NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

Bureau of Behavioral Health Wellness and Prevention

NEEDS ASSESSMENT FINDINGS AND STRATEGIC PLAN (2025-2030)

August 2025

Prepared by Altarum

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Executive Summary

In 2024, the Nevada Bureau of Behavioral Health Wellness and Prevention partnered with Altarum to develop a five-year behavioral health Strategic Plan to strengthen Nevada's behavioral health system. The Plan provides a framework to direct limited resources where they can have the greatest impact, guide future funding and policy decisions, and improve outcomes for residents across the State.

The Plan was built on a comprehensive needs assessment that combined community engagement with data analysis. Between November 2024 – February 2025, Altarum conducted community focus groups and key informant interviews in five regions across Nevada, gathering perspectives from behavioral health providers, policymakers, community members, and individuals with lived experience. These qualitative insights were supplemented with secondary data from sources such as the Nevada Office of Analytics, National Survey on Drug Use and Health, and U.S. Census data.

Findings from the needs assessment highlight persistent challenges across multiple behavioral health domains, including mental health, substance use, gambling, crisis response, and youth services. Participants described fragmented services, long waits for care, and gaps in continuity, compounded by social determinants such as housing, transportation, and economic insecurity. Workforce shortages, particularly in rural and frontier areas, and the persistence of stigma among institutions and caregivers further limit access and quality.

The Strategic Plan is organized by behavioral health domain and emphasizes coordinated, person-centered strategies that integrate clinical care with community-based supports. To ensure progress, the Bureau and Altarum will implement ongoing monitoring and evaluation, including annual performance tracking and interest holder feedback. This approach allows the Plan to remain flexible and responsive to changing needs while holding the system accountable for measurable improvement.

Ultimately, the Plan reflects the Bureau's commitment to building a more integrated and equitable behavioral health system. By grounding investments in both data and community priorities, it establishes a roadmap for lasting change and a healthier future for individuals, families, and communities across the State.

Contents

Background

In early 2024, the Bureau of Behavioral Health Wellness and Prevention (BBHWP) recognized that the enhanced funding made available through COVID-19-related grants would begin to phase out in the coming years. With this anticipated decline, it became increasingly important to ensure that remaining funds were used as strategically and effectively as possible.

At the same time, feedback from subgrantees, community members, and partner organizations continued to underscore longstanding and widespread challenges across Nevada's behavioral health system. While many of these issues were well known, the combination of limited resources and complex needs made it difficult to determine which challenges should be prioritized and where targeted interventions could have the greatest impact.

To support this decision-making process, the BBHWP partnered with Altarum to develop a comprehensive, five-year behavioral health Strategic Plan. This plan identifies the most pressing and actionable issues in Nevada's behavioral health landscape and outlines a data-informed path forward.

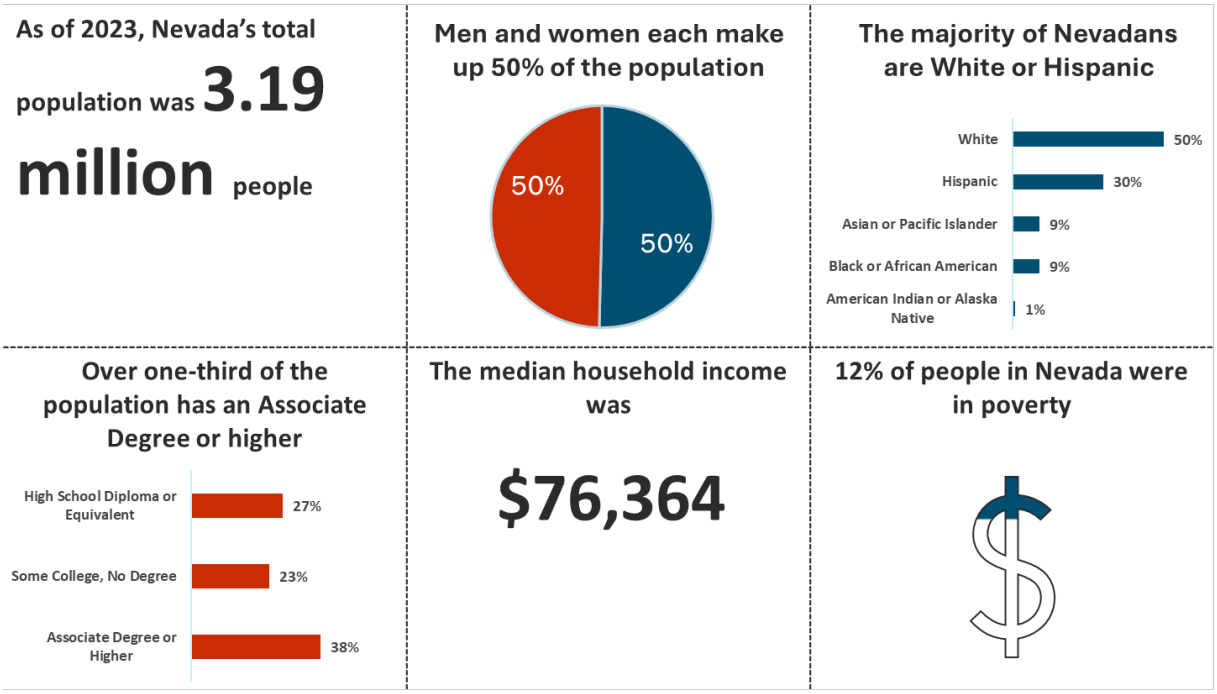
The Strategic Plan is intended to guide future funding decisions and may also inform the realignment of existing programs and resources. By anchoring investments in the strategies and objectives outlined in this plan, the State seeks to maximize its impact and better meet the behavioral health needs of all Nevadans.

Introduction and Project Overview

Nevada faces an ongoing behavioral health crisis. In 2022, 25% of Nevadans experienced a mental illness, including 37% of those aged 18 to 25.[i] In that same year, 3,667 per 100,000 Nevadans were diagnosed with substance use dependence and 29 per 100,000 Nevadans died from substance use.[ii]

These statistics reflect not just individual challenges but a system under strain. These challenges are compounded by demographic and regional disparities across the State. Structural factors, such as income, geography, race and ethnicity, and education, contribute to persistent disparities in behavioral health access across Nevada. Addressing these complex barriers requires more than isolated programs—it calls for a strategic, Statewide approach informed by data, community voices, and shared priorities.

Exhibit 1. Select Nevada Demographics



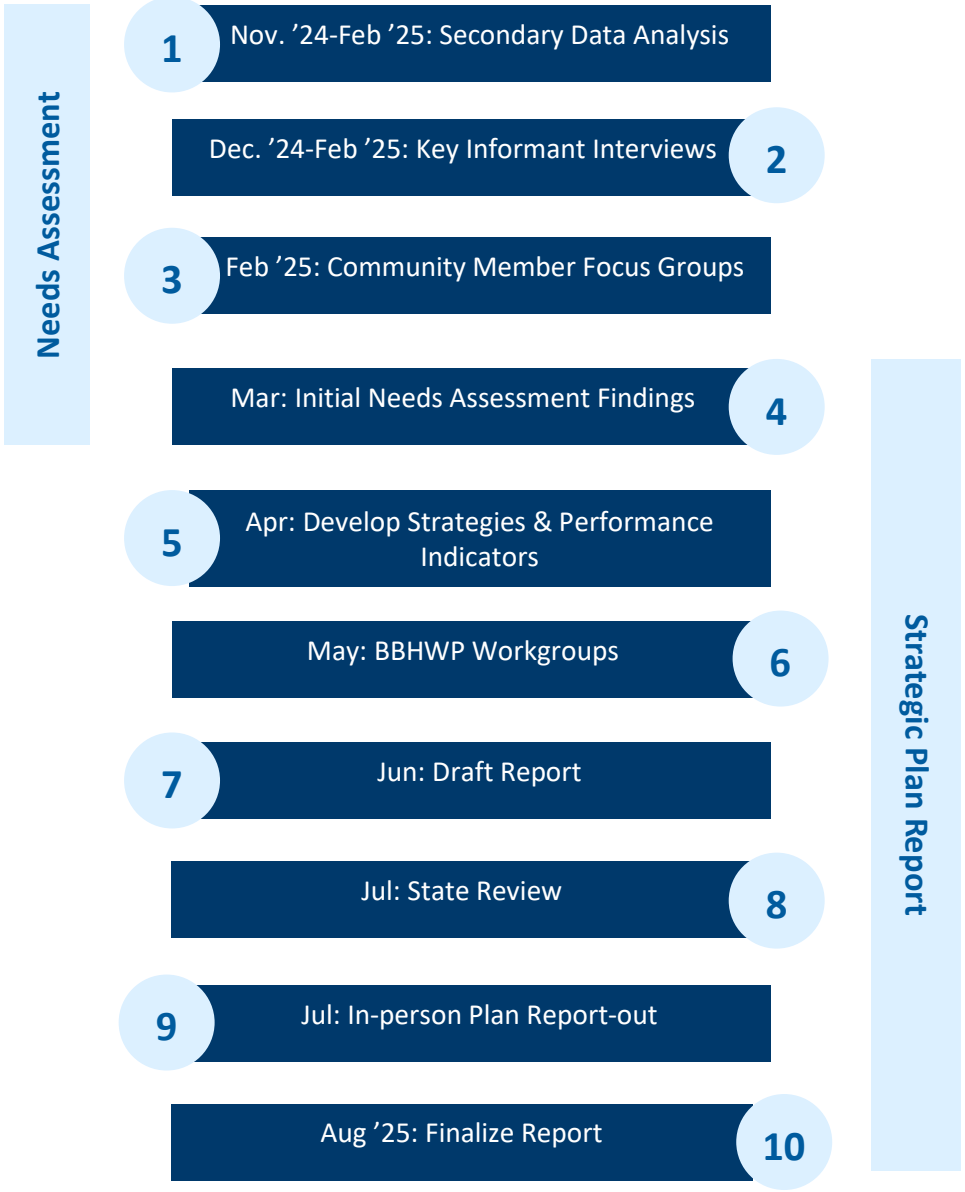
Source: American Community Survey Data - https://www.census.gov/programs-surveys/acs/data.html

The purpose of this Strategic Plan is to outline interventions to guide State-led behavioral health programs.

The Strategic Plan serves as a reflection of the needs, challenges, and opportunities identified by Nevada communities, key informants, and system leaders over the course of a multi-phase, mixed method assessment process. It captures recurring themes across key behavioral health domains, identifies areas where the system is currently strained, and offers strategies aimed at addressing these gaps. Developed in close collaboration between Altarum and the BBHWP, this plan integrated insights from primary data collection, secondary data review, and facilitated subject matter expert workgroup sessions.

The timeline for these activities can be found in the figure on the next page:

Exhibit 2. Timeline for 2025 Project Activities



The document is intended to be an actionable guide for decision-making, program development, and performance tracking at the State level. The strategies and performance indicators outlined in each section are designed to support alignment between programmatic goals and available funding, including federal and State investments. As federal grant funding continues to shift, this plan will guide Nevada’s efforts to prioritize activities that are feasible, impactful, and sustainable.

While the findings and strategies included in the Plan reflect input collected during 2024 and 2025, the Plan is structured to be flexible to support ongoing evaluation, adaptation, and partnership as the behavioral health landscape continues to evolve.

Key Core Definitions	
Term	**Definition**
Behavioral health	Refers to how behaviors, emotions, and habits affect a person's mental and physical well-being. It *includes* mental health, substance use, and lifestyle choices, and focuses on prevention, diagnosis, and treatment to promote overall wellness[iii]
BHCEN Providers	Programs or organizations that are certified under the Behavioral Health Certifications for Excellence in Nevada (BHCEN) framework, which sets Statewide standards for quality, accountability, and service delivery across behavioral health services, including substance use treatment, recovery housing, prevention, and crisis response
Certified Community Behavioral Health Clinic (CCBHC)	A specially designated clinic that provides a comprehensive range of mental health and substance use services to anyone who seeks care, regardless of their ability to pay, insurance status, or place of residence. CCBHCs must offer 24/7 crisis services, coordinate care across physical and behavioral health, and meet strict standards for access, quality, and service integration[iv]
Crisis services	Set of organized, immediate interventions and supports designed to help individuals experiencing urgent mental health, substance use, or emotional distress[v]
Federally Qualified Health Center (FQHC)	Community-based health care organization that provides comprehensive primary care and support services to underserved populations[vi]
Gambling Disorder	A persistent and problematic pattern of gambling behaviors that leads to significant distress or impairment[vii]
Mental health	Emotional, psychological, and social well-being, affecting how people think, feel, and act; mental health conditions include mental disorders (such as anxiety, depression, neurodevelopmental disorder, eating disorders, and others), psychosocial disabilities, and other mental states associated with significant distress or impairment[viii]
Social Determinants of Health (SDOH)	Conditions in the environments where people are born, grow, live, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks[ix]
Substance Use Disorder (SUD)	SUDs occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home[x]

State Certification Process

In May 2025, Nevada officially transitioned from the former Substance Abuse Prevention and Treatment Agency (SAPTA) certifications to a more comprehensive system known as Behavioral Health Certifications for Excellence in Nevada (BHCEN). Managed by the BBHWP, BHCEN reflects a broader vision to recognize and strengthen high-quality behavioral health services across the State. Certification is required for programs to receive State or federal funding administered by the Division of Public and Behavioral Health and is grounded in standards that promote accountability, service quality, and data-informed practices. The framework currently certifies a wide range of provider types, including substance use treatment and recovery programs, detoxification services, co-occurring disorder care, transitional and recovery housing, and prevention coalitions.

As the BHCEN system continues to grow, future Division criteria will expand to include additional areas of behavioral health. Planned additions include certification for mental health services, 988 mobile crisis response teams, Crisis Stabilization Centers (CSCs), and Nevada's Certified Community Behavioral Health

Clinics (CCBHCs). This expansion reflects the State's commitment to building a more integrated, accountable, and responsive behavioral health system.

Because both the Strategic Plan and the BHCEN framework are led by the BBHWP, they are intentionally aligned to reinforce one another. The Strategic Plan defines the vision and system-wide priorities for the behavioral health system, while the BHCEN certification process is an opportunity to operationalize these priorities. As the Strategic Plan was developed, its strategies and goals were directly integrated into the certification requirements, ensuring the goals of the larger system are reflected in what the providers are required to do. This intentional alignment creates a unified, mutually reinforcing approach to strengthening Nevada's behavioral health system.

Overall Approach

This Strategic Plan was developed through a collaborative, community-centered process. At every stage, Altarum worked closely with BBHWP project leaders on design and approach and relied on the voices of community members, key informants, and subject matter experts to guide needs identification and strategy development. Rather than pre-determining rigid focus areas, the Plan was intentionally shaped by the priorities and concerns raised by Nevadans themselves, including those most impacted by behavioral health system challenges.

To accomplish this, Altarum and the BBHWP co-developed semi-structured data collection tools that began with high-level questions about community needs, followed by tailored follow-up questions based on participants' response. While researchers included some targeted questions about specific behavioral health issues, they were instructed to let conversations unfold naturally and allow participants' priorities and perspectives to guide the discussion. As a result, the strategies presented in this plan reflect the lived experiences, insights, and recommendations of interest holders across the State.

Altarum also studied how other states structure their behavioral health strategic plans. This research informed the organization and framing of Nevada's plan, helping ensure it aligns with best practices while remaining responsive to the State's unique context. Building on this research, the Plan was developing using a public health framework,[xi] which views behavioral health as a population-level issue rather than solely as an individual or clinical concern. This framework emphasizes prevention, early intervention, and the social determinants of health (SDOH), such as housing, education, and transportation, which influence behavioral health outcomes. It also focuses on addressing disparities and promoting equity across populations. Unlike a clinical model, which centers on diagnosing and treating individual conditions, the public health approach seeks to improve behavioral health outcomes across entire communities by shaping systems and policies.

By placing community voices at the center of this process and applying a public health lens, the Strategic Plan establishes a foundation for meaningful and sustainable change in Nevada's behavioral health landscape.

Methodology

This Strategic Plan is anchored by a comprehensive needs assessment and informed by input from subject matter expert workgroups. The needs assessment included community focus groups, key informant interviews, and analysis of existing quantitative data to identify key behavioral health challenges across Nevada. Subject matter experts and State agency representatives were engaged in a series of facilitated workgroups to interpret findings, prioritize issues, and shape feasible strategies. This approach ensured the Plan was both data-driven and responsive to on-the-ground realities. A full description of all activities is detailed in the section below.

NEEDS ASSESSMENT: PRIMARY DATA COLLECTION

Study Design and Setting

From December 2024 through February 2025, researchers conducted the qualitative portion of the needs assessment in five regions across Nevada to gather in-depth perspectives on behavioral health needs, gaps, and services. The research included both focus groups and individual interviews with a diverse range of interest holders including behavioral health providers, policymakers, provider leadership, and individuals with lived experience. Participants were selected to reflect geographic, demographic, and sector diversity across the State.

Discussions focused on identifying the most pressing behavioral health challenges, barriers to care, and opportunities to improve access, coordination, and outcomes. Insights from these sessions directly informed the strategic priorities and performance indicators presented in this plan.

Participant Recruitment

Focus Groups: For the focus groups, leadership from State-identified community organizations in each region to lead initial recruitment efforts, using flyers and messaging materials developed by the Altarum team. Due to low turnout and inconsistent participation via this community-based approach, researchers, in partnership with the State, decided to adjust the recruitment strategy. Community organizations were subsequently asked to directly identify and invite specific participants, including both care seekers and providers, to ensure adequate participation.

Interviews: For interviews, the State compiled a list of key contacts, providing details such as role, organization, and program areas. The list included policymakers, other individuals employed at the State, researchers, providers, individuals with lived experience, and other subject matter experts. Recruitment responsibilities were shared between the State and Altarum teams. The State introduced the initiative via email, while Altarum conducted two to three follow-up attempts, with additional follow-up from the State as needed. Interviewees scheduled sessions with Altarum researchers via a Microsoft Bookings link.

Data Collection

Focus Groups: In February 2025, two Altarum researchers conducted six in-person focus groups in five locations: Reno (2 groups), Elko, Carson City, Pahrump, and Las Vegas. Each focus group lasted

approximately 90 minutes and included 7-12 participants. With participant permission, all sessions were audio recorded and subsequently transcribed for analysis. The focus groups included a total of 53 participants.

Participation distribution by site, date, and total number of focus group attendees is presented in the table below:

Exhibit 3. Focus Group Participants by Site

Site	Date	Total Participants
Carson City	Feb 4th, 2025	9
Elko	Feb 3rd, 2025	7
Pahrump	Feb 6th, 2025	7
Reno Group 1	Feb 4th, 2025	15
Reno Group 2	Feb 4th, 2025	6
Las Vegas	Feb 6th, 2025	9

Interviews: Three Altarum researchers conducted 15 interviews virtually over Microsoft Teams between December 2024 and February 2025. The 60-minute interviews were recorded with participant permission and transcribed for analysis. Interview participants represented a range of professionals, including executive directors of behavioral health organizations, public health administrators, academic researchers from Nevada's universities, law enforcement and judicial representatives, and leaders from advocacy groups such as NAMI Western Nevada and the Advisory Committee on Problem Gambling.

The table below provides a detailed summary of key informant interview participants, including service setting or population focus, relevant background, and geographic information.

Exhibit 4. Key Informant Roles & Specialty

Setting/ Population	Background	Location
Crisis	Administrative	Washoe County
Justice-involved individuals	Law Enforcement	Clark County
People with Lived Experience/Peers	Peer Advocacy/Nonprofit Leadership	Southern Nevada
Behavioral Health	Medical	Washoe County
Justice-involved individuals	Law Enforcement	Washoe County
Behavioral Health	Psychology	Southern Nevada
People with Lived Experience/Peers	Peer Recovery	Washoe County
Rural	Public Health	Rural Nevada
People with Lived Experience/Peers	Academic	Washoe County
Behavioral Health	Administrative	Statewide
Problem Gambling	Academic	Southern Nevada
Certifications	Licensed Clinical Social Worker	Washoe County
Rural	Administrative	Rural Nevada

Setting/ Population	Background	Location
Behavioral Health	Behavioral Health Policy/Advisory	N/A
Public Health	Public Health	Southern Nevada

Data Collection Instruments

Altarum and the State co-developed the semi-structured guides for both focus groups and interviews. To ensure alignment with Nevada's behavioral health landscape, the guides were reviewed and refined in consultation with a broader group of State experts and interest holders. This approach ensured the tools comprehensively addressed Nevada's priorities and were tailored to the State's specific context.

The guides were organized by key behavioral health domains, including substance use, mental health, crisis care, and others. This structure allowed researchers to explore common themes across participants while also following participant-driven insights based on individual experiences, roles, and areas of expertise. The approach supported deeper exploration of challenges, service gaps, and potential opportunities for system-level improvement.

Data Analysis

A lead researcher developed a structured qualitative analysis plan to ensure a systematic and rigorous approach to data interpretation. The Plan articulated the purpose of the analysis, including research questions, and details about how the data would be used to drive the Strategic Plan. It also detailed the process for developing codebooks and coding responsibilities by focus group and interview transcript. The five researchers who conducted the analysis used the Plan to confirm their individual responsibilities and maintain consistency in their coding approach.

CODEBOOK DEVELOPMENT AND CODING PROCEDURE

The team began with a draft codebook informed by the structure of the interview and focus group guides. Each researcher then independently reviewed three unique de-identified transcripts to refine and expand the draft codebook based on their observations. Following this review, the team met to compare and discuss their suggested additions and changes. Through consensus, they made mutually agreed-upon revisions to produce a unified and comprehensive codebook. A research lead managed the codebook throughout the analysis to ensure consistency.

This full process, including transcript review, codebook refinement, and collaborative coding, was completed separately for the focus group and interview transcripts to ensure each data source was analyzed based on its unique structure and content.

To establish consistency in code application and promote interrater reliability, the researchers then each coded two focus group transcripts in NVivo. Following this initial round of coding, the team generated two reports – Nodes by Number of References and Coding Summary by Node – to organize content by category, explore relationships across categories, and evaluate consistency in code application. After this discussion, coders recoded their initial two transcripts as needed and applied the updated and final codebook to the remaining transcripts. Transcripts were assigned to researchers based on availability. Coders met biweekly to discuss emerging findings and ensure consistent code application.

THEMATIC ANALYSIS

After all transcripts were coded, the research team conducted an in-depth analysis of the data. To support this process, the NVivo reports were re-run to facilitate synthesis. Researchers examined what was present, absent, and consistent across responses to establish needs identified by Nevadan interest holders. They collaboratively assigned meaning to each category, including both predefined and emergent codes, and reconciled any discrepancies in interpretation through discussion.

Researchers analyzed the data using a deductive approach to ensure sufficient representation of content across the predefined behavioral health domains outlined in the guides. This allowed the team to assess whether each domain was adequately addressed and whether thematic saturation, defined as the point at which no new information or themes emerge, had been reached within each area.

At the conclusion of the qualitative analysis, researchers summarized emergent themes and salient findings in an initial needs assessment report, which was presented to the State. Although the findings from interviews and focus groups are discussed separately to reflect their unique perspectives, the research team ultimately triangulated findings across three data sources – interviews, focus groups, findings from the secondary analysis – to inform and produce comprehensive strategies. This triangulation strengthened the representativeness and broad applicability of the strategies, ensuring they reflected the diverse perspectives and data sources.

Limitations

The focus group recruitment strategy was shifted to a provider-driven model due to low community interest during the initial recruitment phase. As a result, the diversity of perspectives in the focus groups may be limited. To help mitigate this limitation, key informants that were interviewed reflected diverse backgrounds, perspectives, and geographic regions within Nevada.

NEEDS ASSESSMENT: SECONDARY DATA COLLECTION

Approach

To support the quantitative secondary data analysis, two researchers developed a structured analytical plan designed to guide the process, ensure methodological rigor, and align with the overall goals and scope of the project. The purpose of the analysis plan was to provide a systematic approach for exploring behavioral health-related disparities across key population subgroups. The Plan outlined the research questions, defined key variables and indicators within each behavioral health domain, and detailed the statistical methods and tools to be used for analysis and reporting.

Researchers utilized the public data sources listed in the table on the next page to complete the secondary analysis.

Exhibit 5. Secondary Analysis Data Sources

Data Source	Population	Variables
Nevada Office of Analytics	Nevada specific	NV behavioral health conditions (including SUD and suicide)

Data Source	Population	Variables
National Survey on Drug Use and Health	National average data, Nevada specific data	Drug use and health
U.S. Census American Community Survey	National average data, NV specific data	Demographics, insurance coverage, household characteristics (income, education, poverty level)
National Center for Health Statistics	National average data, Nevada specific data	Measures of health status, population and provider survey data, vital statistics data (premature deaths, others)
County Health Rankings	Nevada specific	Health Status
Roadmaps	Nevada specific	Health Status
HRSA Area Health Resource Files	Nevada specific	Health Status
Area Deprivation Index	Nevada Specific	Wealth of neighborhoods/regions/rural/urban

The selection of data sources for the secondary analysis was guided by several factors. First, the State specifically requested that the analysis draw on public datasets due to their relevance to policy and programmatic decision-making. Second, the selected data sources are widely recognized as reliable and high-quality, offering clean datasets with robust population coverage. Lastly, the selection was informed by Altarum's prior work in this area and by established best practices for needs assessments and behavioral health system planning.

Data Analysis

In collaboration with the State, the research team identified a core set of demographic variables to include in the quantitative analysis. These included race/ethnicity, age, sex, insurance status, region, and exposure to adverse childhood experiences (ACEs), among others. The selection of these variables was intended to align with the State's strategic priorities and support the identification of disparities in behavioral health access, outcomes, and needs across diverse population groups and geographic areas.

Researchers extracted relevant national-, state- (Nevada), and, when available, county-level data related to behavioral health indicators. Data were compiled into structured Excel workbooks, which served as both data collection tools and platforms for analysis. Within these workbooks, researchers conducted univariate descriptive analyses, such as frequencies and means, to summarize key demographic indicators across the United States, the State of Nevada, and specific Nevada regions when appropriate.

Because the purpose of the secondary data analysis was to support and enrich the qualitative findings, only select quantitative results are presented throughout the report.

SUBJECT MATTER EXPERT WORKGROUPS

To ensure the Strategic Plan reflected both community perspectives and system-level expertise, the State convened six Nevadan subject matter experts to participate in a series of workgroups. These individuals, all members of the Nevadan community, were selected to represent the full range of

priorities across the BBHWP and brought expertise spanning multiple behavioral health domains, including mental health, crisis care, and SUD. The purpose of these workgroups was to review and refine the draft strategies and performance indicators developed by Altarum based on needs assessment findings. A total of four workgroup sessions were held with these experts in May 2025 via Microsoft Teams, each lasting approximately 90 minutes. Each session was facilitated by a researcher, with a second researcher taking detailed notes. During these sessions, participants provided feedback, offered recommendations for modifications, and suggested new strategies as appropriate. Insights and recommendations from these workgroups directly informed the development of the final Strategic Plan.

About This Document

The purpose of this section is to orient the reader to how the document is organized and how to interpret the findings and strategies that follow.

Unless otherwise noted, each section presents a synthesis of primary data, gathered from community members and key informants, and relevant secondary data. Secondary data, when available, is used to supplement the qualitative findings. Because community and key informant input were collected using different methodologies, their findings are presented separately. Each section has varying levels of data based on availability and frequency of occurrence during qualitative data collection.

Each section concludes with recommended strategies designed to address the identified needs within the behavioral health system. The strategies include sub-strategies and performance measures that will guide implementation and track progress over time. Each strategy is designed to align with overarching goals and respond to identified needs within the behavioral health system.

Cross-Cutting Findings

While this Strategic Plan presents findings and strategies by domain, several themes emerged consistently across all areas of focus. These cross-cutting findings represent systems-wide needs and opportunities.

Stigma Reduction: Across all conversations, interest holders indicated that stigma remains a significant barrier to accessing behavioral health services. Reducing stigma within communities, health systems, and institutions is important to improving prevention, early intervention, and sustained engagement in care.

The Power of Peers: Peers with lived experience were identified as essential partners in behavioral health care. Interest holders described peer support as a uniquely effective strategy for building trust, promoting recovery, and extending the reach of services. Because peers play a vital role across multiple domains, including substance use, mental health, and crisis response, among others, their contributions appear throughout this plan. Repeated reference to and strategies containing peers are intentional, reflecting the synergy of peer roles across systems and their ability to support individuals in diverse settings. A full list of strategies containing peers can be found in Appendix A.

The Importance of Strengthening CCBHCs: CCBHCs were frequently cited as providing essential infrastructure for delivering comprehensive, coordinated care. Interest holders called for relying heavily on the CCBHC model to ensure equitable access to behavioral health services across regions.

Access to Care: Consistent access to behavioral health services remains a challenge across populations. Long wait times, limited-service availability, and affordability concerns were noted as persistent barriers.

Expanding Reach to Rural Population: Rural and frontier communities face limited provider availability and long travel distances. Interest holders spoke of the need for mobile services and telehealth to close service gaps.

School Supports: Schools were viewed as important access points for youth behavioral health services. Expanding school-based programs and parent-school collaborations were identified as a key opportunity.

Addressing Transportation Barriers: Transportation challenges, particularly in rural and frontier regions, are a significant barrier to accessing timely and consistent care. Strategies to improve transportation options were considered necessary for ensuring service delivery across the State.

These cross-cutting themes appear across multiple strategy areas and domains, highlighting their relevance throughout the Plan.

Problem Gambling Prevention and Treatment

Gambling addiction is underrecognized and underfunded, with limited trained providers available in Nevada. Stigma, especially related to employment concerns, prevents many from seeking treatment. There is a strong need for more prevention, public awareness campaigns, and expansion of treatment options, particularly for individuals who suffer from co-occurring behavioral health issues.

Finding 1: Key informants reported that gambling addiction in Nevada is underrecognized, underfunded, and stigmatized, with limited public understanding and differing views on which populations are most at risk.

Key informants believe that gambling addiction is often overlooked as a behavioral health issue. They noted that this lack of attention occurs at all levels, within individual provider settings, at the state level, and at the federal level. There is a lack of funding, knowledge, prevention efforts, and, according to key informants, a lack of urgency in the State of Nevada. Further, key informants believe that individuals are unlikely to seek treatment. This is despite gambling being characterized as an Addiction Disorder by the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Participants also shared details about the populations most likely to be impacted by problem gambling. There was no consensus among those interviewed about trends of those suffering from this addiction. Some described it as “equal opportunity,” some indicated prevention efforts should be geared toward youth, while others felt the elderly population were most likely to suffer. Those who favored youth-prevention explained that, in their view, young people are generally more likely to engage in risky behaviors such as problem gambling. Others pointed to older adults, noting that some research has found age-related mental health changes can increase their vulnerability, including a reduced ability to control gambling behaviors.

There was more agreement on issues related to stigma. Participants acknowledged that stigma significantly impacts individuals’ willingness to seek treatment. They discussed how stigma is not only felt on a personal level but also at the community level, where "gamblers" or just the act of gambling is often viewed negatively. Some felt the stigma surrounding gambling addiction is uniquely challenging because, unlike alcohol or other SUDs, they felt there is less public awareness and recognized frameworks for understanding it as an addiction.

"There is incredible stigma attached to problem gambling. I don't have an empirical way of saying this, but it's worse than other substances." – Key Informant

"There's a great long and storied practice of hiding it [problem gambling behavior]." – Key Informant

Finding 2: Key informants reported that individuals with problem gambling behaviors most often access support through the Gambler's Anonymous Hotline or community-based groups, and they envision a future with expanded prevention, awareness, and treatment resources.

Key informants outlined the key resources that individuals struggling with gambling addiction are most likely to seek out or be referred to. They shared that those who seek treatment often do not do so through a provider, but rather through the national Gambler's Anonymous Hotline (or they access the hotline at a provider's recommendation). Key informants perceive the hotline as an effective tool because it's widely known and easy to access. Additionally, key informants shared that other resources were helpful with addressing gambling addiction. Informal meetings such as workshops or support groups, offered at community centers or provider offices, can be valuable by bringing together those affected, reducing stigma, and, in some cases, sharing practical strategies for recovery.

Problem Gambling Prevention and Treatment Gaps at a Glance:

- Under-recognition of gambling addiction
- Limited availability of trained providers
- Stigma and employment concerns
- Lack of prevention and awareness campaigns
- Gaps in treatment options
- Lack of consensus on population-specific approaches

Key informants envision a future where there are more resources for individuals with gambling addiction. The pathway to get there, as they see it, is through better prevention efforts, increased awareness of gambling addiction as a population-level problem, more funding from the federal and State government to support prevention and treatment efforts, routine prevention screening in behavioral health care settings, and better training for providers to identify and address gambling addiction behaviors.

"The problem with gambling, it's just the shortage of behavioral health providers that would say, 'I'm trained in how to do that. I feel comfortable in knowing how to do that'." – Key Informant

"Gamblers Anonymous is an important piece here. Not everyone participates, but for those that do, it's very, very effective." – Key Informant

Turning Insight Into Action

The following strategies represent the response to the key findings and opportunities identified through qualitative data collection and collaboration with Nevada interest holders. To address the need for enhanced prevention and screening, the Plan includes a strategy to integrate standardized gambling screening and referral protocols into behavioral health and substance use treatment settings. To combat stigma and raise public awareness, another strategy focuses on targeted prevention and awareness campaigns aimed at high-risk populations, such as youth and older adults, along with community education on gambling risks and co-occurring behavioral health conditions.

The tables below detail each strategy and its associated performance indicators for ongoing monitoring and evaluation.

Strategy 1.1: Strengthen Screening & Treatment Capacity for Problem Gambling

Sub-Strategy	Performance Indicator	Data Sources	Population/Unit Being Measured
1.1.1 Integrate standardized screening and referral for gambling behaviors into behavioral health and substance use treatment settings	Percentage of SUD settings implementing routine gambling screening protocols	▪ BHCEN certification data ▪ SUD Provider surveys	▪ Statewide SUD Providers
	Number of Nevada residents downloading the Evive gambling harm prevention app and indicating SUD provider referral source	▪ Evive	▪ Statewide SUD Providers

Strategy 1.2: Increase Public Awareness and Early Prevention of Gambling Addiction

Sub-Strategy	Performance Indicator	Data Sources	Population/Unit Being Measured
1.2.1 Launch targeted prevention and awareness campaigns focused on high-risk populations, including youth and older adults	Number of campaign materials delivered through digital, print, and community-based channels	▪ Campaign delivery records ▪ Communications contractor reports	▪ State-led materials
	Number of prevention campaigns tailored to specific populations (e.g., youth, older adults, high-risk groups)	▪ Campaign design records ▪ Target audience segmentation data	▪ State-led campaigns
1.2.2 Educate communities on the signs and risks of gambling addiction, including co-occurring behavioral health conditions	Number of education efforts that address gambling risks and co-occurring conditions	▪ Outreach event logs ▪ App promotion reports	▪ State-led community events

Behavioral Health Workforce

Nevada's behavioral health workforce faces significant challenges that threaten both current service delivery and future capacity. Low wages, staff burnout, limited training opportunities, and uneven distribution of providers across the State, including in rural and frontier areas, make it difficult to recruit and retain qualified professionals. These challenges are exacerbated by heavy workloads and limited access to essential resources. While emerging technologies like telehealth offer opportunities to expand reach and improve access, sustained investment in workforce development is essential to ensure quality care for all Nevadans.

Finding 1: Key informants expressed concern about workforce shortages, driven by burnout, low pay, and uneven distribution of providers, with these challenges felt most acutely in rural and frontier areas.

Key Definitions	
Frontier setting	Areas that are extremely sparsely populated and geographically isolated from population centers and essential services. These settings are considered the most remote on the urban-rural continuum, often lying beyond what is typically classified as "rural"[xii]
Rural setting	Geographic area located outside of cities and towns, typically characterized by open spaces, agricultural land, and a lower population density; The U.S. Census Bureau defines rural as all population, housing, and territory not included within an urban area or urban cluster, with urban areas generally having at least 2,000 housing units or 5,000 people[xiii]

Key informants highlighted challenges related to staff retention, low pay, the adequacy of training programs, and geographic disparities in workforce distribution. Retention was described as being undermined by high burnout rates, limited career growth opportunities, and the emotional toll of behavioral health work. They noted that the behavioral health workforce is vulnerable to burnout because of the high emotional demands of the work, frequent exposure to crisis situations, and, in rural and frontier areas, the added strain of heavy caseloads and professional isolation. Practitioners in rural and frontier areas also suffer from limited access to clinical resources, specialty services, and professional support networks. These barriers make it harder to ensure consistent, high-quality care.

Finding 2: Low wages, gaps in training for complex cases, and the need to expand telehealth and financial incentives were identified as key factors shaping the future behavioral health workforce, and improving access in underserved areas.

Low pay was cited as a barrier to attracting and keeping qualified staff, with wages for many professionals remaining stagnant. Concerns about training centered on whether current programs provide the skills needed for complex cases, such as co-occurring disorders or crisis intervention.

Key informants also discussed strategies they believe will shape the future behavioral health workforce, including the expanded use of telehealth to improve access in underserved areas and the use of financial incentives to attract and retain providers in hard-to-fill positions. For example, many shared their predictions about the potential impact of technology on service delivery and workforce capacity, such as an increasing trend towards behavioral health treatment provided via telehealth, which will allow for increased access for rural or otherwise hard-to-reach areas. They also cited some examples of providers or organizations in rural areas providing additional financial incentives as part of their hiring package.

"I think some of the retention piece of what we're looking at is burnout amongst the existing workforce." – Key Informant

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"Wages have more or less remained stagnant for a lot of professionals." – Key Informant

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Turning Insights Into Actions

The following strategies respond to the key challenges and opportunities identified through key informant interviews and collaboration with Nevada interest holders. To strengthen and sustain the behavioral health workforce, the Plan includes actions to improve recruitment and retention, with a focus on rural and frontier communities where shortages are most severe. Strategies focus on addressing barriers such as low wages, limited training opportunities, and burnout, while promoting solutions like telehealth to extend service reach. The Plan also draws on lessons from other health professions, using financial incentives and other targeted approaches to attract and retain providers in hard-to-fill behavioral health positions.

The table below details each strategy and its associated performance indicators for ongoing monitoring and evaluation.

Strategy 2.1: Strengthen and Sustain Nevada's Behavioral Health Workforce

Sub-Strategy	Performance Indicator	Data Sources	Population/Unit Being Measured
2.1.1 Expand recruitment and retention strategies, particularly for rural and underserved areas	Number of new or retained behavioral health professionals in designated shortage areas	▪ Nevada Rural and Frontier Health Data Book	▪ Rural and frontier behavioral health professionals

Sub-Strategy	Performance Indicator	Data Sources	Population/Unit Being Measured
2.1.2 Expand training opportunities for BHCEN providers for dual diagnosis, utilizing peer strategies, Medications for Opioid Use Disorder (MOUD), ride along	Number of trainings required for BHCEN certification	▪ BHCEN certification data	▪ BHCEN certified Providers
2.1.3 Promote telehealth as a workforce extender while ensuring quality and appropriateness of care	Number of BHCEN certified providers delivering mental health services via telehealth in underserved regions	▪ BHCEN certification data	▪ BHCEN certified Providers

Social Determinants of Health

Economic instability, lack of stable housing, and inadequate transportation were identified as barriers to accessing and maintaining behavioral health care. Enhancing access to stable housing, improving transportation services, and increasing employment and educational support programs are important to addressing these issues and supporting long-term recovery and wellness.

Finding 1: Community members most often highlighted housing instability, transportation challenges, and other barriers to accessing behavioral health care.

Community members shared stories illustrating how fundamental needs, such as stable housing and reliable transportation, significantly shape their ability to achieve and maintain overall health. They expressed that housing instability not only deepens existing behavioral health struggles but also creates an environment where recovery feels nearly impossible. In addition, participants highlighted how transportation challenges directly impact their ability to engage consistently with health care services. They described frequent disruptions and complexities in accessing reliable transportation, leaving many community members feeling trapped in cycles of missed care opportunities and escalating health issues. Participants felt that addressing these community needs could result in meaningful improvements in their community's behavioral health.

Social Determinants of Health Gaps at a Glance:

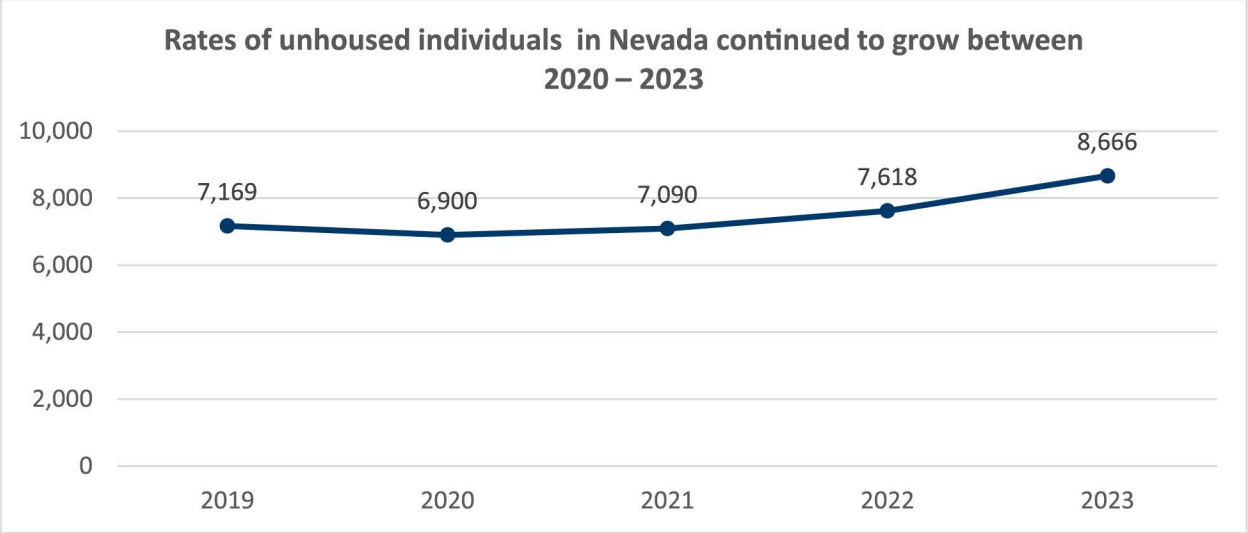
- Housing instability
- Significant transportation challenges, impeding ability to access care
- Economic instability and limited employment opportunities
- Inadequate access to supportive community resources
- Lack of flexible, responsive funding

"One of the biggest perpetuators in my addiction was being homeless. It was a vicious cycle of drugs and being homeless." – Community Member

"If their previous appointment ran late, transportation won't wait. It's layer after layer of complications." – Community Member

The graph below reinforces the community member concern about housing instability by showing the rising rate of unhoused individuals in the state.

Exhibit 6. Rates of unhoused individuals in Nevada, 2019–2023



Source: American Community Survey Data - https://www.census.gov/programs-surveys/acs/data.html

Finding 2: Community members described how a lack of affordable childcare options results in employment challenges, and limited support systems may hinder individuals' ability to achieve lasting recovery and stability.

Participants frequently highlighted how economic and employment limitations directly impact individuals' capacity to achieve lasting recovery and stability. First, community members described their struggles to secure steady employment. They noted that, from their perspectives, available resources often target a narrow group typically "white, middle-class", or "educated" job seekers, leaving others underserved. Additionally, individuals recovering from substance use may face challenges returning to the workforce due to related legal issues or difficulties meeting traditional job expectations, such as fixed working hours. They also noted how financial instability created by being unemployed can reinforce cycles of vulnerability, making both sustained employment and staying in recovery more difficult. They said that the value of employment not just as a source of income but as a factor in building confidence and long-term well-being.

Additionally, community members shared that the lack of reliable, affordable childcare hinders their ability to overcome economic challenges. One community member described the difficulty of accessing quality daycare, which often forces families to make difficult decisions about who can work and who must stay home. Community members consistently called for stronger, better-coordinated local support systems that address these needs and help individuals build pathways to sustained recovery.

"You frequently have families who have to make hard financial decisions about who's going to work [because of a lack of childcare options]."
– Community Member

"Job training after rehab is critical. Without training, people go right back into their old lifestyles because they have no better options." – Community Member

Finding 3: Key informants shared that behavioral health challenges in Nevada are linked to income inequality and housing instability, with limited and often inaccessible resources exacerbating the crisis, especially for vulnerable populations such as unhoused seniors.

Participants felt that it is impossible to discuss behavioral health without addressing income inequality and the critical role of stable housing. They described Nevada's scarce resources for housing as a defining challenge, with complex barriers such as lengthy waitlists, loss of essential documents, and constant displacement by law enforcement. Further, they shared that the influx of large technology companies and real estate developments since 2016 priced out many residents, particularly those with disabilities, criminal records, or low incomes, who relied on affordable motel housing that was bought up and converted by these companies, leaving hundreds displaced. They felt that this housing instability contributed directly to behavioral health crises.

Key informants also drew attention to the challenges faced by unhoused seniors, many of whom have significant health needs, including dementia and limited ability to perform daily activities. They stressed that solutions must go beyond traditional affordable housing models to include innovative approaches such as intergenerational living.

"I think scarcity is like our defining characteristic... yes, there are resources, but they have barriers. That's just on the housing front." – Key Informant

"Lots of seniors... some of them have dementia, many are incontinent... this is criminal in my mind that human beings are quite literally discarded at the steps of a shelter." – Key Informant

Turning Insight into Action

The following strategies represent the response to the key findings and opportunities identified through qualitative data collection and collaboration with Nevada interest holders. While the BBHWP has little impact on overall rates of unhoused individuals, they identified opportunities to expand recovery housing options. Specifically, the Plan includes strategies to expand housing supports by increasing recovery and transitional beds, improve transportation access for rural individuals with behavioral

health conditions, and strengthen employment pathways by boosting job rates among those in recovery programs. It also focuses on enhancing coordination among community organizations, tracked by Memorandums of Understanding (MOUs) and warm handoff policies among providers. Lastly, integrating standardized SDOH screenings into care coordination ensures more inclusive, community-informed systems. Together, these efforts tackle social factors impacting behavioral health outcomes.

The tables below details each strategy and its associated performance indicators for ongoing monitoring and evaluation.

Strategy 3.1: Expand and Stabilize Foundational Supports

Sub-Strategy	Performance Indicator	Data Sources	Population/Unit Being Measured
3.1.1 Expand housing supports	Number of recovery beds in Nevada Number of transitional beds in Nevada	▪ BHCEN certification data	▪ BHCEN certified Providers (recovery and transitional housing)
3.1.2 Improve Transportation Access	Percentage of individuals in rural and frontier Nevada who have a behavioral health condition who had a transportation billing code billed	▪ Medicaid claims data ▪ Key Informant tracking (e.g., bus tickets)	▪ Medicaid recipients ▪ Clients of sub-awardees
3.1.3 Strengthen employment pathways	Employment rates for individuals in recovery programs	▪ Labor department ▪ SOR program data ▪ ESMI patient records	▪ SOR patients; ESMI patients
3.1.4 Invest in coordination across Community Organizations	Number of MOUs[1] Nevada's recovery organizations have with organizations who provide childcare, transportation, treatment centers, and job training	▪ SOR program data ▪ SU block grant program data ▪ Referral tracking	▪ SOR patients; SU block grant patients
	Number of BHCEN-certified providers who have a policy in place on warm handoffs	▪ BHCEN certification data ▪ Referral tracking	▪ BHCEN certified Providers

[1] A memorandum of understanding (MOU) is an agreement between two or more parties/institutions. MOUs are not legally binding, but serve to document each collaborator's expectations or intentions https://hcsra.sph.harvard.edu/memorandum-understanding-mou

Strategy 3.2: Design Inclusive, Community-Informed Systems

Sub-Strategy	Performance Indicator	Data Sources	Population/Unit Being Measured
3.2.1 Integrate SDOH into care coordination	Percentage of patients receiving standardized SDOH screenings at intake	▪ Percentage of patients receiving standardized SDOH screenings at intake*	▪ ESMI program data ▪ BHCEN certification data ▪ Mental Health -URS Tables Analysis Data
3.2.2 Develop culturally responsive[2] services	Number of BHCEN certified providers who have received cultural competency training	▪ Number of BHCEN certified providers who have received cultural competency training.	▪ BHCEN Certification data
	Job role and employer name for each BHCEN-certified provider who has completed cultural competency training		

[2] The National Alliance on Mental Illness (NAMI) indicates that being culturally responsive includes, "centering our approach around honoring one's cultural, racial and intersectional identities." They also share, "To be inclusive, it's vital to serve clients with an approach that is culturally affirming." Source: https://www.nami.org/mental-health-systems/what-does-a-culturally-responsive-framework-look-like/

Substance Use Disorder

Substance use, including alcohol, methamphetamine, and fentanyl, is of growing concern in Nevada communities, according to data collected during interviews and focus groups. Participants shared that stigma, limited access to treatment, and a lack of integrated care options hinder effective recovery. Enhancing community education, expanding access to harm reduction services, and offering more peer support will be key to improving outcomes and addressing the challenges of substance use.

Finding 1: Community members reported shifting substance use patterns, most notably rising methamphetamine use, and described how stigma continues to limit prevention, treatment access, and recovery.

Across discussions, community members described an evolving landscape of substance use, noting shifts in the types of substances affecting their neighborhoods. Several reported that opioid and prescription painkiller use, once a major concern, has been increasingly overshadowed by rising methamphetamine use, while alcohol and marijuana remains a socially accepted presence. They highlighted ongoing concerns about substances deeply embedded within their communities, which complicate family stability, community health, and overall safety. These patterns make it even harder to seek help, as individuals often face stigma that limits honest conversation and early intervention. Community members also shared experiences with deep-rooted negative attitudes toward addiction, describing how societal perceptions often discourage openness and early intervention. These attitudes extend beyond social circles into health care and public services, creating additional hurdles and further isolating individuals from necessary support. They stressed the importance of openly confronting these barriers through education and empathy-driven conversations to support recovery.

Substance Use Disorder Gaps at a Glance:

- Interventions and prevention to address the perceived rising rate of fentanyl use
- Limited access to timely and consistent treatment options
- Pervasive stigma and negative societal attitudes toward addiction
- Lack of public education and awareness around substance use and recovery
- Structural barriers, including cost, insurance restrictions, and transportation
- Insufficient integration between treatment services and peer/community supports
- Inadequate harm reduction resources
- Minimal early intervention efforts, especially for youth
- Fragmented systems that are difficult to navigate during times of crisis

"Alcohol's everywhere in our town. It's socially acceptable, and that makes it harder to talk about or address." – Community Member

"I felt judged by the ER doctor. After that, I didn't want to go back, even when I knew I needed help." – Community Member

The figure below reflects the serious impact of substance use in Nevada, reinforcing community concerns about its widespread presence, associated stigma, and the urgent need for accessible treatment and recovery supports.

In 2023…

2219 per 100,000
Nevadans visited the emergency department for substance-related dependence.

35 per 100,000
Nevadans died from substance use

Source: Nevada Office of Analytics - Substance Use Surveillance Dashboard

Finding 2: Community members stressed that limited public understanding and awareness, combined with misconceptions and normalization of certain substances, hinder timely help-seeking. They called for education, peer networks, and community-driven supports.

Community members repeatedly emphasized that many challenges related to substance use are influenced by limited public understanding and awareness. They highlighted how the normalization of certain substances, such as alcohol and marijuana, combined with broader misconceptions about addiction and a lack of accessible information on available treatments prevents individuals and families from seeking assistance. Community members also stressed the need for stronger educational efforts, especially efforts tailored to younger people, to build awareness that could lead to better community support over time. They discussed the essential role of community-driven networks and peer supports, describing them as uniquely effective at distilling prevention messages due to their authenticity and relatability. These peer-driven resources, they explained, offer vital connections and understanding that traditional treatment services may lack. Many community members shared personal accounts of how peer groups and harm reduction programs served as crucial lifelines during recovery, demonstrating the need to expand these support networks to better meet the needs of their communities.

"Peer support makes all the difference. It feels different when you're talking to someone who's been there." – Community Member

"People just don't understand addiction. They think it's a choice, and that misunderstanding holds us back." – Community Member

Finding 3: Community members identified barriers to accessing and sustaining substance use treatment, including limited-service availability, high costs, and systemic challenges and said there is a need for more affordable, coordinated, and supportive systems.

Community members discussed at length the complex and frequently frustrating process of trying to obtain high-quality substance use care. They described a health care landscape filled with practical barriers, ranging from navigating treatment availability to maintaining consistent care, that frequently hinder recovery efforts. Community members also highlighted structural constraints such as affordability, insurance limitations, and lack of transportation. These systemic issues can undermine even the strongest determination to pursue recovery. Across discussions, community members repeatedly called for more streamlined and supportive systems to eliminate barriers and improve recovery outcomes.

"If you want inpatient treatment, you better plan on traveling because we just don't have enough here." – Community Member

"We've had situations where it takes two or three months just to get into detox. By then, people change their minds." – Community Member

Finding 4: Key informants feel that there is a need for stronger integration between physical and behavioral health systems to improve early identification of substance use, reduce stigma, and provide coordinated care for individuals with co-occurring disorders.

Key informants described a disconnect between physical and behavioral health systems that leaves many individuals without adequate support. They noted that evidence of substance use often first emerges in primary care settings, but limited resources, training opportunities, and system supports can make it challenging to respond effectively. Greater integration across systems was seen as essential for identifying early signs of substance use, reducing stigma, and ensuring individuals receive coordinated, holistic care.

Key informants also stressed the importance of integrated treatment for individuals with co-occurring disorders, where both substance use and mental health issues are addressed simultaneously. Key informants emphasized that, despite the high prevalence of dual diagnoses, there remains a significant gap in services offering this comprehensive approach. As a result, many individuals are left to navigate fragmented systems, seek help from multiple providers, or forgo care altogether, which ultimately leads to poorer outcomes in both recovery and mental health.

"There are a lot of individuals who are dealing with both mental health and substance use issues. Right now, we don't have enough programs that treat both at the same time." – Key Informant

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"Integrated care would really help patients stay more consistent with their recovery, but we don't have the resources to provide that in a seamless way." – Key Informant

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Finding 5: Key informants highlighted the need for flexible treatment models that accommodate the realities of daily life and the expansion of harm reduction programs to address rising substance use and prevent overdose deaths.

Rather than relying solely on rigid group schedules or traditional programming, key informants described an ideal state where services are tailored to individual needs, an approach especially vital for individuals balancing work, school, or caregiving responsibilities. This flexibility helps prevent disengagement and supports sustained recovery. As SUDs continue to rise - for example, with the increased prevalence of opioid and fentanyl use - key informants are also advocating for the expansion of harm reduction programs. They noted that these initiatives, including needle exchange, overdose prevention education, and the distribution of naloxone, have demonstrated life-saving impact. Yet, significant gaps in availability remain, such as those in rural and underserved areas. Key informants stress that broader access to harm reduction services is necessary for both preventative care and effective crisis response.

"People don't fit into boxes. We need systems that adjust to real lives, not the other way around." – Key Informant

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"The rise in fentanyl has made harm reduction strategies, like naloxone distribution, even more critical. But we still don't have enough access to these resources, especially in rural areas." – Key Informant

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Turning Insight Into Action

The following strategies represent the response to the key findings and priorities identified through community discussions and collaboration with Nevada interest holders. To reduce stigma and strengthen community engagement, the Plan focuses on person-first language education, public awareness campaigns, and expanding the role of peer recovery specialists. Access and affordability will be improved by integrating SUD treatment into primary care and non-specialty settings, increasing mobile and telehealth service delivery, expanding access to medications for opioid use disorder, and creating diversion pathways that connect individuals to treatment before arrest. To enhance quality and integration of care, strategies emphasize standardized quality measures, stronger care coordination, post-arrest diversion programs, and outcome tracking to support sustained recovery. Together, these approaches aim to create a more person-centered system of care for individuals and families affected by substance use in Nevada.

The tables below detail each strategy and its associated performance indicators for ongoing monitoring and evaluation.

Strategy 4.1: Reduce Stigma and Strengthen Community Engagement Around SUD

Sub-Strategy	Performance Indicator	Data Sources	Population/Unit Being Measured
4.1.1 Implement Person-First[3] Language and education initiatives	Number of Emergency Depts. trained in person-first language	▪ Subaward program documents	▪ Statewide education materials
	Number of certified providers trained in crisis intervention	▪ CCBHC certification data	▪ CCBHC Providers
4.1.2 Expand opportunities for peers to be integrated into substance use recovery services	Number of certified peer recovery specialists who are billed for providing substance use services in licensed substance use treatment facilities	▪ Nevada Certification Board reporting ▪ Medicaid Data	▪ Certified Peers
4.1.3 Enhance health care providers training and support	Percentage of BHCEN-certified providers who have taken annual continuing education classes	▪ BHCEN certification data	▪ BHCEN certified Providers
4.1.4 Create strategic media and public awareness campaigns	Number of campaign materials delivered through digital, print, and community-based channels	▪ Campaign delivery records ▪ Communications contractor reports	▪ State-led materials
	Number of organizations (including schools, employers, and community groups) participating in campaign	▪ Campaign delivery records ▪ Communications contractor reports	▪ State-led campaigns
	Changes in public attitudes toward people with substance use issues	▪ Pre-post survey of targeted individuals ▪ Survey developed for this purpose ▪ BRFSS/YRBS ▪ Campaign and evaluation data	▪ Survey participants; State-led campaigns
	Number of campaign materials distributed in rural and frontier counties	▪ Campaign delivery records ▪ Communications contractor reports	▪ State-led campaigns

[3] Person-First is defined as language that focuses on the individual rather than their addiction, which research shows is helpful for stigma reduction: https://www.hopkinsmedicine.org/stigma-of-addiction

Sub-Strategy	Performance Indicator	Data Sources	Population/Unit Being Measured
4.1.5 Engage employers in creating Recovery-Supportive Workplaces	Number of workplaces that receive a Recovery Friendly Workplace designation	▪ Partner data (Foundations of Recovery & Recovery Friendly Workplace) in sub-awardee reports	▪ Foundations of Recovery employers; Recovery Friendly Workplace employers
4.1.6 Increase Education, Awareness and access to overdose prevention activities for naloxone and test strips	Number of trainings or educational events completed	▪ Naloxone and test strips distributed	▪ State-led campaigns, funded state partners
	Number of materials on overdose prevention distributed	▪ Campaign and Evaluation data	
	Number of naloxone doses and test strips distributed	▪ Naloxone doses and test strips provided to state funded partners	
	Number of state-funded partners established as naloxone or test strip distributors	▪ Number of community members listed on Nevada's Naloxone & Test Strip Finder	

Strategy 4.2: Expand Access and Affordability of SUD Services

Sub-Strategy	Performance Indicator	Data Sources	Population/Unit Being Measured
4.2.1 Integrate SUD treatment into Primary Care and Non-Specialty settings	Number of FQHCs trained to provide SUD screening and treatment protocols, including alcohol use	▪ FQHCs trained from sub-awardee reports	▪ FQHC organizations;

Sub-Strategy	Performance Indicator	Data Sources	Population/Unit Being Measured
4.2.2 Increase EMS, Emergency Department, and mobile unit partnerships to provide SUD care	Number of mobile units offering MOUD[4]	▪ Nevada Medicaid ▪ BHCEN certification data/OTP registry ▪ EMS survey ▪ Program data, sub-awardee ▪ Medicaid data	▪ EMS Providers ▪ Emergency Departments ▪ Providers running mobile MOUD clinics
	Number of EMS services administering first dose of buprenorphine in the field		
	Number of Emergency Departments trained in crisis response and overdose		
	Number of Emergency Departments administering buprenorphine inductions		
4.2.3 Leverage telehealth solutions	Number of certified BHCEN providers trained to provide SUD services over telehealth platforms	▪ BHCEN certification da ta	▪ BHCEN certified Providers
	Geographic distribution of telehealth SUD services (percentage coverage of rural/underserved areas)	▪ Medicaid claims data by zip code ▪ BHCEN certification data	▪ Rural and underserved geographic areas; BHCEN certified Provider patients
	Percentage of CCBHC providers offering SUD telehealth services with measurable utilization rates	▪ Medicaid claims data ▪ CCBHC certification da ta	▪ CCBHC Providers
4.2.4 Increase access to MOUD	Number of individuals receiving MOUD in Nevada	▪ OTP registry ▪ Medicaid data	▪ OTP Providers
	Number of individuals receiving take home supply of MOUD for 7, 14, and 28 days		
	Number of individuals within the Nevada Department of Corrections on MOUD		
	Number of individuals within Nevada Department of Corrections on MOUD who are released and sustain their treatment		

[4] MOUD include methadone, buprenorphine, and naltrexone—pharmacotherapies that reduce cravings, ease withdrawal, and block opioid effects. When paired with counseling and behavioral therapies, MOUD significantly lowers opioid use, prevents overdose, and supports sustained recovery. https://nvopioidcoe.org/resources/topic/medications-for-opioid-use-disorder-moud/

Sub-Strategy	Performance Indicator	Data Sources	Population/Unit Being Measured
4.2.5 Expand deflection pathways (law enforcement-led, etc.) to connect individuals to treatment pre-arrest	Number of jurisdictions implementing deflection[5] protocols	▪ Law enforcement agency reports ▪ Program MOUs ▪ Sub-awardee reports	▪ Jurisdictions/agencies implementing deflection
4.2.6 Integrate peer recovery specialists into deflection responses or programs, for on-scene engagement and warm handoffs to treatment or other resources	Number of deflection programs with peer integration	▪ Sub-awardee reports ▪ Law enforcement/peer program partnership data	▪ Deflection programs ▪ peer recovery specialists

Strategy 4.3: Enhance Quality and Integration of SUD Care

Sub-Strategy	Performance Indicator	Data Sources	Population/Unit Being Measured
4.3.1 Implement standardized quality measurement and improvement systems	Percentage of patients seen by BHCEN-certified providers receiving evidence-based SUD assessments using validated instruments (e.g., Addiction Severity Index or ASAM-approved criteria)	▪ TEDS ▪ BCHEN certification data	▪ BCHEN certified ▪ Providers
4.3.2 Strengthen care coordination mechanisms	Percentage of patients with SUD who received a follow up service within 7 days after withdrawal management	▪ TEDs data/Smartsheet ▪ Medicaid claims ▪ Suicide attempt and suicide death data ▪ Bed registry data	▪ Individuals who have gone through withdrawal management at a facility ▪ Individuals who have received treatment within a residential treatment facility
	Number of rapid response teams dispatched 24 hours after an overdose in Nevada		
	Number of BHCEN providers appropriately trained in the State's bed registry software		
	Reported suicide attempts and deaths by suicide within a year after release from a residential treatment facility		

[5] Deflection refers to pre-arrest interventions that connect individuals with behavioral health needs to treatment and support services in lieu of justice system involvement. https://documents.ncsl.org/wwwncsl/Criminal-Justice/Deflection-Diversion-f02.pdf

Sub-Strategy	Performance Indicator	Data Sources	Population/Unit Being Measured
4.3.3 By utilizing the Sequential Intercept Model (SIM)[6], expand post-arrest diversion[7] programs linking individuals to evidence-based treatment	Number of specialty court programs for SUD treatment	▪ Administrative Office of the Courts records ▪ Program reports ▪ Sub-awardee data	▪ Specialty court programs ▪ Justice-involved individuals with SUD
4.3.4 Track service engagement and recovery outcomes among diverted individuals	Percentage of diverted individuals who complete treatment or avoid recidivism[8] within 12 months	▪ Court and corrections data ▪ Medicaid claims ▪ Sub-awardee treatment completion records	▪ Diverted justice-involved individuals

[6] The Sequential Intercept Model is a framework that maps how individuals with mental health and substance use disorders come into contact with the criminal justice system, identifying key points—or "intercepts"—where interventions can divert them into treatment and support services instead of further justice system involvement. https://www.samhsa.gov/communities/criminal-juvenile-justice/sequential-intercept-model

[7] Diversion occurs post-arrest but before conviction, offering participants an opportunity to avoid charges or have them dismissed upon successful program completion. https://documents.ncsl.org/wwwncsl/Criminal-Justice/Deflection-Diversion-f02.pdf

[8] Recidivism refers to a person's relapse into criminal behavior after having received sanctions or undergone intervention for a previous offense. It is often measured by rearrest, reconviction, or reincarceration within a specific period following release. https://nij.ojp.gov/topics/corrections/recidivism

Mental Health

Mental health struggles such as anxiety, depression, and trauma, are widespread across Nevada communities. Stigma, limited resources, and a shortage of mental health providers create barriers to accessing care. Addressing these gaps through increased mental health education, workforce expansion, and enhanced access to services, especially in schools, will increase community well-being.

Finding 1: Community members shared personal experiences and observations about mental health challenges faced by themselves and others in their communities. They talked about the ongoing impact of stigma, which continues to hinder open dialogue about mental health and access to care.

Community members observed that anxiety, depression, and trauma are increasingly common, often connected to grief, stress, and unstable life circumstances. Many spoke about how these issues affect people of all ages, with growing concern about suicide, especially among youth.

While mental health needs are widespread, access to consistent support such as community groups, therapists, or other treatment options remains limited, leaving many to manage without help.

Mental Health Gaps at a Glance:

- Widespread stigma and limited public understanding of mental health
- Shortage of qualified mental health providers, especially in rural and frontier areas
- Limited access to timely, consistent, and affordable mental health services
- Structural barriers including low reimbursement rates, insurance restrictions, and transportation challenges
- Limited integration of mental health care with schools, primary care, and community supports

In addition to limited options for those attempting to seek care, stigma also emerged as a significant barrier. Participants shared that fear of judgment prevents people from speaking openly about their mental health or seeking assistance. This was frequently cited among those who belong to self-described “small or close-knit communities”, like those living in small, rural towns. Additionally, some community members shared experiences of feeling dismissed or misunderstood by providers, which can deepen feelings of shame and isolation, further preventing individuals from pursuing the care that could improve their well-being.

“Depression and anxiety are everywhere. It’s like people are barely hanging on, but no one talks about it.” – Community Member

"If somebody would have come out in the public to talk to me and got me more comfortable… I definitely would have been more likely to [seek help] than to just show up to a government building." – Community Member

The figure below provides rates of mental illness and mental health services in Nevada. It encompasses a broad range of conditions, from severe mental illnesses such as psychosis to more common disorders like anxiety and depression. These statistics align with focus group and interview findings highlighting the widespread mental health challenges faced by individuals across Nevada.

In 2022-2023…

23%	**20%**
of Nevadans reported having any mental illness	of Nevadans received mental health services

Source: National Survey on Drug Use and Health (NSDUH) - https://datatools.samhsa.gov/saes/state

Finding 2: Community members emphasized access challenges, including provider shortages, service gaps, and geographic barriers that limit the availability and timeliness of behavioral health care.

Throughout the focus groups, community members painted a clear picture of how limited resources impact mental health support in their communities. Many expressed frustrations over the prolonged struggle to access consistent, quality mental health care, saying that provider shortages significantly impact access to timely interventions. These gaps leave community members feeling unsupported and frequently unable to address mental health concerns proactively.

Participants also described how the unique challenges of living in geographically isolated areas amplify these difficulties. Even when services exist, physical distance and lack of reliable transportation often prevent people from receiving the care they need. In addition to these geographic issues, inconsistent funding patterns were cited as barriers to stable, ongoing mental health programs, leaving communities vulnerable to frequent service disruptions.

"There's quite a gap in mental health providers when it comes to certain insurances… you could literally call every agency and not have availability." – Community Member

"There's a lot of times they're directed to the hospital, which does very little, because they "do not have a mental health component to their operation."
– Community Member

The figure below provides data on trends related to rates of depression and mental health providers. They augment the qualitative findings, where community members emphasized challenges related to access, including provider shortages, service gaps, and geographic barriers that limit both the availability and timeliness of behavioral health services across the State.

In 2022-2023,
10%
of Nevadans reported having a major depressive episode in past year

From 2018-2024, there was a
26% drop
in mental health providers in Nevada

Source: National Survey on Drug Use and Health (NSDUH) - https://datatools.samhsa.gov/saes/state and County Health Rankings - https://www.countyhealthrankings.org/

Finding 3: Community members expressed a clear need for more comprehensive, personalized mental health care that addresses complex, overlapping issues, especially for youth facing rising emotional distress, and called for stronger early intervention and support systems to prevent worsening outcomes.

Throughout the discussions, community members conveyed a desire for more comprehensive and personalized mental health care approaches. For example, they talked about treatments tailored to factors such as cultural backgrounds, co-occurring conditions, and other important personal context. Participants pointed out that traditional treatment alone does not fully address the complexity of mental health concerns, especially for individuals managing multiple challenges such as trauma, substance use, or long-term recovery needs.

Participants frequently voiced concerns about the increasing pressures young people face, talking about rising rates of emotional distress and mental health struggles. They described a pressing need for early intervention strategies, noting that current school and community support systems are inconsistent and often insufficient to meet these urgent needs. Many felt that without proactive efforts to support young people, mental health issues will continue to escalate, leaving youth feeling isolated and without adequate coping tools. (Note: mental health issues among youth are also explored in the "Youth & Other Special Populations" section below.)

Having doctors prescribe physical activity instead of medication… [because] it's giving serotonin, all those magic things for your brain." – Community Member

"The last two Sundays I've spent with a 16 and a 17-year-old boy in crisis… the common thing is that they don't have the skills to cope with problems we did when we were younger." – Community Member

Finding 4: Community input revealed gaps between existing services and the mental health support that individuals and families need.

Community members described mental health services as limited and difficult to access. While outpatient therapy and medication management are available in some areas, long wait times and provider shortages often prevent people from receiving care. Crisis hotlines and school-based programs offer some support, but participants noted these services are inconsistent and lack the follow-up needed to keep people engaged in treatment.

Participants also talked specifically about gaps in services for those who need sustained treatment and ongoing support. Many specifically called for expanded inpatient and residential treatment options, such as for individuals with acute needs, facing limited or no access to appropriate care settings due to their financial situation, isolated geographic region, or other factors.

"There are therapists, but not enough of them. Most people are waiting months, and by then, things get worse." – Community Member

"When someone is having a breakdown, there's nowhere to send them. We need inpatient mental health care, not just the ER or jail." – Community Member

Finding 5: According to key informants, Nevada is experiencing a shortage of mental health professionals, in addition to financial and structural barriers for patients and providers, which has resulted in a fragmented system in which services exist but remain hard to access for those most in need.

Overall, key informants described a fragmented mental health system where services exist but are often hard to access due to workforce shortages, long wait times, and geographic disparities. For example, the crisis intervention and outpatient care options that are available are perceived as insufficient to meet the demand of those requiring intensive support, such as individuals with severe mental illness. Jail-based mental health initiatives and CCBHCs offer structured services, but gaps remain for individuals outside these systems.

Additionally, financial and other structural barriers significantly limit access. Key informants described how low reimbursement rates, insurance restrictions, and transportation challenges create unnecessary hurdles for individuals seeking support. Many small organizations and nonprofit providers specifically struggle to expand services due to limited funding, making it difficult to meet the needs of their communities.

Key informants repeatedly pointed out that, to respond to these needs, there should be a broader range of services made available such as mobile crisis teams, integrated primary care, and long-term treatment options. Many stressed that without expansion in these areas, individuals with serious mental health conditions would continue cycling through emergency rooms, jails, and short-term psychiatric holds without sustained recovery support.

"We have providers, but Medicaid won't cover certain services, so people fall through the cracks." – Key Informant

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"Outpatient services exist but long wait times mean people aren't getting help when they need it." – Key Informant

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Turning Insight Into Action

The following strategies represent the response to the key findings and opportunities identified through qualitative data collection and collaboration with Nevada interest holders. The strategies focus on expanding community-based prevention and early intervention programs, including trauma-informed screenings and first-episode psychosis supports, while enhancing telehealth services to improve access in rural areas. Coordination and referral systems should be strengthened to ensure continuity of care, supported by transportation and navigation assistance. Efforts to grow and retain the mental health workforce in underserved regions are prioritized. To reduce stigma and promote mental health literacy, a Statewide campaign will leverage partnerships across communities. Finally, the strategy emphasizes integrated, person-centered care by expanding access to wraparound services like housing, employment, and peer support, with strong collaboration among community providers. Progress will be tracked using indicators related to service availability, provider training, outreach impact, and patient screening for social needs.

The tables below detail each strategy and its associated performance indicators for ongoing monitoring and evaluation.

Strategy 5.1: Increase Access to Timely and Ongoing Mental Health Services

Sub-Strategy	Performance Indicator	Data Sources	Population/Unit Being Measured
5.1.1 Expand community-based prevention and early intervention programs to address trauma, stress, and early signs of mental health concerns	Number of mental health programs in Nevada State-funded schools	▪ Program data	▪ Nevada schools
	Percentage of adults across the State who received mental health services in the past year	▪ National Survey on Drug Use and Health (SUMHSS) ▪ HEDIS ▪ URS Tables	▪ Statewide individuals
	Number of FQHC pediatricians trained in Early Serious Mental Illness (ESMI)[9] screening and referral protocols	▪ FQHC training records ▪ Sub-awardee reports	▪ FQHC pediatricians
	Number of CCBHC providers trained in ESMI screening and referral protocols	▪ CCBHC training data ▪ CCBHC certification data	▪ CCBHC providers
	Number of youth parole and probation officers trained in ESMI screening and referral protocols	▪ Nevada Division of Child and Family Services (DCFS) training records ▪ Juvenile Justice program reports	▪ Youth parole and probation officers
	Number of certified first-episode psychosis (FEP)[10] programs	▪ State registry/program certification data ▪ Sub-awardee reports	▪ Certified FEP programs

[9] Refers to the initial period of onset for a serious mental illness https://library.samhsa.gov/sites/default/files/early-recognition-esmi-pep24-01-006.pdf

[10] First-episode psychosis refers to the first time a person experiences psychotic symptoms—such as hallucinations, delusions, or disorganized thinking. It often occurs in late adolescence or early adulthood and is a critical time to begin treatment, as early intervention can significantly improve long-term outcomes https://www.nami.org/wp-content/uploads/2023/08/What-is-Early-and-First-Episode-Psychosis.pdf

Sub-Strategy	Performance Indicator	Data Sources	Population/Unit Being Measured
5.1.2 Enhance the use of telehealth to expand mental health access in rural and frontier areas	Number of CCBHCs trained to deliver services via telehealth	▪ BHCEN certification data ▪ Medicaid claims data ▪ ESMI certification data	▪ CCBHC organizations ▪ Medicaid Providers ▪ ESMI Providers
	Geographic distribution of telehealth mental health services (percentage of coverage of rural/underserved areas)		
	Percentage of CCBHC providers offering mental health telehealth services with measurable utilization rates		
5.1.3 Support coordination and referral among providers to improve continuity of care	Number of CCBHCs reporting participation in a State-supported referral coordination system	▪ CCBHC certification data	▪ CCBHC organizations
	Number of 988/211 callers receiving referrals	▪ 988 data ▪ 211 data	▪ 988 callers; 211 callers
	Number of repeat 988/211 callers	▪ 988 data ▪ 211 data	▪ 988 callers; 211 callers
5.1.4 Strengthen transportation and navigation supports to connect individuals with care	Number of CCBHCs with operational transportation or navigation support systems (e.g., MOUs, staff navigators, formal referral pathways)	▪ CCBHC certification data	▪ CCBHC organizations
5.1.5 Strengthen the mental health workforce through recruitment, training, and retention strategies, particularly in rural and underserved regions	Number of certified mental health providers newly hired or contracted in rural and frontier counties	▪ CCBHC certification data ▪ CCBHC survey data	▪ CCBHC Providers
	Percentage of certified mental health providers retained in rural and frontier counties	▪ CCBHC certification data ▪ CCBHC survey data	▪ CCBHC Providers

Strategy 5.2: Reduce Stigma and Strengthen Community Understanding of Mental Health

Sub-Strategy	Performance Indicator	Data Sources	Population/Unit Being Measured
5.2.1 Launch a statewide mental health literacy campaign to normalize help-seeking and reduce stigma through community partnerships	Number of campaign materials delivered through digital, print, and community-based channels	▪ Campaign delivery records ▪ Communications contractor reports	▪ State-led materials
	Number of organizations (including schools, employers, and community groups) participating in campaign	▪ Campaign delivery records ▪ Communications contractor reports	▪ State-led campaigns
	Changes in public attitudes toward people with mental health issues	▪ Pre-post survey of targeted individuals ▪ Survey developed for this purpose ▪ BRFSS/YRBS ▪ Campaign and evaluation data	▪ Survey participants; State-led campaigns
	Number of campaign materials distributed in rural and frontier counties	▪ Campaign delivery records ▪ Communications contractor reports	▪ State-led campaigns

Strategy 5.3: Expand Integrated, Holistic, and Person-Centered Models of Care

Sub-Strategy	Performance Indicator	Data Sources	Population/Unit Being Measured
5.3.1 Expand access to wraparound services such as housing, employment, peer support, and case management for individuals with mental health needs	Percentage of CCBHC patients screened for social needs (housing, food, transportation) to be referred to appropriate services	▪ CCBHC certification data ▪ Path grant data	▪ CCBHC patients; Path patients
	Number of CCBHCs that have MOUs with various community partners for these types of strategies		

Sub-Strategy	Performance Indicator	Data Sources	Population/Unit Being Measured
5.3.2 Provide training and technical assistance to promote trauma-informed, person-centered behavioral health care models that support co-occurring conditions and long-term recovery	Number of CCBHC providers participating in training on trauma-informed and person-centered care, including integrated substance use and mental health treatment pathways	▪ CCBHC certification data ▪ Training participation data ▪ BCHEN certification	▪ CCBHC Providers ▪ BCHEN Unit
5.3.3 Expand the use of peer support specialists as part of the mental health care team	Number of peer specialists employed or contracted by CCBHCs to support individuals with mental health needs	▪ CCBHC certification data ▪ NCB data	▪ CCBHC peer specialists
	Percentage of CCBHC programs that bill Medicaid or other payers for mental health-related peer support services	▪ CCBHC certification data ▪ NCB data	▪ CCBHC organizations ▪

Crisis Response & Suicide Prevention

Crisis response services are not currently meeting the needs of communities, especially in rural areas, with law enforcement often acting as the first point of contact. Respondents emphasize the need for more mental health training for law enforcement, improved coordination of crisis services, and more accessible, community-based solutions such as mobile crisis units and wraparound support for individuals after a crisis.

Finding 1: Community members described the emotional weight of crisis and suicide and expressed concern that law enforcement is too often the default response rather than trained mental health professionals.

Community members were asked to describe their understanding and experience with crisis and crisis services. Those with lived experience shared their personal experiences, including feeling "out of control," engaging in socially unacceptable behavior, self-harm, overdose, and suicide attempts. Others spoke about experiences of supporting children or other loved ones through crises, citing feelings of extreme concern and helplessness. Across these conversations, participants emphasized the subjective nature of crises, noting that what constitutes a crisis can vary from person to person.

Crisis Response & Suicide Prevention Gaps at a Glance:

- Over-reliance on law enforcement for crisis response, often without mental health training
- Limited availability of mobile crisis teams and 24/7 crisis response services
- Inconsistent follow-up and lack of standardized aftercare or wraparound support after crisis events
- Low awareness and underutilization of 988 and other non-police crisis resources

When discussing crisis situations, community members often shared details about their interactions with law enforcement. While some participants acknowledged that law enforcement can be a necessary and sometimes appropriate support, there was a shared sentiment that they should not be the first or only option. They expressed concern about law enforcement's lack of mental health training and the potential for violence escalation. Overall, they wished for additional mental health training for law enforcement and an increased understanding among law enforcement leadership of the need and role of peers and mental health professionals in crises situations.

"Even our local law enforcement… they would rather that a therapist or somebody was called that can actually handle the situation."
– Community Member

"That experience with police showing up at my house is the most terrifying thing when you're in crisis." – Community Member

Recent data show that suicidal thoughts, attempts, and deaths remain a serious concern in Nevada. The data below mirror the experiences shared by community members who described the emotional toll of crisis, the limits of current response systems, and the need for more accessible, compassionate, and coordinated care.

In 2023…

888 per 100,000	**156 per 100,000**	**20 per 100,000**
Nevadans reported thoughts of suicide	Nevadans attempted suicide	Nevadans died by suicide

Source: Nevada Office of Analytics - https://app.powerbigov.us/view?r=eyJrIjoiM2MxYzVlMjMtMTQxZi00M2VhLWFjYjMtOTM0MGM1NTk1YzA3IiwidCI6ImU0YTM0MGU2LWI4OWUtNGU2OC04ZWFhLTE1NDRkMjcwMzk4MCJ9

Finding 2: Community members described varied experiences accessing crisis services, emphasizing delays in care, limited awareness of available resources, and the need for more accessible, coordinated, and community-informed crisis support.

In addition to calling law enforcement, community members described a variety of approaches and services used both in the moment of crisis and afterward. They talked both about services and support for acute crises as well as longer-term assistance for recovery, yet most reported delays in receiving treatment after their initial contact with services. For post-crisis care, participants described using support groups, cognitive behavioral therapy (CBT), in and out of home case management, and hospitalizations.

While community members were aware that crisis stabilization centers exist, none reported knowing of a specific center available to them or having accessed such services. Many offered suggestions for improving crisis care in Nevada, including targeting specific populations, bringing successful services

from other parts of the State into their own community, engaging key community partners, and increasing public knowledge about available crisis services.

"Then I think with some of these programs, they get you situated to almost stand on your feet, and then they push you out the door." – Community Member

"The majority of this community still has no idea that 988 is for mental health" – Community Member

Finding 3: Key informants reported that a lack of coordination, unclear responsibilities, and limited follow-up care after crisis prevent individuals and families from receiving the consistent support needed to reduce repeat incidents and improve outcomes.

Key informants frequently expressed frustration over what they saw as a lack of coordination among entities providing crisis services. They explained that this hinders the continuity of care for individuals experiencing a crisis, which they believe is important for reducing the amount of repeat incidents. They attributed this to lack of funding/general available services in their local jurisdictions, lack of crisis care prioritization across the State, unclear roles across responsible organizations, and a lack of "good options" for individuals to continue to receive treatment after an acute crisis. In response to this, they described an ideal state in which someone can easily call a crisis line for themselves or others, a mobile crisis unit is sent and/or they're able to enter a crisis stabilization unit, and they are then connected to follow up care such as an Assertive Community Treatment (ACT) Team.

Key Definitions	
Crisis Stabilization Center	Facilities that provide crisis stabilization services to people in need of urgent care related to mental illnesses, SUDs, or both[xiv]
Mobile Crisis Teams (MCT)	Mobile Crisis Teams are teams of behavioral health professionals, such as clinicians, peer support specialists, or EMTs, who respond to mental health or substance use crises in the community, providing immediate care and support as an alternative to law enforcement involvement or emergency room visits[xv]

"There does not seem to be any appropriate discharge planning from any of the facilities and no communication with local communities." – Key Informant

"So, we need to know that when somebody gets out of detox that they - what happens? Who's the next person that's going to pick up the ball there?" – Key Informant

Finding 4: While crisis services exist, key informants noted that limited funding and operational constraints, such as hours, eligibility, and geography, often prevent them from reaching those most in need.

Key Informants shared various strategies and identified key organizations that are commonly relied upon for crisis care. Some mentioned trying to access local or regional mobile crisis units or crisis stabilization units as a first step. They also shared examples of when hospitalization seemed like the best option, either because of the acuity of the crisis or because mobile and other crisis services are often only available during certain hours. Lastly, they shared various in-patient options available for qualifying individuals and situations in which handoffs to other mental health professionals were deemed necessary.

In sharing the current state, they identified barriers they experience in seeking appropriate care for their clients or community members. A significantly cited barrier was limited funding that results in a limited reach of available services. They shared that this limited reach may be impacted by restrictions based on geography, eligibility, hours of operation, number of beds or space available, and whether the service could be billed to Medicaid.

"Mobile crisis teams - they just aren't set up to be 24/7, and so they usually function at the same time of normal business hours, which is a challenge."
– Key Informant

"It gets very hard to manage a crisis response and being able to communicate with everyone; everybody's got to get out of their silos where they work."
– Key Informant

Turning Insight Into Action

The following strategies respond to the challenges and opportunities identified by community members and key informants regarding crisis response and suicide prevention in Nevada. To improve access, the Plan calls for expanding Mobile Crisis Teams (MCTs), enhancing alternative response options such as 988, and ensuring services are available beyond traditional hours, especially in rural and underserved areas. Strategies also focus on strengthening post-crisis follow-up and wraparound supports to promote stabilization and reduce repeat crises. Additional priorities include increasing behavioral health crisis training for law enforcement and first responders, raising public awareness of crisis services, and improving coordination across agencies to ensure a timely and consistent responses for individuals and families experiencing a crisis.

The tables below detail each strategy and its associated performance indicators for ongoing monitoring and evaluation.

Strategy 6.1: Expand Access to Crisis Response Services Across Communities

Sub-Strategy	Performance Indicator	Data Sources	Population/Unit Being Measured
6.1.1 Increase the availability of MCTs and ensure they operate in rural or underserved areas	Number of mobile crisis response teams established across the State	▪ BHCEN certification data	▪ BHCEN certified Providers
	Percentage of MCTs providing coverage beyond traditional hours		
	Number of MCTs with an embedded certified peer specialist		
6.1.2 Enhance alternative services for individuals experiencing suicidal ideation or a behavioral health related crisis	Number of calls transferred from 911 to 988 by county	▪ 988 data	▪ 911 callers
	Number of calls deescalated without sending a MCT or transferring to 911	▪ 988 call data	▪ 988 callers
	Number of 911 calls routed to 988 crisis line	▪ 988 data	▪ MCT patients
	Percentage of mobile crisis dispatch that deescalated in the field and provided follow up supports	▪ Medicaid data ▪ CSC program data	▪ Crisis Stabilization Center patients
	Number of patients admitted to Crisis Stabilization Centers by county	▪ 988 data	▪ 911 callers

Strategy 6.2: Strengthen Post-Crisis Continuity of Care and Wraparound Supports

Sub-Strategy	Performance Indicator	Data Sources	Population/Unit Being Measured
6.2.1 Develop standard protocols for follow-up care after crisis incidents to reduce repeat crises and improve health outcomes	Number of individuals who access crisis services, consented to follow-up, and received follow-up contact within 72 hours post-crisis	▪ MCT data ▪ 988 data ▪ CSC discharge data	▪ Patients in the crisis response system
	Number of CCBHC providers implementing standardize post-crisis follow-up protocols	▪ CCBHC certification data	▪ CCBHC Providers
	Percentage of individuals reporting positive experience or perceived improvement following crisis response	▪ Post-survey of targeted individuals	▪ Survey participants
	Percentage of individuals who remain engaged across multiple crisis system touchpoints (e.g., 988, mobile crisis, ER)	▪ Medicaid claims data ▪ 988 data	▪ Patients in the crisis response system participants
6.2.2 Expand access to wraparound services to support ongoing stabilization	Percentage of individuals who access crisis services connected to ongoing wraparound services (e.g., food or housing supports) following a crisis	▪ Various OOA data ▪ MCT data ▪ 988 data	▪ individuals in the crisis response system
	Number of counties with established referral pathways to connect individuals with follow-up services after a crisis (CCBHCs have MOUs in place)	▪ CCBHC certification data ▪ MCT data ▪ 988 data	▪ CCBHC organizations
	Number of crisis residential facilities to transfer those needing longer crisis support in Nevada	▪ Medicaid data ▪ BHCEN certification data ▪ MCT data ▪ 988 data	n/a

Strategy 6.3: Improve Crisis System Collaboration, Training, and Public Awareness

Sub-Strategy	Performance Indicator	Data Sources	Population/Unit Being Measured
6.3.1 Expand behavioral health crisis training for law enforcement and first responders	Number of new law enforcement officers and first responders trained in behavioral health crisis intervention training (CIT)[11]	▪ POST training records	▪ Law enforcement officers and first responders
6.3.2 Increase community awareness of crisis services and other local resources through targeted outreach and education campaigns	Number of campaign materials distributed in the community that focus on 988 and the crisis response system	▪ Campaign delivery records	▪ State-led materials
6.3.3 Strengthen cross-sector collaboration to improve coordinated crisis response and resource access	Number of formal collaboration agreements established between law enforcement, behavioral health organizations, and community-based organizations to address crisis response coordination	▪ 988 data	▪ CCBHC organizations; Law enforcement; Behavioral health organizations; Community-based organizations

[11] CIT is a community partnership of law enforcement, mental health and addiction professionals, individuals who live with mental illness and/or addiction disorders, their families, and other partners to improve community responses to mental health crises. https://www.citinternational.org/What-is-CIT

Youth & Other Special Populations

Youth, Veterans, incarcerated individuals, and LGBTQIA+ communities face unique behavioral health challenges shaped by distinct stigma, social isolation, and prejudice. Youth are seen as especially vulnerable to mental health issues and substance use. Key informants and community members highlighted the need for targeted, inclusive services and strong parent-school partnerships focused on early intervention, education, and youth-friendly support.

Finding 1: Community members feel there is a need for early support for youth, highlighting the role of parents, schools, and accessible mental health services.

Community members shared important perspectives on youth behavioral health, sharing the critical role that parents and schools play in early identification, intervention, and prevention. Drawing from their experiences both as adults and from their own childhoods, many highlighted how parents and families are often the first line of support in recognizing changes in youth behavior or emotional distress. Schools were also frequently cited as key environments for early detection, providing opportunities for awareness, education, and timely referrals to appropriate services. Together, parents and schools were viewed as essential partners in creating a safety net that can catch struggling youth early and connect them to the care and resources they need to prevent crisis.

Youth & Other Special Populations Gaps at a Glance:

- Inadequate early detection and parental involvement in youth mental health care
- Limited access to consistent school-based behavioral health services, especially in rural and frontier areas
- Widespread stigma among parents, caregivers, and marginalized populations limits access to care
- Marginalized populations (e.g., LGBTQIA+, incarcerated individuals, elderly, youth) experience social isolation and lack of tailored supports

"Yes. I think the mindset of parents, they don't want to admit to the fact that their child is struggling." – Community Member

"If there was a one-on-one each couple of weeks to where you could get to know that individual kid [you could] notice if that kid is making changes with his attitude." – Community Member

Finding 2: Community members raised concerns about social isolation and stigma for vulnerable groups like Veterans, LGBTQIA+ people, and the elderly, highlighting the need for more tailored mental health support.

Other sub-populations identified by community members as requiring specialized mental health services included Veterans, members of the LGBTQIA+ community, and the elderly. Participants expressed concerns about the unique and often complex mental health challenges these groups face. For Veterans, issues such as trauma, PTSD, and difficulties reintegrating into civilian life were highlighted. Members of the LGBTQIA+ community often confront stigma, discrimination, and social isolation that can exacerbate mental health struggles. Similarly, the elderly population was recognized as vulnerable to loneliness, depression, and barriers to accessing appropriate behavioral health resources. Community members emphasized the importance of developing tailored, culturally competent, and accessible services to effectively address the distinct needs of each of these populations.

"There's an incredibly high attempted suicide rate among… [LGBTQIA+] because of the stigma put on them by the society." – Community Member

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"I've heard it's [social isolation] just as bad for elderly people in Nevada." – Community Member

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Finding 3: Incarcerated individuals were identified as a vulnerable group often lacking adequate behavioral health care.

Participants emphasized a gap in services for incarcerated individuals that extends beyond incarceration, as individuals frequently face significant barriers when re-entering their communities. Limited access to transitional housing, recovery support programs, and ongoing behavioral health care during this critical period often undermines successful reintegration, increasing the risk of relapse, recidivism, and worsening mental health outcomes.

Participants also described patterns in which people are incarcerated rather than connected to appropriate behavioral health services. They noted that behavioral health crises, such as an untreated mental illness, may result in law enforcement intervention and incarceration instead of needed access to treatment. This dynamic was described as a systemic issue, fueled by limited crisis response options and community-based treatment capacity. Participants emphasized that this approach may perpetuate a cycle of incarceration driven by unmet behavioral health needs.

"Especially our male youth, they wind up incarcerated, instead of in-treatment where they belong." – Key Informant

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"You call, and sometimes facilities won't have beds for boys because they have too many beds for girls right now." – Key Informant

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Turning Insight Into Action

The following strategies respond to key findings from community member and interest holder input and aim to address gaps in access, coordination, and support. Efforts will focus on expanding school- and community-based behavioral health services for youth, leveraging telehealth to improve access for both youth and incarcerated individuals, and applying the Sequential Intercept Model (SIM) to increase diversion from the justice system. Additional priorities include strengthening family, peer, and community-led support systems by empowering parents and caregivers, building inclusive peer networks for diverse populations, and promoting intergenerational and cross-cultural learning.

The table below outlines each strategy alongside performance indicators to guide ongoing monitoring and evaluation.

Strategy 7.1: Increase Access to Timely and Ongoing Behavioral Health Services

Sub-Strategy	Performance Indicator	Data Sources	Population/Unit Being Measured
7.1.1 Expand school and community-based services for youth	Percentage of schools with onsite behavioral health services	▪ MTSS tracking ▪ Dept. Of Education (DOE) reports ▪ School Medicaid data	▪ Schools
	Percentage of schools billing Medicaid for behavioral health services	▪ Medicaid claims data ▪ School Provider networks	▪ Schools
7.1.2 Utilize telehealth to improve access for youth	Percentage of Medicaid providers utilizing telehealth with youth	▪ Medicaid claims data	▪ Medicaid providers
7.1.3 Enhance the use of telehealth to expand mental health access for incarcerated individuals	Number of partnerships established in collaboration with correctional facilities (e.g., Nevada Department of Corrections) to implement or expand telehealth referrals to behavioral health services prior to release	▪ MOUs ▪ NDOC data ▪ BHCEN certification data ▪ NNAMHS data ▪ SNAMHS data ▪ Rural clinical data	▪ Individuals who have been released from an NDOC facility
	Percentage of re-entering individuals who receive a behavioral health appointment within 30 days of release	▪ NDOC reentry records ▪ Medicaid claims data	▪ NDOC individuals;

Sub-Strategy	Performance Indicator	Data Sources	Population/Unit Being Measured
7.1.4 Utilize the SIM to support diversion and deflection	Number of people diverted from initial court hearings or detention	▪ Court administrative data ▪ Jail booking data ▪ Program diversion records ▪ Sub-awardee reports	▪ Justice-involved individuals diverted
	Number of formal partnerships established with parole and probation agencies to support deflection	▪ MOUs ▪ Parole/probation administrative records ▪ Sub-awardee reports	▪ Parole and probation agencies ▪ Deflection program partners
	Number of specialty court judges that participate in SUD training, with the intention of reducing SUD-related stigma	▪ Administrative Office of the Courts (AOC) training records ▪ Judicial training participation logs ▪ Sub-awardee reports	▪ Specialty court judges

Strategy 7.2: Strengthen Family, Peer, and Community-Led Support Systems for Youth & Special Populations

Sub-Strategy	Performance Indicator	Data Sources	Population/Unit Being Measured
7.2.1 Empower parents and caregivers as Behavioral Health Champions	Number of parents engaged in system-level advisory or leadership roles (e.g., councils, feedback groups)	▪ SOR program data ▪ Block grant data ▪ ESMI program records	▪ SOR program data; Block grant; ESMI patients
	Number of middle and high schools that implement a behavioral health initiative	▪ School-based initiative tracking ▪ DOE reporting ▪ SOR or Block grant data if applicable	▪ Middle and High Schools; ▪ SOR and Block grant grantees

Sub-Strategy	Performance Indicator	Data Sources	Population/Unit Being Measured
7.2.2 Build inclusive peer and community support networks	Number of certified peer support specialists hired or trained across youth, LGBTQIA+, justice-involved, and aging populations Number of peer support programs operational inside youth and adult detention facilities	▪ Peer certification board data ▪ Subgrantee reporting ▪ CCBHC certification data	▪ Peer specialists; CCBHC peer specialists
7.2.3 Promote intergenerational and cross-cultural learning	Number of peer endorsement initiatives promoting collaboration across age groups, identities, and lived experiences	▪ Program-level data from NAMI, 988, MOST, and aging agencies	▪ Program participants

Data Infrastructure

In Nevada, effective planning, service delivery, and evaluation of behavioral health services depend on reliable, accessible, and well-coordinated data systems. Interest holders shared that while data is available across multiple sources, its potential is often limited by fragmented systems, access barriers, and resource constraints. Strengthening the State's data infrastructure was seen as essential for improving decision-making, enhancing service coordination, and ensuring timely responses to community needs.

Finding 1: Key informants said that while data is essential to guiding their work, fragmented systems, access barriers, and limited capacity often slow its effective use.

Key informants explained how they use data to perform their jobs effectively and ensure clients receive appropriate services. Some key informants rely on data they collect internally, others use external sources, and many use both. Given the importance of high-quality data in their work, most key informants have developed and refined robust data collection processes over time, leveraging a largely decentralized State system.

Data Infrastructure Gaps at a Glance:

- Data is fragmented, delayed, and difficult to access in real time
- Lack of standardized indicators and inconsistent data across systems
- Insufficient provider training on interpreting and using data effectively
- Administrative and infrastructure barriers to timely data sharing and coordination

Key informants identified access, timeliness, and internal capacity as the main challenges in working with behavioral health data. For example, a mental health provider may not have immediate access to a person's past mental health or primary care records, which means they must request the information, a process that can be slow and time-consuming. Or, they may struggle to have the information they need because different entities or providers often use incompatible systems. Some also noted gaps in tracking certain behavioral health indicators, such as domestic abuse, crime, divorce, and other qualitative family dynamics, because they are difficult to capture routinely. However, most key informants felt that the data they needed did exist and was available, though accessing it often required navigating complex systems and administrative hurdles.

"I think that a lot of the data is available, but it's not condensed into single places." – Key Informant

"It comes up to have client data quickly for emergencies – the emergency departments having adequate information about individuals at times is challenging." – Key Informant

Turning Insight Into Action

The following strategies respond to key findings from interest holder input, focusing on strengthening the State's behavioral health data infrastructure. They aim to create more consistency and reliable data collection processes, improve coordination and information sharing across agencies, and ensure providers have the training and tools needed to use data effectively in service planning and delivery.

The table below outlines each strategy with performance indicators for ongoing monitoring and evaluation.

Strategy 8.1: Improve the Use of Data and Strengthen Local Behavioral Health Infrastructure

Sub-Strategy	Performance Indicator	Data Sources	Population/Unit Being Measured
8.1.1 Standardize behavioral health data collection and reporting requirements across systems	Percentage of behavioral health providers submitting data to a State-defined system	▪ TEDS ▪ BHCEN Certification data	▪ BHCEN Certified Providers
	Percentage of certified providers compliant with required reporting standards	▪ CCBHC certification data	▪ CCBHC Providers
	Number of public-facing dashboards or reports developed and disseminated	▪ OOA dashboards	▪ n/a
8.1.2 Promote cross-agency and provider partnerships to improve timely data access and reduce duplication	Number of formal data-sharing agreements in place across agencies	▪ MOUs and data-sharing agreements ▪ Interagency tracking systems ▪ VA Data ▪ CRSF	▪ n/a

Sub-Strategy	Performance Indicator	Data Sources	Population/Unit Being Measured
8.1.3 Offer training and technical assistance to help providers interpret and apply data to improve care	Number or percentage of certified providers participating in State-led training or quality improvement initiatives	▪ Training participation records ▪ CCBHC certification data	▪ CCBHC Providers
	CCBHC provider satisfaction with or knowledge gained from data training and technical assistance	▪ Post survey of targeted individuals	▪ Survey participants

Discussion

The findings from the needs assessment revealed several consistent themes across behavioral health domains, including mental health, substance use, problem gambling, crisis response, and youth and other special populations. Participants consistently identified barriers to access as a major challenge. These included provider shortages, long wait times, and limited-service availability, particularly in rural and frontier areas. Participants, including community members and key informants, spoke of the heightened impact of these access issues during times of crisis or when attempting to seek ongoing, coordinated care. Access challenges were also facilitated by inadequate infrastructure, including workforce distribution, housing instability, and transportation access.

Stigma also emerged as a significant barrier across domains, especially in the areas of mental health, substance use, and problem gambling. Community members detailed the ways stigma limits help-seeking behavior, discourages early intervention, and fosters isolation, particularly among youth, LGBTQIA+ individuals, and people who are justice-involved. Key informants also described the persistence of stigma within systems of care, including clinical settings, workplaces, and schools, highlighting the need for continued education and engagement of individuals with lived experience in program development and outreach. Though there were reports of decreased stigma among younger populations, many noted that stigma among caregivers and institutions remains a significant concern.

Both groups also emphasized the fragmentation of behavioral health services in Nevada. Gaps in continuity of care were repeatedly cited, whether during post-crisis transitions, re-entry from incarceration, or between service providers. Community members described difficulties in navigating complex and siloed systems, while key informants highlighted the absence of standardized protocols and consistent follow-up care. These findings demonstrate the importance of Statewide coordination, improved referral pathways, and increased access to wraparound services that address both behavioral health and social needs.

Workforce challenges were reported across all behavioral health sectors. Key informants described difficulties in recruitment and retention, especially in underserved areas. Contributing factors included low wages, burnout, limited training opportunities, and administrative barriers to expanding practice. Additionally, there were concerns about the sufficiency of problem gambling-specific training and the

availability of peer support staff. Key informants also expressed interest in telehealth as a potential solution to extend workforce capacity, although concerns about equitable access and quality assurance were raised.

Finally, both community members and key informants across all domains identified SDOH, such as housing instability, transportation barriers, and economic insecurity, as key contributors to behavioral health outcomes. These structural barriers were seen as both drivers of behavioral health challenges and obstacles to sustained recovery. Participants described the need for flexible funding, locally coordinated services, and integrated care approaches that reflect the complexity of people's needs. Together, the findings suggest that meaningful progress will require a coordinated, person-centered response that integrates clinical care with broader systems of community support.

Ongoing Monitoring and Evaluation

The State will conduct an annual evaluation of progress made toward the goals outlined in the Strategic Plan. It will primarily involve State-led tracking of key performance measures to assess whether established targets are being met; it will also include interviews with interest holders, such as BBHWP leaders, to collect qualitative perspectives to help assess overall Strategic Plan progress. Interviews question will address barriers and successes related to plan performance measure tracking, opportunities for additional partnerships to support Strategic Plan implementation, and continued feasibility of specific strategies and measures. Evaluators will synthesize findings across data sources (performance measure data and qualitative interviews) and summarize progress and recommendations for continued success.

Conclusion

The findings and strategies outlined in *the Bureau of Behavioral Health Wellness and Prevention in Nevada: Needs Assessment Findings and Strategic Plan* provide a comprehensive understanding of the behavioral health needs of Nevadans and the roadmap to address them. Drawing from robust data and meaningful community and key informant input, this document serves as a tool for shaping the future of behavioral health in the State. The State will use this Plan to guide funding allocations, inform the development of responsive and equitable policies, and enhance the overall infrastructure of the behavioral health system. Ultimately, it reflects Nevada's deep commitment to driving lasting change and fostering a healthier, more resilient future for individuals, families, and communities across every region of the State.

Appendix A: Peer Strategies

Because peer support emerged as a key theme across multiple areas, such as substance use, mental health, crisis response and suicide prevention, and youth and other special populations, the Appendix below includes a complication of all related strategies and performance indicators. This approach highlights the broad impact of peers with lived experience across the behavioral health system.

Substance Use

Strategy 4.1: Reduce Stigma and Strengthen Community Engagement Around SUD

Sub-Strategy	Performance Indicator	Data Sources	Population/Unit Being Measured
4.1.2 Expand opportunities for peers to be integrated into substance use recovery services	Number of certified peer recovery specialists who are billed for providing substance use services in licensed substance use treatment facilities	▪ Nevada Certification Board reporting ▪ Medicaid Data	▪ Certified Peers

Strategy 4.2: Expand Access and Affordability of SUD Services

Sub-Strategy	Performance Indicator	Data Sources	Population/Unit Being Measured
4.2.6 Integrate peer recovery specialists into deflection responses or programs, for on-scene engagement and warm handoffs to treatment or other resources	Number of deflection programs with peer integration	▪ Sub-awardee reports, ▪ Law enforcement/peer program partnership data	▪ Deflection programs ▪ Peer recovery specialists

Mental Health

Strategy 5.3: Expand Integrated, Holistic, and Person-Centered Models of Care

Sub-Strategy	Performance Indicator	Data Sources	Population/Unit Being Measured
5.3.3 Expand the use of peer support specialists as part of the mental health care team	Number of peer specialists employed or contracted by CCBHCs to support individuals with mental health needs	▪ CCBHC certification data ▪ NCB data	▪ CCBHC peer specialists
	Percentage of CCBHC programs that bill Medicaid or other payers for mental health-related peer support services		

Crisis Response & Suicide Prevention

Strategy 6.1: Expand Access to Crisis Response Services Across Communities

Sub-Strategy	Performance Indicator	Data Sources	Population/Unit Being Measured
6.1.1 Increase the availability of MCTs and ensure they operate in rural or underserved areas.	Number of MCTs with an embedded certified peer specialist	▪ BHCEN certification data	▪ BHCEN certified Providers

Youth & Other Special Populations

Strategy 7.2: Strengthen Family, Peer, and Community-Led Support Systems for Youth & Special Populations

Sub-Strategy	Performance Indicator	Data Sources	Population/Unit Being Measured
7.2.2 Build inclusive peer and community support networks	Number of certified peer support specialists hired or trained across youth, LGBTQIA+, justice-involved, and aging populations	▪ Peer certification board data ▪ Subgrantee reporting ▪ CCBHC certification data	▪ Peer specialists; CCBHC peer specialists
	Number of peer support programs operational inside youth and adult detention facilities		
7.2.3 Promote intergenerational and cross-cultural learning	Number of peer endorsement initiatives promoting collaboration across age groups, identities, and lived experiences	▪ Program-level data from NAMI, 988, MOST, and aging agencies	▪ Program participants

Citations

[i] Nevada Office of Analytics. (n.d.).

[ii] National Survey on Drug Use and Health. (n.d.).

[iii] American Medical Association. (2022). What is behavioral health? Retrieved from https://www.ama-assn.org/delivering-care/public-health/what-behavioral-health

[iv] Substance Abuse and Mental Health Services Administration. (2023). Certified community behavioral health clinics. Retrieved from https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics

[v] National Council for Mental Wellbeing. (n.d.). Crisis response. Retrieved from https://www.thenationalcouncil.org/our-work/focus-areas/integrated-health/crisis-response/

[vi] Federally Qualified Health Centers. (n.d.). What is an FQHC? Retrieved from https://www.fqhc.org/what-is-an-fqhc

[vii] National Center for Biotechnology Information. (2016). Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK519704/table/ch3.t39/

[viii] World Health Organization. (2022). Mental health: Strengthening our response. Retrieved from https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response

[ix] Office of Disease Prevention and Health Promotion. (n.d.). Social determinants of health. Retrieved from https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health

[x] Substance Abuse and Mental Health Services Administration. (2024). Co-Occurring Disorders and Other Health Conditions

[xi] Centers for Disease Control and Prevention. (2024). Original essential public health services framework. Retrieved from https://www.cdc.gov/public-health-gateway/php/about/original-essential-public-health-services-framework.html

[xii] National Rural Health Association. (2016). Frontier and rural health policy paper. Retrieved from https://www.ruralhealth.us/getmedia/132306e1-1643-4b40-818a-4d743317dc7e/NRHAFrontierDefPolicyPaperFeb2016.pdf

[xiii] United States Census Bureau. (2016). Defining rural at the U.S. Census Bureau. Retrieved from https://www2.census.gov/geo/pdfs/reference/ua/Defining_Rural.pdf

[xiv] Council of State Governments Justice Center. (2021). Tips for successfully implementing crisis stabilization units. Retrieved from https://csgjusticecenter.org/publications/tips-for-successfully-implementing-crisis-stabilization-units/

[xv] National Alliance on Mental Illness. (2022). Mobile crisis teams: Providing an alternative to law enforcement for mental health crises. Retrieved from https://www.nami.org/988/mobile-crisis-teams-providing-an-alternative-to-law-enforcement-for-mental-health-crises/