Substance Use, Mental Health, and Suicide in Nevada

Nevada Substance Abuse Prevention and Treatment Agency - SAPTA

2018 Needs Assessment

October 2018

"I wish people could know…addiction can happen to anyone. We have people from every zip code, we are representative of the population here. We have people who are homeless, and we have people who drive up in their Mercedes Benz.

Addiction doesn't discriminate."

-Key Informant Interview, Las Vegas Nevada

Nevada Substance Abuse Prevention and Treatment Prevention Agency - SAPTA

2018 Needs Assessment

Dedication

This needs assessment is dedicated to Barry Lovgren who served the state for more than three decades as a tireless advocate working to ensure accountability, fiscal responsibility, and most importantly access to treatment for all Nevadans. Barry was uncompromisingly unique in his efforts to effect change, and brought humor, a fine intellect, and respectful discourse to every discussion. His contributions to strengthen and improve SAPTA are immeasurable and irreplaceable.

Report Contact

Questions about this assessment can be directed to Sarah Marschall (Sarah Marschall Strategy) at sarahmarschallstrategy@gmail.com or Social Entrepreneurs at contact@socialent.com. This report was developed with Social Entrepreneurs. Inc. with data provided by many community sources.

Acknowledgements

This report is written with gratitude to the dedicated professionals, peers, and family members who serve individuals and our communities through their commitment to behavioral health.

Special thanks goes to Nevada's Office of Data Analytics whose staff provided timely and detailed information for this report.

We are especially grateful for focus group participants, who took time out during their days to share their perspectives and experiences.

The following people participated in a phone interview for this report.

- Amy Adams
- Ali Banister
- Becka Bock
- Becky Coleman
- Chelsi Cheatom
- Jessica Flood
- Chief Dave Fogerson
- Jason Franklin
- Char Frost
- Aishia Grevenberg
- Joelle Gutman
- Kathy Harris
- Sheila Leslie
- Laura O'Neill
- Linda Porzig
- Danica Pierce
- Ariana Saunders
- Stacey Smith (Pahrump/Las Vegas)
- Captain Jaime Swetich

The author of this report would also like to acknowledge and thank the over 40 individuals who attended focus groups all across the State of Nevada.

Contents

Introduction

Nevada's Behavioral Health, Wellness and Prevention Program, within the Division of Public and Behavioral Health (DPBH) is comprised of HIV/AIDS Prevention, Ryan White Part B, Substance Abuse Prevention and Treatment Agency (SAPTA), and Behavioral Health Services Planning efforts. **The mission of SAPTA is to reduce the negative impact of substance abuse in Nevada.** This needs assessment was identified as a priority in SAPTA's most recent strategic plan.

This document has been developed to support the broad aims of the Substance Abuse and Mental Health Services Administration (SAMHSA):

- ✓ **Better Care**: Improve overall quality by making behavioral health care more person-, family-, and community-centered, and reliable, accessible, and safe.
- ✓ **Healthy People/Healthy Communities**: Improve the behavioral health of the U.S. population by supporting proven interventions to address behavioral, social, cultural, and environmental determinants of positive behavioral health in addition to delivering higher quality behavioral health care.
- ✓ **Affordable Care:** Increase the value of behavioral health care for individuals, families, employers, and governments.

Where possible, information is provided with a focus on SAMHSA's priority populations, and other subgroups of interest. Please note that additional figures and tables have been provided in the Data Tables companion document, and more information may be available from the Division of Public and Behavioral Health.

SAPTA is guided by values that also influence this assessment. They are:

- ➢ *Data-driven decision making*
- ➢ *Comprehensive, coordinated, and integrated services*
- ➢ *Affordable and timely care that meets state quality assurance standards*
- ➢ *Culturally and linguistically appropriate services*
- ➢ *Well-trained and incentivized workforce sufficient to meet community needs*
- ➢ *Accountable to the people who are served, local communities, and the public*

About this Report

Purpose:
- •To answer questions about issues, needs, and resources available
- •To provide state and regional perspectives on behavioral health issues

Frames Used:
- •SAMHSA Needs Assessment Guidelines
- •SAMHSA priority populations
- •An equity lens

Suggested Uses:
- •As a resource to deepen understanding of issues and assets in Nevada
- •As a resource to set goals and priorities

About this Report: Sources, Methods, and Limitations

This report seeks to identify and document the unmet needs and service gaps for substance misuse as well as mental illness. Efforts were made to develop a comprehensive report; however, data gaps exist. When possible, more than one source was consulted to create a fuller picture. Data sources, along with major limitations, are listed here:
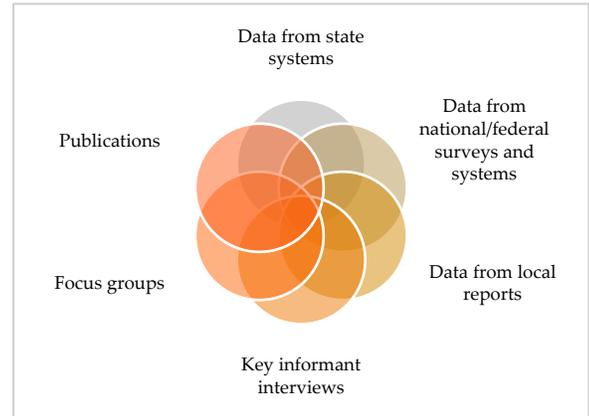
Data from state systems

✓ External requirements and definitions can change, making data difficult to compare year to year.
✓ Improvements to data collection methods can appear as true changes in the population.
✓ State systems collect information from a subset of state-funded providers; data is not currently available for all providers in Nevada.

Data from national/federal surveys and systems

✓ Improving methodology; upward trends can indicate true changes in the population, more accurate measurements, or both.
✓ Requirements and definitions for data can change, making comparisons through time problematic.
✓ There are often long lag times between when data is collected and when it is published.

Data from local reports

✓ Comparable data is not available for every jurisdiction.
✓ Local data can be highly specific to a region or population and may not follow trends of national and state sources.

Key informant interviews

✓ Key informants were asked to offer their professional perspectives and experiences; however, key informants were not expected to represent their organizations or constituencies or speak on behalf of others.

Focus groups

✓ Focus group participants were asked to offer perspectives and experiences; key informants were not expected to represent constituencies or speak on behalf of others.

Publications

✓ Citations are listed. Nearly all publications document specific methods and limitations.

For all sources, data can be problematic to compare due to different definitions and methods as well as time periods.

The State of Nevada: At a Glance

Nevada's population and geography create unique challenges for service delivery and behavioral health systems of care. A primary consideration is the number of people; the state has experienced considerable **population growth** since 2010, and total population approached **3 million** in April 2017. The majority of the state's population is in Clark County, followed by Washoe County and Carson City. Nevada has **19 incorporated municipalities (cities)** and 20 federally recognized tribes composed **of 27 separate reservations, bands, colonies and community councils** (First Nation's Focus: Tribal News of Nevada and the Eastern Sierra, 2018).

Data from the most recent U.S. Census shows that among Nevada's population, roughly one in four people is age 18 or younger. The population of people age 65 and up was 16% in 2017 and is predicted to increase in future years. Roughly 14% of people are in poverty, with rates higher among children and families of young children. Most of Nevada's population has an education of high school graduate or higher. Nearly one in five people were born in a country other than the U.S., and nearly one in three households (30%) speak a language other than English at home.

Racially

The majority of the population is White (68%); 9% is Black/African American, 9% is another race (not specified), 8% is Asian, 5% is two or more races, 1% is American Indian, and 1% is Native Hawaiian or Pacific Islander

Ethnically

- 29% (any race) Hispanic/Latino
- 49% White alone, not Hispanic or Latino

By Age

- 23% Age 18 or Younger
- 16% Age 65 or Older

By Circumstances that May Impact Health Care Access

- 13% lack health insurance
- 13% have a disability
- 8% are veterans
- 30% speak a language other than English at home

(United States Census Bureau, 2017)

Total Population Nearly 3 Million (2017)

109,781.18 square miles
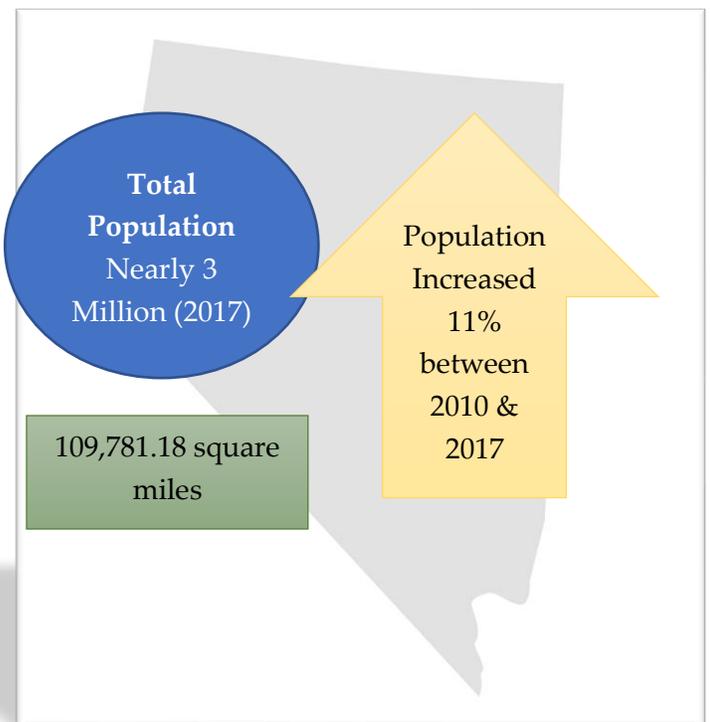
Population Increased 11% between 2010 & 2017

Summary of Findings

Throughout the needs assessment process, critical issues and gaps for attention have been noted along with assets or emerging successes ("bright spots"). Both the deficits and strengths provide insight into what may be addressed through future planning sessions. Note that opportunities suggested by interviewees are also presented throughout the document.

Critical Issues and Gaps

Contextual and Environmental Issues

➢ Widespread availability and use of a number of extremely harmful and addictive substances, including methamphetamine and opioids
➢ Cultural norms that support excessive drinking, smoking, and cannabis/marijuana
➢ Following a national trend, increased pressure on systems through a growing population of older adults with complex needs
➢ Following a national trend, increased pressure on systems from adolescents and young adults with mental health concerns
➢ Limited opportunities for adequate housing, worsened by rising housing costs
➢ Limited or no infrastructure for public transportation within many areas of the state
➢ Stigma associated with behavioral health that impacts access and connection to treatment

Capacity to Serve People with Behavioral Health Needs

➢ Lack of available care for co-occurring disorders
➢ Lack of in-state residential care, especially for adolescents
➢ Severe shortages in the workforce in nearly all needed behavioral health professions
➢ Limited number of providers that have cultural competence to serve the community
➢ An emerging system for care that is fragile; aspects that have the potential to expand availability of care are in the process of development, and not firmly established
➢ Competition rather than collaboration among service providers in some of the most populated areas of the state
➢ Challenges in addressing questions of unmet need; data systems are emerging to better answer these questions but currently much of the information available is qualitative
➢ Populations (geographies and also specific subgroups) that are underserved, including but not limited to incarcerated (and recently released people), homeless people, and adolescents
➢ Progress slow when it comes to the availability of integrated care
➢ Progress slow to spread use of trauma-informed care
➢ Limited adoption of evidence-based practices (EBP)

The Assets and "Bright Spots"

➢ Engaged and responsive providers across the state; a committed group of leaders (both formal and informal) working to address the most challenging problems of behavioral health

➢ Institutions that are establishing a reputation for "being able to help" - regardless of the challenges that individuals face with insurance or circumstance

➢ Strengthened and emerging partnerships between health, law enforcement, and others

➢ Innovative problem solving within organizations creating programs to serve more people, provide better services, or both, including rural Nevada

➢ Formal networks and collaborations working effectively together to find solutions and improve care across agency and geographic boundaries (Prevention Coalitions, Behavioral Health Boards, and Children's Mental Health Consortia, etc.)

➢ Expansion of harm reduction activities that help people to be as safe and as well as possible until they are able to initiate help for substance use disorders (e.g. Naloxone distribution, needle exchanges, etc.)

➢ Promising developments have been made in telehealth – overcoming some of the barriers that have been in place for many years

➢ Improved collective capacity around crisis response, through crisis intervention teams and other multi-disciplinary teams

➢ Improvements to health information technology and infrastructure

➢ Many schools and community-based organizations using evidence-based programs for prevention

➢ Developments in process to better serve pregnant women who may have a substance use disorder and improving capacity to help newborns through the Plan of Safe Care

➢ Increased number of peer recovery supports – both people who have been trained as peer supports, and use of peer supports in Nevada

➢ Progress in implementing Nevada's hybrid "hub and spoke" model for treatment of opioid use disorders through Integrated Opioid Treatment and Recovery Centers (IOTRCs); this includes expansion of availability of Medication Assisted Treatment (MAT)

➢ Medicaid expansion, providing opportunities for more people to access care

➢ Community responses to crises – people coming together across boundaries to help – especially to support children and youth

➢ Effective specialty courts that are able to connect people to pathways and services (that would be difficult to access otherwise)

➢ Increased public and professional awareness about substance use and mental health disorders – an important step in reducing stigma

➢ Outreach to provide technical assistance and capacity building to providers, especially to treat and address opioid use disorders

➢ Improving resources for people who are incarcerated to address mental illness and substance use disorders

Statistics on Mental Illness, Substance Use Disorder, and Related Concerns

In order to understand the context for service provision, data on the rates of mental illness, substance use disorder, and related behavioral health issues are presented. These data provide an estimate of what would be needed in terms of services, if all people who needed assistance sought and were able to access them. It is important to note that often, due to stigma, symptoms of the disease of addiction, and other factors, not all people who need assistance will look for or use services.

Mental Illness: Definitions and Statistics

In the U.S., about one in five adults age 18 or older have experienced some sort of mental illness. Estimates of the number and percentage of people in the nation and Nevada provide a reference for both understanding the scope of the issue, and, as a reference for planning.[1]

> *"Mental illnesses are common, recurrent, and often serious, but they are treatable and many people do recover. Learning about some of the most common mental and substance use disorders can help people recognize their signs and to seek help." (SAMHSA)*

Any mental illness (AMI) is defined as a mental, behavioral, or emotional disorder. AMI can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment (e.g., individuals with serious mental illness with SMI/SED). The rate of Nevadans with AMI is similar to the rate seen nationally.

	Estimate (Number) in the past year	Percentage / Rate	Date/Citation
U.S. AMI	44.7 million	18.3%	2016
Nevada AMI	520,000	18.5%	2014-15

Of those with AMI in Nevada, roughly one third (32.6%) received mental health services in the past year. More than two-thirds (67.4%) did not receive mental health services.

(Substance Abuse and Mental Health Services Administration, 2017), (Substance Abuse and Mental Health Services Adminstration, 2018)

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[1] Estimates can vary depending on the source and by year. These estimates should be used as an approximation, and not as an exact measure of the disease.

A **serious mental illness (SMI)** is defined as a mental, behavioral or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to cause serious functional impairment in an individual's major life activities (going to work, school, interacting with family, etc.). The rate of Nevadans with SMI is estimated to be similar to the rate seen nationally.

	Estimate (Number) in the past year	Percentage / Rate	Date/Citation
U.S. SMI	10.4 million	4.2%	2016 NSDUH
Nevada SMI	77,058-101,3017	4.4%	2016 (2017 Report)

(Substance Abuse and Mental Health Services Administration, 2017)

*Nevada Behavioral Health Barometer, 2017 Volume 4

Serious emotional disturbance has been defined historically by the Substance Abuse and Mental Health Services Administration (SAMHSA) and released as a Federal Register notice. The SAMHSA definition was crafted in order to inform state block grant allocations for community mental health services provided to children with a SED and adults with an SMI. The rate of Nevadans with serious emotional disturbance is similar to the rate seen nationally.

	Estimate (Number)	Percentage / Rate	Date/Citation
U.S. SED	2,299,465- 4,547,239	5%-13%	2016 (2017 Report)
Nevada SED	17,061-37,535	5%-11%	2016 (2017 Report)

(Substance Abuse and Mental Health Services Administration, 2017)

Substance Misuse and Substance Use Disorders: Definitions and Statistics

Definition: A substance use disorder (SUD) occurs when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), a diagnosis of a substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria. Nevada's rate of SUD is likely similar to or higher than the national rate.

	Estimate (Number)	Percentage / Rate	Date/Citation
U.S. SUD	20.1 million	8.4%	2016 NSDUH
Nevada SUD	--	--	--

(Substance Abuse and Mental Health Services Administration, 2017)

Co-Occurring Disorders

Definition: People with mental health disorders are more likely than people without mental health disorders to experience an alcohol or substance use disorder. Co-occurring disorders can be difficult to diagnose due to the complexity of symptoms, as both may vary in severity. In many cases, people receive treatment for one disorder while the other disorder remains untreated. Nationally, nearly one in four adults with serious mental illness also experienced a substance use disorder in the previous year. The rate of Nevadans with co-occurring disorders is not measured; however, those being treated for co-occurring disorders are counted among Nevada's funded providers. *(Center for Behavioral Health Statistics and Quality, 2015).*

> **Critical Gap for Youth and Teens with Co-Occurring Disorders**
>
> "One of the biggest barriers I see is when we have a youth that suffers from a co-occurring disorder. They're suffering from drugs and alcohol, but also from a mental health disorder. And there's really no place to put these kids in the State of Nevada that have the co-occurring diagnosis. And so, we're sending a lot of kids out of state, and that's problematic because they'll spend a year out of state, then they have relatively no contact, a little bit of contact with their families, but not much because families can't go there. …So, it's hard to make meaningful impact, I think, on the youth when they're out of state. That's one of our issues with the kids who have both [mental illness and substance use disorders]. **--Key Informant**

	Estimate (Number) in the past year	Percentage / Rate	Date/Citation
U.S. Co-Occurring	8.5 million	--	2017
Nevada Co-Occurring	ND	ND	ND

(Substance Abuse and Mental Health Services Administration, 2017)

Suicide: Definitions and Statistics

While the definition of suicide is widely understood, several other important concepts are important to share. First suicidal ideation means thinking or planning about suicide. Among individuals it can be a passing thought, or part of a plan. Ideation does not include the final act of suicide (Pederson, 2018). While the number of adults that have had suicidal thoughts is slightly higher in Nevada compared to other states, the rate of suicide is considerably higher than the national rate.

> **Media Can Strongly Influence Perceptions**
>
> "When we talked with people [in communities about suicide] one of their top concerns was "13 Reasons Why" (a Netflix series). They saw an impact in the community. One student talked about how she watched it – thinking this will show why suicide was bad…[but] after the show she thought it was cool. Our volunteers were really concerned about the second season – we did hear that coming up. Desensitization within media and social (suicides and suicidal ideation) are something no one wants to talk about [but we have to].
>
> **--Key Informant**

	Estimate (Number)	Percentage / Rate	Date/Citation
U.S.: Serious Thoughts of Suicide Adults	--	4.0%	NSDUH - 2016
Nevada Serious Thoughts of Suicide Adults	96,000	4.4%	NSDUH - 2016

(Substance Abuse and Mental Health Services Administration, 2017)

	Estimate (Number)	Rate / Per 100,000	Date/Citation
US Suicide	44,695	12.42	AFSP - 2016
Nevada Suicide	650	21.41	NSDUH - 2016

American Foundation for Suicide Prevention (AFSP), 2018)

HIV and Other Infections

People with substance use disorders are at greater risk of contracting or transmitting HIV infection because misuse of drugs can impair decision making. Unprotected sex, sex with multiple partners, and needle sharing are other factors that connect HIV and other similarly transmitted diseases (e.g. viral hepatitis) to substance use. Additionally, the prevalence of HIV in populations receiving mental health care is also considerably higher than for the general public, further relating HIV to issues of behavioral health (Substance Abuse and Mental Health Services Administration, 2017). Nevada's rate of people living with HIV is higher than the national rate.

	Estimate (Number)	Percentage / Rate	Date / Citation
U.S. HIV/AIDS	1.1 million	14.7 (Per 100K)	Kaiser Foundation 2017
Nevada Persons living with HIV	10,823	20.1 (Per 100K)	Kaiser Foundation 2017

(Nevada Division of Public and Behavioral Health, Office of Public Health Informatics and Epidemiology, 2016)

Tuberculosis (TB) is one of the world's deadliest diseases, and is a major cause of death for people who are HIV infected. Since the 1990s, rates have been declining slowly in the U.S., but the disease is still important to track, prevent, and treat. TB is also associated with risk factors such as excessive alcohol use, drug use, and within correctional facilities. Nevada saw an increase between 2016 and 2017. The overall rate of TB in Nevada is similar to the national rate.

	Number of Reported TB Cases	Rate / Incidence	Date/Citation
U.S. TB Cases	9,256	2.8 (Per 100K)	2017
Nevada TB Cases	80	2.7 (Per 100K)	2017

(Centers for Disease Control and Prevention, 2018)

Addressing Stigma and Education among Health Providers About SUD Can Improve Individual and Community Health

"I wish people could understand opioid and drug use a little bit better…we have a list of places where people can go…but they should be able to go anywhere to get wound care and basic medical care. I have heard [from our clients] about seeking care for open abscesses – [and that they were] turned away and laughed at rather than getting the infection treated. Education and harm reduction; stigma and how that can affect people; and what addiction is; [that] is how you can meet someone where they are and get them to help. The [providers that understand this] make a huge difference. They are few and far between. We also hear of people being told by pharmacists that they can't purchase needles. That [is] not the law and [is] not true." **–Key Informant**

Persistent and Emerging Issues: Substances of Public Health Concern

Tobacco / Nicotine and Vaping

Tobacco contributes to numerous diseases including cancer, heart disease, stroke, and diabetes. Despite declines in smoking over the last few decades, it is responsible for millions of premature deaths nationwide. According to a report by the U.S. Surgeon General, if current trends continue, 5.6 million U.S. youth who are currently younger than 18 will die prematurely from smoking (Department of Health and Human Services, 2014).

A related risk is vaping. While rates of smoking have declined among youth, vaping is on the rise. Recently published studies suggest that vaping has considerable negative health effects that were previously unknown (Desert Research Institute, 2018) and, that vaping is an "epidemic" among youth, having been marketed in flavors and in packaging that make vaping devices easy to hide from parents and teachers (Stein, 2018). Vaping can include nicotine, other liquid drugs, or, chemicals that are simply "flavored."

> ➢ Rates of adult smoking are higher in Nevada than the nation.
> ➢ Nearly one in four Nevada high school youth (23.9%) "had ever" smoked a cigarette. Twelve percent (12%) had smoked in the previous 30 days (Department of Health and Human Services Division of Public and Behavioral Health Office of Public Health Informatics and Epidemiology, 2017).
> ➢ Among Nevada's high school youth, 42% "had ever" tried vaping, and 15% had used electronic vapor products 30 days before the survey (Department of Health and Human Services Division of Public and Behavioral Health Office of Public Health Informatics and Epidemiology, 2017).
> ➢ Poisoning from nicotine affects a small portion of children. It should be noted that nicotine is highly toxic in large doses, and therefore a risk to young children (American Academy of Pediatrics, 2017). Liquid nicotine (used for some vaping devices) poses risk due to its concentration.

Cannabis / Marijuana

Legalization of recreational cannabis / marijuana has been a factor in increased use in Nevada. Many are concerned about youth access and increased use among young people.

> ➢ Rates of cannabis / marijuana have increased in recent years. Among Nevada's high school youth, 37% "had ever" used marijuana, and nearly one in five (19.5%) had used marijuana is the past 30 days.

Alcohol

The availability of alcohol, along with its addictive properties, makes it one of the most significant concerns from a public health perspective (Jaffee, 2016).

➢ Among Nevada's high school youth, 60.6% "had ever" drank alcohol; more than one in four (26.5%) had at least one drink of alcohol in the past 30 days, and 3.1% had more than 10 drinks in the past 30 days.

➢ The number of alcohol related deaths in Nevada climbed in recent years, with more than 1,000 in 2017.

Number of Alcohol Related Deaths

Year	Deaths
2010	767
2011	751
2012	844
2013	846
2014	838
2015	971
2016	950
2017	1,053
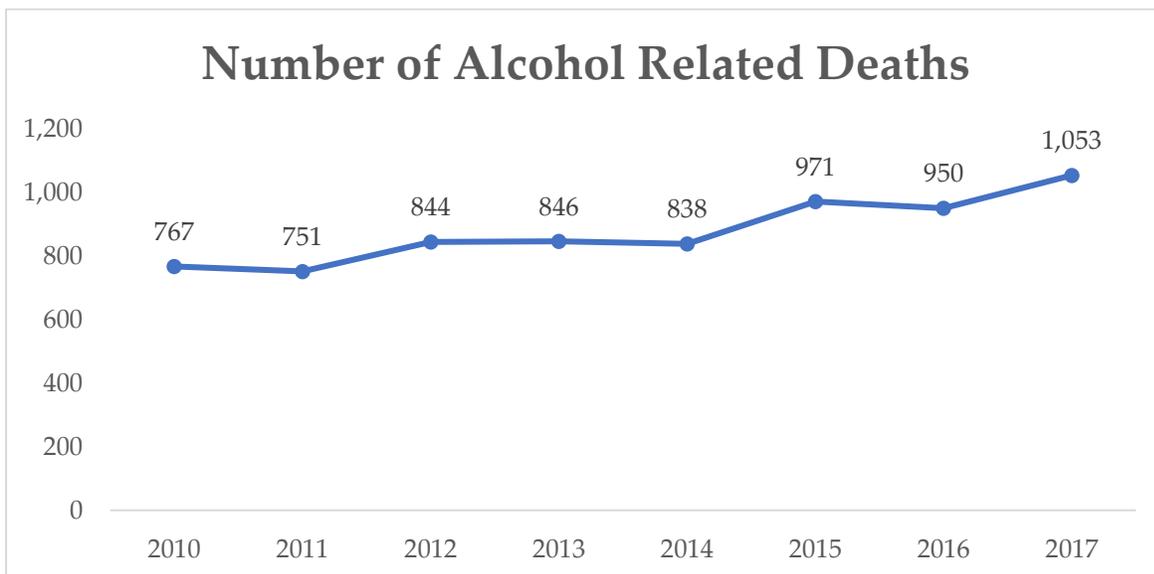
(DHHS Office of Analytics, 2018)

Synthetic Marijuana or "Spice"

Synthetic marijuana, (often called "spice" or K2) uses synthetic (man-made) chemicals that are added to plant material to be smoked or sold as liquids to be vaporized. These products may also be known as herbal or liquid incense. They are marketed as safe alternatives to cannabis but are in fact very dangerous due to their unpredictability in chemical content and dosage (National Institute on Drug Abuse, 2018). Anecdotally, "spice" is a major concern within Nevada's communities.

Methamphetamine

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

- Providers in Nevada are concerned about a resurgence in methamphetamine. This is confirmed with data. According to a recent report, Nevada's death rate from methamphetamines was highest in the U.S. (Associated Press, 2018).
- Methamphetamine may also be contaminated with other drugs like fentanyl, contributing to deaths (Sewall, 2018).
- Among Nevada's high school youth, 3.3% reported having ever used methamphetamine (Department of Health and Human Services Division of Public and Behavioral Health Office of Public Health Informatics and Epidemiology, 2017).

Opioids: Prescriptions, Heroin and Fentanyl

Nevada, like the nation, is experiencing an opioid crisis. Nationwide, deaths involving opioids have increased dramatically over recent years. The following statistics are from the Nevada Opioid Crisis Needs Assessment:

- In 2016, Nevada ranked 13th in opioid painkiller prescribing rates, at 80.7 per 100 residents, compared to a national average of 66.5 (Division of Public and Behavioral Health, 2018).
- Heroin seizures in Nevada more than doubled from 2014 to 2015 (Nevada HIDTA, 2016). Neonatal exposure to substances has increased each year since 2012.
- Opioid painkiller prescribing rates have decreased since 2012, while benzodiazepine prescribing rates have remained steady (Division of Public and Behavioral Health, 2018).
- Nevada counties with the highest prescription rates for both opioid painkillers and benzodiazepines are Mineral, Nye, and Storey counties. (Division of Public and Behavioral Health, 2018)
- Death rates are highest among Whites and individuals between the ages of 45 and 64 and lowest among Asian/Pacific Islander and Hispanic/Latino individuals. Death trends differed by type of opioid. Heroin deaths increased from 2010-2015, then remained stable from 2015-2016. Synthetic opioid deaths (i.e. fentanyl) increased from 2015-2016. Methadone overdose deaths decreased from 2010-2016 (Division of Public and Behavioral Health, 2018).
- Among Nevada's high school youth, 14.8% had taken prescription pain medicine without a prescription or not as prescribed. (Department of Health and Human Services Division of Public and Behavioral Health Office of Public Health Informatics and Epidemiology, 2017). Among Nevada's high school youth, 2.6% reported having used heroin (Department of Health and Human Services Division of Public and Behavioral Health Office of Public Health Informatics and Epidemiology, 2017).

Ecstasy, Molly/MDMA, LSD, Ketamine, Cocaine and Other Drugs

A number of other illegal substances are available and used by adults and youth in Nevada. The percentage of Nevadans reporting that they are current users of "other illegal drugs" was up slightly in 2016 to 1.5% of the adult population (DHHS Office of Analytics, 2018).

Dangerous Combinations

When substances (including prescriptions) are combined, there is often amplified risk of complications, including overdose and accidents that can result in death. For example:

➢ In a recent data collection effort by Trac B, testing of methamphetamine and heroin revealed contamination with fentanyl (increasing risk of overdose and death).

➢ In a study of recent drug-related deaths in Washoe County, more than one substance was frequent within the detailed cause of death (Join Together Northern Nevada, 2016).

➢ In the same study, a large portion of drug-related deaths were due to blunt traumatic force, asphyxia, drowning, firearms, hanging, hypothermia, or motor vehicle accidents. Those cases had substances in their system at the time of death. (Join Together Northern Nevada, 2016).

➢ Contamination of drugs with other substances is often unknown to the user and causes heightened risk of complications or even death.

Research has also raised concerns about the danger of combinations of prescriptions. For example, combining opioids and benzodiazepines can be unsafe because both types of drugs sedate users and suppress breathing—the cause of overdose fatality—in addition to impairing cognitive functions. In 2015, 23 percent of people who died of an opioid overdose also tested positive for benzodiazepines (National Institute on Drug Abuse: Advancing Addiction Science, 2018). These findings point to continued education among prescribers and the public.

> **Drugs in Use Across Socio-Economic Groups**
>
> "I hear about pockets of activity. In more affluent areas I hear a lot of people concerned about heroine. And then some of our more poverty level areas, lots of crystal meth and pot."
>
> **--Key Informant**

> **More Drugs and More People Affected**
>
> "It seems like when I started as a professional the problem was meth, and some cannabis users. Within [the] last few years, we have seen opioid use disorders, [heroine], cocaine. We have clients from 13 [to] 70. Such a wide age range. You can't even say one gender, [perhaps] a few more females.
>
> **--Key Informant**

A Closer Look at Behavioral Health: People in Nevada
Children and Adolescents

Children and adolescents are a critical population to serve. Even the youngest children may experience mental health concerns. Adolescents are also at risk for mental health issues and substance misuse.

Trauma – especially that which is experienced in childhood – is a risk factor for nearly all behavioral health and substance use disorders. While the data presented here is focused on current numbers and rates, it is important to point to the opportunities for "upstream efforts" (family, community, and system efforts to prevent or reduce trauma, including but not limited to physical, psychological, and sexual abuse, and witnessing violence, and neglect).

Population
➢ Nearly one in four Nevadans is age 18 or younger (23%).
➢ There are approximately 686,550 children and youth in Nevada.

Mental Health
➢ The CDC estimated that one in five children and youth in the U.S. have a diagnosable mental, emotional or behavioral disorder in a given year.
➢ Even the youngest children can experience depression and anxiety. In a national study from 2011-12, one in seven U.S. children ages 2 to 8 had a diagnosed mental, behavioral, or developmental disorder (Centers for Disease Control and Prevention, 2018).

> **Youth Far from Families During Substance Use Treatment**
>
> "We only have one substance abuse inpatient program (in our region), and that's in Silver Springs, so it's a distance away from us. And that sometimes becomes problematic because the youth are required to have family meetings, I believe, weekly, but the parents can't drive out there because it's so far away/ A lot of our families don't have transportation."
>
> **--Key Informant**

➢ According to national estimates, 14% of adolescents in Nevada had a major depressive episode (annual average). This rate was higher than the U.S. rate and also increased since 2011. This equates to roughly 31,000 adolescents age 12 to 17 experiencing such an episode (Substance Abuse and Mental Health Services Administration, 2017).
➢ The number of children and youth in Nevada with serious emotional disturbance (SED) was estimated between 17,061 and 37,535 (Substance Abuse and Mental Health Services Administration, 2017).[2]

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[2] The wide range for the estimate includes the lower and upper estimates including lower and more severe emotional disturbance.

Substance Use Disorder

Many adolescents seek substances as a way to self-medicate. Services that can help address both mental health issues and substance use are often more effective than those that work on only one issue.

> ➢ In Nevada, an estimated 5.4% of youth ages 12 to 17 were dependent on or abused illicit drugs or alcohol in the past year. This rate was above the national estimate (United Health Care Foundation, 2018).
>
> ➢ Rates of substance use through time vary depending on the specific substance. Of note, 7.0% of high school students in Nevada took prescription pain medication without a prescription or not as prescribed 19.5% had used cannabis/marijuana, and 26.5% had used alcohol in the past 30 days before being surveyed (Department of Health and Human Services Division of Public and Behavioral Health Office of Public Health Informatics and Epidemiology, 2017).

Innovation and Adaptive Programming to Serve Youth in Need

We saw a need for all these youth that were coming into the juvenile justice system that have a mental health issue. Putting them in detention or even having a probation officer isn't necessarily the best solution, especially for the kids with mental health or co-occurring [disorders]. So, we created a diversion program called the JJASTT program, and that's the Juvenile Justice Assessment Screening Triage Team."

--Key Informant

> ➢ Rates of youth use vary by race and ethnicity and the specific substance being reported. (Department of Health and Human Services Division of Public and Behavioral Health Office of Public Health Informatics and Epidemiology, 2017).

Suicide

> ➢ Suicide is the 2nd leading cause of death for Nevada's youth age 15-24 (Office of Suicide Prevention, 2017).
>
> ➢ 14.4% of all high school youth had made a plan about how they would attempt suicide in the 12 months before the survey. Youth that are Native Hawaiian/Pacific Islander, "other race/ethnicity" and Native American were more likely to have made a plan to attempt suicide within the past 12 months before the survey (Department of Health and Human Services Division of Public and Behavioral Health Office of Public Health Informatics and Epidemiology, 2017).
>
> ➢ The number of admissions for youth suicide attempts increased dramatically between 2010 and 2017. Among teens 15 to 17, the number nearly doubled over 10 years, and among the youngest children and teens, the number more than doubled (DHHS Office of Analytics, 2018).
>
> ➢ In 2017, the number of suicides among youth 15-24 increased.

Number of Inpatient Admissions for Suicide Attempts Among Children and Teens

Legend: 0-14, 15-17
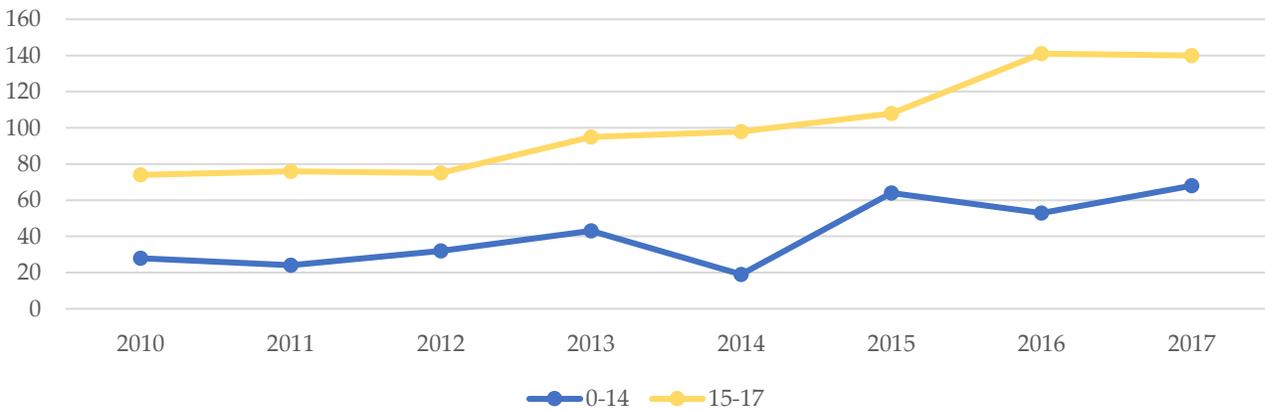
Number of Suicides for Children and Youth
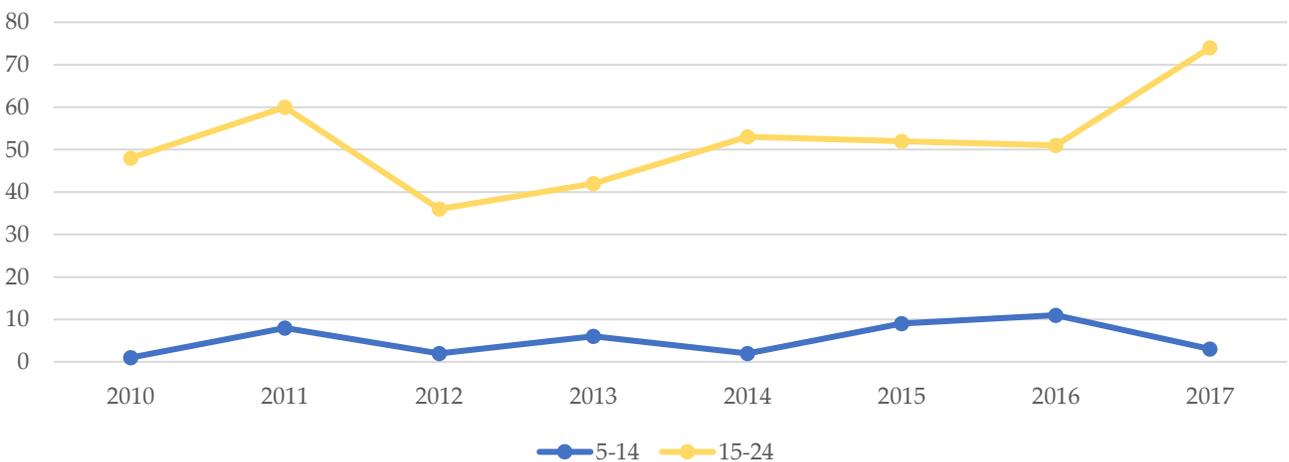
Legend: 5-14, 15-24

Critical Issues and Needs

➢ Mental health, substance misuse, and co-occurring disorders are a major public health concern. The number and percentage of children and youth experiencing these issues has increased in recent years, and experts predict that this trend will continue.

➢ For many teens, help follows after a crisis, like a hospitalization or interaction with juvenile justice. However, interventions that can happen earlier (before crisis or juvenile justice) are preferred, helping youth and families before there is a crisis and also saving costs from higher level services.

➢ Despite recent improvements to behavioral health care in Nevada, children and youth continue to lack adequate and accessible services. High rates of youth mental illness are present in Nevada, but the services for adolescents are not at the levels needed. Each month, hundreds of children are placed or remain in treatment centers out of state.

(Clark County Children's' Mental Health Consortium). Pressure on Nevada's residential and outpatient care can also mean long wait times, and, consequently, more severe symptoms or crises among youth.

➤ State programs intended to address complex needs (such as wraparound) are not available to reach all children and youth that need them.

➤ Children are also impacted by parental or caregiver substance use. While data specific to Nevada is not available, in a recent study of the nation, rates of "drug overdose deaths and drug-related hospitalizations have a statistical relationship with child welfare caseloads (that is, rates of child protective services reports, substantiated reports, and foster care placements" and these substance use indicators correlated to rates of more severe child abuse cases (Radel, Baldwin, Crouse, Ghertner, & Waters, 2018). The authors also found that across the nation, systems were not well-prepared to meet families' needs. They noted "haphazard substance use assessment practices, barriers to collaboration with substance use treatment providers and other stakeholders, and shortages of foster homes and trained staff" as system issues that limited agencies' responses to families.

> **Connecting with At-Risk Youth Early: A Promising Strategy from One Nevada Community**
>
> "We've gone to the principals and we've said, 'Give us your most problematic kids, the ones that you can potentially see making it into the criminal justice system.'"
>
> So, we did it last year where we went into one specific school, we worked with 11 youth for 10 weeks and provided this *Arise* program, and worked on a number of different things. That's something that's definitely preventative in our community that we've started, just because we see a need for services, unfortunately, younger and younger. The kids that we worked with were like 10 years old."
>
> **--Key Informant**

Notable Resources for this Age Group

Programs that were named by key informants are shown to highlight some of the resources in place. This list is intended to provide visibility to some of the programming available. It is not intended as a comprehensive list of programs in Nevada.

➤ Signs of Suicide (SOS) Training
➤ Healthy Schools Healthy Students (Grant Funded Programs)
➤ Healthy Schools Grant Funding
➤ State Funding for Social Workers in Schools
➤ Community-Driven Programs: Big Brothers Big Sisters, Court Appointed Special Advocates (CASA), Boys and Girls Club, etc.
➤ Multi-Tiered Support Systems through Schools
➤ Evidence-Based Prevention Programs Provided through Schools
➤ ARISE Program (see text box)
➤ Play by the Rules

- ➢ JJAST Program: Juvenile Justice Assessment Screening Triage Team (Carson City Probation)
- ➢ Leadership and Resiliency Wilderness Program (Carson City Probation)
- ➢ Nevada Partners (Las Vegas) – Multiple Programs
- ➢ Nevada PEP
- ➢ National Alliance on Mental Illness

Transition Age Youth

Adults of all ages make up the largest proportion of the population. A specific subset of this population, transition age youth (TAY) (often defined as those age 18-25) is highlighted for numerous reasons. Transition age youth may be at higher risk for substance use and first experiences of mental illness. Further, while they may have existing or newly emerging needs, they have typically left childhood homes – and aged out of systems that serve children and youth. They face a complex service system that is often not well-equipped to meet their needs.

> **Transition Age Youth Face Barriers to Care**
>
> "Those barriers include a confusing maze of services that often fail to meet their needs, inappropriate service tunnels, transition cliffs, and ineffective, uncoordinated service delivery. Through thoughtful systems change at the local and state levels, and the adoption of promising new program models promoting collaborative networks of care more youth and young adults with mental health needs can become self-sufficient adults who experience personal and employment success."
>
> *(Successful Transition Models for Youth with Mental Health Needs: A Guide for Workfoce Professionals, 2009)*

Population

- ➢ Young adults or transition age youth (ages 19-25) make up about 9% of the population.

Mental Health

Young adults (transition age) face specific challenges. This is often a time of considerable change, between home and independence, and, from familiar systems to adult systems of care. Youth that have had mental illness, or who are experiencing it for the first time, can find themselves challenged by complex and fragmented systems (Network on Transitions to Adulthood, 2005).   Youth that have left foster care also find themselves working to navigate complex systems with minimal or no assistance.

Substance Use Disorder

- ➢ Transition age youth and young adults have some of the highest rates of alcohol and substance abuse (SAMHSA, n.d.).

Suicide

- ➢ Adult suicide rates in Nevada are high, with ages of 25-44 at particularly at risk for suicide.

Number of Inpatient Admissions for Suicide (Transition Age Youth & Young Adults)

Legend: 18-19, 20-24, 25-34
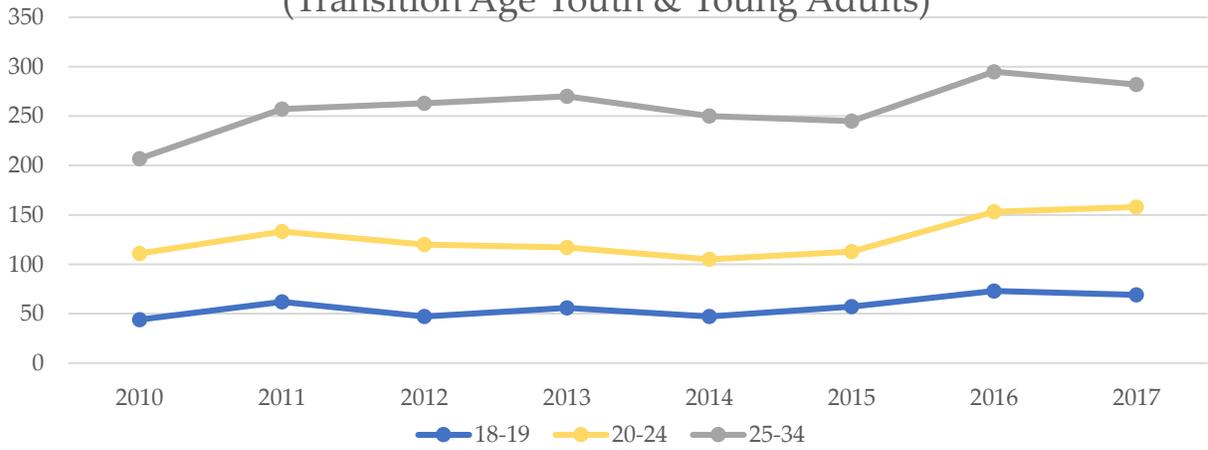
Number of Suicides for Transition Age Youth and Young Adults
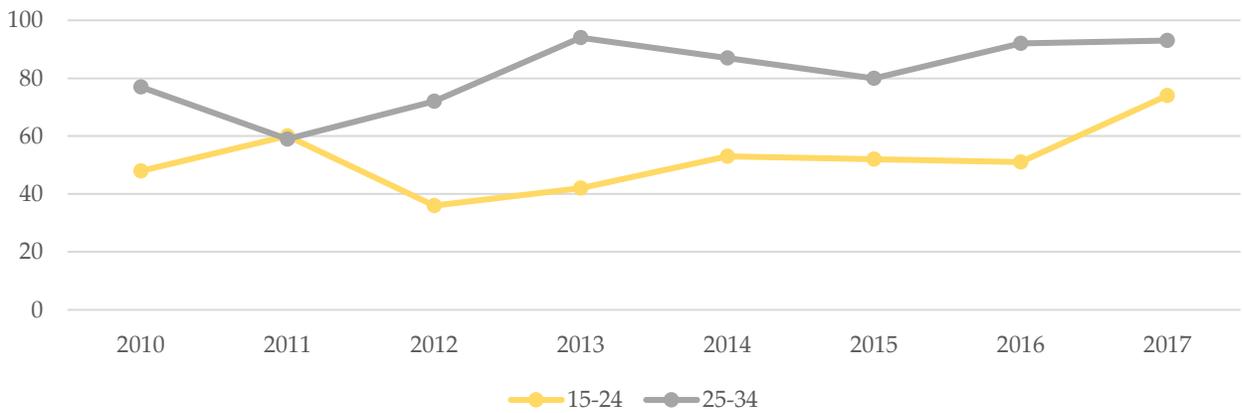
Legend: 15-24, 25-34

Critical Issues and Needs

➢ Mental health, substance misuse, and co-occurring disorders are a major public health concern for transition age youth.

➢ Proximity and availability of drugs, alcohol, and gambling likely contribute to rates of substance use in Nevada.

➢ Improvements to insurance access have been made through Medicaid expansion. However, especially for those who may have trouble navigating an insurance system and set of providers, finding services can be difficult or impossible without assistance.

➢ The limited availability of livable and decent housing impact peoples' ability—especially transition age youth—to find appropriate living situations.

➢ Transportation for services including assessments and treatment are barriers for many, including those with the highest needs.

> **From the Field: Systems that are Competitive Prevent Patient Recovery**
>
> "It does a disservice to the patients, because private health care is a private business. I'm not going to refer you to my competitor. I'm not going to do that. That's not the way private business works. That's [referral and coordination of services] is the way healthcare works and the way mental health *should work*, but that's not the practice. So, the problem is someone leaves the detox with limited resources, what happens? They relapse, they come back, and they start all over again." **–Key Informant**

Notable Resources for this Age Group

Programs that were named by key informants are shown to highlight some of the resources in place. This list is intended to provide visibility to some of the programming available. It is not intended as a comprehensive list of programs in Nevada.

- Nevada's Integrated Opioid Treatment and Recovery Centers (IOTRCs)
- Federally Qualified Health Clinics (FQHCs)
- National Alliance on Mental Illness (NAMI) works in many ways across Nevada, including programming, advocacy, and support around mental illness
- SAPTA Certified Programs (including both funded and non-funded partners)
- Nevada has several Certified Community Behavioral Health Clinics (CCBHC)

Adults (Ages 26-64)

Population

Adults (26-64) make up more than half of the total population in Nevada.

- o Adults ages 26-34 make up about 13% of the population
- o Adults ages 35-55 make up 25% of the population
- o Adults ages 55-64 make up 25% of the 13% of the population

Mental Health

- ➢ Adults make up the majority of the population within psychiatric hospitals (NRI, 2016).
- ➢ Nevada ranked low in terms of overall use of community health settings; however, the largest group to utilize services were adults, who also had the highest rates of utilization compared to other age groups in Nevada (NRI, 2016).

Age Distribution of Clients Served in State Psychiatric Hospitals: Nevada and US, URS 2015

Age 65 and Over 5.1%

Age 0-17 6.9%

Age 18-20 4.4%

Age 21-64 86.9%
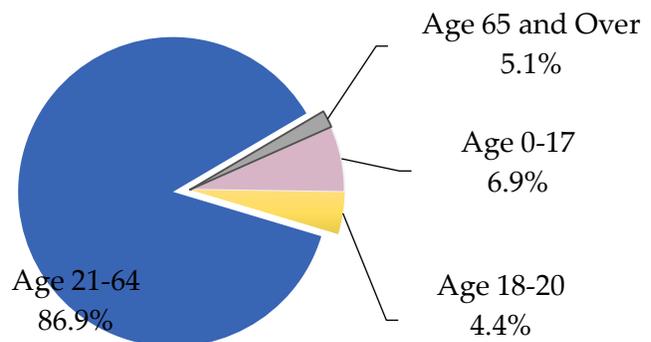
Substance Use Disorder

- ➢ In a review of 2016 data, age groups affected greatest by opioid deaths were ages 45-54 and ages 55-64, with death rates significantly higher than others (Division of Public and Behavioral Health, 2018).
- ➢ According to the Behavioral Health Risk Survey, rates of illegal drug use declined for younger adults between 2010 and 2016. While these percentages are low, because adults make up a majority of the total population, the risk and burden of drug use, including addiction within this population, is considerable (DHHS Office of Analytics, 2018).

Suicide

- ➢ Adult suicides in Nevada are concerning. The number of inpatient admissions for attempts, as well as actual suicides, has increased since 2010. Adult suicides—while higher relative to the nation—stayed stable or even decreased slightly between 2010 and 2017.
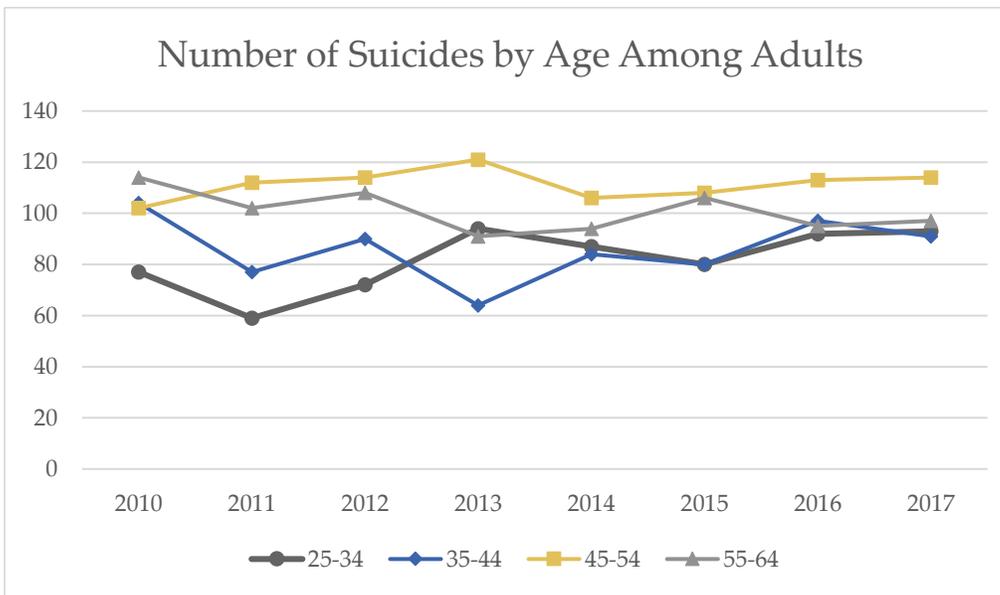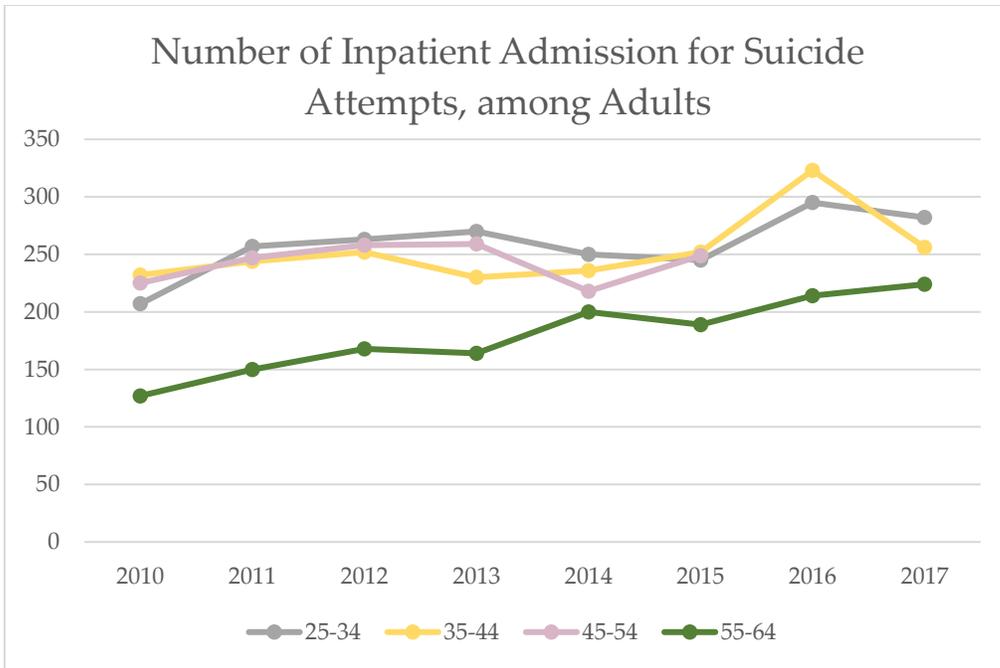
Number of Inpatient Admission for Suicide Attempts, among Adults

Legend: 25-34, 35-44, 45-54, 55-64

Number of Suicides by Age Among Adults

Legend: 25-34, 35-44, 45-54, 55-64

Critical Issues and Needs

➢ Mental health, substance misuse, and co-occurring disorders are a major public health concern for adults.

- Proximity and availability of drugs, alcohol, and gambling likely contribute to rates of substance use in Nevada.
- Improvements to insurance access have been made through Medicaid expansion. However, especially for those who may have trouble navigating an insurance system and set of providers, finding services can be difficult or impossible without assistance.
- The limited availability of livable and decent housing impacts peoples' ability to regain health and wellness.
- Transportation for services including assessments and treatment are barriers for many, including those with the highest needs.

> **Housing is Critical Issue**
>
> "We have a gentleman who has worked all of his life. He had a really good job, but because of his substance misuse, he has lost everything. Now he is living in his car. One of our biggest needs is housing. There is no place for [people] to go! Of the few resources, many require that people be clean and sober – the impossible! And our low-income housing, it so full all the time. It feels like a miracle to find housing for people."
>
> **--Key Informant**

Notable Resources for this Age Group

Programs that were named by key informants are shown to highlight some of the resources in place. This list is intended to provide visibility to some of the programming available. It is not intended as a comprehensive list of programs in Nevada.

- Nevada's FQHCs provide care, including integrated primary and behavioral health care.
- Medicaid expansion has allowed many more adults in Nevada to have insurance. coverage, which allows use of both public and private providers that accept Medicaid
- State and community settings that promote integration are available for adults.
- The state's opioid response – including expanding availability of naloxone, stands to help all Nevadans, including adults who have been particularly at risk of overdose deaths.

Older Adults and Seniors

Older adults are experiencing substance use or mental health disorders at higher rates than in previous years. Both the rates of mental health and substance use appear to have increased within this population, and the total number of older adults (aging of the baby boomer generation) set the stage for systems that are not ready to address these issues.

Population

- About 16% of Nevada's population is 65 and older.
- The population of older adults is expected to increase dramatically, as the "baby boomer" generation continues to age.
- Older adults are more likely to have a disability compared to the population as a whole; more than one in three older adults lives with a disability (Aging and Disability Services Division, Commission on Aging, 2016).

> **Older Adult Suicide Needs More Attention**
>
> "Nevada is the leading state for senior suicides and for our elders in our community. If we have a 16-year-old (that commits suicide) we shut down schools to fix that--but a 72-year-old doesn't even make a headline! People don't see that as the same problem to our community-- and how do we get that solved?"
>
> **--Key Informant**

Mental Health

- National estimates suggest that one in four (25%) of older adults have some type of mental health problem (that is not associated with normal aging). Depression is common among older adults.
- Older adults are at risk of other diseases that impact memory and behavior, such as dementia and Alzheimer's.

Substance Use Disorder

- National data suggests that substance use is a growing issue among older adults, with predictions of higher numbers and rates of older adults with a substance use disorder. (Mattson, Lipari, Hays, & Van Horn, 2017).
- Older adults may be particularly at risk for opioid use disorder, as increased age often comes with painful and chronic conditions. Among older adults with opioid use disorder (OUD) may also be difficult to diagnose, with symptoms similar to depression, delirium, and depression (Tilly, Skowronski, & Ruiz, 2017).
- Additionally, accumulated experiences of trauma, isolation, or loss of loved ones can cause emotional pain, worsening existing mental health concerns or substance use disorders.

Suicide

- Nevada has a high rate of suicides among older adults. Some of the factors that likely contribute to this problem are illness and disease, pain, social isolation, poor nutrition, substance misuse, loss of a loved one, and caregiving (Aging and Disability Services Division, Commission on Aging, 2016).

Number of Inpatient Admissions for Suicide Attempts Among Older Adults

Legend: 65-74 ● 85+ ● 75-84
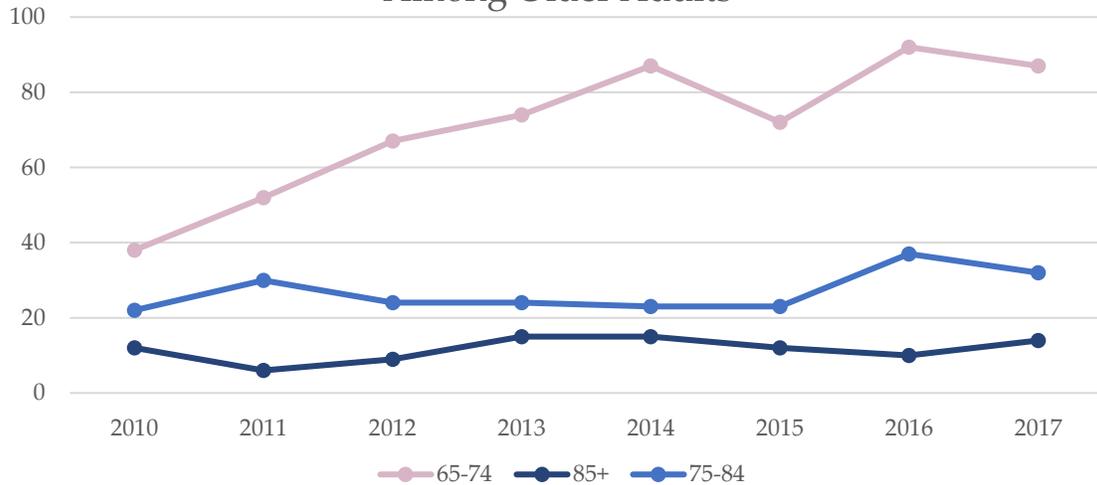
Number of Suicides by Age Among Older Adults

Legend: 65-74 ● 75-84 ● 85+
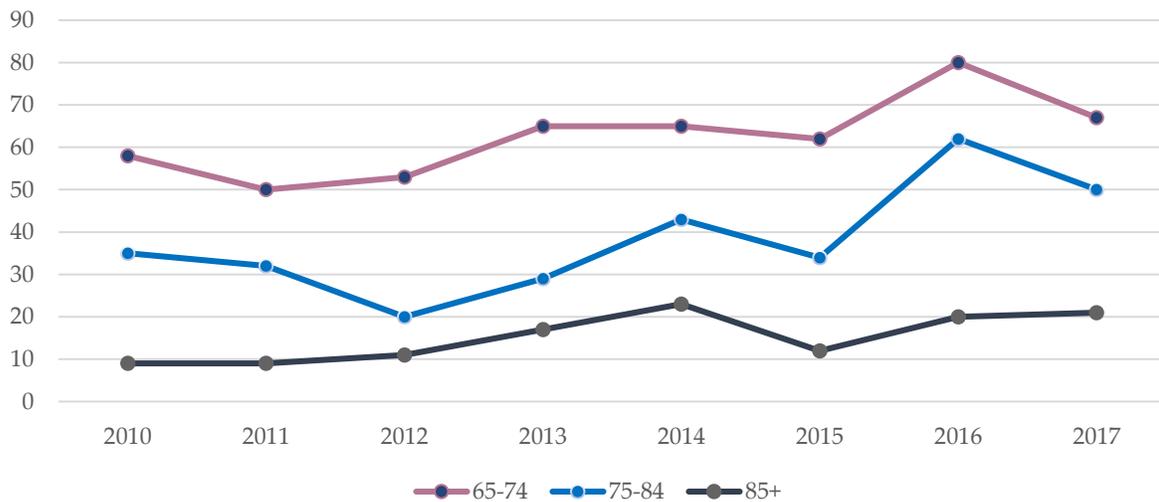
Critical Issues and Needs

➢ While the population of seniors has increased, funding for needed services has not kept pace (Aging and Disability Services Division, Commission on Aging, 2016).

➢ Older adults on fixed incomes are more likely to be negatively affected by rising rental costs in Nevada.

➢ Issues of behavioral health can be difficult to talk about with older adults – stigma and fear is often a barrier.

- Many caregivers (e.g. staff in nursing facilities, etc.) do not have adequate training to manage the array of mental and behavioral health issues. Early intervention is key; however, problems often are not addressed until a person is in crisis.
- Isolation and poverty can worsen symptoms of disease. Many older adults are without enough supportive connections.

Notable Resources for this Age Group

Programs that were named by key informants are shown to highlight some of the resources in place. This list is intended to provide visibility to some of the programming available. It is not intended as a comprehensive list of programs in Nevada.

- Crisis intervention training can be useful for people working with older adults. More people with training is needed.
- Senior centers provide a place for connection and engagement with older adults that may otherwise be isolated.
- A number of programs are available statewide. Those offered by aging and disability services (Nevada DHHS http://adsd.nv.gov/Programs/Seniors/Seniors/).
- The University of Nevada, Reno, Sanford Center on Aging, Geriatric Medication Management Program for individuals over 60 provides individuals with a comprehensive medication evaluation by a geriatric pharmacist – who then works with caregivers and prescribing physicians to recommend changes and address any potential safety concerns.

Hospice Care Serves People in Need – Including People Who Are Incarcerated

Hospice services are for those that are ill, and often those who are terminally ill. A new program has provided hospice training to several inmates in Nevada's Department of Corrections, so that they can help those who will die in custody.

"Hospice is positive changing the culture…it gives the (inmates trained to provide care) some kind of redemption, watching a light go out. One day they will be in that bed. One of the inmates that went through training was able to walk his family through the passing of their father (by phone). That's the reason I do what I do – we hope that they can change the culture…"

--Key Informant Interview

Racial and Ethnic Minorities

Risk behaviors, disease, injury, and even mortality can be the effects or outcomes of social and institutional inequities, as well as differences in living conditions. Reviewing data by race and ethnicity is one step within a larger set of activities that can help to identify levers for equity (Bay Area Regional Health Inequities Initiative, n.d.).

Population

- Racially, 9% are Black/African American, 9% some other race, 8% are Asian, 5% two or more races, 1% American Indian, 1% Native Hawaiian or Pacific Islander.
- Ethnically, 29% identify as Hispanic/Latino.
- Linguistically, 30% of households speak a language other than English at home.
- Nearly one in five, or 19.3% of Nevada's population was born in another country. A portion of this group is undocumented.

Mental Health

- Mental health status by race and ethnicity varies in Nevada. Based on Behavioral Risk Factor Surveillance System (BRFSS) data, people who are Hispanic were least likely to report that their mental health was "not good" between one and 30 days in the past 30 days. People who are Black had the second lowest rate, at 34.8%. The highest rate of was reported among American Indian/Alaska Native (52%) and Asian/Native Hawaiian and Pacific Islanders (42.5%) and "Other" (40.3%) (Kaiser Family Foundation, 2016).
- 52.1% of American Indian adults reported that their mental health was "not good" between 1 and 30 days (past month). Among all states in the nation, this was the *highest percentage recorded*.

Substance Use Disorder

- The rates of substance use disorder are not available for Nevada by race and ethnicity.

Cultural Competency Not Prioritized for Professionals

"So, the motivation to be more invested in cultural competency, what is the motivation? There's that attitude of race not being the issue. [We call] the relationship between the therapist the issue, as opposed to calling these therapists on their privilege, and especially on their class privilege. [There is also] a lack of awareness of poverty, lack of awareness of the reality of racism."

--Key Informant

Structural Components Reinforce Negative Outcomes

"So, you have a liver issue, you're going to be able to use your insurance. You have a mental health issue; a lot of psychiatrists are not going to treat you if you have Medicaid. They don't accept it. So, there's that barrier as well. The people of color, and poor people who are disproportionally of color, receiving [Medicaid] will have trouble having health behavioral care needs met."

--Key Informant

Suicide

➢ Suicide affects people of all races and ethnicities. In 2017, 65% of inpatient admissions for suicides were people who were White. Of all suicides, 76% were people who were White.

Critical Issues and Needs

➢ People of color are disproportionately receiving (Medicaid) in Nevada. In 2017, of the 36% of people on Medicaid, 20% were Black, 33% Hispanic, and 10% "other." (DHHS Office of Analytics, 2018). Considering that many providers don't accept Medicaid, people of color may be less likely to get behavioral health services.

➢ Nationally, and likely in Nevada, people of color use substances at similar rates compared to the rest of the population, but are disproportionately incarcerated for drug-related crimes (Rosenberg, Groves, & Blankenship, 2017).

➢ Nationally, and likely in Nevada, people of color have poorer health outcomes compared to whites (McGuire & Miranda, 2008). Disparities are caused by system problems and inequalities.

➢ Language can also be a barrier to service. Support in Spanish is most commonly needed. Among interviewees, the ability to provide services in Spanish were noted as a gap.

➢ People who are undocumented have access to very public resources. Further, family members of people who are undocumented may not seek out help because they are concerned about the risk of identifying others. Key informants were concerned that people, including youth and children, were not able to get help out of fear for risk of deportation for themselves or family members.

A Need for More Therapists with Sensitivity to Culture, Race, and Privilege

"I have clients who say, 'I can't say this to someone who is white…' Understanding white privilege – it is not taught. [There is] a lack of knowledge, lack of cultural awareness."

--Key Informant

Our Systems Not Able to Serve Some with the Most Severe Needs

"A teen in our community that has been (severe mental health problems) can't be treated in our organization, because we lack the certifications for that level of care. However, we can't refer her – her family's status makes her ineligible for most services, not to mention the financial barriers of travel from rural Nevada to an urban center. She has not been able to get the help she needs."

--Key Informant

LGBTQ[3]

People who identify as lesbian, gay, bisexual, or transgender (LGBT) often face social stigma, discrimination, and other challenges not encountered by people who identify as heterosexual. They also face a greater risk of harassment and violence. As a result of these and other stressors, sexual minorities are at increased risk for various behavioral health issues (National Institute on Drug Abuse, n.d.).

Population

Statistics to estimate the population of people who are lesbian, gay, bi-sexual, transgender are drawn from national data.

➢ 4.5% LGBTQ
➢ Younger people (millennials) account for rise in LGBTQ percentage
➢ 5.1% of women identify as LGBT, compared with 3.9% of men

Mental Health

➢ LGBTQ individuals are almost three times more likely than others to experience a mental health condition such as major depression or generalized anxiety disorder. This fear of coming out and being discriminated against for sexual orientation and gender identities, can lead to depression, posttraumatic stress disorder, thoughts of suicide and substance abuse (National Alliance on Mental Illness, 2018).

> **Isolation in Rural Communities**
>
> Participants noted the lack of services available for the LGBT community in [Eastern Nevada], and the group discussed that the LGBT community still faces stigma within the area. One participant noted that one year there was a Pride Parade, and the next year the community did not allow another parade to take place. The political climate in [rural Nevada] is often largely conservative. Members of the LGBT community may have mental health and substance abuse issues they are not comfortable seeking help for not only due to the stigma of mental health, but for fear of being outed as LGBT.
>
> **-Focus Group**

Substance Use Disorders

➢ A Youth Risk Behavior Survey (YRBS) study of risk behaviors among Nevada's youth showed that teens who were LGBTQ were statistically more likely to use substances than their heterosexual peers.
➢ In 2015 researchers in Nevada compared the YRBS data between youth identifying as heterosexual and youth identifying as LGB. In numerous behaviors measured, the LBG

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[3] LGBTQ stands for lesbian, bisexual, transgender, and questioning. The acronym is sometimes expanded to include AI, for asexual and intersex. The acronym appears differently within this section, as different sources refer to different terms.

had risk behaviors statistically higher than the group identifying as heterosexual. (Lensch, et al., 2015).

➢ 41.5% of students (LGB) had seriously considered attempting suicide (during the 12 months before the survey). This was three times the rate among the students identifying as heterosexual (13.9%) (Lensch, et al., 2015).

Suicide

➢ Rates of suicide, specifically for Nevadans who are LGBTQ, are not available. In Nevada, as well as nationally, sexual orientation is not included in death certificates. However, suicide is the second leading cause of death among young people ages 10 to 24.1.

➢ LGBT youth seriously contemplate suicide at almost three times the rate of heterosexual youth and are almost five times as likely to have attempted suicide compared to heterosexual youth.

➢ In a national study, 40% of transgender adults reported having made a suicide attempt. 92% of these individuals reported having attempted suicide before the age of 25.3.

➢ LGBTQ youth who come from highly rejecting families are 8.4 times as likely to have attempted suicide as LGBTQ peers who reported no or low levels of family rejection.

➢ One out of six students nationwide (grades 9–12) seriously considered suicide in the past year. Each episode of LGBT victimization, such as physical or verbal harassment or abuse, increases the likelihood of self-harming behavior by 2.5 times on average (The Trevor Project, n.d.).

Critical Issues and Needs

➢ While statistical data is not collected, several interviewees noted the challenges that adults and youth can face in finding community support, including but not limited to providers that had the training and competence to serve LBTQ individuals. These challenges can be more extreme in Nevada's rural and frontier communities.

➢ LGBT individuals may encounter or experience the "double or dual stigma" especially when someone seeks treatment. Often termed "minority stress," disparities in the LGBTQ community stem from a variety of factors including social stigma, discrimination, prejudice, denial of civil and human rights, abuse, harassment, victimization, social exclusion and family rejection" (National Alliance on Mental Illness, 2018).

➢ Services and resources that are competent to help people with diverse needs are lacking. This problem is acerbated by a general shortage of behavioral health care providers in the state. People in rural and frontier areas, including youth and teens, may find it very difficult to find the support within small communities.

Women who are Pregnant and Women with Dependent Children

Women who are pregnant or parenting infants and who also have mental illness, substance use disorders, or both, or those that have children in the home, are an important focus for treatment. Both mothers and the children may require special assistance and approaches for care.

Population
- Each year in Nevada there are roughly 36,000 births (36,260 in 2016).
- In Nevada there are 663,212 children under 18 in households.
  - 88% live with a biological, step, or adopted parent.
  - 7% live with a grandparent.
  - 3% live with other relatives.
  - 2% are in foster care or are otherwise unrelated to the householder.
  - 27.4% lived in households with supplemental security income, cash pubic income, food stamps/SNAP benefits (US Census, 2016).

Mental Health
- National data suggests that up to one in five women who are pregnant will experience perinatal mood and anxiety disorders (PMADs) making this health issue one of the most common complications of pregnancy (Best, 2015).
- Public awareness of postpartum depression (PPD) has increased in recent years. But there is still work to do expand the understanding of the types of issues that can affect pregnant women. PMADs encompass a range of emotional disorders, including major depression, generalized anxiety, OCD, panic disorder, and PTSD. (Best, 2015).
- PMAD may affect people disproportionately, such as adolescent mothers, women who are in low income situations, as well as by race and ethnicity (Taylor & Gamble, 2017).

Barriers to Treatment

"Families are in survival mode; treatment is last on the list." **- Focus Group Participant**

Relationship between Domestic Violence, Family, and SUD

Participants in a focus group discussed how abuse within households can be multigenerational, and the patterns learned early on are often seen throughout generations of a family. This can be true of physical abuse as well as substance abuse. Substance abuse often triggers domestic violence, and can be the result of domestic violence when people feel trapped.

--**Focus Group**

Substance Use Disorder
- Data suggests that only a portion of mothers who need treatment get it. In 2017, 213 pregnant women passed through substance abuse centers in Nevada that were publicly funded through SAPTA. (Note that this data reflects only a portion of those receiving services). The total number of those in need, verses those receiving services, is not available.

- In 2017, 667 substance exposed infants were born in Nevada. The number of substance exposed infants born in Nevada has increased each year since 2014.
- National rates of opioid use disorder are increasing among reproductive-aged and pregnant women, and opioid use during pregnancy is associated with adverse maternal and neonatal outcomes. Increasing trends might represent actual increases in prevalence or improved screening and diagnosis. Diagnostic procedures differ by state, and states with enhanced procedures for identifying infants with neonatal abstinence syndrome might ascertain more cases of maternal opioid use disorder.

Births and Drug Use
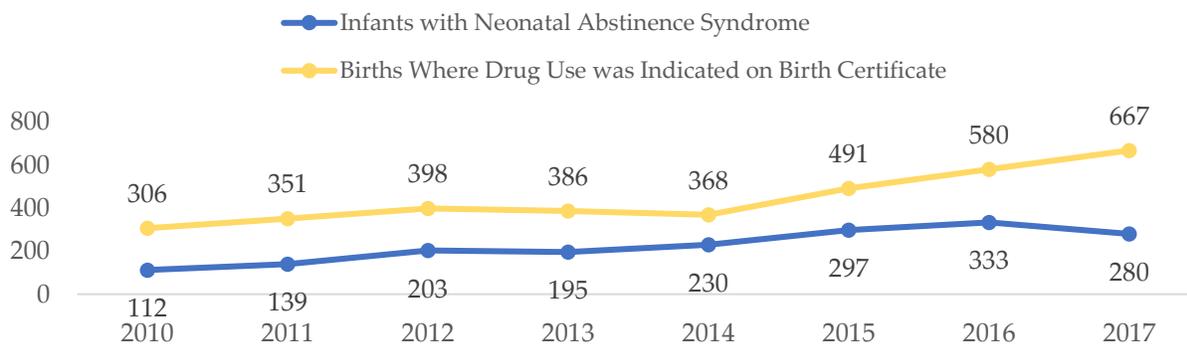
- Preliminary data for 2017 appears to indicate a continued upward trend for drug use identified on the birth certificate, and a slight decline for neonatal abstinence syndrome.

Infants with Neonatal Abstinence Syndrome and Drug Use Indicated on Birth Certificate, Per 1,000 Births
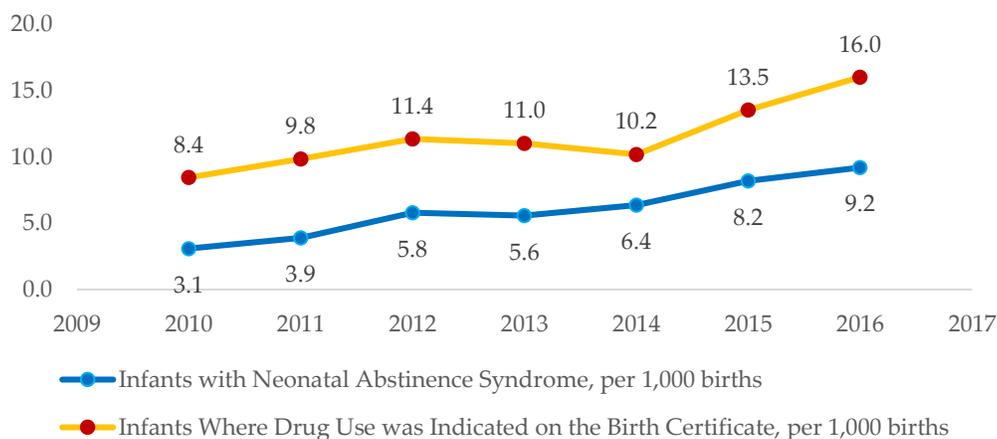
Suicide
- ➢ While no specific data on suicides for pregnant women are provided in this report, perinatal mood disorders may contribute to suicidal ideation.

Critical Issues and Needs
- ➢ Many pregnant women do not get the treatment they need for mental health, substance use disorder, or both. These issues, untreated, leave both mothers and children at risk.
- ➢ When women have substance use disorder, they may avoid sharing this information over fear or reporting and involvement of outside authorities.
- ➢ When women have children and are seeking treatment, they may need specialized care including arrangements with or for their children. The programs in Nevada able to provide these services exist, but are limited; especially in rural or frontier areas. There are also limited programs available for active users.
- ➢ Women experiencing domestic violence may have difficulty accessing shelter if they are active users – this gap was noted by key informant interviews.
- ➢ Many resources exist, but providers and the public may not know how to access them. Many of the tools and resources available to providers can be found here: http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/TitleV/Final%20Substance%20Use%20During%20Pregnancy%20Toolkit.docx.pdf

Additional Populations that May be at Particular Risk, be Underserved, or Hard to Serve

Many other sub-populations are important for focus and priority. These sub-populations may be at higher risk for health issues, be difficult to serve through traditional treatment services, or require specialized services.

Persons Who Inject Drugs (PWID)
Population
- ➢ The population of people injecting drugs is difficult to estimate. A national study in 2014 estimated the lifetime PWID comprised 2.6% of the U.S. population ages 13 and older (Lansky, et al., 2014).
- ➢ Among Nevada's high school youth, 2.6% reported having "ever injected" any illegal drugs.
- ➢ Disparities were noted among youth by race and ethnicity: nearly one in ten high school students who are American Indian (9.9%) reported having ever injected illegal drugs. The rate was also especially high among high school students who are Native Hawaiian and Pacific Islander (6.9%). The rates of injection were lowest among students who were Hispanic (2.2%) and White (2.2%).

Critical Issues and Needs

➢ Injection drug use is a route of transmission of blood-borne infections including but not limited to HIV, hepatitis, and the bacteria that cause heart infections (Centers for Disease Control and Prevention, 2018).

➢ Nationally, among people 18-29, Hepatitis C infection rose by 400% between 2004 and 2014, and admission for opioid injection rose 622% (Centers for Disease Control and Prevention, 2018).

➢ Harm reduction strategies that reduce risk-injection behaviors are available and effective in reducing disease transmission. However, these services are not widely understood or available in all areas of the state.

People who are Incarcerated or Leaving Detention
Population

➢ In 2015, the total population in Nevada's Prisons (Department of Corrections) was 13,692. Of this total, 12,466 were men and 1,226 were women. (State Of Nevada Department of Corrections, Fiscal Years 2014 and 2015).

➢ Between 2005 and 2015, the incarcerated population increased 13.3%. (State Of Nevada Department of Corrections, Fiscal Years 2014 and 2015).

➢ In addition to people in Nevada's prisons, people are held in local jails and other facilities. Youth may also be held in special detention centers.

Critical Issues and Needs

➢ Drug offenses are a significant cause for incarceration. In 2015, 14% of Nevada's DOC population were there for drugs, and 3% for DUI. For women, this percentage is even higher, with 23% held for drugs, and 5% for DUI (State Of Nevada Department of Corrections, Fiscal Years 2014 and 2015).

➢ A portion of the incarcerated population may have mental health, substance use disorder, or both (co-occurring disorders). Resources to help are limited within these settings, in part due to concerns about safety.

➢ Many programs are making their way into Nevada's prisons to help people with recovery. Mental health groups (through NAMI), Crisis Intervention Training, and groups for Substance Use are being piloted in some prisons. As part of Nevada's opioid response, a project is also in place to pilot implantable medication assisted treatment for people incarcerated.

➢ Upon release or probation, housing and other services can be particularly hard to find for people who have been incarcerated. Even with efforts to connect people to housing and resources through a discharge plan, housing may be extremely difficult, with homelessness and recidivism results from limited housing options.

➢ For people within (or leaving detention,) appropriate supports are often not available to address complications of substance use disorders (e.g. detox, withdrawal, etc.).

➢ A recent study comparing re-arrests in Washoe County among those that participated in specialty courts vs. non-specialty courts showed promising results, with a lower

percentage re-arrested during the time period reviewed (Morgan & Popovich, 2018). While preliminary, these data suggest that Nevada's specialty courts reduce recidivism.

People who are Homeless
Population
- ➤ Nevada's population of people who are homeless is large relative to the population size. Point in time counts in January 2017 revealed that there were 7,281 homeless individuals and the time of the count.
- ➤ In 2016, data maintained in the Homeless Management Information System showed 7,398 people homeless in Nevada. Within this group, 1,495, or 20%, had a mental illness.
- ➤ A portion of the population that is homeless has serious mental illness, substance use disorder, or both.

Critical Issues and Needs
- ➤ Mental illness, for some, can have "cascading effects," contributing to precarious housing or no housing. People who are homeless and that have a mental illness, substance abuse, or co-occurring disorder are at risk for escalating and advancing health problems.
- ➤ Trauma experienced before (and during) homelessness can be a factor that exacerbates mental illness, substance use, or both (Substance Abuse and Mental Health Services Adminstration, 2013) (Substance Abuse and Mental Health Services Administration, 2016).
- ➤ People who are homeless may have particular challenges in navigating health services, including insurance, that is available to them.

Veterans
Population
- ➤ In Nevada there are an estimated 216,275 veterans.

Critical Issues and Needs
- ➤ Veterans are at considerably higher risk for suicide. In a special report that reviewed data between 2010 and 2014, 22% of Nevada's suicide deaths were veterans (Interagency Council on Veterans Affairs, 2017).
- ➤ Veterans may experience increased stigma that impacts the ability to access treatment for mental health, substance use, or both. (Interagency Council on Veterans Affairs, 2017).
- ➤ In a national study, 18.5% of veterans who served in Afghanistan or Iraq currently have post-traumatic stress disorder or depression, and 19.5% report experiencing a traumatic brain injury while deployed. Yet, only a portion of those who need help receive it, and the adequacy of care is often insufficient (Tanielian, et al., 2008).

Regional Focus

Assembly Bill (AB) 366 passed in 2017 and introduced the development of behavioral health policy boards. Through this bill, Nevada is divided into 4 regions. A policy board was identified for each region, to consist of 13 members (Flood, Gutman, Saunders, & Leslie, 2018). A breakout by these regions is provided to help support clarification of needs.

Southern Nevada (Clark County, Nye County and Esmeralda Counties) Region

Description

The Southern Nevada region holds the largest population compared to other regions. It includes the greater Las Vegas area within Clark County as well as Nye and Esmeralda Counties, which have small populations and are considered frontier counties. (Note: As of the time frame of this publication, the rural counties of the southern region were being established as a separate region but had not been broken out to date).

Population

	Population	Percentage Under 18	Percentage 65 and Older
Clark County	2,204,079	23%	14%
Esmeralda County	850	15%	33%
Nye County	44,202	17%	30%
Total	2,249,131		

Selected Behavioral Health Indicators

Several county-level indicators are presented below. These indicators can be used to see areas of strength as well as priorities for attention. County data is compared to the nation's top performers in these indicators, as well as to the state as a whole.

	Clark County	Esmeralda County	Nye County	Top US Performers	Nevada
Poor Mental Health Days (Average Number in past 30 Days)	4.3	4.9	4.6	3.1	4.5
Adult Smoking	16%	21%	19%	14%	16%
Excessive Drinking	17%	16%	17%	13%	18%

	Clark County	Esmeralda County	Nye County	Top US Performers	Nevada
Alcohol-Impaired Deaths	32%	20%	29%	13%	32%
Mental Health Providers	570:1	790:0	740:1	330:1	540:1
Violent Crime	706	207	366	62	616
Social Associations	3.4	0.0	6.1	22.1	4.2
Drug Overdose Deaths	21	ND	33	10	21

(Robert Wood Johnson Foundation, 2018)

Highlighted Issues for Attention

The following list of issues is not comprehensive but highlights some of the pressing concerns identified by key informants, focus groups, or reports.

- **System Instability.** Recent program closures and threats of closures leave people without resources and challenge those trying to make referrals and placements. This is worsened by the sudden nature of many of these changes – there is a lack of trust in the systems that are in place locally to provide services.
- **Complex Systems to Navigate**. The system for assistance and treatment is complex and difficult to navigate.
- **High Turnover.** Providers are changing all the time – which impacts the relationships that can enhance collaboration and communication within and among the organizations providing services.
- **Transportation**. Transportation is often an issue for people with limited means – even short mileage distances can be impossible in southern Nevada without a car during summer months due to high temperatures. In the frontier areas of this county, travel time is long and trips to get people to appropriate care is expensive.
- **Workforce Shortages**. There are not enough providers to meet the needs, especially in rural areas.
- **Cultural and Linguistic Competency**. The ability to serve a diverse population – racially, ethnically, linguistically, and for people who are LGBT – are limited.

> **Strong Community but also Fragmented Systems**
>
> "Our twelve-step community is amazingly strong. The professionals that do provide this service are engaged, involved with their patients. So, there is a vibrancy to the recovery community. But our challenge would be the disconnection of the system."
>
> **—Key Informant**

> **Not Enough Providers**
>
> "We just don't have a huge pool of providers, especially in our rural communities. That's a struggle, and ongoing. And I think it's nationwide we see that as a struggle, but since so much of our state is rural it's incredibly frustrating for those families out there. And just finding mental health services. Add substance use on top of it, you know.
>
> **—Key Informant**

- **Lack of Detox Facilities**. Treatment often does not involve detox, and, when people are not in a monitored environment they go back to using.
- **Stigma**. People are often afraid to be labeled on health records, or, even among family members.

Opportunities

The following list of opportunities is not comprehensive but highlights some of key priorities identified by key informants, focus groups, or existing documents.

> Continue work to address the disconnection within the system through communication and collaboration.

> Consider system changes (structures, incentives, funding) that can improve referral and collaboration, toward a recovery-oriented system of care.

> Continue to encourage innovations and collaborations "that work" – regardless of the geographic boundaries that have been established.

> Build upon and share harm reduction strategies across providers and with other areas of the state.

> Continue to support and strengthen the providers that have a reputation for collaboration, results, and high-quality services.

Systems are Siloed

"To me, the very best of Las Vegas [is] that there are truly dedicated professionals here. This is a systems issue. It is not a lack of professionals or professionalism. It's a systems issue. The systems are very disjointed. And as a community we do our best to try to stay connected, and to try to get patients the help that they need. Unfortunately, or fortunately, it can be difficult."

– Key Informant

Systems are Siloed

"One [of the biggest gaps] that is definitely behavioral health and substance abuse related is crisis services. We have the one community triage center that WestCare provides, but we don't have any other crisis stabilization unit, especially a brick and mortar type of place where if somebody is in crisis --whether it's behavioral health-related or intoxication -- whatever it may be is somewhere where our outreach teams or police officers or fire department or ambulance feel that they can take this person instead of using the ER. **– Key Informant**

Washoe Region
Description
The Washoe County region includes Reno and Sparks, the second largest metropolitan area in Nevada.

Population

	Population	Percentage Under 18	Percentage 65 and Older
Washoe County Total	460,587	22%	16%

Selected Behavioral Health Indicators
Several county-level indicators are presented below. These indicators can be used to see areas of strength as well as priorities for attention. County data is compared to the nation's top performers in these indicators, as well as to the state as a whole.

	Washoe County	Top US Performers	Nevada
Poor Mental Health Days (Average Number in past 30 Days)	4.6	3.1	4.5
Adult Smoking	15%	14%	16%
Excessive Drinking	21%	13%	18%
Alcohol-Impaired Deaths	37%	13%	32%
Mental Health Providers	350:1	330:1	540:1
Violent Crime	372	62	616
Social Associations	5.8	22.1	4.2
Drug Overdose Deaths	21	10	21

(Robert Wood Johnson Foundation, 2018)

Highlighted Issues for Attention

The following list of issues is not comprehensive but highlights some of the pressing concerns identified by key informants, focus groups, or reports.

- ➢ **Housing Costs.** Recent rises to housing costs impact people with limited income. Those who are working through treatment and recovery, or those with mental illness, may have particular challenges in finding and maintain affordable and decent housing.
- ➢ **Lack of Detoxification (Detox) Services.** Additional services for detox were noted as a gap, keeping people from using the treatment services available.
- ➢ **Complex and Confusing System to Navigate.** One of the key issues is navigation of managed care organizations (MCOs). Determining how to use and access these services is difficult for those who are suffering from mental illness, substance use, or co-occurring disorders, those who are homeless, or because of other circumstances, have very little understanding – and therefore limited access – to the services that are available.
- ➢ **Wait Time for Services.** Programs and services can have considerable wait times for patients or there can be other barriers to accessing available services within the community.
- ➢ **Lack of Providers.** There is a lack of providers available to meet the needs of the population. Those who are qualified and interested in serving people with addiction disorders are not common, and this contributes to barriers to access.
- ➢ **Affordability.** Many programs have costs associated, including those with sliding scale fees. Even discounted medicine can be out of reach – with the example of some of the medications recommended for medication assisted treatment.

Opportunities

- ➢ Continue to build partnerships between law enforcement, treatment and recovery, and public health.
- ➢ Expand and enhance programs that have a reputation within the community positive outcomes.
- ➢ Expand Crisis Intervention Teams (MOST, FAST).
- ➢ Continue to build capacity of FQHCs to serve people through integrated care models.
- ➢ Enhance the ability for people to access preventative services and supports.
- ➢ Continue work in schools that provides youth and families with social and emotional learning supports.
- ➢ Continue to develop collaborative approaches to serving the community including in service of those with the most challenging needs.

Northern Nevada Rural Region

Description

The Northern Nevada rural region includes Carson City, Storey, Lyon, Douglas, Churchill, and Mineral Counties.

Population

	Population	Percentage Under 18	Percentage 65 and Older
Carson City	54,745	20%	20%
Churchill	24,230	23%	19%
Douglas	48,309	17%	27%
Lyon	54,122	22%	21%
Mineral	4,457	19%	24%
Storey	4,006	12%	30%
Total	189,869		

Selected Behavioral Health Indicators

Several county-level indicators are presented below. These indicators can be used to see areas of strength as well as priorities for attention. County data is show compared to the nation's top performers in these indicators, as well as to the state as a whole.

	Carson	Churchill	Douglas	Lyon	Mineral	Storey	Top US Performers	Nevada
Poor Mental Health Days (Average Number in past 30 Days)	4.1	4.4	3.9	4.5	5.0	3.9	3.1	4.5
Adult Smoking	18%	18%	14%	21%	20%	15%	14%	16%
Excessive Drinking	15%	17%	19%	18%	16%	20%	13%	18%
Alcohol-Impaired Deaths	25%	29%	29%	52%	18%	67%	13%	32%
Mental Health Providers	460:1	600:1	890:1	670:1	1,110:1	1,010:1	1:330	540:1
Violent Crime	257	187	138	273	193	954	62	616

42

	Carson	Churchill	Douglas	Lyon	Mineral	Storey	Top US Performers	Nevada
Social Associations	9.0	10.7	7.8	5.9	4.5	2.5	22.1	4.2
Drug Overdose Deaths	32	28	22	18	21	ND	10	21

Highlighted Issues for Attention

The following list of issues is not comprehensive but highlights some of the pressing concerns identified by key informants, focus groups, and reports.

➢ **Housing.** There is an insufficient amount of affordable housing to cover the needs of the area. The high cost of housing is a challenge for those already living close to poverty, and deters new professionals from moving to the area.

➢ **Families Face Separation for Treatment.** When youth need treatment out of the area, families can have difficulty staying connected and providing the support the child needs.

➢ **Lack of "Upstream" Support.** Lack of appropriate prevention and intervention results in overuse of Emergency Departments, Emergency Services, Law Enforcement) as well as poor outcomes for individuals involved.

➢ **Over-Prescribing.** Key informants identified concerns about doctors that over-prescribe; they were uncertain if new laws had yet had an impact.

> **The Right Agency Can Make a Regional Impact**
>
> "The Mallory Center has been amazing. It has saved emergency rooms countless dollars, and cut down (service use) by some of our super-utilizers because they can get help."
>
> **–Key Informant**

➢ **Service for Co-Occurring Disorders.** Few services are available for people with co-occurring disorders.

➢ **In-Region Resources.** Key informants noted that it may not be possible for their county to have every support needed, but, if treatment was nearby – especially residential, it would reduce barriers to treatment.

Opportunities

The following list of opportunities is not comprehensive but highlights some of key priorities identified by key informants, focus groups, or existing documents.

➢ Continued development and expansion of crisis intervention teams.
➢ Crisis intervention training for personnel at schools and those working with older adults.
➢ Continued professional development of the workforce on crisis intervention.
➢ Support and mechanism for transportation within and especially between counties.

➢ Continued partnerships within and among counties, including law enforcement, social work, county and city governments, schools, and treatment providers.

➢ Additional supports to help people that don't qualify for Medicaid but don't get paid enough for insurance (when it is not available through employers).

➢ Support to shelter people who are homeless – many communities do not have a shelter, and while numbers are small, there is nowhere for people to go.

➢ Expand the initial successes of telehealth, including telehealth that has taken place in jails.

➢ Continue to provide opportunities for rural communities to address workforce shortages through innovations in telehealth, remote (higher education), and supports for recruitment.

Regional Collaboration Helps Communities to Address Challenges

"Our strength is regional collaboration. We have a behavioral health task force that has been working together for about six years now – sheriff, fire, hospitals, rural clinics – we can talk about the issues within the region and also to approach super-utilizers."

–Key Informant Interview

Frontier Nevada Region

This region is the largest in terms of square miles. Counties include Humboldt, Pershing, Lander, Eureka, Elko, White Pine, and Lincoln.

Population

	Population	Percentage Under 18	Percentage 65 and Older
Elko	52,649	28%	11%
Eureka	1,961	23%	17%
Humboldt	16,826	27%	13%
Lander	5,693	26%	15%
Pershing	6,508	16%	16%
White Pine	9,592	20%	17%
Total	*93,229*		
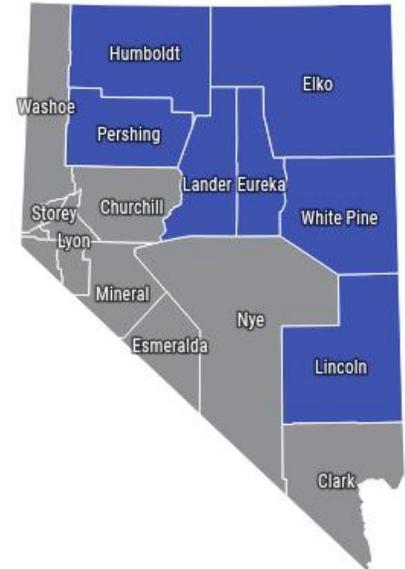
Selected Behavioral Health Indicators

Several county-level indicators are presented below. These indicators can be used to see areas of strength as well as priorities for attention. County data is compared to the nation's top performers in these indicators, as well as to the state as a whole.

	Elko	Eureka	Humboldt	Lander	Lincoln	Pershing	White Pine	Top US Performers	Nevada
Poor Mental Health Days (Average Number in past 30 Days)	4.0	3.9	4.1	4.1	4.1	4.0	4.3	3.1	4.5
Adult Smoking	18%	16%	18%	16%	16%	18%	20%	14%	16%
Excessive Drinking	23%	21%	23%	22%	20%	22%	21%	13%	18%
Alcohol-Impaired Deaths	31%	21%	32%	27%	47%	44%	19%	13%	32%
Mental Health Providers	1,680:1	ND	990:1	1,900:1	1,690:1	2,190:1	320:1	330:1	540:1
Violent Crime	371	359	335	674	44	841	338	62	616

	Elko	Eureka	Humboldt	Lander	Lincoln	Pershing	White Pine	Top US Performers	Nevada
Social Associations	5.4	0.0	12.3	11.9	4.0	4.5	3.1	22.1	4.2
Drug Overdose Deaths	12	ND	ND	ND	ND	ND	ND	10	21

Highlighted Issues for Attention

The following list of issues is not comprehensive but highlights some of the pressing concerns identified by key informants, focus groups, or reports.

➢ **Linguistic and cultural barriers to treatment.** There is one Spanish speaking provider in the Elko area making it difficult for Spanish speakers to receive treatment in their native language. Members of the tribal community are able to seek services through Indian Health Services, but specific tribal providers are available only on the colony.

➢ **Workforce shortages**. There are not enough providers to meet needs within communities. This includes residential and outpatient services.

➢ **Transportation (within and out of county).** For many, treatment has to take place out of the area. However, there is no longer a Greyhound Bus service for Interstate 80. When the person is involved with courts or law enforcement, they may be able to be transported by a deputy, but this means days that staff have to be out of the area.

➢ **Families Face Separation.** People have trouble accessing child care and related services. These problems are exacerbated for people who are faced with a choice between leaving the county for treatment, and staying to care for family. Women don't want to leave their children to go into treatment unless they have proper supports, as they are afraid they will not regain custody.

➢ **Documentation.** People who are undocumented are not able to be served through most programs.

> **Easy Access to Dangerous Drugs**
>
> These substances can be found "on every street corner." One participant noted that meth was "made everywhere – hotels, mobile labs, basements, open land." Meth specifically can be manufactured cheaply, brought in from out of state along I-80 corridor. Participants were concerned that meth leads to criminality and violence. One participant noted methamphetamine causes early onset of mental health issues, and causes paranoia. Several participants agreed that they had "Never seen it this bad."
>
> **– Focus Group (Elko)**

> **Stigma and the Barrier of Seeking Help**
>
> "One barrier [in a small town] is that everyone [can see you.] Rural clinics is a block off of Main Street. Everyone sees who's there."
>
> **– Focus Group**

- ➢ **Lack of "Upstream" Support.** Families may struggle with food, shelter, and bills. Attention and funding for substance use doesn't address the preventative and protective factors.
- ➢ **Child Abuse and Neglect.** The impact of substance misuse within communities affects children.
- ➢ **Over-Prescribing.** Key informants identified concerns about doctors that over-prescribe; they were uncertain if new laws had yet had an impact.
- ➢ **Costs.** Some programs have a charitable fund to help people with financial barriers – however cost (and inadequacy of insurance) was noted as a critical barrier to receiving needed services.

> **Working in the Mines Associated with Risk**
>
> "There is a variation from week to week in work schedule, and children can often be left alone for many hours if both parents work a varying schedule, meaning they may have more unsupervised time in which to use substances. Working in the mine can also lead to isolation which often leads to individuals not seeking treatment, and the group discussed how isolation can lead to increased substance abuse." **–Focus Group**

Opportunities

The following list of opportunities is not comprehensive but highlights some key priorities identified by key informants, focus groups, or existing documents.

- ➢ Funding and support for higher levels of care within frontier areas.
- ➢ Support and mechanism for transportation within and especially between counties.
- ➢ Additional supports to help people that don't qualify for Medicaid but don't get paid enough for insurance (when it is not available through employers).
- ➢ Develop triage or 24-hour stabilization services (like Mallory Center in Carson City).
- ➢ Flexible funding for frontier communities to be able to address specific barriers.
- ➢ Revisit funding formula to provide more funding to rural communities.
- ➢ Support to shelter people who are homeless – many communities do not have a shelter, and while numbers are small, there is nowhere for people to go.
- ➢ Expand the initial successes of telehealth, including telehealth that has taken place in jails.
- ➢ Continue to provide opportunities for rural communities to address workforce shortages through innovations in telehealth, remote (higher education), and supports for recruitment.
- ➢ Support and build community programs that are currently serving the community well and that have a positive reputation for helping people.

Definitions

Any mental illness (AMI) among adults aged 18 or older is defined as currently or at any time in the past year having had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet DSM-IV criteria. Adults who had a diagnosable mental, behavioral, or emotional disorder in the past year, regardless of their level of functional impairment, were defined as having AMI.
https://www.samhsa.gov/data/sites/default/files/Nevada_BHBarometer_Volume_4.pdf

Behavioral Health: Refers to a state of mental/emotional being and/or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders. This includes a range of problems from unhealthy stress to diagnosable and treatable diseases like Serious Mental Illnesses (SMIs) and substance use disorders (SUDs), which are often chronic in nature but that people can and do recover from. The term is also used to describe the service systems encompassing the promotion of emotional health; the prevention of mental and substance use disorders; substance use and related problems; treatments and services for mental and substance use disorders; and recovery support (SAMHSA).

Benzodiazepines are a class of drugs primarily used for treating anxiety, but they also are effective in treating several other conditions. Familiar names include Valium and Xanax. They are some of the most commonly prescribed medications in the United States. **https://www.webmd.com/mental-health/addiction/benzodiazepine-abuse#1**

Co-Occurring Disorder: People with mental health disorders are more likely than people without mental health disorders to experience an alcohol or substance use disorder. Co-occurring disorders can be difficult to diagnose due to the complexity of symptoms, as both may vary in severity. In many cases, people receive treatment for one disorder while the other disorder remains untreated.

CCBHC: Certified Community Behavioral Health Clinics. CCBHCs were created through Section 223 of the Protecting Access to Medicare Act (PAMA). CCBHCs may receive an enhanced Medicaid reimbursement rate based on their anticipated costs of care. CCBHCs are responsible for directly providing or contracting with partner organizations to provide different types of services, with an emphasis on the provision of 24-hour crisis care, utilization of evidence-based practices, care coordination, and integration with physical health care.

Crude death rates equal the total number of deaths during a specific year for a given cause of death (i.e. heroin overdose), divided by the population and multiplied by 100,000.

DPBH: Division of Public and Behavioral Health.

Fentanyl is an extremely potent synthetic opioid. It can be prescribed for pain but is also a common contaminant in unregulated drugs. 50 times stronger than heroin, is responsible for a growing number of overdose deaths each year. Typically manufactured as a white powder, it can be mixed into other drugs such as heroin and cocaine without the user knowing, but with extreme consequences. http://www.latimes.com/health/la-me-ln-fentanyl-test-strips-20180531-story.html

NAC: Nevada Administrative Code.

NRS: Nevada Revised Statutes.

Person-and Family-centered Planning: According to SAMHSA, "Person- and family-centered treatment planning is a collaborative process where care recipients participate in the development of treatment goals and services provided, to the greatest extent possible."

Prevalence: is a measure of disease that allows us to determine a person's likelihood of having a disease. Therefore, the number of prevalent cases is the total number of cases of disease existing in a population.

Recovery Oriented System of Care (ROSC): a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resilience of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.

SABG: Substance Abuse Block Grant. Federal grant administered by SAPTA.

SAMHSA: Substance Abuse and Mental Health Services Administration.

SAPT Grant: Substance Abuse Prevention and Treatment Grant. See SABG.

SAPTA: Nevada's Substance Abuse and Treatment Agency.

SED: Serious emotionally disturbed.

SSA: Single state agencies (SSAs) and state mental health agencies (SMHAs) are the state government organizations responsible for planning, organizing, delivering, and monitoring critical mental health and substance use disorder services in each state. SSAs and SMHAs provide safety-net services to individuals with mental and substance use disorders (M/SUDs) who lack insurance and/or have high levels of service needs. (Substance Abuse and Mental Health Services Administration., 2015).

Suicidal Ideation: While the definition of suicide is well understood, several other important concepts are important to share. First suicidal ideation means thinking or planning about suicide. Among individuals it can be a passing thought, or part of a plan. Ideation does not include the final act of suicide (Pederson, 2018).

Suicidal Contagion: Another important concept in understanding suicide trends, especially among youth, is suicide contagion. Suicide contagion is the exposure to suicide or suicidal behaviors within one's family, one's peer group, or through media reports of suicide and can result in an increase in suicide and suicidal behaviors (U.S. Health and Human Services, 2014).

Serious mental illness (SMI) is defined as a diagnosable mental, behavioral or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to cause serious functional impairment in an individual's major life activities (going to work, school, interacting with family, etc.).

Serious emotional disturbance (SED) has been defined historically by the Substance Abuse and Mental Health Services Administration (SAMHSA) and released as a Federal Register notice. The SAMHSA definition was crafted in order to inform state block grant allocations for community mental health services provided to children with an SED and adults with a serious mental illness (SMI). https://www.samhsa.gov/data/sites/default/files/NSDUH-DSM5ImpactChildSED-2016.pdf.

Substance Use Disorder (SUD): According to SAMHSA, substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.

Suicide contagion: Suicide contagion is the exposure to suicide or suicidal behaviors within one's family, one's peer group, or through media reports of suicide and can result in an increase in suicide and suicidal behaviors (U.S. Health and Human Services, 2014).

Trauma-Informed Approach: According to SAMHSA, a trauma-informed approach is, "A program, organization, or system that is trauma-informed: realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization" (Substance Abuse and Mental Health Services Administration, 2015).

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