# Rural Faith Leaders Workshop: Empowering Faith Leaders to Help Persons with Substance Use Disorder – 5/13/2021

**Betty-Ann Bryce:** Good afternoon, everyone. We'll just give ourselves a minute while we're still pulling in our first panelist. But thank you for joining us today, we're very excited to get this workshop going and have you join us. This is part of our series, and a few of you may have been on the first one, which was very popular and was received well. We're looking forward to doing more of these with you. My name is Betty-Ann Bryce. I have communicated with several of you, so by now you're probably used to or sick of seeing and hearing my name. I'm simply going to be your moderator today. You have a really great group of speakers that will share a lot of important information for you. What I'd like to encourage you to do is to use the chat to ask questions. We want this to be as interactive as possible.

I've asked the speakers to pay attention to the chat, to respond to any questions that you may have as it comes in. Of course, we hope to do Q&A at the end, but we want to make sure that we're engaging with you throughout the process. So, that is the extent of my introduction to you. I would like to turn it over to our first speaker. I'm going to ask John Gale, who I'm so excited, I reached out to him first. I asked him to join us today to really set the stage, because our first workshop was a while ago, so it's really important to at least get an overview and an understanding of the strategies to combat substance use in rural communities. And, I had thought John was the right person to do this. So, I'm not going to do more. His bio is on screen. It's in your PowerPoints. John, the floor is yours, sir. Thank you so much for joining us today.

**John Gale:** Thank you, Betty-Ann, if I could have you advance to the next slide. Our work has been funded by the Federal Office of Rural Health Policy within HRSA. And, I want to start with my takeaway messages and it's such a pleasure to be part of this group today. I've been working in this field for quite some time, and I really think it's an important opportunity to begin to advance the issues related to substance use in rural communities. I always like to start with my takeaway points first in the odd chance that I bore you to tears, so at least to get a chance to hear my primary message. That I think attacking substance use, not just in our rural communities, but across the country and it takes a village. It requires community engagement and involvement, because I believe that these two sets of activities are a central to addressing substance use.

As we look at rural communities and Mr. Kemp identified some of those problems, substance use is very common and it's very driven by a complex set of socioeconomic issues. Some of which rural communities suffer from more than other areas, not the least of which are the travel barriers we experience and isolation. We also have significant gaps in prevention treatment and recovery services in rural communities. And as we begin to develop interventions in our rural areas, we really need to think about adapting them to the geographic resource and cultural realities. So, some of the socioeconomic drivers of substance use, socioeconomic status, poverty, lack of jobs and opportunity, unemployment, cultural factors. One of the things that we've always known in rural areas is there is a greater tolerance for alcohol use, than probably we should have. Their environmental effects and there were social changes going on that are really creating a sense of upheaval in rural communities.

And so, here's some of the role of rural place. I don't want to suggest that it's a terrible place to live, but because of the way our economies have evolved, we have greater sense of stigma that sort of lack of anonymity that people have. I grew up in a rural community and if I was being a typical teenager, my parents knew more about what I was doing than I did. And, they knew what I was up to by the time I got home. You have higher sense of isolation and

hopelessness, lower education, higher rates of poverty. Fewer employment opportunities and higher rates of chronic illnesses. And then, you have very complex... We tend to think of rurality as a very homogenous place, but they're not.

We have tremendous cultural, ethnic and religious differences that all have to be factored into this mix. So, I've always proposed a public health model for substance use. It really involves community leadership and that leadership can come from a variety of places. We need broad cross-sector collaboration. And, I just have such great support for the role of faith communities, because these are often the central organizations that promote, that hold the culture of our communities together. We need data collection and to address and identify the substance use problems. We've got to figure out what the risk factors are and what the protective factors are that can be enhanced, and then develop a prevention treatment and recovery strategies. I think of them as three legs of the stool, and then monitor the impact of what we're doing to be able to improve.

So, this is a framework that I have been working on and developed. I won't spend a lot of time on treatment. I'm going to focus more on prevention and to a slightly lesser extents of recovery, but I think we are foundational activities, I think that we need in every community. Rural communities in particular, is we need a community health needs assessment. How do we get our arms around the problem and understand what's going on in the community? And, that means bringing in people from all walks of life, and those are suffering from substance use disorders, and really beginning to think about planning, and then bringing in community members, because none of this can be done alone. A treatment program isn't enough, prevention program isn't enough. We need all to work together. And, we need screening for mental health and substance use.

And, part of that is in our primary care practices and hospitals, where the providers and professionals screen for these problems, but be aware of the symptoms too, and the challenges, and the signs in all of our social organizations so that we, as community members can begin to be more sensitive to it. And then, we have prevention treatment and recovery. And recovery is interestingly, one of the legs of the stool that often gets forgotten. And, I think that it's important to reinforce the need always. And also, want to say that prevention, treatment and recovery, it's not a continuum. These are things that are constantly interwoven. So, to me, one of the really important strategies is prevention. And, the goal is to delay the onset of substance use, discourage or delay. We know that some adolescents, for example, will experiment with alcohol, generally it's around 15 years of age or so.

And, the use accelerates as they get a bit older. And hopefully as they mature, they begin to go the other way. So ideally, we discourage them from doing that. If we can't discourage them, we have to delay the onset. And once they start, help them to figure out how to minimize high risk behaviors related to driving under the influence, their behaviors, the amount that they drink. The goal is focused on children, adolescents and young adults. That's where the biggest bang for the buck can be. Involving community organizing, and education and figure out what the risk factors are. How do we address attitudes towards substance use? And, I see your question and I'll answer that in a moment. Substance use and stigma, the question is about whether or not marijuana and cannabis is a gateway drug.

And, I struggle with this concept of a gateway drug, because if someone has, I think it's hard to say that marijuana alone isn't that, is a predominant driver going down to a much darker path. I think all substances are a problem, because it's not dealing with that. I am concerned that now that marijuana is being legalized in many areas that we have to begin treating it and thinking about it much more the way we do alcohol, and helping people to understand what the issues

are. One of the other prevention activities, I think it's important to encourage providers, is prescription drug supply. I know we focused a lot on opioids in the past, five or six years, but I'd like to suggest that, that's not enough. We should be thinking about benzodiazepines and other prescription drugs that have addictive properties. Benzos are a much more common problem involved with many car accidents and issues than we think. We've got to start focusing on that as well, and then finally reduce some of the harms related to substance use.

So, we need evidence-based programs. They're out there to reduce substance use, delay initiation, and moderate risk behaviors, and harmful use and inhibit negative consequences. The cost-effective, the evidence I've seen suggests $2 to $20 in savings and future health, social and criminal costs for every dollar spent. It's an incredibly good investment. It's got to be adapted to the community. And when doing that, there has to be an understanding of the basic parts of the intervention and the prevention strategy that works, so that we maintain that fidelity. And then, bring in cross-sector community collaborations. Now, I know there are some very strong and well-regarded faith-based community programs, but I also would argue that another role for the faith-based community is to be part of these cross-sector collaboration, so that they have a role across the system. A couple of models that some of you may have heard of. The first two are opioid related.

The others are broader, more broadly based, but Project Lazarus in North Carolina was developed by a local minister who also ran the local Hospice Program, was concerned about the level of overdoses around opioids and has developed a program that has been extended to every county in North Carolina and programs across the country. Project Vision here in the Northeast and Rutland, Vermont has a Drug Market Intervention Program to reduce the supply of opioids, and has really helped the community take back some of its neighborhoods. SAMHSA has its recovery-oriented systems of care and the community care of the programs, and there are others.

I won't spend much time on this on treatment because it's a little beyond, I think this session, but I do want to reinforce the fact that it's an important area to work on in the community as a role. Okay. Betty and I will be very quick, I apologize. But, substance use is a chronic relapsing disease. And so, it needs that opportunity to develop interventions along the way. So, the final area is recovery. Most people with substance use problems have burned way too many bridges. They've probably impacted their family, local providers, law enforcement. And, what we really need is an opportunity to give them a second chance, begin recovery, which should start before treatment in many ways, or at least parallel address, social rehab and vocational issues and provide a community to reinforce sobriety.

And, here are the four dimensions of a healthy life that has been defined by SAMHSA, health, home, purpose and community, I think a perfect opportunity for faith-based communities to be involved. I'm going to skip over this. So, some of the challenges towards implementing rural programs, they've got to be adapted to the area. Those that are imported from the outside, we rural folks tend to be a bit skeptical of others. Community-based programs have to be sensitive to local cultural, religious and ethnic issues, what I call cultural humility, and engaged local leaders and really have to support local living. Again, as I summarize and I will get to your question in a moment, sir, the community is key, development and implementation of community coalitions are critical, engaging business providers of faith-based communities, residents, law enforcement.

We need broad-based education on the dangers of substance use, and we need to work within existing programs to avoid reinventing the wheel and building local systems. So, let me... If I understand the question, the first question which... Am I considering the capacity of faith-based

institutions? Yes, I believe there's a need to provide greater education and that from community-to-community, that level, and capacity and experience is necessary to bring the capacity and level up. I know many faith leaders are uses of substance and hide it, but I think that's where we need to pull this out of the shadows. Okay. And, I will respond in the chat. I'm sorry, Betty-Ann. Thank you.

**Betty-Ann Bryce:** Thank you so much, John. I want to just go directly to Dr. Christopher Jones. I'm very excited that he was able to join us today. His bio is on the screen. Chris is going to talk to us about prevention, adverse childhood experiences, protection and risk factors, which John alluded to, which Dr. Jones will do a great job of kind of amplifying and put it in context, because I do think understanding these dynamics is really critical to the rest of the conversation today. Chris, the floor is yours, sir.

**Dr. Christopher Jones:** Sure. And, I do think this actually compliments nicely what John laid out in his presentation. But, sort of stepping back a little bit and really thinking about very upstream prevention, oftentimes people think about substance use prevention as like something you do in middle school. But, our view at CDC is that we can start even earlier, and really by looking at what we term adverse childhood experiences. Some people may call this early adversity or childhood trauma, but essentially ACEs are experiences that are traumatic that happened during childhood up to the age of 18. And historically, ACEs have been defined by different types of abuse, neglect and household challenges. And, that stems from some original work from CDC in the 1990s, where they were looking at the connection between things like physical, emotional and sexual abuse. Physical, emotional and neglect, having a parent, or caregiver with mental illness or substance use in the home, or incarcerated relative, or divorce, or domestic violence in the home, or a parent treated violently.

And, they wanted to understand these things that happen early in life, how did they impact later health risk behaviors and health outcomes? And, there was a Seminole study published in 1998 that found that these experiences early in life have substantial impacts on the life course and the health of individuals over their life span. But, as we've come to understand ACEs and the science has matured over the last two decades, we recognize that there are other events that happen to use or during childhood that play out very similarly to the more traditionally defined ACEs. So, those are things like bullying, teen dating violence, peer-to-peer violence, witnessing or experiencing violence in your community or your school, homelessness, death of a parent, really anything that can disrupt a sense of security or a safe, stable, nurturing relationships in a child's life. And, you can really think of that as under a broader rubric, adverse childhood experiences or childhood trauma or early adversity.

And, I think it's important to point out that these things are not uncommon. These are not happening on the fringes of society or the margins of society, these are happening in your backyard. Repeatedly studies have found that about 60% of adults have experienced at least one ACE in their lifetime. And if you think about things like divorce, incarceration, mental illness, substance use in the home, it's not surprising that people would have experienced at least one ACE. But, an analysis that we did a couple of years ago, published in CDC's MMWR, found that about one in six adults had actually experienced four or more ACEs. So again, that's fairly common and happening in communities across the country. And, it's important to point out that the science is very clear that there is a dose response relationship between the number of ACEs and your risk for poor health outcomes or health risk behaviors like engaging in substance use.

So, the fact that one in six adults in the U.S. had experienced four or more really, I think underscores the magnitude of ACEs, but also the potential to reduce things like substance use, if

we address ACEs. We do also know that ACEs are more common among females, among sexual minority populations and among most race, ethnicity groups.

So, we've also conceptualized ACEs and I think, again, this sort of underscores some of John's points that the traditionally defined ACEs are things that sort of happen to an individual or within a family dynamic. But, we also appreciate that other things that are going on in the community and sort of the contextual factors in the community can contribute to or exacerbate ACEs. So, poverty, discrimination, lack of opportunity, unstable housing, violence in the community, community disruption are all sort of feeding into stress in the community, stress within the family environments and exacerbating ACEs. So, as we think about prevention, we have to think at the individual, the family and the community level when we think about prevention.

And, as I mentioned ACEs have lasting impacts across the lifespan. So, impacts on mental health, maternal health, infectious disease transmission, risk behavior, like alcohol and drug use, chronic diseases, opportunity like high school graduation rates, getting a job, having insurance, as well as other types of injuries. So again, there's this sort of broad-spectrum impact of ACEs across a life span. And in the limited time that we have here today, I'm not going to be able to touch a lot on sort of the underlying mechanisms in which early stressful events in a child's life mold their brain and there are systems for responding to emotions, rewards and stress in a way that predisposes them to engage in substance use or to have mental health problems. But, it really comes down to the idea that as you are exposed to increasing levels of stress, because your environment is unpredictable and it's unstable, you don't have enough food, you don't have a place to stay.

There's argument, you're seeing violence in the home or substance use. Your needs are not being met. Basically, your body goes on stress overload and we call that toxic stress. And, that really shapes how the brain systems work together and it dysregulates how people process stress, how they process rewards, how they process emotions, their ability to have executive thinking, coping strategies when presented with stressful events or problems, decision-making cognition. And ultimately, you have impacts on organ function. And so, there is reams of scientific literature that document the impacts of stress, but just know that it is essentially priming areas of the brain that would be responsive to substances and the rewarding effects of substances. And if you're not able to typically handle conflict or emotions, coping with substances may seem like a positive thing to do, and you're already primed to reap a higher reward from substances. And so that's the direct connection between ACEs and substance use, there are also indirect connections as well.

And this just gives a little bit of those life course about how the pieces play out. So, you have these early events in childhood that lead to disruption in the neuro-development, how the brain is functioning and the wiring in the brain and the systems in the brain, which leads to, at a young age and in your developmental years, social, emotional, cognitive impairment. Which oftentimes, again, leads to adoption of health risk behaviors, which again, if you engage in smoking, drinking, substance abuse, other risk behaviors, that has a compounding effect on your risk for disease, disability, social problems, your ability to get a job, graduate from high school. So, it's a cascading effect that ultimately leads to early death. And we know that people who have six or more ACEs are more likely to die 20 years earlier than people who do not have ACEs.

So now moving specifically into substance use, now trying to go through this quickly. This is data from the original ACEs study that was published in 1998. And I think the point here is twofold. One is that across different substances, smoking, alcohol, use disorder, ever using an illicit drug, ever injecting drugs, people who experienced ACEs had an increased risk for engaging in those

substance use behaviors. And that risk grew exponentially as you experienced more ACEs. But even at one ACE, you're still at increased risk for engaging in substance use.

This is a more recent analysis from colleagues at CDC that was published in 2020, which just looks at the relationship between ACEs and misuse of prescription opioids. Obviously, something a lot of communities are struggling with and have been struggling with for some time. But again, the relationship is consistent. As you have ACEs and more ACEs, your risk of engaging in prescription opioid misuse is higher, and this comes from two different states, Florida and Montana. So, folks who are rural, Montana's a rural state, you see that relationship. Florida, which has obviously large urban areas as well as rural areas, again, relationship was consistent.

And then one area that my research has been focusing on over the last couple of years is really the resurgence of stimulants in the U.S. and a great concern about rising methamphetamine use and harms in particular, combined use of methamphetamine and opioids and what that stands to do for the progress that we've been making in the opioid space. This is a paper that was published recently, where we looked at the relationship between ACEs and people who were using stimulants in the past year or people who had a stimulant use disorder, or people who used cocaine or had a cocaine use disorder. The bottom line is that the vast majority of people who are using stimulants or have a use disorder have experienced ACEs. And again, a significant minority have experienced four or more ACEs. So, as we think about prevention in particular, focusing on ACEs, there's a big payoff if we can reduce ACEs.

Similarly, we looked at the age of first use for stimulants, amphetamine type stimulants or cocaine, and consistently we found that people who initiated at a younger age, on average, had a higher number of ACEs. So again, I think it speaks to prevention, that if you can reduce the number of ACEs, people are one, less likely to use these substances, but also delay their use, which we know reduces their chances of developing a substance use disorder later in life.

And it's important again, to point out the strong connection between ACEs and substances. So, these would be the traditionally defined substance use risk factors. They exist at the individual level, the family, the school, and the community level. I won't go through all of these, but to know that many of them are ACEs in and of themselves or factors that contribute to ACEs. But thinking about, especially in the faith-based side, there are things around community norms, community connectedness, opportunities, that I think faith-based help drive those community norms and connectedness in communities, and can have a significant influence on that community level, which does distill down into the family and individual dynamic as well.

And this just looks at protective factors. Again, there are individual as well as family, school and community protective factors, but things like resilience, self-efficacy, spirituality, being able to handle emotions, having some sense of attachment and meaningful involvement in the community, family or school, providing safe, stable, nurturing relationships, positive behavior is reinforced. Seeking help is a norm in the community, accepting violence or substance use is not a norm in the community. And I think there are lots of opportunities for the faith-based community and faith-based leaders to set some of those community norms and to help influence those community norms and a sense of connectedness.

And as I mentioned, we think there's a really big payoff for focusing on upstream prevention of ACEs. This is an analysis we did that was published in 2019, where we asked the question, if you could reduce ACEs, how much could you reduce various health conditions, health risk behaviors, and socioeconomic challenges? And just a couple of examples. We could reduce depressive disorder by 44%, heart disease by 13%, cancer by 6%, those are the two leading causes of death

in the United States. We could reduce smoking by about a third, drinking by almost 25%. And even things like unemployment by 50%, people graduating from high school, having health insurance. So, there is a real public health payoff by focusing on upstream prevention.

And again, if we have more time, and I can go much more in depth to this, but CDC put together a resource that we released last year, which essentially synthesizes the evidence for policies, practices, and programs that we know can reduce adverse childhood experiences based on the best available evidence. And they fall into six major areas. So, the first is strengthening economic supports to families. The second is promoting social norms that protect against violence and adversity. The third is ensuring a strong start for children. The fourth is enhancing parenting skills to promote healthy child development. The fifth is connecting youth to caring adults and activities, and the sixth is intervening to lessen immediate and long-term harms.

And I would encourage you to go to that resource. It's not a long document, but it lays out the evidence phase, the theoretical connection behind why focusing on different policies to strengthen economic supports can reduce ACEs or ensuring a strong start for children. But I think faith leaders will see themselves and the programs and services that they offer to their communities in many of these areas. And there are opportunities to say, "Oh, strengthening families program, that's a community-based program.

We as a faith community could engage with others in our community to offer that to people in our community." Or thinking about how are we engaging with a family who is pregnant? Who's not yet delivered their child? Are we helping them think about what are those supports that they're going to need in those first couple of years of life? How can we provide that support to them, or with youth, again, that sense of connectedness, a stable person that cares for someone, even if their house is chaotic and their parents are not reliable, they may find in their youth group at church or a Sunday school teacher, that there is somebody who shows up, who's consistent, who loves them, who can provide that safe, stable, nurturing relationship that can blunt and mitigate some of those effects they might be experiencing at home. So, I would encourage you to try to find yourself in this document and see what you might be able to apply or things you're already applying in your work, in your communities.

And this is just one example of a social emotional learning to program that has been rigorously tested and largely tested actually in rural areas that showed lasting protective effects in reducing youth substance use up to the age of 19 for this particular study. But basically, it was a combination of a school-based intervention, life skills training in seventh grade and strengthening families in sixth grade, which again, found these long-lasting protective effects. So, there are evidence-based programs that you can engage with others in your community to provide that can be protective and they're agnostic to specific substances. It's really teaching kids how to deal with emotions, how to discuss and handle conflict, the parent-child relationship, things that you're probably intuitively doing in your faith work, but this just puts some scientific rigor behind much of that.

And this is just a plug, we do have a variety of different resources on the CDC violence website where you can find different technical packages for violence prevention, the ACEs prevention resource, as well as some trainings if you want to know more and learn more about ACEs or share that with others in your community. So, thanks very much, Betty Ann and Kemp, for having me here. And I'll take a look at the questions in the chat.

**Betty-Ann Bryce:** Thank you so much, Chris. And a number of questions came in for you. And if you have more questions, just indicate that this is for Chris. Moving right along, and I'm very excited that actually, we arranged it in this way, because Chris emphasized the prevention and thinking

about the individual family and community level. And this is something that USDA does very well through the program that you're going to hear about from Sidney Turner. Why I wanted USDA in this particular role is because stopping drug use before it starts, they were nice enough to provide some evidence-based activities to our work and really focused on rural, and Sydney is going to go through with three examples that I think would be really critical and builds on what Chris Jones shared with you. Sydney, the floor is yours.

**Sydney Turner:** Thank you so much for having me. So, as we all know, we've heard about prevention-based strategies should be a part of this comprehensive approach for prevention, treatment and recovery support services in a continuum care to ensure the best opportunity for effectively addressing the issue of substance misuse. So, implementing population-based prevention, education programs is a key strategy to achieve positive health outcomes and promoting a positive quality of life. And with all prevention programs, they should aim to promote protective factors and reduce the impact of those risk factors.

And so here at USDA, we do a lot with cooperative extension. As you can see on the screen, these are land-grant university or colleges and universities map, which provides the non-formal education and learning to residents and rural communities by taking knowledge gained through their research and education and bringing it directly to the people to create that positive change and using the presence of cooperative extension enables individuals access to free or lower cost educational measures like health literacy skills and physical activities, stress management classes, and things of that nature to improve overall mental and physical health, to include reducing pain. So, I highly suggest you take a look at these slides and go to that link so that you can get in connection with cooperative extension if you're unaware of it.

So, the evidence-based prevention strategies that are highlighted in an article that we provided some input in was three strategies, PROmoting School-community-university Partnership to Enhance Resiliency, which is often known as PROSPER, that has three components. It uses the local community teams, it uses state level university researchers and a coordinator through the land-grant university. There's also chronic pain, self-management programs and a mental health first aid education and training, which is becoming more and more popular.

So, the program that Betty Ann was alluding to that we administer here at USDA's KNIPPA is the rural health and safety education program. So, in 2017, at the request of the President, HHS declared a national drug demand on the opioid crisis as an official public health emergency as we know. A declaration was renewed and has continued to be renewed because it continues to be a critical issue across the United States. So, the goal of this particular program is to foster the life and empower rural residents to make informed decisions about leading healthy lifestyles through research-based educational programs and approaches implemented in extension delivery model.

Now in 2017, they did add a caveat that we were to focus on the opioid and congress has continued to provide guidance and funding for focusing on the opioid epidemic. But we have this program prior to that, which also focused on other areas. Land-grant universities are the only eligible entity, but you can subcontract out the institutions and organizations that aren't necessarily or that aren't eligible to apply, I believe. We get about $4 million annually. The maximum award amount is $350,000 and it's for two a year project period. And the solicitation for this fiscal year, so fiscal year '21 closed April 29, so we are about to undergo the peer review process for that, I highly encourage you to take a look at that link and get to know this program and reach out if you have any questions.

So, through this rural health and safety education, we've been able to fund three really, really good programs that I really want to highlight here today. The opioid prevention for rural health youth, so youth through the PROSPER, which is one of the evidence-based strategies. As you can see, they have a target population, which was their sixth-grade youth and their families and role to prevent them from engaging in behaviors that would lead to substance misuse and other problematic behaviors. The objectives for them to improve the infrastructure, increase the number of youth and adults receiving these evidence-based prevention programming models, and the impact that it has on the community, for this particular program, they were able to, so far with their target population of sixth grade youth in Utah, the 40 out of the total 40 for this particular county had to believe, as you see, indicated on the screen, that a hundred percent of them were enrolled and have completed the programming, so that is a phenomenal thing.

And then there's also, I think it focused on three counties and students are... so students are receiving the lessons and these are working, these are 2019, I think, funded programs. So, this was the impact so far that it's had, we'll continue to get impacts from them as they're closing out and going through their final year of funding.

This is another good one. And they actually presented at the National Health Outreach Conference just last week. It's the Powerful Families Powerful Communities partnering to prevent opioid misuse, and this is in North Carolina. And their purpose was to reach out into the community with information that focuses on building stronger families and having that foundation to protect those protective factors and reduce the risk factors or behaviors, and substance abuse prevention by building life skills and strengthening those family ties and focus on the health-related impacts. And they partnered with neighboring states in a theme to improve parenting skills, to make healthy choices and improve those family relationships and empower families through community change by leveraging their support for healthier lifestyles within the community.

So, this last one that I would like to highlight is out of Wolfe, Texas, which is a team think smart approach to preventing opioid misuse in rural Texas. Now this particular program I do believe was targeted specifically to ninth and 10th graders. And it was a multi-level community-based prevention strategy. And they used two evidence-based components, which was the community mobilization strategy and the school-based prevention education curriculum, think smart, which is what they were using to complete their objectives that are listed there on the screen with implementing quality through their community mobilization strategy and their program effectiveness by decreasing the use of prescription drugs in ninth and 10th graders and promoting adoption and sustainability of their programs to develop those partnerships for long-terms sustainability.

So, all in all, in consideration from the terms or how NIFA, and how we look at it, some action steps for success and things for you to consider when implementing evidence-based strategies, are make prevention the priority at a local community level, make collaboration key. We all know that one person and focusing on one avenue is not going to make the difference, but involving the community, engaging in parents and caregivers, understanding the impact and also partnering with the local cooperative extension team is highly, highly, highly recommended for successful evidence-based implementation of programming, especially to receive low cost or free materials and things of that nature.

So those are what I wanted to highlight here today from the USDA perspective. And if you have any questions at any point. My contact information is there on the screen. You also have access to, if you want to reach out to the project directors to get more information about the programs that I've highlighted there today, you're more than welcome to do so. And I want to thank Betty

Ann for the opportunity to present what we here at NIFA do, with the rural health and safety education portfolio.

**Betty-Ann Bryce:** Thank you so much, Sydney. And I really want to emphasize what Sydney presented, just three examples of a very large portfolio of grantees who are doing amazing things on the ground. I really want your takeaway. Why I wanted Sydney to present, is I wanted your takeaway to be, you have partners in your backyard, you may not know that you do, but you do. And those partners are the corporative extension offices are homed at state land grant universities in each state. These are the folks that need to go out, access these resources, and then subcontract out potentially to partners who are listening in today who didn't realize that maybe your university didn't go after this opportunity, and maybe if your university did, you could subcontract with them, build a partnership and then go on to introduce some of these protective factors that Sydney really highlights.

So, I would love to encourage you to connect with Sydney, to learn more about who are the potential grantees in your backyard, and then continue that conversation offline. Of course, ask Sydney some questions, if you have a question for her, just say, "Sydney, this is for you." She will be monitoring the chat if she wants to share more information. I'm going to go quickly, now you've heard from our overarching and I do apologize, but it was so important, leading into someone who I know uses time very well, Dr. Monty Burks, and he is going to, as the leader of faith-based initiatives, he knows very well how to bring everything you've just heard into the faith community. So, he's going to set this up by focusing on two pillars, which is how to help the faith community identify their their role, and how to connect to the prevention resources in your backyard. Monty, the floor is yours.

**Monty Burks:** Good afternoon, everyone. And I can personally say that I can attest to the fact and the significance of the timeless prevention work of our substance abuse prevention coalitions in the community. Enigmatic, difficult, pragmatic, community-based partnerships. That's how we flourish in our rural communities.

We're going to take a different approach on this. Right here. We're going to... one more back. Yes.

We're going to take a little different approach on this. We're going to talk about how we mobilized and pulled in faith communities to have these unique conversations around prevention, treatment and recovery. One thing that the faith community can do that a lot of other communities can't do is they can attach to a continuum anywhere in the continuum. Prevention, treatment, recovery, criminal justice, the faith community can attach on each level when an institution, as well as an individual, depending on what an individual's preference is.

I'm a person with lived experience. I suffer from substance use disorder and a mental health diagnosis. I'm 21 years free from those issues that controlled my life. And if it was not for work through the prevention coalitions that were in my local area, there wouldn't have been a mobilized community to connect the dots. Our faith-based initiative in Tennessee is very unique. We knew on the ground that we had to pull our faith communities in from an organic space, organic level, to where they wanted to attach to other already defined institutions. And let me throw something at you really quick. Faith-based institutions, as we continue to refer to, we also consistently need for resources. They have been around since before any single one of our institutions that you and I work for. They've been here since before us, and they will be here when we're gone. So, we need to strategically equip them with the capacity to handle any issue that comes their way pre- and post-us.

We are the moving pieces in this puzzle. Our Tennessee community faith-based initiative was designed to connect our faith community to our prevention coalitions, our recovery courts, known as drug courts in some states, treatment programs, jails and prisons, recovery programs, and our Lifeline Peer Project, which we'll present in just a few minutes.

And to be able to be an access point for people to reach out and get resources. So not just prevention, treatment and recovery at the hands of the prevention coalitions, access to resources. Our prevention coalitions cover 12 sectors. The faith community is one sector, but it doesn't have to be one faith community in that one sector, it can be a robust network of faith communities in that one piece of that 12. Congregations willing to work with us in this space, we recognize them through our State Department as Certified Recovery Congregations using a trauma-informed approach.

I loved when we talked about ACES earlier, Adverse Childhood Experiences Syndrome. I'm thankful for my good friends, Andy Clements, who I think is on here right now, and the work they've done with the Holy Faith Collaborative in the East Tennessee Appalachian Region. And our prevention coalitions working with us, we recognized an opportunity to engage in a conversation around prevention and early intervention.

Listen, our faith communities are boots on the ground, whether we want to understand that or not. Sunday school teachers, people who address children on a very organic and natural capacity may reach someone and have access to someone well before we get to them. So, we want to make sure that we equip them with the same resources that any other institution has.

So, congregations who follow these steps here, we connect them and we certify them as Certified Recovery Congregations, and our project, Lifeline Peers, our prevention coalitions, and our faith-based initiatives, connect them to resources and ultimately help them to become the resource in their community that they didn't have when they needed a resource.

So, one, provide spiritual or pastoral support according to your congregation and your belief system. Again, cultural competency 101. We can talk all day, and we can preach all day, but you cannot come in someone else's house and tell them how to do business. You can partner with someone. Make sure you do that through leadership, with leadership's approval.

Two, look at addiction as a treatable disease. Let's move beyond the language of moral failing. Again, not to come in and challenge what somebody believes. Let's partner with someone, figure out the difference between treatment and recovery, and how it applies in this space, as well as prevention.

Three, embrace and support people in recovery and walk with them on the journey. Again, we talked about faith-based institutions. Their original offset was fellowship in the beginning. They've been part of fellowshipping long before we were around.

Number four, disseminate recovery information. Again, our initiative started as a recovery support initiative, but we drove the message through the prevention coalitions because of their unique, unique relationships built in the community. I love prevention coalitions because people don't wear suits every day. There wear Chuck Taylors and holey jeans and a t-shirt that says I love you. That's how you organically approach and connect with people to do a great and masterful work.

Five, host and refer individuals to recovery support meetings. Listen, prevention can start with people in recovery because they can be the beginning prevention process for other people

when they leave programs and don't want to go back to where they're from. This is what we do here in Tennessee. We use this whole system, prevention, treatment, recovery, criminal justice, faith-based community, as one continuum, and continue the cycle and continue to connect people to resources.

Now, with that, I'm going to connect you with my two counterparts, Jennifer Berven and Jason Abernathy, who work in the East Tennessee Appalachian Region. And they're going to tell you about how we built an East Tennessee rural Faith-Based Recovery Network through this initiative. And thank you for your time.

**Jennifer Berven:** So, when Monty first came to us and started talking to us about this initiative, he shared the fact that we had over 11,000 faith-based organizations in our state, over six million people who live in our state. And of those six million, about half of them identify as members of faith-based organizations or congregations, and attend regularly. And it got me to thinking, as a prevention person, what would be important to bring them to both our table as well as the recovery table?

**Jason Abernathy:** When we invited them, we were thinking about strategic locations. So, congregations are located in every type of neighborhood, crossing all the socioeconomic classes. The congregation is protected by the citizens in the communities, whether they attend the organization or not. Folks are looking out for folks in their own backyards. Congregations also have meeting spaces that people can use for fellowship outside of the regular service times of the congregation.

**Jennifer Berven:** So, we started thinking about what that overall impact might be. And we realized that when we look at prevention, it's important for people to know who's at risk. And we realized that there were around 3,000 people of faith for every person who dies by suicide. There are around 2,000 people of faith for every one person who dies from an overdose. And there are around eight people of faith for every person who are needing but not receiving treatment. With prevention, we want people to understand what the need is, and why we need to prevent those things.

**Jason Abernathy:** So, Dr. Burks mentioned the Lifeline Peer Project. It was established in 2013, and the idea being to reduce stigma related to the disease of addiction, and increase community support for those policies, and for support for those policies that provide for treatment and recovery services.

So, with Lifeline, and part of what I do, or have done over the last several years, is establish evidence-based addiction recovery programs. I've done educational presentations for civic groups, faith-based organizations, community leaders. We want to increase their understanding of the disease of addiction, and support for recovery strategies. We want folks to see it not just as a moral failing, but we're looking at sick people that need to get well, not bad people trying to be good.

We also want to facilitate access to treatment and recovery support amongst diverse communities. So, a lot of what we do with Lifeline is we help folks, we direct folks into treatment, and do those warm handoffs to get them plugged into the services that they need.

**Jennifer Berven:** And the Lifeline, our Lifeline Peer Project, is based in our coalitions because it made sense for us to be there because we, in our state, we have 52 abuse prevention coalitions. We bring together people in organizations and leverage resources, so we're used to trying to connect people as well as educate people and make them aware and understand different things.

And we have the deep connections to the local community, and serve as catalyst to reduce substance use locally, as well as the abuse rates.

So, Insight Alliance, we are located up in the Northeast corner of the state, in red. We're the orange in the middle with the star. Of course, we focus on prescription drugs, alcohol, tobacco, and we're about to start another program focusing on stimulants.

The faith sector's already a partner for prevention, it's one of the 12 sectors that we get involved with. Our coalition, when we were meeting in person, actually meets at a church. And to see some of those examples and those documents, if you go to our website, insightalliance.org, and click on the Lifeline tab, you'll see Faith-Based Recovery Network information. But we saw it as a great opportunity to make some further connections.

**Jason Abernathy:** Oh, with the Faith-Based Recovery Network, we want to utilize the prevention coalitions as the driving mechanism. Again, there's such deep roots with these coalitions throughout the region.

We have five main goals. We wanted folks in the recovery communities and in these forums to understand recovery. We want them to understand access to community resources, building those stronger community partnerships. They can come onboard with us here at the coalition, and also with me with Lifeline. Again, connecting to myself here in this region as a Lifeline Peer Project Coordinator. And also, just pulling in congregations as partners. There's a lot of folks out there in the faith community, they want to help. They just need some direction. They can come to us and we can help provide that direction and get them plugged into the different service opportunities that may be out there.

So, when you look at the little puzzle pieces here, we want to connect the faith community to treatment and recovery programs and resources. Those things are out there, we just want to educate folks on how to get plugged into those, and also connecting the faith community to prevention coalitions.

Again, all the deep roots through the coalitions, lots of things going on, and instead of reinventing the wheel and doing something new, let's bring everybody together, get them onboard with us. And that way they can help be part of the solution.

**Jennifer Berven:** Well, we'll skip through these next ones quickly, but basically, we had more than 10 forums in our eight-county region. We had over 1,000 people attend, around 100 churches or faith-based organizations.

And at the same time, there were some other events that were dovetailing. Monty mentioned Dr. Clements ETSU was involved with the Holy Friendship Summit, which involved Duke University, which brought in some education about ACES.

Adoration was an event linked to East Tennessee State University, gathered 1,000... their goal was to gather 1,000 churches, which they gathered quite a few, and there was about 2,800 people who attended that event. Again, it was linking the faith community to the issues we have around substance use, and given us an opportunity to educate folks, reduce stigma, as well as get people looking at prevention.

**Jason Abernathy:** When we think about partners, we have our coalitions, all the coalitions in this region. We work well together. The Lifeline Peer Project, again, where I served the upper eight counties in Northeast Tennessee, I work closely with all the coalitions.

Our development district, our workforce, is so important, just because there's so many folks in the workforce who are affected by addiction, or who struggle or suffer with an addiction. We saw them as being key. Our regional healthcare system. And then other community resource

providers. We don't want to just see folks go to treatment, we want to see them get the wraparound services that they need, so when they come out of, whether it be residential treatment or intensive outpatient, they have that support. So, when they come out they can hit the ground running and have people around there to support them.

**Jennifer Berven:** And so, coalitions do what coalitions do best, we hit the social media. We got people to invite their peers, old-fashioned one by one, just calling, contacting people. We did it in the evening so that lay leaders who work can come. I think somebody mentioned that, that a lot of folks, being faith providers, are not just one job, they have other jobs. So, doing it in the evening so we could get the most amount of people involved. And got food donations or love offerings, but for food provided by the church. And we did it Town Hall Meeting style, where we had evaluation, feedback, let people ask questions, and really helped us understand where they were at and what they needed from us.

**Jason Abernathy:** So, when we talk about who was there, for some of these Town Halls, it was not just churches. We targeted paid and lay leaders, so not just the pastors, but other folks that serve within the church. The different community or neighborhood organizations, we wanted to get those folks involved because when it's in their backyard, they got an invested interest in it, so we wanted to bring them on board.

Other professionals. Dr. Burks said something earlier about the 12 sectors, and we have the 12 different sectors within the coalition, so trying to get folks, a representative from each of those sectors, whether it be law enforcement, education, healthcare, to the table with us. And then again, the community itself. We want folks to feel invested, and feel like they have a say in what's going on. And it's also allowed them an opportunity to see how they can better serve their community, knowing the struggles are going on in their community.

**Jennifer Berven:** And so, what did we do while we were there? Well, we started off really basic. We called it the brain talk, where we talk about addiction, how it happens, why it happens, including all the things that have been mentioned today.

Understanding the resources that are out there. That's one thing that was important that we put in the hands of everybody there, and that is that they know what treatment, recovery and prevention resources are out there.

Laid out what our expectations were. How did they apply? We brought in examples of what other faith-based organizations were doing, and that served as being a place that they could refer to, or if they wanted to build their own recovery ministry, or to add that to what their church was doing, they could do that as well. Like speaks to like. They were able to be a good example.

And then partnership opportunities within the community as a whole. Again, how can the community support the church and the people who are attending? And then there was just plain old networking and community building, which is so important.

**Jason Abernathy:** One of the key things, and it was in the questions earlier in the chat, and Jennifer just hit on it. Those that already have a recovery ministry, one of the things that's been really great about these faith events, you have some smaller churches, you have some of those organizations that they don't have full-time staff, or maybe they don't have the space.

Well, we broke down those congregational, denominational barriers, and we said, "Okay, we're going to put all these differences, or maybe the way we look at things differently, aside. What

can we do to best serve our community? And knowing that, okay, our small faith organization down the road, we don't have the capacity, but we can send them up the road here to this faith organization."

So those that already had a recovery ministry, we gave them some more education, provided them some more resources, but also connected them with other individuals with an opportunity to help each other out, to serve each other.

The partners, they had an increase in service opportunities through referrals, there've been some calls coming in. I'm able through Lifeline, if they call in looking for a house of faith, or different things like that, to direct them to where they need to be.

And then also, it increased the access to resources. So, the faith community, they receive the information, training. We've done some different things like suicide prevention, ACES trainings, trauma-informed care things, to help these folks to better serve the individuals who are struggling in their congregations or in our organization.

And also getting them aware of prevention and treatment. What we gained, prevention, treatment recovery, what we gained was volunteers, folks to help us out. It gave us some meeting space opportunities, and more partners within the coalition. We're always looking for folks in the community to come in. You're nothing about us without us. Let's bring everybody in this community, in this area, in this region, let's bring them to the table and let them have a voice and let them have a say in what's going on.

**Jennifer Berven:** And it was great to deliver those resources to the faith community so that they understood what was out there and what was available to help those people in their congregation.

Some of the benefits that we got as a coalition is the opportunity to introduce the faith community to coalition work. Promoting healthy behaviors, understanding how addiction begins, prevention. Reducing overdose, incarceration, recidivism.

I just glanced, somebody asked in the chat about what is our goal here, and I think it's all of it. We want to prevent it, but we also want to intervene. We want to reduce harm. We want to raise protective factors, reduce the risk factors. And so, there's an opportunity for sharing prevention messages.

We do smoking cessation classes. We have information about underage drinking and social hosting, safe medication storage and disposal. We have data. People want to understand how this is impacting their community, and coalitions have that information. So, the better understanding that people have of the problems that are facing their community, they understand the risk, they understand how it's impacting individuals, makes them all the more invested in wanting to engage in those prevention as well as protection and promotion of healthy behaviors. Our contact information is on there, and we'll respond to any questions you have in the chat.

**Betty-Ann Bryce:** Monte beat you to it, Jennifer and Jason, but please join him in the chat to see if there's anything that you would like to add. I'm going to turn quickly to Pastor Greg Delaney to round out this conversation, providing the faith perspective by really zeroing in on the partnership piece, and also showcasing an innovative faith-based strategy. So, with that, Pastor Greg, the floor is yours.

**Greg Delaney:** Yeah. Thank you, it's good to be here with you, and I'm going to talk in Monty-speed because we're getting a little tight on time.

But really, here in Ohio, the connection to the faith community and to our community resources has been a priority of our governor since he was inducted and he was sworn in. That was one of the very first things he did, was create Recovery Ohio. And as a part of Recovery Ohio, one of the things that I do as a part of that group, is work diligently to connect our faith communities to the work that's going on across all the different spectrum, as Monty had described it, and Monty and I partner all over the place about this stuff.

So, because we're short on time, I just want to go to the next slide. And really what drives me is this quote from pastor Tony Evans. It says, "The government can run and fund programs, but it can't love, it can't show compassion, and it can't embrace."

And our faith, whatever that faith may be, it's designed to have social implication, not just heavenly wants. And so, the spiritual and the social must be connected. And so, what we spend a lot of time here in Ohio doing is educating faith leaders, inspiring faith leaders, inviting them to the table, showing them that they are welcome as a part of the recovery-oriented system of care. Then we find out what talents and gifts they have, whether it's a congregation, whether it's a faith-based organization, how they want to become plugged in and be a part of that, of that care for an individual across that entire recovery-oriented system. And so, over the course of time here in Ohio, that's meant everything from starting a meeting in a church to opening a faith-based men's recovery center in Akron, Ohio.

So, it's all across the board, but today I really wanted to spend some time focusing on a fairly new project that's underway here in Ohio that really shows how we did that, bringing a faith-inspired program and a solution for prevention into the space of making it a community connection, including academia.

And so, what I want to do is, , I want to introduce something called The Good Life. And on the next slide, you'll see Pastor Nathan Chrisman and Dr. Elizabeth Delaney, who I happen to be very close to, who were big instrumental parts of bringing The Good Life to life. And I'm going to turn it over to them because they'll fit those last two objectives, to talking about how we can partner, and then what was a new innovation around this partnership. So, take it away, Dr. Delaney.

**Dr. Elizabeth Delaney:** Thanks. So, like Mr. Gale, I'm hoping that these are the takeaways you'll have from my part. And really, we have... I was an Associate at School of Nursing Professor. I'm also a Nurse Practitioner with background in oncology, palliative care and hospice.

But one of the reasons that I wanted to get involved with this particular work was, being a part of a person, as a person, a daughter of a person who struggled with alcohol, who eventually led to suicide, married to my knight in shining armor, who didn't even start drinking until his late 20s, and having  other family members who are struggling with substance use disorder, anxiety, depression, and distress. If you look on this slide, those were my children, our children, and my nieces who are all part of the impacts of substance use disorder. So, the first thing I want you to think about is when you think about your community and you think about prevention efforts, I want you to contemplate. One of the first Cs for consideration is contemplate. In your community, when you think about prevention, who could be your people? It doesn't matter your faith, it doesn't matter ... You're trying to achieve prevention, so just pause on who might be a person that could help in this effort?

Next, do some checking. The next C is check out your community, check out your public health people, check out your faith-based and community organizations that are focused on prevention. Check them all out, and then start to communicate. Because once you start having dialogue, what we found is one person knows another person, it's just basic networking. But if you have that objective of prevention or substance use disorder, then the person might have some common ground that you guys can work on together. Collaborate instead of create whenever possible.

So that's what we found here is that this person knew this person, they had this effort going on. We had this effort going on, they had this expertise, we had this expertise and ultimately, we were trying to prevent substance use disorder, particularly in our communities and in the people that we love. Whenever possible, don't compete. So sometimes for whatever, money, power, greed, and selfishness, for whatever, whoever you are, sometimes those were issues that were not allowing that collaboration. So, our experience led Greg and Nate, Pastor Nate, to be networking, communicating. They both knew people. I knew him and Nate had started to work in middle school and high schools. So, for us, when he started to talk to me about The Good Life, I was interested in increasing protective factors, increasing and delaying first use. I was interested in middle and high school kids because that's where we might have our greatest impact.

So, Greg knew of this work that Nate was doing in the middle school and high schools. I, as a Doctor of Nursing Practice, learned and have had a lot of work and innovation in science, as well as being a pastor's wife, being in both the circles of faith-based communities and very scientific communities. So how could I bring my knowledge as a Doctor of Nursing Practice, as a scientist, as a person who was interested in evidence-based information to Nate, Pastor Nate, and say, "These are all the things you're doing, but let's be sure that they are evidence informed, that you are working together."

So, what happened is I sat and talked with Nate. That led to a conversation, or I talked with the IRB, the IRB at the Cedarville University. Cedarville is a Christian university, but I would tell you that likely, like we were talking about Ms. Turner said, oftentimes community extension offices, universities, they have people that are interested in your topics that are willing to come alongside of you. So that's what we did. We started to do a program evaluation of what was Nate doing in the middle school and high schools, and then what can we do to make sure that it's evidence-based? We then had another connection to a mental health and recovery board, and truly quickly we decided that we would just try. Let's see what happens if we submit for a grant. Lo and behold, we were funded.

So last year, The Good Life is under now our pilot program with evidence informed, as much as we know. We've surveyed students in one middle school and one high school. Our data is coming in as we speak and tomorrow we will begin our formal program evaluation in hopes of being able to show this evidence informed program. The initial feedback between teachers and superintendents was so positive that unbeknownst to us, the superintendent started talking to other superintendents in Montgomery County. We now have over a dozen schools that are interested in what happens with our evaluation and the fact that its evidence informed. So, I'm going to turn it over now to Pastor Nate so he can give you a little bit more information about the GoodLife.

**Pastor Nate:** Thank you very much for that. I have a picture of my family here, and this is because ... All of us together, our family has been intimately acquainted with the effects of addiction and we have just kind of dedicated our life as a family. When you go into ministry, as many of you know, it becomes a significant part of your life, where things are centered around that idea. But as I've

been in this space, what I realized in meeting people like Greg and so many other people in this space, whether they be coinciding with the faith-based community or outside of that, is we want students and we want people to be ready for life. As we learned earlier in discussing the ACE scores, there are so many things in life that I didn't ask for, but ultimately, we weren't prepared for those and we want to change that.

So, as we meet with principals, superintendents, counselors, especially now coming out of 2020, and now to '21 and all the things that we've all been through, much of the conversation is centered around the idea that our students need this now more than ever. While I totally agree with that, my answer is always the same and that's no, in 2019 is when they needed this now more than ever. So, we want them to be ready for life and whether those are things that they're stepping into in their future that are great and right and exciting, we want them to be ready for that and prepared for that. In the same way, things that they didn't see coming, we want them to be prepared for that as well. So, we can find common ground across faith, beliefs and across those maybe outside of the faith community space that we have some things in common, that we want the same thing for students.

So what was shared so far today is phenomenal, but my personal experience has been that often I have tried to create programs and invited those who may need them to come to me and in exploring how my faith works out in my own community, not just as a pastor, but as someone who cares about the community, what I wanted to do is go into my community and not just preach to problems, but really be someone who pulls for people. So, my goal is not to bring them into a program that I have created and this is something that I think will work and try to invite them in, or even into our facilities or buildings, but how can I pull for people in such a way that I take this to them and make it readily available for them?

So that has kind of become the theme, is that we deliver support to teens, the critical support to teens, schools and communities to see better outcomes for all. So that became our mission and so rather than kind of looking inward, as we oftentimes do, we wanted to look at our community and figure out how can we provide the critical support that may be lacking? The reality is, is it can be difficult making and keeping social emotional learning needs of students a priority in schools. No matter how well meeting teachers are in their schools and how much they would love to do and how much of a need they obviously know is there to support their students and come around them, the reality is it's very difficult.

So, what we believe is that adequately addressing the life challenges that face students in today's world with the significant demands of teaching and meeting academic requirements is not something that schools should have to do alone. It's too much, it's too difficult, and we wanted to come in and figure out how can we do this in a way that doesn't add something onto a teacher's plate? So, while there are many just phenomenal curriculums out there, there are many phenomenal programs out there, oftentimes the programs are designed to be carried out by a teacher or by the staff in a school. So, we wanted to figure out how to make it simple and easy for them to do that.

So, we wanted to develop a partnership with schools that does not add any workload to teachers and staff. So, what we say kind of in a short phrase here, is that social emotional learning, we want to make it simple and we want it to be done for you. So, our goal is oriented on supporting the schools and delivering the critical pieces that are needed for them to succeed to see better outcomes for students. So, we do this, through our classroom teaching program, and we have developed a structure in a way that those from the faith community can become certified. This was kind of a paradigm shift for me, by the way, and primarily through Greg and

Beth here, is that there are so many crossovers between what the science community has to offer and the faith community as a whole.

So, I found myself sitting in prevention certification courses and classes and trainings and thinking, "Well, every ministry leader in the country needs to be educated in this way." Yet that kind of education is completely absent from a seminary and college degrees and things of that nature, internships and the ministry and faith-based world. So how can we come together with those? So, what we're doing in our whole model is that we want to take the pressure off of the school and we want to be able to come into a classroom and deliver the prevention-based curriculum for them. So, we come in and we teach in classrooms, then we have a mentoring program that we're able to do, and we've written a playbook that makes it easy.

Again, there are many people in a community and maybe many of your communities as well, in your faith-based community, community as a whole through business owners and things of that nature as well, college students, who want to invest into the next generation and they believe what we believe, that the future and the keys to the future are held in the hands of the next generation. If we're not doing something now, then what will we look like as a community, as a state, as a country, a few short years from now? So how can we come in and mentor them? There are many people who are willing to do that, but don't know how. So again, we wanted to make it easy.

So, we're not providing a program and resources and hoping that people will do it. In fact, Beth had her number a little bit wrong there. We actually have 20 schools next year in our community that want to do this, and so next year we're slated to teach this to 6,000 students and more than 400 students are going to be going through the mentoring program as well. That's going to be a combination of teachers in a school, in addition to members of the community and members of the faith-based community following a prevention-based social emotional learning strategy for mentoring that student. So, the work is done for you.

Also, we've noticed the need and so we're working to develop a sports leadership program because coaches are facing the same difficulties, and they're trying to teach kids how to run plays and win games, but they're not really sure how to deal with all of the other stuff that encompasses a player. So, we want to be able to help develop students who win, not just on the field, but also able to win in life. Then outside of all three of these, a media campaign, a digital community through YouTube and online supports that kind of reinforced the values that we're trying to teach. All of this, right now is based in an evidence-based framework. Through the studies, we're hoping that the actual curriculum itself will become an evidence-based program. Currently, everything is evidence-based and that's where we are able to ... our curriculum is based on an evidence-based framework.

So being able to partner with the scientific community, with those in education in that way has been very, very helpful to us. So, there's more that we could share, but I know that we're running short on time about the curriculum itself, and so invite you to inquire about that, share your questions, thoughts in the chat. I think our contact information is there as well, but we kind of span across four factor areas of life. This is just kind of in a nutshell, but we talk about focus, friends, freedom and future. So, the classroom curriculum that we deliver on behalf of the school and the mentoring piece, it all follows this four-tiered framework that we call the four-factor life. So, the focus part is all about the inside you, and so we talk about emotional health and wellness and how to overcome challenges and building resiliency in students there. We talk about friendships, which really applies to all relationships in life, and we talk about the idea that relationships can make you a break you. So, it's important to learn how to make and keep great relationships in life.

We look at freedom and it's all about the choices that we make and the outcomes that those choices lead to in our life. Then future, the path of possibility where many students, and this is why we're all here, this is why we're all on this call, and we're all in this in many ways together, even though we come from different backgrounds and different ways of approaching things, but it's the path of possibility. Because we know that in today's world, many students, as a result of their past, they look to the future as the path to fear, as a path to anxiety, a path to dread and just not want to even step into, but we want to illuminate what is possible for students and believe that the way to do that, or at least a way that we have found in doing that is not waiting for students to come to us or waiting for the community to come and be a part of our programs, but really evaluating the needs of our community and evaluating the individual needs of the school.

So, there are many ways with our curriculum that we're able to do that based on a school that might be rural, as one that we're working with in Ohio, or they find themselves in another place in that community. We're able to target things and tailor a custom-made kind of implementation method with each individual school based on their needs. So again, not getting them to conform to our program, but coming in and how can we support them and what we're all trying to do. We want students to ultimately be ready for life. So, thank you for allowing me to share today and, again, think that the real innovation to our system here and what we're trying to do is to support the schools. I think the best thing that we could do as the faith community is find the ways in our own individual communities that we can support and fill in and meet the needs of our schools for the sake of the next generation.

**Betty-Ann Bryce:** Thank you so much, Pastor Nathan. I know you're tight on time, but there is a question in the chat from Nancy Castello asking about the curriculum. So just wondering if you could take a few minutes just to take a look and see if you have any responses regarding that. I apologize, but I hope you found this conversation as rich and filled with information as I did. I wanted to round out with something that is even just as rich and full of information for you, and that is the Rural Health Information Hub. I would like to invite Kristine Sande just to share a bit about the prevention focus information that would help you. I think it's really important, as you've heard, just having that information will help you make some decisions today that are critical to where you want to go. Kristine, the floor is yours.

**Kristine Sande:** All right. Thank you, Betty Anne. Glad to be here with you today and I'll share just a little bit about the Rural Health Information Hub. So, the Rural Health Information Hub is a federally funded information center on rural health, and we hope that you will find it useful. It's targeted to not just healthcare providers, but also community members who are looking to improve the health of the population in their communities. So, you can find resources, information, data, model programs, and funding opportunities. So, I'll tell you a little bit about some of the specific information you can find on the site related to prevention of substance use disorder.

So, first is our prevention and treatment of substance use disorders toolkit and this we developed in conjunction with the NORC Walsh Center for Rural Health Analysis. It's kind of a step-by-step in thinking through what you need to do to start a program related to substance use disorders. So, it talks about strategies, model programs, implementation considerations related to starting a program in the community. We also have a topic guide related to substance use and misuse in rural areas, which kind of gives an overview of some of the issues that are prevalent in rural communities related to substance use. As well as resources, statistics, funding opportunities, there's really a kind of a wealth of information on that topic guide. We also have a related issue guide on the rural response to the opioid crisis that talks about what some

federal agencies have done, what communities have done, what opportunities are available related specifically to the opioid crisis in rural communities.

Then within our online library, you can find funding and if you look specifically for funding by topic and the topic of substance use and misuse, you can find all of the opportunities that we have in our system. We look at federal agencies, state agencies, philanthropic opportunities. So, there's really a wide range of opportunities available in that funding section. So, we give a little bit of information about the opportunity, as well as the link to where you can find more information about those funding opportunities. So that's a really good resource. You can also sign up to receive information from us on a weekly basis in RHI Hub this week, or sign up for custom alerts. If there's just a narrower topic that you're interested in, or you just want information about your state, you can sign up for those custom alerts. We also have information that comes through RSS feeds if that's something that you use.

If you can't find the information that you're looking for on the website, you can always call one of our information specialists through our resource and referral service and get help finding the information you need, whether that's funding, statistics, you need an expert or you're looking for research, give us a call or send us an email, and we can help you find that information. So, this is our contact information, and I encourage you to spend a little time on the website. Again, if you have any questions, don't hesitate to contact us. Thank you so much for your time today.

**Betty-Ann Bryce:** Thank you so much, Kristine. You can go to the last slide. So, with that in mind, I want to thank you for your attention today. If you want to learn more about, you can assume the next workshop in this series will be on connecting faith to recovery. No, we don't have a time yet, but we will keep you informed when that is developed. Otherwise, if you have any other questions, this will be posted. The contact information is on the slide for each speaker, but we will certainly make it more visible for you. Our recording will be made available and any of the resources that are mentioned, we'll do our best to link to them on the website. Thank you so much for your attention today and we look forward to engaging with you again in the future. Have a good afternoon. Bye-bye.