MEETING NOTES

Statewide Substance Use Response Working Group **August 19, 2025**
Treatment and Recovery Subcommittee Meeting **3:30 p.m.**

Zoom Meeting ID: 894 8937 5298
No Physical Public Location

Members Present via Zoom or Telephone
Chelsi Cheatom, Dr. Lesley Dickson, Assm. Heather Goulding, and Steve Shell

Members Absent
Stacey Lance, Guiseppe Mandell, 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 Kelly Marschall

Members of the Public via Zoom
Tray Abney, Linda Anderson, Jamie Bartlett, Dani Brown, D. Davidson, Cade Grogan, Jennifer, Heather Kerwin, Shannon Lepe, Candace Lewis Vaughn, Robert Purday, Sabrina Schnur, Beth Scott, Katie M. Snider, and Trey's Notetaker

1. **Call to Order and Roll Call to Establish Quorum**
   Chair Shell called the meeting to order at 3:01 p.m. Ms. Marschall called the roll and established a quorum.

2. **Public Comment**
   There were no public comments.

3. **Review and Approve Meeting Minutes from June 17, 2025, Treatment and Recovery Subcommittee Meeting**
   Chair Shell noted a correction for the minutes under item #7: the Southern Nevada Substance Misuse and Opioid Prevention Summit should be Thursday, August 21st, not August 19th.[1]
   - Assem. Goulding made the motion to approve the minutes as amended.
   - Dr. Dickson seconded the motion.
   - The motion carried unanimously.

4. **Discussion Related to Proposed Recommendations and July Presentation: "A retrospective assessment or/and prospective study would be conducted to assess the**

[1] During development of the approved minutes, it was identified that the date of the Summit was Thursday, August 14th.

outcomes of patients following discharge from detoxification and examine mortality and overdose."
Chair Shell summarized Mr. Hamilton's presentation for members to discuss and determine next steps for recommendations, as related to Ms. Cheatom's recommendation previously submitted for member consideration:

- *Fund a study to assess the outcomes of patients following discharge from withdrawal management services to examine mortality and overdose for programs implementing harm reduction into treatment versus programs that do not include principles of harm reduction, informed consent for MOUD, and/or recovery coaches.* (See slides posted on the SURG Website for other recommendations.)

Chair Shell also reminded members that with the extension to August 2026 for submission, there is plenty of time to consider and vet all recommendations.

Ms. Marschall noted that Mr. Hamilton's presentation was based on input from his fellow Council members in Connecticut, as detailed in the June 17, 2025, meeting notes. He preferred the term "withdrawal management" to the term "detox" and said informed consent requires discussion of risks, benefits and access to methadone, buprenorphine, or naltrexone, along with provision of naloxone upon discharge. He also supported engagement or outreach specialist recovery coaches for withdrawal management.

Ms. Marschall screen-shared a version of the study Mr. Hamilton referenced[2], that was published in 2024, noting the danger of initiating detox without access to support, compared to if they had not detoxed at all. Ms. Marschall cautioned that given the availability of a study already showing increased mortality and overdose, it could be considered dangerous and unethical to do another study. She referred people back to the presentation and/or the approved minutes, which the slides summarize, as in the table copied below.

[2] https://pubmed.ncbi.nlm.nih.gov/38043226/ coauthored by the Yale School of Public Health, the Yale School of Medicine, the University of Connecticut School of Social Work, and the VA Connecticut Healthcare System.

Principle	Abstinence-Based Recovery	Harm Reduction
Engagement	Often requires commitment to abstinence as a condition of participation	Welcome individuals regardless of whether they are ready or willing to stop using
Philosophy of Readiness	Assumes that recovery begins with the decision to stop using	Meets people where they are and supports any positive change
Common Programs/ Models	12-Step programs (eg, AA/NA), therapeutic communities, residential treatment	Needle exchange, medication for opioid use disorder (MOUD), overdose prevention, housing-first models
Definition of Success	Complete cessation of all non-prescribed substance use	Reduced risks and negative consequences associated with substance use (including continued use)
Primary Goal	Lifelong Sobriety	Improved health, safety, and well-being – regardless of ongoing substance use
Approach to Use	Substance use is seen as inherently problematic and to be stopped entirely	Substance use is seen on a spectrum; focus is on reducing harm rather than eliminating use

Ms. Marschall summarized Mr. Hamilton's recommendation to ask programs to adopt harm reduction principles and meet people where they are to support positive change, engaging in models such as needle exchange, medications for opioid use disorder (MOUD), overdose prevention, and housing first. Reduced risk of negative consequences associated with substance use versus complete abstinence or cessation prioritizes improved health, safety, and wellbeing regardless of ongoing substance use. Viewing substance use on a spectrum with a focus on harm reduction rather than cessation can define success. Informed consent explicitly references MOUD as the gold standard of evidence-based treatment. While counseling and behavioral therapies are an important part of treatment alongside medications, medications alone are effective and can be used to relieve cravings, withdrawal symptoms, and block the euphoric effects of opioids. The medications don't cure the disorder but improve safety and prevent withdrawal symptoms that can lead to relapse and continued substance use.

Ms. Marschall also shared Mr. Hamilton's slides on Informed Consent, where "Liberation Programs" refers to the specific program in Connecticut that he supports.

Informed Consent for Accepting or Refusing Medications for Opioid Use Disorder (MOUD)

Medications for an opioid disorder are available and considered the "gold-standard" of treatment and are an evidence-based treatment for individuals with an opioid use disorder. Counseling and behavioral therapies may be an important part of treatment alongside medications; however, medications alone are effective by themselves. Medications are also used to relieve cravings, relieve withdrawal symptoms and block the euphoric effects of opioids. These medications do not "cure" the disorder, but rather improve safety and prevent withdrawal symptoms which can lead to relapse or continued substance use.

Liberation Programs offers the following medications and suggest anyone with an Opiate use disorder receive one of these approved medications:

- Methadone – Prevents withdrawal symptoms and reduces cravings in people with OUD. It does not cause a euphoric feeling once patients become tolerant to its effects. It is available only in specially regulated clinics.
- Buprenorphine (Subutex)– Partially blocks the effects of other opioids, displaces current opioids in the body, and reduces or eliminates withdrawal symptoms and cravings. Buprenorphine treatment (detoxification or maintenance) is provided by specially trained and qualified clinicians who have received a waiver from the DEA).
- Naltrexone – Blocks the effects of other opioids preventing the feeling of euphoria. It is available from office-based providers in pill form or monthly injection.

In addition, all clients discharged from Liberation Programs will receive Narcan: Naloxone (Narcan) is a life-saving medication used to quickly reverse an opioid overdose. Naloxone is safe and has no effects if administered to someone not experiencing an opioid overdose.

I have been educated on the risks and benefits of both taking and/or refusing MOUD and have willingly:

Accepted Medication
Refused Medication

Client Name Printed: _____
Client Signature: _____
Date: _____
Staff Signature: _____

Ms. Marschall also shared results of the study with the following slide:

Study: Receipt of opioid use disorder treatments prior to fatal overdoses and comparison to no treatment in Connecticut, 2016–17

Robert Heimer a,*, Anne C. Black b,d, Hsiuju Lin c, Lauretta E. Grau a, David A. Fiellin a,b,Benjamin A. Howell b, Kathryn Hawk a,b, Gail D'Onofrio a,b, William C. Becker b,

- 38% decrease with exposure to Methadone
- 34% decrease with exposure to Buprenorphine
- 70% increase in likelihood of fatal overdose with exposure to 30-day abstinence in treatment
- Informed consent we adapted for our residential programs is being used by the Department of Mental Health and Addiction Services as an informed consent to share the risks and benefits of not being on a medication assisted treatment when one discharges for opioid use disorder.

[3]

Ms. Cheatom explained that her recommendation was based on looking at a retrospective of the study from 2017, but she doesn't know all the agencies and groups supporting collection of this information. If they could show that data from the more recent study is similar to what they're seeing in Nevada, that would strengthen the recommendation.

Chair Shell noted that Connecticut is in the top 10 or 15 states in the nation for access to treatment with a lower prevalence of mental illness and substance use issues, so it would be good to have data specific to Nevada. Ms. Cheatom added that even the drug supply on the east coast is different from Nevada.

Assm. Goulding asked if there were other studies to substantiate these findings beyond a single data point, and if so, she would support the practice, collecting data for Nevada. Public education should be included to help people understand harm reduction versus abstinence-based approaches and address possible resistance among the broader population.

Chair Shell asked Ms. Cheatom if she could address these concerns and whether there is any data from SAMHSA. Ms. Cheatom referenced a study from Massachusetts with retrospective data from 2012-2014 which found similar outcomes. She will look for other studies and for SAMHSA data and forward everything to Ms. Marschall to share with the group.

Ms. Cheatom further supported public education on harm reduction and meeting people where they are, because not everybody is looking to get into treatment or to stay abstinent. She advocated getting information on Nevada first to understand what type of education is needed within our state, and looking at MOUD as post-detox treatment, not necessarily as harm reduction, would help with education.

[3] A 2024 version of the study was published in Drug and Alcohol Dependency journal, found online at https://pubmed.ncbi.nlm.nih.gov/38043226/

Assm. Goulding appreciates that as a new member of the subcommittee she is building context to better understand. She wishes the chart for harm reduction would include keeping people alive as a base goal.

Dr. Dickson likes the idea of doing studies, having done them herself working in the field. It's hard to do because someone has to do the follow up which requires hiring researchers for phone calls and record research. Some of the best studies are done by large groups like Kaiser or others that manage patients. In Las Vegas, there are a lot of silos with not too much interaction. She said it was unfortunate that Mr. Iverson was not with them because Crossroads is by far the most utilized detox facility in southern Nevada. She doesn't know if they are doing a lot of studies, but she thinks they're getting a little bit more proactive in referring people to treatment for MOUD because she is starting to see more patients coming from Crossroads. The drug courts are also very helpful with referring people to treatment facilities. High transiency rates and individuals with substance use are highly protected by HIPAA and other laws, so you can't just make phone calls. She's not sure if large insurers in Las Vegas – like Optum – are treating addiction because she never gets referrals from them. She was speaking with John Firestone from NOTA (Nevada Opioid Treatment Association) and they would like to do a lot more awareness raising of treatment options, possibly through public service announcements.

Ms. Cheatom knows information is out there from studies in multiple states, that are retrospective, rather than doing follow-up with patients, looking at other documentation that's readily available through hospitals or the coroner's office. She doesn't know how to get access and put it all together. If they could find one of the researchers, they could learn more about documentation and access. Chair Shell thought this was a great idea, and Ms. Cheatom agreed to follow up on trying to find someone.

Chair Shell asked members about continued vetting of this recommendation or consideration of a motion at this time. Assm. Goulding likes looking into this further before making a recommendation, but she thinks they are on the right path. No members were opposed.

5. Discuss Previous Treatment and Recovery Subcommittee Recommendations to Resubmit

Chair Shell explained that previous recommendations could be brought forward again at the members' discretion. He summarized the first recommendation from 2024, regarding NRS for HCQC (Health Care Quality and Compliance) employment guidelines related to the hiring of Peer Recovery Support Specialists (PRSS) with felony convictions.

Legislation should be considered to amend the NRS pertaining to the Nevada Bureau of Health Care Quality and Compliance's employment guidelines for hospitals, including behavioral health hospitals, to hire certified peer recovery support specialists who have felony backgrounds and are within three years of their last felony conviction. It is recommended that individuals who were convicted of drug offenses or other offenses that do not involve violent acts or sexual exploitation be considered for employment as certified peer recovery support specialists in hospitals.

He hasn't seen any action on this recommendation, and he hopes the subcommittee will agree to keep it for discussion next year, possibly bringing in a presenter from the Bureau which is now under the Nevada Health Authority. He expressed strong feelings about this because PRSS are being eliminated from consideration at a time when the state is trying to build up the pool for this classification. Reducing the timeframe from five years to three years since the last felony conviction could be very helpful.

Dr. Dickson asked if they reached out to anyone about putting this forward as a bill. Chair Shell didn't think it was taken on as a BDR. Dr. Dickson said this would be a good step. She also wondered where the hospitals are on this and on PRSS payment, regardless of their background. Chair Shell suggested talking to NV Hospital Association to learn of any support or opposition. Dr. Dickson suggested asking Patrick Kelly to come talk to them about peer support in general and what it will take to make this happen.

Chair Shell read the second recommendation to make opioid antagonists available on all NSHE campuses, which was passed by the legislature and signed by Governor Lombardo.

Support BDR 95 [AB394 to amend NRS Chapter 396] to ensure opioid antagonists must be available on all campuses under our Nevada System of Higher Education, including in Student Unions, Health Centers, all levels of the dormitories, Residential Advisor's domiciles, sports facilities, and libraries and include training of the administration of opioid antagonists which can take place during online freshman orientations much like we already disseminate information about Title IX, during orientation week, training could be offered throughout the year by various clubs and programs within each institution's design.

Dr. Dickson had questions about how this was being implemented on campuses, with possible regulations, in terms of locations, training, and funding.

Chair Shell said the subcommittee still reserves the right to take portions of this recommendation and put it into a new recommendation for next year.

Ms. Hale reported that the Governor approved the bill on June 5th, and it was effective upon approval, with requirements for education on opioid-related drug overdoses and procedures for the distribution and administration of opioid antagonists. There was an amendment that changed the dosage from 4 mgs. to the lowest effective dosage. The bill also prohibits disciplinary action for obtaining opioid antagonists. Antagonists must be available on all campuses with training provided for administration. Dr. Dickson requested outreach to NSHE to find out where they're going with this. Ms. Hale will follow up and get information for the subcommittee members.[4]

Chair Shell moved discussion to the third recommendation to:

[4] Outreach to Madalyn Larsen for update; response pending.

Support access and linkage for treatment of trauma for people with substance use disorder (SUD) or those who have overdosed and for surviving family members after an overdose fatality. Support training for healthcare professionals to identify and address trauma.

Ms. Cheatom said she didn't believe it made it to a BDR, but she didn't have any other information on it. Chair Shell reiterated the ability to move it forward again in 2026, with possible edits.

Ms. Hale commented on the BDR process in relation to the SURG recommendations that go to state agencies, the legislature, and the governor. Typically, the recommendations do not specify a person or agency to put forward a BDR, and the timing has not always been synched up with the BDR schedule. She has been working with staff from the Department of Human Services (DHS) regarding this process, and they could present more information at a future SURG meeting when they report on progress for some of the recommendations. This could include educating members about the process and maybe how to better target their recommendations.

Assm. Goulding asked if they worked with the Interim Health and Human Services committee in the past, because this would be a good segue into a BDR. Ms. Hale noted that there are other legislators on the SURG and they have worked with Senator Doñate, but the recommendations don't always make the cut. Dr. Kerns clarified that Senator Doñate requested a presentation to the Interim Health Committee from the Attorney General's Office, which was provided with SURG recommendations for their consideration.

Dr. Dickson opined that the legislature turns this stuff into mandates for CMEs (continuing medical education) and CEUs (continuing education units), which has gotten out of control for medical providers, adding *they tried a bill that didn't pass to try to get that more under control*. She went on to say that healthcare professionals should know how to do things like *identify and address trauma*, but she would like to know exactly what "support" means in this recommendation. During residency training, they have a "Green Book" that describes exactly what is required for each specialty. Just saying "we support it" doesn't help with implementation.

Chair Shell suggested the subcommittee could expand on the recommendation if members want to do that. He recommended keeping it on the list for discussion and/or presenters at future meetings.

Dr. Dickson noted that opioid settlement funds can support educational efforts, and they could bypass the legislature and encourage organizations to do educational meetings on trauma and the significant overlap with substance abuse. Possibly the medical society could support CEUs/CMEs every two years. About 10 of the 40 credits for psychiatrists are covered by mandates, but something like this could fit for the other 30, and she thought other professions could do this as well. They could suggest this to program managers for RFPs (requests for proposals) for opioid settlement funds.

Chair Shell referenced the fourth recommendation related to the presentation to this subcommittee by Dr. Kelly Morgan:

Direct the Division of Public and Behavioral Health to identify a funding mechanism for hospitals and providers to enhance the "Bridge Program" for Emergency Departments by incorporating Peer Recovery Support Specialists into their treatment models. Support the use of Peer Support Navigators via telehealth to increase access to treatment and support for individuals identified in Emergency Departments.

Dr. Kerns reported that the Response Subcommittee also had a presentation from Dr. Morgan regarding the Bridge Program with a different aspect. Currently, Foundation for Recovery is providing PRSS to some of the hospitals with grant funding coming through one of the Human Services programs. She suggested that Sean O'Donnell would be a good presenter for this issue, as he is also pushing for Medicaid reimbursement for PRSS.

Chair Shell noted that Foundation for Recovery is currently doing a lot of work in the state. During his time with Renown, they relied on a grant from the state to support PRSS in the emergency room, but the funding ran out so they couldn't keep the team in place. He would like to know if there is current funding under the Fund for a Resilient Nevada, or if there is some other source. Ms. Marschall reminded members that Mr. O'Donnell also presented information to this subcommittee on PRSS, prior to their advancing this recommendation in the 2023 report.

Dr. Dickson referenced a bill for PRSS and community health workers with payment through Medicaid eligibility. Ms. Hale offered to look for that information and get back to members. Chair Shell added that commercial payers he is aware of are still not funding PRSS.

Ms. Hale reported that the DHS progress reports to Subcommittees back in May included one from Medicaid that they were initiating a policy revision for PRSS and adding family peer support as an available service. Also, PRSS is now a specific enrollment specialty. An end of year (2024) SPA (State Plan Amendment) submission was to increase reimbursement rates for behavioral health outpatient services that would include PRSS.[5] There is also grant funding for peer support training and certification through recovery services with partners such as Foundation for Recovery. The Bureau of Behavioral Health, Wellness and Prevention is exploring additional opportunities to ensure those with living and lived experience are embedded in the various aspects of program development. The federal funder SAMHSA also encourages organizations to involve individuals with lived experience.

Chair Shell thanked Ms. Hale for this information and would like to hold these four recommendations open for further discussion moving toward the August 2026 SURG Report.

[5] Recent updates from NV Medicaid staff reported development of a new MSM Chapter 4300 for Peer Services specifically. The current minimum age for youth is 18 in policy, but as this service grows, they are hopeful to work with NCB (Nevada Certification Board) to build a Youth Peer Support specialty or possible endorsement. Additionally, NV Medicaid does not have restrictions for peer service delivery, it can be done via in person, telehealth, or audio-only.

6. **Discuss and Draft Proposed 2025 Treatment and Recovery Subcommittee Recommendations**

Chair Shell shared a new recommendation that he submitted, reiterating the need for stable funding due to a high volume of patients who present with substance use and often with co-occurring mental health conditions.

Hospital emergency rooms in Nevada continue to lack evidence-based peer support teams that can provide a vital service to their patients who present with substance misuse. Many of these patients have multiple visits to the ERs due to not being adequately connected to community services for treatment or not having ongoing support to maintain their recovery. Hospitals lack the financial resources necessary to cover the expenses for peer support teams whose services are not reimbursed by most insurance companies. It is recommended that hospitals be incentivized through an expenditure of opioid settlement funds to establish peer support teams in their ERs.

Chair Shell offered additional justifications that the ER teams do their best to evaluate, treat, and connect to community services, but many team members lack the expertise to effectively manage substance misuse and do not have lived experience like PRSS. Evidence shows that connecting with PRSS in the ER leads to better outcomes with navigation to community-based treatment and ongoing support. Financial assistance for the hospitals is needed for the long term.

Dr. Dickson referenced hospital billing methods requiring different coding for different professional classifications. She supported grant funding until PRSS can be integrated into these finance systems. Chair Shell explained that in his experience at Renown, the PRSS reported to nurses or physicians and needed their authorization to meet with ER patients.

Ms. Cheatom reported that the PACT Coalition has worked with Dr. Morgan at Valley Hospital to get PRSS credentialed or badged. They could ask for a presentation on this particular aspect of PRSS integration with emergency services.

Chair Shell thanked Ms. Cheatom for this excellent suggestion for a presentation. He also liked Dr. Dickson's earlier reference to getting a presentation from Pat Kelly, CEO and President, Nevada Hospital Association. Ms. Marschall will follow up to schedule these presentations.

7. **Discuss Upcoming Presentation and Topics**

Ms. Marschall summarized the laundry list from today's discussion. She will send out the SurveyMonkey link for recommendations to all members. The recommendations do not need to be fully developed, but this will initiate SEI staff reaching out for subject matter experts who can present to the subcommittee at future meetings. She reiterated encouragement for all members to submit at least one recommendation, with a suggested cap of five for each subcommittee, reminding members that the annual report due in January will not include recommendations, because those are now due in August beginning in 2026, to explicitly engage the legislature and policymakers for possible BDRs in a timely manner. The upcoming meeting is September 16th, and the next meeting is on November 18th.

Ms. Marschall summarized outreach to potential presenters for the study on opioid fatalities, and also from PRSS on their lived experience perspective. Dr. Dickson felt strongly the need for a presentation from Crossroads related to their detoxification and rehabilitation programs as well as IOPs (Intensive Outpatient Programs), for patients with moderate to no resources. Ms. Marschall cautioned members that presenters should not advocate for funding their specific programs but should promote evidence-based practices in the state. Dr. Dickson supported having them present on the three different MOUD medications and the value of the study referenced above as related to informed consent, recovery specialists, and adopting the same principles from Mr. Hamilton's presentation and referenced by Ms. Cheatom. She recommended talking to Mr. Iverson who is on the Board of Crossroads, and is also a member of this subcommittee, to have him present or recommend someone to present. Chair Shell suggested they could also share any outcome data they might have.

Dr. Kerns highlighted the Southern Nevada Substance Misuse and Opioid Prevention Summit that was held on August 14th. Amanda Haboush-Deloye, PhD from UNLV Institute of Child Research and Policy, and Kristen Clements-Nolle, PhD, MPH from UNR School of Public Health did a presentation on PACES – positive childhood experiences, and they have also done a lot of work with ACES (adverse childhood experiences), which they could present. She also spoke with community health workers (CHW) from one organization working on a program to bring in med students who go out on home visits with CHW, to learn the holistic aspects [of health care work] rather than just looking at the person in front of them. Chair Shell thanked Dr. Kerns for this suggestion.

8. Public Comment

Beth Scott, NV Medicaid, said she appreciates all the recommendations coming out of this committee. She wanted to highlight some things about PRSS, including a 3-year look back period. Medicaid is in current discussions about the qualification for peers and there are some barriers in the current MSM (Medicaid State Manual) Chapter 100, that impact PRSS enrollment, so their service is being reimbursed through Medicaid funds. Provider enrollment oversees that chapter and it may be worth engaging in discussion on that policy language. The behavioral health policy team has talked with them about it, and it may take legislation to get it changed.

Regarding recommendation #3 on access and linkage for trauma, Ms. Scott oversees substance use policy in Nevada, on the behavioral health benefits team, and they have supported this recommendation by allowing mental health treatment in a Substance Use Disorder Clinic. Effectively, this supports access for family members who may benefit, beyond any limitation to those with recurring disorders.

They welcome any feedback SURG members may have as well. When they talk about peers in emergency room, just to reiterate, – Dr. Morgan spoke at the Summit last week, with PACT Coalition and engaged participants, referencing a lot of work around crisis teams which includes peers. People can go to the Medicaid website and review presentations given and/or coming up related to PRSS.

Chair Shell thanked Ms. Scott.

9. Adjournment.
Chair Shell adjourned the meeting at 4:28 p.m.

Chat File

00:25:20 Heather Goulding:Kelly, can you put a link to that study in the chat?
00:26:35 Laura Hale: We try to avoid using chat because not everyone has access. We will include the link in the meeting notes and can also send to members via email.
00:26:50 Heather Goulding:Reacted to "We try to avoid usin..." with [a thumbs up emoji]
01:11:49 Jennifer: There is a new Medicaid Chapter 4300 that covers Peer Support Services. *Certified Peer Support Specialists are identified as providing Adult Peer Support Services.