Washoe County Opioid Use Disorder Community Needs Assessment

2026-2030

Washoe County

Community Reinvestment | Office of the County Manager

Washoe County Opioid Use/Opioid Use Disorder Community Needs Assessment Needs Assessment

Contents

Acknowledgements

The Washoe County Opioid Use/Opioid Use Disorder Community Needs Assessment would not be possible without collaboration from our community partners. Special thanks to Heather Kerwin, Division of Public and Behavioral Health, for her collaboration on Qualitative Findings. Deepest thanks Dr. Karla Wagner, University of Nevada, Reno and Sarah Maynard, University of Nevada, Reno for their assistance with the Quantitative Findings, and to Christopher McCoy, Public Service Intern Washoe County for his work collecting the Secondary data. 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. None of this would have been possible without the active participation of the Steering Committee over the course of the year.

Agencies/Organizations

The Washoe County Opioid Use/Opioid Use Disorder Community Needs Assessment was led by the Washoe Opioid Abatement and Recovery Fund (WOARF) which manages and distributes the Opioid Settlement Funds. WOARF conducted outreach to the following agencies:

Alternate Public Defender
Black Wall Street Reno
Boys and Girls Club of Northern Nevada
Bristlecone
Catholic Charities of Northern Nevada
Chrysalis Light Recovery Homes
City of Reno Clean and Safe Team
Community Health Alliance
Department of Alternative Sentencing
Eddy House
EMPOWERED – Roseman University
Empowerment Center
Families' CrossRoads
Great Basin Chaplain Core
Join Together Northern Nevada (JTNN)
Karma Box Project
Men's CrossRoads
Mill Street Care Center
Molina Healthcare
National Alliance on Mental Illness (NAMI) Nevada
Nevada Department of Health and Human Services
Nevada Opioid Center of Excellence
Nevada Overdose Data to Action (NVOD2A)
Nevada Urban Indians
Northern Nevada Behavioral Health
Northern Nevada Harm Reduction Alliance
Northern Nevada Public Health
Public Defender's Office
Regional Emergency Medical Services

Authority (REMSA)
Regional Medical Examiner
Reno Behavioral Healthcare Hospital
Reno Fire Department
Reno Initiative for Shelter and Equality
Reno Justice Courts
Reno Police Department MOST
Reno Sparks Indian Colony
Renown Regional Medical Center
Safe Babies Court Team
Second Judicial District Court
SilverSummit HealthPlan
Sparks Police Department MOST
Step 1
Step 2
The District Attorney's Office
The Life Change Center
Truckee Meadows Fire Protection District
University of Nevada, Reno
WakeUp Nevada
Washoe County Emergency Management
Washoe County HOPE Team
Washoe County Human Services Agency
Washoe County Housing and Homeless Services
Washoe County Library
Washoe County Regional Medical Examiner's Office
Washoe County Sheriff's Office
Women's CrossRoads

Abbreviations

ACEs - Adverse Childhood Experiences
ASAM - American Society of Addiction Medicine
BIPOC - Black, Indigenous, and People of Color
BCOS - Building Communities of Support (NNHRA program)
CBPP - Community-Based Participatory Practice
CBPR - Community-Based Participatory Research
CDC - Centers for Disease Control and Prevention
CHA - Community Health Alliance
CHW - Community Health Worker
DARE - Drug Abuse Resistance Education
ED - Emergency Department
EMS - Emergency Medical Services
FQHC - Federally Qualified Health Center
FCR - Families CrossRoads
HCV - Hepatitis C Virus
HIV - Human Immunodeficiency Virus
HOPES - Northern Nevada HOPES (Healthcare for Optimum Personal Excellence and Success)
HSA - Human Services Agency (Washoe County)
IOP - Intensive Outpatient Program
JTNN - Join Together Northern Nevada
LEAB - Living Experience Advisory Board
MAT - Medication-Assisted Treatment (also MOUD)

MOUD - Medication for Opioid Use Disorder

MOST - Mental Health Outreach Safety Team

NA - Narcotics Anonymous

NAMI - National Alliance on Mental Illness

NNHRA - Northern Nevada Harm Reduction Alliance

NOFO - Notice of Funding Opportunity

NRS - Nevada Revised Statutes

OD2A - Overdose Data to Action

OOD - Opioid Overdose Deaths

OTP - Opioid Treatment Program

OUD - Opioid Use Disorder

PDMP - Prescription Drug Monitoring Program

PEP - Post-Exposure Prophylaxis

PrEP - Pre-Exposure Prophylaxis

PRSS - Peer Recovery Support Specialist

PWLE - People with Living Experience

PWUD - People Who Use Drugs

REMSA - Regional Emergency Medical Services Authority

RISE - Reno Initiative for Shelter and Equality

ROSC - Recovery-Oriented System of Care

SAMHSA - Substance Abuse and Mental Health Services Administration

SDOH - Social Determinants of Health

SNAP - Supplemental Nutrition Assistance Program

SSP - Syringe Services Program

STAR - Support, Treatment, Accountability, and Recovery (program)

SUD - Substance Use Disorder

SWAT - Special Weapons and Tactics

WCSO - Washoe County Sheriff's Office

WOARF - Washoe Opioid Abatement and Recovery Fund

YRBS - Youth Risk Behavior Surveillance System

Executive Summary

The Washoe Opioid Abatement and Recovery Fund (WOARF) conducted the Washoe County Opioid Use/Opioid Use Disorder Needs Assessment (Need Assessment) to identify the strengths, needs, and gaps for for addressing opioid use disorder (OUD), prevention, treatment, recovery, and risk reduction services in Washoe County. NRS 433.742 requires the use of community-based participatory research (CBPR) as a methodology to conduct local Needs Assessments. WOARF invited community members into the process as equal partners, which builds relationships and generates trust and buy-in. The gathered data are from multiple sources, including surveys, focus groups, community meetings, and stakeholder feedback, and will inform the allocation of opioid settlement funds.

The Needs Assessment process was guided by a Steering Committed and a Living Experience Advisory Board (LEAB). The combined roles of the Steering Committee and

the LEAB provided a dual framework for the Needs Assessment process. The Steering Committee ensured institutional oversight, strategic alignment, and stakeholder accountability. The LEAB ensured living experience was at the center of survey design, outreach, and interpretation. Their combined contributions guaranteed that the process was comprehensive, inclusive, and responsive to the needs of the community. By incorporating both institutional expertise and living experience, Washoe County established a model of participatory governance that strengthens the legitimacy and effectiveness of the resulting strategies for opioid abatement and recovery.

The Needs Assessment revealed some current practices inadvertently create barriers to recovery. Addressing these systemic issues is as important as adding new services. These structural barriers are discussed at length in Section Five and Section Six.

Findings

Treatment Access & Navigation

Washoe County faces barriers to opioid use disorder (OUD) treatment at every point in the care continuum. The immediacy of access is critical, yet delays in assessments, stabilization, or treatment often cause people to miss their short window of readiness for change. Long waitlists, insurance denials, and lack of real-time navigation discourage individuals and reinforce hopelessness.

Many residents are unaware of available services, who qualifies, or how to access these critical service. This is compounded among people who are houseless. Survey respondents were concerned about people's ability to access services but felt that services were accessible, suggesting greater concern about coordinating and navigating people to appropriate services than expanding services. Community outreach workers have been successful in connecting disconnected populations to care, but funding for these positions ended in October 2025. Once individuals enter treatment, they often lack ongoing navigation or coordination support across systems, leading to relapse and disengagement from care.

Housing & Recovery Stability

Lack of stable housing undermines all treatment efforts. Washoe County has insufficient housing, particularly for low- and middle-income households. Interview participants emphasized that recovery cannot begin or be sustained without a safe place to live. Housing was identified as the number one funding priority. Without it, individuals face instability, stress, and relapse even after treatment. Recovery-friendly and low-barrier housing options are limited, leaving many to return to unsafe environments that jeopardize progress.

Behavioral Health Workforce

Washoe County's ability to provide sustainable quality substance use treatment is undermined by challenges with recruiting and retaining quality professionals. The behavioral health workforce is strained by low pay, burnout, and limited professional development. Staff frequently experience secondary trauma and receive few supports for their own mental health. Providers reported gaps in training—particularly around trauma-responsive care and approaches for "treatment-resistant" individuals. Peers with lived experience are underpaid, undertrained, and often trapped in entry-level roles without clear career advancement pathways.

Minimizing Morbidity and Mortality

Washoe County continues to experience overdose rates higher than state and national averages, between March 2024 and February 2025 179 people died of an overdose death. [1]. Despite strong community support for minimizing morbidity and mortality associated with opioid use and clear evidence of its effectiveness, recent funding changes have created service gaps. Stigma and discrimination from healthcare providers and community members further deter people who use opioids from seeking help or treatment. As one mother shared, "they can't seek recovery if they're dead."

Family & Youth Supports

Substance misuse in Washoe County is intergenerational, often rooted in family trauma and instability. Participants stressed the need for whole-family treatment approaches, noting that addressing parents without engaging children perpetuates the cycle. Youth in the County have higher-than-average substance misuse rates and limited access to pro-social activities and mental health supports. Prevention education in schools is inconsistent and outdated, relying on abstinence-only models that youth perceive as irrelevant or untrustworthy.

Systems Coordination

Systemic barriers—such as fragmented services, low reimbursement rates, loss of Medicaid coverage, and competition among providers—create disjointed care. Participants identified a lack of collaboration and shared data across agencies, which prevents coordinated case management and hinders service quality. Furthermore, the

[1] Centers for Disease Control and Prevention. (2025, September 5). *Mapping injury, overdose, and violence dashboard*. U.S. Department of Health and Human Services. https://www.cdc.gov/injury-violence-data/data-vis/index.html

absence of program evaluation data makes it difficult to identify effective programs or guide referrals, perpetuating inefficiencies and missed opportunities.

Intercepting Justice Involvement

Community members with OUD are often routed through the criminal justice system rather than treatment. Each month, an estimated 130 people with OUD will have their treatment in the community interrupted. Among individuals who receive services in the jail, lack of a coordinated reentry process will disrupt any progress gained. Delays in treatment, lack of coordination with community providers, and inadequate reentry supports lead to relapse and repeated justice involvement.

Next Steps

The WOARF team will develop an initial funding plan for 2026-2027 based on the recommendations in the Needs Assessment. In 2027, WOARF will re-evaluate progress on the priorities and emerging needs in collaboration with the Steering Committee to develop the 2028-2029 Funding Plan. In 2029, WOARF will begin work on the 2030-2033 Needs Assessment. In 2026, WOARF will also develop recommendations for community providers based on the feedback in the Needs Assessment.

Overview of the Needs Assessment Process

The Washoe Opioid Abatement and Recovery Fund (WOARF) conducted the Washoe County Opioid Use/Opioid Use Disorder Needs Assessment (Need Assessment) to identify funding priority strategies for addressing opioid use disorder (OUD), prevention, treatment, recovery, and risk reduction services in Washoe County. The Need Assessment sought to gather comprehensive data from multiple sources, including through surveys, focus groups, community meetings, and stakeholder feedback, to inform the allocation of opioid settlement funds.

Washoe County, in collaboration with the State of Nevada and other jurisdictions across the state, litigated against pharmaceutical companies and other distributors of prescription opioids that played a role in the opioid epidemic. Through this partnership, Washoe County is set to receive approximately $41 million over the course of 20 years to address the opioid epidemic through evidence-based, strategic initiatives in alignment with community needs. As of October 2025, $10.4 million has been received. Washoe

County plans to utilize the funds to coordinate regional efforts and collaboration to address the needs identified during the Needs Assessment process.[2]

NRS 433.742 requires the use of community-based participatory research (CBPR) as a methodology to conduct local Needs Assessments. CBPR is a method of analysis conducted with communities, inviting community members into the research process as equal partners and contributors.[3] CBPR has been linked to reducing health disparities[4] 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.[5] By inviting community members into the process as equal partners, this process builds relationships and generates trust and buy-in.

Section One: Governance and Advisory Structure

To ensure the Needs Assessment process was both evidence-based and community-informed, two advisory bodies were established:

1. The Steering Committee, composed of institutional partners and community stakeholders, including people in recovery and loved ones of people who use opioids.
2. The Living Experience Advisory Board (LEAB), composed of individuals with living experience of substance use disorder.

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[2] *Office of the county manager*. Washoe Opioid Abatement and Recovery Fund. (n.d.). https://www.washoecounty.gov/mgrsoff/divisions/Community%20Reinvestment/WOARF/index.php

[3] 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

[4] 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

[5] 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.

These bodies played distinct but complementary and equal roles in shaping the tools, implementing the outreach, and interpreting the results of the assessment.

The Steering Committee

The Steering Committee served as the ongoing feedback loop that grounded the Needs Assessment in local expertise and community realities while advancing toward clear outcomes. They met monthly from December 2024 through November 2025 and provided guidance on all phases of the assessment. Membership consisted of diverse community stakeholders, including people in recovery, loved ones of people who use opioids, representatives from healthcare, behavioral health, criminal justice, social services, and community-based organizations. Throughout the process, an open-door policy was maintained, allowing new participants to join at any time. While attendance fluctuated, this approach expanded participation and ensured a wide range of community voices were included.

The Steering Committee advised on the Needs Assessment research question, process, and tools. Steering Committee members provided input into the design of the community survey and focus group protocols to ensure comprehensiveness and cultural responsiveness. Initial feedback on the findings of data collection was provided by the Steering Committee to WOARF staff to aid in the interpretation of results. The Steering Committee participated in activities that gave context to the structural challenges in the community and the feasibility of potential recommendations. To determine the final recommendations, the Steering Committee provided feedback on the impact, feasibility, urgency, and equity of each possible strategy. As a critical component, the Steering Committee ensured transparency of process and maintained alignment with the goals and values of WOARF.

Steering Committee Meeting Structure:

Meeting Date	Meeting Topic	Meeting Outcome
12/9/24	Identify the Values of the Work	Values of the Needs Assessment Steering Committee (Appendix B)
1/13/25	Determine the research question	
2/12/25	Initial review of the Survey Guide	
3/19/25	Finalize the Survey Guide and Dissemination Plan	Final Survey Guide (Appendix C)
4/16/25	Review and Finalize the Focus Group Interview Guide for Community Organizations	Interview Guide for Community Organizations (Appendix E)

5/20/25	Review and Finalize the Focus Group Interview Guide for People with Living Experience	Interview Guide for People with Living Experience (Appendix E)
6/25/25	Initial Review of Secondary Data	Refined and added to the data collected for the secondary data section
7/16/25	Counterproductive thinking activity	Worksheet (Appendix F) Notes incorporated in Section Four Qualitative Data
8/20/25	Review of Strategies to Take to the Community Meeting	List of Strategies in Section Seven
9/29/25	Strategy Prioritization	Recommendations in Section Seven
11/13/25	Final Review	

Organizations that participated on the Steering Committee:

Black Wall Street Reno
Boys and Girls Club of Northern Nevada
Bristlecone Family Resources
Catholic Charities of Northern Nevada
Chrysalis Light Recovery Homes
City of Reno Clean and Safe Team
Community Health Alliance
Department of Alternative Sentencing
Eddy House
EMPOWERED – Roseman University
Empowerment Center
Families' CrossRoads
Great Basin Chaplain Core
Join Together Northern Nevada (JTNN)
Karma Box
Men's CrossRoads
Mill Street Care Center
Nevada Department of Health and Human Services
Northern Nevada Harm Reduction Alliance
Regional Emergency Medical Services Authority (REMSA)
Reno Initiative for Shelter and Equality
Reno Justice Courts
Reno Sparks Indian Colony
Second Judicial District Court
Sparks Police Department MOST
The Life Change Center
Truckee Meadows Fire Protection District
University of Nevada, Reno School of Public Health
University of Nevada, Reno Larson Institute
WakeUp Nevada
Washoe County Human Services Agency
Washoe County Regional Medical Examiner
Washoe County Sheriff's Office
Women's CrossRoads

Through these activities, the Steering Committee functioned as a key forum for community participation and guidance.

The Living Experience Advisory Board (LEAB)

The Living Experience Advisory Board (LEAB) was created to ensure the direct inclusion of individuals with living experience of substance use disorder in the Needs Assessment. This body was critical for ensuring the Needs Assessment reflected authentic community realities. The LEAB was created as a separate space to create safety for people who are actively using substances, allowing them to speak on their unique experiences in a closed format.

The LEAB met biweekly from February to March 2025 to provide input on survey design and receive training in data collection methods. Beginning in April 2025, LEAB members conducted surveys within the community, reaching individuals who may not otherwise have participated or completed the survey. The survey closed in June 2025. In October 2025, the LEAB reconvened to review survey responses, qualitative interviews, and community meeting findings, discuss interpretation, and provide feedback on final recommendations.

The LEAB had key roles and responsibilities in the development of the Needs Assessment including:

- Survey Development: Guided the design of the survey to ensure accessibility and clarity for community participants.
- Community Outreach: Directly engaged community members in completing surveys, leveraging trust and peer connections to increase response rates.
- Data Interpretation: Reviewed results and provided context rooted in living experience, ensuring findings were grounded in real-world challenges and opportunities.
- Capacity Building: Enhanced the skills of LEAB members in survey administration, research ethics, and community engagement.

The LEAB's direct involvement in survey design, implementation, and interpretation added a layer of authenticity and inclusivity to the Needs Assessment that would not have been achievable through stakeholder input alone.

The combined roles of the Steering Committee and the LEAB provided a dual framework for the Needs Assessment process. The Steering Committee provided institutional oversight, strategic alignment, and stakeholder accountability. The LEAB centered living experience at every stage including survey design, outreach, and interpretation.

Together, these bodies created a process that was:

- Transparent: Open-door participation and recurring meetings created multiple feedback loops.
- Inclusive: Direct engagement of individuals with living experience balanced the perspectives of institutions and providers.
- Credible: Broad community participation and rigorous oversight to increase trust in findings.
- Action-Oriented: Recommendations emerging from the process were both evidence-based and grounded in the realities of Washoe County residents.

The advisory structures of the Steering Committee and the Living Experience Advisory Board were foundational to the success of the WOARF Needs Assessment. Their combined contributions ensured the process was comprehensive, inclusive, and responsive to the needs of the community. By incorporating both institutional expertise and living experience, Washoe County established a model of participatory governance that strengthens the legitimacy and effectiveness of the resulting strategies for opioid abatement and recovery.

Section Two: Secondary Data

Secondary quantitative data sources were identified by the Steering Committee Members and Washoe County stakeholders to inform a robust perspective on opioid use/misuse within Washoe County. Reports from community partners were requested to add additional nuance to the local landscape, including from existing Washoe Opioid Abatement Recovery Fund (WOARF) grantees. The WOARF grantee data was analyzed to describe the initial impact of the funding in the community and the other data sources were analyzed across the life-course to better understand regional trends related to opioid use/misuse.

Washoe Opioid Abatement and Recovery Fund (WOARF) Grantees

In 2022, Washoe County conducted the first Opioid Use Needs Assessment. The top five priorities in the 2023-2025 Washoe County Opioid Use Needs Assessment, the projects funded to meet the identified needs, and the results of their first year of funding are below:

Ensure funding for the array of opioid use disorder (OUD) treatment services for uninsured and underinsured Washoe county residents.

Northern Nevada HOPES, Opioid Treatment Expansion Project: Northern Nevada HOPES (HOPES) was funded to create an opioid treatment program at a clinic in a high need and under resourced area, directly adjacent to the homeless shelter. The addition of opioid treatment at this new site provided at-risk community members with easily accessible and low-barrier treatment options. In June 2025, the project expanded to cover the cost of care for uninsured and underinsured individuals at the 5th street location. Additionally, HOPES launched a Street Outreach health care team that includes a therapist and a Peer Support Specialist who engage unsheltered individuals directly in the field.

During the first year of the grant, HOPES treated 19 underinsured and uninsured clients at their MAT Clinics and filled 71 MAT prescriptions for new and existing uninsured and underinsured clients. Of these clients 18 (95%) were assessed for holistic services within 30 days of enrollment and 14 (78%) of those assessed were referred to additional support within 30 days of their assessment. Seven (36%) uninsured or underinsured clients were connected to Peer Support Services. HOPES provided care to 112 individuals during the year. The new street outreach team connected with 15 individuals in its first three weeks of operation.

Ridge House LLC, OUD Outpatient Service: Ridge House was funded to provide OUD outpatient services to justice-involved individuals including intensive outpatient programming, group therapy, individual therapy, individual counseling, peer support, case management, family therapy, couples counseling, and aftercare. The OUD Outpatient Services project will provide services to Washoe County residents who are uninsured and underinsured.

As of October 1, 2025, the Outpatient Service project has not launched. In the meantime, Ridge House has provided treatment services to 10 uninsured and underinsured individuals. Of those who have discharged from the program, two-thirds were considered successful discharges. WOARF is working closely with Ridge House to launch outpatient services.

Initiating buprenorphine in the emergency department, as well as during inpatient hospital stays, and care navigators to assist with setting up outpatient resources for continued care and management.

There were no projects funded under this initiative in the 2024 Notice of Funding Opportunity process because no applications were submitted. WOARF is participating in ongoing conversations to identify and eliminate barriers.

Use a multidisciplinary approach to providing overdose prevention outreach and education, inclusive of under-resourced communities, such as BIPOC communities, in a culturally and linguistically appropriate manner (organizations, media, churches).

Northern Nevada Harm Reduction Alliance: The Northern Nevada Harm Reduction Alliances' (NNHRA) Building Communities of Support (BCOS) program was funded to address the needs of people who use drugs (PWUDs) in Washoe County through comprehensive harm reduction strategies, community engagement, and advocacy, led by the expertise and leadership of individuals with lived experience. BCOS embedded Harm Reduction Outreach workers who have lived experience in communities to provide targeted outreach, safer use supplies, and overdose education (including rescue breathing) and naloxone distribution (OEND) to PWUD, developed an advisory council of PWUD to guide program activities, outreach, and education, provided community education on OEND, drug checking supplies, and training on the NNHRA's contaminated drug phone app, and engage families and communities in developing a destigmatizing and supportive environment for PWUD. In September 2025, NNHRA merged with the Reno Initiative for Shelter and Equality (RISE). RISE will continue the project through the end of the grant period.

Over the past year, the program conducted five training events, reached 1,377 individuals through outreach, and developed new educational materials to support overdose awareness. A total of 904 people were trained across multiple sectors, with the majority being individuals at risk of overdose. The program distributed 2,581 naloxone kits. Nearly all (98%) of training participants reported understanding how to prevent overdose following participation. In addition, outreach efforts connected with 505 individuals who use opioids, linking 59 (12%) to additional services or supports.

Join Together Northern Nevada (JTNN) Partnership for Prevention: JTNN was funded to provide outreach to people who are unhoused and use opioids and develop a media campaign to reduce stigma. The outreach to unhoused people who use opioids included connecting people to care through Uber Health rides. The media campaign will

focus on increasing awareness of harm reduction and Nevada's Good Samaritan Law, decreasing stigma, and educating the public on access to and use of Naloxone.

Over the past year, the program conducted eight overdose prevention training events and reached 28 individuals through outreach. A total of 64 people were trained across multiple sectors, with the majority being community organizations. The program distributed 1,223 naloxone kits. Nearly all (82%) of training participants reported understanding how to prevent overdose following participation. In addition, outreach efforts connected with 28 individuals who use opioids, linking 22 (78%) to additional services or supports. In addition to their outreach efforts, JTNN provided Uber Health rides to 2,451 health care appointments through partnerships with healthcare providers. These Uber Health rides meant that people had transportation and were able to keep appointments they otherwise would not have.

Implement child welfare best practices for supporting families impacted by substance use.

Human Services Agency (HSA) CrossRoads Families: HSA's Families CrossRoads (FCR) project, in partnership with RISE, established a facility where parents reside with their children to engage in recovery together. The project addresses the needs of families impacted by opioid use disorder (OUD) through a comprehensive, family-centered approach implementing child welfare best practices to support family stability, promoting family reunification, and preventing child removals. FCR offers a holistic environment where families can rebuild relationships, receive comprehensive support, and transition to independent living together- thereby reinforcing the family unit and interrupting the cycle of trauma and OUD. FCR utilizes a Therapeutic Community model that leverages the community as an agent of change, promoting a family-centered approach that, recognizes the recovery of an individual is closely linked to the well-being of their family. Holistic support services address the physical, psychological, social, and economic needs of both parents and children, thereby enhancing recovery-oriented outcomes and promoting long-term stability.

The FCR program purchased an apartment building and moved in their first two families in June 2025. Four more families had joined by October 2025. Four of the parents were seeking to maintain custody of their combined seven children and one parent was seeking to reunify with his two children. Family members of those involved with CrossRoads can benefit from the resources at FCR without directly moving into the program. Three families who are not enrolled in the program have been able to establish visitation and engage with Family Services programming including community activities, trauma-informed family counseling with the Family Services Coordinator, and community meetings. Since moving in, one family's pending termination of parental

rights case has been dismissed. Additionally, the community culture around “it takes a village” has begun to form among the participants. For example, one participating mother knew another parent and their daughter with enough familiarity and comfortability that she was able to support soothing efforts without undermining the parent's care plan for de-escalation.

Increase detoxification and short-term rehabilitation program capacity.

Bristlecone Family Resources Medical Detox Building: Bristlecone Family Resources will establish a 20-bed detox center in Reno, focusing on equitable access to care, improved continuity of care, and the availability of medication-assisted treatment (MAT) services. Building the detox center provides essential infrastructure to support individuals needing immediate medical intervention for opioid use disorders, ensuring a safe environment during withdrawal. Equitable access is facilitated by accepting Medicaid, utilizing current funding through grants, and providing comprehensive services to uninsured and low-income populations.

As of October 1, 2025, Bristlecone Family Resources has fully spent their grant award, and construction has halted due to insufficient funds. WOARF continues to collaborate with Bristlecone Family Resources to identify solutions.

Secondary Data Through the Life Course of Opioid Use in Washoe County

In addition to the WOARF funded programs, many organizations are addressing opioid misuse in Washoe County. To understand the unique factors contributing to opioid misuse and the incumbent associated morbidity and mortality it is important to review local surveillance data and data regarding current local responses to the opioid epidemic. Washoe County data is drawn from a variety of publicly available databases and on request from programs serving our community. As OUD impacts the health and well-being of people across the course of their life, the following information will follow the life-course of opioid exposure.

Youth Exposure

Research shows substance exposure for both infants and teens is correlated with negative long term health effects that can persist well into adulthood.[6] Substance use in adolescence is associated with increases in acute and long-term morbidity and

[6] Kang J, Kim H J, Kim T, Lee H, Kim M, Lee S W et al. Prenatal opioid exposure and subsequent risk of neuropsychiatric disorders in children: nationwide birth cohort study in South Korea *BMJ* 2024; 385 :e077664 doi:10.1136/bmj-2023-077664

mortality. Longitudinal studies show heavy adolescent substance use correlates with poorer verbal learning, memory, and attention in later years.[7]

Youth Exposure to Parental Substance Use

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; case management; crisis intervention and short-term mental/behavioral health services; medical, legal and long-term mental health services; and other supportive services.

Figure 1 reflects data provided by Washoe County Human Services Agency's (HSA) Children's Services Division from 2022-2025 on Children's Services removals of children from their parents.[8] The overall number of child removals decreased from 345 children in 2022 to 294 children in 2023 and increased in 2024 to 331 children but did not reach 2022 levels. Overall, there has been a decrease in the number of child removals from 2022 to 2024. In 2022, there were 133 substance-related removals reflecting 38.6% of all removals in Washoe County, that proportion increased in 2023 to 51% (150 child removals), and in 2024 decreased 34.4% (114 child removals). The data suggests parental substance-use is a primary contributing factor to children's removal from their parents and there have not been overarching policy or procedural changes that have influenced the reduction in substance-related child removals.

[7] Gray KM, Squeglia LM. Research Review: What have we learned about adolescent substance use? J Child Psychol Psychiatry. 2018 Jun;59(6):618-627. doi: 10.1111/jcpp.12783. Epub 2017 Jul 17. PMID: 28714184; PMCID: PMC5771977

[8] Washoe County Human Services Agency, Child Services Division. (2022–2025). *Children's Services Division Removals Data*. Washoe County.

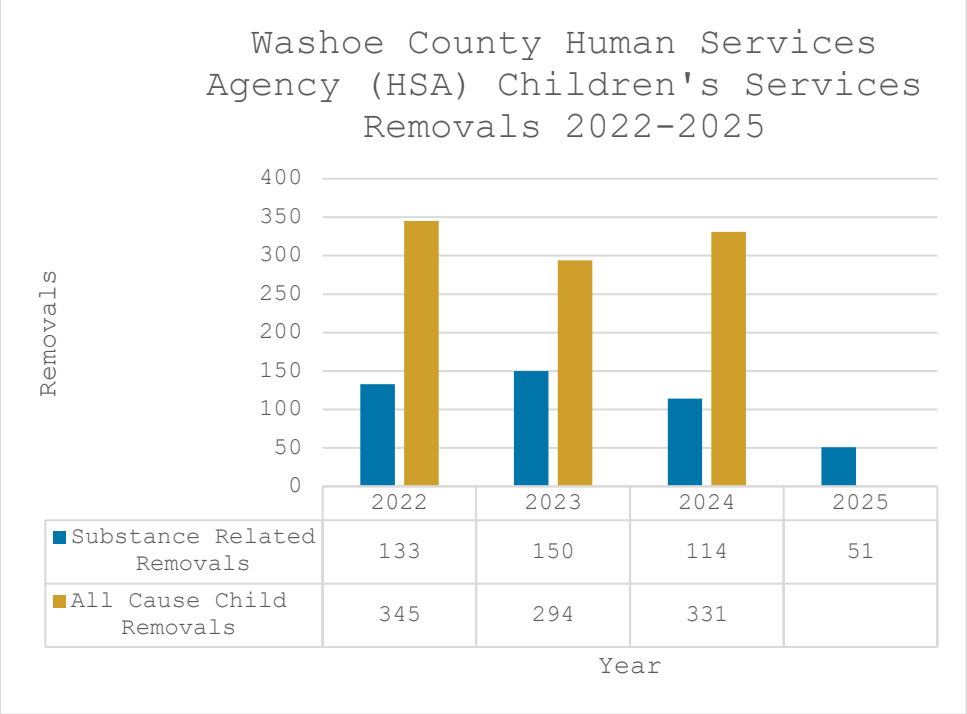

Figure 1 data from Washoe County Human Services Agency (HSA) Children's Services Division 2022-2025

Adolescent Substance Use

Data shared in the recent State of Mental Health in America 2025 report indicated Nevada ranked 48th out of 50 states and DC regarding youth SUD.[9] 10.05% of Nevada youth ages 12-17, or 25,000 youth, had a SUD.[10]

The Youth Risk Behavior Survey(YRBS) is a national survey conducted by the Centers for Disease Control and Prevention every two years to monitor health behaviors and experiences among middle school and high school students in the United States. The survey includes questions regarding lifetime substance use. Figures 2-5 present 2013-2023 YRBS data on student self-reported substance use.[11] The data indicates that high school students in Nevada and Washoe County consistently report higher rates of methamphetamine and heroin usage than the national average for high schoolers

[9] Mental Health America, The State of Mental Health in America 2025, https://mhanational.org/the-state-of-mental-health-in-america/
[10] SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/state-releases
[11] Centers for Disease Control and Prevention. (2013–2023). *Youth Risk Behavior Survey (YRBS) data*. U.S. Department of Health and Human Services.

(Figures 2 and 4). Similarly, heroin usage rates among Washoe County high schoolers were higher than Nevada high schoolers until 2021. Lifetime heroin usage rates among middle schoolers in Washoe County were higher than the state usage rates until 2021 when Nevada usage rates began to outpace Washoe County's. For the most part, middle schoolers showed a lower usage rate of methamphetamines in Washoe County compared to Nevada. Overall substance use rates among high schoolers declined between 2013-2023 but among middle school students, substance use rates began to increase in 2023.

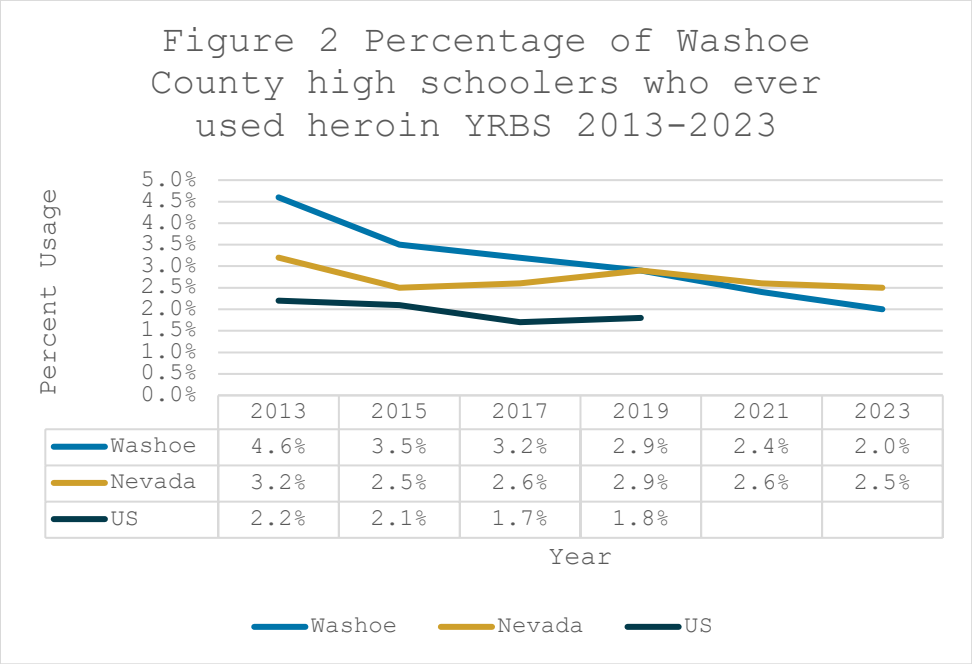

Figure 2 data from 2013-2023 Youth Risk Behavior Survey (YRBS)

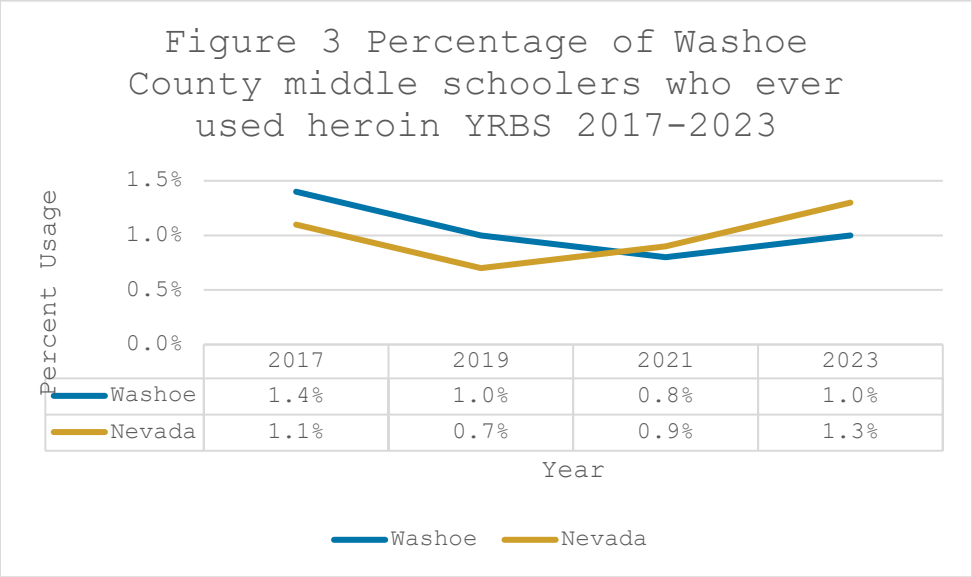

Figure 3 data from 2017-2023 Youth Risk Behavior Survey (YRBS)

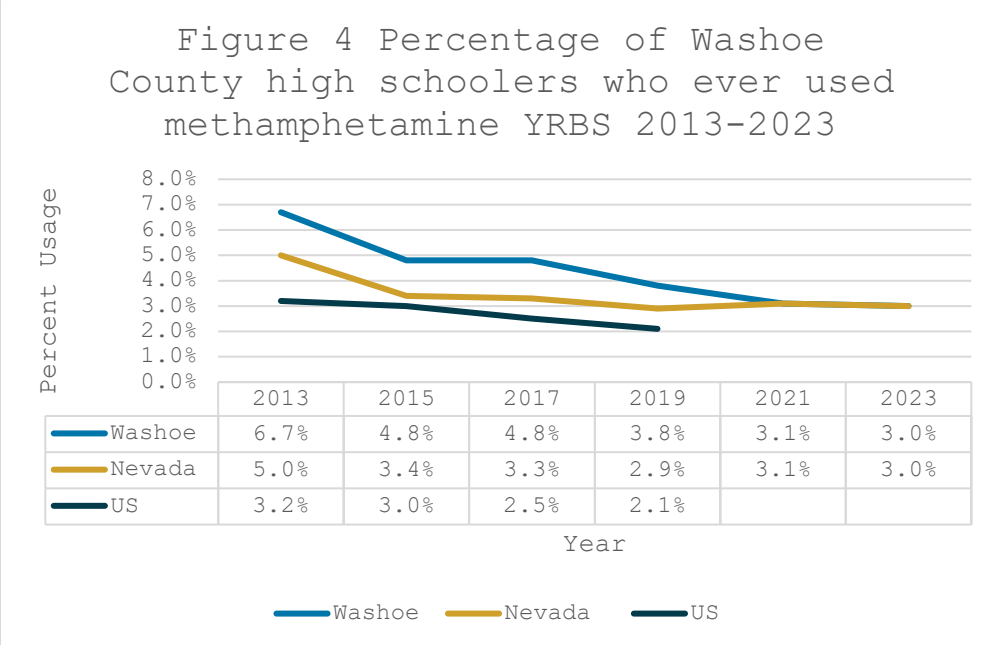

Figure 4 data from 2013-2023 Youth Risk Behavior Survey (YRBS)

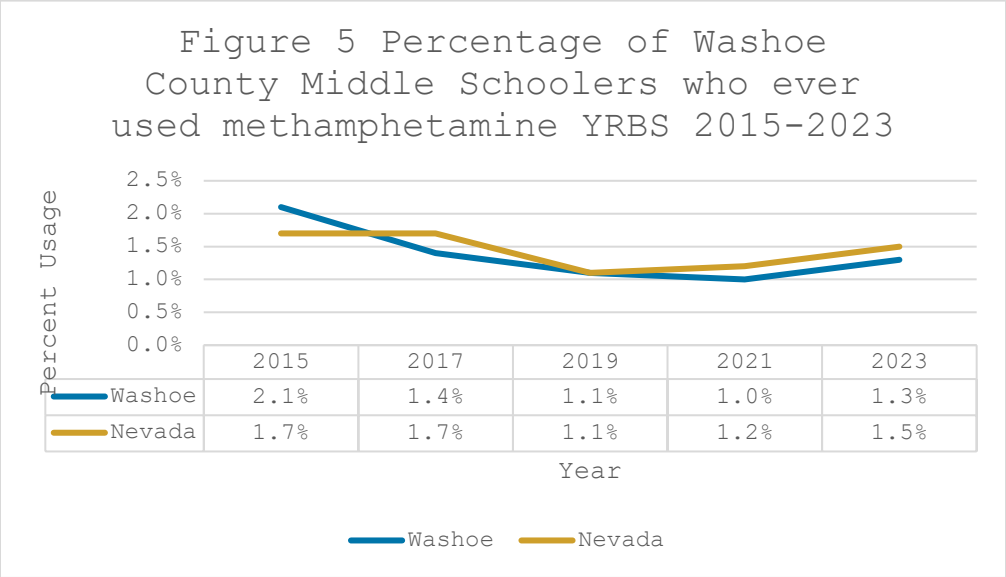

Figure 5 data from 2015-2023 Youth Risk Behavior Survey (YRBS)

Adult Exposure

Mental health in Nevada continues to rank the lowest in the nation.[12] One of the measures that has the largest effect on Nevada's rank is the 553,000 adults with a SUD (22.45% of the population).[13] Of the adults in Nevada with a SUD, 471,000 did not receive any needed treatment, this is over three-quarters (78.12%) of Nevada adults with a SUD.[14] To best support individuals who are ready to stop using substances, treatment must be easily accessed and immediate.[15]

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[12] Mental Health America, The State of Mental Health in America 2025, https://mhanational.org/the-state-of-mental-health-in-america/

[13] SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/state-releases

[14] Substance Abuse and Mental Health Services Administration. (2024). Key substance use and mental health indicators in the United States: Results from the 2023 National Survey on Drug Use and Health (HHS Publication No. PEP24-07-021). Table A.34B. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, https://www.samhsa.gov/data/sites/default/files/reports/rpt47095/National%20Report/National%20Report/2023-nsduh-annual-national.pdf

[15] Mental Health America, The State of Mental Health in America 2025, https://mhanational.org/the-state-of-mental-health-in-america/

Housing in Washoe County

Previous research has found there is a correlation between houselessness and illicit drug use.[16] Whether people start using substances because of losing housing or they lose housing because of a SUD, people who are houseless are more likely to be successful in treatment if they are stably housed.[17,18] Washoe County Housing and Homeless Services Division leads the community in building a system that can house people so homelessness becomes rare, brief, and non-recurring. On January 22, 2025, in Washoe County, 1,389 individuals were homeless living in shelters. According to the Reno Housing Needs Assessment[19] there is a need for roughly 9,058 new affordable (below 80% Area Median Income) housing units over the next 10 years in the City of Reno. The housing shortage disproportionately impacts lower income people and families.

Washoe County Sheriff's Office Forensic Science Division Crime Lab Data

Figure 6 illustrates data from the WSCO Forensic Science Division Crime Lab from 2022-2024 regarding the substances tested. These data provide a partial picture into what is happening within the drug supply. Only substances that will be used as evidence in court are tested for their chemical composition. Methamphetamine has consistently been the most frequently identified illicit drug found in substances tested by the Crime Lab each year suggesting methamphetamine continues to be the most prevalent substance used in the community. Fentanyl was the second highest reported illicit drug identified and has increased from 15% to 23% between 2022 and 2024 while heroin decreased from 6%-2% mirroring other data suggesting fentanyl has largely replaced heroin in the illicit drug market. Crime Lab statistics assessing for the presence of fentanyl found fentanyl or a fentanyl derivative in 365 samples since 2021. Since 2021, fentanyl has only been found mixed in samples with cocaine four times (1%), with cannabis one time (0.2%), and methamphetamine 13 times (3.5%). Even samples

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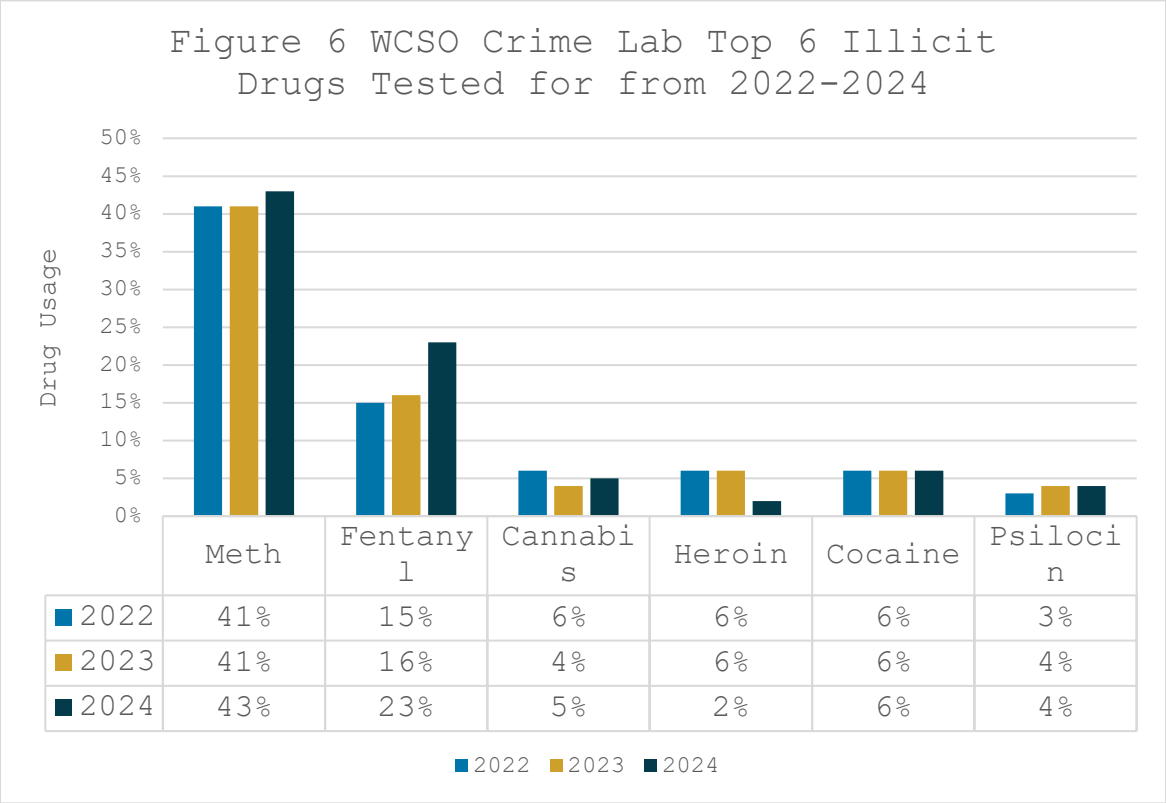
[16] Tomassini, S., O'Brien, A., Desmond, D., et al. (2022). Substance use and homelessness: A longitudinal interview study. *Substance Use & Misuse, 57*(12), 1921–1930. https://pubmed.ncbi.nlm.nih.gov/35961238

[17] National Low Income Housing Coalition. (n.d.). *The evidence is clear: Housing First works* [PDF]. https://nlihc.org/sites/default/files/Housing-First-Evidence.pdf

[18] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. (n.d.). *Choice matters: Housing models that may promote recovery for individuals and families facing opioid use disorder* (ASPE). Retrieved October 2, 2025, from https://aspe.hhs.gov/reports/choice-matters-housing-models-may-promote-recovery-individuals-families-facing-opioid-use-disorder-0

[19] *Housing Needs Assessment*. Retrieved October 2, 2025, from https://experience.arcgis.com/experience/3648fb373dbb4fe58c972d8aad8316c6/page/Housing-Needs-Assessment

mixed with heroin were limited to just 15 (4%). This suggests that contrary to the common myth that “fentanyl is in everything,” fentanyl is not regularly or commonly being mixed with other substances. Over the past three years, xylazine was present in just four samples, suggesting xylazine has not yet reached Washoe County.



	Meth	Fentanyl	Cannabis	Heroin	Cocaine	Psilocin
2022	41%	15%	6%	6%	6%	3%
2023	41%	16%	4%	6%	6%	4%
2024	43%	23%	5%	2%	6%	4%

[20]

Figure 6 data from the Washoe County Sheriff's Office (WSCO) Forensic Science Division 2022-2024

Community Based Medication Assisted Treatment (MAT) Data

Medication Assisted Treatment (MAT), also known as Medication for Opioid Use Disorder (MOUD), is the use of FDA-approved medications including methadone, buprenorphine, or naltrexone in combination with counseling and behavioral therapies to treat OUD. MAT and MOUD are considered the gold standard of OUD treatment. To expand treatment, a former requirement that physicians obtain a special waiver to prescribe buprenorphine for OUD was eliminated in 2023, allowing any licensed provider to prescribe buprenorphine like any other medication.

[20] Psilocin along with psilocybin are naturally found in “Magic Mushrooms.” The psilocybin compound itself is biologically inactive but in the human body to psilocin to cause hallucinogenic effects.

Community Health Alliance MAT Program

Community Health Alliance (CHA) is a non-profit, Federally Qualified Health Center, that provides comprehensive, affordable medical, dental, and behavioral health services to underserved communities in Reno and Sparks, Nevada. CHA started providing MAT services in January 2024, and since then they have served 112 participants. Figure 7, based on data from CHA, shows that 89 (79.5%) MAT participants at CHA were covered by Medicaid or Medicare-indicating low income, older age, or disability.[21] There are a small number of individuals entering the program without any health care insurance (n=7, 6.25%), suggesting there are still people who do not have insurance that need access to treatment.

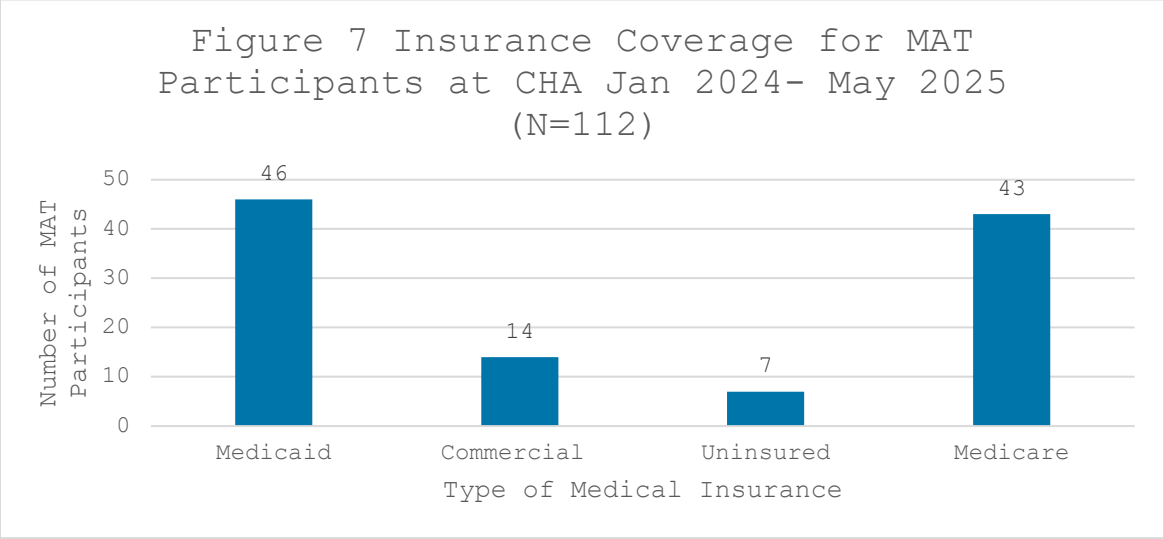


Figure 7 data from Community Health Alliance (CHA)

Northern Nevada HOPES MAT Program

Northern Nevada HOPES (HOPES) is a non-profit, Federally Qualified Health Center, that provides comprehensive, affordable medical, and behavioral health services to underserved communities in Reno and Sparks, Nevada. HOPES began offering MAT services in 2018. Since 2020, HOPES has seen 896 unique patients in their MAT program and billed 11,754 treatments.[22] Figure 8 represents the insurance types billed since January 1, 2020. One participant could have cycled through more than one insurance billing category over the course of their treatment. Nearly half (49.9%, 5,869) of insurance types billed since January 1, 2020, were Medicaid. Self-pay, or individuals

[21] Community Health Alliance. (2025). *Medication-assisted treatment (MAT) program data*.

[22] Northern Nevada HOPES. (2025) Medication Assisted Treatment Program Data.

paying without any insurance coverage accounted for almost a fifth (19.2%, 2,252) of all billings.

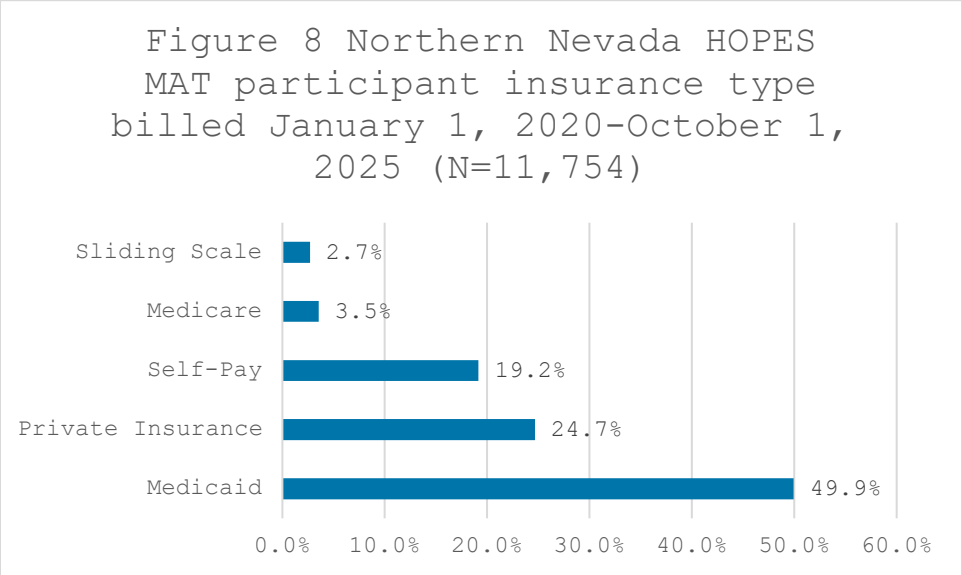


Figure 8 data from Northern Nevada HOPES

Prescription Drug Monitoring Program

A prescription drug monitoring program (PDMP) is a database that tracks controlled substance prescriptions. Figure 9, based on data from the Nevada PDMP shows that despite changes to make buprenorphine more widely available, there has been a steady decline in the amount of Suboxone (buprenorphine) prescriptions in Washoe County between 2020 and 2025.[23]

[23] Nevada Department of Health and Human Services, Office of Analytics. (2020–2025). *Prescription Drug Monitoring Program (PDMP) data*.

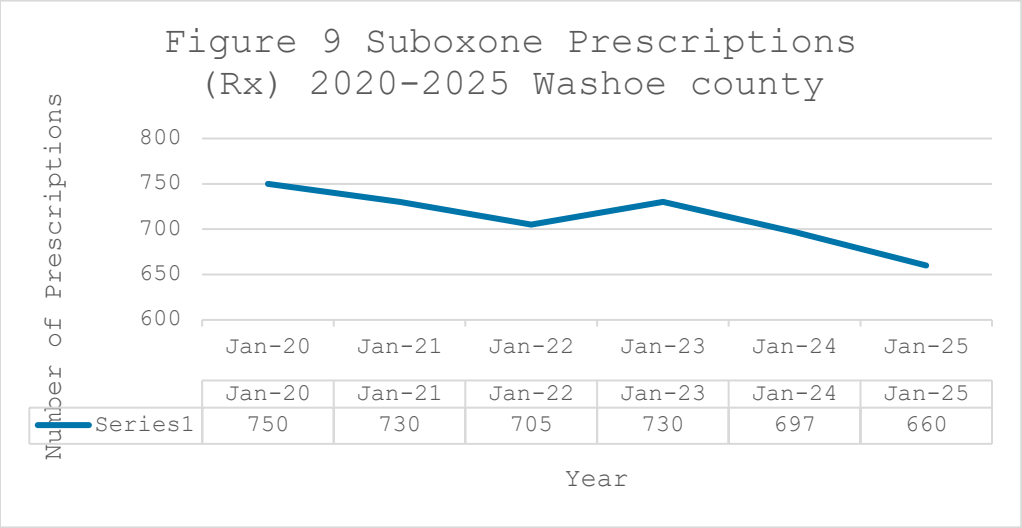


Figure 9 data from the Nevada Office of Analytics, Prescription Drug Monitoring Program (PDMP)

Community Behavior Change Programs

CrossRoads Data

CrossRoads is a Washoe County Human Services Agency (HSA) lead initiative that provides a tiered supportive housing approach for men, women, women & children, and families. The CrossRoads program focuses on identifying, intervening, and stabilizing Washoe County residents with traditionally moderate to higher complexity needs through effective programming, services, community collaboration, and access to a continuum of care. Men's, Women's, Women's & Children, and Families CrossRoads work with members to improve their health, establish safe places to live, engage in purposeful living and build communities.

Men's CrossRoads program data was collected between July 1, 2024-June 30, 2025, on the essential building blocks of recovery. During this time 110 members were admitted to Men's CrossRoads, 63% of whom were exited successfully.[24] The average length of stay among graduates was 285 days. Prior to entering CrossRoads, 35 members were admitted to the hospital, 12 of whom were admitted more than once. Twelve members were admitted to the hospital during their time in the program representing a 75% reduction in hospital admissions. Nearly all members engaged in mental health supports (98%) and established primary care (83%) while at CrossRoads. Among all members, more than two-thirds (69.5%), had established forms of income when leaving CrossRoads, while 82.3% of members who made it past the 30-day induction period had an established income. Over three-quarters (77.9%) of all members obtained housing upon departure, and 84.8% obtained housing if they stayed

[24] Washoe County Human Services Agency. (2025) Men's CrossRoads Program Data.

beyond the induction phase. Arrests among members also decreased from 36 arrests or rearrests prior to CrossRoads to 8 during their stay at CrossRoads, a 75% reduction.

Figure 10 includes data from Men's CrossRoads showing members drug(s) of choice. The top five include methamphetamine (n=53, 55.8%), alcohol (n=52, 54.7%), fentanyl (n=24, 25.3%), opioids (n=23, 24.2%), and cannabis (n=17, 17.9%). In this data members chose their primary, secondary, and tertiary drugs of choice.

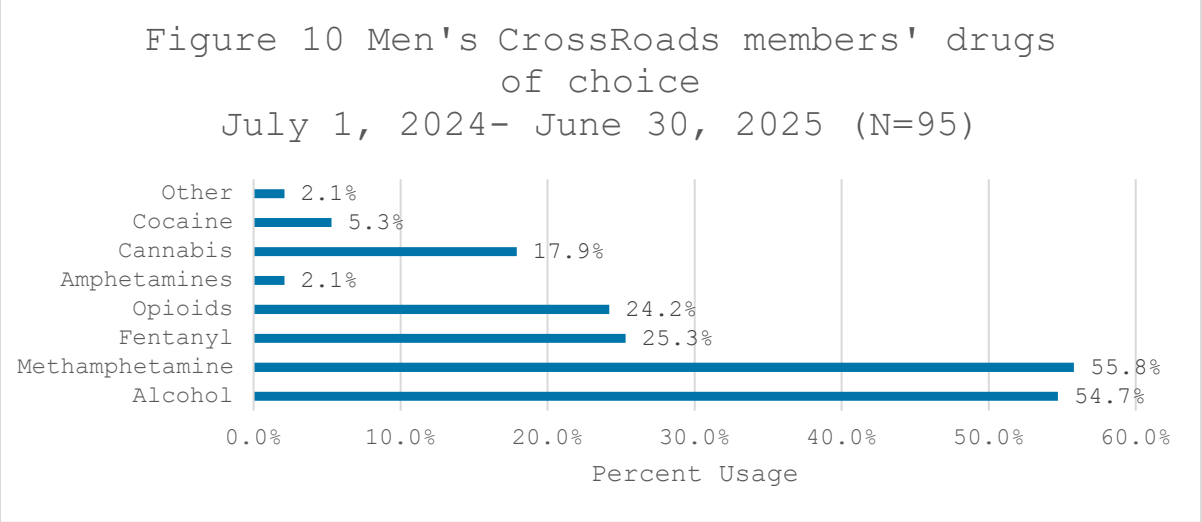


Figure 10 data from Men's CrossRoads 2024-2025

Women's CrossRoads also collected data from July 2024-June 2025 for their members regarding the essential building blocks of recovery. During this time there were 87 members served with an average length of stay of 89.8 days.[25] The members had 87 hospital stays prior to CrossRoads and 11 during CrossRoads an 87.36% decrease. Sixty-six members reported being arrested prior to admission while five members were arrested or rearrested while at CrossRoads, 92.4% decrease. Over half of all members (54.4%) obtained a source of income upon departure, most (80.7%) members were involved in recovery support upon departure, and nearly all (89.5%) were engaged in mental health support while in the CrossRoads program. The majority of members (85.9%) had obtained a form of housing when they departed the program.

Figure 11 includes data from Women's CrossRoads demonstrating members drug(s) of choice. The top five included methamphetamine (n=84, 96.6%), alcohol (n=55, 63.2%), opioids(n=38, 43.7%), cannabis (n=28, 32.2%), and fentanyl (n=17, 19.5%).

[25] Washoe County Human Services Agency. (2025) Women's CrossRoads Program Data

From July 2024-June 2025, Women's and Children's CrossRoads served 19 members.[26] Prior to enrollment, members had 25 hospital stays, during their time at CrossRoads members had 10 hospital stays, a decrease of 60%. Nine members were arrested prior to joining CrossRoads and there were no recorded jail stays for members during their time in the program. Ninety-three percent of members had obtained a form of income upon departure from the program, 100% of members who departed the program had a form of stable housing upon their departure, and 87% of members were involved in recovery support upon departure from the program.

Figure 12 includes data from Women's and Children's CrossRoads demonstrating members' drug(s) of choice. The top five were methamphetamine (n=15, 78.9%), alcohol (n=7, 36.8%), opioids (n=7, 36.8%), fentanyl (n=6, 31.6%), and cannabis (n=5, 26.3%).

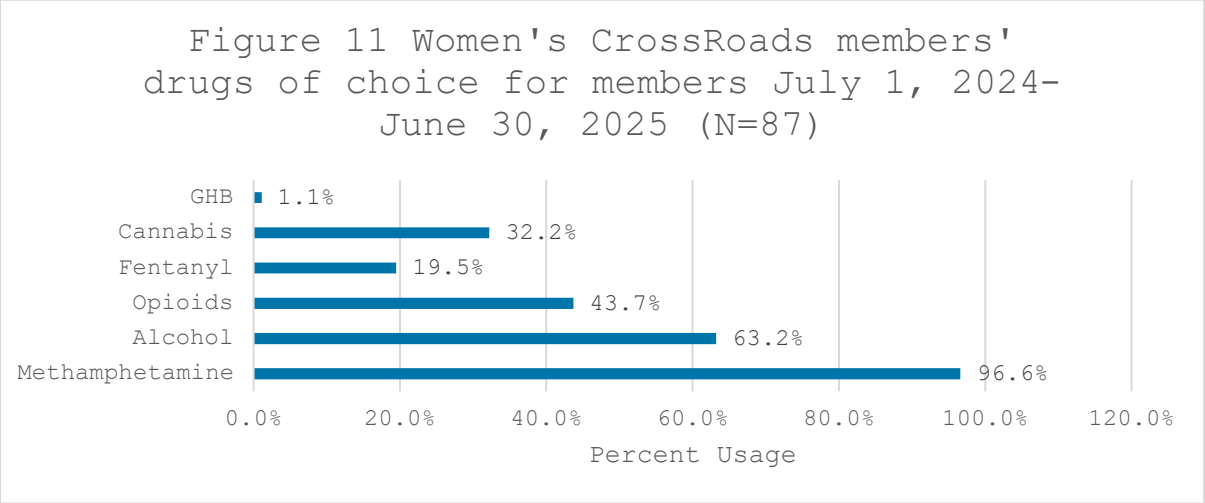


Figure 11 data from Women's CrossRoads 2024-2025

[26] Washoe County Human Services Agency. (2025) Women's and Children's CrossRoads Program Data

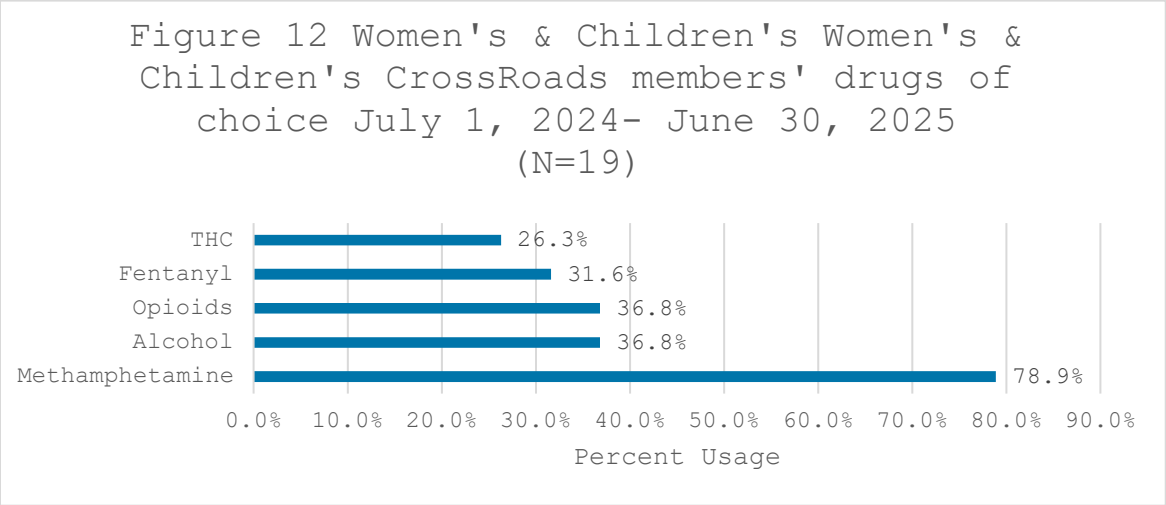


Figure 12 data from Women's and Children's CrossRoads 2024-2025

Criminal Legal System Interventions

MAT Court Data

The Second Judicial District Court's MAT Court is a specialized program that provides intensive court supervision and treatment for defendants with opioid or alcohol use disorders. MAT Court docket had 84 Active cases in annual year 2024.[27] Thirty-four participants in MAT court received in-patient treatment and 52 received outpatient treatment in 2024. The data in Figure 13 illustrates the combined primary and secondary drug-of-choice for participants in the MAT Court in May 2025. More than two-thirds of participants (n=28, 71.8%) reported opioids as a primary or secondary drug of choice.

[27] Second Judicial District Court of Nevada. (2024). *Medication-Assisted Treatment Court docket data*.

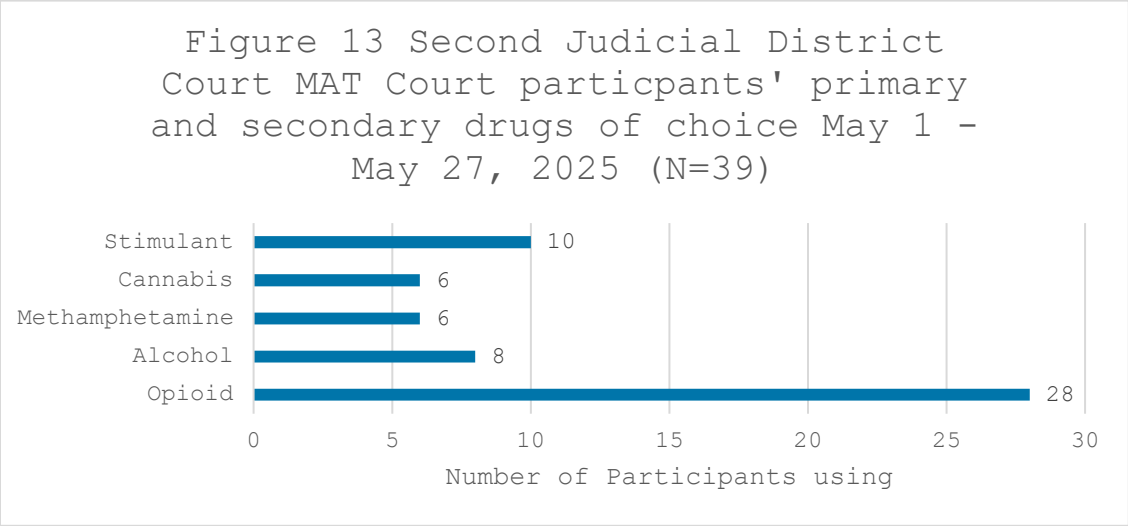


Figure 13 data from the Second Judicial District Court, Medication-Assisted Treatment Court 2025

Washoe County Department of Alternative Sentencing STAR Program Data

The Washoe County Department of Alternative Sentencing STAR program provides wrap-around, community-based treatment services and community supervision for individuals struggling with OUD through 4 stages: Support, Treatment, Accountability, and Recovery. The process is approximately 12 months, with aftercare, and consists of a probation officer, peer support specialist, case manager, and a clinician to help the process of recovery. [28] In 2024 there were eleven successful graduates.

Figure 14 provides data from the STAR program. Out of 6,527 drug tests ordered in 2024, participants missed 790 tests for an 88% compliance rate. Of the 5,737 tests taken in 2024 23% were positive (1,315 tests). The rates of positive tests declined over months 1-7, followed by an increase in positivity beginning at month 8 after people exit intensive outpatient programming, and a decline to 0% positivity for months 22-24. The number of tests ordered decreases as participants exit the program.

[28] Washoe County Department of Alternative Sentencing. (2022–2024). *STAR Program Data*.

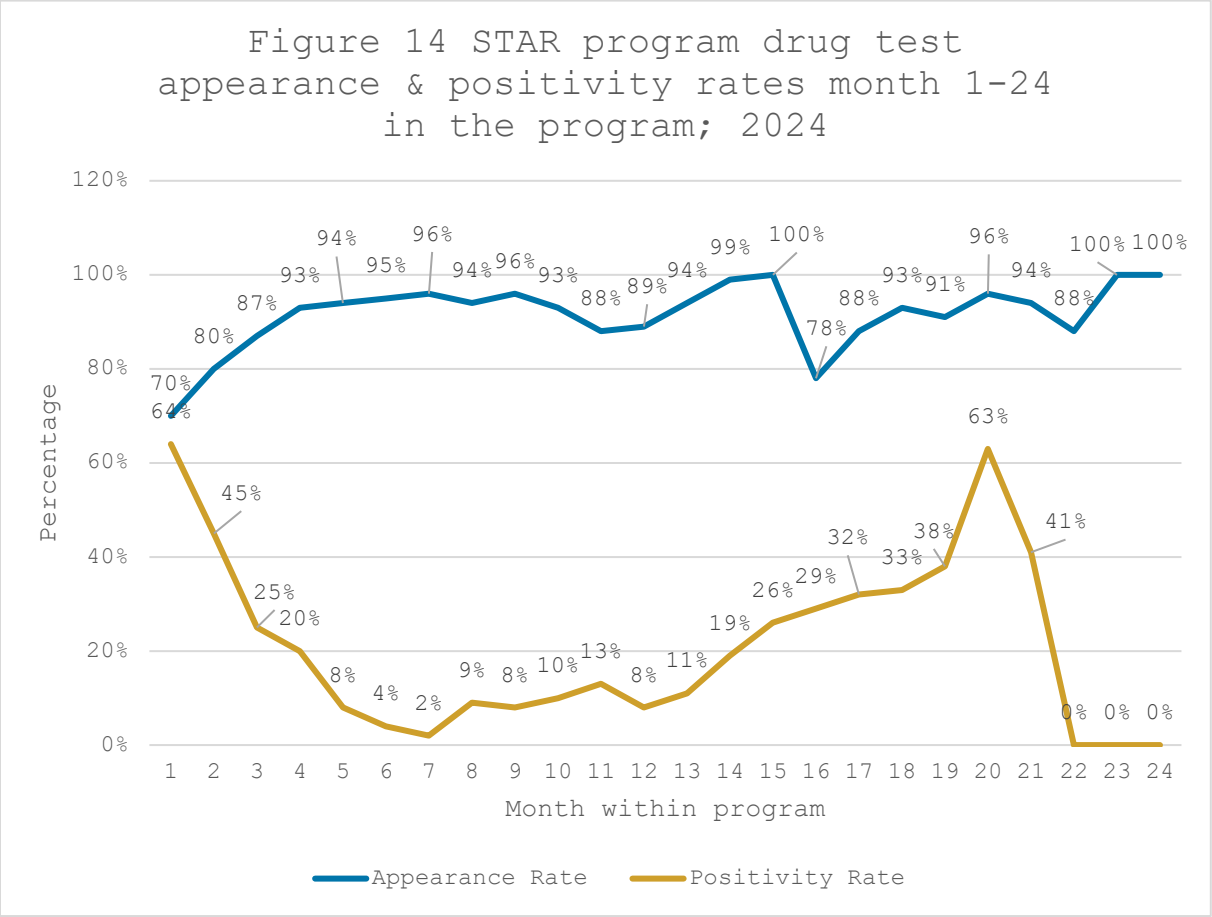


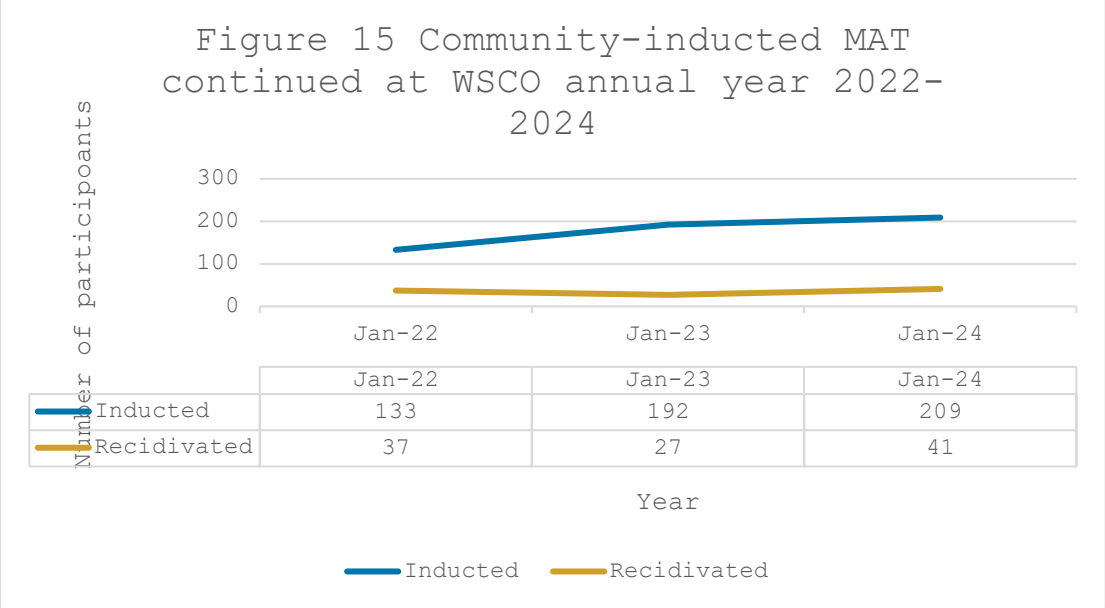
Figure 14 data from Washoe STAR

Washoe County Sheriff's Office Detention Center - MAT Program Data

Washoe County Detention Center is one of the only detention centers in Nevada certified as an Opioid Treatment Program (OTP) by the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide medication-assisted treatment (MAT) for opioid use disorder within the jail system. The Washoe County Sheriff's Office (WCSO) authorized the MAT program in 2019 to help the incarcerated population get treatment for alcohol and opioid addiction. WCSO offers three types of medication: 1) buprenorphine (Subutex), 2) methadone, 3) naltrexone (Vivitrol). This provides a unique opportunity to connect people struggling with opioid use with access to treatment. As of July 2025, there were 39 people on MAT in the jail. On average 130 people test positive on intake per month. The average monthly number of participants is 37 people, or roughly 28% of individuals testing positive at intake.

Figure 15 provides data from the WSCO regarding community members of who were already receiving MAT in a community program prior to being arrested who remained on

the medications while incarcerated at the jail.[29] The figure also highlights the number of MAT participants who recidivate. Recidivism is defined by WSCO as a member of the MAT program, whether they are convicted or not, who is rearrested within a year after being released from the detention facility. During 2022, 37 people recidivated (27.8%), in 2023, 27 people recidivated (14.1%), and in 2024, 41 people recidivated (19.6%). There is no national measure of rearrest for detainees.



	Jan-22	Jan-23	Jan-24
Inducted	133	192	209
Recidivated	37	27	41

Figure 15 data from the Washoe County Sheriff's Office (WSCO) State of the Sheriff's Office Report 2024

Washoe County Sheriff's Office Detention Center - The Bridge Program Data

The Bridge program at the Washoe County Sheriff's Office is an evidence-based re-entry program, tailoring services to assist individuals as they transition back into society after incarceration. The program empowers individuals to thrive within their neighborhoods, workplaces, and families. Figures 16-19 provide The Bridge program data collected through a self-assessment completed by 300 program participants.[30] Figure 19 highlights the social damage that can occur from substance misuse, with 63% of respondents stating how drugs/alcohol either ruined relationships or caused frequent fights or tension in relationships. Over half (56%) of respondent's stated they use drugs

[29] Washoe County Sheriff's Office. (2024). *State of the Sheriff's Office report*. Washoe County Sheriff's Office.
[30] Washoe County Sheriff's Office. (2025, May 14). *Data-driven pathways to reentry success: Findings from the self-assessment needs survey (Self-sufficiency & behavioral health assessment report).* The Bridge Program, Washoe County Sheriff's Office.

or alcohol every day however 54% of respondents felt they could handle avoiding substance on their own.

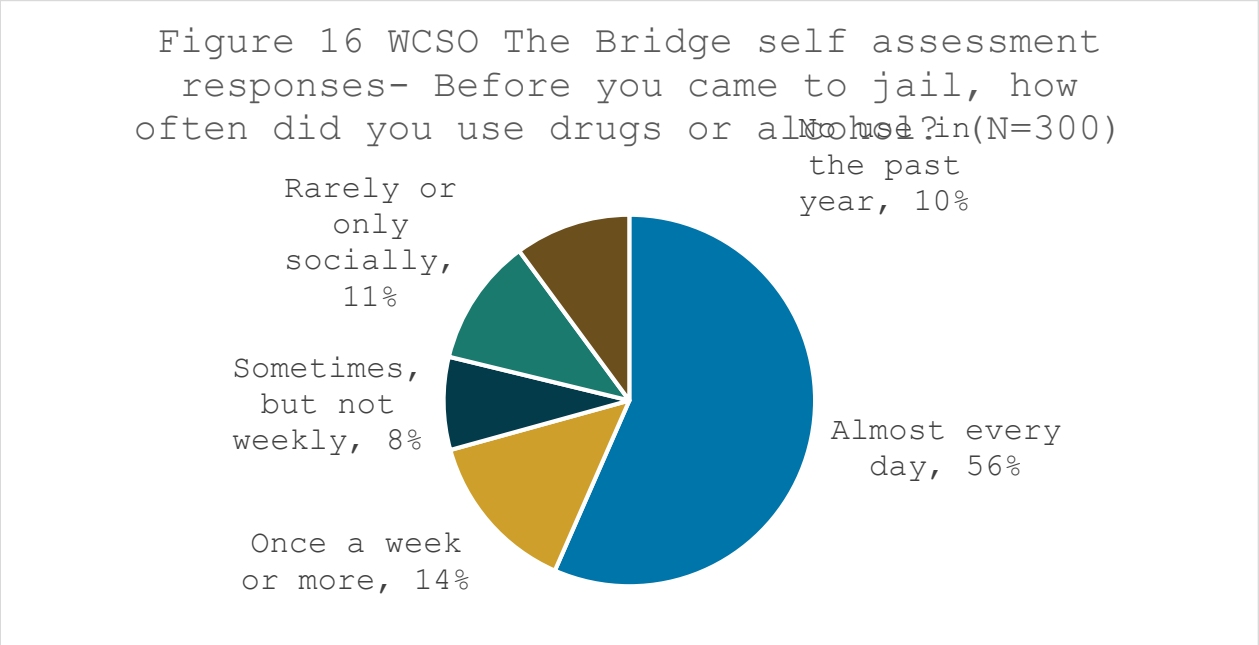


Figure 16-19 data from the Washoe County Sheriff's Office The Bridge Program

Figure 17 WCSO self assessment responses- Has drug or alcohol use caused problems in your life?

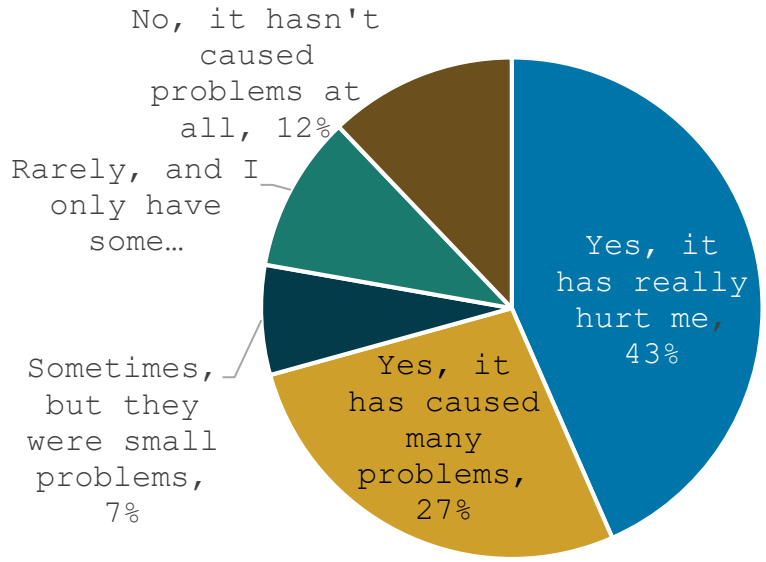
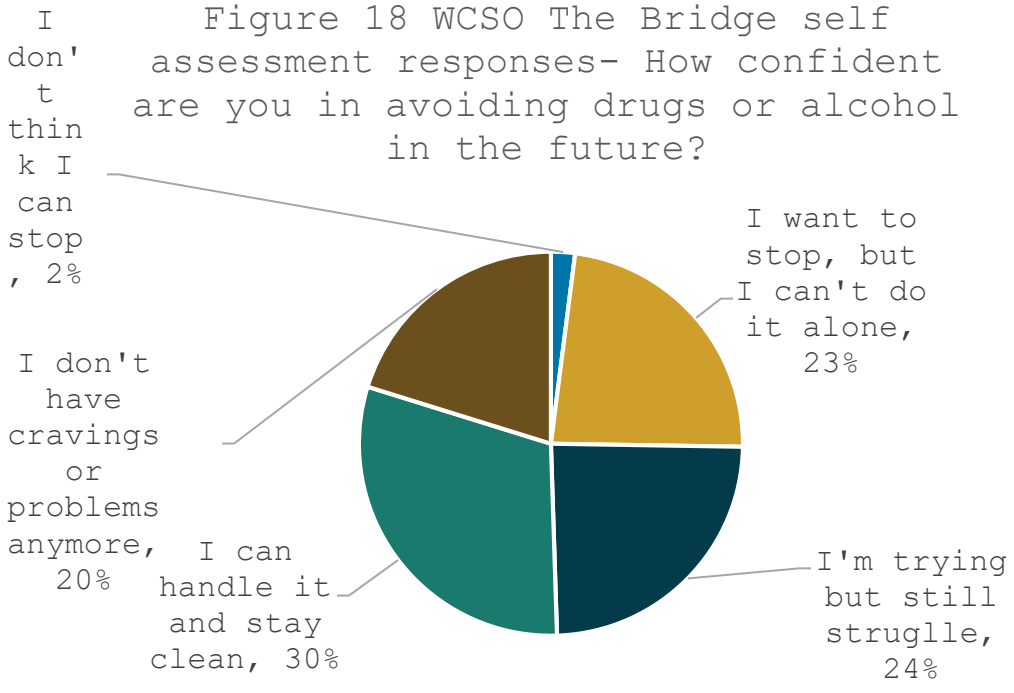
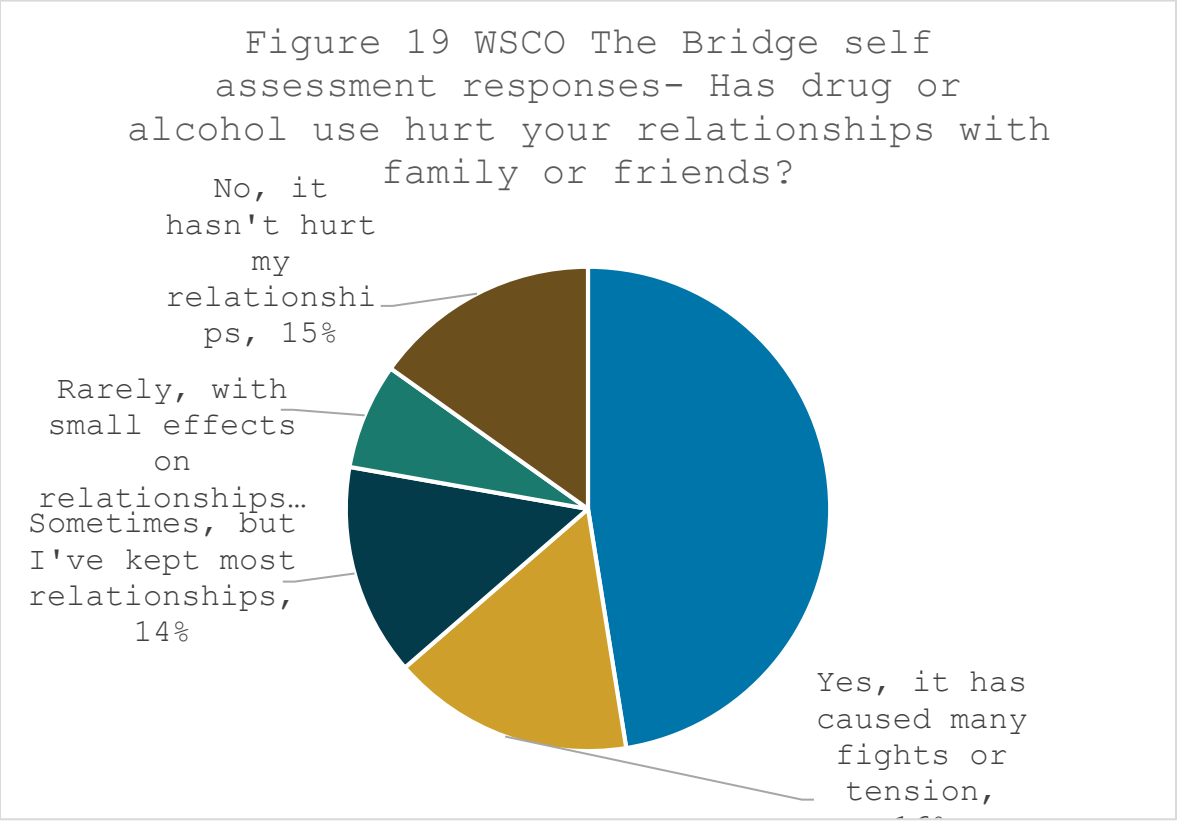


Figure 18 WCSO The Bridge self assessment responses- How confident are you in avoiding drugs or alcohol in the future?





Overdoses

Non-fatal Overdoses

OD2A Suspected Drug-Related Overdose Emergency Department Visits

Figure 20 reflects data collected by the Nevada Department of Health and Human Services Overdose Data to Action (OD2A)[31] on the monthly rates of suspected drug-related overdose emergency department visits per 100,000 people. The rate has a slight drop from 21.3 drug related overdoses per 100,000 in January 2019 to 20.1 per 100,000 in 2020. Drug related overdose emergency department visits rose in 2023 reaching a peak of 31.7 suspected drug-related overdose emergency department visits per 100,000 people. In 2024, suspected drug related overdose emergency department visits fell to 25.0 per 100,000 people.

[31] Nevada Department of Health and Human Services. (2018-2024). *Drug-related overdose emergency department visit data*.

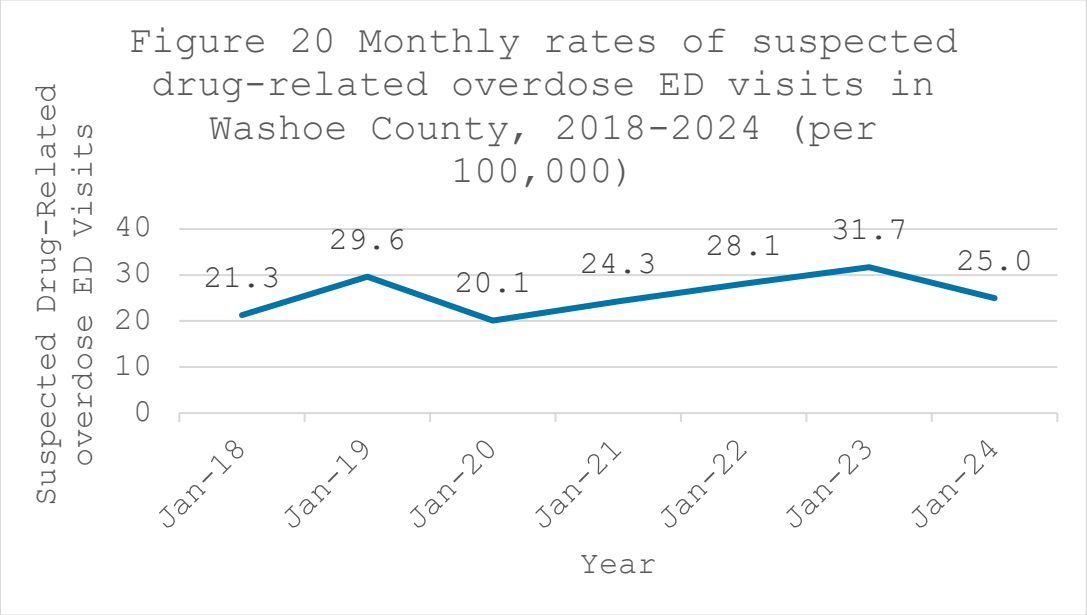


Figure 21 data from the Nevada Department of Health and Human Services (HHS) OD2A

Regional Emergency Medical Services Authority Narcan Administration Incidents

The Regional Emergency Medical Services Authority (REMSA) is a nationally recognized emergency medical services (EMS) system for Washoe County that offers services such as ground and air ambulance services, tactical medical support to SWAT, and community public education programs. In 2024, REMSA teams administered Narcan at a total of 838 incidents.[32] Narcan or naloxone is an opioid overdose reversal medication. Four hundred eighty-two of the incidents, or roughly 57.52%, were described as overdose/drug related disorder for the primary impression from the EMS responder. The primary impression is rapid, initial diagnosis of the most significant or acute problem, a primary impression of something other than overdose does not preclude overdose as a problem or condition. Other primary impressions included cardiac arrest, altered mental status, acute respiratory distress, and alcohol intoxication. Figure 21 provides data from REMSA on Narcan administrations for incidents, by age group, for people who were initially reported as a potential drug overdose. Nearly two-thirds (n=307, 63.7%) of all Narcan administrations involved patients aged 45 or younger.

[32] Regional Emergency Medical Services Authority. (2024). *Naloxone administration data*.

Figure 22 visualizes the number of Narcan administrations provided by REMSA responders by zip code. Zip code 89512 had the highest number of Narcan administrations, at 218 (26%). This zip code, 89512, includes the Cares Campus, which provides housing focused case management to help those who are experiencing homelessness obtain stable independent housing, as well as offering emergency shelter to those same people experiencing homelessness. The next highest zip codes were 89502 (n=128, 15.3%) and 89501 which includes downtown Reno (n=114, 13.6%).

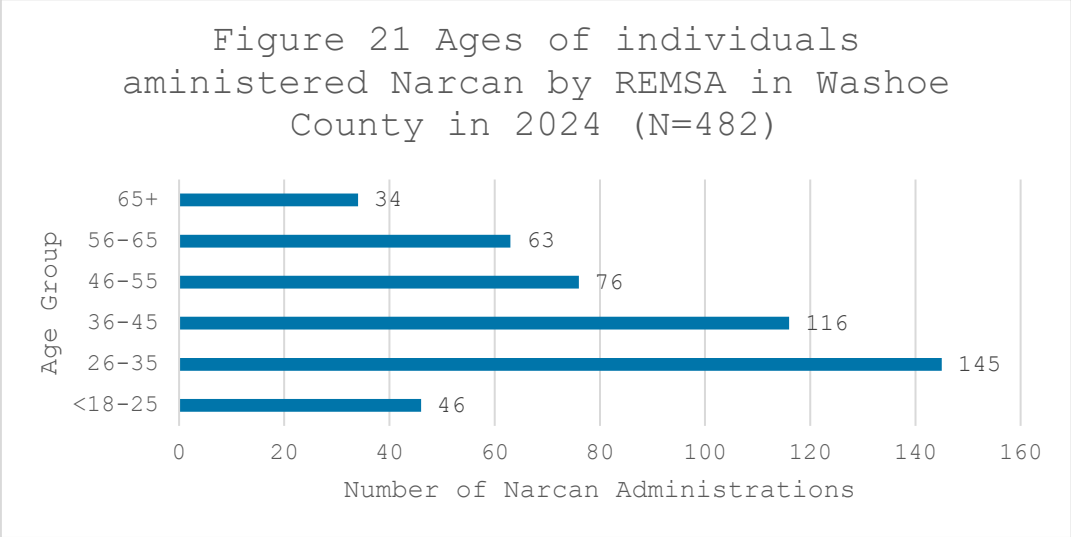
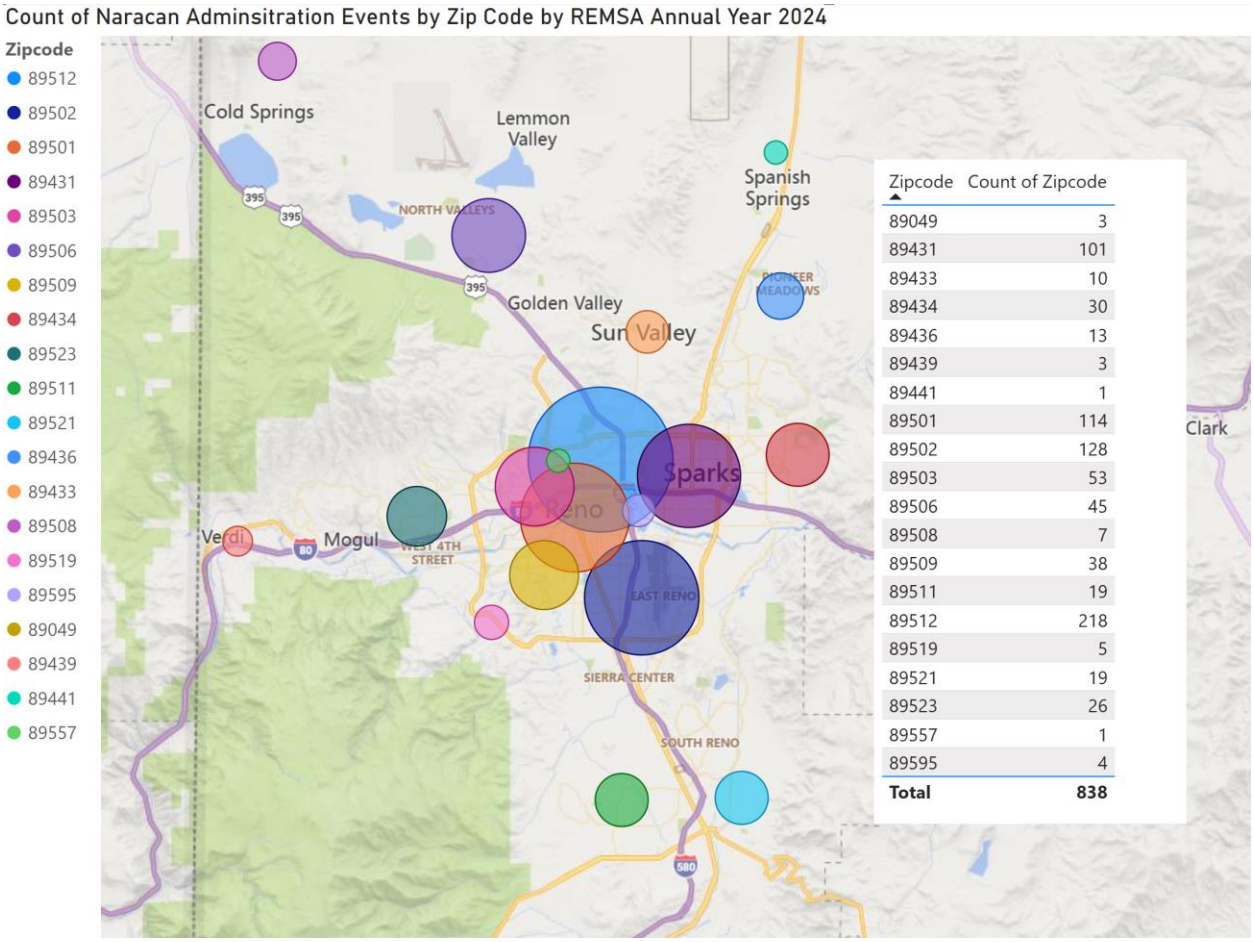


Figure 21 data from REMSA

Figure 22 Map of Narcan administration events by zip code by REMSA in 2024 (N=838)



Fatal Overdoses

National Trends

Since 2018, the United States has seen a steep increase in the number of opioid overdoses deaths, as shown below in Figure 23 coming from CDC Wonder Surveillance Data. One of the major contributors to this spike was the increase in the illicit synthetic opioid supply, (meaning illegally distributed and manufactured opioids such as fentanyl and oxycodone).[33] In January of 2018, the United States had a rate of 14.7 opioid overdose deaths (OOD) per 100,000 people within the previous 12 month-period. Over the next eight years this number increased to a peak of 25.3 OOD per 100,000 people

[33] Daniel Ciccarone, The triple wave epidemic: Supply and demand drivers of the US opioid overdose crisis, International Journal of Drug Policy, Volume 71,2019,Pages 183-188,ISSN 0955-3959, https://doi.org/10.1016/j.drugpo.2019.01.010.(https://www.sciencedirect.com/science/article/pii/S0955395919300180)

within a 12 month-period of January 2023, showing a growth of 74.1%.[34] However, between January 2023 and January 2025, that number dropped to 15.8 OOD per 100,000 people. In the 12-months that ended in April 2025, the CDC predicts that 50,259 people died of opioid overdoses. Experts have identified several interventions that may have helped contribute to the national decrease in overdose deaths including the expanded access to naloxone or Narcan[35] and the implementation of strategies to reduce morbidity and mortality such as distribution of fentanyl test strips.[36]

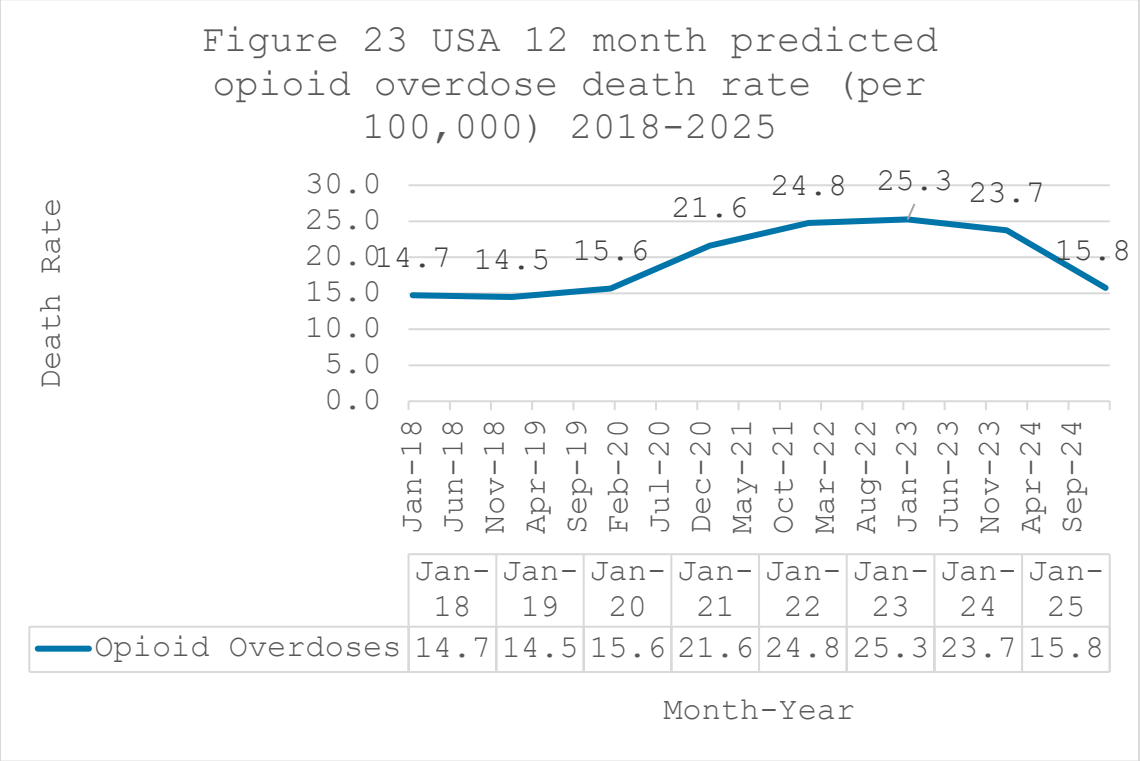


Figure 23 data from the CDC Drug Overdose Death Counts Data 2018-2025

[34] *Ahmad FB, Cisewski JA, Rossen LM, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. 2025. DOI: https://dx.doi.org/10.15620/cdc/20250305008*

[35] Zang X, Skinner A, Krieger MS, et al. Evaluation of Strategies to Enhance Community-Based Naloxone Distribution Supported by an Opioid Settlement. *JAMA Netw Open.* 2024;7(5):e2413861. doi:10.1001/jamanetworkopen.2024.13861

[36] Vickers-Smith RA, Gelberg KH, Childerhose JE, et al. Fentanyl Test Strip Use and Overdose Risk Reduction Behaviors Among People Who Use Drugs. *JAMA Netw Open.* 2025;8(5):e2510077. doi:10.1001/jamanetworkopen.2025.10077

Nevada Trends

Nevada saw an increase of 75.7% in OOD, from 14.4 per 100,000 to 25.3 per 100,000, shown in Figure 24. Furthermore, while the rest of the country saw a decrease in opioid overdose death rates, between January 2023 and January 2024, Nevada increased from 21.9 OOD per 100,000 to 30.3 OOD per 100,000. By January 2025 the rate had decreased slightly to 28.8 OOD per 100,000. However, In the 12-month period in March 2025, there were 31 OOD per 100,000, representing 993 Nevadans dying of opioid overdoses. CDC data indicates Nevada is not just lagging behind national trends but moving in the opposite direction of the rest of the country. This trend highlights the need for continued investment into intervention strategies aimed at curbing the catastrophic impacts of opioid overdoses in Nevada.

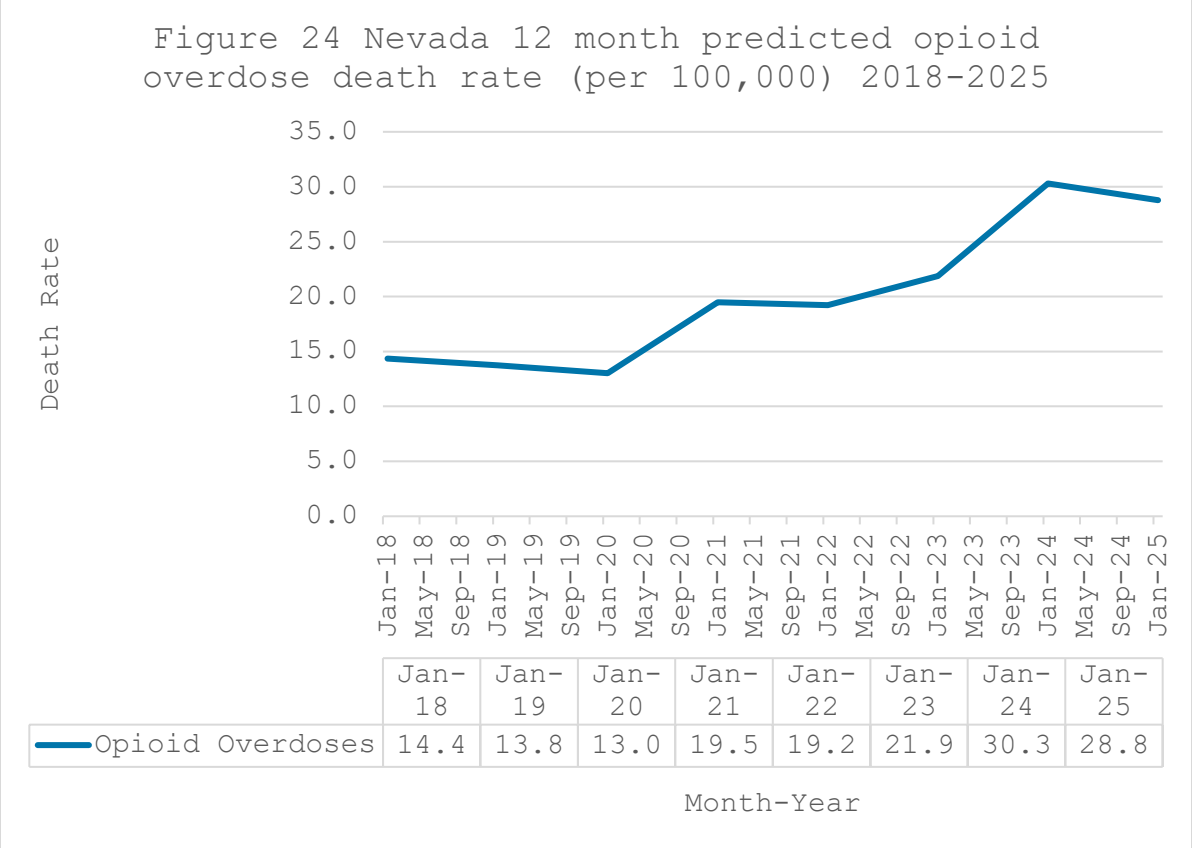


Figure 24 data from the CDC Drug Overdose Death Counts Data 2018-2025

Washoe County Trends

Opioid Overdose Deaths

Figure 25 data from the CDC demonstrates deaths from drug overdose. The overdose data covers all substances and is not opioid specific. Similar to state and national trends, the overdose death rate increased annually between 2019-2023 going from 24.4

overdose deaths per 100,000 to 49.4 overdose deaths per 100,000. There was a decrease between 2023 and 2024 from 49.4 overdose deaths per 100,000 to 37.5 overdose death per 100,000.[37] From March 2024-February 2025 (the most recent data available) there were 179 Washoe County residents who died of an overdose. Overdose death rates in Washoe County are higher than state and national death rates.

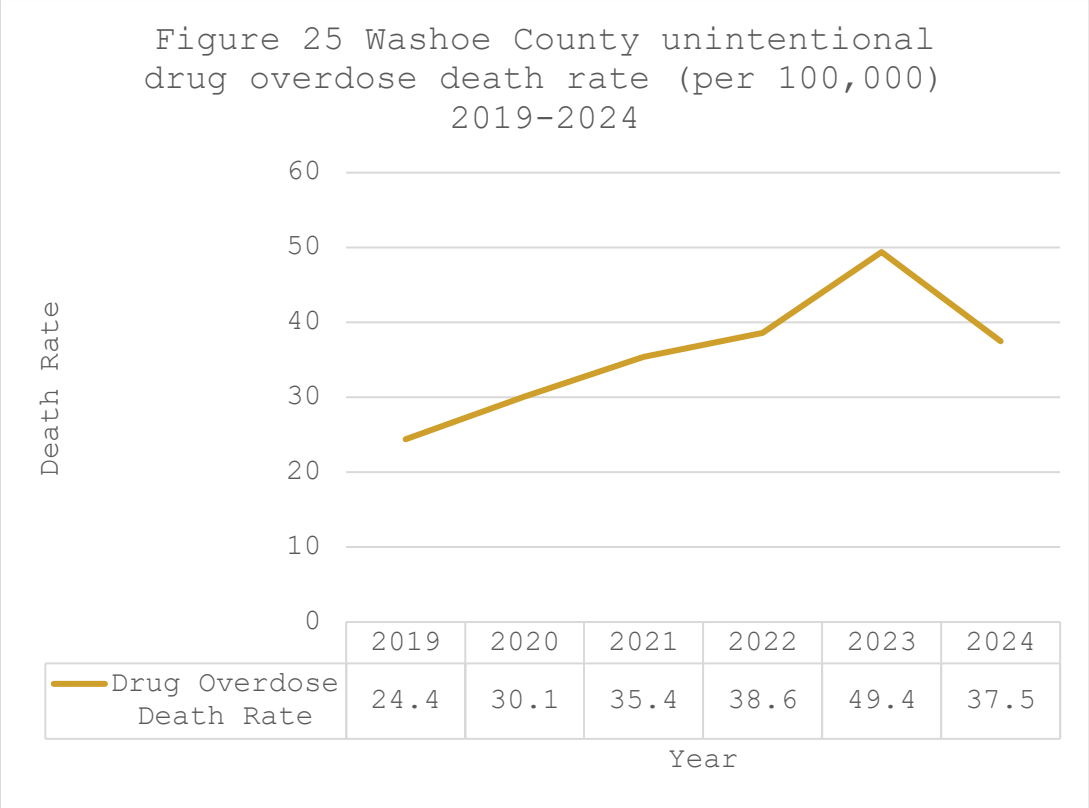


Figure 25 data from the CDC Drug Overdose Death Counts

Drug-Related Deaths

The National Association of Medical Examiners recommends a forensic autopsy for deaths involving suspected criminal violence, unexplained deaths in children, deaths in custody or during police action, certain workplace or motor vehicle incidents, suspected intoxication, and other non-natural or unexplained causes. The Washoe County Regional Medical Examiner's Office conducts toxicology reports when autopsies are performed. Autopsies are also performed when the body is unidentified, skeletonized, charred, or when a forensic pathologist determines one is necessary to establish cause or manner of death or collect evidence. These guidelines highlight that not every death

[37] Centers for Disease Control and Prevention. (2025, September 5). *Mapping injury, overdose, and violence dashboard*. U.S. Department of Health and Human Services. https://www.cdc.gov/injury-violence-data/data-vis/index.html

is screened by the Medical Examiner's Office for possible drug-related death, leading to a possibility of underreporting of drug-related deaths. These drug-related deaths are defined as people who received an autopsy and had drugs in their system at the time of death. This could include people who died from an overdose or people who died in car accident with substances in their system, among other instances.

Data presented in Figure 26 demonstrate the trends of Washoe County all drug-related death rate. Like the Washoe County overdose death data represented in Figure 25, the peak of drug-related deaths occurred in 2023 with 64.8 drug deaths per 100,000 people.[38] The rate of drug-related deaths dropped to 50.1 per 100,000 people in 2024.

Figure 26 Washoe County drug-related death rate (per 100,000) 2018-2024

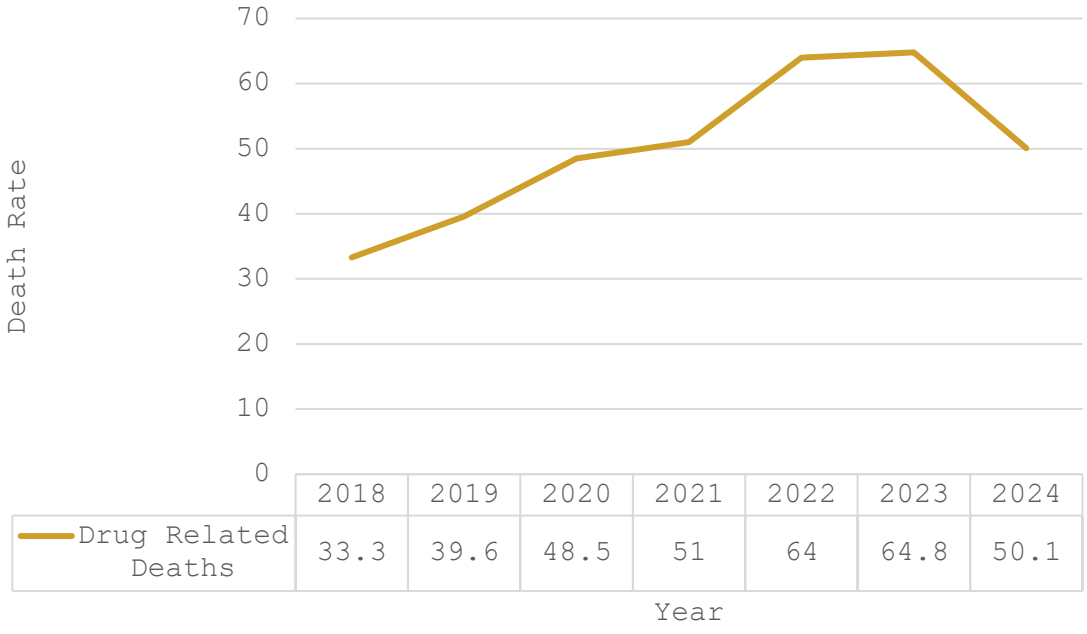


Figure 26 data from the Washoe County Regional Medical Examiner's Office

The highest rates of drug-related deaths were among people who had opioids and/or methamphetamine in their system at the time of death. Figures 27-30 indicate that all substances reported besides heroin saw an increase in deaths that peaked in 2023,

[38] Washoe County Medical Examiner's Office. (2018–2024). *Drug-related death toxicology data*. Washoe County Medical Examiner.

with some declines beginning in 2024, reflecting national trends. Heroin-related deaths have been declining since 2021 and in 2024 there were no heroin-related deaths. However, as heroin has largely phased out of the drug market in Washoe County it has been replaced with fentanyl. Fentanyl death rates grew each year from 2018-2023, going from two fentanyl-related deaths per 100,000 in 2018 to 33.1 fentanyl related deaths per 100,000 in 2023. Methamphetamine continues to be the primary substance found in drug-related deaths, while opioids are the second highest substance identified in drug-related deaths.

Opioid related death rates decreased in 2023, from 39.8 opioid related deaths per 100,000 to 26.4 opioid related deaths per 100,000 in 2024 (Figure 26). Methamphetamine related deaths similarly decreased from 40.9 methamphetamine related deaths per 100,000 in 2023 to 31.9 methamphetamine related deaths per 100,000 people in 2024 (Figure 27).

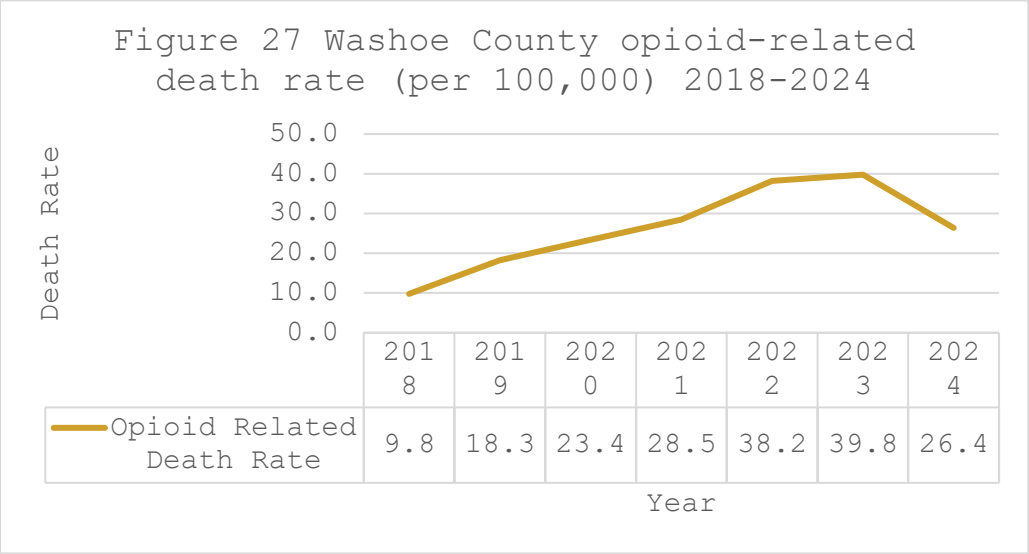


Figure 27 data from the Washoe County Regional Medical Examiner's Office

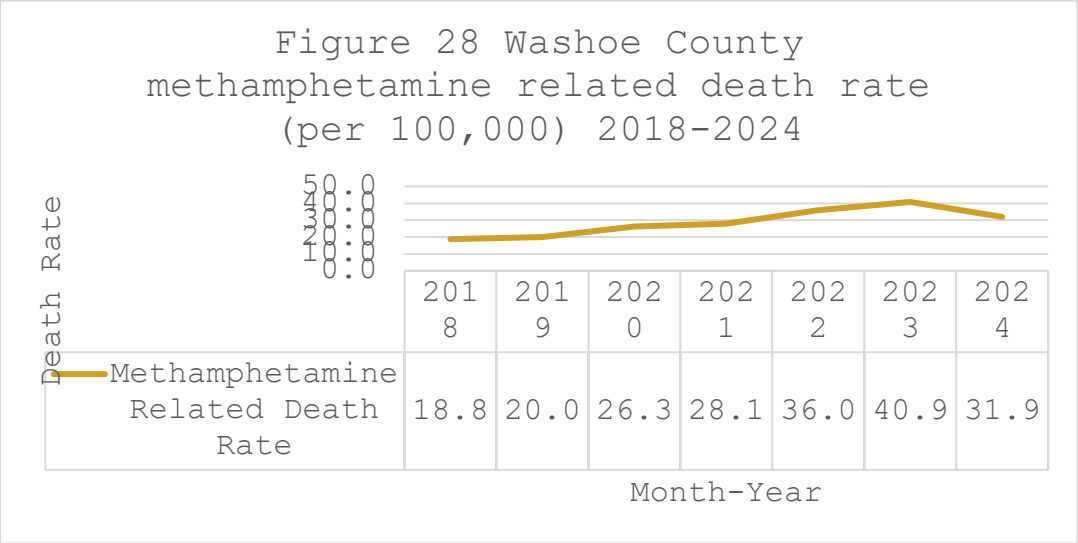


Figure 28 data from the Washoe County Regional Medical Examiner's Office

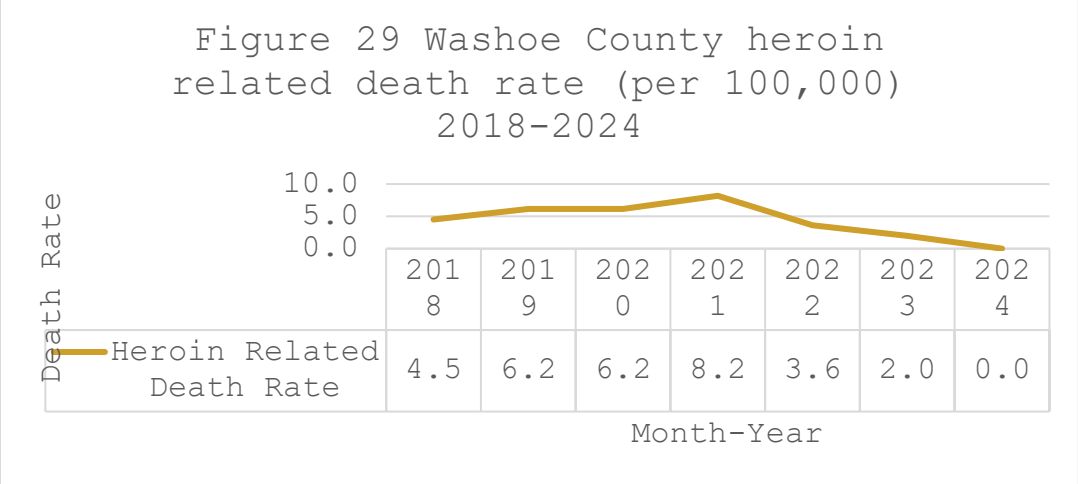


Figure 29 data from the Washoe County Regional Medical Examiner's Office

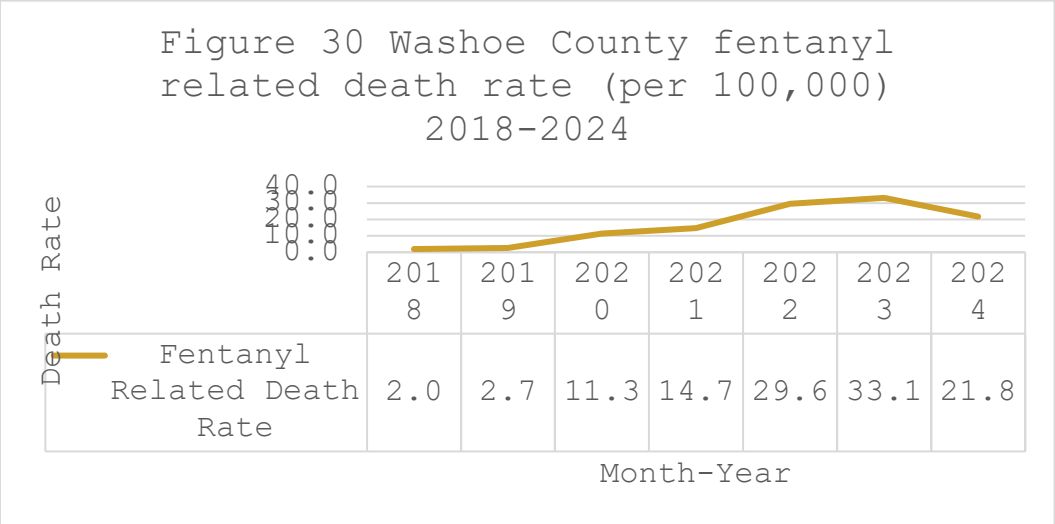


Figure 30 data from the Washoe County Regional Medical Examiner's Office

Secondary Data Findings

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

- Fentanyl is an ongoing challenge in Washoe County and has largely replaced heroin.
- Methamphetamine and polysubstance use continue to be central issues in Washoe County. Methamphetamine is the drug of choice of many program participants and drives drug-related death rates in Washoe County.
- Contrary to the common myth that "fentanyl is in everything," fentanyl is not regularly or commonly being mixed with other substances
- Although substance-related child removals decreased between 2023 and 2024 substance use continues to be a leading cause of child removals.
- Youth in Nevada and Washoe County had higher lifetime usage of both methamphetamine and heroin compared to national percentages.
- Most MAT participants at CHA have insurance. The most common insurance types are Medicaid/Medicare.
- 2024-2025 data from Men's, Women's, and Women's and Children's CrossRoads have shown decreases in member arrests, and hospitalizations following enrollment in the program and increased members' access to healthcare, employment, and housing.
- Washoe County has an insufficient housing supply to meet the needs of the population.
- WSCO's MAT program had a recidivism rate that decreased from 27.8% to 19.6% between 2022 and 2024 and served an average of 37 people a month.

- The majority of WSCO's Bridge Program participants indicated drugs/alcohol either ruined relationships or caused frequent fights/tension in relationships, causing social damage.
- The majority of REMSA's Narcan administration events are in the 89512, 89502, and 89503 zip codes, however overdoses are occurring all across Washoe County.
- In Nevada opioid overdose death rate continues to increase despite a national trend of decreased opioid related overdose death.
- Washoe County's opioid overdose death rate decreased 2024. Despite the decrease, the overall overdose death rate in Washoe County is higher than the state and national opioid overdose death rate.

The data presented illustrates the ongoing impact of the opioid epidemic on Washoe County residents with implications across the lifespan. Parental substance use, despite recent decreases in removals, is a leading cause of Children's Services removals of children from their parents, and adolescents continue to use drugs at higher rates than national averages. Treatment providers, first responders, and our legal system continue to increase their capacity to meet the needs of people who use opioids. Lack of sufficient housing places an ever-growing weight on the community safety net. Despite improvements in overdose rates overdose deaths in Washoe County outpace national and state levels. Fentanyl and polysubstance use are ongoing challenges in Washoe County that must be addressed by cross-sector collaboration.

Section Three: Quantitative Survey Data

Across both community members and individuals with and without lived experience of opioid use, there is strong consensus that access to timely, coordinated care remains a major challenge in Washoe County. Respondents emphasized the importance of housing, mental health treatment, and harm reduction as essential supports, though their priorities diverged in how these services should be structured and delivered.

Methodology

An online survey was created, initially adapted from the 2022 Opioid Use/Opioid Use Disorder Community Needs Assessment. The survey draft was edited iteratively with the Living Experience Advisory Board, the Steering Committee, and the Quantitative Data Subcommittee from January 2025 - April 2025. Stakeholders provided feedback and refined the questions which were added to the final draft (see Appendix C). The survey was opened on April 15, 2025, and closed on June 22, 2025. The survey was shared

via social media, Washoe County newsletters, Washoe County websites, and stakeholder digital communications. Additionally service providers throughout the community placed flyers with QR codes in their businesses. To obtain greater feedback from individuals with living experience, the LEAB was trained in survey collection practices and went into the community to survey people who may not have access to internet or phones. A total of 748 people participated in the survey.

Results

All respondents identified a core set of priorities that form the foundation of an effective local response: immediate access to treatment and detox, aftercare and care navigation, mental health care, harm reduction services, and crisis intervention. These shared themes point to a broad consensus that recovery requires a continuum of supports, starting with rapid access to care and continuing through community reintegration and sustained wellness. Respondents also cited community partnerships, mental health services, and a dedicated treatment provider network as key strengths in Washoe County's system of care.

People with lived experience of opioid use highlighted several needs more strongly than those without personal experience. They placed the highest importance on housing and aftercare services, emphasizing recovery housing and "Housing First" models over transitional housing. They also prioritized long-term recovery supports such as community-based recovery services and familial supports that foster stability and connection. These responses reflect a holistic view of recovery that integrates housing and social connection as essential to sustained wellness. Those without personal experience of opioid use placed slightly higher emphasis on crisis response and mental health care.

A small subset of open responses revealed polarization around criminal legal responses—some advocating harsher enforcement, others supporting treatment-first and harm reduction approaches. This division underscores the need for continued public education and dialogue to strengthen shared understanding of evidence-based solutions.

Top Five Service Priorities

People with Lived Experience of Opioid Use	People without Lived Experience of Opioid Use

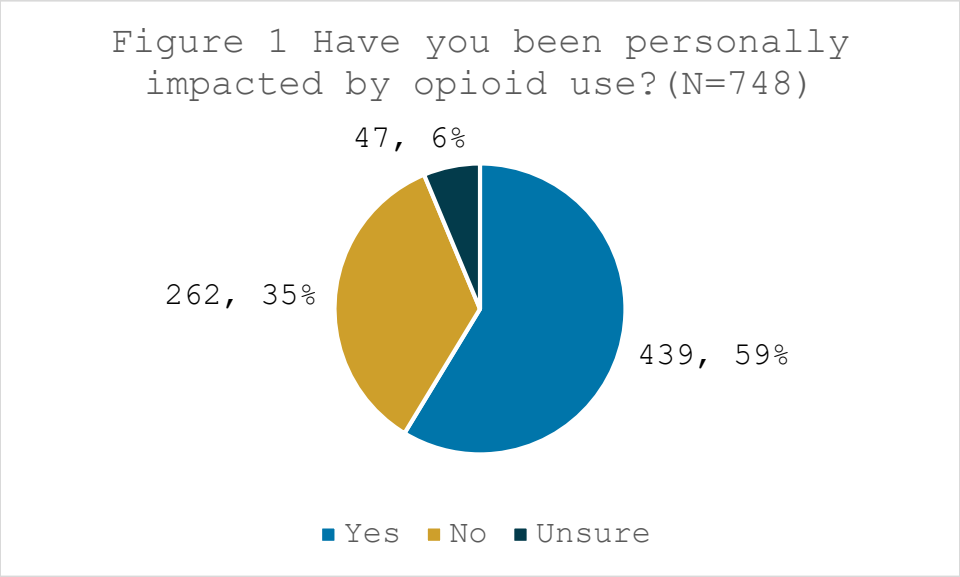
After Care and Care navigation after exiting inpatient treatment	Immediate access to treatment and detox
Immediate access to treatment and detox	After Care and Care navigation after exiting inpatient treatment
Housing services	Mental health care
Harm Reduction Services	Harm Reduction Services
Community-based recovery support	Crisis services (e.g., mobile outreach teams)

Despite these differences, the overarching message is clear: Washoe County needs coordinated, person-centered systems of care that bridge treatment, housing, and mental health services. Respondents agreed that reducing barriers, sustaining the behavioral health workforce, and expanding housing services are key to promoting long-term recovery. While perspectives differ on how best to achieve these goals, there is broad alignment around the vision of a community where recovery is accessible, supported, and sustainable for all.

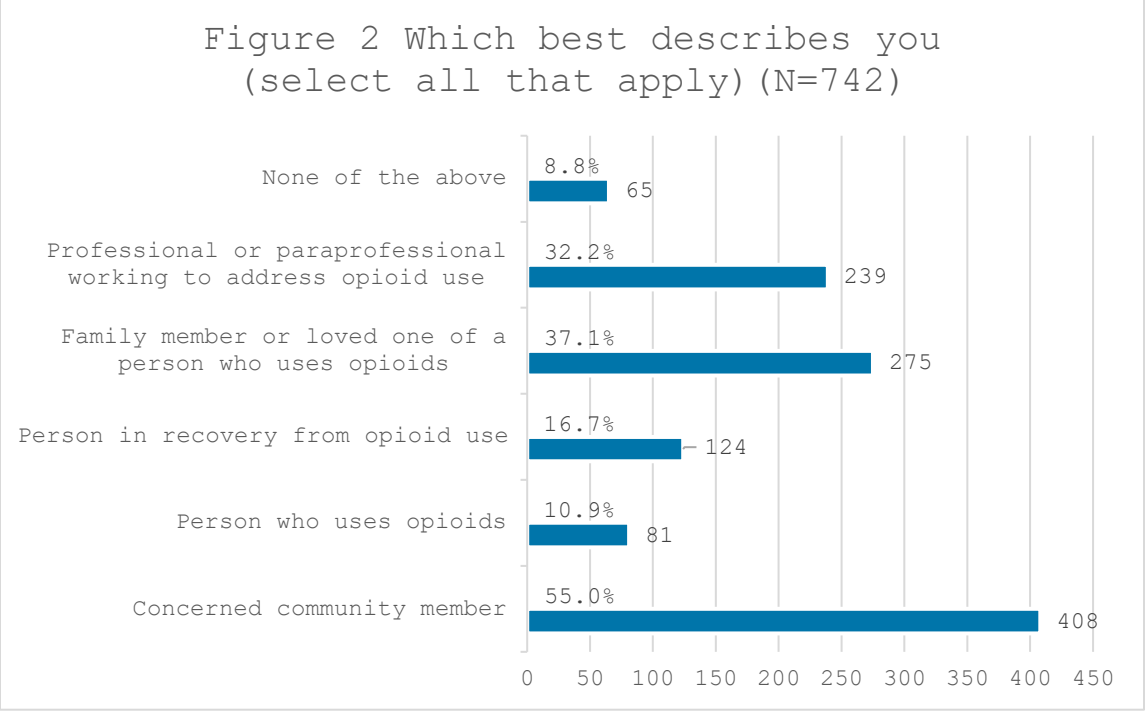
Detailed summaries of responses to the survey questions are below. All of the included percentages are individually calculated excluding missing responses to the question answered. Missing responses vary based on the question. For a table of all the data collected in the survey see Appendix D.

Demographics

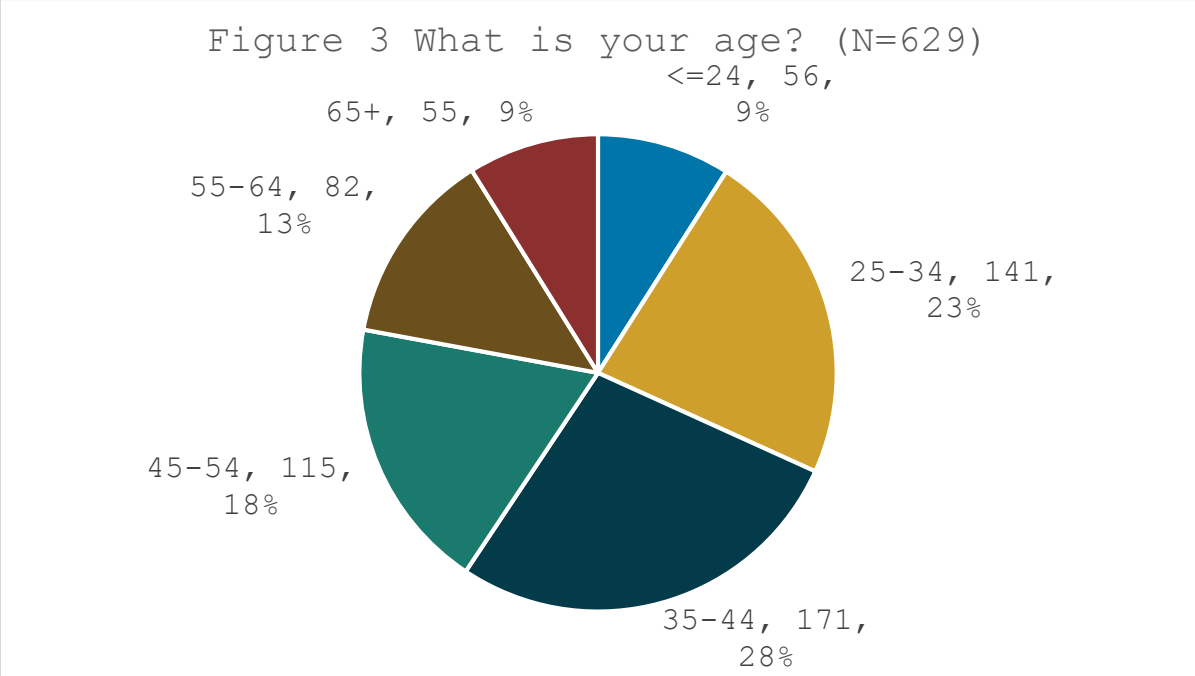
Seven hundred forty-eight individuals responded to questions regarding experiences, needs, and gaps in current resources for individuals affected by opioid use. Over half of respondents, 439 (58.7%), said they had been personally impacted by opioid use while 262 (35%) said they had not. Number of respondents per group (opioid use experience and no opioid use experience) is given per question category, with the percentages of each group noted in respective answers to questions. (Figure 1) Reflective of the areas most impacted opioid overdoses (see REMSA data on page 41), most respondents were from the following zip codes: 89502, 89503, and 89512.

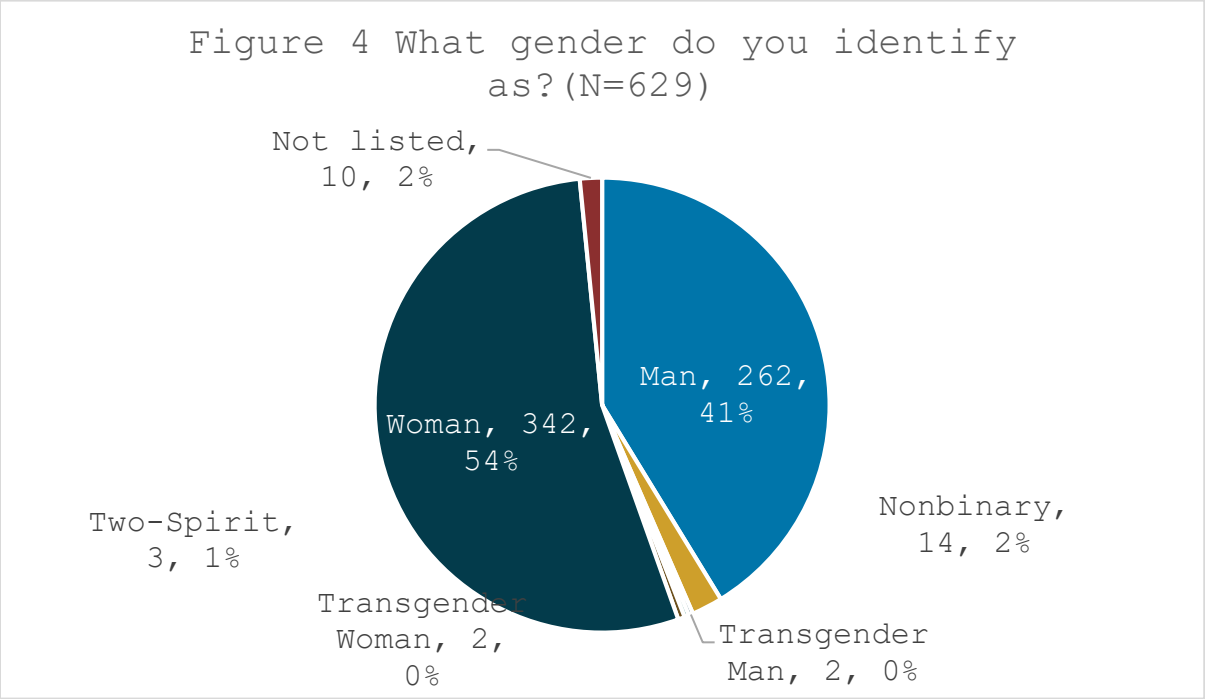


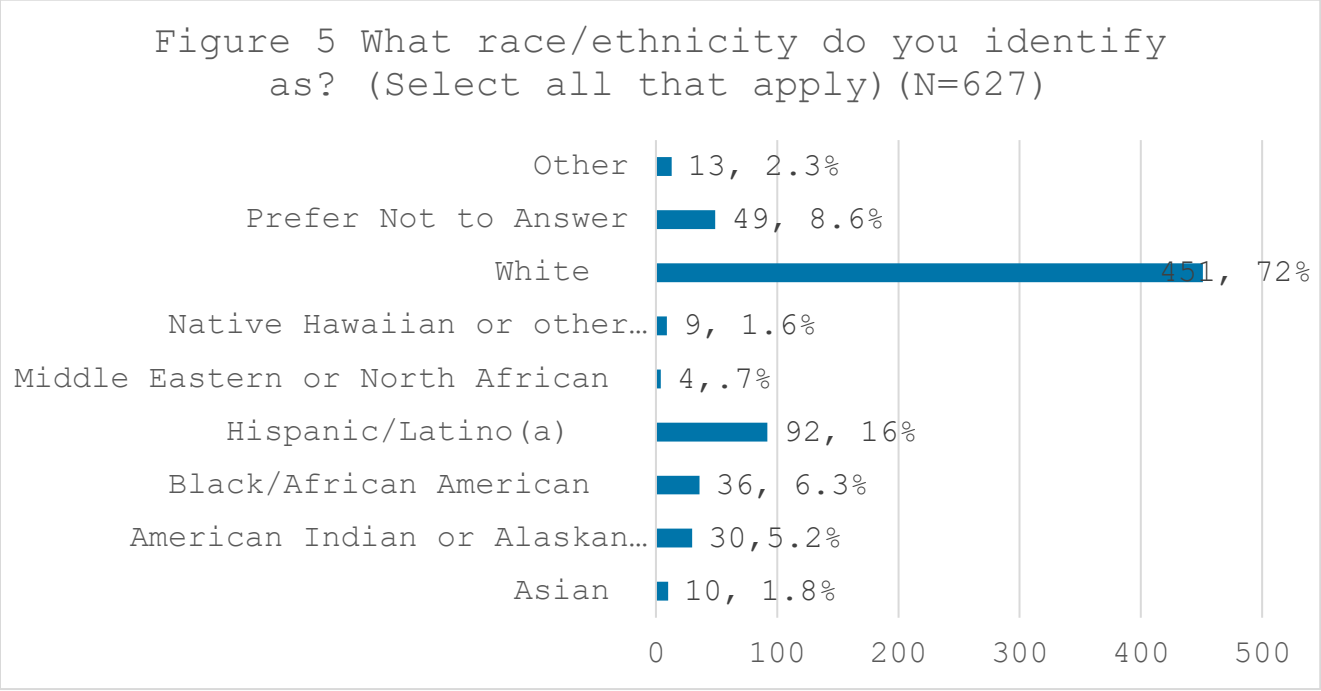
Respondents were asked to describe themselves by selecting all of the following descriptors that applied: concerned community member (n=408, 55.1%), person who uses opioids(n=80, 10.8%), person in recovery from opioid use (n=124, 16.7%), family member or loved one of a person who uses opioids (n=275, 37.1%), professional or paraprofessional working to address opioid use(n=239, 32.3%), and none of the above(n=65, 8.8%)".



The median age of all respondents was 40 (Figure 3). Two hundred sixty-two (41.7%) respondents self-identified as a man, 342 (54.4%) respondents identified as a woman, 14 (2.2%) as nonbinary, 10 (1.6%) as gender not listed, and 5 (0.8%) individuals identified as two or more. Two respondents each identified as transgender man and transgender woman; three identified as Two-Spirit; and 121 respondents did not answer (Figure 4). White respondents were the most prevalent race reported among the sample at 72% (451), while 49 of whom identified as more than one race. The next highest selected race and ethnicities were Hispanic/Latino(a) at 16.1% (92), 31 of whom selected more than one race, and Black/African American at 6.3% (32). Fifty-four (8.3%) respondents identified as more than one race.







233 respondents identified as professionals working in the field. Professionals were asked to select all employment types that represented the organization they worked with. The top five were: first responders at 24.9% (58), homeless services providers at 23.2% (54), healthcare providers at 22.8% (53), substance use treatment providers at 18.5% (43), and harm reduction practitioners at 17.2% (40).

184 respondents identified themselves as either a person who uses opioids or as being in recovery from OUD. The majority, 54.1% (86) of those respondents identified as a man, and 43.4% (69) identified as a woman. A small number, 2.5% (4), identified as another gender category. Two-thirds, 66.5% (105), identified as white, and all other categories were less than 10% each. Ninety respondents (52.6%) said they were currently participating in SUD treatment.

Survey Questions for People in Active Use or Recovery

A series of 13 additional questions were asked of individuals in recovery from OUD or who were still actively using opioids to better understand their needs, experiences, and perspectives. These questions ranged from identifying what services they had accessed in the community and in the jail to what barriers existed in the community.

People with past or current histories of opioid use identified the top three non-treatment-based services to support people who are using opioids are: 1. housing services (126, 73%), 2. mental health treatment (125, 72.7%), and 3. employment support (102, 59.3%).(Figure 6) There was less variation amongst respondents on what they considered the most important treatment modality. As shown in Figure 7, the top three treatment modalities identified by respondents were: 1. long-term recovery housing (116, 67.8%), 2. mental health or trauma therapy (114, 66.7%), 3. Medication Assisted Treatment (108, 63.2%). As demonstrated in Figure 8, when asked which services they had accessed in the past 12 months, the top three identified were: 1. community-based recovery services (72, 41.5%), 2. mental health or trauma therapy (63, 36.8%), and 3. Harm Reduction services (61, 35.7%). Slightly less than half of respondents (72, 418%), noted they had accessed syringe exchange or free naloxone services in the last 12 months. Less than a third (54, 31.4%) attempted to access services and were unable to. The top three reasons people were unable to access services were long waitlists (25, 46.3%), their insurance was not accepted (23, 42.6%), and lack of transportation (22, 40.7%). (Figure 9)

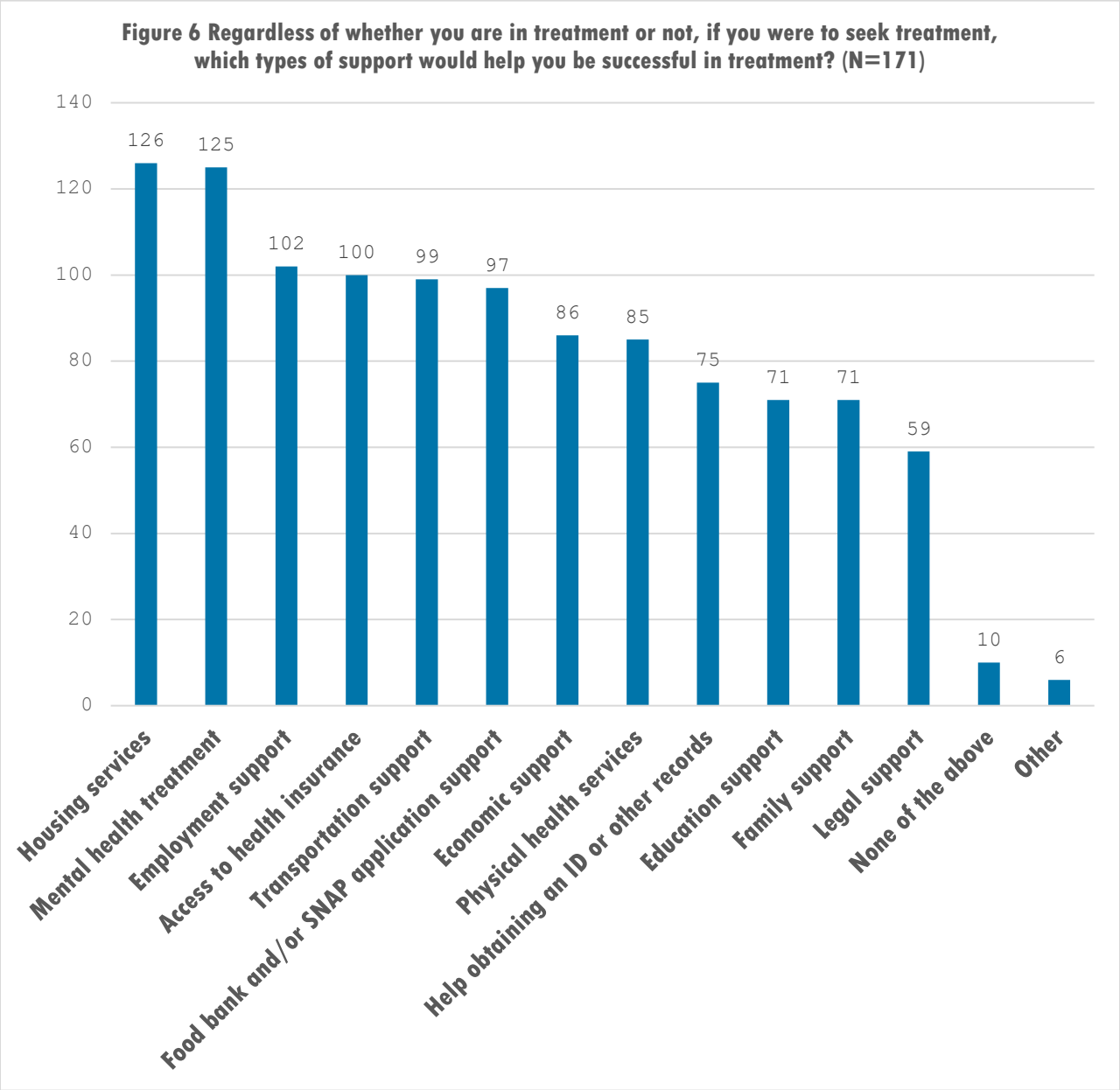


Figure 6 Regardless of whether you are in treatment or not, if you were to seek treatment, which types of support would help you be successful in treatment? (N=171)
140
120
100
80
60
40
20
0
126
125
102
100
99
97
86
85
75
71
71
59
10
6
Housing services
Mental health treatment
Employment support
Access to health insurance
Transportation support
Food bank and/or SNAP application support
Economic support
Physical health services
Help obtaining an ID or other records
Education support
Family support
Legal support
None of the above
Other

Figure 7 Regardless of whether you are in treatment or not, what do you think are the most important aspects of an effective treatment plan? (select all that apply) (N=171)

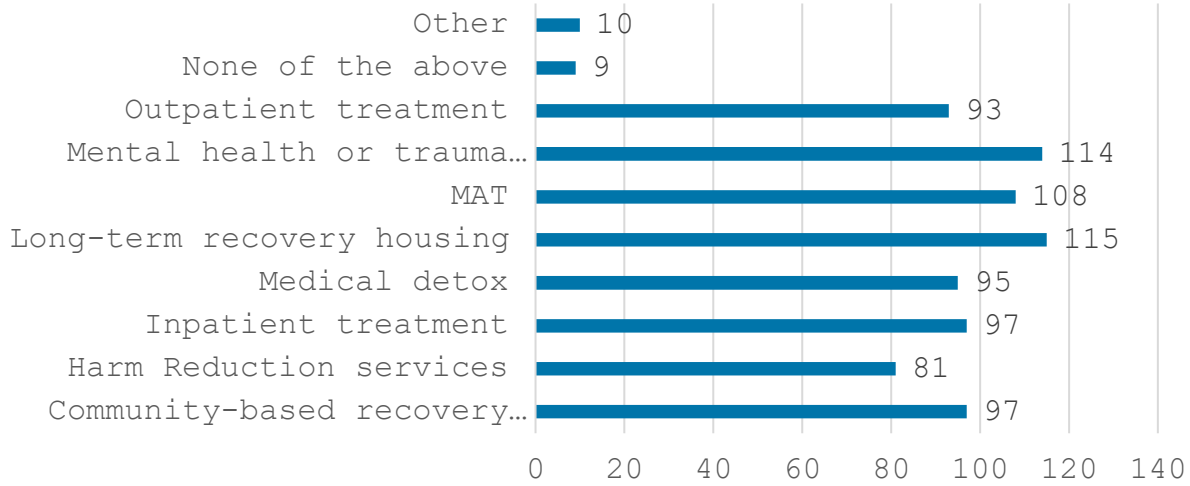


Figure 8 Which of these services have you accessed in Washoe County within the last 12 months? (select all that apply) (N=170)

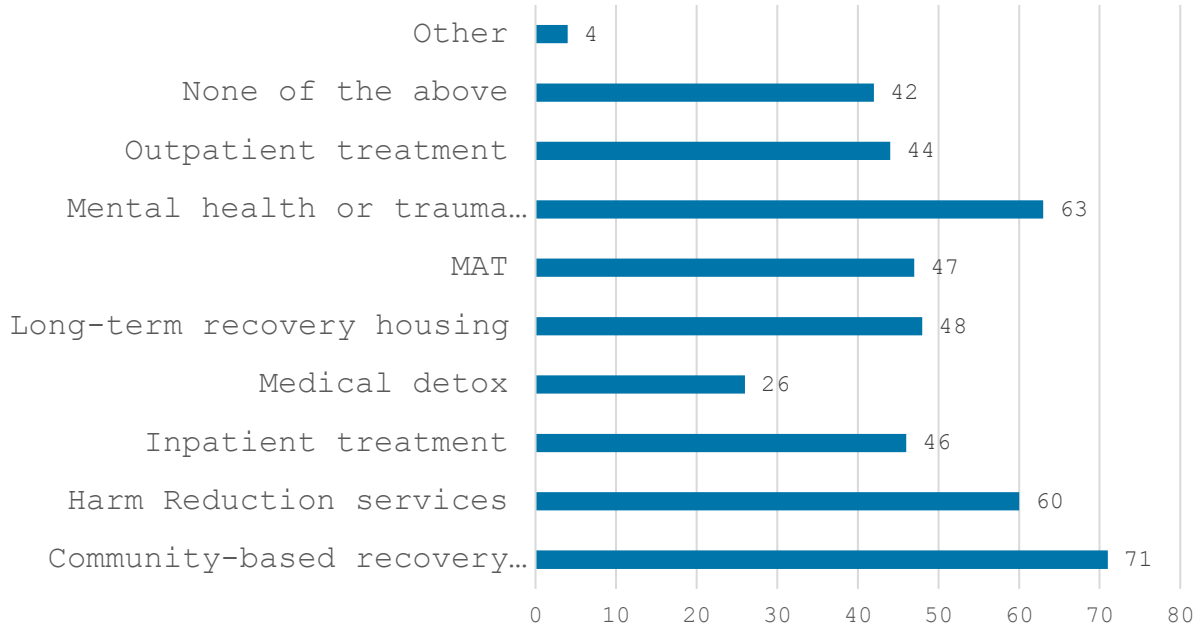
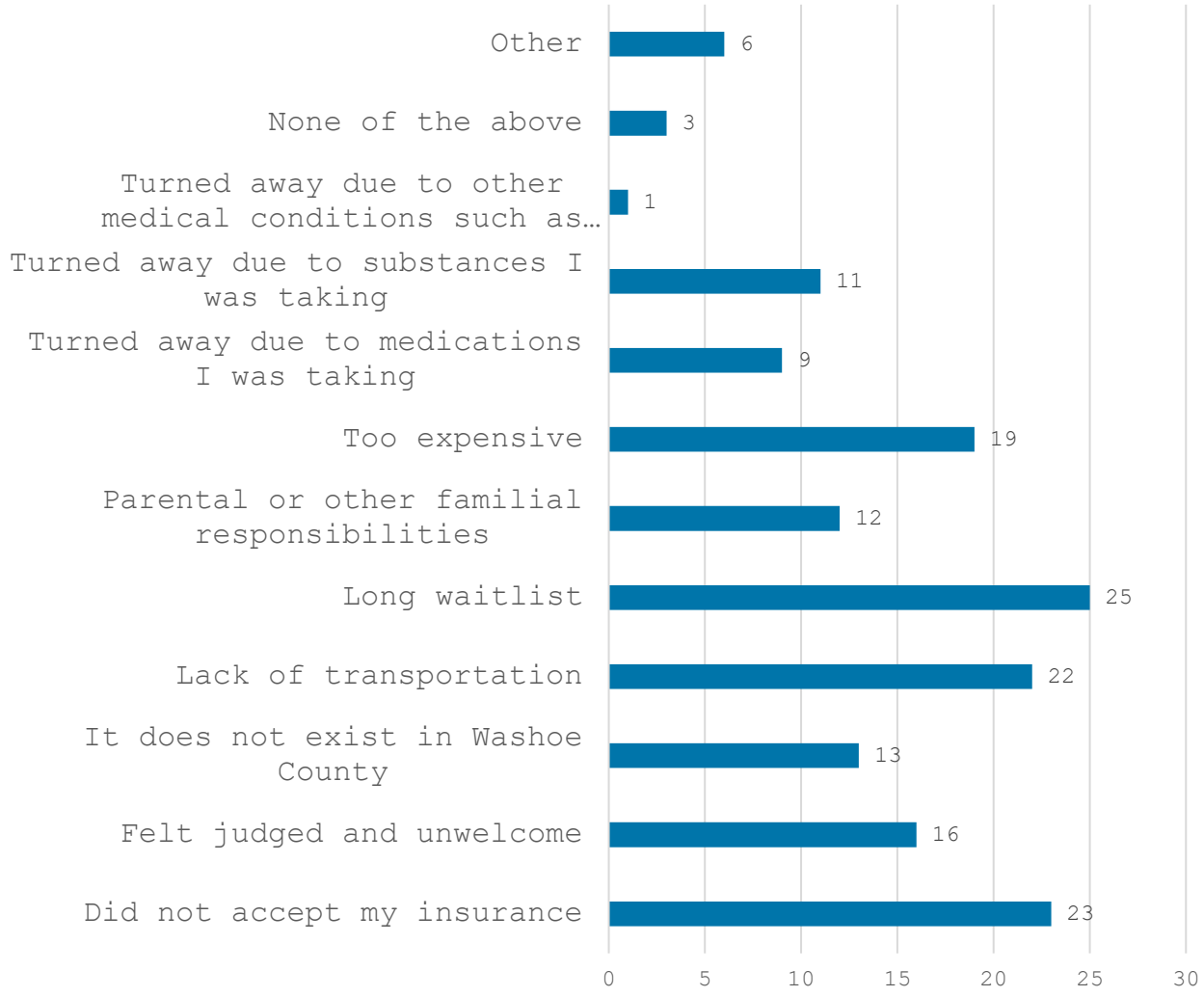


Figure 9. If you were unable to access these resources, select a reason why (select all that apply). (N=54)



Twenty-five (14.8%) respondents identified they had been detained in Washoe County in the last 12 months and 43 (25.4%) had been incarcerated. These individuals were asked a series of additional questions regarding their services while involved in the justice system. Twenty-two were offered MAT while they were at the Washoe County Detention Center. As shown in Figures 10 and 11, 29 reported they were not offered MAT and one person selected other and noted, “MAT program in county is a long process to be approved. I think they said something approx 3 months.” Of those who

received MAT, 4 (22.2%) reported they received MAT within 24 hours of booking and 12 (67%) reported that it took 3 or more days to receive their medications.

Figure 10 If you were incarcerated in Washoe County, were you offered medication to treat opioid use disorder in the jail? (select all that apply) (N=43)

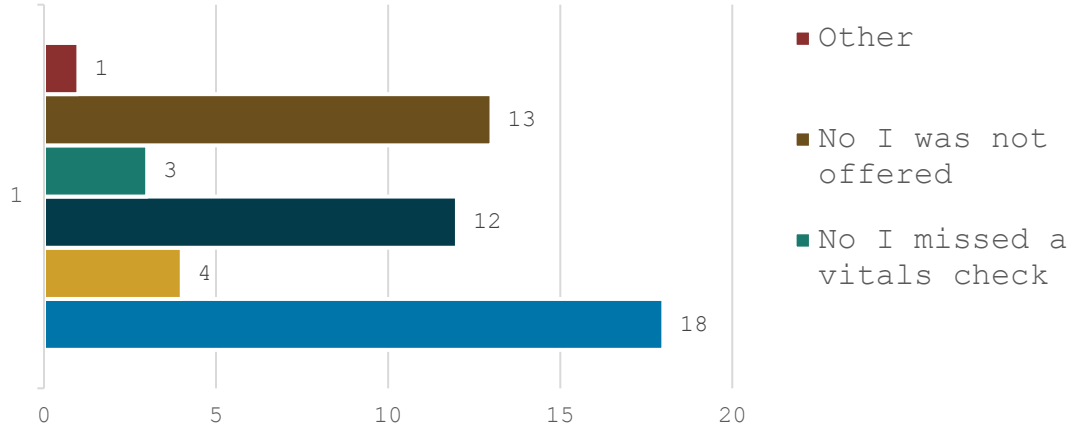
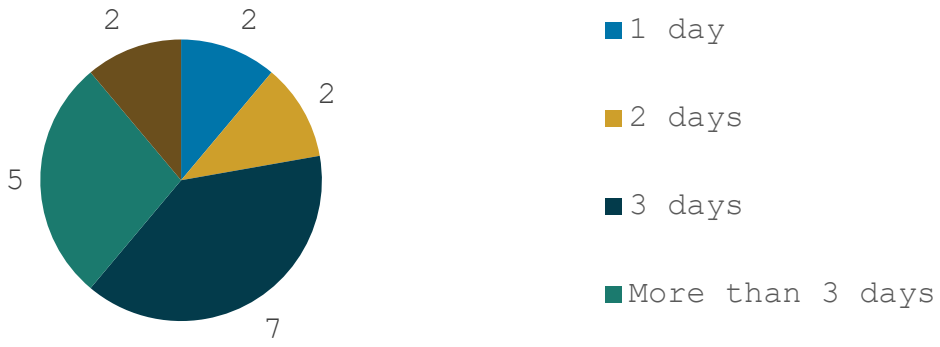


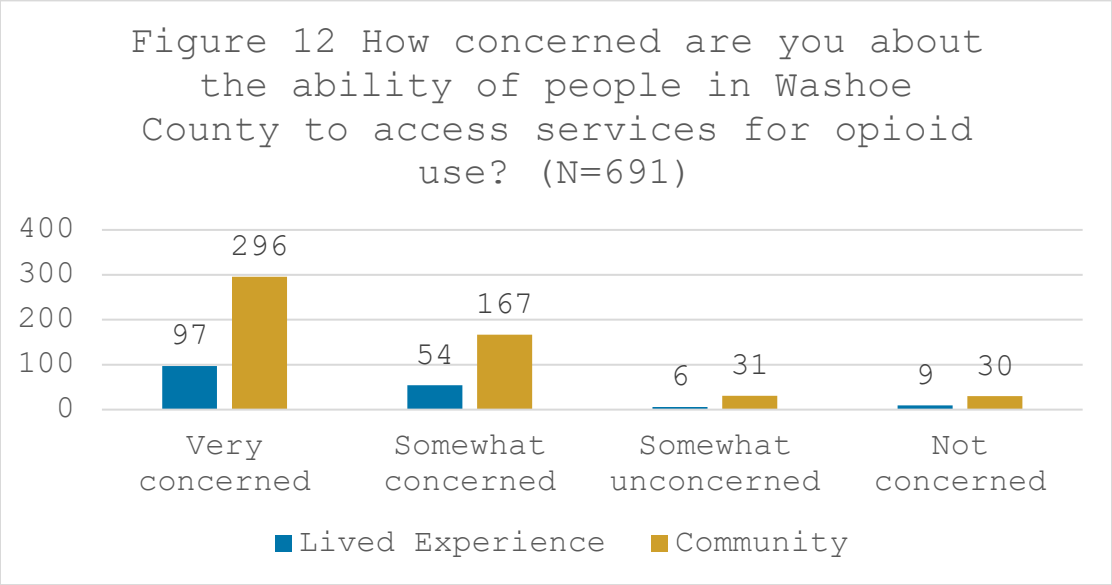
Figure 11 How long after you were booked did it take to receive your medication?(N=18)

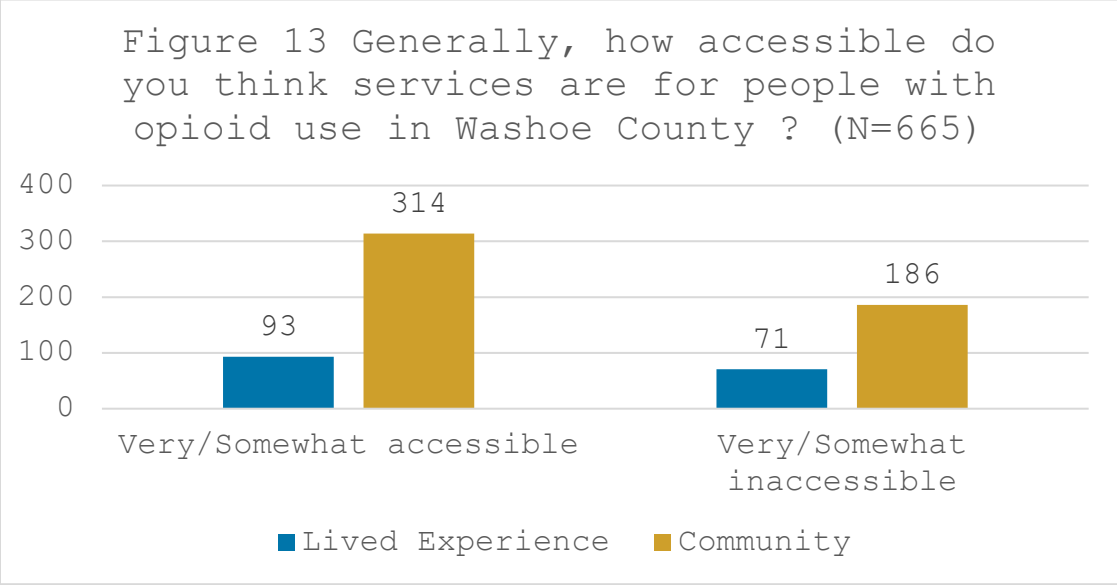


Survey Responses on Strengths, Needs, and Gaps

The most important services, strengths and service gaps stratified by opioid use experience of respondents showed similar percentages between prior/current users(n=184) and non-users(n=557) in their responses to “How concerned are you about the ability of people in Washoe County to access services for opioid use?”(Figure 12) and “Generally, how accessible do you think services are for people with opioid use

in Washoe County?" (Figure 13). Most respondents, 88.9%, (614) were either somewhat or very concerned about the ability of people to access services for opioid use. In contrast, respondents largely thought that services for people who use opioids were somewhat or very accessible (n=407, 61.2%).





In Figure 14 respondents selected their top five most important services. The top five selected across all respondents were 1. immediate access to treatment and detox, 2. after care and care navigation, 3. mental health care, 4. access to harm reduction services, and 5. crisis services. The top five selected by people who use(d) opioids

were 1. after care and care navigation, 2. immediate access to services, 3. housing services, 4. mental health services and 5. access to harm reduction services. Those with experience of opioid use place greater emphasis on aftercare and care navigation after exiting inpatient treatment (n=94, 57.7%) and housing services (n=77, 47.2%) compared to those without disclosed opioid use experience (n=248, 49.9%) and (164, 33%) respectively. Family reunification support was preferred by 16.0% (26) of people who use(d) opioids compared to 8.7% (43)of those who have not. Those without opioid use experience placed greater emphasis on restorative justice (15.7%) than those with use experience (7.4%).

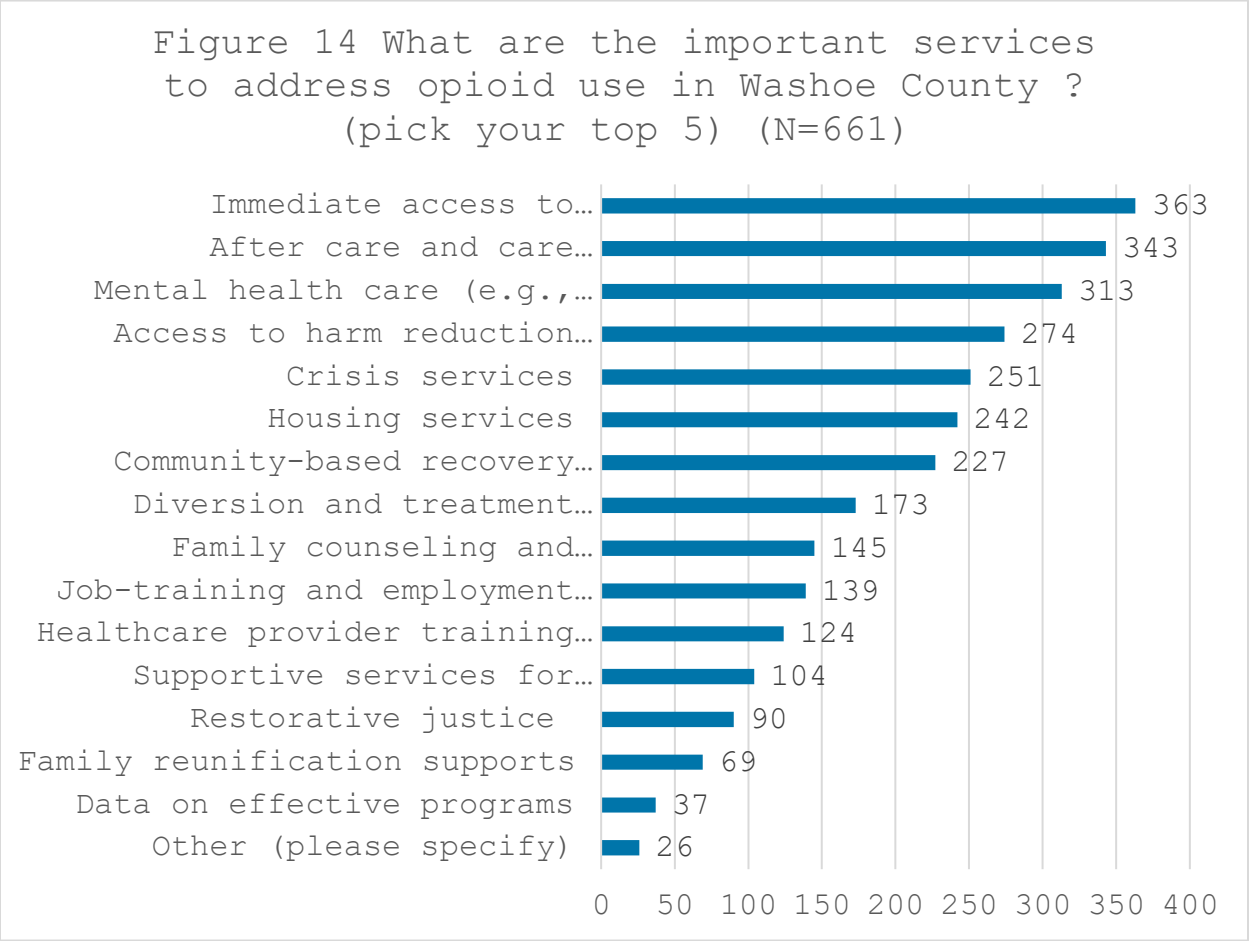
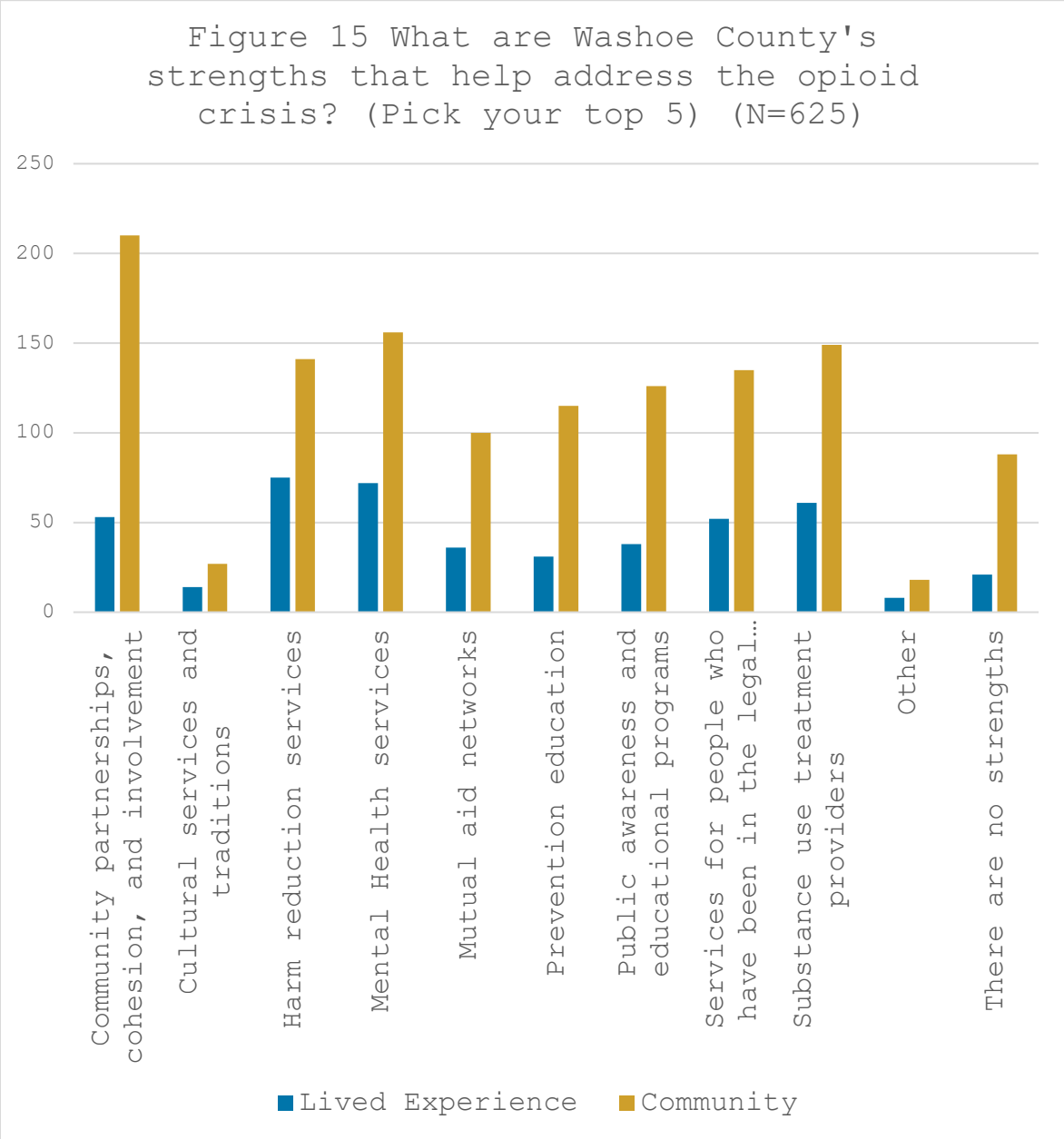


Table 1 What are the important services to address opioid use in Washoe County? (pick your top five)

Table 1	Lived Experience	Lived Experience	Community	Community
After Care and Care navigation after exiting inpatient treatment	94	57.7%	248	49.9%
Immediate access to treatment and detox	83	50.9%	280	56.3%
Housing services	77	47.2%	164	33.0%
Mental health care	71	43.6%	242	48.7%
Harm Reduction Services	63	38.7%	211	42.5%
Community-based recovery support	61	37.4%	166	33.4%
Crisis services (e.g., mobile outreach teams)	55	33.7%	196	39.4%
Job training and employment support	43	26.4%	96	19.3%
Diversion and treatment courts	36	22.1%	137	27.6%
Family counseling and resolution services	31	19.0%	114	22.9%
Family reunification supports	26	16.0%	43	8.7%
Healthcare provider training on opioid prescribing and treatment	26	16.0%	98	19.7%
Supportive services for youth affected by OUD	14	8.6%	90	18.1%
Restorative justice	12	7.4%	78	15.7%
Robust data collection and access to data on effective programs	9	5.5%	28	5.6%
Other	6	3.7%	20	4.0%

In response to “What are Washoe County’s strengths that help address the opioid crisis?” (Figure 15), the top five strengths selected were, 1. community partnerships, cohesion, and involvement (264, 42.2%), 2. mental health services (229, 36.6%), 3. harm reduction services (217, 34.6%), 4. substance use treatment providers (211, 33.7%), and 5. services for people who have been in the legal system (188,30.3%). Those without opioid use experience selected community partnerships, cohesion, and involvement (210, 45.1%) more than those with use experience (53, 34.0%). Higher percentages of those with use experience selected harm reduction services (75, 48.1%)

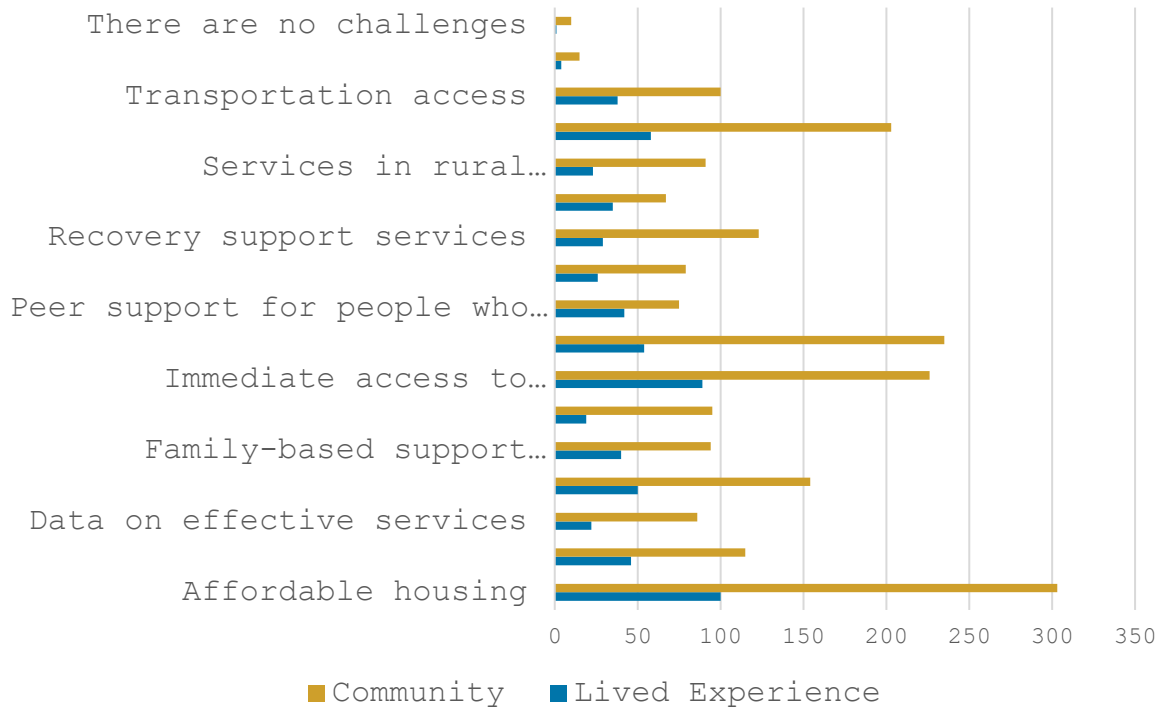
and mental health services (72, 46.2%) compared to those without opioid use experience (141, 30.3%) and (156, 33.5%) respectively.



In responding to “What are the greatest gaps in resources related to addressing opioid use in Washoe County?” (Figure 16), the most selected among all respondents was affordable Housing (405, 63.3%). The remaining top four were immediate access to substance use treatment and detox (315, 49.2%), mental health treatment (290,45.3%), lack of awareness about available services (263, 41.1%), and drop-in services or resource center (i.e. community centers) (204, 31.9%). Immediate access to substance

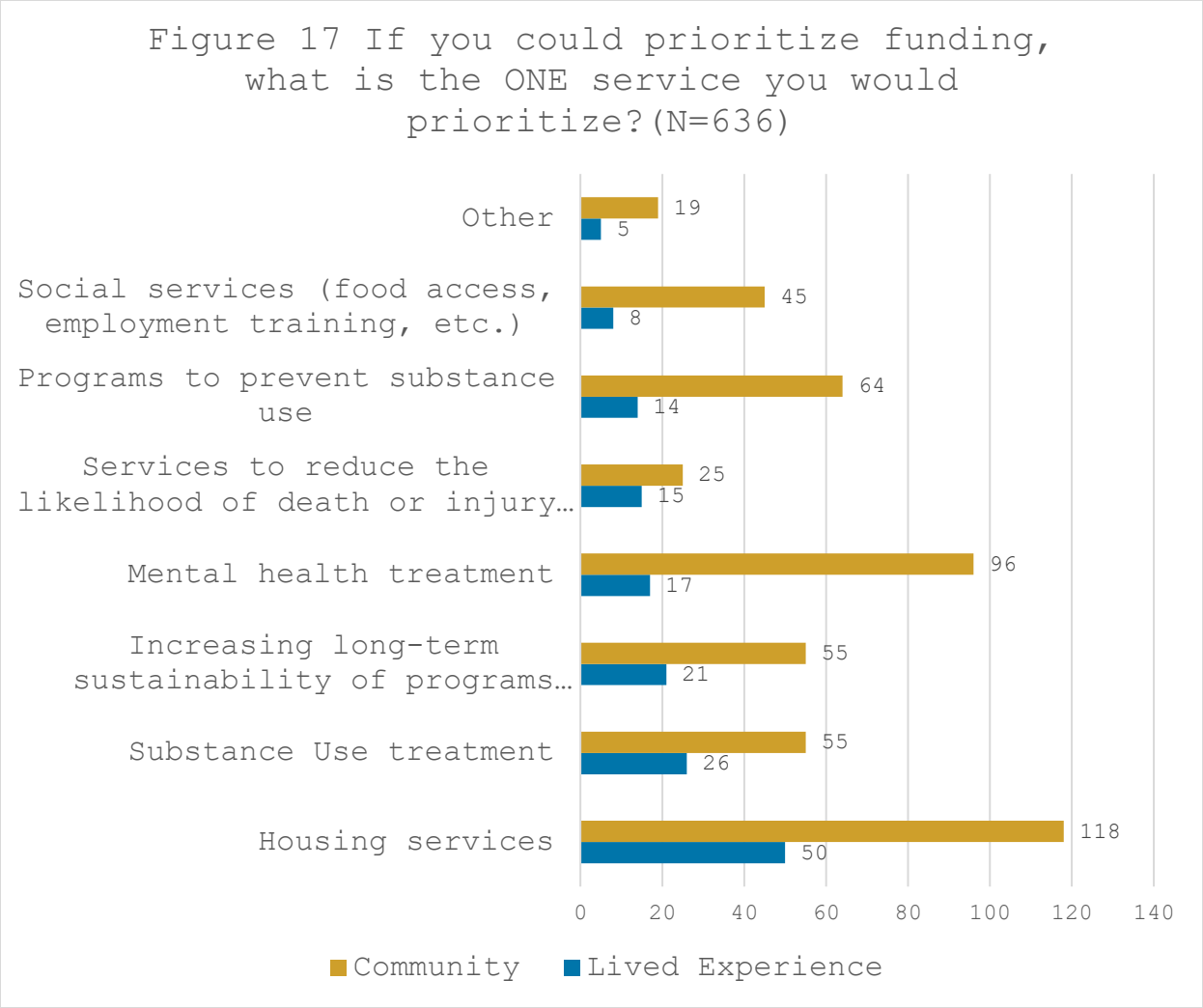
use treatment and detox was selected more by those with opioid use experience (89, 56.7%) compared to those without opioid use experience (226, 47.1%). Inversely, mental health care was selected more by those without opioid use experience (235, 49%) compared to those with experience (54, 34.4%). Although there were differences in rankings, the top five were consistent across the two groups.

Figure 16 What are some of the greatest gaps in resources related to addressing opioid use in Washoe County? (Pick up to 5) (N=640)

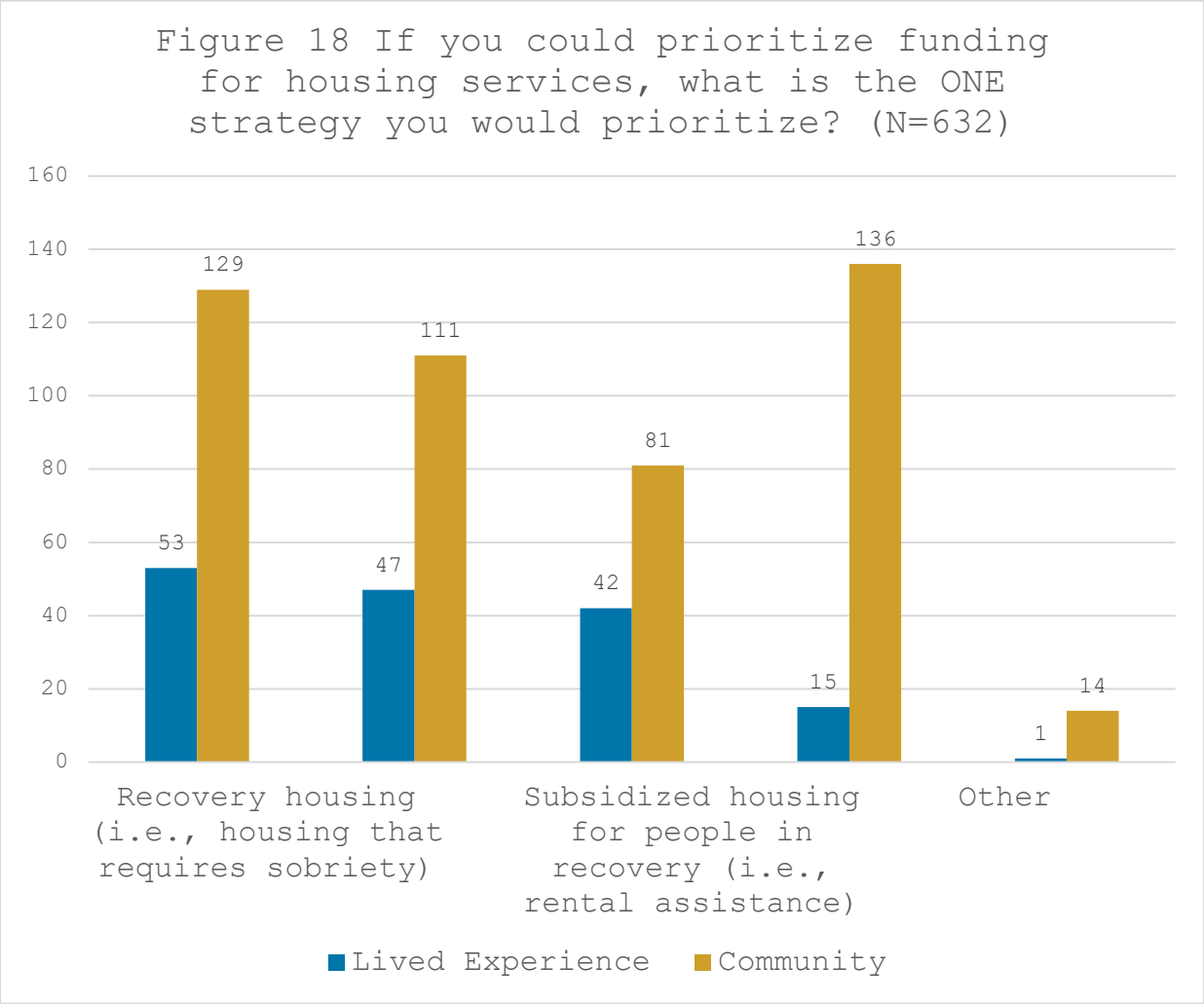


For the question, “What one service would you prioritize for funding, overall?” (Figure 17), the number one selected option across all respondents was housing services (169, 26.6%) followed by mental health treatment (113, 17.8%), and substance use treatment (81, 12. 7%). Among people who use(d) opioids, housing (50,32.1%) was still number one, but the second and third choices were substance use treatment (26, 16.7%) and increasing long-term sustainability of programs and services (21, 13.5%). Mental health treatment was selected more by those without opioid use experience (96, 20.1%) than those with experience (17, 10.9%).

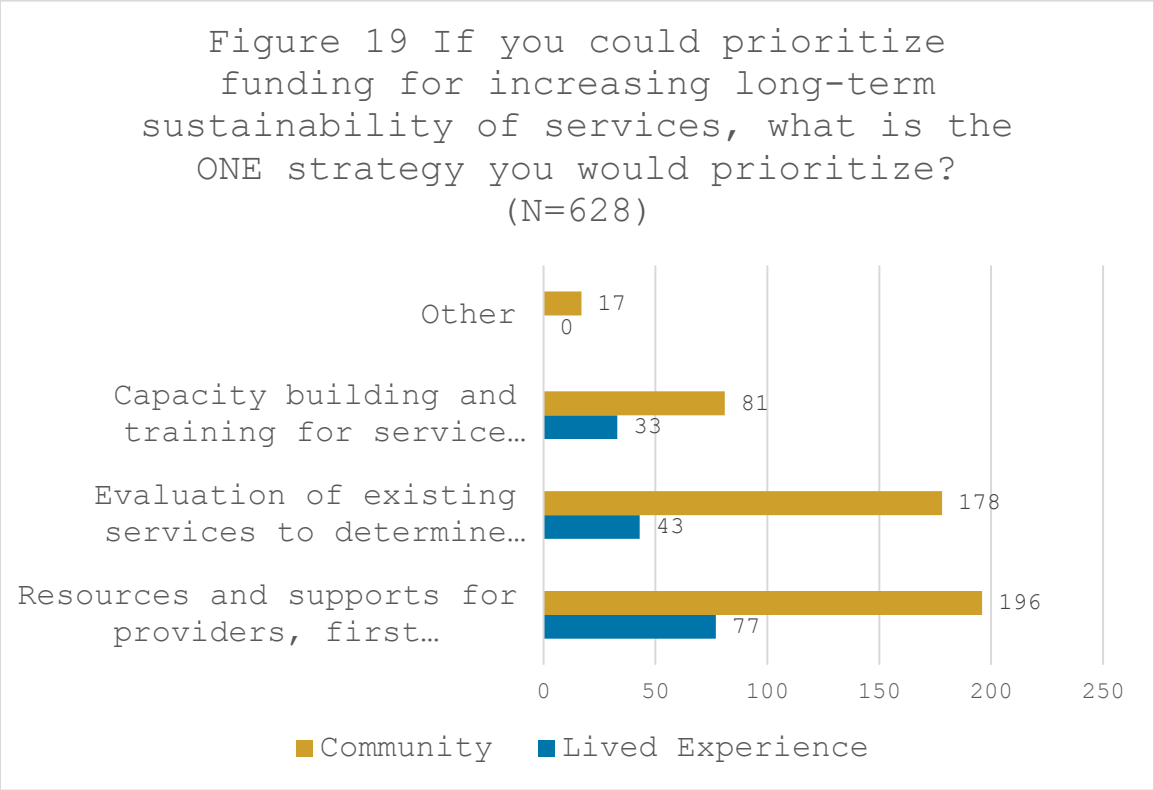
Survey Responses on Funding Priorities



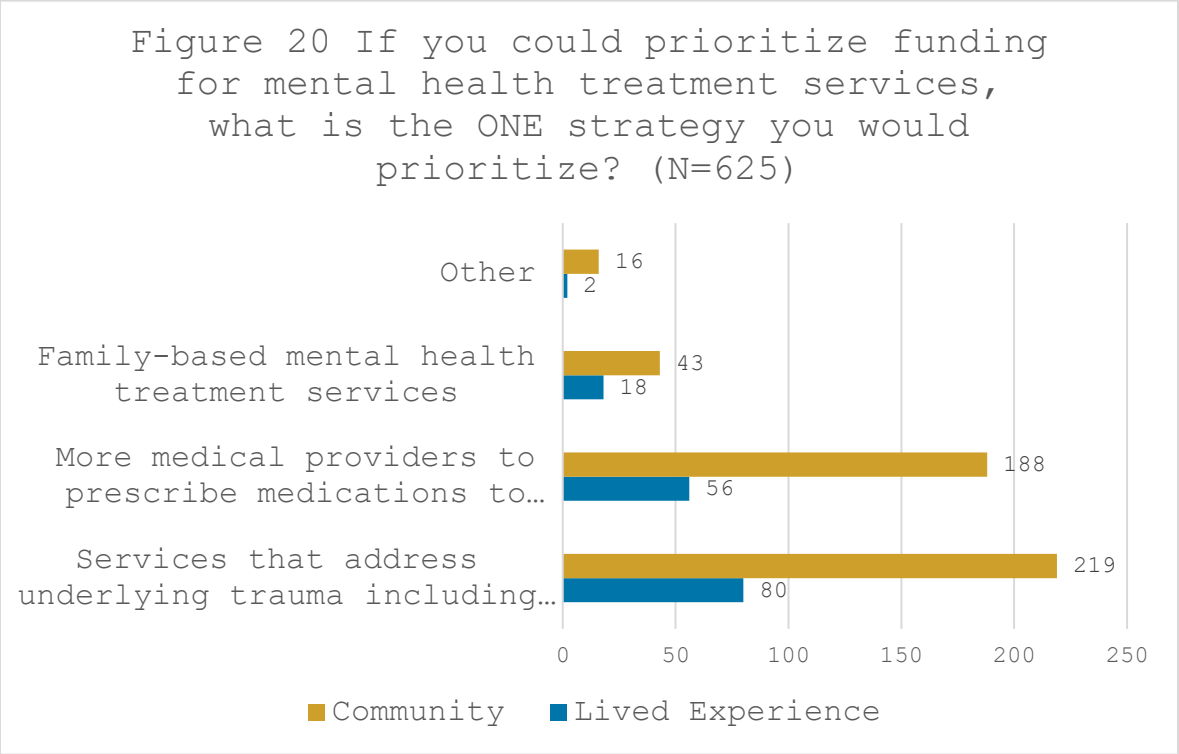
When prioritizing housing services (Figure 18) the top response across all respondents and among people who use(d) opioids was recovery housing (183, 29%), 53 (33.5%) people who have use(d) opioids selected it and 129 (27.4%) people without experience selected it. However, the number one selection for those without opioid use experience was transitional housing (136, 28.9%) which notably was the bottom ranked response among people who use(d) opioids (15, 9.5%). Those with use experience notably selected Housing First (47, 29.7%) as their number two.



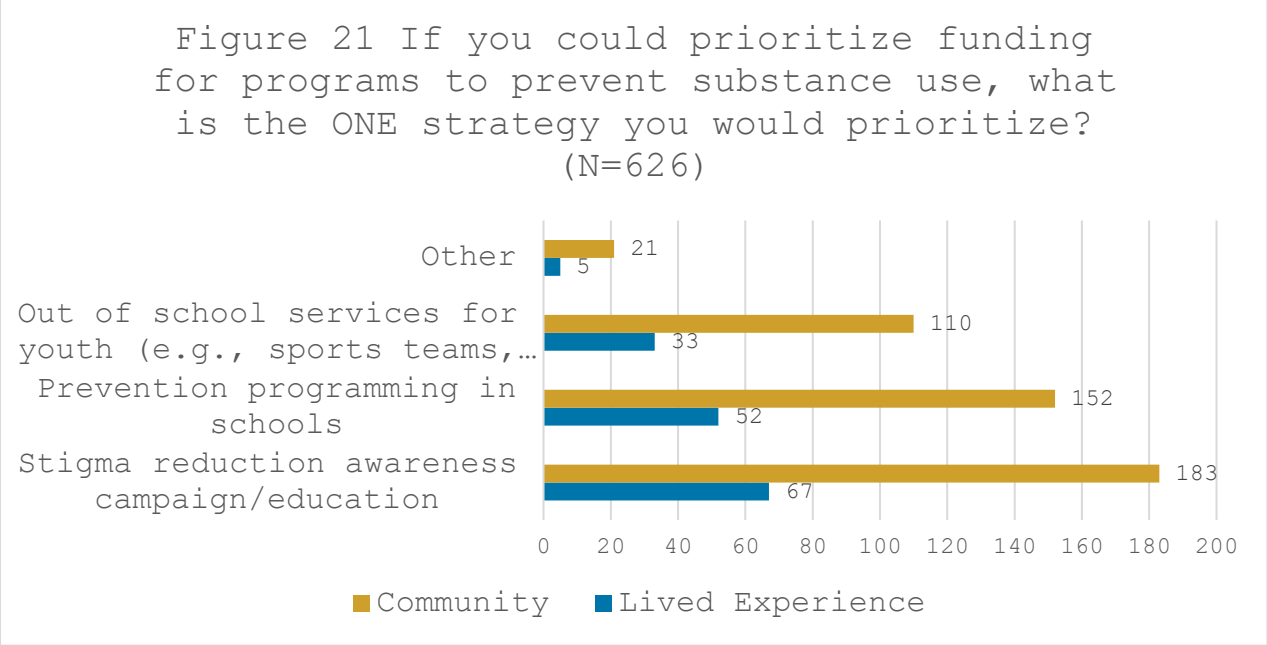
When asked to prioritize strategies for long term sustainability of programs and services (Figure 19) all respondents prioritized resources and supports for providers, first responders, and peer recovery support specialists (274, 436%). Those without opioid use experience (178, 37.7%) placed greater emphasis on evaluation of existing services to determine which are effective compared to those with opioid use experience (43, 28.1%) however each group ranked it second.



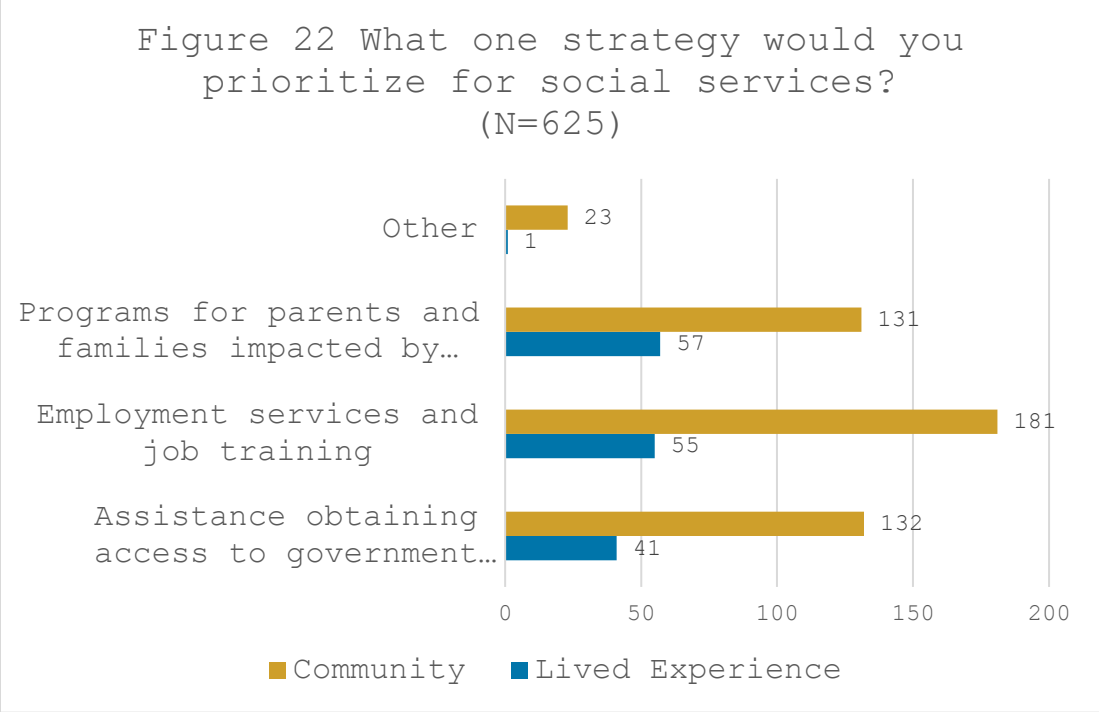
Respondents' choices aligned on strategies for mental health services (Figure 20) by prioritizing services that address underlying trauma including mental health treatment first (301, 48.2%). The second choice was more medical providers to prescribe medications to treat mental illness and social workers, counselors, therapists, or psychologists to provide therapy/counseling (244, 39%).



Responses to prioritizing funding for programs to prevent substance use (Figure 21) were also consistent among both groups. Stigma reduction awareness campaign/education (250, 39.9%) was the most selected option.

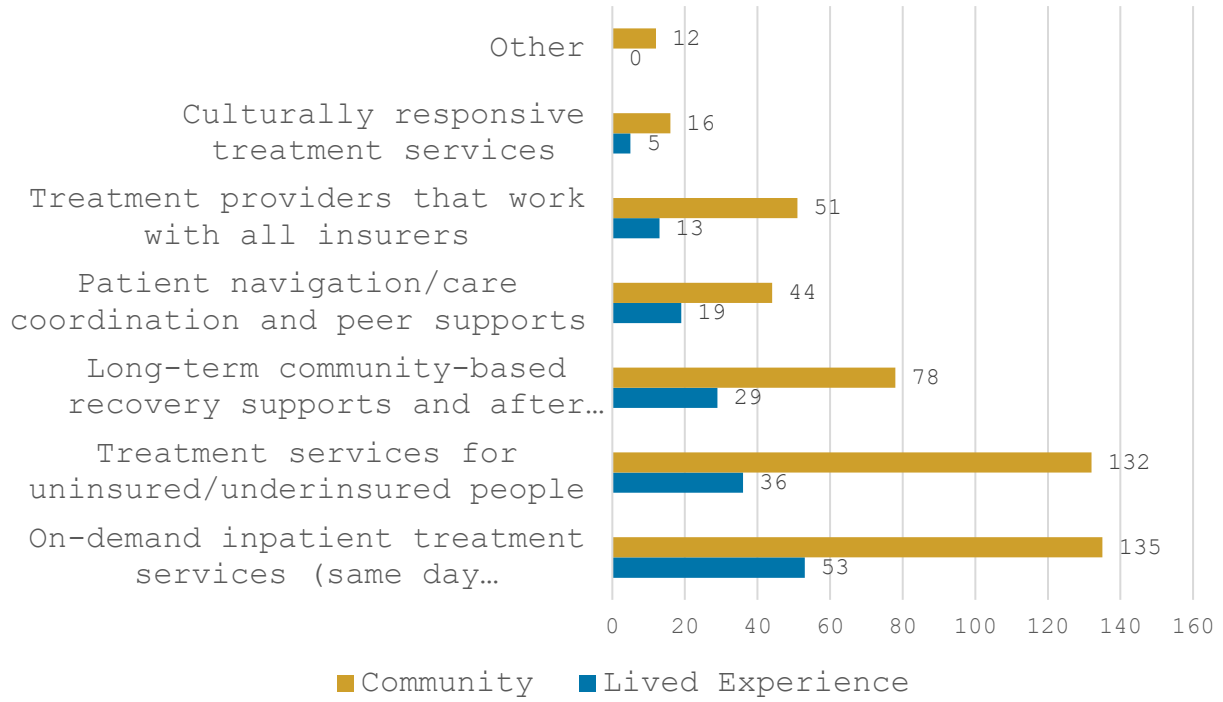


When selecting strategies for social services (Figure 22) those with opioid use experience selected programs for parents and families impacted by opioid use disorder as their priority for social services (57, 37.0%) while those without opioid use experience ranked it last (131, 28.1%). Respondents without opioid use experience prioritized employment services and job training (181, 38.8%) while people who use(d) opioids ranked it second (55, 35.7%).

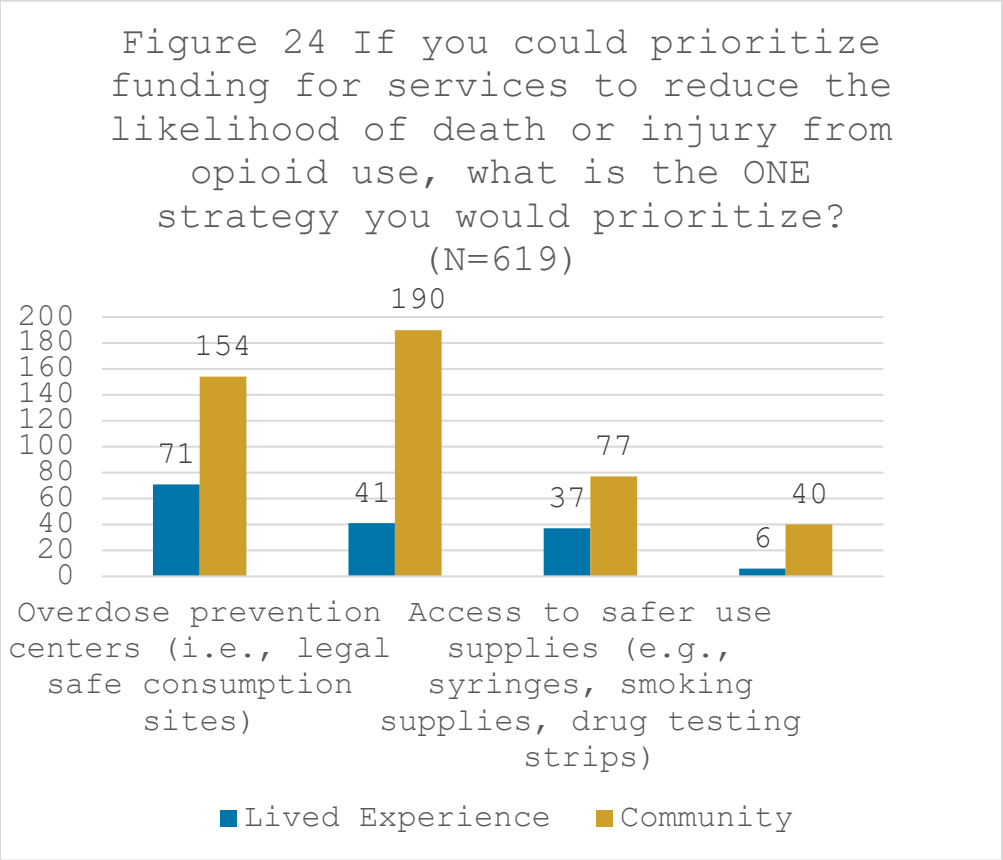


For substance use disorder treatment strategies (Figure 23), on-demand inpatient treatment services (same day availability) was selected the most by both groups (188, 30%). Treatment services for uninsured/underinsured people was second amongst both groups (168, 26.8%).

Figure 23 If you could prioritize funding for substance use disorder treatment, what is the ONE strategy you would prioritize? (N=626)



The top strategy for reducing the likelihood of death or injury from opioid use was naloxone training and distribution (233, 37.6%). However, among people who use(d) opioids the number one selection was overdose prevention centers (i.e., safe consumption sites (71, 45.8%) compared to non-users who selected it second (190, 41.2%). (Figure 24) While representing only small sliver of responses, this survey question had the highest response rate of “other” in the survey (46, 7.4%), the majority (40) of whom were people with no opioid use experience. Many write-in responses suggested a previous funding category in lieu of preventing death or injury from opioid use or doing nothing to prevent death or injury from opioid use.



Consistently across all the ranked strategies, questions roughly 20 respondents without experience with opioid use selected “other” and provided written responses. While these submissions were the minority, written comments revealed polarization around criminal legal approaches—some advocating harsher penalties, others calling for full decriminalization and treatment-first models. This divergence highlights the need for continued community dialogue and public education to build consensus around compassionate, evidence-based strategies. Overall, survey responses indicated that community members are aligned on creating the necessary conditions for people who are struggling with SUD to access resources in the community to heal and thrive. Both groups emphasized that addressing opioid use in Washoe County requires coordinated systems of care that link housing, mental health, and recovery services. While differences in emphasis exist, the data suggest broad agreement on the need for person-centered, low-barrier approaches that sustain long-term recovery.

Survey Findings

Across both community members and individuals with lived experience of opioid use, there is strong consensus that access to timely, coordinated care remains a major challenge in Washoe County. Respondents emphasized the importance of housing,

mental health treatment, and harm reduction as essential supports, though their priorities diverged in how these services should be structured and delivered. The key findings from the survey are:

- The number one funding priority is housing services.
- Washoe County requires coordinated systems of care that link housing, mental health, and recovery services.
- Less than a third of people who use(d) opioids reported they were not able to access a service when they attempted to in the last 12 months. The top three barriers in accessing services are: long waitlists, insurance type not accepted by the provider, and transportation.
- The most used resources in the community as reported by people who use(d) opioids are: community based recovery services, mental health treatment, and harm reduction services.
- Individuals who need MAT in jail are experiencing delays and barriers.
- Major systematic barriers impact access to services, including gaps in affordable housing and awareness of available services.
- Survey respondents were concerned about people's ability to access services yet felt that services were accessible. This suggests greater concern about coordinating and navigating people to appropriate services than service expansion.
- Washoe County's greatest strength is its community partnerships, cohesion, and involvement. The greatest gap is the lack of affordable housing.
- Existing harm reduction services are well utilized in the community and seen as a strength, but there is limited interest in expanding additional services.
- People who use(d) opioids placed a higher emphasis on housing, aftercare/care navigation, and familial support than people who have not use(d) opioids.
- Although there was broad agreement on the need for mental health treatment, people who have not used opioids placed greater emphasis on mental health support.
- There was core agreement on the need to sustain the behavioral health workforce through additional mental health supports for staff.
- The number one strategy in each funding priority area were as follows:
    - Housing: recovery housing
    - Sustainability of services: resources and supports for people in the field
    - Mental health: services that address underlying trauma
    - Prevention services: stigma reduction awareness campaign/education
    - Social services:

        - People who use(d) opioids: programs for parents and families impacted by opioid use disorder
        - People who have not used opioids: employment services and job training
    - Substance use treatment: on-demand inpatient treatment services (same day availability)
    - Reduce death and injury: naloxone training and distribution
- The top service priorities for People who use(d) opioids were:
        - Housing Services
        - Mental health treatment, and
        - Employment support.
    - Their top three treatment modalities:
        - Long-term recovery housing,
        - Mental health or trauma therapy,
        - Medication Assisted Treatment.
- The top five most important services to address opioid use in Washoe County among all respondents were, 1. Immediate access to treatment and detox, 2. After care and care navigation, 3. Mental health care, 4. Access to harm reduction services, and 5. Crisis services.
- The top five selected by people who use(d) opioids were 1. After care and care navigation, 2. Immediate access to services, 3. Housing services, 4. Mental health services and 5. Harm Reduction.
- A small number of written comments revealed polarization around criminal legal approaches, highlighting the need for continued community dialogue and public education to build consensus around compassionate, evidence-based strategies.
- Community members are aligned on creating the necessary conditions for people who are struggling with SUD to access resources in the community to heal and thrive.

Section Four: Qualitative Data

Qualitative data were collected via key informant interviews with people who use opioids, criminal court staff, and legal professionals, focus groups were conducted with loved ones of people who have died of an opioid use disorder, law enforcement officers, community organizations, child welfare court staff, and first responders to better understand barriers, strengths, and needs for people impacted by opioid use in Washoe County.

Methodology

Separate interview guides were developed for:

- people who work in the community directly with people who use opioids (including substance use disorder treatment providers, youth services providers, outreach workers, first responders, law enforcement, and criminal and child welfare court staff)
- people who use opioids or are in early recovery from OUD
- loved ones of people who misused opioids
- Washoe County government leadership

The interview guide drafts were sent out to the Steering Committee qualitative design subcommittee and stakeholders across sectors, including the Living Experience Advisory Board. Stakeholders provided feedback and refined the questions which were added to the final drafts (see Appendix E).

Purposive sampling was used to identify and recruit participants. During the process, feedback was intentionally sought from populations outlined in (NRS) 433.712 through 433.744, 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.

For the professionals and loved ones focus groups and interviews, the WOARF team sent a request for participants to the WOARF listserv and the Steering Committee list of over 90 people to identify individuals who might be interested. Providers were categorized by sector to ensure a diverse array of perspectives within the broader system were represented. Specific invites were sent to individuals whose sector were not represented. For interviews with people with living experience, the LEAB coordinator reached out to people in the community and invited them to participate. The interviews with leadership at Washoe County were coordinated, conducted, and analyzed by Nevada Division of Public and Behavioral Health staff.

Twenty providers, eight people who use drugs, six people in early recovery, three law enforcement officers, three first responders, four child welfare court staff and legal professionals, three criminal court staff and legal professionals, four loved ones of people who misused opioids, and four leaders in Washoe County government provided

insight through key informant interviews and focus groups during July, August, and September 2025.

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? How do people define success for people in recovery? What is needed to support people in the community? What are the strategies and opportunities to enhance care? What are the core health and service needs of people who use drugs? What are the experiences of people who use drugs in accessing services, participating in court, or involvement with child welfare?

In addition to the standard focus group process outlined above, the Steering Committee used a process of contradictory thinking[39], a systematic approach to developing solutions to entrenched problems where the team works to understand what Washoe County must stop doing to reach the goal. The Steering Committee was asked to answer three questions:

- Imagine you are tasked with *ensuring* that every person develops an opioid use disorder and that every person with OUD dies. What actions would you take?
- What activities, programs, policies, or procedures in Washoe County resemble the actions you identified?
- What are the first steps you can take to stop or modify these counterproductive actions?

All interviews were transcribed and coded by WOARF staff and the Steering Committee qualitative design subcommittee members. Upon conclusion, thematic saturation was reached; no new information was emerging from the interviews.

Qualitative Data Themes

Professionals who Work with People Impacted by Opioid Use

Professionals who work with people impacted by opioid use indicated there are many challenges of working in their field and providing services to people with an OUD. There were over 50 themes (See Appendix G) that were identified across the different focus groups. Shared across the groups of professionals were eight key domains:

1. Improve collaboration and communication.
2. Increase access to treatment services across the treatment continuum of need.

[39] Liberating Structures. (n.d.). *Making space with TRIZ*. Liberating Structures. https://www.liberatingstructures.com/6-making-space-with-triz/

3. Increase access to housing services across the continuum of need.
4. Continued investment in reducing morbidity and mortality and preventing overdose.
5. Provide support for youth and families impacted by OUD.
6. Provide support for providers working in the field.
7. Foster education and public awareness.
8. Remove transportation and documentation barriers.

Improve Collaboration and Communication

Professionals working with people impacted by opioid use highlighted that our community is lucky as there are many people who care in our community and want to do the work needed to address opioid misuse. A First Responder noted how the community in Washoe County is close-knit; if there is a need it is easy to reach out to a connection or collaborator to be connected to a relevant service. However, there is still need for greater collaboration and cooperation across programs and services as the professionals noted that too many people fall through the cracks in the continuum of care. Professionals in Washoe County need to be "coming together at the table, talking about the similarities, working with the same clients. We're all working with the same client population." (SUD Provider) As well as our systems, "Our systems need to connect - our databases need to communicate to better support people, but I don't know who the one person is who would be able to do that." (SUD Provider)

There were several challenges noted to building greater collaboration from philosophical challenges such as territorialism and competition to burn out of staff. One SUD provider suggested that providers need to reframe how the look at patients, they need to see that "These are **everybody's patients, and just making sure they're in the correct place that they need to be at, regardless if that's with us or another org** or whoever it is."

In describing what this collaboration should look like participants described regular meetings where frontline staff could meet and discuss the exact resources and support their clients are struggling to obtain and other providers identify if they could help. Lastly, a SUD provider discussed the burnout of continuing to show up at tables to discuss the problem and pose solutions but not create the changes we discuss. Meetings need to have action steps that lead to real change to maintain provider engagement.

There's an absolutely comprehensive and I believe intentional inability for organizations to collaborate with one another. I think that because we are limited in the amount of funding and forced to compete, then it

*becomes about how you can do this with the least amount of resources possible instead of throwing the resources at the problem... **There's collaboration driven by politics as opposed to coordinated care**. So, if I could wave a magic wand, I'd say it's to **build a system where we can actually collaborate**." - PRSS*

Increase Access to Treatment Services Across the Treatment Continuum

Substance use treatment requires a continuum of treatment services to help people transition from chaotic substance misuse to a point in the process of recovery defined by SAMHSA as the goal domains of Health (physical, mental, behavioral, and dental), Home (a stable safe place to live), Purpose (work, school, volunteering, or creative endeavors, meaningful daily activities and the ability to participate in society), and Community (connection, friends, family, and a social group that provides support, friendship, love, and hope).[40]

The continuum of care for individuals with SUD is designed to provide ongoing, flexible support that meets people where they are in recovery. Before care can even begin, people must complete assessments for appropriate levels of care and then be referred to those services in the community. Care often begins with detoxification, where individuals safely withdraw from substances under medical supervision. From there, many transition into residential treatment, an intensive, structured program that provides 24/7 support, therapy, and skill-building in a safe environment. After residential care, people may step down into an Intensive Outpatient Program (IOP), which allows them to live at home or in recovery housing while participating in several hours of treatment per week, maintaining clinical support as they re-enter daily life.

There were concerns at every step of the treatment continuum starting from delays in conducting assessment on. The system must change so that "**people aren't waiting on an assessment to wait on a bed in a program**." (Legal Professional) In Washoe County, there are currently no resources outside of the emergency department for medical detox from opioids unless the individual has serious co-occurring disorders. A SUD Provider pointed out that detox is the entry point to care for many, "**detox is a**

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[40] Substance Abuse and Mental Health Services Administration. (2012, February). *SAMHSA's working definition of recovery: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential* (Publication No. PEP12-RECDEF) [PDF]. U.S. Department of Health and Human Services. https://library.samhsa.gov/sites/default/files/pep12-recdef.pdf

barrier- if you can't do step one, detox, then step two, get a foundation, you can't even come to a place like our program." Beyond these first two steps, professionals described long-waitlists, insufficient bed space, not enough providers, and challenges with insurance coverage at every juncture in the continuum of care. These challenges were compounded when seeking culturally relevant services. One Tribal SUD provider discussed that many of the available resources for Native people are from out of state and not specific to local cultures. Washoe County needs to have immediate access to services so that people have "**something to help them on the exact day they are interested in getting help**." (Law Enforcement)

Across the continuum of recovery services people with OUD should have access to the full suite of the Medication Assisted Treatment (MAT) options. Participants agreed that MAT has been incredibly effective in Washoe County and should be expanded so more people have access. "The bottom line is … **medication assisted treatment gives somebody a better chance of treatment that is long lasting,** that works." (Law Enforcement Officer) However, there are challenges gaining access to MAT. One Court System Professional said, "**We need help paying for medications when people who are in court get jobs and are no longer eligible for Medicaid**." There is also stigma against the use of methadone, one of the gold standards of treatment for OUD, with some programs not accepting participants who are using methadone. Washoe County needs to address "**stigma against medications. We need medication agnosticism**." (SUD Provider)

In brainstorming what the strategy to address some of these issues could be, participants described a low-barrier temporary stabilization center that could connect people out to the appropriate resources. An SUD provider shared their team's vision of a program that operates to connect folks between services. They explained, "It is **a bridge between an encampment or whatever the chaotic, unstable living situation, the bridge between that and services**." In talking about what would be helpful to Law Enforcement officers in interacting with members of the public who use drugs they shared,

> "It would be helpful to have **a place where officers know they can take people or direct them where they can be taken to access resources**… a place where they can go to wait to access services— a bridge to get some of the resources started so that they have a ramp into the program."

There also needs to be outreach to individuals in active use who are disconnected from the community to bring them into programming. A PRSS expressed,

> "You gotta have people out there that are meeting people halfway, **that way when those people are ready, they know where to look, basically. I think the**

> **chances of someone getting on a phone and googling you is, I mean I know I didn't**. But if I would have had someone that has continued to show up, **meet me halfway while I'm [in] active use by the time I was ready, I probably would have sought him out.**"

Outreach workers can develop trust and relationships with people who are not ready for services so that when they are ready there is a trusted person who they can reach out to help them access resources. The development of a relationship through care and compassion can be a route for someone to ask for help.

"It's like trying to leave a lasting impression on somebody's heart and mind that they've been cared for and dignified, so that when it comes time for them to, if they're struggling, that when they're ready to make that decision, we're the people that they can call and they can trust to help them guide through their guide them through the process." - Community Outreach Worker

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Increase Access to Housing Services Across the Continuum of Need

Housing is an essential part of recovery, supporting stability and reducing relapse risk. Housing First allows people to stabilize and get a good night's rest so they can participate in treatment and other services.[41] Recovery housing or sober living homes provide alcohol- and drug-free environments where individuals live with peers committed to sobriety while building independence and accountability. For those rebuilding their lives and working toward long-term stability, transitional housing offers longer-term, structured support—often with case management, employment readiness, and life skills services—bridging the gap between early recovery and fully independent living. This layered continuum ensures individuals can move fluidly between levels of care as their needs evolve, promoting sustainable recovery.

Housing was a central concern for participants. From the challenges of getting from the streets into housing to the difficulties of affording rent during recovery, housing plays a role in barring people from living full and thriving lives. A PRSS who spent over three years on the Reno Housing Authority waitlist shared how they had relapsed by the time they were at the top of the list and then had to start all over.

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[41] National Alliance to End Homelessness. (2022, March 20). *Housing First* (Updated August 2022). https://endhomelessness.org/resources/toolkits-and-training-materials/housing-first/

> "Housing is absolutely needed. **Without housing families are unstable. Emotional safety, physical safety, sexual safety, everything is at risk without housing.** On top of that there is nowhere safe to put their things. Once housing is secure, they can focus on treatment and other changes." (Legal System Professional)

An SUD provider also described the challenges of people exiting treatment and returning to the same spaces they previously lived in, used in, and overdosed in. Returning to these spaces can be trauma triggers that make it harder to maintain sobriety and further trap people in the cycle of chaotic substance use. As he said, "**Why do you think they call a trap house a trap house. You try to leave it? It's the only place you can live so you go back to it**."

Many participants had suggestions and ideas on how to solve the challenge of housing people impacted by opioid use. A PRSS said, "If there was, **like a miracle that happened, motel vouchers, you know, something like to get people indoors at least for one day, so that they can get a good night's sleep**." A Tribal SUD Provider discussed that Washoe County has several great transitional living programs, but there is a need for more of them. A PRSS at a transitional living program was interested in establishing "**more places to go live in a sober community**." Another SUD Provider suggested integrating aspects of recovery programming into non-program specific apartment complexes. They explained it could look like partnering with the apartments to provide community resources to residents and having clusters of program graduates living in the programs.

"Housing is like, for an addict, it's like damn near trying to get approved for a credit card with no job. Especially if you add evictions to it. …Homelessness is going to make it super hard for that person based on sleep, based on the environment. It just makes it super hard to actually take that step forward into treatment." - PRSS

Continued Investment in Harm Reduction and Overdose Prevention

Harm reduction was the most mentioned theme in the focus groups with professionals. Some participants focused on the philosophy of Harm Reduction,

> "**Meeting people where they're at, you know, and supporting them, regardless of where they're at in their like, recovery journey**, and again, back to like, making things accessible to letting them know, like, that's what we're here for. If you're gonna use, we can use safely."

While others focused on the tools, such as Narcan (also known as the generic name naloxone a medication that reverses overdoses) which helps ensure people do not die of preventable overdose. One First Responder said "I think **Narcan should be in, like every business and like everything. Like, it should be absolutely everywhere, along with the education**." Another First Responder shared the availability of Narcan in the community has been a huge asset for our community. Harm Reduction tools also include access to clean use supplies to reduce blood borne pathogens, infections, and other bodily harms, as well as drug checking and test strips so people can know what is in their drugs and make more informed decisions about their use, ideally preventing misuse or overdose. Harm reduction gives people the opportunity to be ready to change and seek recovery. A Community Outreach worker shared,

> "Harm Reduction – naloxone, test strips, sharps. With chaotic substance use, you either change your mind, or you die. **It is important to have the opportunity to change your mind as many times as it takes**. It won't always be the first time. For me it was like the 40th time."

While people were happy with the current level of availability, they pointed out that many of resources in the community would be going away because of federal policy changes. Some of these changes are already starting to take effect, such as "Change Point closing down because of federal changes to Federally Qualified Health Center (FQHC) requirements." The impacts of these changes have not been fully felt in the community, but there is noted concern about how the hole left by the closing of Change Point will be filled.

"Rule #1, don't die." - SUD Provider

Provide Support for Youth and Families Impacted By OUD

An individual's OUD has the potential to impact their loved ones, particularly their children and dependents. Treating the individual without treating the whole family unit can lead to the individual recreating harmful familial patterns. Participants discussed the importance of providing a variety of services that allow families to access treatment. A PRSS at a MAT program talked about needing more residential treatment programs that served the entire family, as she said,

> "**A family's center**, and I know they just started opening that [family-based behavior change program]. But, I mean, we need stuff like that, because we have, **how often do you have a mom and dad where one of them is on drugs and the other one isn't? I mean, it doesn't happen that often**… Because a lot

> of them are obviously, obviously trauma bonded, but they **refuse to go get help without, without the other and that's why I would never go to the shelter when I was on the streets, is because I wouldn't leave [Significant Other]**."

A Legal System professional suggested that existing programs could adjust to better serve parents and families by providing child care and co-locating resources. An SUD provider suggested Nevada needs to change Medicaid billing to allow for prevention activities to qualify for reimbursement. By incorporating prevention activities into Medicaid reimbursable services, more people and families could have access to upstream modalities to ultimately help break the cycle of intergenerational substance use. Another SUD provider felt there needed to be more programs for youth, so that youth can participate in more free pro-social activities as a form of prevention. "**You never know if the kid is showing symptoms of depression, there's a reason for that, … maybe he's lonely. Maybe he needs to be part of a community program, you know, things like that, and like, not just baseball.**"(SUD Provider) A Youth Services provider shared that these activities also need to be tailored to the interests of today's youth. They stated,

> "**A challenge is that we are tied to these "evidence based" programs that are abstinence only and disconnected from youth.** They were written in the 1980s! Kids know when you're BS-ing them- they put up a wall. **They are "evidence based" but they are no longer effective**."

This insight shows that what was previously evidence-based may no longer hold up to the rapidly changing world.

"Weekend hours because families have to work. Childcare at Intensive Outpatient Programming so that parents can focus on their treatment. Have co-located parent and child resources for mental health treatment." -Legal System Professional

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Provide Support for Providers Working in the Field

In Washoe County there are insufficient numbers of providers, additionally those who are working in the field face high levels of burnout. As one Court Professional shared, "**all those folks are being vicariously affected by trauma. Everybody is swimming in this trauma…** And is there **something you could be doing to benefit the professionals so that they can continue to serve** …"

A First Responder shared, "[First Responders**] need to have more empathy**, **but they, run so many calls, it's also very hard to avoid burnout, and that burnout type of attitude**." While a Community Outreach Worker shared, "**We are working in these jobs because we care, it's not for the money. The turnover rate is extremely high because people burn out and don't have the means to self-care**."

Participants not only wanted greater mental health support for staff, but also more training and education to better support and serve their clients. Some people described wanting more training on the available resources while others wanted specific training on how to better understand and support clients.

"We need more training. Training on the early stages of active use and how to recognize it. How to communicate better with our participants, practical tips and tools to communicate with people who seem defiant. Sometimes we see it as defiance but in reality, it could just be that their brain is in such a certain way now that it's not working. What does it actually FEEL like for people. I can read all about it, but I don't know the experience. and like general knowledge of like additional resources if we are not the place for it, right? Trainings of like sometimes your brain works a little bit differently." - *SUD Provider*

Foster Education and Public Awareness

Participants agreed on the need for continued education and public awareness regarding the use of naloxone (Narcan) and to destigmatize people who use opioids, as many people still hold biased views about people who use opioids. One SUD Provider explained, "A lot of people really saw addiction as **just that's just the way they are. They're screwed up, nothing can help them.**" A First Responder shared, "That education component - it has been messaged a lot through advertising and billboards, **not necessarily so much as getting the interaction between an individual instructor or somebody of that type of expertise with the lay person**." Professionals agree on the need for developing more education and awareness that does not rely on outdated modes of advertisement.

Remove Transportation and Documentation Barriers

Key barriers to people receiving care include the ability to physically access resources and the ability to prove their identity. "One of the biggest barriers is transportation. That is the biggest barrier for people getting treatment right." (SUD Provider) A Court Professional discussed how transportation barriers can lead to an individual having too

many “No Call No Shows” and being denied access to future care leading to an even greater barrier to treatment.' A PRSS suggested setting up a program to provide “bus passes, or, like, cab vouchers, something like that.”

Documentation of identity is required to enter many treatment programs and receive MAT. As one SUD provider noted, “one big falling in the cracks that I see as far as treatment is **people, like, want to get in, but don't have ID. ID, and, you know, it's super hard for them to get to the DMV** clear the, you know, [expletive] down there. Like, how are they gonna get there? Walk for two days? You know what I'm saying? Like, that would be where the big pitfall is getting ID.” Not having ID also impacts an individual’s ability to get a job, as one SUD Provider said, “They're constantly losing IDs and social security cards, so it's like almost impossible birth certificates. It's **almost impossible to get them to work, because they've lost all their identification, and then trying to get it is a whole other thing. It's just such a lengthy process**.” A Community Outreach worker noted that sometimes it is the government employees that throw away people’s identification and medications.

A key resource that helps individuals navigate these barriers “is outreach to help patients get access to phones, identification, transport. It’s an effective approach to helping people.” (SUD provider).

“They're already mobile roaming the community. They already have frequent in person encounters with at risk communities. That is a Medicaid, those are both Medicaid billable services. … We just need more peers. We need more CHWs. They need to be strategically positioned.”- First Responder [42]

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[42] Existing outreach services referenced in this quote were defunded in October 2025.

Cross-Cutting Priorities Identified by Professionals

Improved Collaboration & Communication

- Strengthen partnerships and communication across agencies and service providers.
- Embed peers across the system to help navigate services.

Access to Treatment & Services

- Provide a low barrier drop-in center or space where people can access diverse resources to stabilize or begin to connect to resources.
- Expand in-patient and residential treatment options.
- Increase immediate access to detox.
- Provide mobile health care, including mobile clinics, street nursing, dentistry, and HIV/hepatitis testing.
- Increase outreach to disconnected populations.

Housing

- More housing options for people actively using substances or on MAT.
- Expand supportive housing for families, youth, elderly, and disabled individuals.
- Increase sober living and non-sober resource hubs in apartment communities.

Harm Reduction & Overdose Prevention

- Increase Narcan education and distribution.
- Provide syringe exchange sites.
- Support drug-checking services to identify drug contents and reduce overdose risks.

Support for Youth and Families

- Increase family-centered supports and trauma-responsive services.
- Increase culturally relevant, youth focused and trauma-informed services.
- Provide whole family treatment services.

Support for Staff & Providers

- Provide mental health support for staff and individuals in recovery.
- Provide robust ongoing training on staff identified topics.

Education & Public Awareness

- Increase public education on overdose recognition, Narcan use, and realities of addiction.
- Educate local businesses.

Transportation & Documentation

- Expand transportation assistance (e.g., bus passes).
- Improve access to IDs and social security cards for people experiencing homelessness through outreach.

There were also key themes that related to specific needs of different professionals in the community.

First Responders

First Responders, including fire and Emergency Medical Services (EMS) personnel, are often on the front lines of responding to overdoses in the community. First Responders highlighted the need for a mobile crisis or post-overdose response team, like the Trauma Intervention Program, to engage directly with people who overdose and their communities in the aftermath of an overdose.

EMS personnel also noted the current incentive structure for ambulances means that they are only reimbursed for services and care provided if someone is transported to the emergency department (ED). This means that many people who might not be best served by care in an ED setting are often not connected to the appropriate level of care. Many individuals with OUD do not require ED care, but are still transported, leading to stigma and unnecessary costs. While patients could be connected to treatment (e.g., a MAT clinic), there are no reimbursement structures or performance incentives for ambulances to provide alternatives to ED transport.

First Responders have a unique opportunity to meet people where they are and not leave them there. However, EMS and other First Responders are not equipped, and nor should they be, as the resource connector and case manager to appropriate services. As a potential solution to this, First Responders wanted access to a 24/7 resource line. This resource line could connect patients to necessary services as well as provide a feedback loop to EMS to demonstrate that their life saving efforts to support people in accessing additional resources had a positive impact. The First Responders suggested the development of a 24-hour hotline or app that EMS could use while with patients to connect them to resources.

First Responders are also community members who are impacted by substance use within their own families and communities. The First Responders spoke to not only their challenges professionally but also within their family systems. These challenges included uncertainty about how to connect family members to appropriate vocational supports, ensure they have insurance coverage, and provide immediate access to their psychiatric medication upon release from prison or jail. Despite working in the field, they too struggle to connect their family and loved ones to appropriate care, further demonstrating that even professional proximity to prevention and treatment services does not equate familiarity with and ability to engage in appropriate levels of care

Community Service Providers

Providers in the community discussed the challenges of obtaining reliable data on program effectiveness. One SUD Provider said, “There is not a lot of data on program success, so it becomes a thing of word of mouth. Who is showing up. Who collaborated and advocates.” While a person working in Outreach said, “Maybe if we had better data on the efficiency and effectiveness of programs, we would be better able to collaborate.” Providers felt that more accessible data on program outcomes would enhance their ability to connect people to appropriate services.

Community Service Providers and Law Enforcement

Community Service Providers and Law Enforcement both discussed the need to improve the collaboration between the jail and community services. This occurs both as individuals enter and exit the jail. As people enter the jail, SUD providers struggle to ensure their patients medications are being maintained.

> “A challenge is the different systems of communication and continuity. There’s no continuity of care with the jail and vice versa. Tried to get my patient’s MAT to continue in the jail. I talked to staff. I sent the prescription… people won’t be successful if we can’t stay connected.” (SUD Provider)

On the other hand, the jail doesn’t have the capacity to provide the warm hand off many people need as they are released. Law Enforcement shared,

> “The nature of Beast is we just don't have the capacity to connect back to the community. That's the thing, over and over and over again, no matter how robust our treatment is here, oftentimes we're sending people back right off the red curb upstairs. So, it's that we believe what we've studied the most important thing is a comprehensive approach, a community-based approach, right?”

Law Enforcement

Law Enforcement discussed many aspects of services in the jail including the MAT clinic and The Bridge Program. One key theme was the desire to ensure that more people entering the jail were accessing MAT. As one participant shared, “If we can get more people started on treatment in the jail, and then hopefully that transitional care with counseling and stuff within the community, I think that's the most important aspect, and that's what I would like to see.” They also were interested in having a resource hub or center that could connect people to resources immediately on release. “It's somewhere where there is, there is actually no barrier for anyone being released, depending on the hours of operation, to go and receive community-based resources at that reentry center.”

Legal System Professionals

Legal System Professionals identified several unique barriers based on their experiences trying to connect people involved in both criminal courts and child welfare courts to the appropriate resources. A major challenge noted was getting assessments completed in an appropriate amount of time to make sure they are connected to the appropriate level of care. They share it would be great if people “could go get evaluated, you know, ASAP to get a feel for their substance use and what they're going to need.” They also shared that “there is just not enough resources for domestic violence.” SUD and domestic violence are deeply interconnected; many victims of abuse use substances to cope with their experiences. Individuals exiting domestic violence need gender-responsive, trauma informed, substance use treatment and shelter services. Support from domestic violence resources should align with the SUD treatment continuum, recognizing reoccurrence of use as an expected and planned for part of the recovery process. Courts working with families impacted by domestic violence also need to be educated on how abusers utilize their victims past experiences with substance misuse to manipulate and discredit their victims.

Washoe County Leadership

Key informant interviews with Washoe County leadership were conducted and analyzed by Nevada Department of Public and Behavioral Health staff to better understand perceptions, beliefs, and knowledge of gaps, needs, and assets in the local government related to opioids and substance use in general.

Those interviewed were most proud of the work the county has collaborated on to support behavioral health, with the groundbreaking of the new behavioral health center mentioned frequently as a great step towards addressing severe gaps in behavioral health services, specifically bed capacity for inpatient needs. They recognize their organization’s work to address needs across the lifespan, including all ages, and across various topics.

Needs & Barriers

The most frequently identified needs were related to the shortage in providers, healthcare networks, and nonprofits – all of which were accompanied by a gap in funding to sustain any growth and development in closing this gap.

Washoe County’s leadership recognize the need to be proactive, to prevent an increase in burden as addressing needs later, when they are worse, is less cost effective and places additional strain on taxpayer funded systems and resources.

Impacts of Substance Use on the Community

Among members of Washoe County leadership, the most mentioned impact of substance use on the greater community was the visibility of the unhoused population and the jail, or carceral system, being left to attend to those populations as there's an intersection of substance use, homelessness, and incarceration. Several interviewees discussed how mental health and substance use are interwoven, and one cannot be addressed without acknowledging the other.

Economic impacts were also frequently mentioned, showing up as loss of jobs, negative impacts to the workforce, impacts on taxpayers through use of County systems and financial resources. Social impacts were also brought up, including negative impacts to the families, interrupting the family dynamic, and resulting in a serious burden on the foster program.

Approaches & Solutions

Proposed methods to improve and prevent opioid use in Washoe County included a holistic and multi-faceted layering of prevention and early intervention, including treatment without waiting and without insurance-related or financial barriers. The partnership with mental health and working to collectively improve mental health was often brought up, sometimes in conjunction with reducing social isolation, one of the methods was to enhance real human connections, through peer support. Several mentioned the need to reunite and include families in the recovery phase and to have families and those with lived experience speaking to others to share their stories to reduce stigma and foster open conversations.

Organizations Providing Services

A list of services and supports was provided to each key informant, the list was not necessarily reflective of all existing services in the community and did not identify which organizations or entities were providing those resources, if available. Most interviewees were not sure which entities offered which services and to whom.

Overall, there is a lack of awareness across the entire community on which organizations provide which resources, to whom, and when. A limited and finite number of organizations offer more of a one-stop approach, while most organizations are only able to address a narrowed scope of needs. Additionally, many nonprofits as well as the health district are in jeopardy of losing federal funding, and when present, these funding resources are often driven by national priorities and grant-funded initiatives, which do not necessarily reflect regional or local priorities and needs.

Positive Impacts on the Community

According to those interviews, addressing substance use, particularly opioid use, yields benefits that far outweigh the barriers. Many notable pros were identified including keeping families together, a more robust and healthier workforce, reducing the burden on systems (hospitals, the county jail, and public service resources), reducing stigma by acknowledging the existence of opioid use and misuse, and ultimately reducing the number of lives lost.

Overall

According to Washoe County leadership, the largest threat to Washoe County remains the longstanding shortage of funding to support larger networks of care able to provide a holistic approach and consistent service for screening, referrals, and treatment of opioid use disorder and related health issues, including mental health services and supports. The existing system remains fragmented and fragile, with inconsistent networks and the shortage in providers able to accept Medicaid and uninsured patients, insufficient numbers of peer support and patient navigators, a lack of agency coordination, and unawareness of existing resources.

The largest assets to Washoe County include the standing up of a new behavioral health inpatient center, the continued collaboration in recognizing mental health and behavioral health as a gap needing to be addressed by all service providers, the Washoe County jail offering MAT, and implementation of the sequential intercept model, to reduce the unnecessary incarceration of persons with mental health or SUD. Additionally, there are several non-profit and volunteer organizations and individuals who provide street outreach offering naloxone, hygiene supplies, and other helpful items to those in need, while some are funded and others are not formally recognized, their efforts do not go unnoticed.

Loved Ones of People Who Misused Opioids

Loved ones of people who misused opioids shared many of the themes that were presented in the Professionals analysis also surfaced with the Families including: Harm Reduction, stigma/community education, peer supports, whole family supports, immediate access to care, residential treatment, detox, vocational supports, mental health supports for providers and families, and housing. New themes included generational/familial use, the self-isolation of their loved ones, the importance of having people who love and support you through your recovery, and recovery friendly workplaces.

Every single participant in this focus group had lost two or more people they loved to an opioid overdose. Each of them felt strongly that had their loved on had access to naloxone they might still be here today. As a result, Harm Reduction, and in particular

overdose prevention, was the key theme with this focus group. Many shared that they had not heard of Harm Reduction prior to their loved ones starting to misuse opioids and were not immediately open to the concept. One person shared,

> "I come from a 12-step based recovery, and so I only knew that. That's all I knew. And then when I learned more and was very educated about it, I opened my mind and said, well, you know, they may be smoking marijuana, they may be doing this, but, you know what, it's reduced the harm because they're not using heroin, you know, whatever it may be. So that was very helpful and very insightful for somebody who thought that was the only way, abstinence was the only way, and that people couldn't get, you know, sober unless they did that."

Participants also discussed the importance of continuing to have free access to Narcan in the community, one shared their experience filling a community box with Narcan and said, "there's even been notes in there saying, Your Narcan, saved a life. And that's huge." Their discussion on Harm Reduction also focused on the importance of ensuring people who are using drugs can check their drugs to know what they are and how much they are using. "Safe use, safe supply, I should say that's gold standard for me, but most of the issues that we come into with drug use result from an unknown supply with unknown adulterants and unknown quality."

Participants also talked about the toll on them physically and emotionally trying to support their loved one while not receiving support themselves. One mother shared,

> "I can recall getting up at the crack of dawn to take [son] to the methadone clinic... to make sure that he was there at a certain time and was one of the few that could actually get his dose. And that was just rough to know that I had. I thought it was one way I had to help him, and that was my only option at this point. Because again, no insurance, no job, no nothing. How can he go to a doctor? How can he find a counselor? How can he do these things to try and get it on his own? So that was really hard. I mean, **that puts a lot of pressure on the family, a lot."**

The challenges of being a support to a loved one included the long waitlist to get into care, navigating the insurance system, and the difficulty of getting them into a service while they were willing. The loved ones all shared how critical support for the entire family unit is as they care for their loved one who is struggling.

> "The families need, like, some counseling, or like, organized groups for families. That's kind of like, you know, folks who take care of their family as Alzheimer's, like, you need a break. You need self-care. Somehow, you need to take care of

> yourself, because if you don't do that, you can't take care of anybody else, and it's a disease."

A couple of new themes that emerged were the push and pull of loved ones isolating and being isolated during their chaotic opioid use and the critical importance of having support in place to begin the recovery journey. "My mom, as soon as she knew that [my daughter] was using, she shut her off completely. Which was really devastating, and to all of us and then, but my sister was a big help." These relationships are important not only for the person in active chaotic use but also for their loved ones.

The loved ones who participated also highlighted that OUD can be generational. One participant shared, "Addiction runs in my family. It's in our DNA. I've been affected greatly. I've had five family members die of overdose, or actually, six." The cycle of OUD can continue for generations if family members are not connected to appropriate services.

One of the key domains of recovery is a sense of purpose and productivity that many people find through their work. One participant in talking about a loved one who had passed shared, "It really, it was really hard to watch him succeed through some treatment and find a job that really struck a joy in his life and supported his work in Harm Reduction. And then he lost that job, and that was a real big thing that was holding him in place. And so, a couple years later, he passed." Having recovery-friendly workplaces can be a preventative measure for people who are in recovery. Recovery-friendly workplaces are certified employers that enact policies and procedures that wrap people who are struggling with substance misuse in support and connect them to resources rather than using punitive measures such as termination immediately.

Ultimately, the loved ones of people who use opioids emphasized the need for more access to Narcan and lifesaving supports and services because "they can't seek recovery if they're dead."

People with Living Experience Using Opioids and People in Early Recovery

We spoke with eight people who identified as people who use opioids. The role and function of opioids and other substances in their lives changed over time. The themes from these conversations centered on safety and housing, behavioral health and social connection, current patterns of use, and healthcare needs. Because the perspectives shared by this population were particularly diverse and detailed, charting their unique journeys with opioid misuse, this section is organized into sub-themes to highlight the depth and breadth of their experiences.

Safety and Housing

- **Prevalence of Violence:** Violence is common within the homeless community, with women in particular reporting frequent victimization.
- **Theft and Loss of Belongings:** Theft occurs both within encampments and during police-led cleanups, resulting in loss of essential items.
- **Unstable Housing:** Housing is inconsistent and often inaccessible due to lack of steady income or employment. Social Security Income is insufficient to cover rent in Washoe County
- **Low-Barrier Housing:** Participants emphasized the need for housing without sobriety requirements.
- **Identification Challenges:** The loss or theft of IDs creates barriers to employment, prescription access (including MOUD), and healthcare appointments.
- **Limited Drop-In Services:** Mutual Aid resources on Tuesdays at Believe Plaza (IDs, hygiene kits, naloxone) are valued but the once-weekly schedule is insufficient.
- **Access Without Conditions:** Individuals want hygiene services and drop-in support without being required to attend sobriety meetings.
- **Basic Needs Barriers:** Lack of public showers and restrooms significantly impacts mental health and well-being.
- **Insufficient Safety Net:** Disability and senior services are inadequate to cover housing needs, particularly for those who cannot live in congregate settings.
- **Gender Roles:** Women were seen as community hubs for trust and education, while men often perceived themselves as protectors or gatekeepers.
- **Gender Based Violence**: All women described sexual violence and gender-based violence and multiple men mentioned how the community overlooks the violence perpetrated against women who are homeless.

2. Behavioral Health and Social Connections

- **Isolation and Loneliness:** Many reported feeling disconnected, used for their housing, drug supply or resources, or generally, lacking genuine support.
- **Chosen Family:** Some described support within the drug-using community, including the importance of people you trust being present during overdoses.
- **Unstable Connections:** Without housing or cell phones, maintaining relationships and support systems is difficult.
- **Intimate Relationships:** Younger People with Living Experience (PWLE) often mentioned having sexual partners, while older adults reported decreased need for sexual connection.

- **Community Spaces:** There is a desire for safe, inclusive spaces where community members can gather without substance use or sobriety being the focus.
- **Limited Harm Reduction Knowledge:** Many were aware of naloxone and other harm reduction resources, and despite believing they were well-informed, reported improper usage of naloxone.
- **Trusted Messengers:** Information is best received from both professionals (e.g., medical providers) and PWLE with credibility.
- **Harm Reduction Vending Machines and Syringe Exchanges:** Awareness varied—some used them, some had heard of them but did not understand how they worked, and others were unaware but expressed interest.

3. Critical Intervention and Prevention Points

- **Early Intervention Needs:** Prevention begins with stable family supports, safe housing, and healthy coping mechanisms for stress.
- **Trauma as a Trigger:** Many reported relapse or initiation of use following traumatic events, such as the death of a parent or identity theft.
- **Generational Patterns:** Several cited family or intergenerational substance use beginning at a young age.
- **Lack of Future Outlook:** Many did not perceive viable alternatives or opportunities outside of substance use.
- **Pathways to Use:** Common factors included depression, anxiety, trauma, employment in physically demanding industries (e.g., construction), and unresolved chronic pain.

4. Current Patterns of Use

- **Perception of Control:** Many believed they could quit at will and did not view their current use as problematic, despite homelessness.
- **Time and Energy Demands:** Substance acquisition and use occupied most daily focus.
- **Functionality Through Use:** Many reported using substances to maintain stability and avoid withdrawal symptoms.

5. Healthcare Needs

- **Health Concerns:** Participants reported both drug-related (e.g., HCV, infections) and non-drug-related health conditions (e.g., chronic pain, resistant infections).
- **Dental Health:** Nearly all reported significant dental issues, including missing teeth and infections.
- **Insurance Coverage:** Most had Medicaid or Medi-Cal but still faced systemic barriers to timely, coordinated care.

- **Prescription Barriers:** Challenges included transportation to pharmacies, managing prescriptions, and accessing medications.
- **Healthcare Access:** Key barriers included long wait times, lack of appointment reminders, and difficulty navigating the system.
- **Stigma:** Negative experiences with healthcare staff, particularly in ER settings, left individuals feeling unheard or dismissed.
- **Mobile and Street Medicine:** Strong support for expanding visible, accessible healthcare where PWLE spend time.
- **Healthcare Navigation:** Patient navigators, especially those not tied to a single provider system, were identified as critical supports.
- **Peer Recovery Support Specialists (PRSS):** Awareness was low, and the role did not hold strong meaning for many participants as they had not engaged with or met a PRSS.
- **MOUD Preferences:** Participants expressed mixed views—some disliked methadone due to daily requirements, while others avoided buprenorphine because it required withdrawal to initiate.

Steering Committee Counterproductive Practices Discussion

Through a structured exercise, Steering Committee members identified both hypothetical and existing counterproductive practices that hinder progress in addressing OUD in Washoe County and the possible solutions to those practices. This exercise highlighted how harmful systems-level decisions can worsen health disparities and increase community harm.

Worst-Case Scenario Thinking: Participants first imagined extreme policies and practices that would exacerbate the opioid crisis, such as eliminating access to treatment and services to reduce morbidity and mortality, increasing criminalization, removing family support, prolonging waitlists, and restricting education and prevention.

Current Counterproductive Practices: Many of these worst-case ideas reflect real challenges in Washoe County. Stakeholders reported barriers including:

- **Access to Care:** Long waitlists for housing and treatment, requirements for insurance or sobriety before services, and providers dropping contracted insurance plans.
- **Service Gaps:** Limited whole family support, inadequate trauma-informed care, insufficient youth services, and lack of outreach.
- **Systemic Barriers:** Stigma surrounding methadone, overprescribing of opioids, financial inequities, and fragmented collaboration between agencies. These

factors create barriers to treatment, perpetuate stigma, and leave vulnerable populations without needed support.

Opportunities for Improvement: To reverse course, stakeholders identified priority actions such as expanding Medicaid coverage, reducing treatment and housing wait times, implementing housing-first strategies, offering free sober and family activities, increasing access to naloxone and services to reduce morbidity and mortality, and investing in peer workforce development. Trauma-informed care, stigma reduction, and valuing lived experience in the workforce were emphasized as essential.

Implication for Needs Assessment: The findings illustrate that addressing systemic barriers, stigma, and inequities is critical to improving outcomes. Strengthening collaboration, increasing access to services, and supporting families and youth are areas of significant need in Washoe County's response to the opioid crisis.

Themes

Strengths

- Widespread public access to free naloxone is saving lives.
- The providers and people working in the community care.
- There is great cohesion between people working in the community which enhances the potential for collaboration.
- People in the community respect and value the voices and experience of peers and they are being integrated into more aspects of care.
- The Mental Health and Substance Use Treatment support at the Washoe County jail have positively impacted the overall community.
- Harm Reduction is seen as an effective philosophical approach in treatment. By providing harm reduction education to people about how to stay safe, people can stay alive to obtain treatment.
- Community access to tools to reduce morbidity and mortality is seen as effective.
- Outreach to homeless and disconnected people has provided an initial starting point for people to trust service providers when they are ready for change.
- Greater understanding of the multiple pathways to recovery and that not everyone's journey will look the same.

Challenges and Barriers

- Immediate access to services. It is extremely difficult to connect people to the appropriate level of care across the continuum of care, during their window of change. Waitlists are long and there are limited options for people with Medicaid.

- Insufficient support for people in the SUD workforce including monetary and mental health supports which lead to high rates of burnout and turnover in the SUD workforce.
- Successful outreach interventions were defunded in October 2025.
- Lack of affordable housing, recovery housing, or housing first which is a barrier to starting or maintaining recovery.
- Stigmatizing beliefs about people who use substances are a barrier to accessing care, particularly in the emergency departments.
- Lack of dental care providers in the community who will support people on Medicaid.
- Changes at the federal level are having an unpredictable impact on the local level ability to provide care and services.
- Barriers to engaging in services often include basic needs (e.g., insurance, funding, transportation, housing, food, etc.)
- Providers need to collaborate on the specific needs of specific clients and ensure continuity of care across the community and to ensure providers are not creating redundancies and extra work for participants.
- Inconsistent collaboration between the jail and community both at intake and release, many people who are prescribed MAT in the community are not maintained upon intake, and at release, the continuity of care and programming on release is inconsistent.
- Prevention education grounded in lived experience and tailored to the audience is not in all the schools.
- The only options available to individuals detoxing from opioids without co-occurring diagnoses are the emergency departments and the Mallory Behavioral Health Crisis Center in Carson City.
- There are not enough services that support the whole family.
- People who are homeless frequently have their identification and medication stolen, lost, or thrown away (including by law enforcement) which makes it harder to get a job, access health care, and many other resources.
- There are significant issues accessing transportation to treatment services, the DMV, and other supports.
- Federal policy changes are impeding access to life-saving tools and services to reduce morbidity and mortality.
- People who use opioids describe feeling they know how to use naloxone while simultaneously describing improper usage suggesting a need to pair the tool with greater education.

Opportunities

- Provide street outreach and street medicine to help bring services and support to disconnected people.
- Provide mental health supports to peers and other working to support people with substance use disorder.
- Develop a low-barrier drop-in stabilization center where people can temporarily wait for services at the appropriate level of care.
- Increase Recovery Friendly workplaces.
- Maintain in-person access to the tools and supports that reduce morbidity and mortality among people who use drugs, including naloxone and clean use supplies.
- Interrupt generational cycles of use by providing whole family supports.
- Develop training and public awareness opportunities on stigma and trauma.
- Support the ongoing provision of training to the SUD workforce.
- Enhance opportunities for low-barrier, affordable, and recovery-based housing.
- Create pro-social resources for youth.
- Develop a process to help people obtain and maintain identification documents.
- Outreach and efforts to reduce morbidity and mortality must pair naloxone distribution with education on proper usage and rescue breathing.

Section Five: Disparate Impact and Structural Barriers Analysis

This Needs Assessment has revealed universal themes of struggle and resilience, it has also exposed how structural barriers, historical inequities, and systemic practices create disproportionate harm for specific populations. This section identifies populations experiencing disparate outcomes and maps the structural barriers that perpetuate harmful practices.

Populations Experiencing Disproportionate Impact

1. Native American/Indigenous Communities

Evidence of Disparity: The Needs Assessment revealed significant gaps in culturally responsive services for Native people:

- *"Many of the available resources for Native people are from out of state and not specific to local cultures."* (Tribal SUD Provider)

- *"Culturally relevant services"* was identified as a gap with limited access noted
- Traditional healing practices are misunderstood

Specific Barriers:

- Treatment often requires out-of-state referrals, disrupting cultural connections and family/community bonds
- Lack of treatment models incorporating traditional healing practices and indigenous wellness approaches
- Historical trauma from colonization, forced assimilation, and genocidal policies compounds individual trauma

When treatment requires leaving one's community and culture, it creates an impossible choice: access care by severing cultural identity or maintaining cultural connection while forgoing treatment. This false choice leads to lower treatment engagement and poorer outcomes.

2. People Experiencing Homelessness

Evidence of Disparity: Homelessness emerged as the single most compounding vulnerability, intersecting with many gaps and needs in Washoe County:

- *"People who are homeless frequently have their identification and medication stolen, lost, or thrown away (including by government officials) which makes it harder to get a job, access health care, and many other resources."* (Key Finding)
- *"Homelessness is going to make it super hard for that person based on sleep, based on the environment. It just makes it super hard to actually take that step forward into treatment."* (PRSS)
- Housing was identified as the top funding priority across all survey respondents
- Housing was identified as a critical need in the secondary data analysis

Specific Barriers:

- Cannot rest adequately to engage in treatment
- Belongings, identification, and medications stolen or confiscated/thrown away during encampment sweeps
- Lack of stable address/ID prevents employment, benefits enrollment, and service access

- Transportation barriers magnified by distance to services
- Difficulty connecting to existing services due to lack of access to phones and internet
- Stigmatizing experiences in healthcare settings, particularly emergency departments
- Environmental triggers for substance use are constant and unavoidable

Every barrier documented in this assessment is amplified by homelessness. Treatment success rates plummet when individuals must return to the streets or to motels and trap houses after completing programs.

3. Women and Gender-Diverse Individuals

Evidence of Disparity: Gender-based violence emerged as a pervasive and under addressed crisis in Washoe County that amplifies the impacts of the opioid epidemic.

- *"All women described sexual violence and gender-based violence and multiple men mentioned how the community overlooks the violence perpetrated against women who are homeless."* (People with Living Experience)
- Domestic violence and SUD are deeply interconnected
- Legal system professionals identified: *"There is just not enough resources for domestic violence"*

Specific Barriers:

- Family responsibilities (childcare) create barriers to treatment engagement
- Accessing core needs like shelter, traps women and gender diverse people in violent relationships
- Lack of domestic violence services compounded by sobriety requirements
- Many low-barrier shelter options often pose ongoing risks for domestic violence, sexual assault, and sex trafficking
- Limited family-based treatment options that allow parents to maintain custody while in treatment

People facing intimate partner violence must choose between safety and substance use treatment - between fleeing abuse and maintaining custody of children - between accessing services and risking further victimization. Victims' seeking help and services may expose them to losing their children.

4. Rural and Geographically Isolated Communities

Evidence of Disparity: While the assessment focused primarily on Reno/Sparks urban core, rural challenges were noted:

- Survey responses identified *"Services in rural communities"* as a gap
- Transportation barriers mentioned repeatedly affect rural residents disproportionately
- Distance to DMV for ID recovery creates long delays for residents

Specific Barriers:

- Limited or no local treatment providers, compounded for people with mental health needs, disabilities or language access barriers.
- Travel distances of two hours or more in a car to access care
- Lack of public transportation in rural areas

Rural residents face the choice between relocating to access treatment (disrupting employment, family, and community ties) or forgoing care entirely. Geographic isolation compounds every other barrier.

5. People Involved in the Criminal Justice System

Evidence of Disparity: The jail emerged as both a site of potential intervention and perpetuation of harm:

- *"Inconsistent collaboration between the jail and community both at intake, many people who are prescribed MAT in the community are not maintained upon intake, and at release, the continuity of care and programming on release is inconsistent."* (Key Finding)
- Survey data showed varied MAT access in jail: some received immediately, most were unable to access or waited three or more days
- *"We just don't have the capacity to connect back to the community...oftentimes we're sending people back right off the red curb upstairs."* (Law Enforcement)
- Strengths noted: *"The Mental Health and Substance Use Treatment support at the jail have positively impacted the overall community"*
- On average 130 people test positive on intake per month. The average monthly number of MAT participants is 37 people, or roughly 28% of individuals testing positive at intake. (Secondary Data)

Specific Barriers:

- Forced discontinuation of MAT upon booking despite community prescription
- Administrative barriers (missing the jail's vitals check) prevent MAT access
- Trauma of withdrawal in custody
- Release without housing, transportation, or connection to services
- Criminal records create barriers to housing, employment, and benefits

The carceral system inadvertently functions as a destabilizing force that interrupts treatment progress, creates trauma, and increases overdose risk upon release (due to reduced tolerance after forced abstinence).

6. People with Medicaid or No Insurance

Evidence of Disparity: Insurance status emerged as a primary determinant of access:

- Most people gaining access to MAT at FQHCs have Medicaid, but there are still many people who are paying out of pocket (Secondary Data)
- *"Waitlists are long and there are limited options for people with Medicaid."* (Key Finding)
- *"Lack of dental care providers in the community who will support people on Medicaid."* (Key Finding)
- *"Nearly all participants with lived experience reported significant dental issues, including missing teeth and infections"* while simultaneously facing *"Lack of dental care providers...who will support people on Medicaid"*
- Survey data showed "Did not accept my insurance" as barrier to accessing services
- Legal system professional: *"We need help paying for medications when people who are in court get jobs and are no longer eligible for Medicaid"*

Specific Barriers:

- Fewer providers accept Medicaid, creating longer waitlists
- The providers that do accept Medicaid do not accept all Medicaid Managed Care Organizations creating confusion for clients and longer waitlists
- Dental care essentially unavailable for Medicaid recipients and uninsured

- Gaining employment can trigger Medicaid loss, forcing choice between income and treatment
- Private insurance unaffordable on entry-level wages
- Delays in prior authorizations can further delay access to care
- Administrative burden of maintaining coverage during housing/employment transitions

Economic status directly determines access to care. People who gain employment during recovery can lose Medicaid coverage, interrupt treatment and triggering relapse.

7. Families Involved in Child Welfare System

Evidence of Disparity: There are persistent child welfare challenges for families impacted by SUD that are compounded by the lack of family-based supports:

- *"Despite progress in 2024, Washoe County continues to experience high rates of substance-related child removals"* (Secondary Data)
- *"There are not enough services that support the whole family."* (Key Finding)
- *"How often do you have a mom and dad where one of them is on drugs and the other one isn't?... they refuse to go get help without the other."* (PRSS)

Specific Barriers:

- Individual treatment models don't address family systems and can lead to recreation of harmful family dynamics
- Fear of child removal prevents parents from seeking help
- Lack of family-based residential treatment options
- Childcare unavailable during outpatient treatment sessions
- Services operate on workday schedules (8am-5pm) when parents are working
- Limited treatment for children's trauma
- Exacerbated when domestic violence is involved as the abuser may try to manipulate, discredit, or sabotage their victim

Families are separated when they need connection most. Parents choose between seeking treatment (risking child removal) or staying silent (risking continued harm and child removal). Children experience compounded trauma from both parental substance use and removal from parents.

8. Youth and Young Adults

Evidence of Disparity: Prevention gaps leave young people vulnerable:

- *"Prevention education grounded in lived experience and tailored to the audience is not in all the schools."* (Key Finding, p. 39)
- Youth services provider: *"A challenge is that we are tied to these 'evidence based' programs that are abstinence only and disconnected from youth. They were written in the 1980s! Kids know when you're BS-ing them—they put up a wall. They are 'evidence based' but they are no longer effective."*
- Secondary data noted *"elevated youth opioid usage compared to national averages"*

Specific Barriers:

- Outdated, ineffective prevention curricula (e.g., DARE model)
- Abstinence-only messaging disconnected from youth reality
- Limited mental health supports in schools
- Few pro-social activity options for low-income youth
- Trauma is often unaddressed until substance use develops
- Youth not engaged in designing interventions meant for them

Young people receive information that insults their intelligence, leading to disengagement from prevention messages. Early trauma goes unaddressed, creating vulnerability to substance use as coping mechanism. Generational cycles continue uninterrupted.

Structural Barriers: How Systems Create Inequity

Beyond individual barriers, the assessment revealed how institutional policies and practices systematically disadvantage certain populations. These structural barriers require policy-level intervention, not just service expansion.

Structural Barrier 1: Government Practices That Destroy Documentation and Medication

The Practice: *"People who are homeless frequently have their identification and medication stolen, lost, or thrown away (including by government officials)."* (Key Finding)

When law enforcement or clean-up crews discard belongings during encampment sweeps, they destroy:

- Identification needed for employment, housing, benefits, and healthcare
- Prescribed medications, forcing withdrawal or interrupting treatment
- Birth certificates and Social Security cards needed to replace ID

This practice exclusively affects people experiencing homelessness. People with housing face no risk of government officials destroying their belongings or medication (some people living in situations of domestic violence or trafficking may have their identification destroyed by their abusers as a tool of control). Each sweep resets the process of ID recovery (weeks to months), could precipitate a mental health crisis, and deepens distrust of government. The government agencies meant to help (housing and homeless services) become inaccessible due to practices of other government agencies. One solution is to partner with outreach workers who work with the people at encampments to ensure they are able to set aside medications and identification.

Structural Barrier 2: Community – Jail Collaboration

The Practice: *"Inconsistent collaboration between the jail and community both at intake and discharge. Many people who are prescribed MAT in the community are not maintained upon intake. Upon release, the continuity of care and programming on is inconsistent."* (Key Finding)

People with OUD were most likely to report they were not offered MAT at the jail or if they were offered MAT at the jail they had to wait three or more days to receive medications. MAT discontinuation forces withdrawal, creates medical crises, traumatizes individuals, and increases overdose risk upon release (due to reduced tolerance). Upon release there are insufficient warm-handoffs to ensure that people who are leaving jail are connected to appropriate community level supports. Treatment progress achieved in the community is disrupted during incarceration. The progress gained during programming in jail is disrupted by not having warm handoffs to programs and resources in the community. Greater collaboration between the jail and community providers can alleviate some of these structural barriers.

Structural Barrier 3: Medicaid Eligibility Cliffs

The Practice: *"We need help paying for medications when people who are in court get jobs and are no longer eligible for Medicaid."* (Legal System Professional)

Employment, even at wages below , can trigger Medicaid loss, but these wages don't provide enough income to afford the associated private insurance premiums, high

deductibles, and co-pays for MAT and therapy. This benefits eligibility cliff punishes economic advancement and can either trap people in poverty or contribute to cycles of relapse. Recovery requires stability, including employment and income. When employment triggers loss of critical healthcare that undermines recovery and perpetuates poverty.

Structural Barrier 4: Transportation Deserts

The Practice: *"There are significant issues accessing transportation to treatment services, the DMV, and other supports."* (Key Finding)

"One of the biggest barriers is transportation. That is the biggest barrier for people getting treatment right." (SUD Provider)

Washoe County's geography and limited public transportation mean:

- People without cars cannot reach services
- Bus routes don't serve all neighborhoods
- Service appointments during work hours require taking time off (lost wages)
- Rural residents must travel 2+ hours in a car
- DMV appointments for ID recovery require full-day commitment

Residents without cars and people experiencing homelessness cannot access services that people with cars reach easily. Each missed appointment can be recorded as "non-compliance," leading to service denial. Service navigation must include transportation navigation.

Structural Barrier 5: Insufficient Medicaid Reimbursement Rates

The Practice: *"Lack of dental care providers in the community who will support people on Medicaid."* (Key Finding)

Provider noted: *" Nevada needs to change Medicaid billing to allow for prevention activities to qualify for reimbursement."*

Nevada Medicaid reimbursements for MAT is the lowest in the nation. Nevada Medicaid pays roughly $4 but other states pay $15. (MAT Provider)

Medicaid reimburses providers at lower rates than private insurance and has a series of barriers to providers becoming certified. Many providers therefore:

- Don't accept Medicaid patients

- Limit the number of Medicaid patients they'll see
- Provide shorter appointments to Medicaid patients
- Don't offer services that Medicaid doesn't reimburse (prevention, case management, peer support)

This results in a two-tiered healthcare system where low-income individuals have fewer provider options, longer wait times, and lower quality care than those with private insurance. Dental care becomes essentially inaccessible. Healthcare becomes a commodity allocated by ability to pay rather than by medical need. Nevada needs to update Medicaid reimbursement rates to ensure sufficient care for people with OUD.

Section Six: Cycles

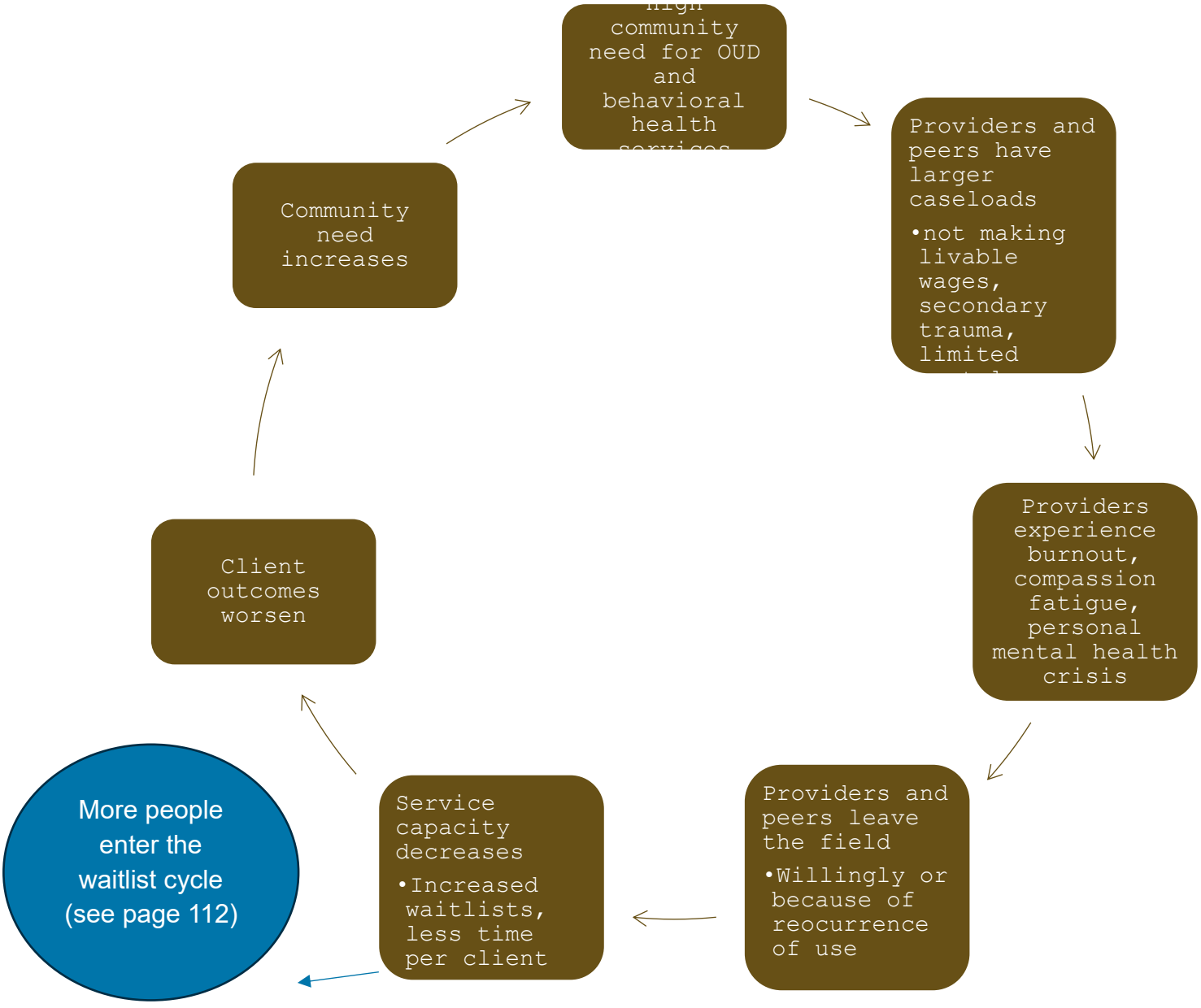
The Needs Assessment revealed a critical insight: barriers to recovery do not exist in isolation. When the WOARF team listened to people's stories, individuals struggling with substance use, families watching loved ones suffer, service providers trying to help, a consistent pattern emerged. People didn't describe single barriers but sequences of barriers where each one created the conditions for the next, making escape feel impossible.

This isn't a description of individual failure. Rather, it reveals how the system itself perpetually recreates barriers. As one Court Professional shared, “let's say somebody does do inpatient treatment. How are we stepping this down so that they don't come out of treatment and there's nothing there for them? And they just go right back out and use because there's no, often, no place for them to go. So, then it's just that cycle. They're cycling through the jail, and they're cycling through the ERs, and they're cycling through the psychiatric hospitals, and it just keeps going.”

This section maps six critical cycles where barriers compound each other. By understanding how these cycles work, we can see why fragmented interventions fail and why the five priority recommendations must function as an integrated system, each one interrupting multiple cycles simultaneously.

These cycles aren't theoretical. Each is grounded in community experiences documented throughout the Needs Assessment. Understanding them is the foundation for designing a system that breaks these patterns rather than perpetuating them.

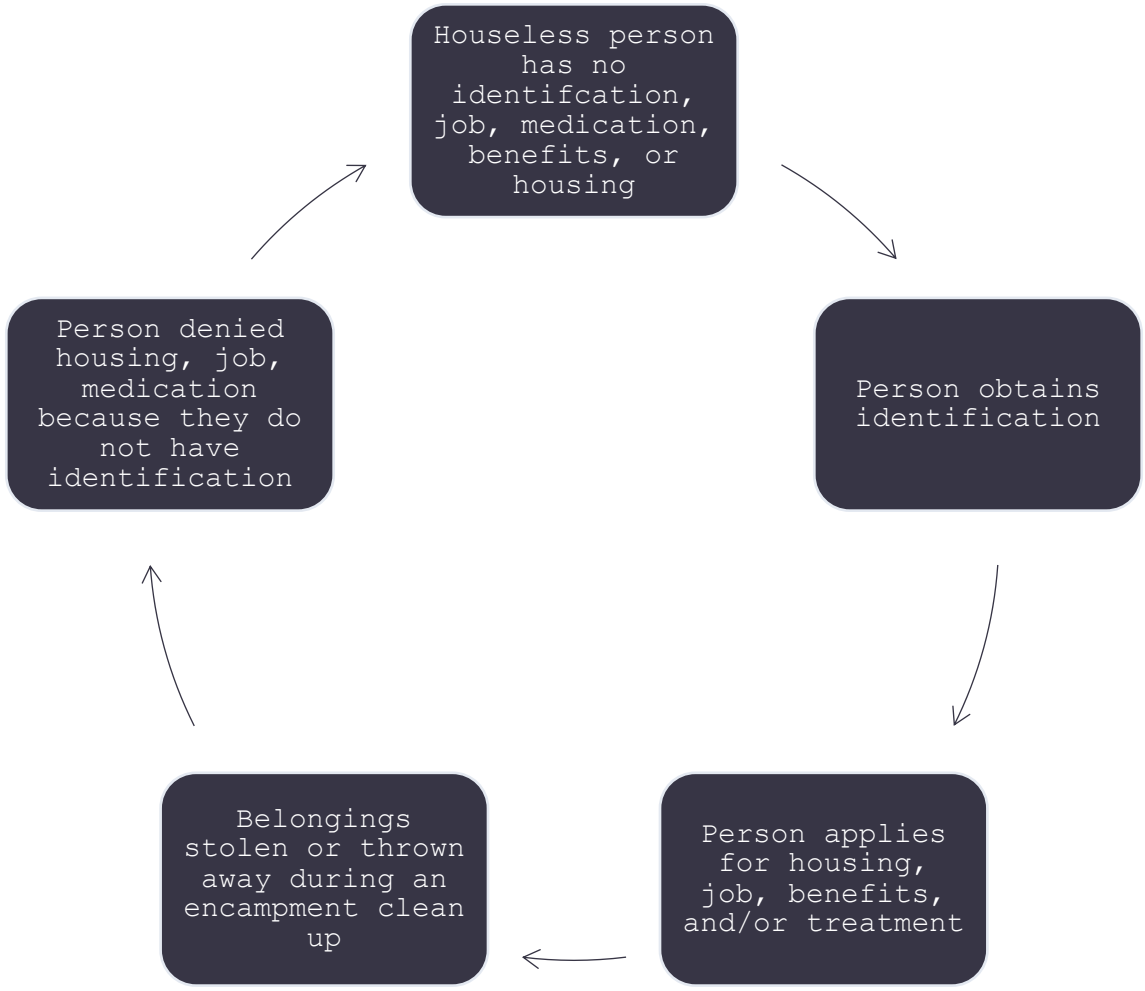
Service Provider Burnout Cycle



“It's not that the people who are doing the work aren't dedicated. There's just not enough of them, and the issues are so overwhelming that, you know, there's only so much they can do.” (Court System Professional)

“Turnover rate is extremely high because people burnout and don’t have the means to self-care. We need to be providing additional support to staff and paying livable wage…People are on the edge of being in the same spot as the folks we serve. We need support systems to help prevent burnout of our staff.” (Community Outreach Staff)

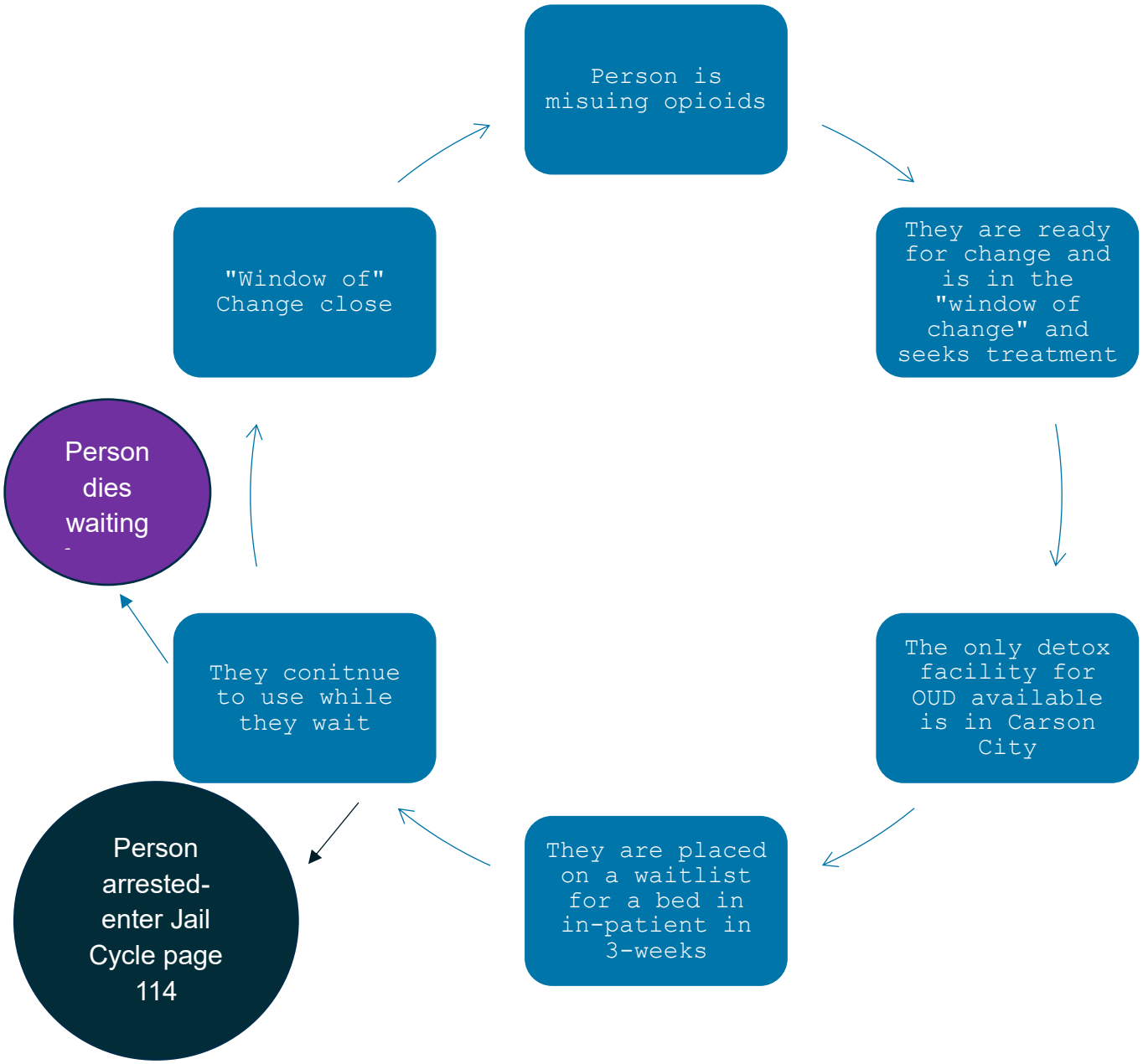
Identification Cycle



“It's almost impossible to get them to work, because they've lost all their identification, and then trying to get it is a whole nother thing. It's just such a lengthy process.” (SUD Provider)

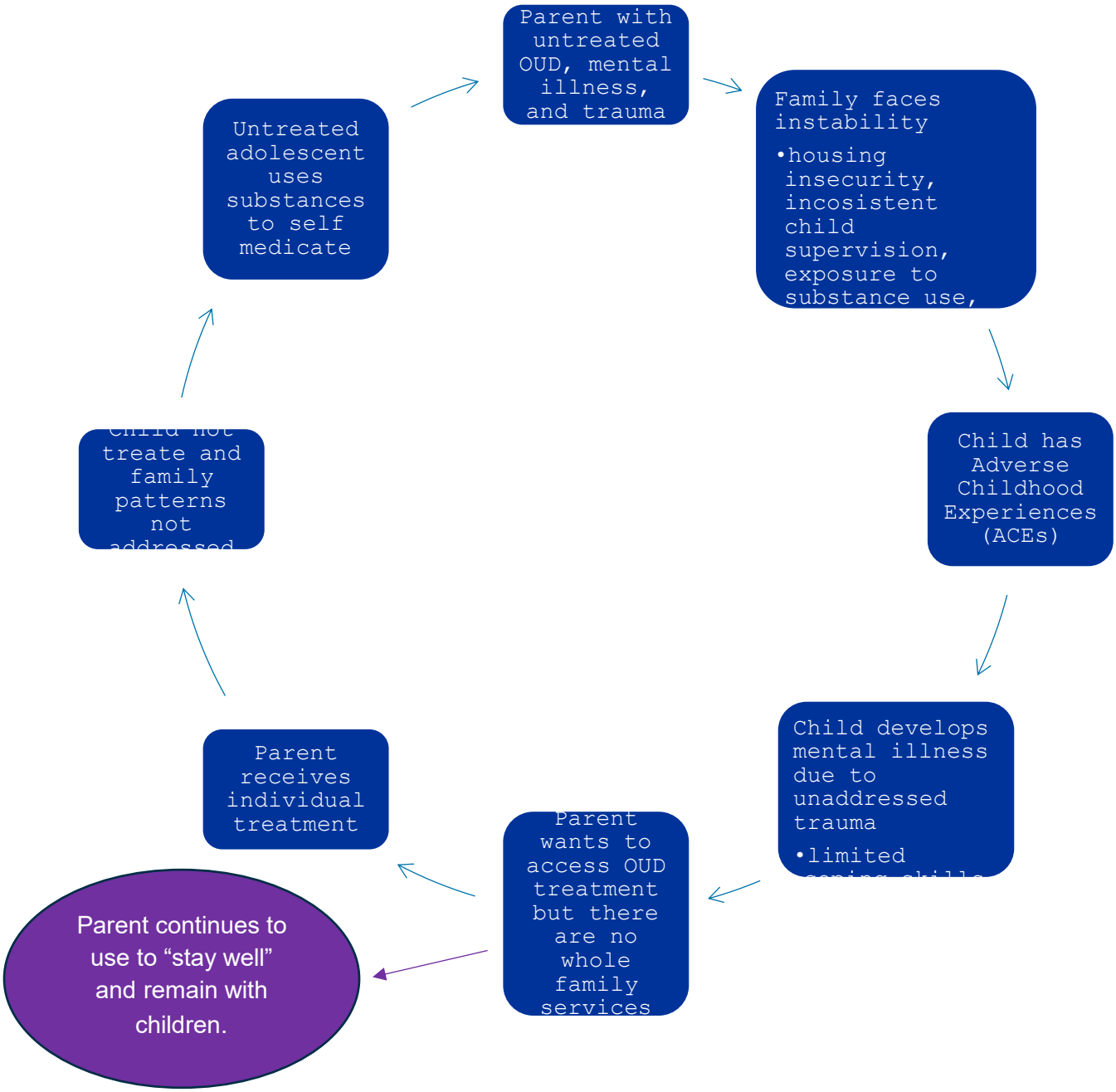
“I think that another barrier for people is that for this treatment, it's required for somebody to have a photo ID to get into treatment. And again, a lot of our people are unhoused. They have their things stolen all the time.” (SUD Provider)

Window of Change and Waitlist Cycle



“I get somebody who's like, I want to get clean. They want to get clean in that moment. So if I had somewhere I could say, right now we're calling this place you're going to get into treatment today, like capitalize on when they decided to get clean and it was easy to access, because people are not going to wait. They're, you know, operating in that tyranny of the urgent. If they can't do it right now, and it's not easy, and they've got to call somebody, and they've got to wait for somebody to call them back, and there's a waitlist, right? They’re not going to do it.” (Legal System Professional)

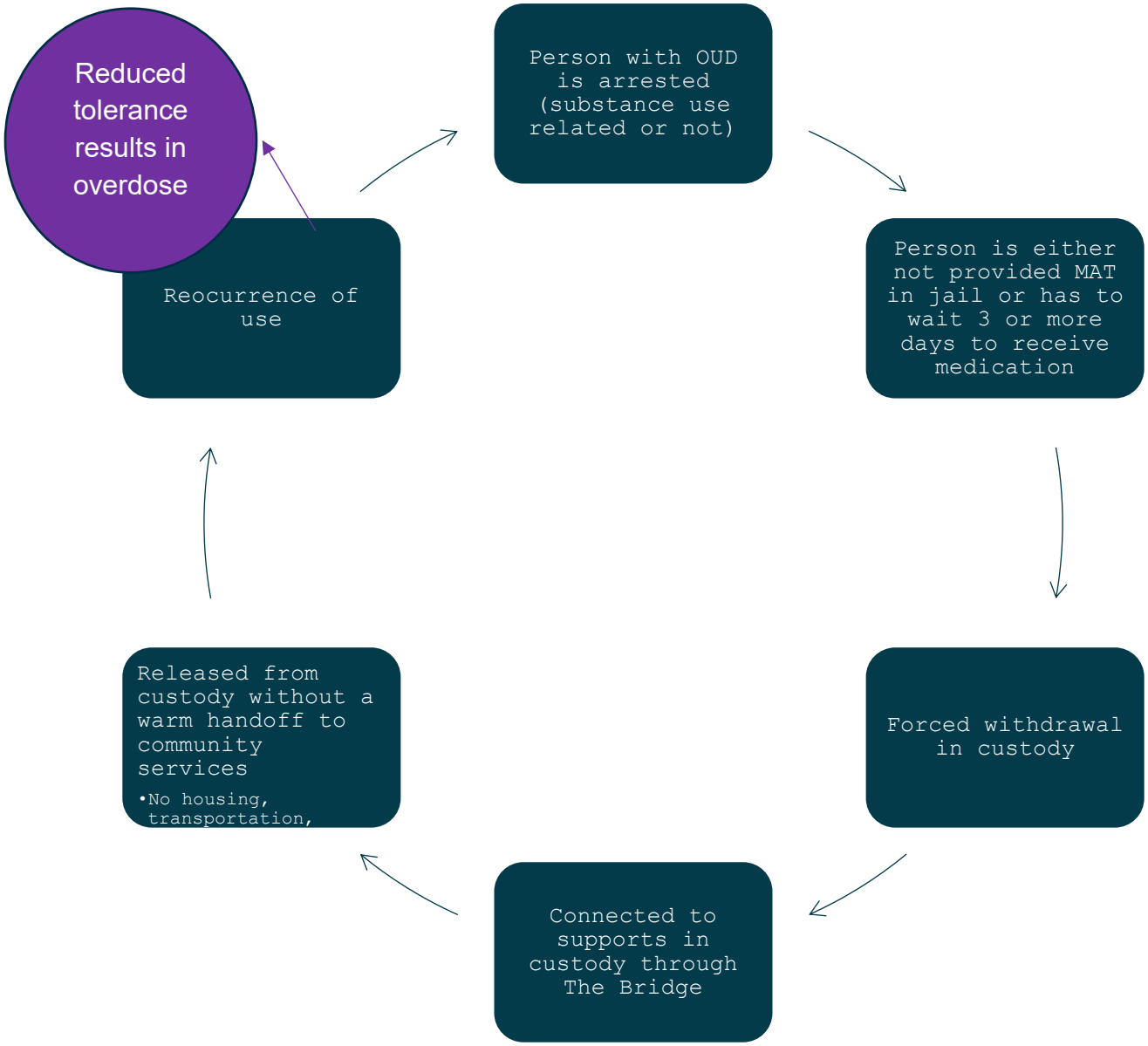
Intergenerational Trauma-Substance Use Cycle



"I knew I was gonna be an addict when I was 5…I just knew that when I grew up, I was gonna be a drug addict because my mom was and I wanted to just be exactly like her. Because I wanted her to like me." (Person with Living Experience)

"Addiction runs in my family. It's in our DNA." (Loved One of a Person with OUD)

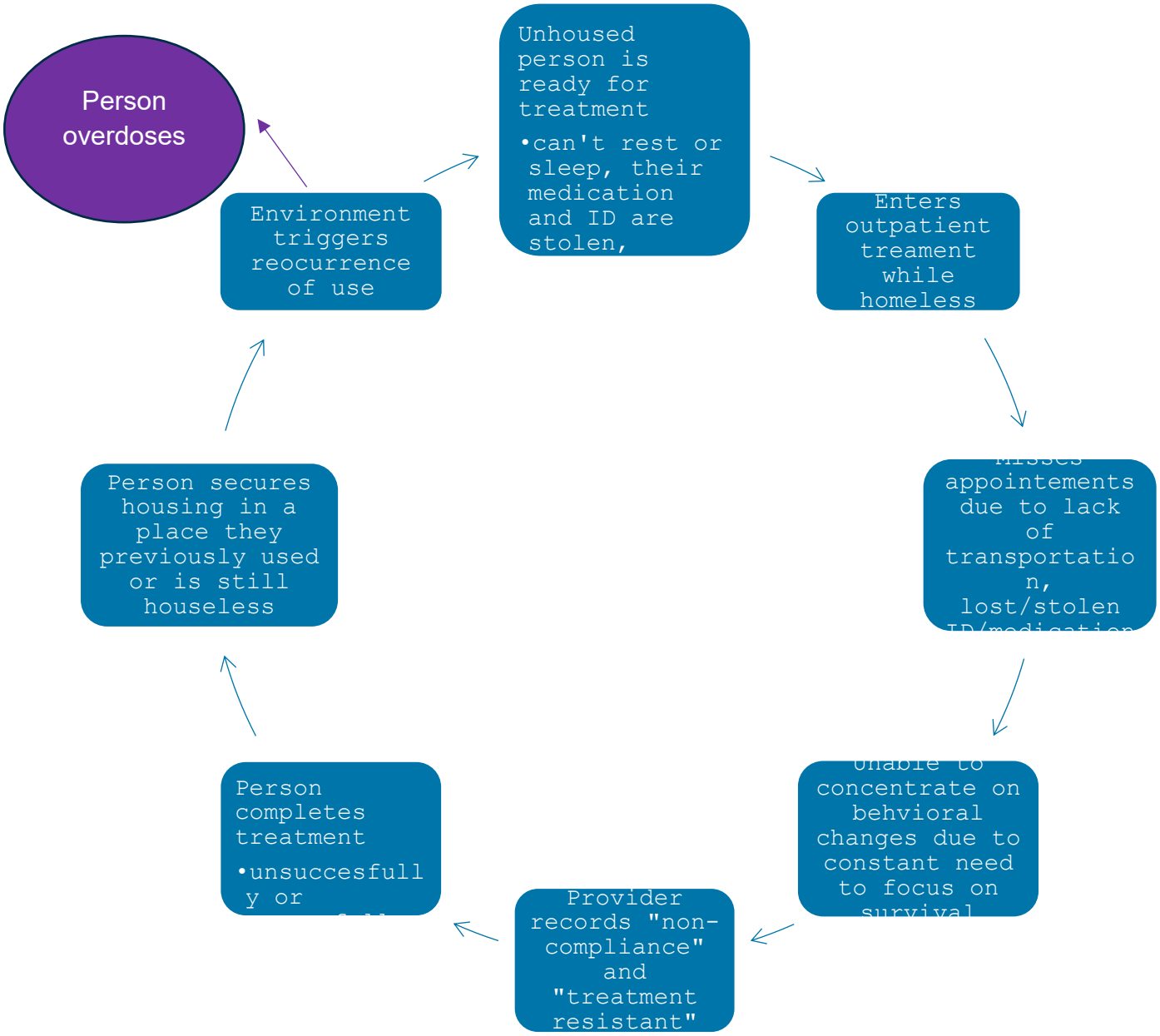
The Jail-Community Disconnection Cycle



“We just don't have the capacity to connect back to the community. That's the thing, over and over and over again, no matter how robust our treatment is here, oftentimes we're sending people back right off the red curb upstairs. The most important thing is a comprehensive approach, a community-based approach.” (Law Enforcement)

“A challenge is the different systems of communication and continuity. There’s not continuity of care with the jail and vice versa. I tried to get my patient’s MAT to continue in the jail. I talked to staff. I sent the prescription… people won’t be successful if we can’t stay connected.” (SUD Provider)

Housing Treatment Stability Cycle



“But I think that there's also this huge barrier for everybody to that keeps them in this cycle. It’s affordable housing.” (SUD Provider)

“And I think housing is a big deal too, because if they're stuck in limbo and they can't get into a program until like three days from now, homelessness is going to make it super hard for that person based on sleep, based on the environment. It just makes it super hard to actually take that step forward into treatment.” (PRSS)

"You might be wasting your money, truly, if you're like, I'm gonna get you this pretty expensive drug treatment, and then when you're done, you're going back to the street. So maybe it's a flip flop. Maybe it's a let's get people somewhere safe and stable where they can eat and sleep and have, like our basic needs met, and then let's look at what do they need for their substance treatment." (Court Professional)

Section Seven: Findings and Strategies

Treatment Access and Navigation

Washoe County has barriers to OUD treatment and care at every step of the continuum of care. The immediacy of access is critical as people have a very short window in which they are ready to make a change.

Finding 1: Delays in people receiving assessments or stabilization greatly shortens their window of change, leaving them without access to services needed at their most vulnerable time.

Survey respondents noted that immediate access to care is the number one most important service to address OUD in Washoe County. People who use(d) opioids shared the top two reasons for being denied access to care were long waitlists and their insurance not being accepted. In the qualitative interviews, participants shared that waitlists and insurance challenges cause individuals to give up on trying to access care. Participants shared that these hindrances reaffirm people with OUD's belief that no one cares or will help them, which erodes their willingness to change.

"Immediate need for access for services- there is only a short window of opportunity we need to capitalize on it. Tomorrow may be too late. Families don't have the luxury of waiting." – Court Professional

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Finding 2: Residents do not know which services are available, to whom, where, or how to access them. Community Outreach workers are successfully able to build rapport with disconnected populations and connect them to services when they are ready.

Survey respondents were concerned about people's ability to access services but felt that services were accessible, suggesting greater concern about coordinating and navigating people to appropriate services than expanding services. Qualitative interview participants highlighted that many people do not know what services exist in the community. People who use opioids described primarily utilizing the emergency departments to access care and relied on word of mouth to determine other supports

that might be available. Participants identified a need for a bridge service that helps people exit chaotic situations and enter community-based treatment. Community Outreach workers can act as those connectors and assist community members with OUD in accessing services, yet, primary funding for community outreach was discontinued in October 2025.

"There're still a lot of barriers to OUD treatment and opiate you know, and so caseworkers are your bridge between follow up for these, these addicted population, if they, you know, oftentimes, they do need somebody to hold their hand and get them to that next step in treatment" – Law Enforcement Officer

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Finding 3: Individuals who access services are not supported with system navigation throughout the continuum of care leading to relapse.

In developing these survey tools, the LEAB noted that despite Managed Care Organizations being obligated to provide care navigation for people exiting treatment, people are discharged from in-patient rehab or detox with no next step, no housing, and no plan. Qualitative interview participants discussed the value of having someone to assist people navigate through the systems, particularly at time of discharge. Without navigation support, people fall through the cracks, increasing their risk for relapse. Peers are uniquely situated to provide this navigation having navigated these systems themselves.

Came out of a hospital? There's PRSS embedded in the system to help navigate between services. It would be fantastic. Like lived experience person. Who's able to help you with like, guiding through the multiple steps of your recovery, right? - PRSS

Potential Strategies:

The following strategies were developed based on this information and refined by the Steering Committee. Strategies focus on breaking barriers to care through coordination and mobile outreach, while expanding access to missing services:

- Develop a drop-in center for individuals to access resources and supports that can conduct relevant ASAM assessment and coordinate referrals and connections to care.

- Develop a central navigation line or app for treatment supports in real time
- Provide short-term low-barrier housing while awaiting treatment beds
- Expand access to MAT, including mobile MAT services and non-traditional community resources such as churches or community centers
- Mobile health care clinics that include dental care
- Provide care coordination and transportation to appointments and treatment
- Conduct outreach to disconnected communities to connect people to existing resources and supports
- Expand access to inpatient, non-hospital based, detox services
- Offer mental health care services that do not require sobriety or someone to seek sobriety
- Provide transportation supports

Housing & Recovery Stability

Washoe County is facing insufficient housing, particularly housing for low- and middle-income individuals. Lack of stable housing negates the purpose of treatment services and compounds all barriers to care. Housing is considered the number one funding priority.

Finding 1: Housing is needed to help stabilize individuals to begin engagement with the treatment process.

Interviewees highlighted that to be successful in a treatment program people need to be able to meet their basic need of housing first as a foundational aspect to their recovery. Lack of housing creates an instability and causes mental stress that can undo the productive changes initiated in treatment.

"You might be wasting your money, truly, if you're like, I'm gonna get you this pretty expensive drug treatment, and then when you're done, you're going back to the street. So maybe it's a flip flop. Maybe it's a let's get people somewhere safe and stable where they can eat and sleep and have, like our basic, you know, Maslow's needs met, and then let's look at what do they need for their substance treatment." - Court Professional

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Finding 2: Safe recovery-friendly housing is needed to help individuals sustain recovery.

Recovery housing was the number one housing service recommended by survey participants. Recovery housing can take multiple forms but are united by creating safe spaces that support and promote the ongoing sobriety and recovery of individuals.

"The fundamentals of recovery person, place, thing, right? The only place they can return to, your only option is a place you formerly OD'd in…" - PRSS

Potential Strategies:

The following strategies were developed based on this information and refined by the Steering Committee. Strategies focus on addressing barriers to housing such as high costs and barriers to access, while promoting solutions:

- Expand low-barrier recovery housing and sober living supports
- Increase access to low-barrier and/or affordable housing & Housing First programs for people in recovery
- Co-locate housing & recovery services using a Pueblo model or spoke model that places community resources and peer supports in apartment complexes and community spaces that are not explicitly sober
- Develop permanent supportive housing for people in recovery from OUD with co-occurring serious mental illness
- Remove the barriers to developing additional transitional living housing arrangements such as zoning laws

Behavioral Health Workforce Sustainability

Washoe County's substance use treatment workforce faces significant challenges that threaten both current service delivery and future capacity. Low wages, high levels of secondary trauma, staff burnout, and limited training opportunities, make it difficult to recruit and retain qualified professionals. These challenges are exacerbated by heavy workloads and limited access to essential resources, such as mental health supports. Sustained investment in workforce development is essential to ensure quality care for residents.

Finding 1: Qualitative interview participants expressed concern about workforce shortages driven by burnout and low pay.

The sustainability of service provision in Washoe County is undermined by high rates of burn out, limited career growth opportunities and the vicarious trauma of working in the field. Participants shared concerns that people working to serve our most vulnerable populations are on the precipice of needing the same services themselves.

"We need to be providing additional support to staff and paying livable wage… People are on the edge of being in the same spot as the folks we serve. We need support systems to help prevent burnout of our staff." – Community Outreach Worker

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Finding 2: Insufficient training in trauma-responsive approaches for individuals labeled as "treatment resistant" was identified as a significant gap hindering staff's ability to provide comprehensive support.

Providers do not have the time or the financial ability to access all of the training they need while working. Employers need to allocate time for staff to participate in appropriate training, and ensure that low-cost, accessible training opportunities are available. Participants identified the need for training around how best to support individuals who have not demonstrated programmatic success in the past (or thus far).

"How to communicate better with our participants, practical tips and tools to communicate with people who seem defiant. Sometimes we see it as defiance but in reality, it could just be that their brain is in such a certain way now that it's not working." – SUD Provider

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Finding 3: There needs to be more supports for peers within the workforce and opportunities for them to grow out of entry-level roles.

During the Steering Committees discussion of counterproductive practices, participants identified that peers are too often relegated to entry level roles and are not provided the training and guidance necessary to support them in growing within organizations and as professionals. Peers are trapped in low paid roles where their experience is nominally valued.

"For folks with lived experience most of them are undertrained, underpaid and under supported. With most organizations you hit the ceiling and without all the other education, experiences, and soft skills there is nowhere else for you to go. There is a lack of support for peers." – Community Outreach Worker

Potential Strategies:

The following strategies were developed based on the above feedback and refined by the Steering Committee. Strategies focus on removing barriers such as low wages, limited training opportunities, and burnout, while promoting solutions:

- Provide job training and education support to peers to allow them to grow into leadership roles
- Create peer-led mental health supports to prevent burnout for peer workers, providers, and professionals working in the field
- Incentivize organizations to increase pay and benefits, and measurably improve working conditions for behavioral health staff
- Provide ongoing training in trauma-informed care, meeting people where they are, and culturally relevant care for providers

Minimizing Morbidity and Mortality

Washoe County continues to have a rate of overdose death that outpaces state and national levels. From March 2024-February 2025, 179 people died of opioid overdoses. Data shows that through implementation of harm reduction practices and philosophy, providers are able to successfully reduce the number of fatalities from overdose each year. People who use opioids described how stigma and mistreatment from community members and medical professionals act as a barrier to accessing treatment.

Finding 1: Funding landscape changes have created gaps in harm reduction services that Washoe County residents find to be successful and needed.

Survey data indicates residents are happy with the current level of harm reduction supports in the community and see these supports as a community asset. Interview findings indicated that federal policy changes resulted in the termination of funding for some community resources, leading to a service gap that developed following the close of the survey.

"They can't seek recovery if they're dead." - Loved One of a Person with OUD

Finding 2: Overdose responses could be improved through connections to additional supports and services.

Life-saving interventions by emergency medical services providers present a unique opportunity to connect someone to sustained care. There is currently no coordinated post-overdose response in Washoe County.

"Approaching a patient immediately, especially after using Naloxone, can be incredibly influential on their journey to recovery. Like, we're not coupling this, this tool, with any education, and I think that's a real missed opportunity." – First Responder

Finding 3: Stigma and limited public understanding have led to people who use opioids to be mistreated by medical professionals and community members at large.

Interview participants with living experience of opioid use described interactions with medical professionals that bordered on medical malpractice. Furthermore, they also reported interactions with community members that were violent. These interactions compound, adding additional barriers to care on top of what they already experience.

"It was all these young doctors, generally frustrated, the ER down here, because I went there last time. I got hit by a truck here in town. The guy that hit me jumped out and said, "You okay?" I couldn't talk. I was like, he really hit me from the center of the block to the sidewalk. I flew. I'm like, trying to breathe and like, kind of trying to jump up and stuff. And he like, throws 20 bucks in my pocket," - Person with Living Experience

Potential Strategies:

The following strategies were developed based on this information and refined by the Steering Committee. Strategies focus on preventing death and disease among opioid users while connecting people to services and promoting greater community awareness:

- Expand syringe services programs, education on safer use, and outreach to disconnected populations
- Train the public in naloxone administration & distribute free naloxone including partnering with local businesses
- Open 24/7 crisis stabilization hubs
- Launch stigma-reduction public awareness campaigns
- Research implementation of overdose prevention centers
- Explore post-overdose and/or co-responder model to follow-up with survivors of a non-fatal overdoses.
- Provide education on stigma and substance use for business owners.

Family and Youth Supports

Youth are the key to ending the cyclical nature of substance misuse. To interrupt the cycle of trauma and OUD the holistic needs whole family must be addressed. Data from the Human Services Agency indicates that parental substance use is a leading cause of children being removed from their homes. Data from the Youth Risk Behavior Survey demonstrated that youth in Washoe County have higher rates of substance misuse than national averages.

Finding 1: Intergenerational substance misuse cannot be disrupted unless the entire family is treated and connected to mental health supports.

Participants shared their concerns about the impacts of providing treatment exclusively to parents without addressing family dynamics, as this often sets the family up to repeat harmful interactions/patterns. People with lived experience highlighted programs and services requiring familial separation are a hindrance as people try to "stay well" and power through their SUD as opposed to leaving their family for treatment.

"We need a variety of services for the whole family. Multiple types of services. Medical and behavioral. If we had more options that would be better." – Court Professional

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Finding 2: Youth need pro-social activities and mental health supports.

Steering Committee members feel that crucial interventions in supporting the health and well-being for youth are missing. Pro-social out of school time activities such as

mentorship programs, arts classes, and sports act as strengths-based prevention of behavioral health issues. Such activities reduce risk factors and increase protective factors through bolstering community interconnection and promoting activities as an alternative to drug use or other risky behaviors.

"You never know if the kid is showing symptoms of depression, there's a reason for that, … maybe he's lonely. Maybe he needs to be part of a community program, you know, things like that, and like, not just baseball."- SUD Provider

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Finding 3: Existing substance use curriculum are inconsistently provided to students, outdated, and sometimes based on disproven prevention practices.

People with Living Experience feel that realistic, pragmatic education on substance misuse would be an effective tool in preventing young people from engaging in substance use. Steering Committee members highlighted that students are not receiving accurate or quality education on substance misuse, and that while some curriculum are evidence based, they are outdated and need refreshing.

"A challenge is that we are tied to these "evidence based" programs that are abstinence only and disconnected from youth. They were written in the 1980s! Kids know when you're BS-ing them- they put up a wall. They are "evidence based" but they are no longer effective." – Youth Service Provider

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Potential Strategies:

The following strategies were developed based on this information and refined by the Steering Committee. Strategies focus on addressing mental health and prevention supports for youth, while promoting whole family treatment solutions:

- Increase trauma-informed programs in schools
- Offer free after-school & weekend youth activities and sports
- Provide family recovery programs for all types of families
- Develop non-abstinence only trainings on drugs for youth that are evidence informed and based in the living experience of people who use substances

- Develop classes for parents and families on life skills that are paired with childcare

Systems Coordination

Systematic failures to provide cohesive care block Washoe County residents from seeking recovery. Community members highlighted structural constraints such as limited grant funding, low Medicaid reimbursement rates, loss of Medicaid for individuals who gain low-paying employment, and counter-productive competition. There is a need for improved communication and collaboration between providers to better serve the needs of Washoe County residents with OUD.

Finding 1: Systemic barriers to receiving OUD treatment include: false competition, low funding sources, and disconnected systems.

The Steering Committee identified fragmented collaboration between agencies creates barriers to treatment and leaves vulnerable populations without support. Qualitative interview participants identified a need for a philosophical shift among providers, moving away from competing for resources, stealing successful models, and hoarding patients towards open communication and collaboration on behalf of all patients. Participants feel that the close-knit nature of the community could help strengthen collaboration among service providers to better meet the needs of individuals who are struggling.

"It's breaking down the barriers of like territory, and instead of like, you know, it's us, and then like, those are our patients. Is like, these are every, everybody's patients, and just making sure they're in the correct place that they need to be at, regardless if that's with us or another org or whoever it is." – SUD Provider

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Finding 2: Lack of programmatic evaluation data of existing services hinders Washoe County's ability to connect people to appropriate and successful programming.

Qualitative interview participants shared that referrals to programs are too often based on word-of-mouth, as there is no data demonstrating which programs are working, for who, and why. While not considered a key resource need in the survey data, the inability to describe programmatic outcomes hinders collaboration between programs and limits organizations' abilities to improve their capacity to serve participants.

"Maybe if we had better data on the efficiency and effectiveness of programs, we would be better able to collaborate." – Community Outreach Worker

Potential Strategies:

The following strategies were developed based on this information and refined by the Steering Committee. Strategies focus on enhancing collaboration and communication across the care continuum while investing in evaluation of services:

- Fund inter-agency collaboration & shared case planning
- Evaluate the effectiveness and outcomes of existing programs and services for people who use substances
- Establish a fund to cover the cost of medication and treatment for individuals who lose their Medicaid coverage and cannot afford private insurance
- Invest in community navigators for system navigation
- Establish a provider workgroup to identify overlap in duplicative data collection and refine opportunities for sharing mechanisms

Intercepting Justice Involvement

People with OUD are best served by community-based treatment but are often routed through the justice system. In order to provide greater supports for people with OUD and promote public safety, Washoe County must intercept individuals from greater involvement in the justice system.

Finding 1: Disjointed collaboration between the jail and community providers results in service interruption.

Each month 130 people entering the jail test positive for OUD and only 37 receive treatment. The majority of survey respondents who use(d) opioids and were arrested in the last year reported that they were either denied MAT or had to wait three or more days to receive their medications. SUD providers discussed sending prescriptions and proof of treatment to the jail only to learn their clients did not receive treatment. Jail staff reported reentry supports are insufficient to meet the needs of people leaving the jail.

Potential Strategies:

The following strategies were developed based on this information and refined by the Steering Committee. Strategies focus on enhancing collaboration and communication between the jail and community.

- Build transitional housing for re-entry from jail and/or treatment (Cross-referenced with Housing)
- Provide reentry case management to people in jail (Cross-referenced with Care Navigation)

"I think our jail systems and prison systems need more support and education, because that is where a lot of our opiate users end up right like they aren't taken to jail, they're put in there for 48 hours, and then they're let go. They're saying, good luck, see you next weekend, because we know we will, right?" -First Responder

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Strategy Development and Refinement

To develop the above initial list of potential strategies WOARF staff used the information in this report, the approved Use of Funds for opioid remediation and abatement according to the litigation settlements and Nevada Revised Statute. The strategies were then presented to the Steering Committee for further refinement and to ensure no critical strategies were missing.

Settlement Agreement Approved Use of Funds

- Naloxone or other FDA-approved drug to reverse opioid overdoses
- Medication-Assisted Treatment ("MAT") distribution and other opioid-related 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 primary, secondary, and tertiary prevention
- Expansion of syringe services programs to include comprehensive services

- Support data collection, research, and analysis of abatement strategies
- Support treatment of OUD and the people in treatment
- Providing connections to care
- Supporting leadership, planning, and coordination at the local level to abate the opioid epidemic
- Conduct training and research

Guidelines Established through NRS 433.744

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:

NRS 433.744 Requirements for regional, county, local or tribal plan for use of grant; authorized uses of grant money.

1. A plan for the use of grant money by a state, local or tribal governmental entity developed pursuant to subparagraph (2) of paragraph (a) of subsection 1 of NRS 433.740 must:
(a) Establish policies and procedures for the administration and distribution of the grant money for which the governmental entity is applying;
(b) Describe the projects to which the governmental entity is proposing to allocate grant money; and
(c) Establish requirements governing the use of the grant money.
2. A plan 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;
(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.

Next Steps

The WOARF team will develop and initial funding plan for 2026-2027 based on the findings in the Needs Assessment. In 2027, WOARF will re-evaluate progress on the priorities and emerging needs to develop the 2028-2029 Funding Plan. In 2029, WOARF will begin work on the 2030-2033 Needs Assessment. In 2026, WOARF will also develop recommendations for community providers based on the feedback in the Needs Assessment.

Appendix A: Glossary

This glossary defines key terms, acronyms, and concepts used throughout the Washoe County Opioid Use/Opioid Use Disorder Needs Assessment. Terms are organized alphabetically with cross-references where relevant.

Abstinence Complete cessation from using alcohol or drugs. Traditionally seen as the only marker of successful recovery, though the Needs Assessment reflects community understanding of multiple pathways to recovery that may include approaches to reduce morbidity and mortality alongside or instead of abstinence-only goals.

Adverse Childhood Experiences (ACEs) Potentially traumatic events that occur in childhood (0-17 years), including abuse, neglect, and household dysfunction. The assessment identified ACEs as contributing to intergenerational cycles of substance use (see Cycle 7, Intergenerational Trauma-Substance Use Cycle).

Aftercare Ongoing support services provided after completion of primary treatment (such as residential or intensive outpatient programs). May include continued counseling, peer support, case management, and recovery monitoring.

American Society of Addiction Medicine (ASAM) Criteria the most widely used and comprehensive set of standards for placement, continued service, and transfer of patients with addiction and co-occurring conditions. *"ASAM now covers Recovery Residences as meaningful forms of treatment"* and connects to *"'social model' as form of treatment."*

Assessment Clinical evaluation to determine an individual's needs, appropriate level of care, and treatment recommendations. The Needs Assessment identified long wait times for assessments as a significant barrier: *"We need more people doing assessments so people aren't waiting on an assessment to wait on a bed in a program."*

Behavioral Health Umbrella term encompassing both mental health and substance use disorders, recognizing their frequent co-occurrence and interconnection.

Biomedical Model Approach to treatment emphasizing medical and biological aspects of addiction, including medication-assisted treatment, detoxification, and understanding addiction as a brain disease.

Buprenorphine (also Subutex, Suboxone) FDA-approved medication used to treat opioid use disorder. Partially activates opioid receptors, reducing cravings and withdrawal without producing euphoria. Can be prescribed in office-based settings. The Needs Assessment notes some people *"avoided buprenorphine because it required withdrawal to initiate."*

Burnout State of physical, emotional, and mental exhaustion caused by prolonged stress, particularly common among helping professionals. The Needs Assessment identified this as Cycle 4 (Provider Burnout-Service Gap Cycle), with *"High rates of burnout and turnover in the SUD workforce."*

Care Continuum (also Continuum of Care) The full range of services needed to support people through recovery, from prevention through detoxification, treatment (residential and outpatient), recovery housing, and ongoing support services. The Needs Assessment found: *"It is extremely difficult to connect people to the appropriate level of care across the continuum of care, during their window of change."*

Care Coordination (also Case Management) Process of organizing and facilitating all services a person needs, ensuring communication among providers, reducing redundancy, and maintaining continuity. The Needs Assessment found this is a significant gap in the current system.

Carceral System The network of institutions involved in detaining, incarcerating, and supervising people, including jails, prisons, probation, and parole.

Certified Peer Recovery Support Specialist (PRSS) Individual with lived experience of substance use disorder and recovery who has completed formal training and certification to provide support services to others in or seeking recovery. Also called Peer Recovery Specialist, Peer Support Specialist, or Peer Worker. The Needs Assessment identified that PRSS are key team members who need ongoing support and training to sustain their work and give them opportunities to grow.

Child Welfare System Government agencies and services responsible for protecting children from abuse and neglect, including investigation, removal, foster care, and family reunification services. The Needs Assessment notes: *"Despite progress in 2024, the region continues to experience high rates of substance-related child removals."*

Co-Occurring Disorders (also Dual Diagnosis) The presence of both a substance use disorder and a mental health disorder in the same individual. The Needs Assessment found limited services addressing co-occurring needs and notes this as a challenge in accessing care.

Community-Based Participatory Practice (CBPP) Approach to program development and evaluation that involves community members as equal partners and co-creators, not just subjects or informants. The Needs Assessment was conducted using this methodology.

Community-Based Participatory Research (CBPR) Research methodology required by NRS 433.742 that involves community members as equal partners in all phases of research, from design through dissemination. *"This process builds relationships and generates trust and buy-in."*

Compassion Fatigue Secondary traumatic stress experienced by those who help people suffering from trauma, characterized by emotional and physical exhaustion and reduced capacity for empathy. Related to but distinct from burnout. The Needs Assessment found that providers need specific mental health supports to prevent compassion fatigue.

Counterproductive Practices Policies, procedures, or practices that inadvertently create barriers or worsen outcomes. The Steering Committee conducted an exercise identifying current counterproductive practices, including long waitlists, sobriety requirements before services, stigmatizing MAT, and throwing away belongings/medications.

Cultural Humility Lifelong process of self-reflection and learning about other cultures, recognizing one's own cultural biases and limitations, and approaching others with

openness and respect. Differs from "cultural competence" by emphasizing ongoing learning rather than expertise.

Culturally Responsive Services (also Culturally Relevant Services) Services designed with and for specific cultural communities, incorporating cultural values, practices, healing traditions, and worldviews. The Needs Assessment found: *"Many of the available resources for Native people are from out of state and not specific to local cultures."*

Detoxification (Detox) Medically supervised process of allowing the body to eliminate substances while managing withdrawal symptoms. Can be inpatient (hospital-based or residential) or outpatient (community-based). The Needs Assessment found: *"The only options available to individuals detoxing from opioids without co-occurring diagnoses are the emergency departments and the Mallory Behavioral Health Crisis Center in Carson City."*

Diversion Programs Alternatives to traditional criminal justice processing that redirect people with substance use or mental health issues into treatment and services rather than incarceration. May occur at various points (pre-arrest, pre-trial, pre-sentencing, post-conviction).

Drop-In Center (also Resource Center, Stabilization Center) Low-barrier facility where people can access services without appointments, eligibility requirements, or commitment to specific programs. The Needs Assessment describes this as: *"A bridge between an encampment or whatever the chaotic, unstable living situation, the bridge between that and services."*

Drug Checking (also Drug Testing Supplies) Use of chemical test strips or other technologies to identify contents of substances, particularly to detect fentanyl or other unexpected adulterants. A tool that allows people to make informed decisions about use.

Emergency Department (ED) Hospital department providing immediate medical care for acute conditions. The Needs Assessment found EDs are often the only option for medical detox and that people with OUD experience stigma in ED settings.

Emergency Medical Services (EMS) Pre-hospital emergency care provided by paramedics and EMTs, including ambulance transport. The Needs Assessment notes EMS personnel are often first responders to overdoses and face reimbursement challenges that incentivize ED transport over alternative care pathways.

Evidence-Based Practice Interventions and programs supported by rigorous research demonstrating effectiveness. The Needs Assessment cautions that some "evidence-

based" programs may be outdated: *"They were written in the 1980s! Kids know when you're BS-ing them—they put up a wall. They are 'evidence based' but they are no longer effective."*

Federally Qualified Health Center (FQHC) Community-based healthcare providers receiving federal funding to serve underserved areas and populations, regardless of ability to pay. The Needs Assessment notes: *"With Change Point closing down because of federal changes to FQHC requirements we need to collaborate on how to fill this gap in the community."*

Fentanyl Synthetic opioid approximately 50 times more potent than heroin, increasingly found in illicit drug supply. Major contributor to overdose deaths due to its potency and presence in drugs people believe to be other substances.

First Responders Personnel who are first on scene during emergencies, generally including law enforcement, but in this Needs Assessment refers specifically to firefighters, and emergency medical services. The assessment includes their perspectives on responding to overdoses and connecting people to services.

Gender-Based Violence Violence directed at individuals based on their gender, including sexual assault, intimate partner violence, and harassment. The Needs Assessment found: *"All women described sexual violence and gender-based violence and multiple men mentioned how the community overlooks the violence perpetrated against women who are homeless."*

Generational Trauma (also Intergenerational Trauma) Trauma transmitted from one generation to the next through family systems, community experiences, or historical oppression. The Needs Assessment identified this as core cycle and was brought up specifically by people with living experience and family members of people who use(d).

Harm Reduction Set of practical strategies and philosophical approach aimed at reducing harmful consequences associated with drug use. Core principle identified in assessment: *"Meeting people where they are at but not leaving them there."* Includes:

- **Harm Reduction Philosophy**: Accepting that people use substances and focusing on reducing harm rather than requiring abstinence
- **Harm Reduction Services**: Specific interventions like naloxone distribution, syringe exchange, drug checking, and safer use education
- **Harm Reduction-Informed Treatment**: Clinical services that don't require abstinence for participation

A provider summarized it as: *"Rule #1, don't die."*

Hepatitis C (HCV) Bloodborne virus that causes liver infection, commonly transmitted through sharing injection equipment. The Needs Assessment notes HCV testing and treatment as important services for people who us opioids.

Historical Trauma Cumulative emotional and psychological wounding across generations resulting from massive group trauma. Particularly relevant for Indigenous communities experiencing ongoing impacts of colonization, forced assimilation, and cultural genocide.

Housing First Approach that provides permanent housing to people experiencing homelessness without preconditions such as sobriety, treatment participation, or service engagement. Based on understanding that housing is a prerequisite for addressing other challenges, not a reward for addressing them. The Needs Assessment found: "*you can't be stable if you don't have a shelter.*"

Human Immunodeficiency Virus (HIV) Virus that attacks the immune system and can lead to AIDS if untreated. Transmitted through blood and sexual contact. The assessment notes HIV testing and prevention (PrEP, PEP) as important services for people who use opioids.

Incarceration Confinement in jail or prison following criminal conviction. Distinguished in the assessment from "detention" (being held by law enforcement before sentencing).

Indigenous Term used to describe Native peoples in their historical and ancestral lands, emphasizing sovereignty and connection to place. Used interchangeably with Native American in the Needs Assessment when referring to tribal communities in the Washoe County area.

Intensive Outpatient Program (IOP) Treatment program provides 9+ hours per week of structured therapy and services while allowing individuals to live at home or in recovery housing. The Needs Assessment notes IOPs lack childcare, creating barriers for parents.

Intersectionality Framework recognizes that multiple forms of marginalization (race, class, gender, disability, etc.) intersect and compound, creating unique experiences of oppression and barriers. The Needs Assessment demonstrates this by showing how homelessness amplifies every other barrier in the section on Cycles.

Jail Local detention facility for people awaiting trial or serving sentences typically less than one year. The Needs Assessment examines the Washoe County Detention Center's MAT program and Bridge Program and notes both strengths and coordination challenges.

LEAB (Living Experience Advisory Board) Group of individuals with living experience of substance use disorder who provided input on survey design, conducted community surveys, and reviewed findings for the Needs Assessment. Met biweekly from February-March 2025 and reconvened in October 2025.

Lived Experience Direct previous personal experience with a phenomenon (in this context, substance use disorder and recovery). People with lived experience are recognized as experts whose knowledge is distinct from and complementary to academic or clinical expertise.

Living Experience Direct current personal experience with a phenomenon (in this context, substance use disorder and recovery). People with living experience are recognized as experts whose knowledge is distinct from and complementary to academic or clinical expertise.

Low-Barrier (also Low-Threshold) Services are designed to minimize requirements for access. In this assessment, defined as:

- Accepts Medicaid/uninsured
- Walk-in or same-day access (no waitlist)
- No ID required for initial contact
- Transportation assistance available
- Culturally responsive

Mallory Behavioral Health Crisis Center Crisis stabilization facility in Carson City (60 miles from Reno) that accepts people for behavioral health crises. The Needs Assessment notes this is the only option besides emergency departments for opioid detox without co-occurring diagnoses.

MAT (Medication-Assisted Treatment, also Medication for Opioid Use Disorder/MOUD) Use of FDA-approved medications (methadone, buprenorphine, or naltrexone) in combination with counseling and behavioral therapies to treat opioid use disorder. Considered the gold standard of opioid use disorder treatment. The Needs Assessment found: *"MAT is an effective tool for treating OUD"* and recommends *"medication agnosticism"* (not favoring one medication over others).

Medicaid Federal and state health insurance program for low-income individuals and families. The Needs Assessment found significant barriers: *"Waitlists are long and there are limited options for people with Medicaid"* and *"Lack of dental care providers in the community who will support people on Medicaid."*

Medication-Agnostic Approach that does not favor one medication (methadone, buprenorphine, naltrexone) over others, allowing client choice and clinical appropriateness to guide decisions. The Needs Assessment recommends this to address *"stigma against medications"* particularly methadone.

Methadone Long-acting opioid agonist medication used to treat OUD. Must be dispensed daily (initially) at specialized clinics. The Needs Assessment found: *"There is stigma against the use of Methadone, one of the gold standards of treatment for OUD, with some programs not accepting participants who are using methadone."*

Mobile Crisis Team (also Mobile Outreach Team) Team of mental health and/or substance use professionals who travel to where people are experiencing crisis, rather than requiring people to come to a facility. May include peers, clinicians, and law enforcement.

Mobile Health Services (also Street Medicine) Healthcare provided where people are—in encampments, on streets, at shelters—rather than in clinical settings. The Needs Assessment recommends mobile health clinics including comprehensive health and dental care as Priority 2.

MOST (Mental Health Outreach Safety Team) Co-responder programs pairing law enforcement with mental health professionals to respond to behavioral health crises. Both Reno and Sparks Police Departments have MOST teams that participated in the Needs Assessment.

Multiple Pathways to Recovery Recognition that there are many valid routes to recovery, including 12-step programs, SMART Recovery, MAT, harm reduction, faith-based approaches, cultural healing, and combinations thereof. The Needs Assessment identifies this understanding as a community strength.

Mutual Aid Voluntary reciprocal exchange of resources and services for mutual benefit, distinct from charity (unidirectional giving). The Needs Assessment notes mutual aid networks as a community strength. Participants particularly identified the resources offered by Family Soup.

Naloxone (brand name Narcan) Medication that rapidly reverses opioid overdose by blocking opioid receptors. Can be administered as nasal spray or injection by non-medical persons. The Needs Assessment found: *"Widespread public access to free naloxone is saving lives."*

Naltrexone (brand names Vivitrol, ReVia) Medication that blocks opioid receptors, preventing euphoric effects if opioids are used. It is used to treat OUD and alcohol use

disorder. Requires complete detoxification before starting (unlike methadone and buprenorphine).

NIMBY ("Not In My Back Yard") Opposition by residents to proposed developments in their neighborhood, particularly services for marginalized populations like recovery housing or homeless shelters. Creates geographic inequity by concentrating services in already-burdened communities.

NOFO (Notice of Funding Opportunity) Public announcement of available funding, including eligibility requirements, priorities, application process, and evaluation criteria. WOARF will issue NOFOs for the priority areas identified in this Needs Assessment.

Non-Fatal Overdose Overdose event where the person survives, either through naloxone administration, spontaneous recovery, or medical intervention..

NRS (Nevada Revised Statutes) Codified laws of the State of Nevada. Specifically relevant sections:

- **NRS 433.712-433.744**: Establishes requirements for opioid settlement funds, including community-based participatory research methodology for Needs Assessments
- **NRS 433.744**: Specifies allowable uses of opioid settlement grant money

Opioid Class of drugs that includes prescription pain medications (morphine, oxycodone, hydrocodone), synthetic opioids (fentanyl), and illicit drugs (heroin). Defined in Needs Assessment as: *"A class of natural, semi-synthetic, and synthetic drugs derived from or mimic opium."*

Opioid Settlement Funds Money paid by pharmaceutical companies and distributors as part of legal settlements for their role in the opioid crisis. Washoe County receives funds that must be used for opioid abatement and recovery according to settlement terms and Nevada law.

Opioid Use Disorder (OUD) Clinical diagnosis from DSM-5 for problematic pattern of opioid use leading to significant impairment or distress. Defined in the Needs Assessment as: *"A diagnosis for the complex, chronic, and treatable medical condition related to the symptoms and behaviors of substance use."*

Outpatient Treatment Treatment services that allow individuals to live at home while attending scheduled therapy sessions, typically 1-8 hours per week. Less intensive than IOP or residential treatment.

Outreach (also Street Outreach) Practice of going to where people are (streets, encampments, parks) to build relationships, provide resources, and connect to services.

The Needs Assessment found outreach ranked #1 across all stakeholder groups and describes effective practice: *"It's like trying to leave a lasting impression on somebody's heart and mind that they've been cared for and dignified, so that when it comes time for them...when they're ready to make that decision, we're the people that they can call."*

Overdose Life-threatening condition resulting from excessive drug use, causing respiratory depression, unconsciousness, and potentially death. Can be reversed with naloxone if caught in time.

Overdose Prevention Centers (also Supervised Consumption Sites, Safe Consumption Sites) Legally sanctioned facilities where people can use pre-obtained drugs under medical supervision, with immediate intervention available if overdose occurs. Not currently legal in Nevada.

Peer (also Person with Lived Experience, Person in Recovery) Someone who has personal experience with substance use disorder and recovery. In professional context, refers to Certified Peer Recovery Support Specialists (PRSS) who provide services based on shared experience.

PEP (Post-Exposure Prophylaxis) Short-term medication taken after potential HIV exposure to prevent infection. Must be started within 72 hours of exposure.

Permanent Supportive Housing Long-term, affordable housing paired with supportive services for people with disabilities, chronic health conditions, or other complex needs. No time limit on residency. Distinct from transitional or recovery housing.

Pre-Exposure Prophylaxis (PrEP) Daily medication taken by HIV-negative people at high risk for HIV to prevent infection if exposed. Focus group and key informant interview participants identified that only men who identified as gay with OUD were referred to PrEP resources.

Prevention Strategies to reduce likelihood of substance use initiation or progression to problematic use. Includes:

- **Primary Prevention**: Universal strategies for general population (school programs, public awareness)
- **Secondary Prevention**: Targeted strategies for at-risk individuals
- **Tertiary Prevention**: Reducing harm and preventing death among people already using substances

The Needs Assessment notes: *"Prevention education grounded in lived experience and tailored to the audience is not in all the schools."*

Pueblo Model Housing approach where multiple levels of support are co-located in the same building or complex (like traditional pueblo architecture with interconnected living

spaces). The Needs Assessment recommends: *"Co-locate housing & recovery services using a Pueblo model...that places community resources and peer supports in apartment complexes."*

Rapid Response Fund Flexible funding mechanism with streamlined application process to address urgent or emergent needs between formal funding cycles. The Needs Assessment recommends WOARF establish such a fund.

Recovery Process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. The SAMHSA defined recovery domains are: Health, Home, Purpose, and Community. The Needs Assessment emphasizes understanding *"multiple pathways to recovery and that not everyone's journey will look the same."*

Recovery Capital Sum of resources (personal, family, social, community) that can be drawn upon to initiate and sustain recovery. Includes internal resources (motivation, skills, resilience) and external resources (housing, employment, supportive relationships).

Recovery Housing (also Sober Living, Recovery Residence) Alcohol- and drug-free living environment for people in recovery. May be peer-run or professionally managed. Ranges from minimal structure (independent living with peer support) to high structure (staff supervision, programming requirements). The Needs Assessment recommends: *"Expand low-barrier recovery housing and sober living environments that include comprehensive wrap-around and tenancy support."*

Recovery-Oriented System of Care (ROSC) Network of services and supports coordinated to provide comprehensive, person-centered care across the recovery journey, emphasizing sustained recovery rather than acute treatment episodes.

Referral Process of connecting someone to another service or provider. The assessment distinguishes between:

- **Cold referral**: Giving someone a phone number to call themselves
- **Warm handoff**: Making the connection while the person is present, sometimes walking them to the service
- **Navigation**: Accompanying the person through the entire process

Warm handoffs and navigation have much higher success rates than cold referrals.

Relapse Return to substance use after a period of abstinence. Understood in modern practice as a common part of the recovery process, not a failure. The Needs Assessment notes environmental triggers (returning to "trap house") as a relapse risk.

Residential Treatment (also Inpatient Treatment) 24-hour treatment in a facility where clients live full-time for weeks or months. Provides intensive services including therapy, skill-building, medical monitoring, and structured environment. The Needs Assessment found: *"At every step of the treatment continuum...long waitlists, insufficient bed space, not enough providers, and challenges with insurance coverage."*

Resiliency (also Resilience) Capacity to recover from difficulties, adapt to change, and persist despite challenges. One of the Steering Committee values: *"Show up today and keep doing the work throughout the process."*

Restorative Justice Approach to addressing harm that emphasizes repairing relationships and involving all stakeholders (person who caused harm, person harmed, community) in determining accountability and resolution. Alternative to punitive justice.

SAMHSA (Substance Abuse and Mental Health Services Administration) Federal agency within U.S. Department of Health and Human Services responsible for behavioral health policy and programs. Defines recovery and establishes evidence-based practice guidelines.

Secondary Data Information collected for purposes other than the current study, such as existing statistics, administrative records, or prior research. This Needs Assessment includes secondary data on overdose deaths, child welfare involvement, and service utilization.

Secondary Trauma (also Vicarious Trauma) Trauma symptoms experienced by those who help people who have experienced trauma, through repeated exposure to traumatic stories and situations. The Needs Assessment found: *"All those folks are being vicariously affected by trauma. Everybody is swimming in this trauma"* and recommends *“Create peer-led mental health supports to prevent burnout among peer workers, providers, and professionals working in the field*”

Sequential Intercept Model Framework for identifying opportunities to divert people with mental illness or substance use disorders away from the criminal justice system at various "intercepts" (points of contact), from first responder contact through jail, court, and community reentry.

Settlement Agreement Legal agreements reached between plaintiffs (states, counties) and defendants (pharmaceutical companies, distributors) in opioid litigation, establishing payment amounts and allowable uses of funds.

Sober Living See "Recovery Housing"

Social Determinants of Health (SDOH) Conditions in environments where people are born, live, learn, work, and age that affect health outcomes. The Need Assessment examines SDOH including housing, transportation, employment, and access to care.

Social Model Approach to recovery emphasizing peer support, mutual aid, community, and social factors rather than medical or clinical interventions. The Need Assessment notes: *"ASAM connecting to 'social model' as form of treatment."*

Spoke Model Hub-and-spoke approach where a central resource hub connects to multiple satellite locations (spokes). The Need Assessment recommends this for housing: *"Places community resources and peer supports in apartment complexes and community spaces that are not explicitly sober."*

Stabilization Process of addressing immediate crisis needs (housing, food, safety, medical care) to create foundation for further treatment or recovery work. The Need Assessment recommends: *"Develop a low-barrier drop-in stabilization center where people can temporarily wait for services at the appropriate level of care."*

STAR Program Washoe County pre-trial diversion program that provides alternatives to traditional prosecution for people with OUD.

Steering Committee Advisory body of diverse community stakeholders (including people in recovery, loved ones, service providers, government, law enforcement) that met monthly December 2024-November 2025 to guide the Needs Assessment process. Organizations participating listed on p. 12-13.

Stigma Negative attitudes, beliefs, and stereotypes about people with substance use disorders that create shame, discrimination, and barriers to care. The Need Assessment found: *"Stigmatizing beliefs about people who use substance are a barrier to accessing care, particularly in the Emergency Departments."*

Street Medicine See "Mobile Health Services"

Structural Barriers Policies, practices, and systems that create obstacles to equity and access, operating at institutional or societal level rather than individual level. The Need Assessment identifies five major structural barriers in Section Five.

Substance Use Disorder (SUD) Clinical term for problematic pattern of substance use causing significant impairment or distress. Encompasses spectrum from mild to severe. Preferred over outdated terms like "addiction" or "substance abuse."

Syringe Exchange (also Syringe Services Program/SSP) A service providing sterile syringes and injection equipment to people who inject drugs, along with safe disposal, naloxone, testing for infectious diseases, and connections to care. Reduces

transmission of HIV, hepatitis C, and other bloodborne infections and increases participation in treatment programs.

System Navigation (also Case Management, Care Coordination) Helping people access and move through complex service systems. The Need Assessment found: *"Providers need to collaborate on the specific needs of specific clients and ensure continuity of care across the community."*

Systems Thinking Approach to problem-solving that views issues as interconnected parts of larger systems rather than isolated problems. This Need Assessment uses systems thinking to map how barriers compound each other in cycles.

Telehealth Healthcare services provided via video, phone, or other technology rather than in-person. Can reduce transportation barriers but requires technology access and internet connectivity.

Territorialism Organizational behavior where agencies protect their "territory" (funding, clients, services) rather than collaborating. The Need Assessment found: *"There's an absolutely comprehensive and I believe intentional inability for organizations to collaborate with one another...because we are limited in the amount of funding and forced to compete."*

Therapeutic Community Residential treatment model using community as the primary method of change, with peers, staff, and structured activities all contributing to recovery. Emphasizes personal responsibility, mutual support, and social learning.

Tolerance Physiological adaptation to a drug requiring increased amounts to achieve the same effect. Important safety concern because after periods of abstinence (such as incarceration), tolerance decreases dramatically, and returning to previous use levels can cause fatal overdose.

Transitional Housing Temporary housing (typically 6-24 months) with supportive services designed to help people move toward permanent housing. May have program requirements or milestones. Distinct from permanent supportive housing (no time limit) and emergency shelter (very short-term).

Trap House Informal term for residence where drugs are sold and used, typically characterized by dangerous conditions, violence, and exploitation. The Need Assessment quotes: *"Why do you think they call a trap house a trap house. You try to leave it? It's the only place you can live so you go back to it."*

Trauma-Informed Care Service approach that recognizes the prevalence and impact of trauma, creates safety, emphasizes trustworthiness and transparency, supports peer

connections, empowers choice, and avoids re-traumatization. The Need Assessment recommends: *"Provide ongoing training in trauma-informed care, harm reduction, and culturally relevant care for providers."*

Treatment Court (also Drug Court, Veterans Court, etc.) Specialized court dockets for people with substance use or mental health issues that provide treatment and intensive supervision as alternative to traditional sentencing. Participants appear regularly before the judge and receive sanctions or incentives based on progress.

12-Step Program Peer-led recovery support model originating with Alcoholics Anonymous, based on spiritual principles and mutual aid. Includes Narcotics Anonymous (NA), among others. The Need Assessment emphasizes that while valuable for many, it is one pathway among several, not the only approach.

Universal Precautions Approach that assumes all people may benefit from certain supports, rather than requiring formal diagnosis or eligibility determination.

Upstream Interventions Prevention strategies that address root causes before problems develop, rather than responding to problems after they occur. The Need Assessment recommends: *"An SUD provider suggested Nevada needs to change Medicaid billing to allow for prevention activities to qualify for reimbursement."*

Vicarious Trauma See "Secondary Trauma"

Waitlist Period between when someone seeks service and when service is available. The Need Assessment identifies this as a critical barrier: *"Waitlists are long and there are limited options for people with Medicaid."* Long waitlists mean windows of change close before service access.

Warm Handoff Process where provider directly connects person to next service, making introduction, sometimes attending first appointment together, ensuring smooth transition. Contrasts with "cold referral" (giving a phone number). Much higher success rate.

Washoe Opioid Abatement and Recovery Fund (WOARF) County entity managing and distributing opioid settlement funds for Washoe County. Responsible for conducting Needs Assessments, issuing funding opportunities, and monitoring funded programs.

Window of Change Period when person is motivated to make changes in their substance use, often following crisis, loss, or moment of clarity. Frequently temporary—may last hours to days. The Need Assessment emphasizes: *"It is extremely difficult to connect people...during their window of change"* due to system delays.

Withdrawal Physical and psychological symptoms that occur when substance use is reduced or stopped after period of regular use. For opioids, includes pain, nausea, anxiety, insomnia, and intense cravings. Medical management of withdrawal is called detoxification.

Workforce Development Training, support, and career advancement opportunities for people working in behavioral health field. The Need Assessment recommends: *"Support the ongoing provision of training to the SUD workforce"* and creating pathways for peers to advance into leadership.

Wrap-Around Services Comprehensive, coordinated support addressing multiple needs simultaneously (housing, employment, healthcare, legal, social support) rather than single-issue services. The Need Assessment recommends: *"Expand low-barrier recovery housing...that include comprehensive wrap-around and tenancy support."*

X-Waiver (also DATA Waiver) Former requirement that physicians obtain special waiver to prescribe buprenorphine for OUD. The X-waiver requirement was eliminated in 2023, allowing any licensed prescriber to provide buprenorphine like any other medication. Some providers and community members may not be aware of this change.

Youth Services Programs and supports designed for children and adolescents. The assessment found: *"Prevention education grounded in lived experience and tailored to the audience is not in all the schools"* and recommends trauma-informed programs in schools and pro-social activities for youth.

Zoning Laws Municipal regulations governing land use, including where different types of buildings and facilities can be located. The Need Assessment identifies zoning as structural barrier: *"Remove the barriers to developing additional transitional living housing arrangements such as zoning laws"* that prevent recovery housing in resource-rich neighborhoods.

Appendix B: Steering Committee Values

- Centering the people who are most impacted.
- Open mindedness and curiosity – be open to hearing perspectives that differ from your own and curious enough to ask to understand what is new or different.
- Collaboration – Collaborate across organizations and systems to understand the needs and resources in the community and to continue to fill the gaps collaboratively.

- Inclusivity – Create a space that is inclusive of all. This includes destigmatizing and dismantling system of oppression and not just inviting people into the space but creating the capacity for people who are not here yet to attend.
- Accountability – both to what you say you will do on behalf of the committee but also to the community.
- Compassion, Empathy, and Care – We will have compassion, care, and empathy not just for our fellow committee members but for all community members impacted by the work.
- Honesty, Integrity, and Honor – We will participate in this work with honesty, integrity, and honor.
- Justice and Equity – These funds are a small repayment for the devastating loss of life and extensive morbidity cause by the opioid epidemic. We must use these dollars to help those who are most impacted.
- Transparency – be clear in the processes that lead this work and how it will be used.
- Resiliency- Show up today and keep doing the work throughout the process.

Appendix C: Survey Tool

Community Survey on Opioid Use in Washoe County

Washoe County is inviting you to help make recommendations for our community's opioid Needs Assessment. This survey will ask questions about opioid use in Washoe County to identify community strengths, gaps, barriers, and needs. Your input will help inform our community's action plan and prioritize spending of funds received from opioid-related settlements.

Participation Details:
- Voluntary and anonymous
- Must reside in Washoe County
- It takes approximately 15 minutes to complete
- Risks & Benefits:
- Minimal risks: some of the questions may be uncomfortable. You may skip any questions or stop at any time.
- No direct benefits, but results may inform policies and services.

Definitions

Opioid - a class of natural, semi-synthetic, and synthetic drugs derived from or mimic opium. These include both prescription medications used to treat pain and illegal drugs like heroin. Opioids include morphine, oxycontin, oxycodone, codeine, and fentanyl.

Opioid Use Disorder (OUD) – a diagnosis for the complex, chronic, and treatable medical condition related to the symptoms and behaviors of substance use.

Contact Information

For any questions related to this project or the survey, please contact Washoe Opioid Abatement and Recovery Fund at woarf@washoecounty.gov. This survey is anonymous. By taking the survey you agree that the information provided will be used to prioritize Washoe Opioids Abatement and Recovery Fund strategies.

Are you a Washoe County resident?

• Yes

• No

Q1 Have you been personally impacted by opioid use?

• Yes

• No

• Unsure

Q2. Which best describes you (select all that apply)

• Concerned community member

• Person who uses opioids

• Person in recovery from opioid use

• Family member or loved one of a person who uses opioids

• Professional or paraprofessional working to address opioid use

• None of the above (please explain)_____

If selected “Professional or paraprofessional working to address OUD” proceed to Question 2A

If selected either " Person who uses opioids” or “Person in recovery from opioid use disorder (OUD)” proceed to Question 2B

If selected only “Concerned community member,” “Family member or loved one of a person with opioid use disorder (OUD),” or “None of the above” proceed to Question 3 on page 8

Q2a. If you are a professional or paraprofessional working to address opioid use, which of the following best describe(s) the type of organization you work with. (Select all that apply.)

• Child welfare agency

• Court staff or Judge

• Educator

• Defense Attorney

• District Attorney

• First responder

• Government

• Harm Reduction

• Healthcare

• Homeless services

• Law enforcement

• Medicaid/managed care organization or other health insurance payer

• Mental health service provider

• Mutual aid organization

• Prevention coalition

• Religious organization

• Social services agency

• Substance use treatment provider

• Veteran services

• Youth services

• Other, Specify: _____

Q2b. If you are a person who uses opioids, are you currently participating in any sort of substance use disorder treatment, recovery support, or receiving Medication Assisted Treatment (e.g. methadone or buprenorphine)?

• Yes

• No

Q2c. Regardless of whether you are currently in treatment or not, if you were to seek treatment which types of support would help you be successful in treatment? (select all that apply):

• Access to health insurance

• Economic support (e.g. Guaranteed basic income or a regular cash payment to individuals in need)

• Education support

• Employment support

• Family supports (e.g. childcare, kinship care supports)

• Food bank and/or SNAP application support

• Housing services

• Help obtaining an ID or other records

• Legal support

• Mental health treatment

• Physical health services

• Transportation support (rides, bus passes, help navigating buses)

• Other: ____

• None of these services

Q2d. Regardless of whether you are currently in treatment or not, what do you think are the most important aspects of an effective treatment plan? (select all that apply):

• Community-based recovery services (e.g. SMART recovery, NA, etc.)

• Harm Reduction services (i.e. non abstinence based supports like community warming centers)

• In-patient treatment

• Medical detox

• Long-term recovery housing

• Medication Assisted Treatment (i.e. a combination of medication, counseling, and behavioral therapies to treat substance use disorders that can include methadone, buprenorphine, and naltrexone to treat opioid use disorder.)

• Mental health or trauma therapy

• Outpatient treatment

• Other: _____

• None of these

Q2e. Which of these services have you accessed in Washoe County within the last 12-months? (select all that apply):

• Community-based recovery services (e.g. SMART recovery, NA, etc.)

• Harm Reduction services (i.e. non abstinence based supports like community warming centers)

• In-patient treatment

• Medical detox

• Long-term recovery housing

• Medication Assisted Treatment (i.e. a combination of medication, counseling, and behavioral therapies to treat substance use disorders that can include methadone, buprenorphine, and naltrexone to treat opioid use disorder.)

• Mental health or trauma therapy

• Outpatient treatment

• Other: _____

• None of these

Q2F. Have you accessed syringe exchange or free naloxone services in Washoe County within the last 12 months?

• Yes

• No

Q2G. Have you wanted to access services in Washoe County within the last 12 months, but were unable to for any reason?

• Yes

• No

If selected “Yes” proceed to Question 2H

If selected “No” proceed to Question 2i

Q2H. If you were unable to access a service, why were you unable to access the service? (select all that apply):

• Did not accept my insurance

• Felt judged and unwelcome

• It does not exist in Washoe County

• Lack of transportation

• Long waitlist

• Parental or other familial responsibilities

• Too expensive

• Turned away due to medications I was taking

• Turned away due to substances I was taking

• Turned away due to other medical conditions such as infection

• Other_____

• None of these

Q2i. Have you been detained or incarcerated in Washoe County in the last 12-months?

• Detained (held by law enforcement but not sentenced to jail/prison)

• Incarcerated (served time in jail or prison as part of a sentence)

• Neither

• Not in Washoe County

If selected “Incarcerated” proceed to Question 2J

If selected only “Detained” or proceed to Question 2L

If selected only “Neither” or “Not in Washoe County” proceed to Question 3

Q2J: Were you offered Medication to treat Opioid Use Disorder in the jail? By medication to treat opioid use disorder, this means methadone or buprenorphine (also known as Subutex or Suboxone).

(select all that apply):

• Yes – and I received treatment

• Yes – and I declined treatment

• No - I did not have a prescription at intake

• No – I missed a vitals check

• No – I was not offered

• Other_____

If selected “Yes – and I received treatment” proceed to Question 2K

If selected “Yes – and I declined treatment” “No” or “Other” proceed to Question 2L

Q2K: How long after you were booked did it take to receive your medication?

• Received it immediately

• 1 day

• 2 days

• 3 days

• More than 3 days

• Never received medication

Q2L: Were you offered any of the following services instead of detainment (select all that apply):

• Diversion or alternative sentencing (e.g. STAR program)

• Treatment Court (e.g. Drug Court, Veterans Court etc.)

• Neither

Other: Specify_____

If selected “Diversion or alternative sentencing” or “Treatment Court” proceed to Question 2M

If selected “Neither” proceed to Question 3

Q2M: Did you agree to participate in the service?

• Yes

• No

If selected “Yes” proceed to Question 2N

If selected “No” proceed to Question 3

Q2N: Was the service helpful to you?

• Yes

• No

Q3. How concerned are you about the ability of people in Washoe County to access services for opioid use?

• Very Concerned

• Somewhat Concerned

• Somewhat unconcerned

• Not concerned

Q4. Have you heard about these opioid-related initiatives/services in Washoe County? (Select all that apply.)

• After care and care navigation after exiting in-patient treatment

• Community-based recovery support services (e.g. AA/NA, SMART Recovery)

• Crisis services (e.g., Mobile outreach teams)

• Diversion and treatment courts

• Family counseling and resolution services

• Family reunification supports

• Harm reduction services (e.g., syringe exchanges, naloxone training and distribution)

• Healthcare provider training on opioid prescribing and treatment

• Housing Services

• Immediate access to treatment and detox

• Job-training and employment support for people who use opioids

• Mental health care (e.g., counseling, psychiatry)

• Restorative justice (a set of practices to repair harm and hold the person who caused the harm accountable)

• Robust data collection and data on effective programs

• Supportive services for youth affected by opioid use

• None of these

Q5. Generally, how accessible do you think services are for people with opioid use in Washoe County?

• Very accessible

• Somewhat accessible

• Somewhat inaccessible

• Very inaccessible

Q6. In your opinion, what are the most important services to address opioid use in Washoe County? (Pick your top five)

___ Access to harm reduction services (e.g., syringe exchanges, free community naloxone boxes)

___ After care and care navigation after exiting in-patient treatment

___ Community-based recovery support services (e.g. AA/NA, SMART Recovery)

___ Crisis services (e.g., Mobile outreach teams)

___ Diversion and treatment courts

___ Family counseling and resolution services

___ Family reunification supports

___ Healthcare provider training on opioid prescribing and treatment

___ Housing services (e.g. housing first, long term supportive housing)

___ Immediate access to treatment and detox

___ Job-training and employment support

___ Mental health care (e.g., counseling, psychiatry)

___ Restorative justice (a set of practices to repair harm and hold the person who caused the harm accountable)

___ Robust data collection and access to data on effective programs

___ Supportive services for youth affected by Opioid Use Disorder

___ Other (please explain)_____

Q7. What are Washoe County's strengths that help address the opioid crisis? (Pick up to 5)

___ Community partnerships, cohesion, and involvement

___ Cultural services and traditions

___ Harm reduction services

___ Mental health services

___ Mutual aid networks (e.g., Family Soup)

___ Prevention education

___ Public awareness and educational programs

___ Services for people who have been in the legal system

___ Substance use treatment providers

• Other_____

• There are no strengths

Q8. What are some of the greatest gaps in resources related to addressing opioid use in Washoe County? (Pick up to 5)

___ Affordable housing

___ Collaboration with businesses (e.g. workforce programs for people in recovery)

___ Data on effective services

___ Drop-in services or resource center (i.e. community centers)

___ Family-based support services

___ Harm reduction services (e.g., syringe exchanges, free community naloxone boxes)

___ Immediate access to substance use treatment and detox

___ Mental health care

___ Peer support for people who are in court and in the jail

___ Public awareness and educational programs

___ Recovery support services

___ Services for people who have been in the legal system

___ Services in rural communities

___ Lack of awareness about available services

___ Transportation access

• Other_____

• There are no challenges

Q9. In your opinion, what types of support do providers in Washoe County need? (select all that apply):

• Community based recovery support for providers and Peer Recovery Support Specialist (e.g. NA/AA, SMART Recovery)

• Cultural humility training

• Mindfulness supports

• Certified Peer Recovery Support Specialist training

• Restorative circles training (i.e., training to repair harm between parents and their children who use(d) opioids to and process a path forward)

• Trauma-informed care training

Other, Specify: _____

Q10. If you could prioritize funding for addressing opioid use in Washoe County, what is the ONE service you would prioritize?

• Housing services (e.g. recovery housing, shelters, etc.)

• Increasing long-term sustainability of programs and services (e.g. program evaluation, capacity building, etc.)

• Mental health treatment (e.g. therapy, psychiatry)

• Programs to prevent substance use

• Services to reduce the likelihood of death or injury from opioid use

• Social services (Food access, employment training, etc.)

• Substance Use treatment

Other, specify: _____

Q11. If you could prioritize funding for housing services, what is the ONE strategy you would prioritize?

_____ Housing first services (i.e. housing that does not require sobriety)

_____Recovery housing (i.e. housing that requires sobriety)

_____Subsidized housing for people in recovery (i.e. rental assistance for people in recovery)

_____Transitional housing supports (i.e. programs to assist people as they exit treatment)

Other, specify: _____

Q12. If you could prioritize funding for increasing long-term sustainability of services, what is the ONE strategy you would prioritize?

_____ Capacity building and training for service providers

_____ Evaluation of existing services to determine which are effective

_____ Resources and supports for providers, first responders, and Peer Recovery Support Specialists

Other, specify: _____

Q13. If you could prioritize funding for mental health treatment services, what is the ONE strategy you would prioritize?

_____ More medical providers to prescribe medications to treat mental illness and social workers, counselors, therapists, or psychologists to provide therapy/counseling

_____ Family-based mental health treatment services

_____ Services that address underlying trauma including mental health treatment

Other, specify: _____

Q14. If you could prioritize funding for programs to prevent substance use, what is the ONE strategy you would prioritize?

_____ Out of school services for youth (e.g. sports teams, Boys and Girls Club)

_____ Prevention programming in schools

_____ Stigma reduction awareness campaign/education

Other, specify: _____

Q15. If you could prioritize funding for social services, what is the ONE strategy you would prioritize?

_____ Assistance obtaining access to government services

_____ Employment services and job training

_____ Programs for parents and families impacted by opioid use disorder

Other, specify: _____

Q16. If you could prioritize funding for substance use disorder treatment, what is the ONE strategy you would prioritize?

_____ Culturally responsive treatment services

_____ On-demand in-patient treatment services (same day-availability)

_____ Long-term community-based recovery supports and after care

_____ Patient navigation/care coordination and peer supports

_____ Treatment services for uninsured/underinsured people

_____ Treatment providers that work with all insurers

Other, specify: _____

Q17. If you could prioritize funding for services to reduce the likelihood of death or injury from opioid use, what is the ONE strategy you would prioritize?

_____ Access to safer use supplies (e.g. syringes, smoking supplies, drug testing strips)

_____ Naloxone training and distribution

_____ Overdose prevention centers (i.e. legal safe consumption sites)

Other, specify: _____

Demographics

Q18. What zip code do you reside in?

Q19. What race/ethnicity do you identify as? (Select all that apply.)

- Asian
- American Indian or Alaskan Native
- Black/African American
- Hispanic/Latino(a)
- Middle Eastern or North African
- Native Hawaiian or other Pacific Islander
- White
- Other
- Prefer Not to Answer

Q20. What is your age?

Q21. What gender do you identify as? (select all that apply)

[ ] Man

[ ] Nonbinary

[ ] Transgender Man

[ ] Transgender Woman

[ ] Two-Spirit

[ ] Woman

[ ] Not listed: _____

Thank you for completing the survey! If you are interested in learning more about the Washoe Opioid Abatement and Recovery Fund please contact WOARF@washoecounty.gov or check out the website https://www.washoecounty.gov/mgrsoff/divisions/Community%20Reinvestment/WOARF/index.php

Appendix D: Survey Response

Table 1. Descriptive Characteristics of Survey Participants (N=748).		
	N	%
Have you been personally impacted by opioid use?		
Yes	439	58.7%
No	262	35.0%
Unsure	47	6.3%
Which best describes you? (check all that apply)		
Concerned Community member	408	55.1%
Person who uses opioids	80	10.8%
Person in recovery from opioid use	124	16.7%
Family member or loved one of a person who uses opioids	275	37.1%
Professional or paraprofessional working to address opioid use	239	32.3%
None of the above	65	8.8%
Missing	7	
Age (median, Q1, Q3)	40	(32, 53)
Gender		
Man	257	41.0%
Nonbinary	11	1.8%
Transgender man	1	0.2%
Transgender woman	1	0.2%
Two-spirit	1	0.2%

	Woman	342	54.5%
	Two or more of these	5	0.8%
	Other/Gender not listed	9	1.4%
	Missing	121	
Race/Ethnicity			
	Asian	4	0.6%
	American Indian or Alaska Native	12	1.9%
	Black/African American	29	4.6%
	Hispanic/Latino	61	9.8%
	Middle Eastern or North African	1	0.2%
	Native Hawaiian or other Pacific Islander	5	0.8%
	White	402	64.3%
	More than one race	54	8.6%
	Other	10	1.6%
	Prefer Not to Answer	47	7.5%
	Missing	123	

Table 2. Descriptive Characteristics of subset of survey participants who use opioids or are in recovery from OUD and their experiences accessing services in Washoe County (N=184)

		N	%
Age (median, Q1, Q3)		38	(32, 46)
Gender			
	Man	86	54.1%
	Nonbinary	2	1.3%
	Transgender man	0	0%
	Transgender woman	0	0%
	Two-spirit	0	0%
	Woman	69	43.4%
	Two or more of these	1	0.6%
	Other/Gender not listed	1	0.6%
	Missing	25	
Race/Ethnicity			
	Asian	0	0%
	American Indian or Alaska Native	4	2.5%
	Black/African American	12	7.6%
	Hispanic/Latino	12	7.6%
	Middle Eastern or North African	0	0%
	Native Hawaiian or other Pacific Islander	0	0%
	White	105	66.5%
	More than one race	14	8.9%
	Other	5	3.2%
	Prefer Not to Answer	6	3.8%

	Missing	26	
Are you currently participating in any sort of SUD treatment?			
	Yes	90	52.6%
	No	81	47.4%
	Missing	13	
Regardless of whether you are in treatment or not, if you were to seek treatment, which types of support would help you be successful in treatment? (select all that apply)_			
	Access to health insurance	100	58.8%
	Economic support	86	50.6%
	Education support	71	41.8%
	Employment support	102	60.0%
	Family support	71	41.8%
	Food bank and/or SNAP application support	97	57.1%
	Housing services	126	74.1%
	Help obtaining an ID or other records	75	44.1%
	Legal support	59	34.7%
	Mental health treatment	125	73.5%
	Physical health services	85	50.0%
	Transportation support	99	58.2%
	None of the above	10	5.9%
	Other	6	3.5%
	Missing	14	
Regardless of whether you are in treatment or not, what do you think are the most important aspects of an effective treatment plan? (select all that apply)			
	Community-based recovery services	97	57.4%
	Harm Reduction services	81	47.9%
	Inpatient treatment	97	57.4%
	Medical detox	95	56.2%
	Long-term recovery housing	115	68.0%
	MAT	108	63.9%
	Mental health or trauma therapy	114	67.5%
	Outpatient treatment	93	55.0%
	None of the above	9	5.3%
	Other	10	5.9%
	Missing	15	
Which of these services have you accessed in Washoe County within the last 12 months? (select all that apply)			
	Community-based recovery services	71	42.0%
	Harm Reduction services	60	35.5%
	Inpatient treatment	46	27.2%
	Medical detox	26	15.4%

	Long-term recovery housing	48	28.4%
	MAT	47	27.8%
	Mental health or trauma therapy	63	37.3%
	Outpatient treatment	44	26.0%
	None of the above	42	24.9%
	Other	4	2.4%
	Missing	15	
Have you accessed syringe exchange or free naloxone services in Washoe County within the last 12 months?			
	Yes	71	41.5%
	No	100	58.5%
	Missing	13	
Have you wanted to access services in Washoe County within the last 12 months, but were unable to for any reason?			
	Yes	54	31.8%
	No	116	68.2%
	Missing	14	
	If you were unable to access a service, why were you unable to access the service? (select all that apply)		
		Did not accept my insurance	23	42.6%
		Felt judged and unwelcome	16	29.6%
		It does not exist in Washoe County	13	24.1%
		Lack of transportation	22	40.7%
		Long waitlist	25	46.3%
		Parental or other familial responsibilities	12	22.2%
		Too expensive	19	35.2%
		Turned away due to medications I was taking	9	16.7%
		Turned away due to substances I was taking	11	20.4%
		Turned away due to other medical conditions such as infection	1	1.9%
		None of the above	3	5.6%
		Other	6	11.1%
Have you been detained or incarcerated in Washoe County in the last 12 months?			
	Detained	24	14.3%
	Incarcerated	42	25.0%
	Neither	109	64.9%
	Missing	16	
	If you were incarcerated in Washoe County, were you offered medication to treat opioid use disorder in the jail? (select all that apply)		
		Yes and I received treatment	18	43.9%
		Yes and I declined treatment	4	9.8%
		No I did not have a prescription at intake	12	29.3%

		No I missed a vitals check	3	7.3%
		No I was not offered	13	31.7%
		Missing	1	

Table 3. Most important services, strengths, and service gaps, stratified by opioid use experience of respondents (N=748).						
	Total (N=748)		People who use or used opioids (Person who uses opioids and/or person in recovery from opioid use) (N=184; 24.8%)		Everyone else (Concerned community member, family member or loved one, professional or paraprofessional, other) (N=557; 75.2%)	
	N	%	N	%	N	%
How concerned are you about the ability of people in Washoe County to access services for opioid use?						
Very concerned	393	57.0%	97	58.4%	296	56.5%
Somewhat concerned	221	32.0%	54	32.5%	167	31.9%
Somewhat unconcerned	37	5.4%	6	3.6%	31	5.9%
Not concerned	39	5.7%	9	5.4%	30	5.7%
Missing	58		18		33	
Generally, how accessible do you think services are for people with opioid use in Washoe County?						
Very accessible	81	12.2%	15	9.1%	66	13.2%
Somewhat accessible	326	49.1%	78	47.6%	248	49.6%
Somewhat inaccessible	190	28.6%	57	34.8%	133	26.6%
Very inaccessible	67	10.1%	14	8.5%	53	10.6%
Missing	84		20		57	
What are the important services to address opioid use in Washoe County? (select all that apply)						

	Harm Reduction Services	274	41.5 %	63	38.7 %	211	42.5%
	After Care and Care navigation after exiting inpatient treatment	342	51.8 %	94	57.7 %	248	49.9%
	Community-based recovery support	227	34.4 %	61	37.4 %	166	33.4%
	Crisis services (e.g., mobile outreach teams)	251	38.0 %	55	33.7 %	196	39.4%
	Diversion and treatment courts	173	26.2 %	36	22.1 %	137	27.6%
	Family counseling and resolution services	145	22.0 %	31	19.0 %	114	22.9%
	Family reunification supports	69	10.5 %	26	16.0 %	43	8.7%
	Healthcare provider training on opioid prescribing and treatment	124	18.8 %	26	16.0 %	98	19.7%
	Housing services	241	36.5 %	77	47.2 %	164	33.0%
	Immediate access to treatment and detox	363	55.0 %	83	50.9 %	280	56.3%
	Job training and employment support	139	21.1 %	43	26.4 %	96	19.3%
	Mental health care	313	47.4 %	71	43.6 %	242	48.7%
	Restorative justice	90	13.6 %	12	7.4 %	78	15.7%
	Robust data collection and access to data on effective programs	37	5.6 %	9	5.5 %	28	5.6%
	Supportive services for youth affected by OUD	104	15.8 %	14	8.6 %	90	18.1%
	Other	26	3.9 %	6	3.7 %	20	4.0%
	Missing	88		21		60	
What are Washoe County's strengths that help address the opioid crisis? (select all that apply)							
	Community partnerships, cohesion, and involvement	264	42.4 %	53	34.0 %	210	45.1%
	Cultural services and traditions	41	6.6 %	14	9.0 %	27	5.8%
	Harm reduction services	216	34.7 %	75	48.1 %	141	30.3%
	Mental Health services	229	36.8 %	72	46.2 %	156	33.5%

	Mutual aid networks	136	21.8%	36	23.1%	100	21.5%
	Prevention education	147	23.6%	31	19.9%	115	24.7%
	Public awareness and educational programs	165	26.5%	38	24.4%	126	27.0%
	Services for people who have been in the legal system	187	30.0%	52	33.3%	135	29.0%
	Substance use treatment providers	211	33.9%	61	39.1%	149	32.0%
	Other	26	4.2%	8	5.1%	18	3.9%
	There are no strengths	109	17.5%	21	13.5%	88	18.9%
	Missing	125		28		91	
What are the greatest gaps in resources related to addressing opioid use in Washoe County? (select all that apply)							
	Affordable housing	403	63.2%	100	63.7%	303	63.1%
	Collaboration with businesses (e.g., workforce programs for people in recovery)	162	25.4%	46	29.3%	115	24.0%
	Data on effective services	108	16.9%	22	14.0%	86	19.7%
	Drop-in services or resource center	204	32.0%	50	31.8%	154	32.1%
	Family-based support services	135	21.2%	40	25.5%	94	19.6%
	Harm reduction services	114	17.9%	19	12.1%	95	19.8%
	Immediate access to substance use treatment and detox	315	49.4%	89	56.7%	226	47.1%
	Mental health care	290	45.5%	54	34.4%	235	49.0%
	Peer support for people who are in court and in the jail	117	18.3%	42	26.8%	75	15.6%
	Public awareness and educational programs	106	16.6%	26	16.6%	79	16.5%
	Recovery support services	152	23.8%	29	18.5%	123	25.6%
	Services for people who have been in the legal system	102	16.0%	35	22.3%	67	14.0%

	Services in rural communities	114	17.9 %	23	14.6 %	91	19.0%
	Lack of awareness about available services	262	41.1 %	58	36.9 %	203	42.3%
	Transportation access	138	21.6 %	38	24.2 %	100	20.8%
	Other	19	3.0 %	4	2.5 %	15	3.1%
	There are no challenges	11	1.7 %	1	0.6 %	10	2.1%
	Missing	110		27		77	

Table 4. Funding priorities stratified by opioid use experience of respondents (N=748)						
	Total (N=748)		People who use or used opioids (Person who uses opioids and/or person in recovery from opioid use) (N=184; 24.8%)		Everyone else (Concerned community member, family member or loved one, professional or paraprofessional, other) (N=557; 75.2%)	
	N	%	N	%	N	%
What ONE service would you prioritize for funding, overall?						
Housing services	168	26.5%	50	32.1%	118	24.7%
Increasing long-term sustainability of programs and services (e.g., program evaluation, capacity building, etc.)	76	12.0%	21	13.5%	55	11.5%
Mental health treatment	113	17.8%	17	10.9%	96	20.1%
Programs to prevent substance use	79	12.5%	14	9.0%	64	13.4%
Services to reduce the likelihood of death or injury from opioid use	40	6.3%	15	9.6%	25	5.2%
Social services (food access, employment training, etc.)	53	8.4%	8	5.1%	45	9.4%

	Substance Use treatment	81	12.8%	26	16.7%	55	11.5 %
	Other	24	3.8%	5	3.2%	19	4.0%
	Missing	114		28		80	
What one strategy would you prioritize for HOUSING SERVICES?							
	Housing first (i.e. housing that does not require sobriety)	158	25.1%	47	29.7%	111	23.6 %
	Recovery housing (i.e., housing that requires sobriety)	182	28.9%	53	33.5%	129	27.4 %
	Subsidized housing for people in recovery (i.e., rental assistance)	123	19.5%	42	26.6%	81	17.2 %
	Transitional housing supports (i.e., programs to assist people as they exit treatment)	152	24.1%	15	9.5%	136	28.9 %
	Other	15	2.4%	1	0.6%	14	3.0%
	Missing	118		26		86	
What one strategy would you prioritize for LONG TERM SUSTAINABILITY OF PROGRAMS AND SERVICES?							
	Capacity building and training for service providers	114	18.2%	33	21.6%	81	17.2 %
	Evaluation of existing services to determine which are effective	221	35.3%	43	28.1%	178	37.7 %
	Resources and supports for	274	43.8%	77	50.3%	196	41.5 %

	providers, first responders, and peer recovery support specialists						
	Other	17	2.7%	0	0%	17	3.6%
	Missing	122		31		85	
What one strategy would you prioritize for MENTAL HEALTH TREATMENT SERVICES?							
	More medical providers to prescribe medications to treat mental illness and social workers, counselors, therapists, or psychologists to provide therapy/counseling	244	39.2%	56	35.9%	188	40.3%
	Family-based mental health treatment services	62	10.0%	18	11.5%	43	9.2%
	Services that address underlying trauma including mental health treatment	299	48.0%	80	51.3%	219	47.0%
	Other	18	2.9%	2	1.3%	16	3.4%
	Missing	125		28		91	
What one strategy would you prioritize for PROGRAMS TO PREVENT SUBSTANCE USE							
	Out of school services for youth	143	22.9%	33	21.0%	110	23.6%

	(e.g., sports teams, Boys and Girls Club)						
	Prevention programming in schools	205	32.9%	52	33.1%	152	32.6 %
	Stigma reduction awareness campaign/education	250	40.1%	67	42.7%	183	39.3 %
	Other	26	4.2%	5	3.2%	21	4.5%
	Missing	124		27		91	
What one strategy would you prioritize for SOCIAL SERVICES?							
	Assistance obtaining access to government services	173	27.8%	41	26.6%	132	28.3 %
	Employment services and job training	237	38.1%	55	35.7%	181	38.8 %
	Programs for parents and families impacted by opioid use disorder	188	30.2%	57	37.0%	131	28.1 %
	Other	24	3.9%	1	0.6%	23	4.9%
	Missing	126		30		90	
What one strategy would you prioritize for SUBSTANCE USE DISORDER TREATMENT?							
	Culturally responsive treatment services	21	3.4%	5	3.2%	16	3.4%
	On-demand inpatient treatment services (same day availability)	188	30.1%	53	34.2%	135	28.8 %

	Long-term community-based recovery supports and after care	108	17.3%	29	18.7%	78	16.7 %
	Patient navigation/care coordination and peer supports	63	10.1%	19	12.3%	44	9.4%
	Treatment services for uninsured/underinsured people	168	26.9%	36	23.2%	132	28.2 %
	Treatment providers that work with all insurers	64	10.3%	13	8.4%	51	10.9 %
	Other	12	1.9%	0	0%	12	2.6%
	Missing	124		29		89	
What one strategy would you prioritize for REDUCING THE LIKELIHOOD OF DEATH OR INJURY FROM OPIOID USE?							
	Access to safer use supplies (e.g., syringes, smoking supplies, drug testing strips)	114	18.5%	37	23.9%	77	16.7 %
	Naloxone training and distribution	232	37.6%	41	26.5%	190	41.2 %
	Overdose prevention centers (i.e., legal safe consumption sites)	225	36.5%	71	45.8%	154	33.4 %
	Other	46	7.5%	6	3.9%	40	8.7%
	Missing	131		29		96	

Appendix E: Interview Guides

Interview Guide for Community Organizations

Interview Date: _____

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

Participants' occupation: ☐ Law Enforcement ☐ First Responder ☐ SUD Provider ☐ Housing Services ☐ Community Outreach ☐ Court Staff ☐ Judge ☐ Child Services ☐ Lawyer

Participants' 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 learn from you as a subject matter experts on opioid use in the community in order to make recommendations for our community's Needs Assessment. I am going to ask 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 leave at any time. I just ask that you speak your mind freely as your perspective is so important. 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 focus group?

Before we start, if you could please share your name, title, and organization.

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.

- Where do you work now and what kinds of services do you provide in the community?
- What does it look like if you are doing well at your job?
    - How do you know that you are successful?

Part II: Opioid Use in the Community

Now we are going to focus on how you interact with people who use opioids.

- What would be helpful to you to support your work as you interact with people with opioid use?
    - Why would that be helpful to you?
    - Who do you think is equipped to help provide that?
    - What do you wish you had to connect with people who use opioids?
- What do you think has been effective with supporting people with an opioid use disorder?
    - What does it look like for someone who is opioid use disorder to be successful in their recovery?
- What are the challenges or barriers of providing services to people with an opioid use disorder?
    - What about the gaps in services, can you tell me about what kinds of gaps you see?
        - What services have you had the most difficulty connecting people to?
    - What do you wish our community would have?
- What are some of the strengths our community has to support people who are seeking recovery?
- If you could develop a strategy to help people who use drugs in our community, what would that look like?
    - What services would be offered? Where would it be located?
- Many people completing the survey thought housing was the biggest funding need in the community, while they felt immediate access to services was this biggest service need.
    - Why do you think these might differ
    - Does this resonate with you? Why/Why not?
- If you could wave a magic wand and change one thing about how opioid use is addressed in Washoe County, what would that be?

Focus Group with Friends and Family of Loved Ones with Opioid Use Disorder

Focus Group Date: _____

Location: _____

Type of Focus Group: _____

Facilitator's name: _____

Notetaker's name: _____

Thank you so much for talking with us today. My name is [facilitator] and this is [notetaker] I'm working with Washoe County to gather information and insight you provide us as a subject matter expert with the experiences as a family or friend of someone who has used or misused opioids, in order to make recommendations for our community's Needs Assessment. We are going to be asking you questions about your family, friends, and substance use the resources you used or relied on or needed that were not or are not available.

Your participation is voluntary, and you do not have to respond to every question if you'd rather not, and you can leave at any time. We just ask that you speak your mind freely as your perspective is important and please be respectful of other people's thoughts they share with us all today. We want to remind you to keep what other people share private, so everyone can talk openly and honestly. Also, we want you to ask questions or let us know if you don't understand something, or if something that we said is bothering you in any way.

We are recording the audio from this discussion so we can take notes and not miss anything that was said. The recording will also be transcribed after the session. Your personally identifiable information will not be included anywhere in the transcript or notes. Your participation should take about an hour, and we would like to record the interview to ensure accuracy. Before we begin, do you feel comfortable participating in this discussion and answering our questions?

Do you have any questions before we start?

Are you willing to participate in the focus group?

Before we start, could please share your alias name you have selected for today's session?

Is it okay to turn on the recorder?

Part I: Background

Thank you for taking time out of your day to speak with us. As we stated, we are speaking with several groups and different types of people to better inform how opioid settlement dollars and resources are allocated in our community. One of the important groups to hear from are friends and family who had or currently have a loved one with opioid use disorder or a history of misuse of opioids. This session today is to learn more about what you needed or need to show up as your best self to offer support for

someone else. We hope to learn what you, as a loved one, believe is important to help people offer support to those who use drugs be in a safer place in relation to their drug use and habits. If you have a history of use yourself, try to focus on your experience with your loved one as opposed to what you yourself may have wanted.

We recognize abstinence is sometimes the first thing that comes to mind when talking about prevention and reduction in use, addiction, and drug-related deaths, however many people experiment with drugs and never enter a phase of misuse, chaotic use, or addiction, while others phase in and out of those levels of use. We want to learn about your experiences - what worked well, what didn't work well, what you needed and what this community is missing in terms of supports for yourself, and your loved one's friends and family.

- With that in mind, what motivates you to participate in this type of discussion with us today?
    - What was your initial reaction to learning about your family member's misuse of opioids? (*probes: how did you feel when you found out?*)
- What did you wish you knew then about resources available to you and your loved one in the community?

Key Questions

1. What types of services are most helpful in this community for people who use drugs? (*probe: where do people who use drugs go to get help if they need it? Are the services they need specific to drug use or are there services needed related to health and stability more broadly?*)
2. What types of services or resources are missing or lacking in this community to address the needs of people who use drugs? (*probe: do these resources exist in this community, but are not being used? Is there not a high enough demand for this resource? Has it been tried, but failed in this community?*)
3. If you had to choose three types of resources or services for people who help those who use drugs, for example caregivers and support systems such as yourselves, what would those be? (*probe: what would be most helpful to you in order for you to support your loved ones?*)
4. What would you like to see from this community to help people like you and your loved ones who use or have used drugs? (*probes: what policies, programs, changes need to happen*)
5. What are the largest health issues or other non-health related issues in this community right now? (*probe: if your neighborhood were to select the biggest impact to the community, what do you think it would be?*)

Closing Questions

6. What do you recommend needs to happen to reduce addiction, particularly opioid addiction, among future generations in this community? (probe: what would help people at risk for addiction, from becoming addicted?)
7. If you could wave a magic wand and change one thing about how opioid misuse and addiction is addressed in Washoe County, what would that be?

Key Informant Interview Questions – People with living experience

Introduction: Thank you for taking the time to meet with me today. I am conducting a statewide assessment on services available for people who use drugs. I am speaking with people in each county about their health and health concerns, including what health-related services are available, people's experiences in accessing those services, and what services are needed in their communities.

Your participation is voluntary, and you do not have to answer any question you don't want to and you can say pass or we can come back to it later. We can also stop the interview at any time. I ask that you speak your mind freely, as your perspective is important. Your identity will be kept confidential and all identifying information will be removed. This interview should take about an hour, and I would like to record the interview to ensure accuracy. The reason I need to record is because I want to pay attention to what you're saying and have a conversation, and I cannot do that and take good notes at the same time. Also, I may not be able to keep up with my notetaking, and I want to be able to listen back our conversation and be able to identify similarities and differences among all the people I speak with across the state over the next few months. Are you willing to participate in the interview?

I am going to turn on the voice recorder and will no longer refer to you by name to preserve confidentiality while recording.

1. **Can you tell me what function drugs have in your life, right now?**
    a. Has that function changed over time? If so, in what way(s)?

2. **Are you interested in changing anything about your drug use?**
    a. If Yes: In what ways? What would make it easier for you to do that/those things?

3. **In general, what are your primary health concerns?**
    a. What services are available to you to address your general health concerns? Probe: What have you heard of or tried to access? How were those experiences? Was it hard to access those services?

b. What would make it easier to access those services? What would you like to see made available in this community?

4. **What are your health concerns related to drugs and drug use?**
   a. What services are available to you to address drug use health concerns? Probe: What have you heard of or tried to access? How were those experiences? Was it hard to access those services?
   b. What would make it easier to access those services? What would you like to see made available in this community?

Here's a list of services or supplies which can help people who use drugs, (hand them this list and read the list out loud)

a. Free HIV testing
b. Free HCV testing (hepatitis C)
c. Medication for preventing HIV if you might have been exposed to HIV
d. Lifetime medication for preventing HIV in persons who are HIV-negative to keep from getting HIV
e. Treatment for hepatitis C
f. Personal hygiene supplies (soap, socks, razors, wipes)
g. Drug education programs
h. Free Narcan or naloxone (overdose reversal medications)
i. Education about overdose reversal medication
j. Free drug test strip to check drugs for fentanyl or other non-wanted substances
k. Education on reducing harms or unwanted experiences of drug use
l. Teaching people how to safely dispose of prescription medication
m. Teaching people how to safely dispose of syringes
n. Access to peer recovery support
o. Medication for opioid use disorder
p. Vending machines with harm reduction supplies
q. Mobile health services
r. Safe smoking supplies
s. Syringe exchange programs

5. **Have you tried accessing these types of services in this community to meet your needs?**
   a. If yes: Which services were the most helpful? What wasn't helpful?
   b. Were your needs met?
   c. If no: What barriers did you face getting your needs met?

6. **People can access these services directly, but sometimes there is an informal network of people (one person or a group of people, outside the walls of an organization) who help distribute these types of services. Is there anyone who**

has helped you access these types of supplies? Probe: Have you relied on an informal network or group of people in the past or currently?
    a. If Yes: How has that experience been?

7. **What do you think it would take to prevent people from becoming addicted to drugs?** Probes: If you could have gone back in time, what might have helped you to prevent or reduce chances of addiction? What supports would you have needed?
8. **What should be the approach for improving health in general in this community?**
9. **Is there anything I have not asked, that I should be asking?**
10. **What questions do you have for me?**

Key Informant Interview Questions – Government Leadership

Thank you again for your time. The findings from our interviews across the state will be shared in the state's opioid assessment, which you will be able to view online.

Introduction: Thank you for taking the time to meet with us today. We are conducting a statewide opioid assessment and are speaking with leadership in each county about perceptions and needs of services for people with opioid use disorder in their communities. We will be utilizing the information to help determine how to guide the spending of the opioid settlement dollars across the state. This interview should take about an hour, and I would like to record the interview to ensure accuracy. Your identity will be kept completely confidential and all identifying information will be removed. Your participation is voluntary, and you do not have to answer any question you don't want to then say, "pass". We can stop the interview at any time. I ask that you speak your mind freely, as your perspective is important. Are you willing to participate in the interview? I am going to turn on the voice recorder and will no longer refer to you by name to preserve confidentiality while recording.

Background

1. How long have you been in your current role (position)?
2. What makes you proud about this county and the residents who live here?
3. What are your major goals for this county?

Perceptions of High-Risk Behavior

4. What are the major impacts of substance use in the community? How do you see it show up in the community? (probe: any patterns in violence, unemployment, domestic violence, incarceration, drug trafficking, overdoses, increases in bloodborne pathogens – hepatitis C, HIV, syphilis).
5. What do you think should be the approach to preventing and reducing substance use in this county?

Perceptions of Services for people with opioid use disorder

6. Services for people with opioid use disorder can include a wide variety of services including: (provide examples below in list). What types of services for people with opioid use disorder are available in your community?

    t. Mobile health services
    u. Free HIV testing and hepatitis C testing
    v. One time medication for preventing HIV in persons who might have been exposed to HIV
    w. Lifetime medication for preventing HIV in persons who are HIV-negative to keep from getting HIV
    x. Free Narcan or naloxone distribution (overdose reversal medications)
    y. Drug education programs
    z. Education on unwanted experiences of drug use
    aa. Teaching people how to safely dispose of prescription medication
    bb. Teaching people how to safely dispose of syringes
    cc. Education about overdose reversal medication
    dd. Personal hygiene supplies (soap, socks, razors, wipes)
    ee. Free Narcan or naloxone (overdose reversal medications)
    ff. Free drug test strip to check drugs for fentanyl or other non-wanted substances
    gg. Community drug checking programs
    hh. Syringe exchange programs
    ii. Access to peer recovery support
    jj. Medication for opioid use disorder
    kk. Vending machines with supplies for people who use opioids
    ll. Vending machines with hygiene supplies
7. Have you tried to implement or support services for people with opioid use disorder in your community?

    a. If yes, what have you seen as the major barriers or facilitators to making that happen?

    b. If no, why not?

8. What are the negative impacts of services for people with opioid use disorder on the wider community?
9. What are the positive impacts of services for people with opioid use disorder on the wider community?
10. Is there anything we have not asked, that we should be asking?
11. Do you have any questions for me?

Thank you again for your time, we will be sure to notify you once the findings of the services for people with opioid use disorder assessment are available.

Appendix F: Counterproductive Practices Worksheet

This worksheet will guide you through a process of identifying potentially counterproductive practices in opioid use disorder (OUD) prevention, treatment, and harm reduction. By considering actions that would worsen the opioid crisis, we can then reflect on our own practices and identify areas for improvement. Please be honest and critical in your responses.

Step 1: The Worst-Case Scenario

Imagine you are tasked with ensuring that every person develops an opioid use disorder and that every person with OUD dies. What actions would you take? Be as specific and comprehensive as possible. Consider factors related to prevention, access to treatment, the quality of treatment, and policies. Write your responses in the space below.

Example: Limit access to naloxone.

Step 2: Identifying Counterproductive Practices

Review the list you created in Step 1. Honestly assess whether any of your current activities, programs, policies, or procedures resemble the actions you identified. Are there any unintended consequences of your work that might be contributing to the problem? Create a list of these potentially counterproductive practices in the space below. It's okay if this is uncomfortable. Recognizing these practices is the first step toward positive change.

Example: Requiring abstinence-only treatment for all clients.

Step 3: Taking Action to Reverse Course

For each item on the list you created in Step 2, identify the first steps you can take to stop or modify these counterproductive actions. Focus on concrete, achievable actions. Even small changes can make a significant difference. Write your proposed first steps in the space below.

Example: Research and implement evidence-based harm reduction strategies.

Step 4: Identify who in the community can do this

In your list of action steps on the previous page, note who in the community can do this action. Once you have completed this share with the person next to you. What was the same? What was different? Discuss your proposed first steps and collaborate on implementing positive changes.

Appendix G: Qualitative Themes

Name	Definition
988	24/7 one click spot to access resources
Access to opioids in prison	Drug supply chain in prison
Assessments	More people conducting assessments
Care Continuum	Options available for the different levels of care needed
Case management	Care and resource navigation
Collaboration	Between organizations to better serve people
Community Cares	The community and providers care and are passionate
Community cohesion	Washoe county as a connected tight knit community
Community connection	Feeling of belongingness as pathway to recovery
Community education	Education on crisis and overdose response for community members
Co-occurring mental health	Challenges accessing resources with co-occurring mental health issues
Culturally relevant services	Limited access to culturally relevant services
Detox	Immediate beds for detox
Dental Care	Dental care for people who use(d) drugs
Distrust of health system	Distrust among people who use drugs of health care system
Domestic Violence	Resources to support people impacted by domestic violence
Drop-in Stabilization Center	Place to take people in need of immediate help with an array of services

Evidence Based	Challenges with “evidence based” requirements
Federal Policies	The impact of Federal policies on the community
Fentanyl Fear	Impact of peoples fear about fentanyl
Funding sources	Challenges with existing funding structures
Generational Family Use	Generational Family use as cause of substance misuse
Harm Reduction	Philosophy, tools and education
Homelessness	The impacts and challenges of homelessness
Housing First	Housing to help get stable
Identification	the challenges getting an id and other documents
Immediate Access	No waitlist, more beds
Insufficient number of providers	Not enough providers
Insurance	Difficulty finding service that takes insurance type
Jail Treatment	Effective treatment in the jail
Jail-community	Connection and support for returning
Lack of Family Support	Disconnected from familial supports
MAT Expansion	Ensure more people can get and stay on MAT
Mental Health support for Youth and Families	Resources to support young people who are having mental health challenges
Multiple Pathways to Recovery	Different options for successful recovery
Non-Judgmental Care	Safe and Accessible care
Outreach	People to reach out to vulnerable populations and connect them to care
Peer Supports	Peers supporting each other as best practice
Post Overdose Response Team Model	Individuals to respond and provide mental health supports after overdose
Program Data	Data on program successes
Recovery Community	People who believe and support them through their recovery.
Recovery Housing	Housing to support long-term recovery
Residential Treatment	Access to in-patient residential treatment
Stigma	Community awareness to reduce Stigma
Support for Providers	More resources to support the mental health and well being of providers
Sustainability	Importance of funding long term sustainable projects
Training	Training for professionals
Transitional living program	Programs for people transitioning from in-patient or incarceration
Transportation	Access to transit
Uninsured	Costs to uninsured

Vocational Training	Providing people in recovery with employment training
Whole Family Supports	Resources to treat and support the entire family unit
Window of change	Window of change
Youth Services	Out of School time Programs for youth

Washoe County Opioid Use Disorder Community Needs

2026-2030