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Adolescent Health Needs Assessment

PREPARED FOR THE SEXUAL RISK AVOIDANCE EDUCATION PROGRAM
(SRAE) OF THE NEVADA DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

BY

HEALTH MANAGEMENT ASSOCIATES RESEARCH TEAM

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Executive Summary

Background & Approach

The Sexual Risk Avoidance Education Program (SRAE) of the Maternal, Child, and Adolescent Health Section (MCAH), Bureau of Child, Family and Community Wellness (BCFCW), in the Nevada Division of Public and Behavioral Health contracted with Health Management Associates, Inc. (HMA), a national research and consulting firm to conduct a statewide needs assessment of adolescent health and safety, including youth sexual health and risk. This assessment and corresponding publication were supported by the SRAE Program through Grant Number 1801 NVSRAE from Department of Health and Human Services, Administration for Children and Families. Its contents are solely the responsibility of the HMA authors and do not necessarily represent the official views of the SRAE Program, the Division nor Department of Health and Human Services, Administration for Children and Families.

The goals of the assessment were to more clearly understand how gaps, barriers and resources in medical, social, educational, and mental health services may be impacting health, teen pregnancy and sexually transmitted infection (STI) rates among 10 to 19-year-old youth in Nevada. Although the primary focus of the report is on adolescent sexual behaviors and health, it is important to be mindful of the interconnectedness of adverse adolescent health outcomes.

Adolescence is a critical period with rapid physical, cognitive and psychosocial development and change which puts youth at greater risk for many health and safety concerns such as bullying, suicide, unintentional injury, substance use, and risky sexual behaviors. It is important for public health practitioners to have a good understanding of the complex set of risk and protective factors at play in promoting health and safety among youth, as well as the gaps and barriers in intervention and prevention services focused on adolescents.

A mixed method design using both quantitative and qualitative methods informed the needs assessment which was made up of five main components: Key informant interviews, focus groups, a community survey, secondary analysis of population health and demographic data, and needs and resource mapping.

Key Findings

By and large, the biggest issues on the rise for youth in the United States are anxiety and depression according to the Pew Research Center. Seventy percent of youth, ages 13 to 17 years, reported anxiety and depression as a major problem, followed by bullying, drug addiction, drinking alcohol, poverty, teen pregnancy, and gangs.¹ Some of the stressors teens face include pressure to get good grades, look good, fit in socially, and be involved in extracurricular activities.² While anxiety and depression cross income

¹ Horowitz, J. M., & Graf, N. (2019). *Most U.S. Teens See Anxiety and Depression as a Major Problem Among Their Peers*. Pew Research Center. Retrieved from <https://www.pewsocialtrends.org/2019/02/20/most-u-s-teens-see-anxiety-and-depression-as-a-major-problem-among-their-peers/> (all websites were accessed between: 08.01.19- 9.30.19).

² Horowitz, J. M., & Graf, N. (2019). *Most U.S. Teens See Anxiety and Depression as a Major Problem Among Their Peers*

boundaries, teen pregnancy and poverty were seen as much bigger issues to teens with a household income of less than \$30,000 a year. Approximately four out of every 10 teens say they spend too little time with their parents compared to only two out of 10 for those with higher incomes.¹

While Nevada has unique characteristics and demographics, many teens across the state face the same issues and pressures as their peers across the country. This can be seen in the data, as well as through the issues brought up during the needs assessment process in discussions with key stakeholders, parents, providers, community members, and teens (13 to 17 years old, with parent consent to participate).

Stakeholders accessed for this report have a strong sense of the challenges in Nevada, as well as what is needed to improve the health of teens across the state. Distinct themes and issues were identifiable in the data. The biggest challenges to adolescent health are presented in the report regarding pressing health issues, barriers to positive health outcomes, and risk and protective factors that exist and influence those outcomes.

With regard to barriers to positive adolescent health outcomes, by far, the most common challenge cited was a lack of access to resources, including health care, healthy foods, housing, and education (particularly education related to sexual health). In more rural areas, this lack of access was compounded by having fewer resources available to begin with, such as a lack of primary care providers, as well as providers who will see adolescents without parental permission (which can be a deterrent for some youth to seek out information and/or care). Even when resources are available to adolescents, many young people are not aware of those resources or have concerns about confidentiality and possible expense.

Regarding the most pressing adolescent health issues, stakeholders perceived the rates of substance use among adults and teens to be significant and having a large impact on their community. Easy access, peer pressure, lack of parental monitoring and involvement, and boredom lead teens to turn to vaping, heroin, alcohol, marijuana, opioids, and prescription drugs, and were thought to be driving up crime, suicide, mental health issues, truancy, unemployment, and child placements to foster care. Generally, high rates of domestic and dating violence, as well as high suicide rates are also factors for concern, with some adolescents having toxic home environments where they are abused.

Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) youth experience extremely high levels of bullying and violence, homelessness, fear, and mental health issues. Additionally, there are few schools or organizations that engage in LGBTQ-specific sexual health education that is inclusive of their needs and concerns and so youth may be more at-risk because of a lack of information, role modeling, and support.

¹ Horowitz, J. M., & Graf, N. *Most U.S. Teens See Anxiety and Depression as a Major Problem Among Their Peers*. Pew Research Center. Retrieved from <https://www.pewsocialtrends.org/2019/02/20/most-u-s-teens-see-anxiety-and-depression-as-a-major-problem-among-their-peers/>

There is a sense of commitment and urgency among stakeholders for improving the sexual health and general well-being of young people. Many communities have engaged partners and leaders who are willing to work for youth, including, but not limited to, many faith-based partners.

Solutions

If the above barriers were addressed, there would still be resources needed in communities to help address adolescent health needs. Those mentioned by stakeholders included mental health services and mental health education for adolescents, programs focused on the positive physical development of youth, and more telemedicine options for youth living in rural areas. Transportation was also mentioned as a needed resource, both providing more resources to allow youth to access transportation, as well as bringing more resources directly to youth to circumvent the transportation issue.

Regarding sexual health education, many felt existing sex education could be strengthened with the inclusion of a focus on what resources are available to youth and how youth can access them.

Stakeholders felt an expanded, LGBTQ-inclusive sex education curriculum is needed to better reach youth. Finally, some stakeholders felt a sex education program that also included a parent component, such as how to talk to youth and education about sexual health issues facing youth, would be very beneficial so conversations about sex can continue into the home, after a program has ended.

The report offers several recommendations based on the information and insight gained from both the community engagement and population health and surveillance data to:

1. Improve Access to Health Care;
2. Build Protective Factors for Adolescents; and
3. Facilitate Understanding of Adolescent Health Issues.

While this assessment aims to be comprehensive, it cannot measure all possible aspects of adolescent health in Nevada, nor can it adequately represent all possible populations of interest. It must be recognized these information gaps might in some ways limit the ability to assess all the community's health needs. For example, certain population groups — such as the homeless, foster children, or children of parents who only speak a language other than English or Spanish — are to varying extents included in the assessment.

Introduction

Background & Approach

The Sexual Risk Avoidance Education Program (SRAE) of the Maternal, Child, and Adolescent Health Section of the Division of Public and Behavioral Health (DPBH) contracted with Health Management Associates, Inc. (HMA), a national research and consulting firm to conduct a statewide needs assessment of adolescent health and safety, including youth sexual health and risk. The goals of the assessment were to understand how gaps, barriers, and resources in medical, social, educational, and mental health services may be impacting health, teen pregnancy and sexually transmitted infection (STI) rates among 10 to 19-year-old youth in Nevada. Although the primary focus of the report is on adolescent sexual risk, it is important to be mindful of the interconnectedness of adverse adolescent health outcomes. The underlying risk behaviors share many of the same causes, including stigma; discrimination; insufficient

health care coverage and access to services; and insufficient health, educational, economic, and social policies or laws. The assessment sought to explore these other health issues and causes as important context for sexual behaviors of adolescents.

The World Health Organization asserts promoting and protecting the health of adolescents will lead to public health, economic and demographic benefits for young people now, into adulthood, and for future generations.⁴ Adolescence is a critical period with rapid physical, cognitive and psychosocial development and change which puts them at greater risk for many health and safety concerns such as bullying, suicide, unintentional injury, substance use, and risky sexual behaviors. It is important for public health practitioners to have a good understanding of the complex set of risk and protective factors at play in promoting health and safety among youth, as well as the gaps and barriers in intervention and prevention services focused on adolescents.

This assessment and corresponding publication were supported by the Nevada SRAE Program and DPBH through Grant Number 1801 NVSRAE from Department of Health and Human Services, Administration for Children and Families. Its contents are solely the responsibility of Health Management Associates (HMA) who authored the report and do not necessarily represent the official views of the SRAE Program, Division or Department of Health and Human Services, Administration for Children and Families.

Methodology

A mixed method design using both quantitative and qualitative methods informed the needs assessment made up of five main components. Notes and transcripts that were a result of interviews or focus groups were analyzed using NVivo to explore themes in the data. De-identified quotes were used in the final summary to provide illustrations of some of the key themes. Thematic codes were developed based on the interview and focus group guides with new codes developed as additional themes emerged through the analysis.

1. Key informant Interviews with Stakeholders Across the State

Seven semi-structured, in-depth interviews were conducted, with a total of 15 individuals from Carson City, Clark, Nye, Elko, Washoe and Eureka counties, to gather information from the perspective of key leaders about what is most needed across the state and where there are barriers and gaps in services and programming for teens, including questions regarding any barriers or gaps associated with Title V Sexual Risk Avoidance Education (SRAE) Program-Promoting Health Among Teens! -Abstinence Only (PHAT-AO).

The list of key informant interviews was finalized in collaboration with SRAE Program staff and included providers of physical health and mental health services to teens, county and city officials, and leaders at key social service organizations, including family resource centers, juvenile probation offices, LGBTQ centers and county coalitions. Each stakeholder provided valuable insight into and information about the issues facing youth in each represented community. The selection of informants was determined to ensure diversity across expertise and geography.

⁴ World Health Organization. (2017, May 16). Why invest in adolescent health? Retrieved from https://www.who.int/maternal_child_adolescent/topics/adolescence/why-invest/en/

Interviews were focused on gaining the perspectives and insights of community leaders about what is needed to improve the health of teens across the state, with an examination of youth sexual health and risk, teens who are pregnant or parenting, and other key indicators of adolescent health and safety. Key informant interviews were designed to gather information about disparities related to geography, race and ethnicity, and other identified socio-cultural differences. An interview guide was developed (See Appendix A).

2. Community Focus Groups

Five focus groups were conducted in Pahrump, Las Vegas, Henderson, and Reno with the assistance of the SRAE Program and key stakeholders identified through the interviews described above. Focus group participants were invited to share their perspective on the most critical gaps, needs and solutions in their regions, as well as to describe the most pressing health issues faced by adolescents in their communities. Focus group participants included a total of 34 participants representing the following:

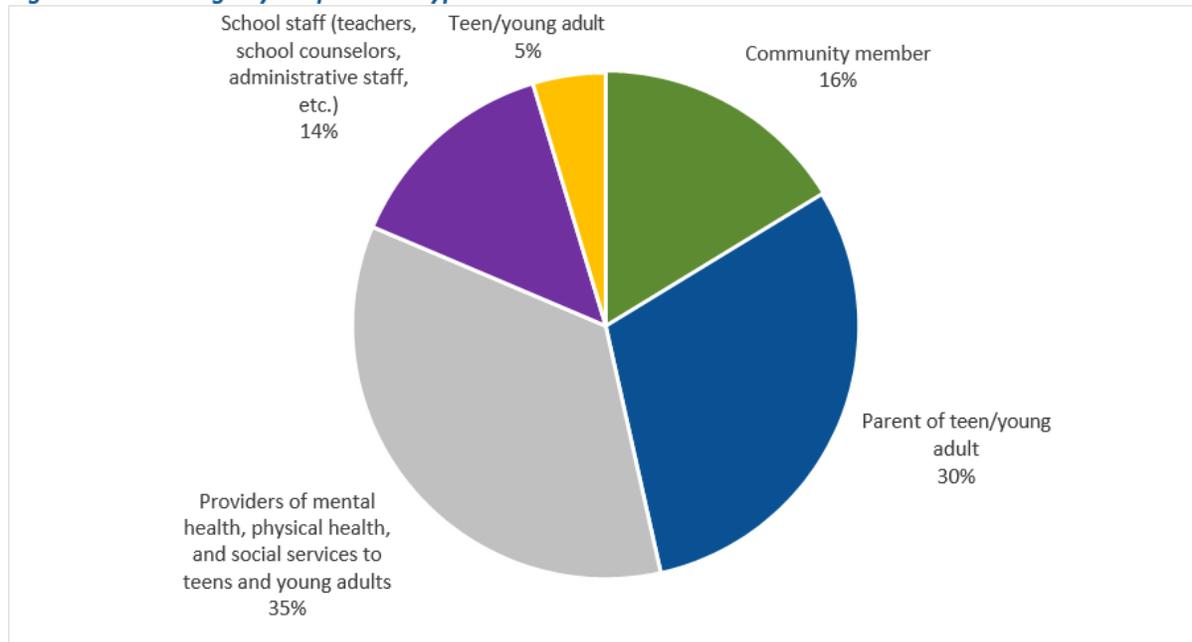
- Teens and young adults;
- Pregnant or parenting teens or young adults;
- Parents of pregnant or parenting teens;
- Teachers and school counselors; and
- Providers of mental health, physical health, and social services to teens and young adults.

Focus groups were used to further understand the needs, barriers, and gaps in services and programming for teens, both from the perspective of people with experience and expertise working with teens, but also from the perspective of teens themselves. An interview guide was developed (See Appendix B). Detailed notes were taken during all focus groups. Consent forms to participate in the groups were signed. Youth under 18 years of age required a parental note of consent. NVivo software was used for the qualitative analysis of the focus group data.

3. Community Survey

A community survey was designed to include the focus group questions. It was distributed via community partners in White Pine, Eureka, Elko, and Humboldt counties. The intention of the survey was to elevate the voices of rural areas of Nevada. It was administered online using Survey Monkey. Forty community members responded to the survey with the vast majority from Elko (91%). Sixty-five percent of the respondents were either a provider of mental health, physical health, and social services to teens and young adults (35%) or a parent of a teen/young adult (30%), followed by community member (16%), school staff (14%), and teen/young adult (5%) as shown in Figure 1.

Figure 1: Percentage by Respondent Type



4. Population Health and Surveillance Data

The needs assessment gathered, organized, and analyzed publicly available data in the following areas:

Demographic data: Demographic data on geography, economic status, race, ethnicity, gender, age, language, religion, and sexual orientation.

Risk and protective factor data: Data on risk and protective factors related to child welfare involvement (including youth in and aging out of foster care), housing security (including runaway youth), juvenile justice involvement, access to pro-social activities, involvement in healthy relationships, experience of violence, substance use, mental distress, and other risk and protective factors identified by the SRAE Program staff or in the data sources.

Existing adolescent health programs: Data on all existing programs addressing adolescent health, with a focus on teen pregnancy and STIs among adolescents age 10 to 19 years.

Existing social service programs supporting adolescent health by providing services addressing social determinants of health: Data to identify programs and services providing medical, social, educational, and behavioral health services for adolescents, including availability of medical and behavioral health providers with adolescent health expertise, mentoring programs, before/after school programs, prevention/education programs related to violence, substance use, sexual health, or mental health, etc. The inclusion of these types of services in the need's assessment provides the SRAE Program a more complete picture of the full spectrum of gaps in services that support the health and well-being of Nevada's youth.

5. Resource and Need Mapping

The needs assessment includes an analysis and mapping of publicly available data to provide visuals of the highest need areas in the state; examining rural, frontier and urban differences as well as differences based

on demographics or existing risk and protective factors. Demographic data, risk and protective data, Health Professional Shortage Area (HPSA) data, data on substance use and mental health across the state and other data providing information about social determinants of health identified in partnership with the SRAE Program were included.

By combining these data with data from interviews and focus groups, the assessment highlights where gaps and needs seem to be highest, as indicated by quantitative data, which are then overlaid with what stakeholders indicate are the greatest gaps and needs. The combination of these data provides a more complete picture of the critical unmet needs across the state.

Key Findings from the Needs Assessment

Community Voices

Incorporating community voices is of utmost importance to the need's assessment process. Focus groups provide opportunities for members of the community being assessed to come together to share individual thoughts and perspectives, and brainstorm collective ideas for change. Community input in describing the problem ensures a clear and consensual understanding of the problem's definition, scope, and impact on community members. This is important level setting for any research. Community members may also have insights into how to best address the problem in their specific communities' context. Building consensus among various stakeholder groups may also prove beneficial in implementing change; spending time engaging community members in the needs assessment process often creates a market for results.⁵

Key Informant Interviews

Key informant interviews were conducted with stakeholders identified by the SRAE Program with the purpose of learning the perspective of community leaders working in adolescent health across the state about gaps and barriers related to services and programming for teens. More specifically, questions were focused on youth sexual health and risk, teen pregnancy and teen parenting, and other key indicators of adolescent health and safety.

What is Adolescent Health?

When asked to describe what adolescent health included, key informants described adolescent health as including mental health, domestic violence, relationship violence, and substance use.

Adolescent Health Issues

Substance use was frequently mentioned as an issue facing adolescents, particularly alcohol and illegal drugs (opioids, methamphetamine, and cocaine), as well as a perceived growth in marijuana use since legalization in 2017. Respondents reported hearing about experiences when access to drugs was easy in either or both the school or home setting. Some key informants reported past circumstances in which they heard parents were supplying the alcohol and/or drugs to ensure their child does use these substances safely at home.

⁵ U.S. Department of Health and Human Services Centers for Disease Control and Prevention. Office of the Director, Office of Strategy and Innovation. *Introduction to Program Evaluation for Public Health Programs: A Self-Study Guide*. Atlanta, GA: Centers for Disease Control and Prevention, 2011.

High rates of violence – particularly domestic and relationship violence – with some adolescents having toxic home environments where abuse had occurred was cited as an issue among youth.⁶ The issue of relationship violence was seen to be larger in rural areas, particularly mining communities, where it was reported by key informants that high demands of the job and the stressful nature of shift work, put adolescents at risk of household substance use and violence in the home.

These issues were all described as being connected to the issue of mental health, which was another common issue cited. Many adolescents have problems with anxiety and depression, along with other mental illnesses which in many areas has led to high suicide rates among youth.

Looking more specifically at issues related to sexual health, many stakeholders cited concerns about a lack of consistent education about the topic. Key informants reported access to sexual education is reliant upon not only the school district and the school, but also the individual teacher who is charged with incorporating sexual education into the health curriculum. This means that many students have varying levels of information, which they often supplement with information gleaned online and from one another, which is thought to perpetuate myths and misinformation about sex. Key informants, particularly in southern Nevada, also felt youth are oversexualized from a very young age due to access to pornography both online and sometimes in homes. This access is thought to skew adolescent views about sex which can then lead to unhealthy and/or risky behaviors.

The understanding of consent was another barrier to positive health outcomes brought forth by key informants. Consent is thought to not be a topic discussed with youth. There are concerns about how much youth understand that saying “no” is an option and how to set boundaries when it comes to sex. Some key informants linked this to the high levels of relationship violence, as many teens struggle to define what a healthy relationship should look like and how to communicate with one another about topics like consent.

Risk Factors for Adolescent Health

Many key informants were able to identify risk and protective factors relating to adolescent health outcomes in their communities. Risk factors are often interrelated so that one risk factor leads to a negative health outcome that becomes a risk for other negative outcomes for teens. For example, teen pregnancy can lead to negative mental health outcomes, a teen’s ability to graduate from high school or attend secondary education, and involvement with the criminal justice system.^{7,8}

Some of the biggest risk factors mentioned relate to what teens “lack” in their communities. Many key informants mentioned a lack of parental guidance and engagement, a lack of public health and health education, a lack of education overall, a lack of resources (especially in rural areas), a lack of future aspirations, and a lack of respect for other people.

One risk factor highlighted among key informants was social isolation and lack of connectedness. In rural northern counties, it was reported that many parents work multiple jobs or both parents work in the mining industry, and often must leave children at home alone for extended periods of time, resulting in

⁶ No youth participant reported experiencing current abuse.

⁷ Perper, K., Peterson, K., & Manlove, J. (2010). *Diploma Attainment Among Teen Mothers*. Retrieved from https://www.childtrends.org/wp-content/uploads/2010/01/child_trends-2010_01_22_FS_diplomaattainment.pdf

⁸ Hoffman, S. D., & Maynard, R. A. (2008). *Kids Having Kids: Economic Costs & Social Consequences of Teen Pregnancy*. Washington, D.C.: The Urban Institute Press.

reduced parental engagement. Additionally, youth in rural areas experience social isolation as many have both parents working outside of the home and are geographically isolated from other people and resources.

Families struggling to make a living wage was also named as a risk factor with more teens dropping out of school in order to earn an income or take care of younger siblings while their parents work.

In terms of sexual health issues, risk factors were the same across the state. Many key informants felt that youth have permissive attitudes towards sex, often because they have very low perceptions of risk for things such as pregnancy, STIs, and HIV. Many felt this was because youth have a mindset of “invincibility,” regardless of what happens. Other issues include many teens have friends who are sexually active, playing into the issue of peer pressure, and a normalization of having sex at a young age, as well as the ease of access most adolescents have to pornography.

Protective Factors for Adolescent Health

Common protective factors mentioned were prosocial events for youth that help them make connections with other youth, as well as with trusted adults. Sports were also mentioned as a protective factor, particularly in rural areas, based in part on the fact many schools require youth to meet certain grade point average (GPA) requirements and to avoid trouble in order to remain on the team. One positive factor noted for smaller communities is that community members look out for one another, so when something happens, there are connections people can rely upon. For pregnant or parenting teens, remaining in school can be a protective factor. Finally, other protective factors mentioned included stable home and family lives and having a relatively higher income as it allows access to resources that are not always available to everyone.

Many communities have engaged partners and leaders who are willing to step up to work for youth, including many faith-based partners. As well, there are existing organizations such as community coalitions, resource centers, Title X family planning clinics (although there are fewer of these in rural areas), partnerships for homeless youth, and health districts that all have juvenile programs available. One key informant from Eureka mentioned a youth roundtable for providers that allowed them to facilitate warm handoffs between services and programs as a great protective factor for youth.

Barriers to Positive Adolescent Health Outcomes

Many risk factors are worth mentioning again here as barriers needing to be addressed in order to make a difference in adolescent health outcomes. These include a lack of access to more thorough sex education, a lack of access to STI testing and birth control, and a lack of access to health care providers willing to work with adolescents without parental permission. Then, even if there are resources available to adolescents, many young people are not aware of those resources or have concerns about confidentiality and costs. Affordability of services was also cited as a barrier to accessing resources that do exist, as many families across Nevada have low to moderate income levels.

Specific to sexual health, key informants noted many families are struggling to make ends meet and finding adequate housing, so other needs like adolescent sex education are not prioritized. Additionally, sexual health can be a very personal topic that not all people feel comfortable discussing

with their kids or others. Key informants felt that may influence the extent to which healthy conversations about sex are occurring between adolescents and their parents and/or other trusted adult. Underlying this issue is thought to be the state's predominantly conservative mindset about adolescents and sexual health and a fear that discussing sex with young people will make them more likely to engage in sex. Related, some key informants mentioned resistance from parents in their communities to including sex education in schools. The combination of this resistance and parental consent for youth participation in sexual education, creates circumstances in which many children are not getting a sexual health education.

Many communities also have issues with transportation. In the more rural counties, it can be hard to get to cities with more resources if personal transportation options are not available. Oftentimes, public transportation is not an alternative. For example, it was reported that Elko County had one taxi service for the county, and no public transportation. Transportation was an issue in larger cities as well, as larger cities do not always have adequate public transportation. It was too costly and/or youth did not feel safe accessing what public transportation may be available, especially teens with young children.

Disparities Among Adolescent Population Groups

Looking at certain sub-populations of adolescents, two were named as being more at risk: LGBTQ youth and migrant youth. For LGBTQ youth, there are issues related to homelessness as they are more likely to be rejected by their families and kicked out of their homes. Youth with access to shelters may fear being bullied or treated poorly in those shelters and so feel they must stay on the street. These same youth have a hard time finding jobs, particularly in areas where the work is centered around alcohol and gambling (meaning they need to be 18 years of age) and so turn to sex work for income, which is then linked to issues of trafficking. Specifically related to sexual health education, there are few places that have an LGBTQ-specific curriculum inclusive of their needs and concerns and so they may be more at-risk for sexual risk behaviors because they do not have the appropriate information.

For migrant children, there are issues related to cultural assimilation due to the current political climate and the focus on immigration. Many migrants are fearful of accessing services (whether they are legally documented or not) and so have "gone underground." This then puts migrant youth at greater risk of health issues because they cannot access resources or help.

In rural areas, key informants indicated there may be unique risk factors and although these might be present in more urban areas, it is often to a lesser extent. For example, while access to health care may be an issue statewide, in rural areas there is a severe shortage of providers, particularly specialty providers, so many teens and families must travel hundreds of miles to find a specialty provider, such as a behavioral health provider.

In response to these barriers, key informants suggested potential solutions and resources for their communities. For example:

1. Increase mental health services and mental health education for adolescents;
2. Programs focused on the positive physical development of youth;
3. More telemedicine options for youth living in rural areas; and
4. Providing more resources to allow youth to access and identify transportation options.

Regarding addressing sexual risk behaviors, key informants suggested:

1. More comprehensive sex education with a focus on what resources are available to youth and how youth can access them;
2. Comprehensive, LGBTQ-inclusive sex education curriculum to better reach those youth; and
3. A sex education program incorporating a parent component, such as how to talk to youth and education about health issues facing youth, so that conversations about sex can continue into the home, after a program has ended.

Community Focus Groups

Community focus group participants reflect many of the issues, barriers, and risk and protective factors identified by the key informants. Highlights of these groups are provided below.

Youth Perspective

Youth saw adolescent health as comprising both mental and physical health and included aspects of fitness, access to food, emotional well-being, coping skills, resiliency, sexual health, and being disease free. Youth participants did share experiences regarding individuals involved in the criminal justice system, as in some cases, having incarcerated friends and family members contributes to feelings of isolation that can lead to poor mental health and substance use.

“It’s like a trend that if you ain’t got a baby you’re not cool.” – Youth Participant

Youth identified the following pressing health issues for themselves:

- the need for more resources such as sexual health education,
- high suicide rates
- youth living in poverty,
- stress that arises having to choose between school and work,
- high teen pregnancy rates

Youth identified the following risk factors:

- the dehumanizing effects and glorification of sex and violence on social media,
- lack of parental supervision, involvement and support,
- easy access to drugs,
- lack of respect at school and at home,
- a light attitude towards substance use,
- the sexualization of girls and women, lending to a negative normalization of sex,
- a lack of awareness around mental health resources and substance use, and
- the stigmatization of getting help for substance use.

To youth participants, sexual health includes the establishment of trust in relationships, testing for sexually transmitted diseases and HIV, safety (i.e. domestic violence, sexual assault), and detailed contraception education.

“I know so many people who have been abused and it is really sad.” – Youth Participant

Risk factors for unhealthy sexual behaviors included:

- normalization of sex,
- romanticizing of intercourse, and
- living with a highly sexually charged environment such as Las Vegas.

Protective factors included:

- involvement in religious groups, and
- positive social groups.

Youth believed observing dramatizations of accidents related to driving under the influence (DUI), commercials of former smokers, and their own loved ones who experienced the negative impacts of cigarette or drug use helps protect teens from making harmful choices.

The risk factors for violence, as youth saw it, included bullying, lack of education around how to express emotions in a healthy way, misinformation, normalization of violent behaviors, and victim blaming.

Parent Perspective

Parents saw adolescent health in much the same way as youth did, but also recognized their role in supporting the mental, physical, and spiritual well-being of their children by providing structure, housing, food, and educational opportunities. Issues identified by parents included substance use—particularly marginalized and disadvantaged groups “looking for an escape” – and mental health.

There is a need to “care more about kids than the test scores.” Parent Participant

Risk factors for poor adolescent health outcomes identified by parents included:

- easy access to a wide variety of drugs,
- living in close proximity to urban areas, such as Las Vegas,
- lack of alternative activities and options for youth,
- an overemphasis on social media,
- lack of extracurricular activities and role models,
- negative peer pressure from social groups,
- academic pressure,
- traumatic events in early childhood, and
- being in the “cycle of substance abuse,” especially if youth have witnessed their parents engaging in behaviors of substance use.

Protective factors according to parents included:

- supportive family background,
- access to affordable counseling/therapy,
- caring teacher and adults at school,
- sports participation
- more drug testing in schools,
- having a long-term, realistic goals, and plans,
- trust-filled, judgement-free relationships,

- positive social groups,
- more rigorous (less "sugarcoated") drug prevention and sexual education programs,
- open communication and honest relationships with parents,
- access to prescriptions and affordable health care, and
- involvement in a religious organization

Solutions from parents included more education for parents about how to parent with stronger discipline and more open communication, as well as more rigorous drug prevention and sexual education programs.

Provider Perspective

When asked to define adolescent health, community members who provide health, education or social services to adolescents focused on both mental and physical health but placed special emphasis on mental and emotional well-being. Beyond the availability of substances, providers identified issues such as a lack of parental support, poverty, mental health, and myths surrounding LGBTQ youth as additional risks to adolescent health.

Protective factors identified by providers included:

- increased dialogue about adolescent health issues, between providers, parents, and youth,
- positive decision-making skills, and
- education about coping mechanisms and healthy outlets for expressing emotions.

Participants discussed the importance of developing decision-making skills, understanding healthy relationships, and building self-esteem among adolescents. The importance of skills around the expression of emotions as preventive for perpetration of violence was also discussed. More counseling, access to community centers, and increased dialogue around healthy relationships were cited as ways to address violence.

Community Survey

A survey was administered to youth, parents, and providers living in White Pine, Eureka, Elko, and Humboldt counties. The intention of the survey was to elevate the voices of rural areas of Nevada, who are often not represented in needs assessments. Forty youth, parents, and providers responded to the survey.

What is Adolescent Health

Survey respondents saw adolescent health as inclusive of mental, emotional, physical, sexual, and spiritual well-being. Important aspects of adolescent health were identified as immunizations, exercise, hygiene, coping skills, healthy development, and safe sex.

What Are Adolescent Health Issues?

Respondents perceived the rates of substance use among adults and teens to be significant and prevalent, and having a large impact on their community by contributing to an increase in crime, suicide, mental health issues, truancy, unemployment, and child placements to foster care.

The impact of substance use in the community, as they see it, is significant and interrelated among family structure, the health care system, education, and the criminal justice system. Substance use is perceived as a waste of community resources and a detriment to the potential users.

Mental health was also mentioned as a pressing adolescent health issue with high suicide rates and depression. Poor mental health contributes to poor daily functioning and feelings of being lost. Compounding this problem is that mental health services were reported to be minimal, and many do not receive assistance either because of long wait lists or lack of transportation.

Risk Factors

Risks to good adolescent health included issues related to the physical environment and easy access to e-cigarettes, marijuana, and other substances. Youth reported over use of electronic devices (smart phones, tablets, computers) have replaced human encounters, which can lead to conflict. They saw a lack of alternative activities and prohibitive prices for theaters as a significant barrier. In addition to the lack of entertainment and pro-social activities for youth, survey respondents saw a significant lack of community services and resources as a problem including few public health nurses and no mental health services for people who are LGBTQ. A lack of community partnership with spiritual organizations was identified as problematic. Issues such as the legalization of marijuana, high rates of crime, and conservative ideologies were also named as a challenge to advancing health.

In summary, risk factors for substance use identified by the rural survey respondents included:

- | | |
|---|--|
| ■ bullying, | ■ curiosity, |
| ■ depression, | ■ lack of positive role models, |
| ■ lack of coping skills, | ■ parental involvement, supervision or |
| ■ easy access and attitude of acceptance for risky behavior, such as substance use, | discipline, and |
| ■ feelings of entitlement, | ■ parental use of drugs, |
| | ■ peer pressure, and |
| | ■ boredom. |

Risk factors for mental health included past trauma, parental struggles, and lack of services and screening. Environmental factors were also cited, including lower and/or higher socioeconomic status, stress, isolation, and obesity. LGBTQ groups were reported as marginalized, stigmatized, and victimized.

In summary, risk factors for mental health identified by survey respondents included:

- | | |
|---|--|
| • negative impacts of social media, | • parents own struggle with mental health and, |
| • poor coping skills, | • lack of screening and treatment resources. |
| • having no self-confidence or self discipline, | |
| • past trauma | |

Protective Factors

Supportive, healthy family relationships were cited to be protective factors against substance use, as well as parental involvement, clear social norms and expectations, community resources, positive

extracurricular activities for adolescents, including involvement in religious groups. Getting youth involved in community leadership, providing them with more education, role models, support networks, and awareness were also cited as protective factors.

In summary, protective factors identified by rural survey respondents included:

- family and social support,
- availability of services,
- decrease in stigma around asking for help,
- healthy avenues for developing self-esteem,
- coping skills,
- real life education,
- adult role models who give positive attention,
- positive extracurricular activities,
- safe spaces to receive guidance, and
- involvement in a religious community.

In general, seven respondents identified resources such as drug and alcohol education, peer support, suicide prevention, reproductive health and knowledge, internet safety, access to birth control and condoms, and mental health services as important to developing and maintaining adolescent health.

Promoting Health Among Teens! – Abstinence Only (PHAT-AO) Strengths and Weaknesses

Taking a closer look at the SRAE Program – PHAT-AO – many stakeholders (e.g., key informants, focus group participants, and survey respondents) who were familiar with PHAT-AO saw that it had both strengths and weaknesses.

The most common strength of PHAT-AO reported by stakeholders was that it went beyond just teaching about abstinence and unsafe sex, but also about healthy relationships and communication. The introduction of life skills was also seen as a great plus, as the topics of teamwork and the use of role-playing helped to keep kids engaged throughout the program. As well, the program is a great way to introduce kids to a trusted adult (i.e., the program implementer) who can provide youth with correct information about sexual health issues.

Weaknesses of PHAT-AO indicated by stakeholders include the program was too long and many teachers are not able to spare the time amid all the other requirements they meet throughout a school year. Some also felt the PHAT-AO curriculum was too rigid, and they wished it allowed more flexibility, such as to include or exclude modules some teachers may or may not want to include in their classroom. Some felt since the curriculum is geared towards a younger population (i.e., middle school) it was challenging at times to implement the program in high schools so they would prefer to be able to alter some of the language to better match the population. Related to this, for kids who are already having sex, the focus on abstinence only makes it harder to reach them as they would rather talk about topics such as birth control and STIs. Finally, it can be challenging for some to get parental consent and many would like to see parents more involved and engaged in the program in some way.

Other Adolescent Health Activities and Initiatives

Stakeholders were not able to create a robust list of existing adolescent and sexual health initiatives happening in their areas. This could point to a lack of available programming and/or a lack of knowledge of community resources available for youth and their families. Both challenges present significant barriers to improving adolescent health.

School-based efforts identified by stakeholders include tobacco prevention programming, and mental health screenings, health exams, and education done by school nurses. Health and sexual information classes were also named, but stakeholders identified these efforts as very basic and often outdated. A suggestion was made for schools to engage in curriculum updates to improve the relevancy and effectiveness of these programs by creating a review committee that would include parents and other relevant partners.

Outside of school environments, stakeholders identified two mental health and addiction treatment services for youth through the Community Counseling Center in Las Vegas. Gender Justice Nevada was also named as a resource for LGBTQ youth providing mental health services for youth and their families, medical advocacy, school advocacy, and social events. Again, the informants recognize others exist; however, these two organizations were able to be named.

The Nevada Teen Pregnancy Prevention Program and the Southern Nevada Health District Youth Access Days were also identified by stakeholders as a resource for adolescents. During youth access days, teens ages 13-19 years old can access pregnancy testing, STI screening, and obtain no-cost birth control. In addition, state funds used to support public health nurses across the state were named as an important way to broaden access to pap smears, intrauterine device (IUD), and other reproductive health and family planning resources.

Population Health and Surveillance Data

Demographics

The assessment includes the following demographics of individuals, families, and adolescents in Nevada:

- Geography
- Age
- Race and ethnicity
- Gender
- Sexual Orientation
- Language
- Religion
- Economic Status

Geography

In Nevada, 73.6 percent of the entire population resides in Clark County followed by 15.4 percent living in Washoe County, so combined 88.4 percent of the entire state's population lives in these two counties.

Age

In total across the state, the population is estimated to be 2,887,725, with a median age of 37.7 years.⁹ As of 2017, there were over 363,800 youth between the ages of 10 and 19 years living in Nevada, which accounts for approximately 12.6 percent of the total state population.¹⁰ The youth population is expected to reach over 420,000 by 2022.¹¹ The adolescent population, between the ages of 10 and 19, is broken down by county in Figure 2, below, and presented in a map in Figure 3.

Figure 2: Population of Nevadans 10 to 19 Years of Age by County, 2017¹²

County	Number	Statewide %	County %	County	Number	Statewide %	County %
Carson City	6,315	1.70%	11.60%	Lincoln	865	0.20%	16.60%
Churchill	2,580	0.70%	10.70%	Lyon	6,040	1.70%	11.50%
Clark	268,750	73.90%	12.70%	Mineral	409	0.10%	9.10%
Douglas	4,787	1.30%	10.00%	Nye	4,384	1.20%	10.10%
Elko	7,959	2.20%	15.20%	Pershing	637	0.20%	9.60%
Esmeralda	103	0.03%	9.30%	Storey	244	0.07%	6.30%
Eureka	272	0.07%	15.70%	Washoe	55,693	15.30%	12.50%
Humboldt	2,789	0.80%	16.30%	White Pine	1,316	0.40%	13.30%
Lander	677	0.20%	11.50%	Statewide	363,820	100.00%	100.00%

Clark and Washoe counties are by far the most populous counties and with a large number of households with individuals ages 12 to 17 years old at 33.2 percent and 32.9 percent of all households, respectively.¹³

⁹ U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates, Table S0101

¹⁰ U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates, Table S010

¹¹ Center for Business and Economic Research. (2017). *Nevada Kids Count Data Book 2017*. Retrieved from <https://www.caanv.org/wp-content/uploads/2018/10/2017-NEVADA-KIDS-COUNT-DATA-BOOK.pdf>

¹² U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates, Table S0101

¹³ U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates, Children Characteristics, Table S0901

Figure 3: Number of Households with Children Under 18 Years¹⁴



Population projections suggest the population of the state will reach 3,461,940 people by 2036. By 2035, it is estimated 21.9 percent of the total population will be older than 65 years (an increase of 49.5 percent from 2015) and only 28.2 percent will be younger than age 25 years (a decrease of 13.1 percent) indicating the population is expected to age.¹⁵

Race and Ethnicity

Across the state, the racial/ethnic distribution of the population is led by White Non-Hispanic (50.5%) followed by Hispanics (28.2%).¹⁶ The racial composition of children under 18 years across the state are 60.3 percent White, 9.8 percent Black, and 5.8 percent Asian with the remainder as a mixture of all other races.¹⁷ By ethnicity composition, 40.8 percent of children under 18 years are Hispanic or Latino, and a 36.3 percent are White non-Hispanic. Except for Clark County depicting the largest proportion of Hispanic or Latinos under 18 (43.1%), the rest of the counties show a larger proportion of White non-Hispanics ranging from 30.4 percent (Clark) to 69.2 percent (Douglas). A similar pattern is found among students enrolled in public school as seen in Figure 4.

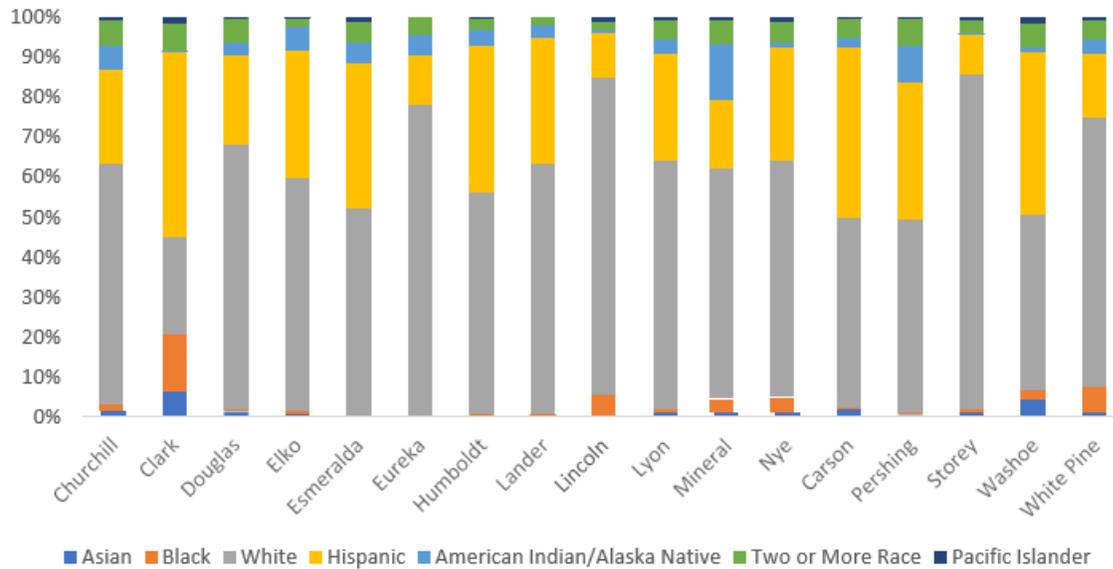
¹⁴ U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates, Children Characteristics, Table S0901.

¹⁵ Jeff Hardcastle. Nevada County Population Projections 2018 to 2037. Nevada Department of Taxation. November 2018. Retrieved from <https://tax.nv.gov/uploadedFiles/taxnv.gov/Content/TaxLibrary/DRAFT-Nevada-County-Population-Projections-2018-to-2037.pdf>

¹⁶ U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates, Selected Characteristics of the Native and Foreign-Born Populations, Table S0501.

¹⁷ U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates, Children Characteristics, Table S0901

Figure 4: Race/Ethnicity of Nevada Student Enrollment by County¹⁸ (different color to show different race/ethnicity)



Gender

For adolescents between the ages of 10 and 19 years, the ratio between males and females is fairly even with males making up 51.6 percent of the age group and females, 48.4 percent.¹⁹ In the total population, males make up 50.2 percent of the population and females, 49.8 percent.²⁰

Sexual Orientation

In 2017, 5.5 percent of the adult population in Nevada identified as Lesbian, Gay, Bisexual, and Transgender (LGBT).²¹ The majority of those who identified as LGBT were White (49%), female (53%) and between the ages of 18 and 24 years (36%).²² For youth, according to 2017 Nevada High School YRBS data, 83.7 percent of high school students self-identified as heterosexual or straight, while 3.0 percent identify as gay or lesbian, 9.6 percent identify as bisexual, and 3.6 percent are not sure about their sexuality.²³

¹⁸ U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates, Children Characteristics, Table S0901.

¹⁹ U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates, Table S0101

²⁰ U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates, Table S0101.

²¹ The Williams Institute, UCLA School of Law. (2019, January). LGBT Demographic Data Interactive. Retrieved from <https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/?topic=LGBT#density>

²² The Williams Institute, UCLA School of Law. (2019, January). LGBT Demographic Data Interactive. Retrieved from <https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/?topic=LGBT#density>.

²³ Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://www.unr.edu/Documents/public-health/2017_yrbs/2017 Nevada High School YRBS.pdf.

Per the Public Religion Research Institute, across the state, 68 percent of adults reported they favored LGBT non-discrimination laws (in housing, jobs, and public accommodations), while 26 percent oppose the laws.²⁴ For same sex marriage, 60 percent strongly favor or favor the practice, while 32 percent oppose or strongly oppose.²⁵

Language

Across the state, 69.5 percent of individuals speak only English at home.²⁶ For those who speak a language other than English, the most common languages spoken are Spanish (21.3%), Asian and Pacific Island languages (5.8%), and other Indo-European languages (2.4%).²⁷ For those that speak a language other than English, 61.3 percent speak English “very well” and 38.7 percent speak English less than “very well.”²⁸ Overall, among youth (age five to 17 years), 67.4 percent speak only English at home, followed by Spanish (27.9%).²⁹

Economic Status

The median family income for the United States was \$71,900 in FY 2018, an increase of 5.7 percent compared to 2017 (\$71,490). For Nevada, the median family income, adjusted for inflation for the five-year estimate in 2017, was approximately \$59,381. The three lowest median incomes are found in Nye, Carson City, and Clark counties.³⁰ As of August 2019, there were 26,555 children on Children’s Health Insurance Program (CHIP) in Nevada (approximately 4.0% of the population under 18) and 267,180 individuals 18 and younger on Medicaid (approximately 39.9% of the population under 18).³¹

Approximately 27.0 percent of children are living in households with Supplemental Security Income (SSI), cash public assistance, or food stamp/SNAP benefits, with the largest proportion in Nye County (39.8%) followed by Carson City (35.1%).³² Furthermore, for households for which poverty status is defined, approximately 20.2 percent of children are living below poverty statewide. The vast majority are in Clark County followed by Washoe County.

In 2018, Nevada was one of the top five states for rates of unsheltered homeless individuals at 59.3 percent, and the *highest* rate of homeless youth who are unsheltered, at 83.8 percent.³³ The National

²⁴ Public Religion Research Institute. American Values Atlas. Retrieved from <http://ava.prii.org/>

²⁵ Public Religion Research Institute. American Values Atlas. Retrieved from <http://ava.prii.org/>

²⁶ U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates, Table S1601

²⁷ U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates, Table S1601

²⁸ U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates, Table S1601.

²⁹ U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates, Table S1603

³⁰ U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates, Table S0901

³¹ Nevada Department of Health and Human Services, Division of Health Care Financing and Policy (2019). *Nevada Medicaid Population Demographics: August 2019*. Retrieved from <http://dhcfp.nv.gov/uploadedFiles/dhcfp/nvgov/content/Resources/AdminSupport/Reports/Caseload-Summary-Aug-2019.pdf>

³² U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates, Table S0901

³³ U.S. Department of Housing and Urban Development, Office of Community Planning and Development (2018). *The 2018 Annual Homeless Assessment Report (AHAR) to Congress – Part 1: Point-in-Time Estimates of Homelessness*. Retrieved from

<https://files.hudexchange.info/resources/documents/2018-AHAR-Part-1.pdf>

Center for Homeless Education estimates about 16,800 students in Nevada public schools identified as homeless in 2018.³⁴

Religion

As of 2018, for adults in Nevada, 62 percent identify as Christian, one percent as Jewish, and 30 percent as unaffiliated (i.e., atheist, agnostic, or nothing in particular).³⁵ In 2014, 44 percent of adults said religion is very important to them and 16 percent say it is not at all important.³⁶ A third attend religious services at least once a week and a third said they seldom or never attend religious services.³⁷ Sixty-three percent of adults said they feel a sense of spiritual peace and wellbeing at least once a week and 14 percent seldom or never feel that sense.³⁸

Adolescent Health Issues

Adolescent health, inclusive of youth ages 10 to 19 years, can be broadly defined by looking at the 21 Adolescent Critical Health Objectives (CHOs) from Healthy People across seven focus areas, most of which were identified as key indicators of adolescent health in Nevada by the community through the interviews, focus groups and survey. The Healthy People 2020 seven focus areas are:

1. Sexual Behaviors,
2. Health and Health Care,
3. Injury and Violence Prevention,
4. Mental and Emotional Health,
5. Substance Use,
6. Prevention of Chronic Diseases, and
7. Social Determinants of Health and Healthy Development.

Each focus area covers the following:

- Magnitude of the Issue and Prevalence,
- Existing Disparities,
- Annual Trends, and
- Community Voice (i.e., findings from the focus groups, key information interviews, and online survey).

³⁴ National Center for Homeless Education. (2019, February). Federal Data Summary Schools Years 2014-15 to 2016-17. Education for Homeless Children Youth. Retrieved from: https://nche.ed.gov/wp-content/uploads/2019/02/Federal-Data-Summary-SY-14.15-to-16.17-Final-Published-2.12.19.pdf?utm_source=Main+list&utm_campaign=40f80c9161-MailChimp- Feb%2019&utm_medium=email&utm_term=0_96caefa5d6-40f80c9161-44945529#page15

³⁵ Public Religion Research Institute. American Values Atlas.

³⁶ Pew Research Center. Adults in Nevada - Religious Landscape Study. Retrieved from <https://www.pewforum.org/religious-landscape-study/state/nevada/>

³⁷ Pew Research Center. Adults in Nevada - Religious Landscape Study

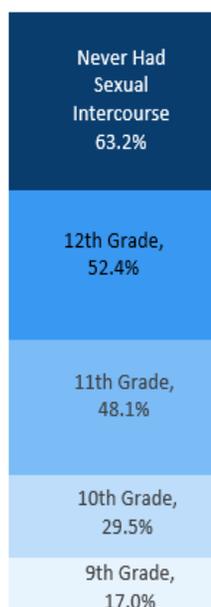
³⁸ Pew Research Center. Adults in Nevada - Religious Landscape Study

Therefore, this section reports a deeper dive into the adolescent health issues of youth in Nevada and seek to explore the alignment between community perception and beliefs with population health and surveillance data.

Sexual Behaviors

The topic of sexual health covers sexual history, interpersonal and sexual violence, teen pregnancy, and sexually transmitted infections.

Figure 5: Proportion of Nevada Students Who Ever Had Sexual Intercourse by Grade³⁷



Magnitude: According to 2017 Nevada High School YRBS data, 63.2 percent of high school students reported not ever having sexual intercourse (higher than the national rate of YBRS 60.5%) and 4.1 percent reported having sexual intercourse for the first time before the age of 13 (higher than the national rate of 3.4 percent)^{39, 40}. Figure 5 shows the proportion of sexually active high school students by grade based on 2017 YBRS data.⁴¹ Just over one in four (25.8%) high school students reported having had sexual intercourse with at least one person in the past three months and 9.5 percent reported having sexual intercourse with four or more persons during their life.⁴² In relation to substance use, 17.3 percent of high school students reported drinking alcohol or using drugs before their last sexual intercourse.⁴³

Looking at harm reduction behaviors, only 55.7 percent of Nevada’s high school students reported using a condom during their last sexual intercourse (higher than national rate of 53.8%), 16.7 percent reported using birth control pills, and 5.8 percent reported using a long-acting reversible contraceptive (e.g., IUD, Depo-Provera, Nuva Ring).⁴⁴ Overall, 16.8 percent of high school students did not use any method to prevent pregnancy during their last sexual intercourse (higher than the national rate of 13.8%).⁴⁵ The differences in these proportions between Nevada and the United States can be seen in figure 6.⁴⁶

³⁹ Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report.

⁴⁰ Kann, L., et al. (2018). Youth Risk Behavior Surveillance — United States, 2017. Morbidity and Mortality Weekly Report: Surveillance Summaries, 67(8), 1–114.

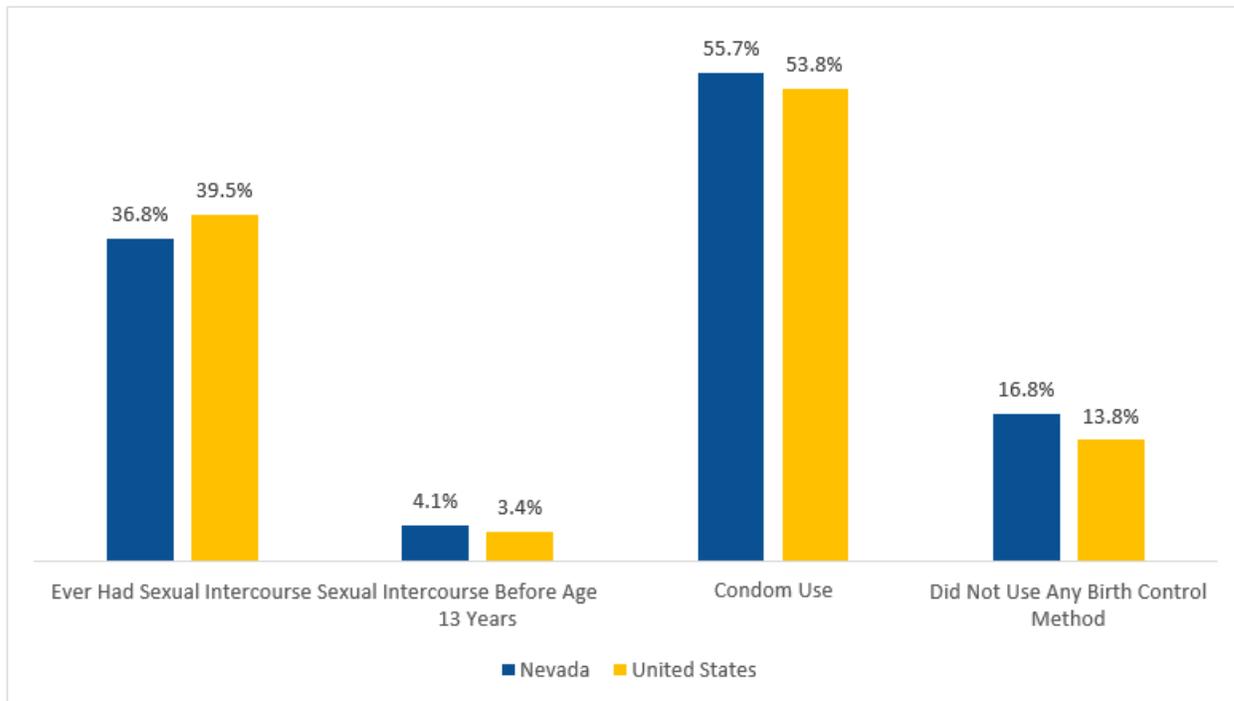
⁴¹ Kann, L., et al. (2018). Youth Risk Behavior Surveillance — United States, 2017.

⁴² Kann, L., et al. (2018). Youth Risk Behavior Surveillance — United States, 2017.

⁴³ Kann, L., et al. (2018). Youth Risk Behavior Surveillance — United States, 2017.

⁴⁴ Kann, L., et al. (2018). Youth Risk Behavior Surveillance — United States, 2017.

Figure 6: Proportion of High School Students Engaging in Certain Sexual Behaviors, Nevada and United States⁴⁷



Disparities: Looking closely at differences in sexual behaviors among different demographic groups, Asian high school students had the lowest proportion of sexually active students (23.8% of all Asian students) while the highest rates belonged to Native Hawaiian/Pacific Islander students (43.0% of all Native Hawaiian/Pacific Islander).⁴⁸ However, looking at the entire student body, White students accounted for 41.4 percent of all students who ever had sexual intercourse, followed by Hispanic/Latino students (39.7%), and all other race/ethnicities (18.9%).⁴⁹

Geographically, the regions with the highest proportion of sexually active high school students were Region 2 (Douglas County) and Region 5 (Lyon, Mineral, and Storey counties) where over half of students reported having had sexual intercourse.⁵⁰ Both Region 7 (Washoe County) and Region 8 (Clark County) had 35.0 percent of high school students report being sexually active as seen in Figure 7.⁵¹

⁴⁵ Kann, L., et al. (2018). Youth Risk Behavior Surveillance — United States, 2017.

⁴⁶ Kann, L., et al. (2018). Youth Risk Behavior Surveillance — United States, 2017.

⁴⁷ Kann, L., et al. (2018). Youth Risk Behavior Surveillance — United States, 2017.

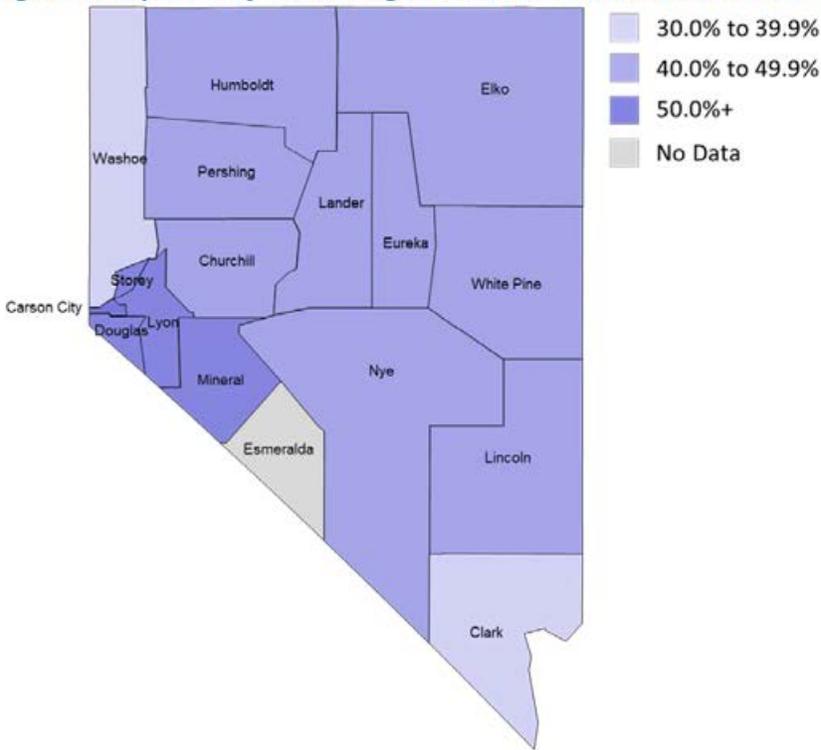
⁴⁸ Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report.

⁴⁹ Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report.

⁵⁰ Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report.

⁵¹ Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report.

Figure 7: Proportion of Nevada High School Students Who Ever Had Sexual Intercourse by Region⁵²



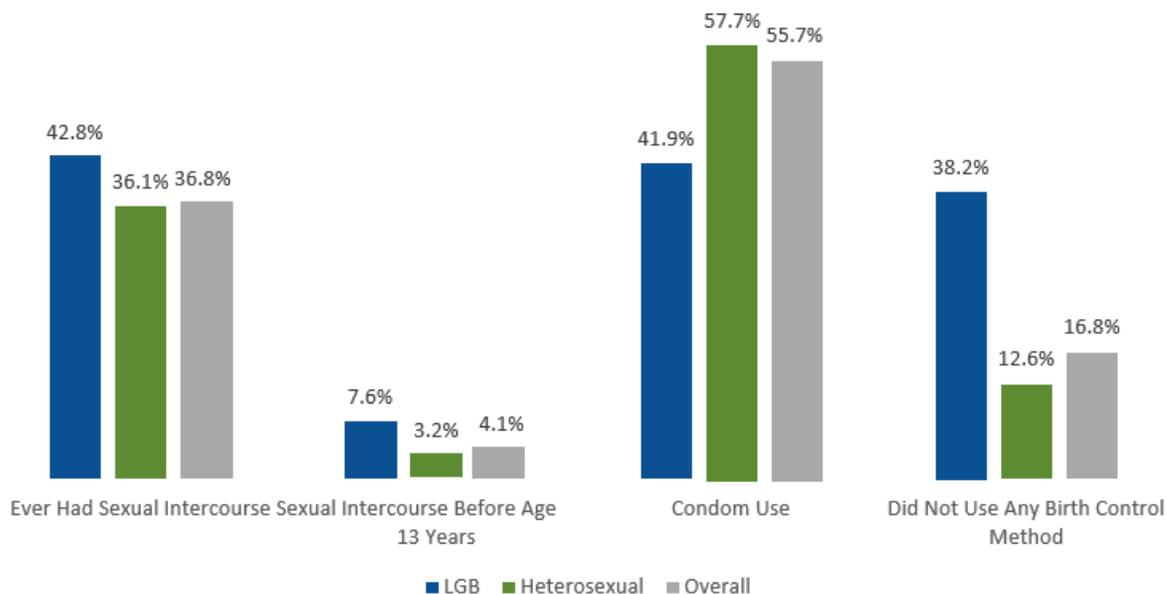
For those who identify as lesbian, gay, bisexual (LGB), 42.8 percent reported as ever having sexual intercourse and 7.6 percent reported having sexual intercourse for the first time before age 13.⁵³ LGB high school students also reported lower levels of condom use (41.9%), and overall higher levels of not using any method to prevent pregnancy during their last sexual intercourse (38.2%) compared to both the overall student body and students who identified as heterosexual.⁵⁴ These differences are represented in Figure 8 below.

⁵² Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report.

⁵³ Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report.

⁵⁴ Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report.

Figure 8: Proportion of Nevada High School Students Engaging in Certain Sexual Behaviors by Sexual Identity⁵⁵



Trends: Between 2007 and 2017, the percentage of high school students in Nevada who ever had sexual intercourse decreased by 15.4 percent (slightly lower than the 17.4% decrease seen nationally over the same time period) and the percentage of students who had sexual intercourse for the first time before age 13 also decreased by over 33 percent (lower than the 52.1% seen nationally).⁵⁶ However, over the last 10 years, the percentage of these students who used a condom during their last sexual intercourse also decreased by 21.3 percent (slightly higher than the 20.0% decrease seen nationally), as shown in Figure 9.⁵⁷ As well, the percentage of students who reported not using any method to prevent pregnancy during their last sexual intercourse increased by 68.8 percent (there was no statistical difference seen nationally).⁵⁸ These trends suggest that while teens may be having less sexual intercourse overall, when they are having sex they are less likely to use safe sex methods.

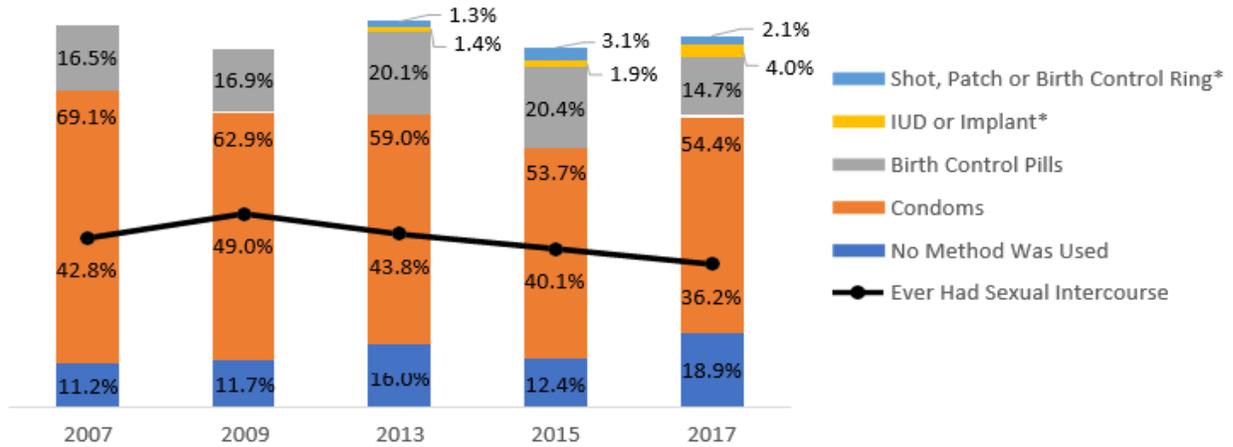
⁵⁵ Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report.

⁵⁶ University of Nevada, Reno. 2017 Youth Risk Behavior Survey Results - Nevada High School Survey: 10-Year Trend Analysis Report. University of Nevada, Reno. Retrieved from https://www.unr.edu/Documents/public-health/2017_yrbs/2017 Nevada High School CDC YRBS 10 Year Trends.pdf

⁵⁷ University of Nevada, Reno. 2017 Youth Risk Behavior Survey Results - Nevada High School Survey: 10-Year Trend Analysis Report.

⁵⁸ University of Nevada, Reno. 2017 Youth Risk Behavior Survey Results - Nevada High School Survey: 10-Year Trend Analysis Report.

Figure 9: Trends in Contraceptive Methods Used for Birth Control Among Sexually Active Youth, Nevada 2007-2017⁵⁹



*Data not available for these methods for 2007 and 2009

Community Voices: Youth in all communities named the lack of activities and entertainment for young people, the beliefs and myths about sex, and the role babies play in decisions around sexual activity as drivers of sexual activity. Participants made statements such as:

- "There are no positive activities for teens in our community."
- "Living in a small community makes it hard to avoid peer pressure."
- "Abstinence doesn't exist anymore."
- "Some people make it a thing where you're not cool if you're a virgin."
- "It's like a trend that if you ain't got a baby you're not cool."
- "In Pahrump, one person had a baby and everybody else got baby fever."
- "[Some teen are] choosing to have a baby to change their life - a baby provides responsibility that keeps them from doing bad things."

Interpersonal and Sexual Violence

Magnitude: In terms of interpersonal violence, 7.9 percent of high school students experienced physical dating violence in the year prior and 5.7 percent experienced sexual dating violence (lower than the national rate of 6.9%).⁶⁰ One in 10 students reported that they were forced to do sexual things when they did not want to in the prior year (10.5%, higher than national rate of 7.0%) and 7.3 percent reported that they were ever physically forced to have sexual intercourse when they did not want to (compared to 7.4%

⁵⁹ University of Nevada, Reno. 2017 Youth Risk Behavior Survey Results - Nevada High School Survey: 10-Year Trend Analysis Report.

⁶⁰ Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report

nationally). For middle school students, 3.9 percent reported being ever physically forced to have sexual intercourse.⁶¹

In 2015, 3.0 percent of calls to the National Domestic Violence Hotline in Nevada were from individuals under the age of 18 (lower than national rate of 4.0%).⁶² For callers into the loveisrespect hotline (the National Domestic Violence Hotline’s dating abuse, prevention, and education project for youth), 14.3 percent were under the age of 15 (nearly twice as high as the national rate at 8.7%) and 14.3 percent were between the ages of 16 and 18 (lower than 21.3% of callers ages 16 to 18 years nationally).⁶³ For the loveisrespect hotline, 82 percent of all calls originating in Nevada came from Las Vegas and 14 percent from Reno.⁶⁴ A large majority of victims who called the hotline were experiencing emotional or verbal abuse (98%, higher than national rate of 92%) while 53 percent were experiencing physical abuse (higher than the national rate of 48%).⁶⁵

Disparities: Among those experiencing interpersonal violence in Nevada’s high schools, adolescent males were more likely to report experiencing physical violence (8.4% compared to 7.3% for adolescent females) while adolescent females were more likely to report experiencing sexual violence (7.1% compared to 4.2% for males).⁶⁶ Adolescent females were also more likely to report being forced to do sexual things when they did not want to (13.4% compared to 7.6% for males) and to report being physically forced to have sexual intercourse (9.3% compared to 5.3% for males).⁶⁷ This same disparity also holds for Nevada’s middle school students reporting they were physically forced to have sexual intercourse (5.1% females compared to 2.6% of males).⁶⁸

For high school students who identify as LBG, they had higher percentages for all the metrics mentioned above – forced to do sexual things when they did not want to, experience physical dating violence, experience sexual dating violence, and being physically forced to have sexual intercourse – in

⁶¹ Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS): Sexual Identity Special Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. Retrieved from https://www.unr.edu/Documents/public-health/2017_yrbs/2017 Nevada High School YRBS - Sexual Identity Special Report_acc.pdf.

⁶² The National Domestic Violence Hotline. (n.d.). 2015 Nevada State Report. Administration on Children, Youth and Families, Family and Youth Services Bureau, U.S. Department of Health and Human Services. Retrieved from https://www.ncedsv.org/wp-content/uploads/2016/12/2015_NDVH_Nevada.pdf

⁶³ loveisrespect (2016). Nevada State Report. Administration on Children, Youth and Families, Family and Youth Services Bureau, U.S. Department of Health and Human Services. Retrieved from <https://www.ncedsv.org/wp-content/uploads/2016/12/2015-LIR-Nevada.pdf>

⁶⁴ loveisrespect. Nevada State Report.

⁶⁵ loveisrespect. Nevada State Report.

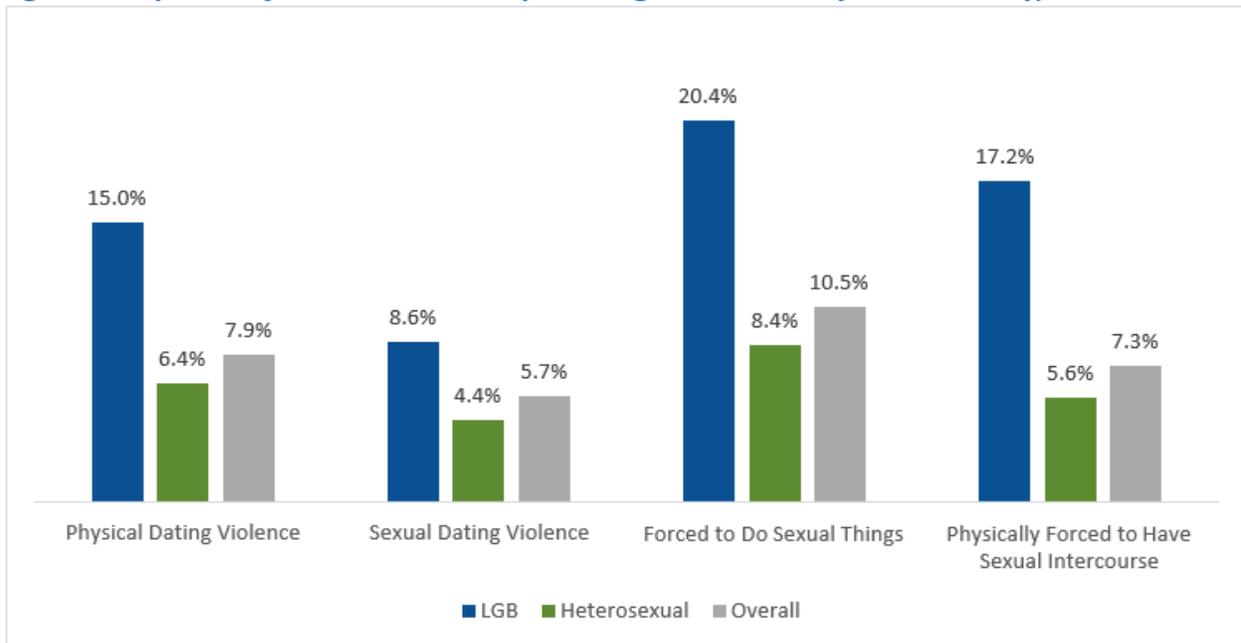
⁶⁶ Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report.

⁶⁷ Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report.

⁶⁸ Lensch, T., et al. 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://www.unr.edu/Documents/public-health/2017_yrbs/2017 Nevada High School YRBS.pdf.

comparison to both the overall student body and students who identify as heterosexual.⁶⁹ These disparities can be more clearly seen in Figure 10. These disparities are approximately double the rate of what heterosexual students report of physical and sexual dating violence and forced to do sexual things and triple the likelihood of being forced to have sexual intercourse.⁷⁰

Figure 6: Proportion of Nevada Students Experiencing Victimization by Sexual Identity, 2017⁷¹



Looking statewide, there are variations in the proportions of students experiencing these different forms of dating and interpersonal violence. Figure 11, shows in Regions 1 and 3 overall have more students reporting different forms of violence, although there is likely overlap between students.⁷² As well, regions 3 and 5 have the highest proportion of students reporting physical dating violence while Regions 1 and 3 have the highest proportion of students reporting being physically forced to have sexual intercourse.⁷³ The data indicate there are regional disparities in terms of where different forms of dating and interpersonal violence are taking place across the state.

⁶⁹ Lensch, T., et al., 2017 Nevada High School Youth Risk Behavior Survey (YRBS): Sexual Identity Special Report.

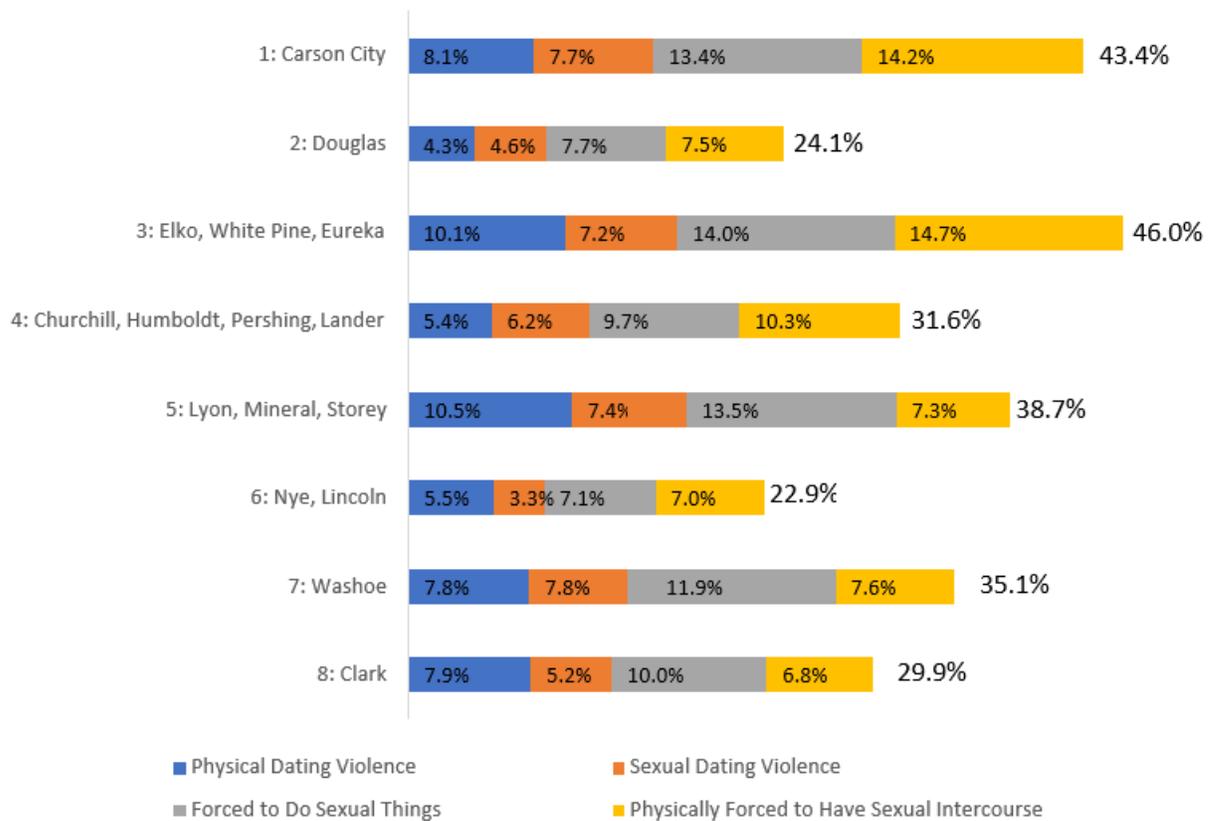
⁷⁰ Lensch, T., et al., 2017 Nevada High School Youth Risk Behavior Survey (YRBS): Sexual Identity Special Report.

⁷¹ Lensch, T., et al., 2017 Nevada High School Youth Risk Behavior Survey (YRBS): Sexual Identity Special Report.

⁷² Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report.

⁷³ Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report.

Figure 7: Proportion of Nevada High School Students Experiencing Victimization by Region, 2017⁷⁴



Trends: Between 2007 and 2017, the percentage of students reporting having ever been physically forced to have sexual intercourse has decreased by 47.8 percent, however the current percentage has been stable since 2013 (there was no statistical difference seen nationally between 2007 and 2017).⁷⁵ The percentages of students experiencing physical and sexual dating violence have also decreased between 2013 (the first year this data was collected in YRBS) and 2017, with a 56.6 percent decrease and 38.5 percent decrease respectively.⁷⁶

Community Voices: Community respondents were aware of high levels of violence and coercion in relationships among youth and also named gaps in prevention, response, and education around how violence can look in relationships, what to do about it, and how to talk about it. LGBTQ youth were

⁷⁴ Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report.

⁷⁵ University of Nevada, Reno. 2017 Youth Risk Behavior Survey Results - Nevada High School Survey: 10-Year Trend Analysis Report.

⁷⁶ University of Nevada, Reno. 2017 Youth Risk Behavior Survey Results - Nevada High School Survey: 10-Year Trend Analysis Report

identified as a group experiencing particularly high rates of violence. For Las Vegas, the context of the city was inseparable from the messaging and ideas about sex youth were receiving.

- "People feel like they don't have the right to say no to sex even if they don't want to."
- "Alcohol and drugs put people in situations that can be very violent."
- "People don't recognize it as violence when it comes to relationships."
- "We don't want to admit that there are these things happening in our community, which makes it hard to access services for these kinds of things."
- "the people who are LGBTQ that are being bullied - when they are standing up for themselves, they are the ones getting into trouble."
- "The dialogue needs to change around healthy relationships."
- "Las Vegas is a unique place. Everything is sexualized here. Sexual abuse rates? I know so many people who have been abused sexually and it is really sad. I don't know how to prevent that."
- Dialogue needs to change around healthy relationships, and goes back to affordable mental health and counseling, etc..."

Teen Pregnancy

Magnitude: In Nevada, the teen birth rate in 2017 was 21.9 births per 1,000 girls between ages 15 to 19 years, accounting for 1,906 births overall.⁷⁷ This rate is higher than the national rate of 20.3. Nationally, Nevada ranks 33rd in their teen birth rate, 41st by their teen pregnancy rate (this rate includes all pregnancies rather than just those that resulted in a birth), and 11th in terms of the decline in their teen birth rate.⁷⁸

Most of the teen births were to older teens (those 18 and 19), which accounted for 45.2 percent of teen births in 2017 and teens ages 15 to 17 years accounted for 8.7 percent of teen births.⁷⁹ Additionally, 16 percent were to teens who already had a child.⁸⁰

From 2017 High School YRBS data, 2.2 percent of high school students reported having ever been pregnant or gotten someone pregnant.⁸¹ The majority of that 2.2 percent consisted of students in 12th grade (36.3%) and were 17 years of age (31.9%).⁸²

Disparities: Black teens experience the highest rates of teen birth at 38.4 per 1,000 girls ages 15 to 19 years, followed by the rates of 30.4 for American Indian and 27.2 for Hispanic teens per 1,000 girls. The rates for these population groups are higher than the state (21.9 births per 1,000 girls).⁸³

⁷⁷ Power to Decide. Teen Birth Rate Comparison, 2017: Teen Birth Rate Among Girls Age 15-19. Retrieved from <https://powertodecide.org/what-we-do/information/national-state-data/teen-birth-rate>.

⁷⁸ Power to Decide. Teen Birth Rate Comparison, 2017: Teen Birth Rate Among Girls Age 15-19.

⁷⁹ National Vital Statistics System. (2019). National Outcome Measure 23: Teen birth rate, ages 15 through 19, per 1,000 females.

⁸⁰ Power to Decide. Teen Birth Rate Comparison, 2017: Teen Birth Rate Among Girls Age 15-19.

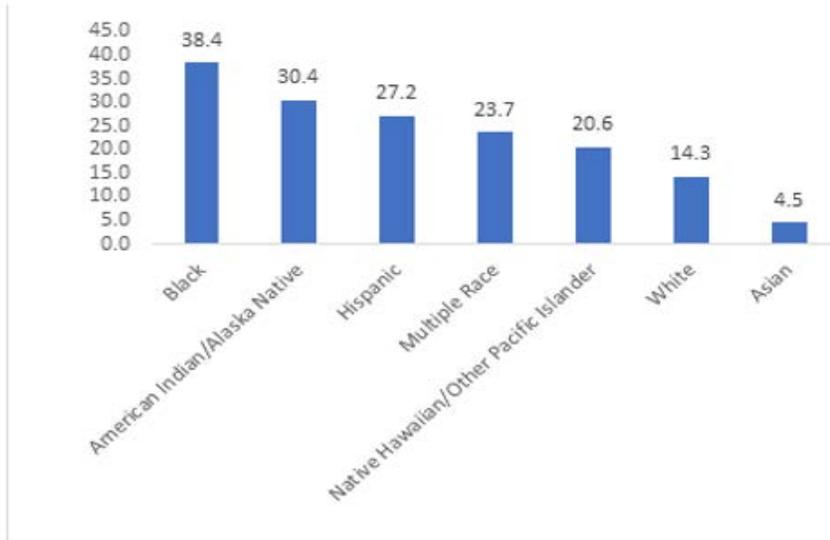
⁸¹ Lensch, T., et al. *2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report*.

⁸² Lensch, T., et al. *2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report*.

⁸³ National Vital Statistics System. National Outcome Measure 23: Teen birth rate, ages 15 through 19, per 1,000 females.

The overall number of teen births by race and ethnicity can be seen in Figure 12.⁸⁴

Figure 12: Proportion of Teen Births in Nevada, by Race/Ethnicity, 2017⁸⁵



Geographically, non-metro Nevada experience higher rates of teen birth compared to the state at 26.7 teen births per 1,000 girls (compared to a rate of 21.9 across the state). Specifically, the teen birth rate also varies by county, with Lander County reporting the highest teen birth rate between 2011 and 2017 at 47 teen births per 1,000 girls ages 15 to 19 years.⁸⁶ Lincoln County reported the lowest rate at 8.0 per 1,000 girls.⁸⁷ The rates by county can be seen in Figure 13 below.⁸⁸

⁸⁴ National Vital Statistics System. National Outcome Measure 23: Teen birth rate, ages 15 through 19, per 1,000 females.

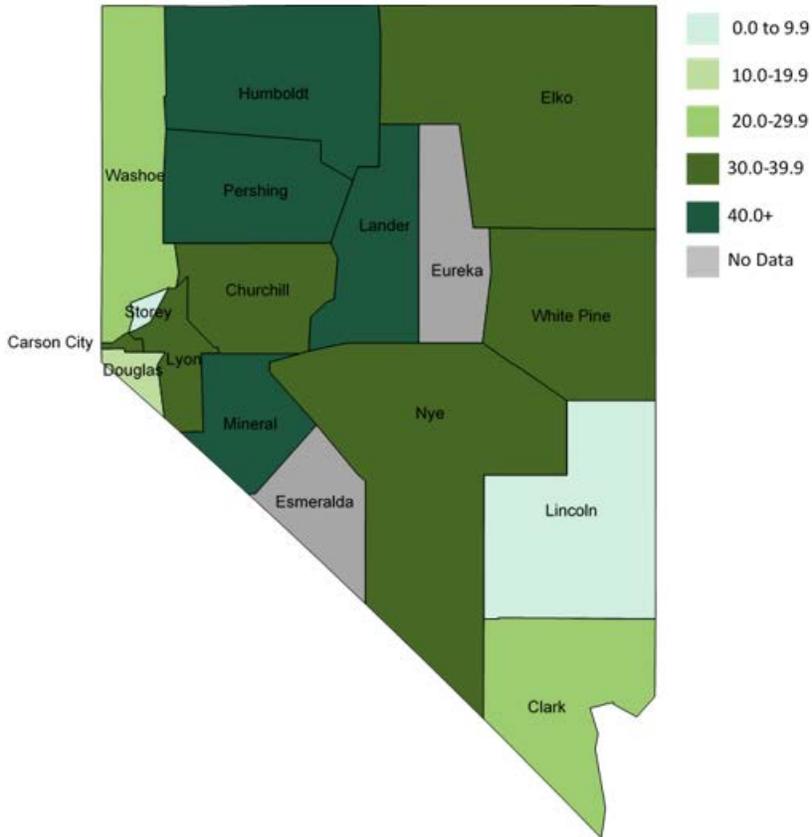
⁸⁵ National Vital Statistics System. National Outcome Measure 23: Teen birth rate, ages 15 through 19, per 1,000 females.

⁸⁶ County Health Rankings & Roadmaps. (2019). Teen births. Retrieved from <https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/health-behaviors/sexual-activity/teen-births>.

⁸⁷ County Health Rankings & Roadmaps. Teen births.

⁸⁸ County Health Rankings & Roadmaps. Teen births.

Figure 13: Teen Birth Rates in Nevada by County, 2011-2017⁸⁹



From 2017 YRBS data, high school students who identified as LGB had a higher percentage of reporting that they have ever been pregnant or gotten someone pregnant (4.3%) compared to their heterosexual peers (1.9%).⁹⁰

Trends: Since 2009, the teen birth rate in Nevada has declined by 50.2 percent (compared to national decline of 50.0%).⁹¹ This same dramatic decrease can be seen across all racial and ethnic groups with the teen birth rates for Non-Hispanic Whites, Non-Hispanic Blacks, and Hispanics decreasing each by at least 73 percent since 1991.⁹² However, when comparing rates to 2015, Hispanic teens had a seven percent

⁸⁹ County Health Rankings & Roadmaps. Teen births.

⁹⁰ Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS): Sexual Identity Special Report.

⁹¹ National Vital Statistics System. (2019). National Outcome Measure 23: Teen birth rate, ages 15 through 19, per 1,000 females.

⁹² Power to Decide. Teen Birth Rate Comparison, 2017: Teen Birth Rate Among Girls Age 15-19.

increase over that two-year period, while both Non-Hispanic Whites and Non-Hispanic Blacks experienced a 25 percent and 12 percent decrease respectively.⁹³

Sexually Transmitted Infections

Magnitude: Sexually transmitted infections (STIs) are another health issue related to having unprotected sexual intercourse. In 2017 in Nevada, there were 3,751 chlamydia cases among adolescents, ages 10 to 19, and those between the ages of 15 to 19 accounted for 22.4 percent of all chlamydia cases statewide (corresponding to a rate of 1845.3 cases per 100,000 population).⁹⁴ Female adolescents were much more likely to report chlamydia, making up 78.4 percent of all cases reported in 2017 among those ages between 10 to 19 years.⁹⁵

Looking at gonorrhea, there were 742 cases of gonorrhea for those ages 10 to 19 years, accounting for 13.4 percent of all gonorrhea cases statewide (lower than the national percentage of 17.2%).⁹⁶ Female adolescents again accounted for the majority of the cases in the age group, accounting for 62.4 percent of cases.⁹⁷ For primary and secondary syphilis, there were no reported cases in 2017 for those under the age of 14 years and 16 cases reported for those ages 15 to 19 years.⁹⁸ The 16 cases made up only 2.7 percent of all cases statewide (lower than national percentage of 4.7%) and represented a 6.7 percent increase from 2016.⁹⁹ For early latent syphilis cases, there were no reported cases for those under the age of 14 in 2017, and a total of 13 cases for those 15 to 19 years.¹⁰⁰ The 13 cases made up 2.6 percent of all cases statewide, a negative 23.5 percent change since 2016.¹⁰¹

For HIV, there were 79 new HIV diagnoses for those between the ages 13 to 24 years, accounting for 16 percent of all new HIV cases statewide.¹⁰² Male adolescents made up the majority of those new infections, accounting for 89.9 percent of cases in that age group.¹⁰³ For new HIV Stage 3 (AIDS)

⁹³ Power to Decide. Teen Birth Rate Comparison, 2017: Teen Birth Rate Among Girls Age 15-19

⁹⁴ Office of Public Health Informatics and Epidemiology, and Division of Public and Behavioral Health (2018). *2017 STD Fast Facts*. Retrieved from

[http://dpbh.nv.gov/uploadedFiles/dpbh.nv.gov/content/Programs/STD/dta/Publications/Fast%20Facts%202017%20State%201.8\(1\).pdf](http://dpbh.nv.gov/uploadedFiles/dpbh.nv.gov/content/Programs/STD/dta/Publications/Fast%20Facts%202017%20State%201.8(1).pdf)

⁹⁵ Office of Public Health Informatics and Epidemiology, and Division of Public and Behavioral Health. *2017 STD Fast Facts*

⁹⁶ Office of Public Health Informatics and Epidemiology, and Division of Public and Behavioral Health. *2017 STD Fast Facts*

⁹⁷ Office of Public Health Informatics and Epidemiology, and Division of Public and Behavioral Health. *2017 STD Fast Facts*

⁹⁸ Office of Public Health Informatics and Epidemiology, and Division of Public and Behavioral Health. *2017 STD Fast Facts*

⁹⁹ Office of Public Health Informatics and Epidemiology, and Division of Public and Behavioral Health. *2017 STD Fast Facts*

¹⁰⁰ Office of Public Health Informatics and Epidemiology. *2017 STD Fast Facts*

¹⁰¹ Office of Public Health Informatics and Epidemiology. *2017 STD Fast Facts*

¹⁰² Office of Public Health Informatics and Epidemiology, Division of Public and Behavioral Health. (2018). *2017 HIV Fast Facts*. Retrieved from

http://dhhs.nv.gov/uploadedFiles/dhhsnv.gov/content/Programs/Office_of_Analytics/Images/HIV_Fast_Facts_2017.pdf

¹⁰³ Office of Public Health Informatics and Epidemiology. *2017 HIV Fast Facts*

diagnoses, there were 20 cases among those ages 13 to 24 years, again a majority of them among male adolescents (90%).^{104,105} Overall, there are 331 individuals living with HIV in the state between the ages of 13 to 24 years, making up 2.8 percent of all people living with HIV in Nevada.¹⁰⁶ From 2017 YRBS data, 9.8 percent of high school students had ever been tested for HIV, indicating the proportion of high school youth who may present risk factors for HIV (compared to 8.3% of high school youth national).¹⁰⁷

Disparities: Regionally, there were differences between Clark County, Washoe County, and the rest of the state (i.e., rural and frontier counties) in terms of new cases in 2017. Figure 14, below, helps to illustrate those differences for chlamydia, gonorrhea, primary and secondary syphilis, and HIV.

Figure 14: Number of New Cases and Corresponding Rates* for Sexually Transmitted Infections by County ages 10 to 19, 2017¹⁰⁸

STI	Clark County		Washoe County		Rural & Frontier Counties	
	No. of Cases	Rate	No. of Cases	Rate	No. of Cases	Rate
Chlamydia						
10-14	65	40.7	23	72.9	7	34.5
15-19	2,554	1,740.9	626	2089.9	326	1,542.0
Gonorrhea						
10-14	20	12.5	3	9.5	1	4.9
15-19	590	402.2	78	260.4	23	108.8
Primary and Secondary Syphilis						
10-14	0	0.0	0	0.0	0	0.0
15-19	10	6.8	5	8.1	1	4.7
HIV						
13-24	73	20.8	5	6.8	NR	NR

*Rate is the rate of the population per 100,000 persons. NR = Not Reported.

For HIV testing, LGB students had a much higher percentage of reporting being ever tested for HIV, at 14.2 percent, compared to 9.1 percent for students who identify as heterosexual.¹⁰⁹

Trends: Looking at STIs, the chlamydia rate increased by 17.4 percent between 2016 and 2017 for those between the ages 10 to 14 years.¹¹⁰ Gonorrhea cases increased by 14.3 percent between 2016 and 2017 for those between the ages 10 to 19 years, with cases among those between the ages 10 to 14 years

¹⁰⁴ Office of Public Health Informatics and Epidemiology, 2017 HIV Fast Facts

¹⁰⁵ Stage 3 (AIDS) diagnoses and HIV diagnoses may duplicate case counts if the person was diagnosed with both stage 3 (AIDS) and HIV in the same year.

¹⁰⁶ Office of Public Health Informatics and Epidemiology, 2017 HIV Fast Facts

¹⁰⁷ Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report

¹⁰⁸ Office of Public Health Informatics and Epidemiology, 2017 STD Fast Fact; Office of Public Health Informatics and Epidemiology, 2017 HIV Fast Facts

¹⁰⁹ University of Nevada, Reno. (n.d.). 2017 Youth Risk Behavior Survey Results - Nevada High School Survey: 10- Year Trend Analysis Report

¹¹⁰ Office of Public Health Informatics and Epidemiology, 2017 STD Fast Facts

increasing by 66.7 percent.¹¹¹ For HIV, the number of new HIV diagnoses decreased by 19 percent from 2016 and the overall rate of new HIV diagnoses has decreased by 19 percent from 2011 (when it was 20.5).¹¹² From YRBS data, between 2015 and 2017, the rate of HIV testing reported by students decreased by 26.4 percent, suggesting a decline in the proportion of high school youth who may present risk factors for HIV.¹¹³

Community Voices: The inconsistency and outdated nature of health and sexual education was named as a significant barrier to adolescent health and pregnancy prevention. The importance of community health nurses was identified in multiple communities, by all groups of participants. As was mentioned in prior sections, some aspects of small-town life and peer pressure were difficult for youth to manage and seem to play a large role in decisions youth are making about sex.

- “[Teens talk about sex] in a way that makes it seem like you have to do it; life changing; like it will give you the love of your life.”
- "There is stigma in both becoming a teen mom but also in talking about prevention."
- "Sex is not talked about in the home."
- "Sex ed is part of the health class curriculum and what gets taught (and how much of it - 1 period or 1 week) is up to the class teacher."
- "Kids don't want to use protection - youth say, "We don't have time."
- "[Teens don't want to] get made fun of for being a virgin."
- "[When I lost my virginity at 13,] the community health nurse was everything to me."
- "Kids feel like it won't happen to them."

Health and Access to Health Care

Magnitude: Overall, between 2016 and 2017, 6.7 percent of children were considered in poor health in Nevada as described by their parents (lower than national rate of 5.8%).¹¹⁴ Among children with special health care needs, this rate is higher at 31.6 percent (slightly higher than national rate of 29.4%).¹¹⁵ Also, 7.1 percent of children (ages zero to 17) in Nevada did not have any form of health insurance in 2017 (higher than the national rate of 4.9%).¹¹⁶ Looking even more broadly, 11.9 percent of children had periods without coverage during the last year.¹¹⁷ These statistics may play into the fact that 3.1 percent of children in Nevada were not able to obtain needed health care in 2017 and that 22.5 percent of children (higher than United States rate of 17.8%) had no preventive care or wellness visit with a doctor or other health care professional in 2017.¹¹⁸ Among children with special health needs, 8.8 percent of

¹¹¹ Office of Public Health Informatics and Epidemiology, *2017 STD FastFacts*.

¹¹² Office of Public Health Informatics and Epidemiology, *2017 STD FastFacts*.

¹¹³ Lensch, T., et al. *2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report*.

¹¹⁴ NVSS 2016-2017. NOM19

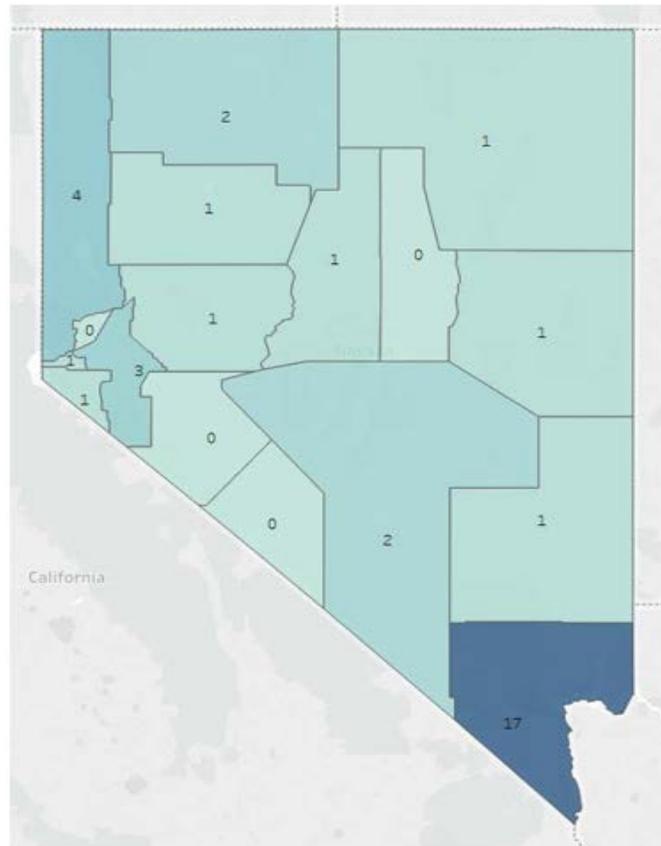
¹¹⁵ NVSS 2016-2017, NOM19

¹¹⁶ National Vital Statistics System. (2019). National Outcome Measure 21: Percent of children, ages 0 through 17, without health insurance.

¹¹⁷ Data Resource Center for Child & Adolescent Health. (2017). National Survey of Children's Health. Retrieved from <https://www.childhealthdata.org/learn-about-the-nsch/NSCH>.

¹¹⁸ Data Resource Center for Child & Adolescent Health. (2017). National Survey of Children's Health.

Figure 17. Number of Mental Health Facilities Serving Children and Adolescents, by County¹⁷⁹



Nevada’s YRBS data reveal that 34.6 percent of high school (higher than the national rate of 31.5%) and 29.3 percent of middle school students felt sad or hopeless almost every day for two or more weeks in a row in 2017.¹⁸² For high school students, in 16.6 percent reported seriously considering attempting suicide in the year prior (low than the national rate of 17.2%) and 8.5 percent attempted suicide (higher than the national rate of 7.4%),¹⁸³ while for middle school students 21.3 percent seriously considered attempting suicide and 8.2 percent made an attempt.¹⁸⁴

Overall, the adolescent suicide rate in Nevada for ages 10 to 19 years was 9.6 per 100,000 in 2017 (higher than the national rate of 7.1).¹⁸⁵ Among older adolescents, 15 through 19 years, the rate is higher, increasing to 13.5 percent in (2015-2017 data) and higher than national rate of 10.5 per 100,000 adolescents.¹⁸⁶

However, despite the number of children reporting having mental and emotional issues, 55.3 percent of high school students never or rarely felt they could get the kind of help they needed when they felt sad, empty, hopeless, angry, or anxious.¹⁸⁸ For middle school students, 46.8 percent felt they never or rarely got the kind of help they needed.¹⁸⁹

Disparities: From 2017 High School YRBS data, more females (45.9%) than males (24.0%) reported feeling sad or hopeless almost every day for two or more weeks in a row during the year prior.¹⁹⁰ The same hold true for students who seriously considered attempting suicide during the year prior (21.7% of females, 11.6% of males).

¹⁸² Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report.

¹⁸³ Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report.

¹⁸⁴ Lensch, T., et al. 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report.

¹⁸⁵ CDC WISQARS, 2017

¹⁸⁶ National Vital Statistics System. (2019). National Outcome Measure 16.3: Adolescent suicide rate ages 15 through 19 per 100,000.¹⁸⁷

CDC National Center for Health Statistics, Suicide Mortality by State, 2017. Retrieved from <https://www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm>.

¹⁸⁸ CDC National Center for Health Statistics, Suicide Mortality by State, 2017.

¹⁸⁹ Lensch, T., et al. 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report.

¹⁹⁰ Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report.

and for students who attempted suicide during the year prior (10.4% of females, 6.6% of males).¹⁹¹ For middle school students, this same difference between the sexes continues with more females reporting they felt sad or hopeless almost every day for two or more weeks in a row (38.3% female, 20.4% male), that they seriously considered killing themselves (28.7% female, 14.2% male), and that they attempted suicide (12.0% female, 4.4% male).¹⁹² The adolescent suicide rate in Nevada among males ages 10 to 19 years was 15.4 per 100,000 in 2017 (compared to 9.7 among all genders ages 10 to 19 years).¹⁹³

According to NVSS, non-Hispanic White adolescents, between the ages of 15 and 19 years, had a higher adolescent suicide rate at 17.5 deaths per 100,000 adolescents compared to 7.9 for Hispanic adolescents.¹⁹⁴

Suicide rates also vary by county, as shown in Figure 18. Specifically, with the highest rates in non-metropolitan regions at 21.7 per 100,000 (2013 to 2017), compared to a rate of 7.5 per 100,000 (2013 to 2017) in metropolitan regions.¹⁹⁵

¹⁹¹ Lensch, T., et al. *2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report*.

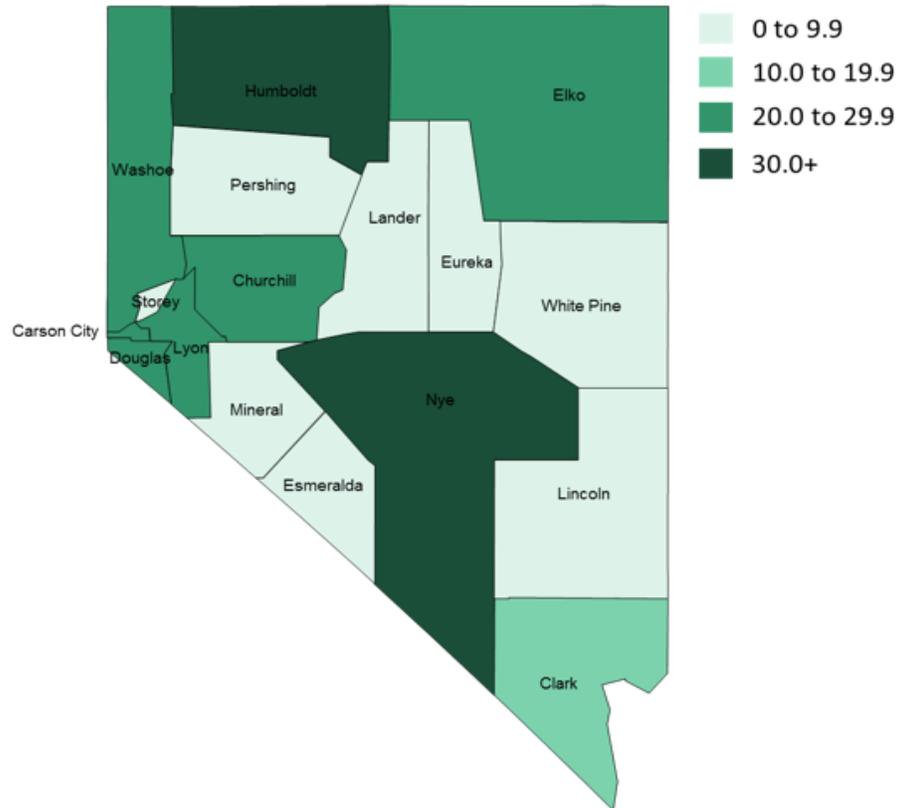
¹⁹² Lensch, T., et al. *2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report*.

¹⁹³ CDC WISQARS, 2019

¹⁹⁴ National Vital Statistics System. (2019). National Outcome Measure 16.3: Adolescent suicide rate ages 15 through 19 per 100,000.

¹⁹⁵ National Vital Statistics System. (2019). National Outcome Measure 16.3: Adolescent suicide rate ages 15 through 19 per 100,000.

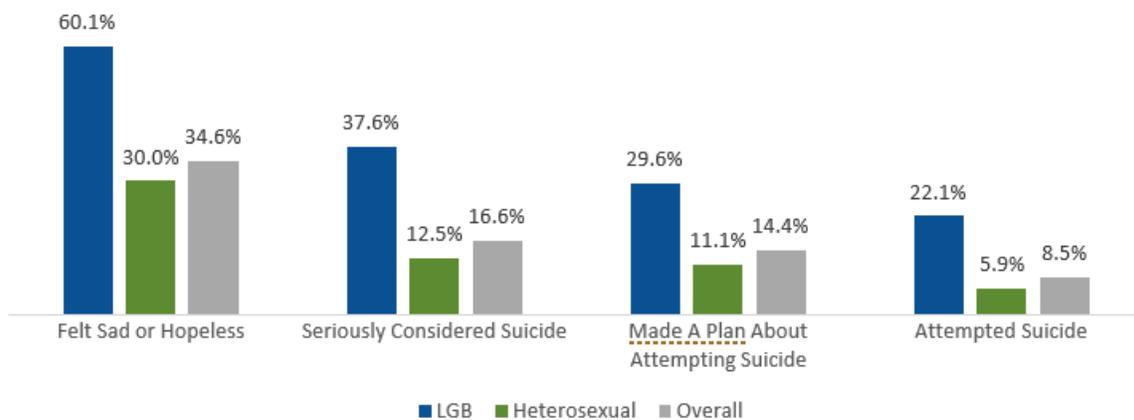
Figure 18: Age Adjusted Suicide Rates per 100,000 individuals by County, 2017¹⁹⁶



Looking at LGB students, there were very significant disparities for all the YRBS emotional health indicators compared to their heterosexual peers. These disparities can be seen in Figure 19.

¹⁹⁶ Centers for Disease Control & Prevention. (n.d.). CDC WONDER. Retrieved from <http://wonder.cdc.gov>.

Figure 19: Proportion of Nevada High School Students with Emotional Health Difficulties by Sexual Identity, 2017¹⁹⁷



Trends: In the past nine years, the adolescent suicide rate (ages 15 to 19 years) has doubled in Nevada by 107.7 percent (from 6.5 in 2009 to 13.5 per 100,000 in 2017), indicating it is a growing problem both in the state, but also nationally where it has increased by 45.8 percent (from 7.2 to 10.5 per 100,000) since 2009.¹⁹⁸

Community Voices: Mental health and a lack of access to services was a significant issue among all groups in the needs assessment. Family environment, community context, and lack of services in communities and schools were all identified as significant issues for youth.

- "There is a lack of screening and availability of mental health providers."
- "There is a lack of parental support, bullies, lack of education about what is normal vs not normal to feel in life and where to get help."
- "Many factors could put teens at risk for mental health challenges: family genes, lack of attention from parents, traumatic events, lack of services in our community, etc."
- "Lack of early detection in pre-school and elementary school; lack of social skills training at home and at school (or in an after school setting) as well as parents who are struggling with depression, mental illness, job security, or relationship challenges."

Unintentional Injury and Violence Prevention

Magnitude: Along with the direct impact of a child's death, a community's mortality rate is an important indicator of underlying problems, such as violence in neighborhoods or inadequate child supervision.¹⁹⁹ Different age groups of children and adolescents are at risk for different types of death. In 2017, the

¹⁹⁷ Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report.

¹⁹⁸ National Vital Statistics System. (2019). National Outcome Measure 16.3: Adolescent suicide rate ages 15 through 19 per 100,000.

¹⁹⁹ Infant, Child and Teen Mortality, Indicators on Children and Youth, Child Trends Data Bank.

adolescent mortality rate in Nevada for ages 10 to 19 years per 100,000 was 33.7 (similar to the national rate of 33.1), a 23.6 percent decrease from the high of 44.1 per 100,000 in 2014.²⁰⁰

In Nevada, the leading causes of death for youth ages 10 to 19 years was unintentional injury (29.6% of all deaths in age group), suicide (27.8%), and homicide (17.5%) in 2017.²⁰¹ Figure 20 compares these rates to those of the United State, noting that the percentage of deaths due to suicide higher in Nevada compared to the United States.

Figure 20: National vs. State Cause of Death Rates, 2017²⁰²

Percent of All Deaths Among Youth Ages 10 to 18 years		
Cause of Death	Nevada	United States
Unintentional Injury	29.6%	34.1%
Suicide	27.8%	21.3%
Homicide	17.5%	14.3%

In 2016, the leading manner of unintentional injuries for children and adolescents, ages zero to 17 years, was non-motor vehicle accidents, which differs from the national trends where motor vehicle accidents are often the leading cause.²⁰³ Between 2015 and 2017, the adolescent motor vehicle mortality rate 10.5 deaths per 100,000 adolescents ages 15 to 19 years.²⁰⁴ Related, among high school students, 17.0 percent reported riding in the car with someone in the past 30 days who had been drinking (similar to national rate of 16.5%).²⁰⁵ For middle school students, this increases to 21.9 percent, putting them at greater risk of being involved in a motor vehicle accident.²⁰⁶

One factor that can impact all facets of a child’s life is their sense of safety, and the extent to which they are protected from unintentional injury, death, and violence. In Nevada, 42.1 percent of the parents of children, ages zero to 17 years, somewhat agree (35.3%) or definitely disagree (6.8%) with the statement that “their child is safe in the neighborhood” (similar to the national rate of to 34.5%) in

²⁰⁰ Health Resources and Services Administration. National Outcome Measures.

²⁰¹ National Center for Health Statistics (NCHS), National Vital Statistics System, accessed via CSC WISQARS.

²⁰² National Center for Health Statistics (NCHS), National Vital Statistics System, accessed via CSC WISQARS.

²⁰³ The Executive Committee to Review the Death of Children. (n.d.). *2016 Statewide Child Death Report. 2016 Statewide Child Death Report.* State of Nevada, Division of Child and Family Services. Retrieved from http://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Tips/Reports/2016_Statewide_Child_Death_Report_final.pdf.

²⁰⁴ National Vital Statistics System. (2019). National Outcome Measure 16.2: Adolescent motor vehicle mortality rate ages 15 through 19 per 100,000.

²⁰⁵ Lensch, T., et al. *2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report.*

²⁰⁶ Lensch, T., et al. *2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report*

2017.²⁰⁷ The same survey found that 35.4 percent of parents somewhat agree or definitely disagree that their child, ages six to 17 years, is safe at school (higher than the national rate of 23.7%).²⁰⁸

Most homicide deaths in 2016 were related to abuse, followed by gunshot wounds, and general neglect for children and adolescents.²⁰⁹ From YRBS data, 5.7 percent of high school students report carrying a weapon on school property during the 30 days prior and for middle school students, the percentage was 32.0. Nearly 20 percent of high school students reported being in a physical fight in the year prior and 19.6 percent of middle school students.^{210,211} Related, 5.0 percent of middle school students reported prevalence of carrying a weapon onto school property is higher among males (5.6%) than females (1.9%), and sits at 3.8 percent, nationally. Black males have the highest incidence of being threatened or injured with a weapon on school property at 10.0 percent, higher than the national average of 6.0 percent, as well as the highest incidence of being in a physical fight at 37.2 percent, higher than the national average of 23.6 percent.²¹²

In 2017, two-thirds of high school students reported having ever been sworn at, insulted by, or put down by an adult, with 72.8 percent of middle school students reporting the same thing.^{213,214} Beyond verbal abuse, 17.7 percent of high school and 12.8 percent of middle school students reported having ever been hit, beaten, kicked or physically hurt in any way by an adult.^{215,216} As well, 14.9 percent of children, ages 12 to 17 years, were reported as being bullied, picked on, or excluded by other children (lower than the national rate of 21.0%).²¹⁷ Among children with special health care needs, this increases to 41.7 percent (higher than the national rate of 38.3%).²¹⁸

Looking at the juvenile justice system, as of August 2019, there were 146 juveniles in the three youth centers across the state.²¹⁹ In the 11 judicial districts across the state, there were 313 children with a

²⁰⁷ Child and Adolescent Health Measurement Initiative. 2017 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration's Maternal and Child Health Bureau (HRSA MCHB). Retrieved August 30, 2019 from www.childhealthdata.org. CAHMI: www.cahmi.org.

²⁰⁸ Child and Adolescent Health Measurement Initiative. 2017 National Survey of Children's Health (NSCH) data query.

²⁰⁹ The Executive Committee to Review the Death of Children. *2016 Statewide Child Death Report*.

²¹⁰ Lensch, T., et al. 2017 *Nevada Middle School Youth Risk Behavior Survey (YRBS) Report*.

²¹¹ Lensch, T., et al. 2017 *Nevada High School Youth Risk Behavior Survey (YRBS) Report*.

²¹² Lensch, T., et al. 2017 *Nevada High School Youth Risk Behavior Survey (YRBS) Report*.

²¹³ Lensch, T., et al. 2017 *Nevada Middle School Youth Risk Behavior Survey (YRBS) Report*.

²¹⁴ Lensch, T., et al. 2017 *Nevada High School Youth Risk Behavior Survey (YRBS) Report*.

²¹⁵ Lensch, T., et al. 2017 *Nevada Middle School Youth Risk Behavior Survey (YRBS) Report*.

²¹⁶ Lensch, T., et al. 2017 *Nevada High School Youth Risk Behavior Survey (YRBS) Report*.

²¹⁷ Data Resource Center for Child & Adolescent Health. (2017). National Survey of Children's Health.

²¹⁸ Data Resource Center for Child & Adolescent Health. (2017). National Survey of Children's Health.

²¹⁹ Division of Child & Family Services. "Juvenile Justice Services." *Nevada Department of Health & Human Services*, Nevada Department of Health & Human Services, <http://dcfs.nv.gov/Programs/JJS/>.

new commitment, meaning they had been adjudicated by a juvenile court in 2018.²²⁰ Of those, 29.0 percent were due to violent offenses, 23 percent to probation offenses, 17 percent to property offenses, 9.0 percent to drug offenses, and 8 percent to weapons offenses.²²¹ The average age of committed youth was 16.2 years old.²²²

Both northern and southern Nevada are grappling with issues of gang violence. In southern Nevada, particularly Clark County, gang violence has been a rising concern for youth with the number of gangs rising in the area.²²³ In 2019, the Department of Justice awarded \$1.2 million in grants in an effort to prevent youths in Clark County from joining gangs.²²⁴ In northern Nevada, it is reported that gangs in Washoe County have multiplied, growing by 30.0 percent in the past 10 years (reported as of 2016).²²⁵ At this time, 15 to 20 active gangs were in the region of Reno. While the rate of gang-related crime remains steady, the organizations are growing. As of April 2016, there were about 1,200 active and known gang members in Washoe County. In response, agencies such as the Reno and Sparks Police Departments, the Washoe County Sheriff's Office and the local school district have created a regional gang unit.

Disparities: In 2016, unintentional injury, suicide, and homicide deaths made up 28.0 percent of all child deaths (ages 0 to 17 years) in the state of Nevada. Among these, males experience increased death rates from asphyxia (61%), motor vehicle accidents (64%), homicides (60%), and non-homicide abuse/neglect (58%) (all of which are consistent with national data), while females had slightly higher rates of drowning, inconsistent with prior years' data, (60%) and suicide (55%), inconsistent with national data.²²⁶ Male adolescents (ages 10 to 19 years) had a higher adolescent mortality rate (47.2 per 100,000) compared to females (24.3 per 100,000) between 2015 and 2017.²²⁷ The NVSS also showed that the majority of deaths between 2015 and 2017 were occurring for those ages 15 to 19 years (55.7 per 100,000), rather than those ages 10 to 14 years (17.6 per 100,000).²²⁸

²²⁰ Division of Child & Family Services. "Youth Parole Bureau Data." *Nevada Department of Health & Human Services*, Nevada Department of Health & Human Services, http://dcfs.nv.gov/Programs/JJS/Youth_Parole_Bureau_Data/.

²²¹ Division of Child & Family Services. "Youth Parole Bureau Data."

²²² Division of Child & Family Services. "Youth Parole Bureau Data."

²²³ Mlnarek, Cassandra. "Gang Activity Possibly on the Rise Among Valley Kids in Las Vegas." *KVVU-TV*, 15 Aug. 2019, https://www.fox5vegas.com/news/gang-activity-possibly-on-the-rise-among-valley-youths/article_d8ee9800-bfe0-11e9-b408-9b1ab6395745.html.

²²⁴ Shoro, M. 2019, March 13. \$1.2M grant aims to suppress gangs in Southern Nevada. *The Las Vegas Review Journal*, available at <https://www.reviewjournal.com/crime/1-2m-grant-aims-to-suppress-gangs-in-southern-nevada-1617466/>.

²²⁵ Hernandez, Ricio. (2016, May 25). Tackling the Growth of Gangs in Reno. *KUNR*. Retrieved from <https://www.kunr.org/post/tackling-growth-gangs-reno#stream/0>.

²²⁶ The Executive Committee to Review the Death of Children. *2016 Statewide Child Death Report*.

²²⁷ National Vital Statistics System. (2019). National Outcome Measure 16.1: Adolescent mortality rate ages 10 through 19 per 100,000.

²²⁸ National Vital Statistics System. (2019). National Outcome Measure 16.1: Adolescent mortality rate ages 10 through 19 per 100,000.

A disproportionate number of African Americans are affected by non-homicide abuse and neglect (40%), homicide (30%), asphyxia (25%), and motor vehicle accidents (21%), as compared to the statewide population for African Americans at 10 percent.²²⁹ Between 2015 and 2017, Hispanic adolescents had the lowest adolescent mortality rate for those ages 10 to 19 years at 28.9 per 100,000, followed by Asian/Pacific Islander adolescents (31.7 per 100,000), non-Hispanic Whites (40.3 per 100,000), and non-Hispanic Blacks (47.8 per 100,000).²³⁰

Among violence-related behaviors, Native Hawaiian/Pacific Islander middle school students and American Indian/Alaska Native high school students are most at risk for being threatened or injured by someone with a weapon on school property (8.6% and 16.0%, respectively).^{231, 232} However, Hispanic/Latino students experience the highest number of incidents (126 middle school students and 171 high school students).^{233,234} Female students experience higher rates of bullying on school property (25.5% vs. 20.0% of male middle school students and 19.3% vs. 13.9% of male high school students), and even greater disparity exists for electronic bullying (18.9% vs. 9.0% of male middle school students and 16.5% vs. 9.9% of male high school students).^{235,236} All non-white students in both middle school and high school, with the exception of Asian students, experience higher incidence of not going to school because they felt unsafe at school or on their way to or from school.

LGB high school students are more likely to be involved in a physical fight (24.6%) and to be threatened or injured with a weapon on school property (12.4%), and twice or more likely to be bullied on school property or electronically (29.3% and 25.4%) and to not go to school because they feel unsafe at school or on their way to or from school (14.1%), as compared to their heterosexual counterparts. Figure 21 shows this disparity of violence and victimization.²³⁷

²²⁹ National Vital Statistics System. (2019). National Outcome Measure 16.1: Adolescent mortality rate ages 10 through 19 per 100,000.

²³⁰ National Vital Statistics System. (2019). National Outcome Measure 16.2: Adolescent motor vehicle mortality rate ages 15 through 19 per 100,000.

²³¹ Lensch, T., et al. 2017 *Nevada Middle School Youth Risk Behavior Survey (YRBS) Report*.

²³² Lensch, T., et al. 2017 *Nevada High School Youth Risk Behavior Survey (YRBS) Report*.

²³³ Lensch, T., et al. 2017 *Nevada Middle School Youth Risk Behavior Survey (YRBS) Report*.

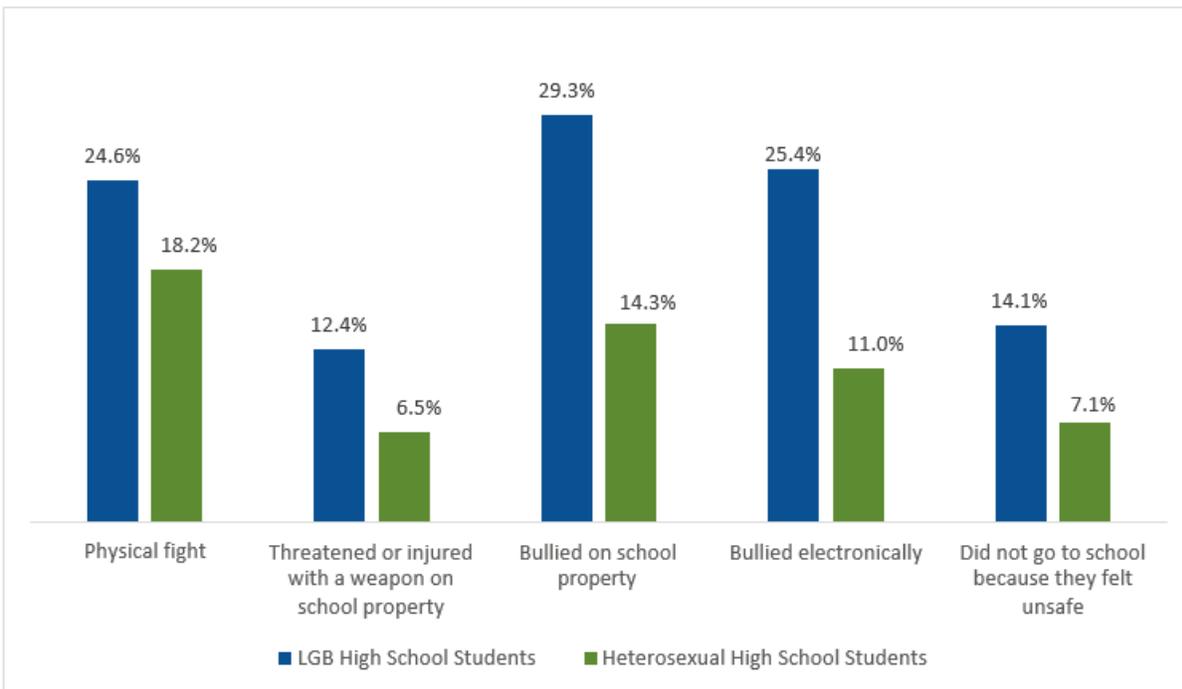
²³⁴ Lensch, T., et al. 2017 *Nevada High School Youth Risk Behavior Survey (YRBS) Report*.

²³⁵ Lensch, T., et al. 2017 *Nevada Middle School Youth Risk Behavior Survey (YRBS) Report*.

²³⁶ Lensch, T., et al. 2017 *Nevada High School Youth Risk Behavior Survey (YRBS) Report*.

²³⁷ Lensch, T., et al. 2017 *Nevada High School Youth Risk Behavior Survey (YRBS): Sexual Identity Special Report*.

Figure 21: Proportion of Nevada Students Experiencing Violence and Victimization by Sexual Identity, 2017²³⁸



Finally, looking at geographic residence, adolescents (ages 10 to 19 years) living in non-metro areas had a higher adolescent mortality rate between 2015 and 2017 at 46.4 deaths per 100,000 adolescents, compared to those living in large central metro areas (34.4 per 100,000) and small/medium metro areas (37.8 per 100,000).²³⁹

Trends: Between 2013 and 2017, the percentage of high school students who drove a car or other vehicle when they had been drinking alcohol decreased by 28.8 percent, and the percentage of students who rode with a driver who had been drinking alcohol decreased 28.2 percent between 2007 and 2017.²⁴⁰ Bullying on school property has also declined between 2013 and 2017 by 18.8 percent (from 19.7% to 16.0%). While electronic bullying has declined between 2013 and 2017 by 13.3% (from 15% to 13%) it is not a significant change.²⁴¹

In Nevada, the incidence of high school students carrying a weapon on school property has not changed between 2007 and 2017, remaining at 4.7 percent, while felt unsafe at school or on their way to or from

²³⁸ Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS): Sexual Identity Special Report.

²³⁹ National Vital Statistics System. (2019). National Outcome Measure 16.2: Adolescent motor vehicle mortality rate ages 15 through 19 per 100,000.

²⁴⁰ University of Nevada, Reno. 2017 Youth Risk Behavior Survey Results - Nevada High School Survey: 10-Year Trend Analysis Report.

²⁴¹ University of Nevada, Reno. 2017 Youth Risk Behavior Survey Results - Nevada High School Survey: 10-Year Trend Analysis Report.

school or who were threatened or injured with a weapon on school property has increased, 28.6 percent and 4.0 percent, respectively.²⁴²

Suicidal ideation among Nevada's high school students has increased by 16.8 percent between 2007 and 2017, while suicide attempts have declined by 16.9 percent, with a 30 percent decrease in attempts that result in injury, poisoning, or overdose.²⁴³

Community Voices: Although unintentional injury and violence are not solely driven by substance use and mental health, the consequences of these issues play a significant role in the lives of Nevada's adolescents. Additionally, poverty, anti-LGBTQ sentiment, and the contextual challenges presented by the culture of Las Vegas all serve as contributing factors.

- "It's the unseen violence that is the issue. From domestic to bullying. People just want to fit in and feel like they are a part of something, as a consequence we are too afraid to speak up."
- "There have been some cases of fighting that have landed kids in the hospital with critical, life-threatening injuries."
- "The teen suicide rate is very high in Elko County."
- "LTBQ youth are struggling for acceptance and many are living in gear from being bullied."
- "Significant, increase suicide, due to legalization of marijuana its use has been minimized and is more acceptable."
- "[Drug use creates] a heavy burden on society, increased costs of acute and chronic issues of these individuals and decreased the life expectancy."
- "A large impact. More and more children/young adults are impacted by adult behavior and then begin to utilize these same negative behaviors, resulting in an increasing negative impact of community health."
- "A kid reported he got thrown down the stairs today and that was my low day. The kids throw me down the stairs all the time."
- "The normalization of attitudes being accepted as normal. So people don't realize that the perpetrator doesn't realize its bullying but those being perpetrated feel that bullied. Victim blaming - no one will believe me anyway."

²⁴² University of Nevada, Reno. *2017 Youth Risk Behavior Survey Results - Nevada High School Survey: 10-Year Trend Analysis Report.*

²⁴³ University of Nevada, Reno. *2017 Youth Risk Behavior Survey Results - Nevada High School Survey: 10-Year Trend Analysis Report.*

Substance Use

Magnitude: Substance use looks at both the uses and abuse of a variety of substances including tobacco, alcohol, and illicit drugs. According to the 2017 High School YRBS results for Nevada, around one third of students has ever lived with someone who was a problem drinker, alcoholic, or abused street or prescription drugs.

In Nevada, 13.7 percent of middle school students reported ever smoking cigarettes and 2.2 percent reported smoking cigarettes at some point in the month prior.²⁴⁴ For high school students, the statistics rise to 23.0 percent (compared to 28.9% nationally) and 6.4 percent, respectively (8.8% nationally).²⁴⁵ However, when looking at percentage of students who have ever used electronic vapor products (e-cigarettes, vape pipes, vaping pens, etc.), 18.6 percent of middle school students and 42.6 percent of high school students (similar to the national rate of 42.4%) have used these products, much higher than those smoking cigarettes.^{246,247}

Looking at alcohol, 60.6 percent of high school students reported ever having drunk alcohol (compared with 60.4% nationally), with 18.2 percent reporting they had their first drink before the age of 13 years (15.5% nationally).²⁴⁸ Over a quarter of high school students also reported having at least one drink of alcohol in the month before the survey (compared to 29.8% nationally). For middle school students, the percentages are lower than high school students, with only 27.4 percent reporting alcohol use.²⁴⁹

For marijuana, of which recreational use has been legal since January 1, 2017,²⁵⁰ 9.8 percent of middle school students reported having ever used marijuana while that number sharply rises with high school students, with 36.6 percent reporting having ever used the substance.^{251,252} The majority of high school students reported smoking marijuana in a joint, bong, pipe or blunt (83.9%), followed by eating it in a food product (10.7%), and vaporizing it (2.1%).²⁵³ Figure 22 shows that the similarity in marijuana use among Nevada and United States students in 2017.

²⁴⁴ Lensch, T., et al. 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report.

²⁴⁵ Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report.

²⁴⁶ Lensch, T., et al. 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report.

²⁴⁷ Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report

²⁴⁸ Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report

²⁴⁹ Lensch, T., et al. 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report

²⁵⁰ United States, Congress, Stinnesbeck, Jann. "Fact Sheet: Recreational Marijuana in Nevada." *Fact Sheet: Recreational Marijuana in Nevada*, Nevada Legislature, Sept. 2018. <https://www.leg.state.nv.us/Division/Research/Publications/Factsheets/RecreationalMarijuana.pdf>.

²⁵¹ Lensch, T., et al. 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report.

²⁵² Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report.

²⁵³ Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report.

Figure 22: Marijuana Use Among Students, 2017²⁵⁴

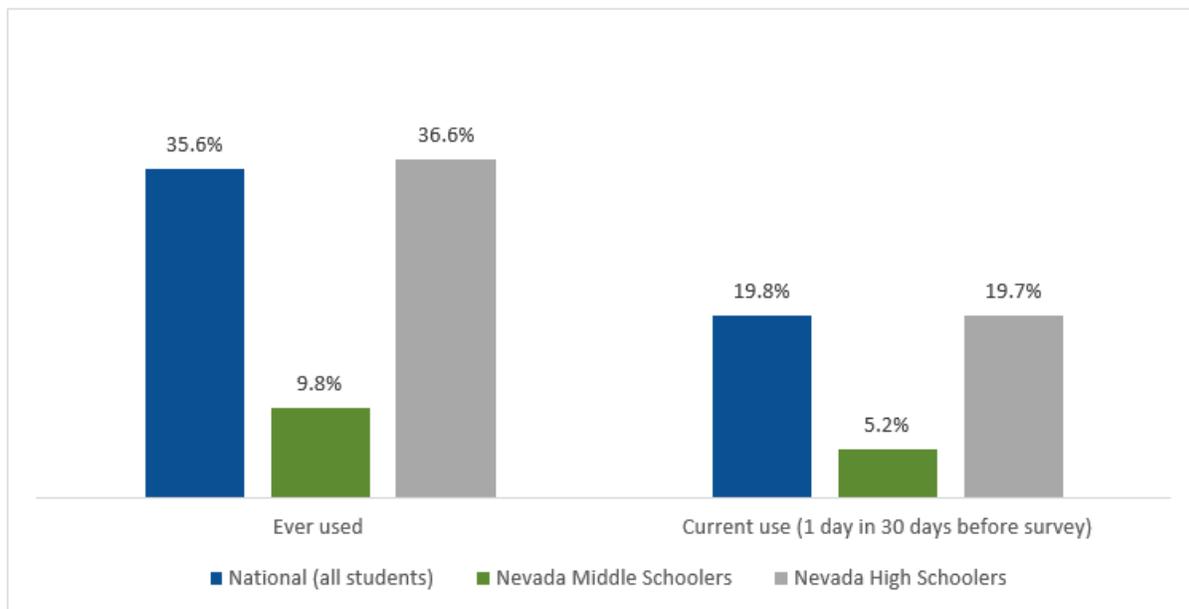


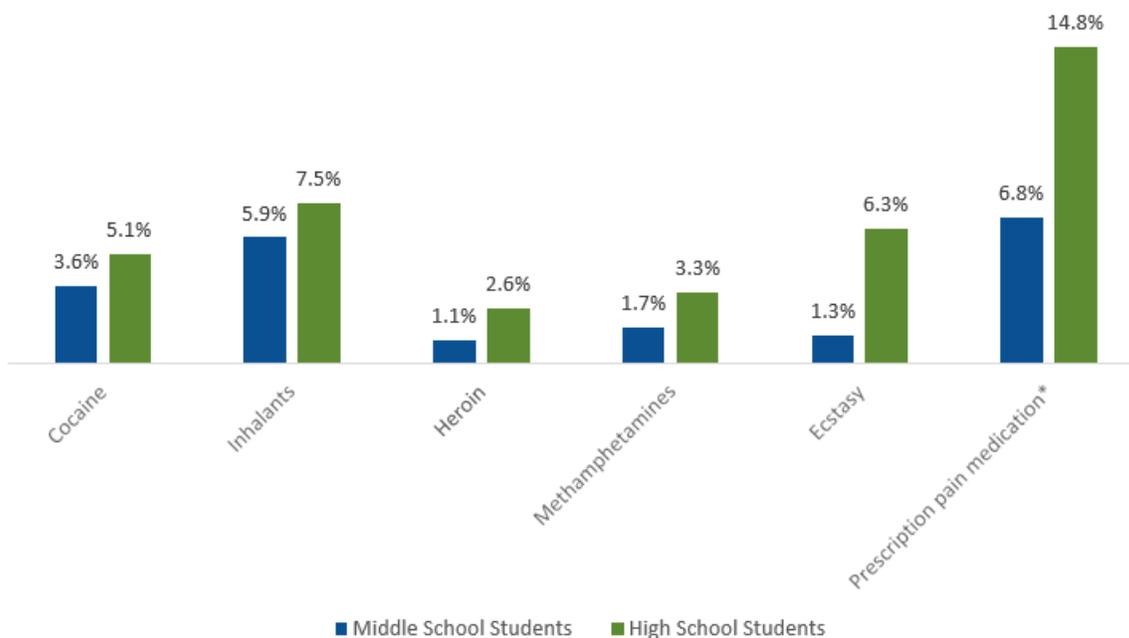
Figure 23 below shows the percentage of students, in both middle and high school, who reported having ever used different substances.^{255,256}

²⁵⁴ Lensch, T., et al. 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report.; Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report.

²⁵⁵ Lensch, T., et al. 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report.

²⁵⁶ Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report.

Figure 23: Percentage of middle and high school students who ever used other drug substances, by drug type, 2017²⁵⁷

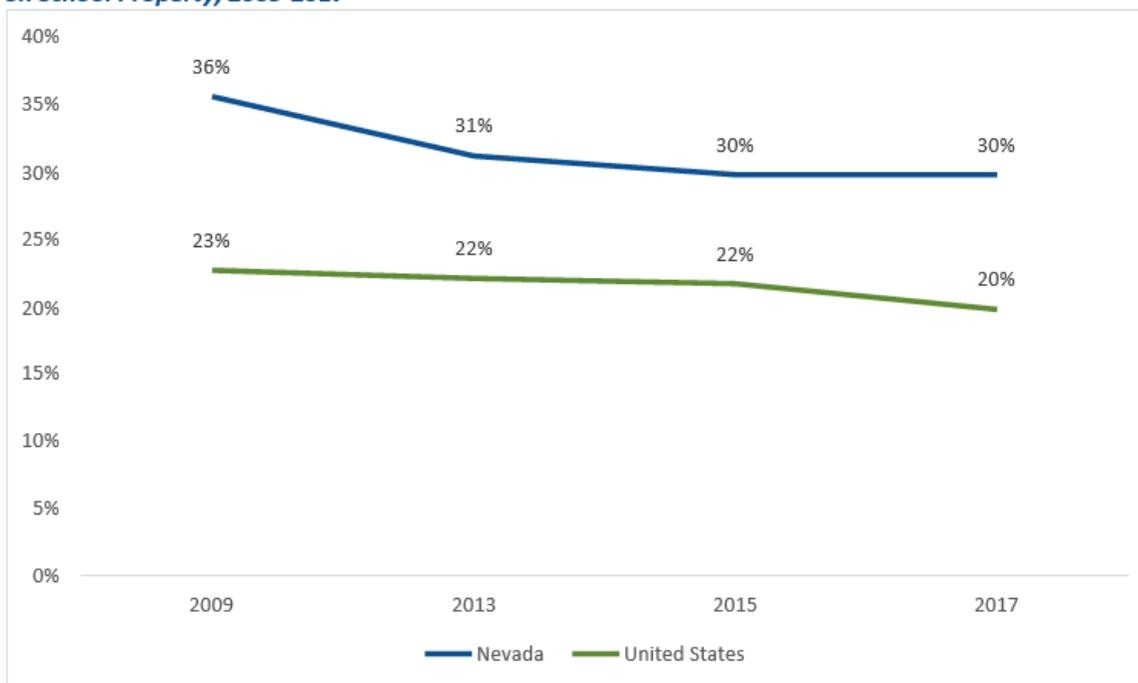


**This includes prescription pain medicating taken without a doctor’s prescription or differently than prescribed.*

YRBS explores to what extent youth access illegal drugs on school property. In 2017, 30.0 percent of high school students reported having this experiencing, which is on a decreasing trend since 2009 at a high of 36.0 percent. Consistently, over the last six years, there is a higher level of perceived access to illegal drugs on school property in Nevada compared the United States, as shown in Figure 24.

²⁵⁷Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report.

Figure 24: Percent of Adolescents (Grades 9-12) Who Have Been Offered, Sold, or Given an Illegal Drug on School Property, 2009-2017²⁵⁸



Disparities: Native Hawaiian/Pacific Islander students (both middle and high school) have the highest percentages of ever having smoked cigarettes at 26.2 percent and 40.4 percent, respectively. Among middle school students, 4.1 percent of Native Hawaiian/Pacific Islander students smoked cigarettes during the 30 days before the survey, while among high school students, American Indian/Alaska Native show the greatest disparity at 12.7 percent. Usage of electronic vapor products is highest among Native Hawaiian/Pacific Islander middle (29.7%) and high school students (52.8%). Among middle school students, 12.4 percent of Native Hawaiian/Pacific Islander students used electronic vapor products during the 30 days before the survey, while among high school students, American Indian/Alaska Native show the greatest disparity at 24.1 percent.^{259,260}

Reports of ever drinking alcohol are higher among Native Hawaiian/Pacific Islander middle school students (32.2%) and Other/Multiple race/ethnicity high school students (66.4%). Native Hawaiian/Pacific Islander middle school students were also more likely to have had at least one drink in the 30 days before the survey (13.4%), compared to 30.2 percent of the same population of high school

²⁵⁸ U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, Healthy People 2020. Adolescent Health. Retrieved from <https://www.healthypeople.gov/2020/topics-objectives/topic/Adolescent-Health/objectives>.

²⁵⁹ U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, Healthy People 2020.

²⁶⁰ Lensch, T., et al. 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report.

students. Disparities among marijuana use exist for Native Hawaiian/Pacific Islander middle school students (14.7% overall, and 6.9% in the 30 days before the survey) and American Indian/Alaska Native high school students (47.2% overall, and 34.3% in the 30 days before the survey).²⁶¹

Native Hawaiian/Pacific Islander middle school students are also disproportionately impacted by use of inhalants (9.7%) and prescription pain medication without a doctor's prescription or differently than prescribed (12.0%). For high school students, American Indian/Alaska Native students are more affected, at 17.0% and 28.0%, respectively. American Indian/Alaska Native students are also more likely to have lived with someone who was a problem drinker, alcoholic, or abused street or prescription drugs (middle school, 28.2% and high school, 43.6%).²⁶²

Across the board, LGB high school students experience higher rates than their heterosexual counterparts of currently smoking cigarettes (11.3%), using electronic vapor products (18.9%), drinking alcohol, using marijuana, and having ever used cocaine (9.3%), inhalants (17.6%), heroin (5.8%), methamphetamines (7.8%), ecstasy (11.9%), synthetic marijuana (11.9%), steroids without a prescription (6.1%), or prescription pain medicine without a prescription or differently than prescribed (26.3%).²⁶³

Trends: Tobacco use among youth in Nevada has trended downward over the past 10 years. High school students who have ever tried cigarettes has decreased by 45.0 percent since 2007, and 50.7 percent fewer high school students currently smoke cigarettes at least one day during the 30 days before the survey. Daily cigarette smokers decreased by 76.3 percent. Between 2015 and 2017, 19.0 percent fewer high school students have tried electronic vapor products and the use of electronic vapor products on at least one day during the 30 days before the survey decreased by 39.5 percent.²⁶⁴

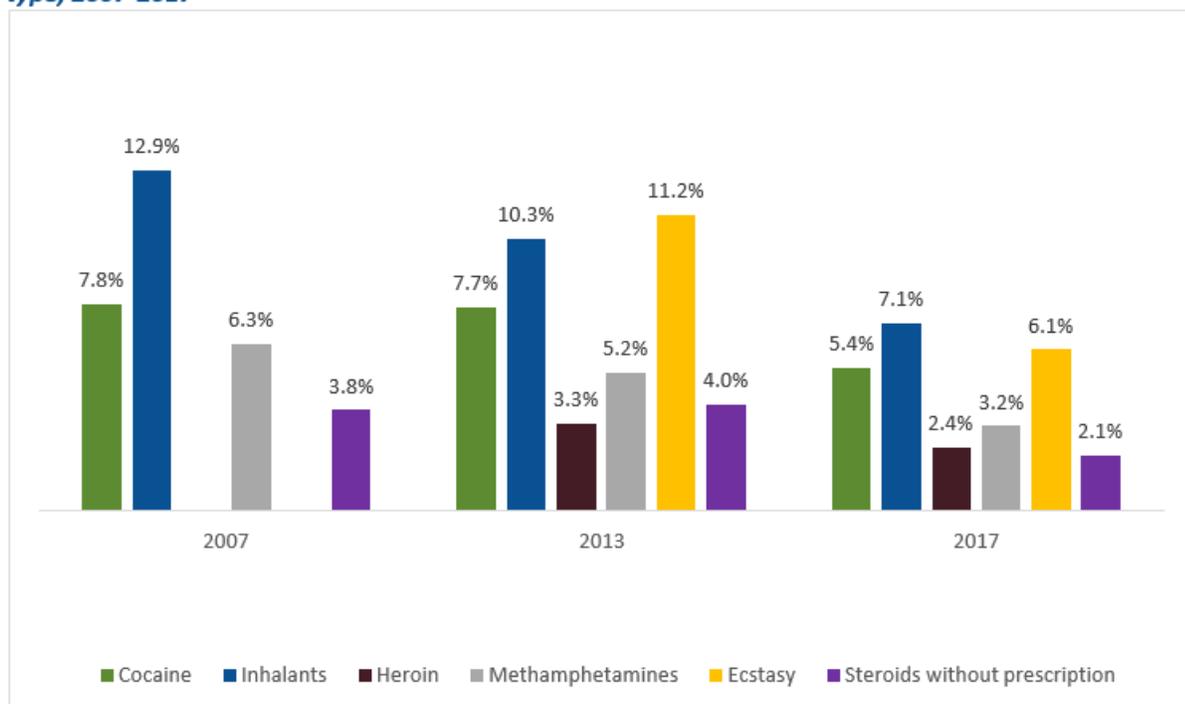
Alcohol use has also declined among high school students between 2007 and 2017. The percentage of students who ever drank alcohol has decreased by 15.9 percent, and the percentage of students who currently drink alcohol on at least one day during the 30 days before the survey has decreased by 30.2 percent. However, marijuana use has increased slightly, with 5.4 percent more high school students trying marijuana at least once, and 15.5 percent more students using marijuana at least one day during the 30 days before the survey. Use of all other drugs in the YRBS also showed decline since 2007. Figure 25 shows these 10-year trends in the percentage of high school students who ever used other drug substances, by drug type.

²⁶¹ Lensch, T., et al. 2017 *Nevada Middle School Youth Risk Behavior Survey (YRBS) Report*.

²⁶² Lensch, T., et al. 2017 *Nevada Middle School Youth Risk Behavior Survey (YRBS) Report*.

²⁶³ Lensch, T., et al. 2017 *Nevada High School Youth Risk Behavior Survey (YRBS): Sexual Identity Special Report*.

Figure 25: Trends in percentage of high school students who ever used other drug substances, by drug type, 2007-2017²⁶⁵



Note: 2007 data for heroin and ecstasy is not available for reporting.

Community Voices: Substance use, along with mental health, were significant challenges identified in the needs assessment. Ubiquitous access to substances, parental use and approval of experimentation, and community issues, such as the legalization of marijuana, were all named as contributors to youth substance use and abuse.

Many kids see family and friends who use, which gives them easy access to drugs. Others see their own parents using drugs and say in a clinic to their parents, "I'll quit when you do."

- "Even if people are trying to get help, it is 'hush hush'."
- "Need to change the stigma around it. For example, people in AA are people who have turned their life around, not a group of addicts."
- "So many kids walk down the sidewalk and kids come across with needles all the time; I used to throw my stuff out the window; or the orange caps see those everywhere; not just downtown could be in a gated community and you see orange caps or rigs sticking out of the trash."
- "I think in many areas it is worse but due to our rural community and the work schedules of many parents, teens can become more involved with substances due to lack of supervision, education, and out of boredom."

²⁶⁵University of Nevada, Reno. 2017 Youth Risk Behavior Survey Results - Nevada High School Survey: 10-Year Trend Analysis Report.

- “Substance use impacts a person's ability to make good decisions, crime rate, school attendance, work/job attendance and productivity. We have a huge problem with opioid addiction, and our community pays the prices for children in foster care, crime, lack of parental involvement, earning potential, etc.”

Social Determinants of Health – Risk and Protective Factors

Prevention focuses on both addressing and minimizing risk factors, things that increase the likelihood of experiencing adverse health outcomes while also promoting protective factors, things that increase resilience in youth or make them less likely to experience adverse health outcomes. This section describes the risk and protective factors adolescents experience in Nevada, providing important context for adolescent sexual behaviors and choices.

Risk Factors That Increase the Likelihood of Experiencing Adverse Health Outcomes

Adverse Childhood Experiences (ACEs) is the term used to describe all types of abuse, neglect, and other potentially traumatic experiences that occur to people under the age of 18.²⁶⁶ ACEs have been linked to risky health behaviors, chronic health conditions, low-life potential, and early death.²⁶⁷

As the number of ACEs increases, so does the risk for these negative health outcomes. One in four (25%) Nevada youth (0 to 17 years old) experience two or more ACEs, compared to approximately one in five (21.7%) youth across the United States in 2018.²⁶⁸ This means youth are more likely to experience one or more of the following ACEs, including socioeconomic hardship, divorce/parental separation, lived with someone who had an alcohol or drug problem, victim or witness of neighborhood violence, lived with someone who was mentally ill or suicidal, domestic violence witness, parent served time in jail, treated or judged unfairly due to race/ethnicity, and/or death of parent.

The YRBS suggests similar findings, with 62 percent of high school and 50 percent of middle school students who have experienced one or more ACE. One in five high school students (21%) have experienced three or more ACEs.²⁶⁹ Among those high school students who identify as American Indian/Alaska Native, this increases to nearly three in four (75.6%) who experience one or more ACEs and is the race/ethnicity group with the highest rate of students who experience three or more ACEs. Sixty-four percent of rural high school students experience one or more ACEs, compared to 62.0 percent of urban students, as shown in Figure 26. The greatest disparity among high school students who experience one or more ACEs is among those students who identify as LGBTQ, at 80.2 percent.

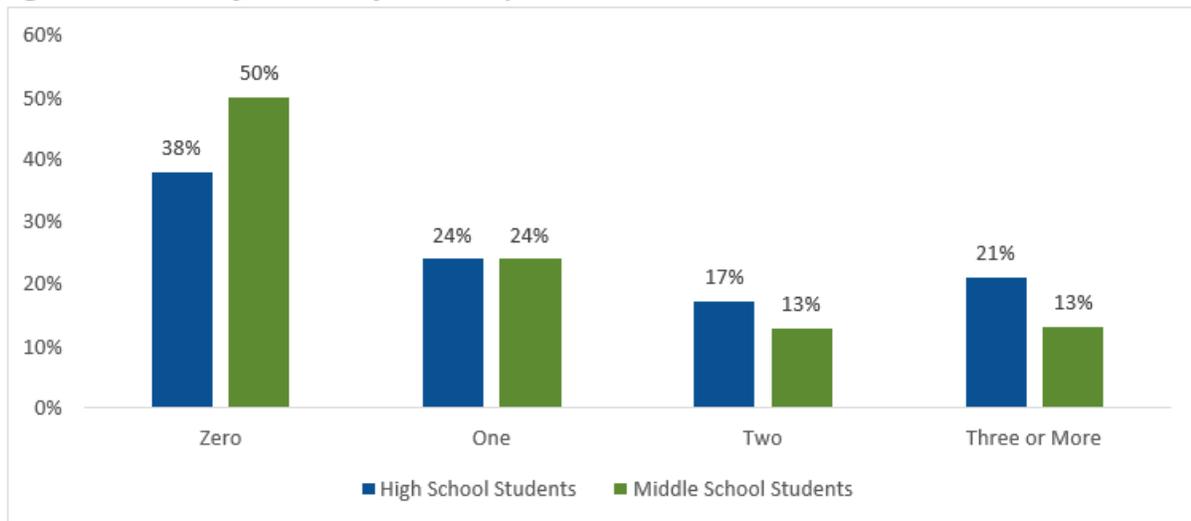
²⁶⁶ National Center for Injury Prevention and Control, Division of Violence Prevention.

²⁶⁷ National Center for Injury Prevention and Control, Division of Violence Prevention.

²⁶⁸ Child and Adolescent Health Measurement Initiative, National Survey of Children's Health, Data Resource Center for Child and Adolescent Health, 2018.

²⁶⁹ 2017 Nevada High School Youth Risk Behavior Survey (YRBS): Adverse Childhood Experiences (ACEs) Special Report.

Figure 26: Percent of Students by ACE Score, 2017²⁷⁰



The assessment explored the prevalence of three ACEs in Nevada, including divorce, household substance use and depression, and child abuse and neglect.

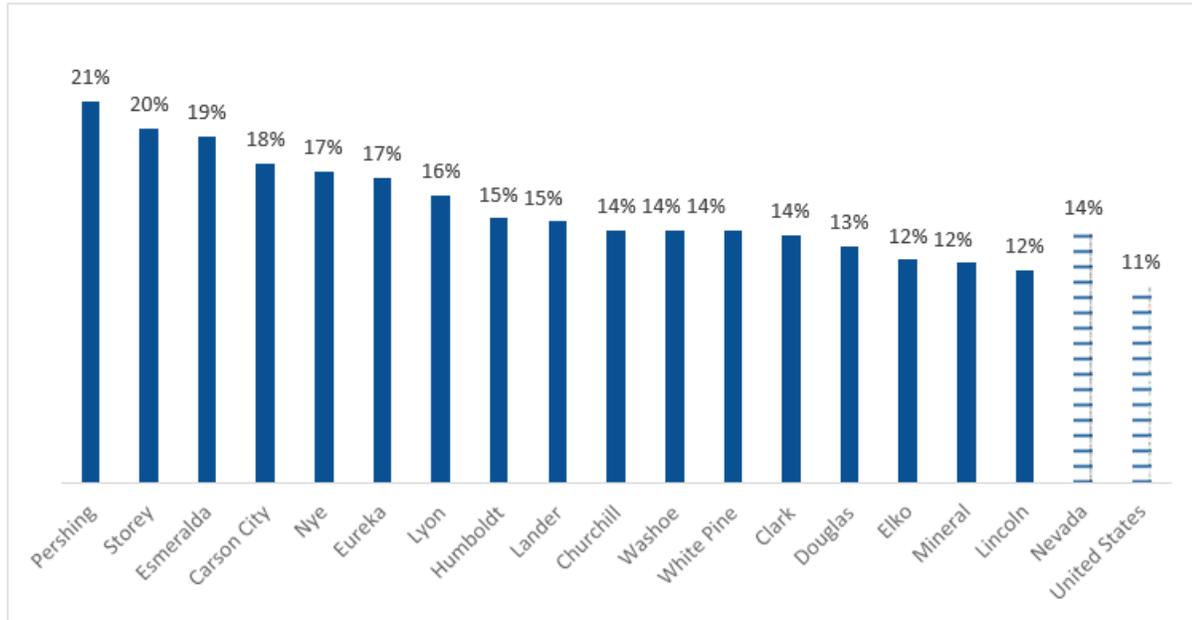
Divorce: Adults 18 years of age and older in Nevada are more likely to respond that they are divorced at 13.9 percent, compared to 10.9 percent across the United States.²⁷¹ Divorce is a risk factor for adverse health outcome among youth and adolescents as can introduce intense feelings of uncertainty, create an environment of chronic stress from anger and fighting, and cause economic strain on one of the divorcing parents. Additionally, it may separate children from a parent and parent’s family members who have been a positive influence or expose youth to parent’s new partners, which can increase risk of physical or sexual abuse. Some counties in Nevada experience twice the rate of individuals reporting they are divorced, such as Pershing County at 21 percent or Storey County at 20 percent, relative to that of the United States, as shown in Figure 27. While most individuals under 18 years old live in a married-couple family household in the state (62.8%), there is a significant proportion of children and youth living in a male (10.3%) or female (26.0%) only household with no partner present.²⁷²

²⁷⁰ 2017 Nevada High School Youth Risk Behavior Survey (YRBS): Adverse Childhood Experiences (ACEs) Special Report

²⁷¹ 2013-2017 American Community Survey 5-Year Estimates, Marital Status, Table S1201.

²⁷² 2013-2017 American Community Survey 5-Year Estimates.

Figure 27: Divorce Rate in Nevada, by County, 2013-2017²⁷³

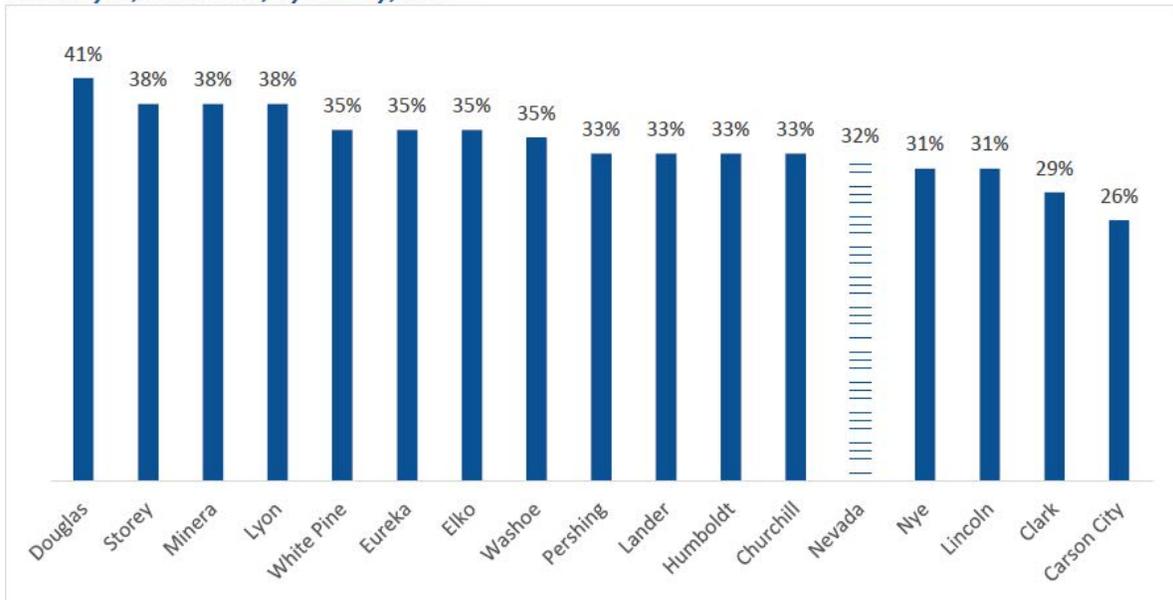


Household Substance Use and Depression: In Nevada, the 2017 YRBS asked youth whether they have ever lived with someone who was a problem drinker or alcoholic, or abused street or prescription drugs, of which 32.3 percent reported “Yes.” ²⁷⁴ As well, 30.3 percent of high school students have lived with someone who was depressed, mentally ill, or suicidal. Across the state, as shown in Figure 28, there are some counties where this more prevalent for adolescents, including Douglas, Storey, Mineral, and Lyon Counties.

²⁷³ 2013-2017 American Community Survey 5-Year Estimates.

²⁷⁴ Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report.

Figure 28: Percentage of high school students who ever lived with someone who was depressed, mentally ill, or suicidal, by County, 2017²⁷⁵

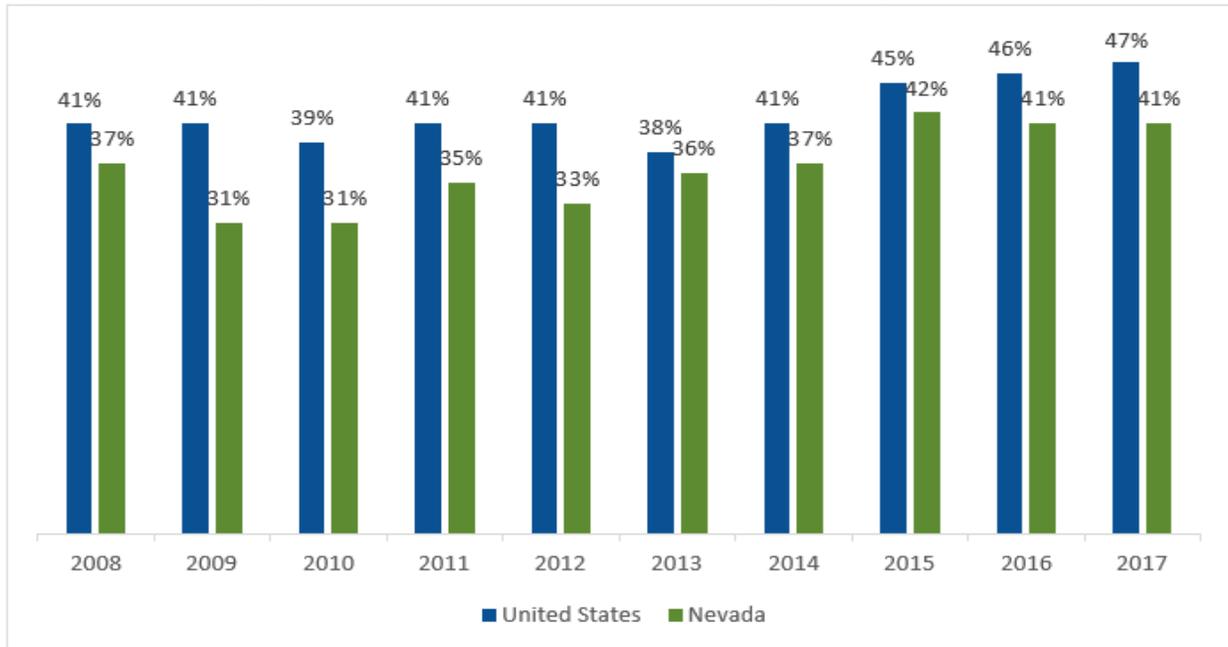


Child Abuse and Neglect: The rate of children who are subject to an investigation of maltreatment is 41 per 1,000 children in Nevada, lower than the United States at 47 per 1,000 children, as shown in Figure 29.²⁷⁶ The percent of adolescents who are confirmed by child protective services as victims of maltreatment is approximately 11.0 percent.

²⁷⁵ Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report.

⁶⁸ U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children’s Bureau. National Child Abuse and Neglect Data System (NCANDS) Child File, FFY 2000–2017.

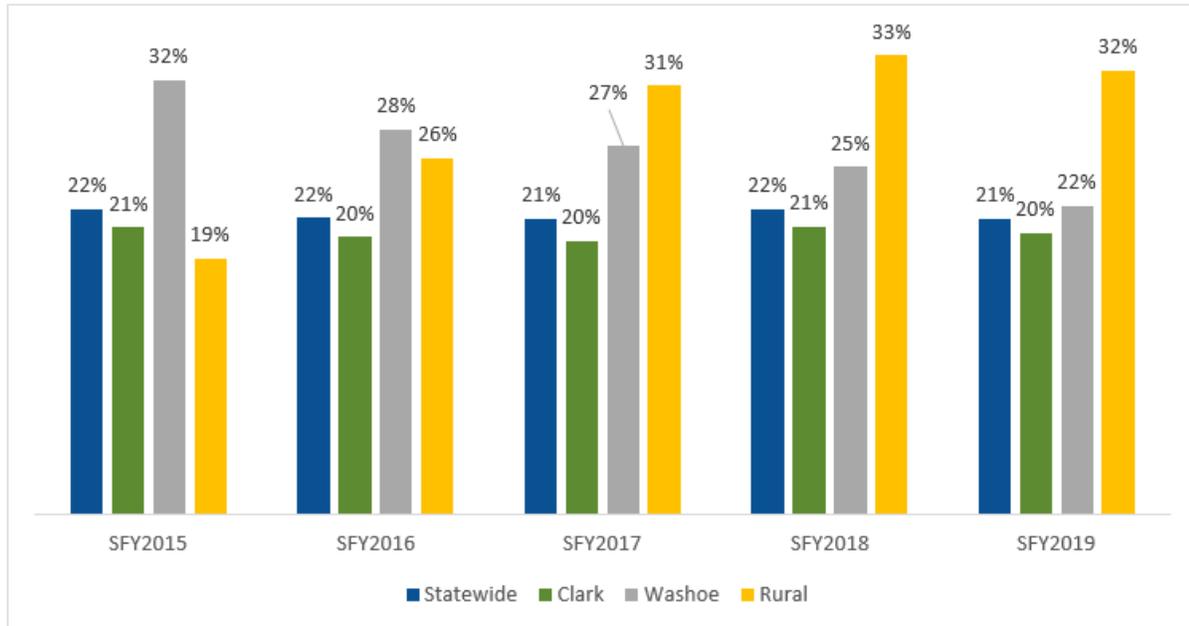
Figure 29: Percent of Children who are Subject to an Investigated Report²⁷⁷



Of those incidents that are reported and investigated, approximately 21 percent are substantiated in Nevada. The rate of child abuse and neglect investigations that are substantiated varies across the state, as shown in Figure 30, with the highest prevalence occurring in rural Nevada.

⁶⁹ U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children’s Bureau. National Child Abuse and Neglect Data System (NCANDS) Child File, FFY 2000–2017.

Figure 30: Percent of Child Abuse/Neglect Investigations Substantiated²⁷⁸



Protective Factors that Increase Resilience in Youth or Make Them Less Likely to Experience Adverse Health Outcomes

Select protective factors described in this assessment include protective family routines and habits, social connectedness, and educational achievement of adolescents.

Protective Family Routines and Habits: The environment at a child’s home is an important protective factor against negative health outcomes. There are routines and habits that parents or caregivers can control that foster protective home environment, such as tobacco exposure, screen time, reading, or doing homework. Nevada ranks 47th among United States in the percent of children who experience protective family routines and habits at 9.6 percent (compared to 12.2% across the United States).²⁷⁹

Social Connectedness: Research shows that adolescent sense of connectedness to caring adults, school or community is protective against a wide range of adverse health-related outcomes. Youth who feel connected are more likely to engage in healthy behaviors and excel academically. Therefore, promoting shared protective factors, such as youth connectedness, have important implications for youth overall health and well-being.

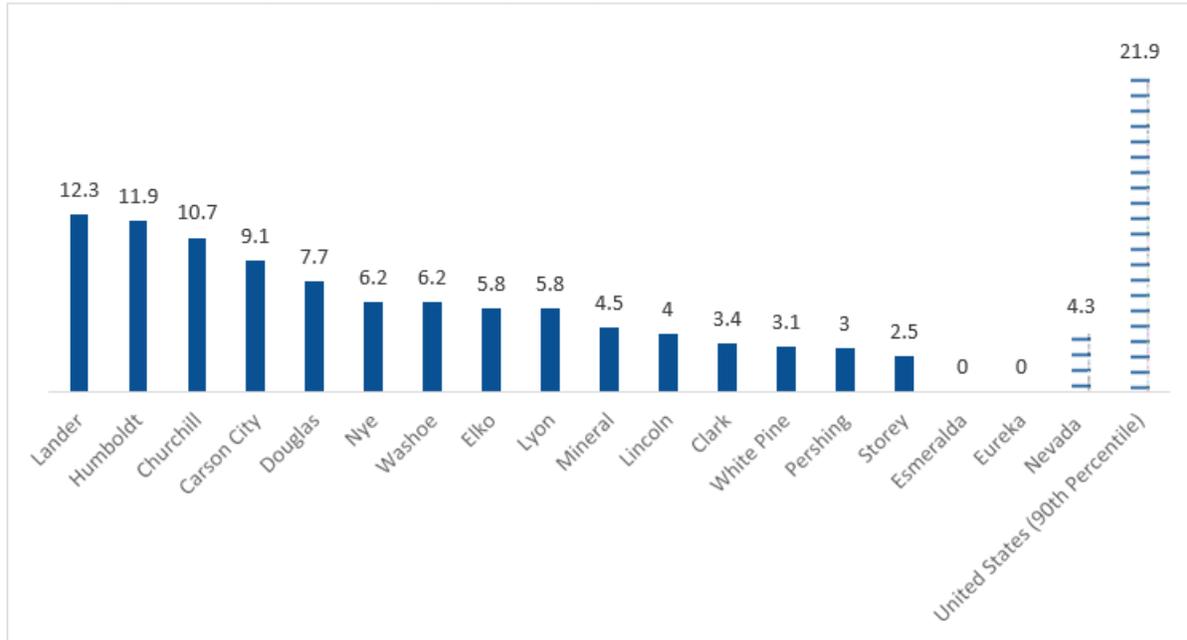
The number of membership associations per 10,000 population or “social associations” is one measure of connectedness within communities. Across Nevada, the overall rate of membership associations per

²⁷⁸ U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children’s Bureau. National Child Abuse and Neglect Data System (NCANDS) Child File, FFY 2000–2017.

²⁷⁹ America’s Health Rankings Analysis of Child and Adolescent Health Measurement Initiative, National Survey of Children’s Health, Data Resource Center for Child and Adolescent Health, United Health Foundation, AmericasHealthRankings.org, Accessed 2019.

10,000 people is 4.3, compared to 21.9 (90th percentile) among top U.S. performers. There is great variation across communities within Nevada, with a low in Esmeralda and Eureka counties of zero membership associations to a high in Lander County of 12.3 membership associations per 10,000 people, as shown in Figure 31.

Figure 31: Social Associations, by County
Number of Membership Associations per 10,000 Population²⁸⁰



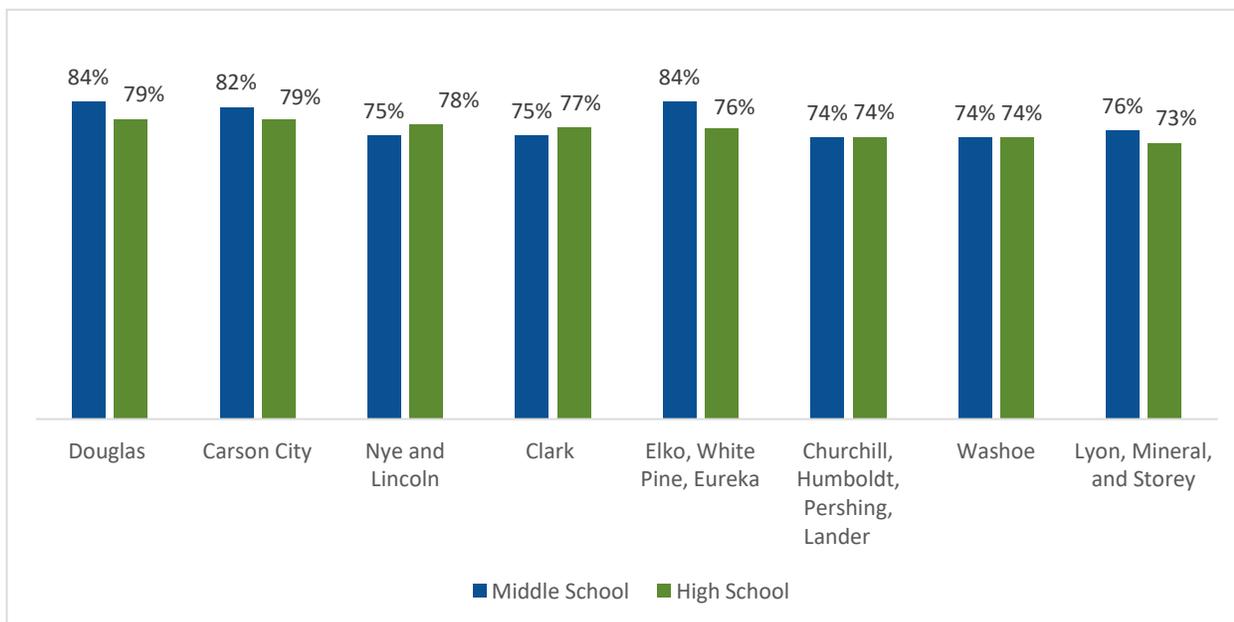
Related, the percentage of students whose parents or other adults asked where they were going or who they would be with most of the time/always was 78.0 percent among high school and 75.0 percent among middle school students.^{281,282} This experience among students varies slightly by county, ranging from a high of 84.0 percent among middle school students in Douglas, Elko, White Pine, and Eureka counties to a low of 73.0 percent in Lyon, Mineral and Storey counties among high school students, as shown in Figure 32.

²⁸⁰ America's Health Rankings Analysis of Child and Adolescent Health Measurement Initiative, National Survey of Children's Health, Data Resource Center for Child and Adolescent Health, United Health Foundation, AmericasHealthRankings.org, Accessed 2019.

²⁸¹ Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report.

²⁸² Lensch, T., et al. 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report.

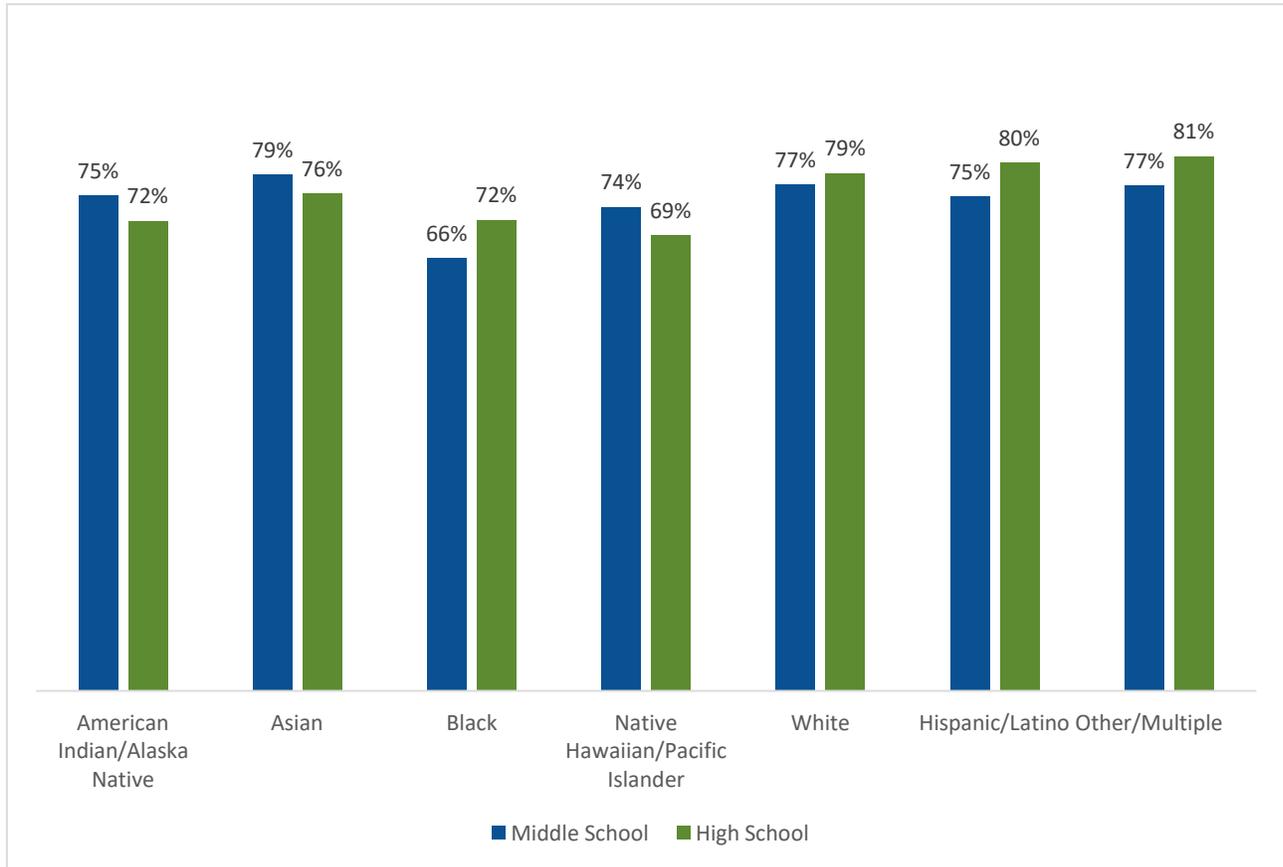
Figure 32: Percentage of High School Students Whose Parents or Other Adults Asked Where They Were Going or Who They Would Be with Most of the Time/Always, by Region²⁸³



The racial and ethnic group with the lowest rate of connected to parents or other adults who asked where they were going or who they would be with most of the time/always were among those middle school students who identified as Black at 66.0 percent, and with the highest rate among multiracial or Hispanic high school students, as shown in Figure 33.

²⁸³ Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report

Figure 33: Percentage of Students Whose Parents or Other Adults Asked Where They Were Going or Who They Would Be with Most of the Time/Always, by Race and Ethnicity²⁸⁴



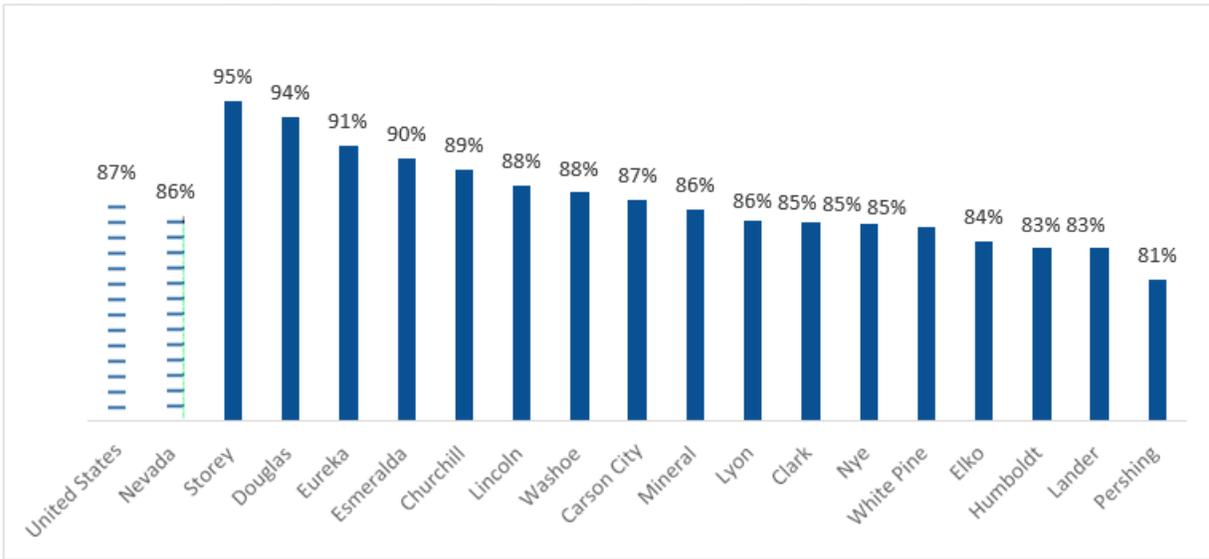
Overall, 83.8 percent high school female students (compared to 79.3% of middle school female students) have parents who ask where they are going or who they will be with compared to 73.5 percent of high school males (compared to 71.0% of middle school male students).

Education and Academic Achievement. Overall, in Nevada, 86.0 percent of the population has a high school degree or higher, compared to 87.0 percent across the United States, as shown in Figure 34.²⁸⁵ By county, there is variation, with a high of 95.0 percent in Storey County to a low of 81.0 percent in Pershing County.

²⁸⁴ Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report.

²⁸⁵ U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates (Table S1501).

Figure 34: Percent of Population with a High School Degree or Higher, 2013-2017²⁸⁶



Twelve percent of children, ages three to 17 years, are not enrolled in either a public or private school.²⁸⁷ Figure 35 shows within Nevada, Nye County experiences the highest rate of children not enrolled in school at 13 percent, followed by Clark and Douglas Counties at 12 percent.²⁸⁸

Figure 35: Percentage of Children 3-17 Years Not Enrolled in School, 2013-2017²⁸⁹

County	Children 3-17 years in Households	Percent Not enrolled in school
Nevada	563,133	12%
Clark	419,803	12%
Douglas	7,589	12%
Elko	12,358	10%
Lyon	9,899	11%
Nye	6,412	13%
Washoe	82,491	10%
Carson City	9,565	10%

Academic achievement among students in part may be measured by high school graduation rates. In school year 2016–17, the adjusted cohort graduation rate for public high school students in the United States was 85 percent, higher than 81 percent in Nevada.²⁹⁰ Looking at 2017 to 2018 graduation rate in

²⁸⁶ U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates (Table S1501).

²⁸⁷ U.S. Census Bureau, 2013-2017 American Community Survey, 5-year estimates, Children Characteristics (Table S0901).

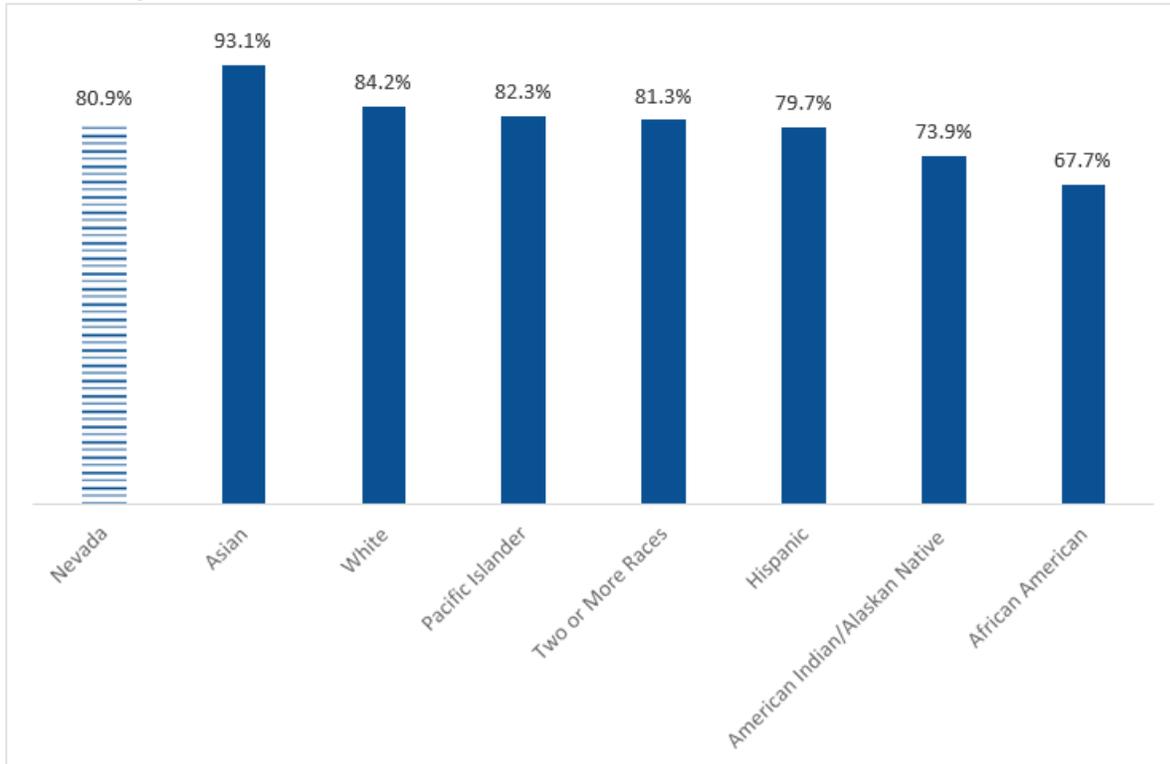
²⁸⁸ Counties are missing due to data not being available because the number of sample cases is too small (<50 cases).

²⁸⁹ U.S. Census Bureau, 2013-2017 American Community Survey, 5-year estimates, Children Characteristics (Table S0901).

²⁹⁰ U.S. Department of Education, Office of Elementary and Secondary Education, Consolidated State Performance Report, 2016–17. See Digest of Education Statistics 2018, table 219.46.

Nevada, there is a racial and ethnic group disparity, with African American students experiencing a 67.7 percent graduation rate, followed by American Indian/Alaskan (73.9%) and Hispanic (79.7%) students, as shown in Figure 36.

Figure 36: 2017/18 Cohort Four Year Graduation Rates, by Race and Ethnicity (Reported for Prior School Year)²⁹¹



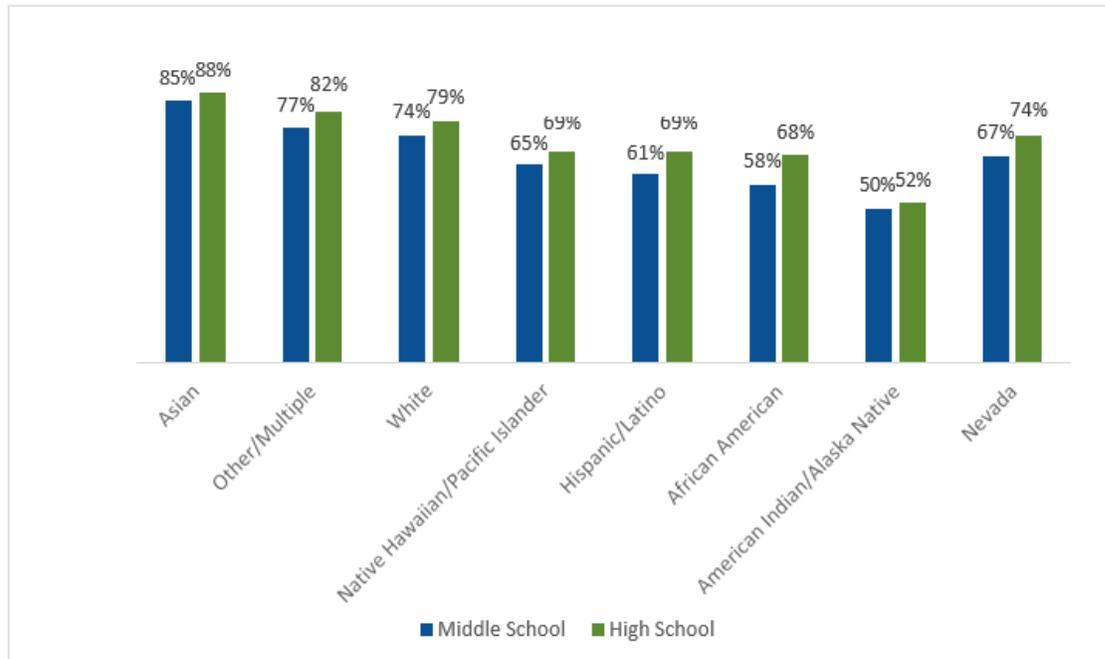
Additionally, YRBS asks students to what extent they get they make most A's and B's in school. Among high school students, 73.5 percent reported they did compared to 67.1 percent of middle school students, as shown in Figure 37.^{292,293}

²⁹¹ U.S. Department of Education, Office of Elementary and Secondary Education, Consolidated State Performance Report, 2016–17. See Digest of Education Statistics 2018, table 219.46.

²⁹² Lensch, T., et al. 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report.

²⁹³ Lensch, T., et al. 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report.

Figure 37: Percentage of Students who made Mostly A's or B's in School in the Previous 12 Months 2017²⁹⁴



Community voices: Respondents had a number of ideas related to protective factors and solutions to address many of the challenges and barriers facing adolescents in Nevada. Family and parent support was identified as a significant opportunity. Additionally, efforts to increase the connectedness of youth to families and communities was mentioned multiple times.

“Learning how to cope with stressful life situations, support from healthy family and friends, resources that screen and assist in managing mental health.”

“Support from family and community.”

“Having strong moral and family values. Having a sense of accomplishment and pride in what they do themselves.”

“Adults who take the time to listen and make them feel welcome and comfortable, awareness of available services for their mental health, and peer support.”

“Positive attention. Good adult role models. Safe space to get guidance.”

“Strong parental involvement, love and care; teacher, school counselors and social workers who are proactive, social skills training for all grade levels; friends; peers who have strong social/emotional skills.”

“Positive family, social and support structures. Being taught personal responsibility and accountability. Taught value of education and community participation.”

⁷⁶ Lensch, T., et al. 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report.

Resource and Need Mapping

Existing Adolescent Health Programs

The assessment includes a review of state funded adolescent health programs, with a particular focus on teen pregnancy and STIs among adolescents age 10 to 19 years. While this is not a comprehensive inventory all of programs that exist in Nevada, it presents a snapshot of the kinds of services and programs that state is currently prioritizing.

Sexual Risk Avoidance Education (SRAE) Program, an evidence-based teen program focused on sexual risk avoidance that teaches participants to voluntarily refrain from sexual activity and other risky behaviors. Using Positive Youth Development (PYD) framework as part of risk avoidance's strategies, the program helps participants build healthy relationships and make healthy decisions and provides tool and resources to prevent pregnancy and sexually transmitted infections. Linking program participants to services provided by local community partners that support the safety and well-being of youth is also key component of SRAE.

Personal Responsibility Education Program (PREP), a teen pregnancy program, is available in 13 counties (76% of all counties) and supports evidence-based program models intended to change behavior by delaying sexual activity, increasing condom or contraceptive use for sexually active youth, or reducing pregnancy among youth.²⁹⁵ In Nevada, implementation of evidence-based, medically accurate, and culturally competent education programming includes the following three adulthood preparation topics: adolescent development, healthy life skills, and healthy relationships. The target group of this program comprises high-risk adolescents, aged 13 to 18 years. PREP is currently located in Carson City, Douglas, Lyon, Storey, Elko, Eureka, Humboldt, Lander, Pershing, White Pine, Washoe, Clark, and Nye counties. Counties that do not offer PREP include Churchill (10.7% of population are adolescents), Esmeralda (9.3%), Lincoln (16.6%), and Mineral (9.1%) counties. However, together these counties make up just 1.0 percent of the state's adolescent population.

The **Adolescent Health and Wellness Program's** focus is to improve the percent of youth who are physically active, and to increase the number of adolescents with an annual preventive medical visit. Adolescent well-visits use evidence-based practices to decrease mortality, suicide attempts/ideation, nicotine use, untreated mental health conditions and obesity. The expected outcomes are to experience more of Nevada's youth in good or excellent health, and to realize an increase in physical activity and immunization uptake. This program works with coalitions, non-profits and federal, state and local agencies on issues related to the enhancement of health amongst Nevada's youth. Project activities involve assisting, supporting, and collaborating with organizations that share similar interests and goals.

²⁹⁵ Nevada Division of Public and Behavioral Health. (2017). Teen Pregnancy Prevention-Personal Responsibility Education (PREP).

Retrieved from <http://dphh.nv.gov/Programs/PREP/PREP-Home/>.

The **Teen Pregnancy Program (TPP) Program** works to promote safe, supportive sexual and reproductive health education to reduce unplanned pregnancies and STIs among adolescents 12 to 19 years of age through evidence-based education programs and community outreach. TPP funds partner organizations to deliver TPP with funding by the U.S. Department of Health and Human Services, Office of Adolescent Health. Funded partners, such as the Nevada Primary Care Association (NVPCA), work with health centers (e.g. Federally Qualified Community Health Centers and other community-based organizations) to provide capacity-building assistance focused on the implementation of evidence-based curricula targeted toward youth and families through clinic services and community partnerships. NVPCA program, for example, will target adolescents and parents/caregivers who reside in Clark, Washoe, Lander, Nye, Carson City, and Eureka counties.

In Southern Nevada Health District, initiatives funded by Office of Adolescent Health, offers several resources and opportunities for Free and Affordable STI Testing, Resources STI Testing with health insurance, coverage education, counseling, and other support Services, including phone and online resources.²⁹⁶ Specifically, eight programs offer comprehensive sex education. For STI testing, there are at least six free and affordable STI testing locations plus two STI testing locations for those with insurance.²⁹⁷

Title V Maternal and Child Health (MCH) Program supports activities across the state improving the health of families, with an emphasis on women, infants, and children, including children and youth with special health care needs (CYSHCN). Specific to adolescents, the MCH program seems to improve preconception health among adolescent and women of childbearing age, increase physical activity, promote establishment of a Medical Home Portal, and increase access to health care service.

Rape Prevention and education (RPE) Program is part of a national effort launched by the Centers for Disease Control (CDC) and Prevention in response to the Violence Against Women Act (VAWA) of 1994, and maintains sexual violence prevention strategies targeting teens and young adults of all genders, cultural and racial backgrounds, sexual orientations, religious affiliation, and socio-economical levels. Strategies focus on approaches and tools to encouraging positive relationship development in young adults to facilitate their adoption of healthy behaviors, and include bystander intervention education and training, healthy relationship education, workshops for professionals and peer educators working within target populations, and awareness campaigns.

School-Based Health Centers (SBHCs) in Nevada support communities in promoting the health and well-being of the school-age population through evidence-based best practices within a public health framework.²⁹⁸ SBHCs provide on-school site health care delivery by an interdisciplinary team of health professionals, which can include primary care and mental health clinicians. SBHC may include physical exams, screenings, immunizations, management of chronic conditions, age-appropriate reproductive health care for adolescents, primary medical care for injuries and illness, laboratory tests, tuberculosis

²⁹⁶ Southern Nevada Health District. (n.d.). *True Health Needs Knowledge: Resource Guide. True Health Needs Knowledge: Resource Guide.*

Southern Nevada Health District. Retrieved from <https://www.southernnevadahealthdistrict.org/download/tppp/resource-guide.pdf>.

²⁹⁷ Southern Nevada Health District. *True Health Needs Knowledge: Resource Guide. True Health Needs Knowledge: Resource Guide.*

²⁹⁸ Bureau of Child Family and Community Wellness. (2018).

tests, over-the-counter medications and prescriptions writing, and referrals and coordination of outside services. Two of Nevada's SBHCs, located in Henderson and Reno, offer school-based telehealth services which connect schools to health care providers utilizing secure and encrypted videoconferencing technology, as shown in figure 38.

SBHCs can select to be certified; however, clinics choosing not to participate in certification are free to operate in Nevada. The goals of certification are to: increase emphasis on best practices, reduce site-to-site variability, advance the ability to study clinical outcomes, and increase the potential for insurance reimbursement.

Figure 38: Number of School-Based Health Centers, 2018²⁹⁹

City/Town	Elementary School	Middle School	High School	Pre-K through 12	Total Schools	Percent of Schools in City/Town with SBHC	Offers Telehealth
Las Vegas	1	2	1	1	5	2%	
Henderson			2		2	4%	1
Carson City	1				1	7%	
Reno		1			1	1%	1
Total Schools	2	3	3	1	9	14%	2

Children and Youth with Special Health Care Needs (CYSHCN) provides resources and support to community agencies serving CYSHCN from birth age to 21 by funding a variety of community programs to bridge service gaps by linking families to appropriate systems-level and enabling resources and providers. This includes developing strategies to better serve children and families through a network of federal, state, and local community and family-based partners. Partnerships within Maternal and Child Health (MCH), with private and nonprofit agencies, universities, health departments, hospitals and providers, state and local entities facilitate efforts to accomplish the goals of the CYSHCN Program.

[http://dpbh.nv.gov/uploadedFiles/dpbh.nv.gov/content/Programs/AH-Comp/SBHC_Toolkit_Appendices_FINAL\(1\).pdf](http://dpbh.nv.gov/uploadedFiles/dpbh.nv.gov/content/Programs/AH-Comp/SBHC_Toolkit_Appendices_FINAL(1).pdf)

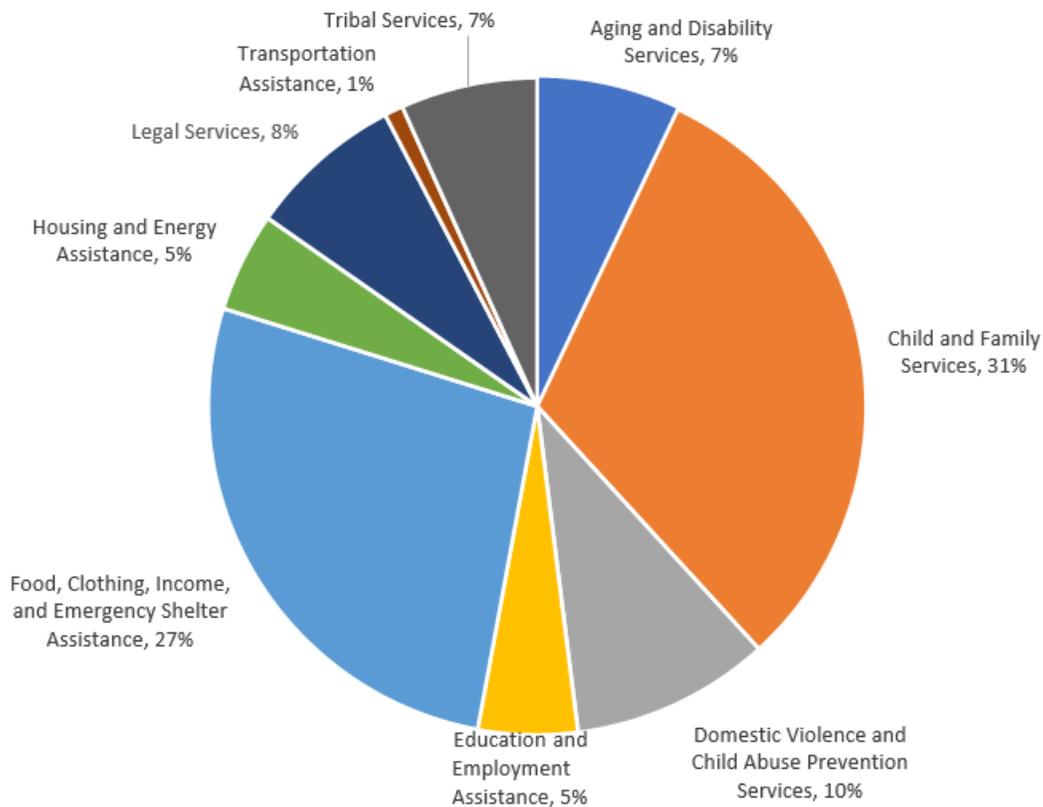
²⁹⁹ Bureau of Child Family and Community Wellness. *Nevada School-Based Health Center Toolkit. Nevada School-Based Health Center Toolkit.*

Existing Social Service Programs that Support Adolescent Health by Providing Services that Address Social Determinants of Health

The assessment also sought to gather data to identify programs and services providing medical, social, educational, and behavioral health services for adolescents, including availability of medical and behavioral health providers with adolescent health expertise, mentoring programs, before/after school programs, prevention/education programs related to violence, substance use, sexual health, or mental health, etc. This should not be considered a comprehensive list of programs; however, rather an illustration of the spectrum of services and where gaps in services or “service deserts” may exist for many of Nevada’s adolescents.

Using the 2019 Maternal Child and Health Program Directory of Services in Nevada, the assessment identified programs by service sector type that serves adolescents and their families.³⁰⁰ Child and Family Services make up the majority (31%) of those services available in Nevada, followed by Food Clothing, Income, and Emergency shelter (27%) services, as shown in Figure 39.

Figure 39: Services for Adolescents and Families in Nevada, by Service Sector, 2019³⁰¹



³⁰⁰ Nevada Home Visiting. (n.d.). *2019 Resource Directory*. Nevada Division of Public and Behavioral Health. Retrieved from [http://dpbh.nv.gov/uploadedFiles/dpbhngov/content/Programs/MIECHV/dta/Publications/2019 Resource Directory.pdf](http://dpbh.nv.gov/uploadedFiles/dpbhngov/content/Programs/MIECHV/dta/Publications/2019%20Resource%20Directory.pdf).

³⁰¹ Nevada Home Visiting. *2019 Resource Directory*.

Figure 40 below presents a sample of the types of services that fall within each sector. A more comprehensive list is provided in Appendix C.

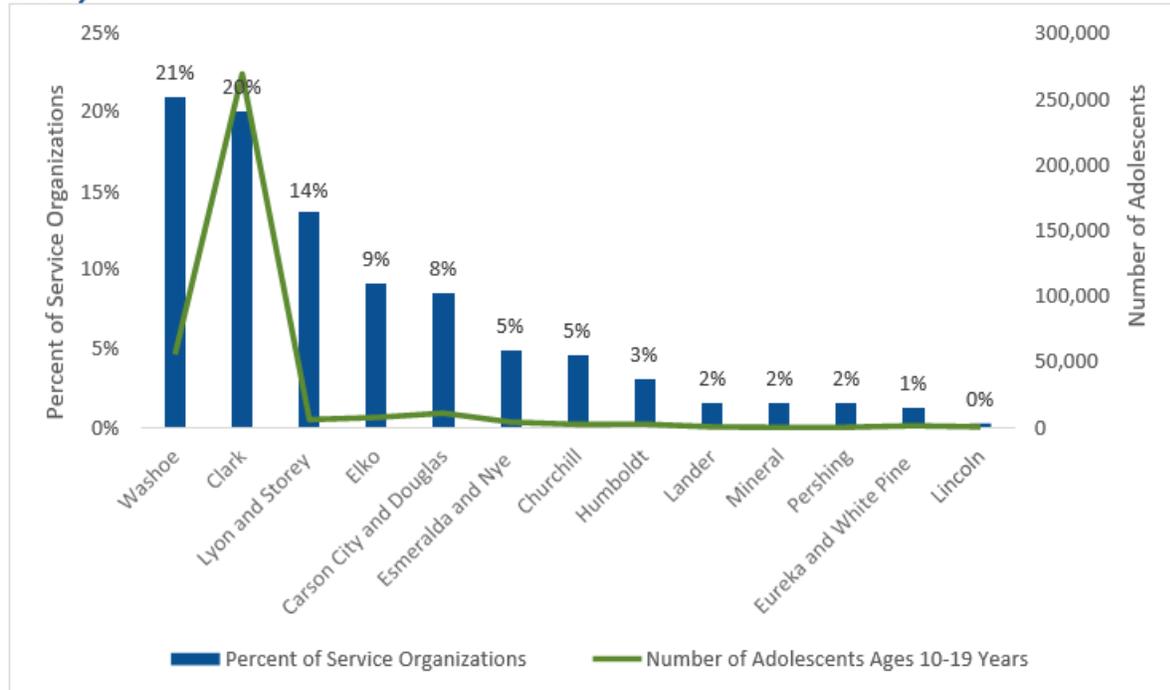
Figure 40: Sample of the Organizations, by Service Sector³⁰²

Organization	Service Sector	County
Community Pregnancy Center	Child and Family Services	Carson City and Douglas Counties
Women, Infant, and Children (WIC) – Fallon	Food, Clothing, Income, and Emergency Shelter Assistance	Churchill
FEAT (Families for Effective Autism Treatment of Southern Nevada)	Aging and Disability Services	Clark
Women and Children’s Center of the Sierra	Education and Employment Assistance	Washoe
Pioneer Territory CASA (Court Appointed Special Advocates)	Legal Services	Esmeralda and Nye Counties
Winnemucca Batterer’s Intervention Program	Domestic Violence and Child Abuse Prevention Services	Humboldt
GET My Ride	Transportation Assistance	Elko
Low Income Energy Assistance Program (Northern Nevada)	Housing and Energy Assistance	Statewide
Ely Shoshone Tribe, <u>Newe</u> Medical Clinic	Tribal Services	Eureka and White Pine Counties

Figure 41 below begins to show the extent to which service organizations exist in communities where adolescents and their families live in Nevada. With the sample of service organizations used in this analysis based on the MCH Directory of Services, there appears to be some responsiveness to providing services in areas where the most adolescents reside. For example, Clark County with the most adolescents in the state, includes 20 percent of the service organizations used in this analysis. In Washoe County, where they have the second highest number of adolescents, they have the highest percent of available services.

³⁰² Nevada Home Visiting, 2019 Resource Directory.

Figure 41: Relationship Between Percent of Service Organizations and Number of Adolescents, by County³⁰³



Lastly, Figure 42 presents the 10 zip codes with the highest percent of service organizations, ranging from a high of 8 percent in Zip 89502 of Washoe County to a low of 0.3 percent (or one organization) in 93 zip codes across the state (not shown in the table).

Figure 42: Top 10 Zip Codes by Percent of Service Organizations³⁰⁴

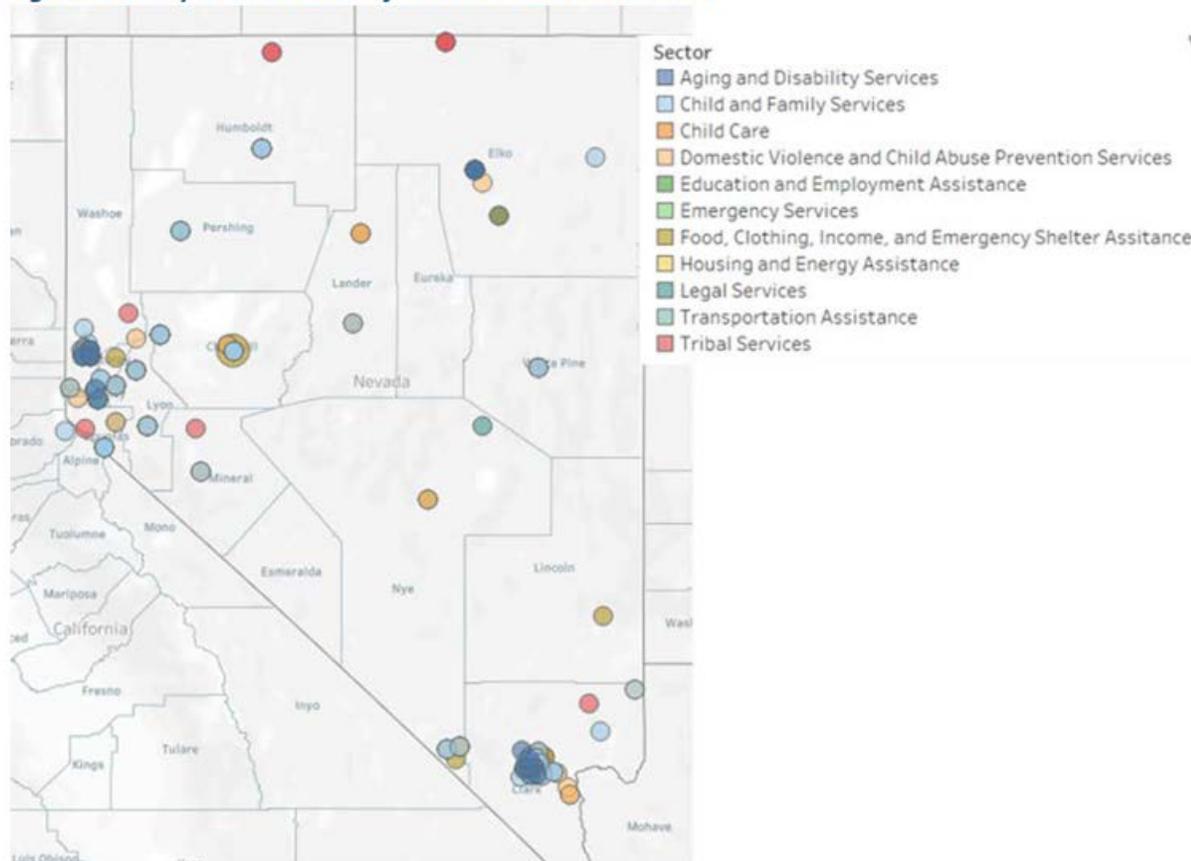
County	Zip Code	Percent of Service Organizations
Washoe	89502	8%
Elko	89801	6%
Carson City and Douglas Counties	89706	6%
Washoe	89512	5%
Churchill	89406	4%
Lyon and Storey	89447	4%
Lyon and Storey	89408	4%
Carson City and Douglas	89701	3%
Lyon and Storey	89429	3%
Clark	89101	2%
Humboldt	89445	2%

³⁰³ Nevada Home Visiting, 2019 Resource Directory.

³⁰⁴ Nevada Home Visiting, 2019 Resource Directory.

The most concentrated zip codes with services serving adolescents and their families are revealed in Figure 43, a map of the MCH services used in this assessment.

Figure 43: Sample MCH Services for Adolescents and Families³⁰⁵



Note: The larger the circle the most organizations are available in that zip code.

Health Care Services Accepting Children and Adolescents

Health care resources, for adults and/or youth, in Nevada are mainly concentrated in Clark County, accounting for 53.0 percent of all health care facilities as shown in Figure 44. Specifically, across the state there are 14 Rural Health Clinics, 61 Hospitals, 28 Mental Health only facilities and 28 Substance Use Disorder only facilities, three facilities offering both mental health and substance use treatment, and 45 Primary care/health centers which includes three Planned Parenthood centers.³⁰⁶ Two planned parenthood centers are located in Clark County (operated by Planned Parenthood Rocky Mountain) and one is located in Washoe County (operated by Planned Parenthood Mar Monte).

A common health care resource for counties are hospitals with at least one hospital or affiliated facility per county, shown in Figure 44. However, other health resources exist to varying extents in each county. For example, Pershing, Storey, Esmeralda, and Eureka counties do not have primary care/health centers

³⁰⁵Nevada Home Visiting. 2019 Resource Directory.

³⁰⁶

Health Resources and Services Administration, 2019.

or rural health centers. Many of the primary care health centers are located in the most populous counties. For example, 70.0 percent of primary care clinics are in Clark County while 73.0 percent of the population also lives in Clark County or 19.0. percent of primary care centers serve in Washoe County while 150 percent of Nevada’s population also lives in this county.

Figure 44: Health Care Resources by Provider Type and County, 2019³⁰⁷

County	Rural Health Clinics (14)	Hospitals (61)	Mental Health Facilities (only) (28)	Substance Use Facilities (only) (28)	Mental Health and Substance Use Facilities (3)	Primary Care/ Health Centers (45)	Percent of All Health Facility Types by County (179)
Nevada - Percent of All Health Care Facilities	8%	34%	16%	16%	2%	25%	100%
Percent of Health Facility Type per County							
Churchill	7%	2%	4%	7%	0%	0%	3%
Clark	7%	66%	43%	46%	67%	60%	53%
Douglas	7%	2%	4%	4%	0%	0%	2%
Elko	0%	3%	4%	7%	0%	9%	5%
Esmeralda	0%	2%	0%	0%	0%	0%	1%
Eureka	0%	2%	0%	0%	0%	0%	1%
Humboldt	7%	2%	4%	4%	33%	0%	3%
Lander	7%	2%	4%	0%	0%	2%	2%
Lincoln	7%	2%	4%	0%	0%	0%	2%
Lyon	43%	2%	11%	11%	0%	0%	7%
Mineral	7%	2%	0%	0%	0%	0%	1%
Nye	0%	2%	7%	4%	0%	2%	3%
Pershing	0%	2%	4%	0%	0%	0%	1%
Storey	0%	2%	0%	0%	0%	0%	1%
Washoe	0%	15%	11%	14%	0%	20%	14%
White Pine	7%	2%	4%	4%	0%	0%	2%
Carson City	0%	3%	0%	0%	0%	7%	3%

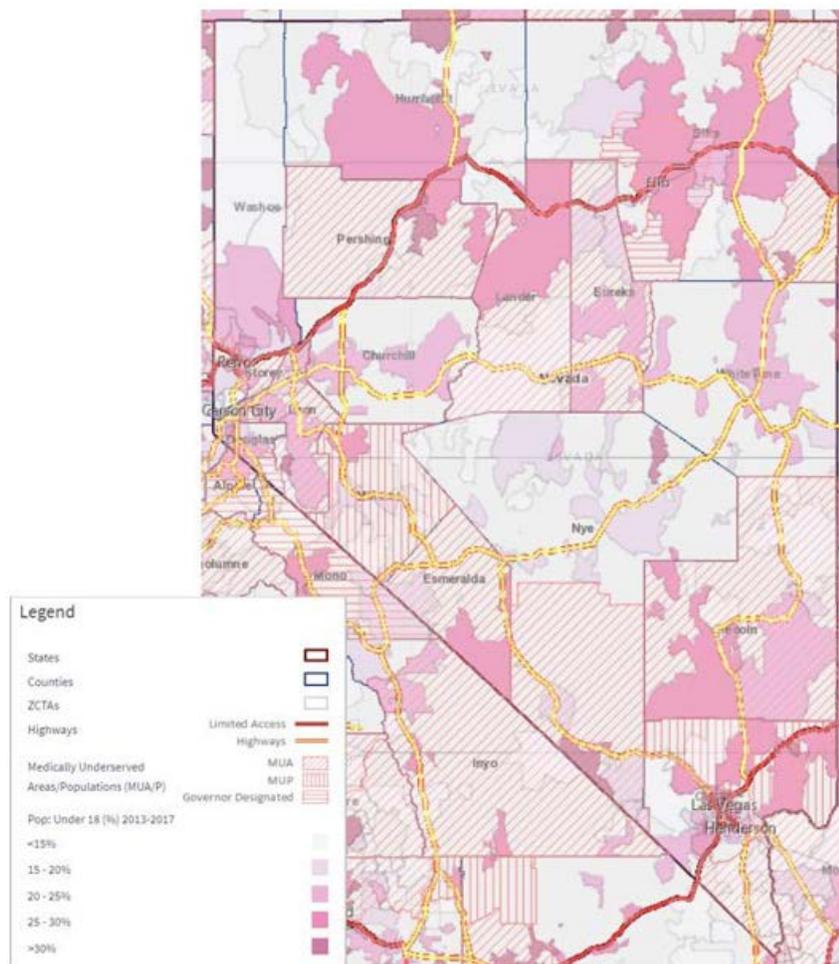
Mental or substance use facilities are not available in five counties. It is important to note; however, it is possible centers serve individuals from neighboring counties. However, for adolescents who rely on neighboring counties to access their health care, they may experience many barriers to accessing these services, primarily transportation barriers. When considering adolescent population, who likely may not have access to a car let alone a driver’s license or the time to drive a distance, accessing services when they need them requires a reliance on public transportation and/or caregivers or trusted adults. If it is hard to access these services, many individuals will count them as non-existent.

³⁰⁷

Health Resources and Services Administration, 2019.

Currently, an estimated 2,026,181 Nevadans or 67.3 percent of the state’s population reside in a federally designated primary medical care health professional shortage area (HPSA) — 11 of 17 counties in Nevada are single-county primary medical care HPSAs.³⁰⁸ Figure 45 shows a map of medically underserved areas and populations by county and the percent of the population under 18 years of age. The maps reveal that nearly every county except Humboldt, White Pine, and Churchill, have populations greater than 25.0 percent youth who live in in medically underserved areas.

Figure 45: Map of Medically Underserved Areas, 2019³⁰⁹

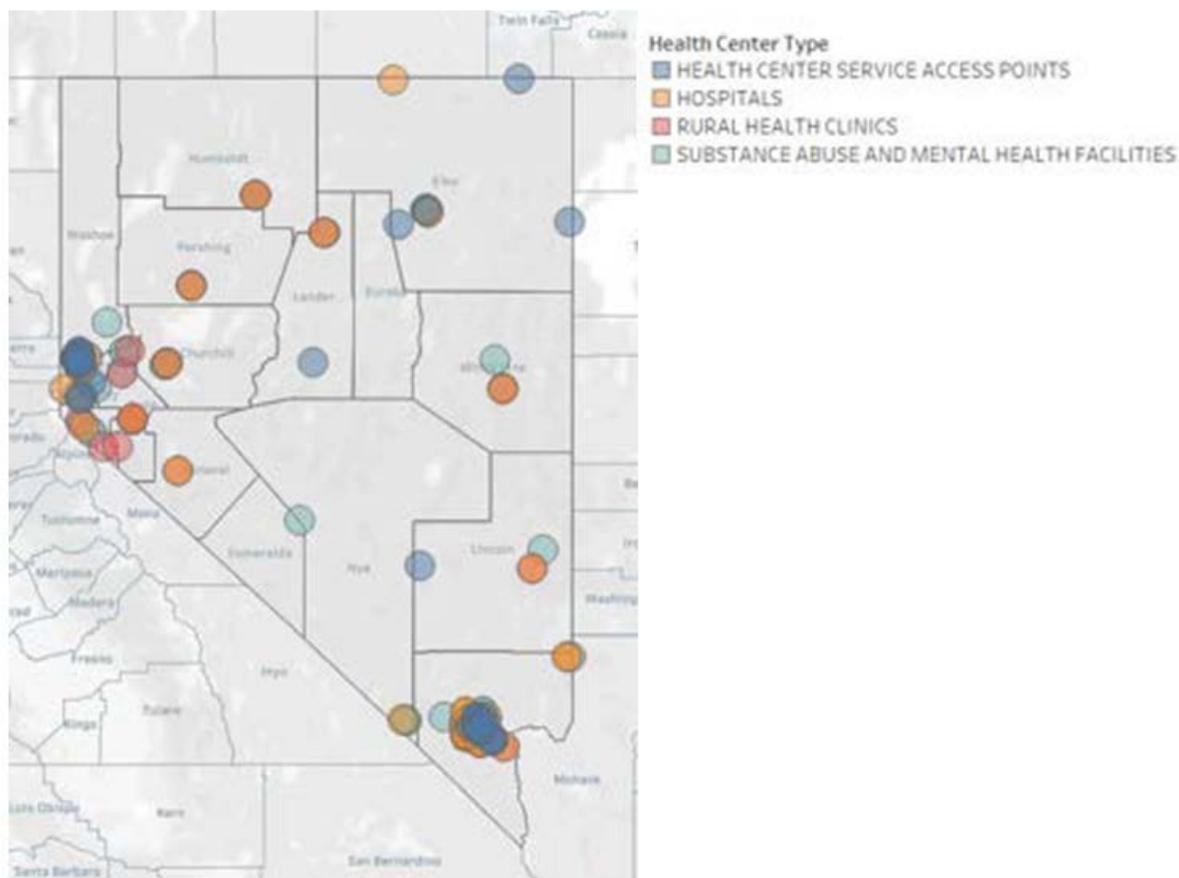


Nevada is a primary care and mental health care professional short area. Figure 46 is a map of the health care services by health center type. This reveals service desert areas across the state where individuals have to travel a significant distance and have limited access to receive services.

³⁰⁸ Nevada Rural and Frontier Health Data Book 9th Ed. Jan 2019.

³⁰⁹ Nevada Rural and Frontier Health Data Book 9th Ed. Jan 2019

Figure 46: Health Care Services by Health Center Type³¹⁰



Additionally, Community Health Services (CHS) is a public program focused on the overall health of individuals, families, and adolescents through the provision of a broad range of family planning services, related prevent health services, public health and infectious disease. CHS provides public health services, emergency preparedness and infectious disease assistance in thirteen of Nevada's rural counties, including Churchill (1 health nurse), Humboldt (1), Lincoln (1), Lyon (4), Mineral (1), Nye (2), Pershing (1) and White Pine (1) counties.³¹¹ Eight of these counties have 12 community health nursing clinics including Dayton, Fallon, Fernley, Silver Springs, Hawthorne, Yerington, Lovelock, Winnemucca, Panaca, Ely, Pahrump, and Tonopah. Essential public health services include adult and child immunizations, identification of communicable diseases, and preparedness activities. Important for adolescents, CHS also provide access to optional services in underserved areas including family planning, HIV screening, STI screening, outreach and education, and referral and navigation to primary and specialty care, as needed.

³¹⁰ Nevada Rural and Frontier Health Data Book 9th Ed. Jan 2019.

³¹¹ Nevada Division of Public and Behavioral Health. (2019, February 14). Community Health Services. Retrieved from <http://dpbh.nv.gov/Programs/ClinicalCN/ClinicalCommunityNursing-Home/>.

Summary of Findings

By and large, the biggest issues on the rise for youth in the United States are anxiety and depression according to the Pew Research Center. Seventy percent of youth, ages 13 to 17 years, reported anxiety and depression as a major problem, followed by bullying, drug addiction, drinking alcohol, poverty, teen pregnancy, and gangs.³¹² Some of the stressors teens face include pressure to get good grades, look good, fit in socially, and be involved in extracurriculars.³¹³ While anxiety and depression cross income boundaries, teen pregnancy and poverty were seen as much bigger issues to teens with a household income of less than \$30,000 a year. As well, approximately four out of every 10 teens say they spend too little time with their parents compared to only two out of 10 for those with higher incomes.³¹⁴

While Nevada certainly has its own unique characteristics and demographics, many teens across the state face the same issues and pressures as their peers across the county. This can be seen in the data captured above, as well as through the issues that arose during the needs assessment process from key stakeholders, parents, providers, community members, and teens themselves.

Stakeholders accessed for this report have a strong sense of the challenges in Nevada, as well as what is needed to improve the health of teens across the state. Distinct themes and issues were identifiable in the data. Some of the following present the biggest challenges to adolescent health in Nevada:

About Barriers to Positive Adolescent Health Outcomes

1. By far, the most common challenge cited was a lack of access to resources, including health care, healthy foods, housing, and education (particularly education related to sexual health). In more rural areas, this lack of access was compounded by having fewer resources available to begin with, such as a lack of primary care providers, as well as providers who will see adolescents without parental permission (which can be a deterrent for some youth to seek out information and/or care).
2. Even when resources are available to adolescents, many young people are not aware of those resources or have concerns about confidentiality and possible expenses.
3. Geographic location are barriers to accessing care, with transportation being a major issue in many parts of the state. Rural communities often lack a critical number of providers, including public health nurses. This can negatively affect immunization rates, access to mental and behavioral health services, accessing regular and specialized medical care, and engaging preventive medical services.
4. Many stakeholders cited concerns about a lack of consistent education about sexual health. Many schools have no standardized curriculum, if they have one at all, and many leave it up to the individual teacher to implement sexual health education in the way they are most comfortable. This means that many students have varying levels of information, which they often supplement with information gleaned online and from one another. This leads to perpetuation of myths and misinformation about sex, often amplified online via social media.

³¹² Horowitz, J. M., & Graf, N. Most U.S. Teens See Anxiety and Depression as a Major Problem Among Their Peers.

³¹³ Horowitz, J. M., & Graf, N. Most U.S. Teens See Anxiety and Depression as a Major Problem Among Their Peers.

³¹⁴ Horowitz, J. M., & Graf, N. Most U.S. Teens See Anxiety and Depression as a Major Problem Among Their Peers.

5. Another issue commonly mentioned was that consent is not a topic often broached with youth and that there are concerns about how much youth understand about asking for and exercising consent. Stakeholders also identified high levels of relationship violence, as many teens struggle to define what a healthy relationship should look like and how to communicate with one another about topics like consent.
6. Many families are struggling to make ends meet and finding adequate housing, so other needs like adolescent sex education are not prioritized. Teens often find themselves struggling to balance work and school themselves.
7. Sexual health can be a very personal topic that not all people feel comfortable discussing with their kids or other adults. This can result in limited discussion about adolescent sexual health and risk among parents, youth, providers of adolescent health services and schools. A predominantly conservative mindset about adolescence and sexual health can perpetuate fear that discussing sex with young people will make them more likely to engage in sex and lead to sexual health and risk being a nearly taboo subject across the state.

About Pressing Adolescent Health Issues

1. Respondents perceived the rates of substance use among adults and teens to be significant and having a large impact on their community. Easy access, peer pressure, lack of parental monitoring and involvement, and boredom are seen as leading teens to turn to vaping, heroin, alcohol, marijuana, opioids, and pills, and were thought to be driving up crime, suicide, mental health issues, truancy, unemployment, and child placements to foster care.
2. LGBTQ youth are experience extremely high levels of bullying and violence, homelessness, fear, and mental health issues. Additionally, there are few schools or organizations that engage in LGBTQ-specific sexual health education inclusive of their needs and concerns and so they are often more at-risk because of a lack of information, role modeling, and support.
3. Generally high rates of domestic and dating violence, as well as high suicide rates are also factors for concern, with some adolescents having toxic home environments where they are abused.
4. Youth in rural areas experience social isolation, due to the fact that many have both parents working outside of the home, and are geographically isolated, from other people and resources.
5. These same youth have a hard time finding jobs, particularly in areas where the work is centered around alcohol and gambling (meaning they need to be 18 years of age) and so turn to sex work for income, which is then linked to issues of trafficking.
6. Many teens have friends who are sexually active, or who they believe to be, playing into the issue of peer pressure and perceived norms around the acceptance of having sex at a young age. Additionally, most teens have easy access to pornography, which can provide them with incorrect messages about relationships and sex.

About Risk and Protective Factors

1. There is a sense of commitment and urgency among stakeholders for improving the sexual health and general well-being of young people. Many communities engaged partners and leaders who are willing to step up to work for youth, including many faith-based partners.

2. Contextually, Las Vegas is a highly sexually charged environment per respondents that can negatively affect teens.
3. All of the sites reported high availability of controlled substances such as tobacco, marijuana, heroin, meth, and opioids.
4. Family trauma histories and little access to mental health services to deal with past and present trauma.
5. One positive factor noted for smaller communities is that members of the community look out for one another so when something happens, there are connections people can rely upon.
6. For pregnant or parenting teens, remaining in school can be a protective factor.

Limitations

While this assessment aims to be comprehensive, it cannot measure all possible aspects of adolescent health in Nevada nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs. For example, certain population groups — such as the homeless, foster children, or children of parents who only speak a language other than English or Spanish — are to varying extents included in the assessment

Recommended Solutions

If the above barriers were addressed, there would still be resources that would need to be present in communities to help address adolescent health needs. Those that were mentioned across the stakeholders included mental health services and mental health education for adolescents, programs focused on the positive physical development of youth, and more telemedicine options for youth living in rural areas. Transportation was also mentioned as a needed resource, both providing more resources to allow youth to access transportation, as well as bringing more resources directly to youth to circumvent the transportation issue.

Regarding sexual health education, many felt that more thorough sex education is needed, particularly with a focus on what resources are available to youth and how youth can access them. Stakeholders felt that a LGBTQ-inclusive sex education curriculum is needed to better reach those youth. Finally, some stakeholders felt that a sex education program that also included a parent component, such as how to talk to youth and education about sex health issues facing youth, would be very beneficial so that conversations about sex can continue into the home, after a program has ended.

Offered below are several recommendations based on the information and insight gained from both the community engagement and population health and surveillance data.

Improve Access to Health Care

1. Invest in community education and outreach efforts designed to increase knowledge among youth and parents about health-care options, including mental health care and services, and providers who specialize in serving adolescents and meeting basic health care needs. Concurrent investment in the education of parents on the health care needs of adolescents, including immunizations, well visits, and child development can result in an increased use of needed services.

2. Invest in the expansion of telemedicine efforts in service deserts to overcome access barriers to health care services for adolescents, in particular, in school-based settings. Improving the availability of providers and preventive health care services to youth and their families can help ensure basic health care needs are met and create opportunities for early detection and treatment of mental, physical, and behavioral health issues that may arise.
3. Support the presence of public health nurses in communities, including incentives to recruit and maintain qualified nurses. To strengthen the health care network, identify opportunities to expand the availability of visiting or traveling nurses, and the potential to engage telehealth technology for nurses, as well as doctors. Public health nurses were identified as a significant positive resource for communities and young people. Increasing the availability of public health nurses has the potential to advance prevention in communities, increase the number of immunizations and regular checkups, and provide resources for teens struggling with sexual health, substance use, and other issues.
4. Continue to support and encourage school-based access to confidential mental health, substance use, and STI screening, referral, and treatment that reduces the stigma associated with these issues and seeking help. Connecting improvements in the availability of services along with efforts to increase the self-efficacy of teens in engaging their own health needs can have long-term positive effect for the health and wellbeing of young people.

Build Protective Factors for Adolescents

1. Capitalize on the energy and urgency in communities to support community-level programming intended to promote resiliency in young people. Encourage collaboration among stakeholders to increase the likelihood and magnitude of program impact. Develop knowledge and skills among providers to address risk and protective factors shared among multiple issues facing Nevada youth.
2. Increase the quality and breadth of social service networks across Nevada. Connecting social services and resource through strategies such as coordinated intake, robust warm referral protocols, and coordinated community response teams can strengthen community safety nets and improve the success of individuals and families needing assistance.
3. Invest in expanded opportunities for adolescents to engage in pro-social activities, establish relationships, and gain meaningful skills and competencies. This also includes opportunities for adolescents to engage in regular physical activity both in and out-of-school (e.g., sports leagues, clubs). These opportunities have the potential to increase connectedness among youth and schools, trusted adults, and their peers which in turn support wellbeing and health.
4. Identify and support parenting resources for parents of adolescents, in particular, those parents or caregivers who have experienced their own issues, such as relationship violence, substance use, and mental health issues. Assisting adult caretakers in addressing their own needs and creating a safe, stable environment for children and youth can mitigate the experiences of adverse childhood experiences and improve the wellbeing of young people.

5. Invest in programming designed to improve parenting skills for all parents, as well as those designed to support parents struggling with the challenges of raising adolescents. Beyond just addressing basic needs for adult caretakers, improving parenting and nurturing skills in adults can increase the number of safe adults available to youth across Nevada.
6. Continue to support programs educating adolescents on healthy relationships and life skill development and encourage mandatory school district-wide policies for middle and high school student participation. Provide support for teachers and administrators in providing information and skill development around sexual health.

Facilitate Understanding of Adolescent Health Issues

1. Work with community partners to understand local priority needs among youth and their families, and work with stakeholders to develop community specific action plans to improve adolescent wellbeing across Nevada.
2. Support the increased availability of information to parents, families, and adult caretakers about normative adolescent development, healthy sexuality, and risk and protective factors for youth, to help normalize conversations about health issues. Identify opportunities to work with caretakers of younger children to build resiliency and protective factors early in childhood and to better prepare families for adolescence.
3. Support the development of communication skills in adults to improve communication between adolescents and their parents or trusted adults about any health issue, including sexual health. Investing in programming providing model language, skill development opportunities, and dispelling myths about sexual health issues can help parents and trusted adults know what to say and how to say it.
4. Work to increase access to quality sexual health information in schools and community settings. Improving the skills of teachers and administrators, increasing availability and consistency of information, and providing youth with wrap around support can dispel myths and improve decision making.
5. Invest in programming designed to prevent violence, including relationship, sexual, and community violence. Support programming aimed at specific communities, such as LGBTQ or immigrant youth, with unique needs around sexual health and general well-being.

Appendix A: Key Informant Interview Guide

Introduction/Purpose of Interview

We are working with the Sexual Risk Avoidance Education Program (SRAE) of the Nevada Division of Public and Behavioral Health to conduct a statewide needs assessment in order to identify gaps and barriers to improve the health of teens across the state, with an examination of youth sexual health and risk, teens who are pregnant or parenting, and other key indicators of adolescent health and safety.

To start this project HMA is conducting interviews with key stakeholders identified by the SRAE program. The purpose of these interviews is to gather information from the perspective of key leaders about what is most needed across the state and where there are gaps and barriers in services and programming for teens, including questions regarding any gaps or barriers associated with Title V Sexual Risk Avoidance Education (SRAE) programming Promoting Health Among Teens! -Abstinence Only (PHAT-AO). Specifically, we intend to learn about the activities and efforts in your community related to adolescent sexual health. We are using the age span of 10-19 years of age.

We value your input and the critical role you play in improving the health of youth for your community. We highly appreciate your time and input to better help adolescent populations.

General Information

1. We would like to make sure that we have the correct information from you. Please verify your name, organization, title and general job responsibilities?
2. Please describe what role you/your organization plays in adolescent health, particularly adolescent sexual health in your community?

Your Community

3. When you think of adolescent health, what comes to mind?
4. What's your perspective on adolescent sexual health in your community?
5. Please describe adolescent health, including sexual health activities/initiatives available in your community within each of the following areas? How are these resourced?
6. What do you think are the risk factors related to negative adolescent health outcomes in your community?
 - a. How much of an impact do they have on the community?
 - b. Are there risk factors that are unique to particular groups in your community?
 - c. Have you noted any changes in your community that have increased the risk for negative adolescent health outcomes?
 - d. Do you think these risks are the same for teen pregnancy and STIs or are there risk factors specific to adolescent sexual health?

7. When you think of your community, what do you think are protective factors related to adolescent health? Protective factors being those things that protect youth from negative health outcomes such as teen pregnancy and STIs?
 - a. Do you believe these may be unique to your community?
 - b. Are there protective factors that are unique to particular groups in your community such as LGBTQ?
 - c. Do you feel that there has been any change in your community that has increased protective factors for adolescent health?
 - d. Do you think the protective factors you named are the same for teen pregnancy and STIs or are there protective factors specific to adolescent sexual health?
8. What are some of the barriers to preventing teen pregnancy and STIs in your community?
9. Are there barriers to prevention programming for youth in general in the community?
10. Are they the same or different than those named for teen pregnancy and STIs?
11. Are you familiar the Title V Sexual Risk Avoidance Education (SRAE) programming Promoting Health Among Teens! -Abstinence Only (PHAT-AO)?
 - a. What barriers or challenges are you aware of with implementing SRAE programming? What are the gaps of the SRAE programming? What are the strengths?
12. What adolescent health activities/efforts do you believe are needed?
 - a. What activities would be the most effective in your community and why?
13. Relative to other communities in Nevada, what do you think about adolescent health efforts and resources in your community?

Focus Groups

HMA will be conducting a series of focus groups across the state. These focus groups will help us further understand the needs, barriers, and gaps in services and programming for adolescents, both from the perspective of people with experience and expertise working with adolescents; also, from the perspective of adolescents who have lived experience.

Focus Group participants will include the following stakeholders:

Parents of pregnant or parenting teens

Pregnant teens or parenting teens

School staff

Local youth-serving non-profit leaders

Other key community members, based on each individual community's needs (faith leaders, health professionals, law enforcement, social services providers)

14. Are there any questions you would like HMA to ask in the focus groups? What information would help in the adolescent health, including sexual health efforts of your community?
15. Are there issues or concerns that may come up in these focus groups to which we should be particularly sensitive?
16. Do you have any recommendations regarding recruiting focus group participants?
17. May we reach out to you in the near future to discuss particular organizations and/or individuals in your community to whom you recommend we outreach to find participants for focus groups?

Key Stakeholders

18. Are there other key stakeholders you would recommend HMA interview?

Wrap Up

19. Before we close, is there anything we did not mention that you would like to add?

Appendix B: Focus Group Discussion Guide

INTRODUCTION

Health Management Associates, Inc. (HMA), a national research and consulting firm with an office based in Colorado is working with the Sexual Risk Avoidance Education Program (SRAE) of the Nevada Division of Public and Behavioral Health to conduct a statewide needs assessment in order to identify gaps and barriers to improve the health of teens across the state, with an examination of youth sexual health and risk, teens who are pregnant or parenting, and other key indicators of adolescent health and safety.

These focus groups will help us further understand the needs, gaps, and barriers in services for adolescents, both from the perspective of people with experience and expertise working with adolescents and from the perspective of adolescents as well.

Focus groups will be conducted with the following:

- Teens and young adults
- Parents of pregnant or parenting teens
- Pregnant teens or parenting teens
- Pregnant teens or parenting teens
- School staff, including teachers, counselors, and health professionals
- Local youth-serving non-profit leaders
- Other key community members, based on each individual community's needs (faith leaders, health professionals, law enforcement, social services providers)

Reno and Las Vegas, Nevada will be anchor locations for focus groups. Focus groups will be conducted in not only Reno and Las Vegas, but also in surrounding areas.

Washoe County (Reno, NV)	Clark County (Las Vegas, NV)
<ul style="list-style-type: none"> • Carson City • Douglas • Storey • Lyon • Elko • Washoe 	<ul style="list-style-type: none"> • Nye (e.g. Pahrump) • Clark (e.g. Las Vegas, Mesquite)

FOCUS GROUP OBJECTIVES

Focus groups will allow participants to interact in a discussion of their opinions about the topics and issues raised by facilitator’s questions. Facilitation will combine the technique of open communication with attentive listening, observation, and skillful direction. The discussion will provide insight to deepen HMA’s understanding of adolescent health, including adolescent sexual health, in Nevada. Information collected will be analyzed and summarized in aggregate. No individual identifying information will be collected or shared. The following type of analysis and summarized information will be provided in a report to the SRAE Program of the Nevada Division of Public and Behavioral Health:

- Summaries by type of group
- Summary of identified themes across groups

- Summaries of any identified differences across geographic communities
- Objectives of the focus groups are to:
1. Gather participant feedback to better guide successful establishment of recommendations for effective strategies to improve adolescent health, particularly adolescent sexual health across the state.
 2. Engage youth, parents, school staff, leaders from local youth-serving organizations, and other key community members working on, or impacted by issues related to adolescent health to better understand common and unique ideas, opinions and attitudes about issues pertaining to sexual health services, teen pregnancy and parenting, violence, mental health, and substance use.
 3. Understand the climate, attitudes, and existing risk and protective factors related to adolescent health, especially sexual health in regions across Nevada.

FOCUS GROUP COMPOSITION

The focus group facilitation team consists of two HMA team members, one focused on active listening to feedback and facilitating the discussion, and one focused on taking notes and capturing the general sentiment of the discussion.

HMA will aim for focus groups that consist of a minimum of six and a maximum of 12 participants. HMA will work with stakeholders in each region and staff of Nevada Division of Public and Behavioral Health to try and recruit a diverse set of participants with a spectrum of ideas— language, race, age, gender, sexual orientation, gender identity, education level and mobility.

FOCUS GROUP GUIDING PRINCIPLES

HMA will conduct focus groups according to the following guiding principles:

- Ensure an accessible location and room set up; create a friendly, comfortable environment.
- Conduct group in a welcoming tone, assuring participants there are no wrong answers and responses in the discussion will not be attributed to specific individuals.
- Establish ground rules for the discussion.
- Ensure neutrality in words, expressions, and sensitivity to participants' emotions.
- Encourage those who are less talkative to participate.
- Ensure all participants feel their voices are heard and valued.
- Ensure participants are respectful of each other and different opinions.
- Provide refreshments for focus group participants.

AGENDA AND SCRIPT FOR FOCUS GROUPS

- I. Welcoming remarks and level setting by HMA
 - a. Hello and welcome. Thank you for being here today.
 - b. Facilitators introduce themselves and a bit about their background and qualifications.

a. Background and purpose

- i. We are talking to groups of community members: young people and adults from two key regions across the state. Nevada Division of Public and Behavioral Health contracted with HMA through the SRAE Program to work with stakeholders in these regions in an effort to identify gaps and barriers to improving the health of teens across the state, with an examination of youth sexual health and risk, teens who are pregnant or parenting, and other key indicators of adolescent health and safety. The primary goal of the project is to understand from the community perspective what is most needed across the state and where there are barriers and gaps in services and programming for teens.
- ii. We have invited you to share your ideas so that we can better understand concerns and thoughts about adolescent health in your community, including risk and protective factors related to adolescent health issues like adolescent sexual health, violence, mental health and substance use. We are also interested in what your community is doing/can do to improve adolescent health.
- iii. If you don't feel like sharing your thoughts with others, you can always decline to answer, or you can answer by jotting notes on your notepad.
- iv. We are not here to collect names or personal stories. Rather, we want to know what you think about these issues, community solutions that already exist, and ideas for solutions that need to be implemented.
- v. We have a few ground rules and would like to have you offer some as well. Notes will be taken so we can capture important ideas and information, but no names will be used in reporting results of the session.
 1. This focus group is a space where each of you can share your experiences and ideas without judgement.
 2. The purpose of the session is to get as many opinions and ideas as possible.
 3. Please do feel free to share your personal opinions.
 4. We are here to help guide the discussion and ensure everyone gets a chance to speak. Please speak one at a time – refrain from sidebar conversations - and allow each other to speak without interrupting.
 5. We understand you may need to have a cell phone for emergencies, but we ask that you please put it on silent and put it away so it does not distract you or others in the group.

6. Please follow the rule of “what is shared in the group stays in the group.”
 - vi. There are no wrong answers to the questions we ask. We really want to know what you think, so we hope you feel free to talk openly. What you share is up to you. You don’t have to answer any questions you don’t want to, and you are free to stop taking part at any time.
 - vii. We will be taking notes and these notes are only to make sure we remember what the group said and so we can include everyone’s point of view in our report. Your name or any identifying information will not be reported with findings from this discussion.
 - viii. Does anybody have any questions about what I’ve just said or anything else? Please help yourself to the refreshments at any time.

II. Discussion Guide

- a. Let’s start by going around the room and saying our first names and tell us what comes to mind when you hear the words “adolescent health?”
- b. Does anything else come to mind with the words “adolescent health” that has not already been described?
- c. You have just described <<summary of what was just mentioned>>. Of these areas of adolescent health, what is most pressing for teens today in your community?
- d. Have you noted any changes in your community that have increased the risk for negative adolescent health outcomes?
- e. You all have listed several important issues. Let’s take a moment to talk about each one.
 - i. Substance Use
 1. How would you describe substance use problems among teens in your community (for youth- among your friends and classmates)?
 - a. Prompts: Any specific substance(s)? Location of use (e.g. home, parties, school, etc)? Grade? Events?
 2. How much of an impact do substances have on the community? Why?
 3. Do you see, or have you experienced particular groups of teens struggling more than others with substance use? If so, which groups and why? Please don’t state what you have heard, but instead what you have seen and experienced.
 4. What do you think puts teens at risk for substance use?
 5. What do you think protects teens from substance use?
 - ii. Mental Health
 1. Can you please describe what mental health means to you?
 2. How much of an impact does poor mental health have on teens?

(for youth- among your friends and classmates) Why?

3. Do you see, or have you experienced certain groups of teens struggling more than others with mental health issues? If so, which groups and why? Please don't state what you have heard, but instead what you have seen or experienced.
4. What do you think puts teens at risk for poor mental health or mental disorders?
5. What do you think protects teens from poor mental health or mental disorders?

iii. Violence

1. What kind of violence involving teens do you feel is an issue among teens (for youth- among your friends and classmates)?
 - a. Sexual violence? Relationship violence? Gang violence? Child abuse?
 - b. Verbal, physical, or emotional abuse?
2. How much of an impact does violence have on the community? Why?
3. Do you see, or have you experienced certain groups of teens struggling more than others with issues of violence? If so, which groups and why? Please don't state what you have heard, but instead what you have seen or experienced.
4. What do you think puts teens at risk for experiencing violence or being violent?
5. What do you think protects teens from experiencing violence or being violent?

iv. Sexual Health

1. Can you describe sexual health issues among teens (for youth- among your friends and classmates)?
2. What does "being in a healthy relationship" mean to you?
3. What do you think puts teens at risk for getting pregnant/getting HIV or STIs?
4. Do you think teens you know are having sex?
5. Do you think teens feel pressure to have sex?
 - a. What kinds of pressures do teens feel to have sex?
 - b. Do these pressures look differently across different groups of teens?
6. What are things that protect teens from pregnancy, HIV or Sexually Transmitted Infections?
7. What protects teens from unhealthy relationships or encounters?
8. What are some of the reasons that teens (you know) don't have sex?
9. FOR PARENTS:
 - a. How likely would you be to have your teen attend a sex ed class? (Scale of 1 to 5-1 being not at all likely and 5 being

very likely)

- a. How prevalent do you think STIs among teens? (Scale of 1 to 5- 1 being non-existent and 5 being the majority of teens)
- b. How prevalent is teen pregnancy in your community? (Scale of 1 to 5-1 being non-existent and 5 being the majority of teens)

10. Other issue brought up by group

- a. Describe <<state additional issue(s) raised by group>> in your community?
- b. How much of an impact does <<state additional issue(s) raised by group>> have on your community?

11. Do you see certain teen groups struggling more than others with <<state additional issue(s) raised by group>>? If so, which groups and why? Please don't state what you have heard, but instead what you have seen or experienced.

12. What do you think puts teens at risk for experiencing <<state additional issue(s) raised by group>>?

13. What do you think protects teens from experiencing <<state additional issue(s) raised by group>>?

f. Seeking and Accessing Resources

i. We would now like to learn more about how individuals in your community seek information and resources, and to what extent ways in which information is looked for depends on the adolescent health issue of concern.

1. How do you learn about programs and resources in your community? From whom do you learn about these resources?

- a. School administration and staff
- b. Community based organizations
- c. Peers/Friends/Classmates
- d. Parents / Trusted Adults
- e. Others

2. If you don't know where to go for support about a question or issue you (or someone who know) is having, do you know how to find out? Who or how might you go about finding out where to go?

3. What has been your experience seeking answers to your questions in this community? What were you looking for? Did you find what you needed?

4. Does your experience seeking help/support change depending on the issue? Does the access differ by topic? Please explain.
 - a. Mental health
 - b. Substance use
 - c. Violence
 - d. Sexual Health
5. FOR PARENTS: What would be helpful to you as a parent in supporting your teen's health? Specifically, what about their sexual health?

g. Community Resources

- i. We would now like to learn more about what services and resources are available in your community to address some of these issues, and where support might be needed.
 1. What is being done in your community to support adolescent health?
Prompts include:
 - a. Medical Health Care Services
 - b. Social Services
 - c. Educational Services
 - d. Mental Health Care Services
 2. What should be done in your community to support teens to be healthy and safe?
 3. Are there barriers to prevention programming for youth in general in the community?

h. About SRAE

- i. Are you familiar the Title V Sexual Risk Avoidance Education (SRAE) programming Promoting Health Among Teens! -Abstinence Only (PHAT- AO)? If no, the purpose of the Title V State Sexual Risk Avoidance Education (SRAE) Program is to fund states and territories to implement education exclusively on sexual risk avoidance that teaches youth to voluntarily refrain from sexual activity. The program is designed to teach youth personal responsibility, self-regulation, goal setting, healthy decision-making, a focus on the future; prevention of youth risk behaviors such as drug and alcohol use without normalizing teen sexual activity is also important. Title V State SRAE projects are implemented using a [Positive Youth Development \(PYD\)](#) framework as part of risk avoidance strategies to help participants develop healthy life skills, increase individual protective factors that reduce risks, make healthy decisions, engage

in healthy relationships and set goals that lead to self-sufficiency and marriage before engaging in sexual activity.

1. What barriers or challenges are you aware of with implementing SRAE programming?
2. What are the gaps of the SRAE programming? What are the strengths?
3. How do you think your community responds to SRAE?

III. Closing

- a. These are all the questions we have for you today. Does anyone have anything they would like to add that might've not been covered?
- b. Please remember that whatever has been said in this room stays in this room.
- c. Thank you very much for your time and participation.

Appendix C: Sample List of MCH Services and Programs Serving Adolescents and Families

Name of Organization	MCH Service Sector	County
Aging and Disability Services Division	Aging and Disability Services	Carson City and Douglas Counties
REM Nevada – Carson City	Aging and Disability Services	Carson City and Douglas Counties
American Comprehensive Counseling Services – ACCS	Child and Family Services	Carson City and Douglas Counties
Community Pregnancy Center	Child and Family Services	Carson City and Douglas Counties
Community Services	Child and Family Services	Carson City and Douglas Counties
Division of Child and Family Services (DCFS)	Child and Family Services	Carson City and Douglas Counties
Douglas County Social Services	Child and Family Services	Carson City and Douglas Counties
Family Support Council	Child and Family Services	Carson City and Douglas Counties
Ron Wood Family Resource Center	Child and Family Services	Carson City and Douglas Counties
Rural Regional Center – Carson City	Child and Family Services	Carson City and Douglas Counties
Rural Regional Center – Gardnerville	Child and Family Services	Carson City and Douglas Counties
Tahoe Youth and Family Services – Gardnerville	Child and Family Services	Carson City and Douglas Counties
Tahoe Youth and Family Services – South Lake Tahoe	Child and Family Services	Carson City and Douglas Counties
United Latino Community	Child and Family Services	Carson City and Douglas Counties
Domestic Violence Victim Assistance Project – Volunteer Attorneys for Rural Nevadans (VARN)	Domestic Violence and Child Abuse Prevention Services	Carson City and Douglas Counties

Name of Organization	MCH Service Sector	County
Douglas County Court Appointed Special Advocates (CASA)	Domestic Violence and Child Abuse Prevention Services	Carson City and Douglas Counties
ComputerCorps – Every Home a Classroom	Education and Employment Assistance	Carson City and Douglas Counties
Florence Phillips – ESL In-Home Program	Education and Employment Assistance	Carson City and Douglas Counties
Family Support Council of Douglas County – Carson Valley Community Food Closet	Food, Clothing, Income, and Emergency Shelter Assistance	Carson City and Douglas Counties
Friends in Service Helping (F.I.S.H.)	Food, Clothing, Income, and Emergency Shelter Assistance	Carson City and Douglas Counties
Salvation Army	Food, Clothing, Income, and Emergency Shelter Assistance	Carson City and Douglas Counties
Salvation Army – Thrift Store	Food, Clothing, Income, and Emergency Shelter Assistance	Carson City and Douglas Counties
Supplemental Nutrition Assistance Program (SNAP)	Food, Clothing, Income, and Emergency Shelter Assistance	Carson City and Douglas Counties
Child Support Office – Minden	Legal Services	Carson City and Douglas Counties
Court Appointed Special Advocates (CASA)	Legal Services	Carson City and Douglas Counties
Family Support Council – Temporary Protective Orders	Legal Services	Carson City and Douglas Counties
JAC – Jump Around Carson	Transportation Assistance	Carson City and Douglas Counties
Washoe Tribe Health Center	Tribal Services	Carson City and Douglas Counties
Care Net Pregnancy Center of Churchill County	Child and Family Services	Churchill

Name of Organization	MCH Service Sector	County
Churchill County Social Services – Fallon	Child and Family Services	Churchill
Division of Welfare and Supportive Services (DWSS) – Kinship Care Program	Child and Family Services	Churchill
Domestic Violence Intervention	Domestic Violence and Child Abuse Prevention Services	Churchill
CSFP (FBNN) Commodities	Food, Clothing, Income, and Emergency Shelter Assistance	Churchill
CSFP (FBNN) Commodities	Food, Clothing, Income, and Emergency Shelter Assistance	Churchill
CSFP (FBNN) Commodities	Food, Clothing, Income, and Emergency Shelter Assistance	Churchill
Division of Welfare and Supportive Services – Supplements Nutrition Assistance Program (SNAP)	Food, Clothing, Income, and Emergency Shelter Assistance	Churchill
Epworth United Methodist Church Fellowship Hall – Fallon Daily Bread	Food, Clothing, Income, and Emergency Shelter Assistance	Churchill
Fallon Church of the Nazarene – Out of Egypt Food Pantry	Food, Clothing, Income, and Emergency Shelter Assistance	Churchill
Room for Ruth	Food, Clothing, Income, and Emergency Shelter Assistance	Churchill
Salvation Army – First Southern Baptist Church Ministries	Food, Clothing, Income, and Emergency Shelter Assistance	Churchill
Women, Infant, and Children (WIC) – Fallon	Food, Clothing, Income, and Emergency Shelter Assistance	Churchill
Child Support Services – Churchill County	Legal Services	Churchill
Fallon Tribal Health Center	Tribal Services	Churchill

Name of Organization	MCH Service Sector	County
Down Syndrome Organization of Southern Nevada (DSOSN)	Aging and Disability Services	Clark
Easter Seals Nevada	Aging and Disability Services	Clark
FEAT (Families for Effective Autism Treatment of Southern Nevada)	Aging and Disability Services	Clark
Nevada PEP (Parents Encouraging Parents) – Main Office	Aging and Disability Services	Clark
Opportunity Village	Aging and Disability Services	Clark
R.A.G.E. – Independent Living Autism Services	Aging and Disability Services	Clark
R.A.G.E. – Independent Living Program	Aging and Disability Services	Clark
The MENTOR Network – REM Nevada State Office	Aging and Disability Services	Clark
Always Better Care	Child and Family Services	Clark
Candlelighters for Childhood Cancer Foundation of Nevada	Child and Family Services	Clark
Catholic Charities of Southern Nevada	Child and Family Services	Clark
Clark County Social Service – Community Resource Center	Child and Family Services	Clark
Clark County Social Services – Las Vegas	Child and Family Services	Clark
Clark County Social Services (Henderson)	Child and Family Services	Clark
East Neighborhood Family Services	Child and Family Services	Clark
East Valley Family Services	Child and Family Services	Clark
Family TIES of Nevada (Training, Information, and Emotional Support)	Child and Family Services	Clark
Family to Family Connection – Cambridge	Child and Family Services	Clark
Family to Family Connection – Cascade Valley	Child and Family Services	Clark
Las Vegas South Family Resource Center (HopeLink)	Child and Family Services	Clark

Name of Organization	MCH Service Sector	County
Las Vegas West Family Resource Center (Boys & Girls Club)	Child and Family Services	Clark
LDS Family Services	Child and Family Services	Clark
Lovaas Center for Behavioral Intervention	Child and Family Services	Clark
Mesquite Family Resource Center (Salvation Army)	Child and Family Services	Clark
Nevada Children’s Center	Child and Family Services	Clark
Olive Crest Family Resource Center	Child and Family Services	Clark
Overton/Logandale/Moapa Family Resource Center (Cappalappa FRC)	Child and Family Services	Clark
Safe Kids Clark County	Child and Family Services	Clark
South Neighborhood Family Services	Child and Family Services	Clark
Southern Nevada Children First	Child and Family Services	Clark
Clark County Foster Care – Child Haven Services Spotlight	Domestic Violence and Child Abuse Prevention Services	Clark
Family and Child Treatment of Southern Nevada (FACT)	Domestic Violence and Child Abuse Prevention Services	Clark
Family Court and Services Center – Family Violence Intervention Program – Protection Orders Program	Domestic Violence and Child Abuse Prevention Services	Clark
Olive Crest	Domestic Violence and Child Abuse Prevention Services	Clark
Rape Crisis Center	Domestic Violence and Child Abuse Prevention Services	Clark
S.A.F.E. House	Domestic Violence and Child Abuse Prevention Services	Clark
Safe Nest (Boulder City)	Domestic Violence and Child Abuse Prevention Services	Clark
Safe Nest (Las Vegas)	Domestic Violence and Child Abuse Prevention Services	Clark

Name of Organization	MCH Service Sector	County
Safe Nest (Mesquite)	Domestic Violence and Child Abuse Prevention Services	Clark
St. Jude's Ranch for Children	Domestic Violence and Child Abuse Prevention Services	Clark
The Shade Tree	Domestic Violence and Child Abuse Prevention Services	Clark
Catholic Charities of Southern Nevada – Meals on Wheels	Education and Employment Assistance	Clark
Communities in Schools (CIS)	Education and Employment Assistance	Clark
Nevada Partnership for Training	Education and Employment Assistance	Clark
Nevada Virtual Academy	Education and Employment Assistance	Clark
One Stop Career Center	Education and Employment Assistance	Clark
Catholic Charities of Southern Nevada – St. Vincent Lied Dining Facility	Food, Clothing, Income, and Emergency Shelter Assistance	Clark
City Mission of Las Vegas	Food, Clothing, Income, and Emergency Shelter Assistance	Clark
Emergency Aid of Boulder City	Food, Clothing, Income, and Emergency Shelter Assistance	Clark
Las Vegas Rescue Mission	Food, Clothing, Income, and Emergency Shelter Assistance	Clark
Las Vegas Urban League	Food, Clothing, Income, and Emergency Shelter Assistance	Clark
Lutheran Social Services of Nevada	Food, Clothing, Income, and Emergency Shelter Assistance	Clark

Name of Organization	MCH Service Sector	County
Nevada Community Associates	Food, Clothing, Income, and Emergency Shelter Assistance	Clark
Salvation Army – Day Resource Center / Emergency Lodge	Food, Clothing, Income, and Emergency Shelter Assistance	Clark
St. Vincent Work Program	Food, Clothing, Income, and Emergency Shelter Assistance	Clark
Three Square Food Bank	Food, Clothing, Income, and Emergency Shelter Assistance	Clark
Family Promise	Housing and Energy Assistance	Clark
ADAMS ESQ – Special Education Law	Legal Services	Clark
CASA Court Appointed Special Advocate Family Courts	Legal Services	Clark
Child Support Office (Las Vegas)	Legal Services	Clark
Clark County Family Court – Family Law Self- Help Center	Legal Services	Clark
Legal Aid Center of Southern Nevada	Legal Services	Clark
Legal Aid Center of Southern Nevada – Children’s Attorney Project	Legal Services	Clark
Las Vegas Paiute Tribe	Tribal Services	Clark
Las Vegas Paiute Tribe Health and Human Services	Tribal Services	Clark
Moapa Tribal Clinic	Tribal Services	Clark
Aging and Disability Services Division Regional Office	Aging and Disability Services	Elko
Elko County School District Special Services	Aging and Disability Services	Elko
Family Respite of Nevada	Aging and Disability Services	Elko

Name of Organization	MCH Service Sector	County
Nevada Department of Employment, Training and Rehabilitation (DETR) – Rehabilitation Division (Elko)	Aging and Disability Services	Elko
Nevada Disability Advocacy and Law Center	Aging and Disability Services	Elko
Children’s Cabinet	Child and Family Services	Elko
Division of Child & Family Services	Child and Family Services	Elko
Elko County Child Support Division (DA)	Child and Family Services	Elko
Elko County Social Services	Child and Family Services	Elko
Family Resource Center of Northeastern Nevada	Child and Family Services	Elko
Friends 4 Life.	Child and Family Services	Elko
Rural Regional Center – Elko Office	Child and Family Services	Elko
Wells Family Resource Center	Child and Family Services	Elko
Committee Against Domestic Violence (CADV) Harbor House	Domestic Violence and Child Abuse Prevention Services	Elko
Communities in Schools (CIS) – Northeastern Nevada	Education and Employment Assistance	Elko
Communities in Schools (CIS) – Northeastern Nevada	Education and Employment Assistance	Elko
Elko Central Dispatch	Emergency Services	Elko
F.I.S.H. – Friends in Service Helping	Food, Clothing, Income, and Emergency Shelter Assistance	Elko
Elko County Human & Social Services – Elko County Welfare	Housing and Energy Assistance	Elko
GET My Ride	Transportation Assistance	Elko
MTM, Inc.	Transportation Assistance	Elko
Consolidated Health Services Te-Moak Tribe of Western Shoshone	Tribal Services	Elko

Name of Organization	MCH Service Sector	County
Duck Valley Senior Center	Tribal Services	Elko
Elko Health Center	Tribal Services	Elko
Indian Health Service	Tribal Services	Elko
Owyhee Community Health Facility (OWHF)	Tribal Services	Elko
Owyhee PHS Indian Hospital	Tribal Services	Elko
South Fork Band Council	Tribal Services	Elko
Southern Bands Health Center	Tribal Services	Elko
Te-Moak Tribe of Western Shoshone Indians of Nevada	Tribal Services	Elko
4R Kids	Child and Family Services	Esmeralda and Nye Counties
Division of Child and Family Services – Pahrump	Child and Family Services	Esmeralda and Nye Counties
Nye School District – Parental Involvement	Child and Family Services	Esmeralda and Nye Counties
ABC Therapy	Domestic Violence and Child Abuse Prevention Services	Esmeralda and Nye Counties
No to Abuse	Domestic Violence and Child Abuse Prevention Services	Esmeralda and Nye Counties
No to Abuse (Tonopah)	Domestic Violence and Child Abuse Prevention Services	Esmeralda and Nye Counties
Faith Fellowship Foursquare Church – Feeding America	Food, Clothing, Income, and Emergency Shelter Assistance	Esmeralda and Nye Counties
NyE Communities Coalition	Food, Clothing, Income, and Emergency Shelter Assistance	Esmeralda and Nye Counties
Nye County School District – McKinney – Vento Homeless Program	Food, Clothing, Income, and Emergency Shelter Assistance	Esmeralda and Nye Counties

Name of Organization	MCH Service Sector	County
Salvation Army – Pahrump Outpost	Food, Clothing, Income, and Emergency Shelter Assistance	Esmeralda and Nye Counties
Women, Infants and Children (WIC) (Pahrump)	Food, Clothing, Income, and Emergency Shelter Assistance	Esmeralda and Nye Counties
Women, Infants and Children (WIC) (Tonopah)	Food, Clothing, Income, and Emergency Shelter Assistance	Esmeralda and Nye Counties
Child Support Office – Pahrump	Legal Services	Esmeralda and Nye Counties
Child Support Office – Tonopah	Legal Services	Esmeralda and Nye Counties
Duckwater Health Department	Legal Services	Esmeralda and Nye Counties
Pioneer Territory CASA (Court Appointed Special Advocates)	Legal Services	Esmeralda and Nye Counties
Family Resource Center	Child and Family Services	Eureka and White Pine Counties
White Pine Social Services	Child and Family Services	Eureka and White Pine Counties
Eastern Nevada Food Bank	Food, Clothing, Income, and Emergency Shelter Assistance	Eureka and White Pine Counties
Ely Shoshone Tribe, Newe Medical Clinic	Tribal Services	Eureka and White Pine Counties
Frontier Community Action Agency Family Resource Center	Child and Family Services	Humboldt
Humboldt County 4-H Youth Development	Child and Family Services	Humboldt
Winnemucca Rural Regional Center	Child and Family Services	Humboldt
Winnemucca Batterer’s Intervention Program	Domestic Violence and Child Abuse Prevention Services	Humboldt

Name of Organization	MCH Service Sector	County
Winnemucca Domestic Violence Services – WDVS	Domestic Violence and Child Abuse Prevention Services	Humboldt
Winnemucca Food Bank	Food, Clothing, Income, and Emergency Shelter Assistance	Humboldt
Women, Infants, and Children (WIC) Office	Food, Clothing, Income, and Emergency Shelter Assistance	Humboldt
Child Support Office – Winnemucca	Legal Services	Humboldt
Fort McDermitt Health Station	Tribal Services	Humboldt
Indian Health Service – The Fort McDermitt Clinic (McDermitt)	Tribal Services	Humboldt
Austin Youth Center	Child and Family Services	Lander
Committee Against Domestic Violence	Domestic Violence and Child Abuse Prevention Services	Lander
Austin Baptist Church – Helping Hands	Food, Clothing, Income, and Emergency Shelter Assistance	Lander
Women, Infants, and Children (WIC) – Battle Mountain Family Resource Center	Food, Clothing, Income, and Emergency Shelter Assistance	Lander
Battle Mountain Band Colony	Tribal Services	Lander
Women, Infants, and Children (WIC) – Caliente	Food, Clothing, Income, and Emergency Shelter Assistance	Lincoln
Amber Creek Counseling and Recovery Services	Child and Family Services	Lyon and Storey Counties
Care Net – Crisis Pregnancy Center	Child and Family Services	Lyon and Storey Counties
Central Lyon County Fire Protection District – Care Seat Safety	Child and Family Services	Lyon and Storey Counties
Children and Family Counseling	Child and Family Services	Lyon and Storey

Name of Organization	MCH Service Sector	County
Community Chest, Inc.	Child and Family Services	Lyon and Storey Counties
Dayton Valley Family Therapy	Child and Family Services	Lyon and Storey Counties
Division of Welfare and Supportive Services (DWSS) – Kinship Care Program	Child and Family Services	Lyon and Storey Counties
Lyon County Child Support	Child and Family Services	Lyon and Storey Counties
Nevada Families First (Parents as Teachers affiliate program)	Child and Family Services	Lyon and Storey Counties
Nevada Families First (Parents as Teachers affiliate program)	Child and Family Services	Lyon and Storey Counties
Poverty Simulations	Child and Family Services	Lyon and Storey Counties
ALIVE (Alternative to Living in Violent Environments)	Domestic Violence and Child Abuse Prevention Services	Lyon and Storey Counties
Boys and Girls Club of Fernley – Food Assistance – Fernley Intermediate School	Food, Clothing, Income, and Emergency Shelter Assistance	Lyon and Storey Counties
Boys and Girls Club of Mason Valley – The Attic Thrift Store	Food, Clothing, Income, and Emergency Shelter Assistance	Lyon and Storey Counties
Boys and Girls Club of Mason Valley – Yerington Food Pantry	Food, Clothing, Income, and Emergency Shelter Assistance	Lyon and Storey Counties
Clothes Closet at Living Faith Food Pantry	Food, Clothing, Income, and Emergency Shelter Assistance	Lyon and Storey Counties
Commodity Supplemental Food Program (CSFP) - Food Bank of Northern Nevada - Dayton Senior Center	Food, Clothing, Income, and Emergency Shelter Assistance	Lyon and Storey Counties
Commodity Supplemental Food Program (CSFP) – Food Bank of Northern Nevada – Living Faith Christian Fellowship	Food, Clothing, Income, and Emergency Shelter Assistance	Lyon and Storey Counties

Name of Organization	MCH Service Sector	County
Division of Welfare and Supportive Services (DWSS) – Supplemental Nutrition Assistance Program (SNAP) – Dayton	Food, Clothing, Income, and Emergency Shelter Assistance	Lyon and Storey Counties
Division of Welfare and Supportive Services (DWSS) – Supplemental Nutrition Assistance Program (SNAP) – Fernley	Food, Clothing, Income, and Emergency Shelter Assistance	Lyon and Storey Counties
Division of Welfare and Supportive Services (DWSS) – Supplemental Nutrition Assistance Program (SNAP) – Yerington	Food, Clothing, Income, and Emergency Shelter Assistance	Lyon and Storey Counties
Hands of Hope Food Bank – Box Delivery Program – Faith Baptist Church	Food, Clothing, Income, and Emergency Shelter Assistance	Lyon and Storey Counties
Healthy Communities Coalition – Dayton Food Pantry	Food, Clothing, Income, and Emergency Shelter Assistance	Lyon and Storey Counties
Healthy Communities Coalition – Silver Stage Food Pantry	Food, Clothing, Income, and Emergency Shelter Assistance	Lyon and Storey Counties
Healthy Communities Coalition – Yerington Food Pantry	Food, Clothing, Income, and Emergency Shelter Assistance	Lyon and Storey Counties
Holy Family Catholic Church – Food Pantry	Food, Clothing, Income, and Emergency Shelter Assistance	Lyon and Storey Counties
Living Faith Christian Fellowship – Fernley Food Pantry	Food, Clothing, Income, and Emergency Shelter Assistance	Lyon and Storey Counties
Lyon County Human Services – Dayton Office	Food, Clothing, Income, and Emergency Shelter Assistance	Lyon and Storey Counties
Lyon County Human Services – Fernley Office	Food, Clothing, Income, and Emergency Shelter Assistance	Lyon and Storey Counties

Name of Organization	MCH Service Sector	County
Lyon County Human Services – Silver Springs Office	Food, Clothing, Income, and Emergency Shelter Assistance	Lyon and Storey Counties
Lyon County Human Services – Yerington Office	Food, Clothing, Income, and Emergency Shelter Assistance	Lyon and Storey Counties
Ole Green House Thrift Store	Food, Clothing, Income, and Emergency Shelter Assistance	Lyon and Storey Counties
Silver Springs Senior Center Thrift Store	Food, Clothing, Income, and Emergency Shelter Assistance	Lyon and Storey Counties
Silver Stage Co-op Association	Food, Clothing, Income, and Emergency Shelter Assistance	Lyon and Storey Counties
St. Robert Bellarmine Parish – Emergency Food Pantry	Food, Clothing, Income, and Emergency Shelter Assistance	Lyon and Storey Counties
Women, Infants, and Children (WIC) – Dayton	Food, Clothing, Income, and Emergency Shelter Assistance	Lyon and Storey Counties
Women, Infants, and Children (WIC) – Fernley	Food, Clothing, Income, and Emergency Shelter Assistance	Lyon and Storey Counties
Women, Infants, and Children (WIC) – Silver Springs	Food, Clothing, Income, and Emergency Shelter Assistance	Lyon and Storey Counties
Women, Infants, and Children (WIC) – Yerington	Food, Clothing, Income, and Emergency Shelter Assistance	Lyon and Storey Counties
Lyon County Human Services – Family Resource Center – Dayton Office	Housing and Energy Assistance	Lyon and Storey Counties
Lyon County Human Services – Family Resource Center – Fernley Office	Housing and Energy Assistance	Lyon and Storey Counties

Name of Organization	MCH Service Sector	County
Lyon County Human Services – Family Resource Center – Silver Springs Office	Housing and Energy Assistance	Lyon and Storey Counties
Lyon County Human Services – Family Resource Center – Yerington Office	Housing and Energy Assistance	Lyon and Storey Counties
Child Support Office – Yerington	Legal Services	Lyon and Storey Counties
Yerington Paiute Tribe (formerly Yerington Paiute Health Clinic)	Legal Services	Lyon and Storey Counties
University of Nevada Cooperative Extension – Mineral County 4-H	Child and Family Services	Mineral
Consolidated Agencies of Human Services (CAHS)	Domestic Violence and Child Abuse Prevention Services	Mineral
11th Judicial District Youth & Family Services	Legal Services	Mineral
Mineral County Child Support Enforcement Office	Legal Services	Mineral
Walker River Paiute Tribe (formerly Walker River Health Clinic)	Tribal Services	Mineral
Cooperative Extension, University of Nevada Reno	Child and Family Services	Pershing
Pershing County Family Resource Center	Child and Family Services	Pershing
Pershing County Domestic Violence Intervention	Domestic Violence and Child Abuse Prevention Services	Pershing
Lovelock Community Food Bank	Food, Clothing, Income, and Emergency Shelter Assistance	Pershing
Child Support Office – Lovelock	Legal Services	Pershing
Nevada Hands & Voices	Aging and Disability Services	State
Nevada PEP – Satellite Office Reno/Spark	Aging and Disability Services	State
Nevada PEP Central – Las Vegas Office	Aging and Disability Services	State
Department of Health and Human Services – Project ASSIST	Child and Family Services	State

Name of Organization	MCH Service Sector	County
Division of Child & Family Services (DCFS) – Children’s Mental Health	Child and Family Services	State
Division of Child & Family Services (DCFS) – Northern and Rural Regions	Child and Family Services	State
Division of Child & Family Services (DCFS) – Southern Region	Child and Family Services	State
Division of Welfare & Supportive Services (DWSS) – Kinship Care Program	Child and Family Services	State
Division of Welfare & Supportive Services (DWSS) – Las Vegas & Southern Nevada	Child and Family Services	State
Division of Welfare & Supportive Services (DWSS) – Reno & Northern Nevada	Child and Family Services	State
Family TIES of Nevada (Training, Information, and Emotional Support) – Northern Nevada	Child and Family Services	State
Family TIES of Nevada (Training, Information, and Emotional Support) – Southern Nevada	Child and Family Services	State
For Kids Foundation (Northern Nevada)	Child and Family Services	State
The Children’s Cabinet – Statewide Child Care Resource & Referral	Child Care	State
Nevada Coalition to End Domestic and Sexual Violence	Domestic Violence and Child Abuse Prevention Services	State
Sexual Assault Support Services	Domestic Violence and Child Abuse Prevention Services	State
Beacon Academy of Nevada – Las Vegas Office	Education and Employment Assistance	State
Beacon Academy of Nevada – Reno Office	Education and Employment Assistance	State
State of Nevada Bureau of Vocational Rehabilitation – Northern Nevada	Education and Employment Assistance	State
State of Nevada Bureau of Vocational Rehabilitation – Southern Nevada	Education and Employment Assistance	State

Name of Organization	MCH Service Sector	County
Nevada Supplemental Nutrition Assistance Program (SNAP)	Food, Clothing, Income, and Emergency Shelter Assistance	State
Low Income Energy Assistance Program (Northern Nevada)	Housing and Energy Assistance	State
Low Income Energy Assistance Program (Southern Nevada)	Housing and Energy Assistance	State
Nevada Housing Division – Carson City Office	Housing and Energy Assistance	State
Nevada Housing Division – Las Vegas Office	Housing and Energy Assistance	State
Nevada Housing Division – Weatherization Program	Housing and Energy Assistance	State
Nevada Rural Housing Authority	Housing and Energy Assistance	State
Nevada Rural Housing Authority – Rental Assistance (HUD Section 8)	Housing and Energy Assistance	State
CASA – Court Appointed Special Advocates – Carson City	Legal Services	State
CASA – Court Appointed Special Advocates – Las Vegas	Legal Services	State
Division of Child & Family Services	Legal Services	State
High Sierra Industries (HSI) – Corporate Office	Aging and Disability Services	Washoe
Nevada Disability Advocacy and Law Center	Aging and Disability Services	Washoe
Nevada Division of Healthcare Financing and Policy – Health Insurance for Work Advancement (HIWA)	Aging and Disability Services	Washoe
Nevada PEP	Aging and Disability Services	Washoe
Northern Nevada Center for Independent Living	Aging and Disability Services	Washoe
American Comprehensive Counseling Services (ACCS) – Sparks	Child and Family Services	Washoe

Name of Organization	MCH Service Sector	County
Brightstar Care	Child and Family Services	Washoe
Casa de Vida (“House of Life”)	Child and Family Services	Washoe
Catholic Charities of Northern Nevada – Adoption Program	Child and Family Services	Washoe
Catholic Charities of Northern Nevada – Kids to Seniors Korner	Child and Family Services	Washoe
Central Reno Family Resource Center	Child and Family Services	Washoe
Crisis Pregnancy Center	Child and Family Services	Washoe
Division of Welfare and Supportive Services – Kinship Care Program (Reno)	Child and Family Services	Washoe
Division of Welfare and Supportive Services – Kinship Care Program (Sparks)	Child and Family Services	Washoe
Division of Welfare and Supportive Services (DWSS)	Child and Family Services	Washoe
Downing Clinic	Child and Family Services	Washoe
Family Counseling Services of Northern Nevada	Child and Family Services	Washoe
Family TIES of Nevada	Child and Family Services	Washoe
Kids First Family Services	Child and Family Services	Washoe
Nevada PEP (Parents Encouraging Parents) – Reno Office	Child and Family Services	Washoe
Northeast Reno Family Resource Center	Child and Family Services	Washoe
Planned Parenthood	Child and Family Services	Washoe
Rose McGuire North Valleys Family Resource Center	Child and Family Services	Washoe
Sierra Regional Center	Child and Family Services	Washoe
Sparks Family Resource Center	Child and Family Services	Washoe
Sun Valley Family Resource Center	Child and Family Services	Washoe

Name of Organization	MCH Service Sector	County
Tahoe Family Solutions	Child and Family Services	Washoe
Washoe County School District – Child Find Project	Child and Family Services	Washoe
Washoe County Social Services Children’s Services	Child and Family Services	Washoe
Child Assault Prevention Program (CAP)	Domestic Violence and Child Abuse Prevention Services	Washoe
Child Protective Services	Domestic Violence and Child Abuse Prevention Services	Washoe
Committee to Aid Abused Women (CAAW)	Domestic Violence and Child Abuse Prevention Services	Washoe
Domestic Abuse Treatment Program	Domestic Violence and Child Abuse Prevention Services	Washoe
Nevada Coalition to End Domestic and Sexual Violence (NCEDSV) (Formerly Nevada Network Against Domestic Violence)	Domestic Violence and Child Abuse Prevention Services	Washoe
Victim Services Program	Domestic Violence and Child Abuse Prevention Services	Washoe
Upward Bound	Education and Employment Assistance	Washoe
Washoe Innovations High School (Cysis Program)	Education and Employment Assistance	Washoe
Women and Children’s Center of the Sierra	Education and Employment Assistance	Washoe
REMSA (Regional Emergency Medical Services Authority)	Emergency Services	Washoe
A Safe Embrace	Food, Clothing, Income, and Emergency Shelter Assistance	Washoe
ABC Nutrition Service	Food, Clothing, Income, and Emergency Shelter Assistance	Washoe

Name of Organization	MCH Service Sector	County
Assistance League / Operation School Bell	Food, Clothing, Income, and Emergency Shelter Assistance	Washoe
Catholic Charities of Northern Nevada	Food, Clothing, Income, and Emergency Shelter Assistance	Washoe
Catholic Charities of Northern Nevada – St. Vincent’s Dining Room Program	Food, Clothing, Income, and Emergency Shelter Assistance	Washoe
Catholic Charities of Northern Nevada – St. Vincent’s Food Pantry	Food, Clothing, Income, and Emergency Shelter Assistance	Washoe
Catholic Charities of Northern Nevada – St. Vincent’s Super Thrift.	Food, Clothing, Income, and Emergency Shelter Assistance	Washoe
Catholic Charities of Northern Nevada – St. Vincent’s Thrift Shop	Food, Clothing, Income, and Emergency Shelter Assistance	Washoe
Good Shepherd’s Clothes Closet	Food, Clothing, Income, and Emergency Shelter Assistance	Washoe
Hands of Hope Food Bank	Food, Clothing, Income, and Emergency Shelter Assistance	Washoe
Project ReStart	Food, Clothing, Income, and Emergency Shelter Assistance	Washoe
Reno-Sparks Gospel Mission	Food, Clothing, Income, and Emergency Shelter Assistance	Washoe
Salvation Army	Food, Clothing, Income, and Emergency Shelter Assistance	Washoe

Name of Organization	MCH Service Sector	County
Salvation Army – Thrift Store	Food, Clothing, Income, and Emergency Shelter Assistance	Washoe
Supplemental Nutrition Assistance Program (SNAP)	Food, Clothing, Income, and Emergency Shelter Assistance	Washoe
Tom Vetica Resource Center – ReStart	Food, Clothing, Income, and Emergency Shelter Assistance	Washoe
Volunteers of America Community Assistance Shelter	Food, Clothing, Income, and Emergency Shelter Assistance	Washoe
Women, Infants, and Children (WIC) – Incline Village Community Hospital WIC Clinic	Food, Clothing, Income, and Emergency Shelter Assistance	Washoe
Women, Infants, and Children (WIC) – South Reno WIC Clinic	Food, Clothing, Income, and Emergency Shelter Assistance	Washoe
Women, Infants, and Children (WIC) – Sparks WIC Clinic	Food, Clothing, Income, and Emergency Shelter Assistance	Washoe
Women, Infants, and Children (WIC) – Washoe County Health District WIC Clinic	Food, Clothing, Income, and Emergency Shelter Assistance	Washoe
Women, Infants, and Children (WIC) – Wells WIC Clinic	Food, Clothing, Income, and Emergency Shelter Assistance	Washoe
Community Services Agency (CSA)	Housing and Energy Assistance	Washoe
Northern Nevada Community Housing Resource Board (NNCHRB)	Housing and Energy Assistance	Washoe
Reno Housing Authority	Housing and Energy Assistance	Washoe
Child Support Office – District Attorney, Reno	Legal Services	Washoe

Name of Organization	MCH Service Sector	County
Washoe County Juvenile Services	Legal Services	Washoe
Nevada Urban Indians	Tribal Services	Washoe
Pyramid Lake Tribal Health Clinic	Tribal Services	Washoe