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Addiction and Substance Abuse in Nevada*

Introduction

Substance abuse is known to cause a host of problems for individual users, their communities, and society as a whole. Its cost is staggering, as measured by lost productivity, medical illness, serious injuries, and premature death, as well as by resources required to run criminal justice system and special education programs (Meara & Frank, 2005). The substance abuse problem is global in scope. Consider these figures released by the United Nations' 2005 World Drug Report **[WDR] (United Nations, Office on Drug and Crime, 2005),**

- In 2003-2004, about 200 million people, or 5% of the world's population age 15-64, had used illicit drugs at least once in the last 12 months – 15 million more than in 2002-2003.
- Many more currently use legal psychoactive substances like tobacco (about 30% of the world's adult population) and alcohol (about 50%).
- The number of cannabis (marijuana) users worldwide is now close to 160 million people or 4% of the population age 15-64.
- An estimated 26 million people now use amphetamines and 8 million use ecstasy – a slightly lower figure than the one given in the previous year's WDR.
- The number of opiate users is estimated to have risen slightly and now stands at about 16 million people worldwide (11 million of which abuse heroin).
- The number of cocaine users has grown slightly and is now estimated to be close to 14 million people (Executive Summary, U.N. 2005 World Drug Report).

The United States faces serious substance abuse issues of its own. The 2004 National Survey on Drug Use and Health [NSDUH], (Substance Abuse and Mental Health Services Administration [SAMHSA], 2005a), reports the following data:

- 110 million Americans aged 12 or over (45.8% of the U.S. population in this age group) used an illicit drug at least once

in their life time. 34.8 million Americans aged 12 or over (14.5% of the U.S. population in this age group) used an illicit drug at least once in the previous year.

- 156.7 million Americans aged 12 years or over (65.1% of the population in this age group) used alcohol in the last 12 months; 120.9 millions (50.3%) used alcohol in the last month; 54.7 million (22.8%) engaged in binge drinking (defined as “five or more drinks on at least one occasion in the 30 days prior to the survey” [p.4]); and 16.7 million (6.9%), heavy drinking (defined as “binge drinking on 5 or more days in the past month” [p. 4]).
- 83.1 million Americans aged 12 years or over (34.5% of the population in this age group) used tobacco in the past year; 70.3 millions (29.2%) used tobacco in the last month.
- 25.5 million Americans aged 12 or over (10.6% of the population in this age group) used marijuana in the last year; 14.6 million (6.1%) used marijuana in the last month.
- 5.7 million Americans aged 12 or over (2.4% of the population in this age group) used cocaine in the last 12 months; 1.3 millions (0.5%) used crack; and 0.4 millions (0.2%) used heroin.

The Silver State has its share of substance abuse problems, as reported by the 2002-2003 NSDUH data (Wright & Sathe, 2005):

- In 2002-2003, 10.3% of Nevadans 12 or older reported using an illicit drug in the last month. Among the respondents in the 12-17 age-group, 12.5% used; in the 18-25 age-group, 22.0% used; and 8.2% of the 26 or older respondents used.
- 50.7% of Nevadans who are 12 or older reported using alcohol in past month. In the 12-17 age-group, 18.4% used; in the 18-25 age-group, 56.4% used; and in the 26 or older group, 54.1% used.
- 35.0% of Nevadans who are 12 or older reported using any tobacco product in past month. In the 12-17 group, 15.3% used; in the 18-25 group, 42.4% used; and in the 26 or older group, 36.5% used.

- 7.6% of 12 or older Nevadans reported using marijuana in the last month. In the 12-17 age-group, 9.6% used; in the 18-25 group, 18.3% used; and 5.7% of those 26 or older used.
- 2.4% of 12 or older Nevadans reported using cocaine in past year. In the 12-17 age-group, 2.0% used cocaine; 7.4% of the 18-25 group and 1.7% of those 26 or older used cocaine in past year (See Appendix 2 for further details).

Scholars proposed different theories explaining why people abuse, or become addicted to, substances. The moral approach is based on the notion that substance abuse is a personal choice and that an addict is simply an irresponsible person. Biological theory, on the other hand, assumes that addiction is hereditary, that people become addicts because they are so predisposed, and that that substance abuse is, consequently, a disease. Psychological theory links addiction to a certain personality type and treats substance abuse as a form of self-medication that helps the individual control depression and anxiety. Sociological theory blames society for drug abuse, citing in particular limited opportunities available to certain social groups and focusing on subcultures that condone drug use. Finally, the multivariate theory, also known as bio-psycho-social theory, is based on the premise that addiction stems from multiple factors, that these factors may include biological predisposition, psychological stress, family and community environment, as well as social deprivation (Fishbein & Pease, 1996; Fisher & Harrison, 2005).

The present report will review the substance abuse patterns in Nevada, place the state's record in the national context, provide a cross-county comparison (where data is available), discuss the substance abuse treatment in the state, and highlight the community resources available to Nevadans confronting addiction and drug dependency problems.

Historical Overview

Federal efforts to control illicit drugs in the U.S. go back to the early 20th century when the government sought to limit the import of opium and cocoa in response to the growing abuse of these substances. In 1914, U.S. Congress adopted the Harrison Narcotic

Act that sought to cut down illegal manufacture, sales, and prescriptions of narcotics. The Harrison Act was replaced by the 1970 Controlled Substance Act (CSA) designed to control access to drugs used for recreational purposes as well substances taken by athletes to improve their performance. The CSA is the legal foundation for regulating drug and other substance manufacture and distribution in the U.S. (U.S. Drug Enforcement Administration [DEA], 2005). While the Food and Drug Administration (FDA) defines which drugs require prescription, the Drug Enforcement Administration (DEA) designates controlled substances – the drugs that cannot be manufactured and sold without a license and dispensed without prescription. The DEA also registers organizations and individuals authorized to write prescriptions.

The 1970 CSA classified drugs into five categories based on criteria such as their potential for abuse, whether the drug has accepted medical use, etc. A Schedule I drug (e.g., heroin) is classified as having high potential for abuse and no currently accepted medical use in treatment. Schedule II drugs (e.g., morphine) include substances with high potential for abuse but also having an accepted medical treatment value. Schedule III drugs (e.g., anabolic steroids) are determined to have less potential for abuse than Schedule I or II drugs and are currently accepted as a medically useful substance. Schedule IV drugs are medicinal substances with acceptable therapeutic use. They have less potential for abuse and dependence than Schedule III drugs. The Schedule V drugs are medicinal drugs with accepted therapeutic use and the lowest potential for abuse or dependence (U.S. DEA, 2005).

Nevada has taken measured steps to comply with the federal laws and offer rehabilitation to people with addictions. Chapter 458 of the Nevada Revised Statutes and Chapter 458 of the Nevada Administrative Code cover “Abuse of Alcohol and Drugs” and provide formal definitions of relevant terms. The Nevada Revised Statutes charge the Health Division with the responsibility of formulating and operating a comprehensive state plan for drug abuse programs, planning and certifying addiction treatment facilities and programs, and allocating and using funds for drug abuse treatment purposes.

Chapter 458 of the Nevada Administrative Code offers further guidelines and regulations for alcohol and drug abuse programs. This code spells out the information that must be included in a treatment program's policy and drug court program's manuals and the services that must be offered to clients, including procedures for determining substance-related and mental health disorders. The code also specifies the qualifications required for a professional conducting addiction assessment as well as proper way of recording the assessment results.

While Nevada has made strides in confronting drug abuse problems among its citizens, the state's records remain uneven. According to the 2002-2003 NSDUH (Wright & Sathe, 2005), which divides all states into five-tiers with the 5th tier containing 10 states (or D.C.) with the worst indicators and the 1st tier listing 10 states (or D.C.) with the best records,

- Nevada placed in the 4th or second-worst tier in the nation for its "alcohol dependence or abuse in past year," middle or 3rd tier for "any illicit drug dependence or abuse in past year," and the worst or 5th tier for its "tobacco products and cigarettes use in past month" in the years 2002-2003.

According to SAMHSA's (1992-2004) TEDS, distributions of primary drug at treatment admission have changed in Nevada since 1992:

- The situation is most worrisome with Methamphetamine/Amphetamines (MA/A) – the leading illicit drug at treatment admission in Nevada since 1994. MA/A use in Nevada has increased from about 5% of all admissions in 1992 to 17.8% in 1994, and to 29% in 2004. (See Table 2 for detailed information).
- Marijuana has increased double, from 6.2% of all admissions in 1992 to 12.4% in 2004.
- The "alcohol only" category has decreased from 35.5% in 1992 to 26.8% in 2002 and 26.7% in 2004 of all admissions. This is consistent with the national trend which shows a comparable drop from 37.2% in 1992 to 23.6% in 2002.
- Smoked cocaine admissions have decreased from 11.9% in 1992 to 7.9% in 2002 and 7.6% in 2004. Again, this is in

keeping with the national trend which registered a decrease from 11.9% in 1992 to 9.4% in 2002.

According to U.S. Sentencing Commission (2003),

- In fiscal year 2003, the overall drug-related cases accounted for 15.2% of all federally-sentenced cases in Nevada, exceeded by immigration (26.6%) and firearms (20.1%).
- Nationally, drug-related cases make up the largest portion of all federally-sentenced cases (37.4%), followed by immigration (21.9%) and fraud (10.8%).

Treatment outreach and availability are two areas where the nation as a whole and the state of Nevada are lagging behind the documented needs. According to the 2002, 2002-2003, and 2004 NSDUH data (SAMHSA, 2005b; Wright, 2004; Wright & Sathe, 2005),

- In 2004, 23.5 million people nationwide needed AOD treatment, but only 2.3 million people received treatment at an AOD specialty facility. (Note: The 2004 NSDUH defined a person “needing treatment” as the individual who met the Diagnostic Statistical Manual IV (DSM-IV) criteria for alcohol or illicit drug dependence or abuse in the past 12 months, or as the individual who received alcohol and/or other drug specialty treatment in the past 12 months (American Psychiatric Association, 1994).
- When it comes to the treatment gap, Nevada ranked in the worst tier for illicit drug use in 2002; 3.0% of Nevadans needed but did not receive treatment for illicit drug use in the past year. Nevada moved to the middle tier in 2002-2003, with a rate of 2.7% (95% prediction interval: 2.3%-3.85%, 2.19-3.31%, respectively). The trend was the opposite in the alcohol abuse category where the treatment gap appears to have increased. Nevada scored in the 3rd tier in 2002, indicating 7.6% of Nevadans needed but did not receive treatment for alcohol use in the past year. Nevada appeared to regress to the 4th tier in 2002-2003, showing 7.8% of Nevadans needed but did not receive treatment for alcohol use

(95% prediction interval: 5.98%-9.63%, 6.49%-9.4%, respectively).

- According to 2004 data, 94.2% of Americans who needed, but did not receive, AOD treatment “did not feel they needed treatment.” On the other hand, 42.5% of Americans who needed, “felt they needed,” and made an effort to get, but did not get, treatment cited “cost/insurance barriers” as a primary reason why they could not obtain treatment.

Drug addiction requires prompt attention, especially when underage individuals are involved. To devise effective strategies of countering illicit drug use, we need to take a closer look at the research findings and statistics in key drug abuse categories.

Current Trends in Substance Dependence and Abuse in Nevada

Please note that “alcohol dependence or abuse” and “any illicit drug dependence or abuse” are defined by NSDUH as meeting the criteria of DSM-IV (American Psychiatric Association, 1994)

Alcohol Dependence or Abuse

According to the 2002-2003 NSDUH data (Wright & Sathe, 2005),

- 7.6% of Americans 12 or older met the criteria for alcohol dependence or abuse in past year. Among the 12-17 age group, 5.9 met the criteria; among the 18-25 age group, 17.4% met the criteria; and among the 26 or older group, 6.1% met the criteria.
- Nevada’s rate for “alcohol dependence or abuse in past year” was 8.01%, slightly higher than the national rate of 7.6%. Among the 12-17 age group, 6.9% met such criteria; among the 18-25 age group, 16.2% met such criteria; and among the 26 or older group, 6.9% met such criteria.
- Nevada found itself in the 4th tier in the “alcohol dependence or abuse in past year” category i.e., the Silver State was among the 10 states with the second highest dependency rate in the nation.

- Among the 10 states with the worst records (those placed in the 5th tier) were North Dakota (10.8%), South Dakota (10.8%), Montana (10.7%), and Nebraska (10.2%).
- States with the best indicators included Alabama (6.1%), Kentucky (6.2%), New Jersey (6.3%), and Mississippi (6.5%).

Illicit Drug Dependence or Abuse

Nevada fared better in the category of “any illicit drug dependence or abuse.” According to the 2002-2003 NSDUH data (Wright & Sathe, 2005),

- 9.2% of Americans 12 or older met the criteria for any illicit drug dependence or abuse in past year. Among the 12-17 agegroup, 8.9% met the criteria; among the 18-25 age group, 21.4% met the criteria; and among the 26 or older group, 7.2% met the criteria.
- 3.0% of Nevadan who are 12 or older met the criteria for any illicit drug dependence or abuse in past year. Among the 12-17 age group, 5.98% met such criteria; among the 18-25 age group, 8.0% met such criteria; and among the 26 or older group, 1.8% met such criteria.
- Nevada placed in the 3rd tier nationwide when all illicit drug use in a previous year was counted, with its rate of 2.98% slightly exceeding the national rate of 2.95%.
- States and districts in the 5th tier included D.C. (4.0%), Rhode Island (3.9%), and New Mexico (3.8%).
- Among the 4th tier states in this category were Montana (3.2%) and Oregon (3.1%), while the best performers included Kansas (2.5%), Iowa (2.5%), Pennsylvania (2.6%), and Wyoming (2.6%).

Tobacco Products and Cigarettes

Nevada ranked among the 10 states with the highest rate of tobacco product or cigarette use in the nation.

- According to 2002-2003 NSDUH data, the average national rate of tobacco product use in a previous month was about

30.1% and the average rate of cigarette use was about 25.7%.

- Nevada was among 10 States in the worst tier of tobacco use, with a rate of 35.0% and cigarette use, with a rate of 30.5%. Yet, it was the only state from the West with such a poor ranking (most states in the 5th tier were from the South).
- Although the Silver State placed in the worst tier (5th tier), only Nevadans in the age group 26 or over fell into the 5th tier compared to the corresponding age group nationwide. Nevada adolescents were ranked in the 2nd tier and young adults aged 18-25 were ranked in the 1st tier compared to their peers nationwide. Therefore, the high national ranking of tobacco products and cigarettes use appears to apply more to Nevadans aged 26 or older than to Nevadans who were 25 or younger.
- Some States (e.g., Arkansas and Kentucky) in the worst tier of using tobacco products or cigarettes had all three age groups (12-17, 18-25, and 26 or older) ranked among the worst tiers compared to the corresponding age groups nationwide.

Cross-County Comparisons

The Nevada BADA compiled cross-county data for 2001 that shows patterns of drug dependency and abuse for key geographical regions in Nevada – Clark County, Washoe County, and Rural Nevada, plus Carson City (Canfield, Towle, & Gibbs, 2003).

- All four Nevada regions had methamphetamine/amphetamine (MA/A) as their second leading drug at admission, with alcohol ranking first. MA/A accounted for 22.4% of all admissions in Clark County, 29.1% in Washoe County, 27.4% in the Rural Nevada, and 17.9% in Carson City. The Clark County MA/A admission rate was lower than the Washoe County and Rural Nevada.
- Clark County's cocaine use rate as measured by admissions was higher than in the other two geographical areas. Cocaine figured in 18.0% of all the admissions in Clark County, 9.3% in Washoe County, and 2.31% in the Rural Nevada (see Table 3 for details).

One possible explanation for this disparity is that, in Clark County, a higher percentage of admission involved African Americans, and as the research in this area suggests, African Americans use cocaine more frequently than MA/A. African American accounted for 20.1% of all admissions in Clark County and 5.3% in Washoe County.

Addiction in Different Demographic Groups

Gender

According to SAMHSA's (2002-2004) TEDS, although more men have substance abuse treatment admissions, both nationally and in Nevada, the Nevada women tended to have a higher rate for amphetamines abuse than women nationwide.

- The Nevada women have a slightly higher rate of amphetamine abuse at admission than the Nevadan men, while the national data show more men than women are involved with the drug.
- Women accounted for 35% of all the treatment admissions in Nevada in 2004. Yet, they made up 50.9% of all the amphetamines admissions .
- The 2002 rates for women were 35.6% for all admissions and 51.3% for amphetamines admissions. Nationally, the 2002 rates for women were 30.1% and 44.6%, respectively.

Pregnant women and teenage girls in Nevada are particularly susceptible to MA/A abuse. According to BADA's 2004 Annual Report (Towle, Bailey, & Gibbs, 2004),

- MA is the leading drug among the pregnant Nevada women served by BADA's funded providers at admission, accounting for 62% of the total drug dependency in this group.
- A distant second most abused substance among pregnant women in Nevada is marijuana and Hashish (14%), followed by cocaine/crack (10%), alcohol (9%), heroin/morphine (4%), and other (2%).
- Among the adjudicated youth aged 12-18 who were assessed as having substance abuse problems and referred to WestCare's AOD treatment program, 52% of the females

reported methamphetamine to be their drug of choice, compared to 14% of the males (Steinberg, 2005).

Nevada women accounted for a higher percentage of total treatment admissions than women nationwide. According to SAMHSA's (2002-2004) TEDS,

- In 2002, men accounted for 69.8% and women for 30.1% of all AOD treatment admissions nationwide. The figures were 64.4% and 35.6% respectively for Nevada.
- In 2003, the Nevada figures in the same categories were 62.7% and 37.3%, and in 2004, 65% and 35% respectively. (The national figures for 2003 and 2004 are not available at this time).

According to the BADA Annual Report (Towle, et al., 2004).

- In 2003, Nevadan men represented 64% of the total population served by BADA-funded providers and women represented 36%.
- Pregnant women in Nevada accounted for 8.2% of all the women served by BADA-funded providers in 2003.

In several drug abuse categories, Nevada women fared worse than U.S. women as a whole. According to SAMHSA's (2002-2004) TEDS,

- In 2002, American women exceeded men in only one category of primary substance abuse at admission – the category of “sedatives” (51.2% of women versus 48.8 % of men).
- Nevada women fared worse than Nevada men in six categories: sedatives – 77.8% vs. 22.2% ($n=9$ [9 persons total]), tranquilizers – 88.2% vs. 11.8% ($n=17$), other stimulants – 83.3% vs. 16.7% ($n=6$), amphetamines – 51.3% vs. 48.7% ($n=2,831$), PCP – 75% vs. 25% ($n=32$), and other opiates – 67.3% vs. 32.7% ($n=107$).

Even after excluding two categories that had a small total admission number (i.e., “other stimulants” and “sedatives”), Nevada women still outweighed Nevadan men in four categories.

- Such a gender-skewed distribution has been observed since 2002 among three of the four above-mentioned drug categories: tranquilizers, amphetamines, and PCP.
- In 2003, Nevada women made up 55% of all tranquilizer users ($n=20$), 52.6% of amphetamines users ($n=3,253$), and 51% of PCP users ($n=51$).
- In 2004, Nevadan women made up 57.1% of all tranquilizer users ($n=21$), 50.9% of amphetamines ($n=3,290$), and 65.5% of PCP users ($n=29$).
- Nevada women outweighed Nevada men for "other opiates" in 2003 (53.6% of a total 233 persons), but were outweighed by Nevada men in 2004 (44.7% vs. 55.3% of a total 295 persons).
- Nevada men showed higher rates of drug abuse in other drug categories, where the gender ratio was, on average, close to 2/3 for men.
- The 2004 data showed the following gender ratios: alcohol only (75.2% vs. 24.8%), alcohol with secondary drug (73.6% vs. 26.4%), smoked cocaine (71.2% vs. 35.5%), cocaine consumed in other ways (71.2% vs. 28.8%), marijuana (71.9% vs. 28.1%), heroin (68.2% vs. 31.8%), and hallucinogens (66.7% vs. 33.3%).

Children and Youth

Nevada youth have higher rates of drug abuse and addiction than youth nationwide, as measured by percentages accounted for among all of the State's AOD admissions. The SAMHSA (2002 – 2004) TEDS findings show:

- In 2002, adolescents (12-17 years old) made up 8.3% of all the AOD treatment admissions in the nation and 12.3% in Nevada . The 2003 figure for Nevada was 11.6% and 2004 figure was 11.3% (The national figures for 2003 and 2004 are not available at this time).

Marijuana, MA/A, and alcohol are three major substance abuse categories among the Nevada youths. According to the Nevada BADA Annual Report (Towle, et al., 2004),

- The top drug of choice among all adolescents at admissions to BADA-funded providers was marijuana/hashish (48%), followed by MA/A (26%), alcohol (22%), cocaine/crack (2%) and other (2%). For Nevada adults, the top drug of choice at admission was alcohol (43%), followed by MA/A (30%), cocaine/crack (11%), marijuana/hashish (8%), heroin/morphine (6%), and other (2%).

Nevada youth had a higher prevalence and incidence (new users) of marijuana use compared to youth nationwide. According to the 2002-2003 NSDUH data (Wright & Sathe, 2005),

- 19.7% of Nevada youth reported "marijuana use in past year" (95% prediction interval: 16.87%-22.81%), whereas 15.4% of youth nationwide reported such use.
- Compared to youth nationwide, Nevada adolescents ranked in the 5th tier in the "marijuana use in past year" category. Compared to all Americans, Nevadans 12 or older were ranked in the 4th tier, the group with the second-highest rates of use.
- 8.4% of Nevada youth reported "first use of marijuana" (95% prediction interval: 7.00%-10.11%), whereas 6.6% of youth nationwide reported such use.
- Compared to youth nationwide, Nevada youth were among the 10 States with the highest rate of "first use of marijuana" or new users (i.e., incidence of marijuana use).

According to the SAMHSA (2002 – 2004) TEDS,

- In 2002 in Nevada, those in the 12-17 age group made up 49.7% of all the marijuana admissions, followed by the 21-25 years old, who made up 15.5% of the total, and 18-20 years old who accounted for 9.5% of the total. Nationwide figures were 34.6% for the age group 12-17, 19.6% for 21-25, and 16.1% for 18-20 years old.
- Adolescents accounted for 44.6% of all the marijuana admissions in Nevada in 2004 and 47.4% in 2003 (The national figures for 2003 and 2004 are not available at this time).

MA/A is also a major drug category among Nevada youth. The Nevada BADA findings (Towle, et al., 2004) show that

- MA is the second leading substance (26%) at admission among the Nevadan adolescents.
- The age group distribution among amphetamines admissions in Nevada in 2004 were 9.3% for the youth (aged 12-17), 29.1% for the 18-25 age group, and 61.6% for those aged 26 or older. The rates in Nevada in 2002 were 9.3%, 27.1%, and 63.6% respectively. The nationwide rates in 2002 were 4.8%, 28.4%, and 66.8% respectively.
- Although youth in Nevada followed the national trend insofar as they were the smallest age group in amphetamine admissions, their rate was nearly double that of the national youth.

Alcohol dependence or abuse is another major problem for Nevada youth. The 2002-2003 NSDUH data (Wright & Sathe, 2005) show,

- The average rate of youth aged 12-17 nationwide who were classified with alcohol dependence or abuse in the past year was 5.9 %. The rate for Nevada youth was 6.9% (95% prediction interval: 5.36%-8.91%), which was lower than the rates of 13 States (e.g., Montana and North Dakota) and higher than the rates of 37 states (e.g., D.C., Mississippi, South Carolina, and Utah). Compared to youth nationwide, Nevada youth were ranked in the 4th tier.

Tobacco product or cigarette use was less of an issue in the nationwide ranking for Nevada youth.

- Although Nevada was ranked in the top 10 States (5th tier) with the highest rate of tobacco and cigarette use (past month use) in 2002-2003, this applies primarily to people aged 26 or older. Nevada adolescents were ranked in the 2 nd tier and young adults aged 18-25 were ranked in the 1 st tier.

With regard to the AOD treatment access, Nevada adolescents were ranked in the 4th tier (the second-worst):

- The NSDUH 2002 data (Wright, 2004) show that 6.1% of Nevada youth were “reporting needing but not receiving treatment for illicit drug use in the past year,” versus 5.1% of youth nationwide were. Nevada youth were ranked in the 5th tier for this category.
- Although the rate improved in 2002-2003, Nevada youth were still ranked in the second-worst tier nationwide. Among the Nevada youth, 5.4% were still “reporting needing but not receiving treatment for illicit drug use in the past year,” (95% prediction interval: 4.09%-7.1%) compared to the national rate of 4.3%.
- With regard to the alcohol treatment gap (people needing but not receive alcohol use treatment), Nevada youth have been consistently ranked in the second-worst tier nationwide. In 2002, the State and national figures were 6.1% and 5.6% respectively and in 2002-2003, 6.8% and 5.6% respectively (Wright, 2004; Wright & Sathe, 2005).

Meth: One of Nevada's Major Drug Abuse Problems

Amphetamines are synthetic stimulants that were first commercially used in U.S. in 1930s to treat medical problems such as narcolepsy and asthma. Later, World War II soldiers were given the compound to fight fatigue. Amphetamines became popular in the 1950's among students and truck drivers struggling to stay awake after a long day's work. Amphetamines were also widely prescribed at the time to patients with obesity and depression problems (Center for Substance Abuse Treatment [CSAT], 1999; Anglin, Burke, Perrochet, Stamper, & Dawud-Noursi, 2000). At first perceived as a benign substance, amphetamines came under close scrutiny by federal authorities as a substance prone to serious abuse. The U.S. Congress passed several legislative acts in the 1960's and 1970's designed to tighten control over amphetamine production and distribution due to the drug's addictive potential (Hohman, et al., 2004, p. 374). “Initially thought to be a relatively benign drug, problems from its use in the 1960s and 1970s led to federal legislation that severely restricted legal production” (Hohman, et al., 2004, p. 374).

MA (Methamphetamine), which is more potent than amphetamine, is a derivative of amphetamines, and its potential for abuse is even greater than that of its parent compound. The Control Substance Act of 1970 (CSA) classified MA/A as a Schedule II drug, defined as a substance with high potential for abuse but an accepted medical use in treatment (U.S. DEA, 2005).

The CSA was not successful in eradicating MA use (CSAT, 1999). The CSAT experts cited several reasons why earlier measures failed to stem the tide of MA abuse.

- Manufacturing MA is inexpensive, and the ingredients are easy to obtain.
- The production of MA is relatively easy. As experts point out, "Creative 'mom and pop chemists' can now download the formula for MA from the Internet and produce small quantities for personal and associate use" (Rawson, Gonzales, and Brethen 2002, p.145).
- Clandestine manufacturers found loopholes in the law, devising ever new methods of MA manufacturing to escape the law's provisions.
- MA has a longer effect than cocaine but is less expensive. MA users typically pay only 25% of what the cocaine users do to get the drug.
- Rawson, Gonzales, and Brethen (2002) cited a United Nation report, indicating that there were 35 million people worldwide using or abusing MA/A regularly, compared to 15 million cocaine users and less than 10 million heroin users. Even though MA addiction is still more prevalent in the Southwest, West Coast area, and Hawaii, MA/A has started to invade the Midwest and some Southern regions of the U.S. (Towle, et al., 2004). The high prevalence in these regions may have to do with the fact that the chemicals used to produce MA (ephedrine and pseudoephedrine) were easy to acquire in Mexico (Hohman, et al., 2004).

In his testimony before the United States Senate Subcommittee on Labor, Health and Human Services, Education and Related Agencies, WestCare Foundation President Richard Steinberg (2005) singled

out Nevada as a test case for the MA abuse. He pointed out that “athletes and students sometimes begin using meth because of the initial heightened physical and mental performance the drug produces. Blue collar and service workers may use the drug to work extra shifts, while young women often begin using meth to lose weight. Others use meth recreationally to stay energized at ‘rave’ parties or other social activities” (pp. 1-2). Studies show that women may use MA to help them do an extra job, take care of their small children, and complete house chores (Irwin 1995; Joe 1995). Cretzmeyer, Sarrazin, Huber, Block, and Hall (2003) cited a study done in Iowa showing that the strongest reason women used MA was its availability, followed by their wanting to be more productive. The strongest reason men used MA was also its availability, followed by curiosity.

The rise of MA abuse in the 1990’s has caught legislators’ attention, and in 1996, the U.S. Congress unanimously passed the Methamphetamine Control Act. This Act instituted new controls over the key ingredients for MA production and toughens criminal penalties for manufacturing, distribution, and possession of the drug.

The impact of MA/A abuse is multi-fold. It affects person’s physical and mental conditions, stimulates drug-related crimes, and spurs drug-related child maltreatment. The symptoms and side-effects observed in habitual MA users are as follows:

- MA is highly addictive. Prolonged MAuse results in the increased substance tolerance, requiring ever greater amounts of the drug to produce the same effect (Rawson, et al., 2002).
- The continued use of MA results in sleep deprivation, which impairs cognitive abilities and causes wide mood swings. In some cases, the addict becomes extremely paranoid, irritable, and fatigued (Cretzmeyer, et al., 2003; Rawson, et al.).
- The most detrimental side effects of MAabuse include insomnia, high body temperature, stroke, cardiac arrhythmia, shaking, stomach cramps, anxiety, paranoid hallucination, poor coping abilities, and a disorganized lifestyle.

- MA addicts are known to be violent and susceptible to unpredictable outbursts (Cretzmeyer, et al.; Rawson, et al.; Cohen, Dickow, and Horner, 2003).
- Prolonged MA use results in the increased substance tolerance, requiring ever greater amounts of the drug to produce the same effect (Rawson, et al.).

MA/A is one of the leading drugs related to crimes in Nevada, according to U.S. Sentencing Commission (2003),

- MA accounted for just over half of all the drug-related sentencing in Nevada (51.4%), and it was the leading drug used in all the federally-sentenced drug cases in Nevada during 2002-2003.
- Following MA, the substance that figured most prominently in the fiscal year 2003 Nevada sentencing was crack cocaine (15.0%), followed by powder cocaine (11.2%), other (8.4%), heroin (7.5%), and marijuana (6.5%).
- Nationwide, the leading drug related to federally-sentenced cases was marijuana (26.2%), powder cocaine (23.1%), crack cocaine (20.7%), MA (17.1%), heroin (7.1%), and other (5.8%).

For over 60% of Nevada pregnant women served by the Nevada BADA funded providers, MA was the primary drug of choice (Towle, et al., 2004). This extremely high rate calls for finelycalibrated provisions of gender/pregnancy/drug-specific treatment and service for the pregnant women and their offspring. Such treatment and services should be provided not only during pregnancy but also after the baby is delivered. The negative impact of MA on children manifests itself in several ways:

- MA adversely affects an exposed fetus. The MA exposed neonates may experience growth retardation and premature birth (Lucas, 1997; Smith, Yonekura, Wallace, Berman, Kuo, & Berkowitz, 2003).
- Sun (2004) summarized various studies suggesting that the negative consequences of prenatal drug-exposure are often compounded by the baby's impoverishing and dysfunctional postnatal environment.

- Children of MA users are known to face higher risks of being neglected or abused.
- Chronic MA users often experience sleep deprivation, which severely undercuts parents' ability to tend for their children.
- The MA production laboratories, particularly the home labs, may expose children and adults to a toxic environment, resulting in short- and long-term health problems (Hohman, et al., 2004).
- MA is particularly dangerous if ingested by children. Some home labs may recruit teens in MA manufacture and delivery, leading to a higher MA use among teens (Cretzmeyer, et al.; Hohman, et al.).

Treatment Needs and Availability

As mentioned earlier, the 2004 NSDUH defined a person "needing treatment" as the individual who met the DSM-IV criteria for AOD dependence or abuse in the past 12 months, or as the individual who received alcohol and/or other drug specialty treatment in the past 12 months. The 2004 NSDUH provided data on the populations "receiving any treatment" and "receiving specialty treatment."

Those receiving any treatment are defined as individuals treated for an AOD related problem, including emergency room, private doctor's office, prison or jail, hospital inpatient, mental health center, inpatient or outpatient rehabilitation, and self-help group.

Those receiving specialty treatment include individuals treated at a specialty facility, such as hospitals (inpatient), AOD rehabilitation facilities (inpatient or outpatient), or mental health centers.

Specialty treatment excludes services offered at an emergency room, private doctor's office, self-help groups, prison or jail, and hospitals on the outpatient basis.

It is critically important to analyze the national and state data on persons needing and receiving treatment (NT), persons needing and receiving treatment (NRT), and persons needing but not receiving treatment (NNRT). The 2004 NSDUH estimates (SAMHSA, 2005a, 2005b) show that nationwide,

- There were 23.5 million persons 12 or older (about 9.8% of the total U.S. population) who needed treatment for an illicit drug or alcohol use problem.
- Of the 23.5 million Americans needing AOD treatment, only 3.8 million people (about 16.2% of the 23.5 million people) obtained “any treatment,” and only 2.3 million people (about 9.9% of the 23.5 million people) received AOD “specialty treatment.”
- This means that nationwide more than 80% of the people who needed AOD treatment did not receive it, and about 90% of the persons who needed AOD treatment did not receive the AOD specialty treatment.

The 2002-2003 NSDUH State-level data (Wright & Sathe, 2005) show (Note: the 2004 State-level data are not available at this time):

- Nevada was ranked the 3rd (middle) tier for NNRT for illicit drug use, with a rate of 2.7%, showing 2.7% of Nevadans needed but did not receive treatment for illicit drug use (95% prediction interval: 2.19%-3.31%).
- Nationwide, New Mexico had the highest rate of NNRT persons for illicit drug use (3.5%) and Kansas had the lowest rate (2.2%) (Note: refer to Wright & Sathe [2005] for 95% prediction interval for each rate).
- Nevada was ranked the 4th tier (the second-worst) for NNRT for alcohol use, showing 7.8% of Nevadans needed but did not receive treatment for alcohol use (95% prediction interval: 6.49%-9.4%).
- Nationwide, Montana had the highest rate (10.0%) for NNRT for alcohol use and Tennessee had the lowest rate (5.7%) (Note: refer to Wright & Sathe [2005] for 95% prediction interval for each rate).

The main reason people who need treatment but do not receive it (the NNRT population) give for their situation is that they “did not feel they needed treatment.”

- The 2004 NSDUH data (SAMHSA, 2005a) show that nationwide, there were 21.1 million people who needed but did

not receive treatment for illicit drug or alcohol use. Among them, 94.2% did not feel they needed treatment, 3.7% "felt they needed treatment and did not make an effort," and 2.1% "felt they needed treatment and did make an effort."

Research shows multiple factors that determine why people who need treatment (who met the DSM IV criteria) but did not feel or realize they needed treatment. The NNRT person may be "in denial," unwilling, or unable to give up an addictive substance. Such individuals may not be "in denial" but simply did not perceive their AOD use as causing a problem serious enough to require treatment. Finally, NNRT individuals may believe that they can recover on their own without any intervention or expert help. Scholars who studied the problem point out that the "majority of alcoholics who recover do so without the benefit of treatment" (Russell, Peirce, Chan, Wieczorek, Moscato, & Nochajski, 2001, p. 1417; See also Russell, et al.; Sobell, Klingemann, Toneatto, Sobell, Agrawal, & Leo, 2001, who discuss the issue of "natural recovery").

On the other hand, we should bear in mind that a substantial number of people with AOD problems realize they need treatment yet are unable to obtain it. The 2003-2004 NSDUH data (SAMHSA, 2005a) shed light on the reasons why Americans who needed, "felt they needed," and "made an effort to get" did not get treatment.

- 42.5% of these individuals cited "cost/insurance barriers" as the primary reason they cannot obtain treatment.

Other reasons included

- "not ready to stop using" (25.3%), "access barriers other than cost" (21.5%), "stigma" (17.8%), "did not know where to go for treatment" (9.8%), "did not feel need for treatment/could handle the problem without treatment" (8.6%), "did not have time" (5.4%), and "treatment would not help" (1.0%).

(Note: This data described the population nationwide. The specific data for individual States were not available. Although we can assume that most States, including Nevada, may follow the national

trend in this regard, it would be more scientific if the State could conduct its own study to verify the results.)

Of particular concern are people prevented from obtaining treatment due to insurance barriers. Close to half of the people who needed and wanted treatment did not get treatment because of cost/insurance barriers. According to the 2004 NSDUH findings (SAMHSA, 2005b),

- About 43.1% of persons who received treatment at an AOD specialty facility reported that they used their own savings/earnings to pay for as a source to pay for their treatment.
- Other sources of payment included “private health insurance” (38%), “Medicaid” (29%), “Medicare” (22.8%), “public assistance other than Medicaid” (22.4%), and “relying on family members” (21.2%). A person may use one or more of these sources for payments of AOD specialty treatment.

Since public-funded AOD treatment programs are still relatively scarce, it is not uncommon for an applicant seeking public-funded AOD treatment to be put on a waiting list. One example is that in Southern Nevada only one residential facility for substance-abusing (pregnant) women and their infants/young children exists and the facility can only take 15 families at a time. The delay in receiving treatment and service may create long-term negative outcomes for the applicant. Empirical studies have shown that the longer the delay between a client’s initial inquiry about treatment and the actual appointment scheduled, the less likely the client would keep the appointment (Festinger, Lamb, Kountz, Kirby, & Marlowe, 1995; Orne & Boswell, 1991). According to Nevada BADA (Towle, et al., 2004),

1,946 clients were on waiting lists for an average of 28 days during the state fiscal year 2004. Among them, 99 clients received “support services in the interim” because they were in categories that qualified them as priority populations (i.e., intravenous drug users and/or pregnant women) (See Appendix 3 for detail).

There is a conflict here between the shortage of facilities and personnel in Nevada AOD treatment centers and the need to

provide a lengthy enough treatment required for a positive outcome (estimated to be 3 months on average). As a result, AOD professionals have to choose between extending the length of stay to assure a positive outcome and delaying admittance of new patients waiting for treatment.

Prospects for the Future and Policy Considerations

Increase State Funding for Drug Abuse Treatment

The social costs caused by AOD abuse are enormous. While we cannot eradicate the problem, we can alleviate some of the suffering it causes to people with addictions and their families and contain the damage it inflicts on our communities. As Susan Ettner showed in a recent UCLA study that she led, every \$1 invested in AOD treatment saves society \$7 (Join Together, 2005). Other studies suggest that for every \$1 invested in AOD treatment/prevention, society saves between \$5.85 and \$9.6 (NIDA, 2002). "Spending taxpayer dollars on substance-abuse treatment appears to be a wise investment," Ettner points out (Join Together).

- Based on a solid consensus among scholars and AOD professionals, we recommend that the Nevada legislature declare funding substance abuse treatment a priority on both humanistic and economic grounds.

Support Public Substance Abuse Treatment Programs

Many drug abusers come from lower socio-economic strata and can obtain help only from public-funded treatment programs. However, these programs are often strapped for resources. These chronic shortages delay urgently needed treatments. As the NIDA web site states: "Because individuals who are addicted to drugs may be uncertain about entering treatment, taking advantage of opportunities when they are ready for treatment is crucial. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible." Research confirms that the longer the time between an AOD client's inquiry about treatment and the actual scheduling date of an appointment, the less likely the

client is to keep the appointment (Festinger, et al., 1995; Orne & Boswell, 1991). Hence, we urge that

- Nevada state officials should shore up, and where possible expand, drug abuse treatment facilities to assure a timely delivery of much needed services.

Mount a State-Wide Drug Abuse Awareness Campaign

Over 90% of people who need but do not receive AOD treatment feel they do not need it. To narrow the treatment gap, we need to raise awareness in at-risk groups and the Nevada population as a whole about the treatable nature of drug addiction and the public facilities available to help those in need. Many of those who need but do not receive substance abuse treatment may end up in the criminal justice and child welfare systems or in emergency rooms or be involved with primary medical care. One way we can minimize the AOD treatment gap is to increase the effectiveness of AOD screening and referrals by professionals in the criminal justice, child welfare, and health care systems. Studies show that primary medical care and child welfare workers are often poorly trained in screening and referring their clients for specialty AOD treatment (Dore, Doris, & Wight, 1995; McGlynn, et al., 2003; Meara & Frank, 2005; Young, Gardner, & Dennis, 1998). We recommend that

- The Nevada government should play a more central role in promoting drug abuse education programs and increasing the community's drug abuse awareness, as well as in enhancing the AOD screening and referral competence among professionals of the various systems that often encounter clients who need, but do not feel they need, AOD treatment.

In addition, empirical evidence shows that "Motivational Interviewing" (MI)/"Motivational Enhancement Therapy" (MET) is particularly effective in promoting clients' entry to and engagement in intensive AOD treatment (Carroll, Libby, Sheehan, & Hyland, 2001; Dunn, Deroo, & Rivara, 2001). We recommend that

- Professionals in the AOD treatment field, as well as in the above-mentioned other systems, must be trained in the

latest techniques that promote the clients' entry in the treatment facilities (See Miller and Rollnick [2002] for details about MI/MET).

Emphasize AOD Treatment Program Accountability and Devise Programs Targeting Special Populations

NIDA has formulated 13 evidence-based principles of "effective treatment," which state among other things that treatment needs to be readily available; that effective treatment attends to multiple needs of the individual, not just his or her drug use; that remaining in treatment for an adequate period of time is critical for treatment effectiveness, and that addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way (see Appendix A for details). For the past three years Nevada BADA has required, and provided training for, NIDA's 13 principles in all their funded treatment programs. We believe that

- BADA should continue to require training in NIDA 13 principles and extend this requirement to non-BADA funded providers.

SAMHSA's Treatment of Improvement Protocol (TIP) #2 spells out guidelines for those working with pregnant women involved with substance abuse. TIP #32 offers advice to those dealing with adolescents, and TIP #33 focuses on "Treatment for Stimulant Use Disorders," including strategies for dealing with rural residents, and so on. The SAMHSA Center for Substance Abuse Treatment-funded Mountain West Addiction Technology Transfer Center and the SAMHSA Center for Substance Abuse Prevention-funded Western Region Center for the Application of Prevention Technologies are two other resources from which practitioners can benefit for AOD treatment/prevention program development and implementation. We recommend that

- Nevada professionals working in the drug abuse treatment area must fine-tune their programs to deliver more efficient services to special populations.

Fund More AOD Research

Nevada has an extremely, perhaps even uniquely, diverse population, which resides in vast rural regions, medium-size metropolitan areas, and a world class metropolis that bills itself as the world capital of entertainment. People residing in these diverse areas are bound to have diverse AOD treatment needs. To deliver effective services to these regions, the state should help organize and fund AOD research that promises to illuminate specific needs of each population.

Conclusion

There is good and bad news for the Silver State when it comes to its AOD prevalence and treatment gap. The good news is that Nevada moved from the worst tier in 2002 to the middle tier in 2002-2003 in the illicit drug use and treatment gap categories. The bad news is that Nevada moved from the middle tier in 2002 to the second-worst tier in 2002-2003 in the area of alcohol use and alcohol treatment. The 2002 and 2002-2003 data show that, overall, Nevada moved back and forth between the middle, the second-worst, and worst tiers for its AOD prevalence and treatment gap rates. Our state's primary goal should be reversing the trend and moving Nevada to top three tiers in the drug abuse and treatment categories. To achieve this goal, we need to move on several fronts: (a) increase the state funding, (b) better use the available resources, and (c) devise innovated strategies for preventing drug abuse and reaching out to people with addiction.

There are several other important tasks facing our state. One is addressing the epidemics of Methamphetamine/ amphetamines use, which has become one of the primary illicit drugs in Nevada and which has had an especially adverse impact on Nevada women, youth, and residents of rural areas. Many of those with a serious meth dependency hail from lower socio-economic strata and lack resources to combat the addiction.

It is also imperative to provide assistance that meets the needs of specific gender and age groups. The Nevada youth, who were among the groups with the highest marijuana use prevalence and incidence (new users) in the U.S., also require special attention. We

need innovative, youth-specific prevention and treatment programs to combat drug abuse and addiction among the Nevada youth.

Data Sources and Suggested Readings

Please note that we derived most of our statistical data from SAMHSA's NSDUHs and Treatment Episode Data Set (TEDS), as well as the Nevada Bureau on Drug Abuse (BADA). According to SAMHSA (2005a), NSDUH is "the primary source of statistical information on the use of illegal drugs by the U.S. population," which "collects data by administering questionnaires to a representative sample of the population through face-to-face interviews at their places of residence." NSDUH sample includes "residents of households, noninstitutional group quarters (e.g., shelters, rooming houses, dormitories), and civilians living on military bases," but not "homeless persons who do not use shelters, military personnel on active duty, and residents of institutional group quarters, such as jails and hospitals" (p. 1). BADA's statistical data cover only clients of BADA-funded providers; they did not include clients of non-BADA-funded providers.

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Community Resources

Bureau of Alcohol and Drug Abuse, Certified Treatment Programs . BADA Phone numbers: North – Tel. 775-684-4190; South – Tel. 702-486-8250. BADA Web site address: <http://health2k.state.nv.us/BADA/>.

Battle Mountain, Vitality Center, Battle Mountain. Contact Main Office in Elko, Battle Mountain NV 89820. Tel. 775-738-8004.

American Comprehensive Counseling Services, 625 Fairview St., Ste. 125, Carson City, NV 89701. Tel. 775-883-4325.

Carson Mediation and Counseling Center, 755 N. Roop St., Ste. 108, Carson City, NV 89701. Tel. 775-887-0303.

Community Counseling Center-CC (Counseling in Spanish), 205 S. Pratt St., Carson City, NV 89701-5240. Tel. 775-882-3945.

Jackie Rasor Evaluation Center, 116 East 7th St., Ste. 3, Carson City, NV 89701. Tel. 775-883-2237.

Cinper Evaluation Center, 2874 N. Carson St., #215, Carson City, NV 89706. Tel. 775-885-7717.

John Glenn Evaluation Center (Counseling in Spanish), 1000 E. William St., #111, Carson City, NV 89703. Tel. 775-882-4340.

Dayton , Lyon Council on AOD, 50 River St., Dayton , NV 89403. Tel. 775-463-6597.

Elko County Juvenile Probation Department , 665 W. Silver St., Elko , NV 89801. Tel. 775-753-4603. Vitality Center (Counseling in Spanish). 3740 E. Idaho St., Elko, NV 89801-4611. Tel. 775-738-8004.

Mental Health and Developmental Services, 1665 Ave. F, Ely, NV 89301. Tel. 775-289-1671.

Vitality Center – Eureka. Contact Main Office in Elko, Eureka, NV 89316. Tel. 775-738-8004.

New Frontier (Counseling in Spanish), 165 N. Carson St., Fallon, NV 89406. Tel. 775-423-1412.

Lyon Council on AOD (Counseling in Spanish), 200 E. Main St., Fernley, NV 89408. Tel. 775-463-6597.

Mental Health and Developmental Services, 1000 'C' St., Hawthorne, NV 89415. Tel. 775-945-3387.

ABC Therapy, 7 Water St., Ste. A. Henderson, NV 89015. Tel. 702-568-9971.

Clark County Department of Family Services – Family Preservation, 522 E. Lake Mead Dr. Henderson, NV 89015. Tel. 702-455-8006.

Henderson Municipal Court Program, 243 Water St., Lower Level, Henderson, NV 89015. Tel. 702-267-1350.

New Life Medical Center, 704 W. Sunset Rd., Ste. B-9. Henderson, NV 89015. Tel. 702-558-8600.

Westcare @ Safehouse, 921 American Pacific, Ste. 300, Henderson, NV 89015. Tel. 702-383-4044.

Las Vegas , ABC Therapy (Counseling in Spanish), 740 N. Eastern Ave., Ste. 110, Las Vegas, NV 89101. Tel. 702-598-2020.

Accessible Space – NCEP, 6375 W. Charleston Blvd., #L-200, Las Vegas, NV 89146. Tel. 702-259-1903.

Adelson Clinic (Counseling in Spanish), 3661 S. Maryland Pkwy., Ste. 64, Las Vegas, NV 89109-3003. Tel. 702-735-7900.

Bridge Counseling Associates (Counseling in Spanish), 1701 W. Charleston Blvd., Ste. 400, Las Vegas, NV 89102-2320. Tel. 702-474-6450.

Center for Behavioral Health (Speaks Spanish), 3050 E. Desert Inn Rd., Ste. 116, Las Vegas, NV 89121. Tel. 702-796-0660.

Center for Behavioral Health, Inc., 721 E. Charleston, #6, Las Vegas, NV 89104. Tel. 702-382-6262.

Center for Independent Living, 1417 Las Vegas Blvd. N., Las Vegas, NV 89101-1115. Tel. 702-385-3776.

Choices Group, Inc. , 800 S. Valley View Blvd., Las Vegas, NV 89107. Tel. 702-252-8342.

Clark County Court Education Program (Counseling in Spanish), 310 S. 3rd St., Rm. 212, Las Vegas, NV 89155. Tel. 702-455-4718.

Community Counseling Center-LV (Counseling in Spanish), 1120 Almond Tree Ln., Ste. 207, Las Vegas, NV 89104-3229. Tel. 702-369-8700.

Economic Opportunity Board, 522 W. Washington, Las Vegas, NV 89106-3327, tel. 702-648-0663.

Family & Child Treatment of Southern Nevada (Counseling in Spanish), 1050 South Rainbow Blvd., Las Vegas, NV 89145. Tel. 702-258-5855.

Human Resource Development Institute (Counseling in Spanish), 3365 E. Flamingo, Ste. 10, Las Vegas, NV 89121. Tel. 702-933-1156.

Las Vegas Indian Center, Inc. , 2300 W. Bonanza Rd., Las Vegas, NV 89106. Tel. 702-647-5842.

Las Vegas Municipal Court Evaluation Center (Counseling in Spanish), 2917 W. Washington, Las Vegas, NV 89107. Tel. 702-229-2252.

Las Vegas Recovery Center, 3371 N. Buffalo Dr., Las Vegas, NV 89129. Tel. 702-515-1373.

Legal Rehab Services (Counseling in Spanish), 2061 E. Sahara Ave., Las Vegas, NV 89104. Tel. 702-732-0214.

Mesa Family Counseling, 1000 S. Third St., Ste. F, Las Vegas, NV 89101. Tel. 702-383-6001.

Nevada Treatment Center (Counseling in Spanish), 1721 E. Charleston Blvd., Las Vegas, NV 89104-1902. Tel. 702-382-4226.

New Choices, Inc., 2121 Western Ave., Ste. A-1, Las Vegas, NV 89102. Tel. 702-383-9777.

New Life Medical Center, 1800 Industrial Rd., Ste. 208, Las Vegas, NV 89102. Tel. 702-474-4104.

Options Evaluation Center, 4528 W. Craig Rd., Ste. 150, Las Vegas, NV 89032. Tel. 702-646-4736.

WestCare Nevada (Counseling in Spanish), 5659 Duncan Drive, Las Vegas, NV 89130. Tel. 702-385-2020.

Westcare-Laughlin, 3650 South Pointe Circle, Ste. 205, Laughlin, NV 89028. Tel. 702-299-142.

New Frontier (Counseling in Spanish), Contact New Frontier in Fallon, Lovelock, NV 89419. Tel. 775-423-1412.

Mental Health and Developmental Services, 61 N. Willow , Ste., 4, Mesquite, NV 89027. Tel. 702-346-4696.

Community Counseling Center, 1624 Library Ln., Ste. C, Minden, NV 89423. Tel. 775-882-3945.

Nevada Medical Systems, 2516 E. Lake Mead Blvd., North Las Vegas, NV 89036. Tel. 702-399-1600.

North Las Vegas Awareness School, Inc. (Counseling in Spanish), 2934 Van Der Meer St., North Las Vegas, NV 89030. Tel. 702-642-9866.

Salvation Army, 211 Judson Ave., North Las Vegas, NV 89030-5642. Tel. 702-399-2769.

Owyhee, Shoshone Paiute Tribes of Duck Valley Reservation, PO Box 130 , Owyhee, NV 89832. Tel. 775-757-2415, ext. 239.

Mental Health and Developmental Services, 1840 S. Pahrump Valley Blvd., Ste. A, Pahrump, NV 89048. Tel. 775-751-7406.

American Therapeutic Association (Counseling in Spanish), 2105 Cappuro Way, Ste. 100, Sparks, NV 89431-8586. Tel. 775-355-7734.

Brennan Evaluations (Counseling in Spanish), 275 Hill St., Ste. 200, Reno, NV 89501. Tel. 775- 329-5006.

Bristlecone Family Resources – Northstar, 480 Galletti Way, Bldgs. 3&4, Sparks, NV 89431. Tel. 775-786-6563.

Bristlecone Family Resources – Sagewind (Counseling in Spanish), 1725 S. McCarran Blvd., Sparks, NV 89431. Tel. 775-954-1400.

Center for Behavioral Health, 160 Hubbard Way, Ste. A, Reno, NV 89502. Tel. 775-829-4472.

Evaluation Center, 150 N. Center St., #318, Reno, NV 89502. Tel. 775-240-5251.

Evergreen Evaluation and Education Center (Counseling in Spanish), 741 Greenbrae Drive, Sparks, NV 89431. Tel. 775-358-1101.

Family Counseling Services of No. NV (Counseling in Spanish), 575 E. Plumb Ln., #100, Reno, NV 89502-3543. Tel. 775-329-0623, ext. 103.

Huntridge Counseling, Inc., PO Box 12541, Reno, NV 89510, Tel. 775-233-8426.

Joann Dwight Evaluation Center, Inc., 1000 Bible Way, #46, Reno, NV 89503. Tel. 775-787-7378.

Lynne Daus Evaluation Center, 421 Hill St., #3, Reno, NV 89501. Tel. 775-348-7550.

Reno Sparks Tribal Health Center (Counseling in Spanish), 34 Reservation Rd., Reno, NV 89502-1588. Tel. 775-329-5162.

Reno Treatment Center, 750 Kuenzli St., Reno, NV 89502. Tel. 775-333-5233.

Ridge House, 900 W. First St., Ste. 200, Reno, NV 89503. Tel. 775-322-8941.

Star Evaluation, 150 N. Center St., #204, Reno, NV 89502. Tel. 775-544-3550.

Step 1, Inc., 1015 N. Sierra St., Reno, NV 89503. Tel. 775-322-3576.

Step 2, Inc., 3695 Kings Row, Reno, NV 89503. Tel 775-787-9411, ext. 202.

S. Lake Tahoe Sierra Recovery Center, 972-B Tallac Ave., S. Lake Tahoe, CA 96150-7995. Tel. 530-541-5190.

Silver Springs, Lyon Council on AOD (Counseling in Spanish), 2475 Fort Churchill/McAtee, Bldg. Silver Springs, NV 89429. Tel. 775-463-6597.

Mental Health and Developmental Services (Counseling in Spanish), 825 S. Main St., Tonopah, NV 89049. Tel. 775-482-6742.

Lyon Council on AOD (Community Chest) (Counseling in Spanish), 991 South C St., Virginia City, NV 89440. Tel. 775-847-9311.

Vitality Center (Great Basin), 915 Wells, Ste. 3, Wendover, NV 89832. Tel. 775-664-3421.

Substance Abuse Counseling and Evaluation Services, 737 E. Fairgrounds Rd., Winnemucca, NV 89446. Tel. 775-442-0537.

Vitality Center (Silver Sage), 530 Melarkey St., Ste. 202, Winnemucca, NV 89445. Tel. 775-623-3626.

Lyon Council on AOD (Counseling in Spanish), 215 W. Bridge St., #8, Yerington, NV 89447-0981. Tel. 775-463-6597.

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Supplementary Materials

Bureau of Alcohol and Drug Abuse - Important Contact Information

Information Only

National Clearinghouse for Alcohol and Drug Info. 1(800) 729-6686
N/A N/A

Nevada Substance Abuse Resource Center N/A (775) 784-6336
(702) 385-0684

Poison Information N/A (775) 982-4129 (702) 732-4989

Referral and Information

AIDS (CDC National AIDS/HIV Hotline) 1 (800) 342-2437 N/A N/A

AIDS-Teen Line 1 (800) 234-8336 N/A N/A

Bureau of Alcohol and Drug Abuse N/A (775) 684-4190 (702) 486-8250

Crisis Mental Health Unit N/A (775) 877-4673 (702) 486-8020

Juvenile Court Services (Abuse and Neglect) N/A (775) 328-2777
(702) 399-0081

National Council on Compulsive Gambling 1 (800) 522-4700 N/A
N/A

National Domestic Violence Hotline 1 (800) 799-7233 N/A N/A

National Mental Health Association 1 (800) 969-6642 N/A

N/A National Youth Crisis Hotline 1 (800) 448-4663 N/A N/A

Rape Crisis Center 1 (800) 752-4528 N/A N/A

Substance Abuse Help Line (Crisis Call Center) 1 (800) 450-9530
N/A N/A

Suicide Prevention Center 1 (800) 992-5757 N/A N/A

Youth Runaway Emergency Shelter 1 (800) 448-4663 N/A N/A

Self Help

Alanon and Alateen Groups N/A (775) 348-7103 (702) 615-9494

Alcoholics Anonymous N/A (775) 355-1151 (702) 598-1888

Gamblers Anonymous N/A (775) 356-8070 (702) 364-2625

Narcotics Anonymous N/A (775) 322-4811 (702) 369-3362

Table 1.**Primary Substance Abuse at Admission (Nevada vs. National)**

	Alcohol Only	Alcohol w/ Secondary Drug	Marijuana	Heroin	Cocaine (smoked)	Cocaine (other route)	Amphetamines	Others	Total
National (2002)	23.6%	19.3%	15.2%	15.1%	9.4%	3.5%	6.6%	7.4%	100%
Nevada (2002)	26.8%	12.8%	14.4%	6.6%	7.9%	2.5%	26.9%	2.0%	100%
Nevada (2003)	25.9%	13.2%	13.2%	5.9%	8.3%	2.3%	27.8%	3.3%	100%
Nevada (2004)	26.7%	13.1%	12.4%	5.6%	7.6%	2.1%	28.8%	3.8%	100%

Source: SAMHSA, Treatment Episode Data Set (TEDS). Available at <http://www.dasis.samhsa.gov/webt/quicklink/US02.htm>
<http://www.dasis.samhsa.gov/webt/quicklink/NV02.htm> - /NV04.htm

Table 2.**Historical Trend of Primary Substance Abuse at Admission in Nevada (1992 – 2004).**

	Alcohol Only	Alcohol w/ secondary drug	Cocaine (smoked)	Cocaine (other route)	Marijuana	Heroin	Amphetamines	Other	Total
1992	35.5%	22.0%	11.9%	4.0%	6.2%	11.6%	5.3%	3.7%	100%
1993	30.0%	24.3%	9.6%	3.9%	7.9%	8.2%	11.3%	2.3%	100%
1994	27.2%	21.2%	12.1%	2.6%	7.8%	9.4%	17.8%	2.0%	100%
1995	27.1%	17.6%	9.6%	2.3%	9.4%	8.7%	21.5%	3.9%	100%
1996	30.7%	17.9%	10.1%	2.1%	10.4%	10.2%	17.1%	1.6%	100%
1997	29.0%	14.7%	10.5%	1.6%	10.6%	10.0%	22.2%	1.3%	100%
1998	27.6%	15.4%	9.9%	2.3%	10.2%	11.5%	21.6%	1.6%	100%

1999	28.3%	17.0%	10.3%	2.2%	10.7%	9.0%	20.8%	2.0%	100%
2000	25.6%	16.5%	10.3%	2.9%	13.7%	7.3%	22.3%	1.4%	100%
2001	28.9%	12.5%	10.3%	2.6%	12.8%	7.2%	23.7%	2.0%	100%
2002	26.8%	12.8%	7.9%	2.5%	14.4%	6.6%	26.9%	2.0%	100%
2003	25.9%	13.2%	8.3%	2.3%	13.2%	5.9%	27.8%	3.3%	100%
2004	26.7%	13.1%	7.6%	2.1%	12.4%	5.6%	28.8%	3.8%	100%

Source: SAMHSA, Treatment Episode Data Set (TEDS). Available at: <http://www.dasis.samhsa.gov/webt/quicklink/NV92.htm> - /NV04.htm

Table 3.

Substance Abuse Treatment Admissions by Primary Substance of Abuse, According to Geographic Areas

	Alcohol	Amphet./ Meth	Cocaine (including crack)	Marijuana/ Hashish	Opioids	Club Drugs/ Hallucino- gens	Other
Clark County	36.99%	22.35%	18.03%	11.06%	10.38%	0.65%	0.54%
Washoe County	39.67%	29.11%	9.33%	14.19%	6.94%	0.20%	0.56%
Rural Nevada	49.40%	27.37%	2.31%	17.42%	2.15%	0.40%	0.95%
Carlson City	66.06%	17.94%	1.95%	12.38%	1.11%	0.00%	0.56%

Source: 2003 Needs Assessment: Bureau of Alcohol and Drug Abuse, Nevada State Health Division.
Available: <http://health.2k.state.nv.us/BADA/2003/NeedsAssessment.pdf>.

Appendix A

The non-priority populations of the 1,946 clients most likely did not receive any services, including the “support services in the interim,” during the waiting period. The purposes of the interim services are to reduce the adverse health effects of such abuse, promote the health of the individual, and reduce the risk of transmission of disease. At a minimum, interim services include counseling and education about HIV and tuberculosis (TB), about the risks of needle-sharing, the risks of transmission to sexual partners and infants, and about steps that can be taken to ensure that HIV and TB transmission does not occur, as well as referral for HIV or TB treatment services if necessary. For pregnant women, interim services also include counseling on the effects of alcohol and drug use on the fetus, as well as referral for prenatal care.

Appendix B

NIDA’s 13 Principles of Effective Treatment

- No single treatment is appropriate for all individuals. Matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.
- Treatment needs to be readily available. Because individuals who are addicted to drugs may be uncertain about entering treatment, taking advantage of opportunities when they are ready for treatment is crucial. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible.
- Effective treatment attends to multiple needs of the individual, not just his or her drug use. To be effective, treatment must address the individual's drug use and any associated medical, psychological, social, vocational, and legal problems.
- An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs. A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient at times may require medication, other medical services, family therapy, parenting instruction, vocational rehabilitation, and social and legal services. It is critical that the treatment approach be appropriate to the individual's age, gender, ethnicity, and culture.
- Remaining in treatment for an adequate period of time is critical for treatment effectiveness. The appropriate duration for an individual depends on his or her problems and needs (see pages 11-49). Research indicates that for most patients, the threshold of significant improvement is reached at about 3 months in treatment. After this threshold is reached, additional treatment can produce further progress toward recovery. Because people often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment.
- Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction. In therapy, patients address issues of motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding nondrug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships and the individual's ability to function in the family and community. ([Approaches to Drug Addiction Treatment section discusses details of different treatment components to accomplish these goals.](#))

- Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies. Methadone and levo-alpha-acetylmethadol (LAAM) are very effective in helping individuals addicted to heroin or other opiates stabilize their lives and reduce their illicit drug use. Naltrexone is also an effective medication for some opiate addicts and some patients with co-occurring alcohol dependence. For persons addicted to nicotine, a nicotine replacement product (such as patches or gum) or an oral medication (such as bupropion) can be an effective component of treatment. For patients with mental disorders, both behavioral treatments and medications can be critically important.
- Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way. Because addictive disorders and mental disorders often occur in the same individual, patients presenting for either condition should be assessed and treated for the co-occurrence of the other type of disorder.
- Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use. Medical detoxification safely manages the acute physical symptoms of withdrawal associated with stopping drug use. While detoxification alone is rarely sufficient to help addicts achieve long-term abstinence, for some individuals it is a strongly indicated precursor to effective drug addiction treatment ([see Drug Addiction Treatment Section](#)).
- Treatment does not need to be voluntary to be effective. Strong motivation can facilitate the treatment process. Sanctions or enticements in the family, employment setting, or criminal justice system can increase significantly both treatment entry and retention rates and the success of drug treatment interventions.
- Possible drug use during treatment must be monitored continuously. Lapses to drug use can occur during treatment. The objective monitoring of a patient's drug and alcohol use during treatment, such as through urinalysis or other tests, can help the patient withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that the individual's treatment plan can be adjusted. Feedback to patients who test positive for illicit drug use is an important element of monitoring.
- Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help patients modify or change behaviors that place themselves or others at risk of infection. Counseling can help patients avoid high-risk behavior. Counseling also can help people who are already infected manage their illness.
- Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning. Participation in self-help support programs during and following treatment often is helpful in maintaining abstinence.

Source: National Institute of Drug Abuse, available at <http://www.nida.nih.gov/PODAT/PODAT1.html>

*This report stems from the Justice & Democracy forum on the Leading Social Indicators in Nevada that took place on November 5, 2004, at the William S. Boyd

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