Washoe Regional Behavioral Health Policy Board

2021 | ANNUAL REPORT

Prepared By

Dorothy Edwards, Regional Behavioral Health Coordinator

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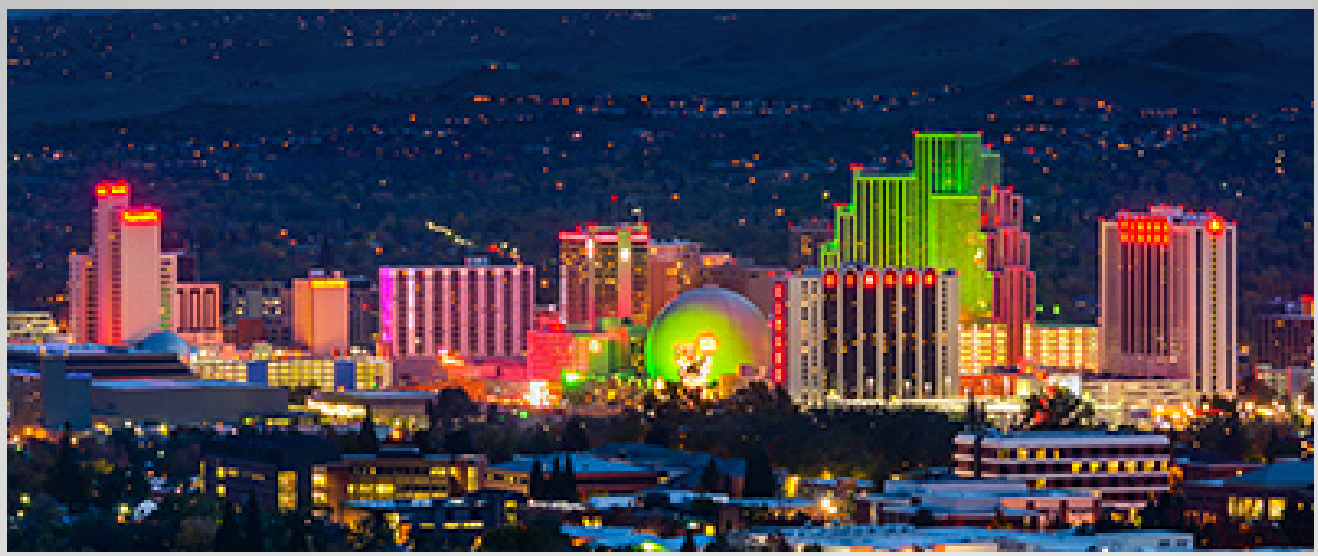
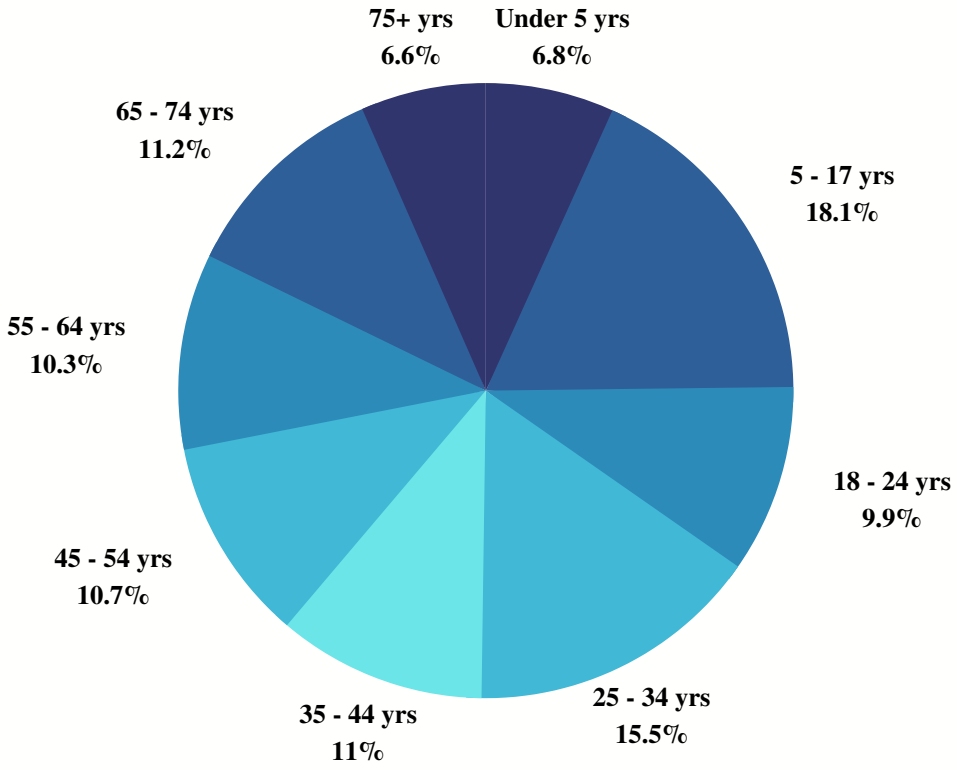
I. Introduction

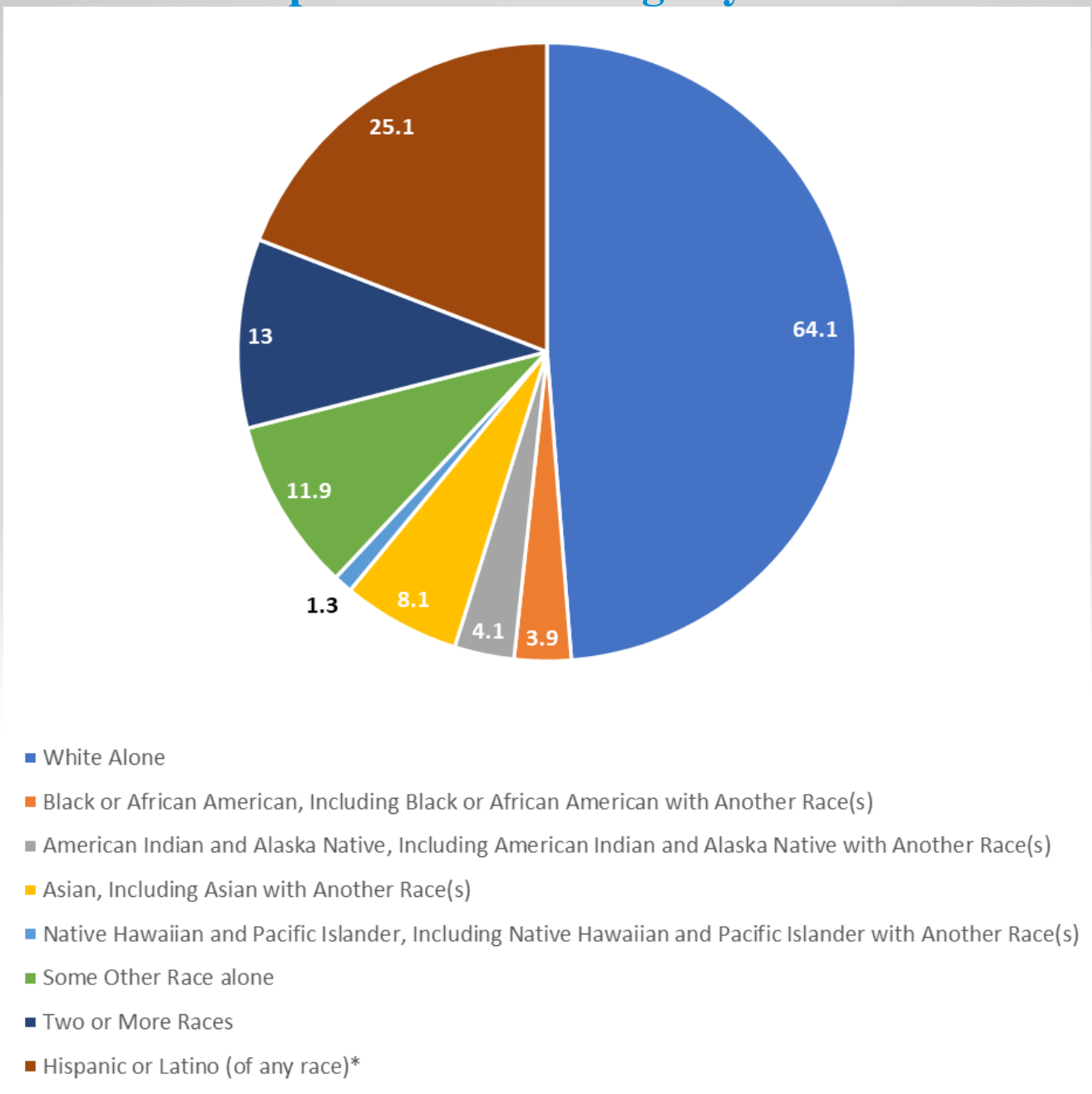


Washoe County is the second most populated county in Nevada with an estimated 486,492 residents in 2020 encompassing 15.7% of Nevada's residents and a growth rate of 1.52% in just the last year and 13.44% since the 2010 census (Census.gov). Washoe County is home to over 6,600 sprawling square miles, bordering both California and Oregon with nearly half a million residents who call our region home. Washoe County's recreation and outdoors experiences are second to none with 49 beautiful parks, 161 miles of trails, and more than 10,000 acres of open space.

Population by Age



Population Percentage by Race



Note: The population database is derived from the 2020 Census Public Law 94-171 Redistricting Data as provided by the U.S. Census Bureau and validated by the Legislative Counsel Bureau. Compiled by Legislative Counsel Bureau, August, 2021. Racial population data is based on self-identification. Respondents have the option of selecting one or more races. Respondents who self-identify as two or more races are counted in each of the minority race categories they selected, as well as the "Two or More Races" category. Therefore, the seven race categories shown in the table will total to more than 100 percent for each entity.*Hispanic or Latino is reported by the Census Bureau as a language group, separately.Demographic Data | Nevada Reapportionment and Redistricting 2021 (state.nv.us)

US Census Bureau Quick Facts Washoe County, NV

Population	
Population Estimates, July 1 2021, (V2021)	NA
Population estimates base, April 1, 2020, (V2021)	NA
Population, percent change - April 1, 2020 (estimates base) to July 1, 2021, (V2021)	NA
Population, Census, April 1, 2020	486,492
Population, Census, April 1, 2010	421,407
Age and Sex	
Persons under 5 years, percent	5.8%
Persons under 18 years, percent	21.3%
Persons 65 years and over, percent	16.8%
Female persons, percent	**49.5%**
Race and Hispanic Origin	
White alone, percent	84.6%
Black or African American alone, percent (a)	2.8%
American Indian and Alaska Native alone, percent (a)	2.2%
Asian alone, percent (a)	5.8%
Native Hawaiian and Other Pacific Islander alone, percent (a)	0.7%
Two or More Races, percent	3.9%
Hispanic or Latino, percent (b)	25.0%
White alone, not Hispanic or Latino, percent	62.3%
Population Characteristics	
Veterans, 2015-2019	32,421
Foreign born persons, percent, 2015-2019	14.1%
Housing	
Housing units, July 1, 2019, (V2019)	205,417
Owner-occupied housing unit rate, 2015-2019	58.3%
Median value of owner-occupied housing units, 2015-2019	$334,100
Median selected monthly owner costs -with a mortgage, 2015-2019	$1,663
Median selected monthly owner costs -without a mortgage, 2015-2019	$460
Median gross rent, 2015-2019	$1,074
Building permits, 2020	4,489
Families & Living Arrangements	
Households, 2015-2019	182,180
Persons per household, 2015-2019	2.47
Living in same house 1 year ago, percent of persons age 1 year+, 2015-2019	81.6%
Language other than English spoken at home, percent of persons age 5 years+, 2015-2019	23.7%
Computer and Internet Use	
Households with a computer, percent, 2015-2019	93.4%
Households with a broadband Internet subscription, percent, 2015-2019	85.5%
Education	
High school graduate or higher, percent of persons age 25 years+, 2015-2019	88.6%
Bachelor's degree or higher, percent of persons age 25 years+, 2015-2019	30.8%
Health	
With a disability, under age 65 years, percent, 2015-2019	8.5%
Persons without health insurance, under age 65 years, percent	12.5%

Economy	
In civilian labor force, total, percent of population age 16 years+, 2015-2019	66.4%
In civilian labor force, female, percent of population age 16 years+, 2015-2019	61.5%
Total accommodation and food services sales, 2012 ($1,000) (c)	1,860,761
Total health care and social assistance receipts/revenue, 2012 ($1,000) (c)	D
Total manufacturers shipments, 2012 ($1,000) (c)	6,427,397
Total retail sales, 2012 ($1,000) (c)	6,167,020
Total retail sales per capita, 2012 (c)	$14,345
Transportation	
Mean travel time to work (minutes), workers age 16 years+, 2015-2019	22.1
Income & Poverty	
Median household income (in 2019 dollars), 2015-2019	$64,791
Per capita income in past 12 months (in 2019 dollars), 2015-2019	$36,071
Persons in poverty, percent	⚠ 10.2%

BUSINESSES

Businesses	
Total employer establishments, 2019	12,972
Total employment, 2019	204,608
Total annual payroll, 2019 ($1,000)	10,068,586
Total employment, percent change, 2018-2019	1.0%
Total nonemployer establishments, 2018	33,976
All firms, 2012	37,029
Men-owned firms, 2012	18,503
Women-owned firms, 2012	12,047
Minority-owned firms, 2012	5,881
Nonminority-owned firms, 2012	28,801
Veteran-owned firms, 2012	4,272
Nonveteran-owned firms, 2012	29,568

II. Executive Summary

Behavioral health refers to the promotion of mental health, resilience and wellbeing; the treatment and intervention of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities. Individuals suffering with behavioral health issues and disorders are unfortunately all too common in the United States. One in five individuals experience a mental health illness; one in twenty experience a severe mental illness; one in fifteen experience both a mental illness and a substance use disorder; and, one over twelve million individuals report having had thoughts of suicide (NAMI, 2020). Regional behavioral health policy boards in Nevada are only one step towards addressing, supporting, collaborating and educating their respective communities on the behavioral health issues and challenges within their community.

The annual report for the Washoe Regional Behavioral Health Policy Board (WRBHPB) addresses the previous year's activities and available data collection related to the promotion of mental health, resilience, and wellbeing; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities. In compliance with NRS 433.4295, this report sheds light on the status of behavioral health in our region, and highlights our priorities, strategies and progress. Work began with the 81st legislative session. There were many bill draft requests submitted dealing with behavioral health and the WRBHPB was pleased to have its bill, Senate Bill 69, passed and signed by the Governor. This bill and other related pieces of behavioral health legislation addresses several existing board priorities and opened up new opportunities and areas on which to focus over the biennium.

Collaborative efforts were a high priority during the past year. Supporting and encouraging the maximization of resources among and between public agencies and community-based agencies, as well as the need for information sharing with other behavioral health entities remains a primary objective.

Support of the development of a comprehensive Crisis Response System in Washoe County remains the priority for WRBHPB. Diversity and inclusion; youth mental health; and the behavioral health workforce are issues on which the board hopes to encourage focus and enhancement of services. Those who experience serious and persistent mental illness and/or substance use disorders are overrepresented in the homeless population, criminal justice system, and often have co-occurring substance use disorders and serious mental illness, all of which can have an adverse impact on community health and quality of life. This compounding effect is one reason the WRBHPB seeks to bring awareness to mental health and substance use issues, and supports efforts to address solutions and service enhancements.

Data collection and evaluation is a critical element of behavioral health initiatives. Data analysis helps the policy boards to understand what is working, what needs to change, and which stated outcomes are achieved. We use data to set goals and assess needs, evaluate program outcomes, and make recommendations for program improvement. The WRBHPB continues its goal to obtain the most current, reliable and credible to data to inform its work. While the process is imperfect, we still rely on available data to assist in our focus areas.

Given the historic times we are living in with the COVID-19 pandemic, the coming year may be dramatically different in terms of planning, both programmatic and fiscal. While we don't know what our new normal will be, we will take this opportunity to think about and focus on the strategic priorities that support our responsibilities as a board.

III. Regional Policy Board History

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 (AB) 366. 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 face 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) was able to collaborate with local experts for suggestions on policy, funding, and implementation issues.

Subsequent legislation from the 80th session in 2019 added a fifth regional board to Nevada Revised Statutes (NRS)433 which also outlines membership criteria, and board obligations. The five boards represent: Washoe Region which includes all of Washoe County; Clark Region which includes Clark County and part of Nye; Southern Region which includes the counties of Esmeralda, Lincoln, Mineral and a portion of Nye; the Rural Region which includes the counties of Elko, Eureka, Humboldt, Lander, Pershing and White Pine; and, the Northern Region which includes Carson City and the counties of Churchill, Douglas, Lyon and Storey.

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.

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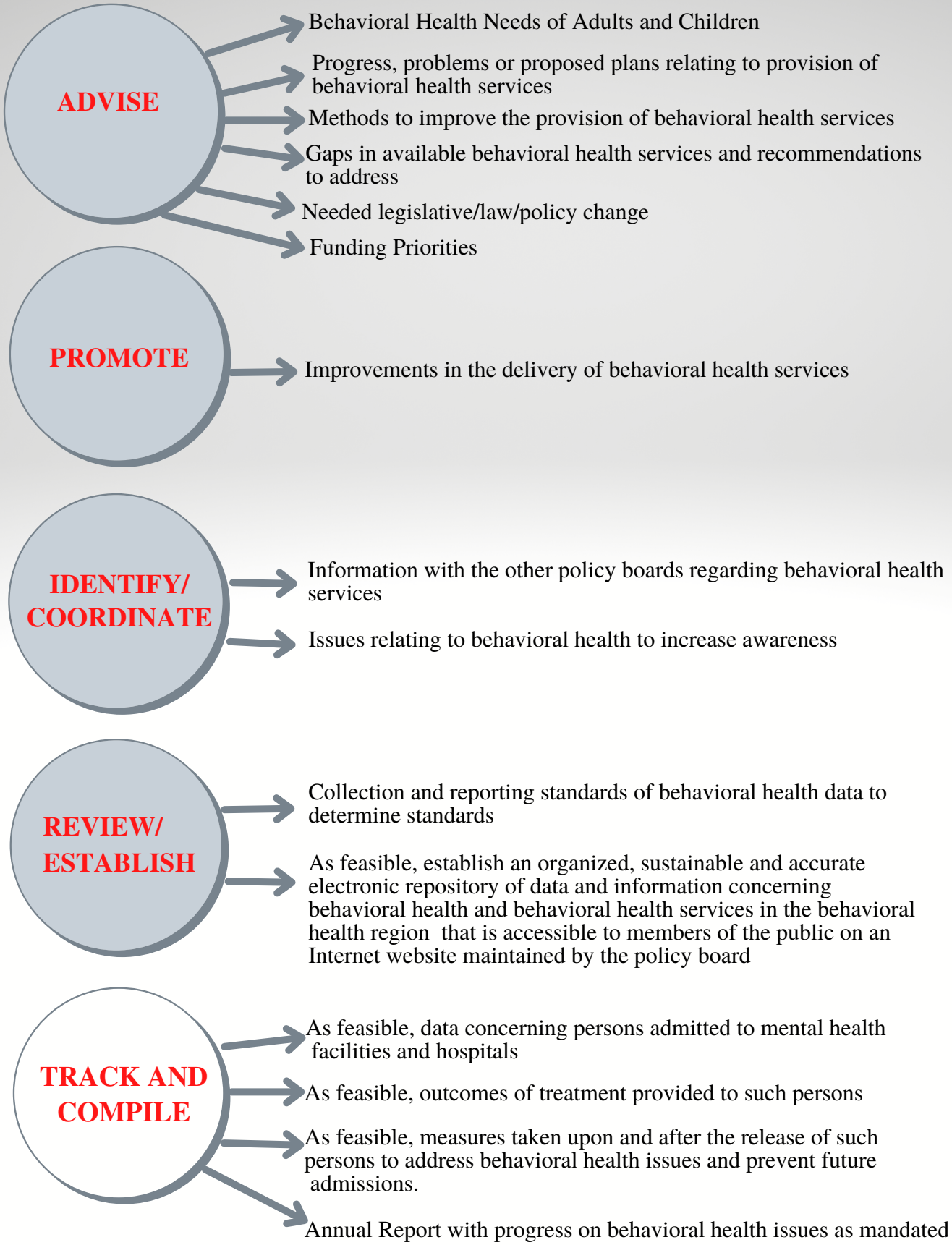
IV. Board Duties and Responsibilities

NRS 433.4295; 433A



V. 2021 WRBHPB MEMBERSHIP

The WRBHPB membership is comprised of individuals who meet the professional criteria outlined in NRS 433.429. 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 serve to move Nevada closer to achieving these objectives. They 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. They believe it is necessary to always work towards diversity and equitable treatment in both service delivery, resources, and workforce development. Board members are committed to working with State, County, and other professional associations to address training, data, and financing issues through support and advocacy. Members continue to identify important and timely behavioral health issues of concern and to promote recommendations related to improving behavioral health services. As of this writing, there is one vacancy on the board and one pending approval.

2021 Members

JULIA RATTI
Director of Programs and Projects
Washoe County Health District
Policy Board Chair

STEVE SHELL
Vice President of Behavioral Health
Renown Health
Policy Board Vice-Chair

SARAH PETERS
Assemblywoman, District 24
Nevada State Assembly

HENRY SOTELO, Esq.
Reno Municipal Court Specialty Court Attorney
Paralegal/Law Program Director,
Truckee Meadows Community College

JENNIFER DELETT SNYDER
Executive Director
Join Together Northern Nevada
*Resigned in 2021. Replacement Pending Administrator Approval

THOMAS ZUMTOBEL
Vice-President, Population Health
Renown Hospital
*Resigned in 2021. New Board Member elected in 2022

SANDRA STAMATES
Community/Family Representative
Behavioral Health Families

WADE CLARK
Lieutenant,
Reno Police Department

CHARMAANE BUEHRLE
Director of Community Programs
WellCare

DR. KRISTEN DAVIS-COELHO
Chief Behavioral Health Officer/Psychologist
Northern Nevada HOPES

FRANKIE LEMUS
Behavioral Health Coordinator Washoe County Human Services Agency

CINDY GREEN
EMS Coordinator
Reno Fire Department

DANI TILLMAN
Executive Director
Ridge House, Inc.
*Resigned in 2022. Vacant.

DOROTHY EDWARDS
Washoe Regional Behavioral Health Coordinator
Washoe County Human Services Agency

Additional Leadership and Participants

Policy Board Appointing Officials for 2020/2021

- Governor Steve Sisolak
- Assemblyman Jason Frierson, Speaker
- Senator Nicole Cannizzaro, Majority Leader
- Richard Whitley, Director, DHHS

State Leadership

- Legislative Commission
- Legislative Committee on Health Care
- Nevada Commission on Behavioral Health
- Nevada Department of Health and Human Services
- Nevada Division of Public and Behavioral Health

Regional Behavioral Health Coordinators

Jessica Abrass, Northern Regional Behavioral Health Coordinator

- Carson City
- Churchill County
- Douglas County
- Lyon County
- Storey County

Valerie Cauhape Haskin, Rural Regional Behavioral Health Coordinator

- Elko County
- Eureka County
- Humboldt County
- Lander County
- Pershing County
- White Pine County

Kim Donohu, Southern Regional Behavioral Health Coordinator (appointed January, 2022)

- Esmeralda County
- Lincoln County
- Mineral County
- Nye County (Portion)

Michelle Bennett, Clark County Regional Behavioral Health Coordinator

- Clark County
- Nye County (Portion)

Dorothy Edwards, Washoe County Regional Behavioral Health Coordinator

- Washoe County

VI. 2021 Meetings and Presentations

The WRBHPB continues to meet with County leadership, public and private agencies, and stakeholders to assess the needs of the County and how prioritizing and strategizing can not only help meet regional needs but coordinate efforts statewide where resources are limited. During 2021, the WRBHPB exceeded the statutory requirement of quarterly meetings and conducted seven monthly meetings, continuing with virtual meetings in response to the ongoing COVID 19 health crisis. The board invited speakers from a variety of public and private organizations providing and supporting behavioral health services in Washoe County to provide their thoughts on the status of behavioral health services or programs in Washoe County, gaps in services, and resource needs. Meetings included updates on the ongoing 81st legislation in an effort to keep board members aware of pending legislation related to behavioral health. Attachments and minutes from meetings can be found at: Washoe Regional (nv.gov)

VII. Regional Behavioral Health Coordinator Activities

The coordinators each provide a variety of different behavioral health activities and responses to their region, guided by their scope within their agencies. They collaborate and share information with each other, their respective boards, and community partners and stakeholders with the goal of creating unified recommendations relating to behavioral health as well as ensuring available resources are maximized to the needs of the communities involved. Coordinators are responsible for the drafting of an annual report and for ensuring that collaboration between the State and other regions is accomplished.

The Washoe Regional Behavioral Health Coordinator provided presentations, guidance, information, support and/or leadership to the following organizations and agencies. While not all inclusive, the list represents the scope of support and guidance within behavioral health and illustrates the continued work and collaboration that needs to be done. More information is available upon request.

- WC Human Services Agency Senior/Adult Leadership
- Nevada Resilience Project (Washoe Supervision)
- Safe Babies Court
- Join Together Northern Nevada Vice Chair
- Northern Nevada Behavioral Health Coalition
- Senior Covid Vaccination outreach
- Mayor's Mental Health Board
- Community Homeless Advisory Board (CHAB)
- Build For Zero Housing Project Outreach
- Mobile Outreach Support Team: Supervision/Data
- Regional Senior Coalitions/Advisory Boards
- Regional Community Court
- Crisis Response Systems Implementation Project
- Agency Legislation Support

- Workforce Wellness Workgroup
- Nevada Association County Human Services Administrators - Legislative Support
- Community Case Manager Supervision
- WC Sheriff Substance Abuse Task Force
- Senator Cortez Masto - Team presentation/BH meetings
- Commission on Behavioral Health
- Commission on Aging Member
- Community Health Improvement Plan (CHIP) support/
- Additional behavioral health support and education meetings/webinars/trainings

VIII. Regional Priorities and Strategies

Through collaboration and communication with all of the regional behavioral health policy boards, Nevada State leadership can lean on local experts for recommendations and information on policy, funding, and implementation issues. The policy boards are charged with the responsibilities specified in NRS 433.429 as noted in Section IV of this report. Each biennium the board works on establishing priorities and opportunities for support within the behavioral health community. Through review and analysis of behavioral health data, collaboration and outreach with State and County behavioral health partners, and a review of existing behavioral health legislation, board members select subjects or areas that might require policy development, revision and/or enhancement in the field of behavioral health along with programmatic support to behavioral health providers and stakeholders in the region.

The geographic distinctiveness of Nevada provides support for the ultimate decision to regionalize certain behavioral health activities within the State. While each of the annual reports reflect the differences, many of the priorities have remained the same across the regions. Several focus areas have emerged and been identified for board support, influence, and collaboration and an update is also provided on those priorities identified from the previous years. The policy board supports the following identified priorities and strategies for success.

Crisis Response System Implementation Plan (CRSIP)

Regional Gap

People are experiencing challenges to mental and behavioral health on a daily basis. Additionally, COVID-19 has impacted not only the economic and physical wellbeing of communities, but the mental health of individuals and families across the country. Social isolation, physical and mental health conditions, and preexisting illness have been exacerbated across communities, specifically among those that are already most at-risk of experiencing a behavioral health crisis. Individuals and families experiencing a behavioral health crisis need to be supported by a crisis response system that provides a continuum of services to stabilize and engage anyone in crisis and provide them appropriate, integrated treatment to address the problem that led to the crisis. A robust crisis response system ensures that every person in crisis receives the right response in the right place every time. Communities should be empowered to respond to behavioral health crisis in the same way they respond to other emergencies. Residents of Washoe County experiencing suicidality or behavioral health emergencies deserve the same prompt, high-quality care as is delivered to individuals with physical medical emergencies.

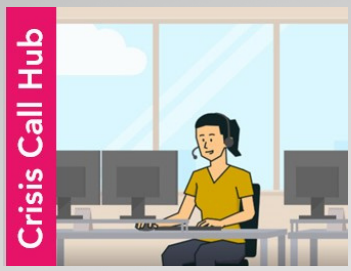
Through its deliberations and briefings by behavioral health experts in 2018/2019, the WRBHPB recognized the need for crisis response/stabilization services in the county. The problem is well known - hospital emergency departments have become the choke point in the current model of crisis care. According to Department of Health and Human Services data, on any given day, Nevada hospital emergency departments can board over 100 individuals waiting for a psychiatric bed to become available. It is not uncommon for patients to wait two or more days before being admitted for behavioral health treatment. Far too often, individuals experiencing a behavioral health crisis are transported to jail – in part due to the likelihood they will receive treatment referral more readily than other methods. That in itself, is also inappropriate and creates an ethical and fiscal issue.

Strategy and Progress

There have been a number of developments at the national level and within Nevada recently that are focused around addressing behavioral health crises and preventing suicide. One is the FCC approving 988 as the three digit call line for experiencing a behavioral health crisis or suicidality. This number will go live across the country on July 16, 2022. There are also state resources, and federal Medicaid dollars to help fund the crisis response system. These efforts are all leading to development of a crisis response system for the Washoe Region.

The goal of a crisis response system is to divert behavioral health and suicidality crises from 911 to 988, save lives, save costs, and ensure that every person in crisis receives the right response in the right place every time. This regional planning project is designing a continuum of services to stabilize and engage anyone experiencing a behavioral health emergency and link them with appropriate interventions to address the crisis. The core elements of this crisis response system are a statewide crisis call center to manage the new 988 behavioral health crisis line, mobile crisis teams, and crisis stabilization programs and policies.

The Washoe County Health District (WCHD) contracted with Social Entrepreneurs, Inc. (SEI) to support the implementation of a behavioral health crisis response system in the Washoe County Region including the City of Reno, City of Sparks, and Washoe County. The project's success depends upon the active involvement of key stakeholders, including those with lived experience, to design the state's first comprehensive crisis response system to address critical behavioral health needs of the residents of Washoe County. Stakeholders have been recruited in six areas, including a Leadership Council of policymakers and a Technical Advisory Committee (TAC) of human services and finance professionals. In addition, four subcommittees composed of subject matter experts have been formed, as recommended by the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Guidelines for Behavioral Health Crisis Care. These components are required for a functional, coordinated, and comprehensive response to behavioral health crises and align with the project's subcommittees.



Regional Crisis Call Hub Services – Someone To Talk To

Regional crisis call services offer real-time access to a live person every moment of every day for individuals in crisis. Regional, 24/7, clinically staffed call hub/crisis call centers provide telephonic crisis intervention services to all callers, meet National Suicide Prevention Lifeline (NSPL) operational guidelines regarding suicide risk assessment and engagement and offer air traffic control (ATC) quality coordination of crisis care in real-time. Ideally, these programs will also offer text and chat options to better engage entire communities in care. Analogous to a 911 call for most emergencies, mental health, substance use and suicide prevention lines must be equipped to take all calls with expertise in delivering telephonic intervention services, triaging the call to assess for additional needs and coordinating connections to additional support based on the assessment of the team and the preferences of the caller.

Mobile Crisis Team Services – Someone To Respond

Community-based mobile crisis is an integral part of a crisis system of care. Mobile crisis interventions provide individuals with less restrictive care in a more comfortable environment that is likely to produce more effective results than hospitalization or Emergency Department (ED) utilization. When collaboration exists with hospitals, medical and behavioral health providers, law enforcement, and other social services, community-based mobile crisis is an effective and efficient way of resolving mental health crisis and preventing future crisis situations. It helps individuals experiencing a crisis event to experience relief quickly and to resolve the crisis situation when possible; meets individuals in an environment where they are comfortable; and provides appropriate care/support while avoiding unnecessary law enforcement involvement, ED use and hospitalization.

Crisis Receiving and Stabilization Services – A Place to Go

Crisis receiving and stabilization services offer the community a no-wrong-door access to mental health and substance use care; operating much like a hospital emergency department that accepts all walk-ins, ambulance, fire and police drop-offs. The need to say yes to mental health crisis referrals, including working with persons of varying ages (as allowed within the facility license) and clinical conditions (such as serious emotional disturbances, serious mental illness, intellectual and developmental disabilities), regardless of acuity, informs program staffing, physical space, structure and use of chairs or recliners in lieu of beds that offer far less capacity or flexibility within a given space. Crisis stabilization facilities providing short-term (under 24 hours) observation and crisis stabilization services to all referrals in a home-like, non-hospital environment.

Equitable Focus on Substance Misuse

Regional Gap

Mental and substance-use problems and illnesses seldom occur in isolation. They frequently accompany each other, as well as a substantial number of general medical illnesses. The term Behavioral Health encompasses mental health and substance misuse, however in the board's contact with community stakeholders during the previous year, some concern was expressed that the focus of programs, funding, and policy might be inequitable between the two. Understanding that the two are often co-occuring, the Board realized a need to work to ensure inclusion and collaboration of all sectors of behavioral health.

Strategy and Progress

Through deliberation during the 2020 meeting year, the WRBHPB agreed that substance misuse should play a role in the Bill Draft Request (BDR) that was crafted for the 81st Legislative Session. As outlined in the 2020 Annual Report, the board's subsequent bill, Senate Bill (SB) 69 incorporated several pieces of legislation around substance misuse. *See Section IX for summary.

The board views the passage of SB69 as successful completion of this priority area, however will continue its support of the inclusion of and focus on substance abuse issues within the region. Improving the quality of mental health and substance use services depends upon the effective collaboration of all mental, substance-use, general health care, and other human service providers in coordinating the care of their clients. (National Academy of Sciences)

Behavioral Health Response: Before, During and After A Crisis/Disaster/Health Crisis

Regional Gap

All disasters and emergencies have a behavioral health component. Following disasters, behavioral health problems may range from transitory distress followed by return to pre-exposure levels to the emergence of new disorders including Post Traumatic Stress Disorder (PTSD), anxiety, or depression. The disaster may also lead to the worsening of pre-existing conditions like Serious Mental Illness (SMI) in adults, Severe Emotional Disturbance (SED) in children, and co-occurring Substance Use Disorders (SUD). Awareness has grown in understanding that all who experience a disaster are affected to varying degrees, individually and collectively. It is not uncommon for those affected (both victims and responders) to report disturbing feelings of grief, sadness, anxiety, and anger. The psychological effects of the disaster may be immediate or manifest months or years after the disaster. When a disaster occurs, normal day-to-day behavioral health services must continue in addition to the potential immediate and extended surge demand caused by the disaster. It is helpful if county behavioral health agencies pre-identify behavioral health responders from both the public (directly operated facilities) and private sectors that have disaster behavioral health qualifications, skill sets and training as part of regional health coalition activities. By identifying capabilities in advance, resources may be assigned so that the appropriate level of clinical support or intervention is provided at the incident site or other community setting. (EOM-Disaster-Behavioral-Health-10-26-2018.pdf (ca.gov)

Strategy and Progress

- Discussion continues with the County Emergency Manager's offfice around the inclusion of the draft Washoe County Regional Behavioral Health Emergency Response Plan Annex with the Washoe County Regional Emergency Operations Plan. While the current health crisis provided lessons learned for moving forward in emergency and disaster planning, it also precluded the ability to exercise the plan given the restrictions and prevention strategies in place. We look forward to working with the State and other regions in the exercising of response plans.

- Nevada Resilience Project (NRP): The Crisis Counseling Assistance and Training Program (CCP), rebranded in Nevada as the Resilience Project, is a short-term disaster relief grant for states, U.S. territories, and federally recognized tribes. The Resilience Project serves to provide early and immediate behavioral health support, triage, intervention, and referral of services in response to the impacts of COVID-19 on Nevada's population understanding that early triage, intervention, and referral to services can reduce the risk of mental health disorders for those impacted by COVID-19. The WRBH Coordinator currently provides high-level supervision and oversight to the Washoe team of Nevada Resilience Ambassadors (NRP). Resilience Ambassadors provide education, information, counseling, and resource navigation while promoting healthy coping, empowerment, and resilience. Resilience Ambassadors can provide support and connection to resources over the phone, through text and video-chat, or face to face. They are able to offer bi-lingual access to services; assistance navigating to needed resources in your community; help to reduce stress, build coping skills, and develop a resilience plan. The effort is a collaboration between the State of Nevada (providing the current funding), the WCHD (providing daily Covid "positive" lists), and Washoe County HSA/Regional Coordinator providing high level supervision of ambassadors.

  The success of this project is substantial. The fact that every individual who is testing positive for COVID-19 has or will be offerered an opportunity to speak to a crisis counselor and obtain referrals for services as needed, is not only significant but potentially unprecedented for a disaster/event of this magnitude.

- The Community Health Improvement Plan (CHIP), developed by the Washoe County Health District is a plan of action to address local conditions that are contributing to or causing poor health in Washoe County. Behavioral health was seen as a top concern cited by the community and is one that greatly suffers from lack of adequate resources and available workforce. The Board supports the efforts taken for the successful implementation of the CHIP.

Additional Areas of Discussion

Diversity and Inclusion

The behavioral health needs of minority communities have been historically and disproportionately underserved. Providers need to be sensitive to cultural issues and equipped with the necessary language skills that facilitate and promote effective service delivery. The proportion of behavioral health providers from diverse groups generally does not represent the proportion of those various diverse groups in the United States. Following SAMHSA's commitment to addressing these behavioral health workforce disparities, WRBHPB, seeks to identify and promote the effective retention strategies for prevention, treatment, and recovery support providers and providers who are or who serve members of racial, gender, and ethnic minority populations or other minority groups such as military members, veterans, and their families; lesbian, gay, bisexual, and transgender (LGBT) individuals; and American Indian/Alaska Native tribal members. WRBHPB will continue to welcome presentations and education, studying the cultural attributes that affect our ability to reach and serve our community members.

Mental and Behavioral Health Needs of Children

During the last two years of the pandemic, children experienced greater rates of anxiety, depression, and suicidality as they have been impacted by grief, economic instability, and isolation from friends and social supports. Children with disabilities have seen their challenges compound. According to the National Center for Education Statistics, seven million (14 percent) of public school students receive special education services. Of children with behavioral and mental health needs, 80 percent rely on school-based services. When schools shut down, many students were left without the lifelines they so desperately needed and at a time when mental health professionals were already in short supply. The lack of early mental health services creates tragic and expensive consequences when youth with emerging mental health issues have difficulty finding timely treatment and a service system that can respond quickly and confidentially (NASHP,2021). The WRBHPB continues to support those regional partners that are working towards the enhancement and improvement of access to mental health care for families and children.

Behavioral Health Workforce

Nationally, there is more demand for behavioral health (mental health and substance use) treatment than workforce capacity to deliver services which impacts timely access to treatment and prevents providers from expanding quality services. Regionally, the pandemic stressed an already overwhelmed behavioral health workforce. The region is fortunate to have many highly competent and committed professionals working hard to deliver behavioral health services, but barriers to educational attainment, professional recruitment, and long-term retention have been included in discussions around workforce development. The WRBHPB continues to support the study and discussion on how Nevada, and Washoe County can affect change to this growing need. The passage of SB69, which acknowledges the role peers can play in the workforce was a positive step.

IX. Legislative Update

While the focus of the WRBHPB is on behavioral health issues in Washoe County, the goal will always remain a collaboration with other regional boards to mitigate duplication of effort and affect positive change for all of Nevada. It is only through working together that we can accomplish goals that might not be obtainable in isolation. One method to affect change in regional behavioral health is the unique opportunity that the regional behavioral health policy boards are afforded to develop and present a Bill Draft Request (BDR) each legislative session. As reported in the 2020 annual report, the WRBHPB was pleased to submit SB69 for consideration in the 81st legislation session. The bill passed and was signed by Governor Steve Sisolak,

Below is a summary of the four regional behavioral health policy board bills introduced in the 81st legislative session as well those bills for which the WRBHPB submitted letters of support. **Several of the pieces of legislation positively impacted the forward momentum of crisis response systems implmentation.**

Senate Bill 69

Washoe Regional Behavioral Health Policy Board

Status: Passed and Signed by Governor

Peer Recovery Support

Legislative Intent: Require certification for Peer Recovery Support Specialists and Peer Recovery Support Specialists Supervisors.

Benefits to Nevada:

- Clearly defines peer recovery support services and Peer Recovery Support Specialists.
- Establishes a required certification process to ensure minimum standards are met before using the title Peer Recovery Support Specialist.
- Establishes requirements governing the supervision of Peer Recovery Support Specialists.

Youth Risk Behavior Survey (YRBS) Passive Consent

Legislative Intent: Increase survey response rates through a uniform passive (opt out) consent process in all school districts.

Benefits to Nevada:

- Cost savings as there is less administrative burdens with passive consent vs. active consent.
- Supports the only common data source related to youth behaviors available to Nevada's 17 counties.
- Eliminates the loss of federal funding due to not having core measure data.
- Greater participation among students ensures reliable data, and less chance of biases and underrepresentation of certain groups.

Substance Misuse K-12 Prevention Education Curriculum

Legislative Intent: Support the move to evidence-based substance misuse prevention programming to meet current standards.

Benefits to Nevada:

- Provides teachers a link to nationally recognized evidence-based substance misuse prevention programs.
- Compiles a list of current curricula and/or programs being implemented in grades K-12.
- Allows partnering community organizations to fund more school-based prevention programs.

Establish Substance Misuse Prevention Coalitions in NRS

Legislative Intent: Legitimize the substance misuse prevention coalitions legal status in statute.

Benefits to Nevada:

- Ensures Nevada is in alignment with national best practice standards as established by the Community Anti-Drug Coalitions of America (CADCA).
- Urban, rural, and frontier communities are equally represented in the coalition model, recognizing the importance of community level decision making.
- The coalition model is science driven, evidence-based, and has been operating as the prevention model in Nevada for 20 years.
- Coalitions have secured $11,864,320 for FY20-21 to support local-level behavioral health issues.

Senate Bill 70

Northern Regional Behavioral Health Policy Board

Status: Passed and Signed by Governor

- Clarifies the distinction between mental health crisis hold and the court-ordered involuntary admission process.
- Clarifies the process for family members to request the court to have a family member be picked up and transported for an evaluation, which is different than a court-ordered involuntary admission.
- Updates the law as to current practices for both conditional release and chemical restraint.
- Separates and clarifies the Assisted Outpatient Treatment program

Senate Bill 44

Rural Regional Behavioral Health Policy Board

Status: Passed and Signed by Governor

- Revises provisions concerning the administration and licensure of certain behavioral health professions.
- Authorizes certain behavioral health licensing boards to issue a temporary provisional license to an applicant who meets certain requirements.
- Requires the Legislative Committee on Health Care (LCHC) to study the licensing practices of behavioral health licensing boards and identify barriers to licensure.
- Requires behavioral health licensing boards to implement strategies to eliminate each barrier identified, unless a barrier is deemed necessary to maintain the quality of services
- Makes various changes to the Board of Examiners for Social Workers

Senate Bill 56

Clark Regional Behavioral HealthPolicy Board
Status: Failed . No Action Taken

- Required health insurance policies to include coverage for behavioral health services provided through telehealth or by standard telephone to the same extent and in the same amount as though provided in person or by other means.
- Prohibited health insurance coverage for behavioral health services provided in the home of an insured to be dependent on the geographic location of such home
- Required the Division of Health Care Financing and Policy of the Department of Health and Human Services to apply for a waiver from the federal centers for Medicare and Medicaid services to approve matching funds for coverage for standard telephone behavioral health services.

Senate Bill 156

Committee on Health and Human Services
Status: Passed and Signed by Governor

- Expands the authority of the Division of Public and Behavioral Health of the Department of Health and Human Services (DHHS) to issue an endorsement as a crisis stabilization center to any licensed hospital that meets certain requirements.
- Expands the list of organizations by which a hospital may be accredited to qualify for renewal of an endorsement, and exempts rural hospitals from the accreditation requirement.
- Expands the existing requirement that DHHS take any action necessary to ensure crisis stabilization services provided at a psychiatric hospital with a crisis stabilization center endorsement are reimbursable under Medicaid to include such services provided at any hospital with endorsement.
- Makes changes to existing law requiring health maintenance organizations or managed care organizations that provide services through Medicaid or the Children's Health Insurance Program to negotiate in good faith to include a hospital with an endorsement as a crisis stabilization center in their provider network

Senate Bill 390

Committee on Health and Human Services
Status: Passed and Signed by Governor

- Provides for the establishment of a suicide prevention and behavioral health crisis hotline;
- Exempts a telecommunications provider from certain damages relating to the hotline; requiring the imposition of a surcharge on certain communications services to support the hotline;
- Creates funding mechanism deposited into a Fund
- Authorizes the use the money in the Fund for certain statewide projects and to award grants to various public and private entities to address the impact of opioid use disorder and other substance use disorders

Senate Bill 154

Committee on Health and Human Services
Status: Passed and Signed by Governor

- Requires DHHS to apply for a waiver from the federal government to receive federal funding to include in the State Plan for Medicaid coverage for substance use disorder treatment for individuals in an institution for mental diseases.
- Authorizes DHHS to apply for a similar waiver to treat adults with serious mental illness or children with severe emotional disturbance in an institution for mental disease.

Assembly Bill 181

Assesmblywoman Peters
Status: Passed and Signed by Governor

- Requires certain health insurers that provide health coverage for their employees to comply with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, which prohibits group health plans and health insurance issuers that provide benefits for mental health or substance use disorders from imposing less favorable benefit limitations on those benefits than on medical and surgical benefits.
- Requires each insurer or other organization subject to those requirements to submit to the commissioner of insurance certain information that demonstrates compliance with the Act. The commissioner may adopt regulations to carry out the provisions of this bill, shall keep certain information confidential, and must submit annually a report to various entities.
- Requires certain providers of health care to report information relating to suicide to the chief medical officer pursuant to regulations adopted by the State Board of Health

X. Behavioral Health Data

Washoe Behavioral Health Profile

The Washoe Regional Behavioral Health Policy Board operates with the intention of addressing the importance and necessity of substance use, mental health, and behavioral health services for Washoe County residents.

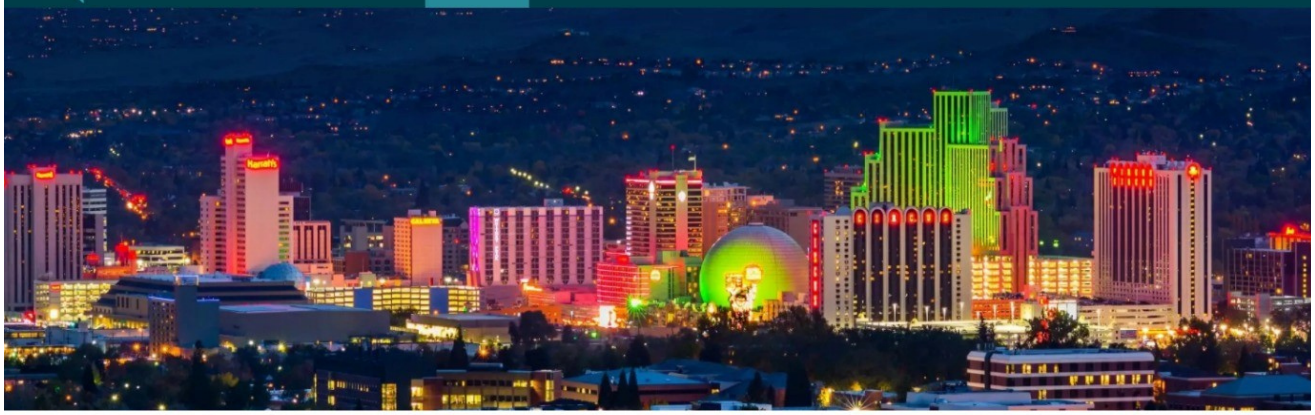
For several years, the board has supported the development of a county specific behavioral health profile. This profile aims to outline key behavioral health indicators associated with Washoe County residents, and to identify trends in available data. By using a wide range of data sources, we can identify key problem areas within Washoe County, and use this information to help guide the policy board towards focusing on the areas deemed to be the most at-risk. This report is shared widely with internal and external stakeholders to provide an overview of how the County compares nationally and statewide in areas of behavioral health.

One of the significant sources of data is the Nevada Regional Behavioral Health Epi Profiles, provided by the Nevada State Office of Analytics. This valuable report combined other state and federal data (CDC) and along with data collected by the Regional Behavioral Health Coordinator from other sources, provided a regionalized lens from which to view Washoe County against the State and Nation in certain behavioral health data points.

The majority of sources of data for these reports are reported biennially and, based on this availability, the Nevada Office of Analytics will begin providing these reports every other year. To avoid unnecessary duplication, the Washoe Regional Behavioral Health Profile will follow this reporting timeline as well. The link for the 2020 Washoe Behavioral Heath Profile as well as additional data resources, is provided in the Appendix A. **While there is no Washoe Behavioral Health Profile this year, there are several data points that have been updated and these are included in sections that follow.**

Nevada Regional Behavioral Health Policy Board Data Website (https://nvbh.org)

Pursuant to requirements outlined in NRS 433.4295, the Regional Behavioral Health Coordinators began discussions with the State around funding for a data repository, and with the assistance of the Northern Behavioral Health Region and the State of Nevada DPBH, a Behavioral Health Website was developed late in 2021. It is still in the piloting stage, as coordinators seek to determine the most efficacious way to include current and accurate behavioral health resources, however it is open for the public to view and utilize.



The Washoe Behavioral Health Region

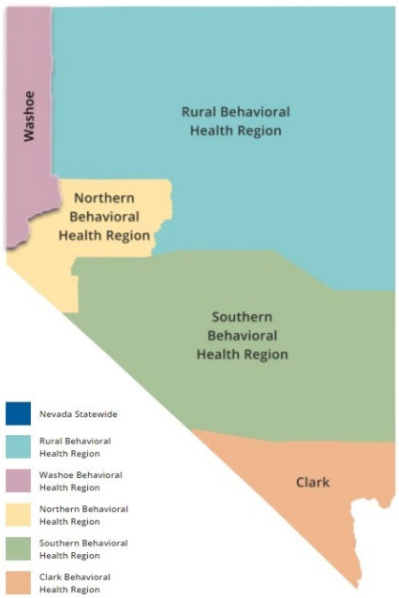
Washoe County is home to over 6,600 sprawling square miles, bordering both California and Oregon with nearly half a million residents who call our region home. Washoe County's recreation and outdoors experiences are second to none with 49 beautiful parks, 161 miles of trails, and more than 10,000 acres of open space. Washoe County's 24 departments are managed by the county's top executive, the Washoe County Manager, and governed by five elected County Commissioners, who also serve as the Board of Fire Commissioners for the Truckee Meadows Fire & Rescue.

In 2019, the estimated population for Washoe County was 469,963, a 10.3% increase from the 2010 estimated population. With 15.2% of Nevada's population living in Washoe County, it is the second most populous area in the state, with an approximately equal percentage of females and males.

More demographic information can be found on the County's home page at Washoe County, NV.

- Members +
- Board Priorities +
- Gaps & Needs +
- Initiatives and Strategies for Success +
- Recommendations +
- Featured Resources +

Click to select Behavioral Health Region



FEBRUARY, 2022

CALENDAR OF EVENTS

NO EVENTS

Mental Health America 2022 Report

While the WRBHPB Annual Report emphasi Washoe County data, it is important to include State and National data to provide comparisons nd identify trends. The Mental Health America annual report identifies a set of common data indicators for mental health that gives a complete picture of mental health status in America. The report provides data on prevalence rates of mental health problems for youth and adults and data on access to care with goals being to provide a snapshot of mental health status for program and policy planning, analysis and evaluation; to track changes in prevalence of mental health issues and access to care; to understand how changes in national data can affect legislation; and, to increase dialogue and improve outcomes. It should be noted that with many behavioral health data reports, while this data is reported annually, it is taken from previous year or two in some surveys. Key findings related to Nevada are listed below; the entire report can be found at the link provided in Appendix A.

Adults: States that are ranked 1-13 have lower prevalence of mental illness and higher rates of access to care for adults. States that are ranked 39-51 indicate that adults have higher prevalence of mental illness and lower rates of access to care. ***Nevada's ranking overall is 40th, improving by 2 from last year's report.***

Adult Ranking Adults with Any Mental Illness (AMI): According to SAMHSA, Any Mental Illness (AMI) is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder. Any mental illness includes persons who have mild mental illness, moderate mental illness, and serious mental illness.

- **United States:** 19.86% of adults are experiencing a mental illness. Equivalent to nearly 50 million Americans. 4.91% are experiencing a severe mental illness which is up from last year.
- **Nevada:** Ranks 34th with 21.97%, a slight improvement from last year

Adults with Substance Use Disorder in the Past Year

- **United States:** 7.74% of adults in America reported having a substance use disorder in the past year. 2.97% of adults in America reported having an illicit drug use disorder in the past year. 5.71% of adults in America reported having an alcohol use disorder in the past year.
- **Nevada:** Ranks 45th, with 9.32%. This is a regression from 40th in the previous year.

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Adults with Serious Thoughts of Suicide

- **United States:** The percentage of adults reporting serious thoughts of suicide is 4.58%. The estimated number of adults with serious suicidal thoughts is over 11.4 million - an increase of over 664,000 people from last year's data set. The national rate of adults experiencing suicidal ideation has increased every year since 2011-2012.
- **Nevada:** Ranks 34th with 4.94% which demonstrates another regression from last reporting period (31st).

Adults with AMI who are Uninsured

- **United States:** 11.1% (over 5.5 million) of adults with a mental illness remain uninsured. The rankings for this indicator used data from the 2017-2018 NSDUH. In December 2017, Congress passed the Tax Cuts and Jobs Act, which eliminated the individual mandate penalty from the ACA. There was a 0.5% increase from last year's dataset, the first time this indicator has increased since the passage of the ACA. The increase in this indicator is consistent with data from the U.S. Census Bureau, which found that in 2018, the rate of uninsured Americans rose for the first time since the ACA took effect. Only twenty states saw a reduction in Adults with AMI who are uninsured in this year's dataset.
- **Nevada:** Ranks 30th with 11.5%, an improvement from 31st in the previous reporting period

Adults with AMI who Did Not Receive Treatment

- **United States:** Over half (56%) of adults with a mental illness receive no treatment. Over 27 million individuals experiencing a mental illness are going untreated.
- **Nevada:** Ranks 41st with 58%, improving from being 44th in the last reporting period.

Adults with AMI Reporting Unmet Need

- **United States:** Almost a quarter (24.7%) of all adults with a mental illness reported that they were not able to receive the treatment they needed. This number has not declined since 2011. Individuals seeking treatment but still not receiving needed services face the same barriers that contribute to the number of individuals not receiving treatment: No insurance or limited coverage of services; Shortfall in psychiatrists, and an overall undersized mental health workforce; Lack of available treatment types (inpatient treatment, individual therapy, intensive community services); Disconnect between primary care systems and behavioral health systems; and, Insufficient finances to cover costs in including copays, uncovered treatment types, or when providers do not take insurance.
- **Nevada:** Ranks 45th with 29.50% which is a significant decline from the previous reporting rank of 39th with 26.1%.

Adults with Disability Who Could Not See a Doctor Due to Costs

- **United States:** 29.67% of adults with a cognitive disability were not able to see a doctor due to costs. According to the Centers for Disease Control (CDC), 12% of people in the U.S. had a cognitive disability, even when adjusted for age. The percentage of people with cognitive disability ranged from 8.9% in some states to 19.6%. The prevalence of adults with cognitive disability who couldn't see a MD due to cost ranges from 18.48% in Rhode Island to 40.65% in Texas.
- **Nevada:** Ranks 15th with 24.51%, which ticks up from last year when Nevada ranked 18th.

Youth: States with rankings 1-10 have lower prevalence of mental illness and higher rates of access to care for youth. States with rankings 39-51 indicate that youth have higher prevalence of mental illness and lower rates of access to care. ***Nevada's overall ranking is 51st which remains the same from last year's reporting.***

Youth with At Least One Major Depressive Episode (MDE) in the Past Year

- **United States:** 15.08% of youth (age 12-17) report suffering from at least one major depressive episode (MDE) in the past year. Childhood depression is more likely to persist into adulthood if gone untreated. The number of youth experiencing MDE increased by 306,000 from last year's dataset.
- **Nevada**: Ranks 47th with 17.93%, a decline from previous reporting ranking of 39th.

Youth with Substance Use Disorder in the Past Year

- **United States:** 4.08% of youth in the U.S. reported having a substance use disorder in the past year. 1.64% had an alcohol use disorder in the past year, while 3.16% had an illicit drug use disorder.
- **Nevada:** Ranks 49th with 5.59%, a decline from previous reporting ranking of 47th.

Youth with Severe MDE

- **United States:** 10.6% of youth (or over 2.5 million youth) cope with severe major depression. The number of youths experiencing Severe MDE increased by 197,000 from last year's dataset.
- **Nevada:** Ranks 38th with 13.2%, a slight improvement from last year's ranking of 39th.

Youth with MDE who Did Not Receive Mental Health Services

- **United States:** 60.3% of youth with major depression do not receive any mental health treatment. Youth experiencing MDE continue to go untreated. Even among the states with greatest access for youth, 1 in 3 youth are still not receiving the mental health services they need. The state prevalence of untreated youth with depression ranges from 30.0% in Maine to 73.1% in Texas.
- **Nevada:** Ranks 40th with 65.2%, a significant improvement from last year's ranking of 51st.

Youth with Severe MDE who Received Some Consistent Treatment

- **United States:** Nationally, only 27.3% of youth with severe depression receive some consistent treatment (7-25+ visits in a year). Late recognition in primary care settings and limited coverage of mental health services often prevent youth from receiving timely and effective treatment.
- **Nevada:** Ranks 45th with 18.70%, an improvement from last year's ranking of 51st.

Children with Private Insurance that Did Not Cover Mental or Emotional Problems

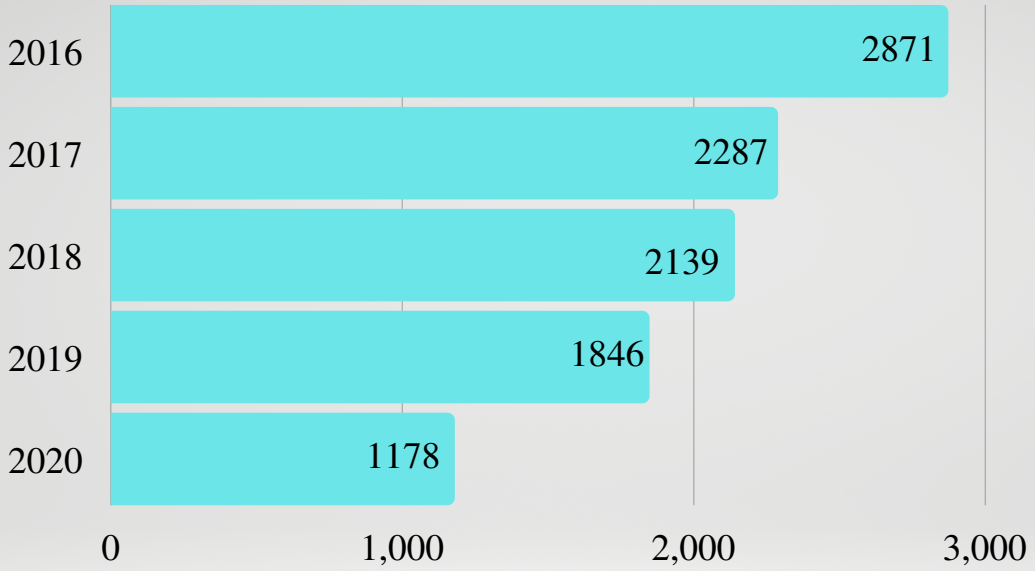
- **United States**: The Mental Health Parity and Addiction Equity law (MHPAE) was enacted in 2008 and promised the equal coverage of mental health and substance use services. However, the rate of children with private insurance that does not cover mental or emotional problems increased 0.3 percent from last year's dataset, and there are still 950,000 youth without coverage for their behavioral health. The state prevalence of children lacking mental health coverage ranges from 1.9% in Massachusetts to 17.7% in Arkansas.
- **Nevada:** Ranks 24th with 7.10%, a significant improvement from previous ranking of 45th.

Students Identified with Emotional Disturbance for an Individualized Education Program

- **United States:** Only .759% of students are identified as having an Emotional Disturbance (ED) for an Individualized Education Program (IEP).The rate for this measure is shown as a rate per 1,000 students. The calculation was made this way for ease of reading. Unfortunately, doing so hides the fact that the percentages are significantly lower. If states were doing a better job of identifying whether youth had emotional difficulties that could be better supported through an IEP the rates would be closer to 8% instead of .8 percent.
- **Nevada:** Ranks 42nd with 4.64%; previous ranking was 43rd.

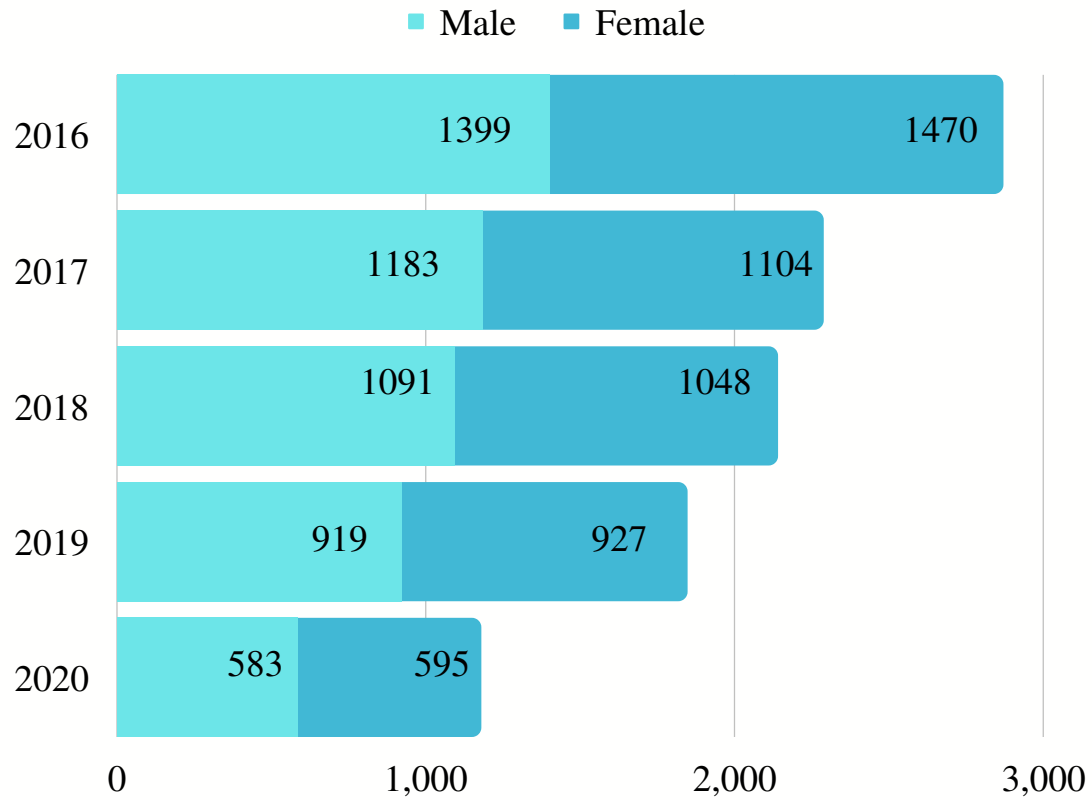
Mental Health Clinic Utilization Data: Washoe County

Unique Clients Served at State-Funded Mental Health Clinics in the Washoe Region 2016-2020



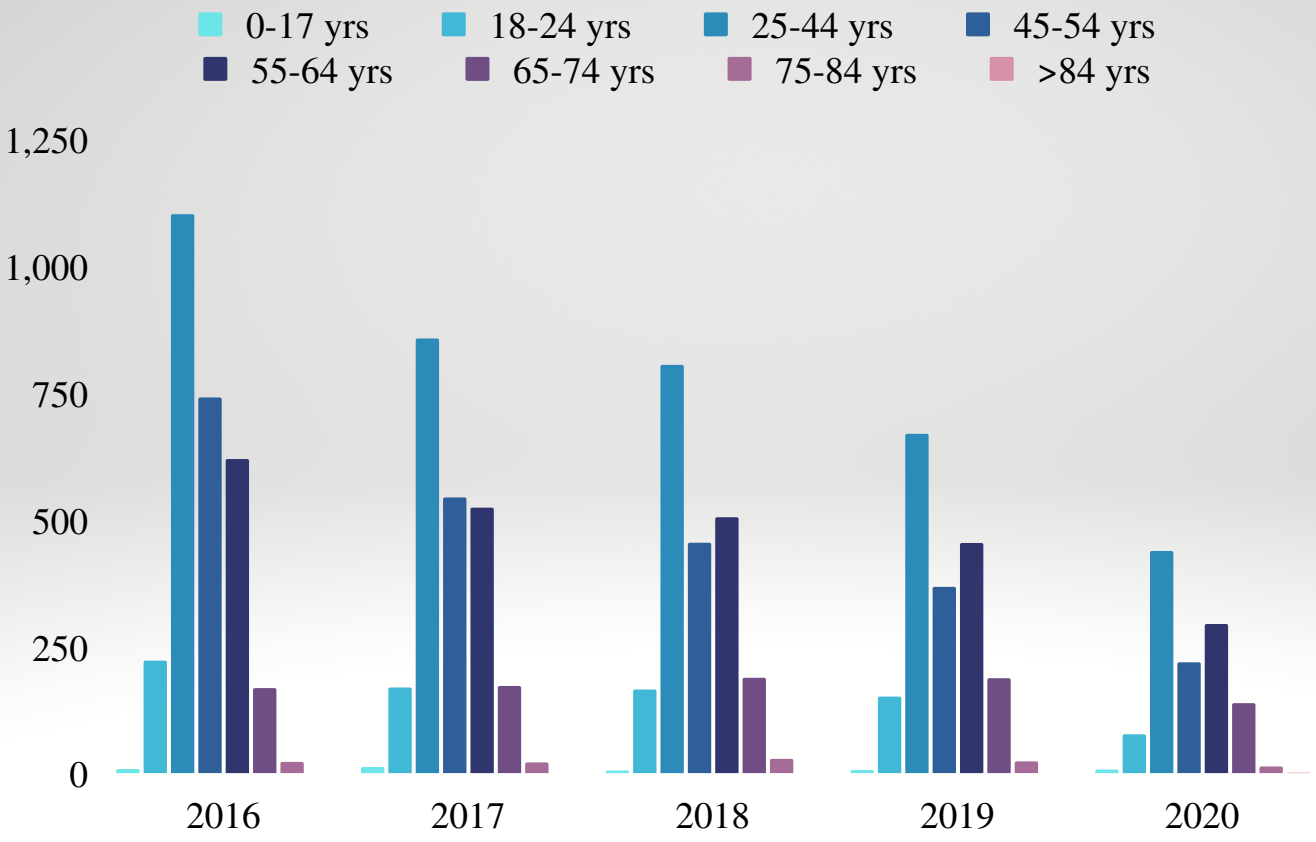
Source: Nevada State Office Of Analytics/Avatar . A client is counted only once per year. Clients may be counted more than once across years.

Unique Clients Served at State-Funded Mental Health Clinics in the Washoe County Region: Gender 2016-2020



Source: Nevada State Office Of Analytics/Avatar . A client is counted only once per year. Clients may be counted more than once across years.

State-Funded Mental Health Clinics Utilization in the Washoe County Region: Age-Group, 2016-2020

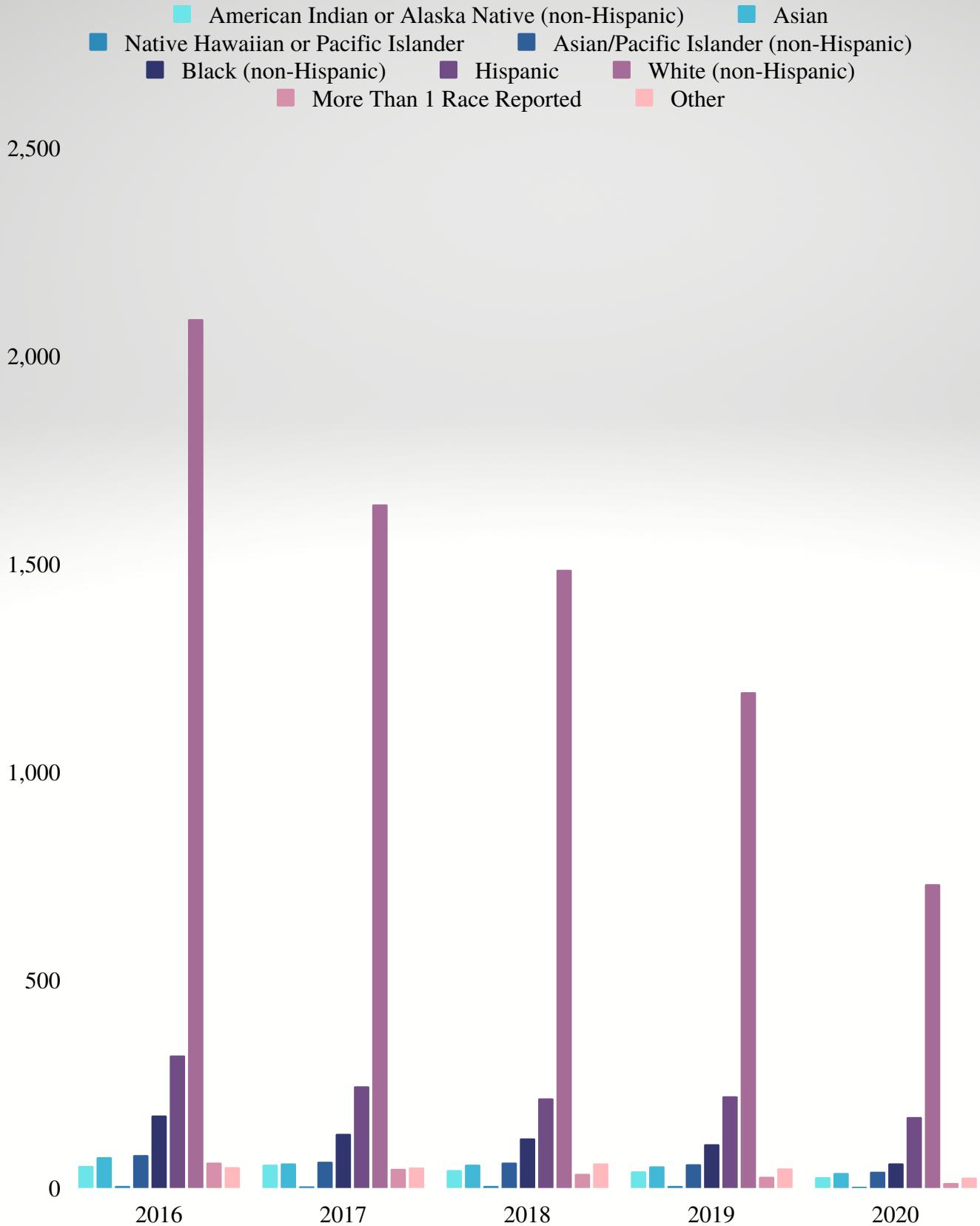


Percentages for 2020

0-17	0.79%
18-24	6.45%
25-34	17.83%
35-44	19.10%
45-54	18.42%
55-64	24.79%
65-74	11.63%
75-84	1.10%
>84	0.08%

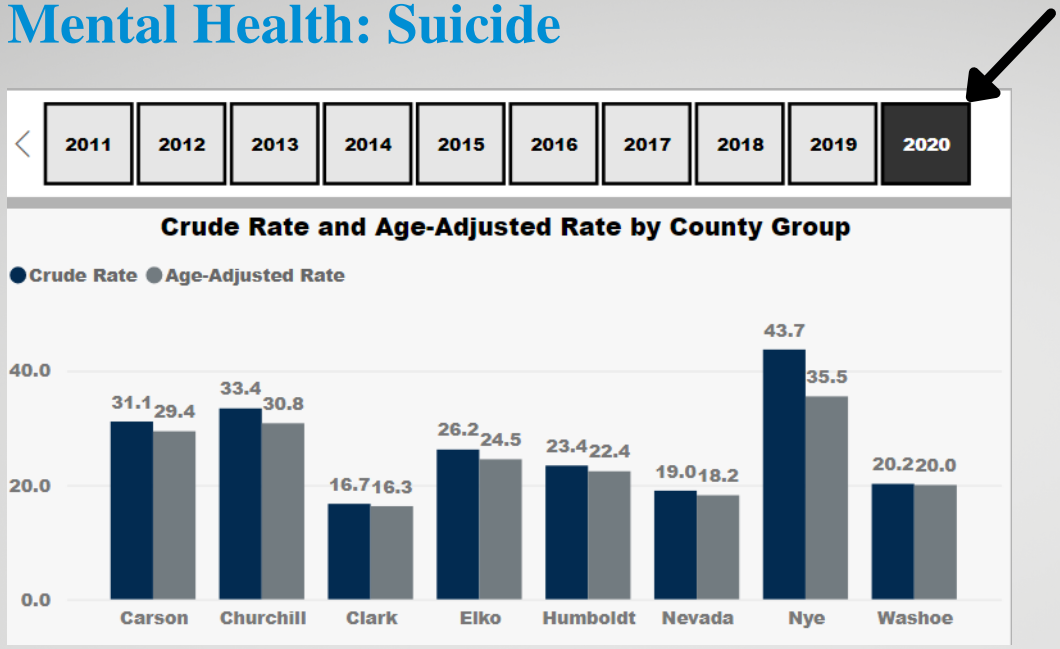
Source: Nevada State Office Of Analytics/Avatar . A client is counted only once per year. Clients may be counted more than once across years.

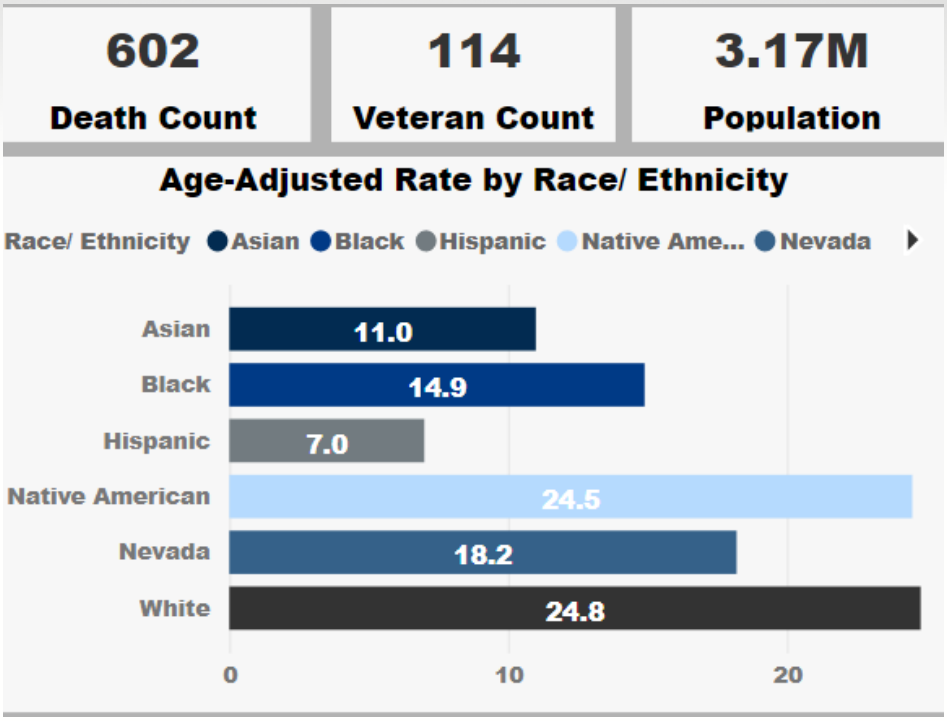
State-Funded Mental Health Clinics Utilization by Washoe County Region and Race/Ethnicity, 2016-2020



Source: Nevada State Office Of Analytics/Avatar . A client is counted only once per year. Clients may be counted more than once across years.

Mental Health: Suicide





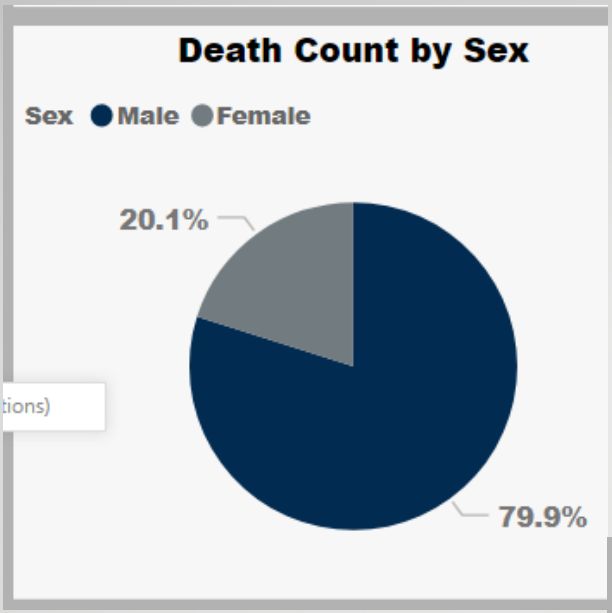
Data Definition

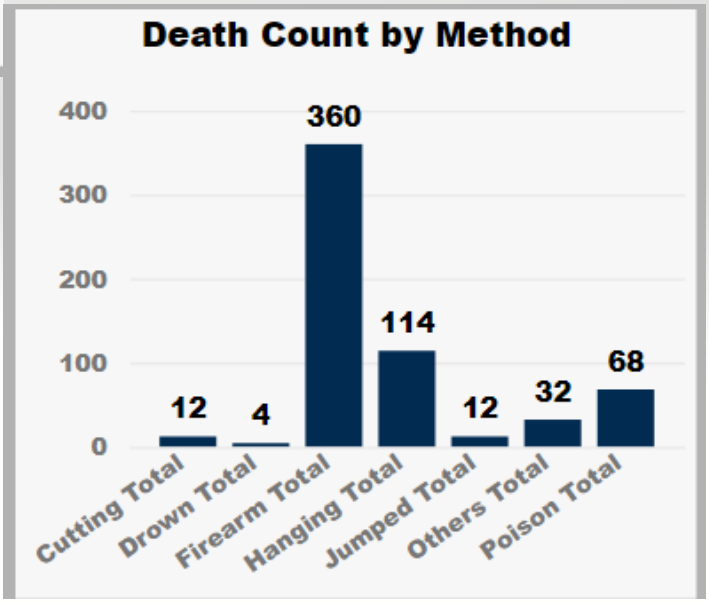
Suicide: The act of intentionally causing one's own death; Mortality Rate: The count of deaths per one hundred thousand population for a specific cause (also called crude rate) Population: Estimated population from the Nevada State Demographer including prisoner population Nevada Resident: Any person with a residence address within the State of Nevada which includes counts outside of the State Age-Adjusted Rate: A modified crude rate to account for changes in age between populations

County Groups: Churchill: Churchill, Lyon, Mineral, Storey; Nye: Nye, Esmeralda; Elko: Elko, Eureka, Lincoln, White Pine; Humboldt: Humboldt, Lander, Pershing

Data Source

Data has been pulled from the Electronic Death Registry System, State Demographer Population Estimates
Provided by Department of health and Human Services, Office of Analytics





Year	County Group	Death Count	Crude Rate	Age-Adjusted Rate
2020	Carson	33	31.0	29.3
2020	Churchill	31	33.4	30.9
2020	Clark	391	16.8	16.3
2020	Elko	19	26.2	24.5
2020	Humboldt	7	23.3	22.3
2020	Nye	22	43.8	35.5
2020	Unknown	3	0.0	0.0
2020	Washoe	96	20.1	19.9

Suicide Counts and Rates by Age Group by County by Year
Nevada Residents, 2010-2020

Year	County Group	Age Groups							
		Age 0-17		Age 18-24		Age 25-64		Age 65+	
		Count	Crude Rate	Count	Crude Rate	Count	Crude Rate	Count	Crude Rate
2010	Clark	7	1.4	25	13.8	277	26.1	64	28.2
2010	Washoe	0	0.0	8	19.2	73	32.8	13	25.2
2010	Balance	1	1.3	8	24.0	47	28.6	25	44.5
2011	Clark	15	3.1	25	13.8	229	21.6	57	24.3
2011	Washoe	4	3.9	14	33.7	55	24.5	13	24.3
2011	Balance	3	4.0	7	20.4	66	39.8	21	36.4
2012	Clark	4	0.8	22	12.0	274	25.6	56	22.9
2012	Washoe	2	2.0	5	11.9	57	25.1	14	25.0
2012	Balance	0	0.0	5	13.8	53	32.0	14	23.6
2013	Clark	6	1.2	19	10.0	253	23.2	66	25.9
2013	Washoe	4	3.9	9	21.4	58	25.3	24	41.2
2013	Balance	3	4.1	7	18.9	59	35.6	21	34.2
2014	Clark	7	1.4	29	15.0	242	21.8	81	30.8
2014	Washoe	2	1.9	6	14.3	63	27.3	21	34.7
2014	Balance	2	2.8	9	25.1	67	40.4	29	45.9
2015	Clark	10	1.9	35	17.9	256	22.7	69	25.6
2015	Washoe	4	3.8	4	9.5	69	29.7	23	36.6
2015	Balance	3	4.3	7	20.5	56	33.4	17	26.2
2016	Clark	12	2.2	31	15.5	278	24.1	90	32.3
2016	Washoe	3	2.9	3	6.9	77	32.8	41	62.8
2016	Balance	4	5.8	9	27.1	58	34.2	32	48.1
2017	Clark	11	2.0	42	20.8	288	24.7	86	29.9
2017	Washoe	3	2.8	13	30.0	56	23.8	22	32.5
2017	Balance	2	2.9	7	22.8	56	32.4	33	48.7
2018	Clark	20	3.7	40	19.2	317	26.5	83	27.8
2018	Washoe	2	1.9	6	13.5	56	23.5	24	34.0
2018	Balance	6	8.7	5	16.4	65	37.1	37	52.0
2019	Clark	10	1.8	32	14.9	275	22.6	100	32.4
2019	Washoe	5	4.6	10	21.5	72	29.7	26	35.7
2019	Balance	1	1.4	11	36.7	66	37.3	34	46.4
2020	Clark	16	2.9	40	18.2	236	19.1	99	31.0
2020	Washoe	1	0.9	10	20.9	63	25.8	22	29.1
2020	Balance	2	2.8	12	42.4	72	40.5	29	38.4

Balance includes: Carson, Churchill, Douglas, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Pershing, Storey, and White Pine counties.

Washoe County Methamphetamine and Stimulant Surveillance 2020*

Summary

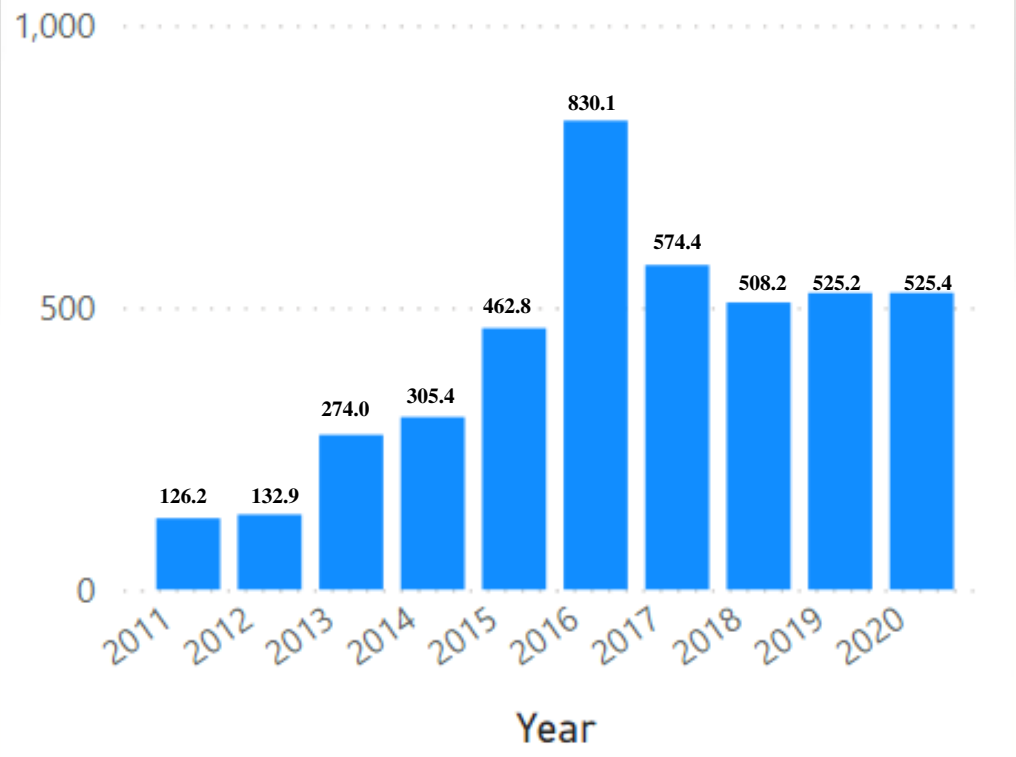
- From 2011 to 2020, methamphetamine-related emergency department (ED) visits increased per 100,000 residents from 115.7 to 512.7 in Nevada and in Washoe County from 126.2 to 525.4
- In 2020, ED visits were most prevalent among Nevada and Washoe County residents 30 -39 years old
- From 2011 to 2020, methamphetamine-related inpatient admissions increased per 100,000 Nevada residents from 88.6 to 402.4 and in Washoe County from 153.1 to 410.0.
- In 2020, methamphetamine-related inpatient admissions were most prevalent among Washoe residents 30-39
- From 2011 to 2020, methamphetamine-related deaths increased per 100,000 residents from 4.4 to 13.7 in Nevada and from 4.4 to 14.7 in Washoe County
- In 2020, methamphetamine-related deaths were most prevalent among Washoe County residents 50 - 59 years of age.
- In 2020, Washoe County methamphetamine-related deaths were most prevalent among Black, non-hispanic residents (40.27)

*Age-Adjusted Rates

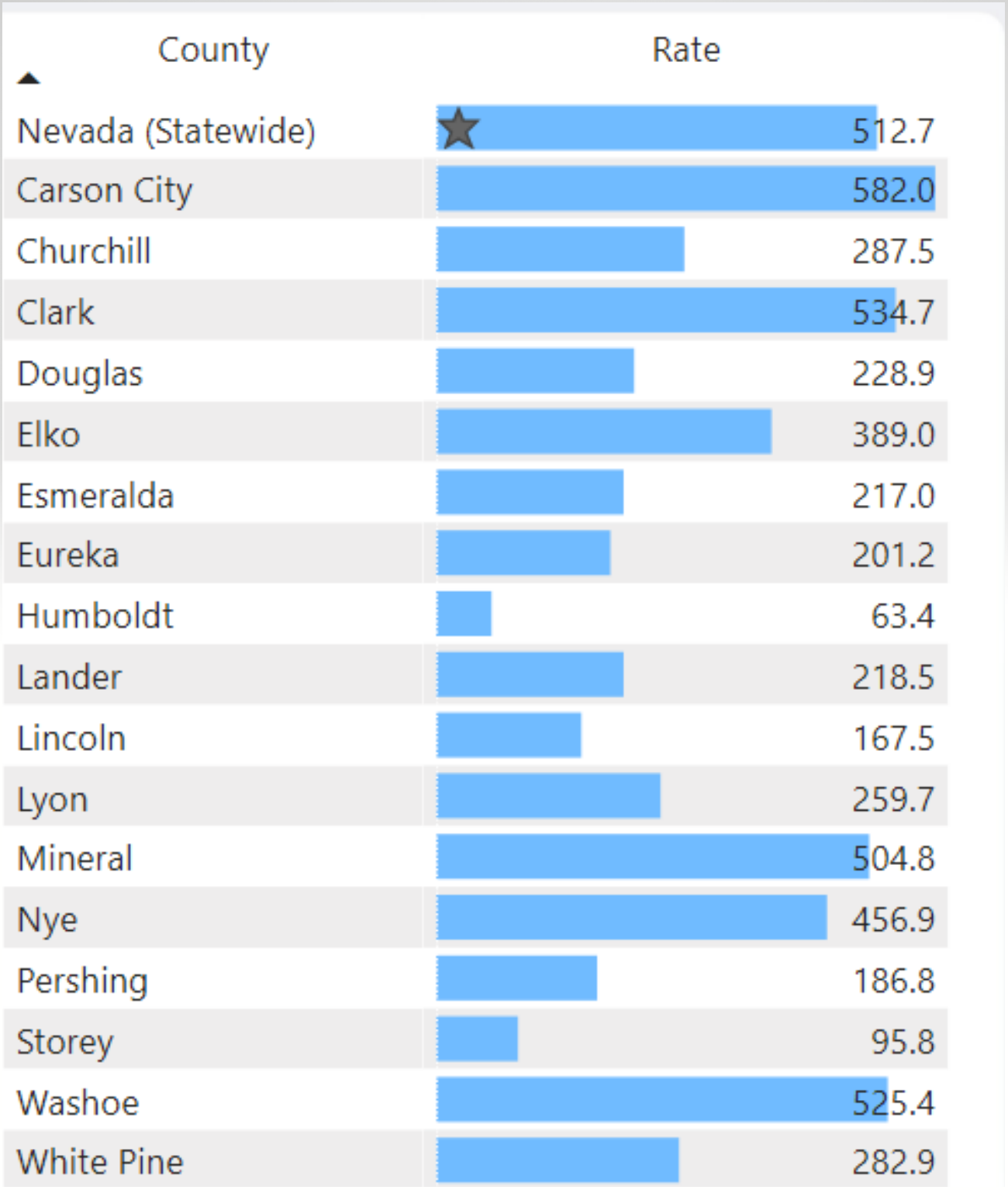
Methamphetamine/Stimulant Related Emergency Department Visits
Washoe County

525.4

Rate per 100,000 Nevada Residents

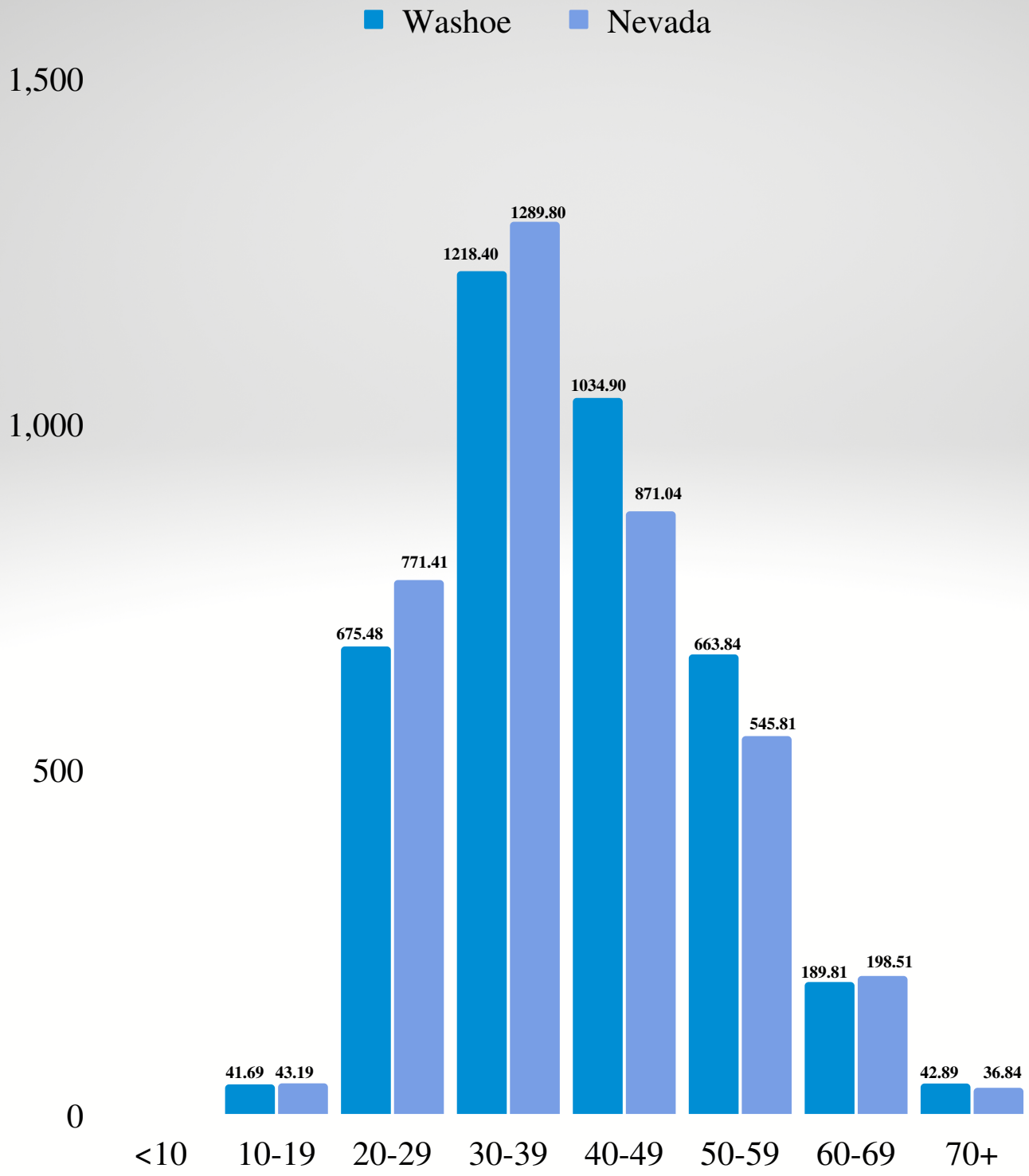


2020 Methamphetamine/Stimulant Related Emergency Department Visits: County (per 100,000)

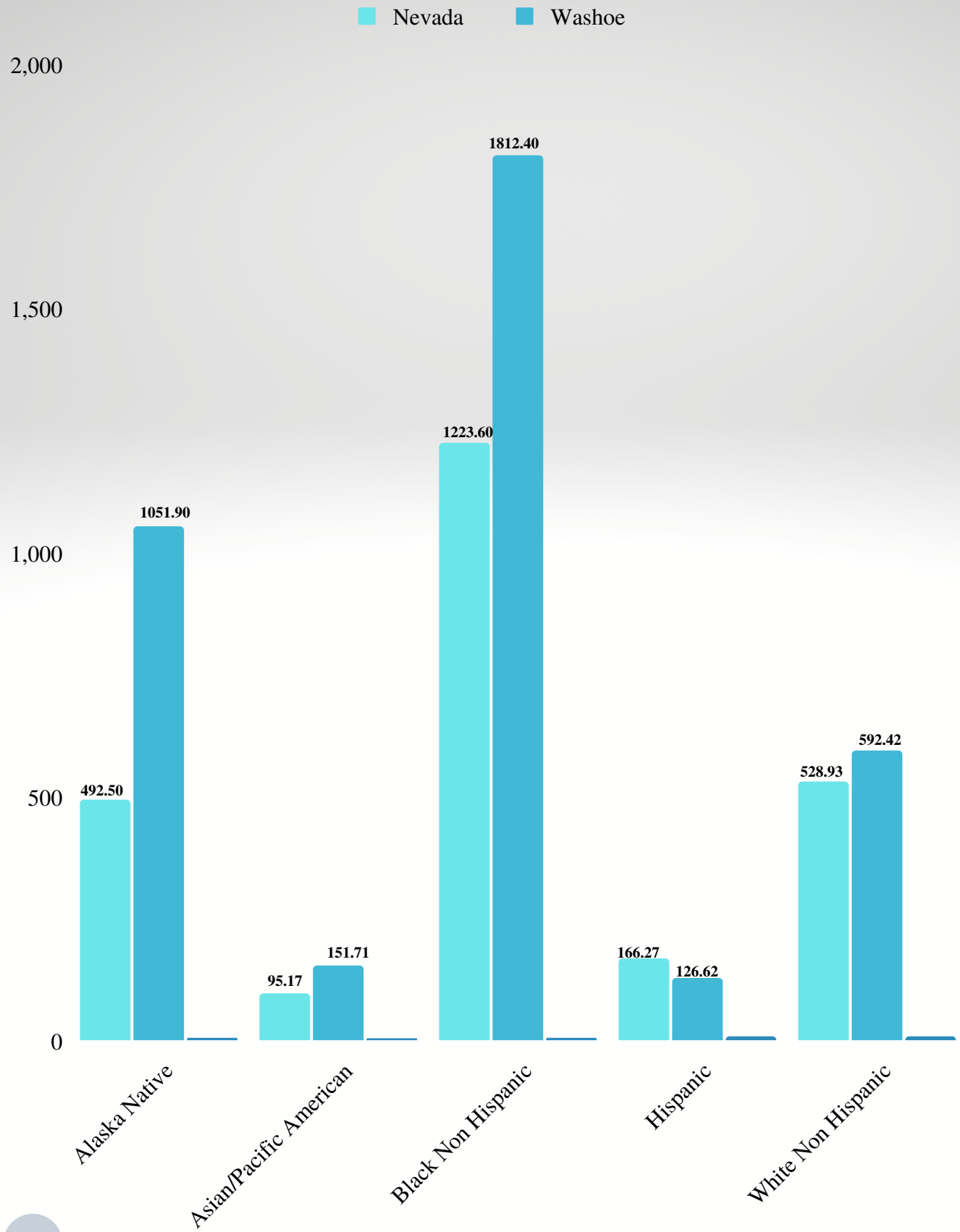


County	Rate
Nevada (Statewide)	512.7
Carson City	582.0
Churchill	287.5
Clark	534.7
Douglas	228.9
Elko	389.0
Esmeralda	217.0
Eureka	201.2
Humboldt	63.4
Lander	218.5
Lincoln	167.5
Lyon	259.7
Mineral	504.8
Nye	456.9
Pershing	186.8
Storey	95.8
Washoe	525.4
White Pine	282.9

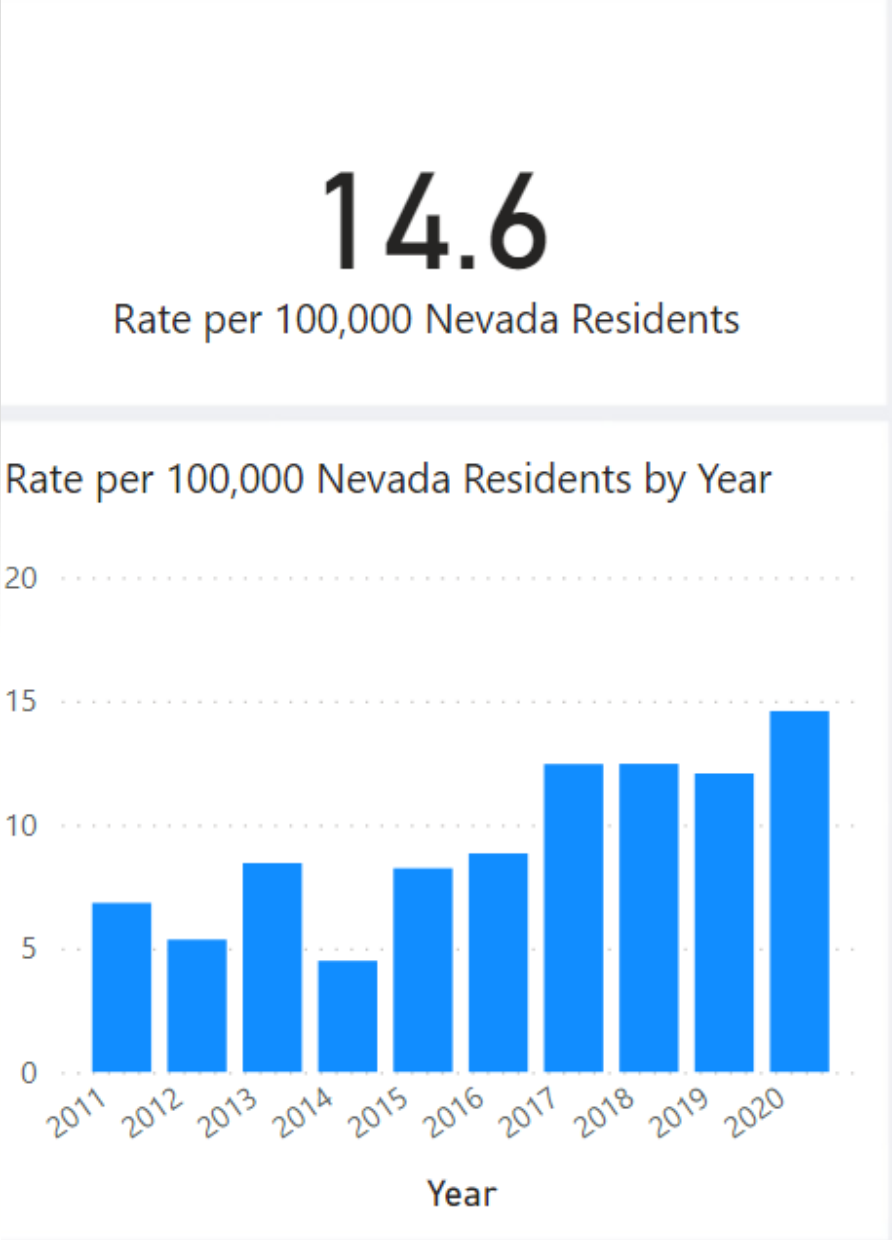
2020 Methamphetamine/Stimulant Related Emergency Department Visits: Age (per 100,000 Nevada Residents)



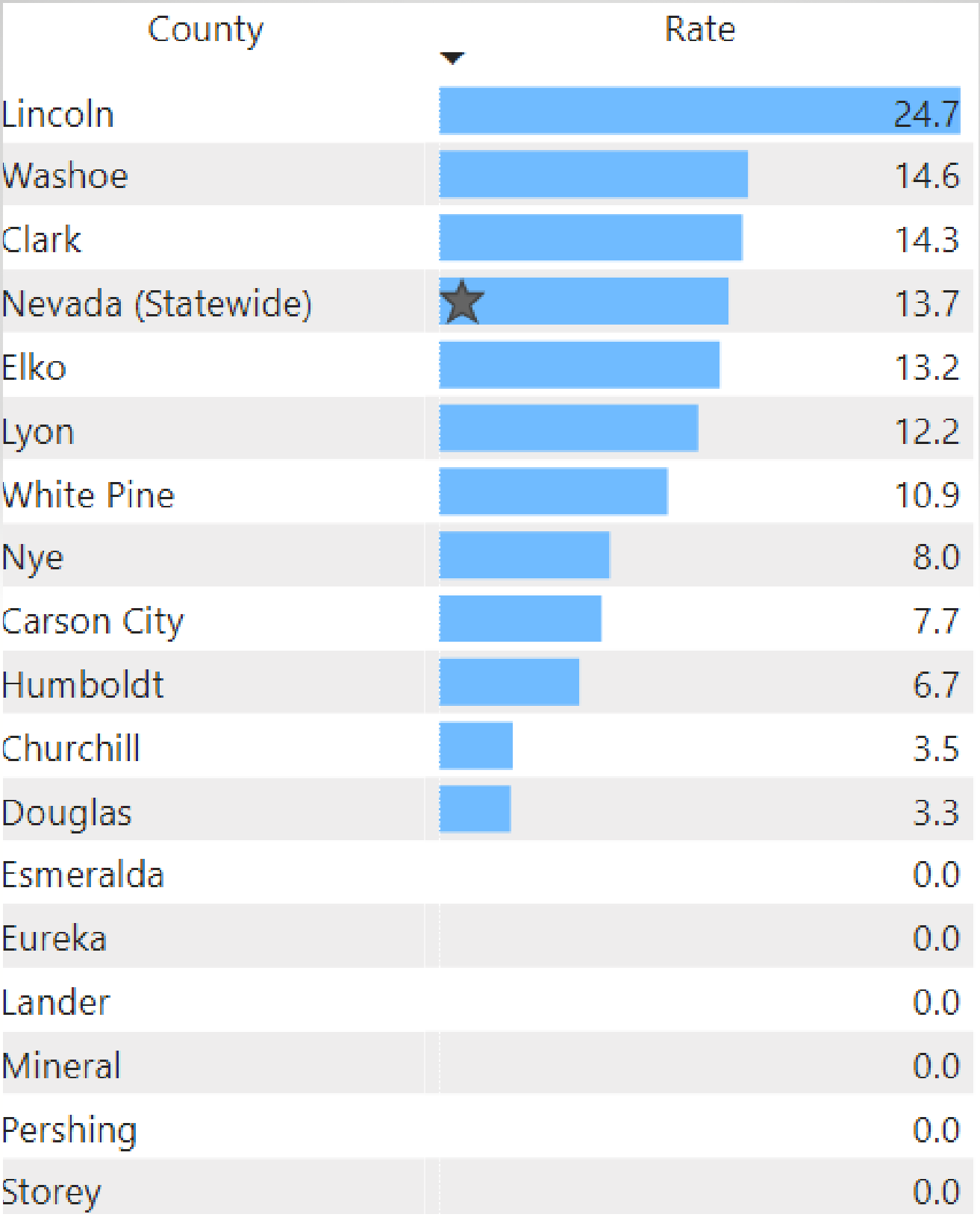
2020 Methamphetamine/Stimulant Related Emergency Department Visits: Race/Ethnicity (Per 100,000 Nevada Residents)



Methamphetamine Deaths

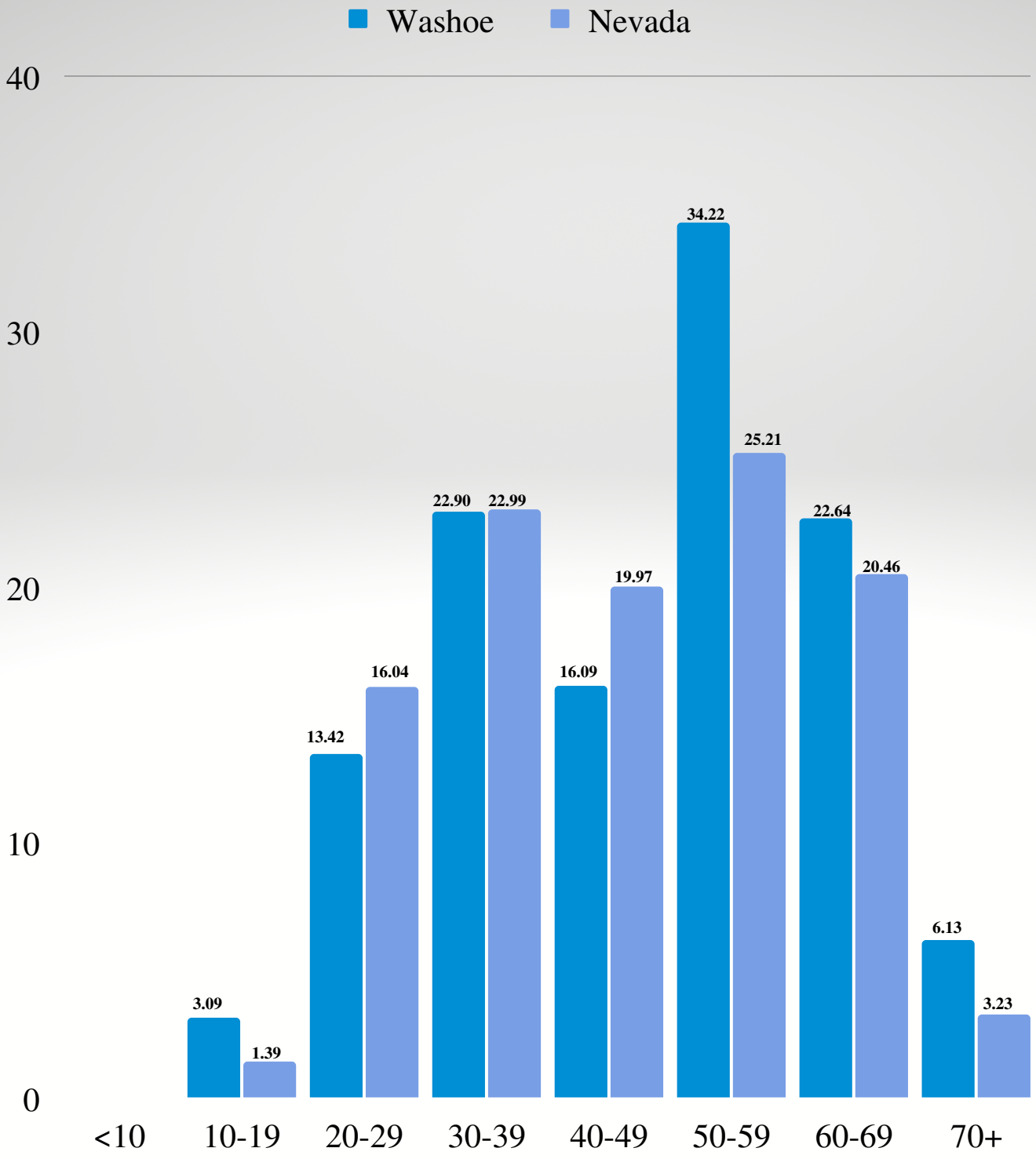


2020 Methamphetamine Deaths: County

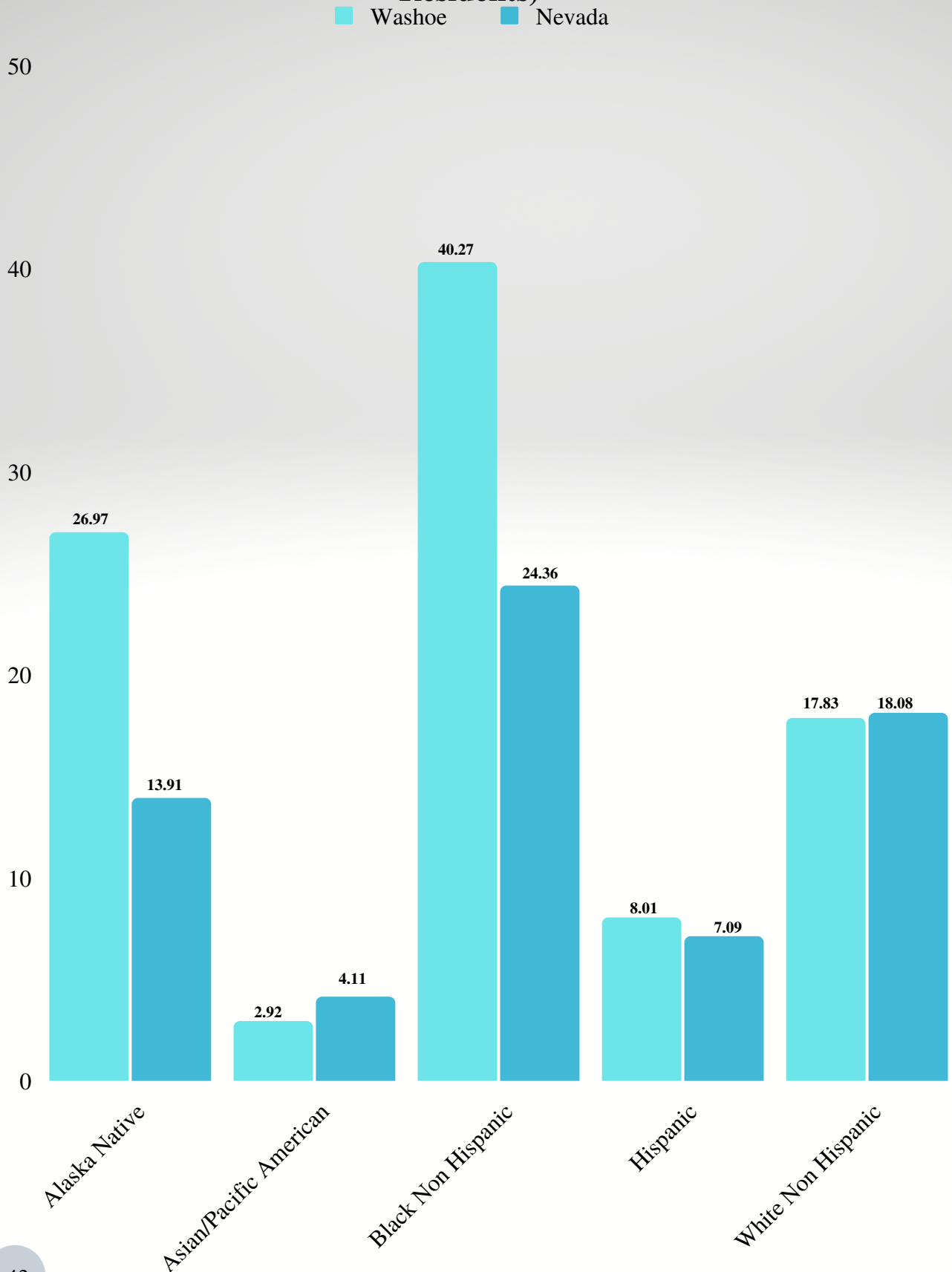


County	Rate
Lincoln	24.7
Washoe	14.6
Clark	14.3
Nevada (Statewide)	13.7
Elko	13.2
Lyon	12.2
White Pine	10.9
Nye	8.0
Carson City	7.7
Humboldt	6.7
Churchill	3.5
Douglas	3.3
Esmeralda	0.0
Eureka	0.0
Lander	0.0
Mineral	0.0
Pershing	0.0
Storey	0.0

2020 Methamphetamine Deaths: Age (Per 100,000 Nevada Residents



2020 Methamphetamine Deaths: Race/Ethnicity (Per 100,000 Nevada Residents)



Opioid Surveillance 2020/2021

- From 2010 to 2020, opioid-related emergency department (ED) encounters increased by 96%
- In terms of demographics, in 2021 the rate of opioid-related ED encounters was highest among Black Non-Hispanics at 234.2 per 100,000 Nevada residents.
- In 2021, Inpatient admissions were highest among White Non-Hispanics at 244.7 per 100,000 Nevada residents and were most prevalent among Nevada residents ages 24-34 (24%)
- From 2010 to 2020, the number of opioid-related overdose deaths increased by 24%
- In terms of demographics, in 2021 the rate of opioid-related overdose deaths wa highest among Black Non-Hispanics and 25-34 year old Nevada residents.
- Nevada has had 587 opioid-related suicide deaths between 2010 and 2020.

Source: Nevada State Office of Analytics; **County specific data not available**

Opioid-Related Overdose Deaths by Drug Category, Nevada Residents

Year	Heroin	Natural and Semi-Synthetic	Methadone	Synthetic Opioids	Unspecified Narcotic
2013	48	241	70	25	39
2014	61	218	63	32	37
2015	82	260	57	33	37
2016	87	235	53	53	29
2017	97	239	46	67	20
2018	106	212	33	83	11
2019	122	168	29	115	12
2020	127	215	30	276	9
2021	96	180	17	288	9

Opioid-Related Deaths, Nevada Residents

Race/Ethnicity	%	Crude Rates
Non-Hispanic American Indian or Alaska Native	0%	11.1
Non-Hispanic Asian/Pacific Islander	1%	3.1
Non-Hispanic Black	7%	22.7
Non-Hispanic White	33%	20.4
Hispanic	9%	9.0
Non-Hispanic Other Race	50%	
Unknown	0%	

Opioid-Related Deaths by Age, Nevada Residents

Year	0-14	15-24	25-34	35-44	45-54	55-64	65+
2013	0	33	76	65	112	80	30
2014	1	33	62	62	95	74	38
2015	3	31	81	75	97	94	38
2016	1	37	72	71	98	97	30
2017	0	40	73	75	103	77	43
2018	0	16	78	64	83	80	49
2019	1	34	71	76	76	75	41
2020	1	98	126	109	83	82	42
2021	1	63	125	100	83	67	49

Opioid-Related Deaths by Intent, Nevada Residents

Cause of Death	N	%
Accidents	4,390	86%
Assault (Homicide)	5	0%
Events Of Undetermined Intent	131	3%
Intentional Self-Harm (Suicide)	587	11%
Total	5,113	100%

XI. SUMMARY

The WRBHPB appreciates the opportunity to discuss current and future activities and values the participation of State legislators as well as State and County leadership in our joint pursuit of improving behavioral health for all Nevadans. The board emphasizes the importance of 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 serve with compassion, empathy, and perseverance for those who are dealing with behavioral health issues; encourage and participate in open communication and to research and encourage sound fiscal management with resources. It is important that we advocate for prevention services for all, for early identification and intervention for those at risk, integrated and efficient access to care and behavioral services for all with recovery as a goal. We believe that gathering and providing current data and information about disparities faced by individuals with mental health challenges/problems is a tool for change.

As behavioral health continues to emerge as a critical community concern across the nation, so too do the options for data resources. Statewide, there is some impressive and comprehensive research which makes the decision around inclusion in this report, challenging. As with most extensive data reports, the results are not always the most current year and often a year or two behind. This ensures the accuracy and fidelity to the data as it takes time to correlate but can sometimes present the impression of a report that is not "current". The data included in this report is the most current available in most subjects and has been selected to provide a picture of areas that emerge in Washoe County as notable. Certain state and national data are also included to provide comparison and trends. Additionally, in the interest of length, certain repetitive data from previous reports was omitted unless it was for annual comparison. There are a myriad of references and links for readers to access at the end of the report for further information. The intention of data analyses most often reflects correlation and not causation. Readers can clearly see trends and patterns but not necessarily explanations. It is the task of all of us to take the next steps in exploring causation and moving towards solutions. Data collection and review is the first step. We look forward to the completion of the Washoe County Behavioral Health Profile next year, when CDC has released 2020/2021 data.

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 and strategies proposed 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 Washoe County or 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.

This report is respectfully submitted to:

DHHS Commission on Behavioral Health

Cc: Chair, Legislative Committee on Health Care
Richard Whitley, Director, Nevada Department of Health and Human Services
Eric Brown, Washoe County Manager
Amber Howell, Director, Washoe County Health and Human Services
Members, Washoe Regional Behavioral Health Policy Board

APPENDIX A

References/Links

National Center for Education Statistics; NCES.ed.gov

National Alliance On Mental Illness (Nami); Mental Health By The Numbers:
Https://Www.Nami.Org/Learn-More/Mental-Health-By-The-Numbers

Nevada Legislature, 79th Session, Ab366:
Https://Www.Leg.State.Nv.Us/Session/79th2017/Bills/Ab/Ab366_En.Pdf

Nevada Legislature, 81st Session,
Sb69 Overview (State.Nv.Us)

State Strategies to Increase Diversity in the Behavioral Health Workforce - The National Academy for State Health Policy (nashp.org)

U.S. Department Of Health And Human Services Substance Abuse And Mental Health Services Administration (SAMHSA): Https://Www.Samhsa.Gov/About-Us/Who-We-Are

Washoe Regional Behavioral Health Policy Board Meetings And Presentations:
Http://Dpbh.Nv.Gov/Boards/Rbhpb/Board_Meetings/2018/Washoe_Regional/

Substance Abuse Prevention And Treatment Agency 2020 Epidemiologic Profile Washoe
Office Of Analytics - Data & Reports (Nv.Gov)

Washoe County Behavioral Health Profile (Board Meeting 3/8/21 Attachment):
Http://Dpbh.Nv.Gov/Boards/Rbhpb/Board_Meetings/2018/Washoe_Regional/

Nevada Office Of Suicide Prevention
Http://Suicideprevention.Nv.Gov/

Public Health Assessment And Wellness
Http://Washoe.Nv.Networkofcare.Org/Ph/Healthindicatorslist.Aspx?Cid=12

Washoe County Health District Community Health Improvement Plan.
Chip-2021-Final.Pdf (Washoecounty.Us)

Mental Health America 2022 State of Mental Health in America Report | Mental Health America (mhanational.org)
ttps://dhhs.nv.gov/Programs/Office_of_Analytics/DHHS_Office_of_Analytics/