MULTIDISCIPLINARY PREVENTION ADVISORY COMMITTEE (MPAC)
MINUTES

DATE: **July 12, 2018**
TIME: **9:00 a.m.**

LOCATION:

	Meeting	*Videoconference*
LOCATION:	**Substance Abuse Prevention and Treatment Agency** **4126 Technology Way, 2nd Floor** **Room 201** **Carson City, NV 89706**	**Health Care Quality and Compliance** **4220 S Maryland Pkwy, Building D** **Suite 810** **Las Vegas, NV 89119**

TELECONFERENCE: **(888) 363-4734 / Access Code: 3865799**

BOARD MEMBERS PRESENT
Stephanie Asteriadis Pyle, Vice Chair, Center for the Application of Substance Abuse Technologies (CASAT)
Carol O'Hare, Nevada Council on Problem Gambling
Heidi Gustafson, Foundation for Recovery
Jennifer DeLett-Snyder, Join Together Northern Nevada (JTNN)
Linda Lang, Nevada Statewide Coalition
Partnership
Dr. Mel Pohl, Las Vegas Recovery Center
Jamie Ross, PACT Coalition
Ivy Spadone, Norther Nevada HOPES

BOARD MEMBERS ABSENT
Karla Wagner, University of Nevada, Reno (UNR), School of Community Health Sciences
Keith Carter, Nevada High Intensity Drug Trafficking Area Program (HIDTA)
Kristen Rivas, Division of Child and Family Services (DCFS)
Patrick Bozarth, Community Counseling Center of Southern Nevada

STAFF & GUESTS PRESENT
James Kuzhippala, Truckee Meadows Community College
Diane Anderson, CARE Coalition
Joelle Gutman, Regional Behavioral Health Coordinator
Sandal Kelly, Consultation and Counseling Associates
Katro Haynes, Adelson Clinic
Marco Erickson, Division of Public and Behavioral Health (DPBH)
Julia Peek, DPBH
Misty Allen, Office of Suicide Prevention
Jessica Flood, Regional Behavioral Health Coordinator
Kathryn Barker, Southern Nevada Health District
Lea Cartwright, Nevada Psychiatric Association
Jen Thompson, DPBH
Raul Martinez, Substance Abuse Prevention and Treatment Agency (SAPTA)
Joan Waldock, SAPTA

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1. Introductions, Announcements, and Roll Call
Ms. Pyle called the meeting to order at 9:13 a.m. There were no announcements. Roll was called. Ms. Pyle determined a quorum was present.

2. Public Comment
There was no public comment.

3. Approval of Minutes from June 15, 2017 Meeting
Ms. DeLett-Snyder asked if there had been a meeting after the one in June, as she and Ms. Ross were approved as members of the Committee. Ms. Pyle said the Nomination Subcommittee met. There was much discussion regarding how to act on the recommendation of the Nomination Subcommittee to add Ms. DeLett-Snyder and Ms. Ross as members.

Ms. Lang noted an error on page 11 of the minutes. She suggested a change. Ms. Lang moved to approve the minutes with the noted edit. Ms. O'Hare seconded the motion. Dr. Pohl and Ms. Gustafson abstained. The motion passed.

4. Review Membership Vacancies and Make Recommendations for Nominees
Ms. Gustafson asked how many seats needed to be filled. Mr. Martinez gave an update on membership, noting that when Ms. DeLett-Snyder and Ms. Ross were added, there would still be need of three more members. He read from the bylaws, "The Committee consists of a minimum of 15 representatives across all disciplines including, but not limited to: mental health; tobacco control; law enforcement; primary care providers; judicial education; juvenile justice; Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ); military, and drug enforcement." Ms. O'Hare suggested changing the bylaws to give a range in the number of members.
Ms. Pyle noted that an organization that is a member of MPAC could fill its vacancy from within that organization. Mr. Martinez noted the organizations with vacancies were: Douglas County Juvenile Probation, Northern Nevada HOPES, Office of the Governor, and Partnership of Community Resources. He added a primary care physician, justice of the State Supreme Court, and someone from the Statewide Native American Coalition had also been members.
Ms. Pyle asked for volunteers to serve on the Nomination Subcommittee for members to bring membership to the minimum of 15 members and for the Chair. Ms. Lang reported that the Nomination Subcommittee met on July 18, 2017, noting Cody Phinney was nominated as Chair and that Ms. DeLett-Snyder and Ms. Ross were nominated as members.
Dr. Pohl moved to accept Ms. DeLett-Snyder and Ms. Ross as members. Ms. Gustafson seconded the motion. The motion passed.
Ms. Pyle requested there be diversity in membership in order to have good representation. Ms. Gustafson, Ms. Lang, and Ms. Ross volunteered to be on the Nomination Subcommittee. Ms. Pyle suggested the subcommittee meet by telephone.
Ms. Gustafson asked what the Committee expected regarding their recommendations. She asked if they would need to provide biographies for each nominee. Ms. Pyle said each member of the subcommittee should have a copy of the bylaws in order to know the representation the Committee was looking for. She noted the bylaws contained attendance requirements, so the subcommittee should make sure candidates were available and willing to attend meetings. She added that MPAC advised on prevention throughout Nevada and affected funding. She reminded the subcommittee they should present three members.

5. Appoint a Nomination Subcommittee for Nominating a Chair
Ms. Pyle asked the subcommittee to consider which member should chair the Committee. She pointed out the bylaws stated elections for Chair and Vice Chair were to occur in alternating years, so this would be the year for choosing a new Vice Chair. She referred to page 3 of the bylaws,

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Article 4.4.6, that stated, "When a Chair or Vice Chair is elected to replace a vacant position and serves in that capacity for two meetings or less prior to the next regular election [which would occur at the first meeting in 2019] for that position he/she will be deemed to have been elected to the full term for that position." She suggested they look for a strong individual who had been active in the state in matters the MPAC was concerned with who was able to make the time commitment. She asked if the subcommittee would be willing to nominate a Chair. Ms. Lang said they would review the bylaws to determine MPAC was in compliance with all membership and officer qualifications. Ms. Pyle noted that she would attend their meeting.

6. Review the Nevada Behavioral Health Summary (Statewide Epidemiology Profile) to Make Recommendations and / or Approve

Mr. Kuzhippala went through the PowerPoint presentation of the Data Profile Summary, which can be found here. He reported the profile was developed with the Office of Analytics, in collaboration with Ms. Morgan, Ms. Thompson, and the Statewide Epidemiology Workgroup (SEW). He reiterated that the PowerPoint contained highlights of the 2017 Epidemiologic Profile Draft (epi profile), which can be found here. He said he would take them through general mental health and substance use trends, an overview of what is found in the data profile. He said he would comment on specific needs and gaps, funding needs, and overall recommendations.

- Slide 3—a visual representation of the state the mental health and substance use treatment centers. The urban counties have many facilities, but facilities are sparsely located throughout the rest of state. He explained that the Nevada Youth Risk Behavior Survey (YRBS) surveys youth for risky behavior in high school students.
- Slide 4—a snapshot of the data captured by the YRBS. The data shows 8.5 percent of high school students reported suicide in the past 12 months, down from 9.8 percent in the 2015 YRBS. About 1 in every 12 students attempted suicide by some means, which is a major concern.
- Slide 5—the adult population, using Behavioral Risk Factor Surveillance System (BRFSS) data, showing a trend from 2011 to 2017 of adults who experienced poor mental or physical health that prevented them from doing usual activities. He explained that the blue bar represents no days of health preventing activities, but that percentage has decreased during the span. There has also been an increase in those who reported they experienced poor mental or physical health one to nine days.
- Slide 6—emergency department data from hospital billing. Mr. Kuzhippala explained that patients admitted to emergency rooms were assigned diagnosis codes according to the treatment provided. For an individual visit, there could be multiple diagnosis codes. The graph shows an increase in most of these categories, especially anxiety and depression. He explained the conversion from International Classification of Diseases (ICD)-9 to ICD-10 took place in 2015, multiplying the number of codes.
- Slide 7—data about people who stayed in the hospital more than 24 hours. He noted the data was similar—anxiety and depression were the major mental health reasons people were admitted. He pointed out a major dip in suicidal ideation that they are still researching. It took place at every facility in the state.
- Slide 8—public facilities that send data to the Office of Analytics and to SAPTA. The slide shows a drastic decrease in the number of unique clients being served in Nevada. That could be due to the Affordable Care Act's (ACA's) having gone into effect in 2014. The graph does not represent the number of services provided—a single client could have gone to a mental health clinic multiple times in one year.

  Ms. Ross pointed out the decrease was represented in state-funded mental health clinics only. She asked if there was any data to show that the inverse was the case with private for-profit mental health facilities. Mr. Kuzhippala replied he did not have access to data

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from private facilities. Mr. Kuzhippala said SAPTA and the Office of Analytics have made effort to get data from private facilities, so data could be available in the future.

Ms. Lang noted that slide 8 startled her. She pointed out that in rural parts of the state there was no access to private facilities with clients relying almost solely on state-funded mental health clinics. The data shows an increase in the issues related to mental illness in the community. Mr. Kuzhippala asked if it would be beneficial to present the data by where clients reside. Ms. Thompson said once the epi profile was approved, the Office of Analytics would provide data relevant to each regional behavioral health board. Ms. Peek said in the past they were able to pull data from private facilities. The information was helpful to determine needs in the rural counties. She suggested they pull data about where clients lived and where they went to receive care. The data sources would be limited to emergency rooms and inpatient facilities. Ms. Thompson pointed out that page 19 of the epi profile showed by county where people went to get services. The data will be broken down further in the regional reports.

- Slide 9—methods of suicide attempt, which are not exclusive. Substance- and drug-related suicide attempts are by far the highest.
- Slide 10—a large spike in 2016 for inpatient admissions showing substance- and drug-related suicide attempts as the highest.
- Slide 11—a constant rate of completed suicides from 2009 to 2017—there was no significant increase for completed suicides, even if there was a significant increase in attempted suicides.
- Slide 12—data broken out by racial and ethnic categories, showing that the white non-Hispanic population has a significantly higher rate than Nevada as a whole. That is a priority population in terms of completed suicides. He pointed out that the Native American population had high rates in 2012, but because of the relatively small number of the population, the value is not technically statistically significant, but it is a concern to investigate.
- Slide 13—significant decrease of mental health related deaths in 2015 without a significant increase afterwards. Mr. Kuzhippala mentioned that all of the ICD codes used to pull the data are included at the end of report.

  Ms. Lang asked for clarification on what "age-related rate" meant. Mr. Kuzhippala explained that if looking at two populations—one group with a lot of elderly individuals and the other with a lot of younger individuals—you would expect to see a high cancer rate in the population with older individuals. To make the populations comparable, both populations are adjusted to include similar proportions of aged individuals; they weight that population. Ms. Thompson said you could identify if the counts and the rate fluctuate by comparing the rate and the numbers. Mr. Kuzhippala said if a lot of people in Nevada for one age group left or came in, it would have a massive impact on specific diseases, so they are adjusted on a year-to-year basis to make multiple years comparable. He added that was why they adjust racial and ethnic categories by age. Ms. Thompson pointed out they followed the national standard to compare Nevada against the rest of the nation. Mr. Kuzhippala explained that crude rates were good for seeing the overall burden of disease, but were not the standard.
- Slide 14—data from Substance Abuse and Mental Health Services Administration (SAMHSA) that shows the National Surveys on Drug Use and Health, 2010-2016. This compares Nevada to the United States in 2011 to 2016, excluding 2015. Generally, for individuals aged 12 years and above, Nevada is becoming more comparable with the United States for alcohol use disorder, which is an improvement.

  Ms. DeLett-Snyder said the slide looked as if Nevada was doing better for alcohol in 2016, but she did not think there was data available. Mr. Kuzhippala said this reflected

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SAMHSA data that came from telephone surveys. Ms. DeLett-Snyder pointed out that the survey pool would only include people who had landlines, excluding many young people. She did not think the data would be accurate.

- Slide 15—perception risk of binge drinking. There is more perceived risk that having five or more drinks of an alcoholic beverage once or twice a week will cause harm.
- Slide 16—based on Monitoring the Future Survey data. Monitoring the Future is a separate survey that is conducted across the nation as a whole—it is not specific to Nevada. While it shows a decrease in alcohol use, it still shows that 62 percent of twelfth graders use alcohol, which is a massive concern.
- Slide 17—annual prevalence of being drunk from alcohol. It show a slight decrease, but the rates are still relatively high.
- Slide 18—any use of marijuana/hashish in the United States. It shows slight increase in more recent years. This slide was included to raise awareness that marijuana use is not an issue that is specific to Nevada, but is impacting the nation as a whole.
- Slide 19—methamphetamine use. The scale is 0-5 percent, so it does not show a massive decrease, but a downward trend for all age grades.
- Slide 20 depicts alcohol use among Nevada high school students. Mr. Kuzhippala pointed out that the YRBS was conducted on a biannual basis. He reviewed the five indicators for alcohol use in that survey. He pointed out there were general decreases in all categories except for the category "someone else providing alcohol."
- Slide 21—questions the middle school YRBS asks regarding alcohol—did they ever drink alcohol, do they currently drink alcohol, and did they drink alcohol before age 11. There have been decreases in ever drinking alcohol and currently drinking alcohol; there has been an increase in drinking before age 11.
  Ms. Lang noted that the Enforcing Underage Drinking Laws (EUDL) dollars for the nation were available from 2001 to 2015 or 2016. She is interested in seeing what will happen now, since the focus has shifted to prescription drugs and marijuana. She said EUDL involved compliance and shoulder taps for people who were buying alcohol for kids. There were environmental strategies, such as social host laws, that hit students from different directions. There are no teeth in it anymore because there are no funds. Ms. Anderson said EUDL ended in 2015; discretionary funding closed out in 2017. Mr. Kuzhippala asked if EUDL efforts were continuing. Ms. Lang said they were gone—laws are on the books, but are not being enforced. The issue was attacked from law enforcement, parent education, and youth education and it worked. Mr. Kuzhippala said that information could be included in the narrative.
- Slide 22—lifetime drug use summary, showing multiple drug categories. When compared to the United States, Nevada has relatively higher rates of use for all drug categories.
- Slide 23—data specific to marijuana use among high school students. The three indicators were: used marijuana before age 13, currently use marijuana, or ever used marijuana. There have been nonsignificant changes for all three questions. There may be changes with more recent changes in Nevada's marijuana laws
- Slide 24—data for middle school students. The changes shown are nonsignificant.
- Slide 25—alcohol- and other drug-related emergency department encounters, with data broken out.
- Slide 26—opioids, marijuana, and methamphetamines are the primary reasons for drug-related emergency department encounters when alcohol is excluded.
- Slide 27—alcohol- and drug-related inpatient admissions.
- Slide 28—opioids, marijuana, and methamphetamines are the primary reasons for drug-related inpatient admissions.

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- Slide 29—death data for alcohol and other drugs, broken out by age groups. Mr. Kuzhippala noted that in more recent years, there have been increasing trends for alcohol- and drug-related deaths among all ages about the age of 35. There were slight decreases in 2017, so something happened in the past year that helped reduce the number of alcohol- and drug-related deaths, but there has been a stark increase since 2009.
- Slide 30—the trend for alcohol- and drug-related deaths in Nevada as a whole. There has been an increase in more recent years.
- Slide 31—alcohol-related deaths. Even though there is a general increase since 2009, the increases are nonsignificant, meaning the bulk of the increase is from drug-related deaths.
- Slide 32--the wrong chart was copied into the PowerPoint, so slide 32 will be removed.
- Slide 33—alcohol- and drug-related deaths by racial and ethnic categories shows the white non-Hispanic population has had a significant increase since 2014.
- Slide 34—other risky behaviors for high school students, comparing Nevada to the United States in 2017.
  Ms. DeLett-Snyder stated that the YRBS had a question regarding alcohol. She wondered if a questions could be added about having sexual intercourse after using alcohol. Mr. Kuzhippala said the information could be included in the data profile.
- Slide 35—prenatal substance use birth rates for select substances. Mr. Kuzhippala pointed out this was one of the gaps in the data because there is not a perfect way of collecting data on this population. This data represents the pregnant population in terms of live births and if the mother used substances during the pregnancy. These statistics are self-reported and do not represent the true number of drugs used. There has been a drastic increase in marijuana use among pregnant women over the past seven years. He pointed out the graph reported rates, not percentages.
  Ms. Lang said in Fallon, some doctors require drug testing with pregnant women. They report that 40 percent or more test positive for drug use. Even after education and intervention, there has been only a 10 percent drop. Mr. Kuzhippala said this would be tied into funding and data needs. He said the Pregnancy Risk Assessment Monitoring System (PRAMS) randomly selects 157 live births each month and surveys maternal and infant characteristics, emotional and physical abuse, prenatal care, substance abuse, and more. He recommended more funding for PRAMS.
- Slide 36—sexual orientation, Nevada high school populations from YRBS, comparing 2015 to 2017. The heterosexual population has slightly decreased, and the gay, lesbian, or bisexual population has increased from 2015. He said the reason they brought that up is that the YRBS data to compare the LGB to the non-LGB population shows increased rates of risky behaviors among the LGB population, which can be seen on slides 37 and 38.
- Slide 37—prevalence of health risk behaviors by LGB population. This slide shows higher rates among the LGB population compared to the unsure of sexual orientation and the heterosexual groups. Mr. Kuzhippala pointed out that the University of Nevada, Reno (UNR) compiled a report for LGB analysis for 2015 YRBS data. Ms. Thompson pointed out that 2017 data was not yet available.
- Slide 38—differences between Nevada LGB and non-LGB populations in health risk behaviors. There are drastic differences between the two groups.
- Slide 39—prevalence of health risks behavior by Nevada transgender adults. There are drastic differences between transgender and non-transgender groups. Mr. Kuzhippala pointed out that because the transgender population is relatively small, a large sample size is necessary to break the statistics out further.
- Slide 40—technical notes containing ICD-9 Clinical Modification (CM) and ICD-10 CM codes.

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Ms. Lang asked if the Office of Analytics used juvenile justice data. She thought it would be interesting to find out about the substance use, mental health, and sexual orientation of those in the juvenile justice system. Ms. Thompson said the Office of Analytics was created to merge data from all of the Department of Health and Human Services divisions, including the Division of Child and Family Services (DCFS). She said juvenile justice only gets data from state juvenile justice, not from counties. She added the information is a very small sample of what is happening in the state. Ms. Lang pointed out that the regional health boards are focusing on the juveniles. Ms. Thompson replied reporting was moving to a new system. She thought counties would be part of that system. She said her office has been given access to the Criminal History Repository, providing them with data on adults.

Ms. DeLett-Snyder asked how many people were reported on in slide 39, Nevada's adult transgender population. Mr. Kuzhippala replied that the sample size in 2016 was around 40. Ms. DeLett-Snyder said the graph makes it look as if there was a huge problem in the transgender population. Ms. Lang said the same thing happens when looking at special populations in determining program emphasis. Mr. Erickson pointed out that when writing disparities impact statements, they note the subpopulation's percentage of the population of the state.

- Slide 41—data needs and gaps. Mr. Kuzhippala pointed out that the majority of the data in the profile came from the YRBS and the BRFSS because it is what is available. Both surveys include Centers for Disease Control (CDC) core questions and state-specific questions. In order to break the data further to see if a specific subpopulation is being negatively impacted, the State needs larger sample sizes.

  Mr. Kuzhippala stated that it made a difference whether active versus passive consent for YRBS was required. He explained that certain counties required active consent. With passive consent, a parent would have to inform the school that his child would not be allowed to participate in the survey, which decreases the sample size. With active consent, a parent has to give permission for his child to take the survey. There has been outreach to parents to encourage them to have their children participate. Clark County requires active consent, so the school district has about a 65 percent response rate. Ms. Lang asked if any legislation was proposed that would change the type of consent needed so that it would be consistent across the state. Mr. Erickson said he had not heard anything from the Nevada Department of Education on that. Ms. Peek said she was unaware of anything being proposed. She suggested that Ms. Lang mention it at an upcoming interim health meeting. Mr. Erickson pointed out that the School Climate Survey has been gathering data, but Clark County does not participate in that survey. He said there was a way to compare Clark County's and Washoe County's existing surveys to the rest of the state. The climate surveys have a high level of participation because funding and school report card scores depend on the level of student participation.

  Ms. Gustafson asked if there was a way to identify people who think they have a problem with their alcohol or other drug use or and data on those who returned to using. Mr. Kuzhippala said he would bring her question to Mr. Brian Parrish for consideration. Ms. Lang asked if the profile could indicate the need for data from juvenile justice since that is a population of youth that would not be taking the YRBS. She also asked if a gap could be noted regarding substance use within the corrections community.
- Slide 42—funding needs.
  - PRAMS—increased incentives to mothers would increase the response rate. Up to 3 mailings and up to 15 calls per mother for individuals who do not respond are required. $75,000 is needed to maintain normal funding.

    Ms. Ross asked how closely PRAMS worked with the Empowered Program at St. Rose Hospital, a program working with pregnant women through State

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Targeted Response (STR) funding. Ms. Peek explained that PRAMS data could be generalized to the community. A supplement related to opioid use will provide data for moms and babies. Data from the Empowered Program will be collected through the STR and in Treatment Episode Data Set (TEDS), but that data would not be generalized. They could look at the success of the wraparound services and what the success was for different moms and different services. She said she would add Plan of Safe Care and Comprehensive Addiction and Recovery Act (CARA) efforts data. Ms. Pyle asked about the increase in marijuana use by pregnant women. She pointed out that before marijuana was legalized anywhere, research was nonexistent. She asked if there were programs that followed up with babies to see what the effects of their mothers' prenatal marijuana use was. Ms. Peek said they worked closely with Child Protective Services (CPS) on how to follow up with the mothers of babies exposed to legalized drugs. She added that a project at UNR would be starting soon researching marijuana use in pregnancy. She pointed out that many of the women were involved in polysubstance use. Ms. Pyle noted mothers may use marijuana to counteract morning sickness. She was curious if those moms continued use. Ms. Peek said she would meet with the PRAMS team to find out if they could add the question or if it was already being asked. Ms. Lang said there are community awareness initiatives across the state that address the effects of marijuana use. She said Maternal Child Health (MCH) provided information. Ms. Pyle wondered if doctors were aware that moms were not asking for morning sickness medication because they are using marijuana. Ms. Peek said obstetricians-gynecologists (ob-gyns) have had a question about using substances during pregnancy in their prenatal screening. Many mothers answered "no." They added an additional question asking if moms were using marijuana and mothers answered "yes." As a result, doctors are educating their patients about marijuana use. She said she would check to see if there was a decrease in the number of moms reporting morning sickness and how to help doctors communicate with their patients about marijuana. Ms. DeLett-Snyder pointed out that alternative sentencing in Washoe County has a small pilot project that tracks moms and the babies.

- BRFSS

  Additional questions cost $2,500. Increasing the sample size will result in increased generalizability and the ability to conduct a more thorough analysis of priority populations. Current funding is $50,000 for substance-related modules and state-added questions.

- YRBS

  The CDC funds approximately 30 high schools, mostly in Clark County. Additional funding of $130,000 pays for an additional 70 high schools and 120 middle schools throughout the state. By having more data, the information is more generalizable to the rest of the state.

  Ms. Lang asked where the money would come from. Ms. Kuzhippala replied that SAPTA has provided funds for the BRFSS and co-sponsored the YRBS. Ms. Peek explained the SEW was required to provide data to help direct funding. The SEW is asking for continued support for their efforts. She pointed out that if MPAC needed more data or more in-depth data, additional funding would be needed—either by re-directing current funds or providing new funding streams that could apply. Mr. Kuzhippala said the CDC supplies $65,000 for YRBS. Ms. DeLett-Snyder asked what the $130,000 for YRBS funded. Mr. Kuzhippala replied that amount would maintain the current number of schools. Ms. Peek said part of that funding was used to provide compensation to teachers and schools

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participating, which helped the response rate in the counties with active consent. Additional funds are used for the purchase of materials and analysis of the staff time and administration. Ms. DeLett-Snyder said coalitions have been prevented from providing incentives for participation and wondered how SAPTA could do that. Ms. Peek said she would review the policy.

Ms. O'Hare asked Mr. Kuzhippala to clarify the funding needs for BRFSS. Mr. Kuzhippala explained that each additional state-added question on the BRFSS costs $2,500. He added that the BRFSS contains four CDC questions that cannot be changed. Nevada can add other questions. If other states do not ask the same question, the data received would not be comparable to the rest of the country, but would be useful for Nevada. The $50,000 is for the substance-related module, which is a whole host of state-added questions. Ms. Peek said the $2,500 amount was based on the time and effort it would take to add additional questions during the survey time. The module consists of a number of questions, as well as separate analysis regarding substance use by UNR and University of Nevada, Las Vegas (UNLV) staff. Ms. O'Hare mentioned that the Advisory Committee on Problem Gambling (ACPG) was looking at a bill to increase funding and there was interest in getting data. She noted that problem gambling had a high co-morbidity with substance use. She asked if this survey was a place where gambling disorder questions could be added. Ms. Peek said it was. Ms. O'Hare asked how the ACPG could do that. Ms. Pyle suggested Ms. O'Hare meet with Dr. Yang at UNR. Ms. Peek stated that SAPTA bought at least a single question regarding problem gambling. Her office can cross-tabulate the problem gambling question by demographic, by substance use, and geographic regions. Ms. Ross said many SAMHSA grants require questions about perception of harm for youth that are not in the YRBS. She asked if perception of harm questions could be on the YRBS. Ms. Lang explained there were National Outcome Measures (NOMS) that are needed for some major federal grants. Those questions were removed from the YRBS several years ago. The coalitions would like to see those questions placed and kept in the YRBS. She noted the perception of harm questions were removed to make room for healthy eating questions. Ms. DeLett-Snyder said the problem was discussed at the last SEW meeting. She said the topic had been covered in the School Climate Survey, but Nevada did not want those questions in their survey. Washoe County School District is the only district still asking the questions because it has its own survey. Mr. Erickson explained that as perceived risk goes down, usage goes up. Ms. Pyle said such questions were removed at the federal level when they eliminated the Safe and Drug-Free Schools program.

- Slide 43—overall recommendations.
    - Alcohol use among youth (9- t0 20-year-olds)
    - Marijuana use among all ages
    - Pregnant women and alcohol/other drugs
    - Suicide ideation
    - Opioid use among all ages

      Mr. Kuzhippala pointed out that the Office of Analytics updates the Opioid Surveillance Tool, which has a wealth of information on opioid-specific indicators.

Ms. Lang asked if these recommendations were open to discussion. Mr. Kuzhippala said the MPAC would decide the SEW's recommendations. Mr. Erickson said the MPAC would need to decide and add anything they view as necessary. Ms. Lang asked that data for amphetamine use be included in the recommendation. She said the data showed that prescription drug use was going down, but methamphetamine use was going up. Ms. O'Hare said methamphetamines probably top opioids in southern Nevada. Ms. Pyle clarified that they would like to add methamphetamines in addition to

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the SEW's recommendations. Ms. Lang replied that cocaine with fentanyl was surpassing amphetamines in some areas. Ms. Peek reported that at its next meeting, the SEW would be considering what special reports they would make over the next year. They already determined that one would be on perinatal substance use. She said they could do one on amphetamines, which would expose gaps in their data. She asked if MPAC would recommend that SEW do a special report on amphetamines for them. Dr. Pohl pointed out that cocaine was different than amphetamines and should be measured differently. He agreed they were both stimulants, but pointed out that cocaine was not an amphetamine. He suggested that, for accurate reporting, they have both. Ms. Ross asked if there could be a report on stimulants—that would also include prescription stimulations like Adderall, which has been a problem in colleges and high schools.

- Slide 44—contact information for the Office of Analytics.

Ms. Pyle asked if there was more discussion on the SEW's recommendations. Dr. Pohl stated that fentanyl was a prominent substance that was being used to cut heroin. If that information was available, he would like to have it.

Ms. Pyle asked for a motion to include the recommendations on Slide 43 and add amphetamines, cocaine, and fentanyl. Ms. Pyle verified that a quorum was still present.

Mr. Erickson explained that, in order to be in compliance with federal guidelines, the SEW was required to make recommendations to MPAC. MPAC sets funding priorities for SAPTA. SAPTA does its best to fund those priorities. He added that the Evidence-Based Practices Workgroup will vet interventions being used to determine if the practices should be approved. Ms. Pyle asked who would vet prevention interventions. Mr. Erickson replied that the Evidence-Based Practices Committee will be made up of a professionals that do prevention and interventions, and coalition partners, some state employees, some university employees—people with expertise in those areas. Ms. Lang said the recommendations page needed to be cleaned up before they vote. She pointed out they were looking at evidence-based programs and funding. She feared that if something was not on this list, it would not be a priority.

Ms. Peek said they would be considering the special reports at the next SEW meeting. She said one that was requested today was on opioids, specifically fentanyl. They already are planning a report on perinatal substance use. She asked for help on the request for a report on stimulants. Dr. Pohl explained that stimulants would be a category. A subcategory would amphetamines, which includes Adderall; methamphetamines, a street drug, and cocaine. Ms. Lang asked if their recommendation was just for a report. Ms. Peek replied they were looking at data recommendations. The SEW has requested additional money for data so that MPAC can have the information needed to make decisions about programs. The next step will be that the evidence-based planning group will look at programs directed at the needs. Ms. DeLett-Snyder said Mr. Devine told her the recommendations that came from MPAC would be what SAPTA funded for the coalitions and prevention going forward. Mr. Erickson explained that Mr. Devine was speaking about the Partnership For Success (PFS) projects. Ms. DeLett-Snyder disagreed as Mr. Devine told her this would include all of their grants, including the competitive process at the end of the year. He said MPAC's recommendations would drive what happened in prevention. Ms. Ross asked if, rather than chasing the drug-of-the-day, they could address the underlying risk factors or Adverse Childhood Experiences (ACES), the reasons people used drugs or participated in risky behavior. If the goal is to focus on specific areas, she would like to focus on protective and risk factors.

Ms. Pyle asked how soon these recommendations were needed. Mr. Erickson said SAPTA needed them as soon as possible. She pointed out that all prevention was data-driven and needed to be supported and evaluated with data. She suggested the Committee meet again. Ms. Gustafson asked if a decision on the recommendations was needed by SEW for their next meeting. Ms. Peek said they would make decisions about the special reports at the October meeting. She said that she and Mr. Kuzhippala have enough information to start to pulling data for their feedback. Mr. Erickson said they used the data from the SEW to help drive the basic priorities. Ms. Peek said it seemed that the issue was the evidence-based programs that would be adopted as a result of the data.

APPROVED

Ms. Lang said she thought MPAC could vote on this information with the changes they discussed. She suggested they add two bullet points—one for stimulants with cocaine, methamphetamines, amphetamines, and Adderall; the other with fentanyl. The recommendations are data-driven. Ms. O'Hare asked who they were making recommendations to and what would be the result of the recommendation. Ms. Lang replied that these recommendations were for what the areas of focus will be for prevention and early intervention priorities. Ms. O'Hare asked if these would be the priority areas the state would focus funding for programming. She recommended that something related to problem gambling be included. Going forward, she would like the MPAC to consider how to find a bridge between funded services for gambling. She noted treatment programs have collected data on co-occurring substance use and gambling. She would like to see SAPTA providers screen for gambling. Ms. Peek said there is data about problem gambling. Ms. O'Hare said she participates on this Committee because the ACPG would like to see problem gambling addressed. Ms. Pyle pointed out that gambling was not mentioned in the draft epi profile. She said MPAC would like to see data on gambling in next year's report. Ms. Peek said she was working on problem gambling. The epi profile was not finalized yet, so problem gambling data could be in the final report. Ms. O'Hare asked that her to coordinate with the ACPG or the gambling providers. Ms. Pyle said some of the data they collect is from existing surveys. Ms. O'Hare said Sarah St. John and a team at UNLV have been collecting data on gambling and that there were years of data available from treatment centers. While not prevention data, she thought data could be gleaned regarding co-morbidity. Ms. DeLett-Snyder asked if SAPTA funded gambling. Mr. Erickson said it did not. Ms. O'Hare said the Department of Health and Human Services (DHHS), through the Office of Community Partnerships and Grants, manages the Problem Gambling Prevention and Treatment Fund that was established by the legislature in 2005. All of the funding for prevention and treatment services comes through that one fund, based on the advice of the ACPG. The ACPG advises the Department and works on the priorities for use of those funds. She pointed out that although gambling disorder was in the same chapter of the Diagnostic and Statistical Manual (DSM) as substance use, there has been no coordination between the substance abuse world and the gambling disorder world regarding prevention and treatment.

Ms. Peek said she located the questions about gambling that are asked.

- In the past 12 months, how often did you bet money or possessions on any of the following activities? Casino gaming including slot machines and table games; lottery including scratch tickets, pull tabs, and lotto; sports betting; internet gambling; bingo, or any other type of wagering.
- Has the money spent gambling led to financial problems and/or has the time you spent gambling led to problems in your family, work, or personal life?

She said the questions will be cross tabulated with substance use and other data and the data added to the epi profile. She suggested the MPAC request a special report on problem gambling. Ms. Pyle said the placement of problem gambling in the DSM provided justification for including the data. Ms. O'Hare added that historically, there has been plenty of national data about the high co-morbidity of pathological gambling (now called gambling disorder) and substance use disorder. Ms. Pyle added that there was co-morbidity with suicide, as well.

Ms. DeLett-Snyder moved to approve the recommendations that were provided, adding stimulants. Ms. Ross seconded the motion. The motion passed.

7. Make Recommendations of Agenda Items for the Next Meeting

Ms. Gustafson asked for discussion on gambling if the data was available.

There was some discussion on when the MPAC should meet again. Mr. Erickson said the SEW provided data and information to MPAC, then MPAC set priorities and decisions and fed them to SAPTA. Mr. Martinez said the SEW would need to meet before the MPAC met, meaning it should meet again in early November.

APPROVED

Ms. Lang asked if Mr. Erickson could report on the Evidence-Based Workgroup at the next meeting. Mr. Erickson said the MPAC had the Evidence-Based Workgroup report as a regular agenda item.
Ms. Pyle said there would also be a report from the Nomination Subcommittee.

8. Public Comment
There was no public comment.

9. Adjourn
Ms. Lang moved to adjourn the meeting. Ms. Gustafson seconded the motion. The motion passed. The meeting was adjourned at 11:43 p.m.

APPROVED