

MEETING NOTES

Statewide Substance Use Response Working Group March 12, 2026
Response Subcommittee Meeting 12:00 pm

Zoom Meeting ID: 884 0825 1817
Call in audio: (719) 359-4580
No Physical Public Location

Members Present via Zoom or Telephone

Robert Banghart; Peter Handy; Nicole Hicks; Chair Kerns; Bud Schawl

Members Absent

Dr. Shayla Holmes; Christine Payson; Senator Jeff Stone

Office of the Attorney General

Christine Jones (CJ) Brady, Assistant Attorney General; Joseph Peter Ostunio, Deputy Attorney General; Ashley Tackett; Todd Weiss, Senior Deputy Attorney General

Social Entrepreneurs, Inc. (SEI) Support Team

Crystal Duarte, Kasey Docena

Members of the Public via Zoom

Linda Anderson; Lea Cartwright – Cartwright NV Government Affairs; Lisa Kelso; Heather Kerwin; Laura Knight, MD; Sabrina Petrel; Ferrari Reeder; Kimberly Sarandos; Beth Scott; Riley Shepard, NV OD2A; Karina Tomco; Samm Warfel, NDVS; Dave Wuest; and Darla Zarley
Unless otherwise identified, members of the public are listed as their name appeared on Zoom.

1. Call to Order and Roll Call to Establish Quorum

Chair Kerns welcomed everyone to the meeting.

Chair Kerns called the meeting to order at 12:02 p.m. and Ms. Duarte called the roll and established a quorum.

Chair Kerns reminded Members that if they must depart a meeting prior to adjournment for any reason, the Member shall formally announce their departure for the record to ensure accurate minutes and to allow the Chair to confirm that a quorum remains in accordance with Nevada's Open Meeting Law. Ms. Duarte also noted this in the chat.

2. Public Comment

Chair Kerns read the statement on public comment and provided call-in information. She reminded Members and attendees about using the chat. "Please do not use the chat for items other than technical support, as this becomes part of the public record. The meeting chat functionality is limited to inquiries regarding technical difficulties or to indicate an interest in offering public comment. Exercise caution with links which may appear in any meeting chat as they could be malicious." This was also noted in the chat by Ms. Duarte.

No public comment was made and Chair Kerns continued to agenda item #3.

3. Review and Approve Minutes from February 3, 2026, Response Subcommittee Meeting

Chair Kerns introduced the item and asked if there were any discussions around the meeting minutes. Seeing none of the Subcommittee Members raise their hands, Chair Kerns wanted to make one change on page four of the meeting minutes, in the second paragraph it should say, “if the recommendation is approved and becomes current legislation, that would repeal that section of NRS.” The Subcommittee wouldn't be repealing that section of the NRS.

The Chair asked if there were any other suggestions to be raised. Hearing none, she asked for a motion to approve the minutes from the February 3, 2026, Response Subcommittee meeting with the revision noted above.

- Bud Schawl made the motion to approve.
- Nicole Hicks seconded the motion to approve the minutes.
- The motion carried unanimously with no abstentions.

Ms. Duarte unmuted to note for future meetings, that if Subcommittee Members could please repeat what the motion is so it is clear on the record what motion is being made, seconded, and voted on.

With no further discussion, Chair Kerns thanked Ms. Duarte and proceeded to agenda item #4.

4. Discuss and Draft Proposed 2025 Response Subcommittee Recommendations

Chair Kerns introduced the agenda item, noting it was the main focus of this meeting.

Chair Kerns spoke on behalf of Subcommittee Member Shayla Holmes, since she was unable to attend the meeting.

Members previously saw recommendation #1 as one recommendation; however, Member Holmes broke down her original recommendation into three, to accurately describe the actions needed for three of the substances that were discussed at the prior Subcommittee meeting. Tianeptine is already a scheduled drug, which left mitragynine or “Kratom”, phenibut, and amanita muscaria to be addressed. During the live meeting, modifications were made to the recommendations in real time.

The three recommendations were as follows:

Recommendation #1 –

Recommend that mitragynine, 7-hydroxymitragynine, and mitragynine pseudoindoxyl including: any isomer, ester, ether, salt, or salt of an isomer; any synthetic, semi-synthetic, or chemically modified derivative; and any compound containing mitragynine, 7-hydroxymitragynine, or mytragynine pseudoindoxyl as an active pharmacological ingredient, regardless of whether the substance is naturally derived, synthetically produced, or manufactured through chemical modification be added to the Schedule 1 of NAC 453.510.

Recommendation #2 -

Prohibit the sale of phenibut (β -phenyl- γ -aminobutyric acid), including: any isomer, ester, ether, salt, or salt of an isomer of phenibut; any synthetic, semi-synthetic, or structurally modified derivative; and any compound that acts as a GABA-B receptor agonist or functional equivalent with similar depressant or psychoactive effects to individuals under 21 years of age, aligning with existing cannabis regulations and mandate that all products containing phenibut or its derivatives have standardized labeling, including clear warnings about potential health risks and age restrictions.

Recommendation #3 –

Prohibit the sale of *amanita muscaria* and its psychoactive constituents, including: muscimol, ibotenic acid, and any isomer, ester, ether, salt, or salt of an isomer thereof; any synthetic, semi-synthetic, or chemically modified derivative of muscimol or ibotenic acid; and any compound that produces hallucinogenic, dissociative, or neuroactive effects substantially similar to those substances to individuals under 21 years of age, aligning with existing cannabis regulations and mandate that all products containing such psychoactive constituents have standardized labeling, including clear warnings about potential health risks and age restrictions.

Chair Kerns then read recommendation #1. Chair Kerns highlighted actions taken since the last Response Subcommittee meeting to refine this recommendation. The substances that are noted in this recommendation were addressed at the February Crime Lab meeting to gather input from members of that group. Chair Kerns, Dr. Holmes, and staff from SEI met with the Board of Pharmacy (BOP) and information was requested from Dr. Karla Wagner, Marco Méndez, and Dr. Daniel Gerrity.

Dr. Wagner is the Associate Director at the Center for Drug Use, Equity, and Policy Research at the University of Nevada Reno. Mr. Méndez is the Public Health Evaluator with the Southern Nevada Health District. Dr. Daniel Gerrity is a Principal Research Microbiologist with the Southern Nevada Water Authority, who does wastewater sampling. Per Dr. Wagner and Mr. Méndez, the compounds listed in the recommendations are detectable by the Radar Laboratory at the National Institute of Standards and Technology, also known as NIST. Where both UNR and the Southern Nevada Health District, also known as SNHD, send their samples to be tested. Dr. Gerrity noted that it is possible to monitor the compounds in the wastewater; however, there are a series of steps needed to be developed and validated for the methods that will be used, before they can be implemented. Additionally, these compounds are not yet included in their routine list, but the Water Authority's Research Chemists identified mitragynine, also known as Kratom, as a high priority for future inclusion to their list. There is a way to get that information on substances that are not on their routine list, but it would not be quantifiable in the manner in which the other substances from the routine list are. Chair Kerns offered additional context to refresh everyone's memory. The samples that are submitted are either off paraphernalia or from drug samples.

Additionally, SEI staff researched and contacted individuals in other states, such as Utah, which addressed phenibut in their 2025 legislative session.

Dr. Laura Knight, the Washoe County Medical Examiner, has done research on mitragynine, that is cited under the first recommendation, and she also provided feedback on the recommendation. Chair Kerns opened the floor for Dr. Knight to add any additional comments, as she was on the Zoom call. Ms. Duarte noted that she noticed Dr. Knight had come in and out of the meeting, possibly indicating technical difficulties.

While they waited for Dr. Knight, Ms. Duarte clicked through the slides and noted that the recommendations #2 and #3 were previously bundled together, and that the new versions of the recommendations are about standardized labeling, restricting locations for sale, and enforcement mechanisms. She noted that further details on recommendations #2 and #3 will be discussed later.

Ms. Duarte went back to slide with information on recommendation #1 and Chair Kerns welcomed Dr. Knight to share her insights. Dr. Knight thanked the Chair for the opportunity to speak about this important topic. She published on the first five years of mitragynine-associated deaths in the Northern Nevada area back in 2021. The first death that had mitragynine involved was in 2015, and in that first five years of having the drug present in the Northern Nevada population, her office saw a total of 35 deaths and published that, including the drug levels that were detected in the blood of the deceased. Since that time, the total death toll for the Northern Nevada area that Dr. Knight's office covers have risen to 102 deaths that have involved the substance—kratom.

Unfortunately, now they are seeing that the other compounds listed in the recommendation (that Dr. Knight suggested adding) are compounds that are even more potent than mitragynine itself. The 7-hydroxymitragynine and the mitragynine pseudoindoxyl are both alkaloid compounds that are present in the Kratom product itself, typically in very small amounts when referring to “ground-up” mitragynine kratom leaf.

However, with these designer drugs comes a lot of ingenuity. People have extracted the 7-hydroxymitragynine itself, produced this in a lab and have taken the 7-hydroxymitragynine to add extra dihydro groups or extra fluoro groups to make the substance even more potent. Their office has found that mitragynine is quoted as being about 13 times more potent than morphine. Then, she stated that 7-hydroxymitragynine is more potent than mitragynine. The other additional isomers, salts, and other compounds being made are up to 240 times more potent, and Dr. Knight expressed that's what she's seen quoted for the derivatives that are made from the 7-hydroxymitragynine.

She summarized her findings by saying it's really important to include each of these compounds, because they are now seeing kratom products sold that are identified as 'kratom', that are entirely 7-hydroxymitragynine. It's important not to just say that mitragynine needs to be regulated—but rather, all of the compounds listed need to be regulated. Dr. Knight said she believed the wording in the recommendation covers this very comprehensively and that it is important that this is regulated in Nevada. She was happy to answer any additional questions that are within her scope and thanked everyone.

Chair Kerns highlighted that the language around isomers in these recommendations was incorporated due to the assistance of the members of the Board of Pharmacy and the Crime Lab. Chair Kerns thanked them and asked if there were any questions for Dr. Knight from any of the Subcommittee Members while she was available.

Seeing none, Chair Kerns elevated that mitragynine and/or its compounds are sold over the counter, at vape shops, or at convenient stores. She referenced Dr. Holmes' previous comment about these products often being misleading, because they are often coined as nutritional supplements or energy drinks. That is what brought this recommendation to light for Dr. Holmes and felt that some people may know what they're getting, but oftentimes it's marketed to others as something else. Chair Kerns asked if Dr. Knight had any additional thoughts.

Dr. Knight said that was correct, *"These are frequently being sold in gas stations, as well as online, and are often marketed in a way that would not make it evident that there is a powerful opioid in this, and people do become addicted to it."* People can become more tolerant and require more of these substances, to then search for more potent versions of them. So, this can lead to addiction when people aren't necessarily expecting that these are opioids. Dr. Knight stated that there is a subset of people who are looking for the opioid though, who may be using mitragynine in lieu of other opioids. Unfortunately, since mitragynine is not regulated, people who may consume these products may be unaware of what is in it and may not know the potency—so this can be very dangerous.

Chair Kerns highlighted in the discussion with the Crime Labs that they have the capacity, and they do test for the compounds listed in Recommendation #1. The Crime Lab did not recommend scheduling the substances or compounds listed in Recommendations #2 and #3. Instead, they suggested information about clear labeling on what is in these substances and then the age restriction being 21.

At the Crime Lab meeting, Chair Kerns was asked by the Crime Lab why this recommendation chose the age limit of 21 and not 18. Per Dr. Holmes', it was because 21 is the age restriction for cannabis. The recommendation describes limiting access to phenibut and amanita muscaria to individuals under the age of 21. Chair Kerns asked if there were any other questions or comments from any Subcommittee Members on recommendations 1-3.

Bud Schawl was shocked that the public isn't made aware of the hazards these products present. He was completely blown away. Chair Kerns agreed and said, *"I think that was really the impetus for Dr. Holmes bringing this forward."*

Chair Kerns called on Deputy District Attorney and Subcommittee Member, Nicole Hicks. At the last meeting there was a question about whether these can be tested in the drug courts. At the time, Member Hicks shared that they are not currently testing for these in Washoe County's Drug Court. Chair Kerns asked for clarification on whether it could be added to the list of substances to test for. Member Hicks said she spoke with some of the members on her team. To their understanding, it could be added. She just has to clarify this with the actual drug testing company. Chair Kerns thanked her for following up on that.

Chair Kerns noticed that Rob Banghart may have wanted to come off mute to comment, but there were technical difficulties. Ms. Duarte and Chair Kerns offered additional support (pressing *6 or unmuting). Due to the technical challenges, Member Banghart wrote in the chat, "*What is the half-life for that drug on drug testing?*" Chair Kerns asked if he was inquiring about Kratom and he confirmed he was. She turned to Dr. Knight for her expertise.

Dr. Knight said that if he was asking about half-life in the body, it depends on the tolerance and how often someone is using that drug or other opioids. It has been cited to stay in the body anywhere from about 8 hours, up to about 24 hours. She wasn't sure if that answered his question or if he was asking how long the substance can be detected after someone dies. Basically, when someone passes away, the metabolism stops right then, and her team is able to detect the drug *as it was* at the time the individual died when performing a post-mortem testing at autopsy. Member Banghart thanked her.

Chair Kerns asked for any final discussion for recommendations 1-3 or suggested changes. She knew that the Board of Pharmacy was on the call too, so if they wanted to offer any changes, they are welcome to do so.

Ms. Duarte said she wanted to offer a reminder for the members of the public and Members of the Subcommittee that these recommendations were provided in a document as one of the meeting materials. If someone wanted to review them, they could look at them in their full listing through that attachment. How they are shown in that document is also how they will appear in the Annual Report, should they be approved and moved forward. There are several links to justify these recommendations. Ms. Duarte recommended that Members of the Subcommittee review it to fully understand what is being recommended. These recommendations will be approved in the May-June timeframe.

Chair Kerns thanked Ms. Duarte. The document that Ms. Duarte was referencing outlines the research and provides additional resources, what populations they believe would be affected, timeframes being short-term vs. long-term, etc.

Chair Kerns offered one more time if anyone had any thoughts or any language to add. Ms. Duarte pulled up the Subcommittee recommendations document that they were referring to for visual reference on the screen. Chair Kerns noted that this is on the Attorney General's website and was sent out to Subcommittee Members with our materials for today's meeting.

Hearing and seeing no additional commentary, she thanked Dr. Knight for her insight into guiding the recommendations.

Chair Kerns moved on to the fourth recommendation, which was one that she had previously submitted and brought back again with some additional language. She read it aloud.

Recommendation #4 -

Recommend state agencies under the legislative, judicial, and executive branches involved with deflection and diversion programs have a comprehensive definition of recidivism and desistance, and standardized policies related to measuring and reporting recidivism. Additionally, require that all publicly funded or publicly administered reentry programs define success using clear, behavior-based outcomes and that programs articulate what meaningful behavior change looks like for participants using tools for measuring engagement, goal attainment, and behavioral milestones.

She described the following updates that took place since the last Response Subcommittee meeting. SEI reached out to the Bureau of Behavioral Health, Wellness, and Prevention within the Division of Public and Behavioral Health. They are going to implement the Sequential Intercept Model, also referred to as the SIM in their Strategic Plan. Deflection, diversion, and desistance programs go into the SIM at different intercept points. The Bureau is currently working to fill the critical positions to begin supporting work in this area.

Additionally, Chair Kerns had reached out to the Washoe County Sheriff's Office whose office previously presented to the Subcommittee. The Sheriff's Office highlighted that they're going to start the IGNITE program¹, which stands for Inmate Growth Naturally and Intentionally Through Education. This is promoted by the National Sheriff's Association (NSA) which helps jails replicate a program that was implemented in the Genesee County, Michigan Sheriff's Office. It offers comprehensive education and job certification, as well as post-incarceration work opportunities and assistance to incarcerated individuals.

Chair Kerns noted that the conversations she had with TJ Mills at the Washoe County Sheriff's was that they haven't started this program yet. They hope to start it and one of the exciting things about this program that they are looking forward to is that there will be a chance for evaluation through Stanford and one other university. The Chair couldn't remember which, but they also offer, through the NSA, assistance with implementation and maintenance of this program once it starts. Chair Kerns thinks they will have monthly or quarterly meetings with other programs that are either implementing or have already implemented the IGNITE program.

The Chair also elevated that The Office of Analytics has compiled some data. They use "persons discharged from programs with or without a conviction in three years after the program discharge date" to define recidivism. It is uncertain whether that is being used as a working definition or just the definition they used to pull the data. She opened it up for any conversation or recommendations for changes.

Member Hicks wanted to discuss further the definition of recidivism and remembered that the Nevada Sentencing Commission was the group that worked on the definition.

¹ The IGNITE Program stands for: Inmate Growth Naturally & Intentionally Through Education. Their goal is to enhance the safety of jails, communities, and correctional staff by creating an environment conducive to rehabilitation and personal growth. For more information, visit <https://www.sheriffs.org/ignite/>

Chair Kerns agreed, and stated that from what she understood, the only definition for recidivism in this state is from the Nevada Department of Corrections. They define recidivism as returning to prison within three years.

Further research was done on the Wisconsin model in looking at their definition of recidivism. That they look at if it is for lesser charges, the length of time since someone recidivated, and the programs they were involved with. They do not only look at whether an individual recidivated or if an individual returned to jail or prison within a certain time frame. They also looked at those behavioral-based and other types of outcomes from programs to see what is working vs. what is not, what causes behavior changes and the types of program outcomes. Chair Kerns noted not seeing anything else from the Nevada Sentencing Commission.

Member Hicks restated to ensure she understood correctly. She thinks the purpose of this recommendation is for the state to have a more detailed definition of recidivism besides what the Nevada Sentencing Commission uses. Chair Kerns confirmed Member Hicks understanding, because what was found in working with some deflection and diversion programs was to measure things, but programs use different definitions. Therefore, there are challenges in comparing one program to another, due to the mismatch in definitions. The hope is to look for agencies that fund programs, for example, the Attorney General's Office or DPBH, that have a definition that can be used by the programs that are receiving funding to better evaluate the program. Things like, since leaving incarceration, if an individual has returned; what the individual's charges were; if it was a lesser charge if the individual returned; if it was a civil matter; or if it was a failure to appear. All these things are taken into consideration when evaluating program efficacy.

Chair Kerns was interested in Peter Handy's thoughts on this recommendation.

Member Handy stated that he still agreed with this recommendation for all the reasons Chair Kerns had articulated. Further emphasizing that not every program's definition of success should be solely based on recidivism. There is a need for other performance measures when trying to obtain funding, especially for new programs, to then compare these programs and see which should be implemented vs. which should be abandoned over time. He said that he thinks creating a new recommendation using behavior-based outcomes, especially for Drug Court programs or rehabilitative programs can help get a better idea of what outcomes are. Rather than only measuring recidivism; if an individual has been arrested for something that may or may not be related to the underlying reason they graduated from Drug Court.

The Chair asked if there were any other comments or questions from Subcommittee Members.

Hearing none, Chair Kerns added that her only change would be to make IGNITE all capitals because it is an acronym for Inmate Growth Naturally and Intentionally Through Education. Although it's not directly in the recommendation, this can be found in the background/justification of the recommendation, so it needed to be updated.

Chair Kerns moved to the next recommendation she submitted and read the original language for recommendation #5.

Recommendation #5 -

Work with the Board of Pharmacy to include Safe Rx Kits with opioid prescriptions and a one pager with information about opioid overdoses/addiction assistance; look into how a prescription can be written for opioid antagonists when opioids are prescribed to reduce costs.

Chair Kerns noted that Safe Rx Kits are not a brand, they're just a description. Since the last meeting, she met with representatives from the Fund for Resilient Nevada (FRN) who suggested targeting education to seniors through a general media campaign about safe disposal of medications. For example, this can be done the same way social media campaigns are targeted towards younger individuals. Dr. Beth Slamowitz suggested that the Board of Pharmacy do education with pharmacists through the Board's quarterly newsletter and perhaps continuing education through the Nevada Opioid Center of Excellence, as well as coordinating with the Nevada Pharmacy Association.

In the meeting with FRN, it was highlighted that in January of 2026, there were over 128,000 opioid prescriptions in Nevada. The cost of a Detera bag, a type of disposal kit, is \$4 a bag. When looking at the opioid prescriptions, that would be an estimated total cost of over \$500,000 per month to cover all opioid prescriptions. If that amount were to be extrapolated to a year, it would be over \$6 million for one year.

Everyone that attended the FRN meeting agreed that this may not be a good use of the opioid litigation funds, because some people will not even use the kits. They suggested looking at education campaigns. Chair Kerns noted that she met with Jamie Ross and Wendy Nelsen. Member Ross is the Executive Director of the Prevention, Advocacy, Choices, Teamwork (PACT) Coalition. Member Nelsen is currently the Vice Chair of the Prevention Subcommittee and is also the Executive Director of the Frontier Community Coalition. Members Ross and Nelsen agreed that the prevention coalitions across the state could take the lead in distributing the disposal kits.

Additional outreach was conducted to Ohio Rx Disposal, and an email was submitted about medication safety policies and resources. To their knowledge, they believed Walmart provided Detera bags through the Health Department or through County Mental Health Addiction and Recovery Service Boards. However, CVS has a policy where they either have a medication disposal box, or they will provide a patient with a DisposeRx kit when an opioid prescription is filled. Furthermore, they have a Statewide Strategic Prevention Framework (SPF) prescription grant through the Ohio Department of Behavioral Health that allows them to provide Detera bags to any Ohio resident at no cost through Ohio Rx Disposal. Ohio Rx Disposal made the following statements in their email response; which was also listed on the slide:

“Our state has an extensive substance use prevention network, so there has been a lot of advocacy to get state funds separate from treatment resources that allow for medication disposal resources to be available. Ohio also is unique in the sense that there is a lot of collaboration between agencies across the state; so often we provide a bulk amount of resources to local pharmacies/health departments who in turn distribute directly to community members, all at no cost due to grant funding. There are not any regulations or policies that require accessible disposal options in the state, it has purely been done through persistent community education, advocacy, and collaboration between public health agencies.”

Ohio Rx Disposal offered that they highly recommend one agency being in charge of ordering Deterra bags, as they have a tiered pricing system and it is the most cost efficient per bag if all the money is spent from a singular account.

Given this information, that is why the Subcommittee revised this recommendation as follows:

Recommendation #5 (as revised)-

Work with prevention coalitions to make available Deterra Bags for safe disposal of opioid prescriptions and to provide education to community members. Work with the Board of Pharmacy to distribute a one-page document with information about opioid overdoses, disposal, and available addiction assistance.

These changes were made based on Ohio Rx Disposal’s suggestions, and because it is not economically feasible or a good use of the opioid litigation funds to distribute disposal kits with every prescription.

Ms. Duarte noted that the justification would be the same as had already been provided but asked for clarity if there were any changes to be made to the action steps. Chair Kerns indicated that the action step should be for prevention coalitions to take the lead on purchasing and providing Deterra bags to members of the public with opioid prescriptions, rather than pharmacies. Technically, they can provide these bags to anyone who asks, but for the purpose of this recommendation specifically, this is focused on opioid prescriptions.

Additionally, the prevention coalitions are to do community education with senior centers/senior citizens, as well as targeted community education toward youth with a social media campaign on safe (opioid) prescription disposal. This funding would be requested from the Fund for Resilient Nevada.

Chair Kerns asked if there were any questions. Member Banghart asked for clarity on what the Chair meant by “prevention coalitions”. Chair Kerns explained that prevention coalitions work on substance use prevention in communities throughout the state. Examples of this are the PACT Coalition in Clark County, where Member Ross is the Executive Director, and the Frontier Community Coalition, where Member Nelsen works. These programs are already recognized by the state as prevention coalitions and are currently working towards certification for certified prevention specialists. She asked if that answered his question, Member Banghart said yes.

The Chair asked if there were other questions from Subcommittee Members. Chair Kerns noted that when she found out the number of opioid prescriptions for one month, she was taken aback by it.

She referred to a conversation she had with former SURG Member, Dr. Slamowitz, the Senior Policy Advisor on Pharmacy at the Nevada Department of Human Services, and a previous pharmacist. Dr. Slamowitz said that providing disposal kits should not be put on the pharmacist or the pharmacy technicians at the pharmacy. They have a lot to do already, and so that was also a direction in reaching out to the prevention coalitions.

Additionally, Chair Kerns had gotten feedback, briefly summarizing a story of an individual who had gone to a pharmacy to get free naloxone because they had gotten an opioid prescription. The first pharmacist they talked to said this was not something they could offer. Then this individual went to another pharmacist at a different location, and that pharmacist said they could provide it. This person was then able to get free naloxone from that pharmacy.

Dr. Slamowitz recommended that maybe there should be some education provided to pharmacists—perhaps offered through the Nevada Opioid Center for Excellence (NOCE) to offer Continuing Education Units (CEUs). This could be virtual, not necessarily in person.

Chair Kerns also asked if members of the Board of Pharmacy could push something out into their quarterly newsletters. She called on David Wuest to ask if he had any thoughts to share.

Member Wuest noted for the record that this Subcommittee are more like policymakers, therefore, his agency will follow what the Response Subcommittee tells them to do. They no longer have the quarterly newsletters but offer alternatives to meet that request. With the internet, they have become more interactive with the licensees, rather than just putting out a quarterly newsletter without any feedback. He said that he is happy to do whatever the Subcommittee recommends and can pass.

Chair Kerns asked if there was an online education opportunity through NOCE, would Member Wuest be interested in it. He said they would absolutely do it without any issues. They can send it too; they have 15,000 prescribers that are registered with the Board, so they can get it to the doctors and pharmacies. The Chair thanked him for that.

The Chair asked for final comments or suggestions. Member Banghart came off mute and noted that he agreed with everything that is written in the recommendation. However, something he disagreed with was not using the Detera bags at the pharmacies. He personally felt that it should be accessible anywhere. He noted that this was just his opinion but felt that pharmacies should have this, on top of education and all the other things. This comment was not at all an attack on pharmacies in any way shape or form, but believed that if they are dealing with this, they should also be responsible. There should be both sides to it.

Member Banghart was not claiming that the pharmacies are not responsible, or that they aren't already making these efforts. He emphasized that the pharmacies do great work. His concern around accessibility was because not everyone has access to social media, not everyone is going to come in contact with the coalitions. Any opportunity to have contact with someone who has an opioid prescription is an opportunity to educate, and it should be happening at the pharmacy, so the individual knows right away how to safely dispose of their prescriptions using the Detera bag. He believes that the Subcommittee should utilize every opportunity and not focus solely on these actions, because it seems like it is shifting the responsibility into the community. This is a good thing, but not by itself. It should be at every step—in his opinion.

Chair Kerns thanked him for his great comment. She stated that she failed to mention that the prevention coalitions are going to work with the pharmacies. She is not sure if that means they will be leaving some Detera bags and education at the pharmacies. But the prevention coalitions will establish relationships with the pharmacies. From what Chair Kerns knows, she believed that there are 600-650 retail pharmacies. Within each of the coalition's areas of responsibility. They would work with the pharmacies to provide the information, one-pagers, and more. So, the pharmacies are not completely left out, but this recommendation aimed to have the prevention coalitions lead this effort. She thanked Member Banghart again for his comment and he replied, thanking her too.

Ms. Duarte didn't want to interrupt Member comments but needed clarity around the action steps. Earlier, the Chair mentioned online education with NOCE. Ms. Duarte asked if that needed to be included, and if so, that revision can be made offline.

Chair Kerns stated that she didn't say that as an action step, but that it would probably be one to add in. It would be to work with NOCE for continuing education units for pharmacists and pharmacy technicians. She thanked Ms. Duarte for pointing that out.

Chair Kerns added, that as Ohio Rx Disposal noted, if the prevention coalitions take the lead on purchasing, they'll get a better deal buying these bags in bulk.

She asked for last comments and questions. The Chair asked a question for Subcommittee Members Handy and Hicks. She asked if they have the ability to get offer this to individuals they interact with and if it would be worthwhile to have the prevention coalitions reach out to them as well.

Member Hicks said she thinks it might not be a terrible idea, and that the drug courts would not need many of them, but that they should always have something to reference. Chair Kerns added the one-pager as well but believed that most should already have it. She clarified if she should contact the drug courts. Member Hicks directed her to Brooke Howard, the coordinator for all the specialty courts, not just drug courts. Chair Kerns missed the name, but Member Hicks said they can get connected over email. The Chair thanked her.

Member Handy said his perspective is the same. He believes that it would be helpful to receive a one-page information sheet, especially in the more rural areas where there isn't as much immediate access to the kind of providers that are typically seen in larger areas.

Chair Kerns thanked him and said that it can be added as well for the prevention coalitions to connect with specialty courts, drug courts, and within the Department of Indigent Defense Services (DIDS). Member Handy said that would be great.

The Subcommittee proceeded to the next slide, which was a placeholder. The Chair opened it up for any other Members to bring forth recommendations.

Member Bud Schawl wanted to briefly discuss a potential recommendation that may be appropriate. He began by noting that University Medical Center (UMC), where he is the Executive Director of the Continuum of Care, operates a Crisis Stabilization Center (CSC). Other CSCs are located in Washoe County and Carson. One of the primary focuses of these centers is to be able to interact with and support individuals who encounter, either the health care system or law enforcement, due to substance use or other behavioral health disorders. Once an individual comes into the CSC, they are wrapped around a number of different interventions, including peer support specialists, to get them into a recovery program. The key is that these individuals have to make it into the Crisis Stabilization Centers in order to have the opportunity to receive this support. Oftentimes, Emergency Medical Services (EMS), as well as even the Crisis Response Teams (CRTs) will take the individuals to an Emergency Department (ED). This becomes a hit or miss opportunity for individuals to get involved or exposed to Peer Support Specialists (PSS). There are protocols suggesting that individuals should just be transported to an approved alcohol and drug use facility, rather than the Hospital Emergency Department, if it is medically determined that the patient meets all the criteria.

He was curious if there was something that would be worth making a recommendation to the various health districts that cover the state to adopt a protocol that is more prescriptive as to where people in crisis are sent. Rather than, “should be transported”, to “is to be transported” to an approved alcohol drug abuse facility. He wanted to further wordsmith this with the purpose of getting people to the appropriate levels of care.

He noted an issue that he has experienced with drug abuse facilities: some take Medicaid, while others don't. It's a lot more payer-dependent on whether an individual is going to be able to be accepted into a program.

He would be happy to draft a recommendation on language that would be more of an encouragement to the health districts in the state to adopt and have more prescriptive language around what CSCs are available to take these individuals to. This would do two things. The first is that it would ensure that patients get to appropriate intervention spots. CSCs keep patients for no more than 24 hours—it is truly an intervention. The second is that this can get individuals into an appropriate care setting without regard to their ability to pay. In summary, if this Subcommittee could create something that is more prescriptive for the health districts, EMS, and other entities could refer to for individuals being directed to available CSCs.

Chair Kerns shared that, to her understanding EMS cannot get paid and transport to a CSC, it's transport to an Emergency Department. She asked Member Schawl if that was correct.

Member Schawl stated that he was under the impression that there is a pay differential—they can still get paid, but it is much less. He is still trying to figure that out. He has gone to several sources, and it is not a simple piece to uncover.

Chair Kerns asked if CSCs are only in Clark and Washoe County. He said yes.² Chair Kerns noted that that leaves our rural and frontier counties with either long transports or not having the capacity, so this may be part of the justification for looking to open more CSCs.

Member Schawl agreed. There would be a caveat—where available. There wouldn't be an expectation for someone to drive 30 miles or 100 miles to get someplace for help. But he believed that would do two things. It would help get the right patients to the right place, at the right time. And it would also provide an incentive and more assurance for others that may consider opening a CSC. It wouldn't have to be a 20-patient filled facility, but rather 6-7. Mallory Behavioral Health Crisis Center has the capacity to serve 10 patients, he believed. This does not have to be a big investment from various providers to open a Crisis Stabilization Center up.

Ms. Duarte noted some additional context around Member Schawl's statement. SEI reached out to have presentations from the CSCs in Nevada for a future SURG Meeting. Member Schawl, at UMC, was contacted as were the leads for centers at Renown and the Mallory Behavioral Health Crisis Center in Carson. She believed there may be three CSCs. Member Schawl confirmed that.

Chair Kerns thanked them for the clarifications. She believed that another thing that was discussed at the Treatment and Recovery Subcommittee was that, in the Emergency Departments, the addiction specialists don't have privileges in the hospitals, only psychiatrists have those privileges. That's why referrals are often not made unless they happen to be from a psychiatrist. She asked if that was correct.

Member Schawl said, to some extent, they do have some privileges. It depends on whether they have access to Peer Support Specialists. Jamie Ross's team at the PACT Coalition works to place Peer Support Specialists inside the Emergency Departments. If the hospital has a mental health or behavioral health clinician there, they can encourage the physicians to make referrals. But for the individuals who come into the Emergency Departments, interacting with patients does require certain levels of credentialing. Typically, medical staff credentials do not extend to non-medical individuals.

Chair Kerns thanked him and apologized for taking over the questions. She asked if other Subcommittee Members wanted to add anything. Then she asked a question to Member Banghart. Knowing that he does a lot of outreach in the community in Clark County, she was curious if he was aware of the CSC and is that seen as a facility that people could be taken to if needed.

² It should be noted that there is a CSC in Carson City, the Mallory Behavioral Health Crisis Center.

Subcommittee Member Rob Banghart said he was aware of the CSC. However, in response to her question, he said no. The continuum of care at his organization, Shine a Light, is to provide detox and triage, expressing they don't have a need for that. He suggested that their agency deals with substance use disorders and homelessness. So, if the individual is not requiring those services and is unwilling to go to sober living to get the individual involved with case management, then they would support as a last resort. It's either the shelter or that. They have created a safety net, so they don't have a need for this. He believed that that was more of a crisis intervention, letting the individual stabilize then filter them through the system.

Member Banghart noted that he also works at Crossroads, which is the next step in care. The issue that they see is that, without a true Continuum of Care in Clark County, there are not a lot of referrals coming through from the CSCs because "...we're not getting referrals to the next step." For example, if a CSC has 60 beds and a possible 24-hour stay, a Continuum of Care agency like Crossroads should receive a certain percentage of that. However, this is not what they are seeing. So, there is a disconnect there as well.

Shine a Light has created their own path, and they know what to do. So, the CSC isn't vital for them. Member Banghart believes that it may be better for those who don't have any experience, don't know what to do, hopefully they run into a CSC and that can become a starting point to get them connected into a continuum—but this is not what he has seen.

Member Schawl added that one of the challenges at the CSC is that they are ready to take 50 patients a day, but their current average is about eight patients. That is not solely substance use disorder patients. It's a combination of all the above.

Additionally, Member Schawl and Member Banghart discussed the kind of individuals who seek help primarily being self-referred individuals. They continued to discuss discrepancies in the amount of people they can support and serve, but Member Banghart and Member Schawl discussed the challenge of not having enough community awareness of what CSCs are and what they do. Member Schawl said it is a combination of awareness, but more of breaking the legacy habits of EMS in total. That's where Member Schawl indicated seeing the largest disconnect.

Chair Kerns asked if there were any other questions. Ms. Duarte asked Member Schawl and the Subcommittee if they wanted her to put some draft language on the blank placeholder slide to review. She wasn't sure where they were in the process of moving forward with this recommendation.

Chair Kerns noted that it needs further development. In her opinion, it's good for starting, but it may not be one that's fully vetted out by the August 1st deadline for this 2025 Annual Report. But she was in favor of putting some draft language.

Member Schawl agreed. They began to fill out the slide, the description being: "*establish CSCs as the preferred destination for people experiencing a behavioral health crisis (e.g. patients in need of crisis stabilization or detoxification).*"

Ms. Duarte noted a slight difference, which would be to “*recommend health districts adopt a protocol that require transportation to an approved alcohol and drug facility*”. She noted that she can put down a few concepts that are being worked on.

Member Schawl stated that he will be meeting with Southern Nevada Health District (SNHD), so they may be able to come up with some refinements. He also offered to connect with Member Banghart for some wordsmithing.

Chair Kerns said she thinks it will need to go through another review to provide justification, research, and action steps, but this looks like a good start. She asked if there were any last questions or comments, but seeing none, she noted that they are ready to move on and continue working on this recommendation.

Chair Kerns concluded this section and moved to agenda item #6.

5. Review 2026 Response Subcommittee Meeting Topics and Timeline

Chair Kerns introduced the item which was to review 2026 Response Subcommittee meeting topics and timeline. The following was reviewed at the prior Subcommittee with minimal changes, and Chair Kerns read the slide.

Subcommittee Meeting Topics and Timeline

March 2026

- *Discuss Preliminary Recommendations*
- *Subject Matter Expert Presentations as Requested*

May 2026

- *Finalize and **Rank** Preliminary Recommendations for Presentation at June SURG Meeting*
- *Subject Matter Expert Presentations as Requested*

June 2026

- *Finalize Recommendations Based on Feedback from SURG, **if needed***
- *September, November, December 2026 (start of new report cycle)*
- *Subject matter expert presentations and development of recommendations*

Please email Subcommittee staff with any speaker recommendations.

Chair Kerns noted for new Subcommittee Members that feedback they may receive from the SURG on their recommendations may be about changing or adding something. In the past, if another Subcommittee had something similar, they would have combined the recommendations. Other times there may be further things to research, and sometimes recommendations will be made by talking to other groups (organizations or subject matter experts).

If Subcommittee Members have speaker recommendations, please submit those to SEI staff.

Chair Kerns noted that it sounds like they have more work to do on the latest recommendation, and that the other ones are in good shape.

They moved to the next slide, which was the Full SURG Meeting and Revised Reporting Timeline and Topics.

Full SURG Meeting and Revised Reporting Timeline and Topics

- *April 2026*
- *Presentations on Peer Certification and the State Budget Process and an Update from the Fund for Resilient Nevada*
- *Review Preliminary Recommendations from Subcommittees*

June 2026

- ***Review Final, Ranked Recommendations***
- *Approve 2025-26 Annual Report Template*

July 2026

- *Approve 2025-26 Annual Report*

October 2026

- *Presentations from Subject Matter Experts*
- ***Overview of Open Meeting Law (pending)***

This is the current cadence for the Subcommittee and Full SURG meetings. For further planning on speaker recommendations for Response Subcommittee meetings, please email SEI staff to get these scheduled. The Chair asked if there were any questions. Seeing and hearing none, the Chair then closed the item and transitioned to agenda item #6.

6. Public Comment

Chair Kerns opened the floor for public comment after reading the statement on public comment and call-in information.

Seeing no public comments, moving the meeting forward to agenda item #7.

7. Adjournment.

Chair Kerns moved to the last agenda item, which was adjournment. Chair Kerns adjourned the meeting at 1:21 p.m.

Chat Log:

12:01 Crystal Duarte: If a member must depart a meeting prior to adjournment for any reason, the member shall formally announce their departure for the record to ensure accurate minutes and to allow the Chair to confirm that a quorum remains in accordance with Nevada's Open Meeting Law.

12:05 Crystal Duarte: Please do not use the chat for items other than technical support, as this becomes part of the public record. The meeting chat functionality is limited to inquiries regarding technical difficulties or to indicate an interest in offering public comment. Exercise caution with links which may appear in any meeting chat as they could be malicious.

12:17 Laura Knight, MD: My zoom crashed, and now does not have sound. I apologize if anyone has addressed me.

12:17 Crystal Duarte: If you can join via phone, that may help. We are hoping to get your input on Recommendation #1.

12:17:35 Lea Cartwright - Cartwright NV Government Affairs: Call In Audio: (719) 359-4580 Meeting ID: 884 0825 1817

12:24:49 Rob Banghart: Can you hear me?

12:25:10 Crystal Duarte: Sorry, Mr. Banghart we can't. Let me try to unmute you.

12:25:45 Rob Banghart: Im working on it can we ask what the half lif is for that drug on drufg testing

12:26:08 Rob Banghart: Yes

13:24:22 Crystal Duarte: Prevention Coalitions to take the lead in purchasing and providing Deterra bags to members of the public with opioid prescriptions, pharmacies, drug courts, DIND, and other partners. Prevention coalitions to also provide education at senior centers and targeted education toward youth to include a social media campaign on safe opioid prescription disposal. Additionally, work with NOCE to develop an online continuing education course for pharmacy technicians and pharmacists.