MEETING NOTES

Statewide Substance Use Response Working Group
Treatment and Recovery Subcommittee Meeting

Monday May 16, 2022
8:30 a.m.

Zoom Meeting ID: 875 4338 0677
Call In Audio: 669 900 6833
No Public Location

Members Present via Zoom or Telephone
Chelsi Cheatom, Dr. Lesley Dickson, Lisa Lee, and Assemblywoman Claire Thomas

Members Absent
Jeffrey Iverson and Steve Shell

Department of Health and Human Services Staff
Dr. Stephanie Woodard and Joan Waldock

Attorney General's Office Staff
Rosalie Bordelove, Terry Kerns, Ashley Tackett

Social Entrepreneurs, Inc. Support Team
Laura Hale and Kelly Marschall

Members of the Public via Zoom
Sarah Adler (Belz and Case Government Affairs); Jeanette Belz (Belz and Case Government Affairs), on behalf of the Nevada Psychiatric Association; Chelsea Capurro; Lea Case (Belz and Case Government Affairs); Mary-Sarah Kinner (Washoe County Sheriff's Office); Tyler Shaw (FRPA); Lea Tauchen (Abney Tauchen Group)

1. **Call to Order and Roll Call to Establish Quorum**
   Chair Thomas called the meeting to order at 8:38 a.m. and read the following statement:

   Please note the statewide substance use response working group SURG and its subcommittees may: 1) take agenda items out of order; 2) combine two or more items for consideration; or 3) remove an item from the agenda or delaying discussion related to an item at any time. If you have a disability and require reasonable accommodation to fully participate in this event, please contact Vicki Beavers, Executive Assistant to Attorney General at 702-684-1212 or vbeavers@ag.nv.gov in advance, to discuss your accessibility needs.

   Ms. Marschall called the roll and announced a quorum, with four out of six members present.

2. **Public Comment** (Discussion Only)
   Chair Thomas asked for public comment, with a three-minute limitation per person.

   There was no public comment.

3. **Review and Approve Minutes from April 25, 2022, Subcommittee Meeting** (For Possible Action)
Chair Thomas asked members to review the minutes and note any changes or corrections. Ms. Lee asked for an amendment to the draft minutes to reflect that she does not currently work in the capacity of a Drug and Alcohol Counselor; but she previously worked as a CADC-I (Certified Alcohol Drug Counselor).
    - Dr. Dickson moved to approve the minutes as amended.
    - Ms. Cheatom seconded the motion.
    - The motion passed unanimously.

4. **Presentation on Medication Assisted Treatment and the Bridge Program** (*For Possible Action)*
Dr. Dickson, Las Vegas Medical Director for The Center of Behavioral Health presented a slide deck that will be available through the Attorney General's Office. Dr. Dickson wants everyone to be on the same page regarding medication assisted treatment (MAT). She explained that a lot more people are using opioids and it's taking over their lives, because their drug tolerance increases requiring more and more to get the same effect. Opioid withdrawal symptoms are very, very unpleasant so they look for relief and a chance to calm down the body and the brain. She described the neurological process triggered by depressants or stimulants, and the history of opiates spreading around the world, then compounded into morphine and perfected with intravenous injection via syringe, ultimately leading to heroin use. Some of these compounds were synthesized in the laboratory to bind to the opioid receptor.

   An extract known as laudanum began use in the 17th century to treat food poisoning and other gastrointestinal problems, for the sedating effects, but addiction arose from people self-medicating. It was used more broadly for pain during the Civil War, when people used it in increasing amounts to get the same effect. In the late 1800s, it was recognized as a dangerous and addictive drug, leading to morphine maintenance clinics up until the Harrison Act of 1914 and creation of the Federal Drug Administration (FDA) to regulate drug manufacturing, pharmacies, and physician prescribing. It then became illegal to treat an opioid use disorder (OUD) by prescribing opiates, driving the practice underground and impacting the criminal justice system.

   Heroin addiction was an underground epidemic in the 1950s, when a book on methadone maintenance was published to help people who were addicted to heroin. Methadone clinics were formed, and the FDA issued rules for legal treatment, but the clinics were limited in number. Dr. Dickson practiced in Kentucky in the 80s where there was only one methadone clinic for the whole state, with only 40 spots. In the 90s, she practiced in New York, where there were more clinics, and she would see people lining up in the morning to get their doses. There were a lot of veterans on methadone.

   Pain pills really caught on in the 1990s, when there was a philosophical change in the medical community, determining that pain was unacceptable and it was regularly evaluated and controlled with prescriptions, along with newer formulations of opioids, such as Oxycontin. Previously, morphine IV drips were used after surgery, then patients were switched to an oral preparation as soon as their GI tract was working again, and a mild opioid was given to leave the hospital. Then, when pain treatment really took off, people would get a month supply with refills, although they could get addicted in less than a week. There was a myth that, as long as you had pain, you couldn't get addicted to opioids, but the brain chemistry is the same regardless of pain. Exogenous drugs that bind to the mu receptor in the brain also bind to the same receptor as an endogenous opioid; in the case of opioids, it's called endorphins, producing a similar feeling to what runners experience after they finish a long race. Withdrawal is so bad because the endogenous system stops working after an overload of exogenous opioid and rapid receptor desensitization. Opiates are still the best drugs out there for pain and cough suppression, but they can actually paralyze the GI system

Fentanyl is a very potent synthetic made in the lab, not from the opium poppy. It is a huge threat with too many accidental deaths and they're putting it into pills and powders. More and more patients are coming in specifically for treatment of fentanyl use. It is a legal Schedule II drug used for medical anesthesia and for post-op pain, and it must be prescribed. Slightly different forms are created in places like Mexico and China that have never been shown to have medical use, so they are put on Schedule I. The Board of Pharmacy sends out lists of new drugs added to the schedule when they appear in the community. Fentanyl is being added to everything: one recent overdose happened to a lady who thought she was buying Xanax over the internet; she actually got fentanyl and died.

Users are aiming for the euphoria and the calming effect, but some people don't tolerate opioids very well and may have vomiting, constricted pupils, slow breathing or nodding off to sleep. Others have wide open eyes and become very non-responsive with a kind of blue-gray color to their skin. Their lungs fill up with fluid, then slow and stop breathing.

Ms. Lee said Dr. Dickson's presentation made her realize why she used opioids, because they are effective at treating emotional pain associated with trauma. She committed to touching on the racist history of criminalization of substance use, beginning with the Harrison Act, and mass incarceration. She recommended The New Jim Crow, by Michelle Alexander. She also noted the difference between dependence and addiction, where the latter describes continued use despite adverse effects. Fentanyl is relatively new on the west coast, and it had not been present in black tar heroin, in the same way it had been present in powdered varieties like China White back east. It's important to be mindful of trends coming this way, including other synthetic analogs that are well beyond fentanyl, that are not showing up using fentanyl test strips.

Dr. Dickson remembered hearing about fentanyl on the east coast long before it ever got here. It's a major problem now, with the whole thing really taking off since 2002. Looking at the symptoms, you can imagine how awful it must feel to experience opioid withdrawal. They're not going to die from it, as opposed to alcohol withdrawal, where you could die. But, they're going to feel like they're going to die and they may want to die. That's why they seek treatment when they can't do anything about withdrawal and run out of their pills. Physicians are now more willing to limit the prescription opiates. Some get emergency room treatment with enough opiates to last until they can get back to their doctor. If they're buying from the streets, they're going to find their dealer and get more and more.

Dr. Dickson referenced different forms of heroin and oxycontin, reiterating the damage they do to functions within the systems in the brain and in the body. It also affects mood and cognition, so people come for help with that, too. There's almost always a split between whose who like stimulants and those who like sedating drugs. She believes in the self-medication hypotheses that people tend to choose drugs that medicate an underlying problem they have like anxiety or depression. Being able to treat co-occurring disorders is so important to get them to stop the use of addictive drugs, because you want to understand underlying issues.

Receptors are in the brain and spinal cord, but opioids don't treat the source of the pain; they modify or dull the experience of pain. Health care providers work hard to get patients to use non-steroidal drugs like Ibuprofen and Tylenol because they actually cut down the inflammation that is causing the pain. Opioid injection can cause medical problems such as hepatitis or HIV and sexually transmitted diseases from some sexual interactions with drug using partners. Some women who use a lot of opioids may stop having menstrual periods, and some men have problems with ejaculation. Other problems include GI problems, constipation being the biggest one. It's important to keep track of that sort of thing because it can actually cause rupture of the bowel. Liver disease from the Hep C virus

and overdose primarily leads to respiratory problems. There is also trauma and a lot of depression and suicide associated with opioid use.

Naloxone (Narcan) is very effective in overdoses if used within a few minutes after breathing stops. It can't be used orally; it's inactivated rapidly in the GI tract so it's always in some sort of other preparation. Injectable solution has been around forever for emergency rooms; most recently we have the nasal spray which is very effective and is mostly handed out from pharmacies and a lot of different agencies. Then there's the Epi pen like injection that's very expensive. Narcan is available for friends, family, and rescue personnel. Supposedly, laws protect those who call to report an overdose, but sometimes friends also have drugs.

Thirty percent of Americans have pain, even more in older adults. Everybody wants to help people in pain, so they do. This country has about 80% of the world's opioid use, but Dr. Dickson doesn't know what's happening in the rest of the world if they're suffering from pain. Opioids may not be as effective in long-term chronic pain. She asks patients where they get their medication, and they say they get it from their dealer who gets them from older adults who have extra supply. If too much of a pain pill is prescribed, people sell the extra to supplement their social security checks.

For opioid use disorder, there is a lot of abstinence based and psychosocial treatments, but more detox facilities are needed with intensive outpatient programs, 12-step programs, counseling therapies and sober living residences. Medication assisted treatment (MAT) is the gold standard now, but not all her colleagues provide it. Short term MAT is used for withdrawal to detox people and long-term maintenance keeps people stable to let them move on with their lives.

People who come in with opioid withdrawal, but don't want to get into maintenance can just do a medicated withdrawal to eliminate drugs from the body, mostly by the liver and then in urine. Different drugs have different half-lives; heroin has a very short half-life and is eliminated very rapidly. A long-acting drug like methadone will take much longer to peak and then be totally gone. Long-term withdrawal symptoms last after the drug is out of the system and can cause bone pain for months, sometimes even years, contributing to relapse. When someone comes back for treatment after relapse, Dr. Dickson asks them what happened. It's frequently a social interaction where they share drugs while visiting with friends.

Methadone or buprenorphine are the two main drugs used for MAT, to detox and prevent adverse effects of drug use, and improve their quality of life through better overall functioning. They can get back into the workforce, maintain stable living, improve their relationships, get their kids back, etc. Motivational interviewing around what would make their lives turn around also helps them to quit using and get into treatment. So, rehabilitation services and counseling are important to have as part of treatment.

Methadone is a synthetic opioid that is a long-acting mu and delta agonist that's been around since 1964. It peaks in two to six hours with euphoria for some. They start new patients at about 30 milligrams per day, increasing to between 60 and 120 milligrams per day until withdrawal and cravings are under control. But it can cause respiratory depression with some overdose deaths. Methadone clinics need to be closely watched and monitored with federal certification and inspections.

MAT patients get regular urine drug tests to know if patients are using something else, but they expect relapses and support return to the program. Dr. Dickson finds it sad and unhelpful that some programs kick people out for relapse. They need to have counseling and referrals to psychiatrists for

other medical and psychiatric issues, as part of their full service. They reward good behavior with "take homes" [of methadone] for up to two weeks

Methadone is a very good pain medication in a monitored program, but not as a prescribed pain medication through a medical office because of the long half-life. It is relatively inexpensive, and most programs take Medicaid, but most other insurance companies don't pay enough. Methadone is not reported on the Prescription Drug Monitoring Program (PDMP), so they encourage patients to let their other physicians know that they are taking methadone, but they don't always do that. Federal rules protect medical records for people with substance abuse problems, even more than psychiatric records.

Buprenorphine was approved for office-based treatment in 2000 so that people wouldn't have to come to the clinic daily. It is a Schedule III drug, and safer than the other opioids. You can give up to 30 days of a prescription with specific training and the DEA (Drug Enforcement Agency) waiver. Patient numbers are initially limited to 30 for the first year, and then 100, but then it was increased to 275 patients.

Recent changes to Medicaid require less prior authorization and may require providers to become Medicaid providers. Advanced Practice Registered Nurses and Physician Assistants can prescribe Buprenorphine after they complete the course and obtain the waiver. Dr. Dickson shared pictures of Buprenorphine and Suboxone, including an implant and sublingual pills. A buprenorphine only tablet is used for pregnant women. She showed a graph of a study which demonstrated people who stay on maintenance are still in the program after a year, but those that did not go on maintenance treatment mostly relapsed; four of them died.

Naltrexone is similar to Naloxone as a pure antagonist, but it comes in a long-acting form, both in tablet and a 30-day shot. If they use on top of it, they're wasting the drug because the receptors are blocked. Clinics are getting more and more patients coming from jail or drug courts that are detoxed and can be started on Naltrexone before they leave jail. SAMHSA keeps a list of all the people that have been waivered, but the list is fairly out of date.

They are developing this Bridge program modeled on some other very effective programs in California with about 200 hospitals participating. They encourage emergency room staff to start buprenorphine and refer people to outpatient treatment. They plan to use Peer Support Recovery Specialists and Community Health Workers in the emergency room to do the actual counseling and referral. The emergency room doctors need to know enough about buprenorphine to know how to prescribe.

Dr. Dickson explained that Senator Dr. Hardy is considering legislation, so they don't have to be waivered just to prescribe three days-worth of drugs. Marissa Brown with the Nevada Hospital Association is taking the lead on this to get four to five pilot programs going.

Chair Thomas thanked Dr. Dickson for her presentation and asked her to make slides available for review. She suggested that subcommittee members reach out to Dr. Dickson directly with questions because they were limited on time for the remaining agenda items.

5. **Review Subcommittee Recommendations and Process for Prioritization** *(For Possible Action)*
Chair Thomas explained that recommendations are not expected for the June SURG meeting, but they will share the presentations that are planned, and describe how they are approaching the prioritization process.

Ms. Marschall shared the subcommittee recommendations tracker which includes recommendations from members and, also from the Interim Health Committee meetings from February and March. Ms. Marschall read through the recommendations noting that member recommendations for changes to categories are welcome.

Ms. Marschall said they could also share Dr. Dickson's presentation from today, and Ms. Kailin See (previously recommended by Ms. Lee) confirmed that she would like to present in July or August.

Chair Thomas described her approach to have members identify their top five priorities among the current recommendations, with the understanding that all recommendations may be brought forward to the SURG working group. She wants to let them know which recommendations had immediate priority status based on member ratings. They will maintain a running list of the recommendations after the meetings in July and August, when she will open up the discussion then ask for a motion.

Ms. Lee asked for clarification and Dr. Dickson noted there are different types of recommendations with potential legislation or funding, as well as implementation plans.

Chair Thomas wants the discussion to go on after members have looked at all the recommendations put forward, but her motion now refers to what is currently most important to them.

Ms. Lee understood there was a deadline for submitting recommendations for this meeting, but they could still submit recommendations on a rolling basis. She also understands that the ACRN and the SURG are supposed to be collaborating in some capacity to make these recommendations, but she is still confused as to how they work together and is frustrated by what appears to be a siloed process. She acknowledged Ms. Marschall nodding assent that they still had time to submit recommendations.

- Ms. Lee made a motion to identify their top five recommendations.

Ms. Marschall clarified that members would select their top five priorities independently, as a way to move the process forward, whether it's a legislative priority or requires funding or other action. SEI will synthesize those recommendations and bring back to the Subcommittee to see where there is agreement and create some efficiency. Recommendations were provided to all the members with the meeting materials, and they are available on the Attorney General's website for SURG. Members can also continue to add recommendations that will be brought forward to subsequent meetings.

Dr. Dickson explained she is on three committees like this, and she gets so many things all the time that she can't keep track. She asked if Ms. Marschall was referring to the tracker.

Ms. Marschall clarified that Ms. Hale was currently sharing on screen, the tracker that is based on member recommendations, and it was also provided as a pdf to members in advance of the meeting.

Dr. Dickson confirmed that she had read the materials, but that she would like a form to put their top five rankings into.

Ms. Marschall asked Deputy Attorney General, Bordelove, to confirm the approach for SEI to provide a survey for members to independently complete with their top five choices, without seeing each other's responses.

Ms. Bordelove confirmed that if the results are then presented at the next meeting in public, that's fine. You just can't have the survey effectively pulling the action outside of the meeting. But if staff

or one individual member wants to gather all the responses and then present them at the next meeting, that would be a great way to do it.

- Ms. Lee amended the motion to include the survey to help them identify the top five priorities moving forward for their next meeting.
- Dr. Dickson seconded the motion.
- The amended motion passed unanimously.

6. **Consider Recommendations for Presentations from Subject Matter Experts for Future Meetings** (*Action Item.)*

Ms. Marschall asked if there was a problem going beyond the 10 a.m. end time listed on the agenda. Ms. Bordelove noted that end times are usually not specified on meeting agendas, but she didn't see an issue with continuing to go ahead and finish.

Chair Thomas asked if there were any other presentations the subcommittee members would like to consider based on Dr. Woodard's recommendations from the April 25th meeting, noted on page 6 of the minutes. She added that Kailin See has committed to a presentation in July or August.

Ms. Lee said she is thrilled that Ms. See is being considered to present. She has a long record of setting up overdose prevention sites, a.k.a., safe consumption sites, in Canada and New York. At the last legislative session, AB 345 was sponsored by Assemblyman Orentlicher to move forward with pilots in Washoe and Clark Counties. So, it would be great to hear from an expert on how things are going in New York and provide some guidance to our state. Ms. Lee thought maybe they could take a field trip.

Dr. Dickson would like to hear a little bit more from law enforcement and how things are going with trying to limit the availability of these drugs. She said, if they don't get amphetamines off the street, they're not going to get much control of this epidemic.

Ms. Marschall explained that the Response Subcommittee is addressing criminal justice issues. A suggested approach is for SURG members to attend meetings of other subcommittees based on their interests, rather than duplicating presentations across different subcommittees. All the meeting links are available on the Attorney General's Website for SURG, and there are also recordings of the different subcommittee meetings.

Ms. Cheatom would like to see a presentation by someone who is an expert in the recovery community, and, also, someone who works in harm reduction in the state of Nevada.

Ms. Lee recommended Tina Willauer from Children and Family Futures; she is the co-founder of a treatment and recovery model that places a Case Worker and a Peer Recovery Support Specialist within child welfare to work with pregnant persons and parents who use drugs. This model was implemented in Ohio in 1997 and now encompasses the entirety of Ohio and they're also working in Kentucky and West Virginia. Ms. Lee is trying to pilot this model in Nevada, and Ms. Willauer offers a wealth of information based on decades of experience working with parents who use drugs and who are involved with child welfare. They are keen on offering multiple pathways to recovery for families, and she can speak to alternative outcomes to child placement through welfare.

Chair Thomas asked about experts to address youth in school, based on the current crisis with youth engaging in opiate use, possibly due to peer pressure, and how to get them into treatment.

Dr. Dickson said some of her younger patients tell her they started using opioids in middle school and high school, but they don't generally do MAT with anybody under 18. Non-medication approaches are preferred for adolescents, but she's not sure it should be absolute. Dr. Adelson's clinic had federal grant money to work with 16 - 17 - year-old patients, but she isn't sure how that worked out. She can find out how they approach teenagers to get admitted to the child adolescent psych wards.

Chair Thomas would appreciate getting that information to reach students in middle school and high school.

Ms. Marschall added that the Prevention Subcommittee is likely hearing some of this information, and they will be hearing from Linda Lang, Director of the Nevada Statewide Coalition Partnership. Barbara Collins, Principle, Mission High School, is also on the SURG.

Chair Thomas asked for a motion regarding these recommended presentations.

- Dr. Dickson made the motion;
- Ms. Cheatom seconded the motion;
- The motion passed unanimously.

7. Public Comment

Chair Thomas asked for any public comments and read a statement that they are *limited to three minutes per person. This is a period devoted to comments by the general public, if any, and discussion of those comments. No action may be taken upon any matter raised during a period devoted to comment by the general public, until the matter has been specifically included on an agenda as an item upon which action may be taken pursuant to NRS 241.020*

There was no public comment.

The meeting was adjourned at 10:20 a.m.