Washoe Regional Behavioral Health Policy Board

2018 Annual Report

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Washoe Regional Behavioral Health Policy Board Final Report to Nevada State Commission on Behavioral Health: NRS 433.4295

I. Executive Summary

During the 79th session of the Nevada Legislature, testimony was provided to members of the Nevada Legislature and the attending public in support of Assembly Bill (A.B.) 366, supporting the creation of four regional behavioral health policy boards. While the idea had originated as a Southern Nevada Forum priority, many stakeholders from throughout the state joined forces to help create A.B. 366, the details which are outlined in the Background section (V) of this document.

Discussion by a diverse group of legislators, and members of professional and public behavioral health disciplines included the opportunity these boards would provide for improvement in Nevada by giving local leaders a more active voice in the decisions that are made as they pertain to behavioral health. Presenters agreed that all regions of the state are facing unique challenges especially in behavioral health issues, and generally agreed that each region is best qualified to address their respective issues. By creating four regional behavioral health boards, the Division of Public and Behavioral Health (DPBH) is able to lean on local experts for suggestions on policy, funding, and implementation issues.

The four regions created by A.B. 366 are Northern, consisting of Carson City, as well as Churchill, Douglas, Lyon, Mineral, and Storey Counties; Washoe, consisting of Washoe County; Rural, consisting of Elko, Eureka, Humboldt, Lander, Pershing, and White Pine Counties; and Southern, consisting of Clark, Esmeralda, Lincoln, and Nye Counties. The policy boards, each staffed with one behavioral health coordinator, collaborate and share information with the other boards focused on behavioral health issues, the goal of which is to create unified recommendations relating to behavioral health as well as ensuring available resources are maximized to the needs of the communities involved.

The Washoe Regional Behavioral Health Policy Board (WRBHPB), along with the other three regional boards, is charged with the responsibilities specified in NRS 433.4295 and outlined in the Background section (V) of this document.

Members of the WRBHPB share the same vision and goals as the Substance Abuse and Mental Health Services Administration (SAMHSA) and the recommendations born out of this vision serves to move Nevada closer to achieving these objectives. We strive to increase awareness and understanding of mental health and substance use disorders, promote emotional health and wellness, address prevention of substance use disorders and mental illness, including those with serious mental illness and to increase access to effective treatment and support recovery. We are committed to working with State, County and other professional associations to address training, data, and financing issues.

The WRBHPB is pleased to present priorities, strategies and recommendations that are based on what has been learned through a careful examination of programmatic research, Nevada and Washoe specific data, national best practices and the experience of many regional experts in the field of behavioral health. The WRBHPB recognizes that many of the recommendations made

may present fiscal, programmatic and logistical challenges in implementation. While recognizing these challenges, we must remember that Nevada remains at the bottom of many national indices for behavioral health issues and how they are addressed. For many other health issues, resources are allocated for their eradication and/or research. It is unacceptable for the State of Nevada to fail to move forward as a leader in our commitment to protect and provide services to those in our communities that are suffering from behavioral health issues. It is with the hope for a positive, productive and secure future for all of Nevada's citizens that this report is respectfully submitted.

II. Washoe Regional Behavioral Health Policy Board Membership: NRS 433.429

CHARLES DUARTE
Chief Executive Officer
Community Health Alliance
Policy Board Chairman

SENATOR JULIA RATTI
District 13
Nevada State Senate

KEVIN DICK
District Health Officer
Washoe County Health District

SHARON CHAMBERLAIN
Chief Executive Officer
Northern Nevada HOPES

HENRY SOTELO
Attorney
Reno Muni Legal Defender

JENNIFER DELETT SNYDER
Executive Director
Join Together Northern Nevada

THOMAS ZUMTOBEL
Vice-President, Population Health
Renown Hospital
(Board member since August, 2018)

SANDRA STAMATES
National Alliance on Mental Illness
Community/Family Representative for
Behavioral Health Families.

WADE CLARK
Sergeant, Reno Police Department
MOST Team

DR. JEREMY MATUSZAK
M.D. Psychiatry

CHARMAANE BUEHRLE
Director, Business Development
West Hills Hospital

J.W. HODGE
Chief Operating Officer
HealthCare Services
REMSA

DR. SAIDE ALTINSAN
M.D. Psychiatry
(Board member through June, 2018)

MONIQUE HARRIS
(Board member through June, 2018)

DR. KRISTEN DAVIS-COELHO
Administrator, Renown Behavioral Health &
Addiction Institute
(Board member since August, 2018)

SHEILA LESLIE
Washoe Regional Behavioral Health
Coordinator (Through August, 2018)

DOROTHY EDWARDS
Washoe Regional Behavioral Health Coordinator
(Since August, 2018)

III. Additional Leadership and Participants

ASSEMBLY BILL 366 SPONSORS

- Assemblyman Nelson Araujo
- Assemblywoman Teresa Benitez-Thompson
- Assemblywoman Irene Bustamante Adams
- Assemblyman Jason Frierson
- Assemblyman Tyrone Thompson
- Assemblyman Steve Yeager
- Assemblyman Paul Anderson
- Assemblywoman Maggie Carlton
- Assemblywoman Amber Joiner
- Assemblywoman Daniele Monroe-Moreno
- Assemblyman James Oscarson
- Assemblyman
- Senator Joyce Woodhouse
- Senator Aaron D. Ford
- Senator Heidi S. Gansert
- Senator Julia Ratti
- Senator Ben Kieckhefer
- Senator Joseph Hardy
- Senator Yvanna D. Cancela
- Senator Mark Manendo
- Senator Becky Harris

POLICY BOARD APPOINTING OFFICIALS

- Governor Brian Sandoval
- Assemblyman Jason Frierson
- Senator Aaron D Ford

LEGISLATIVE COMMISSION 2017-2018

- Assemblyman Jason Frierson, Chair
- Assemblywoman Teresa Benitez-Thompson, Vice Chair
- Senator Kelvin Atkinson
- Senator Moises Denis
- Senator Patricia Farley
- Senator Aaron Ford
- Senator Scott Hammond
- Senator Ben Kieckhefer
- Assemblywoman Maggie Carlton
- Assemblyman James Oscarson (*Appointed September 22, 2017*)
- Assemblyman Keith Pickard
- Assemblyman Jim Wheeler

LEGISLATIVE COMMITTEE ON HEALTH CARE 2017-2018

- Senator Pat Spearman, Chair
- Assemblyman Michael Sprinkle, Vice Chair
- Senator Joseph Hardy
- Senator Julia Ratti
- Assemblyman James Oscarson
- Assemblywoman Ellen Spiegel

NEVADA COMMISSION ON BEHAVIORAL HEALTH

NEVADA DEPARTMENT OF HEALTH AND HUMAN SERVICES

NEVADA DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

JESSICA FLOOD
Northern Regional Behavioral Health Coordinator

JOELLE GUTMAN
Rural Regional Behavioral Health Coordinator

ARIANA SAUNDERS
Southern Regional Behavioral Health Coordinator

JOSEPH FILIPPI
Executive Assistant, Division of Public and Behavioral Health

IV. Individuals Providing Presentations to the Washoe Regional Behavioral Policy Board

- **SHEILA LESLIE**
- **SARAH A BRADLEY**
- **KYRA MORGAN**
- **MISTY VAUGHN-ALLEN**
- **JULIA PEEK**
- **HEATHER KERWIN**
- **JENNIFER RAINS**
- **DUANE YOUNG**
- **JUDGE CYNTHIA LU**
- **JACQUELYN KLEINEDLER**
- **CATRINA PETERS**
- **CHRISTINA SAPIEN,**
- **JEFF ALLEN,**
- **CODY PHINNEY**
- **SHANNON SPROUT**
- **STEVE SCHELL**

V. Background

Mental illness and substance use disorders, together referred to as behavioral health, are common, with an estimated 46% of adults experiencing mental illness or a substance abuse disorder at some point in their lifetime, 25% in a year.[1] Depression is by far the most well-researched behavioral health diagnosis; approximately 16-23% of Americans experience a major depressive episode in their lifetimes, 7.6% in any two-week period. [2,3,4] Somatic symptoms, including fatigue and pain, are associated with depression and anxiety, leading to high use of medical care.[5] Approximately 8.4% of Americans have a substance use disorder, 20.2 million adults; 7.9 million also had a co-occurring mental disorder.[6] There is far greater stigma attached to mental health and substance abuse diagnoses than for other conditions; a less developed state and national infrastructure for measuring and improving care quality; a need for connecting a greater variety and number of clinicians, specialists, and organizations working in "silos"; lower use of health information technology and sharing behavioral health information; and barriers in the health insurance marketplace.[7]

The 2017 Washoe County Behavioral Health Profile (Appendix A) and the 2017 Washoe County Epidemiologic Profile (Appendix B: Link) support key findings related to the emergent behavioral health trends in the region.

Key Findings

Mental Health

- While mental health utilizations for state funded facilities have decreased since 2009, hospital visits in both the emergency department and inpatient have increased, especially for depression and anxiety.
- More than half of high school students in Washoe County report never or rarely receiving mental health support in a time of need.
- In 2017, more than one in four of Washoe County middle school students reported having experienced feeling sad or hopeless almost every day for two or more weeks in a row so that they stopped doing some usual activities, a rate that was lower than Nevada overall.
- The rate of having ever attempted suicide among middle school students in Washoe County was greater than Nevada overall.
- Among middle school students who felt sad, empty, hopeless, angry, or anxious 46.6 percent reported rarely or never receiving the kind of help they needed.
- In 2017, more than one in three of Washoe County high school students reported feeling sad or hopeless for two or more weeks during the previous year, a rate that was higher than Nevada and the United States.
- Among high school students who felt sad, empty, hopeless, angry, or anxious 56.8 percent reported rarely or never receiving the kind of help they needed.
- In 2016, 14.1 percent of adults in Washoe County reported having experienced two or more weeks of poor mental health days including high levels of stress, depression, and problems with emotions during the prior month. The percent of adults in Washoe County experiencing any mental illness, serious mental illness, or major depressive disorder was slightly higher compared to Nevada and the United States.

Fatalities/Suicide

- Between 2011 and 2017, the average prevalence for suicide consideration in Washoe County was 3.3%.
- Substance use is the most common method of suicide attempts in Washoe County with 286 emergency department encounters, and 266 admissions.
- In 2016, the age-adjusted suicide rate in Washoe County was nearly double the rate of the United States. The highest age-adjusted suicide rate for Washoe County was in 2016 at 26.6 per 100,000 age-specific population. In 2017 the rate dropped to 20.0 per 100,000 age specific population.
- Suicide among Washoe County residents aged 65 years and older has greatly exceeded the rate of Nevada and the United States. Of particular concern is the suicide rate for Washoe County residents age 85 and older, which from 2012 to 2016 was nearly four times the national average.
- Mental health-related deaths have increased in Washoe County significantly from 2009 to 2017 at 25.2 per 100,000 age-specific population

Substance Abuse

- The prevalence of drug use in Washoe County is higher in Washoe County than Nevada and the United States.
- Washoe county youth reported having at least using marijuana once. Both high school (12.5%) and middle school student use (3.2%) are higher than Nevada. Emergency department and inpatient visits for marijuana use (not overdose) were more prevalent than methamphetamine, opioid and cocaine use in 2017.
- Drug-related deaths have increased significantly from 2009; 469 deaths to 706 deaths in 2017. Deaths from natural and semi-synthetic opioids (e.g. morphine, codeine, oxycodone, hydrocodone, etc.) had been decreasing, however, 2014 to 2017 data indicates that the number of heroin- related and fentanyl-related deaths are increasing following the national trend
- Self-reported marijuana and cannabis use in pregnant women has increased from 1.9 per 1,000 live births in 2011 to 8.6 per 1,000 live births in 2017.
- Neonatal abstinence syndrome has increased significantly from 1.3 per 1,000 live births in 2011 to 8.0 per 1,000 live births in 2017.
- The Lesbian/Gay/Bisexual/Transgender/Questioning (LGBTQ) population has higher responses to health risk behaviors including binge drinking and being told they have a depressive disorder.
- From 2012-2016, the prevalence of binge drinking and heavy drinking among adults in Washoe County has remained higher than Nevada and the United States.
- In 2017, alcohol-related inpatient admissions in Washoe County were more than double the rate in Nevada.
- From 2007 to 2016, the average age- adjusted rate of alcohol-induced cause of death was more than double the United States.
- More than one in three high school students in Washoe County reported they have been exposed to household substance use and mental illness.

In an effort to address the alarming increase to issues surrounding behavioral health, Assembly Bill 366 was introduced. Subsequently, during the 79th (2017) Legislative Session, Governor Brian Sandoval signed Assembly Bill 366 (NRS 433.425 through 433.4295) which created four behavioral health regions in this State; and created a regional behavioral health policy board for each region to advise the Division of Public and Behavioral Health and the Commission on Behavioral Health of the Department of Health and Human Services regarding certain behavioral health issues. The four policy boards include: The Northern Behavioral Health Region consisting of Carson City and the counties of Churchill, Douglas, Lyon, Mineral and Storey; Washoe Behavioral Health Region consisting of the county of Washoe; the Rural Behavioral Health Region consisting of the counties of Elko, Eureka, Humboldt, Lander, Lincoln, Pershing and White Pine; and, the Southern Behavioral Health Region consisting of the counties of Clark, Esmeralda and Nye.

According to statute, the Governor or his/her designee appoints six members; at least one member must be a behavioral health professional who has experience in evaluating and treating children, including:

- One (1) member who represents the criminal justice system;
- Two (2) members who have extensive experience in the delivery of social services in the field of behavioral health;
- Three (3) members who represent the interests of one or more of the following:
    - Hospitals, residential long-term care facilities or facilities that provide acute inpatient behavioral health services;
    - Community-based organizations which provide behavioral health services;
    - Administrators or counselors who are employed at facilities for the treatment of abuse of alcohol or drugs; or
    - Owners or administrators of residential treatment facilities, transitional housing or other housing for persons who are mentally ill or suffer from addiction or substance abuse.

The Speaker of the Assembly appoints three members as follows:

- One (1) member who is a health officer of a county or who is in a position with duties similar to those of such a health officer;
- One (1) member who is a psychiatrist or doctor of psychology with clinical experience and who is licensed to practice in Nevada; and,
- One (1) member who represents private or public insurers who offer coverage for behavioral health services.

The Senate Majority Leader appoints three members as follows:

- One (1) member who has received behavioral health services in this State or a family member of such a person, or if such a person is not available, a person who represents the interests of behavioral health patients or the families of behavioral health patients;
- One (1) member who represents providers of emergency medical services or fire services; and,
- One (1) member who represents law enforcement agencies.

The Legislative Commission appoints one (1) Legislator.

The Policy Boards are tasked with following responsibilities:
Advise DHHS, the Division (DPBH), and the Commission (Behavioral Health Commission) regarding:

- The behavioral health needs in the region;
- Any progress, problems or proposed plans relating to behavioral health services and methods to improve services in the region;
- Identified gaps in the behavioral health services and any recommendations or service enhancements to address those gaps;
- Priorities for allocating money to support and develop behavioral health services in the region;
- The promotion of improvements in the delivery of behavioral health services;
- The coordination and exchange information with the other policy boards to provide unified and coordinated recommendations to the Department, Division and Commission;
- The review of the collection and reporting standards of behavioral health data to determine standards for such data collection and reporting processes; and,
- In coordination with existing entities, the submission of an annual report to the Commission which includes, without limitation, the specific behavioral health needs of the behavioral health region.

The report must include:

- The epidemiologic profiles of substance use and abuse, problem gambling and suicide;
- Relevant behavioral health prevalence data for each behavioral health region; and,
- The health priorities set for each behavioral health region.

The Statute also provides the opportunity for each policy board to request the drafting of not more than one legislative measure which relates to matters within the scope of the policy board, to be submitted to the Legislative Counsel on or before September 1st preceding the regular session.

VI. Washoe Regional Behavioral Health Needs

In 2018, the Washoe Regional Behavioral Health Policy Board (WRBHPB) utilized three major mechanisms to determine the behavioral health needs and gaps in services in Washoe County. These included a variety of presentations at monthly Policy Board meetings from local, state, and national experts, community surveys, and community focus groups. Each of these components is discussed in this section of the Annual Report including the content of the presentations and the methodology and analysis of survey and focus group reports.

Presentations at Policy Board Meetings

During 2018, WRBHPB invited speakers from a variety of public and private organizations providing behavioral health services in Washoe County to address the Board and provide their thoughts on the status of behavioral health services or programs in Washoe County, gaps in services, and particular resource needs. A brief synopsis of these presentations, (provided by the speaker in their role at the time), is provided below.

- Sarah Bradley, Senior Deputy Attorney General, presented training on **Nevada's Open Meeting Law** and answered questions about how it applies to the Washoe Regional Behavioral Health Policy Board.

- Kyra Morgan and Jennifer Thompson, Division of Public and Behavioral Health, Office of Analytics, presented the **Washoe County Behavioral Health Data Report**, a compilation of data collected by the state to help policy-makers make data-based decisions.

- Misty Vaughn-Allen, Nevada Office of Suicide Prevention, presented **Nevada and Washoe County 2016 Suicide Data**, noting that Nevada's suicide rate went up by 15% in 2016, pushing the state to the 5th highest rate in the nation. While Nevada's youth suicide rate has fallen, the senior suicide rate in Washoe County is three times the national average for age 65+ and nearly four times the national average for those ages 85 and older. An analysis of Washoe County Coroner's data showed 30 to 40 per cent of those who died had previously attempted to commit suicide.

- Sheila Leslie, Washoe County Behavioral Health Coordinator (through August, 2018) presented the Executive Summary from **Mental Health Governance: A Review of State Models and Guide for Nevada Decision-Makers**, published by the Guinn Center for Policy Priorities. She also presented a summary of LCB Bulletin 17-6 on **Regionalizing the Mental Health System in Nevada: Consideration and Options**, noting the key issues associated with regionalization are access to behavioral health care, the impact of the Affordable Care Act and Medicaid expansion, the relationship between the mental health care system and other systems, and expansion of state funding for behavioral health care. Although many states have regionalized behavioral health governance and service delivery, Nevada's behavioral health system has been centralized at the state level with policy development, oversight, service provision, and funding provided by the state. A 10-member Commission on Behavioral Health was established in 1975 that guides state policy in this area

and provides oversight of the system.

- Julia Peek, Deputy Administrator, Community Services, Division of Public and Behavioral Health presented information regarding **State Funding of Mental Health Services in Washoe County**, providing a detailed overview of Federal and state funding resources for mental health care in the region.

- Kyra Morgan, state Biostatistician, presented **Medicaid Behavioral Health Data – Washoe County**, and discussed the most recent patient and claims data available.

- Chuck Duarte, CEO of Community Health Alliance, presented the National Governor's Association **"Housing as Health Care"** report and discussed the challenge of turning Medicaid savings into funding that could be used for supportive housing for those with a Severe Mental Illness.

- Heather Kerwin from the Washoe County Health District presented an **Overview of the 2018-2020 Washoe County Community Health Needs Assessment**, and discussed the chapters on Mental Health, Substance Abuse, and the scoring, ranking and prioritization process.

- Jennifer Rains, Chief Deputy Public Defender in Washoe County, provided an overview of the **Legal 2000 Process** and discussed a variety of concerns that have caused a significant increase in the forensic population and in civil commitment hearings in Washoe County and increased difficulties in addressing the needs of severely mentally ill residents experiencing a crisis.

- Washoe County Human Services Agency staff Sheila Leslie (Washoe County Behavioral Health Coordinator) and Christy Butler presented an overview of the **Mobile Outreach Safety Team (Most)** and its current operations responding with law enforcement throughout Washoe County to calls for service involving people living with a mental illness. Of particular interest is the steady increase in calls and the reported lack of access to mental health care, as 73% of people interacting with MOST report they are not currently receiving any mental health treatment.

- Judge Cynthia Lu provided an overview of the **Assisted Outpatient Treatment (AOT) program in Washoe County**, noting its reliance on a Federal grant from SAMHSA which is scheduled to end in FY 2019. She provided preliminary information about the program's success in greatly reducing jail days and hospitalizations for enrolled clients.

- Jacquelyn Kleinedler, Chair of the Washoe County Children's Mental Health Consortium, presented an overview of the **Washoe County Children's Mental Health Consortium**, and its strategic plan and goals. The Consortium intends to collaborate with the Washoe Regional Behavioral Health Policy Board to ensure the needs of children with behavioral health are addressed in the plan.

- DuAne Young, Deputy Administrator, Division of Public and Behavioral Health, discussed the **Legal 2000 Process** and the unique issues faced in rural Nevada counties as compared to the much larger volume of Legal 2000 referrals in the urban counties.

- Dr. Stephanie Woodard, Division of Public and Behavioral Health, discussed the creation of **Certified Community Behavioral Health Clinics (CCBHC)** in Nevada and the implementation difficulties encountered by the first CCBHC in Washoe County, operated by WestCare.

- Catrina Peters, Director of Programs and Projects in the Washoe County Health District presented the **Behavioral Health Measures of the Community Health Improvement Plan (CHIP)**.

- Christina Sapien, Carson Tahoe Behavioral Health Services, presented an overview of **The Mallory Center in Carson City, a psychiatric urgent care center** providing crisis stabilization services.

- Jeff Allen, Executive Director of the Crisis Intervention and Recovery Center in Canton, Ohio, presented an overview of the **crisis stabilization services and mobile response network** operating in an integrated model in Ohio.

- Cody Phinney, Deputy Administrator, Division of Health Care Financing and Policy, presented an update on the **proposal to expand the 1915(i) Medicaid option** to provide additional resources for homeless, severely mentally ill individuals.

- Shannon Sprout, Deputy Administrator, Division of Health Care Financing and Policy, provided information regarding the reasons for the closure **of the Health Care Guidance Program (HCGP)** in Nevada.

- DuAne Young, Deputy Administrator of the Division of Public and Behavioral Health, provided an update on **services provided by the Northern Nevada Adult Mental Health Services (NNAMHS).**

- Sheila Leslie, Washoe County Behavioral Health Coordinator, provided on update on the closing of the **WestCare Triage Center** and current planning efforts with the goal of reopening it.

- Steve Schell, CEO of the **Reno Behavioral Health Hospital**, provided a tour of the new facility and an overview of services that will be offered when it is at full capacity.

- Jennifer Delett-Snyder, Executive Director of Join Together Northern Nevada (JTNN), Heather Kerwin, Consultant for JTNN, and Jolene Dalluhn, Executive Director of Quest Counseling, presented an **overview of substance abuse prevention and treatment issues** in the Washoe County region.

- State Senator Julia Ratti presented an update on **the recommendations of the Legislative Committee to Study Issues Regarding Affordable Housing**, especially in regards to housing for people living with a mental illness.

- Trish Romo-Macaluso, Outpatient Services Manager at Northern Nevada Adult Mental Health Services, presented an update on the transfer of the Enliven/Raise Up Nevada program serving people experiencing a **first episode of psychosis** from the Children's Cabinet to the Northern Nevada Adult Mental Health Services.

- Lauren Williams, MPH Intern from UNR, presented the **Washoe Regional Behavioral Health Profile** and led a discussion regarding the data.

- Kevin Dick, Washoe District Health Officer, Julia Peek, Deputy Administrator of the Division of Public and Behavioral Health, and Jennifer Delett-Snyder, Executive Director of Join Together Northern Nevada, presented information on **addressing the public health impact of recreational marijuana.**

- Chuck Duarte, CEO of Community Health Alliance, provided background information and led the discussion on the state **Medicaid proposal to require prior authorization requirements for psychotherapy** and the impact this policy would have in regards to accessing mental health services.

- Janet Rosenzweig

- Melissa Kern

The Washoe Regional Behavioral Health Policy Board appreciates the time these individuals took to present valuable information to the Board members and the attending public.

Stakeholder Surveys

Five groups of stakeholders were surveyed during May and June, 2018 as detailed below. A copy of the survey is included as Appendix C at the end of the Annual Report. The raw survey data, by surveyed group, is also available upon request which includes individual answers to several open-ended questions. The stakeholder groups who were surveyed and the number of participants who completed the surveys follow:

- Northern NV Behavioral Health Coalition (26 participants)
- American Association of University Women (8 participants)
- Community Case Managers (9 participants)
- Washoe County Children's Mental Health Consortium (11 participants)

- National Alliance on Mental Illness – No. NV Chapter (22 participants)

The major problems or issues related to behavioral health in Washoe County noted by survey participants can be categorized into six categories as follows:

- Housing Concerns
- Provider Concerns
- Medicaid Concerns
- Resource Concerns
- System Concerns
- General Concerns

"We need to house our homeless. No one deserves to live on the street just because they can't think or look like an executive producer."

2018 Stakeholder Survey

Each category is analyzed below by general themes. Survey participants were also asked to generate ideas for solutions to the problems they identified and general themes are also noted by category.

Housing Concerns

The major concerns noted by the stakeholders included the following:

- Insufficient affordable housing
- Lack of appropriate housing for homeless, mentally ill persons
- Lack of affordable, quality group care homes, with appropriate staffing

The only stakeholder group who did not mention housing as a major concern was the Children's Mental Health Consortium. A wide variety of solutions to these problems were generated by survey participants. The solutions most-often mentioned have been grouped together by similar approaches.

- Encourage builders to include low-income units through the use of incentives and tax breaks
- Tax builders of higher-priced homes to provide funding for rental assistance
- Have local and state government invest in creating more affordable housing, especially Single Room Occupancy/Tiny Homes/conversion of old hotels/motels into subsidized housing
- Implement the Medicaid waivers/options to provide funds for housing
- Provide shelters/housing with mental health and other wrap-around services, including a Housing First program for the mentally ill homeless population
- Implement the evidence-based practice of supportive housing more widely
- Higher standards and monitoring of group homes
- Higher wages and higher level staff at group homes

Provider Concerns

The major provider concerns noted across all stakeholder groups were the following:

- General shortage of providers, particularly psychiatrists and psychologists
- Recruitment problems, including inflexible professional boards
- Lack of providers for long-term case management
- Low insurance reimbursements, particularly from Medicaid

- Not enough providers for uninsured and underinsured

Solutions to these problems focused around the following ideas:

- Incentives to attract and retain behavioral health providers
- Funding for more coordinated workforce development
- Increase scholarships, loan forgiveness, internships
- Improve reciprocity process through professional boards to streamline licensing/certification requirements and improve process
- Increase pay for staff in group homes to improve quality and education
- Increase compensation to attract higher quality psychiatrists

Medicaid Concerns

The major concerns regarding Medicaid are noted below:

- Low reimbursement rates
- Lack of providers
- Administrative requirements such as prior authorization requests taking too long, denials of service, limits on PSR & BST hours, inability to bill for case management of SMI population

General solutions to the Medicaid concerns are listed below although many more specific suggestions were also provided.

- Increase Medicaid reimbursement rates
- The state needs to address the reasons providers won't accept Medicaid
- Make policies more user-friendly
- Monitor quality of service provided by managed care companies and insist on more case management services for SMI population

Resource Concerns

The major concerns expressed by survey participants are as follows:

- Limited funding overall, but especially for client needs and family caregivers
- Cuts to services at NNAMHS

Solutions to these concerns revolved around two areas:

- Additional funding throughout the behavioral health system
- Specific funding to address resource concerns within the state system, specifically at NNAMHS to re-establish a drop-in center, expand recreational facilities, off-campus activities, classes, groups, a community garden, and vocational rehabilitation

System Concerns

There were many detailed and specific concerns raised about the behavioral health system in Nevada. More generally, they can be described as follows:

- Need for a more developed continuum of care for adults and for children
- Needs for respite services for families of children with mental health needs and for caregivers of adults with mental health needs
- Services to assist 18 year olds transition to adult services
- Insufficient residential treatment beds
- Lack of in-state options for long-term needs, including programs for medically complex clients

- Need better ways of linking people in need with available services
- Need improvement in communication and collaboration between state and local services and with community providers
- Increasing numbers of mentally ill people in jail
- Lack of training for school personnel, law enforcement, jail, courts, first responders and other public agencies about how to work with people living with a severe mental illness
- Lack of crisis stabilization services
- Access to substance use disorder treatment
- Need for reforms to the Legal 2000 system

Proposed solutions to these concerns were also quite specific. Generally, they focused around the following areas:

- Funding to address various gaps in the system to address detailed concerns. For example, development of a new state facility for longer treatment for children and for adults
- Require training for personnel in various systems who come into contact with persons living with a mental illness
- Provide a mechanism to link people with available resources that is up to date
  - Increase community case managers to assist people in accessing services
  - Provide more ways for various parts of the system to communicate and collaborate
  - Create more partnerships such as a state/county partnership with Managed Care companies to open detox or day treatment facilities for vulnerable individuals on a walk-in basis
  - Create a psychiatric ER for centralized assessment and stabilization
  - Develop more comprehensive aftercare plans or extended stays in residential treatment until the plan is completed
- Better data collection and analysis to guide development of needed resources, including authentic feedback from youth and families who are systems-involved

"We need help and a safe place from the horrible stigma of having a brain that just went down a little different road."

2018 Stakeholder Survey

General Concerns

A number of disparate concerns were recorded in a general category that covers a wide variety of issues. Some examples are recorded below.

- Access to or information about a particular needed service
- Quality of services/case management in the community
- Families unable to access services due to transportation, child care, funding, or language barriers
- A silence halo around the epidemic of youth suicide
- Stigma concerns around people with a mental illness or substance use disorder
- Increasing homelessness
- Overlapping "solutioning" groups
- More leadership from elected officials

Solutions to general concerns were also wide-ranging, with a few examples recorded below:

- Increase in communication with parents, youth, community about youth suicide
- Ongoing media campaign on the value of treatment and recovery
- Better education in schools to decrease stigma and increase willingness to accept treatment
- Require new businesses to financially support the development of crisis centers
- Louder advocacy
- Whatever is necessary to move us from the bottom

Recent Policy Changes and Progress

A variety of policy changes were singled out by survey participants as worthy of praise. Policies that were cited by more than one person are listed below:

- New opioid treatment programs
- Emphasis on Re-Entry programming
- Expansion of MOST Team in Washoe County
- Regional Behavioral Health Policy Boards
- Peer certification
- Safe school professionals (school social workers)
- Opening of new behavioral health hospital in south Reno
- Expansion of Medicaid
- Mobile outreach in rural areas
- Reducing the silos to produce a continuum of care
- Federally Qualified Health Centers (No. NV HOPES/Community Health Alliance) and their increasing array of services throughout Washoe County
- Community case managers focused on severely mentally ill populations (need more)
- Washoe County School District mandate for Signs of Suicide screenings (though unfunded)
- Mobile outreach for children (MCRT)
- Training for police in mental illness (CIT)
- Sub-standard group homes having to come up to standards

One Thing That Needs to Be Changed

Survey participants were asked if there was one thing they would change, what it would be. A number of highly detailed answers were provided (complete list available upon request). A representative sample of these responses is presented below.

- Systematic planning, i.e. look at the continuum of care and see what's lacking and fund it.
- 24-hour MOST Team services
- Promotion of tele-health services
- More facilities like HOPES that are all-inclusive, one-stop for patients (including child care).
- Build up NNAMHS again as it is highly dysfunctional as services/programs have been reduced and there is very high staff turnover.
- Too many NNAMHS and MOHAVE consumers have fallen through the cracks and no longer have services or medications. NNAMHS needs effective and stable leadership.

"Medicaid – raising reimbursements, cutting bureaucracy and reimbursement hurdles, streamlining authorizations for services."

2018 Stakeholder Survey

- Nevada needs more long-term care and programs for various at-risk populations.
- Provide drop-in crisis centers and a coordinated response like Colorado and Ohio.
- A continuum of affordable housing options is desperately needed, especially for those who need wrap-around or supportive services to successfully live in the community.
- More behavioral health clinics to help people before there is a crisis would be so nice. It's actually cheaper than sending them to jail.

"A continuum of care with one point of entry that anyone can access that is not dependent on payment source"

"Give us back what we had at NNAMHS: Voc. rehab, library, canteen, outings, drop-in center, pharmacy, chapel, groups, jobs, and so much more!"

"We need more community-based providers and assertive community treatment."

"We need a "point of entry" for families where they can get a comprehensive assessment and long-term care coordination"

"We need to be concerned about non-Medicaid families too"

2018 Stakeholder Survey

Stakeholder Focus Groups

As part of the WRBHPB's community engagement process, five stakeholder focus groups were conducted by the Washoe Behavioral Health Coordinator in May and June of 2018 to gather input from individuals directly affected by behavioral health policies and programs in Nevada. A copy of the questions asked of focus group participants is included at the end of this section of the Annual Report as Appendix D.

Stakeholder focus groups included the following:

- Northern NV Behavioral Health Coalition (28 participants), on 5/8/18
- Washoe County Children's Mental Health Consortium (11 participants), on 5/17/18
- Northern Nevada Adult Mental Health Services Clients (6 participants), on 5/31/18
- National Alliance on Mental Illness – No. NV Chapter (25 participants), on 6/28/18
- Assisted Outpatient Treatment Clients (12 participants), on 6/29/18

A brief analysis of the responses to the five questions posed to the stakeholder focus groups follows.

What changes could be made to improve the delivery of behavioral health services in Washoe County for adults?

The answers from the **Behavioral Health Coalition and the Children's Mental Health**

Consortium were naturally very detailed as these participants are primarily professionals working in the behavioral health field and family members who are very knowledgeable about the system. Participants cited the need for additional or enhanced resources such as 24/7 Crisis Centers to include detox, walk-in assessments, immediate access to treatment, and stabilization beds for 10 to 14 day stays. They also mentioned the need for more supported housing and semi-independent housing, the creation of drop-in centers in the community using the evidence-based Clubhouse model, ideally 24/7, but at least during day time hours. The idea of a Mobile Outreach van was mentioned, to provide behavioral health services in the community and in the rural parts of the Washoe region. Concern for a "warm hand-off" for youth turning 18 as they transition to the adult system was also expressed, perhaps through the use of system navigators.

These two groups also mentioned system-wide issues such as the need for more behavioral health providers. Participants want community providers to be able to access reimbursement for Targeted Case Management services as well as receive higher reimbursement rates from Medicaid for behavioral health services. There was also support noted for additional inpatient and long-term beds and increased use of tele-mental health technology. The particular struggles of homeless youth and adults living with a mental illness were mentioned as well as those who are incarcerated and have difficulty reinstating their behavioral health care.

The National Alliance on Mental Illness (NAMI) focus group mentioned many of the same needs including strong support for crisis stabilization centers, expansion of affordable housing options for people with mental illness, and more support for those re-entering the community after incarceration. This group was also very vocal about the need to put more funding back into the state behavioral health system to revitalize it and urged the state to "drop the going out of business strategy." NAMI members expressed support for increased peer support services and complained that the certification requirements are constantly changing. They would like to see a warm line in the community along with financial support for caretakers for those living with a severe mental illness. Participants also wanted the state to do more to attract and retain psychiatrists.

Two focus groups targeted **consumers of mental health services**. These participants liked the services currently available at Northern Nevada Adult Mental Health Services (NNAMHS) but wanted the services expanded. They want the cantina to open again and they want recreational opportunities they used to have, including field trips. Several mentioned their desire to have a service coordinator again that would help them with independent living skills, such as taking the bus.

The overriding theme of the client focus groups was the need for more services that help them live successfully in the community. Many expressed their desire to have a job, be able to take public transportation without fearing for their safety, to learn how to cook and 'handle life' and to not be constantly worried about money and accessing their medication. They want a drop-in center where they feel welcome and several mentioned their desire to have stronger family and community connections.

What changes could be made to improve the delivery of behavioral health services in Washoe County for children?

The **Behavioral Health Coalition and Children's Mental Health Consortium** focus groups

generated many ideas for enhanced behavioral health services for children and youth in Washoe County. They noted the lack of children's psychiatrists in the region and the frustration of providers who are dependent on reimbursements from insurance companies and Medicaid to survive. Members expressed desire for in-state Residential Treatment Centers able to accept youth with intense behavioral needs, expanded hours for mobile crisis teams, and more wrap-around teams. Both groups were troubled by the lack of services for parents who are struggling to access behavioral health care for their children and wanted resources to assist them in navigating the system, especially for families who are not eligible for Medicaid.

The **NAMI** focus group discussed the need for better education and training for teachers and school counselors regarding mental illness to enable them to be effective advocates for students and their families and to provide more early intervention. They also noted that some children need additional support when they are living with an adult who has a severe mental illness. NAMI members also mentioned the need for education regarding mental illness in children and youth for pediatricians and medical students. Mental Health First Aid was recommended by the NAMI focus group as a resource that could be used to educate children and youth about emotional health concerns. The participants were also concerned about homeless youth and supported the idea of a 24/7 shelter at the Eddy House with mental health supports.

What do family members need to support their loved ones living with a mental illness or substance use disorder?

The **Behavioral Health Coalition and Children's Mental Health Consortium** focus groups continued their discussion of the need to support family members through a variety of delivery methods and languages. They suggested more active mechanisms to link families to Residential Treatment Centers and inpatient resources, noting the difficulties many have in navigating the system. These two focus groups also expressed the need for expanding financial supports for caregivers and for the expansion of the entire spectrum of respite services. They were strong advocates for ensuring families whose children are not receiving Medicaid have access to a full range of services, as some children's services providers only accept Medicaid. Participants also want more emphasis placed on earlier in-home services, parent education, in-home therapy services, and more advocacy for parental custody children.

The **NAMI** focus group discussed the need for respite care as well, stating it's much easier to have someone come into a home environment than to take the client to an unfamiliar place, especially for those experiencing dementia. Participants were especially concerned about caregivers needing a break and more support. NAMI would like mental health professionals to make more of an effort to get input from family members and include them on the treatment team. They were strong believers in supportive family collaboration as is often done with chronic medical conditions such as diabetes. They would like more expansive wrap-around services to include things like helping a client get glasses or dental care. They also suggested more home visits to ensure that interactions between family members are going well. Finally, the NAMI focus group members were strongly in support of an expanded peer specialist program. One person suggested that peers could engage in paid work for other peers, such as cleaning houses, and then they would be able to check up on each other and offer more consistent peer support.

Do you have any recommendations for policy changes at the state legislative level?

During discussion with the focus groups involving participants in the **Behavioral Health Coalition**, reforms to the legal hold (Legal 2000) system was brought up several times, with members expressing different views about what those reforms should be, reflecting the statewide debate about how to make the system work better for the clients, their family members, hospitals, treatment professionals, law enforcement, and the judicial system.

Other policy changes suggested by Coalition members revolved around payment for services from the State. Several members would like the State to change the way grants are paid (reimbursement only) to provide up-front dollars which would enable agencies to implement programs without accruing debt. Other members want the State to continue funding for non-profit behavioral health outpatient programs which cannot survive while they are waiting for Medicaid payments which are often reimbursed long after the service is rendered and at a rate that is lower than the cost of providing the service.

Participants in the focus group at the **Children's Mental Health Consortium** meeting would like to see an enhanced coordination effort to address system fragmentation and more oversight from the Division of Child and Family Services on programs operating in the community. A better structure for behavioral health services to children and youth is needed at the state level, including an increase in staff. Participants noted a lack of leadership for these issues from a designated state person who could lead strategic planning around the gaps in services. They also were concerned about the lack of parity of services between "system" kids and those not yet system-involved.

The **NAMI** focus group members suggested a policy change to make it a requirement that all law enforcement, paramedics, judges, and professionals in the criminal justice system be trained in brain disorders or attend a course covering basic mental health topics, similar to Community Intervention Training (CIT).

How can our community move forward with prevention efforts and raise public awareness about behavioral health?

The **Behavioral Health Coalition** focus group members would like to see a bigger push to integrate behavioral health with primary medical care with the goal of reducing stigma and increasing access to care for those experiencing a mental health or substance use concern. Members also expressed the need to promote early diagnosis and intervention, mentioning the Mental Health First Aid program as one that is easy to implement at a community level. Finally, this focus group discussed the need to ensure there is regional awareness of specific behavioral health issues and developing region-specific approaches to prevention and public awareness.

The **Children's Mental Health Consortium** focus group members agreed that more Crisis Intervention Team training is needed to promote public awareness and support prevention efforts. Participants mentioned they would like a public service campaign focusing on environmental strategies and utilizing social media, including an "app" for a smartphone, as well as more traditional media platforms. Adequate funding would be needed to enable the campaign to be effective.

The **NAMI** focus group members would like to see a much broader media strategy to decrease stigma and link people to the services they need. Ideas for a media campaign include newspaper features such as employers who have successfully hired someone with a mental illness, 30-minute television talk shows, and billboards that put a "face" to mental illness. NAMI members mentioned the idea of using listening sessions and focus groups to help with the design of a public awareness campaign. The NAMI members also expressed a desire for more pro-active prevention activities such as an urban hiking meet-up group, and peer social events to break through isolation and prevent a mental health crisis.

VII. Regional Priorities and Strategies

Since its inception, the Washoe Regional Behavioral Health Policy Board (WRBHPB) has met with County leadership, public and private agencies and stakeholders to assess the needs of the County and how prioritizing and strategizing could not only help meet regional needs but coordinate efforts statewide where resources were limited or duplicative. Several of the emergent needs were considered for submission as a Bill Draft Request (located in Section IX) and many others continue to be issues on which this Board will commit time and efforts. The WRBHPB works toward ensuring:

- The provision of the highest quality of behavioral health care to patients and their families;
- The development and enhancement of acute, residential, and outpatient services; and,
- The provision of services to children and adults in need of mental health and substance abuse care.

In the accomplishment of those goals, the WRBHPB strives:

- To have compassion, empathy, & perseverance for patients and their families;
- To utilize a "team" approach to care;
- To focus on proactive communication with patients/families/payors/referral sources/stakeholders/policy makers; and,
- To research and encourage sound fiscal management with resources.

With the above in mind, throughout the year the WRBHPB has identified many areas that are considered priorities to either create, support, maintain and/or enhance. The below issues are in addition to those submitted to the Legislative Committee on Health Care as potential Bill Draft Request concepts and may be submitted in future sessions for support and/or consideration.

Mobile Outreach Support Team:

The Mobile Outreach Safety Team (MOST) was created in response to the Governor's Behavioral Health and Wellness Council's recommendation to create an intervention team to work with law enforcement professionals to be operated at the local level to respond to individuals with a mental health condition who are in crisis. The existing MOST Team, funded by a grant from the State of Nevada increases coordination with the local law enforcement agencies in Washoe County by providing:

- Immediate crisis intervention up to and including Legal 2000 holds for persons at least 18 years old with a Serious Mental Illness;
- Referrals for ongoing mental health and other social services such as medical care, housing, and other supportive services needed for stabilization;
- Follow-up case management to monitor referral outcomes and ensure linkages to ongoing services as needed; and,
- Outreach to local law enforcement agencies, human services organizations, mental health advocacy groups and other community-based organizations to enhance and coordinate ancillary referrals.

The WRBHPB supports the efforts and applauds the success of this critical community resource and will encourage sustained funding for its continuation.

Targeted Case Management (TCM):

Targeted Case Management (TCM) refers to case management for specific Medicaid beneficiary groups or for individuals who reside in state-designated geographic areas. Essentially, at least when used by Medicaid, TCM refers to the provision of case management services to specific "target" populations. Historically, TCM has been used by states as a funding vehicle for state or local government providing services to specific populations, e.g. individuals with serious mental illness and has been shown to be an effective service to reduce unnecessary institutionalizations and emergency room use when done with fidelity to the model. The WRBHPB has seen evidence of the effectiveness of intensive case management on individuals suffering from behavioral health disorders, including co-occurring disorders. Revising the State Plan for Medicaid allowing TCM to be provided by organizations beyond state and local governmental entities could be an effective means of assisting Medicaid beneficiaries with mental illness stay safe and effectively housed.

Medicaid Section 1915(i):

Medicaid Section 1915(i) refers to a section of the Social Security Act allowing states to amend the State Plan for Medicaid to provide long-term services and supports for a designated population of Medicaid beneficiaries. The services allowed are generally not covered through the Medicaid program but are allowed under this section of the law. Specifically, states have used this to provide services geared to keep individuals with serious mental-illness and who are chronically homeless housed and supported which better enables them to maintain active treatment for their condition(s). Services such as tenancy supports (e.g. housing searches and application; eviction prevention, and case management), health care services (e.g. accompanying client to appointments, medical respite, basic skills training), and referrals to social support services, work to assist the client with treatment while in housing. These programs have shown great promise in reducing unnecessary health care costs, such as avoidable hospitalizations and emergency room use. Additionally, they have been shown to reduce arrests and jail time for minor infractions associated with their mental-illness. The WRBHPB supports the further exploration/implementation of this waiver/amendment to the State Plan for Medicaid.

Affordable Housing Initiatives:

For programs such as 1915(i) and TCM to be effective there is a need for an inventory of affordable housing options for clients. The WRBHPB supports those initiatives that increase housing availability and options, particularly supportive housing for individuals with chronic serious mental illness. This could include transitional housing (i.e. supportive yet temporary housing, usually less than six months) to long-term affordable housing options focused on individuals and families living below 60% of the Area Median Income (AMI).

CHIP Behavioral Health Areas:

The Community Health Improvement Plan (CHIP) is a long-term, systematic effort to address health problems in a community based on results from a Community Health Needs Assessment (CHNA). The plan recommends priorities for action and outlines measurable objectives to address the needs of a community. This is a collaborative process and is used by health and other governmental, education, and social service agencies and organizations to implement policies and programs that promote health.

The Washoe County Health District in partnership with Renown and Truckee Meadows Healthy Communities aligned planning efforts and initiated a comprehensive CHNA which contains a

prioritization of health needs to better understand and organize the large amount of secondary data (county, state and national level statistics/numbers) and primary data (online community survey) contained within the assessment. After careful consideration and deliberation, three focus areas emerged as the highest areas of need and the areas where there was community capacity to initiate work:

1. Housing
2. Behavioral Health
3. Nutrition/Physical Activity

Washoe Regional Behavioral Health Policy Board commits its resources to and supports the efforts to the issues surrounding behavioral health and the closely related housing issue which include: to stabilize and improve housing security for the severely mentally ill (SMI); to assess and address current status and need for Behavioral Health services in Washoe County; and, to reduce depression and suicidal behaviors in adolescents.

VIII. Regional Recommendations to the State

Crisis Stabilization Unit (CSU)

Discussion

Crisis Stabilization Units (CSUs) are considered an emergency healthcare alternative, providing persons with an acute behavioral health problem (including co-occurring disorders) with prompt action, gentle response and effective support in a respectful environment. A CSU can provide intensive, short-term voluntary interventions for someone experiencing a psychiatric and/or substance abuse crisis, including stabilization services and medical detoxification.

Crisis Services are designed to stabilize and improve symptoms of distress and feature a continuum of core services including 23-hour crisis stabilization/observation beds, medical detox, short term crisis residential services and crisis stabilization, mobile crisis services, 24/7 crisis hotlines, warm lines, psychiatric advance directive statements, and peer crisis services.

The research based on the effectiveness of crisis services is growing. There is evidence that crisis stabilization, community-based residential crisis care, and mobile crisis services can divert individuals from unnecessary hospitalizations and ensure the least restrictive treatment option is available to people experiencing behavioral health crises. Additionally, a continuum of crisis services can assist in reducing costs for psychiatric hospitalization, without negatively impacting clinical outcomes (SAMSHA, 2014).

Recommendation

The Washoe Regional Behavioral Health Policy Board recommends legislation that supports both programmatically and fiscally, a Crisis Stabilization Unit in Washoe County and has submitted a Bill Draft Request (BDR #40-486) to address that need.

Affordable Housing

Discussion

The Washoe Policy Board carefully reviewed the National Governor's Association Housing as Health Care report and agrees with the principles outlined therein regarding the need for affordable, accessible, quality housing. The affordable housing crisis in Reno has disproportionately affected those living with a severe mental illness, many on a fixed income that is not increasing as rents soar. The Policy Board also remains concerned about the quality

of housing available to this population as outlined in the audit of the Community Based Living Arrangements (CBLA) funded by the state.

Recommendation
The Policy Board agrees with the recommendations from the legislature's Affordable Housing Committee to exercise the 1915(i) Medicaid option for reimbursement for supportive services provided to those individuals in permanent supportive housing. The Policy Board also agrees with the Committee's recommendation to create a Nevada Affordable Housing Tax Credit Program.

Assisted Outpatient Treatment (AOT)

Discussion
The Assisted Outpatient Treatment (AOT) allows the most severely mentally ill individuals to be court-ordered into treatment *without* ordering them into a hospital. It represents a less-restrictive, less-expensive, more humane form of 'commitment' than inpatient commitment. The criteria to place someone in assisted outpatient treatment are easier to meet than the "imminent dangerousness" standard often required for inpatient commitment. AOT allows an individual to be ordered into treatment to prevent a relapse or deterioration which would likely result in serious harm to the patient or others. The court order not only commits the patient to accept treatment, but also commits the mental health system to providing it. AOT legislation has been shown to reduce hospitalization, arrest and incarceration, homelessness, victimization, and also to prevent violent acts associated with mental illness, including suicide and violence against others.

Recommendation
During the 2013 Nevada Legislative session, AB287 was introduced and passed (NRS 433A.310) resulting in one funded state program (Southern Nevada Adult Mental Health Services (SNAMHS)). Northern Nevada Adult Mental Health Services (NNAMHS) successfully applied for a SAMSHA grant to create an AOT program in Washoe County but that funding is scheduled to end in 2019. The Washoe Regional Behavioral Health Policy Board identified a need to include funding for the NNAMHS program in the next biennial budget.

Super-Utilizer Pilot Program

Discussion
Super-utilizers are individuals whose complex medical problems make them disproportionately heavy users of expensive health care services, particularly Emergency Medical Services (ambulance/fire), Emergency Room treatment and in-patient hospitalizations. These are people who typically overuse emergency departments and hospital inpatient services, making more visits to those facilities in a month than some people make in a lifetime. These patients often suffer from multiple chronic complex diseases, including mental health issues along with inadequate – or nonexistent – housing. They also lack a primary care physician or other medical home, so their health care may be haphazard and uncoordinated resulting in a huge burden being placed on our health care system.

Recommendation
While all emergency responders and health care providers agree they see these same individuals regularly, having the ability to identify each one and share approaches and services offered, is

an important first step. Data sharing emerges as a goal to enable this process to become more streamlined and to provide services that will mitigate multiple entries into the hospitals, jails, etc. The Washoe Regional Behavioral Health Policy Board identified the need for a staff position to allow for a pilot Super-Utilizer Multi-Disciplinary Team to be convened, using data-sharing to identify the shared top utilizers of services and have the resources to develop highly-specialized case intervention plans to decrease inappropriate calls for services across systems.

New 1% Excise Tax to Address Impacts of Marijuana

Discussion

The Washoe Regional Behavioral Health Policy Board heard presentations from community-based entities regarding lack of data on the impact the legalization of marijuana has had in our region and ideas for more systemic data collection and surveillance and coordinated public education campaigns to address second-hand marijuana smoke, disparate populations such as pregnant and breastfeeding women, and youth prevention.

Recommendation

A proposal to raise the excise tax on marijuana sales to fund these types of activities was discussed.

Mandate Substance Abuse Prevention Program in Schools

Discussion

Data collected for Washoe County reveals the levels of substance abuse by adolescents. Substance use during adolescence has been associated with alterations in brain structure, function, and neurocognition. According to the United States Office of Juvenile Justice and Delinquency Programs, adolescents who abuse substances are at risk for a wide variety of issues that may interfere with their development. The physical, social and psychological effects of adolescent substance abuse can have lasting consequences on the individual, and may interfere with a successful transition from adolescence to adulthood. Drug-related accidents and overdoses often result in physical injuries and illnesses, and teens abusing substances have a higher risk of practicing unsafe sex, which may expose them to HIV and other sexually transmitted infections. Substances such as alcohol and psychoactive drugs can have lasting effects on the psychological development of an adolescent. Data suggests that teens who abuse these substances are at higher risk for mood disturbances and mental health disorders, such as conduct disorders. Depression and anxiety resulting from prolonged substance abuse can disrupt an adolescent's ability to function and develop in a constructive manner. Adolescents with substance abuse problems are more likely to experience issues with social development. The American Academy of Child and Adolescent Psychiatry notes teens who abuse substances are more likely to withdraw from peers and family, and are more likely to have problems with the law. In addition, these teens may experience difficulties in school due to an inability to study or participate, and this often inhibits the successful development of academic and employment skills.

Preventing alcohol, tobacco, and other drug use among youth requires a comprehensive approach that addresses a range of risk and protective factors. The responsibility for preventing youth substance abuse does not lie with one discipline or group. Consistent prevention messages must be present from early childhood through young adulthood and be reinforced by multiple messengers at home, at school, and in the community.

Schools have a significant role to play in addressing student substance abuse. Research shows that youth who receive universal, school-based substance abuse prevention programming are less likely to drink, smoke, and use other drugs. Schools—from kindergarten through high school—are an ideal venue to deliver age-specific, developmentally appropriate, and culturally responsive prevention programming. Teachers and administrators can foster positive school climates, create and enforce substance abuse prevention policies, and communicate consistent norms that youth substance abuse is unacceptable. The benefits are many: students who do not regularly use alcohol and other drugs are more likely to have higher grades, better attendance, and superior overall academic achievement than those who do use substances. Substance abuse can contribute to bullying and other violent behaviors in schools; thus, decreasing substance use contributes to safer schools. In addition, reducing substance abuse and related disciplinary and intervention responses can free up teacher, administrator, and staff time to focus on students' academic success.

Recommendation

The National Institute on Drug Abuse (NIDA) has identified early intervention as one of many evidence based prevention programs. Intervening early—before high school—is critical. The data suggest that patterns of substance abuse become worse in the high school years. Individuals who begin using alcohol or tobacco when they are very young are more likely to abuse them later in life, when it becomes much more difficult to quit.

Recognizing and appreciating the tremendous work our teachers in Nevada do, but also cognizant of the problem that faces our children, the Washoe Regional Behavioral Health Policy Board identified this issue as a possible BDR request, asking for a mandate to require age appropriate education within our schools that will assist students in learning learn how to understand and identify the causes, preventions, and treatments for diseases, disorders, injuries, and addictions. It is the Board's understanding that the Attorney General's office is pursuing a bill draft for this purpose and would support this effort.

Clubhouse or Drop-In Center for Consumers

Discussion

Drop-In Centers offer a safe, supportive environment within the community for individuals who have experienced mental/emotional problems. It is a place to go, a place to be, a place to make friends, and be accepted and allows individuals the opportunity to learn to live in the community and to take control of their lives.

The concept of a drop in center allows individuals to interact with others who have shared similar experiences, such as hospitalizations, medications, doctors, therapies, etc. Understanding of the pain and suffering of mental health problems is shared. A support system is built that helps individuals through painful times and helps individuals to have a sense of normalcy in their world which is often chaotic. A center of this sort would provide another resource to our community's population experiencing mental and emotional health needs.

Recommendation

The Washoe Regional Behavioral Health Policy Board received input from consumers of mental health services regarding their desire for a Clubhouse or Drop-In Center to enable them to access these peer services and supports in our region.

IX. Legislative Bill Draft Request

EXECUTIVE DEPARTMENT BILL DRAFT REQUEST
FOR THE 2019 LEGISLATIVE SESSION

Authority: NRS 218D.175

Deadline: Executive Department BDRs must be submitted by no later than **September 1, 2018.**

Person Submitting Request:
Dorothy Edwards on behalf of the Washoe Regional Behavioral Health Policy Board

Person to Contact for Clarification or Additional Information:
Name: Dorothy Edwards, Regional Behavioral Health Program Coordinator
Email: daedwards@washoecounty.us
Phone: (775) 337-4506

1. **Intent of Proposed Bill or Resolution** (Describe the problem to be solved, intended effect, and/or the goal(s) of the proposed bill or resolution – may be attached as separate document):
See attached document

2. **If known, list any existing state law that is sought to be changed or which is affected by the measure (NRS Title(s), Chapter(s) and Section(s) affected, Statutes of Nevada Chapter(s) and Section(s) affected and/or Nevada Constitutional provision):**

3. **Any additional information that may be helpful in drafting the bill or resolution** (May include any relevant legislative measures, cases or federal laws or other supporting materials – may be attached):

According to a study performed by the Substance Abuse and Mental Health Services Administration (SAMHSA, Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies. HHS Publication No. (SMA)-14-4848. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014, https://store.samhsa.gov/shin/content//SMA14-4848/SMA14-4848.pdf), the most frequently reported funding sources for crisis services are state and county general funds and Medicaid. Although states finance crisis services using different payment mechanisms, and the concept of crisis stabilization centers may look differently from county to county, many states and jurisdictions are using multiple funding sources to ensure that a continuum of crisis care can be provided to all who present for services, regardless of insurance status. Each of the states studied in this report, indicated that using funding from multiple sources has been an effective way to support a continuum of crisis care. States also emphasized the value of collecting data on crisis services quality indicators to inform policy decisions around crisis care. With this in mind, the Washoe Regional Behavioral Health Policy Board plans to submit further analysis of available data. The report will be

available to improve assessment of fiscal impacts prior to the commencement of the 2019 legislative session.

4. Effective Date:

- □ Default (October 1, 2019)
- □ July 1, 2019
- X January 1, 2020
- □ Upon Passage and Approval
- □ Other

5. Description of any known cost to the State or a local government that would result from carrying out the changes in the measure if enacted:

State General Funds for services not reimbursable by Medicaid and/or other insurance providers; Medicaid, including Medicaid Waiver funds. These costs may be offset by the reduced cost of crisis stabilization services as compared to costs of treatment in emergency departments and hospitalizations

REQUIRED PREFILING:

A bill draft requested by the Executive Department of State Government is required to be prefiled on or before November 21, 2018. By statute, a measure that is not prefiled on or before that date is deemed to be withdrawn. There is no authority to waive this requirement.

Please submit completed Bill Draft Request form by mail to: Brenda Erdoes, Legislative Counsel, Legislative Building, 401 South Carson Street, Carson City, Nevada 89701, by e-mail at erdoes@lcb.state.nv.us or by fax at (775) 684-6761.

EXECUTIVE DEPARTMENT BILL DRAFT REQUEST FOR THE 2019 LEGISLATIVE SESSION, CONT.

Intent of Proposed Bill or Resolution (Describe the problem to be solved, intended effect, and/or the goal(s) of the proposed bill or resolution)

Definition (s)

Crisis Stabilization**:**
Crisis stabilization is defined as "a direct service that assists with deescalating the severity of a person's level of distress and/or need for urgent care associated with a substance use or mental health disorder". Crisis stabilization services are designed to prevent or ameliorate a behavioral health crisis.

Behavioral Health:
Behavioral health includes mental health *and* substance use, encompassing prevention,

early intervention, education, treatment, recovery, and resiliency.

Co-occurring Disorders:

Co-occurring disorders describe the presence of both a mental health and a substance-use disorder.

Problem to be Solved:

Nevada currently has a critical need to fill a gap in crisis stabilization services. This gap in services leaves those in a behavioral health crisis to receive treatment in the hospital emergency departments resulting in a significant increase in overall healthcare expenditures. Populations include some of Nevada's most vulnerable such as seniors, veterans, homeless and those experiencing Post Traumatic Stress Disorder. The ability to address diversity and cultural differences must also be included as a critical role in the direction of resources and services.

Providing behavioral health crisis assessment and treatment in busy emergency departments that produce long waits for care can be a challenging environment for those in need of immediate treatment for psychological needs. "Cold" referrals to mental health care run the risk of minimal follow up and emergency departments have become the default mental health crisis center. Crisis service settings often have more in common with jails; police transport to sometimes distant hospitals, taking law enforcement off the "beat" and the result can be stigmatizing for people in crisis. Despair and isolation is worsened by attempting to navigate a complex mental health system maze.

A recent Washoe County Behavioral Health Profile, supported with data from regional and national sources, revealed devastating numbers related to behavioral health not only in Washoe County but Nevada as a whole. A few of the related statistics include:

- On average from 2012 to 2016, the percentage of adults in Washoe County who experienced any mental illness (19.6%) and serious mental illness (5.1%) was higher than Nevada and the United States, however the percentage of adults who received mental health services in the past year was lower in Washoe County (13.2%) compared to the United States (14.5%).

- In 2016, the age-adjusted rate of death due to intentional self-harm in Washoe County (26.8 per 100,000 people) was nearly double the rate of the United States (13.5 per 100,000 people).

- From 2006 to 2016, the average suicide rate in Washoe County (20.4 per 100,000 population) was higher than Nevada (19.1 per 100,000 population) and the United States (12.4 per 100,000 population).

- Aggregate data from 2012 to 2016 indicate the rate of death due to suicide in Washoe County increased as age increased. The rate of death due to suicide among Washoe County residents aged 85+ (72.3 per 100,000 population) was more than six times the rate among residents aged 15-24 years (11.5 per 100,000 population).

- The rate of death due to suicide among those aged 85+ in Washoe County was nearly four times the rate for the United States, and the rate of death due to suicide among those aged 65 to 84 years in Washoe County was more than double the United States.

- In 2017, the top conditions seen in emergency departments in Washoe County were anxiety (28.1% of encounters), drug-related (18.4%), alcohol-related (16.5%), and depression (15.9%). In 2017, the top conditions that led to an inpatient admission in Washoe County were depression (21.8% of admissions), drug-related (20.7%), anxiety (20.1%), and alcohol-related (16.7%).

Intended Effect:

Crisis Stabilization Centers (CSCs) are considered an emergency healthcare alternative, providing persons with an acute behavioral health problem (including co-occurring disorders and substance abuse events) with prompt action, gentle response and effective support in a respectful environment.

CSCs are effective at providing suicide prevention services, addressing behavioral health treatment, diverting individuals from entering a higher level of care and addressing the distress experienced by individuals in a behavioral health crisis. Studies also show that the cost of CSCs is significantly less than psychiatric inpatient units and satisfaction among clients is greater. (Saxon, V. 2018). Crisis stabilization services are designed to stabilize and improve symptoms of distress and feature a continuum of core services including 23-hour crisis stabilization/observation beds, medical detox, short term crisis residential services and crisis stabilization, mobile crisis services, 24/7 crisis hotlines, warm lines, psychiatric advance directive statements, and peer crisis services. Different crisis stabilization models exist but generally a CSC can provide intensive, short-term voluntary interventions for someone experiencing a psychiatric and/or substance abuse crisis, including stabilization services and medical detoxification. If inpatient care is required, a stay of five days or less in the proposed average.

The research based on the effectiveness of crisis services is growing. There is evidence that crisis stabilization, community-based residential crisis care, and mobile crisis services can divert individuals from unnecessary hospitalizations and ensure the least restrictive treatment option is available to people experiencing behavioral health crises. Additionally, a continuum of crisis services can assist in reducing costs for psychiatric hospitalization, without negatively impacting clinical outcomes (SAMSHA, 2014). Many communities have only two basic options available to those in crisis, and they represent the lowest and highest end of the continuum. For those individuals whose crisis represents the middle of the ladder, outpatient services are not intensive enough to meet their needs, and acute care inpatient services are unnecessary. Crisis stabilization facilities offer an alternative that is less costly, less intrusive, and more easily designed for successful and deliberate focus and response.

The expectation is to begin to mitigate the growing crisis around our behavioral health issues by supporting our current successful programs such as the Mobile Outreach Support Team (MOST), and to create new and critical resources.

Goal(s) of Proposed Bill:

1. This bill would authorize the establishment of a certified crisis stabilization center to be operational during the 2019-2020 interim.

- The expansion of crisis stabilization services in Nevada and establishment of a certified 24 hr. walk-in crisis stabilization center.
- The purchase of crisis services from a private behavioral health organization through a request for proposal (RFP) process. Services would be managed via performance contracts and formal reviews.
    - Contracted services will include at a minimum:
        - The establishment of treatment protocols, documentation standards, and administrative procedures, consistent with best practices and other evidence-based medicine, for appropriate treatment to individuals who are provided crisis stabilization services.
        - Planning and delivery of services consistent with the philosophy, principles, and best practices for mental health consumers.
        - Assurance of behavioral health equity which is the right to access quality health care for all populations regardless of the individual's race, ethnicity, gender, socioeconomic status, sexual orientation, geographical location and social conditions through prevention and treatment of mental health and substance use conditions and disorders.
        - The promotion of concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.
        - The promotion of consumer-operated services as a way to support recovery.
        - Planning for each consumer's individual needs.

2. This bill would authorize funding at sufficient levels to ensure that Nevada can provide each individual served pursuant to this part with the medically necessary mental health services, medications, and supportive services set forth in the applicable treatment plan developed by the successful contractor.
    a. Funding shall only cover the portions of those costs of services that cannot be paid for with other funds including other mental health funds, public and private insurance, and other local, state, and federal funds.

X. References

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2. National Institute for Mental Health. Major Depression Among Adults. Accessed: August 2016. Available: www.nimh.nih.gov/health/statistics/prevalence/major-depression-among-adults.shtml.
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6. Substance Abuse and Mental Health Services Administration. Mental and Substance Use Disorders. Accessed: October 2016. Available: www.samhsa.gov/disorders.
7. Disorders Institute of Medicine (US) Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive. Improving the Quality of Health Care for Mental and Substance-Use Conditions. Washington DC: National Academies Press, 2006.
8. DHHS Office of Analytics PowerPoint, 2/5/18

APPENDIX A

Washoe Regional Behavioral Health Profile

August 2018

Introduction

A note from Charles Duarte, Chair of the Washoe Regional Behavioral Health Policy Board:

This report is presented on behalf of the Washoe Regional Behavioral Health Policy Board as part of its Annual Report to the Behavioral Health Commission. The Policy Board was established by the 2017 Nevada Legislature through Assembly Bill 366 for the purpose of informing and advising the state Division of Public and Behavioral Health and the Behavioral Health Commission about the behavioral health issues and needs that uniquely affect Washoe County.

Behavioral health includes both mental health and substance use, encompassing prevention, early intervention, education, treatment, recovery, and resiliency. This report sheds light on the status of behavioral health in our region, and highlights our successes and our challenges. Unfortunately, Washoe County has fallen behind the rest of Nevada and the nation in addressing the behavioral health needs of our residents. We believe this report will inform policy-makers and funders for years to come and help guide strategies for improvement. We hope you will find the information useful.

On behalf of the Policy Board, I would like to extend our gratitude to Lauren Williams, a graduate student in the Masters in Public Health program at the University of Nevada, Reno (UNR) for her hard work and dedicated effort to collecting, analyzing, and presenting this information as the focus of her Summer Internship, sponsored by the Washoe County Health District. This collaborative effort between UNR, the Health District, the Washoe County Human Services Agency, and the Behavioral Health Policy Board is a partnership that reflects our community's determination to tackle the challenges ahead of us together as we make progress in our mutual goal of improving the behavioral health status in our region.

Charles Duarte

Chair, Washoe Regional Behavioral Health Policy Board

Geography and Demographics

Nevada is the 7th largest state in the nation with land area reaching 109,781 square miles, yet Nevada is the 35th most populated state with an estimated population density of 26.7 persons per square mile in 2017.[1] Three urban counties (Carson City, Clark County, and Washoe County) comprise 91.5% of the state's total population.

Image 1 – Nevada

Image 2 – Washoe County

Washoe County is the second most populated county in Nevada with an estimated 452,181 residents in 2017 encompassing 15.4% of Nevada's residents and a population density of 71.8 persons per square mile.

[1] Nevada Department of Taxation, Nevada State Demographer (2017). Source: Nevada County Age, Sex, Race, and Hispanic Origin Estimates and Projections 2000 to 2036. Accessed https://tax.nv.gov

Table 1: Population in Nevada, 2017 Estimates

	Population	Square Land Miles	Population Per Square Mile	Percent of Total Population
Urban Counties				
Washoe County	452,181	6,302	71.8	15.4
Carson City	53,250	145	367.2	1.8
Clark County	2,179,066	7,891	276.1	74.3
Rural/Frontier Counties	249,355	95,443	2.6	8.5
Nevada	2,933,852	109,781	26.7	

In 2017, the Reno-Sparks metropolitan area comprised 75.6% of the Washoe County population and only 2.2% of the total land area.[2]

Table 2: Estimated Population Growth by Selected Demographics, Washoe County, 2017 & 2022

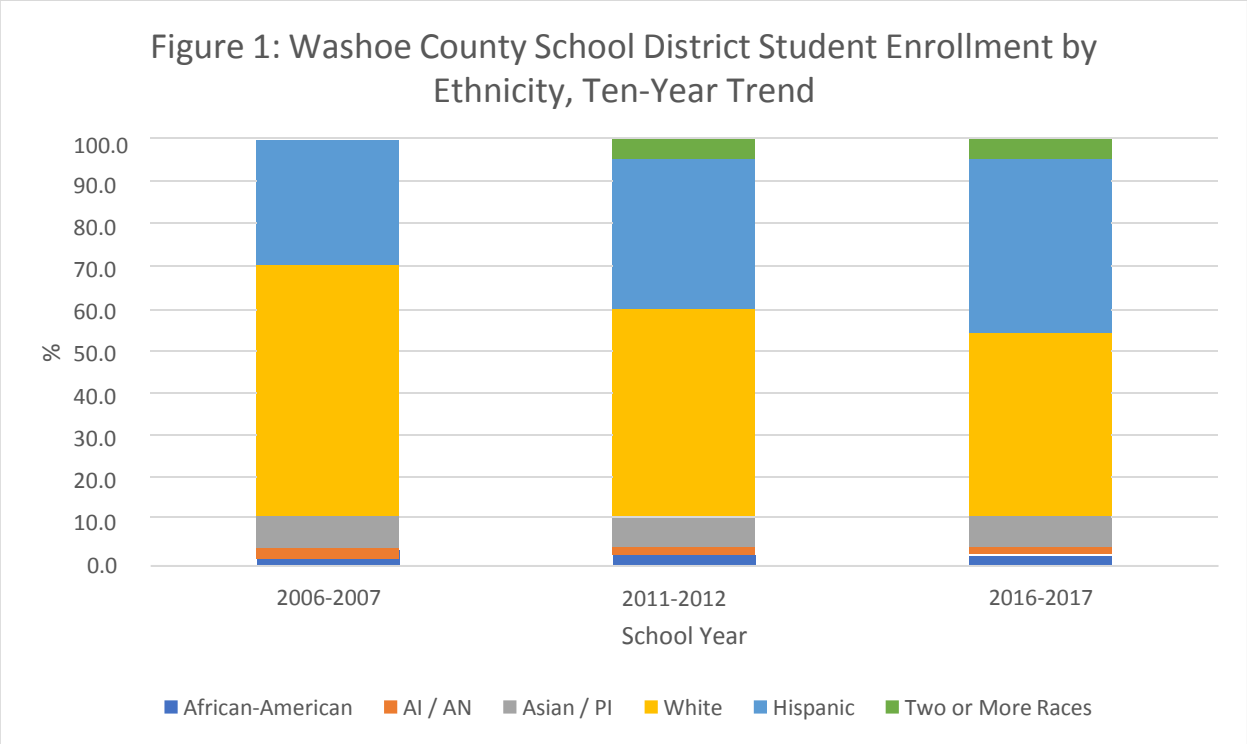
	2017		2022		Change from 2017-2022	
	(n)	(%)	(n)	(%)	(n)	(%)
Age Group						
0-9	56,392	12.5	60,019	12.3	3,627	6.4
10-19	61,447	13.6	64,418	13.1	2,971	4.8
20-29	63,022	13.9	68,880	14.1	5,858	9.3
30-39	62,035	13.7	66,782	13.7	4,747	7.7
40-49	53,747	11.9	57,999	11.9	4,252	7.9
50-59	58,427	12.9	57,554	11.8	-873	-1.5
60-69	53,699	11.8	58,826	12.0	5,127	9.5
70-79	30,907	6.8	37,311	7.6	6,404	20.7
80+	12,507	2.8	15,624	3.2	3,117	24.9
Race/Ethnicity						
African-American*	11,358	2.5	12,858	2.6	1,500	13.2
AI / AN*	7,268	1.6	7,427	1.5	159	2.2
Asian / PI*	31,276	6.9	36,034	7.4	4758	15.2
White*	289,703	64.1	300,006	61.4	10,303	3.6
Hispanic	112,577	24.9	128,341	26.3	15,764	14.0
Total Population	452,181		488,395		36,214	8.0

*Non-Hispanic
AI = American Indian AN = Alaska Native PI = Pacific Islander

In 2017, non-Hispanic whites accounted for 64.1% of the population followed by 24.9% Hispanics, 6.9% Asian or Pacific Islanders, 2.5% African-American, and 1.6% American Indians.

From 2017 to 2022 the population in Washoe County is predicted to increase by 8.0%. The largest growth is among individuals 60 years and older indicating an aging population. A 15.2% increase among the Asian or Pacific Islander population is projected by 2022 followed by 14.0% among Hispanics and 13.2% among African-Americans.

[2] Nevada State Demographer's Office, 2017 - 2017 ASHRO Estimates and Projections Summary Working Copy, Population as of July 1, 2017. Data provided upon request.



The youth population in Washoe County is more diverse than the adult population. The proportion of students in Washoe County School District who were white decreased from the 2006-2007 school year (55.9%) to the 2016-2017 school year (44.8%). The proportion of students in Washoe County School District who were Hispanic increased from the 2006-2007 school year (31.6%) to the 2016-2017 school year (40.1%). Combined students who were African-American, American Indian/Alaska Native, Asian/Pacific Islander, or two or more races comprised less than 15.0% of the student population over the previous ten years.

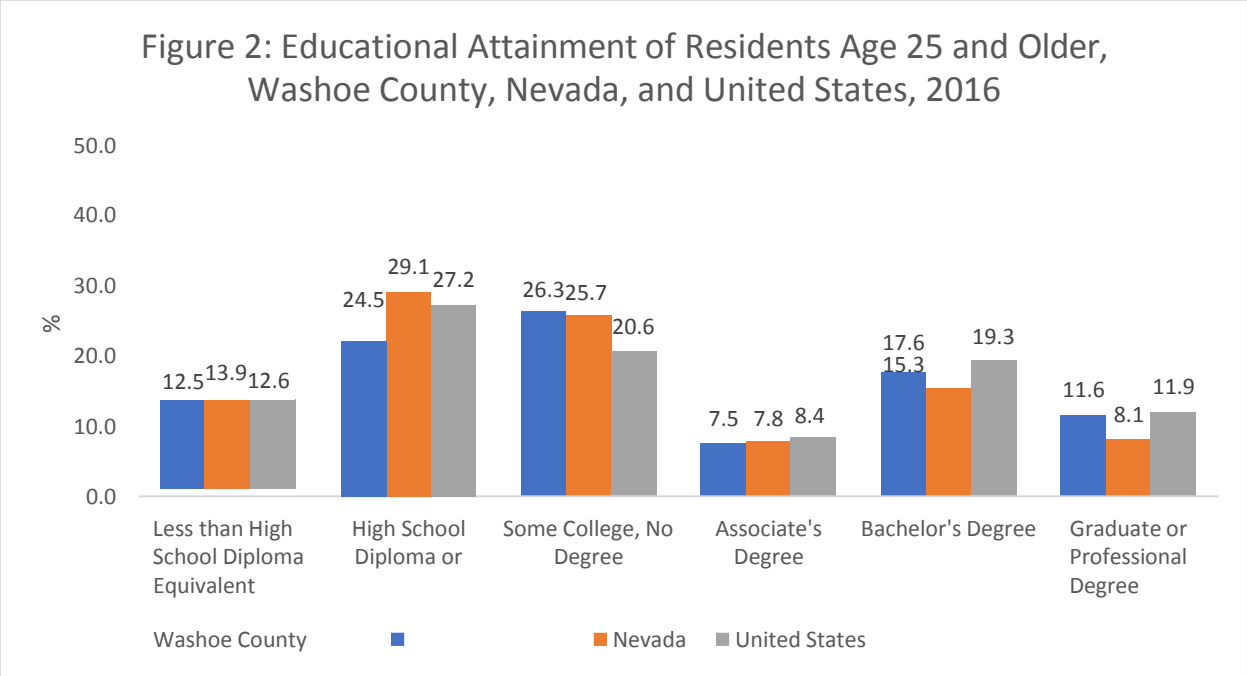
Table 3: Primary Language Spoken at Home
Washoe County Residents, 2016

Language	Residents (n)	(%)
English	328,202	77.0
Spanish	74,523	17.5
Indo-European Language	9,894	2.3
Asian and Pacific Island Languages	12,332	2.9
Other Languages	1,356	0.3

According to the 2016 American Community Survey, 23.0% of Washoe County residents primarily spoke a language other than English highlighting the importance of designing a health care system that improves care for patients with limited English proficiency. Limited English proficiency is associated with challenges scheduling appointments, obtaining information over the phone, misunderstandings between the care provider and patient due to language barriers, and poor compliance with treatment regimen.[3]

[3] Nathenson, R.A., Saloner, B., Richards, M.R., & Rhodes, K.V. (2016). Spanish-speaking immigrants' access to safety net providers and translation services across traditional and emerging US destinations: Spanish-speaking immigrants' safety net access. *The Milbank Quarterly, 94*(4), 768-799.

The more limited a person's economic conditions are, the higher one's risk for poor mental health.[4] Education level is an important predictor for income level and employment that support the worker's well-being through a healthy working environment and the provision of adequate health insurance. Socioeconomic status is an important indicator for an individual's and family's overall health and ability access to supportive services.



In 2016, 36.7% of Washoe County residents 25 years and older received a college degree, which was lower than the United States (39.6%).

Table 4: Inflation-Adjusted Incomes and Housing Costs
Washoe County and Nevada, 2016

	Washoe County	Nevada	United States
Median Household Income	$58,175	$55,180	$57,617
Median Annual Income for Males*	$45,360	$45,326	$50,586
Median Annual Income for Females*	$37,865	$36,681	$40,626
Median Monthly Housing Cost	$1,057	$1,047	$1,022
Percent of Households with Monthly Rent of 30% or More of Household Income	47.1	47.3	46.1
Percent of Households with Monthly Mortgage of 30% or More of Household Income	29.1	31.2	28.1

*Full-time, year-round workers

In 2016, Washoe County's inflation-adjusted household income level was higher than the United States. However, the median annual income for males and females was lower in Washoe County than the United States. The percentage of Washoe County residents who paid more than 30% of their gross monthly income for rent or home mortgage costs was higher in Washoe County than the United States.

[4] Hudson, C. G. (2005). Socioeconomic status and mental illness: Tests of the social causation and selection hypotheses. *American Journal of Orthopsychiatry, 75*(1), 3-18.

Figure 3: Economic Benchmarks Compared to Household Annual Income Distribution Washoe County, 2016

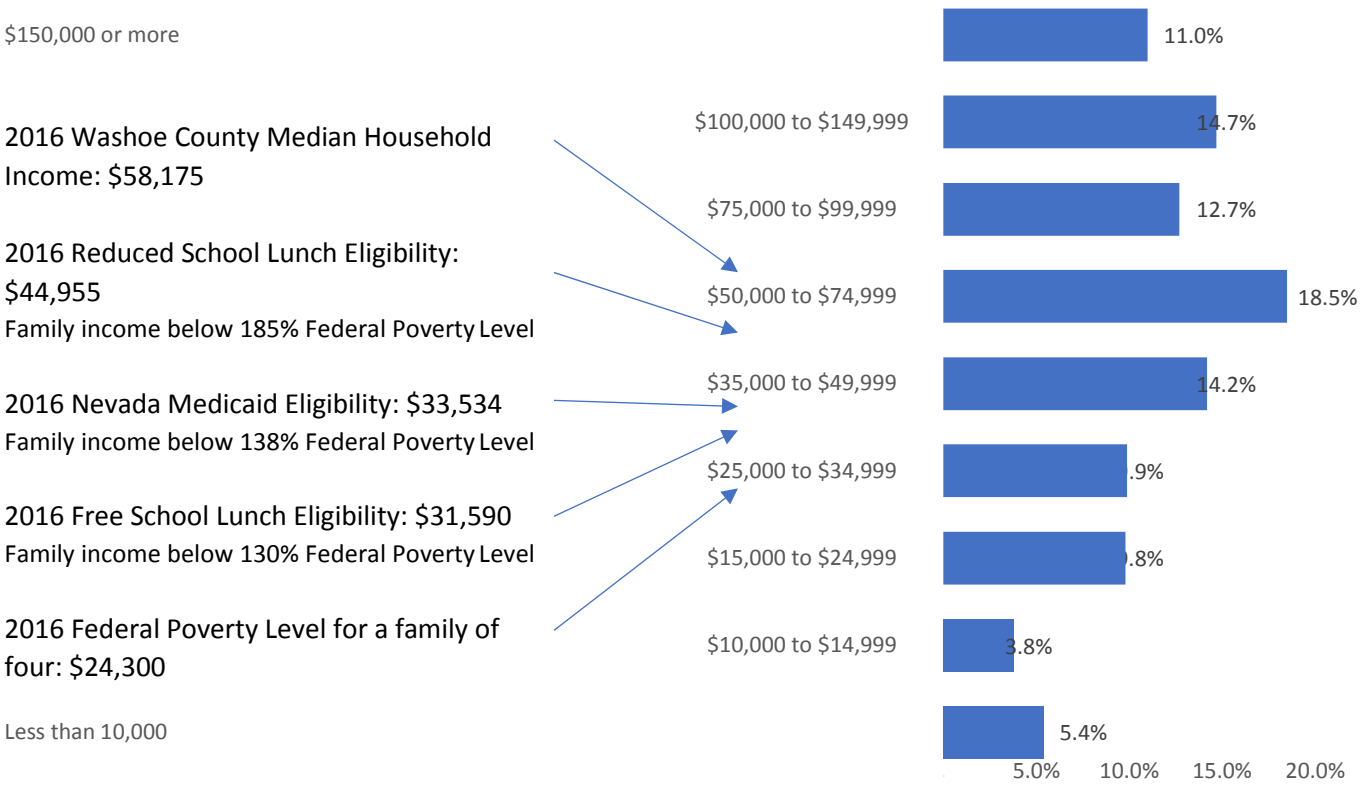


Table 5: Poverty Status During Prior 12 Months, 2016

Age	Washoe County %	Nevada %	United States %
Under 18 years	16.0	19.1	19.5
18 to 34 years	16.0	15.2	17.0
35 to 64 years	9.4	11.8	11.0
65 years and over	8.0	8.7	9.2
Total	12.2	13.8	14.0

In 2016, the total percent of individuals experiencing poverty in Washoe County was 12.2% falling below Nevada (13.8%) and the United States (14.0%). Among individuals aged 18 to 34 years living below the poverty level was greater in Washoe County (16.0%) than Nevada (15.2%).

Table 6: Persons Under the Age of 65 Years Without Health Insurance, 2016

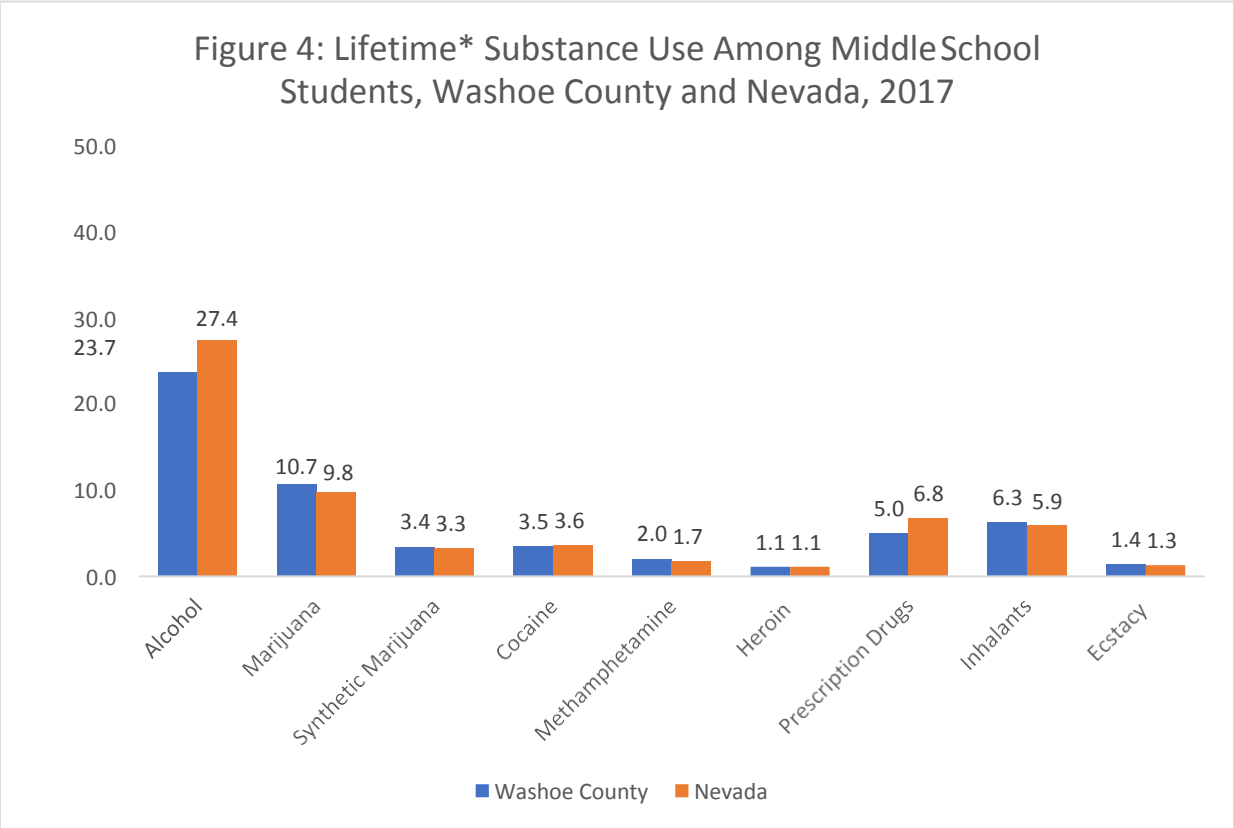
	Percent
Washoe County	17.9
Nevada	22.3
United States	16.5

In 2016, 17.9% of Washoe County residents under the age of 65 years did not have health insurance which was higher than the United States (16.5%).

Substance Use

A substance use disorder develops after repeated use of alcohol and/or drugs causes functionally significant impairment and can result in a variety of consequences including health problems, a physical withdrawal state, disability, and failure to meet major responsibilities at work, home, or school. The coexistence of both a mental illness and a substance use disorder is defined as a co-occurring disorder. Among the 20.2 million adults in the United States who have self-reported a substance use disorder in 2014 nearly 40 percent experienced a co-occurring mental illness.[5]

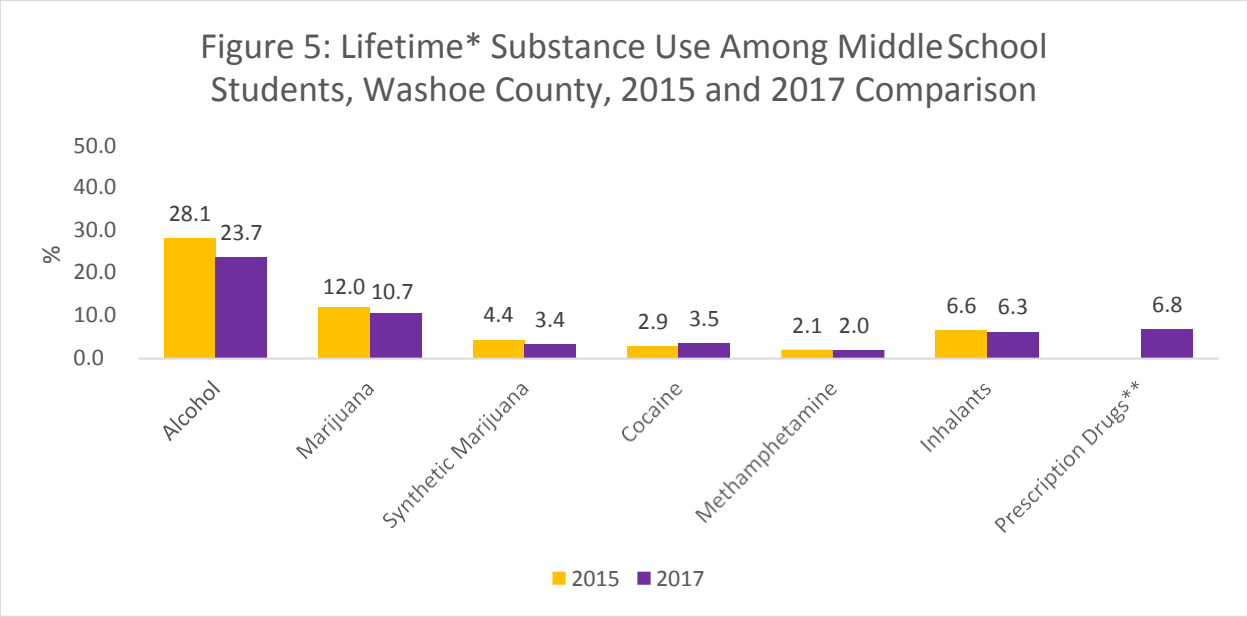
Middle School Students



*One or more times during their life

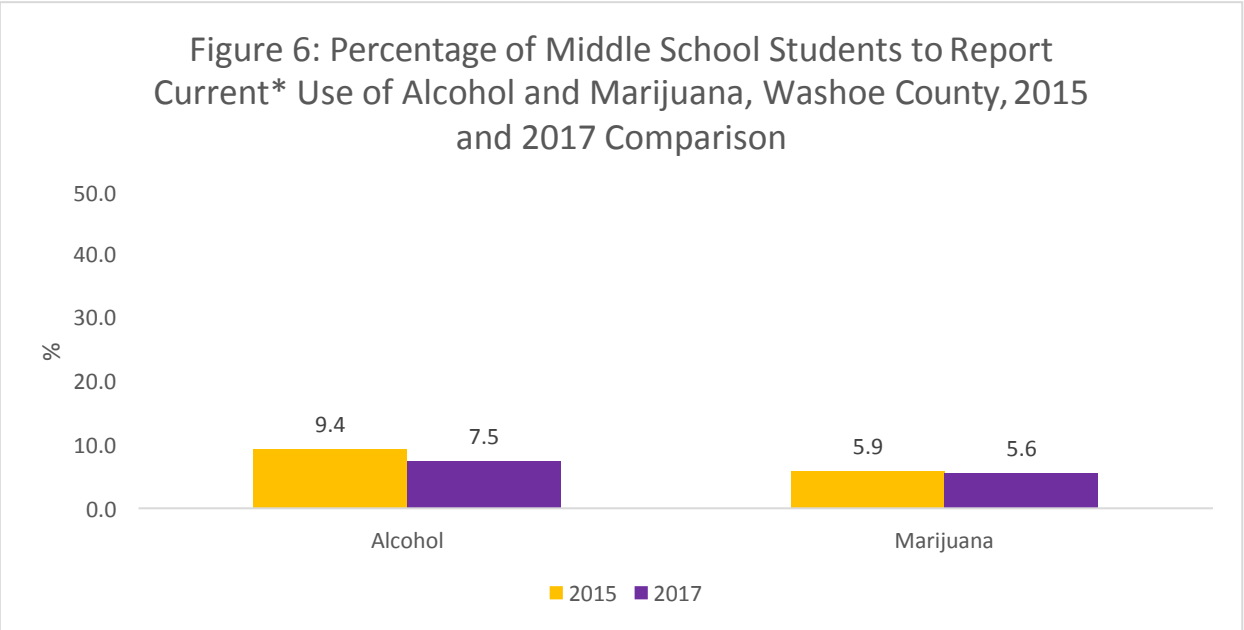
In 2017, the percent of Washoe County middle school students who reported using marijuana, synthetic marijuana, methamphetamine, inhalants, and ecstasy one or more times during their life was greater than Nevada. A lower percentage of middle school students reported having ever tried alcohol, cocaine, and prescription drugs in Washoe County compared to Nevada. The percentage of middle school students who reported having ever used cocaine in Washoe County and Nevada was equal.

[5] Substance Abuse and Mental Health Services Administration. (2015) Results from the 2014 National Survey on Drug Use and Health: Mental Health Findings, NSDUH Series H-50, HHS Publication No. (SMA) 15-4927. Accessed from http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf



*One or more times during their life
**2015 data for lifetime prescription drug use is not included because the wording of the question changed in 2017, therefore data are not comparable to previous years.

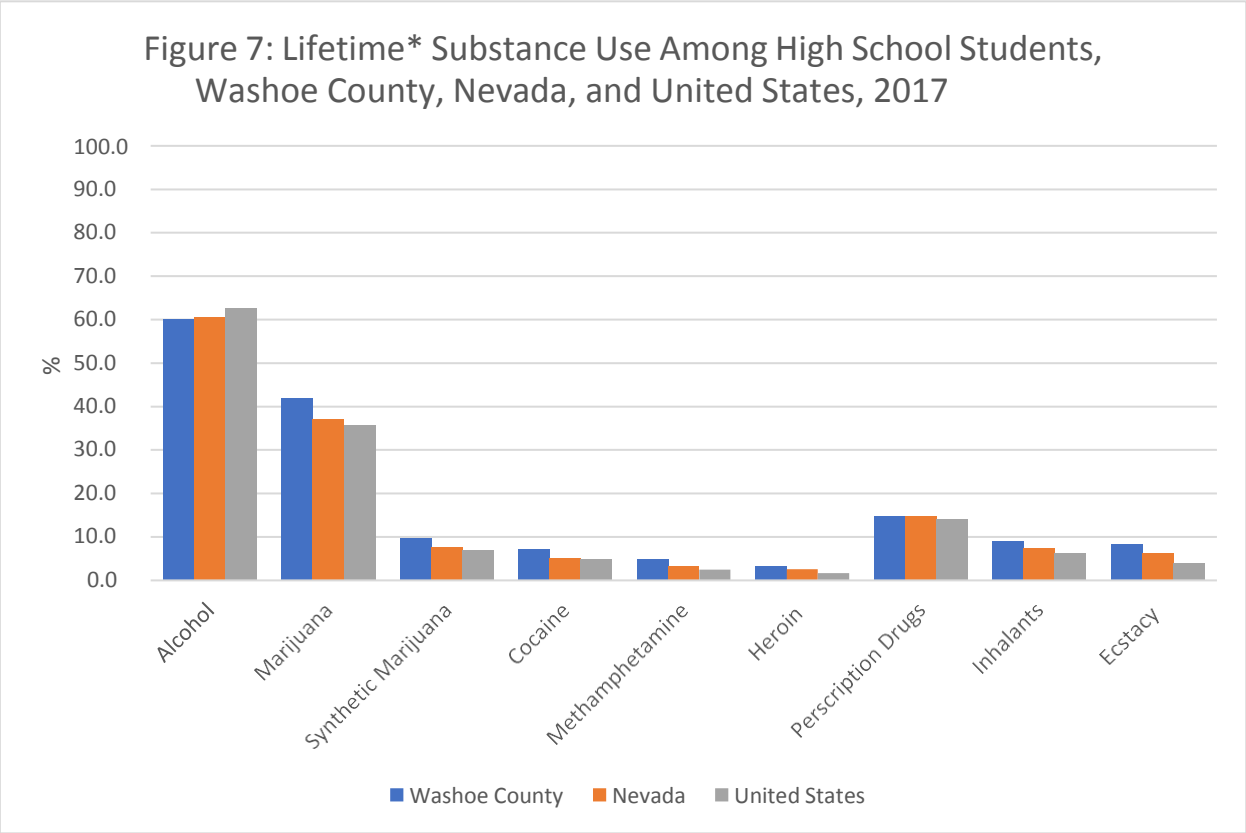
From 2015 to 2017, the percent of middle school students who reported having ever tried the substances identified in Fig. 5 decreased across all categories with the exception of cocaine which increased from 2.9% to 3.5%.



*Had at least one use on at least 1 day during the 30 days before the survey

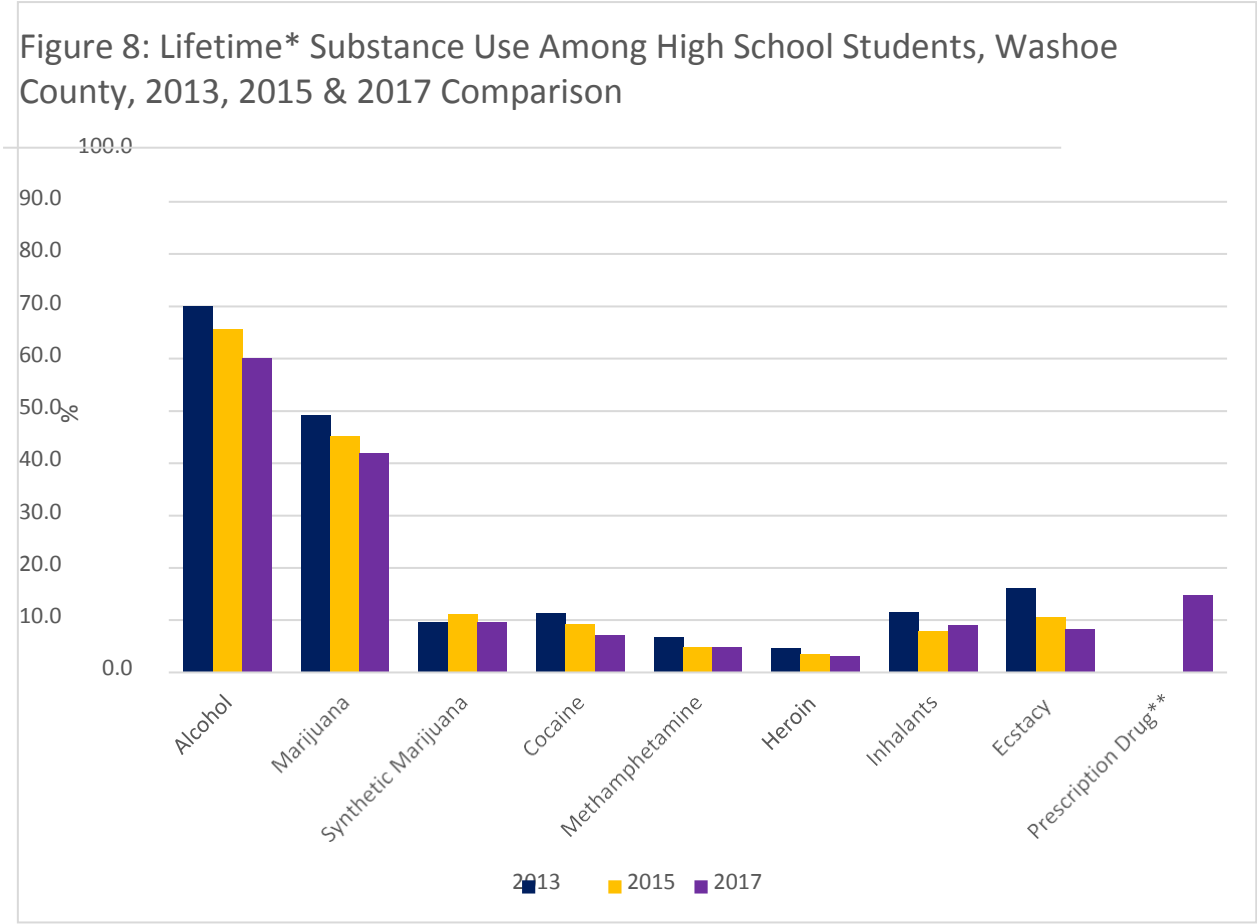
The percentage of middle school students who reported having had at least one drink of alcohol during the previous 30 days decreased from 2015 (9.4%) to 2017 (7.5%). he percentage of middle school students who reported they currently use marijuana decreased from 2015 (5.9%) to 2017 (5.6%).

High School Students



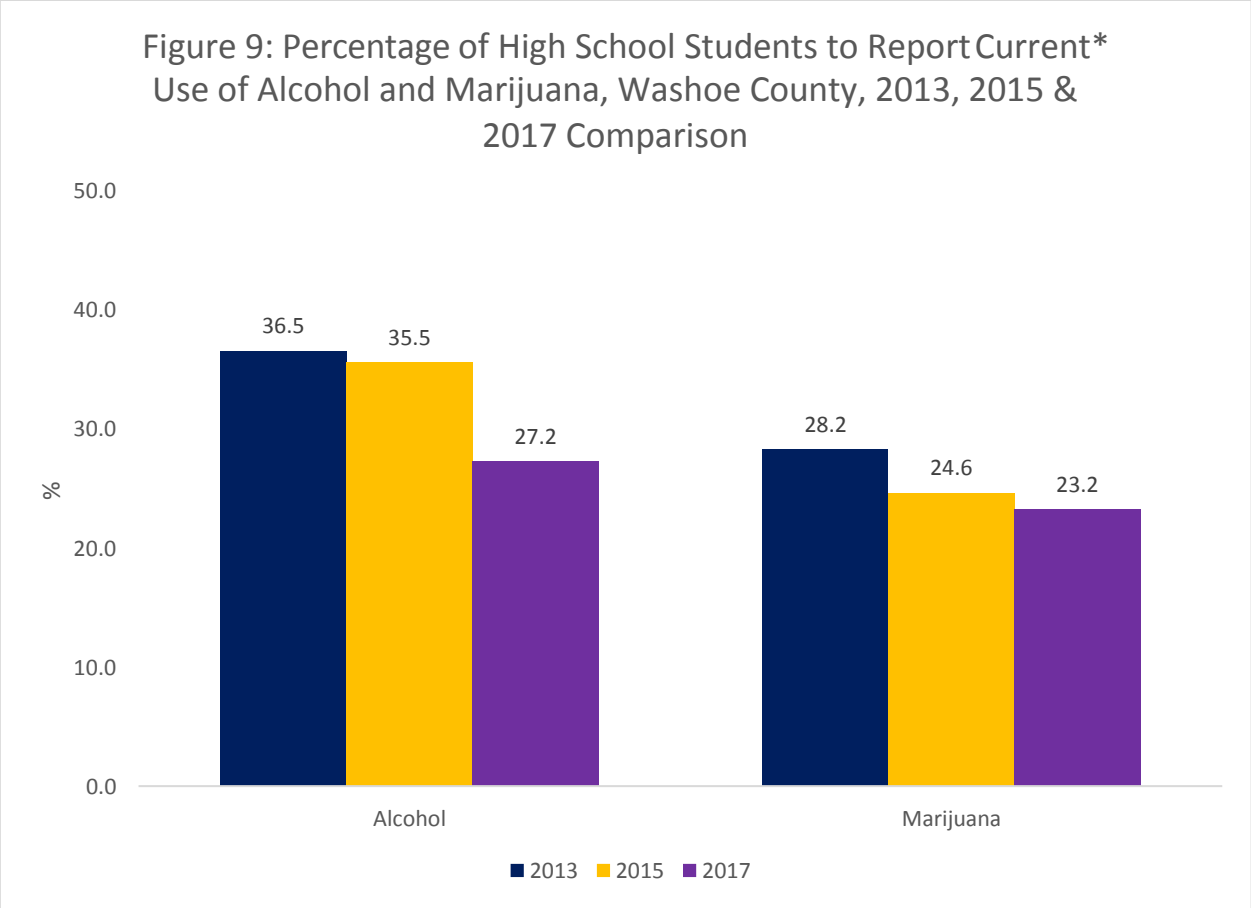
*One or more times during their life

In 2017, the percentage of high school students who reported ever used marijuana, synthetic marijuana, cocaine, methamphetamine, heroin, inhalants, and ecstasy was greater in Washoe County than in Nevada and the United States. Lifetime alcohol use among high school students was lower in Washoe County (60.2%) than in Nevada (60.6%) and the United States (62.6%).



*One or more times during their life
**2015 data for lifetime prescription drug use is not included because the wording of the question changed in 2017, therefore data are not comparable to previous years.

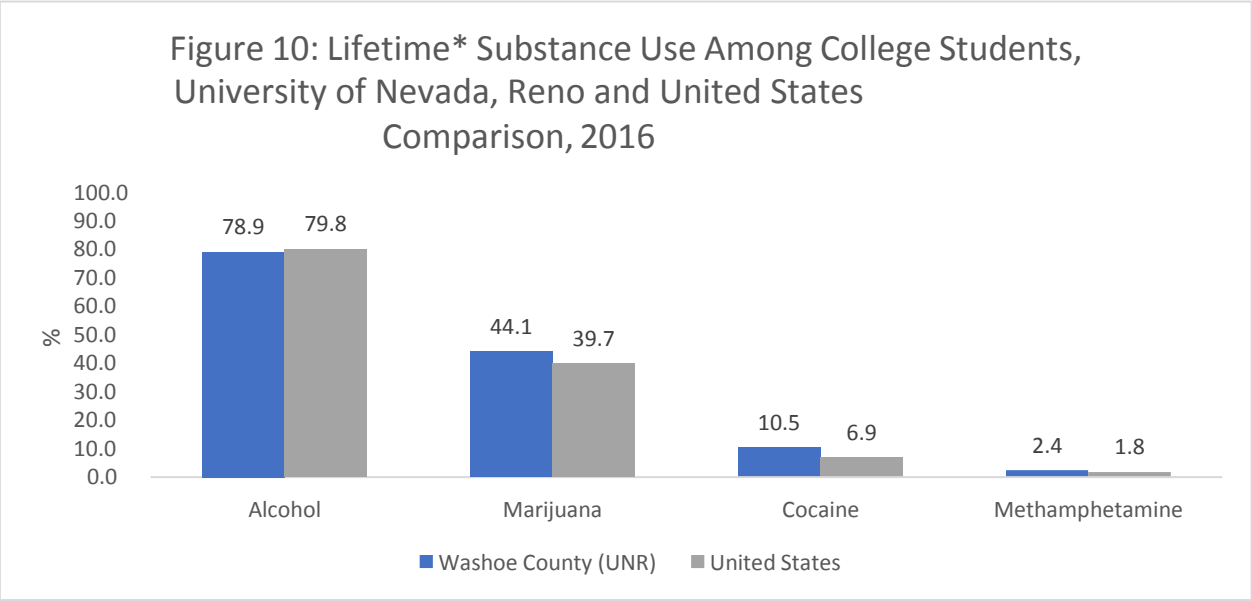
- From 2013 to 2017, the percent of high school students in Washoe County who reported ever trying alcohol, marijuana, cocaine, heroin, and ecstasy decreased.
- Synthetic marijuana use reached 11.1% in 2015 followed by a decrease to 9.7% in 2017.
- Methamphetamine use remained at 4.8% in 2015 and 2017.
- Inhalant use in 2017 (9.1%) was higher than in 2015 (8.0%).



*Had at least one use on at least 1 day during the 30 days before the survey

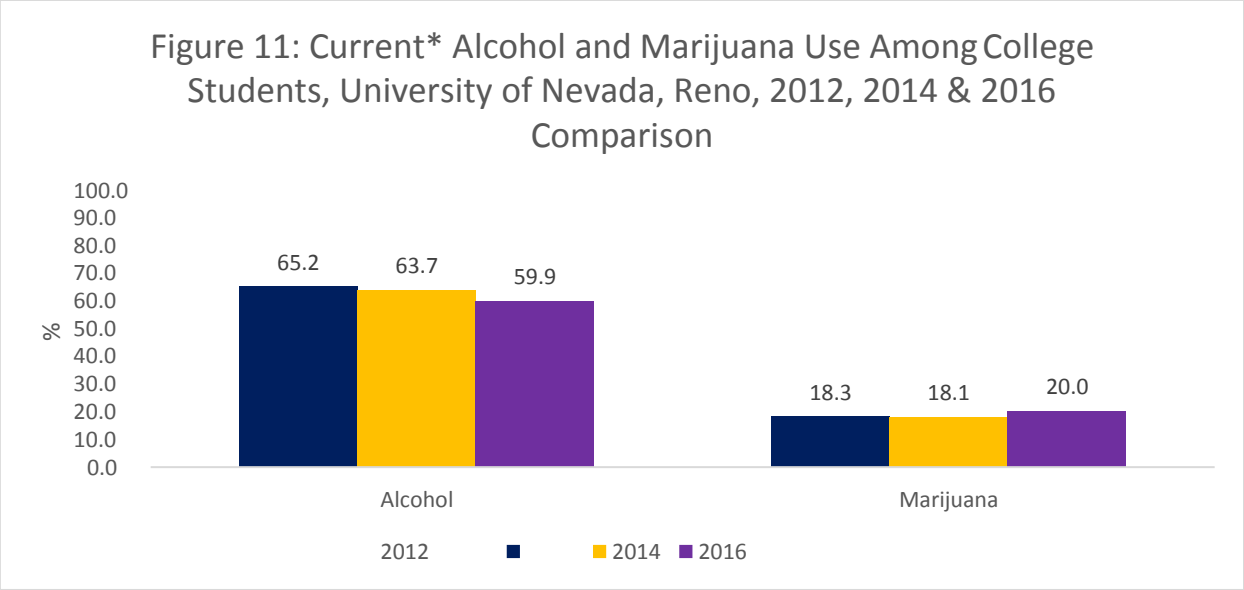
- The percentage of high school students who reported having had at least one drink of alcohol during the previous 30 days decreased from 2013 (36.5%) to 2017 (27.2%).
- The percentage of high school students who reported they currently use marijuana decreased from 2013 (28.2%) to 2017 (23.2%).

College Students



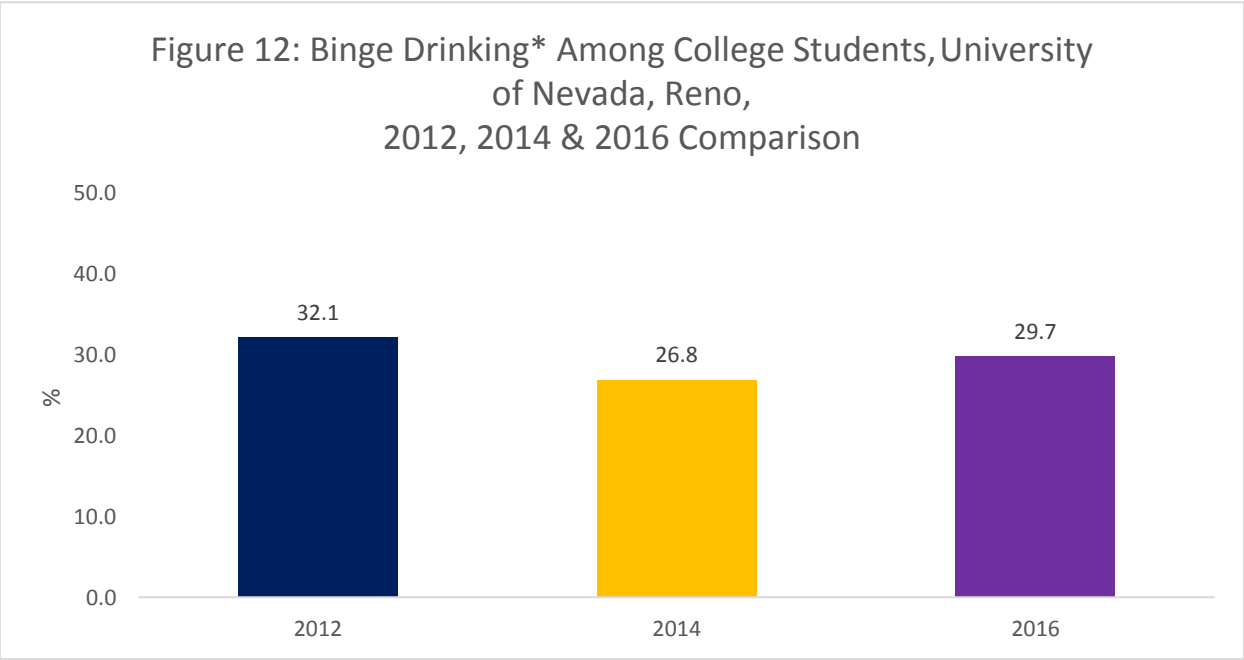
*Have used one or more times

- The percentage of UNR students who reported lifetime marijuana, cocaine, and methamphetamine use was greater than the average reported by other postsecondary education students in the United States.
- A lower percentage of alcohol use was reported by UNR students (78.9%) compared to the United States (79.8%).



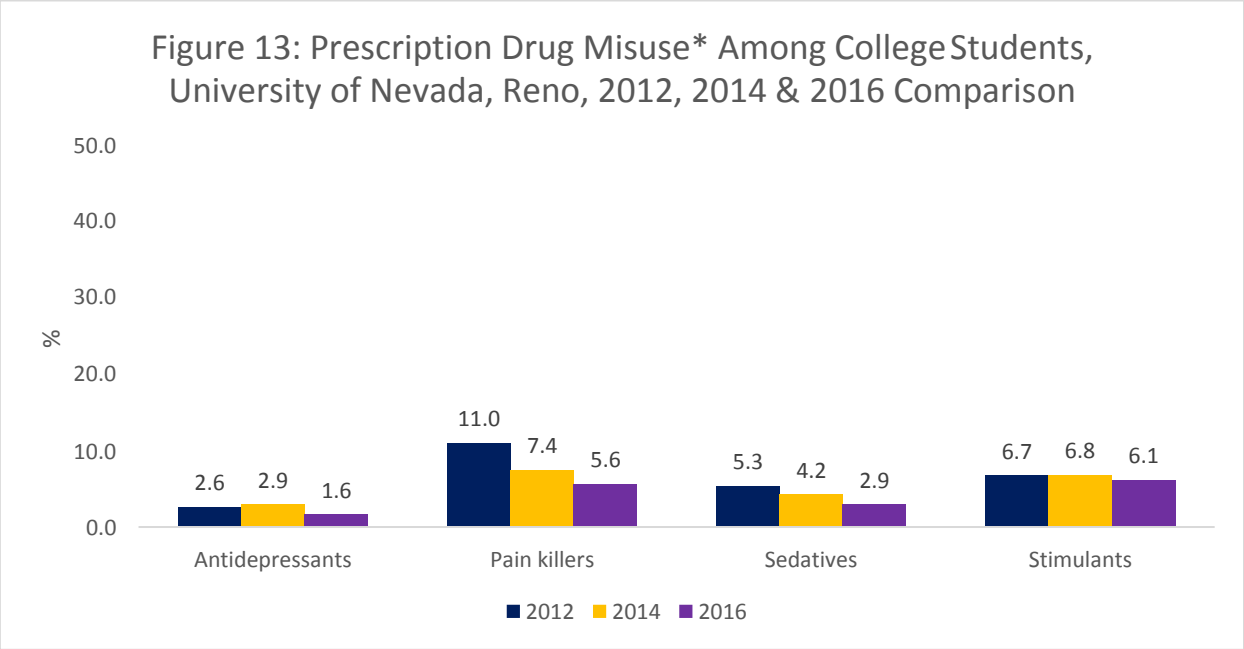
*Within the last 30 days

- The percentage of UNR students who reported having used alcohol within the last 30 days decreased from 2012 (65.2%) to 2016 (59.9%).
- Current marijuana use among UNR students increased from 2012 (18.3%) to 2016 (20.0%).



*Five or more drinks of alcohol a sitting, over the previous two weeks

- In 2016, 29.7% of UNR students reported binge drinking in the past two weeks.



*Taken the drug without a prescription, during the previous 12 months

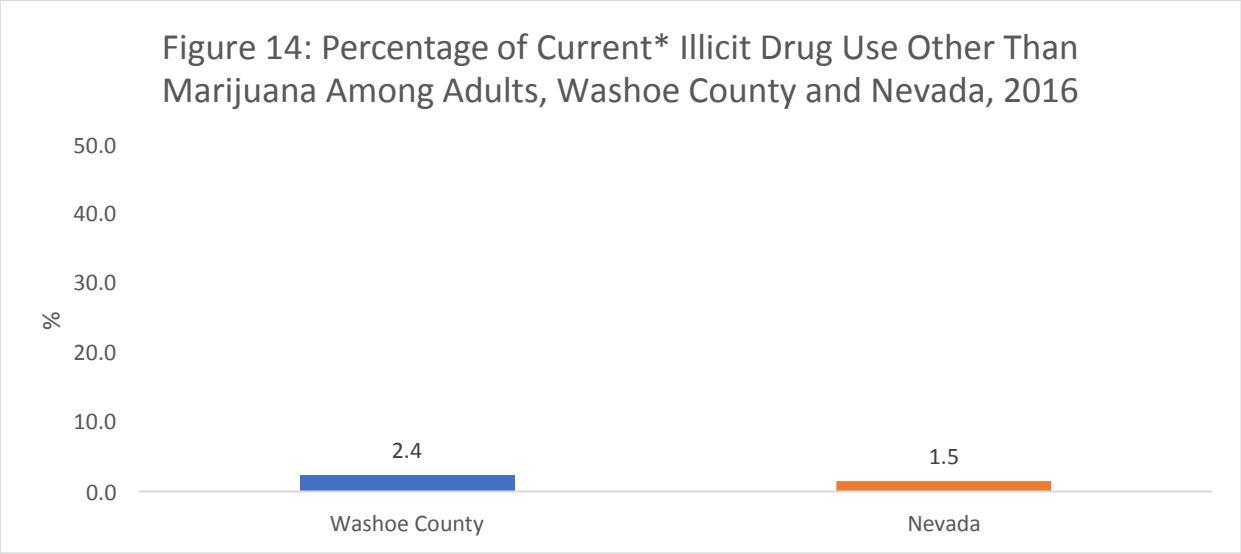
- UNR students reported misusing pain killers and stimulants more frequently than other prescription drugs.
- The percentage of UNR students reporting they had taken the prescription drugs in Fig. 13 decreased from 2012 to 2016.
- In 2016, stimulants passed pain killers and became the most commonly misused prescription drug among UNR students with 6.1% having used during the previous 12 months compared to 5.6% having used pain killers.

Adults

Table 7: Substance Use Among Population Aged 18 to 25 - Washoe County, Nevada, and United States, 2012-2014 Annual Averages

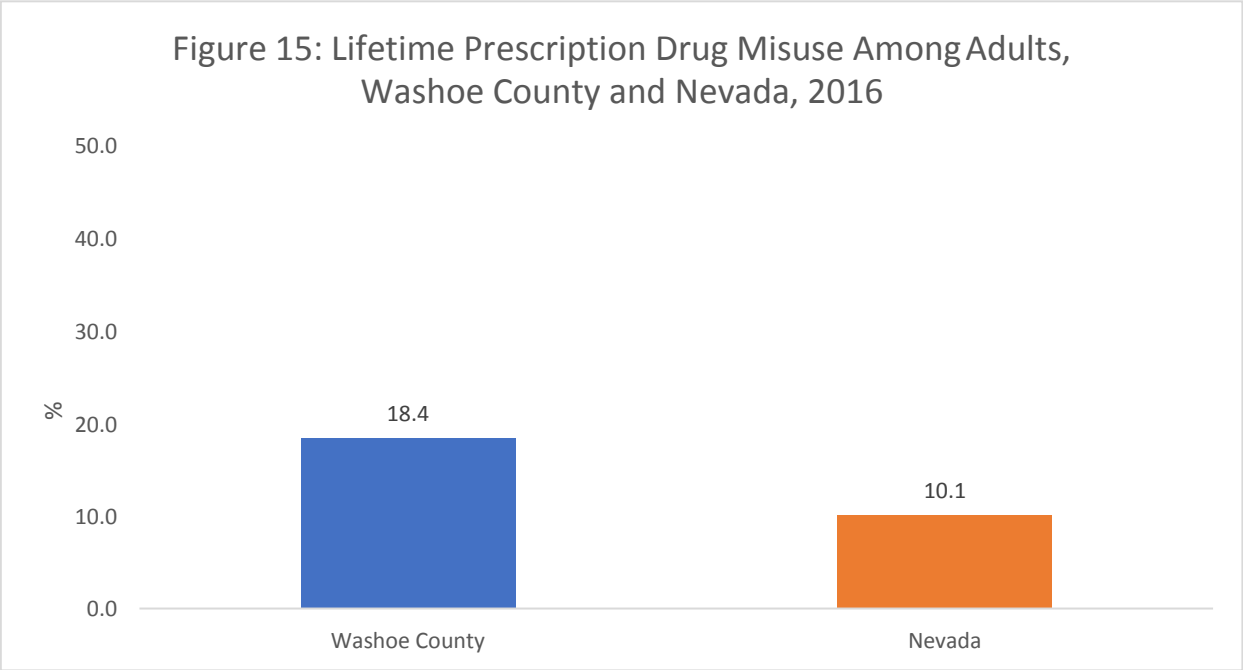
	Percent of Population		
	Washoe County	Nevada	United States
Alcohol Use			
Use in the past month	66.1	57.8	59.8
Binge drank in the past month	42.8	37.0	38.4
Dependence in the past year	7.1	7.1	5.7
Dependence or abuse in the past year	15.5	14.1	13.2
Needing treatment for alcoholism in the past year	15.4	13.8	12.8
Drug Use			
Cocaine use in the past year	6.5	3.8	4.6
Pain relievers nonmedical use in the past year	9.7	9.9	8.9
Illicit drug use in the past month	24.0	21.4	21.6
Illicit drug use other than marijuana in the past month	7.3	7.0	6.7
Illicit drug dependence in the past year	5.9	5.6	5.2
Illicit drug dependence or abuse in the past year	7.9	7.3	7.3
Needing treatment for illicit drug use in the past year	7.5	6.9	6.7
Dependence on or abuse of illicit drugs or alcohol in the past year	20.2	18.1	17.5

- On average from 2012 to 2014, individuals aged 18-25 years reported alcohol use, dependence, and abuse a higher percentage in Washoe County than Nevada and the United States.
- Illicit drug use in Washoe County was more prevalent compared to Nevada and the United States.

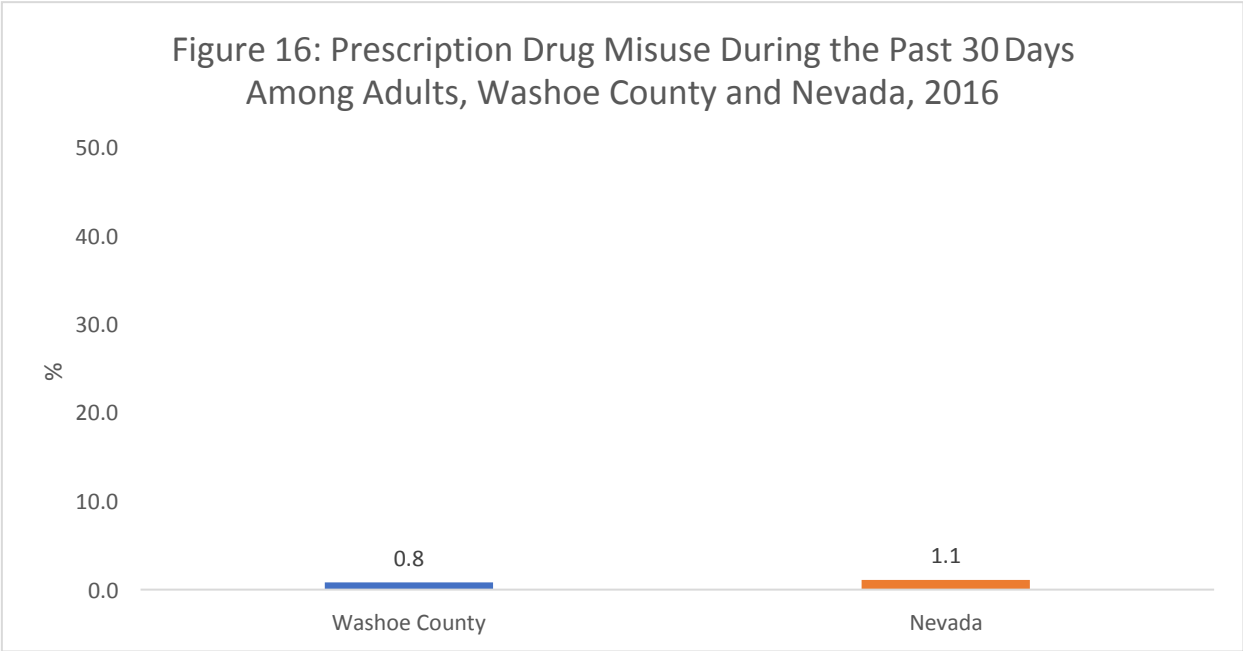


*During the past 30 days

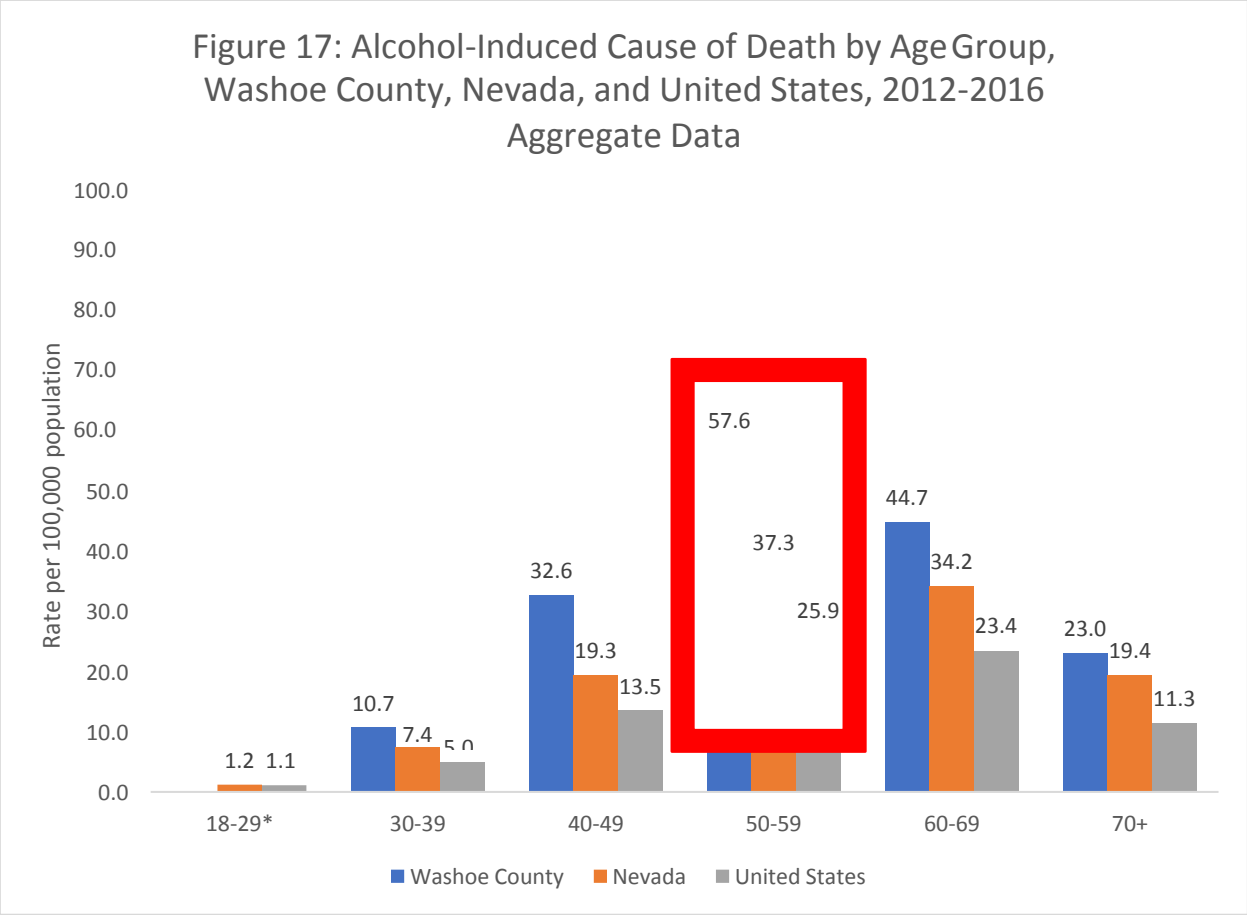
- In 2016, the percentage of adults in Washoe County who reported illicit drug use in the past month (2.4%) was higher than Nevada (1.5%).



- In 2016, the percentage of adults in Washoe County who reported having ever taken a prescription drug without a doctor's prescription (18.4%) was higher than Nevada (10.1%).



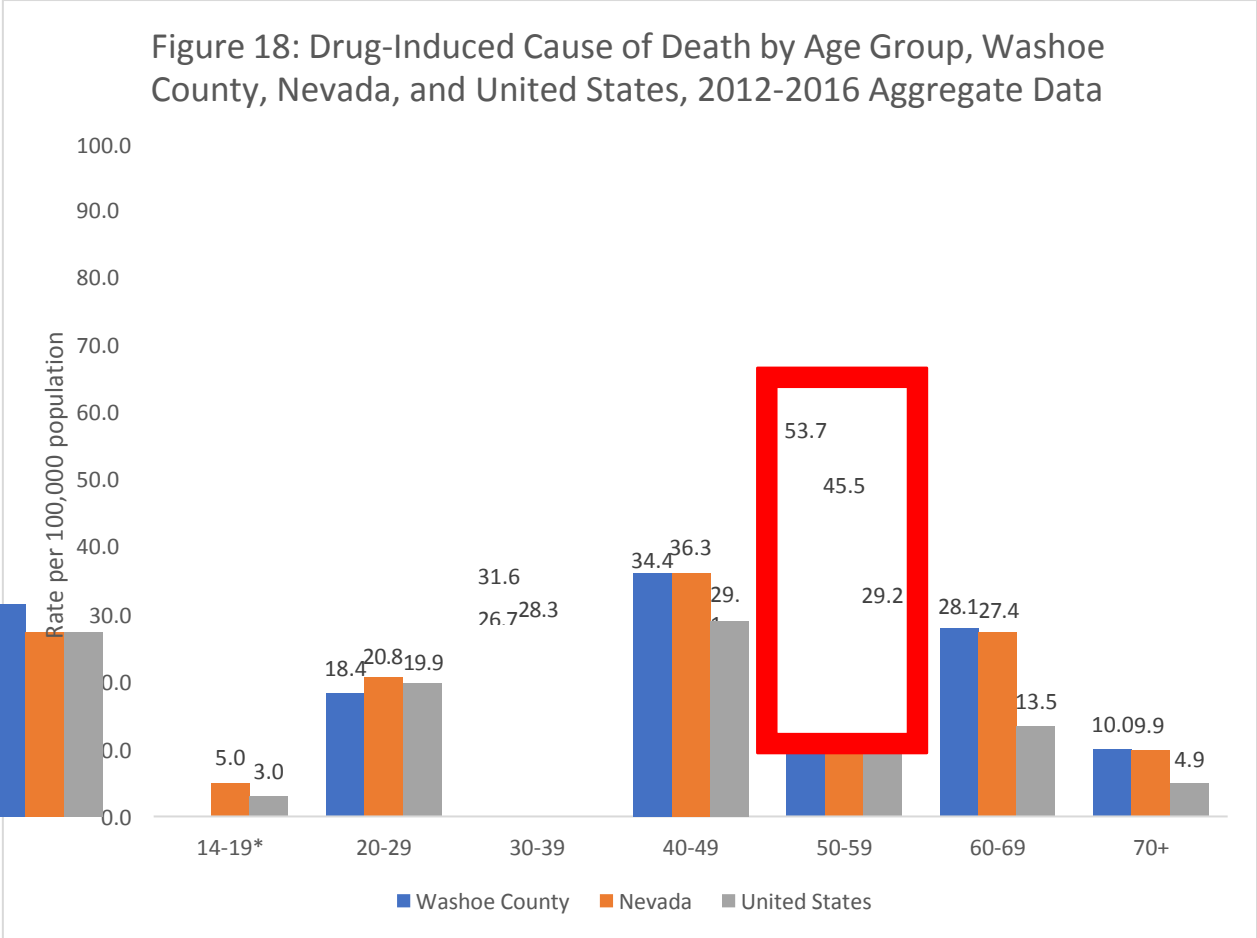
- The percentage of Washoe County adults who reported having used prescription drugs without a doctor's order to "feel good" or to "get high" (0.8%) was lower than Nevada (1.1%).



*Washoe County data not available because the data meet the criteria for confidentiality constraints

Mental and behavioral disorders due to use of alcohol, harmful use (F10.1); Mental and behavioral disorders due to use of alcohol, dependence syndrome (F10.2); Alcoholic hepatitis (K70.1); Alcoholic cirrhosis of lover (K70.3); Alcoholic hepatic failure (K70.4); Alcoholic liver disease, unspecified (K70.9);
Accidental poisoning by and exposure to alcohol (X45)

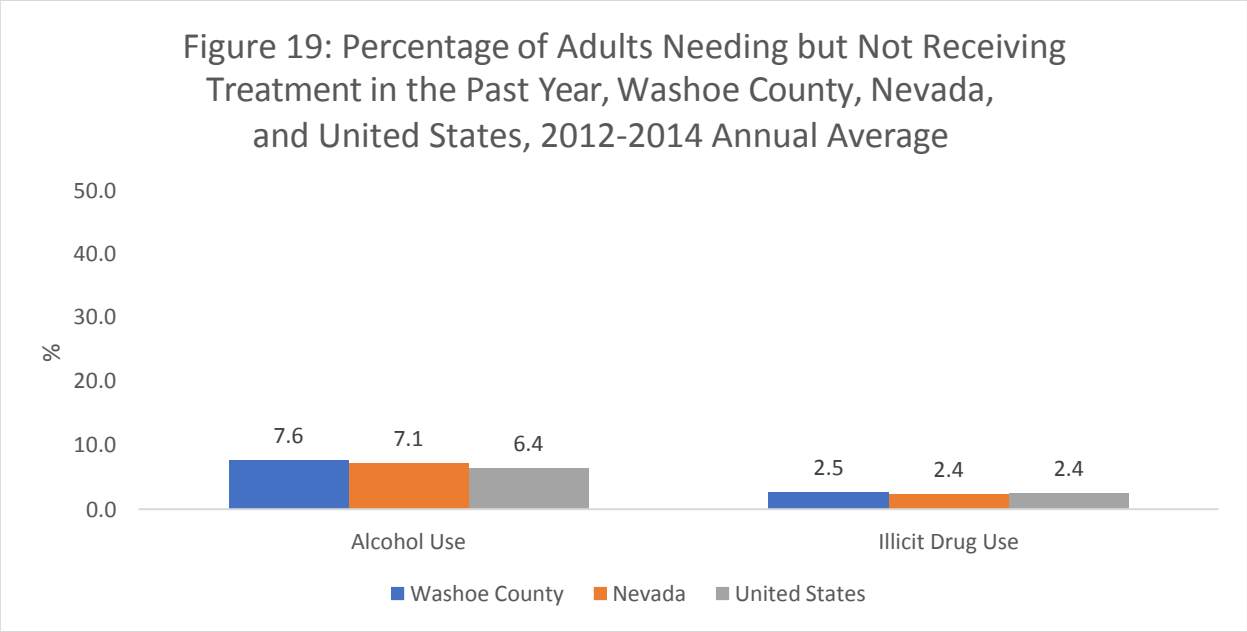
- The rate of alcohol-induced deaths in Washoe County among age groups 30-39, 40-49, 50-59, and 70+ years were more than double the United States.



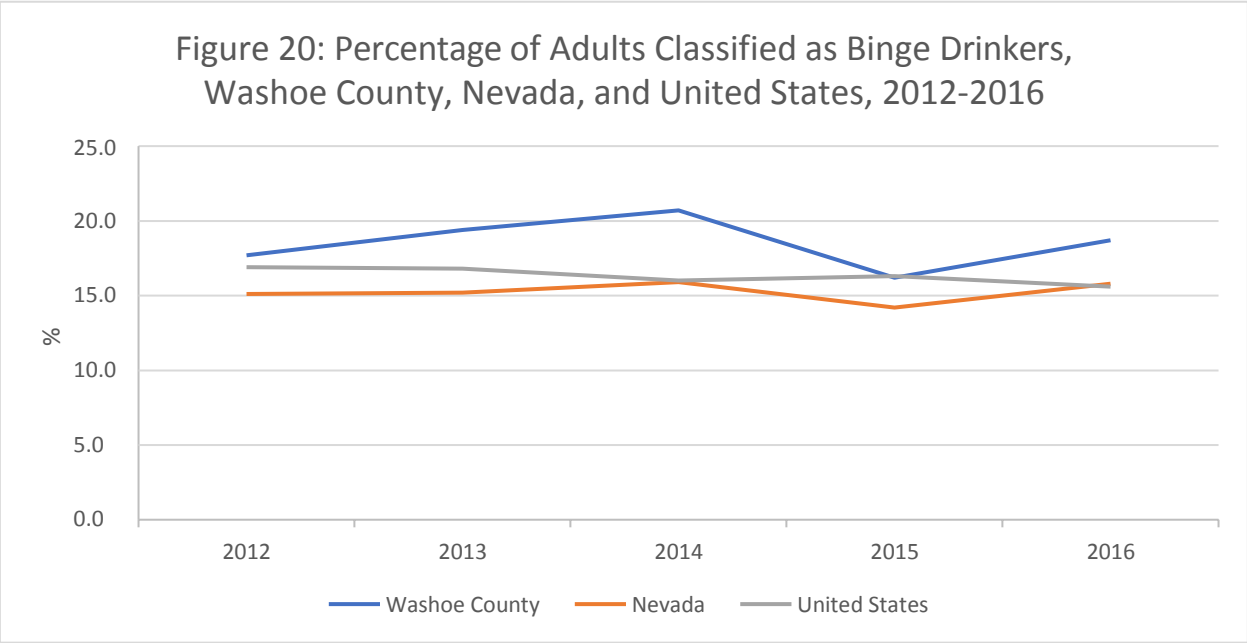
*Washoe County data not available because the data meet the criteria for confidentiality constraints

Drug poisonings (overdose) unintentional (X40-X44); Drug poisonings (overdose) suicide (X60-X64); Drug poisonings (overdose) homicide (X85); Drug poisonings (overdose) undetermined (Y10-Y14)

- The five-year drug-induced cause of death rate was greater in Washoe County for age groups 30-39, 50-59, 60-69, and 70+ years compared to Nevada.

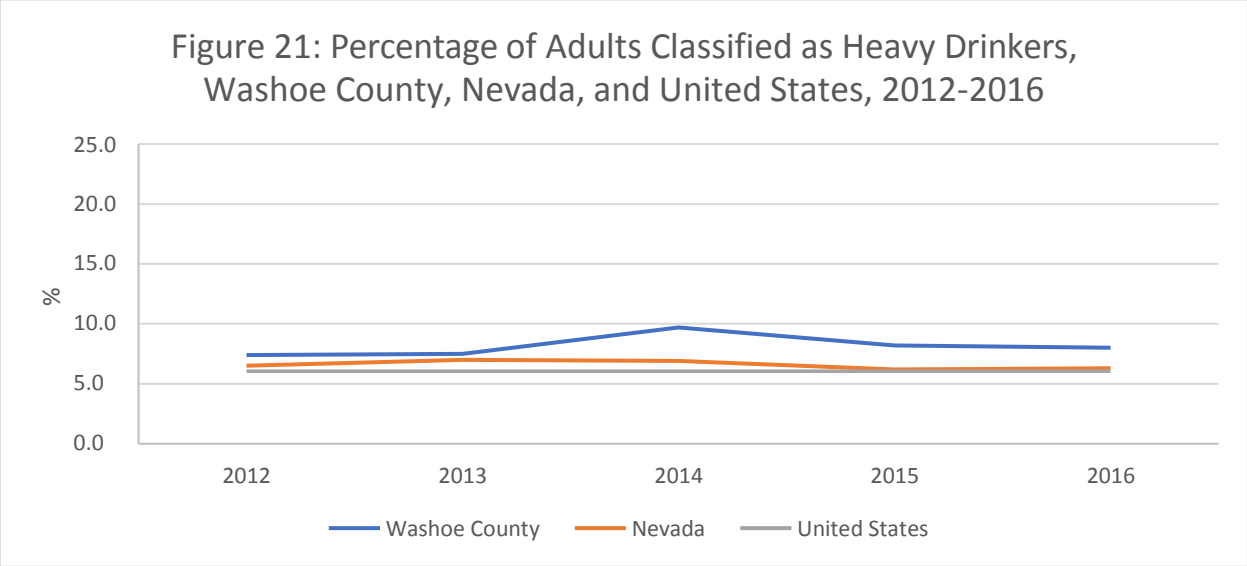


- On average from 2012 to 2014, the percentage of adults needing treatment for alcohol use in the past year was greater in Washoe County (7.6%) than Nevada (7.1%) and the United States (6.4%).
- The percentage of adults needing treatment for illicit drug use in the past year was slightly greater in Washoe County (2.5%) than Nevada (2.4%) and the United States (2.4%).



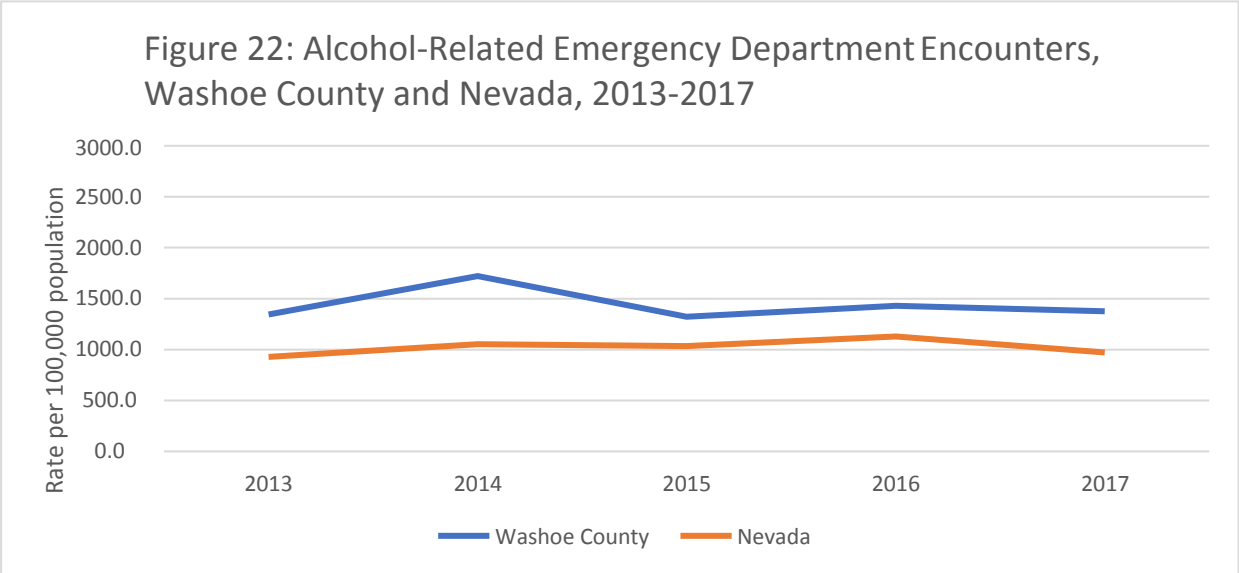
*Binge drinking is classified as men having five or more drinks on one occasion and for women having four or more drinks on one occasion

- The percentage of Washoe County adults who were classified as binge drinkers was greater in 2016 (18.7%) than in 2012 (17.7%).
- In 2016, the percentage of Washoe County adults who were classified as binge drinkers was higher than Nevada (15.8%) and the United States (15.6%).

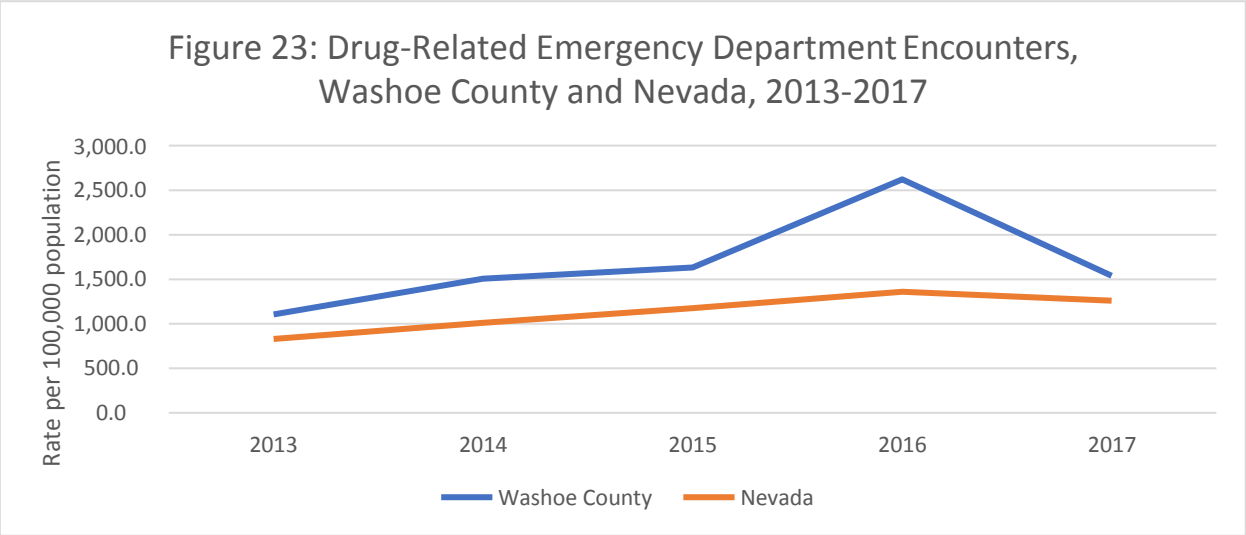


*During 2012-2014 heavy drinking was classified as men having more than two drinks per day and for women having more than one drink per day
**During 2015 and 2016 heavy drinking was classified as men having more than 14 drinks per week and for women having more than seven drinks per week

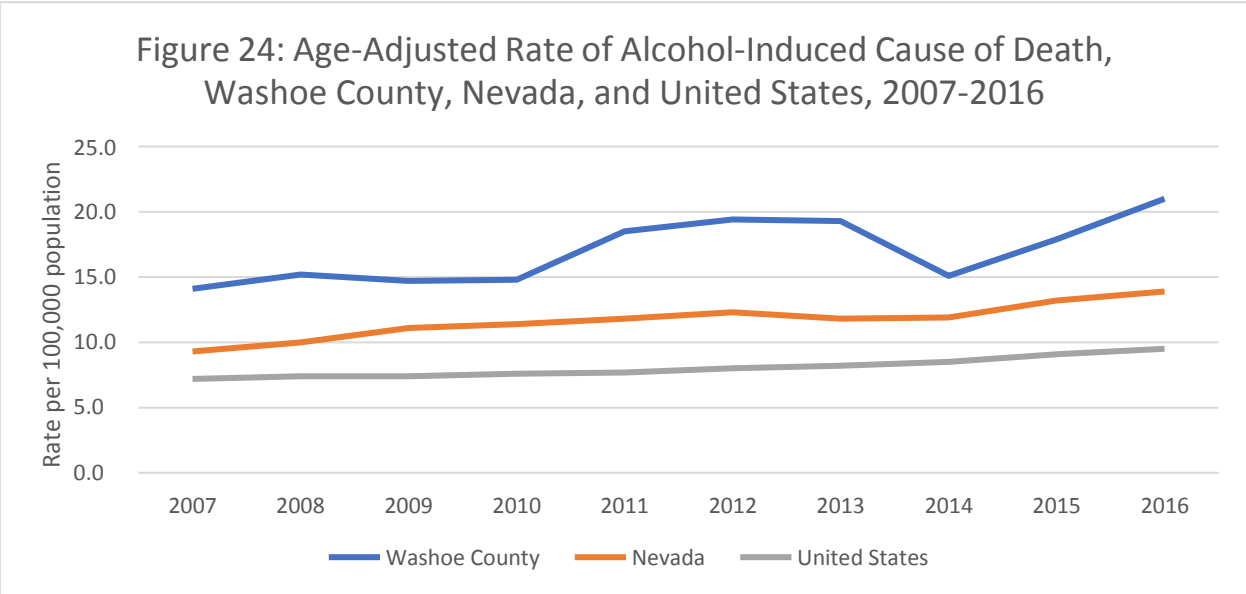
- The percentage of Washoe County adults who were classified as heavy drinkers was greater in 2016 (8.0%) than in 2012 (7.4%).
- From 2012 to 2016, the percentage of adults in Washoe County classified as heavy drinkers has remained higher than the percentage in Nevada and the United States.



- The rate of alcohol-related Emergency Department encounters has remained fairly stable over the past five years other than an increase in 2014.
- In 2017, the rate in Washoe County (1,377 per 100,000 population) was higher than Nevada (971 per 100,000 population).

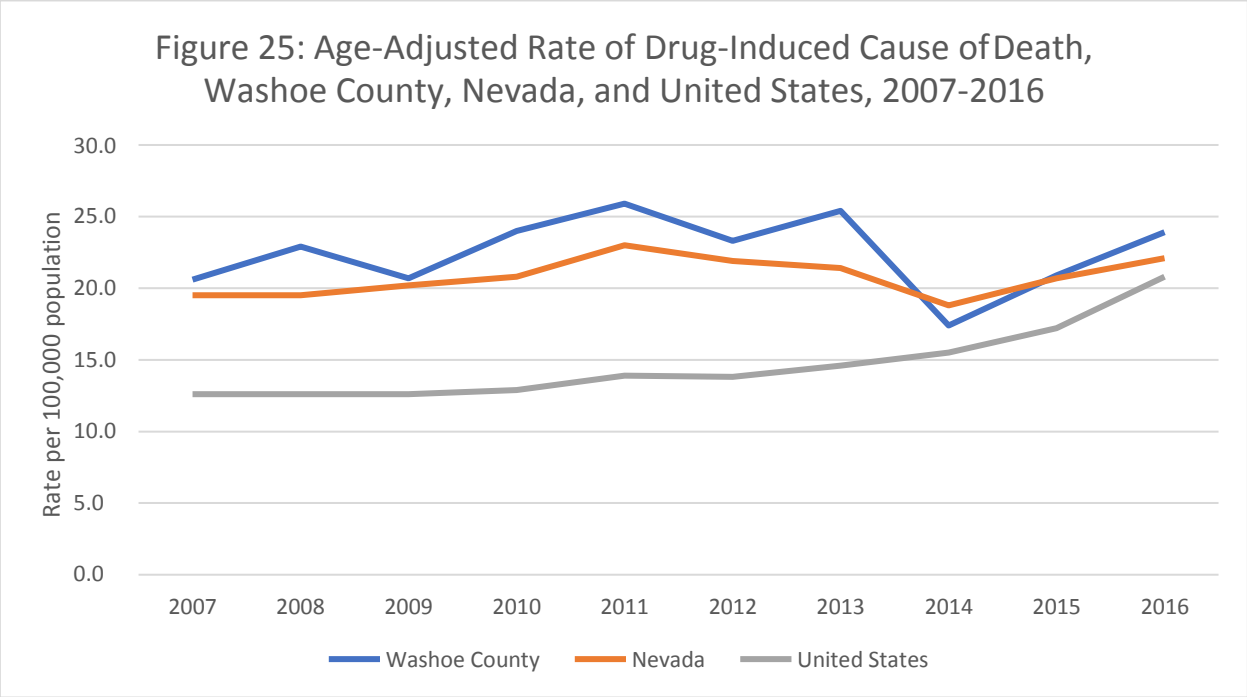


- In 2015, Washoe County began to experience more drug-related emergency department encounters than alcohol-related encounters.
- In 2017, the rate of drug-related emergency department encounters in Washoe County (1,583 per 100,000 population) was higher than Nevada (1,260 per 100,000 population).



Mental and behavioral disorders due to use of alcohol, harmful use (F10.1); Mental and behavioral disorders due to use of alcohol, dependence syndrome (F10.2); Alcoholic hepatitis (K70.1); Alcoholic cirrhosis of lover (K70.3); Alcoholic hepatic failure (K70.4); Alcoholic liver disease, unspecified (K70.9); Accidental poisoning by and exposure to alcohol (X45)

- In 2016, the age-adjusted rate of alcohol-induced deaths in Washoe County reached the highest point over the ten-year period at 21 persons per 100,000 population.
- From 2007 to 2016, the average rate of alcohol-induced deaths in Washoe County was 17 persons per 100,000 population which was greater than Nevada (12 persons per 100,000 population) and the United States (8 persons per 100,000 population).



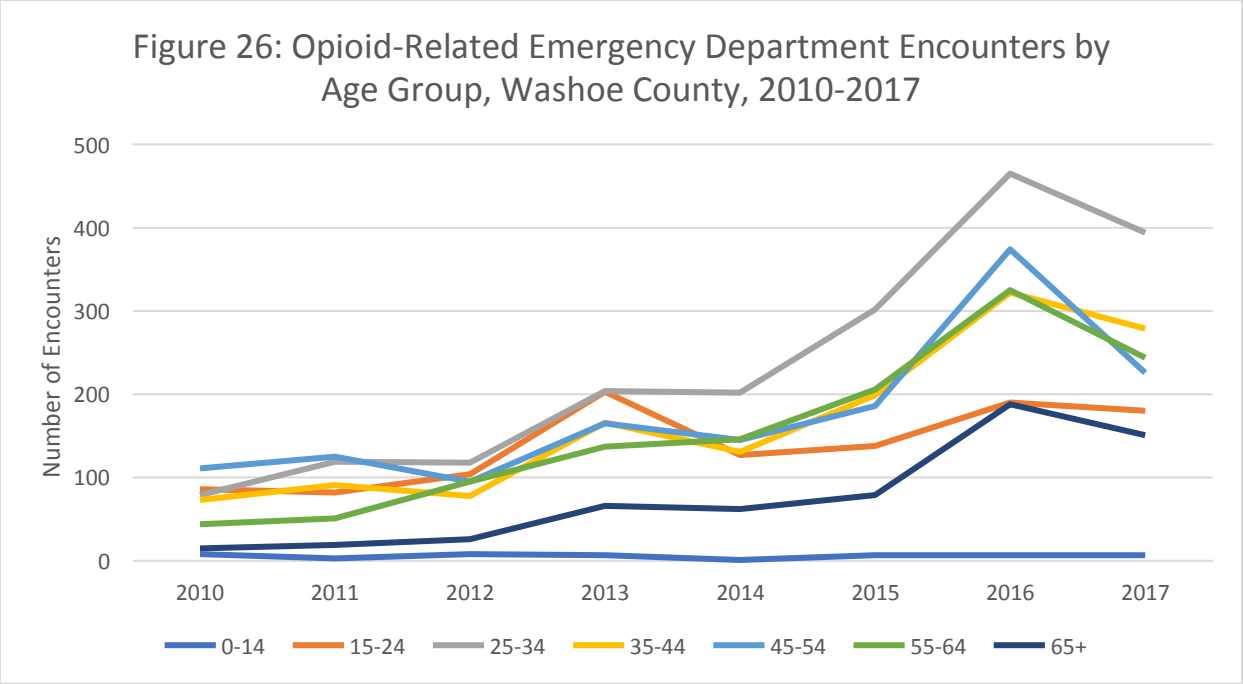
Drug poisonings (overdose) unintentional (X40-X44); Drug poisonings (overdose) suicide (X60-X64); Drug poisonings (overdose) homicide (X85); Drug poisonings (overdose) undetermined (Y10-Y14)

- In 2016, the age-adjusted rate of drug-induced deaths in Washoe County (23.9 per 100,000 population) was greater than the rate in Nevada (22.1 per 100,000 population) and the United States (20.8 per 100,000 population).
- From 2007 to 2016, the average rate of drug-induced deaths in Washoe County was 23 persons per 100,000 population which was greater than Nevada (21 persons per 100,000 population) and the United States (15 persons per 100,000 population).

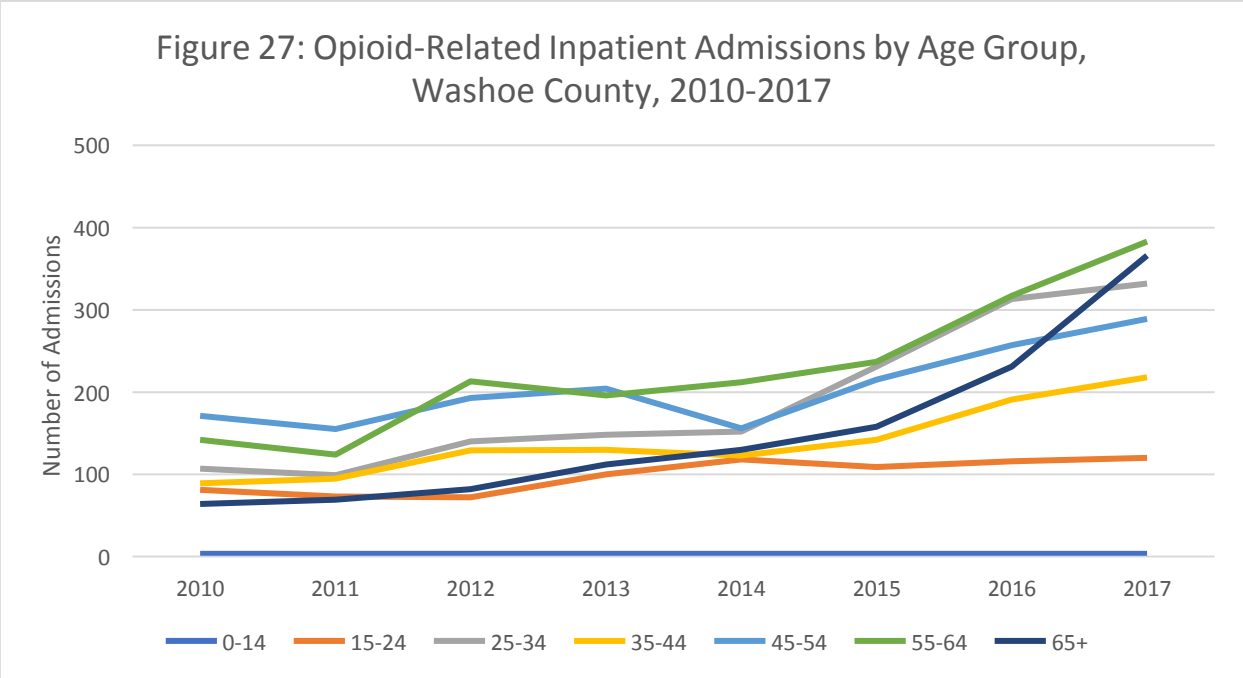
Opioid Specific

- Description of the opioid categories:
- Heroin: an illicit opioid synthesized from morphine that can be a white or brown powder, or a sticky black substance
- Methadone: a synthetic opioid
- Natural and Semi-synthetic: morphine, codeine, oxycodone, hydrocodone, hydromorphone, and oxymorphone
- Synthetic Opioids: fentanyl and tramadol

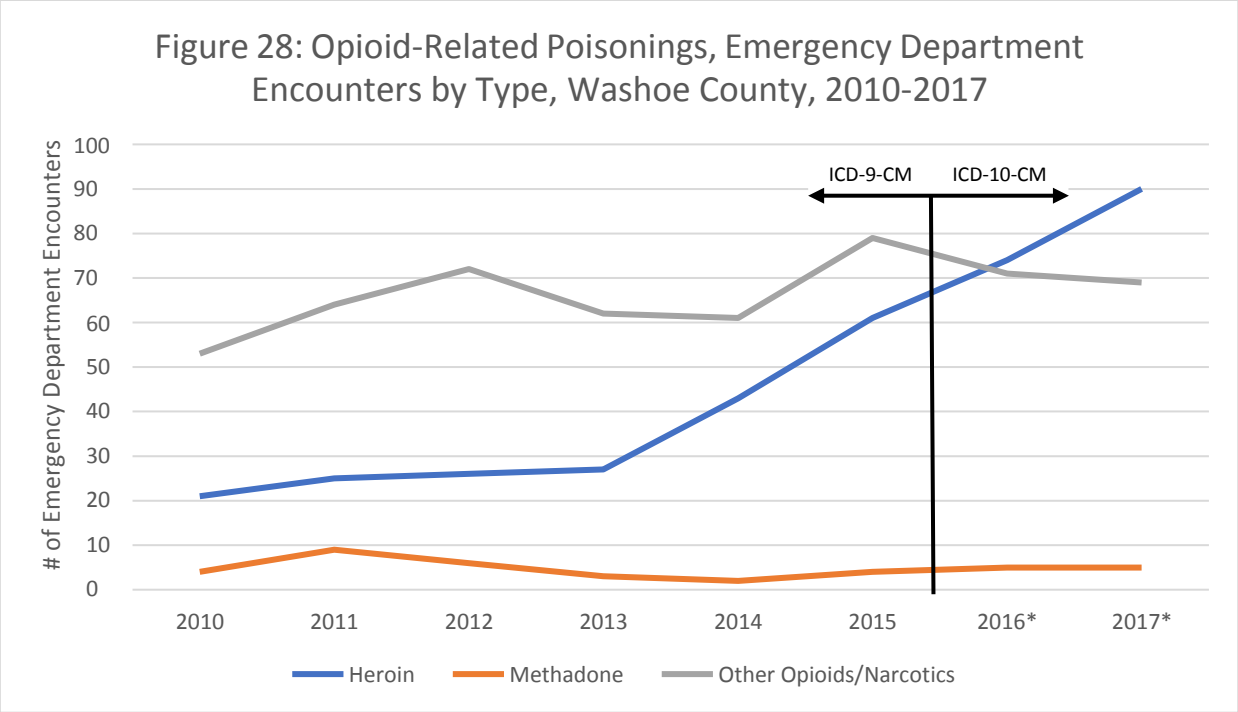
ICD Codes used for analysis:
Opioid Related Disorders
All Diagnosis
304.0 Opioid type dependence (ICD-9-CM); 304.7 Combinations of opioid type drug with any other drug dependence (ICD-9-CM); 305.5 Nondependent opioid abuse (ICD-9-CM); F11 Opioid related disorders (ICD-10-CM)
Opiate Poisoning Principal
Diagnosis
965.0 Poisoning by opiates and related narcotics (ICD-9-CM); T40.0 Poisoning by, adverse effect of and underdosing of opium (ICD-10-CM); T40.1 Poisoning by and adverse effect of heroin(ICD-10-CM); T40.2 Poisoning by, adverse effect of and underdosing of other opioids ICD-10-CM; T40.3 Poisoning by, adverse effect of and underdosing of methadone (ICD-10-CM); T40.4 Poisoning by, adverse effect of and underdosing of other synthetic narcotics (ICD-10-CM); T40.6 Poisoning by, adverse effect of and underdosing of other and unspecified narcotics (ICD-10-CM)
All Diagnosis
E850.0-E850.2 Accidental poisoning by heroin, methadone, and other opiates (ICD-9-CM)
Deaths
Deaths with any of the following ICD-10 codes as an underlying cause of death were first selected:
X40-X44 Accidental poisonings by drugs; X60-X64 Intentional self-poisoning by drugs X85 Assault by drug poisoning; Y10-Y14 Drug poisoning of underdetermined intent
Opioids listed as a contributing case of death:
T40.0 Opium; T40.1 Heroin; T40.2 Natural and semi-synthetic opioids; T40.3 Methadone; T40.4 Synthetic opioids; T40.6 Other and unspecified opioids



- The number of opioid-related Emergency Department encounters was highest among individuals aged 25-34 years.
- The number of opioid-related Emergency Department encounters has increased from 2010 to 2017 among all age groups except for those aged 0-14 years.



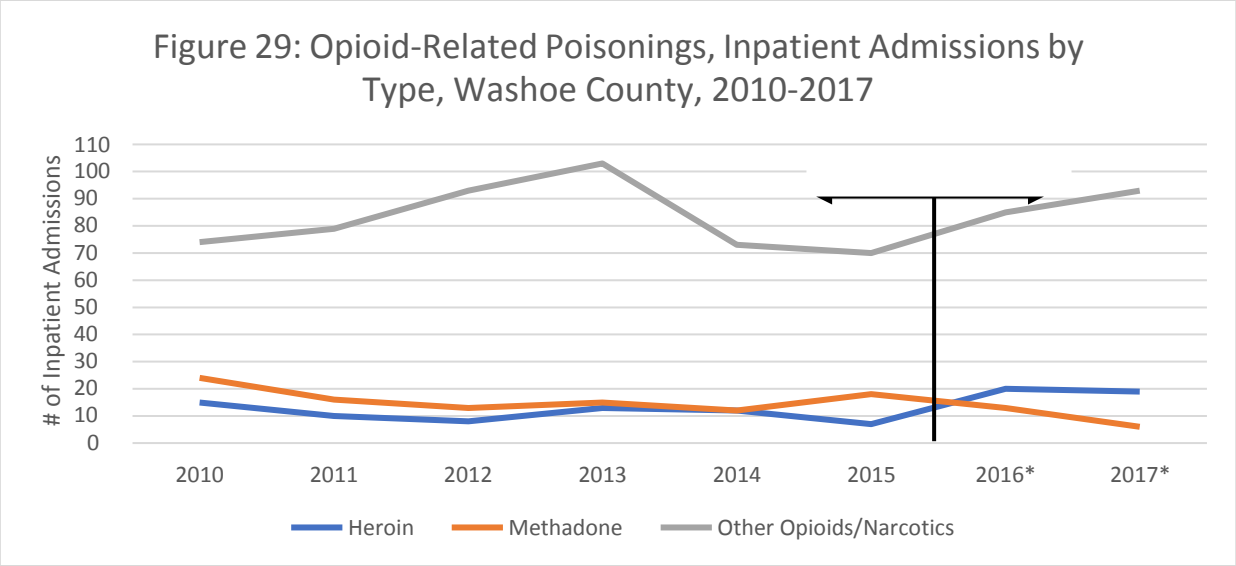
- From 2010 to 2017, the number of opioid-related inpatient admissions was highest among individuals aged 55-64 years in Washoe County.
- The number of opioid-related inpatient admissions has increased from 2010 to 2017 among all age groups in Washoe County.



*Data are preliminary and subject to change
Prior to 2016, one visit could include more than one drug group. In 2016, counts became mutually exclusive.

Other Opioids/Narcotics category may include: morphine, codeine, oxycodone, hydrocodone, fentanyl and tramadol

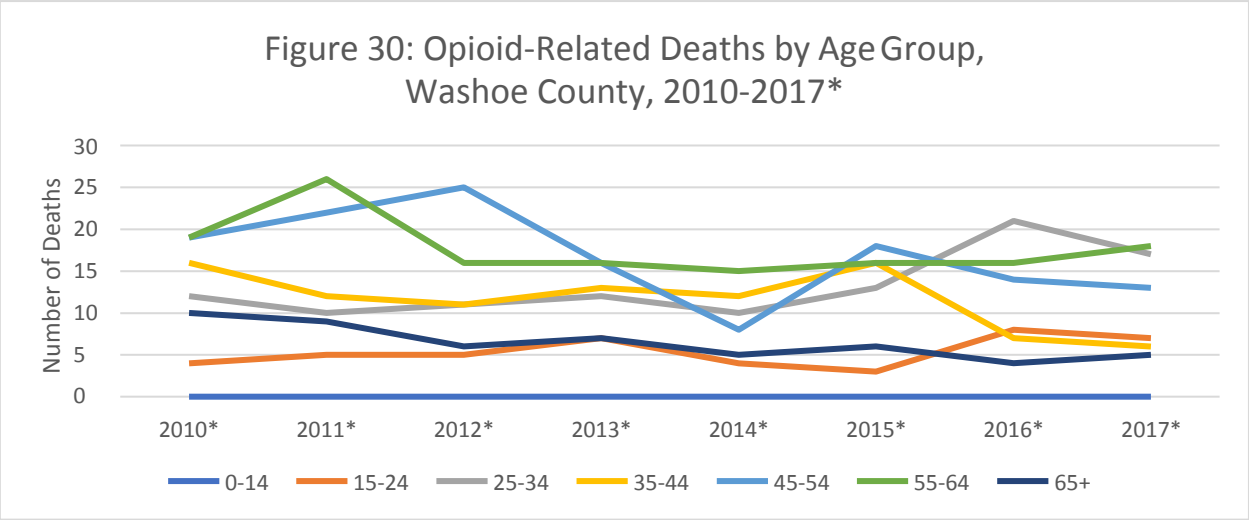
- In 2017, more heroin related poisonings (90 encounters) were seen in the emergency department followed by other opioids/narcotics (69 encounters) and methadone (5 encounters).



*Data are preliminary and subject to change
Prior to 2016, one visit could include more than one drug group. In 2016, counts became mutually exclusive.

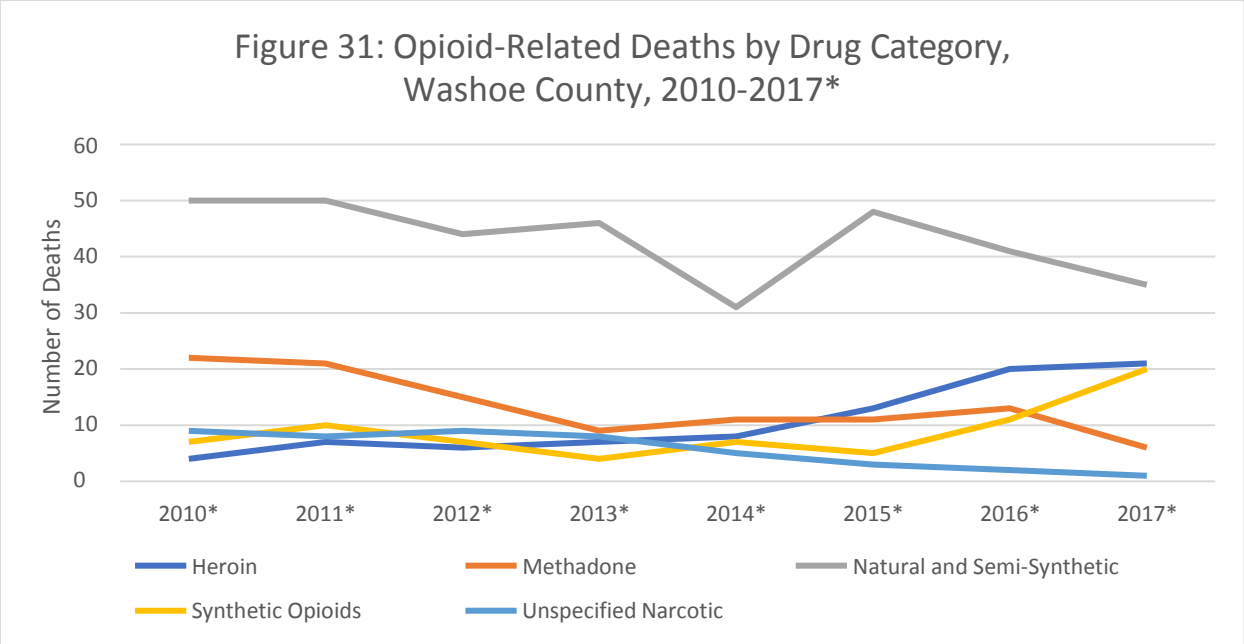
Other Opioids/Narcotics category may include: morphine, codeine, oxycodone, hydrocodone, fentanyl and tramadol

- From 2010 to 2017, the average number of other opioid/narcotics inpatient admissions (83.8) was more than five times the average number of heroin inpatient admissions (13.0) and more than four times the number of methadone admissions (14.6) in Washoe County.
- In 2017, other opioid/narcotics related poisonings (93 admissions) has the highest number of people who were admitted as an inpatient compared to heroin (19 admissions) and methadone (6 admissions).



*Data are preliminary and are subject to changes

- The number of opioid-related deaths was highest among Washoe County residents aged 55-64 years from 2010 to 2017.
- In 2017, the number of opioid-related deaths was highest among Washoe County residents aged 55-64 years (18 deaths) followed by the 25-34 years age group (17 deaths) and the 45-54 years age group (13 deaths).



*Data are preliminary and are subject to changes One death can include more than one drug category

- From 2010 to 2017, natural and semisynthetic opioids caused the most deaths, however this number decreased from 50 deaths in 2010 to 35 deaths in 2017.
- The number of deaths caused by synthetic opioids and heroin in Washoe County increased from 2010 to 2017.

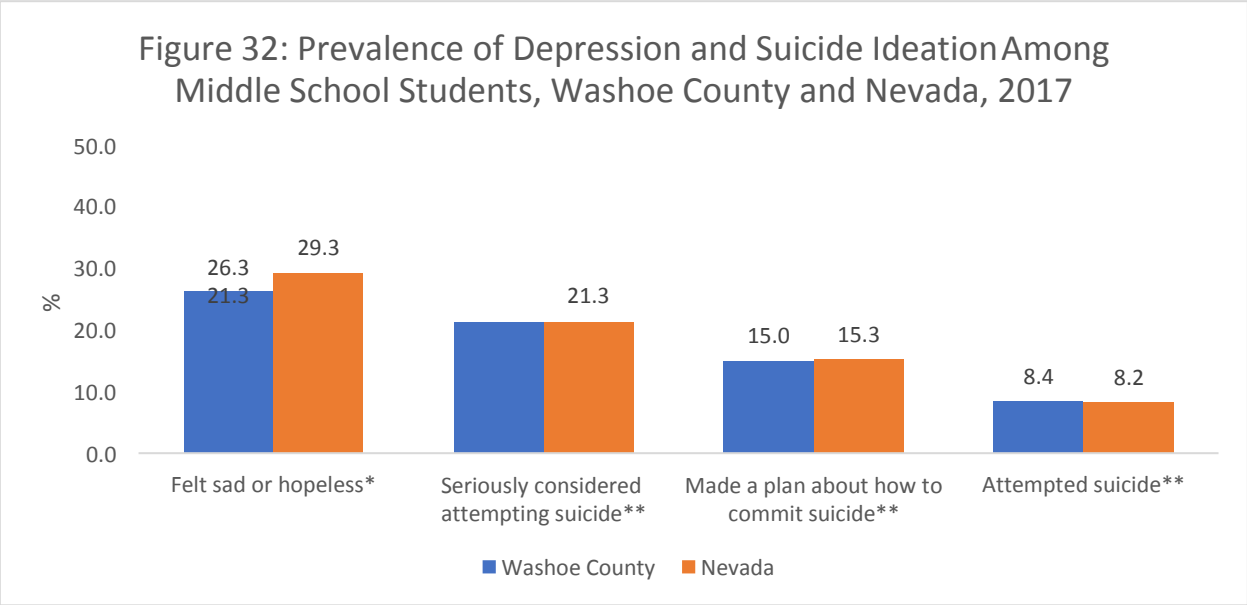
Summary of Substance Use

In 2017, the prevalence of current alcohol and marijuana use among Washoe County middle school and high school students decreased from the previous data collection year. The percent of middle school and high school students in Washoe County who reported having drank alcohol one or more times during their life was less than Nevada and the United States, however, the percent of middle school and high school students in Washoe County who reported having used marijuana one or more times during their life was greater than Nevada and the United States. The percentage of UNR students who reported having drank alcohol within the last 30 days has decreased from the previous collection year, but current marijuana use has increased. From 2012-2016, the prevalence of binge drinking and heavy drinking among adults in Washoe County has remained higher than Nevada and the United States. Over the ten-year period from 2007 to 2016, the average rate of alcohol-induced cause of death and the average rate of drug-induced cause of death in Washoe County was greater than Nevada and the United States. The percent of adults in Washoe County needing treatment for alcohol use and drug use was greater in Washoe County than in Nevada and the United States.

Mental Health

Mental health encompasses a person's emotional, psychological, and social well-being. Emotional well-being includes an interest in life and satisfaction; psychological well-being incorporates creating fulfilling relationships with people, managing responsibilities, and the ability to effectively adapt to change and cope with stress; and social well-being involves contributing to society and being integrated in a community.[6] A strong link has been found between mental health and physical health including elevated risk factor for incident coronary heart disease and stroke and lower engagement of physical activity.[6,7,8] Nearly 20% of adults in the United States experience mental illness in a given year with 4% facing serious mental illness that substantially interferes with major life activities.[10] On average, the life expectancy among adults in the United States living with serious mental illness is 25 years shorter than others.[10] Addressing the mental health needs of Washoe County residents will likely lead to an improvement in quality of life and an increase in life expectancy.

Middle School Students



*Almost every day for 2 or more weeks in a row so that they stopped doing some usual activities
**One or more times during their life

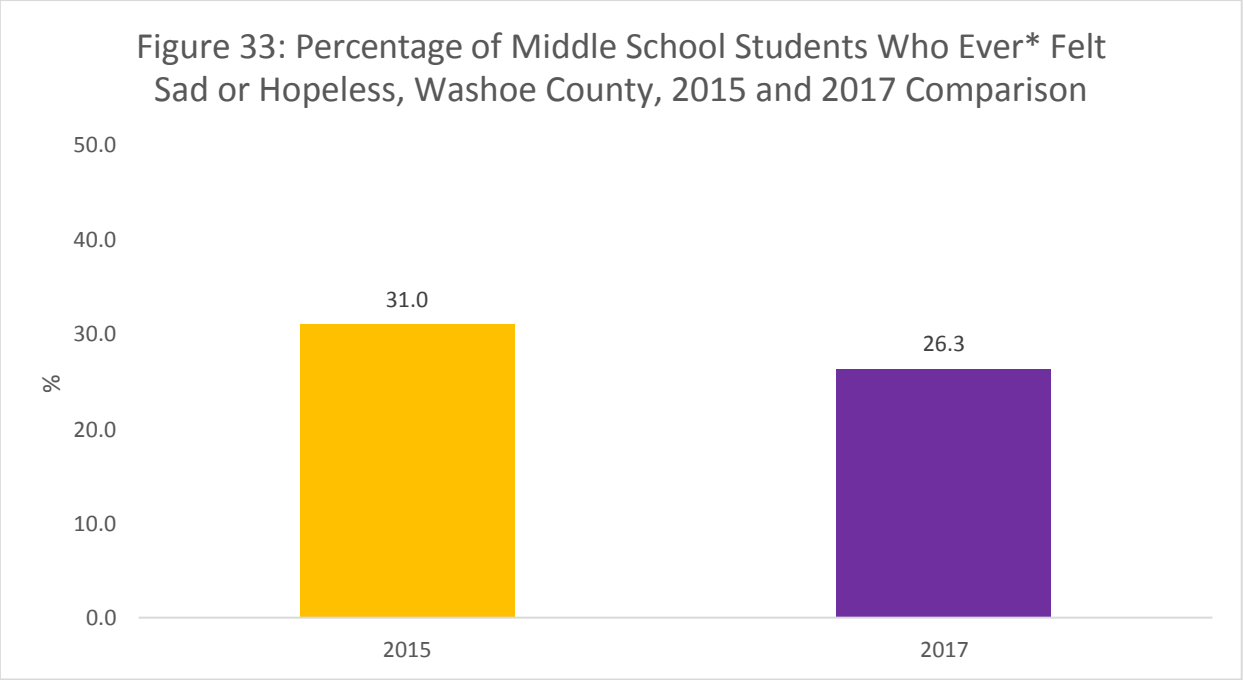
- In 2017, the percentage of middle school students who reported experiencing sadness or hopelessness almost every day for two or more weeks in a row was lower in Washoe County (26.3%) than Nevada (29.5%).
- In 2017, the percentage of middle school students who seriously considered attempting suicide was 21.3% in both Washoe County and Nevada.
- In 2017, the percentage of middle school students who made a plan about how to commit suicide was lower in Washoe County (15.0%) than Nevada (15.3%).
- In 2017, the percentage of middle school students who reported attempting suicide one or more times during their life is higher in Washoe County (8.4%) than Nevada (8.2%).

[6] Keyes, C. L. M. (2005). Mental illness and/or mental health? investigating axioms of the complete state model of health. *Journal of Consulting and Clinical Psychology, 73*(3), 539-548.

[7] Rowan, P. J., Haas, D., Campbell, J. A., Maclean, D. R., & Davidson, K. W. (2005). Depressive symptoms have an independent, gradient risk for coronary heart disease incidence in a random, population-based sample. *Annals of Epidemiology, 15*(4), 316-320.

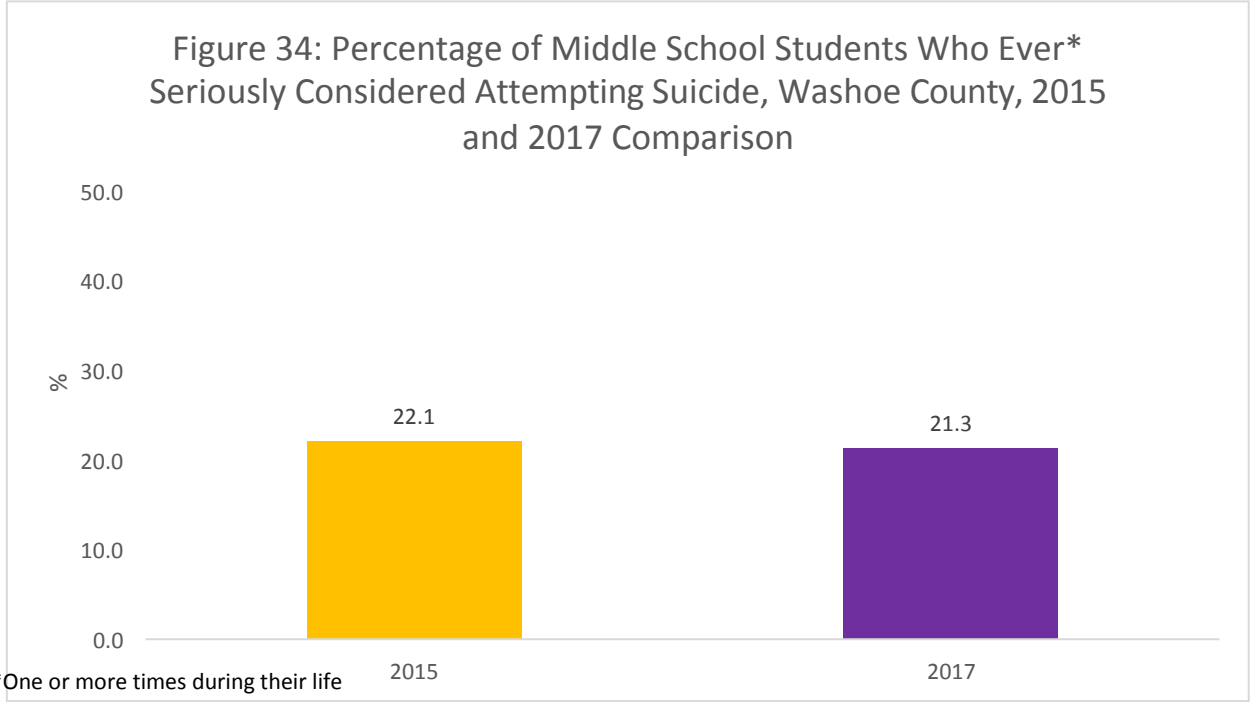
[8] Schuch, F., Vancampfort, D., Firth, J., Rosenbaum, S., Ward, P., Reichert, T., Stubbs, B. (2016; 2017 ;). Physical activity and sedentary behavior in people with major depressive disorder. *Journal of Affective Disorders, 210*, 139-150.

[10] National Alliance on Mental Illness. (2018). Mental health by the numbers. Accessed https: //www.nami.org/learn-more



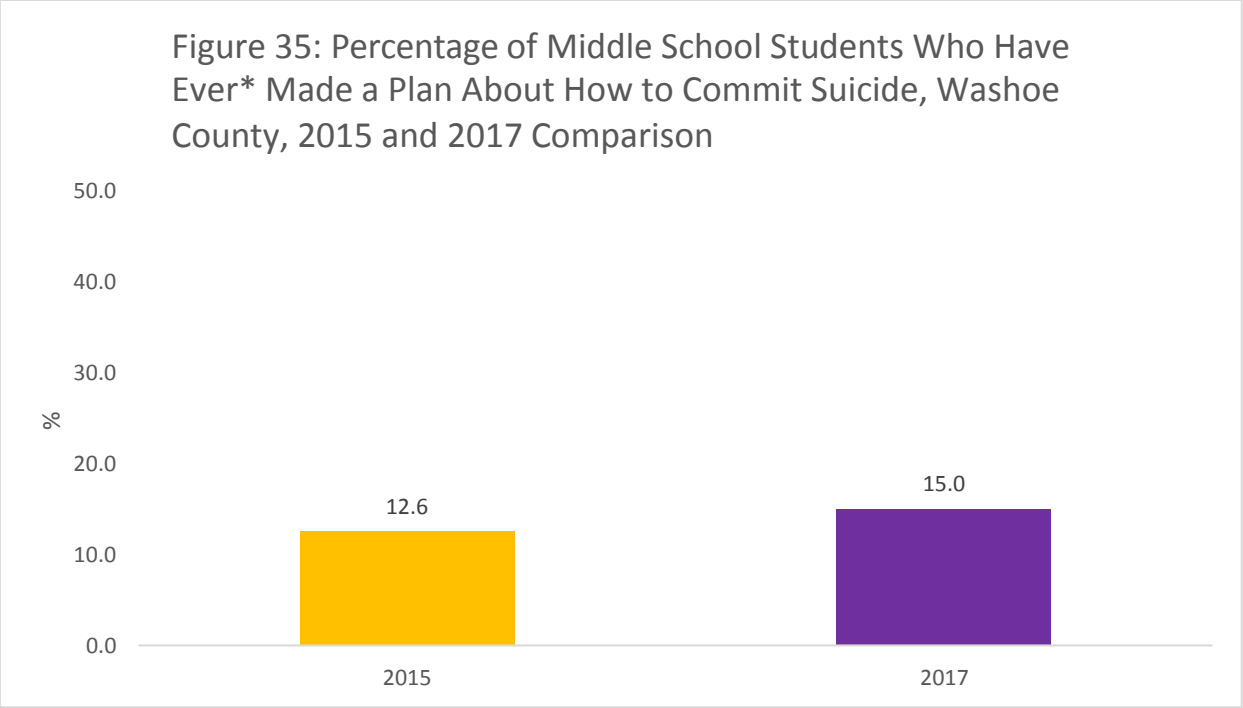
*Almost every day for 2 or more weeks in a row so that they stopped doing some usual activities, one or more times during their life

- The percentage of middle school students who reported feeling sad or hopeless one or more times during their life decreased from 2015 (31.0%) to 2017 (26.3%).



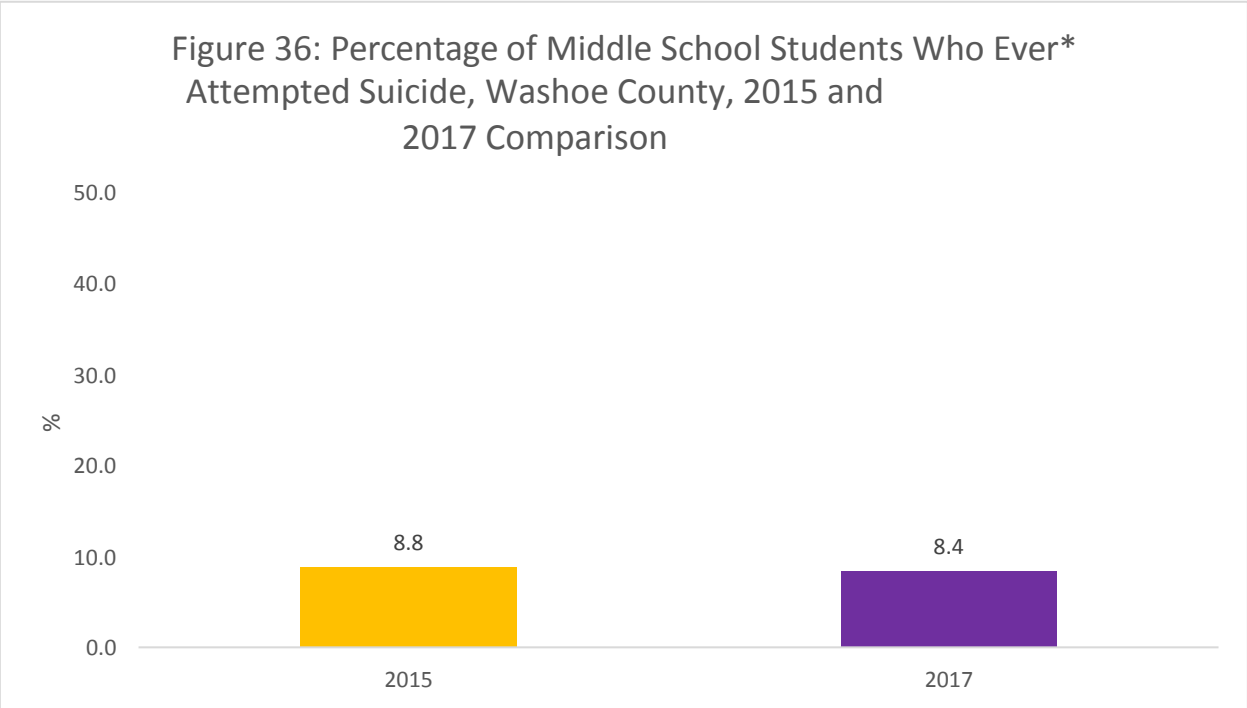
*One or more times during their life

- The percentage of Washoe County middle school students who have ever seriously considered attempting suicide decreased from 2015 (22.1%) to 2017 (21.3%).



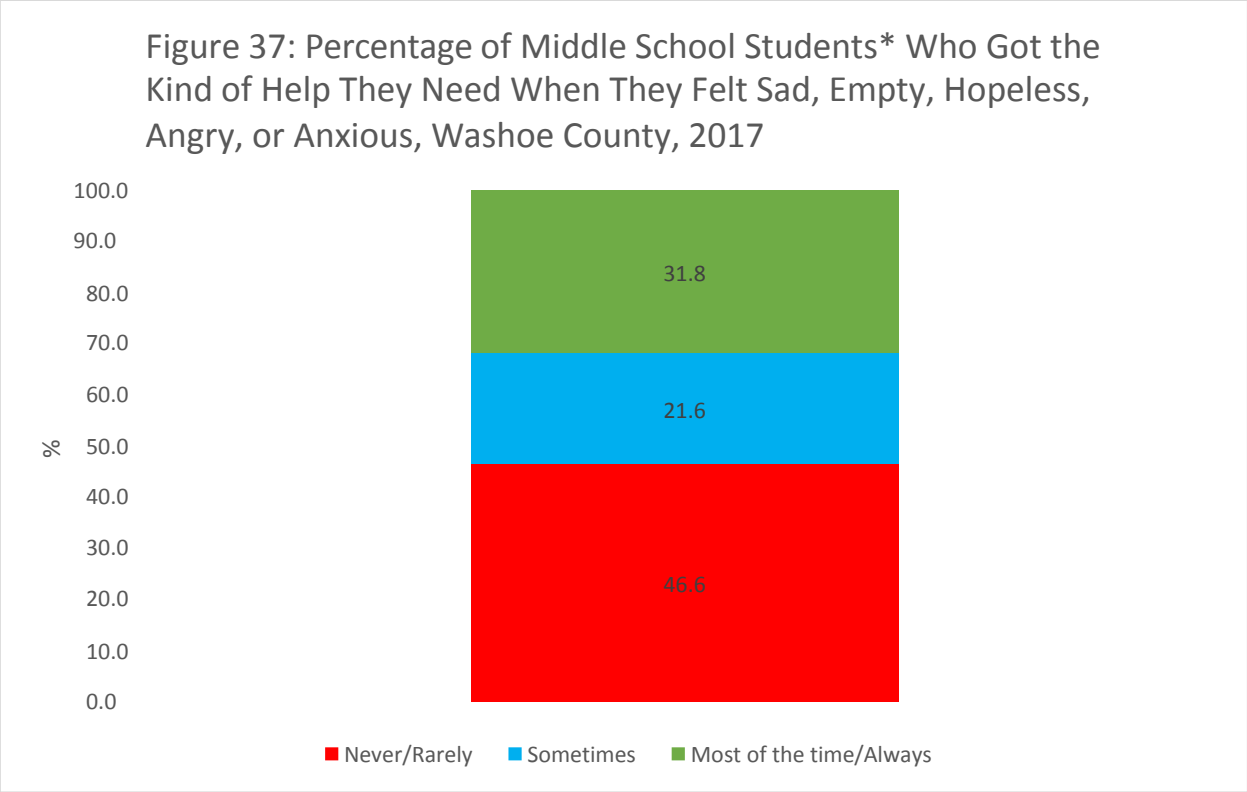
*One or more times during their life

- The percentage of middle school students in Washoe County who reported ever making a plan to commit suicide increased from 2015 (12.6%) to 2017 (15.0%).



*One or more times during their life

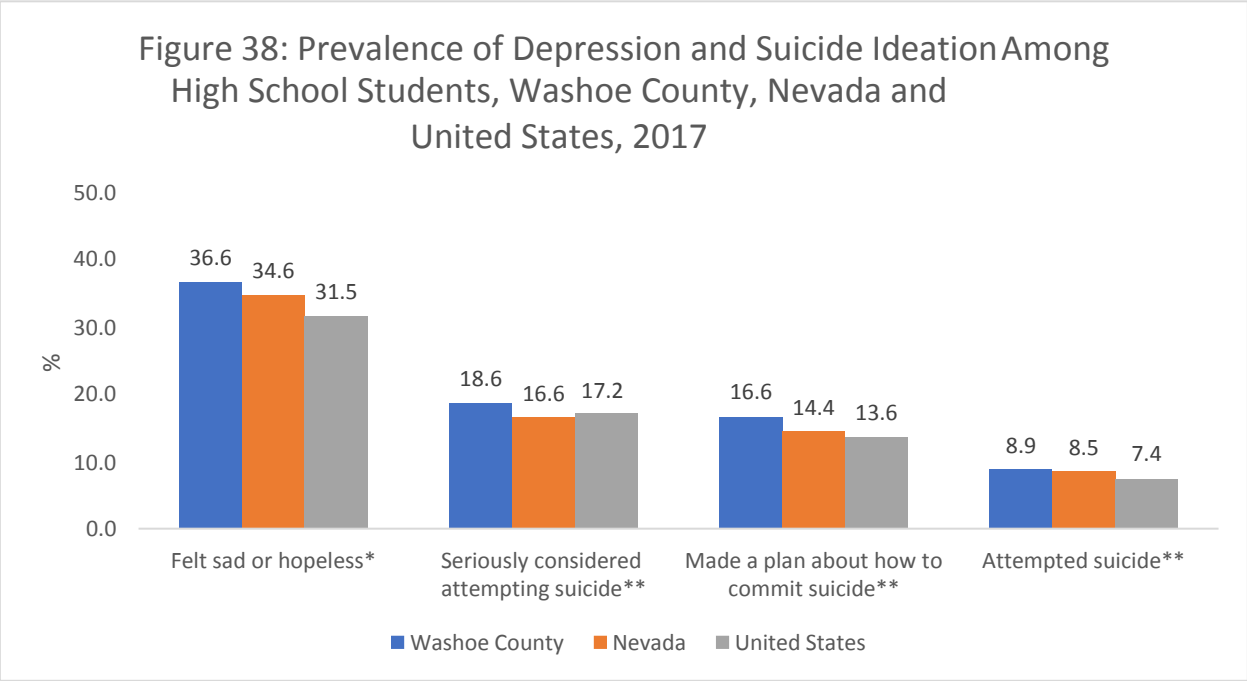
- The percentage of middle school students in Washoe County who reported attempting suicide one or more times during their life decreased from 2015 (8.8%) to 2017 (8.4%).



*Among those who reported feeling sad, empty, hopeless, or anxious

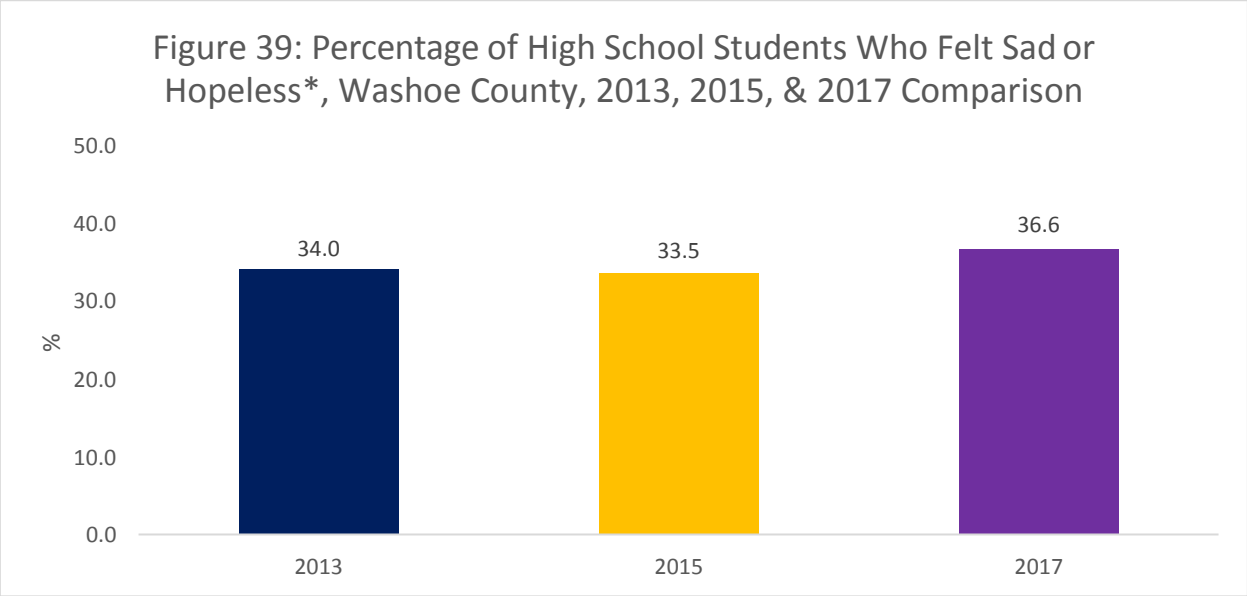
- Among middle school students who reported feeling sad, empty, hopeless, or anxious, 46.6% reported never or rarely receiving the help they needed.

High School Students



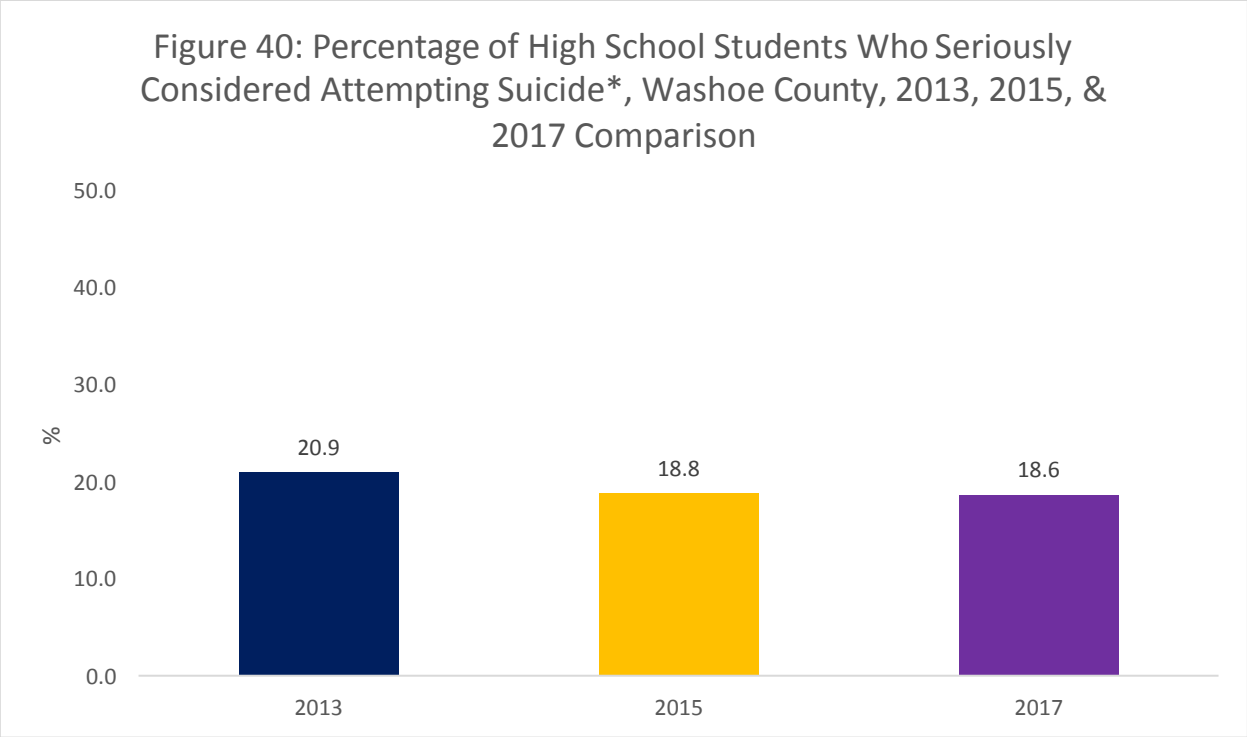
*Almost every day for 2 or more weeks in a row so that they stopped doing some usual activities, during the 12 months before the survey
**During the 12 months before the survey

- In 2017, the prevalence of depression and suicide ideation among high school students in Washoe County was higher than Nevada and the United States.



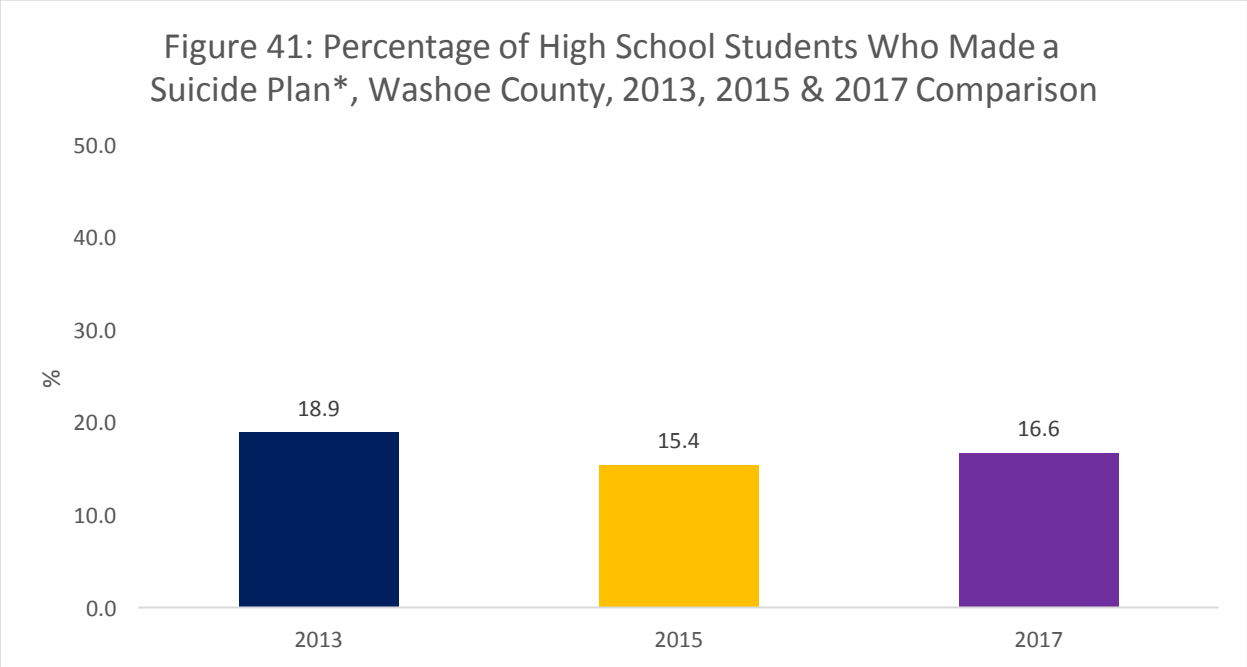
*Almost every day for 2 or more weeks in a row so that they stopped doing some usual activities, during the 12 months before the survey

- The percentage of high school students in Washoe County who reported feeling sad or hopeless almost every day for two or more weeks increased from 2013 (34.0%) to 2017 (36.6%).



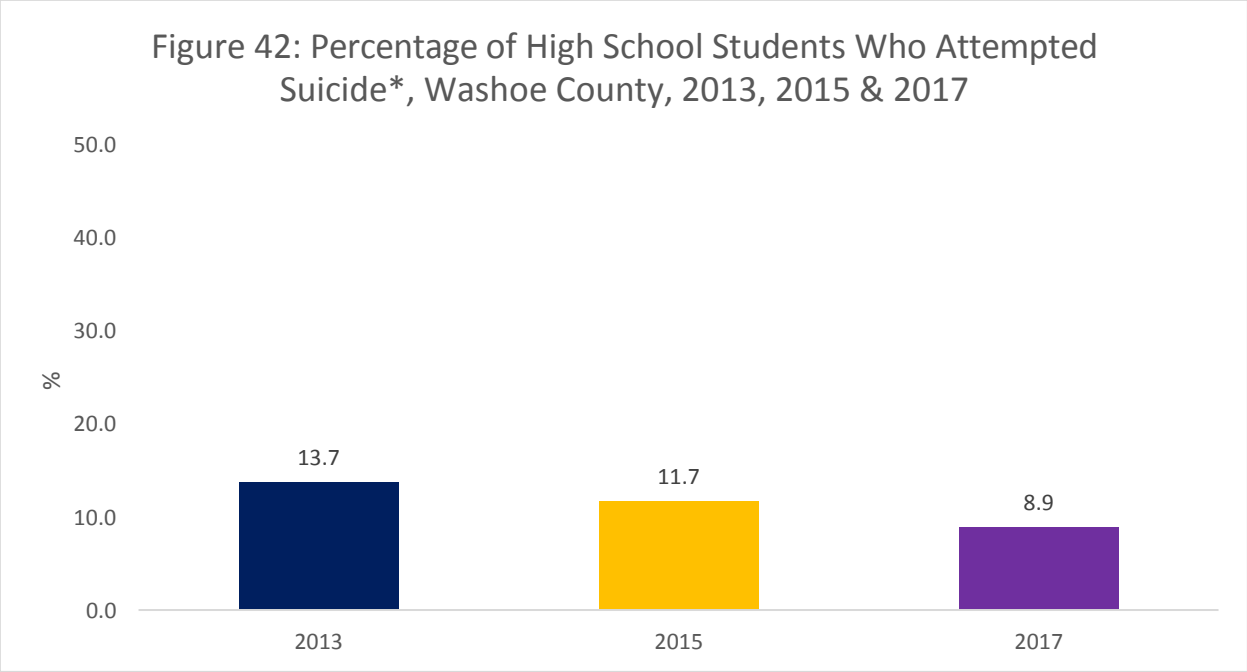
*During the 12 months prior to the survey

- The percentage of Washoe County high school students who reported they had seriously considered attempting suicide during the previous 12 months decreased from 2013 (20.9%) to 2017 (18.6%).



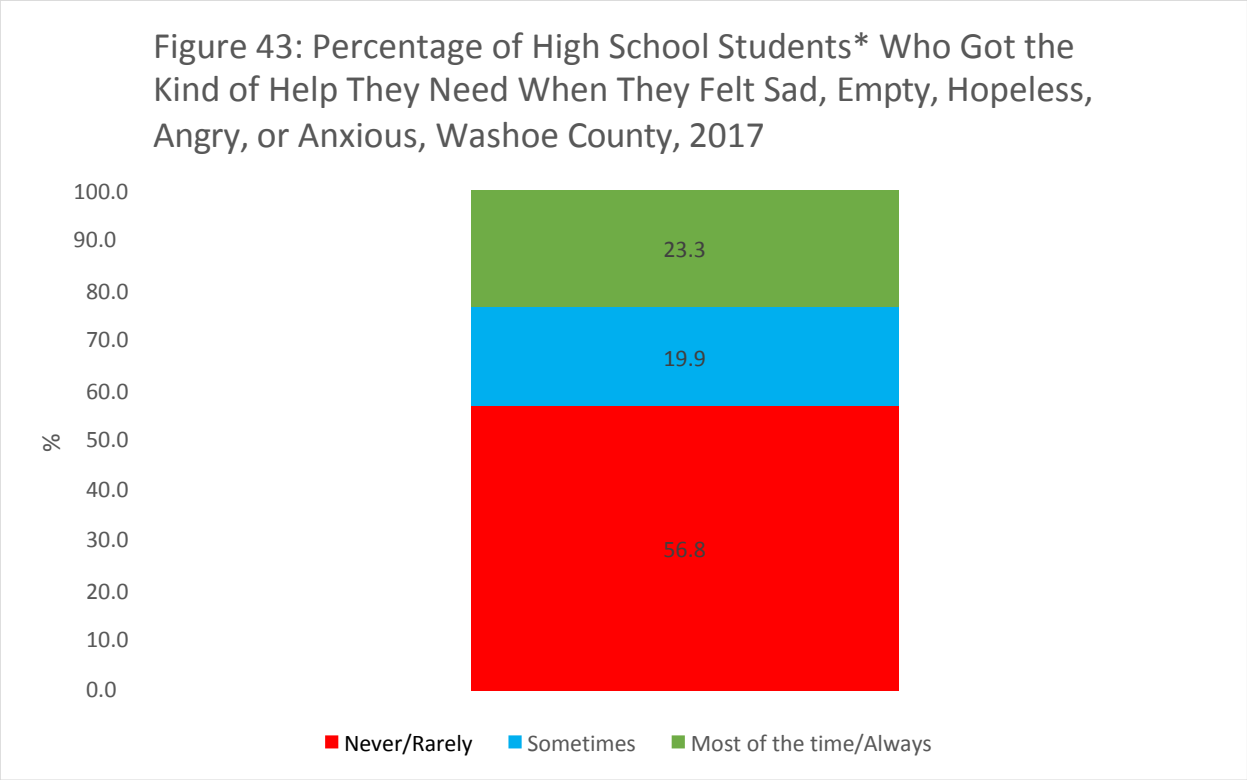
*During the 12 months prior to the survey

- The percentage of high school students in Washoe County who reported making a plan to commit suicide during the previous 12 months decreased from 2013 (18.9%) to 2017 (16.6%).



*One or more times during the 12 months prior to the survey

- The percentage of high school students in Washoe County who reported attempting suicide one or more times over the previous 12 months decreased from 2013 (13.7%) to 2017 (8.9%).



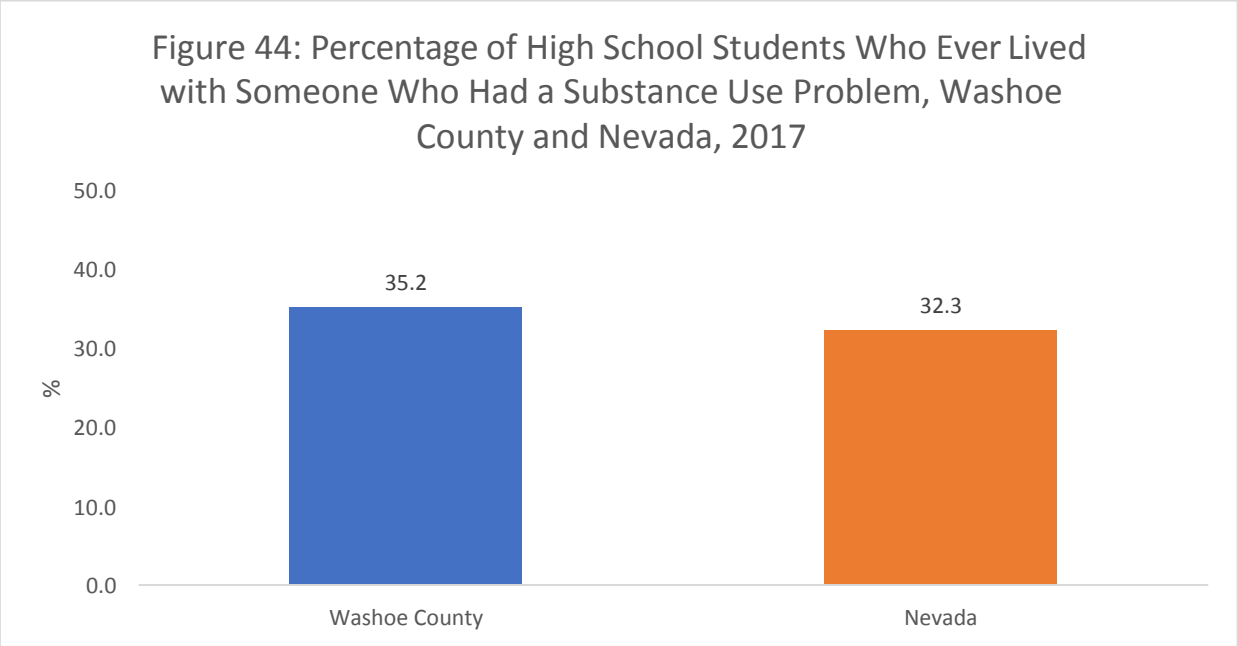
*Among those who reported feeling sad, empty, hopeless, or anxious

- In 2017, among high school students who reported feeling sad, empty, hopeless, or anxious, 56.8% reported never or rarely receiving the help they needed.

Lifetime prevalence factors of Adverse Childhood Experiences (ACEs)

The Nevada Youth Risk Behavior Survey incorporated five state-added questions designed to assess the lifetime prevalence of adverse childhood experiences (ACE) of high school students in Nevada. These five questions explore 1) household substance use; 2) household mental illness; 3) forced sexual intercourse; 4) physical abuse by an adult; and 5) household domestic violence.

For each increase in the number of ACEs experienced there is a correlated increase in the prevalence of poor health outcomes throughout the lifespan.[11] Exposure to chronic stressful events during childhood can disrupt social, emotional, and cognitive development which can impact a child's ability to effectively manage emotions. Unhealthy coping mechanisms, such as substance use, high-risk sexual behaviors or self-harm, may be adopted and can contribute to a wide range of health and social consequences.[12] ACEs have been linked to more than 40 negative health outcomes including chronic health conditions, smoking, alcoholism, drug use, depression, attempted suicide, unintended pregnancies, and poor work/school performance among others.[13] The following figures depict point in time prevalence rates among Washoe County high school students for ACEs.

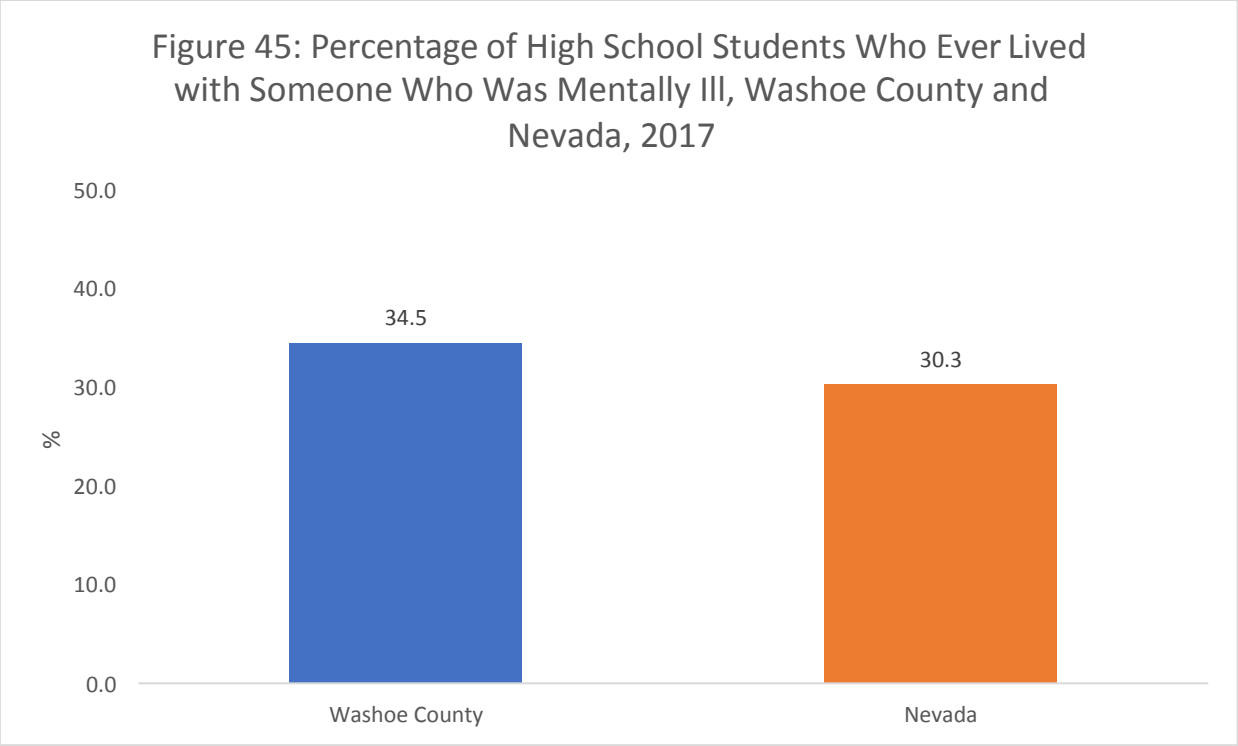


In 2017, the percentage of high school students who ever lived with someone who was a problem drinker, alcoholic, or abused street or prescription drugs was higher in Washoe County (35.2%) than Nevada (32.3%).

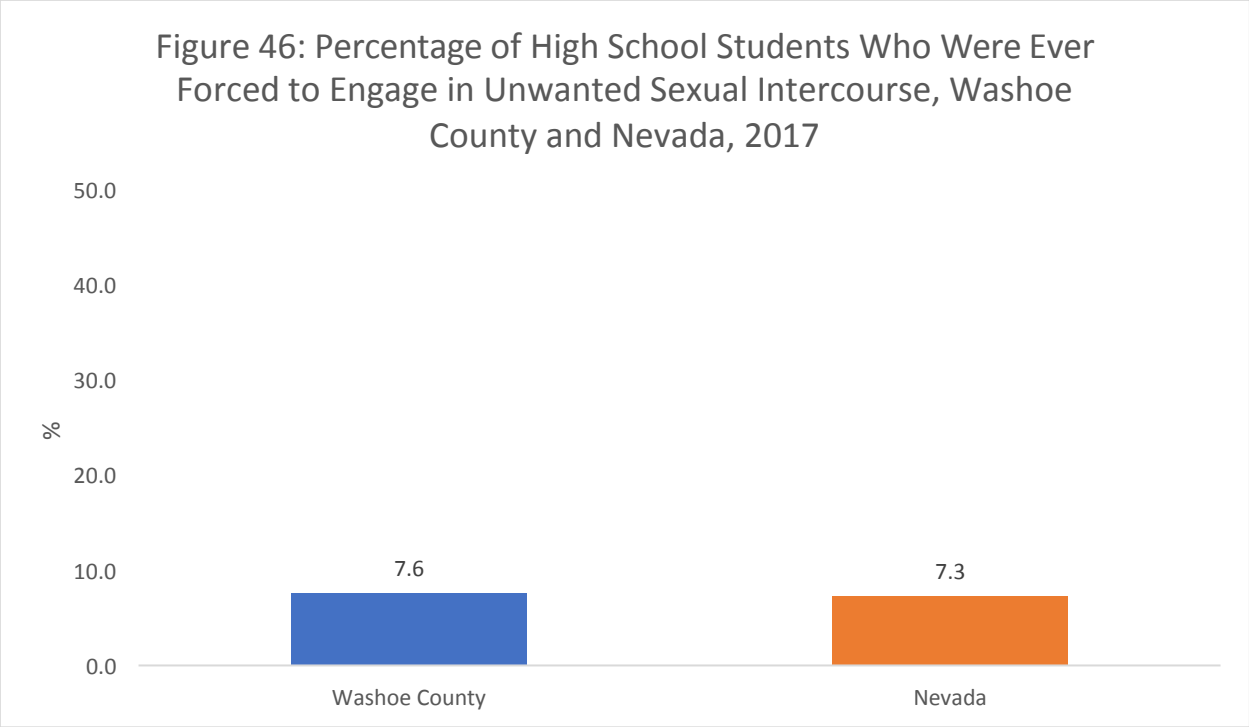
[11] Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine, 14*(4), 245-258.

[12] Substance Abuse and Mental Health Services Administration. (2018). Adverse childhood experiences. Accessed https: //www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/adverse-childhood-experiences

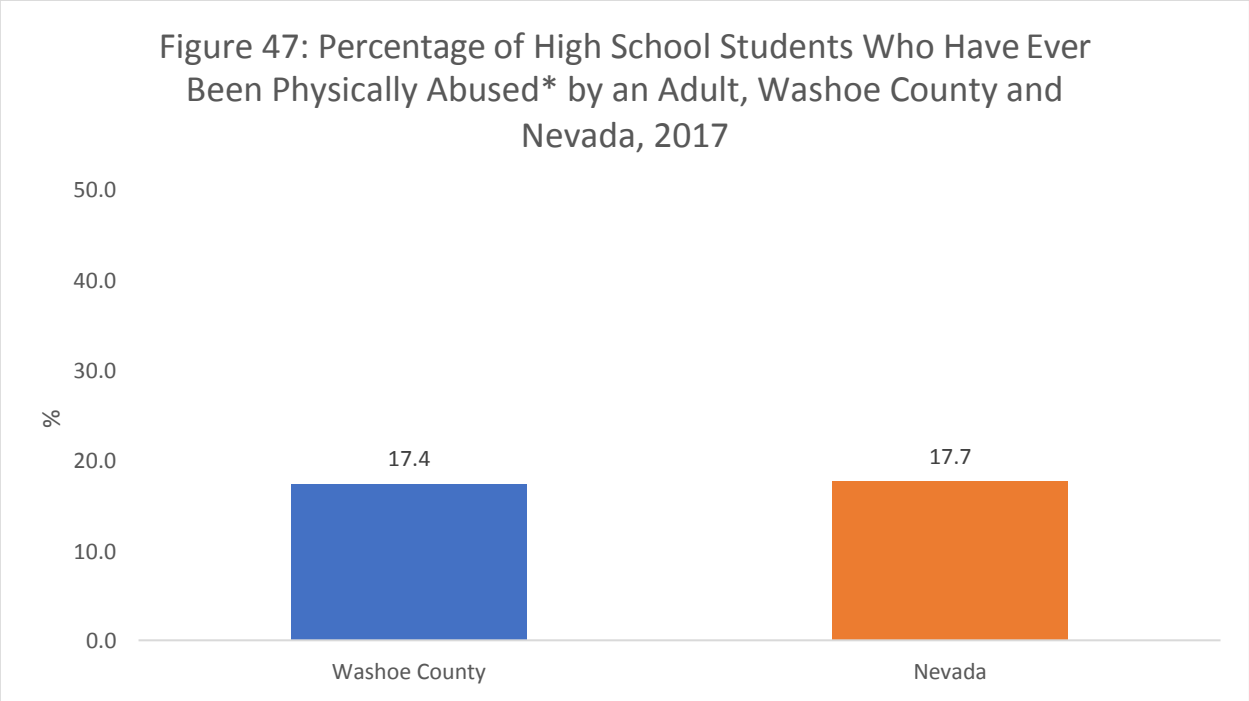
[13] Centers for Disease Control and Prevention. (2016). About adverse childhood experiences. Accessed https: //www.cdc.gov/violenceprevention/acestudy/about_ace.html



- In 2017, the percentage of high school students who ever lived with someone who was depressed, mentally ill, or suicidal was higher in Washoe County (34.5%) than Nevada (30.3%).

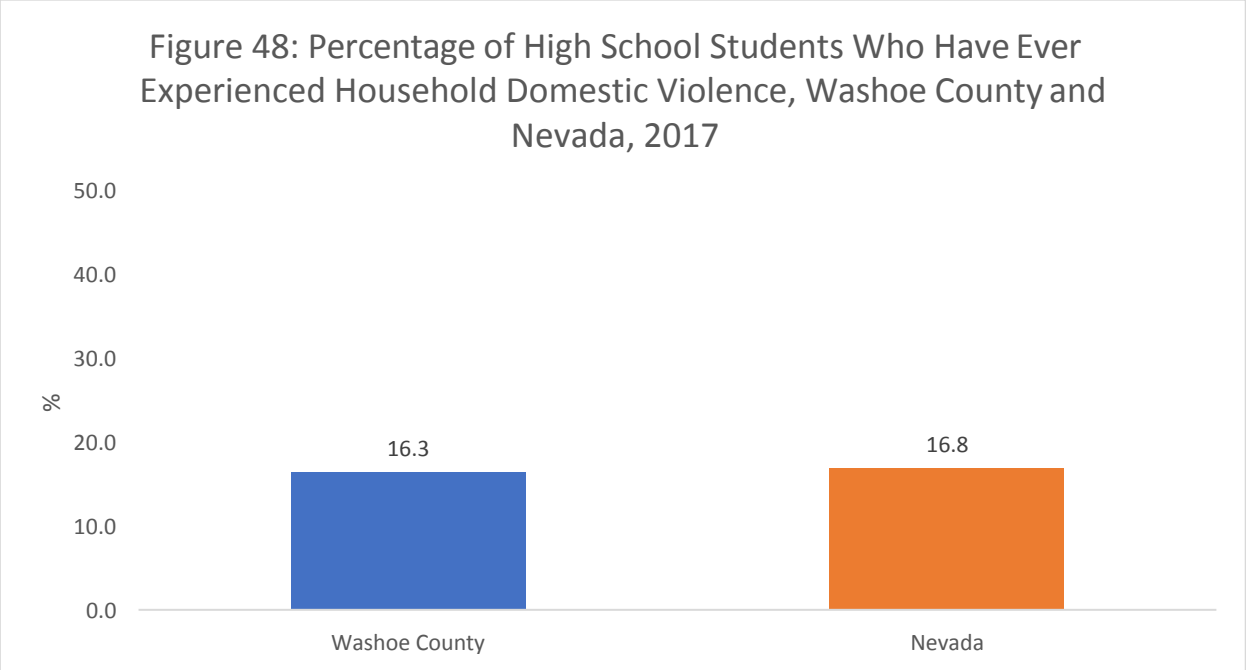


In 2017, the percentage of Washoe County high school students who reported ever being physically forced to have sexual intercourse when they did not want to, was higher in Washoe



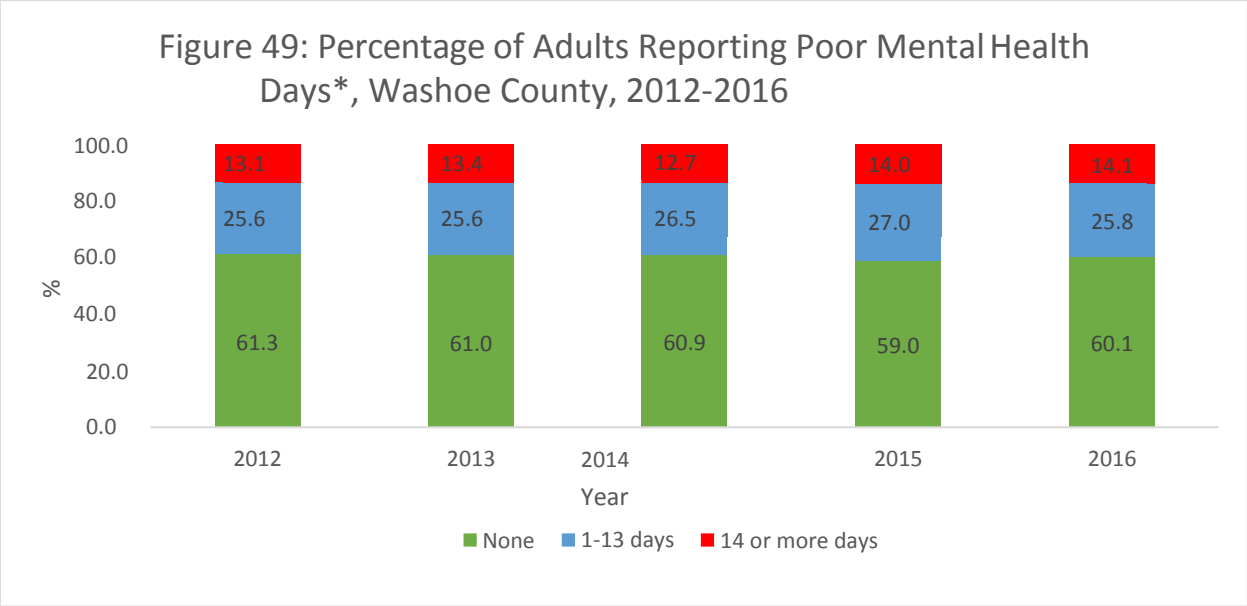
* Excluding spanking for bad behavior

- In 2017, the percentage of high school students who have ever been hit, beaten, kicked, or physically hurt in any way by an adult was lower in Washoe County (17.4%) than in Nevada (17.7%).



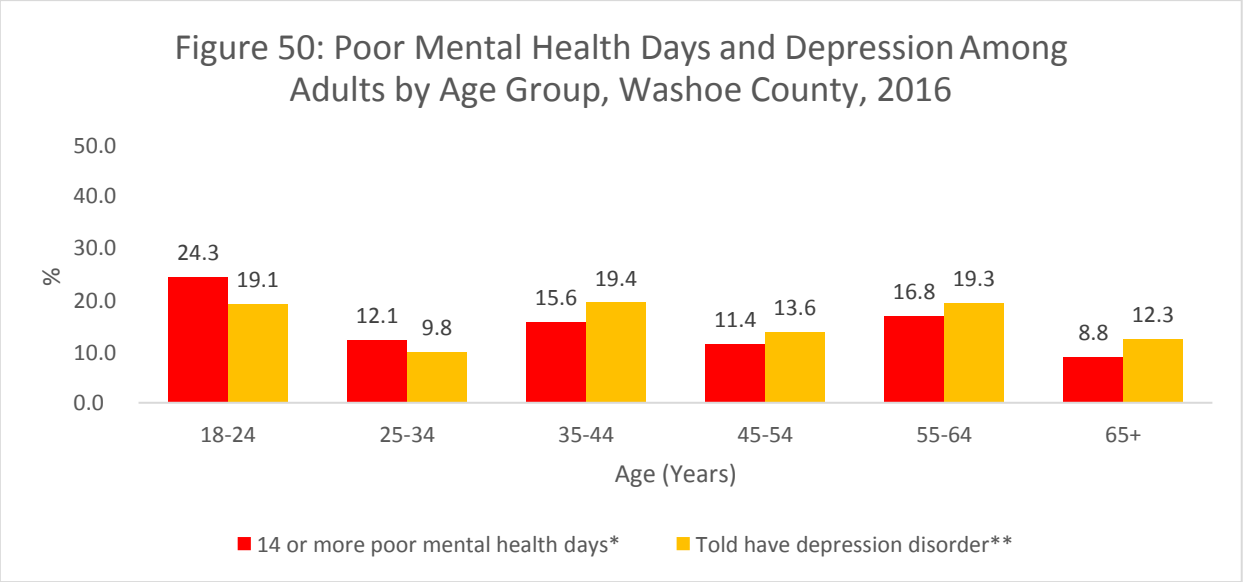
- In 2017, the percentage of high school students who have ever seen adults in their home slap, hit, kick, punch, or beat each other up was lower in Washoe County (16.3%) than in Nevada (16.8%).

Adults



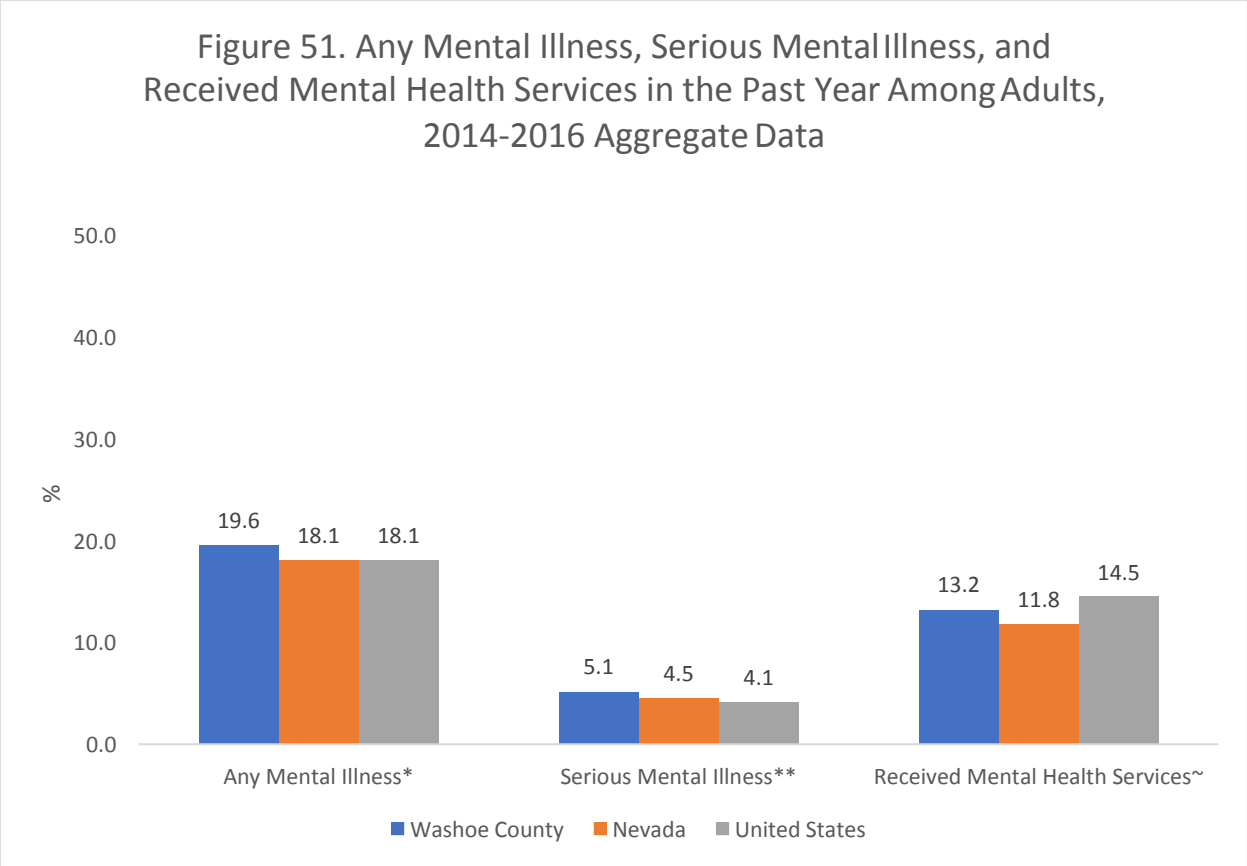
*During the prior 30 days

- The percentage of Washoe County adults who report having experienced 14 or more poor mental health days during the prior 30 days has increased from 2012 (13.1%) to 2016 (14.1%).



*During prior 30 days
**Including depression, major depression, dysthymia, or minor depression

- In 2016, Washoe County residents who reported experiencing 14 or more poor mental health days during the prior 30 days was highest among residents aged 18 to 24 years (24.3%) followed by residents aged 55 to 64 years (16.8%).
- Washoe County adults who have ever been told by a doctor, nurse, or other health care professional they have a depression disorder was highest among those aged 35 to 44 (19.4%) followed closely by those aged 55 to 64 years (19.3%) and 18 to 24 years (19.1%).

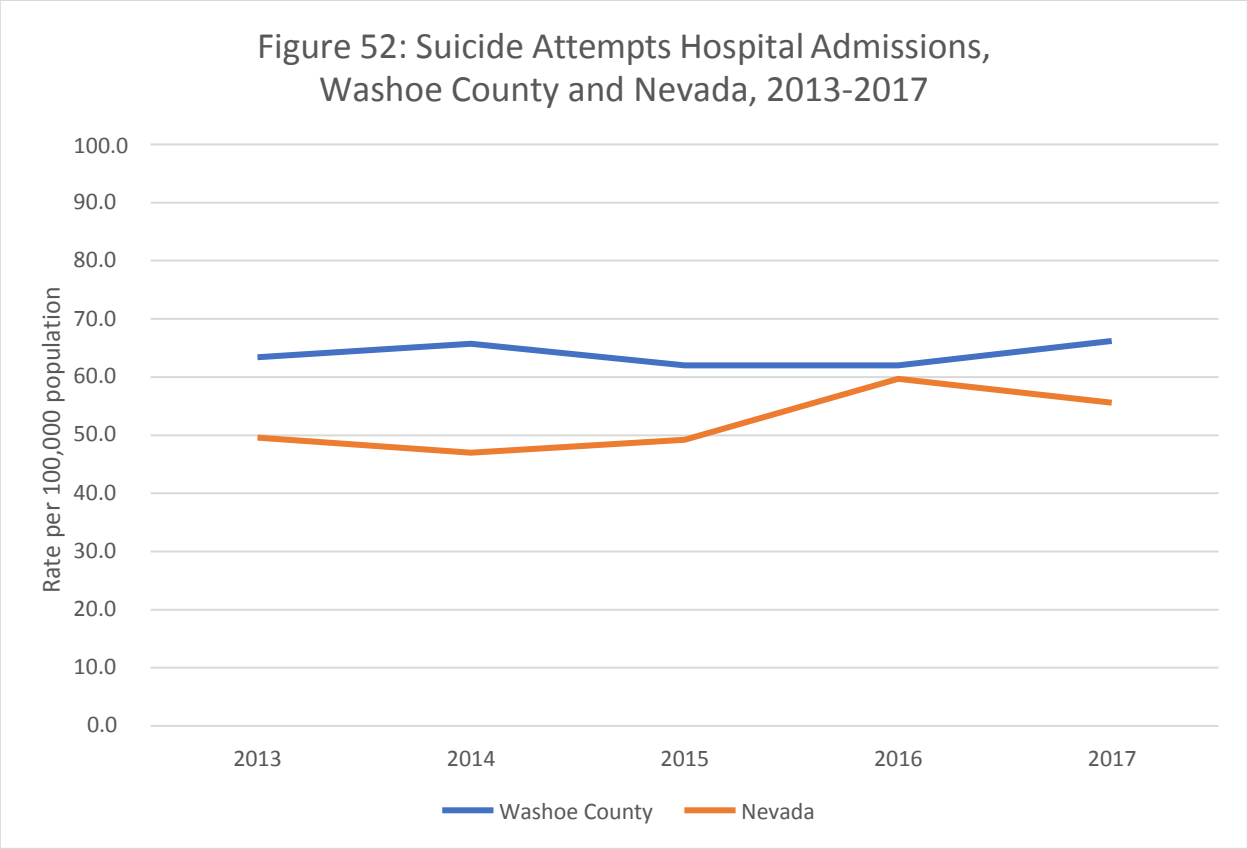


*Any mental illness (AMI) is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder.
**Serious mental illness (SMI) is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder. SMI includes individuals with diagnoses resulting in serious functional impairment.
~Mental health services are defined as having received inpatient treatment/counseling or outpatient treatment/counseling or having used prescription medication for problems with emotions, nerves, or mental health. Respondents were not to include treatment for drug or alcohol use.

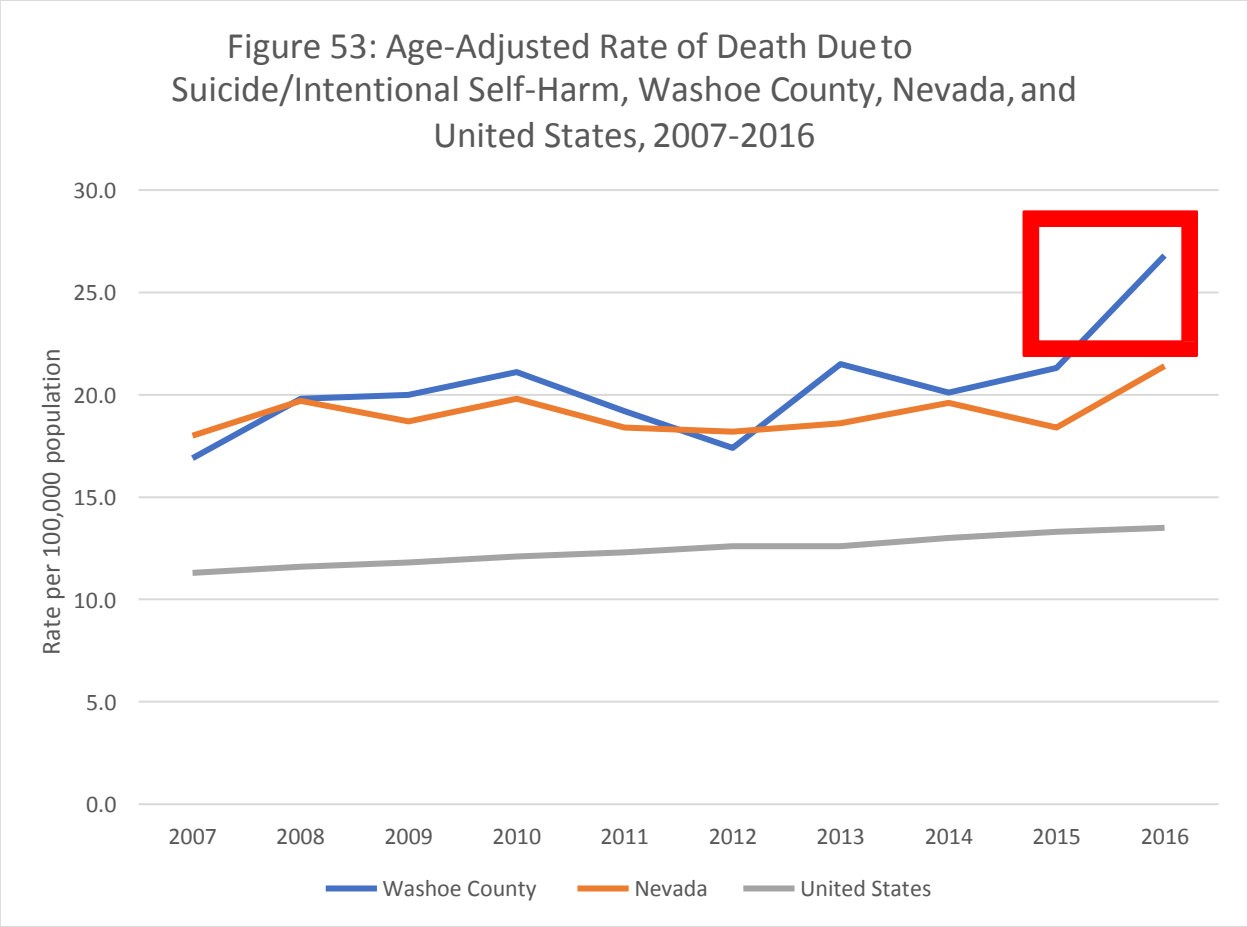
- On average from 2012 to 2014, the percentage of adults in Washoe County who experienced any mental illness (19.6%) and serious mental illness (5.1%) was higher than Nevada and the United States, however the percentage of adults who received mental health services in the past year was lower in Washoe County (13.2%) compared to the United States (14.5%).

Suicide

Suicide was the 7th leading cause of death among residents in Nevada in 2016 compared to the 10th leading cause of death among residents in the United States.[14]

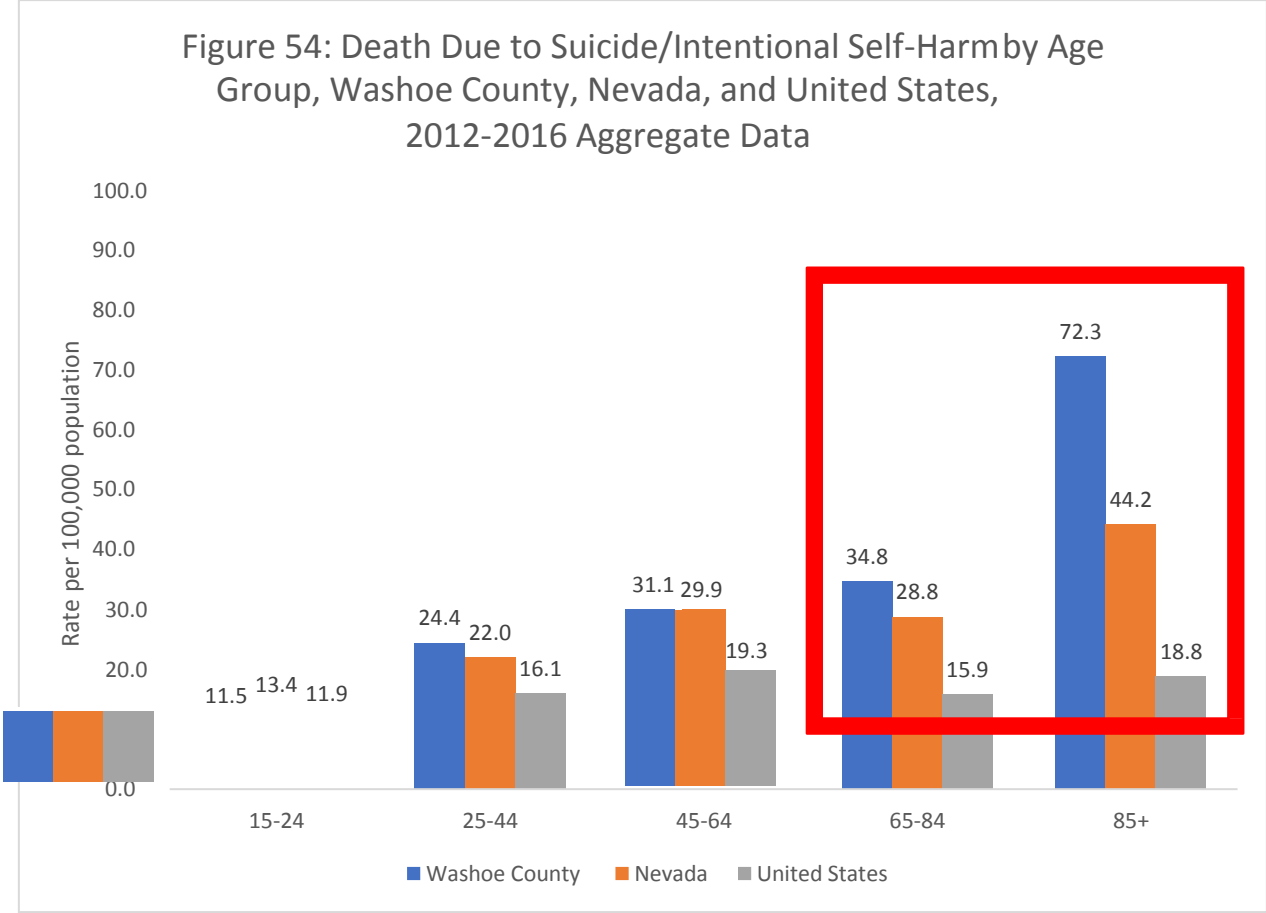


- The rate of suicide attempts resulting in a hospital admission in Washoe County increased from 2013 (63.4 per 100,000 population) to 2017 (66.2 per 100,000 population).
- From 2013 to 2017, the rate of suicide attempts resulting in a hospital admission in Washoe County was higher than in Nevada.



ICD-10 Codes used for analysis: U03 (Terrorism Intentional [Suicide]), X60-X84 (Intentional Self-harm), Y87 (Sequelae of intentional self-harm, assaults and events of undetermined intent

- In 2016, the age-adjusted rate of death due to intentional self-harm in Washoe County (26.8 per 100,000 people) was nearly double the rate of the United States (13.5 per 100,000 people).
- From 2006 to 2016, the average suicide rate in Washoe County (20.4 per 100,000 population) was higher than Nevada (19.1 per 100,000 population) and the United States (12.4 per 100,000 population).



ICD-10 Codes used for analysis: U03 (Terrorism Intentional [Suicide]), X60-X84 (Intentional Self-harm), Y87 (Sequelae of intentional self-harm, assaults and events of undetermined intent

- Aggregate data from 2012 to 2016 indicate the rate of death due to suicide in Washoe County increased as age increased.
- The rate of death due to suicide among Washoe County residents aged 85+ (72.3 per 100,000 population) was more than six times the rate among residents aged 15-24 years (11.5 per 100,000 population).
- The rate of death due to suicide among those aged 85+ in Washoe County was nearly four times the rate for the United States, and the rate of death due to suicide among those aged 65 to 84 years in Washoe County was more than double the United States.

Summary of Mental Health

In 2017, more than one in four of Washoe County middle school students reported having experienced feeling sad or hopeless almost every day for two or more weeks in a row so that they stopped doing some usual activities, a rate that was lower than Nevada. The rate of having ever attempted suicide among middle school students in Washoe County was greater than Nevada. Among middle school students who felt sad, empty, hopeless, angry, or anxious 46.6 percent reported rarely or never receiving the kind of help they needed.

In 2017, more than one in three of Washoe County high school students reported feeling sad or hopeless for two or more weeks during the previous year, a rate that was higher than Nevada and the United States. Additionally, the rate of attempted suicide among high school students in Washoe County was greater than Nevada and the United States, however, this number has decreased since 2013. Among high school students who felt sad, empty, hopeless, angry, or anxious 56.8 percent reported rarely or never receiving the kind of help they needed. More than one in three high school students in Washoe County reported they have been exposed to household substance use and mental illness.

In 2016, 14.1 percent of adults in Washoe County reported having experienced two or more weeks of poor mental health days including high levels of stress, depression, and problems with emotions during the prior month. The percent of adults in Washoe County experiencing any mental illness, serious mental illness, or major depressive disorder was slightly higher compared to Nevada and the United States.

From 2007 to 2016, the age-adjusted rate of death due to suicide increased from 16.9 per 100,000 population to 26.8 per 100,000 population in Washoe County. In 2016, the age-adjusted rate of death due to suicide was higher in Washoe County compared to Nevada and the United States. The rate of death due to suicide among those aged 85+ in Washoe County was nearly four times greater than the United States, and the rate among those aged 65 to 84 years in Washoe County was more than double the United States.

[15] Centers for Disease Control and Prevention. (2017). Heroin overdose data. Accessed https: //www.cdc.gov/drugoverdose/data/heroin.html

[16] Centers for Disease Control and Prevention. (2016). Reported law enforcement encounters testing positive for fentanyl increased across US. Accessed https: //www.cdc.gov/drugoverdose/data/fentanyl-le-reports.html

Behavioral Health Services

Table 8: Behavioral Health Workforce, 2016

Number per 100,000 population

	Washoe County	Nevada	United States
Alcohol, Drug, and Gambling Counselors	65.7	42.1	79.3
Clinical Professional Counselors	4.0	3.4	45.6
Marriage and Family Therapists	59.7	25.2	12.6
Psychiatrists	11.8	6.8	11.1
Psychologists	32.4	13.4	50.8
Licensed Clinical Social Workers	37.3	24.0	51.1
Licensed Social Workers	79.2	42.6	207.8

Important considerations regarding behavioral health care providers:

- Are they currently accepting new patients?
- Do they accept patients covered by Medicaid?
- Residents of rural communities may receive behavioral health services in Washoe County.
- Do they offer bilingual services?

Table 9: Behavioral Health Emergency Department Visits, Washoe County & Nevada, 2017

Condition	Washoe County		Nevada	
	Crude rate per 100,000 population	%	Crude rate per 100,000 population	%
Anxiety	2,352.7	28.1	1,787.0	26.7
Drug-Related	1,538.3	18.4	1,259.5	18.8
Alcohol-Related	1,376.6	16.5	971.2	14.5
Depression	1,333.0	15.9	1,039.6	15.5
Bipolar Disorder	720.6	8.6	580.2	8.6
Suicidal Ideation	412.7	4.9	476.0	7.1
Schizophrenia	322.0	3.8	306.9	4.6
PTSD	231.2	2.8	173.7	2.6
Suicide Attempts	81.4	1.0	108.8	1.6

*Categories are not mutually exclusive – one patient can have one or multiple conditions present at the time of emergency department visit one patient can have more than one visit

- In 2017, the top conditions seen in emergency departments in Washoe County were anxiety (28.1% of encounters), drug-related (18.4%), alcohol-related (16.5%), and depression (15.9%).

Table 10: Behavioral Health Inpatient Admissions, Washoe County & Nevada, 2017

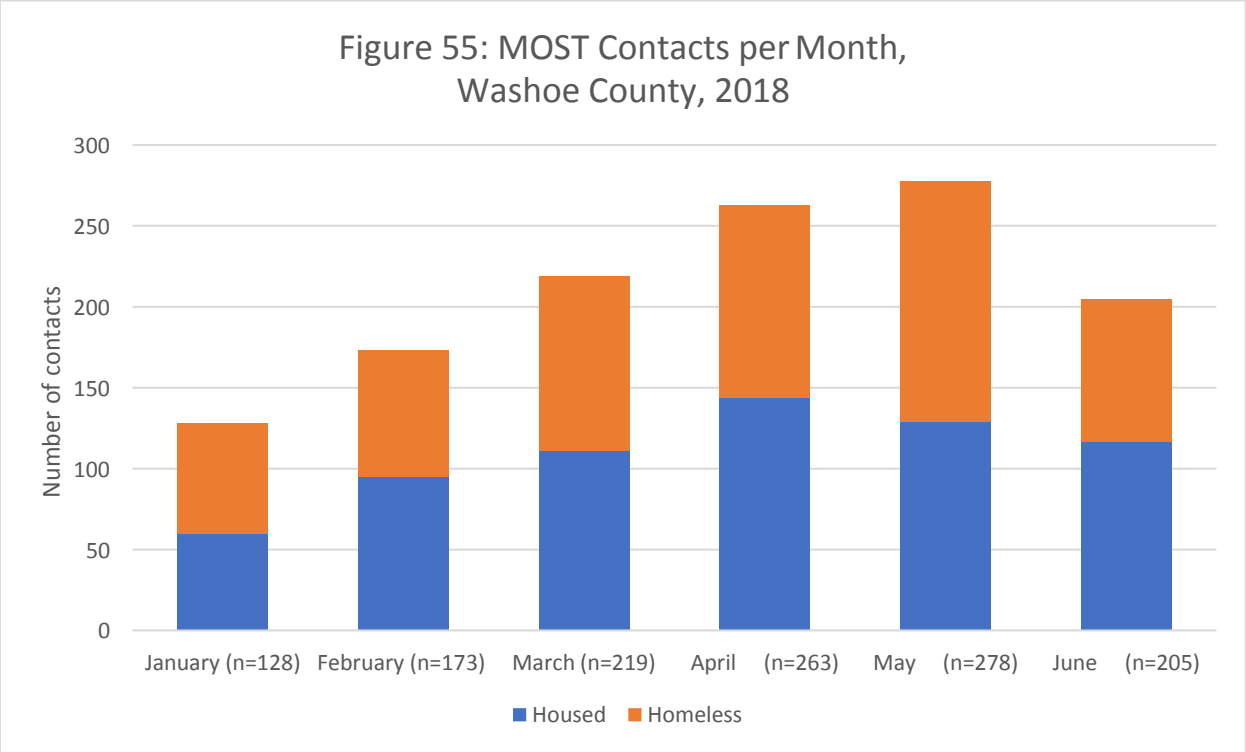
Condition	Washoe County Crude Rate per 100,000 population	%	Nevada Crude Rate per 100,000 population	%
Depression	1,201.3	21.8	1,134.5	32.8
Drug-Related	1,140.0	20.7	751.0	0.3
Anxiety	1,107.3	20.1	1,054.7	30.5
Alcohol-Related	922.7	16.7	441.9	0.2
Suicidal Ideation	426.8	7.7	426.4	12.3
Bipolar Disorder	332.2	6.0	428.2	12.4
PTSD	225.4	4.1	163.8	4.7
Schizophrenia	93.7	1.7	180.7	5.2
Suicide Attempts	66.2	1.2	53.8	1.6

*Categories are not mutually exclusive – one patient can have one or multiple conditions present at the time of admission and one patient can have more than one admission

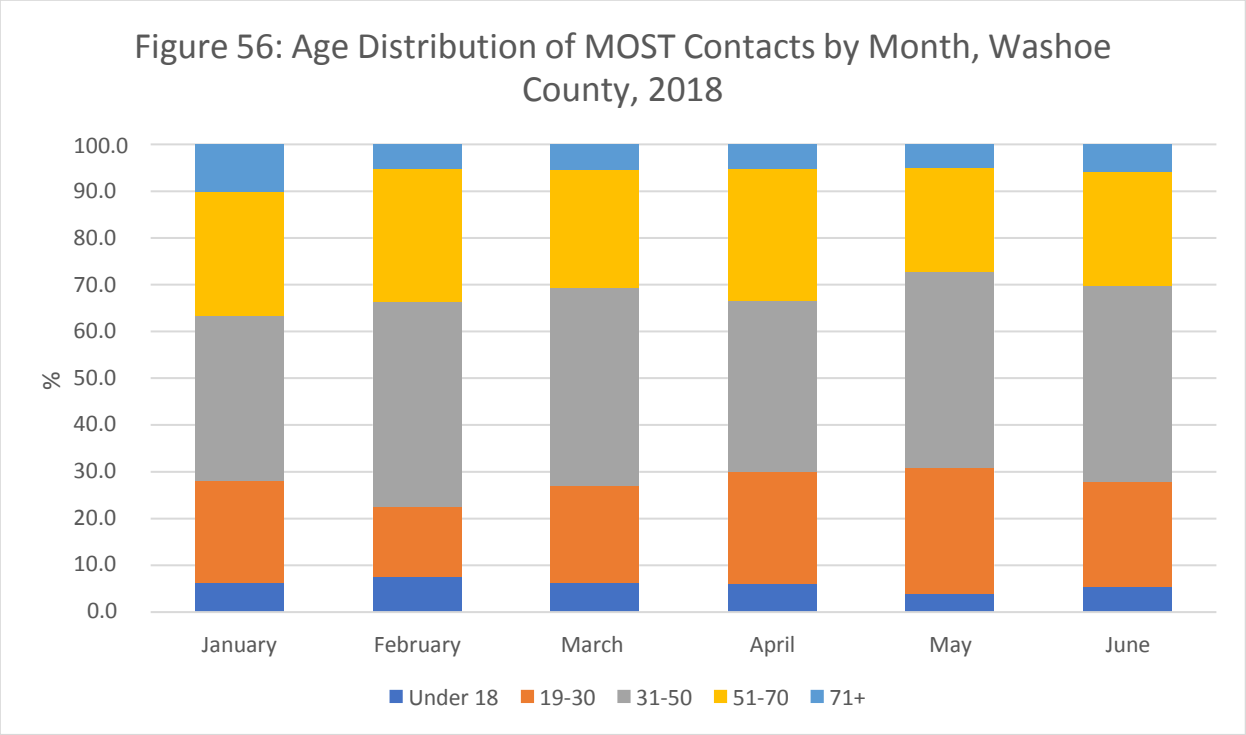
- In 2017, the top conditions that led to an inpatient admission in Washoe County were depression (21.8% of admissions), drug-related (20.7%), anxiety (20.1%), and alcohol-related (16.7%).
- The crude rate per 100,000 population of alcohol-related inpatient admissions in Washoe County was more than double the rate in Nevada.

Mobile Outreach Safety Team (MOST)

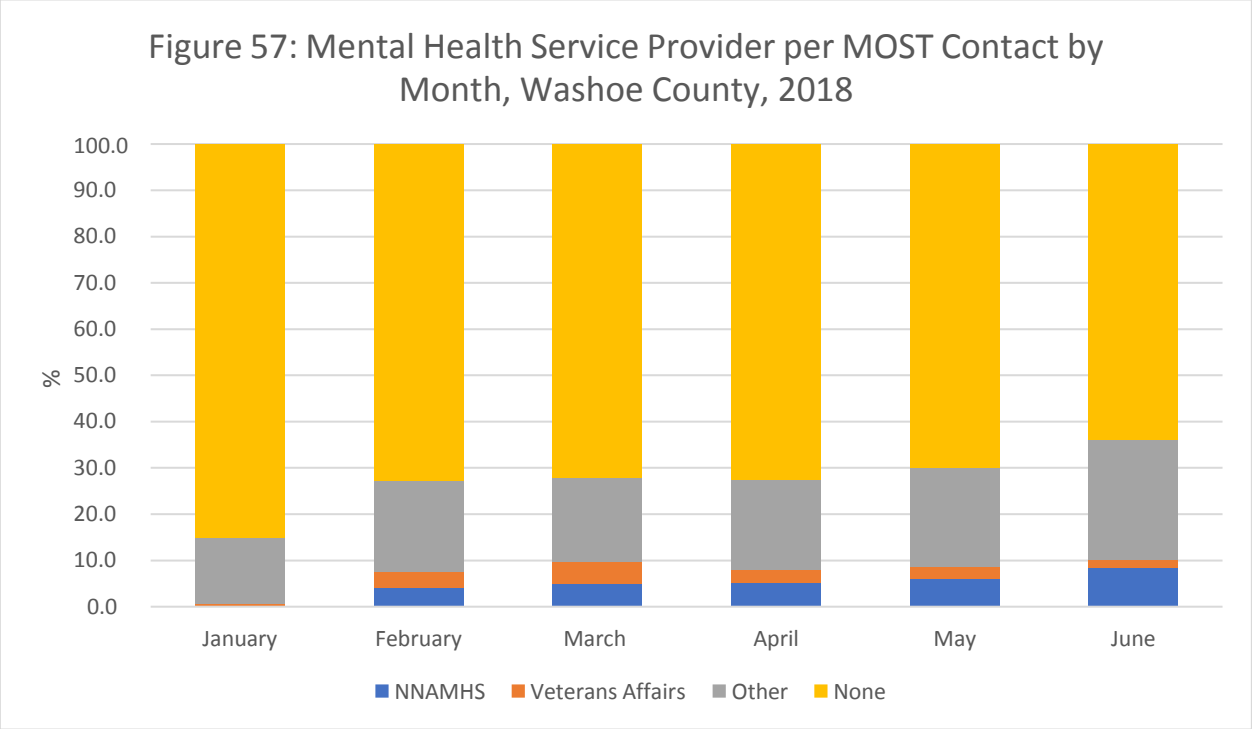
MOST (Mobile Outreach Safety Team) is a law enforcement/mental health co-response team in Washoe County designed to provide early and voluntary crisis intervention services to avoid emergency room visits/hospitalizations and reduce calls for service. The mental health component of the MOST team was expanded to five therapists and a case manager in 2018, employed by the Washoe County Human Services Agency, thanks to additional funding provided by the Nevada Legislature through SB 192 (2017 legislative session). The expansion allows for coverage 7 days a week, on day and swing shifts. The mental health team responds with law enforcement to calls for service with individuals whose mental illness may be a danger to the community or themselves, providing skilled therapeutic intervention and referrals to community resources.



- The number of MOST contacts each month has increased from January to June.
- In May of 2018 54% of the MOST contacts made were with individuals who were homeless at the time of the contact. This is the only month between January and June that more contacts were made with individuals who were homeless than housed.



- From January to June, the age group 31-50 years comprised 40.3% of MOST contacts followed by 51-70 years (25.8%), and 19-30 years (21.7%).



- From January to June 72.7% of MOST contacts did not have a mental health service provider, 19.8% were classified under other, 4.8% received services at Northern Nevada Adult Mental Health Services, and 2.7% from Veterans Affairs.

Conclusion

This profile has provided valuable insight that can be utilized by the Washoe Region Behavioral Policy Board, as well as community stakeholders, leaders, and residents by informing discussion pertaining to the behavioral health needs of Washoe County.

Important stand-out items from the profile:

Alcohol use in Washoe County is a major problem. In 2017, alcohol-related inpatient admissions in Washoe County were more than double the rate in Nevada. From 2007 to 2016, the average age-adjusted rate of alcohol-induced cause of death was more than double the United States. The prevalence of drug use in Washoe County was higher in Washoe County than Nevada and the United States. Deaths from natural and semi-synthetic opioids (e.g. morphine, codeine, oxycodone, hydrocodone, etc.) had been decreasing; however, 2014 to 2017 data indicates that the number of heroin- related and fentanyl-related deaths are increasing following the national trend.[15, 16] The 2017 Youth Risk Behavior Survey substance use indicators showed improvements among Washoe County high school students when compared to 2013 benchmark data.

While some progress is being made among the youth in Washoe County regarding substance use, access to mental health services are sorely lacking. More than half of high school students in Washoe County report never or rarely receiving mental health support in a time of need. In 2016, the age-adjusted suicide rate in Washoe County was nearly double the rate of the United States. Suicide among Washoe County residents aged 65 years and older has greatly exceeded the rate of Nevada and the United States. Of particular concern is the suicide rate for Washoe County residents age 85 and older, which from 2012 to 2016 was nearly four times the national average. Several mental health and substance use needs are apparent in this profile and now it is the responsibility of the community to respond.

The goal of this profile is to identify the strengths and weaknesses of behavioral health services in Washoe County and to assist in future planning to improve upon the highest priority needs in our community. Moving forward the profile will be updated annually and will serve as a tool to track changes over time. Proposed additions to the profile include data from Mobile Crisis Response Team (MCRT) which responds to crisis situations involving children and youth under 18, Pregnancy Risk Assessment Monitoring System (PRAMS), and the Washoe County Regional Medical Examiner's Office.

The development of this profile was the focus of a summer graduate Internship and wouldn't have been possible without the support and guidance from the following:
Catrina Peters, Washoe County Health District
Charles Duarte, Chair, Washoe Regional Behavioral Health Policy Board Heather
Kerwin, MPH, CPH
Join Together Northern Nevada
Kevin Dick, Washoe County Health District
Nevada Department of Health and Human Services, Office of Analytics Nevada
Division of Public and Behavioral Health, Office of Suicide Prevention Sheila Leslie,
Washoe County Human Services Agency
University of Nevada, Reno School of Community Health Sciences Washoe
Regional Behavioral Health Policy Board

Data Sources

Geography and Demographics Sources

Image 1 – Image 2 Same Source
Image 1: Nevada
Image 2: Washoe County
Google Maps

Table 1 – Table 2 Same Source
Table 1: Population in Nevada, 2017 Estimates
Table 2: Estimated Population Growth by Selected Demographics, Washoe County, 2017 & 2022
Nevada Department of Taxation, Nevada State Demographer (2017). Source: Nevada County Age, Sex, Race, and Hispanic Origin Estimates and Projections 2000 to 2036. Accessed https://tax.nv.gov

Figure 1: Washoe County School District Student Enrollment by Ethnicity, Ten-Year Trend
Washoe County School District Grade K-12 by Race/Ethnicity, 2006-2007, 2011-2012, and 2016- 2017
Nevada Department of Education. Nevada Report Card. Accessed http://nevadareportcard.com/di/

Table 3: Primary Language Spoken at Home, Washoe County Residents, 2016
U.S. Census, 2016 American Community Survey -1 year estimates- TABLE S1601- Language Spoken at Home

Figure 2: Educational Attainment of Residents Age 25 and Older, Washoe County, Nevada, and United States, 2016
U.S. Census, 2016 American Community Survey -1 year estimates- TABLE S1501- Educational Attainment

Table 4: Inflation-Adjusted Incomes and Housing Costs, Washoe County and Nevada, 2016
Median Household Income data source: U.S. Census, 2016 American Community Survey -1 year estimates- TABLE S1901- Income in the Past 12 Months
Median Annual Income by Sex data source: U.S. Census, 2016 American Community Survey -1 year estimates- TABLE S2001- Earnings in the Past 12 Months
Median Monthly Housing Cost data source: U.S. Census, 2016 American Community Survey -1 year estimates- TABLE B25105- Median Monthly Housing Costs
Rent as a Percentage of Income data source: U.S. Census, 2016 American Community Survey -1 year estimates- TABLE B25070- Gross Rent as a Percentage of Household Income in the Past 12 Months
Mortgage as a Percentage of Income data source: U.S. Census, 2016 American Community Survey -1 year estimates- TABLE S2506- Financial Characteristics for Housing Units with a Mortgage

Figure 3: Economic Benchmarks Compared to Household Annual Income Distribution, Washoe County, 2016
Median Household Income data source: U.S. Census, 2016 American Community Survey -1 year estimates- TABLE S1901- Income in the Past 12 Months

2016 Free School Lunch Eligibility data source: United States Department of Agriculture and Child Nutrition Programs Income Eligibility Guidelines, 2016.
2016 Federal Poverty Level: United States Department of Health and Human Services 2016 Poverty Guidelines.
2016 Nevada Medicaid Eligibility data source: Nevada Health Link 2016 Medicaid Eligibility.

Table 5: Poverty Status During Prior 12 Months, 2016
U.S. Census, 2016 American Community Survey -1 year estimates- TABLE S1701- Poverty Status in the Past 12 Months
Table 6: Persons Under the Age of 65 Years Without Health Insurance, 2016
U.S. Census, 2016 American Community Survey -1 year estimates- TABLE S2701- Selected Characteristics of Health Insurance Coverage in the United States

Substance Use Sources

Figure 4: Lifetime* Substance Use Among Middle School Students, Washoe County and Nevada, 2017
Nevada 2017: Lensch, T., Martin, H., Zhang, F., Parrish, B., Clements-Nolle, K., Yang, W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. *2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report*.
Washoe County 2017: Lensch, T., Martin, H., Zhang, F., Clements-Nolle, K., Yang, W. University of Nevada, Reno. *2017 Nevada Middle School Youth Risk Behavior Survey (YRBS): Washoe County Special Report*.
Figure 5 – Figure 6 Same Source
Figure 5: Lifetime* Substance Use Among Middle School Students, Washoe County, 2015 and 2017 Comparison
Figure 6: Percentage of Middle School Students to Report Current* Use of Alcohol and Marijuana, Washoe County, 2015 and 2017 Comparison
Washoe County 2015: Lensch, T., Gay, C., Zhang, F., Clements-Nolle, K., Yang, W. University of Nevada, Reno. *2015 Nevada Middle School Youth Risk Behavior Survey (YRBS): Washoe County Analysis*.
Washoe County 2017: Lensch, T., Martin, H., Zhang, F., Clements-Nolle, K., Yang, W. University of Nevada, Reno. *2017 Nevada Middle School Youth Risk Behavior Survey (YRBS): Washoe County Special Report*.
Figure 7: Lifetime* Substance Use Among High School Students, Washoe County, Nevada, and United States, 2017
United States 2017: Centers for Disease Control and Prevention. (2018). Youth Risk Behavior Surveillance-United States, 2017. MMWR, 67(8).
Nevada 2017: Lensch, T., Martin, H., Zhang, F., Parrish, B., Clements-Nolle, K., Yang, W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. *2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report*.
Washoe County 2017: Lensch, T., Martin, H., Zhang, F., Clements-Nolle, K., Yang, W. University of Nevada, Reno. *2017 Nevada High School Youth Risk Behavior Survey (YRBS): Washoe County Special Report*.
Figure 8 – Figure 9 Same Source

Figure 8: Lifetime* Substance Use Among High School Students, Washoe County, 2013, 2015 & 2017 Comparison
Figure 9: Percentage of High School Students to Report Current* Use of Alcohol and Marijuana, Washoe County, 2013, 2015 & 2017 Comparison
Washoe County 2013: Frankenberger, D., Clements-Nolle, K., Zhang, F., Larson, S., & Yang, W. University of Nevada, Reno. (2014). *2013 Nevada Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, Nevada*.
Washoe County 2015: Lensch, T., Gay, C., Zhang, F., Clements-Nolle, K., Yang, W. University of Nevada, Reno. (n.d.). *2015 Nevada High School Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, Nevada*.
Washoe County 2017: Lensch, T., Martin, H., Zhang, F., Clements-Nolle, K., Yang, W. University of Nevada, Reno. *2017 Nevada High School Youth Risk Behavior Survey (YRBS): Washoe County Special Report*.
Figure 10: Lifetime* Substance Use Among College Students, University of Nevada, Reno and United States Comparison, 2016
Washoe County (UNR): American College Health Assessment-National College Health Assessment II data for Spring of 2016. Unpublished data provided upon request. Reno, NV. United States: American College Health Assessment-National College Health Assessment II Reference Group reports for Spring of 2016. Accessed http://www.acha- ncha.org/pubs_rpts.html
Figure 11 – Figure 13 Same Source
Figure 11: Current* Alcohol and Marijuana Use Among College Students, University of Nevada, Reno, 2012, 2014 & 2016 Comparison
Figure 12: Binge Drinking* Among College Students, University of Nevada, Reno, 2012, 2014 & 2016 Comparison
Figure 13: Prescription Drug Misuse* Among College Students, University of Nevada, Reno, 2012, 2014 & 2016 Comparison
Washoe County (UNR): American College Health Assessment-National College Health Assessment II data for Spring of 2012, 2014, and 2016. Unpublished data provided upon request. Reno, NV.

Table 7: Substance Use Among Population Aged 18 to 25 - Washoe County, Nevada, and United States, 2012-2014 Annual Averages
Substance Abuse and Mental Health Services Administration. Population Data/NSDUH. Substate/Metro 2012-2014 NSDUH Substate Region Estimates –Excel Tables and CSV Files. Accessed https://www.samhsa.gov/data/population-data-nsduh/reports

Figure 14 – Figure 16 Same Source
Figure 14: Percentage of Current* Illicit Drug Use Other Than Marijuana Among Adults, Washoe County and Nevada, 2016
Figure 15: Lifetime Prescription Drug Misuse Among Adults, Washoe County and Nevada, 2016
Figure 16: Prescription Drug Misuse During the Past 30 Days Among Adults, Washoe County and Nevada, 2016
Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. 2016 Nevada BRFSS Data. Data provided upon request. Carson City, NV

Figure 17: Alcohol-Induced Cause of Death by Age Group, Washoe County, Nevada, and United States, 2012-2016 Aggregate Data
Figure 18: Drug-Induced Cause of Death by Age Group, Washoe County, Nevada, and United States, 2012-2016
Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2016 on CDC WONDER Online Database, released December, 2017. Data are from the Multiple Cause of Death Files, 1999-2016, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10.html
Figure 19: Percentage of Adults Needing but Not Receiving Treatment in the Past Year, Washoe County, Nevada, & United States, 2012-2014 Annual Average
Substance Abuse and Mental Health Services administration. Population Data/NSDUH. Substate/Metro 2012-2014 NSDUH Substate Region Estimates –Excel Tables and CSV Files. Accessed https://www.samhsa.gov/data/population-data-nsduh/reports
Figure 20 – Figure 21 Same Source
Figure 20: Percentage of Adults Classified as Binge Drinkers, Washoe County, Nevada, & United States, 2012-2016
Figure 21: Percentage of Adults Classified as Heavy Drinkers, Washoe County, Nevada, & United States, 2012-2016
Nevada and Washoe County: Nevada Office of Public Health Informatics and Epidemiology. Nevada Behavioral Risk Factor Surveillance Survey (BRFSS). Data provided upon request. Carson City, NV. United States: Centers for Disease Control and Prevention. BRFSS Prevalence and Trends Data query tool, Accessed https://www.cdc.gov/brfss/brfssprevalence/index.html
Figure 22 – Figure 23 Same Source
Figure 22: Alcohol Related Emergency Department Encounters, Washoe County and Nevada, 2013-2017
Figure 23: Drug Related Emergency Department Encounters, Washoe County and Nevada, 2013-2017
Nevada Department of Health and Human Services. 2013-2017 Hospital Inpatient and Emergency Department Billing Data. Data provided upon request. Carson City, NV.
Figure 24 – Figure 25 Same Source
Figure 24: Age-Adjusted Rate of Alcohol-Induced Cause of Death, Washoe County, Nevada, and United States, 2007-2016
Figure 25: Age-Adjusted Rate of Drug-Induced Cause of Death, Washoe County, Nevada, and United States, 2007-2016
Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2016 on CDC WONDER Online Database, released December, 2017. Data are from the Multiple Cause of Death Files, 1999-2016, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10.html
Figure 26 – Figure 29 Same Source
Figure 26: Opioid-Related Emergency Department Encounters by Age Group, Washoe County, 2010-2017
Figure 27: Opioid-Related Inpatient Admissions by Age Group, Washoe County, 2010-2017

Figure 28: Opioid-Related Poisonings Emergency Department Encounters by Opioid, Washoe County, 2010-2017
Figure 29: Opioid-Related Poisonings Inpatient Admissions by Opioid, Washoe County, 2010-2017
Nevada Department of Health and Human Services. 2010-2017 Hospital Inpatient and Emergency Department Billing Data. Data provided upon request. Carson City, NV.
Figure 30 – Figure 31 Same Source
Figure 30: Opioid-Related Deaths by Age Group, Washoe County, 2010-2017*
Figure 31: Opioid-Related Deaths by Drug Category, Washoe County, 2010-2017*
Nevada Department of Health and Human Services. 2010-2017 Electronic Death Registry System. Data provided upon request. Carson City, NV.

Mental Health Sources

Figure 32: Prevalence of Depression and Suicide Ideation Among Middle School Students, Washoe County and Nevada, 2017
Nevada 2017: Lensch, T., Martin, H., Zhang, F., Parrish, B., Clements-Nolle, K., Yang, W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. *2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report*.
Washoe County 2017: Lensch, T., Martin, H., Zhang, F., Clements-Nolle, K., Yang, W. University of Nevada, Reno. *2017 Nevada Middle School Youth Risk Behavior Survey (YRBS): Washoe County Special Report*.
Figure 33 – Figure 36 Same Source
Figure 33: Percentage of Middle School Students Who Ever* Felt Sad or Hopeless, Washoe County, 2015 and 2017 Comparison
Figure 34: Percentage of Middle School Students Who Ever* Seriously Considered Attempting Suicide, Washoe County, 2015 and 2017 Comparison
Figure 35: Percentage of Middle School Students Who Have Ever* Made a Plan About How to Commit Suicide, Washoe County, 2015 and 2017 Comparison
Figure 36: Percentage of Middle School Students Who Ever* Attempted Suicide, Washoe County, 2015 and 2017 Comparison
Washoe County 2015: Lensch, T., Gay, C., Zhang, F., Clements-Nolle, K., Yang, W. University of Nevada, Reno. *2015 Nevada Middle School Youth Risk Behavior Survey (YRBS): Washoe County Analysis*.
Washoe County 2017: Lensch, T., Martin, H., Zhang, F., Clements-Nolle, K., Yang, W. University of Nevada, Reno. *2017 Nevada Middle School Youth Risk Behavior Survey (YRBS): Washoe County Special Report*.
Figure 37: Percentage of Middle School Students* Who Got the Kind of Help They Need When They Felt Sad, Empty, Hopeless, Angry, or Anxious, Washoe County, 2017
Washoe County 2017: Lensch, T., Martin, H., Zhang, F., Clements-Nolle, K., Yang, W. University of Nevada, Reno. *2017 Nevada Middle School Youth Risk Behavior Survey (YRBS): Washoe County Special Report*.
Figure 38: Prevalence of Depression and Suicide Ideation Among High School Students, Washoe County, Nevada and United States, 2017
United States 2017: Centers for Disease Control and Prevention. (2018). Youth Risk Behavior Surveillance-United States, 2017. MMWR, 67(8).

Nevada 2017: Lensch, T., Martin, H., Zhang, F., Parrish, B., Clements-Nolle, K., Yang, W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. *2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report*.

Washoe County 2017: Lensch, T., Martin, H., Zhang, F., Clements-Nolle, K., Yang, W. University of Nevada, Reno. *2017 Nevada High School Youth Risk Behavior Survey (YRBS): Washoe County Special Report*.

Figure 39 – Figure 42 Same Source

Figure 39: Percentage of High School Students Who Felt Sad or Hopeless*, Washoe County, 2013, 2015, & 2017 Comparison

Figure 40: Percentage of High School Students Who Seriously Considered Attempting Suicide*, Washoe County, 2013, 2015, & 2017 Comparison

Figure 41: Percentage of High School Students Who Made a Suicide Plan*, Washoe County, 2013, 2015 & 2017 Comparison

Figure 42: Percentage of High School Students Who Attempted Suicide*, Washoe County, 2013, 2015 & 2017 Washoe County 2013: Frankenberger, D., Clements-Nolle, K., Zhang, F., Larson, S., & Yang, W. University of Nevada, Reno. (2014). *2013 Nevada Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, Nevada*.

Washoe County 2015: Lensch, T., Gay, C., Zhang, F., Clements-Nolle, K., Yang, W. University of Nevada, Reno. (n.d.). *2015 Nevada High School Youth Risk Behavior Survey (YRBS): Washoe County Analysis. Reno, Nevada*.

Washoe County 2017: Lensch, T., Martin, H., Zhang, F., Clements-Nolle, K., Yang, W. University of Nevada, Reno. *2017 Nevada High School Youth Risk Behavior Survey (YRBS): Washoe County Special Report*.

Figure 43: Percentage of High School Students* Who Got the Kind of Help They Need When They Felt Sad, Empty, Hopeless, Angry, or Anxious, Washoe County, 2017

Washoe County 2017: Lensch, T., Martin, H., Zhang, F., Clements-Nolle, K., Yang, W. University of Nevada, Reno. *2017 Nevada High School Youth Risk Behavior Survey (YRBS): Washoe County Special Report*.

Figure 44 – Figure 48 Same Source

Figure 44: Percentage of High School Students Who Ever Lived with Someone Who is a Substance Use Problem, Washoe County and Nevada, 2017

Figure 45: Percentage of High School Students Who Ever Lived with Someone Who Was Mentally Ill, Washoe County and Nevada, 2017

Figure 46: Percentage of High School Students Who Were Ever Forced to Engage in Unwanted Sexual Intercourse, Washoe County and Nevada, 2017

Figure 47: Percentage of High School Students Who Have Ever Been Physically Abused* by an Adult, Washoe County and Nevada, 2017

Figure 48: Percentage of High School Students Who Have Ever Experienced Household Domestic Violence, Washoe County and Nevada, 2017

Nevada 2017: Lensch, T., Martin, H., Zhang, F., Parrish, B., Clements-Nolle, K., Yang, W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. *2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report*.

Washoe County 2017: Lensch, T., Martin, H., Zhang, F., Clements-Nolle, K., Yang, W. University of Nevada, Reno. *2017 Nevada High School Youth Risk Behavior Survey (YRBS): Washoe County Special Report*.

Figure 49 – Figure 50 Same Source

Figure 49: Percentage of Adults Reporting Poor Mental Health Days*, Washoe County, 2012-2016 **Figure 50:** Poor Mental Health Days and Depression Among Adults by Age Group, Washoe County, 2016

Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. 2012-2016 Nevada BRFSS Data. Data provided upon request. Carson City, NV.

Figure 51: Any Mental Illness, Serious Mental Illness, and Received Mental Health Services in the Past Year, 2014-2016 Aggregate Data

Substance Abuse and Mental Health Services Administration. Population Data/NSDUH. 2014- 2016 NSDUH Substate Region Estimates –Excel Tables and CSV Files. Accessed https://www.samhsa.gov/data/population-data-nsduh/reports

Figure 52: Suicide Attempts Hospital Admissions, Washoe County and Nevada, 2013-2017

Nevada Department of Health and Human Services, Office of Public Health Informatics and Epidemiology. 2013-2017 Hospital Inpatient and Emergency Department Billing Data. Data provided upon request. Carson City, NV.

Figure 53 – Figure 54 Same Source

Figure 53: Age-Adjusted Rate of Death Due to Suicide/Intentional Self-Harm, Washoe County, Nevada, and United States, 2007-2016

Figure 54: Death Due to Suicide/Intentional Self-Harm by Age Group, Washoe County, Nevada, and United States, 2012-2016 Aggregate Data

Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2016 on CDC WONDER Online Database, released December 2017. Data are from the Multiple Cause of Death Files, 1999-2016, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10.html

<u>Behavioral Health Services Sources</u>

Table 8: Behavioral Health Workforce, 2016

Washoe County and Nevada data source: Office of Statewide Initiatives. Nevada Instant Atlas: County-Level Health and Workforce Population Database. Accessed https://med.unr.edu/statewide/instant-atlas

United States data source: Office of Statewide Initiatives, University of Nevada School of Medicine. (2018). Data provided upon request.

Table 9 – Table 10 Same Source

Table 9: Behavioral Health Emergency Department Visits, Washoe County & Nevada, 2017

Table 10: Behavioral Health Inpatient Admissions, Washoe County & Nevada, 2017

Division of Public and Behavioral Health. 2017 Hospital Inpatient and Emergency Department Billing Data. Data provided upon request. Carson City, NV.

Figure 55 – Figure 57 Same Source

Figure 55: MOST Contacts per Month, Washoe County, 2018
Figure 56: Age Distribution of MOST Contacts by Month, Washoe County, 2018
Figure 57: Mental Health Service Provider per MOST Contact by Month, Washoe County, 2018 Leslie, S. 2018 Monthly MOST data report. Data provided upon request. Reno, NV.

APPENDIX B
Substance Abuse Prevention and Treatment Agency
Behavioral Health Region Washoe County 2017 Epidemiologic Profile

The Nevada Office of Analytics provides analytical support to the Divisions within the Nevada Department of Health and Human Services (DHHS), with a goal of moving from an analytic culture centered on required reporting and reactionary analytics to an analytic culture of proactive analytics which drive policy and decision making across DHHS.[8]

The Washoe Regional Behavioral Health Policy Board is grateful for the amount of time and effort that went into the preparation of the Substance Abuse Prevention and Treatment Agency Behavioral Health Region Washoe County 2017 Epidemiologic Profile which can be found at the link below. The data presented supports and expands upon the data presented in Appendix A, Washoe Behavioral Health Profile.

http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/OPHIE/dta/Publications/SAPTA-EPI-Profile-Washoe-County2017.pdf

APPENDIX C
Washoe Regional Behavioral Health Policy Board
Community Stakeholder Survey
Spring, 2018

The Washoe Regional Behavioral Health Policy Board would like to hear your thoughts on the gaps in behavioral health services in our community as they prioritize the needs of our region in the annual report to the Behavioral Health Commission. Your perspective is valued! Please assist the Board by completing this survey, adding any other information or concerns you'd like the Board to be aware of. For more information or to complete the survey via telephone, please contact the Regional Behavioral Health Coordinator, Sheila Leslie at (775) 328-2771 or via email at sleslie@washoecounty.us. Thank you for your collaboration.

1. Please name the top 3 problems or issues related to behavioral health in Washoe County.

Problem 1: _____

Problem 2: _____

Problem 3: _____

2. Please provide your ideas for solutions to these problems.

(Please turn over)

3. Tell us about the top 3 recent policy changes or promising areas of progress for behavioral health in Washoe County (or Nevada as a whole).

A. _____

B. _____

C. _____

4. If you could change one thing about how behavioral health services are delivered in Washoe County, what would it be?

5. Is there anything else you would like to add?

APPENDIX D

Focus Group Questions – Washoe Regional Behavioral Health Policy Board, 2018

1. What changes could be made to improve the delivery of behavioral health services in Washoe County for adults?

2. What changes could be made to improve the delivery of behavioral health services in Washoe County for children?

3. What do family members need to support their loved ones living with a mental illness or substance use disorder?

4. Do you have any recommendations for policy changes at the state legislative level? (Prioritize?)

5. How can our community move forward with prevention efforts and raise public awareness about behavioral health?