Nevada Substance Abuse Prevention and Treatment Agency

Capacity Assessment Report: Nevada

July 2019

Nevada Department of Health and Human Services

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

Acknowledgements

The Bureau of Behavioral Health, Wellness and Prevention would like to recognize members from the Northern region, Rural region, Southern region - Clark County, Southern Rural region, and Washoe region for their input and contributions to this report. This report was developed with the guidance and support of the Regional Behavioral Health Coordinators from each region.

Guidance on CAST and priorities were provided by community stakeholders, members of the Regional Behavioral Health Policy Boards and Regional Behavioral Health Coordinators, including:

- Ariana Saunders, Clark County Regional Behavioral Health Coordinator

- Dorothy Edwards, Washoe County Regional Behavioral Health Coordinator

- Jessica Flood, Northern Rural Regional Behavioral Health Coordinator

- Kim Johnson, Nye Communities Coalition Prevention and Wellness Director

- Mary Duffy, Former Nye Communities Coalition Director of Community Building

- Valeria Cauhape, Rural Regional Behavioral Health Coordinator

- Members of the Clark County Regional Behavioral Health Policy Board

- Members of the HOPE Committee, facilitated by the Nye Communities Coalition

- Members of the Northern Rural Regional Behavioral Health Policy Board

- Members of the Rural Regional Behavioral Health Policy Board

- Members of the Washoe County Regional Behavioral Health Policy Board

This report would not have been possible without the support of the CAST model's primary author, Dr. Brandn Green. His work to adjust estimates in the tool to reflect region specific differences were invaluable in making the tool a resource that could inform decision-making throughout each region.

Social Entrepreneurs, Inc., a company dedicated to improving the lives of people by helping organizations realize their potential, conducted assessment activities for the project and developed this report.
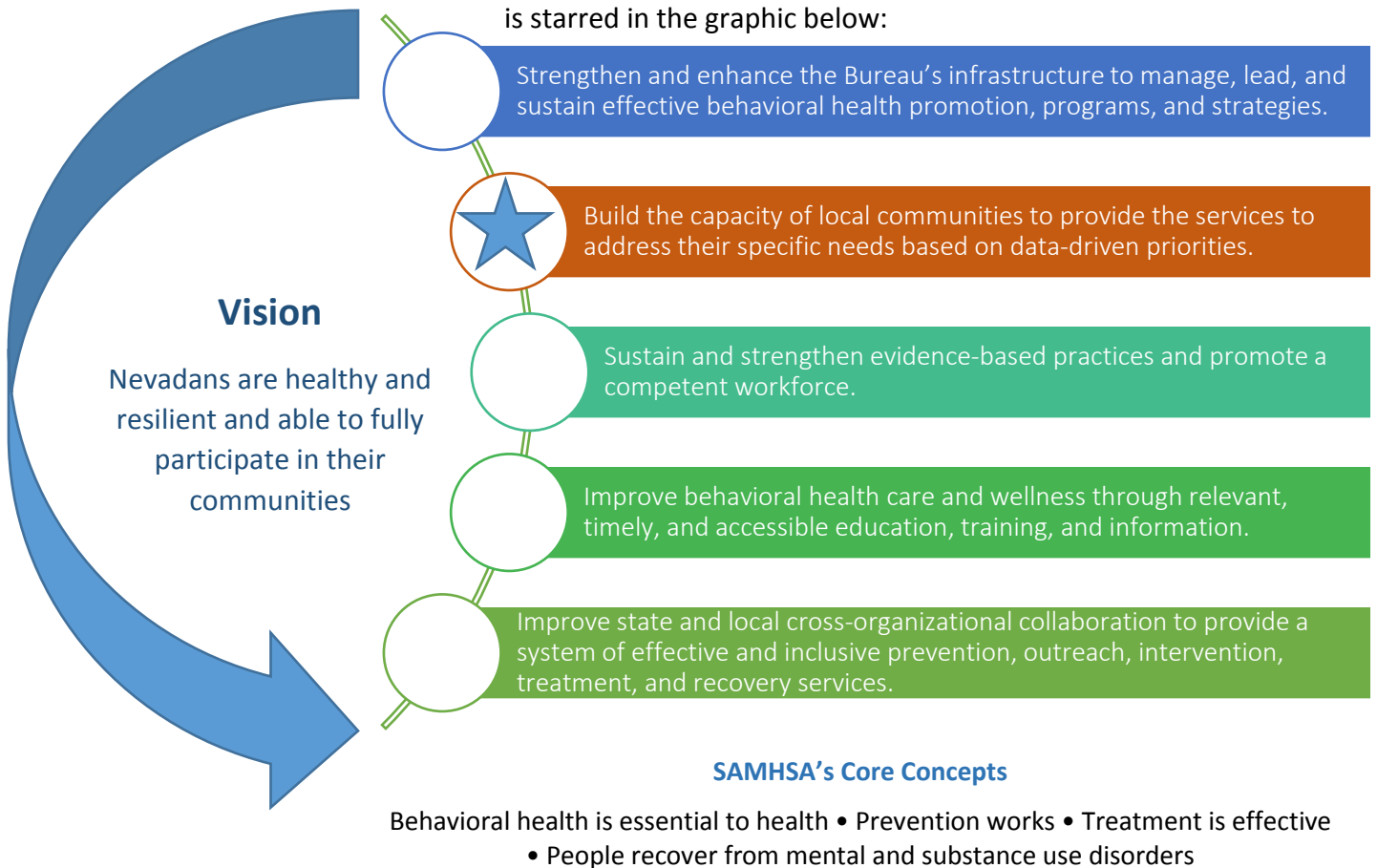
Contents

Background and Introduction

Substance Abuse Prevention and Treatment Agency

This report was commissioned by Nevada's Substance Abuse Prevention and Treatment Agency (SAPTA), which is part of the Bureau of Behavioral Health, Wellness and Prevention (BBHWP) within the Division of Public and Behavioral Health (DPBH). SAPTA plans, funds, and coordinates Nevada's statewide substance use disorder service delivery system, which is the primary focus of this regional capacity assessment effort.[1] SAPTA's key roles include distributing funds (tax dollars, general fund, and grants), creating and implementing statewide plans for substance use disorder services, and developing standards for certification of programs and services.

In 2017, SAPTA updated its strategic plan with a focus on promoting healthy behaviors and reducing the impact of substance use and co-occurring disorders for Nevada's residents and communities. The following vision and the U.S. Substance Abuse and Mental Health Services Administration's (SAMHSA) core concepts were adopted in the plan.

The goals outlined in the strategic plan include the following and the focus of this report is starred in the graphic below:

Vision

Nevadans are healthy and resilient and able to fully participate in their communities

Strengthen and enhance the Bureau's infrastructure to manage, lead, and sustain effective behavioral health promotion, programs, and strategies.

Build the capacity of local communities to provide the services to address their specific needs based on data-driven priorities.

Sustain and strengthen evidence-based practices and promote a competent workforce.

Improve behavioral health care and wellness through relevant, timely, and accessible education, training, and information.

Improve state and local cross-organizational collaboration to provide a system of effective and inclusive prevention, outreach, intervention, treatment, and recovery services.

SAMHSA's Core Concepts

Behavioral health is essential to health • Prevention works • Treatment is effective • People recover from mental and substance use disorders

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[1] SAMHSA defines **behavioral health** as "a term used to refer to both mental health and substance use" (www.integration.samhsa.gov/glossary). For this report, behavioral health is primarily used to refer to substance use and substance use disorders (SUD) rather than mental health, as the scope of the capacity assessment was limited to the SUD service system.

Regional Behavioral Health Policy Boards

 Created by the 2017 Nevada Legislature, the Regional Behavioral Health (RBH) Policy Boards (Northern, Washoe, Rural and Southern regions) consist of 13 members each and, in accordance with NRS 433.4295, advise DBPH on matters pertaining to behavioral health issues, promote improvements in the delivery of behavioral health services, coordinate with other regional policy boards and submit a report to the Commission on Behavioral Health.[2] The RBH Policy Boards oversee behavioral health planning and resource development for each region in Nevada. For the purpose of this report, the Southern region included two assessments. One assessment focused specifically on Clark County, while the other focused on Nye and Esmeralda Counties as the rural counties in the region. Throughout the report these two assessments are referred to as Southern region – Clark County and Southern Rural region.

SAMHSA's Strategic Prevention Framework

SAMHSA's Strategic Prevention Framework (SPF)[3] is one tool that RBH Policy Boards can utilize as a resource to guide their efforts. The SPF is a planning process for preventing substance misuse. The five steps (assessing needs, building capacity, planning, implementing and evaluating the plan's implementation) and two guiding principles (sustainability and cultural competence) of the SPF offer prevention professionals a comprehensive process for addressing the substance misuse and related behavioral health problems facing their communities.

Figure 1: SAMHSA Strategic Prevention Framework (SPF)

The SPF begins with establishing a clear understanding of community needs and involves community members in all stages of the planning process. This project is designed to address Steps 1 and 2, *Assess Needs* and *Build Capacity*.

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[2] Retrieved on May 28, 2019 from http://dpbh.nv.gov/Boards/BoardsCouncils2/
[3] Retrieved on March 31, 2019 from https://www.samhsa.gov/capt/applying-strategic-prevention-framework

Purpose of Report

The purpose of Capacity Assessment Report is to help SAPTA understand:

SUD prevention and treatment systems, unmet need and hospitalization risk by region

Scope and location of existing SUD prevention and treatment services by region

Trends across programs, regions and at the state level

This report offers SAPTA capacity building priorities for each region in Nevada as well as priorities identified by SAPTA funded providers, based on an organizational assessment. It also includes research around best and promising practices to support the regional priorities identified.

Methods and Approach

Assessment of Systems Capacity

In order to identify capacity at the regional level, SEI used information gathered from The Calculating and Adequate System Tool (CAST), which was developed for the Substance Abuse and Mental Health Services Administration (SAMHSA). Notes from the lead developer of the tool can be found in Appendix A.

SEI conducted research from publicly available sources for every county and region in Nevada, based on guidance from the CAST. Sources of data can be found in Appendix B.

Assessment of Community Needs

To assess community needs by region, public data was collected by zip code and region. Additional documents were collected and reviewed to inform the report and provide context for the regional system and its capacity. Lists of additional documents reviewed can be found in Appendix C.

Assessment of Program Capacity

SAPTA funded programs were invited to participate in a free, online organizational assessment. The assessment used was the McKinsey & Company Organizational Capacity Assessment Tool (OCAT).

Descriptions of each tool and the methodology utilized for each tool can be found later in this report. The CAST Assessment is described on the following pages. The OCAT description can be found later in this report.

CAST Assessment

In 2019, as part of an effort to understand current statewide and regional capacity for Substance Use Disorder (SUD) prevention and treatment services and establish priorities to build future capacity, SAPTA conducted a system-wide assessment using the CAST. Social Entrepreneurs, Inc. (SEI) was engaged by the state to facilitate completion of the CAST at the regional level, in collaboration with Nevada's Regional Behavioral Health Coordinators (RBHCs).

The CAST Model

CAST was developed by an interdisciplinary group of researchers at SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ) in 2016. Since this publication, CAST has been updated, and a manual was recently developed which describes the purpose of CAST as follows:

> "CAST was created as a method for evaluating the capacity of the substance abuse care system within a defined geographic area. CAST provides users with both a risk assessment of county-level social and community determinants of substance abuse, and an assessment of local service need across the continuum of care […] CAST uses social determinants of behavioral health and social disparities in behavioral health outcomes to provide insight into the chronic social conditions that may be contributing to behavioral health outcomes in your community. Most often, CAST has been used to estimate need for a county as the geographic unit, but it can be used for smaller or larger areas, as long as data at those geographic levels is available or could be produced at that scale." (p. 3)

The first iteration of CAST was a proof of concept that was tested in two pilot regions (Chicago and Newaygo County MI), leading to the publication of an article in Preventing Chronic Disease. There were two basic goals built into the CAST model, which were to:

- Quantitatively assess the relative risk that a population had for adverse outcomes related to alcohol or drug use.
- Provide a mathematical method for comparing the observed totals of the substance misuse care continuum components that existed within a community to research informed estimate of need for that community.

By providing two distinctive community assessment methodologies, CAST provides information to community leaders about both the people who live in their place and the composition of their SUD care system. When taken together, these elements help to define the demand, need, and current service capacity of a community behavioral health care system related to SUD prevention, intervention, and treatment. The two complimentary assessments that inform the CAST are the Risk Score and the Community Capacity Calculator. Both are described further in the CAST Results section.

The CAST was used to generate estimates of need that can help to inform community or organizational planning efforts in Nevada. RBHCs were asked to assist by:

➢ Identifying and convening community stakeholders
➢ Assisting in data collection of local assets and resources
➢ Reviewing data collected by SEI
➢ Validating data
➢ Facilitating community meetings with SEI support to solicit information from community stakeholders
➢ Reviewing and providing input on the CAST summary for their region

A handbook was developed and provided to the RBHCs to assist in the collection of specific data to produce estimates of regional service capacity and need. This handbook included:

• An overview of the data required for CAST and an overview of the data collection approach
• Tools to assist in each step of the data collection approach, including:
    o Outlines of the process, timing, and responsibilities
    o Guidance, suggestions, and tips
    o Templates for communication and data collection
    o Electronic surveys customized for each region
    o Handouts and worksheets
    o Assessment component definitions and units of measure for reference

To populate the CAST for the individual regions, both primary (publicly available) and secondary (regionally available) data was collected. Independent research was conducted in the first quarter of 2019. SEI contacted regional resources and worked with the RBHCs to compile data and seek information through publicly available sources.

> Additional information regarding the CAST tool and the method for conducting the assessments are found throughout the document within blue call-out boxes to assist the reader in understanding each component of the assessment and how results were tabulated.

OCAT Assessment

In addition to CAST, SEI worked with funded SAPTA providers (who voluntarily applied to participate) to conduct, complete, and review the McKinsey & Company Organizational Capacity Assessment Tool (OCAT) assessments for their organizations. The OCAT is an in-depth survey that allows the board, leadership, and staff of a nonprofit to measure how well their organization performs against best practices.[4] The OCAT measures organizational capacity within ten essential elements which are described in the results section. For the purposes of this report, SEI has combined all OCAT scores and displayed findings in aggregate to protect organizational anonymity.

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[4] Retrieved on July 27, 2018 from: https://www.mckinsey.com/industries/social-sector/how-we-help-clients/organizational-capacity-assessment-tool

Timeline

The following is a timeline of activities conducted throughout the project:

Month	CAST Assessments	OCAT Assessments
January 2019	• Orientation of CAST tool for RBHCs • Tools and resources provided to assist RBHCs in data collection efforts	-
February 2019	• Webinar conducted with RBHC's to review tools, resources and process • Surveys established and distributed to RBHC's to assist with data collection • Research conducted on community resources and social determinants of health	-
March 2019	• Initial CAST data collection was input into region specific CAST tools • SEI met with RBHCs to review preliminary results • SEI worked with CAST author to revised CAST tool to meet unique needs of each region	• OCAT Tools developed for SAPTA providers
April 2019	• SEI facilitated calls with RBHCs and the CAST author to adjust and validate regional specific variances to the CAST • SEI met with RBHCs to review and finalize results based on custom regional CAST tools • SEI developed a PowerPoint of results for presentation to Policy Boards and other stakeholders	• Invitation to participate in OCAT process distributed to SAPTA funded providers • SEI hosted informational OCAT webinar • SEI conducted outreach to encourage participation
May 2019	• CAST priorities were set within each region • SEI established Regional Capacity Reports • RBHC's provided feedback to finalize Reports • SEI presented results to multiple Policy Boards	• OCATs completed by participating organizations • OCAT results compiled and reviewed by SEI
June 2019	• CAST priorities were validated by RBHCs • SEI drafted Statewide Capacity Assessment Report using Regional Capacity Reports and Individual Program Capacity Building Plans	• SEI conducted site visits with participant organizations to review OCAT results and set priorities • SEI completed Individual Capacity Building Plans
July 2019	• Final version of the Capacity Assessment Report provided to SAPTA leadership for review • SEI met with SAPTA leadership to review report and identify revisions • Delivery of Final Report	

SEI worked in partnership with the RBHCs, their policy boards and other community stakeholders in each region to ensure efficient and accurate data collection.[5]

Limitations and Assumptions

1. CAST: Regional characteristics are based on social determinants of health for the whole population of a region and are not limited to low-income or Medicaid populations.

2. CAST: Data collected about resources change regularly. The data contained within this report and provided to each region depicts the system at a particular point in time and serves as a baseline for the region. It is likely that over time resources will differ from those described in CAST and depicted in maps which were generated in April 2019.

3. CAST: The numerical estimates are intended to provide a succinct and universal understanding of the care system. This is a view that is missing from assessment methodologies that utilize public surveys and focus groups, hence the value. Assessment using the CAST method occurs within a complex social environment of varied priorities and perspectives. The numbers were used to help facilitate conversations in a way that can be more precise and more informed. However, it was dependent on the degree to which engagement with community stakeholders provided input, which varied by region.

4. CAST: Numeric estimates indicate the quantity of services at a point in time of the project (April 2019). However, an assessment of the quality of the services counted was not included in the scope of this report.

5. CAST: CAST is limited by the availability of high-quality data about each component of the care system. Users should be careful to document their sources and use those same sources for any future assessment.

6. CAST: CAST is limited by the generalness of the terms used for each component. For example, "school-based prevention programs" can vary widely depending on the evidence-based approach selected and/or the population of focus that is being addressed. Adjustments to usage rates and population totals were made in collaboration with RBHCs to address much of this variation, but there is still a level of estimation and error in this approach, since very precise differences between programs will be overlooked and replaced with place-informed estimates of populations receiving services and program delivery methods.

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[5] For more information about the technical calculations, processes, and methods of producing CAST, please refer to the CAST Manual published in 2018.

7. CAST: CAST is limited by the nature of population-level surveillance of alcohol and drug use in the United States. The National Survey on Drug Use and Health (NSDUH) is the standard method for estimating use prevalence, but this survey, updated annually, provides state-level data only. This means that county and regional-level estimates must be extrapolated from NSDUH state-level prevalence estimates. Many counties and regions are anecdotally different from their state average. This has the effect of minimizing differences among counties or regions with high use rates or very low use rates.

8. CAST: Risk modeling for CAST was undertaken at the county-level. Analysis that attempts to aggregate totals across a region, as was done during this project, will likely lose some variation.

9. OCAT: While outreach was done through the SAPTA listserv, Regional Behavioral Health Coordinators and one-on-one contacts, the number of providers who applied to participate in the OCAT process was significantly less than the target. It is not possible to draw broad assumptions about the capacity building needs of SAPTA funded providers based on the small sample size.

10. OCAT: The OCAT is a self-assessment. All results are therefore subjective. While meetings were held with each organization to discuss areas where there was a lack of consensus, the aggregate scores for the organization averages the ratings of each respondent, regardless of the level of consensus by question.

Regional Assessment Results

The following regions were assessed as a component of this report:

Northern region

•Encompassing Storey, Carson City, Douglas, Lyon, Mineral, and Churchill Counties

Rural region

•Encompassing Elko, Eureka, Humbolt, Lander, Lincoln, Pershing and White Pine Counties

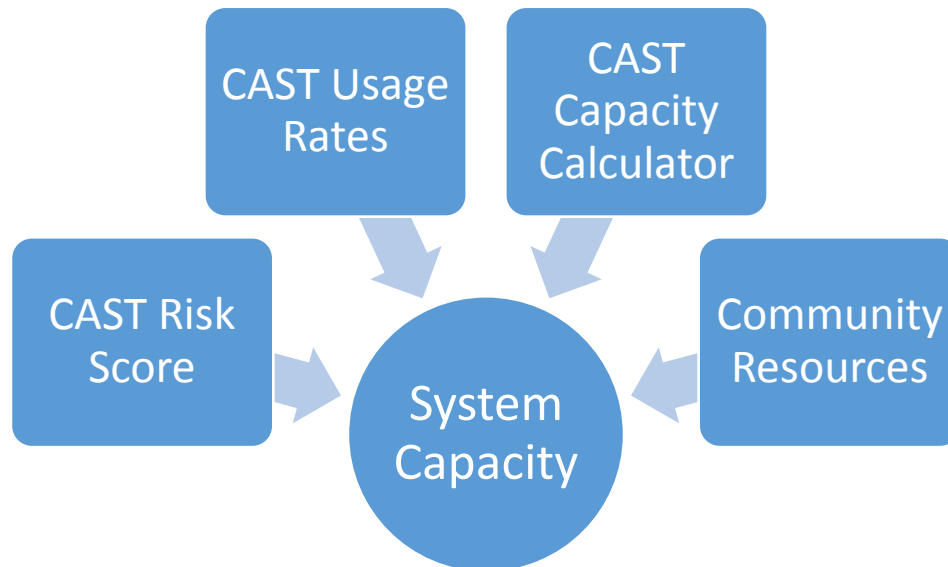### Southern region – Clark County

•Encompassing Clark County

Southern Rural region

•Encompassing Esmeralda and Nye Counties

Washoe region

•Encompassing Washoe County

This section presents a high-level summary of each region's SUD prevention and treatment system capacity, to include:

CAST Regional Risk Score

The Risk Score uses a social determinants of behavioral health framework and operationalizes this framework at the regional level by calculating the risk contribution of the region's social determinants of health and health disparities to the likelihood that the region's hospitalization rate for SUDs will be above the national median hospitalization rate for SUDs. CAST uses a color-coding mechanism to provide a visual benchmark to users about a county's or region's general risk level as compared to other counties across the United States for hospitalization due to SUDs. There three risk levels by color code include:

a. **Low risk** (green) – The aggregated and calculated risk score for a community is equal to or lower than the national median for hospitalization due to drug/alcohol diagnosis.

b. **Medium risk** (yellow) – The aggregated and calculated risk score for a community is between 0-25% above that of the national median for hospitalization due to drug/alcohol diagnosis.

c. **High risk** (red) – The aggregated and calculated risk score for a community is more than 25% above that of the national median for hospitalization due to drug/alcohol diagnosis.

Table 1. Risk Level of Hospitalization for Drug or Alcohol Related Cause by Region[6]

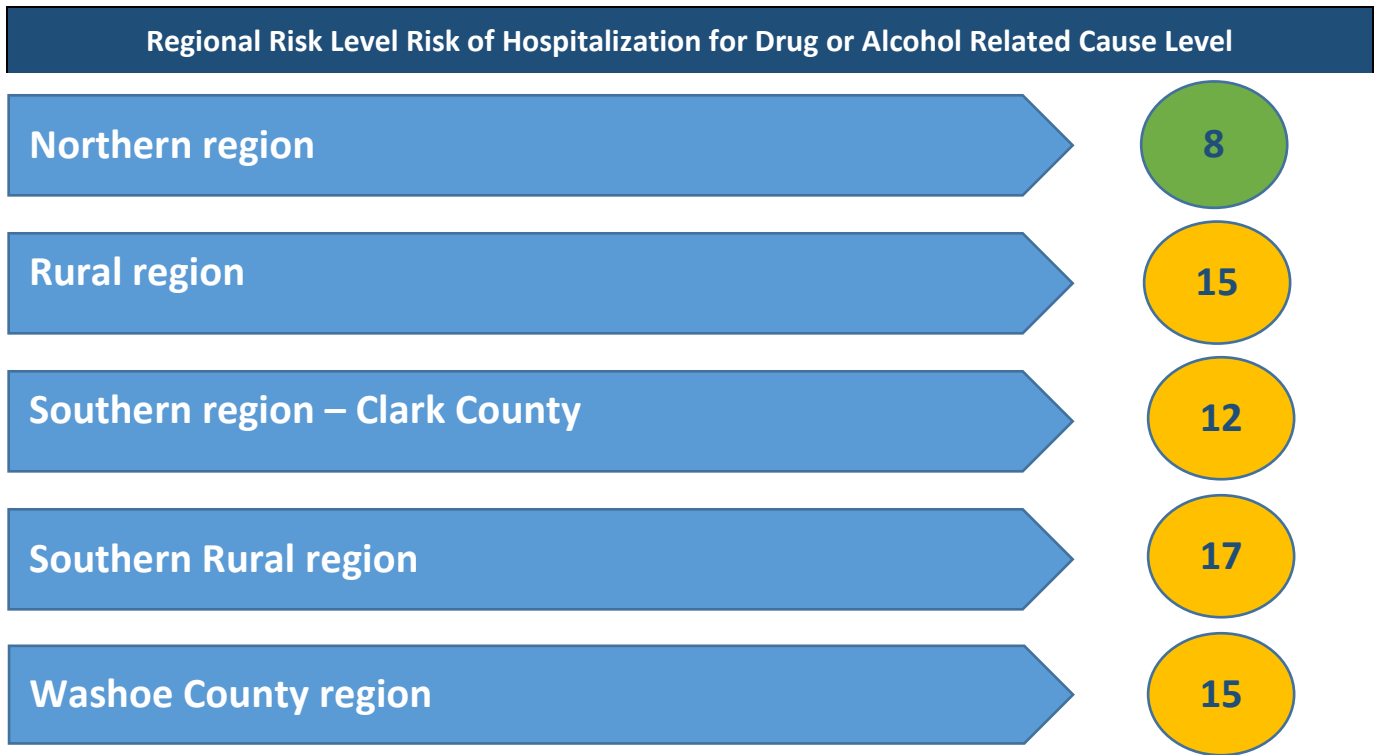| Regional Risk Level Risk of Hospitalization for Drug or Alcohol Related Cause Level	
Northern region	8
Rural region	15
Southern region – Clark County	12
Southern Rural region	17
Washoe County region	15

Table 2. Social Determinants of Health in Nevada

CAST uses a regressive analysis of social determinants of health informed by national data and research on factors that increase the likelihood for a county or region to have higher than the national median for hospitalization due to SUDs. The characteristics for CAST based on regional data that contributed to a risk score are detailed below.

The following characteristics were collected for each region based on overall population and publicly available data to establish risk scores.

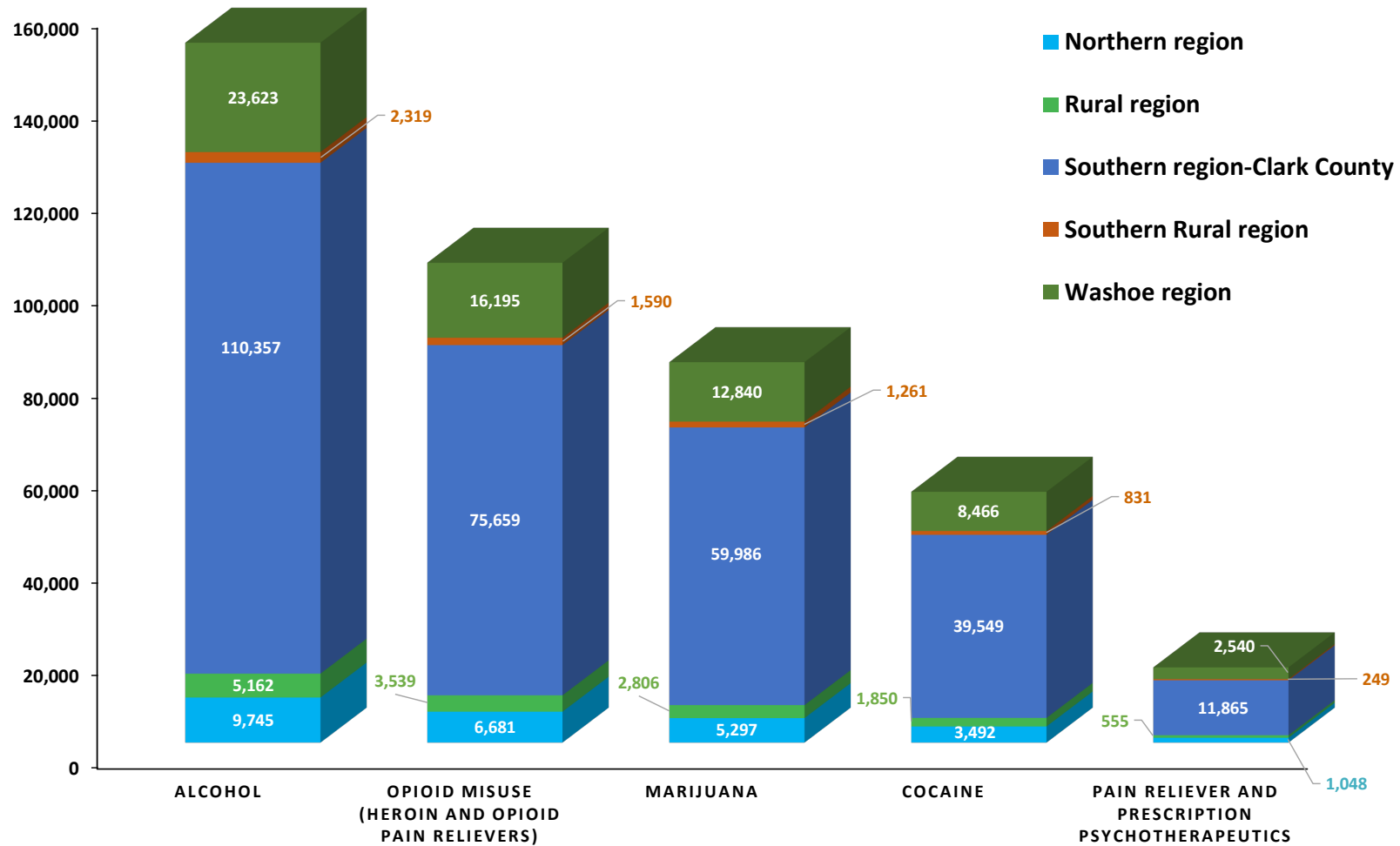| Characteristics |
|---|
| % of adult population that is male |
| % of county that is rural |
| High school dropout rate |
| % of households with income below $35,000 |
| % of population with a college degree |
| Association rate per 100,000 people |
| Alcohol outlet density rate per 100 non-alcohol businesses |
| Violent crime rate per 100,000 people |
| % of population with access to physical activity |

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[6] Regional risk scores do not reflect variance within counties in the region. It is likely that some counties in the Northern region have greater risk but other counties with lower risk resulted in the region as a whole assessed as low risk.

CAST Usage Rates

CAST additionally estimates regional usage rates for the five most commonly misused substances according to the National Survey on Drug Use and Health (NSDUH). The estimated number of users needing, but not receiving, treatment within the past year for the five most commonly misused substances was calculated by the CAST tool for each region, and is summarized for the State by substance and region in Table 3. The process by which these totals were calculated is as follows; the total number of individuals estimated to fall into each of the categories bolded in the list below are detailed in each regional capacity report:

1. The regional population was multiplied by the SAMHSA produced state-wide usage rate for each substance to produce the **total estimated number of users in the region**.
2. The regional population was multiplied by CAST - developer determined percentages to produce the **total estimated number of users in the region with a use disorder**.
3. The regional population was multiplied by CAST - developer determined percentages to produce the **estimated number of users in the region who will receive treatment**.
4. The total estimated number of users in the region with a use disorder was multiplied by CAST - developer determined percentages to produce the **estimated number of users in the region needing, but not receiving, treatment in the past year**.

Table 3. Estimated number of individuals needing, but not receiving, treatment for the most commonly misused substances in Nevada

Legend:
- Northern region
- Rural region
- Southern region-Clark County
- Southern Rural region
- Washoe region

ALCOHOL
- 23,623
- 2,319
- 110,357
- 5,162
- 3,539
- 9,745

OPIOID MISUSE (HEROIN AND OPIOID PAIN RELIEVERS)
- 16,195
- 1,590
- 75,659
- 2,806
- 6,681

MARIJUANA
- 12,840
- 1,261
- 59,986
- 1,850
- 5,297

COCAINE
- 8,466
- 831
- 39,549
- 555
- 3,492

PAIN RELIEVER AND PRESCRIPTION PSYCHOTHERAPEUTICS
- 2,540
- 249
- 11,865
- 1,048

CAST Capacity Calculator

The Cast tool calculates scores according to each of the CAST assessment categories. Two components were not included in the regional assessment as they were not applicable based on the CAST definitions. They include Primary Care Physicians with Substance Abuse Training which was not verifiable in Nevada, and Mental Health Awareness Trained Police which is required for all police in Nevada. One component was broken into three parts as requirements and licensing boards for each varied. Psychologists, Psychiatrists and Counselors are all reported separately, rather than as one component.

CAST Assessment Categories:

- Promotion
- Prevention
- Referral
- Treatment
- Recovery

These five categories encompass 29 components of a behavioral health care system.

A description of each assessment category is found below.

Promotion	•Behavioral health promotion efforts are intended to raise awareness about specific substance use concerns, provide universal outreach to your community, and facilitate the intentional coordination of population health promotion efforts by community coalitions.
Prevention	•Prevention programs are early-intervention strategies intended to reduce the impact of substance use disorders. Prevention programs are organized around the three population defining strategies of Universal, Selective, and Indicated programs. (descriptions of the three populations can be found on page 15)
Referral	•The referral system as defined in CAST is one that links individuals to treatment, be it voluntarily or involuntarily.
Treatment	•Treatment service types vary widely, and CAST does not offer tools for assessing the quality of care provided within a community. The use of CAST is intended to provide insight about the amount of treatment access and type of treatment access that members of the community are being offered.
Recovery	•Knowing the nature of a community's recovery support network can help to understand how and if resources may need to be allocated to support those in recovery, thereby reducing risk of relapse.

The CAST Community Capacity Calculator uses algorithms to estimate the numerical totals for core components of the SUD prevention and treatment continuum in a region. Each estimate is based upon a population total, a frequency of service utilization, and a group size receiving one unit of service. When the estimate is compared to observed totals, a rating is given for each component if it is calculated to be above or below the minimal level needed to provide care to community members most likely to use that component. It should be emphasized that this calculation reflects a *minimal level of care*, and communities may decide to prioritize specific populations or types of interventions. In multiple locations, it has been observed that even when the CAST assessment suggests a particular component is in adequate supply, community stakeholders will articulate clear reasons why they may want a program to serve a broader population group within their community than the minimum level of need indicated by CAST.

The table/charts found on the following pages detail the estimated need across the State for each of the CAST categories, by region. Tips for interpreting the tables/charts:

- A negative number, demonstrated within a red box, denotes that the region does not have sufficient capacity for that component, based on the CAST algorithms.
- A positive number, demonstrated in a red box, denotes that the region has sufficient capacity for that component, again, based on the CAST algorithms.
- The estimated regional counts for each CAST component have been combined to give a picture of statewide capacity and need. If more of the bar for a specific component is above the "0" line, then the State overall has sufficient capacity; if more of the bar is below the "0" line, then the State overall has insufficient capacity. Insets are provided to detail those components with smaller ranges, as necessary.
- Some values of "0" are marked in red and others in green. This difference is due to the way in which CAST calculates and rounds values. A green "0" is actually a value between .001 and .990; a red "0" is a value between -.001 and -.990. Therefore, a green "0" indicates that the region exceeds need for that component, but only fractionally. Conversely, a red "0" indicates that the region fails to meet need for that component, but only fractionally.

Promotion

Behavioral health promotion efforts are intended to raise awareness about specific substance use concerns, provide universal outreach to a community, and facilitate the intentional coordination of population health promotion efforts by community coalitions. Collecting data about these types of efforts is one of the more difficult data collection tasks in CAST. It is difficult because the scope of activities is broad and can be undertaken by a diverse set of stakeholders.[7]

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[7] Excerpt from the CAST Manual.

Table 4. Promotion Capacity Calculator Results
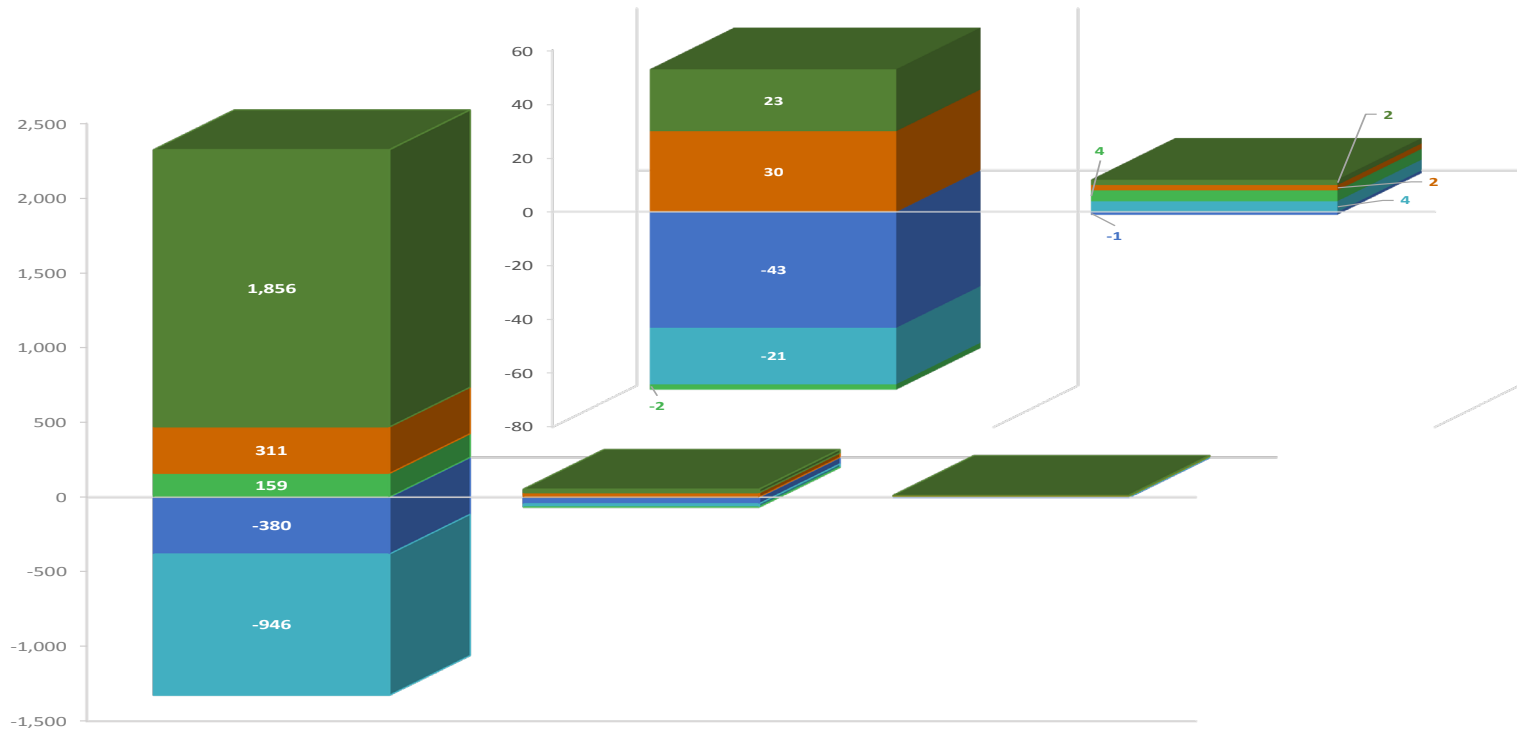
	MARKETING ADVERTISEMENTS	MEDIA ADVOCACY EVENTS	COMMUNITY COALITIONS
NORTHERN REGION	-946	-21	4
RURAL REGION	159	-2	4
SOUTHERN REGION - CLARK COUNTY	-380	-43	-1
SOUTHERN RURAL REGION	311	30	2
WASHOE REGION	1,856	23	2
STATEWIDE CAPACITY (RELATIVE TO NEED)	1,000	-13	11

In the Promotion category, more capacity is evident in the Rural, Southern Rural and Washoe regions while a lack of capacity is evident in the Northern region and in the Southern region - Clark County. Numbers depict actual results from the CAST calculator.
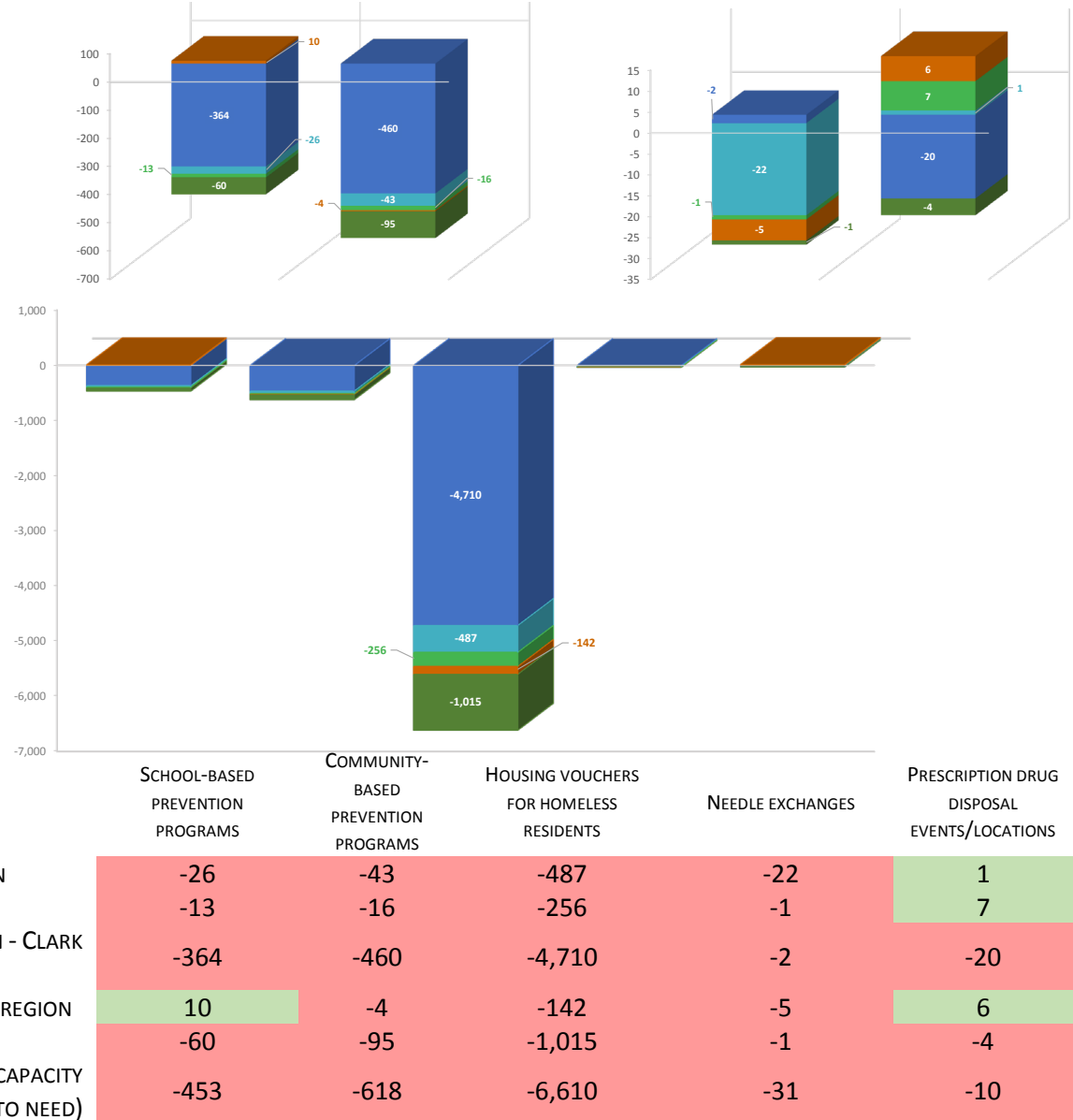
Prevention

This category encompasses early-intervention strategies intended to prevent the onset and mitigate the impact of SUDs on individuals and communities. Prevention activities are organized around the three population-defining strategies of Universal, Selective, and Indicated programs.

- **Universal** programs include environmental prevention strategies and programs which aim to provide information to all individuals.
- **Selective** programs target subgroups of the community that are known to be at increased risk to engage in substance misuse.
- **Indicated** programs are intended for individuals who have demonstrated early signs of substance use problems.

In the Prevention category, a general lack of capacity is evident in all regions, with some positive capacity noted in the category of prescription drug disposal events and locations, where three of the five regions have sufficient capacity. Numbers depict actual results from the CAST calculator.

Table 5. Prevention Capacity Calculator Results

|	SCHOOL-BASED PREVENTION PROGRAMS	COMMUNITY-BASED PREVENTION PROGRAMS	HOUSING VOUCHERS FOR HOMELESS RESIDENTS	NEEDLE EXCHANGES	PRESCRIPTION DRUG DISPOSAL EVENTS/LOCATIONS
NORTHERN REGION	-26	-43	-487	-22	1
RURAL REGION	-13	-16	-256	-1	7
SOUTHERN REGION - CLARK COUNTY	-364	-460	-4,710	-2	-20
SOUTHERN RURAL REGION	10	-4	-142	-5	6
WASHOE REGION	-60	-95	-1,015	-1	-4
STATEWIDE CAPACITY (RELATIVE TO NEED)	-453	-618	-6,610	-31	-10

Referral

Knowing how individuals are accessing or being directed to SUD services can assist RBH Policy Boards as they develop an integrated system of behavioral health care for the region. The referral system as defined in CAST is one that links individuals to treatment, be it voluntarily or involuntarily.

Table 6. Referral Capacity Calculator Results

Each of the regions has sufficient capacity in adult specialty courts. The majority of regions have sufficient capacity with youth specialty courts, with the exception of the Rural region and Southern region – Clark County. However, the lack of social workers is evident in all rural regions of the state.
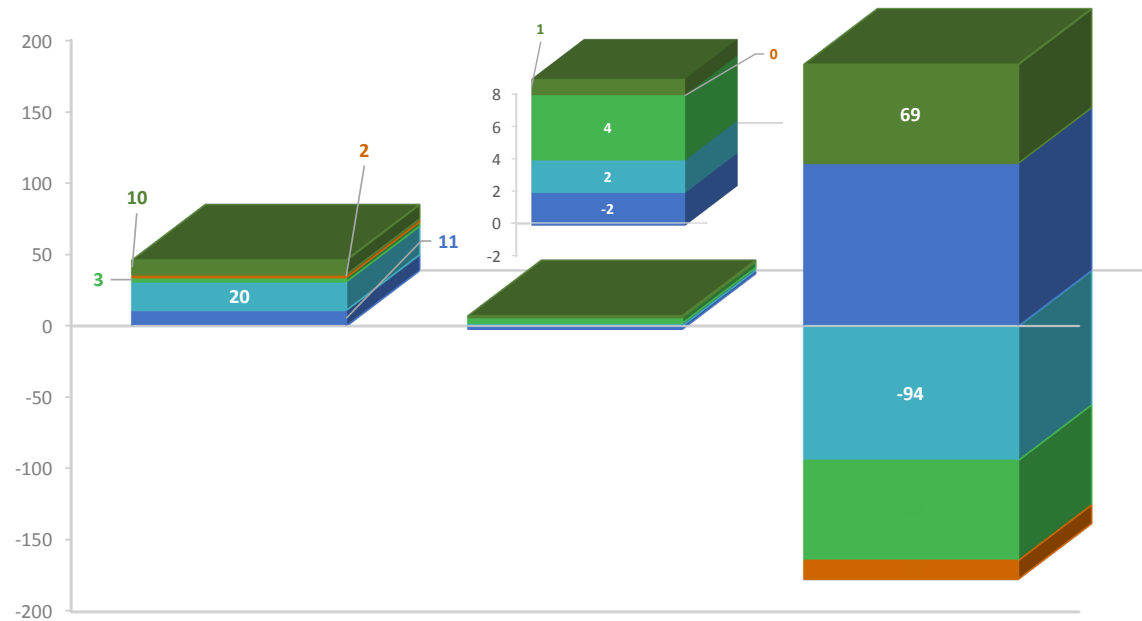
|	ADULT SPECIALTY COURT	YOUTH SPECIALTY COURT	SOCIAL WORKERS
NORTHERN REGION	20	2	-94
RURAL REGION	3	4	-70
SOUTHERN REGION - CLARK COUNTY	11	-2	114
SOUTHERN RURAL REGION	2	0	-13
WASHOE REGION	10	1	69
STATEWIDE CAPACITY (RELATIVE TO NEED)	46	5	6

Treatment

To support an effective and responsive referral system, it is critical to have an adequate and accessible supply of SUD treatment resources to refer individuals to when they request or are identified as needing services. Treatment service levels and types vary widely, and the use of CAST is intended to provide communities with insight about the primary inpatient and outpatient components of treatment to better understand the array of treatment options available in Nevada. It is important to note that CAST does not assess the quality of care being provided within the region.

In-Patient Treatment

In the Inpatient Treatment category, capacity is evident in all regions for Ambulatory Treatment. All regions lack capacity in Short-Term and Long-term Inpatient Treatment. Numbers depict actual results from the CAST calculators for each region.

Table 7. Inpatient Treatment Capacity Calculator Results
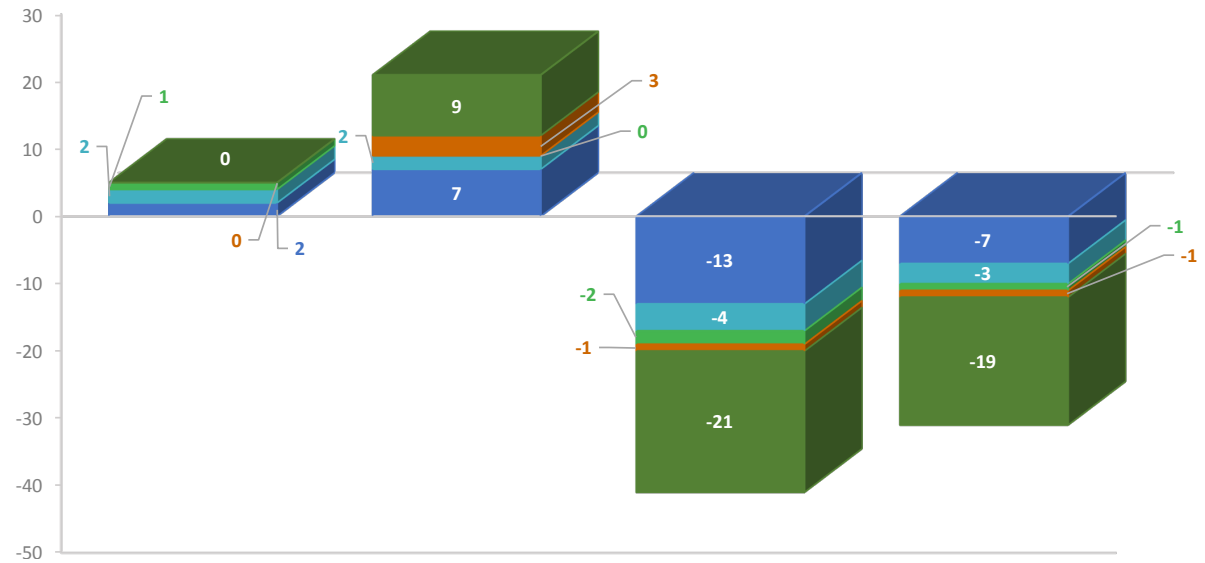
	DETOXIFICATION (INPATIENT)	AMBULATORY TREATMENT	SHORT-TERM REHABILITATION (<30 DAYS)	LONG-TERM REHABILITATION (30+ DAYS)
NORTHERN REGION	2	2	-4	-3
RURAL REGION	1	0	-2	-1
SOUTHERN REGION - CLARK COUNTY	2	7	-13	-7
SOUTHERN RURAL REGION	0	3	-1	-1
WASHOE REGION	0	9	-21	-19
STATEWIDE CAPACITY (RELATIVE TO NEED)	5	21	-41	-31

Outpatient Treatment

There are designated mental health professional shortage areas (HPSA) throughout Nevada due to a high ratio of low-income residents to providers in urban areas of the region plus a high ratio of mental health needs in northern part of the county. In urban areas, poverty is a significant factor in shortage designation, because many providers do not accept Medicaid. In rural and frontier areas, travel time to access a provider can be several hours, which is also a significant factor in shortage designation. While capacity improvement is desired for all of the outpatient components identified by CAST, an increase in psychiatrists is a high priority where RBH Policy Boards can work with DPBH to address this critical workforce gap.

Table 8. Outpatient Treatment Capacity Calculator Results

In the Outpatient Treatment category, all regions lack capacity in the number of Psychiatrists, Psychologists, Opioid Treatment Programs, and Office Based Opiate Substitution. Capacity for Detoxification and the number of Counselors varies by region, with Northern, Southern region - Clark County, and Washoe indicating sufficient capacity in Detoxification, while Southern region - Clark County, Southern Rural, and Washoe indicate sufficient capacity in number of Counselors. Numbers depict actual results from the CAST calculator.
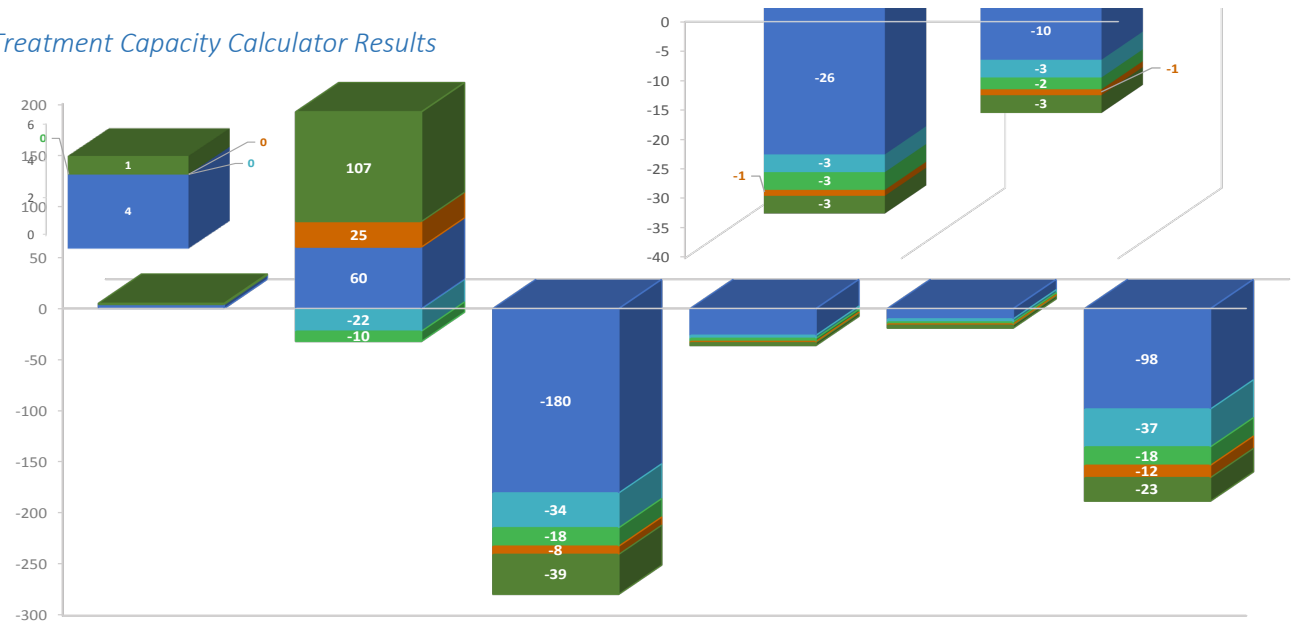

	Detoxification (Outpatient)	Counselors (drug and alcohol licensed only)	Psychiatrists specializing in substance abuse	Psychologists specializing in substance abuse	Opioid treatment (OTP)	Office-based opiate substitution (OBOT), buprenorphine only
Northern region	0	-22	-34	-3	-3	-37
Rural region	0	-10	-18	-3	-2	-18
Southern region - Clark County	4	60	-180	-26	-10	-98
Southern Rural region	0	25	-8	-1	-1	-12
Washoe county region	1	107	-39	-3	-3	-23
Statewide capacity (relative to need)	5	160	-279	-36	-19	-188

Recovery Support

Relapse among those who have received treatment is a major concern for regional SUD care systems.

In the Recovery Support category, capacity varies by region for all elements except Religious or Spiritual Advisors where lack of capacity is evident in all regions. Employment Support, Assistance Obtaining Housing and Health Insurance were also gaps. Numbers depict actual results from the CAST calculator.

*Table 9. Recovery Support Capacity Calculator Results*
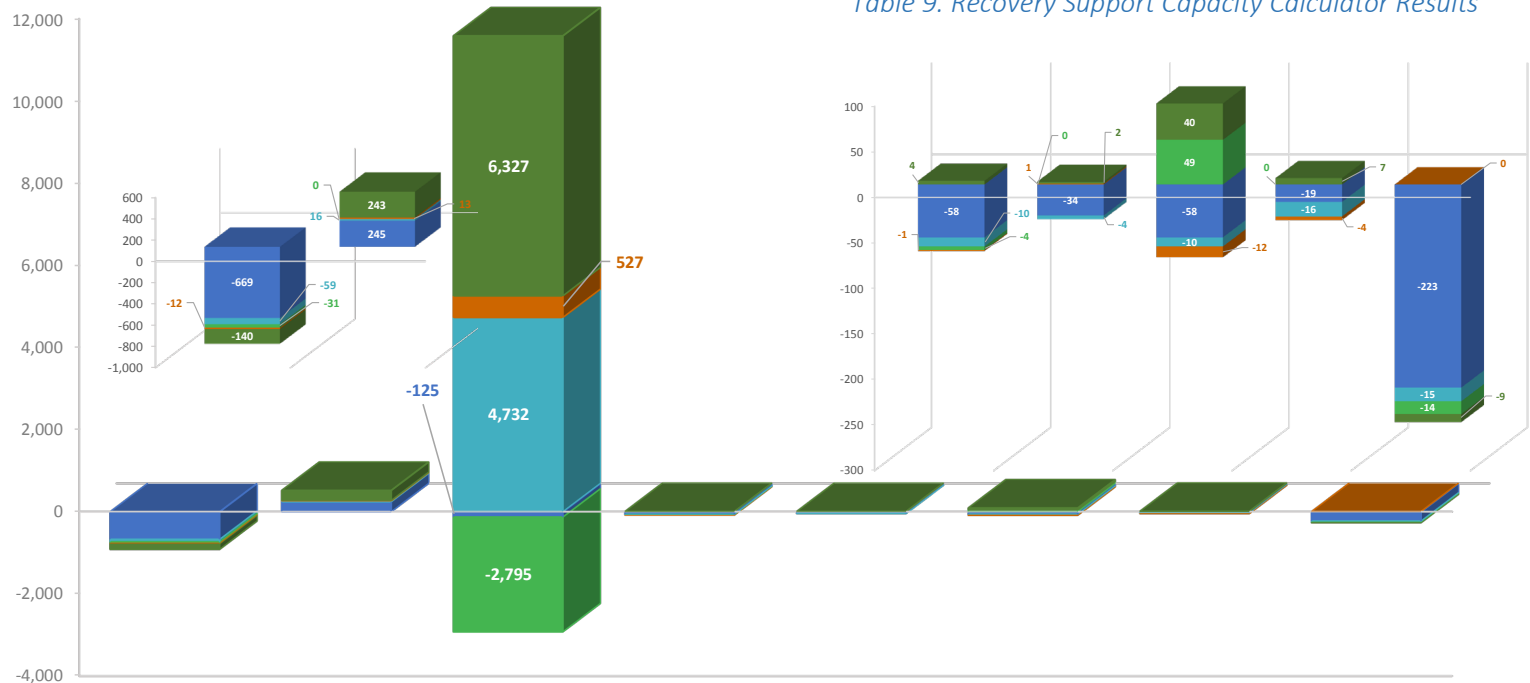
	RELIGIOUS OR SPIRITUAL ADVISORS	12-STEP GROUPS	TRANSPORTATION FOR THOSE RECEIVING TREATMENT	EMPLOYMENT SUPPORT FOR THOSE RECEIVING TREATMENT	EDUCATIONAL SUPPORT FOR THOSE WHO HAVE COMPLETED TREATMENT	PARENTING EDUCATION FOR INDIVIDUALS WITH A USE DISORDER	ASSISTANCE OBTAINING HOUSING	ASSISTANCE OBTAINING HEALTH INSURANCE
■ NORTHERN REGION	-59	16	4,732	-10	-4	-10	-16	-15
■ RURAL REGION	-31	0	-2,795	-4	0	49	0	-14
■ SOUTHERN REGION - CLARK COUNTY	-669	245	-125	-58	-34	-58	-19	-223
■ SOUTHERN RURAL REGION	-12	13	527	-1	1	-12	-4	0
■ WASHOE REGION	-140	243	6,327	4	2	40	7	-9
STATEWIDE CAPACITY (RELATIVE TO NEED)	-911	517	8,666	-69	-35	9	-32	-261

Resource Availability

Using the five CAST categories to define the SUD continuum of care, data on regional resources was collected from publicly available sources as well as from community partners via input from the RBH Policy Board community workgroup members, and targeted surveys of community providers and stakeholders (e.g. law enforcement, coalitions, faith-based organizations). Each region was provided detailed spreadsheets with resources by region that encompassed the five categories of CAST. This was used to help populate the CAST Capacity Calculator and map where resources existed throughout the state.

An interactive, web-based map that community members, stakeholders, and government agencies may embed on their websites or share with clients is available at https://urlzs.com/5U97P. This map summarizes the SUD resources available across Nevada and gives a holistic, geographic snapshot of the promotion, prevention, referral, treatment, and recovery efforts taking place within Nevada. Upon completion of this report, control of the map will be transferred to the RBHCs, who can collectively coordinate efforts to manage updating, sharing, and usage of the map. A screen shot of the interactive map is provided below:
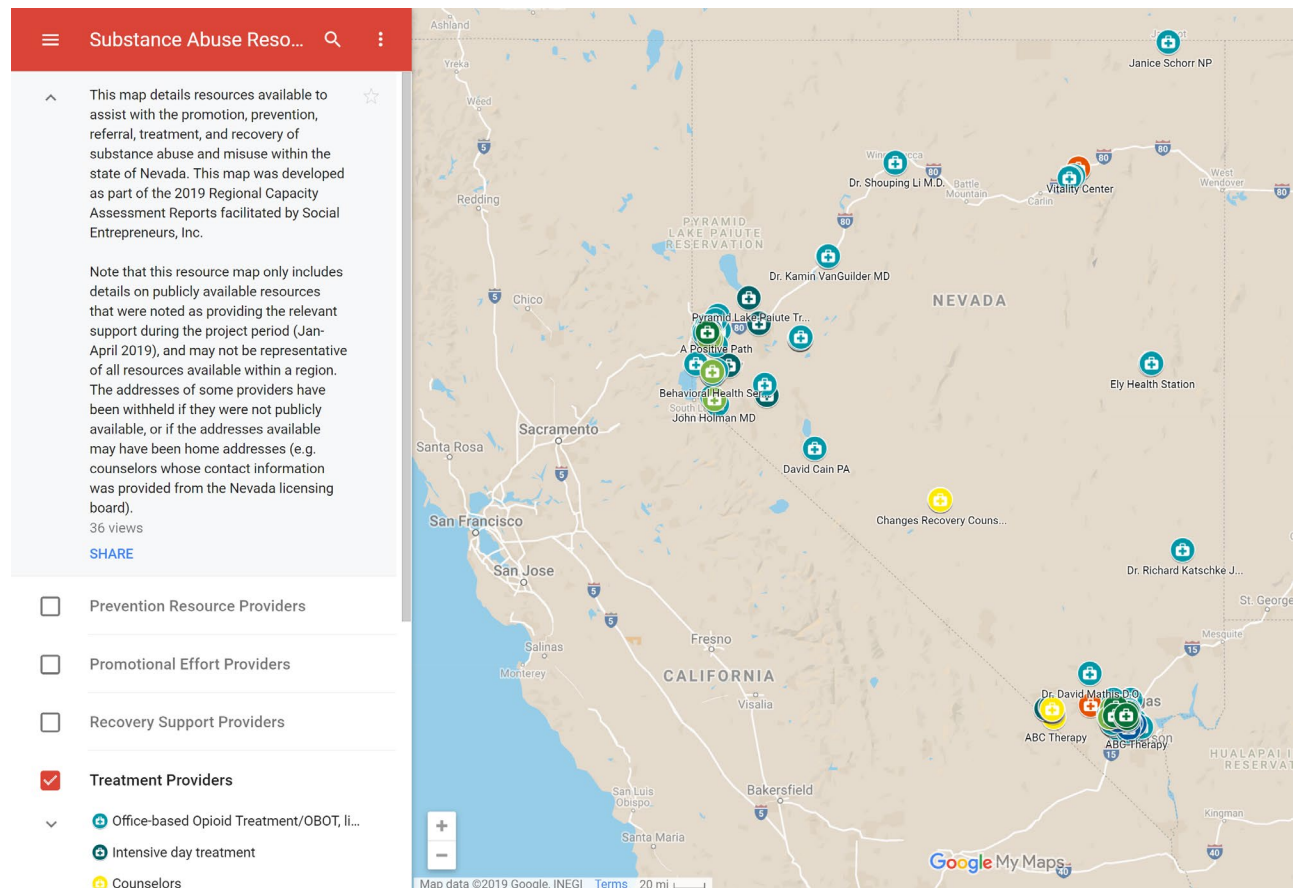
Priorities for Action

Following a facilitated review and discussion of each region's CAST results, including an analysis of the region's social characteristics, risk score and unmet need analysis in the context of planning efforts already underway, up to five priorities were identified for each region by their respective RBH Coordinators in consultation with the region's Behavioral Health Policy Board and stakeholders. Priorities related to building regional behavioral health capacity to meet community needs for SUD services were set based on data and discussion in the region.

In keeping with principles of effective planning, priorities were limited to no more than five per region to ensure that efforts won't be diffused by focusing on too many areas at one time. These results provide important feedback to the State of Nevada about shared priorities that most of the regions see as essential to building their capacity to provide SUD services. Equally as important, this summary offers insight into regional differences that are critical for state and local policy makers to understand.

The chart below reflects the collective priorities the five regions assessed in Nevada and highlights shared priorities that can inform state planning efforts and resource allocations in a manner that achieves maximum impact in response to regional diversity. As progress is made on these initial priorities, other areas of unmet need identified by CAST and other gap analysis efforts can be revisited at the regional level as well as at the state level.

Table 10. Collective Regional Priorities
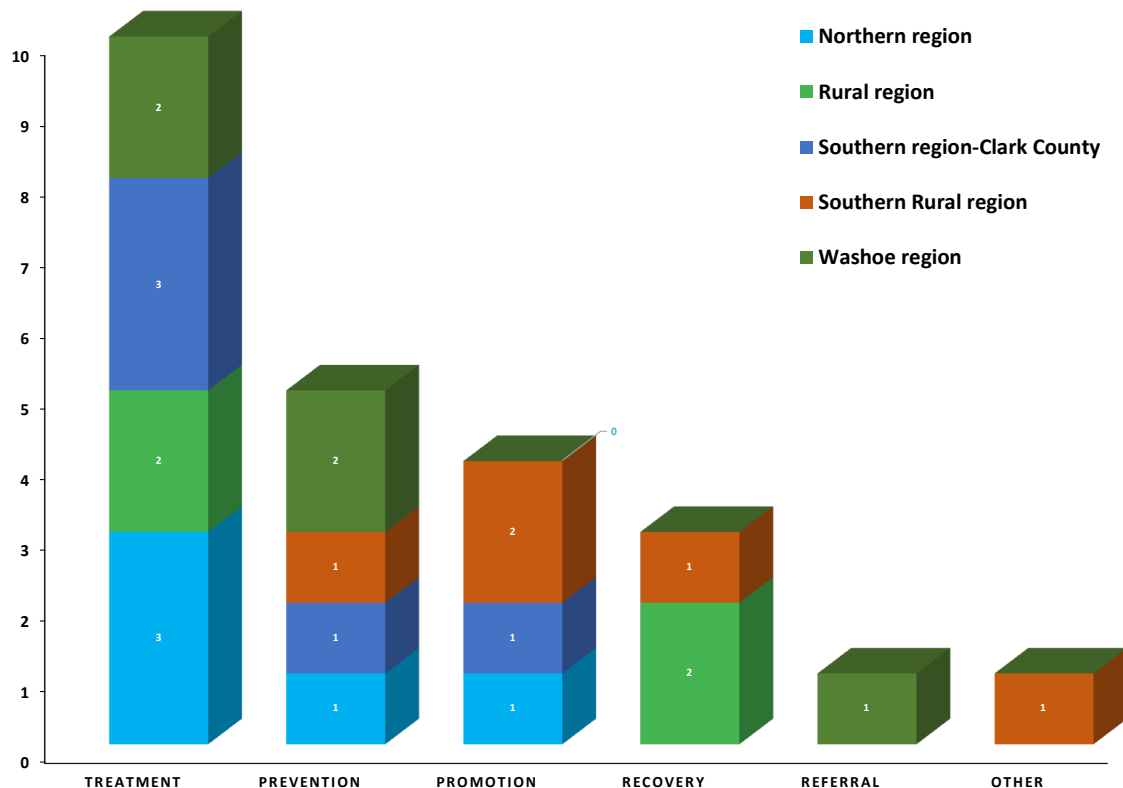
The summary chart on the preceding page highlights that the most frequently identified need is to build Nevada's SUD <u>Treatment</u> capacity across the state and in all levels of care, with emphasis on increasing the availability of:

- **Crisis stabilization and outpatient detoxification services;**
- **Outpatient treatment** for individuals with co-occurring disorders (including via increased availability and utilization of technology and telehealth resources);
- **Residential treatment** – both short-term (>30 days or less) and long term (<30 days);
- **Psychiatrists and psychologists**, as well as office-based opioid therapy services (OBOTs).

Specific regional priorities are provided in the next section of the document to highlight the unique treatment capacity concerns from one region to the next. For example, while all but one region identified some aspect of treatment capacity as at least one of five priorities, two regions (Northern region and Southern region – Clark County) included treatment capacity as a focus for three of their top five concerns. Furthermore, in each region that identified increasing treatment as a priority, the focus on which type and level of treatment varies by region.

Following the need for more SUD treatment services, <u>Prevention Services</u> emerge as the second highest collective need for Nevada based on identified regional priorities. The specific prevention needs identified include increasing the availability of:

- School-based prevention programs (Washoe region);
- Prescription drug disposal locations and events (Southern Rural region); and
- Housing vouchers and affordable housing programs for low-income individuals and families (Northern region, Southern region – Clark County and Washoe region).

The third highest collectively expressed priority focuses on <u>Promotion Activities</u>, specifically:

- Marketing advertisements (Northern region, Southern region - Clark County, Southern Rural region); and
- Advocacy events (Southern Rural region).

Following Promotion Activities, <u>Recovery Supports</u> were identified as priorities in two of the regions, with a focus on:

- Transportation (Rural region, Southern Rural region); and
- Housing assistance (Rural region).

Finally, there were two regions which identified a priority unique to themselves:

- Washoe region identified the need to increase the number of case managers available to assist with care coordination (referral); and
- The Southern Rural region identified the need to increase mental health training for law enforcement in conjunction with administering Naloxone (e.g. Narcan).

The priorities established by each region are provided in the following tables for easy reference.

Northern region Priorities
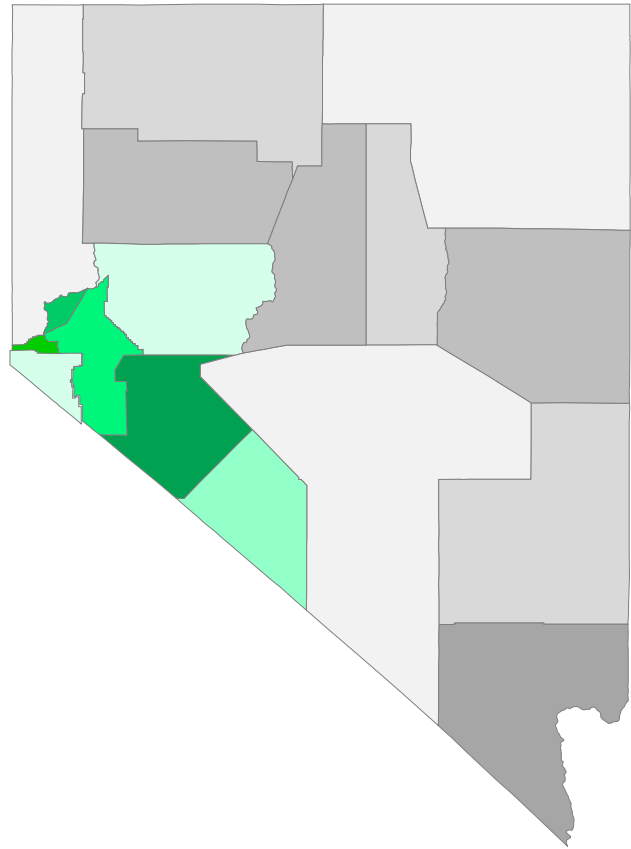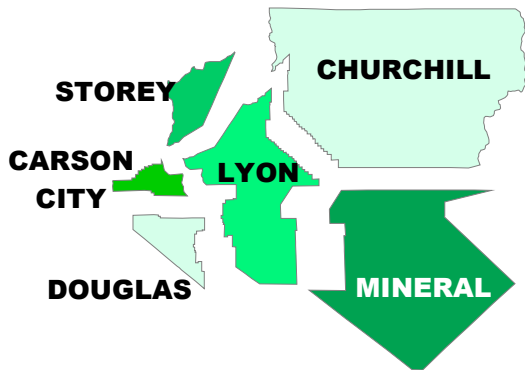
The top five (unranked) priorities for the **Northern region** are:

Promotion: Marketing Advertisements

- Increase individual advertisements placed on tv, radio, print, billboards, web, and social media within one year.

Prevention: Housing Vouchers

- Increase the number of year round beds available via a voucher program.

Treatment: Short-Term Inpatient Treatment

- Increase the number of facilitites providing less than 30 days of non-acute care in a setting with treatment services for alcohol and other drug abuse and dependency.
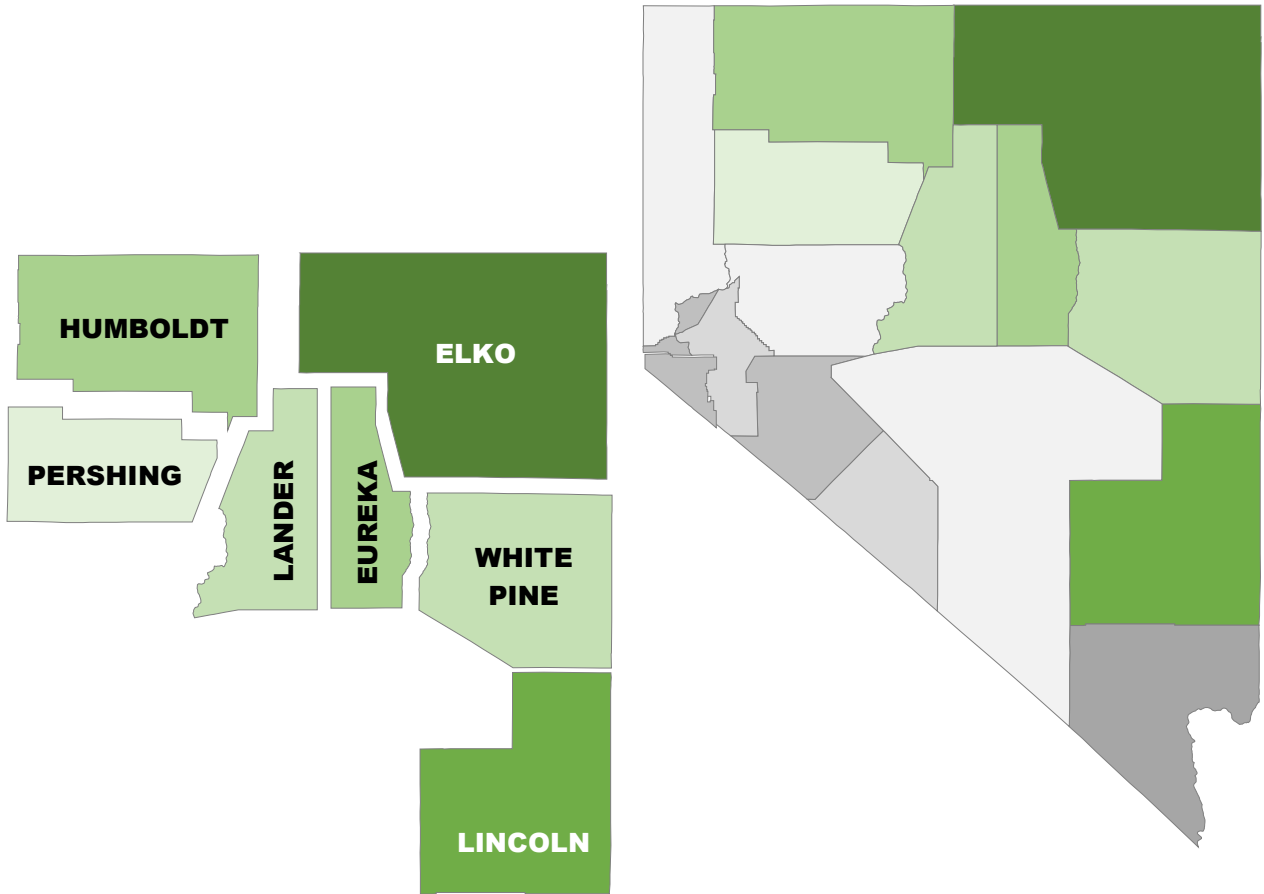
Treatment: Long-Term Inpatient Treatment

- Increase the number of facilitites providing 30 days or more of non-acute care in a setting with treatment services for alcohol and other drug abuse and dependency.

Treatment: Psychiatrists and Psychologists

- Increase the number of psychiatrists and psychologists listed as specializing in substance abuse and addiction issues.

Rural region Priorities

The top four (ranked) priorities for the **Rural region** are:

Recovery: Transportation

- Increase the availability of transportation services.

Treatment: Outpatient

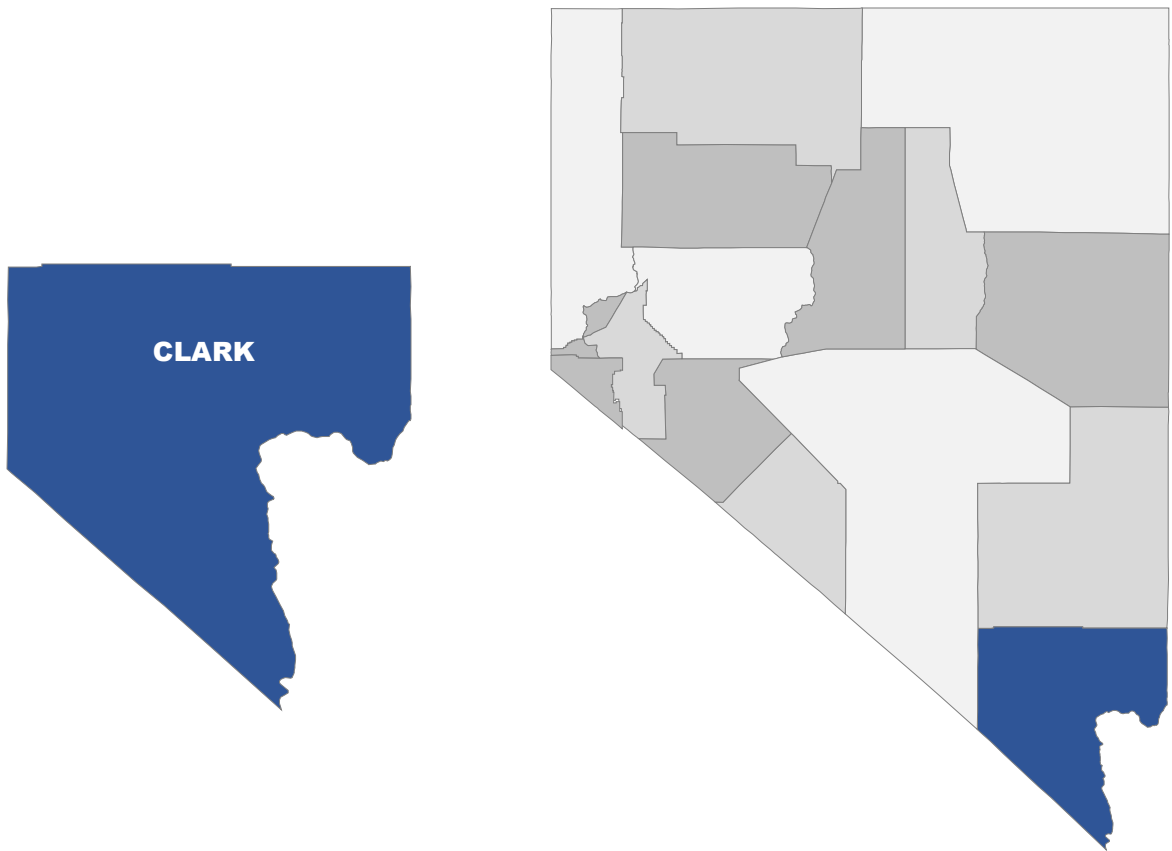- Increase the availability of outpatient treatment by leveraging technology.

Treatment: Outpatient

- Increase the availability of outpatient treatment for co-occurring disorders.

Recovery: Housing Support

- Increase the number of housing supports available.

Southern region - Clark County Priorities

The top five (unranked) priorities for **Southern region - Clark County** are:

Promotion: Marketing Advertisements

- Increase individual advertisements placed on tv, radio, print, billboards, web, and social media within one year.

Prevention: Housing Vouchers

- Increase the number of year round beds available via a voucher program.

Treatment: Short-Term Inpatient Treatment

- Increase the number of facilitites providing less than 30 days of non-acute care in a setting with treatment services for alcohol and other drug abuse and dependency.
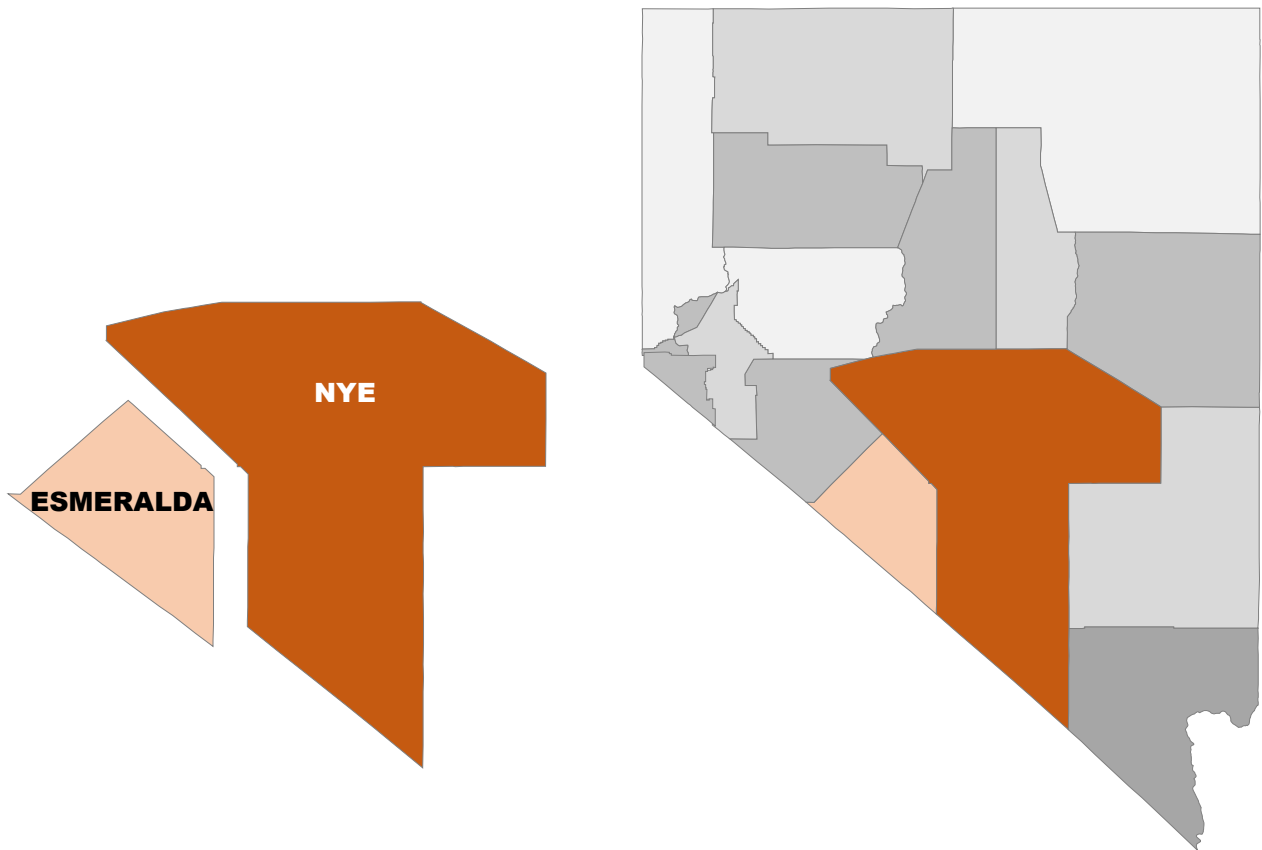
Treatment: Long-Term Inpatient Treatment

- Increase the number of facilitites providing 30 days or more of non-acute care in a setting with treatment services for alcohol and other drug abuse and dependency

Treatment: Psychiatrist Availability

- Increase the number of psychiatrists in Clark County.

Southern Rural region Priorities

The top five (unranked) priorities for the **Southern Rural region** are:

Promotion: Marketing Advertisements

- Increase individual advertisements placed on tv, radio, print, billboards, web, and social media.

Promotion: Advocacy Events

- Increase events to promote education regarding substance use and misuse.

Prevention: Drug Disposal

- Expand prescription drug disposal locations and events to communities that do not currently have them.

Recovery: Transportation

- Increase the availability of transportation vouchers available to people seeking treatment.

Other: Training

- Increase the frequency of training provided to law enforcement officers to cover mental health as well as the administration of overdose prevention medication.

Washoe region Priorities
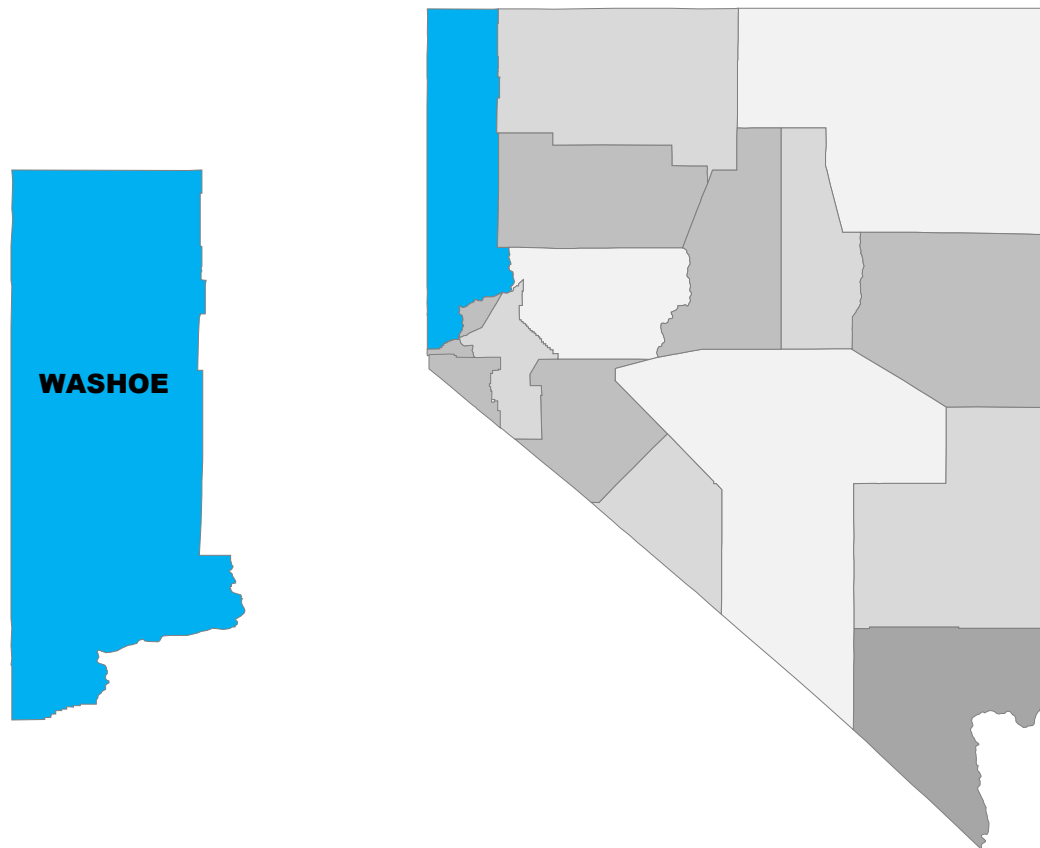
The top five (unranked) priorities for the **Washoe County Region** are:

Prevention: School-Based Prevention Programs

- Increase prevention programming in schools targeted to middle school-age youth.

Prevention: Housing Vouchers

- Increase the affordable housing options for low-income individuals and families, including transitional housing.

Referral: Case Manager Availability

- Increase the number and availability of case managers that are available to assist with care coordination for individuals with behavioral health care needs.

Treatment: Crisis Stabilization, Detoxification, and Rehabilitation

- Increase regional capacity to provide crisis stabilization, detoxification services, and short-term (> 30 days) residential treatment.

Treatment: Psychiatrist Availability

- Increase the number of psychiatrists in Washoe County.

Best Practices to Address Priorities

To support the State of Nevada in determining the optimal approach to addressing the collective priorities summarized above, a list of best practice strategies related to capacity expansion in the areas identified as priorities by multiple regions is provided in this section.

TREATMENT

SUD TREATMENT CAPACITY EXPANSION: OUTPATIENT, RESIDENTIAL AND SPECIALITY PROVIDERS

States including Nevada are increasingly exploring new partnerships, funding strategies and policy innovations in their efforts to build their SUD service system capacity. As the need for SUD treatment grows, primary care clinics (PCCs) and community health centers (CHCs) are partnering with traditional treatment providers to play an important role in capacity expansion efforts related to SUD care as they invest in new ways to deliver care in places where treatment options are in short supply[8] (e.g. utilizing technology such as telehealth and telepsychiatry to enhance care for those with difficulty accessing care). By providing much needed SUD services to their patients, these primary care health centers are rising to the challenge associated with the dramatic increase in the prevalence of SUD and Opioid Use Disorders (OUD) over the past decade.

In both rural and urban communities in Nevada, scarcity of high-level professionals is one issue impacting the availability of services. This shortage is across every category of health care professional, but the lack of psychologists and psychiatrists is especially apparent. As new integrated care models are developed that provide better services for people who receive public benefits, a qualified and professional workforce is needed.

Given that treatment access is, in part, a function of affordability and availability, and availability is a function of provider capacity, transportation, and use of technology, it is important to identify solutions that take the sum of those elements into account when considering the best approach for expanding treatment services at every level of care. State partnerships are needed that include SAPTA, Medicaid and Nevada's health plans to ensure that reimbursement structures and policies don't unnecessarily limit options for consumers with provisions and riders that may

> **PROMISING PRACTICE**
>
> In terms of workforce expansion, community health centers have increased their behavioral health workforce nearly eightfold since 2000 to meet communities' needs.[1] Additionally, providers from more than 175 health centers are receiving in-depth opioid addiction treatment training via the virtual Project ECHO model[1], which uses video conferencing to train primary care clinicians to provide specialty care services, such as Medication Assisted Treatment (MAT) or performing evidence-based SUD screening procedures.

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[8] Retrieved on June 28, 2019 from: https://www.commonwealthfund.org/publications/newsletter-article/2017/sep/focus-expanding-access-addiction-treatment-through-primary

affect eligibility and coverage conditions, including preexisting condition riders and lifetime limit clauses.

CRISIS STABILIZATION AND OUTPATIENT DETOXIFICATION SERVICES

In addition to outpatient detoxification, core SUD crisis services may include: mobile crisis services, 24/7 crisis hotlines, warm lines, and peer crisis services. Detoxification (detox) services are an important component in the treatment of SUDs, often serving as a gateway to longer term treatment. Detox includes a set of interventions designed to manage acute intoxication and withdrawal while minimizing the medical complications and/or physical harm caused by withdrawals from substance abuse.[9] This process consists of three components: evaluation, stabilization, and fostering patient entry into substance abuse treatment. A successful detoxification program can be partly measured by the progression from detox to entry into and compliance with substance abuse treatment.[10]

Aside from managing the medical aspects of withdrawal, detoxification is intended to prepare patients for treatment and recovery. This requires engaging patients in the transition to longer-term treatment. SAMHSA identifies seven strategies for engaging and retaining patients in detoxification:

- Educate the patient on the withdrawal process;
- Use support systems;
- Maintain a drug-free environment;
- Consider alternative approaches;
- Enhance motivation;
- Tailor motivational intervention to stage of change; and
- Foster a therapeutic alliance.[11]

One of the most important of these strategies is the development of a therapeutic alliance, which helps patients see themselves part of an empathic support system and may aid in successful transition to treatment and recovery.

PREVENTION

In April 2019, SAMHSA launched a web-based Evidence-Based Practices Resource Center[12] to provide communities, clinicians, policy makers and others in the field with the information and tools they need to incorporate evidence-based practices into their communities or clinical

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[9] Lenardson, J, et. al. Availability, Characteristics, and Role of Detoxification Services in Rural Areas. Maine Rural Health Research Center, Working Paper #41. December 2009. Retrieved on June 25, 2019 at https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=8&ved=2ahUKEwj7s4S4gYbjAhVXJ80KHY9rBSYQFjAHeg QIARAC&url=http%3A%2F%2Fmuskie.usm.maine.edu%2FPublications%2Frural%2Fwp41%2FDetox-Services-Rural.pdf&usg=AOvVaw3fPKfme36Rtw1_AKrt5Zh2

[10] Center for Substance Abuse Treatment. Detoxification and Substance Abuse Treatment. (DHHS Publication No. SMA 06-4131). Rockville, MD: Substance Abuse and Mental Health Services Administration; 2006. Treatment Improvement Protocol; Series 45.

[11] Ibid.

[12] https://www.samhsa.gov/ebp-resource-center

settings. Nevada is fortunate to have a regional Prevention Technology Transfer Center (PTTC) located in the state (the Pacific Southwest Prevention Technology Transfer Center[13]) that is federally funded to provide training and technical assistance (TTA) services to the substance misuse prevention field in Region IX, which includes Nevada. The overall goal of regional PTTCs is to advance Region IX's substance misuse prevention workforce's ability to identify, select, plan for, implement, and evaluate evidence-based and promising substance misuse prevention interventions to achieve a reduction in substance misuse and harmful consequences. [14]

PTTCs are established to improve implementation and delivery of effective substance abuse prevention interventions and provide training and technical assistance services to the substance abuse prevention field, by:

- Developing and disseminating tools and strategies needed to improve the quality of substance abuse prevention efforts;
- Providing intensive technical assistance and learning resources to prevention professionals in order to improve their understanding of prevention science, epidemiological data, and implementation of evidence-based and promising practices; and
- Developing tools and resources to engage the next generation of prevention professionals.[15]

SCHOOL-BASED PREVENTION PROGRAMS

There are multiple school-based substance use prevention programs backed by strong, scientific evidence for lasting impacts on alcohol, tobacco, prescription opioids and other drugs. Many of these programs have also been shown to improve outcomes like academic achievement and attendance and address behavior issues such as bullying, violence, fighting, delinquency and risky sexual behavior. Intervening during school-age years has the potential to prevent substance use and put children on a path for success in school and as adults. Resources, including toolkits and program guidance, are available from SAMHSA's Evidence-Based Practice Resource Center, described above.

RECOVERY SUPPORTS

Recovery-oriented care and recovery support systems help people with SUDs manage their conditions successfully. Recovery is a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential. There are four major dimensions that support recovery:

- **Health**—overcoming or managing one's disease(s) or symptoms and making informed, healthy choices that support physical and emotional well-being.

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[13] https://casat.org/grants-contracts/
[14] https://pttcnetwork.org/centers/global-pttc/about-pttc-network
[15] Ibid.

- **Home**—having a stable and safe place to live.
- **Purpose**—conducting meaningful daily activities and having the independence, income, and resources to participate in society.
- **Community**—having relationships and social networks that provide support, friendship, love, and hope.

Hope, the belief that these challenges and conditions can be overcome, is the foundation of recovery. The process of recovery is highly personal and occurs via many pathways. Recovery is characterized by continual growth and improvement in one's health and wellness that may involve setbacks. Because setbacks are a natural part of life, resilience becomes a key component of recovery.

The process of recovery is supported through relationships and social networks. This often involves family members who become the champions of their loved one's recovery. Families of people in recovery may experience adversities that lead to increased family stress, guilt, shame, anger, fear, anxiety, loss, grief, and isolation. The concept of resilience in recovery is also vital for family members who need access to intentional supports that promote their health and well-being. The support of peers and friends is also crucial in engaging and supporting individuals in recovery.

Recovery services and supports must be flexible. What may work for adults may be very different for youth or older adults. For example, the nature of social supports, peer mentors, and recovery coaching for adolescents is different than for adults and older adults. Supporting recovery requires that behavioral health services:

- Are responsive and respectful to the health beliefs, practices, and cultural and linguistic needs of diverse people and groups;
- Actively address diversity in the delivery of services; and
- Seek to reduce health disparities in access and outcomes.

SAMHSA established recovery support systems to promote partnering with people in recovery and their family members to guide the behavioral health system and promote individual, program, and system-level approaches that foster health and resilience (including helping individuals with behavioral health needs be well, manage symptoms, and achieve and maintain abstinence); increase housing to support recovery; reduce barriers to employment, education, and other life goals; and secure necessary social supports in their chosen community.[16]

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[16] Retrieved on June 26, 2019 and excerpted from https://www.samhsa.gov/find-help/recovery

SAPTA Funded Program Organizational Capacity Results

SEI provided support to five funded SAPTA providers in completion of an organizational assessment of capacity using the OCAT. The McKinsey & Company OCAT is a free, online tool that provides the most up to date descriptions of best practice components needed for sustainable nonprofits. Access to the OCAT is free and available here: https://ocat.mckinseyonsociety.com/account/login

The OCAT is a helpful tool for both assessing an organization and also educating key staff, board members, and other stakeholders on the best practices for nonprofit organizations. The assessment is structured by asking questions and having participants anonymously assess where the organization is by reading descriptions and selecting the description that best represents the organization's current reality.

To illustrate, when asked to determine an organization's level of capacity for the question, "Is our vision clear?" participants first read the definition for a "level 4" organization. The description provides what the best practice in an organization would include.

Level 1	Level 2	Level 3	Level 4
Little shared understanding of what organization aspires to become or achieve beyond the stated mission	**General shared understanding** of what organization aspires to become or achieve organizational aspirations, but **rarely used** to direct actions or set priorities—it exists mainly "on the wall".	**Clear, specific, and inspiring** understanding of what organization aspires to become or achieve; **Broadly held** within the organization and **consistently used** to direct actions and set priorities.	**Clear and specific** understanding of what organization aspires to become or achieve; **Held by many** within the organization and **often used** to direct actions and set priorities.

Participants determine whether they are able to answer "yes" to the entire description, if so, they would select level 4. If not, they continue to move left, to the next lower level until they are confident the organization meets all of the elements of the description. Answers to questions are then rolled up to create an average score for the category as a whole. The ten categories of the OCAT assessment are detailed in the following call out box.

The OCAT measures organizational capacity within ten essential elements, which are described below:

1. **Aspirations:** An organization's mission, vision, and overarching goals, which collectively articulate its common sense of purpose and direction.

2. **Strategy:** The coherent set of actions and programs aimed at fulfilling the organization's overarching goals.

3. **Leadership, Staff, and Volunteers:** The collective capabilities, experiences, potential and commitment of the organization's board, management team, staff, and volunteers.

4. **Funding:** The systems, individuals, and budgeting processes that ensure that an organization has enough financial resources to operate in a sustainable manner.

5. **Values:** The connective tissue that binds together the organization, including shared values and practices, behavioral norms, and the level of the organization's performance orientation.

6. **Learning and Innovation:** The performance measures, information management systems, learning assessment loop mechanisms, and innovative practices that the organization has in place.

7. **Marketing and Communications:** The means through which an organization builds awareness of its cause and goals amongst its constituents and beyond.

8. **Advocacy (optional category):** The organization's ability to effectively plan and deploy advocacy efforts that are aligned with the organization's mission and effectively influence stakeholders.

9. **Managing Processes:** The organization's operational, risk-management, and decision-making processes that affect its ability to run successfully.

10. **Organization, Infrastructure, and Technology:** The combination of governance, information technology (IT) capabilities, physical infrastructure, organizational design, inter-functional coordination, and individual job descriptions that shape the organization's legal and management structure.

The OCAT includes multiple questions within each of these categories. The number of questions per category ranges from four questions related to Aspirations to 48 questions related to Leadership, Staff, and Volunteers. Individuals are asked to assess the organization on a continuum of "one" to "four," where each number corresponds to a description of capacity (one represents a low score, while four represents a high score with a description of best practice for the element being assessed).

Table 11 provides the aggregate average for all organizations that responded to the OCAT. Scores are provided for nine of the 10 categories, as the majority of organizations did not identify as an advocacy organization and therefore did not rate elements within that category.

The combined scores indicate that the organizations that completed the OCAT together have moderate capacity in each of the categories assessed. This means that to identify areas where more capacity is needed, it is necessary to look at individual questions, rather than just the high-level category. For that reason, following the aggregate scores by category, a list of more specific strengths that were common among respondents are provided, along with a list of specific areas where there were common capacity building needs.

Table 11. Combined Average OCAT Scores by Category

Capacity by Category Ratings	Average	Range of Scores	Level
Aspirations	3.13	2.96 - 3.36	Moderate Capacity
Strategy	2.78	2.55 - 2.95	Moderate Capacity
Funding	2.97	2.82 – 3.09	Moderate Capacity
Leadership, Staff and Volunteers	2.80	2.43 – 3.29	Moderate Capacity
Values	2.91	2.55 – 3.10	Moderate Capacity
Learning and Innovation	2.82	2.59 – 3.04	Moderate Capacity
Marketing and Communication	2.77	2.60 – 3.43	Moderate Capacity
Managing Processes	2.81	2.12 – 3.04	Moderate Capacity
Organization, Infrastructure and Technology	2.78	2.39 – 2.95	Moderate Capacity

For the purpose of this report, aggregate scores above a 3.25 on specific questions were considered organizational strengths and scores at or below 2.40 on specific questions were considered areas for potential capacity building.

Capacity Building Strengths to Leverage

The following are aggregate combined scores for all organizations that completed the OCAT. Elements receiving an aggregate score of **3.25** and above are included as strengths across substance abuse providers participating in this project:

➢ **Compelling Vision and Mission:** The organizations' have a strong sense of purpose that is shared by many. Their missions provide a clear expression of their reason for existence and reflect an inspiring view of a better future for those with SUD.

➢ **Strong Leadership:** Leaders of the organizations seek opportunities for personal growth and development and use innovative principles to find solutions to the social issues surrounding SUD. They have significant experience in nonprofit management as well as specific expertise in services to treat substance use disorders. The CEOs/Executive Directors have garnered local and national recognition in the substance abuse field.

➢ **Organizational Impact:** It is compelling that each of the organizations scored relatively high in the area of organizational impact. They are making progress toward achieving their goals and have seen significant improvement in client outcomes.

➢ **Strong Financial and Compliance Systems:** The organizations have systems in place to comply with state and federal regulations, including regulations regarding board and staff (e.g., required number of board members and offices, proper paperwork and payroll procedures in place). Each has a system of financial controls and clear expense accountability policies. The organizations have systems to back up important files and data that are generally secure.

Opportunities for Capacity Building

Elements receiving an aggregate score of **2.40** and below are included as areas for capacity building across substance abuse providers participating in this project:

➢ **Board Development:** For the most part, board members are engaged and enthusiastic about the work of the organization they serve, but they are not participating in any skill building individually or as a group to improve their effectiveness. For the most part, board member performance is only evaluated on an ad hoc basis and term limits are frequently changed or waived. There are many reasons that providers may want to keep board members beyond their initial terms, but without additional skill building or regular evaluations they may not be growing along with the organization.

➢ **Talent Management:** Organizations do not have a strategic approach to talent management. Attention could be paid to establishing a pipeline of talent, identifying incentive systems to maintain talent, and developing succession planning that sustains talent and grows the next generation of leaders in the substance abuse treatment field.

➢ **Volunteer Support:** Participating providers do not use volunteers to a great extent. Even so, it is important that they have a well-planned strategy to recruit, use and retain volunteers within their organizations when needed. These organizations could benefit from the development of a targeted recruitment strategy and system of application, as well as a plan to nurture and sustain long-term involvement by matching skills and desires of their volunteer base to mission-linked activities of the organization being served.

➢ **Disaster Preparedness:** Organizations' plans in the event of a disaster vary. Such plans are extremely important given the nature of their work. Plans need to include considerations for staff, residential clients for those providers that provide inpatient treatment, and clients participating in outpatient services when onsite. Disaster plans should be communicated at every level of the organizations with clear roles and responsibilities delineated.

➢ **Goals, Targets, and Metrics:** Many of the organizations' programs have general metrics related to activities and outputs but data connecting the organizations' work to larger social impact, like reduced incarceration rates, or to their strategic plan is less common.

Capacity Building Priorities

Following completion of the OCAT survey, SEI analyzed results and met separately with representatives from each of the organizations to identify capacity building priorities to focus on over the next 18 to 24 months. Those high-level priorities are reflected in the graphic that follows.
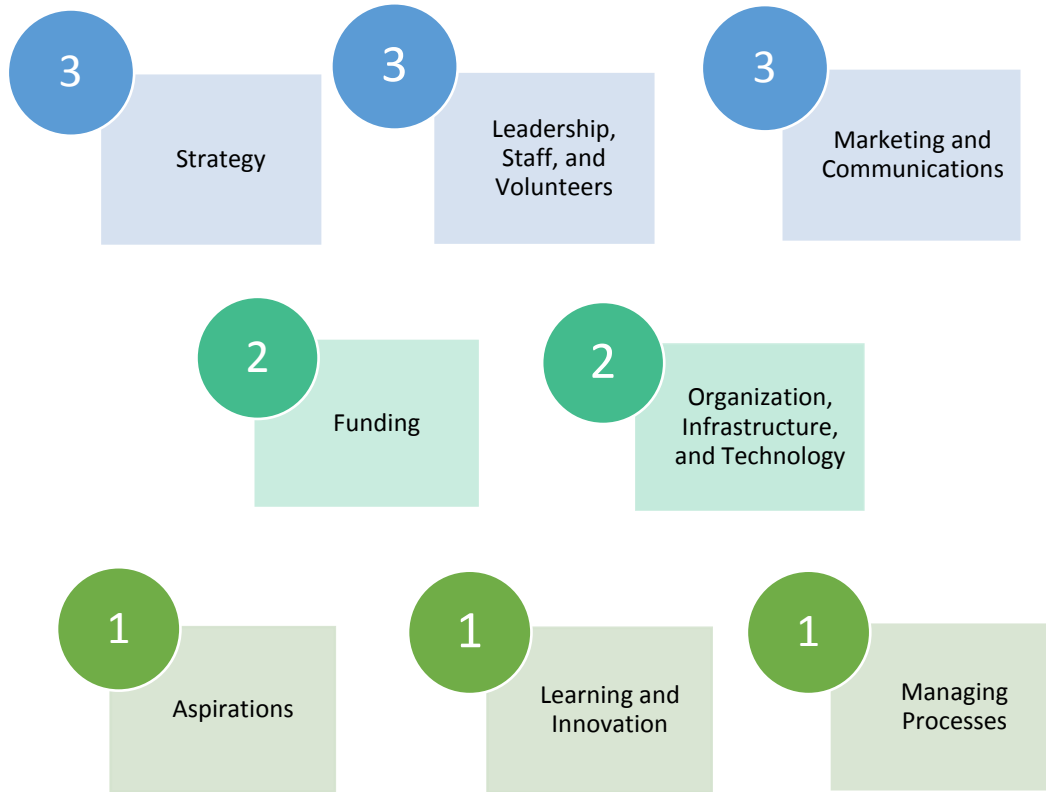
Under the Strategy category, organizations expressed a need to focus on strengthening linkages between program activities and outcomes and making the organization's strategic plan visible to the entire organization. This may include updating or revising an existing strategic plan or engaging in a process to develop a new plan.

As previously mentioned, the Leadership, Staff, and Volunteers category assesses a broad range of topics including senior leadership, an organization's board and board structure, staff quality and staff development, and volunteers.

The organizations' specific priorities in this area focus on:

➢ Board Development and Evaluation
➢ Talent Management
➢ Succession Planning

The OCAT results highlighted the need for improved internal communication for two organizations. One organization would like to expand its network through external communication such as increasing its social media presence.

Two organizations prioritized diversifying their funding base beyond current sources which primarily consist of state and federal grants. Many of the participating providers have expanded relatively quickly to accommodate the needs of the communities in which they operate and to keep up with demand for substance abuse treatment. Two organizations determined that their organizational structure and the coordination among various programs could be strengthened to meet the realities of how the organizations are currently operating and the many services they are providing.

One organization prioritized revising its vision and mission and ensuring both are used to drive the organization's strategy at every level. Another organization prioritized putting performance targets in place across all activities and then reporting on performance in order to drive organizational learning and innovation. As organizations innovate and introduce new programs to serve clients with SUD, it is important to develop an effective program planning process, and for this reason one organization prioritized managing processes.

Conclusion

In seeking to make strides in achieving SAPTA's strategic plan goal to, "Build the capacity of local communities to provide the services to address their specific needs based on data-driven priorities," the CAST and program assessments provide valuable insight into what data indicates are the greatest capacity building needs in the state.

First and foremost, the assessment process acknowledged that a continuum of activities and services, from Promotion, Prevention, Treatment, Referral and Recovery are essential to building local capacity. Assessment results help pinpoint the needs and gaps by region across the state, highlighting specific treatment needs as a primary concern in each region. The overwhelming need for short- and long- term residential treatment is evident in the data, but regional nuances are also clear and help underscore the importance of ensuring a sufficient workforce and supportive services to promote recovery.

At the organizational level, the need to invest in workforce is mirrored in the priorities of programs that completed the OCAT. That, coupled with board engagement and development,

illustrate how critical human resources are to the service delivery capacity at the local and regional level.

It is important to note that system capacity building should coincide with program capacity building. It is only by investing in both levels that SAPTA can realize its vision that *Nevadans are healthy and resilient and able to fully participate in their community*.

Appendix A: Notes from the CAST Tool Developer

Utilization

CAST was designed to be used in conjunction with a community process. This requirement of using CAST is for two reasons. One, the values used to estimate each component of the care continuum were based upon national averages gleaned from the existing research literature. These values are likely to need to be adjusted to reflect the particular delivery models of each component within a given community or region. Two, the secondary data that is readily available for many elements of a care continuum are limited. This runs the risk of undercounting the presence of certain components, which in turn runs the risk of delegitimizing the CAST assessment within a place. Primary data collection among stakeholders as well as quality review by stakeholders are needed to mitigate this risk and to ensure data collection that is as full as possible.

After an initial phase of data collection has been completed, CAST should be shared with key community stakeholders. They should provide feedback on which elements of the estimates appear to be in alignment with their understanding of their care system, and which ones appear to be out of alignment with their understanding of their care system. At this stage, users of CAST can make adjustments to the values used in the algorithms for estimating component need. Two values in particular should be considered: the population totals and the usage rate. The population being served by any given program vary significantly across places, due to differences in geography, composition of the public/private nature of payers, and unique history of the community. Usage rate varies by the availability of a given component, geography, and the amount of outreach and system integration of a given community care system. Adjusting these totals provides each community with a method for making the CAST estimates align as closely as possible to their community characteristics. After one round of tweaks, the second, and potentially third, drafts should be reviewed again by the community stakeholders.

After the completion of a community-adapted CAST assessment, CAST can be used to facilitate the complex political conversations that arise when priorities and choices are to be made about a care system with limited resources and emotional investment from stakeholders and community members. These conversations, hopefully, will be strengthened and informed by the estimated totals produced by CAST. If the community has an adequate supply of school-based prevention programs, but few community-based prevention programs, the assessment creates an opportunity for this discussion.

Status Update

Since 2016, CAST has been updated by the principal researchers. These updates were presented in a handbook that is still available upon request. Due to changes in the SAMHSA administration and corresponding changes within the priorities of CBHSQ, the tool no longer received technical assistance from SAMHSA. The principle researcher, Brandn Green, and his colleagues Rob

Lyerla, Kristal Jones, and Donna Stroup have continued to develop and refine the tool, often in collaboration with professional evaluators who have been asked by clients to use the assessment methodology.

This status update is being completed in April of 2019, more than three years since the publication of the original CAST article. Over these three years, the principle researcher is aware of CAST being utilized to assess the care system of Chester County, PA, Sussex County, DE, Hillsborough, NH, and Maricopa County, AZ. Since September 2018, Dr. Green has been providing external consultation to the United States Army Public Health Service as they adapt the tool for use at US Army installations. This handbook update was prompted by the use of CAST to assess the five different regions of Nevada.

Appendix B: Data Sources and Definitions

Components	Definition and Units of Measurement	Data Source
Promotion		
Marketing Advertisements	Individual advertisements placed on tv, radio, print, billboards, web, and social media within one year.	Stakeholder surveys/worksheets distributed or managed by RBHCs and project leaders
Media Advocacy Events	Individual, in-person gatherings meant to raise awareness of substance misuse.	Stakeholder surveys/worksheets distributed or managed by RBHCs and project leaders
Community Coalitions	Individual coalitions of political, non-profit, and/or business organizations that receive and allocate grant funding to limit substance misuse.	Stakeholder surveys/worksheets distributed or managed by RBHCs and project leaders
Prevention		
School-Based Prevention Programs	Substance misuse disorder prevention programs being implemented within schools. Each program was counted as 1.	Stakeholder surveys/worksheets distributed or managed by RBHCs and project leaders
Community-Based Prevention Programs	Substance misuse prevention programs being implemented within community settings. Each program was counted as 1.	Stakeholder surveys/worksheets distributed or managed by RBHCs and project leaders
Housing Vouchers for Homeless Residents	Dedicated beds for homeless, across all types of Continuum of Care (CoC) project types.	https://housing.nv.gov/resources/HUD_Reports/ supplemented by stakeholder surveys distributed by RBHCs
Needle Exchange	Number of locations offering needle exchange.	Web search
Prescription Drug Disposal Events/Locations	Number of drug disposal events held per year, combined with all drug disposal locations.	https://takebackday.dea.gov/, https://nabp.pharmacy/initiatives/awarxe/drug-disposal-locator/, and stakeholder surveys distributed by RBHCs
Referral		
Adult Specialty Court	All specialty courts that serve adults.	List supplied by Specialty Courts Coordinator, Administration Office of the Courts
Youth Specialty Court	All specialty courts that serve youth.	List supplied by Specialty Courts Coordinator, Administration Office of the Courts
Social Workers	Licensed social workers with a substance use or mental health focus.	National Association of Social Workers, find a social worker locator website using a substance misuse filter. Also cross-checked against occupations statistics 21-1023 (Mental Health and Substance Abuse Social Workers). Used whichever count was higher between the two sources.

Components	Definition and Units of Measurement	Data Source
Treatment		
Inpatient		
Detoxification	Facilities providing in hospital or residential detoxification.	https://findtreatment.samhsa.gov/
24-hour/Intensive Day Treatment	Facilities providing non-residential, psychiatric care programs, lasting two or more hours per day for 3 or more days per week.	https://findtreatment.samhsa.gov/
Short-Term (30 days or fewer)	Facilities providing less than 30 days of non-acute care in a setting with SUD treatment services.	https://findtreatment.samhsa.gov/
Long-Term (more than 30 days)	Facilities providing 30 days or more of non-acute care in a setting with SUD treatment services.	https://findtreatment.samhsa.gov/
Outpatient		
Detoxification	Facilities providing outpatient/ambulatory detoxification.	https://findtreatment.samhsa.gov/
Counselors	Counselors licensed by the state to assist clients with drug and alcohol issues.	List provided by Board of Examiners for Alcohol, Drug and Gambling Counselors
Psychiatrists	Psychiatrists listed as specializing in substance use disorders.	http://finder.psychiatry.org/ Cross-checked/supplemented by https://www.psychologytoday.com/us/psychiatrists/substance-abuse/nevada
Psychologists	Psychologists listed as specializing in substance use disorders.	https://www.psychologytoday.com/us/therapists/addiction/nevada (only psychologists included)
Opioid Treatment Program (OTP)	Providers that offer opioid treatment programs (OTPs), that offer daily supervised dosing.	https://dpt2.samhsa.gov/treatment/
Office Based Opiate Substitution (OBOT)	Providers that offer office-based opioid treatment (OBOT), which provides medication on a prescribed weekly or monthly basis (is limited to buprenorphine).	https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/certified-physicians

Components	Definition and Units of Measurement	Data Source
Recovery Support		
Religious or Spiritual Advisors	Individual, religious or spiritual professionals providing SUD therapy and counseling.	Stakeholder surveys/worksheets distributed or managed by RBHCs and project leaders
12-Step Groups	Number of substance misuse support groups offered weekly.	https://findtreatment.samhsa.gov/locator/link-focSelfGP, https://www.lvcentraloffice.org/lvaa_printed.pdf, and http://nnig.org/meetings
Transportation for Those Receiving Treatment	Number of vouchers provided within a year to assist those seeking treatment.	Utilized https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/nssats_directory_2018.pdf to determine which groups offer transportation assistance, supplemented by survey distributed by RBHCs. Average number of vouchers indicated by respondents to survey was used as proxy for those groups included in the report, and for which specific counts of vouchers were not available.
Employment Support for those Receiving Treatment	Number of programs offered by each responding or reported group (number not specified counted as 1).	Utilized https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/nssats_directory_2018.pdf to determine which groups offer employment support, supplemented by survey distributed by RBHCs.
Educational Support	Number of programs offered by each responding group (number not specified counted as 1)	Stakeholder surveys/worksheets distributed or managed by RBHCs and project leaders
Parenting Education for Individuals with a Use Disorder	Number of programs offered by each responding group (number not specified counted as 1).	Stakeholder surveys/worksheets distributed or managed by RBHCs and project leaders
Housing Assistance	Number of programs offered by each responding group (number not specified counted as 1).	Utilized https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/nssats_directory_2018.pdf to determine which groups offer housing assistance, supplemented by survey distributed by RBHCs.
Insurance Assistance	Individual professionals who provide insurance enrollment support.	https://www.nevadahealthlink.com/get-help/navigator-organizations/

Appendix C: Data and Documents Reviewed for CAST

Documents reviewed included:

- Washoe Regional Behavioral Health Policy Board 2018 Annual Report
- Regional Behavioral Health Policy Board Minutes 2018-2019
- Presentation: Washoe County Behavioral Health and Homelessness
- Presentation: A Community Coalition's Role in Behavioral Health
- Presentation: Harm Reduction in Washoe County
- Issues Facing Washoe County Regarding Substance Use and Mental Health
- SAPTA Provider List
- SAPTA Needs Assessment 2018
- Presentation: Southern Nevada Behavioral Health and Homelessness
- Presentation: Harm Reduction in Southern Nevada
- Issues Facing Clark County Regarding Substance Abuse and Mental Health, handout for RBH Policy Board
- Prevention, Advocacy, Choices, Teamwork (PACT) Coalition Comprehensive Community Substance Abuse Prevention Plan
- Regional Behavioral Gaps 2018 Handout
- Introduction to Carson Tahoe Behavioral Health NAVIGATE Program Handout
- Presentation: Rural Children's Health Consortium Annual Progress Report for Ten-Year Strategic Plan, 2018
- Presentation: Guardian Health Transportation Company, 2019
- Presentation: Mobile Crisis Response Team, 2019
- Presentation: The Crisis Now Model; Transforming Services is Within Our Reach, 2018
- 2018 Rural Regional Behavioral Health Report
- 2018 Southern Nevada Behavioral Health Annual Report
- HOPE Committee Minutes
- Community Provider List