Nevada

UNIFORM APPLICATION
FY 2022/2023 Only ApplicationBehavioral Health Assessment and Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 09/23/2021 11.15.53 AM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

State Information

State Information

Plan Year

Start Year 2022

End Year 2023

State DUNS Number

Number 625364849

Expiration Date 8/13/2017

I. State Agency to be the Grantee for the Block Grant

Agency Name Nevada Division of Public and Behavioral Health

Organizational Unit Nevada Department of Health and Human Services

Mailing Address 4150 Technology Way, Suite 300

City Carson City

Zip Code 89706

II. Contact Person for the Grantee of the Block Grant

First Name Stephanie

Last Name Woodard

Agency Name Division of Public and Behavioral Health

Mailing Address 4126 Technology Way Suite 200

City Carson City

Zip Code 89706

Telephone (775)684-2211

Fax

Email Address swoodard@health.nv.gov

III. Expenditure Period

State Expenditure Period

From

To

IV. Date Submitted

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name Brook

Last Name Adie

Telephone (775) 684-4077

Fax

Email Address badie@health.nv.gov

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Churchill Community Coalition

90 North Maine Ste 301
Fallon, NV 89406
(775) 423-7433
www.churchillcoalition.com

"Building community bridges to promote positive behavior."

Lisa Sherych, Administrator
Nevada Department of Health and Human Services
Division of Public and Behavioral Health
4126 Technology Way, Suite 200
Carson City, NV 89706

Dear Ms. Sherych,

I am writing this letter of commitment for the Nevada Department of Health and Human Services (DHHS)'s combined FY22/23 Substance Abuse and Mental Health Block Grant Application to fund efforts to develop and implement goals, objectives, and strategies for prevention and treatment of substance abuse and a Behavioral Health Assessment and Plan, in accordance with Block Grant application process initiated by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Under Block Grant application guidelines, DHHS and SAPTA are expected to use the Substance Abuse Prevention and Treatment (SAPT) Block Grant and the Community Mental Health Services (CMHS) Block Grant for prevention, treatment, recovery supports and other services that will supplement services covered by Medicaid, Medicare and private insurance or fill the gaps not covered by Medicaid, Medicare, and private insurance.

It is our understanding that the goals of the block grant programs are consistent with SAMHSA's vision for a high-quality and satisfying life in the community for everyone in America. This life in the community includes:

(a) A physically and emotionally healthy lifestyle (health);

(b) A stable, safe and supportive place to live (a home);

(c) Meaningful daily activities such as a job, school, volunteerism, family caretaking, or creative endeavors and the independence, income, and resources to participate in society (a purpose); and

(d) Relationships and social networks that provide support, friendship, love, and hope (a community).

Additional aims of the block grant programs reflect SAMHSA's overall mission and values, specifically:

- To promote participation by people with mental and substance use disorders in shared decision making and self-direction of their services and supports.
- To ensure access to effective culturally and linguistically appropriate services for underserved populations including Tribes, racial and ethnic minorities, and LGBT.

- To promote recovery, resiliency and community integration for adults with serious mental illness and children with serious emotional disturbances and their families.
- To prevent the use, misuse, and abuse of alcohol, tobacco products, illicit drugs, and prescription medications.
- To conduct outreach to encourage individuals injecting or using illicit and/or licit drugs to seek and receive treatment
- To provide early intervention services for HIV at the sites at which individuals receive substance use disorder treatment services.
- To coordinate behavioral health prevention, early identification, treatment and recovery support services with other health and social services.
- To increase accountability for prevention, early identification, treatment and recovery support activities through uniform reporting regarding substance use and abstinence, criminal justice involvement, education, employment, housing, and recovery support services.
- To ensure access to a comprehensive system of care, including education, employment, housing, case management, rehabilitation, dental services, and health services, as well as behavioral health services and supports.
- To provide continuing education regarding substance abuse prevention and substance use disorder treatment services to any facility or program receiving amounts from the SABG for such activities or services.

The Churchill Community Coalition will be available to contribute to this process by providing Primary substance abuse prevention education to community members, promoting and supporting community treatment agencies in their efforts. Churchill Community Coalition is an active member of the Churchill County Behavioral Health Task Force, partnering with Churchill County Social Services, Sheriff's Department, Juvenile Probation Department, Fallon Police Department, Banner Healthcare, Fallon Mental Health, New Frontier Treatment Center, and many other state and community partners. Task force members share current data, trends, and relative information to assess community and member's needs. Churchill Community Coalition works within this network to ensure that community members receive the education and resources that are available, assessing gaps and working to help in filling/bridging those gaps. The Coalition partners with the Fallon Paiute Shoshone Tribe's Behavioral health, Education and Environmental Departments, as well as Churchill County School District, Oasis Academy, Charter school, and our local after school and summer youth programs, allowing the Coalition opportunity to educate youth and parents in prevention and provide information on current federal, state, and local resources and services.

I look forward to participating in this endeavor and in assisting in the development and implementation of a comprehensive plan to benefit the residents of our state.

Sincerely,

Mary Beth Chamberlain
Executive Director
Churchill Community Coalition
marybeth@churchillcoalition.com

JTNN Join Together Northern Nevada
Building Partnerships for a Healthy Community

July 28, 2021

Lisa Sherych, Administrator
Nevada Department of Health and Human Services
Division of Public and Behavioral Health
4126 Technology Way, Suite 200
Carson City, NV 89706

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Additional aims of the block grant programs reflect SAMHSA's overall mission and values, specifically:

- To prevent the use, misuse, and abuse of alcohol, tobacco products, illicit drugs, and prescription medications.
- To ensure access to effective culturally and linguistically appropriate services for underserved populations including Tribes, racial and ethnic minorities, and LGBT.
- To coordinate behavioral health prevention, early identification, treatment and recovery support services with other health and social services.
- To provide continuing education regarding substance abuse prevention and substance use disorder treatment services to any facility or program receiving amounts from the SABG for such activities or services.

505 S. Arlington, Suite 110, Reno, NV 89509
775-324-7557 – www.jtnn.org

JTNN Join Together Northern Nevada
Building Partnerships for a Healthy Community

Join Together Northern Nevada will available to contribute to this process by delivering evidence-based programming and other educational programming to individuals in the second largest county in Nevada.

I look forward to participating in this endeavor and in assisting in the development and implementation of a comprehensive plan to benefit the residents of our state.

If you have any questions related to the letter of support, please do not hesitate to contact me at jennifer@jtnn.org or 775-324-7557.

Sincerely,

Jennifer DeLett-Snyder
Executive Director
Join Together Northern Nevada

PACE Coalition
Healthy Communities ... Whatever it Takes
www.pacecoalition.org

Lisa Sherych, Administrator
Nevada Department of Health and Human Services
Division of Public and Behavioral Health
4126 Technology Way, Suite 200
Carson City, NV 89706

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•To promote participation by people with mental and substance use disorders in shared decision making and self-direction of their services and supports.

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•To coordinate behavioral health prevention, early identification, treatment and recovery support services with other health and social services.

•To increase accountability for prevention, early identification, treatment and recovery support activities through uniform reporting regarding substance use and abstinence, criminal justice involvement, education, employment, housing, and recovery support services.

•To ensure access to a comprehensive system of care, including education, employment, housing, case management, rehabilitation, dental services, and health services, as well as behavioral health services and supports.

•To provide continuing education regarding substance abuse prevention and substance use disorder treatment services to any facility or program receiving amounts from the SABG for such activities or services.

The PACE Coalition will be available to contribute to this process by implementing substance abuse and mental health issues prevention activities throughout our service area and using statewide collaboration and initiatives.

I look forward to participating in this endeavor and in assisting in the development and implementation of a comprehensive plan to benefit the residents of our state.

Sincerely,

Laura L Oslund

Executive Director

Dear Ms. Sherych,

I am writing this letter of commitment for the Nevada Department of Health and Human Services (DHHS)'s combined FY22/23 Substance Abuse and Mental Health Block Grant Application to fund efforts to develop and implement goals, objectives, and strategies for prevention and treatment of substance abuse and a Behavioral Health Assessment and Plan, in accordance with Block Grant application process initiated by the Substance Abuse and Mental Health Services Administration (SAMHSA).

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The CARE Coalition will be available to contribute to this process through prevention services and community efforts. I look forward to participating in this endeavor and in assisting in the development and implementation of a comprehensive plan to benefit the residents of our state.

Sincerely,

Diane M Anderson

Diane M. Anderson
Executive Director
CARE Coalition
www.carecoalitionnv.org

VITALITY UNLIMITED
VITALITY INTEGRATED PROGRAMS

July 28, 2021

Lisa Sherych, Administrator
Nevada Department of Health and Human Services
Division of Public and Behavioral Health
4126 Technology Way, Suite 200
Carson City, NV 89706

Dear Ms. Sherych:

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Elko NV Business Office- 775.738.4158. VIP Elko- 775-777-8477. Elko- Vitality Center 775.738.8004
P. O. Box 2580, Elko NV 89803 www.vitalityunlimited.com

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Vitality Unlimited is available to contribute to this process effective today, July 28, 2021.

I look forward to participating in this endeavor and in assisting in the development and implementation of a comprehensive plan to benefit the residents of our state.

Sincerely,

Ester M. Quilici, CEO/COO

July 28, 2021

Lisa Sherych, Administrator
Nevada Department of Health and Human Services
Division of Public and Behavioral Health
4126 Technology Way, Suite 200
Carson City, NV 89706

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Living Free Health
2050 N Highway160 Suite 600-700 | www.LivingFreeHealth.org
Pahrump, Nevada 89060-6241
Office 775-505-1625 Fax 775-403-1755

- To promote recovery, resiliency and community integration for adults with serious mental illness and children with serious emotional disturbances and their families.
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- To provide continuing education regarding substance abuse prevention and substance use disorder treatment services to any facility or program receiving amounts from the SABG for such activities or services.

Living Free Health will be available to contribute to this process by continuing to provide the highest quality substance use and co-occurring disorders outpatient and transitional living services.

I look forward to participating in this endeavor and in assisting in the development and implementation of a comprehensive plan to benefit the residents of our state.

Sincerely,

Rochelle "Shelley" Poerio

CEO, LADC-S, LADC

Living Free Health
2050 N Highway160 Suite 600-700 | www.LivingFreeHealth.org
Pahrump, Nevada 89060-6241
Office 775-505-1625 Fax 775-403-1755

July 28, 2021

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Nevada Department of Health and Human Services
Division of Public and Behavioral Health
4126 Technology Way, Suite 200
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- To promote participation by people with mental and substance use disorders in shared decision making and self-direction of their services and supports.

3700 Safe Harbor Way
Reno, NV 89512
www.step2reno.org
775.787.9411 tel 775.787.9445 fax

- To ensure access to effective culturally and linguistically appropriate services for underserved populations including Tribes, racial and ethnic minorities, and LGBT.
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- To provide continuing education regarding substance abuse prevention and substance use disorder treatment services to any facility or program receiving amounts from the SABG for such activities or services.

STEP2 will be available to contribute to this process by providing comprehensive, culturally sensitive, and collaborative substance use disorder treatment, housing, and support services.

I look forward to participating in this endeavor and in assisting in the development and implementation of a comprehensive plan to benefit the residents of our state.

Sincerely,

Mari Hutchinson

Mari Hutchinson, CEO

3700 Safe Harbor Way
Reno, NV 89512
www.step2reno.org
775.787.9411 tel 775.787.9445 fax

Ridge House, Incorporated
900 West 1st Street, Suite 200 * Reno, NV 89503
Phone: 775-322-8941 * Fax: 775-322-1544

July 28, 2021

Lisa Sherych, Administrator
Nevada Department of Health and Human Services
Division of Public and Behavioral Health
4126 Technology Way, Suite 200
Carson City, NV 89706

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Ridge House will be available to contribute to this process by providing residential and outpatient treatment services to Nevada residents. Ridge House offers a comprehensive system of care including substance use and co-occurring treatment, workforce development, education, housing, and case management services. The primary population served are justice involved adults with a focus on trauma informed care. Our long-standing collaboration with the State of Nevada has ensured access to treatment in our area for nearly 40 years.

I look forward to participating in this endeavor and in assisting in the development and implementation of a comprehensive plan to benefit the residents of our state.

Sincerely,

Dani Tillman, MSW, LSW, LADC
Executive Director
Ridge House, Inc.
900 West First Street, Suite 200
Reno, Nevada 89503
Phone: (775) 322-8941 ext. 129
Fax: (775) 322-1544
dtillman@ridgehouse.org
www.ridgehouse.org

STEP1
RECOVERY
Hope · Integrity · Family · Safety

AN ADULT MEN'S TRANSITIONAL LIVING FACILITY
1015 NO. SIERRA ST., RENO, NV 89503 / Phone & Fax: (775) 329-9830
Website: www.step1inc.org

July 28, 2021

Lisa Sherych, Administrator
Nevada Department of Health and Human Services
Division of Public and Behavioral Health
4126 Technology Way, Suite 200
Carson City, NV 89706

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Step 1, Inc. will be available to contribute to this process by providing supportive stable transitional housing and ASAM Level 1 outpatient substance use disorders counseling.

I look forward to participating in this endeavor and in assisting in the development and implementation of a comprehensive plan to benefit the residents of our state.

Sincerely,

Dani L. Doehring, LADC

Dani L. Doehring,
Executive Director

July 28, 2021

Lisa Sherych, Administrator
Nevada Department of Health and Human Services
Division of Public and Behavioral Health
4126 Technology Way, Suite 200
Carson City, NV 89706

Dear Ms. Sherych,

I am writing this letter of commitment for the Nevada Department of Health and Human Services (DHHS)'s combined FY22/23 Substance Abuse and Mental Health Block Grant Application to fund efforts to develop and implement goals, objectives, and strategies for prevention and treatment of substance abuse and a Behavioral Health Assessment and Plan, in accordance with Block Grant application process initiated by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Under Block Grant application guidelines, DHHS and SAPTA are expected to use the Substance Abuse Prevention and Treatment (SAPT) Block Grant and the Community Mental Health Services (CMHS) Block Grant for prevention, treatment, recovery supports and other services that will supplement services covered by Medicaid, Medicare and private insurance or fill the gaps not covered by Medicaid, Medicare, and private insurance.

It is our understanding that the goals of the block grant programs are consistent with SAMHSA's vision for a high-quality and satisfying life in the community for everyone in America. This life in the community includes:

(a) A physically and emotionally healthy lifestyle (health);

(b) A stable, safe and supportive place to live (a home);

(c) Meaningful daily activities such as a job, school, volunteerism, family caretaking, or creative endeavors and the independence, income, and resources to participate in society (a purpose); and

(d) Relationships and social networks that provide support, friendship, love, and hope (a community).

OFFICE LOCATION
1490 Grimes Street
P.O. Box 1240
Fallon, NV 89407-1240
Ph: (775) 423-1412
Fax: (775) 423-4054

Additional aims of the block grant programs reflect SAMHSA's overall mission and values, specifically:

- To promote participation by people with mental and substance use disorders in shared decision making and self-direction of their services and supports.
- To ensure access to effective culturally and linguistically appropriate services for underserved populations including Tribes, racial and ethnic minorities, and LGBT.
- To promote recovery, resiliency and community integration for adults with serious mental illness and children with serious emotional disturbances and their families.
- To prevent the use, misuse, and abuse of alcohol, tobacco products, illicit drugs, and prescription medications.
- To conduct outreach to encourage individuals injecting or using illicit and/or licit drugs to seek and receive treatment
- To provide early intervention services for HIV at the sites at which individuals receive substance use disorder treatment services.
- To coordinate behavioral health prevention, early identification, treatment and recovery support services with other health and social services.
- To increase accountability for prevention, early identification, treatment and recovery support activities through uniform reporting regarding substance use and abstinence, criminal justice involvement, education, employment, housing, and recovery support services.
- To ensure access to a comprehensive system of care, including education, employment, housing, case management, rehabilitation, dental services, and health services, as well as behavioral health services and supports.
- To provide continuing education regarding substance abuse prevention and substance use disorder treatment services to any facility or program receiving amounts from the SABG for such activities or services.

New Frontier will be available to contribute to this process by providing all of the services specified above with a focus on providing crisis and wrap-around behavioral health services to all Nevadans. New Frontier has Level 3.2WM, 3.1, 3.5, transitional housing for women, women's Parent-Child Assistance Program (P-CAP) and are also a Certified Community Behavioral Health Clinic (CCBHC). We believe that we are well-prepared to support the Substance Abuse Prevention and Treatment Agency (SAPTA) in Nevada to meet all of the goals and objectives of Substance Abuse and Mental Health Services Administration (SAMHSA) for 2022 and beyond.

I look forward to participating in this endeavor and in assisting in the development and implementation of a comprehensive plan to benefit the residents of our state.

Respectfully submitted,

Lana K. Robards
Executive Director

Rural Nevada Counseling

720 South Main Street, Suite C
Yerington, NV 89447
1-866-831-2774
Phone: 775-463-6597
Fax: 775-463-6598
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Dayton
775-246-6214
Fernley
775-575-6191
Silver Springs
775-577-6565
CCBHC
775-577-6441

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Rural Nevada Counseling is available currently ready to contribute to this process.

I look forward to participating in this endeavor and in assisting in the development and implementation of a comprehensive plan to benefit the residents of our state.

Sincerely,

Tenea Smith, ED, LCADC-LC, LCADC-LCS, CPC-I
720 South Main Street, Suite C
Yerington, NV 89447
775-463-6597

WestCare Nevada, Inc.
1711 Whitney Mesa Drive
Henderson, NV 89014

Lisa Sherych, Administrator
Nevada Department of Health and Human Services
Division of Public and Behavioral Health
4126 Technology Way, Suite 200
Carson City, NV 89706

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WestCare Nevada will be available to contribute to this process in any way necessary.

I look forward to participating in this endeavor and in assisting in the development and implementation of a comprehensive plan to benefit the residents of our state.

Sincerely,

Shawn Jenkins, Chief Operating Officer
WestCare Foundation - Western Region

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2022

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
Section 1923	Intravenous Substance Abuse	**42 USC § 300x-23**
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	**42 USC § 300x-24**
Section 1925	Group Homes for Recovering Substance Abusers	**42 USC § 300x-25**
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	**42 USC § 300x-26**
Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
Section 1932	Application for Grant; Approval of State Plan	**42 USC § 300x-32**
Section 1935	Core Data Set	**42 USC § 300x-35**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**

Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: _____

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

ONE HUNDRED ONE NORTH CARSON STREET
CARSON CITY, NEVADA 89701
OFFICE: (775) 684-5670
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555 EAST WASHINGTON AVENUE, SUITE 5100
LAS VEGAS, NEVADA 89101
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Office of the Governor

September 12, 2019

Ms. Diane Abbate,
Director - Division of Grant Review
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Rockville, MD 20857

RE: Substance Abuse Prevention and Treatment Block Grants (SAPTA)
Community Mental Health Services Block Grants (CMHS)
Projects for Assistance in Transition from Homelessness (PATH)

Dear Ms. Abbate:

As Governor of the State of Nevada, I delegate authority to Lisa Sherych, Administrator of the State of Nevada, Division of Public and Behavioral Health, for all transactions required to administer the Substance Abuse and Mental Health Services Administration Grants to include SAPTA, CMHS, and PATH grants.

Ms. Sherych will ensure that Nevada complies with the Certifications and Assurances for these grants and may be contacted at:

Nevada Division of Public and Behavioral Health
4150 Technology Way, Suite 300
Carson City, Nevada 89706
(775) 684-4200

This designation will remain in effect until further notice.

Sincerely,

Governor Steve Sisolak
State of Nevada

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL).

Standard Form LLL (click here)

Name

Title

Organization

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems of care, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system of care is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems of care address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations. Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems of care, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system of care is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems of care address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

NEVADA SUMMARY

Nevada's population identified in the 2020 census is 3,108,462 which is an increase of 15% from 2010. Nevada is expected to increase another 1.7% over the next year. The population is made up of approximately equal percentages of females and males. The median household income is $63,276. Nevada's land area is approximately 110,567 square miles. This area would include up to seven northeastern states within Nevada's geographic borders. Nevada's poverty level by county ranges from 12% to 18.9%. In 2019, there were 384,900 Nevadans in poverty (12.7% of the state's population). There were 32,077 rural and frontier residents in poverty (10.9% of the population). The median home level has increased significantly with Clark County's (Las Vegas) median home price at $324,738 and Washoe County's (Reno) median home price at $406,905. This has increased the level of anxiety and stressors in the community due to the higher cost of living. Nevada's unemployment rate continues to fluctuate from 29.5% in June 2020 to 7.8%, above the current national unemployment rate of 5.9%. This also impacts access to care issues with many families required to work two jobs or who are out of work with minimal health or behavioral health insurance. In 2018, 12.9% of Nevadans under the age of 65 were uninsured, including 13.0% rural and frontier residents. There were 57,246 uninsured Nevadans under the age of 19 (8.0%), including 6,002 uninsured rural and frontier children In addition, Nevada is projected to be a minority-majority state by the year 2023, which requires approaches that are culturally and linguistically appropriate to improve access of care to all populations.

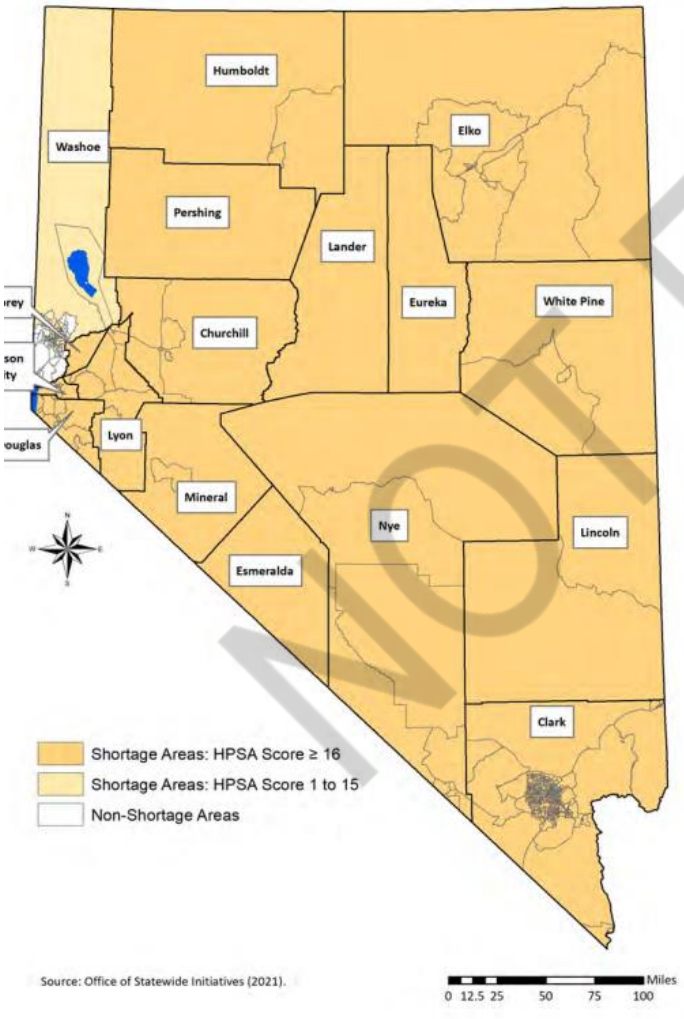
Nevada has biennial legislative sessions are every two years. This elevates the importance of planning for behavioral health services. During the 2017 legislative session, Nevada established the regional behavioral health policy boards to address behavioral health in Nevada by geographic catchment areas. This includes a Regional Behavioral Health Coordinator (RBHC) who works directly within the region to support behavioral health needs, gaps, assessments, coordination, and communications. In the 2021 legislative session, Nevada worked with the Senate Committee on Health and Human Services for provisions relating to crisis stabilization center and crisis care to ensure that Medicaid was a viable option for continuity of care. Nevada intends to submit an application to CMS for a Mobile Crisis Planning Grant to provide for sustainable funding for the services within the state Medicaid program. Nevada was also able to implement legislation to start the process of developing regulations to support the maintenance of the 988 line (beyond implementation) and to be part of the braided funding for crisis care systems as part of Senate Bill 390. The legislation will result in the development of the Crisis

Response Account with funding derived from a 988 surcharge on all eligible phone lines. Planning for 988 and the entire crisis continuum of care has been primary behavioral health priority for Nevada for the past few years and the impact of COVID has prompted even greater focus on designing and implementing the system of crisis care.

The population density of Nevada's counties varies widely, but the state has made it a priority that all citizens are represented by a Regional Behavioral Health Board (RBHB). with 73.6% of Nevada's population, Clark County is the most populous area in the state, with an estimated 2,251,175 persons. Esmeralda County, by comparison, is the least populous county, with less than one percent of Nevada's population, an estimated 969 persons. Yet each of these counties have representation as part of the RBHB.

Nevada has seventeen counties with only three being identified as urban. The remaining counties are defined as rural and frontier counties, which further challenges the behavioral health system with the large geographic areas, limited services, and lack of public transportation. The coordination with the Regional Behavioral Health Coordinators provides linkage and support strategizing with other counties on access to care issues and county specific priorities based on population, especially with limited resources.

Map 5.3: Mental Health Professional Shortage Areas (HPSAs) in Nevada



Compounding the struggle for Nevada's population to access services are the shortages that exist within the behavioral health workforce. All 17 counties have significant regions that are identified as Mental Health Shortage Areas (HPSAs) with 16 counties recording HPSA scores greater than 16 by the Nevada Health Workforce Research Center in the Office of Statewide Initiatives at the University of Nevada, Reno School of Medicine (2021). Currently, 3 million Nevadans or 94.5% of the state's population reside in a federally designated mental health professional shortage area, 16 of 17 counties in Nevada are single-county mental HPSAs.

Despite the significant barriers to workforce and access outlined above, Nevada's behavioral health plans are evidence-based, data driven, and geographically focused. Mental health data are collected by numerous data sources in Nevada, including YRBS, BRFSS, hospital billing, state-funded mental health facilities, and vital records. These also include utilizing Client Level Data System (CLDS) and the Department of Health and Human Services Data Analytics to trend and identify high need areas or changes in

needs over time. Nevada also works with other Divisions to identify services, needs or populations who are underinsured, uninsured or have limited abilities to access behavioral health care. As part of the efforts, Nevada has also been working to improve suicide analytics for attempts and access to care. Nevada has been focused on reducing the number of emergency room visits with plans for stabilization units, Assertive Community Treatment (ACT) teams, mobile crisis, and a structured crisis support system that is capable of providing tailored services for adults and children, youth, and families.

NEVADA'S DIVERSE POPULATIONS

The State of Nevada works continuously to address the needs of diverse populations. During the 2005 legislative session, the Nevada State Legislature created the Office of Minority Health with passage of Assembly Bill 580. Included in the bill was the creation of an Advisory Committee, composed of nine members reflecting the ethnic and geographical diversity of the state. During the 2017 legislative session, AB 141 was passed broadening the entities' title to the Nevada Office of Minority Health and Equity (NOMHE) and revising the definition of "minority" to include members of the LGBTQ community and people who are disabled. Pursuant to NRS 232.474, NOMHE provides an organized statewide focus serving to:

- Identify, assess, and analyze issues related to the health status of minority populations and to communicate this information where needed;
- Participate in, and lead when appropriate, the development of minority needs assessments; service strategies; and the collection of minority health data;
- Provide reference and resource information on minority health issues;
- Engage internal and external entities to support initiatives that address specific minority health needs, including target health care program resources to meet these needs;
- Monitor programs, policies, and procedures for inclusiveness and responsiveness to minority health needs; and
- Facilitate the development and implementation of research and scientific investigations to produce minority-specific findings.

All DHHS agencies are expected to abide by the National Standards for Culturally and Linguistic Appropriate Services (CLAS) in order to advance and sustain culturally and linguistically appropriate services. Further, all funded providers are required to comply with the requirements of the Civil Rights Act of 1964, as amended, and the Rehabilitation Act of 1973, P.L. 93-112, as amended, and with any relevant program-specific regulations, and shall not discriminate against any employee or offer for employment because of race; national origin; creed; color; sex; religion; age; disability; or handicap condition (including AIDS and AIDS-related conditions).

Further, DHHS has established a statewide Special Populations & Health Disparities Quality Improvement Team. The team consists of eight workgroups that study the needs and service gaps of individuals in encompassing the following special populations:

- Adolescents and young adults
- Transitional age youth
- Criminal justice-involved persons
- Individuals with unstable housing/dislocated individuals/individuals experiencing homelessness

- LGBTQIAP+ individuals
- Native American and Hispanic/Latino people
- Older adults
- People with co-occurring mental health and substance-related disorders
- Intellectual and developmental disabilities (IDD)
- Black, Indigenous (and) People of Color (BIPOC)
- Veterans, active duty military, and their families

In keeping with SAMHSA's guiding principles, DHHS holds that recovery is culturally based and influenced and that services should be culturally grounded, attuned, sensitive, congruent, and personalized to meet each individual's unique needs. To this end, the agency includes representatives from diverse populations on its various advisory councils; includes racial and minority data sections in all of its needs assessments and gap analysis; and conducts surveys to measure staffs' cultural competence in the ability to understand, communicate with, and effectively interact with people across cultures. The state has specific agencies dedicated to serving people who are LGBTQ in both the northern and southern parts of the state.

DHHS provides all surveys in English and Spanish and provides surveys in other languages, as requested. In addition, the Division offers consumer advocates to assist individuals in navigating the system. Many of the consumer advocates are peers with similar diversity and backgrounds to the people they assist.

DHHS partners with the 27 American Indian Tribes within the State of Nevada through a Tribal Consultation Process Agreement. This coordination establishes and strengthens ties and relationships with the tribal governments, provides education and outreach, and notifies the tribes of funding opportunities. A network of liaisons represents each division within DHHS. The group meets on a quarterly basis. Tribal mental health and substance-related disorder services are provided by Indian Health Services and Medicaid.

Division Of Public and Behavioral Health

The Nevada Division of Public and Behavioral Health (DPBH) is part of the Department of Health and Human Services (DHHS), under the Executive Branch of the State of Nevada. DPBH is comprised of the former Health Division and of the former Division of Mental Health and Developmental Services which merged in 2013 in order to protect, promote and improve the physical and behavioral health of the people of Nevada.

As authorized by Nevada Revised Statute (NRS) 433.316, DPBH serves as the state's Public Health Authority and Mental Health Commissioner. The DHHS director appoints both the Single State Authority (SSA) for substance abuse and the Single Mental Health Authority (SMHA); currently, the DHHS Senior Advisor on Behavioral Health serves as both the SSA and the SMHA. This executive staff provides oversight and quality assurance to behavioral health providers statewide; designs, plans, funds, and implements systems of care, including behavioral health prevention, early intervention, treatment and recovery support services; establishes funding priorities for behavioral health services and supports through close collaboration with communities and stakeholders; evaluates outcomes of behavioral health interventions; and guides policy and financing options across DHHS.

DPBH is organized into five branches, each overseen by a Deputy Administrator: a) Administrative Services, b) Bureau of Behavioral Health Wellness and Prevention, c) Clinical Services, d) Community Services, and e) Regulatory and Planning Services:

Administrative Services

- Administration - Executive Team
- Administrative Services
- Fiscal
- Human Resources
- Office of Informatics and Technology
- Revenue Management Unit

Bureau of Behavioral Health Wellness and Prevention

- Behavioral Health Services Planning
- Substance Abuse Prevention and Treatment Agency (SAPTA)
- Delegated authority for SSA and SMHA
- Problem Gambling
- Office of Suicide Prevention

Clinical Services

- Administrative - Clinical Services
- Lake's Crossing Center (LCC)
- Northern Nevada Adult Mental Health Services (NNAMHS)
- Southern Nevada Adult Mental Health Services (SNAMHS)
- Rural Clinics (RCs)

Community Services

- Administrative – Community Services
- Bureau of Child, Family, & Community Wellness
- Office of Public Health Informatics and Epidemiology
- Ryan White Part B Programs and Services
- Community Health Nurses

Regulatory and Planning Services

- Administrative - Regulatory and Planning Services
- Behavioral Health
- Bureau of Health Care Quality & Compliance
- Bureau of Health Protection and Preparedness
- Environmental Health Program
- Primary Care Office

Advisory Groups

The SSA/SMHA relies on the oversight and direction of stakeholders across multiple advisory groups focusing on services aimed at both adult and youth populations:

Behavioral Health Planning Advisory Council (BHPAC): The BHPAC was created in 2013 by an Executive Order of the Governor with the goal of serving as an advocate for individuals experiencing chronic mental illnesses, children and youth experiencing serious emotional disturbances, and other individuals experiencing mental illnesses or emotional problems, substance use disorders, and co-occurring disorders. The members of BHPAC work in a variety of ways to: improve the way services are provided to individuals, to help bring more money into the

state system, to promote awareness of mental health issues; and to provide education and training opportunities. BHPAC has three federal mandates:

1. Review the Mental Health Block Grant Plan and Priorities and make recommendations.
2. Serve as an advocacy group for adults with serious mental Illness, children with severe emotional disturbance, individuals with other mental health conditions or emotional problems; and people with co-occurring substance-related and mental health disorders.
3. Monitor; review; and evaluate; not less than once each year, the allocation and adequacy of behavioral health services within the state.

Children's Behavioral Health Consortium: As established in NRS 433B.333 & 433B.335, the statewide Children's Behavioral Health Consortium provides Nevada's children and their families with timely access to an array of behavioral health treatment services delivered through a system of care (SOC) that supports their needs in the least restrictive environment.

Commission on Behavioral Health (CBH): The CBH is a 10-member legislatively (NRS 433.314) created body and appointed by the Governor. CBH establishes and sets policies to ensure adequate development and administration of services and to provide programmatic and financial oversight of Nevada's public system of integrated care and treatment of adults and children with mental health disorders, intellectual disorders, substance-related disorders or co-occurring substance-related and mental health disorders, and developmental disabilities-related conditions. DPBH and the Division of Child and Family Services (DCFS) administer the service delivery system. CBH also promotes and assures the protection of the rights of all people in the system.

Epidemiological Outcomes Workgroup (SEOW):The SEOW workgroup attempts to use data to create reports and materials that are useful across the State. The SEOW has zero policy making or regulatory authority which allows it to remain neutral. The data for the SEOW comes from members and participants who have access to data sources in the health districts, counties, State government, hospitals and medical professionals, coroners, prevention agencies, universities, the justice system, law enforcement, and other sectors as needed. Some of the data provided includes coroners' reports, State billing data from hospitals and Medicaid billing claims, Behavioral Risk Factor Surveillance System (BRFSS), The Youth Risk Behavioral Survey (YRBS), Nevada Report Card from the Department of Education, The United States Census Bureau and more. The SEOW generates the epidemiology report which includes data from multiple sources and allows other committee's to use the data to drive decision making for projects and programs they oversee.

Multidisciplinary Prevention Advisory Committee (MPAC): MPAC provides ongoing advice and guidance to SAPTA and makes practice recommendations as related to substance use prevention. The committee was originally authorized under the State Incentive Grant in 2002 and was re-authorized under the Strategic Prevention Framework-Partnerships for Success Grant (SPF-SIG) in 2013. MPAC is a freestanding committee that was designed to:

- Monitor progress toward objectives;
- Create a comprehensive statewide prevention strategy;
- Maximize all available alcohol, tobacco, and other drug prevention and resources;
- Remove state barriers to enhancing the delivery of effective local substance abuse prevention services;
- Ensure prevention services are culturally relevant and target populations of need;

- Develop shared responsibility among state and local governmental units; and
- Promote the prevention and treatment of alcohol and other drug use.

Regional Behavioral Health Policy Boards (RBHPB): The 2017 Nevada Legislature (Assembly Bill 366) initially created four behavioral health regions (BHR) in the state and created a RBHPB for each of those regions. Just recently, the 2019 Nevada Legislature (Assembly Bill 76) added a fifth BHR and reconfigured the regional assignments:

- Clark – consists of only Clark County (Las Vegas area);
- Northern – consists of five counties: Carson City, Churchill, Douglas, Lyon, and Storey;
- Rural – consists of six counties: Elko, Eureka, Humboldt, Lander, Pershing, and White Pine;
- Southern – consists of four counties: Esmeralda, Lincoln, Mineral, and Nye; and
- Washoe - consists of only Washoe County (Reno area).

Each RBHPB consists of 13 members and advises DPBH on matters pertaining to the behavioral health needs of adults and children in each region. This includes identifying potential problems with proposed policy changes and service delivery, identifying gaps in services, and making recommendations for service enhancements and allocation of funds.

Regional Mental Health Consortia are tasked with developing a long-term strategic plan for the provision of mental health services to children in their jurisdiction. The strategic plan is submitted to the Director of DHHS. Each even-numbered year, the consortia submit a list of service-priorities in order to implement the long-term strategic plan with an itemized cost to provide the services and to recommend any revisions to the plan. On odd-numbered years, the consortia submit a status report on the long-term strategic plan and on any revisions that were made to the plan.

SAPTA Advisory Board (SAB): SAB serves in an advisory capacity to the SAPTA Bureau Chief and to the SSA. SAB ensures the availability and accessibility of treatment and prevention services within the state. SAB consists of 15 members who serve for 2-year terms; the members are chosen from SAPTA-funded prevention and treatment programs. The chairperson is elected by the membership and serves as the chief executive of the board and provides general supervision, direction, and control of affairs of the board. The SAB meets at least quarterly, and the chairperson presides at all meetings.

OVERVIEW OF THE BEHAVIORAL HEALTH SYSTEM

Nevada's health care system has a strong emphasis on coordinated and integrated care along with the need to improve services for persons with mental disorders. The block grant provides Nevada the opportunity to focus on the specific needs of our State to provide services for Children with Serious Emotional Disturbance (SED) and Adults with Serious Mental Illness (SMI) as defined below.

Serious Emotional Disturbance (SED) pertains to children and youth up to age 18 who have had a diagnosable mental, behavioral, or emotional disorder in the past year that resulted in functional impairment that substantially interfered with or limited the child's or youth's role or functioning in family, school, or community activities. Conditions that are excluded from the diagnosis of SED are substance abuse or addictive disorders, irreversible dementias, as well as intellectual disabilities and other related conditions, unless they co-occur with another SED that meets current diagnostic criteria and that results in functional impairment.

Serious Mental Illness (SMI) concerns individuals, 18 years of age and older, who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder that meets the defining criteria specified in the current diagnostic manual of the American Psychiatric Association (APA) and that has resulted in serious functional impairment. Serious functional impairment is defined as difficulties that substantially interfere with or limit one or more major life activities, such as achieving or maintaining housing, employment, education, relationships or safety. Conditions that are excluded from the diagnosis of SMI are substance abuse or addictive disorders, irreversible dementias, as well as intellectual disabilities, unless they co-occur with another SMI that meets current diagnostic criteria.

All program activities are to be provided under the Vision and Guiding Principles established by Nevada's Behavioral Health Community Planning Committee. The vision is that Nevadans, regardless of age or ability will enjoy a meaningful life led with dignity and self-determination.

The DHHS Strategic Framework has adopted the following guiding principles:

- ➢ *Independence:* People should have options and the ability to select how they live.
- ➢ *Access:* People's needs are identified and met quickly.
- ➢ *Dignity:* People are viewed and respected as human beings.
- ➢ *Integration:* People can live, work, and play as part of their community.
- ➢ *Quality:* Services and supports achieve desired outcomes.
- ➢ *Sustainability*: Services and supports can be delivered over the long term so individuals can be self-sufficient.

The MHBG provides mental health service agencies throughout Nevada with a degree of flexibility to design and implement mental health related services and activities to address the complex needs of individuals, families, and communities with SMI and children with SED specific to our population. The purpose of the block grant program is to support these services.

In order to ensure that the block grant program continues to support the needed and necessary services for the identified target population(s), SAMHSA has indicated that Nevada may use block grants:

1) To fund priority treatment and support services for individuals without insurance, underinsured or for whom coverage is terminated for short periods of time;

2) To fund those priority treatment and support services not covered by Children's Health Insurance Program (CHIP), Medicaid, Medicare, or private insurance for low-income individuals and that demonstrate success in improving outcomes and/or supporting recovery; and

3) To collect performance and outcome data for mental health and substance use, determine the ongoing effectiveness of promotion, treatment and supportive services and to plan the implementation of new services.

Targeted populations that Nevada's MHBG program will serve include:

- Children with SED and their families (Age 0-17)
- Adults with SMI (Age 18-64)

- Older Adults with SMI (65 years or older)
- Individuals with SMI or SED in the rural and homeless populations
- Individuals with first episode psychosis or early SMI

DPBH and DHHS are strong advocates of prevention, early intervention, treatment and referral in order to have a coordinated system of care. This past year, Nevada was able to implement The Nevada Resilience Project. This project focuses on early intervention, resource and referral for individuals experiencing crisis. Nevada's Resilience Ambassadors provide education, information, counseling, and resource navigation while promoting healthy coping, empowerment, and resilience. Nevada provides bi-lingual access to services; assistance navigating to needed resources; support to reduce stress, build coping skills, and develop a resilience plan.

Nevada NAVIGATE Early Treatment Program for First Episode of Psychosis (FEP)
This evidence-based intervention evolved from the National Institute of Mental Health RAISE (Recovery After an Initial Schizophrenia Episode) research initiative (Heinssen et al., Evidence-based Treatments for First Episode of Psychosis: Components of Coordinated Specialty Care, April 2014), and its efficacy and feasibility have been demonstrated within community mental health settings and for rural and low-density population regions in the United States (Kane et al., Am J Psychiatry, 2016 April 1; 173(4): 362–372). Coordinated specialty care (CSC) is being provided to Nevada residents by multi-disciplinary teams of mental health professionals whose expertise span biological, psychological and social work domains. Recovery-oriented interventions involve clients, CSC Team members and, when appropriate, family members and significant others. This program is manualized and includes four core interventions (April 2020, Revised Versions: https://navigateconsultants.org/manuals/): Individual Psychotherapy; Pharmacotherapy & Primary (Medical) Care Coordination; Family Education Program; and Supported Employment & Education. Case Management and Peer Support Services are also provided.

Access to Services for Early Serious Mental Illness (ESMI) and First-Episode Psychosis (FEP) in Nevada, 2019-2021
Beginning in 2019, the State of Nevada adopted the strategic goal of achieving statewide implementation of evidence-based coordinated specialty care for residents who are experiencing early-stage schizophrenia spectrum and other psychotic disorders, including schizophrenia, schizoaffective disorder, schizophreniform disorder, brief psychotic disorder, and other specified schizophrenia spectrum and other psychotic disorder. The current status of access to coordinated specialty care services for this population in Nevada is summarized by State statute-defined behavioral health region (below).

1. Northern Behavioral Health Region: Carson Tahoe Health, Behavioral Health Services, Carson City, Nevada was the first site selected to implement the Nevada NAVIGATE early treatment program of CSC to serve individuals experiencing first-episode psychosis and living in Carson City and the counties of Churchill, Douglas, Lyon and Storey. The Carson Tahoe FEP Program opened its doors in February 2019 and is active and ongoing.

2. Clark Behavioral Health Region: University of Nevada, Las Vegas/Mojave Counseling, Las Vegas, Nevada was the second site selected to implement the Nevada NAVIGATE early treatment program of CSC to serve individuals experiencing first-episode psychosis and living in Clark County and the portion of Nye County that is south of the 38th parallel of north latitude (NRS 433.314). The UNLV/Mojave Counseling FEP Early Treatment Program opened its doors in February 2020 and is active and ongoing.

3. Washoe Behavioral Health Region: University of Nevada, Reno, School of Medicine, Department of

Psychiatry and Behavioral Sciences, Reno, Nevada was the third site selected to implement the Nevada NAVIGATE early treatment program of CSC to serve individuals experiencing first-episode psychosis and living in Washoe County. The University Health First Episode of Psychosis Program will begin enrolling patients in August 2021.

Crisis Services

Nevada is moving toward building a Crisis Care Response System that is both supportive of local communities, families, and individuals by fostering resilience, and responsive to the needs of individuals in crisis. The development of a Crisis Care Response System in Nevada is possible and existing infrastructure is in place to support, at least in part, each of the core elements of the Crisis Care Response Model.

Crisis Call Center Hub

The greatest asset in Nevada for Crisis Call Center Hubs is Crisis Support Services of Nevada (CSSNV). It is available to individuals and professional organizations throughout the entire state. CSSNV provides immediate crisis support via numerous technological platforms and can coordinate referrals to other resources and establish connections to other crisis response services, such as Mobile Crisis Teams or Crisis Stabilization Program.
In addition to this statewide service, there are also several local crisis lines available in certain regions. For example, Vitality Unlimited in the Rural Region has a locally operated crisis line that contracts with CSSNV for after-hours crisis calls. There are several examples of this in different counties, and having these lines operating at a local level has proven to be beneficial in being able to bring individuals into other services offered by the agencies operating these local crisis lines. Nevada has one of six National Suicide Prevention Lifeline National Call Centers and the crisis line is experiencing great success deploying resources when necessary and otherwise deescalating people in crisis.

Mobile Crisis

Similar to the implementation of different crisis call lines, several regions and counties in Nevada have been resourceful in developing different types of mobile outreach units. Various configurations of mobile crisis teams have already been established throughout the state and include law enforcement deflection and diversion programs. There are several examples of units that are connected to hospitals, such as Desert Parkway Behavioral Health in Las Vegas, or law enforcement agencies, such as MOST in Washoe County. These connections between Mobile Crisis Teams and agencies that have the capacity to offer other targeted services can be invaluable to an individual experiencing a crisis. These programs are also facilitating diversion from hospitals and meeting patients where they are at in the community. Children's mobile crisis response is currently being expanded in both northern and southern areas of Nevada through the use of the SAMHSA COVID-19 Emergency Behavioral Health Grant. The close relationship between Mobile Crisis Teams and law enforcement is known to be very effective in de-escalating crisis situations and diverting individuals from held in a jail or emergency department.
For the Mobile Crisis Teams that are in place in Nevada, many are utilizing assessment tools, prioritizing safety and security, and providing connections to other resources for the individuals they serve. These resources are implemented by licensed mental health professionals that are staffed as part of the Mobile Crisis Teams that are in place. The clinical understanding and training that these professionals bring to these teams can be very effective in ensuring the safety and security of everyone involved in responding to a crisis.

Crisis Stabilization Programs

In more populated areas, there are several options for acute and sub-acute care. In the areas where crisis stabilization programs are easily accessible, there are psychiatric and clinical mental health staff on site to

support individuals beyond a crisis. Staff is also provided with adequate training on suicide prevention, trauma-informed care, and safety and security practices for crisis stabilization. These regions also have the infrastructure to support the recommended ratio for the number of beds per 100,000 residents in each area. Community Triage Centers were defined in Nevada Revised Statute in 2005 and provide a different pathway for accessing mental health services, ensuring stabilization within a community setting without first accessing a hospital. These centers were funded creatively, including resources from both state and local sources. Currently, there are three Triage Centers operating in Nevada (two in Las Vegas, and one in Reno). With the additional funding obtained through the SAMHSA COVID-19 Emergency Behavioral Health Grant, two hospitals are expanding to provide this crisis stabilization as an alternative to an emergency department for individuals in crisis (Desert Parkway Behavioral Healthcare Hospital in Las Vegas, and Reno Behavioral Healthcare Hospital in Reno). (Woodard, 2020) Crisis Stabilization Programs are intended to provide more than just a bed to individuals, and instead offer a welcoming environment to provide compassionate care that supports an individual both during a crisis and after they return to their community. (Stephanie Woodard, 2020)

Essential Principles

Across the state, there is reference to various staff in different programs being trained in practices such as Zero Suicide, evidence-based assessment tools, and suicide prevention. There is also a consistent reference to prioritizing safety and security in crisis response services. It appears in all five regions that there is significant buy-in for a Crisis Care Response System. This benefits not only those in crisis, but also those providing crisis support services. Several regions also referenced the use of trauma-informed care among staff within crisis response agencies such as the crisis call center hubs that are used, the mobile team clinicians, and the staff in crisis stabilization facilities. There are four elements include prioritizing focus on safety and security, implementing suicide care best practices, including screening, planning, and follow-up, utilization of a trauma-informed recovery model, and having peer support in crisis response services. In Nevada, the Office of Suicide Prevention has committed to these essential principles as part of their suicide prevention efforts. Since their inception they have worked to implement evidence-based practices for suicide screenings, such as Signs of Suicide in Nevada schools, training and outreach for professionals in numerous disciplines across the state, and they have worked to establish partnerships with other agencies to collaborate and coordinate their work to prevent suicide. Additional foundational elements of an improved mental health system are in place with mental health uniformity, insurance coverage expansion resulting from the Affordable Care Act, the launch of the Certified Community Behavioral Health Centers, the Excellence in Mental Health Act, and the implementation of First Episode Psychosis programs throughout the state. The state has also moved to implement OpenBeds technology to support these efforts. Further funding is coming in from the Crisis Counseling Assistance and Training Grant offered by the Federal Management Agency (FEMA) and SAMHSA. These funds are intended to bring a total of 31 crisis counselors to Nevada across all regions to support individuals seeking assistance related to COVID-19.

Clinical Services

Nevada's adult mental health clinical services are organized into three regions: Northern, Southern, and Rural. Four agencies deliver mental health services throughout these regions: Lake's Crossing Center (LCC), Stein Forensic Hospital (Stein), Northern Nevada Adult Mental Health Services (NNAMHS), Southern Nevada Adult Mental Health Services (SNAMHS), and Rural Clinics (RC).

Northern Region

LCC provides comprehensive forensic mental health services. This agency provides evaluation and/or treatment for court-ordered individuals to restore them to legal competency. This facility also provides

outpatient evaluations of legal competency, risk assessments, and recommendations for treatment for individuals living in the northern rural counties and Washoe County. LCC is Nevada's only maximum-security facility. As such, the agency serves people from throughout the state.

NNAMHS is a comprehensive, community-based behavioral health agency for adults; the agency is fully accredited by The Joint Commission and is certified by the Centers for Medicare and Medicaid Services (CMS). Services are provided on a sliding fee scale, and the agency accepts private insurance; Medicaid; and Medicare.

Southern Region

Stein provides comprehensive forensic mental health services. This agency provides evaluation and/or treatment for court-ordered individuals to restore them to legal competency. This facility also provides outpatient evaluations of legal competency, risk assessments, and recommendations for treatment for individuals living in the Southern and Clark Counties. Stein is a medium-secure facility.

SNAMHS provides mental health services for adults living in Clark County and for adults, children, and adolescents living in rural counties (Nye and Lincoln) that may be closer geographically to this agency than to a rural mental health center. The agency also provides services for the adult forensic population. The main campus is co-located with the state hospital for children and adolescents and with the southern facility for individuals who have intellectual disabilities. SNAMHS has five regional behavioral health clinics; three are urban and two are rural. SNAMHS is fully accredited by The Joint Commission and is certified by CMS.

Rural Region

RCs are facilities located in areas not designated as an urban area by the Bureau of the Census, where medical services are provided by licensed physician assistants or by advanced practice registered nurses who are under the supervision of licensed physicians (NRS 449.0175). RCs provide a full array of outpatient behavioral health services for adults and children in 16 clinics in 12 counties situated in the rural and frontier areas of the state between Clark and Washoe counties. These centers provide comprehensive services to severely emotionally disturbed (SED) children and adolescents, as well as adults with serious mental illness, and most of the RCs provide crisis service during business hours.

In the more remote areas of the state (Hawthorne, Lovelock, Tonopah, and Panaca) where therapists are not frequently available on site, medical staffs of Board-Certified Psychiatrists and Advanced Practice Nurses provide a variety of health care services through the use of telehealth, which is audiovisual communication technology. Medical staff from different offices also use telehealth for ”hard-to-treat” cases.

RCs also co-locate the Community Health Nursing (CHN) program in 14 rural and frontier communities. The CHN program provides public health nursing, preventative health care, early detection of threats to public health, disaster response, and education. Services include adult and child immunizations, well child examinations, chronic disease education, lead testing, family planning, cancer screenings, and the identification and treatment of communicable diseases including sexually transmitted infections, and tuberculosis (TB).

RCs provide mental health services to adults and children in all counties with the exception of the two most populated counties in the state, Clark (the greater Las Vegas area) and Washoe (the Reno/Sparks

area). Services are provided for people who qualify regardless of their ability to pay.

Services include: assessment and diagnosis, testing, basic medical and therapeutic services, crisis intervention, therapy (family, group, and individual), outpatient, intensive outpatient, partial hospitalization, medication management, medication training and support, and case management.

In addition, DPBH either provides or has funded providers to be able to offer a number of specialty services:

- **Assertive Community Treatment (ACT):** These specialized, mobile, multidisciplinary teams provide intensive, integrated, community-based mental health services where and when they are needed. ACT teams serve individuals with serious mental illnesses who tend to have significant thought disorders, higher rates of substance-related disorders, histories of victimization and trauma, repeated hospitalizations, heightened arrests and incarcerations, homelessness, and additional functional challenges related to the lack of supportive social relationships and the lack of employment. Services are personalized, and care is comprehensive and not time limited.
- **Assisted Outpatient Treatment (AOT):** AOT provides involuntary court-ordered, community-based outpatient treatment for individuals who are diagnosed with severe and persistent mental health conditions and who have a recent, repeated history of medication noncompliance and/or incarceration.
- **Certified Community Behavioral Health Clinics (CCBHC):** These organizations are designed to improve the behavioral health outcomes for targeted populations through innovation and transformation of the primary and behavioral health care delivery systems. CCBHCs serve the 'whole person' by offering person-centered and family-centered care. These community-based clinics serve: 1) Adults with serious mental illnesses; 2) Children with serious emotional disturbances and their families; 3) Individuals with severe substance-related disorders; and 4) Individuals with mild to moderate co-occurring mental health and substance-related disorders. CCBHCs provide: crisis services; outpatient primary care screening and monitoring; outpatient mental health and substance-related disorder screening, assessment, diagnosis, risk assessment, and treatment; targeted case management; peer support; family support and counseling; and psychiatric rehabilitation services. The CCBHCs serve any eligible individual in need of care regardless of the person's ability to pay for the service. There are currently three CCBHCs in Nevada, and seven agencies are in the process of becoming certified as CCBHCs.
- **Crisis Intervention Teams (CIT):** These teams provide crisis intervention services for individuals with behavioral health disorders; they create connections between law enforcement, mental health providers, and ERs. The CITs also provide a 40-hour training for professionals who are interested in working with this population.
- **Forensic Assessment Service Triage Teams:** These jail-based multi-disciplinary teams are comprised of staff from social service agencies, mental health agencies, and substance-related treatment agencies. Services include behavioral health screenings, criminogenic risk/needs screenings and assessments, educational groups, medical referrals, case management, and peer recovery supports. The services are provided while the individuals are incarcerated and as they re-enter the community.
- **Forensic Mental Health Services:** Clinicians provide maximum-security inpatient treatment of people who are mentally disordered and who are involved in the criminal justice system. Services also include outpatient evaluations of competence.
- **Intensive Service Coordination (ISC):** This is an increased level of service coordination for

individuals who are diagnosed with mental illnesses and who have felony legal involvement. Individuals are referred by the judicial system or by agency programs. ISC assists high-need individuals in getting services necessary to live in the community and to understand and comply with their court orders.

- **Juvenile Justice Assessment Services Triage Teams:** These county-based teams provide an early mental health diversion program for youth involved in the criminal justice system. The teams consist of juvenile probation officers, mental health providers, and the juveniles and their families.
- **Mental Health Court:** This specialty court is a multijurisdictional, community-based program that provides court supervision and services to justice-involved individuals who have mental illnesses. The program provides participants with behavioral health treatment and supportive services such as basic skills training, case management for court compliance activities, medication management, supervision, transportation, and housing.
- **Mobile Crisis and Outreach Services:** Clinicians provide evaluations within hospital emergency departments or provide psychiatric services to people who are experiencing homelessness, have mental illnesses, and who are involved with law enforcement.
- **Mobile Crises Response Teams:** These youth-specific teams support youth and their families in behavioral and mental health crisis situations and help them find community services. The teams are designed to reduce hospital emergency room (ER) visits due to a psychiatric crisis and to reduce psychiatric hospitalizations by providing immediate support and crisis interventions, short-term stabilization, and case management services. Interventions are provided in the community, in the home, and through mobile consultation.
- **Mobile Outreach Safety Teams:** These county-based teams provide psychiatric services to individuals who have mental illnesses and who are homeless and to individuals who have mental illnesses and who are involved with law enforcement. Depending on the county, the teams are composed of a mental health clinician, a law enforcement deputy, and a social services case manager. Also depending on the county, the teams respond to law enforcement calls; psychiatric emergencies; and community referrals. They also provide community outreach and maintenance check-ups for individuals who have received previous contacts with the team.
- **Outpatient Psychiatric Services:** These services include ongoing psychiatric care for individuals with mental health diagnoses, such as depressive disorders; bipolar disorders; anxiety disorders; schizophrenia; and post-traumatic stress disorder. Services include pharmacy services and medication monitoring.
- **Psychiatric Assessment Services:** These services Include intake and screening for all psychiatric services and initial assessment and referrals to an outpatient program or to a stabilization unit.
- **Residential Support:** This service includes a range of community housing and assisted living options for individuals with serious mental health disorders. Alternative living arrangements include: family group homes, supported living apartments, substance-related disorder treatment facilities, Housing & Urban Development programs, and specialized rehabilitation homes.
- **Service Coordination:** This service assists individuals to obtain benefits and services throughout the community. Services include coaching and other supports designed to keep the individuals engaged in treatment and in recovery.
- **Telehealth:** This is a telecommunications system that facilitates the provision of health care services from a health care provider at one location to a recipient at a different location through the use of information and audiovisual communication technology. The system is

used for professional consultations, office visits, office psychiatry services, and a limited number of other medical services.

OVERVIEW OF THE CHILDREN'S MENTAL HEALTH SYSTEM AND SYSTEM ORGANIZATION

Children's services are currently provided by the Division of Child and Family Services. They provide services through Children's Mobile Crisis Teams which will continue to be expanded in order to service youth throughout the state. Children/Youth are also seen in psychiatric care units. There is also the availability to expand a psychiatric access line also specific or youth care. Nevada is working with non-profit direct service providers to increase access of care for youth and adolescent, which may include working through partners engaged with youth populations at schools, community centers, or other family serving organizations.
In 2018 Nevada published Nevada's Behavioral Health Community Integration Strategic Plan and priorities included the following children's services:

- Juvenile justice diversion
- Residential treatment facility treatment capacity, discharges and linkages to services
- Transitional Age Youth services
- Access to services: crisis services, partial hospitalization programs (PHP), intensive outpatient programming (IOP), day treatment, wraparound, respite, family peer support and habilitation services. (DHHS, 2018)

Nevada's children's behavioral health system encompasses the emotional, mental, physical, and social well-being of children from infancy through adolescence. Nevada incorporates a system of care (SOC) approach to children's mental health that guides the method in which services are delivered. The SOC is designed to meet the multiple and changing needs of families, children, and youth through a strength-based, family-driven, comprehensive, integrated, and coordinated continuum of services and supports. Oversite of children's mental health is statutorily mandated through NRS Chapter 433 (state agencies only) and NRS 433B for Clark, Washoe, and Rural Children's Mental Health Consortiums.

Division of Children and Family Services

DCFS is responsible for the operation of state-funded children's outpatient community mental health programs, residential programs, juvenile justice programs, and foster care programs. As legislated by NRS 433, the division is responsible for planning; administration; policy setting; monitoring; and budget development of all state-operated children's mental health programs in Washoe and Clark Counties. The DCFS Administrator coordinates the administration of children's behavioral health services with the SSA and the SMHA. In addition, the DCFS administration is also directly involved in decisions regarding agency structure; staffing; program administration; and budget development.

DCFS receives oversight and direction through stakeholder and advisory groups: The Nevada Commission on Behavioral Health, the statewide Children's Behavioral Health Consortium and the Regional Children's Mental Health Consortia. The Regional Consortia are required by statute and offer recommendations on the children's behavioral health service-array to the Nevada Commission on Behavioral Health and to the legislature. These consortia are supported by staff from DCFS's Planning and Evaluation Unit (PEU).

DCFS is currently implementing its second four-year SAMHSA System of Care Expansion Grant, which is a complement to previous SOC grants DCFS was awarded, including a recent Expansion grant focused on urban Nevada. The division and its grant partner, Nevada Parents Encouraging Parents – Statewide Family Network (which offers training, resources, and support to parents who have children with disabilities ages 0-26), share responsibility for implementing the grant. The current SOC grant focuses on building out the service array in Rural Nevada and creating an infrastructure for DCFS to serve as the Children's Mental Health Authority. In this role DCFS will set provider standards, provide training and technical assistance to providers, and will provide quality oversight over children's mental and behavioral health services in Nevada. Within Quality & Oversight, PEU and SOC grant-staff conduct strategic planning; provide trainings for providers; facilitate the implementation of evidence-based practices; and provide quality assurance activities.

DCFS staff also collaborate with Nevada's CCBHCs on training related to children's services; provide consultation to childcare centers, foster care providers, and juvenile justice facilities; and provide input in numerous statewide initiatives to improve access to services for youth.

Other initiatives include collaborating with other Nevada divisions to determine the state's role in assuring, providing, funding, and regulating behavioral health services to promote community integration; workforce development and training; and state planning for integrating physical and behavioral health including the division's recent Human Resources and Services Administration Pediatric Mental Health Access grant award.

Children's Community-Based and Residential Services

DCFS is a direct service provider and serves children and families who have fee-for-service Medicaid, have certain managed care Medicaid coverage, are uninsured, or are underinsured. DCFS provides services in the two urban areas of the state, a) Reno area (Northern Nevada) and b) Las Vegas area (Southern Nevada). In Las Vegas, DCFS has three neighborhood care centers, plus 24-hour care facilities. In Northern Nevada, there is one outpatient facility and several 24-hour care facilities. There are two youth centers located in rural Nevada. Outpatient behavioral health services for children in rural Nevada are provided by DPBH. Depending on the region, DCFS provides the following community-based services:

Caliente Youth Center: This is a secure facility for male and female youth who are committed to DCFS by the juvenile court. The center follows a criminogenic model that targets the individuals' crime-producing needs in order to improve treatment outcomes and to reduce the risk of recidivism. Upon successful completion of the programming within the center, youth are released back into the community with supervision and case management services provided by Youth Parole. Youth committed for mental health treatment are placed directly on parole and receive treatment and case management services based on their identified needs.

Desert Willow Treatment Center: This center provides intensive mental health services in a secure environment with both an acute care unit and a residential treatment unit. The acute care unit serves children with critical mental health conditions and provides short-term psychiatric, diagnostic, and stabilization services. The residential unit provides longer-term care to youth who cannot currently be served with community-based programming.

Early Childhood Mental Health Services: These services are for children between birth

and six years of age who have emotional disturbances or who may be at high-risk for developing emotional and behavioral disturbances and the associated developmental delays. The goals of services are to strengthen parent-child relationships, support the family's capacity to care for their children, and enhance the child's social and emotional functioning. Services include: behavioral and psychological assessments; psychiatric services; family, individual, and group therapies and behavioral management; day treatment; clinical case management; in-home crisis intervention; childcare and pre-school consultation, outreach, parent training; and consultation to other child-serving providers.

Mobile Crisis Response Teams: These teams provide information, crisis response (at any location), and stabilization services to children and adolescents in the community up to age 18. The teams also provide up to 45 days of in-home stabilization services following a crisis response, and families are linked to their current provider or connected to new long-term services and supports. Services are available 24 hours per day.

Nevada Youth Training Center: This is a staff-secure facility for male youth who are committed to DCFS by the juvenile court. The program follows a criminogenic model that targets the individuals' crime-producing needs in order to improve treatment outcomes and to reduce the risk of recidivism. Upon successful completion of the program, youth are released back into the community with supervision and case management services provided by youth parole. Youth committed for mental health treatment are placed directly on parole and receive treatment and case management services based on their identified needs.

Psychiatric Residential Treatment Facilities: These highly structured, staff-secure treatment homes provide round-the-clock care, mental health assessment, psychiatric assessment and evaluation, psychoeducation, and mental health rehabilitation services. There are two facilities located in Northern Nevada and one located in Southern Nevada.

Outpatient Mental Health Services: These community-based, family-oriented, mental health services are for children from 6 through 17 years of age. They include: clinical case management; psychiatric services; psychological assessment and evaluation; individual, family, and group therapies and behavioral management; care coordination with other child serving entities involved with the child and family; and 24-hour on-call emergency professional coverage.

Specialized Foster Care: Pursuant to NRS 424.041-424.043, DCFS is authorized to act as the oversight body over specialized foster care. Specialized foster care is an "advanced" version of traditional foster care that targets youth who have behavioral or mental health needs that cannot be met in traditional family foster care; are struggling to maintain placement in traditional family foster care due to behavioral and emotional needs; have disrupted from a placement due to behavioral and mental health needs; and/or are returning or stepping down from a higher level of care. With specialized foster care, staff provide foster parents with additional training, support, and consultation in order to provide specialized care and support to high-needs youth. Like other programs within a system of care approach, a fundamental assumption of treatment foster care is that the most effective treatment environment for a youth is his/her home, community, and school. Within this model, foster parents pay close attention to the youth's behavior on a daily basis and are in close communication with other members of the youth's treatment team in order to provide individualized, coordinated treatment.

Summit View Youth Center: This is a maximum-security facility for male youth who are involved in the juvenile justice system. The program follows a criminogenic model that targets the individuals' crime-producing needs in order to improve outcomes and to reduce the risk of recidivism. The center also includes an education program that is provided on-site through the Clark County School District.

Wraparound in Nevada (WIN): WIN is an ecologically based process and approach to care planning that builds on the collective action of a committed group of family, friends, community, professionals, and cross-system supports. WIN mobilizes resources and talents from a variety of sources resulting in the creation of a plan of care that is the best fit between the family vision and story, team mission, strengths, needs, and strategies. WIN in Northern Nevada and Rural Nevada includes both High Fidelity Wraparound services and FOCUS. FOCUS is an intermediate care coordination model that supports youth and their families who do not rise to the intensive WIN level of care but who are multi-system involved, at risk of deeper system involvement, and whose challenges exceed the resources of a single organization.

OVERVIEW OF THE SUBSTANCE USE DISORDER SYSTEM

Substance Abuse Prevention and Treatment Agency

The Substance Abuse Prevention and Treatment Agency (SAPTA) is part of the Bureau of Behavioral Health Wellness and Prevention (BBHWP) within the DPBH. Pursuant to NRS 458.025 and the Nevada Administrative Code (NAC) 458, SAPTA has the regulatory authority to govern the substance-related prevention and treatment programs and services. As such, SAPTA serves as the SSA for the Federal Substance Abuse Prevention and Treatment Block Grant. The role of the SSA with respect to the delivery of substance use disorder services includes: 1) formulation and implementation of a state plan for prevention, early intervention, treatment, and recovery support; 2) statewide coordination and distribution of all state and federal funding (tax dollars, general fund, and grants) for community-based public and nonprofit organizations; 3) development and publication of standards for certification, such as the requirement that certified programs adopt evidenced-based programs and practices; and 4) certification of facilities, programs, and services.

Certification of Alcohol and Other Drug Abuse Programs

The State of Nevada has a comprehensive process to oversee the statewide substance use prevention and treatment programs. Programs receiving any state or federal funding through DPBH must be certified by the Division as required in NRS 458/NAC 458, which relates to operational; personnel; programmatic; and clinical services. In addition, Medicaid Chapter 400 requires any programs seeking reimbursement for substance use treatment and/or co-occurring treatment under Provider Type 17-215 be certified through SAPTA under NAC 458 and Division Criteria established through NAC 458. SAPTA, through its contractor, the University of Nevada, Reno's Center for the Application of Substance Abuse Technologies (CASAT) certifies the coalitions, prevention, and treatment programs based on the types of services they provide. SAPTA maintains an on-line, searchable database for treatment services with quality indicators to assist individuals in locating treatment programs across the state.

Adult Substance Use Treatment Services:

- **Level 0.5: Early Intervention**
- **Level 1: Outpatient**
- **Level 2.1: Intensive Outpatient**
- **Level 2.5: Partial Hospitalization**
- **Level 3.1: Clinically Managed Low Intensity Residential**
- **Level 1-WM: Ambulatory Withdrawal Management**
- **Level 3.2-WM: Clinically Managed Residential Withdrawal Management – This level of service exceeds ASAM requirements.**
- **Level 3.5: Clinically Managed High-Intensity Residential – This level of service exceeds ASAM requirements.**
- **Level 3.7: Medically Monitored Intensive Inpatient**
- **Level 3.7-WM: Medically Monitored Inpatient Withdrawal Management – This level of service exceeds ASAM requirements.**
- **Office-Based Opioid Treatment: Level 1: Outpatient**
- **Office-Based Opioid Treatment: Level 2.1: Intensive Outpatient**
- **Integrated Opioid Treatment and Recovery Services:** There are two options for certification under this designation, and the provider can only be certified for one of the options: Option 1: Opioid Treatment Program – Uses methadone and other FDA approved medications for the treatment of an opioid use disorder; Option 2: MAT Program - Uses a minimum two of the three FDA approved medications for an opioid use disorder. The provider shall also have a formal written care coordination plan with an opioid treatment program that utilizes methadone.
- **Opioid Treatment Program** (Level 1: Outpatient and Level 1: Withdrawal Management)

Adolescent Substance Use Treatment Services:

- **Level 0.5: Early Intervention**
- **Level 1: Outpatient**
- **Level 2.1: Intensive Outpatient**
- **Level 2.5: Partial Hospitalization**
- **Level 3.1: Clinically Managed Low-Intensity Residential**
- **Level 1-WM: Ambulatory Withdrawal Management**
- **Level 3.2-WM: Clinically Managed Residential Withdrawal Management**
- **Level 3.5: Clinically Managed Medium-Intensity Residential**
- **Level 3.7: Medically Monitored High-Intensity Inpatient**
- **Level 3.7-WM: Medically Monitored Inpatient Withdrawal Management**
- **Office-Based Opioid Treatment: Level 1: Outpatient**
- **Office-Based Opioid Treatment: Level 2.1: Intensive Outpatient**
- **Opioid Treatment Program** (includes Level 1: Outpatient and Level 1: Withdrawal Management)

Division Criteria Services

- **Civil Protective Custody (CPC) (alcohol) (NRS 458.270)** – These programs provide intoxication management services for persons taken into CPC by a peace officer for being under the influence of alcohol in a public place and unable to provide for the health or safety of self or others. CPC is not provided in a jail. The CPC facility must be a provider that is SAPTA-certified

for Withdrawal Management: Level 3.2 WM Clinically Managed Residential Withdrawal Management or Level 3.7 WM Medically Monitored Inpatient Withdrawal Management. Required Services: 1) During intake, a BAC and/or urine screen will be administered; 2) At the earliest practical time, the person's family or next of kin must be advised they are in CPC if they can be located; 3) The person's vital signs must be monitored at least once every two hours during the person's waking hours by a staff with a nursing license, physician license, or SAPTA detoxification technician certificate; 4) Prior to discharge, a good faith effort must be made to advise the person of his/her treatment options, and if the person was taken into custody for a public offense, the person must be remanded to the custody of the apprehending peace officer upon release from the withdrawal management unit. ((NRS 458.270 (4)); and 5) The person may not be required against his or her will to remain in a licensed facility or detention facility longer than 48 hours. (NRS 458.270 (3)).

- **Civil Protective Custody (CPC) (controlled substance) (NRS 458.175)** – These programs provide intoxication management for persons taken into CPC by a peace officer for being unlawfully under the influence of drugs in a public place and unable to provide for the health or safety of self or others (NRS 458.175). CPC is not provided in a jail. The CPC facility must be a provider that is SAPTA certified for Withdrawal Management: Level 3.2 WM Clinically Managed Residential Withdrawal Management or Level 3.7 WM Medically Monitored Inpatient Withdrawal Management. Required services: 1) during intake, a BAC and/or urine screen will be administered; 2) the person's vital signs must be monitored at least once every two hours during the person's waking hours by a staff with a nursing license, physician license, or SAPTA detoxification technician certificate; and 3) upon release from the withdrawal management unit, the person must immediately be remanded to the custody of the apprehending peace officer.
- **Co-Occurring Disorder Certification and Service Endorsements (Adult and Adolescent)** - Providers with Service Endorsements are certified for specific treatment levels of service and receive an endorsement for Co-Occurring Disorder services based on the Dual Diagnosis Capability in Addiction Treatment (DDCAT) Rating Scale. The DDCAT is an evidence-based benchmark instrument for measuring a provider's capacity to deliver integrated services for persons with co-occurring mental health and substance use disorders. SAPTA uses the DDCAT to certify programs as Co-Occurring Capable or Co-Occurring Enhanced. Currently, 14 programs are certified as Co-Occurring Enhanced, and 100 programs are certified as Co-Occurring Disorder Capable.
- **Drug Court Service (Adult and Adolescent)** - Provides general assessment and referral for adult clients referred from local and state courts/municipalities related to alcohol and other drug violations. The program complies with all applicable provisions of NAC 458.
- **Evaluation Center** – These programs determine whether a person is appropriate for substance use treatment per ASAM criteria. The program complies with all applicable provisions of NAC 458.
- **Transitional Housing (Adult and Adolescent)** - Services consist of a supportive living environment for individuals who are receiving substance-related treatment in an SAPTA-certified Intensive Outpatient, or Outpatient program and who are without appropriate living alternatives. Individuals admitted to Transitional Housing services must be concurrently admitted to a Level 1 Outpatient program or to a Level 2.1 Intensive Outpatient program, per an assessment.

Certification of Substance Use Disorder Programs

Nevada Revised Statutes (NRS) 458.025 requires that any alcohol and drug abuse program that receives state and/or federal funds through the Substance Abuse Prevention and Treatment Agency (SAPTA) must be certified by SAPTA. Nevada Administrative Code (NAC) 458 outlines the requirements necessary to obtain program certification, and allows SAPTA or its designated contractor to inspect each program that is certified to determine if state certification should be continued. In addition to NAC 458, and Division Criteria, programs are eligible to bill SAPTA if approved through the Request for Qualifications (RFQ) process which specifies the type of services to be provided and places specific requirements upon those programs receiving funding. Additionally, Providers who bill Medicaid under Provider Type 17 must be certified by SAPTA.

§ State Certification is available to any alcohol and drug use program, which meets the requirements for certification identified in NAC 458. Certification can be for a period of up to two years. State Certification determines if a program has met minimum requirements related to service delivery. Certification is mandatory for all programs receiving SAPTA grant funding through the RFQ process and programs that bill Medicaid under Provider Type 17. Other than for DUI Evaluation Centers and Opioid Treatment Programs, certification is optional for programs that do not receive SAPTA funding or bill Medicaid under Provider Type 17. Certification determines if a program has the necessary organizational structure and staff to provide a specified service.

Administrative Programs

Programs receiving SAPTA funding, both directly and indirectly, are required to participate in compliance monitoring. This function is regulatory in nature and focuses on administrative, programming, and fiscal activities of a program. All administrative programs are mandated to participate in any evaluation process that is required by their funding sources. Funded and certified agencies must comply with all evaluation requirements set forth by both the state and the federal evaluators.

Certified, Funded, Programs

SAPTA currently certifies and funds 20 agencies for a total of 50 *adult* substance use treatment programs and a total of 21 certified *adolescent* substance use treatment programs.

Certified, Non-Funded, Programs

With the exception of Driving Under the Influence (DUI) Evaluation Centers and Opioid Treatment Programs, certification is optional for programs not receiving SAPTA funding or not billing Medicaid under Provider Type 17-215. DUI Evaluation Centers located within counties with populations of 100,000 or more are not funded by SAPTA but must be certified. Agencies that are not funded often choose to become certified in order to obtain Medicaid, to meet third-party requirements, to better compete for grants, or to meet the requirements from drug courts and other types of courts that will only work with certified providers even though certification for those programs is not required in statute and regulations. SAPTA currently certifies, but does not fund, 69 agencies for a total of 81 *adult* substance use treatment programs and a total of 26 *adolescent* substance use treatment programs.

Licensure of Alcohol and Drug Treatment Facilities

In addition to certification, any residential substance use treatment program (regardless of funding source) is required by NRS/NAC 449 to be licensed as an Alcohol and Drug Treatment Facility. Pursuant to NAC 449, licensed residential substance use treatment facilities are overseen by the Nevada Bureau of Health Care Quality and Compliance (HCQC), which focuses on the health and safety aspects of licensing. Under NAC 449, programs using methadone for the treatment of an opioid use disorder must be licensed as a Narcotic Treatment Program by HCQC and must be certified by SAPTA as Ambulatory Withdrawal Management and Level 1 Outpatient. CASAT and HCQC work closely together to provide oversite and quality improvement of certified and licensed programs.

Program Funding

State General Funds - Financing behavioral health services in Nevada depends on state general fund revenue with contributions from grants and Medicaid. Each service system has its own budget established within the state system. The Division of Health Care Financing and Policy (DHCFP), also known as Nevada Medicaid, operates Medicaid Fee-For-Service (rural Nevada); the Managed Care Organizations (MCO) (urban Nevada); and the Care Management Organization (CMO) for patient centered care in rural Nevada. The prioritization of projects and funding is based on the Governor's performance-based budgeting, state strategic and need based plans, as approved by the Nevada State Legislature. With the cross-over of systems and supports, Nevada is able to utilize the sources of funding and resources most effectively.

State General fund dollars are primarily used for funding infrastructure to expand services, prevention and treatment services, services for justice involved individuals, the re-entry population, and individuals/families with social services referrals in the state of Nevada.

Substance Abuse Block Grant – Collaboration with our state Medicaid agency resulted in the addition of Medicaid coverage of substance use disorder services effective January 2014. This has offset the need for general fund and block grant funding for treatment services provided in the Medicaid-approved model. Medicaid generously worked with SAPTA to develop a Provider Type 17 agency model that resulted in all nineteen providers being able to bill and be reimbursed by Medicaid.

In response to the changing needs of the treatment delivery system, SAPTA is shifting its block grant funding previously needed for treatment that Medicaid normally pays for such as outpatient and intensive outpatient to enhancing "gap" services. Some of these gap services include residential, transitional care, targeted case management, recovery-oriented systems of care, and expanding access to recovery support services for adolescents and adults.

Mental Health Block Grant (MHBG) | The expenditure plan has identified 5% for administration, 20% for youth/adolescent as mandatory set-asides. As required, Nevada is utilizing 10% of the MHBG supplemental funds to enhance and expand FEP Services through the existing service providers to expand the number of services and service recipients.

State Opioid Response Grant - In October of 2018, Nevada was awarded a State Opioid Response Grant (SOR). Activities and services will build on the work accomplished during the 2017-2020 funding cycle that established three integrated opioid treatment and recovery centers (IOTRCs) across the State of Nevada. The SOR program aims to address the opioid crisis by increasing

access to medication assisted treatment (MAT) using the three FDA-approved medications for the treatment of opioid use disorder; reducing unmet treatment need; and reducing opioid overdose related deaths through the provision of prevention, treatment, and recovery activities for opioid use disorder. As a SOR Grantee, the State of Nevada is expanding availability of MAT services and will provide supportive services in collaboration with SAPTA-certified behavioral health providers, CCBHCs, and the IOTRCs (when geographically able) in an effort to provide integrated primary and behavioral health care for adults and adolescents with opioid use disorder.

In September of 2020, Nevada was awarded a No Cost Extension (NCE) for the State Opioid Response Grant (SOR I) and the first year of Nevada State Opioid Response II (SOR II). Between September 30, 2020, and March 31, 2021, the Nevada State Opioid Response project funded 15 activities under the NCE and an additional 19 under the SOR II to a total of 22 agencies. All agencies supported through NCE were a continuation of funding from Year 2 of SOR I. Activities and services have expanded on the initial SOR funding to build on the work accomplished during the past funding cycle that supports Nevada's identified priority areas: 1) Prescriber Education & Guidelines, 2) Treatment Options & Third-Party Payers, 3) Data Collection & Intelligence Sharing, 4) Criminal Justice Interventions.

The SOR program aims to address the opioid crisis by increasing access to MAT using the three FDA-approved medications for the treatment of opioid use disorder; reducing unmet treatment need; and reducing opioid overdose related deaths through the provision of prevention, treatment, and recovery activities for opioid use disorder. As a SOR Grantee, the State of Nevada is expanding availability of MAT services and will provide supportive services in collaboration with SAPTA-certified behavioral health providers, CCBHCs, and the IOTRCs (when geographically able) to provide integrated primary and behavioral health care for adults and adolescents with opioid use disorder. Focus areas for the SOR funding include outpatient clinical treatment and recovery services, MAT expansion for SAPTA-certified providers, tribal treatment and recovery services, criminal justice treatment and recovery services, peer recovery support services, community preparedness planning for tribal communities, mobile opioid recovery outreach teams, and neonatal abstinence syndrome prevention.

Nevada continues to concentrate on expansion of evidence-based technical assistance to include key resources to assist organizations with Adopt SBIRT, which was expanded to 2 Federally Qualified Health Centers (FQHC) and targeted OB/GYN and physicians serving women of childbearing age. Ongoing supports provided state-wide distribution of no-cost naloxone kits, that includes Nevada overdose education which has been funded through the Opioid STR NCE and the SOR Supplement funding. Wrap around treatment and recovery support services have been expanded to include attention to special populations, such as veterans and faith-based supports and increased adoption of peer-based services. The implementation of the Zero Suicide initiative enhanced screening and service coordination with hospitals throughout Nevada. Nevada is also supporting further criminal justice-involved programs including expansion to support a MAT re-entry program that included transitional housing, residential treatment ad needed and coordination of treatment, care coordination and job development, jail-based MAT services, and naloxone discharge programs. Approximately twenty-two unique providers are being funded under the SOR funding streams.

Implementing Zero Suicide. A position within the Office of Suicide Prevention was established to coordinate with hospitals throughout Nevada to initiate the adoption of Zero Suicide and begin

to introduce Crisis Now to communities. This position has worked individually with hospital systems throughout the state to commit to implementing Zero Suicide. The coordinator is providing ongoing TA to the 9 of the 12 hospital systems for participating hospitals from the first learning series from April to August 2020.The monthly meetings allow for sharing EHR questions or concerns, changes in hospital leadership, data collection and evaluation, and policy and procedure updates. There are five (5) more COLs scheduled for this cohort. One of the first hospital systems that completed the initial training series over the summer of 2020 has adopted Zero Suicide initiatives within their EHR system that will launch fall 2021. The Zero Suicide coordinator has been providing ongoing TA to ensure that appropriate screenings and measures are embedded within the EHR and workflow. The Zero Suicide team has received commitment from five (5) new hospital systems to participate in the second round of training series for Zero Suicide with a goal of ten (10) systems. The team has been working with each hospital independently to complete a hospital wide readiness assessment. These assessments will then be used to guide specific trainings for hospital staff, policy and procedure development, and individualized TA throughout and following the training series. These trainings may include safety planning training, SafeTalk, ASIST, counseling for access to lethal means, Columbia Assessment Tool, and CAMS training as well as peer input from the first round.

Service Expansion. Nevada's behavioral health services have been evolving considerably since the expansion of Medicaid in 2014 under the Affordable Care Act (ACA). Prior to 2014, the majority of behavioral health care services for individuals in poverty, who were otherwise not eligible for Medicaid, were provided within the state system. After Nevada expanded Medicaid, under Governor Brian Sandoval, the numbers of individuals covered by Medicaid benefits grew exponentially from 351,315 in 2013 to 655,366 in 2018. At the same time, Nevada expanded substance use treatment benefits through an integrated behavioral health clinic model to provide substance-related and/or co-occurring conditions treatment for outpatient and inpatient clients using ASAM as the framework for assessment and for matching multidimensional severity and level of function with type and intensity of service.

In addition, Nevada participated in the 223 Demonstration Program to develop and implement (CCBHCs). Under the demonstration program, Nevada has three active CCBHCs: New Frontier Treatment Center in Fallon, Nevada (rural); Vitality Unlimited in Elko, Nevada (rural); and Bridge Counseling in Las Vegas, Nevada (urban). The implementation of CCBHCs has expanded accessibility, availability, and the scope of services available in the communities with CCBHCs. Further, under the demonstration program, CCBHCs expanded the scope of community based behavioral health agencies to include non-state plan services, such as chronic disease self-management; supported employment; and targeted case management for individuals with primary substance-related disorders. The CCBHCs also expanded their scope of services to allow them to provide state plan services in an integrated setting to include: MAT; ambulatory withdrawal management; primary care services; 24/7 crisis intervention, which includes mobile crisis; psychiatric rehabilitation services, such as basic skills training and psychosocial rehabilitation; Assertive Community Services; and family-to-family peer interventions.

Communities in which CCBHCs operate have benefited from greater access to behavioral health and primary care services including a reduction in the number of unnecessary episodes of care in the emergency departments. As such, the CCBHCs have become essential safety-net behavioral health service providers in Nevada. The demonstration program ended in July of 2019, and Nevada has been working with the Division of Health Care Finance and Policy(DHCFP_ to develop a 1915(b4) expansion in

order to continue reimbursement for services provided by CCBHCs. In total the state has 16 CCBHC's Nine are Medicaid enrolled providers and seven are SAMHSA Direct funded working on establishing programming.

Nevada CCBHC/ACT Providers

M = Medicaid Enrolled Provider; SDF = SAMHSA Direct Funded Provider – NOT enrolled with Medicaid

* = ACT provider only – NOT a CCBHC

M	New Frontier (Cohort 1)	1490 Grimes St., Fallon, NV 89406
M	Bridge Counseling Associates - Alta (Cohort 1)	1640 Alta Dr., Las Vegas, NV 89106
M	Vitality Unlimited - Elko (Cohort 1)	215 Bluffs Ave., Ste 100-101, Elko, NV 89801
M	Bridge Counseling Associates - McLeod (Cohort 2)	4221 McLeod Dr., Las Vegas, NV 89121
M	Vitality Unlimited - Carson (Cohort 2)	119 E. Long St., Carson City, NV 89706
M	Carson City Community Counseling (Cohort 2)	205 S. Pratt Ave., Carson City, NV 89701
M	Rural Nevada Counseling (Cohort 2)	3595 US-50, Ste 2, Silver Springs, NV 89429
M	Quest Counseling (Cohort 2)	3500 Lakeside Ct. Unit 101, Reno, NV 89509
M	FirstMed (Cohort 2)	400 Shadow Lane, Ste 106, Las Vegas, NV 89106
SDF	Silver State Health (Cohort 3)	2965 S. Jones Blvd, Las Vegas, NV 89146
SDF	CPLC - Hawthorne (Cohort 3) CERTIFICATION PENDING	1000 C St., A-1, Hawthorne, NV 89415
SDF	CPLC - Minden (Cohort 3) CERTIFICATION PENDING	1616 US Highway 395N Minden, NV 89423
SDF	Community Outreach Medical Center (Cohort 3)	1090 E. Desert Inn Rd., Ste 200, Las Vegas, NV 89109
SDF	Vitality Unlimited – Reno (Cohort 3) CERTIFICATION PENDING	Reno (New location; TBD)
SDF	Vitality Unlimited – Dayton (Cohort 3) CERTIFICATION PENDING	120 Pike St, Dayton, NV 89403
SDF	First Person Care Clinic (Cohort 3) CERTIFICATION PENDING	Location TBD
*	Carson Tahoe Hospital **(ACT- ONLY)**	775 Fleischmann Way, Carson City, NV 89703

Additional Information to Note:

- All Nevada CCBHCs must provide ACT services.

- Those enrolled with Medicaid knew this requirement upon applying to become a Nevada CCBHC, and all Medicaid enrolled programs should have an ACT program up and running.
- The pandemic has impacted Cohort 2's ACT implementation because many of them were certified between the second half of 2019 and April 2020. Initial certification does not require a fully functioning ACT, as this program takes time to build and is resource heavy, so newly certified CCBHCs are given 6 months to build their ACT program after initial certification. This 6 month build period put most of Cohort 2's ACT program due date just around when the pandemic hit and shut down many in-person services.
- Currently there is only one Cohort 2 CCBHC (FirstMed) that does not have a functioning ACT team.
- Those who have been directly funded by SAMHSA did not necessarily know about this state requirement and may have barriers with implementing this service due to the possibility of not accounting for this service in their grant application and fund allocation. As far as certification goes, they are still required to plan for and offer ACT services, though due to how resource heavy this particular program is, they may not be able to implement this service in a meaningful way until they are able to enroll with Medicaid or get additional funding elsewhere.
- Nevada Medicaid cannot enroll anymore CCBHCs until they are authorized more spots for this specialty enrollment through the next legislative session. There is no guarantee more spots will be authorized.
- Carson Tahoe Hospital has two ACT programs, one regular ACT Team and the other is a FACT (Forensic ACT) Team, which focuses on consumers in the legal system.

SAPTA Substance-Related Disorder Specialty Populations

SAPTA has a Special Populations Plan that specifically addresses the needs of four specialty populations: 1) adolescents; 2) women who are pregnant and parenting; and 3) people who are injection drug users. SAPTA also provides for the special needs of people who are involved in the criminal justice system.

Adolescents: Considerations for this specialty population include: gender, ethnicity, disability status, stage of readiness for change, sexual orientation, cultural background, cognitive and social-emotional development issues resulting from the adolescent's substance use, and the role of the family as it relates to sustaining the adolescent's continued substance use. Additional areas of concern are: how to provide necessary services for adolescents in rural or frontier areas where limited accessibility presents a significant obstacle to treatment access, how to best serve those who are involved in the juvenile-justice system, and how to provide age-appropriate detention programming.

Women who are pregnant and parenting: Primary medical services for this population include: prenatal intake; prenatal follow-up; labor/delivery with prenatal care; postpartum follow-up; neonatal follow-up and nutritional considerations; primary pediatric care for their children, including immunizations. Therapeutic interventions are provided for children of women in treatment to address the children's developmental needs and to address any issues resulting from sexual abuse, physical abuse, and/or neglect. Psychosocial services include trauma counseling for women who have experienced sexual or physical abuse, mental health counseling for all family members, and general family services including assisting the women to plan for reunification with their other children. Additional services include case management, child care, housing assistance, home management training, transportation, life skills training, parenting

training, vocational training and job-skill development, education programs, and legal assistance.

People who are injection drug users: Services for this population include comprehensive substance-related treatment, on-going and continuing care with community providers, medication assisted treatment for individuals with opioid use disorders, recovery supports, such as housing assistance, legal resource access, vocational and job-skill building, and outreach services that adhere to the National Institute of Drug Abuse's Community Based Outreach Model, which is used to identify potential and to provide them with risk-reduction interventions.

People who are involved in the criminal justice system: SAPTA provides a variety of residential and transitional living programs for people re-entering society from prison or jail. Transitional services include but are not limited to: cognitive-behavioral therapy, mental health counseling, trauma informed care, peer support services, skills training, and vocational services and job training. The agency also funds drug court programs which provide a sentencing alternative of treatment combined with supervision for people living with serious substance-related disorders.

Substance Use Prevention

SAPTA is responsible for prevention services and is responsible for ensuring the state uses a variety of evidence-based programs, policies, and practices in their prevention efforts. Nevada Administrative Code (NAC) 458 identifies three areas relating to the use of alcohol and other drugs: a) Prevention Programs, b) Coalition Programs, and c) Administrative Programs.

Prevention Programs

SAPTA currently approves six strategies to prevent the initial onset of substance-related disorders and to eliminate or reduce the harmful effects of alcohol, tobacco, and other drugs in individuals, families, and communities. The methods are recognized by SAMHSA's Center for Substance Abuse Prevention (CSAP), and all SAPTA-funded prevention programs use a structure that is based on one or more of these strategies: a) Information Dissemination, b) Education, c) Alternatives, d) Problem Identification and Referral, e) Community-Based Process, and f) Environmental:

a) **Information Dissemination:** This strategy provides awareness and knowledge of the nature and extent of alcohol, tobacco, and other drug use, abuse, and addiction and their effects on individuals, families, and communities. It also provides knowledge and awareness of available prevention programs and services. The method is characterized by one-way communication from the source to the audience, with limited contact between the two.
b) **Education:** This strategy involves two-way communication and is distinguished from the information dissemination strategy by the fact that interaction between the educator/ facilitator and the participants is the basis of its activities. Activities under this method are intended to affect critical life and social skills, including decision-making; refusal skills; critical analysis (e.g., of media messages); and systematic judgment abilities.
c) **Alternatives:** This strategy provides for the participation of target populations in activities that decrease alcohol, tobacco, and other drug use. The assumption is constructive and healthy activities offset the attraction to, or otherwise meet, the needs usually filled by alcohol and other drugs and would, therefore, minimize or obviate resort to the latter.

d) **Problem Identification and Referral:** This strategy identifies those who have indulged in illegal or age-inappropriate use of tobacco or alcohol and those individuals who have used illicit drugs for the first time. The intent is to assess if the behavior of these individuals can be reversed through education. This strategy does not include any activity designed to determine if a person needs treatment.

e) **Community-Based Process:** This strategy aims to improve the community's ability to more effectively provide prevention services for alcohol, tobacco, and other substance-related disorders. Activities in this strategy include: organizing, planning, enhancing efficiency and effectiveness of service implementation, interagency collaboration, coalition building, and networking.

f) **Environmental:** This strategy influences the incidence and prevalence of the abuse of alcohol, tobacco, and other drugs in the general population. This is achieved by establishing or changing written and unwritten community standards, codes, and attitudes. This method is divided into two subcategories to permit distinction between activities: a) legal and regulatory initiatives and b) service and action-oriented initiatives.

Prevention Classifications

The prevention interventions are divided into five classifications based on the service delivery method and on the targeted population:

- **Universal:** Targets the general public or a whole population group that has not been identified on the basis of individual risk.
- **Universal Direct:** Directly serves an identifiable group of people who have not been identified on the basis of individual risk (e.g., school curriculum, afterschool program, parenting class). This also could include interventions involving interpersonal and ongoing/repeated contact (e.g., coalitions).
- **Universal Indirect:** Supports population-based programs and environmental strategies (e.g., establishing pertinent policies and modifying advertising practices) and could include interventions involving programs and policies implemented by coalitions.
- **Selective:** Targets subsets of the total population deemed to be at risk for a substance-related disorders by virtue of their membership in a particular population segment (e.g., children of parents with substance-related disorders, students who are failing academically, or students who dropout). Risk groups may be identified on the basis of biological; psychological; social; or environmental risk factors known to be associated with substance misuse, and targeted subgroups may be defined by age; gender; family history; place of residence, such as high drug-use or low-income neighborhoods; and victimization by physical and/or sexual abuse. Selective prevention strategies target the entire subgroup regardless of the degree of risk of any individual within the group. The selective prevention program is presented to the entire subgroup because the subgroup as a whole is at higher risk for a substance-related disorders than the general population. An individual's personal risk is not specifically assessed or identified and is based solely on a presumption given his or her membership in the at-risk subgroup (e.g., children of parents who have substance-related disorders).
- **Indicated:** Identifies individuals who are exhibiting early signs of a substance- related disorder or other problem behaviors associated with a substance-related disorder (e.g., falling grades and consumption of alcohol and other gateway drugs) and targets them with special programs. These interventions are designed to prevent the onset of a

substance related disorder for individuals who do not meet the DSM-5 criteria for a substance use disorder.

Prevention Coalitions

There are 10 substance abuse prevention coalitions that serve all 17 counties in the state. Each coalition must have a board of directors, and the board must be broadly representative of the community and geographic area to be served. The coalitions are funded by Nevada's State General Fund through SAPTA and by discretionary grants from SAMHSA's CSAP. SAPTA oversees the coalitions to ensure they implement evidence-based prevention strategies as recommended by the federal and state governments.

The coalitions are restricted from providing direct services. However, they act as pass-through entities to fund prevention services at the community level. This restriction is to ensure there will be no conflict of interest between the coalitions as funding/oversight organizations and the direct service providers in their communities. The coalitions provide environmental strategies, information dissemination, and community-based strategies, which include developing needs assessments, coordinating data collection, developing comprehensive community prevention plans, implementing the plans, and evaluating outcomes.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system of care as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system of care.
States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, SUD prevention, and SUD treatment goals at the state level.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

FFY 2020-2021 BLOCK GRANT APPLICATION

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

(SABG)

PLAN AND REPORT

Step 2: Unmet Service Needs and Critical Gaps in Nevada's Current System

***Submitted by*:**

The Nevada Department of Health and Human Services

Division Of Public and Behavioral Health

Bureau Of Behavioral Health Wellness and Prevention

Introduction

Nevada's Substance Abuse Prevention and Treatment Agency (SAPTA) is part of Nevada's Bureau of Behavioral Health Wellness and Prevention (BBHWP) within the Division of Public and Behavioral Health (DPBH) under the Nevada Department of Health and Human Services (DHHS). SAPTA plans, funds, and coordinates statewide substance abuse service delivery. While SAPTA is not responsible for direct service delivery, it distributes state and federal grant funding, creates and implements statewide plans for substance abuse services, and develops standards for certification of programs and services.

SAPTA plans, funds, and coordinates Nevada's statewide substance use disorder service delivery system, which is the primary focus of this regional capacity assessment effort. SAPTA's key roles include distributing funds (tax dollars, general fund, and grants), creating and implementing statewide plans for substance use disorder services, and developing standards for certification of programs and services.

The Nevada Division of Public and Behavioral Health (DPBH) is the Single State Authority (SSA) for federal grants issued by the Substance Abuse and Mental Health Services Administration (SAMHSA). As part of the DPBH, SAPTA administers programs and activities that provide community-based prevention and treatment through the Substance Abuse Prevention and Treatment Block Grant - referred to as SABG by SAMHSA and SAPT by DPBH. Note that "prevention and treatment" is used throughout this document to summarize a broad continuum of approaches including outreach, prevention, (early) intervention, treatment, and recovery. The mission of SAPTA is to promote healthy behaviors and reduce the impact of substance use and co-occurring disorders for Nevada's people and communities.

Nevada's Substance Abuse Block Grant Priority Populations

SABG has identified target populations and service areas to include:

- Pregnant women and women with dependent children
- Persons who inject drugs
- Tuberculosis
- Primary prevention services (at 20% or more)

Nevada's Bureau of Behavioral Health Wellness and Prevention 2020 Epidemiologic Profile[1]

The Office of Analytics prepares an annual behavioral health epidemiologic report intended to provide an overview of behavioral health in Nevada for the prevention coalitions, public health authorities, Nevada legislators, behavioral health boards and the public. The analysis can be used to identify issues of concern and areas that may need to be addressed. The Nevada Bureau of Behavioral Health and Wellness supports 10 community coalitions that passthrough the funding for direct services to providers for prevention. The programs are funded to provide one or more prevention strategies that are promoted by the Center for Substance Abuse Prevention. The strategies are: information dissemination, prevention education, alternative activities, problem identification and referral, community-based processes, and environmental strategies. This report groups the data by prevention coalition region to provide a more detail analysis of significant findings in the counties by coalition region.

Nevada's coalition regions are:

- CARE Community Coalition (CARE): Clark County
- CHURCHILL Community Coalition (CHURCHILL): Churchill County
- Frontier Community Coalition (FCC): Humboldt, Pershing, and Lander
- Healthy Community Coalition (HCC): Lyon, Storey and Mineral
- Join Together Northern Nevada (JTNN): Washoe
- NYE Community Coalition (NYE): NYE, Esmeralda, and Lincoln
- Partner Allied for Community of Excellence (PACE): Elko, Eureka, and White Pine
- PACT Coalition for SAFE and Drug Free Communities (PACT): Clark County
- Partnership Carson City (PCC): Carson City
- Partnership Douglas County (PDC): Douglas County

The content below contains excerpts from the 2020 report. The full report can be found at https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/Bureau%20of%20Behavioral%20Health%20Wellness%20and%20Prevention,%20Epidemiologic%20Profile%20for%20Nevada,%202020.pdf

[1] *Department of Health and Human Services, Office of Analytics, 2021*

Demographic Snapshot

Figure 1 – Selected Demographics for Nevada[2]	Nevada
Population, Census, April 1, 2020	3,104,614
Population, Census, April 1 2010	2,700,551
Population, percentage change	15%
Male persons, 2020 Census	1,558,516 (50.2%)
Female Persons, 2020 Census	1,546,098 (49.8%)
Median household income (2019)	$63,365
Per capita income in the past 12 months (2019)	$31,557
Persons in poverty, percent (2019)	12.5%
With a disability, under the age 65 years, percent (2019)	8.6%
Land area (square miles)	109,781.18 sq miles

Nevada's population identified in the 2020 census is 3,108,462 which is an increase of 15% from 2010. Nevada is expected to increase another 1.7% over the next year. The population is made up of approximately equal percentages of females and males. The median household income is $63,365. Nevada's land area is approximately 109,781.18 square miles. This area would include up to seven northeastern states within Nevada's geographic borders.

Nevada's poverty level by county ranges from 12% to 18.9%. In 2019, there were 384,900 Nevadans in poverty (12.7% of the state's population). There were 32,077 rural and frontier residents in poverty (10.9% of the population). The median home level has increased significantly with Clark County's (Las Vegas) median home price at $324,738 and Washoe County's (Reno) median home price at $406,905. This has increased the level of anxiety and stressors in the community due to the higher cost of living. Nevada's unemployment rate continues to fluctuate from 29.5% in June 2020 to 7.8%, above the current national unemployment rate of 5.9%. This also impacts access to care issues with many families required to work two jobs or who are out of work with minimal health or behavioral health insurance. In 2018, 12.9% of Nevadans under the age of 65 were uninsured, including 13.0% rural and frontier residents. There were 57,246 uninsured Nevadans under the age of 19 (8.0%), including 6,002 uninsured rural and frontier children. In addition, Nevada is projected to be a minority-majority state by the year 2023, which requires approaches that are culturally and linguistically appropriate to improve access to care for all populations.

[2] *United States Census Data, 2021*

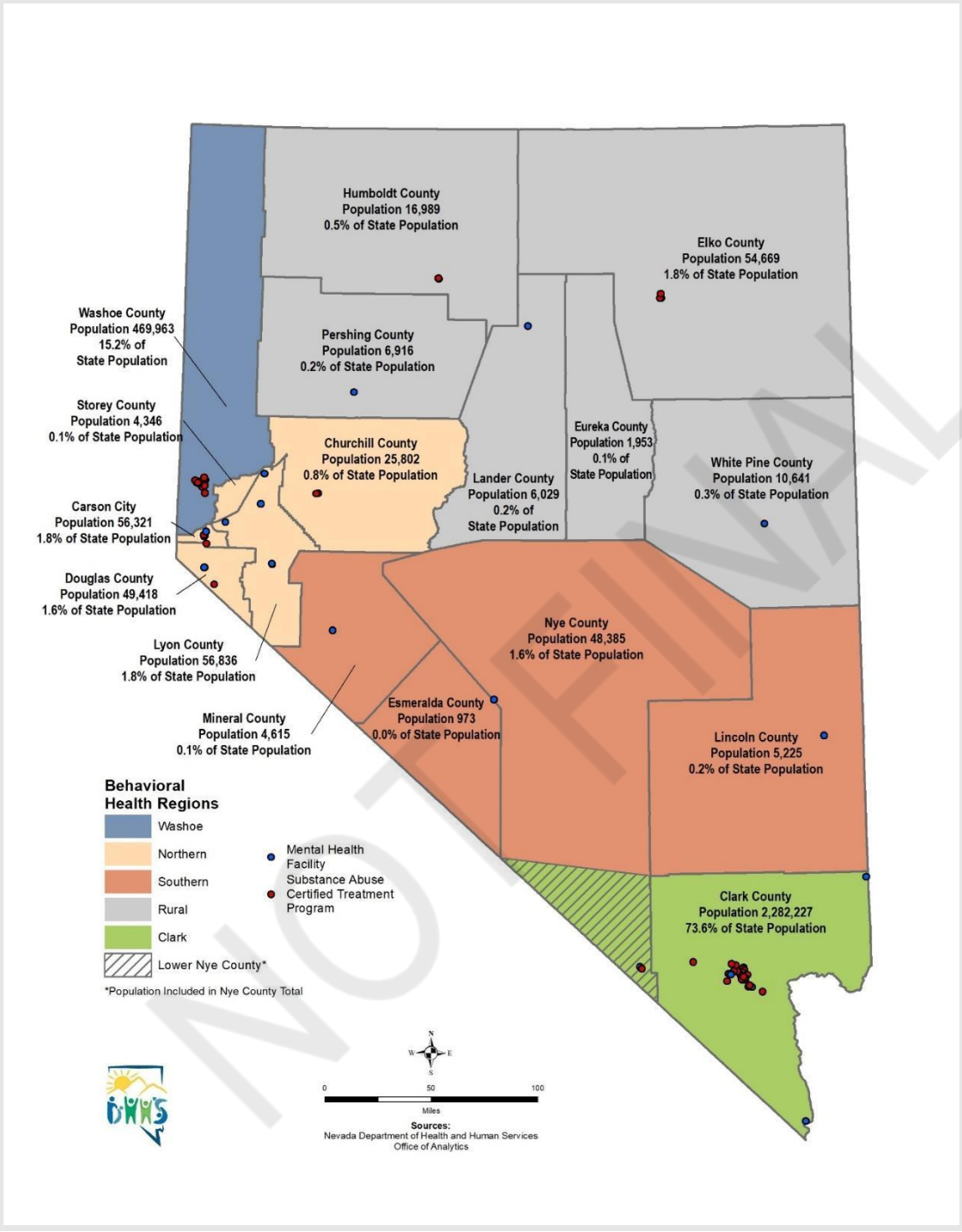
Nevada has biennial legislative sessions. This elevates the importance of planning for behavioral health services. During the 2017 legislative session, Nevada established the regional behavioral health policy boards to address behavioral health in Nevada by geographic catchment areas. This includes a Regional Behavioral Health Coordinator (RBHC) who works directly within the region to support behavioral health needs, gaps, assessments, coordination, and communications. In the 2021 legislative session, Nevada worked with the Senate Committee on Health and Human Services for provisions relating to crisis stabilization center and crisis care to ensure that Medicaid was a viable option for continuity of care. Nevada intends to apply to CMS for a Mobile Crisis Planning Grant to provide for sustainable funding for the services within the state Medicaid program. Nevada was also able to implement legislation to start the process of developing regulations to support the maintenance of the 988 line (beyond implementation) and to be part of the braided funding for crisis care systems as part of Senate Bill 390. The legislation will result in the development of the Crisis Response Account with funding derived from a 988 surcharge on all eligible phone lines. Planning for 988 and the entire crisis continuum of care has been a primary behavioral health priority for Nevada for the past few years and the impact of COVID has prompted even greater focus on designing and implementing the system of crisis care.

Nevada has seventeen counties with only three being identified as urban. The remaining counties are defined as rural and frontier counties, which further challenges the behavioral health system with large geographic areas, limited services, and lack of public transportation. The coordination with the RBHCs provides linkage and support strategizing with other counties on access to care issues and county specific priorities based on population, especially with limited resources.

Compounding the struggle for Nevada's population to access services are the shortages that exist within the behavioral health workforce. All 17 counties have significant regions that are identified as Mental Health Shortage Areas (HPSAs) with 16 counties recording HPSA scores greater than 16 by the Nevada Health Workforce Research Center in the Office of Statewide Initiatives at the University of Nevada, Reno School of Medicine (2021). Currently, 3 million Nevadans or 94.5% of the state's population reside in a federally designated mental health professional shortage area, 16 of 17 counties in Nevada are single-county mental health HPSAs.

The population density of Nevada's counties varies widely, but the state has made it a priority that all citizens are represented by a Regional Behavioral Health Board (RBHB). Containing 73.6% of Nevada's population, Clark County is the most populous area in the state, with an estimated 2,251,175 persons. Esmeralda County, by comparison, is the least populous county, with less than one percent of Nevada's population, an estimated 969 persons. Yet each of these counties have representation as part of the RBHB.

Figure 2. Map of Nevada Counties and Population Estimates, 2021[3]



[3] *Nevada State Demographer, Vintage 2020.* ***Clark Region****: Clark County and southern Nye County,* ***Northern Nevada Region:*** *Carson City, Churchill, Douglas, Lyon, and Storey Counties,* ***Rural Nevada Region:*** *Elko, Eureka, Humboldt, Lander Pershing, and White Pine Counties,* ***Southern Nevada Region:*** *Esmeralda, Lincoln, Mineral and northern Nye Counties,* ***Washoe Region****: Washoe County. *Nye County: North Nye County is included in Southern Region and southern Nye County is in part of Clark County Region. For data purposes, Nye County data is included in Southern Nevada Region Report and not in the Clark County Region report.*

Figure 3. Nevada Population, 2010-2019.[4]

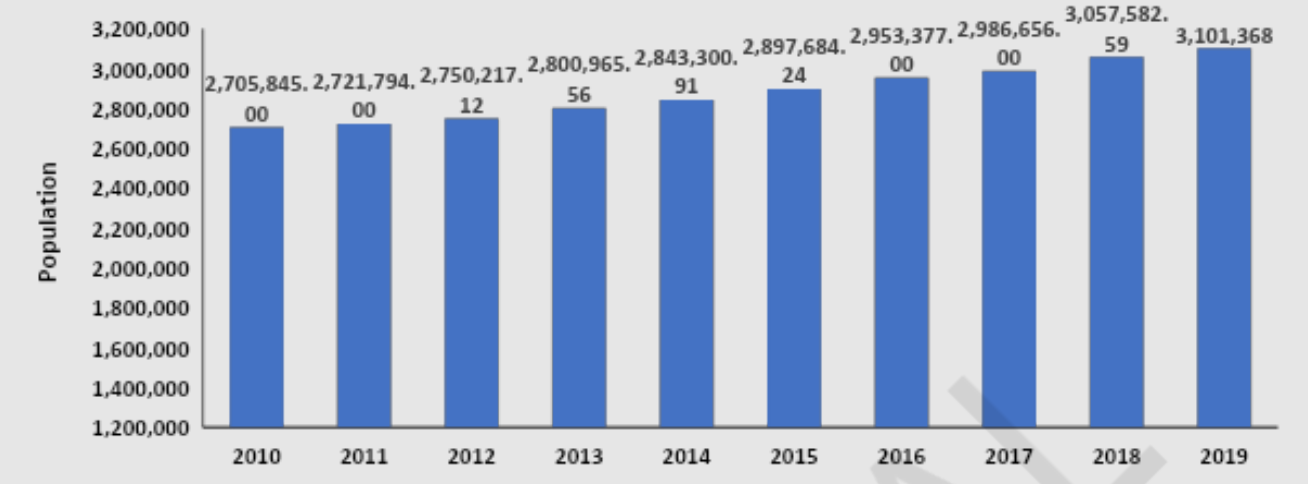


Figure 4. Nevada Population by Race/Ethnicity, 2019.[5]

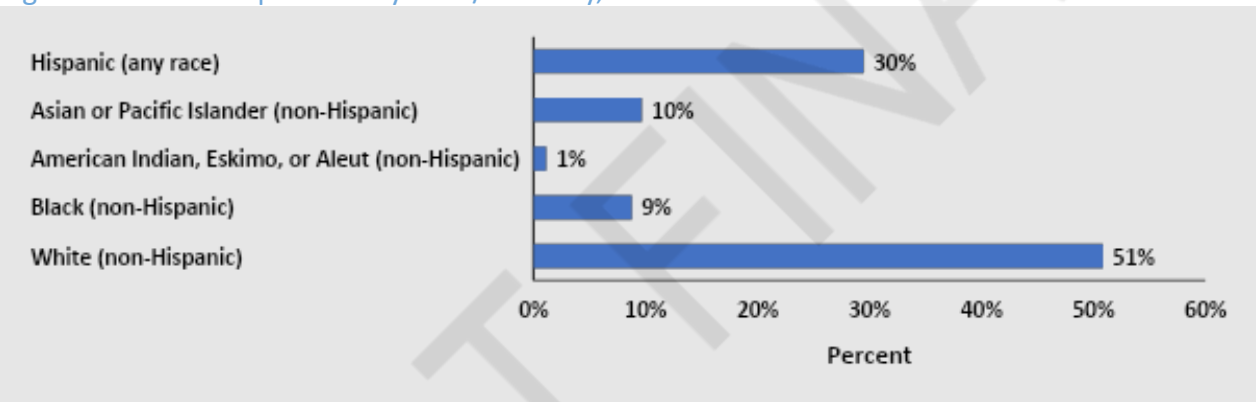
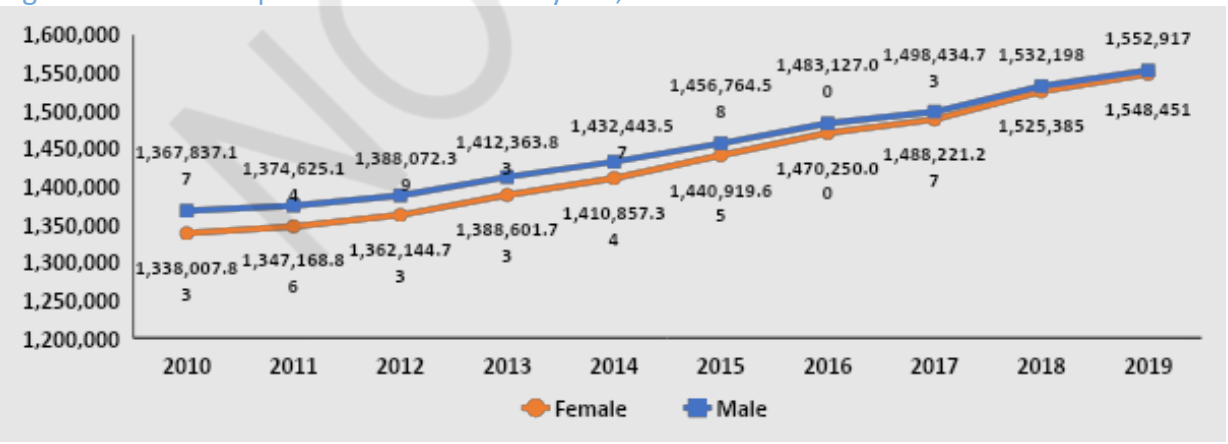


Figure 5. Nevada Population Distribution by Sex, 2010-2019.[6]



[4] *Nevada State Demographer, Vintage 2020.Chart scaled to display differences among groups.*
[5] *Nevada State Demographer, Vintage 2020.Chart scaled to 16% to display differences among groups.*
[6] *Nevada State Demographer, Vintage 2020.Chart scaled to 60% to display differences among groups.*

Key Findings for Substance Use

- Nevada is comparable to the nation with marijuana use among youth (YRBS).
- Drug use among teens is higher in Nevada than the nation (YRBS).
- There was no significantly higher coalition county region with reported higher marijuana/hashish use, however, reported use has continued to rise since to 2017 (BRFSS).
- Emergency department and inpatient admissions due to drugs or alcohol continue to increase in both count and rate (Emergency).
- Males had significantly higher emergency department encounters than females for cocaine, methamphetamines, marijuana/cannabis, and hallucinogens use for 2019 (Emergency).
- The PACT/CARE coalition region both in Clark County had significantly lower rate of drug and alcohol deaths then the remainder of the state (Deaths).
- In roughly 33% of the unintentional or undetermined overdose deaths in 2019, the deceased had been identified as currently having a mental health problem (Deaths).
- The most common substance listed in cause of death is opioid (type not specified, 57.5%), followed by methamphetamine (51.4%) [Deaths].
- Since marijuana has been legalized in 2017, reported marijuana use during pregnancy has more than doubled and has surpassed all other substances (MCH).
- Tobacco use during pregnancy has decrease for all mothers ages since 2016 (MCH).
- The adult LGBT community have significantly higher percent of current marijuana use (LGBT).

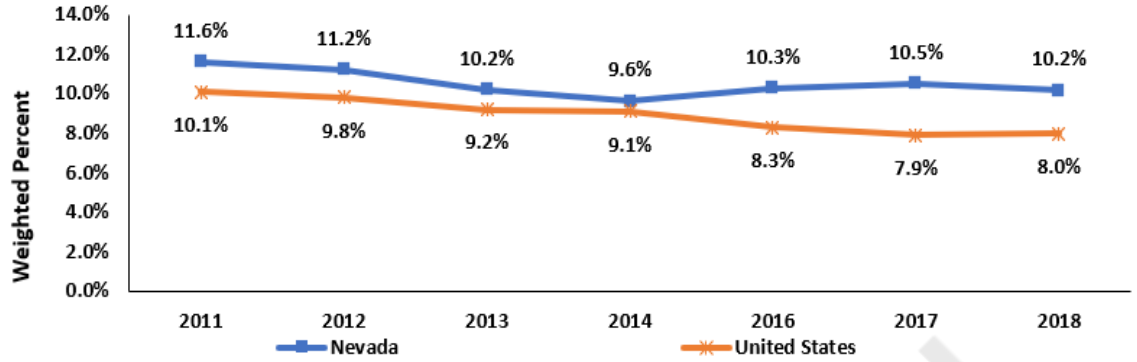
Substance Use

Substance use data are collected from hospital billing data, Center for Health Information and Analysis (CHIA), vital records data, and through national survey data including Substance Abuse and Mental Health Service Administration, BRFSS and YRBS.

National Survey on Drug Use and Health

The Substance Abuse and Mental Health Services Administration (SAMHSA) sponsors the National Survey on Drug Use and Health (NSDUH). The survey tracks trends of illicit drug, alcohol, and tobacco use, as well as mental health issues throughout the United States. For more information about the national survey, please go to the following website: SAMHSA NSDUH.

Figure 6 Drug Use Among Adolescents in the Past Month, Aged 12-17, Nevada and the United States (US), 2011-2018.[7]



Nevada adolescents illicit drug use has remained within 2% from 2011 to 2018, 10.2% reported illicit drug use in 2018. Alcohol use disorder in the past year has decreased from 9.0% in 2011 to 5.5% in 2018.

Figure 7. Alcohol Use Disorder Aged 12 and Above, Nevada and the US, 2011-2018.[8]

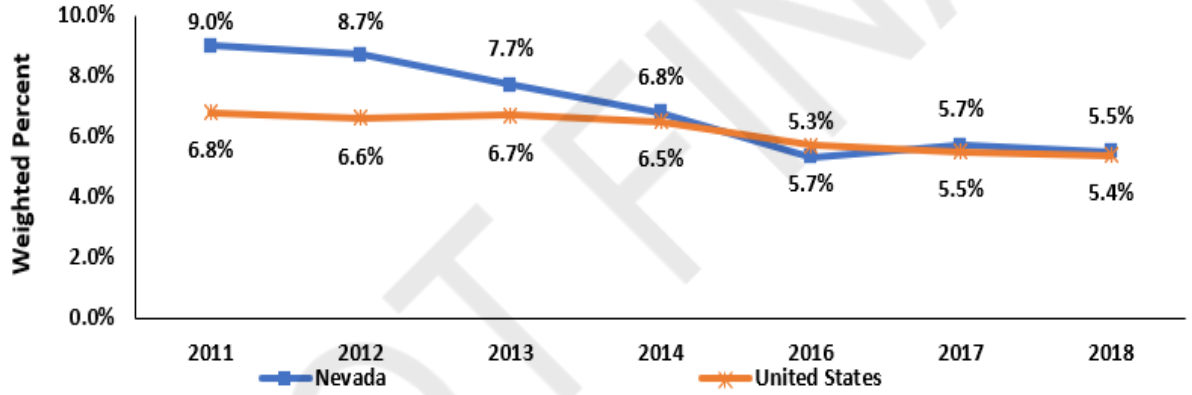
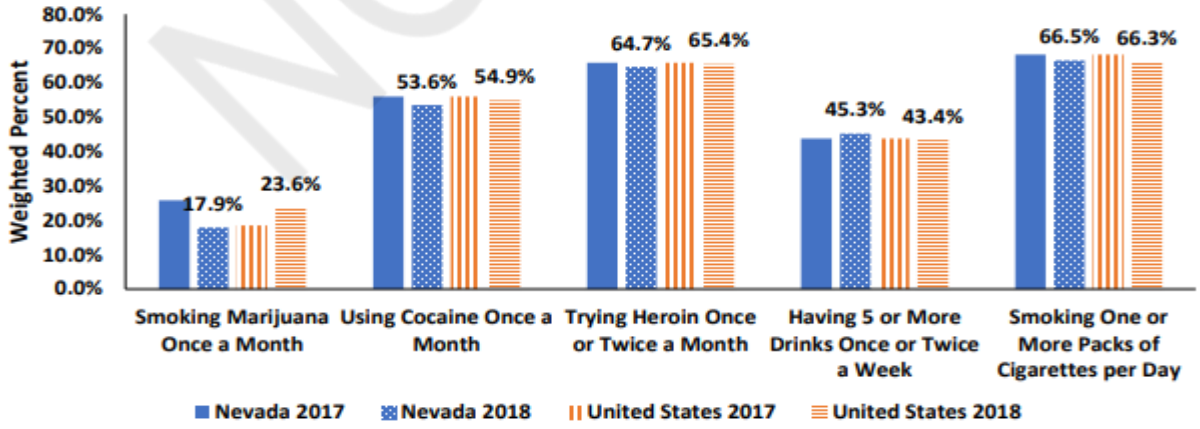


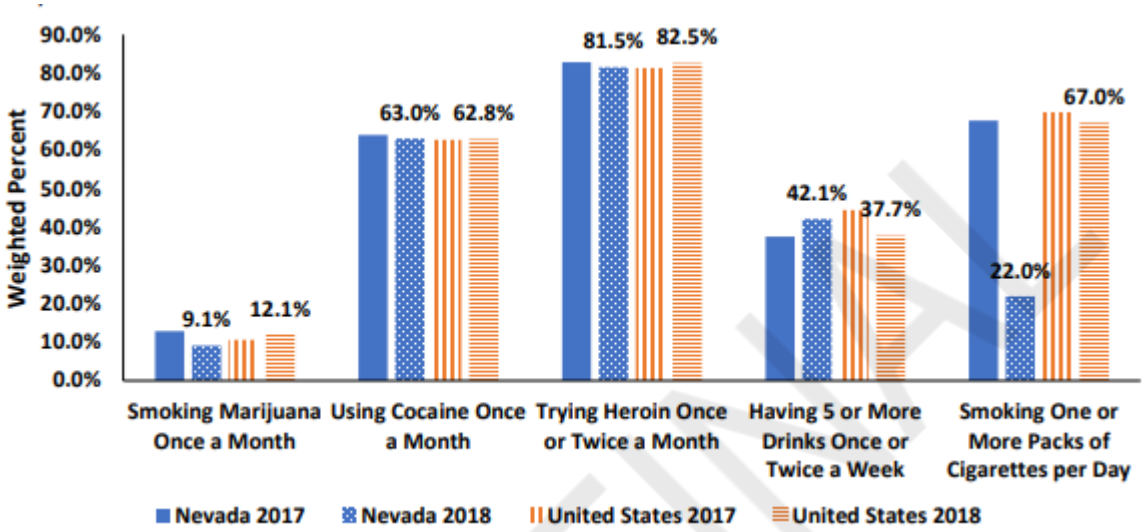
Figure 8. Perceptions of Great Risk from Alcohol or Substance, Aged 12-17, Nevada and the US, 2018.[9]



[7] *Source: SAMHSA, Center for Behavioral Health Statistics and Quality, NSDUH*
[8] *SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health*
[9] *SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health*

For perceived risks, the higher percent the more the person perceives there is a risk from it. Nevadans perceived risk among both teens (Figure 8 and 9) and young adults is lower than the nation for most substance uses, including smoking one or more packs of cigarettes per day in young adults, 22.0% in Nevada and nationally at 67.0%

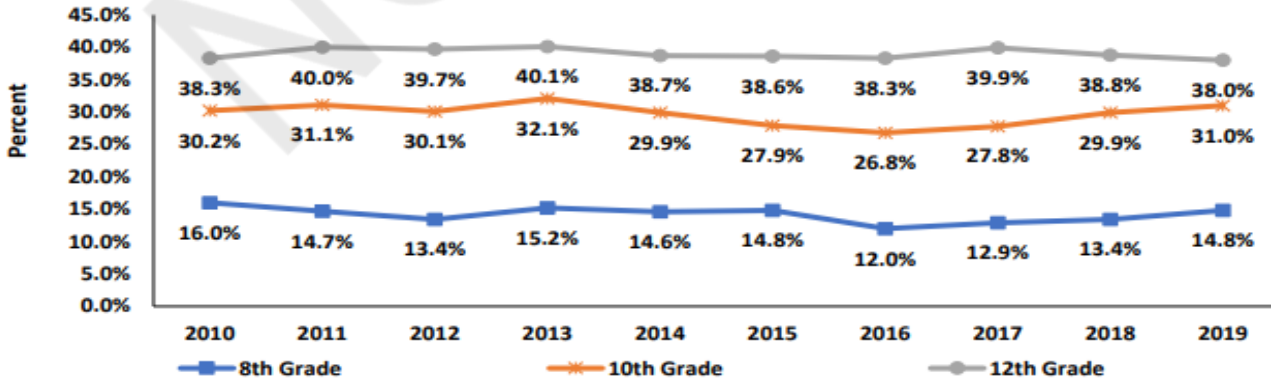
Figure 9. Perceptions of Great Risk from Alcohol or Substance, Aged 18-25, Nevada and the US, 2018.[10]



Monitoring the Future Survey

Monitoring the Future is an ongoing study of the behaviors, attitudes, and values of American secondary school students and young adults. Each year, a total of approximately 50,000 students in 8th, 10th and 12th grades are surveyed. The Monitoring the Future Study (annual prevalence & lifetime prevalence) is funded under a series of investigator-initiated competing research grants from the National Institute on Drug Abuse, a part of the National Institutes of Health. Monitoring the Future Survey is conducted at the Survey Research Center in the Institute for Social Research at the University of Michigan. This data is collected nationality, and state level is not provided.

Figure 10. Annual Prevalence of Any Illicit Drug Use, United States, 2010-2019.[11]

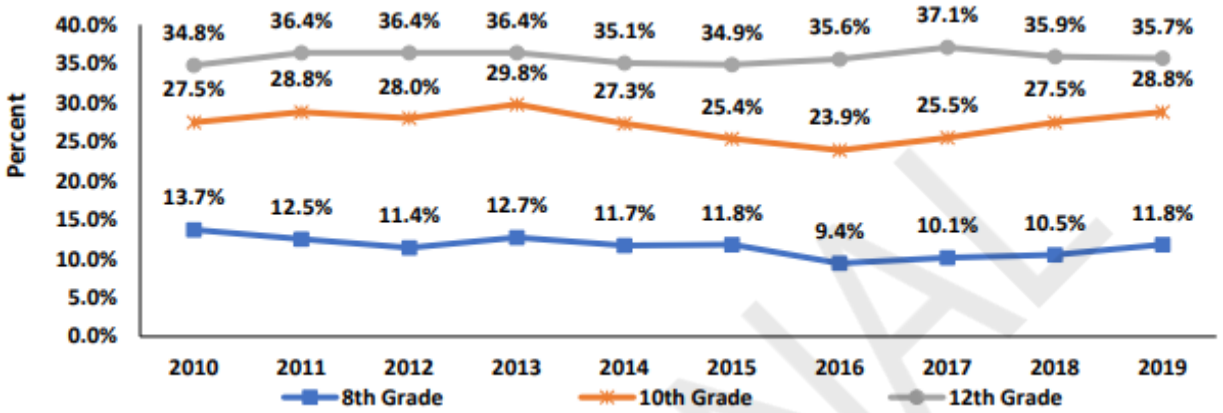


[10] *SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health*

[11] *Monitoring the Future Survey.*

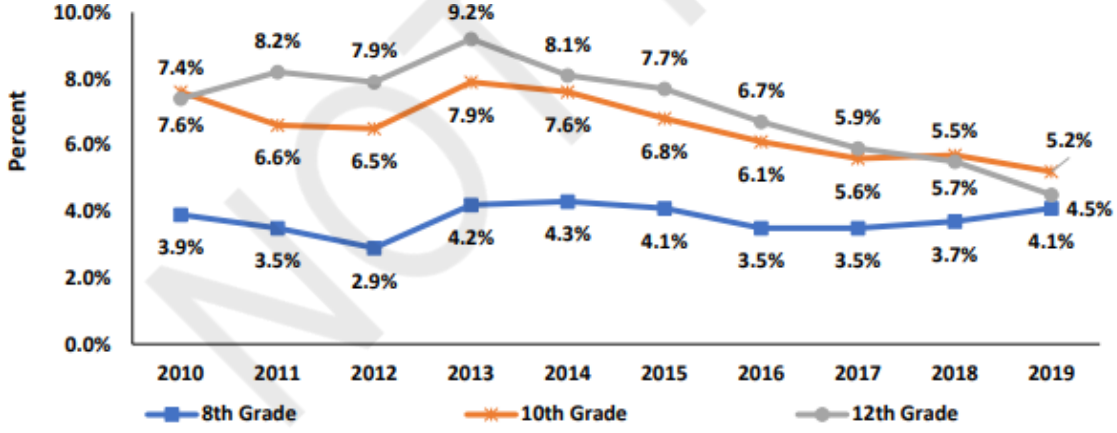
On average, approximately 40% of 12th graders, 30% of 10th graders, and 14% of 8th graders in the United States have reported using any form of illicit drugs from 2010-2018. Lifetime illicit drug use has remained steady as well. In 2019, the lifetime illicit drug for 12th graders was 47.4%, 10th graders was 37.5%, and 8th graders was 20.4%.

Figure 11. Annual Prevalence of Marijuana/Hashish Use, 2010-2019.[12]



On average, approximately 36% of 12th graders, 27% of 10th graders, and 12% of 8th graders have reported using marijuana/hashish in the United States. Lifetime marijuana/hashish use has remained steady for all grades from 2010 to 2019. In 2019, the lifetime marijuana/hashish use for 12th graders was 43.7%, for 10th was 34.0%, and for 8th graders was 15.2%.

Figure 12. Annual Prevalence of Amphetamine Use, United States, 2010-2019.[13]



The annual prevalence of amphetamine use decreased from 2010 to 2019 for 12th from 7.4% to 5.2% respectively. In contrast, the 8th grade prevalence has increased from 3.9% to 4.1%. In addition, Methamphetamine use has decreased by an average of 59% among all three surveyed grades since 2010 in the United States. Lifetime prevalence has decreased as well. In 2019, the lifetime use among 12th graders was 0.8%, 10th graders was 0.7%, and 8th graders was 0.9%.

[12] *Monitoring the Future Survey.*

[13] *Monitoring the Future Survey*

Figure 13. Annual Prevalence of Methamphetamine Use, United States, 2010-2019.[14]

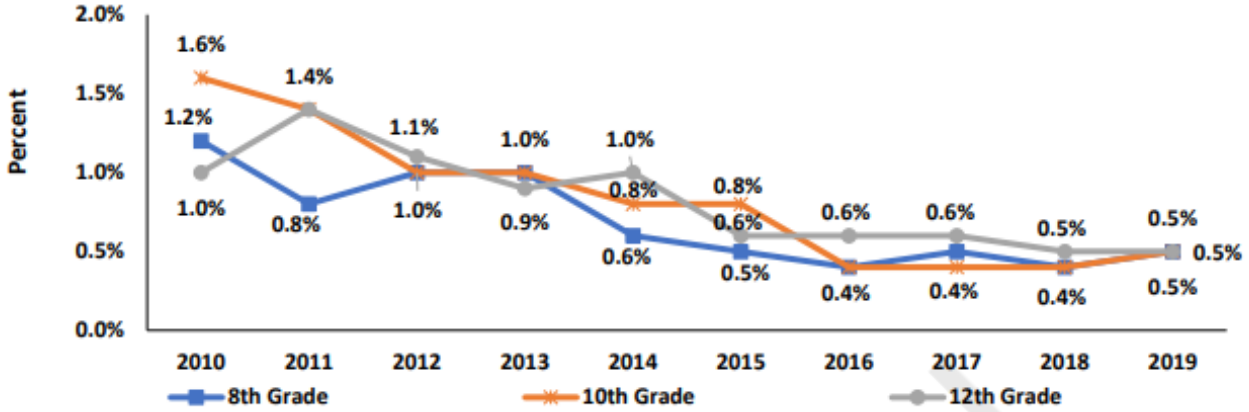
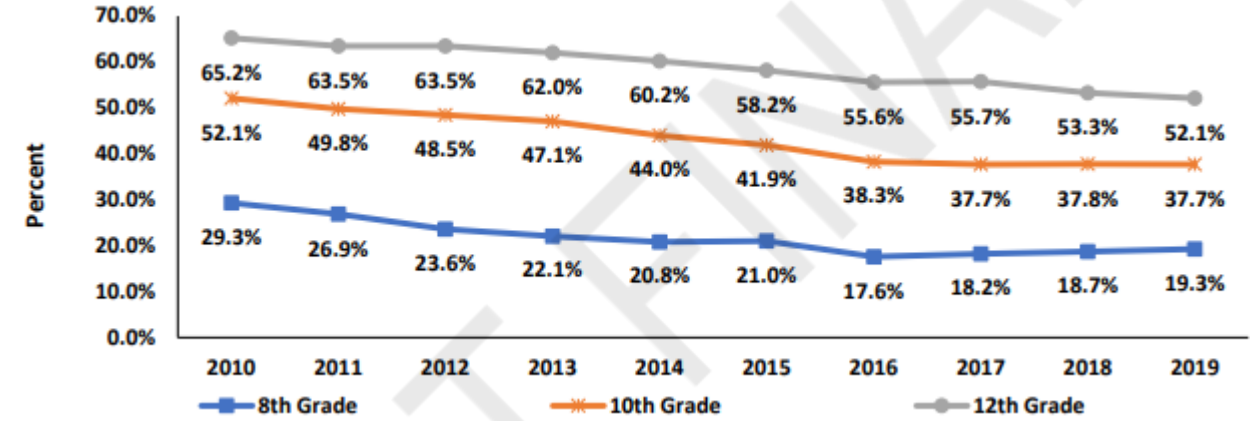
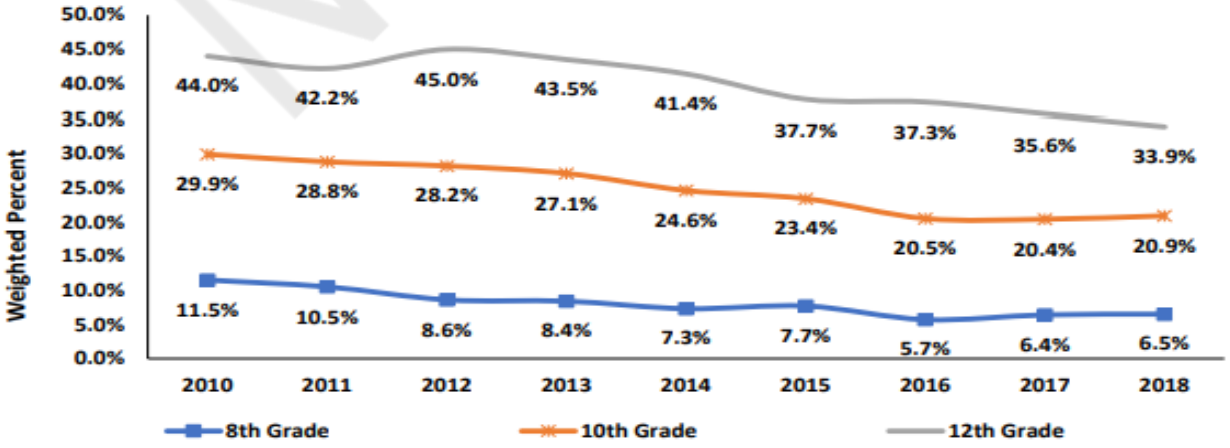


Figure 14. Annual Prevalence of Alcohol Use, United States, 2010-2019.[15]



The prevalence of alcohol use including being drunk from alcohol has decreased in all grades since 2010 through 2015 in the United States. Since 2015, the prevalence has remained steady among all grades. The lifetime prevalence of any alcohol use has remained steady as well, from 2010 to 2019. In 2019, lifetime alcohol use was 58.5% for 12th graders, 43.1% for 10th graders, and 24.5% for 8th graders.

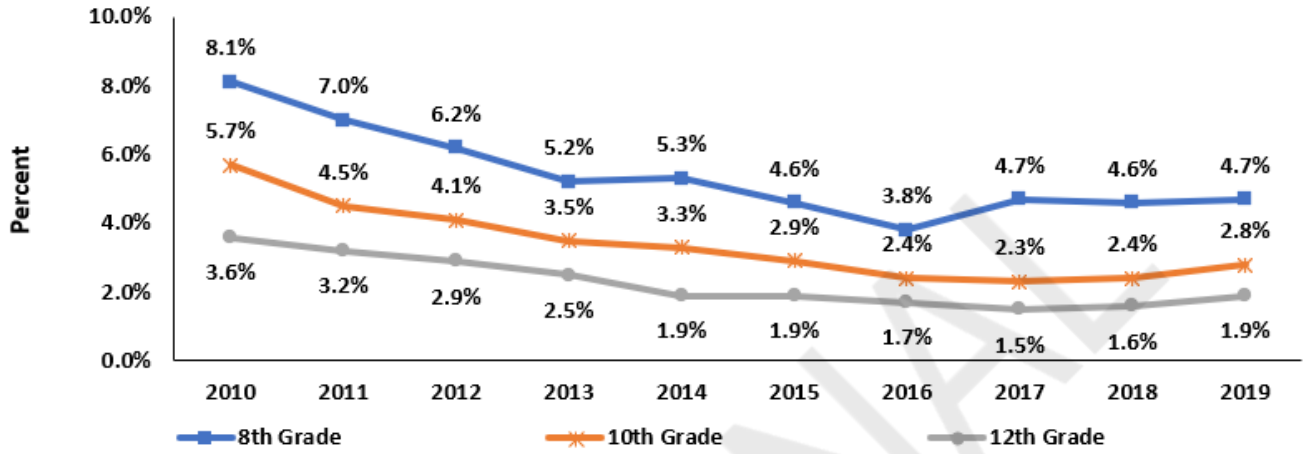
Figure 15. Annual Prevalence of Being Drunk from Alcohol, United States, 2010-2019.



Source: Monitoring the Future Survey.

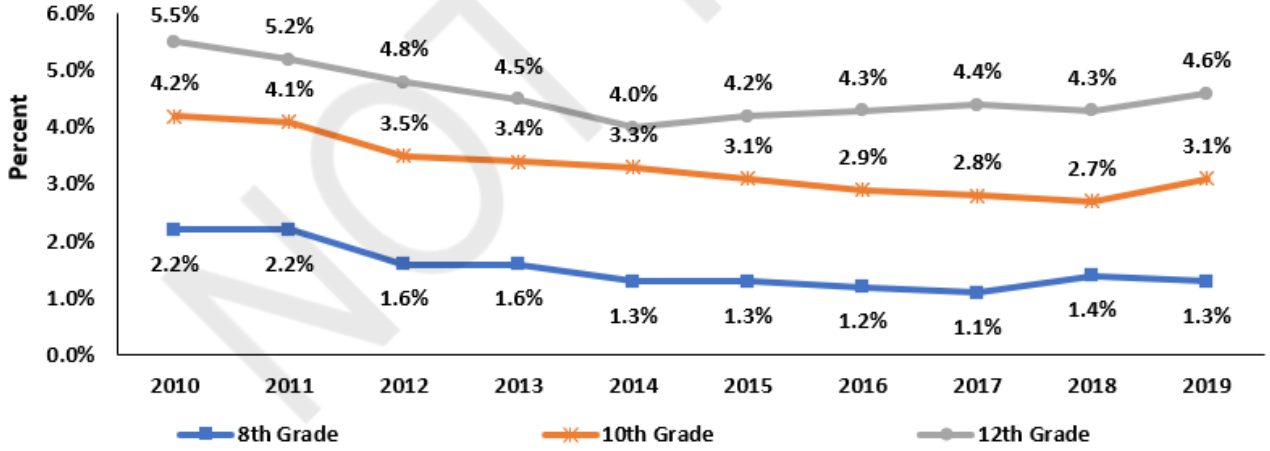
On average, approximately 39% of 12th graders, 24% of 10th graders, and 8% of 8th graders in the United States have reported being drunk from 2010 to 2018. Lifetime use for ever been drunk for 12th graders decreased from 42.9% in 2018 to 40.8%. In contrast, among 8th graders, the number increased from 9.2% to 10.1% which is the first increase in this indicator since 2015.

Figure 16. Annual Prevalence of Inhalant Use, United States, 2010-2019.[17]



The prevalence of inhalant use has decreased among all grades since 2010 through 2015 in the United States and then has increased slightly since 2016. The lifetime use is higher than the annual prevalence for all age groups in 2019, with 5.3% for 12th graders, 6.8% for 10th graders, and 9.5% for 8th graders.

Figure 17. Annual Prevalence of Hallucinogen Use, United States, 2010-2019.

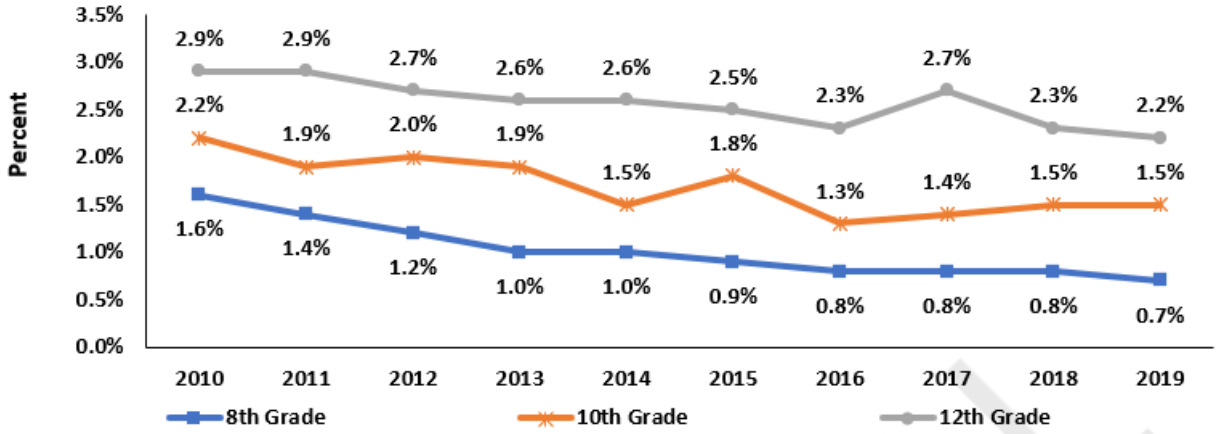


On average, approximately 3% of the grades surveyed have reported using hallucinogens in the United States from 2010 to 2019. The lifetime use for hallucinogen use in 2019 increased for all grades from 2018, with 6.9% up .2% from 2018 for 12th graders, 4.7% up .8% from 2018 for 10th graders, and 2.4% up from 2.2% in 2018, for 8th graders.

[17] *Monitoring the Future Survey.*

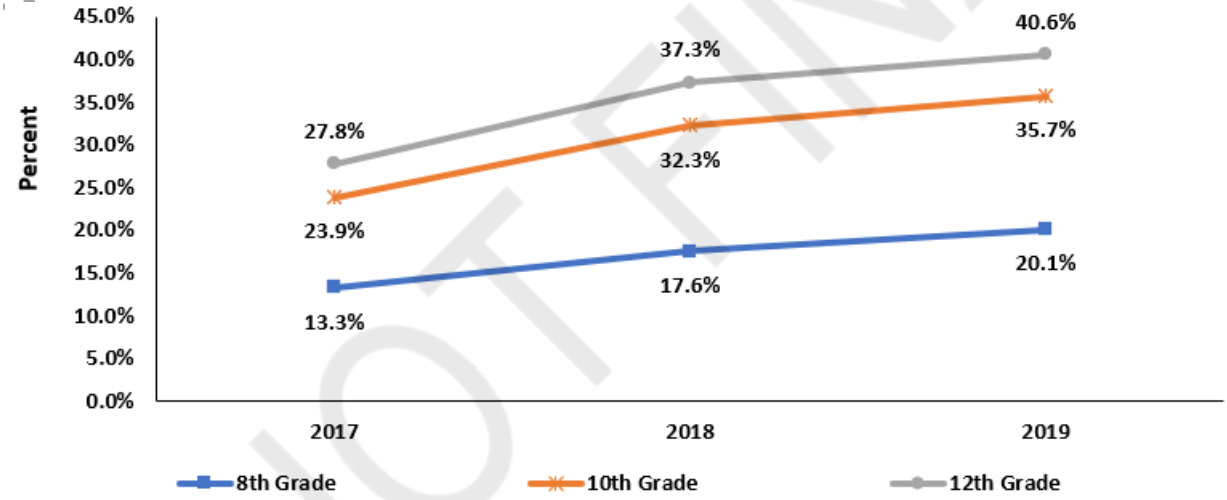
[18] *Monitoring the Future Survey.*

Figure 18. Annual Prevalence of Cocaine Use, United States, 2010-2019.[19]



The annual prevalence cocaine use on average for 12th grade is 2.2%, 1.5% for 10th grade, and 0.7% for 8th grade. The lifetime prevalence use of cocaine for 12th grade is 3.8%, 2.5% for 10th grade, and 1.2% for 8th grade.

Figure 19. Annual Prevalence of Vaping Use, United States, 2010-2019.[20]



The annual prevalence for vaping has continued to increase from each year. The lifetime increased from 2018 to 2019 in all grades, 45.6% for 12th grade, 41.0% for 10th grade, and 24.3% for 8th grade. In 2018, 42.5% 36.9% and 21.5% respectively.

[19] *Monitoring the Future Survey.*

[20] *Monitoring the Future Survey.*

Youth Risk Behavior Survey

The YRBS monitors six categories of health-related behaviors that contribute to leading causes of death and disabilities among youth and adults. Nevada high school and middle school students are surveyed during the odd years. In 2019, 4,980 high school, and 5,31 middle school students participated in the YRBS in Nevada. The University of Nevada, Reno maintains the YRBS data and publishes data on each survey. For more information on the YRBS survey, please go to the following site: UNR YRBS.

Figure 20. Tobacco Use, Nevada High School Students, 2015, 2017, 2019, and National High School Students, 2019.[21]

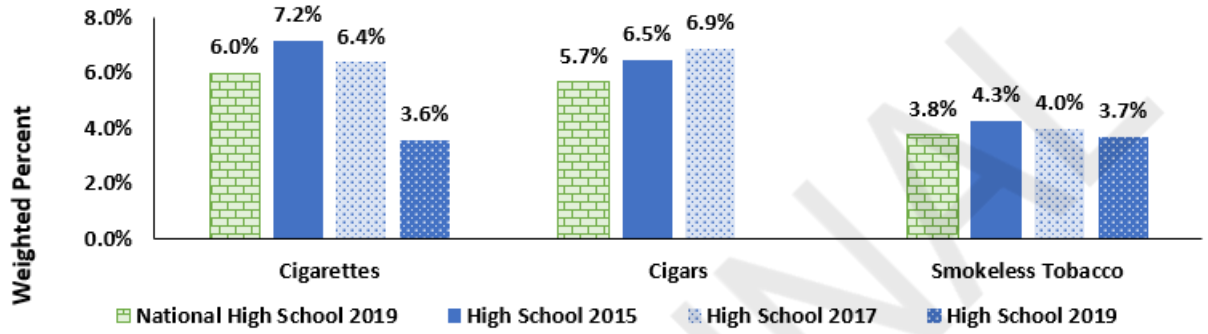
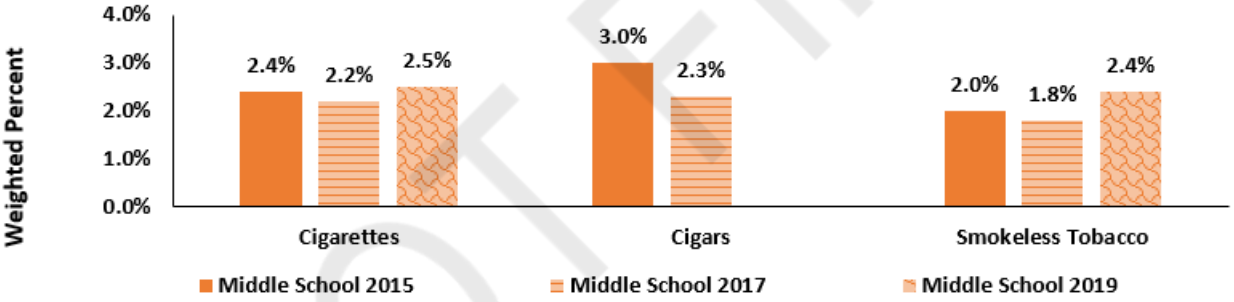


Figure 21. Tobacco Use, Nevada Middle School Students, 2015, 2017, 2019.[22]



Of Nevada high school students in 2019, 3.6% have smoked cigarettes, which is lower than the national reported at 6.0%. Churchill, Humboldt, Pershing, and Lander counties combined have a significantly higher tobacco use at 12.7%, and Nye and Lincoln counties combine at 9.3%. Among middle school students to have smoked cigarettes, those 14 or older are significantly higher than other ages.

[21] *Nevada Youth Risk Behavior Survey.*

[22] *Nevada Youth Risk Behavior Survey.*

Figure 22. Electronic Vapor Product Use, Nevada High School Students, 2015, 2017, 2019, and National High School Students, 2019.[23]

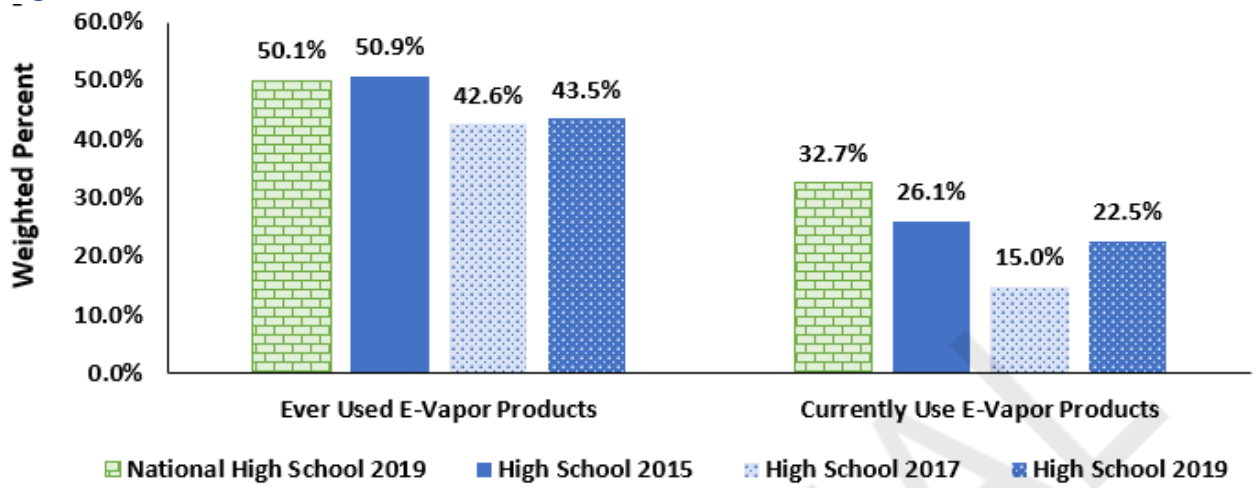
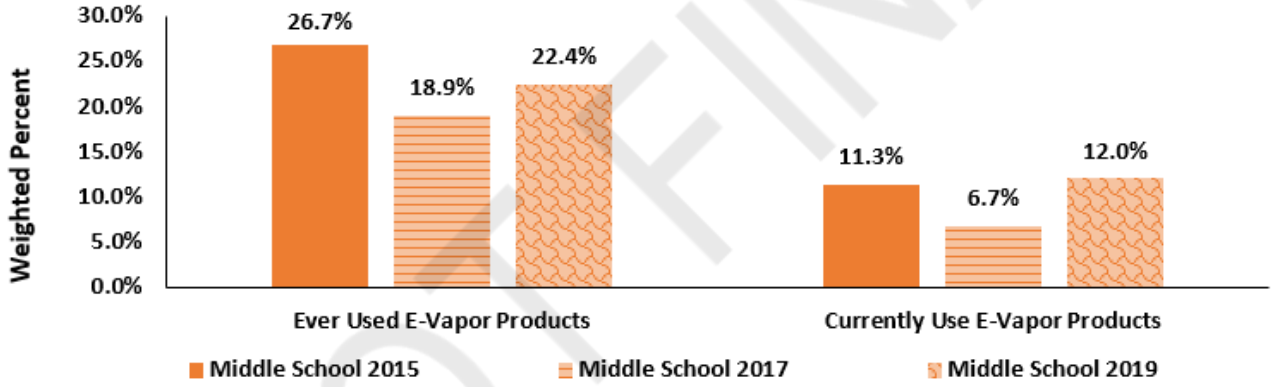


Figure 23. Electronic Vapor Product Use, Nevada Middle School Students, 2015, 2017, 2019.[24]



In Nevada, 22.5% of high school students reported using E-vapor products, which is lower than the nation (32.7%). High school students from the Carson City; Douglas County, Elko, White Pine and Eureka counties combined; Churchill, Humboldt, Pershing, and Lander counties combined; and Lyon, Mineral, and Storey, counties combined have significantly higher reports of using electronic cigarettes. Among middle school students, those 14 years or older were significantly higher than younger ages, at 36.3% who reported ever using an electronic cigarette.

[23] *Nevada Youth Risk Behavior Survey.*

[24] *Nevada Youth Risk Behavior Survey.*

Figure 24. Alcohol Use, Nevada High School Students, 2015, 2017, 2019, and National High School Students, 2019.[25]

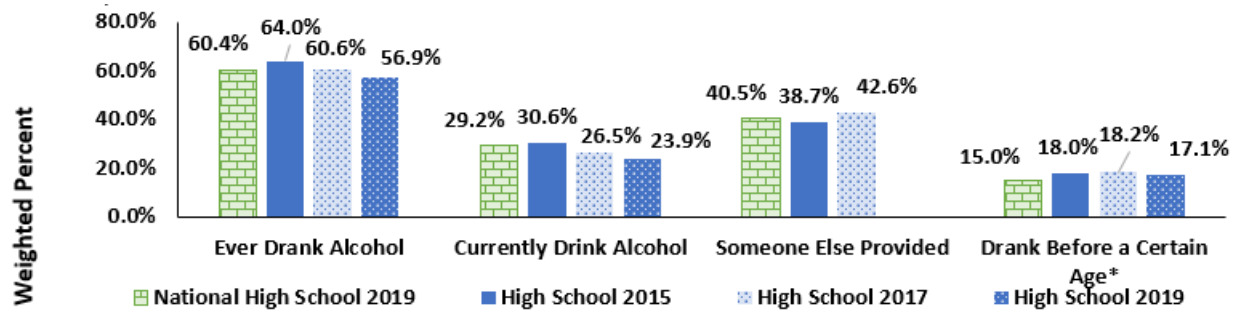
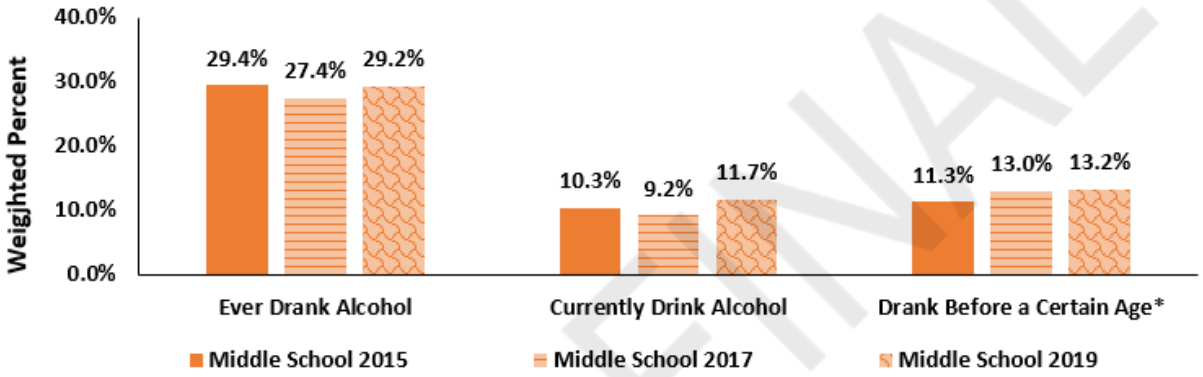
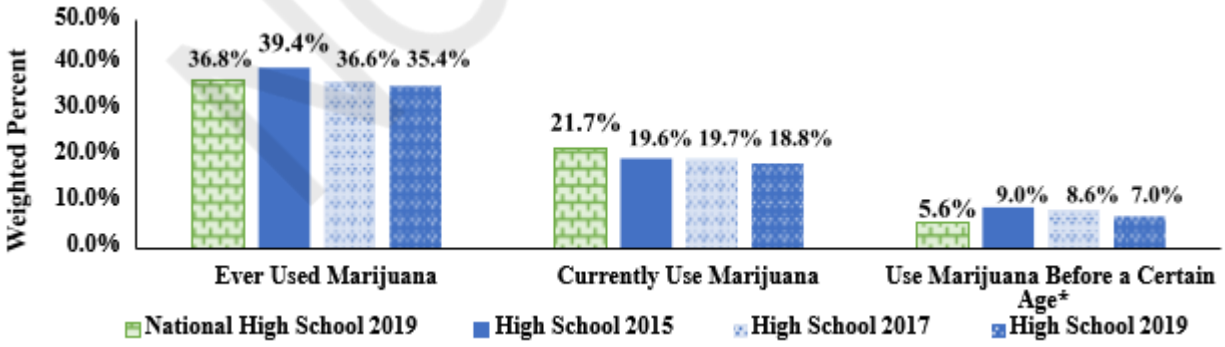


Figure 25. Alcohol Use, Nevada Middle School Students, 2015, 2017, 2019.[26]



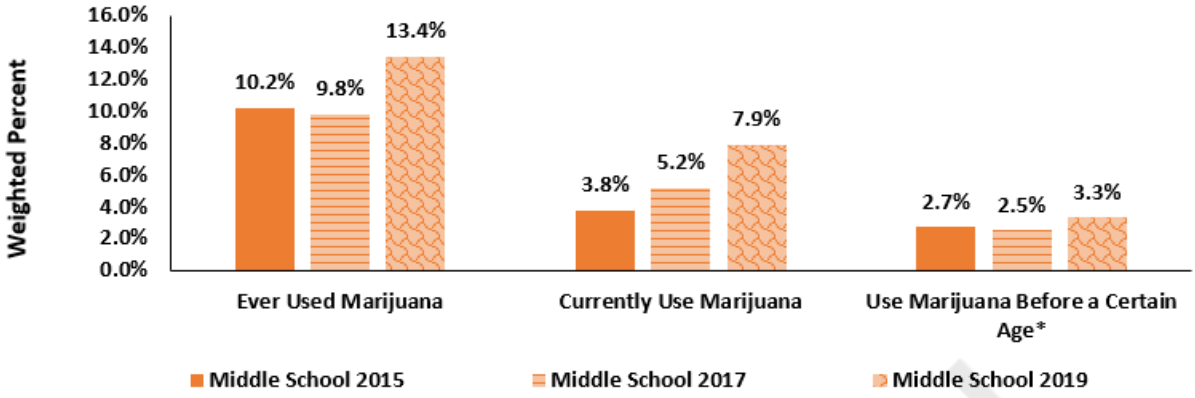
There was a significant decrease in high school students from both ever drinking alcohol and current use of alcohol. In high school students, Douglas County had a significantly higher percent of students who ever drank alcohol (69.3%). The Churchill, Humboldt, Pershing, and Lander counties combined (66.4%) for high school and 43.0% for middle school.

Figure 26. Marijuana Use, Nevada High School Students, 2015, 2017, 2019, and National High School Students, 2019.[27]



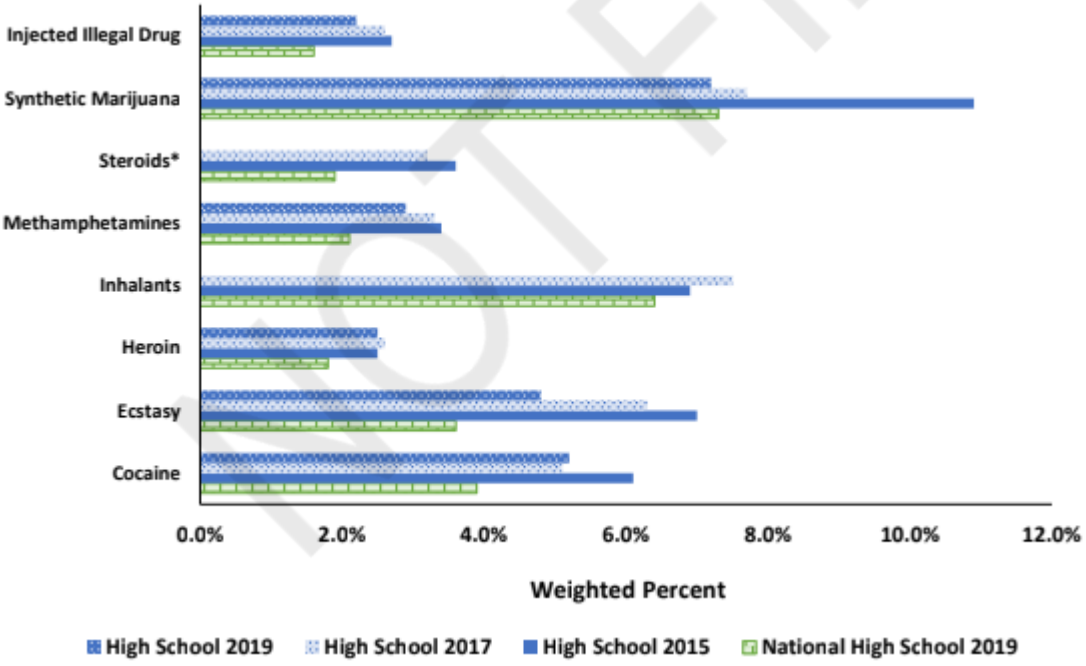
[25] *Nevada Youth Risk Behavior Survey.*
[26] *Nevada Youth Risk Behavior Survey.*
[27] *Nevada Youth Risk Behavior Survey.*

Figure 27. Marijuana Use, Nevada Middle School Students, 2015, 2017, 2019.[28]



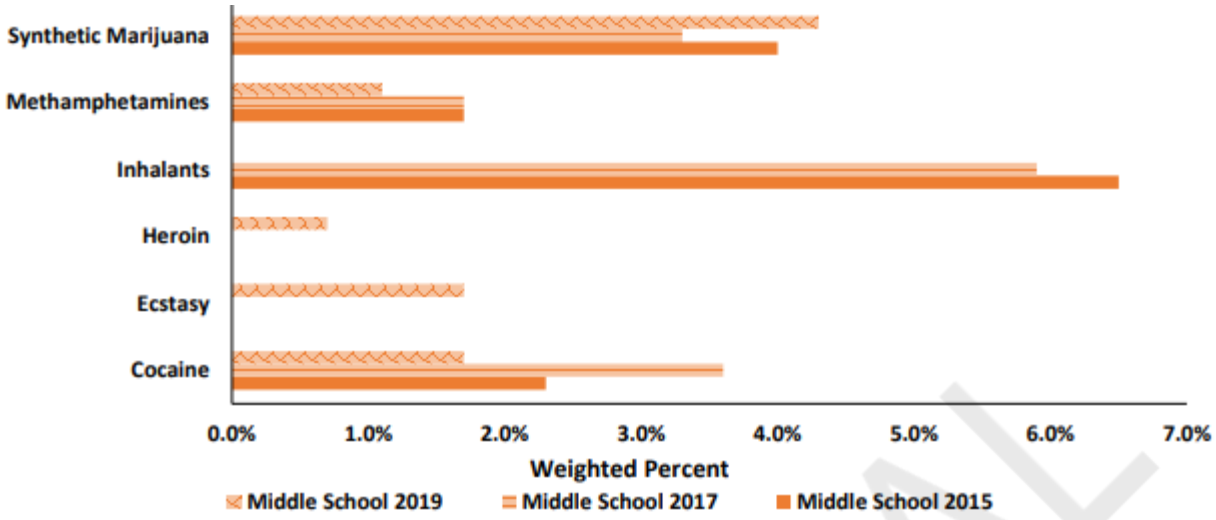
Nevada is comparable to the nation, which is 35.4% for marijuana use in high school students. Older high school students, 12th grade, and 18 years or older have a significantly higher percent for ever using marijuana before, 44.1%, and 44.0% respectively which is lower from 2017. Middle school students in 8th grade and those 14 years or older have a significantly higher percent for ever using marijuana before, 22.3% and 26.5% respectively which has increased from 2017.

Figure 28. Lifetime Drug Use, Nevada High School Students, 2015, 2017, 2019, and National High School Students, 2019.[29]



[28] *Nevada Youth Risk Behavior Survey.*
[29] *Nevada Youth Risk Behavior Survey.*

Figure 29. Lifetime Drug Use, Nevada Middle School Students, 2015, 2017, 2019

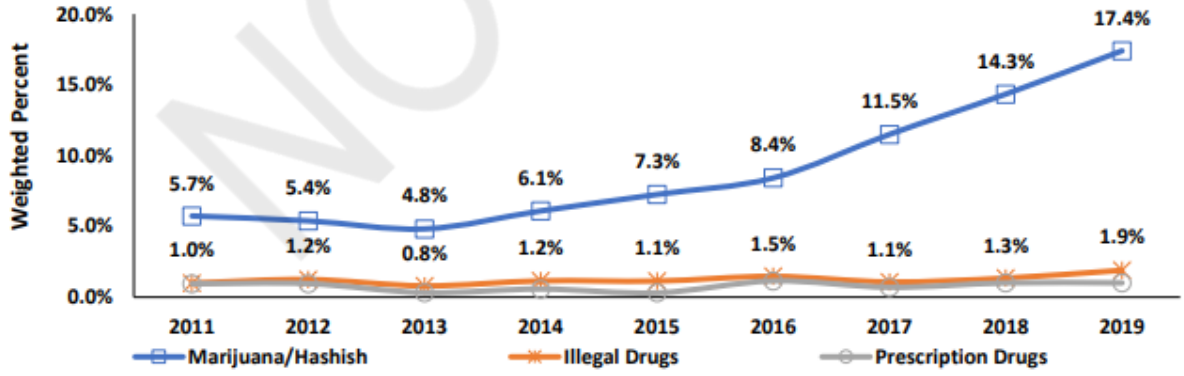


There was a significant decrease for synthetic marijuana use from 2015 to 2017. Drug use among high school students is higher in Nevada than the nation. Of Nevada high school students, 7.2% have used synthetic marijuana, while the national percentage is lower at 7.3%. Churchill, Humboldt, Pershing, and Lander counties combine have significantly higher lifetime use for cocaine (9.4%).

Behavioral Risk Factor Surveillance System

BRFSS collects information on adult health-related risk behaviors. According to the Centers for Disease Control and Prevention, BRFSS is a powerful tool for targeting and building health promotion activities. The survey has questions focusing on substance use including illegal drug use, e-cigarettes, and drunkenness.

Figure 30. Adult Nevada Residents Who Used Marijuana/Hashish, Illegal Substances, or Painkillers to Get High in the Last 30 Days, 2011-2019.



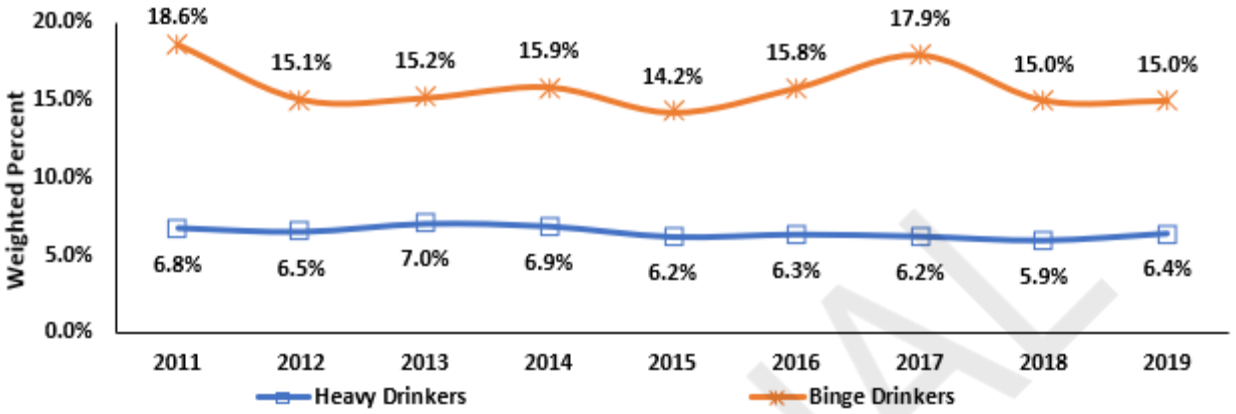
Marijuana use has more than doubled since 2011. In 2018, 17.4% have used marijuana in the past 30 days, up from 5.7% in 2011. Self-reported use of marijuana is expected to increase as marijuana was legalized in Nevada

[30] *Nevada Youth Risk Behavior Survey.*
[31] *Behavioral Risk Factor Surveillance System*

in 2017. Of Nevadans surveyed, 1.0% (on average) used painkillers to get high in the last 30 days and 1.9% used other illegal drugs to get high in the last 30 days.

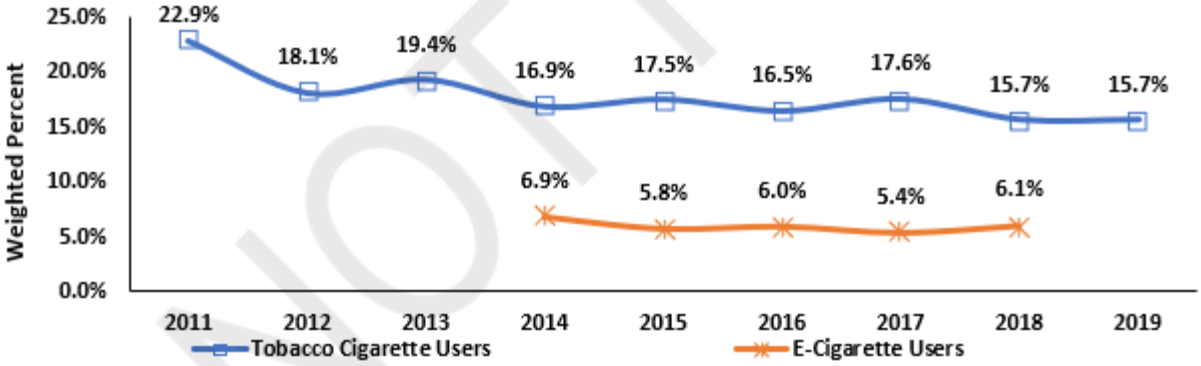
There was no significantly higher coalition county region with reported higher marijuana/hashish use, but the counties served in the FCC region had the most reported use at 29.3%.

Figure 31. Percentage of Adults Who are Considered Binge Drinkers or Heavy Drinkers, 2011-2019.[32]



Binge drinking is defined in men as having five or more alcoholic beverages and woman having four or more alcoholic beverages on the same occasion. Heavy drinking is defined in men as consuming more than two alcoholic beverages, and in women as consuming more than one alcoholic beverage per a day. Binge drinking is significantly higher among Douglas County, the PDC region at 25.6% in 2019.

Figure 32. Percentage of Adults Who are Current Cigarette or E-Cigarette Smokers, 2011-2019.[33]



In 2019, 15.7% of adults were current cigarette smokers, which has decreased significantly since 2011, at 22.9%. E-cigarette use is higher among those never married and among young adults aged 18-24 at 16.5% in 2018. This question was not asked in 2019. Reported cigarette use was higher in the counties served in HCC coalition region, at 23.1%.

[32] *Behavioral Risk Factor Surveillance System. Heavy drinkers (adult men having more than 14 drinks per week and adult women having more than seven drinks per week). Binge drinkers (adult men having five or more drinks on one occasion, adult women having four or more drinks on one occasion).*

[33] *Behavioral Risk Factor Surveillance System.. E-cigarette use was not collected until 2014 and was not collected in 2019.Current cigarette smokers are defined as individuals who have smoked at least 100 cigarettes in their lifetime and currently smoke. Current e-cigarette smokers are defined as individuals who currently have smoked on at least one day in the past 30 days or who currently report using e-cigarettes or other electronic "vaping" products every day or some days.*

Nevada 211 is a phone number that connects Nevadans with needed services. Substance use services including alcohol support and medication-assisted treatment for opioid disorders. During the 2019 fiscal year (July 1, 2019 -June 30, 2020), Nevada 211 received 1,342 calls relating to substance use services, including 415 for drug detoxification support.

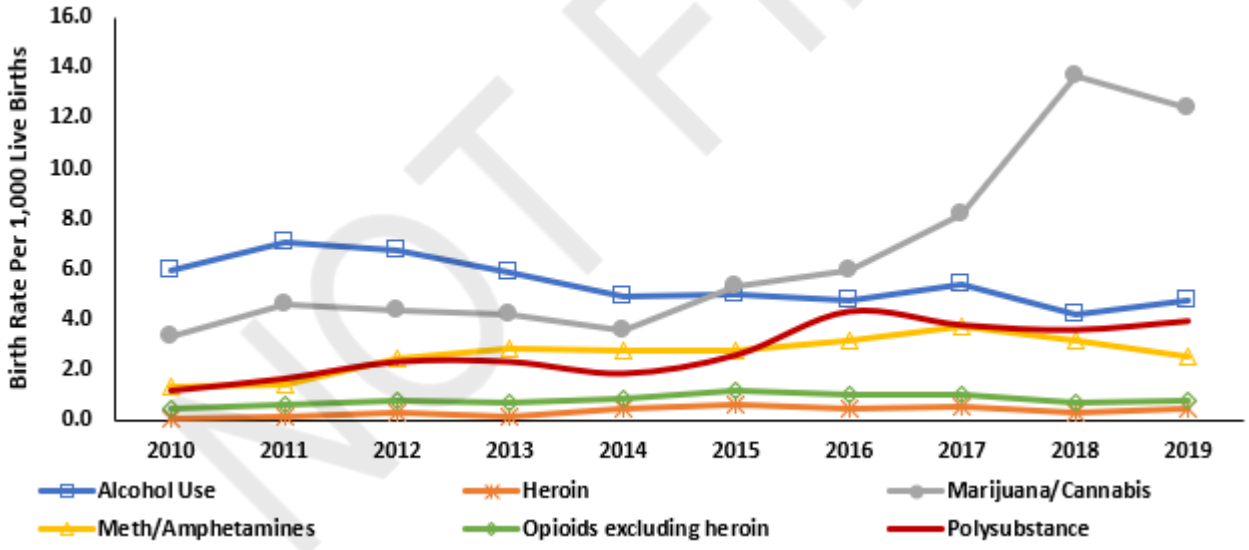
Maternal and Child Health

Nevada 211 is a phone number that helps Nevadans connect with services they need, including pregnancy- related mental health services. During the 2020 fiscal year (July 1, 2019 -June 30, 2020), Nevada 211 received 30 calls relating to mental health similarly to fiscal year 2019 with 33 call. The most calls received were for information regarding parent support groups and parent counseling.

Substance Use Among Pregnant Women (Births)

The data in this section is reflective of self-reported information provided by the mother on the birth record. On average, there were 35,352 live births per year to Nevada residents between 2010 and 2019. In 2019, 167 birth certificates indicated alcohol use, 434 birth certificates indicated marijuana use, 89 indicated meth/amphetamine use, 26 indicated opiate use, and 17 indicated heroin use during pregnancy.

Figure 33. Prenatal Substance Use Birth Rates (Self-Reported) for Select Substances, NV Residents, 2010-2019.[34]



Of the self-reported substance use during pregnancy among Nevada mothers who gave birth between 2010 and 2019, the highest rate was with marijuana use in 2018, at 13.7 per 1,000 live births. Since 2015, the marijuana use rate has surpassed the alcohol use rate, which was 4.8 per 1,000 births in 2019. In 2019, a rate of 2.5 per 1,000 live births was reported for meth/amphetamines, which is lower than the previous year at 3.2 per 1,000 live births. Polysubstance use (more than one substance) has increased from 2.6 per 1,000 live births in 2015 to 3.9 per 1,000 live births in 2019.

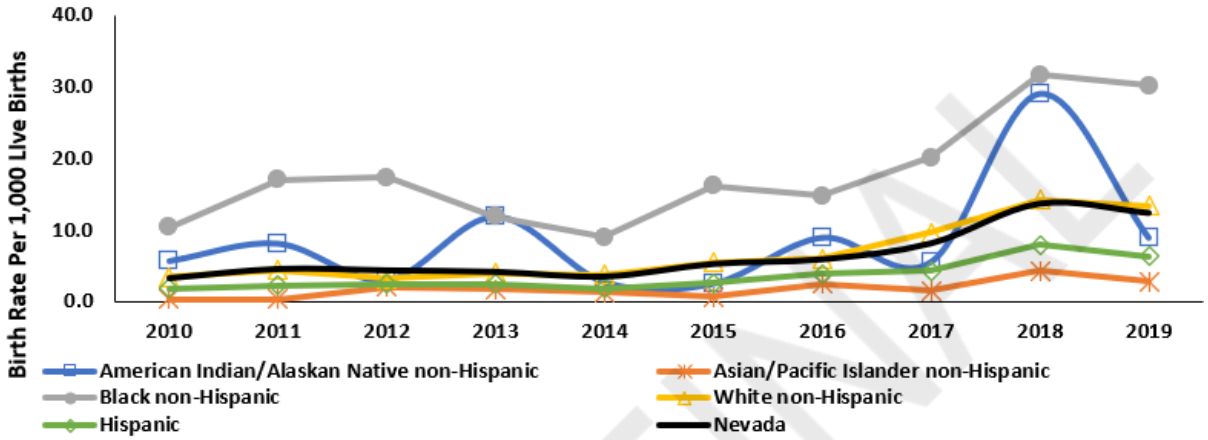
Marijuana/cannabis use among pregnant females was significant in the 20-24 age group, at 24.7 per

[34] *Nevada Electronic Birth Registry System.*

1,000 live births (age specific). There is a significant increase in marijuana /cannabis use for the PACT/CARE coalition county region from 2017 to 2019, at 8.2 to 12.4 women using marijuana/cannabis per 1,000 live births.

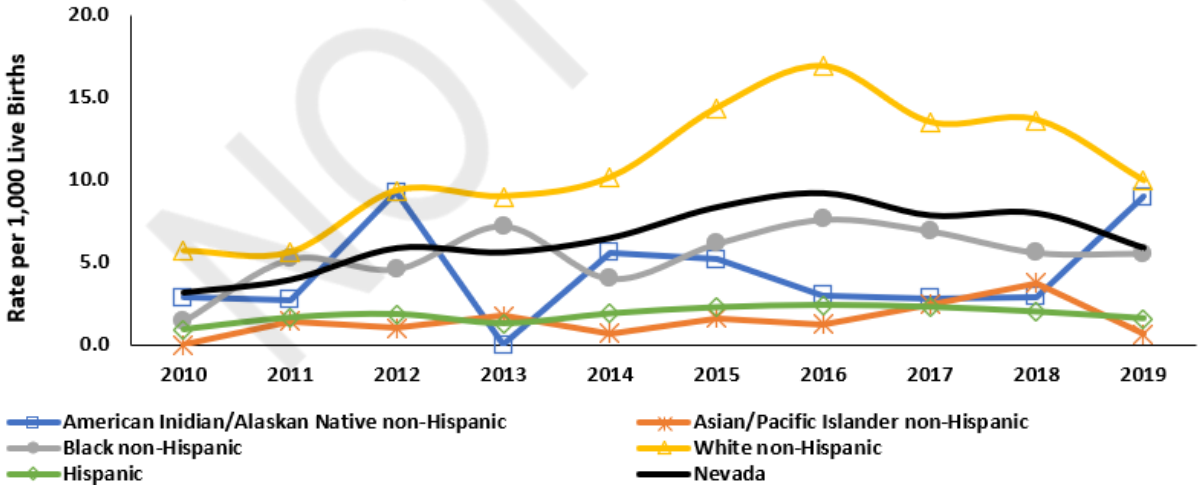
Because alcohol and substance use during pregnancy is self-reported by the mothers, rates are likely lower than actual rates due to underreporting, and expectant mothers may be reluctant to be forthcoming on the birth record for a variety of reasons.

Figure 34. Prenatal Marijuana Use by Race/Ethnicity Birth Rates (Self-Reported), Nevada Residents, 2010-2019.[35]



Black non-Hispanic mothers self-reported marijuana use was significantly higher than Nevada at 30.2 per 1,000 live births.

Figure 35. Prenatal Tobacco Use Birth Rates by Mother' Age (Self-Reported), Nevada Residents, 2010-2019.[36]



Woman over 45 were not included in the above graph but did have a significant decrease in tobacco use during pregnancy from 2010-2015 (244.8 to 189.4 per 1,000 live births respectively). In 2019, the

[35] *Nevada Electronic Birth Registry System.*

[36] *Nevada Electronic Birth Registry System.*

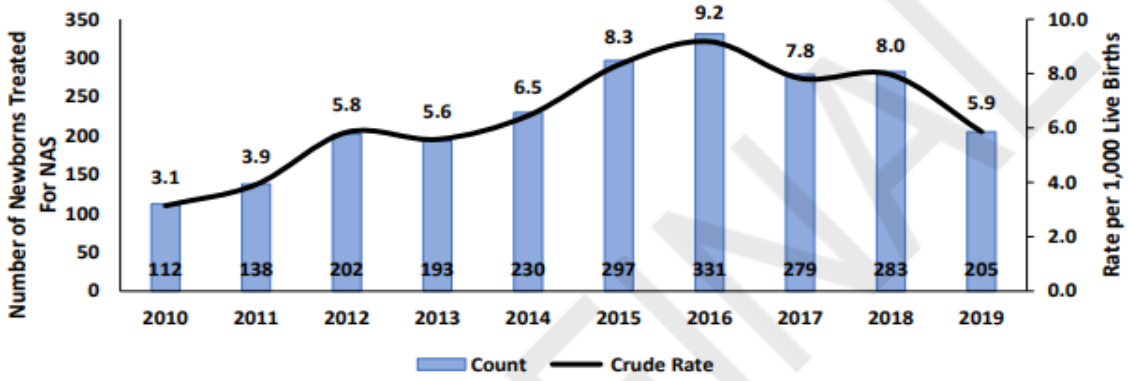
tobacco use during pregnancy was 86.5 per 1,000 live births for woman over 45. Tobacco use during pregnancy has decrease for all mothers ages since 2016.

In 2019, there were 17 pregnant women (out of a total of 1,464 women) surveyed in BRFSS. When pregnant women were surveyed for BRFSS, they had significantly higher use for tobacco smoking, at 21.4%, from non-pregnant women 13.7%.

Neonatal Abstinence Syndrome

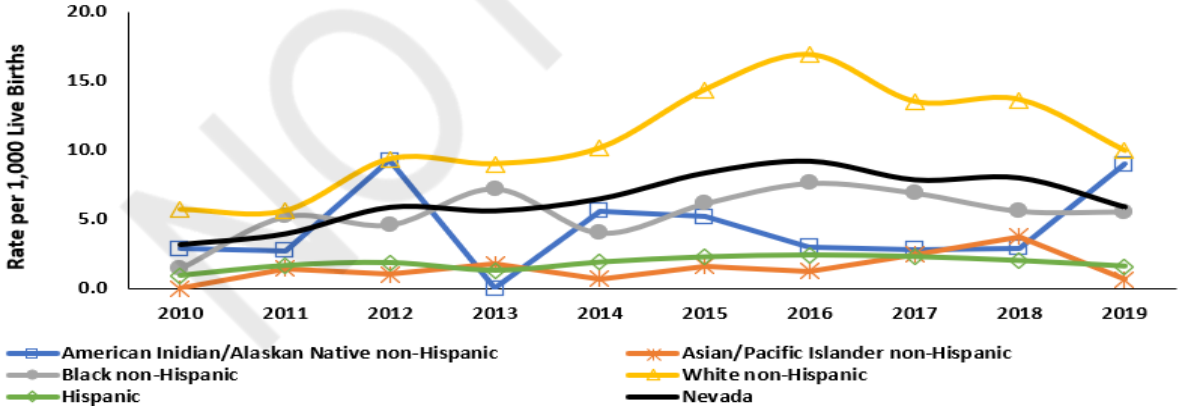
Neonatal abstinence syndrome (NAS) is a group of issues that occur in a newborn who was exposed to addictive, illegal, or prescription drugs while in the mother's womb. Withdrawal or abstinence symptoms develop shortly after birth.

Figure 36. Neonatal Abstinence Syndrome, Nevada Residents, 2010-2019.[37]



Inpatient admissions for NAS has doubled since 2011, from 112 newborns admitted to 205 newborns admitted in 2019 but has significantly decreased from 2018. White non-Hispanic have significantly higher NAS rate compare all other races. The average length of stay for newborns with NAS in 2019 was 19 days.

Figure 37. Neonatal Abstinence Syndrome by Race and Ethnicity, Nevada Residents, 2010-2019.[38]



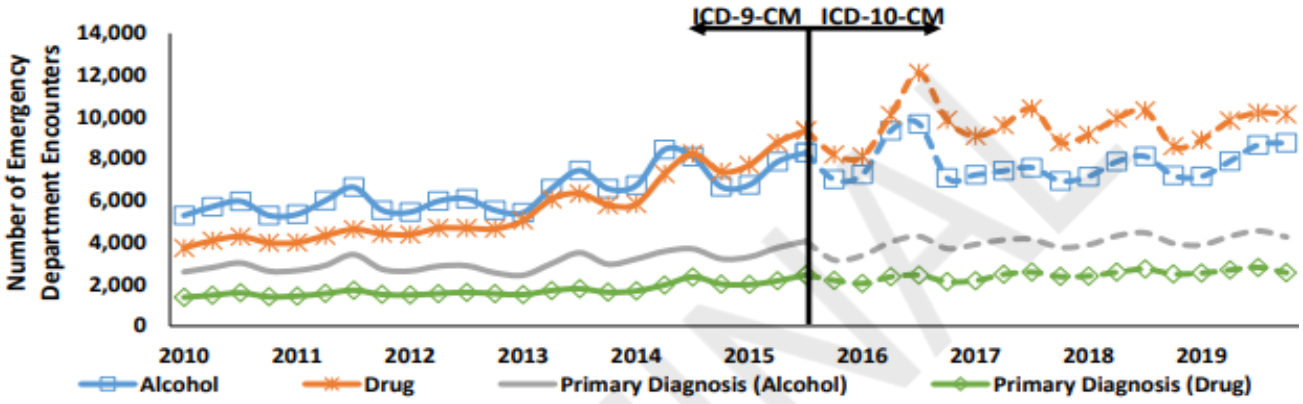
[37] *Hospital Inpatient Department Billing and Nevada Electronic Birth Registry System. ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.*

[38] *Hospital Inpatient Department Billing and Nevada Electronic Birth Registry System.*
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Hospital Emergency Department Encounters

The hospital emergency department billing data provides health billing data for emergency department patients in Nevada's non-federal hospitals. Since an individual can have more than one diagnosis during a single emergency department visit, the following numbers are not mutually exclusive.

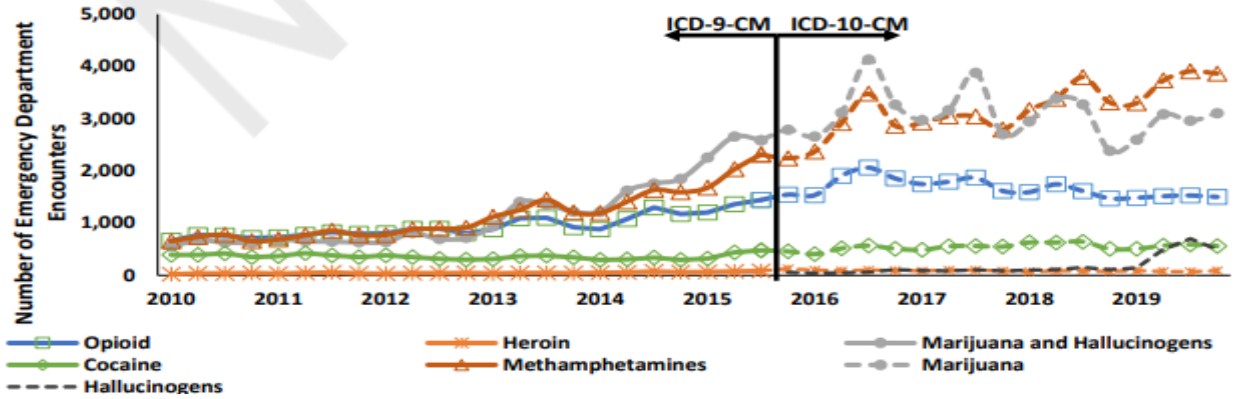
Figure 38. Alcohol and Drug-Related Emergency Department Encounters by Quarter and Year, 2010-2019.



The "primary diagnosis" is the condition established to be chiefly responsible for the emergency department visit. The "alcohol" and "drug" categories are for any visits where alcohol/drugs were listed in any of the diagnoses.

Alcohol visits were more common than drug visits until 2014 where drug-related visits to the emergency department surpassed alcohol and have remained higher through 2019. In 2019, there were a total of 67,405 alcohol and drug-related emergency department encounters. Out of these encounters, 16,979 were related to alcohol (primary diagnosis) and 10,576 were drug-related (primary diagnosis).

Figure 39. Drug-Related Emergency Department Encounters by Drug and Quarter and Year, 2010-2019.[39]



[39] *Hospital Emergency Department*

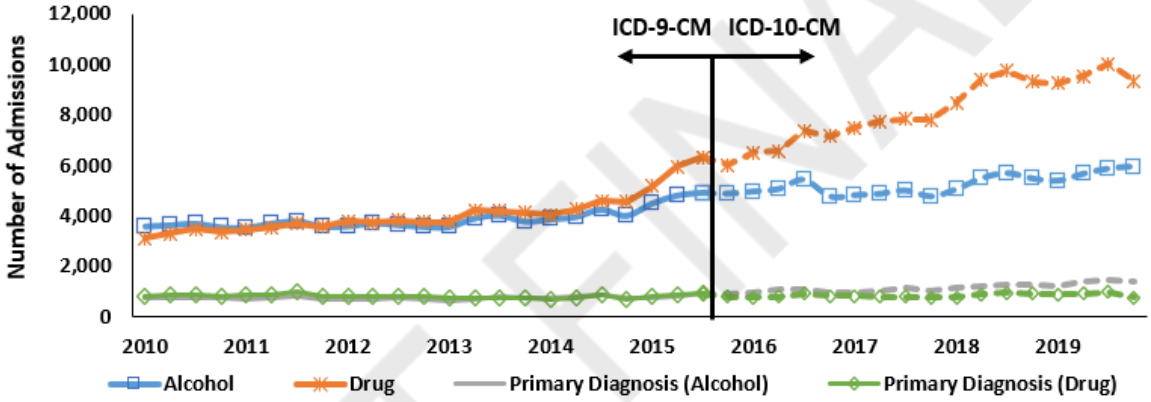
Hallucinogens and marijuana were grouped together in the ICD-9-CM, but in 2015 were separated into different groups in the ICD-10-CM codes. Methamphetamines, and hallucinogens drug use rates were significantly higher in 2019 than in 2018. Males had significantly higher emergency department encounters for cocaine, methamphetamines, marijuana/cannabis, and hallucinogens use for 2019.

The following coalitions service area counties regions had significantly higher marijuana use compared to the state: JTNN, PACT/CARE, and PDC. Other drugs that had had significantly higher use were hallucinogens and cocaine in the PACT/CARE coalition county region, and opioid use in NCC coalition county region.

Hospital Inpatient Admissions

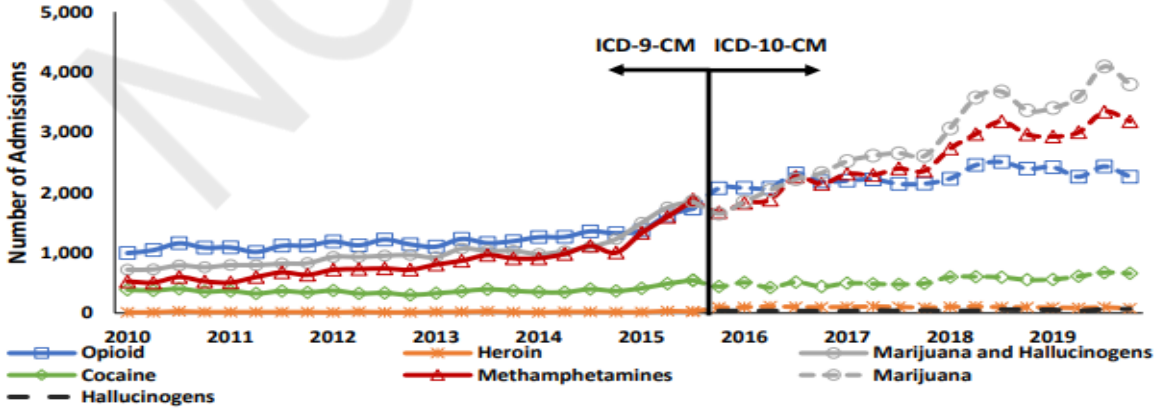
The hospital inpatient admission billing data provides health billing data for patients admitted to hospitals for longer than a 24-hour period. Of the 54,385 alcohol and drug-related admissions, 22,953 were alcohol- related and 38,184 were drug-related.

Figure 40. Alcohol and/or Drug-Related Inpatient Admissions by Quarter and Year, 2010-2019.[40]



Alcohol-related admissions were more common than drug-related admissions until 2011 where drug-related admissions surpassed alcohol and have remained higher through 2019. There were 5,489 admissions related to alcohol as a primary diagnosis and 3,567 were drug-related as primary diagnosis.

Figure 41. Drug-Related Inpatient Admissions by Quarter and Year, 2010-2019.[41]



[40] Hospital Emergency Department Billing. Hospital Bill Codes are not mutually exclusive. ICD 9 CM codes were replaced with ICD 10 CM codes in quarter of 2015, therefore data prior to that may not be directly comparable.

[41] Hospital Emergency Department Billing.

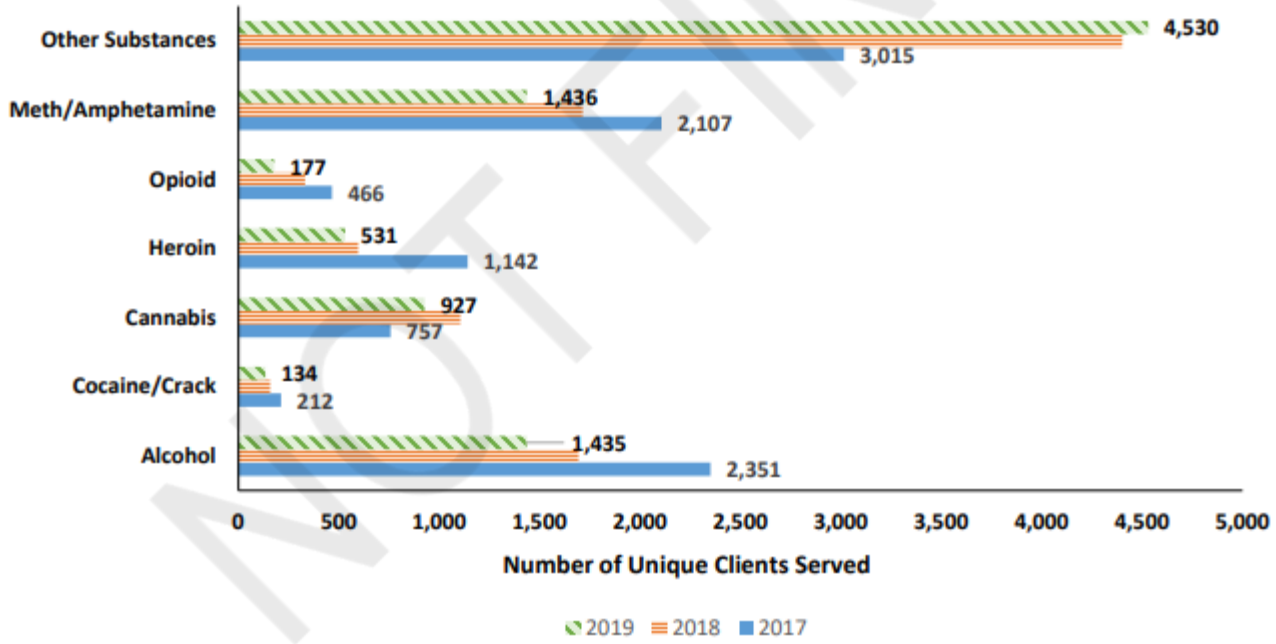
Hallucinogens and marijuana were grouped together in the ICD-9-CM, but in 2015 were separated into different groups in the ICD-10-CM codes. Inpatient admission for males in 2019 were significantly higher than females overall, as well as for cocaine, methamphetamines, hallucinogens, and marijuana-related admissions.

Carson City, area serviced by the PCC coalition had significantly higher inpatient admission rates compared to Nevada for opioid, methamphetamine, and marijuana use. Washoe county, the area served by the JTNN coalition had significantly higher inpatient admission rates for opioid, heroin, and methamphetamines use. Similarly, the counties served by HCC coalition had significantly higher rates for opioid and heroin use. Finally, Clark County, the area served by PACT/CARE coalition had a significantly higher inpatient admission rate for cocaine use.

Substance Treatment Centers

Treatment Episode Data Sets (TEDS) are a compilation of demographic and drug history information on persons who are receiving publicly funded substance use and/or mental health services. The state role in submitting TEDS to the Substance Abuse and Mental Health Services Administration (SAMHSA) is critical, since TEDS is the only national data source for client-level information on persons who use substance use treatment services.

Figure 42. Primary Substance Used for Clients at Substance Abuse Treatment Centers, 2017-2019[42]



Of the total treatment episodes for males, 20% are for alcohol whereas for females visits only 16% are for alcohol-related use and 20% for methamphetamines. Alcohol is the primary substance for use among all races, except Asian/Pacific Islanders, where the primary substance is methamphetamines.

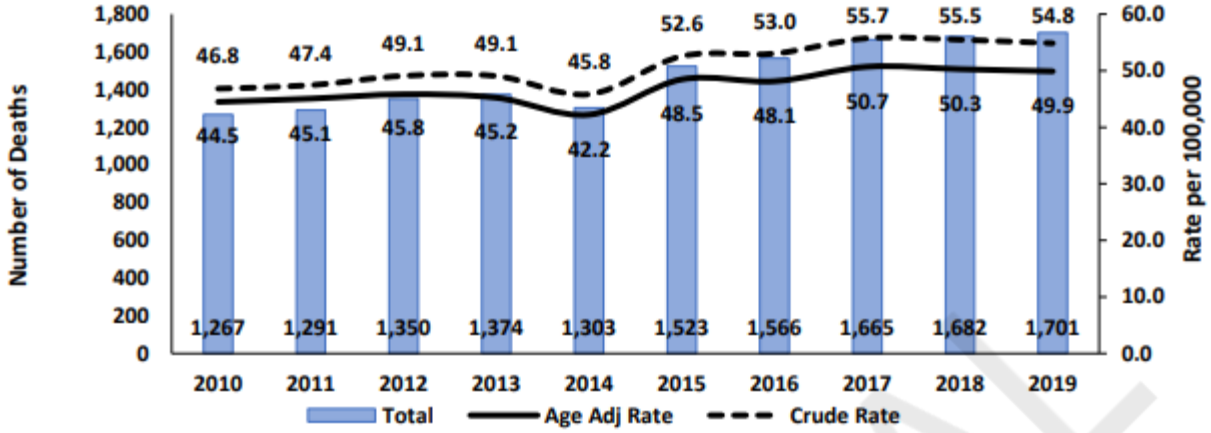
Alcohol and/or Drug-Related Deaths

Alcohol and/or drug-related deaths include deaths where alcohol/drugs are listed as the cause of death. In previous reports, contributing causes of death for alcohol/drugs were included; therefore,

[42] Treatment Episode Data

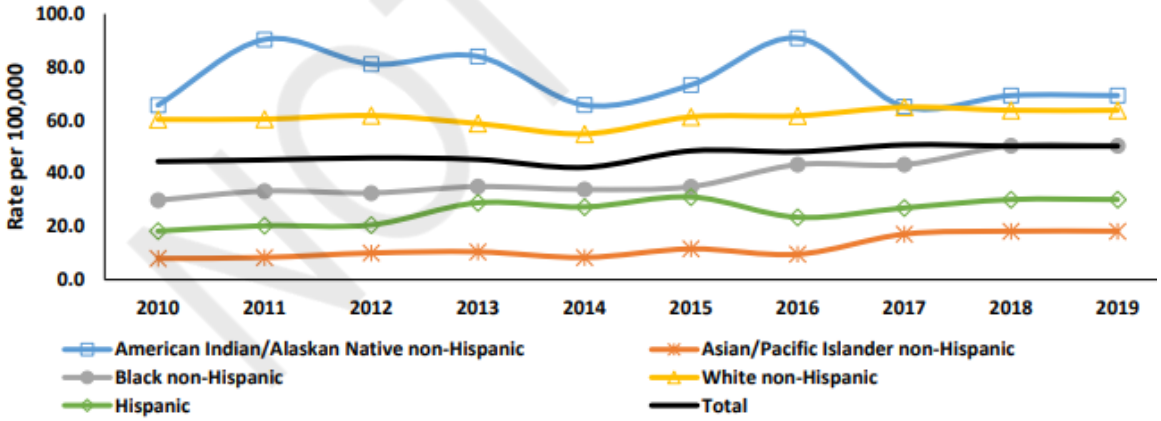
counts will be lower than in the previous report. In 2019, 1,702 deaths were related to alcohol and drugs.

Figure 43. Alcohol and/or Drug-Related Deaths and Rates, 2010-2019.[43]



The alcohol and/or drug-related age-adjusted rate increased significantly in 2015 from previous years (95% confidence interval) and has remained at a significantly higher rate through 2019. Males have a significantly higher death rate than females, with 72.1 per 100,000 age specific population and 32.9 per 100,000 age specific population, respectively. The 55-64 and 65-74 age groups have the highest rates and are significantly higher than all other age groups at 128.9 and 117.5 (respectively) deaths per 100,000 population. The counties served in PCC, JTNN, HCC and CCC coalition regions had a significantly higher rate for alcohol/drug-related deaths in 2019, and Clark County (PACT/CARE service area) and the counties served in PACE coalition county regions had significantly lower rates for 2019.

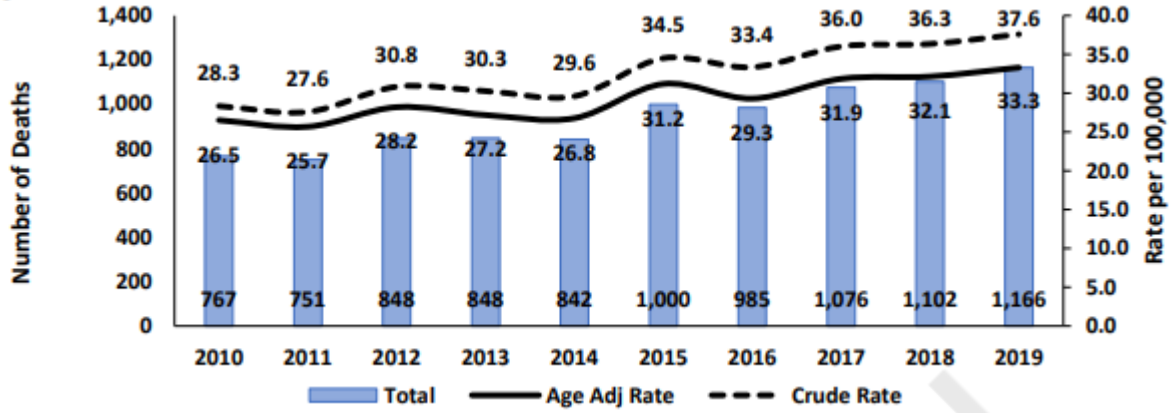
Figure 44. Age-Adjusted Rate for Alcohol and/or Drug-Related Deaths by Race, 2010-2019.[44]



The White non-Hispanic and the American Indian/Alaskan Native non-Hispanic populations had a significantly higher rate of alcohol and/or drug-related deaths in 2019. While deaths in the American Indian/Alaskan Native non-Hispanic population increased in 2011 and 2016, these deaths are not statistically significant (95% confidence interval) due to the relatively small population size.

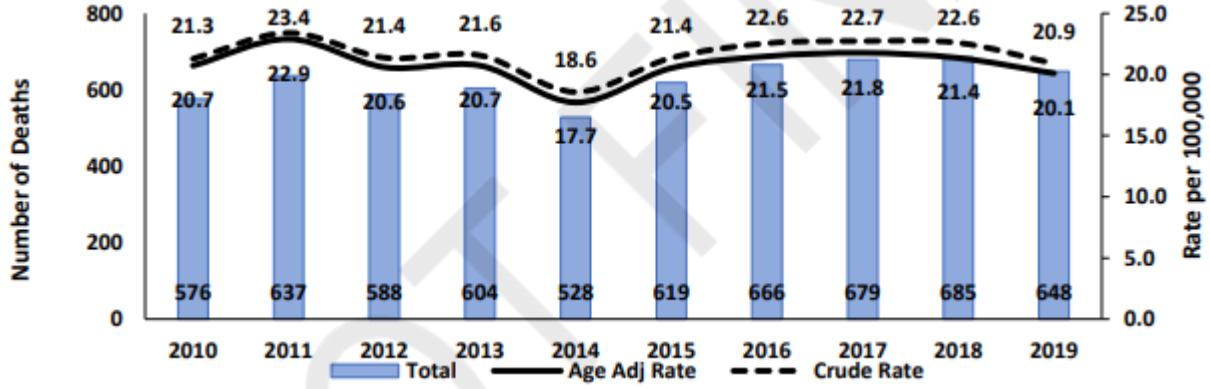
[43] *Electronic Death Registry System.*
[44] *Electronic Death Registry System.*

Figure 45. Alcohol-Related Deaths and Rates, 2010-2019.[45]



Alcohol-related deaths have not increased significantly between 2010 to 2018. Females have significantly lower rates than males. The age groups between 45-84 were significantly higher for alcohol-related deaths. Washoe County (JTNN service area) had a significantly higher rate than other coalitions for alcohol-related deaths.

Figure 46. Drug-Related Deaths and Rates, 2010-2019.[46]



In 2019, males had significantly higher deaths due to drugs than females, at 25.2 and 15.0 per 100,000 age-specific population respectively. The JTNN county region had significantly higher drug-related death rates at 33.6 per 100,000 age-specific population.

The State Unintentional Drug Overdose Reporting System (SUDORS) tracks data related to fatal drug-involved overdoses in Nevada. SUDORS uses death certificates and coroner/medical examiner reports (including post-mortem toxicology testing results) to capture detailed information on toxicology, death scene investigations, route of drug administration, and other risk factors that may be associated with a fatal overdose.

Of the 510 total drug overdose deaths of unintentional/undetermined intent among Nevada residents in 2019, decedents were mostly male, white, had a high school education or less, and between the ages of 35-64. Opioids were listed in the cause of death for over half of cases. Prescription opioids

[45] Electronic Death Registry
[46] *Electronic Death Registry System.*

were listed in the cause of death in about 21% of cases, heroin was listed in about 20% of cases, and fentanyl was listed in about 16% of cases. Methamphetamine was listed as one of the substances in the cause of death in over half of cases reported. Approximately 33% of cases had a documented mental health problem prior to death. About 9% of cases had a documented prior history of overdose, and about 8% of cases were recently released from a hospital prior to death.

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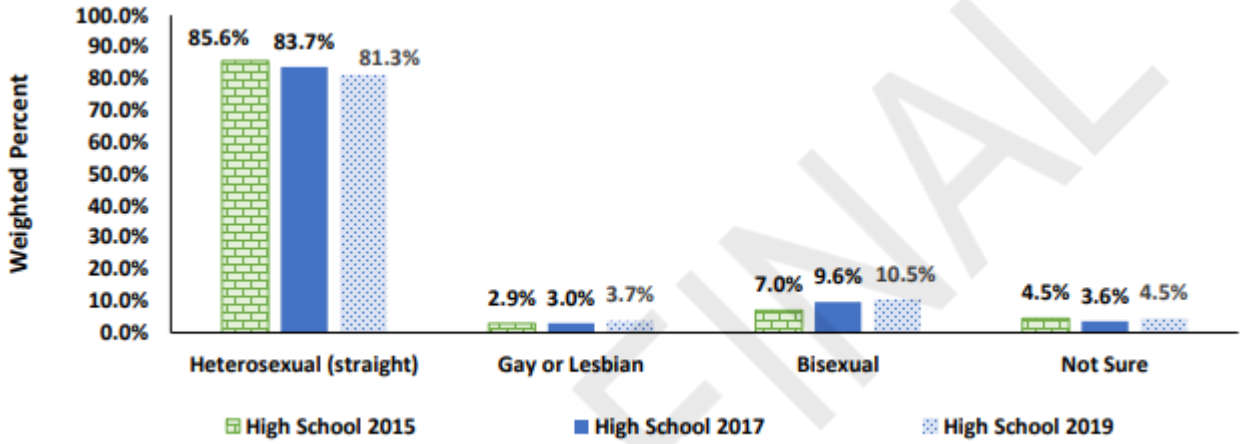
Lesbian, Gay, Bisexual, and Transgender

Youth Risk Behavior Survey (YRBS)

The YRBS monitors six categories of health-related behaviors that contribute to leading causes of death and disabilities among youth and adults. For more detail information about YRBS and sexual orientation and gender identity, UNR has a Sexual and Gender Minority Special Report. Of the students surveyed, 902 (18.8%) are LGB or not sure, and 165 (3.5%) are transgender or not sure.

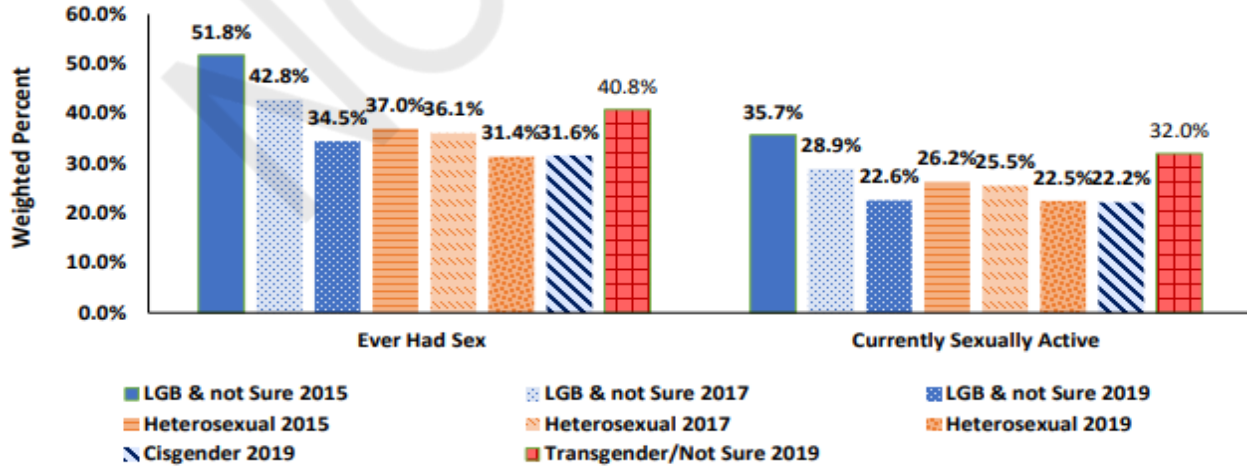
Figure 47. Sexual Orientation, Nevada High School Population, 2015, 2017, and 2019.[47]



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 90% to display differences among groups.

In Nevada high schools, 3.7% of the students identify as gay or lesbian, 10.5% bisexual, and 4.5% are not sure of their sexual orientation, which is a slight increase from the 2017 survey.

Figure 48. Sexual Behaviors Among Students, Nevada High School Students, 2015, 2017, and 2019.



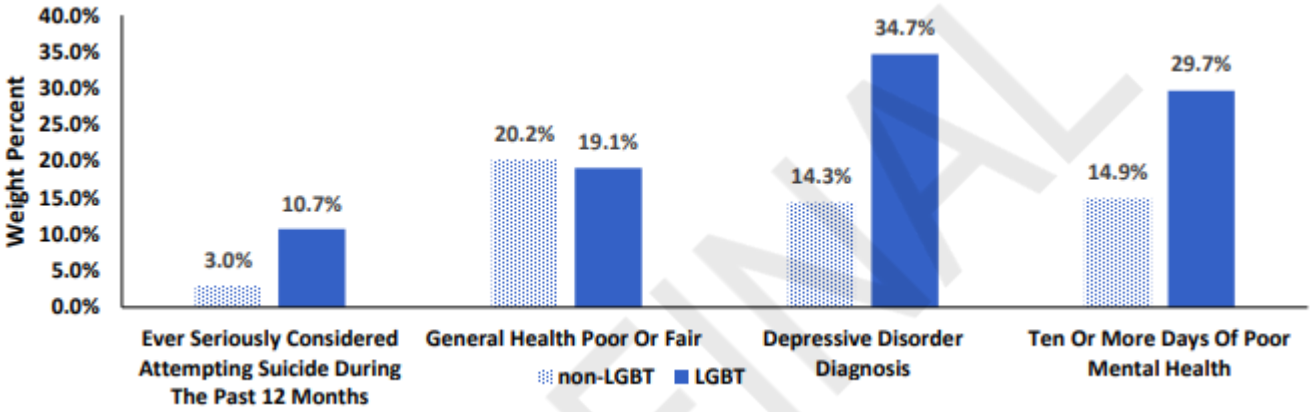
[47] Nevada Behavioral Health Survey
[48] Nevada Behavioral Health Survey

In 2019, 34.5% of gay, lesbian, or bisexual (LGB) high school students have previously had sex, and 22.6% LBG students are currently having sex. Transgender have highest percent of ever had intercourse at 40.8% but it is not significantly higher.

Behavioral Risk Factor Surveillance System

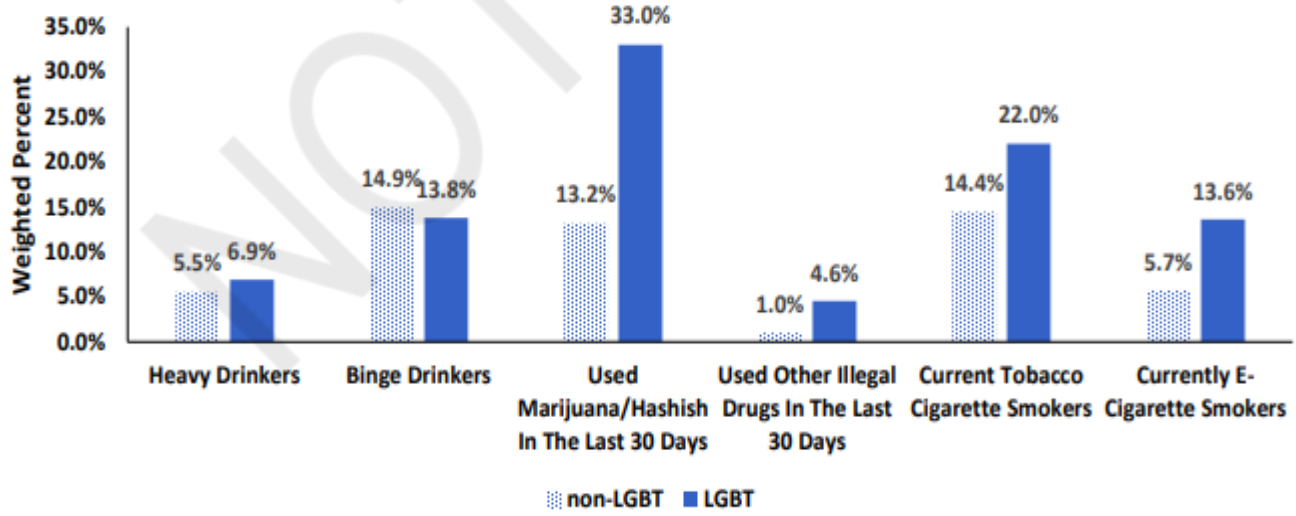
BRFSS collects information on adult health-related risk behaviors. According to the Centers for Disease Control and Prevention, BRFSS is a powerful tool for targeting and building health promotion activities. The survey has questions focusing on substance use including illegal drug use, e-cigarettes, and drunkenness. The LBGT questions were not asked on the 2019 survey.

Figure 49. Mental Health Behaviors, by LGBT and non-LGBT Nevada Adults, 2018.



The LGBT population had significantly higher percentages for both depressive disorder diagnoses and days of poor mental health.

Figure 50. Substance Use-Related Risk Factors, by LGBT and non-LGBT Nevada Adults, 2018.



The LGBT population had a significantly higher percent of current marijuana/hashish use.

Gambling

In 2018, the BRFSS survey added two questions relating to gambling:

> *In the past 12 months, how often have you bet money or possessions on any of the following activities? Casino gaming including slot machines and table games; or lottery including scratch tickets pull tabs and lotto; sports betting; internet gambling; bingo; or any other type of wagering.*
>
> *Has the money you spent gambling led to financial problems and/or has the time you spent gambling led to problems in your family, work, or personal life?*

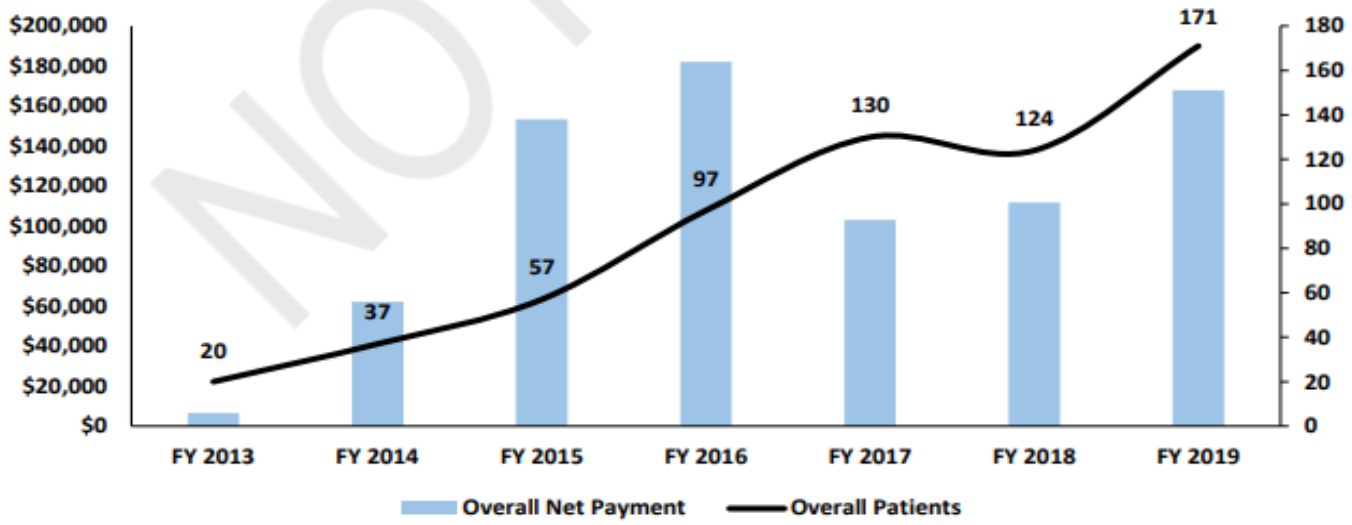
Among Nevadans, 8.5% participate in heavy gambling, (once a week or more). Those 65 years or older were significantly higher than the state, at 14.1%. Males are significantly higher than females, at 10.5% and 6.5% respectively.

In 2020, 84% of individuals presenting for treatment for problem gambling reported using one or more substances in the year prior and 20% of individuals in care were subsequently diagnosed with a substance use disorder (UNLV 2020 Nevada Annual Report on Problem Gambling, 2021).

A survey of substance use treatment facilities found 84% of treatment providers rating the need to improve the capability of substance use treatment providers to address problem gambling issues as a very high or critical need (Marotta; 2021).

Medicaid patients can only access services for pathological gambling through a Medicaid-enrolled behavioral health provider.

Figure 51. Clients with Pathological Gambling Diagnosis, Clients and Payment, Fiscal Year 2013-2019.[49]



[49] *DSS and Medicaid*

Persistent and Emerging Issues of Public Health Concern

Tobacco / Nicotine and Vaping

The Nevada Public Health Cannabis and Vaping Summit was initiated through a request for funding originally submitted to the Nevada Office of the Attorney General. In the request, the Nevada DHHS, DPBH sought funds to address the alarming increase in cannabis use as well as the use of vaping products in the state. The request noted that increase in lung injury associated with vaping had recently been identified in Nevada and linked to both cannabis and nicotine vaping products. Nevada, along with the nation, is seeing troubling trends in morbidity associated with the use of e-cigarettes, vape juice, e-liquids such as liquid nicotine, additives, and cannabis; however, the state lacked the resources to provide sufficient surveillance and public health prevention messaging to adequately address the impacts to the public and to youth and young adults affected by these startling trends. In January of 2021, Nevada put on a Cannabis, Vaping Summit. to address strategy efforts on Cannabis and Vaping in Nevada. Overall themes included Cannabis prevention Action Plan, Cannabis and Vaping Policy and Regulation Action Plan, Cannabis and Vaping Law Enforcement and Public Safety Action Plan, and Cannabis Specialist populations Action Plan.

A related risk is vaping. Vaping is also considered to be a significant health threat in Nevada with 6.1% of adults who report current use of electronic vapor products, higher than the national weighted percentage at 5.4% reported from the 2018 BRFSS. While rates of smoking have declined among youth, vaping is on the rise. Recently published studies suggest that vaping has considerable negative health effects that were previously unknown (Desert Research Institute, 2018) and, that vaping is an "epidemic" among youth, having been marketed in flavors and in packaging that make vaping devices easy to hide from parents and teachers *(Stein, 2018)*. Vaping can include nicotine, other liquid drugs, or, chemicals that are simply "flavored."

In the fall of 2019, an unknown lung injury epidemic was found to be attributed to vitamin E acetate in electronic vapor products. Between September 2019 and August 2020, the number of new cases per month of EVALI fluctuated between 17 and 4 new cases a month. The greatest number of new cases occurred in September 2019 (Diedrick, et al.,2021).

Rates of adult smoking are higher in Nevada than the nation. In 2019, 15.7% are current smokers like the national weighted percentage at 15.3% reported from the Behavioral Risk Factor Surveillance System (NV DHHS, 2021c).

Nearly one in four Nevada high school youth (23.9%) "had ever" smoked a cigarette.

Twelve percent (12%) had smoked in the previous 30 days *(2019 Youth Risk Behavior Survey (YRBS))*

Of Nevada high school students in 2019, 3.6% have smoked cigarettes, which is lower than the national reported at 6.0%. (2017 Youth Risk Behavior Survey YRBS).

Poisoning from nicotine affects a small portion of children. It should be noted that

nicotine is highly toxic in large doses, and therefore a risk to young children *(American Academy of Pediatrics, 2017).* Liquid nicotine (used for some vaping devices) poses risk due to its concentration.

Cannabis / Marijuana

The legalization of adult-use cannabis/marijuana has been a factor in increased use since dispensaries became available in 2021. Between 2015 and 2019, past 30-day cannabis/marijuana use increased and was higher in Nevada compared to the United States (NV DHHS, 2020).

Many are concerned about youth access and increased use among adolescents. Among Nevada's high school students, 35.4% reported using cannabis/marijuana in their lifetime, and 18.8% reported using cannabis/marijuana is the past 30 days (Diedrick, et al., 2021).

Between 2017 to 2019, Nevada middle school students reported a significant increase in lifetime cannabis use (p=0.0087), past 30-day cannabis use (p<0.0001), and riding in a car with someone who had been using cannabis. In 2019, almost a third (29.9%) of Nevada high school students said it would be very easy to obtain cannabis (Diedrick, et al., 2021). The proportion of middle school students who used cannabis primarily by vaping it also increased from 2.1% in 2017 to 11.1% in 2019 (Diedrick, et al., 2021).

Figure 52. Trend of Adolescent Cannabis Use, YRBS, 2017- 2019

		Middle School YRBS			High School YRBS		
		2017	2019	Change	2017	2019	Change
Cannabis	Lifetime use	9.9%	13.4%	↑ p = 0.0021	36.4%	35.4%	—
	Early initiation	2.5%	3.3%	—	8.6%	7.0%	—
	Past 30-day use	5.2%	7.9%	↑ p = 0.0007	19.7%	18.8%	—

Alcohol

The availability of alcohol, along with its addictive properties, makes it one of the most significant concerns from a public health perspective *(Jaffee, 2016).* In Nevada there was a significant decrease in high school students both from ever drinking and current use of alcohol.

Among Nevada's high school youth, 56.9 % "had ever" drank alcohol a decrease from 60.6%; 23.9% currently drink alcohol, a decrease from 26.5%. *(2019 Youth Risk Behavior Survey (YRBS))*

Alcohol-related deaths have not increased significantly between 2010 to 2018. Females have significantly lower rates than males. The age groups between 45-84 were significantly higher for alcohol-related deaths. Washoe County had a significantly higher rate than other counties for alcohol-related deaths.

Synthetic Marijuana or "Spice"

Synthetic marijuana, (often called "spice" or K2) uses synthetic (man-made) chemicals that are added to plant material to be smoked or sold as liquids to be vaporized. These products may also be known

as herbal or liquid incense. They are marketed as safe alternatives to cannabis but are in fact very dangerous due to their unpredictability in chemical content and dosage *(National Institute on Drug Abuse, 2018)*.

Of Nevada high school students, 7.2% have use synthetic marijuana while the national percentage is lower at 7.3%. (2020 State of Nevada Epidemiological Profile)

Methamphetamine

Methamphetamine is a powerful, highly addictive stimulant that has numerous adverse effects including addiction, anxiety, confusion, mood disturbance, and violent behavior. People using methamphetamine may also display psychotic features such as hallucinations and delusions *(National Institute on Drug Abuse: Advancing Addiction Science, 2013)*. Methamphetamine addiction takes a particular toll on children when parents or caregivers are addicted.

Providers in Nevada are concerned about a resurgence in methamphetamine. This is confirmed with data. According to a recent report, Nevada's death rate from methamphetamines was highest in the U.S. *(Associated Press, 2018)*.

Methamphetamine may also be contaminated with other drugs like fentanyl, contributing to deaths *(Sewall, 2018)*.

Females rates of methamphetamine use in Nevada are 20% (2020 State of Nevada Epidemiological Profile)

In 2019, a rate of 2.5% per 1,000 live births, mothers self reported methamphetamine/amphetamines use. (2020 State of Nevada Epidemiological Profile)

In 2019 among Nevada's middle school youth, 1.1% reported using methamphetamines a decrease from 1.7% in 2017; while, among Nevada's high school youth, 2.9% reported having ever used methamphetamine a decrease from 3.3% in 2017

Opioids: Prescriptions, Heroin and Fentanyl

The opioid epidemic in Nevada continues to evolve and worsen. Nevada HIDTA has classified heroin, fentanyl, and methamphetamines as three of the top threats in 2021 (Nevada HIDTA, 2020)

Opioid Surveillance Report (Office of Analytics, 2021) is updated semi-annually with data from medica billing data and vital records. The summary of findings from the most recent report is below.

From 2010 to 2020 emergency department encounters increased by 67% and inpatient admissions increased by 66%. The rate of emergency department encounters per 100,000 Nevada residents increased from 109.5 to 183.4, and the rate per 100,000 Nevada residents of inpatient admissions increased from 161.2 to 268.3.

In terms of demographics in 2020, 68% of the opioid-related emergency department encounters were White non-Hispanic. In the hospital, 68% of the inpatient admissions were White non-Hispanic and were most prevalent among 25-34 years old Nevada residents (24%).

In 2020, Medicaid paid 52% of the opioid-related emergency department encounters and 45% of the opioid-related inpatient admissions.

From 2010 to 2020, opioid poisonings in the emergency department increased by 5%, and inpatient admissions decreased by 36%. The rate per 100,000 Nevada residents in the emergency department

increased from 28.8 to 30.4 and inpatient admissions rates per 100,000 Nevada population decreased from 22.1 to 14.2.

In 2020:

- Heroin was included in 32% of the emergency department encounters and 19% of the inpatient admissions.
- Methadone was included in 1% of the emergency department encounters and 3% of the inpatient admissions.
- Other opioids and narcotics accounted for 67% of the emergency department encounters and 77% of the inpatient admissions.

From 2010 to 2020, the number of opioid-related overdose deaths increased. The rate per 100,000 Nevada residents for opioid-related overdose deaths increased by 5% from 16.2 to 16.9.

From 2010 to 2020, each year

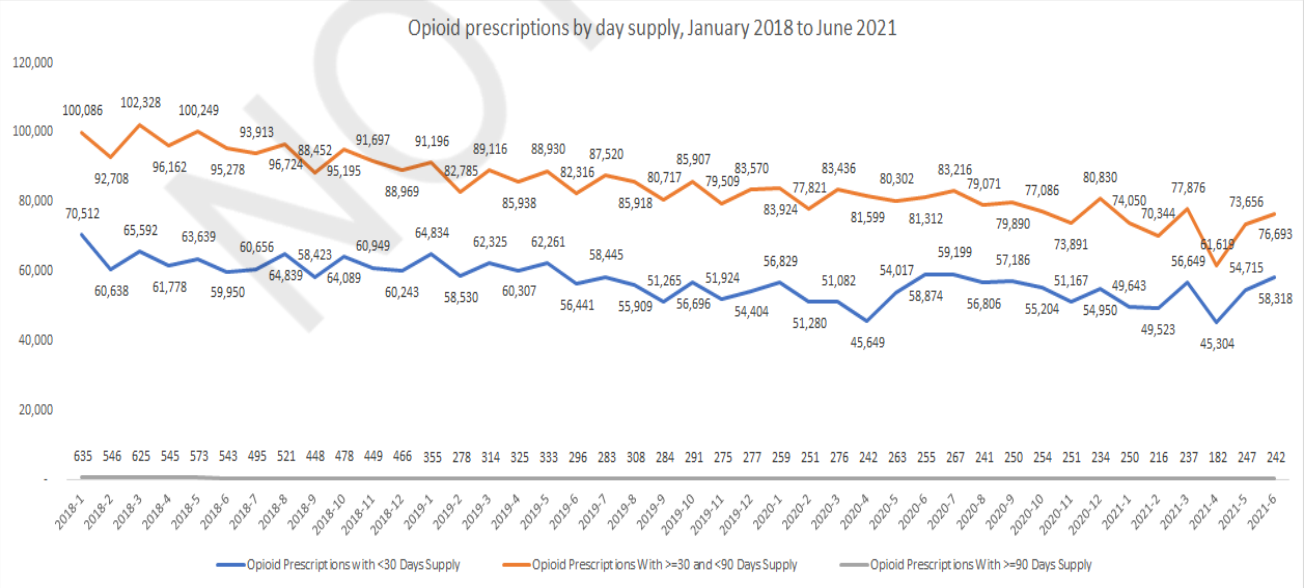
- Roughly 85% of all benzodiazepine-related overdose deaths also involve opioids.
- Roughly 30% of all opioid-related overdose deaths also involve benzodiazepines.

In terms of demographics in 2020, 66% of the opioid-related overdose deaths were White non-Hispanic and opioid-related deaths were most prevalent among 25-34 years old Nevada residents, which is different than other years.

Opioid-related overdose deaths, in 2020, were more prevalent among the male gender.

Opioid-related overdose deaths in Nevada by suicide accounted for 12% of all opioid-related deaths. Nevada has had 558 opioid-related suicide deaths between 2010 and 2020.

Figure 53. Opioid Prescription Counts and Rates per 100 Population by Month, January 2017- June 2021

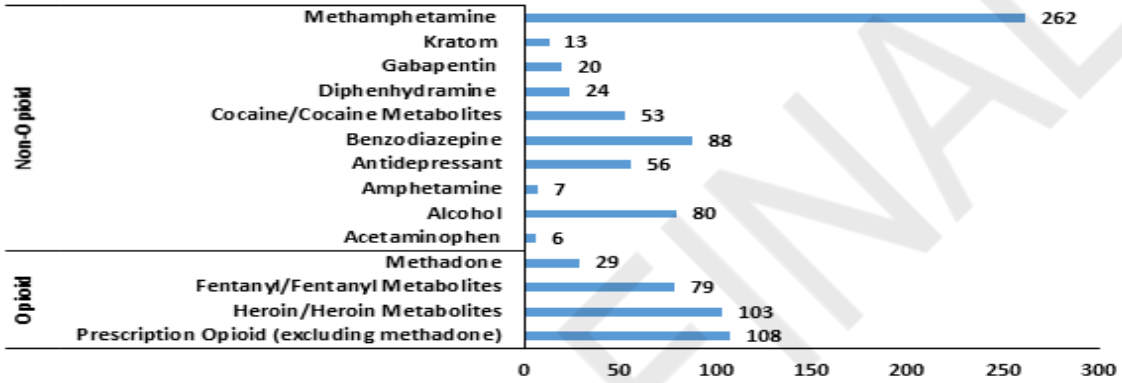


Among Nevada's high school youth in 2019, 18.18% had taken prescription pain medicine without a prescription or not as prescribed an increase from 14.8% in 2017. *(2019 Youth Risk Behavior Survey (YRBS)*

Among Nevada's high school youth, 2.6% reported having used heroin in the 2017 YRBS, this number remains flat as of the 2019 YRBS.

Among Nevada's middle school students there has been an increase from 6.8% in 2017 to 10.3% in 2019 in the percentage of middle school students who ever took prescription pain medicine without a doctor's prescription or differently than prescribed. *(2019 YRBS)*

Figure 54. Nevada's 2019 Substances Listed in Cause of Death Among unintentional/undetermined Overdose Deaths



Nevada's Capacity Assessment

In 2019, SAPTA partnered with Social Entrepreneurs Inc. (SEI) and the Regional Behavioral Health Coordinators (RBHC's) to conduct regional assessments of the substance abuse prevention and treatment systems, unmet need, hospitalization risk, scope of services and location of existing substance use prevention and treatment services by region, and to identify trends across programs, regions, and the state. The report offers SAPTA capacity building priorities for each region in Nevada along with best and promising practices to support the regional priorities identified.

Methods and Approach

Assessment of Systems Capacity

In order to identify capacity at the regional level, SEI used information gathered from The Calculating and Adequate System Tool (CAST), which was developed for the Substance Abuse and Mental Health Services Administration (SAMHSA). SEI conducted research from publicly available sources for every county and region in Nevada, based on guidance from the CAST.

Assessment of Community Needs

To assess community needs by region, public data was collected by zip code and region. Additional documents were collected and reviewed to inform the report and provide context for the regional

system and its capacity.

CAST Assessment

CAST was developed by an interdisciplinary group of researchers at SAMHSA's enter for Behavioral Health Statistics and Quality (CBHSQ) in 2016. Since this publication, CAST has been updated, and a manual was recently developed which describes the purpose of CAST as follows:
"CAST was created as a method for evaluating the capacity of the substance abuse care system within a defined geographic area. CAST provides users with both a risk assessment of county-level social and community determinants of substance abuse, and an assessment of local service need across the continuum of care […] CAST uses social determinants of behavioral health and social disparities in behavioral health outcomes to provide insight into the chronic social conditions that may be contributing to behavioral health outcomes in your community. Most often, CAST has been used to estimate need for a county as the geographic unit, but it can be used for smaller or larger areas, as long as data at those geographic levels is available or could be produced at that scale." (p. 3)

There were two basic goals built into the CAST model, which were to:

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

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

Regional Priorities

Northern region included Storey, Carson, Douglas, Churchill, Lyon, and Mineral counties

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

Promotion: Marketing Advertisements

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

Prevention: Housing Vouchers

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

Treatment: Short-Term Inpatient Treatment

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

Treatment: Long-Term Inpatient Treatment

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

Treatment: Psychiatrists and Psychologists

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

Rural region included Humboldt, Pershing, Lander, Eureka, Elko, White Pine, and Lincoln counties

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

Recovery: Transportation

- Increase the availability of transportation services.

Treatment: Outpatient

- Increase the availability of outpatient treatment by leveraging technology.

Treatment: Outpatient

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

Recovery: Housing Support

- Increase the number of housing supports available.

Southern region included Clark County

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

Promotion: Marketing Advertisements

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

Prevention: Housing Vouchers

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

Treatment: Short-Term Inpatient Treatment

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

Treatment: Long-Term Inpatient Treatment

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

Treatment: Psychiatrist Availability

- Increase the number of psychiatrists in Clark County.

Southern Rural region included Nye and Esmerelda counties

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

Promotion: Marketing Advertisements

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

Promotion: Advocacy Events

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

Prevention: Drug Disposal

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

Recovery: Transportation

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

Other: Training

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

Washoe region included Washoe County

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

Prevention: School-Based Prevention Programs

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

Prevention: Housing Vouchers

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

Referral: Case Manager Availability

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

Treatment: Crisis Stabilization, Detoxification, and Rehabilitation

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

Treatment: Psychiatrist Availability

- Increase the number of psychiatrists in Washoe County.

Substance Abuse Block Grant Prevention and Treatment Activities

SUD TREATMENT CAPACITY EXPANSION: OUTPATIENT, CRISIS, RESIDENTIAL, TRANSITIONAL HOUSING, AND SPECIALITY PROVIDERS

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

In addition, it has been identified that there is a need for substance use disorder treatment services to continue to focus on becoming co-occurring capable and enhanced. Since 2014, Medicaid has required all enrolled substance use disorder treatment providers to be at least co-occurring capable. A provider's co-occurring capabilities is assessed during certification site visits using the Dual Diagnosis Capability Toolkits (McGovern; 2006). SAPTA is committed to continuing to promote the need for co-occurring enhanced services and will continue to partner with providers to offer the needed technical assistance and training to support them in achieving co-occurring enhanced endorsements.

In addition, Nevada's high rate of problem-gambling co-occurring with substance use disorders has promoted the development of an implementation plan to further integrate co-occurring disorders treatment for problem gambling into substance use disorder treatment programs. In partnership with the Nevada Advisory Committee on Problem Gambling, CASAT and SAPTA have launched an integration project focused on enhancing substance use disorder treatment providers capabilities for identifying and treating gambling disorder into their treatment settings. This work is being accomplished through the integration of the Problem Gambling Capability Toolkit, as developed by Lori Rugle, into the certification process for agencies who wish to being the work of integrating problem gambling services into treatment for substance use disorders.

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

Given that treatment access is, in part, a function of affordability and availability, and availability is a function of provider capacity, transportation, and use of technology, it is important to identify solutions that take the sum of those elements into account when considering the best approach for expanding treatment services at every level of care. State partnerships are needed that include SAPTA,

Medicaid and Nevada's health plans to ensure that reimbursement structures and policies don't unnecessarily limit options for consumers with provisions and riders that may affect eligibility and coverage conditions, including preexisting condition riders and lifetime limit clauses.

In 2021, Nevada Medicaid, with the support of BBHWP and SAPTA, will be expanding access to withdrawal management and residential treatment services through a state plan amendment and a 1115 Demonstration program through CMS. Section 1115 Demonstration waiver will expand statewide access to comprehensive behavioral health services for the most vulnerable Nevadans, including those with opioid use disorders (OUDs) and other substance use disorders (SUDs). Specifically, DHHS is seeking authority to provide a limited waiver of the federal Medicaid Institutions for Mental Diseases (IMD) exclusion (hereinafter referred to as the "Demonstration"). This Demonstration will further the objectives of Title XIX and Title XXI of the Social Security Act by improving access to high-quality, person-centered services that produce positive health outcomes for individuals; and advancing innovative delivery system and payment models to strengthen provider network capacity and drive greater value for Medicaid. The Demonstration will not modify the State's current Medicaid program or Children's Health Insurance Program (CHIP) outside of the benefits and reimbursement methodologies described within the application.

All mandatory and optional eligibility groups approved for full benefit coverage under the Nevada Medicaid and CHIP State Plans will be eligible for the Demonstration.

The Demonstration will target high-risk, high-need beneficiaries requiring enhanced services to effectively treat SUD and/or OUD. The State is seeking a limited waiver of the federal IMD exclusion to ensure meaningful access to services. Nevada residential and withdrawal management providers are currently licensed as either residential facilities (i.e., "Facility for the treatment of abuse of alcohol or drugs," or ADA), community triage centers (CTC), or withdrawal management facilities (i.e., "Facility for modified medical detoxification," or MDX). As the majority of these providers are located in Las Vegas and Reno, Nevada's two urban areas, most individuals residing in rural or frontier areas must travel great distances to find an adequate level of care. Despite the number of licensed IMD providers in Nevada, access to SUD treatment services is severely limited for the uninsured, underinsured, and Medicaid beneficiaries. This is primarily due to the federal IMD exclusion, which prohibits Federal Financial Participation (FFP) for medically necessary services provided in hospitals, nursing facilities, or other institutions of more than 16 beds, that are primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

Nevada Medicaid managed care organizations are contractually permitted to authorize coverage for stays of up to 15 days in an IMD for inpatient services related to SUD in lieu of other settings; however, this option is limited to managed care enrollees and the allowance is not always sufficient to meet beneficiaries' clinical needs. As such, the State is requesting a limited waiver of the IMD exclusion for all Medicaid beneficiaries ages 21-64, regardless of delivery system, with short-term stays averaging 30 days. By making residential and withdrawal management services reimbursable for these providers, Nevadans across the State will have significantly improved access to medically appropriate care.

The BBHWP and SAPTA will continue to work collaboratively with Nevada Medicaid on the design and implementation of the 1115 Demonstration waiver since the waiver will directly impact providers traditionally funded by SAPTA for residential, crisis residential, and withdrawal management treatment services. These activities include provider engagement, training and technical assistance, utilization management, unified billing, quality improvement processes, data collection and reporting, integration of recovery supports, and provider standards.

SAPTA will continue to fund outpatient and ASAM levels 3.1, 3.5, 3.2WM and 3.7WM during this project period with an emphasis on improved data quality and reporting for the Treatment Episode Data Set (TEDS), National Outcome Measures (NOMs), 90% capacity and waitlist, and participation in the OpenBeds treatment registry system for referrals and transitions of care.

Recovery Focused Housing and Supports

Grant funding will be allocated to expand access to transitional living program capacity to help individuals with substance use disorders achieve and maintain safe and supportive housing options while they engage in care. Nevada has recently begun to plan for the implementation of recovery housing in collaboration with Foundation for Recovery, a statewide recovery organization, the National Alliance for Recovery Residences (NARR), and the CASAT. This project will require the development of a certification/licensing standard, technical assistance, training for providers, and the funding to launch recovery housing. Grant funds are planned to be used, in part, for the development and implementation of Nevada's recovery housing program.

Nevada will work with CASAT to implement recovery housing infrastructure and resources in the state. This includes consumer protection and public information, including standards, certification, referral resources, ensure that state funds only go to quality providers and residences, expansion of the capacity of recovery housing for individuals receiving MAT, ensure those environments can adequately support the needs of this population, workforce training, continuing education, and peer-to-peer communities of practice. This process will identify areas where additional resources are needed by geographic areas, within populations disproportionately impacted by substance use, and those with specialized need including LGBTQ, families with children, youth, and individuals re-entering the community following incarceration.

Recovery support, including the promotion and integration of peer recovery support services, requires continued efforts to educate providers, communities, and individuals impacted by substance use and co-occurring disorders, of the value and impact recovery supports. SAPTA will continue to support the expansion of recovery support services through training, technical assistance, and policy development.

Additionally, in an ongoing effort to address substance use prevention and treatment in the Silver State, Governor Steve Sisolak and the Department of Health and Human Services have continued a recovery Friendly Workplace Program to reduce the stigma of substance use and encourage workplaces to support treatment and recovery. This program encourages business owners to educate their staff on substance use and recovery; to develop policies and procedures to support recovery of an employee; and support employees who are caring for a family member in recovery. The program is

designed to give business owners free resources — including training, policy guidance, and technical assistance — to become a recovery-friendly workplace.

Workforce Training and Support

The Bureau of Behavioral Health Wellness and Prevention works with the Center for the Application of Substance Abuse Technologies (CASAT) to increase and expand training for workforce development in Nevada. Trainings are for mental health, treatment and/or prevention topics such as peer recovery support services, evidence passed practices, co-occurring treatment, telehealth, trauma informed care, cultural diversity and special services for vulnerable populations such as adolescents. CASAT trainings are in the following formats: face-to-face workshops, self-paced and online courses, webinars, via tele-health, compressed video workshops, technical assistance, and via online video library. CASAT staff apply continuing education hours (CEU's) approval from appropriate licensing boards in Nevada. Currently, all CASAT sponsored workshops are approved by the following Nevada State Boards: Alcohol, Drug, and Gambling Counselors; Marriage and Family Therapists and Clinical Professional Counselors; Nursing; and Social Workers. Other national and state continuing education provider ships held by CASAT include: the National Board for Certified Counselors (NBCC); the National Association of Alcohol and Drug Abuse Counselors (NAADAC); California Association of Alcohol and Drug Abuse Counselors; California Association of Alcohol and Drug Educators; and California Board of Behavioral Science (this board licenses marriage and family counselors and clinical social workers).

BHWP continues to target Opioid Use Disorder prevention and evidence-based treatment through continued education and training. BHWP is working in tandem with CASAT to bring in the American Society of Addiction Medicine (ASAM) Treatment of Opioid Use Disorder course curriculum to Nevada. The ASAM course coverall all medications and treatments for opioid use disorder, and it provides the required education needed to obtain the waiver to prescribe buprenorphine. The course is 8 hours; 4 hours of online learning followed by 4 hours of interactive learning. This training will further develop knowledge and skills necessary to continue the treatment and education of treating opioid use disorders in Nevada.

Pregnant and Parenting Women

The BBHWP intends to use funds to provide services for primary medical care, prenatal care, home visiting, plans of care, child-care including pediatric care and immunizations, therapeutic interventions for women that may address sexual/physical abuse, parenting and child-care, case management and transportation to support while receiving treatment services. Support provider capacity for families to stay together during treatment and/or reunification during recovery. Improve access to SUD treatment, by improving identification of persons in need, reducing barriers to admission to treatment improve identification of need using SBIRT. To increase knowledge and resources for medical professionals, families, and pregnant women regarding treatment options and treatment facilities.

SAPTA will continue to engage community stakeholders, DHHS Division leadership, treatment and recovery providers, home-visiting programs, the medical community, child welfare agencies, and community-based organizations that support pregnant persons and parents impacted by substance use disorders to identify policies and programs that support healthy, safe starts for families. This work will include convening a DHHS task force, continuing to build the perinatal treatment network, supporting the Division of Child and Family Services in implementing Child Abuse Prevention and

Treatment Act (CAPTA) and the Families First Prevention Act, and working with Nevada Medicaid on the dissemination of information regarding transportation options.

Continue the Prevention Set-Aside at 25% (SAP)

The Nevada Bureau of Behavioral Health Wellness and Prevention (Bureau) is the Nevada Substance Abuse Prevention Treatment Agency (SAPTA) and is supported by two diverse groups of specialists and experts, the Statewide Epidemiological Organizational Workgroup (SEOW) and the independent Multidisciplinary Prevention Advisory Committee (MPAC). Additionally, supporting the SEOW and in support of the Bureau, there is an SEOW Compliance Review Team and an Evidence-Based Practice, Policy, and Program Active Workgroup (EBPPPAW), which are requirements of the Partnership for Success (PFS) award, but have also been deployed to help facilitate the Substance Abuse Prevention and Treatment Block Grant (SABG).

Behavioral Health Wellness and Prevention intends on increasing funding for primary prevention activities from 20% to 25% for primary prevention activities to allow state general fund dollars to focus on primary prevention with the expansion to tertiary prevention. Prevention activities will be Implemented based on data driven decision through the Statewide Epidemiology Organizational Workgroup , Evidence-Based Practice, Program, and Policy Active Workgroup and the independent Multidisciplinary Prevention Advisory Committee (MPAC).

Beginning with the SEOW, the Bureau seeks specialized feedback and direction from the diverse group of specifically selected representatives from a variety of backgrounds to support the analysis of data and trends to determine critical gaps recognized through a written recommendation for prevention programming. This includes increasing the number of data driven outcomes for prevention services and periodic review of data sets to identify additional gaps and provide recommendations. The SEOW is a requirement of the PFS award from 2018-2023 and although not a requirement of SABG funding awards is deployed to support SABG funded projects to create a holistic systemic support for prevention coalitions and prevention programming. In the newly enhanced data supportive structure, as shown in the Flow Chart, the SEOW is further supported by work of a compliance review team and the EBPPPAW, which are independent groups that can also interact directly with the Bureau as needed.

Additionally, the SEOW is recommended and encouraged to collaborate with the independent MPAC, which is not a requirement of the PFS or SABG awards, but is an existing multidisciplinary group that is responsible for making policy recommendations to the Bureau for current and future consideration and implementation. Specifically, the guidance provided by MPAC to the Bureau includes creating a comprehensive prevention strategy; maximize prevention resources; remove barriers to enhance programmatic efficacy, effectiveness, and efficiencies; develop shared responsibility across service provides specifically the County and State; and promote the prevention and treatment of alcohol and other substance use.

Revisiting the SEOW Compliance Review Team and EBPPPAW, these subgroups that support the SEOW are requirements of the PFS grant, but not the SABG award. However, the SEOW compliance review team and the EBPPPAW applicability of the work conducted by both groups is of immense importance to the integrated and consistent programming implemented and administered in both the PFS and

SABG awards. Both the SEOW Compliance Review Team and the EBPPPAW are able to interact and engage with the Bureau directly or through the SEOW as an indirect support or facilitator. The purpose of the SEOW Compliance Review Team is to ensure compliance with PFS regulations as well as assist in the identification of high-need areas as required by the Framework of Award (FOA).

The EBPPPAW has been utilized previously under a different naming convention and has recently been reinstituted to foster the deployment of EBPPPs as part of the PFS and SABG funding award as a requirement as a standard practice to align and integrate the two funding streams more substantively. Nevada developed a specific EBPPP Manual that guides decision-making across the lifespan of funded projects from planning and scoping to implementation and administration to evaluation and reporting. This life-cycle approach mirrors a cradle-to-cradle support process that is discussed extensively in Industrial Ecology and other engineering and sustainable design industries and sciences (McDonough & Braungart, 2003; McDonough, Braungart, Anastas, & Zimmerman, 2003; Mulhall & Braungart, 2010; Kumar & Putnam, 2008).

Recommendations made from the SEOW or the two subgroups, (PFS SEOW Compliance Team Review and PFS-SABG Diverse Active Work Group) are presented to either the SEOW, the Bureau, or both the SEOW and the Bureau. Following such a recommendation, the Bureau reviews the recommendations presented from the MPAC for review and consideration at which time the MPAC makes a policy recommendation or other modification instructions to the Bureau for implementation and administration.

While this process is extensive, these various working groups and supportive entities ensure maximized outcomes and sustained compliance with funding requirements. Such adherence and compliance are imperative for Nevada to not only maintain current funding levels, but also be able to potentially increase available funding opportunities.

The Behavioral Risk Factor Surveillance System (BRFSS) was established and sponsored by the Centers for Disease Control and Prevention (CDC) as a national system of health-related telephone surveys. The main purpose of the BRFSS is to monitor and assess the prevalence of chronic disease, health-related risk behaviors, and use of preventive services among adults. Data from the BRFSS is often used to inform and assess public health interventions and policy. The Nevada BRFSS is an annual anonymous voluntary telephone survey of adults (aged 18 years or older). This special report provides the combined 2018 and 2020 Nevada BRFSS prevalence estimates of behavioral health outcomes for adults with different levels of exposure to adverse childhood experiences (ACEs). The data from this report help describe the prevalence of ACE exposure in Nevadans and its association with poor mental health and substance use outcomes and can be used to inform ACE's prevention, intervention, and mitigation.

ACE exposure is common among Nevadans. Lifetime prevalence estimates for each ACE exposure are as follows: 23.8% physical abuse, 31.2% emotional abuse, 14.5% sexual abuse, 17.9% household mental illness, 32.1% household substance use, 21.4% household domestic violence, 10.3% incarcerated household member, 34.8% parental separation or divorce. Nearly two-thirds of respondents have experienced at least 1 ACE and 29.9% have experienced 3 or more ACEs. A higher percentage of females experienced 3 or more ACEs compared to males 32.1% and 27.5% respectively. Younger respondents (18-34 years of age) had the highest prevalence of exposure to 3 or more ACEs

(38.4%) compared to those aged 35-64 years (30.2%) and those aged 65 years and older (17.0%). Respondents who identified as Black non-Hispanic (33.3%) and other non-Hispanic (41.9%) were more likely to experience high ACE exposure (3 or more ACEs). Respondents with the highest educational attainment (college graduates) had the lowest prevalence of any ACE exposure (59.0% reported 1 or more ACEs) compared to respondents with some college (69.2%) and those with a high school degree or less; 66.6%. Married respondents were more likely to experience 3 or more ACEs (35.4%) compared to single respondents (23.9%). Homeowners had a lower prevalence of any ACE exposure (61.6% reported 1 or more ACEs) compared to those who do not own a home (72.5%; Table 3). High ACE exposure (3 or more ACEs) was more common in Washoe (34.2%) and other Counties (35.5%) compared to Clark County (27.9%). There was no significant difference in ACE exposure and the following categories: income, health care coverage, and previous military service.

In the 2018 and 2020 Nevada BRFSS analyses, there was a strong dose response relationship between ACE exposure and fair/poor mental health, suicidal ideation, and substance use. The 2019 Nevada Middle School Youth Behavioral Risk Survey (YRBS): Adverse Childhood Experiences (ACEs) Special Report1 and in the 2019 Nevada High School Youth Behavioral Risk Survey (YRBS): Adverse Childhood Experiences (ACEs) Special Report2 also explored the relationship between ACEs and select health behaviors. While the findings of the 2018 and 2020 Nevada BRFSS and the 2019 Nevada YRBS are not directly comparable due to differences in methodology and measurement, the 2019 Nevada YRBS also found that the influence of ACEs was strongest between ACES and depressive symptoms, suicidal ideation, and substance use (2018 & 2020 Nevada BRFSS ACEs Special Report; University of Nevada, Reno 2021). Nevada plans to conduct a comparison analysis of the ACES YRBS high school and middle school parallel to BRFSS annually.

Work being done to conduct an ACES YRBS Middle and High School comparison analysis to the BRFSS in 2021 was the first opportunity where Nevada was able to gear down the critical elements of concern and assist in redefining their priorities within high-risk populations. The outcome goals are for Nevada to have a comparison analysis every year that may provide the state with an in-depth look into the results of adverse childhood experiences and open additional positive impactable possibilities. Nevada continues to expand tools and resources in collecting their data for prevention efforts as it will only enhance opportunities to where the state can focus on their high-risk high need targeted populations. The data analysis used will be reflective from the reporting on ACEs from 2018 and 2020 data. This analysis will also be used to provide Nevada with a communication level connection to communities, and will support key performance indicators. BRFSS data mapping, policy and procedural discrepancies, and focal point in barriers and gaps.

Synar

The Synar Amendment to the Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act, 45 C.F.R. 102-321 § 1926 aims to prevent underage tobacco use by requiring States to conduct random inspections of retail stores to ensure they do not sell tobacco to anyone under the age of 21 (Synar Amendment, HHS PL 102-321, 1994). To receive the full block grant award funding, states must comply with the Synar Amendment and the Bureau of Behavioral Health Wellness and Prevention (BBHWP), within the Nevada Department of Health and Human Services (DHHS), is the entity responsible for establishing Nevada's Synar Strategic Plan and providing oversight of the Synar requirements. The Bureau in partner with the Office of the Attorney General's Tobacco Enforcement

Unit combine to conduct underage tobacco stings and enforcement, and also partners with the Tobacco Control Program (TCP) within DPBH to coordinate tobacco prevention efforts and planning statewide.

The purpose of the Synar Strategic Plan is a five year plan to identify strengths and weaknesses within Nevada's Synar program, identify improvements that can be made, and create avenues through which the Synar program can contribute to the State's goal of reducing tobacco use by underage consumers. The plan is also designed to ensure that enforcement, Synar programmatic compliance, coverage study compliance, and merchant education are in line with the requirements of the substance abuse block grant and federal Synar programmatic guidance.

Mission, Goals, and Objectives Summary

The mission, goals, and objectives focus on decreasing youth and young adult access to tobacco products in Nevada by implementing and enforcing laws prohibiting the sale of tobacco to those under 21 years old. The ASR measures the State's success in reducing underage sales of tobacco. Also, the DPBH works with coalitions to educate communities to reduce tobacco initiation, reduce tobacco use, promote cessation resources, eliminate secondhand smoke exposure and more.

Goal 1 – Education on Tobacco Laws

Provide education using evidence-based practices to improve knowledge of tobacco laws and regulations, including that it is illegal to sell products containing tobacco, nicotine, or vapor products to anyone under the age of 21 years old.

Goal 2 – Retail Environment Improvements

Promote retail environment improvements to align with laws including the minimum age of sale federal law and related regulations.

Goal 3 – ASR Completion and Evaluation

Complete ASR requirements and assess the program to improve processes, team capacity, and evaluate the annual RVR proportion and whether it meets the goal of 20% or below.

Goal 4 – STARS Survey

Assess and evaluate data collected through Standardized Tobacco Assessment for Retailers Survey (STARS), conduct STARS, and review information from the STARS assessment.

The BBHWP intends to use funding for enforcement, Synar programmatic compliance, coverage study compliance, and merchant education are in line with the requirements of the substance abuse block grant and federal Synar programmatic guidance and to meet the State's goal of reducing tobacco use by underage consumers.

Nevada's Annual Synar Report showed that in 2019 the state's RVR was at 30.4%, which is 10.4% points above the target rate of 20% set by the Compliance Rate Goals outlined in Implementing the Synar Regulation. The regulation requires that "…each State reduce its RVR to 20% or less…". A violation is defined as "The fraction (or percentage) of tobacco-selling outlets in a State that are accessible to minors and sell tobacco to them." (https://www.samhsa.gov/synar/requirements.)

In the 2020 ASR, the RVR was 30.4%, which was an increase of 17% between 2019 and 2020. Nevada was above the 20% SAMHSA Annual Synar Report RVR threshold by 10.4%.

In the 2021 Annual Synar Report; the ASR RVR was 16.8%, which was a decrease of 13.6% from the prior year. The ASR RVR was also below the SAMHSA threshold. However, the 16.8% ASR RVR is based on limited inspection data due to the Severe Acute Respiratory Syndrome Coronavirus 2 or SARS-CoV-2 (COVID-19) pandemic, which resulted in a temporary suspension of inspections for the health and safety of the inspection teams. The implementation of the federal law restricting tobacco sales to people over the age of 21 (T21) also significantly impacted results during inspections in 2020.

The Bureau is working with the Nevada Tobacco Control Unit and other stakeholders to identify strategies for implementation to reduce the rates of underage sales.

The State of Nevada DPBH received $2.5 million dollars allocated in last legislative session to cover youth vaping prevention activities for the tobacco control program and funds for local health jurisdictions and nonprofits. Tobacco retail activities are covered under that funding, which includes the implementation of retailer clerk training through the Responsible Tobacco Nevada website, local funding for tobacco retail assessments, and merchant education. Also, the Synar Team and Synar Coordinator developed a 5-year strategic plan to address the high RVR in 2019, improve merchant education, and facilitate the implementation of Tobacco at 21. The purpose of the Synar Strategic Plan is to identify strengths and weaknesses within Nevada's Synar program, identify improvements that can be made, and create avenues through which the Synar program can contribute to the State's goal of reducing tobacco use by underage consumers. The plan is also designed to ensure that enforcement, Synar programmatic compliance, coverage study compliance, and merchant education are in line with the requirements of the substance abuse block grant (SABG) and federal Synar programmatic guidance.

Tuberculosis (TB)

The Nevada DPBH Tuberculosis (TB) Program was established to identify, control, and prevent tuberculosis in Nevada with the goal of tuberculosis elimination. The major duties of the DPBH TB program are identifying individuals with active tuberculosis disease (TB disease) and latent tuberculosis infection (LTBI), ensuring access to care for individuals with TB disease treatment and LTBI treatment, providing education on TB disease and LTBI to all stakeholders including the public, and conducting surveillance and epidemiologic studies of TB disease in Nevada. Recently, the DPBH TB program has partnered with the Nevada Bureau of Behavioral Health Wellness and Prevention (BBHWP) to provide TB education, identification, and treatment to a specific targeted population in Nevada, individuals with substance abuse or with a history of substance abuse, through the Substance Abuse Treatment and Prevention Block Grant (SAPT BG). The SAPT BG enables subgranted community partners identified by the DPBH TB program to conduct these activities in their local communities of Clark County, Washoe County, and Carson City. The numerous rural Nevada counties receive SAPT BG funded services through a separate collaboration between BBHWP and the Nevada Community Health Services.

The DPBH TB program's subgranted community partners have successfully met the goals of screening all individuals housed within inpatient substance abuse treatment facilities and have met the goals of diagnosing and counseling any positive LTBI cases. The DPBH TB program believes emphasis should also be place on individuals not residing in inpatient facilities. These individuals may encounter greater barriers to accessing care, socially and financially. As of June 2019, through the SAPT BG, the program has not met the activity goal of providing TB screening, education, diagnosis and treatment to individuals with substance abuse or with a history of substance abuse not affiliated with an inpatient program or facility. These individuals are equally at risk of progression from LTBI into active TB disease so identification is imperative. The challenge lies in efficiently managing DPBH TB program and subgrantee resources to provide this needed service. The DPBH TB program desires to increase their subgranted community partners' knowledge of a basic TB screening process to identify those at higher risk and requiring subsequent medical evaluation and testing. In this manner, larger numbers of individuals can be served and identified as needing linkage to care for both TB medical services and substance abuse treatment services or social services. In the future, the DPBH TB will work with subgranted partners to identify populations and geographic areas within their respective communities that demonstrate a higher prevalence of individuals with substance abuse and develop a plan for effectively accessing these populations for general TB screening and education without creating a negative stigma.

To assist with the goal of increasing TB activities in out-patient populations, the additional activity of delivering TB education to providers, staff, and outreach workers is essential. Properly informed medical and social services personnel, can be very effective. Training this service base will increase the capacity and efficiency of the program to provide TB screenings and linkage to care in the out-patient, as well as inpatient, populations. Furthermore, increasing knowledge of the TB disease process within this provider and service base will most likely result in increased acceptance of LTBI treatment. Increasing LTBI treatment and completion will reduce likelihood of progression to active TB disease and thus decreasing incidence in Nevada.

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Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Workforce Training and Support

Priority Type: SAP, SAT

Population(s): PWWDC, PP, PWID

Goal of the priority area:

To provide training opportunities for individuals in the field for treatment and/or prevention.

Strategies to attain the goal:

Partner with the Center for the Application of Substance Abuse Technologies to create and host in-person, online and self-paced learning opportunities.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Online Courses

Baseline Measurement: 100 online, self-paced courses with 8,000 participants

First-year target/outcome measurement: Maintain 100 online, self- paced online courses, increase participants to 8,200 participants

Second-year target/outcome measurement: Maintain online, self-paced online courses, increase participants to 8,500 participants

Data Source:

Center for Applied Substance Abuse Technologies (CASAT) annual report.

Description of Data:

Data provides number of individuals enrolled in training, type of training and the number of certificated received.

Data issues/caveats that affect outcome measures:

n/a

Indicator #: 2

Indicator: Webinars

Baseline Measurement: 25 webinars annually

First-year target/outcome measurement: Provide 28 webinars annaully

Second-year target/outcome measurement: Maintain 28 webinars annually

Data Source:

Annual report form the Center for Applied Substance Abuse Technologies (CASAT)

Description of Data:

The annual report provides the number of trainings, the number of individuals enrolled and description of training.

Data issues/caveats that affect outcome measures:

N/A

Indicator #: 3

Indicator: In-person Training

Baseline Measurement: Provide 100 in-person training each year across the state

First-year target/outcome measurement: Increase in-person training to 110 annualy

Second-year target/outcome measurement: Increase in-person training to 120 annually

Data Source:

Annual report from the Center for Applied Substance Abuse Technologies (CASAT)

Description of Data:

The annual report provides information on the number of trainings, location, date, content and number of individuals registered.

Data issues/caveats that affect outcome measures:

N/A

Priority #: 2

Priority Area: Certifications

Priority Type: SAT

Population(s): PWWDC, PP, PWID

Goal of the priority area:

Enhance integrated, high quality services for substance use disorders and co-occurring disorder treatment through state certification criteria.

Strategies to attain the goal:

Maintain current certification processes using the Dual Diagnosis Capability Assessment Toolkit and promote policies and technical assistance to increase co-occurring capabilities from capable (CoC) to enhanced (CoE).

Expand certification to include an endorsement for problem gambling, medication assisted treatment, recovery housing, and supportive housing services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: % of SUD treatment programs with co-occurring enhanced (CoE) endorsement.

Baseline Measurement: 165 certified providers

First-year target/outcome measurement: Increase the percentage of SUD treatment programs with CoE endorsement to

Second-year target/outcome measurement: Increase the percentage of SUD treatment programs with CoE endorsement to

Data Source:

The certification database ALiS. This system is used to manage and track all certification for facilities and is able to provide a count of all providers certified as well as those with CoC and CoE endorsements.

Description of Data:

Number of certified SUD treatment programs. Number of certified SUD treatment programs with CoE endorsement.

Data issues/caveats that affect outcome measures:

Indicator #: 2

Indicator: Expanded certifications and/or endorsements available for problem gambling, recovery

housing, and/or supportive housing.

Baseline Measurement: No certifications or endorsements currently exist for these programs.

First-year target/outcome measurement: Develop Division criteria for certifications and/or endorsements available for problem gambling, recovery housing, and/or supportive housing.

Second-year target/outcome measurement: certify and/or endorse programs for problem gambling, recovery housing, and/or supportive housing.

Data Source:

Division criteria
AliS database

Description of Data:

Division criteria with definitions and criteria of certifications and/or endorsements available for problem gambling, recovery housing, and supportive housing.
Number of programs with certifications and/or endorsements available for problem gambling, recovery housing, and/or supportive housing.

Data issues/caveats that affect outcome measures:

N/A

Priority #: 3

Priority Area: Pregnant and Parenting Women

Priority Type: SAT

Population(s): PWWDC, PWID

Goal of the priority area:

Provide services for primary medical care, prenatal care, home visiting, plans of care, child care including pediatric care and immunizations, therapeutic interventions for women that may address sexual/physical abuse, parenting and child care, case management and transportation to support while receiving treatment services. Support provider capacity for families to stay together during treatment and/or reunification during recovery.

Strategies to attain the goal:

Improve access to SUD treatment through on-line referral system for care.
Improve identification of women at risk for substance misuse and women who need referral to SUD treatment through implementation of SBIRT.
Reduce barriers to admission to treatment through the use of Women's Set-aside funding.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Referrals for pregnant and parenting women facilitated through the on-line referral system

Baseline Measurement: No referrals

First-year target/outcome measurement: Referrals will accompany no less than 25% of CARA forms

Second-year target/outcome measurement: Referrals will accompany no less than 50% of CARA forms

Data Source:

Openbeds

Description of Data:

Number of CARA Forms with accompanying referrals for care

Data issues/caveats that affect outcome measures:

This is a new process therefore baseline data does not exist.

Indicator #: 2

Indicator: Electronic submission of CARA Plans of Care

Baseline Measurement:

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

Open Beds

Description of Data:

CARA Plans of Care submitted electronically through the OpenBeds Platform

Data issues/caveats that affect outcome measures:

This process is new. Use of the electronic submission portal will require training of hospital staff. There tends to be a high level of turnover in the positions who submit the forms. Repeated trainings and TA support for hospitals is anticipated.

Indicator #: 3

Indicator: Interim services are provided for all women in priority populations (pregnant and IVDU) on waitlists for services

Baseline Measurement: All women are offered interim services if placed on a waitlist for care; documentation is not provided to WSN.

First-year target/outcome measurement: All women are offered interim services if placed on a waitlist for care; documentation is provided to WSN

Second-year target/outcome measurement: All women are offered interim services if placed on a waitlist for care; documentation is provided to WSN

Data Source:

Clinical records

Description of Data:

Documentation of interim services offered is confirmed in the clinical records during certification site visits. Such documentation will be required if women in a priority population are placed on a waitlist for care.

Data issues/caveats that affect outcome measures:

Policy analysis will need to be conducted to determine the policy changes to require information to be communicated to the WSN is needed. Procedures will also need to be developed.

Priority #: 4

Priority Area: Primary Prevention

Priority Type: SAP

Population(s): PP

Goal of the priority area:

Reduce substance use initiation and substance misuse.

Strategies to attain the goal:

Increase education and awareness of substance use and misuse.

Increase primary prevention workforce.

Increase and/or maintain prevention activities targeted for high risk populations.

Enhance community level prevention activities that require cross-sector collaboration.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: To maintain or increase Primary Prevention Certification Specialist (PPCS) onsite within each prevention coalition.

Baseline Measurement: Each prevention coalition has at least one PPCS.

First-year target/outcome measurement: Increase PPCS by 50% (increase PPCS from 10 to 15).

Second-year target/outcome measurement: Increase PPCS by 100% (increase PPCS from 15 to 20).

Data Source:

CASAT on-site certification reviews of prevention coalitions key personnel.
ALiS.

Description of Data:

Prevention Coalition key personnel.

Data issues/caveats that affect outcome measures:

N/A.

Indicator #: 2

Indicator: Increase Veterans, active duty military personnel and their families awareness of risk-factors related to alcohol use and misuse.

Baseline Measurement: Increase awareness of Alcohol use among Veterans, active duty military personnel and their families.

First-year target/outcome measurement: To increase the hosting of four (4) informational fairs for Veterans, active duty military personnel and their families.

Second-year target/outcome measurement: To increase the hosting of six (6) informational fairs for Veterans, active duty military personnel and their families.

Data Source:

Pre and post survey's of attendees.

Description of Data:

Pre and post surveys are administered before and after prevention programming events.

Data issues/caveats that affect outcome measures:

Events canceled.

Indicator #: 3

Indicator: Nevada prevention coalitions will co-host Prescription Drug Take Back (Round Up) events with law enforcement, local retailer, the Reno Sparks Indian Colony, Elks Club, and other partners at several Washoe County locations.

Baseline Measurement: Nevada will co-host annual Prescription Drug Take Back (Round Up) events .

First-year target/outcome measurement: Nevada will co-host three annual Prescription Drug Take Back (Round Up) events with law enforcement, local retailer, the Reno Sparks Indian Colony, Elks Club, and other partners at several Washoe County locations

Second-year target/outcome measurement: Nevada will co-host four annual Prescription Drug Take Back (Round Up) events with law enforcement, local retailer, the Reno Sparks Indian Colony, Elks Club, and other partners at several Washoe County locations

Data Source:

DEA Report
Coalition Reports

Description of Data:

The Drug Enforcement Administration (DEA) focuses on community outreach prevention support in reducing the use and misuse of (Cocaine, Fentanyl/Hereon, Marijuana, Prescription Drugs(Opioid) and Methamphetamines'.
Coalition report activities monthly, quarterly, and annually.

Data issues/caveats that affect outcome measures:

COVID-19 and Delta Variant, Tribal Council members cancel the event. and this measure is a programmatic measure and is reliant on the DEA report.

Indicator #: 4

Indicator: Percentage of middle school students who reported that they think people risk harming themselves physically or in other ways if they use prescription drugs that are not prescribed to them.

Baseline Measurement: 12.6% of middle school students awareness of harm indicted no risk to the use of prescription drugs that are not prescribed to them.

First-year target/outcome measurement: To increase middle school students awareness of harm to 14.0% of no risk to the use of prescription drugs that are not prescribed to them.

Second-year target/outcome measurement: To increase middle school students awareness of harm to 16.0% of no risk to the use of prescription drugs that are not prescribed to them.

Data Source:

YRBS

Description of Data:

The Nevada Youth Risk Behavior Survey (YRBS) administered by the University of Nevada, Reno (UNR). The Nevada YRBS is designed to mirror the YRBSS-CDC with a limited number of questions to monitor six categories of health-related behaviors that contribute to leading causes of death and disabilities among youth and adults.

Data issues/caveats that affect outcome measures:

N/A

Priority #: 5

Priority Area: Synar

Priority Type: SAP

Population(s): PP

Goal of the priority area:

To ensure compliance with Synar and to reduce the retail violation rate of tobacco sales to individuals under the age of 21.

Strategies to attain the goal:

Create a Synar position to increase subject matter expertise, increase efforts to reduce the retail violation rate through merchant education, increase funding to prevention coalitions to address tobacco use among youth with the increase in prevention set aside from 20% to 25%.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Develop a Synar Strategic Plan for Nevada Communities.

Baseline Measurement: Develop a Synar Strategic Plan to reflect Synar activities including Nevada T21 regulation.

First-year target/outcome measurement: To completed 70% in fiscal year 2022, reflecting updated Synar activities including T21.

Second-year target/outcome measurement: To completed 100% in fiscal year 2022, reflecting updated Synar activities including T21.

Data Source:

Annual Synar Report

Description of Data:

Substance Abuse Block Grant -Synar Act; requires states to provide a complete Annual Synar Report reflecting data collected and community activities impacted.

Data issues/caveats that affect outcome measures:

Removal of Administration support;
T21 is a newly passed Law in Nevada, it will take multiple years to gain community support.

Indicator #: 2

Indicator: Reduce and/or maintain the minimum 20% Retail Violation Rate (RFR) of retailer inspections.

Baseline Measurement: To reduce the retailer violation rate from 30.4%.

First-year target/outcome measurement: To reduce the retailer violation rate inspections by 5% .

Second-year target/outcome measurement: To reduce the retailer violation rate inspections by 5% .

Data Source:

Annual Synar Report.

Description of Data:

Annual Synar Report (ASR) provides data on the number of facilities inspected, number of facilities that passed, number of facilities that failed giving and overall violation rate.

Data issues/caveats that affect outcome measures:

The SAMHSA approved Section B of the Annual Synar Report methodology, does not take into consideration Pandemic Delta-Variant.

Indicator #: 3

Indicator: Increase the perception of great risk from substances use- Tobacco, Aged 18-25.

Baseline Measurement: Increase the perception of great risk in substance use-Tobacco.

First-year target/outcome measurement: To increase by 10% the perception of great risk in substance use- Tobacco.

Second-year target/outcome measurement: To increase by 10% the perception of great risk in substance use- Tobacco.

Data Source:

BRFSS

Description of Data:

The Behavioral Risk Factor Surveillance System (BRFSS) is primarily funded by the Centers for Disease Control and Prevention (CDC). Data provided by the BRFSS often informs public health policy and measures progress toward achieving state and national health objectives. The BRFSS is a powerful tool for targeting and building health promotion activities within communities. The BRFSS is only for respondents 18 years and up.

Data issues/caveats that affect outcome measures:

N/A

Priority #: 6

Priority Area: TB

Priority Type: SAT

Population(s): TB

Goal of the priority area:

To ensure individuals who are receiving treatment through the state certified treatment providers are screened and tested for TB.

Strategies to attain the goal:

Provide funding to the health districts and community nursing programs to implement the services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Educated/Screened/Tested

Baseline Measurement: Provide education, screening and testing for 500 individuals

First-year target/outcome measurement: Provide education, screening and testing for 800 individuals

Second-year target/outcome measurement: Provide education, screening and testin for 1000 individuals

Data Source:

Office of Public Health Investigations and Epidemiology

Description of Data:

Number of individuals that received education, screening and testing.

Data issues/caveats that affect outcome measures:

Priority #: 7

Priority Area: Data Collection, Quality, and Reporting

Priority Type: SAT

Population(s): PWWDC, PWID

Goal of the priority area:

SAPTA will have a complete and high quality data set from providers

Strategies to attain the goal:

Enhance policy to establish standards for data collection, quality, and reporting.
Develop a public facing dashboard to report on data collection, quality, and reporting.
Provide training and technical assistance to providers to support data quality.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Treatment programs will submit timely, complete, high quality data on a monthly basis

Baseline Measurement: Rates of unknown, not collected, and/or not applicable above acceptable ranges for TEDS and NOMs data sets

First-year target/outcome measurement: Reduce rates of unknown, not collected, and/or not applicable to acceptable ranges for TEDS and NOMs data sets

Second-year target/outcome measurement: Maintain rates of unknown, not collected, and/or not applicable to acceptable ranges for TEDS and NOMs data sets

Data Source:

TEDS and NOM's quarterly data reports

Description of Data:

Treatment Episode Data Sets and National Outcome Measures are collected and reported by treatment providers on admissions, transfers, and discharges for substance use disorder and co-occurring disorder treatment in partial fulfillment of grant assurances.

Data issues/caveats that affect outcome measures:

Data must be reviewed and cleaned prior to the data being used for analysis. Providers may require additional training and technical assistance to support complete, timely, high quality data submissions.

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2022/2023.
ONLY include funds expended by the executive branch agency administering the SABG.

Planning Period Start Date: Planning Period End Date:

Activity (See instructions for using Row 1.)	Source of Funds									
	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SABG)[a]	J. ARP Funds (SABG)[b]
1. Substance Abuse Prevention[c] and Treatment	$11,653,479.00		$0.00	$0.00	$2,385,501.00	$0.00	$0.00		$11,953,063.00	$10,323,099.00
a. Pregnant Women and Women with Dependent Children[c]	$774,000.00								$1,195,306.00	$1,032,310.00
b. All Other	$10,879,479.00				$2,385,501.00				$10,757,757.00	$9,290,789.00
2. Primary Prevention[d]	$4,251,252.00		$0.00	$0.00	$1,798,709.00	$0.00	$0.00		$3,067,484.00	$2,752,827.00
a. Substance Abuse Primary Prevention	$4,251,252.00				$1,798,709.00				$3,067,484.00	$2,752,827.00
b. Mental Health Primary Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Tuberculosis Services	$250,028.00									
5. Early Intervention Services for HIV	$0.00									
6. State Hospital										
7. Other 24-Hour Care										
8. Ambulatory/Community Non-24 Hour Care										
9. Administration (excluding program/provider level) MHBG and SABG must be reported separately	$850,250.00								$796,871.00	$688,207.00
10. Crisis Services (5 percent set-aside)										
11. Total	**$17,005,009.00**	**$0.00**	**$0.00**	**$0.00**	**$4,184,210.00**	**$0.00**	**$0.00**	**$0.00**	**$15,817,418.00**	**$13,764,133.00**

[a] The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between July 1, 2021 – March 14, 2023 should be entered in Column I.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between September 1, 2021 and June 30, 2023 should be entered in Column J.

[c] Prevention other than primary prevention

[d] The 20 percent set aside funds in the SABG must be used for activities designed to prevent substance misuse.

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Footnotes:

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	2,300	190
2. Women with Dependent Children	33,089	3,662
3. Individuals with a co-occurring M/SUD	30,500	2,371
4. Persons who inject drugs	16,535	1,466
5. Persons experiencing homelessness	1,380	749

Please provide an explanation for any data cells for which the state does not have a data source.

*1 Women with Dependent Children: Women of child-bearing age) were counted. *2% of the homeless population has SU and/or MH problems:% X 6,900 homeless in 2020 = 1,380. *3 Estimations of People in Need: Number of pregnant women 2018 (42,944) and Percentage of Pregnant women using elicit drugs (5.4% NV) Past year (TEDS Survey 2018-2019, Nevada State). Percentage of Co-Occurring Severe Mental Illness/SUD in 18 year old and older Table 11.B (1.3% National) - SAMHSA Survey NSDUH Detail National Results 2018-2019, table 8.11B. Percentage of NV Use of heroin(0.21%), cocaine (2.74%) and methamphetamines (1.21%) Past year in 12years old and older, SAMHSA Survey 2018-2019 Table # 7, by State (% NV) , and Percentage of users of injection as route of administration by each substance: heroine(54.32%), 2018-2019- TEDS Survey by State, Nevada State.

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Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Expenditure Category	FFY 2022 SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]
1 . Substance Use Disorder Prevention and Treatment[3]	$11,653,479.00	$11,953,063.00	$10,323,099.00
2 . Primary Substance Use Disorder Prevention	$4,251,252.00	$3,067,484.00	$2,752,827.00
3 . Early Intervention Services for HIV[4]	$0.00		
4 . Tuberculosis Services	$250,028.00		
5 . Administration (SSA Level Only)	$850,250.00	$796,871.00	$688,207.00
6. Total	**$17,005,009.00**	**$15,817,418.00**	**$13,764,133.00**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in this column.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in this column.

[3]Prevention other than Primary Prevention

[4]For the purpose of determining which states and jurisdictions are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant (SABG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state's AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

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Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

A		B		
Strategy	IOM Target	FFY 2022		
		SA Block Grant Award	COVID-19[1]	ARP[2]
1. Information Dissemination	Universal	$868,685		$125,129
	Selective	$62,478	$278,863	$125,129
	Indicated	$24,409	$557,724	$250,257
	Unspecified	$21,050		$125,129
	Total	**$976,622**	**$836,587**	**$625,644**
2. Education	Universal	$639,556		
	Selective	$195,164	$557,724	$250,257
	Indicated	$183,779		
	Unspecified	$22,500		$125,129
	Total	**$1,040,999**	**$557,724**	**$375,386**
3. Alternatives	Universal	$217,321		
	Selective	$17,013		
	Indicated	$16,350		
	Unspecified	$851		$125,129
	Total	**$251,535**	**$0**	**$125,129**
4. Problem Identification and Referral	Universal	$105,035	$278,862	
	Selective	$23,081		$125,129
	Indicated	$8,500		$250,257
	Unspecified	$0		$125,129
	Total	**$136,616**	**$278,862**	**$500,515**
	Universal	$392,828		$125,129

	Selective	$14,372		$125,129
5. Community-Based Process	Indicated	$15,572	$278,862	$250,257
	Unspecified	$0	$557,724	$0
	Total	**$422,772**	**$836,586**	**$500,515**
6. Environmental	Universal	$216,839		
	Selective	$12,750		
	Indicated	$3,551		$125,129
	Unspecified	$0		$250,257
	Total	**$233,140**	**$0**	**$375,386**
7. Section 1926 Tobacco	Universal	$81,000		
	Selective			
	Indicated			
	Unspecified	$876,030		
	Total	**$957,030**	**$0**	**$0**
8. Other	Universal	$199,645		
	Selective	$4,205	$278,862	$125,129
	Indicated	$2,136		$125,123
	Unspecified	$26,552	$278,863	
	Total	**$232,538**	**$557,725**	**$250,252**
Total Prevention Expenditures		**$4,251,252**	**$3,067,484**	**$2,752,827**
Total SABG Award[3]		**$17,005,009**	**$15,817,418**	**$13,764,133**
Planned Primary Prevention Percentage		**59.23 %**	**63.67 %**	**73.17 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

[3]Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Activity	FFY 2022 SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]
Universal Direct	$2,720,909	$278,862	$250,258
Universal Indirect	$946,983	$836,587	$750,773
Selective	$329,063	$1,115,449	$750,773
Indicated	$254,297	$836,586	$1,001,023
Column Total	**$4,251,252**	**$3,067,484**	**$2,752,827**
Total SABG Award[3]	**$17,005,009**	**$15,817,418**	**$13,764,133**
Planned Primary Prevention Percentage	**25.00 %**	**19.39 %**	**20.00 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

[3]Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2022 and FFY 2023 SABG awards.

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

	SABG Award	COVID-19 Award[1]	ARP Award[2]
Targeted Substances			
Alcohol	☑	☐	☐
Tobacco	☑	☐	☐
Marijuana	☑	☐	☐
Prescription Drugs	☑	☐	☐
Cocaine	☑	☐	☐
Heroin	☑	☐	☐
Inhalants	☑	☐	☐
Methamphetamine	☑	☐	☐
Bath salts, Spice, K2)	☑	☐	☐
Targeted Populations			
Students in College	☑	☐	☐
Military Families	☑	☐	☐
LGBTQ	☑	☐	☑
American Indians/Alaska Natives	☑	☐	☐
African American	☑	☑	☑
Hispanic	☑	☐	☐
Homeless	☐	☑	☑
Native Hawaiian/Other Pacific Islanders	☑	☐	☐
Asian	☐	☑	☐
Rural	☑	☑	☑

Underserved Racial and Ethnic Minorities	☑	☑	☐

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023.

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Planning Tables

Table 6 Non-Direct Services/System Development

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Activity	FFY 2022				
	A. SABG Treatment	B. SABG Prevention	C. SABG Integrated[1]	D. COVID-19[2]	E. ARP[3]
1. Information Systems			$212,973.00	$300,000.00	$137,500.00
2. Infrastructure Support	$30,000.00	$46,000.00		$5,763,953.00	$2,566,375.00
3. Partnerships, community outreach, and needs assessment			$209,470.00	$200,000.00	$95,000.00
4. Planning Council Activities (MHBG required, SABG optional)				$5,000.00	$5,000.00
5. Quality Assurance and Improvement			$140,000.00	$200,000.00	$122,500.00
6. Research and Evaluation			$272,750.00	$50,000.00	$100,000.00
7. Training and Education			$1,353,796.00	$45,000.00	$55,000.00
8. Total	**$30,000.00**	**$46,000.00**	**$2,188,989.00**	**$6,563,953.00**	**$3,081,375.00**

[1]Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in Column D.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in Column E.

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Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[22] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[23] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[24]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[25] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[26] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[27]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[28]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[30] Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[35] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[36] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.[37] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[38] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.
SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[39] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds.
The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs.
SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.
Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[40]
SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[41] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

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Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

The State of Nevada works to integrate mental and primary health by partnering with Federally Qualified Health Centers (FQHC), Certified Community Behavioral Health Centers (CCBHC), the University of Nevada, Las Vegas and the University of Nevada, Reno outpatient clinics, In addition, as part of the ongoing partnerships, Mental Health is moving to provide expand service capacity by partnering with organizations that bring medical services into behavioral health such as Desert Parkway Behavioral Health and Reno Behavioral Health or bring behavioral health services into the medical clinics such as the rural health clinics. The integration of care is a consideration and identified as a priority in funding announcements.

2. Describe how the state provides services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, and payment strategies that foster co-occurring capability.

The Department of Health and Human Services includes public and behavioral health services. The Director's Office provided infrastructure incubator funds (general funds) for FQHCs to expand telehealth to include behavioral services and even MAT treatment. The CCBHC is a prospective payment rate that provide integrated systems of care for individuals, with a bundled rate. Nevada is also working with Medicaid to expand and enhance the ability of primary care providers to bring behavioral health screening as an allowable activity into primary practice, so they would be able to bill for the screening and a medical service. In addition, Nevada has been working on crisis triage centers (currently two of them) which include medical screenings and releases, as part of the behavioral health care treatment services.

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through Qualified Health Plans? ○ Yes ◉ No

b) and Medicaid? ◉ Yes ○ No

4. Who is responsible for monitoring access to M/SUD services provided by the QHP?

Commissioner of the Division of Insurance

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? ◉ Yes ○ No

6. Do the M/SUD providers screen and refer for:

a) Prevention and wellness education ◉ Yes ○ No

b) Health risks such as

ii) heart disease — (•) Yes ( ) No

iii) hypertension — (•) Yes ( ) No

iv) high cholesterol — (•) Yes ( ) No

v) diabetes — (•) Yes ( ) No

c) Recovery supports — (•) Yes ( ) No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? — (•) Yes ( ) No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? — (•) Yes ( ) No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

Nevada has a vast geographic area where some areas have more than a two hour drive to access any type of medical or behavioral health service. In addition, there are limited services in the rural and frontier communities. There is a stigma associated with accessing care for many of our tribal and BIPOC communities. Nevada communities also have limited access to bandwidth and in some instances, have shared they do not want telehealth but services in person (tribal partners). With Nevada being in a HRSA mental health personnel shortage area, this is a challenge in addressing parity provisions. However, Nevada has been launching teams into rural and frontier communities and has been working to gain trust with person-to-person services in at-risk and BIPOC communities to bridge these gaps.

10. Does the state have any activities related to this section that you would like to highlight?

Nevada has made significant investments in expanding access to integrated care. Certified Community Behavioral Health Clinics were expanded from three to nine clinics with SAPTA and Mental Health Block Grant funding. The CCBHC's are now enrolled providers in Nevada Medicaid. In collaboration with Nevada Medicaid, Screening, Brief Intervention, and Referral to Treatment (SBIRT) are now covered services. Technical assistance, training, and provider toolkits have been developed to support provider implementation of SBIRT in Ob/Gyn settings as well and Labor and Delivery as well as FQHC's.

Please indicate areas of technical assistance needed related to this section

No technical assistance requested at this time.

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2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[42], **Healthy People, 2020**[43], **National Stakeholder Strategy for Achieving Health Equity**[44], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)[45].

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[46]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[47]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[48]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

[42] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

[43] **http://www.healthypeople.gov/2020/default.aspx**

[44] **https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf**

[45] **http://www.ThinkCulturalHealth.hhs.gov**

[46] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[47] https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

[48] https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

a) Race	(•) Yes ( ) No
b) Ethnicity	(•) Yes ( ) No
c) Gender	(•) Yes ( ) No
d) Sexual orientation	( ) Yes (•) No
e) Gender identity	(•) Yes ( ) No
f) Age	(•) Yes ( ) No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? (•) Yes ( ) No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? (•) Yes ( ) No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? (•) Yes ( ) No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) Standards? (•) Yes ( ) No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? (•) Yes ( ) No

7. Does the state have any activities related to this section that you would like to highlight?

Nevada has the funding through the Centers for Disease Control (CDC) Health Disparity Grant to identify and remediate disparities in and for access to M/SUD care through an aggressive and data-driven program centered with the Nevada Office of Minority Health and Equity and Minority Health and Equity Coalition partners. The Division of Public and Behavioral Health (DPBH) which includes the Bureau of Behavioral Health Wellness and Prevention works collaboratively with the Nevada Office of Minority Health and Equity to track health disparities among high-risk and underserved, including racial and ethnic minority populations rural populations. Nevada is utilizing funds from the CDC Health Disparity Grant to expand data collection to include gender identity and to develop a more robust technology focused on data-driven initiatives, which includes trending and data analysis. This is expected to result in improved access to care for those with serious mental illness, substance use disorder, or co-occurring and to reduce the stigma in many at-risk communities on seeking support.

Nevada completed the Minority Health Report in February 2021, to highlight existing health disparities by race and ethnicity in Nevada and is expanding data collection to include gender identity as well as those with substance use disorder as part of the focus on at-risk populations. This will also include area of residence (i.e. rural, frontier or urban communities). The impact of COVID-19 further exacerbated the challenges of access to healthcare for certain populations. Black, Indigenous, and Latinx people, immigrants, low wage earners, and economy driven professions who have low access to paid sick leave and medical leave. These populations experience reduced access to health care, and is exacerbated by lack of medical insurance or being underinsured. People of color, immigrants, non-English speakers, and individuals with low socioeconomic status tend to have lower health literacy. This has required Nevada to expand efforts within the Bureau to improve health equity through peer-to-peer, provider health equity toolkits, and tailored messaging utilizing Community Based Participatory Research. The Nevada Office of Minority Health works collaboratively with all divisions to improve the quality of health care services for members of minority groups, increase access to health care services, to seek and provide education, and to address, treat and prevent diseases and conditions that are prevalent among minority and underserved populations. Nevada is also working with the LGBTQ, religious, and immigrant populations to address access to health services and addressing stigma associated with accessing care. In addition, Nevada will be adding quality assurance measures as party of program monitoring to request copies of health disparity plans and/or to provide access for technical assistance in developing health disparity plans for those funded with federal dollars. This will continue efforts focused on expanding and improving access to M/SUD care in Nevada.

Please indicate areas of technical assistance needed related to this section

No technical assistance requested at this time.

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3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,[49] The New Freedom Commission on Mental Health,[50] the IOM,[51] NQF,and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).[52]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[53] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[54] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[55] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

[49] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[50] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[51] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[52] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[53] **http://psychiatryonline.org/**

[54] **http://store.samhsa.gov**

[55] **https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-how-to-use-the-ebp-kit-10112019_0.pdf**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? (●) Yes ( ) No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** ☑ Leadership support, including investment of human and financial resources.
- **b)** ☑ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** ☑ Use of financial and non-financial incentives for providers or consumers.
- **d)** ☑ Provider involvement in planning value-based purchasing.
- **e)** ☑ Use of accurate and reliable measures of quality in payment arrangements.
- **f)** ☑ Quality measures focused on consumer outcomes rather than care processes.
- **g)** ☑ Involvement in CMS or commercial insurance value based purchasing programs (health homes, accountable care organization, all payer/global payments, pay for performance (P4P)).
- **h)** ☑ The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

The state also utilizes open and competitive process for master service agreements (MSAs) to expedite the evaluation of qualified vendors so that dollars from federal awards can be distributed in a more expeditious manner. This includes both professional and vendor funding. For example, Nevada has a master service agreement for evaluation, public outreach, marketing, and augmented staffing, to name a few.

Nevada Medicaid support value based purchasing strategies through Managed Care contracts and encourages innovation in payment and service provision. CCBHC's have quality incentive payments for meeting specific benchmarks on quality measures.

Please indicate areas of technical assistance needed related to this section.

No technical assistance requested at this time.

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6. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No

3. Does the state have any activities related to this section that you would like to highlight?

The Department of Health and Human Services has direct resources to include training videos on financial requirements, as well as the Grant Instructions and Requirements (GIRS) to ensure compliance with program, reporting, monitoring and fiscal regulations.

The Department of Health and Human Services has Grants Management and contracts units that both assist with quality assurance of program and fiscal monitoring. Program analysts provide monthly provider monitoring and scope of work review with providers and again during requests for reimbursement. During this time it is identified if a provider is spending down funds appropriately and adequately. Other internal controls include certification of providers per NAC 458 and a management analyst that completes desk and physical monitors which includes fiscal and program monitoring.

Please indicate areas of technical assistance needed related to this section

No technical assistance requested at this time.

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7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

The State of Nevada has a longstanding government-to-government relationship with each of the 28 federally-recognized tribes. The Nevada Department of Health and Human Services (DHHS) is no exception. DHHS honors the sovereign governments of each the tribes and does not require any of the tribes to waive their sovereign immunity as a condition of receiving state support or grant funds. The DHHS and five divisions (Aging and Disability Services Division, Division of Child and Family Services, Division of Health Care Financing and Policy, Division of Public and Behavioral Health, and Division of Welfare and Supportive Services) have an established and formalized government-to-government relationship with each of the tribes. The Director of DHHS and the division administrators actively engaged in the consultation process. Among other efforts, DHHS hosts quarterly and upon-request roundtable consultations with elected tribal leaders and/or their representatives. This is not less than six consultations per year, which can be more based on the needs of any respective nation.

The DHHS Director participates at the annual ITCN conference. As part of the consultation process, DHHS and each of the five divisions have appointed culturally competent tribal liaisons. The tribal liaisons work directly with state and tribal leaders to identify, address, and meet tribal healthcare needs. They also work closely with tribal and Indian Health Services (IHS) clinic directors. To help ensure DHHS provides culturally competent care and services, DHHS has tribal liaison representation at all tribal and IHS clinic directors' meetings. Tribal liaisons also work with non-tribal agencies, such as ITCN, the Nevada Statewide Native American Coalition (Nevada SNAC), the Inter-Tribal Emergency Response Commission (ITERC), the Nevada Indian Commission (NIC), and IHS. Tribal liaisons also routinely promote cultural awareness and competency presentations to DHHS employees, stakeholders, and key partners statewide.

Nevada Prevention Coalition have presented to the Nevada Indian Tribal Council addressing events in multiple rural areas of Nevada. Nevada Bureau of Behavioral Health Wellness and Prevention has also been successful in attaining a Tribal representative

to be on the Nevada Evidence-Based Practice Policy and Procedure Active Workgroup, providing rich insight on the gaps and barriers in Indian communities.

2. What specific concerns were raised during the consultation session(s) noted above?

1. The need to consider a State Plan Amendment for Long Term Support Services
2. Ongoing discussion of creating set aside funding from the State under or with SAPTA for tribal prevention programs that give the opportunity to truly implement meaningful prevention activities through Cultural Based Practices.
3. Addressing the growing need of psychiatric and behavioral health needs within our tribal populations and significant lack of resources within this State to address this issue and its impact on the homeless situation, which directly impacts the RSIC facilities, the tribal lands, Tribal businesses such as the Walmart location, and homelessness amongst the AIAN populations in need
4. Ongoing discussion on the transition into Tribal FQHC, moreover the plans for reinvesting the State savings back into tribal communities and/or programs specifically addressing the disproportionate health disparities and substance use issues amongst the populations
5. Working on collaborative 1115 Demonstration Waivers to address the needs in tribal communities, while being creative in the approach as budget neutral initiatives
6. Remote Pharmacy initiatives to address the needs of rural communities with innovative opportunities to expand access to services by utilizing technology based systems for our pharmacies
7. Youth Residential Treatment Billing allowances, YRTC's that offer residential treatment for AIAN youth should be able to bill at the AIR rate.
8. A Foster Care Assistance and Certification process that better supports the significant need for foster parent opportunities in tribal communities
9. Community Health Assistant Program (CHAP), Dental Health Assistant Therapy (DHAT), Behavioral Health Assistant Therapy (BHAT) models that allow the expansion of midlevel healthcare workers, more broad scope of work for expanding access to care within our tribal Communities. The need to consider models that help to support access to care issues within rural/urban Indian areas and allow greater opportunities for the Tribal Healthcare Delivery Systems to truly sustain costs in providing such care
10. Covid-19 has shown the significant deficiencies in having necessary epidemiology resources to assist in tracking, forecasting, and preparing for the impact of the pandemic overall.

The DPBH Tribal Liaison also states, the COVID-19 pandemic has revealed to OPHIE that there is a considerable gap in tribal data. This lack of data makes it difficult to accurately represent the tribal nations in county and statewide reporting. Nevada is working to bridge the gap in reporting through agreements with one nation at a time. This includes utilizing the prevention coalitions that serve the areas of the sovereign nations. Prevention coalitions are identifying methods to enhance their efforts and to support tribal nations through outreach and engagement that is culturally relevant particularly with the youth and adolescents.

3. Does the state have any activities related to this section that you would like to highlight?

The State of Nevada worked to provide community crisis counselors as part of the FEMA/SAMHSA community crisis grant to provide services to tribal communities during COVID. The crisis counselors were called resilience ambassadors and provide suicide training, suicide prevention activities, as well as direct interface with the tribal populations. For those tribes that allowed information to be provided to the health district, those that tested positive for COVID received outreach calls for preventative measures using holistic and strength-based approaches to build resilience. This also worked to support resource referral and reduce stigma with needed support with SUD/CO. The Office of Suicide Prevention has a strong relationship with tribes throughout Nevada and continues to provide on-site and off-site consultation, training, healing circles, and resources to reduce suicide risk and recover with postvention.

Please indicate areas of technical assistance needed related to this section.

No technical assistance requested at this time.

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8. Primary Prevention - Required SABG

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? (●) Yes ( ) No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) (●) Yes ( ) No

- **a)** ☑ Data on consequences of substance-using behaviors
- **b)** ☑ Substance-using behaviors
- **c)** ☑ Intervening variables (including risk and protective factors)
- **d)** ☐ Other (please list)

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- ☑ Children (under age 12)
- ☑ Youth (ages 12-17)
- ☑ Young adults/college age (ages 18-26)
- ☑ Adults (ages 27-54)
- ☑ Older adults (age 55 and above)
- ☑ Cultural/ethnic minorities
- ☑ Sexual/gender minorities
- ☑ Rural communities
- ☐ Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- [x] Archival indicators (Please list)

Past system data is trended with curren data through the Office of Analytics, which is an internal data collection system with the Department of Health and Human Services.

- [x] National survey on Drug Use and Health (NSDUH)
- [x] Behavioral Risk Factor Surveillance System (BRFSS)
- [x] Youth Risk Behavioral Surveillance System (YRBS)
- [x] Monitoring the Future
- [ ] Communities that Care
- [ ] State - developed survey instrument
- [x] Others (please list)

Coroners Report, Clark County Metropolitan Report, and Nevada Low Birth Rate Babies. the Center for Health Information and Analysis (CHIA) Reports, the Office of Minority Health and Equity Disparity Report, the State of Nevada Health and Human Services needs assessment, Office of Suicide and Prevention attempts and number of suicides by population, age, race, etc., State Medicaid Data

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds? (●) Yes ( ) No

If yes, (please explain)

The State of Nevada is required to utilize needs assessments and gap analysis to identify priority funding. This includes working with Regional Behavioral Health Coordinator who support the review of the information at behavioral health boards and includes input from each community of focus as well as prevention coalition partners. In addition, the State utilizes the Office of Minority Health and Equity which produces information on health and behavioral health disparities.

Data collected from the needs assessment drive decisions regarding areas of SU/CO focus, targeted geographical areas and gaps in services to specific populations of focus. This also works to support the development of programs in rural/frontier, minotiry-majority, and economically underserved communities.

The state collects both qualitative and quantitative data from the sources identified above as well as through the State Office of Rural Health and University Health systems. In addition, each prevention coalition creates a Community Coalition Prevention Plan (CCPP) which is updated not less than every-three years. This allows the prevention coalitions to contribute by identifying the community-based need, set priorities, and allot their fiscal resources to address those needs.

SAPTA recently conducted a situational analysis and strategic plan to assist in developing key strategies over the next five years. As reports are updated related to behavioral health, SAPTA reviews the data, trends results and works to utilize it in planning. Nevada also utilizes State Medicaid and MCO data, results of the various state surveys, data from billing codes, and any other sources available throughout the State which provides insight into the issues impacting Nevadans. These plans include the three consortium plans, and individual agency plans within the Division of Public and Behavioral Health which all utilize consumer input and stakeholder feedback prior to being published.

Nevada includes coalitions representing all counties that utilize the strategic prevention framework and are highly trained in that model. The coalition structure is such that there is representation from a minimal of 12 sectors of participants in each community, and all communities are represented in a lead from the middle framework which helps partners feel they are a part of the whole process. This avoids a top down approach, or a bottom up approach but a true partnership between the communities and the State. Coalitions provide sub grants to various community partners through a competitive process to ensure the prevention priorities are implemented well and that the experts from the proper sectors are utilized. For example, if a media campaign is needed then they partner with a local or national media company that meets the needs identified and in compliance with the funding allocation.

If no, (please explain) how SABG funds are allocated:

N/A

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
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5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? (●) Yes ( ) No

If yes, please describe

Our State requires certification for funding, and funding they must have one prevention specialist. The state encourages all prevention providers to have more than one staff member certified in prevention. This certification started in 2016. Many of the providers sought national prevention certifications previously.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce? (●) Yes ( ) No

If yes, please describe mechanism used

ur State has ongoing communication with providers through monthly provider calls, and a state liaison to the providers that can be contacted for technical assistance needs. When training needs are identified the State works with providers to try and find solutions, and at times hosts collaborative training's for state staff and community prevention partners. Attempts are made whenever possible to communicate trainings that are being held that will be mutually beneficial and can serve the needs of all who participate in the field. Also, the coalitions provide information to the State regarding training's they are holding and invite state staff to participate when appropriate.
SAPTA has relied on the CAPT West RET along with the Center for the Application of Substance Abuse Technologies (CASAT) and Community Anti-Drug Coalitions of America (CADCA) to provide training and technical assistance to SAPTA staff as well as all of the state's prevention workforce. All of these entities offer live trainings, webinars, and conferences. SAPTA makes every effort to notify prevention and treatment providers of any pertinent training opportunities of which it becomes aware.
A top priority for SAPTA is the continuous education on substance abuse prevention. In support of this priority, the Center for Application of Substance Abuse Technologies (CASAT) offers workshops and trainings on substance abuse for prevention professionals, Coalitions and, in its advisory capacity the SEW, MPAC, and the SAPTA Advisory Board, meet and offer recommendations on the types of trainings needed to further SAPTA's goals and objectives. This supports the updating of the partners with evidence-based practices and the workforce trends in substance abuse. CASAT offers many training sessions during each year.
In addition, the Nevada Prevention Resource Center (NPRC - CASAT Clearinghouse) will serve as an information clearinghouse to SAPTA and the 12 community coalitions. The Crisis Call Center will provide training and continuing education to those taking calls regarding substance abuse issues through the Nevada 211 system, as part as information and crisis management. The Nevada Statewide Partnership, which is the "coalition of coalitions" made up of the Executive Directors of the 12 funded coalitions, will also offer training sessions to coalition staff and board members. Nevada will create a competency-based statewide training designed to increase professional and volunteer ability to impact community substance and abuse and related risk and protective factor.

3. Does your state have a formal mechanism to assess community readiness to implement prevention (●) Yes ( ) No

strategies?

If yes, please describe mechanism used

Our State has a request for qualification application. In the application are agency capacity questions including policies and procedures for managing funds properly, maintaining the proper staffing ratios needed to manage projects, and demonstrating an understanding of the federal rules and regulations. There have been times in the past where agencies struggled to maintain the proper capacity to perform duties of the grants and requirements of the projects and have closed their doors. This typically happened after many supportive interactions with the State providing technical assistance as well as peers providing supportive services. Most State partners are willing to mentor other providers as needed to help them be successful as Nevada struggles with keeping professionals of all backgrounds in the workforce.

Most of the twelve coalitions have served their community for many years and have a keen sense of their community's challenges. During the economic downturn, several of the rural and frontier communities were greatly affected. Unemployment in some counties was as high as 20%, and the ability to buy food for families was on the decline. In response to this turn of events, several of the coalitions applied for grants from other sources such as the FDA in an effort to expand their reach and available resources. Because of the leadership of these coalitions, food banks and thrift stores were created. Some of the communities experienced an increase in mental health and crime related issues. The Coalitions began to broaden their membership to include businesses, schools, law enforcement, physicians, and dentists to assist their underserved. In addition, some coalitions have now expanded through other grant resources to include assisting with mental health capacity building and have increased their partnerships with the schools to build referral systems and decrease mental health stigma. This broadened approach allows for a coordinated, focused, intentional response to community challenges. With the funding and technical assistance from the Bureau of Behavioral Health Wellness and Prevention the coalitions will continue to grow their organizations. The issue of workforce development has been a challenge for the Bureau for many years.

Workforce development is a topic of concern from every state agency and community agency that provides care. One of the goals in the Bureau's Strategic Plan is to engage with educational partners including higher education and secondary education partners to create a pipeline of qualified workforce to address community needs. Building capacity in the workforce is mentioned in most strategic meetings across the state and is being addressed on a continual basis until there is no longer a shortage in professionals. With Nevada's growing
population and increased need, based on population growth it is unlikely the need will go away soon.

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

Nevada Substance Abuse Block Grant Strategic Prevention 5-year Plan is currently in draft.
Nevada State Epidemiological Profile 2020.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) (●) Yes ( ) No ( ) N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- **a)** ☑ Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
- **b)** ☑ Timelines
- **c)** ☑ Roles and responsibilities
- **d)** ☑ Process indicators
- **e)** ☑ Outcome indicators
- **f)** ☑ Cultural competence component
- **g)** ☑ Sustainability component
- **h)** ☐ Other (please list):
- **i)** ☐ Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? (●) Yes ( ) No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? (●) Yes ( ) No

If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

Evidence-Based Practice Program Policy and Procedural Active Workgroup

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☐ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☑ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☑ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☑ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☑ The SSA funds regional entities to provide prevention services.
- **f)** ☑ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☑ The SSA funds community coalitions to provide prevention services.
- **h)** ☐ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☑ The SSA directly funds other state agency prevention programs.
- **j)** ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

Health Fairs-Nevada's rural and frontier regions rely on these types of community gatherings to get the word out about substance abuse and underage drinking.
• Printed Material-When coalitions make presentations to parents, bartenders, or students, often they take home printed materials with information and phone numbers or referrals for future reference.
• PSA Development- PSA's are a part of coalitions regular operation. Many new PSA's are being developed to address marijuana use and build traffic to sites like knowmj.org where people can learn more about marijuana, and coalition prevention work including the harmful effects of various substances. Other uses are when coalitions want to announce their events to draw community members to attend.
• Speaking Engagements Email requests- Because the coalitions have a long history of serving their communities, they are often called upon to make presentations to the public or speak at conferences and events about strategies and the latest trends in use and prevention efforts.
• Coalitions are frequently called upon to provide information to legislative bodies who use the information to make informed decisions about issues facing their community.
• Social Media Dissemination- All of the coalitions have websites and most have Facebook pages or Twitter accounts. These social media outlets help to attract youth to their activities and mission. This is also true for the State partners including Maternal and Child Health which promotes the website sobermomshealthybabies.org, and the Department of

Health and Human Services Tobacco Prevention and Control Program which both provide appropriate prevention information.

b) Education:

Education for Youth Groups-Presentations to youth K-12 related to substance abuse. Many coalitions engage youth to conduct peer-to-peer educational presentations.

• Education to parents-Coalition staff or guest speakers from the community present to parents at high schools. In this way, parents are engaged in the prevention process and can reinforce and support information youth are receiving regarding substance use and abuse.

• Education and information to medical providers- Multiple resources are available to help providers do a better job at detecting and making referrals to the proper places. Prevention partners come together to ensure resources are shared and utilized by providers.

• Education to Treatment and Prevention providers on addiction- In an effort to assist prevention and treatment providers with information to hone their skills or keeping abreast of current trends.

• Education to bartenders and servers on the importance of carding their customers before serving them alcohol to reduce underage drinking. Additional focus is placed on responsible beverage service to address binge-drinking and other hazards such as alcohol poisoning.

• Education to tobacco sales merchants about carding customers before selling.

• Education to Marijuana dispensaries about the laws associated with sales. Focus is also placed on harm to minors, and assistance given to help avoid access to minors.

c) Alternatives:

Recovery picnic which is held every September in northern Nevada in an effort to normalize the decision to be drug-free and support those in recovery.

• Safe and Sober graduation parties are held in many of Nevada's high schools. Block grant funds are often combined with the Safe and Sober organizations throughout the state to offer a safe, drug-free graduation experience.

• Block Grant funds are utilized to form and support youth prevention clubs in middle and high schools across the state. These groups offer youth a safe, constructive and meaningful way to spend their time.

d) Problem Identification and Referral:

Most of the coalitions in the state fund direct service programs that address high risk youth (incarcerated, on probation, or whose parents are incarcerated). In some of the counties, Signs of Suicide (SOS) is being conducted as well as Mental Health First Aid (MHFA) and Youth Mental Health First Aid (YMHFA) where there are increases in number of referrals to services taking place across the State, and an annual increase in trainers who help communities know signs and symptoms and make referrals to triage centers to get people the proper help. Some communities are mapping out their resources and deliberately creating a formalized triage process that all community partners can follow giving it a no wrong door approach.

Military- Brochure: Binge Drinking/High-Intensity Drinking

e) Community-Based Processes:

. This is the most powerful strategy used in Nevada and it begins within the twelve community coalitions. Attending the coalition meetings, one sees members of the community from all walks of life and business including the 12 sectors from the SPF SIG model. Included, but not limited to, are food banks, domestic violence agencies, law enforcement, farmers, ranchers, health care providers of mental health as well as medicine, tribal entities, government agencies, schools, students, youth, parents, and clergy all working together to improve their community. Again, with the various sectors working together and seeking to solve problems as a group rather than in silo's they are able to close the service gaps more efficiently.

The Statewide partnership and a select few coalitions are tasked with mentoring new and existing coalitions to improve their practices, and build capacity to serve their perspective communities better which includes sharing experiences, managing grants, building lasting relationships with community members, understanding reporting, evaluation, community outreach techniques and following proper state processes.

f) Environmental:

Service and Actions oriented Initiatives:

• RX Round-ups which are held semi-annually. These events highlight the issue of availability to youth of prescription medication for non-medical purposes, as well as bring awareness to misuse/abuse of these medications.

• Block Grant funds are utilized to form and support youth prevention clubs in middle and high schools across the state. These groups are working towards shifting social norms regarding drug use among youth.

• Media campaigns which focus:

o On the need to limit the over-prescribing of opioids

o Locking up prescriptions from youth

o Dangers of second hand smoke especially around children

o Governor's campaign to improve birth outcomes

o Substance use including Marijuana, alcohol, and Opioids.

Legal and regulatory initiatives:

• Quarterly compliance checks especially during Reno's Pub Crawls. These checks spread the word that the community will not tolerate underage drinking and/or misuse of alcohol.

• Working with Nevada's legislators and local city councils to inform policies.
• Coalition Youth participate in legislation days and attend hearings on important issues that affect youth in Nevada related to substance use and mental health, and offer their voice and are heard. Typically, when youth speak the adults listen.

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means? (●) Yes ( ) No

If yes, please describe

Our state has a no supplanting requirement in place for all sub recipients. While integrating the need is encouraged for sustainability
purposes it is to be done within the proper parameters that avoid duplication of efforts or supplanting. There are two federal substance abuse-related grants DPBH oversees (Block, and PFS) and two state grants awarded to the prevention coalitions, and monitored by SAPTA. Each funding source has its priorities, thus complimenting or enhancing the other funding streams. The Coalitions report on each grant's quarterly activities separately, to maintain separate scopes of work and avoid any supplanting of funds. Additionally, a monitor is conducted annually to include a fiscal review to ensure all sources are accounted for separately as well as whether each is complying with federal and state regulations.

Narratve Question

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

A combined collaborative meeting with the State Epidemiological Organization Workgroup, the independent Multi-Disciplinary Advisory Committee and the Evidence-Based Practice Active Workgroup meets to discuss the findings outlined in Nevada Epi-Profile to address the gaps and barriers.
State Epidemiological Organization Workgroup- Flow Chart.
Evidence-Based Practice Evaluation Form.
Evidence-Based Practice Evaluation Form Guidance.

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** ☐ Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- **b)** ☑ Includes evaluation information from sub-recipients
- **c)** ☑ Includes SAMHSA National Outcome Measurement (NOMs) requirements
- **d)** ☑ Establishes a process for providing timely evaluation information to stakeholders
- **e)** ☑ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** ☐ Other (please list:)
- **g)** ☐ Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

- **a)** ☑ Numbers served
- **b)** ☑ Implementation fidelity
- **c)** ☐ Participant satisfaction
- **d)** ☑ Number of evidence based programs/practices/policies implemented
- **e)** ☑ Attendance
- **f)** ☑ Demographic information
- **g)** ☐ Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

a) ☑ 30-day use of alcohol, tobacco, prescription drugs, etc

b) ☑ Heavy use

☑ Binge use

☑ Perception of harm

c) ☑ Disapproval of use

d) ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

e) ☐ Other (please describe):

Footnotes:

Evidence-Based Practices, Programs, and Policies Proposal Review Form Instructional Guide

March 2021

STRATEGIC PROGRESS, LLC.
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Table of Contents

Introduction and Overview of the Evidence-Based Practices, Programs, and Policies (EBPPP) Proposal Review Form

In collaboration with the Evidence-Based Practices, Programs, and Polices Active Workgroup (EBPPPAW) and the Bureau of Behavioral Health Wellness Prevention, Strategic Progress, LLC has designed a series of tools and reports to support wider and more standardized implementation of Evidence-Based Practices (EBPs) through Partnership for Success (PFS) and Substance Abuse Prevention and Treatment Block Grant (SABG) funded prevention coalition projects across Nevada. The increased emphasis on funding EBPs with PFS and SABG awarded funding is based on directives from the Substance Abuse and Mental Health Services Administration (SAMHSA). EBPs offer scientifically tested and validated programs, practices, and policies for implementation among specified or similarly oriented populations or target populations.

While there are numerous available EBPs, it is understood that unique community attributes as often found in Nevada based on the population dynamics, distribution, and diversity of the Silver State. However, such population considerations should not restrict the utilization of existing EBPs. Fundamentally, there is a funding-based need for Nevada to commit resources and energy to increasing utilization of highly rated EBPs as part of PFS and SABG funded programming and project-based activities. This instructional guide is designed to facilitate the completion of the redesigned EBPPP Proposal Review and Approval Form, which will be required for all proposed EBP or EBP-style projects included in PFS and SABG annual scope of work proposals for funding award. In addition to this instructional guide, an EBPPP Manual has also been developed to summarize the most recently proposed and implemented EBPs from the Nevada PFS and SABG grant awards.

Although historically only waiver-based or provisional-waiver projects were required to complete a review and approval form, going forward PFS and SABG proposed EBP or EBP-style projects and programming will be required to complete the EBPPP Proposal Review and Approval form and provide at least minimal documentation of the EBP being proposed from a

nationally recognized clearinghouse (refer to the EBPPP Manual for a comprehensive list of current and recent EBPs as well as literature resources associated with each listed EBP or proposed EBP). The goal of this approach is to connect proposals and scopes to actionable evaluation and compliance monitoring related to EBP implementation and administration to ensure PFS and SABG funding is impacting the identified target populations from a statewide perspective, a prevention coalition-based perspective, and a specific program-based perspective. The following sections of this instructional guide will provide overall guidance to completing the EBPPP Proposal Review and Approval Form as well as present specific Question-by-Question guidance and expectations for review and approval process.

Guidance to Completing the EBPPP Proposal Review Form:

This EBPPP Proposal Review and Approval Form will be completed by prevention coalitions for all proposed projects considered to be EBPs or designed to align with EBP standards. This includes all projects regardless of EBP rating by a nationally recognized clearinghouse. To complete the EBPPP Proposal Review and Approval Form, prevention coalitions should refer to the EBPPP Manual and the provided project specific literature as initial resources for inclusion as supporting documentation. Many of the sections are self-explanatory and will have limited guidance, while other sections have more extensive instructions to support prevention coalitions in the formulation of responses to each of the required questions.

Following an initial section of overview and proposal summary information, the form incorporates a series of 12-questions of which 1-2 and 7-12 are required for all projects. The determination for completion of Questions 3-6 is based on responses to Questions 1-2, as noted on the EBPPP Proposal and Review Form. Fundamentally, any proposed project that has a response of “No” to either Question 1 or Question 2 will be required to complete Questions 3-6. Projects that meet the requirements of both Question 1 and Question 2 are not required to complete the Supplemental Questions (3-6). Each section of this form incorporates a review and response section for the EBPPPAW or

Independent Science Review (ISR) Team to complete as part of the official review of all proposed EBP for both PFS and SABG.

EBPPP Proposal Coalition Overview

The information collected in the EBPPP Proposal Coalition Overview is general identification and background information related to both the program and the prevention coalition. As previously stated, this form will be required to be completed for all proposed EBP or EBP-related projects as part of the scope of work process. As such, there is a possibility that prevention coalitions will complete multiple EBPPP Proposal Review and Approval Forms. It is important that the main point of contact identified is EBP proposal specific so we can reach out directly with questions related to the proposal and planned implementation, administration, and evaluation. For the funding source, please indicate whether the proposed project is PFS, SABG, or both. In the cases where funding from both grant funds is utilized, please provide the applicable budget for PFS and SABG separately. Remember, the required cost information is the proposed project cost, not the overall prevention coalition budget request.

EBPPP Proposal Summary

The EBPPP Proposal Summary section includes specific content areas and details for each content area as well as a simple "Yes" or "No" EBPPPAW review to determine if the requirements were met. The content areas included are: Program Name, Target Population, Risk and Protective Factors (Individual, Family, and Community perspectives), Problem Statement, Institute of Medicine (Codes and Categories based on scope of work), and EBP Program Description. The Target Population response should identify any specific target populations for the proposed EBP with notation to the source of data utilized to select the target population.[1] For the Risk and Protective Factors, the initial response should include which levels of factors are incorporated into the proposed EBP.

[1] Please refer to the EPI Profiles, Disparity Impact Statement, EBPPP Manual and other documentation made available on http://dpbh.nv.gov/Programs/ClinicalSAPTA/dta/Partners/ToolsforProviders/.

Subsequently, each incorporated level of factors should be summarized in detail as applicable for Individual, Family, and Community. If any of the three levels are not pertinent to the proposed EBP a note should be included to indicate N/A, not applicable, or something similar. The Problem Statement is specifically aligned with the proposed EBP and should provide some connection or alignment with the overall scope of work for the prevention coalition at the broader coalition level. The Institute of Medicine (IOM) section should include listed IOM codes and categories being addressed with proposed programming as aligned with scope of work details and information. Finally, the EBP Program Description field should include a short synopsis of the proposed EBP.

EBPPP Proposal Review Information (Q1-Q2)

Questions 1 and 2 are designed to assess proposals from the perspective of EBP ratings of either “highest rated” or “promising/emerging” rating status from one of the nationally recognized EBP clearinghouses. Information about current or recent EBP related programming from a rating and documentation perspective should be accessed in the EBPPP Manual as noted earlier in this instructional guide.

If the program is on a national registry or list as a "Model" or highly-rated substance abuse prevention strategy, coalitions need to answer "Yes" to Question 1, and provide a link to the documentation (there is a section at the end of the EBPPP Proposal Review and Approval Form for including journal articles and other reporting documentation – the cited article in Question 1 or 2 can be further explored as part of that section of the form or additional articles and/or reports can be added to support modifications made to the listed EBP), add explanations of any planned or proposed modifications (if any) to be made to the referenced model, list N/A in the response section to Question 2, and proceed to complete Questions 7-12. If additional space is required, please complete in a separate document, and attach as an addendum with addendum title noted in the provided space on the EBPPP Proposal Review and Approval Form. Specific instructions and guidance are provided below on a Question-by-Question basis.

1) If the answer to Question 1 is "No," but the program shows positive Alcohol, Tobacco, and Other Drug reduction outcomes as rated by one of the nationally recognized clearinghouses with documented outcomes in a peer-reviewed journal, coalitions please answer "Yes" to Question 2.
2) In the Question 2 response area, provide a link to the nationally recognized clearinghouse for rating information, add explanations of any planned proposed, provide a link to the journal article(s) that providing supporting documentation of the proposed program (any journal article or report listed here will be required to be further explored as part of the journal article and report sections at the end of this EBPPP Proposal Review and Approval Form), and proceed to answer Questions 7-12.

If a coalition answers "No" to both Questions 1 and 2, it must complete Questions 3-6 before continuing to address and answer Questions 7-12.

EBPPPAW Reviewers (Q1-Q2 Responses)

Each section of the EBPPP Proposal Review and Approval Form will include a EBPPPAW Reviewers section to assess whether the provided documentation and summary information meets the requirements for approval and address any potential impediments or limitations that would result in a Waiver, Provisional Waiver, or Not Approved outcome. This specific section refers to Questions 1 and 2 and explanations based on whether provided documentation were acceptable with regards to addressing the requirements for either of those questions.

Supplemental Questions (Q3-Q6)

Supplemental Questions 3-6 are only required for those projects where the answers to Questions 1 and 2 are both “No”. This set of supplemental questions are designed to determine the eligibility of the proposed project for a waiver or provisional waiver approval status. In the process of completing these supplemental questions, a logic model

should be developed and presented in addition to providing narrative and literature or research-based support for utilizing the proposed EBP in lieu of an existing highest rated or promising/emerging best practice EBP. If additional space is required, please complete in a separate document, and attach as an addendum with addendum title noted in the provided space on the EBPPP Proposal Review and Approval Form. Specific instructions and guidance are provided below on a Question-by-Question basis.

3) The implementation of the program must be grounded in a strong conceptual model. A logic model including the strategy should be submitted to demonstrate the outcome.

4) The implementation must be similar to other evidence-based programs, policies or practices that are listed on a federal registry. This similarity should be documented and an explanation of why the EBP is not being used should be included (i.e., it was implemented and studied with Latino rural youth and this program will be implemented with urban youth who are primarily Caucasian).

5) If the strategy has been implemented in the past with a consistent pattern of credible and positive effects, provide local data with a narrative to support this claim. Use data that most closely represents the agent of change and target of change that will be affected (i.e., middle school youth ages 10-14).

6) If there is a similar evidence-based practice or strategy that is already approved in the EBP SAMHSA list, provide the rationale for not selecting it. Why would the alternative strategy be a better fit? If Questions 3-5 were not answered, provide a logic model including the strategy as part of Question 6.

EBPPPAW Reviewers (Q3-Q6 Responses)

Each section of the EBPPP Proposal Review and Approval Form will include a EBPPPAW Reviewers section to assess whether the provided documentation and summary information meets the requirements for approval and address any potential impediments

or limitations that would result in a Waiver, Provisional Waiver, or Not Approved outcome. This specific section refers to Questions 3-6 and explanations based on whether provided documentation were acceptable with regards to addressing the requirements for those questions as applicable from responses to Questions 1 and 2.

Required Questions (Q7-Q12)

All projects will be required to answer Questions 7-12 regardless of EBP rating from a nationally recognized clearinghouse. The goal of these questions is to ascertain how the proposed EBP will be implemented and administered based on the scientifically rated EBP. If there are tools available from the cited EBP, regardless of rating, to address any of the content requirements or questions asked as part of Questions 7-12, please make notation of those resources in the answer block provided and attach as addendum materials. Similarly, if the responses to Questions 7-12 require additional space, please make notation in the space provided and attach the applicable response information as an addendum. If additional space is required, please complete in a separate document, and attach as an addendum with addendum title noted in the provided space on the EBPPP Proposal Review and Approval Form. Explanations and guiding questions to respond to Questions 7-12 are provided below to guide responses, selection of documentation and resources, and generally address each content area sufficiently pursuant to each individual question.

7) Provide the resources necessary, including any costs or training, to implement this strategy.

8) Provide your estimate of the number of people/families/offices, etc. you anticipate this program will reach or serve this fiscal year. Be sure to include the unit of analysis.

9) Identify and provide how barriers such as implementation fidelity, costs, training, capacity, stakeholder buy-in, etc., will be addressed. Provide the staff

who will be responsible for implementation and their credentials for providing the program.

10) How will the strategy/concept be successfully implemented in the county? Include resources needed and any action taken to secure stakeholder buy-in.

11) How will the process and outcomes of the strategy get evaluated? How will they be tracked? Provide copies of tools, consents, and participant protection procedures if individual data is collected that will be used in the evaluation process.

12) Does this program have a history in this community? Is this strategy sustainable and how it would be sustained after the grant ends? Describe how it would be sustained and who would be responsible.

EBPPPAW Reviewers (Q7-12 Reponses)

Each section of the EBPPP Proposal Review and Approval Form will include a EBPPPAW Reviewers section to assess whether the provided documentation and summary information meets the requirements for approval and address any potential impediments or limitations that would result in a Waiver, Provisional Waiver, or Not Approved outcome. This specific section refers to Questions 7-12 and explanations based on whether provided documentation were acceptable with regards to addressing the requirements therein.

Article Review Information

The Article Review Information section is reserved for Journal Articles published in a recognized peer-reviewed journal. It is expected that at least one journal article will be provided for every proposed EBP, even those with highest ratings to ensure implementation and administration with PFS and/or SABG funding is consistent with literature-based resources and citations. The article information provided will include 1) the name of the peer-reviewed article, 2) link to the article, 3) date of publication, and 4) the publishing journal. If there are more than one journal articles submitted, please complete one Article Review Information page for each submitted journal article.

EBPPPAW Reviewers (Journal Article Response)

Each section of the EBPPP Proposal Review and Approval Form will include a EBPPPAW Reviewers section to assess whether the provided documentation and summary information meets the requirements for approval and address any potential impediments or limitations that would result in a Waiver, Provisional Waiver, or Not Approved outcome. This specific section refers to attached Journal Article(s) and explanation of determination of whether the cited journal article(s) was acceptable pursuant to EBPPP waiver or Provisional waiver approval. This will also address the applicability of any modification to the cited EBP as proposed.

Report Review Information

The Report Review Information section is reserved for professional publications that are not peer-reviewed to include agency-based annual or evaluation reports, Congressional Budget Office reports, public and behavioral health reports from organizations such as Kaiser Family Foundation or Robert Wood Johnson Foundation, or other similar such reports. While not required for any of the proposals, these professional reports can be useful tools or resources related to modifications made to existing EBPs to serve target or hard to reach populations, modify a delivery model as has been required with the COVID-19 pandemic, or other adaptations in implementation or administration. Any submitted professional report will include 1) the name of the report, 2) link to the report, 3) date of publication, and 4) a link to additional supporting documentation or program website (to include publishing organization or agency website). If there is more than one professional report submitted, please complete one Report Review Information page for each submitted professional report.

EBPPPAW Reviewers (Report Response)

Each section of the EBPPP Proposal Review and Approval Form will include a EBPPPAW Reviewers section to assess whether the provided documentation and summary

information meets the requirements for approval and address any potential impediments or limitations that would result in a Waiver, Provisional Waiver, or Not Approved outcome. This specific section refers to attached published report(s) and explanation of determination of whether the cited published report published report(s) was acceptable pursuant to EBPPP waiver or Provisional waiver approval. This will also address the applicability of any modification to the cited EBP as proposed.

EBPPP Proposal Form: Approval Decision

The EBPPP Proposal Form: Approval Decision section is reserved for the EBPPPAW and the identified members of the Science Group (NAME). The Reviewers as noted in this section of the EBPPP Proposal Review and Approval Form refers to those Science Group (NAME) members who will have approximately 30-days from receipt of the completed form and related documentation to respond to the EBPPPAW with a recommendation for approval decision to include Approved, Waiver Approved, Provisional Waiver Approval (with additional documentation requirements), or Not Approved. Any decision resulting in Provisional Waiver Approval or Not Approved status will be provided justification and explanation in the Additional Comments Related to EBPPP Proposal Form subsection of this form. Refer to section BLAH of the EBPPPAW Mission and Guidelines document for more information about the Science Group (NAME) and the members who will be tasked with reviewing each submission.

Additional Comments Related to EBPPP Proposal Form:

This section of the form is reserved for clarification comments from the EBPPPAW or ISR Team to include any special directions, required documentation, data to review or collect, and other relevant explanations to support implementation and administration of EBPs as either Approved, Waiver, or Provisionally Waived.

Utilizing the EBPPP Approval Form

The EBPPP Proposal Review and Approval Form is designed to support the PFS

Strategic Prevention Framework implementation efforts in Nevada as well as achieve stated goals from SAMHSA related to the implementation and administration of EBPPPs with funding awards. The requirement for prevention coalitions to complete this form for all proposed projects is to assist with the gathering of documentation as well as the review, evaluation, and reporting of outcomes from funding awards. As noted previously, all projects that are not implemented and administered as rated by one of the nationally recognized clearinghouses (SAMHSA; California Evidence-Based Clearinghouse for Child Welfare (CEBC); PEW Charitable Trusts Results First Initiative and Clearinghouse, Collaborative for Academic, Social, and Emotional Learning (CASEL); National Institute on Drug Abuse (NIDA); Office of Juvenile Justice and Delinquency Prevention (OJJDP); CrimeSolutions; youth.gov; and Prevention Technology Transfer Center (PTTC)) with a highest rating will be required to submit at least one journal article or report to support any modification or adaptation made to the rated EBP. The lower the rating as cited in the EBPPP Manual, the more documentation that will be required. Additionally, more documentation will also be required based on the level of modification or adaptation to the implemented EBP in Nevada as compared to the nationally rated EBP.

The EBPPPAW will utilize this form and the knowledge of the ISR Team to review proposed EBPs and make decisions about the approval determination. The outcomes of this process will be utilized during annual evaluation as well as annual monitoring processes to ensure projects are being implemented as proposed and help to measure the impact of the implemented EBP. Completed on an annual basis, this form can be informed by previous submissions, but should not be copied and pasted from year to year with notation of updated content annually to ensure alignment with resources and data such as EPI Profiles, Disparity Impact Statement, Evaluation Plan, Annual Evaluation Report, Annual SPARS Reporting (for PFS) or WebBGAS (SABG) reporting, and other similar data or reports made available as part of the larger systems change innovation at the system level. While the proposal review and approval form and associated instructions are designed for the review and approval of the EBPPPAW and ultimately the review,

evaluation, and reporting by the BBHWP, it also serves as a useful tool for the prevention coalitions.

This form will help prevention coalitions assess needs in order to inform proposals, guide implementation and administration, support evaluation and compliance, and generally improve the capacity of the prevention coalitions to provide prevention programming across Nevada to your ages 9-20.

Questions and Points of Contact

As presented earlier in this guidance document, the EBPPP Proposal Review form will be completed for all proposed projects as part of the Scope of Work for both PFS and SABG grant funding awards. If there are questions about what should be included, required documentation, EBPPPAW review and approval process, or any other related topic area, please contact the grant-specific Program Analyst.

- Partnership for Success (PFS) at (775) 684- 2217
- Substance Abuse Block Grant (SABG) at (775) 684- 2227

Any other additional question, please contact the Prevention Administrative Assistance at (775) 684- 4081.

Evidence-Based Practices, Programs, and Policies Proposal Review Form: Approved vs. Waiver or Provisional Approval

March 2021

STRATEGIC PROGRESS, LLC.
Analyze. Innovate. Evolve.

INNOVATIVE RESEARCH & ANALYSIS LLC
Vision Driven | Data Derived

Table of Contents

EBPPP Proposal Coalition Overview:

Coalition Name:	
Date of Submission:	
Funding Source for Program:	
Estimated Cost of Program:	
Contact Name for this Proposal:	
Phone Number:	
Email Address:	

EBPPP Proposal Summary:

Content Area	***Project-Specific Content Details***	***Requirement Met***	
		Yes	***No***
Program Name:		○	○
Target Population:		○	○
Risk and Protective Factors:		○	○
▪ Individual		○	○
▪ Family		○	○
▪ Community		○	○
Problem Statement:		○	○
Institute of Medicine (IOM):		○	○
EBP Program Description:		○	○

EBPPP Proposal Review Information (Q1-Q2):

Question	*Yes*	*No*	*Response*
1. Is the program, policy, or practice listed as a "Model Program" or promising substance abuse prevention program on a national list or registry of evidence-based interventions?	◯	◯	
2. Is the program, policy, or practice reported (with positive effects on similar target audiences or a 'promising program') in peer-reviewed journals? Please provide the citation or links to the articles here.	◯	◯	

FOR EBPPP Active Workgroup Reviewers Only:

Question	*Yes*	*No*	*Explanation of Determination*
Does the proposal adequately address Questions 1&2?	◯	◯	
Is additional documentation required for Questions 1 or 2 in order to make an EBPPP Approval Status determination?	◯	◯	

If 1 and 2 are answered "NO", proceed to Questions 3-6. If 1 or 2 are answered "YES", proceed to Questions 7-12, and then a logic model must be developed and provided.

Supplemental Questions (Q3-Q6):

The following Questions 3-6 are only required for those proposals that did not have "Yes" responses to either Question 1 or Question 2. If the response provided in Question 1 or Question 2 was "Yes," please proceed to Questions 7-12.

Question	*Yes*	*No*	*Response*
3. Is the program, policy, or practice based on solid information documented in a conceptually clear logic model? Please attach the logic model.	○	○	
4. Is the program, policy, or practice similar in content and structure to interventions that appear in registries or peer-reviewed literature? If so, please provide the name of the program and other information to support its comparability.	○	○	
5. Has the program, policy, or practice been effectively implemented in the past with a consistent pattern of credible and positive effects by the coalition? (Strong local data may be used in this section. Please provide a full report of the impact outcomes along with tools used to collect the information.)	○	○	
6. Was SAMHSA EBP list or approved clearinghouse lists reviewed to identify a "Model program" or "promising program" that is similar in design to this proposal? Provide a rationale or justification statement for the proposed program, policy, or practice. This should include why the proposed program was selected in lieu of a listed "Model program" or "promising program" and target service population or geolocational considerations.	○	○	

FOR EBPPP Active Workgroup Reviewers Only:

Question	*Yes*	*No*	*Explanation of Determination*
Does the proposal adequately address Questions 3-6?	○	○	
Is additional documentation required for Questions 3-6 in order to make an EBPPP Approval Status determination?	○	○	

Proceed to Questions 7-12, which must be answered and/or addressed as part of this proposal.

Required Questions (Q7-Q12):

The following questions MUST be answered or addressed as part of this proposal.

Question	*Response*
7. Provide the resources necessary, including all costs or staff training, travel, materials, etc., to implement this strategy.	
8. How many people/families do you anticipate this program will reach or serve this fiscal year?	
9. What resources will be needed to implement the program. Identify and provide information on how barriers such as fidelity, cost, training, capacity, stakeholder buy-in, etc., will be addressed.	
10. How will the program be successfully implemented with fidelity? a. Provide the staff who will be responsible for oversight of monitoring roll out and implementation fidelity. b. Provide the staff who will be responsible for providing the program and credentials qualifying them to do so. c. Are implementation fidelity tools available for this program?	
11. How will you evaluate the process and outcomes of the strategy? Please provide tools, metrics, participant protections.	
12. Address continuity of the program: Has this program been offered in the past? Are there plans to offer this program in the future?	

FOR EBPPP Active Workgroup Reviewers Only:

Question	*Yes*	*No*	*Explanation of Determination*
Does the proposal adequately address Questions 7-12?	◯	◯	
Is additional documentation required for Questions 7-12 in order to make an EBPPP Approval Status determination?	◯	◯	

Article Review Information (if applicable):

Name of Peer Reviewed Article:	
Link to Article:	
Date of Publication:	
Link to Publishing Journal:	

FOR EBPPP Active Workgroup Reviewers Only:

Question	***Yes***	***No***	***Explanation of Determination***
Does the article meet the criteria for EBPPP Waiver or Provisional Approval?	○	○	

Report Review Information (if applicable)

Name of provided Report:	
Link to Report: (if applicable)	
Date of Publication:	
Link to supporting documentation or program website: (if applicable)	

FOR EBPPP Active Workgroup Reviewers Only:

Question	*Yes*	*No*	*Explanation of Determination*
Does the report meet the criteria for EBPPP Waiver or Provisional Approval?	◯	◯	

EBPPP Proposal Form: Approval Decision

*****This page is FOR EBPPP Active Workgroup Reviewers Only*****

Reviewers Name:			Date Proposal Submitted:	
Reviewers Affiliation:			Date Review Completed:	
Approval Status?	◯ Approved	◯ Waiver Approved	◯ Provisional Waiver Approval[1]	◯ Not Approved[2]
Provide more information here if answer above is "Provisional Waiver Approval" or "Not Approved".				

Additional Comments Related to EBPPP Proposal Form:

[1] Additional documentation is required pursuant to the operationalized definition of the term, Provisional Waiver. Specific requirements will be communicated in the "Provide more information here…" and/or "Additional Comments Related to EBPPP Proposal Form" sections above.

[2] If a project is determined to be "Not Approved" there will be documentation of the rationale and reasoning for the decision in the "Provide more information here…" and/or "Additional Comments Related to EBPPP Proposal Form" sections above.

Accessibility Disclosure

We understand the importance of making reports accessible to everyone. Most of this document has been made accessible, however the tables are not up to the State of Nevada's standards. If you have any problems related to the accessibility or you need any enhanced accessibility, please email data@dhhs.nv.gov.

Bureau of Behavioral Health Wellness and Prevention 2020 Epidemiologic Profile

Nevada
January 2021

Office of Analytics on behalf of

Nevada Department of Health and Human Services
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

Steve Sisolak
Governor
State of Nevada

Richard Whitley, MS
Director
Department of Health and Human Services

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Table of Contents

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Chief Biostatistician

Multidisciplinary Prevention Advisory Committee

Statewide Epidemiologic Workgroup

University of Nevada, Reno School of Community Health Sciences, Nevada Youth Risk Behavior Survey

Data Sources/Limitations/Terminology

Age-Adjusted Rates
A rate is a measure of the frequency of a specific event over a given period, divided by the total number of people within the population over the same period of time. An age-adjusted rate is a rate that has been adjusted, or weighted, to the same age distribution as a "standard" population. Throughout this report, rates are adjusted to the 11 standard age groups of the U.S. population in the year 2000 (Census table P25-1130). Rates are age-adjusted in order to eliminate any potential confounding effects, or biases, that may be a result of health factors that are associated with specific ages.

Behavioral Risk Factor Surveillance System (BRFSS)
BRFSS is a state-based system of health surveys that collects information on health risk behaviors, preventive health practices, chronic health conditions, and use of preventive services. More than 350,000 adults are interviewed each year, making the BRFSS the largest telephone health survey in the world. For many states, the BRFSS is the only available source of timely and accurate data on health-related behaviors. The survey consists of a set of federally grant funded core questions and states may include and pay for their own questions in the survey. While the survey's focus is chronic disease and injury, topics covered by the survey include car safety, obesity, and exercise among many others. Since state-added questions are not asked nationwide, these questions are not comparable.

Crude Rates
The crude rate is the frequency with which an event or circumstance occurs per unit of population.

Enhanced HIV/AIDS Reporting System
The Enhanced HIV/AIDS Report System (eHARS) is a Centers for Disease Control and Prevention (CDC) developed application used by Nevada Division of Public and Behavioral Health for data management, reporting, and analysis.

Hospital Billing Data (Emergency Department Encounter and Inpatient Admissions)
The hospital billing data provides health billing data for emergency department encounters and inpatient admissions for Nevada's non-federal hospitals. NRS 449.485 mandates all hospitals in Nevada report information as prescribed by the director of the Department of Health and Human Services. The data are collected using a standard universal billing form. The data includes demographics such as age, gender, race/ethnicity, and uses International Classification of Diseases-9-Clinical Modification (ICD-9-CM) diagnoses codes and International Classification of Diseases-10-Clinical Modification (ICD-10-CM) diagnoses. ICD-10-CM diagnoses codes replaced ICD-9-CM diagnoses codes in the last quarter of 2015. Therefore, data prior to last quarter in 2015 may not be directly comparable to data thereafter. In addition, the data includes billed hospital charges, procedure codes, discharge status, and external cause of injury codes. The billing information is for billed charges and not the actual payment received by the hospital.

International Gaming Institute
The University of Nevada, Las Vegas International Gaming Institute (IGI) has provided cutting-edge research and insights to global gaming leaders. The IGI with Department of Health and Human

Services prepared an annual report on Nevada Problem Gambling Study. A quick summary is taken from this report and included in this profile.

Monitoring the Future Survey
Since 1975 Monitoring the Future Survey has measured alcohol and drug use, and related attitudes among adolescent students nationwide. Survey participants report their drug use behaviors across three-time periods: lifetime, past year, and past month. Students from both public and private schools participate in the survey. The survey is funded by the National Institute on Drug Abuse (NIDA), a component of the National Institutes of Health (NIH), and conducted by the University of Michigan.

Medicaid
The Division of Health Care Financing and Policy (DHCFP) data warehouse is comprised of claims data submitted by over 28,000 Medicaid providers from within Nevada and across the country. While DHCFP staff conscientiously make every effort to validate these data through continuous provider education and the use of highly experienced audit staff, the Division relies heavily on providers to submit accurate and complete information on Medicaid patients. It should therefore be understood by the users of DHCFP reports on disease morbidity and patient health that the data source for these reports are based solely on patient claims data and may not be a complete and comprehensive health record.

Nevada 211
Nevada 211 is a phone number that helps Nevadans connect with services they need including mental health-related services, substance abuse and prevention, suicide crisis intervention, and pregnancy-related concerns and help.

Nevada Report Card
The Nevada Report Card is the accountability reporting website of the Nevada Department of Education. In compliance with federal and state law, it assists community members (parents, educators, researchers, lawmakers, etc.) in locating a wealth of detailed information pertaining to K-12 public education in Nevada. The web site has three categories: “school and district information,” “assessment and accountability” and “fiscal and technology.”

Nevada State Demographer
The Nevada State Demographer’s office is funded by the Nevada Department of Taxation and is part of the Nevada Small Business Development Center. It is responsible for conducting annual population estimates for Nevada’s counties, cities, and towns.

Prevention Coalitions
The Bureau of Behavioral Health and Wellness and Prevention fund the following coalitions :

- Churchill Community Coalition (CCC): Churchill County
- Frontier Community Coalition (FCC): Humboldt, Lander and Pershing Counties
- Health Communities Coalition (HCC): Lyon, Mineral and Storey Counties
- Join Together Northern Nevada (JTNN): Washoe County
- Nye Community Coalition (NCC): Esmeralda, Lincoln and Nye Counties
- Partners Allied for Community Excellence (PACE): Elko, Eureka, and White Pine Counties
- PACT Coalition for Safe and Drug-Free Communities/CARE: Clark County
- Partnership Carson City (PCC): Carson City
- Partnership Douglas County (PDC): Douglas County

State-Funded Mental Health Services (Avatar)
Avatar is a database containing demographic, treatment, billing, and financial information for Nevada mental health facilities throughout the state of Nevada. These data are representative of Nevada state-operated mental health facilities and are not generalizable to the rest of the population.

Substance Abuse and Mental Health Data
The National Survey of Drug Use and Health (NSDUH) is a survey on the use of illicit drugs, alcohol, tobacco, and mental health issues in the United States. The study includes those who are 12 years of age or older at the time of the survey. For more information on the survey: SAMHSA.

Treatment Episode Data Sets
Treatment Episode Data Sets (TEDS) are a compilation of demographic, substance use, mental health, clinical, legal, and socioeconomic characteristics of persons who are receiving publicly funded substance use and/or mental health services. State administrative data systems, claims, and encounter data are the primary data sources. The state role in submitting TEDS to the Substance Abuse and Mental Health Services Administration (SAMHSA) is critical, since TEDS is the only national data source for client-level information on persons who use substance use treatment services. TEDS also provide a mechanism for states to report treatment admissions and discharges of persons receiving mental health services. This reporting framework supports SAMHSA's initiative to build a national behavioral health data set accessible (with appropriate confidentiality protection) by the public; local, state, and federal policymakers; researchers; and many others for comparisons and trends on the characteristics of persons receiving substance use and/or mental health treatment services. TEDS provides outcomes data in support of SAMHSA's program, performance measurement, and management goals.

United States Census Bureau
The United States Census Bureau is responsible for the United States Census, the official decennial (10-year period) count of people living in the United States of America. Collected data are disseminated through web browser-based tools like the American Community Survey, which provides quick facts on frequently requested data collected from population estimates, census counts, and surveys of population and housing for the nation, states, counties, and large cities. The Bureau also offers the American Fact Finder, which profiles the American population and economy every five years.

Web-Enabled Vital Records Registry Systems (WEVRRS)
Statewide births and deaths are collected by the Office of Vital Records, in the Division of Public and Behavioral Health. WEVRRS is a software utilized by physicians, registered nurses, midwives, informants or funeral directors, and other individuals to collect and consolidate birth and death-related information.

Youth Risk Behavior Survey (YRBS)
The purpose of the YRBS is to provide Nevada data to assess trends in priority health-risk behaviors among high school students, measure progress toward achieving national health objectives for Healthy People 2020 and other program and policy indicators and evaluate the impact of broad school and community interventions at the national, state, and local level. The YRBS is a biennial, anonymous, and voluntary survey of students in 9th through 12th grade in traditional, public high schools, and in Nevada charter schools and public middle schools that monitors the prevalence of health risk behaviors among youth. The survey asks students to self-report their behaviors in six major areas of health that directly lead to morbidity and mortality; these include: (1) Behaviors that contribute to unintentional injuries and violence; (2) Sexual behaviors that contribute to human immunodeficiency virus (HIV) infection, other

sexually transmitted diseases, and unintended pregnancy; (3) Tobacco use; (4) Alcohol and other drug use; (5) Unhealthy dietary behaviors; and (6) Physical inactivity. For more information on YRBS: UNR YRBS.

Executive Summary

Purpose

This report is intended to provide an overview of behavioral health in Nevada for the prevention coalitions, public health authorities, Nevada legislators, behavioral health boards and the public. The analysis can be used to identify issues of concern and areas that may need to be addressed.

The Nevada Bureau of Behavioral Health and Wellness supports 10 community coalitions that pass-through the funding for direct services to providers for prevention. The programs are funded to provide one or more prevention strategies that are promoted by the Center for Substance Abuse Prevention. The strategies are: information dissemination, prevention education, alternative activities, problem identification and referral, community-based processes, and environmental strategies. This report groups the data by prevention coalition region to provide a more detail analysis of significant findings in the counties the coalition support.

Key Findings

Mental Health

- Both female high school and middle school students have significantly higher percent of feeling sad/hopeless, and suicide thoughts including considering, planning and attempting suicide (YRBS).
- For emergency department encounters, anxiety is the leading mental health-related diagnosis. Females have significantly higher visits for anxiety, depression, bipolar disorder and PTSD, whereas males are significantly higher encounters for schizophrenia and suicide ideation. The Churchill Community Coalition (CCC) region, and Partners Allied for Community Excellence (PACE) region had significantly higher visits for anxiety, and depression (Emergency). Clark County hard significantly higher emergency department encounters for schizophrenia, anxiety, depression, bipolar disorder, and suicide ideation.
- For inpatient admissions unlike emergency department encounters, depression is the leading diagnosis for mental health-related inpatient admissions. The Clark County has significantly higher admissions for schizophrenia and suicide ideation, whereas CCC and Nye Community Coalition (NCC) county regions have significantly higher admissions from anxiety (Inpatient).
- Unduplicated clients served at state-funded mental health clinics have declined significantly since 2011. The Affordable Care Act (ACA) went into effect in 2014. Therefore, many Nevada residents are now able to access non-state-funded facilities through the expansion of Medicaid (AVATAR).
- When asked “Have you seriously considered attempting suicide during the past 12 months,” 4.8% of Nevada residents responded yes in 2019, and increase from 3.5% in 2018. (Suicides)
- The PACE county regions have a significantly higher age-adjusted rate for suicide in 2019 (Suicides).
- The Partnership Carson City coalition (PCC) and Join Together Northern Nevada (JTNN), Healthy Communities Coalition (HCC), and CCC coalition county regions have significantly higher rates for mental health related deaths (Deaths).
- The LGBT community have significantly higher percent of depressive disorder diagnoses and more days of poor mental health (LGBT).

Substance Use

- Nevada is comparable to the nation with marijuana use among youth (YRBS).
- Drug use among teens is higher in Nevada than the nation (YRBS).
- There was no significantly higher coalition county region with reported higher marijuana/hashish use, but reported use has continued to rise since to 2017 (BRFSS).
- Emergency department and inpatient admissions due to drugs or alcohol continue to increase in both count and rate (Emergency).
- Males had significantly higher emergency department encounters than females for cocaine, methamphetamines, marijuana/cannabis, and hallucinogens use for 2019 (Emergency).
- The PACT/CARE coalition region both in Clark County had significantly lower rate of drug and alcohol deaths then the remainder of the state (Deaths).
- In roughly 33% of the unintentional or undetermined overdose deaths in 2019, the deceased had been identified as currently having a mental health problem (Deaths).
- The most common substance listed in cause of death is opioid (type not specified, 57.5%), followed by methamphetamine (51.4%) [Deaths].
- Since marijuana has been legalized in 2017, reported marijuana use during pregnancy has more than doubled and has surpassed all other substances (MCH).
- Tobacco use during pregnancy has decrease for all mothers ages since 2016 (MCH).
- The adult LGBT community have significantly higher percent of current marijuana use (LGBT).

Demographic Snapshot

Figure 1. Selected Demographics for Nevada.

	Nevada
Population, 2019 estimate*	3,101,368
Population, 2010 estimate*	2,705,845
Population, percentage change*	14.6%
Male persons, 2019 estimate*	1,552,917 (50.1%)
Female Persons, 2019 estimate*	1,548,451 (49.9%)
Median household income (2019) **	$63,276
Per capita income in the past 12 months (2019)**	$33,575
Persons in poverty, percent (2019) **	12.5%
With a disability, under the age 65 years, percent (2019)**	8.0%
Land area (square miles)**	110,567 sq miles

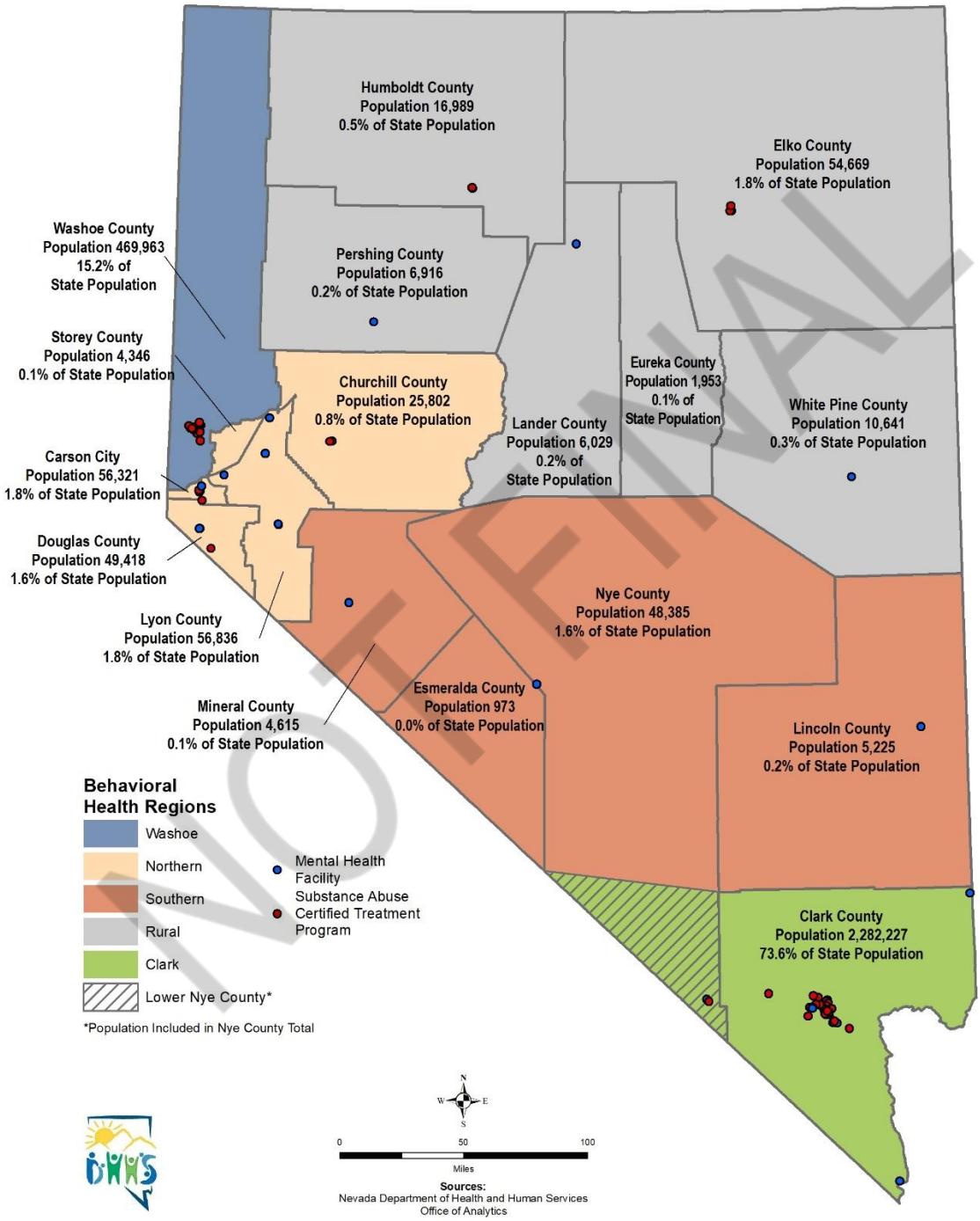
*Source: *Nevada State Demographer, Vintage 2019 and **US Census Bureau.*

In 2019, the estimated population for Nevada was 3,101,368, a 14.6% increase from the 2010 estimated population. The population is made up of approximately equal percentages of females and males. The median household income is $63,276. Nevada's land area is approximately 110,567 square miles.

During the 2017 session, regional behavioral health boards were formed to address behavioral health in Nevada. The regions were redrawn during the 2019 session and Nye County was split into regions. The northern half of Nye County is part of the southern region and the south half is part of the Clark County region. For data purposes, Nye County data is included in the southern region.

With 73.6% of Nevada's population living in Clark County, it is the most populous area in the state, with an estimated 2,251,175 persons. Esmeralda County is the least populous county, with less than a percent of Nevada's population, an estimated 969 persons.

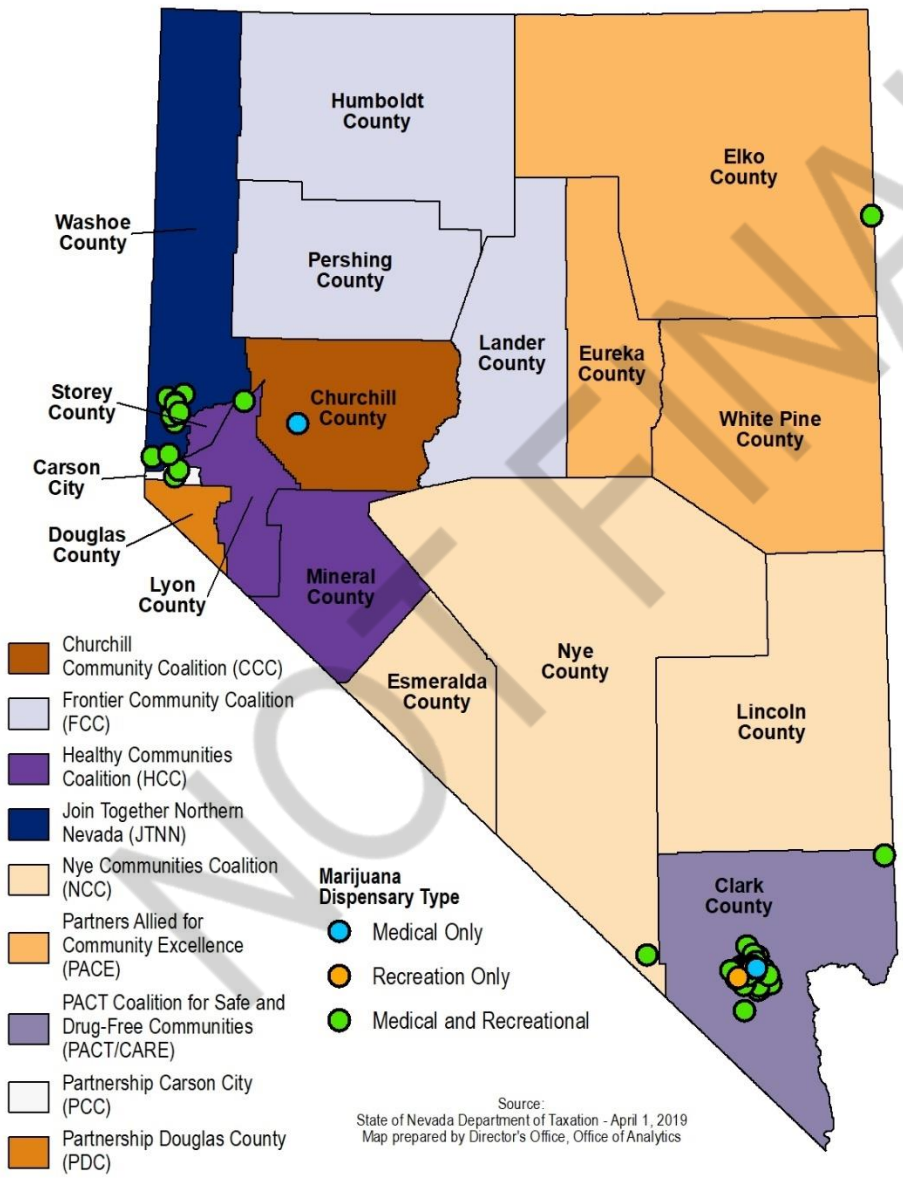
Figure 2. Nevada Population Distribution by County, 2019.



Source: Nevada State Demographer, Vintage 2020. Notations continue on the next page.
***Clark Region**: Clark County and southern Nye County.*

Northern Nevada Region: *Carson City, Churchill, Douglas, Lyon, and Storey Counties.*
Rural Nevada Region: *Elko, Eureka, Humboldt, Lander Pershing, and White Pine Counties.*
Southern Nevada Region: *Esmeralda, Lincoln, Mineral and northern Nye Counties.*
Washoe Region*: Washoe County.*
**Nye County: North Nye County is included in Southern Region and southern Nye County is in part of Clark County Region. For data purposes, Nye County data is included in Southern Nevada Region Report and not in the Clark County Region report.*

Figure 3. Prevention Coalitions and Marijuana Dispensary Locations.

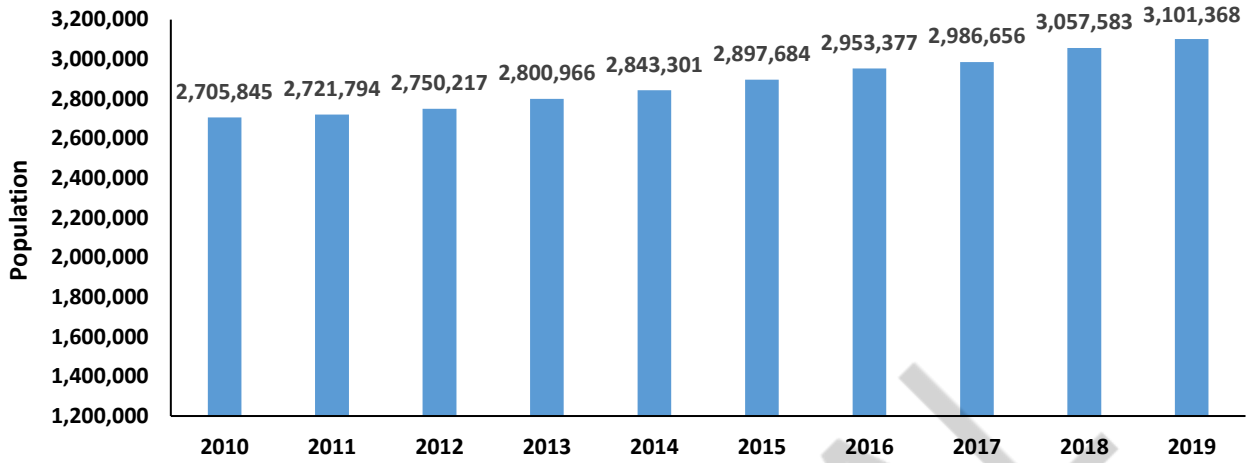


The Bureau of Behavioral Health and Wellness currently supports 10 (2 in Clark County) community coalitions that pass-through the funding for direct services to providers for prevention. The programs are funded to provide one or more prevention strategies that are promoted by the Center for Substance Abuse Prevention (CSAP). Those strategies are:

- Information dissemination
- Prevention education
- Alternative activities
- Problem identification and referral
- Community-based processes
- Environmental strategies

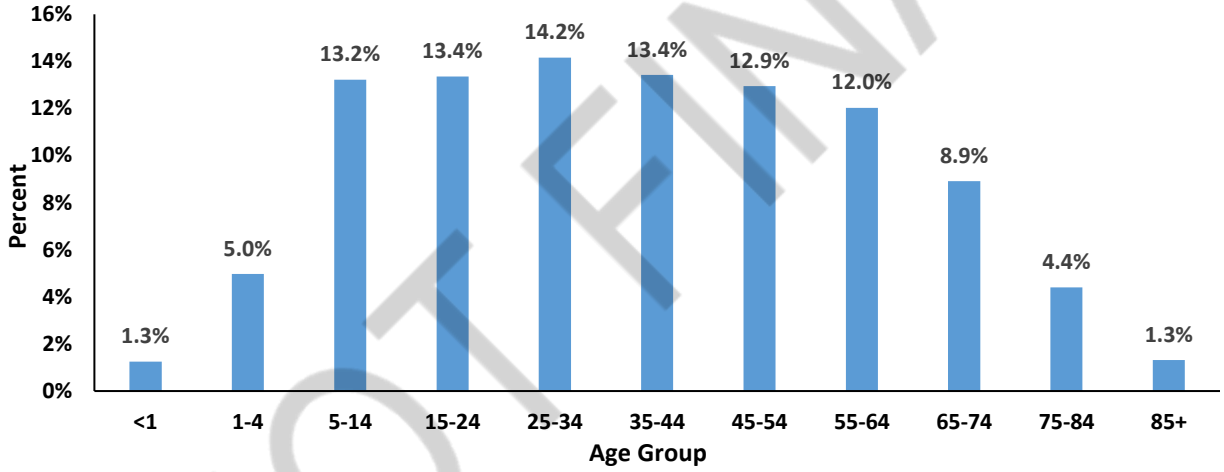
Source: State of Nevada Department of Taxation, April 1, 2020.

Figure 4. Nevada Population, 2010-2019.



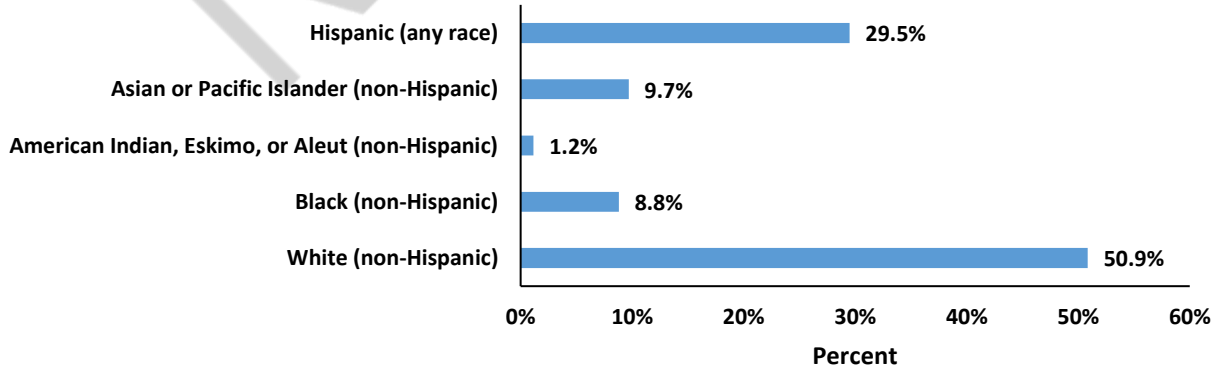
Source: Nevada State Demographer, Vintage 2020.
Chart scaled to display differences among groups.

Figure 5. Nevada Population by Age Group, 2019.



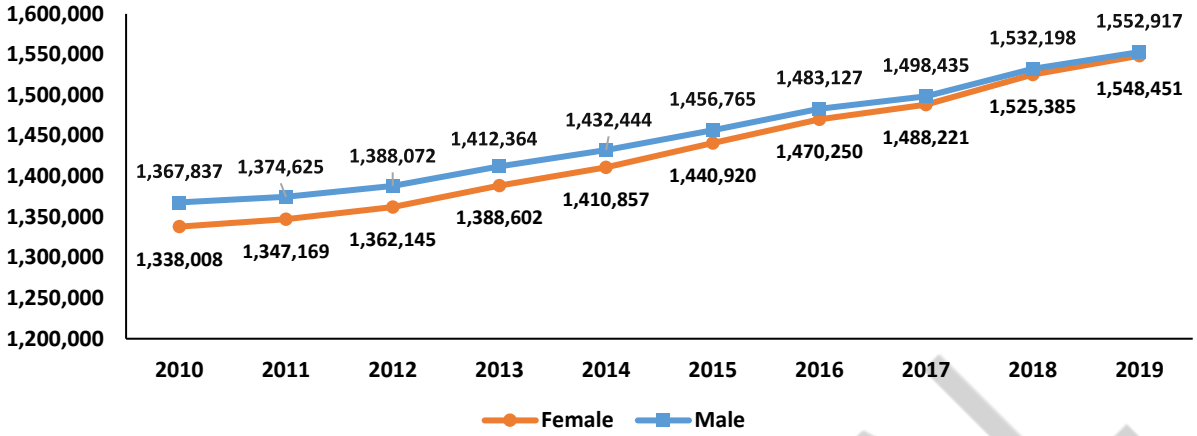
Source: Nevada State Demographer, Vintage 2020.
Chart scaled to 16% to display differences among groups.

Figure 6. Nevada Population by Race/Ethnicity, 2019.



Source: Nevada State Demographer, Vintage 2020.
Chart scaled to 60% to display differences among groups.

Figure 7. Nevada Population Distribution by Sex, 2010-2019.



Source: Nevada State Demographer, Vintage 2020.
Chart scaled to display differences among years.

In 2019, the estimated population for Nevada was 3,101,368, a 14.6% increase from the 2010 estimated population. The population is made up of approximately equal percentages of females and males.

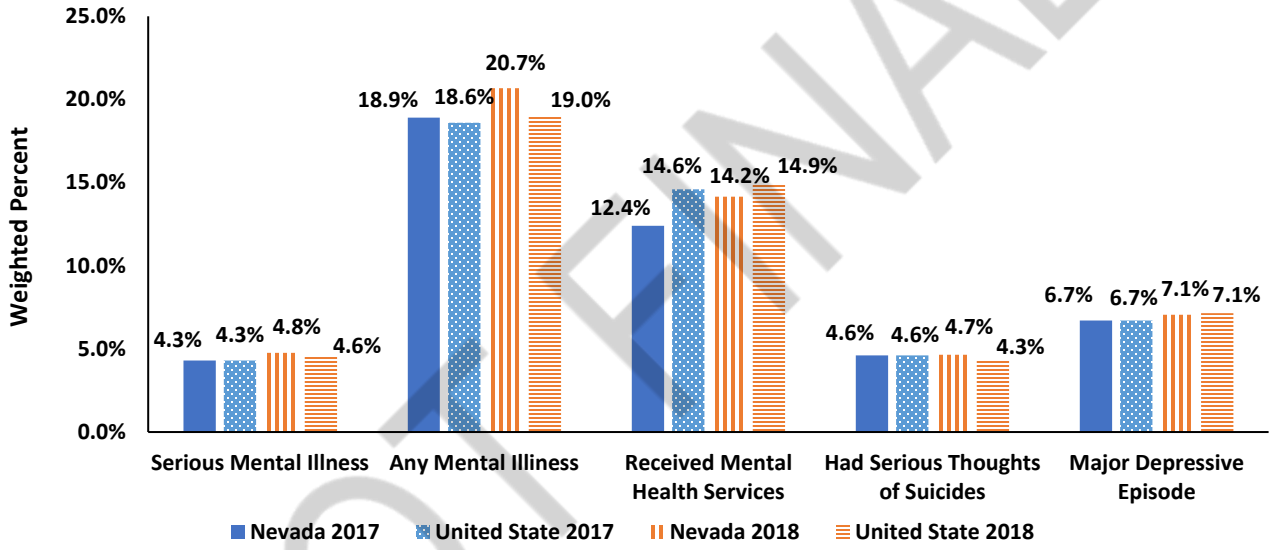
Mental Health

Mental health data are collected by numerous data sources in Nevada, including YRBS, BRFSS, hospital billing, state-funded mental health facilities, and vital records.

National Survey of Drug Use and Health

The Substance Abuse and Mental Health Services Administration (SAMHSA) sponsors the Nation Survey on Drug Use and Health (NSDUH). The survey tracks trends of illicit drug, alcohol, and tobacco use, as well as mental health issues throughout the United States.

Figure 8. Percent of Mental Health Measures, Nevada and United States, 2017-2018.



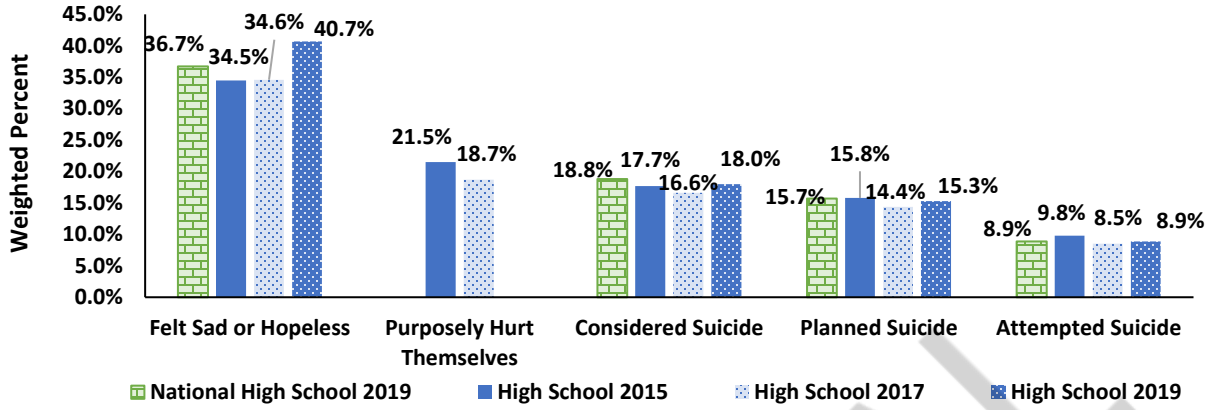
SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2017-2018.
Chart scaled to 20% to display differences among groups.

Nevada has remained within a percent of the Nation for most mental health issues. Nevada was slightly higher than the nation for the measure with "any mental illness" and "had serious thoughts of suicide."

Youth Risk Behavior Survey

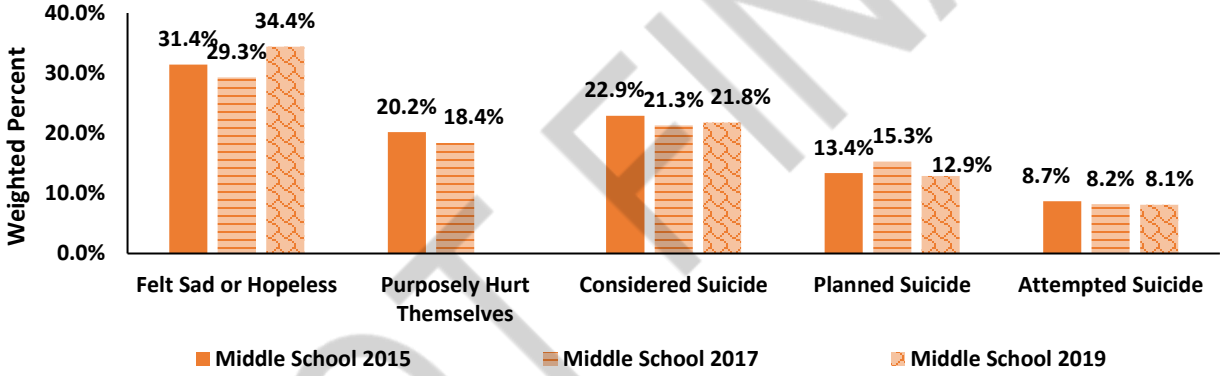
The YRBS monitors six categories of health-related behaviors that contribute to leading causes of death and disabilities among youth and adults. Nevada high school and middle school students are surveyed during the odd years. In 2019, 4,980 high school, and 5,341 middle school students participated in the YRBS in Nevada. The University of Nevada, Reno maintains the YRBS data and publishes data on each survey. For more information on the YRBS survey, please go to the following site: UNR YRBS.

Figure 9a. Mental Health Behaviors, Nevada High School Students, 2015, 2017, and 2019 and National High School Students, 2019.



Source: Nevada Youth Risk Behavior Survey (YRBS).
Chart scaled to 45% to display differences among groups.

Figure 9b. Mental Health Behaviors, Nevada Middle School Students, 2015, 2017, and 2019.



Source: Nevada Youth Risk Behavior Survey (YRBS).
Chart scaled to 40% to display differences among groups.

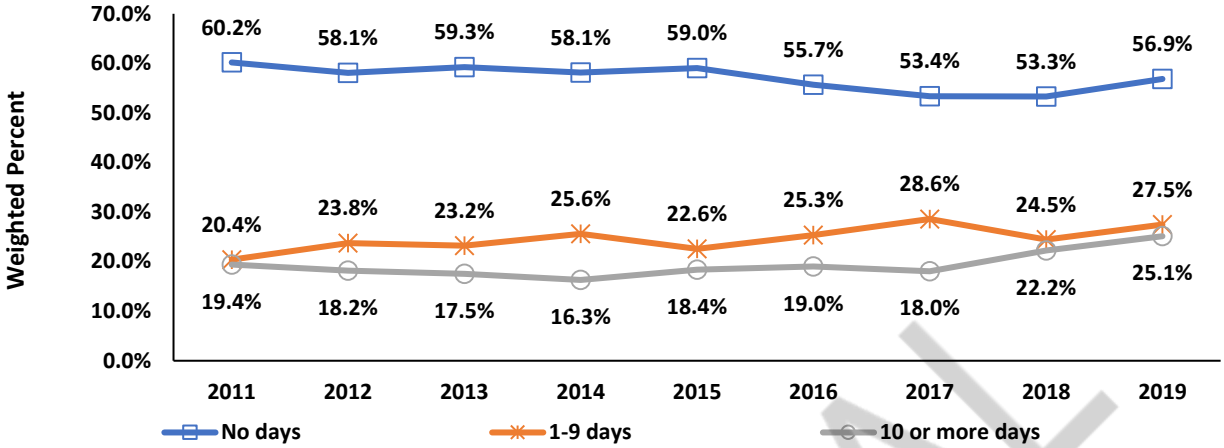
Female high school students are significantly higher for having felt sad or hopeless almost every day for two or more weeks than males, at 50.1% and 31.4% respectively. Likewise, females have a significantly higher percent for considering suicides (22.9%), planning a suicide (18.7%), and purposely hurting themselves (25.9%).

Similarly, female middle school students are significantly higher for having felt sad or hopeless almost every day for two or more weeks (44.8%), purposely hurting themselves (27.9%), considering suicide (28.9%), planning suicide (17.4%), and attempting suicide (10.9%).

Behavioral Risk Factor Surveillance System

BRFSS collects information on adult health-related risk behaviors. According to the Centers for Disease Control and Prevention (CDC), BRFSS is a powerful tool for targeting and building health promotion activities.

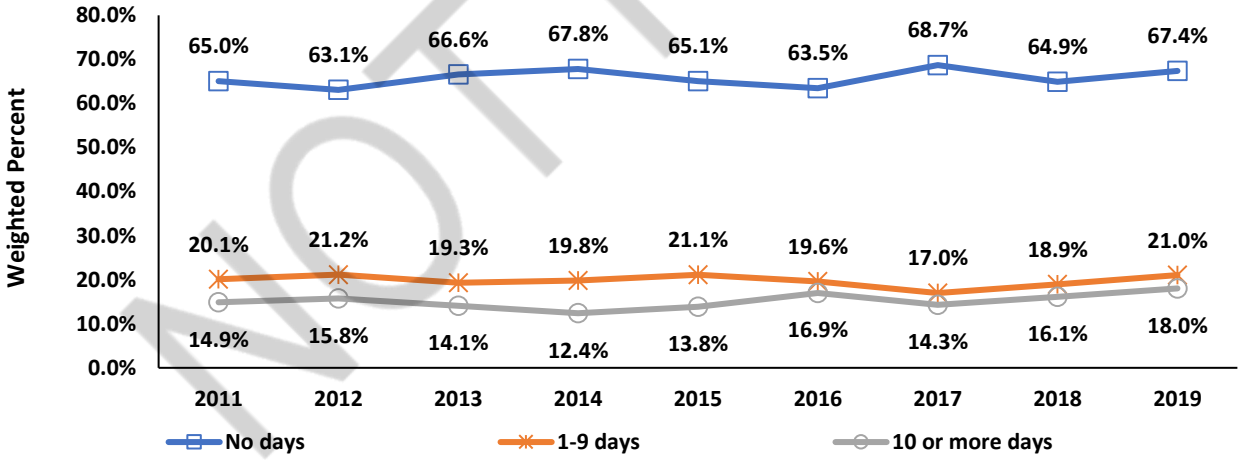
Figure 10. Percentages of Adults Who Experienced Poor Mental or Physical Health that Prevented Them from Doing Usual Activities by Days Affected in Past Month, Nevada Residents, 2011-2019.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 70% to display differences among groups.
Specific question asked in survey: "During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?"

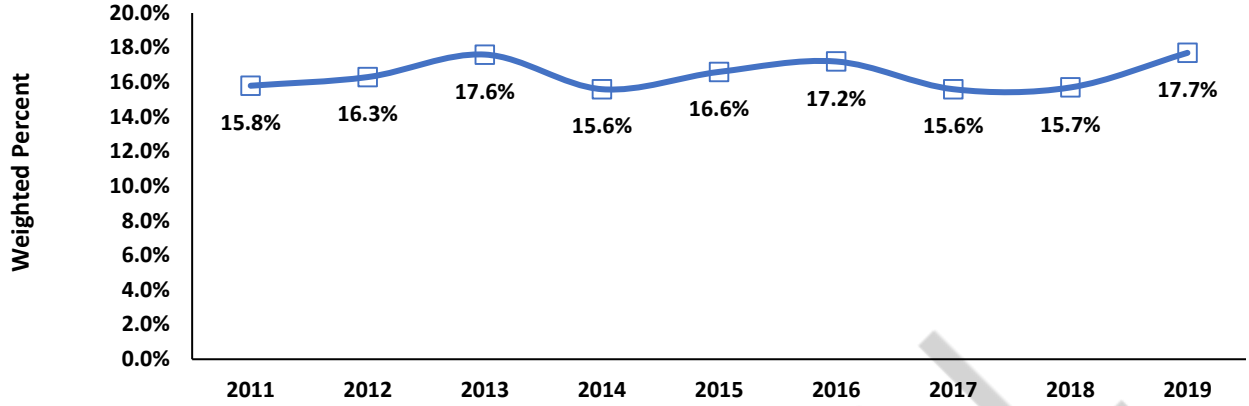
There has been an increase in days where poor mental health or physical health prevented those surveyed from doing usual activities.

Figure 11. Percentages of Adults in which Their Mental Health was Not Good by Number of Days Experienced in the Past Month, Nevada Residents, 2011-2019.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 80% to display differences among groups.
Specific question asked in survey: "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"

Figure 12. Percentages of Adults Who Have Ever Been Told They have a Depressive Disorder, Including Depression, Major/Minor Depression, or Dysthymia, Nevada Residents, 2011-2018.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 20% to display differences among groups.
Specific question asked in survey: "(Ever told) you have a depressive disorder (including depression, major depression, dysthymia, or minor depression)?"

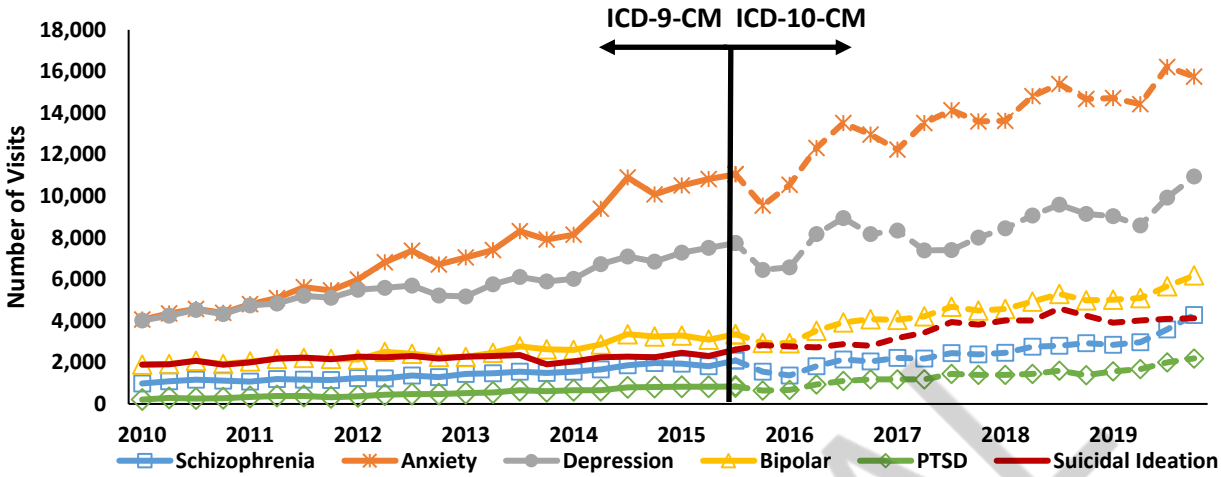
Roughly 18% of Nevadans have been told they have a depressive disorder in 2019.

Nevada 211 is a phone number that helps Nevadans connect with services they need including mental health-related services. During the 2020 fiscal year (July 1, 2019 - June 30, 2020), Nevada 211 received 3,614 calls relating to mental health, excluding suicide-related calls. The most calls received were for general counseling services (n=1,284).

Hospital Emergency Department Encounters

The hospital emergency department billing data includes data for emergency room patients for Nevada's non-federal hospitals. There were 114,443 visits related to mental health disorders among Nevada residents in 2019. Since an individual can have more than one diagnosis during a single emergency department visit, the following numbers reflect the number of times a diagnosis in each of these categories was given, and therefore the following numbers are not mutually exclusive.

Figure 13. Mental Health-Related Emergency Department Encounters, by Quarter and Year, 2010-2019.



Source: Hospital Emergency Department Billing.
Categories are not mutually exclusive.
Rates were calculated to account for population growth and are included in the Appendix.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

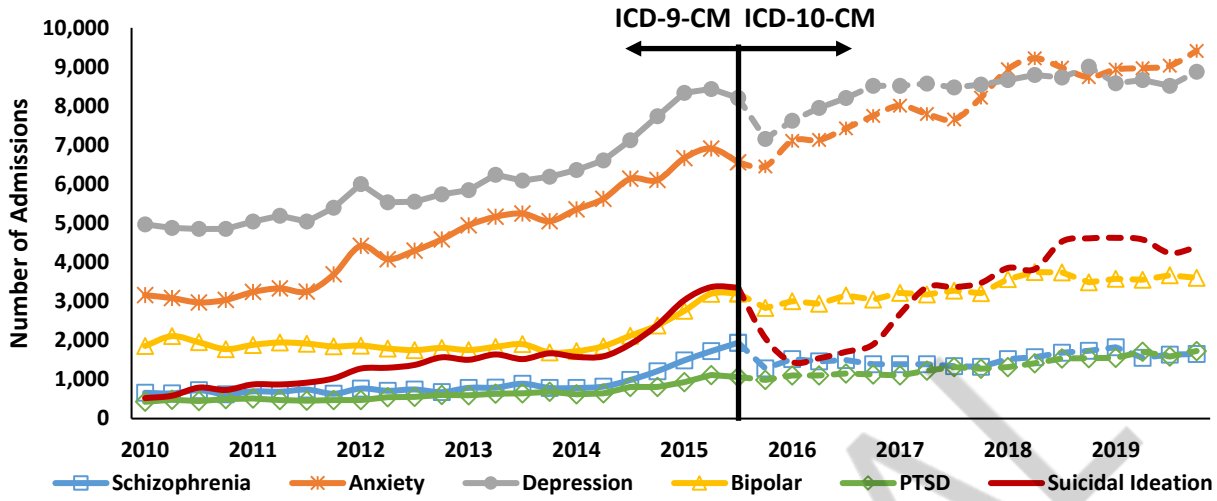
Anxiety has been the leading mental health-related diagnosis since 2012 in emergency department encounters. Anxiety-related encounters increased significantly from 2010 to 2019 in both counts and rates. Males have significant higher visits for schizophrenia (66%) and suicide ideation (62%), whereas females have significant higher visits for anxiety, depression, bipolar disorder, and PTSD (65%, 61%, 54%, and 55% respectively).

The counties served by the CCC and PACE coalition had significantly higher rates for emergency department visits for anxiety and depression. Clark County (PACT/CARE service area) had significantly higher emergency department encounters for schizophrenia, anxiety, depression, bipolar, and suicide ideation. Carson City (PCC coalition service area) had a significantly higher rate for bipolar, and NCC service county regions for suicide ideation.

Hospital Inpatient Admissions

Hospital Inpatient Billing data includes data for patients discharged from Nevada's non-federal hospitals. There were 75,569 inpatient admissions related to mental health disorders among Nevada residents in 2019. Since an individual can have more than one diagnosis during a single inpatient admission, the following numbers reflect the number of times a diagnosis was given, and therefore the following numbers are not mutually exclusive.

Figure 14. Mental Health-Related Inpatient Admissions, by Quarter and Year, 2010-2019.



Source: Hospital Inpatient Billing.
Categories are not mutually exclusive.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Unlike emergency department encounters, depression is the leading diagnosis for mental health-related inpatient admissions from 2010-2018, but in 2019 there were more admissions related to anxiety. All the mental health-related diagnosis for hospital inpatient admissions increased significantly from 2010 to 2019. Females inpatient admissions for anxiety, depression, PSTD, and bipolar disorders were significantly higher than males, whereas males have significantly higher admissions for suicidal ideation and schizophrenia.

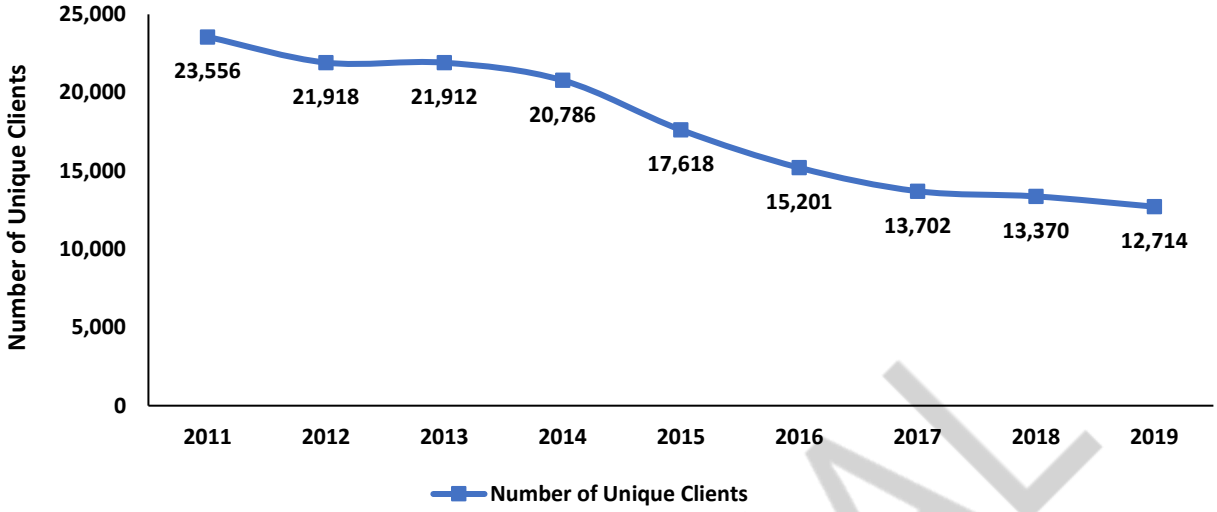
Suicidal ideation also increased from 2009 to 2017 but should be noted that in 2016 inpatient admissions statewide dropped and then increased in 2017. This may be due to ICD-9-CM conversion to ICD-10-CM or another change in medical billing.

Clark County, the PACT/CARE coalition service area had significantly higher admissions for schizophrenia and suicidal ideation. Carson City, the PCC service area has significantly higher admissions for all mental health-related admission except schizophrenia. The counties served by CCC and NCC coalitions have significantly higher admissions from anxiety. Washoe County, the JTNN coalition area has significantly higher admissions for PTSD.

State-Funded Mental Health Services

State-funded mental health facilities are divided into Northern Nevada Adult Mental Health Services (NNAMHS), Southern Nevada Adult Mental Health Services (SNAMHS), and Rural Clinic and Community Health Services. Services that state-funded mental health facilities provide include inpatient acute psychiatric, mobile crisis, outpatient counseling, service coordination, and case management.

Figure 15. Unique Clients* Served at State-Funded Mental Health Clinics, 2011-2019.

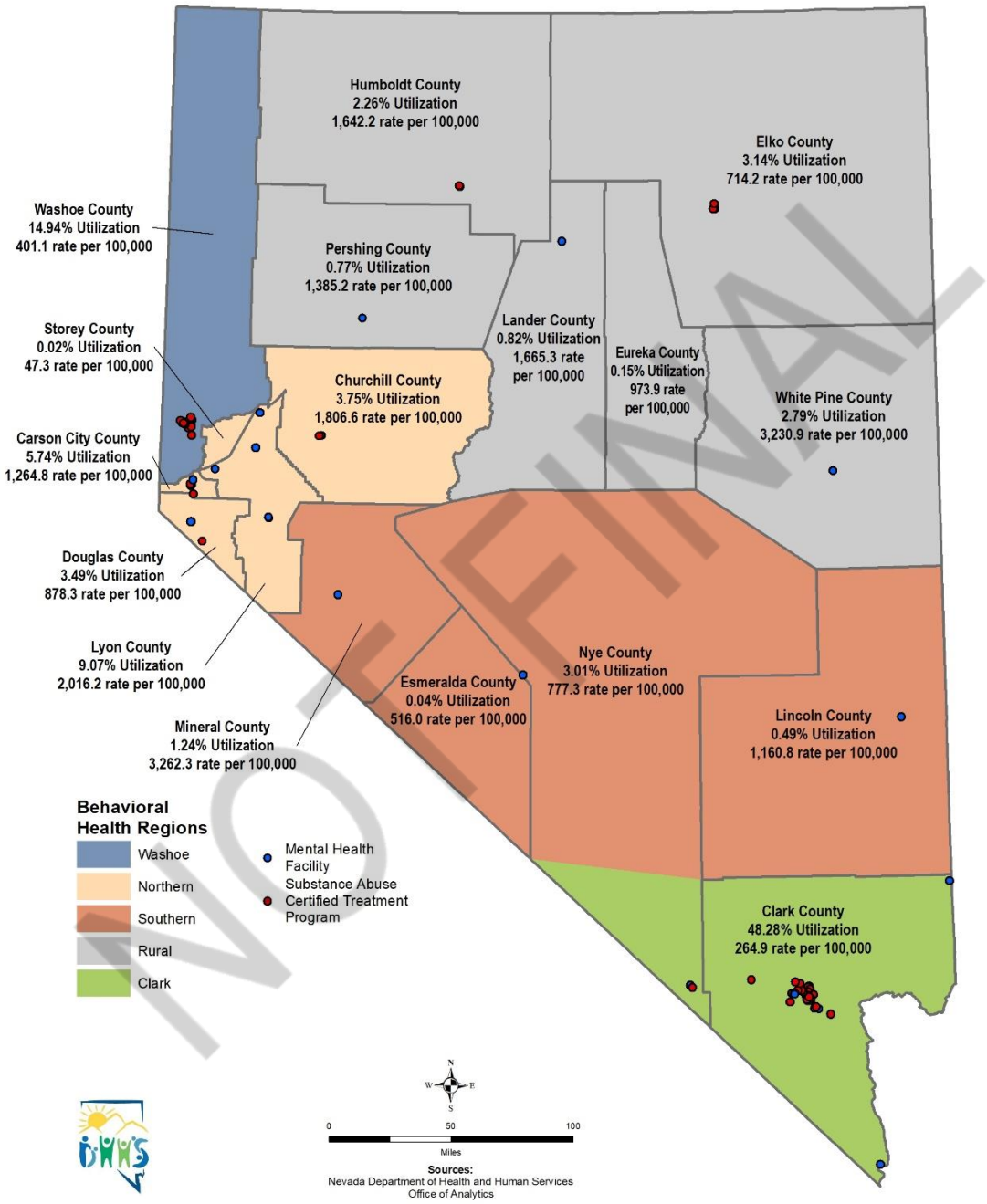


Source: State Funded Mental Health: Avatar.
**A client is counted only once per year. Clients may be counted more than once across years.*

The number of unique clients served by state-funded mental health facilities continues to decline. There were 12,714 clients served in 2019, which has decreased significantly from 2011 (23,556). The Affordable Care Act (ACA) went into effect in 2014. Therefore, many Nevada residents are now able to access non-state-funded facilities through the expansion of Medicaid. This likely contributes to the decline of the clients represented in the above chart.

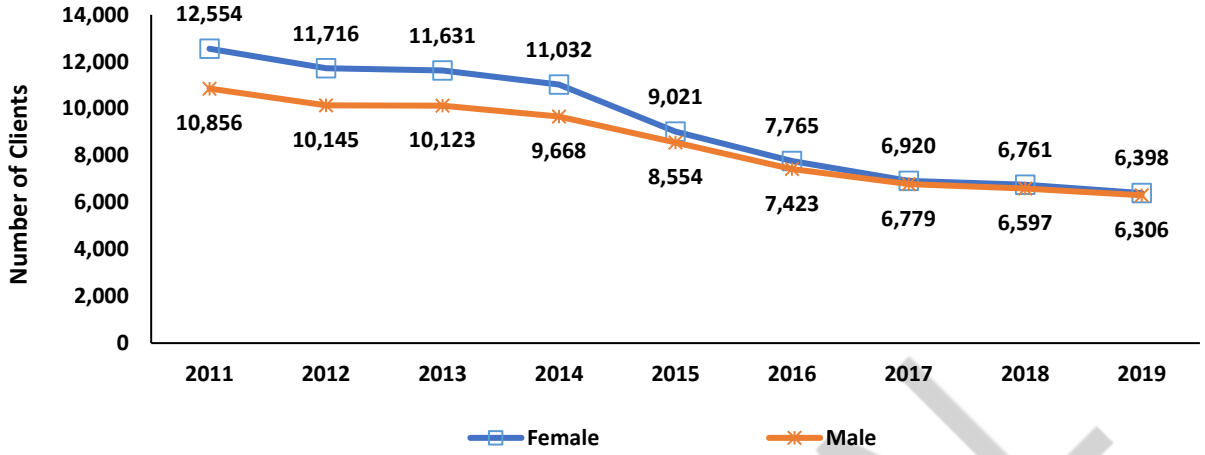
Of the Nevada residents accessing DPBH mental health services in 2019, 48.2% lived in Clark County and 14.9% lived in Washoe County. Mineral County had the highest rate of adults accessing state mental health services, 3,315.6 per 100,000 population.

Figure 16. State-Funded Mental Health Clinics Utilization by County, 2019.



Source: State Funded Mental Health: Avatar.
**A client is counted only once per year. Clients may be counted more than once across years.*
***Percent (%)**: Number of clients who utilize mental health services in that county, divided by total utilization.*
***Rate**: Number of clients who utilize mental health services in that county divided by county population per 100,000 people.*

Figure 17. State-Funded Mental Health Clinics Utilization* by Gender, 2011-2019.

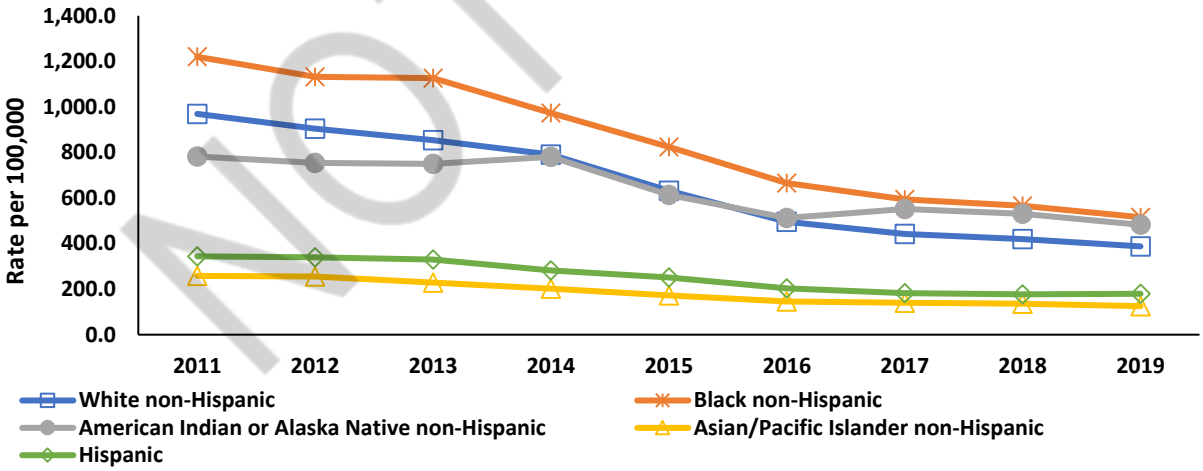


Source: State Funded Mental Health: Avatar.
**A client is counted only once per year. Clients may be counted more than once across years.*

From 2011 to 2015, females significantly utilized the state-funded mental health clinics more than males except in 2017 and 2018, where the difference between male and female is not significant (95% confidence interval). In 2019, 406.1 per 100,000 male population utilized the state-funded mental health clinics, compared females at 413.2 per 100,000 female population.

Of patients that utilized state-funded mental health services, the most common age group was 25-34 years old, on average accounting for 20.1% of patients. High school graduates accounted for 32.1% of patients, followed by those with those with less than 12th grade, no diploma education at 26.8% in 2019.

Figure 18. State-Funded Mental Health Clinics Utilization* by Race/Ethnicity Crude Rates, 2011-2019.



Source: State Funded Mental Health: Avatar.
Race "Unknown" not included in analysis.
**A client is counted only once per year. Clients may be counted more than once across years.*

The patient utilization crude rate has gone down significantly across all races from 2011 to 2019. The Black non-Hispanic population had the highest rate over the seven-year period at 515.6 per 100,000 population, whereas Asian and Pacific Islander non-Hispanic have a significantly lower rate at 125.1 per 100,000 population.

Figure 19. Top Mental Health Clinic Services by Number of Patients Served*, 2011-2019.

Program	Year								
	2011	2012	2013	2014	2015	2016	2017	2018	2019
SNAMHS Medication Clinic Adult	8,492	8,081	8,481	8,082	5,500	4,307	3,891	3,397	2,590
NNAMHS Medication Clinic Adult	3,790	3,678	3,838	3,508	3,149	2,310	1,920	1,922	1,532
SNAMHS Inpatient Hospital Adult	2,106	2,222	2,359	2,592	2,685	1,960	1,881	1,842	1,090
SNAMHS Ambulatory Service Coordination Adult	3,331	3,137	2,711	1,520	823	1,843	1,517	1,234	539
SNAMHS Observation Unit Adult~	4,458	4,736	3,106	~	~	~	~	~	~
NNAMHS Ambulatory Service Adult	1,369	1,537	1,822	1,560	1,326	692	56	16	10
SNAMHS Service Coordination Adult	698	742	1,052	1,051	867	644	521	631	493
SNAMHS Outpatient Counseling Adult	1,061	967	673	649	526	575	566	448	240

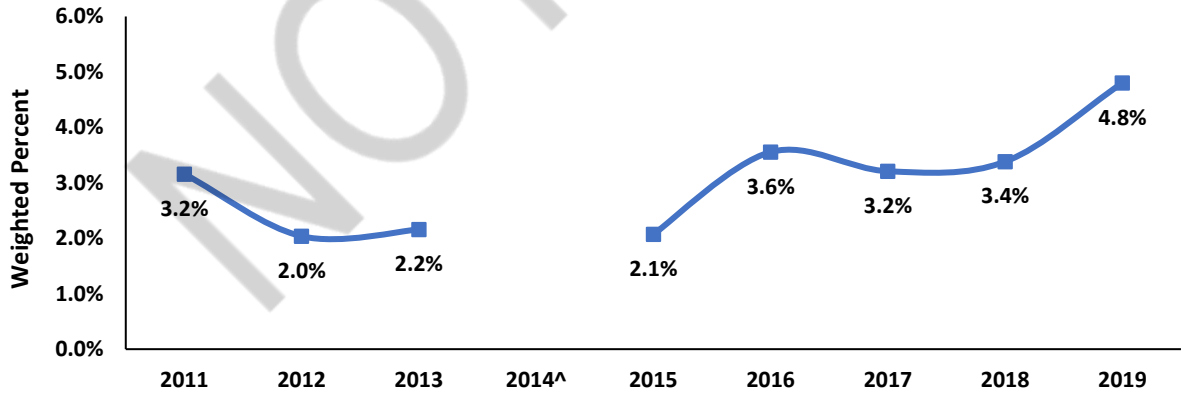
Source: State Funded Mental Health: Avatar.
~Program no longer active.
**A client is counted only once per year. Clients may be counted more than once across years.*

Patients were counted only once per program per year. Since a patient can receive services in more than one program, the counts above are not mutually exclusive. The SNAMHS medication clinic for adults continuously has the highest client count.

Suicide

While suicide is not a mental illness, one of the most common causes of suicide is mental illness. Risk factors for suicide include depression, bipolar disorder and personality disorders. Of those who attempt or complete suicide, many have a diagnosed mental illness.

Figure 20. Percentage of Adult Nevada Residents Who Have Seriously Considered Attempting Suicide, 2011-2019.

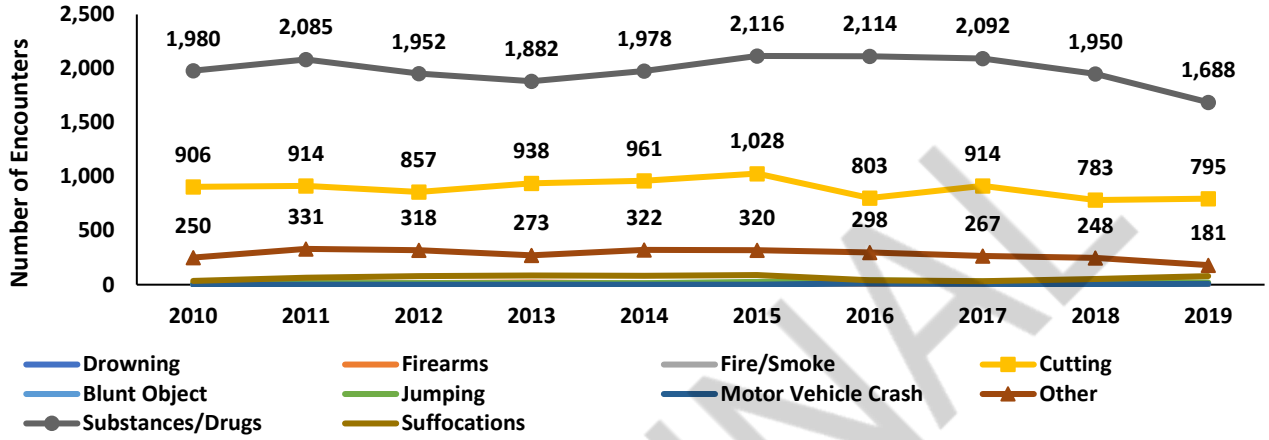


Source: Behavioral Risk Factor Surveillance System (BRFSS).
Chart scaled to 20% to display differences among groups.
^Indicator was not measured in 2014.
Specific question asked in survey: "During the past 12 months have you ever seriously considered attempting suicide?"

When asked "Have you seriously considered attempting suicide during the past 12 months," 4.8% of Nevada residents responded yes in 2019. Between 2011 and 2019, the average prevalence for suicide consideration in the state of Nevada is 3.0%.

Nevada 211 is a phone number that helps Nevadans connect with services they need. During the 2020 fiscal year (July 1, 2019 -June 30, 2020), Nevada 211 received 504 calls relating to suicide. This included referrals to suicide survivors support groups (n=6), prevention hotlines (n= 264), in-person intervention (n=25), and mobile response teams (n=209).

Figure 21. Suicide Attempt Emergency Department Encounters by Method, Nevada Residents, 2010-2019.

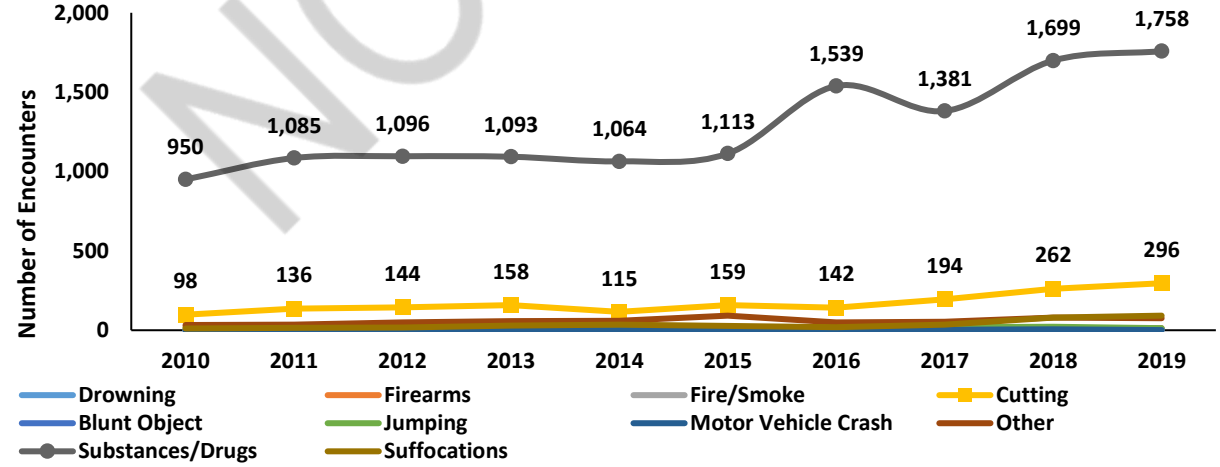


Source: Hospital Emergency Department Billing.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.
A person can be included in more than category and therefore the counts above are not mutually exclusive.

Emergency department encounters related to suicide attempt, where the patient did not expire at the hospital, have remained steady from 2010 to 2019. The most common method for attempted suicide is a substance or drug overdose attempt.

The counties served in NCC and PACE coalitions regions have significantly higher emergency department encounters for substance use and cutting suicide attempts.

Figure 22. Suicide Attempt Inpatient Admissions by Method, Nevada Residents, 2011-2019.

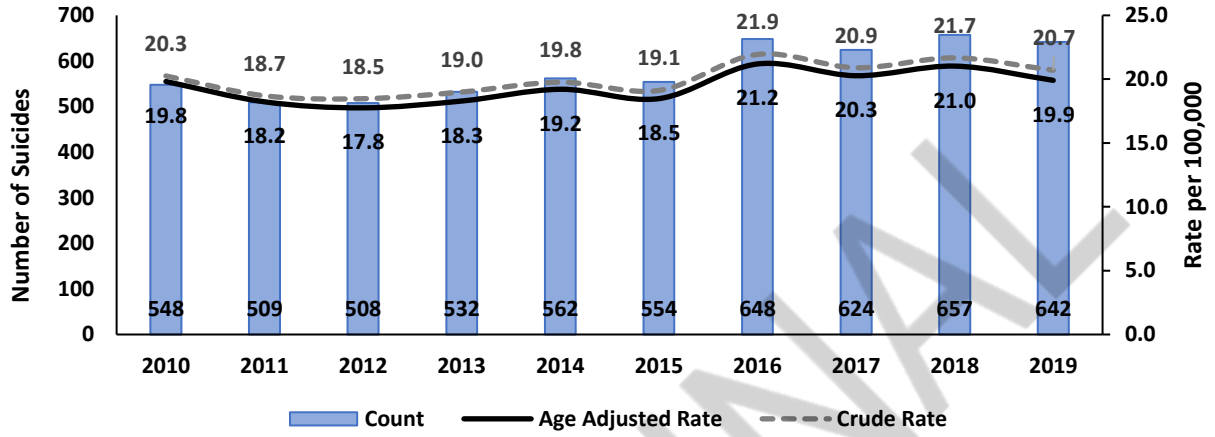


Source: Hospital Inpatient Billing.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.
A person can be included in more than category and therefore the counts above are not mutually exclusive.

Inpatient admissions for attempted suicide where the patient was admitted and did not expire at the hospital have increased where the method was substances or drugs.

The counties served in HCC, PCC, and JTNN coalitions regions were significantly higher for inpatient admissions relating to suicide attempts.

Figure 23. Number of Suicides and Rates, Nevada Residents, 2010-2019.

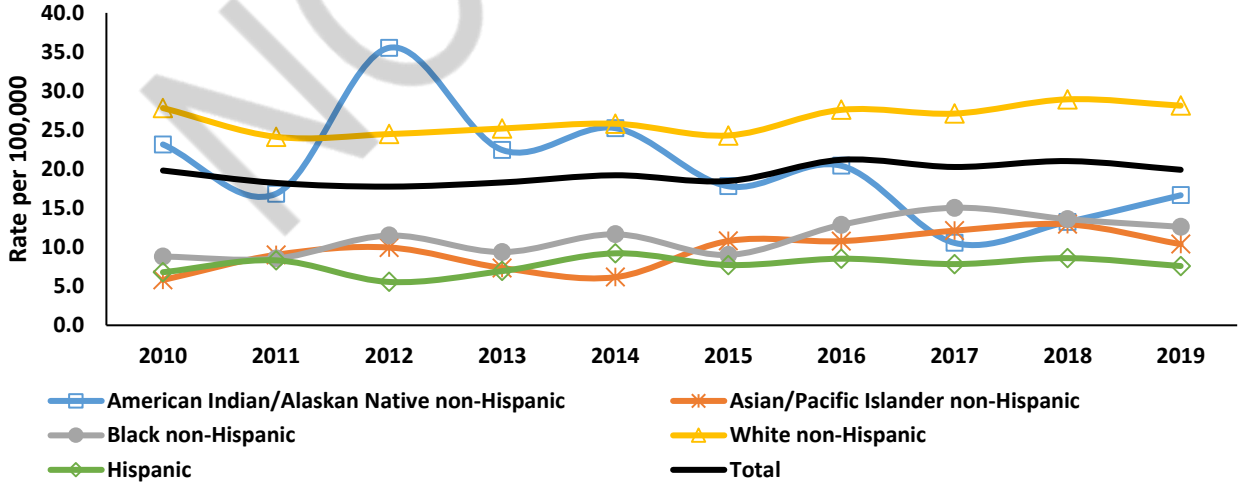


Source: Nevada Electronic Death Registry System.

The age-adjusted suicide rate for 2019 in Nevada was 20.7 per 100,000 population. Suicides in Nevada are highest among those in the 25-34 age group, with 114 suicides in 2019 which is different from past year where the 45-54 age group had the highest number of suicides. Suicides are highest among persons with a high school degree, with 281 suicides in 2019, which has been similar in past years.

The counties served in PACE coalition regions have a significantly higher crude rate for suicide in 2019 at 37.2 per 100,000 population.

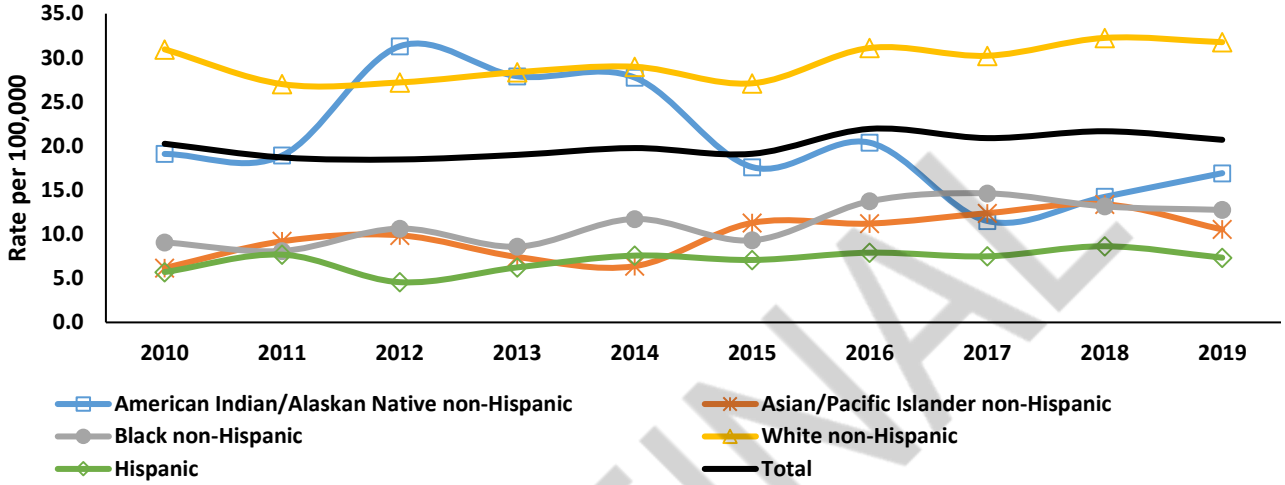
Figure 24. Age-Adjusted Suicides Rates by Race/Ethnicity, Nevada Residents, 2010-2019.



Source: Nevada Electronic Death Registry System.

The age-adjusted suicide rates for White non-Hispanics were significantly higher than the Nevada overall rate for each year from 2010 to 2019 with 28.1 per 100,000 population in 2019. The age-adjusted suicide rate for American Indian/Alaskan Native non-Hispanic was above the total Nevada rate (2010, 2012, 2013, 2014), but was not significantly higher based on 95% confidence intervals. Rates among Hispanics are significantly lower than overall Nevada rates for all years.

Figure 25. Crude Suicides Rates by Race/Ethnicity, Nevada Residents, 2010-2019.



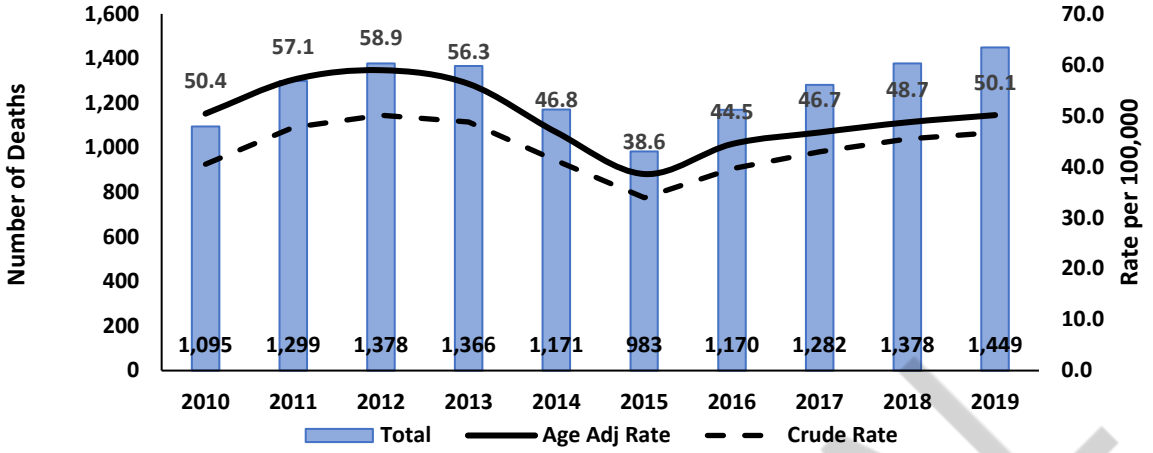
Source: Nevada Electronic Death Registry System.

Mental Health-Related Deaths

Mental health-related deaths are deaths with the following ICD-10 codes groups listed as a contributing cause of death (F00-F99 excluding F10-F19):

- Organic, including symptomatic, mental disorders
- Schizophrenia, schizotypal and delusional disorders
- Mood [affective] disorders
- Neurotic, stress-related and somatoform disorders
- Behavioral syndromes associated with physiological disturbances and physical factors
- Disorders of adult personality and behavior
- Mental retardation
- Disorders of psychological development
- Behavioral and emotional disorders with onset usually occurring in childhood and adolescence; Unspecified mental disorder

Figure 26. Mental Health-Related Deaths and Rates, Nevada Residents, 2010-2019.

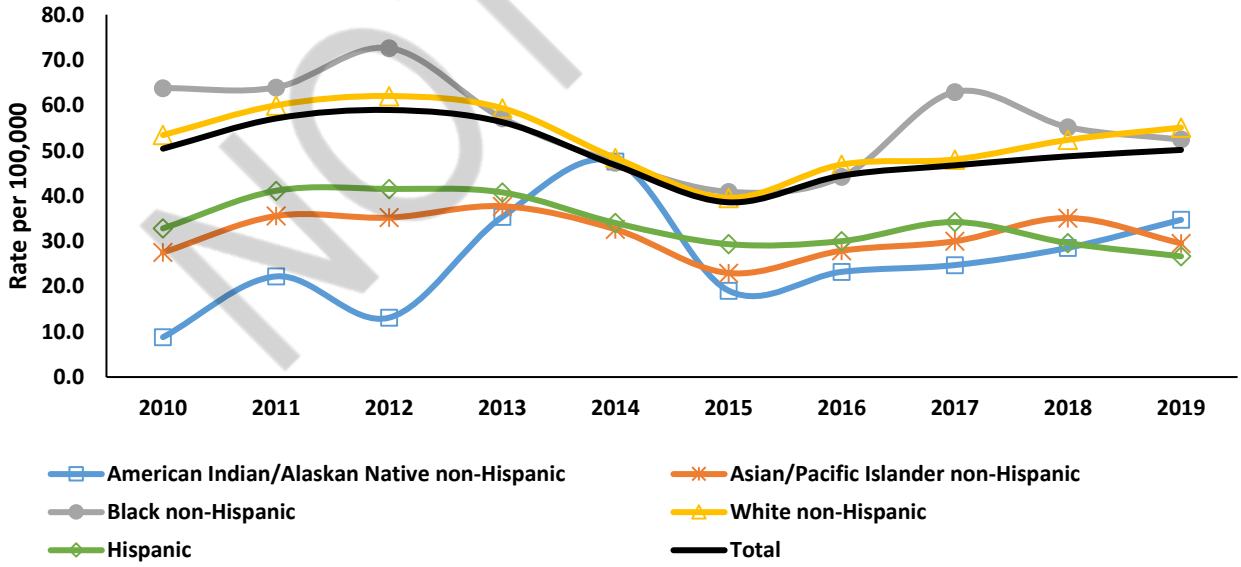


Source: Nevada Electronic Death Registry System.

There were 12 mental health-related deaths among individuals under 45 years old in 2019. The most common age group for mental health-related deaths were those aged 85 and above with 800 deaths in 2019. Mental health-related deaths were highest among individuals who had high school diplomas.

The counties served in CCC, HCC, JTNN, and PCC coalition regions mental health-related deaths are significantly higher than the state at the age-adjusted rate of 91.0, 72.5, 71.7, and 109.7 per 100,000 population (respectively). The counties served in the PACE and PACT/CARE coalition regions have a significantly lower age-adjusted rate at 26.5 and 42.0 per 100,000 population (respectively).

Figure 27. Age-Adjusted Mental Health-Related Death Rates by Race/Ethnicity, Nevada Residents, 2010-2019.



Source: Nevada Electronic Death Registry System.

There are no significant differences between the age-adjusted mental health-related death rates among races/ethnicities for 2019.

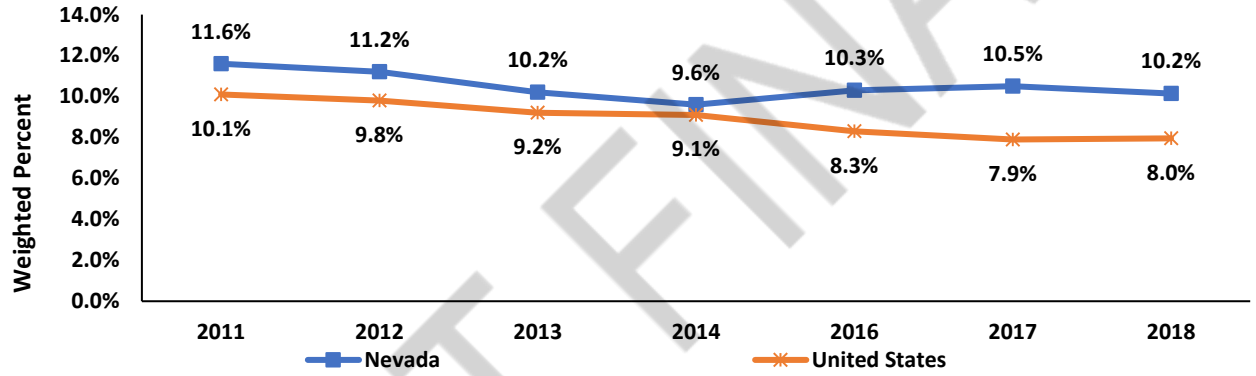
Substance Use

Substance use data are collected from hospital billing data, vital records data, and through national survey data including Substance Abuse and Mental Health Service Administration, BRFSS and YRBS.

National Survey on Drug Use and Health

The Substance Abuse and Mental Health Services Administration (SAMHSA) sponsors the National Survey on Drug Use and Health (NSDUH). The survey tracks trends of illicit drug, alcohol, and tobacco use, as well as mental health issues throughout the United States. For more information about the national survey, please go to the following website: SAMHSA NSDUH.

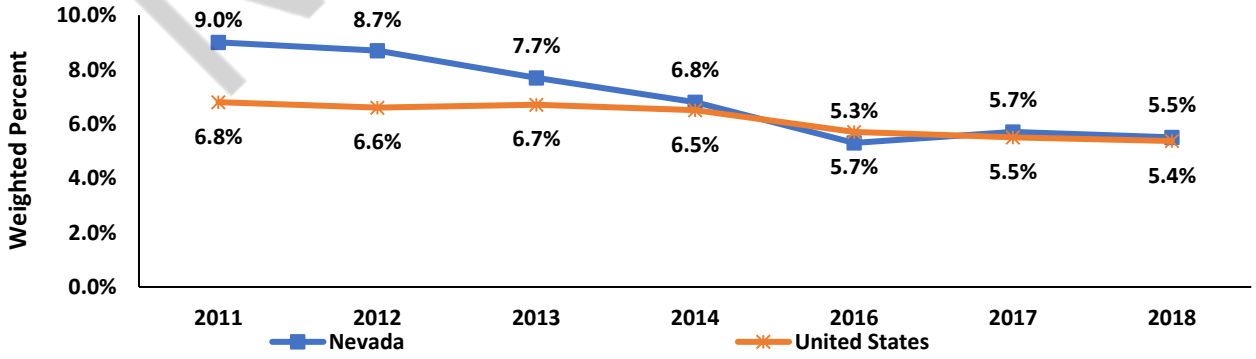
Figure 28. Illicit Drug Use Among Adolescents in the Past Month, Aged 12-17, Nevada and the United States, 2011-2018.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health.
Chart scaled to 14% to display differences among groups.

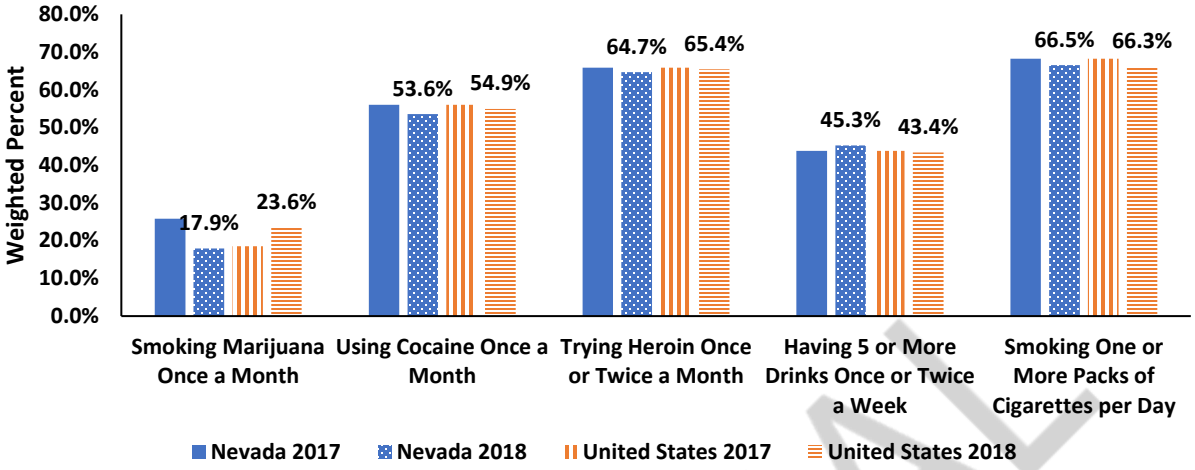
Nevada adolescents illicit drug use has remained within 2% from 2011 to 2018, 10.2% reported illicit drug use in 2018. Alcohol use disorder in the past year has decreased from 9.0% in 2011 to 5.5% in 2018.

Figure 29. Alcohol Use Disorder in the Past Year Aged 12 and Above, Nevada and the United States, 2011-2018.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health.
Chart scaled to 10% to display differences among groups.

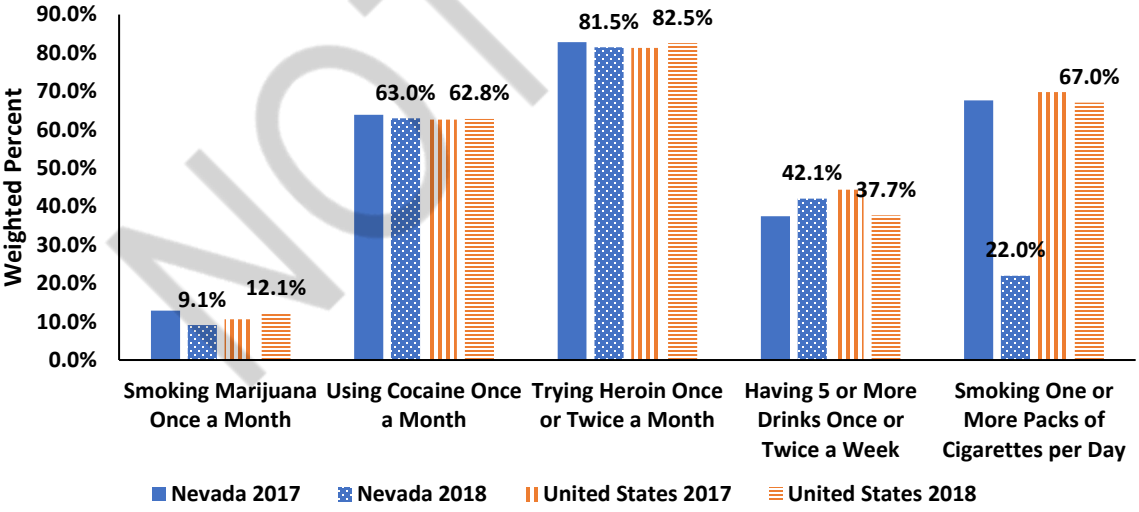
Figure 30. Perceptions of Great Risk from Alcohol or Substance, Aged 12-17, Nevada and the United States, 2018.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health.
Chart scaled to 80% to display differences among groups.

For perceived risks, the higher percent the more the person perceives there is a risk from it. Nevadans perceived risk among both teens (Figure 30 and 31) and young adults is lower than the nation for most substance uses, including smoking one or more packs of cigarettes per day in young adults, 22.0% in Nevada and nationally at 67.0%

Figure 31. Perceptions of Great Risk from Alcohol or Substance, Aged 18-25, Nevada and the United States, 2018.

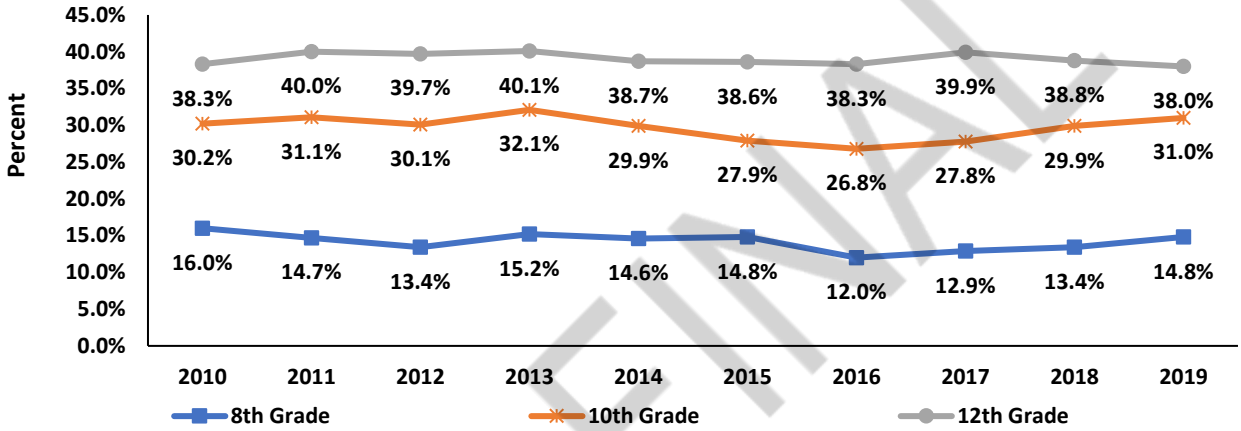


Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health.
Chart scaled to 90% to display differences among groups.
Table in the Appendix.

Monitoring the Future Survey

Monitoring the Future is an ongoing study of the behaviors, attitudes, and values of American secondary school students and young adults. Each year, a total of approximately 50,000 students in 8th, 10th and 12th grades are surveyed. The Monitoring the Future Study (annual prevalence & lifetime prevalence) is funded under a series of investigator-initiated competing research grants from the National Institute on Drug Abuse, a part of the National Institutes of Health. Monitoring the Future Survey is conducted at the Survey Research Center in the Institute for Social Research at the University of Michigan. This data is collected nationality, and state level is not provided.

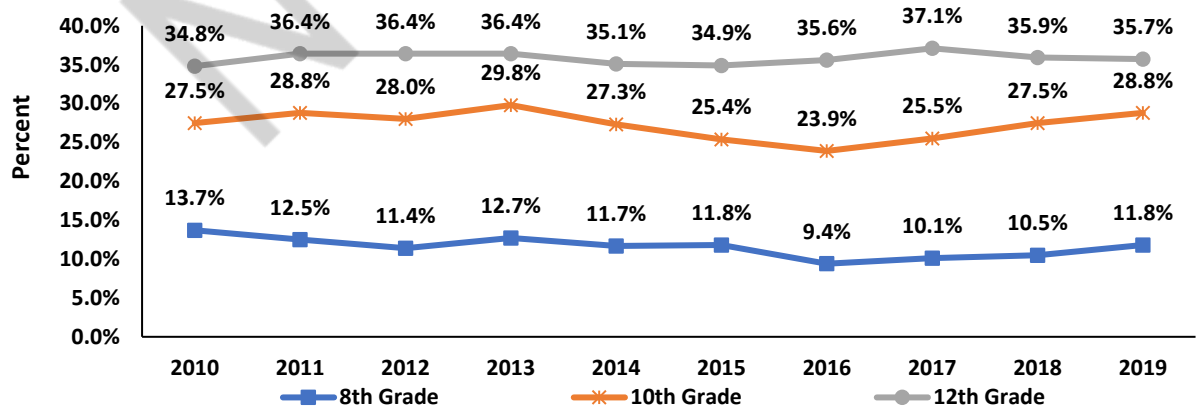
Figure 32. Annual Prevalence of Any Illicit Drug Use, United States, 2010-2019.



Source: Monitoring the Future Survey.
Chart scaled to 50% to display differences among groups.

On average, approximately 40% of 12th graders, 30% of 10th graders, and 14% of 8th graders in the United States have reported using any form of illicit drugs from 2010-2018. Lifetime illicit drug use has remained steady as well. In 2019, the lifetime illicit drug for 12th graders was 47.4%, 10th graders was 37.5%, and 8th graders was 20.4%.

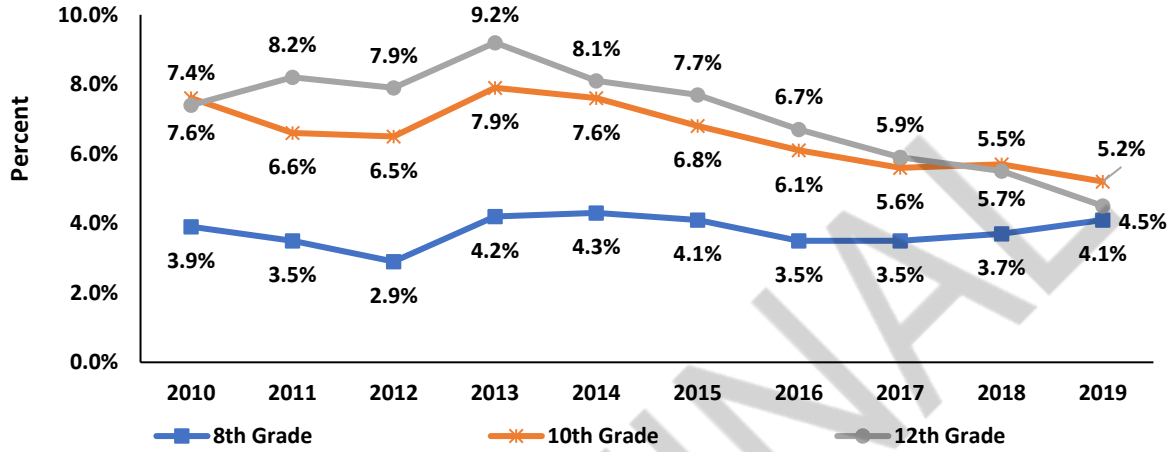
Figure 33. Annual Prevalence of Marijuana/Hashish Use, United States, 2010-2019.



Source: Monitoring the Future Survey.
Chart scaled to 50% to display differences among groups.

On average, approximately 36% of 12th graders, 27% of 10th graders, and 12% of 8th graders have reported using marijuana/hashish in the United States. Lifetime marijuana/hashish use has remained steady for all grades from 2010 to 2019. In 2019, the lifetime marijuana/hashish use for 12th graders was 43.7%, for 10th was 34.0%, and for 8th graders was 15.2%.

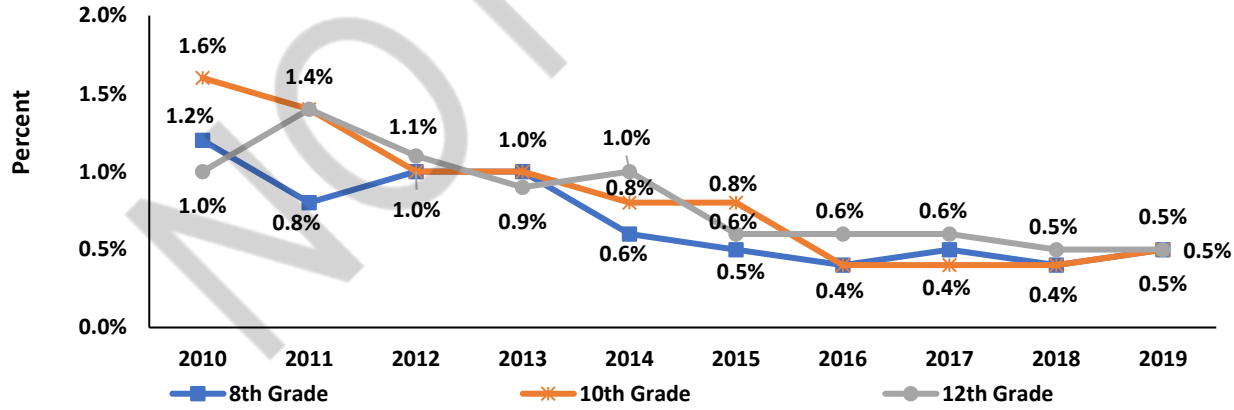
Figure 34. Annual Prevalence of Amphetamine Use, United States, 2010-2019.



Source: Monitoring the Future Survey.
Chart scaled to 10% to display differences among groups.

The annual prevalence of amphetamine use decreased from 2010 to 2019 for 12th from 7.4% to 5.2% respectively. In contrast, the 8th grade prevalence has increased from 3.9% to 4.1%.

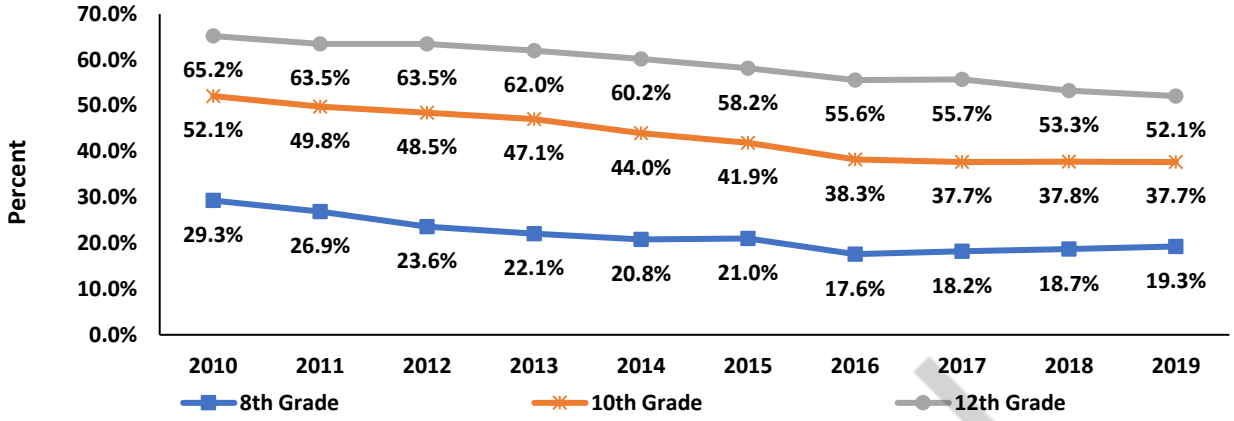
Figure 35. Annual Prevalence of Methamphetamine Use, United States, 2010-2019.



Source: Monitoring the Future Survey.
Chart scaled to 2% to display differences among groups.

Methamphetamine use has decreased by an average of 59% among all three surveyed grades since 2010 in the United States. Lifetime prevalence has decreased as well. In 2019, the lifetime use among 12th graders was 0.8%, 10th graders was 0.7%, and 8th graders was 0.9%.

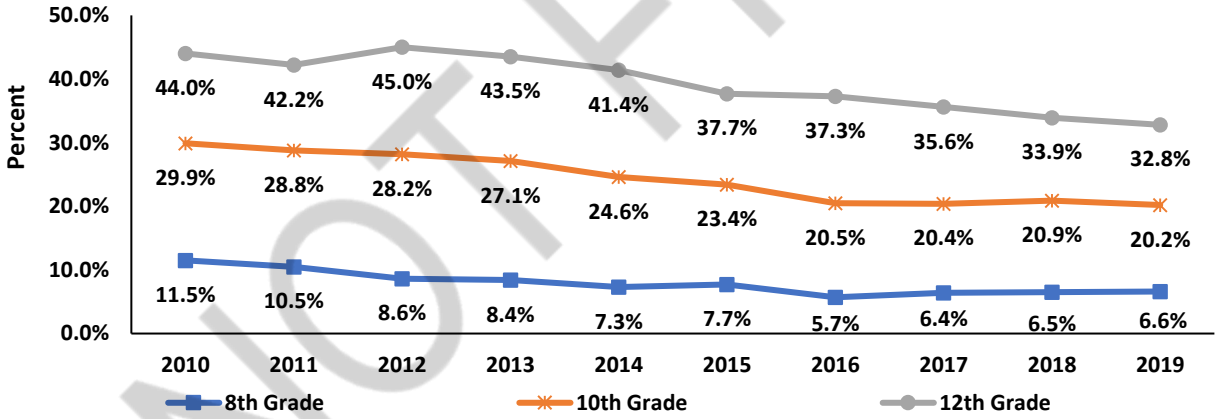
Figure 36. Annual Prevalence of Alcohol Use, United States, 2010-2019.



Source: Monitoring the Future Survey.
Chart scaled to 70% to display differences among groups.

The prevalence of alcohol use including being drunk from alcohol has decreased in all grades since 2010 through 2015 in the United States. Since 2015, the prevalence has remained steady among all grades. The lifetime prevalence of any alcohol use has remained steady as well, from 2010 to 2019. In 2019, lifetime alcohol use was 58.5% for 12th graders, 43.1% for 10th graders, and 24.5% for 8th graders.

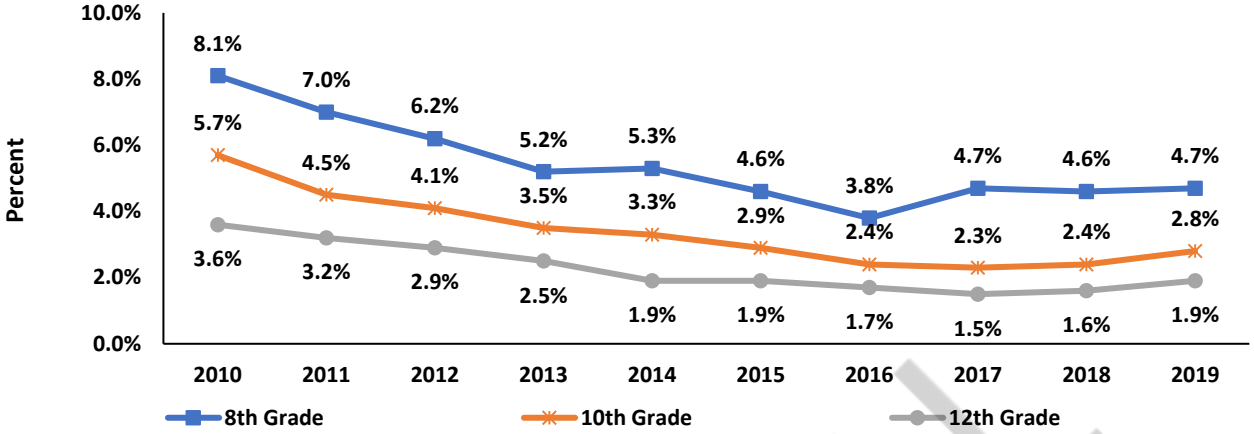
Figure 37. Annual Prevalence of Being Drunk from Alcohol, United States, 2010-2019.



Source: Monitoring the Future Survey.
Chart scaled to 50% to display differences among groups.

On average, approximately 39% of 12th graders, 24% of 10th graders, and 8% of 8th graders in the United States have reported being drunk from 2010 to 2018. Lifetime use for ever been drunk for 12th graders decreased from 42.9% in 2018 to 40.8%. In contrast, among 8th graders, the number increased from 9.2% to 10.1% which is the first increase in this indicator since 2015.

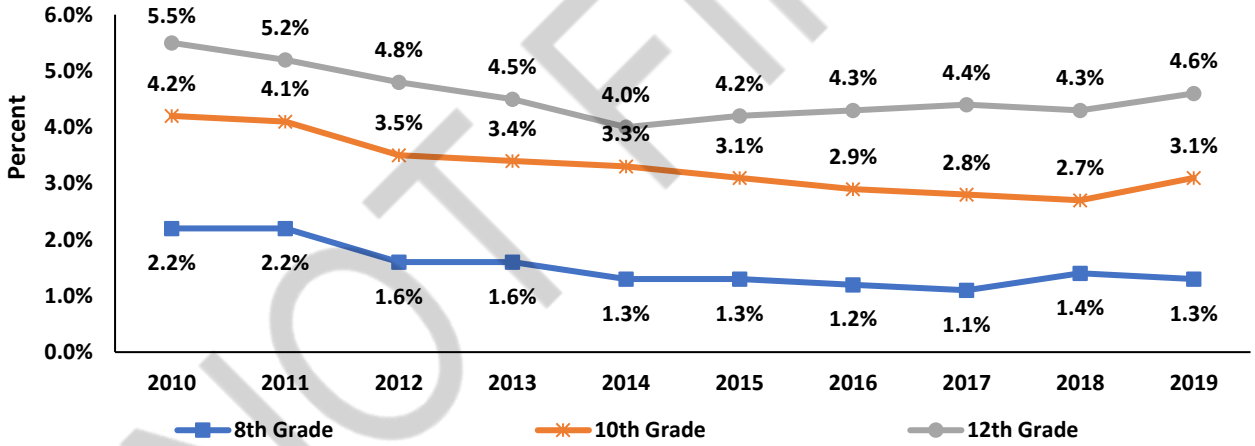
Figure 38. Annual Prevalence of Inhalant Use, United States, 2010-2019.



Source: Monitoring the Future Survey.
Chart scaled to 10% to display differences among groups.

The prevalence of inhalant use has decreased among all grades since 2010 through 2015 in the United States and then has increased slightly since 2016. The lifetime use is higher than the annual prevalence for all age groups in 2019, with 5.3% for 12th graders, 6.8% for 10th graders, and 9.5% for 8th graders.

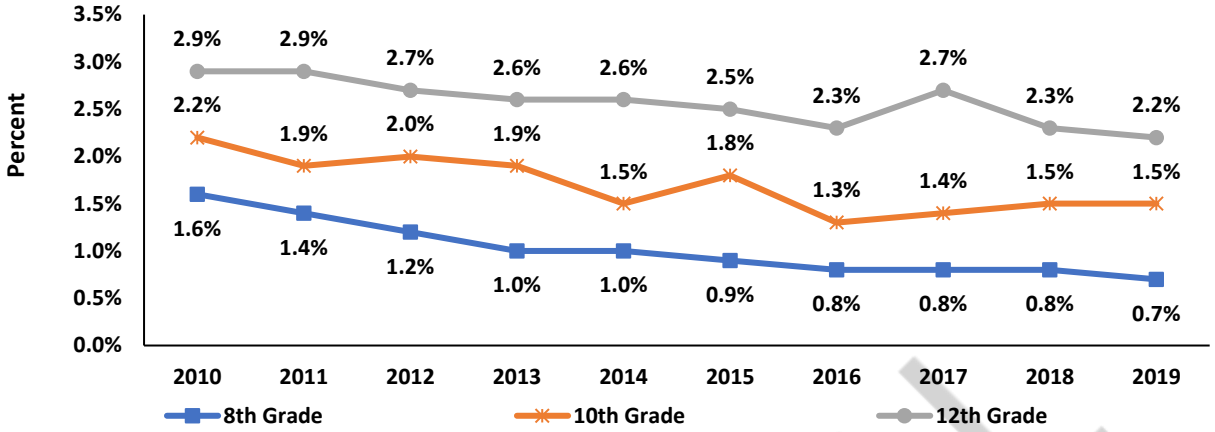
Figure 39. Annual Prevalence of Hallucinogen Use, United States, 2010-2019.



Source: Monitoring the Future Survey.
Chart scaled to 10% to display differences among groups.

On average, approximately 3% of the grades surveyed have reported using hallucinogens in the United States from 2010 to 2019. The lifetime use for hallucinogen use in 2019 increased for all grades from 2018, with 6.9% up .2% from 2018 for 12th graders, 4.7% up .8% from 2018 for 10th graders, and 2.4% up from 2.2% in 2018, for 8th graders.

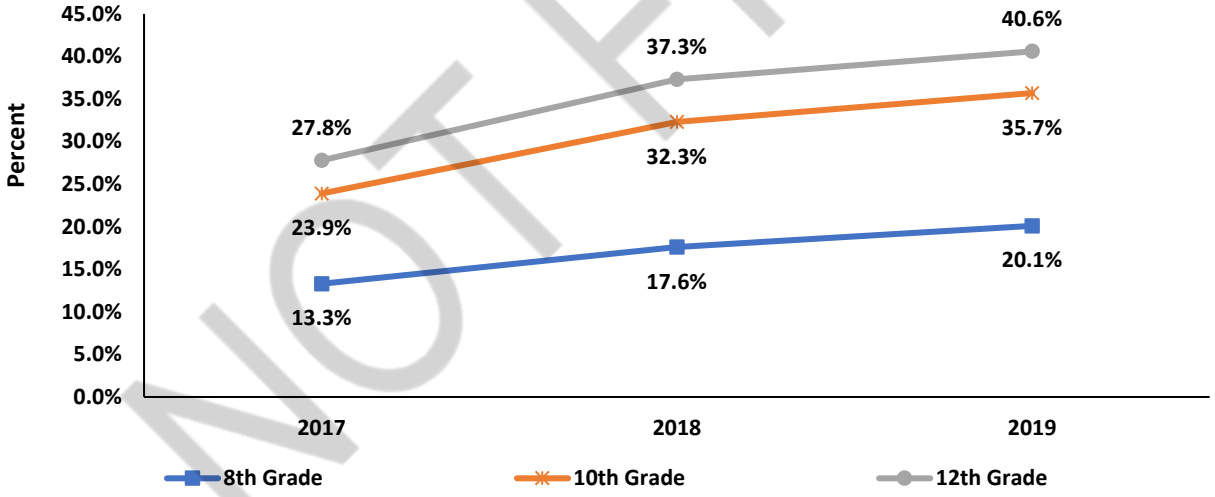
Figure 40. Annual Prevalence of Cocaine Use, United States, 2010-2019.



Source: Monitoring the Future Survey.
Chart scaled to 5% to display differences among groups.

The annual prevalence cocaine use on average for 12th grade is 2.2%, 1.5% for 10th grade, and 0.7% for 8th grade. The lifetime prevalence use of cocaine for 12th grade is 3.8%, 2.5% for 10th grade, and 1.2% for 8th grade.

Figure 41. Annual Prevalence of Vaping Use, United States, 2010-2019.



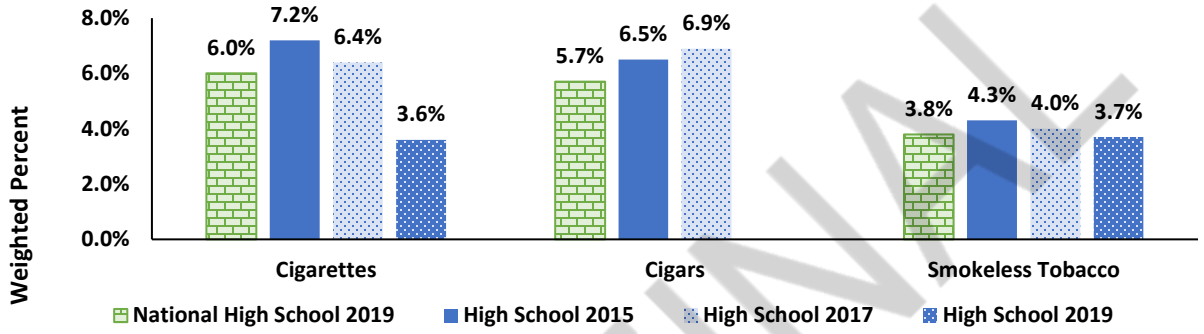
Source: Monitoring the Future Survey.
Chart scaled to 5% to display differences among groups.

The annual prevalence for vaping has continued to increase from each year. The lifetime increased from 2018 to 2019 in all grades, 45.6% for 12th grade, 41.0% for 10th grade, and 24.3% for 8th grade. In 2018, 42.5% 36.9% and 21.5% respectively.

Youth Risk Behavior Survey

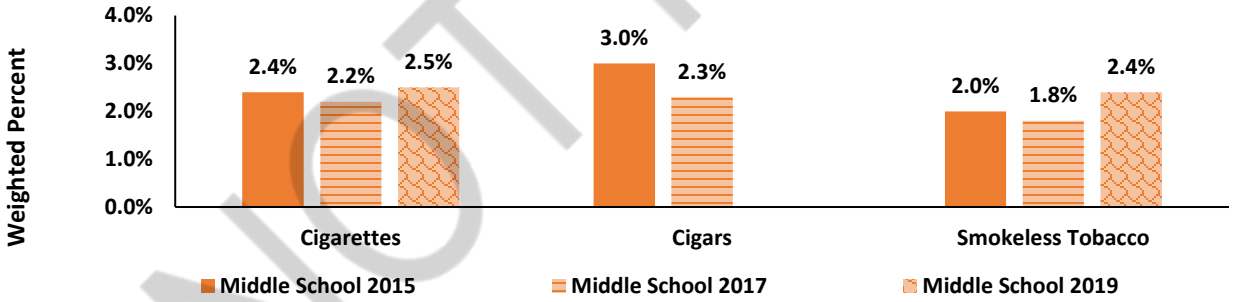
The YRBS monitors six categories of health-related behaviors that contribute to leading causes of death and disabilities among youth and adults. Nevada high school and middle school students are surveyed during the odd years. In 2019, 4,980 high school, and 5,31 middle school students participated in the YRBS in Nevada. The University of Nevada, Reno maintains the YRBS data and publishes data on each survey. For more information on the YRBS survey, please go to the following site: UNR YRBS.

Figure 42a. Tobacco Use, Nevada High School Students, 2015, 2017, 2019, and National High School Students, 2019.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 8% to display differences among groups.

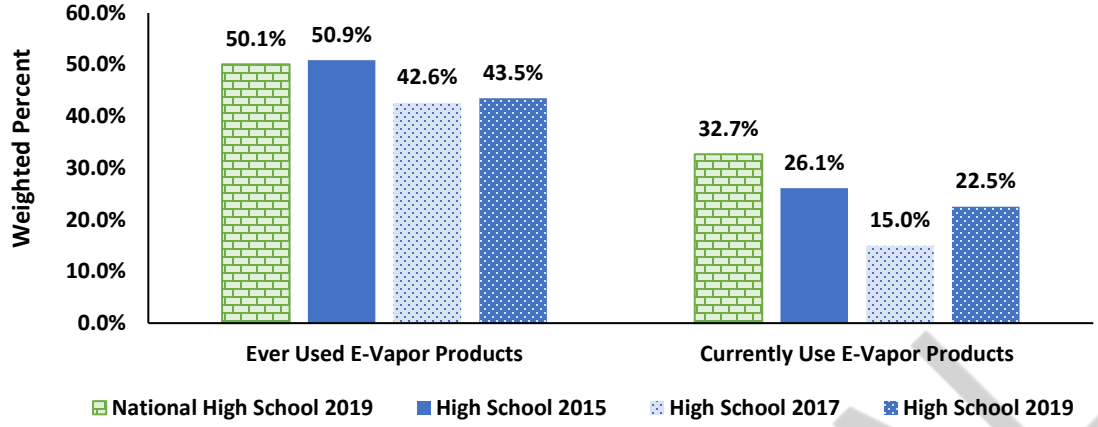
Figure 42b. Tobacco Use, Nevada Middle School Students, 2015, 2017, 2019.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 4% to display differences among groups.

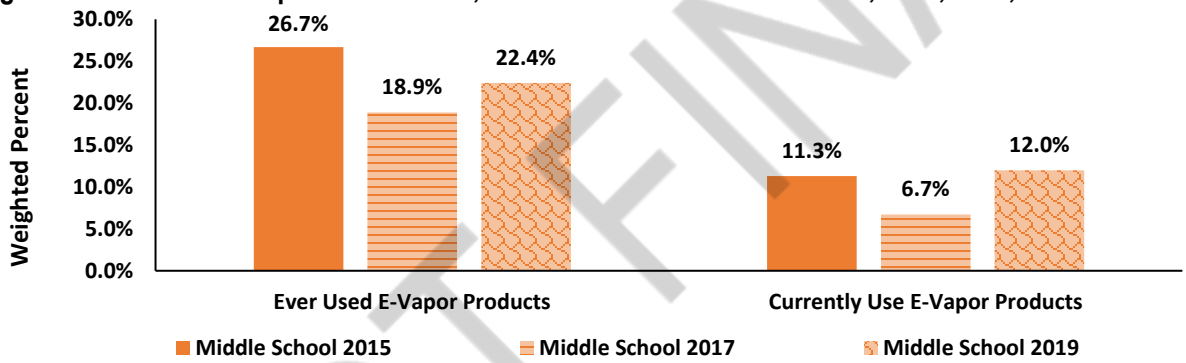
Of Nevada high school students in 2019, 3.6% have smoked cigarettes, which is lower than the national reported at 6.0%. Churchill, Humboldt, Pershing, and Lander counties combined have a significantly higher tobacco use at 12.7%, and Nye and Lincoln counties combine at 9.3%. Among middle school students to have smoked cigarettes, those 14 or older are significantly higher than other ages.

Figure 43a. Electronic Vapor Product Use, Nevada High School Students, 2015, 2017, 2019, and National High School Students, 2019.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 60% to display differences among groups.

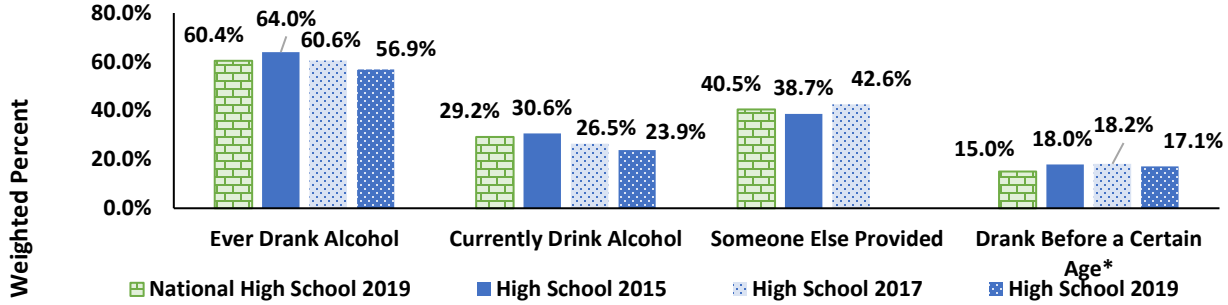
Figure 43b. Electronic Vapor Product Use, Nevada Middle School Students, 2015, 2017, 2019.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 60% to display differences among groups.

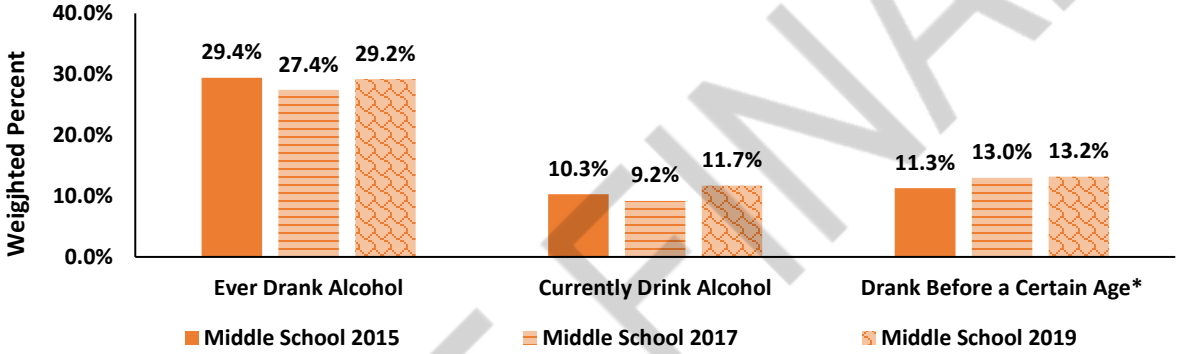
In Nevada, 22.5% of high school students reported using E-vapor products, which is lower than the nation (32.7%). High school students from the Carson City; Douglas County, Elko, White Pine and Eureka counties combined; Churchill, Humboldt, Pershing, and Lander counties combined; and Lyon, Mineral, and Storey, counties combined have significantly higher reports of using electronic cigarettes. Among middle school students, those 14 years or older were significantly higher than younger ages, at 36.3% who reported ever using an electronic cigarette.

Figure 44a. Alcohol Use, Nevada High School Students, 2015, 2017, 2019, and National High School Students, 2019.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 80% to display differences among groups.
**In high school students, if they ever drank before age 13.*

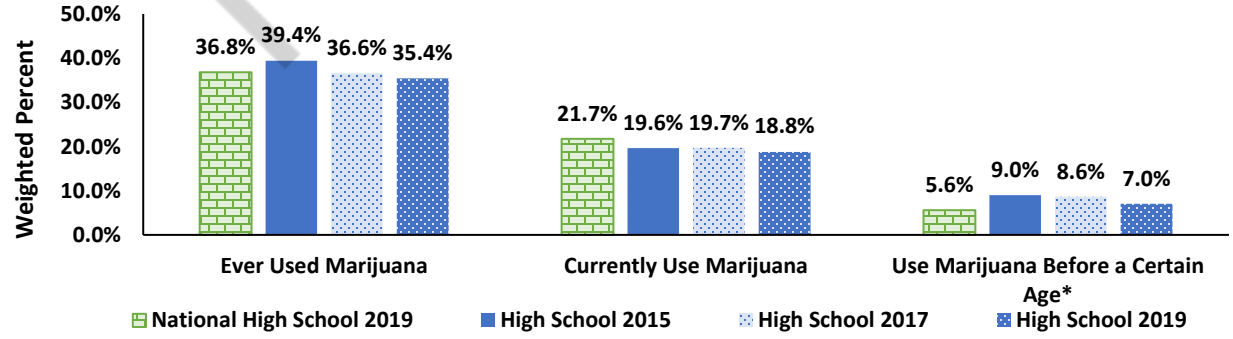
Figure 44b. Alcohol Use, Nevada Middle School Students, 2015, 2017, 2019.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 35% to display differences among groups.
**In middle school students if they ever drank before age 11.*

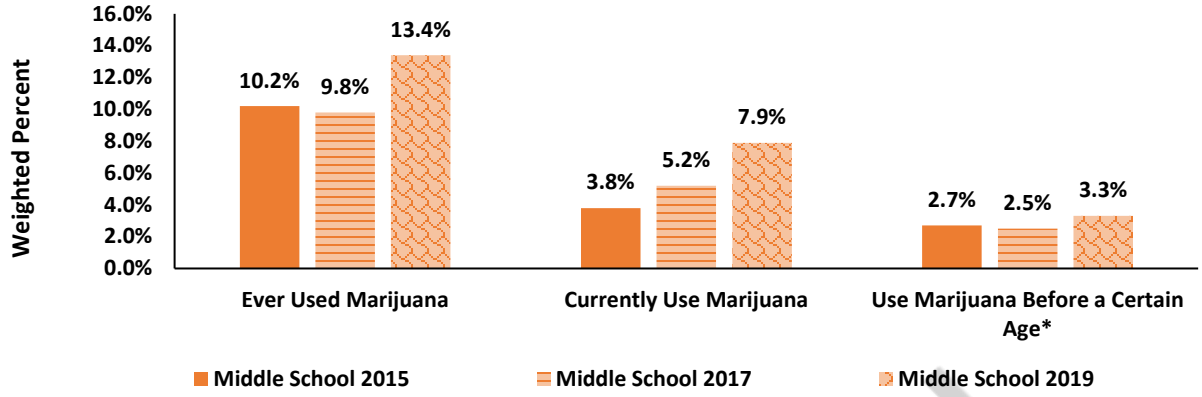
There was a significant decrease in high school students from both ever drinking alcohol and current use of alcohol. In high school students, Douglas County had a significantly higher percent of students who ever drank alcohol (69.3%). The Churchill, Humboldt, Pershing, and Lander counties combined (66.4%) for high school and 43.0% for middle school.

Figure 45a. Marijuana Use, Nevada High School Students, 2015, 2017, 2019, and National High School Students, 2019.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 50% to display differences among groups.
**In high school students, if they ever used marijuana before age 13, and in middle school students if they ever used marijuana before age 11.*

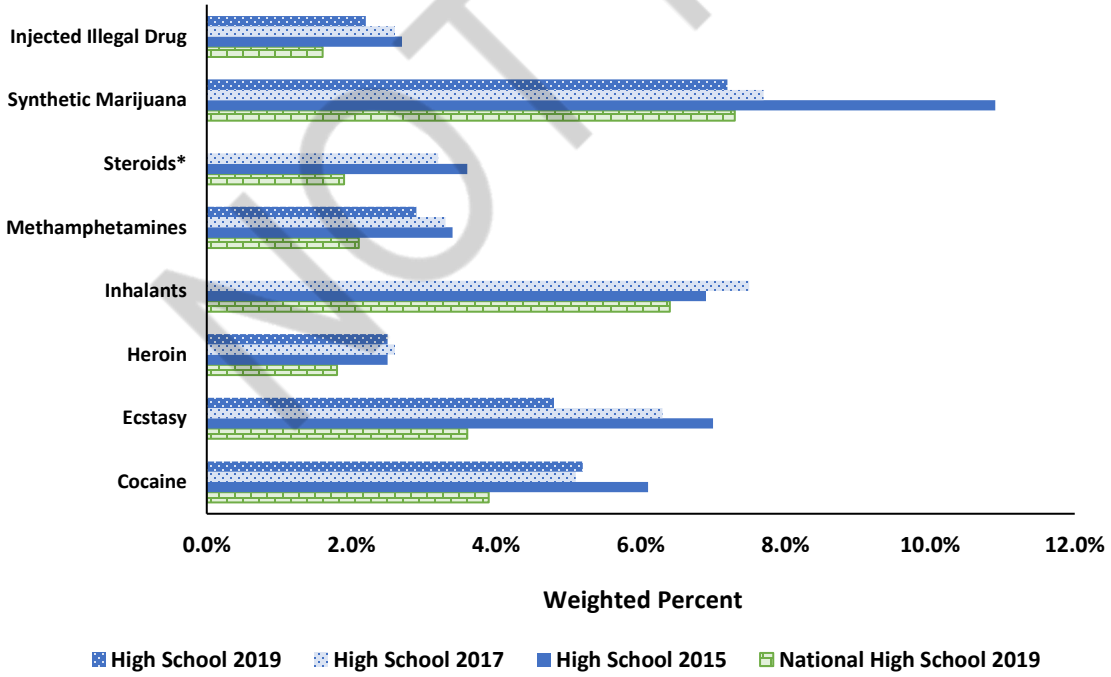
Figure 45b. Marijuana Use, Nevada Middle School Students, 2015, 2017, 2019.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 16% to display differences among groups.
**In high school students, if they ever used marijuana before age 13, and in middle school students if they ever used marijuana before age 11.*

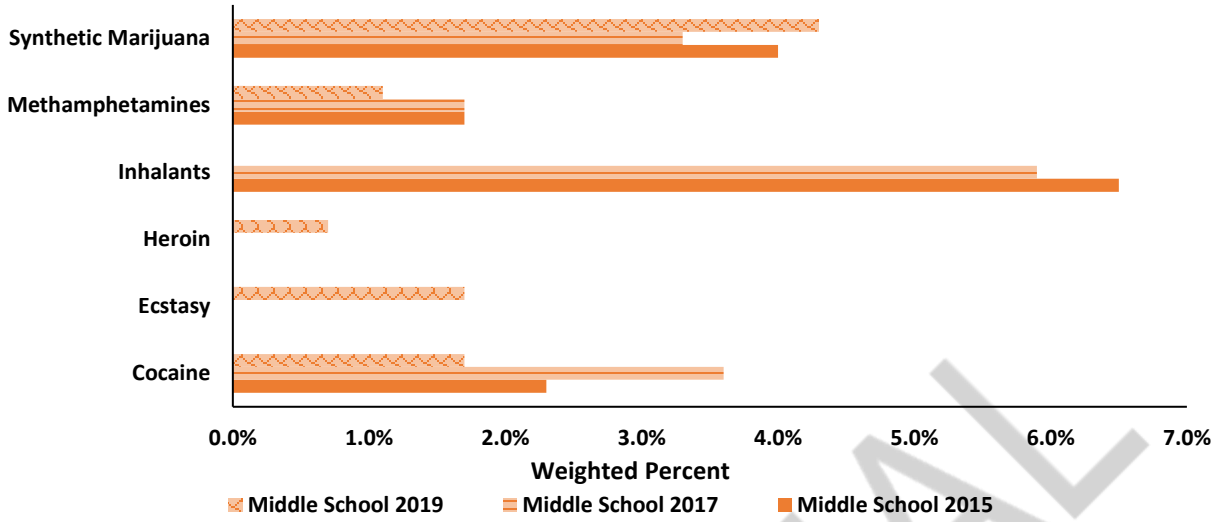
Nevada is comparable to the nation, which is 35.4% for marijuana use in high school students. Older high school students, 12th grade, and 18 years or older have a significantly higher percent for ever using marijuana before, 44.1%, and 44.0% respectively which is lower from 2017. Middle school students in 8th grade and those 14 years or older have a significantly higher percent for ever using marijuana before, 22.3% and 26.5% respectively which has increased from 2017.

Figure 46a. Lifetime Drug Use, Nevada High School Students, 2015, 2017, 2019, and National High School Students, 2019.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 12% to display differences among groups.

Figure 46b. Lifetime Drug Use, Nevada Middle School Students, 2015, 2017, 2019



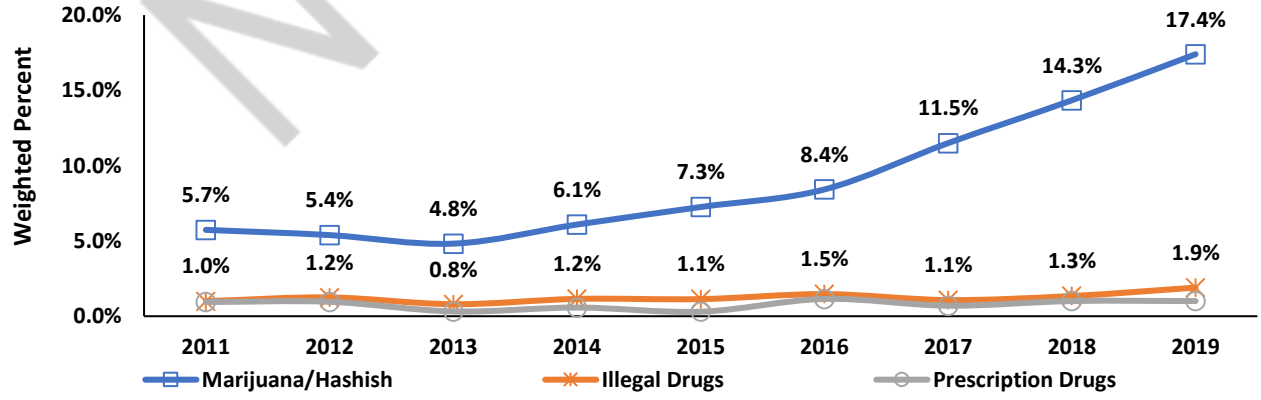
Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 7% to display differences among groups.

There was a significant decrease for synthetic marijuana use from 2015 to 2017. Drug use among high school students is higher in Nevada than the nation. Of Nevada high school students, 7.2% have used synthetic marijuana, while the national percentage is lower at 7.3%. Churchill, Humboldt, Pershing, and Lander counties combine have significantly higher lifetime use for cocaine (9.4%).

Behavioral Risk Factor Surveillance System

BRFSS collects information on adult health-related risk behaviors. According to the Centers for Disease Control and Prevention, BRFSS is a powerful tool for targeting and building health promotion activities. The survey has questions focusing on substance use including illegal drug use, e-cigarettes, and drunkenness.

Figure 47. Adult Nevada Residents Who Used Marijuana/Hashish, Illegal Substances, or Painkillers to Get High in the Last 30 Days, 2011-2019.

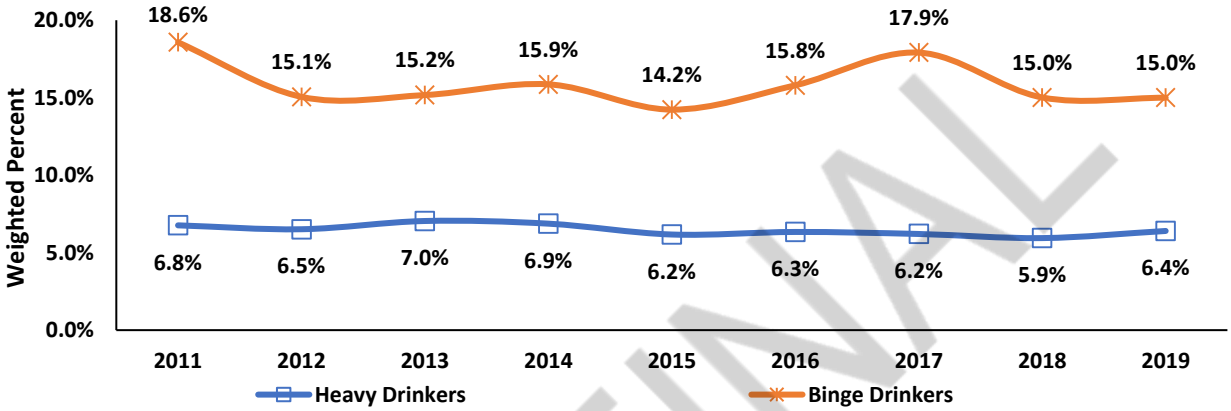


Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 10% to display differences among groups.
Specific question asked in survey: "During the past 30 days, on how many days did you use marijuana or hashish / any other illegal drug / prescription drugs without a doctor's order, just to "feel good," or to "get high"?"

Marijuana use has more than doubled since 2011. In 2018, 17.4% have used marijuana in the past 30 days, up from 5.7% in 2011. Self-reported use of marijuana is expected to increase as marijuana was legalized in Nevada in 2017. Of Nevadans surveyed, 1.0% (on average) used painkillers to get high in the last 30 days and 1.9% used other illegal drugs to get high in the last 30 days.

There was no significantly higher coalition county region with reported higher marijuana/hashish use, but the counties served in the FCC region had the most reported use at 29.3%.

Figure 48. Percentage of Adults Who are Considered Binge Drinkers or Heavy Drinkers, 2011-2019.

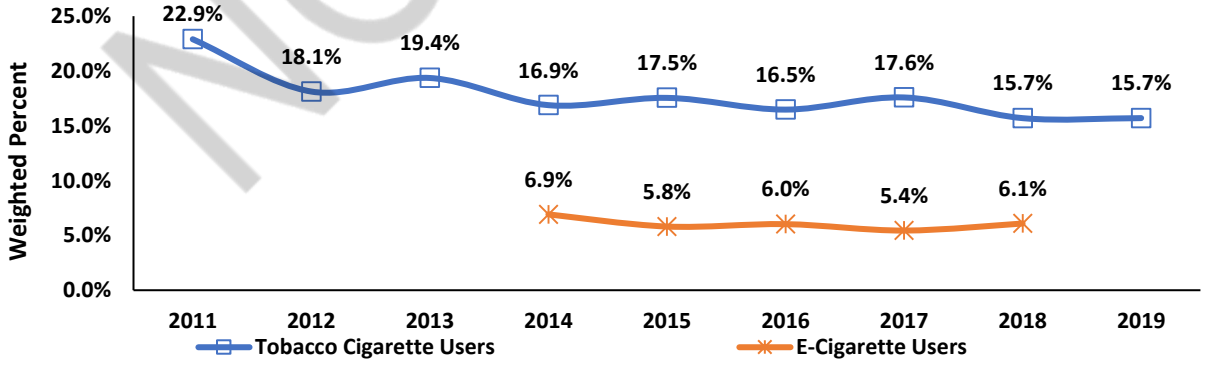


Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 20% to display differences among groups.
Heavy drinkers (adult men having more than 14 drinks per week and adult women having more than seven drinks per week).
Binge drinkers (adult men having five or more drinks on one occasion, adult women having four or more drinks on one occasion).

Binge drinking is defined in men as having five or more alcoholic beverages and woman having four or more alcoholic beverages on the same occasion. Heavy drinking is defined in men as consuming more than two alcoholic beverages, and in women as consuming more than one alcoholic beverage per a day.

Binge drinking is significantly higher among Douglas County, the PDC region at 25.6% in 2019.

Figure 49. Percentage of Adults Who are Current Cigarette or E-Cigarette Smokers, 2011-2019.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 20% to display differences among groups.
E-cigarette use was not collected until 2014 and was not collected in 2019.
Current cigarette smokers are defined as individuals who have smoked at least 100 cigarettes in their lifetime and currently smoke. Current e-cigarette smokers are defined as individuals who currently have smoked on at least one day in the past 30 days or who currently report using e-cigarettes or other electronic "vaping" products every day or some days.

In 2019, 15.7% of adults were current cigarette smokers, which has decreased significantly since 2011, at 22.9%. E-cigarette use is higher among those never married and among young adults aged 18-24 at 16.5% in 2018. This question was not asked in 2019.

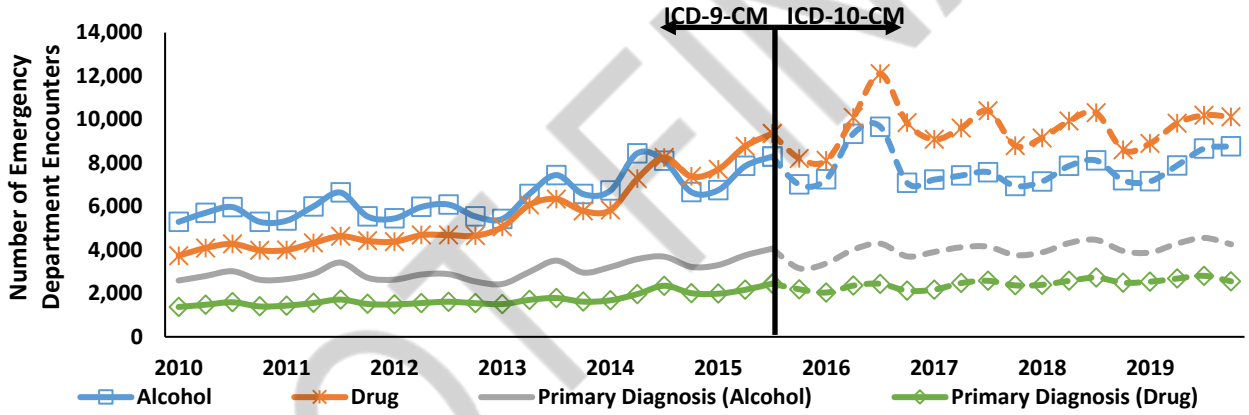
Reported cigarette use was higher in the counties served in HCC coalition region, at 23.1%.

Nevada 211 is a phone number that connects Nevadans with needed services. Substance use services including alcohol support and medication-assisted treatment for opioid disorders. During the 2019 fiscal year (July 1, 2019 -June 30, 2020), Nevada 211 received 1,342 calls relating to substance use services, including 415 for drug detoxification support.

Hospital Emergency Department Encounters

The hospital emergency department billing data provides health billing data for emergency department patients in Nevada's non-federal hospitals. Since an individual can have more than one diagnosis during a single emergency department visit, the following numbers are not mutually exclusive.

Figure 50. Alcohol and Drug-Related Emergency Department Encounters by Quarter and Year, 2010-2019.

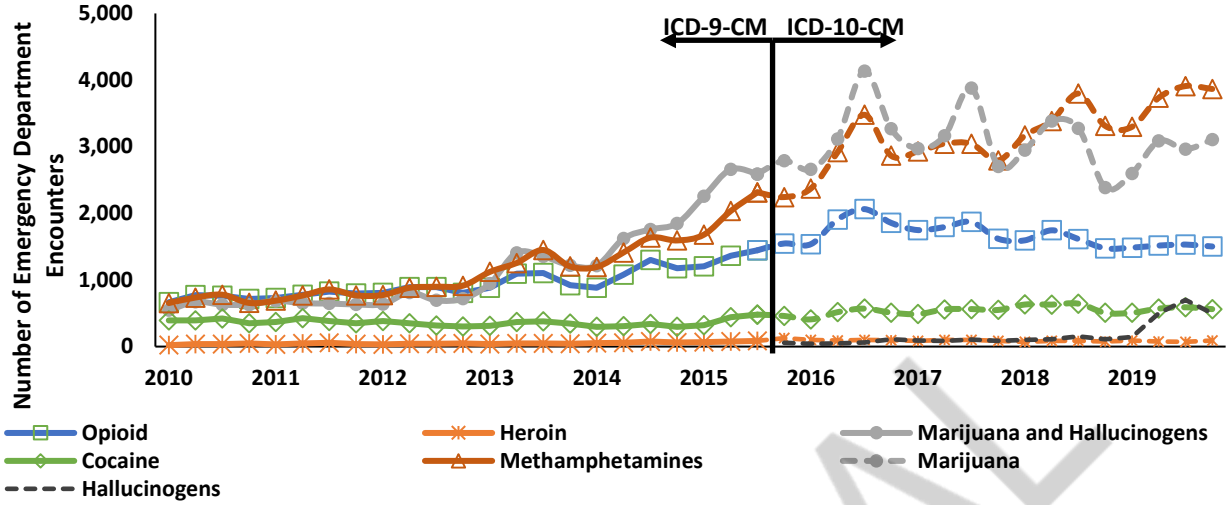


Source: Hospital Emergency Department Billing.
Categories are not mutually exclusive.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

The "primary diagnosis" is the condition established to be chiefly responsible for the emergency department visit. The "alcohol" and "drug" categories are for any visits where alcohol/drugs were listed in any of the diagnoses.

Alcohol visits were more common than drug visits until 2014 where drug-related visits to the emergency department surpassed alcohol and have remained higher through 2019. In 2019, there were a total of 67,405 alcohol and drug-related emergency department encounters. Out of these encounters, 16,979 were related to alcohol (primary diagnosis) and 10,576 were drug-related (primary diagnosis).

Figure 51. Drug-Related Emergency Department Encounters by Drug and Quarter and Year, 2010-2019.



Source: Hospital Emergency Department Billing.
Categories are not mutually exclusive.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

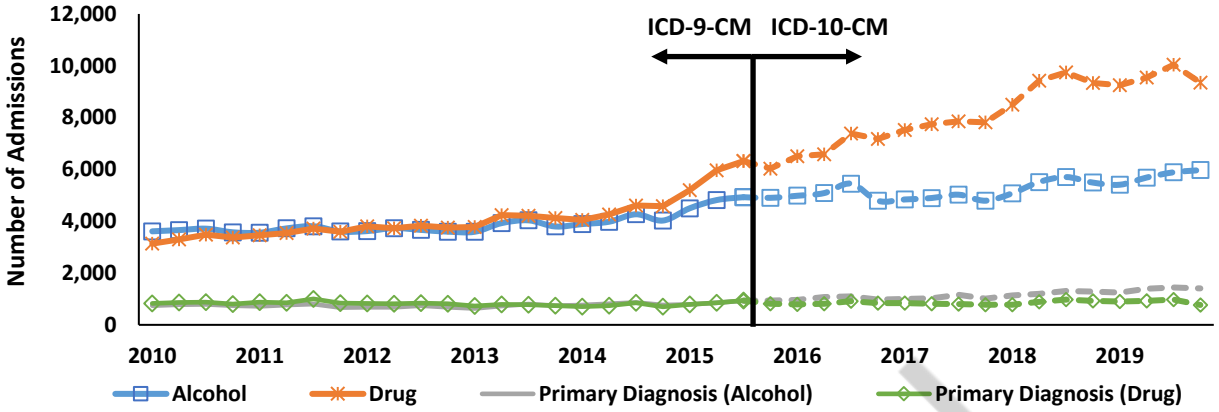
Hallucinogens and marijuana were grouped together in the ICD-9-CM, but in 2015 were separated into different groups in the ICD-10-CM codes. Methamphetamines, and hallucinogens drug use rates were significantly higher in 2019 than in 2018. Males had significantly higher emergency department encounters for cocaine, methamphetamines, marijuana/cannabis, and hallucinogens use for 2019.

The following coalitions service area counties regions had significantly higher marijuana use compared to the state: JTNN, PACT/CARE, and PDC. Other drugs that had had significantly higher use were hallucinogens and cocaine in the PACT/CARE coalition county region, and opioid use in NCC coalition county region.

Hospital Inpatient Admissions

The hospital inpatient admission billing data provides health billing data for patients admitted to hospitals for longer than a 24-hour period. Of the 54,385 alcohol and drug-related admissions, 22,953 were alcohol-related and 38,184 were drug-related.

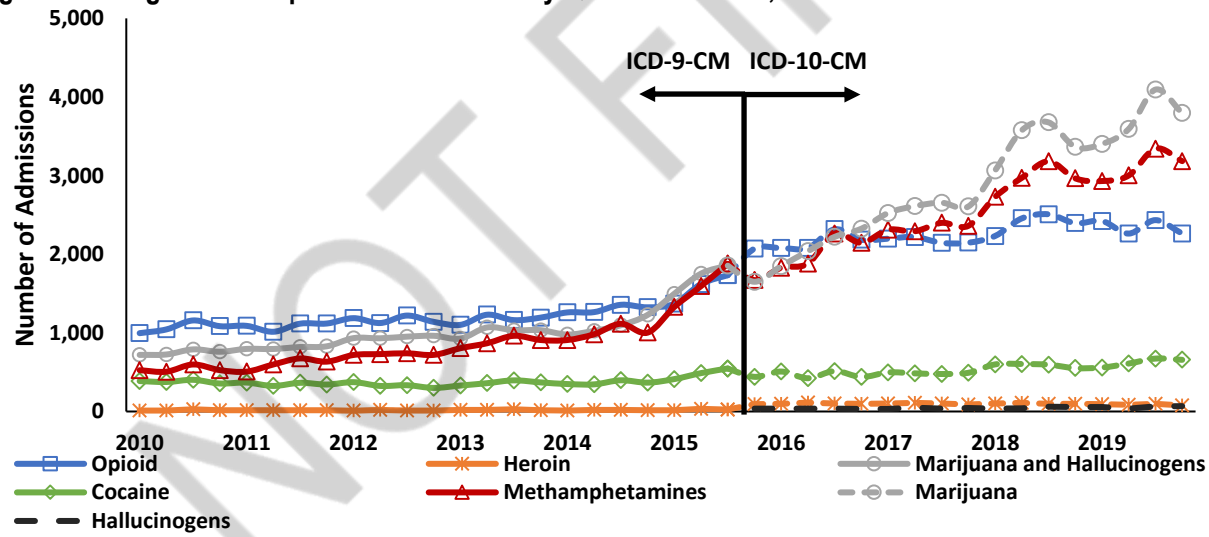
Figure 52. Alcohol and/or Drug-Related Inpatient Admissions by Quarter and Year, 2010-2019.



Source: Hospital Inpatient Billing.
Categories are not mutually exclusive.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Alcohol-related admissions were more common than drug-related admissions until 2011 where drug-related admissions surpassed alcohol and have remained higher through 2019. There were 5,489 admissions related to alcohol as a primary diagnosis and 3,567 were drug-related as primary diagnosis.

Figure 53. Drug-Related Inpatient Admissions by Quarter and Year, 2010-2019.



Source: Hospital Inpatient Billing.
Categories are not mutually exclusive.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Hallucinogens and marijuana were grouped together in the ICD-9-CM, but in 2015 were separated into different groups in the ICD-10-CM codes. Inpatient admission for males in 2019 were significantly higher than females overall, as well as for cocaine, methamphetamines, hallucinogens, and marijuana-related admissions.

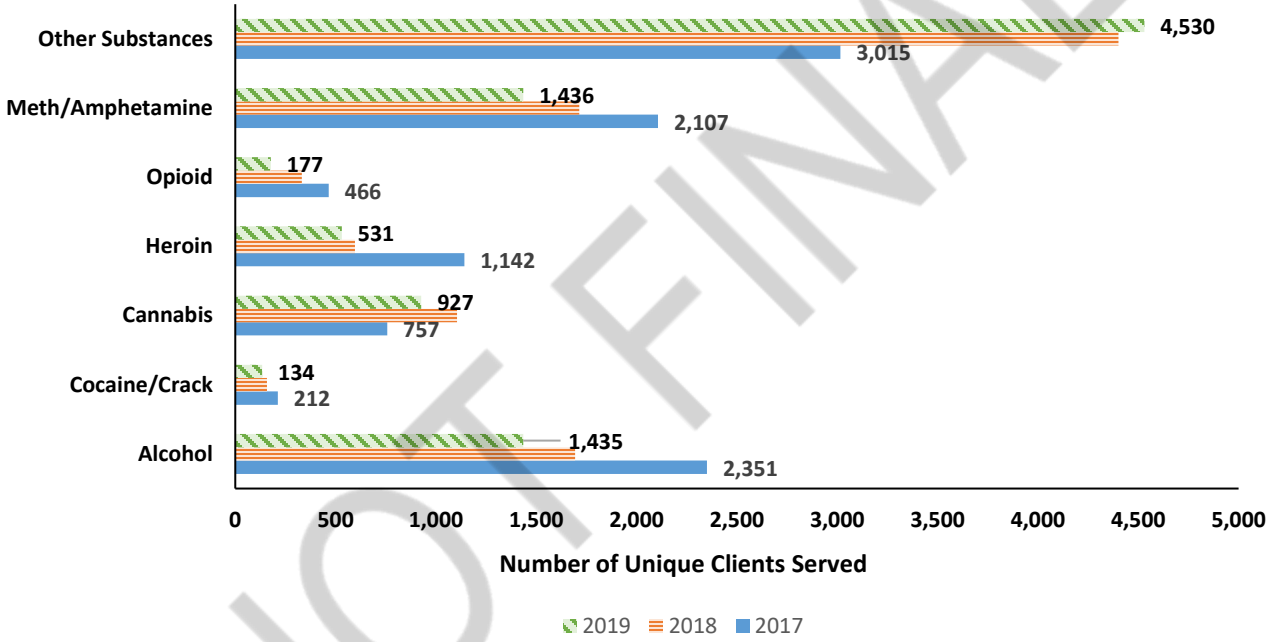
Carson City, area serviced by the PCC coalition had significantly higher inpatient admission rates compared to Nevada for opioid, methamphetamine, and marijuana use. Washoe county, the area served by the JTNN coalition had significantly higher inpatient admission rates for opioid, heroin, and

methamphetamines use. Similarly, the counties served by HCC coalition had significantly higher rates for opioid and heroin use. Finally, Clark County, the area served by PACT/CARE coalition had a significantly higher inpatient admission rate for cocaine use.

Substance Treatment Centers

Treatment Episode Data Sets (TEDS) are a compilation of demographic and drug history information on persons who are receiving publicly funded substance use and/or mental health services. The state role in submitting TEDS to the Substance Abuse and Mental Health Services Administration (SAMHSA) is critical, since TEDS is the only national data source for client-level information on persons who use substance use treatment services.

Figure 54. Primary Substance Used for Clients at Substance Abuse Treatment Centers, 2017-2019.



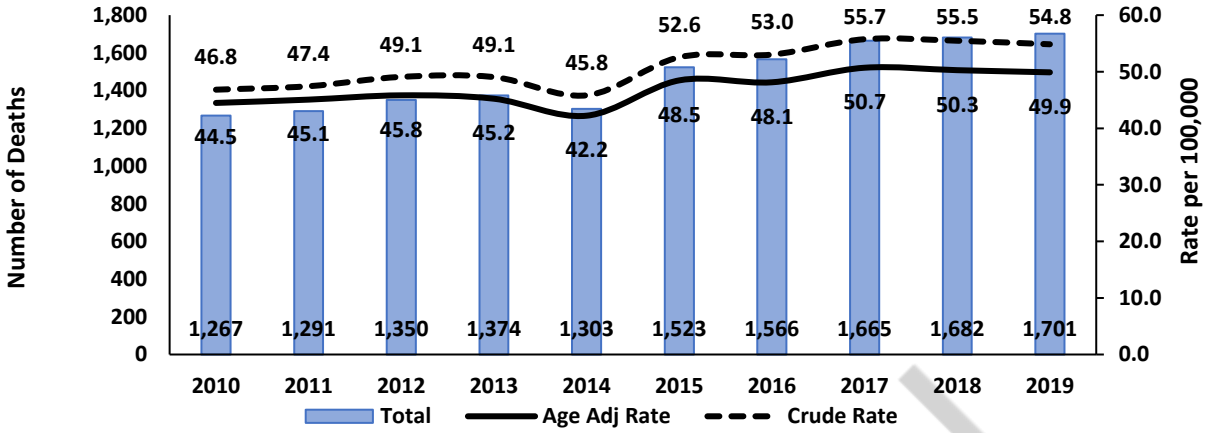
Data Source: Treatment Episode Data Sets.

Of the total treatment episodes for males, 20% are for alcohol whereas for females visits only 16% are for alcohol-related use and 20% for methamphetamines. Alcohol is the primary substance for use among all races, except Asian/Pacific Islanders, where the primary substance is methamphetamines.

Alcohol and/or Drug-Related Deaths

Alcohol and/or drug-related deaths include deaths where alcohol/drugs are listed as the cause of death. In previous reports, contributing causes of death for alcohol/drugs were included; therefore, counts will be lower than in the previous report. In 2019, 1,702 deaths were related to alcohol and drugs.

Figure 55. Alcohol and/or Drug-Related Deaths and Rates, 2010-2019.

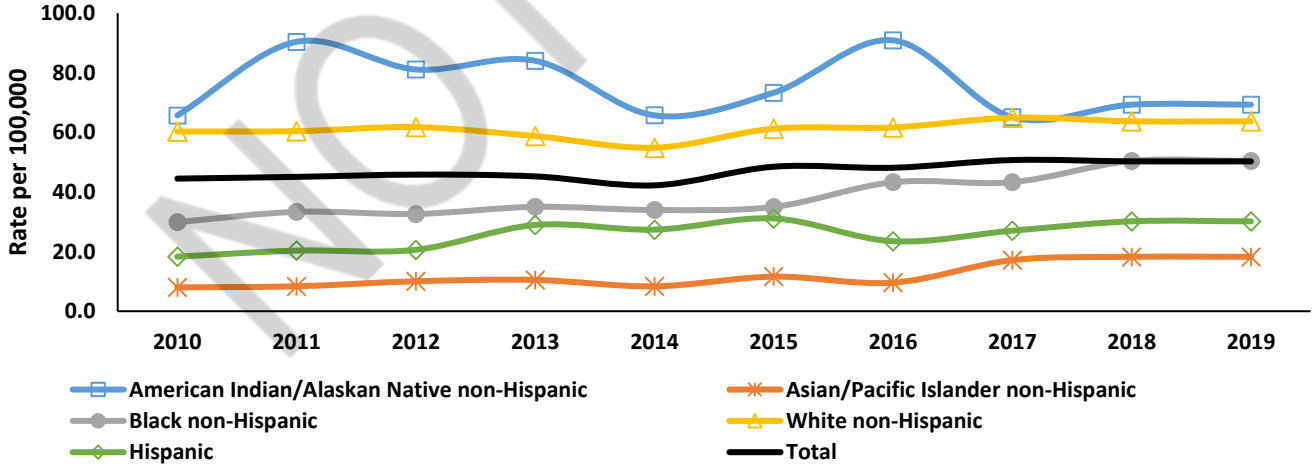


Source: Electronic Death Registry System.

The alcohol and/or drug-related age-adjusted rate increased significantly in 2015 from previous years (95% confidence interval) and has remained at a significantly higher rate through 2019. Males have a significantly higher death rate than females, with 72.1 per 100,000 age specific population and 32.9 per 100,000 age specific population, respectively. The 55-64 and 65-74 age groups have the highest rates and are significantly higher than all other age groups at 128.9 and 117.5 (respectively) deaths per 100,000 population.

The counties served in PCC, JTNN, HCC and CCC coalition regions had a significantly higher rate for alcohol/drug-related deaths in 2019, and Clark County (PACT/CARE service area) and the counties served in PACE coalition county regions had significantly lower rates for 2019.

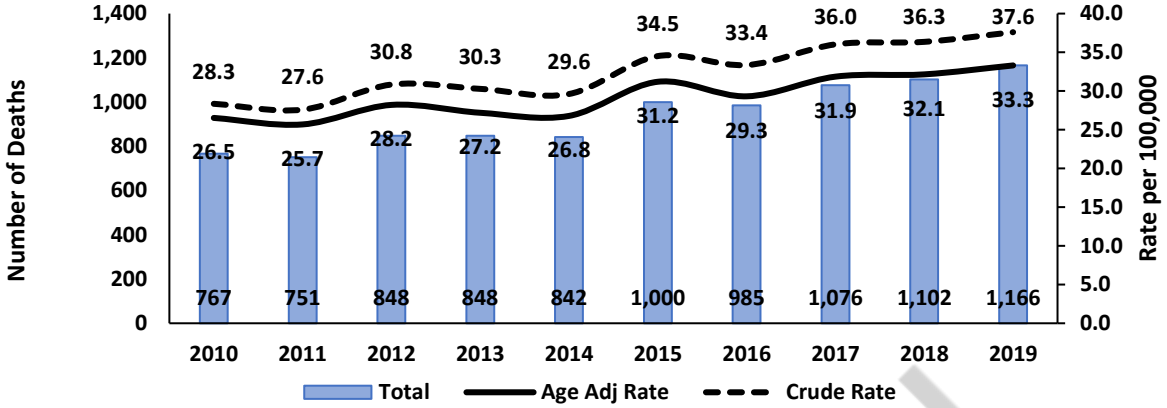
Figure 56. Age-Adjusted Rate for Alcohol and/or Drug-Related Deaths by Race, 2010-2019.



Source: Electronic Death Registry System.

The White non-Hispanic and the American Indian/Alaskan Native non-Hispanic populations had a significantly higher rate of alcohol and/or drug-related deaths in 2019. While deaths in the American Indian/Alaskan Native non-Hispanic population increased in 2011 and 2016, these deaths are not statistically significant (95% confidence interval) due to the relatively small population size.

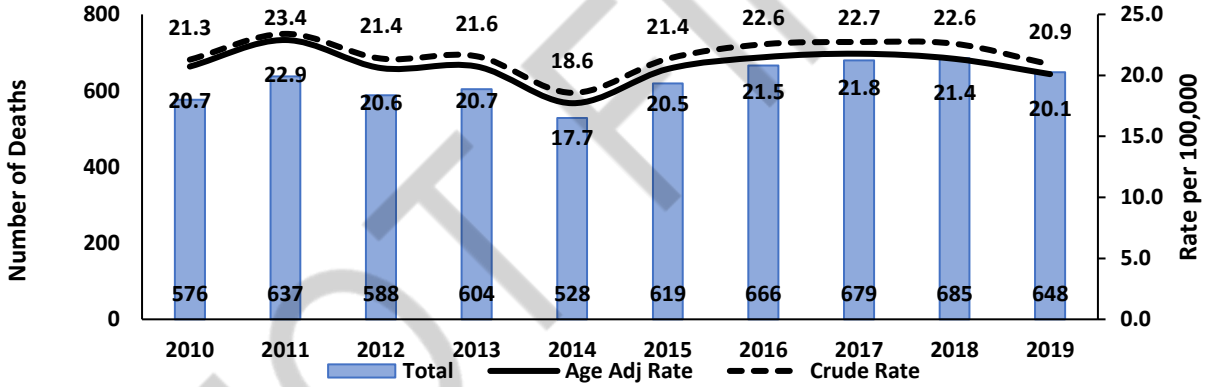
Figure 57. Alcohol-Related Deaths and Rates, 2010-2019.



Source: Electronic Death Registry System.

Alcohol-related deaths have not increased significantly between 2010 to 2018. Females have significantly lower rates than males. The age groups between 45-84 were significantly higher for alcohol-related deaths. Washoe County (JTNN service area) had a significantly higher rate than other coalitions for alcohol-related deaths.

Figure 58. Drug-Related Deaths and Rates, 2010-2019.



Source: Electronic Death Registry System.

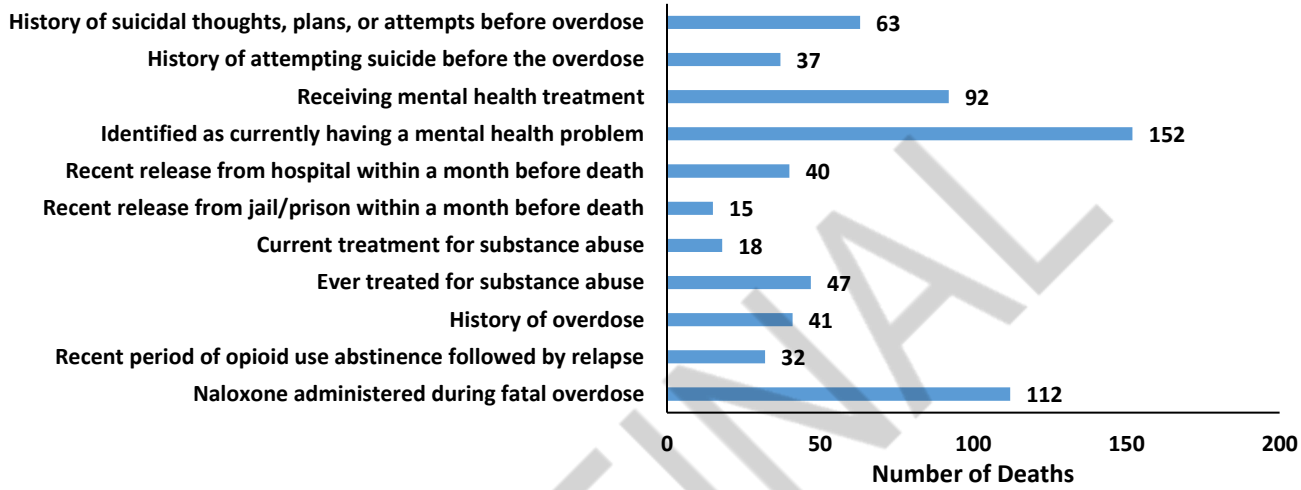
In 2019, males had significantly higher deaths due to drugs than females, at 25.2 and 15.0 per 100,000 age-specific population respectively. The JTNN county region had significantly higher drug-related death rates at 33.6 per 100,000 age-specific population.

The State Unintentional Drug Overdose Reporting System (SUDORS) tracks data related to fatal drug-involved overdoses in Nevada. SUDORS uses death certificates and coroner/medical examiner reports (including post-mortem toxicology testing results) to capture detailed information on toxicology, death scene investigations, route of drug administration, and other risk factors that may be associated with a fatal overdose.

Of the 510 total drug overdose deaths of unintentional/undetermined intent among Nevada residents in 2019, decedents were mostly male, white, had a high school education or less, and between the ages of 35-64. Opioids were listed in the cause of death for over half of cases. Prescription opioids were listed in the cause of death in about 21% of cases, heroin was listed in about 20% of cases, and fentanyl was listed

in about 16% of cases. Methamphetamine was listed as one of the substances in the cause of death in over half of cases reported. Approximately 33% of cases had a documented mental health problem prior to death. About 9% of cases had a documented prior history of overdose, and about 8% of cases were recently released from a hospital prior to death.

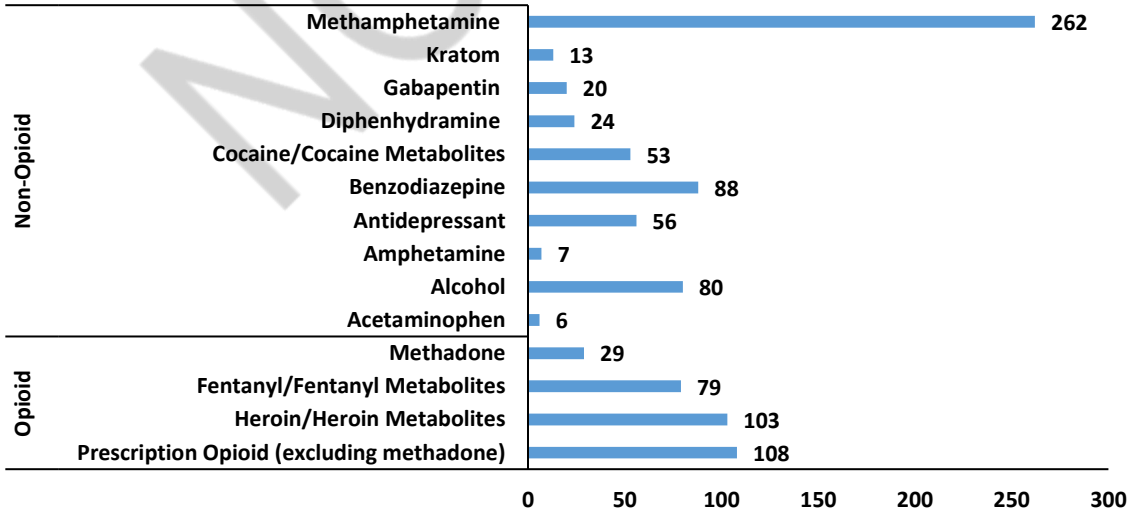
Figure 59. Circumstances Preceding Death Among unintentional/undetermined Overdose Deaths, Nevada, 2019.



Source: SUDORS.

In 2019, in roughly 33% of the unintentional or undetermined overdose deaths, the deceased had been identified as currently having a mental health problem. Roughly 24% had Naloxone administered during the fatal overdose. The most common substance listed in cause of death is opioid (type not specified, 57.5%), methamphetamine (51.4%). Since a person can have more than one drug in their system, these counts are not mutually exclusive.

Figure 60. Substances Listed in the Cause of Death Among unintentional/undetermined Overdose Deaths, Nevada, 2019.

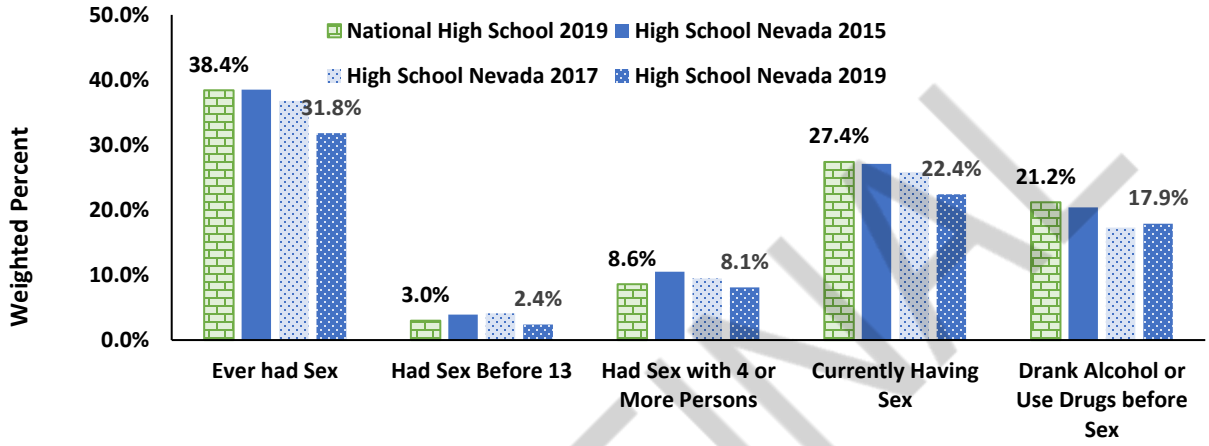


Source: SUDORS.

Youth

Youth Risk Behavior Survey (YRBS)

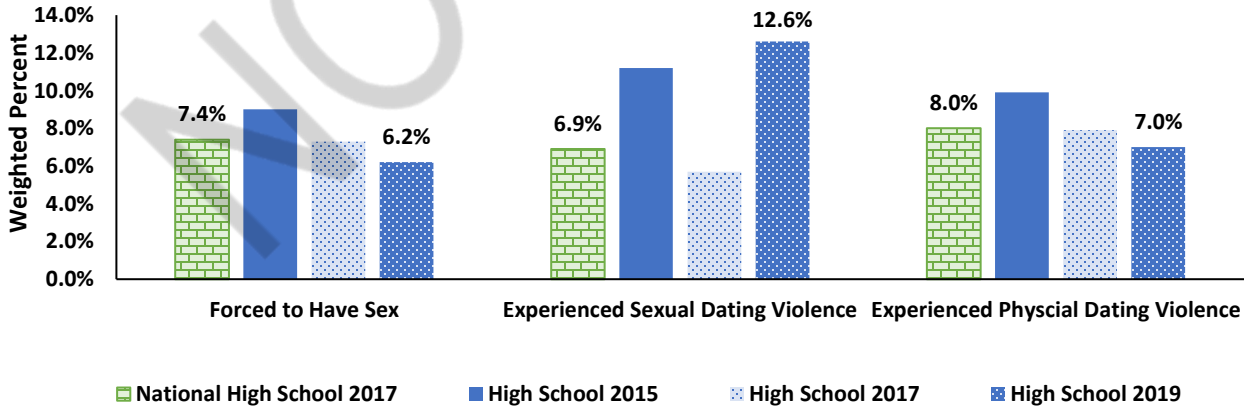
Figure 61. Sexual Behaviors Among Students, Nevada High School Students, 2015, 2017, 2019, and National High School Students, 2017.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 45% to display differences among groups.

High school students from Churchill, Humboldt, Pershing, and Lander counties (grouped) have significantly high percent of ever having sexual intercourse and currently having intercourse, 45.6% and 32.4% respectively.

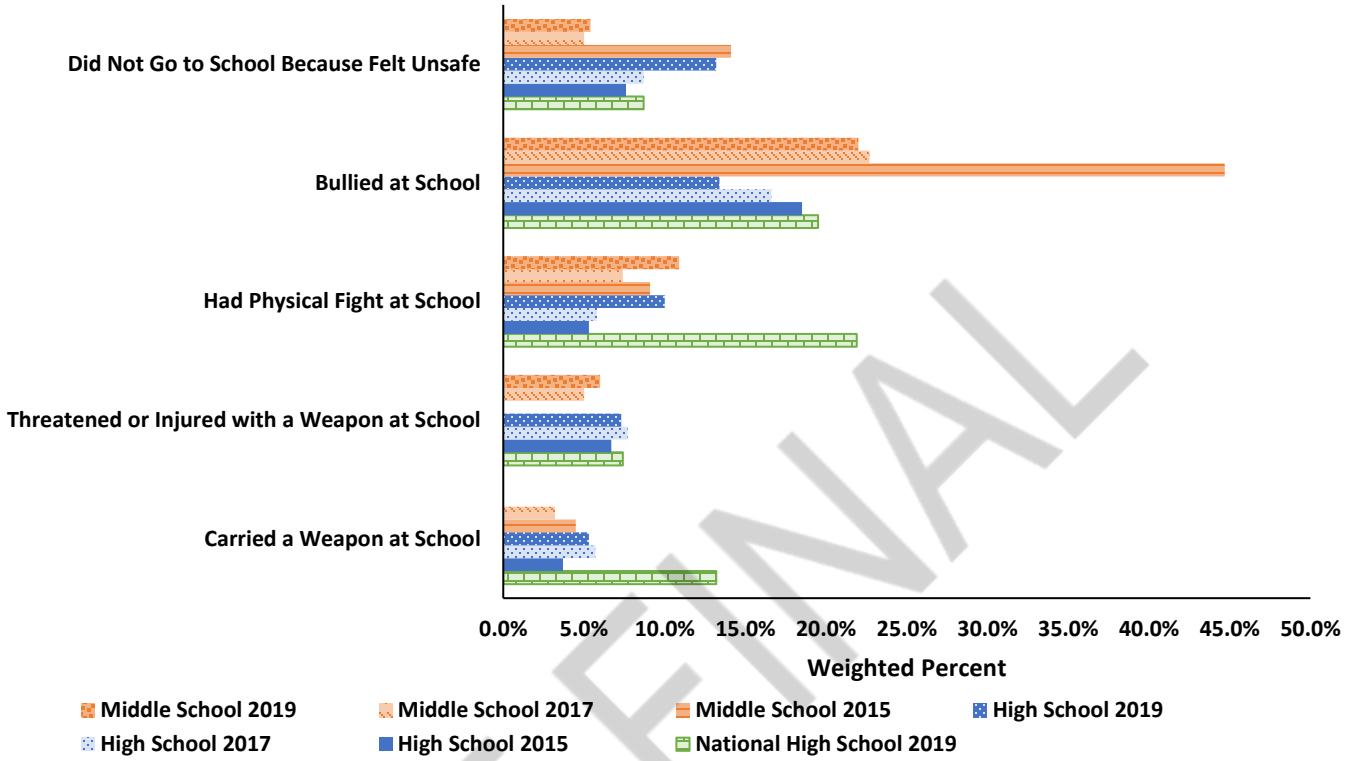
Figure 62. Sexual Violence Among Students, Nevada High School Students, 2015, 2017, 2019, and National High School Students, 2017.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 14% to display differences among groups.

In 2019, 6.2% of Nevada high school students reported being forced to have sex, which is lower than the nation at 7.4%. Additionally, 12.6% of Nevada high school students report experiencing sexual dating violence and 6.9% for the national high school students.

Figure 63. Violence Among Students, Nevada Middle School and High School Students, 2015, 2017, 2019 and National High School Students, 2019.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 25% to display differences among groups.
Carried a weapon at school in 2019 survey is carried a gun during the 12 months before the survey.

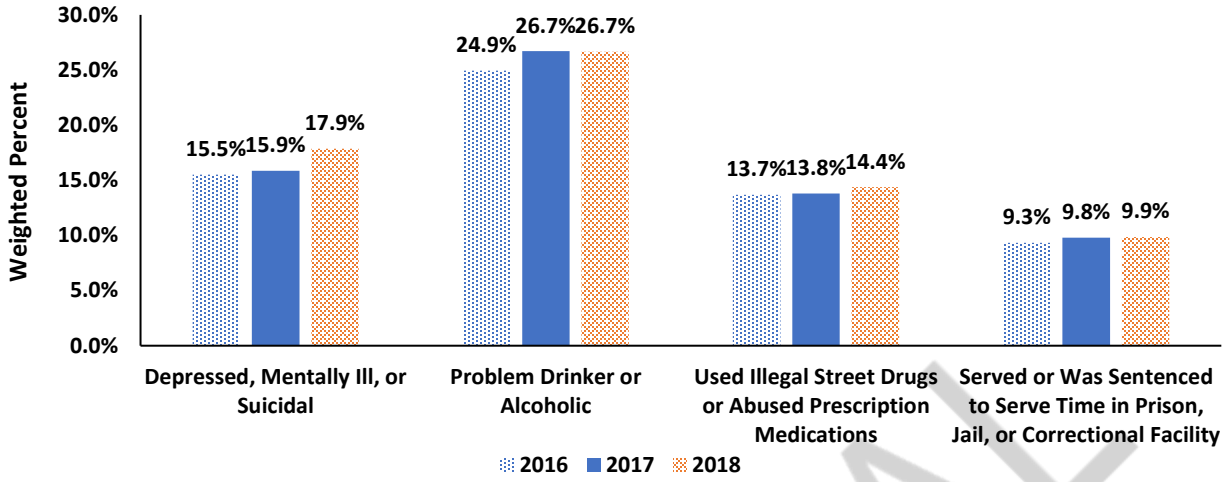
The high school students in Churchill, Eureka, and White Pine (grouped), Carson City, Lyon counties had significantly higher percents for being bullied at school. The middle school students in Lyon, Mineral and Storey counties (grouped) have significantly higher percents for being bullied at school.

Behavioral Risk Factor Surveillance System

In 2018, according to the BRFSS, 33.7% of Nevada adults reported their parents being separated or divorced during their childhood, before they were 18 years of age. The 2019 BRFSS did not ask these questions.

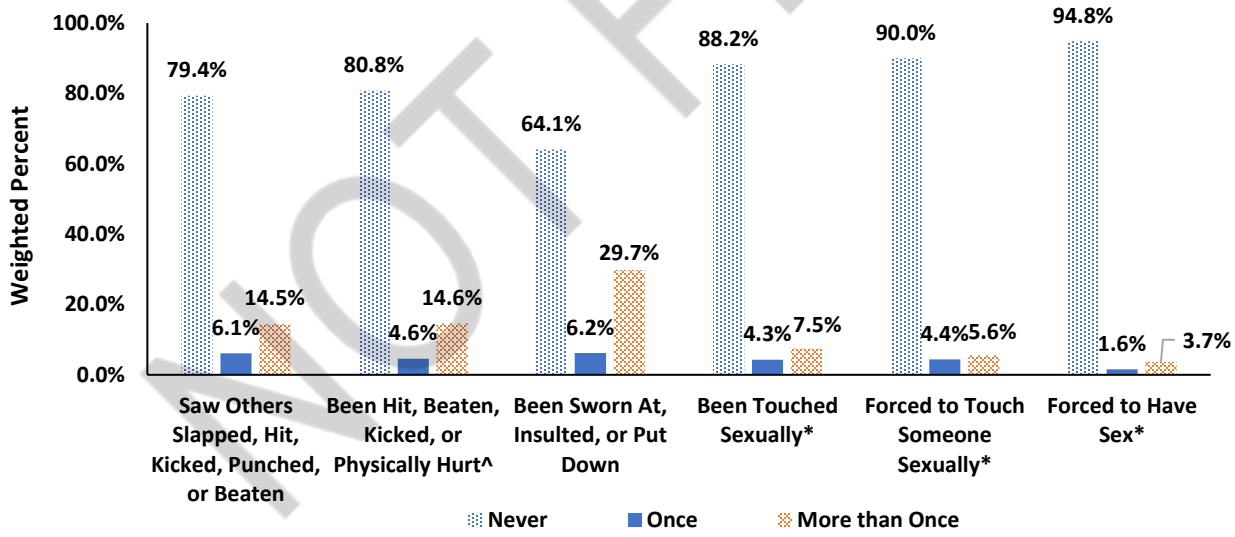
The following charts are from state added BRFSS questions about events that happened during childhood. This information is to better understand problems that may occur early in life and may help others in the future. The question refers to living with a person and not to the actual person being interviewed.

Figure 64. Adults Childhood Experiences, Nevada Residents, 2016-2018.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 30% to display differences among groups.
Childhood refers to before the age of 18
Questions: "Did you live with anyone who was depressed, mentally ill, or suicidal?"
"Did you live with anyone who was a problem drinker or alcoholic?"
"Did you live with anyone who used illegal street drugs or who abused prescription medications?"
"Did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility?"

Figure 65. Adults with Adverse Childhood Experiences, Nevada Residents, 2018.



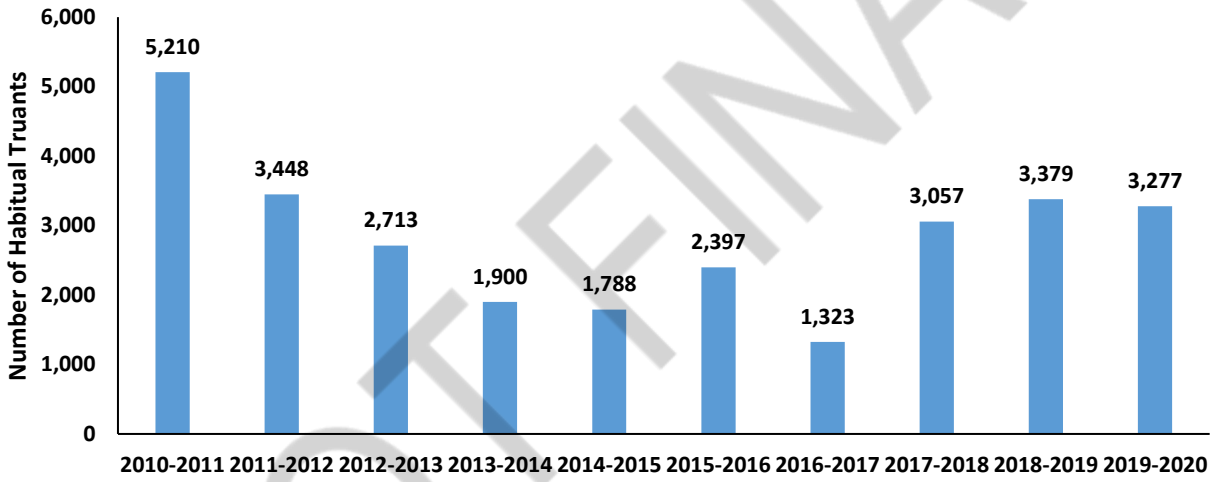
Source: Behavioral Risk Factor Surveillance System.
Childhood refers to before the age of 18.
Questions: "How often did your parents or adults in your home ever slap, hit, kick, punch or beat each other up?"
"Before age 18, how often did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?"
"How often did a parent or adult in your home ever swear at you, insult you, or put you down?"
"How often did anyone at least 5 years older than you or an adult, touch you sexually?"
"How often did anyone at least 5 years older than you or an adult, try to make you touch them sexually?"
"How often did anyone at least 5 years older than you or an adult, force you to have sex?"
^Do not include spanking.
**Someone at least 5 years older than the you or an adult.*

Nevada Report Card

The Nevada Report Card is the accountability reporting website of the Nevada Department of Education. In compliance with federal and state law, it assists community members (parents, educators, researchers, lawmakers, etc.) in locating a wealth of detailed information pertaining to K-12 public education in Nevada. The web site has three categories: "school and district information," "assessment and accountability" and "fiscal and technology."

When student behavioral health needs are not identified or not provided with the necessary attention, they are more likely to experience difficulties in school. These include higher rates of suspension, expulsion, dropout, and truancy, as well as lower grades. Nationally, 50% of students age 14 or older who are living with a mental illness drop out of high school. This is the highest dropout rate of any disability group.

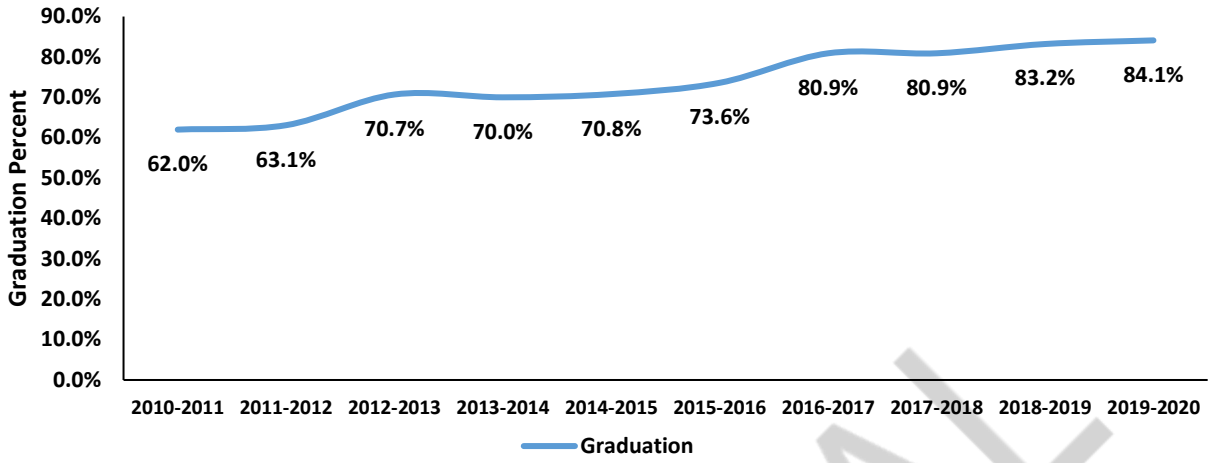
Figure 66. Number of Habitual Truants, Nevada, Class Cohorts 2010–2020.



Source: Nevada Department of Education, Report Card.

Nevada's numbers of habitual truant students have been decreasing since the peak of 5,210 truant students during the 2010-2011 school year. Nevada recorded the lowest number of 1,323 truant students during the 2016-2017 school year. In 2019-2020 school year the number of truants was similar to the previous school year at 3,277.

Figure 67. High School Graduation Percentage, Nevada, Class Cohorts 2010–2020.



Source: Nevada Department of Education, Report Card.

Graduation rate is defined as the rate at which 9th graders graduate by the end of the 12th grade (number of students who graduate in four years with a regular high school diploma divided by the number of students from the adjusted cohort for the graduation class). Nevada high schools posted the highest graduation rate at 84.1% for the class of 2020.

Figure 68. Bullying and Cyber Bullying by Demographics, 2019-2020.

	Bullying		Cyber Bullying	
	N	%	N	%
Total	3,912		470	
Race/Ethnicity				
American Indian	21	0.5%	0	0.0%
Asian	50	1.3%	11	2.3%
Black	1,135	29.0%	100	21.3%
Pacific Islander	43	1.1%	0	0.0%
Two or More	256	6.5%	21	4.5%
White	1,060	27.1%	117	24.9%
Hispanic	1,258	32.2%	173	36.8%
Sex				
Female	1,188	30.4%	283	60.2%
Male	2,724	69.6%	187	39.8%
Other				
Economically Disadvantaged	2,465	63.0%	288	61.3%
English Learners	392	10.0%	34	7.2%
Homeless	37	0.9%	0	0.0%
In Foster Care	62	1.6%	0	0.0%
Individuals with Disabilities	729	18.6%	44	9.4%
Migratory Children	0	0.0%	0	0.0%
Parents in the Military	23	0.6%	0	0.0%

Source: Nevada Department of Education, Report Card.

There were 3,912 reports of bullying during the 2019 school year and 470 incidents of cyber bullying. Roughly 60% of these incidents involved students that were economically disadvantaged. Most of the bullying involved males, whereas cyber bullying involved a higher percent of females.

Figure 69. Suspensions by Demographics, 2019-2020.

	Due to Violence to Other Students		Due to Violence to School Staff		Due to Possession of Weapons		Due to Possession or Use of Alcoholic Beverages		Due to Possession or Use of Controlled Substances	
Total	9,487		612		433		384		3,067	
Race/Ethnicity										
American Indian	68	0.7%	0	0.0%	0	0.0%	0	0.0%	28	0.9%
Asian	118	1.2%	14	2.3%	0	0.0%	0	0.0%	46	1.5%
Black	3,432	36.2%	167	27.3%	76	17.6%	20	5.2%	590	19.2%
Pacific Islander	122	1.3%	0	0.0%	0	0.0%	0	0.0%	33	1.1%
Two or More	661	7.0%	61	10.0%	19	4.4%	23	6.0%	182	5.9%
White	1,576	16.6%	167	27.3%	102	23.6%	97	25.3%	629	20.5%
Hispanic	3,474	36.6%	176	28.8%	190	43.9%	193	50.3%	1,462	47.7%
Sex										
Female	3,050	32.1%	103	16.8%	95	21.9%	192	50.0%	1,078	35.1%
Male	6,437	67.9%	509	83.2%	338	78.1%	192	50.0%	1,989	64.9%
Other										
Economically Disadvantaged	6,699	70.6%	416	68.0%	269	62.1%	198	51.6%	1,845	60.2%
English Learners	1,205	12.7%	69	11.3%	71	16.4%	68	17.7%	492	16.0%
Homeless	130	1.4%	0	0.0%	0	0.0%	0	0.0%	47	1.5%
In Foster Care	197	2.1%	25	4.1%	0	0.0%	0	0.0%	46	1.5%
Individuals with Disabilities	2,020	21.3%	299	48.9%	83	19.2%	55	14.3%	479	15.6%
Migratory Children	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Parents in the Military	65	0.7%	0	0.0%	0	0.0%	0	0.0%	17	0.6%

Source: Nevada Department of Education, Report Card.

Suspensions in students is highest among those in economically disadvantaged situations. Suspensions relating to violence occur more among males than females.

Suicide

Figure 70. Suicide and Suicide Attempts by Year, 18 years and Younger, Nevada Residents 2010-2019.

Of the emergency department encounters and inpatient admissions, females comprise nearly 75% of the visits, whereas among completed suicide, 78% are males.

Year	Suicide Attempts				Suicides	
	Emergency Department Encounter		Inpatient Admission			
	N	Rate	N	Rate	N	Rate
2010	525	74.6	123	17.5	11	1.6
2011	579	82.4	128	18.2	27	3.8
2012	601	85.3	135	19.2	8	1.1
2013	643	90.5	163	22.9	18	2.5
2014	724	101.0	145	20.2	16	2.2
2015	820	111.2	211	28.6	24	3.3
2016	775	103.7	236	31.6	21	2.8
2017	802	106.7	257	34.2	21	2.8
2018	780	103.0	410	54.1	32	4.2
2019	741	96.2	490	63.6	23	3.0

Source: Hospital Emergency department billing and Inpatient Billing, and Electronic Death Registry System.
Crude rate 100,000 age specific population.

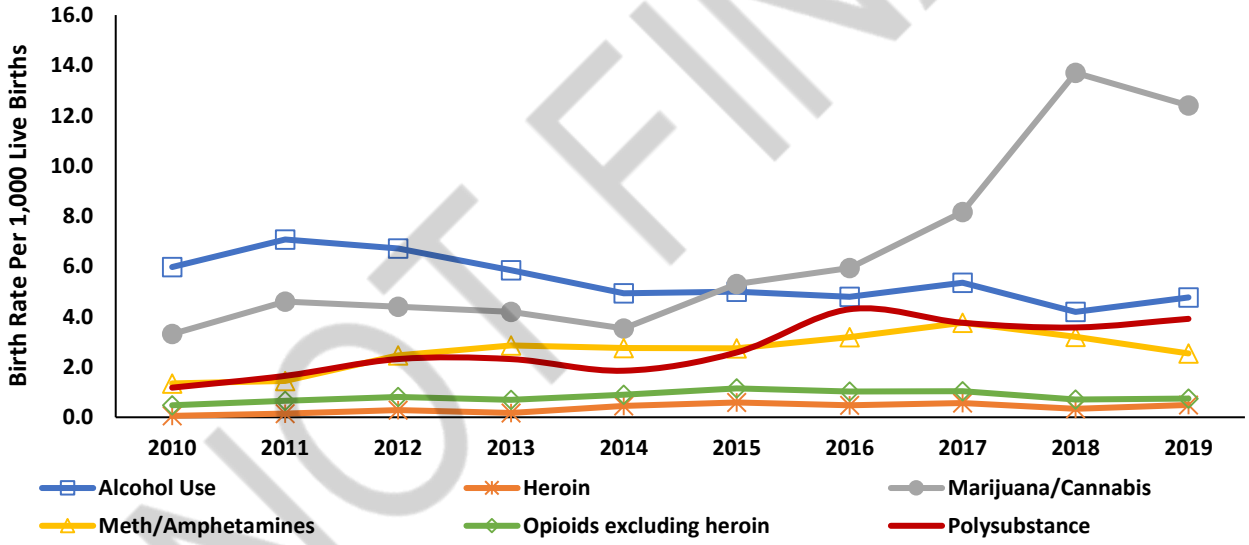
Maternal and Child Health

Nevada 211 is a phone number that helps Nevadans connect with services they need, including pregnancy-related mental health services. During the 2020 fiscal year (July 1, 2019 -June 30, 2020), Nevada 211 received 30 calls relating to mental health similarly to fiscal year 2019 with 33 call. The most calls received were for information regarding parent support groups and parent counseling.

Substance Use Among Pregnant Women (Births)

The data in this section is reflective of self-reported information provided by the mother on the birth record. On average, there were 35,352 live births per year to Nevada residents between 2010 and 2019. In 2019, 167 birth certificates indicated alcohol use, 434 birth certificates indicated marijuana use, 89 indicated meth/amphetamine use, 26 indicated opiate use, and 17 indicated heroin use during pregnancy.

Figure 71. Prenatal Substance Use Birth Rates (Self-Reported) for Select Substances, Nevada Residents, 2010-2019.



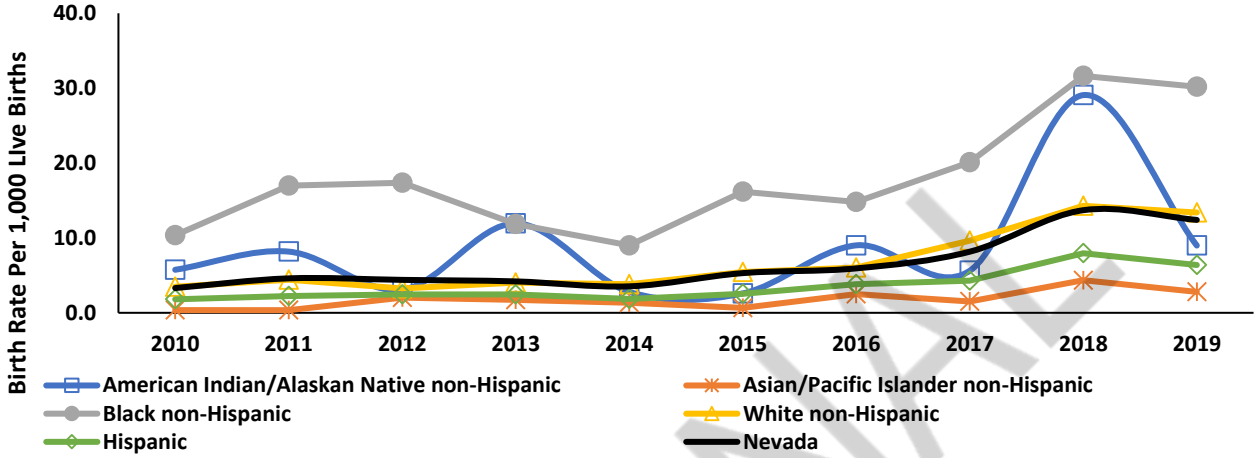
Source: Nevada Electronic Birth Registry System.

Of the self-reported substance use during pregnancy among Nevada mothers who gave birth between 2010 and 2019, the highest rate was with marijuana use in 2018, at 13.7 per 1,000 live births. Since 2015, the marijuana use rate has surpassed the alcohol use rate, which was 4.8 per 1,000 births in 2019. In 2019, a rate of 2.5 per 1,000 live births was reported for meth/amphetamines, which is lower than the previous year at 3.2 per 1,000 live births. Polysubstance use (more than one substance) has increased from 2.6 per 1,000 live births in 2015 to 3.9 per 1,000 live births in 2019.

Marijuana/cannabis use among pregnant females was significant in the 20-24 age group, at 24.7 per 1,000 live births (age specific). There is a significant increase in marijuana /cannabis use for the PACT/CARE coalition county region from 2017 to 2019, at 8.2 to 12.4 women using marijuana/cannabis per 1,000 live births.

Because alcohol and substance use during pregnancy is self-reported by the mothers, rates are likely lower than actual rates due to underreporting, and expectant mothers may be reluctant to be forthcoming on the birth record for a variety of reasons.

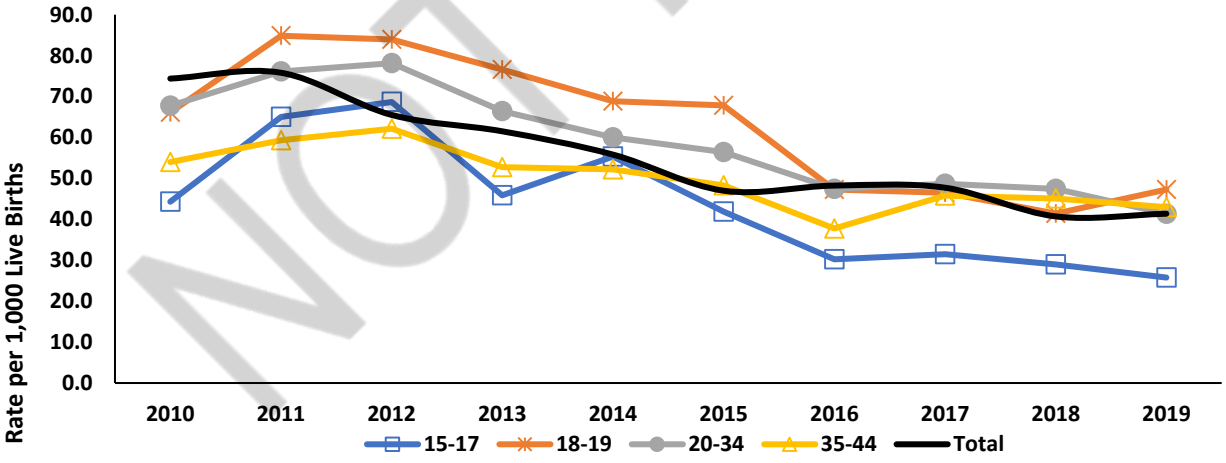
Figure 72. Prenatal Marijuana Use by Race/Ethnicity Birth Rates (Self-Reported), Nevada Residents, 2010-2019.



Source: Nevada Electronic Birth Registry System.

Black non-Hispanic mothers self-reported marijuana use was significantly higher than Nevada at 30.2 per 1,000 live births.

Figure 73. Prenatal Tobacco Use Birth Rates by Mother' Age (Self-Reported), Nevada Residents, 2010-2019.



Source: Nevada Electronic Birth Registry System.

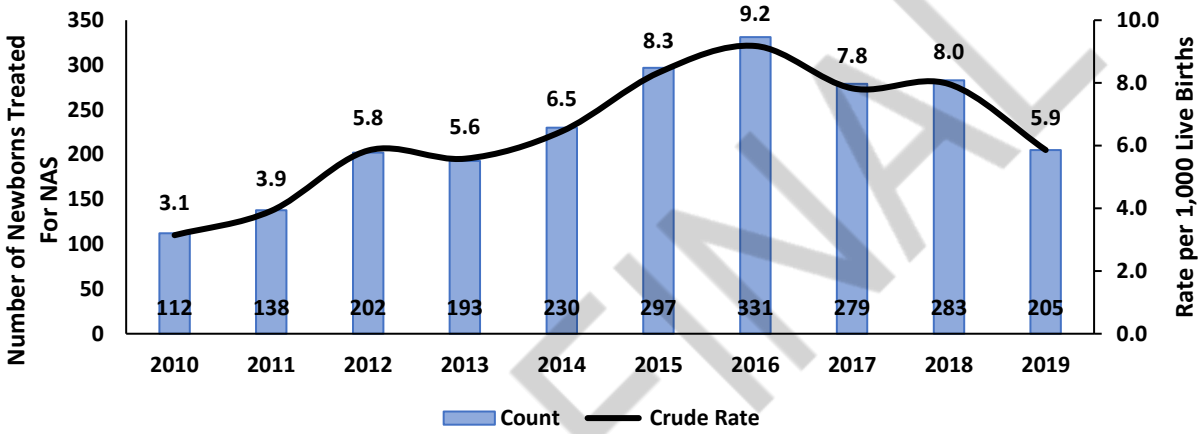
Woman over 45 were not included in the above graph but did have a significant decrease in tobacco use during pregnancy from 2010-2015 (244.8 to 189.4 per 1,000 live birth respectively). In 2019, the tobacco use during pregnancy was 86.5 per 1,000 live births for woman over 45. Tobacco use during pregnancy has decrease for all mothers ages since 2016.

In 2019, there were 17 pregnant women (out of a total of 1,464 women) surveyed in BRFSS. When pregnant women were surveyed for BRFSS, they had significantly higher use for tobacco smoking, at 21.4%, from non-pregnant women 13.7%.

Neonatal Abstinence Syndrome

Neonatal abstinence syndrome (NAS) is a group of issues that occur in a newborn who was exposed to addictive, illegal, or prescription drugs while in the mother's womb. Withdrawal or abstinence symptoms develop shortly after birth.

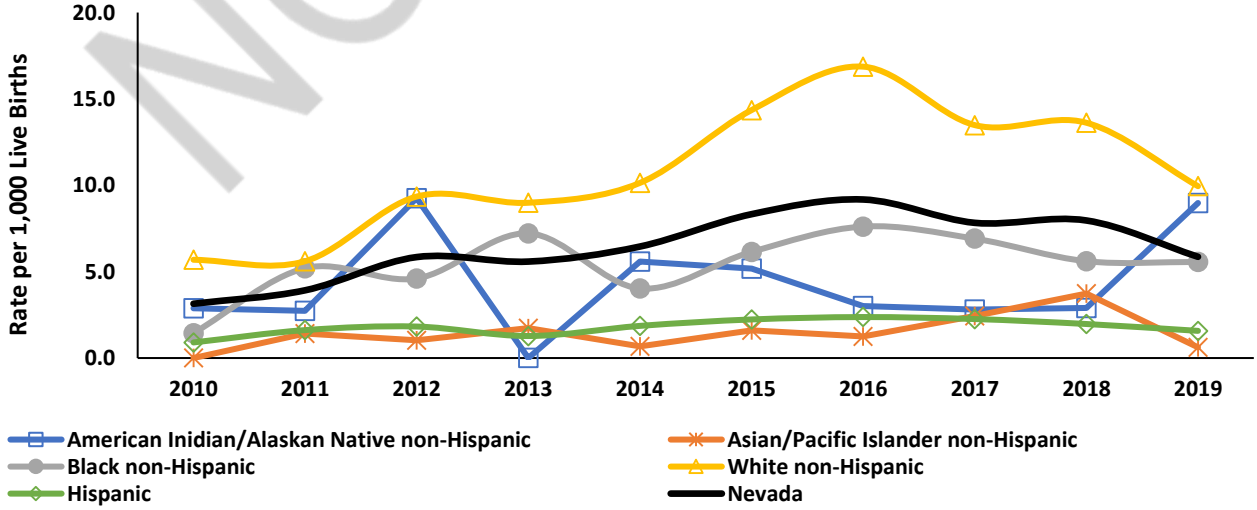
Figure 74. Neonatal Abstinence Syndrome, Nevada Residents, 2010-2019.



Source: Hospital Inpatient Department Billing and Nevada Electronic Birth Registry System.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Inpatient admissions for NAS has doubled since 2011, from 112 newborns admitted to 205 newborns admitted in 2019 but has significantly decreased from 2018. White non-Hispanic have significantly higher NAS rate compare all other races. The average length of stay for newborns with NAS in 2019 was 19 days.

Figure 75. Neonatal Abstinence Syndrome by Race and Ethnicity, Nevada Residents, 2010-2019.



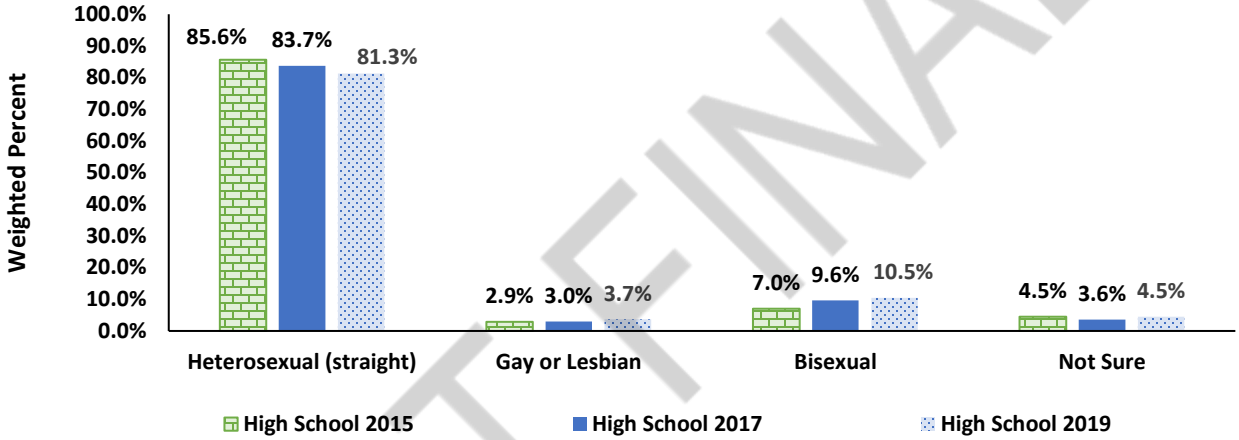
Source: Hospital Inpatient Department Billing and Nevada Electronic Birth Registry System.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Lesbian, Gay, Bisexual, and Transgender

Youth Risk Behavior Survey (YRBS)

The YRBS monitors six categories of health-related behaviors that contribute to leading causes of death and disabilities among youth and adults. For more detail information about YRBS and sexual orientation and gender identity, UNR has a Sexual and Gender Minority Special Report. Of the students surveyed, 902 (18.8%) are LGB or not sure, and 165 (3.5%) are transgender or not sure.

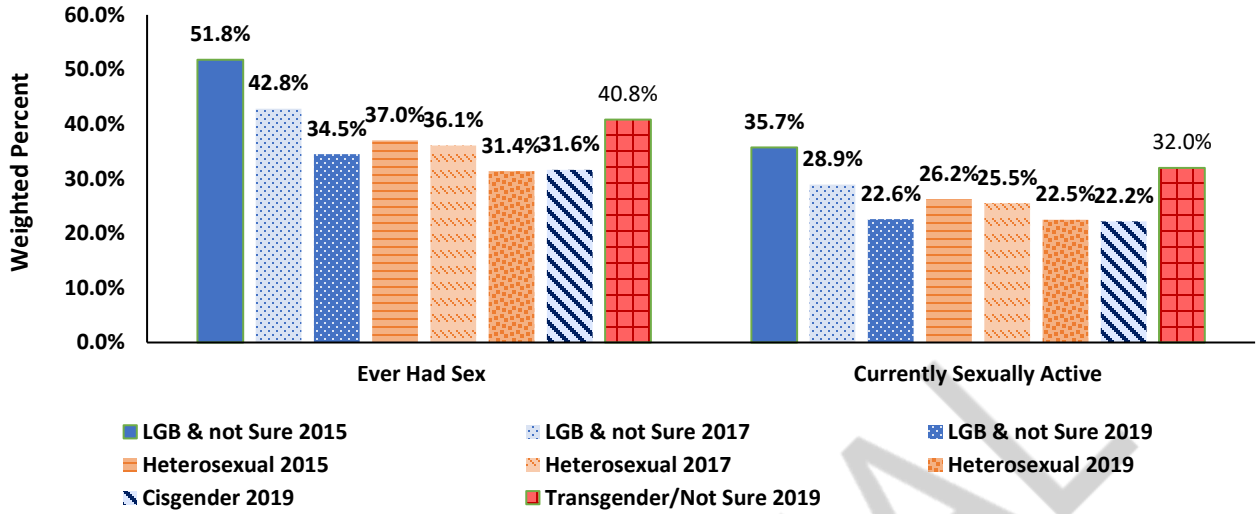
Figure 76. Sexual Orientation, Nevada High School Population, 2015, 2017, and 2019.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 90% to display differences among groups.

In Nevada high schools, 3.7% of the students identify as gay or lesbian, 10.5% bisexual, and 4.5% are not sure of their sexual orientation, which is a slight increase from the 2017 survey.

Figure 77. Sexual Behaviors Among Students, Nevada High School Students, 2015, 2017, and 2019.



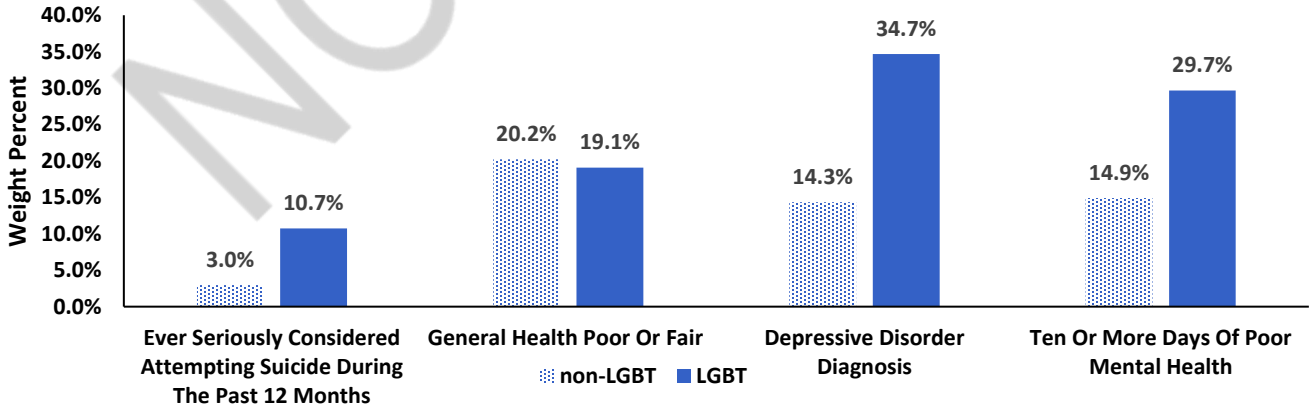
Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 60% to display differences among groups.

In 2019, 34.5% of gay, lesbian, or bisexual (LGB) high school students have previously had sex, and 22.6% LBG students are currently having sex. Transgender have highest percent of ever had intercourse at 40.8% but it is not significantly higher.

Behavioral Risk Factor Surveillance System

BRFSS collects information on adult health-related risk behaviors. According to the Centers for Disease Control and Prevention, BRFSS is a powerful tool for targeting and building health promotion activities. The survey has questions focusing on substance use including illegal drug use, e-cigarettes, and drunkenness. The LBGT questions were not asked on the 2019 survey.

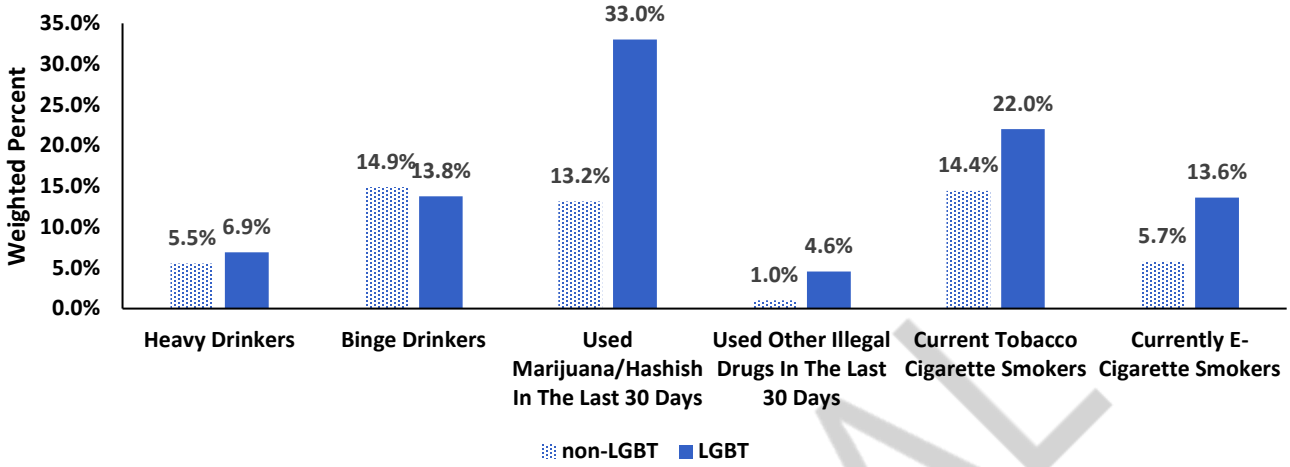
Figure 78. Mental Health Behaviors, by LGBT and non-LGBT Nevada Adults, 2018.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 40% to display differences among groups.

The LGBT population had significantly higher percents for both depressive disorder diagnoses and days of poor mental health.

Figure 79. Substance Use-Related Risk Factors, by LGBT and non-LGBT Nevada Adults, 2018.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 35% to display differences among groups.

The LGBT population had a significantly higher percent of current marijuana/hashish use.

Gambling

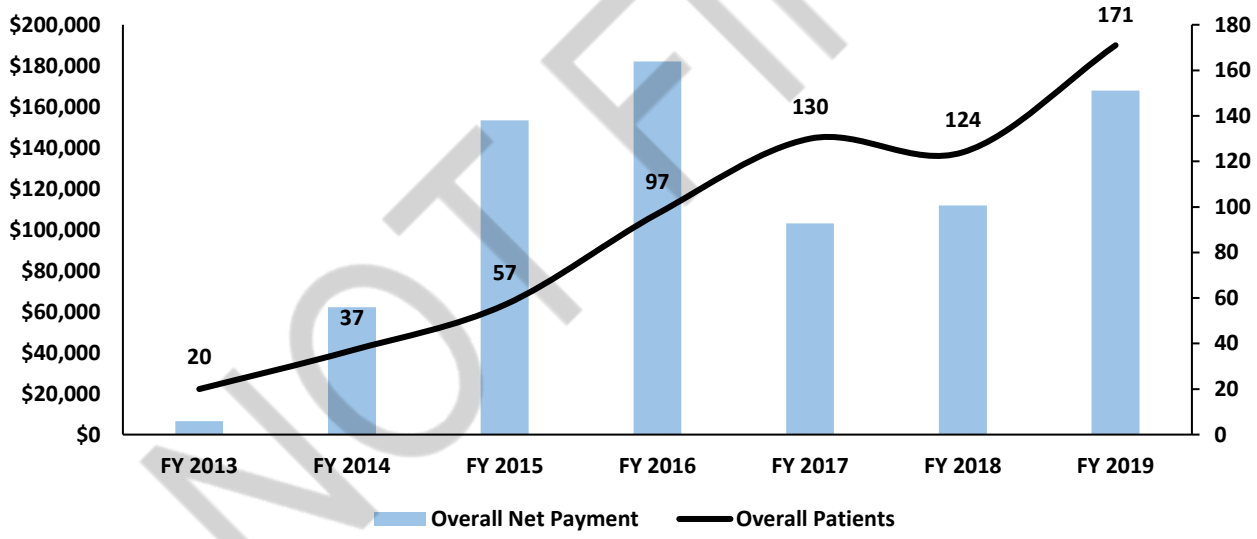
In 2018, the BRFSS survey added two questions relating to gambling:

> *In the past 12 months, how often have you bet money or possessions on any of the following activities? Casino gaming including slot machines and table games; or lottery including scratch tickets pull tabs and lotto; sports betting; internet gambling; bingo; or any other type of wagering.*
>
> *Has the money you spent gambling led to financial problems and/or has the time you spent gambling led to problems in your family, work, or personal life?*

Among Nevadans, 8.5% participate in heavy gambling, (once a week or more). Those 65 years or older were significantly higher than the state, at 14.1%. Males are significantly higher than females, at 10.5% and 6.5% respectively.

Medicaid patients can access services for pathological gambling.

Figure 80. Clients with Pathological Gambling Diagnosis, Clients and Payment, Fiscal Year 2013-2019.



Sources: DSS and Medicaid Data Warehouse.
This includes the costs for all claims that had a Pathological Gambling Diagnosis. Net Payment represents only paid claims.

The following figure is from the University of Nevada, Las Vegas, Nevada Problem Gambling Study.

Figure 81. Treatment System Summary.

TREATMENT SYSTEM SUMMARY QUICK GLANCE

Total number of people receiving a **problem gambling evaluation** in FY20	436
Outpatient Services	
Number of **gamblers** entering outpatient treatment	290
Average number of sessions per client treatment episode	17.4
Average cost per client treatment episode	$1,259
Number of **concerned others** entering outpatient treatment	47
Average number of sessions per client treatment episode	9.9
Average cost per client treatment episode	$731
Over the past year, **percent change** in the number of clients (see Figure 2)	-23.1%
Residential Services	
Number of clients entering **residential gambling treatment**	63
Average length of stay in residential treatment	25.4 days
Maximum length of stay in residential treatment	55 days
Average cost per client treatment episode	$2,826
Over the past year, **percent change** in the number of clients (see Figure 2)	+5%
Number of clients receiving assessment only	36
Number of clients receiving court-mandated treatment	44
Access	
Average number of days between first contact and first available service	1
Average number of days between first contact and treatment entry	1.5
Average number of days between first available date and treatment entry	.7
Successful Completion of Treatment Program	
Total non-adjusted percent of successfully discharged clients	34.4%
Percent of successfully discharged clients, adjusted for external factors.	50%
Client Satisfaction	
"I would recommend this agency to a friend or family member."	95%
Improvements in Functioning and Well-Being after 90 days	
"I am getting along better with my family."	92%
"I do better in school and/or work."	89%
"I have reduced my problems related to gambling."	97%
"I am meeting my goal to stop or control my gambling."	94%
Improvements in Functioning and Well-Being after 12 months	
"I am getting along better with my family."	84%
"I do better in school and/or work."	79%
"I have reduced my problems related to gambling."	87%
"I am meeting my goal to stop or control my gambling."	90%

Source: University of Nevada, Las Vegas, International Gaming Institute.

For more information on problem gambling: UNLV International Gaming Institute.

Appendix

Hospital billing data (emergency department and inpatient admissions) and mortality data both utilize International Classification of Diseases codes (ICD). Hospital billing uses ICD-CM which is a 7-digit code verses death where the ICD codes are 4-digit. In hospital billing data, the ICD codes are provided in the diagnosis fields, while death data the ICD codes are coded from the literal causes of death provided on the death certificate.

In October 2015, ICD-10-CM codes were implemented nationwide. Before October 2015, ICD-9-CM codes were used for medical billing. Therefore, 2015 data consists of two distinct coding schemes, ICD-9-CM and ICD-10-CM respectively. Due to this change in coding schemes, hospital billing data from October 2015 forward may not be directly comparable to previous data.

The following ICD-CM codes were used to define hospital encounters and admissions:

All Diagnosis:

Anxiety: 300.0 (9); F41 (10)
Bi-Polar: 296.40-296.89 (9); F32.89, F31 (10)
Depression: 296.20-296.36, 311 (9); F32.0-F32.5, F33.0-F33.4, F32.9 (10)
Post-Traumatic Stress Disorder: 309.81 (9); F43.10, F43.12 (10)
Schizophrenia: 295 V11.0 (9); F20, Z65.8 (10)
Suicidal Ideation: V62.84 (9); R45.851 (10)
Suicide Attempts: E95.0-E95.9 (9); X71-X83, T36-T65, T71 (10)

Primary and All Diagnosis:

Alcohol: 291, 303, 980, 305.0, 357.5, 425.5, 535.3, 571.0, 571.1, 571.2,571.3, 790.3 (9); F10, K70, G62.1, I42.6, K29.2, R78.0, T51 (10).
Drug: 292, 304, 965, 967, 968, 969, 970, 305.2, 305.3, 305.4, 305.5, 305.6, 305.7, 305.8, 305.9 (9); F11- F16, T39, T40, T43, F18, F19 T410, T41.1, T41.2, T41.3, T41.4, T42.3, T43.4, T42.6, T42.7, T42.8 (10).

*Alcohol and Drug Use encounters are both Primary Diagnosis and All diagnosis were analyzed:

The following ICD-10 codes were used to define mortality causes:

Suicide-related deaths: X60-X84, Y87.0 (Initial cause of death is suicide).
Mental and Behavioral-related deaths: F00-F09, and F20-F99 (Initial or contributing cause of death).
Alcohol-related deaths: K70, Y90, Y91, X45, X65, Y15, T51, K73, K74, G31.2, G62.1, I42.6, K29.2, K86.0, K85.0, R78.0, E24.4, O35.4, Q86.0, and Z72.1 (Initial cause of death).
Drug-related Deaths: X40-X44, X60-S64, X85, Y10-Y14 (Initial cause of death).
*The 2019 EPI Profile utilized contributing cause of death for drug and alcohol related deaths, this methodology is changed to only the initial cause of death in this report, numbers will have decreased due to this change.

Data Tables

Table 1. Population Distribution, Nevada, 2010-2019.

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Nevada	2,705,845	2,721,794	2,750,217	2,800,966	2,843,301	2,897,684	2,953,377	2,986,656	3,031,919	3,101,368
Sex										
Female	1,338,008	1,347,169	1,362,145	1,388,602	1,410,857	1,440,920	1,470,250	1,488,221	1,512,700	1,548,451
Male	1,367,837	1,374,625	1,388,072	1,412,364	1,432,444	1,456,765	1,483,127	1,498,435	1,519,219	1,552,917
Age										
<1	36,579	35,112	34,516	34,389	35,964	35,453	36,460	37,252	37,731	38,862
1-4	160,891	155,936	149,531	146,081	144,034	145,106	146,339	146,925	149,642	154,053
5-14	361,591	368,234	376,669	386,142	391,533	405,007	407,823	408,426	408,361	409,928
15-24	363,570	364,218	368,737	375,934	379,820	387,182	394,928	395,471	400,823	414,275
25-34	377,553	374,494	372,983	376,947	381,591	396,649	407,260	416,478	425,942	439,173
35-44	387,788	387,069	389,725	395,766	399,542	398,838	403,408	405,872	410,862	416,233
45-54	372,166	373,149	375,197	379,995	385,828	387,647	394,646	396,403	397,010	401,498
55-64	310,919	318,128	323,370	331,756	338,075	344,172	351,960	356,916	362,800	373,125
65-74	207,114	212,292	223,092	233,677	241,857	248,456	254,595	260,147	268,415	276,648
75-84	95,725	99,748	101,759	104,280	108,183	111,916	117,805	123,615	130,392	136,706
85+	31,950	33,416	34,638	35,998	36,876	37,258	38,153	39,151	39,941	40,867
Race/Ethnicity										
White non-Hispanic	1,508,507	1,510,392	1,514,399	1,523,159	1,528,666	1,530,902	1,539,684	1,541,655	1,547,186	1,554,968
Black non-Hispanic	220,374	222,186	225,778	232,837	238,788	247,229	254,921	259,779	266,109	268,945
Native American/Alaskan Native non-Hispanic	31,417	31,707	31,941	32,250	32,424	34,075	34,353	34,787	35,115	35,291
Asian/Pacific Islander non-Hispanic	227,115	228,367	232,862	242,606	250,934	265,838	276,711	282,653	291,200	296,201
Hispanic	718,432	729,142	745,238	770,113	792,488	819,641	847,708	867,782	892,309	902,178
Behavioral Health Region										
Clark County	1,959,491 72.4%	1,967,722 72.3%	1,988,195 72.3%	2,031,723 72.5%	2,069,450 72.8%	2,118,353 73.1%	2,166,177 73.3%	2,193,818 73.5%	2,232,176 73.6%	2,282,227 73.6%
Northern Region	183,903 6.8%	185,429 6.8%	185,042 6.7%	185,445 6.6%	184,943 6.5%	184,942 6.4%	186,445 6.3%	187,866 6.3%	190,228 6.3%	192,723 6.2%
Rural Region	90,213 3.3%	91,827 3.4%	94,345 3.4%	96,185 3.4%	96,141 3.4%	95,803 3.3%	96,130 3.3%	95,845 3.2%	95,919 3.2%	97,257 3.1%
Southern Region	54,902 2.0%	55,223 2.0%	54,931 2.0%	55,289 2.0%	55,970 2.0%	56,640 2.0%	56,318 1.9%	57,204 1.9%	57,558 1.9%	59,198 1.9%
Washoe County	417,336 15.4%	421,593 15.5%	427,704 15.6%	432,324 15.4%	436,797 15.4%	441,946 15.3%	448,307 15.2%	451,923 15.1%	456,038 15.0%	469,963 15.2%
Coalition										
Churchill Community Coalition (CCC)	25,055 0.9%	25,136 0.9%	25,238 0.9%	25,322 0.9%	25,103 0.9%	25,126 0.9%	25,256 0.9%	25,387 0.9%	25,816 0.9%	25,802 0.8%
Frontier Community Coalition (FCC)	29,141 1.1%	29,970 1.1%	30,618 1.1%	30,682 1.1%	30,662 1.1%	30,054 1.0%	29,767 1.0%	29,921 1.0%	29,673 1.0%	29,994 1.0%
Healthy Communities Coalition (HCC)	61,056 2.3%	61,167 2.2%	61,027 2.2%	61,639 2.2%	61,902 2.2%	61,859 2.1%	62,343 2.1%	63,415 2.1%	64,164 2.1%	65,797 2.1%
Join Together Northern Nevada (JTNN)	417,336 15.4%	421,593 15.5%	427,704 15.6%	432,324 15.4%	436,797 15.4%	441,946 15.3%	448,307 15.2%	451,923 15.1%	456,038 15.0%	469,963 15.2%
Nye Communities Coalition (NCC)	50,137 1.9%	50,622 1.9%	50,252 1.8%	50,627 1.8%	51,386 1.8%	52,101 1.8%	51,744 1.8%	52,530 1.8%	52,946 1.7%	54,583 1.8%
Partners Allied for Community Excellence (PACE)	61,072 2.3%	61,857 2.3%	63,727 2.3%	65,503 2.3%	65,479 2.3%	65,749 2.3%	66,363 2.2%	65,924 2.2%	66,246 2.2%	67,263 2.2%
PACT Coalition for Safe and Drug Free Communities/CARE	1,959,491 72.4%	1,967,722 72.3%	1,988,195 72.3%	2,031,723 72.5%	2,069,450 72.8%	2,118,353 73.1%	2,166,177 73.3%	2,193,818 73.5%	2,232,176 73.6%	2,282,227 73.6%
Partnership Carson City (PCC)	55,360 2.0%	56,066 2.1%	55,441 2.0%	54,668 2.0%	53,969 1.9%	54,273 1.9%	55,183 1.9%	55,438 1.9%	55,945 1.8%	56,321 1.8%
Partnership Douglas County (PDC)	47,197 1.7%	47,661 1.8%	48,015 1.7%	48,478 1.7%	48,553 1.7%	48,223 1.7%	48,237 1.6%	48,300 1.6%	48,915 1.6%	49,418 1.6%

Source: Nevada State Demographer, Vintage 2019.

Table 2: Prevalence Estimates of Health Risk Behaviors by Coalition, Nevada Adults, 2019.

Indicator	CCC	FCC	HCC	JTNN	NCC	PACE	PACT/CARE (Clark County)	PCC	PDC	Nevada
Ever seriously considered attempting suicide during the past 12 months	1.2% (0.0-03.7)	6.8% (0.0-14.8)	3.6% (0.0-07.3)	4.1% (2.6-05.5)	0.0% (0.0-13.4)	5.7% (0.2-11.2)	4.8% (3.2-06.5)	8.4% (2.9-14.1)	5.6% (0.0-12.8)	4.8% (3.5-06.1)
Heavy Drinkers	0.3% (0.0-00.6)	10.1% (0.0-20.5)	4.7% (0.0-09.6)	6.8% (4.8-08.8)	0.0% (0.2-06.8)	6.1% (2.1-10.0)	6.2% (4.6-07.9)	9.4% (4.1-14.8)	17.1% (7.1-27.0)	6.4% (5.1-07.7)
Binge Drinkers	9.2% (1.9-16.5)	20.5% (7.0-34.0)	14.1% (6.5-21.7)	18.3% (15.2-21.4)	0.0% (4.6-22.6)	22.6% (14.4-30.9)	16.4% (13.8-19.0)	16.9% (9.4-24.5)	25.6% (13.9-37.4)	16.8% (14.8-18.8)
General Health Poor or Fair	19.4% (9.9-28.8)	25.9% (15.2-36.8)	22.4% (14.7-30.1)	19.5% (16.3-22.8)	0.0% (16.9-36.2)	17.4% (9.8-24.9)	21.4% (18.5-24.3)	22.5% (13.8-31.2)	24.0% (12.9-35.2)	20.9% (18.7-23.1)
Depressive Disorder Diagnosis	12.5% (3.9-21.2)	18.4% (6.6-30.3)	22.0% (15.0-29.0)	16.8% (13.8-19.9)	0.0% (8.7-24.3)	13.7% (7.3-20.1)	18.0% (15.4-20.5)	20.5% (12.7-28.3)	15.0% (5.9-24.1)	17.7% (15.7-19.7)
Ten or more days of poor mental health	12.0% (4.5-19.5)	14.7% (3.7-25.6)	23.4% (14.9-32.0)	17.3% (14.4-20.2)	0.0% (10.0-29.5)	21.8% (13.5-30.1)	17.4% (14.8-20.1)	19.0% (11.5-26.5)	13.1% (3.8-22.1)	17.6% (15.5-19.6)
Ten or more days of poor mental or physical health kept from usual activities	23.5% (11.7-35.4)	23.1% (2.8-43.6)	17.1% (9.7-24.6)	20.3% (16.1-24.5)	0.0% (19.7-43.2)	25.0% (12.6-37.5)	23.4% (19.3-27.3)	213.0% (10.8-31.9)	25.1% (6.8-43.5)	22.9% (19.8-25.9)
Used marijuana/hashish in the last 30 days	15.7% (6.8-24.5)	29.3% (14.5-44.1)	17.6% (10.0-25.3)	18.6% (15.4-21.9)	0.0% (13.8-34.0)	17.7% (9.2-26.2)	16.4% (13.7-19.1)	22.5% (13.9-31.0)	24.0% (11.3-36.7)	17.3% (15.3-19.4)
Used other illegal drugs in the last 30 days	2.4% (0.0-05.7)	0.0% (0.0-00.0)	3.1% (0.0-07.5)	3.1% (1.6-04.6)	0.0% (0.0-03.1)	0.0% (0.0-00.0)	1.7% (0.8-02.6)	0.6% (0.0-01.5)	0.0% (0.0-00.0)	1.9% (1.2-02.6)
Used prescription drugs/pain killer to get high in last 30 days	1.1% (0.0-03.3)	2.8% (0.0-06.8)	1.7% (0.0-05.0)	0.9% (0.3-01.5)	0.0% (0.0-00.0)	0.0% (0.0-00.0)	0.6% (0.0-01.1)	0.7% (0.0-02.2)	0.0% (0.0-00.0)	0.7% (0.2-01.1)
Current tobacco cigarette smokers	14.9% (6.5-23.4)	21.9% (8.7-35.1)	23.1% (14.2-31.9)	15.7% (12.7-18.8)	0.0% (16.5-37.6)	23.7% (14.6-32.7)	14.9% (12.5-17.3)	11.8% (6.3-17.3)	22.3% (11.2-33.4)	15.7% (13.8-17.5)
Difficulty doing errands alone because of physical, mental, or emotional condition	8.9% (2.8-14.9)	4.3% (0.2-08.4)	13.9% (6.7-21.1)	7.5% (5.5-09.5)	0.0% (2.7-14.2)	8.6% (3.1-14.0)	8.7% (6.7-10.8)	10.9% (4.6-17.2)	9.4% (0.5-18.4)	8.6% (7.1-10.2)
Serious difficulty concentrating, remembering, or making decisions because of physical, mental, or emotional condition	9.8% (1.5-18.1)	19.8% (6.9-32.6)	16.7% (9.1-24.3)	11.1% (8.4-13.7)	0.0% (6.8-21.1)	12.0% (5.0-18.9)	13.0% (10.7-15.3)	17.2% (9.4-24.9)	6.6% (0.0-13.2)	12.8% (11.0-14.6)

Source: Behavioral Risk Factor Surveillance System (BRFSS).

For more information about BRFSS indictors: Office of Analytics Reports.

Table 3a. Age-Adjusted Rates per 100,000 of Mental Health-Related Emergency Department Encounters by Year, Nevada Residents, 2010-2019.

Year	Schizophrenia	Anxiety	Depression	Bipolar	PTSD	Suicide Ideation
2010	161.5 (156.7-166.3)	643.2 (633.6-652.7)	631.4 (622.0-640.9)	288.6 (282.2-295.0)	37.9 (35.6-40.2)	288.1 (281.7-294.5)
2011	169.8 (164.9-174.7)	769.3 (758.9-779.7)	726.6 (716.5-736.7)	316.3 (309.7-323.0)	51.7 (49.0-54.4)	317.2 (310.5-323.9)
2012	187.6 (182.5-192.8)	972.5 (960.8-984.1)	793.3 (782.9-803.8)	339.4 (332.5-346.3)	63.1 (60.2-66.1)	331.2 (324.4-338.1)
2013	213.6 (208.2-219.1)	1,091.1 (1,078.9-1,103.4)	808.2 (797.7-818.6)	361.8 (354.8-368.9)	83.4 (80.0-86.8)	318.7 (312.1-325.4)
2014	248.3 (242.5-254.1)	1,345.4 (1,332.0-1,358.9)	924.4 (913.3-935.4)	423.9 (416.3-431.4)	102.8 (99.0-106.5)	312.2 (305.7-318.7)
2015	256.3 (250.5-262.2)	1,439.2 (1,425.4-1,453.0)	985.2 (973.9-996.6)	439.1 (431.5-446.8)	108.2 (104.4-112.0)	354.9 (348.0-361.7)
2016	251.7 (246.0-257.5)	1,658.2 (1,643.6-1,672.9)	1,058.1 (1,046.5-1,069.7)	489.7 (481.7-497.7)	132.1 (128.0-136.3)	381.6 (374.5-388.7)
2017	378.0 (371.0-385.0)	312.0 (305.7-318.4)	1,777.1 (1,762.0-1,792.2)	1,023.3 (1,011.9-1,034.6)	586.8 (578.1-595.5)	176.6 (171.8-181.4)
2018	361.5 (354.7-368.3)	1,912.7 (1,897.2-1,928.2)	1,172.1 (1,160.0-1,184.1)	654.1 (645.0-663.2)	194.1 (189.1-199.0)	566.7 (558.2-575.3)
2019	445.4 (438.0-452.9)	1,945.8 (1,930.3-1,961.2)	1,212.8 (1,200.7-1,224.9)	707.6 (698.2-717.0)	242.9 (237.4-248.5)	527.8 (519.6-535.9)

Source: Hospital Emergency Department Billing.
Rates are per 100,000 age-specific population, provided by the state demographer, vintage 2019.
Categories are not mutually exclusive.

Table 3b. Crude Rates per 100,000 of Mental Health-Related Emergency Department Encounters by Year, Nevada Residents, 2010-2019.

Year	Schizophrenia	Anxiety	Depression	Bipolar	PTSD	Suicide Ideation
2010	161.7 (156.9-166.4)	641.6 (632.0-651.1)	631.9 (622.5-641.4)	288.3 (281.9-294.7)	38.1 (35.8-40.5)	286.6 (280.2-293.0)
2011	169.0 (164.1-173.9)	770.4 (759.9-780.8)	730.6 (720.5-740.8)	315.9 (309.2-322.6)	52.3 (49.6-55.0)	314.5 (307.8-321.1)
2012	186.8 (181.7-191.9)	977.3 (965.6-989.0)	799.6 (789.0-810.1)	338.3 (331.5-345.2)	63.8 (60.8-66.8)	327.4 (320.6-334.2)
2013	213.0 (207.6-218.4)	1,095.4 (1,083.2-1,107.7)	818.8 (808.2-829.4)	361.1 (354.1-368.2)	83.9 (80.5-87.3)	315.8 (309.2-322.4)
2014	247.3 (241.5-253.1)	1,354.7 (1,341.1-1,368.2)	938.2 (926.9-949.5)	424.1 (416.5-431.7)	102.8 (99.1-106.5)	309.6 (303.1-316.1)
2015	254.5 (248.7-260.3)	1,446.8 (1,433.0-1,460.7)	1,000.2 (988.7-1,011.7)	437.3 (429.7-445.0)	108.6 (104.8-112.4)	352.3 (345.5-359.2)
2016	249.4 (243.7-255.1)	1,670.7 (1,656.0-1,685.4)	1,078.3 (1,066.4-1,090.1)	489.1 (481.2-497.1)	131.8 (127.6-135.9)	377.7 (370.7-384.7)
2017	373.5 (366.6-380.4)	309.0 (302.7-315.3)	1,790.6 (1,775.5-1,805.8)	1,042.4 (1,030.8-1,054.0)	583.2 (574.5-591.9)	174.0 (169.3-178.7)
2018	360.5 (353.8-367.3)	1,929.5 (1,913.9-1,945.2)	1,195.8 (1,183.5-1,208.1)	652.0 (642.9-661.1)	192.1 (187.2-197.0)	556.4 (548.0-564.8)
2019	441.9 (434.5-449.3)	1,970.2 (1,954.6-1,985.8)	1,241.4 (1,229.0-1,253.8)	708.0 (698.6-717.3)	239.8 (234.3-245.2)	520.2 (512.1-528.2)

Source: Hospital Emergency Department Billing.
Rates are per 100,000 age-specific population, provided by the state demographer, vintage 2019.
Categories are not mutually exclusive.

Table 4a. Age-Adjusted Rates per 100,000 of Mental Health-Related Emergency Admissions Department Encounters by Coalition, Nevada Residents, 2019.

Coalition	Schizophrenia	Anxiety	Depression	Bipolar	PTSD	Suicide Ideation
Churchill Community Coalition (CCC)	312.2 (242.9-381.5)	2,279.1 (2,094.9-2,463.3)	1,490.7 (1,343.2-1,638.3)	743.6 (635.0-852.3)	238.8 (176.8-300.8)	475.0 (387.8-562.2)
Frontier Community Coalition (FCC)	148.3 (101.7-194.8)	1,051.0 (934.0-1,168.0)	878.0 (768.7-987.3)	301.0 (235.9-366.2)	142.2 (99.2-185.2)	323.1 (256.0-390.2)
Healthy Communities Coalition (HCC)	114.8 (88.3-141.4)	1,339.8 (1,252.1-1,427.6)	588.4 (531.8-644.9)	330.9 (285.8-376.0)	111.4 (85.9-137.0)	201.0 (164.6-237.5)
Join Together Northern Nevada (JTNN)	309.6 (293.5-325.8)	1,876.0 (1,837.0-1,915.0)	1,142.6 (1,112.3-1,172.8)	565.8 (544.4-587.2)	238.6 (224.5-252.7)	415.0 (396.5-433.5)
Nye Communities Coalition (NCC)	226.7 (182.5-270.9)	1,668.4 (1,559.7-1,777.1)	900.1 (819.6-980.5)	523.0 (457.9-588.1)	237.4 (195.1-279.7)	641.8 (569.0-714.5)
Partners Allied for Community Excellence (PACE)	287.2 (246.3-328.1)	3,502.0 (3,358.5-3,645.6)	2,738.9 (2,611.6-2,866.1)	769.9 (702.6-837.2)	613.8 (548.6-679.1)	410.1 (361.2-459.0)
PACT Coalition for Safe and Drug Free Communities/CARE	508.6 (499.4-517.9)	1,983.1 (1,964.9-2,001.2)	1,254.6 (1,240.2-1,269.0)	763.0 (751.7-774.3)	245.3 (238.9-251.7)	577.9 (568.1-587.8)
Partnership Carson City (PCC)	242.1 (198.2-285.9)	1,828.8 (1,710.5-1,947.1)	575.1 (509.8-640.4)	863.8 (779.9-947.7)	174.6 (136.8-212.4)	192.8 (152.8-232.9)
Partnership Douglas County (PDC)	50.1 (30.8-69.4)	847.1 (767.6-926.6)	226.5 (187.8-265.1)	138.6 (104.7-172.6)	58.5 (36.4-80.6)	152.0 (113.5-190.5)
Nevada	445.4 (438.0-452.9)	1,945.8 (1,930.4-1,961.3)	1,212.8 (1,200.7-1,224.9)	707.6 (698.3-717.0)	242.9 (237.4-248.5)	527.8 (519.7-535.9)

Source: Hospital Emergency Department Billing.
Rates are per 100,000 age-specific population, provided by the state demographer, vintage 2019.
Categories are not mutually exclusive.

Table 4b. Crude Rates per 100,000 of Mental Health-Related Emergency Department Encounters by Coalition, Nevada Residents, 2019.

Coalition	Schizophrenia	Anxiety	Depression	Bipolar	PTSD	Suicide Ideation
Churchill Community Coalition (CCC)	302.5 (235.4-369.6)	2,280.2 (2,095.9-2,464.5)	1,520.1 (1,369.7-1,670.6)	698.0 (596.1-800.0)	221.0 (163.7-278.4)	442.1 (360.9-523.2)
Frontier Community Coalition (FCC)	130.1 (89.3-171.0)	1,034.4 (919.3-1,149.6)	827.5 (724.6-930.5)	273.6 (214.4-332.9)	140.1 (97.8-182.5)	297.0 (235.3-358.7)
Healthy Communities Coalition (HCC)	109.5 (84.2-134.8)	1,360.7 (1,271.6-1,449.9)	632.5 (571.7-693.2)	314.7 (271.8-357.6)	111.0 (85.5-136.4)	177.9 (145.6-210.1)
Join Together Northern Nevada (JTNN)	300.4 (284.8-316.1)	1,889.3 (1,850.0-1,928.6)	1,168.6 (1,137.7-1,199.5)	570.9 (549.3-592.5)	234.5 (220.6-248.3)	411.1 (392.8-429.4)
Nye Communities Coalition (NCC)	185.2 (149.0-221.3)	1,659.1 (1,551.0-1,767.2)	881.8 (803.0-960.6)	454.6 (398.1-511.2)	221.8 (182.3-261.3)	548.1 (486.0-610.3)
Partners Allied for Community Excellence (PACE)	281.1 (241.0-321.2)	3,401.4 (3,262.0-3,540.8)	2,645.9 (2,522.9-2,768.8)	748.1 (682.7-813.5)	505.7 (451.9-559.4)	401.6 (353.7-449.5)
PACT Coalition for Safe and Drug Free Communities/CARE	510.6 (501.3-519.8)	2,008.1 (1,989.7-2,026.5)	1,281.0 (1,266.3-1,295.7)	769.4 (758.0-780.8)	244.8 (238.3-251.2)	575.4 (565.5-585.2)
Partnership Carson City (PCC)	207.7 (170.1-245.3)	1,629.7 (1,524.2-1,735.1)	529.0 (469.0-589.1)	722.5 (652.3-792.7)	145.6 (114.1-177.1)	158.0 (125.2-190.8)
Partnership Douglas County (PDC)	52.6 (32.4-72.9)	882.5 (799.6-965.3)	267.2 (221.6-312.7)	129.5 (97.8-161.3)	54.6 (34.0-75.3)	121.4 (90.7-152.2)
Nevada	441.9 (434.5-449.3)	1,970.3 (1,954.7-1,985.9)	1,241.4 (1,229.0-1,253.8)	708.0 (698.6-717.4)	239.8 (234.4-245.3)	520.2 (512.2-528.2)

Source: Hospital Emergency Department Billing.
Rates are per 100,000 population, provided by the state demographer, vintage 2019.
Categories are not mutually exclusive.

Table 5a. Age-Adjusted Rates per 100,000 of Mental Health-Related Inpatient Admissions by Year, Nevada Residents, 2010-2019.

Year	Schizophrenia	Anxiety	Depression	Bipolar	PTSD	Suicide Ideation
2010	94.1 (90.5-97.6)	449.3 (441.4-457.3)	718.9 (708.9-729.0)	278.6 (272.4-284.8)	67.4 (64.3-70.4)	96.6 (92.9-100.3)
2011	97.5 (93.9-101.1)	485.9 (477.7-494.1)	747.8 (737.6-758.0)	270.7 (264.6-276.8)	69.2 (66.1-72.3)	134.7 (130.4-139.1)
2012	100.3 (96.6-103.9)	612.0 (602.9-621.1)	806.0 (795.6-816.5)	252.5 (246.7-258.3)	76.8 (73.6-80.1)	199.7 (194.5-205.0)
2013	110.0 (106.2-113.7)	699.7 (690.1-709.3)	839.5 (828.9-850.0)	246.6 (240.9-252.3)	88.9 (85.4-92.3)	224.4 (218.9-230.0)
2014	127.6 (123.6-131.7)	777.6 (767.6-787.6)	935.3 (924.3-946.3)	270.7 (264.8-276.6)	98.5 (94.9-102.0)	258.6 (252.7-264.5)
2015	219.5 (214.1-224.8)	877.2 (866.7-887.8)	1,065.8 (1,054.1-1,077.4)	404.7 (397.5-411.9)	139.7 (135.4-144.0)	407.0 (399.6-414.3)
2016	196.5 (191.5-201.5)	943.5 (932.7-954.3)	1,043.5 (1,032.1-1,054.8)	401.0 (393.9-408.1)	149.9 (145.6-154.3)	223.0 (217.6-228.4)
2017	177.8 (173.1-182.5)	999.2 (988.2-1,010.2)	1,086.2 (1,074.7-1,097.8)	419.8 (412.6-427.1)	161.8 (157.3-166.4)	431.2 (423.7-438.6)
2018	210.3 (205.2-215.4)	1,117.2 (1,105.6-1,128.8)	1,102.0 (1,090.4-1,113.5)	466.2 (458.6-473.8)	189.5 (184.7-194.4)	556.8 (548.4-565.2)
2019	210.4 (205.4-215.5)	1,104.3 (1,093.0-1,115.7)	1,056.9 (1,045.8-1,068.1)	448.8 (441.5-456.2)	209.0 (203.9-214.0)	575.5 (567.1-584.0)

Source: Hospital Inpatient Billing.
Rates are per 100,000 age-specific population, provided by the state demographer, vintage 2019.
Categories are not mutually exclusive.

Table 5b. Crude Rates per 100,000 of Mental Health-Related Inpatient Admissions by Year, Nevada Residents, 2010-2019.

Year	Schizophrenia	Anxiety	Depression	Bipolar	PTSD	Suicide Ideation
2010	98.1 (94.4-101.9)	452.8 (444.8-460.9)	722.9 (712.7-733.0)	284.4 (278.1-290.8)	68.8 (65.7-71.9)	97.4 (93.7-101.1)
2011	101.5 (97.7-105.3)	496.3 (487.9-504.6)	759.4 (749.1-769.8)	279.2 (272.9-285.5)	70.5 (67.4-73.7)	135.8 (131.4-140.2)
2012	105.6 (101.7-109.4)	632.1 (622.7-641.5)	829.9 (819.2-840.7)	262.6 (256.6-268.7)	79.1 (75.8-82.4)	200.8 (195.5-206.1)
2013	116.2 (112.2-120.2)	728.7 (718.7-738.7)	870.1 (859.1-881.0)	256.6 (250.7-262.5)	91.5 (87.9-95.0)	226.4 (220.8-231.9)
2014	133.8 (129.5-138.0)	816.7 (806.2-827.2)	978.6 (967.1-990.1)	284.3 (278.1-290.5)	101.9 (98.1-105.6)	262.7 (256.8-268.7)
2015	222.3 (216.9-227.7)	917.6 (906.6-928.7)	1,108.9 (1,096.7-1,121.0)	413.6 (406.2-421.0)	141.4 (137.1-145.8)	407.5 (400.1-414.8)
2016	198.9 (193.8-204.0)	995.8 (984.5-1,007.2)	1,093.5 (1,081.5-1,105.4)	411.1 (403.8-418.4)	152.1 (147.6-156.5)	223.3 (217.9-228.7)
2017	182.4 (177.6-187.3)	1,060.4 (1,048.7-1,072.1)	1,142.2 (1,130.1-1,154.4)	431.1 (423.6-438.5)	165.0 (160.4-169.6)	431.1 (423.7-438.6)
2018	214.8 (209.6-220.1)	1,183.6 (1,171.4-1,195.9)	1,160.7 (1,148.6-1,172.8)	479.8 (472.0-487.6)	192.1 (187.1-197.0)	554.8 (546.4-563.2)
2019	215.3 (210.2-220.5)	1,171.8 (1,159.7-1,183.8)	1,116.6 (1,104.9-1,128.4)	464.3 (456.7-471.9)	212.6 (207.4-217.7)	574.7 (566.3-583.2)

Source: Hospital Inpatient Billing.
Rates are per 100,000 population, provided by the state demographer, vintage 2019.
Categories are not mutually exclusive.

Table 6a. Age-Adjusted Rates per 100,000 of Mental Health-Related Inpatient Admissions by Coalition, Nevada Residents, 2019.

Coalition	Schizophrenia	Anxiety	Depression	Bipolar	PTSD	Suicide Ideation
Churchill Community Coalition (CCC)	162.9 (115.3-210.4)	1,663.9 (1,513.0-1,814.8)	1,143.2 (1,016.7-1,269.6)	378.7 (304.5-452.9)	338.1 (267.1-409.1)	568.0 (472.5-663.4)
Frontier Community Coalition (FCC)	33.9 (12.9-55.0)	609.0 (521.7-696.3)	887.4 (781.7-993.1)	161.2 (115.1-207.3)	139.2 (96.0-182.3)	352.1 (281.6-422.5)
Healthy Communities Coalition (HCC)	80.9 (60.0-101.7)	1,140.4 (1,062.7-1,218.1)	1,226.4 (1,145.8-1,307.1)	382.9 (335.8-430.0)	336.0 (289.4-382.6)	622.5 (558.8-686.2)
Join Together Northern Nevada (JTNN)	132.9 (122.7-143.2)	988.0 (960.2-1,015.7)	1,077.1 (1,048.1-1,106.1)	402.8 (384.9-420.7)	281.9 (266.6-297.1)	713.4 (689.0-737.7)
Nye Communities Coalition (NCC)	100.3 (73.6-127.1)	1,430.4 (1,343.9-1,517.0)	991.4 (916.1-1,066.6)	573.4 (508.0-638.7)	249.6 (208.8-290.4)	429.6 (373.1-486.2)
Partners Allied for Community Excellence (PACE)	29.9 (18.0-41.9)	558.6 (502.0-615.2)	571.8 (514.4-629.3)	161.7 (130.5-193.0)	115.9 (89.7-142.1)	261.2 (222.3-300.1)
PACT Coalition for Safe and Drug Free Communities/CARE	245.6 (239.2-251.9)	1,135.3 (1,121.7-1,148.8)	1,066.8 (1,053.6-1,079.9)	473.5 (464.7-482.2)	187.4 (181.8-192.9)	559.7 (550.1-569.4)
Partnership Carson City (PCC)	130.0 (99.1-160.9)	1,966.9 (1,846.9-2,086.8)	1,895.1 (1,778.4-2,011.7)	700.7 (626.9-774.5)	464.9 (404.4-525.4)	925.1 (838.6-1,011.7)
Partnership Douglas County (PDC)	42.4 (24.3-60.6)	887.4 (809.4-965.4)	935.4 (853.7-1,017.2)	220.0 (178.7-261.3)	277.1 (228.1-326.0)	506.5 (435.3-577.8)
Nevada	210.4 (205.4-215.5)	1,104.4 (1,093.1-1,115.8)	1,057.0 (1,045.9-1,068.2)	448.8 (441.5-456.2)	209.0 (203.9-214.0)	575.5 (567.1-584.0)

Source: Hospital Inpatient Billing.
Rates are per 100,000 age-specific population, provided by the state demographer, vintage 2019.
Categories are not mutually exclusive.

Table 6b. Crude Rates per 100,000 of Mental Health-Related Inpatient Admissions by Coalition, Nevada Residents, 2019.

Coalition	Schizophrenia	Anxiety	Depression	Bipolar	PTSD	Suicide Ideation
Churchill Community Coalition (CCC)	174.5 (123.5-225.5)	1,811.0 (1,646.7-1,975.2)	1,217.7 (1,083.0-1,352.4)	387.8 (311.8-463.8)	337.4 (266.5-408.3)	527.4 (438.8-616.0)
Frontier Community Coalition (FCC)	33.4 (12.7-54.1)	624.0 (534.6-713.4)	904.3 (796.6-1,012.0)	156.8 (112.0-201.7)	133.5 (92.1-174.8)	320.3 (256.3-384.4)
Healthy Communities Coalition (HCC)	88.2 (65.5-110.9)	1,258.9 (1,173.1-1,344.6)	1,350.1 (1,261.3-1,438.9)	386.2 (338.7-433.7)	304.1 (261.9-346.2)	558.0 (500.9-615.1)
Join Together Northern Nevada (JTNN)	136.8 (126.2-147.4)	1,034.6 (1,005.5-1,063.6)	1,125.4 (1,095.1-1,155.7)	413.0 (394.6-431.4)	277.9 (262.8-293.0)	702.8 (678.9-726.8)
Nye Communities Coalition (NCC)	99.0 (72.6-125.4)	1,924.9 (1,808.5-2,041.3)	1,220.9 (1,128.2-1,313.7)	542.6 (480.8-604.5)	264.0 (220.9-307.1)	407.0 (353.4-460.5)
Partners Allied for Community Excellence (PACE)	35.7 (21.4-50.0)	556.2 (499.9-612.6)	566.7 (509.8-623.6)	153.2 (123.6-182.8)	111.5 (86.3-136.8)	257.3 (219.0-295.6)
PACT Coalition for Safe and Drug Free Communities/CARE	251.6 (245.1-258.1)	1,183.2 (1,169.1-1,197.3)	1,107.4 (1,093.7-1,121.0)	490.0 (480.9-499.1)	192.0 (186.4-197.7)	564.3 (554.6-574.1)
Partnership Carson City (PCC)	120.7 (92.0-149.4)	1,833.8 (1,722.0-1,945.6)	1,800.1 (1,689.3-1,910.9)	614.2 (549.5-678.9)	403.0 (350.6-455.4)	779.3 (706.4-852.2)
Partnership Douglas County (PDC)	42.5 (24.3-60.7)	1,005.9 (917.5-1,094.4)	1,018.1 (929.1-1,107.0)	220.6 (179.2-262.0)	249.0 (205.0-292.9)	392.7 (337.4-447.9)
Nevada	215.3 (210.2-220.5)	1,171.8 (1,159.8-1,183.9)	1,116.7 (1,104.9-1,128.4)	464.3 (456.7-471.9)	212.6 (207.4-217.7)	574.7 (566.3-583.2)

Source: Hospital Inpatient Billing.
Rates are per 100,000 population, provided by the state demographer, vintage 2019.
Categories are not mutually exclusive.

Table 7a. Facilities that had Mental Health Related Encounters in 2019 and Number of Psychiatric Beds.

Facility	Reported		*Number of Psychiatric Beds:	
	Emergency Department	Inpatient	Adult	Adolescent
BHC West Hills Hospital	Yes	No	63	32
Banner Churchill Community Hospital	Yes	Yes		
Battle Mountain General Hospital	Yes	Yes		
Boulder City Hospital	Yes	Yes		
Carson Tahoe Continuing Care Hospital	Yes	No		
Carson Tahoe Regional Medical Center	Yes	Yes	52	
Carson Valley Medical Center	Yes	Yes		
Centennial Hills Hospital Medical Center	Yes	Yes		
Complex Care Hospital at Tenaya	Yes	No		
Desert Parkway Behavioral Healthcare Hospital LLC	Yes	No	131	21
Desert Springs Hospital Medical Center	Yes	Yes		
Desert View Hospital	Yes	Yes		
Dignity Health - St. Rose Dominican Blue Diamond, LLC	Yes	Yes		
Dignity Health - St. Rose Dominican Craig Ranch, LLC	Yes	Yes		
Dignity Health - St. Rose Dominican Sahara, LLC	Yes	Yes		
Dignity Health - St. Rose Dominican West Flamingo, LLC	Yes	Yes		
Dignity Health Rehabilitation Hospital	Yes	No		
Elite Medical Center	No	Yes		
Encompass Health Rehabilitation (Desert Canyon)	Yes	No		
Encompass Health Rehabilitation (Henderson)	Yes	No		
Encompass Health Rehabilitation (Las Vegas)	Yes	No		
Grover C Dils Medical Center	Yes	Yes		
Henderson Hospital	Yes	Yes		
Horizon Specialty Hospital - Las Vegas	Yes	No		
Horizon Specialty Hospital of Henderson	Yes	No		
Humboldt General Hospital	Yes	Yes		
Incline Village Community Hospital	Yes	Yes		
Kindred Hospital - Las Vegas (Flamingo Campus)	Yes	No		
Kindred Hospital - Las Vegas (Sahara Campus)	Yes	No		
Kindred Hospital - Las Vegas at St Rose Dominican	Yes	No		
Las Vegas-AMG Specialty Hospital	Yes	No		
Mesa View Regional Hospital	Yes	Yes		
Montevista Hospital	Yes	No	90	44
Mount Grant General Hospital	Yes	Yes		
MountainView Hospital	Yes	Yes		
North Vista Hospital	Yes	Yes	74	
Northeastern Nevada Regional Hospital	Yes	Yes		
Northern Nevada Medical Center	Yes	Yes		
Orthopedic Specialty Hospital of Nevada	Yes	No		
Pam Rehabilitation Hospital Of Centennial Hills	Yes	No		
Pershing General Hospital	Yes	Yes		
Reno Behavioral Healthcare Hospital, LLC	Yes	No	62	21
Renown Regional Medical Center	Yes	Yes		

Source: Hospital Inpatient Billing and Health Care Quality Compliance Online Licensing System AliS (CLICS).
**Bed counts are updated daily, therefore the current bed counts are from November 2020.*

Table 7b. Facilities that had Mental Health Related Encounters in 2019 and Number of Psychiatric Beds.

Facility	Reported		*Number of Psychiatric Beds:	
	Emergency Department	Inpatient	Adult	Adolescent
Renown Rehabilitation Hospital	Yes	No		
Renown South Meadows Medical Center	Yes	Yes		
Saint Mary''s Regional Medical Center	Yes	Yes	12	
Seven Hills Behavioral Institute	Yes	No	90	18
South Lyon Medical Center	Yes	Yes		
Southern Hills Hospital and Medical Center	Yes	Yes	40	20
Spring Mountain Sahara	Yes	No	30	
Spring Mountain Treatment Center	Yes	No	82	28
Spring Valley Hospital Medical Center	Yes	Yes		
St. Rose Dominican Hospitals - Rose de Lima Campus	Yes	Yes		
St. Rose Dominican Hospitals - San Martin Campus	Yes	Yes		
St. Rose Dominican Hospitals - Siena Campus	Yes	Yes		
Summerlin Hospital Medical Center	Yes	Yes		
Sunrise Hospital and Medical Center	Yes	Yes		
Tahoe Pacific Hospitals - Meadows	Yes	No		
Tahoe Pacific Hospitals - North	Yes	No		
University Medical Center of Southern Nevada	Yes	Yes		
Valley Hospital Medical Center	Yes	Yes	48	
William Bee Ririe Hospital	Yes	Yes		
Willow Springs Center	Yes	No		116

Source: Hospital Inpatient Billing and Health Care Quality Compliance Online Licensing System AliS (CLICS).
**Bed counts are updated daily, therefore the current bed counts are from 10/22/2019.*

Table 8. Suicide Attempts and Suicides by Leading Method and Coalition, Nevada Residents, 2019.

Coalition	Suicide Attempts						Suicides		
	Emergency Department Encounters			Inpatient Admissions					
	Substance	Cutting	Hanging/ Suffocation	Substance	Cutting	Hanging/ Suffocation	Substance	Hanging/ Suffocation	Firearms/ Explosives
Churchill Community Coalition (CCC)	81.4 (46.6-116.2)	38.8 (14.7-62.8)	0.0 -	81.4 (46.6-116.2)	7.8 (0.0-18.5)	0.0 -	3.9 (0.0-11.5)	3.9 (0.0-11.5)	7.8 (0.0-18.5)
Frontier Community Coalition (FCC)	70.0 (40.1-100.0)	53.3 (27.2-79.5)	0.0 -	43.3 (19.8-66.9)	13.3 (0.3-26.4)	0.0 -	0.0 -	6.7 (0.0-15.9)	10.0 (0.0-21.3)
Healthy Communities Coalition (HCC)	53.2 (35.6-70.8)	22.8 (11.3-34.3)	3.0 (0.0-07.3)	80.6 (58.9-102.2)	15.2 (5.8-24.6)	0.0 -	4.6 (0.0-09.7)	4.6 (0.0-09.7)	18.2 (7.9-28.6)
Join Together Northern Nevada (JTNN)	51.7 (45.2-58.2)	11.3 (8.2-14.3)	3.4 (1.7-05.1)	87.2 (78.8-95.7)	12.1 (9.0-15.3)	3.0 (1.4-04.5)	3.8 (2.1-05.6)	6.4 (4.1-08.7)	13.0 (9.7-16.2)
Nye Communities Coalition (NCC)	82.4 (58.4-106.5)	66.0 (44.4-87.5)	7.3 (0.1-14.5)	49.5 (30.8-68.1)	12.8 (3.3-22.3)	0.0 -	5.5 (0.0-11.7)	5.5 (0.0-11.7)	23.8 (10.9-36.8)
Partners Allied for Community Excellence (PACE)	81.8 (60.2-103.4)	43.1 (27.4-58.8)	3.0 (0.0-07.1)	31.2 (17.9-44.6)	5.9 (0.1-11.8)	0.0 -	0.0 -	3.0 (0.0-07.1)	32.7 (19.0-46.4)
PACT Coalition for Safe and Drug Free Communities/CARE	54.4 (51.4-57.4)	27.0 (24.9-29.1)	2.3 (1.7-02.9)	49.3 (46.5-52.2)	8.2 (7.1-09.4)	3.4 (2.7-04.2)	3.2 (2.4-03.9)	3.9 (3.1-04.7)	9.6 (8.4-10.9)
Partnership Carson City (PCC)	12.4 (3.2-21.6)	19.5 (8.0-31.1)	3.6 (0.0-08.5)	104.8 (78.0-131.5)	24.9 (11.8-37.9)	0.0 -	3.6 (0.0-08.5)	14.2 (4.4-24.0)	17.8 (6.8-28.8)
Partnership Douglas County (PDC)	40.5 (22.7-58.2)	18.2 (6.3-30.1)	4.0 (0.0-09.7)	54.6 (34.0-75.2)	20.2 (7.7-32.8)	0.0 -	0.0 -	14.2 (3.7-24.7)	20.2 (7.7-32.8)
Nevada	54.4 (51.8-57.0)	25.6 (23.9-27.4)	2.6 (2.0-03.1)	56.7 (54.0-59.3)	9.5 (8.5-10.6)	3.0 (2.4-03.6)	3.2 (2.6-03.8)	4.7 (3.9-05.4)	11.4 (10.2-12.6)

Source: Hospital Emergency Department Billing, Inpatient Billing, and the Electronic Death Registry System.
Rates are per 100,000 population, provided by the state demographer, vintage 2019.

Table 9. Suicides (Crude) Rates by Age, Race/Ethnicity and Coalition, Nevada Residents, 2019.

	CCC	FCC	HCC	JTNN	NCC	PACE	PACT/CARE (Clark County)	PCC	PDC	Nevada
Age Group										
Less then 15	0.0 -	0.0 -	0.0 -	3.3 (0.0-07.9)	0.0 -	0.0 -	0.6 (0.0-01.5)	0.0 -	20.5 (0.0-60.8)	1.2 (0.2-02.3)
15-24	0.0 -	0.0 -	0.0 -	19.9 (9.1-30.7)	0.0 -	72.2 (18.7-125.6)	13.0 (9.0-17.1)	31.0 (0.0-74.0)	43.5 (0.0-103.8)	15.4 (11.7-19.2)
25-34	77.4 (0.0-164.9)	35.9 (0.0-85.7)	23.6 (0.0-56.2)	28.8 (15.8-41.7)	48.1 (0.0-102.5)	30.2 (0.6-59.9)	24.2 (18.8-29.6)	12.4 (0.0-36.6)	37.4 (0.0-89.2)	26.0 (21.2-30.7)
35-44	0.0 -	32.4 (0.0-96.0)	42.3 (0.0-90.1)	23.3 (11.1-35.5)	78.1 (1.6-154.7)	47.6 (0.0-101.5)	17.1 (12.6-21.6)	98.4 (12.1-184.6)	40.8 (0.0-97.3)	20.9 (16.5-25.3)
45-54	0.0 -	55.8 (0.0-133.2)	47.9 (1.0-94.8)	30.4 (16.0-44.9)	31.9 (0.0-76.0)	25.0 (0.0-59.6)	23.2 (17.7-28.6)	36.5 (0.0-77.9)	86.5 (10.7-162.3)	26.4 (21.4-31.4)
55-64	0.0 -	26.2 (0.0-77.6)	33.1 (0.0-70.6)	36.4 (21.2-51.7)	34.9 (0.0-74.4)	11.9 (0.0-35.3)	27.2 (20.9-33.5)	43.1 (0.0-91.8)	12.1 (0.0-35.9)	28.4 (23.0-33.8)
65-74	0.0 -	0.0 -	48.7 (1.0-96.5)	23.9 (9.8-38.0)	50.4 (1.0-99.9)	62.1 (1.2-122.9)	29.2 (21.5-37.0)	27.7 (0.0-66.0)	12.9 (0.0-38.3)	29.3 (22.9-35.7)
75-84	72.5 (0.0-214.6)	0.0 -	22.0 (0.0-65.2)	67.7 (32.2-103.1)	18.7 (0.0-55.4)	144.7 (2.9-286.4)	35.6 (23.5-47.8)	56.6 (0.0-135.0)	45.5 (0.0-108.5)	42.4 (31.5-53.3)
85+	0.0 -	316.9 (0.0-937.9)	85.6 (0.0-253.5)	16.1 (0.0-47.5)	134.2 (0.0-320.3)	0.0 -	44.0 (19.1-68.9)	124.2 (0.0-296.2)	133.9 (0.0-319.4)	51.4 (29.4-73.4)
Race/Ethnicity										
White non-Hispanic	20.0 (0.4-39.6)	20.1 (0.4-39.7)	32.9 (17.3-48.6)	34.2 (27.5-40.8)	39.8 (20.9-58.8)	48.2 (28.5-67.9)	29.1 (25.7-32.4)	47.4 (26.1-68.7)	45.4 (24.4-66.4)	31.8 (29.0-34.6)
Black non-Hispanic	0.0 -	0.0 -	0.0 -	8.2 (0.0-24.4)	0.0 -	0.0 -	13.2 (8.8-17.7)	0.0 -	0.0 -	12.8 (8.5-17.0)
Native American/Alaskan Native non-Hispanic	0.0 -	66.4 (0.0-196.5)	0.0 -	13.5 (0.0-40.1)	0.0 -	26.6 (0.0-78.7)	19.8 (0.0-42.1)	0.0 -	0.0 -	16.9 (3.4-30.4)
Asian/Pacific Islander non-Hispanic	0.0 -	0.0 -	0.0 -	12.0 (0.2-23.7)	0.0 -	0.0 -	10.6 (6.7-14.6)	0.0 -	0.0 -	10.5 (6.9-14.2)
Hispanic	0.0 -	26.4 (0.0-63.0)	10.2 (0.0-30.2)	4.1 (0.5-07.7)	24.8 (0.0-59.3)	7.1 (0.0-21.1)	7.5 (5.6-09.5)	7.8 (0.0-23.0)	0.0 -	7.3 (5.6-09.1)
Total	15.5 (0.3-30.7)	23.3 (6.0-40.6)	27.4 (14.7-40.0)	24.0 (19.6-28.5)	34.8 (19.2-50.5)	37.2 (22.6-51.7)	18.3 (16.5-20.0)	35.5 (19.9-51.1)	36.4 (19.6-53.3)	20.7 (19.1-22.3)

Source: Electronic Death Registry System.
Rates are per 100,000 population, provided by the state demographer, vintage 2019.

Table 10. Mental Health-Related Deaths Age-Adjusted Rates by Coalition, Nevada Residents, 2019.

Coalition	White non-Hispanic	Black non-Hispanic	Native American/ Alaskan Native	Asian/Pacific Islander	Hispanic	Total
Churchill Community Coalition (CCC)	91.0 (56.0-125.9)	0.0 -	0.0 -	72.1 (0.0-213.5)	113.0 (0.0-334.6)	91.0 (57.9-124.1)
Frontier Community Coalition (FCC)	65.5 (32.4-98.7)	0.0 -	0.0 -	0.0 -	29.4 (0.0-87.2)	56.8 (28.9-84.6)
Healthy Communities Coalition (HCC)	71.3 (52.9-89.6)	178.0 (0.0-527.0)	145.5 (2.9-288.2)	0.0 -	26.7 (0.0-63.7)	72.5 (54.9-90.2)
Join Together Northern Nevada (JTNN)	77.1 (68.0-86.1)	55.6 (0.0-118.6)	60.8 (1.2-120.3)	42.0 (16.0-68.1)	35.1 (15.2-54.9)	71.7 (63.7-79.7)
Nye Communities Coalition (NCC)	37.0 (24.9-49.0)	81.6 (0.0-241.6)	0.0 -	95.4 (0.0-227.5)	19.8 (0.0-58.6)	38.0 (26.4-49.6)
Partners Allied for Community Excellence (PACE)	14.1 (6.7-21.6)	0.0 -	0.0 -	0.0 -	37.4 (0.0-89.2)	15.1 (7.7-22.4)
PACT Coalition for Safe and Drug Free Communities/CARE	45.5 (41.9-49.1)	51.1 (40.1-62.1)	15.3 (0.0-45.3)	27.1 (20.0-34.3)	26.1 (19.3-32.8)	42.0 (39.1-44.9)
Partnership Carson City (PCC)	114.8 (92.3-137.2)	0.0 -	76.3 (0.0-225.8)	134.4 (0.0-397.8)	0.0 -	109.7 (88.5-130.9)
Partnership Douglas County (PDC)	58.2 (41.6-74.9)	0.0 -	0.0 -	0.0 -	0.0 -	51.8 (37.0-66.6)
Nevada	55.1 (51.9-58.2)	52.3 (41.4-63.1)	33.1 (12.6-53.6)	29.5 (22.5-36.4)	26.5 (20.6-32.5)	50.1 (47.5-52.7)

Source: Electronic Death Registry System.

Rates are per 100,000 age-specific population, provided by the state demographer, vintage 2019.

Table 11a. Drug-Related Emergency Department Encounters Age-Adjusted Rates by Drug Type and Year, Nevada Residents, 2010-2019.

Year	Opioids	Heroin	Marijuana/ Hallucinogens	Cocaine	Methamphetamines	Marijuana	Hallucinogens
2010	106.6 (102.7-110.5)	5.3 (4.5-6.2)	92.9 (89.3-96.6)	57.8 (55.0-60.7)	106.4 (102.5-110.4)	- -	- -
2011	114.0 (110.0-118.0)	6.6 (5.6-7.5)	97.6 (93.9-101.4)	56.2 (53.4-59.0)	56.2 (111.7-119.8)	- -	- -
2012	122.0 (117.9-126.1)	6.1 (5.2-7.1)	105.9 (102.0-109.8)	49.2 (46.6-51.9)	129.3 (125.0-133.7)	- -	- -
2013	141.7 (137.3-146.1)	6.4 (5.4-7.3)	179.2 (174.2-184.2)	49.6 (47.0-52.2)	184.4 (179.3-189.5)	- -	- -
2014	154.0 (149.5-158.5)	8.8 (7.7-9.9)	230.1 (224.5-235.7)	43.3 (40.9-45.7)	211.1 (205.7-216.5)	- -	- -
2015	189.4 (184.4-194.4)	12.3 (11.1-13.6)	261.8 (255.9-267.8)	57.8 (55.0-60.5)	293.3 (287.0-299.6)	97.7 (94.1-101.4)	2.1 (1.5-2.6)
2016	245.0 (239.4-250.6)	12.6 (11.3-13.8)	- -	67.5 (64.5-70.4)	403.4 (396.1-410.7)	451.2 (443.5-458.9)	9.0 (7.9-10.1)
2017	231.5 (226.1-236.9)	11.8 (10.6-13.0)	- -	71.6 (68.5-74.6)	406.3 (399.0-413.6)	431.0 (423.5-438.5)	12.7 (11.4-14.0)
2018	207.4 (202.3-212.5)	10.1 (9.0-11.2)	- -	78.6 (75.5-81.8)	463.0 (455.3-470.8)	401.1 (393.9-408.2)	16.3 (14.8-17.7)
2019	200.1 (195.1-205.0)	10.4 (9.3-11.5)	- -	70.7 (67.7-73.6)	489.1 (481.2-496.9)	382.7 (375.8-389.6)	19.9 (18.3-21.5)

Source: Hospital Emergency Department Billing. Categories are not mutually exclusive.
Rates are per 100,000 age-specific population, provided by the state demographer, vintage 2019.

Table 11b. Drug-Related Emergency Department Encounters Crude Rates by Drug Type and Year, Nevada Residents, 2010-2019.

Year	Opioids	Heroin	Marijuana/ Hallucinogens	Cocaine	Methamphetamines	Marijuana	Hallucinogens
2010	107.6 (103.7-111.5)	5.3 (4.5-6.2)	91.4 (87.8-95.0)	57.8 (54.9-60.6)	104.3 (100.5-108.2)	- -	- -
2011	115.0 (111.0-119.0)	6.5 (5.6-7.5)	96.1 (92.4-99.8)	56.1 (53.3-59.0)	113.2 (121.9-130.3)	- -	- -
2012	123.5 (119.4-127.7)	6.0 (5.1-7.0)	104.0 (100.2-107.8)	49.2 (46.6-51.9)	126.1 (121.9-130.3)	- -	- -
2013	142.9 (138.5-147.3)	6.3 (5.4-180.7)	175.8 (170.9-180.7)	50.1 (47.5-52.7)	179.5 (174.5-184.4)	- -	- -
2014	156.2 (151.6-160.7)	8.7 (7.6-9.8)	226.6 (221.1-232.1)	43.6 (41.2-46.0)	205.3 (200.0-210.5)	- -	- -
2015	191.9 (186.8-196.9)	12.2 (10.9-13.5)	258.9 (253.0-264.7)	58.8 (56.0-61.6)	285.5 (279.3-291.6)	96.2 (92.6-99.8)	2.0 (1.5-2.5)
2016	249.3 (243.6-255.0)	13.1 (11.8-14.4)	- -	67.9 (64.9-70.8)	394.0 (386.8-401.1)	446.3 (438.7-454.0)	8.74 (7.7-9.8)
2017	235.4 (229.9-240.9)	12.4 (11.1-13.7)	- -	72.3 (69.2-75.3)	395.4 (388.3-402.5)	426.0 (418.6-433.4)	12.3 (11.1-13.6)
2018	212.0 (206.8-217.2)	10.3 (9.2-11.5)	- -	79.5 (76.3-82.7)	450.7 (443.1-458.2)	395.5 (388.4-402.6)	15.73 (14.3-17.1)
2019	200.1 (195.1-205.0)	10.4 (-9.3-11.5)	- -	70.7 (67.7-73.6)	489.1 (481.2-496.9)	382.7 (375.8-389.6)	19.9 (18.3-21.5)

Source: Hospital Emergency Department Billing.
Rates are per 100,000 population, provided by the state demographer, vintage 2019.
Categories are not mutually exclusive.

Table 12a. Drug-Related Emergency Department Encounters Age-Adjusted Rates by Drug Type and Coalition, Nevada Residents, 2019.

Coalition	Opioids	Heroin	Cocaine	Methamphetamines	Marijuana	Hallucinogens
Churchill Community Coalition (CCC)	158.9 (110.3-207.5)	11.0 (0.0-23.4)	11.6 (0.0-27.7)	265.4 (199.9-331.0)	176.6 (126.1-227.1)	0.0 -
Frontier Community Coalition (FCC)	145.5 (103.4-187.5)	23.3 (8.1-38.6)	13.9 (0.3-27.5)	242.5 (186.5-298.5)	276.4 (216.9-335.9)	10.0 (0.0-21.2)
Healthy Communities Coalition (HCC)	168.1 (137.9-198.3)	10.6 (2.7-18.4)	30.0 (16.1-43.8)	278.0 (235.5-320.6)	440.7 (387.5-493.9)	3.2 (0.0-7.6)
Join Together Northern Nevada (JTNN)	236.2 (222.3-250.1)	18.3 (14.4-22.2)	38.5 (32.9-44.1)	525.1 (503.9-546.2)	240.5 (226.4-254.6)	7.7 (5.1-10.2)
Nye Communities Coalition (NCC)	249.0 (206.8-291.1)	20.5 (9.8-31.2)	19.4 (7.4-31.5)	414.2 (355.9-472.5)	254.5 (209.1-299.8)	9.1 (0.2-18.1)
Partners Allied for Community Excellence (PACE)	133.3 (105.9-160.7)	3.7 (0.0-8.0)	29.7 (16.0-43.4)	274.5 (234.2-314.9)	734.6 (668.9-800.4)	10.4 (2.1-18.6)
PACT Coalition for Safe and Drug Free Communities/CARE	196.5 (190.8-202.2)	8.6 (7.4-9.8)	83.6 (79.9-87.3)	507.7 (498.4-517.0)	390.3 (382.2-398.4)	24.0 (21.9-26.0)
Partnership Carson City (PCC)	227.4 (188.9-265.9)	6.8 (0.8-12.7)	43.6 (25.4-61.9)	427.1 (370.9-483.2)	1,035.3 (947.2-1,123.5)	7.6 (0.2-15.1)
Partnership Douglas County (PDC)	135.1 (101.2-169.0)	6.2 (0.0-13.2)	27.0 (9.3-44.6)	133.3 (99.3-167.4)	496.6 (430.5-562.6)	0.0 -
Nevada	200.1 (195.1-205.0)	10.4 (9.3-11.5)	70.7 (67.7-73.6)	489.1 (481.2-496.9)	382.7 (375.8-389.6)	19.9 (18.3-21.5)

Source: Hospital Emergency Department Billing.
Rates are per 100,000 age-specific population, provided by the state demographer, vintage 2019.
Categories are not mutually exclusive.

Table 12b. Drug-Related Emergency Department Encounters Crude Rates by Drug Type and Coalition, Nevada Residents, 2019.

Coalition	Opioids	Heroin	Cocaine	Methamphetamines	Marijuana	Hallucinogens
Churchill Community Coalition (CCC)	158.9 (110.3-207.5)	11.6 (0.0-24.8)	7.8 (0.0-18.5)	244.2 (183.9-304.5)	182.2 (130.1-234.2)	0.0 -
Frontier Community Coalition (FCC)	153.4 (109.0-197.7)	30.0 (10.4-49.6)	13.3 (0.3-26.4)	240.0 (184.6-295.5)	276.7 (217.2-336.3)	10.0 (0.0-21.3)
Healthy Communities Coalition (HCC)	180.9 (148.4-213.4)	10.6 (2.8-18.5)	27.4 (14.7-40.0)	249.3 (211.1-287.4)	401.2 (352.8-449.6)	3.0 (0.0-7.3)
Join Together Northern Nevada (JTNN)	236.6 (222.7-250.5)	18.3 (14.4-22.2)	38.5 (32.9-44.1)	504.7 (484.4-525.0)	237.5 (223.5-251.4)	7.4 (5.0-9.9)
Nye Communities Coalition (NCC)	245.5 (203.9-287.1)	25.6 (12.2-39.1)	18.3 (7.0-29.7)	355.4 (305.4-405.4)	221.7 (182.2-261.2)	7.3 (0.1-14.5)
Partners Allied for Community Excellence (PACE)	135.3 (107.5-163.1)	4.5 (0.0-9.5)	26.8 (14.4-39.1)	264.6 (225.8-303.5)	713.6 (649.8-777.5)	8.9 (1.8-16.1)
PACT Coalition for Safe and Drug Free Communities/CARE	200.9 (195.1-206.7)	8.9 (7.6-10.1)	85.9 (82.1-89.7)	501.8 (492.6-511.0)	389.3 (381.2-397.4)	23.6 (21.6-25.6)
Partnership Carson City (PCC)	237.9 (197.6-278.2)	8.9 (1.1-16.7)	39.1 (22.7-55.4)	394.2 (342.3-446.0)	941.0 (860.9-1,021.2)	7.1 (0.1-14.1)
Partnership Douglas County (PDC)	123.4 (92.5-154.4)	6.1 (0.0-12.9)	18.2 (6.3-30.1)	119.4 (88.9-149.9)	439.1 (380.7-497.5)	0.0 -
Nevada	204.0 (199.0-209.1)	10.7 (9.6-11.9)	71.8 (68.9-74.8)	477.4 (469.7-485.1)	378.9 (372.1-385.8)	19.2 (17.7-20.8)

Source: Hospital Emergency Department Billing.
Rates are per 100,000 population, provided by the state demographer, vintage 2019.
Categories are not mutually exclusive.

Table 13a. Drug-Related Inpatient Admissions Age-Adjusted Rates by Drug Type and Year, Nevada Residents, 2010-2019.

Year	Opioids	Heroin	Marijuana/Hallucinogens	Cocaine	Methamphetamines	Marijuana	Hallucinogens
2010	154.2 (149.6-158.9)	2.5 (1.9-3.1)	110.8 (106.8-114.8)	54.6 (51.8-57.3)	79.8 (76.5-83.2)	- -	- -
2011	155.1 (150.5-159.7)	2.3 (1.7-2.9)	118.9 (114.8-123.0)	49.7 (47.1-52.3)	49.7 (85.2-92.3)	- -	- -
2012	163.6 (158.9-168.3)	1.9 (1.4-2.4)	137.4 (133.0-141.8)	46.1 (43.6-48.5)	105.5 (101.7-109.3)	- -	- -
2013	160.2 (155.6-164.7)	3.1 (2.5-3.8)	145.3 (140.8-149.7)	49.5 (46.9-52.0)	126.7 (122.6-130.9)	- -	- -
2014	175.0 (170.2-179.7)	2.4 (1.9-3.0)	151.4 (146.9-155.9)	48.4 (45.9-50.8)	140.8 (136.5-145.2)	- -	- -
2015	226.7 (221.3-232.1)	5.4 (4.6-6.3)	175.7 (170.9-180.5)	62.8 (59.9-65.6)	226.5 (221.0-232.0)	56.5 (53.8-59.2)	1.2 (.8-1.6)
2016	281.8 (275.9-287.8)	12.9 (11.6-14.1)	- -	62.1 (59.3-64.9)	277.6 (271.6-283.7)	282.2 (276.2-288.2)	4.8 (4.0-5.6)
2017	278.1 (272.3-284.0)	12.3 (11.1-13.5)	- -	62.1 (59.3-64.9)	316.7 (310.3-323.1)	342.4 (335.8-349.0)	5.5 (4.6-6.3)
2018	300.1 (294.1-306.1)	12.3 (11.1-13.5)	- -	73.7 (70.7-76.6)	393.9 (386.8-401.0)	443.0 (435.6-450.4)	6.7 (5.8-7.7)
2019	293.9 (288.0-299.7)	10.3 (9.3-11.4)	- -	76.0 (73.0-79.0)	401.7 (394.7-408.8)	470.6 (463.1-478.2)	7.3 (6.3-8.2)

Source: Hospital Inpatient Billing.
Rates are per 100,000 age-specific population, provided by the state demographer, vintage 2019.
Categories are not mutually exclusive.

Table 13b. Drug-Related Inpatient Admissions Crude Rates by Drug Type and Year, Nevada Residents, 2010-2019.

Year	Opioids	Heroin	Marijuana/Hallucinogens	Cocaine	Methamphetamines	Marijuana	Hallucinogens
2010	158.3 (153.5-163.0)	2.6 (2.0-3.2)	110.7 (106.7-114.7)	56.2 (53.4-59.0)	79.6 (76.3-83.0)	- -	- -
2011	159.4 (154.7-164.2)	2.3 (1.7-2.9)	119.0 (114.9-123.1)	51.5 (48.8-54.2)	88.7 (101.9-109.6)	- -	- -
2012	169.9 (165.0-174.7)	1.9 (1.4-2.4)	137.4 (133.0-141.8)	48.4 (45.8-51.0)	105.8 (101.9-109.6)	- -	- -
2013	167.4 (162.6-172.2)	3.1 (2.4-149.5)	145.1 (140.6-149.5)	52.0 (49.3-54.7)	126.6 (122.4-130.7)	- -	- -
2014	183.1 (178.1-188.1)	2.4 (1.9-3.0)	152.3 (147.8-156.8)	51.3 (48.6-53.9)	141.0 (136.7-145.4)	- -	- -
2015	234.5 (229.0-240.1)	5.8 (4.9-6.6)	176.2 (171.3-181.0)	65.2 (62.2-68.1)	223.4 (218.0-228.9)	56.9 (54.2-59.7)	1.2 (.8-1.6)
2016	293.2 (287.0-299.4)	14.0 (12.6-15.3)	- -	63.8 (60.9-66.7)	274.9 (268.9-280.9)	285.5 (279.4-291.6)	4.67 (3.9-5.5)
2017	291.6 (285.5-297.7)	13.5 (12.2-14.8)	- -	65.3 (62.4-68.2)	313.5 (307.1-319.8)	348.1 (341.5-354.8)	5.4 (4.5-6.2)
2018	316.3 (310.0-322.7)	13.4 (12.1-14.7)	- -	77.5 (74.4-80.6)	390.7 (383.7-397.8)	451.3 (443.7-458.9)	6.60 (5.7-7.5)
2019	310.1 (303.9-316.3)	11.4 (10.2-12.6)	- -	80.6 (77.4-83.7)	401.8 (394.7-408.8)	479.9 (472.2-487.7)	7.2 (6.2-8.1)

Source: Hospital Inpatient Billing.
Rates are per 100,000 population, provided by the state demographer, vintage 2019.
Categories are not mutually exclusive.

Table 14a. Drug-Related Inpatient Admissions Age-Adjusted Rates by Drug Type and Coalition, Nevada Residents, 2019.

Coalition	Opioids	Heroin	Cocaine	Methamphetamines	Marijuana	Hallucinogens
Churchill Community Coalition (CCC)	254.9 (194.7-315.0)	6.6 (0.0-15.7)	12.8 (0.0-27.3)	330.6 (259.9-401.3)	406.0 (327.2-484.7)	5.8 (0.0-17.2)
Frontier Community Coalition (FCC)	150.6 (107.6-193.7)	8.7 (0.0-18.6)	16.8 (0.3-33.3)	208.0 (155.8-260.2)	233.1 (179.3-287.0)	7.6 (0.0-18.1)
Healthy Communities Coalition (HCC)	403.3 (357.6-449.1)	9.9 (4.0-15.8)	27.7 (14.5-40.9)	367.4 (318.5-416.3)	481.2 (426.8-535.5)	3.4 (0.0-8.0)
Join Together Northern Nevada (JTNN)	387.9 (370.4-405.3)	16.6 (13.0-20.2)	50.3 (43.8-56.8)	502.3 (481.8-522.9)	438.6 (419.8-457.4)	5.1 (3.0-7.2)
Nye Communities Coalition (NCC)	166.2 (134.8-197.5)	8.5 (1.0-15.9)	21.4 (9.8-33.0)	287.2 (240.3-334.1)	417.4 (364.2-470.7)	3.7 (0.0-8.7)
Partners Allied for Community Excellence (PACE)	108.4 (83.4-133.5)	5.7 (0.1-11.3)	20.9 (9.5-32.2)	193.7 (160.3-227.1)	213.7 (178.3-249.1)	1.4 (0.0-4.2)
PACT Coalition for Safe and Drug Free Communities/CARE	275.2 (268.6-281.9)	9.6 (8.3-10.8)	89.5 (85.8-93.3)	393.8 (385.7-401.9)	486.3 (477.4-495.2)	7.9 (6.8-9.1)
Partnership Carson City (PCC)	583.8 (524.5-643.2)	10.7 (1.3-20.1)	38.1 (21.8-54.3)	634.6 (564.8-704.5)	770.9 (696.5-845.4)	18.8 (5.8-31.8)
Partnership Douglas County (PDC)	290.9 (244.5-337.3)	7.5 (0.1-14.8)	25.4 (8.8-42.0)	222.3 (176.1-268.5)	358.9 (302.1-415.8)	2.5 (0.0-7.5)
Nevada	293.9 (288.0-299.7)	10.3 (9.3-11.4)	76.0 (73.0-79.0)	401.7 (394.7-408.8)	470.6 (463.1-478.2)	7.3 (6.3-8.2)

Source: Hospital Inpatient Billing.
Rates are per 100,000 age-specific population, provided by the state demographer, vintage 2019.
Categories are not mutually exclusive.

Table 14b. Drug-Related Inpatient Admissions Crude Rates by Drug Type and Coalition, Nevada Residents, 2019.

Coalition	Opioids	Heroin	Cocaine	Methamphetamines	Marijuana	Hallucinogens
Churchill Community Coalition (CCC)	267.4 (204.3-330.5)	7.8 (.0-18.5)	11.6 (.0-24.8)	325.6 (255.9-395.2)	395.3 (318.6-472.0)	3.9 (.0-11.5)
Frontier Community Coalition (FCC)	156.7 (111.9-201.5)	10.0 (.0-21.3)	13.3 (.3-26.4)	203.4 (152.3-254.4)	240.0 (184.6-295.5)	6.7 (.0-15.9)
Healthy Communities Coalition (HCC)	452.9 (401.5-504.3)	16.7 (6.8-26.6)	25.8 (13.6-38.1)	329.8 (285.9-373.7)	457.5 (405.8-509.1)	3.0 (.0-7.3)
Join Together Northern Nevada (JTNN)	403.0 (384.9-421.2)	17.4 (13.7-21.2)	49.4 (43.0-55.7)	488.5 (468.6-508.5)	446.2 (427.1-465.3)	4.9 (2.9-6.9)
Nye Communities Coalition (NCC)	197.9 (160.5-235.2)	9.2 (1.1-17.2)	23.8 (10.9-36.8)	263.8 (220.7-306.9)	432.4 (377.2-487.5)	3.7 (.0-8.7)
Partners Allied for Community Excellence (PACE)	107.0 (82.3-131.8)	5.9 (.1-11.8)	19.3 (8.8-29.8)	191.8 (158.7-224.9)	208.1 (173.7-242.6)	1.5 (.0-4.4)
PACT Coalition for Safe and Drug Free Communities/CARE	288.8 (281.8-295.8)	10.4 (9.1-11.7)	95.7 (91.7-99.7)	398.9 (390.7-407.1)	497.8 (488.7-507.0)	8.0 (6.8-9.1)
Partnership Carson City (PCC)	660.5 (593.4-727.6)	8.9 (1.1-16.7)	37.3 (21.3-53.2)	562.8 (500.9-624.8)	731.5 (660.9-802.2)	14.2 (4.4-24.0)
Partnership Douglas County (PDC)	305.6 (256.8-354.3)	8.1 (.2-16.0)	18.2 (6.3-30.1)	180.1 (142.7-217.5)	309.6 (260.5-358.7)	2.0 (.0-6.0)
Nevada	310.1 (303.9-316.3)	11.4 (10.2-12.6)	80.6 (77.4-83.7)	401.8 (394.7-408.8)	479.9 (472.2-487.7)	7.2 (6.2-8.1)

Source: Hospital Inpatient Billing.
Rates are per 100,000 population, provided by the state demographer, vintage 2019.
Categories are not mutually exclusive.

Table 15. Drug- and Alcohol-Related Age-Adjusted Death Rates by Race/Ethnicity and Coalition, Nevada Residents, 2019.

Coalition	White non-Hispanic	Black non-Hispanic	Native American/ Alaskan Native	Asian/ Pacific Islander	Hispanic	Total
Churchill Community Coalition (CCC)	68.8 (36.1-101.5)	0.0 -	340.6 (42.0-639.1)	0.0 -	153.6 (0.0-327.4)	89.6 (54.5-124.7)
Frontier Community Coalition (FCC)	92.4 (50.8-133.9)	0.0 -	175.7 (0.0-374.6)	0.0 -	0.0 -	72.8 (42.4-103.3)
Healthy Communities Coalition (HCC)	67.2 (47.1-87.3)	150.7 (0.0-446.1)	224.3 (27.7-420.9)	0.0 -	48.9 (6.0-91.8)	72.7 (53.3-92.1)
Join Together Northern Nevada (JTNN)	78.9 (69.7-88.1)	131.9 (65.1-198.6)	90.3 (23.4-157.2)	14.0 (1.7-26.2)	37.6 (24.8-50.5)	67.0 (59.9-74.0)
Nye Communities Coalition (NCC)	55.5 (37.6-73.4)	0.0 -	90.7 (0.0-268.4)	0.0 -	20.6 (0.0-61.1)	48.3 (33.1-63.5)
Partners Allied for Community Excellence (PACE)	33.9 (19.4-48.4)	0.0 -	0.0 -	0.0 -	18.2 (0.0-38.8)	29.4 (17.6-41.1)
PACT Coalition for Safe and Drug Free Communities/CARE	57.4 (53.3-61.6)	48.5 (39.9-57.0)	60.2 (22.9-97.5)	16.0 (11.2-20.7)	29.6 (25.2-34.0)	44.5 (41.8-47.1)
Partnership Carson City (PCC)	92.6 (68.3-116.8)	113.5 (0.0-336.0)	194.7 (3.9-385.4)	82.4 (0.0-243.9)	17.5 (0.0-41.7)	86.0 (65.1-106.9)
Partnership Douglas County (PDC)	43.4 (26.7-60.0)	0.0 -	0.0 -	0.0 -	0.0 -	35.6 (21.9-49.2)
Nevada	62.7 (59.2-66.2)	52.2 (43.7-60.8)	89.8 (60.1-119.6)	15.8 (11.4-20.2)	30.3 (26.3-34.3)	49.9 (47.5-52.3)

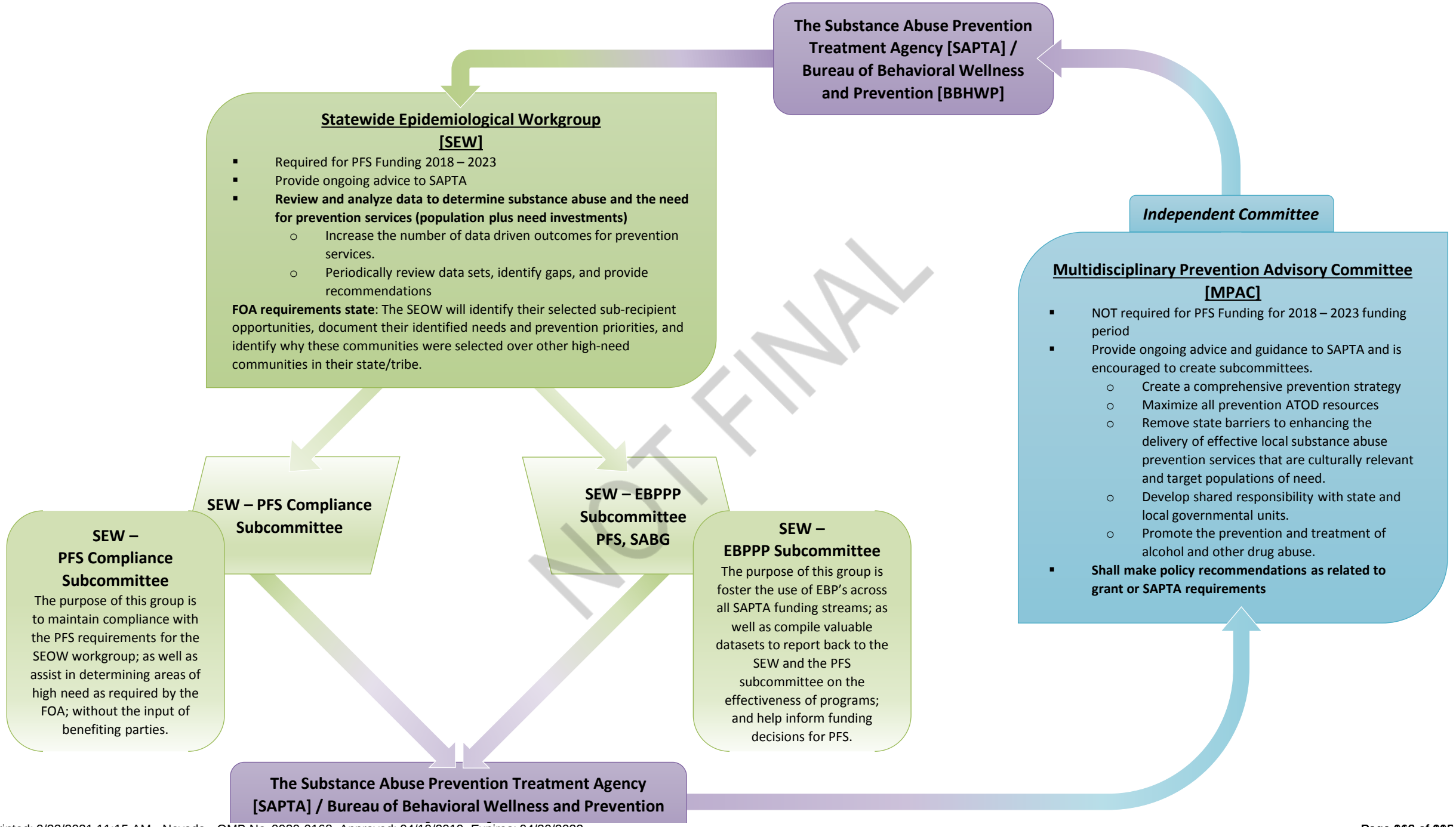
Source: Electronic Death Registry System.

Rates are per 100,000 age-specific population, provided by the state demographer, vintage 2019.

Table 16. The State of Mental Health in America 2020, Nevada Summary

Category	Previous Rankings (2016-2017)	Current Rankings	Percent (%) Change	Nevada	US
Overall Ranking	51	51	0%		
Adult Rankings	47	42	-11%		
Adults with Any Mental Illness (AMI)^	24	36	50%	20.7	19.0
Adults with Substance Use Disorder in the Past Year^	33	40	21%	9.0	7.7
Adults with Serious Thoughts of Suicide^	36	26	-28%	4.7	4.3
Adults with AMI who Did Not Receive Treatment~	47	44	-6%	60.3	57.0
Adults with AmI Reporting Unmet Need~	49	39	-20%	26.1	23.6
Adults with AMI who are Uninsured~	34	31	-9%	10.5	10.8
Adults with Cognitive Disability who Could Not See a Doctor Due to Costs~	34	18	-47%	25.6	28.7
Youth Rankings	51	51	0%		
Youth with At Least One Major Depressive Episode (MDE) in the Past Year^	47	39	-17%	15.1	13.8
Youth with Substance Use Disorder in the Past Year^	43	47	9%	5.1	3.8
Youth with Severe MDE^	51	39	-24%	11.8	9.7
Youth with MDE who Did Not Receive Menth Health Services~	36	51	42%	71.0	59.6
Youth with Severe MDE who Received Some Consisten Treatment~	46	51	11%	11.2	27.3
Childern with Private Insurance that Did Not Cover Mental or Emotional Problems~	49	45	-8%	12.6	7.8
Students Identified with Emotional Disturbance for an Individualized Education Program~	43	43	0%	4.4	7.6
Access to Care Rankings (made up of indicators listed abover and below, marked with ^)	51	49	-4%		
Mental Health Workforce Availablitity~	33	32	-3%	-	-
Prevalence of Mental Illness (made up of indicators listed above, marked with ~)	45	43	-4%	-	-

Source: Mental Health in America 2020.


The Substance Abuse Prevention Treatment Agency [SAPTA] / Bureau of Behavioral Wellness and Prevention [BBHWP]
Statewide Epidemiological Workgroup [SEW]
Required for PFS Funding 2018 – 2023
Provide ongoing advice to SAPTA
Review and analyze data to determine substance abuse and the need for prevention services (population plus need investments)
Increase the number of data driven outcomes for prevention services.
Periodically review data sets, identify gaps, and provide recommendations
FOA requirements state: The SEOW will identify their selected sub-recipient opportunities, document their identified needs and prevention priorities, and identify why these communities were selected over other high-need communities in their state/tribe.
Independent Committee
Multidisciplinary Prevention Advisory Committee [MPAC]
NOT required for PFS Funding for 2018 – 2023 funding period
Provide ongoing advice and guidance to SAPTA and is encouraged to create subcommittees.
Create a comprehensive prevention strategy
Maximize all prevention ATOD resources
Remove state barriers to enhancing the delivery of effective local substance abuse prevention services that are culturally relevant and target populations of need.
Develop shared responsibility with state and local governmental units.
Promote the prevention and treatment of alcohol and other drug abuse.
Shall make policy recommendations as related to grant or SAPTA requirements
SEW – PFS Compliance Subcommittee
SEW – EBPPP Subcommittee PFS, SABG
SEW – PFS Compliance Subcommittee
The purpose of this group is to maintain compliance with the PFS requirements for the SEOW workgroup; as well as assist in determining areas of high need as required by the FOA; without the input of benefiting parties.
SEW – EBPPP Subcommittee
The purpose of this group is foster the use of EBP's across all SAPTA funding streams; as well as compile valuable datasets to report back to the SEW and the PFS subcommittee on the effectiveness of programs; and help inform funding decisions for PFS.
The Substance Abuse Prevention Treatment Agency [SAPTA] / Bureau of Behavioral Wellness and Prevention
NOT FINAL

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	(•) Yes ( ) No
ii)	Education	(•) Yes ( ) No
iii)	Brief Intervention	(•) Yes ( ) No
iv)	Assessment	(•) Yes ( ) No
v)	Detox (inpatient/social)	(•) Yes ( ) No
vi)	Outpatient	(•) Yes ( ) No
vii)	Intensive Outpatient	(•) Yes ( ) No
viii)	Inpatient/Residential	(•) Yes ( ) No
ix)	Aftercare; Recovery support	(•) Yes ( ) No

b) Services for special populations:

Targeted services for veterans?	(•) Yes ( ) No
Adolescents?	(•) Yes ( ) No
Other Adults?	(•) Yes ( ) No
Medication-Assisted Treatment (MAT)?	(•) Yes ( ) No

Criterion 2: Improving Access and Addressing Primary Prevention -See Narrative 8. Primary Prevention-Required SABG.

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? (●) Yes ( ) No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (●) Yes ( ) No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (●) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? (●) Yes ( ) No

5 Has your state identified a need for any of the following:

a) Open assessment and intake scheduling (●) Yes ( ) No

b) Establishment of an electronic system to identify available treatment slots (●) Yes ( ) No

c) Expanded community network for supportive services and healthcare (●) Yes ( ) No

d) Inclusion of recovery support services (●) Yes ( ) No

e) Health navigators to assist clients with community linkages (●) Yes ( ) No

f) Expanded capability for family services, relationship restoration, and custody issues? (●) Yes ( ) No

g) Providing employment assistance (●) Yes ( ) No

h) Providing transportation to and from services (●) Yes ( ) No

i) Educational assistance (●) Yes ( ) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Nevada actively works with treatment providers to ensure the PWWDC population is prioritized for services and to ensure that required set aside is applied to the population. The Program Officer for the program reviews the monthly report of activity in alignment with the funding allocation to ensure that all activities are targeted to the community of focus, and are allowable, within the original scope and eligible activities. In addition, the utilizes on-site and desk monitoring to ensure compliance with all activities aligned under the strategic plan to support the PWWDC population. This includes reviewing the program income and grant dollars are supplementing and not supplanting. Nevada also works to review the required data reporting to review the number of individuals supported by agency and the census of the program to ensure consistency.

Nevaa also utilizes treatment referrals through Open Beds. Open Beds is a web-based referral and bed monitoring system that is used by hospitals and treatment providers to ensure a streamlined referral into treatment. Nevada monitors waitlists for all funded providers to ensure the PWWDC population is prioritized for treatment and/or referred to an appropriate provider.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

a)	90 percent capacity reporting requirement	(•) Yes ( ) No
b)	14-120 day performance requirement with provision of interim services	(•) Yes ( ) No
c)	Outreach activities	(•) Yes ( ) No
d)	Syringe services programs, if applicable	(•) Yes ( ) No
e)	Monitoring requirements as outlined in the authorizing statute and implementing regulation	(•) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Electronic system with alert when 90 percent capacity is reached	(•) Yes ( ) No
b)	Automatic reminder system associated with 14-120 day performance requirement	(•) Yes ( ) No
c)	Use of peer recovery supports to maintain contact and support	(•) Yes ( ) No
d)	Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)?	(•) Yes ( ) No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The Division of Public and Behavioral Health, Bureau of Behavioral Health Wellness and Prevention (Bureau) policy requires funded substance use treatment providers to report to the Bureau within one day when any level of service to admit individuals to the program reaches 90% capacity or greater. Although per 45 CFR [§ 96.126 (a)], the requirement to report exceeding the 90% capacity to the State is seven days for programs that receive block grant funds and treat persons who inject drugs, the Bureau is requiring this reporting within one-day for all substance use services to better serve the public and expedite access to services for those in need, including pregnant women seeking substance use services per 45 CFR § 96.131 (c).

For PWID provider must:
a. Provide immediate services, and if unable to do so, the provider must contact the Bureau immediately to notify the Bureau of the need for client placement. If available resources are known, the provider may refer the client to an alternate provider but must also contact the program officer assigned by the Bureau for the program. The Bureau works to ensure that appropriate referrals are made, and the client obtains needed services, including interim services as defined in [§ 96.121 (4)].
b. If the Bureau determines that no treatment facility has the capacity to admit the woman, the Bureau may authorize the woman to be placed on a wait list and will work with appropriate providers to make available interim services, including a referral for prenatal care, available to the woman not later than 48 hours after the woman seeks the treatment services. The woman must receive priority admission as soon as capacity becomes available.
c. If the woman is placed on a wait list, the provider must maintain a mechanism to effectively track, maintain contact with, and report on any individual awaiting admission to treatment in accord with 45 CFR § 96.126(f). The provider must report weekly to the Bureau on contact efforts and assurance that the woman is receiving interim services.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? (•) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Business agreement/MOU with primary healthcare providers	( ) Yes (•) No
b)	Cooperative agreement/MOU with public health entity for testing and treatment	(•) Yes ( ) No
c)	Established co-located SUD professionals within FQHCs	(•) Yes ( ) No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The primary focus of the SAPT TB program is prevention, prevention from exposure to tuberculosis and prevention from activation of latent TB infection into active, communicable TB disease. Individuals with SUD are at an increased risk of exposure to airborne communicable TB disease and subsequent infection with tuberculosis due to congregate situations. Additionally, individuals with SUD are at greater risk for progression of the TB infection into TB disease, associated with weakened immune systems and/or recent TB bacteria infection (individuals with recent with tuberculosis, infection less than two years, are at greatest risk for progression to disease condition). Currently, the DPBH TB SAPT program delivers the necessary TB screening and testing to individuals entering into congregate inpatient SUD treatment facilities.

Nevada reviews the activities below for compliance:
The activities performed by the subrecipients, as established through the approved Scope of Work within the subawards, are to upon admission to the facility provide the clients with the following:
• TB screening (signs and symptoms);
• TB testing using TB blood test (preferred) or TB skin test (2-step procedure);
• Education about TB disease transmission, disease process, and treatment for TB disease and TB infection;
• Direct treatment for identified TB infection or referral for treatment of TB infection;
• Immediate referral to the local health authority TB program for TB disease report, treatment, and case management if active TB disease is suspected.
Additionally, the subrecipients may utilize subaward funds to:
• Conduct TB screening, testing, and education for individuals with substance use disorders not associated with an inpatient SAPT certified facility, as the funding and resources permit;
• Demonstrate the competency of the subrecipient staff associated with TB screening, testing, and education and participate in ongoing human resource development;
• Provide outreach activities of training and education to the staff of the SAPT certified facilities and other agencies serving individuals with substance use disorders (SUD).

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery? ○ Yes ◉ No

2. Has your state identified a need for any of the following:

a) Establishment of EIS-HIV service hubs in rural areas ○ Yes ◉ No

b) Establishment or expansion of tele-health and social media support services ○ Yes ◉ No

c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS ○ Yes ◉ No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)(F)? ◉ Yes ○ No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? ○ Yes ◉ No

3. Do any of the programs use SABG funds to support elements of a Syringe Services Program? ○ Yes ◉ No

If yes, plese provide a brief description of the elements and the arrangement

N/A

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Workforce development efforts to expand service access — (●) Yes ( ) No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — (●) Yes ( ) No
- **c)** Establish a peer recovery support network to assist in filling the gaps — (●) Yes ( ) No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — (●) Yes ( ) No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — (●) Yes ( ) No
- **f)** Explore expansion of services for:
  - **i)** MAT — (●) Yes ( ) No
  - **ii)** Tele-Health — (●) Yes ( ) No
  - **iii)** Social Media Outreach — (●) Yes ( ) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — (●) Yes ( ) No
- **b)** Establish a program to provide trauma-informed care — (●) Yes ( ) No
- **c)** Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — (●) Yes ( ) No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? — ( ) Yes (●) No

2. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — ( ) Yes (●) No
- **b)** An organized referral system to identify alternative providers? — ( ) Yes (●) No
- **c)** A system to maintain a list of referrals made by religious organizations? — ( ) Yes (●) No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Review and update of screening and assessment instruments — (●) Yes ( ) No
- **b)** Review of current levels of care to determine changes or additions — (●) Yes ( ) No
- **c)** Identify workforce needs to expand service capabilities — (●) Yes ( ) No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — (●) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements — ( ) Yes (●) No

b) Training on responding to requests asking for acknowledgement of the presence of clients — ( ) Yes (●) No

c) Updating written procedures which regulate and control access to records — ( ) Yes (●) No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure: — ( ) Yes (●) No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — (●) Yes ( ) No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

One funded provider is randomly selected from each of the three regions, North/South/Rural. An orientation is conducted with the three providers and the Peer Reviewers to discuss the process and expectations both as a Peer Reviewer and as an agency being reviewed.

A Peer Review is conducted by peers from other SAPTA funded agencies. The Center for Application of Substance Use Technology (CASAT) as part of the University of Nevada, Reno and NBHA manage the process by providing orientation, scheduling and support. All reviewers are required to sign a confidentiality statement based on 42 CFR Part 2. The review takes approximately 3-5 hours, which depends on the size of the agency. The review is intended to gain a sense of how the program has incorporated the NIDA 13 Principles and other Evidence-based Practices commonly utilized in the substance use and co-occurring disorder field. Recommendations for enhancement, training or technical assistance will be noted in the final report. Materials to be reviewed include, but are not limited to: policy and procedures manual, organizational chart, personnel records, clinical records, and a visual observation of the overall operations.

Each year, three SAPTA funded agencies from the list will participate in the process for a total of three Peer Reviews annually. All agencies will have a peer review conducted through the process. Peer Review Reports will be presented to the Provider and maintained by Nevada Behavioral Health Association.

3. Has your state identified a need for any of the following:

a) Development of a quality improvement plan — ( ) Yes (●) No

b) Establishment of policies and procedures related to independent peer review — ( ) Yes (●) No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations — (●) Yes ( ) No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — ( ) Yes (●) No

If Yes, please identify the accreditation organization(s)

i) ☐ Commission on the Accreditation of Rehabilitation Facilities

ii) ☐ The Joint Commission

iii) ☐ Other (please specify)

N/A

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ○ Yes ◉ No

2. Has your state identified a need for any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service ○ Yes ◉ No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ○ Yes ◉ No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state ◉ Yes ○ No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services ◉ Yes ○ No

c) Performance-based accountability: ◉ Yes ○ No

d) Data collection and reporting requirements ◉ Yes ○ No

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs ○ Yes ◉ No

b) Addition of training sessions designed to increase employee understanding of recovery support services ○ Yes ◉ No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services ◉ Yes ○ No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort ◉ Yes ○ No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

a) Prevention TTC? ◉ Yes ○ No

b) Mental Health TTC? ◉ Yes ○ No

c) Addiction TTC? ◉ Yes ○ No

d) State Targeted Response TTC? ◉ Yes ○ No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women ○ Yes ◉ No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis ○ Yes ◉ No

b) Early Intervention Services Regarding HIV ○ Yes ◉ No

3. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment ○ Yes ◉ No

b) Professional Development ○ Yes ◉ No

c) Coordination of Various Activities and Services ○ Yes ◉ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

https://www.leg.state.nv.us/nrs/NRS-458.html
https://www.leg.state.nv.us/NAC/NAC-458.html

Footnotes:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2020-FFY 2021? ○ Yes ◉ No

Please indicate areas of technical assistance needed related to this section.

No technical assistance requested at this time.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma [57] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing ?business as usual.? These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[58] paper.

57 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*
58 *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues? (●) Yes ( ) No

2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? (●) Yes ( ) No

3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? (●) Yes ( ) No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? (●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight.

Nevada's Behavioral Health Community Integration Strategic Plan has system goals which include ensuring individuals have access to appropriate, timely services in the most integrated settings based on a self-determination plan. Strategies include providing community based treatment and trauma informed interventions. Certified Community Behavioral Health Clinics provide trauma informed care to individual regardless of ability to pay.

For Youth: The Mobile Crisis Response Team (MCRT) was created to provide crisis intervention and support to Nevada families dealing with a behavioral or mental health crisis.

SAPTA is a strong advocate of prevention, early intervention, treatment and referral in order to have a coordinated system of care. Nevada has been able to initiate and implement the Nevada Resilience Project (NRP) to produce highly trained paraprofessionals who are trained in crisis management; but understand community resources that are needed for individuals in crisis. To date, the NRP has provided services to over 100,000 Nevadans on one-year. In addition, the NRP provided training. In one year, over 1000 community individuals have been able to participate in psychological first aid. Nevada's resilience ambassadors (RA's) fit into our system of care at one of the most integral parts of care. Trainings are as follows:

CCP Immediate Services Program Training
CCP Transition and Mid- Program to Regular Services Training
CCP Phasedown and Anniversary Training
Just in Time Training
CCP Forms and Training
CCP Online Data Collection and Evaluation System
Skills For Psychological Recovery
Psychological Fist Aid
Nevada Office Of Suicide Prevention Training Gatekeepers Workshop
Level 1 Nevada Care Connection Training
Elderly Abuse
Child and Neglect Abuse Training
Health Insurance Portability and Accountability Act & Confidentiality Training

Please indicate areas of technical assistance needed related to this section.

No technical assistance requested at this time.

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13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[59]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[60]
A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

[59] Journal of Research in Crime and Delinquency: *: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.*Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Ren?e L. Binder. **OJJDP Model Programs Guide**

[60] **http://csgjusticecenter.org/mental-health/**

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services? (●) Yes ( ) No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? (●) Yes ( ) No

3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system? (●) Yes ( ) No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? (●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

Nevada has launched several programs to support criminal and juvenile justice deflection and diversion programs for adults and youth who have behavioral health treatment needs. Nevada's youth mobile crisis teams (MCRT) reduce the need for law enforcement involvement when a child or youth is struggling with a behavioral health crisis. In addition, Clark County has developed the Harbor program for youth who need to be connected to care and resources and divert from Juvenile Justice involvement. Similarly, programs such as the Law Enforcement Intervention for Mental Health and Addiction (LIMA) program in Clark County works on justice diversion. The LIMA program is a partnership with the Metropolitan Police Department, the Eighth Judicial District Court and Nevada's Departmentof Health and Human Services to provide a nine to 12 month pre-booking diversion program developed to address low-level drug crimes. They have recently implemented law enforcement teams who provide outreach to homeless adults and offer diversion into care for individuals who have mental health and substance use treatment needs. Through the Division of Welfare and Supportive Services, individuals who are incarcerated can now be connected to eligibility workers to support obtaining benefits such as Medicaid and SNAP. These benefits, in addition to discharge planning to care, support individuals transition into the community from incarceration, The SAPTA and Mental Health team are working collaboratively with Clark County Justice system to blend the crisis now program to those returning citizens

(previously incarcerated) for pre and post diversion. This is focused on those with serious mental illness or co-occurring to have access to mental health screening, triage facilities, mobile crisis teams, FACT teams and other services to allow law enforcement to utilize diversion away from incarceration or emergency rooms for support. Prevention of substance use and misuse of Alcohol, Tobacco and Drug Education training and education continue to be part of the ongoing efforts with criminal and justice system.

Please indicate areas of technical assistance needed related to this section.

No technical assistance requested at this time.

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14. Medication Assisted Treatment - Requested (SABG only)

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], 49 [4], and 63[5].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

TIP 40 - https://www.ncbi.nlm.nih.gov/books/NBK64245/ [ncbi.nlm.nih.gov]

TIP 43 - https://www.ncbi.nlm.nih.gov/books/NBK64164/ [ncbi.nlm.nih.gov]

TIP 45 - https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4131.pdf [store.samhsa.gov]

TIP 49 - https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4380.pdf [store.samhsa.gov]

TIP 63 - https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-006_508.pdf [store.samhsa.gov]

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? (●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds? ( ) Yes (●) No

- **a)** ☐ Methadone
- **b)** ☐ Buprenophine, Buprenorphine/naloxone
- **c)** ☐ Disulfiram
- **d)** ☐ Acamprosate
- **e)** ☐ Naltrexone (oral, IM)
- **f)** ☐ Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? (●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

The State of Nevada Passed Legislation specific to the distribution and administration of naloxone. (NRS 453C.100 Authorization to prescribe, dispense and administer opioid antagonist; immunity from liability and professional discipline.) The legislation outlines the following:
• A pharmacist may, with or without a prescription, furnish naloxone
• A physician may prescribe and dispense naloxone to the person at risk, their family member, friend, or other person in a position to assist

• Community-based agencies can dispense naloxone if those activities are undertaken without charge or compensation
• Any person may possess and administer naloxone who they reasonably believe is experiencing an overdose
Under STR, an agency was funded to provide academic detailing on the co-prescription of naloxone with opioids. They provided materials to 1,586 physicians in 361 physician offices in 12 of 17 counties.

In August 2017, all Data 2000 waivered prescribers were sent a survey surrounding their prescribing of buprenorphine. Among waivered prescribers who responded (39%), none were prescribing at capacity. Providers indicated reasons for not prescribing at capacity and what would increase their willingness to prescribe at capacity. One of the top reported reasons for not prescribing at capacity was insufficient reimbursement rates. This theme also arose in focus groups involving providers conducted in July 2017.

Two media campaigns have been running since April 2019. One is targeting stigma reduction and one target naloxone/Good Samaritan Act. The commercials have aired on TV/radio 27,120 times for a return on investment of 11 to 1.

SOR implemented prevention education services, including training of healthcare professions on the assessment and treatment of OUD, training of peers and first responders on recognition of opioid overdose and appropriate use of opioid overdose antidote naloxone.
• Opioid Prescribing Guidelines:
o Best Practices and Tools for Prescribing Controlled Substances: Three-day course for prescribers who have been identified by the PDMP as top prescribers in the state. Covers personal characteristics which influence current decisions; the different change theories and how they can be incorporated in daily life; apply MI and CBT techniques; burnout and utilize skills to avoid personal burnout; high risk patients and how to use refusal skills; different personality profiles and how to communicate with different personality types; screening tools for depression, anxiety, and co-occurring disorders; apply ethical thought processes and how to implement them; suicide risk and utilizing screening tools for awareness, intervention, and prevention; referral resources to treat the whole patient with a team approach; substance use disorders and addictions in patients; current information regarding controlled substances, use, trends, and resources available; apply tools to screen, assess, and diagnose substance use disorders; Nevada's laws and requirements for prescribing controlled substances including PMP and Controlled Substances Prevention Act; risk prescribing practices and replace them with safe prescribing practices; and personal and professional tools to help the physician and office staff when prescribing drugs
o Evidence-based Pain Prescribing: 30-minute online course on evidence-based pain treatments for commonly encountered musculoskeletal pathologies and factors that can contribute to increased pain perception
o Misuse, Abuse, and Dependence of Controlled Substances: One-hour online course defining misuse, abuse, and dependence; diagnosing substance use disorders; and schedule 1-5 controlled substances.
• Continued Education Efforts specific to the Controlled Substances Prevention Act:
o Back Pain: Diagnosis and Pain Management: 30-minute online course covering differential diagnosis in back pain; common etiologies of back pain by prevalence; common treatments for back pain; and the importance of an exact diagnosis.
o Pain Medicine Update: 45-minute online course on cultural change in approach to pain management; the latest guidelines for pain management in the inpatient and outpatient settings; precautions, concerns for special populations, and psychosocial/addiction issues; and nonpharmacologic pain management strategies.
• Continued Education Efforts on updated legislative language after 2019 legislative session:
o Board of Pharmacy trainings
• Continued Education on MAT:
o MAT and Pain Management Project ECHO Clinics: Offered biweekly. The trainings have addressed a variety of topics, including:
• Mental Health Implications of Pain: Complications that mental health may have in pain management.
• Strategies for Pain Patients: Naloxone, the Good Samaritan Law, MAT, & PMP.
• How to Integrate Behavioral Health in the Primary Care Setting: Defining integrative care, identifying the appropriate model for your agency, and considerations for rural communities.
• Behavioral Health and Available Resources: Prevalence of co-occurring disorders, interaction between behavioral health and MAT, resources within Nevada.
• CDC Guidelines for Opiate Prescribing: Approved medications, matching the appropriate medication to the client, tapering.
• Neuroscience of Addiction: Introduction to the science of addiction.
• Patient Retention and Responding to Behaviors: How to increase patient retention by simplifying the intake process, completing a comprehensive assessment, implementing accountability checks, and leveraging psychosocial and environmental supports.
• Polysubstance Use and Abuse: Prevalence of use, underlying reasons for use, complications from drug interactions, considerations when prescribing MAT.
• Trauma Informed Care: Neuroscience of trauma, defining trauma, the relationship between trauma and substance use, and how to enhance client engagement using a trauma-informed approach.
• Addressing Challenging Client Situations with Cultural Humility: Defining cultural humility, introduction to strategies and treatment approaches consistent with cultural humility and client-centered approaches to care, addressing patient behaviors that conflict with providers' personal perspectives.
• Principles of Harm Reduction: Defining what harm reduction is and utilizing the stages of change within a Harm Reduction model.
• Ethics for Addiction and Other Treatment
• Informed Consent and Treatment Agreements
o Medication Assisted Treatment Opioid Response (MATOR): One-hour online course covering the reasons to implement a MAT program; review the opioid epidemic; screening tools and appropriate levels of care; discuss solutions, Naloxone and MAT

medications; and creating a MAT program and team
o Treatment of Opioid Use Disorder: Use of Naltrexone – Part I: 30-minute online course on the risk reduction in prescribing opioids; discuss how opioids impact the rewards system; opioid use disorder and how to screen it; the mechanism of naltrexone and how to initiate treatment with naltrexone; the naloxone challenge test; and the benefits and risks of naltrexone in the treatment of opioid use disorder
o Treatment of Opioid Use Disorder: Opioid Agonist Medications – Part II: 30-minute online course covering the FDA approved opioid agonist medications for treatment of opioid use disorder; opioid withdrawal management with buprenorphine and methadone; the benefits and risks of buprenorphine and methadone; adjunct medications that may assist in opioid withdrawal management; challenges with MAT using agonist medications; and additional resources for patients clinicians
o The Science and Practice of Treating Pregnant Women with OUD: how stigma affects women's ability to access treatment for OUD while pregnant; the Standard of Care for treatment of pregnant women with OUD; the three medication options available for OUD and the evidence for each treatment in pregnancy; common signs/symptoms of Neonatal Opioid Withdrawal Syndrome (NOWS); the differences between traditional NAS/NOWS treatment and Eat, Sleep, Console methodology; high risk periods for overdose/death related OUD; the role of drug testing while treating pregnant women in their own setting; the role of medications for OUD in women with polysubstance use; and legal/liability concerns related to treating pregnant women with SUD and take steps to minimize this risk
o Tribal MAT: how MAT can assist AI/AN experiencing opioid use disorders; strategies to ensure that MAT are provided in a culturally appropriate manner; the interactions between historical/intergenerational trauma and SUD; historical and cultural considerations in healthcare and behavioral health treatment with AI/AN; and knowledge of traditional healing from historical trauma into care of patients with medical, behavioral, and SUDs

Through the SOR project Perinatal Toolkits were developed in collaboration with Nevada's ASTHO OMNI stakeholders. The toolkits focus on both inpatient and outpatient perinatal and specifically targets physicians. This toolkit introduces best practices and incorporates Screening, Brief Intervention and Referral to Treatment (SBIRT) into the clinical setting. Also discussed are MAT options for pregnant/postpartum women.

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

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15. Crisis Services - Required for MHBG

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.[61] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[62],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

[61] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

[62] Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. **http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427**

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention

- **a)** ☑ Wellness Recovery Action Plan (WRAP) Crisis Planning
- **b)** ☑ Psychiatric Advance Directives
- **c)** ☑ Family Engagement
- **d)** ☑ Safety Planning
- **e)** ☑ Peer-Operated Warm Lines
- **f)** ☐ Peer-Run Crisis Respite Programs
- **g)** ☑ Suicide Prevention

2. Crisis Intervention/Stabilization

- **a)** ☑ Assessment/Triage (Living Room Model)
- **b)** ☑ Open Dialogue
- **c)** ☑ Crisis Residential/Respite
- **d)** ☑ Crisis Intervention Team/Law Enforcement
- **e)** ☑ Mobile Crisis Outreach
- **f)** ☑ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- **a)** ☑ Peer Support/Peer Bridgers
- **b)** ☑ Follow-up Outreach and Support
- **c)** ☑ Family-to-Family Engagement
- **d)** ☑ Connection to care coordination and follow-up clinical care for individuals in crisis
- **e)** ☑ Follow-up crisis engagement with families and involved community members

f) ☑ Recovery community coaches/peer recovery coaches

g) ☑ Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

Crisis Call Center Hub
Assets: The greatest asset in Nevada for Crisis Call Center Hubs is Crisis Support Services of Nevada (CSSNV). It is available to individuals and professional organizations throughout the entire state. CSSNV provides immediate crisis support via numerous technological platforms and can coordinate referrals to other resources and establish connections to other crisis response services, such as Mobile Crisis Teams or Crisis Stabilization Program.
In addition to this statewide service, there are also several local crisis lines available in certain regions. For example, Vitality Unlimited in the Rural Region has a locally operated crisis line that contracts with CSSNV for after-hours crisis calls. There are several examples of this in different counties, and having these lines operating at a local level has proven to be beneficial in being able to bring individuals into other services offered by the agencies operating these local crisis lines. Nevada has one of six National Suicide Prevention Lifeline National Call Centers and the crisis line is experiencing great success deploying resources when necessary and otherwise deescalating people in crisis.

Mobile Crisis
Assets: Similar to the implementation of different crisis call lines, several regions and counties in Nevada have been resourceful in developing different types of mobile outreach units. Various configurations of mobile crisis teams have already been established throughout the state and include law enforcement deflection and diversion programs. There are several examples of units that are connected to hospitals, such as Desert Parkway Behavioral Health in Las Vegas, or law enforcement agencies, such as MOST in Washoe County. These connections between Mobile Crisis Teams and agencies that have the capacity to offer other targeted services can be invaluable to an individual experiencing a crisis. These programs are also facilitating diversion from hospitals and meeting patients where they are at in the community. Children's mobile crisis response is currently being expanded in both northern and southern areas of Nevada through the use of the SAMHSA COVID-19 Emergency Behavioral Health Grant. The close relationship between Mobile Crisis Teams and law enforcement is known to be very effective in de-escalating crisis situations and diverting individuals from held in a jail or emergency department.
For the Mobile Crisis Teams that are in place in Nevada, many are utilizing assessment tools, prioritizing safety and security, and providing connections to other resources for the individuals they serve. These resources are implemented by licensed mental health professionals that are staffed as part of the Mobile Crisis Teams that are in place. The clinical understanding and training that these professionals bring to these teams can be very effective in ensuring the safety and security of everyone involved in responding to a crisis.

Crisis Stabilization Programs
Assets: In more populated areas, there are several options for acute and sub-acute care. In the areas where crisis stabilization programs are easily accessible, there are psychiatric and clinical mental health staff on site to support individuals beyond a crisis. Staff is also provided with adequate training on suicide prevention, trauma-informed care, and safety and security practices for crisis stabilization. These regions also have the infrastructure to support the recommended ratio for the number of beds per 100,000 residents in each area. Community Triage Centers were defined in Nevada Revised Statute in 2005 and provide a different pathway for accessing mental health services, ensuring stabilization within a community setting without first accessing a hospital. These centers were funded creatively, including resources from both state and local sources. Currently, there are three Triage Centers operating in Nevada (two in Las Vegas, and one in Reno). With the additional funding obtained through the SAMHSA COVID-19 Emergency Behavioral Health Grant, two hospitals are expanding to provide this crisis stabilization as an alternative to an emergency department for individuals in crisis (Desert Parkway Behavioral Healthcare Hospital in Las Vegas, and Reno Behavioral Healthcare Hospital in Reno). Crisis Stabilization Programs are intended to provide more than just a bed to individuals, and instead offer a welcoming environment to provide compassionate care that supports an individual both during a crisis and after they return to their community.

Nevada is contracting with RI International in order to consult on protocols and standards for mobile crisis teams and stabilization units. They will also be providing a capacity analysis for the state lifeline.

Please indicate areas of technical assistance needed related to this section.

No technical assistance requested at this time.

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16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? (●) Yes ( ) No

b) Required peer accreditation or certification? (●) Yes ( ) No

c) Block grant funding of recovery support services. (●) Yes ( ) No

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? (●) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? (●) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Nevada's treatment and recovery framework supports SAMHSA's Theory of Change through an expansion and improvement of policy, both administrative and regulatory, focused on the gaps and needs assessments that turn strategic plans into widely adopted action plans. Nevada has been working towards the innovation and dissemination of policies and has a large support network to implement system of care measures. Working towards a comprehensive system of early mental health identification, the First Episode Pyschosis (FEP) and Early Serious Mental Illness (ESMI) is being implemented in Clark, Carson and Washoe Counties and focuses on the recovery of the individual and their families. In addition, Nevada has identified mobile crisis and no wrong door services as immediate priorities. These support the identification of technical assistance and supports needed at all levels of service delivery. This one-stop model provides immediate support for and provide an intensive system of care individual and family.

As part of the recovery and recovery support, Nevada reduces barriers to employment through partner organizations, provides supportive and transitional housing, transportation for health and behavioral health, and care coordination. Recovery support is also done with access to certified community behavioral health clinics, warm lines through NAMI, and recovery group access. In addition, Nevada has been working to expand recovery supports to Federally Qualified Health Centers (FQHC)s.

Through the SOR project Perinatal Toolkits were developed in collaboration with Nevada's ASTHO OMNI stakeholders. The toolkits focus on both inpatient and outpatient perinatal and specifically targets physicians. This toolkit introduces best practices and incorporates Screening, Brief Intervention and Referral to Treatment (SBIRT) into the clinical setting. Also discussed are MAT options for pregnant/postpartum women.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

The DPBH funds the Center for the Application of Substance Abuse Technologies (CASAT) who provides training regarding peer support services and is working to finalize the certification of peer supportive services. DPBH utilizes peer support to 1) address workforce challenges; and 2) For peer support and service coordinators to support individuals with SMI/SUD who can adapt and provide culturally and linguistically appropriate services towards recovery. The focus is on health, home, purpose and community and works to provide wrap-around services through reducing barriers to employment, increasing supportive housing, transportation for health and behavioral health, and care coordination. This is also done through the expansion of certified community behavioral health clinics, warm lines through NAMI, and recovery group access.

The workforce of Peer Recovery Support Specialists is well established across the country and rapidly emerging here in Nevada. Peer Recovery Support Specialists use their lived experience and training to connect people with resources, act as a mentor and model recovery behavior, build relationships, help participants set goals and build recovery plans, advocate for the rights, wellbeing, and recovery of their participants, and encourage resilience and any transitions back to the community.

Organizations providing Recovery Support Services must provide services in accordance with principles that support state of change, harm reduction, patient engagement and the use of evidence-based practices. Recovery Support Services are intended to complement, supplement, and extend formal behavioral health services throughout the continuum of care.

Through the States SOR grant: A peer led intervention within emergency departments has been established. The peers are in the emergency department 24 hours a day, 7 days a week. The certified peers offer in-person peer recovery support to individuals identified to have a primary, secondary, or tertiary opioid and/or stimulant use disorder, adverse drug reaction or overdose. Peers use motivational interviewing techniques to discuss recovery supports, treatment options, harm reduction strategies and provide warm referrals for requested services.

5. Does the state have any activities that it would like to highlight?

During the 2021 legislative session, the State of Nevada passed SB69 which encompassed a Peer Support Specialist certification. The legislation includes:
- Standards for employers,
- Baselines for education and continual learning requirements for individuals providing peer recovery support services,
- Standards in ethics and practice,
- Standards in language and titles (e.g. peer recovery support specialist, certified peer recovery support specialist, recovery coach)
- Protection for the individual receiving services, the peer providing services and the public.

Continuing education trainings offered through a State contractor, the University of Nevada Reno's Center for the Application of Substance Abuse Technologies for the recovery workforce (Peer Recovery Support Specialists, Supervisors, and employer

organizations) include:

- 46-hour Peer 101 online self-paced course
- Motivational Interviewing: Changing the Conversation for Peers and Community Health Workers
- Peers in the Workplace
- Compassion Fatigue for Community Health Workers and Peer Recovery Support Specialists
- Psychological First Aid: helping others in times of distress
- Problem Gambling 101 for Peers
- Serving Veterans and Members of the Military
- Stress Management and Wellness
- Skills for Psychological Recovery
- Addressing Burnout in Times of Uncertainty

Please indicate areas of technical assistance needed related to this section.

No technical assistance requested at this time.

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Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

Please respond to the following items

1. Does the state's Olmstead plan include :

Housing services provided.	(•) Yes ( ) No
Home and community based services.	(•) Yes ( ) No
Peer support services.	(•) Yes ( ) No
Employment services.	(•) Yes ( ) No

2. Does the state have a plan to transition individuals from hospital to community settings? (•) Yes ( ) No

Please indicate areas of technical assistance needed related to this section.

No technical assistance requested at this time.

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18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[63]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[64]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.[65].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[66]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[67].

According to data from the 2015 Report to Congress[68] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

[63]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[64]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[65]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[66]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[67]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[68] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery and resilience of children and youth with SED? (●) Yes ( ) No

b) The recovery and resilience of children and youth with SUD? (●) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? (●) Yes ( ) No

b) Juvenile justice? (●) Yes ( ) No

c) Education? (●) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? (●) Yes ( ) No

b) Costs? (●) Yes ( ) No

c) Outcomes for children and youth services? (●) Yes ( ) No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? (●) Yes ( ) No

b) Mental health treatment and recovery services for children/adolescents and their families? (●) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? (●) Yes ( ) No

b) for youth in foster care? (●) Yes ( ) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The State of Nevada's Division of Child and Family Services (DCFS), as part of the Nevada Department of Health and Human Services (DHHS) provides a wide range of services for children, youth and families in Nevada.DCFS program areas include Rural Child Welfare, Youth Parole, as well as Children's Mental Health Services. DCFS also provides severely emotionally disturbed children and youth direct services as well as oversight for the programs administered at the state and county level. In recognizing the important role the State has to protect and provide services to Nevada's vulnerable children, the Governor and Legislature passed and enacted Nevada Revised Statute (NRS) 433B to provide additional provisions related to children. NRS 433B mandates that any county, whose population is 100,000 or more establish a Mental Health Consortia. Nevada's vast geographic area required that a consortia be created in Washoe County (Reno/Tahoe), Clark County (Las Vegas and area), and Rural Nevada (15 of 17 Nevada counties in rural/frontier Nevada). Each consortium is mandated to include partners from the local, county and regional level including school districts, chambers of commerce and business community, state agencies, juvenile probation, community behavioral health care providers, foster care providers, a parent of a child with an emotional disturbance, substance abuse agencies, advocates and provider organizations. DCFS serves as Nevada's Mental Health System of Care (SOC) expert and manages Nevada's Children's Mental Health System of Care Subcommittee as part of the Governor's Wellness and Behavioral Health Council. Nevada is committed to statewide implementation to create sustainable infrastructure and services as part of the Children's Mental Health Initiative (CHMI). The State of Nevada was awarded the Substance Abuse and Mental Health Services Administration System of Care- Expansion and Sustainability Grant for youth with Serious Emotional Disorders. This grant

supports efforts to further establish and monitor a comprehensive system of care for seriously emotionally disturbed children, youth and their families as well as young adults, who age out of the foster care system in Nevada. Nevada's focus of the SOC expansion and sustainability is to improve mental health outcomes for children and youth (birth to 21 years of age) with serious emotional disturbances (SED) and their families.

To ensure integrated services, DPBH - Mental Health, has worked to expand and enhance providers to including not only DCFS who provide mobile crisis services to youth and adolescents, but also to a school-based provider who is also available to provide telehealth services for youth and families. In addition, Nevada expanded psychiatric services to you FQHCs by expanding direct youth services in at-risk communities that have higher populations of child welfare services, justice services, and social services needs. Nevada utilizes the gaps and needs assessments which develop the state plan on behavioral health needs to ensure services are integrated through the full system of care.

7. Does the state have any activities related to this section that you would like to highlight?

The State of Nevada's Division of Child and Family Services (DCFS), as part of the Nevada Department of Health and Human Services (DHHS) provides a wide range of services for children, youth and families in Nevada.

DCFS's Infant and Early Childhood Mental Health (IECMHS) programs provide evidence-based, relationship-focused mental health treatment to children 0-6 years of age in concert with their caregivers in the Las Vegas and Reno metro areas. The State of Nevada's Medicaid plan includes utilization of the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-3)[1] allowing for more accurate diagnostic formulation for children in infancy and early childhood.

The most recent CMHI award received by Nevada's System of Care is focused on developing a broad mental health service array throughout Rural/Frontier/Tribal Nevada AND to meet the needs of the targeted population of children 0-6 years and their families. CMHI grant funds for Nevada's System of Care are providing training to support qualified mental health clinicians in rural communities in the evidence-based practice model of Child-Parent Psychotherapy.

The DCFS IECMHS program at Northern Nevada Child and Adolescent Services is a primary community stakeholder in the Washoe County Human Service Agency specialty family court program, Zero To Three's Safe Babies Court Team (SBCT). DCFS IECMH clinicians provide Child-Parent Psychotherapy, a mandatory component of the SBCT process. SBCT program began in July of 2019 and the impacts on the well-being of children 0-3 years and their families involved in this program are being evaluated by the team at Zero To Three.

To ensure Nevada's children, youth, and families receive individualized and coordinated care, Wraparound In Nevada offers High Fidelity Wraproud or FOCUS. Our partnership with the MHBG has allowed us to decrease time spent waiting for clinical information, meaning our partnerships with families are taking around a week or less to start services. WIN is also implementing clinical support from 2 MHC3's with the MHBG to provide oversight with crisis plans, plans of care, and case consultation. WIN also has staff going through the coaching certification process with NWIC to help support staff practice each model to fidelity.

With support and after certification, staff will be able to also provide trainings to new staff and in the community on how to do HFW or FOCUS.

Lastly, WIN continues to hire for vacant positions and has increased support through our Administration, Human Resources, and Fiscal departments to ensure that there are no barriers for children, youth, and families to access our services. DCFS also provides Mobile Crisis Response Teams (MCRT) in the Las Vegas and Reno metro areas which account for approximately 89% of Nevada's overall population. DCFS's MCRT coordinates and supports rural/frontier crisis service access with State of Nevada's Division of Public and Behavioral Health's rural MCRT. DCFS's MCRT teams are available in-person or by telehealth 24 hours per day, 7 days per week, and 365 days per year. MCRT is a critical element of the system of care for preventing acute and residential placements. MCRT diverts approximately 87% of youth from acute psychiatric hospitalization to community-based services. DCFS's MCRT is considered one of three model MCRT programs nationwide. The MHBG allows DCFS's MCRT to identify and offer intensive in-home services to youth in crisis with the highest multi-system needs (e.g., youth repeatedly using crisis services). The MHBG provides a pathway from acute crisis services to long-term care coordination through Wraparound in Nevada. Additionally, the MHBG allows DCFS to provide intensive in-home services and linkage to Wraparound in Nevada to youth returning from residential placement. Together, the MHBG supports the State of Nevada's response to challenges identified in DOJ investigations. The State of Nevada has implemented the System of Care, to support the effort in establishing and monitoring a system of care for children, youth and young adults, who age out of the foster care programs. This program implements a comprehensive system of care for youth, adolescents and young adults in Nevada. Services (DHHS) provides a wide range of services for children, youth and families in Nevada. The State of Nevada has implemented the System of Care, to support the effort in establishing and monitoring a system of care for children, youth and young adults, who age out of the foster care programs. This program implements a comprehensive system of care for youth, adolescents and young adults in Nevada.

Please indicate areas of technical assistance needed related to this section.

No technical assistance required at this time.

Footnotes:

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Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.

Start Year: 2022 End Year: 2023

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Dr. Megan Freeman	Youth/adolescent representative (or member from an organization serving young people)			
Charlene Frost	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Garrett Hade	State Employees			
Marshal Hernandez	State Employees			
Ali Jai	Others (Advocates who are not State employees or providers)			
Pearl Kim	State Employees			
Mavis Major	Others (Advocates who are not State employees or providers)			
Bob Moore	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Sean O'Donnell	Persons in recovery from or providing treatment for or advocating for SUD services			
DaNeese Parker	Others (Advocates who are not State employees or providers)			
Ariana Saunders	Others (Advocates who are not State employees or providers)			
Misty Shore	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Drew Skeen	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Gillian Rae Stover	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			gillians@cox.net

Footnotes:

Education (1 seat)
Dr. Pearl Kim
Mental Health (1 seat)
Dr. Megan Freeman
Social Services (1 seat)
Aria Saunders
Substance Use (1 seat)
Garrettt Hade
Criminal Justice (1 seat)
DaNeese Parker
Housing (1 seat) - vacant
Vocational Rehab
Marshal Hernandez
Medicaid (vacant)
Public and priviate entities (3 seats)
Ali Jai Faison
Mavis Major
Vacant
Persons with MI, SUD, COD (4 seats)
Gillian Stover
Vacant
Vacant
Vacant
Persons with SUD, COD (4 seats)
Sean O'Donnell
Vacant
Vacant
Vacant
Families of persons with MI, SUD, CO
Drew Skeen
Misty Shore
Char Frost
Bob Moore

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Advisory Council Composition by Member Type

Start Year: 2022 End Year: 2023

Type of Membership	Number	Percentage
Total Membership	**21**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	1	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	4	
Parents of children with SED/SUD*	0	
Vacancies (Individuals and Family Members)	6	
Others (Advocates who are not State employees or providers)	4	
Persons in recovery from or providing treatment for or advocating for SUD services	1	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	**16**	**76.19%**
State Employees	3	
Providers	0	
Vacancies	2	
Total State Employees & Providers	**5**	**23.81%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	2	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**2**	
Youth/adolescent representative (or member from an organization serving young people)	1	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?
The planning council was provided state and regional priorities identified from the regional behavioral health policy boards, the children's consortia and the commission on behavioral health. They were asked individually to make recommendations on priorities. Due to the timeframe, they did not make recommendations; but were also give the option to comment when the application goes live for public comment.

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22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a)	Public meetings or hearings?	(•) Yes ( ) No
b)	Posting of the plan on the web for public comment?	(•) Yes ( ) No
	If yes, provide URL:	
c)	Other (e.g. public service announcements, print media)	( ) Yes ( ) No

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23. Syringe Services (SSP)

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act**, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs**,

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.hiv.gov/sites/default/files/hhs-ssp-guidance.pdf ,**

2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf,**

3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf ,**

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2] Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a)(6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

[4] Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5]***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a **description of the elements of an SSP** that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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Footnotes:

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Syringe Services (SSP) Program Information-Table A

If the state is planning to expend funds from the COVID-19 award, please enter the total planned amount in the footnote section.

Syringe Services Program SSP Agency Name	Main Address of SSP	Planned Dollar Amount of SABG Funds Expended for SSP	SUD Treatment Provider (Yes or No)	# Of Locations (include mobile if any)	Narcan Provider (Yes or No)
No Data Available					

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