The Brookings Institution

***The Killing Drugs* podcast**

"From cradle to grave: Responding to Nevada's fentanyl crisis"

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Episode Summary:

In this episode, Vanda Felbab-Brown discusses the fentanyl and opioid crisis in Nevada with Dr. Anne Weisman and Dr. Sara Hunt of the University of Nevada, Las Vegas (UNLV). They analyze the high rates of opioid misuse in the state and the resulting strain on health systems and behavioral health workers as well as coroners, a professional group essential in responding to drug use, but often neglected in policy focus. Their conversation explores the significant innovations that the state of Nevada adopted as a result of UNLV research and policy work and ways in which it can serve as an exemplar to other U.S. localities struggling with inadequate resources to deal with fentanyl.

[music]

FELBAB-BROWN: I am Vanda Felbab-Brown, a senior fellow at the Brookings Institution, and this is *The Killing Drugs*. With more than 100,000 Americans dying of drug overdoses each year, the fentanyl crisis in North America, already the most lethal drug epidemic ever in human history, remains one of the most significant and critical challenges we face as a nation. In this podcast and its related project, I am collaborating with leading experts on this devastating public health and national security crisis to find policies that can save lives in the United States and around the world.

Today, I am on the campus of the University of Nevada, Las Vegas. With Nevada experiencing a devastating number of opioid overdoses. This crisis has become a focal point of research and frontline interventions here. As part of the Brookings Mountain West Partnership between UNLV and the Brookings Institution, I am speaking with experts who are directly confronting the issue. Joining me today are Doctor Anne Weisman, director of wellbeing and integrative medicine and associate professor of medical education at the Kirk Kerkorian School of Medicine, and Doctor Sara Hunt, executive director of BeHERE Nevada, and associate professor at the Kirk Kerkorian School of Medicine also.

Sara, thank you so much for joining me today.

HUNT: Thank you so much for having us.

FELBAB-BROWN: And, Annie, it's really terrific to have you be on the show as well.

WEISMAN: Thank you. I'm so glad to be here with you.

FELBAB-BROWN: Sara, let's just start with the basics. What is the opioid crisis like in Las Vegas and Nevada?

[1:48]

HUNT: Let me start by saying that Las Vegas and Nevada have certainly been experiencing many issues with the opioid crisis. And I pulled, just tried to find the most recent data that I could find about misuse prevalence rates and overdose rates. So, from the National Survey on Drug Use from '21 and '22, it indicates that as far as opioid misuse prevalence, we're at about 4% of our population in Nevada, and that comes in higher than the national average. And both compared to the western states as well. What we do see is the highest misuse is in the 26 and over population. And still about 2% of those between 12 and 17 would qualify as having an opioid misuse disorder. So, with that level of misuse, it does seem to track higher than the average national rates.

As far as overdose numbers back in 2022, the data indicated that there were 836 unintentional fatal drug overdoses in Nevada for that year, which compared to 2021 was a 6% increase in the number of unintentional overdoses. From that we know that opioids contributed to about 60% of those overdose fatalities. And half of those overdose deaths included a stimulant and 31% of the overdose deaths involved both

an opioid and a stimulant. So, again, I think the numbers show that we certainly have not avoided this crisis and we're still experiencing it.

FELBAB-BROWN: Well, absolutely. You know, we spoke on several of our other episodes about how fentanyl, synthetic opioid has spread westward and the delay between when it hit the East Coast and eventually made it west, as well as the fact that it is mixed today into very many other drug stimulants such as cocaine, methamphetamine. And we also spoke on one of our first episodes about the great increase in lethality of methamphetamine itself.

So, the trends you are describing, Sara, are, of course, disturbing, including the 800 plus deaths you spoke about.

Annie, let me turn to you. We think about people who are ill, who overdose, perhaps die. But we often do not think about the people they left behind. What are the implications of the crisis for the loved ones of the victims of overdose?

[4:24]

WEISMAN: The implications are devastating. Each person that dies from this, they're leaving behind loved ones. If there's children involved, if there's spouses, anybody who loves them, cares about them. Not to even mention the potential, the loss of potential that their human life had and the memories that they could have made and the contributions to this community. So, I think the implications are so far reaching, and we see that in our community for sure.

FELBAB-BROWN: Well, that's really interesting what you're seeing about the loss of experiences and perhaps the loss of memories. On one of our shows we spoke about fentanyl, opioids, and Native American communities, the ethnic group that is most affected, disproportionately affected by fentanyl opioid overdose deaths. And one of the dimensions that was so striking was precisely the impact on the loved ones with children of parents dying, sometimes both parents dying, but also the cultural and community impact, including the loss of memories, the loss of cultural heritage.

So, Annie, let me stay on that theme a little bit more. So, you know, one of the other topics that few think about are not simply the victims, not simply the loved ones, not even the first responders, but people at the other end of the process of the grieving: the coroners. How has the increase in suspected opioid overdose deaths impacted coroners and medical examiners?

[5:55]

WEISMAN: I think it's completely overwhelmed coroners and medical examiner offices across the nation and the globe. It's been just astronomical the increase in number of decedents that they're receiving. And, you know, in Clark County there's funding, so our local office has been able to hire additional people to help handle the number of deaths that they're seeing. But that's not normal. Many of the offices across the country that we hear about, they're experiencing significant delays in care and in treatment. And it's just been a devastating ripple effect.

FELBAB-BROWN: Absolutely fascinating. One often things of the hardships of police officers, medical professionals who respond to someone being called in. But the impact on coroners, medical examiners is often overlooked. And obviously their role is so absolutely essential in ascertaining what was the cause of death and what role opioids, drugs played in it.

I'll come back more to thinking with you about that. But, Sara, let's just get more of a basic picture established. What has been the mental health and behavioral health response to this crisis in Las Vegas, at the state level in Nevada?

[7:10]

HUNT: That's a great question. I have seen a lot of new things come about, some of it from state funding, but some of it coming from the opioid response and the settlement monies that the state is getting. There's a couple things that I've been excited to see, and I continue to see grow and progress and help the mental and behavioral health treatment opportunities in our state, but also help the mental and behavioral health professionals know how to best deal with the opioid crisis and other substance use issues.

So, one, in 2021, our state legislature passed what they created the Fund for a Resilient Nevada. And that is under the Department of Health and Human Services here. And it is the place that decides on how we're spending that opioid settlement money and how it's dispersed. And so, they've done a great job of putting together a pretty thorough needs assessments and then aligning their goals and how we're dispersing those funds to meet those assessment needs.

So, they've really focused on putting the money out towards prevention efforts, harm reduction efforts, expanding treatment opportunities across our state, and as well as implementing more recovery communities or more opportunities for recovery programs in Las Vegas as well as the state. Some of that looks like it has been put towards creating mobile recovery units, especially which would be helpful out in our rural and frontier areas. They've also been able to increase, again, that service delivery or the access to care through creating more outpatient programs, intensive outpatient programs. And expanding the use of medication assisted treatment.

And then the other project that just has come on board in the past few months up at the University of Nevada, Reno, is called the Nevada Opioid Center of Excellence project. And it is there to house a lot of good information and training about evidence-based practices for the mental and behavioral health community. Again, for those providers to implement the treatments that are showing the best results on treating opioid use disorder. And so, I think those two efforts I continue to see grow and really try and reach all corners of the state.

FELBAB-BROWN: It sounds impressive and terrific in the fact that the response is designed based on needs and seems to be really thoughtful and careful in the way the money is spent allocated. I've had the pleasure a few times to travel across Nevada. Wonderful, gorgeous state. I love deserts, so it's a pleasure for me to be in Nevada. But I absolutely get your point about the need to have mobile units and deal with the challenges of distance. It is true across the United States that rural communities often have far less access to treatment than people in urban spaces.

And I can just imagine how magnified that issue is here in Nevada, given the distances, given the population density per the landscape.

Annie, you spoke about getting to those who normally fall through the cracks, and a lot of the effort being targeted on expanding access to wide set of people. One set of people that we often do not think about, Sara, are the newborns, the newborns to mothers who are dealing with drug use, who are dealing with opioid use disorders. Can you tell us what it is like here? What kind of treatment and support are mothers with drug use disorder and newborns able to access?

[10:43]

HUNT: That's a really great question, and I appreciate asking that because that is often an unthought of population that needs support in treatment. So, again, I've seen a lot of good efforts happening for that population in our state. So, in Nevada, some of that funding from the federal government, but through the opioid settlement, has been going to create a program called Empowered Program that's run by Roseman University in Las Vegas. And they're solely focused on providing recovery oriented, family-based programs for mothers. And I would say they're available for supporting pregnant and postpartum individuals that have some connection with opioid use or previous opioid use.

So, through this Empowered Program, they are offering things like healthcare counseling, peer support, health and education. But also, they're providing wraparound services to these mothers and newborns. So, connecting them with resources in the community to, again, address any social determinants of health that would be helpful in continuing their recovering in their treatment from opioid use.

FELBAB-BROWN: For a long time in the United States, and frankly in other parts of the world, the tendency was to take children away from mothers who were struggling with some sort of substance use disorder. And there's been a lot of evidence that this is not beneficial to the family, to the child necessarily, only perhaps in some extreme circumstances. What is it like here, Sara? Has there have been more of an understanding that providing support for the family unit and holding the unit together is a better approach, or is there still a lot of tendency to take children away from mothers who have some opioid use or other substance use disorder?

[12:32]

HUNT: Yes, that's also a very good question and one that I can't speak to necessarily directly. But my general impression is that I think we are trying to do whether better, whether it's substance use or mental health issues in the caregivers, a better job of really trying to surround them with, again, that wraparound service idea. So, what do we need to do to help treat the mental health issue, but also the other issues that that family is experiencing that may be a result of that? Are there things that they're experiencing that are contributing to exacerbation of the substance use, of mental health?

It's not a perfect system yet by any means. But I do see, again, a lot of efforts to really try and bring in a system of care that there's no wrong door for a family to enter. And when they enter it, they're provided the exact services and the treatment

that they need before maybe reaching that level of is there something more that needs to happen to remove a child, that type of thing. Those type of systems, of course, always need more resources to help them run as effectively as they can and serve the most people that they can.

FELBAB-BROWN: And I would also remind our listeners that in the 2020 version of the opioid project that Brookings was conducting, we have a research paper on women and drug use specifically and women and newborns. So, further information available there.

Annie, let's turn to the other side of the spectrum now from the newborn to what happens when people die. We started talking about the underexplored issue of coroners and medical examiners. But please walk us through what the process is like at the end—someone overdoses and dies. What is the current standard of care for a decedent, which is the person who dies for our listeners, from a suspected opioid overdose?

[14:26]

WEISMAN: Sure. So, right now, the current standard of care is when the call comes in that somebody has passed away, the coroner's office will then dispatch some investigators. They'll go to the scene where the death occurred, and they'll investigate. They'll take pictures, they'll interview people, they'll really get to know the scene and the decedent and what was occurring at time of death.

From there, the body is then transferred to the Coroner's Office. Once it's received, some laboratory tests will be drawn, some blood and different specimens. And then those get sent off to toxicology, which can take an extremely long time, because with this increase in deaths, the labs are also getting overwrought.

FELBAB-BROWN: And what is an extremely long time, Annie?

WEISMAN: You know, I'm not exactly sure. I was speaking with our former coroner this morning, and he said In Las Vegas, we have a 24-hour turnaround from getting the person into the office, pulling the fluids, and then getting the body to the funeral home. The toxicology can take a lot longer, and I don't know what that is. That can be dependent on each jurisdiction. But that delay—and the different jurisdictions can then delay the funeral—can then delay lots of other things.

So, it's really unique and interesting here in Clark County that our office is able to process more rapidly because they have funding and because they're able to respond in this way. But in other jurisdictions where they aren't able to bring in other additional medical examiners, that toxicology lapse and that different amount of time that can be taken can delay things quite a bit.

FELBAB-BROWN: Well, understandable. And obviously this just compounds the hardship for the loved ones. But it also is a challenge for policy, especially as we are entering a situation where all kinds of drugs are entering the drug market, retail markets. Obviously not just fentanyl, but xylazine is hitting the East Coast. In other parts of the world, like Britain, we are seeing outbreaks of nitazenes and other forms of synthetic opioids, and there is a wide spectrum of what other drugs could be

mixed into the system. So, there is also real implication for policy for realizing that something new is moving in the market that might not respond to drug overdose medications like naloxone, for example.

So, let's a little bit more think about the process, Annie. So, how important is it that a full autopsy is conducted for the results that are necessary to determine the death, but also to have information to which policy can respond?

[17:08]

WEISMAN: Right now, that's currently the standard of care, is that a full autopsy is conducted with each suspected opioid overdose death. What's interesting is that some of these offices that I was talking about across the country that have been overloaded, that don't have additional funding, they've had to change their policies where when a person comes in, a decedent comes in, an examination is done, which is different than an autopsy. An examination would be a physical examination which takes from what I have been told about 15 minutes, versus an autopsy, which will take about an hour-and-a-half.

So, it's really interesting because when doing just the examination and the death scene, looking at that data, and then looking at toxicology, there's a hypothesis that we're working with currently that if we were able to look at those different data points and show those to physicians that were medical examiners or coroners, could they then determine manner and cause of death without having done a full evisceration? So, we're unclear yet. This research is ongoing. But it's a really interesting hypothesis because that could potentially, if we find what I think we may, that could change, hopefully, the standard of care so that the process is easier for everybody involved.

FELBAB-BROWN: So, essentially, we would get to more efficiency, but without compromising the information that needs to be gathered? That's the hope?

WEISMAN: That's the hope. And currently there are rapid tests that have been developed—I don't believe we're using them in Clark County yet—but that can be used for drugs like cocaine or methamphetamine. And so, with the addition of something like that coming onto the scene, we would have another data point which could then maybe change the standard of care. We'll see. But I'm really interested in this research.

FELBAB-BROWN: No, no, absolutely. And of course, this has implications across the United States, but also for very many countries where the ability to do any kind of testing, any kind of postmortem, is much more limited very frequently. Not every single country, of course, but I'm thinking about countries like Mexico, where there is, or has been, a government reluctance to admit that fentanyl is a problem in Mexico, where pioneering morgues on their own decided to do autopsies, but where death rates are also enormous as a result of violent criminality. So, finding ways to streamline, make more efficient and shorter the process yet remain true to the validity of the data would obviously be very useful.

Sara, we just heard about the autopsy process and the challenges that coroners and medical examiners are dealing with because of the immense spike in work, because

of the immense spike in drug overdose. But let's look at the medical responders. What are the workforce challenges like in Nevada for treating people who are dealing with substance use disorder.

[20:17]

HUNT: In Nevada—and we're not unlike many other states—we have a shortage of mental and behavioral health professionals to begin with. So, we have high prevalence rates of mental health needs and substance use needs, but our workforce numbers are not sufficient to meet those needs. So, sometimes there's a significant barrier to accessing treatment when you need it, whether it's standard outpatient care or residential inpatient care.

So, we also are working on efforts to create better access at kind of a paraprofessional level. So, a lot of efforts to train more individuals with lived experience to be peer support specialists, and then really implement them in the care settings that they would be most effective.

We also sometimes struggle with the having enough supervisors. So, if we are doing a great job at the higher education level to train more individuals to be mental health professionals in our state, sometimes in some areas of our state we don't have enough supervisors to then train those students past their graduation and get them to licensure. So, we're struggling with some of those workforce issues.

When it comes to being able to access your insurance to get mental and behavioral health care, sometimes that's a barrier as well. There is concern in our provider community that some insurance rates are just not enough to really be worth the process of getting paneled on that insurance and then taking that insurance. So, there is a growing movement to in a provider to be cash pay. And so, then that also presents another barrier for those individuals who have to rely on insurance to get care.

FELBAB-BROWN: Absolutely. And I would alert our listeners that we did an episode with Doctor Harold Pollack and Doctor Nicole Gastala on barriers to treatment, barriers to access for treatment, and the issue of insurance, Medicaid, loomed very large. So, if you're looking for more information on this, I highly recommend that episode, which was episode three.

Sara, you have nonetheless been a pioneer in Nevada with trying to beef up and increase the workforce, the medical professionals who are available to respond to treatment. Can you tell us what BeHERE Nevada is and how it is addressing some of those workforce challenges?

[22:47]

HUNT: Yes, I can. Thank you so much for asking that. So, BeHERE Nevada is a designated behavioral health workforce development initiative. It was created by some legislation that was passed in our 2023 state legislature. And the idea is because we are short of many different mental and behavioral health professionals, and it's going to be difficult to recruit the number that we need to come into the state

because we're competing with those other states, then let's invest in a grow-our-own model.

So, BeHERE Nevada just started in October of 2023. And we are tasked with looking at ways that we can go out and just educate more individuals about the career options to work in mental and behavioral health, which would include, also, working in substance use disorder treatment. So, we will be doing a lot of that in the K-through-12 space. I'm a psychologist by training, and mental health professionals have just not shown up in that space to promote our careers. So, we will be doing that across the Nevada school systems.

Then we want to work on recruiting those individuals who may be interested in mental and behavioral health careers, recruit them into our higher education system here. So, then we're training them within our state. And then we're also very invested in the retention side of that. So, if we get this great pipeline of individuals interested in our careers, we're training them within our state, then what do we need to do to encourage those graduates to stay in our state, work towards licensure and employment in Nevada? So that is what BeHERE Nevada is all about and what we are working on. And we have a great team that's doing a lot of that work.

FELBAB-BROWN: Well, it sounds like a really important and absolutely terrific initiative that it's centered on Nevada, it's Nevada's own model. But I would imagine that in time, other communities, other states will be able to learn from it as well. And so, BeHERE Nevada might end up going out of Las Vegas instead of staying in Las Vegas, as the saying goes.

Annie, we spoke a lot about death in the show today. Perhaps in ways that will be distressing to our listeners. And we spoke about, to some extent, dealing with death, like with coroners and medical examiners. Your work is your research is very challenging but also very important. But tell us what gives you hope and what gives you some perseverance in the kind of research that you do?

[25:18]

WEISMAN: Gosh, the students that I get to work with give me such hope for our future. And I was really fortunate while I was training in my doctoral program and in my master's program, I was really lucky. I also worked at a hospice, so I spent a lot of my time at end-of-life care. And then in the evening, I would go study prevention as a public health graduate student. And so, having that lens has been really interesting. And accepting the fact that death is a part of life really informs how I live.

But then also thinking about all of the different ways that we can create new policies or different opportunities for education and prevention, I feel like that gives us a really great opportunity to create fuller, healthier, richer lives so that we can be as healthy as we want to be until we come to the end of our life. So, I try to find something that gives me a little joy each day, and often that's a cup of coffee or a bath.

FELBAB-BROWN: I appreciate it. And, I remember my favorite TV show, *Twin Peaks*, where Agent Cooper every day gets a treat with a pitch-black coffee and a cherry pie. And I learned that lesson from him. And that show also dealt with a lot of

death. But your comments about integrating death into how we think about not just medical care and the medical process, but about how we think about life, I think it's very fundamental and yet challenging. And with that Annie, what are some of the implications that your research has locally, nationally, internationally?

[26:56]

WEISMAN: Gosh, my hope is that by focusing on death and bringing awareness to people that work in our coroner's office, when our former coroner called them the last of the first responders, I really hope to bring more awareness to life. I would like for us to talk about death more, to really think about the ways that we can as a community help each other. I believe healing happens in community. So, I would like to see more policies and more collaboration so that we can help support each other through this journey from the cradle to the grave, so that we can live as healthy and as fully as we would like to.

FELBAB-BROWN: Absolutely. And, in the podcast show, in the large research project at Brookings, we are thinking a lot about very many different interventions. But I would say that the aspect of death is the one that is getting least policy focus, that's getting least conversation. So, I'm really delighted that we were able to do this episode today.

And with that, Sara, let me turn to you in conclusion. We have looked at the fentanyl crisis and synthetic opioids at various levels of policy, from transnational all the way down to local. And I'm really delighted that we are able to shoot in Las Vegas today. I'm curious, from your various vantage points, what are some of the best practices or policies that you would like to see in Nevada or beyond?

[28:23]

HUNT: That's such a great question. And I would say, up front, I'm not quite the policy expert on this area of substance use disorder and treatment. But I would say in general, I think in Nevada, any policies that really incorporate that comprehensive way to care for substance use, reducing silos, making it easy to access the care when you need it at the level that you need it. I think those are always best policies to follow. And again, I see some of that and I'm hopeful that Nevada will continue to, to grow in that direction.

I think it's important that whatever we establish in kind of our main population areas that's working, whether it's Las Vegas or up in Reno, I think the rural and frontier counties often feel overlooked. And so, making sure that whatever is working well in these areas that there's some way to recreate that and make it appropriate for the rural and frontier counties as well.

And we have a long way to go, again, to just create the access to care points that we really need to best serve our state. And I'm going to go back to a word, you mentioned "integration" before. And I think any policies that we can continue to follow that would help integrate mental and behavioral health care, substance use care into medical care, primary care settings, the more that we can create those opportunities where we know individuals are going anyway to get medical care in their primary care setting, and if there's a way to access mental and behavioral health care right

there on the spot in the same clinic from different providers but be able to bill for all of those services for that same day would, I think, really help open up access to care.

FELBAB-BROWN: Well, thank you very much. Certainly, the theme of integration is a very important theme across the show, across the papers and the project. And, again, I'm absolutely delighted to have been able to speak with you today, Sara and Annie, and thank you so much for your work.

[music]

WEISMAN: Thank you.

HUNT: Thank you.

FELBAB-BROWN: *The Killing Drugs* is a production of the Brookings Podcast Network. Many thanks to all my guests for sharing their time and expertise on this podcast and in this project.

Also, thanks to the team at Brookings who makes this podcast possible, including Kuwilileni Hauwanga, supervising producer; Fred Dews, producer; Gastón Reboredo, audio engineer; Daniel Morales, video editor; and Diana Paz Garcia, senior research assistant in the Strobe Talbott Center for Security, Strategy, and Technology; Natalie Britton, director of operations for the Talbott Center; and the promotions teams in the Office of Communications and the Foreign Policy program at Brookings. Katie Merris designed the compelling logo.

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I am Vanda Felbab-Brown. Thank you for listening.