collaboration.
	⇨ Compliance with federal block grant requirements and federal and state regulations is lacking. Examples given include the lack of outreach to intravenous drug users (IVDU), the lack of a capacity management system, the lack of a needs assessment that meets federal requirements, and insufficient referrals to pregnant women, among others.
	⇨ There is a struggle to align across state systems, divisions, and bureaus. Additionally, a lack of institutional knowledge and lack of subject matter expertise create barriers for providers and prevention professionals to effectively interact with the state.

Issues and Challenges

	Examples and Support for Finding
Substance Misuse Is Elevated for Many Substances and Populations	➡ Rates of substance misuse including dependency are higher among many populations within Nevada compared to the nation. ➡ Survey data shows that many people needing treatment do not get the care they need. ➡ Admissions for substance abuse treatment in Nevada in 2014 were for a variety of substances including alcohol, methamphetamines, heroin, marijuana/hashish, and other opiates/synthetic opiates. ➡ Hundreds of Nevadans die each year from drug and alcohol related illness and injury.
Workforce Shortages	➡ A lack of providers across the state contributes to people needing services and not receiving them. This is a challenge for both consumers and providers. ➡ Compensation for licensed professionals was identified as inadequate to attract and retain the workforce at the level needed. Additionally, professionals, especially in rural areas, experience a high level of 'burnout.' ➡ While many grants have been successfully obtained, these programs, (e.g. Community Case Managers funded through Cooperative Agreement to Benefit Homeless Individuals or "CABHI") will end when grant funding ends. Resources to sustainably build and fund the workforce is lacking. ➡ Funding for case managers and other positions in corrections and state systems has been limited, but these professionals are important to making systems more effective and navigable. ➡ More outreach and services are needed in languages other than English and that are culturally competent. ➡ Many people with behavioral health problems are found in local jails. Education and resources on substance abuse treatment and recovery is important for those professionals working in jails. ➡ Training is needed for people that regularly encounter substance misuse, including nurses, first responders, and other professionals. They may not recognize the signs and symptoms, know how to treat an overdose, or to whom they should refer.

Issues and Challenges

Examples and Support for Finding

Service Gaps	➡ People needing support for substance use may also have other major unmet needs including housing and transportation. These issues impact their ability to access and have successful outcomes from treatment and for recovery.
	➡ Insurance requirements can create problems with continuity of care and individualization of care.
	➡ It is difficult to provide the appropriate level of care to individuals seeking help at any point from early intervention to appropriate treatment to recovery services. There are basic barriers to entry into the system, like having an address and transportation issues that prevent people from getting to the care they need. Additionally, services are sometimes simply unavailable. For example, youth whose parents are in treatment require supports and would benefit from early intervention and prevention services.
Data Issues	➡ Data systems are imperfect, and there are still gaps in terms of data available for prevention, planning, and treatment. This includes coordination for individuals (e.g. case management systems), surveillance data (e.g. waiting lists for treatment and recovery), comparable data across communities, and support for monitoring and evaluation.
	➡ Data on treatment and recovery is also in need of development (or made more accessible) to answer questions about the use of evidence-based practices, person-centered care, etc.
	➡ Some data requests are often duplicative or not coordinated. For providers, this results in time lost that could be spent with clients. For prevention, this limits responsiveness to emerging situations.
	➡ For funded providers throughout the state, enhanced two-way communication with the state would support data, evaluation, reporting, and funding.

Threats and Emerging Issues

	Examples and Support for Finding
Policy Changes	➡ The ACA has contributed many improvements to Nevada's system for care. Loss of the ACA without a replacement could have major consequences for programs that have been planned and developed leveraging provisions of the ACA. ➡ Legalization of marijuana, both medical and recreational, may have an impact on behavioral health and substance misuse in the state.
Emerging Substance Issues	➡ Substance misuse has increased among specific populations including youth, pregnant women, and older adults. ➡ Vaping and e-cigarettes have emerged among youth populations as a new issue. Rates of marijuana use also increased between 2013 and 2015. More than one in 10 middle school youth reported currently drinking alcohol, and 3.8% reported currently using marijuana. ➡ Several concerning patterns of misuse that mirror national trends include increased opioid addiction and children born with Neonatal Abstinence Syndrome (NAS). The severe consequences of opioid misuse have made it a priority for Nevada.
Funding	➡ Many key informants are concerned that funding is not adequate to address and sustain system needs in Nevada. ➡ Information about funding opportunities and assistance to seek these opportunities are unavailable in a timely manner.

Opportunities

	Examples and Support for Finding
Engage in Effective Planning	➡ Many states are innovating, including Nevada. Nevada can learn from other states' efforts to improve policies, systems, and practices toward improved behavioral health outcomes. ➡ The strategic prevention framework, public health model, and collective impact framework can be leveraged to strengthen Nevada's planning efforts. ➡ Continued integration of substance outreach, prevention, intervention, treatment, and recovery with mental health provides an opportunity to better serve Nevadans.

Opportunities	
	Examples and Support for Finding
Build Sustainability	➡ Outreach indicated a willingness by providers to work with limited resources and collaborate to better serve communities. The state can help to increase this capacity by enhancing transparency related to funding that would allow for a clearer picture of the funding available and the identification of effective collaborations. ➡ Sustainability planning for programs and services provides an opportunity to stabilize systems. ➡ The work of other planning processes, for example Olmstead Planning and *Nevada's No Wrong Door,* can be leveraged to support better outcomes for people seeking services. Additionally, there are existing collaborative processes and systems (e.g., among the coalitions, Nevada 2-1-1, etc.) that could be leveraged and built upon.
Enhance Communication, Relationships, and Collaboration	➡ SAPTA could serve as the high-level coordinator of services and oversight, working to integrate and consolidate community services and improve access to the system. Data is an important tool for communication, and the state can work to improve existing data collection systems, enhance capacity to report on both services provided and service outcomes, and strengthen two-way communication with local and regional partners. ➡ Improvements to functionality and better coordination of advisory boards holds the potential to improve communication and transparency. ➡ There are many opportunities for the state to work more closely and collaboratively within communities. ➡ Providers' collaboration could be incentivized. Additionally, it could be facilitated with better information (e.g., a comprehensive directory of providers) and formal opportunities to work together toward shared goals.
Regional and Local Control	➡ Town Hall participants and key informants indicated that a "one size fits all" approach may not take into account the distinct needs of different communities. There may be an opportunity to create greater regional and local control. Doing so would allow communities to better address the needs of specific populations and geographies, assist with training the workforce, and develop effective programs.

Opportunities

Examples and Support for Finding

Develop the Workforce	➡ Cross-systems expertise can increase training and educational opportunities. Educational institutions can be engaged to create better programs, the use of "force multipliers" (e.g., first responders, law enforcement, etc.) can be increased, and masters-level providers can supervise workers with less education to better meet demand.
Expand Knowledge and Practice of Effective Services	➡ Key informants identified many practices that hold promise for improved outcomes, including: ▪ Targeted outreach and messaging for prevention ▪ Assistance with navigation and coordination for services ▪ Interventions that utilize family members and peer support ▪ Medication-assisted treatment (MAT), including walk-in clinics ▪ Trauma–informed approaches to care ▪ Cognitive behavioral therapy and related practices ▪ Best practices for working with people recovering from opioid addiction ▪ Supportive transitions through a continuum of treatment services ➡ Providers are very interested in learning more and using the best tools. SAPTA can help to support widespread use of effective practices and a shared vocabulary, helping to ensure training and support by reducing financial and geographic barriers.

Methods and Limitations

Methods

Both quantitative and qualitative data were used to develop the situational analysis. Data from multiple sources, including data systems, reports, and publications, were compiled to answer key questions about service availability, utilization, needs, and gaps. These sources are cited throughout the document can be found in the Appendix. In addition, SEI interviewed stakeholders across the state to help identify and clarify the most important assets and issues related substance abuse prevention, outreach, intervention, treatment, and recovery.

The following table, Table 1, summarizes research and outreach components. These elements were based on Substance Abuse Prevention Block Grant (SABG) 2018-2019 Draft Application Requirements, the Ryan White HIV/AIDS Part B regulations, Nevada Revised Statutes and Nevada Administrative Code, as well as the Bureau's expressed desire to align with the Mental Health and Substance Abuse and Prevention Objectives from the National Healthy People 2020 initiative.

Table 1: Elements for Inquiry

Element for Inquiry	Data Request	Key Informant
Nevada's Services and Systems		
State Partners		
Provider collaboration and partnerships regarding health information systems, electronic health records and effective and efficient service systems	X	X
Provider collaboration between primary, specialty, emergency and rehabilitative care, and behavioral health providers	X	X
Participation in and state support of provider networks	X	X
Types of providers and their certifications	X	X
Primary Prevention Strategies		
Evidence-based and cost-effective prevention programs, policies and practices: a. Tobacco use prevention and tobacco-free facilities b. Alcohol and under-age drinking c. Drug Use	X	X
Prevention efforts that target: a. Youth and adolescents b. Harder to reach minority communities, including racial/ethnic minorities and people that are LGBTQ c. Other populations	X	X
Prevention efforts that engage schools, workplaces and communities	X	X
Changes in perceptions of risk related to substance use and abuse	X	
Prevention program outcomes or assessment activities	X	X
Treatment and Recovery Activities		
Treatment activities for the general population including adults, adolescents and children	X	
Treatment activities for populations designated by the SABG, including: a. Pregnant women and women with dependent children b. Persons who inject drugs c. People with tuberculosis and HIV/AIDS	X	X

Element for Inquiry	Data Request	Key Informant

Treatment activities for targeted services to other specific populations:
   a. People that are homeless
   b. Older adults
   c. People that are LGBTQ
   d. Adults with co-occurring mental illness and substance use disorders
	X	X

The use of wait lists and, if available, duration of wait, especially for priority populations	X	X
The use of person-centered planning, self-direction, and participant directed care	X	X
Recovery services	X	X
Nevada's Behavioral Health System		
Other potential components of Nevada's Behavioral Health System that overlap with substance abuse and prevention	X	X
Statewide Needs and Gaps		
Trends in alcohol and drug use and alcohol and drug-related deaths amongst general and priority populations	X	
Services, outreach, prevention, intervention, and treatment outcomes, and potential disparities for the general population including adults, adolescents, and children	X	X

Services, outreach, prevention, intervention, and treatment outcomes, and potential disparities for populations identified by the SABG, including:
   a. Pregnant women and women with dependent children
   b. Persons who inject drugs
   c. People with tuberculosis and HIV/AIDS
	X	X

If available, services, outreach, prevention, intervention, and treatment outcomes, and potential disparities for targeted services to other specific populations:
   a. People that are homeless
   b. Older adults
   c. People that are LGBTQ
   d. Adults with co-occurring serious mental illness and substance use disorders
	X	X

Service Systems and Capacity		

State and provider capacity to provide evidence-based intervention and treatments:
   a. Culture-specific interventions
   b. Trauma-informed delivery
   c. Interactive communications technology
	X	X

Service coordination, referrals, and patient records	X	X
Charitable choice organizations, group homes,	X	
Workforce and licensing needs		X
Agency Gaps		
Statewide epidemiological data gaps	X	X
If available, comprehensive community plans to improve mental, emotional, and behavioral health outcomes	X	X
Compliance with federal and state laws regarding open meetings and transparency		X

Key Informant Interviews

A total of nine individual interviews, one shared interview, and one focus group were held with key stakeholders. Key informants were selected by the Steering Committee to represent diverse perspectives across the state.

Table 2: Key Informants

Name	Title	Organization
Malcolm Ahlo	Program Coordinator	Tobacco Control Program, Southern Nevada Health District
Sarah Beers	Training Coordinator at the Parenting Project	Parenting Project, Clark County Department of Family Services and Child Welfare
Dr. Reka Danko	Medical Director of St. Mary's Hospitalist Group Hospitalist Clinical Assistant Professor	St. Mary's Regional Medical Center University of Nevada, Reno School of Medicine
Darcy Davis, PhD	Quality Assurance Manager for Behavioral Services	Nevada Department of Corrections
Chris Empey	Program Specialist	Washoe County Social Services and member of the Nevada Children's Behavioral Health Consortium
Joann Flanagan	Alcohol and Substance Abuse Supervisor	Reno-Sparks Indian Colony
Jessica Flood	Regional Behavioral Health Coordinator	Carson Tahoe Behavioral Health Services
Sheila Leslie	Regional Behavioral Health Coordinator	Washoe County Social Services
Catherine O'Mara	Executive Director	Nevada State Medical Association
Lisa Staikoff	Community Member	Narcotics Anonymous
Multiple	Coalition Representatives	*See Table 3*

Table 3: Coalitions Focus Group 2-24-17

Name	Coalition
Jennifer Delett-Snyder	Join Together Northern Nevada
Jessica Flood	Carson Tahoe Behavioral Health Services
Cheryl Bricker	Partnership of Community Resources
Kimberly Hargrove	The Children's Cabinet
Marco Erickson	Nevada Department of Education
Hannah McDonald	Partnership Carson City
Brooklyn Mow	Partnership Carson City
Kathy Bartosz	Partnership Carson City
Linda Lang	Nevada Statewide Coalition Partnership
Meg Matta	SAPTA

Name	Coalition
Wendy Madson	Healthy Communities Coalition
Karla Banda	CARE Coalition
Jennifer Lee	CARE Coalition
Vernalyn Willis	CARE Coalition
Amber Neff	Statewide Native American Coalition
Laura L. Oslund	PACE Coalition
Stacy Smith	Nye Communities Coalition
Jeffrey Munk	Frontier Community Coalition
Andrea Zeller	Churchill Community Coalition
Jamie Ross	PACT Coalition

Town Hall Meetings

Town Hall Meetings were held to share high-level findings from the situational analysis and solicit feedback. Themes from Town Hall meetings were used to enhance the situational analysis findings. Participants were presented with a high-level overview of the situational analysis and then asked to provide their perspective on the mission, vision, concepts, and values for the Strategic Plan; the needs identified via the Situational Analysis; and the critical issues recognized by the committee. Each meeting lasted a total of 1.5 hours. At each meeting, participants were asked to sign in and self-identify as consumers, family members, professionals in the field, policy makers, or advocates. A total of 64 participants were recorded on sign-in sheets.

Limitations

Information presented in this document was intended to inform planning. For each data source, there are limitations. Caution should be used when interpreting data from a single source, as various factors can contribute to the result. Data from multiple sources is presented when possible to provide a more complete picture of the current situation. Limitations that particularly effect the interpretation and presentation of a data set are noted within the document. These may include (but are not limited to):

- Some data are preliminary, particularly estimates for 2015.
- Some methods limit comparability of data across geography. For example, differences in consent models for the YRBS should be considered in comparing geographies as well as understanding overall rates presented.
- Reports from state data systems typically collect and compile information for a particular purpose and may not be comprehensive. For example, substance abuse information provided from state systems reflects state-funded programs and services, and not all seeking or using services across the state.
- Data that require self-reporting may include bias due to inaccurate recall, fear, or stigma related to reporting accurately, etc. A related issue is that while the actual demand for services isn't known, not all who meet the criteria for treatment services may be interested in receiving them. Experts note that strategies to reduce this treatment gap should focus not only on increasing

access to effective treatment but on reducing stigma, raising awareness, and providing appropriate screening and referrals (National Institute on Drug Abuse, n.d.).

- Changes to International Classification of Diseases (ICD) codes from year to year can impact comparability through time. For example, in 2015, providers migrated from the use of ICD-9 to ICD-10. ICD-10 codes for substance abuse are more comprehensive than the previous version; however, their use only became mandatory in October of 2015 (APA Practice Organization, 2017). Data sources Center for Health Information Analysis (CHIA) as well as other sources may include this limitation.
- Town Hall meetings were largely made up of professionals representing consumers, rather than by consumers and their families.
- The situational analysis is not comprehensive and does not constitute an adequate needs assessment as required by CFR 96.133. While efforts were made to compile data from many sources the following data were not available for this situational analysis:
  o Waiting list data
  o A detailed description of current prevention and treatment activities
  o Treatment capacity data
  o Incidence and prevalence data as they relate to:
    - Pregnant women with substance use disorder
    - Women with substance use disorder who have dependent children
    - Intravenous drug users
    - People with substance use disorders who have HIV or tuberculosis
  o Prevention activities by strategy
  o The availability of prevention and treatment activities, with special attention to the following groups:
    - Pregnant women with substance use disorder
    - Women with substance use disorder who have dependent children
    - Intravenous drug users
    - People with substance use disorders who have HIV or tuberculosis
  o A description of the populations at risk of becoming substance abusers

Addressing these data gaps has been identified as a priority within the current strategic plan.

Nevada's Population

In 2015, Nevada's population was just below 2.8 million (U.S. Census Bureau, 2015). Nevada has experienced considerable growth in recent years, second only to Utah during the period from July 1, 2015 to July 1, 2016. Nevada's State Demographer noted that it may be possible to reach 3 million people by 2017 (Brean, 2016). Nevada's population has grown through migration and births. On average, there are 35,654 live births per year in Nevada (Divsion of Public and Behavioral Health, State of Nevada, 2016).

Figure 1: 2015 Population by County
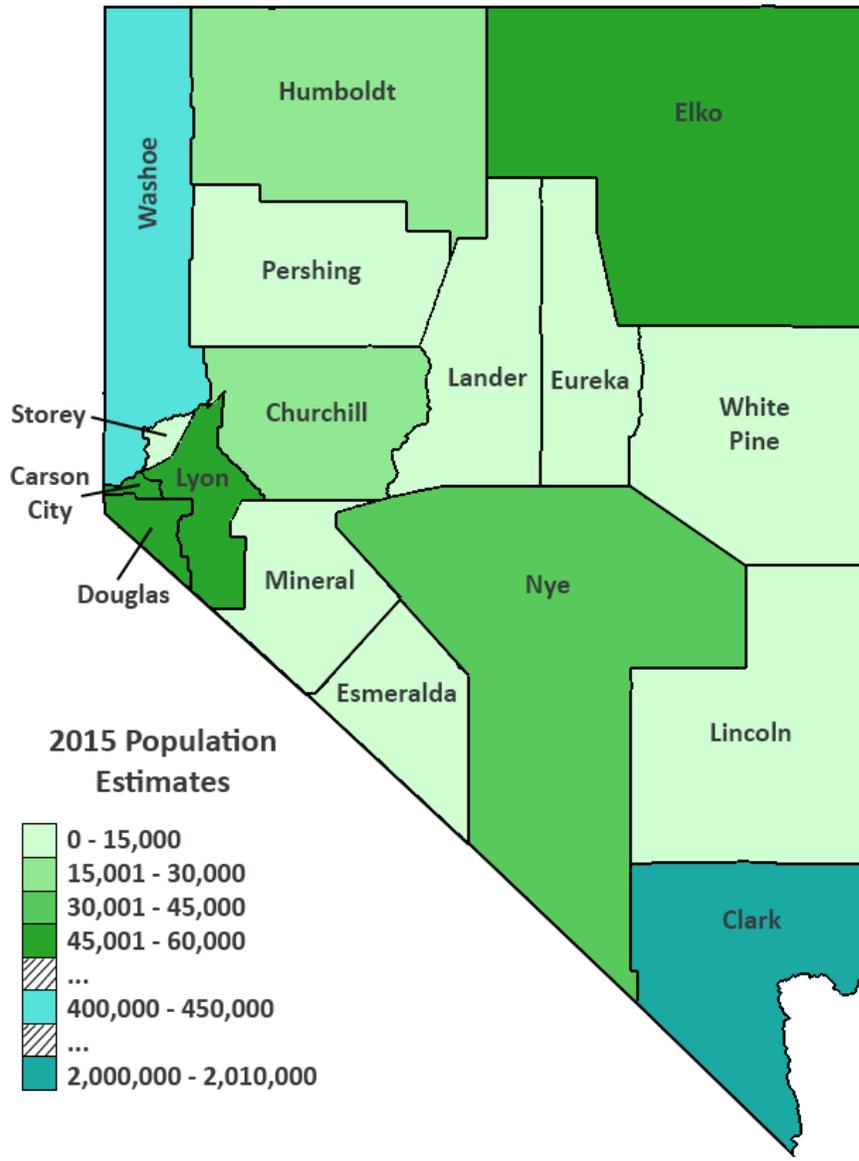
Source: The above map used the most recent population estimates from the American Community Survey (ACS) 1-Year Estimates for 2015.

Births in Nevada averaged 35,654 between 2010 and 2014. Of these 74% took place in Clark County, 15% in Washoe County, and 11% in the balance of the state.

Figure 2: Births in Nevada

Births in Nevada 2010-2014

36,287

36,153

35,714

NV Average:
35,654

35,066

35,051

| 2010 | 2011 | 2012 | 2013 | 2014 |
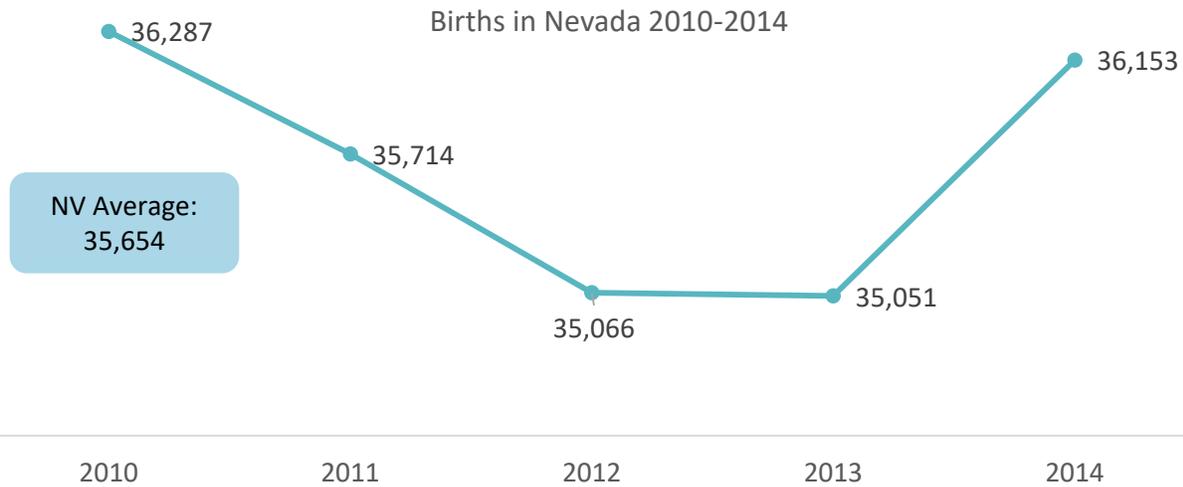
Source: (Office of Public Healh Informatics and Epidemiology)

Children and youth make up a large portion of the state's population, with people 19 and under comprising 26% of the population. Adults ages 19-64 make up 60% of the population, and older adults age 65 and above make up 14% of the population in 2015 (U.S. Census Bureau, 2015).

Table 4: Population by Age

Total Population by Age	Number	Percentage
<19	726,719	26%
19-65	1,691,211	60%
65+	380,706	14%
Total	**2,798,636**	100%

Source: (U.S. Census Bureau, 2015)

Nevada's population is also racially and ethnically diverse. People that are 'white alone' make up just over half of the state's population, and people that are Hispanic or Latino of any race make up 27% of the population.

Figure 3: Race and Ethnicity of Nevada's Population

Pie chart with the following segments:
- Hispanic or Latino (of any race) 27%
- Some other race alone 0%
- Native Hawaiian and Other Pacific Islander alone 1%
- American Indian and Alaska Native alone 1%
- Two or more races 3%
- Asian alone 8%
- Black or African American alone 8%
- White alone 52%
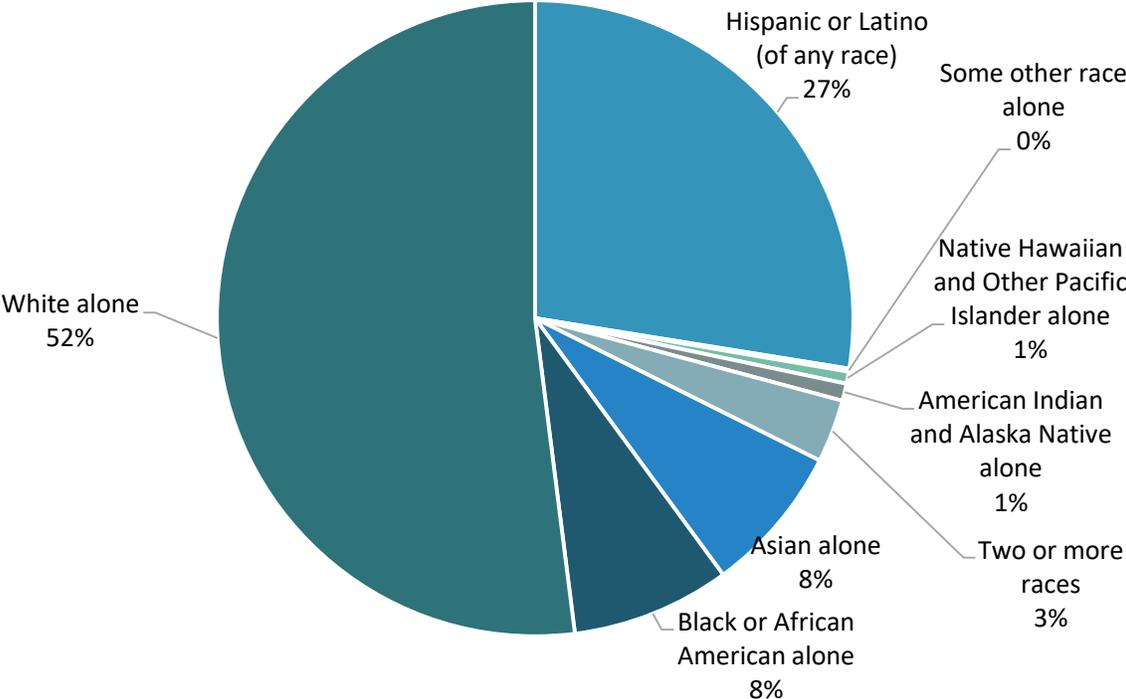
Source: (U.S. Census Bureau, 2015)

Insurance is important for people who need care. According to the 2015 *Nevada Health Gaps* report, 25% of people under 65 are uninsured, with county ranges from 22-32% (Robert Wood Johnson Foundation, 2017).

Figure 4: Nevadans with Health Insurance

Health Insurance Status for Nevadans Under Age 65
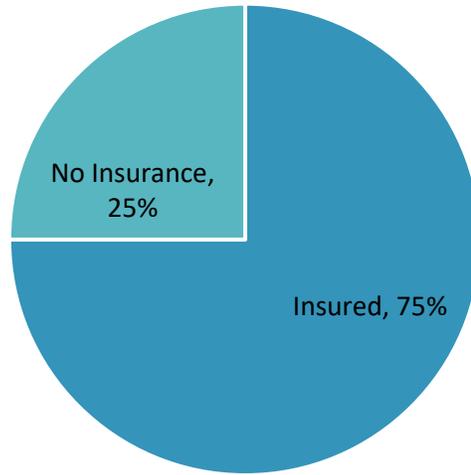
Source: (Robert Wood Johnson Foundation, 2017)

The number of people who were uninsured decreased in recent years, largely due to the Affordable Care Act. In 2016, a total of 631,843 people had Medicaid as their insurance. This represents nearly double the population insured in 2013, prior to statewide Medicaid expansion (Division of Public and Behavioral Health, 2016).

Table 5: Medicaid in Nevada

Nevada Medicaid Population Demographics (June 2016)		
	#	%
North	83,324	13.2%
South	485,251	76.8%
Rural	63,268	10.0%
Total	631,843	

Source: (Division of Public and Behavioral Health, 2016)

Other Important Subpopulations

Pregnant Women and Women with Dependent Children

While the count of pregnant women is not available, 36,000 births per year provide an estimate of pregnancies. Women with dependent children can be estimated both in terms of the number of total families with children under the age of 18, as well as female headed households with no spouse in the home. Of 1,016,709 households in Nevada (2011-2015 average), 293,110 were households with their own children under age 18, and 75,400 were female headed households with no husband present and with children under 18 years (U.S. Census Bureau, 2016).

Adverse Childhood Experiences

While the estimated rates of substance use are discussed later in this document, the situations that contribute to negative behavioral health outcomes are discussed here. Adverse childhood experiences, or, "ACEs" have been associated with problems later in life, including substance use disorder and mental illness. In Nevada, it is estimated that 40% of children aged birth to 17 experienced one or two ACEs, and 13% experienced three or more. ACEs in Nevada were compared to the national average where 54% experienced no ACES, 35% one to two, and 11% three or more. This information points to the probability that Nevada's need for behavioral health care will be higher than the national average (Sacks, Murphey, & Moore, 2014). ACEs also point to the opportunity to create 'upstream' prevention strategies through work with children and their families.

Table 6: ACEs among Nevadans

Total Population by Age	No (0) ACES	1-2 ACES	3+ ACES
Nevada	47%	40%	13%
U.S.	54%	35%	11%

Source: (Sacks, Murphey, & Moore, 2014)

People that are Homeless

Nevada's Homeless Information Management System (HMIS) tracks information about the number of people that are homeless including special circumstances and conditions. While counts may have some limitations, the overall trends and percentages of people that are mentally ill and also homeless provide a starting point for understanding needs and planning appropriate services. For some, untreated mental illness and substance misuse can be a cause of homelessness, and continued lack of treatment along with homelessness can exacerbate the situation. Between January and December 2016, there were 17,827 unduplicated clients, 5,020 of whom reported having a mental health condition upon entry to the program or services. This includes clients in emergency shelter, transitional housing, permanent supportive housing, safe havens, other permanent housing projects, and rapid re-housing projects across Nevada (BitFocus Datasystem, 2017).

Figure 5: Annual "Point in Time Count" of People who are Homeless (shows trends through time but counts are only a portion of people who are homeless)

Homeless Population 2012-2016

|	2012	2013	2014	2015	2016
Homeless (HMIS)	8,497	8,443	8,582	8,743	7,398
Homeless and Mentally Ill	1,817	1,828	1,383	1,192	1,495
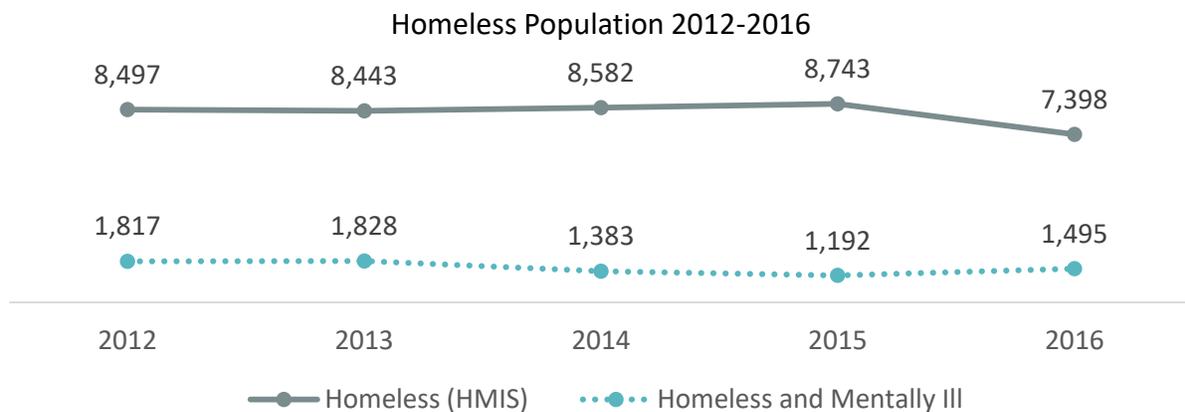
Source: (Office of Public Healh Informatics and Epidemiology)

People with Serious Emotional Disturbance (SED) or Serious Mental Illness (SMI)

Early intervention for people with serious mental illness offers an important opportunity for harm reduction. Additionally, substance abuse often co-occurs with mental illness. The number of people with SED and SMI is estimated for Nevada based on population and prevalence rates.

Figure 6: Estimates of SED and SMI

Nevada's SED and SMI Population 2012-2015 (Estimates)

	2012	2013	2014	2015
State SMI population - Adults	81,215	82,306	86,120	91,893
State SED population - Children	8,497	8,443	8,582	8,743

• State SED population - Children ━━● State SMI population - Adults
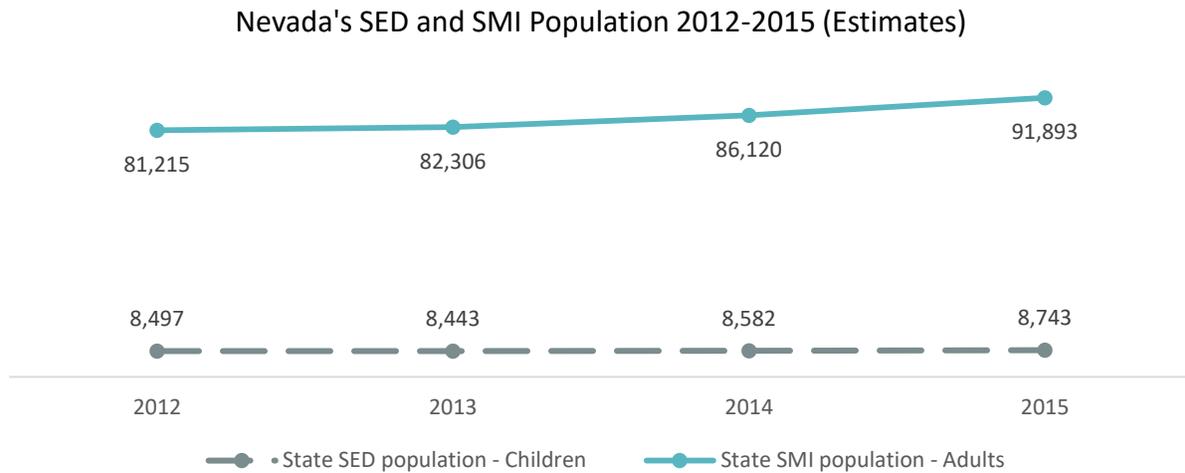
Source: (Office of Public Healh Informatics and Epidemiology)

People with HIV/AIDS

The Substance Abuse Prevention and Treatment Block Grant (SABG) program includes provisions for public health services, i.e., tuberculosis services and early intervention services for HIV. Services through the block grant are not intended to be comprehensive but rather "the minimum needed to encourage a substantial number of substance abusers to learn of their HIV infection, educate them in ways to avoid transmission of HIV to others, and maintain their health" (SAMHSA). Data on HIV, which includes AIDS, shows that the rate of people with HIV has increased over time. There are several factors that contribute to this, including continued transmission and people who have been diagnosed with HIV living longer.

Figure 7: HIV and AIDS in Nevada

People Living with HIV (Includes "AIDS "or HIV Stage 3)

7,938   8,191   8,439   8,663   9,078   9,773

2009   2010   2011   2012   2013   2014
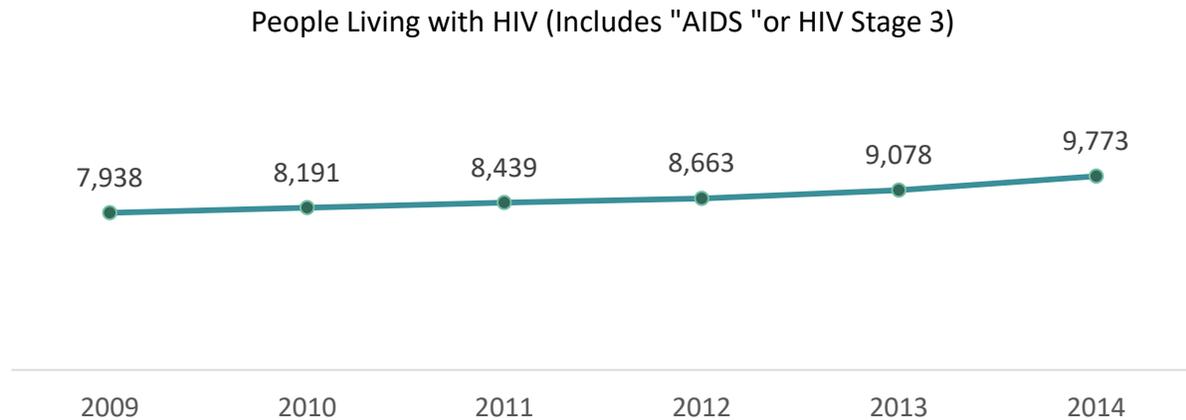
Source: (Division of Public and Behavioral Health)

People with Tuberculosis

The Substance Abuse Prevention and Treatment Block Grant (SABG) program includes provisions for public health services, i.e. tuberculosis services (SAMHSA). Nevada's rate of tuberculosis within the population was 2.9 per 100,000 in 2015. This rate has improved in recent years (Feng, 2016).

Figure 8: Tuberculosis Rate

Tuberculosis
(Cases Per 100,000)

3.5   3   3.3   2.6   2.9

2011   2012   2013   2014   2015
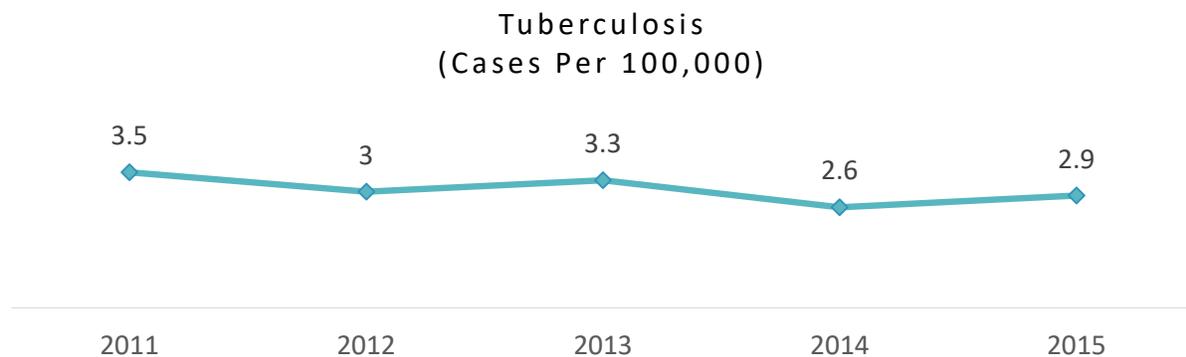
Source: (Feng, 2016)

People with Co-Occurring Disorders

The coexistence of both a mental health and a substance use disorder is referred to as co-occurring disorders (previously referred to as dual diagnoses). In 2014, approximately 7.9 million adults in the United States had co-occurring disorders (SAMHSA, n.d.). Specific data for Nevada are not available, in part because co-occurring disorders can be difficult to diagnose due to the complexity of symptoms, as both may vary in severity. Often people receive treatment for one disorder while the other disorder remains untreated. Integrated treatment is helpful for people with co-occurring disorders (SAMHSA, n.d.). Diagnosis and treatment of co-occurring disorders was low in Nevada compared to the national rate, suggesting an opportunity to better diagnose and treat people that experience both mental illness

and substance use disorder (SAMHSA). A lack of clarity around how best to diagnose, refer and treat people with co-occurring disorders was identified as a gap within the state. Nationally, nearly one in for adults with serious mental illness also experienced a substance us disorder in the previous year (23.3%, 2014) (Center for Behavioral Health Statistics and Quality, 2015).

People with Involvement with Criminal and Juvenile Justice

In Nevada, the prison population in 2016 was 13,286, of which 5,858 were white; 3,887 black; 2,793 Hispanic; 365 Asian; and other races and ethnicities represented by smaller numbers (Robison, 2016). People who come in contact with law enforcement and the criminal or juvenile justice systems are likely to have a mental and/or substance use disorder. Nationally, SAMHSA states that "according to a 2006 Bureau of Justice Statistics report, approximately 74% of state prisoners, 63% of federal prisoners and 76% of jail inmates met the criteria for a mental health disorder. An estimated 42% of state prisoners and 49% of jail inmates met the criteria for both a mental health and substance use disorder. Studies have found that for youth in the juvenile justice system, 50% to 70% met criteria for a mental disorder and 60% met criteria for a substance use disorder. Of those youth with co-occurring mental and substance use issues, almost 30% experienced severe disorders that impaired their ability to function" (SAMHSA, 2016).

Persons Who Inject Drugs

While not available for the whole population, demographics are available by service type where an individual was classified as an intravenous drug user. The years provided are from 2010 to 2014 due to a few providers transitioning to their own Electronic Health Records (EHRs) during 2015, so this time period would be more representative of the state-funded providers. Note that data is for admissions and so an individual may appear multiple times during one year (may include duplicates). Slight increases are observed between 2010 and 2014.

Table 7: IV Drug Use by Service Type

| Service Type					
	2010	**2011**	**2012**	**2013**	**2014**
Detoxification, 24-hour service, Free-Standing Residential	684	753	729	714	797
Residential Treatment, Short-Term	498	620	618	620	484
Residential Treatment, Long-Term	0	0	0	0	6
Intensive Outpatient	280	324	373	325	303
Outpatient	781	747	954	845	794

Source: (Office of Public Health Informatics and Epidemiology (OPHIE))

Nevada's Services and Systems

Nevada's Substance Abuse, Prevention and Treatment Agency (SAPTA) is a component of the Behavioral Health, Wellness and Prevention Bureau within the Division of Public and Behavioral Health (DPBH). The executive team that leads DPBH is comprised of the Administrator, Chief Medical Officer, Medical Epidemiologist, and State Epidemiologist (Department of Health and Human Services, 2016).

SAPTA works with partners across the state to fulfill its mission and mandates. The Substance Abuse Block Grant (SABG) under the Substance Abuse and Mental Health Services Administration (SAMHSA) helps states to plan, implement, and evaluate activities that prevent and treat substance abuse.

Figure 9. SAMHSA Continuum of Promotion, Prevention, Treatment, and Recovery
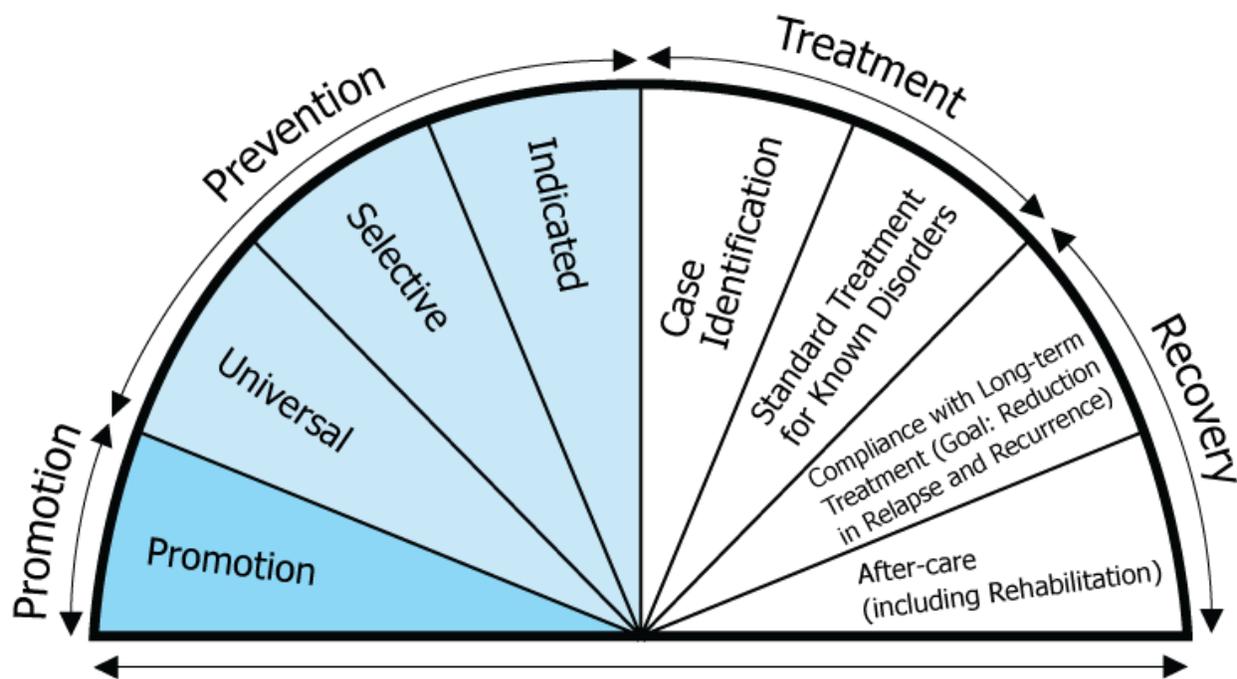
The Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant serves as a foundation for Nevada's substance abuse outreach, prevention, intervention, treatment, and recovery system. The grant is allotted to states by a formula based on the overall level set by Congress each year. The allotments for the SAPT Block Grant for Nevada are included below (National Association of State Alcohol and Drug Abuse Directors, Inc., 2016):

- FY 2013: $13,015,618
- FY 2014: $16,462,188
- FY 2015: $16,698,170
- FY 2016: $16,890,047

Nevada's Workforce

The state's workforce that helps to treat and prevent substance abuse has changed in recent years. A 2015 rural health report states that in 2014, "there were 1,227 licensed alcohol, drug, and gambling counselors in Nevada, including 158 licensed alcohol, drug, and gambling counselors in rural and frontier counties – since 2004, the number of licensed alcohol, drug, and gambling counselors in Nevada has decreased by 6 or -0.5% and the per capita number of licensed alcohol, drug, and gambling counselors has declined from 45.0 to 43.4 per 100,000 population" (Nevada State Office of Rural Health, 2015).

Additionally, in a 2016 report, DPBH noted that "despite unprecedented access to healthcare coverage in Nevada, the infrastructure of the system of care to improve access to high-quality care is still evolving and remains heavily dependent on high-cost services provided by emergency rooms (ER) and inpatient psychiatric hospitalizations. Meanwhile, community-based treatment and recovery services remain uncoordinated with physical health services and difficult to access due to significant workforce shortages and lack of providers offering a continuum of care options ranging from crisis services to assertive community treatment and peer services" (Division of Public and Behavioral Health, 2016).

Provider shortages are a persistent challenge in Nevada, especially in rural and frontier areas. All people (100%) living in rural and frontier areas are in Health Provider Shortage Areas (HPSAs). In urban areas, this falls to 48%. For the state overall, 38% of the population live in behavioral health shortage areas (State of Nevada, 2016).

Table 8: HPSAs in Nevada

Region Type	Primary Medical	Behavioral Health
Rural and Frontier		
% of Population in HPSAs	50.6%	100%
Number in HPSAs	40	39
Urban		
% of Population in HPSAs	31.8%	48.1%
Number in HPSAs	31	22
State		
% of Population in HPSAs	33.7%	38.1%
Number in HPSAs	71	61

Source: (State of Nevada, 2016). *For primary care the population to provider ratios must be at least 3,500 to 1 (3,000 to 1 if there are usually high needs: For mental health care, it must be 30,000 to 1 (20,000 to 1 if there are unusually high needs).*

Advancements such as telemedicine hold promise for the rural and frontier areas. For example, the National Frontier and Rural Addiction Technology Transfer Center (ATTC) focusing on telehealth technology funded by SAMHSA is helping to address shortage issues in rural and frontier areas (National Frontier and Rural ATTC, n.d.).

Compensation for providers was identified as an issue among key informant interviews. Levels of compensation may not be adequate to recruit and maintain qualified staff in public systems. Reimbursement for providers through payers is another challenge for community-based providers.

Some key informants also pointed to the lack of incentives for a workforce on the frontlines and noted the high turnover rate in the field. Other key informants identified training as challenge. One mentioned the difficulty of practicing within a limited scope of practice while helping clients with co-occurring behavioral health disorders. Another identified the lack of knowledge amongst providers and prescribers about substance use disorders.

Primary Prevention Strategies

Nevada has an established system of local prevention providers and substance abuse coalitions. They are the foundation of substance abuse prevention in Nevada. In 2014, DPBH developed operating standards to assist these providers in providing high-quality services (Nevada Division of Public and Behavioral Health, 2014). Coalitions in Nevada work to prevent substance abuse for all ages through advocacy, education, reduction of stigma, support, and outreach.

Certified Coalitions

- Statewide Coalition Partnership (Statewide)
- Care Coalition (Clark County)
- Churchill Community Coalition (Churchill County)
- Coalition Partners Allied for Community Excellence Coalition (PACE) (Elko, Eureka, White Pine Counties)
- Frontier Community Coalition (Humboldt, Lander, Pershing Counties)
- Healthy Communities Coalition (Lyon, Storey, Mineral Counties)
- Join Together Northern Nevada (Washoe County)
- Community Prevention Coalition (Rural Clark County)
- NyE Communities Coalition (Nye, Lincoln, and Esmeralda Counties)
- PACT Coalition for Safe & Drug Free Communities (Clark)
- Partnership Carson City (Carson)
- Partnership of Community Resources Coalition (Douglas County)
- Statewide Native American Coalition (Statewide)
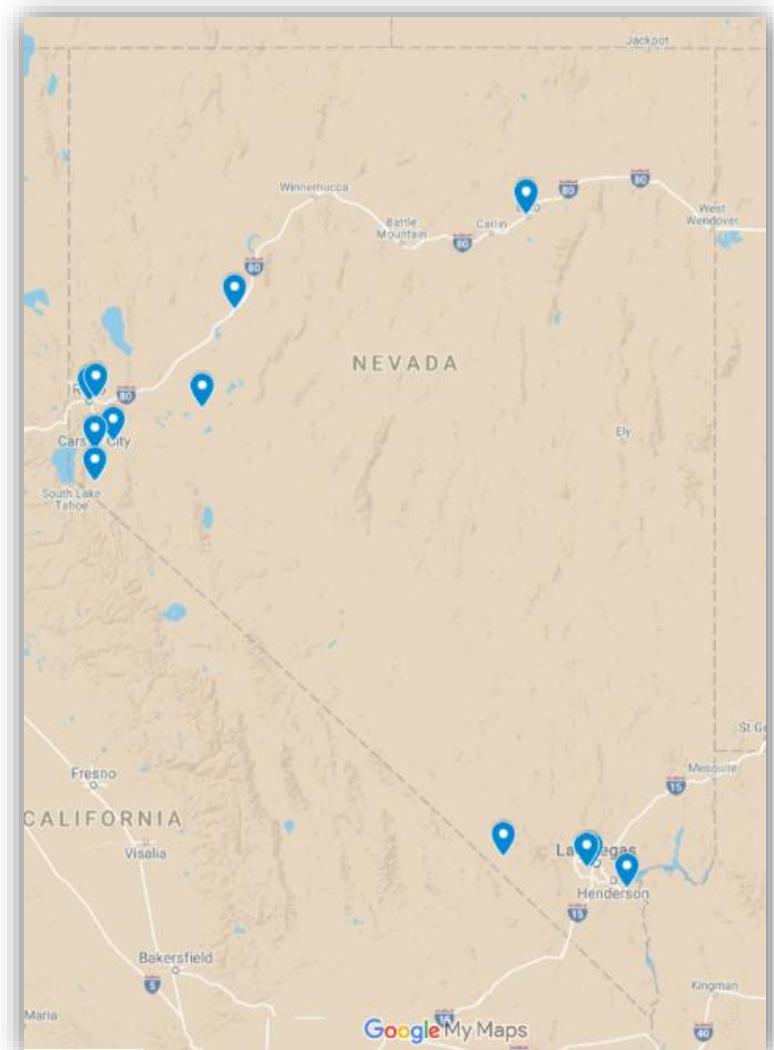
Each coalition partners with local organizations and institutions for the purpose of prevention. Several key informant interviews identified these coalitions as great strengths within the state system.

Certified prevention programs also exist across the state providing prevention through alternative activities, environmental factors, information dissemination, education, and problem identification and referral. Prevention education is the most common service type among Nevada's certified providers. Prevention providers may target youth (preschool-elementary), adolescents, adults, and, the general public.

SAPTA also works with prevention programs across the state. In 2016, a total of 61 certified prevention programs operated in Nevada, with 51 of these funded through SAPTA. Prevention programs offer strategies such as environmental strategies, information, problem ID/Referral, Prevention Education, Alternative Activities (Nevada Division of Public and Behavioral Health (DPBH), 2016).

Certified Prevention Programs

In 2016, Nevada had more than 60 certified prevention programs working through prevention education, environmental strategies, information, problem identification and referral, and alternative activities.

Other Critical Components of Prevention

A critical component of a prevention system is an "infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences" (SAMHSA, 2016). Nevada's access to hospital data, including monthly extracts from BioSense and CHIA, provide agencies with the opportunity to understand existing and new issues. Data from youth surveys can help identify trends among youth and target information. State systems that track disease and treatment could also help identify areas and populations to focus resources as well as understand results of interventions. However, key informants indicate that data that is provided to the state or by the state is often not timely enough to fully understand the immediate needs of the community, nor to best support the argument for funding during grant-writing.

Treatment and Recovery Activities

In 2016, there were more than 100 certified treatment programs statewide. Roughly 50% accepted Medicaid. A portion (40%) received SAPTA funding. Additionally, a total of 95 certified detox technicians were available statewide (Nevada Division of Public and Behavioral Health (DPBH), 2016).

SAPTA certified treatment programs and detoxification technicians, and SAPTA funded and non-SAPTA funded programs are part of the larger behavioral health support system within Nevada.

Nevada has shifted from directly funding agencies to utilizing community-based providers for care. From this perspective, insurance type is key to peoples' identification of providers, particularly Medicaid.

Nevada's Behavioral Health System – New Components

Nevada is working to better serve people in communities who experience mental illness, substance abuse, or both. Many assets are emerging or in place. In a recent report by the Nevada Department of Health and Human Services (DHHS), many of these are noted (State of Nevada, 2016):

Paramedicine Efforts: Two community paramedicine efforts support fragile transitions from an inpatient to an outpatient setting.

Balancing Incentive Program (BIP): The Nevada 2-1-1 system, funded through the BIP program, helps connect individuals with resources and assists in navigating the health care system.

Medicaid Incentives for the Prevention of Chronic Diseases (MIPCD): This expired grant program educated, supported, and incentivized patients to modify behavior and achieve targeted health improvement goals. Although expired, Nevada will leverage the success and lessons learned from this grant program.

Medicaid Electronic Health Record (EHR) Incentive Program: The federally funded Medicaid EHR Incentive Program assists providers with adoption and Meaningful Use (MU) of EHRs.

Certified Community Behavioral Health Clinics (CCBHCs): Nevada received a CCBHC grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), an operating division within the U.S. Department of Health and Human Services (HHS), which will establish behavioral health clinics, promote integration of behavioral and physical health, as well as introduce value-based reimbursement for these clinics.

Children's Heart Center Healthy Hearts Program: This program promotes healthy lifestyles for the entire family with an emphasis on modifying behaviors, improving eating habits, increasing physical activity, and improving self-esteem.

The National Governors Association (NGA) Medicaid Transformation Project: This project implements an innovative, cost-effective approach to address the behavioral health issues in Nevada's youth population, age 11 to 18 years, and transitions the current crisis-based service system to a system of prevention and early intervention.

Project ECHO: Project ECHO increases access to specialty treatment in rural and underserved areas by providing front-line clinicians with the knowledge and support they need to manage patients with complex conditions. The project engages patients in a continuous learning system and partners them with specialist mentors at an academic medical center or hub.

Peer Support Specialists: Individuals with appropriate training who also are in recovery or have significant life-altering experiences assist other individuals' substance use or mental health disorders. Peer support services are available in the community through several private and public organizations.

Prevention Specialists: Certified prevention practitioners who stay abreast of the latest research findings employ science-validated practices, apply innovations in prevention methods, and follow industry trends in order to ensure that services are provided competently. Prevention is health

promotion - the "active, assertive process of creating conditions and/or fostering personal attributes that promote the well-being of people."

Mental Health Parity Addiction Equity Act: "The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits" (Centers for Medicare & Medicaid Services, n.d.).

Regional Behavioral Health Coordinators: In 2015, the DPBH awarded subgrants to fund a behavioral health coordinator in three regions of the State: (1) Clark County; (2) the "Quad County Region," which includes Carson City and Churchill, Douglas, and Lyon Counties; and (3) Washoe County. The DPBH is planning to issue additional grants to the Elko County area and other regions of the State. Funding is provided through the federal Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grants.

CASAT: (Center for the Application of Substance Abuse Technologies), provides training, technical assistance, evaluation, research, and other services to support prevention, treatment and recovery in the alcohol and other drugs field. CASAT strives to improve substance abuse prevention and treatment services by helping states, organizations, agencies, and individuals apply evidence-based practices.

Peer Prevention Specialists: The Peer Support Specialist (PSS) is designed for those with "lived experience" who are interested in providing support, advocacy, wellness, and community engagement services to individuals. Program participants complete four university courses and time in the field where knowledge is put into practice within a behavioral health agency. This certificate provides students an opportunity to experience the professional side of the substance abuse and mental health treatment field and may be utilized as a stepping-stone for further career advancement.

School-based Social Workers: The Nevada Department of Education's Office for a Safe and Respectful Learning Environment awarded block grants in 2016 to the neediest schools to receive a minimum of 161 social workers and other mental health professionals to provide immediate support across 132 schools.

Embedded Eligibility Workers: Nevada State Welfare District Offices located throughout the state determine a person's eligibility for TANF, CHAP, and Medicaid. If applicants appear to be Nevada Check Up eligible, rather than Medicaid, they are appropriately referred. Out stationed sites (FQHCs, county hospitals, and local county health departments) help people apply for Medicaid or Nevada Check Up and send their applications and eligibility determination to the local Nevada State Welfare District Office. Local public health agencies identify low income, uninsured children through referrals from a variety of sources including: WIC, child health and immunization clinics, community health and social services agencies, and schools.

Statewide Adolescent and Transitional Aged Youth Treatment Enhancement Plan: In order to develop a statewide plan, an interagency council has been established to improve the infrastructure for adolescents and transitional age youth substance use treatment and recovery. Their work towards creation of this plan includes addressing workforce training, improving data collection from all SAPTA

certified agencies, improving peer support services, increasing cultural and linguistic competence, and resolving potential payment problems resulting from insurance copays or deductibles.

Funding to Address the Opioid Epidemic: Nevada has received notice from United States Health and Human Services (HHS) that Nevada will receive a $5,663,328 grant to combat opioid addiction. The funding, which is the first of two rounds provided for the 21st Century Cures Act, will be provided through the State Targeted Response to the Opioid Crisis Grants administered by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Statewide Needs

A 2015 needs assessment of behavioral health identified consumers' barriers to accessing care through both surveys and focus groups. In the statewide survey of providers, five populations were identified as having high need for substance abuse services:

- Adolescents with substance abuse and/or mental health problems
- Parents with substance use and/or mental disorders who have dependent children
- Individuals with substance abuse disorders in rural areas
- Women who are pregnant and have a substance use and/or mental disorder
- Unaccompanied minor children and youth

Barriers Identified through Surveys: (Christiansen, 2015)

- Cost
- Lack of knowledge of resources
- Lack of transportation
- Lack of insurance coverage
- Lack of available providers
- Long wait lists
- Fear

Barriers Identified by Focus Group Participants: (Christiansen, 2015)

- Lack of knowledge of resources
- Lack of insurance coverage
- Stigma
- Fear
- Cost
- Perception that treatment wouldn't help
- Too much time to get services
- People that are undocumented are not able or willing to seek help for fear of being deported (Christiansen, 2015)

Ryan White Part B: Grants to States & Territories

"Part B of the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87) provides grants to States and Territories to improve the quality, availability, and organization of HIV health care and support services.

Core medical services include outpatient and ambulatory health services, (Aids Drug Assistance Program or "ADAP", AIDS pharmaceutical assistance, oral health care, early intervention services, health insurance premium and cost-sharing assistance, home health care, medical nutrition therapy, hospice services, home and community-based health services, mental health services, outpatient substance abuse care, and medical case management, including treatment-adherence services."

One of the many issues identified is that the needs for behavioral health care cannot be met through current resources (State of Nevada, 2016). According to a recent report, "Behavioral Health Utilization has increased significantly as the numbers of individuals enrolled in Medicaid have also increased (see Table 5). Lack of access to community-based crisis services contributes to high rates of utilization of

emergency room (ER) services for behavioral health needs within both fee-for-service (FFS) and managed care Medicaid. The most common primary diagnoses in individuals treated in the ER for behavioral health needs in 2015 included non-dependent abuse of substances, alcohol abuse and/or intoxication, anxiety disorders, mood disorders, suicidal ideation, and psychotic disorders. In 2015, adults in managed care had approximately 65.67 behavioral health related ER visits [per] 1,000 members, adults in FFS had approximately 108.13 behavioral health related ER visits [per] 1,000 members. Also in 2015, children in managed care had approximately 7.52 behavioral health related visits [for] every 1,000 members, approximately 16.78 behavioral health related ER visits [per] 1,000 members" (Division of Public and Behavioral Health, 2016).

Estimates of Need

Deaths Related to Drugs or Alcohol

In Nevada, over 100 people die from alcohol-related illness and injury each year. In 2015, numbers appear to have increased, although 2015 data are preliminary and subject to changes.

*Figure 10: Alcohol Related Deaths: Nevada Residents (All Ages)*
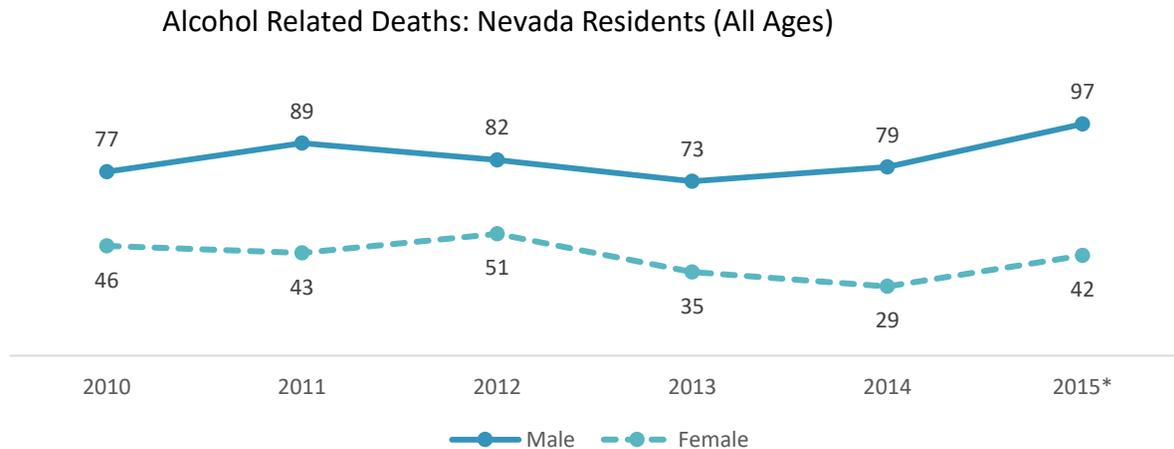
Alcohol Related Deaths: Nevada Residents (All Ages)

Source: (Office of Public Health Informatics and Epidemiology (OPHIE), 2017)
*2015 data are preliminary and are subject to changes.

Across the nation, drug overdose deaths and opioid-involved deaths continue to increase. According to the Centers for Disease Control and Prevention, more than 60% of drug overdose deaths involve an opioid. Since 1999, the number of overdose deaths involving opioids (including prescription opioids and heroin) quadrupled (Centers for Disease Control and Prevention, n.d.). In Nevada, deaths due to opioids were high compared to a decade ago, but appear to be declining since 2011 (Office of Public Health Informatics and Epidemiology, 2017). One possible source of error is the potential for differences among coroners in reporting opioid deaths across the state. The opportunity to standardize reporting to improve data was identified in Governor Brian Sandoval's Prescription Drug Abuse Prevention Summit (Social Entrepreneurs Inc., 2016).

Figure 11: Opioid-Related Overdose Deaths, Nevada Residents, 2010-2015
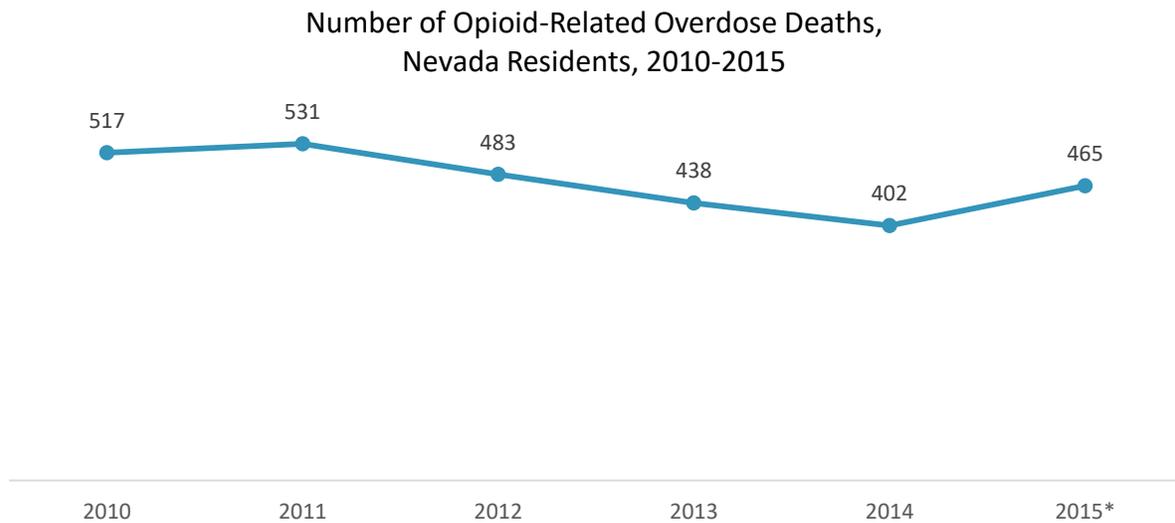
Number of Opioid-Related Overdose Deaths, Nevada Residents, 2010-2015

| 2010 | 2011 | 2012 | 2013 | 2014 | 2015* |

517   531   483   438   402   465

Source: (Office of Public Health Informatics and Epidemiology (OPHIE), 2017)
**2015 data are preliminary and are subject to changes.*

Young Adult and Adult Population

Illicit drug use and binge alcohol use among Nevada's young adult (ages 18-25) and adult populations may be on the decline. From 2011-2014, the rate of reported illicit drug and binge alcohol use has begun to fall more in line with national trends. Regardless, there is still a significant problem in the state, where nearly one in 10 adults report dependence or abuse on alcohol or illicit drugs, and for young adults, the problem is even greater. In addition to greater rates of dependence and abuse, young adults report needing but not receiving treatment for that dependence more frequently than their older counterparts.

Self-reported illicit drug use in the young adult population has decreased slightly from 2011-2014, but increased somewhat in adults. In 2014, the percentage of young adults in Nevada who reported drug use in the past month before the survey was slightly below that of the national rate.

Figure 12*: Young Adult Illicit Drug Trends*

Illicit Drug Use In The Past Month: Young Adults
(NSDUH)

22.69%

23.14%

21.56%

21.75%

21.49%

21.39%

21.44%

20.00%

2011   2012   2013   2014

━●━ Nevada 18-25   ━●┅ US 18-25
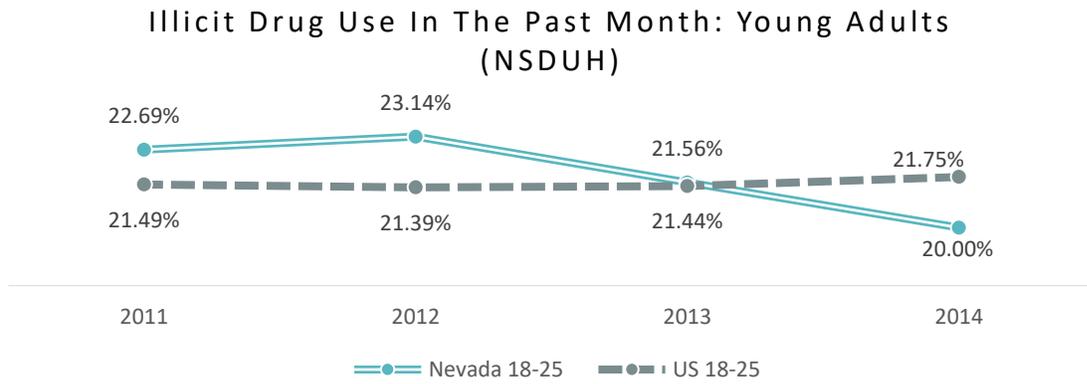
Source: (SAMHSA, n.d.)

Adult Nevadans above age 26, however, decreased illicit drug use from a 2013 high of 9.13% to 7.9% in 2014. While the national percentage of adults reporting illicit drug use seems to be increasing slightly year over year, Nevada's percentages have come closer to the national rate.

*Figure 13: Adult Illicit Drug Trends*

Illicit Drug Use In The Past Month: Adults (NSDUH)

9.11%

9.13%

7.68%

7.90%

6.46%

6.69%

7.19%

7.81%

2011   2012   2013   2014

━●━ Nevada 26+   ━▲┅ US 26+
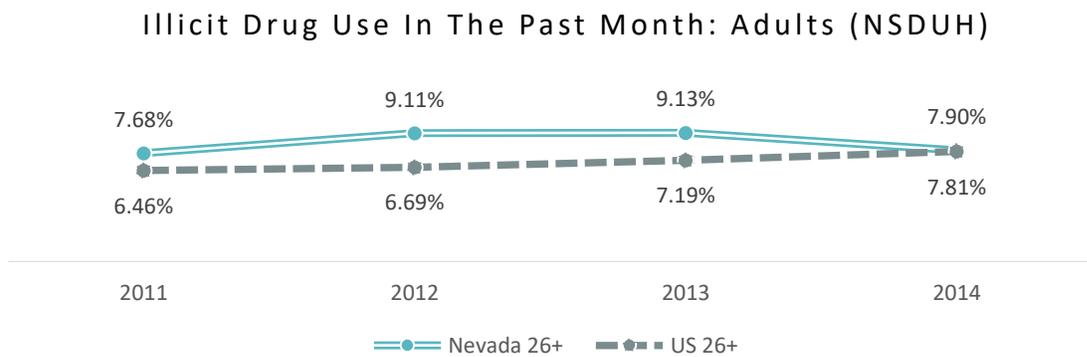
Source:
(SAMHSA, n.d.)

Binge alcohol use for young adults is slightly lower in Nevada than in the nation as a whole and the overall trend appears to be declining (improving) for this age group since 2011.

Figure 14: Young Adult Binge Alcohol Trends

Binge Alcohol Use: Young Adults (NSDUH)
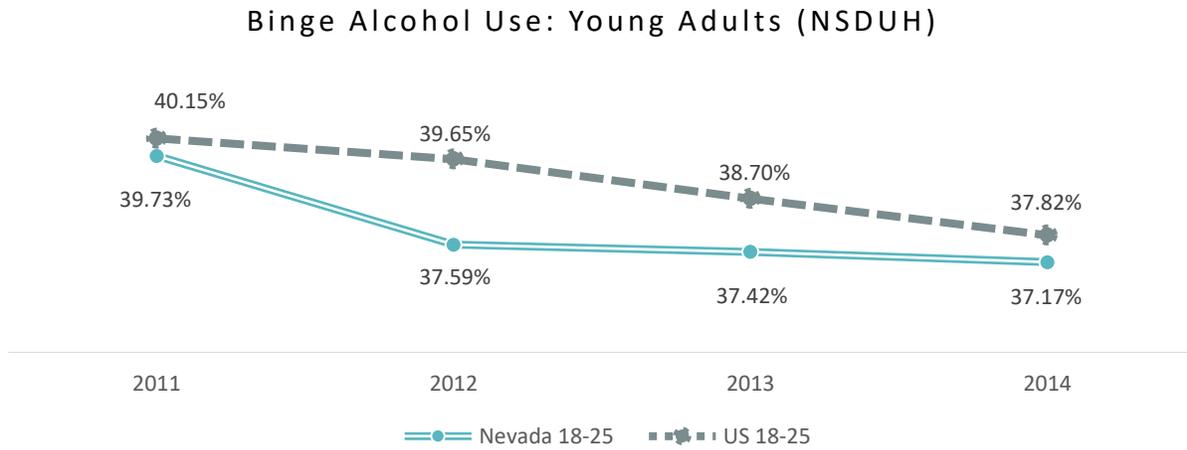
Source: (SAMHSA, n.d.)

Unfortunately, Nevada's adult binge alcohol use remained steady from 2011-2014 and was well-above the national rates.

*Figure 15: Adult Binge Alcohol Trends*

Binge Alcohol Use: Adults (NSDUH)
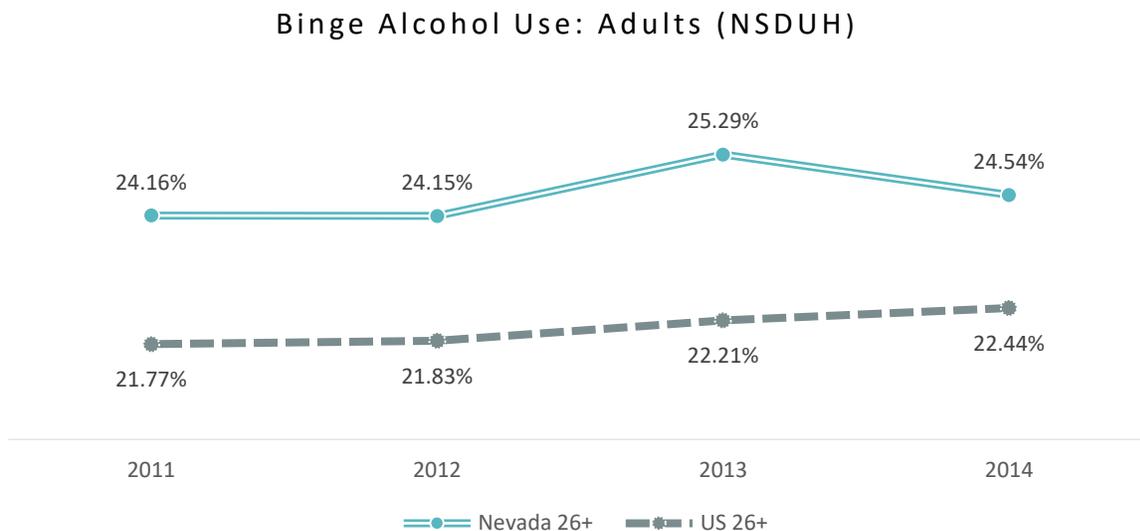
Source: (SAMHSA, n.d.)

Dependence on or abuse of these substances for each population has declined since 2011. For young adults, dependence has decreased by nearly 3%. While the decrease in the percentage of adults who report dependence or abuse is not nearly as striking (at a little more than 1%), the decrease in these years may be a positive sign.

Figure 16: Young Adult Dependence Trends

Dependence Or Abuse Of Illicit Drugs Or Alcohol In The Past Year: Young Adults (NSDUH)
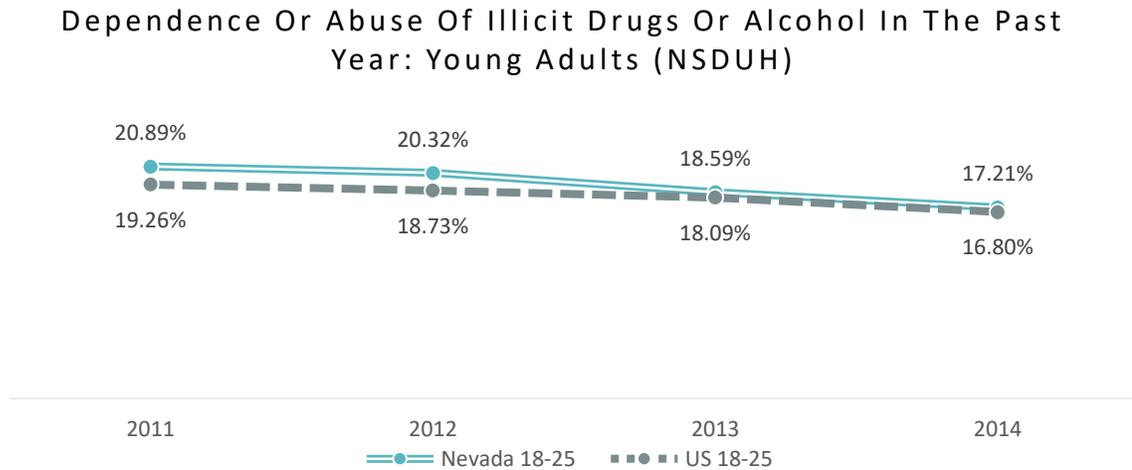
Source: (SAMHSA, n.d.)

Adult rates of dependence have decreased between 2011 and 2014 in Nevada, while rates nationwide increased slightly.

Figure 17: Adult Dependence Trends

Dependence Or Abuse Of Illicit Drugs Or Alcohol In The Past Year Adults: (NSDUH)
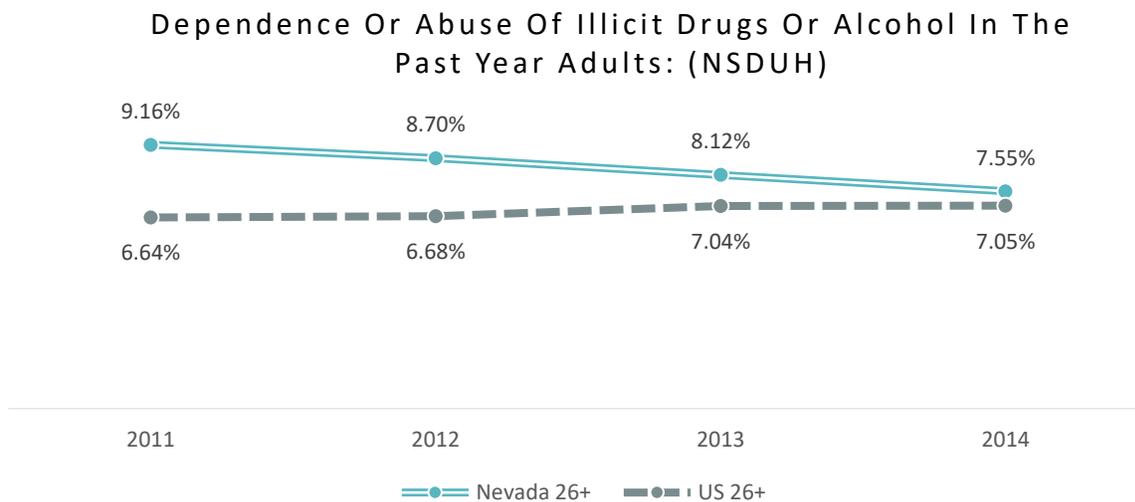
Source: (SAMHSA, n.d.)

Young adults needing but not receiving treatment within the past year was 6.5% in Nevada, similar to the national rate.

Figure 18: Young Adult Unmet Needs-Drugs

Needing But Not Receiving Treatment For Illicit Drug Use In The Past Year-Young Adults (NSDUH)

5.85% 7.10% 7.06% 6.54%

7.03% 6.94% 6.40%

7.05%

2011 2012 2013 2014

Nevada 18-25   US 18-25
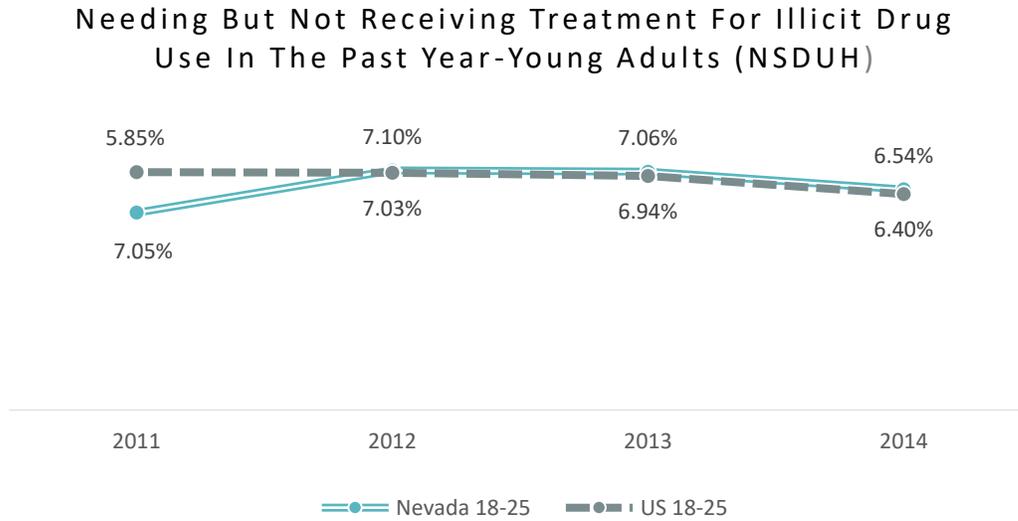
Source: (SAMHSA, n.d.)

Adults needing but not receiving treatment within the past year was 1.6% in Nevada, similar to the national rate.

*Figure 19: Adult Unmet Needs-Drugs*

Needing But Not Receiving Treatment For Illicit Drug Use In The Past Year-Adults (NSDUH)

1.65% 1.34% 1.45% 1.56%

1.51% 1.55%

1.34% 1.38%

2011 2012 2013 2014

Nevada 26+   US 26+
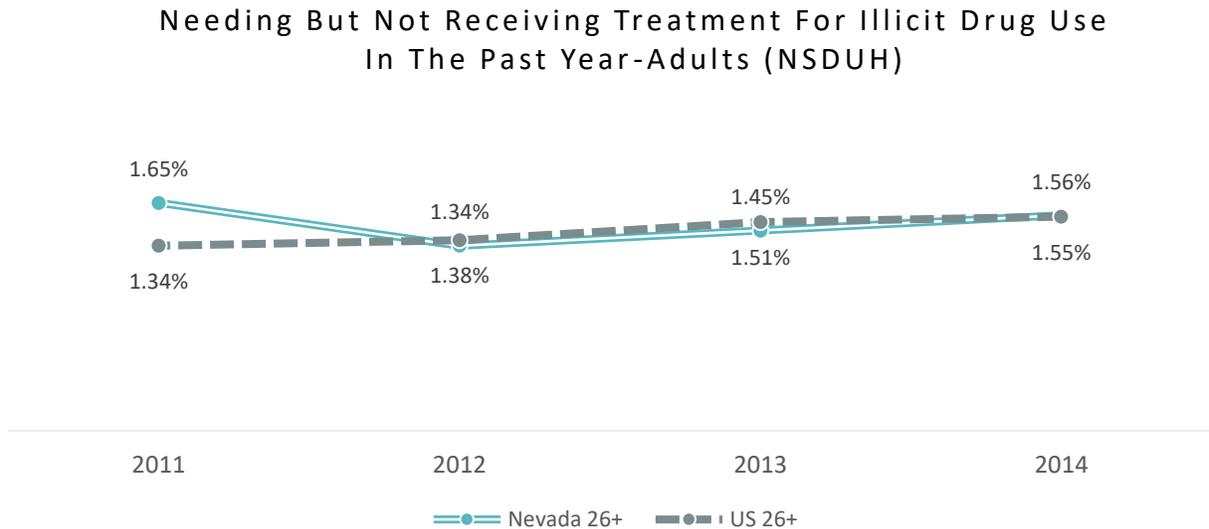
Source: (SAMHSA, n.d.)

Young adults are at very high risk of needing but not receiving treatment for alcohol. Despite improvements in recent years both nationally and statewide, it's estimate that more than one in 10 Nevadans between the age of 18 and 25 needs help for alcohol use and does not get it.

Figure 20: Young Adult Unmet Needs-Alcohol

Needing But Not Receiving Treatment For Alcohol Use In The Past Year: Young Adults (NSDUH)
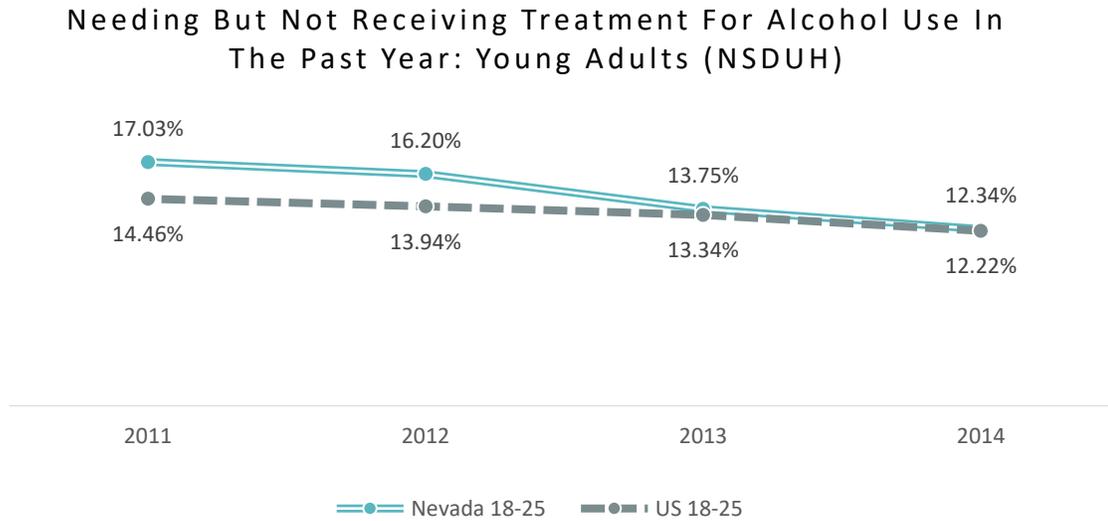
Source: (SAMHSA, n.d.)

The percentage of adults that needed treatment for alcohol but did not receive it declined between 2011 and 2014.

Figure 21: Adult Unmet Needs-Alcohol

Needing But Not Receiving Treatment For Alcohol Use In The Past Year: Adults (NSDUH)
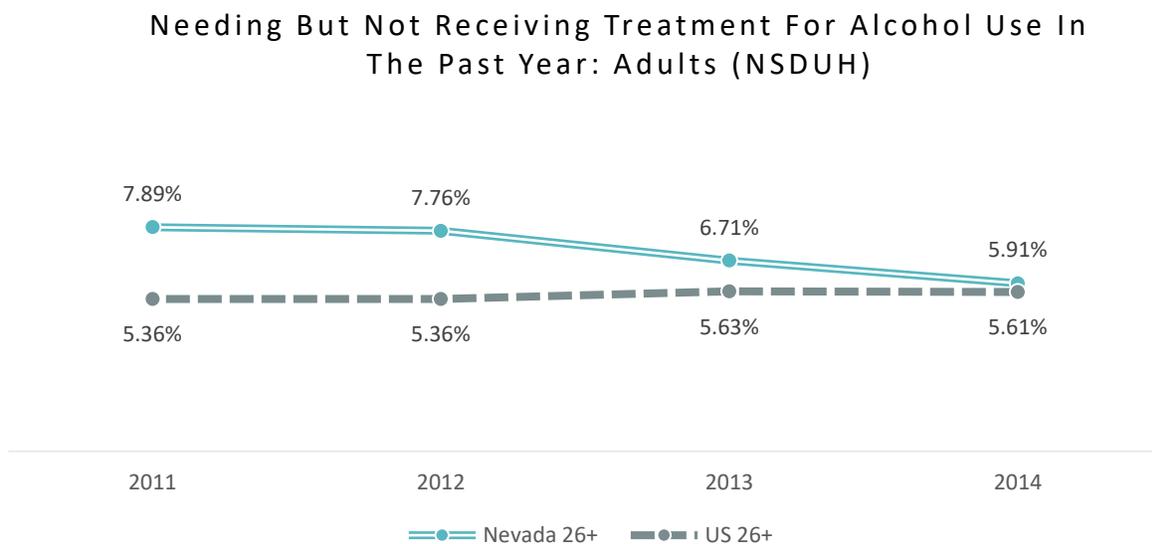
Source: (SAMHSA, n.d.)

Opioid-related hospitalizations have increased dramatically in recent years. Between 2010 and 2015, there was a 114% percent change in emergency room rates, and, 72% increase inpatient admissions *(Office of Public Health Informatics and Epidemiology, 2017)*. Adults ages 25-34 are particularly at risk; however, adults of all ages, especially older adults, are also experiencing issues with opioids *(Office of Public Health Informatics and Epidemiology, 2017)*.

Figure 22: Opioid-Related Hospitalizations - All Ages

Opioid-Related Hospitalizations (ED and IP), Nevada Residents, 2010-2015 (All Ages)

	2010	2011	2012	2013	2014	2015
Inpatient Admission (IP)	4,518	4,889	5,143	5,172	5,601	8,231
Emergency Room Encounters (ED)	3,095	3,348	3,594	4,250	4,661	7,035
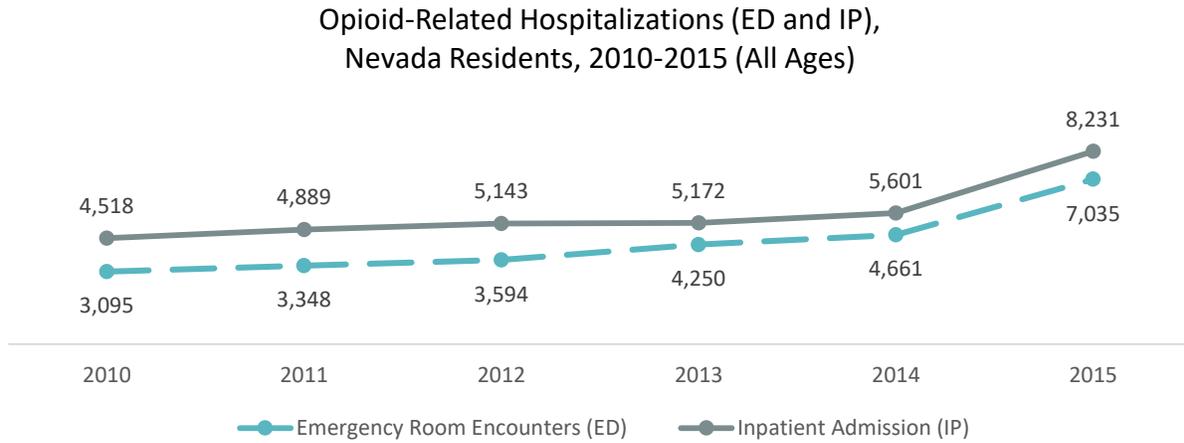
Source: (Office of Public Health Informatics and Epidemiology, 2017)

Law enforcement information related to arrests can also help illustrate substance use in the state. Many of these numbers have declined in recent years.   However, it is important to note that policies and funding for law enforcement can influence the increase or decrease in the number of arrests, and so caution should be taken in interpreting the following data.

As figures 23 and 24 demonstrate, the number of adult DUIs has declined in recent years along with the number of liquor law arrests. Males were considerably more likely to be arrested on liquor law charges compared to women.

Figure 23: Adult DUI

Driving Under The Influence Arrests-Adults
(Nevada Department of Public Safety, Records and Technology)
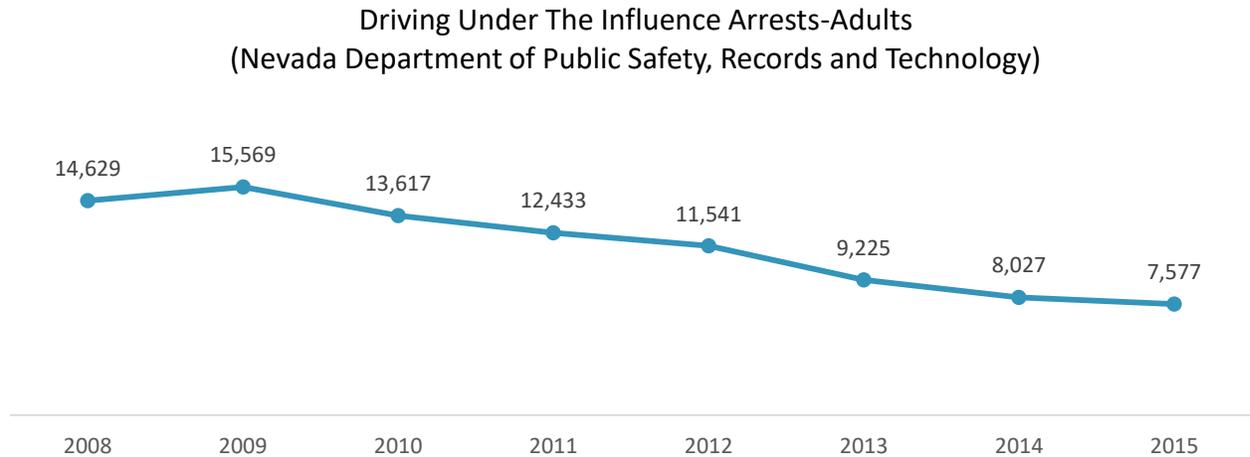
Source: (Office of Public Health Informatics and Epidemiology (OPHIE), 2017)

Figure 24: Adult Liquor Law Arrests

Liquor Law Arrests-Adults
(Nevada Department of Public Safety, Records and Technology)
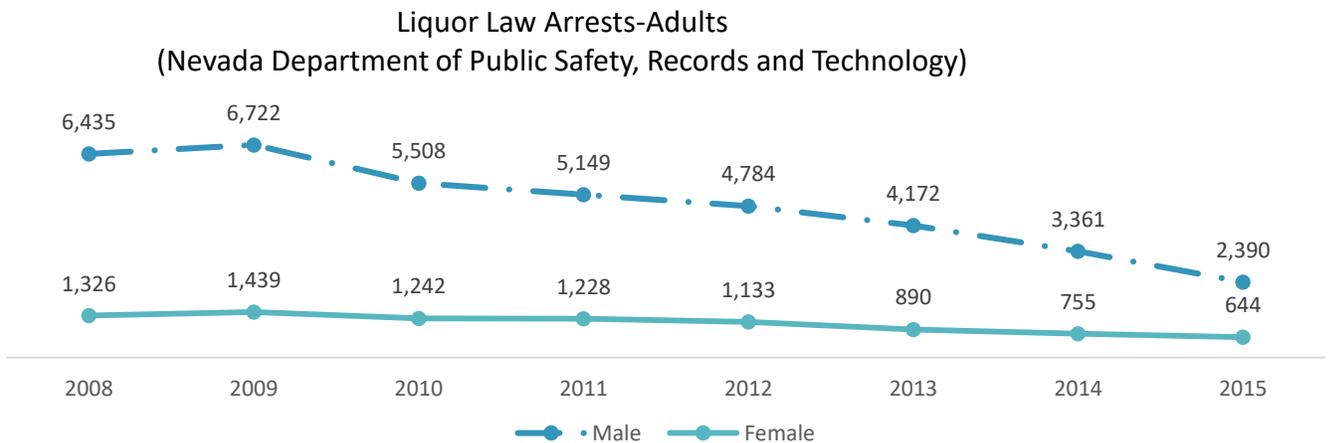
Source: (Office of Public Health Informatics and Epidemiology (OPHIE), 2017)

It is interesting to note that the numbers of drunkenness arrests decreased for males between 2010 and 2012 but increased steadily between 2012 and 2015. Additionally, the number of arrests for women increased between 2012 and 2015.

Figure 25: Adult Drunkenness Arrests

Drunkenness Arrests-Adults
(Nevada Department of Public Safety, Records and Technology)
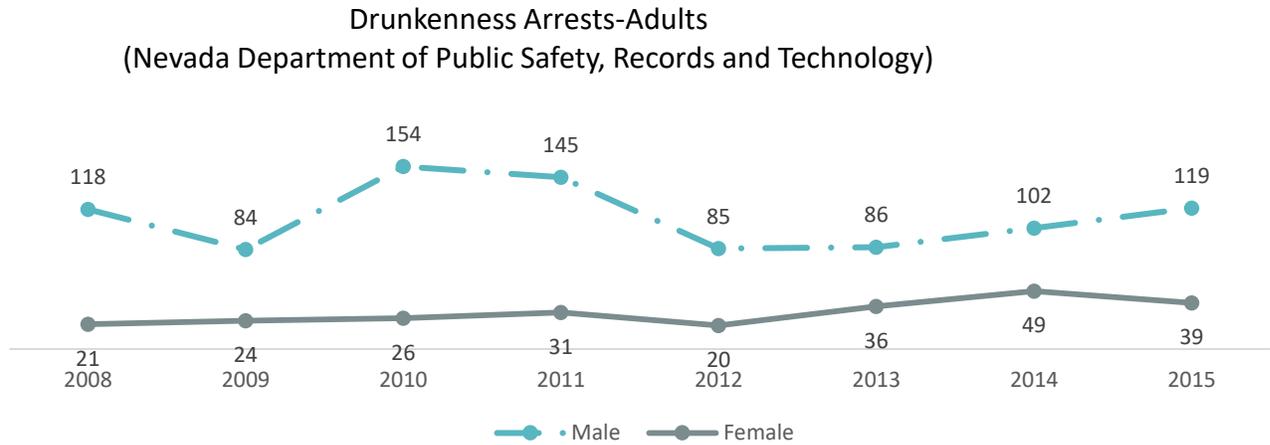
*Source:* (Office of Public Health Informatics and Epidemiology (OPHIE), 2017)

Arrests due to drug abuse violations have declined since 2011.

Figure 26: Ault Drug Abuse Violations
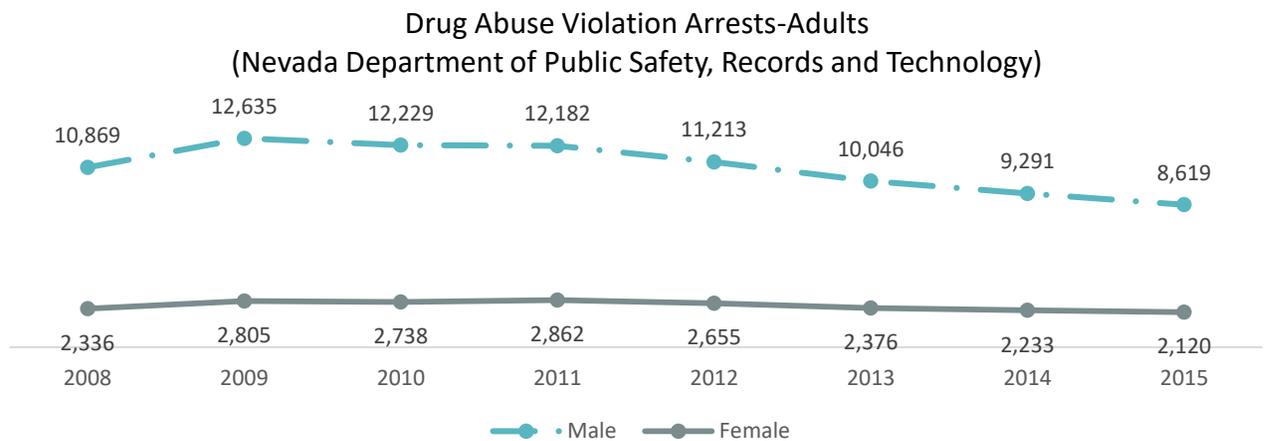
Drug Abuse Violation Arrests-Adults
(Nevada Department of Public Safety, Records and Technology)

(Office of Public Health Informatics and Epidemiology (OPHIE), 2017)

Recovery and Treatment Outcomes

Key informants indicated that waiting time for services is long for adults. They may not get the level of care that is needed or may be awaiting a type of care that does not necessarily fit their needs because they are not properly screened. Data from the National Outcome Measures (NOMS) through the SAMHSA Uniform Reporting System provide some insights into outcomes for adults that interface with the state mental health system. Improving linkages among data systems and enhancing capacity to analyze and report on treatment outcomes can help to identify trends and build on what is working.

Youth Population

Survey data provides information about youth ages 12-17. Several substance use trends are shown in the following charts. In general, youth rates are higher in Nevada compared to the nation, but for many situations the gap appears to be narrowing. The Youth Risk Behavior Survey (YRBS) also provides information to inform outreach, prevention, intervention, treatment and recovery needs. Other information from public safety and crime reporting is also used to understand trends.

Figure 27: High School Figure Tobacco Use

Tobacco Usage Among High School Students (YRBS)
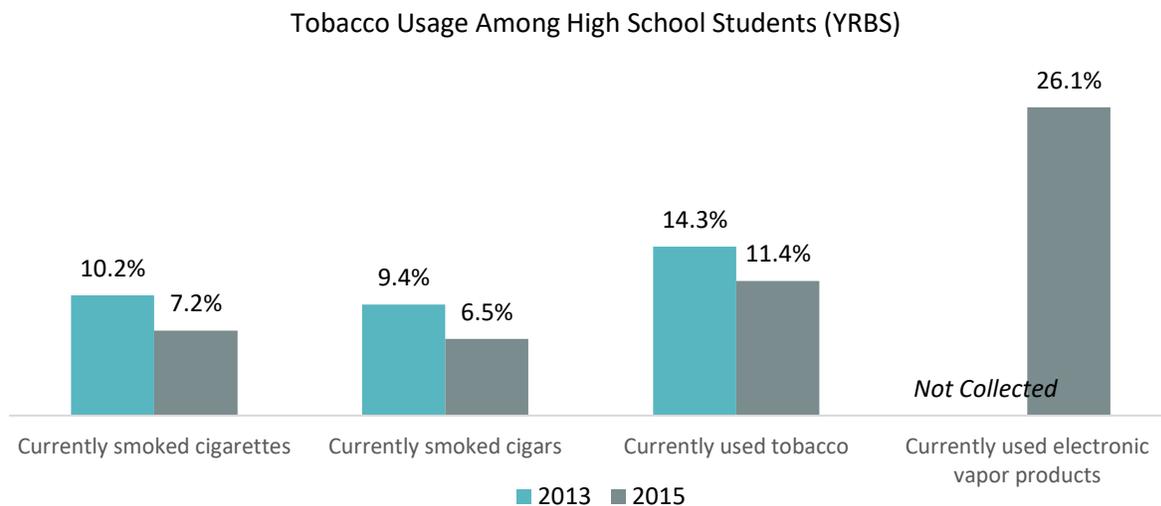
Source: (University of Nevada, Reno Community Health Sciences, 2013 & 2015)

Use of cigarettes and other tobacco products like cigars have declined in recent years. However, use of vapor products has become widespread and poses serious risks. Nationally, e-cigarettes are very popular among youth. Added flavors make them especially attractive to kids and teens (O'Neill Institute for National & Global Health Law, 2016). The impacts of this practice are not well known; while nicotine is highly addictive, a recent study showed that majority e-cigarettes and vaping devices did not include nicotine. Harmful chemicals are still involved in vaping, with limited information about their effects (Ingraham, 2016). According to key informants, other substances are often used through vaping devices, including alcohol and marijuana.

Between 2013 and 2015, there were slight declines measured through YRBS among teens drinking and binge drinking. Slightly less than one in three reported that they 'currently drink alcohol' and 15% had recently participated in binge drinking. There are many risks to youth who drink alcohol, including increased likelihood to experience issues such as school problems, physical and sexual assault, and abuse of other drugs (Centers for Disease Control and Prevention, n.d.).

Figure 28: Alcohol Use among High School Students

Alcohol Usage Among High School Students (YRBS)
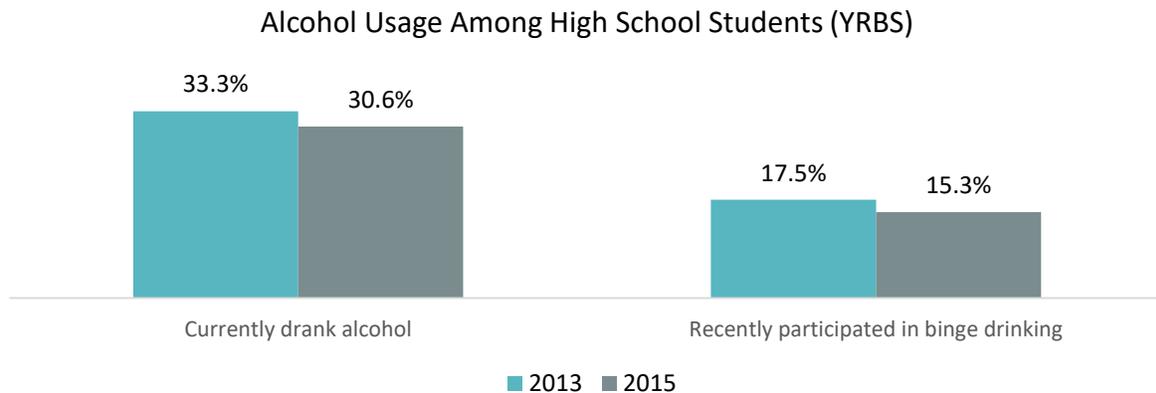
Source: (University of Nevada, Reno Community Health Sciences, 2013 & 2015)

Among high school students, YRBS showed that use for many drugs is declining; however, marijuana was slightly up between 2013 and 2015. Data from surveys showed significant decreases in use were observed among high school youth between 2013 and 2015 for 'ever smoking cigarettes,' 'currently used tobacco,' 'drank first alcohol before 13,' 'ever used cocaine,' 'ever used inhalants,' 'ever used methamphetamine,' 'ever used MDMA,' and 'ever used synthetic marijuana.' Factors- including prevention efforts - are likely contributing to these declines. These data follow national trends, with marijuana use up among youth and many other substances decreased in recent years (Centers for Disease Control and Prevention).

Figure 29: High School Drug Use
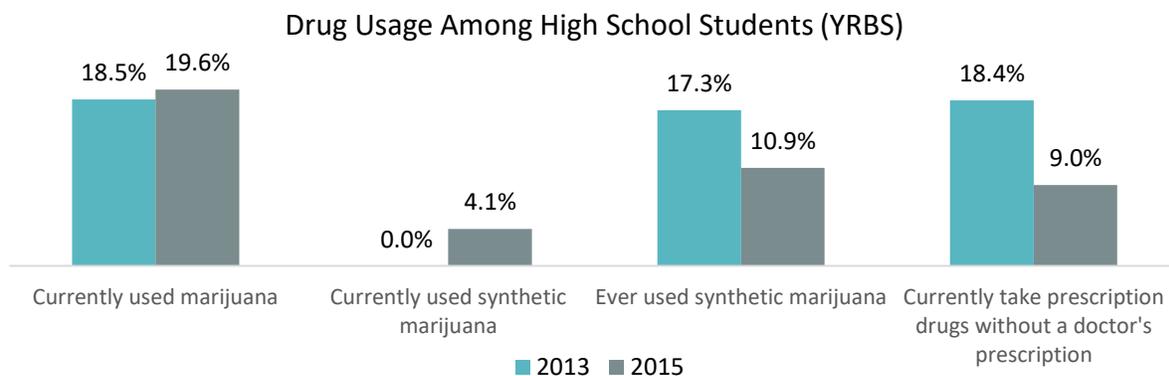
Drug Usage Among High School Students (YRBS)

Source: (University of Nevada, Reno Community Health Sciences, 2013 & 2015)

Data on substance use by middle schoolers was collected in 2015 as the starting year. Drug use in the early years is associated with negative outcomes including substance use disorder.

Figure 30: Middle School Drug Use
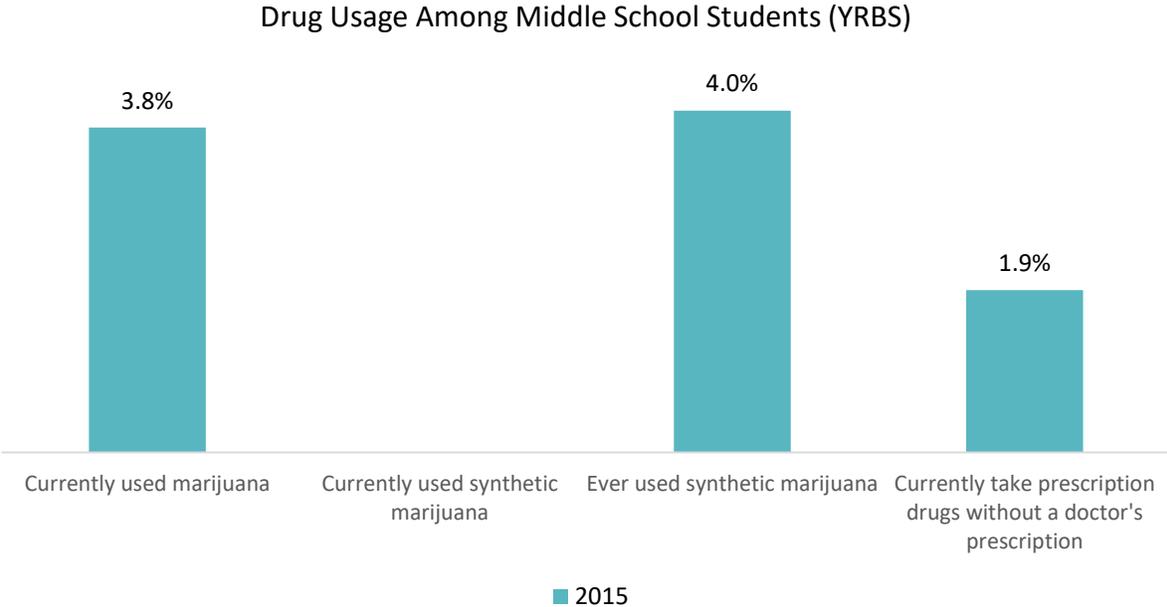
Drug Usage Among Middle School Students (YRBS)

Source: (University of Nevada, Reno Community Health Sciences, 2013 & 2015)

Data on substance use by middle schoolers was collected in 2015 as the starting year. Alcohol use in early years is associated with negative outcomes including addiction.

Figure 31: Middle School Alcohol Use

Alcohol Usage Among Middle School Students (YRBS)
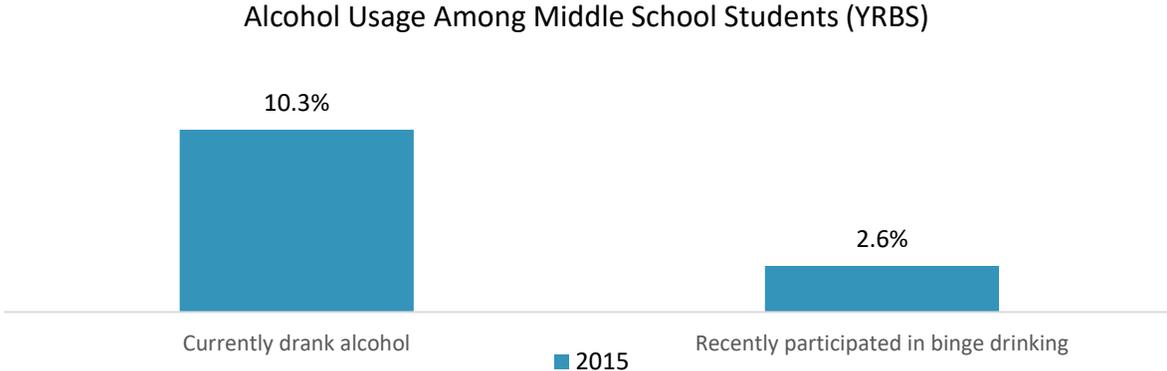
Source: (University of Nevada, Reno Community Health Sciences, 2013 & 2015)

The National Survey on Drug Use and Health (NSDUH) provides another source to view youth behaviors for Nevada. Slight downward trends for use of and dependence on illicit drugs among youth was reported between 2010 and 2014, as shown in the figures below.

Figure 32: Youth Drug Use

Illicit Drug Use In The Past Month: Youth (NSDUH)
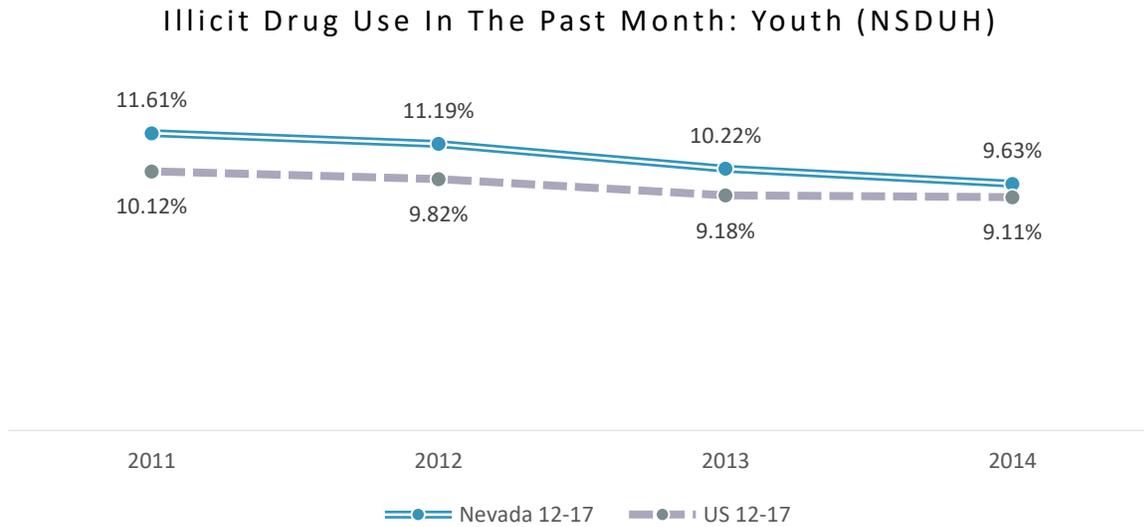
Source: (SAMHSA, n.d.)

Figure 33: Youth Dependence

Dependence Or Abuse Of Illicit Drugs Or Alcohol In The Past Year: Youth (NSDUH)
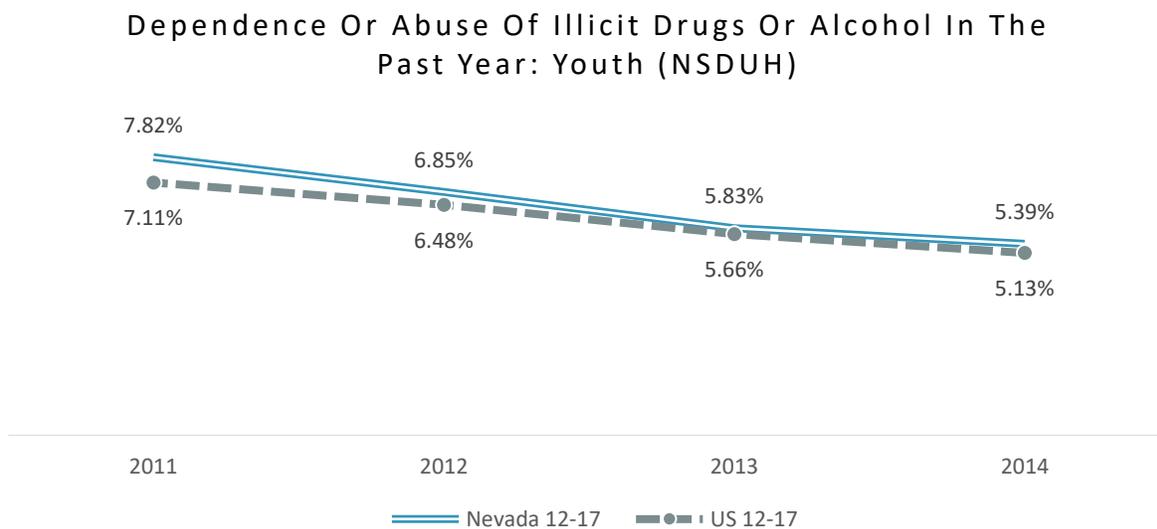
Source: (SAMHSA, n.d.)

The percentage of youth needing but not receiving care for alcohol declined between 2010 and 2014.

Figure 34: Youth Alcohol Use

Needing But Not Receiving Treatment For Alcohol Use In The Past Year: Youth (NSDUH)

4.51%

3.85%

2.98%

3.05%

4.03%

3.46%

2.96%

2.62%

2011   2012   2013   2014

━●━ Nevada 12-17   ━●━ US 12-17
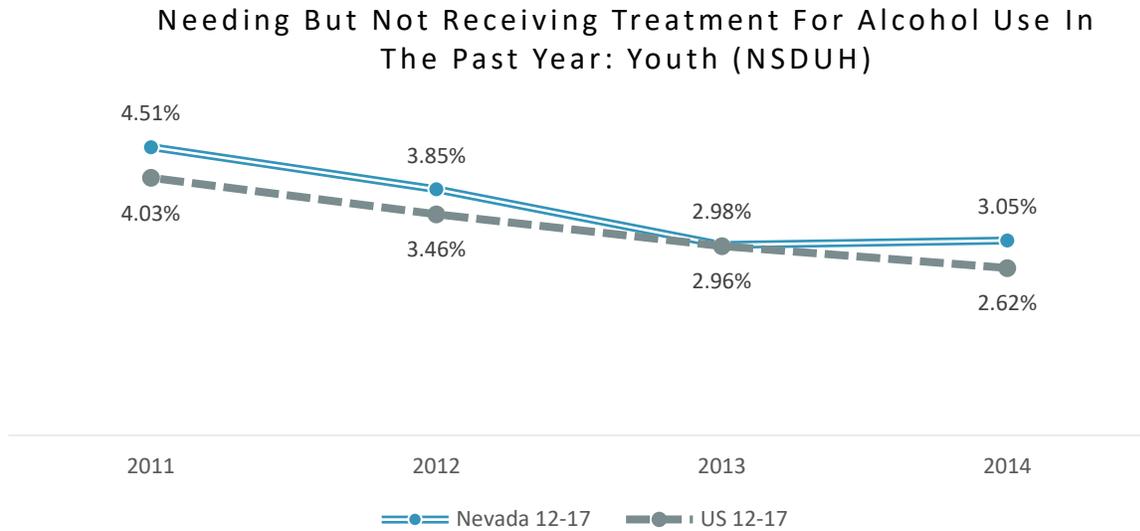
Source: (SAMHSA, n.d.)

Similarly, the percentage of youth needing but not receiving care for illicit drug use declined between 2010 and 2014.

Needing But Not Receiving Treatment For Illicit Drug Use In The Past Year: Youth (NSDUH)

4.31%   4.26%

3.55%   3.52%

4.34%

3.97%

3.49%   3.29%

2011   2012   2013   2014

━●━ Nevada 12-17   ▪●▪ US 12-17
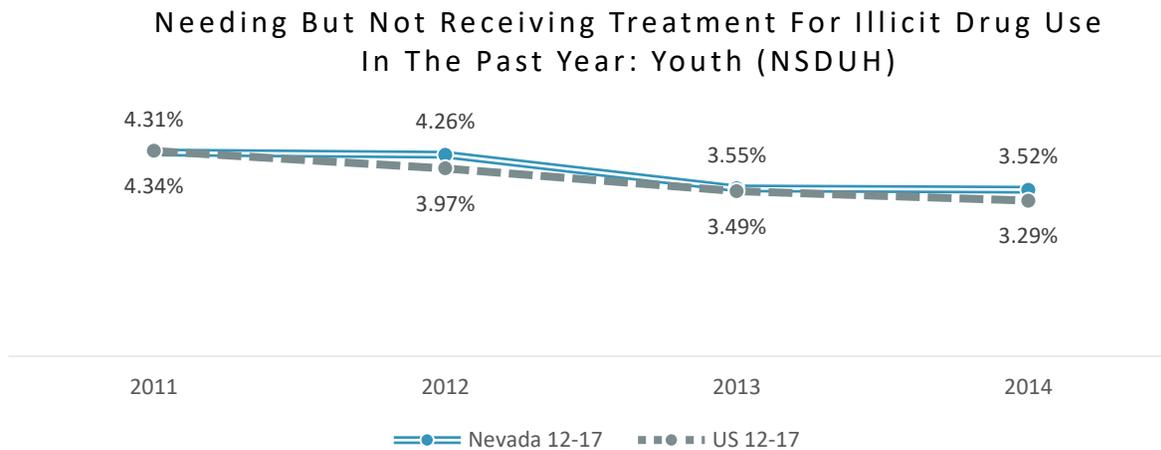
Figure 35: Youth Drug Use

Source: (SAMHSA, n.d.)

Interaction with law enforcement can also help to understand youth substance use. Again, it is important to note that policies and funding for law enforcement may affect the arrest rates seen in the

following figures. Youth arrests for drug violations have varied considerably depending on the year. Variances in arrest by gender are observed among youth, with females less likely to be arrested for DUI.

Figure 36: Youth DUI
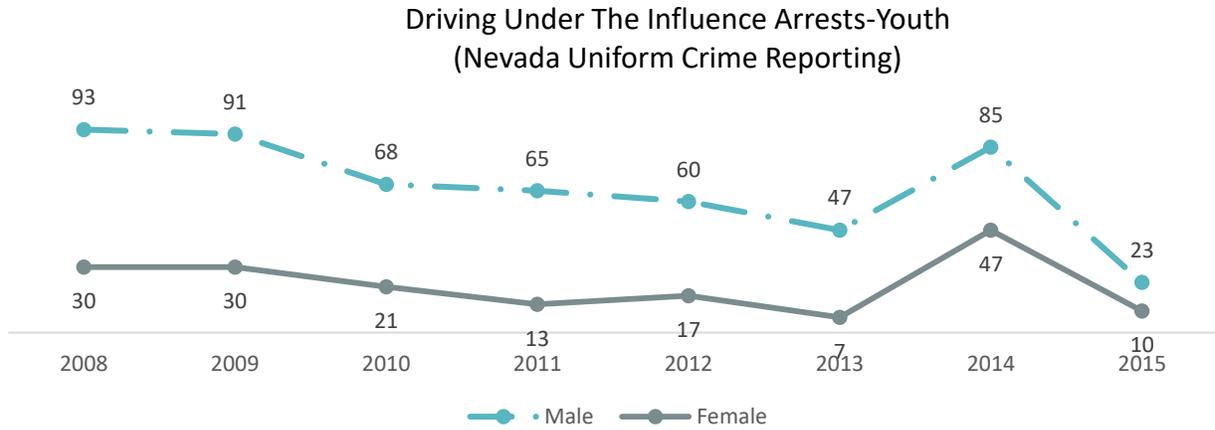
Driving Under The Influence Arrests-Youth
(Nevada Uniform Crime Reporting)

Source: (Office of Public Health Informatics and Epidemiology (OPHIE), 2017)

Youth arrests for liquor law violations have decreased in recent years.

Figure 37: Youth Liquor Law
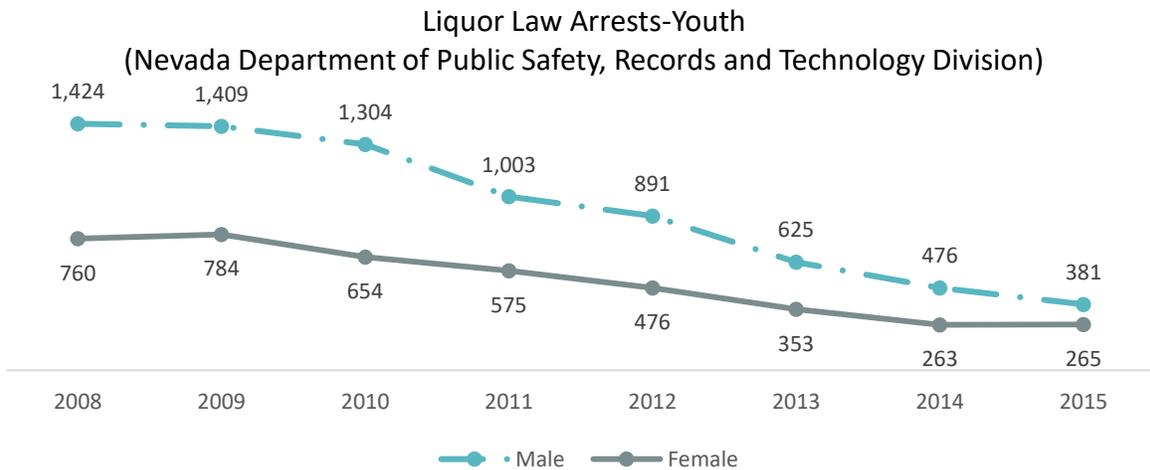
Liquor Law Arrests-Youth
(Nevada Department of Public Safety, Records and Technology Division)

Source: (Office of Public Health Informatics and Epidemiology (OPHIE), 2017)

Youth arrests for drunkenness have fluctuated.

Figure 38: Drunkenness Arrests - Youth
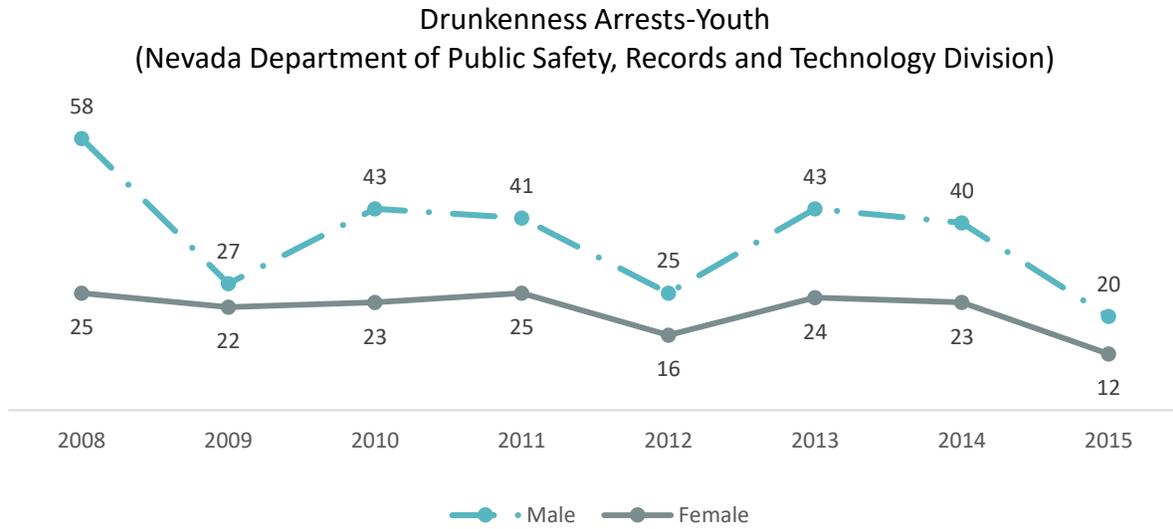
Drunkenness Arrests-Youth
(Nevada Department of Public Safety, Records and Technology Division)

Source: (Office of Public Health Informatics and Epidemiology (OPHIE), 2017)

Youth arrests for drug violations have decreased in recent years.

Figure 39: Youth Drug Arrests
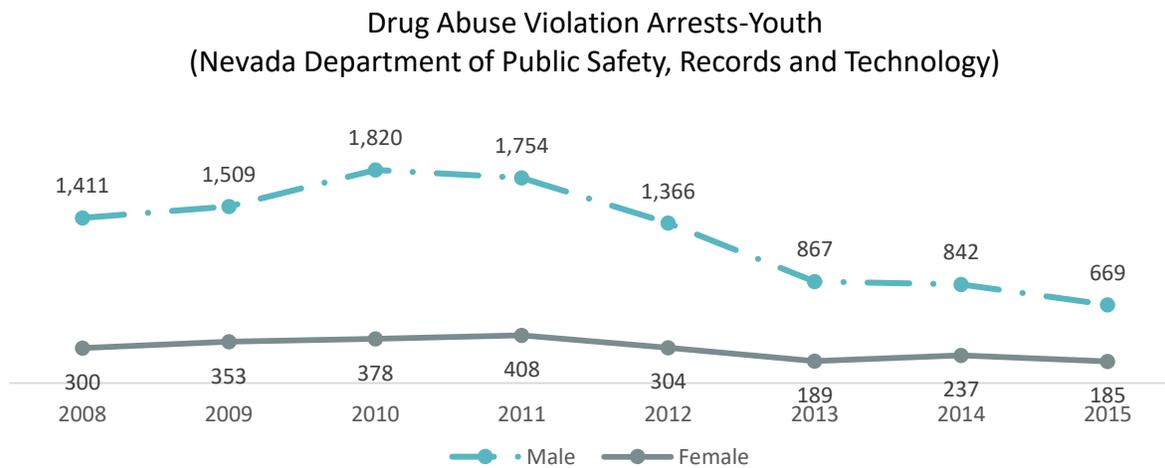
Drug Abuse Violation Arrests-Youth
(Nevada Department of Public Safety, Records and Technology)

Source: (Office of Public Health Informatics and Epidemiology (OPHIE), 2017)

Recovery and Treatment Outcomes

Key informants indicated that more services specific to adolescents are needed, waiting time for services is long and that the level of care may be insufficient. Specific treatment options noted included residential/inpatient care but not many outpatient services for youth.

During the January 2017 Youth and Family Mental Health Engagement Summit, participants responded to a qualitative group survey with open-ended prompts about "what helps," "what harms," and "what's needed" in regards to substance abuse in Nevada. Responses were separated according to which region participants were from, either southern Nevada or northern Nevada. Participants across the state indicated that social supports, access to services, and educational opportunities help with the issue of substance abuse for youth in the state. When asked what harms, peer pressure and negative environments, as well as lack of education and awareness were the top two topics indicated. Finally, when asked what was needed, of 129 responses, many needs were indicated, with the majority of responses centered around services and access.

Figure 40: What's Needed for Substance Abuse
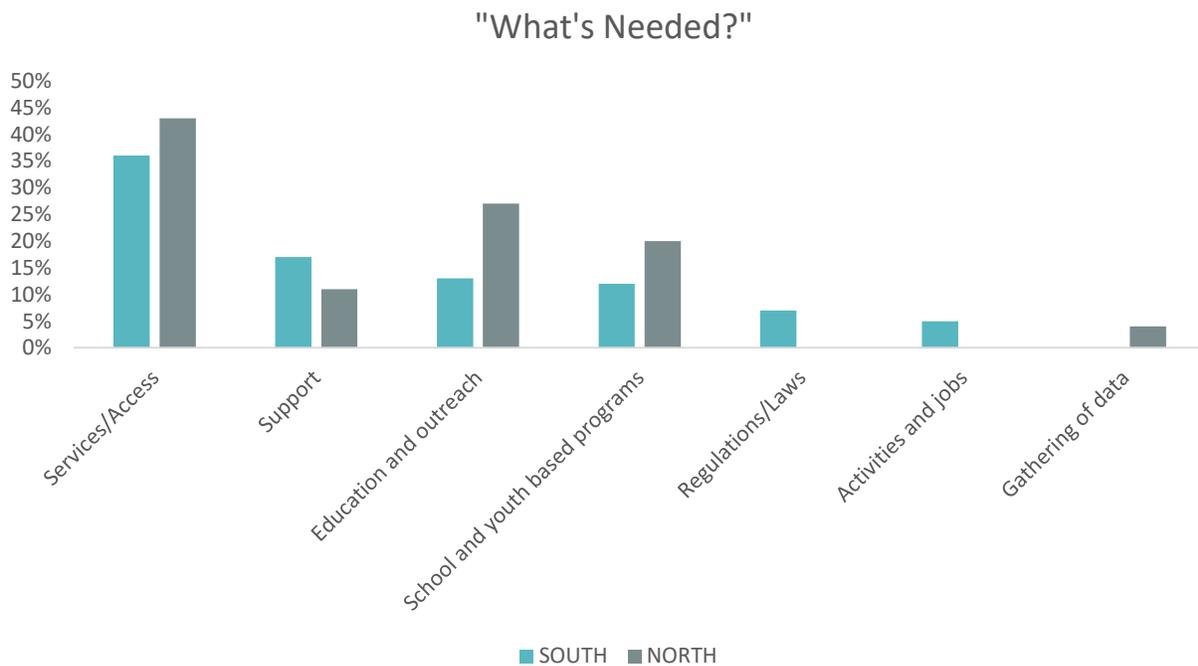
Source: (Division of Child and Family Services, March 9, 2017)

Data from NOMS through the SAMHSA Uniform Reporting System provide some insights into outcomes for youth that are engaged with the state mental health system. In 2015, 78.3% of child/family consumer measures were positive about outcomes, compared the US rate of 69.7%. However, for hospital readmission rates were high compared to the nation.

Diagnosis and treatment of co-occurring disorders was low compared to the national rate, suggesting an opportunity in Nevada to better diagnose and treat children that experience both mental illness and substance use (SAMHSA).

Pregnant Women and Women with Dependent Children

To be able to serve pregnant women in accordance with 45 CFR 96.131, it is particularly vital to understand the population requiring these services, and more importantly, ensure it has the capacity for compliance with this regulation. However, data regarding drug use and abuse by pregnant women can be difficult to accurately report given the existing data collection tools employed by the state. Currently, the state examines the number of pregnant women receiving state-funded treatment. It also uses self-reported birth certificate information. Both sets of data may prove to underestimate the number of pregnant women using or abusing drugs in Nevada, but the sets do serve to help create a basic understanding of Nevada's mothers and expectant mothers' use or abuse of drugs.

In Fiscal Year 2016, the state reported to the Substance Abuse Block Grant reporting system (SAMHSA, n.d.) (WebBGAS) 121 pregnant women receiving treatment. Figure 41 represents the count of unduplicated pregnant women receiving services since 2006. The state has indicated that the reported numbers may not accurately reflect the number of pregnant women receiving services. They are currently working to improve the system to better account for this and other data.

Figure 41: Service Counts of Pregnant Women

Unduplicated Counts Of Pregnant Women Receiving Substance Abuse Treatment In Nevada through SAPTA
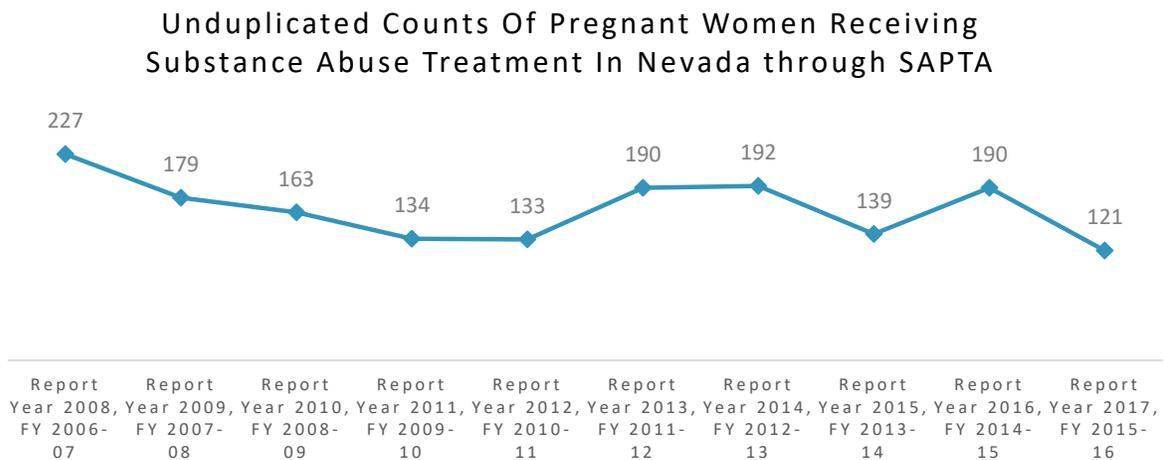
Source: (Office of Public Health Informatics and Epidemiology (OPHIE), 2017)

It is important to note that the count of women receiving services does not indicate need in the state. Rather it speaks more to the state's capacity for services and ability to identify and treat pregnant women.

Additional data from the Center for Health Information Analysis (CHIA) can be found using the World Health Organization's International Classification of Diseases (ICD) codes. In 2015, providers migrated from the use of ICD-9 to ICD-10. ICD-10 codes for substance abuse are more comprehensive than the previous version; however, their use only became mandatory in October of 2015 (APA Practice

Organization, 2017). This will make it difficult to compare information from 2016 to information from the previous years.

Figure 42: Babies Born with NAS in Nevada

Babies Born with Neonatal Abstinence Syndrome in Nevada
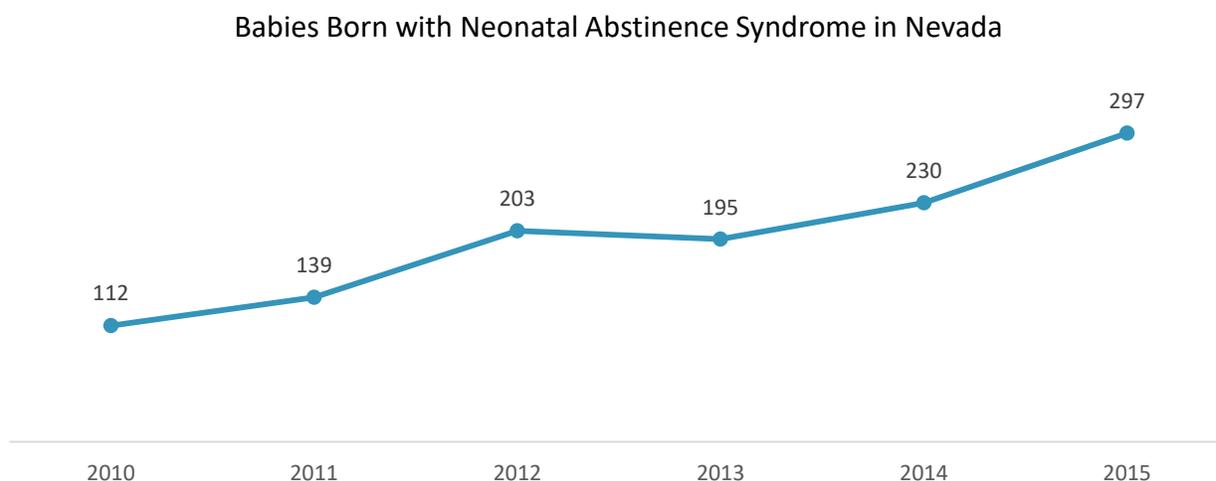
(Office of Public Health Informatics and Epidemiology (OPHIE), 2017)

Mental Health

In Northern Nevada, mental health clinics serve people with a variety of diagnoses, including poly-substance dependence. As mentioned previously, mental health disorders and substance use disorders are often co-occurring.

Almost one in five adults in Nevada have some kind of mental illness. This is comparable to other states where the percentage of adults with mental illness ranged from 16% to 21%. The most recent estimates of prevalence rate of any mental illness among adults was 18.52% by the Substance Abuse and Mental Health Services Administration in 2014. This is an increase since the 2011 estimate of 16.48%.

Table 9: Estimated Adults with Mental Illness

Year	Total Population Ages 18+	Estimated Adults with Mental Illness*	SAMHSA Estimation of Prevalence Rate
2011	2,011,277	331,458	16.48%
2012	2,040,581	327,513	16.05%
2013	2,067,996	380,098	18.38%
2014	2,100,484	389,010	18.52%

Source: (U.S. Census Bureau, 2016)

*Estimate is based off an 18.52% prevalence rate of adults in Nevada. Source: (Substance Abuse and Mental Health Services Administration (SAMHSA), 2016): http://www.samhsa.gov/data/sites/default/files/NSDUHsaePercents2014.pdf

Service Delivery and Capacity

Nevada's service delivery and capacity were assessed in a three-part outreach process. First, key informant interviews were conducted and included in the draft situational analysis. Then, a review of a working draft of the situational analysis conducted with the Steering Committee helped to establish critical issues. Finally, during a series of Town Hall Meetings held from March 10-14, 2017, the public was given the opportunity to confirm those issues identified by the Steering Committee and further identify any additional state needs.

Key Informants

Through key informant interviews and focus groups, systems strengths and challenges were identified. Additionally, key informants recognized potential opportunities and/or strategies to meet these challenges. A synthesis of key informants' perspectives appears in this section.

Systems Strengths

Prevention

- The sub granting process allows the coalitions to work with local partners collaboratively, bringing them together to serve their communities, distribute work and funds, and facilitate "statewide conversation" and collaboration.
- The coalitions facilitate relationships for the benefit of the community.
- Coalitions that have successfully engaged local youth and school districts have high quality prevention efforts in their communities that are youth-driven.
- Community champions exist in every county and support the coalitions.
- Prevention Specialist Certification and Community Health Worker Certifications help to legitimize the efforts of individuals as well as provide the training needed for these members of the workforce.
- The use of environmental strategies for prevention including programs, policies, and practices makes a difference.
- The Department of Education has implemented state management teams to bridge prevention services and funding.
- At the state level, DPBH administration and staff understand community-based decision making. There are people who are willing to ask tough questions and get to the root of problems.
- Use of apps and websites for communication can be effective tools to target sub-populations with information. For example, web applications for tobacco cessation are more appropriate than call lines for youth. Social branding has shown promise for prevention among subpopulations including LGBTQ.
- In most communities, law enforcement has a reputation as an ally and assists with prevention efforts.
- The promotion and use of safe disposal sites and distribution of lockboxes is seen as very helpful.

Treatment and Recovery

- The statewide effort to address the opioid epidemic has focused efforts across many sectors. Several interviewees noted aspects of the work that were making a difference in public awareness, treatment, and recovery.

- Many public systems are using evidence-based practices. For example, the Department of Corrections uses evidence-based frameworks, and invests in training for its providers. Many other programs use or are expanding use of EBP.
- Data collection and tracking have improved in recent years, helping to provide actionable information. For example, electronic health records, surveillance systems, and shared data systems (Avatar, HMIS) collect information across providers and systems. While this was noted as an improvement, key informants agreed much work has yet to be done to improve data collection.
- Recent system advances such as Regional Behavioral Health Care Coordinators and Community Health Workers are seen as effective strategies to address Nevada's needs.
- Where they exist, wraparound services are described as working well. For example: The Division of Child and Family Services' Wraparound In Nevada (WIN) program is recognized nationally as a promising practice that helps children.
- The majority of providers are viewed as passionate about helping people and person-focused in their approach.
- Continuing Medical Education (CME) and Continuing Education Units (CEUs) offer opportunities for professional learning in areas related to substance misuse. Training and education were noted as helpful to providers in addressing issues and needs.

Issues and Challenges

Prevention

- Within different communities there are systematic barriers that prevent the coalitions from accessing youth: these barriers include school hours, a need to build effective partnerships with youth and create productive and mutually beneficial relationships with schools and school districts.
- Demand for prevention education is high and the coalitions cannot meet the demand, especially in rural areas where a dispersed population is difficult to reach. Coalitions also expressed concern about driving a great distance to give a presentation for very few people.
- Marijuana prevention efforts are challenging in the face of legalization of recreational marijuana statewide.
- For coalitions and treatment providers, federal funding priorities can stand in the way of meeting community needs.
- Coalitions feel that youth engagement is made challenging by school district barriers, the way that programs have been pushed to after-school hours, and liability issues associated with transportation after-school. It is difficult to incentivize participation because of funding limitations (e.g. can't provide snacks, at one point couldn't provide t-shirts, etc.).
- Data collection specific to prevention is problematic and may affect funding and information dissemination. Data is reported to the state, but then cannot be accessed to further prevention efforts or support funding requests.

Treatment and Recovery

- There is a lack of recognition of the signs and symptoms of substance use and abuse. Trainings have been provided but continued attention is needed in this area.
- More information about available services is needed for those seeking to help to connect with services.
- Adolescent service providers have struggled because many families don't access them. Parents can be reluctant to recognize their child has a problem and may not be open to asking for help outside the family. The 24/7 environment in Nevada can also impede people's ability to access treatment, including parents helping their children to get to treatment.
- More residential programs are needed to meet demand. Treatment and recovery should begin when a person is ready. When a person needs treatment, an hour can be a long time – waiting times can be weeks, or even months. People often have to leave their communities to get care.
- People need assistance transitioning from inpatient care and more intensive services to step-down services.
- The Affordable Care Act has been built into many improvements to Nevada's system for care. Threats to repeal the ACA have major consequences for programs that have been planned and developed that leverage provisions of the ACA.
- Housing and transportation can be considerable barriers, especially for difficult to serve populations such as former offenders and people with mental health problems.
- More opportunities for people to get medication assisted treatment (MAT) are needed. Providers lack education about MAT and additionally, are concerned with the regulatory burden of offering it.
- More outreach, programs, and services that are culturally and linguistically relevant are needed. There is a lack of culturally specific services, especially for the Native American population.
- The state needs more providers including behavioral health and primary care physicians as well as specialists (psychiatrists, pain management specialists, etc.), especially those that are able to effectively address co-occurring disorders.
- More consideration should be given to the social determinants of health and addressing those.
- Insurance and availability of services are often a barrier to person-centered planning because they limit patient choice.

> "I think everyone in substance abuse prevention and treatment [field] knows that there's never enough funding to do what we want to do or what we should do. But I think if we collaborate and we don't duplicate efforts, I think we can make a big, big impact. So, I think as long as people don't feel ownership and territorial over their product or their service, then I think we're in good shape."
>
> --Key Informant

Cross-Cutting Issues

- Uncertainty about the ACA's future raises concerns for treatment delivery systems under development.
- There is a lack of awareness about resources available, for example reimbursement for case management through Medicaid and SAPTA funding.
- Lack of effective communication across state divisions, data systems, and funding sources contributes to challenges in implementing data-driven solutions.
- Stigma exists for people needing care and treatment. This can also extend to families.
- Compensation is often not adequate to attract and maintain the workforce.

- Medicaid reimbursement rates are too low – and delays for payment as well as other payment issues can be a disincentive or make it too difficult for providers to make their budget work.
- Many physicians won't repeat medication assisted treatment if it has failed.
- There is need to continue to improve technology including electronic health records, data systems to facilitate better referral, outcomes management, and understanding of needs.
- Some key informants suggested that the change to Medicaid-funded service was the cause of increased admissions to emergency rooms and jails – as people aren't able to get the help they need and are interfacing with these systems.
- Laws and policies are not always adequate to support public health approaches to services.
- Communication, understanding of community needs, and consistency at a state level is also a problem. The state can be disconnected from the realities of the diverse communities' specific needs.
- Lack of institutional knowledge makes it so that coalitions have to continuously reeducate about their programs because there is turnover at the state level. Regulations are interpreted differently, confusion of state directives result in punitive measures for the coalitions, providers, or both.
- There are too few effective measurements for success. As one person said: "It takes longer than a quarter to effect change."
- Inconsistencies in reporting and budgeting requirements can be a challenge to building effective systems.
- In conjunction with communications with the state, funding is always a challenge.
- Coalitions feel that youth engagement is made challenging by school district barriers, the way that programs have been pushed to after school hours, and liability issues associated with transportation after-school.
- Grant recipients may not be certified, eligible for funding, capable or willing.

Recommendations for Planning
Key informants also addressed aspects of the system that could be improved.

Planning
- Include the Strategic Prevention Framework in design and planning of systems.
- Utilize collective impact to strengthen results of collaborative efforts.
- Use the public health model where people are viewed holistically.
- Many states are innovating, including Nevada. Nevada can learn from other states to improve policies, systems, and practices for more effective outcomes related to behavioral health. However, Nevada has unique needs, and plans and practices need to be tailored to Nevada specifically.

Build Sustainability
- Identify opportunities to develop funding that addresses community needs.
- Better define rural, urban, and frontier at the state level and how they affect funding, etc.
- Look at Grants Management Advisory Council (GMAC) sub grants to leverage their system to meet coalition needs.
- Look at the Department of Education's 21st century grant and E-page.
- Ensure that grant funded programs that are effective can continue into the future.
- Create a sustainability plan.

Strengthen Use of Data

- Improve accuracy of data and the reports for legislative and other purposes.
- Improve data sharing between state and the agencies themselves.
- Improve comparability of data.
- Streamline duplicative requests.
- Use data for planning and learning.
- Develop systems that can support evaluative learning.

Enhance Communication and Relationships

- Improve interdepartmental communication. Consider more mid-level employees at the state to allow for better distribution of the work.
- State workers need a way to see the programs in action and connect their administrative work to the programs on the ground; "they need to understand how they are part of the team."
- Strengthen continuity of knowledge at state level, including steps to reduce turnover.
- Move the agency from an 'enforcement role' to a collaborative relationship with coalitions and providers.
- Address what is and what is not working well in advisory boards; consider opportunities to further develop these structures for public engagement.
- Enhance public awareness, especially around the issues of potential harm from addiction to opioids. Individuals and their doctors can work together to prevent potential problems related to substance use disorder.

Expand Effective Programs and Services

- Key informants identified many practices that hold promise for improved outcomes, including:
    - Targeted outreach and messaging for prevention
    - Assistance with navigation and coordination for services
    - Interventions that utilize family members and peer support
    - Medication assisted treatment, including walk-in clinics
    - Trauma-informed approaches to care
    - Cognitive behavioral therapy and related practices
    - Best practices for working with people recovering from opioid addiction
    - Supportive transitions through levels of treatment
    - Web-based prevention resources
    - Wraparound Services
- The agency can help to support widespread use of treatments to meet emerging needs through training and support. Reimbursement for providers to attend should be considered to help address financial barriers faced by providers (especially those in small practices and the not for profit sector).

> "The people who work in the field are really passionate about it, whether it is treatment or prevention. They are not doing it for the paycheck…. We do a good job of recruiting people who are truly passionate about helping families and working with our kids."
>
> --Key Informant

Improve Systems and Structure

- Institutionalize the coalitions as the state has done with Family Resource Centers
  - Allow for baseline funding to create stability.
- Optimize 2-1-1 so that it is the first return when someone searches for a term; ensure directories are up to date

Strengthen Workforce

- Identify opportunities for providers to strengthen their knowledge and resources in EBP, and provide funding for providers to attend trainings. Without it, they may not be able to attend.
- Partner with other divisions on issues of reimbursement, funding, and coordination.
- Include opportunities for cross-sector education where there is an opportunity to share practices and understanding.
- Identify opportunities to reduce turnover and bolster workforce morale both at the agency and among providers statewide.
- Enhance cultural competency all around—rural, frontier, urban, socioeconomic, etc. Identify opportunities to not only increase the number of providers, but to enhance diversity.

Steering Committee

A draft of this Situational Analysis that included data and key informant information was presented during the third Steering Committee meeting on March 3, 2017. Using this draft as a basis for discussion, the Steering Committee completed a SWOT analysis. The SWOT analysis was a facilitated discussion seeking to identify organizational and systemic strengths and weaknesses, as well as potential opportunities and external threats. After completing this analysis, the group identified six critical issues to address in the Strategic Plan.

Strengths
- Medicaid expansion is working to help more people.
- There has been improvement of the certification system as well as the criteria for certification.
- There is long-term leadership at the state level.
- The administrative restructuring process that began in 2013 has helped the agency.
- On the ground level, providers are ensuring that every person is receiving treatment because SAPTA is functioning as a safety net for services not covered by Medicaid.

Weaknesses
- There has been a failure to comply with federal Block Grant requirements. For example, no Needs Assessment has been conducted in recent years.
- There are still considerable issues with the certification system.
- There is a lack of institutional knowledge and cross-training, and high turnover at the state level lead to loss of grant funding and missed grant opportunities.
- There is a lack of subject matter expertise at state level.
- There has also been a failure to comply with federal regulations:
    - No referrals given to pregnant women when a program is full (not meeting requirement for priority admission)
    - No outreach for IV users
    - No capacity management system
    - No strategy for monitoring compliance for sub grantees
    - While there is a point in time survey, there needs to be better systems
- There are barriers to the public to knowing what's available and how to access it.
  There is a lack of alignment within the state across bureaus, divisions, and departments.
- There has been a lack of supervision of behavioral health services.
- The advisory councils don't meet regularly and have trouble getting quorum when they do.
- Systems for oversight are needed.
- Medication assisted treatment is not tracked or certified and is underutilized.
- Serious data gaps inhibit the function of the agency. These data gaps include the following:
    - Waiting list data that identifies the extent to which demand for treatment exceeds the resources available.
    - Statute-required data on the evaluation, treatment, and transitional housing available for adolescents.
    - The Epidemiological Profile developed through the Strategic Prevention Framework grant from SAMHSA.

o An accurate number of pregnant women who received substance abuse treatment through the SABG.

o The number of pregnant women who received substance abuse treatment funded by Nevada Medicaid.

Opportunities

- SAPTA could be the single state authority to provide high level coordination of services and oversight, working to integrate and consolidate community resources.
- Promote and update resources available.
- The agency could work to become the single point of entry or increasing points of access to improve system navigation.
- The potential expansion of Medicaid-funded treatment would benefit the community.
- Leverage and build upon strong collaborative processes and systems.
- Increase the functionality of 2-1-1.
- The State Targeted Response to Opioids Grant provides many opportunities for the state to improve efforts.
- Federal Grants are on the horizon to further develop the workforce, including Nevada Works and Workforce Connection.
- Harm reduction strategies related to marijuana could be developed.

Threats

- Potential elimination of the ACA and Medicaid expansion may cause complications.
- Funding reductions at a national level are a potential threat.
- Legalization of recreational marijuana is a threat for public health, treatment, and youth. Research suggests that marijuana impairs critical thinking and memory functions and, that regular marijuana use in the early teen years lowers IQ into adulthood (National Institutes of Health , 2014).

Critical Issues

Critical issues central to the achievement of the vision were identified by the Steering Committee based on the draft of the situational analysis and the S.W.O.T. These issues are high impact, strategic areas that cannot be addressed easily or resolved in the near-term.

1. STATE CAPACITY

- A critical issue is the state's capacity to assess need, manage available resources, and report on utilization and outcomes. The capacity gap includes state-level subject matter expertise, knowledge capture, and the transfer of institutional knowledge.

2. LACK OF COMPLIANCE

- A critical issue (related to 1) is the lack of compliance with federal regulations and federal grant requirements. This issue contributes to lack of integration as specified in statute and has the potential to impact much-needed funding.

3. WORKFORCE ISSUES

- A critical issue is lack of workforce across the state to meet demand. The bureau can help address this through grants, collaboration, certification, and cross-agency initiatives.

4. SERVICE GAPS

- A critical issue is the gap in services needed for prevention, outreach, intervention, treatment, and recovery in Nevada, including (but not limited to):
  - a. Lack of wraparound services
  - b. Lack of person-centered planning and recovery supports
  - c. Services for adolescents
  - d. Services to address needs in justice systems

5. INSUFFICIENT FUNDING AND SUSTAINABLE RESOURCES FOR EVIDENCE-BASED AND INTEGRATED APPROACHES

- A critical issue is the need for funding to sustain and strengthen the evidence-based practices that have been adopted by the bureau and its partners.

6. PUBLIC EDUCATION AND INFORMATION

- A critical issue is insufficient public education and information that addresses stigma and promotes the availability of resources to allow for better navigation of the system.

Town Hall Meetings

The purpose of the town hall meetings was to gather feedback regarding the critical issues identified by the SAPTA Strategic Planning Steering Committee as part of the strategic planning process. Participants were presented with a high-level overview of the situational analysis and then asked to provide their perspective on the mission, vision, concepts, and values for the Strategic Plan; the needs identified via the Situational Analysis; and the critical issues recognized by the Steering Committee. Each meeting lasted a total of 1.5 hours. At each meeting, participants were asked to sign in and self-identify as consumers, family members, professionals in the field, policy makers, or advocates. A total of 64 participants were recorded on sign in sheets. The results of each individual meeting appear in the appendix of this document.

Table 10: Town Hall Meeting Attendance

	Las Vegas **March 10, 2017**	Carson City **March 13, 2017**	Elko **March 14, 2017**
Total Participants	26	26	12
Consumer			
Family Member			
Professional	12	14	5
Policy Maker		1	
Advocate	2	5	4
Multiple Designations	2	1	
Unmarked	2	3	3
Other		2 (Educators)	

Summary of Feedback

Mission, Vision, Concepts, and Values

The mission, vision, concepts, and values were well-received by each of the groups.

Timely treatment and workforce development were suggested as additional potential values.

Needs

Each town hall group agreed with the majority of the overview of the situational analysis as presented, emphasizing the importance of treatment for youth, workforce shortages, the challenge of housing and transportation, and challenges related to data sharing and use. People in all locations underscored the importance of wraparound services and case management and reducing stigma associated with substance abuse. Each group also recognized the lack of information available to professionals and the public about providers and services.

Each group identified several needs that they did not see reflected in the overview of the Situational Analysis. Some of these needs were recognized as specific to their region and some of them were acknowledged as problematic for the whole system.

- Information about the service system is needed so that people (including providers) can make appropriate referrals.
- The resources available to people with co-occurring disorders are lacking. More information, training, and resources are needed to effectively treat co-occurring disorders.
- Burnout is common in the workforce—especially in rural areas—because people are trying to help with such a broad spectrum of issues.
- Provider collaboration is lacking in many areas of the state.
- Substance use and other mental health issues are inextricably linked—from problem gambling to suicide. The state needs to consider how to address people holistically.

- There is a need for flexibility in the plan because of upcoming changes, including federal and state. The legalization of marijuana and changes to the ACA will affect how any plan is implemented.
- Social determinants of health along with substance abuse need to be addressed, including the influence of poverty on substance abuse.
- Seniors, Native Americans, and Veterans are special populations that should not be ignored. Services for youth had already been identified. Nevada's large population of people that are Hispanic (Latino) is also an important population to consider. People that are considered extremely hard to serve, people who are homeless, and, people who are under-insured are examples of other groups noted as important to consider in planning resources and improving the service system.
- There is a need to understand the unintended impact of regulation and the opioid crisis on prescribers.
- Health systems are not connected and so cannot serve people fully, e.g. dental, behavioral, etc.
- Individualizing care is challenging given what is available via providers and what is dictated by insurance. Insurance can cause problems with continuity of care, especially if there are insurance coverage gaps.
- Legislative advocacy is needed to support policies that promote health and do not worsen substance misuse trends. Gambling and the casino culture contribute to the substance abuse problem. Local decisions--for example zoning for liquor sales--play a role in promoting healthy behaviors (or conversely, encouraging unhealthy behaviors).
- Nurses, first responders, and other professionals do not have the training nor the funding to support training for substance abuse issues.

Critical Issues and Opportunities

Each group responded to each critical issue separately, providing additional notes, and potential opportunities or strategies for addressing problems. Opportunities and/or potential strategies to address critical issues follow.

#1: STATE CAPACITY
- Difficult to compare data across communities.
- Inconsistent communication from the state about what's funded, what's available, and what's happening.
- Outsourcing should be to qualified and high-quality resources.
- Data needs to be used to inform funding.

#2: LACK OF COMPLIANCE
- Further define what is meant by "statute specified plan integration."

#3: LACK OF WORKFORCE TO MEET DEMAND
- Knowledge capture and transfer is a problem among the workforce itself.
- Include cross-systems initiatives.
- Reciprocity is a barrier to entry. The vetting process for Nevada is not realistic.

#4: SERVICE GAPS

- Lack of youth and family services, especially services to support youth whose parents are in treatment.
- Better wraparound services are needed.
- Transportation to and from providers, even within communities, but especially between rural and urban is a challenge for providing complete care.
- Early intervention.
- Appropriate levels of care.
- Recovery services are needed.
- Basic barriers to entry into the system, like having an address.
- Lack of training for overdose.
- Special populations include but are not limited to youth, veterans, Native Americans, LGBTQ, racial and ethnic minorities, women, and seniors. Also, it is important to consider those hardest to serve (e.g. people who are homeless) and those that may have some access to care but are underinsured / not getting appropriate care (working poor and professionals).

#5: INSUFFICIENT FUNDING AND SUSTAINABLE RESOURCES

- The problem is not that funding is insufficient; it is that money is not well-used or well-placed.
- Medicaid reimbursements are too low.
- Awareness about the funding provided by SAPTA needs to increase.
- Bundled and unbundled services make billing difficult.
- No grant-writing assistance or technical assistance from the state to increase funding.
- Grants are not regionalized.

#6: INSUFFICIENT PUBLIC EDUCATION AND INFORMATION

- Lack of time and staff to receive the training and knowledge that already exists within the community. Professionals across the spectrum, including first responders, nurses, etc., need to be given time to participate in trainings to address stigma, suicide prevention, etc.
- The problem affects the entire population including all classes and all people.
- There are barriers to getting information into schools.

SUGGESTED ADDITIONAL CRITICAL ISSUE

- Silos exist that create obstacles to an effective system of referral and care for people needing treatment and recovery.

Opportunities

The group identified several opportunities or potential strategies for the state. These fall under key themes listed below:

State System

- Enhance local and regional and local ability to be responsive to the needs of local populations, assist with local education and prevention, certify and develop programs, and disburse funding. ("One size does not fit all!").
- Align data systems so that entry for the same information happens into one system. Improve two-way communication from data systems.

- Encourage and support meaningful coordination and collaboration, especially for early intervention, treatment, and recovery.
- Clarify language related to the field. Define what terms like substance abuse, mental illness, co-occurring disorders actually mean so that everyone uses them the same way.
- Improve infrastructure for telehealth needs to better serve rural and frontier areas.
- Improve grant transparency to allow for a better understanding of what is available, who else is working on the same type of project, and potential collaborations to better leverage funding. Improve long-range planning for funding.
- Strengthen training opportunities in evidence-based practices (including financial supports for providers). Additional training and support for co-occurring disorders is an example of where additional training and resources would be helpful within communities.

Consumers
- Provide consumers with immediate access to evidence-based treatment.
- Look at people holistically. Bridge services from the hospital to treatment so that people don't have to navigate the system on their own. Improve care management and wraparound services (and work toward recovery oriented system of care).
- Create a system that allows consumers to provide regular feedback about what they need.

Corrections
- Improve screening and assessment to get individuals where they need to be instead of sending them to jail.
- Establish a diversion program to keep people out of jails.
- Enhance mental health and substance use resources in jails.

Workforce
- Promote the use of community college-level educated workforce who can be supervised by masters-level providers, especially in rural areas.
    o Engage educational institutions in creating a program that helps build community health workers.
- Leverage expertise across systems for cross training (e.g. medical, social services, dental, law enforcement).
    o Better use and training of "force multipliers," including mobile units, peer support services, first responders, law enforcement, etc.
    o Educate providers about trauma-informed care. Funding should be allocated to get providers the right training they need.
    o More training for naltrexone for overdoses.
- Improve peer support supervision and training.

Providers
- Create a comprehensive directory of providers, listing who is doing what in the community, what insurance they accept. Perhaps CCBHC's could help with this.
- Educate providers about how they can collaborate. Incentivize the providers to collaborate and meet standards. A strong provider association could possibly use the coalition model. Already a few groups or associations in the works.
- Educate providers about chronic pain management without opioids.

General or Systemic
- Address other root causes like poverty and supply of illegal substances into communities.
- Help people through better 'upstream' interventions – prevention and early intervention as well as appropriate levels of care within communities.
- Improve understanding of trauma and its effect on the lifespan.
- Begin prevention in early childhood with healthy attachment, stable families, and family support and parenting help. Connect prevention to all levels of education.
- Use the coalitions to identify and address duplications within communities.
- Partner with universities to provide education, training, and other system supports.
- Look to rural and frontier systems because they are creative and innovative with more engaged communities.
- Share information more broadly using technology to allow for more knowledge transfer, especially important when it comes to changes at the federal level. Leverage the information that is available from national resources and other states to improve practices within Nevada.

Appendices

Town Hall Meetings to Assess Critical Issues

Town Hall Meeting Summary: Las Vegas

Date: March 10, 2017

Time: 1:30 pm - 3 pm

Method

The purpose of the town hall meeting was to gather feedback regarding the critical issues identified by the SAPTA Strategic Planning Steering Committee as part of the strategic planning process. Participants were presented with a high-level overview of the situational analysis and then asked to provide their perspective on the mission, vision, concepts and values for the Strategic Plan, the needs identified via the Situational Analysis, and the critical issues recognized by the committee.

The meeting lasted a total of 1.5 hours.

Participants

26 total participants joined the Town Hall Meeting. Participants were asked to sign in and self-identify.

Self-identification	
Consumer	
Family Member	
SA Professional	12
Policy Maker	
Advocate	2
Multiple/Designations:	2
Unmarked	10

Summary of Feedback

Mission, Vision, Concepts, and Values

The mission, vision, concepts, and values were well-received by the group, with participants nodding in assent. One person suggested adding workforce development (education, training, investment, expansion) as a potential value.

Needs

The group agreed with the needs of the community identified in the presentation, emphasizing the importance of treatment for youth, workforce issues, housing and transportation, funding, and data capacity. Additionally, the group identified several needs that they did not see reflected in the overview of the Situational Analysis. Some of these needs were recognized as specific to Southern Nevada and some of them were acknowledged as problematic for the whole system.

Las Vegas Specific Needs

- Southern Nevada needs better representation at the state level in committees and workgroups.
- Provider collaboration is lacking:

- o Working together to provide the best service to clients. Some providers say: "If someone needs care, instead of losing a client, I will hold on to someone as long as I can even if I don't have space."
  - o Sharing programs and services.
  - o Focusing on funding versus the good of the community
- Some fraud exists within systems.
- People living in tunnels beneath the city represent a very hard to reach group with extreme needs.
- The sheer number of people in need of treatment or intervention is too great to be treated on demand.
- Gambling and the casino culture contribute to the substance abuse problem.

System-wide Needs

- Problem gambling needs to be screened for as a co-occurring disorder.
- Some people are resistant to getting the help they need.
- Individualizing care is challenging given what is available via providers and what is dictated by insurance.
- Services in the community are unknown and unverified.
- There is discomfort in providing referrals to services when there is not a relationship in place. Providers want to be confident that they are sending people to a service that they perceive as high quality.
- People are unable to navigate the system after discharge. This often leads to cycling back into intensive programs and criminal justice systems instead of moving into recovery.
- Legislative advocacy is needed to help support policies that promote health and reduce substance misuse and dependency (and stand against those that promote substance misuse or contributed to source issues).
- Loss of federal funding to prevent underage drinking is problematic and is anticipated to result in increased problems among children and youth.

Critical Issues and Opportunities:

The group responded to each critical issue separately, providing additional notes, and potential opportunities or strategies for addressing problems. Opportunities and/or potential strategies to address critical issues follow.

#1: STATE CAPACITY

- Outsource to qualified and high-quality resources.
- Data for treatment episodes and recovery services to support funding.

#2: LACK OF COMPLIANCE

- There was no feedback about this critical issue.

#3: LACK OF WORKFORCE TO MEET DEMAND

- Include cross-systems initiatives.
- Reciprocity is a barrier to entry. The vetting process for Nevada is not realistic.

#4: SERVICE GAPS

- Early intervention.

- Appropriate levels of care.
- Unequal funding of treatment and recovery services.
- Family recovery and support are lacking.
- Program evaluation has to be evidence-based.
- Basic barriers to entry in the system, like having an address.
- Lack of training for overdose.
- Special populations: Veterans, Native Americans, LGBTQ, African Americans, Women.

#5: INSUFFICIENT FUNDING AND SUSTAINABLE RESOURCES

- No grant-writing assistance or technical assistance.
- Grants are not regionalized.

#6: INSUFFICIENT PUBLIC EDUCTAION AND INFORMATION

- The problem affects the entire population including all classes and all people.
- There are barriers to getting information into schools.

Additional Critical Issues

The group identified "silioing" as a critical issue citing trust issues, lack of coordination, competition for funding, inability to coalesce around important advocacy issues, etc. Instead the group would like to see a focus on outcomes for people and the community.

Opportunities

The group identified several opportunities or potential strategies for the state including the following:

- Provide consumers with immediate access to evidence-based treatment.
- Expand use of "force multipliers," including mobile units, peer support services, first responders, etc.
- Ensure that medical professionals have access to reliable information about the resources available to people. A referring source should be specific, speak to both treatment types and outcomes, and have up to date information about how to connect people to the resources needed.
- Create a comprehensive directory of providers, listing who is doing what in the community, what insurance they accept. Perhaps CCBHC's could help with this in effort.
- Enhance collaboration among prevention and treatment providers.
- Bridge services from the hospital to treatment so that people don't have to navigate the system on their own.
- Look to rural and frontier systems because they are creative and innovative with more engaged communities.
- A strong provider association is necessary to promote collaboration and improved outcomes; it may be possible use the coalition model. There are already a few groups that could be strengthened to accomplish this goal.
- Empower the community at a grassroots level. Advocacy within the community.
- Connect prevention to all levels of education.
- Prevent overcrowding in places like the ER, jail, etc.
- Partner with universities to provide needs assessments, etc.

- Improve peer support supervision and training.
- Invest in telehealth services.
- Provide more training for naltrexone for overdoses.
- Educate providers about how they can collaborate. Incentivize the providers to collaborate and meet standards.
- Regionalize grants to ensure that they are aligned with local needs.
- Look at people holistically.

Town Hall Meeting Summary: Carson City

Date: March 13, 2017
Time: 1:30 pm - 3 pm

Method

The purpose of the town hall meeting was to gather feedback regarding the critical issues identified by the SAPTA Strategic Planning Steering Committee as part of the strategic planning process. Participants were presented with a high-level overview of the situational analysis and then asked to provide their perspective on the mission, vision, concepts, and values for the Strategic Plan; the needs identified via the Situational Analysis; and the critical issues recognized by the committee. At the end, they were asked to provide any further comments.

The meeting lasted a total of 1.5 hours.

Participants

26 total participants joined the Town Hall Meeting. Participants were asked to sign in and self-identify.

Self-identification	
Consumer	
Family Member	
SA Professional	14
Policy Maker	1
Advocate	5
Multiple Designations	1
Other: Educator	2
Unmarked	3

Summary of Feedback

Mission, Vision, Concepts, and Values

The mission, vision, concepts, and values were well-received by the group.

Needs

The group agreed that people are becoming more comfortable with talking about the issue of substance misuse and so there is more awareness in general in the community. However, the group identified several needs that they did not see reflected in the overview of the Situational Analysis.

Data Suggestions:

- Utilize youth probation data to better understand needs.
- Share key informant list to see representation of stakeholder groups.
- Review data by job type to understand trends among professionals that are in need of treatment.

System-wide Needs

- It is not clear what funding exists and how to connect people to resources that are available. Resources listed on the State website are out of date and there is not a reliable source of information.
- Health systems are not connected and so cannot server people fully, e.g. dental, behavioral, etc.
- Stigma is still strong among the Latino population, and this needs to be addressed to better serve people in Northern Nevada.
- There is a lack of funded programs that support treatment for opioid issues. This includes the population that is not considered 'highest need' financially but has everything to lose through dependency (e.g. the working poor and professionals with inadequate insurance).
- There is no direct funding to help the children of those with substance use disorders. Support for the family is important to recovery and also prevent related problems for other family members.
- Nurses and other professionals need additional training and funding for substance abuse issues.
- Funding is needed for more treatment services.
- Targeted case management is needed as part of treatment services.
- People with substance abuse issues are marginalized, even by some 'supportive' services. Stigma exists among some providers as well as the public at large.
- Insurance reimbursement is driving treatment options but is not necessarily delivering what people need.
- The cost of housing and lack of transitional housing is barrier.

Critical Issues and Opportunities

The group responded to each critical issue separately, providing additional notes, and potential opportunities or strategies for addressing problems. Opportunities and/or potential strategies to address critical issues follow.

#1: STATE CAPACITY

- Difficult to compare data across communities.
- Two-way communication with coalitions is a challenge.

#2: LACK OF COMPLIANCE

- Statute specified plan integration needs to be addressed.

#3: LACK OF WORKFORCE TO MEET DEMAND

- Knowledge capture and transfer is a problem among the workforce itself.
- Lack of rural workforce.
- Lack of trauma-informed care.

#4: SERVICE GAPS

- Lack of basic services like housing, transportation, and food can impede recovery.
- Very little prenatal and perinatal help for substance use.
- Prevention and intervention services needed.
- Transitional planning is not available from the corrections system.

- In rural and frontier areas, where the workforce may get injured in physical labor, there is a greater use of opioids. Workforce compensation claims are not being adequately handled by the state and contribute to these issues.

#5: INSUFFICIENT FUNDING AND SUSTAINABLE RESOURCES

- The problem is no that funding is insufficient; it is that money is not well-used or well-placed.
- Medicaid reimbursements are too low.
- Awareness about the funding provided by SAPTA needs to increase.
- Unbundled services are especially difficult to bill.
- Providers can't attend trainings because they have limited resources and can't bill for this time away. Need to help financially support providers to get the additional information and training they need.

#6: INSUFFICIENT PUBLIC EDUCATION AND INFORMATION

- Opioid patients are getting mixed information from their providers about best practices.
- Personal connections are required to help navigate the system.

Additional Critical Issues

The group emphasized the importance of regional and local control to address the needs of the populations, assist with local education, and certify and develop programs.

Opportunities

The group identified several opportunities or potential strategies for the state including the following:

- Strengthen progress made by partnerships with law enforcement to have an expanded role and impact in prevention and early intervention.
- Clarify language related to the field. Define what terms like substance abuse, mental illness, co-occurring disorders actually mean so that everyone uses them the same way.
- Share information more broadly using technology to allow for more knowledge transfer, especially important when it comes to changes at the federal level. Leverage the information that is available from national resources and other states to improve practices within Nevada.
- Use the coalitions to reduce duplications and identify service needs.
- Promote protective factors in communities to help prevent substance misuse.
- Develop grant transparency that will allow for a better understanding of what is available, who else is working on the same type of project, potential collaborations to better leverage funding, and improve long-range planning for funding.
- Provide accurate information to providers to refer.
- Promote the use of community college-level educated workforce who can be supervised by Masters level providers, especially in rural areas.
  - Engage educational institutions in creating a program that helps build skills of community health workers.
- Explore and support chronic pain treatment (trainings, best practices) that doesn't center on opioids.
- Enhance telehealth mechanism for rural Nevada.
- Leverage expertise across systems for cross training (e.g. medical, social services, dental, law enforcement).

- Educate providers about trauma-informed care.
- Help people through prevention, early intervention and with the right levels of care to avoided more expensive and difficult situations.
- Allocate funding to get providers the right training.
- Address underlying issues through awareness and training on trauma, ACEs, etc.
- Begin prevention in early childhood with healthy attachment, stable families and family support and parenting.
- Improve care management and wraparound services.
- Build in flexibility of this plan to address emerging issues, understand what is happening in communities and consider block grants to the community to disburse. ("One size does not fit all!")
- Revisit state integrated systems for concrete, collaborative actions.
- Create a system that allows consumers to provide regular feedback about what they need. This could be through interviews, a form completed by funded providers, or, other mechanisms. Review this data to help inform system improvements.

Town Hall Meeting Summary: Elko

Date: March 14, 2017
Time: 1:30 pm -3 pm

Method

The purpose of the town hall meeting was to gather feedback regarding the critical issues identified by the SAPTA Strategic Planning Steering Committee as part of the strategic planning process. Participants were presented with a high-level overview of the situational analysis and then asked to provide their perspective on the mission, vision, concepts, and values for the Strategic Plan; the needs identified via the Situational Analysis; and the critical issues recognized by the committee. At the end, they were asked to help prioritize these issues.

The meeting lasted a total of 1.5 hours.

Participants

12 total participants joined the Town Hall Meeting. Participants were asked to sign in and self-identify.

Self-identification	
Consumer	
Family Member	
SA Professional	5
Policy Maker	
Advocate	4
Multiple Designations	
Unmarked	3

Summary of Feedback

Mission, Vision, Concepts, and Values

The mission, vision, concepts, and values were well-received by the group. One person suggested timely treatment as an important aspect of the value regarding effective and quality treatment.

Needs

The group agreed that the local community is engaged in the issues. However, the group identified several needs that they did not see reflected in the overview of the Situational Analysis. Some of these needs were recognized as specific to the frontier region or Elko and some of them were acknowledged as problematic for the state as a whole.

Data Suggestions
- Review regional assessments developed by coalitions.

Frontier/Elko Specific Needs
- Frontier communities have unique challenges and need flexibility to meet those needs. Many of the solutions that work in urban or even rural areas are not feasible in frontier communities.

- It is difficult for providers to get sufficient education locally including CEU's and higher-level education.
- The location makes it challenging to maintain a workforce. Professionals who are brought to the community from other areas often don't stay long. They are trained, organizations or agencies invest time and money in training them, and as soon as they find a job somewhere else they leave. Being able to recruit and train people within our community for our community shows promise for creating and maintaining a qualified workforce.
- Telehealth shows promise but cannot be used with some populations including children and those with the most acute needs. Improvements to internet infrastructure are also needed for telehealth to fulfill its promise.
- While a strength of frontier communities is the ability of people to 'wear many hats,' burnout is common because people are trying to help with such a broad spectrum of issues and cover so many needs.

System-wide Needs

- People ending up incarcerated when they really needed treatment instead.
- There is not sufficient capacity to address co-occurring disorders. Training and professional development is needed, including how to properly diagnose and refer people with co-occurring disorders.
- There is a high suicide rate, and this relates to substance use disorders (and people not getting the help that they need).
- Need to have information about what the legalization of recreational marijuana looks like and mitigate negative impacts.
- Providers experience paperwork overload, working in multiple data system (often to report the same data for different requirements). Providers cannot bill for their time completing the documentation required. Also, this communication is 'one-way'; it is not provided back in a way that supports providers to improve outcomes.
- Many funding cycles are built using data that is several years old, and therefore, solutions are reactive instead of proactive.
- Insurance causes problems with continuity of care, especially if there are insurance coverage gaps. Additionally, insurance doesn't necessarily cover what patients need.
- Changes to insurance coverage often result in provider changes. People often have to request and be responsible for their own records. Transitions of providers can also be very difficult.
- People in poverty are people at risk of substance misuse. The lifestyle supported by selling can be a draw and difficult to exit, especially when it is very difficult to get by on low-paying, low-skilled jobs.
- The older adult population has emerging needs; for example, people are affected by prescription misuse. It is also important to consider that adults with substance misuse age, but if untreated, their issues continue. Managing multiple prescriptions can be a challenge as well; while there is a database that connects pharmacists, the system is not perfect. People also may cross state lines for care which makes coordination of providers and medications more challenging.

- Pain medication is a complex issue. While it is important to control access, and reduce the possibility of dependency, people needing medication can have difficulty getting it or face stigmatization in requesting what they need. Doctors face challenging decisions with little information about how to make the best decisions with and for their patients.

Critical Issues and Opportunities

The group responded to each critical issue separately, providing additional notes, and potential opportunities or strategies for addressing problems. Opportunities and/or potential strategies to address critical issues follow. The group had nothing further to add to the first two critical issues as they were presented, nor to the fifth.

#3: LACK OF WORKFORCE TO MEET DEMAND

- Knowledge capture and transfer is a problem among the workforce itself.

#4: SERVICE GAPS

- People with acute conditions are sent to Reno. There is no local acute treatment or long-term care, and many people have no transportation to return to Elko. This can be especially problematic for youth.
- There is a lack of youth and family services, especially services to support youth whose parents are in treatment. It is critical that families have support when a parent has left the area, including appropriate information.
- Better wraparound services are needed.
- Transportation even with the local area is a challenge for providing complete care.

#6: INSUFFICIENT PUBLIC EDUCATION AND INFORMATION

- Lack of time and staff to receive the training and knowledge that already exists within the community. Professionals across the spectrum, including first responders, etc. need to be given time to participate in trainings to address stigma, suicide prevention, etc.

Additional Critical Issues

The group emphasized the importance of regional and local control to address the needs of the populations, assist with local education, and certify and develop programs.

Opportunities

The group identified several opportunities or potential strategies for the state including the following:

- Help people get in touch with the correct resources.
- Expand mental health and substance use treatment in jails.
- There are many best practices in the Elko area, but there are not always resources or assistance to support monitoring and evaluation. As a result, the process (utilization of the best practice) and outcomes are not well understood.
- Identify barriers at the local level and work on them to work better together. Elko is in the process of developing a needs assessment that will help to inform decisions.
- Improve screening and assessment to get individuals where they need to be instead of sending them to jail. Additionally, establish a diversion program to keep people out of jails.
- Invest in local people as the workforce and help them to grow professionally and serve their community. Expand local educational opportunities through Great Basin Community College.

- Address awareness in families and in schools and educate about risk factors like trauma in early childhood.
- Address root causes like poverty and social determinants of health. Also consider opportunities to cut or reduce the supply of illegal drugs into the area.
- Improve infrastructure for telehealth needs including internet resources and provider training.
- Employ a rural coordinator.

Priorities

The group identified more beds for treatment and more providers as a key priority, as well as prevention efforts.

Center for Community Capacity Development Prioritization Criteria

On July 14, 2015, the Behavioral Health Planning and Advisory Council met to review Nevada's behavioral health, gaps and priorities, and recommendations meta-analysis summary report and Nevada's Behavioral Health Barometer. Following the presentation of data and discussion by the Council, public comment on both documents was heard.

A rating tool, based on Illinois's Public Health Institute, Center for Community Capacity Development Prioritization Criteria was used to rate priority issues as outlined in the meta-analysis summary and quantified in the Behavioral Health Barometer. Needs and gaps were rated as high, medium and low by Council members using the following criteria:

- Important to the Community/Seriousness of not addressing
- Size of the problem
- Feasibility
- Disparities and subpopulation needs

Results of the ratings were presented back to the Council for further deliberation. The top needs and gaps adopted by the Council included:

1. The need for Behavioral Health Capacity building related to: (a) costs, (b) degree program capacity, (c) recruitment and retention, (d) clinical supervision, and (e) clinical site availability to address the behavioral health workforce shortage, poor workforce retention/high staff turnover rates, low wages and front-line staff burnout,
2. The need to enhance prevention of substance abuse and mental illness including limited crisis intervention services, early intervention services and early identification and intervention for at-risk populations,
3. The need to enhance person-centered planning and recovery supports including lack of affordable housing options, peer support services, habilitative services and supports, and to confront cultural and community stigma associated with needing or seeking services

Recommendations in the meta-analysis were rated by Council members with each member submitting their top five recommendations. The results were presented back to the Council for further deliberation. The recommendations adopted by the Council included:

Strategic Initiative #1: Prevention of Substance Abuse and Mental Illness

1. Improve screening, assessment, and referral services for at-risk populations

2. Support earlier access to prevention and early intervention services

3. Increase community-based services across the system of care

Strategic Initiative #2: Health Care and Health Systems Integration

1. Provide behavioral health services in primary care and non-traditional settings

2. Enhance collaboration between behavioral health and other systems of care

Strategic Initiative #3: Trauma and Justice via Trauma-informed Approach

    1.   Provide community-based intervention and support to address trauma and prevent incarceration

Strategic Initiative #4: Person-centered Planning and Recovery Supports

    1.   Prioritize community-based strategies and solutions that enhance the system of care

    2.   Improve discharge planning and transition support

Strategic Initiative #6: Workforce Development

    1.   Increase the number and quality of behavioral health professionals in Nevada

    2.   Remove barriers to behavioral health professional licensure and certification

Rating Analysis:
Average Scores of Strategic Initiatives

Strategic Initiative	Average Score
Strategic Initiative 1: Prevention of Substance Abuse and Mental Illness	173.0
Strategic Initiative 2: Health Care and Health Systems Integration	168.3
Strategic Initiative 3: Trauma and Justice via Trauma-informed Approach	138.5
Strategic Initiative 4: Person-Centered Planning and Recovery Supports	179.6
Strategic Initiative 5: Health Information Technology	156.3
Strategic Initiative 6: Workforce Development	176.6

Certified Community Behavioral Health Clinics Focus Group Summary

Focus groups were also recently completed for the Community Behavioral Health Clinics Focus Group (CCBHC) planning process. Several needs were identified and are summarized here:

Service Needs

- Need for mobile, in-home (including home visiting programs for children and families) and on-line services
- Satellite clinics throughout the community also suggested in Elko
- Jail based assessment and support identified at both rural and urban sites
- 24/7 linkage to crisis services and a "live person" identified by both rural and urban sites and providers and consumers
- Need for more of all services identified by both rural and urban sites and providers and consumers with focus on volume in urban areas and infrastructure in rural areas

Focus Group Results: Workforce and Staffing

- Workforce shortage issues identified by all groups and linked to wait times for services
- Psychiatrists, Clinical Psychologists, School Social Workers in need
- Emphasis on Peer Support
- Specialty staffing needs vary by site but include geriatric and children's services specialists including developmental screening
- Other staffing needed included job developers, community points of contact for Information and Referral (I&R), Transportation aids

Care Coordination to Date

- Enhanced collaboration, coordination and communication including shared data and access to electronic records identified by both rural and urban sites and providers and consumers
- Ongoing care and care coordination in the form of agreements, barrier reduction and facilitation of access was a universal theme
- Linkages to specialty courts, jails, hospitals, schools and primary care physicians identified by all sites and in varying degrees by both types of participants
- More school social workers identified as a need at both rural and urban focus groups

Scope of Services to Date

- Evidence Based Practices concepts were supported by all groups and sites
- More prevention and treatment options were also supported by all groups and sites
- School based and jail based services specifically identified
- Crisis services and training of all provider types both on resources, eligibility and how to manage persons in crisis was a universal theme
- Peer and family support services were also suggested by all groups and sites
- Supportive services including education assistance, job training, life and basic skills, more 12 step options were all identified to varying degrees at all sites and by both types of participants
- Lack of sufficient gambling addiction services noted at both rural and urban locations
- Lack of housing options identified at every focus group with emphasis varying based on location or type (homeless, homeless youth, sex offenders, domestic violence)

Other Issues Identified

- Lack of cultural and linguistic services, especially Spanish speaking providers, assessors, therapists etc.
- Need for Behavioral Health Coordinator in Elko
- Social stigma and community and provider education identified at all sites and by all groups
- Need for veteran specific services and access to VA Hospital (Elko)

Glossary of Terms and Acronyms

Behavioral Health: Refers to a state of mental/emotional being and/or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders. This includes a range of problems from unhealthy stress to diagnosable and treatable diseases like Serious Mental Illnesses (SMIs) and substance use disorders (SUDs), which are often chronic in nature but that people can and do recover from. The term is also used to describe the service systems encompassing the promotion of emotional health; the prevention of mental and substance use disorders; substance use and related problems; treatments and services for mental and substance use disorders; and recovery support (SAMHSA).

CCBHC: Certified Community Behavioral Health Clinics. CCBHCs were created through Section 223 of the Protecting Access to Medicare Act (PAMA). CCBHCs may receive an enhanced Medicaid reimbursement rate based on their anticipated costs of care. CCBHCs are responsible for directly providing or contracting with partner organizations to provide different types of services, with an emphasis on the provision of 24-hour crisis care, utilization of evidence-based practices, care coordination, and integration with physical health care.

CFR: Code of Federal Regulations

Charitable Choice: Provisions of the SAMHSA Charitable Choice regulations are designed to strengthen the capacity of faith-based and other neighborhood organizations to deliver services effectively to those in need and provide people with a choice of SAMHSA-supported substance use prevention and treatment programs. Provisions also ensure that funding administered by SAMHSA is accomplished without impairing the religious character of such organizations and without diminishing the religious freedom of SAMHSA beneficiaries.

Co-Occurring Disorder: People who have substance use disorders as well as mental health disorders are diagnosed as having co-occurring disorders, or dual disorders. This is also sometimes called a dual diagnosis. Substance use disorder. A substance use disorder includes. Alcohol or drug abuse (Behavioral Health Evolution, n.d.)

DPBH: Division of Public and Behavioral Health

NAC: Nevada Administrative Code

NRS: Nevada Revised Statutes

Person-and Family-centered Planning: According to SAMHSA, "Person- and family-centered treatment planning is a collaborative process where care recipients participate in the development of treatment goals and services provided, to the greatest extent possible."

Prevalence: is a measure of disease that allows us to determine a person's likelihood of having a disease. Therefore, the number of prevalent cases is the total number of cases of disease existing in a population.

Recovery Oriented System of Care (ROSC): a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resilience of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.

SABG: Substance Abuse Block Grant. Federal grant administered by SAPTA.

SAMHSA: Substance Abuse and Mental Health Services Administration.

SAPT Grant: Substance Abuse Prevention and Treatment Grant. See SABG.

SAPTA: Nevada's Substance Abuse and Treatment Agency.

Serious Mental Illness (SMI): Serious mental illness among people ages 18 and older is defined at the federal level as having, at any time during the past year, a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities. Serious mental illnesses include major depression, schizophrenia, and bipolar disorder, and other mental disorders that cause serious impairment. In 2014, there were an estimated 9.8 million adults (4.1%) ages 18 and up with a serious mental illness in the past year. People with serious mental illness are more likely to be unemployed, arrested, and/or face inadequate housing compared to those without mental illness (Substance Abuse and Mental Health Services Administration., 2015).

Serious Emotional Disturbance (SED): Serious emotional disturbance. The term serious emotional disturbance (SED) is used to refer to children and youth who have had a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities. A Centers for Disease Control and Prevention (CDC) review of population-level information found that estimates of the number of children with a mental disorder range from 13 to 20%, but current national surveys do not have an indicator of SED (Substance Abuse and Mental Health Services Administration., 2015).

SSA: Single state agencies (SSAs) and state mental health agencies (SMHAs) are the state government organizations responsible for planning, organizing, delivering, and monitoring critical mental health and substance use disorder services in each state. SSAs and SMHAs provide safety-net services to individuals with mental and substance use disorders (M/SUDs) who lack insurance and/or have high levels of service needs. (Substance Abuse and Mental Health Services Administration., 2015).

Substance Use Disorder (SUD): The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), no longer uses the terms substance abuse and substance dependence, rather it refers to substance use disorders, which are defined as mild, moderate, or severe to indicate the level of severity, which is determined by the number of diagnostic criteria met by an individual. Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social

impairment, risky use, and pharmacological criteria (Substance Abuse and Mental Health Services Administration., 2015).

Trauma-Informed Approach: According to SAMHSA, a trauma-informed approach, "A program, organization, or system that is trauma-informed: realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization" (Substance Abuse and Mental Health Services Administration, 2015).

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