OFFICE OF THE ATTORNEY GENERAL
AARON D. FORD, *ATTORNEY GENERAL*

100 NORTH CARSON STREET
CARSON CITY, NV 89701

WEB – HTTP://AG.NV.GOV

TELEPHONE – (775) 684-1100
FAX – (775) 684-1108

SUBSTANCE USE RESPONSE WORKING GROUP

NOVEMBER 16, 2026

1. CALL TO ORDER AND ROLL CALL TO ESTABLISH QUORUM

Attorney General Aaron Ford, Substance Use Response Working Group Chair

2. PUBLIC COMMENT

(Information Only)

PUBLIC COMMENT

Public comment shall be limited to three (3) minutes per person. We will begin with comments from Las Vegas and then invite comments from Carson City, followed by virtual participants.

No action may be taken upon a matter raised during a period devoted to comments by the general public until the matter itself has been specifically included on an agenda as an item upon which action may be taken pursuant to NRS 241.021.

IN PERSON

Please form a line.

Before commenting, please state your full name for the record.

PUBLIC COMMENT

ATTENDING VIRTUALLY/BY PHONE

If you are dialing in from a telephone:

- Dial 917-809-8575
- When prompted, enter the Conference ID: 616 314 117#
- Wait to be connected; do not identify yourself as an organizer
- **Use your keypad during the meeting:**
  - ***5** to raise or lower your hand and then ***6** to mute or unmute

If you are joining virtually with computer audio, please use the "raise hand" feature to indicate you would like to provide public comment so the host can prompt you to unmute.

Before commenting, please state your full name for the record.

Members of the public are requested to refrain from commenting outside the designated public comment periods, unless specifically called upon by the Chair.

The chat is disabled during the meeting. For technical difficulties, please notify Vicki Beavers, Executive Assistant to the Attorney General at (775) 684-1212 or by email at *vbeavers@ag.nv.gov.*

**Comments can also be emailed to mdelgiudice@socialent.com. These comments and questions will be recorded in meeting minutes.*

3. REVIEW AND APPROVE MINUTES FROM JULY 8, 2026 SURG MEETING

(Possible Action)

Chair Ford

4. UPDATE ON OPIOID LITIGATION, SETTLEMENT FUNDS, AND DISTRIBUTION

(Information and Discussion)

Mark Krueger, Chief Deputy Attorney General, Office of the Attorney General

5. PRESENTATION ON OPEN MEETING LAW AND CONFLICTS OF INTEREST DISCLOSURE

(Information and Discussion)

Rosalie Bordelove, Deputy Attorney General, Office of the Attorney General



NEVADA'S OPEN MEETING LAW

Rosalie Bordelove

Chief Deputy Attorney General

Nevada Attorney General's Office

1

What is the Open Meeting Law?

2

When does the OML apply?

3

How do I comply with the OML?

4

What happens when the OML is violated?

5

2025 Updates

What is the Open Meeting Law (OML)?



- NRS Chapter 241
- "In enacting this chapter, the Legislature finds and declares that all public bodies exist to aid in the conduct of the people's business. It is the intent of the law that their actions be taken openly and that their deliberations be conducted openly."NRS 241.010(1).

When does the OML apply?

PUBLIC BODY

- The OML generally applies to all meetings of public bodies in the State of Nevada.
  - Includes subcommittees, regardless of name
  - Exceptions are strictly construed
  - Definition contained in NRS 241.015(5)
  - Legislature of the State of Nevada is exempt from the OML

MEETING

- Under the OML, a "meeting" requires a **Quorum + Deliberation *or* Action**
- Quorum means a simple majority of the total body or other proportion established by law.
- Deliberate means collectively to examine, weigh and reflect upon the reasons for or against an action.
- Action means a majority vote of the members present (all members for elected bodies).

When does the OML apply?

- A gathering of a quorum at a social or professional function or for training is *not* a meeting *as long as* there is no deliberation or action.
- Exception: Attorney client conference regarding legal advice, can include deliberation, so long as the deliberation is limited to the legal advice.
- Electronic communication between a quorum of members can constitute a meeting.
  - Email pitfall: "reply all"
- Serial communications or "walking quorums" constitute a constructive meeting.
  - A constructive quorum can exist with less than a quorum speaking together at any given time if opinions are relayed between members.



How do I comply with the OML?

Meeting Notice and Agenda

- Must include:
  - Time, place and location (or information on remote technology system)
  - Name, contact and business address for supporting material, plus location (physical or electronic)
  - Clear and complete statements of topics
  - Action items denoted as “for possible action”
  - Public comment periods and restrictions
- Requirements can be found in NRS 241.020

- Agenda posting requirements:
  - Office of the public body or location of meeting
  - Public body website
  - Nevada notice website
- Posted no later than 9 AM of the 3rd working day before the meeting.
- Notice must be sent to persons who have requested notice of meetings.

Additional Meeting Requirements

- Public bodies shall make reasonable efforts to assist and accommodate persons with physical disabilities desiring to attend.
- Additional notice required for consideration of a person's character, misconduct or competence or to take administrative action against a person.
- Meetings must be recorded or transcribed.
- Minutes must be kept in conformance with NRS 241.035.
- Supporting material is required to be available to the public at the time it is provided to members of the public body.
- An emergency meeting may only be called where the need to act upon a matter is truly unforeseen and circumstances dictate that immediate action is required.

Public Comment

- Minimum requirement:
  - Two options—general or limited to agenda items prior to any action item *or* on each action item after discussion, but prior to vote
  - General public comment period at some time prior to adjournment
- Restrictions must be reasonable time, place, and manner restrictions. NRS 241.020(3)(d)(3).
- The OML does not "[p]revent the removal of any person who willfully disrupts a meeting to the extent that its orderly conduct is made impractical."
- New in 2025: Remote options are only required for public comment where there is no physical location available to the public.



Other Meeting Considerations

CLOSED SESSIONS

- Closed sessions may be held by a public body to consider the character, alleged misconduct, professional competence or physical or mental health of a person. NRS 241.030
  - May also be held to grade examinations.
- Exceptions:
  - Appointment of a member to the public body
  - Consider the chief officer of the body/agency
- Action must still occur during a public meeting.

VIRTUAL ATTENDANCE

- Additional requirements where there is no physical location available for public to attend and participate
- Public must be able to hear and observe to the same level as members
  - Pit-fall: chat function in remote technology system

What happens when the OML is violated?



- Actions taken in violation of the OML are void.
- Attorney General's Office has authority to investigate and prosecute violations.
- Corrective action is recommended and while it may not eliminate the violation, it can mitigate severity and further ensure that the business of government is accomplished in the open.
  - Prospective only
  - Requires independent deliberative process

2025 Updates

- Attorney-client exception is no longer limited to advice regarding potential or existing litigation.
- Physical location requirements for meetings to adjudicate contested cases or consider regulations are clarified in application.
- No longer have to read phone number and instructions for public comment when there is a physical location for the meeting.
- Clarification that the OML does not provide protection for defamation during public comment.

LINKS

- https://ag.nv.gov/Hot_Topics/Training_Materials/
- https://ag.nv.gov/About/Governmental_Affairs/OML_Opinions/
- https://ag.nv.gov/uploadedFiles/agnvgov/Content/About/Governmental_Affairs/2019-03-26_OML_12TH_AGOMANUAL.pdf



6. BILL DRAFT REQUEST (BDR) UPDATES RELATED TO SURG RECOMMENDATIONS

(Information and Discussion)

Michael Morton, Special Assistant Attorney General,
Office of the Attorney General

INTRODUCTION

- The 84th Session of the Nevada Legislature begins on February 1, 2027.
- The Attorney General's Office is sponsoring 20 pieces of legislation in the upcoming session.
- SURG: BDR 40-552

BDR 40-552
ATTORNEY GENERAL'S OFFICE

- Double the annual state investment in primary opioid misuse prevention to protect prevention infrastructure via a general fund line item committed to BBHWP's prevention programming for people aged 0-24. Monies should be directed to local agencies that prioritize evidence-based programming. This funding should not be at the expense of existing programming, should be the State's contribution to prevention efforts, and should not be supplanted by federal or other grant dollars.

BDR 40-552

- After discussion with LCB and the Prevention Subcommittee, the bill will require the Governor to include such funding in his proposed Executive Budget beginning in FY30.

BDR 39-422
WASHOE REGIONAL BEHAVIORAL HEALTH POLICY BOARD

- Proposes to increase and/or restructure the current $0.35 telecommunications surcharge pursuant to NRS 433.708 to provide more sustainable funding for Nevada's Crisis Response Account, which supports 988, mobile crisis teams, and crisis stabilization services.
- The current surcharge generates about $15 million annually, while program expenditures exceed $20 million per year, and reserves are projected to be depleted by SFY 2029.

BDR 38-526
SOUTHERN REGIONAL BEHAVIORAL HEALTH POLICY BOARD

- Create a pilot program and study for Non-Emergency Secure Behavioral Health Transportation (NESBHT) services in Mineral, Esmeralda, Nye, and Lincoln Counties, including Tribal communities, beginning July 1, 2027.
- Directs state health agencies to assess transportation needs, service models, regulatory barriers, and best practices while testing solutions to improve access to behavioral health treatment. It also requires Medicaid to pursue reimbursement for "empty miles" and increase NESBHT reimbursement rates by at least 15% in the pilot area.
- The goal is to expand safe, sustainable transportation options for behavioral health patients, reduce reliance on law enforcement and emergency medical services, and provide recommendations for future statewide expansion.

BDR 39-495
NORTHERN REGIONAL BEHAVIORAL HEALTH POLICY BOARD

- Allow Marriage and Family Therapists (MFTs) and Clinical Professional Counselors (CPCs) to de-certify mental health crisis holds (MHCHs)
- **Context**: This will allow more mental health providers to be added to the toolbox to de-certify holds more efficiently when people are safety planned and ready to go home. Furthermore, this will continue to bring MFTs and CPCs up to parity with Licensed Clinical Social Workers (LCSWs) in Nevada.

BDR 39-495

- Clarify the definition of a person in a mental health crisis (NRS 433A.0175) to ensure that anyone who is presenting substantial likelihood of serious harm to himself or herself or others **CAN** be put on a MHCH despite any diagnoses including epilepsy, intellectual disability, dementia, delirium, brief periods of intoxication caused by alcohol or drugs, or dependence upon or addiction to alcohol or other substances.
- **Context**: As NRS 433A.075 is currently written, it is being misinterpreted across various professions. Some people see the diagnoses listed above and are hesitant to put people on a MHCH even when they are expressing suicidality or homicidality. We are proposing language to clarify that none of these diagnoses will preclude someone from being put on a hold if they are at imminent risk to themselves or others.

BDR 34-524
RURAL REGIONAL BEHAVIORAL HEALTH POLICY BOARD

- Require all school district-sponsored coaches and support staff who are not currently required to do so, to complete evidence-based youth suicide awareness and prevention training
- Ensure youth suicide prevention training completed by teachers and other staff is evidence-based, and removing grades 7-12 restrictions
- Require the inclusion of behavioral health considerations in all school district Emergency Operations Plans (EOPs).

BDR 57-407
JOINT INTERIM STANDING COMMITTEE ON HEALTH AND HUMAN SERVICES

- Eliminates prior authorizations needed for starting medication assisted therapy with buprenorphine and buprenorphine products of all types for opioid use disorder.
- This would apply to all payors, including Medicaid managed care organizations.
- The Committee sponsored this bill from a recommendation from the SURG Treatment and Recovery Subcommittee.

AB23
JOINT INTERIM STANDING COMMITTEE ON HEALTH AND HUMAN SERVICES

- Currently, NRS 62E.620 requires a juvenile court to order a delinquent child to undergo an evaluation for an alcohol or substance use disorder if the child committed a crime involving alcohol or a controlled substance.
- Currently, the evaluation must be conducted by an alcohol or drug counselor or a physician.
- This bill would authorize a licensed clinical social worker to conduct such an evaluation.

LEGISLATIVE LOGISTICS

- The bills discussed above will become public no later than November 18, 2026.
- Will need SURG member support for BDR 40-552.
- Can track other substance use/opioid legislation and update SURG as requested.

CONTACT INFORMATION

Name	Michael K. Morton
Title	Special Assistant Attorney General
Phone	775-687-2110
Email	mkmorton@ag.nv.gov

7. PRESENTATION ON SUBSTANCE USE MORBIDITY AND MORTALITY

(Information and Discussion)

Jhoeren Andrion, Senior Health Resource Analyst, Office of Analytics, Nevada Health Authority

NEVADA HEALTH AUTHORITY

Overview of Substance Use Trends in Nevada 2016-2025

Jhoeren Andrion, MPH

Office Of Analytics, Behavioral Health Unit

Agenda

1	Overview of Nevada's Population Growth in the Last Decade
2	Substance Use Trends
3	Dashboards and Other NVHA Data
4	Questions

NEVADA HEALTH AUTHORITY

Population Growth Context

- Population grew 2.90M in 2016 to 3.3M in 2025
- 13.7% increase over the decade
- Sets the context for interpreting absolute trends in substance use

NEVADA HEALTH AUTHORITY

Key Takeaway: *More Nevadans means more potential burden, even when the rate stays flat.*

History of Opioids

- **Wave 1 (1990s):** Overdose deaths shift from street drugs to prescription opioids
- **Wave 2 (2010):** Tighter prescription oversight drives a rise in heroin-related deaths
- **Wave 3 (2013–present):** Synthetic opioids (fentanyl, fentanyl analogs/IMFs) become the leading cause of overdose deaths in the U.S.

Response

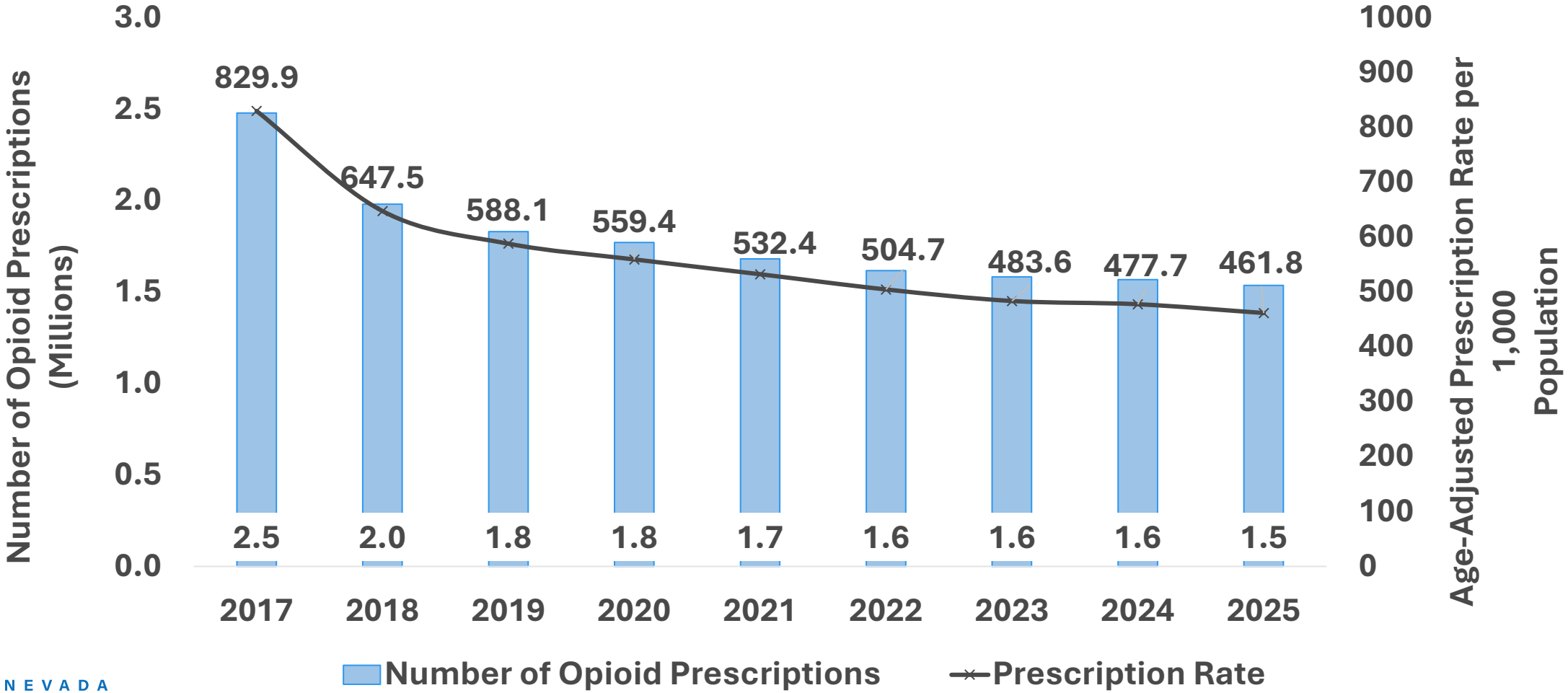
1. Assembly Bill 474 revised NRS 453.226 in 2017
2. Prescription Drug Monitoring Program (PDMP)
3. CDC's Overdose Data to Action (OD2A) > State Unintentional Drug Overdose Reporting System (SUDORS), Drug Overdose Surveillance and Epidemiology (DOSE)

NEVADA HEALTH AUTHORITY

***Key Takeaway**: The U.S. opioid crisis has unfolded in three waves, from prescription opioids to heroin to synthetic fentanyl, and Nevada has responded with stronger prescribing laws, prescription monitoring, and CDC-funded overdose surveillance.*

Opioid Prescriptions vs Harm

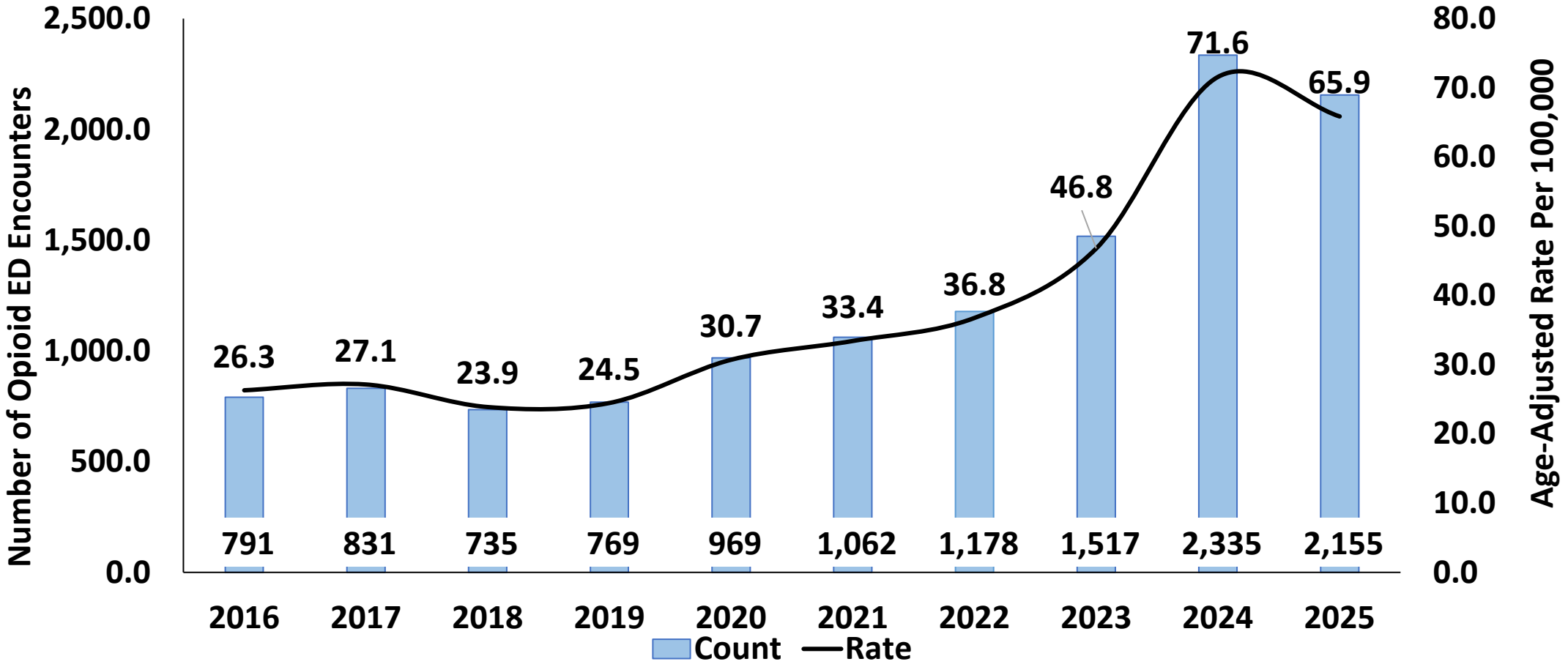
- Since 2017 opioid prescription rates dropped from 830 to 462 per 1,000 Nevadans in 2025



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Opioid Emergency Department Encounters

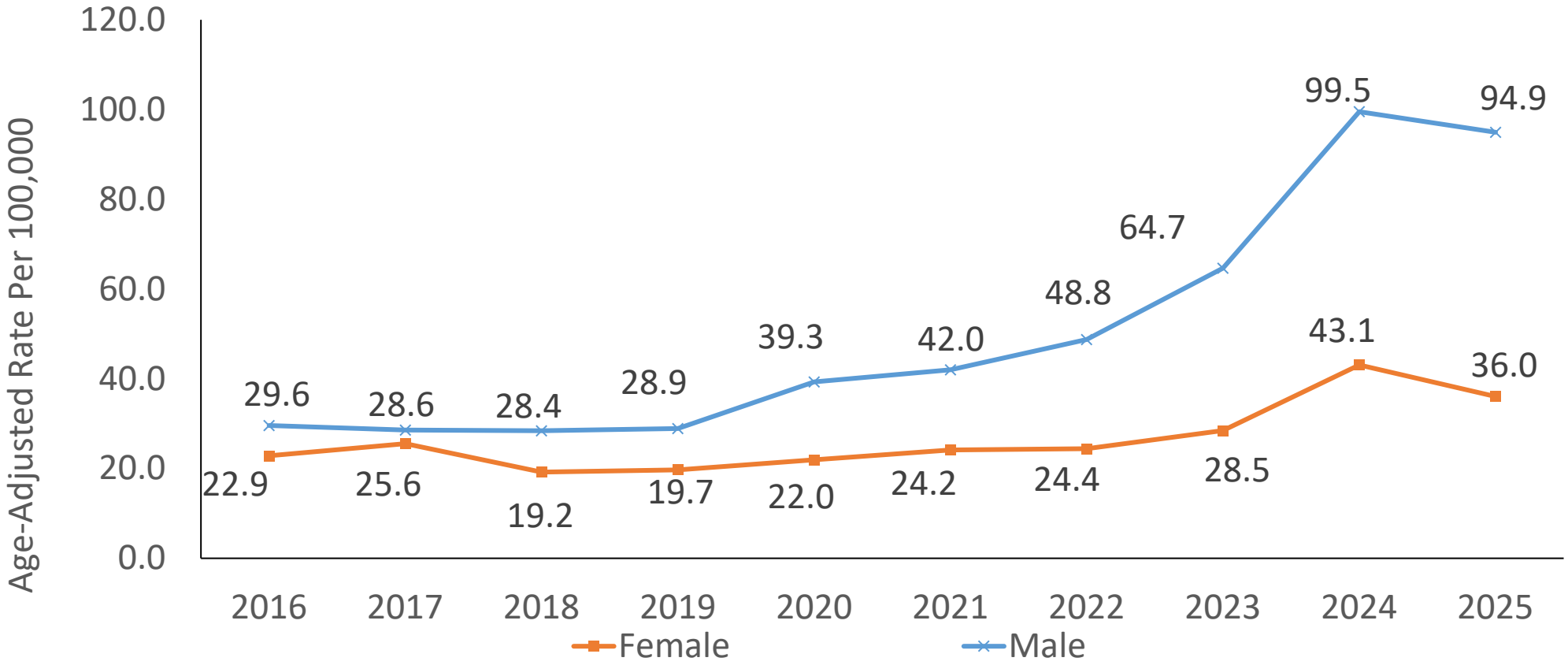
- Since 2016 ED encounters increased from 26 to 66 per 100,000 Nevadans in 2025



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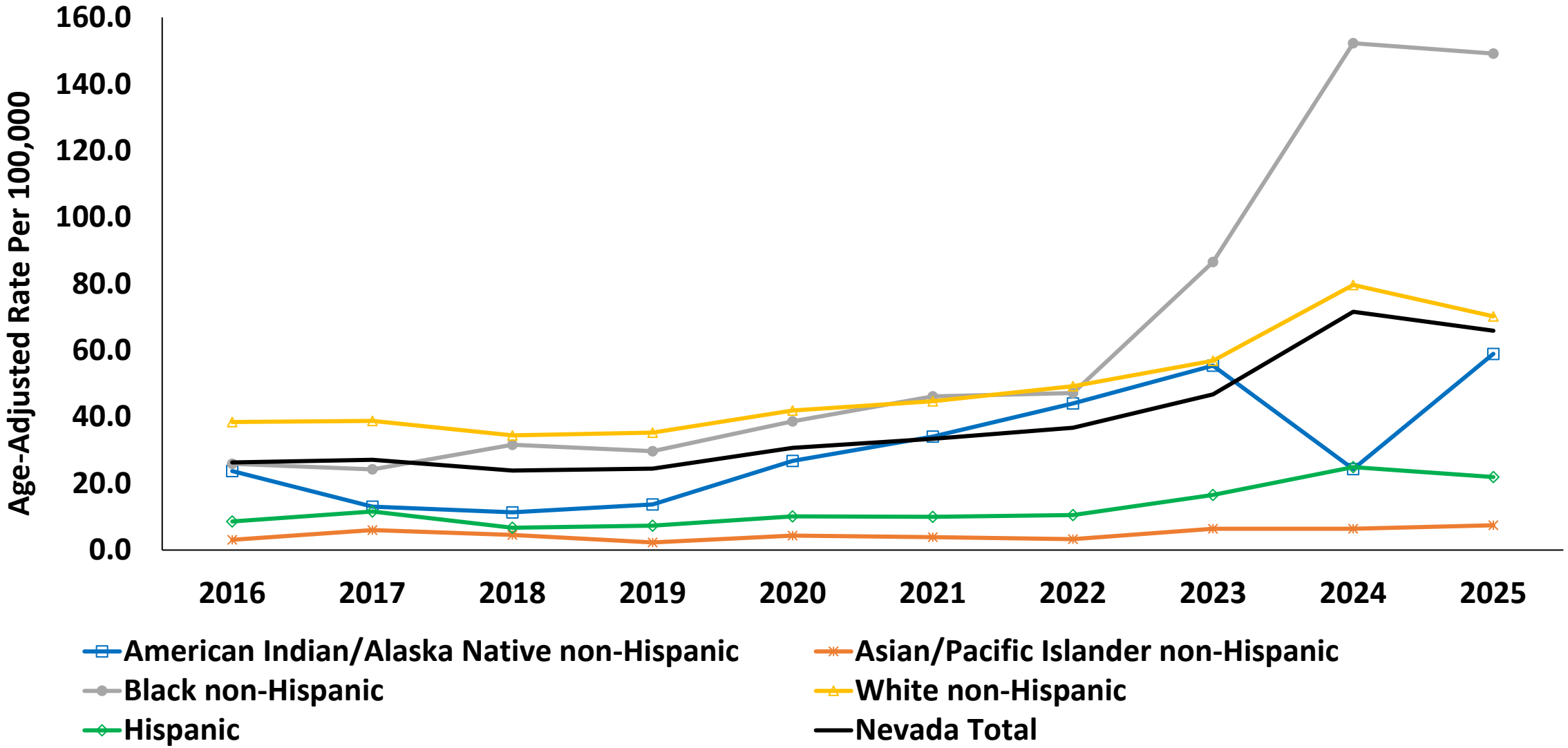
Opioid ED Encounter Rates by Sex

- Opioid-related ED rate has more than tripled among men since 2019



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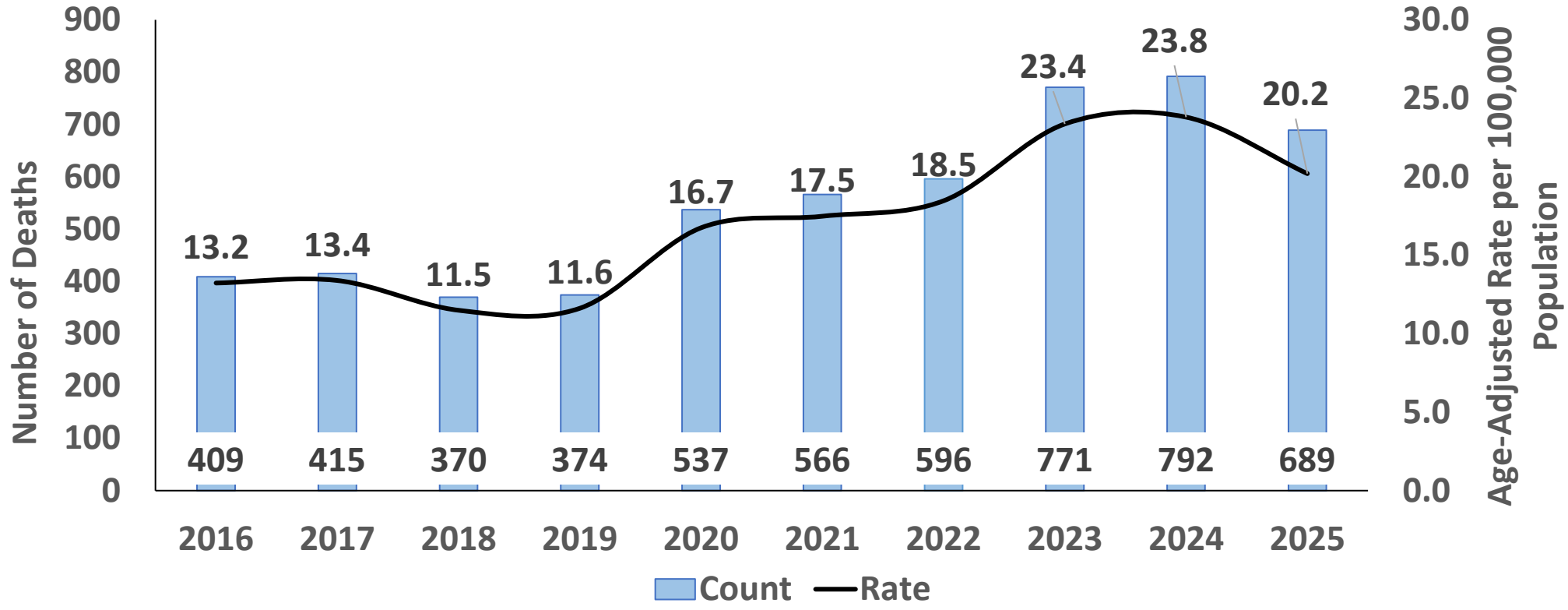
Opioid ED Encounter Rates Race/Ethnicity



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Opioid Deaths

- Opioid deaths more than doubled between 2018 and 2024 (370 to 792) then fell 13% in 2025 (689).



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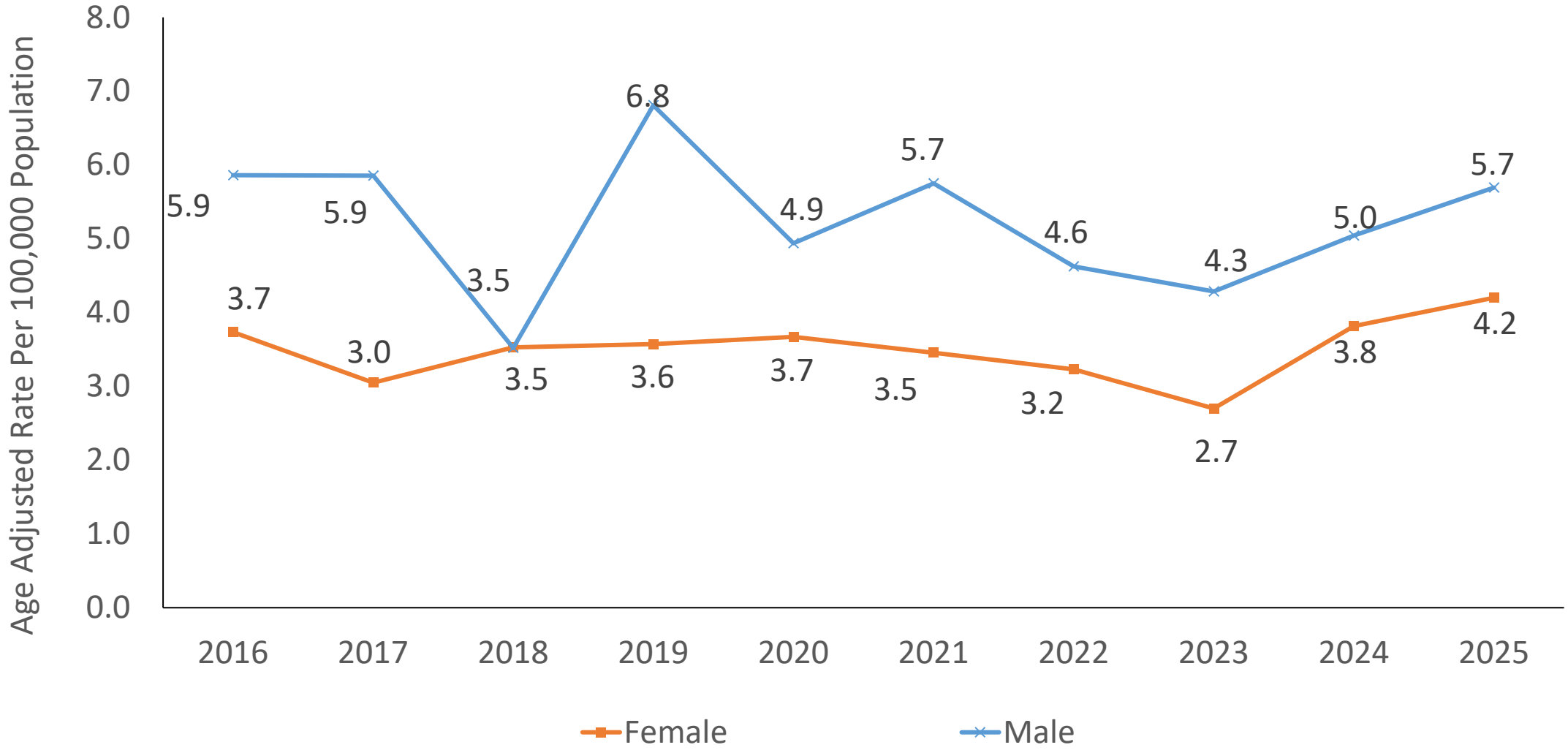
***Key Takeaway**: After years of increases, opioids deaths fell in 2025. Whether that reflects prevention efforts, a changing drug supply, or both it the question we turn to next.*

Stimulants

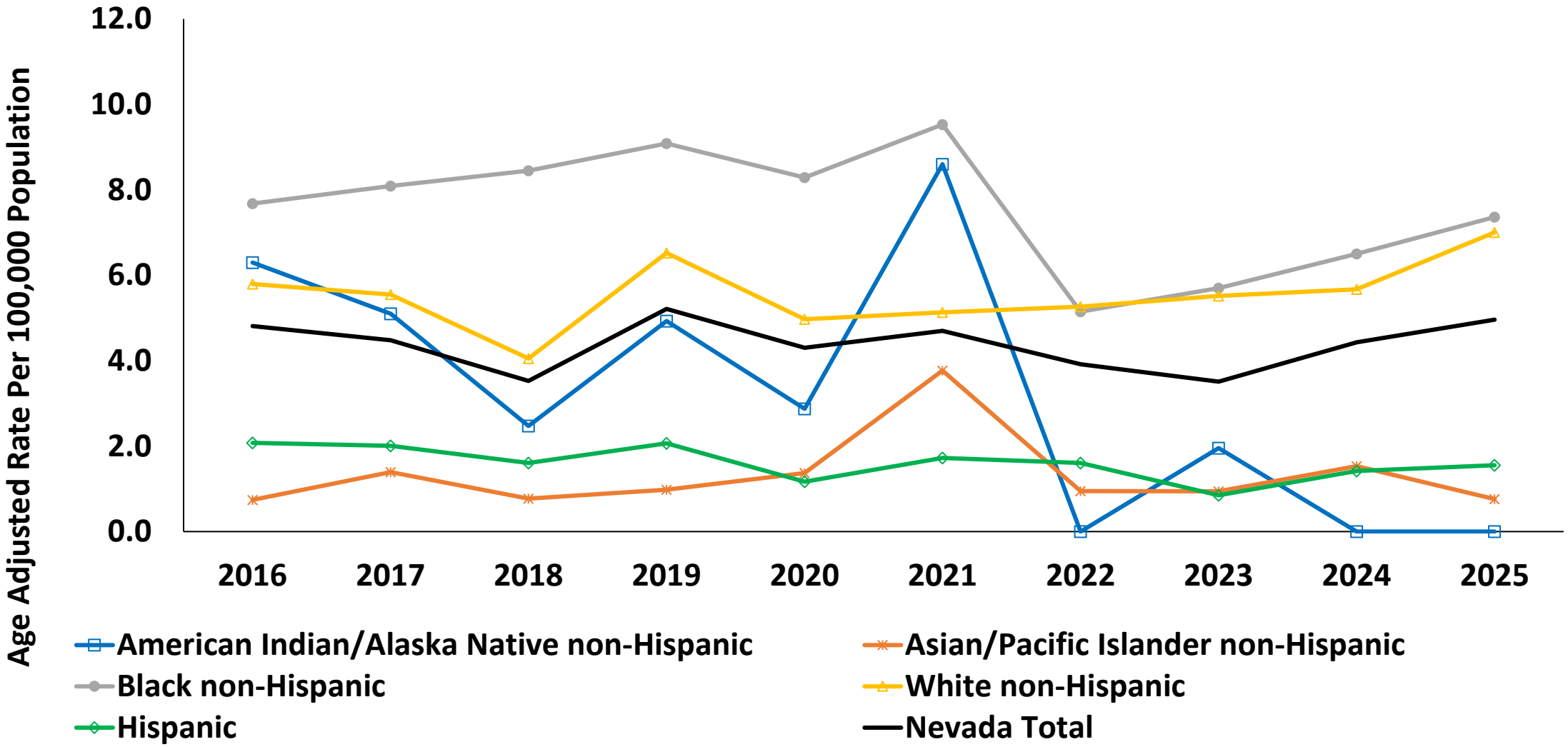
- Stimulants are a class of drugs that speed up activity in the central nervous system. They increase alertness, energy, heart rate, blood pressure, and breathing, mainly by boosting brain chemicals like dopamine and norepinephrine.
- **Illicit:** methamphetamine, cocaine (including crack)
- **Prescription:** amphetamines (Adderall), methylphenidate (Ritalin), used for ADHD and narcolepsy
- **Everyday/legal:** caffeine, nicotine

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Stimulant ED Encounters by Sex



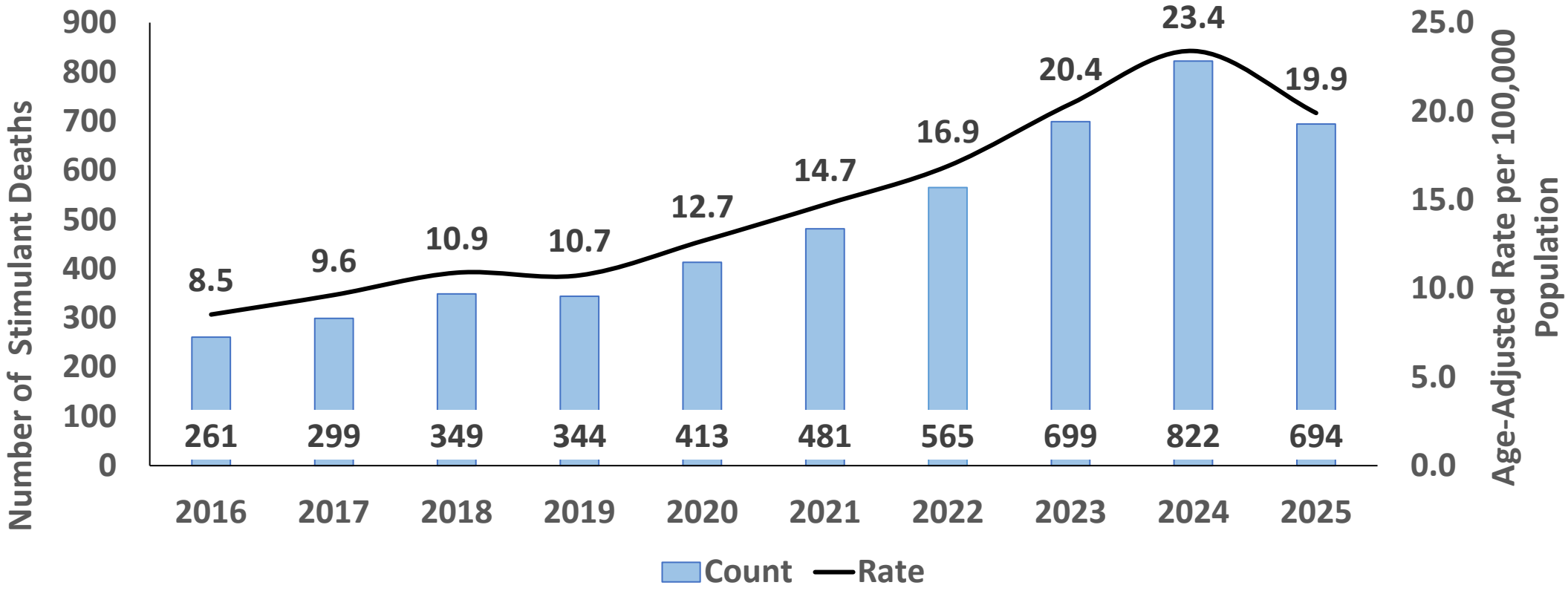
Stimulant ED Encounters by Race/Ethnicity



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Stimulant Deaths

- The stimulant death rate has increased 134% since 2016



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***Key Takeaway**: In 2024 and 2025, stimulant-involved deaths slightly exceeded opioid involved deaths (822 vs 792, then 694 versus 689). Like opioids 2025 shows a decline of about 15%*

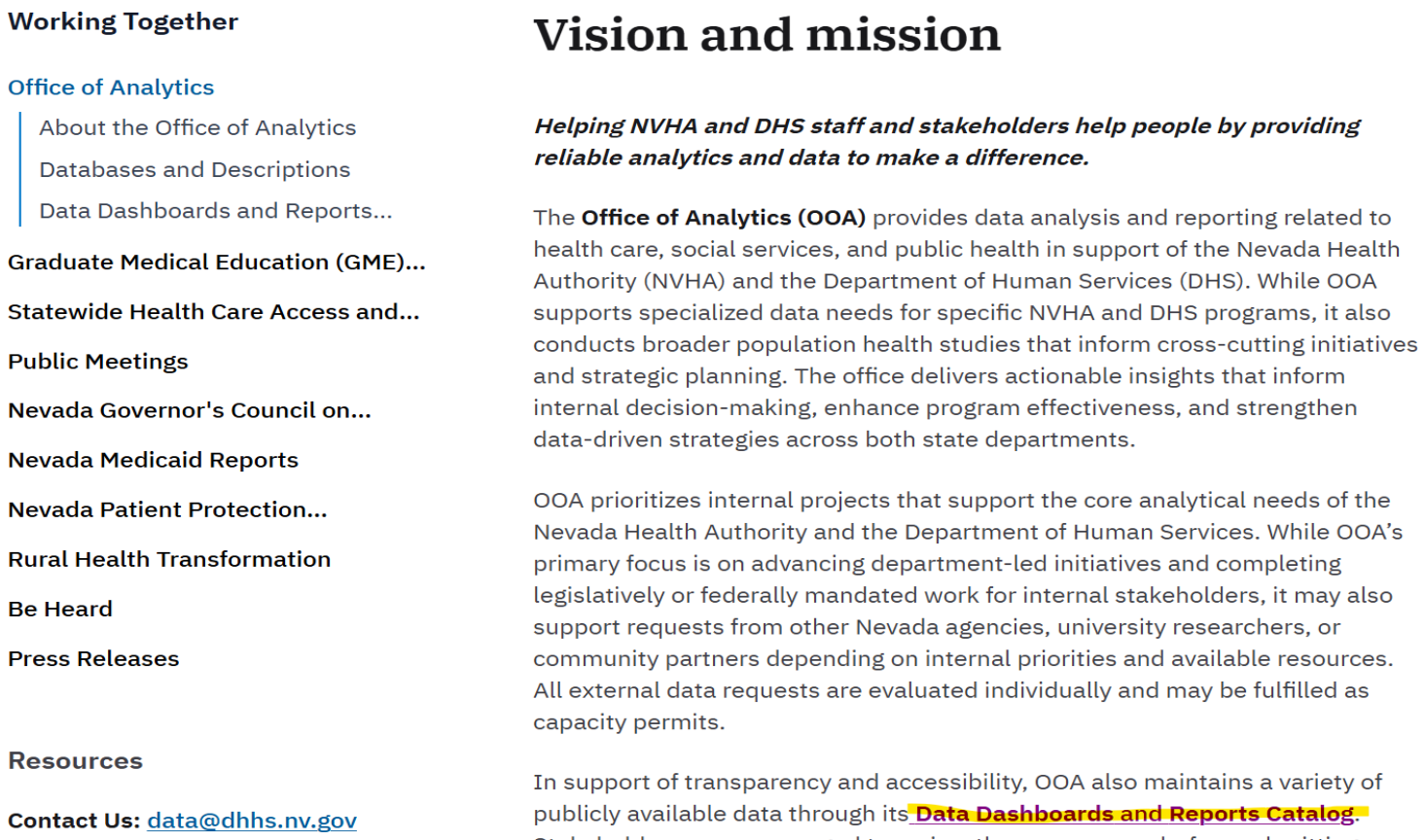
Summary

- Primarily Male, Black Non-Hispanic in Opioid & Stimulant ED Encounters.
- Both Opioid and Stimulant Deaths have been increasing over time, both declining in 2025.
- What could be the cause?

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Office of Analytics Home Page

- https://www.nvha.nv.gov/working-together/office-of-analytics/



Working Together

Office of Analytics

- About the Office of Analytics
- Databases and Descriptions
- Data Dashboards and Reports...

Graduate Medical Education (GME)...

Statewide Health Care Access and...

Public Meetings

Nevada Governor's Council on...

Nevada Medicaid Reports

Nevada Patient Protection...

Rural Health Transformation

Be Heard

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Resources

Contact Us: data@dhhs.nv.gov

Vision and mission

Helping NVHA and DHS staff and stakeholders help people by providing reliable analytics and data to make a difference.

The **Office of Analytics (OOA)** provides data analysis and reporting related to health care, social services, and public health in support of the Nevada Health Authority (NVHA) and the Department of Human Services (DHS). While OOA supports specialized data needs for specific NVHA and DHS programs, it also conducts broader population health studies that inform cross-cutting initiatives and strategic planning. The office delivers actionable insights that inform internal decision-making, enhance program effectiveness, and strengthen data-driven strategies across both state departments.

OOA prioritizes internal projects that support the core analytical needs of the Nevada Health Authority and the Department of Human Services. While OOA's primary focus is on advancing department-led initiatives and completing legislatively or federally mandated work for internal stakeholders, it may also support requests from other Nevada agencies, university researchers, or community partners depending on internal priorities and available resources. All external data requests are evaluated individually and may be fulfilled as capacity permits.

In support of transparency and accessibility, OOA also maintains a variety of publicly available data through its **Data Dashboards and Reports Catalog**. Stakeholders are encouraged to review these resources before submitting a

NEVADA HEALTH AUTHORITY

Data Dashboards and Reports

Reports present detailed data analysis, findings, and context over a specific period and/or topic. They are a structured document (typically a PDF), and include narrative, tables, charts, and appendices, and can occasionally include recommendations. They are used by analysts, stakeholders, and researchers, and reports are generally required by oversight bodies, such as the Nevada Legislature, another Nevada Public Body, a federal agency, a court, or the Nevada Governor's Office.

Behavioral Health

Children and Families

Community Health

Health Care Coverage and Costs

Infectious Diseases

Mortality

Nevada Population Demographics Dashboard

Social Services

Behavioral Health in Nevada: Data That Drives Action

Behavioral health is a vital component of overall well-being, and the Nevada Health Authority is committed to addressing the complex challenges our communities face. This section provides access to reports on key behavioral health topics, including substance use, overdose trends, suicide, and mental health indicators. These data help inform prevention efforts, guide resource allocation, and support the development of effective, evidence-based programs aimed at improving the lives of individuals and families across Nevada.

Dashboards	Reports
Adult Behavioral Health Services Dashboard	Behavioral Health Epidemiologic Profile 2024: Clark County .PDF
Behavioral Risk Factor Surveillance System (BRFSS) Dashboard	Behavioral Health Epidemiologic Profile 2024: Nevada .PDF

NEVADA HEALTH AUTHORITY

Thank You for Your Participation!

Learn More & Stay Involved

Website:
https://www.nvha.nv.gov/working-together/office-of-analytics/

Contact Us

Office Of Analytics
Behavioral Health Unit
j.andrion@nvha.nv.gov
zrees@nvha.nv.gov
data@dhhs.nv.gov

For accommodations or translated materials, please contact us at the information above.

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8. PRESENTATION ON THE PRIORITIZATION OF FUND FOR A RESILIENT NEVADA (FRN) RECOMMENDATIONS

(Information and Discussion)

Heather Kerwin, MPH, CPH, Opioid & Infectious Disease Epidemiologist, Contractor, Office of State Epidemiology, Division of Public and Behavioral Health (DPBH)

Joe Lombardo
Governor

Laura Rich
Director

Nevada Opioid Assessment

Results of Ranked Recommendations for Addressing Opioid Settlement Goals

Heather Kerwin, MPH, CPH
Opioid & Infectious Disease Epidemiologist

November 2026

Department of Human Services

Helping people. It's who we are and what we do.

Today's Presentation

1. Results from the ACRN and SURG survey for ranking recommendations for each Goal (see handout)
2. Alignment and gaps with community feedback (survey priorities identified and focus groups plus key informant interviews/qualitative data)
   a) Provides the top priorities for each goal, as identified through ~350+ survey respondents (each goal had different number of survey respondents who opted to select a top a priority)
   b) Includes community feedback from focus groups and key informants

Recommendation Ranking Survey

- ACRN and SURG members were requested to rank recommendations within each of the goal areas
- The recommendations originated from the (already ranked) list of recommendations from each of the SURG Subcommittees as well as the recommendations put forth by ACRN Subcommittees (not yet ranked)
- Opioid-related SURG recommendations were sorted into one of the 7 FRN goals
- Both ACRN and SURG recommendation reports are provided in full
  - ACRN 2026 Biennial Report
  - SURG 2026 Annual Report

ACRN and SURG Member Respondents

- ACRN respondents
  - 13 ACRN of 17 ACRN Committee member positions were filled at the time of the survey
  - 11 of the 13 ACRN members responded, 1 member started the survey, but only filled out their name and did not rank any of the recommendations
- SURG respondents
  - 23 SURG Committee members at the time of the survey
  - 14 SURG members responded, 1 member started the survey, but only filled out their name and did not rank any of the recommendations
- Overall recommendation rankings based on combined responses (ACRN n = 11; SURG n = 14)

Overview of Alignment & Gaps in ACRN & SURG Ranked Recommendations

- Goal 1 is widely supported, specifically for PRSS
- Goal 2 is widely supported, but lacking a cohesive youth prevention plan
- Goal 3 largely focused on naloxone and 988 Crisis Response
- Goal 4 needs to ensure all providers have stigma awareness, harm reduction (as a way to approach people), and MOUD referral systems or training
- Goals 5 & 6 both have major gaps
  - Goal 5 – does not directly address housing and other basic needs which may have gone unmet for a long period of time, lacking recommendations to support community spaces to engage with people without focusing on sobriety, or family reunification
  - Goal 6 – no plan for diversion program capacity, lacking mental health supports for law enforcement/judicial staff

Goal 1 Workforce Development & Implementation of Recommendations

This goal aims to **increase workforce development and capacity for programs that equip both the future and current workforce with the skills, knowledge, and expertise across the continuum of care**.

This also includes **strategic thinking, visioning, action planning, and implementation** to create proactive systems with a positive impact on Nevada's communities.

Goal 1: Workforce Development & Capacity

What Nevadans Identified as Top 3 Priorities for G1 (Survey):

1. Expand peer recovery support specialists (PRSS) & community health workers
2. Increase evidence-informed training & technical assistance
3. Reduce stigma in workplaces and service systems

What Communities Said (Qualitative Findings):

- Workforce is dedicated but stretched thin across all sectors
- PWLE stressed the need for respectful, non-judgmental care
- Rural areas face more severe provider shortages
- Stigma in healthcare and emergency response remains a major barrier

(G1) Priority 1: Peer Recovery Support Specialists

Where Recommendations Align:

- Peers integrated into screening, referral, and treatment teams
- Need to remove barriers to hiring and sustaining PRSS roles
- Peers help families navigate complex systems
- Stigma reduction supports better use of peer services

What Communities Added:

- PWLE value peers because they provide trust, consistency, and no judgment
- Peers help bridge gaps when relationships with professionals break down
- Consider PRSS beyond hospitals, consider schools, shelters, EMS, courts, housing navigation

Gaps:

- No statewide plan for PRSS career pathways or long-term stability
- Limited strategies for peer integration outside healthcare settings

(G1) Priorities 2 and 3: Training, Technical Assistance & Stigma Reduction

Where Recommendations Align:

- Expand Project ECHO and similar models
- More clinical training on MOUD, chronic conditions, and special populations
- Stigma-reduction efforts embedded in healthcare
- Need for culturally responsive and trauma-informed training

What Communities Added:

- Many providers lack training on addiction as a chronic disease
- PWLE report painful experiences due to stigma and misunderstanding
- Training must extend beyond clinics to law enforcement, employers, and schools

Gaps:

- No statewide approach to stigma training for workplaces
- Community sectors outside healthcare have limited access to evidence-informed training

Goal 2 Prevent the Misuse of Opioids

This goal includes prevention across all levels from general public to prevention of negative outcomes among those using opioids.

Activities implemented should consider differential impacts and accessibility limitations, resulting in health disparities (e.g. cultural, linguistic, and environmental considerations). Detailed data collection, selection of appropriate interventions, and involvement of impacted community members in planning and implementation are essential for ensuring health equity across prevention efforts.

Goal 2: Prevent the Misuse of Opioids

What Nevadans Identified as Top 6 Priorities for G2 (Survey):

1. Mental health and emotional regulation education
2. School-based and out-of-school youth prevention programming
3. Public awareness and stigma-reduction
4. Education on risks of opioids/substances
5. Using data to guide prevention
6. Provider training on opioid prescribing and treatment

What Communities Said (Qualitative Findings):

- Prevention is inconsistent, not standardized, and often outdated
- Youth learn more from social media than from adults
- Early initiation of use (often before age 13) is common among PWLE
- Parents lack support and tools to talk openly about substances
- Youth mental health needs (anxiety, depression, trauma) are rising
- Community education is limited, especially for adults

(G2) Priority 1 : Mental Health Education

Mental Health & Emotional Regulation Alignments:

- Prevention programs should be culturally responsive and developmentally appropriate
- Messaging should engage youth and families through modern channels
- Family communication and coping skills are essential
- Supportive relationships and mentorship build resilience

What Communities Said:

- Youth experience high anxiety, depression, trauma
- They turn to TikTok/Instagram for information, not adults
- Many lacked stable adult role models; PCEs matter
- Mentorship and structured activities protect against early use

Gaps:

- No statewide mental health or social-emotional learning curriculum
- Prevention is usually a one-off class or delivered inconsistently
- Parents lack support and education on how to talk openly about substance use

(G2) Priority 2: Youth Prevention Programming

School-Based & Out-of-School Prevention Alignments:

- Schools need prevention specialists and screening systems
- Youth-tailored messaging is needed
- Investment in early prevention (ages 0–24) is strongly supported

What Communities Said:

- Prevention depends on individual teachers or outside coalitions, sometimes law enforcement are providing the education in K-12 settings
- Youth with unstable households need mentors and early identification
- Outdated or abstinence-only programs don't resonate with youth

Gaps:

- No opioid-specific or standardized prevention curriculum
- Department of Education guidance is broad and lacks defined content expectations

(G2) Priority 3: Public Awareness

Public Awareness & Stigma Reduction Alignments:

- Messaging must reach youth and families through accessible channels
- Communication should address real-life substance use dynamics
- Promote positive childhood experiences (PCEs) and supportive environments
- Provide simple education on safe disposal and overdose risk

What Communities Said:

- Youth receive misinformation online
- Parents feel unprepared and sometimes deliver mixed messages
- Trauma, lack of role models, and inconsistent parenting worsen risk
- Adults outside the justice system have almost no access to education

Gaps:

- No employer-focused or system-wide stigma reduction strategy

(G2) Priority 4: Education on Risks

Prevention Education on Risks Alignments:

- Expand youth/family education
- Provide age-appropriate information
- Support healthy, substance-free alternatives
- Educate on overdose and safe disposal

What Communities Said:

- Youth want honest information, not “just don’t do it”
- Early exposure to substance use in homes normalizes use
- Prevention is often too late and not reinforced across grades

Gaps:

- Prevention curricula lack specificity and consistency
- Reinforcement across grade levels is rare

(G2) Priorities 5 & 6: Using Data + Provider Training Gaps

Using Data to Inform Prevention (Priority 5)

Alignments (Indirect):

- Evidence-based prevention relies on strong data
- Screening and referral systems require reliable data

What Communities Said:

- Limited evaluation of prevention programs
- Data use is inconsistent across schools and counties

Gaps:

- No statewide prevention data system
- No infrastructure or training for schools/providers to use data
- Evaluation often limited to simple pre/post tests

Provider Training Gaps (Priority 6)

No Alignment in Recommendations

- None of the recommendations address prescriber training

What Communities Said:

- Some providers avoid prescribing opioids even when clinically appropriate
- Others refuse to provide MOUD even when patients ask

Gaps:

- No training on prescribing guidelines, risk education, or opioid competence
- Pharmacist CE recommendations do not apply to prescribers and are voluntary

Goal 3 Reduce Harm Related to Opioid Use

Includes approaches that engage directly with individuals who use drugs to prevent overdose and transmission of infectious disease.

Harm reduction involves improving the physical, mental, and social well-being of those served, reducing stigma, and offering low-threshold options for accessing substance use treatment.

Purchase of items that are considered paraphernalia pursuant to NRS 453 are unallowable.

Goal 3: Reduce Harm Related to Opioid Use

What Nevadans Identified as the 5 Top Priorities for G3 (Survey):

1. Access to harm reduction services & supplies
2. Street outreach programs
3. Mobile crisis response
4. Drop-in/resource centers
5. Exploration of overdose prevention centers

What Communities Said (Qualitative Findings):

- Recovery is not linear; relapse is common and needs planning
- Isolation increases relapse risk
- Naloxone is well known but not always easy to find
- PWLE and peers are key to reaching those most at risk
- Rural regions often resist harm reduction (some communities have “cold turkey” expectations)

(G3) Priority 1: Harm Reduction Services & Supplies

Where Recommendations Align:

- Expand low-barrier naloxone access statewide
- Improve public and provider overdose-response education
- Support ED-based naloxone distribution
- Use overdose-prevention framing to maintain funding

What Communities Added:

- Hard to find naloxone; not enough distribution locations
- Kits need clear instructions and safety education
- Persistent misinformation about fentanyl exposure
- PWLE and peers are trusted messengers and supply distributors
- Syringe access and drug-checking supplies face stigma, especially in rural areas

Gaps:

- No strategy to fund or expand full harm-reduction supplies
- No integration of harm-reduction principles into workforce training
- Federal limits constrain supply distribution; state options unexplored

(G3) Priorities 2 & 3: Street Outreach & Crisis Services

Street Outreach (Priority 2)

What Communities Added:

- "Meet people where they are" physically, so encampments, streets, gathering spots
- Many will not access clinical or government buildings
- Ongoing relationships, not single touchpoints, make outreach effective

Gaps:

- No discussion of street-based outreach
- Focus remains on hospital follow-up, not community engagement

Mobile Crisis Response (Priority 3)

Where Recommendations Align:

- Post-overdose engagement and 988 crisis reference

What Communities Added:

- Crises happen in the community — need in-person mobile teams
- MOST teams are not substance-use focused
- 988 is helpful but not designed for in-person response
- PWLE are unlikely to call a hotline; they need real people who can come to them

Gaps:

- No plan to expand mobile crisis teams to focus on substance use
- Rural areas especially lack in-person crisis options

(G3) Priorities 4 & 5: Drop-In Centers & Safe Consumption Sites

Drop-In / Resource Centers (Priority 4)

Where Recommendations Align:

- No recommendations currently address drop-in or resource centers

What Communities Added:

- Need safe locations to stabilize, rest, and connect
- Survival needs often outweigh treatment & drop-in centers can bridge the gap

Gaps:

- No proposals for low-barrier community hubs
- No discussion of housing navigation, daytime stabilization, or basic-needs supports

Overdose Prevention Centers (Priority 5)

Where Recommendations Align:

- None of the recommendations address, evaluate, or explore these models

What Communities Added:

- Significant misinformation about fentanyl exposure fuels hesitation
- Mixed acceptance among law enforcement, medical staff, and communities
- Some concerns are based on inaccurate beliefs (“touching fentanyl causes overdose”)

Gaps:

- No exploration of feasibility, legal pathways, or public health impact

Goal 4 Provide Behavioral Health Treatment

Behavioral health includes **mental health, substance use, and/or co-occurring disorders such as life stressors, crises, and stress-related physical symptoms**.

Behavioral health care and behavioral health integration is the **prevention, diagnosis, and treatment of these conditions by promoting whole-person care**, closing treatment gaps, enhancing access to long-term monitoring services, reducing risk of self-harm, increasing positive health outcomes, improving patient satisfaction, and promoting long-term cost effectiveness.

Behavioral health treatment is integral to aiding communities in prevention of and recovering from opioid use disorders among those with mental health diagnoses. This includes prenatal though geriatric populations.

Goal 4: Provide Behavioral Health Treatment

Top 3 Priorities Identified by Nevadans for G4 (Survey):

1. Immediate access to substance use treatment & detox
2. Mental health care & treatment
3. Trauma-informed care

What Communities Said (Qualitative Findings):

- Substance use often begins early as a coping tool for trauma, stress, grief
- Co-occurring mental illness makes treatment entry and re-entry harder
- Isolation drives use and use deepens isolation
- Trust, stability, consistent providers, and integrated services matter
- Readiness to seek help comes in brief windows and delays lead to disengagement
- Rural residents do not trust telehealth unless paired with consistent in-person care

(G4) Priority 1: Immediate Access to Treatment & Detox

Where Recommendations Align:

- Remove prior authorization for buprenorphine
- Support all forms of MOUD equally
- Improve rural access through hub-and-spoke and mobile units
- Fund hospital-based addiction consults
- Support the Saturation Plan (MOUD + behavioral health)
- Remove buprenorphine dosage limits

What Communities Added:

- Delays lead to relapse or loss of readiness
- PWLE have mixed feelings about MAT including side effects, stigma, personal preference
- Rural PWLE stated few prescribers, no trust in telehealth unless relationships are built first
- Hospitals are often the only place people interact with care

Gaps:

- No strategies for rapid detox, crisis stabilization, or same/next-day placement
- Lack of safe spaces during withdrawal increases relapse and overdose risk

(G4) Priorities 2 & 3: Mental Health Treatment & Trauma-Informed Care

Mental Health Care & Treatment (Priority 2)

Where Recommendations Align:

- Promote evidence-based standards and prescriber clarity
- Fund hospital addiction consult services
- Support integrated behavioral health through the Saturation Plan

What Communities Added:

- Stigma from providers (dismissal, refusal to treat) prevents engagement
- Co-occurring mental health challenges complicate treatment entry and re-entry
- Integrated care is essential — mental health, SUD treatment, and recovery supports

Gaps:

- Recommendations do not fully address expansion of mental health workforce or services
- Many avoid mental health care due to distrust or negative past experiences

Trauma-Informed Care (Priority 3)

Indirect Alignments:

- Evidence-based standards include trauma-informed care
- PRSS/CHWs naturally support trauma-informed approaches
- Saturation Plan includes behavioral health interventions

What Communities Added:

- Nearly all PWLE reported trauma as central to their substance use
- Safety, respect, and stable relationships define effective treatment
- Lack of consistent providers deepens trauma and isolation

Gaps:

- No direct recommendations to expand trauma-informed care or training
- No guidance on trauma screening, treatment models, or integration into MOUD programs

Goal 5 Implement Recovery Communities

Recovery communities provide connections to treatment and services for individuals in recovery to integrate into the community to increase chances of maintaining recovery.

Recovery communities incorporate the social determinants of health (SDOH) as an integral part of recovery and living successfully in the community.

SDOH includes financial resources, social and community factors, education access and quality, health care access and quality, the neighborhood and environment in which a person lives.

Goal 5: Implement Recovery Communities Across Nevada

Top 7 Priorities Identified by Nevadans for G5 (Survey):

1. Housing (recovery housing, transitional housing, Housing First)
2. Recovery support services
3. Care navigation after incarceration or detox
4. Job training & employment support
5. Capacity building for providers & PRSS
6. Family reunification supports
7. Community partnerships & cohesion

What Communities Said (Qualitative Findings):

- Early recovery requires managing housing, employment, legal issues, transportation, and health needs all at once
- Family is the strongest motivator for entering and maintaining recovery
- Employment and livable wages support long-term stability
- People want neutral, non-judgmental places to connect - not “sober-only” spaces
- Health needs accumulate during active use (dental, chronic pain, nutrition)
- Access to supportive peers, NA/AA, and mutual aid helps maintain recovery

(G5) Priorities 1 & 2: Housing & Recovery Support Services

Housing Services (Priority 1)

Where Recommendations Align:

- Explore strategies for transitional housing for youth
- Explore feasibility of recovery housing certification

What Communities Added:

- Transitional housing is scarce outside Clark County
- Time limits don't match individual recovery pacing
- Rural areas resist permitting recovery housing even when funding exists
- Affordable housing shortages also prevent hiring behavioral health staff

Gaps:

- Recommendations do not expand housing capacity
- No statewide approach to increasing recovery housing

Recovery Support Services (Priority 2)

Where Recommendations Align:

- Strengthen coordination across care levels
- Recognize and reimburse PRSS/CHWs
- Promote second-chance hiring and recovery-friendly workplaces
- Reduce employment barriers for PRSS
- Increase funding for Contingency Management

What Communities Added:

- Early recovery requires simultaneous help with housing, employment, health, and legal needs
- Peers help navigate complex systems
- Employment supports recovery by restoring purpose and stability
- People want safe, neutral social spaces not centered on substance use
- NA is often the only recovery resource in rural counties

Gaps:

- No mention of sober recreation centers, peer-led groups, or recovery community organizations
- No support for neutral gathering spaces that promote belonging

(G5) Priorities 3 & 4: Reentry Navigation & Employment

Care Navigation (Priority 3)

Where Recommendations Align:

- Strengthen transitions across hospital, community, crisis, and correctional settings
- Expand home and community-based services for families
- Reimburse PRSS/CHWs for navigation and transitions

What Communities Added:

- Reentry is a vulnerable time as many people lack IDs, birth certificates, transportation
- Need for legal help (criminal, family, landlord-tenant)
- Peers provide crucial continuity

Gaps:

- No strategy identified for navigating healthcare and legal systems
- Case management for long-deferred medical needs is missing

Job Training & Employment Support (Priority 4)

Where Recommendations Align:

- Collaborate with workforce agencies (DETR)
- Promote second-chance hiring and recovery-friendly workplaces

What Communities Added:

- Employment and wages are major motivators for sustained recovery
- Job stability enables housing, transportation, and a sense of normalcy

Gaps:

- No scalable statewide job training, placement, or funding for employment programs (limited to partnering with DETR to identify practice support models)

(G 5) Priorities 5, 6, & 7: PRSS Capacity, Family Reunification, Community Partnerships

Where Recommendations Align:

- Many of the recommendations support PRSS, expansion, reimbursement, reduce employment barriers.
- Strengthen coordination across hospitals, corrections, child welfare, workforce agencies

What Communities Added:

- Family is a strong motivating factor for seeking and sustaining recovery
- Non-judgment and unconditional support are essential

Gaps:

- No reunification programs or parenting supports in recommendations
- No recommendations for grassroots recovery involvement, sober recreation, or community building

Goal 6 Provide Opioid Prevention and Treatment Consistently across the Criminal Justice and Public Safety Systems

This goal aims to **improve the access to quality care for justice-involved individuals and support individuals with opioid use history leaving levels of confinement**.

This includes access to medications for opioid use disorder (MOUD) and other treatment interventions within the carceral setting and other criminal justice settings through transitional periods, so people can recover from OUD and maintain recovery in the community.

This should incorporate connections to care, assessment and diagnosis, wraparound services, and facilitating release into treatment with prescriptions, developing relationships with pharmacies, treatment providers, parole and probation as well as court systems.

Goal 6: Prevention & Treatment in Criminal Justice & Public Safety Systems

Top 6 Priorities Identified by Nevadans for G6 (Survey):

1. Diversion & treatment court programs
2. Reentry, reintegration & workforce supports
3. Program sustainability & capacity building
4. MAT & counseling in jails/prisons
5. Mental health services for law enforcement
6. Restorative & supportive justice approaches

What Communities Said (Qualitative Findings):

- People cycle repeatedly through jails, ERs, and psychiatric hospitals
- Incarceration interrupts use but rarely leads to recovery
- The weakest link is the gap between release and reentry services
- MAT in jail often lacks continuity after release
- Housing, employment, and IDs are essential post-release
- Misinformation about fentanyl is widespread among the public and responders
- Law enforcement lacking funding for diversion options and behavioral health support in the field

(G6) Priorities 1 & 2: Diversion & Reentry & Reintegration

Diversion & Treatment Court Programs (Priority 1)

Where Recommendations Align (Indirect):

- Standardize recidivism/desistance definitions and outcomes
- Provide training to law enforcement, EMS, and courts on fentanyl and overdose response

What Communities Added:

- People cycle through jail/ER/psychiatric care repeatedly
- Misinformation about fentanyl exposure creates safety concerns
- Need for earlier intervention “first contact,” not “third strike”

- PWLE emphasize incarceration is *not* a recovery pathway

Gaps:

- No expansion of diversion program capacity or eligibility
- No deflection, family-preservation, or treatment-first models

Reentry, Reintegration & Workforce Supports (Priority 2)

Where Recommendations Align:

- Improve continuity of care at release; reduce overdose risk
- Standardize outcomes; strengthen braided funding
- Support MOUD treatment programs during and after incarceration

What Communities Added:

- Reentry is the most vulnerable point — lack of housing, employment, case management
- MAT often stops at release, leading to relapse and overdose
- IDs, birth certificates, and transportation are major barriers

Gaps:

- No vocational training, transitional jobs, or workforce development plans
- No coordination with workforce agencies for job placement
- Employment barriers due to criminal records remain unaddressed

Priorities 3 & 4: Sustainability & MAT in Jails/Prisons

Program Sustainability & Capacity Building (Priority 3)

Where Recommendations Align:

- Standardize success metrics across justice programs
- Continue braided funding for reentry and MOUD services

What Communities Added:

- Funding gaps cause service interruptions, leading to ER/jail cycling
- Lack of shared expectations and data prevents cross-system coordination

Gaps:

- No dedicated funding streams to stabilize programs long-term
- No evaluation benchmarks for systemic improvement

MAT & Counseling in Jails/Prisons (Priority 4)

Where Recommendations Align:

- Improve continuity of MOUD when entering or leaving incarceration
- Braided funding can support MOUD in justice settings

What Communities Added:

- Jail may stop use briefly but is not a recovery environment
- MAT access inside jail is inconsistent and does not transition smoothly to community care
- Participants reported opioids available inside facilities and recent fatal overdoses

Gaps:

- Counseling and behavioral health services in jails/prisons not addressed
- Overdose prevention in facilities not included in recommendations

(G6) Priorities 5 & 6: Law Enforcement Mental Health & Restorative Approaches

Mental Health Services for Law Enforcement (Priority 5)

Indirect Alignment:
- Training on fentanyl, overdose response, and naloxone

What Communities Added:
- Officers need more behavioral health support when responding to people in crisis
- Significant misinformation about fentanyl exposure impacts safety and decision-making
- Limited diversion options result in transporting non-criminal individuals to ERs

Gaps:
- No mental health supports for officers
- No crisis co-response models or tele-behavioral health tools for field situations

Restorative & Supportive Justice Approaches (Priority 6)

Indirect Alignment:
- Strengthen community connections for people leaving incarceration
- Standardized measures support individualized, person-centered approaches

What Communities Added:
- Family and relationships are major motivators for reducing use and staying sober
- Incarceration disrupts support networks; people want earlier, supportive interventions

Gaps:
- No mention of restorative justice models (family conferencing, mediation)
- No strategies for repairing harm, rebuilding relationships, or informal community support

Goal 7 Provide High Quality and Robust Data and Accessible, Timely Reporting

This goal aims to **improve data collection and reporting to better understand the impact of opioids on Nevadans**.

This includes survey data, monitoring trends, criminal justice data, overdoses, healthcare utilization, and co-occurring health conditions, with a focus on health disparities to identify solutions.

Recommendation High Level Summary

- There are some areas where community feedback was strong and while there may be supporting recommendations, those recommendations may not have ranked high or are still “missing the key concept”.
- Many recommendations align with statewide community priorities and feedback, however most recommendations lack specifics, meaning they do not contain enough detail to determine *how* the recommendation will be achieved.

Contact Information

Heather Kerwin, MPH, CPH
Opioid & Infectious Disease Epidemiologist
H.Kerwin@health.nv.gov
(775) 688-0457

9. REVIEW OF 2026-27 SURG MEETING TIMELINE AND TOPICS

(Discussion or Possible Action)

Terry Kerns, Ph.D., Substance Use/Law Enforcement Coordinator, Office of the Attorney General

FULL SURG MEETING TOPICS AND TIMELINE

January 2027

- Election of Officers and Appointment of Subcommittee Chairs and Members
- Results of SURG Annual Satisfaction Survey
- Presentation(s) from Subject Matter Experts:
  - Crisis Response System (pending)
  - Washoe County Opioid Needs Assessment (pending)
  - Perspectives from Tribal Representatives and Organizations (pending)

10. PUBLIC COMMENT

(Information Only)

PUBLIC COMMENT

Public comment shall be limited to three (3) minutes per person. We will begin with comments from Las Vegas and then invite comments from Carson City, followed by virtual participants.

No action may be taken upon a matter raised during a period devoted to comments by the general public until the matter itself has been specifically included on an agenda as an item upon which action may be taken pursuant to NRS 241.021.

IN PERSON

Please form a line.

Before commenting, please state your full name for the record.

PUBLIC COMMENT

ATTENDING VIRTUALLY/BY PHONE

If you are dialing in from a telephone:

- Dial 917-809-8575
- When prompted, enter the Conference ID: 616 314 117#
- Wait to be connected; do not identify yourself as an organizer
- **Use your keypad during the meeting:**
  - ***5** to raise or lower your hand and then ***6** to mute or unmute

If you are joining virtually with computer audio, please use the "raise hand" feature to indicate you would like to provide public comment so the host can prompt you to unmute.

Before commenting, please state your full name for the record.

Members of the public are requested to refrain from commenting outside the designated public comment periods, unless specifically called upon by the Chair.

The chat is disabled during the meeting. For technical difficulties, please notify Vicki Beavers, Executive Assistant to the Attorney General at (775) 684-1212 or by email at *vbeavers@ag.nv.gov.*

**Comments can also be emailed to mdelgiudice@socialent.com. These comments and questions will be recorded in meeting minutes.*

11. ADJOURNMENT

Chair Ford

ADDITIONAL INFORMATION, RESOURCES & UPDATES AVAILABLE AT:
https://ag.nv.gov/About/Administration/SURG_Info_Page/

OFFICE OF THE ATTORNEY GENERAL

AARON D. FORD, *ATTORNEY GENERAL*

100 NORTH CARSON STREET

CARSON CITY, NV 89701

WEB – HTTP://AG.NV.GOV

TELEPHONE – (775) 684-1100

FAX – (775) 684-1108