2025-2026

ANNUAL REPORT

Substance Use Response Working Group

Report Date: August 1, 2026

For submission to the Governor, the Attorney General, the Advisory Commission on the Administration of Justice, any other entities deemed appropriate by the Attorney General, and the Director of the Legislative Counsel Bureau for transmittal to: (1) During an even-numbered year, the Legislative Committee on Health Care and the Interim Finance Committee; or (2) During an odd-numbered year, the next regular session of the Legislature.

TABLE OF CONTENTS

Table of Contents ii
Executive Summary 1
Purpose 1
Background 1
2025-2026 Recommendations 1
Overview 5
Purpose 5
Background 5
Support 7
SURG Process 8
Appointments and Subcommittee Membership 8
Recommendations Development 8
Recommendations Ranking 9
Detailed Recommendations 10
2025-2026 Recommendations 10
Detailed Recommendations by Subcommittee 13
Appendices 31
Appendix A: Additional Information for Recommendations – Research Links 32
Appendix B: Additional Information for Recommendations – Target Population(s) Impacted 47
Appendix C: Additional Information for Recommendations – Legislation Addressed 49
Appendix D: Status of 2024 Recommendations (as of June 2026) 61
Appendix E: Information Regarding SURG Membership and Presentations Received 78
Appendix F: Information Regarding Opioid Settlement Funds 84
Appendix G: Signature 85

EXECUTIVE SUMMARY

Purpose

The Attorney General's Substance Use Response Working Group (SURG) [1] is required to "comprehensively review various aspects of substance misuse and substance use disorders and programs and activities to combat substance misuse and substance use disorders in this State" and to "study, evaluate and make recommendations concerning the use of [state and local money]." [2]

Background

Established in 2021 by Assembly Bill 374 and revised in 2025 under Assembly Bill 19[3], the SURG assesses evidence-based strategies for preventing substance use and intervening to stop substance use, examines qualitative and quantitative data to understand the risk factors that contribute to substance use and the rates of substance use, and substance use disorders, and makes recommendations to the Department of Health and Human Services.

The SURG is comprised of three subcommittees that make recommendations specific to each area of the governing legislation (see pages 5 through 7).

Prevention Subcommittee *(including harm reduction strategies)*	**Treatment and Recovery Subcommittee**	**Response Subcommittee**

2025-2026 Recommendations

From March 2025 through June 2026, the subcommittees received presentations from subject matter experts and drafted the following ranked recommendations.

PREVENTION RECOMMENDATIONS
1. Support a bill draft request in the 2027 legislative session that would double the annual state investment in primary prevention to protect prevention infrastructure via a general fund dollar line item committed to BBHWP's prevention programming for people aged 0-24. Monies should be directed to local lead agencies that prioritize evidence-based programming. For example, if the current level of investment was $1.6 million, then this would be raised to $3.2 million for the next biennium. This funding should not be at the

[1] The Attorney General's Statewide Substance Use Response Working Group (SURG) is codified in NRS 458.460. To read NRS 458.460, visit the following link: https://www.leg.state.nv.us/nrs/nrs-458.html#NRS458Sec450.
[2] To read Assembly Bill 374, visit the following link: https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/7952/Overview.
[3] To read Assembly Bill 19, visit the following link: https://www.leg.state.nv.us/App/NELIS/REL/83rd2025/Bill/11779/Overview.

PREVENTION RECOMMENDATIONS
expense of existing programming and should be the State of Nevada's contribution to Prevention efforts; additional Federal and/or other monies that are secured would not change the target allocation of State dollars for primary prevention efforts.
2. Create a bill draft request to set aside funding* for youth vaping prevention to be distributed using a local lead agencies model to reach $2 per capita, a recommended funding goal from the Nevada Tobacco Control & Smoke-free Coalition and subject matter experts. *Given that vaping is a delivery method for cannabis, nicotine, and other substances like fentanyl, multiple funding sources should be considered, including the cannabis wholesale tax, tobacco or vaping settlement, tobacco tax dollars, the Fund for Resilient Nevada, or other appropriate sources as related to substance use.
3. Request guidance from the Nevada Board of Pharmacy be posted to their website and communicated to pharmacists to clarify regulations pertinent to the distribution of naloxone in hospitals to permit low barrier naloxone distribution from Emergency Departments (EDs) and permit EDs to adopt a naloxone-specific standard operating procedure (SOP) for community-based naloxone distribution, separate from and exempt from the regulatory framework surrounding hospital formulary medications used in patient care.

TREATMENT AND RECOVERY RECOMMENDATIONS
1. Elimination of 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 MCOs (Managed Care Organizations).
2. Recommend to the Nevada Department of Human Services that they incentivize the implementation of cohesive addiction consult services. Hospitals would receive Department funds to hire certified peer recovery specialists and/or community health workers/representatives, if they meet the following specific criteria: adoption of delineation of privileges for addiction medicine as a medical specialty, as well as established protocols for the inclusion of midlevel providers and peer recovery navigators.
3. Recommend that insurers and payors not impose dosage limitations for buprenorphine when used for Medications for Opioid Use Disorder (MOUD).
4. A retrospective assessment or/and prospective study would be conducted to assess the outcomes of all patients following discharge from certified withdrawal management facilities within five years of discharge, including trends in the

TREATMENT AND RECOVERY RECOMMENDATIONS
patterns of step down and use of MOUD, to examine potential contributors to overdose and develop best practices for continued care after treatment.
5. Recommend that state funding be increased for Contingency Management, to be used to support people in recovery through rewards for reaching their recovery goals.

RESPONSE RECOMMENDATIONS
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 I of NAC 453.510.
2. 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. Restrict Sales Locations: Limit the sale of these substances to licensed establishments that can verify the age of purchasers and prohibit sales near schools and other youth-centered facilities. Enhance Enforcement Mechanisms: Provide regulatory agencies with authority and resources to monitor compliance, conduct inspections, and enforce penalties for violations. Explore taxation options for education and prevention.
3. Work with prevention coalitions to make available mechanisms for safe disposal of opioid prescriptions (i.e., Deterra Bags) and to provide education to community members (i.e., youth and senior groups). Prevention coalitions will also provide a one-page document with information about opioid overdoses, disposal, and available addiction assistance to be provided with opioid prescriptions. Board of Pharmacy will provide education via their website and work with the Nevada Opioid Center of Excellence for a continued education course.
4. Recommend state agencies under the legislative, judicial, and executive branches involved with adult deflection and diversion programs have a comprehensive

RESPONSE RECOMMENDATIONS
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.
5. 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. Restrict Sales Locations: Limit the sale of these substances to licensed establishments that can verify the age of purchasers and prohibit sales near schools and other youth-centered facilities. Enhance Enforcement Mechanisms: Provide regulatory agencies with authority and resources to monitor compliance, conduct inspections, and enforce penalties for violations. Explore taxation options for education and prevention.

The above recommendations are made for consideration by policymakers, direct service providers, state and local agencies, and funders. Additional details on action steps and background research for each recommendation are contained within the body and appendices of the full SURG 2025-26 Annual Report.

SURG meeting materials are available through the SURG website: https://ag.nv.gov/About/Administration/Substance_Use_Response_Working_Group_(SURG)/

OVERVIEW

Purpose

The Attorney General's Substance Use Response Working Group (SURG) is required to "comprehensively review various aspects of substance misuse and substance use disorders and programs and activities to combat substance misuse and substance use disorders in this State" and to "study, evaluate and make recommendations concerning the use of [state and local money]." [4]

Background

The SURG was established in 2021 by Assembly Bill 374 and revised in 2025 under Assembly Bill 19[5], which changed annual reporting to August 1st, effective July 1, 2026. Additionally, Assembly Bill 19 expanded SURG membership to include representatives from the general public, with a preference for a bilingual representative; emergency response; the Department of Indigent Defense Services; the Division of Child and Family Services; and the Nevada District Attorneys Association. Per Assembly Bill 19, the representative from the Department of Human Services must be from within the Division of Public and Behavioral Health.

The SURG is comprised of three subcommittees that make recommendations specific to each area of the legislation that governs this group. Subcommittee work is aligned with NRS 458.480 Section 1, Paragraphs a-q[6] as follows:

Prevention Subcommittee *(including harm reduction strategies)*	• (a) Leverage and expand efforts by state and local governmental entities to **reduce the use of substances which are associated with substance use disorders**, including, without limitation, heroin, other synthetic and non-synthetic opioids, and stimulants, and identify ways to enhance those efforts through coordination and collaboration. • (g) Make recommendations to entities including, without limitation, the State Board of Pharmacy, professional licensing boards that license practitioners, other than veterinarians, the State Board of Health, the Division, the Governor, and the Legislature, to **ensure that controlled substances are appropriately prescribed** in accordance with the provisions of NRS 639.2391 to 639.23916, inclusive • (j) Study the efficacy and expand the implementation of programs to: (1) **Educate youth and families about the effects of substance use and substance use disorders**; (2) **Reduce the harms associated with substance use and substance use disorders** while referring persons with substance use disorders to evidence-based treatment.

[4] To read Assembly Bill 374, visit the following link: https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/7952/Overview.
[5] To read Assembly Bill 19, visit the following link: https://www.leg.state.nv.us/App/NELIS/REL/83rd2025/Bill/11779/Overview.
[6] In 2021, guidance from prior Vice Chair Assemblymember Jill Tolles, prior Member and Department of Health and Human Services Designee Stephanie Woodard, and Attorney General Designee Terry Kerns determined subcommittee alignment.

Treatment and Recovery Subcommittee	• (c) **Assess and evaluate existing pathways to treatment and recovery** for persons with substance use disorders, including, without limitation, such persons who are members of special populations. • (e) Evaluate ways to improve and expand evidence-based or evidence-informed programs, procedures, and strategies to **treat and support recovery from opioid use disorder and any co-occurring substance use disorder**, including, without limitation, among members of special populations. • (f) **Examine support systems and programs for persons who are in recovery** from opioid use disorder and any co-occurring substance use disorder.
Response Subcommittee	• (d) Work to understand how residents of this State who are involved in the criminal justice system access supports for treatment of and recovery from substance use disorders at various points, including, without limitation, by **reviewing existing diversion, deflection, and reentry programs** for such persons. • (i) Develop **strategies for local, state, and federal law enforcement and public health agencies to respond to and prevent overdoses** and plans for implementing those strategies. • (k) Recommend strategies to **improve coordination between local, state, and federal law enforcement and public health agencies** to enhance the communication of timely and relevant information relating to substance use and reduce duplicative data collection and research. • (l) **Evaluate current systems for sharing information between agencies regarding the trafficking and distribution of legal and illegal substances** which are associated with substance use disorders, including, without limitation, heroin, other synthetic and non-synthetic opioids, and stimulants. • (m) **Study the effects of substance use disorders on the criminal justice system**, including, without limitation, law enforcement agencies and correctional institutions. • (n) **Study the sources and manufacturers of substances which are associated with substance use disorders**, including, without limitation, heroin, other synthetic and non-synthetic opioids and stimulants, and methods and resources for preventing the manufacture, trafficking, and sale of such substances. • (o) **Study the effectiveness of criminal and civil penalties at preventing the misuse of substances and substance use disorders and the manufacture, trafficking and sale of substances** which are associated with substance use disorders, including, without limitation, heroin, other synthetic and non-synthetic opioids, and stimulants. • (p) **Evaluate the effects of substance use disorders on the economy of this State**.

The following items were considered **cross-cutting** across all subcommittees:

- (b) **Assess evidence-based strategies for preventing substance use and intervening to stop substance use**, including, without limitation, the use of heroin, other synthetic and non-synthetic opioids and stimulants. Such strategies must include, without limitation, strategies to: (1) Help persons at risk of a substance use disorder avoid developing a substance use disorder; (2) Discover potentially problematic substance use in a person and intervene before the person develops a substance use disorder…
- (h) **Examine qualitative and quantitative data to understand the risk factors that contribute to substance use and the rates of substance use, and substance use disorders, focusing on special populations.**
- (q) **Study, evaluate and make recommendations to the Department of Health and Human Services concerning the use of the money** described in section 10.5 of this act to address substance use disorders, with a focus on: (1) The use of the money described in subsections 1, 2 and 3 of section 10.5 of this act to supplement rather than supplant existing state or local spending; (2) The use of the money described in section 10.5 of this act to support programs that use evidence-based interventions; (3) The use of the money described in section 10.5 of this act to support programs for the prevention of substance use disorders in youth; (4) The use of the money described in section 10.5 of this act to improve racial equity; and (5) Reporting by state and local agencies to the public concerning the funding of programs to address substance misuse and substance use disorders.

Support

The Attorney General chairs the SURG. Staff from the Office of the Attorney General serve as the Attorney General's designee and provide project and administrative direction for all activities and materials. Legal guidance for all meetings is provided by an assigned Deputy Attorney General.

Social Entrepreneurs, Inc. (SEI) provides additional support, including survey development, distribution, and analysis; coordination of presentations from subject matter experts (SMEs); development of agendas and related meeting materials; technical support for in-person and remote meeting scheduling and participation; and assistance developing and documenting the justification and background for recommendations.

SURG PROCESS

Appointments and Subcommittee Membership

At the first meeting of each calendar year, the SURG elects from its members a Vice Chair and allows members to identify their preferred subcommittee. For the current reporting period, this occurred twice, once in January 2025 and again in January 2026. New members added via the expansion of membership roles outlined in AB19 were onboarded in October 2025 and selected subcommittees at that time.

From January 2025 through the published date of this report (August 1, 2026), Subcommittee Chairs and Vice Chairs were appointed as follows:

Prevention	
Prior Period (Jan-Dec 2025)	**Current Period** (Jan-Aug 2026)
• Jessica Johnson, Chair • Erik Schoen, Vice Chair	• Jessica Johnson, Chair • Wendy Nelsen, Vice Chair

Treatment and Recovery	
Prior Period (Jan-Dec 2025)	**Current Period** (Jan-Aug 2026)
• Steve Shell, Chair • Dr. Lesley Dickson, Vice Chair	• Steve Shell, Chair • Guiseppe Mandell, Vice Chair

Response	
Prior Period (Jan-Dec 2025)	**Current Period** (Jan-Aug 2026)
• Terry Kerns, Chair • Shayla Holmes, Vice Chair	• Terry Kerns, Chair • Shayla Holmes, Vice Chair

Recommendations Development

Subcommittee members, with leadership provided by the Chairs and Vice Chairs, were instrumental in driving forward the process of developing recommendations with comprehensive justifications; the expertise, skills, and commitments of all members are essential to the success of the SURG and the development of recommendations.

Subcommittee members submit recommendations and/or suggestions for presentations from subject matter experts via a survey submitted to SEI. Information submitted is then reviewed by subcommittee members during subcommittee meetings and revised throughout the year based on member research, presentations from subject matter experts, and meeting discussions. Recommendations may also be developed live in subcommittee meetings with supporting information being provided following the meeting and made public at future meetings of the subcommittees.

The SURG working group met in 2025 during the months of January, April, July, and October. Thus far in 2026, the group met in January, April, June, and July. A list of presentations contributing to recommendations received by the SURG and the three subcommittees are included in Appendix E.

Recommendations Ranking

Recommendations were ranked within respective subcommittees at their May 2026 meetings prior to review by the full SURG in June. Spreadsheets were developed for each subcommittee, based on their specific recommendations, with descending weights assigned to each rank, with a rank of 1 being the highest, descending to 4, 5, or 6, depending on the number of recommendations.

The results of subcommittee rankings were then brought to the full SURG for adoption, with consideration of any final changes and formal votes on the slate of recommendations from each of the subcommittees.

At the June 10, 2026 SURG meeting,[7] members reviewed each subcommittee's ranked recommendations. Members were able to approve recommendations as is, approve with changes, or express dissent on a particular recommendation or vote in opposition of a subcommittee's slate of recommendations. Recommendations receiving majority support through the formal voting process were approved and have been included as the final recommendations throughout this report.

[7] SURG meeting materials are available through the SURG website: https://ag.nv.gov/About/Administration/Substance_Use_Response_Working_Group_(SURG)/

DETAILED RECOMMENDATIONS

This section includes the list of recommendations as ranked, by subcommittee, as well as a more detailed list of the recommendations that includes the justification/background, action step(s), and additional information on the recommendations' impact, capacity, feasibility, urgency, and advancement of racial and health equity. Information is, for the most part, included as submitted via survey by the SURG member who made the recommendation, with some changes made to support consistent formatting or due to updates made following the initial submission. See **Appendices A-C** for other supporting information, including links to research related to the recommendation, populations impacted, and legislation addressed.

2025-2026 Recommendations

From March 2025 through June 2026, the subcommittees received presentations from subject matter experts and drafted the following ranked recommendations.

PREVENTION RECOMMENDATIONS
1. Support a bill draft request in the 2027 legislative session that would double the annual state investment in primary prevention to protect prevention infrastructure via a general fund dollar line item committed to BBHWP's prevention programming for people aged 0-24. Monies should be directed to local lead agencies that prioritize evidence-based programming. For example, if the current level of investment was $1.6 million, then this would be raised to $3.2 million for the next biennium. This funding should not be at the expense of existing programming and should be the State of Nevada's contribution to Prevention efforts; additional Federal and/or other monies that are secured would not change the target allocation of State dollars for primary prevention efforts.
2. Create a bill draft request to set aside funding* for youth vaping prevention to be distributed using a local lead agencies model to reach $2 per capita, a recommended funding goal from the Nevada Tobacco Control & Smoke-free Coalition and subject matter experts. *Given that vaping is a delivery method for cannabis, nicotine, and other substances like fentanyl, multiple funding sources should be considered, including the cannabis wholesale tax, tobacco or vaping settlement, tobacco tax dollars, the Fund for Resilient Nevada, or other appropriate sources as related to substance use.
3. Request guidance from the Nevada Board of Pharmacy be posted to their website and communicated to pharmacists to clarify regulations pertinent to the distribution of naloxone in hospitals to permit low barrier naloxone distribution from Emergency Departments (EDs) and permit EDs to adopt a naloxone-specific standard operating procedure (SOP) for community-based naloxone distribution, separate from and exempt from the regulatory framework surrounding hospital formulary medications used in patient care.

TREATMENT AND RECOVERY RECOMMENDATIONS
1. Elimination of 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 MCOs (Managed Care Organizations).
2. Recommend to the Nevada Department of Human Services that they incentivize the implementation of cohesive addiction consult services. Hospitals would receive Department funds to hire certified peer recovery specialists and/or community health workers/representatives, if they meet the following specific criteria: adoption of delineation of privileges for addiction medicine as a medical specialty, as well as established protocols for the inclusion of midlevel providers and peer recovery navigators.
3. Recommend that insurers and payors not impose dosage limitations for buprenorphine when used for Medications for Opioid Use Disorder (MOUD).
4. A retrospective assessment or/and prospective study would be conducted to assess the outcomes of all patients following discharge from certified withdrawal management facilities within five years of discharge, including trends in the patterns of step down and use of MOUD, to examine potential contributors to overdose and develop best practices for continued care after treatment.
5. Recommend that state funding be increased for Contingency Management, to be used to support people in recovery through rewards for reaching their recovery goals.

RESPONSE RECOMMENDATIONS
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 I of NAC 453.510.
2. 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.

RESPONSE RECOMMENDATIONS
Restrict Sales Locations: Limit the sale of these substances to licensed establishments that can verify the age of purchasers and prohibit sales near schools and other youth-centered facilities. Enhance Enforcement Mechanisms: Provide regulatory agencies with authority and resources to monitor compliance, conduct inspections, and enforce penalties for violations. Explore taxation options for education and prevention.
3. Work with prevention coalitions to make available mechanisms for safe disposal of opioid prescriptions (i.e., Deterra Bags) and to provide education to community members (i.e., youth and senior groups). Prevention coalitions will also provide a one-page document with information about opioid overdoses, disposal, and available addiction assistance to be provided with opioid prescriptions. Board of Pharmacy will provide education via their website and work with the Nevada Opioid Center of Excellence for a continued education course.
4. Recommend state agencies under the legislative, judicial, and executive branches involved with adult 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.
5. 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. Restrict Sales Locations: Limit the sale of these substances to licensed establishments that can verify the age of purchasers and prohibit sales near schools and other youth-centered facilities. Enhance Enforcement Mechanisms: Provide regulatory agencies with authority and resources to monitor compliance, conduct inspections, and enforce penalties for violations. Explore taxation options for education and prevention.

Detailed Recommendations by Subcommittee

Prevention Subcommittee

Recommendation #1

Support a bill draft request in the 2027 legislative session that would double the annual state investment in primary prevention to protect prevention infrastructure via a general fund dollar line item committed to BBHWP's prevention programming for people aged 0-24. Monies should be directed to local lead agencies that prioritize evidence-based programming.

For example, if the current level of investment was $1.6 million, then this would be raised to $3.2 million for the next biennium. This funding should not be at the expense of existing programming and should be the State of Nevada's contribution to Prevention efforts; additional Federal and/or other monies that are secured would not change the target allocation of State dollars for primary prevention efforts.

- Justification/Background:
  - This recommendation has been revised to make it "evergreen" and applicable to "upcoming" legislative sessions. As well, it provides further clarification that these funds should come directly from the State budget.
  - While there are strong, evidence-based primary prevention programs that are in place in Nevada along with a robust coalition network, there is not enough financial support to reach all students with primary prevention programming. The most effective interventions target salient risk and protective factors at the individual, family, and/or community levels and are guided by relevant psychosocial theories on substance use. This funding should be allocated on a per pupil basis to ensure maximum reach within the state.
  - The 2022 National Drug Control Strategy report on cost effectiveness of prevention states that "Prevention is not only effective, it is also [a] cost-effective approach to prevent later SUD [and has] been identified as an underutilized response to the opioid crisis." The 2016 Surgeon General's Report on Alcohol, Drugs, and Health also noted that prevention science demonstrates that effective prevention interventions exist, can markedly reduce substance use, and evidence-based programs and policies are underutilized. There are multiple examples of cost-effective prevention programs. For example, the average effective school-based prevention program is estimated to save $18 per dollar invested… There are also cost-benefit assessments of individual programs. Too Good for Drugs, a school-based prevention program for students in kindergarten through 12th grade, was designed to increase social competencies (e.g., develop protective factors) and diminish risk factors associated with alcohol, tobacco, and other drug use. It has a benefit-to-cost ratio of + $8.74 and it is estimated that there is a 94-percent chance that benefits will exceed costs. Other effective and cost-effective programs include Botvin Life Skills which has benefit-to-cost

ratio of $13.49, and the Good Behavior Game with a benefit-to-cost ratio of $62.80.

- Action Step:
  - DHS Policy
  - Other—Specific departmental budget recommendation / requirement
- Impact, Capacity and Feasibility of Implementation, Urgency, and How the Recommendation Advances Racial and Health Equity:
  - **Impact**: 3 - Substantive progress on important prevention initiatives and efforts that would help to decrease initiation and use of harmful substances.
  - **Capacity and feasibility of implementation**: 3 - We have coalitions in every rural Nevada county ready and willing to provide more substantive services.
  - **Urgency**: 3 - Our stats essentially speak for themselves -- typically 51 out of 51 states / territories -- in MH and SUD indices.
  - **Racial and health equity**: 3 - This would help to ensure that resources are getting to everyone.

Recommendation #2

Create a bill draft request to set aside funding* for youth vaping prevention to be distributed using a local lead agencies model to reach $2 per capita, a recommended funding goal from the Nevada Tobacco Control & Smoke-free Coalition and subject matter experts. *Given that vaping is a delivery method for cannabis, nicotine, and other substances like fentanyl, multiple funding sources should be considered, including the cannabis wholesale tax, tobacco or vaping settlement, tobacco tax dollars, the Fund for Resilient Nevada, or other appropriate sources as related to substance use.

- Justification/Background:
  - Since legalizing cannabis in 2016, Nevada has built a robust market generating nearly $1 billion in annual sales and more than $118 million in cannabis tax revenue. However, none of this funding is currently directed toward youth prevention, even as youth substance use patterns evolve.
  - Vaping has emerged as the dominant method of substance use among youth, cutting across nicotine, cannabis, and increasingly other drugs. In 2023, one in three Nevada high school students reported ever using electronic vapor products, and cannabis use remains similarly widespread, with nearly 29% reporting lifetime use. Importantly, youth are increasingly consuming cannabis through vaping, highlighting a critical overlap that current prevention funding structures do not address.
  - This convergence presents a clear policy challenge: funding streams remain siloed while youth behavior is not. Nevada continues to significantly underinvest in prevention, allocating just 0.5% of tobacco-related revenues despite ranking near the bottom nationally. At the same time, cannabis revenues, derived in part from a legalized product with known youth risks, are not reinvested in prevention efforts.
  - The result is a structural gap between revenue generation and public health response, leaving local communities without the resources needed to address rapidly changing substance use trends. This gap disproportionately impacts youth and other priority populations and limits the state's ability to implement evidence-based prevention strategies at scale.
  - A more aligned and responsive approach is needed. Because vaping is a shared delivery system across substances, prevention funding should also be integrated and flexible. Establishing a dedicated set-aside for youth vaping prevention would directly connect funding to current patterns of use.
  - Setting a minimum investment of $2 per capita, as recommended by the Nevada Tobacco Control & Smoke-free Coalition and subject matter experts, would create a sustainable baseline for prevention. Distributing these funds through a local lead agencies model would ensure that resources are deployed efficiently, equitably, and in ways that reflect local needs and conditions.
  - A bill draft request to establish this funding structure offers a practical, evidence-informed solution to modernize Nevada's prevention system, better

align funding with risk, and protect youth in an evolving substance use landscape.

- Action Step:
  - Bill Draft Request (BDR)
- Impact, Capacity and Feasibility of Implementation, Urgency, and How the Recommendation Advances Racial and Health Equity:
  - **Impact**: 3 - The proposed recommendation will bolster youth-focused prevention programs across Nevada. By reaching the $2 per capita funding goal, this policy ensures a sustained investment in evidence-based prevention efforts aimed at reducing youth initiation and use of cannabis. Investing in early prevention has been shown to reduce lifetime health risks, lower healthcare costs associated with substance use, and promote healthier behaviors among young people, ultimately leading to improved public health outcomes for future generations.
  - **Capacity and feasibility of implementation**: 2 - Leveraging the local lead agencies model ensures that funds are distributed efficiently and effectively to communities with the highest needs. Local agencies are well-positioned to implement youth-specific prevention programs, building on existing infrastructure and expertise in public health interventions. Nevada already has a coalition and framework in place to distribute these prevention funds. The feasibility of this approach is supported by the ability of local agencies to collaborate with schools, youth organizations, and community groups, ensuring that prevention efforts are culturally relevant and impactful.
  - **Urgency**: 3 - Youth and young adults are particularly vulnerable to the harmful effects of substances, including long-term cognitive, physical, and emotional impacts. Without timely investment in youth prevention programs, Nevada risks exacerbating future public health and social challenges, such as increased substance dependence and reduced academic achievement. The urgency of this funding is clear: investing in youth prevention now will mitigate these risks and create healthier communities for years to come.
  - **Racial and health equity**: 3 - Youth from communities of color and low-income backgrounds often face higher exposure to tobacco and cannabis, along with fewer resources for prevention and education. By directing these funds toward youth prevention programming, this policy ensures that local agencies prioritize outreach to underserved communities, addressing health disparities, and ensuring equitable access to prevention services. Targeted investments in these communities will help close gaps in health outcomes and provide critical resources to those most affected by substance use, advancing both racial and health equity across the state.

Recommendation #3

Request guidance from the Nevada Board of Pharmacy be posted to their website and communicated to pharmacists to clarify regulations pertinent to the distribution of naloxone in hospitals to permit low barrier naloxone distribution from Emergency Departments (EDs) and permit EDs to adopt a naloxone-specific standard operating procedure (SOP) for community-based naloxone distribution, separate from and exempt from the regulatory framework surrounding hospital formulary medications used in patient care.

- Justification/Background:
  - Emergency departments (EDs) could serve as effective settings for tackling opioid-related deaths by providing naloxone. Multiple hospital representatives have expressed interest in distributing naloxone but are uncertain of the ability of the hospital to dispense naloxone to community outside of the pharmacy protocols for medication dispensing.
- Action Step:
  - Regulatory or Licensing Board
- Impact, Capacity and Feasibility of Implementation, Urgency, and How the Recommendation Advances Racial and Health Equity:
  - **Impact**: 3 - The anticipated impact would be that the hospitals that are currently interested in setting up an ED distribution protocol could move forward and begin distributing this important medication in the next few months.
  - **Capacity and feasibility of implementation**: 3 - The SURG could request clarification from the Board of Pharmacy and the Board of Pharmacy could publish this statement of clarification on their website.
  - **Urgency**: 3 - This could have a major impact on the opioid overdose death rates especially as we are moving into the hot summer months, which typically have increased overdose rates.
  - **Racial and health equity**: 3 - People with less access to healthcare, housing, and other important protective factors are more likely to find themselves in the ED experiencing an opioid overdose than those with more access to treatment, housing, and other protective factors. Connecting these ED patients with important harm reduction supplies and information about treatment may help them gain access to treatment.

Treatment and Recovery Subcommittee

Recommendation #1

Elimination of 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 MCOs (Managed Care Organizations).

- Justification/Background:
  - Prior authorizations present an unnecessary delay in initiation of treatment for opioid use disorder. In the era of fentanyl, this can be a particularly dangerous delay of care, as it can often result in a patient relapsing and dying of an unintended overdose while waiting for the medication to be approved. All of which can be avoided by eliminating the barrier that is prior authorization. The best way is to mandate coverage for any and all buprenorphine products when being used to initiate treatment for opioid use disorder by any insurance, but specifically Nevada Medicaid and all Medicaid products including MCOs, as well as Medicare. As it is, no prior authorization is required to initiate Sublocade or Brixadi, which are injectable versions of buprenorphine and which are the most costly options for treatment, so this change will, in fact, generate savings for Medicaid, as less expensive, but equally effective options may be exercised readily.
- Action Step:
  - DHS Policy
  - Change Medicaid policy to eliminate prior authorizations for buprenorphine products of all kinds.
- Impact, Capacity and Feasibility of Implementation, Urgency, and How the Recommendation Advances Racial and Health Equity:
  - **Impact**: 3 - It will help prevent delay of care for patients that are actively seeking treatment for opioid use disorder by allowing them access to lifesaving medications in a timely fashion.
  - **Capacity and feasibility of implementation**: 3 - It would only require Medicaid to change its policy and ban prior authorizations in this, very specific, situation.
  - **Urgency**: 3 - These are unforced errors that our medical system creates CURRENTLY and on a daily basis.
  - **Racial and health equity**: 3 - It would allow much better access to treatment for opioid use disorder, regardless of the patient's current insurance. This would lead to better health equity between those that are privately insured and those that are insured by Medicaid.

Recommendation #2

Recommend to the Nevada Department of Human Services that they incentivize the implementation of cohesive addiction consult services.

Hospitals would receive Department funds to hire certified peer recovery specialists and/or community health workers/representatives, if they meet the following specific criteria: adoption of delineation of privileges for addiction medicine as a medical specialty, as well as established protocols for the inclusion of midlevel providers and peer recovery navigators.

Note that this recommendation combines one originally submitted by Steve Shell on June 17, 2025 and one submitted by Dr. José Maria Partida Corona, MD, FASAM on March 23, 2026. The back-up and justification have been combined below. When appropriate, the content provided by Member Shell or Dr. Partida Corona are delineated.

- Justification/Background:
  - Hospital emergency rooms (ERs) continue to struggle with a high volume of patients who present with substance misuse and often with co-occurring mental health conditions. A high percentage of these individuals have multiple visits to the ERs for various reasons that are associated with their substance misuse. The ER teams do their best to evaluate, treat and connect to community services, but many of their team members lack the expertise to effectively manage substance misuse and do not have lived experience like peer recovery support specialists. Evidence has shown that connecting individuals with substance misuse to a peer while in the ER leads to better outcomes as the peer can help navigate a transfer to treatment options in the community as well as maintain communication with the individual for a period of time to encourage recovery. Hospitals would be more motivated to establish peer support teams if financial assistance is provided on a long-term basis. *Submitted by Steve Shell.*
  - The establishment of delineation of privileges for addiction specialists will allow them to be recognized as a specialty within the hospital, such as cardiologists or neurologists are currently. This allows a pathway for insurances to reimburse for their services as specialists, rather than having their services go unreimbursed. Also, by establishing a clear pathway for midlevels to provide supervised assistance to these specialists, as well as peer recovery navigators, we create the environment for a much more robust level of care for both patients that will be hospitalized for further care, as well as patients that will be discharged from the ER. *Submitted by Dr. Partida Corona.*
- Action Step:
  - Expenditure of Opioid Settlement Funds
  - DHS Policy *Submitted by Dr. Partida Corona.*
  - Requiring hospitals meet these goals in order to be eligible for Opioid Settlement Funds *Submitted by Dr. Partida Corona.*

- Impact, Capacity and Feasibility of Implementation, Urgency, and How the Recommendation Advances Racial and Health Equity:
  - **Impact**:
    - 3 - Due to the high volume of patients with substance misuse in hospital emergency rooms around Nevada, establishing peer support teams is the most efficient way to address these individuals to get them connected to community resources as quickly as possible. *Submitted by Steve Shell.*
    - 3 - Highly impactful, by opening the door to the creation of addiction treatment services in the hospital setting, as well as creating a much better system for warm hand off to outpatient treatment from the ER. *Submitted by Dr. Partida Corona.*
  - **Capacity and feasibility of implementation**:
    - 3 - Due to CASAT's phenomenal certification program for peer recovery support specialists, there are many peers around Nevada who can be hired by hospitals to work in emergency rooms. *Submitted by Steve Shell.*
    - 2 - There are already models to work from both in the Las Vegas community and readily available from ASAM (American Society of Addiction Medicine) or NVSAM (Nevada Society of Addiction Medicine). *Submitted by Dr. Partida Corona.*
  - **Urgency**:
    - 3 - Due to the high volume of patients with substance misuse in hospital emergency rooms around Nevada, it is imperative that we act quickly to establish peer support teams that are extremely effective to connect individuals to treatment and guide them on their path to recovery. *Submitted by Steve Shell.*
    - 3 - It will take time to implement such regulatory changes in hospital policies and procedures, so the sooner this is initiated, the better. *Submitted by Dr. Partida Corona.*
  - **Racial and health equity**:
    - 2 - No additional description provided. *Submitted by Steve Shell.*
    - 2 - It will provide greater access to addiction specialists to underserved populations, as they tend to use the ER and hospitals more readily than the outpatient setting given limitations of insurance coverage. *Submitted by Dr. Partida Corona.*

Recommendation #3

Recommend that insurers and payors not impose dosage limitations for buprenorphine when used for Medications for Opioid Use Disorder (MOUD).

- Justification/Background:
  - Placement of limitations on buprenorphine dosages is actually counterproductive in several ways. First, by placing restrictions on dosing, it engenders in the minds of physicians, a mindset that buprenorphine is a dangerous medication that could easily lead to overdose. This could not be further from the truth. It actually serves to protect from overdose. Second, it stigmatizes patients that are trying to stay in compliance and treatment for their opioid use disorder. Third, it creates a barrier to trust between physician and patient, by introducing limitations from a third party, which is highly problematic when treating a stigmatized population. Fourth, it interjects a limitation to treatment that is not based on best practices, but that is, in fact, rooted in institutional stigmatization of a patient population.
- Action Step:
  - DHS Policy
- Impact, Capacity and Feasibility of Implementation, Urgency, and How the Recommendation Advances Racial and Health Equity:
  - **Impact**: 3 - It will increase the success of medication assisted treatment when it is allowed to happen.
  - **Capacity and feasibility of implementation**: 3 - It will only require a change in Medicaid policy.
  - **Urgency**: 3 - The sooner we make this change, the less barriers will exist for patients currently seeking treatment for fentanyl dependency or use disorder.
  - **Racial and health equity**: 3 - It will help patients on higher doses of fentanyl, which is more common among the unhoused, a group that generally gets less regular healthcare and less treatment for substance use disorders.

Recommendation #4

A retrospective assessment or/and prospective study would be conducted to assess the outcomes of all patients following discharge from certified withdrawal management facilities within five years of discharge, including trends in the patterns of step down and use of MOUD, to examine potential contributors to overdose and develop best practices for continued care after treatment.

- Justification/Background:
  - Previous studies (Strang J, McCambridge J, Best D, Beswick T, Bearn J, Rees S et al. Loss of tolerance and overdose mortality after inpatient opiate detoxification: follow up study; https://doi.org/10.1136/bmj.326.7396.959) have shown that treatment reduces mortality but sometimes increases in mortality are seen when tolerance is reduced and people return to opiate misuse (relapse). This study, either prospective or retrospective, can be used to examine mortality and relapse after opioid detoxification to develop best practices for continued care after treatment within the state. Previous studies have found reduced mortality when individuals received MOUD and/or residential treatment.
- Action Step:
  - DHS Policy
- Impact, Capacity and Feasibility of Implementation, Urgency, and How the Recommendation Advances Racial and Health Equity:
  - **Impact**: 2 - This recommendation could expand requirements for service referrals after a patient completes treatment.
  - **Capacity and feasibility of implementation**: 3 - Data is currently available that could be reviewed.
  - **Urgency**: 1 - This is a study, so it is not urgent.
  - **Racial and health equity**: 3 - This recommendation could help with best practices for referring patients following detoxification.

Recommendation #5

Recommend that state funding be increased for Contingency Management, to be used to support people in recovery through rewards for reaching their recovery goals.

- Justification/Background:
  - Contingency management has been a strategy used to reward people for treatment and recovery goals. While there may be funding in the state to support contingency management, it is not currently covered by Medicaid (as far as I know). Additional support could help to support more treatment providers to incentivize patients reaching their treatment goals.
- Action Step:
  - Bill Draft Request (BDR)
  - Expenditure of Opioid Settlement Funds
  - DHS Policy
- Impact, Capacity and Feasibility of Implementation, Urgency, and How the Recommendation Advances Racial and Health Equity:
  - **Impact**: 2 - People in treatment and recovery can gain financial supports to help them stay in recovery.
  - **Capacity and feasibility of implementation**: 2 - We believe that the Southern Nevada Health District (SNHD) is supporting this effort currently and some providers are supporting contingency management in a smaller scale.
  - **Urgency**: 1 - N/A
  - **Racial and health equity**: 2 - This will help to support people in treatment financially.

Response Subcommittee

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 I of NAC 453.510.

- Justification/Background:
  - The available medical, public health, and law enforcement evidence shows that mitragynine, 7-hydroxymitragynine (7-OH), and related synthetic or chemically modified substances pose a growing threat to public safety because of their opioid-like effects and high potential for abuse and addiction. Federal agencies including the FDA, CDC, and National Institute on Drug Abuse have warned that these substances can cause dependence, withdrawal symptoms, respiratory depression, overdose, and death, while poison center reports and overdose cases linked to kratom-related products continue to rise nationwide. Recent lawsuits and enforcement actions in states such as Texas and Missouri also show that highly concentrated 7-OH products are being widely sold and marketed despite reports of serious addiction, financial harm, and other health consequences. Given the increasing availability of these potent products, documented fatalities in Nevada, and the lack of consistent regulation across states, adding these substances and their derivatives to Schedule I of NAC 453.510 is necessary to help protect public health and safety.
- Action Step:
  - Regulatory or Licensing Board
  - Develop or enhance prevention education
- Impact, Capacity and Feasibility of Implementation, Urgency, and How the Recommendation Advances Racial and Health Equity:
  - **Impact**: 1 - Reduce the access to alternative sources for substance misuse that are just as deadly and do not flag on standard testing.
  - **Capacity and feasibility of implementation**: 2 - It will require multiple agencies to work together to create and enforce labeling and oversight.
  - **Urgency**: 2 - Nevada needs to figure out how to address this growing trend of street drug alternatives/gas station counter drugs.
  - **Racial and health equity**: 3 - Individuals that frequent gas stations for these types of drugs are those living in indigent neighborhoods and communities with higher poverty rates.

Recommendation #2

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.

Restrict Sales Locations: Limit the sale of these substances to licensed establishments that can verify the age of purchasers and prohibit sales near schools and other youth-centered facilities.

Enhance Enforcement Mechanisms: Provide regulatory agencies with authority and resources to monitor compliance, conduct inspections, and enforce penalties for violations.

Explore taxation options for education and prevention.

- Justification/Background:
  - Psychoactive mushrooms may be legally accessible due to their specific chemical compositions and lack of comprehensive regulation. This creates potential loopholes that could allow minors to obtain and misuse these substances.
- Action Step:
  - Regulatory or Licensing Board
  - Direct tax revenue to prevention and education
- Impact, Capacity and Feasibility of Implementation, Urgency, and How the Recommendation Advances Racial and Health Equity:
  - **Impact**: 1 - Reduce the access to alternative sources for substance misuse that are just as deadly and do not flag on standard testing.
  - **Capacity and feasibility of implementation**: 2 - It will require multiple agencies to work together to create and enforce labeling and oversight.
  - **Urgency**: 2 - Nevada needs to figure out how to address this growing trend of street drug alternatives/gas station counter drugs.
  - **Racial and health equity**: 3 - Individuals that frequent gas stations for these types of drugs are those living in indigent neighborhoods and communities with higher poverty rates.

Recommendation #3

Work with prevention coalitions to make available mechanisms for safe disposal of opioid prescriptions (i.e., Deterra Bags) and to provide education to community members (i.e., youth and senior groups). Prevention coalitions will also provide a one-page document with information about opioid overdoses, disposal, and available addiction assistance to be provided with opioid prescriptions. Board of Pharmacy will provide education via their website and work with the Nevada Opioid Center of Excellence for a continued education course.

- Justification/Background:
    - It is an evidence-based harm reduction practice to co-prescribe opioid antagonist and safe disposal kits when prescribing opioids.
        - **Targeted Co-prescribing**: Naloxone should be prescribed to patients receiving opioids who are at high risk, specifically those with:
            - Concurrent benzodiazepine use
            - High daily morphine milligram equivalents (MME) (e.g., ≥50 MME/day)
            - A history of substance use disorder or prior nonfatal overdose
            - Risks for, or history of, opioid misuse, including those in methadone treatment
        - **Targeted Education**: Providing naloxone should be accompanied by overdose education for both the patient and their family members or caregivers.
        - **Use of Clinical Decision Support (CDS)**: Implementing electronic health record (EHR) alerts for pharmacists and clinicians is an effective strategy to increase naloxone co-prescribing.
        - **Pharmacist Involvement**: In many US states, pharmacists can dispense naloxone under standing orders without a patient-specific prescription, which should be used to increase accessibility.
        - **Patient-Centered Counseling**: Frame the naloxone prescription as a "safety measure" or "fire extinguisher" for the "worst-case scenario" to reduce stigma and improve acceptance.
    - ***Key Findings on Effectiveness***
        - **Reduction in Overdose Deaths**: Studies show that communities with higher rates of naloxone distribution have significantly reduced opioid overdose deaths.
        - **Cost-Effectiveness**: Scaling up naloxone distribution to those prescribed high-dose opioids is considered a cost-effective intervention.
        - **Reduced Healthcare Utilization**: Patients receiving a naloxone prescription have shown 63% fewer opioid-related emergency department visits.
        - **Low Risk of Harm**: Evidence suggests that making naloxone available does not result in increased opioid misuse.
    - ***Barriers and Facilitators***
        - **Barriers**: Lack of provider confidence, time constraints, and stigma.
        - **Facilitators**: Using "academic detailing" (educational outreach) and Electronic Health Record (EHR)-based prompts (Best Practice

Advisories). Providing patients with prescription disposal kits alongside opioid prescriptions is considered an evidence-based practice for increasing the rate of safe and proper disposal of unused opioids. Multiple studies show this intervention is effective in reducing the amount of leftover opioids in homes, which helps prevent misuse and diversion.

- ***Evidence-Based Findings***
  - **Increased Disposal Rates**: Numerous studies have demonstrated that patients who receive a disposal kit are significantly more likely to dispose of their leftover opioids compared to those who do not receive a kit. Some studies show an increase in disposal rates from less than 10% (without intervention) to over 50% or even 80% (with kits and follow-up).
  - **Convenience as a Key Factor**: A primary reason for the success of these kits is convenience. They allow patients to neutralize the medication at home and dispose of it with their regular trash, bypassing the need to travel to a designated take-back location or wait for specific events.
  - **Cost-Effectiveness**: The kits are relatively low-cost (often a few dollars each), making them a feasible option for hospitals and healthcare systems to include as part of standard care.
  - **Complementary Strategy**: Providing disposal kits is viewed as a valuable complement to other opioid stewardship efforts, such as prescribing smaller quantities of opioids initially.
  - **Enhanced by Education**: The effectiveness of disposal kits is often improved when combined with patient education and follow-up reminders (e.g., text messages or phone calls) regarding the risks of keeping unused opioids and the proper disposal method.
- ***Considerations***
  - While the evidence supports the use of disposal kits to increase disposal rates, some studies note that:
    - The quality of evidence for how this translates to health outcomes, such as a direct reduction in overdose rates, is still low.
    - The intervention works best when implemented actively (e.g., given directly to the patient with counseling) rather than passively (e.g., left in a waiting room for patients to take).
    - There can be "self-selection" bias in studies where participants self-report disposal, meaning those who are more likely to dispose of the medication are also more likely to respond to follow-up surveys. Overall, major health institutions and the FDA recognize and encourage the use of in-home disposal products as a safe and effective option, alongside take-back programs and drop-off boxes, to reduce the public health risks associated with unused prescription opioids.

- <u>Action Step</u>:
  - Expenditure of Opioid Settlement Funds: Prevention Coalitions to take the lead in purchasing and providing Deterra bags to members of the public with

opioid prescriptions, pharmacies, drug courts, Department, and other partners including specialty courts and within the Department of Indigent Defense Services.
    - Regulatory or Licensing Board: Work with the Nevada Board of Pharmacy and the Nevada Pharmacist Association to distribute information.
    - Education: Prevention coalitions to also provide education to seniors (e.g., at senior centers) and targeted education toward youth to include a social media campaign on safe opioid prescription disposal. Additionally, work with the Nevada Opioid Center on Excellence (NOCE) to develop an online continuing education course for pharmacy technicians and pharmacists.

- Impact, Capacity and Feasibility of Implementation, Urgency, and How the Recommendation Advances Racial and Health Equity:
    - **Impact**: 2 - Could prevent overdoses through the use of pharmacy provided naloxone with opioids and disposal of unused opioids by providing disposal kits with each opioid recommendation.
    - **Capacity and feasibility of implementation**: 3 - Board of Pharmacy could assist with this program and potentially the statewide prevention coalitions. Funding would be through the Fund for a Resilient Nevada (FRN).
    - **Urgency**: 1 - While naloxone and disposal kits are provided to Nevadans upon request, this recommendation would provide these items to any Nevadan receiving an opioid prescription.
    - **Racial and health equity**: 2 - This program implementation would be to any individual receiving an opioid prescription.

Recommendation #4

Recommend state agencies under the legislative, judicial, and executive branches involved with adult 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.

- Justification/Background:
  - Desistance is potentially a more accurate way to measure program impact.
- Action Step:
  - State agencies that support diversion and deflection programs have a definition of recidivism. Also have a working group to address this.
- Impact, Capacity and Feasibility of Implementation, Urgency, and How the Recommendation Advances Racial and Health Equity:
  - **Impact**: 2 - More standardized data collection to address the impact of diversion and deflection programs within the communities.
  - **Capacity and feasibility of implementation**: 2 - It would be easy for state agencies to implement a definition of recidivism.
  - **Urgency**: 2 - Better understanding of the impact of these programs.
  - **Racial and health equity**: 2 - Addresses those involved in the criminal justice system to get out of that cycle.

Recommendation #5

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.

Restrict Sales Locations: Limit the sale of these substances to licensed establishments that can verify the age of purchasers and prohibit sales near schools and other youth-centered facilities.

Enhance Enforcement Mechanisms: Provide regulatory agencies with authority and resources to monitor compliance, conduct inspections, and enforce penalties for violations.

Explore taxation options for education and prevention.

- Justification/Background:
  - In Nevada, it is illegal for individuals under 21 to purchase or possess cannabis products, including Delta-9 THC, unless they are medical marijuana cardholders. These same limitations are necessary to restrict the sale and use of phenibut.
  - Phenibut is not approved as a licensed drug by the Food and Drug Administration (FDA) for clinical use but is marketed as a dietary supplement. Side effects of phenibut may include seizures, irritability, increased heart rate, coma, and delirium.
  - Alabama banned the sale of the drug, classifying it as a Schedule 2 Controlled Substance. As of 2021, it was considered a controlled substance in Australia, France, Hungary, Italy, Lithuania, and Germany.
- Action Step:
  - Regulatory or Licensing Board
  - Direct tax revenue to prevention and education
- Impact, Capacity and Feasibility of Implementation, Urgency, and How the Recommendation Advances Racial and Health Equity:
  - **Impact**: 1 - Reduce the access to alternative sources for substance misuse that are just as deadly and do not flag on standard testing.
  - **Capacity and feasibility of implementation**: 2 - It will require multiple agencies to work together to create and enforce labeling and oversight.
  - **Urgency**: 2 - Nevada needs to figure out how to address this growing trend of street drug alternatives/gas station counter drugs.
  - **Racial and health equity**: 3 - Individuals that frequent gas stations for these types of drugs are those living in indigent neighborhoods and communities with higher poverty rates.

APPENDICES

A brief description of each of the documents contained within the appendices is offered below.

Appendix A

Additional Information for Recommendations – Research Links: This table provides links to research used to support recommendations.

Appendix B

Additional Information for Recommendations – Target Population(s) Impacted: This table cross-references special populations cited in Assembly Bill 374 by recommendation.

Appendix C

Additional Information for Recommendations – Legislation Addressed: This appendix cites Assembly Bill 374 Section 10 requirements, followed by a table indicating which requirements are met by each recommendation.

Appendix D

Status of 2024 Recommendations (as of June 2026): This table provides updates on recommendations included in the 2024 Annual Report, which immediately preceded this 2025-2026 Annual Report.

Appendix E

Information Regarding SURG Membership and Presentations Received: This appendix summarizes SURG membership and presentations given during SURG and subcommittee meetings. Links are also provided that offer information about SURG related legislation, bylaws, past annual reports, and access to meeting materials.

Appendix F

Information Regarding Opioid Settlement Funds: This appendix provides details as to how up-to-date information on opioid settlement funded programs and services can be accessed online via the Fund for a Resilient Nevada Dashboard.

Appendix G

Signature: This page includes the signature of the Chair of the Substance Use Response Working Group.

Appendix A: Additional Information for Recommendations – Research Links

Note that the information in the tables below is, for the most part, included as submitted initially by the SURG member who made the recommendation, with some changes made to support consistent formatting or due to updates made following the initial submission by the originating or other members.

Prevention Subcommittee

RECOMMENDATION	LINKS
1. Support a bill draft request in the 2027 legislative session that would double the annual state investment in primary prevention to protect prevention infrastructure via a general fund dollar line item committed to BBHWP's prevention programming for people aged 0-24. Monies should be directed to local lead agencies that prioritize evidence-based programming. For example, if the current level of investment was $1.6 million, then this would be raised to $3.2 million for the next biennium. This funding should not be at the expense of existing programming and should be the State of Nevada's contribution to Prevention efforts; additional Federal and/or other monies that are secured would not change the target allocation of State dollars for primary prevention efforts.	• SAPTA 9/26/2023 "Funding Update: SPF-PFS Grant for Nevada" email • Evidence-based interventions for preventing substance use disorders in adolescents. (2010): https://doi.org/10.1016/j.chc.2010.03.005

RECOMMENDATION	LINKS
2. Create a bill draft request to set aside funding* for youth vaping prevention to be distributed using a local lead agencies model to reach $2 per capita, a recommended funding goal from the Nevada Tobacco Control & Smoke-free Coalition and subject matter experts. *Given that vaping is a delivery method for cannabis, nicotine, and other substances like fentanyl, multiple funding sources should be considered, including the cannabis wholesale tax, tobacco or vaping settlement, tobacco tax dollars, the Fund for Resilient Nevada, or other appropriate sources as related to substance use.	• Vaping Opioids: Should We Be Worried? (2023): https://pmc.ncbi.nlm.nih.gov/articles/PMC11626417/ • Reports of fentanyl-laced vape pens in schools spark online debate (2025): https://publichealthcollaborative.org/alerts/reports-of-fentanyl-laced-vape-pens-in-schools-spark-online-debate/ • Nye County investigators believe THC, vape pens handed out at Pahrump high school (2026): https://www.8newsnow.com/news/local-news/nye-county-investigators-believe-thc-vape-pens-handed-out-at-pahrump-high-school/ • Nevada YRBS Data Link: https://www.unr.edu/public-health/research-activities/nevada-youth-risk-behavior-survey • CDC Tobacco Funding Recommendations (2024): https://www.cdc.gov/tobacco/php/tobacco-control-programs/program-funding.html • CDC Tobacco Control Best Practices (2024): https://www.cdc.gov/tobacco/php/state-and-community-work/guides-for-states.html • Nevada Tobacco Control & Smoke-Free Coalition: https://nvtobaccopreventioncoalition.org/ • Marijuana and Teens (2026): https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Marijuana-and-Teens-106.aspx • Cannabis Facts and Stats (2025): https://www.cdc.gov/cannabis/data-research/facts-stats/index.html • California, Nevada, and Oregon See Increase in Youth Marijuana Use (2020): https://www.dfaf.org/california-nevada-and-oregon-see-increase-in-youth-marijuana-use/ • OPINION: Seven years later, is legal recreational cannabis really worth it? (2024):

RECOMMENDATION	LINKS
	https://thenevadaindependent.com/article/opinion-seven-years-later-is-legal-recreational-cannabis-really-worth-it • The Reality of Teens and Weed (2024): https://www.psychologytoday.com/us/blog/addiction-outlook/202405/the-reality-of-teens-and-weed?amp • Cannabis Use in Young Adults: Challenges During the Transition to Adulthood (2015): https://www.psychiatrictimes.com/view/cannabis-use-young-adults-challenges-during-transition-adulthood
3. Request guidance from the Nevada Board of Pharmacy be posted to their website and communicated to pharmacists to clarify regulations pertinent to the distribution of naloxone in hospitals to permit low barrier naloxone distribution from Emergency Departments (EDs) and permit EDs to adopt a naloxone-specific standard operating procedure (SOP) for community-based naloxone distribution, separate from and exempt from the regulatory framework surrounding hospital formulary medications used in patient care.	California Bridge recommendations provided to the SURG Prevention Subcommittee: • ED-Base Naloxone Distribution in Nevada https://ag.nv.gov/uploadedFiles/agnvgov/Content/About/Administration/CA%20Bridge%20Addendum%20(1).pdf • Circumstances Surrounding Non-Fatal Opioid Overdoses Attended by Ambulance Services (2016): https://pmc.ncbi.nlm.nih.gov/articles/PMC5434850/#:~:text=Summer%20months%20had%20more%20overdoses,1.92%2C%20P%20%3D%200.042 • Naloxone distribution programs in the emergency department: A scoping review of the literature (2024): https://pmc.ncbi.nlm.nih.gov/articles/PMC11079430/ Sample post text could include the following: Nevada hospital emergency departments are eligible entities for the Nevada State Opioid Response Naloxone distribution program or its local affiliate and may provide take-home doses of naloxone to patients and visitors. Emergency departments should provide the following supplemental documentation with the application:

RECOMMENDATION	LINKS

	• Policies and procedures for naloxone distribution. Example policies and procedures are located here:
	  ○ https://bridgetotreatment.org/resource/guide-to-naloxone-distribution/
	  ○ https://media.southernnevadahealthdistrict.org/download/naloxone/Naloxone-Hospital-Distribution-Guide.pdf
	
	The Nevada Division of Public and Behavioral Health (DPBH), Nevada Department of Human Services (DHS) and the Nevada State Board of Pharmacy clarify regulations pertinent to the distribution of naloxone in hospitals. Essential requirements of compliance are:
	
	• The naloxone must be acquired and stored separately from the hospital's pharmacy inventory.
	• The emergency department is required to keep a log to track the distribution of the naloxone doses distributed through this program.
	• The hospital emergency department is required to have policies and procedures which will dictate how the hospital emergency department will distribute the naloxone, including storage locations and whether the naloxone will be labeled or not labeled.
	
	With this guidance, the Nevada Board of Pharmacy has clarified that naloxone obtained through the Nevada State Opioid Response Naloxone distribution program or its local affiliate and stored separately from the hospital's pharmacy inventory for distribution to the public is not a pharmaceutical that will be used in the healthcare setting and is exempt from NAC 639.742 - 639.900, NRS 639.2801, and NAC 639.5007 - 639.520. As the inventory is considered separate from the pharmacy inventory, it does not need to be maintained, stored or labeled in compliance with NAC 639.742 - 639.900 or NAC 639.5007 - 639.520.

Treatment and Recovery Subcommittee

RECOMMENDATION	LINKS
1. Elimination of 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 MCOs (Managed Care Organizations).	• Removal Of Prior Authorization for Medication-Assisted Treatment: Impact on Opioid Use and Policy Implications in a Medicare Advantage Population (2021): https://www.jmcp.org/doi/10.18553/jmcp.2021.27.5.596 • Updated Nevada Medicaid Informational Bulletin on Medications and Services for Substance Use Disorders (NMO-3146). State of Nevada: https://www.nevadamedicaid.nv.gov/programs/behavioral-health-services/.
2. Recommend to the Nevada Department of Human Services that they incentivize the implementation of cohesive addiction consult services. Hospitals would receive Department funds to hire certified peer recovery specialists and/or community health workers/representatives, if they meet the following specific criteria: adoption of delineation of privileges for addiction medicine as a medical specialty, as well as established protocols for the inclusion of midlevel providers and peer recovery navigators.	• Peer Navigator Intervention and Opioid-Related Adverse Events for Emergency Department Patients: A Randomized Clinical Trial (2026): https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2844716 • The Role of Peer Navigators After Nonfatal Opioid Overdose—Context, Evidence, and Future Directions (2026): https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2844720 • Inpatient Addiction Medicine Consultation and Post-Hospital Substance Use Disorder Treatment Engagement: a Propensity-Matched Analysis (2019): https://doi.org/10.1007/s11606-019-05251-9

RECOMMENDATION	LINKS
3. Recommend that insurers and payors not impose dosage limitations for buprenorphine when used for Medications for Opioid Use Disorder (MOUD).	• Higher Buprenorphine Doses Associated with Improved Retention in Treatment for Opioid Use Disorder (2023): https://nida.nih.gov/news-events/news-releases/2023/09/higher-buprenorphine-doses-associated-with-improved-retention-in-treatment-for-opioid-use-disorder • Buprenorphine Maintenance vs. Placebo for Opioid Dependence (2014): https://thennt.com/nnt/buprenorphine-maintenance-vs-placebo-opioid-dependence/] • Updated Nevada Medicaid Informational Bulletin on Medications and Services for Substance Use Disorders (NMO-3146). State of Nevada: https://www.nevadamedicaid.nv.gov/programs/behavioral-health-services/.

RECOMMENDATION	LINKS
4. A retrospective assessment or/and prospective study would be conducted to assess the outcomes of all patients following discharge from certified withdrawal management facilities within five years of discharge, including trends in the patterns of step down and use of MOUD, to examine potential contributors to overdose and develop best practices for continued care after treatment.	• Loss of Tolerance and Overdose Mortality After Inpatient Opiate Detoxification: Follow Up Study (2003): https://pmc.ncbi.nlm.nih.gov/articles/PMC153851/ • Association Between Mortality Rates and Medication And Residential Treatment After In-Patient Medically Managed Opioid Withdrawal: A Cohort Analysis (2020): https://pubmed.ncbi.nlm.nih.gov/32096908/, which showed that mortality risk was reduced in individuals who received medication treatment (0.81 all-cause deaths & 0.52 opioid-related deaths per 100 person years), residential treatment (1.27 all-cause & 1.06 opioid-related deaths per 100 person years), or a combination of the two (fewer than 1.23 all-cause and opioid-related deaths per 100 person years), relative to those who did not receive treatment (2.04 all-cause deaths & 1.42 opioid-related deaths per 100 person years) within the 12 months following detoxification. • New and Emerging Opioid Overdose Risk Factors (2021): https://pubmed.ncbi.nlm.nih.gov/33907663/ • Commentary on Burns et al: MOUD Saves Lives, Especially After 60 Days, and the Longer the Better(2022): https://doi.org/10.1111/add.16043 • Receipt of Opioid Use Disorder Treatments Prior to Fatal Overdoses and Comparison to No Treatment in Connecticut, 2016–17 (2024): https://pubmed.ncbi.nlm.nih.gov/38043226/

RECOMMENDATION	LINKS
5. Recommend that state funding be increased for Contingency Management, to be used to support people in recovery through rewards for reaching their recovery goals.	• Legislative Analysis and Public Policy Association: Contingency Management (2023): https://legislativeanalysis.org/wp-content/uploads/2023/10/Contingency-Management-Fact-Sheet-FINAL.pdf • Incentivizing Recovery: Payment, Policy, and Implementation of Contingency Management (2024): https://cherishresearch.org/news-and-events/news/incentivizing-recovery-payment-policy-and-implementation-of-contingency-management/ • Rewarding recovery: the time is now for contingency management for opioid use disorder (2022): https://pmc.ncbi.nlm.nih.gov/articles/PMC9045772/ • Using SAMHSA Funds to Implement Evidence-Based Contingency Management Services (2025): https://library.samhsa.gov/sites/default/files/contingency-management-advisory-pep24-06-001.pdf

Response Subcommittee

RECOMMENDATION	LINKS
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 I of NAC 453.510.	• AMA Strengthens Policy to Highlight Risks of Kratom Products (2026): https://www.ama-assn.org/press-center/ama-press-releases/ama-strengthens-policy-highlight-risks-kratom-products • MITRAGYNINE & 7-HYDROXY MITRAGYNINE (2026) : https://www.cfsre.org/images/content/reports/public_alerts/Mitragynine_and_7-Hydroxy_Mitragynine_NPS_Discovery_050626.pdf • Attorney General Paxton Sues Kratom Retailers for Selling Products Containing Nearly Fifty Times the Legal Limit of the Potentially Deadly Alkaloid Known as 7-OH (2026): https://www.texasattorneygeneral.gov/news/releases/attorney-general-paxton-sues-kratom-retailers-selling-products-containing-nearly-fifty-times-legal • Attorney General Hanaway Files Suit Against American Shaman for Unlawfully Manufacturing and Selling Deadly Opioid 7-OH: https://ago.mo.gov/attorney-general-hanaway-files-suit-against-american-shaman-for-unlawfully-manufacturing-and-selling-deadly-opioid-7-oh/ • Increases in Kratom-Related Reports to Poison Centers — National Poison Data System, United States, 2015–2025 (2026): https://www.cdc.gov/mmwr/volumes/75/wr/mm7511a1.htm • Missouri Man Claims Company Fraudulently Misrepresented Its 7-Oh Products: Joseph Maguire v. Relax Relief Rejuvenate Trading LLC d/b/a EDP Kratom, Missouri Circuit Court (St. Louis County), Case No. 26SL-CC01270 (suit filed February 3, 2026). A Missouri man has filed a suit against Relax Relief Rejuvenate Trading LLC, which does business under the name EDP Kratom (EDP), over claims that the company's fraudulent, misleading, deceptive, and negligent sales practices of its 7-hydroxymitragynine (7-OH) products resulted in serious

RECOMMENDATION	LINKS
	injuries. 7-OH is an alkaloid found naturally in the kratom plant Mitragyna speciosa in small quantities, but it can also be synthetically produced and sold in a concentrated form. 7-OH binds to mu-opioid receptors in the body and can cause dependance, addiction, withdrawal, respiratory depression and overdose. According to the complaint, in 2025, Joseph Maguire broke a tooth and was experiencing pain. While browsing in a convenience store, a store employee overheard Maguire complaining about his pain and suggested that he try one of EDP's 7-OH products to help manage his pain. Maguire bought and tried the 7-OH product and after a few weeks of continued use of the product, he claimed that he became addicted to it. Maguire claimed that he progressed to spending hundreds of dollars a day on 7-OH products to fuel his addiction, which depleted his savings account. He tried to stop using 7-OH products on his own but was unsuccessful and eventually sought help from a substance use disorder treatment facility. While receiving treatment, Maguire was forced to close the ice cream shop that he owned, which resulted in lost profit, revenue, and income. The suit brings forth claims that EDP violated the Missouri Merchandising Practice Act (MO. ANN. STAT. § 60-9.100 (West 2025)) by failing to disclose that 7-OH is addictive and can cause opioid-like withdrawal. Maguire also brings forth a claim of negligent misrepresentation, asserting that EDP misrepresented material facts by advertising and marketing its products as a safe pain reliever. Note that Missouri currently does not have a kratom consumer protection law. Maguire is asking the court for damages in excess of $25,000. • Kratom-Associated Fatalities in Northern Nevada—What Mitragynine Level Is Fatal? (2021): https://pubmed.ncbi.nlm.nih.gov/34091497/

RECOMMENDATION	LINKS
	• Legislative Analysis and Public Policy Association, Kratom: Summary of State Laws (2026): https://legislativeanalysis.org/kratom-summary-of-state-laws/ • FDA and Kratom (2025): https://www.fda.gov/news-events/public-health-focus/fda-and-kratom • FDA Issues Warning Letters to Firms Marketing Products Containing 7-Hydroxymitragynine (2025): https://www.fda.gov/news-events/press-announcements/fda-issues-warning-letters-firms-marketing-products-containing-7-hydroxymitragynine • From Plant to Patient: Clinical Approaches to Kratom Consumption and Addiction (2025): https://nvopioidcoe.org/event/understanding-kratom-consumption-patterns-and-treatment-strategies-for-kratom/ • Kratom. National Institute on Drug Abuse (2026): (https://nida.nih.gov/research-topics/kratom#safe • Centers for Disease Control, Morbidity and Mortality Weekly Report Notes from the Field: Unintentional Drug Overdose Deaths with Kratom Detected — 27 States, July 2016–December 2017 (2019): https://www.cdc.gov/mmwr/volumes/68/wr/mm6814a2.htm • Legal But Lethal: The Increasing Danger of “Gas Station Drugs” (2025): https://www.tallcopsaysstop.com/blog/legal-lethal-increasing-danger-gas-station-drugs • Hiding in Plain Sight: 7-OH Products (2025): https://www.fda.gov/news-events/public-health-focus/hiding-plain-sight-7-oh-products • What’s this “Kratom” I’m hearing about? Is it a problem at my workplace?: https://myemail.constantcontact.com/What-s-this--Kratom--I-m-hearing-about--Is-it-a-problem-at-my-workplace-.html?soid=1121542279689&aid=Uo-uDEXwgHw

RECOMMENDATION	LINKS
	• Kratom: Mitragyna Speciosa: https://www.dfaf.org/wp-content/uploads/2025/09/Kratom-Final.pdf
2. 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. Restrict Sales Locations: Limit the sale of these substances to licensed establishments that can verify the age of purchasers and prohibit sales near schools and other youth-centered facilities. Enhance Enforcement Mechanisms: Provide regulatory agencies with authority and resources to monitor compliance, conduct inspections, and enforce penalties for violations. Explore taxation options for education and prevention.	• The "Delta-8 of Hallucinogens"? A Closer Look at Amanita Muscaria in Today's Market (2026): https://www.tallcopsaysstop.com/blog/delta-8-hallucinogens-closer-look-amanita-muscaria-todays-market • Severe Illness Associated with Eating Mushroom-Containing Chocolate Products — United States, January–October 2024 (2026): https://www.cdc.gov/mmwr/volumes/75/wr/mm7513a2.htm?s_cid=OS_mm7513a2_e&ACSTrackingID=USCDC_921-DM154267&ACSTrackingLabel=Week%20in%20MMWR%3A%20Vol.%2075%2C%20April%209%2C%202026&deliveryName=USCDC_921-DM154267 • Unregulated Sales of a Toxic and Hallucinogenic Mushroom Endanger Public Health (2024): https://today.ucsd.edu/story/unregulated-sales-of-a-toxic-and-hallucinogenic-mushroom-endanger-public-health?utm • Notes from the Field: Schedule I Substances Identified in Nootropic Gummies Containing Amanita muscaria or Other Mushrooms — Charlottesville, Virginia, 2023–2024 (2024): https://www.cdc.gov/mmwr/volumes/73/wr/mm7328a3.htm?utm_ • FDA Alerts Industry and Consumers about the Use of Amanita Muscaria or its Constituents in Food (2024): https://www.fda.gov/food/hfp-constituent-updates/fda-alerts-industry-and-consumers-about-use-amanita-muscaria-or-its-constituents-food?utm_source ("The FDA is aware of these ingredients in foods intended to have hallucinogenic effects that look like their conventional counterparts, like candy bars.") • Need for a Public Health Response to the Unregulated Sales of *Amanita muscaria* Mushrooms (2024):

RECOMMENDATION	LINKS
	https://www.ajpmonline.org/article/S0749-3797(24)00163-6/fulltext • 2025 Louisiana Laws Revised Statutes, Title 40 - Public Health and Safety §40:989.1. Unlawful production, manufacture, distribution, or possession of hallucinogenic plants (2025): https://law.justia.com/codes/louisiana/revised-statutes/title-40/rs-40-989-1/
3. Work with prevention coalitions to make available mechanisms for safe disposal of opioid prescriptions (i.e., Deterra Bags) and to provide education to community members (i.e., youth and senior groups). Prevention coalitions will also provide a one-page document with information about opioid overdoses, disposal, and available addiction assistance to be provided with opioid prescriptions. Board of Pharmacy will provide education via their website and work with the Nevada Opioid Center of Excellence for a continued education course.	• Enhancing Naloxone Distribution for Opioid Users in the USA: A Cost-Utility Analysis of Academic Detailing to Clinicians (2025): https://pmc.ncbi.nlm.nih.gov/articles/PMC12535941/ • Evidence-Based Strategies for Preventing Opioid Overdose: What's Working in the United States: https://www.cdc.gov/overdose-prevention/media/pdfs/2024/03/Evidence-based-strategies-for-prevention-of-opioid-overdose.pdf • Best Practices in Naloxone Treatment Programs for Opioid Overdose (2015): https://centerforevidencebasedpolicy.org/wp-content/uploads/2016/11/MED_best_practices_naloxone_report_final_2015.pdf • Naloxone Co-Prescriptions for Surgery Patients Prescribed Opioids: A Retrospective Cohort Study (2023): https://www.sciencedirect.com/science/article/pii/S2666262023000633 • Prescribing Naloxone for Opioid Overdose Intervention (2018): https://www.tandfonline.com/doi/full/10.2217/pmt-2017-0065 • Opioid Disposal Kits May Help Patients Dispose of Unneeded Painkillers (2025): https://ldi.upenn.edu/our-work/research-updates/opioid-disposal-kits-may-help-patients-dispose-of-unneeded-painkillers/ • Preventing Opioid Diversion and Abuse by Using an At-home Opioid Disposal Method: An Improvement Project in a Pediatric Outpatient Surgical Center (2024):

RECOMMENDATION	LINKS
	https://www.sciencedirect.com/science/article/pii/S276827652400573X • Epidemiology Review: Consumer Opioid Disposal Literature Scan and Search Results (2021): https://www.fda.gov/media/158570/download • Envisioning Disposal Systems to Remove Opioids from the Home (2024): https://www.ncbi.nlm.nih.gov/books/NBK603211/
4. Recommend state agencies under the legislative, judicial, and executive branches involved with adult 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.	• Washoe County is starting the IGNITE Program from the National Sheriff's Association to "help jails replicate a program from Genesee County (MI) Sheriff's Office, that offers comprehensive education, job certification, and post-incarceration work opportunities and assistance to incarcerated individuals.": https://www.sheriffs.org/ignite

RECOMMENDATION	LINKS
5. 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. Restrict Sales Locations: Limit the sale of these substances to licensed establishments that can verify the age of purchasers and prohibit sales near schools and other youth-centered facilities. Enhance Enforcement Mechanisms: Provide regulatory agencies with authority and resources to monitor compliance, conduct inspections, and enforce penalties for violations. Explore taxation options for education and prevention.	• Phenibutan—an Illegal Food Supplement With Psychotropic Effects and Health Risks (2024): https://pmc.ncbi.nlm.nih.gov/articles/PMC11539871/ • Phenibut (β-Phenyl- γ-aminobutyric Acid) Dependence and Management of Withdrawal: Emerging Nootropics of Abuse (2018): https://pubmed.ncbi.nlm.nih.gov/29854531/ • Legal But Lethal: The Increasing Danger of "Gas Station Drugs" (2025): https://www.tallcopsaysstop.com/blog/legal-lethal-increasing-danger-gas-station-drugs • What is Phenibut? (2024): https://americanaddictioncenters.org/phenibut • Notes from the Field: Phenibut Exposures Reported to Poison Centers — United States, 2009–2019 (2020): https://www.cdc.gov/mmwr/volumes/69/wr/mm6935a5.htm

Appendix B: Additional Information for Recommendations – Target Population(s) Impacted

Note that the information in the tables below is, for the most part, included as submitted initially by the SURG member who made the recommendation, with some changes made to support consistent formatting or due to updates made following the initial submission by the originating or other members.

In 2021 the bylaws were amended to change the term "Intravenous drug users," to "people who inject drugs."

Prevention Subcommittee

Recommendation	Veterans, Elderly Persons, and Youth	Persons who are involved in the criminal justice/juvenile systems[8]	Pregnant women and the parents of dependent children	Lesbian, gay, bisexual, transgender, and questioning persons	People who inject drugs (as revised)	Children who are involved with the child welfare system	Other populations overly impacted by substance use disorders
Recommendation 1.	**X**		**X**			**X**	
Recommendation 2.							**X**
Recommendation 3.	**X**	**X**	**X**	**X**	**X**	**X**	**X**

[8] Full definition of this target population: Persons who are incarcerated, persons who have committed nonviolent crimes primarily driven by a substance use disorder and other persons involved in the criminal justice or juvenile systems.

Treatment and Recovery Subcommittee

Recommendation	Veterans, Elderly Persons, and Youth	Persons who are involved in the criminal justice/juvenile systems[9]	Pregnant women and the parents of dependent children	Lesbian, gay, bisexual, transgender, and questioning persons	People who inject drugs (as revised)	Children who are involved with the child welfare system	Other populations overly impacted by substance use disorders
Recommendation 1.*							
Recommendation 2.*							
Recommendation 3.*							
Recommendation 4.							**X**
Recommendation 5.*							

* For Treatment and Recovery Subcommittee Recommendations 1-3 and 5, there is not a special population of focus.

Response Subcommittee

Recommendation	Veterans, Elderly Persons, and Youth	Persons who are involved in the criminal justice/juvenile systems[10]	Pregnant women and the parents of dependent children	Lesbian, gay, bisexual, transgender, and questioning persons	People who inject drugs (as revised)	Children who are involved with the child welfare system	Other populations overly impacted by substance use disorders
Recommendation 1.	**X**	**X**			**X**	**X**	
Recommendation 2.	**X**	**X**			**X**	**X**	
Recommendation 3.							**X**
Recommendation 4.		**X**					
Recommendation 5.	**X**	**X**			**X**	**X**	

[9] Full definition of this target population: Persons who are incarcerated, persons who have committed nonviolent crimes primarily driven by a substance use disorder and other persons involved in the criminal justice or juvenile systems.
[10] Ibid.

Appendix C: Additional Information for Recommendations – Legislation Addressed

To understand the extent to which recommendations do or do not address the founding legislation, the following information is provided:

- Legislative language
- Tables presenting the recommendations by topic area according to their priority and the component of the legislation that is addressed. These are presented first as summary tables which include only the number and not the text of the recommendation for ease of review. They are then presented with the full text of the recommendation.
- For all tables, the component of the founding legislation assigned to each subcommittee is indicated with an asterisk; see pages 5 through 7 of this document for a full description of the components assigned to each subcommittee. Note that components b, h, and q are considered cross-cutting across all subcommittees.
- The information in the tables beginning on page 50 is included as submitted by the SURG member who made the recommendation.

NRS 458.480 Duties [Effective July 1, 2026.]

(a) Leverage and expand efforts by state and local governmental entities to reduce the use of substances which are associated with substance use disorders, including, without limitation, heroin, other synthetic and non-synthetic opioids and stimulants, and identify ways to enhance those efforts through coordination and collaboration.

(b) Assess evidence-based strategies for preventing substance use and intervening to stop substance use, including, without limitation, the use of heroin, other synthetic and non-synthetic opioids and stimulants. Such strategies must include, without limitation, strategies to:

(1) Help persons at risk of a substance use disorder avoid developing a substance use disorder;
(2) Discover potentially problematic substance use in a person and intervene before the person develops a substance use disorder;
(3) Treat the medical consequences of a substance use disorder in a person and facilitate the treatment of the substance use disorder to minimize further harm; and
(4) Reduce the harm caused by substance use, including, without limitation, by preventing overdoses.

(c) Assess and evaluate existing pathways to treatment and recovery for persons with substance use disorders, including, without limitation, such persons who are members of special populations.

(d) Work to understand how residents of this State who are involved in the criminal justice system access supports for treatment of and recovery from substance use

disorders at various points, including, without limitation, by reviewing existing diversion, deflection and reentry programs for such persons.

(e) Evaluate ways to improve and expand evidence-based or evidence-informed programs, procedures and strategies to treat and support recovery from opioid use disorder and any cooccurring substance use disorder, including, without limitation, among members of special populations.

(f) Examine support systems and programs for persons who are in recovery from opioid use disorder and any co-occurring substance use disorder.

(g) Make recommendations to entities including, without limitation, the State Board of Pharmacy, professional licensing boards that license practitioners, other than veterinarians, the State Board of Health, the Division, the Governor and the Legislature, to ensure that controlled substances are appropriately prescribed in accordance with the provisions of NRS 639.2391 to 639.23916, inclusive.

(h) Examine qualitative and quantitative data to understand the risk factors that contribute to substance use and the rates of substance use and substance use disorders, focusing on special populations.

(i) Develop strategies for local, state and federal law enforcement and public health agencies to respond to and prevent overdoses and plans for implementing those strategies.

(j) Study the efficacy and expand the implementation of programs to:

(1) Educate youth and families about the effects of substance use and substance use disorders; and
(2) Reduce the harms associated with substance use and substance use disorders while referring persons with substance use disorders to evidence-based treatment.

(k) Recommend strategies to improve coordination between local, state and federal law enforcement and public health agencies to enhance the communication of timely and relevant information relating to substance use and reduce duplicative data collection and research.

(l) Evaluate current systems for sharing information between agencies regarding the trafficking and distribution of legal and illegal substances which are associated with substance use disorders, including, without limitation, heroin, other synthetic and non-synthetic opioids and stimulants.

(m) Study the effects of substance use disorders on the criminal justice system, including, without limitation, law enforcement agencies and correctional institutions.

(n) Study the sources and manufacturers of substances which are associated with substance use disorders, including, without limitation, heroin, other synthetic and non-synthetic opioids and stimulants, and methods and resources for preventing the manufacture, trafficking and sale of such substances.

(o) Study the effectiveness of criminal and civil penalties at preventing the misuse of substances and substance use disorders and the manufacture, trafficking and sale of substances which are associated with substance use disorders, including, without limitation, heroin, other synthetic and non-synthetic opioids and stimulants.

(p) Evaluate the effects of substance use disorders on the economy of this State.

(q) Study, evaluate and make recommendations to the Department of Health and Human Services concerning the use of the money described in section 10.5 of this act to address substance use disorders, with a focus on:

(1) The use of the money described in subsections 1, 2 and 3 of section 10.5 of this act to supplement rather than supplant existing state or local spending;
(2) The use of the money described in section 10.5 of this act to support programs that use evidence-based interventions;
(3) The use of the money described in section 10.5 of this act to support programs for the prevention of substance use disorders in youth;
(4) The use of the money described in section 10.5 of this act to improve racial equity; and
(5) Reporting by state and local agencies to the public concerning the funding of programs to address substance misuse and substance use disorders.

Summary Tables | Recommendations by Legislative Components

Asterisks denote components that were assigned to the subcommittee in 2021 as described on page 5 of this report. Components b, h, and q are considered cross-cutting across all subcommittees.

Prevention	a*	b	c	d	e	f	g*	h	i	j*	k	l	M	n	O	p	q
Rec. 1.										X							X
Rec. 2.	X	X						X		X							X
Rec. 3.		X					X										X

Treatment and Recovery	a	b	c*	d	e*	f*	g	h	i	j	k	l	M	n	O	p	q
Rec. 1.		X	X		X												
Rec. 2.		X	X		X	X		X									X
Rec. 3.			X		X			X									X
Rec. 4.		X	X		X	X		X									X
Rec. 5.		X			X	X											X

Response	a	b	c	d*	e	f	g	h	i*	j	k*	l*	m*	n*	o*	p*	q
Rec. 1.		X							X					X	X		
Rec. 2.		X							X					X	X		
Rec. 3.		X														X	X
Rec. 4.				X				X					X			X	
Rec. 5.		X							X					X	X		

Full Recommendation Text Tables | Recommendations by Legislative Components

Asterisks denote components that were assigned to the subcommittee in 2021 as described on pages 5 through 7 of this report. Components b, h, and q are considered cross-cutting across all subcommittees.

Prevention Recommendation	a*	b	c	d	e	f	g*	h	i	j*	k	l	m	n	o	p	q
1. Support a bill draft request in the 2027 legislative session that would double the annual state investment in primary prevention to protect prevention infrastructure via a general fund dollar line item committed to BBHWP's prevention programming for people aged 0-24. Monies should be directed to local lead agencies that prioritize evidence-based programming. For example, if the current level of investment was $1.6 million, then this would be raised to $3.2 million for the next biennium. This funding should not be at the expense of existing programming and should be the State of Nevada's contribution to Prevention efforts; additional Federal and/or other monies that are secured would not change the target allocation of State dollars for primary prevention efforts.										**X**							**X**

Prevention Recommendation	a*	b	c	d	e	f	g*	h	i	j*	k	l	m	n	o	p	q
2. Create a bill draft request to set aside funding* for youth vaping prevention to be distributed using a local lead agencies model to reach $2 per capita, a recommended funding goal from the Nevada Tobacco Control & Smoke-free Coalition and subject matter experts. *Given that vaping is a delivery method for cannabis, nicotine, and other substances like fentanyl, multiple funding sources should be considered, including the cannabis wholesale tax, tobacco or vaping settlement, tobacco tax dollars, the Fund for Resilient Nevada, or other appropriate sources as related to substance use.	**X**	**X**						**X**		**X**							**X**
3. Request guidance from the Nevada Board of Pharmacy be posted to their website and communicated to pharmacists to clarify regulations pertinent to the distribution of naloxone in hospitals to permit low barrier naloxone distribution from Emergency Departments (EDs) and permit EDs to adopt a naloxone-specific standard operating procedure (SOP) for community-based naloxone distribution, separate from and exempt from the regulatory framework surrounding hospital formulary medications used in patient care.		**X**					**X**										**X**

Treatment and Recovery Recommendation	a	b	c*	d	e*	f*	g	h	i	j	k	l	m	n	o	p	q
1. Elimination of 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 MCOs (Managed Care Organizations).		**X**	**X**		**X**												
2. Recommend to the Nevada Department of Human Services that they incentivize the implementation of cohesive addiction consult services. Hospitals would receive Department funds to hire certified peer recovery specialists and/or community health workers/representatives, if they meet the following specific criteria: adoption of delineation of privileges for addiction medicine as a medical specialty, as well as established protocols for the inclusion of midlevel providers and peer recovery navigators.		**X**	**X**		**X**	**X**		**X**									**X**
3. Recommend that insurers and payors not impose dosage limitations for buprenorphine when used for Medications for Opioid Use Disorder (MOUD).			**X**		**X**			**X**									**X**

Treatment and Recovery Recommendation	a	b	c*	d	e*	f*	g	h	i	j	k	l	m	n	o	p	q
4. A retrospective assessment or/and prospective study would be conducted to assess the outcomes of all patients following discharge from certified withdrawal management facilities within five years of discharge, including trends in the patterns of step down and use of MOUD, to examine potential contributors to overdose and develop best practices for continued care after treatment.		**X**	**X**		**X**	**X**		**X**									**X**
5. Recommend that state funding be increased for Contingency Management, to be used to support people in recovery through rewards for reaching their recovery goals.		**X**			**X**	**X**											**X**

Response Recommendation	a	b	c	d*	e	f	g	h	i*	j	k*	l*	m*	n*	o*	p*	q
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 I of NAC 453.510.		**X**							**X**					**X**	**X**		
2. 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		**X**							**X**					**X**	**X**		

Response Recommendation	a	b	c	d*	e	f	g	h	i*	j	k*	l*	m*	n*	o*	p*	q
warnings about potential health risks and age restrictions. Restrict Sales Locations: Limit the sale of these substances to licensed establishments that can verify the age of purchasers and prohibit sales near schools and other youth-centered facilities. Enhance Enforcement Mechanisms: Provide regulatory agencies with authority and resources to monitor compliance, conduct inspections, and enforce penalties for violations. Explore taxation options for education and prevention.																	
3. Work with prevention coalitions to make available mechanisms for safe disposal of opioid prescriptions (i.e., Deterra Bags) and to provide education to community members (i.e., youth and senior groups). Prevention coalitions will also provide a one-page document with information about opioid overdoses, disposal, and available addiction assistance to be provided with opioid prescriptions. Board of Pharmacy will provide education via their website and work with the Nevada Opioid Center of Excellence for a continued education course.		**X**														**X**	**X**

Response Recommendation	a	b	c	d*	e	f	g	h	i*	j	k*	l*	m*	n*	o*	p*	q
4. Recommend state agencies under the legislative, judicial, and executive branches involved with adult 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.				**X**				**X**					**X**			**X**	

Response Recommendation	a	b	c	d*	e	f	g	h	i*	j	k*	l*	m*	n*	o*	p*	q
5. 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. Restrict Sales Locations: Limit the sale of these substances to licensed establishments that can verify the age of purchasers and prohibit sales near schools and other youth-centered facilities. Enhance Enforcement Mechanisms: Provide regulatory agencies with authority and resources to monitor compliance, conduct inspections, and enforce penalties for violations. Explore taxation options for education and prevention.		**X**							**X**					**X**	**X**		

Appendix D: Status of 2024 Recommendations (as of June 2026)

Staff from various Divisions of the Department of Human Services as well as the Nevada Health Authority report annually to the SURG to provide updates on recommendations from previous years. Implementation of recommendations may include updating requests for applications to target specific populations and giving special consideration to shared goals such as enhancing funding levels and allowing greater flexibility in the allocation of resources.

For this Report, updates were provided by the Division of Public and Behavioral Health (DPBH), the Division of Child and Family Services (DCFS), the Fund for a Healthy Nevada (FHN), the Fund for a Resilient Nevada (FRN), and the Nevada Health Authority (NHA). SEI staff also included areas in which the 2025-2030 DPBH Bureau of Health Wellness and Prevention Strategic Plan aligned with SURG recommendations.

2024 SURG Recommendation	2025-2026 Updates
Prevention	
1. Recommend to DHS/DPBH/the Bureau of Behavioral Health Wellness and Prevention to include in their Governor's budget request, a request to double the amount of investment in SAPTA primary prevention programming (i.e., increase from current $12 million to $24 million for this biennium) for ages 0-24 and review the funding allocations annually. This funding should not be at the expense of existing programming.	**Division of Public and Behavioral Health (DPBH):** • DPBH's Bureau of Behavioral Health, Wellness, and Prevention (BBHWP) funds primary prevention activities with the following funding sources: State Opioid Response Federal Grant, SUPTRS Federal Block Grant (BG), Prevention General Fund Account and the Partnership for Success (PFS) Federal Grant. Within the last year, they were able to stand up the PFS grant, adding $982,383 (79% of the one-year award) to directly fund primary prevention community coalitions. The SUPTRS BG is coming up on its two-year cycle in which they intend to increase the dollars that support primary prevention activities by 17.84 % in FFY2026. For SUPTRS, the total for primary prevention activities is 30.42%. The SOR grant is currently funding $709,677 in primary prevention activities directly to the community and SOR is looking at level funding for primary prevention programs and related activities in FFY26. • Strategic Plan Strategy 4.1: Reduce Stigma and Strengthen Community Engagement Around SUD ○ 4.1.4 Create strategic media and public awareness campaigns **Fund for a Resilient Nevada (FRN):** • FRN currently allocated around $3.8 million to direct prevention efforts. However, other projects may have a secondary or tertiary touchpoint to prevention. This amount does not include upcoming allocations for TAY/aging out of foster care youth.

2024 SURG Recommendation	2025-2026 Updates
Prevention	

2. Create a bill draft request to amend the NRS for a 15 percent set aside of tobacco control and prevention funds from the Fund for a Healthy Nevada. This would be distributed using a local lead agencies model to reach $2 per capita, a recommended funding goal from the Nevada Tobacco Control & Smoke-free Coalition and subject matter experts.	**Division of Child and Family Services (DCFS):**
	• The Family First Prevention Services Act fundamentally reorients child welfare funding toward prevention and family preservation and acknowledges three primary service areas:
	  ○ Mental Health Services
	  ○ Substance Abuse Prevention and Treatment Services
	  ○ In-Home Parenting Skill Building
	• The state plan further commits to allowing each region to prioritize service expansion aligned with community needs and implementation capacity. However, as of the date of this report, no FFPSA-funded substance abuse prevention or treatment services have been deployed within the DCFS System of Care.
	• Additionally, there are no dedicated, youth-specific substance use prevention or early intervention services within the DCFS System of Care.
	Fund for a Healthy Nevada (FHN):
	• A Bill Draft Request (BDR) could start the process for increasing tobacco prevention funds; however, it would have to go to the money committees during a regular legislative session. If a legislator agreed to sponsor a BDR to increase tobacco prevention funds, they would have to compete with programs historically funded by FHN.
	• Specific to the FHN spending, the Grants Management Advisory Committee oversees the subgrants and makes recommendations for funding, based on statutory requirements, which eliminated specific program-based percentages, starting with the 2014-2015 budget. A 2025 Notice of Funding Opportunity for Tobacco Services[11] under the FHN was posted by the Chronic Disease Prevention and Health Promotion program within the Division of Public and Behavioral Health.
	• Additionally, Tobacco Settlement funding has declined over the years, because tobacco use has declined. This has caused the competition for funding to increase.
	Fund for a Resilient Nevada (FRN):
	• Funding for FRN is based on a data driven needs-based approach and would be difficult to have this type of legislation in place.

[11] For more details on the 2025 Notice of Funding Opportunity for Tobacco Services, visit the following link: https://www.dhs.nv.gov/siteassets/content/programs/grants/SFY26-SFY27_Tobacco_FHN_NOFO_ADA_1.pdf

2024 SURG Recommendation	2025-2026 Updates
Prevention	
3. Require the state office of Medicaid to develop a state plan amendment to implement changes to support the recommendation requesting rates and billing standards for CHWs and Peers be increased to align with the national average and CMS standard.	**Division of Public and Behavioral Health (DPBH):** • Strategic Plan Strategy 5.3: Expand Integrated, Holistic, and Person-Centered Models of Care ○ 5.3.3 Expand the use of peer support specialists as part of the mental health care team **Nevada Health Authority (NHA):** • There were two State Plan Amendments (SPAs) submitted to the Centers for Medicaid and Medicare Services (CMS). The SPA to clarify coverage for Peer Services and delineate between Adult Peer Recovery Support Services, Family Peer Support Services, and Youth Peer Support Services was approved on 9/5/25. The 2nd SPA will increase the Peer Support Services rate to $15 per 15 min for individual peer services and $3 per 15 min. for group peer support services with an effective date of 1/1/25. This 2nd SPA was approved 2/4/26.

4. Create a bill draft request to allocate a 15 percent set aside of cannabis retail funds to be distributed using a local lead agencies model to reach $2 per capita, a recommended funding goal from the Nevada Tobacco Control & Smoke-free Coalition and subject matter experts.	**Division of Child and Family Services (DCFS):**
	• The Family First Prevention Services Act fundamentally reorients child welfare funding toward prevention and family preservation and acknowledges three primary service areas:
	  ○ Mental Health Services
	  ○ Substance Abuse Prevention and Treatment Services
	  ○ In-Home Parenting Skill Building
	• The state plan further commits to allowing each region to prioritize service expansion aligned with community needs and implementation capacity. However, as of the date of this report, no FFPSA-funded substance abuse prevention or treatment services have been deployed within the DCFS System of Care.
	• Additionally, there are no dedicated, youth-specific substance use prevention or early intervention services within the DCFS System of Care.

2024 SURG Recommendation	2025-2026 Updates
Harm Reduction *(developed the Prevention Subcommittee)*	
1. Recommend to DHS to develop an annual or biannual saturation and distribution plan for overdose reversal medication. DHS should utilize opioid settlement dollars to designate a baseline level of identification and overdose reversal medication for the next 10 years in Nevada (which should be based on the state's Naloxone Saturation Plan) to create a supply of stable, sustainable overdose reversal medication throughout the state.	**Division of Public and Behavioral Health (DPBH):** • The State Opioid Response (SOR) Grant Team has developed a preliminary draft of the Statewide Opioid Antagonist Saturation Plan. However, due to limited staffing capacity, the team has not yet had the opportunity to present the plan to community stakeholders or finalize its components. SOR's Quality Assurance Specialist developed a centralized Naloxone Procurement and Distribution system during Q1 and Q2 of 2026 however, due to limited staffing capacity, the launch date is halted until further notice. • Strategic Plan Strategy 4.1: Reduce Stigma and Strengthen Community Engagement Around SUD ○ 4.1.6 Increase education, awareness and access to overdose prevention activities for naloxone and test strips **Fund for a Resilient Nevada (FRN):** • FRN continues to set aside dollars specific to NARCAN procurement and distribution. $1.5 million per year is from FRN directly.

2024 SURG Recommendation	2025-2026 Updates
Harm Reduction *(developed the Prevention Subcommittee)*	

2. Establish a statewide initiative for community drug checking that incorporates qualitative and quantitative drug checking and includes the following parameters:
• Utilize a regional implementation approach with standardized, statewide indicators, since local jurisdictions are best equipped to respond to findings from community drug checking.
• Work with harm reduction community to identify partners/ locations and provide guidance and training.
• Start all sites with mail-based testing while piloting on-site drug checking in a subset of early adopters to refine implementation needs.
• Standardize the data collection, entry, testing, mailing, analysis, reporting as a best practice. Make this as transparent of a process as possible.
• Articulate principles and plans for what will happen to the data.
	Division of Public and Behavioral Health (DPBH):
	• In FFY25, the Nevada State Opioid Response (SOR) Grant funded the University of Nevada, Reno (UNR) School of Public Health to establish a Community Drug Checking and Harm Reduction Initiative in Washoe County. The initiative, known as What the Cut, launched a drug checking program in partnership with syringe service providers and community organizations. It includes mail-based testing and is working toward implementing point-of-care testing using Fourier Transform Infrared (FTIR) technology. The program has developed standardized procedures for sample collection, testing, data analysis, and stakeholder communication, and has shared findings through monthly alerts and outreach efforts.
	• SOR will continue funding UNR for this initiative in FFY26, with planned enhancements including the acquisition of FTIR devices for rapid testing, expanded outreach staffing, and continued development of data-sharing agreements with local health authorities.
	• Strategic Plan Strategy 4.3: Enhance Quality and Integration of SUD Care
	  ○ Implement standardized quality measurement and improvement systems
	• Strategic Plan Strategy 8.1: Improve the Use of Data and Strengthen Local Behavioral Health Infrastructure
	  ○ 8.1.1 Standardize behavioral health data collection and reporting requirements across systems
	Fund for a Resilient Nevada (FRN):
	• FRN continues to fund Impact Exchange with advanced dollars for syringe programs.

2024 SURG Recommendation	2025-2026 Updates
Harm Reduction *(developed the Prevention Subcommittee)*	
3. In collaboration with local agencies and through community conversations, DHS to provide for shipping costs for evidence-based harm reduction supplies (e.g., naloxone, sharps, test strips, etc.) and for travel costs for the pickup of used sharps products to be returned for destruction. Increase advertising about shipping programs to rural Nevada. Establish an alternative strategy for harm reduction supply delivery if people can't receive delivery of the supplies directly.	**Division of Public and Behavioral Health (DPBH):** • In FFY25, the Nevada State Opioid Response (SOR) Grant funded Impact Exchange (Trac-B) to implement the Overdose and Infectious Disease Prevention Expansion Initiative. This program expanded access to harm reduction supplies statewide through vending machines and mail distribution services. Key activities included installing five new vending machines (bringing the total to 20 active locations), distributing 3,920 naloxone units, and sending 449 mail shipments of overdose prevention supplies to individuals, particularly in rural and underserved areas. The initiative also conducted 205 outreach events, 15 community forums, and five educational workshops to raise awareness and promote harm reduction strategies. • Impact Exchange will continue to receive SOR funding in FFY26 to further expand vending machine placements, enhance mail distribution, and strengthen outreach and education efforts. The program plans to improve internal reporting processes and increase staffing to support growth. • Additionally, SOR funds the purchase and distribution of naloxone, fentanyl, and xylazine test strips for northern, rural, and frontier Nevada. CASAT ships these supplies—at no cost to community-based agencies—ensuring broad access to overdose prevention tools across the state.

2024 SURG Recommendation	2025-2026 Updates
Harm Reduction *(developed the Prevention Subcommittee)*	
4. Recommend a bill draft request to support legislation that will (1) help to fund/establish a statewide association for Peers, and (2) better define supervision requirements for Peers under the age of 18.	**Division of Public and Behavioral Health (DPBH):** • For Peer PRSS supervision, the proposed updates to the MSM Ch. 4300 regarding youth peers include the following language regarding youth peer supervision: "Supervision must be provided by a clinical supervisor (per MSM Chapter 400) or a Youth Peer Support Specialist Supervisor holding active certification from a Nevada Medicaid-approved program". Also, this new adjustment gave authority around licensing for in-state facilities to DPBH (MSM Ch 4300: MSM Ch 4300 06-24-25). • Strategic Plan Strategy 7.2: Strengthen Family, Peer, and Community-Led Support Systems for Youth & Special Populations ○ 7.2.2 Build inclusive peer and community support networks **Nevada Health Authority (NHA):** • Medicaid has developed a new Medicaid Services Manual (MSM) Chapter 4300 https://www.nevadamedicaid.nv.gov/siteassets/content/resources/adminsupport/manuals/msm/c4300/msm_4300_26_02_25.pdf for Peer Support Services specifically. The current minimum age for youth providers is 18 in policy, but as this service grows, we are hopeful to work with the Nevada Certification Board (NCB) in the future to support and develop training paths for youth. NCB has developed a certification for family peer support specialists and family peer support specialist supervisors.

2024 SURG Recommendation	2025-2026 Updates
Treatment and Recovery	
1. Legislation should be considered to amend the Nevada Revised Statutes pertaining to the Nevada Bureau of Health Care Quality and Compliance's employment guidelines for hospitals, including behavioral health hospitals, to hire certified peer recovery support specialists who have felony backgrounds and are within three years of their last felony conviction. It is recommended that individuals who were convicted of drug offenses or other offenses that do not involve violent acts or sexual exploitation be considered for employment as certified peer recovery support specialists in hospitals.	**Division of Public and Behavioral Health (DPBH):** • Strategic Plan Strategy 4.1: Reduce Stigma and Strengthen Community Engagement Around SUD ○ 4.1.2 Expand opportunities for peers to be integrated into substance use recovery services **Nevada Health Authority (NHA):** • Medicaid is currently working with the Provider Enrollment team to identify possible exceptions and develop a process to review enrollments on a case-by-case basis, although Code of Federal Regulations (CFR) does not allow Medicaid enrollment for individuals who have felonies within the past 10 years. CFR 424.530 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-P/section-424.530

2024 SURG Recommendation	2025-2026 Updates
Treatment and Recovery	

2. Support BDR 95 to ensure opioid antagonists must be available on all campuses under our Nevada System for Higher Education, including in Student unions, Health centers, all levels of the dormitories, Residential Advisor's domiciles, sports facilities, and libraries and include training of the administration of opioid antagonists which can take place during online Freshman orientations much like we already disseminate information about Title IX, during orientation week, training could be offered throughout the year by various clubs and programs within each institution's design.	**Division of Public and Behavioral Health (DPBH):**
	• DPBH BBHWP worked in collaboration with the bill champion, Madalyn Larson, to support the passage of this bill. We have reached out to her and shared the State Opioid Response Section team members information if additional support is needed by our Bureau. No additional action is needed at this time.
	• Strategic Plan Strategy 4.1: Reduce Stigma and Strengthen Community Engagement Around SUD
	  ○ 4.1.4 Create strategic media and public awareness campaigns
	  ○ 4.1.6 Increase education, awareness and access to overdose prevention activities for naloxone and test strips

3. Support access and linkage for treatment of trauma for people with substance use disorder (SUD) or those who have overdosed and for surviving family members after an overdose fatality. Support training for healthcare professionals to identify and address trauma.	**Division of Child and Family Services (DCFS):** • The Family First Prevention Services Act state plan includes mental health and substance abuse prevention and treatment services that can assist children and families who have experienced trauma related to substance use in order to prevent formal entry into the child welfare system. **Division of Public and Behavioral Health (DPBH):** • In FFY25, the Nevada State Opioid Response (SOR) Grant funded Adam's Place in Clark County to implement the Healing and Support for Families Affected by Opioid and Stimulant Loss initiative. The program provided trauma-informed emotional and psychosocial support to children and families grieving the loss of a loved one due to substance use. Services included individualized support plans, Child Life consultations, case management, and monthly follow-ups. A key component was Camp Cope, which offered therapeutic activities and coping tools in a

2024 SURG Recommendation	2025-2026 Updates
Treatment and Recovery	
	family-centered setting. Outreach and education efforts also empowered professionals and caregivers to support grieving families effectively. • Additionally, UNR Project ECHO and UNR's Screening, Brief Intervention, and Referral to Treatment (SBIRT) program through CASAT provided trauma-informed training to healthcare professionals during FFY25. Project ECHO delivered 36 sessions reaching 424 participants, including SBIRT-focused cohorts and case consultations addressing substance use and trauma-related care. UNR SBIRT offered in-person and virtual trainings, technical assistance, and extended learning series, training over 300 professionals and supporting SBIRT integration into healthcare workflows. • Due to the sunsetting of funds from the SOR 3 No Cost Extension Award, DPBH is unfortunately unable to continue funding Adam's Place, UNR Project ECHO, and UNR SBIRT initiatives in FFY26. **Nevada Health Authority (NHA):** • NV Medicaid has allowed for an increase in access to treatment for individuals with trauma with SUD as well as family members who may need support by allowing mental health treatment within the SUD treatment model. There has also been an increase in CCBHC providers in the state, as well as current CCBHCs developing access sites across the state to increase availability of BH services to all Nevadans. **Fund for a Resilient Nevada (FRN):** • The FRN funds the Nevada Opioid Center for Excellence to support training. FRN is also currently funding the Pediatric Access Line to fill gaps in training for primary care. In the 2025 fiscal year, of the 574 doc to doc consultation calls, we provided 156 tele-video direct patient consultations. Those tele-video consultations resulted in our team identifying 28% of the youth and families' Substance Use impact. Our data from the past year illustrate the disconnect between clinical need (the 28% of youth for whom primary care did not previously recognize Substance Use) and actual recognition (only 0.7% calls with primary care identified Substance Use).

2024 SURG Recommendation	2025-2026 Updates
Treatment and Recovery	

4. Direct the Division of Public and Behavioral Health to identify a funding mechanism for hospitals and providers to enhance the "Bridge Program" for Emergency Departments by incorporating Peer Recovery Support Specialists into their treatment models. Support the use of Peer Support Navigators via telehealth to increase access to treatment and support for individuals identified in Emergency Departments.	**Division of Public and Behavioral Health (DPBH):**
	• In FFY25, the Nevada State Opioid Response (SOR) Grant—administered with support from CASAT—funded the PACT Coalition for Safe and Drug-Free Communities to implement the Enhancing Care Linkages and Buprenorphine Access initiative in Clark County. CASAT provided subaward management, technical assistance, and oversight of data collection and reporting to ensure programmatic compliance and impact.
	• The PACT initiative focused on improving emergency department (ED) responses to opioid overdoses by integrating Peer Recovery Support Specialists (PRSS) into ED workflows, developing protocols for Buprenorphine initiation, and strengthening linkages to ongoing care. Activities included hosting educational mixers, coordinating with EMS and 911 systems, providing transportation to treatment, and maintaining a resource database to support seamless transitions from EDs to recovery services.
	• SOR will continue funding this initiative in FFY26. Under the new scope of work, PACT will expand PRSS integration through hospital staff training, warmline enhancements, transportation coordination for at least 250 clients, and Medicaid enrollment support for PRSS staff to ensure long-term sustainability.
	• Strategic Plan Strategy 2.1: Strengthen and Sustain Nevada's Behavioral Health Workforce
	  ○ 2.1.3 Promote telehealth as a workforce extender while ensuring quality and appropriateness of care
	• Strategic Plan Strategy 4.1: Reduce Stigma and Strengthen Community Engagement Around SUD
	  ○ 4.1.2. Expand opportunities for peers to be integrated into substance use recovery services
	• Strategic Plan Strategy 4.2: Expand Access and Affordability of SUD Services
	  ○ 4.2.3 Leverage telehealth solutions
	  ○ 4.2.6 Integrate peer recovery specialists into deflection responses or programs, for on-scene engagement and warm handoffs to treatment or other resources
	Nevada Health Authority (NHA):
	• Medicaid does not have restrictions for peer service delivery. It can be done via in-person, telehealth or audio-only.

2024 SURG Recommendation	2025-2026 Updates
Response	

1. Recommend research into implementation of statewide data sharing agreements with the Chief Data Officer of the State of Nevada and implementation of a cross-sector database housing multiple points of data across prevention, treatment, recovery, and criminal justice to include data such as controlled substance outlets (tobacco, cannabis, alcohol) to help tailor interventions geographically.	**Division of Public and Behavioral Health (DPBH):**
	• Strategic Plan Strategy 8.1: Improve the Use of Data and Strengthen Local Behavioral Health Infrastructure
	  ○ 8.1.1 Standardize behavioral health data collection and reporting requirements across systems
	  ○ 8.1.2 Promote cross-agency and provider partnerships to improve timely data access and reduce duplication
	Nevada Health Authority (NHA) - Office of Analytics:
	• Currently, Nevada is not pursuing the development of a centralized, cross-sector database to house prevention, treatment, recovery, and criminal justice data. However, the State has formed a Data Governance Committee which is now meeting regularly.
	• The Committee approved a recommendation to adopt a four-tier data classification framework for the Executive Branch. Beginning in 2026, the Committee will begin addressing the technical controls expected for each tier, which will include defining when Data Sharing Agreements (DSA) are required based on classification level.
	• Additionally, the Committee is planning to modernize the DSA process by transitioning to a standardized, electronic format. This effort is intended to improve visibility into existing agreements across agencies and to support more consistent and efficient data sharing practices statewide.

2024 SURG Recommendation	2025-2026 Updates
Response	
2. Support the collaborative proposal to the Fund for a Resilient Nevada to conduct wastewater sampling of high schools, college/university campuses and bars/nightclubs and use information gained to develop public health awareness programs, deploy targeted naloxone, increase provision of fentanyl test strips to targeted locations and to develop a plan for expanding high risk substance wastewater surveillance in Nevada and review the outcomes from this pilot program to identify if it and similar targeted programs may aid in the community response.	**Fund for a Resilient Nevada (FRN):** • FRN continues to fund wastewater programming. The program is now in Year 2, expanding to additional Nevada university campuses, incorporating composite sampling, and broadening the analyte panel to address emerging threats in the drug supply. • This program aims to extend wastewater-based drug monitoring to all high schools across Nevada, positioning the state among national leaders in campus-based surveillance for youth substance use prevention. Results are shared with the local health department, the city's mobile crisis intervention team, and the university student wellness team, creating a direct pipeline from wastewater signal to student-facing public health response. A new dashboard being developed provides interactive visualization of drug analyte concentrations across monitoring sites and time points.

2024 SURG Recommendation	2025-2026 Updates
Response	

3. Resolve the conflict between the Good Samaritan Drug Overdose Act and Drug Induced Homicide Law; immediate actions may include recommending community-level education using best practice guidelines, as well as education for law enforcement personnel, and exploring options for altering the Good Samaritan language to expand coverage to a greater population of individuals living with substance use disorder.	**Division of Public and Behavioral Health (DPBH):**
	• The DPBH 2025-2030 Strategic Plan was finalized and released on October 13, 2025 and the strategies have been implemented into the Bureau's deliverables and funded agencies' scopes of work. DPBH BBHWP will be supporting a large-scale state-run anti-stigma campaign that will focus on some high-need topics, such as MOUD and prevention activities in schools.
	• Strategic Plan Strategy 4.1: Reduce Stigma and Strengthen Community Engagement Around SUD
	  ○ 4.1.4 Create strategic media and public awareness campaigns
	  ○ 4.1.6 Increase Education, Awareness and access to overdose prevention activities for naloxone and test strips
	Fund for a Resilient Nevada (FRN):
	• Resolve the conflict between the Good Samaritan Drug Overdose Act and Drug Induced Homicide Law: This would need to be at the legislative level.
	• Recommending community-level education using best practice guidelines: Good Samaritan is built into all of our overdose education. NOCE is looking at doing a series of social media clips on who the Good Samaritan applies to, what circumstances are covered, and what the limitations are.
	• Education for law enforcement personnel: CASAT produced a training targeting law enforcement in partnership with the Attorney General's office last year, though did not see any attendees from law enforcement at that time. The team developed a flyer that can be sent out to law enforcement agencies letting them know that this is available. Another idea that they had was sending out a solicitation from law enforcement partners regarding questions they specifically had regarding the intersection of Good Samaritan Drug Overdose Act and Drug Induced Homicide Law and develop another training that can be self-paced.
	• Exploring options for altering the Good Samaritan language to expand coverage to a greater population of individuals living with substance use disorder: CASAT/NOCE are looking at possibly putting together a working group regarding this.

2024 SURG Recommendation	2025-2026 Updates
Response	
4. Review the operations and lessons learned from the Clark County Regional Opioid Task Force when that body's report is released in December 2024 and take this into account when supporting legislation to establish regional Overdose Fatality Review (OFR) Committees allowing flexibility as to the makeup and practice and for the OFR to remain at the county or regional level, as needed, to effectively identify system gaps and innovative community-specific overdose prevention and intervention strategies in accordance with established best practices such as the Bureau of Justice Assistance's Overdose Fatality Review: A Practitioner's Guide to Implementation. Funding to be provided through the Fund for Resilient Nevada and to support this recommendation, additional funding may need to be provided to the Coroner or Medical Examiner's office for personnel.	**Division of Public and Behavioral Health (DPBH):** • DPBH BBHWP has not done any work in this space, related to the Clark County Regional Opioid Task Force.

2024 SURG Recommendation	2025-2026 Updates
Response	
5. Recommend state agencies under the legislative, judicial, and executive branches involved with deflection and diversion programs have a comprehensive definition of recidivism, and policies related to measuring and reporting recidivism.	**Division of Public and Behavioral Health (DPBH):** • The Attorney General's Office is involved in efforts to define recidivism and recommends that all state agencies that have diversion/deflection programs have a definition for recidivism with the state moving in the direction of a common definition. • Strategic Plan Strategy 7.1: Increase Access to Timely and Ongoing Behavioral Health Services ○ 7.1.4 Utilize the SIM to support diversion and deflection **Nevada Health Authority (NHA):** • Medicaid's 1115 Reentry Waiver is still under review with CMS, but we hope to gain approval in 2026, 1115 reporting requirements may have definitions established for reporting recidivism like they do under the 1115 SUD Waiver Demonstration.
6. Implement a voluntary program to install “drug take back bins” in retail pharmacies.	**Division of Public and Behavioral Health (DPBH):** • SB231 was passed during the 2025 Legislative Session. This bill created an appropriation from the Fund for Resilient Nevada to the Nevada Board of Pharmacy to assist collectors with the destruction of home-generated pharmaceutical waste deposited in a secure drug take-back bin. **Fund for a Resilient Nevada (FRN):** • SB231 working with the Board of Pharmacy to install drug take back bins in pharmacies that request them. Some pharmacies already have means for collection.

Appendix E: Information Regarding SURG Membership and Presentations Received

Membership

Current SURG membership as of July 2026 includes:

Member Name	Role	Anticipated Term End Date
Attorney General Aaron Ford	The Attorney General or his or her designee	1/1/2027
Terry Kerns	Attorney General's designee to the Response Subcommittee	NA
Stephanie Cook	The Director of the Department of Human Services, or his or her designee from within the Division of Public and Behavioral Health	10/1/2027
Peter Handy	The Executive Director of the Department of Indigent Defense Services, or his or her designee	10/1/2027
Senator Dina Neal	One member of the Senate who is appointed by the Senate Majority Leader	1/1/2027
Senator Jeff Stone	One member of the Senate who is appointed by the Senate Minority Leader	1/1/2027
Assemblymember Heather Goulding	One member of the Assembly who is appointed by the Speaker of the Assembly	1/1/2027
Assemblymember Rebecca Edgeworth	One member of the Assembly who is appointed by the Assembly Minority Leader	1/1/2027
The following members are appointed by the Attorney General		
Jessica Johnson	One representative of a local governmental entity that provides or oversees the provision of human services in a county whose population is 700,000 or more	1/1/2027
Stacey Lance	One representative of a local governmental entity that provides or oversees the provision of human services in a county whose population is 100,000 or more but less than 700,000	1/1/2027
Shayla Holmes	One representative of a local governmental entity that provides or oversees the provision of human services in a county whose population is less than 100,000	1/1/2027
Dr. José Maria Partida Corona	One provider of health care with expertise in medicine for the treatment of substance use disorders	1/1/2028

Member Name	Role	Anticipated Term End Date
Christine Payson	One representative of the Nevada Sheriffs' and Chiefs' Association, or its successor organization	1/1/2027
Steve Shell	One advocate for persons who have substance use disorders and family members of such persons	1/1/2028
Guiseppe Mandell	One person who is in recovery from a substance use disorder	1/1/2028
John Firestone	One person who provides services relating to the treatment of substance use disorders	1/1/2028
Wendy Nelsen	One representative of a substance use disorder prevention coalition	1/1/2028
Chelsi Cheatom	One representative of a program to reduce the harm caused by substance misuse	1/1/2028
Bud Schawl	One representative of a hospital	1/1/2028
Rosa O'Bannon	One representative of a school district	1/1/2028
Rob Banghart	One member of the general public, with preference given to a person who is fluent in more than one language and resides in a household where more than one language is spoken	10/1/2027
Noël Chounet	One person who is an emergency response employee	10/1/2027
Kyra Morgan	One representative of the Division of Child and Family Services of the Department of Human Services	10/1/2027
Nicole Hicks	One representative of the Nevada District Attorneys Association, or its successor organization	10/1/2027

The following former SURG members also served in 2025-2026:

- **Dave Briggs**, in the role of a person who provides services relating to the treatment of substance use disorders
- **Senator Fabian Doñate**, in the role of a member of the Senate who is appointed by the Senate Majority Leader
- **Dr. Lesley Dickson**, in the role of a provider of health care with expertise in medicine for the treatment of substance use disorders
- **Dorothy Edwards**, in the role of a representative of a local governmental entity that provides or oversees the provision of human services in a county whose population is 100,000 or more but less than 700,000

- **Assemblymember Ken Gray**, in the role of a member of the Assembly who is appointed by the Assembly Minority Leader
- **Assemblymember Melissa Hardy**, in the role of a member of the Assembly who is appointed by the Assembly Minority Leader
- **Jeffrey Iverson**, in the role of a person who is in recovery from a substance use disorder
- **Nancy Lindler**, in the role of a person who provides services relating to the treatment of substance use disorders
- **Debbie Nadler**, in the role of an advocate for persons who have substance use disorders and family members of such persons
- **Angela Nickels**, in the role of a representative of a school district
- **Erik Schoen**, in the role of a representative of a substance use disorder prevention coalition
- **Dr. Beth Slamowitz**, in the role of a designee of the Director of the Department of Human Services

Presentations Received by the Full SURG

The SURG working group met in 2025 during the months of January, April, July, and October. In 2026, the group met in January, April, June, and July. In January of 2025 and 2026, members approved the 2024 Annual Report and the 2025 Progress Report, respectively. Presentations were made at the April, July, and October 2025, and April 2026, SURG meetings on the following topics:

April 2025

- **Compassionate Overdose Response** by Karla Wagner, Ph.D., University of Nevada, Reno School of Public Health
- **Presentation of Fund for a Resilient Nevada 2024 Annual Report** by Dawn Yohey, Nevada Department of Human Services, Director's Office, Fund for Resilient Nevada
- **Presentation on Legislative Bills from Behavioral Health Policy Boards** by Dorothy Edwards, Washoe Regional Behavioral Health Policy Coordinator; Valerie Haskin, Rural Regional Behavioral Health Policy Coordinator; Mark Funkhouser, Southern Regional Behavioral Health Policy Coordinator; and Cherylyn Rahr-Wood, Northern Regional Behavioral Health Policy Coordinator

July 2025

- The July meeting highlighted current trends in substance use and included the following presentations:
- **Update for Opioid/Overdose Prevention Activities from CASAT** by Michelle Berry, MBA, Associate Director, and Morgan Green, MA, Project Manager, Center for Application of Substance Abuse Technologies (CASAT)
- **Nevada Substance Use Trends and Public Health Implications** by James Dardis, MS, Biostatistician III, Fund for Resilient Nevada, Office of Analytics, Nevada Department of Human Services

- **Current Drug Use and Seizure Trends in Nevada** by Christine Payson, Drug Intelligence Officer for Nevada High Intensity Drug Trafficking Area (HIDTA)
- **Drug Testing Performed by Public Health Programs** by Karla Wagner, Ph.D., University of Nevada, Reno, School of Public Health
- **Surveillance of the Clark County Illicit Drug Supply** by Marco G. Méndez, MPH, Public Health Evaluator, Division of Disease Surveillance & Control, Southern Nevada Health District

October 2025

- **Presentation of Strategic Plan from Division of Public and Behavioral Health** by Shannon Bennett, Bureau Chief, Bureau of Behavioral Health Wellness and Prevention, Division of Public and Behavioral Health
- **Update on MOUD (Medications for Opioid Use Disorder) in Rural Jails** by Bill Teel, GROWLER Consulting
- **Update on the Clark County Regional Opioid Task Force** by Melanie Rouse, Clark County Coroner and Opioid Task Force Chair
- **Fund for Resilient Nevada Assessment and State Plan** by Heather Kerwin, MPC, CPH, Opioid & Infectious Disease Epidemiologist, Contractor, Office of State Epidemiology, Division of Public and Behavioral Health

April 2026

- **Status Update from the Fund for Resilient Nevada** by Dawn Yohey, MFT, LCADC, Clinical Program Planner, Nevada Department of Human Services, Fund for a Resilient Nevada
- **Presentation on the State Budgeting Process** by Christina Hadwick, Deputy Director, Fiscal Services, Nevada Department of Human Services
- **Presentation on Peer Certification** by Anne-Elizabeth Northan, MPA, Program Director, Center for the Application of Substance Abuse Technologies

Each meeting, aside from April 2026, also included an update on Opioid Litigation, Settlement Funds, and Distribution by Chief Deputy Attorney General Mark Krueger, Office of the Attorney General.

Presentations Received by Subcommittees

Prevention Subcommittee members met in 2025 during the following months: March, May, June, and November. Note that the Subcommittee was scheduled to meet in August but did not have quorum; presentations were provided on this date but no action was taken. The subcommittee met in March and May 2026. Presentations were made on the following topics:

- **Low Barrier Emergency Department Based Naloxone Distribution** by Kelly Morgan, MD, Emergency Physician; Medical Director, Las Vegas Fire & Rescue; Cofounder/Chief Medical Officer, Elite 7 Sports Medicine and Josh Luftig, PA-C, Cofounder Bridge, CA Bridge
- **Update on Multi-Tiered System of Support (MTSS) Project** by Kaci Fleetwood, M. Ed, BCBA, LBA; Ashley Greenwald, Ph.D., BCBA-D, LBA; and Brooke Wagner, MSC-SC, M.Ed., BCBA, LBA
- **Boys and Girls Club of Nevada Alliance: Fund for Resilient Nevada SMART Moves Tween & Teen Initiative** by Noelle Hardt and Tamika Shauntee Rosales
- **Presentation on Naloxone Distribution in Nevada Hospital Emergency Departments** by Darla Zarley, Pharm.D., Nevada State Board of Pharmacy
- **Presentation on Substance Use Prevention Allocations** by Stephanie Cook, BSBM, State Opioid Treatment Authority
- **Tobacco and Cannabis Prevention Funding Landscape and Recommendation** by Lisa Sheretz, Health Educator, Northern Nevada Public Health, Nevada Tobacco Control & Smoke-free Coalition President; and Malcolm Ahlo, Tobacco Control Program Coordinator, Southern Nevada Health District, Nevada Tobacco Control & Smoke-free Coalition Immediate Past President

Treatment and Recovery Subcommittee members met in 2025 during the following months: March, May, June, August, and November. The subcommittee met in 2026 during February, March, and May. Presentations were made on the following topics:

- **A Retrospective Assessment or/and Prospective Study to Assess the Outcomes of Patients Following Discharge From Detoxification and Examine Mortality and Overdose** by John Hamilton, Liberation Programs, Connecticut
- **Code of Federal Regulations (CFR) 42, Part 8**: **Updating Regulations for Opioid Treatment Programs** by John Firestone, Executive Director, Life Change Center, Reno
- **Trends and Opportunities Related to Substance Misuse Treatment** by Dr. José Maria Partida Corona, Partida Corona Medical Center, Las Vegas
- **Presentation on Contingency Management** by Michelle Berry, MBA, Executive Director, Center for the Application of Substance Abuse Technologies (CASAT), School of Public Health, University of Nevada, Reno

Response Subcommittee members met in 2025 during the following months: March, May, June, August, and November. The subcommittee met in 2026 during February, March, and May. Presentations were made on the following topics:

- **Good Samaritan Drug Overdose Act Community Education and Prescription Take-Back Programs** by Jamie Ross, CEO, PACT Coalition, Director, Nevada Statewide Coalition Partnership and Daria Singer, Executive Director, Partnership of Douglas County
- **Emergency Bridge Program** by Kelly Morgan, MD, Emergency Physician; Medical Director, Las Vegas Fire & Rescue; Cofounder/Chief Medical Officer, Elite 7 Sports Medicine
- **Medication Assisted Treatment (MAT)/Medications for Opioid Use Disorder (MOUD) Access in Certified Community Behavioral Health Clinics (CCBHCs)** by Mark Disselkoen, MSW, LCSW, LADC Project Manager, CASAT, University of Nevada, Reno, and Lori Follett, Social Services Chief II, Nevada Department of Human Services , Division of Health Care Financing and Policy (DHCFP), Behavioral Health Benefits Coverage Team
- **Update on Wastewater Surveillance of High-Risk Substances in Nevada** by Daniel Gerrity, Ph.D., P.E., Principal Research Scientist, Southern Nevada Water Authority, and Edwin Oh, Ph.D., Associate Professor, Neurogenetics and Precision Medicine Lab, University of Nevada, Las Vegas
- **Presentation on Behavioral Health Education, Retention & Expansion Network of Nevada (BeHERENV)** by Sara Hunt, PhD, Executive Director BeHERE Nevada and Roberta A. Miranda-Alfonzo, PhD, CPC-S (NV), LCADC-S (NV), NCC, ACS, CPCG-I (NV), Associate Director of Recruitment and Outreach, Kirk Kerkorian School of Medicine, University of Nevada, Las Vegas
- **Drug and Alcohol Prevention, Education, and Enforcement** by Officer Jermaine Galloway, Tall Cop Says Stop
- **Presentation on the Nevada Recovery Friendly Workplace Initiative** by Jonathon Lambson, Recovery Friendly Workplace Ambassador, Foundation for Recovery and Sean O'Donnell, MS, Executive Director, Foundation for Recovery

Appendix F: Information Regarding Opioid Settlement Funds

In accordance with NRS 458.480, this report does not include accounting of opioid settlement funds.[12] However, the Nevada Health Authority Office of Analytics has developed a cloud-based application to support annual and real-time reporting of opioid settlement funded programs and services by all signatories under the One Nevada Agreement. That information can be found on the Fund for Resilient Nevada Dashboard.[13]

[12] To read NRS 458.480, visit the following link: https://www.leg.state.nv.us/nrs/nrs-458.html#NRS458Sec480.

[13] To review the Fund for a Resilient Nevada Dashboard, visit the following link: https://app.powerbigov.us/view?r=eyJrIjoiMzg2MDYzYzEtNmQwYy00NjYwLTk1MDgtYzJiY2VjOGVjZmJkIiwidCI6ImU0YTM0MGU2LWI4OWUtNGU2OC04ZWFhLTE1NDRkMjcwMzk4MCJ9.

Appendix G: Signature

_____ _____

Chair, Substance Use Response Working Group Date