Opioid Use/Opioid Use Disorder Community Needs Assessment

Washoe County, Nevada, December 2022

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List of Abbreviations

Abbreviation	Definition
ACT	Acceptance and commitment therapy
CBT	Cognitive behavioral therapy
CCBHC	Certified community behavioral health clinics
CST	Clinical Services Team
DAS	Department of Alternative Sentencing
DBT	Dialectical behavior therapy
EMDR	Eye movement desensitization and reprocessing (therapy)
FQHC	Federally qualified health center
FTS	Fentanyl test strips
IMF	Illicitly manufactured fentanyl
IOTRC	Integrated Opioid Treatment and Recovery Center
IPSE	Infants with prenatal substance exposure
MAT	Medication-assisted treatment
MOUD	Medications for opioid use disorder
OTP	Opioid Treatment Program
OEND	Overdose education and naloxone distribution
OUD	Opioid use disorder
PWUD	People who use drugs
SUD	Substance use disorder
WCHSA	Washoe County Human Services Agency
WCSO	Washoe County Sheriff's Office

Acknowledgments

The Opioid Use/Opioid Use Disorder Community Needs Assessment for Washoe County would not be possible without collaboration from our community partners, Taylor Allison, MBA, Public Health Coordinator Nevada Association of Counties, and Dawn Yohey, MFT, LCADC, Clinical Program Planner 3, Nevada Department of Health and Human Services. Deepest thanks to Tara Goodsell for collaboration on conducting and analyzing interviews, to interview participants, the recommendation and scoring team, and to the community for participating in the survey. Additionally, many thanks to people who use opioids in our community who took the time to review the interview guides, provide feedback, assist with recommendations and take the time to meet and discuss opioid use in Washoe County.

Thank you to all of the agencies/organizations listed below for their collaboration on this needs assessment:

Join Together Northern Nevada (JTNN)
The Life Change Center
Washoe County Department of Alternative Sentencing
Washoe Regional Medical Examiner's Office
Washoe County Public Defender's Office
Washoe County Public Guardian
SilverSummit HealthPlan
Groups Recover Together
Washoe County Health District
Washoe County Sheriff's Office
Washoe County Human Services Agency
Washoe County Manager's Office
Reno Justice Court
Washoe County School District
Women's CrossRoads
Anthem
Domestic Violence Resource Center
Department of Health & Human Services
Nevada Association of Counties
Second Judicial District Court
High Intensity Drug Trafficking Area (HIDTA)
Black Wall Street Reno
Nevada's Recovery & Prevention Community (NRAP)
Reno Initiative for Shelter and Equality
University of Nevada Reno, School of Public Health, Dr. Wagner
Renown Regional Medical Center
Regional Emergency Medical Services Authority (REMSA)
Men's CrossRoads
Overdose Data to Action (OD2A)
Bristlecone

Agencies/Organizations

The Washoe County Opioid Use/Opioid Use Disorder Community Needs Assessment was lead by the Washoe County Human Services Agency (HSA) which provides child welfare, adult services, and senior services for the region. HSA conducted outreach to the following agencies:

The District Attorney's Office
Washoe County Emergency Management
Washoe County Health District
Washoe County Sheriff's Office
Alternate Public Defender
Department of Alternative Sentencing
Homeless Services
Public Defender's Office
Public Guardian
Regional Medical Examiner
Sparks Justice Courts
Reno Justice Courts
Second Judicial District Court
Juvenile Services
Karma Box
Men's CrossRoads
Women's CrossRoads
OUR Place
Washoe County School District
Join Together Northern Nevada (JTNN)
National Alliance on Mental Illness (NAMI) Nevada
Quest Counseling and Consulting
Reno Behavioral Healthcare Hospital
Early Head Start
Northern Nevada Community Housing
Reno Housing Authority
Trac-B (Hospital Team)
Change Point
Life Changes
Groups Recover Together
Northern Nevada Behavioral Health
Health Plan of Nevada
SilverSummit HealthPlan
Molina Healthcare
Renown NICU
St. Mary's NICU
Mednax
Nevada Early Intervention
Reno Police Department MOST
Nevada Overdose Data to Action (NVOD2A)
Community Triage Center (CTC)
Bristlecone
The Life Change Center
Step 2
Community Health Alliance
Northern Nevada HOPES
Alta Vista Mental Health
Renown
Nevada Center for Excellence in Disabilities (NCED), Prenatal Exposure Assessment Team (PEAT)
Domestic Violence Resource Center
Renown Regional Medical Center
Regional Emergency Medical Services Authority (REMSA)

Executive Summary

The purpose of this needs assessment is to present available information on trends, gaps, and needs pertaining to opioid use in Washoe County to provide recommendations and propose an action plan for the allocation of opioid litigation funds to ameliorate harms of opioid use. The 2021 Nevada Legislature passed Senate Bill 390 (SB390), an act relating to behavioral health; providing for the establishment of a suicide prevention and crisis hotline; establishment of the Fund for a Resilient Nevada; and establishing guidance for state, local, or tribal governmental entities to address the impact of opioid use disorder and other substance use disorders. SB390 is one of many efforts in Nevada to address the opioid crisis which is responsible for many of the over 107,000 overdose and drug poisoning deaths in the United States in 2021[1].

SB390 suggests the use of community-based participatory research (CBPR) as a methodology to conduct local needs assessments. This needs assessment was conducted using a similar process, community-based participatory practice (CBPP) that is often used by governmental agencies to inspire participation and collaboration with community stakeholders[2].

Secondary data were provided by the state and local stakeholders and primary data were collected through key informant interviews and a community survey and analyzed to better understand regional trends related to opioid use/misuse.

Key Findings from Secondary Data

- Opioid pain medication misuse has decreased from 2013-2019 among high school students in Washoe County, aside from a slight increase from 2017-2019.
- Lifetime use of heroin among Washoe County high school students has shown a steady decline from 2013-2019.
- Increase in emergency department and inpatient hospitalizations for drug related poisonings for youth aged ≤ 17 and no changes in drug poisoning fatalities for that age group from 2019-2021.
- Youth in Washoe County and Nevada generally experience a higher prevalence of adverse childhood experiences than the United States overall.
- Among participants monitored through the Department of Alternative Sentencing (DAS), prescription opioid positivity has been relatively stable, while heroin and fentanyl positivity has increased.
- Medication-assisted treatment (MAT) use has increased for participants of DAS.
- The majority of participants of MAT Court from (FY2018-FY2022) have been charged with a felony.
- The majority of participants from MAT Court (FY2018-FY2022) favored heroin as their primary drug of choice followed by methamphetamine. Methamphetamine is a popular secondary drug of choice for participants.
- 162.4% increase of prenatal substance exposure from 2011-2020 with a marginal decrease in 2021.

[1] Ahmad, F. B., Cisewski, J.A., Rossen, L. M., & Sutton, P. (2022, June 15). Provisioning drug overdose death counts. National Center for Health Statistics. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

[2] Grills, C., Hill, C. D., Cooke, D., & Walker, A. (2018). California reducing disparities project (CRDP) phase 2 statewide evaluation: Best practices in community based participatory practice. Psychology Applied Research Center. Los Angeles, CA: Loyola Marymount University.

- Prenatal cannabis/THC exposure followed by polysubstance and methamphetamine exposure is an issue in Washoe County.
- Increase in removals due to parental substance use for children of all ages in Washoe County (there are more removals per capita in Washoe County than Nevada statewide).
- Suboxone prescriptions have declined in Washoe County from 2019-2021.
- Decline in emergency department (ED) encounters related to opioids along with a slight decline in inpatient admissions related to opioids in the last five years 2017-2021.
- Increase in fatal drug poisonings in Washoe County, especially with methamphetamine, opioid, and fentanyl involvement.
- Deaths of individuals aged 55-64 declined, being surpassed by younger individuals aged 25-54 in 2021.
- Majority of participants served in Men's CrossRoads during the first eight months of 2022 are between 25-34 years of age, a demographic that has been associated with increases of emergency department visits, inpatient admissions, and deaths.
- Majority of Men's CrossRoads participants' primary substance of choice are: 1) alcohol; 2) methamphetamine; and 3) opioid.
- Methamphetamine and polysubstance use continue to be an issue in Washoe County.

Gaps

Based on the secondary data received, the following gaps have been identified:

- Lack of coordinated real-time data shared amongst providers to alert community of potential drug trends or overdose spikes.
- Lack of specialized programs to address adverse childhood experiences (ACEs) of children in Washoe County or robust ACEs screening programs.
- Lack of ample specialized programming to address parental substance use within the child welfare system.
- Some data requested from the state were inaccurate and unable to be provided/corrected by the time of writing this report.
- Lack of accurate treatment data entered into the Treatment Episode Data Set Admissions/Discharges (TEDS-A/TEDS-D)

Key Findings from Qualitative Data

- Illicitly manufactured fentanyl (IMF) is a growing concern across a multitude of opioid and non-opioid substances, people are transitioning to fentanyl as a preferred substance, and fentanyl use is complicating treatment stabilization and retention.
- Lack of available information or resources on treatment options for methamphetamine use treatment. Lack of funding, policy, and attention towards methamphetamine as meth use is not seen as iatrogenically caused.
- Insurance reimbursements are low, which results in staff being unable to afford housing and keep up with inflation.
- Insurance is a barrier to accessing appropriate treatment.
- No cohesive or effective surveillance system to notify the community in real-time of an overdose spike and trigger a targeted response.
- Hybrid models that offer telehealth help transgress boundaries to treatment.
- Pain management patients and persons with a history of OUD encounter barriers and stigma when attempting to control pain (even after major surgeries).
- Youth are experiencing high rates of stress and low coping mechanisms

- Access to housing is a barrier to recovery.
- Barriers to engaging in services often include basic needs (e.g., insurance, funding, transportation, housing, food, etc.).
- Lack of quality and accessible treatment providers, especially providers who treat SUD holistically and support multiple pathways to recovery.
- Stigma against people with an SUD and provider biases against people in medication-assisted recovery (particularly methadone).
- Cultural competence and outreach to Black, Indigenous, and People of Color (BIPOC) communities for prevention education, treatment, harm reduction, and overdose prevention is needed.
- Prevention education and trauma informed schools are a significant need.
- Services that address underlying trauma are needed.

Key Recommendations from Providers, People who Use Drugs, and Community Members

• Law enforcement diversion programs • Post-overdose response programs • Holistic integrated services for adults and children to foster resilience • Outreach to special populations (e.g., justice-involved adults and adolescents, BIPOC communities) • Streamline assessments and intake processes • Build supportive relationships and community (community spokes) • Low-barrier substance use treatment services, regardless of ability to pay • Low-barrier, walk-in availability (on-demand) of medication-assisted treatment	• Harm reduction services such as syringe services programs, outreach, drug checking (including fentanyl test strips), HIV/hepatitis C testing, wound care, and naloxone • Increase access to low-barrier and/or affordable housing & Housing First • Prevention education and trauma-informed services in K-12 schools • Interventions that address underlying trauma, basic needs, and stability • Provider education on stigma, titration, & treatment

Recommendations for the County Plan

Stakeholders reviewed the needs assessment and met to discuss recommendations. All recommendations were rated by a variety of stakeholders. The top five priorities are as follows:

- Ranked 1st: Ensure funding for the array of OUD services for uninsured and underinsured Washoe County residents.
- Ranked 2nd: Incentivize providers to initiate buprenorphine in the emergency department (ED), as well as during inpatient hospital stays. All EDs and hospitals should have providers that will provide buprenorphine induction as well as involve care navigators to assist with setting up outpatient resources for continued care and management.
- Ranked 3rd: Use a multidisciplinary approach to providing overdose prevention outreach and education to BIPOC communities in a culturally and linguistically appropriate manner (organizations, media, churches).
- Ranked 4th (tie): Implement Child Welfare best practices for supporting families impacted by substance use.
- Ranked 4th (tie): Increase access to low-barrier and/or affordable housing & Housing First programs.
- Ranked 5th: Increase detoxification and short-term rehabilitation program capacity.

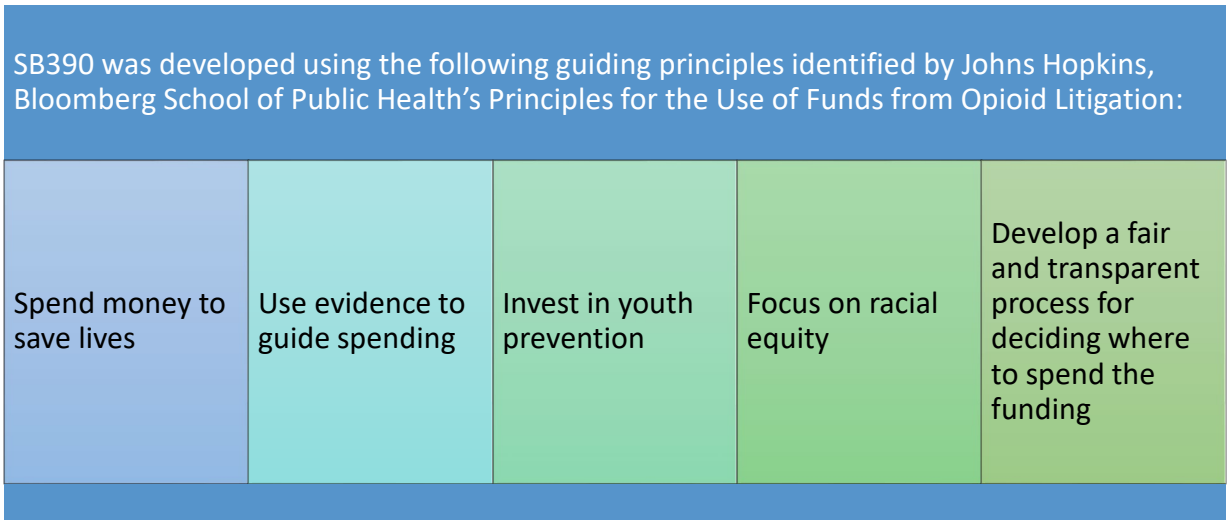
Section I

Background

Section I: Background

The 2021 Nevada Legislature passed Senate Bill 390 (SB390), an act relating to behavioral health; providing for the establishment of a suicide prevention and crisis hotline; establishment of the Fund for a Resilient Nevada; and establishing guidance for state, local, or tribal governmental entities to address the impact of opioid use disorder and other substance use disorders. SB390 is one of many efforts in Nevada to address the opioid crisis which is responsible for many of the over 107,000 overdose and drug poisoning deaths in the United States in 2021[3]. SB390 was developed using the guiding principles established by Johns Hopkins Bloomberg School of Public Health[4] in which opioid litigation funds are used to save lives using the substantial body of scientific evidence to guide programming, including the use of medications for opioid use disorder (MOUD) like methadone and buprenorphine across the continuum of treatment services. Johns Hopkins (n.d.) maintains that the current funding levels are not adequate to meet the needs of people who use drugs (PWUDs), leaving many people who are seeking treatment without adequate care. Additionally, Johns Hopkins[4] recommends investing in primary prevention efforts to enhance protective factors and resilience and to protect our youth from addiction and overdose. Racial equity must be a focus to tackle historical injustice and prevent fatal overdoses in communities of color. Black overdose deaths have been rising and "Black individuals represent just 5% of people who use drugs, but 29% of those arrested for drug offenses and 33% of those in state prison for drug offenses"[4]. Lastly, Johns Hopkins suggests that the plan to allocate funding be a transparent and inclusive process that is "guided by public health leaders with the active engagement of people and families with lived experience, as well as other key groups"[4].

Figure 1 Guiding Principles for Opioid Litigation Funding



(Johns Hopkins Bloomberg School of Public Health, n.d.)

[3] Ahmad, F. B., Cisewski, J.A., Rossen, L. M., & Sutton, P. (2022, June 15). Provisioning drug overdose death counts. National Center for Health Statistics. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

[4] Johns Hopkins Bloomberg School of Public Health. (n.d.). The principles to guide jurisdictions in the use of funds from the opioid litigation, we encourage the adoption of five guiding principles. https://opioidprinciples.jhsph.edu/the-principles/

The purpose of this needs assessment is to present available information on trends, gaps, and needs pertaining to opioid use in Washoe County to provide recommendations and propose an action plan for the allocation of opioid litigation funds to ameliorate harms of opioid use.

Community Overview

Washoe County encompasses a broad geographic area of 6,542 square miles of northwestern Nevada. While Washoe County is primarily rural or frontier, its most populated cities include Reno and Sparks. Access to healthcare continues to be a challenge for Washoe County residents in rural and frontier areas of the county and residents often have to travel to urban areas for services. The county's name is derived from the Washoe or Washeshu, an indigenous tribe of the Great Basin. Other Native people of the region include the Numu (Northern Paiute), the Newe (Shoshone), and the Nuwuvi (Southern Paiute)[5]. According to the U.S. Census Bureau[6], Washoe County's population was estimated at 493,392 in 2021, of which 21.2% were under age 18 and 5.4% were under age five. Washoe County is less diverse than Clark County, however, racial and ethnic diversity is increasing. The U.S. Census (n.d.) indicates that 60.9% of the population is White (non-Hispanic/Latinx), 25.9% Hispanic/Latinx, 6.1% Asian, 4.1% bi-/multi-racial, 2.9% Black/African American, 2.3% American Indian or Alaska Native, and 0.8% Native Hawaiian or Pacific Islander.

Community-Based Participatory Practice (CBPP)

Overview

SB390 suggests the use of community-based participatory research (CBPR) as a methodology to conduct local needs assessments. CBPR is a method of analysis that is done with communities, inviting community members into the research process as equal partners and contributors[7]. CBPR has been linked to reducing health disparities[8] and empowering communities. This needs assessment was conducted using a similar process, community-based participatory practice (CBPP) that is often used by governmental agencies to inspire participation and collaboration with community stakeholders[9]. By inviting community members into the process as equal partners, this process builds relationships and generates trust and buy-in. Moreover, this needs assessment would benefit from a mixed methods analysis to better understand the opioid use/misuse in the community, and needs of the targeted population to inform programs, service delivery, and outreach activities and to advance health equity. Creswell and Creswell[10] discuss this mixed method design as an explanatory (two-phase) sequential design. Quantitative data aids in providing relevant information on the current opioid use trends in the community, including within special

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[5] Reno-Sparks Indian Colony. (n.d.). History: Profile of the Reno-Sparks Indian colony people. https://www.rsic.org/rsic-history/

[6] United States Census Bureau. (n.d.). Quick facts Washoe County, Nevada. https://www.census.gov/quickfacts/washoecountynevada

[7] Blumenthal, D. S. (2011). Is Community-Based Participatory Research Possible? American Journal of Preventive Medicine, 40(3), 386– 389. https://doi.org/10.1016/J.AMEPRE.2010.11.01

[8] Salimi, Y., Shahandeh, K., Malekafzali, H., Loori, N., Kheiltash, A., Jamshidi, E., Frouzan, A. S., & Majdzadeh, R. (2012). Is community based participatory research (CBPR) useful? A systematic review on papers in a decade. International Journal of Preventive Medicine, 3(6), 386-393. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3389435/pdf/IJPVM-3-386.pdf

[9] Grills, C., Hill, C. D., Cooke, D., & Walker, A. (2018). California reducing disparities project (CRDP) phase 2 statewide evaluation: Best practices in community based participatory practice. Psychology Applied Research Center. Los Angeles, CA: Loyola Marymount University.

[10] Creswell, J. W., Creswell, J. D. (2018). Research design: Qualitative, quantitative, and mixed methods (5th ed.). Thousand Oaks, CA: Sage.

populations, to provide a cursory understanding of opioid use in Washoe County and to inform the qualitative portion of the needs assessment.

Assessing community health involves historical and sociopolitical analysis and assessing community needs via engaging with community members and organizations[11]. Rissel and Bracht[11] suggest that several considerations be taken to define a community including geospatial boundaries, community cleavages, social norms, and other social control mechanisms. Additionally, Rissel and Bracht[11] describe two distinct paradigms that underpin community assessments, health planning "top-down" (p. 63) and community development "bottom-up" (p. 63). The former requires minimal engagement with the community and can be conducted through population health and sociodemographic surveillance data and planning is conducted by public health professionals without much cross-sector coordination. The latter is engaged with the community and the contexts which impact health outcomes (e.g., social determinants of health), encourages and empowers communities as experts in the issues and solutions and builds leadership capacity. Israel et al.[12] identifies several key principles that underpin CBPR including power-sharing and equity, mutual benefit, ecological and social justice perspective, and partnering in dissemination efforts which have informed the methodology of the Washoe Opioid Use/Opioid Use Disorder Community Needs Assessment.

[11] Rissel, C., & Bracht, N. (1999). In Bracht, N.F., Health Promotion at the Community Level New Advances (2nd ed., pp. 59-64). Sage Publications INC Books. Reprinted by permission of Sage Publications INC Books via the Copyright Clearance Center.

[12] Israel, B. A., Schulz, A. J., Parker, E. A., Becker, A. B., Allen III, A. J., Guzman, R., & Lichenstien, R. (2018). In Wallerstein, N., Duran, B., Oetzel, J., & Minkler, M. (Eds.), Community-based participatory research for health: Advancing social and health equity (3rd ed., pp. 31-44). San Francisco, CA: Jossey-Bass.

Section II

Washoe County Health Data

Section II: Washoe County Health Data

Secondary Data

Using a CBPP framework, Washoe County Human Services Agency (HSA) engaged community stakeholders and the Nevada Department of Health and Human Services (DHHS) to provide secondary quantitative data sources to inform a robust perspective on opioid use/misuse within Washoe County. Additionally, a variety of reports were reviewed from community partners, including Join Together Northern Nevada's (JTNN) *Comprehensive Community Prevention Plan 2020-2022*[13], the *2020 Community Health Needs Assessment,*[14] and the *2021 Community Health Improvement Plan*[15]. Data were gathered from a variety of sources and analyzed by a group of stakeholders to better understand regional trends related to opioid use/misuse.

Data Sources

The secondary data for this report were obtained through the following sources:

- Department of Health and Human Services (DHHS) Office of Analytics, CHIA Death PDMP Opioid by County 2021
- Department of Alternative Sentencing, Drug Screening Data from Sober 24
- Department of Health and Human Services (DHHS) Office of Analytics, Division of Child and Family Services (DCFS) Branch, Drug-Related CPS Tracking Characteristics CY2012-2021
- Join Together Northern Nevada (JTNN), *Comprehensive Prevention Plan for Washoe County (CCPP) 2020-2022*
- Department of Health and Human Services (DHHS) Office of Analytics, Opioid County Surveillance Ver 2
- Washoe County Regional Medical Examiner's Office, Medical Examiner's Quarterly Drug Stats Report
- Department of Health and Human Services (DHHS) Office of Analytics, Division of Child and Family Services (DCFS) Branch, Substance Exposed Infants CPS Referrals CY2011-2021
- Department of Health and Human Services (DHHS) Office of Analytics, Division of Child and Family Services (DCFS) Branch, Drug or Alcohol Abuse Tracking Characteristics Associated with Child Protective Services (CPS), Foster Care Removals due to Substance Abuse CY2012-21
- Department of Health and Human Services (DHHS) Office of Analytics, Electronic Death Registry System (EDRS), Center for Health Information Analysis (CHIA), Prescription Drug Monitoring Program (PDMP), Washoe County Suboxone RX with Drug Related Overdose Hospitalizations and Deaths for Patients Aged 17 and Under
- Second Judicial District Court, 5 years of data from the Second Judicial District Courts, Medication-Assisted Treatment Court for Fiscal Years 2018-2022
- Washoe County Human Services Agency, Infants Affected by Prenatal Substance Exposure
- Department of Health and Human Services Office of Analytics, State-Run Substance Abuse Facility Admission and Discharge Counts by Year Washoe County, Nevada Facilities 2017-2021 [Treatment Episode Data Set, Admissions & Discharges (TEDS-A, TEDS-D)]

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[13] Join Together Northern Nevada (JTNN). (n.d.). *Comprehensive Community Prevention Plan 2020-2022*. https://jtnn.org/wp-content/uploads/2021/01/JTNN-CCPP-2020-2022-1.pdf

[14] Conduent Healthy Communities Institute. (n.d.). *2020 Community Health Needs Assessment*. https://www.renown.org/about/community-commitment/community-health-needs-assessment/?hcn=%2Fpromisepractice%2Findex%2Fview%3Fpid%3D3928%26hcnembedredirect_%3D1

[15] Washoe County Health District. (n.d.). *2021 Community Health Improvement Plan*. https://www.washoecounty.gov/health/files/data-publications-reports/CHIP-2021-FINAL.pdf

- Department of Health and Human Services (DHHS) Office of Analytics, Washoe County Suboxone Rx with Drug Related Overdose Hospitalizations and Deaths, 2019-2021
- Washoe County Sheriff's Office MAT and Naloxone Programs
- Men's CrossRoads 2022
- Overdose Data to Action (OD2A)

Methodology

The initial activity of this needs assessment was to identify stakeholders who provide services to people at risk of using opioids, people who use opioids, people with an opioid use disorder, and relatives of people who use opioids through systems mapping (see Appendices A & B). Upon completion of the systems map, a list of internal (Washoe County) and external stakeholders was collaboratively developed and stakeholders were invited to participate in a survey which assessed subject matter expertise, areas of interest, and level of commitment and/or time to participate. From this survey, many organizations provided data to review, and several workgroups were established to conduct quantitative data analysis, qualitative research design, and qualitative data analysis. Additionally, stakeholders volunteered to participate in focus groups, disseminate results, or to receive updates.

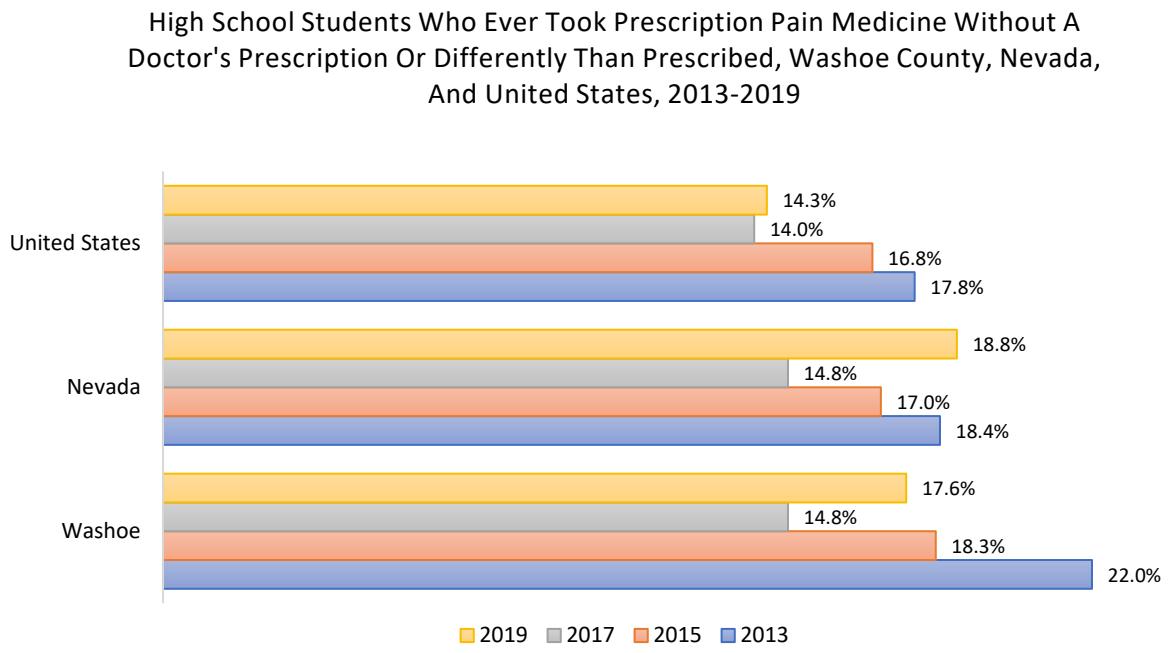
Youth Opioid Use

Data from the Youth Risk Behavior Surveillance System (YRBSS)[16] in Figure 2 indicate a decrease in use of prescription pain medication not as prescribed/without a prescription among high school students in Washoe County decreased from 2013-2017 with a slight increase in 2019. Additionally, lifetime use of heroin among Washoe County high school students has shown a steady decline from 2013-2019 (Figure 3).

Overdose data provided by DHHS indicate a rise in emergency department and inpatient hospitalizations for non-fatal drug related poisonings for youth aged ≤ 17 and no changes in drug poisoning fatalities for that age group from 2019-2021 (Figure 4 and Table 1). Additionally, it is important to note that Join Together Northern Nevada's (JTNN) *Comprehensive Community Prevention Plan 2020-2022*[16] indicates that youth in Washoe County and Nevada generally experience a higher prevalence of adverse childhood experiences than the United States overall, which can increase risk for negative health outcomes including substance use.

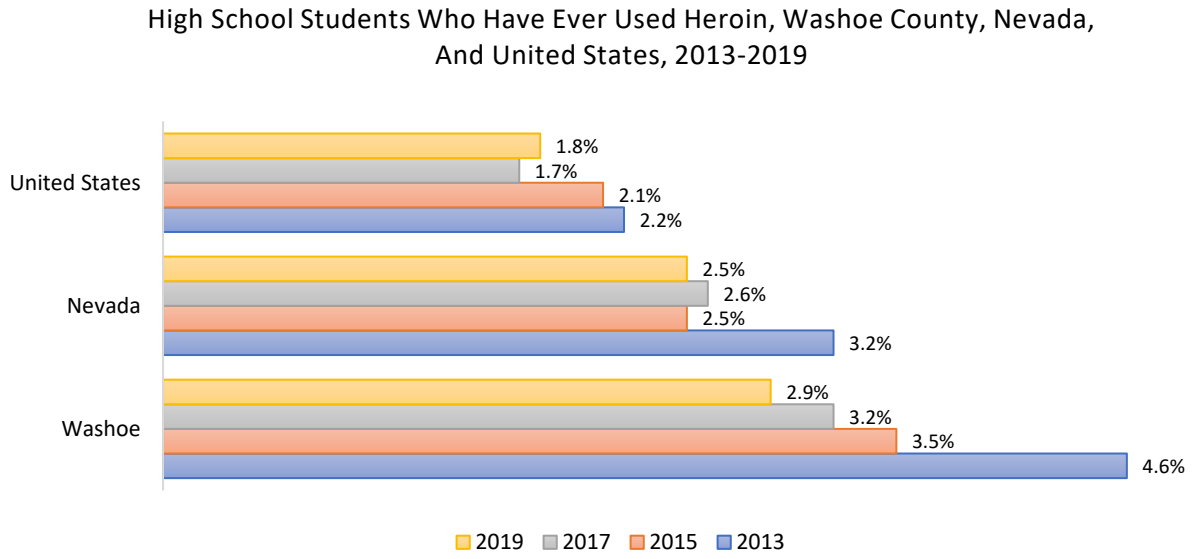
[16] Join Together Northern Nevada (JTNN). (n.d.). *Comprehensive Community Prevention Plan 2020-2022*. https://jtnn.org/wp-content/uploads/2021/01/JTNN-CCPP-2020-2022-1.pdf

Figure 2- High School Students Who Ever Took Prescription Pain Medicine Without a Doctor's Prescription or Differently than Prescribed, Washoe County, Nevada, and United States, 2013-2019



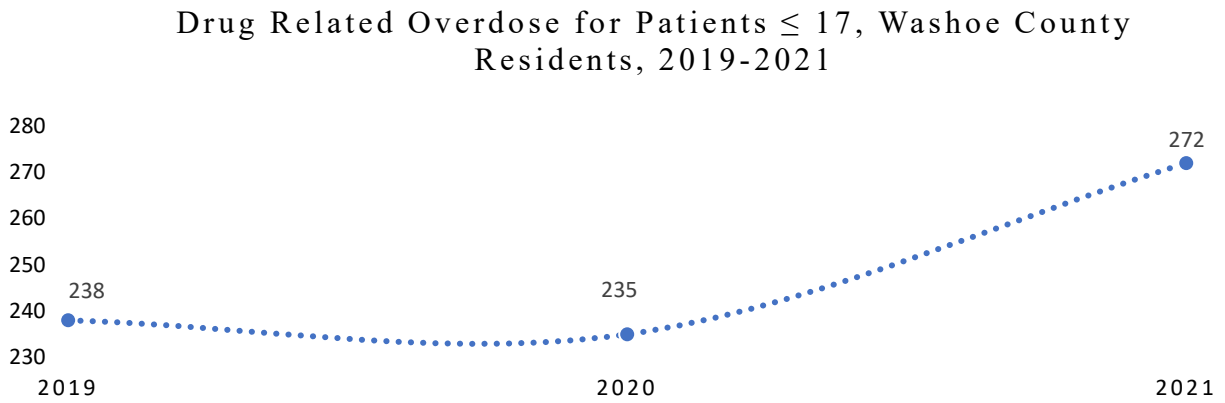
Data Source: Youth Risk Behavior Surveillance System (YRBSS) as cited by Join Together Northern Nevada, n.d.

Figure 3- High School Students who Have Ever Used Heroin, Washoe County, Nevada, and United States, 2013-2019



Data Source: Youth Risk Behavior Surveillance System (YRBSS) as cited by Join Together Northern Nevada, n.d.

Figure 4-Drug Related Overdose for Patients ≤ 17



Note: Includes inpatient and emergency department hospitalizations. Drug related overdose visits are flagged using ICD-10 codes T36-T50.
Data Source: Electronic Death Registry System (EDRS) and the Center for Health Information Analysis (CHIA)

Table 1- Drug Related Overdose Deaths ≤ 17, Washoe County Residents, 2019-2021

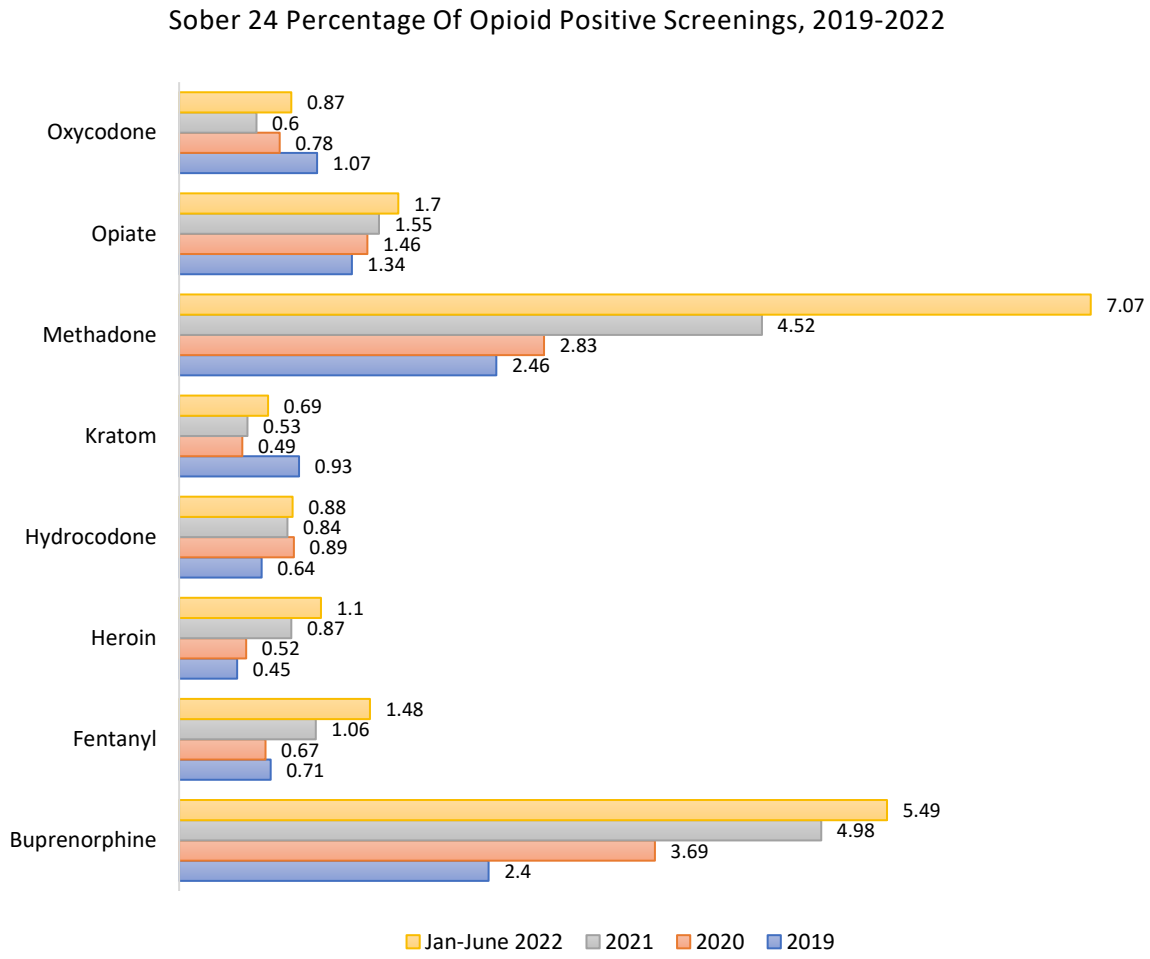
Drug Related Overdose Deaths ≤ 17, Washoe County Residents, 2019-2021	
2019	2
2020*	3
2021*	3

Note: * Data are preliminary and are subject to change. Drug related overdose deaths are flagged using ICD-10 codes X40-X44, X60-X64, X85, and Y10-Y14.
Data Source: Electronic Death Registry System (EDRS) and the Center for Health Information Analysis (CHIA)

Justice Involved Persons

Sober 24 is an essential component of pretrial and post-conviction monitoring through the Department of Alternative Sentencing in Washoe County and conducts urine drug screenings and breath analyses for individuals whose drug or alcohol use was a factor in their case. The data shown in Figure 5 is specific to the percentage of opioids found in urine drug screenings from 2019 through the first two quarters of 2022. Generally, prescription opioid positivity has been relatively stable, while heroin and fentanyl positivity has increased. Additionally, medication for opioid use disorder (MOUD) has increased for this justice-involved population, which signals the growing acceptance of evidence-based practices within the justice system.

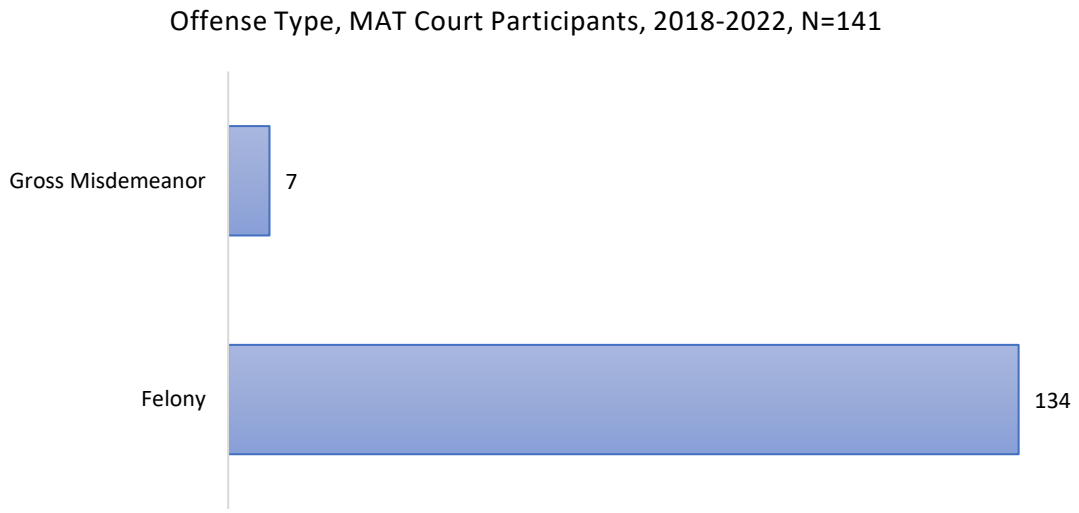
Figure 5- Opioid Positivity Rates at Sober 24, 2019-2022



Data Source: Sober 24 Drug Screens, 2019-2022

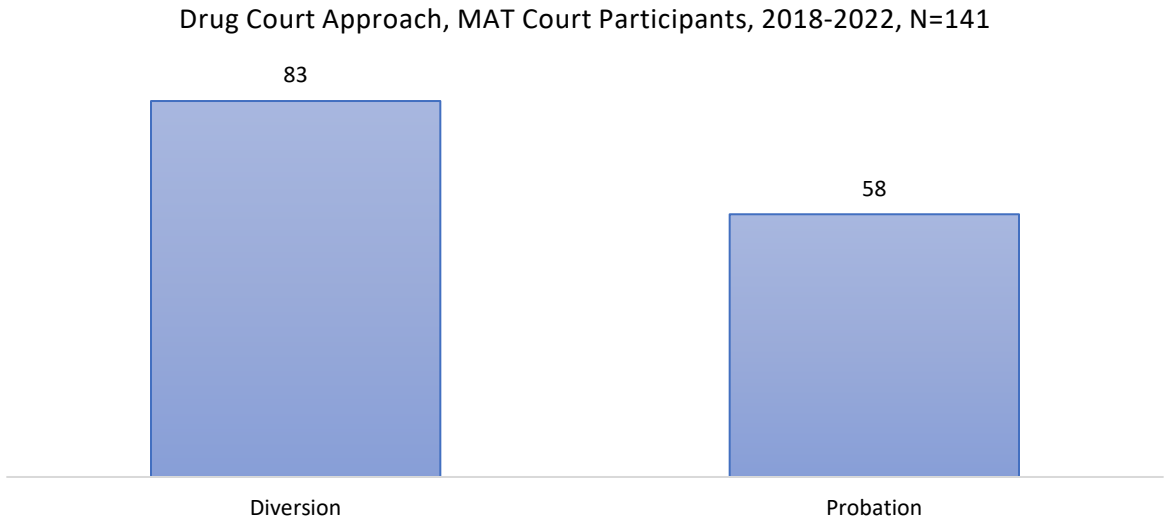
The Second Judicial District Court implemented the Medication-Assisted Treatment (MAT) Court for justice-involved participants with a primary diagnosis of alcohol or opioid use disorder in 2015. The majority of participants of MAT Court from FY2018-FY2022 have been charged with a felony (n=134) as shown in Figure 6 and are part of a diversion approach in which convictions are kept off the records of participants who complete the program (n=83) as indicated in Figure 7. The majority of participants from FY2018-FY2022 favored heroin (n=68) as their primary drug of choice followed by methamphetamine (n=32) in Figure 8. Methamphetamine is a popular secondary drug of choice for participants (n=49) followed by participants who do not have a secondary drug of choice (n=37) in Figure 9.

Figure 6- Offense Type, MAT Court Participants, 2018-2022



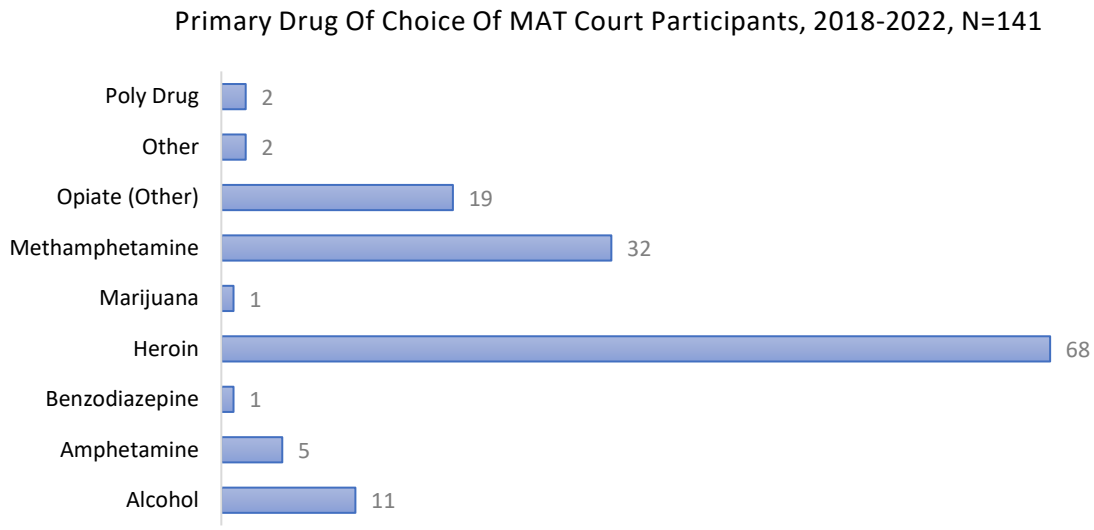
Data Source: Second Judicial District Courts, Medication-Assisted Treatment Court for Fiscal Years 2018-2022

Figure 7- Drug Court Approach, MAT Court Participants, 2018-2022



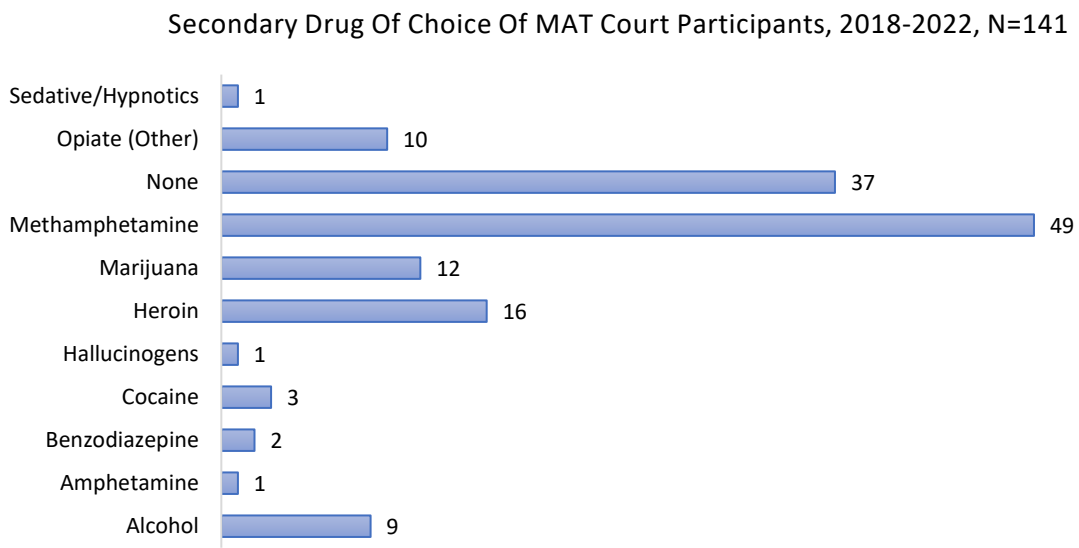
Data Source: Second Judicial District Courts, Medication-Assisted Treatment Court for Fiscal Years 2018-2022

Figure 8- Primary Drug of Choice of MAT Court Participants, 2018-2022



Data Source: Second Judicial District Courts, Medication-Assisted Treatment Court for Fiscal Years 2018-2022

Figure 9- Secondary Drug of Choice of MAT Court Participants, 2018-2022



Data Source: Second Judicial District Courts, Medication-Assisted Treatment Court for Fiscal Years 2018-2022

Washoe County Sheriff's Office

The Washoe County Sheriff's Office (WCSO) is addressing the opioid crisis in two separate programs: the Medication Assisted Treatment program for inmates that suffer from alcohol and opioid addiction and the Naloxone leave behind program. This program supplies deputies on patrol with Naloxone kits to leave with people that are affected by possible opioid overdose. These kits are also available for inmates who

are released from the Washoe County Sheriff's Office to take with them and potentially reduce the chances of overdose when they return to the community. Due to the influx of fentanyl in our region, fentanyl test strips are also available to add to the Naloxone/Narcan kit upon release. Five fentanyl test strips are provided for each kit requested.

Washoe County Sheriff's Office Medication Assisted Treatment Program

Sheriff Balaam authorized the **M**edication **A**ssisted **T**reatment (MAT) program to help the incarcerated population get treatment for alcohol and opioid addiction. WCSO offer three types of medication: 1) buprenorphine (Subutex), 2) methadone, 3) naltrexone (Vivitrol). Since April 15, 2019, the MAT program has provided services to **565 unique individuals**. Each individual is provided services while in custody and expected to participate in counseling at least once a month. They currently (as of August 24,2022) have **22 active patients in the program**. Once the inmate has a date for release from custody, a decision will be made to either start tapering off the medication or ensuring they inmate has the appropriate contacts and support to continue their medication when they return to the community. Detention Services Unit staff help with the transition to community programs that support the MAT program.

Child Protective Services

Washoe County Human Services Agency (WCHSA) has provided child protective services in Washoe County for over 35 years. Children's Services provides the full continuum of child welfare services to victims of child abuse, including child protective services (intake, differential response, and assessment), foster care (permanency) and adoption, foster care licensing, congregate care, Independent Living, licensing, and regulating childcare providers, as well as Clinical Services and Clinical Case Management. Services are provided through an array of supports including services to help temporarily meet a child/family's basic needs (e.g., diapers, Pak-n-Plays; access to shelters; nutrition); case management (e.g., help with completing applications for services; linkage/referral to identified service needs); crisis intervention and short-term mental/behavioral health services (e.g., parent training, short-term individual, family, and group therapies; treatment readiness for substance use counseling; and clinical care coordination to access services); medical, legal and mental health services (i.e., limited psychiatric care); and other supportive services.

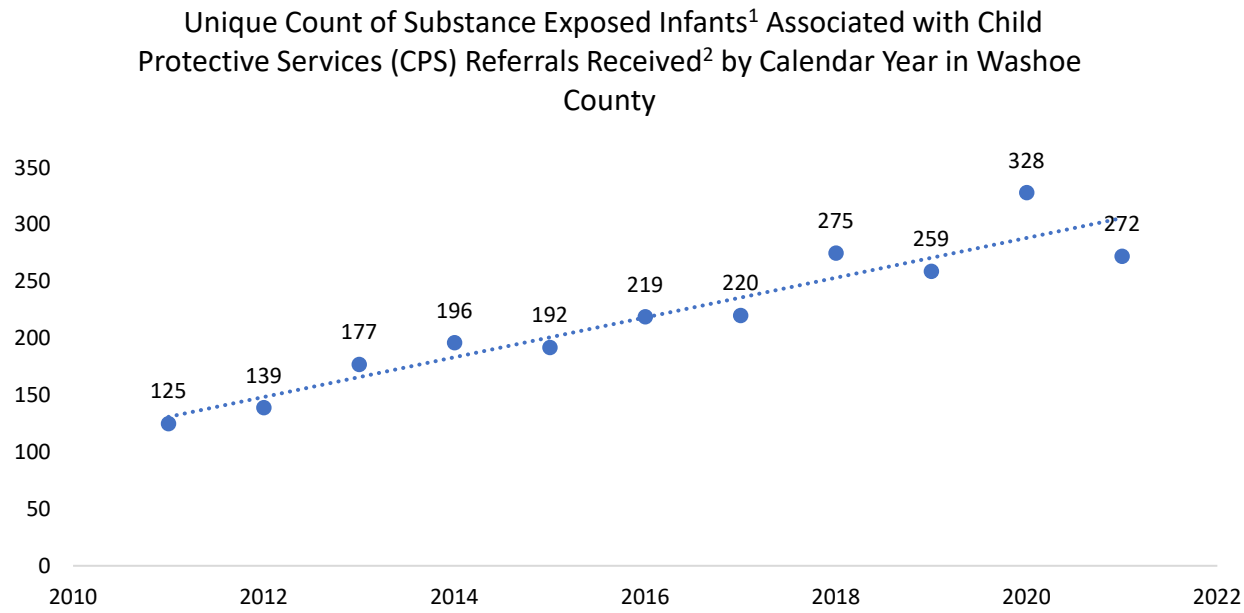
WCHSA has several programs that work with parents with a substance use disorder that include:

- **The Safe Babies Court:** designed to address the needs of young children placed in foster care that includes a heavy emphasis on addressing and reducing trauma and adverse childhood experiences (ACEs).
- **The Clinical Services Team:** Clinicians work to ensure the well-being of children, parents, caregivers or the entire family, when coming into contact with WCHSA's child welfare system by addressing their identified behavioral/mental health needs. Through these clinical services (i.e., solution-focused brief therapy, child parent psychotherapy, EMDR, trauma-focused CBT, play therapy, DBT, & ACT) the CST mission is to help with the client's behavioral and psychological safety to surround the family by increasing their success rates.
- **Early Head Start Home Visiting Program:** In partnership with the University of Nevada, Reno's Early Head Start, the home visiting program provides services to families with children from the prenatal period to kindergarten. This is available to all families with young children (screened in or screened out of child welfare) including infants affected by prenatal substance exposure.
- **Sobriety Treatment and Recovery Team (START):** A specialized child welfare service delivery model that has been shown, when implemented with fidelity, to improve outcomes for children and families affected by parental substance use and child maltreatment. The model uses

a variety of strategies to promote collaboration and systems-level change within and between child welfare agencies, substance use and mental health treatment providers, the judicial system, and other family-serving entities. Additionally, the START model incorporates peer recovery support as a central component of the model. Peer recovery support services are an evidence-based model which supports recovery from mental health and substance use disorders. WCHSA is piloting this model with our prenatal substance exposure population in which there have been identified safety risks.

Figure 10 shows the total reports to Washoe County Human Services Agency for infants with prenatal substance exposure (IPSE) during calendar years 2011 through 2021 and indicates a trend upward in reports for IPSE. These data indicate a 162.4% increase of prenatal substance exposure from 2011-2020 with a marginal decrease in 2021.

Figure 10- Unique Count of Substance Exposed Infants[1] Associated with Child Protective Services (CPS) Referrals Received[2] by Calendar Year in Washoe County



Data Source: Department of Health and Human Services, Office of Analytics

Note: * UNITY stands for Unified Nevada Information Technology for Youth and is Nevada's Comprehensive Child Welfare Information System (CCWIS) which holds the official case record for child welfare related case management activities in Nevada. This information system and its data are dynamic and constantly being modified or updated. Data reflected in these tables is accurate as of the data extraction date noted in the header.

[1] In this analysis, "substance exposed infants" are defined as child participants on CPS referrals who are indicated to be alleged victims of abuse or neglect with an allegation code of 34A - Substance Exposed Infant.

[2] Unique substance exposed infants counted in this table are those associated with any CPS referral received by calendar year indicated, regardless of final screening decision and subsequent agency response.

Table 2-Substances Used During Pregnancy in Cases of Infants Affected by Prenatal Substance Exposure Reported to Washoe County Human Services Agency During Calendar Year 2020

Substances Used During Pregnancy in Cases of Infants Affected by Prenatal Substance Exposure Reported to Washoe County Human Services Agency During Calendar Year 2020

Substance	Single substance	With other substances
Alcohol	0	4
Amphetamine/methamphetamine	**43**	**10**
Cocaine	2	3
Heroin	0	18
Methadone	14	11
RX Opioids	6	8
RX Stimulants	0	1
Suboxone/Subutex	6	0
THC/Cannabis	**179**	28
Polysubstance	**103**	------
Polysubstance + Alcohol	4	------
Baby Negative (parent in recovery or used during 1st trimester)	10	------

Data Source: Washoe County Human Services Agency, data extracted from narrative text in reports for infants affected by prenatal substance exposure in UNITY.

According to referral data for 2020 in Washoe County, the majority of referrals involved cannabis/THC exposure (65.3%). The second highest was for prenatal polysubstance use (32.5%) followed by methamphetamine comprising 16.7% of exposures (Table 2). Additionally, there were trends among pregnant and birthing persons that included being unstably housed, parents having CPS cases as children, lack of prenatal care (often due to COVID-19), using cannabis for nausea/morning sickness, severe medical fragility of babies, and babies delivered outside hospital settings. Table 3 shows that in 2021, the majority of referrals were for prenatal cannabis exposure (57.3%). The second highest was for prenatal polysubstance use (18.5%) with methamphetamine comprising 49.1% of that polysubstance exposure. The trends among pregnant and birthing persons included being unstably housed, co-occurring disorders, trauma, CPS cases as children, babies born at home, minimal prenatal care, lack of transportation and housing. Notably, there were two IPSE reported born to mothers in recovery (one mother had 10 years).

Figure 11 illustrates the number of reports to Washoe County Human Services Agency in which at least one drug or alcohol use characteristic was recorded as a factor to a report of child neglect or abuse to Washoe County Human Services, Child Protective Services (CPS) for calendar years 2012 through 2021. Figure 12 shows the increase in removals of children <1 year of age due to parental substance use, removals with substance use as a factor of child abuse and neglect is much higher in Washoe County compared to Nevada (statewide). Figure 13 shows an increase in removals due to parental substance use for children of all ages in Washoe County, again, there are more removals in Washoe County than Nevada (statewide). These data show the potential harms that parental alcohol or substance use can have on children and families in our community.

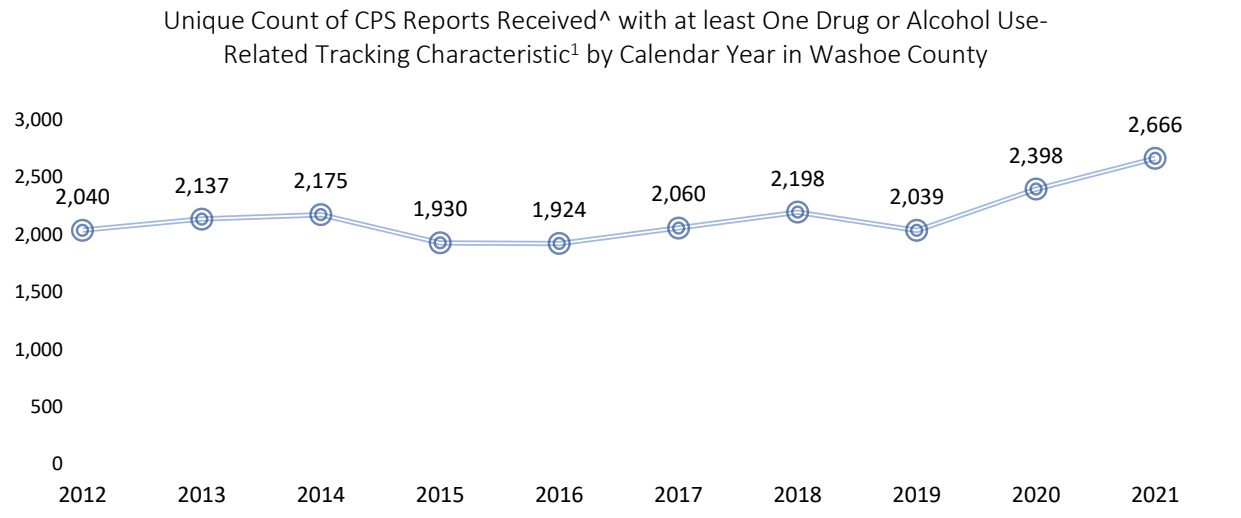
Table 3-Substances Used During Pregnancy in Cases of Infants Affected by Prenatal Substance Exposure Reported to Washoe County Human Services Agency During Calendar Year 2021

Substances Used During Pregnancy in Cases of Infants Affected by Prenatal Substance Exposure Reported to Washoe County Human Services Agency During Calendar Year 2021

Substance	Single substance	With other substances
Alcohol	1	5
Amphetamine	2	1
Barbiturates	1	0
Benzodiazepines	0	1
Cocaine	2	2
Ecstasy	0	1
Fentanyl	0	1
Heroin	3	**14**
Methamphetamine	9	**26**
Methadone	6	4
Polysubstance	**53**	----------
RX Opioids	1	5
Subutex/suboxone	5	2
THC/Cannabis	**164**	7
Baby negative	19	----------

Data Source: Washoe County Human Services Agency, data extracted from narrative text in reports for infants affected by prenatal substance exposure in UNITY.

Figure 11- Unique Count of CPS Reports Received^ with at least One Drug or Alcohol Use-Related Tracking Characteristic[1] by Calendar Year in Washoe County

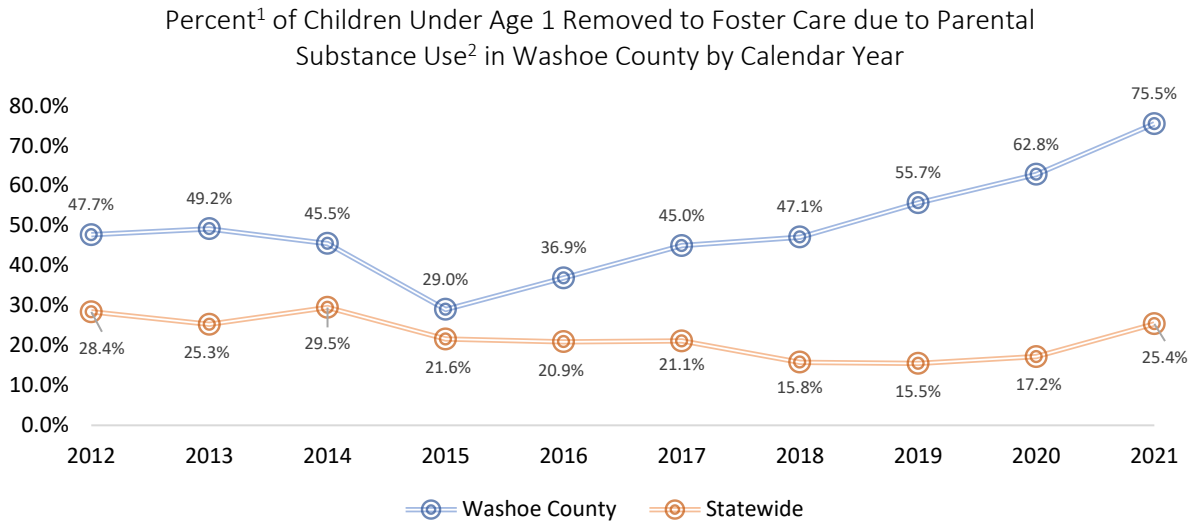


Data Source: Department of Health and Human Services, Office of Analytics, UNITY database, AFCARS extract

Note: ^ Reports represent any CPS report received by calendar year indicated, regardless of final screening decision and subsequent agency response, with at least one drug or alcohol abuse-related tracking characteristic associated with the report.

[1] The marijuana-related report tracking characteristics of MARIJUANA ABUSE and MARIJUANA EXPOSED INFANT were added to UNITY on 10-23-2015. The opioid-related report tracking characteristics of ILLEGAL OPIOID ABUSE, PRESCRIPTION OPIOID MISUSE/ABUSE, and OPIOID EXPOSED INFANT were added to UNITY on 7-20-2018.

Figure 12- Percent[1] of Children Under Age 1 Removed to Foster Care due to Parental Substance Use[2] in Washoe County by Calendar Year

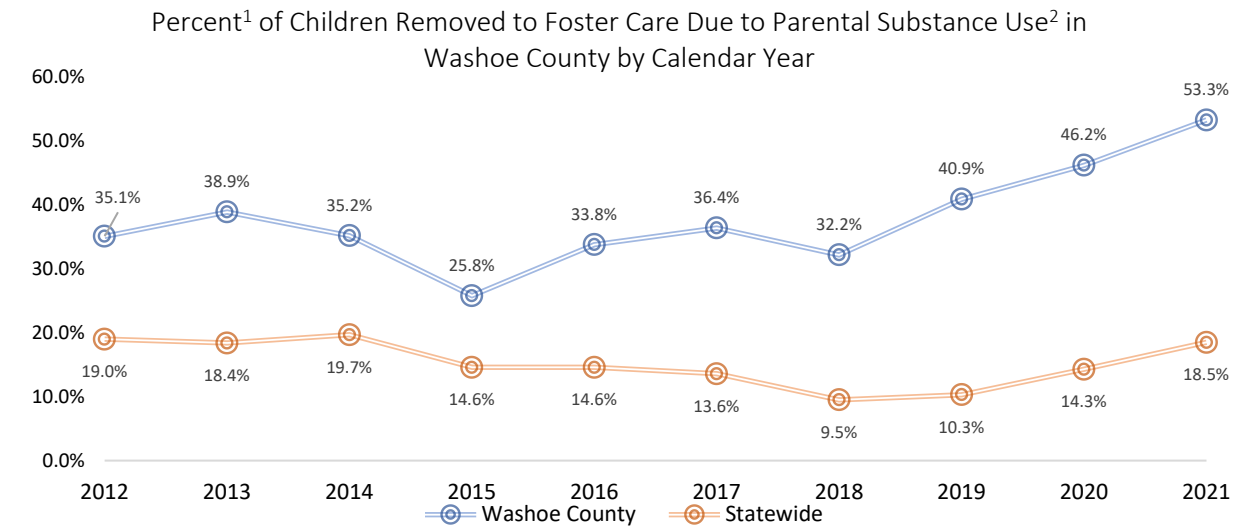


Note: [1] Percentages in this table are calculated as follows: numerator = the count of children removed to foster care for the reason indicated in the table's title for the county and year; denominator = total children removed to foster care for any reason for the county and year. Some cells in the table may be blank if no children were removed for the reason indicated and no children were removed to foster care that year (no numerator or denominator) and others may display 0.0% if at least one child was removed to foster care that year for any reason but there was no child removed for the reason indicated in the table title (no numerator).

[2] This table contains youth of any age removed to foster care in the year indicated for the AFCARS removal reason of 'Parental Drug Use.' This category contains the following specific UNITY removal reasons: Parent's Drug Abuse, Parent's Meth Use, and Parent's Opioid Use. One or more of these specific UNITY removal reasons may be selected for the youth indicated as having the AFCARS removal reason of 'Parental Drug Use.'

Data Source: Department of Health and Human Services, Office of Analytics, UNITY database, AFCARS extract

Figure 13- Percent[1] of Children Removed to Foster Care Due to Parental Substance Use[2] in Washoe County by Calendar Year



Note: [1] Percentages in this table are calculated as follows: numerator = the count of children removed to foster care for the reason indicated in the table's title for the county and year; denominator = total children removed to foster care for any reason for the county and year. Some cells in the table may be blank if no children were removed for the reason indicated and no children were removed to foster care that year (no numerator or denominator) and others may display 0.0% if at least one child was removed to foster care that year for any reason but there was no child removed for the reason indicated in the table title (no numerator).

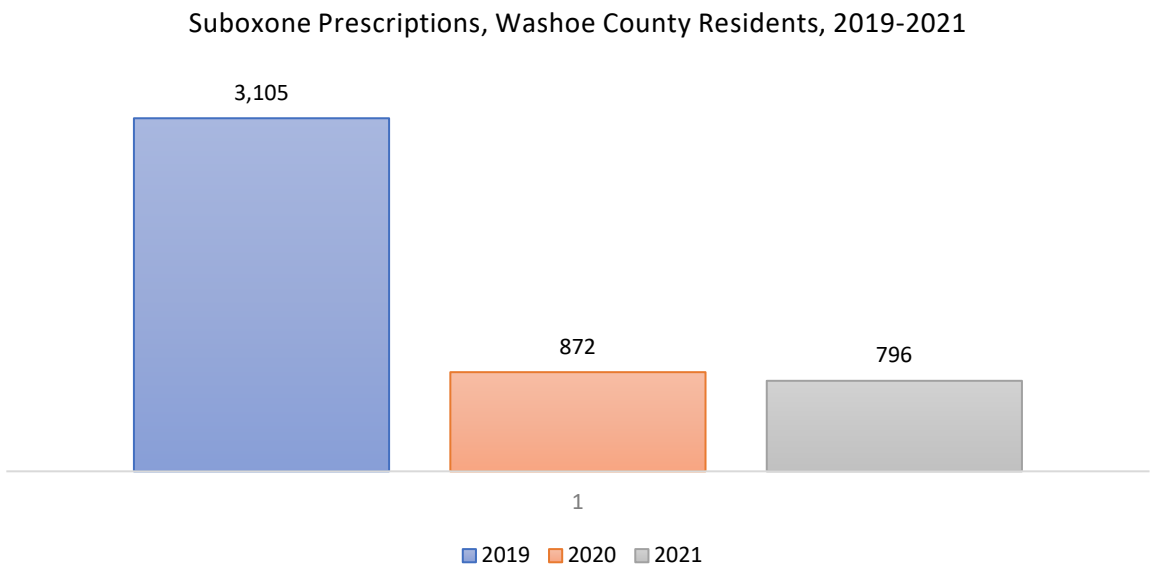
[2] This table contains youth of any age removed to foster care in the year indicated for the AFCARS removal reason of 'Parental Drug Use.' This category contains the following specific UNITY removal reasons: Parent's Drug Abuse, Parent's Meth Use, and Parent's Opioid Use. One or more of these specific UNITY removal reasons may be selected for the youth indicated as having the AFCARS removal reason of 'Parental Drug Use.'

Data Source: Department of Health and Human Services, Office of Analytics, UNITY database, AFCARS extract

Treatment of Opioid Use Disorder

Treatment of opioid use disorder in Washoe County consists of a diverse array of services that include detoxification, inpatient, outpatient, intensive outpatient, residential, and recovery residences. MOUD is offered within opioid treatment programs (OTPs), integrated opioid treatment and recovery centers (IOTRCs), and office-based opioid treatment (OBOT) in which physicians are able to prescribe suboxone. Figure 14 captures the number of suboxone prescriptions for Washoe County residents from 2019-2021 which indicates a **substantial decline** in OBOT prescribing of suboxone. Appendix D shows a list of providers who are able to prescribe suboxone in Washoe County.

Figure 14- Suboxone Prescriptions, Washoe County Residents, 2019-2021



Note: Suboxone was flagged using National Drug Codes (NDC)

Data Source: Prescription Drug Monitoring Program (PDMP)

Opioid-Related Hospital Data

The Nevada Association of Counties and the Department of Health and Human Services provided Washoe County hospitalization data as show below in Tables 4 and 5. The data indicate a decline in emergency department (ED) encounters related to opioids along with a slight decline in inpatient admissions related to opioids in the last five years 2017-2021(Table 4). Table 5 shows lengths of inpatient hospitalizations have decreased for short-term and long-term stays.

Table 4-Opioid-Related Hospital Data-2017-2021

	Inpatient Admissions				Emergency Department Encounters (ED)			
Year	Number of Visits	Crude Rate	CI Lower	CI Upper	Number of Visits	Crude Rate	CI Lower	CI Upper
2017	1,715	379.5	361.5	397.5	1,481	327.7	311.0	344.4
2018	1,804	392.0	373.9	410.1	1,114	242.0	227.8	256.3
2019	1,854	394.6	376.7	412.6	1,091	232.2	218.4	246.0
2020	1,513	317.8	301.8	333.8	879	184.6	172.4	196.8
2021*	1,193	247.4	233.4	261.5	669	138.8	128.2	149.3

Note: Hospital billing data for 2021 are preliminary and subject to change. Data are through September 30, 2021. Death data for 2020 and 2021 are preliminary and subject to change. Data are as of April 14, 2022. All preliminary data are marked with an asterisk (*). Rates are per 100,000 population, provided by the state demographer.

Data Source: Division of Public and Behavioral Health, Hospital Inpatient and Emergency Department Billing Data. Data Provided by: Center for Health Information Analysis.

Table 5-Opioid-Related Hospitalization (Inpatient) Visits by Length of Stay-2017-2021

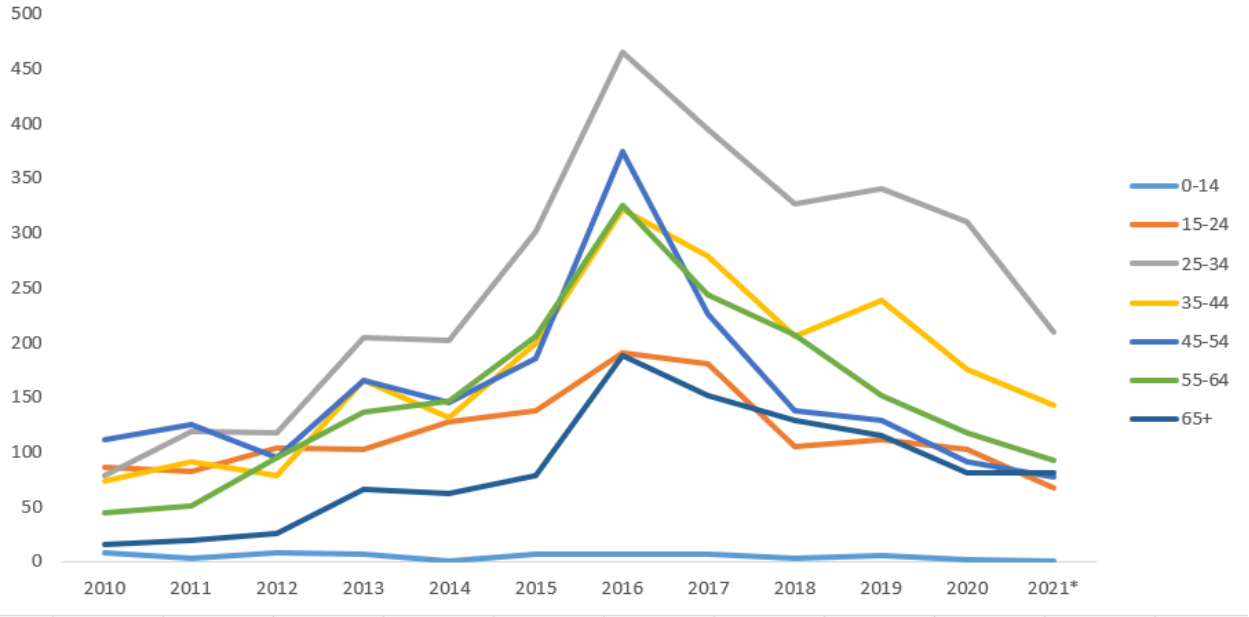
Sum of Count	Days Spent Inpatient						
Year	0-1	2-4	5-9	10-14	15-19	20-24	25+
2017	204	751	513	112	44	32	59
2018	235	749	549	134	53	45	39
2019	238	779	555	144	61	26	51
2020	239	600	445	115	39	22	53
2021*	179	526	340	80	24	14	30

Note: Hospital billing data for 2021 are preliminary and subject to change. Data are through September 30, 2021. Death data for 2020 and 2021 are preliminary and subject to change. Data are as of April 14, 2022. All preliminary data are marked with an asterisk (*). Rates are per 100,000 population, provided by the state demographer.

Data Source: Division of Public and Behavioral Health, Hospital Inpatient and Emergency Department Billing Data. Data Provided by: Center for Health Information Analysis.

Figure 15 indicates a decline in emergency department encounters for all age groups since 2017, except for a slight increase in persons aged 15-24 during 2020. Figure 16 shows that since 2017, there have been decreases or flattened trends in inpatient admissions for all age groups, apart from persons 25-44 who experienced an increase in 2019.

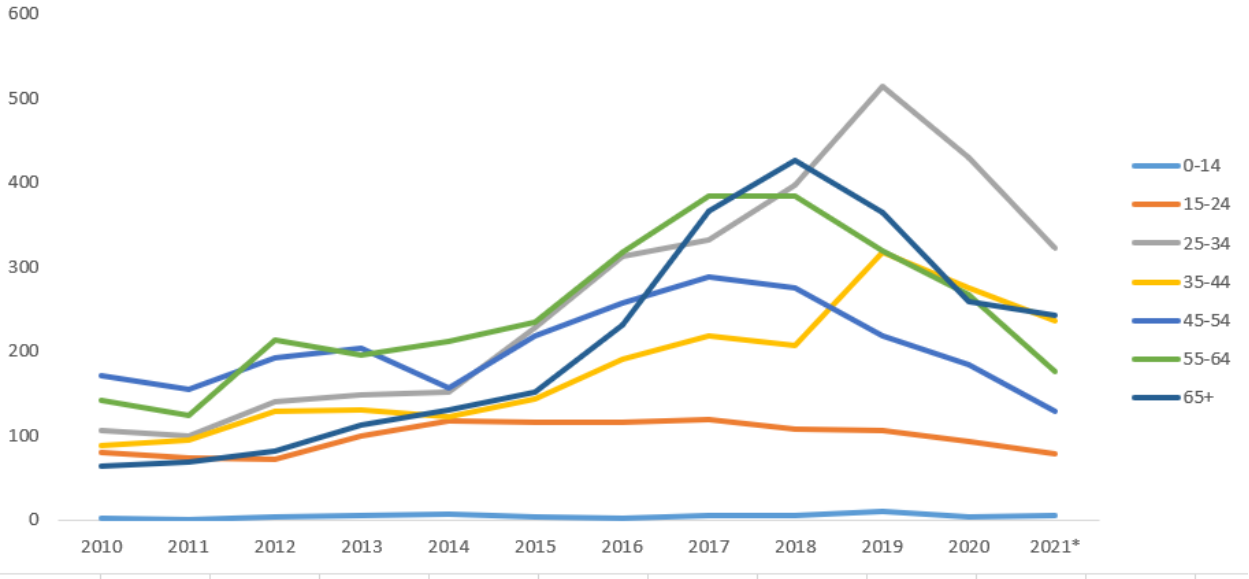
Figure 15- Emergency Department Encounters by Age-2010-2021



Note: Hospital billing data for 2021 are preliminary and subject to change. All preliminary data are marked with an asterisk (*).

Data Source: Division of Public and Behavioral Health, Hospital Inpatient and Emergency Department Billing Data. Data Provided by: Center for Health Information Analysis.

Figure 16- Inpatient Admissions by Age-2010-2021



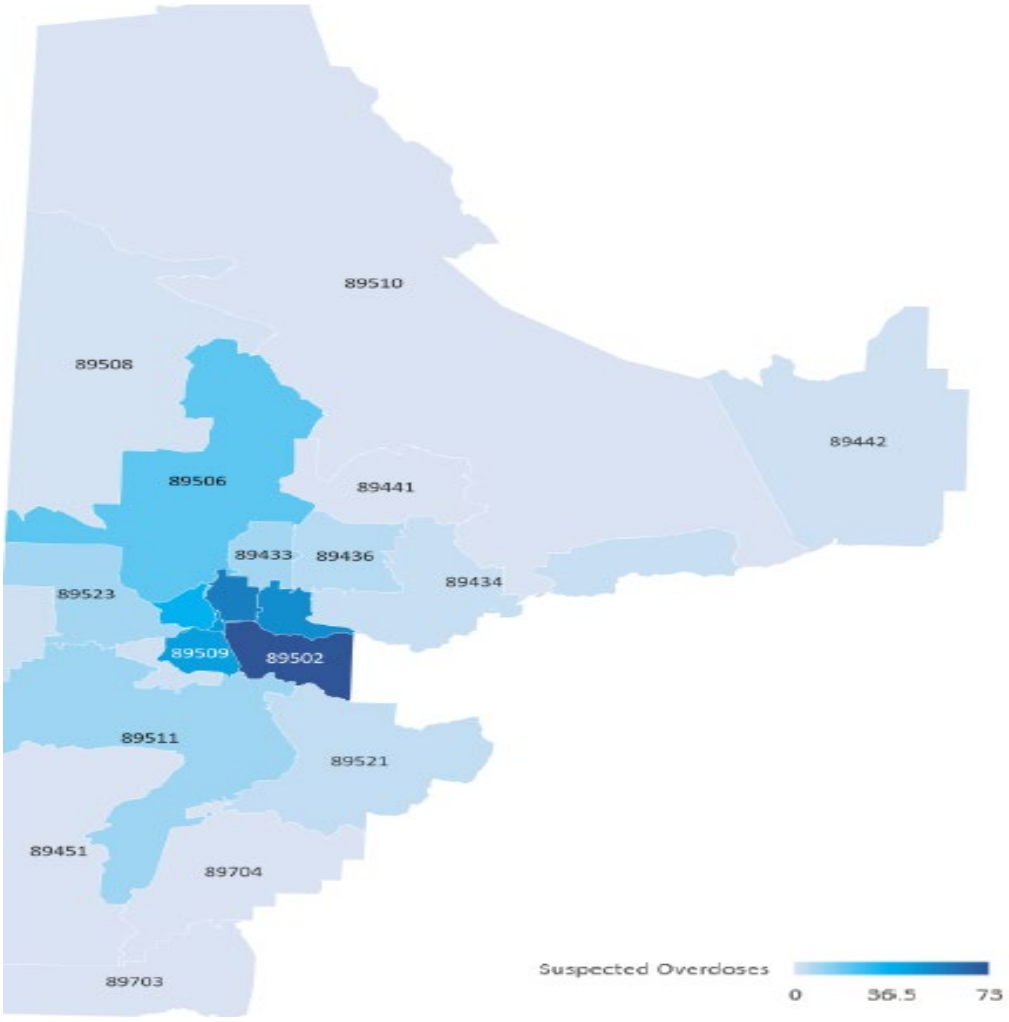
Note: Hospital billing data for 2021 are preliminary and subject to change. All preliminary data are marked with an asterisk (*).

Data Source: Division of Public and Behavioral Health, Hospital Inpatient and Emergency Department Billing Data. Data Provided by: Center for Health Information Analysis.

Non-fatal Overdoses

According to Thomas[17], there were 375 EMS incidents in Washoe County in 2021 related to suspected non-fatal opioid overdose. The top five zip codes with the highest EMS incidents for non-fatal overdose were 89502 (19.5%), 89512 (15%), 89431 (13.4%), 89501 (12.3%), and 89509 (11.5%) (Figure 17). Figure 18 shows that persons aged 18-54 had the highest non-fatal overdoses, with individuals 25-34 experiencing the most incidents[17]. Rates were highest among Black non-Hispanic individuals (Figure 19)[17].

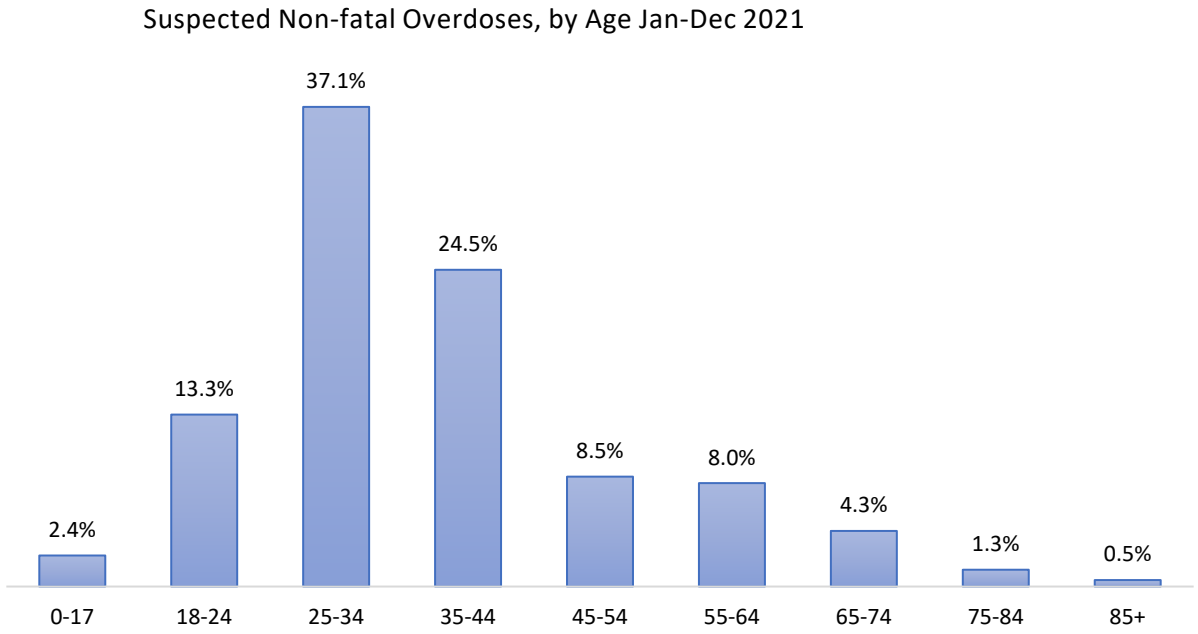
Figure 17- Zip codes: non-fatal opioid related EMS incidents, Jan-Dec 2021.



Data Source: ImageTrend is used by the state of Nevada and helps emergency professionals and hospitals collect, connect and analyze important data for EMS, fire, trauma, emergency preparedness, and community paramedicine. Data were acquired through Thomas, S. (2022). Nevada suspected opioid overdose bulletin, Washoe County – January 2022. School of Public Health, University of Nevada, Reno. https://nvopioidresponse.org/wp-content/uploads/2019/05/od_bulletin_washoe_q1_2022.pdf

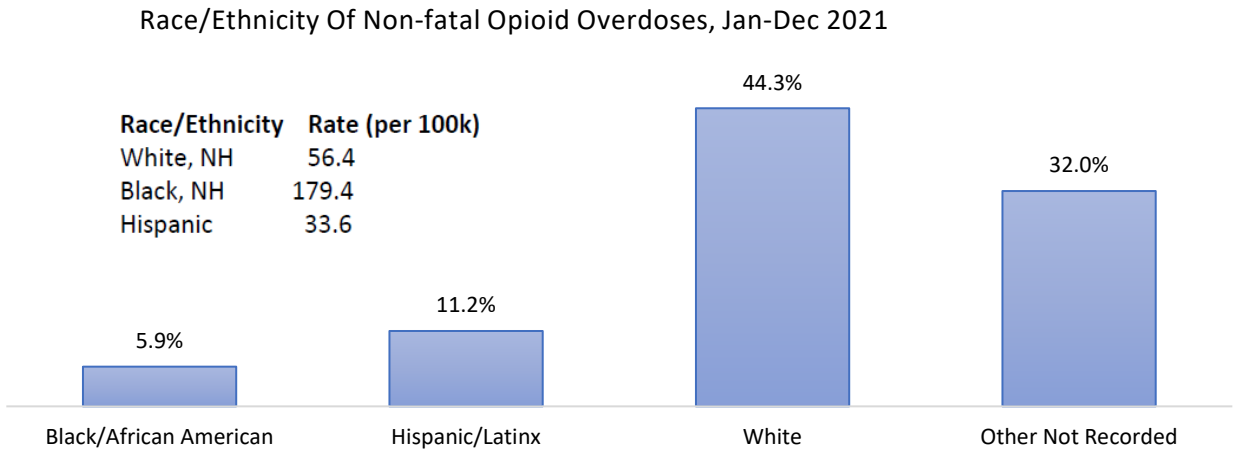
[17] Thomas, S. (2022). Nevada suspected opioid overdose bulletin, Washoe County – January 2022. School of Public Health, University of Nevada, Reno. https://nvopioidresponse.org/wp-content/uploads/2019/05/od_bulletin_washoe_q1_2022.pdf

Figure 18-Suspected Non-fatal Overdoses, by Age, Jan-Dec 2021



Data Source: ImageTrend is used by the state of Nevada and helps emergency professionals and hospitals collect, connect and analyze important data for EMS, fire, trauma, emergency preparedness, and community paramedicine. Data were acquired through Thomas, S. (2022). Nevada suspected opioid overdose bulletin, Washoe County – January 2022. School of Public Health, University of Nevada, Reno. https://nvopioidresponse.org/wp-content/uploads/2019/05/od_bulletin_washoe_q1_2022.pdf

Figure 19-Race/Ethnicity of Non-Fatal Opioid Overdoses, Jan-Dec 2021



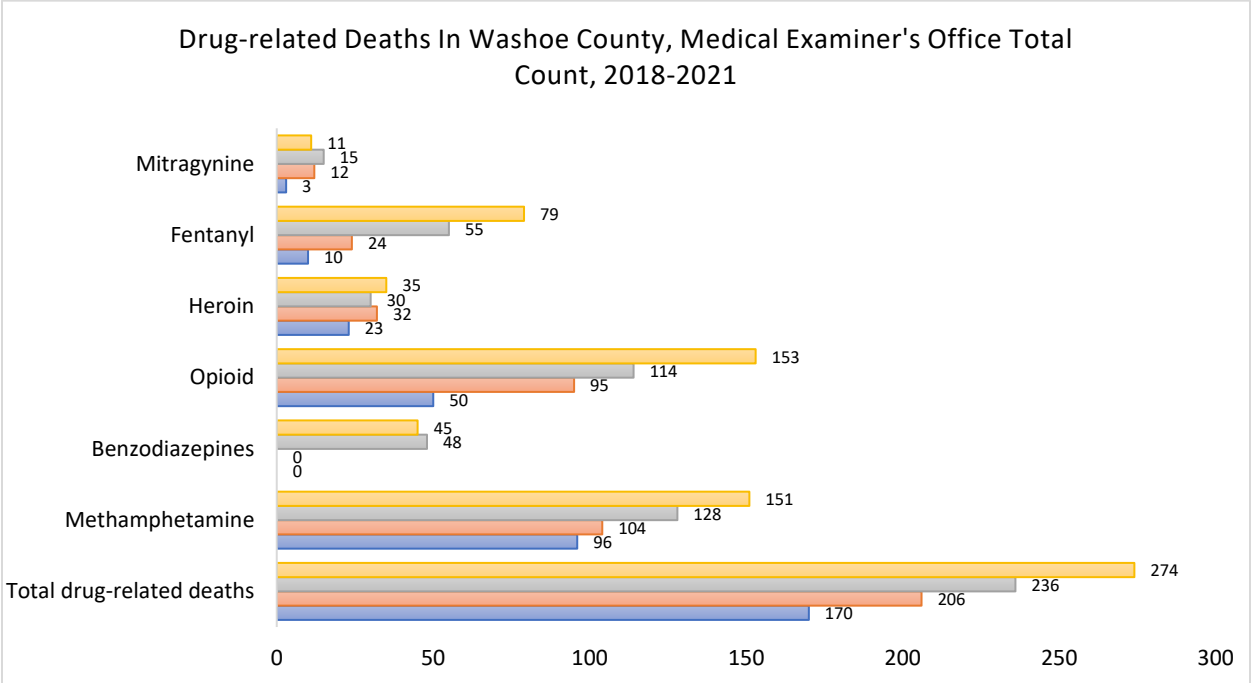
Data Source: ImageTrend is used by the state of Nevada and helps emergency professionals and hospitals collect, connect and analyze important data for EMS, fire, trauma, emergency preparedness, and community paramedicine. Data were acquired through Thomas, S. (2022). Nevada suspected opioid overdose bulletin, Washoe County – January 2022. School of Public Health, University of Nevada, Reno. https://nvopioidresponse.org/wp-content/uploads/2019/05/od_bulletin_washoe_q1_2022.pdf

Death Data

Fatal drug poisoning data were obtained from the Washoe County Regional Medical Examiner's office and the Department of Health and Human Services, Office of Analytics. Figures 20 and 21 below show an increase in overall fatal drug poisonings as well as an increase in deaths involving fentanyl, heroin, opioid, and methamphetamine. Drug-related deaths have increased by 61.2% and fentanyl related deaths have increased by 690% since 2018. It is important to note that the majority of fatalities involve multiple substances and would be included across multiple categories. The majority of fatalities occur in a home setting (79.8%), by a person with current or past substance misuse (77.4%), and over half (55.3%) had a bystander present; however, only a third of fatalities were given naloxone (Figure 22).

Table 6 shows that the majority of opioid-related deaths (82.3%) in Washoe County from 2010-2021 were accidental while a minority were intentional (11.8%). Tables 7 and 8 highlight racial and gender-related demographic information on persons who died of a fatal drug poisoning. Table 7 shows that Black, Indigenous, and People of Color (BIPOC) deaths have increased over time. Table 8 shows increases overall in opioid-related deaths of males and females, yet males have a higher rate of fatalities. Figure 23 shows the ages of individuals who died from opioid overdose or opioid poisoning. Deaths of individuals aged 55-64 declined, being surpassed by younger individuals aged 25-54 in 2021.

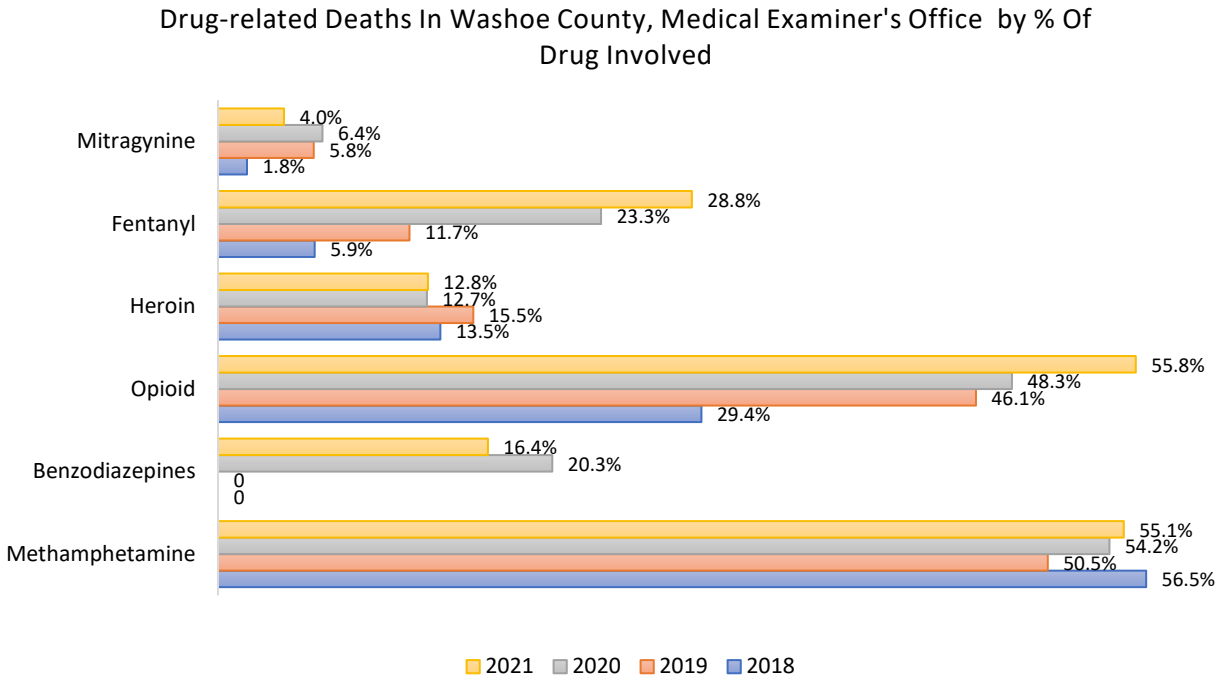
Figure 20- Drug-related Deaths in Washoe County--Medical Examiner's Office Total Count-2018-2021



	Total drug-related deaths	Methamphetamine	Benzodiazepines	Opioid	Heroin	Fentanyl	Mitragynine
2021	274	151	45	153	35	79	11
2020	236	128	48	114	30	55	15
2019	206	104	0	95	32	24	12
2018	170	96	0	50	23	10	3

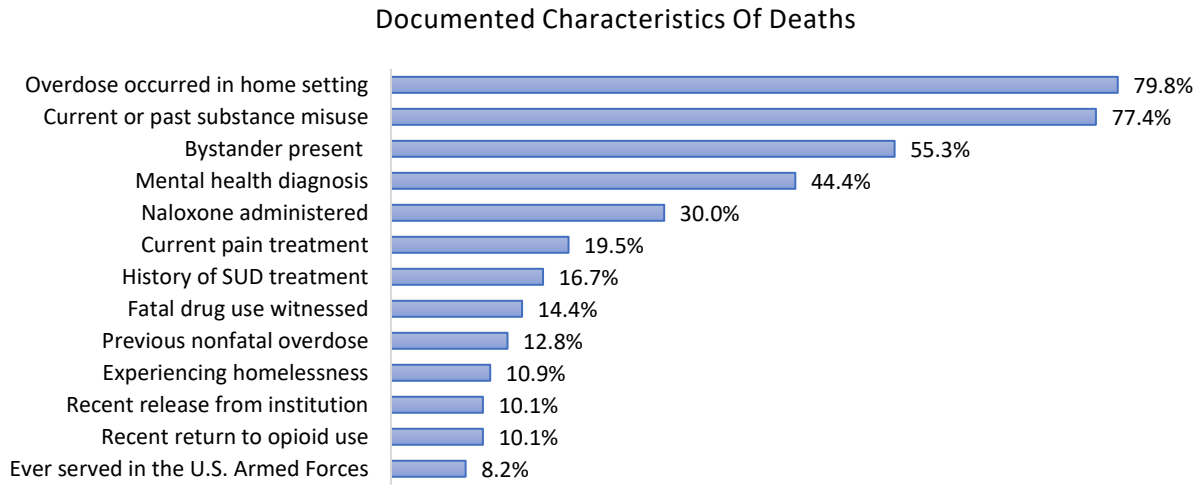
Note: Polysubstance related deaths will be included in multiple columns (e.g. a person whose death was related to methamphetamine and heroin would be counted in the methamphetamine, opioid, and heroin columns)
Data Source: Washoe County Regional Medical Examiner's Office, Drug Related Deaths in Washoe County 2018-2021

Figure 21- Drug-related Deaths in Washoe County--Medical Examiner's Office by % of Drug Involved, 2018-2021



Data Source: Washoe County Regional Medical Examiner's Office, Drug Related Deaths in Washoe County 2018-2021

Figure 22- Documented Characteristics of Deaths in Washoe County, 2021



Data Source: Nevada State Unintentional Drug Overdose Reporting System (SUDORS) and the Washoe County Medical Examiner's Office, analyzed by Shawn Thomas (2022), School of Public Health, University of Nevada, Reno.

Table 6-Opioid-Related Deaths by Intent in Washoe County, 2010-2021

Type of Death	Number of Deaths	Percentage of Deaths
Accidents	1,180	82.3%
Intentional self-harm (suicide)	169	11.8%
Events of undetermined intent	83	5.8%
Assault (homicide)	2	0.1%
Grand Total	**1,434**	**100.0%**

Data Source: Department of Health and Human Services, Office of Analytics

Table 7-Opioid-Related Deaths by Race/Ethnicity, 2017-2021

Race/Ethnicity	Percent by Year				
	2021	2020	2019	2018	2017
Asian	2.3%	2.0%	2.3%	0.9%	0.8%
Black	4.6%	5.2%	6.9%	2.8%	3.1%
Hispanic	13.2%	15.7%	9.9%	3.7%	5.5%
Native American	3.4%	1.3%	3.1%	1.9%	1.6%
White	76.4%	75.8%	76.3%	90.7%	82.7%
Unknown			1.5%		6.3%

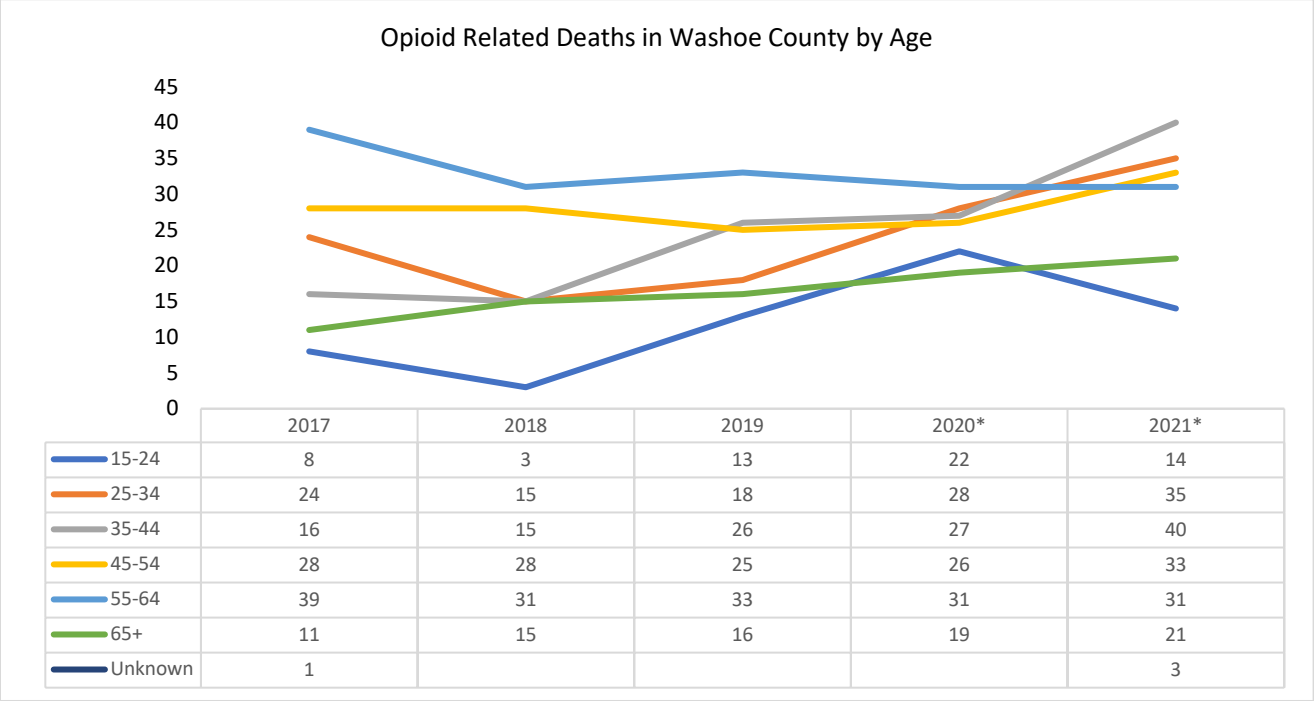
Data Source: Department of Health and Human Services, Office of Analytics

Table 8-Opioid-Related Deaths by Sex in Washoe County, 2010-2021

Year	Female	Male
2010	47	57
2011	51	70
2012	48	57
2013	40	77
2014	28	52
2015	60	45
2016	53	57
2017	52	75
2018	30	77
2019	47	84
2020*	55	98
2021*	64	110
Grand Total	**575**	**859**

Data Source: Department of Health and Human Services, Office of Analytics

Figure 23-Opioid Related Deaths in Washoe County by Age



	2017	2018	2019	2020*	2021*
15-24	8	3	13	22	14
25-34	24	15	18	28	35
35-44	16	15	26	27	40
45-54	28	28	25	26	33
55-64	39	31	33	31	31
65+	11	15	16	19	21
Unknown	1				3

Note: Death data for 2020 and 2021 are preliminary and subject to change. Data are as of April 14, 2022. All preliminary data are marked with an asterisk (*).

Data Source: Department of Health and Human Services, Office of Analytics

Recovery Residences

The CrossRoads Men's Program is a supportive living community that provides recovery-centered alcohol and drug free housing and programming for men transitioning out of homelessness. The CrossRoads program provides intensive case management, a range of supportive services, leisure and recreational activities, mutual aid and self-help groups, transportation, volunteer opportunities, and basic life skills programming. The data below (Figures 24 to 28) highlight the characteristics of men within the program from January 1, 2022 through August 31, 2022. Figure 24 shows the majority of participants served in the first eight months of 2022 are between 25-34 years of age, a demographic that has been associated with increases of emergency department visits, inpatient admissions, and deaths. Figure 25 illustrates the racial and ethnic characteristics of participants, showing the majority identify as Caucasian/White. Alcohol, methamphetamine, and heroin are top substances of choice (Figures 26-27) and 72% of participants are probationers (Figure 28).

Figure 24-Age of Men's CrossRoads Participants

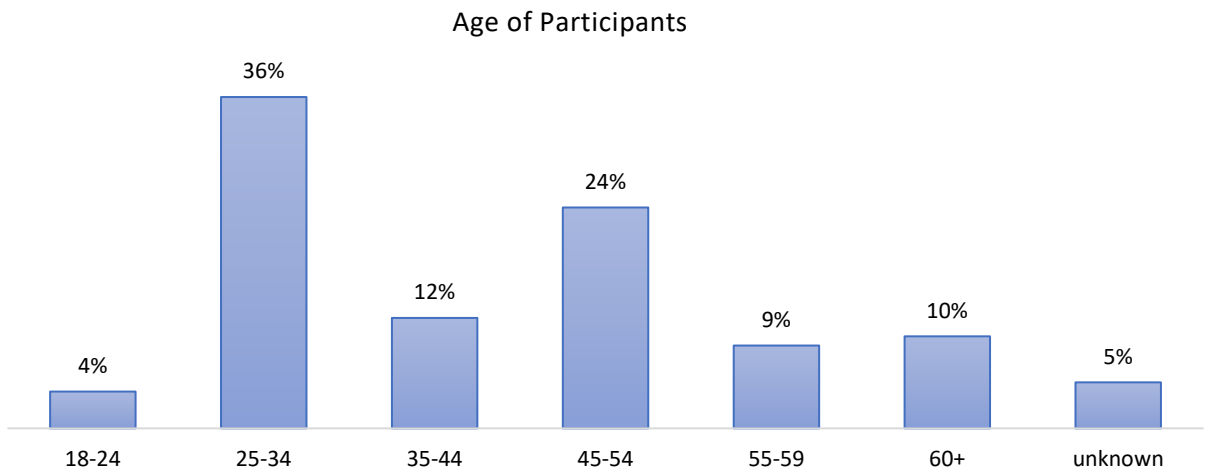


Figure 25-Race/Ethnicity of Men's CrossRoads Participants

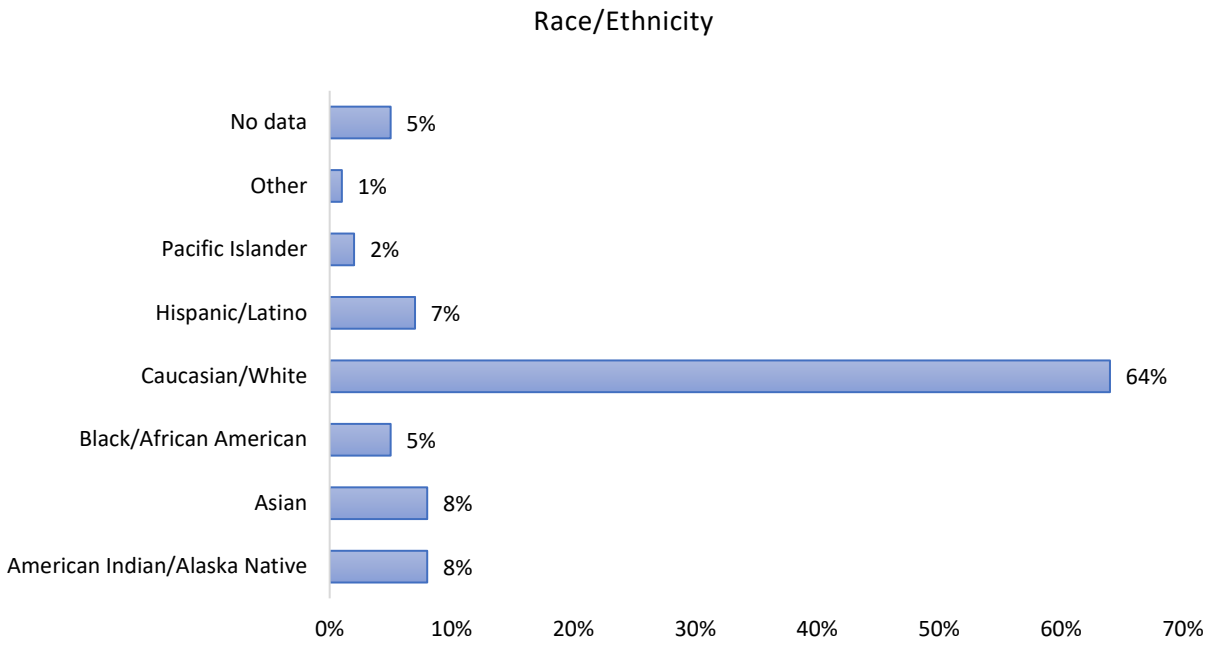


Figure 26-Substance of Choice--Men's CrossRoads

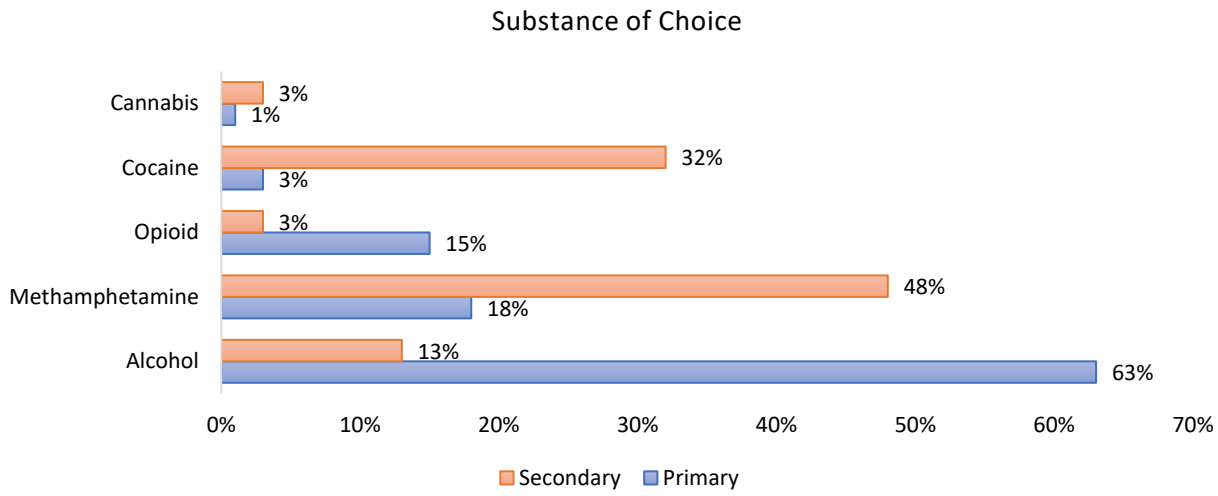


Figure 27-Current Substance of Choice--Men's CrossRoads

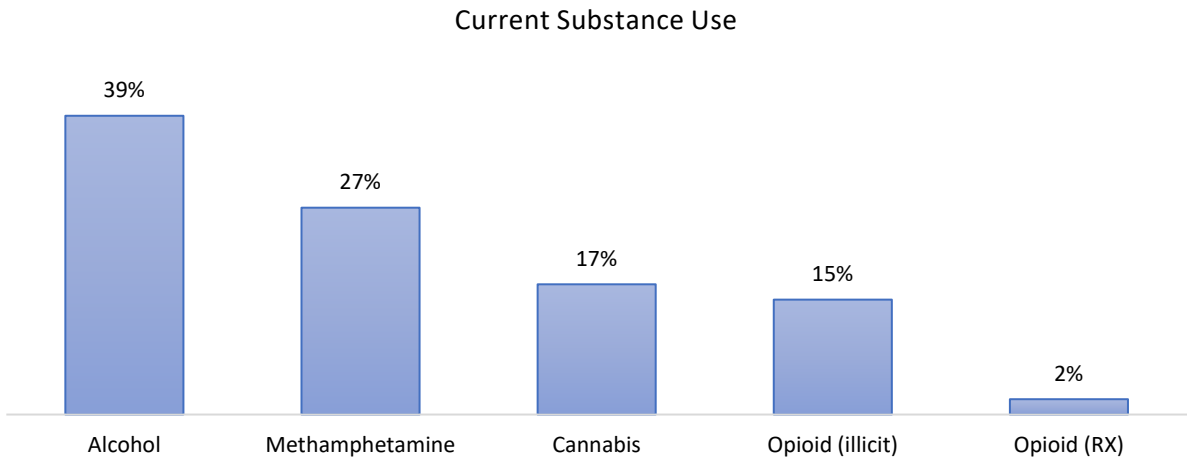
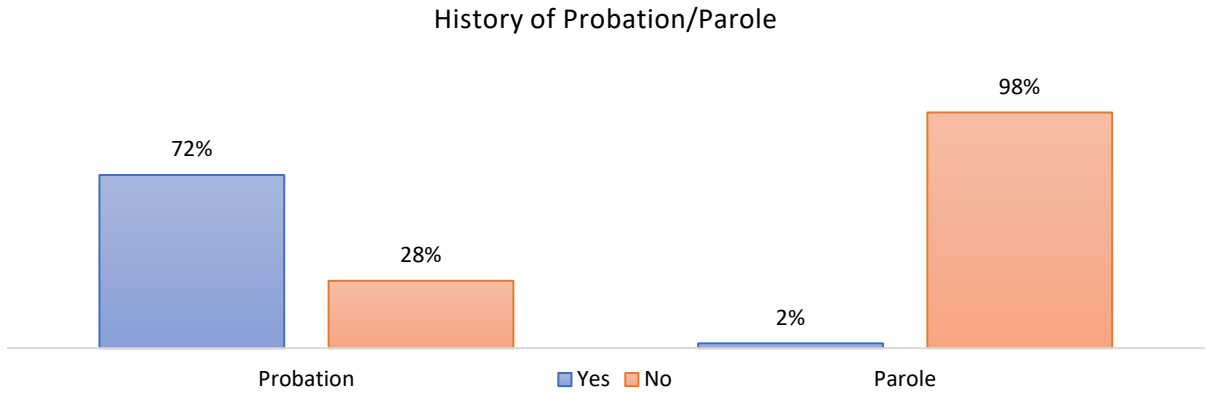


Figure 28-History of Probation/Parole--Men's CrossRoads



Data Source: Men's CrossRoads Program Coordinator, September 2022

Trends

Based on the secondary data received, the following trends were identified:

- Fentanyl is an emergent threat in Washoe County.
- Psychostimulant and polysubstance use continue to be an issue in Washoe County.
- Opioid pain medication misuse has decreased from 2013-2019 among high school students in Washoe County. There was a slight increase from 2017-2019.
- Lifetime use of heroin among Washoe County high school students has shown a steady decline from 2013-2019.
- Increase in emergency department and inpatient hospitalizations for drug related poisonings for youth aged ≤ 17 and no changes in drug poisoning fatalities for that age group from 2019-2021.
- Youth in Washoe County and Nevada generally experience a higher prevalence of adverse childhood experiences than the United States overall.
- Among participants monitored through the Department of Alternative Sentencing (DAS), prescription opioid positivity has been relatively stable, while heroin and fentanyl positivity has increased.
- MOUD use has increased for participants of DAS.
- The majority of participants of MAT Court from (FY2018-FY2022) have been charged with a felony.
- The majority of participants from MAT Court (FY2018-FY2022) favored heroin as their primary drug of choice followed by methamphetamine. Methamphetamine is a popular secondary drug of choice for participants.
- 162.4% increase of prenatal substance exposure from 2011-2020 with a marginal decrease in 2021.
- Prenatal cannabis/THC exposure followed by polysubstance and methamphetamine exposure is an issue in Washoe County.
- Increase in removals due to parental substance use for children of all ages in Washoe County (there are more removals per capita in Washoe County than Nevada statewide).
- Suboxone prescriptions have declined in Washoe County from 2019-2021.
- Decline in emergency department (ED) encounters related to opioids along with a slight decline in inpatient admissions related to opioids in the last five years 2017-2021.
- Increase in fatal drug poisonings in Washoe County, especially with methamphetamine, opioid, and fentanyl involvement.
- Deaths of individuals aged 55-64 declined, being surpassed by younger individuals aged 25-54 in 2021.
- The majority of participants served in Men's CrossRoads during the first eight months of 2022 are between 25-34 years of age, a demographic that has been associated with increases of emergency department visits, inpatient admissions, and deaths.
- Majority of Men's CrossRoads participants' primary substance of choice are: 1) alcohol; 2) methamphetamine; and 3) opioid.

Gaps

Based on the secondary data received, the following gaps have been identified:

- Lack of coordinated real-time data shared amongst providers to alert community of potential drug trends or overdose spikes.
- Lack of specialized programs to address adverse childhood experiences (ACEs) of children in Washoe County or robust ACEs screening programs.
- Lack of ample specialized programming to address parental substance use within the child welfare system.
- Lack of usable and sharable data—some data requested was inaccurate and unable to be provided/corrected by the time of writing this report.
- Lack of accurate treatment data entered into the Treatment Episode Data Set Admissions/Discharges (TEDS-A/TEDS-D).
- Incongruence between state and local data.
- Lack of data on drug disposal programs.

Section III

Qualitative Data

Section III: Qualitative Data

Qualitative data were collected via key informant interviews with community providers and people who use opioids/people in early recovery from opioid use disorder to better understand gaps, barriers, strengths, and needs for harm reduction, treatment, and recovery services in Washoe County.
This needs assessment sought feedback from several populations outlined in SB390, including: persons and families impacted by the use of opioids and other substances; providers of treatment for opioid use disorder and other substance use disorders; communities of persons in recovery from opioid use disorder and other substance use disorders; providers of services to reduce the harms caused by opioid use disorder and other substance use disorders; persons involved in the child welfare system; providers of social services; providers of health care and entities that provide health care services; and members of diverse communities disproportionately impacted by opioid use and opioid use disorder.

Methodology

Interview guides were developed for providers of services to people who use opioids or are at risk of developing opioid use disorder and for people who use opioids or are in early recovery from opioid use disorder (OUD). The survey drafts were sent out to the quantitative design workgroup and stakeholders across sectors, including people who use opioids. Feedback from workgroup members was centered around the questions of, "what do we need to ask community members?" "what information is important to know from community members?" Stakeholders provided feedback as well as proposed questions which were added to the final drafts (see Appendix C). The author reviewed a list of providers who indicated an interest in participating in focus groups (focus groups were not selected, rather key informant interviews and a survey were chosen) and categorized providers by sector to ensure a diverse array of perspectives within the broader system were represented. Thus, purposive sampling was used to recruit interviewees from organizations. Invitations to participate in interviews were sent to fifteen providers and scheduled with one of two WCHSA staff. People who use opioids or are in early recovery from OUD were recruited through purposive and convenience sampling through the PWUD stakeholder group and partner organizations. The interviews aimed to answer the following questions: How do providers and people who use opioids understand the strengths, challenges, barriers, and gaps of providing services to support people who use opioids or are seeking recovery from OUD? What is needed to support your work? What trends are you seeing related to opioid use? What is the future of opioids in the community? What are your ideas for solutions? What are the benefits and challenges of using opioids and what motivates people to seek services? How do people who use opioids think about overdose prevention and what is the understanding of Good Samaritan and drug induced homicide laws? What are the experiences of people who use drugs in accessing services, participating in court, or involvement with child welfare? What is important for people to know about people who use drugs?

Due to the short timeline of this project and the difficulties of scheduling with persons with problematic opioid use, there were limitations to recruitment and obtaining the goal of fifteen provider and fifteen PWUD interviews. In total, we interviewed ten providers and five people who use opioids or are in early recovery from opioid use disorder. All interviews were transcribed and coded using *a priori* codes by two WCHSA staff (LL and TG). Saturation was reached in a short time, that is, no new information was emerging from the interviews. Thematic analysis was conducted using Interpretive Phenomenological Analysis (IPA) to deepen the understanding of the experiences and perspectives of providers of services and people who use opioids/are in early recovery from opioid use disorder.

Key Informant Interview Themes

Thematic analysis was conducted on all transcriptions of key informant interviews, however, they differed across cohorts of participants (professional staff and people who use opioids/are in early recovery).

Organization/Provider Themes

Experience of Providing Services in Washoe County

Participants indicated that there are many challenges of working in their field and providing services to people with an OUD. The following sections include the basic concepts that participants conveyed, a more comprehensive account (including verbatim responses) can be found in Appendix E.

Key Strengths

Additionally, participants discussed the various strengths of their individual programs, collaborative efforts, and overall strengths of the community to ameliorate drug related harms in Washoe County.

- **State level surveillance, technical assistance, behavioral health and SUD treatment providers, drug supply control (enforcement), collaboration, media.**
- Changes in the justice system to become more understanding of recovery as a process and that individuals with SUD need supports to rebuild their lives rather than a punitive approach.
- DAS is working in conjunction with WCSO to ensure that justice-involved individuals receiving MAT can transition seamlessly back to the community without interruptions to their treatment.
- Law enforcement is more educated about substance use disorder and is more centered on "partnership than adversarial now."
- Suboxone and methadone are helpful for a lot of people—MAT is an effective tool for treating OUD.
- There is a benefit of working in the field, seeing people change their lives.
- Narcan, fentanyl test strips (FTS), one on one outreach and support.
- The benefit of having people with lived experience in the field as service work can help to support recovery.
- Benefit of telehealth to reach more people as well as the benefit of in-person groups in a hybrid treatment setting.
- Effectiveness of a harm reduction approach in treatment. Providing harm reduction education to people who use opioids but also to people who use stimulants about how to stay safe. Harm reduction is effective to keep people safe until they are ready for change.
- Person-centered approach that allows the individual to "drive their own recovery."
- The importance of using person-first recovery friendly language.
- Meeting people "where they're at," building relationships and being a safe person that they can come to.
- Compassionate providers.
- Improvement with insurance companies, federal money, and state grants to pay for treatment.
- Prevention efforts for youth focus on protective factors, positive choices, and building leadership and resilience.
- Services for youth are growing.

Key Trends

- **Increased illicitly manufactured fentanyl (IMF) contamination in a multitude of opioid and non-opioid substances and people are transitioning to preferring fentanyl. Fentanyl use is complicating MAT stabilization and retention.**
- Inverse relationship with decrease in opioid prescriptions but increase in suspected drug overdoses from opioids, fentanyl, and methamphetamine. A shift from a regulated supply to an illicit, uncontrolled supply. What began as overprescribing is now systemic under-prescribing for legitimate pain. Provider stigma is interfering with legitimate pain management.
- Opioid use impacts children, adults, and seniors.

- Increased acceptance of MAT, including in child welfare; more removals due to opioids being considered "hardcore drugs."
- More people in the community carrying naloxone, and changes in using behaviors (e.g., fear of using alone).
- Cannabis and psychostimulant use rates are high in Washoe County.
- Currently domestic violence and substance use are the main drivers for homelessness for female identifying persons and families.
- Increasing overdose or drug poisoning deaths in the community and collective trauma in service providers.
- Prescription misuse in high school and middle school and medications are often laced.
- Increases of overdoses in the schools.
- Stress is impacting youths' ability to cope (testing, social media, etc.).

Key Challenges

- No cohesive or effective surveillance system to notify the community in real-time of an overdose spike and trigger a targeted response.
- Secondary trauma exposure in the workforce.
- Insurance reimbursements are low, which results in staff being unable to afford housing and keep up with inflation.
- Children exposed in utero have less capacity to self-regulate and self-soothe and can present challenges for foster families due to behaviors.
- A lack of available recovery housing and permanent housing is a barrier to maintaining recovery.
- Many clients die either from overdose or from health issues from long-term drug use.
- Tension between abstinence-based approach and harm reduction approach in treatment.
- Difficulty engaging people in treatment, despite flexible policies.
- Lack of available information or resources on treatment options for methamphetamine use treatment. Lack of funding, policy, and attention towards methamphetamine as meth use is not seen as iatrogenically caused.
- While there was overprescribing of opioids, a challenge has been that providers cut people off "cold turkey and expect them to be okay." Also, there people with chronic pain that need pain management.
- Regulatory agencies have not kept up with treatment needs related to fentanyl and there is tension between state and federal regulations for OTPs.
- The breadth of the problem is bigger than the capacity of local providers.
- Washoe county is a large community, with many different schools, different demographics, and different cultural considerations.
- Washoe County has a culture that supports the consumption of alcohol and parental permissive attitudes on alcohol and drug use as well as stigma around mental health.
- Prevalence of opioids outpacing community awareness.

Key Barriers

- **Most respondents cited insurance and wait lists as barriers to accessing appropriate treatment. "It's tough on the patients. It's like it ruins lives. It literally ruins lives, not just for them but of their family of their loved ones...and it's like, you know, it sucks. But the bottom line is, is we also got to pay people and we got to keep the doors open." "We live in a tilted economy that's favored towards a corporation that manage their care for their profits, for their profit margins, rather than the health outcomes."**
- MAT can be a barrier to recovery housing. Lack of availability of housing for people with arrest history (violence or sexual offenders)- current resources will not take them.

- Lack of providers who treat SUD holistically.
- Lack of support for multiple pathways to recovery.
- Court system is based on adversarial relationships, but case plans are based on collaboration. This can delay reunification of parents with their children.
- Barriers to engaging in services often include basic needs (e.g., insurance, funding, transportation, housing, food, etc.)
- A barrier to innovative programs within the criminal justice system is that there are people in positions of power, such as judges, that are deeply entrenched in the old moral model rather than evidence-based practices.
- Redundancies in assessments across multiple providers for one individual.
- Siloed providers and lack of communication.
- Provider biases against methadone as an MOUD option.
- Lack of understanding on research that supports intrinsic motivation as being positively associated with long term recovery outcomes more so than external factors such as family members, courts, etc.
- Stigma against people with an SUD.
- Readiness to engage.
- Adequately addressing underlying mental health issues of which substance use is a symptom.
- Patients may have been treated poorly by treatment providers in the past where a punitive or coercive system of care prevailed and are hesitant about requirements of treatment due to past trauma.
- The difficulty recovering in a society that glamorizes inebriation.
- Access to suboxone after inpatient treatment, not enough detox facilities, and few options for treatment to choose from.
- "Patient dumping" from the hospitals to inappropriate services upon discharge.
- The stigma of having a history of SUD prevents people from getting proper care or medication.
- Prevention education is not in all the schools due to lack of funding.
- Parental attitudes towards using substances and permissive attitudes towards their children using substances are culturally derived and difficult to challenge in prevention education.

Key Gaps

- Misinformation about naloxone distribution.
- Lack of support for diversion programs.
- Lack of support for harm reduction or overdose prevention centers.
- Disconnect between local support for policy and state policy.
- More research into effective treatment for trauma.
- Lack of acute care beds. Low-barrier crisis centers for people who do not meet the criteria for hospitalization.
- Lack of options for nonclinical recovery support outside of 12-step and sober activities.
- Licensing boards: lack of oversight of continuing education to ensure medical providers are trained on current evidence-based medical practices.
- Provider education on opioid dependence: Rather than providers abruptly cease prescribing medications that create physiological dependence, empower and educate them to safely titrate people off.
- Mental health and housing resources for people with mental health disorders.
- Black and Brown communities are not represented in outreach literature or education and may not see themselves as opioid dependent. Outreach to BIPOC communities, youth prevention education.
- Lack of cohesive set of resources for people reentering from incarceration who are at risk.
- Lack of harm reduction resources to meet the needs of the community.

- "Safe use sites" or overdose prevention centers.
- Schools are not trauma informed as the school district does not provide trauma informed trainings for counselors and do not conduct ACEs screenings.

Key Needs

- More mental health services.
- Street medicine to address health issues.
- Education to youth on the dangers of fentanyl.
- Comprehensive data collection, analysis, and outcome measures at the systems level. CQI measures at the organizational level to ensure data is being input.
- Quantitative drug checking so that PWUDs can understand the quantity of contaminants in their drugs (e.g. Raman spectrometer, mass spectrometer).
- Training and education.
- Low-barrier and easily accessible resources in the community, such as certified community behavioral health clinics (CCBHCs) and FQHCs).
- Upstream interventions for infants affected by prenatal substance exposure.
- Stigma reduction. Realistic knowledge about people who use opioids & stigma reduction.
- Case management available to everyone through their insurance to navigate difficult systems.
- Safe, supportive, affordable housing.
- Capacity to serve the community's needs (e.g., physical building, staff, funding, etc.).
- Lack of understanding among providers about harm reduction, MAT, and non-linear recovery process.
- Providers need to be culturally competent, and state needs to be aware of the demographic makeup of Washoe County.
- Training for teachers so they know how to handle students who are trauma induced and a focus on social emotional learning.
- Certified prevention specialists in every school.

The Future

Almost all of the respondents indicated being fearful of the future, all referencing fentanyl and any new adulterants that may arise in the illicit drug supply.

People Who Use Opioids/Are in Early Recovery Themes

Key Benefits and Challenges of Using Opioids

Benefits of Using Opioids	Challenges of Using Opioids
"**I don't have to worry** or it's not I don't have to worry. But I forget about because I think personally that I'm not that good of a person. So I don't have to think about that. You know what I mean? And I feel like I'm not a good provider. So I feel like I don't have to think about that either. **It just numbs my mind** to a lot of shit." (100) "**A mother's loving embrace is what it feels like**." (101) "I see fucking it **numbing the past of people** I see it creating more problems in their present. And I don't see them seeing that they just see that they're in pain and emotionally physically. And **the only thing that's going to work is not feeling it** and not feeling it means not being coherent." (101) "And it was the **best feeling ever, you know, is that that euphoric feeling you get from pills**." "I had postpartum depression pretty bad. And I started seeking out treatment for that for myself, you know, **self-medicating**." (102) "It made you **feel good**. It **took away the pain**." (102) "It would make me not miss my kids as much. **I wouldn't feel bad about the choices I made**. When I was using opioids, I was like another person. **I was more bolder and more confident** and I just wasn't that shy, you know, scared girl that I was before I just I hated myself, but I like myself more. So more bold." (103) "My motor function isn't impaired and my personality is unaffected. This **allows me to function as a normal member of society** and continue to work and earn money." (104) "For those who have seemingly insurmountable problems **drugs will always be a palliative** along the lines of '**I don't do drugs to feel good, I do them so I don't feel anything**'." (104)	"I found out that **he was held down and shot up**." (101) Participant lost a friend who was held down and shot up (with heroin) and he died when participant was 17. "I really **ruined my life** with this whole situation. I had a very, very beautiful life that I had set up for myself, my parents set up for me and worked hard for and I I've literally lost everything. I've lost at all. I beat from…you can take away stuff, everything I've had in my life that's good, from career to friends, family, my children. Gone, everybody's gone. **Everything's gone**...I would never want anyone to make it out to something that it that it's not it's an ugly, terrible thing. It's terrible." (102) "I was definitely the girl who was saying, 'Oh, that's not gonna be me. **I got control of this. I got a handle on it**'." (102) "The downside was the **guilt and missing family**. Missing my children's lives being part of their lives and missing out on my family's lives. After a while started to hate myself and the choices I made. It just became a huge part of my life. I spent all my time and energy and money trying to maintain this high. **It just became so exhausting**." (103) "**The time lost** trying to find a vein, sometimes a couple of hours a day or more." (104) "The **risk of overdose death from lack of dosing control. The deleterious effects my health and the risk of death from endocarditis**." (104)

Key Experiences with Fentanyl

Participants' responses fell into one of two categories: 1) a preference for fentanyl; or 2) an avoidance of fentanyl adulterated drugs. Most participants indicated a fear of losing people to overdose or drug poisoning. Many described the shortcomings of fentanyl test strips (FTS) as they do not provide information on the *quantity* of fentanyl in the substance. Additionally, participants described overdose prevention strategies including test shots, or smoking before injecting, and the known danger of using alone.

Fentanyl	FTS & Overdose Prevention
Seeks out stronger heroin that contains fentanyl. "I look for stronger you know **I don't want weak dope I want strong dope** like strong dope is what puts people out unfortunately that's what's worked for me, that's how it is. What I mean so if you have like a sack of like some bullshit dope and then you hear about somebody ODing. You just… my thought would be oh, they just took so much I'll just take a little bit less and I'm just gonna get high as shit. That's how I think of. I just like getting high." Experiences with fentanyl: "**I don't mind fentanyl. It makes my shots have a better initial rush**." Trend of smoking fentanyl in the community. "And then fucking like **smoking fentanyl**. That makes somebody's go out way quicker than heroin or just heroin by itself and yeah, yeah, it's scary fucking shit because I don't know when the people I know are going to fucking just stop breathing." Participant states that she tries to avoid it, even though sometimes that is not possible. "**I've really been good about steering clear from it**, as far as I can control, you know, obviously, sometimes I can't control it so it's in there and I don't know about it. And I've done it." Fentanyl is killing people in our community. "Well, fucking **friends dying** more friends than I've ever lost in my fucking life." Concerned about friends, not himself: "For me personally no I don't just because I just don't but as far as the community goes yeah I'm **worried I'm really worried about a couple of my friends**." Participant states that she has seen the ugly side of fentanyl use such as overdose and it driving people's behavior. "You know, it's just like, they are going to do what they got to do to get that drug. And it's like, wow, yeah, **potent stuff mentally and physically**." Participant knows a lot of people who have died from it and identifies it as a problem in the community. "**I know a lot of people that died from it like a lot of people and it's sad**. Fentanyl is definitely an epidemic, it is definitely a problem."	Limitations of FTS: Does not provide information about the quantity of fentanyl. "Well the thing with my whole thing is as how like, what's the fucking… **How much does it register**? Does it register because it only takes like point 002 or whatever, right? Does that met register that point 001? Before you know, I mean, or is it point zero? Like, I just don't **have a lethal amount? Yeah. Or is it non lethal**? Yeah, cuz that's, I mean, I could test almost every heroin that I get, and it's gonna come back with some kind of fentanyl in it. So it's just how much right? Yeah, I don't know if there's a way it would be feasible to do." Limitations of FTS. "And then the tests like it **you don't know if you're doing it right, right, because it's not registering**. We've had one test actually register all the tests that I've done, one of them registered as fentanyl and I know that's not the case. You know?" Limitations of FTS: they do not provide the end user any information on quantity of fentanyl. "Yeah, **the only way I can guess is that the quicker the line shows up more than it's in it**. Yeah. And that's really bad when you're fucking with somebody's life." Test shots: Using less than normal as a strategy. "Like **he does a test shot** and it's relatively smaller than it normally is." Overdose prevention: Participant used to carry naloxone and would **smoke it before injecting to test it**. She did not use FTS. "I was smoking it. I was smoking before I would…" Participant keeps naloxone at home but is useless as participant uses alone. "I keep it on hand at home where I inject but **it's virtually useless as I shoot up alone typically**." FTS: Everything tests positive. "**Everything I've tested both meth and heroin has tested positive**. They need to make a test to see if there is heroin in the fentanyl."

Services in Washoe County

Key Strengths, Concerns, Barriers, & Gaps

- Strengths: Most participants stated they found MAT and the syringe services program (SSP) helpful.
- Strengths: Safe places for people who use drugs that offer life sustaining resources and a sense of belonging and community. Available IOP, MAT, recovery meetings, and recovery homes are helpful. Non-stigmatizing hospital providers. Two participants felt being honest with medical providers is helpful. "When I do go, I'm always honest with my doctors in order to receive proper treatment. Being conversant to some extent in the language used by medical practitioners helps them to identify I'm interested in my care, if not health."
- Concerns about what people will do to maintain their dependence on opioids (e.g., theft).

- Stigma against MAT (especially methadone). Lack of community education and education to families about substance use and treatment, including methadone, to reduce stigma.
- Stigma and lack of understanding about harm reduction.
- Lack of coordination to treatment in medical settings (e.g., OBGYN provider calling CPS when participant asked for help with opioid use disorder during pregnancy).
- Mistreatment in hospital and medical settings. The stigma of a substance use disorder can also mean inhumane treatment after surgery and lack of access to proper pain relief or management (even after surgery).
- Lack of understanding of available resources.
- Criminalization versus treatment: "Modern prohibition relies on punishment as opposed to treatment, and no amount of penalization will stop the use of drugs, particularly as society becomes more difficult to negotiate and more individuals fall through the cracks and are without recourse."
- Stigma and lack of understanding of who a person who uses drugs is versus imagined. "Public perception identifies with a stereotype that isn't necessarily true. Drug addicts live and work among us without the knowledge of others and remain hidden by maintaining control of their habit and avoiding associated problems. Wanting to alter one's perception is not anomalous among humans nor animals. Many species from elephants to butterflies get drunk when fruiting flora rots and ferments."
- Detox centers do not meet needs of patients who need MAT.
- Distrust of 12-step groups and group members.
- Poor quality treatment services. "There was a group where I literally had the lady come, put on a video of Danny Trejo in an AA meeting doing comedy and left the room."
- High workforce turnover in counselors reinforces childhood abandonment and trust issues.
- Inability (even for pregnant person) to get timely access to Subutex or Suboxone in the community.
- Lack of services that adequately address trauma.

Experience with Courts and Child Protective Services

- Failures of foster system during childhood as a cause of trust and mental health issues as an adult.
- Child protective services (CPS): goals for parents are not clear and parents feel unsupported by caseworkers. Lack of standardized decision-making creates inequality.
- Criminal justice system: specialty courts seen as something to manipulate or "game." Prison is an ineffective deterrent for behavior change.
- Treatment court: it does not work for people who are not ready ("a set up for failure") and is punitive rather than recovery focused.

The Future

Ideas for the Future--Solutions	
Providers	**People who Use Opioids**
Provider indicated that there needs to be a **multifaceted approach** and "reliable, consistent care, you know, at their level when they're when they're ready, and advocate so remove as many barriers as humanly possible and increase the amount of available services for substance use disorder." Additionally, "other effective support would include, like the opioid reversal, you know, medication and the fentanyl test strips those, you know, that's probably right now one of our most effective tools at preventing drug overdoses or overdose deaths. I think right now, so then that is system level, effective, broad, complete saturation and distribution of those products throughout the community, where it's normal. It's everywhere. It's known and understood not stigmatized." **Law enforcement diversion programs** in which individuals are diverted from the legal system into community-based services. "So walking him into a different type of kind of continuum instead of into the legal system, which can seem to like further and that legal implications can further damage their ability to sustain and gain you know, gainful employment, housing." **Post-overdose follow-up for overdoses reversals** who do not go to the hospital. **Upstream interventions** that address trauma, basic needs, household stability. "upstream right causative factors." **Robust harm reduction services**. "We would have complete access to harm reduction, I guess supplies so that would be you know, syringe service program would be Narcan or Naloxone and that would be you know, the fentanyl test strips that would be safe use wound care as well as like, you know, some of the sexual health stuff and other just general harm reduction. stuff." **Holistic, integrated care for adults. For children, early childhood learning programs, and many more supports in K-12 to build protective factors to create resilience.** "So I think like for adults, who already are having concerns having more of a holistic kind of place that they could go to have all of their needs met. But I think as far as prevention is concerned, like we should have kids in daycare, pre K, whatever, and those programs should be designed to support families and children. And really the purpose being kids are being exposed to you know, they're being read to they're getting lunch. They're learning calming techniques, because if mom can't give it to them, maybe they can get it from school to build more resilient kids." **Holistic approach**- address mental health, substance use, personal needs, and individual history. "we have to take a more holistic, individualized approach to it all."	**Non-judgmental spaces that treat PWUDs as equals.** "It's nothing more than somebody talking to you like you're a normal person. Not like you're a piece of shit but like a normal fucking human being." **Safe consumption site with drop-in center services.** "Just how are you like a safe like a safe haven a safe places do your drugs I guess or like a one stop shop? Like just so you know what's in it? We're giving people a place where you could go hang out, be safe, not get harassed by cops. Don't get your stuff stolen, maybe set a lockers, public lockers, public showers, shit I don't know man...Just because I feel that that's what's needed is not something that hasn't really been done. I don't think out here in the US as far as that so it needs to be at least tried or at least a little clinical study or something to see that the damn thing is gonna work. Obviously it does, it works in Canada or wherever it's at and in New York. So why not? What's what's what's the hurt? " **Housing First and building relationships.** "Well, you earn some respect. You build a rapport. You get people to tell you the truth, and slowly they get you to trust and they figure out that there is a way that you can do things that's cohesive like yeah, that's not forced like that. **The importance of community as necessary to healing**. "communes, communities that are started with people that fucking have it not necessarily together but have the goal, have that vision and can promote that properly without getting conveyed into something else. Right that can teach this lesson by just being. Once again, they don't have to be clean in my opinion." "That's what makes it run though, right, is that we've been there and we're people not necessarily clean but we're up and we can maintain. Right that the experience part Exactly. Not clean but experienced people that actually know the disorders that people have and how hard it is sometimes, and it gives somebody something good to do with their day. If nothing else, maybe your high but you only get high and get high and I go tend the plants dog. Go run the hose for a minute. It gets people involved in the community." **A person-centered , non-judgmental, hub where individuals seeking services can be connected to what they need.** Participant also preferred **gender specific treatment options**. "a standardized, standardized way of initiating all these things first of all. Because it's just even though we're all different and we all have individual needs, the basics are there. You just…we all have it's a basic need for to get treatment. It's just how, how

Outreach to justice-involved adults and juveniles and more prevention efforts through youth engagement, and building protective factors.

Streamline assessments and intake processes to reduce redundancies.

A program similar to Onsite and Insite in Vancouver, B.C. in which the bottom floor offers **an overdose prevention center, middle floor offers treatment, and top floor offers recovery housing**. "safe use site, the woman who spoke to us from New York, at the harm reduction conference, but she had actually come from Canada and they had a program that was essentially on the bottom floor safe use on the middle floors. Like outpatient treatment and then on the top floor, transitional housing, awaiting for permanent housing. So like a full on system, you know."

Access regardless of ability to pay. "I would love a program that didn't have to turn anyone away that had a sliding scale down to zero, if someone couldn't afford the treatment. We weren't sending them somewhere else."

Managed care organizations have their own inpatient treatment centers for their members. "Then let's have a detox for every single MCO why can't we do that? You got Anthem? Why can't we have a Silver Summit and an HPN and then when I have them and then they just get them in there? Make things happen."

A center with broad service array ranging from harm reduction services such as SSP, lockers for belongings, and drug checking, a detox, medication assisted treatment, and housing. "a refuge like a like a safe haven, a safe haven where not only would you have harm reduction in one corner, and you would have the thing to test them. But you would also have a detox open to anybody and everybody if they need something, and then they can make that choice and when they're in there of what they want as far as insurance or whatever they need. We'll set them up while they're in their food stamps, insurance, just like a little little five day, maybe longer if they need longer than we'll roll them into one of our other houses, you know, but some kind of safe haven for everyone to be able to access and if they're walking up to that front door, it doesn't matter what they have at that moment, get them in, get them safely detoxed if they want that, get their drugs tested, if they want to get the needle exchange if they want that whatever they need."

Trauma-informed services, “focus on the root cause of what’s leading people to experience these struggles"

Certified prevention specialists in every school who do substance use prevention, trauma prevention, ACEs training, mindfulness, and suicide prevention. "We have seen states who have done this, who have put a CPS (certified prevention specialist) in every school, and they have seen a drastic shift in not only their substance abuse, but also in trauma and bullying and everything else, because the kids had a safe person to talk to."

much treatment? You know, that's when you start branching off into specialties for what you need. But I would have a place that would have a…I would want to be able to pick my comfort level. Some people don't like…I didn’t like going to treatment with guys."

Centralized treatment hub that connects people to appropriate resources. "one place that everybody knows okay, if you want treatment, you’re going to go to this one place, you're gonna start there. And when you get there, they're going to evaluate you, they're gonna see where you actually need to be from there. And if you need to go to Door number A, that your head that direction, or if you need to go Door number B, you’re gonna go that direction. But you're gonna start at one spot."

Robust service provisions with people with lived experience. "Low key, not clinical. Staffed by experienced addicts and not merely former alcoholics, councilor personal experience in the field of the patient. Psychologist, medical, one-on-one and group counciling, maybe NA, prescription services, safe use site, exchange and needle provision, trauma therapy."

What People Should Know About People Who Use Drugs

What People Should Know About People Who Use Drugs	"That **we're people too**. Though that's it. We all have we all have our demons that are our addictions. Some people's might be coffee or yoga. And some people use heroin and crack. So that's pretty much what it comes down to. We're people too." (100) "**Not every person is a bad person**. And the majority of the people that use drugs if they had their drugs, they wouldn't be doing something stupid to get their drugs if they were able to go to a dispensary of some sort and be able to pick up their prescription and know that they're not going to fucking go out. What they just got is going to actually be real, that they can do their issue and go on with their day." (101) "**That they are people**. They hurt and they love, and they are embarrassed, and they are everything that you feel the same, the very same, they're the same people. Your loved one who uses drugs now is the same person that they were back then they just have a lot more to deal with now. It's hard having to be a person in the shadows now. You can't be out with everybody else because nobody wants to see an addict, you know? You got to walk behind everybody. It's just, it's so not right to be treated like that. But I just think that what they need to know is that this person is hurting. There's something in their life that's causing them to want to make it different or better or medicate and you need to find out what that is because something's wrong. That's what people should know, they need to know." (102) "**That not all people that use drugs are bad people**. It's not a moral thing, it's it's a sickness. And if we treat the addiction, I think that…just be more understanding, compassionate towards people with addiction" (103) "That **the systemic problems associated with substance use**, abuse, and addiction are a direct result of the criminalization of drug use, and that model of prohibition-i.e. punishment not rehabilitation already failed in the 20s just as it has failed and continues to fail today. Possibly 90% of property crime of theft, overcrowding of prisons and jails and the broken lives and families of the punished, cases of premature death and other health-related concerns, the burden on the courts and law enforcement whose time would be better spent catching rapists, murderers, and God-forbid white collar criminals, produce an enormous immeasurable cost to domestic and foreign societies. Mexico's ongoing cartel wars which are on the scale of warfare between smaller nations are a direct result of black market pricing of the American drug market, and America's ever-expanding gang problems have their forebears in Detroit's Purple Gang, the Capone Gang, and others in the 20s whose bread and butter was alcohol running. Today's gangs are however much more violent and widespread. The waves of death that follow drug trends are directly the result of a lack of pharmaceutical quality and measurable dosing level, as well as the penalties meted out for those involved." (104) "**We do recover**. We do recover. Might take 20 years, it may take a year. But be patient...And when I hit my rock bottom, they were hands to pull me up. So just be ready to pull those people. " (005)

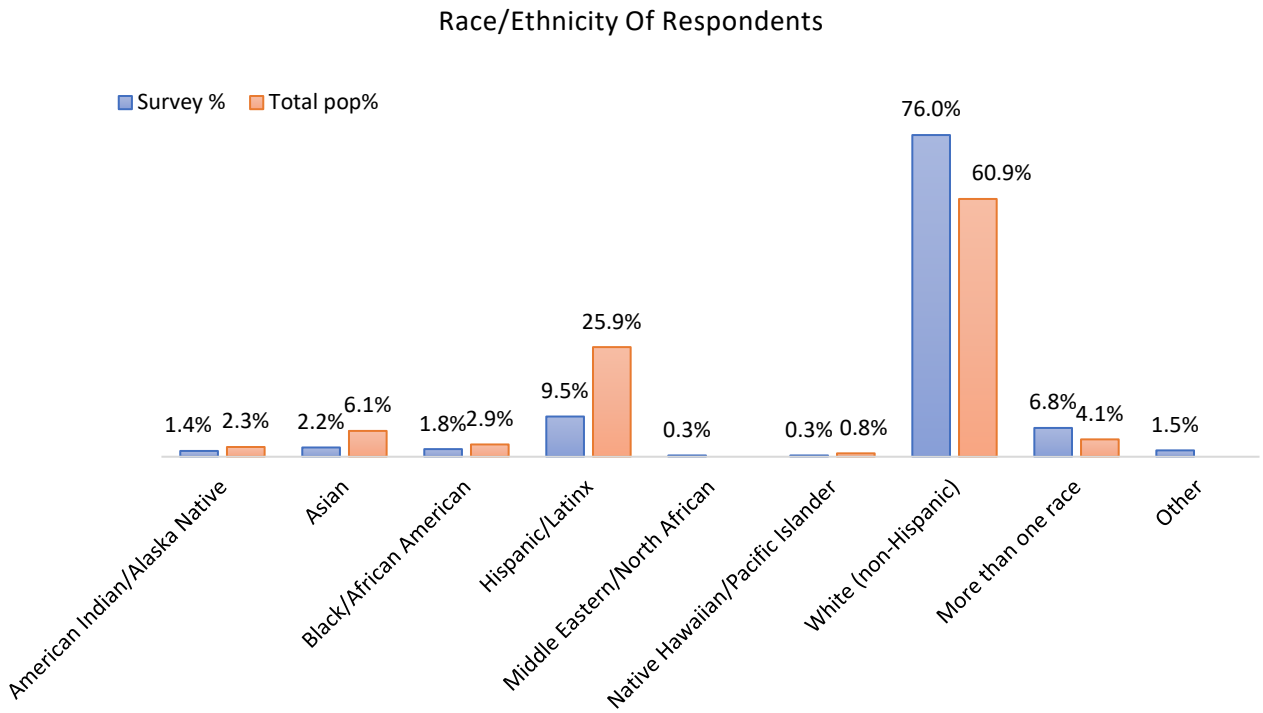
Survey

An online survey was created, initially adapted from a survey in Illinois (Pickett et al., n.d.) and modified through collaboration with a variety of stakeholders from various sectors. The survey was distributed through a network of stakeholders, in-person events, and through social media. Data were analyzed using Qualtrics and Microsoft Excel. The survey opened on August 17 and closed on September 19, 2022. Out of 376 responses, 366 confirmed consent to participate and met the inclusion criteria of being 18 or over and living in Washoe County. There were 25 incomplete surveys, leaving a total of 336 respondents (N=336). Respondents ranged in age from 18-80 years old with a mean age of 44. This sample size is too small to be representative of the perspectives of Washoe County residents on the opioid epidemic, however, as an exploratory effort it does offer insight from a variety of citizens.

In addition to basic demographic information, community members were asked about their personal impacts of opioids in their lives, their perceptions on fentanyl and other drugs of concern, existing initiatives to address the opioid epidemic in Washoe County, the source of their information about opioid use in the community, disproportionately affected populations, and questions about strengths, gaps, barriers, and challenges. Additionally, respondents were asked to rate priorities and about their ideas to address this epidemic.

Figure 29 below shows the race and ethnicity of the respondents compared to the general population of Washoe County from the United States Census Bureau. Figure 30 shows that the majority of respondents did not identify themselves as professionals, family members, or a person who uses opioids. The second largest group of respondents identified themselves as a family member of a person with OUD, followed by individuals who work for a social services non-profit. More than ¾ of survey respondents (77.5%) have been personally impacted by opioids (e.g., friend, family member, or used themselves) (Figure 31).

Figure 29-Race/Ethnicity of Survey Respondents



Source: Washoe County population estimates as of July 1, 2021 from United States Census Bureau (n.d.).

Figure 30-Identities of Survey Respondents

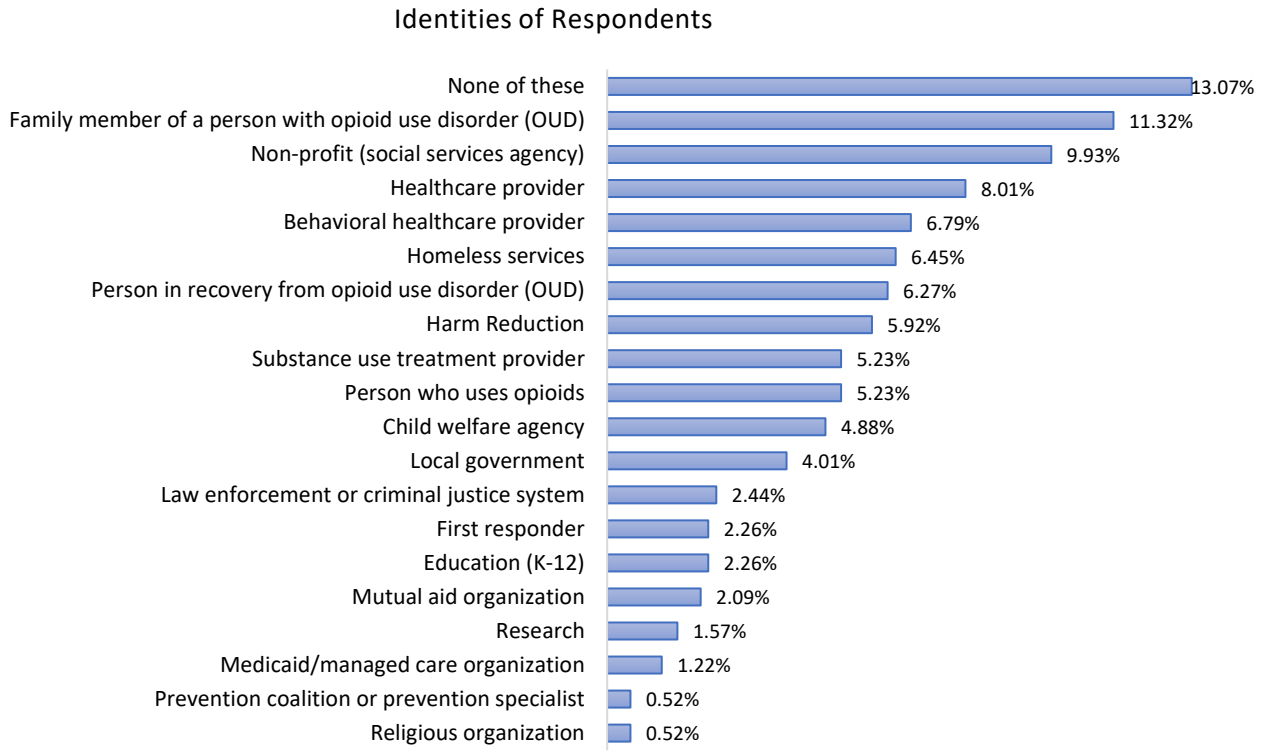
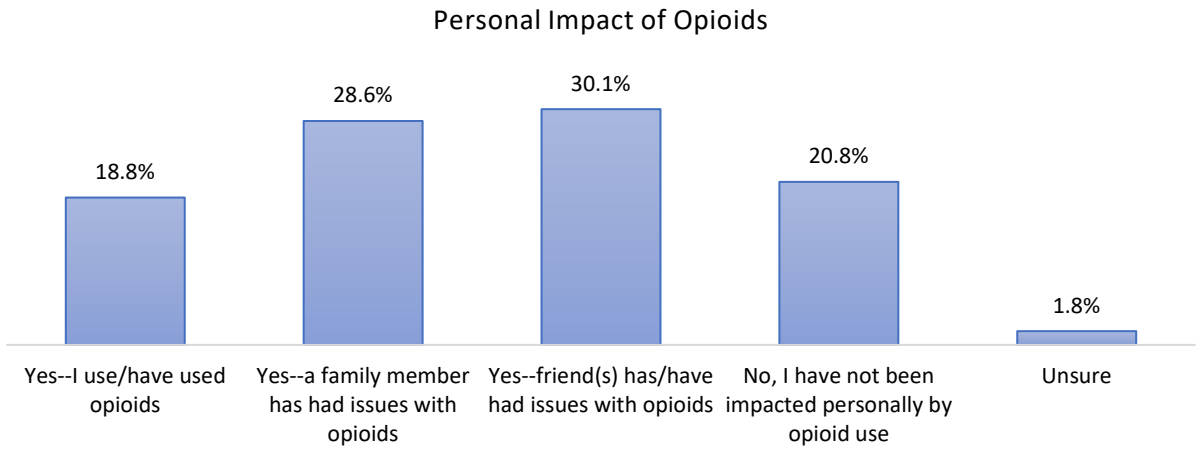
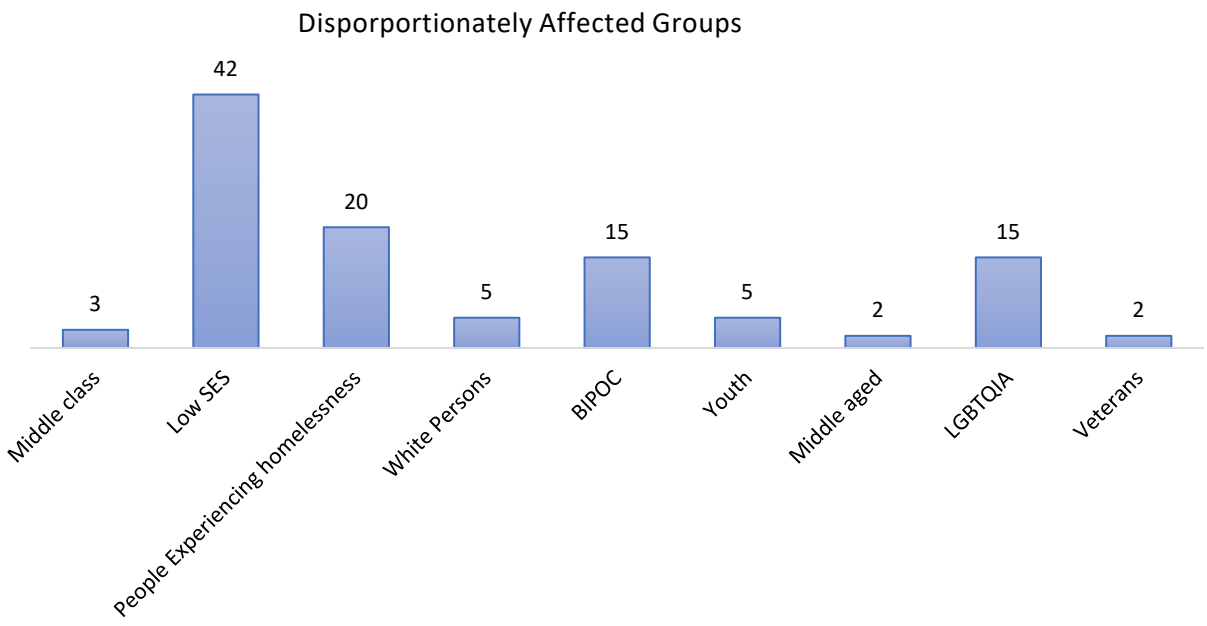


Figure 31-Personal Impact of Opioids on Survey Respondents



70.26% of respondents perceive that some groups are disproportionately impacted by the opioid epidemic. When asked which groups, many perceived persons with low socioeconomic status, people experiencing homelessness, Black, Indigenous, and People of Color (BIPOC), and lesbian, gay, bisexual, trans, queer/questioning, intersex, and asexual (LGBTQIA) individuals to be disproportionally affected (Figure 32).

Figure 32-Disproportionately Impacted Populations



Survey respondents perceived fentanyl to be an issue in Washoe County, with 65.4% responding that fentanyl is a huge issue (Figure 33). Other substances that respondents were concerned about included methamphetamine (145 respondents), fentanyl (79 respondents), and alcohol (26 respondents) (Figure 34).

Figure 33-Respondents' Perception of Fentanyl in Washoe County

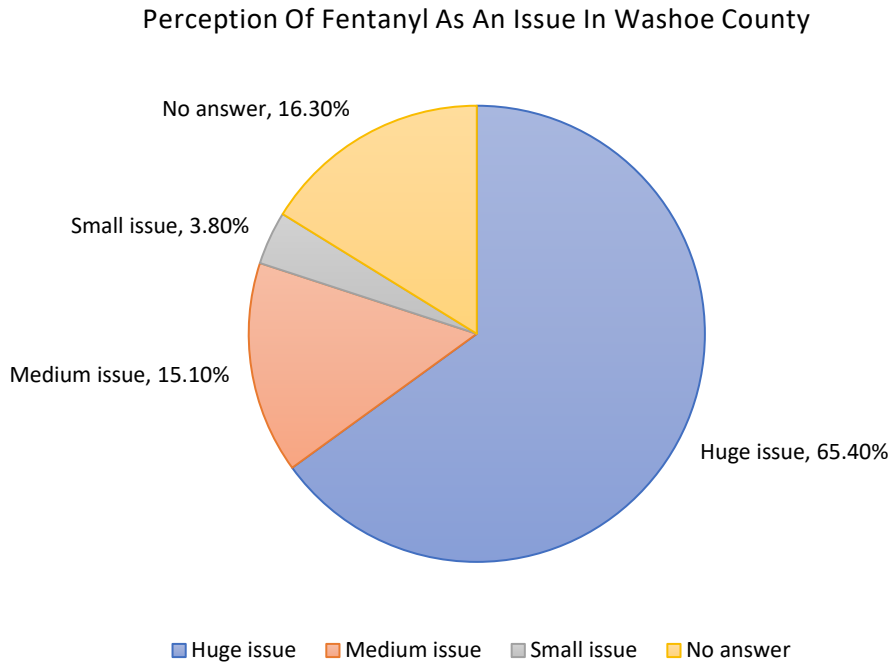
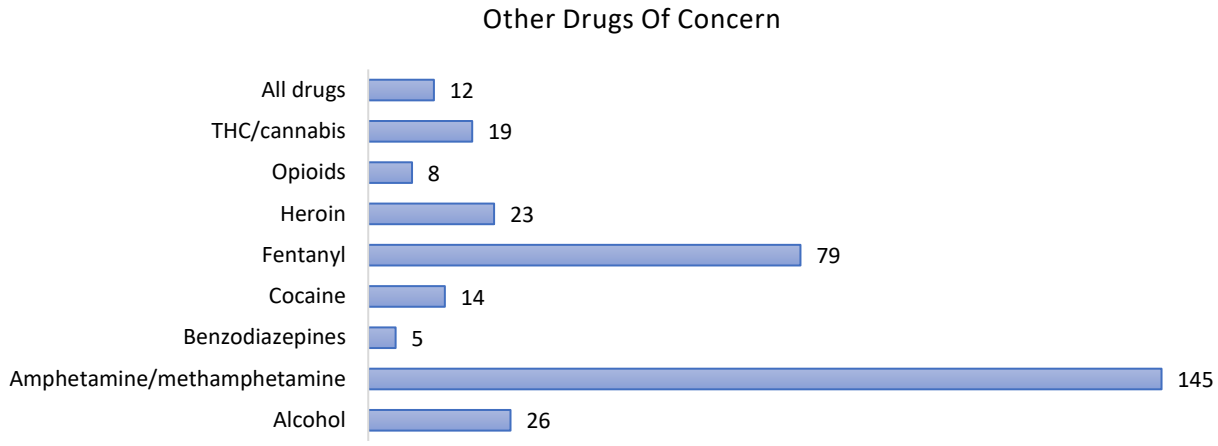


Figure 34-Other Drugs of Concern in Washoe County



Only 7 respondents indicated they had not heard about opioid-related issues (overdoses, opioid/heroin related crimes, misuse of prescription opioids, problems accessing opioid treatment, concerns about fentanyl) in Washoe County in the past 12-months. Respondents listed the sources of information on opioid-related issues in Figure 35, which indicate that colleagues and friends and local online news media are common sources. Additionally, respondents indicated awareness of a variety of opioid-related community initiatives (Figure 36).

Figure 35-Sources of Information on Opioid-Related Issues

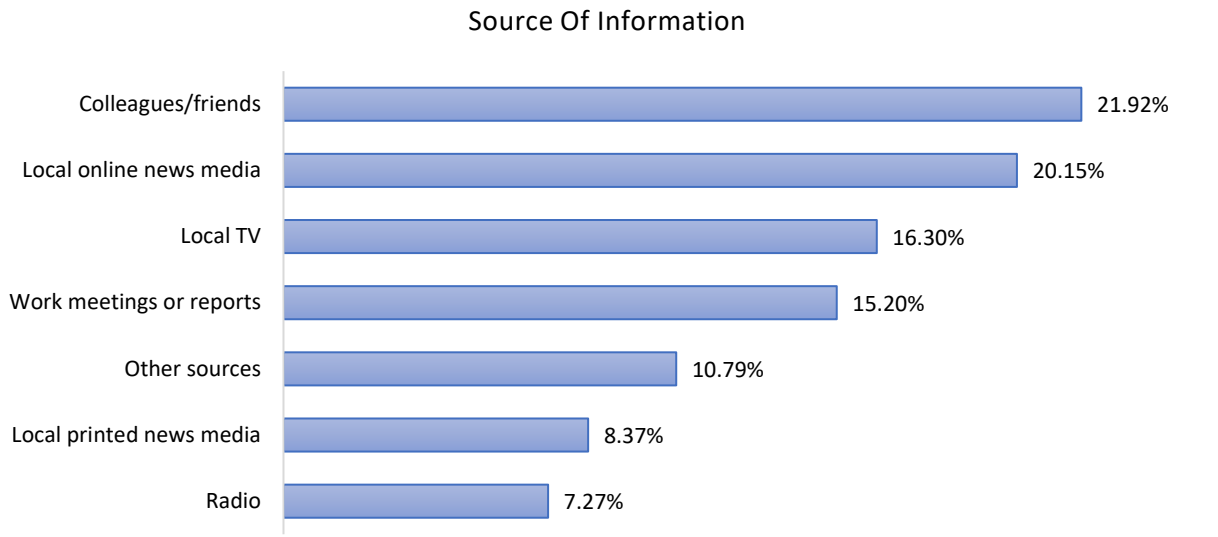
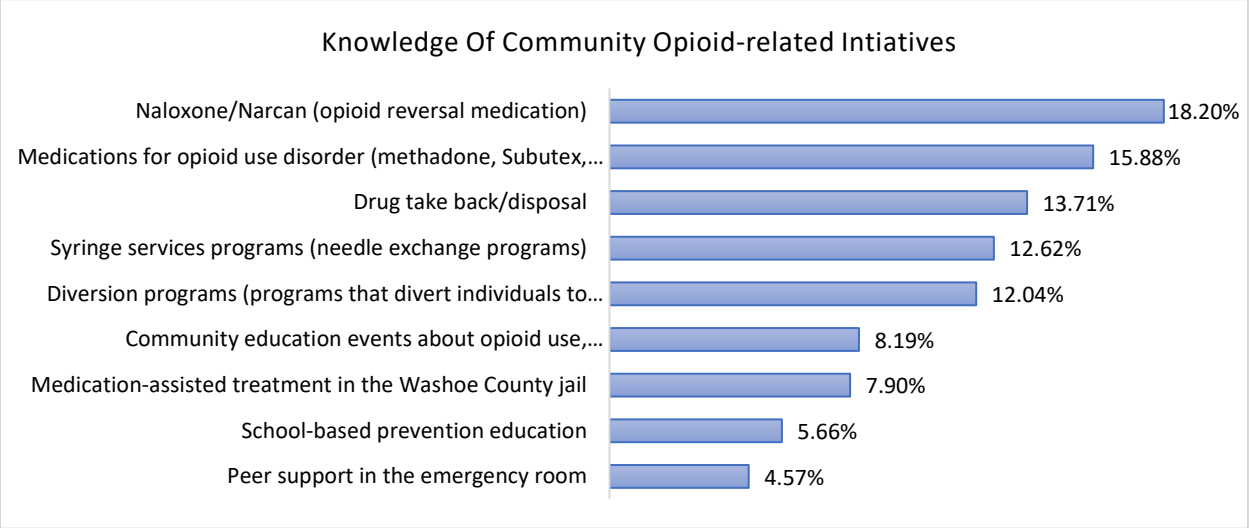
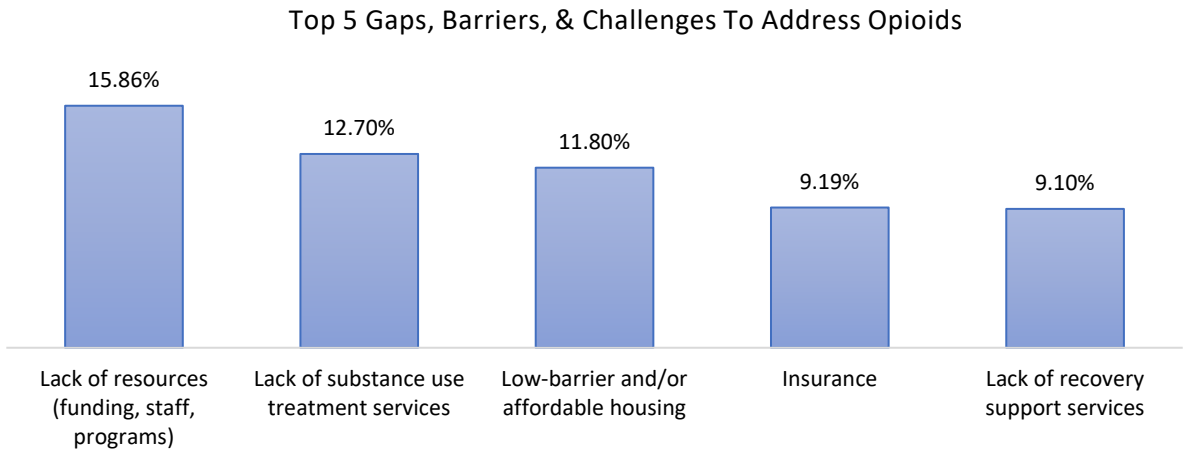


Figure 36-Knowledge of Opioid-Related Initiatives



When asked to identify the top five opioid-related needs in Washoe County, the most popular five needs were: recovery support services (135 votes), increase low-barrier access to treatment (127 votes), mobile outreach teams who provide education, overdose prevention, drug checking, and linkage to services (123 votes), stigma awareness/education (106 votes), and healthcare provider training on opioid prescribing and how to get people off opioids if they are dependent (106 votes). Respondents also rated their top five choices on the strengths in Washoe County to address the opioid crisis. The most selected strengths were: community partnerships (92 votes), harm reduction services (86 votes), public awareness (61 votes), substance use treatment providers (57 votes), and 52 respondents who answered there are no strengths. Respondents were also asked to select the top five gaps, barriers, and challenges to addressing opioid use in Washoe County, which corroborate findings from key informant interviews (see Figure 37).

Figure 37-Top 5 Gaps, Barriers & Challenges to Addressing Opioid Use in Washoe County



Additional barriers that respondents provided are summed up below. The full narratives can be found in Appendix F.

- Insurance (access, reimbursements, provider barriers)
- Wait lists and timely access to detox & treatment
- Difficulty engaging PWUDs
- Lack of funding or support for prevention education in schools
- Difficulty accessing MAT
- Pain management patients are not getting adequate care or are stigmatized
- Stigma
- Lack of support for families
- Transportation
- People are forced to attend 12-step groups rather than evidence-based services
- Co-occurring mental health disorders
- Siloed providers
- Lack of education on substance use disorders for medical providers
- Legal barriers
- Lack of "centralized leadership by health department"
- Stigma against people in recovery who are not able to manage pain after surgeries or procedures due to stigma
- Lack of harsh penalties for drug use or drug sales

Lastly, respondents were tasked with ranking priorities out of fourteen options. The top five priorities overall were:

1. Low-barrier substance use treatment services
2. Low-barrier, walk-in availability (on-demand) access to MAT
3. Services that address underlying trauma
4. Harm reduction services such as syringe services programs, outreach, drug checking (including fentanyl test strips), HIV/hepatitis C testing, wound care, and naloxone
5. Low-barrier and/or affordable housing

The results were assessed by respondent type and interestingly, people who use opioids and family members of persons with OUD both prioritized prevention programming in schools. These results are shown in Table 9.

Table 9-Top 5 Priorities Overall and by Respondent Identity

Top 5 Priorities Overall and by Respondent Identity				
Low-barrier substance use treatment services Low-barrier, walk-in availability (on-demand) of medication-assisted treatment Services that address underlying trauma Harm reduction services such as syringe services programs, outreach, drug checking (including fentanyl test strips), HIV/hepatitis C testing, wound care, and naloxone Low-barrier and/or affordable housing				
People who use opioids	**People in recovery from OUD**	**Service providers**	**Education K-12**	**Family members of persons with OUD**
Low-barrier substance use treatment	Low-barrier substance use treatment (tied #1)	Low-barrier substance use treatment	Low-barrier substance use treatment (tied #1)	Low-barrier substance use treatment
Low-barrier, walk-in availability (on-demand) of medication-assisted treatment	Low-barrier, walk-in availability (on-demand) of MAT (tied #1)	Low-barrier, walk-in availability (on-demand) of MAT	Low-barrier, walk-in availability (on-demand) of MAT (tied #1)	Low-barrier, walk-in availability (on-demand) of MAT
Services that address underlying trauma	Harm reduction services (tied #2)	Harm reduction services	Services that address underlying trauma (tied #1)	Harm reduction services (tied #3)
Prevention programming in schools	Services that address underlying trauma (tied #2)	Services that address underlying trauma	Harm reduction services	Services that address underlying trauma (tied #3)
Harm reduction services	Naloxone distribution and the number of community members trained in reversing overdoses	Low-barrier and/or affordable housing	Low-barrier and/or affordable housing	Prevention programming in schools

Note: Primary identity selected for people who use opioids, people in recovery from OUD, and family members of a person with OUD, regardless of employment status/sector. Most respondents had multiple identity categories selected.

Key Findings from Qualitative Data

- Illicitly manufactured fentanyl (IMF) is a growing concern across a multitude of opioid and non-opioid substances, people are transitioning to fentanyl as a preferred substance, and fentanyl use is complicating treatment stabilization and retention.
- Lack of available information or resources on treatment options for methamphetamine use treatment. Lack of funding, policy, and attention towards methamphetamine as meth use is not seen as iatrogenically caused.
- Insurance reimbursements are low, which results in staff being unable to afford housing and keep up with inflation.
- Insurance is a barrier to accessing appropriate treatment.
- No cohesive or effective surveillance system to notify the community in real-time of an overdose spike and trigger a targeted response.
- Compassionate and collaborative providers.
- Hybrid models that offer telehealth help transgress boundaries to treatment.
- Pain management patients and persons with a history of OUD encounter barriers and stigma when attempting to control pain (even after major surgeries).
- Youth are experiencing high rates of stress and low coping mechanisms
- Access to housing is a barrier to recovery.
- Barriers to engaging in services often include basic needs (e.g., insurance, funding, transportation, housing, food, etc.).
- Lack of quality and accessible treatment providers, especially providers who treat SUD holistically and support multiple pathways to recovery.
- Stigma against people with an SUD and provider biases against people in medication-assisted recovery (particularly methadone).
- Cultural competence and outreach to BIPOC communities for prevention education, treatment, harm reduction, and overdose prevention is needed.
- Prevention education and trauma informed schools are a significant need.
- Services that address underlying trauma are needed

Recommendations from Providers, PWUDs, and Community

• Law enforcement diversion programs • Post-overdose response programs • Holistic integrated services for adults and children to foster resilience • Outreach to special populations (e.g., justice-involved adults and adolescents, BIPOC communities) • Streamline assessments and intake processes • Build supportive relationships and community (community spokes) • Low-barrier substance use treatment services, regardless of ability to pay • Low-barrier, walk-in availability (on-demand) of medication-assisted treatment	• Harm reduction services such as syringe services programs, outreach, drug checking (including fentanyl test strips), HIV/hepatitis C testing, wound care, and naloxone • Increase access to low-barrier and/or affordable housing & Housing First • Prevention education and trauma-informed services in K-12 schools • Interventions that address underlying trauma, basic needs, and stability • Provider education on stigma, titration, & treatment

Section IV

Recommendations

Section IV: Recommendations

Recommendations are based on the available information in this report and the **approved uses** for opioid remediation and abatement below:

- Expansion of naloxone distribution
- Increased access to prevention education, treatment and recovery support services, and medication-assisted treatment
- Expansion of services to pregnant and postpartum persons with OUD, SUD, and co-occurring disorders
- Expansion of support for neonatal abstinence syndrome
- Expansion of recovery support services and services that provide "warm handoff" connection to care
- Expansion of OUD, SUD, and mental health treatment (including MAT) for incarcerated persons
- Support prevention strategies
- Expansion of syringe services programs to include comprehensive services
- Support data collection, research, and analysis of abatement strategies

Our recommendations align with the Addiction Policy Forum's *Evidence-Based Interventions to Address the Opioid Epidemic*[18], the *Nevada Resiliency Fund: Opioid Needs Assessment* [19] and guidelines established through SB390 (below).

An evidenced based plan that includes qualitative and quantitative data for the use of grant money by a state, local or tribal governmental entity may allocate money pursuant to paragraph (b) of subsection 1 to:

(a) Projects and programs to:

(1) Expand access to evidence-based prevention of substance use disorders, early intervention for persons at risk of a substance use disorder, treatment for substance use disorders and support for persons in recovery from substance use disorders;

(2) Reduce the incidence and severity of neonatal abstinence syndrome;

(3) Prevent incidents of adverse childhood experiences and increase early intervention for children who have undergone adverse childhood experiences and the families of such children;

(4) Reduce the harm caused by substance use;

(5) Prevent and treat infectious diseases in persons with substance use disorders;

(6) Provide services for children and other persons in a behavioral health crisis and the families of such persons; and

(7) Provide housing for persons who have or are in recovery from substance use disorders;

(b) Campaigns to educate and increase awareness of the public concerning substance use and substance use disorders;

(c) Programs for persons involved in the criminal justice or juvenile justice system and the families of such persons, including, without limitation, programs that are administered by courts;

(d) Evaluation of existing programs relating to substance use and substance use disorders;

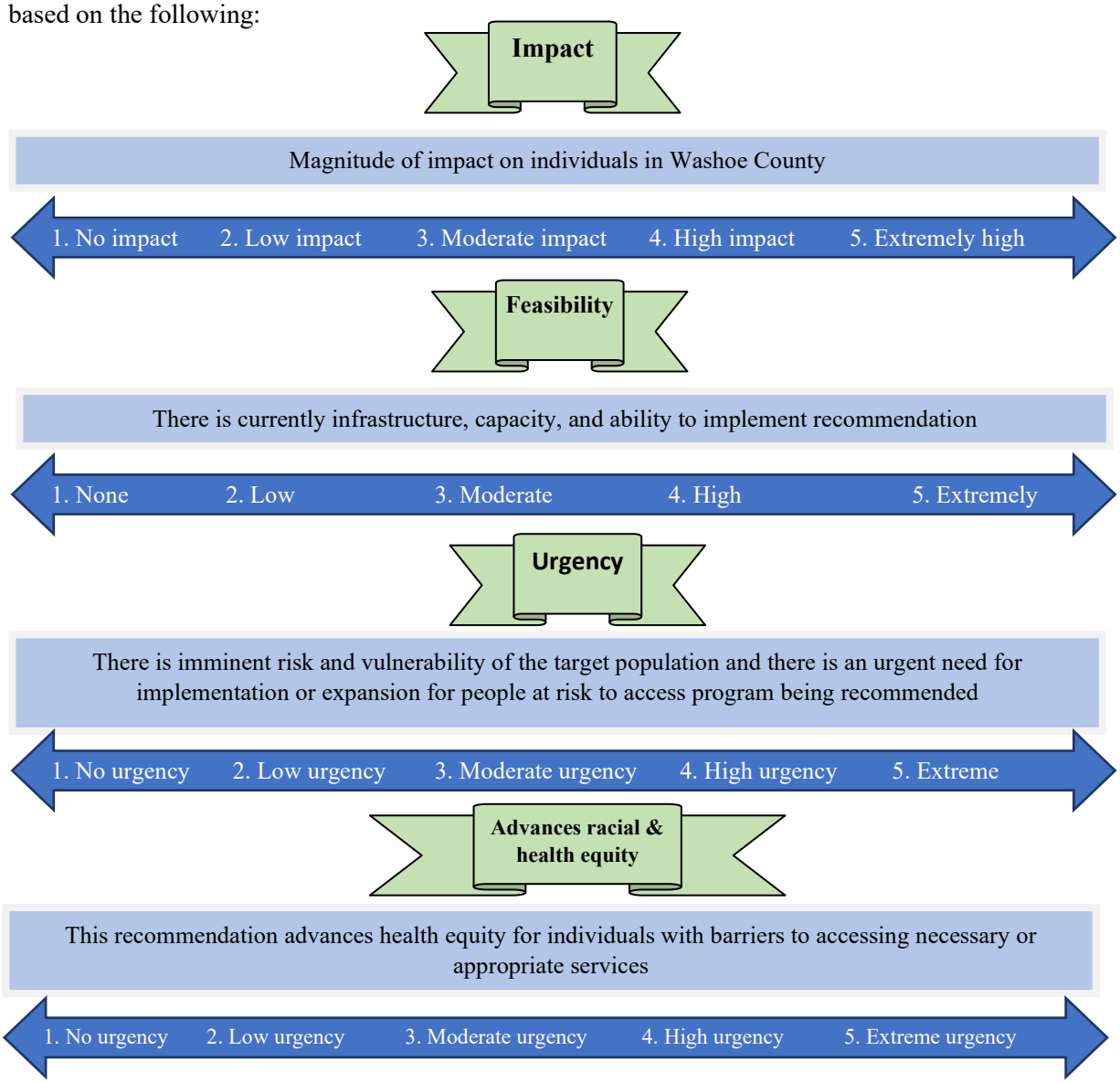
[18] Addiction Policy Forum. (2022, October 5). *Evidence-Based Interventions to Address the Opioid Epidemic*. https://reports.addictionpolicy.org/evidence-based-strategies/

[19] Mercer. (2022, August 1). *Nevada resiliency fund: Opioid needs assessment*. https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Grants/Advisory_Committees/ACRN/081722NeedsAssessment2022.pdf

(e) Development of the workforce of providers of services relating to substance use and substance use disorders;
(f) The collection and analysis of data relating to substance use and substance use disorders; and
(g) Capital projects relating to substance use and substance use disorders, including, without limitation, construction, purchasing and remodeling.

Methodology

Stakeholders were provided a draft of this needs assessment and met several times to create targeted, actionable recommendations based on the broader recommendation categories described on the previous page. After the refined recommendations were completed and the stakeholder group was comfortable moving forward, the group met for an orientation on using a Pugh Matrix scoring tool to prioritize needs. To ensure recommendations remained within the guidelines of SB390 and applied to the special populations in Section 7.5, scores were weighted with a multiplier of one (1) if they did not meet the requirements and a two (2) if they did meet NRS requirements. All recommendations from the stakeholder group did meet statutory guidelines. Each recommendation was scored on a Likert scale based on the following:



The scoring methodology was based on the *Nevada Resiliency Fund: Opioid Needs Assessment* (Mercer, 2022) to ensure continuity across the state. Mean scores were calculated from the reviewers and totaled with a multiplier of two (2) for recommendations that met the criteria set forth in SB390 (Table 10). The total scores were then ranked from 1 to 26, as some recommendations were tied.

Top Five Recommendations for Washoe County

The top five priorities are as follows:

- Goal 5: Low-barrier substance use treatment services, regardless of ability to pay
- Ranked 1st: 5.1: Ensure funding for the array of OUD services for uninsured and underinsured Washoe County residents.
- Ranked 2nd: 5.4: Incentivize providers to initiate buprenorphine in the emergency department (ED), as well as during inpatient hospital stays. All EDs and hospitals should have providers that will provide buprenorphine induction as well as involve care navigators to assist with setting up outpatient resources for continued care and management.
- Goal 2: Outreach to special populations (e.g., justice-involved adults and adolescents, BIPOC communities)
- Ranked 3rd: 2.3: Use a multidisciplinary approach to providing overdose prevention outreach and education to BIPOC communities in a culturally and linguistically appropriate manner (organizations, media, churches).
- Goal 7: Holistic integrated services for adults and children to foster resilience
- Ranked 4th (tie): 7.3: Implement Child Welfare best practices for supporting families impacted by substance use.
- Goal 12: Increase access to low-barrier and/or affordable housing & Housing First programs (ranked 4th tie).
- Goal 5: 5.2: Increase detoxification and short-term rehabilitation program capacity (ranked 5th).

Washoe County Allocation

Opioid litigation funding has been allocated across the stated based on population and need. Funding of the program is dependent on settlement amounts and damage awards from the pending opioid litigation filed by Washoe County, and the One Nevada Agreement entered between Washoe County, the State of Nevada and the other participating political subdivisions. To date, the settlement has been reached with the Johnson & Johnson and the main distributors.

To date, the first allocation payment from the settlement of Johnson & Johnson was deposited in July with Washoe County in the amount of $1,845,569.45.

Table 10 Recommendations for Opioid Litigation Spending

Recommendations	Targets programs defined by SB390	Impact	Capacity & feasibility of implementation	Urgency	Advances racial and health equity	Total	Rank
Harm Reduction and Outreach Recommendations							
Goal 1: Robust harm reduction services (e.g., naloxone, fentanyl test strips, drug checking, drop-in center, overdose prevention center, lockers, syringe services program, etc.) and multifaceted approach to overdose prevention and treatment							
1.1: Form committee to research implementation of overdose prevention centers.	2	3.42	3.42	3.83	3.17	27.68	12
1.2: Purchase and provide availability of mass spectrometry for drug checking in the community.	2	3.08	2.7	3.58	2.5	23.72	25
1.3: Explore options for additional syringe services programs and outreach.	2	3.17	3.33	3.17	3.17	25.68	22 tie
Goal 2: Outreach to special populations (e.g., justice-involved adults and adolescents, BIPOC communities)							
2.1: Explore implementation of peer support within Washoe County Jail.	2	3.58	3.83	3.08	3.5	27.98	11
2.2: Using a multidisciplinary approach to improve quality of life, reduce recidivism, and increase community safety and awareness by engaging justice involved individuals in intensive supervision, treatment programs, and community-based interventions.	2	3.67	3.17	3	2.92	25.52	23
2.3: Use a multidisciplinary approach to providing overdose prevention outreach and education to BIPOC communities in a culturally and linguistically appropriate manner (organizations, media, churches).	2	3.67	3.67	3.58	4.25	30.34	**3**
Justice System Interventions							
Goal 3: Law enforcement diversion programs							
3.1: Explore implementation of law enforcement assisted diversion for low-level/risk offenders in Washoe County.	2	3.25	3.17	3.33	2.92	25.34	24

Recommendations	Targets programs defined by SB390	Impact	Capacity & feasibility of implementation	Urgency	Advances racial and health equity	Total	Rank
3.2: Evaluate outcomes from efforts to support SUD treatment for the criminal justice-involved population. Monitor outcomes of criminal justice-involved individuals. This may include individuals who are inducted onto MAT prior to discharge, or other interventions such as drug courts for individuals with polysubstance conditions and working with probation and parole officers.	2	3.5	3	3.25	3.17	25.84	21
Treatment							
Goal 4: Interventions that address underlying trauma, basic needs, and stability (both treatment and prevention)							
4.1: Recruitment and retention of local behavioral health workforce by providing support for salaries.	2	4.42	2.83	4	3.17	28.84	7
4.2: Assist with training opportunities for clinicians on trauma specific evidence-based interventions.	2	3.42	3.67	3.5	3.17	27.52	13
Goal 5: Low-barrier substance use treatment services, regardless of ability to pay							
5.1: Ensure funding for the array of OUD services for uninsured and underinsured Washoe County residents.	2	4.42	3.33	4.25	4.33	32.66	**1**
5.2: Increase detoxification and short-term rehabilitation program capacity.	2	4.08	3.08	4.25	3.58	29.98	**5**
5.3: Increase capacity of residential programs.	2	4.17	2.67	3.92	3.42	28.36	9
5.4: Incentivize providers to initiate buprenorphine in the emergency department (ED), as well as during inpatient hospital stays. All EDs and hospitals should have providers that will provide buprenorphine induction as well as involve care navigators to assist with setting up outpatient resources for continued care and management.	2	3.92	3.42	4.25	3.75	30.68	**2**

Recommendations	Targets programs defined by SB390	Impact	Capacity & feasibility of implementation	Urgency	Advances racial and health equity	Total	Rank
Goal 6: Low-barrier, walk-in availability (on-demand) of medication-assisted treatment							
6.1: Fund organizations' (including IOTRCs) ability to expand availability of MOU (this includes the ability to have prescribers available 5+ days/week).	2	3.75	2.92	2.92	3.42	26.02	19 tie
6.2: Explore induction hubs with telehealth options for providers with DATA 2000 waivers to provide buprenorphine.	2	3.42	3.17	3.58	3.33	27	15
Prevention							
Goal 7: Holistic integrated services for adults and children to foster resilience							
7.1: Implement Universal Screening for ACEs and SBIRT in pediatric and adult care settings.	2	3.67	3.83	3.83	3.42	29.5	6
7.2: Develop and implement parent education opportunities, resources, and supports for SUD prevention.	2	3.45	3.64	3.64	3.36	28.18	10
7.3: Implement Child Welfare best practices for supporting families impacted by substance use.	2	4	3.45	3.82	3.73	30	**4 tie**
7.4: Invest in Families First Prevention Services Act activities to reduce risk for child welfare involvement.	2	3.5	3.25	3.33	3.33	26.82	16
Goal 8: Prevention education and trauma-informed services in K-12 schools							
8.1: Implement trauma informed schools in Washoe County.	2	3.91	3	3.82	3.64	28.74	8
8.2: Implement a school screening tool to identify adverse childhood experiences and provide early intervention for children and their families. Provide appropriate referrals for treatment/counseling services.	2	3.5	3.08	3.33	3.42	26.66	17
8.3: Provide a certified prevention specialist (CPS) or an individual overseen by a Prevention Education Specialist in each high school to provide prevention services that are equitable, data-informed, evidence-based programs to that high school and its feeder schools to oversee transitional growth in year-to-year prevention.	2	3.5	2.75	3.33	3.42	26	20

Recommendations	Targets programs defined by SB390	Impact	Capacity & feasibility of implementation	Urgency	Advances racial and health equity	Total	Rank
8.4: Collaboration with the juvenile justice system to implement tertiary prevention strategies and interventions by a Nevada Board Certified Professional.	2	3.18	2.73	3.55	3.55	26.02	19 tie
Data							
Goal 9: Streamline assessments and intake processes							
9.1: Establish provider workgroup to identify overlap in duplicative data collection and refine opportunities for sharing mechanisms.	2	2.83	2.42	2.83	2.67	21.5	26
Recovery Supports							
Goal 10: Build supportive relationships and community (spokes)							
10.1: Engage non-traditional community resources to expand treatment access in rural or underserved areas and targeting populations that experience health disparities. Encourage non-traditional community resources such as churches or community centers to serve as spokes in the Medication Assisted Treatment (MAT) hub-and-spoke model.	2	3.67	2.75	3.58	3.67	27.34	14
Goal 11: Post-overdose response							
11.1: Explore post-overdose and/or co-responder model to follow-up with survivors of a non-fatal overdoses.	2	3.42	2.75	3.5	3.17	25.68	22 tie
Goal 12: Increase access to low-barrier and/or affordable housing & Housing First programs	2	4.33	2.42	4.33	3.92	30	**4 tie**
Education							
Goal 13: Provider education on stigma, titration, & treatment							
13.1: Establish collaboration between educational providers and the licensing boards to require education on stigma, titration, and available treatment for providers.	2	3.42	3.08	3.5	3.17	26.34	18

The estimated payment structure for the settling parties is shown in Table 11 below:

Table 11-Estimated Payment Structure for Settlements

Settlement Name	Estimated Payment Date	Month	Gross Allocation	Fees at 15%	Net allocation
Initial J&J Payment	2022	April	$2,089,267.46	$313,390.12	$1,775,877.34
Distributors	2022	May	506,395.31	75,959.30	430,436.01
Distributors	2022	July	532,196.78	79,829.52	452,367.26
Distributors	2023	July	532,196.78	79,829.52	452,367.26
Distributors	2024	July	666,119.66	99,917.95	566,201.71
J&J	2025	April	136,890.77	20,533.62	116,357.15
Distributors	2025	July	666,119.66	99,917.95	566,201.71
Distributors	2026	July	666,119.66	99,917.95	566,201.71
Distributors	2027	July	666,119.66	99,917.95	566,201.71
Distributors	2028	July	783,436.98	117,515.55	665,921.43
Distributors	2029	July	783,436.98	117,515.55	665,921.43
Distributors	2030	July	783,436.98	117,515.55	665,921.43
Distributors	2031	July	658,557.85	98,783.68	559,774.17
Distributors	2032	July	658,557.85	98,783.68	559,774.17
Distributors	2033	July	658,557.85	98,783.68	559,774.17
Distributors	2034	July	658,557.85	98,783.68	559,774.17
Distributors	2035	July	658,557.85	98,783.68	559,774.17
Distributors	2036	July	658,557.85	98,783.68	559,774.17
Distributors	2037	July	658,557.85	98,783.68	559,774.17
Distributors	2038	July	658,557.85	98,783.68	559,774.17
Total			**14,080,99.48**	**$2,112,029.97**	**$11,968,169.51**

State Allocation

Local governments and community-based organizations are eligible to apply for funding from the Nevada Department of Health and Human Services (DHHS). The DHHS state plan can be found here:

https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Grants/Advisory_Committees/ACRN/NV%20Opioid%20Needs%20Assessment%20and%20Statewide%20Plan%202022_FINAL_R%20(002).pdf

DHHS will release Notification of Funding Opportunities at various intervals at which time local entities may apply for funding for evidence-based programming that aligns with state and local goal areas.

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Appendix A—Opioid System Map

https://kumu.io/LCLee/washoe-opioid-system-map#untitled-map

Appendix B—Assets and Resources in the Community

- Certified Community Behavioral Health Clinics (CCBHCs)
    - **Vitality Integrated Programs**, 1135 Terminal Way, #208B, Reno, NV 89502, 775-322-3668, https://vitalityunlimited.org/outpatient-services/
    - **Quest Counseling and Consulting**, 3500 Lakeside Court, Unit 101, Reno, NV 89509, 775-786-6880, https://www.questreno.com/
- Crisis Call Centers
    - **988**
    - **Crisis Support Services of Nevada**
- Crisis Intervention Team (CIT) Training Programs
    - **Nevada Crisis Intervention Team** (statewide), https://nvcit.org/
- Crisis Stabilization Centers
    - **Well Care Community Triage Center**, 315 Record Street, Suite 103, Reno, NV 89512, 775-405-4111, https://wellcarefoundation.org/
- Community Health Workers
    - **NV Community Health Worker Association** (statewide), https://www.nvchwa.org/
    - **Nevada Certification Board** (state certification), https://nevadacertboard.org/certified-community-health-workers/
- Drug Take Back and Disposal
    - **Join Together Northern Nevada (JTNN)**, https://jtnn.org/projects/prescription-drug-round-up/ Bring your unneeded, unwanted medications to any of the locations listed below for safe disposal. **Call 775-324-7557 with any questions.**
    - **Reno:**
      Raley's – 18144 Wedge Parkway
      Raley's – 1630 Robb Drive
      Reno Elks Lodge – 597 Kumle Lane (across from Convention Center)
      Smith's – 750 S Meadows Pkwy
      Smith's – 175 Lemmon Dr
    - **Reno-Sparks Indian Colony**:
      Human Services Dept – 405 Golden Lane
    - **Sparks:**
      Smith's – 1255 Baring Boulevard
- Harm Reduction Programs
    - **Change Point, Northern Nevada HOPES**, https://www.nnhopes.org/patients/services/change-point/
    - **Trac-B** (statewide), https://www.harmreductioncenterlv.com/
- Jail and Prison Reentry Programs
    - **My Journey Home**, voigtelaine2@gmail.com

    - **Life Changes**, https://www.lifechangesinc.solutions/
    - **Ridge House**, https://ridgehouse.org/
- Medication Assisted Treatment (MAT) Providers
    - **Life Change Center**, https://www.thelifechangecenter.org/
    - **Center for Behavioral Health**, https://www.bhgrecovery.com/locations/reno
    - **Groups Recover Together**, https://locations.joingroups.com/nv/reno/groups-recover-together-reno-nv-grt814.html
    - See comprehensive list of DATA 2000 Waivered prescribers in Appendix D
- Mental Health Treatment Providers/Co-Occurring Disorders for Adults/Youth
    - **Alta Vista Community Resource Center** (adults), https://altavistamh.com/
    - **Family Counseling Service of Northern Nevada** (adults), http://www.fcsnv.org/
    - **Groups Recover Together** (adults), https://locations.joingroups.com/nv/reno/groups-recover-together-reno-nv-grt814.html
    - **Maple Star** (adults & youth), https://www.maplestarreno.com/
    - **New Dawn Treatment Center** (adults), https://www.newdawntreatmentcenters.com/
    - **Quest Counseling & Consulting** (adults & adolescents 11-17), https://www.questreno.com/
    - **Ridge House** (adults), https://ridgehouse.org/
    - **Step 1** (adults), https://www.step1inc.org/
    - **Step 2** (female identifying adults with/without children), https://step2reno.org/
    - **The Empowerment Center** (female identifying adults), https://empowermentcenternv.org/
    - **The Life Change Center** (adults), https://www.thelifechangecenter.org/
    - **True North Treatment Center** (youth, adolescents), (775) 870-5027, http://tntcreno.com/
    - **Vitality Unlimited—Reno** (adults & adolescents 13-17), https://vitalityunlimited.org/
    - **Well Care Medical & Behavioral Clinic**, https://www.wc-health.com/
- Mobile Crisis Teams (Adults and Children)/Mobile Outreach Safety Teams
    - **Children's Mobile Crisis Response Team**, 775-688-1670
    - **MOST Team, Reno Police Department**, most@reno.gov
    - **MOST Team, Sparks Police Department,** non-emergency dispatch (775) 353-2231
    - **MOST Team, Washoe County Sheriff's Office,** non-emergency dispatch 775-785-WCSO
- Naloxone Distribution Sites
    - **Center for Behavioral Health**, 160 Hubbard Way, Reno, NV 89502, (775)829-4472
    - **Northern Nevada HOPES**, 580 W 5th Street, Reno, NV 89503, (775)786-4673
    - **Change Point**, 445 Ralston Street, Reno, NV 89503, (775)997-7519
    - **Northern Nevada Outreach Team**, (775)386-2727
    - **Ridge House Reno**, 900 W 1st Street #200, Reno, NV 89503, (775)322-8941
    - **Quest Counseling & Consulting**, 3500 Lakeside Court, Suite 101, Reno, NV 89509, (775)786-6880
    - **Reno Initiative for Shelter and Equality (RISE),** mary.charles@ourplacenv.org
    - **Reno-Sparks Indian Colony Tribal Health Clinic**, 1715 Kuenzli Street, Reno, NV 89502, (775)329-5162
    - **Join Together Northern Nevada**, 505 South Arlington Avenue, #110, Reno, NV 89509, (775)324-7557
    - **Empowerment Center**, 7400 S. Virginia St., Reno, NV 89511, (775)853-5441

    - **Sober 24/Department of Alternative Sentencing**, 1530 E. 6th St., Reno, NV 89512, (775)221-8400
    - **Washoe County Human Services Agency**, 350 S. Center, Reno, NV 89501, (775) 624-4908
    - **Washoe County Sheriff's Office**, 911 E. Parr Blvd, Reno, NV 89512, (775)328-3001
    - **The Life Change Center**, 130 Vine St., Reno, NV 89503, (775)900-8522
    - **The Life Change Center**, 1755 Sullivan Lane, Sparks, NV 89431, (775)355-7734
- Peer Support Specialists
    - **Nevada Certification Board** (state certification), https://nevadacertboard.org/peer-support/
- School Based Health Centers
    - None currently in operation
- Specialty Courts
    - **The Second Judicial District Court** operates eight specialty courts programs for those identified with a substance use, mental health, or co-occurring diagnosis: Adult Drug Court; Family Treatment Court; Felony Driving Under the Influence Court; Medication-Assisted Treatment Court; Metal Health Court; Prison Reentry Court; Veterans Treatment Court; and Young Offender Court. Specialty Courts serve around 500 participants a year. https://www.washoecourts.com/SpecialtyCourts#:~:text=The%20Second%20Judicial%20District%20Court,Metal%20Health%20Court%3B%20Prison%20Reentry
    - **The Reno Municipal Court** operates four specialty courts including: Fresh Start DUI Program; Co-Occurring Disorders (COD) Court; Young Adult Offender (YAR) Court; Veterans' Treatment Court (CAMO-RNO); and Community Court.
- Substance Use Primary Prevention Programs
    - **Join Together Norther Nevada**, 505 S. Arlington Ave., #110, Reno, NV 89509, (775) 324-7557
- Treatment Providers (OP, IOP, Transitional Living, Residential, Detox, Inpatient)
    - Detox
        - **New Dawn Treatment Center** (adults—detox is in Sacramento), (775) 964-4898 https://www.newdawntreatmentcenters.com/
        - **Reno Behavioral Healthcare Hospital**, (775) 393-2201, https://www.renobehavioral.com/admissions/chemical-dependency
        - **Vitality Unlimited—Reno** (adults & adolescents 13-17 in Elko and adults in Carson City), https://vitalityunlimited.org/
        - **WC Health Community Triage Center (CTC)**, (775) 405-4111, https://wellcarefoundation.org/
    - Inpatient
        - **Bristlecone Family Resources**, (775) 954-1400, www.bristleconereno.com
        - **Reno Behavioral Healthcare Hospital**, (775) 393-2201, https://www.renobehavioral.com/admissions/chemical-dependency
    - Outpatient
        - **Alta Vista Community Resource Center** (adults), https://altavistamh.com/
        - **Bristlecone Family Resources**, (775) 954-1400, www.bristleconereno.com
        - **New Dawn Treatment Center** (adults), (775) 964-4898 https://www.newdawntreatmentcenters.com/

        - **Reno Behavioral Healthcare Hospital**, (775) 393-2201, https://www.renobehavioral.com/admissions/chemical-dependency
        - **Ridge House,** (775) 322-8941, https://ridgehouse.org/
        - **Step 2** (female identifying adults with/without children), https://step2reno.org/
        - **The Life Change Center** (adults), https://www.thelifechangecenter.org/
        - **True North Treatment Center** (youth, adolescents), (775) 870-5027, http://tntcreno.com/
        - **Vitality Unlimited—Reno** (adults & adolescents 13-17), https://vitalityunlimited.org/
        - **Well Care Medical & Behavioral Clinic**, https://www.wc-health.com/
    - Intensive Outpatient Program (IOP)
        - **Alta Vista Community Resource Center** (adults), https://altavistamh.com/
        - **Bristlecone Family Resources**, (775) 954-1400, www.bristleconereno.com
        - **New Dawn Treatment Center** (adults), (775) 964-4898 https://www.newdawntreatmentcenters.com/
        - **Reno Behavioral Healthcare Hospital**, (775) 393-2201, https://www.renobehavioral.com/admissions/chemical-dependency
        - **Step 2** (female identifying adults with/without children), https://step2reno.org/
        - **True North Treatment Center** (youth, adolescents), (775) 870-5027, http://tntcreno.com/
        - **Vitality Unlimited** (adults & adolescents 13-17), https://vitalityunlimited.org/
        - **WC Health**, https://www.wc-health.com/

    - Residential
        - **Bristlecone Family Resources**, (775) 954-1400, www.bristleconereno.com
        - **New Dawn Treatment Center** (adults residential treatment in Sacramento), https://www.newdawntreatmentcenters.com/
        - **Step 2** (female identifying adults with/without children), https://step2reno.org/
        - **Vitality Unlimited—Reno** (adults & adolescents 13-17 in Elko and adults in Carson City), https://vitalityunlimited.org/
        - **Willow Springs** (adolescents), (775) 858-3303, https://willowspringscenter.com/treatment-and-services/for-adolescents/
    - Recovery Residences
        - **Bristlecone Family Resources**, (775) 954-1400, www.bristleconereno.com
        - **Women's and Women and Children's CrossRoads**, (775) 328-2700, https://www.washoecounty.gov/hsa/adult_services/crossroads/womens_crossroads/index.php or https://www.washoecounty.gov/hsa/adult_services/crossroads/Women_and_children_crossroads/index.php
        - **Men's CrossRoads**, (775) 785-4006, https://www.washoecounty.gov/hsa/adult_services/crossroads/mens_crossroads/index.php
        - **Life Changes**, (775) 360-5481, https://www.lifechangesinc.solutions/
        - **Ridge House,** (775) 322-8941, https://ridgehouse.org/
        - **Step 1** (men only), (775) 329-9830, https://www.step1inc.org/
        - **Step 2** (women only), (775) 787-9411, https://step2reno.org/

- **The Empowerment Center** (women only), (775) 853-5441, https://empowermentcenternv.org/
- **WC Health- Puff House,** (775) 538-6700, https://www.wc-health.com/

Appendix C—Interview Guides

Interview Guide for People Who Currently or Formerly Use(d) Opioids

Interview Date: _____

Interview Location (participant's location if conducted remotely): _____

Participant number: _____

Participant's age: _____

Participant's self-identified gender: _____

Facilitator's name: _____

Thank you so much for talking with me today. My name is [*facilitator*] and I'm working with Washoe County to gather information from subject matter experts on services provided to people at risk of, or who are currently challenged with opioid use disorder. We will use this information to make recommendations for our community's needs assessment. I am going to ask you questions about your experiences accessing services. Your participation is voluntary, and you do not have to answer any question you don't want to (just say, "pass") and can stop the interview at any time. I just ask that you speak your mind freely as your perspective is so important. We hope that the insights you provide will help us create a better system and keep people alive and well. Please know that your identity will be kept completely confidential and any identifying information will be removed. Your participation should take about an hour and we would like to record the interview to ensure accuracy. Are you willing to participate in the interview? Is it okay to turn on the recorder?

Part I: Participant's history

Thank you again for taking time out of your day to speak with me. This first part of the interview process helps me understand a bit about your history.

- Where did you grow up? What was your life like growing up?
- Can you tell me about when you first began to use? [e.g. what did you begin with? How old were you?]
- How about opioids, when did opioids first enter your life?

Part II: Current/recent past opioid use

This part of the interview will help me understand your current/recent use of opioids and how you stay safe.

- What kinds of opioids do/did you prefer? How do/did you use opioids (ingesting, smoking, injecting, boofing, etc.)? How do/did you get them (pharmacy/script, dealer, friends, etc.)

    - If IDU: Do/did you use the local syringe services program/needle exchange?
- What are/were the benefits of using opioids?
- What is/was the downside of using opioids?
- What are/were some of your concerns about opioid use in your life? In the community?
- Have you had any experiences with fentanyl?
    - If yes: can you tell me more about them?
- Thinking about strategies to prevent overdose, do you carry naloxone/Narcan? Have you had any experiences with fentanyl test strips? Or test shots or using less? [Probe: can you tell me more about your experiences, when they carry naloxone and why, where, etc. What are their experiences with using test strips?]
- What can you tell me about the Good Samaritan Act? [Probes: have they had any experiences with law enforcement after an overdose or known anyone who had a drug-induced homicide case]

Part III: Services

This part of the interview asks questions about your experiences in accessing services like treatment, recovery supports, housing, etc. to help us understand what strengths are in the community and what the gaps are.

- What are the current needs you have right now?
    - Have you tried accessing services in our community to meet those needs?
    - If yes: Which services were the most helpful? What wasn't helpful?
    - Were your needs met?
        - If no: What barriers did you face getting your needs met?
- What can you tell me about the services that are available to people in Washoe County who want to stop using?
    - Have you tried accessing any of those services or programs?
    - If yes: What helped you seek those services before? What worked for you? What didn't?
    - If yes: Did you consider it successful?
        - If yes, what made it successful?
        - If no, what made it unsuccessful?
- Have you ever tried suboxone or methadone?
    - If yes: Can you tell me about your experience?
    - If yes: Was the medication helpful?
    - If yes: Did you experience any barriers accessing medication?
- If you had the resources to create a program to help people who use drugs in our community, what would that look like? What services would be offered? Where would it be located? Why would you build it that way? Why would you build it that way?
- What can you tell me about your experiences with law enforcement or the courts? Have you ever worked with a specialty court or other kind of diversion program in Washoe County? Can you tell me about that?
    - What worked for you? What didn't?

- How interested are you in recovery or supporting your recovery?
- What personal supports or resources do you have?

Part IV: Personal Reflection

- What are your dreams for your future? Do you have any dreams? What role do opioids have in your future?
- What do you think is important for people to know about people who use drugs?

Part V: Additional Questions

- Have you been in the emergency department or hospital in the last 12 months? [Probe: how many times? For what?]
    - If yes: How were you treated at the hospital?
    - Were you honest with your doctor, if not why?
- Have you been incarcerated in the last 12 months? [Probe: how many times? For what?]
- How about homelessness, have you experienced homelessness in the past 12 months? [Probe: How long? Did you go to the shelter?]
    - If yes: Where did you use when you were homeless?
- Do you have any children?
    - If yes: How have they been impacted by your opioid use?
    - If yes: Did you ever have CPS involvement?
        - If yes, can you tell me more about your experience?
        - If yes, what kind of supports or services would have been helpful?

Those are all of the questions I have for you, and I am grateful for you taking the time to talk with me today. Do you have any questions for me?

Interview Guide for Community Organizations

Interview Date: _____

Interview Location (participant's location if conducted remotely): _____

Participant number: _____ **Participant's gender:** _____

Participant's occupation: _____

Participant's position in org: ☐ Leadership ☐ Frontline Staff

Facilitator's name: _____

Thank you so much for talking with me today. My name is [*facilitator*] and I'm working with Washoe County to gather information and insight you provide us as a subject matter expert on services provided to people at risk of, or that are currently challenged with opioid use disorder in order to make recommendations for our community's needs assessment. I am going to be asking you questions about the services you provide, strengths, challenges, and barriers. Your participation is voluntary, and you do not have to answer any question you don't want to (just say, "pass") and can stop the interview at any time. I just ask that you speak your mind freely as your perspective is so important. We hope that the insights you provide will help us create a better system and keep people alive and well. Please know that your identity will be kept completely confidential and any identifying information will be removed. Your participation should take about an hour and we would like to record the interview to ensure accuracy, any identifying information will be removed in the transcript. Are you willing to participate in the interview? Is it okay to turn on the recorder?

Part I: Background

Thank you for taking time out of your day to speak with me. I am interested in getting to know you better by learning about your background and about what brought you to the field.

- Please tell me a little about your background working in this field.
- Where do you work now and what kinds of services to you provide in the community? How does your work intersect with opioid use?
- What is your favorite thing about working in your field? What is your least favorite thing?

Part II: Opioid Use in the Community

- Can you tell me about opioid use in Washoe County? Are there any trends you are seeing?
- What do you think has been effective with supporting people with an opioid use disorder?
- What are the challenges or barriers of providing services to people with an opioid use disorder?

- What are some of the strengths our community has to support people who are seeking recovery?
    - What about the gaps in services, can you tell me about what kinds of gaps you see?
    - What do you wish our community had?
- What would be helpful to you to support your work treating and/or supporting people with opioid use disorder (training, education, identification, Narcan training, resources, etc.)?
- If you had the resources to create a program to help people who use drugs in our community, what would that look like? What services would be offered? Where would it be located?
- What are some concerns you have about the future of opioid use in the community?

Appendix D—Suboxone Providers

First	Last	Suffix	Address	Suite	City	Zip Code	Telephone	Reached Patient Limit	Certified For100
Kori	Singleton	MD	975 Kirman Ave		Reno	89502	775-786-7200	Y	Y
Andrew	Wesely	MD	Nevada Pain and Spine Specialists	605 Sierra Rose, Unit #4	Reno	89511	775-689-5410	Y	N
Ryan	Zeller	D.O.	411 East Taylor Street		Reno	89502	775-786-3330	Y	Y
Aaron	Bertalmio	MD	25 McCabe Drive		Reno	89511	775-826-8100	Y	Y
Dwarakanath	Vuppalapati	MD	2375 East Prater Way		Sparks	89434	775-356-4595	Y	N
Michael	O'Brien		5575 Kietzke Lane	Suite B	Reno	89511	775-851-1505	Y	Y
Inder	Bhanver	MD	5365 Mae Anne Avenue	Suite A-35	Reno	89523	775-787-6463	Y	Y
Dan	Snow	MD	661 Sierra Rose		Reno	89511	775-853-7669	Y	Y
Kenneth	Pitman	MD	Nevada Pain and Spine Specialists	605 Sierra Rose Drive, Suite 4	Reno	89511	775-689-5410	Y	Y
Taylor	Tomlinson	MD	4286 Caughlin Pkwy		Reno	89519	775-786-4673	Y	Y
Garen	Mirzaian	MD	975 Kirman Avenue		Reno	89502	775-326-2920	Y	Y
Abdollah	Assad	MD	261 East 9th Street		Reno	89512	775-322-8900	Y	Y
Eric	Lamberts	MD	160 Hubbard Way	Suite A	Reno	89502	775-829-4472	Y	Y
Sarah	Zinati	D.O.	Unsom Fellowships	975 Kirman Avenue (111)	Reno	89502	775-785-7104	Y	N
Mark	Viner	MD	145 Isidor Court	Suite A	Sparks	89441	775-772-6015	Y	N
Steven	Berman	MD	605 Sierra Rose Drive	Suite 2,3,4	Reno	89511	775-689-5410	Y	Y
Ellen	Mcbride		540 West Plumb Lane		Reno	89509	775-322-2221	Y	N
Troy	Ross		2205 Glendale Avenue	Ste 131	Sparks	89431	775-331-3361	Y	N
Cameron	Duncan	NP	4773 Caughlin Parkway		Reno	89519	775-221-7400	Y	Y
Tanya	Temple	NP	850 Mill Street	Suite 100	Reno	89502	775-538-6700	Y	Y
Susan	Bauman	PA	1240 East 9th Street		Reno	89512	503-267-8992	Y	N

Michele	Stewart	NP	315 Record Street		Reno	89512	775-348-8811	Y	N
Sharon	Rederford	NP	850 Mills Street	Suite 100	Reno	89502	775-538-6700	Y	Y
Meredith	Kelly	NP	605 Sierra Rose Drive		Reno	89511	775-689-5410	Y	N
Kaylee	Nelson	PA	605 Sierra Rose Drive	Suit #4	Reno	89511	775-689-5410	Y	N
Jonathan	McCaleb	MD	975 Kirman Avenue		Reno	89502	775-786-7200	Y	N
Eric	Lamberts	MD	160 Hubbard Way STE A		Reno	89502	775-829-4472	Y	Y
Jeremy	Matuszak	MD	6940 Sierra Center Parkway		Reno	89511	775-393-2200	Y	N
Tyhesia	White	NP	975 Ryland Street		Reno	89502	775-982-6337	Y	N
Kimberly	Nischik	PA	580 W 5th Street		Reno	89509	775-786-4673	Y	Y
Frank	Akpati	NP	911 E Parr Boulevard		Sparks	89512	775-328-2950	Y	N
Depinder	Singh		1155 Mill Street		Reno	89502	832-229-0067	Y	N
Joseph	Ryan	MD	10768 Grayslake Drive		Reno	89521	530-305-9567	Y	N
John	Edgcomb	MD	3830 Bowers Drive		Reno	89511	775-830-6712	Y	N
Sukumar	Gargya	MD	10623 Professional Circle	Suite A	Reno	89521	775-250-2390	Y	N
Melissa	Vega	NP	Reno Primary Care	3773 Baker Lane Suite 6	Reno	89509	776-799-6700	Y	Y
Sherry	Watts		850 Mill Street		Reno	89502	775-538-6700	Y	N
Walter	Smith		5190 Neil Road	Suite 215	Reno	89502	775-784-6388	Y	N
John	Swanson	MD	1155 Mill Street		Reno	89502	775-982-2001	Y	N
James	McLennan	MD	Advanced Medical Arts	513 Hammill Lane	Reno	89511	775-358-3522	Y	N
Adewale	Busari	NP	6880 S McCarran Boulevard	Suite 14	Reno	89509	775-393-9101	Y	N
Suzanne	Watson	MD	Dept of Psychiatry and Behavioral Science	5190 Neil Road, Suite 215	Reno	89502	775-784-4917	Y	N
Thomas	Gonda	Jr., MD	131 Ryland Street		Reno	89501	775-389-8631	Y	Y
Steven	Huerta	NP	343 Elm St	Suite 308	Reno	89503	775-238-3082	Y	Y
Ryan	Zeller	D.O.	518 Pyramid Way		Sparks	89431	775-800-1587	Y	Y
Thomas	Gonda	Jr.	131 Ryland Street		Reno	89501	775-389-8631	Y	Y

Mark	Broadhead	MD	Northern Nevada HOPES Clinic	580 W. 5th Street	Reno	89503	775-786-4673	Y	Y
Jennifer	Crozier		Sierra Nevada Health Care System	975 Kirman Avenue	Reno	89502	970-773-1896	Y	Y
Brandee	Shipman	NP	505 S Arlington Avenue Ste 203		Reno	89509	775-657-9991	Y	N
Julie	Westwood	NP	3773 Baker Lane STE 6		Reno	89509	775-799-6700	Y	N
Keith	Swanson	MD	411 E Taylor St		RENO	89502	775-786-3330	Y	Y
Julie	Cope	NP	5421 Kietzke Lane	Suite 100	Reno	89511-1025	775-500-0403	Y	Y
Regina	Speights	NP	5470 Kietzke Lane	SUITE 300	RENO	89511	702-817-2258	Y	Y

Appendix E—Interview Narratives

Organizations
Challenges

No cohesive or effective surveillance system to notify the community in real-time of an overdose spike and trigger a targeted response. " I can tell you, I know at least one day like two weeks ago or last month, month ago, where there were eight suspected drug overdoses in a 24 hour period. And so, there is some system level issues with like EMS, or with the database updates themselves. As to how that's working. That's preventing our overdose response plan from being triggered."

Conservative policies that do not embrace evidence-based or emerging evidence. "right wing or leaning direction as it… as you know, speaks to substance use disorder and treatment and even evidence-based or emerging trends that communities are trying."

Secondary trauma exposure in the workforce. "when I talk with caseworkers or supervisors and I hear about some of the things that they're you know, exposed to the secondary trauma." **Counselors experiencing secondary trauma from their patients and personal trauma due to not being able to find affordable housing for themselves and their own families. Pay for counselors can't keep up with inflation and housing rates in the community. Unable to pay more due to challenges with Medicaid and insurance companies decreasing rates and not wanting to cover treatment.** "You know, but it's also like now, not just, it's not just secondary, it's like, you know, people are struggling. I know, counselors, they can't pay their rent, that leaves their houses that can't find places to live, you know, that family, you know, they're struggling, they make pretty good money, and they still can't find a place to live. So it's not just, you know, the way the economy has changed and everything like that. I mean, we've, we've done across the board pay increases for everybody. And as soon as we did it, you know, inflation went up again. Yeah, the gas prices hit. Right after we did that gas went up, like two bucks now. Ah, you know, and meanwhile, Medicaid is trying to decrease the reimbursement rates, you can't raise them, because it's like, we know, you know, we know, we know that. Like, we can't do that to people."

The opioid crisis is not new, it just affects a different demographic. "it's sad that only when it is impacting the quote unquote, important people that people care about it, you know, but people have been dying for a long time.

Children exposed in utero have less capacity to self-regulate and self-soothe and can present challenges for foster families due to behaviors. "Like I remember this little girl was she was like six and she would just scream and say like, for our she would scream and she couldn't regulate herself and like we couldn't even get a foster home to take a six year old little girl because she was so high needs. And that was the girl that we confirmed that she had been exposed in utero."

A lack of available recovery housing and permanent housing is a barrier to maintaining recovery. "we still have a shortfall in regards to sober living and housing."

The current stigmatization of law enforcement can obfuscate the positive work being done to reform the justice system. "there's a lot of stigmatization happening around law enforcement. And it's easy to easy as a uniform law enforcement agency to get pigeonholed, and people overlook all of the good that agencies like this are doing and trying to do. So that can be a frustrating aspect when you are actively trying to do a good job."

Agencies are constantly having to adjust their testing assay to be inclusive of new synthetic analogues and opioid substitution products to keep up with current trends in use. " It's just we're always chasing, you know, testing is always chasing, especially synthetics."

Resources are limited. "I mean, it's hard because you can't make somebody do anything and the resources are kind of limited."

People have to get in trouble before they can get help. "It's just really, it can be frustrating, because I feel like a lot of times people have to get in trouble before they can get help."

Intergenerational substance use that becomes normalized. "if you grow up poor and your parents are, you know, using meth and you're always poor because they're more interested in buying meth or opioids, then you know, providing for their family or feeding their addiction no matter what it is. I mean, you just you grow up seeing that and you kind of feel like that's normal. And so that's just kind of what you go into as well."

Location of the program can be a trigger for some people, as they are unable to get out of the environment/away from people who are using. "You know, like this building is right in the midst of, you know, here. Yeah , so like, initially, we thought, Oh, that's great, because then they're all close by they know what it is. But then it's also like, you can't get them out of this situation. And it's, you know, we just had a person say the other day that she didn't want to go downtown because that's a trigger for her, like coming into this area of town as a trigger."

Death. "the people that die I think that is it affects me, but I try not to, but it's hard not to be affected by that. It's almost impossible not to have feelings, especially with these same people that you used with some people that you know that just probably just the death part is what gets me...I also say well, the next time I can save two people since I lost one." **Many clients die either from overdose or from health issues from long-term drug use.** "All the time. I lose people. Like we have lost someone every other week. We just lost three people just this last month."

Tension between abstinence-based approach and harm reduction approach in treatment. "I like recovery, because harm reduction model not quite as much, but you're either sober or you're not, you're either recovering or you're in active addiction. And yeah, there's some harm reduction, you know, kind of meet in the middle in between, but even if they have reduced their use, and they're still using something, they are still in recovery, they're still connected, they're still engaged, it's happening."

Difficulty engaging people in treatment, despite flexible policies. "But we have a lot of members who have really inconsistent attendance, they need to get that somebody to our notice letter, they're back in it again, but not really engaged and just kind of spotty attendance again for another month or so. And we're continually trying to reach out to those members, get them involved and engaged in groups. And that's probably one of my least favorite things is, you know, it's one thing when the members are shouting from the rooftops, you saved my life, and you changed my life, and everything's better. It's another thing when someone is really still struggling in their own recovery and having trouble making it through the door. "

Lack of available information or resources on treatment options for methamphetamine use treatment. "There were a ton of people who asked about methamphetamine use treatment and I didn't even feel like I had a lot of good even pointing in the right direction kind of answers for folks. So that's something I'm going to be seeking out some information on."

Lack of funding, policy, and attention towards methamphetamine as meth use is not seen as iatrogenically caused. "And I've done a little research on it, like with methamphetamine use disorder.

And it, it looks like there's some good MAT for methamphetamine use disorder. But some of the things that I've read had said, they're not getting the same funding and policy attention and lobbying because it's not like, it's not a nice white person's disorder. And I'm saying That was sarcasm, you know, that they've gone to the doctor and gotten addicted to pain medication. And so now we feel really bad for them that they have this disorder, you know, it's like, “oh, you are a meth user, you brought this on yourself. “So there's not the same funding and attention into treatment for them."

While there was overprescribing of opioids, a challenge has been that providers cut people off “cold turkey and expect them to be okay.” Also, there people with chronic pain that need pain management. "that doesn't mean that you should stop people cold turkey and expect them to be okay. And that doesn't mean that you know, there are people out there that need pain meds." **Another challenge is seeing people being abruptly cut off from medications.** "I mean, people aren't seeing, I think, big picture when they're cutting you off from medication. There needs to be more support and structure in place for that."

Insurance companies making staffing requirements in order to cover the treatment, and the provider is unable to hire staff that meet those requirements. "you have to have a psychiatrist on staff full time at every site. Right? You can't even hire psychiatrists right now. You can’t even hire talk therapists, an LCSW. So they do these little things where they stay within the fidelity well not fidelity, but they stay in the gray area of the law, or, you know, but then, you know, so hopefully fidelity what to what, they just find a way to get through it, you know, and so they, they're like, oh, we'll cover it. But you have to have these kind of providers on staff, or your counselors have to be co-occurring master's level, we have to have a psychiatrist on staff. So they give us this dance with them, you have to explain like, I can't do it like that."

Regulated increase of suboxone and methadone cannot keep up with treatment needs related to fentanyl. "Fentanyl and regulations regarding how quickly we can increase medication, both suboxone and methadone is just doesn't keep up with it."

The breadth of the problem is bigger than the capacity of local providers. "I just I sometimes it feels like I'm, I'm running up the uphill battle by ourselves. And I know we're not I know there's there's plenty of partners and agencies that we all work together. And it just sometimes just feels like we are hitting our heads against the wall. Because these, these kids are so getting into things and they're still buying things, and they're still they're still getting hurt. What are you supposed to do with that?"

Washoe county is a large community, with many different schools, different demographics, and different cultural considerations. "We have 15 high schools, and they all have different demographics. So just like the mindset and the cultural aspects."

Alcohol culture embedded in schools, including fundraisers and PTA events. "I mean, if you tell them it's gonna be a fundraiser at for like a brewery fundraiser. It's like a, like a, what is an eat and taste or something where they like the food pairings. I've seen those across the county where they do like food pairing nights where they have local breweries donate beer, and then they have a local caterer paired with the different foods. That's all you're doing is enticing alcohol." **Parental attitudes and stigma on mental health.** "'Well, my child doesn't have a problem.' Because they want to ignore the fact that there is a problem. So instead of getting the child to help they need, they just let them suffer."

Prevalence of opioids outpacing community awareness. "We can just mail-order opioids now. It's, it's it's so prevalent in our community, and I don't think people realize what's happening. I don't think we we have enough community awareness around the issue." "Because how can you do community change if the community is not ready, because they don't believe there's a problem?"

Strengths

Additionally, participants discussed the various strengths of their individual programs, collaborative efforts, and overall strengths of the community to ameliorate drug related harms in Washoe County.

State level surveillance, technical assistance, behavioral health and SUD treatment providers, drug supply control (enforcement), collaboration, media. “I do see programs collaborating supporting each other at events, education and continuing education, strategic efforts and otherwise."

Changes in the justice system to become more understanding of recovery as a process and that individuals with a substance use disorder need supports to rebuild their lives rather than a punitive approach. "You know, so we're trying to be more collaborative effort in their recovery than just, oh, you slipped up, you're going to jail, understanding that relapse is actually a part of recovery."

DAS is working in conjunction with WCSO to ensure that justice-involved individuals receiving MAT can transition seamlessly back to the community without interruptions to their treatment. "So, we're trying to develop a pathway to where people that are receiving MAT services and our wraparound services that say they need to go back to jail for whatever reason, they're not getting it, or they need to see the judge. They continue to receive those services. And their MAT team is aware of our team, and we can use that pathway to say hey, John's coming back. Yeah, you know, he's he's using this medication. He has a court date. In two days. He's having a hard time. We need to make sure that when he's done with that, and he gets released, that he's coming right back to us, and we can pick up where we left off."

During the pandemic, DAS remained open and only experienced a 4% increase in positivity rates versus the 18-20% trend nationally. They credit their staff as a source of socialization for participants and a protective factor against isolation. "So you know, at least they got to come out of their house. So twice a week and socialize a little bit with my staff and so our people that we will continue to test after that it didn't have quite that rise or I think that mental health aspect of the isolation and a lot of people felt."

DAS asserts that technology, specifically smart phone availability, has aided their ability to conduct testing and remove the barriers of participants having to come down in person, difficulties with transportation, taking time off from work, and having to arrange childcare. " We fully embrace technology. It’s coming out, why not utilize it. And it's actually easier. You know a lot of our people don't have driver's licenses and stuff. So why do I want to force them to ride a bus four hours round trip to get here and interrupt their daily life where maybe they can't get a job now because who wants to give them a job. Where I can give this piece of equipment that notifies them on the phone which everybody has a phone, the smartphone, it takes them 30 seconds and they're back into their life, so."

Law enforcement is more educated about substance use disorder and is more centered on “partnership than adversarial now.” “I think they appreciate that our officers have gone above and beyond to try to give them resources and options and maybe a better understanding of the disease itself than before. It's like I don't understand why you you just don't quit drinking and I'm taking you to jail. Not that it has a physical effect on them and that they are not normal without the drink at this moment. There's a process to weaning yourself off. So, I think that has made us more and now we're going to add more tools to our tool belt to be more successful."

Participant incentive/accountability to stay on track through testing and court. "We do their testing here and they go to court regularly so they have a little more incentive to, we hope they have more incentive to you know, stay on track more accountability, I guess."

Suboxone and methadone are helpful for a lot of people. "I think like the Suboxone and the methadone is helpful for a lot of people." **MAT is an effective tool for treating OUD.** "I think, you know, the, to me, one of the silver linings of opioid use disorder is that the medication assisted treatment is so effective. When I listened to members talk about their suboxone and the fact that they have zero cravings, no desire to use, and not everybody starts off there, of course, you know, they have to get their dose adjusted just right, and there can still be triggering events in life. And it's not a perfect, it's not a perfect magic pill, I get that. But I've, again, compared to some of my other recovery settings, watching people, you know, truly white knuckle it through things just trying to get through the next day or hour without a drink or a drug. Knowing that our members, it's like this medication takes so much of that just off their shoulders already right off the bat." **Jail is offering methadone, giving options for treatment (suboxone and methadone), linking with service providers, and offering medications and naltrexone when they are released.** "the jail is offering induction on methadone now. I mean, they're offering methadone. Like, they're giving them options like what do you want? Do you want a methadone, Suboxone or naltrexone when you leave here, you know, like who would you like to be linked up with? Like, that is huge. That's huge. So that's good. I think law enforcement is getting more on board with it."

There is a benefit of working in the field, seeing people change their lives. "The hugs and thank you because I think you're just doing the right thing but it's actually saving lives which is doing the right thing but when those people come to you with those stories and it makes you feel good you know make you want to do a little bit more you know, when they when they come and say hey, you did this to change my life even if they're not completely where you think they should be there were there and as long you meet them where they're at and you can't go wrong." **Seeing the changes in people.** "My favorite thing is to see the changes in them, see the light in them to see the reunification with the families and with the for them to love themselves again. That's a huge thing. You know, they start loving themselves and start feeling like they're amazing." **Motivated to make a positive impact on people.** "When I go home during the week, at least once or twice, it's like, no, I had an impact on something that might trickle down somewhere that might help some somebody else out down the road, you know what I mean? "

Narcan, FTS, one on one outreach and support. "Narcan training and dropping off Narcan, the test strips, one on one conversations." **The life-saving work of providing naloxone to people at risk.** "You know, we truly are saving lives, we are preventing people from overdosing by giving Narcan. So it is absolutely lifesaving work." **Availability of FTS to help keep people safe.** "I think it's absolutely amazing that we have test strips because no matter what if they're going to use and they're not ready, they might as well use safely."

The benefit of having people with lived experience in the field as service work can help to support recovery. "I believe that service work is a big thing. You have to stay you have to replace those old bad habits with new habits and whatever that service work and self-care looks like it has to be applied."

Benefit of telehealth to reach more people. "I think a pro was just access, of course, because, you know, again, thinking of the members in more rural areas who don't live in Reno and Las Vegas, especially specifically, kind of like in Nevada right now, knowing that they can attend group is really flexible for people who need to work around a work schedule, we will have members who will take their group during their lunch hour at work in their car, and, you know, to be able to get the treatment that they need and not have it, you know, interrupt their entire day, I think is really a benefit...you know, members aren't having to arrange childcare, just to attend this weekly group to be able to stay in treatment. So, I think it's really meeting the member where they're at and giving them what they need."

Benefit of in-person groups in a hybrid treatment setting. "they're asking more frequently, when can we come back, they miss the hugs with each other and the connection that they feel that they get in a room, face to face."

Effectiveness of a harm reduction approach in treatment. "And I think because we're harm reduction, I think it feels safer and gentler to some of our members then maybe some of the abstinence-based treatments they've chosen or been forced to do in the past." **Providing harm reduction education to people who use opioids but also to people who use stimulants about how to stay safe.** "Even people that maybe are not specifically using opiates. Like, I mean, they're impacted as well. And so having conversations psychoeducation on 'Hey, cool. You've been using the same dealer for a long time, but like, do you know where they're getting this stuff? You know what's in it like? How do you make sure that you're using safely...how can we keep you safe in the meantime, so you can live to the day that you're ready.'" **Harm reduction is effective to keep people safe until they are ready for change.** "Oh, harm reduction is so effective, absolutely effective, and I feel like when they are ready, then they're ready. But otherwise, why can't we have them out there safe?"

Effectiveness of a non-punitive approach. "Even if your drug screen lights up like a Christmas tree might not say like that, but I might, depending on the member picked out a group, you know, this is not a punitive thing. Because a lot, you know, come from a history of dealing with dealing with corrections as well parole probation or another sort of program where if you test positive, even for THC, you're out. And we do not take that approach at all. And I think because, again, we meet the member where they're at, and allow them to be the driver of their own recovery, I think it is more successful."

Person-centered approach that allows the individual to "drive their own recovery." "And so you know, not only do we have this group therapy, but I feel we have this really just helpful model that is about allowing people to drive their own recovery. And I think that makes a huge difference."

The importance of using person-first recovery friendly language. "we use very client centered member centered language...even you know, calling our members addicts, you know, they're members, they're people, they're mothers and fathers, brothers and sisters. And so, you know, I know a recurrence versus relapse, illicit versus dirty."

Meeting people "where they're at," building relationships and being a safe person that they can come to. "Just meeting them where they're at . You can't force things on people and expect them to respond positively to that...And helping people like, feel supported, and then building that like relationship with them, so that when they are ready for something more than they can they know who to come back to? Like, oh, you never forced me into this or you never judged me for this. Like, now I know that you're a safe person that I can talk to and go to and I think that is the game changer."

Political and community support has aided DAS to be proactive about implementing innovative solutions to support recovery. "I think we're fortunate to be on this side of the justice system right now. On the recovery, the long-term solution side of it. As everybody wants to see folks, figure it out and become successful and leave the justice system. And we're well positioned to do that...I've always said we don't want repeat customers. I always thought that when I hope I never see you again on in this aspect. I want to see you again out in society and doing well but I never want to see you here."

Collaboration and developing a network. "we're developing the network. And if there's not availability here, maybe there's some there maybe there's some here and we can just kind of work together to try to find the path that makes sense." **Collaboration, education and trainings (referenced Harm Reduction Summit).** ". So looking at the partners who are already involved in this and what they do, I think, you

know, has been a great asset to us. And I hope we've been an asset to them, too. " "there's a training and education opportunities and that they're focused, to be focused on harm reduction, and on some level on opioid use disorder is pretty amazing. I think that we're moving in that direction to have those kind of resources for the community. So I'd say our other community partners and the training and education opportunities in Washoe County have been good." (

Access to resources/knowledge of resources after arrest. "I think a lot of people don't know that. There are all of the resources that we have or they either don't know or they don't know how to get in contact with them. So, I think that is helpful, you know, unfortunately, getting arrested and having to go through the system."

Recovery meetings. "The meetings are the strength" "it doesn't have to be 12 steps, you can just be outside at the park. If it works for you, I'm there or you know, wherever you need me to be I'll be there."

Compassionate providers. A lot of "people that have a heart that would go bend over backwards," however, this provider does not see that "in the big places" (larger treatment providers). "You know, there are people that have heart that would go bend over backwards, but I don't see that in the big places." **There are people in the community who care deeply.** "There are people in this community that care deeply lived experience or not that want to see change." **Wide variety of support in the community to address substance use.** "We actually have of people who are out there willing to help someone willing to take them in willing to help them get through the process."

Improvement with insurance companies, federal money and state grants. "Well, in the same vein, you know, as bad as the insurance and Medicaid and all that stuff is at least it does cover it further, so it's a hell of an improvement from 10 years ago. So, you know, so that helps. I do think that the federal money that the grants from the states has helped, I think that's helped a lot, I think has had an impact."

Stigma reduction: UNR sends a lot of interns to the clinic and as they go into other professions they help reduce the stigma and advocate for MAT. "I think, I think the UNR has been a big help they provide a lot interns here, the interns get that experience, they go out to other professions, and I think that helps. And I think really, I'm trying to think of what else I just think that was probably yeah, those are things that helped part of it." **Provider seeing some reduction in stigma in the recovery community, criminal justice system, behavioral health and medical providers, and patients' family members.** "a lot of times people are getting referred or people that they use when they're like "you need to go get on the clinic, you need to go get help." You know, I think the other strengths that we have is definitely like, you know, funding sources, Medicaid, Medicare, private, you know, private insurance, Medicare is a big thing, too. That's like, you know, that's since 2020. So that definitely, you know, increase access and funding."

In MAT program, the provider did not feel like a "prison guard" with people who continued to use. Instead, he used "rolling with resistance or reluctance, motivation interviewing, all those things" to help individuals with forming a therapeutic alliance and readiness to change. "first week of treatment, I realize everybody was there, they weren't being kicked out because they were struggling with their drug abuse. Like this is pretty cool. Like you actually really I don't have the courts telling me what I got to do with somebody that relapsed. You know, it's like these people, whether they're there… you really use them the you know, rolling with resistance or reluctance, motivational interviewing all those things, you really need to do it because you know, you are the people are volunteering to be there, and you're coming to see you and they don't have…there's not a court or a judge behind it. So it was pretty cool. I didn't feel like I was a prison guard."

Agency provides prevention education and training to youth and parents and harm reduction services in the community. "we help them in multiple aspects because you have to help the whole being before you can just center on one thing. Because it's not just a substance use disorder that's happening. It's everything that's happening to them. So we try to make sure they get the complete services to help them as a person and help them be successful. "
Prevention for youth focuses on protective factors, positive choices, and building leadership and resilience. "And then we talk about the one choice, because we're really big in the one choice prevention, because a lot of times we talk about 15%, that use or the 12%, that are doing alcohol binging. But we don't talk about the 85%, who choose not to. And it encourages them of like, you want to be part of the 85%. Like you want to be part of the winning side, because that side is working together to make a difference. And they go Oh, like, all they hear is about all the bad things, if we tell them about the good things it actually does change their mindset. And that's the mindset change that we're working on in our community, we're going to start doing one choice. pep rallies with the schools, and have them kind of do like a one choice pledge, and work on that resiliency and work on that combined effort of like standing together against substance abuse."

Building leadership skills and peer to peer programming. "And what this group does is they not only do leadership skills, because we help them build their resiliency and talk about their futures and help them get into their getting set on their life goals, whether it's in a career program, or a college program, you know, depending on which direction they want to go, and we support both, we help them get the process, but we also encourage them to be leaders in their youth community. So they go and they teach youth programming to after school programs at Title One schools, which are the classified as the more high risk areas. So we send those kids into those schools after school. And they do after school programming to talk about substance use, because we're finding that the youth will listen more to a team than they will to an adult."
Prevention programming includes students already using- focuses on choice to change. "if the students are using we don't reject them. And it's like, well, you can make a choice today or tomorrow, change. It's never too late. It's never too late to make the choice. And that's something that we incorporate. It's like, well, I'm already I'm already using well, okay, well, maybe today's the day you're not. And we talk about like how it's a choice to once you are ready To start getting help, we're here to help you we're not going to, we're not going to shame you, we're not going to stigmatize you."

Trends

Inverse relationship with decrease in opioid RX but increase in suspected drug overdoses from opioids, fentanyl, and methamphetamine. "Yeah, it's skyrocketing. Well, I would tell you that over overdose, suspected overdose rates and overdose deaths are increasing, you know, over the past, I think, I would guess maybe four to six years. Despite you know, since the 2015, I believe it was those efforts with the prescription drug monitoring program. So we've seen a decrease in opioid prescriptions opioid prescription rates, but a sort of inverse shift or inverse relationship in suspected drug overdoses from opioids. Including fentanyl and other drugs as well including methamphetamine and a rise in deaths here in our region." **Providers are seeing more overdoses and the fallout of collective trauma from their losses and the losses of their patients.** "It doesn't matter how hardcore they are, how, like, you know, they were a suburbia user, they got carried away, they all know somebody that has died of an overdose and it's usually fentanyl related."

A shift from a regulated supply to an illicit, uncontrolled supply. "And, you know, folks on the ground attribute that to really increase in illicit or, you know, amount whether amounts or turned to an uncontrolled drug supply. You know, not sort of regulated as far as like mainly from a manufacturing

standpoint. And so, a change in where these drugs are, you know, to illicit drugs from like, pharmaceutical based drugs. So, you could argue that that is like an unintentional consequence."

Opioid use impacts children, adults, and seniors through HSA's program areas. "I think that probably across all of our populations, our clients use opioids."

What began as overprescribing is now systemic under-prescribing for legitimate pain. "And then where we are now is people can't get the care that they need." **Stigmatizing providers and inability to receive pain management.** "He's had his own struggles. He's had three knee replacement, four level fusion in his back like he's not a drug seeker. He has legitimate problems. And just like he won't even go to the doctor half the time because of his experiences, which is frustrating because I know that that will probably reduce his life because he needs to take care of himself, but he's been treated so badly...Or he won't tell them everything, because he's afraid of how he'll be treated. So you know, he goes to the dentist and he's honest, and then he's sorry for that. Now, he goes to the next dentist and he's just not going to say everything when he needs to tell him everything. Yeah, but he is afraid. And it's terrible that people have to do that...That yeah, like people have legitimate pain. And not that I want him to have opiates, I do not want him to be on opiates. But when he needs them, when he has a surgery, he needs them. Nobody should have to have an invasive surgery with no pain management, but that's literally what some doctors expect. And it's not right because then those people don't have those needed surgeries and they have a shorter lifespan."

Increased acceptance of MAT, including in child welfare; more people are dying and it is affecting more people; greater availability of naloxone. "I think we see an increase in utilization of MAT for people. So I think that's a positive trend that we're seeing. We're seeing more acceptance of that within our caseworker population. Because, you know, used to be like if you're on methadone, like that's just as bad as being on heroin, and we know that's not true. So, I'm seeing some increased education and knowledge with staff around it. But I'm also just seeing like, I know a lot of people who have lost family. Like, I feel like so many people know within maybe like one or two degrees of consanguinity. Yeah, I've had somebody who has died or even several people that they know. So it just seems like it's more and more people are dying. I think to the other trend is seeing that the Naloxone becoming more and more available. People know what it's for. And you know, to have a kid like if you have a teenager you should probably have a kit because you never know. Yeah. So some positive but it just seems like you know, the deaths are just more and more."

Opioids in the child welfare system: More removals due to opioids being considered "hardcore drugs." "I think opiates are really considered to be one of the more hardcore drugs and so I think we've seen an increase in children being removed from their families, especially those infants that are exposed because we're not reaching the mom before the baby comes. We don't intervene until there's a child outside of the womb. And so I still see that I have some we have some things in place to try to help with that." (002)

Fentanyl contamination and people that are transitioning to preferring fentanyl. "and now, people are just searching out street fentanyl. That's scary." **Seeing a lot more fentanyl- seeing it in everything (example cannabis and kratom).** "We didn't always have the fentanyl test in our panels. And so, you know, when we got them it was interesting to see what it was in and it was like in everything. in marijuana and it was in kratom. And, like, all the things that people were like, oh, no, I don't do fentanyl. And it's like, well, yeah, you do. So a lot of people were actually really shocked by that, you know, thinking that they're just you know, smoking their weed and there's actually fentanyl in their test." **Fentanyl contamination in all sorts of drugs.** "the fentanyl contamination is showing up even in the

crystals." **Increased preference in drugs containing fentanyl or preferring fentanyl by itself.** "increased use of fentanyl. That's well documented, I see that in the records. I'm still shocked. And I shouldn't be, but I am still shocked. Every time I see someone who intentionally uses fentanyl. Like that, that is their number one drug of choice, not just like, Oh, I hope I get a batch of heroin with some extra fentanyl in it, because I'm gonna feel extra good, but like, I am shooting up fentanyl. It's terrifying. It's shocking to me every time I see it. And it's alarming because we know how lethal it can be, and how dangerous it is. And so, um, you know, that is definitely something that that we are seeing." **Fentanyl contamination in all types of drugs (pills, stimulants, etc.).** "now we're hitting fentanyl. Okay, and it's crazy how we're going through those trends. Right? It's the pills, it's the meth, is it's everything is laced with it no matter what they're using. They're possibly going to die. Yeah. And that's what I'm seeing right now is that we're hitting it so hard with the fentanyl. In everything, everything. We just had someone pass away from a pill. We just had someone pass away from meth. Meth!" **Increase of opioids in other drugs, more people in the community carrying naloxone, and changes in using behaviors (e.g., fear of using alone).** "just like having opiates show up and things that they've been using that maybe didn't have opiates in them before. I would say also in the beginning, I remember that initial push for a Narcan or Naloxone, you know, for everyone to like, have that. And it being such a new thing. And I think for some people, it is kind of a new thing. But now I see more like our guests here kind of like also carrying it." **Fentanyl and methamphetamine are prevalent. Provider is seeing a shift of people moving from injection heroin use to exclusively smoking fentanyl. Fentanyl use is complicating treatment as users have difficulty stabilizing on medications at a comfortable dose due to their tolerance and are difficult to retain in treatment.** "Seeing a lot of our older IV drug users or IM users and kind of like a weird benefit of fentanyl to where they're not doing that. Like they're not IMing because now they can smoke, fentanyl, or you have IV users that don't shoot up anymore. I talked to this guy that worked in San Diego, and he was talking to his former colleagues down there and they haven't seen heroin in a year, which is not good. But it's all fentanyl. And then a lot of the patients there, I think the IV drug use has dropped a lot. But their tolerances are still going through the roof is so crazy. So we're seeing like people would not…with difficulty stabilizing on methadone. We're kind of capped on how quickly you can increase people based on the type of provider we are. So there's a lot of struggles that people…we're seeing more people kind of walk off treatment."

THC positivity is the highest. "THC is by far our biggest drug."

Methamphetamine is still a bigger issue for many. "I'm also hearing from a lot of people that you know, method methamphetamine use is really the bigger issue for them."

In the female identifying and family population experiencing homelessness, domestic violence and substance use are the main drivers currently. "this is a whole new population, like we're dealing with more domestic violence. We're dealing always dealing with substance use, but I think even more so."

Providers who were on the opioid dispensing side of the opioid crisis are not on the opioid treatment end. "There's doctors that made it on the first program, and now they're making it on the other end. They went from pain management clinics to opioid, you know, office-based treatment, you know, centers."

Prescription misuse in high school and middle school. "that's a very common type of misuse (prescription misuse) that happens in high school and middle school. And it's just because they think, Oh, I can take my friends pill and all of a sudden, you know, like, I'm not feeling right, and things start going downhill, because then they want more. And it's something that isn't talked about a lot because there's a lot happening in our community with that." **Kids getting medications that are laced.** "We're seeing a high influx of kids getting medications that are laced." **Colored fentanyl that is attractive to youth.**

Increases of overdoses in the schools. "I mean, we've had multiple overdoses in the schools, and the teachers are even afraid to touch a kid when he's asleep on the desk, because they're not sure if he's asleep, or if he's, if he's, you know, it's causing fear. And it's causing to where the teachers are just they're so concerned, because they don't know how to handle that."

Stress is impacting kids' ability to cope- testing, social media, etc. School age youth are living in a constant state of panic and stress to the point that youth vaping melatonin to sleep.

Barriers

MAT can be a barrier to recovery housing. "If you're on any kind of MAT, like we literally used to have it where people couldn't go into [recovery home]. If they were on MAT, they would make them go off of MAT."

Lack of providers who treat SUD holistically. "has to be like a holistic approach mental health, physical health, nutrition, all of those things. But we don't really have a lot of providers that look at it that way or that work together so that you can be treated holistically."

Lack of support for multiple pathways to recovery. "So, like this, you know, you have to do AA or NA. Well, some people may not like that they may need something different. Maybe they want a CBT approach. Maybe they can get by with minimal clinical interventions, and they can do MAT and they're fine, but understanding that it's based on what they need and what works for them and not what I think you should be doing. So I think there's still a lot of that mindset out there a bit like here's your cookie cutter, how you get your life back, and really, that doesn't work for people."

Court system is based on adversarial relationships, but case plans are based on collaboration. With CPS cases, the nature of the justice system can be a barrier of timely reunification. "You know, and so for CPS, particularly one of the barriers is when you come in, oftentimes you have you might have criminal charges pending, you might have dependency findings pending with the court and you have a public defender and oftentimes they will tell the individual don't talk to them about what happened because you have to, you know, wait till the courts are done because it can be used against you which I get that. But that results in people who aren't engaging with us early...it kind of ebbs and flows with who the PD is who the judge is but sometimes I think those PDs, they're they're doing their job and they have their role, but they may not really understand how that can negatively impact the person's progression towards change. Like they don't want me to talk about any don't admit to anything, which means you can talk about what needs to change. And so we you know, we're delayed by months, you know, and we have short timeframes to get those children home."

Insurance, funding, transportation, housing, food. "I think some of the social services that are needed to be successful insurance, money, transportation, housing, food, all those things that can get in the way of being able to engage in a program." **Housing and transportation.** "There's a direct correlation to the number of homeless people at our Reno clinic, to their recovery outcomes. You know, everybody wants to say fentanyl but I'm like, they don't have housing. You know what I mean, like, you're not gonna stay clean, if you don't have housing. You know, and they're not just couch surfing like, you know, like they are just living on the street." **Medicaid does not cover transportation for town and city unless patient can show physically or cognitively unable to take public transportation, but bus lines are cutting services.** "I mean, the bus lines keep cutting stuff off, there's not a lot of really good funding for in the town, in the city, because, you know, the Medicaid reimbursement actually works better for rurals, you know, to get them into places. But if not, if you can't show that physically or cognitively, you're not able

to take public transportation, then that's what you get, you know." **Transportation.** "Transportation is probably our worst barrier in our community. And that it breaks my heart."

A barrier to innovative programs within the criminal justice system is that there are people in positions of power, such as judges, that are deeply entrenched in the old moral model rather than evidence-based practices. "we have a lot of good judges in Washoe County, but we're still dealing with some old school judges here too, and that that was kind of the reason. Part of the reason why we wanted to create this program that we controlled rather than just the specialty courts, who pick and choose who they want to take you know, and so, we have our own program, and we're hoping and we have a judge to champion it."

Redundancies in assessments for one individual. "some of the redundancies that take place in assessment and identifying needs throughout that process."

Siloed providers and lack of communication. "it's the silo effect. And this is the biggest challenge. Everybody has the same goal. We just need to figure out how to how to put our goals into the same category and work together and communicate."

Provider biases against methadone as an MOUD option. "The suboxone can be super helpful. Methadone is my personal dislike towards it. Just because I feel like people use it as more of a crutch with a suboxone because methadone basically is heroin or opiates. So it's, you know, they're just, they're not clean, because they're still using them. They're using lower doses and it's supposed to be more maintained, but we've been seeing like I said, that it's people are using heroin and opiates on top of it. So but the suboxone I guess it's like a blocker. So that blocks the cravings and so they don't have the the cravings and then they don't feel the need to do it. So I feel like that's more effective. Again, that's my own personal bias." **Stigma of methadone and coordinating care with doctors and working with outside agencies, CPS, other providers.** "Probably stigma, you know, stigma with other providers, getting them to like other services, coordinating care with doctors, coordinating care of mental health professionals. You know, we do pretty good provider stuff internally, but, you know, you almost like patients are forced to be secretive about their treatment when it comes to interacting with because you can guarantee if they're getting something from their doctor, their doctor is just gonna immediately cut them off and criminalize them. So it's really, you know, and then let's not talk about dealing with CPS or, you know, other entities. So, you know, engaging, you know, you know, advocating for the patients with other providers in the community is pretty difficult to reduce some barriers."

Lack of understanding on research that supports intrinsic motivation is associated with long term recovery outcomes more so than external factors such as family members, courts, etc. " I think just support and the counseling and the accountability. And I've heard that, you know, from not just opiate users, but the drug users and alcohol users all the way around that if you have someone holding you accountable, and you're more likely to you know, think about it before you do it."

Housing for people with arrest history (violence or sexual offenders)- current resources won't take them. "a lot of the programs won't take people who have violence in their history or mental health issues or, you know, sex offenders is a big one, which I get on some level, but, you know, you can't like help the overall person if you don't, you know, you have to let I think it should be more of a case by case basis instead. of just a flat we're not going to take you because you have violence in your history. Because a lot of the mental health people when they're off their meds, or they're using meth to you know, self-medicate or heroin to self-medicate. You know, that's not like a stable situation and then they get violent and they do something stupid, but their nature when they're stabilized is not to be that way. So that I've seen as a large barrier, and a gap that, you know, they're automatically denied because of their, you know, violence

or their history or, you know, there's in different places have different rules and I mean, I get it on one level, but it also I think they need to look at it more individually."

Stigma against people with an SUD. "those that are still out there struggling need the help, and are sometimes overlooked if not all the time. And kind of the stigma of addiction or substance use disorder is frowned upon to me. I think that once you can walk past a person and not ask them if they're okay is kind of a feeling of our society has failed, because when does it become okay to leave somebody in their own puke either is behind alcohol use or a substance?"

Readiness to engage. "The barrier is I believe that they have to be ready may have to participate in their own rescue because I can go out there every day till I'm blue in the face and if they don't want to go they don't want to go."

Adequately addressing underlying mental health issues of which substance use is a symptom. "if you don't address the mental issues that go along with the drug addiction, meaning they're right back."

Patients may have been treated poorly by treatment providers in the past where a punitive or coercive system of care prevailed and are hesitant about requirements of treatment due to past trauma. "I know there are some people who are still afraid to turn into UDS because they're worried even though we've told them, it will be okay. We're not going to kick you out. You know, they've probably been lied to in the past. And they're worried that we're not being straight with them either."

Funding, insurance, accessibility, affordability, difficulty recovering in a society that glamorizes inebriation, the very real concern related to patients overdosing and dying. "funding is still a barrier." "You know, cancer is an extremely powerful disease, too. But most people don't have a set of peers in their life, who, when they hang around them fuel their cancer, you know, and so addiction is even more compounded. On top of that, not only do they have the brain and body disease, but then there's all the just pressures of society that, you know, drinking and drugging is fun and cool and interesting. And, you know, they're dealing with just trying to recover in an environment that you know, I mean, we don't live in a sober world. Let's put it that way, especially in Las Vegas. I see sickness everywhere I go, you know, like, this job has really changed that for me. I like Vegas. It's very fun here. I have a good time here. But I can't look at someone laying on the street, asking for money or even someone on vacation with a big tall drink and a bunch of huge beads around her neck was clearly you know, totally inebriated. I can't look at that as people having fun or people just making choices even though you know they certainly are. I see, I see illness, I see disease, I see addiction. And it's just so prevalent."

Access to suboxone after inpatient treatment, not enough detox facilities, insurance is a barrier to accessing appropriate treatment. "we've hit the mark on the detoxes. Sometimes we're really able to get them in there, but it's the aftercare. We don't have anything for the aftercare if we walked him up for with a prescription for suboxone to keep them stable. We're not getting it...We still don't have enough detox facilities that don't take it all the insurance you only have one that you can walk in without insurance and then they try and hook you on their insurance. It's all crazy. We need to have more. We only have two. Two! And that's why they send them to the jails or they send them to the hospital and then our hospitals are overloaded and they don't help them. They just push ‘em right out."

Insurance and wait lists. "there's times out walking straight up to the door and they are there turned around. So what are they gonna do? I can't hold their hand through the night they're gonna go. They're gonna go find something to hold them over until that time they can walk in again. So we don't have that. We don't have the ability to handhold someone to walk them straight into a place." **A barrier to accessing services is insurance and few options to choose from. Also, “patient dumping” from the**

hospitals to inappropriate services upon discharge, and lack of compassion. "barriers that people face, or that like I face as a clinician trying to get people help, like by having somebody that's like ready to go detox, and then we like, drive them to a place and they're like, oh, sorry, we don't take their insurance. And it's like, okay, well the other place is full. So like, what are they supposed to do? You know, so and then just patient dumping like that sort of stuff that happens. Just like the lack of compassion that you see. Other I wouldn't say individuals necessarily, but like these bigger entities, as a whole. It's just really frustrating and sometimes I think you can get caught up in feeling really helpless in that, like, I don't even know what to do right now. How would this person possibly know what to do right now, you know, in their worst moment, so like, yeah, so feeling like stuck when somebody wants help, and not being able to get them what they need? " **The provider describes the barriers to accessing treatment when a person is ready, noting that there are few resources and insurance is an issue.** "My least favorite thing is to see the struggle and to not be able to help you know I will go over and above my job. And sometimes it's heartbreaking to lead them right to that door when they make that change. When they're ready when they are ready and they come to you and then you aren't able to follow through the community doesn't have a follow through like a lot of these organizations. They turn them away. And they say they don't do it, yes they do. I've been standing right there when they do . It's all about the insurance and it's all about the numbers. It's not about the heart and what they need. It's it's crazy." **Insurance.** This provider stated that what the MCOs have to offer on paper differ from the services that members can actually access. The provider states that providers drop insurance plans for non-payment, leaving their patients without care and many people give up. The provider also sited lack of aftercare after discharging from an inpatient program, lack of quality group homes for people who need that type of housing, lack of education on drugs, and that methamphetamine (a commonly used drug in the region) use is often not given the attention that opioids are. "the insurance game is the worst . I mean, and then it feels so gamey." **Insurance is often a barrier to accessing care when a person is ready.** "Okay, and then that person is ready to go and they're ready. And then you might have talked to the person at Reno Behavioral Health and "oh, yeah, bring him in." When you get there and they don't have the right one. Man, that person is discouraged now. Now they're like "ah, nobody cares." And then you got the reamp went back up, just to go to maybe Well Care or something like that. So yeah, insurance is a game so when I'm working with the clients, the first thing I ask them what insurance do you have?" **Insurance is a barrier to providers as costs go up and reimbursements do not. Additionally, some plans do not cover MAT treatment at the clinic and in the end, people needing help are penalized for these systemic issues.** Moreover, this impacts agencies and their ability to pay staff a living wage. "It's tough on the patients. It's like it ruins lives. It literally ruins lives, not just for them but of their family of their loved ones...and it's like, you know, it sucks. But the bottom line is, is we also got to pay people and we got to keep the doors open." **Providers operating in health care system with for profit insurance companies refusing to pay for treatment.** "We live in a tilted economy that's favored towards a corporation that manage their care for their profits, for their profit margins, rather than the health outcomes."

The stigma of having a history of SUD prevents people from getting proper care or medication. "Oh, you're you have a history of a substance use disorder, like, sorry, I can't help you. I'm not going to prescribe this medication even though it has been like the most helpful medication for you. Because there's a risk that you might become dependent on this med." It's like, really any meds you prescribe, in some way, you're depending on that med."

Prevention education is not in all the schools due to lack of funding. "We should have somebody in every school serving those kids. And we can't we just can't we don't have we don't have the capacity. We don't have the funding. We don't have the support to really make that change. So yeah, we're hitting 15

schools a year or 20. But there's still 100 and some odd that we're not touching. So we have to make choices. is on who has a greater need? We shouldn't have to do that. We shouldn't have to choose which kids get the better who gets to get services, which don't. Because we're gonna miss those kids who really need help."

Parental attitudes towards using substances and permissive attitudes towards their children using substances are culturally derived and difficult to challenge in prevention education. "So you try to teach them the skills to do soft refusals with their parents." "Alcohol vaping marijuana, it's the three we get the most pushback on. We have people call our agency and threaten us."

Needs

More mental health services. "More mental health services. And I know this is about opioids, but I mean, it all kind of boils down in the end to a lot of people are self-medicating and they're using opioids and other drugs to self-medicate and you know, people are getting hooked on pain pills after a surgery or this or that and, you know, there needs to be more counseling and more mental health emphasis." **Street medicine to address health issues.** First aid kits to distribute--People are losing feelings in their legs. "first aid kits will be good or something because I see them leaned over so bad that they're starting to lose feeling in their legs."

Education to youth on the dangers of fentanyl. "Like it's trying to off our young kids off, our population. And we just need to get the word out. Education is key. We have to get the word out in our schools. We have to get the word out. And I don't know that we have we need more of that...We need to get more education out. Commercials, talking in schools, everything. It's huge." **Education in schools**. You know, the other gaps I feel like education like I don't feel like they're schools and the younger kids and the younger generations that really know how dangerous it is out there." **Prevention education.** "I don't see broad based preventative like education, messaging, curriculum that focuses on substance use disorder and substance use disorder prevention."

Comprehensive data collection, analysis, and outcome measures at the systems level. "so having some sort of coordinated data collection and analysis. Somebody, whether it's the county, the state, or whoever, who is educated and knowledgeable about how to analyze the problem in our community, who can work with our providers that would provide that data on what data they should be collecting, so that like we could actually study what's happening in our community in an organized manner that will actually help guide us and measure whether we're making a difference, because I think right now we just, like, throw money at the problem, and we don't have a good way to know if it's made a difference. I mean, we don't even I don't think we even look at like did it decrease the deaths? I mean, simple things, but I'm sure there are far more sophisticated analysis that could be done with all the data in the community. So just having some really smart person, you know, who can help guide this?" **CQI measures at the organizational level to ensure data is being input.** "Everybody hates documentation. Everybody hates doing the data. Everybody hates it, except for weird people like you and me. Yeah. But it's so important. It is super important. It is so important, but you know we see it in all fields within the helpers, like they want to, they want to be working with the people. They want to be down and dirty with the people. They don't want to be writing stuff down or keeping track of things."

Quantitative drug checking so that PWUDs can understand the quantity of contaminants in their drugs (e.g. Raman spectrometer, mass spectrometer). "It doesn't tell you the amount. So sometimes they think oh, it might just be a little and they'll use it anyway."

Training, low-barrier and easily accessible resources in the community (such as CCBHCs and FQHCs). "I always love training. So that's always helpful. I think trainings for models that match, like kind of what services that we are able to provide. So like, I would really love a training on I always joke I'm like, is this meth or mania? Like is this mental health related only? Or is this substance induced? Because the intervention might look a little different based on that information. And then I think again, just having more resources in our community to be able to access that don't have as many barriers." **Training and education. A training budget.** "I think training and education are both good categories. Personnel. I mean, I think we need more personnel that are treatment familiar and trained."

Upstream interventions for infants affected by prenatal substance exposure. "we're not seeing a lot of people utilize those resources that we try to get out before CPS can intervene. So I mean, we're trying but I don't know how effective we are at the prevention side will come in by then it's too late. Mom doesn't have what she needs. We end up having to remove the baby and once the baby's in foster care, it's a lot more difficult for her to get that baby back. You know, the bonding is impacted. It's it's not good for anyone. And you have a baby who has very high needs that we placed with a foster care provider who may or may not be equipped to take care of that baby that screams all the time. Yeah, you know, and they don't necessarily have that same love connection that the mom would have to be able to like overcome that."

Stigma reduction. "And I think people have certain ideas about people who use heroin or who use opiates and I think reduction of that stigma has helped. Because if I looked down on you, how are you ever you know, if someone looks down on me, how am I ever going to be able to do the hard work which requires a lot of vulnerability? To get better? I have to be able to admit what's happening. And if you're looking down on me, it's never going to happen. And so I think there's more education that has been done." **Realistic knowledge about people who use opioids & stigma reduction.** "I think some people who use opiates if they have them, they function very well. It's when they go off that they have problems. So just having more education around like what it really means we use opiates. What does it really look like? It's not like what you think about or see on TV. You know, not everybody's going to run out and sell their bodies on the street. You know, the minute they can't get it, you know? It's an It's everybody. It could be anybody. Can be your kid. Your mom, your dad, anybody."

Case management available to everyone through their insurance to navigate difficult systems. "It's hard for me to help my family member access services. And if I am a professional, I'm in a very high position at this agency. I do CQI and data and systems. If I have a hard time it's impossible for some people. Yeah. And then they're judged because they don't follow through. And so I think that case management piece is super important. Like, I feel like that should be available to everybody through their insurance to have somebody who's going to advocate for you and get you what you need. Because some people they just don't have the energy to do it. Or you know, the wherewithal."

Safe, supportive, affordable housing. "Housing. Low-cost housing...Safe housing. Supportive housing. Affordable housing."

DAS has outgrown their current building and capacity and need space and personnel to enhance their ability to serve the community's needs. "We've outgrown this building. you know, and so we want what he's talking about. We have nowhere to put it in anymore."

Lack of understanding among providers about harm reduction, MAT, and non-linear recovery process. "But there's also we've seen lately actually quite a few people who are using methadone and using heroin still are taking pills and using fentanyl on top of that, too. So, I mean, that's not good, especially when the methadone clinics are supposed to be testing them to see if they're using heroin or

not. And they're still they're actively using heroin or pills and still getting on methadone on a regular basis. So that is frustrating. And I've seen that a lot more lately. And I don't know that much about the methadone clinics. I don't know exactly what their practices are, what's going on over there, but that is not good."

Mandatory assessment if a counselor's patient dies. "This should be something more like, you know, especially like, what if it's their patient, something happens to their patient, like, there should be something more kind of mandatory, like, almost like, if you're involved in a shooting as a cop, where you got to go get some sort of assessment."

More understanding from regulatory entities. "More understanding from regulatory entities about what it is the work that we're doing, how hard it is, and how their expectations are not really realistic. It burns out staff. Because it has to be done, there's no they don't care. That doesn't matter, they're not going to accept any excuse even during COVID. They're just not." **Policies and procedures from regulatory entities specifically for MAT and long term recovery patients.** "policy set specifically for MAT and especially for long term recovery patients, than lump everybody that's in the other treatment models into this, 'cause it's completely different. So we're this, we're the square hole, and there's a round peg that fits into every other thing that they audit, and they govern, but then they just grab the hammer to pound that friggin, you know, you know, I guess we're the square peg and they're the round hole and every other agency is a round hole, that goes in there. But we're the square ones, you know, and they're the hammer that is like "you're gonna fit." It doesn't work. And it's, it's actually it's punitive to the staff. You know, it's almost like you're punished for working in this field."

Providers need to be culturally competent and state needs to be aware of the demographic makeup of Washoe County. "That's another area that I think as a whole in our community, we need to be more culturally aware of the diversity in our community." "When I go to [school] elementary school that is 95% Hispanic, I am not going to use 43.5%, which is what our diversity marker is in our community for Hispanic people through the census, I'm not going to use that marking when that that school is 95%, Hispanic. That's that's a disservice to those people. Yeah. Because you're not you're not taking into fact, of their cultural backgrounds and their identities. So there's, there's that barrier that we're facing as a reporting agency, because we get a lot, the state doesn't look at the person. They just look at the numbers."

Training for teachers so they know how to handle students who are trauma induced and a focus on social emotional learning. "Maybe we should do a little more SEL and a little more training in that aspect for teachers, so they know how to handle students who are trauma induced."

Gaps

Misinformation at local health authority about naloxone distribution. "Yep. And then so and then that, as far as from an authority standpoint, I wasn't aware that we were able to, or I'm not sure if, you know, the agency was aware that we're able to become to distribute like Naloxone or Narcan or perhaps there wasn't anyone here that felt like that was you know, something we should do or something we can do or vice versa?"

Lack of support for diversion programs: DA's office does not support diversion programs. "I will tell you that our DA's Office does not support arrest deflection as it relates to like a bridge service period."

Criminal justice system does not support harm reduction or overdose prevention centers. "law enforcement and local prosecutors and stuff have verbally stated opposition to like, overdose prevention sites are safe use consumption sites and some of that stuff, even the harm reduction efforts."

Disconnect between local support for policy and state policy. "So you know, state law really overrides that local level effort. So if there is like, broad support or regional support here, for certain policies."

More research into effective treatment for trauma. "but I think we need to do more research around like, what's going to fix the trauma because I think the trauma and the pain is what takes people back. You know, you can get through the physical addiction and get off of it. But if you still have the trauma and pain, you're going to find another way you'll go back. So I think just more we got to do more to figure out how the brain can let go of this trauma for folks and help them heal."

Acute care, options for nonclinical recovery support outside of 12-step, sober activities. I think the acute care for the mental health is super important. What else? I mean other options for recovery support. I haven't heard of a big you know push of anything other than AA and NA for those nonclinical interventions."

Licensing boards. "I feel like the licensing boards to need to have a role in like, what are the continuing if you are a MAT provider, you should have some continuing education that isn't just like it's a free for all you do what you want to get the CEUs it's, here's the new things coming up and there's recommendations from the board on like, what is the new what's the continuing education need to look like and maybe statewide, they can come up with things that have to be you have to take take this you have to know about the new research and the data and what's changed so that you're not you know, the person that's been practicing for 35 years and you're doing things as you did them when you started."

Rather than providers cut people off from medications that create physiological dependence, empower and educate them to safely titrate people off. "I think if you're going to prescribe any kind of drug that requires a step down, you should have some education on how to do that. And it's not even just opiates, but any drug that you need to step down that has some addictive quality, like you should have education around what it does to the person's brain and why you need to set them down so that they're not just cutting people off."

Mental health and housing resources for people with mental health disorders. "even the transitional housing places like they won't take people you know, on certain medications because they can't they don't have the people there like the nurses or you know, certified people to administer those drugs or, you know, keep an eye on it. I'm not exactly sure how it works, but we've had people denied because of their mental health status. And we just see a lot of habitual criminals do have mental health issues. So I would you know, definitely add in some mental health services, whether it be evaluators and counselors, and you know, the treatment centers having more access to that as well. I mean, that's kind of that's the biggest thing we've been seeing lately is there's so much mental health and there's really not that many resources, unfortunately here."

Black and Brown communities are not represented in outreach literature or education and may not see themselves as opioid dependent. "I think the ones that are affected by it, the ones that really don't know, which is the black and brown community. Like I said, I think that if it's not being used by needle or smoked by foil, that they think that the pills that come in opiate form is even better. So a lot of them are slipping into comas. I believe that the stigma, they don't see the stigma, because people aren't dying, the way they're dying. They're not partying the way they're partying. They don't see themselves as heroin users. So they're more subject to falling into the traps of not knowing and what you don't know will kill

you." (005) **Solution:** Peer outreach to BIPOC communities and representation in stigma reduction efforts to reduce disparities, increase education, saturate the community with naloxone, and advance health equity. **Outreach to BIPOC communities, youth prevention education.** "More advertising on black and brown youth. Yeah, more to put the black and brown… and more flyers. Maybe that's something I can look into making more flyers that it does affect you, it does, and it's hitting you and in the last month and a half it's been at least four black guys and women that has overdose. They might not say overdose but that's exactly what it is. You know, so however you look at it, how are you addressing it is not being addressed. More pamphlets that we can take into schools, you know, because we're at the junior high schools, three times a week. We're at the high schools and there's high school students that's overdosing too. So more literature about what's going on."

Lack of cohesive set of resources for people reentering from incarceration who are at risk. "I feel like the population of individuals leaving jail and prison is fairly untapped for us in Washoe County right now. And because it just seems like such a no brainer to me, because it's so structured...While they're still incarcerated, while they're highly motivated before they return to the people places and things that are risk factors for them in the first place."

Harm reduction, detoxes, "we don't have enough harm reduction stuff. We don't have enough detoxes. We don't have enough our waits are way too long for people."

"Safe use sites" or overdose prevention centers. "I wish that we had safe use sites here that were like medically supported like with a nurse on staff. I wish because I think that that would help in so many ways."

Low-barrier crisis centers for people who do not meet the criteria for hospitalization. "A crisis center. That's like, okay, this person doesn't necessarily need to go inpatient, but they need somewhere to stabilize just right now. Maybe they maybe they're detoxing and they don't necessarily meet medical criteria to be held in the hospital. Because they're detoxing off of meth and that's uncomfortable, but they're not going to die"

Sporadic resources. "Our resources are kind of sporadic, they kind of seem to come and go like with West Hills shutting down, that's been kind of rough and new places pop up here and there and so it's kind of it's just it's not great right now."

Coordination of care when patients are discharged from the hospital- protocols between hospital and provider doesn't match, provider unable to access patient records due to electronic system. "coordination of care with hospitals when they discharge somebody. The whole like, it just doesn't happen fluidly. You know, and it's not purposely done, maliciously done, it's just that better our you know, there's our own protocols don't match what their protocols are."

Schools are not trauma informed as the school district does not provide trauma informed trainings for counselors and do not conduct ACEs screenings. "Our district is not traumas informed centered at all. They don't they don't believe in using the ACES markers. They don't believe in using trauma informed education. So their teachers and their staff are not trauma centered." **Lack of peer support in schools for the last 10-20 years.** "There was a shift somewhere. That happened where the peers no longer wanted to do peer for work. And I'm not sure if that's because the teachers aren't presenting it correctly. And so the kids aren't interested, or the kids are just so stressed out and busy that they don't have time to do that kind of work anymore. So I don't know, there was a shift there. So I would love to get back to the peer mentor aspect and the peer, the peer conflict resolutions and, you know, really allow the kids to take that ownership. And you know, there's the handful that wants to and then there's none. So

there was a there was a cultural shift in the youth mindset somewhere. And I'm not sure when that happened, like within the last 10-20 years."

The Future

Fear of more people dying. "I mean, I'm always concerned people are gonna die."

Fears about the future include more people dying and more youth initiating use. "I mean population control. You know, so that's how I look at it. But drugs are always going to be there. I just think that if we don't educate the kids it's just going to be more and more alcoholics more you know drug use."

Fentanyl and new adulterants in the illicit supply and additional iatrogenic drug dependence. "there's always the concern, though, of course, you know, fentanyl remains. They mentioned in today's training, they said, and it's not even just fentanyl anymore. There's even new drugs that are happening, that we're even concerned about now. And then I was like, What are these new drugs? What is the next thing I need to learn about? And so there's always that fear and the worry about what is the next thing you know, as people adapt to having a tolerance for fentanyl? What else are dealers going to do to make people use and get hooked in a way that will just destroy their lives?"

Fear of what is coming and that fentanyl crisis will worsen. "Right now, I'm afraid for what we have next year what we have coming because we it has so impacted our community so heavily that we're losing people left and right and I'm worried and worried because it's impacting kids and it's impacting adults and we're just, they're dying , so I don't know. I'm scared to see what's happening next year. Every year is getting worse. It's not getting solved."

Concerned about future drug trends in the community. "I'm always concerned about that drug suppliers, as a drug suppliers will continue to come up with creative and innovative ways to wreak havoc on our community with like the level of in the danger and toxicity of the drugs that are being offered."

People Who Use Opioids/Are in Early Recovery Themes

Concerns about opioid use in community: theft and what people will do. "You need to have this drug, because you don't wanna be sick…and you're willing to pretty much do whatever you got to do to get it."

Concerns about opioid use: Participant fears that she will not be able to fully recover and she worries about people dying and what people will do to continue using. "My concern with opioid use in my life is that I won't ever be strong enough to beat that addiction. And then in the community I worry that just about all the deaths and the craziness you know like to obtain that drug what people are willing to do to get it to see how far people fall. How far I fell. It's so scary. It's sad."

Concerns about opioid use in the community: the inherent danger of seeking out a new supplier where the product may be deadly or one may be in withdrawals. "My dealer getting busted and my supply being cut-off is a big worry."

Barrier: Stigma against MAT (and especially methadone). "the stigma is huge, huge. I am finding that this has become a personal issue because it's it's hindering my sobriety because I have no support system. And so without my dad and my mom, my family, you know, I don't have anyone. So if he's not willing to be on board with my treatment, you know, what does that leave me? "

Barrier: Stigma and lack of understanding about harm reduction. "He doesn't understand the harm reduction, and he doesn't understand the whole how it brings you out of the lifestyle of the rat race, you know, the whole thing. He doesn't get it."

Barrier: Lack of coordination to treatment in medical settings. When participant was pregnant, she told the medical provider that she wanted help for her substance use and rather than being offered treatment resources, a CPS call was made. "I told the woman I said, "you know, I'd like to get some help for this situation. I'm addicted and I'm using." She walked out the room and called CPS. She didn't tell me what to do. She didn't tell me to get on methadone. She walked out the room and called CPS on me. Yeah, I couldn't believe it."

Barrier: Mistreatment in hospital and medical settings. "I told the doctor I said "I'm gonna, I need to be discharged because I need to go." It was just awful." **The stigma of a substance use disorder can also mean inhumane treatment after surgery and lack of access to proper pain relief or management.** "I was I wasn't offered any medication. Because I'm an addict. But that happens so much now. I am like labeled by [hospital] or something my chart that I'm an addict, because I go there and they don't offer me anything. I had surgery and they didn't give me any medication after surgery."

Barrier: Lack of understanding of available resources. Noted helpful resources are SSP and telehealth Suboxone provider. "all sorts you got the detox call center right there by [organization] not [organization] by Record Street. Which is I mean, if that's what you want to call that place, you got West Hills. Okay, no more West Hills. You've got NNAMHS. Okay, no more NNHAMS. They know where you've got no more exchange. So there's I mean, you got [organization] you got like those are if you want to get clean you've got [organization] you've got [organization]. Okay. Yeah, as far as that though, I know that [SSP] or [telehealth Suboxone provider], I think is magnificent. Like, that's a really cool program. So I think that should be utilized a little bit more"

Barrier: Participant's mobility is a barrier to accessing many services. "My mobility."

Barrier: criminalization versus treatment. "Modern prohibition relies on punishment as opposed to treatment, and no amount of penalization will stop the use of drugs, particularly as society becomes more difficult to negotiate and more individuals fall through the cracks and are without recourse. Methamphetamine for example is a tool for many homeless people as it negates the need to find a place to sleep or rest, something that exposes them to law enforcement harassment and/or having meager possessions stolen."

Barrier: Stigma and lack of understanding of who a person who uses drugs is versus imagined. "Public perception identifies with a stereotype that isn't necessarily true. Drug addicts live and work among us without the knowledge of others and remain hidden by maintaining control of their habit and avoiding associated problems. Wanting to alter one's perception is not anomalous among humans nor animals. Many species from elephants to butterflies get drunk when fruiting flora rots and ferments."

Barrier: Detox centers do not meet needs of patients who need MAT. Participant talks about difficulty with detox- inpatient didn't have medical beds and had to wean herself off of medication in detox center. "So, I had to pay, my dad had to pay out of pocket to go back to [treatment center]. I was scared for what happened the first time so of course I brought methadone in with me. Stupid, I get kicked out, they find it, and I kicked out. Back to square one."

Barrier: Distrust of 12-step groups & group members. "I can't trust people in NA I know what they say to fucking about. I hear what they say in the meeting, let alone what they say outside of the meeting. And you just took a selfie with me in the background? What the fuck?"

Barrier: Low quality services. Issues with retention of staff at methadone clinic prevented client from making progress in treatment. "the quality of the fucking care and everything has been shit. But the service has been like as far as like the methadone clinic and stuff like that. It's just a terrible because I was there for how many years like a year and a half and I didn't go up a level. And that's the simple fact that I kept having all these different counselors. And I couldn't go up level like you have to have a counselor to go up a level they have to put you through the board and all that. And there was no counselor do that for me." **Barrier: Poor quality treatment services.** "There was a group where I literally had the lady come, put on a video of Danny Trejo in an AA meeting doing comedy and left the room."

Barriers to recovery: high workforce turnover in counselors reinforces childhood abandonment and trust issues. Counselors are not there long enough to establish rapport or the continuity to move forward in program. "We've tried the methadone clinic. They couldn't keep a counselor in so he couldn't he couldn't make any progress in that program. Because he couldn't see a fucking counselor. Like every he would finally get one that he conversate with and then next week, the bitch would be gone. Not that she's a bitch like that. That's the high turnover rate and the counselors which makes no trust built between clients. That means Oh, look, they don't give a that's just a methadone clinic. Like I was getting pissed off for him. Just because like, how are you supposed to move on from everyday pickup? And we want and you're like trying to get your life back together. If you gotta go to the clinic every day. If you build a rapport with somebody who sees what everything you're doing, and get that your white picket fence ain't necessarily white and picket. And then they change it on you. It's fucking reinstalls those shitty ways some people grew up. It just reminds them that nobody, really nobody cares. You can't count on anybody. They're just going…and it's not necessarily their…what's going on, but that's what and that keeps them in their addiction. Or to fucking how when they kick somebody off of methadone or suboxone clinic, it's just, "Have a good day." Like and not even that like it's "bye" you know no call no nothing. You just don't get no meds. You may be broke as fuck and now sick because the methadone and fucking suboxone both come off hard to the point that we've gone from methadone to suboxone to heroin. And that was the point to get off heroin like."

Barrier: High cost of treatment. "But $3,000 a day that could be far better spent. That's what it just cost me to get help. That's what it cost me to get clean just now. No joke. Well, that's not even the whole thing because they just spent another week in there. $22,000 That was for the that was for the week last month. And for the week I just spent today just today when I had to go back to finish getting clean."

Barriers: Participant is pregnant and was not able to get timely access to Subutex or Suboxone after initiating treatment at the jail and continuing in an inpatient program. "Just it's been hard to…when I was almost out of my Subutex or Suboxone to set up an appointment within a reasonable timeframe to obtain…And they had made appointments like weeks, weeks out, and then they have to do like, I guess you have to like do intake, you know, just like a whole process before you can even get the medication. So that was really frustrating. And I can see why people relapse honestly."

Barrier: Lack of services that adequately address trauma. Participant was unsuccessful at previous attempts at treatment (detox, methadone, suboxone). Participant states that the lack of addressing trauma has kept him using for 40 years. "Failure to address the foundation for my addiction. That may not be possible as it relates to cortisol exposure during my childhood and those responsible are dead or very old."

Gap: Lack of community education and education to families about substance use and treatment, including methadone, to reduce stigma. "I think there should be more education for people. He's so against the methadone and methadone clinic, and he doesn't understand because he doesn't know. And I wish there was more education about that program, and other resources that are available."

Gaps: Participant asserts that many people do not know where or how to access services. "I think that would be helpful for people if they knew where to start. Not knowing where to start is probably the hardest part and most reasons people don't start."

Strength: Perception that there are a lot of services with easy access. "I've never had an ill experience with services. Like there's a lot of services out here actually." **Strength: There are a lot of available resources and warm handoffs are helpful.** "There's a lot of resources out there if you look" (PWOUD, #103) "there's a lot of resources out there if you look or if you… I don't know if that's the right word. A lot of resources have been offered to me and I've been very lucky. Very lucky."

Strengths: Most participants stated they found MAT and the syringe services program (SSP) helpful. "The suboxone and the needle exchange." **Strength: Syringe services program (SSP) is helpful.** Long time user of syringe exchange. "Yes, of course I use the needle exchange. Like I said, I've been using a harm reduction needle exchange since I was 17 years old and I'm 40 years old." **Strength: MAT is helpful.** In methadone maintenance therapy but still uses occasionally. "I've been at the clinic here for I think about a year and a half. And I've used sporadically here and there. So no, I wouldn't say I'm 100% clean because, you know, to be honest I've used so." **Strength: Participant found suboxone helpful.** "I kicked my narcotic habit twice with suboxone."

Strength: Safe places for people who use drugs that offer life sustaining resources and a sense of belonging and community. "I used to be there [SSP] religiously. Every morning. Fucking getting bagels or the food. But they used to let me go upstairs and take a shower, in that little bathroom upstairs. It was it was a lifesaver for sure. I could go out there. I could nod out safely. I could. I could take a nap. Yeah, and fucking eat."

Strength: Our Place has been helpful. "Our Place and the social worker there. They've been awesome. They're there are what's helping me she... They are what's helping me with you know, obtaining resources and letting me know what resources I do have. And so yeah, it's been pretty awesome."

Strength: Available IOP, MAT, recovery meetings, and recovery homes are helpful. "there's IOP of course. There's the MAT program and suboxone. There's of course the AA and NA meetings. There's different sober living places to go to so I don't know. I think that's it as far as I know."

Strength: Non-stigmatizing hospital providers. Participant reports not feeling judged or not noticing/caring if she was. "A lot of people say that they don't like going to the hospital for like abscesses because they're they feel judged, but I never felt like that I never felt or I just didn't care. But I've been twice from abscesses. And they were very professional and it was a painful experience but they took care of me." **Honesty with medical providers.** Reports always being honest with doctors. "I'm always honest with my doctors. I know enough medicine to where in conversation they recognize I'm not a stupid person. Give respect and get respect, but you have to speak their language." **Honesty with medical providers.** Participant is honest with providers as an active participant in their own health. "When I do go I'm always honest with my doctors in order to receive proper treatment. Being conversant to some extent in the language used by medical practitioners helps them to identify I'm interested in my care, if not health."

Experience with Courts and Child Protective Services

Failures of foster system during childhood as a cause of trust and mental health issues as an adult. ": I want kids that are in foster care and not you have to fucking when they timeout they've got a family to go to. So, you can go back like a foster a group home but not your forever group like you're welcome back."

Child protective services: goals for parents are not clear and parents feel unsupported by caseworkers. Participant discusses the painful experience of her newborn son entering foster care from the hospital and believes she would have benefited from a CARA Plan of Care. She describes the heartbreak of signing over her parental rights and of her older son going to live with his father. "I didn't ever have a clear idea of what I needed to be doing. So I feel like I was floundering everywhere. I was just like, I don't know where I need to be focusing my time. So I just tried to focus my time being with my son. But that's not what they wanted me to do. So I wasn't doing what they wanted. So then it was just like, I didn't never, ever know what I was supposed to be doing. I didn't feel like I was supported. I didn't feel like I could call my caseworker at any time and just talk to her and tell her how I was feeling or tell her what was going on. I mean, I have hundreds of emails I've saved over this whole situation of just me asking what am I supposed to be doing?"

CPS: Lack of standardized decision-making creates inequality. "All these caseworkers just do whatever they want, you know? It's like there should be a standard, a standard procedure for decision making, you know, and not just favorites and not based on how they feel that day. It's just so unfair. And I just think that you're already seeing these women at their worst times, they lost their kids. And then you ask them to do these things. And don't mess up. Don't mess up one bit."

Criminal justice system: specialty courts seen as something to manipulate or "game." "Like it's like when it comes to that as long as you know how to step up and play their game. You make it through real quick, a perfect program."

Treatment court: it does not work for people who are not ready ("a set up for failure") and is punitive rather than recovery focused. "I was in the drug court. I don't really have anything really positive to say. It's just that you're not gonna, if you're not ready, you're not gonna succeed in there. I also I feel like it's a set up for failure..I just feel like they they just expect you to come in and drug test and I feel like they hope you.. if you don't and it's a wrap and I don't know. I didn't feel like it focused on recovery. You know, like it didn't… But maybe it's just because I wasn't ready. Who knows. I know some people that you've seen it and in that program, but I don't I don't think I personally did because I wasn't ready."

Prison is an ineffective deterrent for behavior change. "The system sucks. Prison was great. Like I had a lot of fun in there. I learned a lot. I grew up a lot and I probably wouldn't be here today. If it wasn't that like it made me definitely a stronger person. As far as the system itself, the prison system sucks.

Experience of Using Opioids

Initiation of use: Participant began with meth but after being prescribed opioids for oral surgery, the participant enjoyed the feeling of opioids and became dependent. Due to the price of opioids, participant began using heroin.

Participant was MAT naïve but had used Suboxone on the street when heroin was not available. "I would get suboxone on the street because for when I didn't have or I couldn't get you know, heroin. But I never was a part of the program, the MAT program."

Recovery capital: Participant reports a recovery residence with accountability measures, groups, meetings, family, ex-husband, friends, and children as part of her recovery capital. "Well, I have people at [recovery residence]. I'm being held accountable by being drug tested and going to my groups and meetings. I have my family, who has always been awesome. My ex-husband, he's amazing. I have a few friends that they love me through, that love me unconditionally. Through the good and the bad, they're still there rooting for me. And my children."

Participant had an extensive history of childhood trauma, including bullying, physical abuse, medical abuse, and abandonment.

Participant stated that he felt like a "zombie" on methadone. "Because I'll still have cravings on it. But the methadone is just too fucking… I'm a zombie on it, I guess. Or I'm just different on it. It's weird."

Motivation for Change

"Being in a relationship with her pretty much and just trying to change for the better, because I was tired. I am tired of nodding out all day. Just my body can't take it anymore. I'm going to end up dead. So I needed like I need to stop for me, not for her. And that's what I am doing."

"I've been in recovery since March 22 of this year, so almost six months. It's looking good. I feel strong. I'm hopeful. I'm also scared. It's so new. But still I would be lying if I didn't say I still think about it. I think about all the people and places. It just so easy for me to obtain that you know I can go right back there. But in the meantime I can't, being pregnant and I'm just tired. I've been doing the same thing for all these years I wanna try and do something new."

"I wanted to quit because society told me in order to be a good person I had to."

Participant found cognitive behavioral therapy helpful, "So that we learned a lot about that and how to use it to in everyday life and situations."

Appendix F—Survey Responses: Barriers

Barriers—*Community Survey on Opioid Use in Washoe County*

Q23 - Is there anything else you would like to share about barriers to services?

Our family was relying on referrals and ended up in a **45 day wait list** for IOP
Housing barriers for people trying to be in recovery from opoid disorder.
almost all of the above barriers exist, this needs to be focused on way more.
The **struggle to get insurance** after you have been let go from a job because you are addicted
Addicts can not hold a job therefore don't have **insurance, transportation**, money and turn to crime to fill their overpowering need for drugs. Without access to free and convenient services, it is a vicious cycle that will not end.
Users not accepting responsibility and **demanding services and not matching the efforts**
Lack of prioritization by school districts and no funding for PBIS/MTSS **prevention programming in schools to address SU and trauma**
Something had to be done; far too many people who wander the streets who need these services. They're also in the ER's unnecessarily and inappropriately
Compassion vs persecution
More medical providers able to prescribe **suboxone** are NECESSARY and it needs to be managed so that addicts can abuse the system but have access to a provider 7-days a week and at no cost for appointment or medication.
Insurance reimbursements are lacking
The time it takes for an addict to get access to **methadone or suboxone**
Don't **punish the patients and providers who are prescribing this medications appropriately**
We as a community need to end the **stigma** of drug users,; we need to help support them so they will be open to recovery when times is right, but intil they ready for recovery we need to work to keep them safe
I've seen Alternative Sentencing in the Sparks Court turn around an addicts life.
Mental health sucks here
I would say some challenges are that people treat this like its not illegal. Maybe start locking up abusers instead of just drug dealers. They might have a better chance getting clean by being in jail as opposed to opening medical facilities where they can do drugs.
With there only being a handful of providers that are trained properly treat those who are detoxing or experiencing opioid use, it makes it challenging for those who want services to access them. There is usually a **wait list**, or they get turned away completely unless they are deemed an "emergency." Anyone who wants help, should be able to access it.
mandatory isolation of drug users and providers from public areas!!!!!!!! I see it every day
The opioid service system is significantly lacking in Washoe County. CTC is not licensed to provide adequate services. The system is not supportive of those who use drugs nor is it **supportive of the**

families that suffer and are left behind. Addiction harms more than just the addict. The cycle is recreated every day in future generations as we ignore familial implications.

Barriers to these services are the same barriers to others like for mental health…**money, insurance, transportation**, knowledge of

So much has been learned in the past decade about co occurring disorders we should really look into **evidence based services rather than aa/na**

Mental health is also a reason many don't seek treatment.

If each **silo** would stop needing to be the one to get credit and work on **stronger collaboration** I believe that more lives could be saved, more resources could be utilized, and we would have plenty of funding and providers to help.

Housing is huge, unsheltered people too often give up on sobriety & are not motivated to change.

Lack of people interested in committing to staying sober

Housing is the major issue

We need permanent supportive **housing**.

All of these are extremely important

We can do so much better

I feel bad for **people who need them**. The people Who need them are denied by insurance and/or the pharmacy. You come down hard on prescribers who are treating the patient. My friend had extensive surgery, and the doctor could only give her one week of medication. We know where the legal substances are coming from, MEXICO, and instead of targeting that problem, who ties the hands of the prescriber.

Not enough jail cells.

Cost of Living vs pay, lack of **affordable housing**, price gouging by land owners etc

Most **middle high school educators will not address getting a opioid educational program in their school**. Why ? The school system stigmatized anything educational to do with opioid education. " not my kids, not in my school". Very sad but very true !

Quit **juding people that are prescribed opioids by doctors** the **stigma** is horrible and it has gone to far!

I hope one day they have the information to

We have plenty, drug users choose not to use them.

from my perspective as a physician working in a MAT program, there is a **dearth of medical student, resident, and physician education regarding treatment of SUD**

Often than not client's run into limitation's because of **insurance**

There are also **legal and social barriers** that keep people trapped in addiction. **Housing** is crucial to recovery.

Not enough **affordable tx** programs

If you don't have **insurance** your opportunities are severely limited.

Some people manage opioids carefully to manage pain and those that have abused them ruined it for those that need it.

Lack of centralized leadership by health department - who is even in charge?
Too many diversion programs **rely on religious and/or 12 step models**
Housing is an incredibly huge challenge for our community
It's hard for addicted parents to **get and stay clean and continue to care for their children**
Housing is huge
I definitely could pick more than 5 barriers
Many drugs are so addictive - **preventing** initial use may be the greatest strategy - reducing demand and access (upstream). However, those addicted or who will be, at risk of OD, (downstream approaches) eed more supports, less **stigma, a much higher access to behavioral health and treatment services, education and harm reduction programs**
Our city is not working together. If individuals detox, they need somewhere to go so they don't immediately relapse.
Detox is a challenge for those on medicaid - mental health stabilization is a challenge for those on medicaid
When a person is on MAT and they **need medical care that requires pain management** oftentimes the physician will refuse to prescribe opioid pain meds, even for a brief recovery period. **It seems cruel that someone with OUD is forced to undergo surgeries or invasive dental treatments with no pain management.** need more education with the medical community on how they can work with people in long term recovery who continue MAT.
People suffering from SUD are in need of **affordable and sustainable housing** to increase their chances of being successful in treatment. **AA and NA has been proven ineffective as treatment yet we continue to mandate attendance for those in recovery**.
Opioid crisis in Reno is real and something needs to be done**. Drug dealers should be put away for life** as their drug deals have cost many their lives.

Appendix G—Financial Management

Financial Management	Describe how grant expenditures are separated in your accounting structure. (Job number/ categories etc.)
Upon grant acceptance, each grant is assigned an internal order (IO) number. Expenses and revenue are charged to the IO in SAP through the duration of the grant. At the conclusion of the funding period, the IO is reconciled and closed out.	
Financial Management	Describe the process your organization completes in order to have permission to incur expenses for this grant program.
Program staff complete a Purchase Authorization Request (PAR) form. The program supervisor and/or coordinator signs the form and forwards to the grant coordinator/fiscal compliance officer for signature. Then the completed form is sent to HSA Purchasing	
Financial Management	Describe how employees get permission to travel; how travel arrangements are made; and how travel expenses are reimbursed.
WCHSA has a form that requires approval for travel. Employee submits to supervisor then coordinator, then division director for approval. Bookkeeping staff makes all travel arrangements following GSA rates. The employee is required to submit receipts and then bookkeeping processes the reimbursement.	
Financial Management	Describe how an employee would purchase an item/subscription etc. for your organization. Does this process change when the item is a piece of equipment? Does the projected cost of the item change the process?
Once an employee has purchase approval, employees use HSA assigned pro-cards for purchase. Purchases up to $300 require supervisor signature, $300-$5000 Coordinator, $5000-49,999.99 Division Director, $50,000+ Admin & Finance Director. For equipment – the dollar threshold followed, but the Admin & Finance Director is required to sign	
Financial Management	Describe how your organization determines that an expense gets billed to a specific account.
The PAR includes the grant IO#. Invoices are sent to the grant coordinator and/or fiscal compliance officer to assign IO# for payment and sign. POs are set up to charge against an IO#, but invoices are still sent to grant coordinator and/or fiscal compliance officer to sign. Documents uploaded to SAP	
Financial Management	Describe how a bill/invoice gets paid.
Upon receipt, bookkeeping or purchasing sends to grant coordinator and/or fiscal compliance officer to approve for an IO. Upon approval, bookkeeping pays invoice. Documents uploaded to SAP	
Financial Management	Describe what (and where) payment information is retained for future use.
All financial information is maintained in SAP and bookkeeping staff also maintain copies of bookkeeping records in a system called Documentum.	
Financial Management	Describe the process for submitting a request for reimbursement.
The grants coordinator takes the monthly information, reviews expenditures, and then prepares the workbook, goes fiscal compliance officer (FCO) for approval and then reviewed and forwarded to division supervisor for signature. Then returned to FCO for submission to DCFS.	
Financial Management	Describe the process for bringing revenues (and reimbursements) into your organization.

When RFR is submitted, a debit memo is created, when we receive advance notice that payment is pending, match memo to receivable, bookkeeping finishes process to accept payment and move it through system. Cash Desk is the name of the process	
Financial Management	Describe the process that occurs if an expense is found to have been coded incorrectly.
Grant coordinator, fiscal compliance officer, or bookkeeping submits journal entry for approval and release to Washoe County Accounting Division for posting to correct account.	
Personnel Management	Describe how your organization hires an individual.
The agency has a website where job opportunities are posted. Applicants are screened or tested for ranking on a certified list. List is used to schedule interviews. Check references. Background checks. Employment offer is conditional on passing all background checks.	
Personnel Management	Describe how your organization completes timesheets and how employees get paid.
Through the county's SharePoint website – Employee Self Service portal that records timesheets in SAP. Employees enter their time worked on any given day, time is coded accordingly, released to supervisor for approval, and payroll is processed through 9th street central HR. Most employees are paid electronically. Comptroller has oversight of payroll.	
Personnel Management	Describe how your organization determines what position and level of compensation are appropriate for an employee.
The county uses pay group model for job descriptions and pay classifications. When staff are hired, they are hired at the pay class associated with their title.	
Personnel Management	Describe how your organization ensures that the amount of employee time expensed to a specific grant is accurate.
WCHSA uses time studies for employees or employees are 100% coded to a grant. Employees code time in 15 min increments. Employee time is automatically goes to the grant or payroll is journal entry to a grant	
Property Management	Describe how often inventory is reviewed and when the last inventory was completed.
Annually at the county level. Inventories are due June 30 of each fiscal year end. Last one started in July 2021 and completed by September.	