MEETING NOTES

Statewide Substance Use Response Working Group **June 17, 2025**
Treatment and Recovery Subcommittee Meeting **3:00 p.m.**

Zoom Meeting ID: 894 8937 5298
No Physical Public Location

Members Present via Zoom or Telephone
Dr. Lesley Dickson, Dorothy Edwards, Assemblymember Heather Goulding, and Steve Shell

Members Absent
Chelsi Cheatom and Jeffrey Iverson

Office of the Attorney General
Dr. Terry Kerns, DAG Joseph Peter Ostunio, and Ashley Tackett

Social Entrepreneurs, Inc. Support Team
Laura Hale and Kim Hopkinson

Members of the Public via Zoom
Tray Abney, Linda Anderson, Jess Angel, Haylee Butler, Amy Fleming, John Hamilton, Abigail Hatefi, Shannon Lepe, Abe Meza, Roberta Miranda-Alfonzo (BeHERE NV), Tracie Rogers, Kimberley Sarandos, Sabrina Schnur, Marcie Trier, and Candace Lewis Vaughn

1. **Call to Order and Roll Call to Establish Quorum**
   Chair Shell called the meeting to order at 3:01 p.m. and welcomed Assemblymember Goulding to the subcommittee, who said she was delighted to be there and looked forward to learning a lot. Ms. Hopkinson called the roll and established a quorum.

2. **Public Comment**
   Chair Shell read the statement on public comment. There were no public comments.

3. **Review and Approve Meeting Minutes from May 22, 2025 Treatment and Recovery Subcommittee Meeting**
   - Dr. Dickson made the motion to approve the minutes.
   - Ms. Edwards seconded the motion.
   - The motion carried unanimously.

4. **Presentation: Related to Proposed Recommendation: "A retrospective assessment or/and prospective study would be conducted to assess the outcomes of patients following discharge from detoxification and examine mortality and overdose."**

   John Hamilton, President and CEO, Liberation Programs, Inc., said he was delighted to be there and shared his slides (see PPT posted for this meeting to the SURG website). Liberation

Programs, Inc is a large behavioral health organization in Connecticut, where Mr. Hamilton is also Chair of the State Advisory Board for the Department of Mental Health and Addiction Services. He has also sat on a lot of national committees, including the Dissemination Committee for the National Institute of Drug Abuse, and put together the first voluntary treatment system for the Republic of Vietnam.

Mr. Hamilton said his presentation is based on a 2016-17 study of overdoses in Connecticut.[1] He said the point of his presentation is that **when people leave detox and residential treatment, and they are not connected post-discharge, they actually have a greater risk of dying of an overdose than if they hadn't gone to detox or residential care at all.** This is like the iatrogenic effect of treatment where somebody goes into the hospital for a broken leg and they die of a staph infection.

Mr. Hamilton's agency works in harm reduction, so he sees it as all prevention whether it's preventing brain damage or preventing death. Only one out of 10 individuals in our country will actually seek treatment so they try to engage with keeping alive the other 90%, through prevention, relapse prevention, recovery management, or prevention of harm and death. Detox is just a good beginning; the greatest prognosis of detox alone is relapse or consistent use of detox again, or death, without a connection to care.[2] Mr. Hamilton explained that the vernacular is changing to refer to "withdrawal management" rather than "detox" as less pejorative language.

Referring to Johann Hari's new book, *The Magic Pill*, about Ozempic, Mr. Hamilton said it is being used in clinical trials to reduce craving for alcohol, tobacco, opiate stimulants, and other substances, to translate the success with lowering food cravings. Mr. Hamilton elaborated on Johann Hari's quote noting that oftentimes the first opportunity for connection is detox, and we often miss that opportunity: "The opposite of addiction is not sobriety. The opposite of addiction is connection."

Putting recovery coaches and family recovery coaches in detox centers supports *Stages of Change* from the Prochaska and DiClemente model. Many people who come into treatment have external pressure to do so with legal mandates or family pressure. Trying to move people toward a stage of readiness to contemplate the action stage helps them to see that they might have a problem that hurts them and their loved ones.

Mr. Hamilton thinks the treatment system is flawed because it is still predicated on people coming in prepared to do whatever it takes, when they are usually forced to be there. Rather than internal change, this is compliance to meet requirements or get their family to stop worrying. Without their own buy-in, they are at greater risk. With opiates, in particular, they are at greater risk of overdose, because they have no tolerance, and they don't want to

[1] Receipt of opioid use disorder treatments prior to fatal overdoses and comparison to no treatment in Connecticut, 2016-17, Drug and Alcohol Dependence 254 (2024) 111040 Robert Heimer, Anne C. Black, Hsiuju Lin, Lauretta E. Grau, David A Fiellin, Benjamin A. Howell, Kathryn Hawk, Gail D.'Onofrio, William C. Becker, www.elsevier.com/locate/drugalcdep,
[2] Mr. Hamilton cited a study from Dr. Walter Ling on Buprenorphine and detox.

disappoint their sponsor or others who drove them to treatment. They are going to relapse in shame and in private, without Narcan or somebody to revive them.

A summary from Nora Volkov's work with NIDA (National Institute on Drug Abuse) notes that people do drugs for two reasons: to feel good or feel better. Most of them are self-medicating for trauma, anxiety, or depression. Mr. Hamilton suggested that if providers assume a level of "recovery capital," they miss the trauma and vulnerability, failing to make a safe connection. The result is compliance rather than real change. That is why his agency shifted to a system of care focused on harm reduction. He has also been involved with a group called Connecticut Communities of Addiction Recovery, one of the pioneers in the recovery coach movement. They do curriculum for most states with a focus on meeting people where they are, but Mr. Hamilton saw that as meeting people where agencies wanted them to be, based on their agenda to get them into recovery with abstinence-based pathways.

If somebody is ready for recovery, and they meet for withdrawal management, the recovery coach asks what they can do to help them, and what recovery looks like to them at that time. This extends to the other nine out of ten people who aren't interested in recovery, to meet them where they are whether it's in the emergency department or anywhere else. Support can extend to housing, food, or employment.

Mr. Hamilton, a licensed family therapist, said if staff get frustrated with the process, they haven't met the client where they are, because they had an expectation of where they wanted the client to be; he extended this to couples' therapy as well, where any human being should be met where they are.

Mr. Hamilton shared a chart based on Tom McClellan's work, reflecting that 25 million people could benefit from treatment that meets diagnostic criteria for substance use disorder (SUD), but in 2025, only 2.3 million people are presently in treatment. This underscores his earlier statement that 90% are not in treatment. They don't actually know who is harmfully involved and could benefit from treatment.

From *Maslow's Hierarchy of Needs*, if people aren't physically safe with a sense of belonging and self-worth, they can't be self-actualized and connect and feel lovable and capable. Meeting basic needs should be a reasonable starting place for a conversation for full abstinence. Otherwise, Mr. Hamilton believes, we are just wasting our time and actually causing them more shame and hurt. There's no such thing as a resistive client. There's only a system and an individual or a counselor recovery coach who's resistive to paying attention to what that person needs in the moment.

On the (Connecticut) Governor's Task Force for Alcohol and Drug Policy, they infused this approach within their practices and principles, to meet people where they are. They've also adopted harm reduction principles in all the treatment programs now, but it's a process moving in the direction to get everyone on board.

The 2016-17 research study Mr. Hamilton referenced at the beginning of his presentation considered people with opiate use disorder (OUD) with a six-month exposure to treatment.

For people who were exposed to a 30-day abstinence program, or detox alone, it increased their likelihood of dying by 70% over not having gone to treatment at all.

Mr. Hamilton believes this is a wake-up call and if you don't have a good engagement specialist recovery coach and outreach specialist harm reductionist in your withdrawal management detox centers and connection to a recovery pathway . . . you're causing more harm than good. It's time to stop that because it's nothing short of malpractice.

In Liberation Programs, they developed an informed consent form as adopted by the Department of Mental Health and Addiction Services in Connecticut to ensure that individuals leaving detox get Narcan as the gold standard for medication assisted treatment (MAT), and counseling behavioral therapies may be an important part of that. However, they recognize that MAT alone can be effective because it quiets the brain until the miracle happens. These medications alone are not a cure, but they've proven to be safe and prevent withdrawal symptoms.

Their informed consent includes all three FDA approved medications for OUD: Methadone, Buprenorphine, and Naltrexone, letting people know the risks and benefits of these medications, as well as the risks and benefits of not being on medications. Everyone leaves with a supply of Narcan and the information that it is lifesaving.

The philosophy is to meet people where they are and treat everyone with dignity and respect, even if they've come through detox 5, 10, or 20 times. Mr. Hamilton's Chief Clinical Officer is a licensed social worker who would be the first to tell people that it took her 24 times with detox before she was ready to turn her life around in recovery, and she leads with this rather than her credentials. Mr. Hamilton added that sometimes relapse is part of the recovery, so never give up on people, because she's grateful nobody gave up on her. It's more important to show people how much you care before you show them how much you know.

People talk about harm reduction being enabling and people going through withdrawal management more than once is enabling, but Mr. Hamilton believes "tough" and "love" should never be in the same sentence. People usually feel that kind of treatment as abandonment and betrayal. It's about half as effective as a community craft model. Family members can realign and redefine their relationships in a manner that recognizes that their recovery process and their healing is separate from the process of their loved ones, moving people toward feeling lovable, capable, and connected.

Following the presentation, Chair Shell asked Mr. Hamilton about data collection. He explained there is a Data Performance System (DDaP) in Connecticut where every licensed nonprofit taking Medicaid has a SUD waiver for every level of care under the ACM criteria from outpatient to residential to detoxes. They all must collect data for admission and discharge criteria. An administrative service organization tracks everybody on Medicaid for all their connected care rates. He said the data are abysmal for people utilizing detoxes without being connected to the next level of care.

Chair Shell appreciated this information as critical for moving any recommendations forward to include data gathering and analysis methods, and thanked Mr. Hamilton for the presentation.

Chair Shell noted to members that they had the option of following up to adopt this recommendation to go to the full SURG or wait until they've heard other recommendations in subsequent meetings.

Assemblymember Goulding asked if they would look into the cost or mechanics of the recommendations, and how all that gets rolled out. Chair Shell explained that all of these could be elaborated before submission to the full SURG. They can ask for additional presentations from subject matter experts (SME) and have additional discussions with members.

Dr. Kerns reminded members that AB19 increased SURG membership and also changed the due date of the SURG Annual Report from January to August to better fit timelines for bill draft requests. There will still be an annual report in January 2026, but the recommendations will not be due until August 2026, then the annual report and the recommendations will be synched up in August 2027. Dr. Kerns also explained that SURG members receive an online survey to complete relevant details for any recommendations that they put forward, including special populations, relevant mandates, fiscal notes, etc. Those can then be workshopped through the subcommittee meetings.

Chair Shell explained that this recommendation came from Ms. Cheatom, who could possibly answer some of Assemblymember Goulding's questions at the next meeting.

Dr. Dickson noted her experience as a treatment clinician since 2008, and she is always wondering what happens to these patients. While some of her group patients are stable, most of the new patients for whom she does intake, they never see again. With a smaller group they may see a couple of times along with a few who are referred from a detox facility. She is 100% in favor of doing a study like this, with all the details that need to be worked out. Doing this study will likely require some grant money and research assistance.

5. **Review Progress on Prior SURG Subcommittee Recommendations**

Laura Hale, Social Entrepreneurs Inc., explained that there are two different types of reports she is sharing with SURG members. One is a report on recommendations that go back over the past few years with a lot of information coming from the Department of Health and Human Services (DHHS). The tracker she shared for this meeting was specific to bills that were in the recent legislative session, and the status of those bills. While some might relate to specific recommendations, they can also be more general as being relevant to the SURG and their scope of work under AB374 from the 2021 session. She then reviewed the SURG Related Bills Status 6.10.25 (posted for this meeting on the SURG website).

Following this review, Dr. Dickson referenced SB300 which was included on the list of bills, noting it would increase the money paid per patient per visit to the Methadone clinics, as specified in the exhibits. The payment for Methadone had not been increased since the 1980s

and could make it more feasible to keep these clinics open. The only problem, she noted, is that many of their patients are going to lose their Medicaid if the "Big Beautiful Bill" goes through at the federal level. Both Dr. Dickson and Chair Shell noted they had read that the US Senate was proposing even more cuts to Medicaid.

Ms. Edwards noted that she also represents the Washoe Regional Behavioral Health Policy Board, as their Coordinator, and she tracked additional bills that were submitted by other Regional Behavioral Health Policy Boards. They were glad to see that AB60 had passed. She noted that AB31 was the bill from the Southern Board on transportation, which did not pass, and neither did SB47 from the Washoe Board to address parity within Nevada. Another bill, AB207 also addressed parity and was put forth by the Nevada Psychological Association, which did pass. There is also a proposal at the federal level for parity. Ms. Edwards said that she thought that the Rural Board bill SB68 for a Social Worker Interstate Compact might have a chance to pass, but it did not. She didn't think any of the interstate compact bills were passed.

Ms. Edwards and Ms. Hale will share notes to make a single combined document.

Chair Shell thanked Ms. Edwards and Ms. Hale for their presentations and encouraged members to go through the document at their leisure and consider any potential related recommendations.

6. **Discuss 2025 Treatment and Recovery Subcommittee Recommendations Process and Any Proposed Recommendations**

Kim Hopkinson, Social Entrepreneurs, Inc., provided a few highlights of the recommendations submission process for new member Assemblymember Goulding, and a reminder for continuing members. The survey that members use to submit recommendations is quite hefty and moving from one question to the next requires some level of entry, even if it's just an asterisk, if you're not yet ready to complete the questions. You can also enter notes to the SEI team if you have questions or need them to follow up on something. Eventually, everything from the SurveyMonkey is made publicly available as part of the Annual Report and in public meetings.

Chair Shell reminded members that they are encouraged to submit at least one recommendation. Chelsea Cheatom and Chair Shell have each submitted a recommendation. Ms. Hopkinson noted that she had not yet incorporated Chair Shell's recommendation that was submitted the day prior to the meeting into the PPT being shared today.

Chair Shell provided a quick overview of his recommendation to allocate some opioid settlement funds to hospitals in Nevada to establish Peer Support Teams in emergency rooms who would then maintain communication and tracking for follow-up appointments and avoid future unnecessary visits to the emergency room. He suggested further discussion at a subsequent meeting, possibly bringing in speakers. One of the reasons hospitals have not moved in this direction is due to the lack of financial resources and most payers do not reimburse for those types of services.

These teams were in Reno hospitals for a year or so, but they were dissolved due to lack of funding. Hospitals could tap into the Fund for Resilient Nevada to incentivize coordination with Peer Support Teams, meeting patients where they are as suggested by Mr. Hamilton's presentation. This could improve the efficacy of hospital-based emergency treatment for these patients.

Potential presenters for the subcommittee include representatives from CASAT (Center for Application of Substance Abuse Technologies) and Trac-B, where Peer Support Teams have been established.

Dr. Dickson asked whether Dr. Farzad Kamyar would still be presenting to this Subcommittee. Ms. Hopkinson explained there was another scheduling conflict, so they will try to reschedule again, for August, in addition to the presenters Chair Shell has suggested, including Sean Hampton and his team at Foundation for Recovery, who have expertise for establishing Peer Support Teams.

Dr. Dickson referenced Crossroads as probably the biggest detox facility in Las Vegas, where a recent graduating fellow is working to improve discharge planning and getting people into treatment. They have a lot of intensive outpatient service, but MAT referral is needed. Dr. Dickson would like a presentation from Crossroads on how their services are changing and whether they're getting more people into treatment. She thinks Westcare Nevada may be reopening their detox service, so they could also be a source for presenters.

Chair Shell noted that any recommendations for presenters can also be emailed to SEI staff at any time and he encouraged members to submit their formal recommendations through the survey. He also reminded members that the next subcommittee meeting is August 19th at 3pm and the full SURG meeting is coming up on July 9th at 2p.m.

7. Public Comment

Chair Shell read the statement on public comment.

Dr. Kerns said the Southern Nevada Substance Misuse and Opioid Prevention Summit will be held on Thursday, August 19th. There is a minimal registration fee of $25 per person, but there are scholarships available, although they don't cover travel.[3]

8. Adjournment.

Chair Shell adjourned the meeting at 4:03 p.m.

Chat File

01:01:33 Jess Angel: Nevada has one of the lowest Medicaid reimbursement rates for Peer Support Services!!!
01:07:55 Heather Goulding: Thank you. Appreciate those tips.

[3] For more information about the summit and to register, please visit https://bit.ly/SNSMOPS2025.

01:12:02 Jess Angel: https://www.carsrecovery.org/product-library/medicaid-reimbursement-for-peer-support-services-a-detailed-analysis-of-rates-processes-and-procedures
01:13:25 Marcie Trier, LCADC, LCPC: Phi Core - CARA Act