Coordinating Council on Juvenile Justice and Delinquency Prevention Meeting

U.S. Department of Justice
Office of Justice Programs
810 Seventh Street NW.
Washington, DC 20531

Thursday, March 14, 2019
10:00 a.m.-Noon ET

SUMMARY

The Coordinating Council on Juvenile Justice and Delinquency Prevention ("Coordinating Council" or "Council") held a meeting on March 14, 2019. The meeting was hosted by the U.S. Department of Justice (DOJ) Office of Justice Programs (OJP) Office of Juvenile Justice and Delinquency Prevention (OJJDP). Council members participated in person and via phone, and members of the public observed.

Jeff Slowikowski, *OJJDP Associate Administrator, and Designated Federal Official of the Coordinating Council,* along with other staff members, supported the meeting.

Caren Harp, *OJJDP Administrator and Vice-Chair of the Coordinating Council,* led and moderated the meeting.

June Sivilli, *Senior Science Policy Advisor, Office of National Drug Control Policy (ONDCP);* **Ramon Bonzon,** *Public Health Advisor, Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS);* **Tara Kunkel,** *Senior Drug Policy Advisor, Bureau of Justice Assistance (BJA), OJP, DOJ;* **Kellie Blue,** *Associate Administrator, OJJDP;* and **Betty-Ann Bryce,** *Special Advisor, Rural Public Health Education and Treatment, Office of National Drug Control Policy* participated in a panel presentation on the national opioid crisis and its impact on America's youth.

A discussion including racial disparities, rural realities, diversion of medical assisted treatment (MAT) drugs, interagency activity, and blended funding followed the panel presentation.

WELCOME, OPENING REMARKS, INTRODUCTIONS

Jeff Slowikowski welcomed everyone to the Coordinating Council meeting. He reviewed logistics and the agenda, and he noted that the meeting would be webcast and open to the public for observation.

Elizabeth Wolfe, Training and Technical Assistance Coordinator, OJJDP, added that members of the public would be able to submit comments after the meeting to her at Elizabeth.Wolfe@ojp.usdoj.gov; all comments would be posted to the OJJDP website within 90 days.

Remarks by OJJDP Administrator Caren Harp
Administrator Harp, welcomed the participants, noting that one element of the Council's job is to collaborate and to report out on that collaboration. She reported that OJJDP and HHS are working together to leverage HHS resources to support homeless youth and bring the resources to the state advisory groups (SAGs). OJJDP also is collaborating with the Department of Defense (DoD).

Administrator Harp explained that OJJDP needs to know about interagency collaborations and seeks members' recommendations regarding issues raised in Council meetings. The office will use those pieces of information in preparing its Council report after the end of the fiscal year (FY).

The topic for this meeting was the opioid epidemic and its effects on youth.

PANEL PRESENTATION: THE NATIONAL OPIOID CRISIS AND ITS IMPACT ON AMERICA'S YOUTH

June Sivilli, *Associate Director of Public Health, Education, and Treatment, ONDCP*
Ramon Bonzon, *Public Health Advisor, Center for Substance Abuse Treatment (CSAT), SAMHSA, HHS*
Tara Kunkel, *Senior Drug Policy Advisor, BJA, OJP, DOJ*
Kellie Blue, *Associate Administrator, Intervention Division, OJJDP*
Betty-Ann Bryce, *Special Advisor, Rural Public Health Education and Treatment, ONDCP*

Administrator Harp welcomed, thanked, and introduced the panelists.

Ms. Sivilli has worked for many years— both domestically and internationally — on drug control policies around youths. With 18 years of public health experience, Mr. Bonzon works with pregnant and postpartum women, youth, and family treatment and recovery programs. Ms. Kunkel currently is on detail at BJA from the National Center for Safe Harbors. She has extensive experience with evidence-based practices in the court system, serving for 14 years as an adult drug court administrator. Ms. Blue handles all of OJJDP's reentry initiatives, juvenile and family court drug programs, Opioid Affected Youth Program, and other intervention-related work. Ms. Bryce, on detail from the U.S. Department of Agriculture (USDA), has significant international experience with a focus on rural communities.

Federal Response to Youth and Young Adult Opioid Use

Ms. Sivilli provided an overview of data to frame the context of the opioid problem and to share steps the administration is taking to respond to this epidemic as it affects youth and young adults.

Data points included:

- In 2017, more than 70,000 people died of a drug overdose in the United States.
- Approximately 47,000 of those deaths involved an opioid.
    - In 2017, death from opioid overdose in 15-to-24-year-olds was 4,094 (males: 2,885; females: 1,209).
    - It is not known if the deaths in the 15-to-24-year-olds category are specifically juvenile justice-involved youth.
- The next highest category is 25-to-34-year-olds. This age group is being hit hard and will continue to be if we do not stop use in the 15-to-24 age group.
    - It appears that that risk increases as youth age out of protective institutions (i.e., colleges, the military) and family.

Past-Year Initiates: Ages 12 to 17

Ms. Sivilli shared findings on past-year initiates ages 12 to 17 — the juvenile justice and probation population — highlighting the need for pediatricians, teachers, and others to identify and engage these youth with treatment and to ensure that, if they are using, they have access to the opioid overdose-reversal drug naloxone. Adjustments to the awareness campaign and the release of some prescribing precautions may be taking effect. Youth are using marijuana, alcohol, cocaine, cigarettes, and hallucinogens; this means that they are using drugs to change how they feel before they begin opioid use. They come to the doctor's office drug-exposed; if they obtain or find an unnecessary prescription, they may use it or share it with friends.

Past-Year Initiates: Ages 18 to 25

Past-year initiates to all drugs ages 18 to 25 years old experience high rates of prescription opioid use in this age category but experience still higher rates for cigarettes, alcohol, cocaine, marijuana, hallucinogens, and ecstasy. If someone is going to try heroin for the first time, it generally occurs during this time; heroin first-time use generally is a young adults-to-adults phenomenon. We badly need pediatricians, dentists, nurses, oral surgeons, and others who see youth in this age range to identify and engage any individual with opioid misuse or heroin use, and to get them into treatment.

Prescription Opioid Misuse

Young people ages 18 to 25 are more at risk than 12-to-17-year-olds. This makes sense given what we know about adolescent development and transition to independence: After high school, youth experience more freedom and potential opportunities to use drugs. Prescription drug use is much more frequent in teens than is heroin use. There was about 3.1 percent of prescription misuse in 12-to-17-year-olds over the past year.

Opioid Misuse

Ms. Sivilli shared data from a U.S. household survey and noted how much more prescription opioid misuse in the above populations; heroin use really only begins starting with 18-to-25-year-olds. She explained that prescription opioid misuse remains a big concern even with lower

prescribing practices, because it contributes to overdose and can lead to heroin misuse. Analyses conducted by SAMHSA have shown that about 80 percent of new heroin initiates misused prescription opioids first. Heroin use is very rare in teens; prescription opioid use is much more frequent. Ms. Sivilli pointed out that prescription opioid use, heroin use, and pill use generally are very rare, but would still benefit from intervention. Misuse is a major risk factor for overdose, especially now that much of what we know on the street is that pills are potentially deadly pressed synthetic opioids from illicit pill manufacturing operations.

Teen and Young Adult Opioid Use Disorder Totals
Although the National Survey on Drug Use and Health did not detect rates of heroin use disorders in this population, in the juvenile justice population these rates may be higher. Teens, by and large, are not yet addicted to heroin, but a sizeable number is addicted to prescription opioids. Along with pediatricians and other health providers, we also need people who handle cases — i.e., social workers, judge advocates, family court judges — to identify and treat teens engaged in such use and, where possible, help reduce the exposure to unnecessary opioids in this population.

Statistical Roundup
Ms. Sivilli summarized the findings this way: 12-to-17-year-olds have prescription opioid misuse and low rates of addiction, and 18-to-25-year-olds have prescription misuse and heroin use. Addiction climbs to 1 percent and heroin addiction to .5 percent. She noted that even one episode of misuse can lead to overdose, and that tainted pills, cocaine, and methamphetamine are a major problem on the street.

The President's Initiative to Stop Opioid Abuse and Reduce Drug Supply and Demand
Ms. Sivilli shared the federal response to opioid abuse, explaining that, in April 2018, the President hosted a White House summit on opioids and shortly thereafter released an opioid initiative. The administration has branded this problem "The Crisis Next Door," because so many American family members and neighbors are affected or know someone who is. The website crisisnextdoor.gov includes videos of individuals describing how they overcame addiction, volunteered at a recovery center, worked getting a family member into treatment, or helped someone get on the path to recovery.

National Drug Control Strategy Metrics
In February, the 2019 National Drug Control Strategy ("National Strategy") was released. Ms. Sivilli outlined its goals:

- The number of Americans dying from a drug overdose has been significantly reduced within 5 years.
- Nationwide, opioid prescription fills have been reduced by one-third within 3 years.
- Within 5 years, all health care providers have adopted best practices for prescribing opioids.
- Evidence-based addiction treatment, particularly MAT, is more accessible to those who need it.
- Production of plant-based and synthetic drugs outside the U.S. has been significantly reduced.
- Illicit drugs are less available.

- Drug seizures at ports of entry have increased over the course of 5 years.

Major Prevention-Related Objectives
Major prevention-related objectives in the National Strategy include:
- Implementing a nationwide media campaign, named "The Truth About Opioids";
- Addressing safe prescribing practices;
- Expanding the use of prescription drug monitoring programs;
- Strengthening the capacity of state, local, and tribal communities to identify and prevent abuse of all drugs;
- Enhancing research and development of evidence-based drug prevention programs;
- Expanding drug take-backs across the country; and
- Continuing to strengthen the Drug-Free Communities program.

New Prevention Effort: Media
Because youth often do not know that prescription opioids are highly addictive, ONDCP partnered with the Truth Initiative and the Ad Council to develop and launch addiction-prevention digital and TV ads. The ads are quite graphic and demonstrate the lengths that people with opioid addiction will go to get medications.

Major Treatment and Recovery-Related Objectives
The major treatment and recovery-related objectives of the National Strategy include:
- Improving response to overdose;
- Increasing adoption of evidence-based approaches to addiction treatment;
- Reducing barriers to treatment;
- Addressing workforce and infrastructure deficits;
- Stimulating research on prevention;
- Developing and replicating law enforcement or deflection and diversion models, including drug courts, safe stations, and initiatives that address the opioid epidemic locally and get people who need care into treatment instead of into the criminal justice system;
- Encouraging employment opportunities for people in recovery;
- Creating peer recovery support services; and
- Reducing stigma, and increasing an understanding of addiction and recovery.

MAT Barriers for Youth
Barriers exist for youths' access to MAT (methadone and extended-release naltrexone) to treat opioid use disorder. MAT is off label in some cases for youth, and federal regulations bar most patients under 18 from entering a methadone program. The U.S. Food and Drug Administration (FDA) has approved naltrexone for people ages 18 years and up, and buprenorphine is available for people ages 16 years and up. However, doctors can legally prescribe or write an off-label prescription for any patient should the medication be appropriate for that younger patient.

MAT Keeps Youth in Care
Ms. Sivilli highlighted Sharon Levy, MD, MPH, of Boston Children's Hospital, who has been a major advocate for pediatricians to learn about providing MAT to young people and getting

waivered to do so. Dr. Levy suggests that treating substance use disorders is no more complex than treating any other disease state for which a young person is treated by a pediatrician. Dr. Levy explains the importance of communities identifying their resources and infrastructure, as well as ways they can help ensure people who need access to medication get it.

Ms. Sivilli noted that only 1 in 21 youths ages 17 and under accesses MAT. In young adults ages 18 to 22, only 1 of 4 receive MAT as part of opioid use disorder treatment. MAT keeps young people in care. Compared to behavioral interventions alone, MAT is associated with greater success, greater retention, lower rates of illicit substance use, lower criminal justice involvement, and lower rates of overdose. There is an elevated risk of overdose fatality following release from detention, particularly in the first few weeks. It is critical that someone with a history of opioid use disorder is provided an opportunity to use MAT before they leave an institution and then be linked to a community-based provider to ensure they get medication if needed. Opioid use disorder treatment for youth includes some FDA-approved medications, and studies show that 42 percent of patients are less likely to drop out of treatment including buprenorphine. With naltrexone, 46 percent are less likely to drop out, and 68 percent are less likely to drop out with methadone.

Building MAT Capacity

Ms. Sivilli asserted that building capacity locally to provide MAT to young people requires ensuring increased utilization. Models include expert consultations that support pediatricians providing MAT in suburban offices or through hub-and-spoke systems. Therefore, it is important to know which physicians, nurse practitioners (NPs), and physicians' assistants (PAs) in the community have waivers or can obtain them. Also, SAMHSA's Physicians Clinical Support System provides support and mentoring of practitioners to learn how to access and use waivers.

Diversion Models for Teens Needing MAT Are Limited

Ms. Sivilli asserted that pediatricians need to learn to provide MAT. Courts in particular can explore ways to engage providers in order to encourage MAT adoption. Again, it is understanding the local network – pediatricians or physicians, NPs, and PAs. MAT can be operated in both inpatient and outpatient settings.

Major Objectives to Reducing Illicit Opioid Availability

ONDCP is focused on addressing drug trafficking organizations, combating Internet drug sales, and stopping drugs coming through the mail. It also is working on prescriber education and guidelines, interdiction, borders, task forces, U.S. Treasury Department financial activities, and enhancement of law enforcement capacity. These critical efforts are underway to reduce drug availability in the U.S.

Special Considerations for Policymakers

Those looking to provide MAT for young people locally need to understand the resources in their community. Questions to ask are:

- What insurance plans are available in the community?
- What services do the plans cover?
- What types of providers are in the network?
- Which providers in your community have waivers? Are those providers in the network?

- How can we make sure that more of those who can prescribe have waivers?
- How can we educate parents on the importance of prescription drug safety, storage, and disposal?

SAMHSA's Response to the Opioid Crisis

Mr. Bonzon explained that SAMHSA is the leading public health agency that focuses on behavioral health, as it works to improve the lives of individuals with mental and substance abuse disorders. The 21st Century Cures Act created the new SAMHSA Assistant Secretary position; the SAMHSA National Mental Health and Substance Use Policy Laboratory, which focuses on addressing substance use and mental health at a policy level; and the SAMHSA Office of the Chief Medical Officer.

SAMHSA includes CSAT; the Center for Substance Abuse Prevention; the Center for Mental Health Services; and the Center for Behavioral Health Statistics and Quality, its evaluation data center that analyzes and evaluates SAMHSA programs and survey data.

SAMHSA Strategic Plan 2019–2023

Mr. Bonzon shared SAMHSA's new strategic plan, highlighting the priority area of combatting the opioid crisis through expansion of prevention, treatment, and recovery support services. SAMHSA understands that recovery is very much part of the system and produces better outcomes, and it sees the need to focus and support recovery services. SAMHSA also recognizes that prevention works. The strategic plan can be found on the SAMHSA website. Mr. Bonzon asserted that all of SAMHSA's work is aimed at addressing the opioid crisis; many of its programs focusing on issues such as homelessness and postpartum women also seek to build infrastructure and provide comprehensive treatment for those with opioid use disorders.

2018 National Survey on Drug Use and Health

Many youth entering SAMHSA's youth treatment programs are not coming into treatment with opioid abuse disorders. Instead, their first substances primarily are marijuana and alcohol. However, certain states and communities have been hit heavily with this crisis, so addressing it is recognized as a priority.

National Survey on Drug Use and Health 2018 data show continued high rates of prescription opioid misuse and abuse. Many of those who use opioids obtain them from friends, relatives, or a health care provider or prescriber. There is a significant decrease in prescription opioid abuse from 2015, so signs exist that efforts are making some impact. Buprenorphine has the highest rate of misuse. New users of heroin decreased dramatically in 2017; at the same time, Ms. Sivilli shared the need to monitor and address the crisis within this population, especially transition-age youth. Despite a modest decline in heroin use, overdose deaths continued to increase.

SAMHSA Opioid Programs

Some SAMHSA grant programs that focus on opioids:

- The *State Response to Opioid Crisis Grant*, also known as *OPIOID STR (State Targeted Response)* was awarded to states, territories, and jurisdictions to enhance and expand services and programs currently in place through the single state agency of each state and

territory jurisdiction; it is a grant specifically to the state agency to build infrastructure and increase access to treatment for opioid use disorders.

- The new *State Opioid Response Grant*, also known as *SOR Grant,* which funded $930 million, was released on June 14, 2018, directly to the states.
- Based on SAMHSA's focus on responding to the needs of tribal populations and building their capacity, the agency funded $50 million with *Tribal Opioid Response Grants,* released in June 21, 2018. Similar to the *SOR Grant*, tribes were able to apply for money to respond to the opioid crisis within their communities. SAMHSA currently funds 134 tribes under this grant.
- The *Opioid Addiction Grant*, known as *Medication Assisted Treatment – Prescription Drug and Opioid Addiction (MAT-PDOA),* awarded 128 grants to states, political subdivisions of states, and nonprofit organizations within states with the highest primary treatment admissions for heroin and opioids per capita. It includes those with the most dramatic increases for heroin and opioids as identified in SAMHSA's 2015 treatment episode data set. This is a targeted grant for those communities most hit by the crisis.
- Another opioid-focused grant is the *HIV/HCV (hepatitis C virus) and Related Comorbidities in Rural Communities Affected by Opioids Grant,* which focuses on addressing opioids through HIV and hepatitis C prevention and treatment.
- With a focus on the injection drug epidemic in the U.S., SAMHSA offers the *Building Systems for Prevention and Treatment and Control Grant.* This CSAT project focuses on a memorandum of understanding with the National Institutes of Health (NIH) and through the National Institute on Drug Abuse (NIDA), which serves as cofounder and supporter of activities being implemented by SAMHSA grantees.
- The *Building Communities of Recovery program* comprises 19 grants that focus on comprehensive addiction recovery for communities. SAMHSA has funded this at $200,000 per year.

Many other SAMHSA programs focus on directly addressing the opioid crisis; the above list highlights its most recent funding vehicles. SAMHSA also has a program supplying waivers to physicians for providing MAT, and a new program provides exemptions for PAs and NPs to provide MAT. At last check, SAMHSA has certified more than 48,000 physicians to prescribe buprenorphine under the Data 2000 Waiver. Under 42 CFR, SAMHSA is able to provide exemptions to PAs; this should be of interest to many communities wanting to increase access to MAT.

Collaborations

Some collaborations in which SAMHSA is involved are:

- The NIH/NIDA collaboration (mentioned above): This will support the HEALing Communities Study, which will test the immediate impact of implementing an integrated set of evidence-based interventions across the health care system as well as in behavioral health, justice, and other community-based settings to prevent and treat opioid misuse and opioid use disorders;
- A National Academies collaboration on a study of MAT: In collaboration with NIH, the agency will support a study of evidence-based MAT for opioid abuse disorders;
- HHS SAMHSA Behavioral Health Coordinating Council activities; and
- Rural opioid use disorder prevention and treatment with USDA and DOJ.

Opioid Treatment Resources
Mr. Bonzon shared SAMHSA's treatment resources, including:

- The SAMHSA TIP 63: Medications for Opioid Use Disorder provides guidance for clinicians.
- The Clinician Guidance for Treating Pregnant and Postpartum Women with Opioid Use Disorders and Their Infants was published in fall 2018 and has received great feedback from practitioners.

Mr. Bonzon offered for members to reach out to him and his colleagues John Berg (a member of the Council), and Dr. Larke Huang.

BJA Opioid Portfolio Overview
BJA is one of the grantmaking arms within OJP. The Comprehensive Addiction Recovery Act (CARA) delineated five grant programs as part of BJA's opioid portfolio. Of those five, funding through the new *Comprehensive Opioid Abuse Program (COAP)* is directed entirely toward opioids. The other four grant programs have been in existence for a number of years and have been reshaped to prioritize the funding toward communities addressing opioid abuse; those four are:

- The *Adult Drug Court Program* also funds tribal healing to wellness courts and co-occurring disorder courts, in addition to adult drug courts and veterans' treatment courts.
- The *Justice and Mental Health Collaboration Program* is focused on co-occurring disorders, and BJA has funded a number of opioid-specific grants under that program, the focus of which is supporting law enforcement-behavioral health partnerships and outreach at the front end to divert individuals with co-occurring disorders and mental health disorders from the criminal justice system.
- The *Residential Substance Abuse Treatment* Program is focused on providing treatment within jail-based and prison-based treatment, and a number of projects focus on MAT within jails and prisons.
- The *Harold Rogers Prescription Drug Monitoring Program (PDMP)* focuses on assisting prescribers in supporting PDMP and disseminating information to dispensers' pharmacies and prescribers. BJA focuses funding on integration with electronic health records and health information exchanges so that clinicians do not have to go out of workflow to get access to information about the patients that they are treating.

FY 2019 CARA Appropriation
At $157 million for FY 2019, COAP is BJA's largest appropriation. PDMP appropriation has been fairly level at $30 million for the last 2 years. The total it is $347 million, but COAP is the only 100 percent opioid-focused appropriation. Other grantmaking programs within BJA include a focus on prosecution and policing, and a number of awards are being made specifically to focus on opioids in a particular community.

COAP Specifics
There was an enormous funding increase for COAP efforts from FY 2017 to FY 2018. The bureau released the solicitation of the combined PDMP and COAP, its CARA-funded program solicitation. It is easier for applicants to think about their interventions in a comprehensive way,

and the bureau does not want prescriber education and prescriber habits to be separated out from all of the other responses. BJA made 50 site-based awards in FY 2017 and 168 site-based awards in FY 2018.

Many of the federal agencies, including SAMHSA and the Centers for Disease Control and Prevention (CDC), have primarily directed funding toward the states, which have funneled the money to local communities. BJA's categories are specific to states, localities, and tribes. This division of funds has been fairly effective and well received.

Ms. Kunkel reviewed the four goals of COAP:

Goal 1: Promote Public Safety and Support Access to Treatment and Recovery Services in the Criminal Justice System

- The biggest interest area from communities has been in supporting diversion/deflection – all manner of partnerships between law enforcement and public health and behavioral health partners.
- Some of these projects also have incorporated peer recovery support services as part of the response team.
- Much of the focus has been on responding to those who have survived non-fatal overdoses – how to get a team out and respond to individuals either in emergency departments or post overdose in the following 24 and 48 hours, trying to engage that individual if they are interested in any recovery- or treatment-oriented service, and encouraging and offering MAT.
- BJA also has seen major interest on behalf of the courts and prosecutors in having front-end diversion programs that minimize an individual's impact and keep them from entering the criminal justice system.
    - Jails and prisons have been interested, and BJA sees growing interest every year in implementing MAT behind bars and in thinking through how to make that transition if a person is inducted while they are in jail, and how to maintain that treatment as they transition into the community. This has been the first area of focus.
- BJA also has provided a number of awards to law enforcement and other first responders to carry naloxone.

Goal 2: Strengthen the Collection and Sharing of Data Across Systems to Understand and Address the Impact of the Opioid Epidemic

- Data sharing is an expressed need of BJA grant recipients. The bureau has provided a number of awards focused around integrating various data sources either at the state or community level to better understand the landscape – specifically, to target interventions more directly.
- As states receive funding from CDC, they want to make sure that that funding gets to the right people in the right places. BJA has supported a number of projects integrating such things as probation drug testing data with PDMP data and naloxone deployment data to get a clearer picture.
- In addition to funding the High Intensity Drug Trafficking Area program (HIDTA), BJA has been supporting a product of the Washington/Baltimore HIDTA, the Overdose

Detection Mapping Program (ODMAP). ODMAP is a real-time tracking system for non-fatal and fatal overdoses. Initial investment has come from HIDTA, but BJA has invested approximately $3 million in encouraging states to enact statewide adoptions in order to create more transparency around the non-fatal overdoses.

- Understanding the picture with non-fatal overdoses helps communities deploy response teams based on that real-time data and instantly get naloxone, behavioral health, and public health partners to areas in the communities that are being hit. They can send out proactive alerts to harm-reduction communities and alert schools, parents, and emergency departments, and others in real time.
- BJA has prioritized funding to applicants that have included a research partner, and approximately 47 percent of BJA grantees have included that as an aspect of their projects. The projects listed are just a bit over 1 year old, so there is little to report out at this time. But, BJA is encouraged and excited about the coming years and what it is learning out of the funding that it is awarding.

Goal 3: Align and Maximize Resources Across Systems and Leverage Diverse Program Funding
Grantees are expressing interest and excitement around BJA's 43 grants on aligning public health systems, behavioral health systems, and public safety systems at the local and state levels through data and resource sharing. Also, in 2018, BJA partnered with the DOJ Office for Victims of Crime (OVC) to co-fund nine awards supporting an approach that includes responding appropriately to a child who has been at the scene of a fatal or non-fatal overdose and connecting information to schools and other youth-serving organizations for their awareness and the effective response by other systems. BJA intends to partner and put out additional awards in this area, and it is conducting research to gauge program effectiveness.

Goal 4: Prevent Opioid Misuse and Addiction
BJA's work in prescription drug monitoring programs is the best illustration of its work around prevention opioid misuse and abuse. Forty-eight grantees are developing public education and awareness campaigns, and a subset is focused on the quality of the prescription drug monitoring data. There are some issues around quality and timeliness, so seven grantees are bringing in additional staff to brainstorm quality improvement and implementation ideas.

Collaboration Within OJP
As noted above, BJA partnered with OVC for joint grantmaking last year. Ms. Kunkel reported on BJA's collaborative programs with other bureaus and offices within OJP:

- BJA also partnered with OJP's National Institute of Justice (NIJ) on a project studying how law enforcement can build intelligence networks in rural settings, where outsiders are easily identified.
- BJA is partnering with NIJ and CDC to co-fund a fentanyl safety project to take a deeper look at the risks associated with various fentanyl analogs and the approaches officers and other first responders are taking.
- BJA spends a significant amount of time coordinating opioid courts, a front-end pre-drug court model geared at inducting an individual into MAT almost immediately upon arrest and doing some work while that individual is in pretrial (before he or she potentially enters a drug court or another appropriate alternative). The bureau is developing promising practices around opioid courts versus drug courts.

Cross-Agency Collaboration

ONDCP Rural Public Health Education and Treatment

BJA is collaborating with its broader HHS partners. BJA is conducting a series of workshops – the first of which took place in Tennessee – about regional upper judges and sheriffs, who are considered in many instances the natural conveners in their communities. In Tennessee, representatives from five states learned about the challenges and the innovation in rural America. A workshop will take place in April in Columbus, Ohio (Region 5) with representatives of multiple states; SAMHSA and USDA will present along with BJA.

BJA has collaborated quite a bit with SAMHSA:

- Last year, the agencies held two expert panels – one around MAT, and one around law enforcement diversion or deflection.
    - A series of publications will be coming out from SAMHSA and BJA as a result of those workshops.
- BJA is co-funding a series of demonstration projects with CDC that will be released in approximately one month.
- BJA works extensively with CDC to co-fund a number of efforts around PDMPs, and it more recently has worked with the Office of the National Coordinator for Health Information Technology and Centers for Medicare and Medicaid Services around prescription drug monitoring issues.
- Within DOJ, there is a strike force against health care fraud in very rural regions. The force has a strong focus on preventing patients from being harmed as arrests are made of health care providers. Multiple federal agencies, including DOJ, are exploring how a safety net can be put in place that is reported by HHS and DOJ to ensure that a community and patients have what they need to transition to better care.

Partnerships with Philanthropy

BJA has worked closely with Arnold Ventures, known until recently as the Laura and John Arnold Foundation. The foundation has provided funding to support two full-time staff members and one part-time staff member; they currently are onboarding and will be in place at BJA for 2 years on an interagency personnel agreement to support the bureau's work.
BJA currently has a solicitation out co-funded by the foundation. They will select 15 communities interested in developing a planning initiative for building capacity to deliver MAT in jails with transition to community-based treatment.

OJJDP Opioid Youth Programs

In FY 2018, OJJDP received an appropriation to support the Opioid Affected Youth Initiative (OAYI). In addition, OJJDP was directed to use a portion of its mentoring appropriation funds to implement targeted mentoring programs for youth impacted by opioids.

The Opioid Affected Youth Initiative

OAYI supports six sites to develop data-driven coordinated responses to identify the opioid problem in their communities. This initiative then will support the sites to develop responses to the opioid problem that has impacted youth, family, and community safety, and to collect and

interpret data for understanding the issue and developing strategies to combat it. Sites will establish a multidisciplinary task force – comprising an array of partners in the community including law enforcement, prosecution, public health, substance abuse treatment providers, community-based providers, child welfare, and more – to identify specific areas of concern. This program's funding will support the sites to implement a broad array of programs and services that will address intervention, prevention, and treatment needs for youth and families impacted by opioids. OJJDP awarded a total of $7 million from this program in 2018; $6 million was awarded to six sites across the country, and $1 million was awarded for a technical assistance (TA) provider.

The six OAYI sites are:

- Alameda County, CA, Probation Department;
- Franklin County, MA, Sheriff's Department;
- Miami Dade County, FL;
- Tennessee Bureau of Investigation;
- Clackamas County, OR; and
- The Georgia Criminal Justice Coordination Council.

OAYI Technical Assistance

OAYI funds TA for the Institute for Intergovernmental Research to work alongside OJJDP to help the sites develop effective data-sharing tools, develop and track short- and long-term outcomes, and analyze the impact and effect site-implemented strategies have on the opioid issue in their communities.

Mentoring Strategies for Youth Impacted by Opioids

This program is designed to provide mentoring services as part of a prevention and treatment approach to youth impacted by opioids and to implement innovative mentoring approaches for youth impacted by opioids. OJJDP awarded $3.5 million to seven mentoring programs that had been operating for 1 year; each site is required to partner with a public or private substance abuse treatment provider. Sites are identifying youth being impacted by opioids and are beginning to provide mentoring services.

The program sites are:

- LUK Crisis Center (MA);
- Volunteers of America (UT);
- The Mentor Connector (VT);
- Youth Action Project (CA);
- Big Brothers Big Sisters of America of Rockland County (NY); and
- Connection Training Services (PA).

Statewide and Regional Mentoring Initiative for Youth Impacted by Opioids

Through this program, OJJDP awarded a total of $6.2 million via national mentoring organizations, states, and tribal governments for the purposes of implementing statewide or regional approaches to expand mentoring for youth impacted by opioids. States can use the funds to provide sub-grants to mentoring organizations in particular regions, with a focus on rural areas. Tribes would use the money to provide mentoring programs in tribal communities, and the

national mentoring organizations must use the funds to support local chapters dealing with high rates of opioid abuse. Sites are in the process of hiring coordinators, and most of the sites are working on establishing their task forces. OJJDP hopes to convene the sites sometime this summer.

The program sites are:

- Boys and Girls Clubs of America (GA);
- Boys and Girls Clubs of America (FL);
- National Recreation and Park Association (VA);
- Iowa Commission on Volunteer Services; and
- Indiana Family and Social Services Administration.

FY 2019 Plans for OJJDP Opioid Youth Programs
For FY 2019, OJJDP has received a $9 million appropriation for the Opioid Affected Youth Initiative and has released the solicitation, which will be available through early May.
Also, as part of its larger mentoring appropriation, OJJDP allocated $14 million to supporting mentoring services for youth impacted by opioids.

Juvenile and Family Drug Courts
For many years, OJJDP has supported juvenile and family drug courts. In 2018, it awarded a total of $16.2 million to support nationwide juvenile and family drug court programs, training, and research. In 2019, OJJDP anticipates releasing $21.4 million to support juvenile and family drug court programs across the nation, along with training and TA.

Collaboration
OJJDP now will begin a process of identifying areas of collaboration and partnerships. It has begun discussions with some Council members and is very interested in finding ways to collaborate and partner across OJP with sister agencies, as well as with other federal agencies.

Rural Perspective

Ms. Bryce – on detail to ONDCP Public Health, Education, and Treatment from the USDA – provided a rural perspective. She noted that a significant amount of funding is being put toward the opioid issue from many different agencies, but that rural communities currently are not equipped to make use of those federal resources. Chances are — in a rural community of 50,000 or less, especially if the population size decreases – the community leader is handling all of the tasks associated with funding. Across the board, rural communities are not prepared to take advantage of the programs highlighted in this meeting.

Understanding the Gaps and Challenges
Ms. Bryce shared her experience of USDA participating in the Council, given that the agency receives questions about judges, the environment, housing, and more because it has offices in local communities. Therefore, it was not surprising as the opioid crisis intensified that USDA staff began to get basic questions about substance use and drugs. USDA representatives understand the gaps and the challenges at the local level; most rural communities are in some form of economic distress. Many communities start off with poorer access to resources, gaps in

transportation, and a lack of Internet connectivity. There may only be 1 doctor in 100 miles with no pediatricians or medical specialists. Treatment facilities are an average of 65 miles or more away, and families have 1 car in a home. This is important information for understanding challenges in rural communities.

Then, add substance use. Based on her visits to approximately 85 percent of U.S. rural communities and holding local conversations in town halls and elsewhere, Ms. Bryce reported that communities did not understand the scope of the problem at that very local level or what they could do. They understood something was happening and that things were getting worse, but everything else was very unclear. And they started to lose children. Stories included 12-year-olds raising siblings because parents were lost in addiction, children learning to count by separating pills for their parents, kids starving for attention because they were isolated and because there are no resources running through the schools, kids needing to learn how to live with sober parents because they spent so much time living with parents who were not sober, children now vulnerable to abuse because of the environment in which they had lived, and kids coming to school elated knowing they did not have to worry about what was going on at home because their mother had been arrested. Another issue is the lack of families willing to foster children, which translates to children living in hotels or not being removed from abusive homes.

Ms. Bryce explained that a broken family unit is highly significant in a rural community, where the whole fabric is the social, small town setting; when that fabric is broken, it has more of an impact in a rural community than it does in a larger urban community. She shared a story of meeting a 14-year-old from a community of 14,000 who told her that, like many others, she lives with adults who are in long-term recovery and who are not her parents. The community is seeing fewer kids come to school because the parents are so wrapped up in their addiction that they do not care if their children attend school.

Ms. Bryce shared three threats to young people in rural communities: abuse; neglect; and desperation. Children are either justice involved or "not yet justice involved." Social services infrastructures at very local levels already were under stress, and now they are faced with a higher need for child services and social services and have a limited number of counselors. Day-to-day challenges include children not coming to school and/or not eating; parents who do not care; high addiction rates; second and third arrests of parents, and grandparents raising children they did not anticipate they would need to raise.

The Response

The lion's share of the resources needed to engage rural communities and help them to engage their residents will come from agencies working together; coordination and partnership are critical to helping federal resources penetrate at the very local level. The number of applications for agency grant solicitations from rural communities is very low.

Ms. Bryce and Ms. Sivilli co-chaired a rural opioid interagency task force to help bring agencies to the table. They asked the task force members what resources are available directly and indirectly that can help rural communities address the crisis. Resources for substance use disorder are directed to prevention, treatment, and recovery. We must look at the indirect issues driving the crisis — unemployment, broken education systems, and broken family units. It is not

enough to concentrate only on a health-focused initiative; we must look at the community as a whole and focus on both direct help and long-term support and solutions. This includes connectivity, as in broadband infrastructure. A tele-health system cannot become the savior of rural communities where there is no Internet connectivity. Agencies never invited to the discussion in this area are the Federal Communications Commission and the Department of Transportation. We must ask ourselves, "Which direct contributors or indirect contributors are not at the table?" It is also crucial that federal agencies working with communities are informed about the available agency resources (i.e., transportation, drug courts), so they are able to share that information with the local officials.

Rural Resources

ONDCP created a *PDF of resources* grouped in 22 categories. Federal partners are asked to review and provide comments on it, and to make sure they are included. ONDCP provides the document to communities – including grant-writers – for their use; it includes links to all agencies by categories such as "Children." This is one response to, "I do not know where everything is, and no one understands grants.gov. It is not for rural folks."

ONDCP plans to build a *rural-friendly federal website* page housing all resources for a rural community, for a local mayor, for a local leader who is looking to do something. For example, here are the five agencies that can help you find an ambulance; here are their criteria and their rules. ONDCP hopes that all the agencies around the table will support this initiative and ensure rural resources will be well accessed.

ONDCP also built and has been disseminating a *community assessment tool* to be used by local mayors. Between the tool and the resource PDF, the mayor now can understand the problem at the very local level. Because the tool does not do any analysis, agencies are encouraged to share the tools with those who drive applications in order to know what the community is studying. Another goal of the tool is to help community leaders understand what makes them vulnerable and what protection factors they have. This is important because communities are triaging and need guidance on how to allocate funds holistically so as not to end up back in the same situation 3 years from now.

The current, second phase involves working with academics to build in indicators; Ms. Bryce asked federal partners who want to be engaged to reach out to her. The goal is to have a prototype available within 4 months.

ONDCP is preparing to release a *rural community action guide* with 19 challenges raised by rural communities, such as MAT and drug courts. The guide is intended to help a community leader prepare to engage with agency partners.

Another Challenge: Stigma

Stigma is a huge problem in rural communities, making it very difficult to get people into treatment. If we break stigma, we open a dialogue that brings everyone together at different levels – the pastors, the judge, community members, and others. If we do not spend some time on breaking stigma, no one is going to feel comfortable applying to seek any type of service.

Opportunity: Tailoring Prevention

Prevention must be tailored to reach rural communities. Everyone in the rural community who can reach the child is coming in through a social network within that community. Peer-to-peer work needs to include farming organizations and 4H clubs. It is very important to identify the stakeholders in order to educate the community and gain traction. For example, if churches and religious institutions are not at the table, one sermon can derail an entire justice-involved initiative.

Ms. Bryce shared an example of involving youth in innovative ways. A school in rural Kentucky, in one of the hardest hit areas, engaged male high school drop-outs in building tiny homes. Retired plumbers, retired engineers, and other retirees trained the kids, who started building the homes. The homes sold, and school attendance increased. It was a very simple project, but they started to see that it was engaging young men who were not going to school. Many other examples exist of repurposing the community.

Discussion

Administrator Harp thanked the panelists for doing a great job in providing such useful information and solicited questions from Council members.

Question 1

Council practitioner member Jim St. Germaine noted that the language around the crack epidemic was much different than it is around this crisis. He asked the panel for clarification of any disparities as they relate to race and what we can learn from it and apply it widely.

Ms. Bryce:

This is disproportionately a white male problem in rural America; for every three white males, the opioid crisis affects one African American and one Latino. Opioids can be ordered, and they spread in the rural community by sharing of prescriptions. This does not mean the crisis is not growing in places such as Mississippi, North Carolina, and South Carolina. It simply means that, taking it holistically, it is still at a lesser level. I am speaking strictly about rural communities.

Mr. Bonzon:

Those who apply for SAMHSA grant programs must identify health disparities. The goal is to have states and localities see mental health and substance abuse as a public health issue and take a public health approach, which also means looking at social determinants – such ACES or trauma, transportation, and housing – and understanding the need for health integration. We need to recognize that economic, transportation, and education policy is health policy.

Ms. Sivilli:

It is very clear that the crack epidemic in the 1980s was treated very differently than this epidemic. We now understand addiction as a disease of the brain and a public health problem. A substance use addiction epidemic is killing 70,000 Americans every year, and we recognize it is a much larger public health problem that needs to be addressed in every community and discussed in every family.

Council member Laura Rigas from the Corporation for National and Community Service (CNCS):
CNCS runs AmeriCorps and Senior Corps and can provide volunteers to serve in unique data-gathering and community-building capacities. It also has an incredible foster grandparent program; in one example, the Maryland program is in its 37th year and is co-located in the Department of Juvenile Services. Parents and grandparents, and certainly the 55-plus volunteers in the Senior Corps, are having an incredible impact on both the prevention side and on sustaining sobriety and helping with building a future for young people who have been affected. I encourage the Council to identify intergenerational solutions as well as how Senior Corps and AmeriCorps can support this work.

Mr. Bonzon:
SAMHSA is creating a technical expert panel to support clinicians on better serving families impacted by opioid use disorder. Many children are entering foster care or are living with a grandparent.

Question 2
Council practitioner member William Thorne commented that this conversation has changed dramatically for the better from what it was 5 years or even 2 years ago. According to *24/7 Wall Street,* 10 of the 25 worst counties in the United States to live in are located in South Central Kentucky. He described the problem in rural America as a coexistence of physical health issues, mental health issues, lack of economic opportunity, under-education, dependence upon public assistance, lack of transportation, poor housing opportunities, and drugs. All those issues have to be addressed, as they are lately particularly by BJA and USDA efforts. Mr. Thorne expressed his excitement at seeing that effort.

Mr. Thorne also noted the very welcome statement in the SAMHSA 2018 SOR, which spoke of the different types of MAT and their appropriate uses. He stated that there is usually a problem with adults or juveniles who are detoxed involuntarily, at least in the criminal justice population with which he deals. There is information available in rural areas, a lot of it anecdotal, about which is the best form of MAT. The SOR stating that naltrexone would be preferred for individuals who have been medically detoxed is important to rural communities where such a diversion issue exists, particularly with other forms of MAT. The statement takes into account the distinction between urban and rural communities in the U.S. Mr. Thorne was thrilled to hear that at least an incremental effort is being explored to extend those opportunities for children under the age of 18, and he asserted that it is absolutely essential to continue to research as quickly as prudently possible similar opportunities for youth who suffer from opioid use disorder.

Mr. Bonzon:
SAMHSA created a technical expert panel for MAT for adolescents and youth. The state of Massachusetts is drafting some guidance for clinicians for properly providing MAT for youth 18 and under. Many states already are tackling this issue.

Question 3
Jacob Horowitz of Pew Charitable Trusts asked panelists to recommend the best interagency activity they have ever seen done, or could imagine, specific to young adults in the 15-to-24-year range, to help address drug misuse or disorders. Would it be any different for opioids versus other drugs?

Ms. Kunkel:
I posed this very question to grantees yesterday, and their answer went something like this: There are a lot of resources out there. Each of our agencies has a specific charge with funding. We would want to see the funding combined. Instead of a very discrete incremental progress in small areas – beyond substance abuse are housing, transportation issues, and broader health issues – could the federal government put together a larger, blended funding package that allowed communities to combine several initiatives and conduct a much more holistic project at the community level? It is not that we need new things – instead, we need to combine existing things. This would help both in being more comprehensive and in streamlining grant management, which takes a major toll. One grantee spoke of monitoring 17 different grants.

Ms. Sivilli:
We collaborate regularly through interagency working groups to address the issues that are pressing. I would not point to any one thing that we have done. We work together on the drug issue very aggressively and as fast and as hard as bureaucracy allows us. We all are committed, and we work very hard to address these issues.

Mr. Bonzon:
A lot of recognition exists at the state level that there is a big difference between the systems that serve 12-to-16-year-olds versus 17-year-olds or even 18-to-25-year-olds. Recognizing that transitional age youth needs are very different from those of adolescents, SAMHSA is focusing on how to create a system specific to transitional age youth.

Ms. Blue:
Regarding coordination across the federal government, I had the opportunity many years ago to work on a fairly large interagency initiative, Safe Schools/Healthy Students, developed in response to school violence issues occurring across the country. OJJDP (representing DOJ), SAMHSA, the Department of Education (DOE), and the Community Oriented Policing Services (COPS) Office participated in this program that combined funding. SAMHSA's funds paid for substance abuse treatment, DOE's funds paid for activities related to education, the COPS funds paid for school resource officers and OJJDP's funds paid for a portion around justice-involved youth.

Question 4
Administrator Harp asked how to reconcile the high retention rate in treatment of those using buprenorphine with the fact that the drug has the highest rate of misuse. She solicited recommendations or thoughts about how to approach this.

Ms. Sivilli:
There is a lot of diversion of different drugs and misappropriate use, but we know that buprenorphine has been diverted/inappropriately used. The drug is very successful, very affordable, and diverted on the street. Anecdotally, people divert it because people are self-medicating to treat themselves because they might not be able to access it. I believe MAT is one of the most highly regulated substances under the Controlled Substances Act.

Mr. Bonzon:
SAMHSA has tried to support in its grant programs the idea that MAT, by definition, needs to be used in conjunction with counseling. Recovery support, including counseling and other mental health services, and services such as transportation and housing are needed to sustain recovery.

SAMHSA is putting out a new resource guide, hopefully this fall, focused on how to implement MAT in the criminal justice setting, and encouraging policies and educating staff in facilities about monitoring. The document also will look at what medications are most appropriate within the facilities or environments in which youth or adults are being treated. Just yesterday, we released a short document on the subject.

Ms. Bryce:
Echoing the concern about diversion, we hear this anecdotal answer that people are self-medicating. I have a tremendous volume of individuals who abuse buprenorphine. Some certainly are using it as a prop until they can get their next prescription of opioids or more heroin.

I recently have had discussions with representatives from the Drug Enforcement Administration because it (buprenorphine) has spiked a tremendous diversion problem in rural America. Having information in threat assessments regarding the extent of the diversion and misuse would be extremely helpful in helping to target diversion issues so that we can use buprenorphine more appropriately. It is a wonderful drug like the other two forms of MAT, and the most obvious downfall is this diversion issue. Without empirical data we always will come back to this issue of the information being anecdotal and not being given credence. But practitioners on the street or the country roads are very familiar with the problems associated with diversion, and we need hard data.

WRAP-UP AND ADJOURNMENT

The Council will meet next on June 13.

Administrator Harp expressed thanks to the panelists for all of the information and recommendations they provided.

Public comments may be sent to Elizabeth Wolfe, Training and Technical Assistance Coordinator, OJJDP at Elizabeth.Wolfe@ojp.usdoj.gov.

The meeting was adjourned at noon.