2018-2019 RURAL NEVADA NAMI PROGRAMMING AND NEEDS ASSESSMENT
NAMI Western Nevada Rural Nevada Programming and Needs Assessment

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**Introduction**

NAMI Western Nevada’s mission is to improve the quality of lives of individuals living with mental illness and their families through support, education and advocacy. We encourage the engagement in services with a team of supports, including natural supports, treatment teams and family members.

Initially formed in October 2013 by family members and civic leaders passionate about mental illness issues and the need for services in the Carson City area, NAMI Western Nevada has rapidly expanded throughout the rural and frontier communities. Our volunteer base and leadership, as at our inception, has continued to be composed of family members and peers that are community leaders and educated professionals within the communities we serve. We have worked to develop strong leadership in our Board of Directors that include professionals, family members and peers with a broad array of skills and community engagement. Our current board consists of Sarah Adler, a family member who brings strong skills in non-profit management and federal grant management; Jessica Flood, MSW, Regional Behavioral Health Coordinator; Rick Porzig, a family member and retired Chief Financial Officer; Sandie Draper, a family member with a background in infrastructure for the library and police department; Tyson League, Carson City Deputy District Attorney working with Mental Health Court; Don Williams, retired director of the Research Division of the Legislative Counsel Bureau; and Linda Porzig, a family member and retired school teacher. The diversity of skill of our board members has provided us the ability to build a strong foundation for growth and expansion of services.

Due to the work of our dedicated volunteers, NAMI Western Nevada is viewed as the leading NAMI affiliate in Nevada. In 2015, NAMI Western Nevada was recognized as the Affiliate of the Year from the National Alliance out of the 1,100 affiliates nationwide, include affiliates that are significantly larger in membership and funding. For our outstanding results in program implementation, in 2015 we also were awarded the NAMI Basic Outreach Award.

NAMI Western Nevada has rapidly expanded throughout the rural and frontier communities. We currently support, either in person or through our helpline, 14 counties comprising 10.6% (285,624) (United States Census Bureau, 2018) of Nevada’s population over 67% of the state (110,552 square miles) (United States Census Bureau, Accessed September 2018). Because of the work of over 75 active volunteers, we have rapidly expanded throughout these geographically challenging and culturally diverse communities.

In June 2017, we hired our first staff, Executive Director Laura O’Neill. Through funding from the Community Mental Health Block Grant from the Department of Public and Behavioral Health and other community grants, we have been able to expand our staff to include a Program Support Coordinator, Juntos Edificando Esperanza Outreach Coordinator, and NAMI Western Nevada CARES Warmline Operators.

In December 2018, we launched both the NAMI Western Nevada CARES (Community Assistance for Recovery through Education and Support) Program and the NAMI Western Nevada Warmline. Both programs offer one-on-one peer support with the Warmline focusing on individuals impacted by mental illness and the CARES program focusing on both individuals and families impacted by mental illness. The goals of the program are to be responsive to community need for peer support, assistance navigating the resources and increasing knowledge about mental illness and systems of care.
As our organization has grown, it became important to hear from our volunteers, membership and the communities we serve as to what they viewed the communities’ needs to be. In order to learn more, NAMI Western Nevada conducted a Community Mental Health Needs Assessment focused on NAMI Programs and advocacy issues. Our goal was to not only reach those involved with or that NAMI has touched, but also a broader community base. To inform NAMI programming and advocacy, we wanted to learn:

- What NAMI programs are needed by communities?
- What are the barriers to engagement in NAMI Programs?
- What are the communities’ highest priorities for improvement of services for individuals impacted by mental illness?

To answer these questions, we used three method of information gathering: focus groups, community survey and insight conversations with community members. Information was compiled throughout 2018.
Hi

Highlights and Trends of Nevada Rural Communities

Rural and frontier counties comprise 73,846 square miles representing over 67% of Nevada. The population of these communities in 2017 was 294,183. The population grew approximately 3.4% from 284,245 in 2010. In 2010, Nevada’s population included 26.5% Latino, having increased 6.8 percentage points from 19.7% in 2000. (US Census Bureau, Accessed December 2018)

According to the Physician Workforce in Nevada, 2018, there are 183 psychiatrists in Nevada. These psychiatrists are located primarily in metro areas with no psychiatrist in Northeastern Nevada. (Griswald PhD, Gunawan MPH, & Packham PhD, June 2018). Rural and frontier communities have a total of 8 Psychiatrist with 3 from Douglas County and 5 from Carson City. (Griswold, Packham, Etchegoyhen, Young, & Friend, 2019).

Further workforce shortages can be seen in mental health therapy and treatment professionals. The percentage of the workforce in rural and frontier Nevada for Psychologist, Marriage and Family Therapist, Licensed Clinical Social Workers and Licensed Clinical Professionals is below the percentage of population residing in these areas. (Griswold, Packham, Etchegoyhen, Young, & Friend, 2019)

<table>
<thead>
<tr>
<th>Area</th>
<th>Psychologist</th>
<th>Marriage and Family Therapist</th>
<th>Licensed Clinical Social Workers</th>
<th>Licensed Clinical Professional Counselors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural and Frontier Nevada</td>
<td>26</td>
<td>76</td>
<td>83</td>
<td>22</td>
</tr>
<tr>
<td>Statewide Nevada</td>
<td>405</td>
<td>852</td>
<td>818</td>
<td>230</td>
</tr>
<tr>
<td>Percentage of Workforce in Rural Nevada</td>
<td>6.4%</td>
<td>8.9%</td>
<td>10.1%</td>
<td>9.5%</td>
</tr>
</tbody>
</table>

Figure 1: Nevada Population Distribution by County (Office of Analytics Department of Health and Human Services, 2018)
While all of Nevada is seriously impacted by lack of resources and stigma, rural (Northern) and frontier (Rural) are often the hardest impacted. According to a report Rural Mental Health: Challenges and Opportunities Caring for the Country, persons living in the rurals are not well informed about mental illness and “enter care later, sicker and with a higher level/cost” (Western Interstate Commission for Higher Education Center for Rural Mental Health, Accessed October 1, 2018).

According to the DOCH II Final Report: Measuring Stigma to assess the impact of anti-stigma intervention targeted to adolescents (DOCH II Final Report: Measuring Stigma to access the impact of an anti-stigma intervention targeted to adolescents citing Corrigan, 2004), “Education interventions aim to decrease discrimination by replacing stereotypes with factual knowledge about mental illness. These can reach large audiences and have been shown to be effective at lowering stigmatizing attitudes. Contact with a person with mental illness is the most effective way to challenge stigmatization.” Interactions that best achieve this educational intervention are: “Contact usually includes “on-the-way-down” summaries of the illness, “on-the-way-up” replies representing recovery, statements of the personally hurtful impact of stigma, and calls to action depending on target group”. (Corrigan, 2014)

Nevada currently ranks 6th in the nation for completed suicides with a rate of 21.4% (American Foundation for Suicide Prevention, 2018). Rural communities had 78 completed suicides in 2017 and have averaged 78.6 completed suicides over the last 5 years. While suicide is not a mental illness, it is often a factor. Rural communities are very concerned about the high numbers of suicide. Winnemucca and Elko have both begun Zero Suicide Initiatives to address the issue of suicides and suicide attempts.
The average age of completed suicide varies greatly by region. With the exception of 2016, completed suicides in the Rural Region were primarily in their late teens. The Northern Region average age of completed suicide was 24.6. It should be noted that the average age of completed suicide in most years fall in the average age range of the onset of mental illness (National Alliance on Mental Illness, Accessed 2019).

To improve law enforcement engagement with individuals with mental illness in rural Nevada, several Police Departments and Sheriff Offices offer the Crisis Intervention Team (CIT) Training. CIT, also known as the “Memphis Model” began in 1988 to “improve Office and Consumer Safety and to help persons with mental disorders and/or additions access mental health treatment rather than place them in the criminal justice system due to illness related behaviors.” (CIT International, 2019) CIT is a partnership between law enforcement, mental health professionals, peers, families and other mental health advocates.

The Regional CIT Committee was formed in 2018 to promote shared resources and coordination by the 7 CIT programs in rural Nevada. By having CIT training opportunities offered at various times of year, more rural departments and offices can send staff to this valuable training. Currently, CIT Training is offered by Carson Sheriff’s Office, Douglas Sheriff Office, Lyon Sheriff Office, Churchill Sheriff’s Office, Elko Police Department, Winnemucca Police Department and Northern Nevada Correction Center.

Three counties in rural Nevada have instituted Mobile Outreach and Safety Teams (MOST). The purpose of these teams is to assess individuals who may be in crisis, attempt to connect them to a lower level of care that is appropriate to the situation and connection to community resources. Each community has designed their MOST based on the available resources and what best fits the needs of their communities.

Carson MOST recently added a full-time Behavioral Health Peace Officer as a result of a 3-year grant. The dedicated Peace Officer began January 1, 2019. Carson MOST is composed of the Behavioral Health Peace Officer and a licensed clinician that are on shift 4 days a week. Now that the team is able to respond to solely mental health crisis calls and not "beat calls" their numbers doubled in their first month of the grant from 25-30 to 54 in-person contacts. It should be noted that the team also dedicates a portion of their time to continuing mental health education of law enforcement and other community members. (Bock, 2019)

Douglas MOST is composed of a Sargent from Douglas County Sheriff’s Office, an Emergency Medical Services staff, and a licensed clinician. The MOST is available 1 day per week but recently add a half day for outreach via phone. In 2018, they averaged 18.4 referrals, 24.6, and 16.2 follow-ups per month.
By comparison, in January 2019, they had 36 referrals, 47 contacts and 27 follow-ups. The contacts were made by phone or in person. Unfortunately, there were 482 times that a follow-up was needed that the team was unable to do in 2018. In January 2019, they have already had 53 times that follow-up was needed but due to the limited time available, they were not able to do. (Savage, 2019)
Programs NAMI Western Nevada Offers

NAMI Western currently offers the following program in rural and frontier Nevada:

NAMI Basics is a class for parents and other family caregivers of children and adolescents who have either been diagnosed with a mental health condition or who are experiencing symptoms but have not yet been diagnosed. This course is also available in Spanish, Bases y Fundamentos de NAMI.

NAMI Family-to-Family is a class for families, partners and friends of individuals with mental illness. The course is designed to facilitate a better understanding of mental illness, increase coping skills and empower participants to become advocates for their family members. This program was designated as an evidence-based program by SAMHSA. The course is also available in Spanish, De Familia a Familia de NAMI.

NAMI Homefront is a class for families, partners and friends of military service members and veterans experiencing a mental health challenge. The course is designed specifically to help these families understand those challenges and improve the ability of participants to support their service member or veteran.

NAMI Peer-to-Peer is a mental health recovery education course open to anyone experiencing a mental health challenge. The course is designed to encourage growth, healing and recovery among participants. This program is also available in Spanish, De Persona a Persona de NAMI. Although we do not currently run the Spanish program, we are actively trying to recruit Program Leaders to launch the program.

NAMI Family & Friends is a 90-minute seminar that informs and supports people who have loved ones with a mental health condition. Participants learn about diagnoses, treatment, recovery, communication strategies, crisis preparation and NAMI resources. Seminar leaders have personal experience with mental health conditions in their families. The seminar will have a national limited release throughout the remainder of 2018.
NAMI Ending the Silence is an in-school presentation designed to teach middle and high school students about the signs and symptoms of mental illness, how to recognize the early warning signs and the importance of acknowledging those warning signs.

NAMI IOOV is an interactive presentation that provides insight into what it’s like to live with mental illness. Using their personal stories, NAMI IOOV presenters walk you through their experience with mental illness.

NAMI FaithNet is a resource and network for NAMI members, clergy and people of faith from faith traditions. The goal of FaithNet is to encourage the development of welcome environments that are spiritually nourishing for individuals with mental illness in every place of worship.

NAMI Connection is a weekly or monthly support group for people living with a mental health condition. This program is also available in Spanish, NAMI Conexión. Although we do not currently run the Spanish program, we are actively trying to recruit Program Leaders to launch the program.

NAMI Family Support Group is a weekly or monthly support group for family members, partners and friends of individuals living with a mental illness.

Juntos Edificando Esperanza (Building Hope Together) is an outreach effort to reach the 21% Latino population in Western Nevada. The Latino population is the largest minority group in Nevada; this is according to the US census bureau. NAMI’s efforts are to break down the rooted stigma about mental health illness among this underserved population. NAMI Western Nevada approach of providing services and materials in Spanish extends and sends the message to this community, that NAMI has a clear understanding of their culture and sensitivity to their needs.
One-on-one peer and family support to assist with the complex systems of care for mental health and community resources. The program is delivered by trained peer and family members that have taken the NAMI Western Nevada CARES Program. The program is offered in-person at the Carson office and via phone for other rural and frontier areas.

The NAMI Western Nevada CARES program is the foundation for the NAMI Western Nevada CARES Warmline. The Warmline is a one-on-one peer support program offered by phone, text and video conference. Referrals can be made by self-referred, from families or from professionals. All calls are returned within 24 hours.
Methods

Survey

NAMI Western Nevada conducted a Rural Nevada Community Needs Survey from May 17, 2018 to July 15, 2018. The survey was conducted online and through hardcopy surveys. The survey was promoted through community partners, at in-person meetings, on social media, and via email. The survey was eight questions focused on the research questions for this assessment. The goal of the survey was to reach a broader base of the community than just individuals NAMI has touched or had contact with.

Focus Groups

NAMI Western Nevada hosted four focus groups conducted by Community Wealth Partners on May 17, 2018 as part of NAMI’s Strategic Planning Process. The focus groups were divided by population or geographic specific communities to ensure the voice of the community was not diluted. The focus group specific populations were: Latino Communities, Rural Communities, Frontier Communities and NAMI Western Nevada Board Members. We strove for a diversification of community and resource representation.

Focus group questions included:

- How would you describe NAMI’s impact in 6 words or less?
- What aspects of NAMI’s work are most impactful and why?
- Are there ways that NAMI could have more impact?
- Imagine it is 2030. How would you hope that this society would look different for individuals affected by mental illness? How could NAMI contribute to what you want to see?
- If there was one thing you wanted to never see changed about NAMI, what would it be?

Insight Conversations

Insight Conversations were held with NAMI volunteer groups and community partners throughout 2018. Conversations focused on what each group or individual interviewed felt were their communities most pressing issue and possible strategies to address these issues. Insight Conversations we conducted by the Executive Director and Education Director in person. Key stakeholders included NAMI Latina, rural and frontier volunteers, community leaders, law enforcement and mental health providers.
Findings

Focus Groups

In order to ensure a diversified perspective in focus groups, NAMI Western Nevada reached out to various communities. Below is a table of the communities represented in the four focus groups.

<table>
<thead>
<tr>
<th>Communities represented at the focus groups:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• NAMI Program Participants</td>
</tr>
<tr>
<td>• Frontier Community Members</td>
</tr>
<tr>
<td>• Rural Community Members</td>
</tr>
<tr>
<td>• Transition Age Young Adults</td>
</tr>
<tr>
<td>• Law enforcement</td>
</tr>
<tr>
<td>• Native American Community</td>
</tr>
<tr>
<td>• Faith-based Community</td>
</tr>
<tr>
<td>• Seniors</td>
</tr>
<tr>
<td>• Crisis Intervention Teams</td>
</tr>
<tr>
<td>• Rural Mental Health Professionals</td>
</tr>
<tr>
<td>• Deaf Community</td>
</tr>
<tr>
<td>• NAMI Volunteers and Members</td>
</tr>
<tr>
<td>• Peers and Family Members</td>
</tr>
<tr>
<td>• Family Member of Veterans</td>
</tr>
<tr>
<td>• Dual Diagnosis Peers and Family Members</td>
</tr>
<tr>
<td>• School District Staff</td>
</tr>
<tr>
<td>• Latino Community</td>
</tr>
<tr>
<td>• African American Community</td>
</tr>
<tr>
<td>• Health Care Navigator</td>
</tr>
<tr>
<td>• Criminal Justice</td>
</tr>
<tr>
<td>• Family member of LGBTQ+</td>
</tr>
<tr>
<td>• Certified Community Behavioral Health Center</td>
</tr>
</tbody>
</table>

The six words participants used to describe the impact of NAMI were incredibly powerful and reflective of NAMI’s mission in the community. There was a common thread with responses to this question throughout all four focus groups.

Several common themes were discussed in the four focus groups. These themes include:

- The need to support youth and their families to increase early intervention and reduce stigma.
- The importance of advocacy at the state level to change laws, increase funding and improve services to include more wraparound type service such as Certified Community Behavioral Health Centers (CCBHC).
- The need for anti-stigma campaigns that utilize various methods of reaching the community such as social media, presentations, newspapers and television.
• Outreach and engagement with the Spanish speaking, LGBTQ+, elderly, veterans, youth and families of youth were a priority.
• Utilization of Zoom support groups works and should be continued and expanded.
• The appreciation for the work that NAMI Volunteers and the affiliate have done to reach underserved communities such as Latino and frontier communities.

**Latino Community**

• The value of the training, the website, having the website in Spanish and classes in schools were identified as the greatest impact of NAMI.
• Having classes in high schools, educating teachers, presence of television, newspapers and social media in Spanish, NAMI classes for professionals, more Zoom support groups, anti-stigma activities were areas where NAMI could have more of an impact.
• The ideal for 2030 would include more inclusion, children in schools would not be stigmatized, more resources in Spanish or native language, and integrated mental and physical health in one office.
• NAMI should have more for the Spanish speaking community at various reading levels with a focus on parents of youth and there should not be a delay in NAMI offering programs in Spanish.
• NAMI should target youth and their families, Spanish speaking, elderly and veterans.
• NAMI should never change education component, focus on hope and helping people who need it.

**Rural Community**

• The value of the lived experience, anti-stigma in schools, starting the conversation about mental illness, NAMI Connection and In Our Own Voices were identified as the greatest impact of NAMI.
• The development of more funding and community partnerships for programming, housing, more anti-stigma, support for employment for persons with mental illness, and population specific support groups such as dual diagnosis were areas where NAMI could have more of an impact.
• The ideal for 2030 would include team of people supporting an individual with mental illness, expansion of Certified Community Behavioral Health Centers (CCBHC), earlier interventions and integration of physical and mental health and there would be no stigma.
• NAMI should target youth and their families, LGBTQ+, co-occurring disorders by offering programs such as SMART or Dual Diagnosis Anonymous, schools including students, teachers and administrators and the rurals.
• NAMI should never change the human piece of experience, emotion, love and respect, partnerships and collaboration, and the shared lived experience.
**Frontier Community**

- The website, value of NAMI education programs, having a safe place to discuss mental illness, getting support, advocacy and the power of In Our Own Voice were identified as NAMI’s greatest impacts.
- The NAMI Western Nevada online support groups allows participants the flexibility to attend the group anywhere and works for rural communities.
- Further development in the Northeastern Region to include hiring a staff, establishment of an office for resources and support and possible development of an affiliate
- Increased acceptance from employers including implementation of the NAMI Nevada Stop from the Top program
- The ideal for 2030 would be a place with no suicides and that stigma did not exist
- NAMI should target youth and their families, first responders, indigenous groups and tribes, and Spanish speaking communities
- NAMI should never change having a support group model that is updated as needed, the feeling of acceptance, willingness to collaborate and the supportive environment.

**Board of Directors**

- Empowering peers, educating communities, support for people who feel alone in the rural and advocacy were identified as the greatest impact of NAMI.
- Advocacy was a reoccurring theme of the groups including the importance of NAMI’s established credibility, that advocacy is in-person and gives a face to mental illness, changing perceptions about people impacted by mental illness and the empowerment of the NAMI Nevada Advocacy Academies.
- Increasing membership, having a comprehensive social media campaign and having tangible recognition of appreciation for volunteers were areas where NAMI could have more of an impact.
- The ideal for 2030 would include not criminalizing mental illness and the diversion from being judicially involved, adequate services in programs for individuals with mental illness, parity for the urban and rural areas, being able to talk about mental illness without stigma, more community-based programs such as Certified Community Behavioral Health Centers and having enough housing.
- NAMI should target youth and their families, Native American, the most severely affected individuals with mental illness, children of people living with mental illness, and youth impacted by suicidality and suicide.
- NAMI should never change families and peers working together, education programs, focus on building peer community, maintaining NAMI’s excellent reputation for credible and effective advocacy.
Survey

The survey had 257 responses in 16 of the 17 counties in Nevada. Based on the number of respondents, the survey had a +/- 7 margin of error (The Community Needs Assessment Workbook, 2016). Elko County and Carson City, two of the three counties with high responses, are areas NAMI has a strong presence in. NAMI did not have a strong presence at the time of the survey in Lyon County and the high response rate is due to strong social media advertisement from volunteers.

Respondents to the survey represented 16 of the 17 Nevada Counties. Elko, Carson, and Lyon were the three highest responding communities. Because of the support of community partners and volunteers we were able to reach a broad base of community members in these communities. Many of these community stakeholders such as Health and Human Services and Law Enforcement are not typically surveyed for mental health community need assessments.

Respondents identification included under “Other” RN/Nurses, Housing Provider, Certified Community Behavioral Health Center Staff, Non-profit Worker, Advocate, Prevention Coalition, Broadcast and Media, Professional, Transportation Staff, Coordinator, Public Housing Authority, Pastor, Non-profit Social Services, Lyon County Commissioner, School Administrator, Nurse and Counselor, Substance Abuse Counselor and Community Health Worker.
As part of the survey we asked what NAMI programs that person knew were available in their area and programs they felt were needed. Of note is the highest percentage of those polled for NAMI programs available in their area was “I do not know what NAMI programs are available in my area”. Results for the most needed programs were NAMI Family-to-Family, NAMI Basics, NAMI Peer-to-Peer and Ending the Silence.

<table>
<thead>
<tr>
<th>Top 5 needs regarding NAMI Services</th>
<th>Top 5 barriers regarding NAMI Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 One-on-one peer support</td>
<td>1 Awareness of programs</td>
</tr>
<tr>
<td>2 Education classes</td>
<td>2 Stigma of mental illness</td>
</tr>
<tr>
<td>3 Support Groups</td>
<td>3 Available transportation</td>
</tr>
<tr>
<td>4 Broad-based Anti-stigma campaign</td>
<td>4 Distance to classes and groups</td>
</tr>
<tr>
<td>5 Advocacy to change laws</td>
<td>5 Time to participate</td>
</tr>
</tbody>
</table>

It should be noted that while respondents identified two aspirations of NAMI Western Nevada core mission as community needs, awareness and stigma are the highest identified barrier to meeting the need.

Advocacy is one of NAMI's three core functions, and appropriately so. As NAMI's most active members are frequently families of individuals living with mental illness and peers themselves, they are in the best position of any to accurately shape the public policies and budgets that affect their lives. In viewing the two charts below, one can see that it is not easy to directly translate need into policy. How, for example, can
rural and frontier communities actually have increased access to psychiatrists? One way would be for the State of Nevada to hire and place one, but how long will that person stay in state service in a rural community? Loan-forgiveness for a rural placement? Tele-psychiatry?

Fortunately, the 2017 session of the Nevada Legislature created four regional behavioral health boards (Washoe, Clark, Northern and Rural) and they each did an outstanding job of examining needs, services, and systems within their region. Each was also given an opportunity to draft a bill to be presented to the 2019 legislature. NAMI has a statewide Advocacy Committee that is actively examining over 40 bills and 10 budgets potentially related to behavioral health, two lobbyists (the NSO Executive Director and a volunteer), and many members who are actively participating in the legislative process. NAMI is also working with a group of allied organizations as part of the legislative process and is a co-sponsor of Mental Health Awareness Day at the Legislature. Taken all together, Nevada is making strides in its awareness of mental illness and its integration with other addictions and disorders, yet it has far to go. Overall, Mental Health America reports Nevada as 51st in the nation in its effectiveness in supporting the mentally ill.

**Highlights by Northern and Rural Community Coalitions**

**Churchill Community Coalition**
Because the survey was distributed at a Crisis Intervention Team Training, law enforcement was by far the largest self-identified group responding to the survey. Respondents reported that a phone number for support and resources, education classes, and one-on-one support were the most needed NAMI supports needed in their communities. They also identified awareness of classes, availability of transportation and stigma as the top 3 barriers to engaging in NAMI programs. The top three advocacy issues were identified as access to mental health services, funding for mental health services and MOST (Mobile Outreach and Safety Team).

**Top 5 Most Important Mental Health Services Needed**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Mental Health services for youth</td>
</tr>
<tr>
<td>2</td>
<td>Access to a psychiatrist</td>
</tr>
<tr>
<td>3</td>
<td>Access to mental health services</td>
</tr>
<tr>
<td>4</td>
<td>Access to a therapist</td>
</tr>
<tr>
<td>5</td>
<td>Transition Housing</td>
</tr>
</tbody>
</table>

**Frontier Community Coalition**
Humboldt, Lander and Pershing Counties had a total of 13 responses to the survey. Respondents reported that one-on-one support, education classes, anti-stigma/broad based community education, and support groups were the most needed NAMI supports in their communities. They also identified awareness of classes, stigma and distance to classes as the top 3 barriers to engaging in NAMI programs. The top three advocacy issues we identified as
access to mental health services, Crisis Intervention Team (CIT) Training and housing/affordable housing. The most needed services in their communities was identified as access to mental health hospital, access to a psychiatrist and mental health services for youth.

**Health Communities Coalition of Lyon, Storey and Mineral Counties**

Because the survey was heavily promoted on social media, Health Communities Coalition was the most diversified group of respondents and reached the most people who had little to no contact with NAMI. The top three self-identified respondents were family members of a loved one living with mental illness, concerned community members and individuals living with mental illness. Respondents reported that a one-on-one support, education classes and support groups were the most needed NAMI supports in their communities. They also identified awareness of classes, distance to class and available transportation as the top 3 barriers to engaging in NAMI programs. Over 69% of respondents did not know what NAMI programs were available in their area. The top advocacy issues we identified as access to mental health services, funding for mental health, housing/affordable housing, and medication access. Mental health services for youth, access to a psychiatrist, and access to a therapist were the highest rated needs of the communities.

**Nye Community Coalition**

<table>
<thead>
<tr>
<th>Top 5 Most Needed NAMI Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> Basics Education Class</td>
</tr>
<tr>
<td><strong>2</strong> Family-to-Family Education Class</td>
</tr>
<tr>
<td><strong>3</strong> Ending the Silence</td>
</tr>
<tr>
<td><strong>4</strong> Family Support Group</td>
</tr>
<tr>
<td><strong>5</strong> Bases y Fundementos</td>
</tr>
</tbody>
</table>

Nye County had a total of 10 responses to the survey. Respondents reported that one-on-one support, education classes, advocacy to change laws and support groups were the most needed NAMI supports in their communities. They also identified awareness of classes, distance to classes, available transportation and lack of family support as the top barriers to engaging in NAMI programs. The top three advocacy issues were access to mental health services, funding for mental health and housing/affordable housing. The most needed services in their communities was identified as access to a psychiatrist, mental health services for youth and access to a therapist.
PACE Coalition

PACE Coalition was the highest responding coalition for the survey. The top three self-identified respondents were individuals living with mental illness, family members of individuals living with mental illness, and concerned community members. Respondents reported that one-on-one support, education classes and advocacy to change laws were the most needed NAMI supports in their communities. They also identified stigma of mental illness, time to participate, and lack of family support as the top 3 barriers to engaging in NAMI programs. Over 38% of respondents did not know what NAMI programs were available in their area; however, In Our Own Voice, Family-to-Family, and NAMI Nevada Advocacy Academy we identified as the most needed NAMI Programs. The top advocacy issues we identified as access to mental health services, funding for mental health, and Crisis Intervention Team (CIT) Training.

Partnership Carson City

<table>
<thead>
<tr>
<th>Top 5 Most Needed NAMI Services</th>
<th>1</th>
<th>One-on-one peer support</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2</td>
<td>Support groups</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Anti-stigma/broad-based community education.</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Education classes</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Advocacy to change laws</td>
</tr>
</tbody>
</table>

Partnership Carson City’s highest responses on the survey came from concerned community members, health and human services workers and family members of individuals impacted by mental illness. They identified awareness of classes, stigma of mental illness and available transportation as the top 3 barriers to engaging in NAMI programs. While over 36% of respondents did not know what NAMI programs were available in their area, respondents in this area had the highest awareness of Family-to-Family and Basics Education programs. They identified Ending the Silence, Basics Education Class, NAMI Connections, and Base y Fundamentos as the most needed NAMI Programs. The top advocacy issues we identified as access to access to mental health services, funding for mental health, and housing/affordable housing. The most important services need in the Carson area were identified as supported housing, mental health services for youth, and transition housing.

Partnership of Community Resources (Douglas County)

Partnership of Community Resources had a total of 25 responses to the survey. Respondents reported that education classes, support groups and advocacy to change laws were the most needed NAMI supports in their communities. The lowest percentage of respondents knew what NAMI programs were available in their area. They identified NAMI Connections, NAMI Peer-to-Peer, Base y Fundamentos, NAMI Family-to-Family and Family Support Group as the most needed NAMI Programs. The top barriers regarding NAMI Services

<table>
<thead>
<tr>
<th>Top 5 barriers regarding NAMI Services</th>
<th>1</th>
<th>Stigma of mental illness</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2</td>
<td>Available transportation</td>
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<tr>
<td></td>
<td>3</td>
<td>Time to participate</td>
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<tr>
<td></td>
<td>4</td>
<td>Lack of family support</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Awareness of classes</td>
</tr>
</tbody>
</table>
three advocacy issues were funding for mental health, access to mental health services and housing/affordable housing. The most needed services in their communities was supported housing, transition housing, peer support, access to a psychiatrist and case management.

**Insight Conversations**

Highlights of the insight conversations include:

- The need for a community wide anti-stigma campaign for the Latino/Hispanic community to break down the wall of silence about mental illness and allow families to get help.
- The need for Spanish Language support groups for families and families of youth.
- A concern for the suicide rate in Northeastern Nevada and the impact of popular streaming shows such as *13 Reasons Why* that glamorize suicide.
- The need to have peer support from peers living in communities other than the person to ensure confidentiality for small communities.
- The need for one-on-one peer support.
- Having peer support for individual that are on waitlist; encourage use of peer support groups as a bridge until the person can get mental health treatment.
- An emphasis on youth and families of youth to provide early intervention and engagement in treatment.
- The need to develop family community as NAMI has done with building peer community in the rurals and frontier areas of Nevada.
- The need to develop peer and family support in a centralized area of Lyon County.
Conclusions and Recommendations

Research Questions

1. What NAMI programs are needed by communities?

Affiliate wide, NAMI Family to Family, NAMI Basics, NAMI Peer to Peer and NAMI Ending the Silence were the highest identified needed NAMI Programs. In each coalition area, respondents identified NAMI Program priorities unique to their areas. These areas can be broken out into “hub areas” for target education programs, outreach and partnerships to meet the needs of those communities with the programs that are most important to them.

Throughout the Community Needs Assessment, a universal theme was early intervention, supports and education for youth and their families. Programs such as NAMI Ending the Silence and NAMI Basics address these issues and should be a focal point of programming in most areas.

Programs need to be available in English and Spanish. Continued advocacy with NAMI to have parity of language specific programs will be an important part of achieving this.

2. What are the barriers to engagement in NAMI Programs?

While there was an identified need for NAMI Services and Supports, awareness and stigma remain the top two barriers affiliate wide. This is further demonstrated in the number of respondents that indicated they did not know what NAMI Programs were available in their communities. As we work to address the barriers of awareness and stigma, we need to strengthen community partnership engagement for support in referring and running programs in their communities.

Additional barriers were identified as:

- Lack of time or inability to commit the amount of time programs require such as 2.5 hours for 12 weeks for NAMI Family to Family
- Difficulties with transportation or cost of travel to programs
- Fear of being identified by the community as someone or a family with mental illness
- Awareness of community partners on how to refer to NAMI Programs
- Cost of child care for families with young children, specifically for NAMI Basics program.
- Timing of programs around local employer work schedules

Overcome barriers with:

- Increase zoom support groups and classes
- Increase presences on social media
- More speaking/education programs in school and community including NAMI Ending the Silence, NAMI Family and Friends, NAMI FaithNet, and In Our Own Voice
- Utilize a “hub” system to recruit, engage and mobilize volunteers as well as de-centralize programming
3. What are the communities’ highest priorities for improvement of services for individuals impacted by mental illness?

The needs identified under this section are not services that NAMI directly provides. The information on priorities can be used to educate policy makers about what mental health services and supports communities identified as most needed. While there is an overall trend, each community had slightly different priorities based upon services and supports available in their communities. It should be noted that many of the identified needs are in line with those identified by the Northern and Rural Regional Behavioral Health Policy Boards. A full copy of the NAMI Western Nevada 2018-2019 Rural Nevada NAMI Programming and Needs Assessment will be shared with the NAMI Nevada Public Policy Committee.

Other Observations

- Peer workforce development and re-entering working environments focusing on long-term development projects by partnering with our community
- While many communities identified NAMI services and supports their community needed, we continue to struggle to find volunteers to offer these programs.
References


