Transcript: The Nexus of Substance Misuse Prevention and Suicide Prevention

Presenters: Jana Boocock and Alex Karydi
Host: Erin Ficker
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REBECCA BULLER: [INAUDIBLE]

ERIN FICKER: Oh, I had a-- who's recording?

REBECCA BULLER: Welcome, everyone. If you've just joined us, we're going to get started in about one minute. Please feel free to greet people in the chat and hold on. We'll get-- like I said, we'll get started in just a minute.

All right. I'm going to go ahead and get us started. Welcome to everyone who's joined us this morning. You have joined the Nexus of Substance Misuse Prevention and Suicide Prevention with Jana Boocock and Alex Karydi, and with our host, Erin Ficker.

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A few housekeeping items. If you're having technical issues, please individually message Rebecca Buller-- that's me-- Alyssa Chwala, or Jen Winslow in the chat section at the bottom of your screen, and we will be happy to help you.

Questions for our speakers, please put those questions in the Q&A section at the bottom of the screen. It helps because we can keep them in order. Sometimes questions get lost in the chat, so please use that Q&A section, and our speakers will respond to those questions at pauses or at the end.

You will be directed to a link to a short survey at the end of the presentation. We would really appreciate it if you could fill it out. It takes about three minutes. And it is helpful for us to report to our funders and continue to provide low and no-cost training experiences. Certificates of attendance will be sent out via email to all who attend the session in full.

You know you could find out more about what's happening at future times and find resources on our social media. So please visit these different links and join us again in the future.

And now to introduce our presenters. Jana Boocock is a Senior Prevention Specialist on the Suicide Prevention Resource Center Project. Jana's primary experience includes managing the implementation of suicide and substance use prevention programming in South Dakota communities.

Jana received her master of social work in 2021 from Arizona State University, and is a certified addiction counselor, certified prevention specialist. In addition to her state and community-led prevention experience, Jana also has experience working with youth and adults experiencing behavioral health disorders within the community.

Alex Karydi leads and provides technical assistance for the Suicide Prevention Resource Center's State and Communities Initiative. Before joining EDC, she served as Director of Project 2025 at the American Foundation for Suicide Prevention, and was the Director of the Callen-Lorde Community Health Center's Certified Community Behavioral Health Clinic, a global leader in LGBTQ health care.

Karydi is a certified addictions counselor and a licensed marriage and family therapist. Fluent in French and English, Alex holds a PhD in marriage and family therapy from North Central University and a PhD in clinical sexology from the American Academy of Clinical Sexology. And now I'm going to turn things over to Erin Ficker, who is one of our prevention managers, to get us started.

ERIN FICKER: Hi, and welcome, everyone. Thank you so much for being here. As-- there we go. [LAUGHS] As Rebecca shared, my name is Erin Ficker. I'm one of two prevention managers at the Great Lakes PTTC. And I am so glad to have you here with us today, so thank you. I did see some familiar faces. Or not faces, but really names in the chat-- or in the participant list, so it's great to see that people are coming back.

As you come in to our webinar and as we get started, I'm curious, why did you decide to join us today? We're happy you're here, but curious. What inspired you to be a part of this webinar today? Was it knowledge, ideas, inspiration, networking? My boss made me. I appreciate the honesty of those folks. Or for some other reason.

Looks like we have a lot of folks saying that knowledge was their primary motivator and a few people whose boss made them. Again, that's OK. We're just glad you're here, and we hope that you get something out of it and find today's material useful.

OK. Well, thank you guys so much for taking the time to vote. Like I said, we see a lot of people are here for knowledge and ideas, and I think that's just exactly what we're looking to provide you today.

So like they said, today we're talking about suicide and substance misuse and the nexus of where those two things meet. Today we are really honored to have some amazing presenters that Rebecca introduced for you.

This is part of a series that we're doing on the nexus of substance misuse and other-- oops-- [LAUGHS] and other behavioral health issues, including problem gambling and mental health promotion. We'll be doing problem gambling next month in June, and then in July we'll be tackling the issue of-- the nexus of substance misuse and mental health promotion.

So today's objectives for our training are really to think about creating a common understanding of substance use and suicide prevention, to describe the relationship between substance misuse and suicide, to review the key overlaps of substance misuse, and to identify areas for collaboration. So hopefully, that's where we'll get to spend the majority of our time is really digging into those overlaps and that collaboration. And I believe this is where I'm going to turn it over to Jana.

JANA BOOCOCK: Yes, thank you so much, Erin. Thank you, everybody. It's so nice to be here with you today. As Erin and Rebecca had shared, my name is Jana Boocock, and I'm a senior prevention specialist with SPRC.

So just to introduce as we move into creating that common understanding of suicide and substance use prevention, suicide and substance misuse prevention overlap in many ways, which means prevention efforts can benefit and stretch shared resources by coordinating and collaborating across these two fields.

However, identifying how and where to collaborate can be challenging, especially as terminology, funding, priorities, infrastructure, and approaches may differ among suicide prevention and substance misuse prevention. So we really want to set that shared understanding and set the stage for what these two things mean, and then go into, how do they intersect and overlap?

So historically, substance misuse prevention refers to the prevention of any substance misuse or preventing the onset of regular substance use. Often, this is focused on youth and preventing underaged drinking, but efforts also include prevention of illicit drug misuse among youth and other age groups.

Substance misuse prevention does also include adult misuse prevention. As I say, I like to share some spirit from my former professor of my undergrad. She always said, prevention is womb to tomb, and I always keep that in the back of my mind.

Preventing opioid overdose has grown in recent years as a part of substance misuse prevention, but it's often addressed and funded separately from substance misuse prevention efforts among youth. Typically, federally driven, correct? But both youth substance misuse prevention and opioid overdose

prevention offer opportunities for collaboration with suicide prevention initiatives. Next slide, please.

So suicide prevention refers to the prevention of suicide attempts and deaths. Suicide prevention includes upstream prevention efforts to prevent the onset of suicidal thoughts and risk factors. It also includes early identification and support for those at risk to prevent suicidal behaviors, crisis response, and follow-up to those who attempt suicide, and postvention to respond after suicide deaths to support those left behind who are often themselves at higher risk due to the suicide loss of a loved one.

Suicide prevention is done across the lifespan, although federal, state, and local efforts have predominantly focused on youth and young adults. Suicide is a complex health outcome that is influenced by many factors, many of which also impact the risk for substance misuse. And often, substance misuse itself is a risk factor for suicide. Therefore, collaboration with substance misuse prevention efforts is critical for suicide prevention initiatives. Next slide, please.

So there is substantial evidence that links alcohol and drug use with suicide risk. For example, people with substance use disorders are at higher risk for suicide than the general population, and that risk is even greater among people with co-occurring disorders, mental health and substance use disorders.

In addition, studies of suicide and of substance misuse reveal shared risk and protective factors such as adverse child experiences and social connectedness. The rise in tragic deaths from overdose, suicide, and alcohol-related disease and the interconnectedness of these issues make the link between substance misuse and suicide an area of increasing importance to the field of suicide prevention and an opportunity to work in collaboration with substance misuse professionals as well. Next slide, please.

So to further demonstrate the relationship between substance use and suicide, I did want to highlight a few key data points. I will be upfront and honest that I am not an expert in the data, but if you do have questions related to data, I'm happy to go back and get answers for you following the presentation today. But I do just want to highlight a few things.

So this graph depicts suicide rates by sex. So from 2011 to 2020, the total age-adjusted suicide death rate increased from 12.3 to 13.5 per 100,000 people. And over the same time period, the rate increased from 20 to 22-- sorry, 20 to 22 per 100,000 for males. And among females, the rate increased from 5.2 in 2011 to 5.5 in 2020. Next slide, please.

This graph depicts suicide and homicide rates from 2011 to 2020. Suicides consistently outnumber homicides. And historically, the homicide rate has not consistently shown the upward trend that we would see with suicide rate.

However, the homicide rate did increase from 2019 to 2020 with rates of 6 and 7.8, respectively, as you can see on the graph by that green line. Next slide, please.

This pie chart illustrates the means of suicide deaths by various methods. Poisonings accounted for 12% of suicide deaths in 2020. And you'll see that the accompanying bar graph illustrates the contribution of various substances to poisoning suicides. Next slide.

This graphic comes from the CDC-- vital signs: suicide rising across the US-- and depicts factors contributing to suicide among those with and without mental health conditions. As you'll see depicted on the graph, within 28% of deaths by suicide, problematic substance use was identified as a contributing factor.

It is important to note, however, that persons who died by suicide may have multiple circumstances, and the data that comes for this comes from mental health-- sorry, the data on mental health conditions and other factors for this data comes from coroner and medical examiner reports as well as law enforcement reports. Therefore, it's possible that mental health conditions or other circumstances could have been present and not diagnosed, or known or reported at the time. And the next slide, please.

So finally, just to kind of wrap up the data that shows the connectedness between problematic substance use and suicide, 15.4% of people ages 18 and older have a past year substance use disorder. So this means we're looking at one in seven adults have a current substance use disorder. Nearly 46,000 people died by suicide in 2020, or 45,979. And in 2020, drug poisoning, which includes opioid and heroin overdose, was present in 9.4% of suicide deaths.

In 2020, rates of suicide in the US were almost four times higher for men than for women. And then according to SAMHSA, 22% of deaths by suicide in the US involve alcohol intoxication. So again, I didn't want to bore you with data-- or I don't want to say bore, because some people really enjoy data-- but beat you down with data. But just really wanted to demonstrate with data that there is a connection in how they influence one another. So with that, I'm going to hand it over to my colleague Alex to talk about the intersection.

ALEX KARYDI: Hi, everyone. So I'm going to go a little bit more into depth around the intersection between substance misuse and suicide. So if we could go to the next slide.

So as you can see here, suicide is the leading cause of death amongst people who are misusing alcohol and drugs. And when we do psychological autopsies or we're conducting the different investigations that happen with a potential suicide, we see that based on the alcohol tests conducted after their death that nearly one in four suicide decedents exceeded the legal limit for

drinking and operating a motor vehicle. So that suggests that the person was intoxicated at the time of their death. Next slide.

Up to 40% of individuals seeking treatment for substance use disorders reported a history of suicide attempts. Usually, this data is collected through screening and when we're doing assessments.

But if you're looking at the intersection around substance use and suicide, what we're really seeing is that it's a form of suffering, right? The individuals who are seeking treatment or who are using substances, misusing substances are at a level of suffering or trauma. We see the same condition with those who are suffering with suicidal ideation and attempts. There's a high level of suffering and pain involved.

Adults who have opioid use disorders are 13 times more likely to die by suicide than the general population. And interestingly, we see a very similar correlation with chronic pain and suicide. People who live with chronic pain are six times more likely to die by suicide. So you start to see how they're all intersecting and they're not just separate pieces of experiences that people have, but that they can very much interconnect. Next slide.

So here's the continuum of care. I think most people have seen this tool. It helps identify where and how substance misuse prevention and suicide prevention overlap. Substance misuse prevention and substance use disorder treatment are different fields, but this image shows the continuum, that where actually both fields of suicide and substance use treatment are-- we're both really trying to track how the person is doing across time and where they are, and how to help support them through their experiences. Next slide.

So in suicide prevention, we use the socioecological model to help explain a lot of what's happening to people and how things happen. So a unifying theme across suicide and substance misuse prevention is addressing the social determinants of health. These are often the root causes of underlying health issues.

So for example, poverty, financial housing, food insecurity, systemic racism, trauma, community violence. All of those things are examples of things that could happen that cause negative health outcomes.

Both fields also focus on systems change. We really want our systems to change. It's not just up to the individual, but for all of us and how we create our system to shift in order to see a difference in the way we live, learn, and work. We want to be able to shift that.

These systems need support. And any individual change is done with our colleagues, our providers, our teachers, our faith-based leaders. We're all kind of accountable for this shift.

So if we kind of buy into the idea that we all play a role in suicide prevention or we all play a role in supporting and minimizing the traumas that exist within different systems, we can reduce risk and we can increase the protective factors that exist within our communities. And that's really how we support our populations that we serve.

So by addressing social determinants of health and using policy and practice and systems change, we can not only reduce suicide and substance misuse risk, but we can also reduce risk for many other negative health outcomes. So to work effectively to prevent these complex issues, programs need to be multifaceted rather than just doing one training or intervention in order to improve health outcomes.

We're really trying to change behavior and how people function. Knowledge alone doesn't change behavior, and I think we all kind of know that, right? Just telling somebody that this is what happens when you smoke is not enough to make somebody change not smoking, right? There's a lot more that has to be done from that individual to that community to that system as a culture, how we function, to help that person not pick up a cigarette, for example.

Both suicide prevention and substance misuse prevention operate within socioecological frameworks. That is, prevention efforts should look at different ways to mitigate risk and strengthen protective factors at the individual relationship like family, peers, community, which is like schools, workplace, faith-based communities, and societal, which is your policy with stigma. We see stigma, living our norms kind of are under that umbrella levels.

By taking into account the different levels of the framework that can impact suicide and substance misuse risk, we acknowledge the importance of not only working with individuals and families, but also addressing the context in which they live, which has profound impact on health outcomes, as evidenced by the description of the social determinants of health here.

So I usually give the example to people, if you're thinking about somebody that is dealing with a particular trauma for themselves-- maybe they're experiencing intimate partner violence, so there's trauma within the person. There's the relationship trauma that's happening. Maybe there's no shelter nearby, so that's a community risk factor.

And maybe they live in a community where it's kind of normalized, intimate partner violence. It's not something that people are maybe necessarily addressing or it's not-- there might be a culture of, it's none of my business. I'm not going to say anything. So that's how we look across the board. Just looking at the person just on their own doesn't help us actually make the shifts needed so that true prevention happens, which is that it stops to exist, that particular event in people's lives and communities.

So let's go to the next slide. Let's look at shared risk factors between substance misuse and suicide. So from an individual level, you might have behavioral health problems, physical health problems, special needs, poor coping skills, trauma, family, relationship issues. Ooh-- OK. [LAUGHS] There's bullying, family conflict, financial stress, social isolation, lack of support. Communities, community connection. Maybe they have easy access to substances. Maybe alcohol is easily accessible.

I'll give you a true example. My daughter is born with a congenital disorder, so she lives with chronic pain, and she's also part of the deaf community. And as an individual, I tell people, so she has this chronic pain that she has to deal with. She identifies as a deaf person.

And all of those can be kind of risk factors, right? Living with chronic pain. Having to go through a hearing world is challenging, and sometimes the coping skills are not enough to deal with the environment, right? So that's what's happening on the individual.

In terms of relationships, if you have a deaf child going to a regular school, you might encounter bullying. You might encounter difficulty kind of adapting to different environments. And some environments are not really great, right? So my daughter can never be in a cafeteria. It's too loud and it hurts her-- hurts her hearing, so that disconnects her from her peers during eating time where people are actually connecting.

And then you look at communities, like how communities look at individuals living with chronic pain or who may be part of the deaf community. People are always yelling at my daughter. And I'm like, it's not that she doesn't-- [LAUGHS] you yelling at her is not going to make her hear you any more than she can hear right this minute. So just kind of the understanding of others, right? That low understanding and that lack of connection or wanting to connect.

And then societal, right? My daughter's always telling me, I live in a world that doesn't really think about people who can't hear. It's a privilege to be hearing, and that's how people build their world, around the hearing.

And so that's a societal culture, right? This stigma around-- people will say, your bad ear. Or I'm so sorry that she's deaf. And it's like, she's very proud to be deaf. She's like, I'm just-- it's a variation of one's lived experience. So those can become risk factors if you can-- it's hard to-- virtually usually I get people's nods and stuff like that, and I can see if I'm making sense, but hopefully that makes sense.

So let's look at protective factors. I think we're going back in time. OK, let's go in the future. Great. So protective factors could be how we do conflict resolution, right? What kind of coping skills do we have? The healthy relationships that we build, strong parenting skills.

In terms of relationship protective factors is having caring adults around you or caring community around you. Connection to school or community is more of a community protective factor.

And then societal protective factors are really those policies and procedures that protect the individual. Maybe they reduce access to lethal means. Maybe there's treatments that are really supporting those individuals.

And we have access to health, right? So for my daughter, her protective factors is I'm a protective factor. I hope I am, anyway. I'm a caring, loving, supportive adult. She is taught all the time how to address and advocate for herself. She goes to a school that makes a lot of accommodations and support for her.

And then I'm very lucky. I live in a city that very much focuses on being accessible for those who are living in the community-- the deaf community. So that would be a protective factor. That is keeping my daughter at lower risk of killing herself. And we don't have firearms in our house. So things like that are protective factors. Thank you. Next slide. I don't know if it's coming. And I'm handing it over to Jana.

JANA BOOCOCK: Thanks, Alex. Erin, you can go ahead and go to the next slide, please. So now we're going to really talk about those key areas of collaboration. So we had demonstrated the intersection between risk and protective factors, as well as the social-ecological model. And so now we're going to move into, how can you collaborate at a local level?

So in both substance misuse prevention and suicide prevention, we tend to talk about upstream prevention as taking place earlier in life. And it is true that childhood experiences can significantly influence lifetime suicide or substance misuse risk.

So this is known as primary prevention and health promotion, the idea of preventing risk from developing in the first place. Even though intervening early with youth can have a powerful impact on their life trajectory, primary prevention can occur at any point over the course of a lifetime. So just as primary prevention is focused on preventing any onset of a disease, so secondary and tertiary prevention are focused on what you can do once you may get it.

In the same way, we can also think about the strategies that we put in place. There are universal strategies which focus on the entire population and may focus on education about the issue. Selective strategies focus on those populations who are at higher risk for substance misuse, such as an individual with multiple risk factors and access to fewer supports or protective factors.

And finally, we have indicated strategies, which are focused on those populations who have already initiated use in a way that is harmful. So an example would be youth who have began drinking alcohol regularly.

Both substance misuse prevention and suicide prevention rely on getting community buy-in and participation in our efforts. Both specific sectors we need to engage more actively in prevention for overall community engagement in the issues.

At the same time, prevention initiatives need to connect to the hard data and best practices around who is most at risk, and what kind of strategies are likely to work? So critically, both suicide prevention and substance misuse prevention take a strategic planning approach to achieve the best results. While this process may not look identical across the two fields, both aim to ensure that prevention efforts prioritize populations most at risk, look at risk and protective factors that can be changed, and use best practices in what we know works, as well as evaluating efforts and sustaining what is working.

So there are really five key areas for collaboration among substance misuse and suicide prevention, and that includes identifying the problem, sector engagement and partnerships, planning, strategies, language and stigma. So Erin, you can go the next slide for me.

So both suicide and substance misuse prevention practitioners or professionals often use a needs assessment and strategic planning process to identify prevention priorities and develop a strategic plan. You might update those every couple years, whether it's three years, or very commonly five years across your community. But you use that strategic plan to drive and address those priorities.

So in this process, practitioners gather data from sources such as school-based health surveys, hospital and emergency department data, Behavioral Risk Factors Surveillance System or the BRFSS, the National Violent Death Reporting System, as well as collecting qualitative data via one-on-one interviews and focus groups within community gatekeepers and stakeholders.

So a really key collaboration recommendation among identifying the problem is to identify local data sources and identify whether they are both substance misuse and suicide prevention data points. If so, what are these? And identify any overlaps.

Here are a few data questions you might want to answer. Is substance misuse and suicide impacting the same populations? Are there specific spaces where prevention efforts can reach these populations, such as school or primary care providers?

Are there resources in place and/or potential partners that can support these populations? Are there shared risk and protective factors that the priority

populations have in common? How are these two health outcomes connected within the community?

With the rise of opioid overdoses, there has been an increased interest in collaborating and suicide opioid overdose intersection. Prevention professionals can look for specific opportunities to collaborate here by focusing on some key components of data collection.

You can identify community-level data sources to assess cause of death, collect data on both method of suicide and presence of opioids and suicide attempts and deaths, compare local data to national or state data, and identify potential partners who can contribute qualitative data as well as understand what populations are at increased risk for suicide in your community. Next slide, please. Thank you.

So sector engagement and partnerships. Suicide prevention and substance misuse prevention are both most effective when they collaborate closely with other sectors in our communities. This means that prevention programs in both areas are likely already collaborating with some of the same partners.

In my experience in my former role with South Dakota, we actually had a lot of our local coalitions that were dual, as we call them, that were addressing both substance use and suicide prevention because of the relationships they had in their community and identifying that both were issues in their community.

So a collaboration recommendation would be identifying, who is working on suicide or substance misuse prevention in your community? And find all the sectors with whom they collaborate. So having a discussion about how you work with each partner and identify ways in which you can support one another.

So here are some examples. If substance misuse prevention is working with an alcohol licensing commission to provide responsible beverage server training, ask them to include community data and resources on suicide prevention as part of their training. If suicide prevention is working with local emergency departments to conduct brief follow-up for suicide attempts, ask if they also follow up with overdose patients. And then provide resources on local substance use disorder treatment providers, as well as resources for both teens and parents on substance misuse prevention efforts.

The benefits of a coordinated approach include that it avoids duplication of effort and provides good value for prevention dollars, which we know can be rare and few and far between sometimes, and then allows prevention programs to leverage new contacts and relationships. It also allows partners and community stakeholders to focus on broader goals of health and wellness rather than siloing prevention efforts. Next slide, please.

So another key area of cooperation is during the planning phase. So during the planning phases, substance misuse and suicide prevention efforts can strategically identify ways in which they can work together on one another's strategic plans. So a collaboration recommendation here would be during the planning phase of your prevention initiative, consider reviewing those shared and risk protective factors that we just discussed that are effective in both addressing suicide and substance misuse prevention. Find those key strategies that overlap as well, and work through that together. Next slide, please.

So speaking of strategies, there are key areas in which suicide and substance misuse prevention can collaborate when it comes to strategies. Here are some select examples of strategies that overlap, but keep in mind, this list is not exhaustive.

So many schools implement evidence-based curriculum that have health-related outcomes such as reduced substance misuse and address factors related to suicide prevention, such as increased emotional well-being. So a couple examples would include Good Behavior Game.

This is an example of an evidence-based program that focuses on building the social-emotional coping skills of young children. And studies show that by supporting young children in developing these types of skills decreases their likelihood of substance use and suicide later in life, while also enhancing other positive outcomes.

Positive Action is a comprehensive program that focuses not just on classroom-based instruction, but also the overall climate within a school. So by practicing or picking those strategies or school programs that address both kind of spectrums of substance use and suicide prevention, you can really make that collaboration go further.

And then another area would be on community policies such as alcohol outlet density. So research shows that greater alcohol availability is associated with increased alcohol-related suicides, and addressing alcohol availability and increasing social connectedness can reduce alcohol-related suicide.

Similarly, in substance misuse prevention, limiting access to alcohol also reduces social norms of alcohol use, which is also associated with decreased underage drinking. Therefore, both suicide and substance misuse prevention professionals have an interest in reducing alcohol outlet density, so partnering together to work on those things has a joint impact.

And then another important consideration in identifying areas of collaboration or when working with populations who may be at an increased risk for suicide or substance misuse, these should be determined based on the local data and local population's needs. So again, going back to that strategic planning process when you're walking through those questions that are important to

consider when collecting data, using that data to develop, who are maybe our shared populations that are at risk? And how can we address these risk factors and protective factors together? Next slide, please.

So finally, language and stigma. And as you mentioned-- Rebecca had mentioned earlier today about language and why that matters. So in addition to areas of collaboration and coordination we have already spoke about, language and stigma are also important in addressing substance misuse and suicide prevention.

The language practitioners use is important in reducing stigma, and the nuances of using the best terms and language in these two fields is important and changing frequently. An important commonality, however, is using person-first language. For suicide prevention, caution is also recommended around referencing suicide as inevitable, normal, or a glamorous way to deal with distress. So really focusing on using that person-first language in both fields will help to reduce stigma and the overall impact. And then moving on. Next slide, please.

So what does this all mean, and what does this mean for you individuals today? Some key actions to take away as substance misuse prevention professionals is to learn who is responsible for suicide prevention within your communities. Familiarize yourselves with suicide prevention plans, strategies, and programs.

Identify public health goals you have in common. Leverage and/or collaborate each other's strengths and ask to partner. Plan and implement cross-training on the link between the two, and use process and outcome data to evaluate and make the case. And then on the flip flide-- [LAUGHS] and then on the flip side-- sorry. Next slide. I got side and slide confused.

[LAUGHS] Again, key action steps to take away today for suicide prevention professionals is just vice versa, right? So learning who is responsible for substance misuse prevention, familiarizing yourself with substance misuse prevention plans, strategies, and programs. Again, identifying public health goals you have in common, leveraging and collaborating, planning and implementing cross-training, as well as using process and outcome data to evaluate and make the case for both. So with that, I am going to hand it back over to Alex, and she's going to share some real life community examples of where this intersection has happened.

ALEX KARYDI: Thank you. Next slide. So we're going to watch a short four-minute video now of Barri Faucett. She is the Suicide Prevention Lead for West Virginia. She's going to describe a statewide initiative to integrate West Virginia's substance abuse and suicide prevention efforts.

In partnership with the State Bureau of Behavioral Health, Barri was able to duly address these issues by training intervention specialists to assess and

ensure rapid follow-up for people who survived an overdose or a suicide attempt. So Erin, if you don't mind. Thank you.

So just another example of how somebody could use funding, get the partnerships and collaboration together to be able to create something new for their state. Next slide.

Several years ago, the Native Americans for Community Action, NACA, in Northern Arizona noticed that more than half of the youth at the local detention center were Native American. The NACA was determined to change this trajectory for other native youth and keep them out of the juvenile justice system by building their life skills and resiliency to adversity.

After careful consideration, the NACA chose an evidence-based program called Coping And Support Training, CAST, which has been used successfully with Native youth. The program aligned well with their goals to help youth manage their emotions, make better decisions, reduce their substance use, and improve their grades in school.

To implement the program, the NACA needed a partner with direct access to the youth they wanted to reach. They knew from local data that many of the Native American youth in the county juvenile detention center came from specific towns on the reservation. So they reached out to the schools in those towns to see if they could and would participate.

While partner buy-in can be a major hurdle, the NACA was fortunate to already have working relationships with the school system. Still, it's a big commitment for schools to integrate CAST into their curriculum, identifying teachers to facilitate the 12-session program each semester, and select students to participate.

So the NACA provided ongoing support. They used grant funding to pay for CAST-facilitated training, program materials, and monthly support calls with facilitators. They overcame common challenges like retaining teachers and students in the program. They provided stipends to CAST facilitators and incentives like movie tickets to students.

To help encourage and celebrate youth who completed the program, they also held graduation ceremonies. To date, six schools have partnered with NACA to implement CAST programs among students aged 13 to 17. Approximately 40 students at each school participated in the program every year.

The results were that at the beginning and the end of the CAST program, participants completed self-assessments that evaluated their personal growth. Those test results have shown substantial improvement in the areas of self-worth, coping, and connection.

After the program, there was a 51% increase in the number of students who agreed with the statement I'm proud of myself, and 66% increase in the number of students who agreed with the statement I know where I can get help when I have a problem. So another wonderful program to explore. Next slide.

ERIN FICKER: Ah!

ALEX KARYDI: Erin, is that--

ERIN FICKER: I'm-- yep. Give me-- sorry. There we go. [LAUGHS]

ALEX KARYDI: No worries.

ERIN FICKER: So we are going to pause for questions. We've heard a lot of information from our presenters today, and I do have a couple of questions. So I am going to pose those to both Jana and Alex now. And then if you have more questions, now's the time. Go ahead and enter those in to the Q&A section that you'll find at the bottom of your screen, and we'll see if we can get to them. I think we will have plenty of time to get to questions.

So we have one question that says, Jana quickly mentioned data questions, identifying the problem-- on the identifying the problem slide. Are we able to access those questions? Those are exactly-- a useful tidbit I was looking for.

And this question comes from Angela. So Angela, if there's any more detail you could add to the chat that might provide some context, that'd be helpful. Otherwise, Jana?

JANA BOOCOCK: Yeah, Angela. Thank you for the question. Yes. I don't know, Erin, if you want to talk about the handouts, but I'm more than happy to make sure we call those questions out specifically that you should be considering as far as that data piece in those questions.

ERIN FICKER: Yeah. So we will be creating some handouts at the end of the series of all three of these. We're creating them now. And in large part, they'll be based on the content here with a little bit more depth, but also building on some of the questions that you asked. So we'll be recording these questions, and if we don't have the answers right now, absolutely be including those in the handouts and then in our follow-up. OK. Anything else on that question before I move to our next question? Great.

So we have a question regarding rural communities. So tips for smaller rural communities where the same people are at every table, where the practice is talking about the problems, but not engaging in solutions because there is staff to do it. Insert eye roll. [LAUGHS] I will insert the eye roll for you.

I was once-- a colleague once shared with me about when working in a rural community, she kept referring to TPS-- TSP, the Same Ten People, and having those same people at the table she referred to as TPS, the same 10 people, or TSP. So do you guys have any tips for rural communities where they tend to be problem-focused and you have those same 10 people all at the table?

JANA BOOCOCK: Yeah, I definitely have some thoughts, because I come from rural communities. I grew up in a town of 500 people. [LAUGHS] And I currently live in a town of, like, 13,000, and I participate in a Communities That Care collaborative within my community, addressing both substance use and suicide. And we see similarly-- we have a lot of the same people around the table where we're doing a lot of talking, and sometimes that action doesn't necessarily take place.

One thing that I always stressed previously in my prior role with the state of South Dakota was really looking at that sector engagement and making sure you have the right person within that sector at the table. So we all know maybe it's not the head chief of police, for example. Maybe it's the community resource officer instead who would be more apt to help with some solutions instead.

So making sure-- that's just one example. Making sure that even though in those sectors you might go to that top person, it might not always be that top person that has the time to provide the commitment to the work that needs to be done.

And then the other thing I always emphasized was giving your members a role and making sure you're involving them in the work. A lot of times, I would see historically that coalition meetings just got to be reporting out, this is what I'm doing [LAUGHS] and not, how are we working together for the best of the community? And so making sure we're involving those individuals, those sectors within the work, and giving them work to do within that if they can and have the time. So Alex, I don't know if you have anything to add.

ALEX KARYDI: No that was really good. And I worked for a long time in South Carolina, and mostly in the rural communities. And one of the things, when I used to go to those meetings as their-- because I used to be the Suicide Prevention Lead for the state of South Carolina.

So I'd often show up to smaller communities that were doing really important work and really cared very much about their communities, because they were born and raised there, and they cared about the next generation. And I mean, there was a lot of love there.

But sometimes as an outsider, I needed to remind them that they needed to be organized, right? So you can't really-- it's not enough to have good ideas. You actually have to have a plan, right?

I used to do a lot of therapy with vets, and they used to tell me-- they're like, ideas are great, but they're dreams. Without a plan, you don't have anything.

So when I would sit after those communities, I'm like, we need a strategic plan. And basically, my role was to teach them how to create a strategic plan. Like, who's going to do what, when, how?

And really define those roles, because it can become very much like a therapy session. We get angry. We get passionate. We get upset and we get stuck in the problem like you were sharing, Melissa. So I think it's very important to remind people that that's something that can happen when you're in a group, and to really stay focused on a strategic plan.

And there's lots of wonderful tools. I mean, you can definitely reach out to SPRC. We have tools available to help you create strategic plans around these issues. So that's just something I would add, is just reminding people, ideas are great, but without the steps, you're not doing anything.

ERIN FICKER: That's great, Alex. Thank you. I think that's a really good point that strategic planning can help continue to move things forward. And Melissa just had a follow-up to say she does feel like being new to the work that she's really getting good at asking questions, but hasn't seen much change yet. And I love that yet at the end of your question or comment.

ALEX KARYDI: I think that's fair. I mean, I think that's fair in all communities. I mean, I grew up and lived in Africa, and I was doing HIV work at the time when I was in South Africa. And we'd have the same issue. We're like, why is nobody doing anything? Why are we talking about the same thing over and over again? And often it's, we all care, we just forget to make the steps. [LAUGHS]

JANA BOOCOCK: Yeah. I just want to add, because Alex, that was fantastic, bringing up the strategic plan too was when you have those steps in place and you say-- we outline this is what we're going to do and those impacts that you're hoping to see. When people maybe come up with those ideas of, we need to host a drug-free, alcohol-free dance for our youth, you can say, well, that's a great idea, but it's not on our strategic plan. And so we've got to go back to what we know is going to be kind of shown and proven to work.

And then that yet just being that prevention is a long-term process, right? And remembering that, that that investment takes time to see. And I know it's such a hard ask to ask people, like, oh, we don't have those outcomes or we can't show those things yet. But that strategic plan will then help you kind of develop and show those outputs, right? So yeah.

ERIN FICKER: Great. Thank you so much. Those strategic plans are so helpful in keeping us focused, keeping things moving. Great points. Thank

you guys, both. So someone asked about the program in Arizona, and if there was any links or information that you could provide about that program.

ALEX KARYDI: I'll put it in the chat. I have the direct link. So I'll put it the chat, and you can click on it. And yeah. And there's even contact information if you want to contact somebody about it.

ERIN FICKER: Oh, wonderful. Thank you so much. It does sound like a very cool program. Great. So the next question is so tips for us that aren't in rural communities, but there is one main coalition that communicates for everything, but aren't forthcoming with you because you are in prevention. Hmm. Yet, there is no prevention in your direct county, and everything else is focused on counties around you. It's weird, but it's real.

Jacqueline, I'm going to just identify you. That's a lot. It sounds like there's a lot happening around you, but not happening directly in your county. So if you want to expand on that at all in the chat, feel free to do that. Otherwise, I'm going to turn it over to our panelists-- or our presenters today to answer that tips for those folks who are in that situation.

ALEX KARYDI: I hope I'm understanding this right, Jacqueline, and please correct me if I'm wrong. But this is where I think data plays a big role for me. So when I work with communities, whether they're rural or not, the first thing I want to know is, how are they making decisions? How are you making decisions on who you're targeting and how?

And if they're not bringing up numbers, that worries me, right? So I'm always like-- because if they're going to other counties, I would want to know, how did you decide that those counties are the ones you need to go to? Because maybe they have very valid reasons, like if they pull up the data and they're like, well, look at this, right? It's like, oh. That makes complete sense.

But also, if your county is not on this list of high-risk counties, maybe your county's doing something interesting, or different, or healthy, or good. And I would want to learn from those gaps as well.

So this is where I think when we are working collaboratively with people, it's interesting-- or coalitions in particular, coalitions have so much power to bring people at the table and make them accountable for who they represent and how. And the glue for me is always the data, right?

We're all here. We all have a set vision or mission that we want to do as a coalition. And how we make decisions should be very much driven by the collective information that we share and data that we share. And that explains why we go after X, Y, an Z in our community.

So I say all that, and yet we're human, and dysfunction lives in humans, in groups and all that. And I don't know. Maybe Jana and Erin have different

ways. I tend to be somebody that calls out the dysfunction [LAUGHS] in systems. I tend to be the person that says, hey, I don't know how we're making decisions, and I think they could be done with a lot of love, but love is not facts for me. It's a feeling, and I need data.

So can I take a bit of your passion and your love for your community, add it to data so I know where you're going and how you're going with it? But I don't know what you all think. [LAUGHS]

ERIN FICKER: Jacqueline says that's good. And I totally agree. I think that's wonderful to be someone who can call out a community and be-- we say sometimes in substance misuse prevention, pleasantly persistent and persistently pleasant. Please, the data would be helpful. The data. And continuing to ask for that to make sure that you're grounded is smart. Do you have anything to add, Jana?

JANA BOOCOCK: Not much. I think Alex did a really great job of explaining that. I would just say too, just going back to relationship building is probably another significant thing. And then maybe you'll have that opportunity to ask some of those more pointed questions too with Alex by establishing that kind of relationship with that individual.

And having that shared common understanding and a shared goal I think is important too. So yeah. Not much to add, but I think Alex did great. [LAUGHS]

ERIN FICKER: That's a great point, is that the stronger the relationship is, the more likely you are to be able to have those conversations and be really frank and direct. So it all I think always comes back to relationship building and having strong relationships with your partner. So that was a good addition. Thank you, Jana.

I don't have any other questions in the Q&A at the moment. Are there any other questions before I move on? I'm not seeing any. I will move on and turn it over to Alex to tell us a little bit about the Suicide Prevention Resource Center.

ALEX KARYDI: One of the best places--

[LAUGHTER]

--on the internet. Yes, if you have any kind of questions, thoughts, ideas, or you are curious, please visit the Suicide Prevention Resource Center. We are the only federally funded technical assistance center for suicide prevention, and we serve all states or territories in all communities from faith-based schools to universities to workplace.

We're basically an environment where you can come and find other tools, resources, information, knowledge, articles. But you also have access to all of

us, and we are happy to answer questions or connect you to your state leads. So every state and territory has a designated person or group of people in some places. Not all places, unfortunately. Usually it's just one human [LAUGHS] that's doing suicide prevention work.

And if you go on our website, you can find out in your state who is doing that work. Also, what kind of funding they have, because we also publish what grants they currently have and they're working on with SAMHSA, and also other organizations that they might be connected to.

The other nice thing that you could do is when you go to the state and you see who the leaders, you can also see what your state's suicide prevention plan is. And is there substance misuse programming that's been embedded into your suicide prevention state plan? And what does that look like, and what role could you play in it? Because everybody plays a role in suicide prevention. All of us do.

And so there is always opportunity for us to expand, challenge, and grow in our systems and how we do this work. I don't know, Jana. Anything you'd like to add?

JANA BOOCOCK: No. I don't think so.

ALEX KARYDI: No? I don't think I ever do that good of a job, but--

[LAUGHTER]

ERIN FICKER: There is a question about, are there any printed materials like pamphlets or so on for youth that SPRC or the Suicide Prevention Resource Center provides that people could get?

ALEX KARYDI: Yes. If you go to our website, we actually also have by population what information's available. And everything is free to download and print. You shouldn't have a problem finding anything. But again, please contact us if there's anything specific that you're looking for, because we can always, again, connect you to your state lead that would have state-specific materials or connections to youth information that you might want.

ERIN FICKER: Great. Thank you. Yes, the Suicide Prevention Resource Center is a wealth of information and truly one of the best resources out there on the internet. With that, I wanted to share this next slide. And Jana, were you going to take this one?

JANA BOOCOCK: No?

ERIN FICKER: Oh, I will then. [LAUGHS] The other piece I wanted-- I'm sorry. The other piece I want to direct your attention to is on PS collaboration or Prevention Solutions collaboration at edc.org. And this is a really amazing

resource called the Collaboration Toolkit or Prevention Collaboration in Action.

It has all the information you could ever need, including examples, stories, and kind of walks you through the process of how to build collaboration and how to build partnerships. So this tool is absolutely rich with tools that you can use in your prevention work, whether it's substance misuse prevention or other prevention work, and how you can connect with the right partners.

So hopefully, you can find this. There are slides available that Rebecca just put in there. And if we could, Rebecca, also maybe put a link to the SPRC website as well as to the Collaboration Toolkit website, that would be great. There's the Collaboration Toolkit link from Melissa in the chat. And we'll get you the SPRC link as well. But I wanted to just let you know that this is a resource that I find incredibly useful, specifically as we get into-- when you get into building partnerships.

We do have another question that I want to take a minute to address, which is from one of our participants. Would you have information on how to change or create policies on underage drinking if there currently isn't a policy in a rural tribal community? Oh, that's a great question. Before I dive into that, Jana, [LAUGHS] do you have any thoughts from your experience in South Dakota?

JANA BOOCOCK: I'm kind of blanking, so if you've got something, I'll definitely turn over to you right now.

ERIN FICKER: Sure. I think we have a lot of-- we're doing some upcoming webinars this year on underage alcohol policy and underage drinking. It's more difficult to get specific information about rural and tribal communities, but if you want to reach out to us, we can see if we can connect you with someone who has more information on specifically tribal communities and has information on building that.

You can also reach out to the-- there's a national PTTC center that focuses on American Indian and Alaska Native communities, and they may have resources that could be useful to you. So hopefully, we could get a link to the American Indian Native Alaskan PTTC in the chat if we are able to pull that up quickly. Thank you so much, Chris. So they may have information for you there. OK. If there aren't any other questions-- oh, it looks like I have one more OK. Nope. Not a curveball at all. Not at all.

OK. So moving on, that was our presentation for today, and we really appreciate your participation and your questions, which made it richer. So much to absorb, so you will receive the slides. And there will be a recording posted to our page.

You can always stay current on new resources and upcoming events in the Great Lakes PTTC by going to our Facebook page. And like Chris mentioned

in the chat there, we will be hosting a three-session training series on alcohol policy in September and October, so keep your eye out for those.

Our Great Lakes PTTC page-- our Facebook page looks something like this. We do encourage you to follow it and the like it so you get updates. We often after an event will post questions and ask people to chime in and to share information and experiences with the rest of the community that participates on that Facebook page. I've found it to be really useful.

We do have some upcoming webinars that I wanted to share with you. There is an upcoming webinar on June 23 on risk factors for youth substance misuse. We have a substance misuse prevention series that we're going to continue. June will focus on problem gambling and July will focus on mental health promotion, both big topics that have big overlap with substance misuse. So we'll be talking about the prevention there.

I encourage you to go to our-- excuse me-- to our Events link here at the bottom. And that'll take you to all of our events. There are a number of other events coming up over the summer that you may find interesting.

And we as always would love your feedback. We take our improvement very seriously. So if you could take a moment to complete the post-training feedback, you can either follow the link that was just put in the chat. Also, when you leave the webinar, it'll take you directly to that page.

Or you can use that QR code. Just point your phone to it, and it'll take you directly there. But you will be redirected at the end of the webinar as well to that. And we do take that feedback really seriously and do take it to heart and try to improve our webinars. Any last questions before we move on about upcoming events, about the PTTC, or about for our presenters today and about the nexus of suicide and substance misuse?

If there aren't any last questions-- I'm seeing a lot of thank you's. Thank you all so much for being here. We couldn't be happier to have spent this time with you. Thanks so much.