

STEVE SISOLAK
Governor



LISA DURETTE
Acting Chair

STATE OF NEVADA
GOVERNOR'S COMMISSION ON BEHAVIORAL HEALTH
4150 Technology Way
Carson City, Nevada 89706
Telephone (775) 684-4200 • Fax (775) 687-7570
<http://dpbh.nv.gov>

The Honorable Governor Steve Sisolak
Office of the Governor
101 North Carson Street, Suite 1
Carson City, Nevada 89701

July 12, 2019

Dear Governor Sisolak,

The State of Nevada's Commission on Behavioral Health is a 10-member legislatively created body designed to provide policy guidance and oversight of Nevada's public system of integrated care and treatment of adults and children with mental health, substance abuse, and intellectual/developmental disabilities and related conditions. This 2019 report will address the following issues in accordance with NRS 433.314:

1. Information concerning the quality of the care and treatment provided for persons with mental illness, persons with intellectual disabilities, persons with developmental disabilities, persons with substance use disorders or persons with co-occurring disorders in this state and on any progress made toward improving the quality of that care and treatment
2. In coordination with the Department of Public and Behavioral Health, any recommendations from the regional behavioral health policy boards created pursuant to NRS 433.429. The report must include, without limitation:
 - a. The epidemiologic profiles of substance use and abuse, problem gambling and suicide
 - b. Relevant behavioral health prevalence data for each behavioral health region created by NRS 433.428
 - c. The health priorities set for each behavioral health region
3. Review and make recommendations concerning regulations submitted to the Commission for review pursuant to NRS 641.100, 641A.160, 641B.160 and 641C.200

Information regarding quality of care amongst persons with mental illness, developmental/intellectual disabilities, substance use and co-occurring disorders as well as information regarding prevalence of these disorders is gleaned from the 2019 State of Mental Health in America report published by Mental Health America (www.mentalhealthamerica.net). Mental Health America (MHA) derives their statistics from state submitted reports to the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Disease Control and Prevention (CDC) and the Department of Education. The MHA report addresses prevalence, access to insurance, access to mental health care and barriers to accessing mental health care. The following data reflect the 2018-9 statistics submitted to SAMHSA, the CDC and the Department of Education from the State of Nevada, and are compared against the other 50 states in the form of ranking:

1. Prevalence of mental illness: This score encompasses adults with any mental illness, adults with substance use disorder (SUD) in the past year, adults with serious thoughts of suicide, youth with at least one major depressive episode in the past year, youth with SUD in the past year, youth with severe major depressive episode. Of the 51 states, NV ranks 44.

2. Access to care: This score encompasses adults with acute mental illness who did not receive treatment, who report unmet needs, who are uninsured, who could not see a doctor due to costs, youth who did not receive services, children with private insurance that did not cover behavioral health problems, students identified with Emotional Disturbance for an Individualized Education Program and mental health workforce availability. NV ranked 47:51.
3. Nationwide, 18% of adults are experiencing a mental health illness. The prevalence rates vary from the lowest prevalence state (NJ, at 15.5%) to the highest prevalence state (OR at 22.6%). NV ranks 24:51 with a total 18.33% prevalence rate.
4. Adults with SUD nationwide in the past year is 7.93%. NV ranks 16:51 with a rate of 7.44%.
5. Adults with serious thoughts of suicide nationwide is 4%. NV ranks 30:51 with a rate of 4.3%.
6. Nationwide, 12.6% of youth report suffering at least one major depressive episode in the past year. In NV, 15.6% youth report same, with a ranking of 50:51.
7. Nationwide, 4.6% of youth report a SUD in the past year. In NV, 5.45% youth report same, with a ranking of 41:51.
8. Over 2 million youth nationwide suffer severe major depression, which often co-occurs with other mental health diagnoses including SUD, anxiety and behavioral disorders. The national prevalence is 8.7%; NV's prevalence is 12.7%, with a ranking of 51:51.
9. Nationally, over half (56%) adults with a mental illness did not receive treatment last year. In NV, 63% adults with a mental illness did not receive treatment in the last year, with a ranking of 50:51.
10. Nationally, 20% of adults with a mental illness reported they were not able to receive the treatment they needed. In NV, 26% adults report same, with a ranking of 50:51.
11. Over 5.3 million adults nationwide remain uninsured (12%). 15% Nevada adults remain uninsured, ranking 38:51.
12. The prevalence of adults with a disability who could not see a physician due to cost nationally is 21.6%. In NV, 24.75% adults could not see a physician due to cost, ranking 41:51.
13. Nationwide, 61.5% youth with major depression did not receive any mental health treatment in the past year. 59.8% youth in NV did not receive same, ranking 21:51.
14. Of youth receiving treatment for depression nationally, only 25% received consistent treatment (7-25+ visits per year). In NV, 16% youth received consistent care, ranking 45:51.
15. Despite the enactment of the Mental Health Parity and Addiction Equality law, many youths with private insurance still do not have coverage for mental health disorders. 7.8% youth nationally lack coverage; 11.2% in NV lack coverage (45:51).
16. The national rate of students identified as having an Emotional Disturbance for an Individualized Educational plan is 7.4%; in NV that rate is only 4.3%, ranking 43:51.
17. Mental health workforce encompasses psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists and advanced practice nurses specializing in mental health care. The state of MA has the highest ratio of mental health workforce participants at 180:1; AL the lowest at 1180:1 and NV ranks 32:51 at 540:1.

Children's Behavioral Health Services

Despite Nevada's overall low rankings in the areas of behavioral health disorder prevalence and access to care, there has been progress made over the year. Our state's three Children's Mental Health Consortia (Clark County, Washoe County and Rural) have submitted annual reports detailing their successes and future goals. The full reports are included as an appendix to this letter.

This Commission supports the recommended action steps of the Clark County Children's Mental Health Consortium, detailed in their 2019 status report, and summarized below:

1. Re-structure the public children's behavioral health financing and delivery system to ensure quality, accountability, and positive outcomes for Clark County's children and families.

- a. Recommended action steps include implementation of an integrated local system management of all publicly funded children's behavioral health services in Clark County in coordination with the Regional Health Boards.
 - b. Re-structure Medicaid policies and funding to support a single, accountable entity in Clark County which can blend other Medicaid and public resources allowing flexibility to implement individualized services to support and strengthen the family, reduce the need for out of home placement and improve positive outcomes for youth.
 - c. Recommend Medicaid adjust its rates for children's behavioral health services.
 - d. Include the following services as essential health benefits for youth with severe emotional disturbance under public insurance plans: family peer support, mentoring, mental health consultation, mobile crisis intervention and respite care.
 - e. Develop and implement a statewide set of quality standards that require children's behavioral health providers receiving public funding to utilize.
2. Provide mobile crisis intervention and stabilization services to Clark County youth in crisis.
 - a. Provide stable funding for DCFS to maintain evidence based mobile crisis intervention for Clark County youth in crisis.
 - b. Recommend DHHS develop interagency protocols and policies to ensure 24/7 access to mobile crisis services and seamless transition to appropriate aftercare including both public and privately insured youth.
 - c. Sustain funding for Family Peer Support to enhance outcomes and reduce out of home admissions for youth served by mobile crisis.
 - d. Develop a mechanism for providing presumptive Medicaid eligibility to appropriate youths referred for crisis intervention services.
3. Expand access to family peer support services for the families of Clark County's children at risk for long term institutional placement.
 - a. Expand funding to provide family peer support for Clark County youth with severe emotional disturbance at risk for long term residential treatment by implementing a pilot project for 200 youths discharged from psychiatric hospitalization and referred from the Clark County School District Mental Health Transition team.
 - b. Recommend that the pilot project established under AB307 of the 2015 NV Legislature should be implemented as the law intended and provide an intensive level of family peer support for at least 50 Clark County youth with co-morbid behavioral health needs and intellectual/developmental disability to prevent long term institutional placement.
4. Develop partnerships between schools and behavioral health providers to implement school-based and school-linked interventions for children identified with behavioral health care needs.
 - a. Recommend the NV Office of Suicide Prevention, along with the Clark County School District and the NV Institute for Children's Research and Policy conduct a comprehensive survey of Clark County public, charter and private schools to determine the degree to which mental health screening and/or suicide prevention screening has been implemented.
 - b. The NV Department of Education Social Workers in Schools Program should support the implementation of an effective model of school-based mental health and suicide prevention screening that is evidence based, cost effective, utilizes parental consent and includes procedures and resources to link identified students with needed services.

This Commission supports the recommendations of the Washoe County Children's Mental Health Consortium, detailed in their 2018 status report and summarized below:

1. The Consortium recommends a priority to expand the emergency response services for youth and their families who are experiencing a behavioral health crisis, which includes continued partnership with both DCFS and the NV Division of Health Care Financing and Policy to further the local service array necessary to expand the H1NT demonstration project and to identify potential avenues for Medicaid

funding within that service array; sustain the NV System of Care (SOC) and with the SOC and DCFS identify strategies for a single point of entry for families and youth to access services; expand wraparound services, expand mobile crisis and emergency services, sustain practices developed during the Washoe Pilot for Specialized Foster Care (SFC), review and expand funding allocation for the Department of Education and the Department of Public Safety's SafeVoice reporting system in response to high demand; develop community capacity to provide step-down services for youth discharged from residential treatment facilities; develop community capacity to provide short term crisis stabilization and respite services.

2. The Washoe County Children's Mental Health Consortia priority recommendations support their four goals:
 - a. Developing access to care
 - b. Encouraging families to advocate for themselves
 - c. Helping youth succeed in school
 - d. Support youth in transition

This Commission supports the recommendations of the Rural Children's Mental Health Consortium, detailed in their 2019 status update report and detailed below:

1. Address workforce development needs for rural NV by reviewing current Medicaid provider lists, increasing provider training in trauma, pursuing options for identifying Medicaid providers who work with children and adolescents and pursue options for developing telehealth providers.
2. Promote appropriate mental health providers to public schools via the Safe Schools Professional program. The Consortium will work with the State Department of Education to identify contacts and engage them in Consortium activities.
3. Support a SOC designed for NV's rural region by the following:
 - a. Define a SOC for rural NV and implement a demonstration project
 - b. Support the implementation of the CANS assessment tool with provider training
 - c. Assess the available array of services in accordance with the SOC Toolkit
 - d. Replicate the Community Discussion event in other rural areas to engage partners and disseminate information
 - e. Diversify community representation in SOC development, identify rural consortium stakeholders and invite them to the meetings, increase consortium representation at other community meetings and identify County-based consortium member contacts
4. Promote adequate technology to support the use of telehealth services in NV's rural regions by the following:
 - a. Develop providers who offer telehealth services
 - b. Increase parent and family familiarity and level of comfort in use of telehealth services.
 - c. Facilitate on-site orientations
 - d. Partner with key stakeholders to develop, update and distribute community resource guides and make resource guides through technology.
 - e. Implement activities to decrease the stigma associated with telehealth services
5. Create a Rural Children's Mobile Crisis Response Team. Plans for 2019 include promoting the need and benefits of rural mobile crisis and advocate for its continuation, funding to expand the program to include 24/7 services, increase advertising and marketing in the rural areas to inform how to access mobile crisis services and explore different telehealth services that would allow mobile crisis to provide better services to rural families.
6. Promote prevention and intervention via addressing behavioral health issues early. Specific 2019 plans include:
 - a. Developing a fact sheet to promote the Early & Periodic Screening, Diagnostic & Treatment tool as an early intervention tool.
 - b. Replicate REACH as a demonstration project (Elko).

- c. Disseminate information on evidence-based practices for children and families.
 - d. Support a trauma-informed behavioral health system and trauma specific services that is specific to parents and caregivers
 - e. Make parent voice a priority.
7. Increase transitional services to support youth receiving treatment in inpatient and residential centers, especially those out of state through increased local service array.

The 2019 MHA report ranked Nevada as the worst state (51st) in providing access to behavioral health care for its youth (Mental Health America, 2019). Nevada saw a 12% increase in adolescents aged 12-17 experiencing a Major Depressive episode in 2015-2016.

The mission of the Nevada Division of Child and Family Services (DCFS) states, “together in genuine partnership with families, communities and other governmental agencies, provides support and services to assist Nevada's children and families in reaching their full human potential. DCFS recognizes that Nevada's families are our future and children, youth and families thrive when they: live in safe, permanent settings, experience a sense of sustainable emotional and physical well-being and receive support to consistently make positive choices for family and the common good.” DCFS’ mental health services include Community-Based Outpatient Services, Residential and Day Treatment Services and Contracted Services (Northern Nevada Child and Adolescent Services, Southern Nevada Child and Adolescent Services and Rural DCFS).

A system of care is defined as “a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.”

The Nevada System of Care (SOC), is comprised of a broad array of both behavioral health and support services. These services include both home and community-based treatment, as well as out of home treatment services that are provided when necessary. The NV SOC has been actively educating and recruiting providers on how to become integrated into the SOC. The SOC offers free trainings to those providers looking to join the SOC. The SOC continues to advocate for families, through its Statewide Family Network, Nevada PEP.

A staggering number of children in the State of Nevada have significant mental health challenges and are frequently served by multiple systems; Juvenile Justice, Children’s Mental Health, Child Welfare, Developmental Services, and local school districts across Nevada. During the past 3.5 years with the System of Care Implementation Grant, DCFS has made significant progress toward achieving goals consistent with the Strategic Plan and has been successful in building the initial framework. DCFS would like to continue their effort in expanding and sustaining a collaborative, comprehensive, and community-based array of services. This includes emergent and planned diagnostic services, family-peer support, respite, Mobile-Crisis response, and other evidence-based interventions that are family/youth-driven, culturally and linguistically appropriate, and meet the unique needs of youth and families in each of Nevada’s communities.

The Commission recommends for DCFS to continue to develop a robust workforce to serve the unique needs of Nevada, both Northern, Southern and Rural. Each part of the state has its own challenges with regards to workforce. Specifically, in the rural communities, adequate technology is lacking to provide telehealth mental health services. Provider shortages exist as well, especially in the rural communities. Ensuring that the rural communities gain access to adequate technology to provide telehealth, will allow for youth and their families to receive consistent care for their mental health needs.

Due to Nevada’s 51st ranking for behavioral health services, it is recommended that Nevada move into more of a proactive stance rather than reactive. Nevada must make a shift and begin investing resources in prevention and

early intervention for children and youth. By engaging youth and their families early on through programs such as early childhood programs, which often teach appropriate social emotional skills, Nevada's children and families can prevent future entry points into the various systems such as juvenile justice and child welfare. Providing comprehensive access to prevention programs, accessing not only mental health agencies, but engaging the faith communities and schools as well, to provide additional supports to youth and their families is key. Expanding the mobile crisis response teams throughout the state can also assist youth and their families by having immediate access to care during difficult times.

Another recommendation is to re-structure the public children's behavioral health financing and delivery system to ensure quality, accountability, and positive outcomes for Clark County's children and families. One concern is youth being placed outside of Nevada for residential treatment. Between September 2017 and August 2018, more than 50% of youth were placed outside of Nevada for residential treatment, removing them from their family, friends, and other social support networks. This is not best practice. By allowing Desert Willow Treatment Center to financially restructure to increase its capacity of 12 residential beds, this will allow for fewer out of state residential placements for our youth, keeping their support systems intact.

Adult Behavioral Health Services

RURAL REGIONAL BEHAVIORAL HEALTH POLICY BOARD

(Elko, Eureka, Humboldt, Lander, Lincoln, Pershing and White Pine Counties)

The Rural Regional Behavioral Health Policy Board has made significant progress this year with the installation of telehealth equipment in all seven county jails, a licensed mental health professional is now available to an inmate within hours. The Board launched its first Elko Crisis Intervention Team training program in May 2018, resulting in over thirty first responders from 5 counties in the region being now equipped with skills to help identify behavioral health symptoms, deescalate individuals in crises, and possibly offer a diversion from jail or emergency department if available. The Policy Board has given 14 presentations in the region to inform and educate the community on issues of resources for rural behavioral health

The Board's annual report lists a variety of priorities and needs. These include:

- **Supporting development of rural infrastructure:** Funding, grant opportunities, regional "space" to house the grant dollars, creation of a Regional Behavioral Health Authority
- **Workforce development:** Providing a psychiatry residency rotation in this region, incentivizing health professionals to work in the rural region, increased Medicaid reimbursement rates for behavioral health services
- **Program development:** Creation of a community behavioral health crisis triage system, expansion of Certified Community Behavioral Health Centers, in this region, funding for the Crisis Intervention Team, funding for Mobile Outreach Crisis Teams, funding for Forensic Assessment Service Triage Teams, direct funding to this region to develop community-based behavioral health solutions, and support for development of information sharing mechanisms for vulnerable adults
- **Transportation:** Support development for non-law enforcement behavioral health transportation options, support for changes to Nevada statutes to allow secure non-emergency medical transportation
- **Regional Behavioral Health Coordinator:** Continue funding to support this position

Rural Regional Epidemiological Profile

Substance Use:

According to the 2018 Epidemiologic Profile, Rural Region the substance use data were collected from hospital billing data, vital records data, and through national survey data including BRFSS and YRBSS.

Youth Risk Behavior Surveillance System (YRBSS)

- Of the Rural Region high school students, 12.8% reported using cigarettes in the past 30 days and 19.1% currently use tobacco, this is higher than the Nevada at 12% in 2017.
- Of the Rural Region middle school students, 5.4% reported use of tobacco in the past 30 days; 2.4% reported using cigarettes in the past 30 days and used cigars in the past 30 days which is similar to Nevada.
- In the Rural Region, about 47% high school students have used electronic vapor (E-vapor) products and 19% are currently using E-vapor products, which is higher than the Nevada (15%) for high school students.
- In the Rural Region, 19.7% of middle school students have used E-vapor products and 7.1% are currently using E-vapor products which is slightly higher than Nevada.
- At least 6 out of 10 high school students have ever had a drink of alcohol (64%). Approximately 33.1% currently drink alcohol and 43.5% have had alcohol provided to them by someone else. Of Rural Region high school students, 22.4% had alcohol before the age of 13 years and 19.7% had a recent binge drinking experience.
- At least one out of ten middle school students drank alcohol before age 11 in the Rural Region of Nevada. Also, 8.8% currently drink alcohol and three out of ten had drank alcohol before (28.9%) which is slightly higher than Nevada.
- In the Rural Region, 34.4% of high school students reported trying marijuana, and 18.9% currently use marijuana. Nevada is like the nation for marijuana use.
- About 3% of the Rural Region middle school students, had tried marijuana before they turned 11 years old, 8.9% have ever tried marijuana before, and 4.4% currently use marijuana.
- Approximately 15% of the Rural Region high school students, have used prescription drugs that were not prescribed to them in their lifetime, while about 5% of middle school students have ever taken a prescription drugs that were not prescribed to them. Of the Rural Region's high school students, 4.6% have tried non-prescribed steroids.
- Drug use among high school students is slightly higher in the Rural Region than in Nevada. Of the Rural Region high school students 8.8% have use inhalants and ever using synthetic marijuana, while 6.3% have reported the use of cocaine.
- Middle school students in the rural region have the same percent of ever using methamphetamines 1.7%

Behavioral Risk Factor Surveillance System

The Behavioral Risk Factors Surveillance System (BRFSS) is a state based system that collects information through telephone and mobile phone surveys on adult health risk behaviors.

- Between 2011 and 2016, on average, 5% of Rural Region Nevada adults used marijuana or hashish in the last 30 days Marijuana use has increased consistently since 2014 and is expected to increase as marijuana was legalized in Nevada in 2017.
- Men who considered themselves heavy drinkers continue to decrease in the Rural Region and is lower than Nevada. For men, heavy drinking consists of consuming more than two alcoholic beverages a day.
- Women who considered themselves heavy drinkers has relatively remain steady from 2011 to 2017, at 2.8% in 2017 which is less than Nevada at 5.6%. For women, heavy drinking consists of consuming more than one alcoholic beverage a day.
- Binge drinking is defined in men as having five or more alcoholic beverages on an occasion. Binge drinking percentages continue to fluctuate between 15.6% (2017) and 33.6% (2013). Men in the Rural Region reported the lowest binge drinking percentage in 2017 which was 15.6%.
- Binge drinking is defined in women as having four or more alcoholic beverages on an occasion. Women in the Rural Region reported the highest binge drinking percentage in 2017, which was 28.1%. The lowest reported binge drinking was in 2015 at 7.3%.

Hospital Emergency Department Encounters:

The hospital emergency department billing data provides health billing data for emergency departments patients for Nevada's non-federal hospitals. Since an individual can have more than one diagnosis during a single emergency department visit, the following numbers are not mutually exclusive.

- Alcohol visits were more common than drug visits to the emergency department. In 2017, there was a total of 2,064 alcohol and drug-related emergency department encounters. Out of this number, 432 were related to alcohol (primary diagnosis) and 247 were drug-related (primary diagnosis).

Hospital Inpatient Admissions:

The inpatient billing data provided health billing data for patients admitted to hospital for longer than a 24-hour period. In 2017, more people were admitted into Nevada hospitals for drug-related issues than alcohol-related issues. Out of the 825 alcohol and drug-related admissions, 374 were alcohol-related and 451 were drug-related.

- Alcohol-related admissions were more common than drug visits until 2016 where drug-related admissions surpassed alcohol for the Rural Region. In 2017, there was a total of 1,777 alcohol and/or drug-related inpatient admissions. Out of this number, 55 admissions were related to alcohol (primary diagnosis) and 47 were drug-related (primary diagnosis).
- Inpatient admissions for drug use have risen significantly since 2009. In 2017, there were 125 inpatient admissions where marijuana/cannabis-related disorders were listed on the diagnosis, which includes all diagnoses and much of marijuana visits are for marijuana/cannabis-related disorders and not for overdose or poisonings.

Alcohol and/or Substance-Related Death:

Alcohol and/or drug-related deaths include deaths where alcohol/drugs are listed as either the cause of death or as a contributing cause of death; therefore, the main cause of death may not be due to alcohol or drugs but contributing to the cause of death. In 2017, 4,909 deaths were related to alcohol and drugs of which 168 (3%) were to Rural Region residents.

- In 2016, the 65-74 age group had a significant increase in alcohol and drug-related deaths. In 2017, years 65-74 age group had the most alcohol and drug-related deaths with 48 deaths reported. This was followed by 75-84 age group with 39 drug and alcohol-related deaths.
- The age-adjusted rate increased significantly in 2010 and has remain relatively high since for alcohol and/or drug-related deaths. In 2017, 168 deaths in the Rural Region were due to alcohol and/or drug use.
- Alcohol-related deaths have not increased significantly between 2009 to 2017. The alcohol-related deaths make up 20% of the alcohol and/or drug-related deaths. In 2017, there were 34 alcohol-related deaths (30.1 age-adjusted rate per 100,000 age-specific population).
- Drug-related deaths have increased significantly since 2015 (95% confidence interval). The increase in 2017, 134.4 age-adjusted rate per 100,000 age-specific population, is significantly higher than 2015 and 2016.
- White non-Hispanic have had a relatively stable rate of alcohol and/or drug-related deaths. While Black non-Hispanic deaths increased in 2012 and 2015, these deaths are statistically significant (95% confidence interval) due to the population size.

NORTHERN BEHAVIORAL HEALTH POLICY BOARD

(Carson City, Churchill, Douglas, Lyon, Mineral and Storey Counties)

The Northern Behavioral Health Policy Board has made good progress this year. Four out of six counties in the region have signed on to the Stepping Up Initiative, a national initiative to divert individuals from the criminal justice system when behavioral health conditions are evident. They have continued and expanded funding for Mobile Outreach Safety Teams, Forensic Assessment Services Triage Teams, Crisis Intervention Training, and Juvenile Assessment Service Triage Teams. Treatment providers in this region have received

funding to develop three additional Certified Community Behavioral Health Centers, a regional First Episode Psychosis Team, and an Assertive Community Treatment program. The Policy Board has given 23 presentations in the region to inform and educate the community on issues of rural behavioral health and resources available to the regional communities.

The Board's annual report lists a variety of priorities and needs. These include:

- Youth: Need for a 24/7 youth behavioral health crisis response, sustainable funding and expansion of youth mental health diversion programs, identification and funding for evidence-based youth treatment and interventions for juvenile justice diversion, and behavioral health professionals capable of treating youth.
- Behavioral health system with a variety of levels of care: Currently, only inpatient and outpatient behavioral health services are available, sustainable funding for Assertive Community Treatment, sustainable funding for support and expansion of Certified Community Behavioral Health Clinics, peer support services, group homes with varying levels of care, affordable and supportive housing, clarification of the legal hold process for better understanding by providers, options for non-emergency behavioral health transport for mental health crisis holds, development of a legal information sharing process for multidisciplinary teams to service vulnerable adults, development of services to support continuity of care, and funding options for inmate healthcare
- Crisis stabilization and diversion: Need for 24/7 behavioral health crisis response, need for sustainable funding mechanism for crisis triage centers, need for crisis triage centers in strategic locations to allow individuals to stay in their communities, sustainable funding and case management follow up to support Mobile Outreach Safety Teams, sustainable funding for existing Forensic Assessment Services Triage Teams, sustainable funding to support Crisis Intervention Training programs, and funding to expand crisis stabilization programs to the remaining counties
- Workforce development: Attracting and sustaining psychiatrists, behavioral health clinicians, substance use treatment professionals, specifically behavioral health professionals with the capability to treat youth and co-occurring disorders, securing clinical internship sites, creative funding opportunities to entice healthcare providers into rural areas
- Data needs: Accessing accurate behavioral health data that is aligned with national indicators, accessing legal hold tracking data, obtaining technical assistance for program evaluation, development of a data infrastructure to enhance communication between state and county services, and streamlining the use of research screening/assessment tools

Northern Region Epidemiological Profile

- Substance Abuse/Nonprescription Substance Use: Approximately 18% of high school students have used prescription drugs that were not prescribed to them, while 5.8% of middle school students have taken prescription drugs that were not prescribed for them. Drug use among high school students is slightly higher than the state.
- Marijuana: A survey between 2008-2017 found on average 44% of 12th graders, 32% of 10th graders and 15% of 8 graders have smoked marijuana in some compacity without a significant rise or drop in percentage.
- Alcohol: Alcohol use disorders among teens between 12-17 have diagnosed less every year in Nevada while the national average has stayed relatively the same every year with 2016 being the first year that Nevada had a lower percentage than the national average 5.3% - 5.7%. In 2016, 44.6% of Nevada's children reported having five or more drinks once or twice a week are at great risk for health problems.

Which is higher than the national average and this rate has climbed every year since 2011 which was at 40.2%.

- **Methamphetamines:** In the year 2008 the highest use of drug use at 2.8% while in 2017 there was a large drop to as low as 0.7% of teenage children that report using.
- **Illicit Drugs:** Illicit drugs in Nevada has kept even with the national average at 2.7% for every year except 2016 where we have risen to 3.0% for teens 12-17.
- In 2009-2017 youths between Nevada's population has shown a steady increase every year. The census shows that in 2017, 23.8% of the 2,985, 184-people living in Nevada were between the age of 15-17, while 19.8% or 591,066 were between 0-14 years of age.
- The mental health related deaths totaled 46.3% per 1000,000 people. This is an upwards trend from the previous two year but significantly less than the period between 2010-2014. Within the span of 2009-2017 Nevada has only seen 40 mental health related deaths for all ages under 45.
- **Suicide:** Among Northern Nevada youths' suicide is more common among high school graduates with 28 suicides in 2017 – 8th grade or less, 3 suicides – 9th to 12th grade, 10 suicides high school with a GED – 30 suicides. In 2017, there were 191 inpatients admitted for attempted suicide. Of those, 79% were for substance and drug overdoses. For 2009-2017 there have been 438 suicides in Northern Nevada, and an average 49 suicides occurred each year. Methods of suicides included substance abuse being the highest, with motor vehicle crashes being the lowest.

WASHOE REGIONAL BEHAVIORAL HEALTH POLICY BOARD

(Washoe County)

The Washoe Regional Behavioral Health Policy Board in 2018 utilized three mechanisms to determine the behavioral health needs and gaps in service in Washoe County.

Presentations at Policy Board Meetings: Over 25 public and private organizations providing behavioral health services in Washoe County were invited to address the Board.

Community Surveys: Five groups of stakeholders were surveyed in 2018. The major problems or issues were categorized into six categories:

Housing Concerns: The major concerns include insufficient affordable housing, lack of appropriate housing for the homeless, mental ill persons, and lack of affordable, quality group care homes, with appropriate staffing.

Stakeholders recommendations:

1. Encourage builders to include low-income units using incentives and tax breaks.
2. Tax builders of higher-priced homes to provide funding for rental assistance.
3. Have local and state government invest in creating more affordable housing, especially single room occupancy/tiny homes/conversion of old hotels/motels into subsidized housing.
4. Implement the Medicaid waivers/options to provide funds for housing.
5. Provide shelters/housing with mental health and other wrap-around services, including a Housing First program for the mentally ill homeless population.

6. Implement the evidence-based practice of supportive housing more widely.
7. Higher standards and monitoring of group homes.
8. Higher wages and higher-level staff at group homes.

Provider Concerns:

The major provider concerns are the following:

1. General shortage of providers, particularly psychiatrists and psychologist.
2. Recruitment problems, including inflexible professional boards.
3. Lack of providers for long-term case management.
4. Low insurance reimbursements, particularly from Medicaid.
5. Not enough providers for uninsured and underinsured.

Recommendations:

1. Incentives to attract and retain behavioral health providers.
2. Funding for more coordinated workforce development.
3. Improve reciprocity process through professional boards to streamline licensing/certification requirement and improve process.
4. Increase pay for staff in group homes to improve quality and education. Increase compensation to attract higher quality psychiatrists.

Medicaid Concerns:

1. Low reimbursements rates.
2. Lack of providers.
3. Administrative requirements.

Recommendations:

1. Increase Medicaid reimbursement rates
2. Address the reasons providers won't accept Medicaid.
3. Make policies more user-friendly.
4. Monitor quality of service provided by managed care and insist on more case management services for SMI population.

Resource Concerns:

1. Limited funding overall, especially for clients' needs and family caregivers.
2. Services cuts at NNAMHS.

Recommendations:

1. Additional funding throughout the behavioral health system.
2. Specific funding to address the state system resources specifically at NNAMHS to re-establish a drop-in center, recreational facilities, off-campus activities, classes, community garden and voc. rehab.

System Concerns:

There were many detailed and specific concerns raised. Some are described as follows:

1. More developed continuum of care for adults and children.
2. Services to assist 18-year-old transition to adult services.
3. Lack of in-state options for long-term needs and programs for medically complex clients.
4. Increasing numbers of mentally ill people in jail.
5. Lack of crisis stabilization services.

Recommendations:

1. Funding to address various gaps in the system
2. Required training for personnel who encounter persons with a mental illness.
3. Increase community case managers to assist people in accessing services and up-to date resources.

General Concerns: Number of disparate concerns were recorded in a general category covering a wide variety of issues:

1. Quality of service/case management in the community
2. Families unable to access services due to child care, language barriers, etc.
3. A silence halo around the epidemic of youth suicide.
4. Increasing homelessness

Recommendations:

1. Increase in communication with parents, youth, and community about youth suicide
2. Better education in schools to decrease stigma and increase willingness to accept treatment.
3. Louder advocacy

Washoe Region Epidemiological Profile

Mental Health:

Mental illness and substance use disorders, together referred to as behavioral health, are common with an estimated 46% of adults experiencing mental or a substance abuse disorder as some point in their lifetime, 24% in a year. While mental health utilizations for state funded facilities have decreased since 2009, hospital visits in both the emergency department and inpatient have increased, especially for depression and anxiety. More than half of high school students in Washoe County report never or rarely receiving mental health support in a time of need. The rate of having ever attempted suicide among middle school students in Washoe County was greater than Nevada overall. In 2016, 14.1 % of adults in Washoe County reported having experienced two or more weeks of poor mental health days. The percent of adults in Washoe County experiencing any mental illness, serious mental illness, or major depressive disorder was slightly higher compared to Nevada and the United States.

Mortality:

Between 2011 and 2017, the average prevalence for suicide consideration in Washoe County was 3.3%. Substance use is the most common method of suicide attempts in Washoe County with 286 emergency department encounters and 266 admissions. Mental health-related deaths have increased in Washoe County significantly from 2009 to 2017 at 25.2 over 100,000 age-specific population.

Substance Abuse:

A substance use disorder develops after repeated use of alcohol and/or drugs causes functionally significant impairment and can result in a variety of consequences including health problems, a physical withdrawal state, disability, and failure to meet major responsibilities at work, home or school. The coexistence of both mental illness and a substance use disorder is defined as a co-occurring disorder. The prevalence of drug use in Washoe County is higher in Washoe County than in Nevada and the United States. Drug-related deaths have increased significantly from 2009; 469 deaths to 706 deaths in 2017. Death from natural and semi-synthetic opioids had been decreasing, however, 2014 to 2017 data indicates the number of heroin-related and fentanyl deaths are increasing following the national trend. Self-reported marijuana and cannabis use in pregnant women have increased by 6.7% per 1,000 live births between

2011 to 2017. Neonatal abstinence syndrome has increased significantly (6.7%) per 1,000 live births. The LGBTQ population has higher responses to health risk behaviors including binge drinking and heavy drinking and having been told they have a depressive disorder. From 2012-2016, the prevalence of binge drinking and heavy drinking among adults in Washoe County has remained higher than Nevada and the United States. In 2017, alcohol-related inpatient admissions in Washoe County were more than double the rate in Washoe. Washoe County youths reported having at least using marijuana once. Both high school (12%) and middle school student use (3.2%) are higher than Nevada. Emergency department and inpatient visits for marijuana use (not overdose) were more prevalent than methamphetamine, opioid and cocaine use in 2017. More than one in three high school students in Washoe County reported they have been exposed to household substance use and mental illness.

Washoe Regional Priorities and Strategies

The Washoe Policy Board has identified areas that are considered priorities to either create, support, maintained or enhance. The following issues are in addition to those submitted to the Legislative Committee on Health Care as potential Bill Draft Request concepts and may be submitted in future sessions for support: Mobile Outreach Support Team, Targeted Case Management, Medicaid Section 1915(i), Affordable Housing Initiatives, and CHIP Behavioral Health Areas. Housing, Behavioral Health and Nutrition/Physical Activity emerged as the highest areas of need and where there was community capacity to initiate work.

Washoe Regional Recommendations to the State

Crisis Stabilization Unit (CSU)

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

Crisis Services are designed to stabilize and improve symptoms of distress and feature continuum of care services including 23-hour crisis stabilization/observation beds, medical detox, short term crisis residential services and crisis stabilization, mobile crisis services, 24/7 crisis hotlines, warm lines, psychiatric advance directive statement, and peer crisis services. A continuum of crisis services can assist in reducing costs for psychiatric hospitalization, without negatively impacting clinical outcomes (SAMSHA, 2014)

Recommendation: Recommends legislation that supports both programmatically and fiscally, A Crisis Stabilization Unit in Washoe County and has submitted a Bill request (BDR #40-486) to address that need.

Affordable Housing

The Policy Board reviewed the National Governor's Association Housing as HealthCare report and agree with the principles outlined therein regarding the need for affordable, accessible, quality housing. The Policy Board also remains concerned about the quality of housing available to this population as outlined in the audit of the Community Based Living Arrangements funded by the state.

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

Assisted Outpatient Treatment (AOT)

AOT allows the most severely mentally ill individuals to be court-ordered into treatment without ordering them into a hospital. It represents a less restrictive, less-expensive, more humane form of commitment than inpatient commitment. The court order not only commits the patient to accept treatment, but also commits the mental health system to providing it.

Recommendation: Northern Nevada Adult Mental Health Services (NNAMHS) successfully applied for a SAMSA grant to create an AOT program in Washoe County but that funding is scheduled to end in 2019. The Policy Board identified a need to include funding for the NNAMHS program in the next biennial budget.

Super-Utilizer Pilot Program.

Super-utilizers are individuals whose complex medical problems make them disproportionately heavy users expensive health care services, particularly emergency medical services, emergency room treatment and in-patient hospitalization. These patients often suffer from multiple chronic complex diseases, including mental health issues along either inadequate, or nonexistent housing, lack of a primary care physician or medical home. This places a high burden on our health care system.

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

New 1% Excise Tax to Address Impacts of Marijuana

After hearing presentations from community-based entities regarding lack of data on the impact legalization of marijuana has had in our region, ideas for more systemic data collection, surveillance and coordinated public education campaigns to address second-hand marijuana smoke, disparate populations such as pregnant, breastfeeding and youth prevention need to be addressed.

Recommendation:

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

Mandate Substance Abuse Prevention Program in Schools

Data reveals the level of substance abuse by adolescents. Substance use during adolescence has been associated with alteration in brain structure, function and neurocognition. Adolescent who abuse substances are at risk for a wide variety of issues that may interfere with their development such as depression, anxiety and can disrupt an adolescent ability to function and develop in a constructive manner. Drug-related accidents and overdoses often result in physical injuries, illnesses, and a higher risk of practicing unsafe sex which may expose them to HIV and other sexually transmitted infections. Teens may experience difficulties in school due to an inability to study or participate and often inhibits the successful development of academic and employment skills.

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

Schools have a significant role to play in addressing substance abuse, alcohol and tobacco. Youth who receive universal, school-based substance abuse prevention programming are less likely to use drugs, drink or smoke. Teachers and administrators can foster positive school limits, create and enforce prevention

policies and communicate consistent norms that these activities are unacceptable. The benefits are many: better grades, better attendance superior overall academic achievement than those who use.

Recommendation

Early intervention services which occur prior to high school are critical. The policy Board identified this issue as a possible BDR request asking for a mandate to require age appropriate education within our schools that will assist students in learning how to understand and identify the causes, preventions, and treatments for diseases, disorders, injuries, and addictions. It is the Board's understanding the Attorney General's office is pursuing a bill draft for this purpose and would support this effort.

Clubhouse or Drop-In Center for Consumers

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

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

Recommendation:

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

SOUTHERN REGIONAL BEHAVIORAL HEALTH POLICY BOARD **(Clark, Esmerelda and Nye Counties)**

The Southern Nevada Behavioral Health Policy Board met several times this past year, engaging local stakeholders, and submitting a community-wide survey eliciting perceptions of behavioral health in our region eliciting responses from 56 participants. Their two core recommendations, which this Commission supports, are as follows:

1. Regional allocation of funds from DHHS and DPBH to fund
 - a. Stable funding for transitional and crisis-intervention services for children and adults in the form of mobile crisis, additional triage centers, and updated emergency-management protocols that eliminate barriers to use of crisis services
 - b. A study on other states' or jurisdictions' efforts to enact policies in the spirit of the "Freedom to Heal Act" described above
 - c. Stable funding for diversionary mental health programs, such as Assisted Outpatient Treatment and specialty court programs (e.g., Mental Health Court, Drug Court, etc.)
 - d. The infrastructure to collect civil commitment data, including details from law enforcement, transports by emergency medical services to hospital emergency rooms, the course of treatment in the emergency rooms, and a summary of any transition to psychiatric services
 - e. Workforce development (e.g. tuition reimbursement, enhanced rates, etc.)
2. Create and support standards for data collection and reporting.

- a. Obtain and evaluate all routine data each state entity currently receives, including its source and purpose
- b. Increase coordination among public entities when addressing behavioral health matters
- c. Publicize and maintain an online organized, user-friendly repository of information on behavioral health relevant to all stakeholders
- d. Identify and eliminate barriers to community engagement when evaluating behavioral health systems
- e. Identify and coalesce state, regional, and local groups currently engaged in similar behavioral health data-related activities and explore potential for collaboration.

These two recommendations culminate in a legislative request to modify Assembly Bill 366 as follows:

- Re-align the counties that comprise the Southern Board, by adding Lincoln County to the Southern Board.
- Provide for flexibility of membership if the appointing body cannot find a qualified appointee. For example, the rural region does not have a public health officer, does not have a psychiatrist or psychologist, and does not have a private or public insurer.
- Clarify that the mandate to meet at least quarterly does not apply during the 120-day legislative session or, if the board does meet then, that the Legislator is excused.
- Seek an allocation of funds for full-time coordinators to help each Board carry out its duties in its region and to coordinate with the four other Boards.
- Edit the Boards' existing duties and what needs to be included in the Board's reports, such as:
 - o A description of the methods of collecting and analyzing regional data about behavioral health needs, problems, and gaps, including all data sources. A description of the efforts to coordinate and exchange information to ensure unified, coordinated recommendations that balance statewide goals with region-specific priorities. A description of any duplicative, conflicting, or obscure federal, state, regional, or local regulations.
- Task each Board with tracking data relating to Legal-2000 civil commitments happening in their respective regions, with a focus on collecting data relative to what happened on the back end of the process, including whether the person was civilly committed or not and any aftercare that took place.
- Task each Board with creating/maintaining a website or providing information to be uploaded to an existing website so that there is a "one-stop shop" for information in those regions.
- Name the specific entities with whom the Boards must coordinate. It may be prudent to ask the state, counties, and cities which of their entities ought to coordinate with the Regional Policy Boards. Including them in the discussion could gain buy-in, increase awareness of the Boards' existence, and begin the process of routing behavioral health issues through the Boards.
- Include language that calls upon the Regional Policy Boards to organize and consolidate accurate, actionable, and easily accessible behavioral health data.

Southern Epidemiological Profile:

Substance Use:

According to the 2018 Epidemiologic Profile Southern Nevada Region (Clark, Esmeralda, and Nye Counties) Substance use data were collected through survey data including two national surveys, hospital billing data, and vital records data.

Youth Risk Behavior Surveillance System (YRBSS):

The YRBS monitors six categories of health-related behaviors that contribute to leading causes of death and disabilities among youth and adults. Nevada high school and middle school students are surveyed during the odd years. In 2017, 5,336 high school, and 5,464 middle school students participated in the YRBS.

- Of all high school students, 5.4% in Southern Nevada reported using cigarettes in the past 30 days and 10.5% have used tobacco at one time. This is lower than the weighted percentage for Nevada which is 12.0%.

- Of Southern Nevada middle school students surveyed, 2.0% reported using cigarettes, 2.3% used cigars and 4.4% used tobacco in the past 30 days all of which is slightly lower than Nevada.
- In Southern Nevada, 40.7% of high school students have used electronic vapor (E-vapor) products and 12.9% are currently using E-vapor products, which is lower than the weighted percentage for Nevada (15.0%).
- In Southern Nevada, among middle school students, 18.2% have used E-vapor products and 6.2% are currently using them, which is lower than Nevada at 6.7%.
- At least, 6 out of 10 Southern Nevada high school students have had a drink of alcohol (60.0%), 25.2% currently drink alcohol, 43.1% had alcohol provided to them by someone else, 17.9% had alcohol before the age of 13 years and 9.8% indulged in a recent binge drinking experience (had at least five or more drinks of alcohol in a row for males and four or more for females within a couple of hours).
- Out of Southern Nevada middle school students, 13.5% drank alcohol before age 11, 9.4% currently drink alcohol and 27.1% have had alcohol before which is slightly lower than Nevada at 27.4%.
- In Southern Nevada, 33.4% of high school students reported trying marijuana, 18.4% currently use marijuana and 7.9% used marijuana before the age of 13, lower than Nevada at 8.8%.
- About 2% of Southern Nevada middle school students have tried marijuana before they turned 11 years old, 9.3% have tried marijuana before and 4.9% currently use marijuana.
- Approximately 15% of Southern Nevada high school students have used prescription drugs that were not prescribed to them in their lifetimes; 2.8% have tried non-prescribed steroids; and around 7% have used prescription drugs that were not prescribed to them.
- Drug use among Southern Nevada high school students is slightly lower when compared to drug use in Nevada statewide. Synthetic marijuana and inhalant use tops the list at about 7.0% followed by ecstasy at 5.7% and cocaine at 4.3%.
- Inhalant use is predominant at 5.9% among middle-schoolers followed by cocaine use at 3.6% and synthetic marijuana use at 3.3% in Southern Nevada for 2017.

Behavioral Risk Factor Surveillance System:

BRFSS collects information on adult health-related risk behaviors. According to the Centers for Disease Control and Prevention, BRFSS is a powerful tool for targeting and building health promotion activities.

- Between 2011 and 2016, on an average, 6.1% of Southern Nevada adults surveyed through BRFSS had used marijuana or hashish in the past 30 days. Marijuana use has increased consistently since 2014 and is expected to increase as marijuana was legalized in Nevada in 2017. On average, 1.0% of Southern Nevadans had used pain killers and 1.8% had used other illegal drugs to get high in the past 30 days.
- Southern Nevada men who considered themselves heavy drinkers in 2017 was 6.7%. For men, heavy drinking is defined by consuming more than two alcoholic beverages per day.
- Women in Southern Nevada, who are considered heavy drinkers, have remained relatively steady from 2011 to 2017, at about 5.4%. For women, heavy drinking is defined by consuming more than one alcoholic beverage per day.
- Binge drinking is defined in men as having five or more alcoholic beverages on an occasion. Southern Nevada men reported the lowest binge drinking percentage in 2016 which was 18.8%. In 2017, this was at 24.0% which was more than Nevada at 21.3%.
- Binge drinking is defined in women as having four or more alcoholic beverages on an occasion. Southern Nevada women reported the highest binge drinking percentage of 13.5% in 2011. In 2017, this was 10.8% which is not a significant (95% confidence interval) decrease.

Hospital Emergency Department Encounters:

The hospital emergency department billing data provides health billing data for emergency departments patients for Nevada's non-federal hospitals. Since an individual can have more than one diagnosis during a single emergency department visit, the following numbers are not mutually exclusive.

- In 2017, there was a total of 19,162 alcohol and drug-related emergency department encounters. Out of this number, 11,612 were related to alcohol (primary diagnosis) and 7,550 were drug-related (primary diagnosis)
- From October 2015, marijuana/cannabis use alone is more common for emergency department encounters than hallucinogens, opioids, and heroin. This includes all diagnoses, and many of the marijuana visits are for marijuana/cannabis-related disorders and not for overdose or poisonings.

Hospital Inpatient Admissions:

The hospital inpatient billing data provided health billing data for patients admitted to hospital for longer than a 24-hour period. In 2017, more people were admitted into Nevada hospitals for drug-related issues than alcohol-related issues.

- In 2017, there was a total of 35,969 alcohol and drug-related inpatient admissions. Out of this number, 2,333 were related to alcohol (primary diagnosis) and 2,300 were drug-related (primary diagnosis).
- Inpatient admissions for drug use have risen significantly since 2009. In 2017, there was an increase in inpatient admissions where marijuana/cannabis-related disorders and dependence were listed on the diagnosis.

Mortality:

Alcohol and/or drug-related deaths include deaths where alcohol/drugs are listed as either the cause of death or as a contributing cause of death; therefore, the main cause of death may not be due alcohol or drugs but a contributing to the cause of death. In 2017, 3,427 deaths were related to alcohol and drugs.

- In 2016, the 65-74 age group had a significant increase with 996 deaths. In 2017, the 65-74 age group had the most deaths with 874 deaths reported, followed by the 75-84 age group with 729 drug and alcohol-related deaths.
- The age-adjusted rate increased significantly in 2015 and has remained high for alcohol and drug-related deaths. In 2017, for Southern Nevada, 3,427 deaths were related to alcohol and drugs.
- Alcohol-related deaths increased in 2015 and have remained increased through 2017 for Southern Nevada. Alcohol-related deaths make up 19% of alcohol and/or drug-related deaths.
- Drug-related deaths have increased significantly since 2015 (95% confidence interval). The 142.3 age adjusted rate for 2016 is significantly higher in comparison to prior years.
- White non-Hispanics have had a significantly higher increase in alcohol and/or drug-related deaths since 2014. While Native American deaths increased in 2014, these deaths are not statistically significant (95% confidence interval) due to the population size.

Respectfully submitted,



Dr. Lisa Durette, Acting Chair
Governor's Commission on Behavioral Health
State of Nevada

CC: Director of the Legislative Counsel Bureau