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Voices of the Opioid Epidemic

Perspectives of Those with Lived
Experience in Nevada

Nevada Minority Health and Equity Coalition

SCHOOL OF PUBLIC HEALTH | UNIVERSITY OF NEVADA LAS VEGAS

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PROJECT TEAM

This report was prepared by members of the Nevada Institute for Children’s Research and Policy (NICRP) and the Nevada Minority Health and Equity Coalition (NMHEC), both under the School of Public Health (SPH) at the University of Nevada, Las Vegas (UNLV).

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BACKGROUND

Nevada, like much of the United States, is experiencing substantial challenges with opioid and substance use disorders, further exacerbated by the COVID-19 pandemic. Opioid-related overdose (OD) deaths in Nevada previously decreased 24% between the years of 2010 and 2018, with 2019 prevalence demographics of 75% non-Hispanic white, 12% Hispanic, 9% non-Hispanic black, and over 50% were 45 years of age or older. Rates were most prevalent between the ages of 45 and 54 (Office of Analytics, 2020). Opioid-related death rates then spiked by 76% between 2019 and 2020, specifically increasing in young adult and minority populations (Nevada Statewide Substance Use Response Working Group, 2022). Likewise, opioid-related emergency department visits increased 97% and opioid-related hospital admissions increased 119% during this timeframe. In addition to elevated rates in minority populations during 2020, Fentanyl-related ODs increased from 3% in 2018 to 30.4% in 2020 and overall fentanyl use increased by 227% during this 2-year span (Nevada Statewide Substance Use Response Working Group, 2022). This abrupt change in opioid consumption and ODs triggered a heightened urgency for our state to improve treatment and preventative efforts.

The Nevada Senate Bill (SB) 390, Department of Health and Human Services (DHHS) Fund for a Resilient Nevada, was championed by Senators Ratti and Kieckhefer and it was passed in Nevada's 81st Legislative session. The bill assesses five principal areas, including (1) Spend Money Saving Lives, (2) Use Evidence to Guide Spending, (3) Invest in Youth Prevention, (4) Focus on Racial Equity, and (5) Develop a Fair and Transparent process for deciding when to spend the funding (*Senate Bill No. 390–Fund for a Resilient Nevada*, 2021). These are the main drivers in the bill's future efforts, of which include the State Needs Assessment.

The State Needs Assessment is based on community outreach, guiding opioid and substance-related funding and policy efforts within the State of Nevada. A part of the needs assessment includes a qualitative analysis of focus group interviews and discussions among individuals currently using opioids, in recovery, and friends or family of users in order gain a better understanding of what adjustment need to be made to reduce this epidemic. To better serve our communities, it is imperative to identify and understand where the gaps in service delivery originate, improve resource availability, and develop program initiatives that could help those suffering amidst the opioid crisis.

The purpose of the current project was to better understand the experiences of those who currently use opioids, those in recovery, and friends and family of those who use/used opioids utilizing a community-based participatory research framework.

METHODS

To better understand the environment, perceptions, and experiences of Nevada residents with addiction to opioids, focus group discussions and individual interviews were conducted between February and March 2022. These group discussions and interviews were open to anyone with personal experiences related to opioid addiction, including current users, past users, family members, and friends. A full list of focus group and interview questions can be found in Appendix A.

Study Design - Community Based Participatory Research (CBPR)

The opioid epidemic has far-reaching effects. As a part of the Nevada SB-390, the Nevada Minority Health and Equity Coalition was contracted to gather feedback from individuals, families, and friends affected by the opioid epidemic using a community based participatory research (CBPR) framework. The goal of the CBPR approach is to benefit research participants and their communities, incorporating a flexible partnership approach to research involving community members, organizational representatives, and researchers as equal partners in all aspects of the process (Blumenthal, 2011; Duran et al., 2005; Israel et al., 2012). CBPR has been demonstrated to promote community-level action to improve health and well-being and minimize health disparities in communities (Salimi et al., 2012). Promoting community-level action is particularly important because it provides community members with a sense of empowerment to strive for the goal of health and social change. Based on a review of the CBPR process, it was found that among studies utilizing CBPR within the last decade, 85% saw statistically positive outcomes (McFarlane et al., 2021).

Utilization of a CBPR framework improves the success of outcomes and has been proven as a useful qualitative model in opioid research (Ashford et al., 2019; Marchand et al., 2021; Zimmerman et al., 2020). Given the marginalized nature in communities of people who use substances or are in recovery, the use of CBPR “may help to improve outcomes and should be looked to as a viable option for more research... especially by those engaging in recovery and harm reduction research” (Ashford et al., 2019). CBPR places the needs and preferences of target communities at the forefront when guiding research. Because it promotes an attitude of co-learning and sharing, CBPR has the potential to guide the collection of meaningful data about communities impacted by opioid use.

Bearing this in mind, CBPR is the ideal basis for this type of work because it allows for open discussion with individuals while maintaining consistent communication among all parties throughout the process. Participants are not seen as subjects, but people with powerful voices and stories behind their experiences, which in turn shapes how decisions are made that impact the community.

Recruitment and Procedures

Focus Groups and Interviews: For the current project, focus groups were determined to be the main vehicle to understand the experiences of those affected by the opioid epidemic. However, among discussions with community partners about this approach it was suggested that individual

interviews should also be offered as some may not feel comfortable sharing information in a group setting. Therefore, both options were offered. Furthermore, due to the ongoing concerns with the pandemic, local partners where the focus groups were going to be held in person were consulted and it was determined that in person focus groups were not advised. Therefore, virtual focus groups were scheduled, individual interviews were offered over the telephone, and in Clark, Mineral, and Washoe counties, in-person interviews were also available.

Online Survey for Tribal Populations: In addition to the focus group and interview format, an online survey was created in order to capture additional information from Native American populations in Nevada. Community partners indicated that speaking to someone, even individually, would still be a barrier to gathering information. It was recommended to have an alternative method to collect data such as an online survey.

Recruitment: To advertise for participation, project staff developed English and Spanish flyers (Appendix B). The flyers were reviewed by a few individuals that were eligible to participate and they provided feedback on the language and overall design of the flyer. Their recommendations for changes were implemented prior to the dissemination of the flyer.

Information to participate was sent out to the members of the Nevada Minority Health Coalition and list serves for mental and behavioral health professionals. Individuals were recruited in Clark, Mineral, and Washoe counties, and partners with lived experience were also trained to facilitate interviews. Facilitators were peer-support individuals trained to conduct in-person interviews with those who currently use opioids or those in recovery. The facilitators all met with the Principal Investigator (PI) to review the intent of the project, the questions, and the process of data collection. All facilitators were also provided with a recorder.

Flyers listed registration links that took participants to a Qualtrics survey where they could register for either the focus group, the individual interview, or for Native individuals take the online survey. For their participation, individuals were offered a 25-dollar gift card for the interview or the focus group, and \$15 for the online survey. For focus groups, project staff sent out emails to participants with the meeting information, and tips for video conferencing such as how to use zoom, finding a quiet space, using a laptop to see other participants, and headphones to minimize background noise. Reminder emails were sent out the day of, and, when needed, phone calls were utilized to remind participants of the focus group. For individual interviews, they were contacted to schedule the best time to conduct the interview. The participants were reminded the day of the interview by email and then a project staff member called the participant to conduct the interview. For the data collected in person, facilitators scheduled the interviews with participants and conducted the interview. Focus groups lasted approximately 60 minutes and individual interviews ranges from 10 minutes to 30 minutes.

Measures

Demographic assessment. A brief demographic questionnaire was created to gather basic information about interview participants. Questions included age, gender, race/ethnicity, sexuality, educational attainment, and relationship to opioid use. No personal identifying

information was saved with the demographic information and was only used to contact individuals for participation and follow up information about the results of the study.

Interview Question Development. Original interview questions were developed by project staff based on the understanding of the project, review of the current literature, and other needs assessments conducted in Nevada. After review and revisions from the project funders, the questions were then sent to several professionals and individuals in the community with lived experience for review and revisions. The final interview questions are provided in Appendix A.

Online Survey Development. The online survey was developed based on the interview questions which were modified to include both multiple choice questions and a few open ended responses. The modifications can be referenced in Appendix C.

Data Collection

Focus Groups and Interviews: At the initiation of each focus group and interview, participants were informed of the purpose of the project and that the discussion would be audio recorded to allow the team at UNLV to ensure all data was captured accurately. Personal identity would not be disclosed, as to assure privacy and confidentiality of all participants. A semi-structured interview format was implemented, as this enabled a flexible conversation to capture the most relevant information. After each focus group or interview, \$25.00 gift cards were provided to every participant.

Online Survey for Tribal Populations: After the distribution of the online survey, responses were monitored in Qualtrics. Unfortunately, automated programs detected the survey and had automated bots provide thousands of false responses to the survey. The survey was redone and sent out again, but the same problem occurred. Responses were reviewed to determine which entries were valid by examining the open ended responses for similarities and content, calling and emailing respondents to determine if their response was animated, and by having community partners review email addresses to identify referrals to the survey.

Data Analysis

Following each group discussion and interview, audio recordings were reviewed, and a detailed spreadsheet of responses was independently transcribed by two separate UNLV team members to capture key issues addressed during the conversations. This was performed to assure appropriate interpretation of the qualitative data. A thematic text analysis was then implemented to identify principal themes as well as specific attributes due to variables such as location or socio-demographic indicators. Once the draft of the results was ready, it was sent to both the facilitators and participants for review to assure the interpretation of the data was appropriately portrayed. Individuals had one week to respond but could request more time if needed. While only a few individuals chose to respond back with comments, all feedback was very positive and no changes were requested.

Limitations

There were a few limitations that should be considered when reviewing the results. First, the focus groups and interviews were conducted during a major spike in the COVID-19 pandemic which impacted the ability to hold in person sessions in different parts of the state. While some individuals may prefer a virtual format for participation, there were not options in every county to participate in person and it excluded those that do not have access to technology. However, adequate sample sizes were collected to provide feedback from those with lived experience. Next, for all focus groups and interviews, participation was based on the willingness of individuals to choose to sign up to participate. In addition, due to the way flyers were distributed, individuals that were not currently connected to some resource may not have known about the opportunity to participate. Therefore, there could be something different about those that participated compared to those that chose not to participate. Finally, participation from certain racial groups, such as Asian, Pacific Islander/Native Hawaiian, and Native American/Alaskan Native had low participation. Therefore, the results may not generalize to individuals that identify in those racial categories. Similarly, even though we had advertisements for the individual interviews in Spanish, there was no participation from individuals who spoke only Spanish. Finally, the online survey distributed for tribal partners received thousands of false respondents. It was very challenging to determine which responses were legitimate and therefore it is possible that legitimate responses were not included in the final data set.

RESULTS

A total of 58 individuals from the state of Nevada participated in either a focus group (27.59%), individual interview (56.90%), or survey (15.52%) held between February and April 2022. Of the total participants, 68.97% were based in urban and 31.03% were based in rural counties. Full participant demographics are provided below in Table 1.

Table 1. Interview and Focus Group Participant Demographics (N=58)

	N	%		N	%
County			Sexual orientation		
Washoe	22	37.93	Heterosexual	21	36.21
Clark	18	31.03	Bisexual	1	1.72
Rural	18	31.03	Did not disclose	36	62.07
Race			Education		
White	28	48.28	Some high school	2	3.45
Hispanic	7	12.07	High school	16	27.59
Black	8	13.79	Vocational training	1	1.72
AIAN	12	20.69	Some college	18	31.03
Asian	0	0.00	Associate degree	5	8.62
NHPI	0	0.00	Bachelor degree	9	15.52
Black/Hispanic	1	1.72	Graduate degree	4	6.90
Did not disclose	2	3.45	Did not disclose	3	5.17
Gender			Substance use status		
Male	26	44.83	Currently use	11	18.97
Female	30	51.72	Used prior	32	55.17
Trans male	1	1.72	Family or friend	13	22.41
Did not disclose	1	1.72	Did not disclose	2	3.45

The Impact of Opioids

Despite efforts over the past several years, the opioid epidemic continues to be a problem of significant proportion in Nevada, especially pervasive in low income and rural settings. This was evident in the findings of the focus group interviews, as stories and recollections of current users, past-users and family members continued to demonstrate common themes alluding to a lack of both resources and education within the community. From these discussions, five key themes were revealed among all participant interviews: (1) harm reduction methods are used and accessible; (2) medication-assisted treatment (MAT) and other residential and community-based treatment is helpful but unavailable; (3) stigmatization of opioid and substance use is a big problem for people who are in recovery; (4) limited access to other services hinders recovery; and (5) dispersal of community awareness is needed. Each of these overlying themes are addressed in further detail below.

I. Harm reduction methods are used and accessible

Among both urban and rural settings, there was a general consensus that harm reduction methods are highly beneficial, if and when, they are accessible. Locations near bus stops would improve accessibility, as transportation to these resources is a recurrent barrier for individuals. Participants also felt that, due to varying political views on harm reduction methods, marketing and awareness is limited, especially for those without access to electronics or internet.

Harm reduction in urban settings. Many of the interviewees detailed their experiences with harm-reduction services, such as clean needle exchange sites, test-strips, and Narcan/Naloxone access. One primary barrier to accessibility is the limited hours of operation, leaving only a small window of opportunity for individuals requiring services. Frequent requests for evening and weekend hours were of mention, as this relates to when, where, and how individuals are using and accessing opioids and other substances. Many individuals were grateful to have access to harm-reduction services, seeing its impact firsthand in a crisis, yet the general consensus was that there is very little education provided for administering Narcan to others.

Harm reduction in rural settings. Needle exchange sites and test strips are less frequently available in rural settings, prompting several requests to increase access to these resources as many of the interviewees were never educated on, or aware of, harm reduction methods until at the time of the focus group discussions. In the rarity that vending machines are accessible, rural communities reported increased levels of fear and apprehension with use due to both a lack of privacy and the tendency of the Sheriff's department to use that location for patrolling. Clean needles are also being confiscated by the police in these settings. Several participants in rural communities detailed their experiences of the introduction to opioids through the medical system; specifically, they discussed issues such as living with chronic pain or illness and having very little resources or education regarding the severity and addictiveness of these medications. They became addicted, and once access to prescription medication was denied, they found other sources of access. If harm reduction methods were available, they believe it would be the first step toward reducing the burden in their communities.

Multiple participants noted that people who are addicted to opiates and other substances are going to use, and continue to use, by any means necessary. Many community-based programs are now providing a safe place to use that has a nurse or other professional available who is trained in overdose and medication-assisted treatments. It was agreed that this type of setting may not work in a rural community due to the inherent nature of low population sizes and subsequent stigmatization. Despite this, many interviewees requested this service if it were in a setting that was able to maintain anonymity. This infrastructure, participants agree, would be much more feasible in larger communities such as Reno and Las Vegas, as long as it did not become a target place for the criminal justice system.

II. Medication-assisted treatment (MAT) and Other Residential and Community-Based Treatment

Medication-assisted treatment (MAT) for opioid and heroin users decreases all-cause mortality and frequency of overdose, while also decreasing frequency of use, lowering risk of HIV infection, and reducing relapse rates of individuals who are in recovery (MacArthur et al., 2012;

Ma et al., 2018). This has been highly beneficial for many of the participants in the focus groups, but it is not accessible in all communities, especially on reservations and rural communities. Furthermore, across all demographics, participants express concern regarding current policies on physician certification to prescribe Buprenorphine and Naloxone:

...How does it make sense that a provider, from the minute they graduate from med school, nursing school, PA school... are able to prescribe narcotics to people and get them addicted. But yet they need additional certifications to prescribe suboxone?! That doesn't make sense. Every doctor who can prescribe narcotics should be able to prescribe suboxone.

One specific participant recounted her experience of dealing with years of chronic pain and migraines while living on a tribal reservation, approximately two hours away from the nearest hospital or medical facility. She, like others on her reservation, does not have access to MAT therapy due to a lack of a credentialed provider.

...With chronic migraines, the doctors have recommended acupuncture, chiropractic care, physical therapy. But, yeah, how am I supposed to do these things when the nearest location is [nearby city], and they expect me to be there 2-3 times a week? I can't afford missing three days of work every week. The alternative is pharmaceutical pain management and taking pills. Because there is no other way to handle it for us. I can't even see my doctor more than once every couple of months. Can I move? Yes. But I'm going to do that on my dime. And I'm going to do it without the support of my people and my tribe. Which for us, is, we come together for ceremonial purposes with our people. To step away from that, is devastating for us. You lose your culture... The reason I went on opioids in the first place is because of where I am located. Can I go to the ER and get treated? Sure. But I have to drive for an hour and 15 minutes while in excruciating pain, then sit at the hospital for hours on end waiting to get in. Then I get into a room and wait another 3-4 hours... There are many times this has taken up to 10-12 hours before being treated for my migraine... Then I have to drive another hour and 15 minutes home. So yeah, I am out of work that whole day, usually out of work the next day because I have IV medications running through my system. And then possibly a third day. That's 3 days out of work! ...I don't like taking these pills. I do not like being dependent. But I do not have any other choice right now.

MAT in rural settings. In addition to limited access to MAT, there are many other barriers individuals in rural settings are perceiving. Access to, and duration of therapy is limited, forcing people to return to their current environment which is typically highly triggering and increases risk of relapse. Several rural community members commented on this pressing concern:

...We have found that we can get someone into detox fairly quickly. But what we've seen is that we have to get them to Reno [from a rural county]. So, we've got to transport them, or family, or someone to transport them... but then there is a wait between detox and getting into rehab.

...In recovering addicts, if you want to quit- you want to quit right now. That window of opportunity is so small. And you either wait - or get high- so what are you going to

probably do? You're gonna get high. So definitely, I think, accessibility is huge. We just need more. And we need SOMETHING in [county of residence].

Another participant commented on his inability to access MAT and other services, stating he would get medication from his dog's veterinarian. This further emphasizes that, although MAT is beneficial, it is imperative that other resources are accessible in conjunction to this treatment. One specific interviewee directly commented on the availability of these services.

...We can get a caramel macchiato from Starbucks at all hours of the day, but people are dying on the streets from this because it's not available at all hours, for all people who need it.

Suggestions for improvement included facilities providing bus passes to individuals and increasing operation hours, as most facilities are open from 5:00am – 2:00pm Monday through Friday. These limited hours cause difficulty with compliance for two overarching reasons: (1) if individuals have a job, they most likely have to go to the clinic before work in the mornings since they cannot take time off midday, and (2) many individuals with a substance use disorder need assistance during peak hours of use, which is evenings and weekends.

Another recommendation was that family members and support systems need to be involved in the recovery process so the family know how to support their relative who is currently using or is recovering. Many interviewees recalled instances in which they, or family members, were in treatment and how scary it was for loved ones to not know where they were or how to contact them. One mother in a rural community reported that her only resource when she was going through this process with her son was to call the Sheriff's department, or post on Facebook. Participants also expressed how helpful it would be as a family member to know and understand everything involved with MAT, so they would be better-educated on triggers and potential barriers to success.

Access to Residential and Community Based Treatment. The interviewees who have previous experience with MAT report a need for more long-term mental health treatment, both in conjunction to the MAT therapy, and following completion of MAT. They believe this will improve recovery rates by decreasing the frequency of relapse and providing individuals with the appropriate tools to heal and reintegrate into the community. Long-term care of addiction, in general, is nonexistent among all communities within the state.

Residential treatment settings are inaccessible as they have long wait times until admission is possible and there is a high costs of participating in these programs. Furthermore, many participants report that insurance does not cover these services, so they would not be able to go even if an opening was available.

“Most rehabs make you detox first. Before they ever take you. So then you have to go back out into the streets. And STAY clean and wait for your bed date in rehab. So, like, how hard is that? Because detox takes 72 hours, you know, maybe up to 5 days. Sometimes people can get into rehab within a couple days after detox. But most people aren't that lucky. So they are probably going to relapse again.”

III. Stigmatization of opioid and substance use is a big problem for people in recovery

Each participant of the focus group interviews, regardless if they were the user or the family member, had their own personal story of how stigmatization was a painful experience of shame and self-doubt through this journey. In the rural communities, many participants reported that they were worried to seek help because they were afraid their medical information would not remain confidential, putting them at risk of losing their job, housing, relationships, or in the cases of tribal members, being forced out of the reservation. Likewise, participants who were Veterans had similar concerns and stated they were worried they would lose their benefits if they were honest with their physician. While Veterans may not actually lose their benefits, the fear and stigma prevent them from asking questions or seeking assistance.

Stigmatization deepens disparities for racial and ethnic minority individuals. A general consensus among the participants who identified as a racial or ethnic minority expressed an even greater disparity in access to recovery and treatment services. Multiple respondents indicated that substance use is a secondary effect of deep-rooted trauma and lack of access to mental and behavioral health services. Examples of experiences that lead to substance use include early adverse events in childhood, generational traumas, racism, and poverty were all frequently related to initial substance use. Due to lack of access to preventive care, lack of education by medical providers, and lack of financial resources, many participants expressed that there were no other therapeutic avenues, and substance use was much more readily available. Although pain management was an additional factor, it was much less frequently reported as the cause of initial use in racial minorities. Both individuals from Native American and African American descents described emotionally painful histories of intergenerational traumas and subsequent substance abuse cycles. One interviewee described his perception of substance use on tribal reservations, elaborating on the concept that while drugs, violence and addiction are frequently discussed among tribal members, the ways in which people overcome adverse experiences is seldom acknowledged.

... [We need to] find ways to, I guess, become more aware of the larger world. So maybe more enhanced world views when it comes to your addiction that, especially for tribal people in remote reservations, very often they'll look at their circumstances and say 'Man nobody is coming here to help us, we're on our own. And not only is nobody coming here to help us, I think people actually hate us.' Right? So, they start creating a belief system around their addiction. And so, it's like, well, 'I'm just having this experience in a really isolated way and I'm just on my own and I guess this is where I'm at.' And nobody gives a shit. It can be very difficult for people in recovery to maintain their sobriety with very little exposure to people who have overcome their addictions... We don't really talk about people who overcome these things... It actually works in reverse. So, in our culture for tribal people, it's almost frowned upon if you were to tell people 'Hey, man, I'm out of my recovery and I'm doing pretty good.' People would be like, look at this person they think they're better than us. And you know, screw those people. There's still a lot of work that needs to be done there...

Similar experiences of stigma also exist in recovery. Several tribal participants indicated that it is unacceptable for tribal men to discuss weaknesses or mental health difficulties. Likewise, many

people spoke of similar difficulties within the black and Hispanic cultures, further elaborating that education and awareness are severely under-acknowledged among public schools and medical providers in low income and rural areas. Many respondents indicated a need to improve communication about recovery within minority populations, it was also widely agreed that youth should be the target population for education and prevention, as many adolescents are now turning to substance use to cope with mental health problems. If the stigma and perception can be changed in future generations, it is believed that the prevalence of addiction can be reduced.

Stigmatization affects access to healthcare. In addition to the direct impact of stigmatization on reduced quality of life, access to and quality of medical care was also reported to be affected due to opioid and substance abuse. Many interviewees reported that they avoided healthcare settings all together, stating that it would not matter what they were going to the hospital for, the doctors would assume they were drug-seeking and frequently circumvent a full evaluation.

...Say you want to get help and you're withdrawing off opioids and we know how sick you are, and you go to the ER. How are you treated? Like shit! There's such a stigma and judgement that if you even go in there with something that you are in pain and gosh forbid you even ask for something, they treat you like you're drug-seeking or trying to get something from them. It's a stigma that needs to go away, in general with everybody. You know? Because there's people that legitimately go in there that have never used a drug in their life, and THEY get that stigma because of maybe how they look. There's just too much judgement. Not everyone is there to just want to get high. A lot of people need help.

Participants also relayed how healthcare providers would speak belittlingly to them, often making assumptions of what they, as the patient, needed. One interviewee described his experiences with being turned away from help by multiple providers, on several occasions:

...I really needed help. And I was never 'addicted enough' to get help.

A participant recalled attempting to self-treat his abscess at home. Another individual thought she had the flu but was afraid of how she would be treated if she went to the hospital. One participant recalled an incident when she was recently in the emergency department for several hours.

...We also need to consider both sides of the story. In medical settings for example, yes, they get irritated and impatient with us. But speaking for myself, I was never an easy patient. I was dirty, I was also very impatient, and I wanted to be fixed quickly and get on my way. The culture shift needs to happen on all sides.

Overall, the majority of participants agreed that this issue has drastically escalated since COVID-19. It was also agreed that urgent care centers or mobile care units open 24/7 would be of great benefit to the community. Both of these would decrease the need for people to go to the emergency department for opioid-related issues, potentially decreasing rates of overdose and additional secondary medical problems related to use.

Stigmatization affects access to housing and job retention. Among both rural and urban settings, focus group participants expressed great concern regarding the impact of perception and stigmatization on access to housing and jobs, specifically during treatment and following recovery. All individuals stated that this is one of the most difficult barriers to overcome through recovery because of its emotional impact. Recovery from addiction is excessively difficult in itself; adding the inability to find affordable housing and a job causes people to feel that their efforts toward reintegrating into society is futile. Participants repetitively stated that it was often easier to remain addicted, no matter how horrible they knew it was or how many relationships were ruined in the process. A tribal community member addressed this concern, stating that she was fortunate to retain a job during treatment, but acknowledged how many individuals she is associated with are not as fortunate.

... There has to be a focus in shifting funding out to these rural areas, even just to help a couple of people. I get it, money has to follow where there's more people. But it would make such a difference here. In our eyes, we are not a priority.... We need resources here too. And we don't have those.... This is a human being. Treat them like one...I am not 'some drunk Indian'. I am an educated, strong Native American woman. Yeah, the disparity is there, but it's not impossible... I know my body is chemically dependent on this medication. But so many people out there have no idea. And to manage that. And manage life. Is impossible. And you lose everything. And there are no resources here to help manage. I have to be a voice for the people who don't have one.

Addressing these barriers exposes the fact that many people in recovery lack the necessary skills to seek work, write a resume, or apply for a job, let alone one which does not question drug or criminal history.

IV. Limited access to other services hinders recovery

Limitations with transportation and communication. One limitation mentioned numerous times from participants included transportation and how inaccessible this can be. Many in recovery do not have financial freedom or a personal vehicle, thus relying heavily on public transit. However, most detox and treatment centers do not provide bus passes to ensure clients are able to show up to their appointments. One participant described this issue, recalling that it took several months to finally start the recovery process. He was able to attend his first several appointments, but then was unable to get a ride to the next visit and did not have enough money to pay for public transportation. Among other factors, this resulted in relapse and it was not until almost a year later when he tried to initiate this first step again. Likewise, when discussing with interviewees how current treatment options could improve, several people mentioned that it is extremely difficult if they do not have means of communication such as access to a telephone to check in with family, friends, or case workers. In turn, it decreases commitment and motivation to continue their treatment. In current society, the majority of public awareness and communication is via internet and social media. Support groups, outreach efforts, and educational resources are frequently released online, limiting accessibility for those without a phone or internet. Many of the participants expressed that they already feel like a burden to those around them, and relying on others for transportation or internet creates an even greater divide.

Limitations with maintaining a stable job and housing. Even if individuals had access to transportation, difficulties of time constraints and the impinged stress placed on maintaining a stable job ultimately affected access to housing. Recovery and treatment require both time and finances. If people are trying to better themselves, it is likely that they are attempting to get a stable job, which inherently requires consistent scheduling and attendance. This is not conducive to recovery programs. Likewise, many participants have had difficulty applying for housing, as many of them have records that were red flags for criminal background checks. The facilities that do not require background checks typically have very little availability. One specific interviewee discussed the difficult process of community reentry and her desire to see more outreach programs in the community:

...Workforce development funding to help people reenter the community is really valuable and helps people build their self-worth.... When I was on methadone, I was just existing, and I would go to my appointments, just because I didn't want to be sick anymore, but it was not real. At that time, there wasn't a lot of push for me to be better. I could have very much benefitted from outreach efforts coming into these facilities.

Housing, agreed unanimously, is one of – if not the most – important indicator of success through recovery. All participants of the focus groups agreed that the times in which they did not have stable housing were the times they were the most vulnerable and therefore most likely to relapse. Without stable housing, individuals are forced to live on the streets or in shelters, which are inundated with toxic environmental constraints. Several interviewees described it as a slippery slope, expressing their apprehension of telling their boss about being in recovery for fear of losing their job. If they lost their job, they would then be unable to afford housing, which would result in returning to the same toxic environment. One participant compared it to putting a person on a diet in the middle of a candy store. It is excessively difficult to be around constant temptation without relapsing, especially if you are mentally in a negative place due to work or financial strain.

V. Dispersion of community awareness is needed

...Not everybody connects to the 12-step meetings, but we all connect to connection... We all want some kind of connection.

Several interviewees who are past-users mentioned that they are hesitant to tell their stories for fear of judgement, but deep down they know these stories are needed. People who are currently using need to hear them; they need to know that it will be a long, difficult road. Although, it is possible. The public needs to understand that not every person who is addicted to opioids or other substances is a bad person. Professionals and organizations need to hear these voices in order to improve their outreach and treatment efforts. Everyone needs to hear encouragement and feel a sense of community. Addiction is not, and will never be, a problem of a single individual. Rather, it is the combined experiences of adverse events, tied into a lack of appropriate skills and resources for coping, which evolves over time into a problem that is very difficult to pull out of. If the community shows deep care and concern for the issue, one participation expressed, people will feel cared for and be motivated to return to their livelihoods, knowing the community stands by them, not against them.

An interviewee, who had a family member pass away from an overdose, expressed how they were never aware of harm reduction techniques or MAT when their sibling was going through recovery. They stated that they were not able to help the sibling, but are hopeful that they will be able to help someone in the future since they now have the knowledge and resources that were previously lacking. One mother expressed a deep concern for a lack of parental awareness regarding youth access to social media, stating that her teenage son was buying opioids and other illicit drugs through various social media sites and accounts. Another mother, whose son had been battling addiction for many years, confessed her frustration and regret for feeling like she was failing him because she did not have the necessary education or resources.

...As a parent, I thought I had failed. We didn't have support groups. So, you just keep your pain and suffering to yourself. We NEED more services like that in [rural county]. There's always someone going through something. We become codependent and enabling because we don't know any better. Yes, you want to love and support. But there's a fine line between love and support and enabling. Most addicts are very codependent... To reach out and help those friends, and to let them know you're there, to the point of destroying yourself. And that is codependency. You know, it really is, where we'll sacrifice ourselves and our feelings, and our morals, and our values... for somebody else. So not having those resources... you HAVE to know that you are not alone.

Many organizations are aware of these issues and are beginning to take the appropriate steps toward improving preventative and rehabilitative services. However, one interviewee discussed her observation of these services within the community. She addressed that these organizations are vastly underfunded, causing the individuals working there to be very busy and under high levels of stress, resulting in burnout and compassion fatigue. With this burnout, it is very difficult to be empathetic toward others, causing a downstream effect on the individuals seeking services. She further explained that, even in these facilities where people should be getting support and mentorship, they continue to feel like a burden to society because they see the strain that it is placing on the employees and volunteers. There has to be a way, she elaborated, that these services can be provided in a productive effort which will improve the wellbeing of everyone involved. Other interviewees also addressed this issue, stating that resources such as peer-to-peer, sober activities, sports, extra-curricular activities, and professional development would be highly beneficial.

DISCUSSION

This needs assessment, capturing the voices of individuals with lived experience in Nevada, provided an opportunity to better understand how funding can best be utilized to impact communities. From these discussions, five key themes were revealed among all participant interviewed:

- (1) harm reduction methods are used and mostly accessible;
- (2) medication-assisted treatment (MAT), residential treatment, and community based treatment is helpful but not accessible in many communities;
- (3) stigmatization of opioid and substance use is a big problem for people who are in recovery;
- (4) limited access to other services hinders recovery; and
- (5) dispersal of community awareness is needed.

Overall, there was a high level of agreement among participants, both rural and urban, regarding the five themes. In addition, differences related to race or ethnicity did not emerge. While each of the five themes presented as a problem among all populations, it was apparent that the severity of urgency was heightened in rural and low-income regions, disproportionately impacting the underserved and minority populations. Likewise, underlying issues among themes revealed a substantial need for transportation, housing, and job resources for those in treatment and recovery. Accessibility and feasibility of the transition from detoxification to rehabilitation, and then finally to long-term recovery, is very much lacking.

Comparison to Additional Reports in Nevada. These results were consistent with other reports specific to Nevada, as well as in other states. For instance, a recent report of interactions with a similar population in Nevada in 2021 demonstrated comparable barriers to services and recovery such as lack of access to basic needs, lack of treatment options, lack of support groups that were flexible to meet individuals where they were in the recovery process, and the imposed stigma that is experienced (Swigart, 2021). In a similar report for a project conducted in Clark County in December 2021, over half of the respondents had a negative or mixed experience while trying to access treatment, and some responded that after care treatment was hard to access (outside of detox). Services that were often used by individuals included harm reduction strategies such as needle exchanges, emergency rooms, mental health counseling, other medical care and housing assistance. Respondents had mixed feelings when accessing these services. Some did not have any issues, while others found it more challenging to find availability and felt like a burden to the service providers. In addition, there were mixed feelings about the overall invitingness of organizations. Just under half of participants reported they felt unwelcome, further expressing that they felt judged, were treated rudely, and even had security called on them (Southern Nevada Health District, 2022).

Comparison to Western States' Needs Assessments. Each of the states within the Western region of the United States completed a needs assessment in response to the Opioid Crisis. The

most recent needs assessments from 4 state different states, Colorado, Arizona, California, and New Mexico, were reviewed. The results of their reports were all highly consistent with the current findings in the Nevada interviews of those with lived experience.

In Colorado, a statewide opioid needs assessment was conducted in 2017 that utilized existing data to provide an overview of the pandemic in the state (Colorado Health Institute, 2017). From the compiled data, the following needs were identified: A lack of a supportive environment for MAT, improvements needed in the prescription drug monitoring program, improved accessibility and availability of MAT, increased public awareness and education, and improved access to treatment services (Colorado Health Institute, 2017). Several counties conducted additional needs assessments to enhance local understanding of specific populations.

For example, Denver conducted interviews with individuals who use opioids to better understand peoples' experiences accessing and engaging in treatment. A total of 30 interviews were conducted and the results were similar to those in Nevada. Housing was indicated as an issue and homeless shelters were identified as a needed resource, but one with some barriers. This was an area that was not discussed in detail from our respondents, but likely exist in our state. Barriers reported within shelters included accessibility for couples, strict curfews, and unsafe environments. Transportation, information about services, and access to healthcare were also mentioned as barriers to services. With regard to treatment, similar to Nevada, many were able to access MAT; however, costs were still a barrier, as well as needing to visit the clinic daily for treatment, limited counseling and therapeutic services, and stigma around receiving MAT. Finally, barriers to recovery included inability to change other circumstances such as housing and employment, as well as remaining with the same group of people that trigger use (Rorke, Koester, Denver Department of Public Health and Environment, 2018). In addition to this assessment, Denver also conducted focus groups with families of individuals with opioid use disorder to understand their needs. A total of 13 individuals were interviewed for this assessment and demographic information was not provided. Similar to Nevada's results, mental health counselling for the individual and the family were needed, as well as support groups for the family members, easier ways to find information about resources, and increased efforts to reduce stigma (Denver Department of Public Health, n.d.).

Three rural counties in Colorado also completed a joint needs assessment that included several focus groups with a total of 15 individuals, and 10 individual interviews. The main findings from these individuals with lived experience indicated barriers included knowledge of available services, transportation, COVID-19 restricted resources, focus on punitive punishment for opioid use such as jail timer versus treatment, relapse due to lack of resources and social support, challenges related to the rural nature of towns, and unavailability of resources within towns or transportation to reach resources (Schreiber Research Group, 2017).

Arizona reported similar problems in its 2018 needs assessment, including a lack of continuity of care for those who are receiving MAT, lack of behavioral health referrals from emergency department OD treatments, limited access to treatment facilities and recovery homes, and inability to receive treatments due to cost barriers (Arizona Department of Health Services, 2020). Both key informants and focus group interviews were included in this assessment. Focus

groups included four subpopulations of interest (youth and those serving youth, veterans, seniors and those that identify as LGBTQ) spread evenly over the three main regions of Arizona (North, Central, South) with a mix of urban and rural communities.

New Mexico's 2019 State Needs Assessment was highly cohesive with Nevada and other Western states' assessments, with qualitative data collected from individuals at multiple levels, including recipients of opioid use disorder (OUD) services (n=8). New Mexico described the following barriers, specific to the southern rural areas of the state: Structural and administrative barriers to entering treatment, stigmatization toward MAT and those with opioid addiction, lack of access to treatment and resources due to cost and funding, and difficulties with transportation (Southwest Center for Health Innovation, 2019).

Finally, as this current report is preliminary and data are still being gathered with tribal partners, one needs assessment was found that focused on the American Indian/Alaskan Native (AIAN) population. California performed a statewide needs assessment in this subgroup, completed in 2019. A CBPR approach was utilized to gather community perspective from Tribal and urban AIAN populations in California in the form of interviews and focus groups. This process took 9 months and resulted in participation from 163 adults and 83 youth. There was no requirement to have lived experience with opioid use for this assessment, however 55% of adults reported that they were in active substance abuse disorder recovery. This extensive assessment produced similar recommendations as were reported in rural Nevada, including: addressing stigmas in minority populations, increasing preventative methods, increasing availability and accessibility to MAT, a need for culturally centered recovery programs, and increase availability of treatment centers and sober living (Soto et al., 2019).

In summary, triangulation, or the convergence of information from multiple sources, was used to test the validity of the data obtained through interviews with those with lived experience in Nevada. This demonstrates a consistency of the current findings with other reports in the state of Nevada, and reports from surrounding states.

RECOMMENDATIONS

Collectively, the stories gathered for this needs assessment demonstrate a deep need for change, and the voices of the opioid crisis are calling to action where Nevada can do better in serving its community. These stories provide a direct and apparent lens to this issue, and can hopefully encourage decision makers to empathize with those struggling with the realities of this crisis. This crucial information is fundamental to the consideration of the next steps in combatting the opioid crisis in Nevada.

The following recommendations are based on the voices of those with lived experience. Policy makers and stakeholders should work with communities to implement these recommendations in order to reduce the opioid crisis in Nevada.

Harm Reduction Strategies

- Increase knowledge of access to harm reductions strategies

Medical Assistance

- Increase empathy among medical staff in all settings, specifically within hospital and urgent care facilities to reduce stigma and shame
- Increase availability of medical assistance in the evenings for common issues that can be handled in an outpatient setting, such as a mobile clinic, or after-hours for urgent care facilities to decrease seeking care in the ER.
- Increase availability of access to harm reduction strategies

Treatment

- Work with the community to find ways to improve access to mental health treatment including residential treatment programs.
- Discuss community efforts to offer treatment in ways that can reduce stigma or fear of accessing treatment due to lack of confidentiality
- Provide long-term supportive services to increase recovery success rates
- Ensure specific treatment options are available for specific groups such as youth and individuals with various cultural backgrounds and beliefs.

Peer Support for individuals who use/used and for families of those who use/used

- Increase availability of support groups to help both individuals who use/used and for families of those who use/used
- Alcoholics anonymous (AA) seems to be the most common and available but the program does not work for everyone and, at times, there can be stigma within that group due to the use of MAT. More options are needed to provide choice in support.
- Provide education to those in AA to better assist those who are using other substances to reduce the stigma and increase empathy

Transportation

- Support efforts to improve transportation, thus increasing access to basic needs, treatment, and other supportive services.
- Increase awareness of existing transportation programs

Housing

- Support programs that are affordable, allow for those with a criminal background, and do not allow for relapses.

Reduce Stigma and Increase Awareness

- Improve efforts to reduce the stigma associated with opioid use to increase help-seeking behaviors
- Individuals who use need to be seen and heard so others can better understand what they are going through, which may improve empathy and compassion in all sectors of the community.
- Education and awareness should include stories of recovery to show individuals that there is hope. Ensure there are diverse voices within the conversation which can help relate to those with the deepest disparities.
- Increase the Availability of Culturally Centered Prevention, Treatment, Recovery, and Stigma reduction efforts

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APPENDIX A: Semi-Structured Interview

Introduction:

Hello everyone,

Thank you for agreeing to do this interview today. The purpose of this interview is to better understand what supports and services are needed in the community for individuals that use opioids, are in recovery, or for friends and family of those who use opioids. This information will be used to help inform funding and policy decisions in the state.

Your participation is completely voluntary and you can choose not to discuss certain questions if you do not feel comfortable. I also want to ask you if it is ok to record this interview so I can be sure to capture all the information. The recording is only used by a team at UNLV and will not be shared publicly. Please know that your name will not be connected with your responses and will not include any identifying information from examples you may share. Everything you share is confidential.

1) Harm Reduction

If you currently use or when you did use, what do you need to use safely?

Prompts:

- Can you talk about your experience accessing and/or using:
 - Naloxone? Needle exchange sites? Methods to test drugs?
- Is the community supportive of making these available? What would make it easier to access these items.

2) Treatment Access and barriers

If you are looking to stop using opioids, what are the most helpful resources and treatments?

Prompts:

- Are these resources accessible?
- What are some barriers to accessing existing resources?

Prompts: For example, are there places nearby to access treatment, is there a wait to get in, is it affordable?

- Does accessing treatment impact your ability to get other services? Or in other ways?
- What policies or practices of treatment facilities keep people from staying in treatment? Are they kicked out for using substances (relapsing)?

3) Staying in Recovery

What is most important for people to stay in recovery?

Prompts:

- What does aftercare look like in the community? Is it easy to access? Are there sober living houses?

4) **Stigmas**

What are some stigmas associated with opioid addiction or addiction treatment?

Prompts:

- What messages or advertisements do you think could be used to influence people around you to get treatment?

Last Thoughts

- Is there any additional information you think would be helpful to better understanding the needs of the community around opioid use?

Additional questions to consider:

Factors that Contribute to Use

- How would you describe the local culture or attitudes related to opioid use in your community? What about other substances?
- What are some factors specific to your community that lead you or those you know to misuse opioids?
- How do you or those you know in the community access opioids? Other substances?
- Can you talk about how using opioids/knowing someone that uses has impacted your life? Prompts: relationships, family, friends, work

Resources for Friends and Family Members

- Now I'd like to learn about the resources or services available for friends or family members of those who use opioids or other substances.
 - What are the resources available?
 - What are barriers to those resources?
 - What are resources that are needed?



Do you or someone you know use opioids or other drugs?

YOUR INPUT IS IMPORTANT

If you live in Nevada and currently use opioids such as heroin or prescription painkillers, have used in the past, or if you have family or friends that use them, please join our discussion. Your ideas will help decide what support, programs, or other resources are needed in your community.

Please join us for a group discussion or schedule a one-on-one interview to talk about your experience. The information you share will be anonymous.



REGISTER NOW!



GROUP MEETING



2-15-2022 or 2-16-2022



6:00 - 7:00 PM 6:00 - 7:00 PM



bit.ly/ofg_215 bit.ly/ofg_216

ONE-ON-ONE CALL

Feb. 14 through Feb. 27



702-895-1121
or



bit.ly/OFInterview

*Spots for interviews and focus groups are limited. Reserve your spot today!

Please contact us with any questions: nicrp@unlv.edu or 702-895-1121

Tarjeta de regalo de \$25!*

¿Usted o alguien que conoce usa opioides u otras drogas?

SU CONTRIBUCIÓN ES IMPORTANTE

Si vive en Nevada y actualmente usa opioides como heroína o analgésicos recetados, los ha usado en el pasado, o si tiene familiares o amigos que los usan, únase a nuestra discusión. Sus ideas ayudarán a decidir qué apoyo, programas u otros recursos se necesitan en su comunidad.

Por favor, programe una entrevista individual para hablar sobre su experiencia.

La información que comparta será anónima.

¡REGÍSTRESE AHORA!



14 de febrero al 27 de febrero



702-895-1121



bit.ly/OFInterviews



*Espacios para entrevista son limitados. ¡Reserve su lugar hoy!

Por favor contactenos con cualquier pregunta: nicrp@unlv.edu o 702-895-1121

APPENDIX C: Analysis of Responses from Tribal Surveys

Table A1. Tribal Survey Analysis (N=9)

		Disagree		Agree	
Opioids are a problem in my tribal community		0%		100%	
It is easy to obtain opioids (e.g., heroin or prescription painkillers) in my tribal community.		0%		100%	
Methods that help people safely use opioids (e.g., heroin or prescription painkillers) or to prevent overdose (like Naloxone, needle exchange sites, methods to test drugs, or access to clean supplies) are available in my tribal community.		100%		0%	
Medication-assisted treatment (MAT) is available in my tribal community.		78%		22%	
There are support networks, such as peer support or support groups, available for individuals and families dealing with the effects of the opioid crisis in my tribal community.		56%		44%	
		Not enough is available		There is enough available	
What are your thoughts on current advertisements or educational materials that help people access treatment for opioids (e.g., heroin or prescription painkillers)?		78%		22%	
		Unable to access	Able to access	Did not need	Did not answer
If you have received help for opioid misuse (e.g., heroin or prescription painkillers), which treatment services were you able to access?	MAT	44%	11%	11%	33%
	Other detox programs	11%	11%	33%	44%
	Residential treatment programs	11%	33%	0%	56%
	Peer-to-peer support	11%	44%	0%	44%
	Other support groups	33%	11%	11%	44%
	Mental health services	22%	22%	11%	44%
	Sober living communities	11%	22%	11%	56%
	Housing assistance	33%	22%	0%	44%
	Long-term recovery programs	33%	22%	0%	44%
Transportation services	33%	11%	0%	56%	
		Not accessible		Accessible	
How accessible are the following services for people trying to get help or are in recovery from opioids in your tribal community?	Housing	22%		78%	
	Jobs	33%		56%	
	Transportation	44%		56%	
	Tribal support	11%		78%	
	Food	89%		11%	
	Education	33%		56%	
	Childcare	11%		78%	
	Legal help	56%		33%	
	Medical care	11%		89%	
Internet/phone	22%		56%		

Summary of open-ended responses:

People access opioids or other substances in the tribal community through the following methods:

- Given to them from friends/family
- Taken or stolen from friends/family
- Bought from a dealer
- Prescription from a licensed medical provider

Frequent reasons for inability to access services in the tribal communities include the following:

- Service not available in the tribal community
- Transportation difficulties
- Unaware that services were available
- Conflicts with work schedule
- Conflicts with family/tribal responsibilities