Douglas County's Community Prevention Plan

A Blueprint for Prevention Programming

2019

Serenity of the Carson Valley

Beautiful Lake Tahoe Nevada

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EXECUTIVE SUMMARY

Partnership Douglas County (PDC), formerly Partnership of Community Resources, is a non-profit community-based coalition formerly founded in 1993 to support and strengthen citizen, agency, business, and government collaborations in Douglas County. PDC members include the Board of Directors, staff, advisory teams, partner agencies and community stakeholders who work together to: 1) address countywide health issues, 2) share information, 3) provide up-to-date training, 4) coordinate limited resources, and 5) facilitate the development of countywide strategies to reduce issues relating to youth and family substance abuse, violence, behavioral health and socioeconomic disparities.

The purpose of this document is to create a common focus, include all segments of the population when possible, and outline a system of service development and delivery. The idea is to make a positive impact on Douglas County residents by thoughtfully following a research-based system to improve the health and wellbeing of the community.

Mission Statement

Our mission is to promote a healthy community through education and resource connection.

What is Comprehensive Community Prevention?

A comprehensive approach to behavioral health means seeing prevention as part of an overall continuum of care. The Behavioral Health Continuum of Care Model recognizes multiple opportunities for addressing behavioral health problems and disorders. Based on the Mental Health Intervention Spectrum, first introduced in a 1994 Institute of Medicine report, the model includes the following components:

- **Promotion**—These strategies are designed to create environments and conditions that support behavioral health and the ability of individuals to withstand challenges. Promotion strategies also reinforce the entire continuum of behavioral health services.
- **Prevention**—Delivered prior to the onset of a disorder, these interventions are intended to prevent or reduce the risk of developing a behavioral health problem, such as underage alcohol use, prescription drug misuse and abuse, and illicit drug use.
- **Treatment**—These services are for people diagnosed with a substance use or other behavioral health disorder.
- **Recovery**—These services support individuals' abilities to live productive lives in the community and can often help with abstinence.

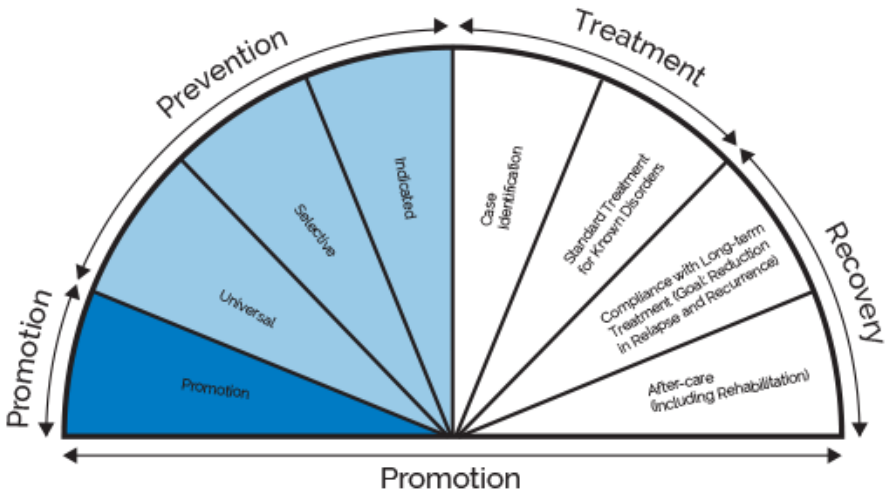


Figure 1: Behavioral Health Continuum of Care Model

For the purposes of this plan, Partnership Douglas County's scope is limited to the **Promotion** and **Prevention** areas of the Behavioral Health Continuum of Care. Members of PDC's coalition may be working in other areas of the continuum based on their individual organization's mission.

The Strategic Prevention Framework

Partnership Douglas County has structured this Community Prevention Plan according to Substance Abuse and Mental Health Services Administration's (SAMSHA) Strategic Prevention Framework (SPF).

The five steps that comprise the SPF enable coalitions to build the infrastructure necessary for effective and sustainable prevention. Each step contains key milestones and products that are essential to the validity of the process. The SPF is conceived of in systemic terms and reflects a public health, or population-based, approach to delivering effective prevention.

Utilizing the SPF, members of Partnership Douglas County work together to centralize data collection, assess needs, prioritize risk and protective factors and build assets around prioritized risk factors.

For more information on the SPF process and other SAMSHA resources, visit https://www.samhsa.gov/capt/applying-strategic-prevention-framework

A Description of the SPF Steps

Step #1: Assessment - Profile population needs, resources, and readiness to address needs and gaps

Assessment involves the collection of data to define problems within a geographic area and mobilizing key stakeholders to collect the needed data and foster the SPF process.

PDC engages in collecting existing health-related data from various sources, conducts community-based surveys and focus groups, and conducts qualitative studies (*See Appendix __ for the 2018 Partner Impact Report)*.

Step #2: Capacity – Mobilize and/or build capacity to address needs

Capacity involves the mobilization of resources within a geographic area. A key aspect of capacity is convening key stakeholders, coalitions, and service providers to plan and implement sustainable prevention efforts in Steps 3-4 of the SPF.

PDC spends much of its time mobilizing the capacity of the community to deal with the identified health problem. This mobilization effort is seen in PDC's committees and many other teams of which PDC is engaged in the Douglas County community. For example, PDC is a key stakeholder in the Douglas County Behavioral Health Task Force, a collaborative comprised of agencies mobilizing to address issues related to the behavioral health continuum of care.

Step #3: Planning – Develop a comprehensive strategic plan

Planning involves the development of a strategic plan also called a logic model that includes policies, programs, and practices that create a logical, data-driven plan to address the problems identified in Step 1 of the SPF.

After the assessment and capacity building, PDC in concert with its many partners developed a strategic plan that addresses each of the risk factors identified in the assessment section. This plan will serve as the prevention blueprint for action for January 1, 2019 through December 31, 2021.

Step #4: Implementation – Implement evidence-based prevention programs, policies, and practices

Implementation involves taking action guided by the strategic plan created in Step 3 of the SPF. This step also includes the creation of an evaluation plan, the collection of process measure data, and the ongoing monitoring of implementation fidelity.

Currently, PDC funds evidence-based programs in Douglas County targeted at the prioritized risk factors. Further, PDC and its committees are continually looking at practices designed to bring the community together and spread the coalition's message. Finally, through the Youth Behavioral Health Subcommittee to the Douglas

County Behavioral Health Task Force and other policy boards, PDC advocates for changing social norms and implementing policies and ordinances designed to protect our local youth.

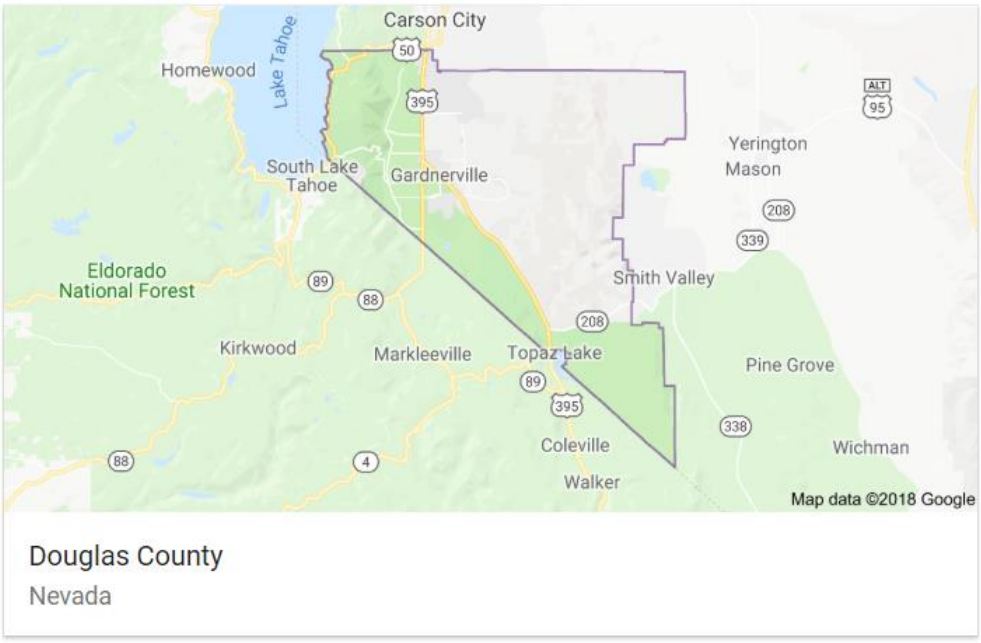
Step #5: Evaluation – Monitor, evaluate, sustain, and improve or replace those that fail

Evaluation measures the impact of the SPF process and the implemented programs, policies, and practices. All programs that are funded through PDC are rigorously evaluated using standardized instruments. The coalition itself is evaluated to ensure it is operating efficiently and effectively.

STEP #1: ASSESSMENT

Effective substance abuse prevention planning begins with a solid assessment of the communities to be served, along with the identification of relevant risk and protective factors and includes specifically identified needs of the residents of those communities. PDC utilizes local, state and federal quantitative data to define readiness, community problems, resources, and gaps in Douglas County. In addition, PDC conducts focus groups and interviews with key stakeholders to understand the qualitative needs of the community.

Service Area and Demographic Profile



Demographic Profile*	2017
Land Area in Square Miles	709.72
Population (2017 estimate)	48,309
Youth – under 18 years	17.3%
Seniors – 65 years and older	27.2%
White	80.4%
Hispanic	12.9%
Black	1.1%
American Indian	2.3%
Asian	1.8%
Veterans (2012-2016)	5,394
High School graduation rate	87.3%
% of persons in poverty	9.7%
Persons without health insurance, under 65 years (2012-2016)	12%
Unemployment**	4%
Average home ownership rate	69.2%

**Source: US Census Bureau 2017; **Source: US Bureau of Labor Statistics*

Douglas County Community Health Needs Assessment (CHNA)

In September 2016, Partnership Douglas County collaborated with Carson Valley Medical Center (CVMC), Douglas County, Carson City Health & Human Services, and the University of Nevada School of Medicine to produce the 2016 Douglas County Community Health Needs Assessment. This document is a requirement of Douglas County's local non-profit hospital. A CHNA provides health organizations with a snapshot of the health status of the community being served. The CHNA process is what PDC relies on to compile several state and local data sets necessary to complete Step 1 of the Strategic Prevention Framework.

Top Health Needs Identified in 2016 CHNA Survey:*

- **Cost of Healthcare** – Decreased from 44.8% in 2013 to 13.5% in 2016
- **Substance Abuse** – Decreased from 56.6% in 2013 to 12.4% in 2016
- **Access to Healthcare** – Decreased from 24.1% in 2013 to 10.4% in 2016
- **Mental Illness** – Decreased from 23.5% in 2013 to 8.9% in 2016
- **Obesity** – Decreased from 24.6% in 2013 to 8.3% in 2016

**From 2013 – 2016, the survey identified similar top health needs in our community, however the percentages have reduced during this period.*

For the purposes of the Strategic Prevention Framework, Partnership Douglas County will address substance abuse and mental illness. Carson Valley Medical Center and other key stakeholders play lead roles in addressing the other three priority areas. For more information about the work being done in these areas visit CVMC's website https://cvmchospital.org. Their website includes the 2016-2019 CHNA Implementation Plan.

Substance Abuse Data

Trends can be identified by examining current consumption patterns data at the local, state, and national levels.

For the purposes of this report, regional data is identified as the Northern Nevada Behavioral Health Region. The Northern Region consists of Carson City, Churchill, Douglas, Lyon, Mineral, and Storey Counties, stretching across 11,802 square miles in northwestern Nevada. The total population of the Northern Region, estimated to be 192,784 in 2017, has increased 2.2% over the past 10 years. The median household income is $50,892, with a per capita income of $28,063 for the past 12 months. Approximately 12.5% of the population is in poverty, and 15.2% of the population under 65 has a disability. Many of the counties in the region have a larger aging population with 35.6% of the population 55 years or older. 77.7% of the Northern Region's residents are White not of Hispanic origin, while 15.5% individuals are Hispanic. 3.3% of the population are Native American, 2.3%, Asian, and 1.2% of the population are Black.

Source: 2018 Northern Regional Behavioral Health Report, Northern Nevada Behavioral Health Policy Board (See Appendix __ for full report).

Statewide Consumption Data Trends

Tables 1-5: Weighted prevalence estimates of health risk behaviors — Nevada, Youth Risk Behavior Survey, 2015 to 2017

TABLE 1: YOUTH ALCOHOL USE

Participant Characteristics	*2015*	*2017*	*Change*
Percentage of students who ever drank alcohol	64.0	60.6	No change
Percentage of students who drank alcohol before age 13 years (other than a few sips)	18.0	18.2	No Change
Percentage of students who had at least one drink of alcohol during the 30 days before the survey	30.6	26.5	Significant Decrease
Percentage of students who usually obtained the alcohol they drank by someone giving it to them (among students who currently drank alcohol)	38.7	42.6	No Change
Percentage of students who rode in a car or other vehicle during the 30 days before the survey driven by someone who had been drinking alcohol	21.4	17.0	Significant Decrease
Percentage of students who drove a car or other vehicle during the 30 days before the survey when they had been drinking alcohol	6.9	5.5	No Change

Source: Nevada High School Youth Risk Behavior Survey (YRBS) Comparison Report, 2015-2017, accessed https://www.unr.edu

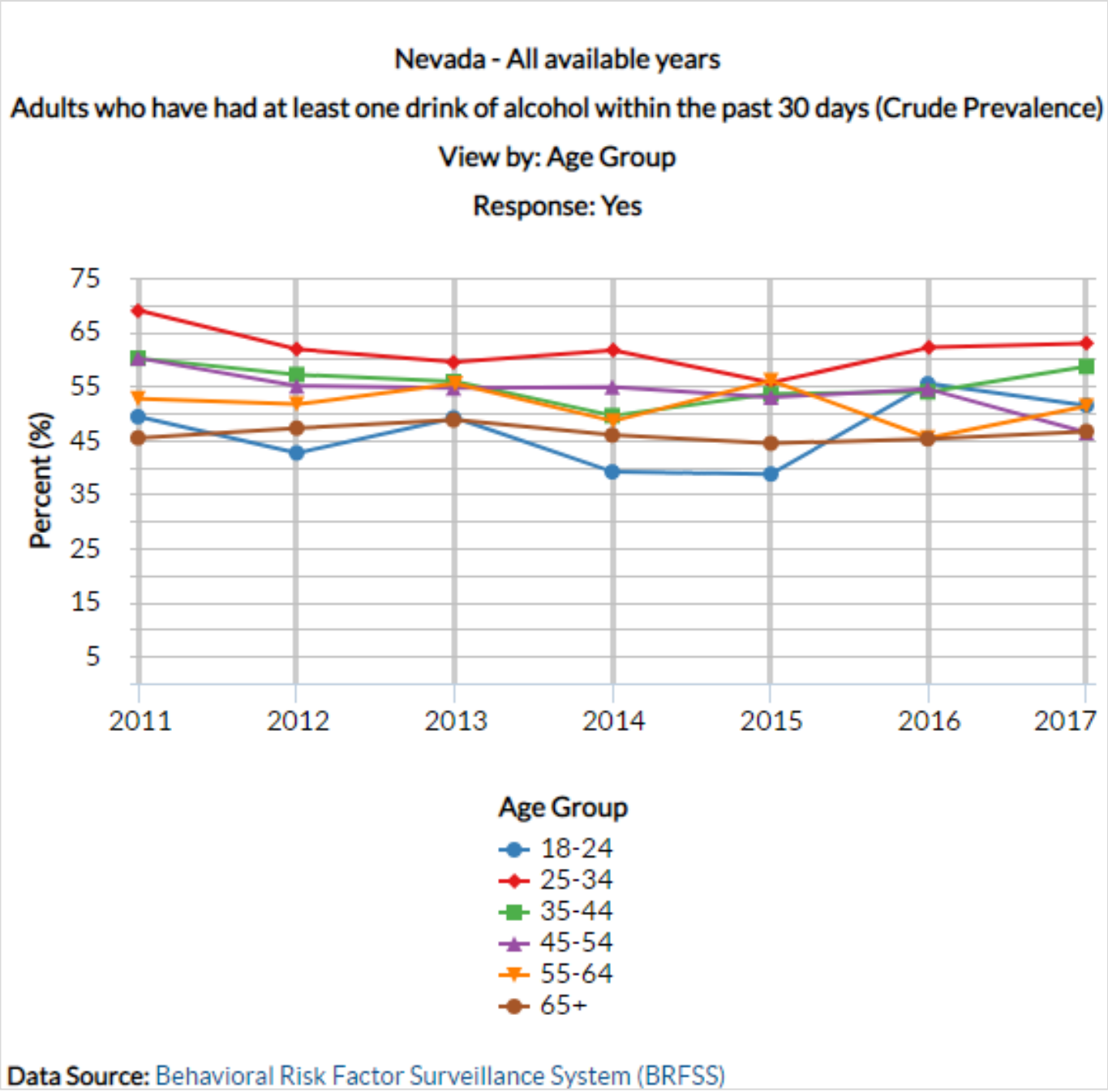


Chart 1: Nevada Adult Alcohol Consumption, BRFSS 2011-2017

TABLE 2: YOUTH MARIJUANA USE

Participant Characteristics	*2015*	*2017*	*Change*
Percentage of students who ever used marijuana	39.4	37.0	No Change
Percentage of students who tried marijuana f0r the first time before age 13 years	9.0	8.8	No Change
Percentage of students who used marijuana during the 30 days before the survey	19.6	19.5	No Change

Source: Nevada High School Youth Risk Behavior Survey (YRBS) Comparison Report, 2015-2017, accessed https://www.unr.edu

TABLE 3: YOUTH OTHER DRUG USE

Participant Characteristics	*2015*	*2017*	*Change*
Percentage of students who ever used cocaine (any form of cocaine, such as powder, crack, or freebase, one or more times during their life)	6.1	5.1	No Change
Percentage of students who ever used inhalants (sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paints or sprays to get high, one or more times during their life)	6.9	7.5	No Change
Percentage of students who ever used heroin (also called “smack”, “junk”, or “China White” one or more times during their life)	2.5	2.6	No Change
Percentage of students who ever used methamphetamines (also called “speed”, “crystal”, “crank”, or “ice” one or more times during their life)	3.4	3.3	No Change
Percentage of students who ever used ecstasy (also called "MDMA”, one or more times during their life)	7.0	6.3	No Change
Percentage of high school students who ever used synthetic marijuana (also called “K2”, “Spice”, “fake weed”, “King Kong”, “Yucatan Fire”, “Skunk”, or “Moon Rocks”, one or more times during their life)	10.9	7.7	Significant Decrease
Percentage of students who ever took steroids without a doctor's prescription (one or more times during their life)	3.6	3.3	No Change
Percentage of students who ever injected any illegal drug (used a needle to inject any illegal drug into their body one or more times during their life)	2.7	2.6	No Change
Percentage of students who were offered, sold, or given an illegal drug on school property during the 12 months before the survey	29.2	28.4	No Change
Percentage of high school students who ever lived with someone who was a problem drinker, alcoholic, or abused street or prescription drugs	30.4	32.3	No Change

Source: Nevada High School Youth Risk Behavior Survey (YRBS) Comparison Report, 2015-2017, accessed https://www.unr.edu

TABLE 4: YOUTH TOBACCO USE

Participant Characteristics	*2015*	*2017*	*Change*
Percentage of students who ever tried cigarette smoking (even one or two puffs)	32.4	23.9	No Change
Percentage of high school students who smoked cigarettes during the 30 days before the survey	7.2	6.4	No Change
Percentage of high school students who smoked cigarettes on 20 or more days during the 30 days before the survey	1.9	1.3	No Change
Percentage of high school students who smoked more than 10 cigarettes per day during the 30 days before the survey	5.7	4.9	No Change
Percentage of high school students who usually obtained their own cigarettes by buying them in a store or gas station during the 30 days before the survey (among students who currently smoked cigarettes who were aged <18 years)	6.3	7.3	No Change
Percentage of high school students who used smokeless tobacco during the 30 days before the survey	4.3	4.0	No Change
Percentage of high school students who smoked cigars during the 30 days before the survey	6.5	6.9	No Change
Percentage of high school students who used tobacco during the 30 days before the survey	11.4	12.0	No Change

Source: Nevada High School Youth Risk Behavior Survey (YRBS) Comparison Report, 2015-2017, accessed https://www.unr.edu

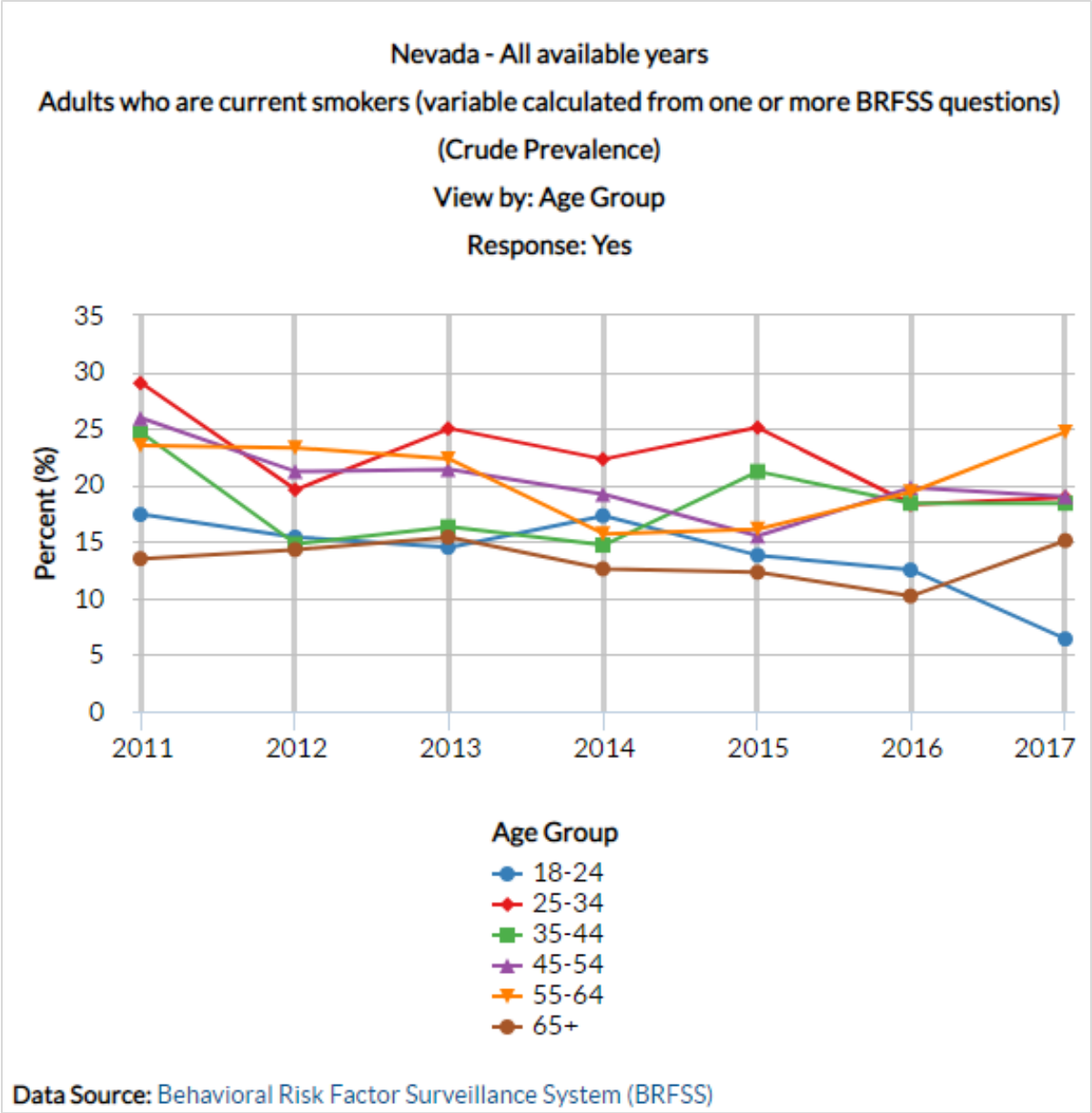


Chart 2: Nevada Adult Tobacco Use, BRFSS 2011-2017

TABLE 5: YOUTH ELECTRONIC VAPOR PRODUCT USE

Participant Characteristics	*2015*	*2017*	*Change*
Percentage of high school students who ever used electronic vapor products (including e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens)	50.9	42.6	Significant Decrease
Percentage of high school students who used electronic vapor products during the 30 days before the survey (including e-cigarettes, e-cigars, epipes, vape pipes, vaping pens, e-hookahs, and hookah pens)	26.1	15.0	Significant Decrease

Source: Nevada High School Youth Risk Behavior Survey (YRBS) Comparison Report, 2015-2017, accessed https://www.unr.edu

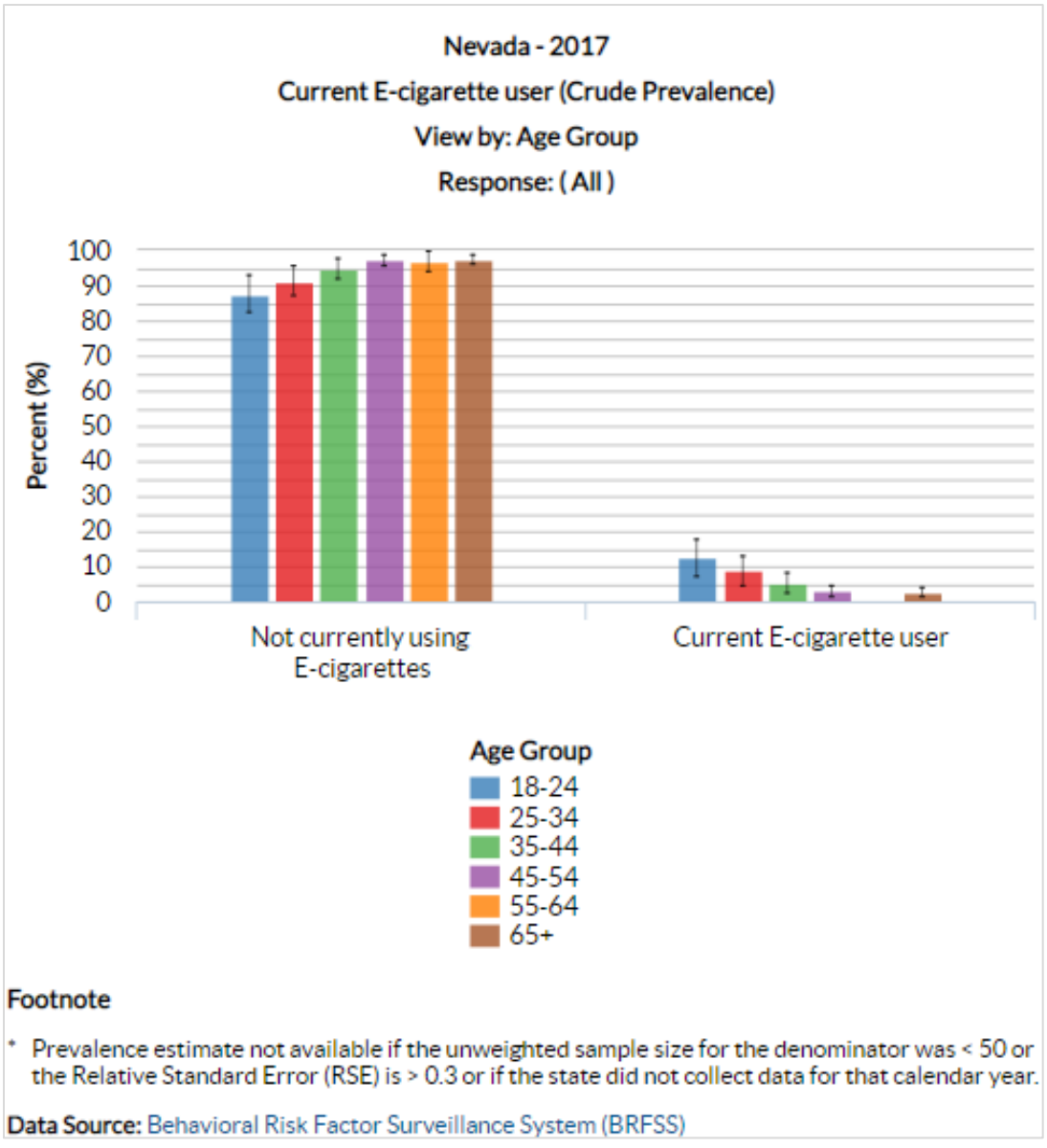


Chart 3: Nevada Adult E-cigarette Use, BRFSS 2017

Regional Data Trends

Youth Substance Use:

- Drug use rates for Northern Nevada high school students (including heroin, methamphetamines, cocaine, inhalants, ecstasy, and synthetic marijuana) are slightly higher than state and national rates.
- Northern Nevada high school and middle school students have higher rates of alcohol and tobacco use than the overall rate in Nevada as well.

Tobacco:

- The Northern Region's high school students show significantly higher use of tobacco and electronic vapor products than high school students in Nevada.
- 21.3% of high school students in the Northern Region compared to 12% of youth in Nevada use tobacco.
- 9.7% of high school students use smokeless tobacco in comparison to 4.0% of youth in Nevada.
- 12.3% of high school students in the Northern Region reported smoking cigarettes, versus 6.4% of youth in Nevada.
- The Northern Region's middle school students show high rates of use of tobacco and electronic vapor products than middle school students in Nevada as well.

Alcohol:

- 35.8% high school students report currently drinking alcohol in comparison to 26.5% of high school students across Nevada.
- Northern Region's high school students report recent binge drinking (19.7%) in comparison to overall rate in Nevada (11.1%).
- Over 1 in 10 middle school students report drinking before the age of 11 (13.8%).
- 32.3% of middle school students reported drinking alcohol at some point in their lives.

Marijuana:

- In Northern Nevada, 44.7% of youth reported ever trying marijuana in comparison to 37% of high school students in Nevada. Youths in the Northern Region report using marijuana more (25.4%) in comparison to high school students in Nevada (19.5%).

Prescription drug use:

- 18% of high school students in the Northern Region reported using prescription drugs that were not prescribed to them in their life time.

Adult substance use:

- Between 2011 and 2017, there was a significant increase in the population who reported using marijuana/ hashish to get high in the past 30 days. The percentage of adults reporting use was 3.2% in 2011 and increased to 15.1% in 2017.
- Between 2011 and 2017, an average of .07% of the population used pain killers to get high.
- 8.6% of men and 9.8% of women in the Northern Region were considered heavy drinkers in 2017.

- 17.8% of men and 14.8% of women in the Northern Region were considered "binge drinkers" in 2017.

  Substance use hospital Emergency Department ED) encounters and hospital admissions:
  - In 2017, of the 1,262 total alcohol and drug related ED visits, 837 were alcohol related.
  - Since 2013, Marijuana/hashish has been the most common drug associated with emergency department visits, followed by methamphetamines, and opioids. In 2017, there were 719 visits related to marijuana, and 442 visits related to methamphetamine.
  - Since 2009, alcohol related admissions were the most common, until 2016 when drug related admission passed alcohol. In 2017 there were 4,281 drug and/ or alcohol related admissions.
  - Inpatient admissions related to drugs and alcohol significantly increased from 2009-2017. Marijuana/ cannabis, opioids, and methamphetamines were the top three substances, respectively, listed on diagnoses. Notably, hospital admissions for methamphetamine almost quadrupled from 153 in 2009 to 581 in 2017.

  Alcohol and substance use related deaths:
  - Age-adjusted rates for alcohol and/or drug related deaths increased significantly in 2016 and remained at that higher rate in 2017.
  - In 2017, alcohol related deaths, which make up 31% of alcohol and drug related deaths, increased 55% in per 100,000 age specific population between 2009 and 2017.
  - Drug related deaths increased 13% in per 100,000 age specific population from 2009 to 2017.

Source: 2018 Northern Regional Behavioral Health Report, Northern Nevada Behavioral Health Policy Board (See Appendix __ for full report).

Safety and Violence-related Data

Statewide Data Trends

Table 6-7: Weighted prevalence estimates of health risk behaviors — Nevada, Youth Risk Behavior Survey, 2015 to 2017

TABLE 6: YOUTH SAFETY

Participant Characteristics	*2015*	*2017*	*Change*
Percentage of high school students who rarely or never wore a seat belt when riding in a car driven by someone else	6.2	7.1	No Change
Percentage of high school students who texted or e-mailed while driving a car or other vehicle during the 30 days before the survey (among students who drove a car or other vehicle)	37.7	31.5	Significant Decrease

Source: Nevada High School Youth Risk Behavior Survey (YRBS) Comparison Report, 2015-2017, accessed https://www.unr.edu

TABLE 7: YOUTH VIOLENCE-RELATED BEHAVIORS

Participant Characteristics	*2015*	*2017*	*Change*
Percentage of high school students who carried a weapon on school property during the 30 days before the survey (ex. A gun, knife, or club)	3.7	5.7	Significant Decrease
Percentage of high school students who were threatened or injured with a weapon on school property during the 12 months before the survey (ex. A gun, knife, or club)	6.7	7.7	No Change
Percentage of high school students who were in a physical fight during the 12 months before the survey	19.3	19.3	No Change
Percentage of high school students who were in a physical fight on school property during the 12 months before the survey	5.3	5.8	No Change
Percentage of high school students who were bullied on school property during the 12 months before the survey	18.5	16.6	No Change
Percentage of high schools students who were electronically bullied during the 12 months before the survey	13.8	13.1	No Change
Percentage of high school students who did not go to school because they felt unsafe at school or on their way to or from school during the 30 days before the survey	7.6	8.7	No Change
Percentage of high school students who experienced physical dating violence during the 12 months before the survey	9.9	7.9	Significant Decrease
Percentage of high school students who experienced sexual dating violence during the 12 months before the survey	11.2	5.7	Significant Decrease
Percentage of high school students who were every physically forced to have sexual intercourse when they did not want to	9.0	7.3	Significant Decrease
Percentage of high school students who have ever been hit, beaten, kicked, or physically hurt in any way by an adult	15.8	17.7	No Change
Percentage of high school students who have ever seen adults in their home slap, hit, kick, punch, or beat each other up	16.4	16.8	No Change

Source: Nevada High School Youth Risk Behavior Survey (YRBS) Comparison Report, 2015-2017, accessed https://www.unr.edu

Mental Health Data

Statewide Data Trends

Table 8: Weighted prevalence estimates of health risk behaviors — Nevada, Youth Risk Behavior Survey, 2015 to 2017

TABLE 8: YOUTH EMOTIONAL HEALTH

Participant Characteristics	*2015*	*2017*	*Change*
Percentage of students who felt sad or hopeless almost every day for 2 or more weeks in a row during the 12 months before the survey (so that they stopped doing some usual activities)	34.5	34.6	No Change
Percentage of students who seriously considered attempting suicide during the 12 months before the survey	17.7	16.6	No Change
Percentage of students who made a plan about how they would attempt suicide during the 12 months before the survey	15.8	14.4	No Change
Percentage of students who attempted suicide during the 12 months before the survey	9.8	8.5	No Change
Percentage of students who attempted suicide that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse during the 12 months before the survey	3.2	2.6	No Change
Percentage of high school students who did something to purposefully hurt themselves without wanted to die, such as cutting or burning themselves on purpose during the 12 months before the survey	21.5	18.7	Significant Decrease
Percentage of high school students who ever lived with someone who was depressed, mentally ill, or suicidal	30.4	30.3	No Change

Source: Nevada High School Youth Risk Behavior Survey (YRBS) Comparison Report, 2015-2017, accessed https://www.unr.edu

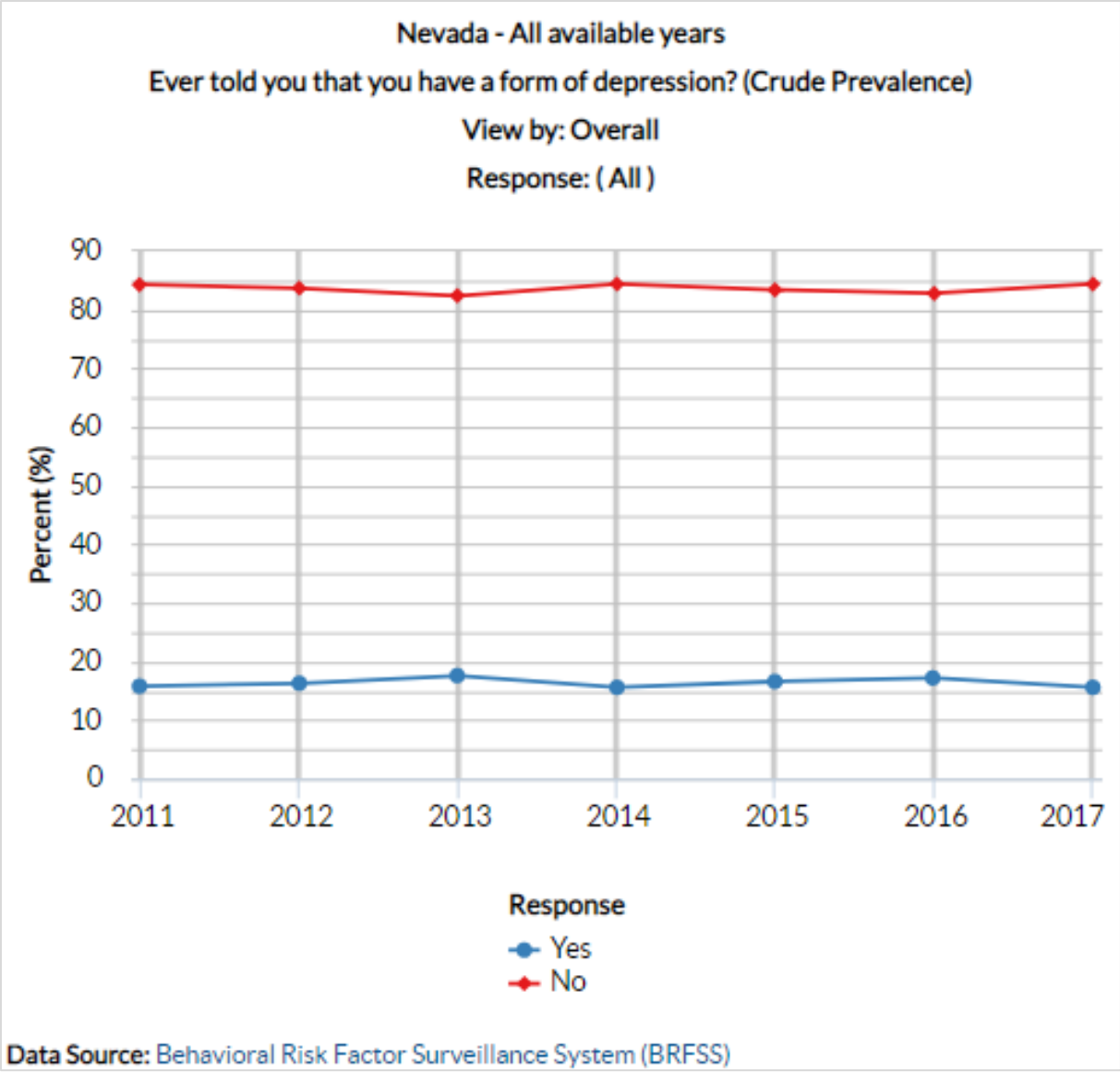


Chart 4: Nevada Adult Depression, BRFSS 2011-2017

Regional Data Trends

Youth Mental Health:

Northern Nevada high school students have a greater suicide risk than high school students statewide.

- 18.2 % considered suicide in comparison to 16.6% in Nevada
- 16.6% planned suicide versus 14.4% in Nevada
- 10.8% attempted suicide versus 8.5% for Nevada high school youth

Northern Nevada middle school youth experience mental health risk behaviors at higher rate than middle school youth statewide.

- 32.4% of the youth felt sad or helpless in comparison to 29.3% of middle school youth in Nevada
- 23.4% considered suicide in comparison to 21.3% statewide
- 16.7% planned suicide versus 15.3% of middle school youth in Nevada
- 9.7% attempted suicide in comparison to 8.2% in Nevada
- 21.2% cut/burned themselves in comparison to 18.4% of middle school youth in Nevada.

The Northern Region's high school youth have highest rates of suicidal ideation and behaviors in the state

Adult Mental Health:

Adults who experienced 10 or more days of poor mental or physical health that prevented them from doing usual activities increased from 23.7% of the Northern Region's population in 2011 to 26.6% in 2017. This percentage of the population is significantly higher than in the Rural/ Frontier Region (14%), Washoe (17.7%), and in the Southern Region (17.4%).

Mental Health Related Emergency Department Encounters:

- Anxiety has been the most prevalent mental health related diagnosis in hospital emergency rooms (ER) since 2012.
- Adjusted for population growth, ER visits for anxiety almost tripled between 2009 and 2017. In the 2017 Epidemiological Profile for the Northern Region, DPBH reports that there were 1,962 anxiety related visits in the ER (1,026.3 per 100,000) which increased to 5,565 visits in 2017 (2,886.7 per 100,000).
- ER visits for depression increased by 1251% between 2009 and 2017, from 84 in 2009 (43.9 per population of 100,000) to 1,144 in 2017 (593.4 per population of 100,000 of Northern Nevada residents). ED encounters for anxiety increased from 1,026.3 per 100,000 population in 2009 to 2,886.7 per 100,000 population in 2017.
- Anxiety and depression are leading diagnoses for mental health related inpatient admissions as well. Anxiety related hospital admissions have increased 187% and depression related admissions have increased 356 % in 8 years.

Suicide:

- 3.0% of adults reported seriously considering suicide in 2017.

- The most common method for attempted suicide was substance use or drug overdose attempt, consisting of 56% of suicide attempts.
- Since 2015, there has been an increase in inpatient admissions where a patient did not expire due to suicide attempt. 82% of these admissions were related to substance and drug overdose.
- Over the past 12 years, 445 residents completed suicide, with an average of 49 suicides each year.
- Suicides are most common for the population aged 45-54 in 2017.
- Over the past 12 years, suicides were most common among high school graduates with 28 suicides in 2017.
- Age adjusted rates for suicide for the White non-Hispanic population were significantly higher than the statewide rate from 2009-2017. In 2017, there were 27.1 suicides per population of 100,000 in the region.
- Rates of suicide for the Hispanic were significantly lower than Nevada for all years.

Source: 2018 Northern Regional Behavioral Health Report, Northern Nevada Behavioral Health Policy Board (See Appendix __ for full report).

Local Focus Groups

Key Issues Impacting Youth

2018 Douglas County Prioritization of Key Issues by Community Stakeholders

Partner Priority Issues -	Weight (1st=5 points, 2=4 points, 3 =3 points, 4=2 points, 5=1 point)						
Key Issue | Age Group	**5**	**4**	**3**	**2**	**1**	**Total Points**	**Notes**
Mental Health Conditions | <18	10	20	3	10	2	**45**	Getting consistent treatment, mental health of parent impacts children, support for the whole family
Family Structure/Environment	25	4	0	6	2	**37**	Wrap around services, affordable housing, parents need to be involved, family groups, relationships, more resources on how to better communication, starting earlier teaching social skills, providing family services
Suicide | <18	10	8	9	2	0	**29**	Jr. High Schools, Increase in suicide idiation in middle schools
Suicide | 18-59	10	6	3	6	2	**27**	18-54 years, veterans
Mental Health Conditions | 18-59	10	4	3	6	0	**23**	Depression, Reducing stigma, finding resources, need more treatment options, veterans
Co-occuring Conditions |18-59	5	4	6	4	1	**20**	Depression self-medication, alcohol leading to suicide
Violence | 18-59	5	4	6	2		**17**	Domestic Violence affects children, Dating Violence
Suicide | 60+	5	4	6	0	1	**16**	rates have increased
Suicide | All Ages	0	4	6	4	0	**14**	It's out of control here, all age groups
Rx Opiates | 18-59	5	4	3	0	1	**13**	Prevention of life-long challenge
Mental Health Conditions | 60+	10	0	0	0	0	**10**	
Mental Health Conditions | All ages	10	0	0	0	0	**10**	
Co-occuring Conditions | All ages	10	0	0	0	0	**10**	We need more services
Violence | <18				4	4	**8**	
Marijuana | <18	0	4	3	0	1	**8**	Marijuana prevention
Alcohol | 18-59	0	4	0	4	0	**8**	Precurser to depression and suicide, 18-54
Heroin | 18-59	5	0	3	0	0	**8**	
Alcohol | <18	0	4	0	2	1	**7**	Affects children and families
Marijuana | 18-59	0	0	0	4	1	**5**	
Other Drugs | 18-59	0	4	0	0	1	**5**	Make substance abuse classes/groups avialable, Parents who use drugs impact their children
Co-occuring Conditions |<18	0	0	3	0	1	**4**	
Other Drugs | <18	0	0	3	0	1	**4**	
Co-occuring Conditions |60+	0	0	3	0	0	**3**	
Meth | 18-59	0	1	1	0	0	**2**	Lack of affordable treatment/housing
Opiates | All ages	0	0	0	2	0	**2**	
All Tobacco | <18	0	0	0	0	1	**1**	Middle School vaping/OTP use
Other Stimulants |18-59	0	1	0	0	0	**1**	
Rx Opiates | <18	0	0	0	0	1	**1**	Kids experiment and don't understand the consequences
All Tobacco | 18-59	0	0	0	0	0	**0**	
All Tobacco | 60 +	0	0	0	0	0	**0**	
Meth | <18	0	0	0	0	0	**0**	
Meth | 60 +	0	0	0	0	0	**0**	
Cocaine | <18	0	0	0	0	0	**0**	
Cocaine | 18-59	0	0	0	0	0	**0**	
Cocaine | 60+	0	0	0	0	0	**0**	
Other Stimulants |<18	0	0	0	0	0	**0**	
Other Stimulants | 60+	0	0	0	0	0	**0**	
Violence | 60+	0	0	0	0	0	**0**	
Marijuana | 60+	0	0	0	0	0	**0**	
Alcohol | 60+	0	0	0	0	0	**0**	
Heroin | <18	0	0	0	0	0	**0**	
Heroin | 60+	0	0	0	0	0	**0**	
Rx Opiates | 60+	0	0	0	0	0	**0**	
Other Drugs | 60+	0	0	0	0	0	**0**	

2018 Douglas County Prioritization of Key Issues by Community Stakeholders (Continued)

In December 2018, Douglas County key stakeholders prioritized key issues that need to be addressed in 2019-2021 based on data collected throughout the year. Page 25 is the total ranking of all indicators identified by Douglas County partners. Below are the top 10 substance abuse priority areas and the top 10 mental health priority areas. The partner consensus is that as a community we should be looking at families and individuals as a whole. Which means all agencies should focus on co-occurring conditions and comorbidities. Community-based services providers should also consider providing an individual and all of their natural supports wrap around services.

Top Substance Abuse Priority Areas

Priorities	Age Groups	Ranking Score
Family Structure/Environment	All	37
Rx Opiates	18-59	13
Marijuana	<18	8
Alcohol	18-59	8
Heroin	18-59	8
Alcohol	<18	7
Marijuana	18-59	5
Other Drugs	18-59	5
Co-occurring Conditions	<18	4
Other Drugs	<18	4
Co-occurring Conditions	60+	3
Meth	18-59	2
Opiates	All	2
All Tobacco (Vaping)	<18	1
Other Stimulants	18-59	1
Rx Opiates	<18	1

Top Mental Health Priority Areas

Priorities	Age Groups	Ranking Score
Mental Health Conditions	<18	45
Family Structure/Environment	All	37
Suicide	<18	29
Suicide	18-59	27
Mental Health Conditions	18-59	23
Co-occurring Conditions	18-59	20
Violence	18-59	17
Suicide	60+	16
Suicide	All	14
Mental Health Conditions	60+	10
Mental Health Conditions	All	10
Co-occurring Conditions	All	10
Violence	<18	8
Co-occurring Conditions	<18	4
Co-occurring Conditions	60+	3

All other indicators were not recognized as a priority area for 2019-2021. Partnership Douglas County will continue to assess the partners each year and update this plan, as needed to meet the needs of Douglas County residents.

2018 Qualitative Impact Study

Overview

In Spring of 2018, Partnership Douglas County completed a qualitative impact study to identify the impact of substance abuse and mental health work on community partners. This study was completed as part of Project Impact, a program that provides non-profit organizations with the capacity to prove and improve impact. Project Impact is a research methodology owned by Dialogues in Action.

Partnership Douglas County interviewed 16 key stakeholders in the community. Interview participants were selected based on the following sampling strata:

- Level of Service –
  - Level 1: 1st Responder
  - Level 2: Direct Service Provider (non 1st responder)
  - Level 3: Indirect Service Provider
- Gender
- Years of Service
- Age

All subpopulations identified above were represented in the study.

Goal

Identify the impact substance abuse and mental health work has on coalition partners.

Key Findings

1. **As a coalition, we still have barriers that need to be addressed in order to be successful.**
2. **When partners are overwhelmed and can't find solutions, they have hope that there are solutions with the youth population.**
3. **Destigmatization of substance abuse and mental and eliminating assumptions are keys to success.**
4. **We have community partners willing to come to the table in order to cultivate change.**
5. **Legalization of marijuana is negatively impacting our efforts.**
6. **Partners value family relationships.**

STEP #2: CAPACITY

In the Assessment step the data was collected, risk and protective factors identified, and problems, as defined by the data, were defined.

A key aspect of identifying community capacity to deal with substance abuse problems in Washoe County is bringing together key agencies, individuals, and organizations to plan and implement appropriate and sustainable prevention efforts in the community. During 2019-2021, PDC will continue to accomplish this mobilization in a number of ways:

- PDC General Membership: Comprised of representatives from the following community sectors:
    - Youth and family representatives
    - Business
    - Media
    - Schools
    - Youth and family serving-organizations
    - Law enforcement
    - Religious organizations
    - Civic and volunteer groups
    - Healthcare professionals
    - State, local or tribal agencies with expertise in the field of substance abuse
    - Other organizations involved in reducing substance abuse

  PDC General Membership meetings occur monthly, as needed, to monitor and reduce key health issues in Douglas County.

- Douglas County Behavioral Health Task Force: A collaborative team joined together to address all behavioral health needs in the community. Douglas County Behavioral Health Task Force Subcommittees:

    - Youth Subcommittee – originated as the Douglas County School District's Community Engagement Task Force in 2017 when Douglas County was awarded Project AWARE grant funds from the Nevada Department of Education. The Community Engagement Task Force was formally merged with the Douglas County Behavioral Health Task Force for sustainability of the program. This committee focuses on youth (individuals <=18 years of age) utilizing a tiered-system of support. This committee also addresses needs identified in the Douglas County Child Protective Services multidisciplinary team (MDT).

    - Senior Subcommittee – formed to addressed key issues occurring among Douglas County's senior population, including high rates of senior suicide. Other key issues include lack of basic needs and other supports to prevent onset of substance use, chronic illness, and other high-risk behaviors. This committee

also addresses needs identified in the Douglas County Elder Protective Services multidisciplinary team (MDT).

- Information Sharing Subcommittee – designated to address both internal and external information sharing needs. For example, internal information sharing includes formalizing Douglas County's referral system and warm hand-offs. This subcommittee also hopes to eliminate any barriers that hinder internal communication. External information sharing activities include promoting programs and services that already exist in the community.

- Access to Healthcare/Provider Subcommittee: formed to address the shortage in behavioral health clinical services and providers of services in Douglas County. This subcommittee brainstorms and seeks out innovative solutions to service shortage issues.

- Cross-Sector Behavioral Health Training Subcommittee: addresses training needs of law enforcement, EMS, healthcare, social services, and other partner agencies to provide quality services and ensure a competent behavioral health workforce.

- MOST/FASTT/CIT Policies, Procedures, and Data Collection Subcommittee: comprised of all the players that contribute to the Douglas County Mobile Outreach Safety Team (MOST), Forensic Assessment Service Triage Team (FASTT), and Crisis Intervention Team (CIT). This subcommittee's goal is to formalize these programs by creating standardized policies, procedures, and data collection protocols. This subcommittee also reports progress on these teams to grant funders.

- Empower Youth: A youth-led program for middle school and high school students ages 10-18 in Douglas County. This programs trains students in peer-to-peer education, evidence-based prevention programs, positive behaviors and other life skills to reduce onset of alcohol, tobacco, and other drug use.

STEP #3: PLANNING

Planning involves the development of a strategic plan that outlines policies, programs, and practices that create a logical, data-driven plan to address the priority areas. PDC's planning process produced objectives, strategies, and evaluation data specific to goals addressing each priority area.

The following pages contain PDC's logic model for the next three years. Logic models not only make explicit the intended outcomes and assumptions for the project, but make evaluation more feasible and effective. They enable coalitions to focus on appropriate evaluation questions that have meaning and value to key stakeholders.

Logic Model/Strategic Plan

	Priorities	Data Indicators	Outcome	Intervening Variables	Strategies	Activities
Mental Health Conditions (All ages)	Increase resources for individuals with mental illness	Number of Individuals seeking services experiencing barriers Number of Individuals receiving inappropriate levels of care	Reduce the number of individuals receiving inappropriate levels of care	Low awareness of mental illness Lack of resources available for all levels of care across the continuum	Community Education Community Awareness Campaigns Programs that fill gaps in levels of care	Education to individuals and families in need of MH services through events, health fairs, other means Media campaigns – print, social Implement evidence-based programs and practices
	Increase number of trainings available to community-based service providers	Trained service providers Increased knowledge of how to provide safe, quality services, screenings Increased confidence among community-based providers	Increased percentage of trained, knowledgeable, and confident community-based service providers	Low competency in crisis intervention, screening, and other areas Low confidence in providing mental health services	Training Standardized Screening	Train community-based service providers on crisis intervention, trauma-informed care, overall awareness of mental health stigmas Implement evidence-based screens across sectors
Family Structure	Decrease rate of high school students who	High rates of high school students who	Reduced percentage of high school	Social norms	Community education	Education to parents and community

	ever lived with someone who was a problem drinker, alcoholic, or abused street or prescription drugs Increase number of resources for families to improve communicatio n, promote health behaviors, etc.	ever lived with someone who was a problem drinker, alcoholic, or abused street or prescription drugs Resources available	students who ever lived with someone who was a problem drinker, alcoholic, or abused street or prescription drugs Increased number of resources available Increased knowledge of resources available	Social determinant s favoring unhealthy stress (i.e. lack of housing and basic needs resources)	Community awareness campaigns Programs addressing family communicati on, coping skills, promotion of healthy behaviors	members through events, health fairs and other means Media campaigns – print, social Implement evidence-based programs and practices
Suicide (All ages)	Increase the number of resources for individuals and families impacted by suicidal ideation	Alarmingly high rates of suicide Rates of individuals referred to services for suicidal ideation Rate of students who felt sad or hopeless almost every day for 2 or more weeks in a row Rate of adults who experienced 10 or more days of poor mental or physical health that prevented them from doing usual activities	Reduce the number of completed suicides Reduce the percentage of students who felt sad or hopeless almost every day for 2 or more weeks in a row Reduce the percentage of adults who experienced 10 or more days of poor mental or physical health that prevented them from doing usual activities	Low awareness of suicide Social Norms Levels of impulsivity Social determinant s favoring hopelessnes s (i.e. lack of housing and basic needs resources)	Community education Community awareness campaign Programs addressing prevention Programs addressing social determinants favoring hopelessness	Education through events, health fairs, other means Media campaigns – print, social Implement evidence-based programs and practices

Rx Opiate use 18-59 years	Reduce the percentage of adults 18-59 who have used opioids for a non-medical reason Reduce the percentage of opioid overdoses by all ages	Number of adults that report using prescription opioids for non-medical use Number of overdose deaths	Reduce the percentage of adults who report using prescription opioids for non-medical use Reduce the percentage of opioid overdoses	Low perception of risk Social availability (obtaining through family members or friends)	Community education Community awareness campaigns	Education 18-59-year-olds and their families through events, health fairs, other means Media campaigns – print, social Implement evidence-based programs and practices Peer-to-peer education Prescription Take Back Events
Marijuana Use by Youth	Percentage of youth using marijuana Raise the first age of onset for high school students using marijuana	Perception of risk of using marijuana Rate of students who have used marijuana in the last 30 days Rate of youth who have used marijuana by age 13	Reduce the percentage of youth who have used marijuana in the last 30 days Reduce the percentage of youth who have used marijuana by age 13	Low perception of risk Laws and norms favorable to use	Community education Community awareness campaigns School-based programs	Education to parents and community members through events, health fairs, and other means Media campaigns – print, social Implement evidence-based programs and practices
Heroin Use 18-59 years	Reduce the percentage of adults 18-59 who have used heroin	Number of adults that reported using heroin	Reduce the percentage of adults who report using heroin	Lack of community awareness Laws restricting access to prescription opiate alternatives	Community education Community awareness campaigns	Education 18-59-year-olds and their families through events, health fairs, other means Media campaigns – print, social Implement evidence-based programs and practices

Alcohol – 18-59 years	Reduce the percentage of adults to engage in binge drinking	High percentage of binge drinking among adults	Reduce binge drinking in ages 18-59	Easy Retail Access Promotion Social Norms	Community awareness campaigns	Social norm campaign Presentations specific to high-risk subpopulations Presentations to staff members of liquor serving establishments Implement evidence-based programs and practices
Alcohol Use by Youth	Reduce the rate of youth who reported binge drinking Raise the first age of onset for alcohol use	Rate of youth reported of binge drinking Rate of youth who consume alcohol by age 13	Reduce the percentage of youth reporting binge drinking Reduce the percentage of youth who use alcohol by age 13	Low perception of risk Laws and norms favorable to use	Community education Community awareness campaigns School-based programs	Education to parents and community members through events, health fairs, and other means Media campaigns – print, social Implement evidence-based programs and practices Peer-to-peer education Presentations to staff members of liquor serving establishments Compliance checks for sales to minors
Marijuana Use 18-59 years	Increase perception of risks associated marijuana use	Low perceived risk of using marijuana	Increased percentage of adults who perceive risk from suing marijuana	Low perception of risk Social Norms Laws and norms favorable to use Retail access	Community awareness campaigns	Media campaign – print, social Implement evidence-based programs and practices Peer-to-peer education

STEP #4: IMPLEMENTATION

This section includes the identification of evidence-based programs, policies, and practices to implement and address the strategies outlined in the planning section. This involves taking action guided by the strategic plan. Having researched and evaluated the current drug trends in Douglas County, and having established a plan of action to address those trends, PDC now looks at the coalition's ability to implement that plan and affect those priority issues.

Policies – that address substance abuse and barriers related to mental health among targeted populations:

Douglas County Behavioral Health Task Force

This group:

- Collaborates to collect data and monitor activities related to substance abuse and mental health
- Organizes trainings and educational opportunities related to laws and ordinances that impact substance abuse and mental health
- Reports up to the Northern Nevada Regional Behavioral Health policy board to identify barriers in statute to address substance abuse and mental health
- Provides information to the Douglas County Committee on Health and Board of Health to identify local solutions to issues related to substance abuse and mental health

Practices - address issues identified in the strategic plan/logic model:

Information Dissemination

PDC creates custom educational content, social media messaging, monthly newsletters, billboards, informational flyers, print advertisements, online advertisements, and public service announcements relating to various prevention and drug-related topics.

Education, Training, and Speaking Engagements

Substance abuse in the workplace costs employers billions of dollars annually. We believe our mission of promoting a healthy community though education and resource connection. Therefore, PDC offers a variety of training opportunities for many types of groups: parents, teachers, law enforcement personnel, employers, and other community-based service providers. PDC also seeks out train-the-trainer opportunities to sustain training opportunities for cross-sector service providers.

Prescription Drug Round Up

The Prescription Drug Round Up, held each spring and fall, is a safe place to dispose of expired, unwanted prescription drugs. Rates of prescription drug abuse are increasing throughout the country, and studies show that a majority of abused prescription drugs are obtained from family and friends. The community is safer without unneeded

prescription drugs in a home with the potential for abuse by young children or others. Proper disposal of unused medicines is a public health issue since the environment can become polluted by medicines that are thrown away or flushed down toilets.

Host Community Events

PDC plans, organizes, and hosts numerous community events including large-scale educational summits and town hall events with local media partners. These events educate community members on topics related to substance abuse. Past events have included learning about the effects of marijuana, how to build or update a workplace drug policy, the non-medical use of prescriptions drugs, and conferences specific to youth substance abuse.

Evidence-based Programs and Practices

PDC funds direct prevention service programs implemented by partnering community agencies. *The table below summarizes the programs that are currently funded, partially-funded, or provided by PDC:

Organization	Program	**Description** *(as provided by NREPP or another registry)*	Scope
Me For Incredible Youth, Inc. (MEFIYI)	**LifeSkills**	Botvin LifeSkills Training (LST) is a research-validated substance abuse prevention program proven to reduce the risks of alcohol, tobacco, drug abuse, and violence by targeting the major social and psychological factors that promote the initiation of substance use and other risky behaviors. This comprehensive and exciting program provides adolescents and young teens with the confidence and skills necessary to successfully handle challenging situations.	Middle and High School-age student athletes
Partnership Douglas County	**Too Good for Drugs and Violence**	Too Good for Drugs and Too Good for Violence Social Perspectives build on the prevention concepts of Too Good beginning in Kindergarten incorporating real-world challenges youth face in middle school, high school and beyond. The program explores practical guidance for understanding dating and relationships, violence and conflict, underage drinking, substance abuse, and healthy friendships. Lessons further enhance skills for responsible decision-making, effective communication, media literacy, and conflict resolution. Too Good for Drugs and Too Good for Violence Social Perspectives are evidence-based, skill building programs designed to mitigate risk factors and build the basis for a safe, supportive, and respectful learning environment.	Middle and High School-age youth participating in Empower Youth program
Partnership Douglas County	**Loving Solutions (Spanish Only)**	Loving Solutions is a parent-training program designed specifically for parents raising difficult younger children, ages 5-10 years. Also known as "Parent Project®, Jr.," this program utilizes the same principles found successful in Parent Project® Sr., adapted to the needs of younger children.	Spanish-speaking parents of children ages 5-10
Partnership Douglas County	**Youth/Adult Mental Health First Aid**	Mental Health First Aid is an evidence-based 8-hour course that teaches you how to identify, understand and respond to signs of mental illnesses and substance use disorders. The training gives you the skills you need to reach out and provide initial help and support to someone who may be developing a mental health or substance use problem or experiencing a crisis.	Community-based service providers, adults
Suicide Prevention Network	**American Indian Life Skills (AILS)**	American Indian Life Skills (AILS) is a universal, school-based, culturally grounded, life-skills training program that aims to reduce high rates of American Indian/Alaska Native (AI/AN) adolescent suicidal behaviors by reducing suicide risk and improving protective factors. The curriculum emphasizes social-cognitive skills training and includes seven main themes: 1) building self-esteem, 2) identifying emotions and stress, 3) increasing communication and problem-solving skills, 4) recognizing and eliminating self-destructive behavior, 5)	Native American Youth

		information on suicide, 6) suicide intervention training, and 7) setting personal and community goals. The curriculum also incorporates three domains of well-being that are specific to tribal groups: 1) helping one another, 2) group belonging, and 3) spiritual belief systems and practices.	
Suicide Prevention Network	**Alternative Activities/Weekly Talking Circles**	This program connects local Native American youth with a mentor to discuss healthy behaviors through culturally competent activities.	Native American Youth
Tahoe Youth and Family Services	**Mentoring**	This program connects youth ages 4-17 to a caring adult mentor who is trained and fully screened with a comprehensive background check.	
Partially-funded/Supported Programs			
Douglas County Juvenile Probation	**Parent Project - Changing Destructive Adolescent Behavior (CDAB)**	A Parent's Guide to Changing Destructive Adolescent Behavior (CDAB) is the only parent training program that addresses the MOST destructive of adolescent behaviors. Now in its 12th edition, CDAB has become the program of choice for parents raising difficult or out-of-control teens.	Parents of Children with Destructive Behaviors ages 11-17
Douglas County Social Services	**Loving Solutions Parent Project (CDAB)**	Loving Solutions is a parent-training program designed specifically for parents raising difficult younger children, ages 5-10 years. Also known as "Parent Project®, Jr.," this program utilizes the same principles found successful in Parent Project® Sr., adapted to the needs of younger children.	Parents of Children with Destructive Behaviors ages 5-10| 11-17

*Please note: The evidence-based programs provided above are for the funding years 2016 – 2019. This table may need to be updated based on the competitive funding process for 2019-2023.

For Parent Project and Loving Solutions parenting classes and Youth/Adult Mental Health, PDC has supported the external trainer with training materials and supplies.

STEP #5: EVALUATION

Evaluation measures the impact of the SPF and the implemented programs, policies, and practices. The evaluation process is meant to be a tool that provides useful information to help coalitions in their work. Evaluation basically involves collecting, analyzing, and interpreting information about how a coalition implements its strategies and activities and what changes occur as a result. PDC completes its evaluation measures through different methods: monitoring progress of grant completion, activities, gathering data and watching data trends, and conducting annual focus groups.

Scopes of Work

For each grant, PDC develops a "Scope of Work" document based on the goals/objective that must be met for that grant. This document is used throughout the grant year to track which services and activities have been completed and which services and activities still need to be met. This allows the PDC staff to monitor the progress of each grant and know what services and activities need to be implemented next.

Data and Trends

PDC staff members also keep a close eye on data and data trends throughout the year. Monitoring data trends and community-level and population-level outcomes allows PDC's staff to be aware of changes in substance use, mental illnesses, overdoses, deaths, access, barriers, social norms, perceptions, and even the emergence of new drugs or substance abuse problems in the community. This may result in the need for more community awareness, education, and the development of new short-term and long-term strategies.

Community Focus Groups

PDC hosts community focus groups that allow participants to voice their opinions and concerns about issues in the community. This helps PDC staff to hear what issues the Washoe county community is concerned about and what issues the community feels are being adequately addressed.

Qualitative Impact

PDC studies the impact substance abuse and mental illness work has on key community stakeholders. This study is conducted using a specific qualitative methodology referenced on page 26.