UNMET SERVICE NEEDS AND CRITICAL GAPS

WITHIN NEVADA'S CURRENT SUBSTANCE ABUSE AND PREVNETION SYSTEM

FFY 2018-2019 Joint SABG MHBG Application

Substance Abuse Prevention and Treatment Block Grant

(SABG)

Plan and Report

DRAFT

Nevada

DEPARTMENT OF HEALTH & HUMAN SERVICES

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

BUREAU OF BEHAVIORAL HEALTH WELLNESS AND PREVENTION

Working Draft: 7/12/17

Introduction

Several documents and additional research were utilized to compile the following analysis of substance use disorder prevalence in the state of Nevada. It summarizes the key findings of the state's strengths, needs and priorities, taking into account specific populations required by the block grant. An appendix can be found at the end of this planning step for referral.

Both quantitative and qualitative data were used to develop the analysis. Data from multiple sources, including data systems, reports, town halls, and publications, were compiled to answer key questions about service availability, utilization, needs, and gaps, and recommendations. Informants include services providers, educators, consumers, family members of consumers, and other community members. It is important to note that this assessment does not meet federal standards as a comprehensive needs assessment as defined by CFR 96.133.

Overview

Nevada's population is growing and much of the data available indicates that more resources and better outcomes are needed for prevention and treatment of substance misuse. The current system of care appears overly reliant on emergency rooms and criminal justice settings to identify and engage individuals with substance and mental health needs. Additionally, wait lists for services are long within the state. Uncertainty about the Affordable Care Act (ACA) could impact already threatened provider groups struggling with workforce issues. Solutions are needed to provide access, expand the workforce, and support prevention, outreach, intervention, and effective treatment and recovery. Disproportionate representation of people with mental illness and substance issues in the criminal justice system points to lost opportunities to reach people early and intervene before additional adverse events impact their lives. Nevada's identified issues align well with SAMHSA's strategic initiatives. Several highlights are provided below, followed by a summary of what is working, needs and issues, emerging issues, and opportunities identified through the analysis.

Strategic Initiative #1: Prevention of Substance Abuse and Mental Illness

Focus on high risk populations - Key informants identified subpopulations that may have limited access and exposure to resources available for prevention and treatment. These include people speaking a language other than English, youth, and people that are lesbian, gay, bisexual, transgender and questioning (LGBTQ). Data shows that transition-age youth are particularly at risk for substance misuse in Nevada. The rate of older adults with dependence on opioids has also increased in recent years, pointing to the importance of surveillance to identify emerging populations and develop targeted prevention efforts.

Strategic Initiative #2: Health Care and Health Systems Integration

Integrate behavioral health with health promotion and health care delivery - Continued attention and work to collaborate across behavioral health systems is important to achieve the long-term goal of successful integration. Data from the analysis suggests that stronger support for people with co-occurring disorders should be a priority in Nevada. Cross-sector training and education are also promising approaches to better align and integrate best practices throughout Nevada.

Strategic Initiative #3: Trauma and Justice

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Reduce the involvement of individuals with trauma and behavioral health issues in the criminal and juvenile justice systems - Data from the analysis suggests considerable gains are possible through attention to trauma. The state is engaged in several innovative programs around the justice system, which may shed light on additional needs and opportunities. Work through local corrections (jails) and hospitals is an important short-term strategy to address the current situation. It is important to strengthen behavioral health systems so that people are interfacing with appropriate treatment and care. Finally, 'upstream' prevention efforts, for example focusing on reducing adverse childhood experiences and the impact of community trauma, can play an important role in addressing the root causes of some mental health and substance use disorders.

Strategic Initiative #4: Person-centered Planning and Recovery Supports

Partner with people in recovery from mental and substance use disorders and their family members to guide the behavioral health systems and promote individual, program, and system-level approaches that foster health and resilience - Assistance with navigation and advocacy were identified as important workforce needs. Families and peers, with training and support, are an under-utilized asset. Housing and transportation are two important needs that were identified as barriers to treatment, treatment outcomes, or both. Several specific services, such as residential treatment, were identified as inadequate to meet community demand. Wraparound or continuum-of-care approaches were identified as solutions to improve outcomes for those with complex needs.

Strategic Initiative #5: Health Information Technology

Ensure that the behavioral health systems, including community providers, patients, peers, and prevention specialists can fully participate with the healthcare delivery system in the adoption of health information technology (Health IT). Nevada has made many advancements in this regard, including expansion of electronic health records and improvements to data systems. Development of specific data, enhanced communication between state and community groups, and enhanced capacity to analyze and use data to improve outcomes, were key themes identified through this analysis.

Strategic Initiative #6: Workforce Development

Support active strategies to strengthen and expand the behavioral health workforce - Nevada continues to face shortages of providers. Continued efforts to address reciprocity, compensation, and training/licensure issues are needed. Other opportunities include leveraging the planning and activities that are taking place at the state to address issues of reimbursement and payment for providers.

Limitations

Information presented in this document was intended to inform planning. For each data source, there are limitations. Caution should be used when interpreting data from a single source, as various factors can contribute to the result. Data from multiple sources is presented when possible to provide a more complete picture of the current situation. Limitations that particularly effect the interpretation and presentation of a data set are noted within the document. These may include (but are not limited to):

• Some data are preliminary, particularly estimates for 2015.

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- MyAvatar, a Netsmart product, is a database containing demographic, treatment, billing, and financial information for Nevada mental health facilities throughout the state of Nevada. This data is representative of Nevada state funded mental health facilities and is not generalizable to the rest of the population.

• Some methods limit comparability of data across geography. For example, differences in consent models for the YRBS should be considered in comparing geographies as well as understanding overall rates presented.

• Reports from state data systems typically collect and compile information for a particular purpose and may not be comprehensive. For example, substance abuse information provided from state systems reflects state-funded programs and services, and not all seeking or using services across the state.

• Data that require self-reporting may include bias due to inaccurate recall, fear, or stigma related to reporting accurately, etc. A related issue is that while the actual demand for services isn't known, not all who meet the criteria for treatment services may be interested in receiving them. Experts note that strategies to reduce this treatment gap should focus not only on increasing access to effective treatment but on reducing stigma, raising awareness, and providing appropriate screening and referrals (National Institute on Drug Abuse, n.d.).

• Changes to International Classification of Diseases (ICD) codes from year to year can impact comparability through time. For example, in 2015, providers migrated from the use of ICD-9 to ICD-10. ICD-10 codes for substance abuse are more comprehensive than the previous version; however, their use only became mandatory in October of 2015 (APA Practice Organization, 2017). Data sources Center for Health Information Analysis (CHIA) as well as other sources may include this limitation.

• Town Hall meetings were largely made up of professionals representing consumers, rather than by consumers and their families.

• The assessment is not comprehensive and does not constitute an adequate needs assessment as required by CFR 96.133. While efforts were made to compile data from many sources the following data were not available:

o Waiting list data

o A detailed description of current prevention and treatment activities

o Treatment capacity data

o Incidence and prevalence data as they relate to:

▪ Pregnant women with substance use disorder

▪ Women with substance use disorder who have dependent children

▪ Intravenous drug users

▪ People with substance use disorders who have HIV or tuberculosis

o Prevention activities by strategy

o The availability of prevention and treatment activities, with special attention to the following groups:

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▪ Pregnant women with substance use disorder

▪ Women with substance use disorder who have dependent children

▪ Intravenous drug users

▪ People with substance use disorders who have HIV or tuberculosis

o A description of the populations at risk of becoming substance users

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What's Working Well	Examples and Support for Finding
Improvements to Nevada's Behavioral Health System	Nevada has successfully applied for a number of grants that are helping to improve behavioral health systems. For example, Certified Community Behavioral Health Clinics (CCBHC) will expand resources available within the state. Other programs like Community Health Workers provide an example of a grant-funded resource that helped connect hard-to-reach populations with resources. Interviewees for this report recognized progress toward a recovery-oriented system of care, including integration, inclusion, and person-centered care.
Use of Evidence-Based Practices (EBP)	Many systems and organizations use EBP. There is interest in continuing or strengthening existing models and practices and promoting training so more people can benefit across systems and settings.
Local Coordination for Prevention	Coalitions are locally driven and relevant within their communities. They provide information about emerging issues across providers, systems, and geographies. Coalitions that have successfully engaged local youth and school districts have high quality prevention efforts in their communities.
Substance Misuse Decreasing for Many Substances and Populations	Data from surveys (e.g. National Survey on Drug Use and Health or "NSDUH" and Youth Risk Behavior Survey or "YRBS") show that for many substances and among many populations, Nevada's rates of misuse are decreasing. Significant decreases in use were observed among high school youth between 2013 and 2015 for 'ever smoking cigarettes,' 'currently used tobacco,' 'drank first alcohol before 13,' 'ever used cocaine,' 'ever used inhalants,' 'ever used methamphetamine,' 'ever used [methylenedioxy-methamphetamine, known as] MDMA, 'and 'ever used synthetic marijuana.'
Insurance Coverage	Since Medicaid expansion in Nevada in 2013, the rate of people covered by Medicaid has increased dramatically, providing a source of insurance. Further, the Mental Health Parity Addiction Equity Act has helped to ensure people get the treatment they need. SAPTA is in the process of revising policies to provide treatment by functioning as a safety-net for claims that are denied by Medicaid.
State-level Improvements	Administrative longevity and restructuring has started to improve the operations at the state level, including improvements to the certification system.

Issues and Challenges	*Examples and Support for Finding*
System Challenges	➢ Emergency rooms have shown dramatic increases for behavioral health needs in recent years. Key informants also identified that jails are in contact with more people for behavioral health issues. The reasons are not fully clear. Some believe that access to insurance has driven these increases. Others are concerned that the shift to community-based providers has resulted in new access gaps. ➢ Services aren't well-known within the community. Online resource directories are not always up to date. Even when people know of services, they often need help navigating and advocating for services. This includes people seeking care for the first time, exiting institutions, and transitioning from treatment. Transitions from higher to lower levels of treatment were identified by key informants as contributing to higher rates of relapse and higher costs due to recurring need for more intensive services. Besides affecting community members, this information gap also affects providers' ability to refer. ➢ Rates of diagnosis and treatment for co-occurring disorders are lower in Nevada compared to the rest of nation. Integrated care is a best practice, and differences between Nevada and the nation for diagnosis and treatment point to the potential for improvement in this area. ➢ There are long wait times for people seeking services within their communities. A lack of services to meet demand, especially residential programs, was noted as a key challenge across the state. ➢ Providers struggle to collaborate to provide the best care to community members, and seek to better understand resources that are available and reliable within their community to improve collaboration. ➢ Compliance with federal block grant requirements and federal and state regulations is lacking. Examples given include the lack of outreach to intravenous drug users (IVDU), the lack of a capacity management system, the lack of a needs assessment that meets federal requirements, and insufficient referrals to pregnant women, among others. ➢ There is a struggle to align across state systems, divisions, and bureaus. Additionally, a lack of institutional knowledge and lack of subject matter expertise create barriers for providers and prevention professionals to effectively interact with the state.

Issues and Challenges	*Examples and Support for Finding*
Substance Misuse Is Elevated for Many Substances and Populations	➢ Rates of substance misuse including dependency are higher among many populations within Nevada compared to the nation. ➢ Survey data shows that many people needing treatment do not get the care they need. ➢ Admissions for substance abuse treatment in Nevada in 2014 were for a variety of substances including alcohol, methamphetamines, heroin, marijuana/hashish, and other opiates/synthetic opiates. ➢ Hundreds of Nevadans die each year from drug and alcohol related illness and injury.
Workforce Shortages	➢ A lack of providers across the state contributes to people needing services and not receiving them. This is a challenge for both consumers and providers. ➢ Compensation for licensed professionals was identified as inadequate to attract and retain the workforce at the level needed. Additionally, professionals, especially in rural areas, experience a high level of 'burnout.' ➢ While many grants have been successfully obtained, these programs, (e.g. Community Case Managers funded through Cooperative Agreement to Benefit Homeless Individuals or "CABHI") will end when grant funding ends. Resources to sustainably build and fund the workforce is lacking. ➢ Funding for case managers and other positions in corrections and state systems has been limited, but these professionals are important to making systems more effective and navigable. ➢ More outreach and services are needed in languages other than English and that are culturally competent. ➢ Many people with behavioral health problems are found in local jails. Education and resources on substance abuse treatment and recovery is important for those professionals working in jails. ➢ Training is needed for people that regularly encounter substance misuse, including nurses, first responders, and other professionals. They may not recognize the signs and symptoms, know how to treat an overdose, or to whom they should refer.

Issues and Challenges	*Examples and Support for Finding*
Service Gaps	➡ People needing support for substance use may also have other major unmet needs including housing and transportation. These issues impact their ability to access and have successful outcomes from treatment and for recovery. ➡ Insurance requirements can create problems with continuity of care and individualization of care. ➡ It is difficult to provide the appropriate level of care to individuals seeking help at any point from early intervention to appropriate treatment to recovery services. There are basic barriers to entry into the system, like having an address and transportation issues that prevent people from getting to the care they need. Additionally, services are sometimes simply unavailable. For example, youth whose parents are in treatment require supports and would benefit from early intervention and prevention services.
Data Issues	➡ Data systems are imperfect, and there are still gaps in terms of data available for prevention, planning, and treatment. This includes coordination for individuals (e.g. case management systems), surveillance data (e.g. waiting lists for treatment and recovery), comparable data across communities, and support for monitoring and evaluation. ➡ Data on treatment and recovery is also in need of development (or made more accessible) to answer questions about the use of evidence-based practices, person-centered care, etc. ➡ Some data requests are often duplicative or not coordinated. For providers, this results in time lost that could be spent with clients. For prevention, this limits responsiveness to emerging situations. ➡ For funded providers throughout the state, enhanced two-way communication with the state would support data, evaluation, reporting, and funding.

Threats and Emerging Issues	***Examples and Support for Finding***
Policy Changes	➢ The ACA has contributed many improvements to Nevada's system for care. Loss of the ACA without a replacement could have major consequences for programs that have been planned and developed leveraging provisions of the ACA. ➢ Legalization of marijuana, both medical and recreational, may have an impact on behavioral health and substance misuse in the state.
Emerging Substance Issues	➢ Substance misuse has increased among specific populations including youth, pregnant women, and older adults. ➢ Vaping and e-cigarettes have emerged among youth populations as a new issue. Rates of marijuana use also increased between 2013 and 2015. More than one in 10 middle school youth reported currently drinking alcohol, and 3.8% reported currently using marijuana. ➢ Several concerning patterns of misuse that mirror national trends include increased opioid addiction and children born with Neonatal Abstinence Syndrome (NAS). The severe consequences of opioid misuse have made it a priority for Nevada.
Funding	➢ Many key informants are concerned that funding is not adequate to address and sustain system needs in Nevada. ➢ Information about funding opportunities and assistance to seek these opportunities are unavailable in a timely manner.

Opportunities	***Examples and Support for Finding***
Engage in Effective Planning	➢ Many states are innovating, including Nevada. Nevada can learn from other states' efforts to improve policies, systems, and practices toward improved behavioral health outcomes. ➢ The strategic prevention framework, public health model, and collective impact framework can be leveraged to strengthen Nevada's planning efforts. ➢ Continued integration of substance outreach, prevention, intervention, treatment, and recovery with mental health provides an opportunity to better serve Nevadans.

Opportunities	***Examples and Support for Finding***
Build Sustainability	➢ Outreach indicated a willingness by providers to work with limited resources and collaborate to better serve communities. The state can help to increase this capacity by enhancing transparency related to funding that would allow for a clearer picture of the funding available and the identification of effective collaborations. ➢ Sustainability planning for programs and services provides an opportunity to stabilize systems. ➢ The work of other planning processes, for example Olmstead Planning and *Nevada's No Wrong Door,* can be leveraged to support better outcomes for people seeking services. Additionally, there are existing collaborative processes and systems (e.g., among the coalitions, Nevada 2-1-1, etc.) that could be leveraged and built upon.
Enhance Communication, Relationships, and Collaboration	➢ SAPTA could serve as the high-level coordinator of services and oversight, working to integrate and consolidate community services and improve access to the system. Data is an important tool for communication, and the state can work to improve existing data collection systems, enhance capacity to report on both services provided and service outcomes, and strengthen two-way communication with local and regional partners. ➢ Improvements to functionality and better coordination of advisory boards holds the potential to improve communication and transparency. ➢ There are many opportunities for the state to work more closely and collaboratively within communities. ➢ Providers' collaboration could be incentivized. Additionally, it could be facilitated with better information (e.g., a comprehensive directory of providers) and formal opportunities to work together toward shared goals.
Regional and Local Control	➢ Town Hall participants and key informants indicated that a "one size fits all" approach may not take into account the distinct needs of different communities. There may be an opportunity to create greater regional and local control. Doing so would allow communities to better address the needs of specific populations and geographies, assist with training the workforce, and develop effective programs.

Opportunities	Examples and Support for Finding
Develop the Workforce	➡ Cross-systems expertise can increase training and educational opportunities. Educational institutions can be engaged to create better programs, the use of "force multipliers" (e.g., first responders, law enforcement, etc.) can be increased, and masters-level providers can supervise workers with less education to better meet demand.
Expand Knowledge and Practice of Effective Services	➡ Key informants identified many practices that hold promise for improved outcomes, including: ▪ Targeted outreach and messaging for prevention ▪ Assistance with navigation and coordination for services ▪ Interventions that utilize family members and peer support ▪ Medication-assisted treatment (MAT), including walk-in clinics ▪ Trauma–informed approaches to care ▪ Cognitive behavioral therapy and related practices ▪ Best practices for working with people recovering from opioid addiction ▪ Supportive transitions through a continuum of treatment services ➡ Providers are very interested in learning more and using the best tools. SAPTA can help to support widespread use of effective practices and a shared vocabulary, helping to ensure training and support by reducing financial and geographic barriers.

Statewide Needs

A 2015 needs assessment of behavioral health identified consumers' barriers to accessing care through both surveys and focus groups. In the statewide survey of providers, five populations were identified as having high need for substance abuse services:

- Adolescents with substance abuse and/or mental health problems
- Parents with substance use and/or mental disorders who have dependent children
- Individuals with substance abuse disorders in rural areas
- Women who are pregnant and have a substance use and/or mental disorder
- Unaccompanied minor children and youth

Barriers Identified:

- Cost
- Lack of knowledge of resources

• Lack of transportation

• Lack of insurance coverage

• Lack of available providers

• Long wait lists

• Fear

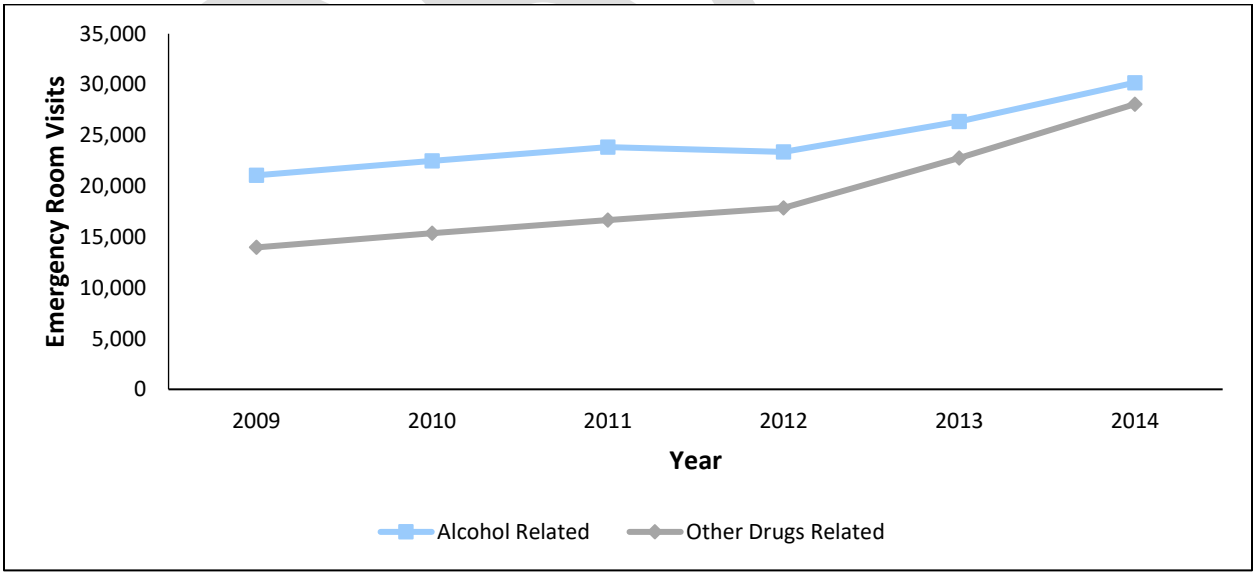
• Lack of knowledge of resources

• Stigma

• Perception that treatment wouldn't help • People that are undocumented are not able or willing to seek help for fear of being deported

One of the many issues identified is that the needs for behavioral health care cannot be met through current resources (State of Nevada, 2016). Lack of access to community-based crisis services contributes to high rates of utilization of emergency room (ER) services for behavioral health needs within both fee-for-service (FFS) and managed care Medicaid. The most common primary diagnoses in individuals treated in the ER for behavioral health needs in 2015 included non-dependent abuse of substances, alcohol abuse and/or intoxication, anxiety disorders, mood disorders, suicidal ideation, and psychotic disorders. ER visits related to alcohol and other drug use from 2009 to 2014. Alcohol-related visits increased from 21,063 visits in 2009 to 30,180 visits in 2014, a 43% increase. Visits related to other drugs followed the same trend, with a low of 13,969 visits in 2009 to a high of 28,065 visits in 2014, a 101% increase.

Alcohol and Other Drug Related Emergency Room Visits, Nevada Residents, 2009-2014.



Demographics of Substance Related Emergency Room Visits, Nevada Residents, 2009-2014.

	Alcohol-Related		Other Substance - Related	
	N	Column %	N	Column %
Sex				
Female	45,230	30.7	52,040	45.4
Male	102,078	69.3	62,645	54.6
Race				
White	98,291	66.7	74,686	65.1
Native American	4,409	3.0	1,790	1.6
Hispanic	18,033	12.2	12,566	11.0
Asian/Pacific	2,231	1.5	1,724	1.5
Black	14,937	10.1	17,862	15.6
Other	5,341	3.6	3,921	3.4
Unknown	4,072	2.8	2,140	1.9
Age				
0-14	514	0.3	2,217	1.9
15-24	15,437	10.5	23,250	20.3
25-34	25,137	17.1	30,144	26.3
35-44	29,287	19.9	23,212	20.2
45-54	42,420	28.8	21,411	18.7
55-64	24,248	16.5	10,519	9.2
65-74	7,824	5.3	2,879	2.5
75-84	1,913	1.3	757	0.7
85+	518	0.4	299	0.3

Payer Distribution of Mental Health and Substance Use Related Emergency Room Visits by Residence Status, 2009-2014.

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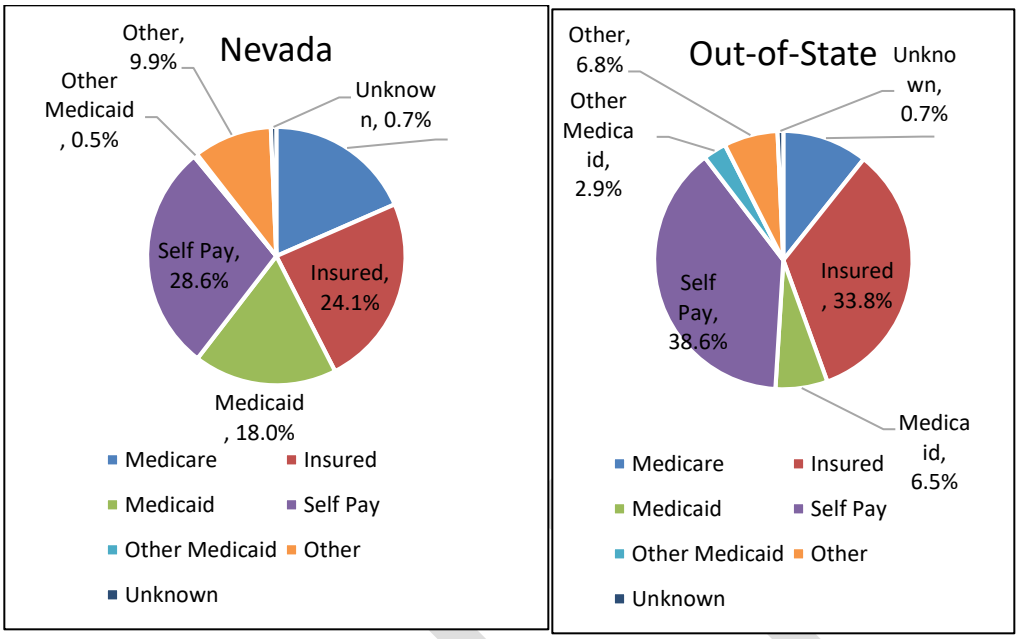

Source: Division of Public and Behavioral Health, Hospital Emergency Room Discharge

Payer was consolidated into the following format:

- Medicare: Medicare, Medicare HMO
- Insured: CHAMPUS OR CHAMVA, Commercial Insurer, Negotiated Discounts e.g. PPO, HMO, All Workers Compensation
- Medicaid: Nevada Medicaid, Nevada Medicaid HMO
- Self-Pay: Self Pay
- Other Medicaid: Out of State Medicaid
- Other: Charity, Miscellaneous, County Indigent Referral
- Unknown: Unknown, Blank

A majority of mental health and substance-related ER visits for Nevada residents was paid by Self-pay (29%), followed by "Insured" (24%), Medicare (18%), and Medicaid (18%).

Substance Use Disorder Prevalence/Treatment

The data in this section is reflective of services received by Nevada residents at treatment facilities funded by SAPTA. This is not a comprehensive accounting of all Nevada residents who receive substance use treatment. The data are based on admissions, not patients; therefore a single person may represent multiple admissions.

Top Primary Substances of Admissions to Nevada Substance Abuse Treatment Facilities, Nevada Residents, 2014.

Rank	Substance	Percent

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1	Alcohol	35.0
2	Amphetamines/Methamphetamines	28.4
3	Marijuana/Hashish	13.4
4	Heroin	12.4
5	Other Opiates/Synthetic Opiates	5.8

Source: Division of Public and Behavioral Health, Nevada Health Information Provider Performance System

Of the Nevada residents who received substance abuse treatment services from a SAPTA provider in 2014, alcohol was the most common substance abused (35.0%), followed by amphetamines/methamphetamines (28.4%), marijuana (13.4%), and heroin and other opiates (12.4% and 5.8% respectively).

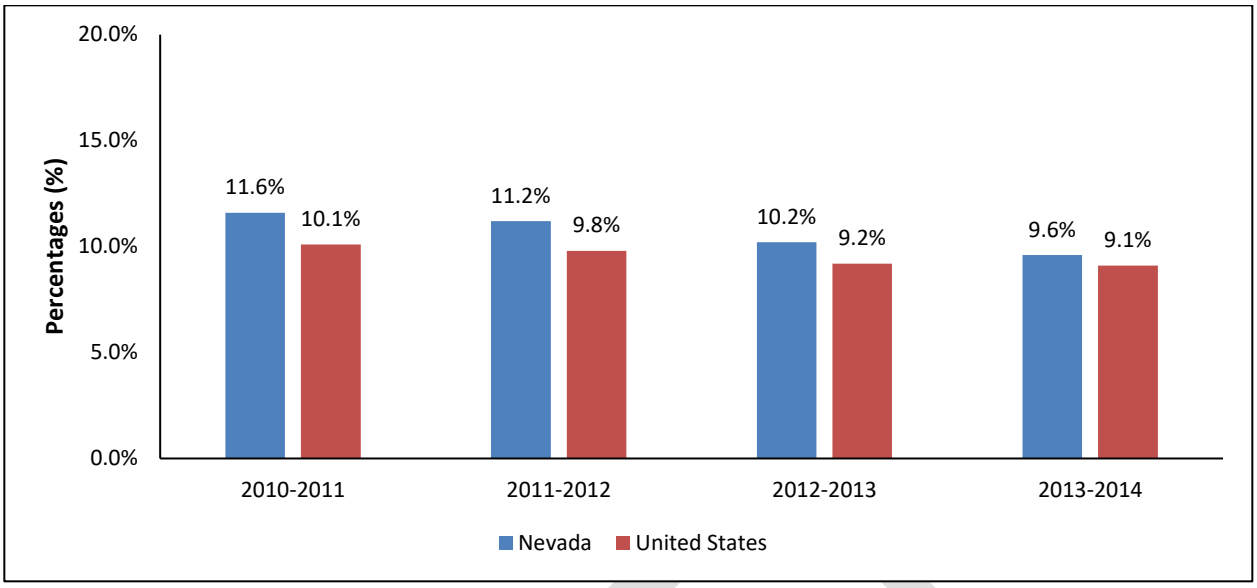
It is highly important to ensure that appropriate detoxification services are provided to persons who are under the influence of a substance. Many of the substances will cause withdrawal that can range from anxiety, hallucinations, seizures or even death.

Demographics of Unduplicated Persons in Nevada State Funded Substance Abuse Treatment Facilities, SFY 2011-2015.

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015
Sex					
Male	5,659	6,688	6,662	4,660	5,677
Female	2,912	3,834	3,974	2,853	3,788
Pregnant Woman	133	190	192	139	190
Age					
0-17	928	1,060	1,038	574	605
18-24	1,788	2,189	2,176	1,384	1,632
25-44	3,845	4,832	5,100	3,787	5,048
45-64	1,950	2,366	2,236	1,705	2,119
65+	60	75	86	63	61
Race/Ethnicity					
White	5,790	7,074	7,208	5,064	6,625
Black or African American	1,021	1,191	1,135	845	1,005
Native Hawaiian/Other Pacific Islander	66	75	99	63	91
Asian	64	111	107	56	68
American Indian/Alaska Native	222	280	274	221	272
Multiple	383	481	521	347	391
Unknown	1,025	1,310	1,292	917	1,013
Total	**8,571**	**10,522**	**10,636**	**7,513**	**9,465**

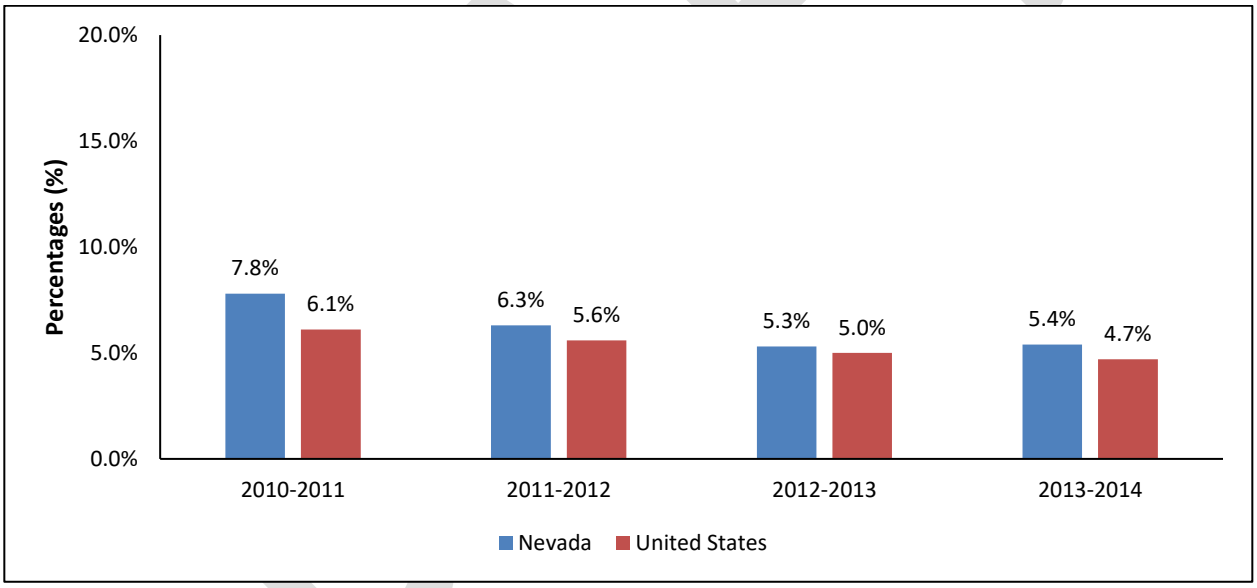
Source: SAMHSA Block Grants, WebBGAS

Past Month Illicit Drug Use Among Adolescents Aged 12-17 in Nevada and the United States, 2010-2011 to 2013-2014.



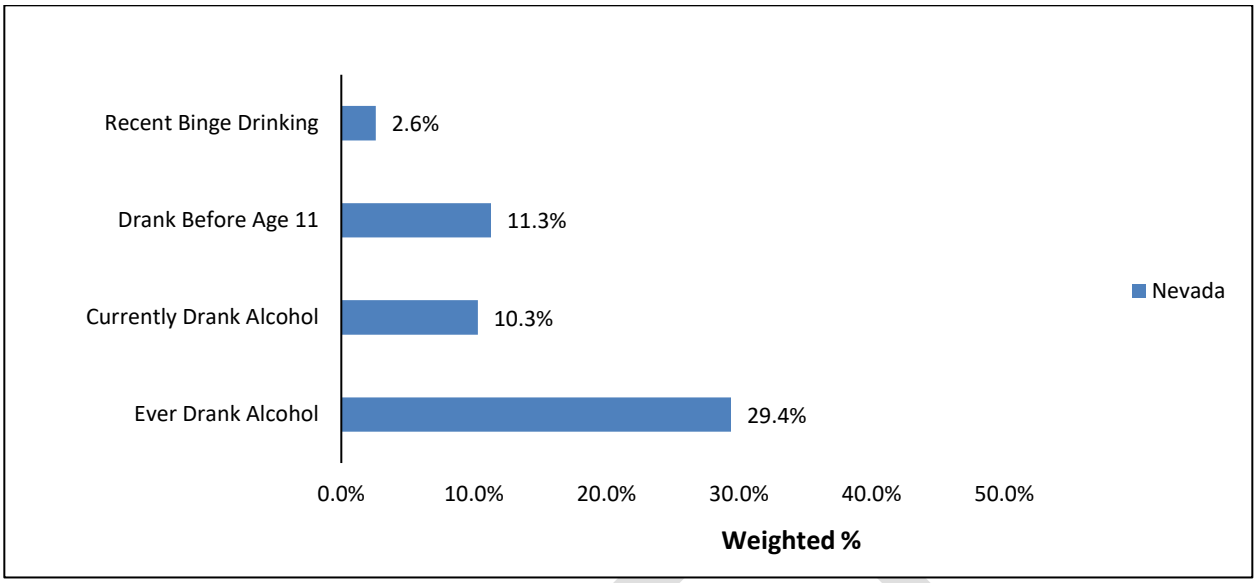
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2010-2011 to 2013-2014.

Past Year Nonmedical Use of Pain Relievers Among Adolescents Aged 12-17 in Nevada and the United States 2010-2011 to 2013-2014.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2010-2011 to 2013-2014.

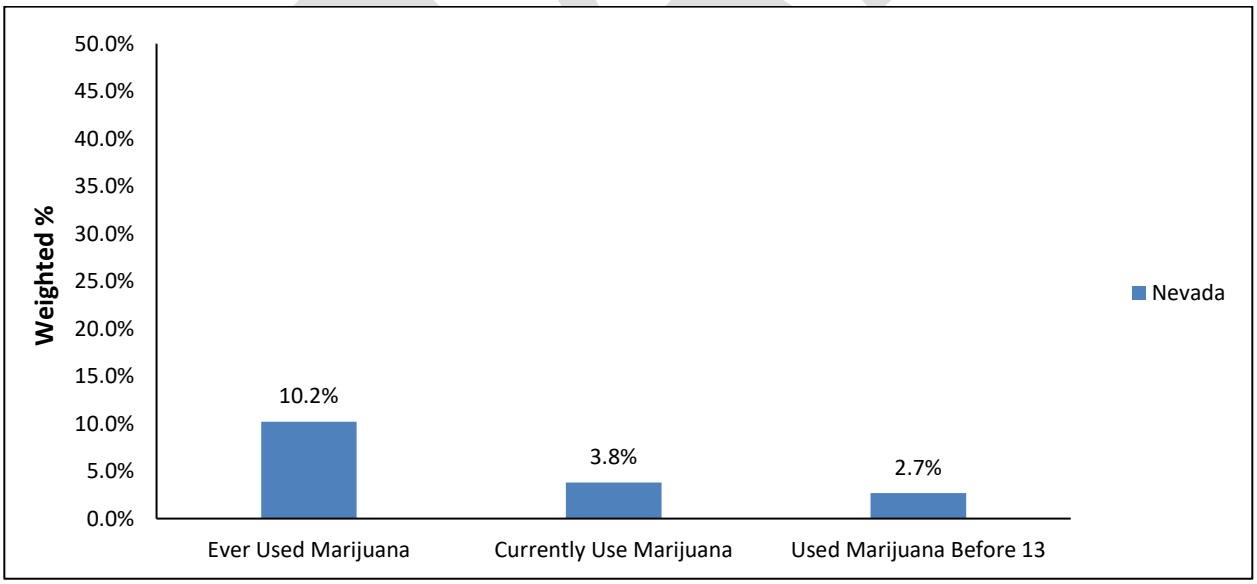
Alcohol Use Summary, Nevada Middle School Students, 2015



Source: Division of Public and Behavioral Health, Nevada Youth Risk Behavior Survey (YRBS)

Approximately one third (29.4%) of middle school students in Nevada have had at least one drink of alcohol (more than a few sips). About 10% of middle school students currently drink. About 11% of Nevada middle school students had alcohol before the age of 11 years, and over 2% of students had a recent binge drinking experience (had at least 5 drinks in a couple of hours in the past 30 days).

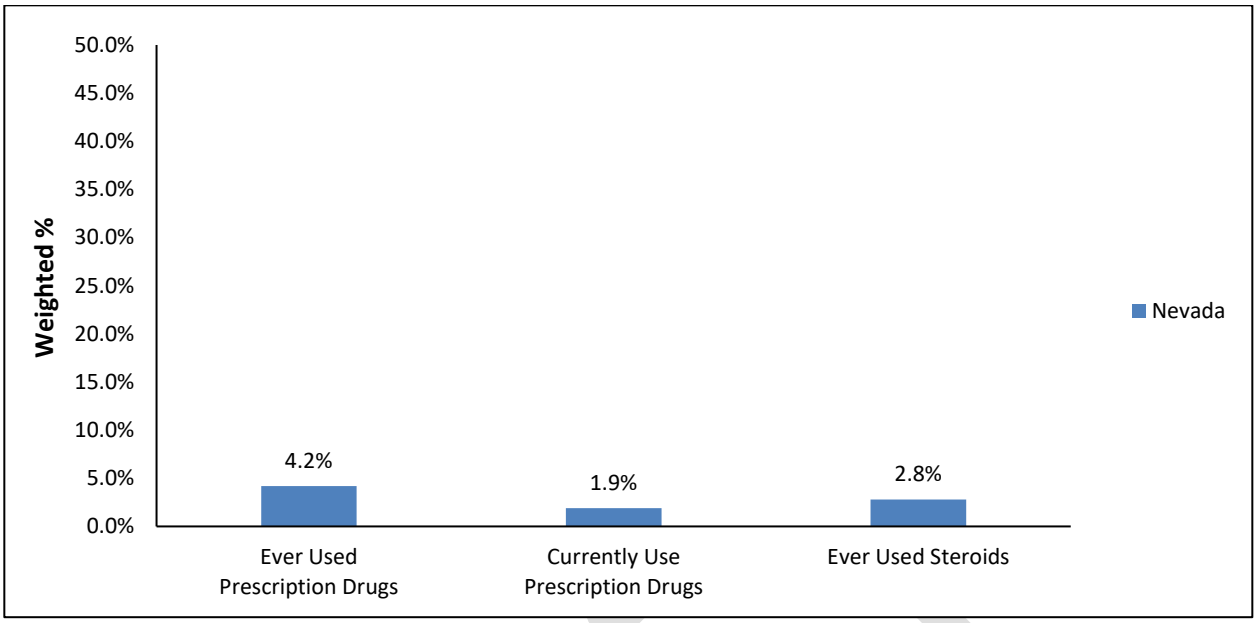
Marijuana Use Summary, Nevada Middle School Students, 2015



Source: Division of Public and Behavioral Health, Nevada Youth Risk Behavior Survey (YRBS)

Approximately 10% of middle school students in Nevada reported trying marijuana, and 4% have used marijuana in the past 30 days. Approximately 3% of middle school students have tried marijuana before the age of 11 years.

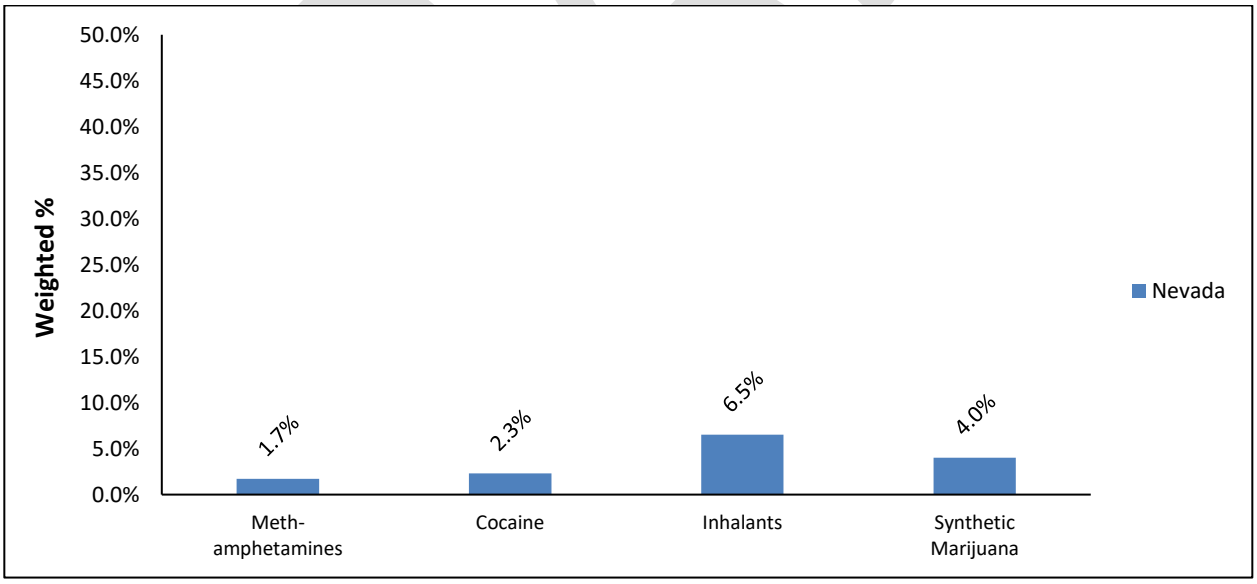
Nonprescription Substance Use Summary, Nevada Middle School Students, 2015



Source: Division of Public and Behavioral Health, Nevada Youth Risk Behavior Survey (YRBS)

Approximately 4% of middle school students in Nevada have already tried prescription drugs that were not prescribed to them in their lifetime, while about 2% of students have used them in the past 30 days. About 3% have tried non-prescribed steroids.

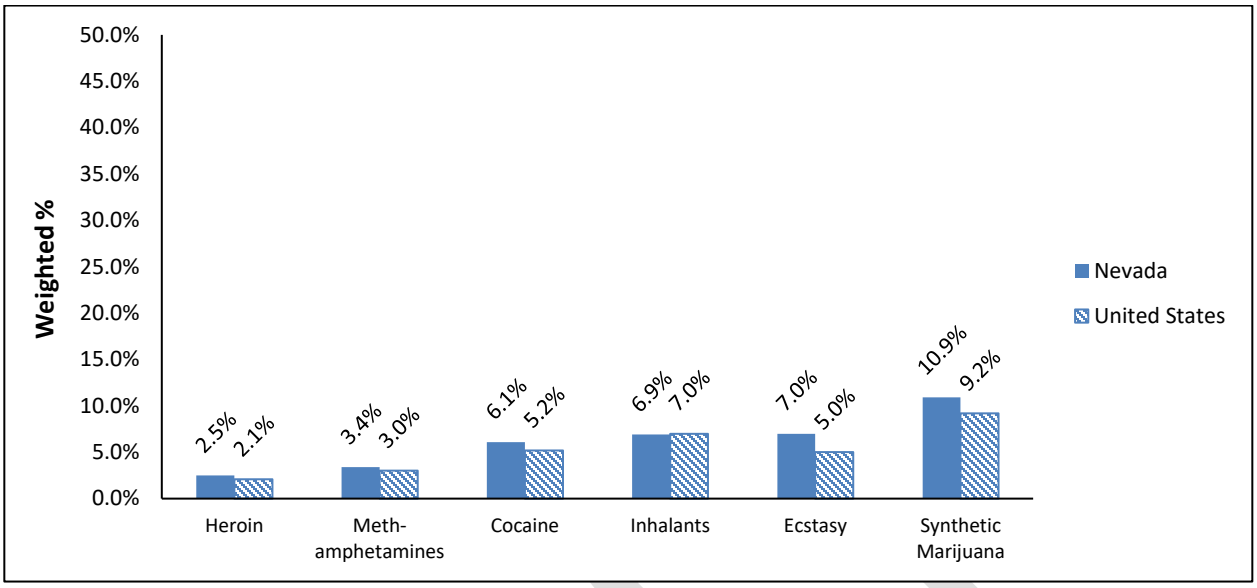
Lifetime Drug Use Summary, Nevada Middle School Students, 2015



Source: Division of Public and Behavioral Health, Nevada Youth Risk Behavior Survey (YRBS)

In terms of substance abuse among middle school students in Nevada, nearly 7% have used inhalants, the highest percentage of the select substances. About 2% of students have used cocaine, 2% have used methamphetamines, and 4% have used synthetic marijuana.

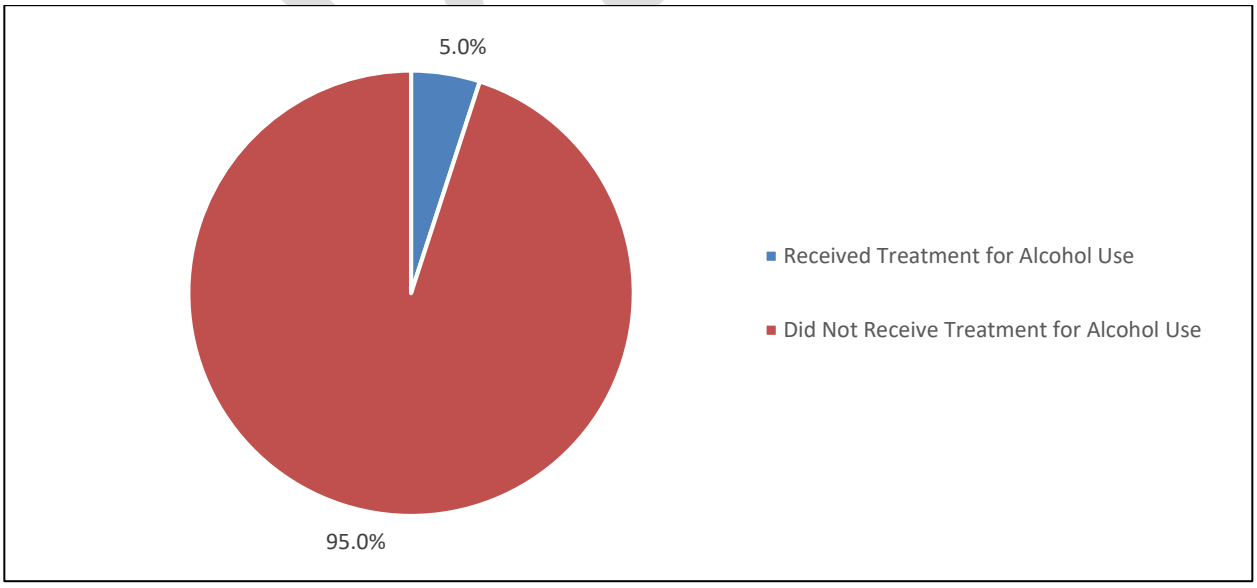
Lifetime Drug Use Summary, Nevada High School Students, 2015



Source: Division of Public and Behavioral Health, Nevada Youth Risk Behavior Survey (YRBS)

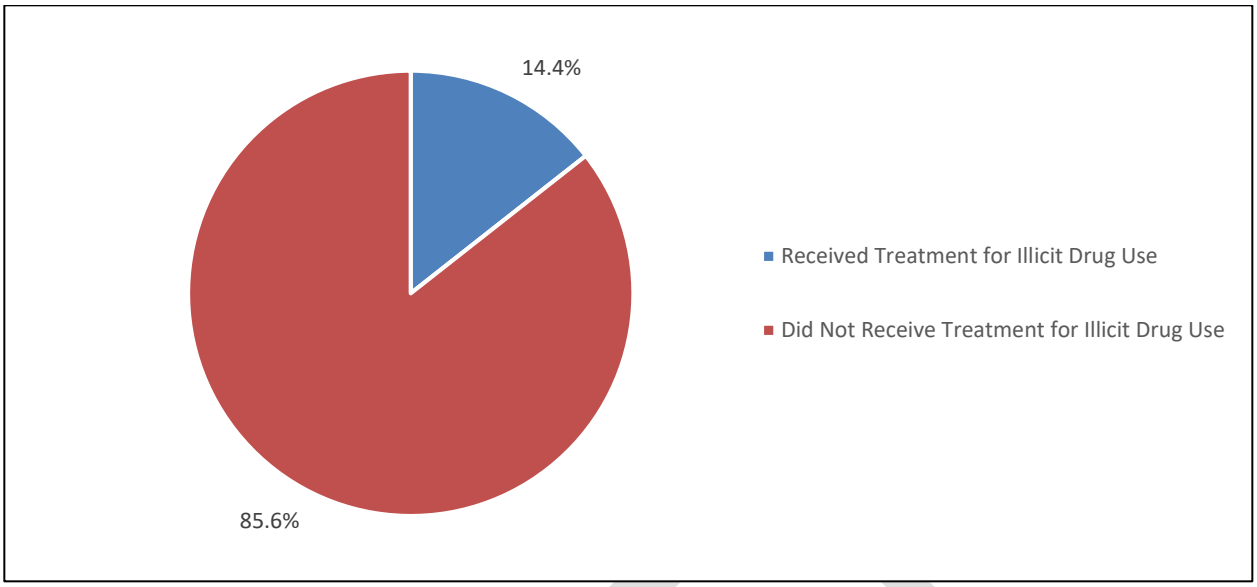
In terms of substance abuse among high school students in Nevada, nearly 11% have used synthetic marijuana, the highest percentage of the select substances. About 7% have taken ecstasy, and 7% of students have tried inhalants. About 6% of students have used cocaine, 3% have used methamphetamines, and almost 3% have used heroin.

Past Year Treatment for Alcohol Use Among Individuals Aged 12 or Older with Alcohol Dependence or Abuse in Nevada, 2010-2014.



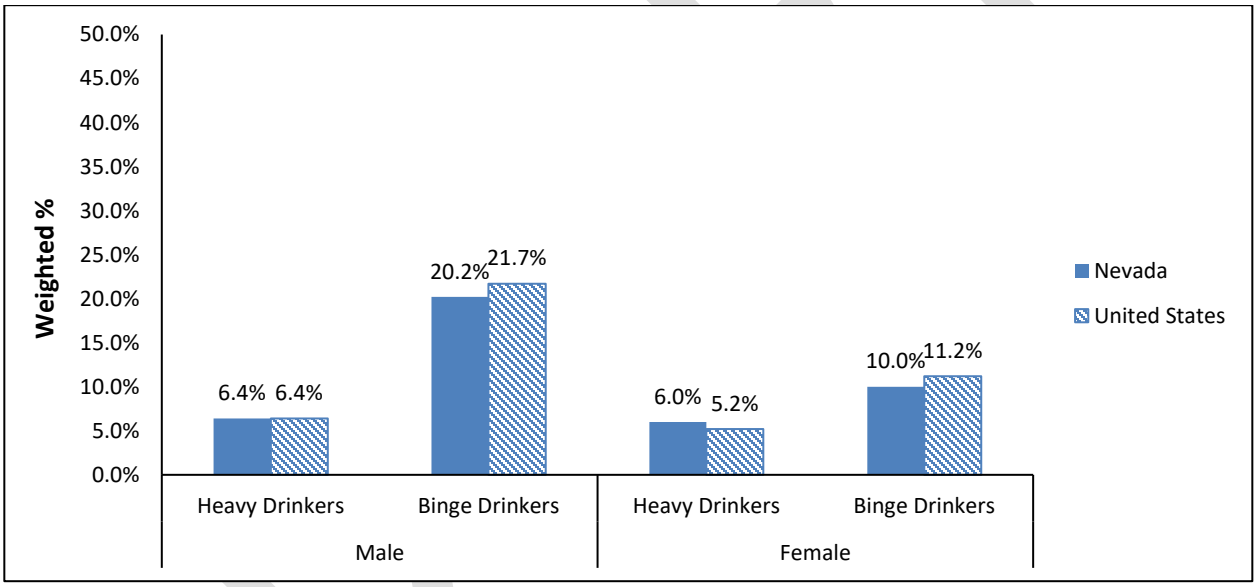
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2010--2014.

Past Year Treatment for Illicit Drug Use Among Individuals Aged 12 or Older with Illicit Drug Dependence or Abuse in Nevada, 2010-2014.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2010--2014.

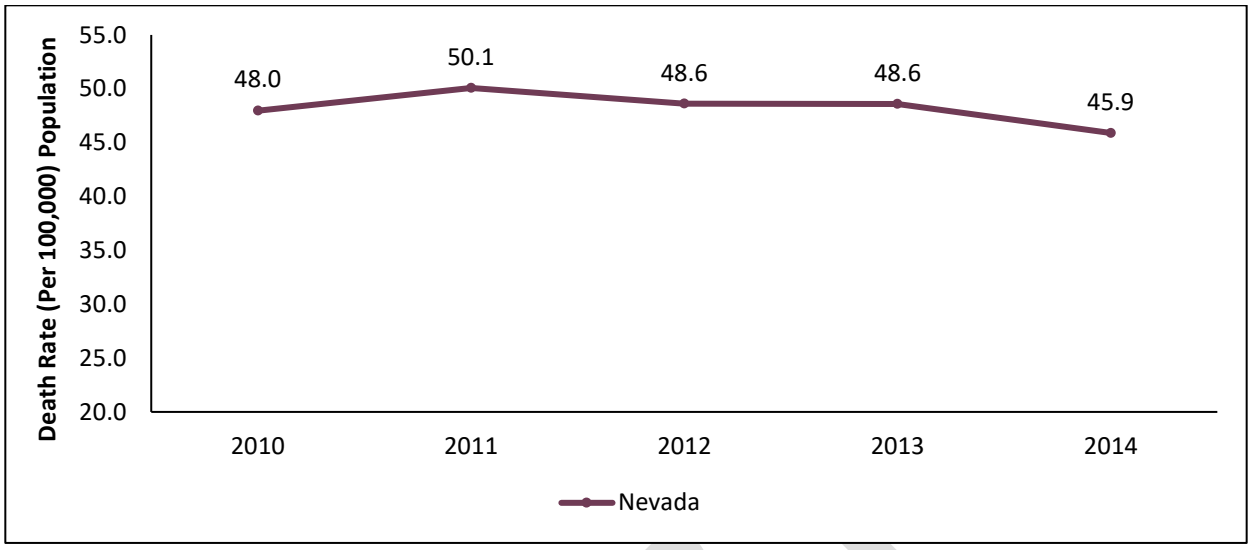
Percentages of Adult Residents Who are Considered Heavy/Binge Drinkers, 2015



Source: Division of Public and Behavioral Health, Behavioral Risk Factor Surveillance System

Over 6% of adult Nevada males and females reported being heavy drinkers. Heavy drinking consists of males consuming more than two alcoholic beverages a day and females consuming more than one alcoholic beverage a day.

Substance-Related Deaths, Nevada, 2010-2014



Source: Division of Public and Behavioral Health, WEVRRS

There were 6,664 substance-related deaths in Nevada between 2010 and 2014. During that timeframe the death rate varied between from 45.9 deaths per 100,000 and 50.1 deaths per 100,000.

Note: the following codes were used to define substance-related deaths: ICD10 codes G312, G621, I426, G721, K292, K70, K860, R78, Y90, Y91, X40-X49, T36-T60, T65, F10, X60-X69, E244, K852, O354, Y10-Y19, P043, Q860, Z721, R781-R786, F11-F16, F18, X85-X90, O355, D521, P961, T96-T97, Y40-Y59, K711, N141, P044.

Demographics of Substance Related Deaths, Nevada 2010-2014

	N	Column %
Sex		
Female	2,384	35.8
Male	4,280	64.2
Race		
White	5,317	79.8
Black	423	6.3
Native American	118	1.8
Hispanic	588	8.8
Asian/Pacific	114	1.7
Other	6	0.1
Unknown	98	1.5
Age		
<1	15	0.2
1-4	12	0.2
5-14	12	0.2
15-24	293	4.4
25-34	660	9.9
35-44	974	14.6

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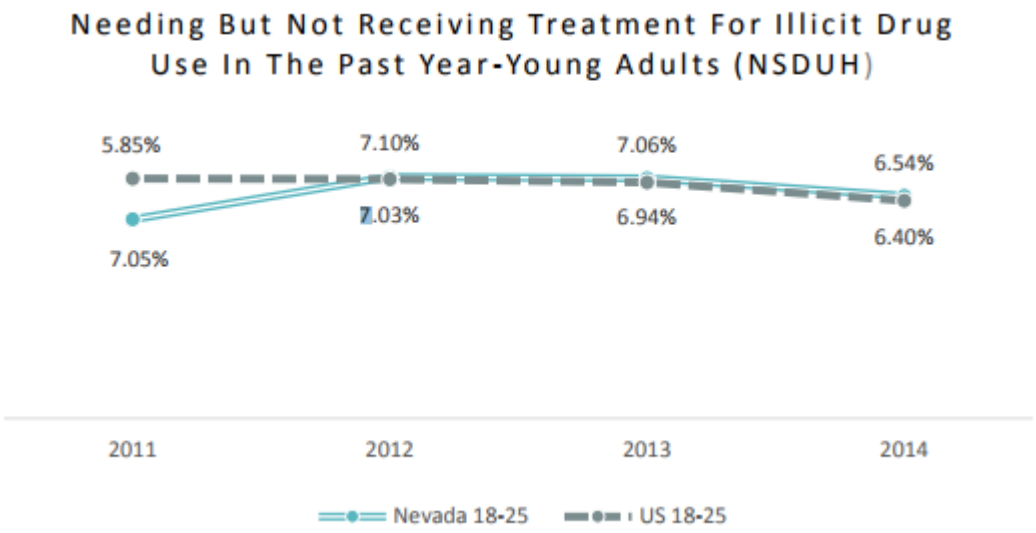
45-54	1,899	28.5
55-64	1,700	25.5
65-74	767	11.5
75-84	254	3.8
85+	77	1.2

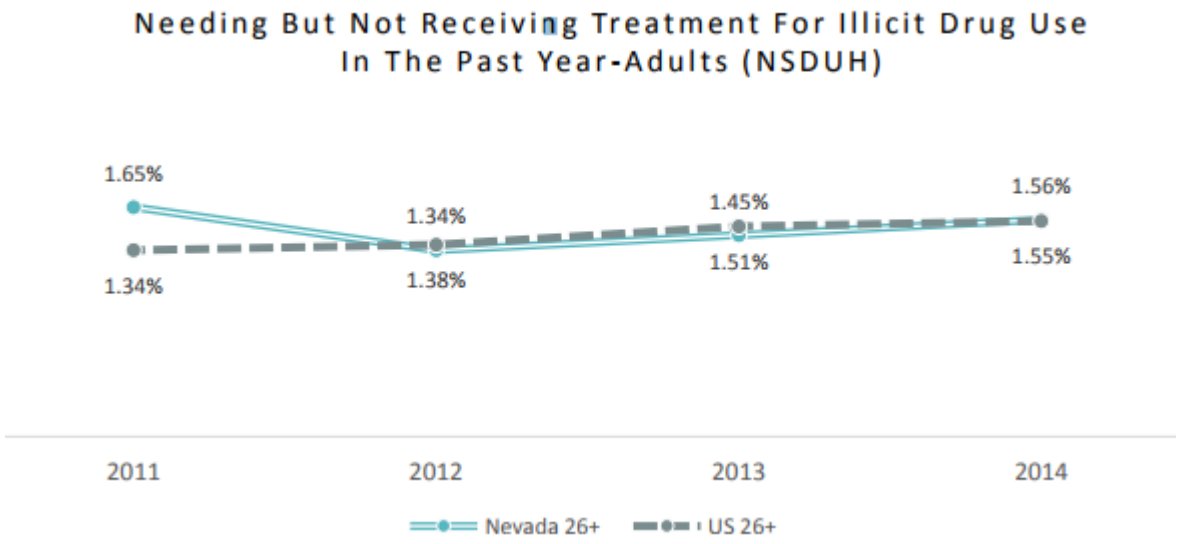
Source: Division of Public and Behavioral Health, WEVRRS

In Nevada, the most common demographic groups to die of a substance-related death included: males (64.2%), White non-Hispanics (79.8%), and those aged 45 to 64 years of age (54.0%).

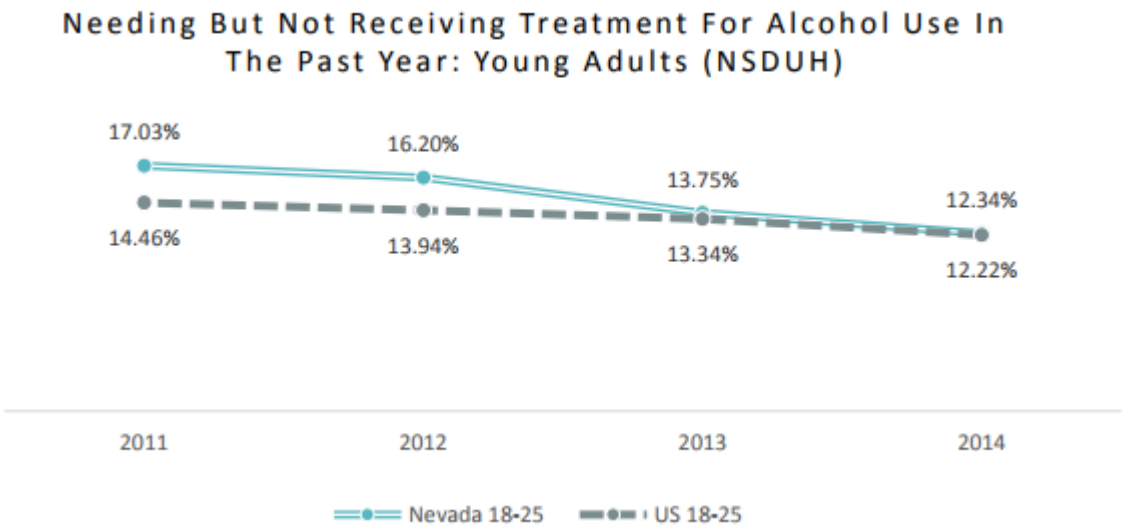
Young adults needing but not receiving treatment within the past year was 6.5% in Nevada, similar to the national rate.



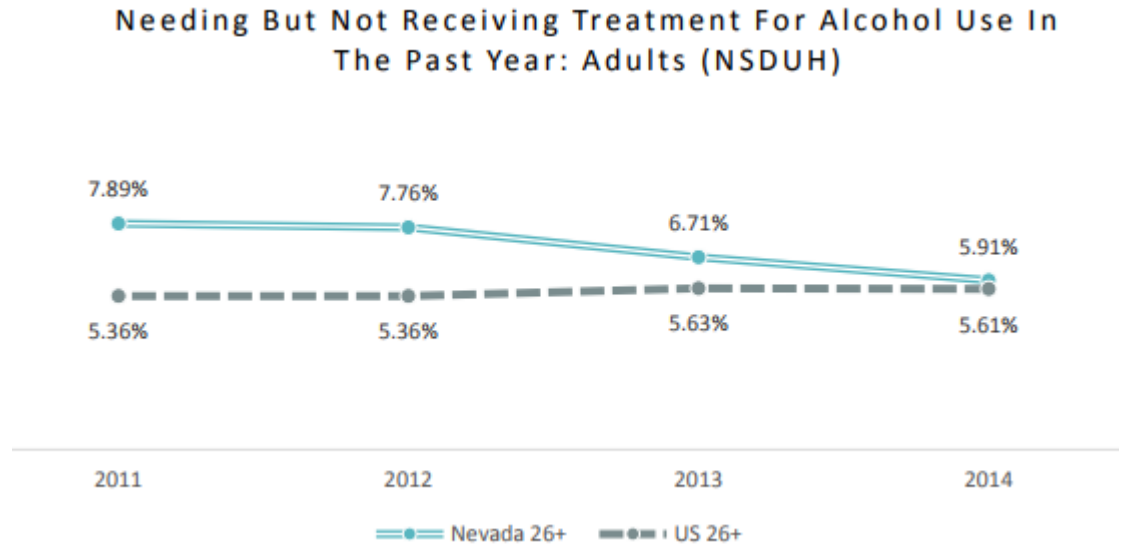
Adults needing but not receiving treatment within the past year was 1.6% in Nevada, similar to the national rate.



Young adults are at very high risk of needing but not receiving treatment for alcohol. Despite improvements in recent years both nationally and statewide, it's estimate that more than one in 10 Nevadans between the age of 18 and 25 needs help for alcohol use and does not get it.



The percentage of adults that needed treatment for alcohol but did not receive it declined between 2011 and 2014.

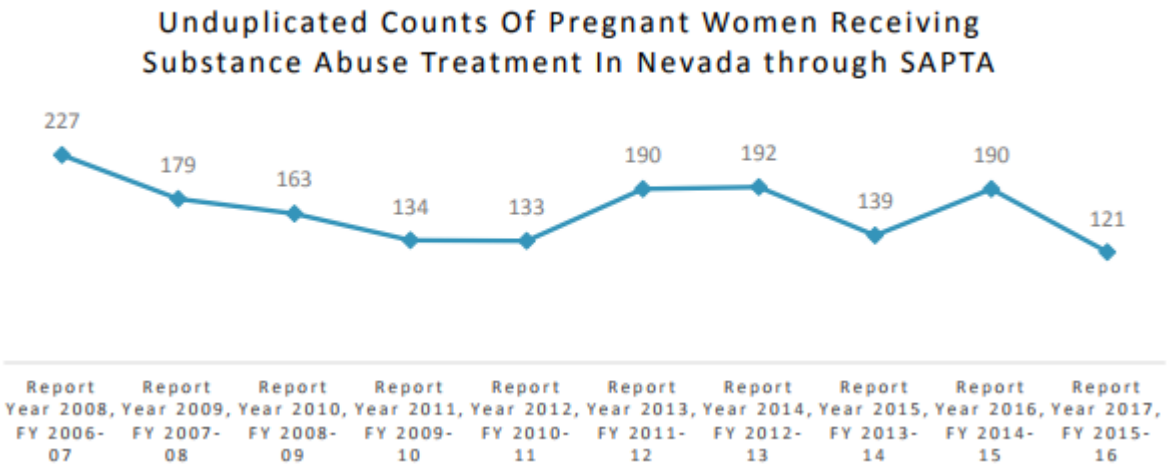


Special Populations

Pregnant Women

To be able to serve pregnant women in accordance with 45 CFR 96.131, it is particularly vital to understand the population requiring these services, and more importantly, ensure it has the capacity for compliance with this regulation. However, data regarding drug use and abuse by pregnant women can be difficult to accurately report given the existing data collection tools employed by the state. Currently, the state examines the number of pregnant women receiving state-funded treatment. It also uses self-reported birth certificate information. Both

sets of data may prove to underestimate the number of pregnant women using or abusing drugs in Nevada, but the sets do serve to help create a basic understanding of Nevada's mothers and expectant mothers' use or abuse of drugs. In Fiscal Year 2016, the state reported to the Substance Abuse Block Grant reporting system, (SAMHSA, n.d.) (WebBGAS) 121 pregnant women receiving treatment. The state has indicated that the reported numbers may not accurately reflect the number of pregnant women receiving services. They are currently working to improve the system to better account for this and other data.



On average there are 35,126 live births per year to Nevada residents. From 2010 to 2014, 1,074 had alcohol use indicated on the birth certificate. 672 birth certificates indicated marijuana use, 381 indicated meth/amphetamine use, 114 indicated opiate use, and 3 indicated heroin use during pregnancy.

Prenatal Substance Abuse Birth Rates (self-reported) for Select Substances, Nevada 2010-2014.

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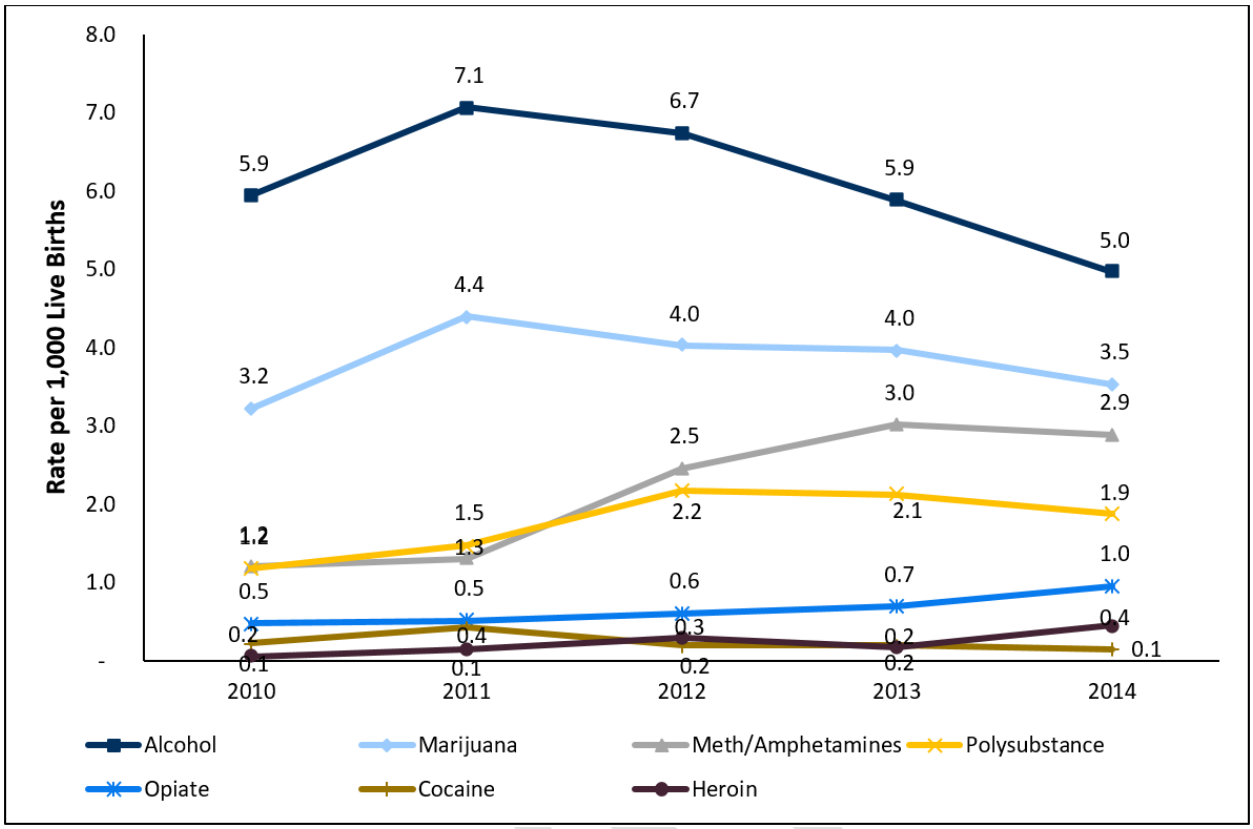
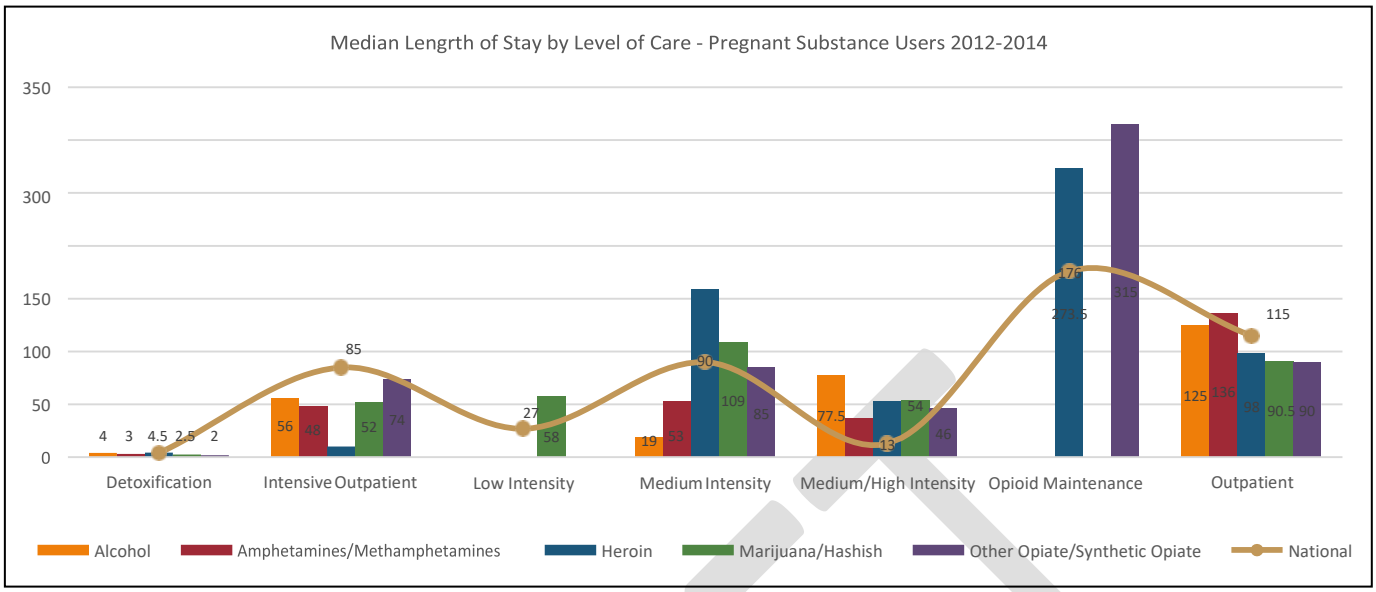


Source: Division of Public and Behavioral Health, WEVRRS

Of the Nevada mothers who gave birth between 2010 and 2014 that self-reported using a substances while pregnant, alcohol has the highest prenatal substance abuse birth rate, at 5.0 per 1,000 births in 2014. A rate of 3.5 per 1,000 was reported for marijuana, 2.9 per 1,000 reported for meth/amphetamines, and 1.9 per 1,000 births reported multiple drug use. These numbers are likely significantly underestimated because data is self-reported by the mothers, and they may be reluctant to be forthcoming on the birth record for many reasons.

The median length of stay for the priority population Pregnant Substance Users per level of care for each of the top five primary substances used in NHIPPS between 2012 and 2014. Notable observations include the median length of stay for medium intensity residential is considerably lower for alcohol and amphetamines/methamphetamines and considerably higher for heroin. This observation is interesting since the same level of care has been considerably lower for all substances for the previous priority populations. Other observations include low intensity residential median length of stay is quite a bit higher than the national median; medium-high intensity residential median length of stay is considerably higher than the national median along with opioid maintenance level of care.

Median Length of Stay by Level of Care-Pregnant Substance Users 2012-2014


Median Lengrth of Stay by Level of Care - Pregnant Substance Users 2012-2014
350
300
150
100
50
0
4
3
4.5
2.5
2
56
48
52
74
85
27
58
19
53
90
109
85
77.5
54
46
13
177
315
125
136
98
90.5
90
115
Detoxification
Intensive Outpatient
Low Intensity
Medium Intensity
Medium/High Intensity
Opioid Maintenance
Outpatient
Alcohol
Amphetamines/Methamphetamines
Heroin
Marijuana/Hashish
Other Opiate/Synthetic Opiate
National

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LGB

Nevada does not have adequate data on Transgender individuals so information is only provided for Lesbian, Gay and Bisexual.

Prevalence Estimates of Health Risk Behaviors, by Sexual Orientation – Nevada Adults, 2014 — 2015

Indicator	LGB (%)	Non-LGB (%)	Difference
Binge drinking	22.5%	15.0%	Not significantly different
General health fair or poor	29.9%	18.0%	Significantly Higher
Limited because of physical, mental, or emotional problems	32.2%	21.1%	Not significantly different
Ever told had depressive disorder	37.6%	16.6%	Significantly Higher
Ten or more days of poor mental health	32.8%	13.5%	Significantly Higher
Ten or more days poor mental or physical health kept from usual activities	20.6%	16.3%	Not significantly different

Source: Division of Public and Behavioral Health, Behavioral Risk Factor Surveillance System
†Statistical differences could not be determined

Prevalence Estimates of Health Risk Behaviors, by Sexual Orientation — Nevada High School Students, 2015

Indicator	LGB (%)	Non-LGB (%)	Difference
Drove when drinking alcohol.	10.6%	5.9%	Significantly Higher
Did not go to school because they felt unsafe at school or on their way to or from school.	13.1%	6.3%	Significantly Higher
Were ever physically forced to have sexual intercourse	24.4%	6.8%	Significantly Higher
Were electronically bullied	26.8%	11.9%	Significantly Higher
Felt sad or hopeless	63.5%	30.3%	Significantly Higher
Seriously considered attempting suicide	41.5%	13.9%	Significantly Higher
Made a plan about how they would attempt suicide	37.2%	12.7%	Significantly Higher
Attempted suicide	28.5%	6.8%	Significantly Higher
Ever tried cigarette smoking	51.7%	29.6%	Significantly Higher
Currently smoked cigarettes	21.3%	5.1%	Significantly Higher
Ever drank alcohol	78.1%	62.1%	Significantly Higher
Currently drank alcohol	46.8%	28.1%	Significantly Higher
Ever used marijuana	57.1%	37.0%	Significantly Higher
Currently used marijuana	34.7%	17.5%	Significantly Higher
Ever used cocaine	13.8%	4.7%	Significantly Higher
Ever used heroin	7.3%	1.5%	Significantly Higher
Ever took prescription drugs without a doctor's prescription	32.1%	14.5%	Significantly Higher
Currently use prescription drugs without a doctor's prescription	21.3%	7.1%	Significantly Higher

Source: Division of Public and Behavioral Health, Nevada Youth Risk Behavior Survey (YRBS)

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American Indian/Alaskan Natives

Prevalence Estimates of Health Risk Behaviors, by Race/Ethnicity Status — Nevada High School Students, 2015

Indicator	AI/AN (%)	Nevada (%)	Difference*
Drove when drinking alcohol.	30.5%	21.4%	Not significantly different
Did not go to school because they felt unsafe at school or on their way to or from school.	16.2%	7.6%	Not significantly different
Were ever physically forced to have sexual intercourse	12.0%	9.0%	Not significantly different
Were electronically bullied	22.3%	13.8%	Not significantly different
Felt sad or hopeless	36.4%	34.5%	Not significantly different
Seriously considered attempting suicide	21.1%	17.7%	Not significantly different
Made a plan about how they would attempt suicide	16.4%	15.8%	Not significantly different
Attempted suicide	18.0%	9.8%	Not significantly different
Ever tried cigarette smoking	53.1%	32.4%	Significantly Higher
Currently smoked cigarettes	22.4%	7.2%	Significantly Higher
Ever drank alcohol	46.6%	26.1%	Significantly Higher
Currently drank alcohol	44.3%	30.6%	Not significantly different
Ever used marijuana	59.1%	39.4%	Significantly Higher
Currently used marijuana	36.9%	19.6%	Significantly Higher
Ever used cocaine	17.9%	6.1%	Significantly Higher
Ever used heroin	9.2%	6.9%	Not significantly different
Ever took prescription drugs without a doctor's prescription	11.9%	3.6%	Not significantly different
Currently use prescription drugs without a doctor's prescription	28.5%	16.9%	Not significantly different

Source: Division of Public and Behavioral Health, Nevada Youth Risk Behavior Survey (YRBS)

**While most of these differences are not statistically significant due to small sample size, the highlighted risk behaviors are reflective of questions related to behavioral health among Nevada high school students.*

Opioid Related Indicators by Race/Ethnicity Status – Nevada Residents, 2015

Indicator	AI/AN Rate*	Nevada Rate*
Opioid Related Emergency Room Encounter	236.8	244.8
Opioid Related Inpatient Hospitalization	522.9	286.4
Opioid Related Overdose (Death)	21.5	16.2

Source: Division of Public and Behavioral Health, Hospital Emergency Room Discharge, Hospital Inpatient Billing, WEVRRS

**Rate per 100,000 population*

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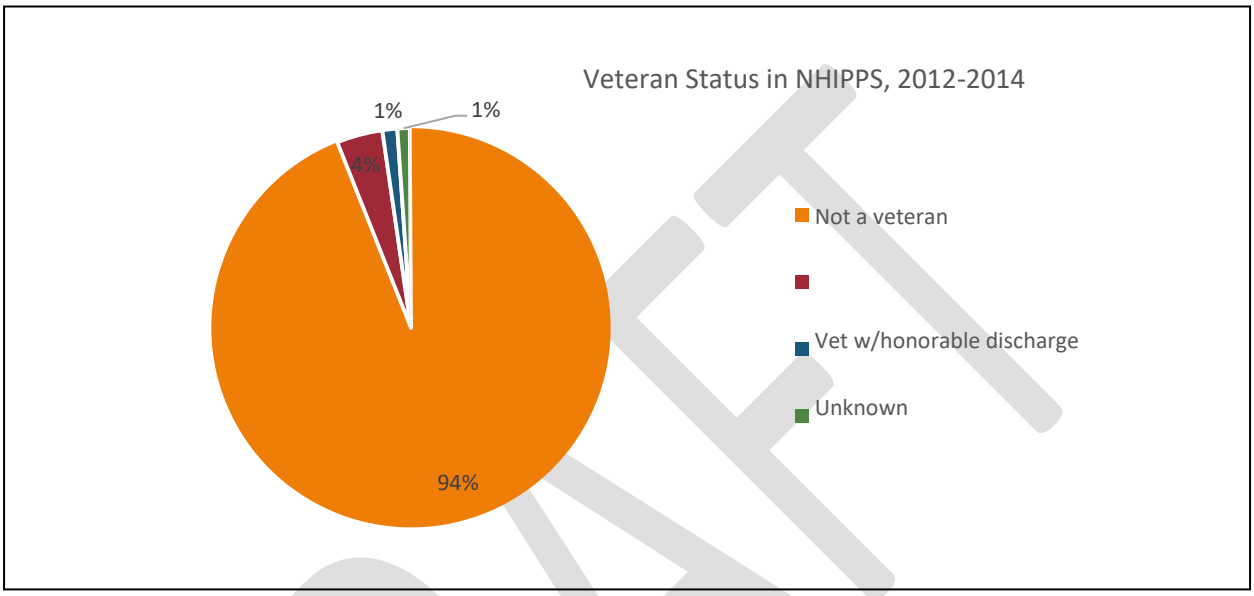
Persons who Inject Drugs

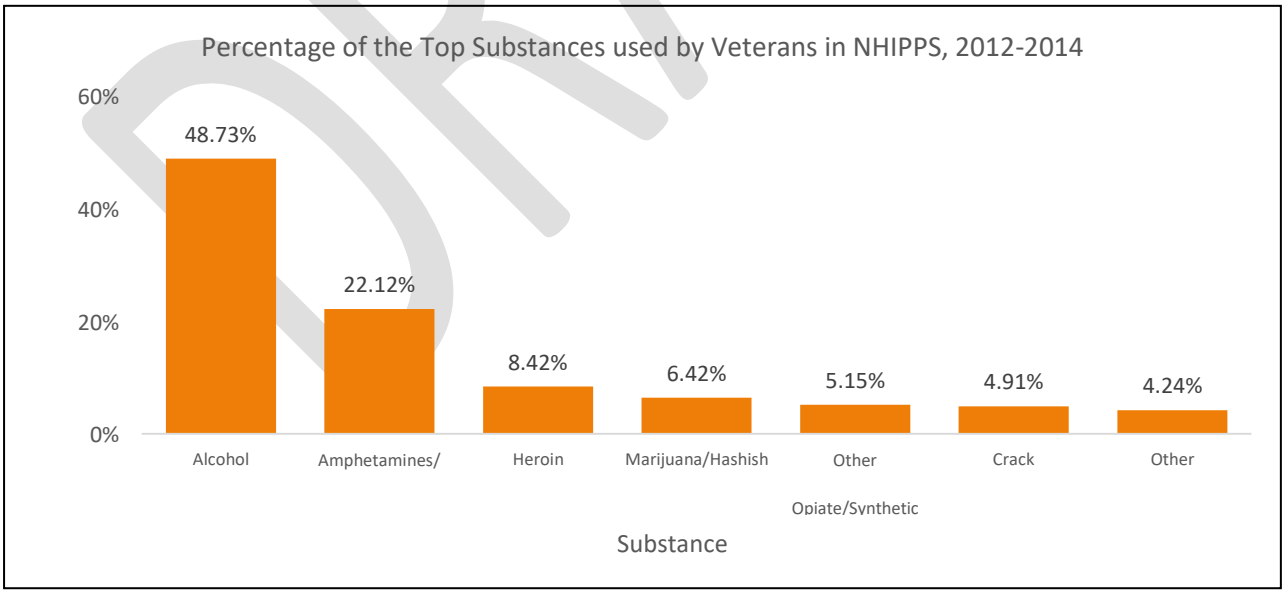
Rural Nevada

Veterans

According to the US Census Bureau's American Community Survey, veterans account for 11% of the Nevada population in 2013.



Percentage of the Top Substances used by Veterans in NHIPPS, 2012-2014



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Recommendations for Strategic Initiatives

Recommendations in the meta-analysis were rated by Council members with each member submitting their top five recommendations. The results were presented back to the Council for further deliberation. The recommendations adopted by the Council included:

Strategic Initiative #1: Prevention of Substance Abuse and Mental Illness

1. Improve screening, assessment, and referral services for at-risk populations
2. Support earlier access to prevention and early intervention services
3. Increase community-based services across the system of care

Strategic Initiative #2: Health Care and Health Systems Integration

1. Provide behavioral health services in primary care and non-traditional settings
2. Enhance collaboration between behavioral health and other systems of care

Strategic Initiative #3: Trauma and Justice via Trauma-informed Approach

1. Provide community-based intervention and support to address trauma and prevent incarceration

Strategic Initiative #4: Person-centered Planning and Recovery Supports

1. Prioritize community-based strategies and solutions that enhance the system of care
2. Improve discharge planning and transition support

Strategic Initiative #6: Workforce Development

1. Increase the number and quality of behavioral health professionals in Nevada
2. Remove barriers to behavioral health professional licensure and certification

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